Review Body on Doctors' and Dentists' Remuneration

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Forty-First Report 2013

Chair: Ron Amy OBE

Cm 8577

£38.75

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

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

Presented to the National Assembly for Wales by the
First Minister and the Minister for Health and Social Services

Presented to the Northern Ireland Assembly by the First Minister,
Deputy First Minister and Minister for Health, Social Services
and Public Safety

March 2013

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Review Body on Doctors' and Dentists' Remuneration

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

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

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

the need to recruit, retain and motivate doctors and dentists;

regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;

the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;

the Government's inflation target;

the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

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

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

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

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

Members of the Review Body are:

Ron Amy, OBE *(Chair)*
Lucinda Bolton
Mark Butler[1]
John Glennie, OBE
Professor Steve Thompson
Nigel Turner, OBE[2]
Professor Ian Walker
David Williamson

The Secretariat is provided by the Office of Manpower Economics.

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[1] Mark Butler was appointed to the Review Body by the Secretary of State for Health from 1 April 2012.

[2] Nigel Turner OBE was appointed to the Review Body by the Secretary of State for Health from 1 April 2012.

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Terms of reference and the remits

This year, our terms of reference remain unchanged, but the specific remits and public sector pay policies for the 2013-14 pay round vary across the United Kingdom. Chapter 1 gives details of these differences, but the final position reached after lengthy correspondence is that we are making recommendations on all salaried doctors and dentists, all independent contractor general medical practitioners (GMPs) and independent contractor general dental practitioners (GDPs) in Scotland.

While we accept that the parties are free to negotiate directly, if that is their preferred option, we believe that the Review Body process and the interest of all parties concerned is best served when we are able to fulfil our terms of reference without any constraints being placed upon us. **We urge the governments to give us unrestricted remits in future, so that the parties' trust and confidence in the independent Review Body process is maintained.**

Remit groups and the evidence

In this report, we make recommendations for the annual pay increases for 2013-14. Our remit groups have increased by around 1.9 per cent since last year and now cover around 207,000 doctors and dentists comprising approximately: 48,000 consultants; 19,000 specialty doctors, associate specialists, staff grades and others; 64,000 doctors and dentists in training; 48,000 GMPs; 28,000 GDPs; and 380 ophthalmic medical practitioners. We have considered written and oral evidence from: the Health Departments for England, Wales, Scotland and Northern Ireland; NHS Employers; the Foundation Trust Network; the Advisory Committee on Distinction Awards; the Scottish Advisory Committee on Distinction Awards; the British Medical Association (BMA); the British Dental Association (BDA); the BDA Scottish Dental Practice Committee; and Healthcare Audit Consultants.

Conclusions and recommendations

In making our recommendations for this pay round, we have been mindful of our standing terms of reference as well as the governments' public sector pay policies. We have noted the Chancellor's announcement in the *Autumn Statement* for 2011 that public sector pay awards would average 1 per cent for the two years following the pay freeze and the subsequent letter from the Chief Secretary to the Treasury describing the United Kingdom government's public sector pay policy for 2013-14 limiting uplifts to an average of 1 per cent. We have also noted the letters from the Department of Health and the devolved administrations outlining the application of the 1 per cent pay policy cap to our remit groups.

As in previous years, we have considered the usual range of economic and labour market evidence, as well as that provided by the parties. In our view, the parties' evidence for this round has been reduced in its scope and quality; this may or may not have been in response to the context provided by governments' pay policies and changing responsibilities for providing evidence. The absence of satisfactory evidence on a number of fronts has limited our ability to exercise our judgement to fulfil our terms of reference and consider a full range of options: some evidence was sparse or did not address all parts of our remit groups; some of the data, for example on pay costs, was too general and applied to the whole NHS rather than being specific to our remit groups; and there was an absence of robust statistics on vacancies.

We would like to pursue the motivation strand of our remit with more rigour, in particular the link between motivation and reward. Given the recent organisational changes within the NHS, the two-year pay freeze, changes to pension arrangements and quality issues referred to in the Francis report, we think that this is now the right time for the parties to work with us, before the next round, to consider ways of gathering more meaningful evidence.

Doctors and dentists have been subject to a pay freeze for two years, in common with much of the rest of the public sector; indeed, consultants and independent contractor GMPs and GDPs have had three years of frozen pay, and may now have expectations of a return to the established norm of annual pay reviews. We also note that pay settlements in the wider economy have picked up in the last two years during the public sector pay freeze, to around 2.6 per cent in the private sector during 2012, that the median settlement in the public sector was 0.7 per cent in the 12 months ending December 2012, and that the available data show that the earnings position of our remit groups has deteriorated relative to comparator professions. The latest staff survey data for England show a decline in the percentage of doctors and dentists reporting satisfaction with their pay, with the exception of those in training, and an increase in reported dissatisfaction, following a period when satisfaction had increased year on year. We believe that there is a need to maintain the motivation of doctors and dentists to address quality and care issues and help bring about the many proposed changes in the NHS, noting the comment from the BMA that doctors have made significant contributions to the overall performance of the NHS. A 1 per cent award is the minimum sought by the BMA and the BDA. The factors above would provide support for a reasonable increase in basic pay.

In contrast, we note the evidence we received on the financial situation in the NHS. Although we understand that financial provision has been made for a 1 per cent pay uplift, employers also have to make substantial efficiency savings. We are conscious that in oral evidence the Department of Health encouraged us towards making a recommendation for no uplift, and that zero is what NHS Employers and the Foundation Trust Network would prefer. Though there is a continuing lack of vacancy data for England, we are assured that the recruitment and retention situation for our remit groups in general remains healthy; indeed, staff numbers have continued to rise, despite budgetary constraints. We are also mindful of the expectations raised by the announcement in the Chancellor's *Autumn Statement* in 2011, of an average 1 per cent pay uplift for public sector workers following the pay freeze. These factors provide support for either no increase or a modest increase in pay. However, we believe that a zero uplift, in the light of these expectations, could be demotivating.

Weighing all these factors, our judgement is that there should be an increase of 1 per cent in basic pay for our remit groups.

The Chief Secretary to the Treasury suggested that we might want to consider the level of progression pay and the potential for payments to be more generous for certain groups of staff. We have considered this carefully. With regard to progression pay, we are not persuaded by the argument that many in the workforce will receive increments, as we know that there are many who will not. Furthermore, increments are contractual. We do need to know the cost of pay progression so that we can engage in the issue of its affordability, but the Health Departments were unable to provide data on the cost of increments for doctors and dentists. We have considered the possibility of focusing our award on those salaried doctors and dentists not in receipt of increments, but we do not think that this would be appropriate as it could distort pay scales. We have also considered whether payments should be more generous for some groups of staff. All of the parties said that they did not want a differential award. In the absence of any evidence to the contrary, we are recommending that the 1 per cent increase should apply across the board.

We have also given thought to the public sector pay policy of the Scottish Government, which placed a 1 per cent cap on the cost of the increase in basic pay for staff earning under £80,000; whilst maintaining a pay freeze (zero per cent basic award) for staff earning £80,000 and above. We are not persuaded that our evidence base would support such a recommendation in line with this policy, on either a United Kingdom basis or a Scotland only basis. We note, however, that the Scottish public sector pay policy has been drawn up to take account of the whole of its public sector, and is partly intended to favour those public sector workers who earn £21,000 or less. Our evidence base is, by definition, not concerned with such staff, as all doctors and dentists earn more than £21,000 on a full-time equivalent basis. We are also mindful that it

would be difficult to apply this pay policy to independent contractor GMPs and GDPs because it is not known whether or not individual practitioners' income falls above or below the £80,000 threshold.

Having considered carefully all the evidence, we have concluded that the most appropriate uplift for 2013-14 is 1 per cent on basic pay, across the board. We therefore **recommend for 2013-14 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists**. We consider that it is for the Scottish Government to determine how to apply our recommendations within the context of its public sector pay policy. Although the Northern Ireland Executive did not require us to make recommendations, we note that our proposed increase of 1 per cent is in line with its intended uplift.

We make a separate recommendation for salaried GMPs whose pay falls within a salary range rather than an incremental pay scale. **We recommend that the minimum and maximum of the salary range for salaried general medical practitioners be increased by 1 per cent for 2013-14.**

For independent contractor general medical practitioners, we recommend that the overall value of General Medical Services contract payments be increased by a factor intended to result in an increase of 1 per cent to general medical practitioners' net income after allowing for movement in their expenses. Using our formula, we recommend that an uplift of 2.29 per cent be applied to the overall value of General Medical Service contract payments for 2013-14 for general medical practitioners.

For independent contractor general dental practitioners in Scotland, we recommend that the overall value of item-of-service fees be increased by a factor intended to result in an increase of 1 per cent to general dental practitioners' net income after allowing for movement in their expenses. Using our formula, we recommend that an uplift of 1.49 per cent be applied to item-of-service fees in Scotland in 2013-14. This increase should be compounded with the outstanding uplifts for 2011-12 and 2012-13.

We make the following observation on the GMP trainers' grant. In view of the ongoing delay in reviewing the general medical practitioner trainers' grant, we believe strongly that the grant should be uplifted by the same amount as basic pay, which for 2013-14 would represent an increase of 1 per cent.

RON AMY, OBE *(Chair)*
LUCINDA BOLTON
MARK BUTLER
JOHN GLENNIE, OBE
PROFESSOR STEVE THOMPSON
NIGEL TURNER, OBE
PROFESSOR IAN WALKER
DAVID WILLIAMSON

OFFICE OF MANPOWER ECONOMICS
25 February 2013

Part I: Overview

CHAPTER 1: INTRODUCTION

Structure of the report

1.1 We have divided the report into nine chapters, comprising: this introduction; a chapter covering economic and general considerations; a chapter on each of the following remit groups: general medical practitioners (GMPs), general dental practitioners (GDPs), salaried dentists, doctors and dentists in hospital training, consultants, and specialty doctors and associate specialists (SAS); and finally a chapter with our main pay recommendations. The remit letters from the parties are at Appendix A. Correspondence about the role of the public sector Pay Review Bodies is at Appendix B. The detailed pay scales which result from our recommendations are set out in the green pages at Appendix C. There are tables showing the number of doctors and dentists in the NHS in the United Kingdom in Appendix D. Links to the evidence on the parties' websites are in Appendix E. Appendix F covers pay comparability by anchor point. There is a list of our previous reports in Appendix G. Appendix H contains a glossary of terms and Appendix I provides a list of abbreviations and acronyms used in the report. We have not included a chapter on ophthalmic medical practitioners as the recommendation in our *Thirty-Sixth Report* covered future years.[1]

1.2 We set out the overall context for our review in this introductory chapter, including the essential facts about our remit groups and how we have collected evidence. The chapters for each remit group discuss some of these matters in more detail. Our terms of reference are set out at the beginning of this report.[2]

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

Remit groups

1.4 Our remit groups this year comprise 206,580 doctors and dentists, a 1.9 per cent increase on the previous year. The breakdown by group is given in Table 1.1. Further details are given at Appendix D.

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

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

Table 1.1: DDRB remit groups at September 2011[1] and change since September 2010, United Kingdom

	Staff as at September 2011		Change since September 2010 (%)	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Consultants[2]	45,059	47,727	3.2	3.5
Associate specialists/staff grades/specialty doctors	10,903	13,046	2.3	3.1
Registrar group	45,280	46,389	2.2	2.8
Foundation house officer 1 and 2	16,967	17,265	0.2	0.8
Other staff[3]	2,597	5,586	-4.1	-5.0
Total Hospital and Community Health Services[4]	120,806	129,717	2.1	2.4
General medical practitioners[5]	*	48,151	*	0.9
General dental practitioners[6]	*	28,332	*	1.3
Ophthalmic medical practitioners	*	380	*	-3.1
Total[4]	*	206,580	*	1.9

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

Notes:

* Data not available.

[1] Some data are not for September 2011, but are for the closest time period available.

[2] The grade of consultant also includes Directors of Public Health.

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

[4] Total is not exactly the sum of the categories as some doctors carry out more than one role.

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

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

1.5 Table 1.2 below gives an outline of the status of the contracts for each remit group and any changes are described more fully in the relevant chapters.

Table 1.2: Status of contracts for each of our remit groups

General medical practitioners	General Medical Services contract across United Kingdom from 1 April 2004. Other contracts, on which we do not make recommendations for the uplift, include: Personal Medical Services in England; Section 17C arrangements in Scotland; Alternative Providers of Medical Services; and Primary Care Trust Medical Services.
General dental practitioners	Contract from 1 April 2006 – England and Wales (slight variations in each country). Negotiations in progress in Northern Ireland. Pilots for new contract underway or planned in England, Wales and Northern Ireland. Scotland and Northern Ireland still on an item-of-service fee scale.
Salaried dentists	Contract in England and Wales from 1 June 2007; new contracts forthcoming in Scotland and Northern Ireland. Pilot contracts underway in England.
Doctors and dentists in training	Contract from December 2000. New contractual arrangements under consideration following publication of NHS Employers scoping study,[3] December 2012.
Consultants	Contract from October 2003 – contract differs in each of the four countries. Fewer than 10 per cent of consultants in each of England, Scotland and Northern Ireland remain on the pre-2003 contract; all consultants in Wales are on the 2003 contract. New contractual arrangements under consideration.
Specialty doctors and associate specialists	Contract from 1 April 2008 with minor differences in each of the devolved countries. The associate specialist grade was closed to new entrants from 31 March 2008.

1.6 A new contract for doctors and dentists in training is being discussed by the parties as the current contract is considered by NHS Employers to be "not suitable".[4] The government is also seeking changes to the consultant contract, partly as a result of the recommendations in our *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*,[5] but also for other reasons such as to support seven day working in the NHS.[6] We address these contractual developments in the relevant chapters. In addition, in December 2012, the National Audit Office published its study of how far the expected benefits of the consultant

[3] NHS Employers. *Scoping report on the contract for doctors in training – June 2011.* NHS Employers, December 2012. Available from: https://www.wp.dh.gov.uk/publications/files/2012/12/FINAL-PDF-revised-for-DH.pdf

[4] NHS Employers. *Scoping report on the contract for doctors in training – June 2011.* NHS Employers, December 2012. Paragraph 1.6. Available from: https://www.wp.dh.gov.uk/publications/files/2012/12/FINAL-PDF-revised-for-DH.pdf

[5] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[6] Department of Health. Written Ministerial Statement: review of awards for NHS consultants and publication of NHS Employers report on junior doctors' contracts. *Hansard,* 17 December 2012, column 74WS-76WS. Available from: http://www.parliament.uk/documents/commons-vote-office/December_2012/17-12-12/8.HEALTH-Review-awards-NHS-consultants.pdf

contract have been realised.[7] We look at this in more depth in Chapter 7. As before, we have approached the round on the basis of what has been agreed between the parties. While the terms of the contracts are outside our remit, we offer comment throughout the report on those elements of the contracts that we believe affect aspects of our remit.

1.7 Revalidation came into force across the United Kingdom on 3 December 2012; the process is overseen by the General Medical Council. Doctors are now legally required to show that they are keeping up to date and are fit to practise. Regular appraisals will be a requirement in order to remain licensed as a doctor. Further information on revalidation is contained in the glossary at Appendix H.

The devolved countries

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

The remits

1.9 This year, the remits for our review vary across the United Kingdom. The relevant letters can be seen in Appendix A. The guidance for this round was set by a letter from the Chief Secretary to the Treasury, dated 16 July 2012, which noted the need for continued pay restraint across the public sector. It said that the government would limit uplifts to an average of 1 per cent in each workforce and that we should focus on considering how the 1 per cent should be divided within the remit groups. The letter suggested that we might additionally want to consider the level of progression pay provided to the workforce and the potential for payments to be more generous for certain groups of staff. It said that the 1 per cent average uplift should be applied to basic salary based on the normal interpretation of basic salary in each workforce and did not include overtime or any regular payments such as London weighting, recruitment and retention premia or other allowances.

1.10 We also received a number of letters from the Department of Health and each of the devolved administrations setting out their individual interpretations of the remit.

1.11 The letter from the then Secretary of State for Health, Andrew Lansley, dated 3 July 2012, predated the letter from the Chief Secretary to the Treasury. It noted that public sector pay increases would be capped at an average of 1 per cent but that there would not be any requirement for us to make recommendations on independent contractor GMPs or GDPs for 2013-14 in England. For both groups, the Department of Health would make final decisions on the overall gross uplifts to contract prices needed to deliver a 1 per cent increase in net income after allowing for expenses, taking into account discussions with the British Medical Association (BMA) and British Dental Association (BDA) about quality and efficiency gains.

1.12 On 23 October 2012, a letter was received from the current Secretary of State for Health, Jeremy Hunt; it stated that subsequent developments had led to the potential need for us to make recommendations on the uplift for the General Medical Services (GMS) contracts in England for 2013-14. The letter stated that negotiators had not yet been able to agree the changes in the contract required by the government in return for a 1.5 per cent uplift in GMP practice income, intended to provide an average 1 per cent uplift in net income.

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[7] National Audit Office. *Managing NHS hospital consultants.* Report by the Comptroller and Auditor General. HC 885. Session 2012-13. 6 February 2013. TSO, 2013. Available from: http://www.nao.org.uk/publications/1213/nhs_hospital_consultants.aspx?utm_source=GovDelivery&utm_medium=email&utm_campaign=naoorguk

1.13 Andrew Lansley's letter stated that while our remit covered the whole of the United Kingdom, it was for the individual devolved administrations to make their own decisions on their approach to the pay round and to communicate this to us.

1.14 The remit letters from the Minister for Health and Social Services in the Welsh Government, dated 8 August 2012 and 12 September 2012, stated that we were not required to make recommendations on pay and expense uplifts for 2013-14 for independent contractor GMPs and GDPs. Other increases would be capped at an average of 1 per cent as per the United Kingdom government public sector pay policy. A follow-up letter on 9 January 2013 informed us that agreement had not yet been reached with the BMA and drew to our attention the need to make a recommendation on the uplift to the GMS contract for 2013-14. A further letter on 7 February 2013 recorded the agreement that had been reached with the BMA for an increase in the current levels of investment in general practice of 1.5 per cent, but that the Welsh Government would be mindful of our recommendations on pay and expenses should they be in excess of 1.5 per cent.

1.15 The remit letter from the Cabinet Secretary for Health and Wellbeing in the Scottish Government, dated 11 October 2012, asked that we use the key features of the Scottish Government public sector pay policy for 2013-14 as our remit for considering the pay uplift for doctors and dentists in Scotland. Features of the pay policy of particular relevance to our remit groups are: a 1 per cent cap on the cost of the increase in basic pay for staff earning under £80,000; and a pay freeze to apply to all staff earning £80,000 and over. It said that no pay recommendations were sought from us for either medical and dental staff earning £80,000 and over or independent contractor GMPs and GDPs. In January 2013, supplementary evidence from the Scottish Government reported that agreement had been reached with the BMA on elements of change to the GMS contract in Scotland for 2013-14, but that a recommendation on an uplift to the value of the contract was sought.

1.16 The remit letter from the Minister for Health, Social Services and Public Safety of the Northern Ireland Executive, dated 25 September 2012, said that we were not required to make any recommendations on uplifts. It said that increases for salaried doctors and dentists would be limited to an average of 1 per cent as per the United Kingdom government public sector pay policy; the Minister would decide the uplift for independent contractor GMPs and had already agreed to an increase of 0.5 per cent to the expenses element of the *Statement of Dental Remuneration* for independent contractor GDPs. We subsequently established that the 0.5 per cent increase related to 2012-13 and that no decision had been taken on 2013-14. However, in the remit letter, the Minister requested a review of earnings and expenses for dentists in Northern Ireland, similar to that carried out by us last year for Scotland, for proposed implementation in 2014-15. We will carry out this work for our next report, which will make recommendations for 2014-15. Follow-up letters on 29 October 2012 and 30 January 2013 informed us of the need to make recommendations on the uplift for GMS contracts in Northern Ireland for 2013-14.

1.17 Until we received the letter from the Secretary of State for Health on 23 October 2012, the four administrations of the United Kingdom were in agreement that they did not require us to make recommendations on the uplift for independent contractor GMPs; however, the BMA disagreed. The Chair of Council wrote to us on 30 August 2012 and said that the BMA intended to submit full evidence on GMPs, noting that it wished us to revisit the expenses formula used for GMP contractors to ensure that it was fit for purpose. The BMA said that it did not consider that the Department of Health was able to change unilaterally our remit and that it expected us to make recommendations in the usual way.

1.18 Both the BMA and NHS Employers updated us during November 2012 on the GMS contract negotiations. The BMA made it clear that it saw no point in discussing what it perceived as a "predetermined outcome", but NHS Employers told us that they did not believe that negotiations had moved sufficiently to a position that would prove acceptable to the four Health Departments.

1.19 Finally, the covering letter for the BDA evidence, dated 12 October 2012, stated that the BDA would welcome our independent scrutiny and assessment of the contract value uplift for England and Wales, based on its submission to the Department of Health and Welsh Government. The BDA told us that its request would be satisfied by our consideration of its evidence on recruitment, retention and motivation of dentists, and of changes in dentists' earnings and expenses in England and Wales. It also told us that, having since seen the remit letters from Scotland and Northern Ireland, it was content to negotiate an uplift with all four administrations. However, evidence received subsequently from the BDA Scottish Dental Practice Committee in November 2012 sought a recommendation from us for independent contractor GDPs in Scotland in the absence of negotiations between the Scottish Government and the BDA Scottish Dental Practice Committee.

1.20 In making our recommendations for this pay round, we have been mindful of our standing terms of reference[8] as well as government public sector pay policy. We have noted the letter from the Chief Secretary to the Treasury describing the government's public sector pay policy for 2013-14, and the announcements in the *Autumn Statement* for 2011 that public sector pay awards would average 1 per cent for the two years following the pay freeze. We have also noted the letters from the Department of Health and the devolved administrations outlining the application of the 1 per cent pay policy cap to our remit groups. These letters are described in the preceding paragraphs and shown in Appendix A.

The evidence

1.21 We received written evidence from: the Health Departments, comprising the English Department of Health, the Welsh Government, the Scottish Government Health and Social Care Directorates and the Northern Ireland Executive Department of Health, Social Services and Public Safety; NHS Employers; the Foundation Trust Network; the Advisory Committee on Clinical Excellence Awards (ACCEA); the Scottish Advisory Committee on Distinction Awards (SACDA); the BMA; the BDA; the BDA Scottish Dental Practice Committee; and Healthcare Audit Consultants. The parties provided supplementary written evidence in response to other parties' evidence and to our requests.

1.22 In addition, we heard oral evidence from: Dr Dan Poulter, Parliamentary Under Secretary of State; the Department of Health; the Welsh Government; Alex Neil MSP, Cabinet Secretary for Health and Wellbeing; the Scottish Government; the Northern Ireland Executive; NHS Employers; the Foundation Trust Network; the BMA; and the BDA Scottish Dental Practice Committee. Oral evidence is an important part of our review process as it enables us to inform our views by following up and discussing issues that have arisen in the evidence and elsewhere.

1.23 We are grateful to the parties for their time and effort in preparing and presenting evidence to us and for the speed with which they have responded to our questions. However, we urge the parties to meet the deadlines that we set for the submission of evidence. We work to a very tight timetable, which was disrupted this year because of delays in receiving evidence.

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[8] Our terms of reference can be found at the beginning of this report.

1.24 In our view, the parties' evidence for this round has been reduced in its scope and quality; this may or may not have been in response to the context provided by governments' pay policies and changing responsibilities for providing evidence. The absence of satisfactory evidence on a number of fronts has limited our ability to exercise our judgement to fulfil our terms of reference and consider a full range of options: some evidence was sparse or did not address all parts of our remit groups; some of the data, for example on pay costs, was too general and applied to the whole NHS rather than being specific to our remit groups; and there was an absence of robust statistics on vacancies. We have identified a number of evidence requirements for our next review, which are summarised at the end of each chapter.

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

1.26 Changes in the structure of the NHS in England have led to the creation of new bodies and there have been changes for this round in the way that the Department of Health presented evidence to us. We had a useful presentation from the Centre for Workforce Intelligence and hope that next year the Centre for Workforce Intelligence, Health Education England, and the NHS Commissioning Board will also submit evidence to us, as appropriate. Where there are corresponding bodies in the devolved countries, we ask the devolved administrations to ensure that we are provided with the appropriate evidence.

1.27 We were disappointed that the Dental Professionals Association again declined to provide us with evidence.

Visits

1.28 Each year we carry out a series of visits, usually over the early summer. In 2012, we visited acute trusts, health boards and primary care organisations across the United Kingdom to meet representatives of both management and of the doctors and dentists to whom our recommendations apply, and were pleased that our visits attracted a large number of attendees. Unfortunately, we made no visit to Scotland in 2012 as our proposed visit was cancelled at the request of the host organisation; one of our proposed visits within England was also cancelled at the request of the primary care trust. If possible, we intend to reschedule these visits for the 2013 visit programme.

1.29 These visits do not form an official part of our evidence gathering, as the evidence is mainly anecdotal, but they are valuable in informing our views, particularly on motivation and morale, and we are grateful to those we meet for their time and the frank opinions expressed, which we find helpful.

The role of the Review Body

1.30 We have become increasingly concerned about the impact of the government's current approach to pay policy and the impact of this on our independence, to such an extent that our chairman, together with the other chairs of the Review Bodies, wrote a joint letter to the Chief Secretary to the Treasury in September 2012. The correspondence can be seen in Appendix B.

1.31 We believe that we can add more value, and operate with the trust and confidence of all the parties, when our reports are produced under the normal terms of reference, without specific restrictions being made by the government on the scope of our recommendations. Our terms of reference include the need to take account of recruitment, retention, motivation, affordability, the government's inflation target, and

economic and other evidence. We accept that the government has the right to reject or modify our recommendations, although we hope that in view of the independent, evidence-based nature of our work, this would not be a routine or lightly-taken decision.

1.32 We fully appreciate the exceptional circumstances that led to the government's decision to announce a two-year public sector pay freeze, and we believe that our remit groups understand this as well. We understand the government's concern about the affordability of changes to pay following the pay freeze and that a further period of pay restraint is necessary. We rely on receiving clear evidence on these issues, and the effect on recruitment, retention and motivation, which we consider carefully.

1.33 In our view, the way in which our remit has been expressed has led to our remit groups increasingly questioning our independence, and we are concerned that this puts the trust and confidence that they have in us at risk. For example, in its evidence for this review, the BMA said that it continued to value the independence of the Review Body and that it continued to disagree with the governments' instructions in relation to a cap on pay. It wished to place on record, once more, that it believed it was inappropriate to restrict the Review Body. The BMA stated that it was particularly disappointed that the government had instructed us in this way. It believed that as our remit obliged us to take account of the economic climate, it was unnecessary to impose restrictions, which limited consideration of any structural changes surrounding the pay and conditions of doctors. The BDA has also expressed disappointment in previous years at the governments' decisions requiring us not to report on contract values.

1.34 We believe that the Review Body process and the interests of the parties are best served when we are able to fulfil our terms of reference without any constraints being placed upon us. **We urge the governments to give us unrestricted remits in future, so that the parties' trust and confidence in the independent Review Body process is maintained.**

Last year's recommendations and monitoring round

1.35 Last year, which was the second year of the two-year pay freeze, we were not required to make recommendations for the majority of our remit groups, as all doctors and dentists had full-time equivalent earnings of more than £21,000 per annum and were therefore subject to the pay freeze. We did, however, continue to monitor recruitment, retention, motivation and other relevant matters for our *Fortieth Report*. We made recommendations, at the request of the Scottish Government, in relation to dental practice expenses for 2011-12 and 2012-13 for independent contractors in the General Dental Services in Scotland. The Scottish Government has not yet responded to us on these recommendations, nor implemented them, as it is consulting with the dental profession. We comment further on this in Chapter 4.

Future evidence requirements

1.36 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to meet the deadlines that we set for the submission of evidence; and
- the Centre for Workforce Intelligence, Health Education England, and the NHS Commissioning Board to submit evidence to us, as appropriate. Where there are corresponding bodies in the devolved countries, we ask the devolved administrations to ensure that we are provided with the appropriate evidence.

CHAPTER 2: ECONOMIC AND GENERAL CONSIDERATIONS

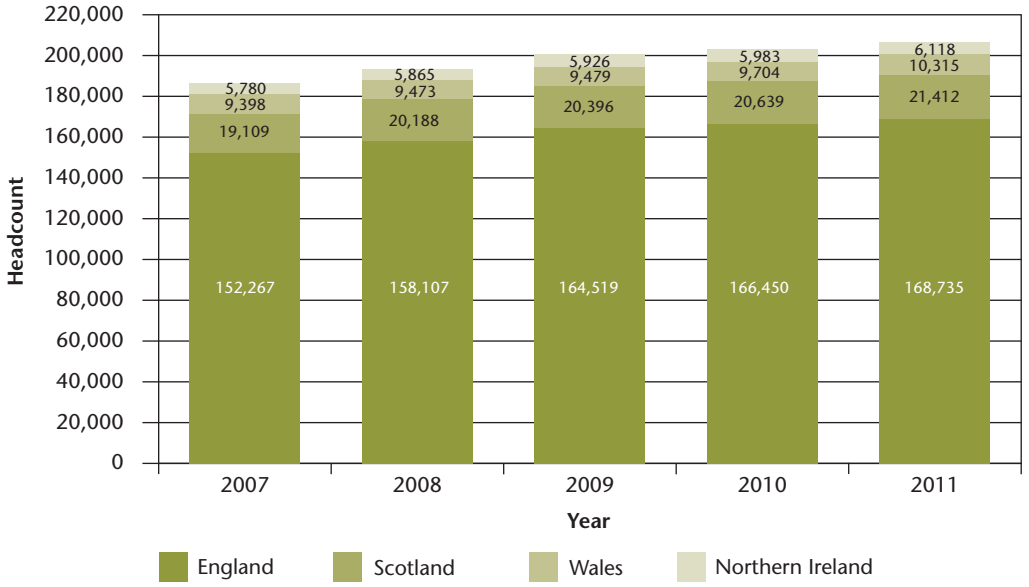
Introduction

2.1 In this chapter, we consider the current economic background and the elements of our terms of reference in a general context for the review. The chapters for each remit group discuss some of these matters in more detail.

Recruitment and retention

2.2 We are required to have regard to the need to recruit and retain doctors and dentists, and we see this as a fundamental element of our terms of reference. It also formed a significant theme in the evidence we received. Figure 2.1 below shows that the number of medical and dental staff in each of the devolved countries has increased each year between 2007 and 2011.[1] The latest data at September 2011 show that the total headcount for the United Kingdom is now 206,580, a 1.9 per cent increase on the previous year.

Figure 2.1: Total number of medical and dental staff, 2007 – 2011, United Kingdom



Note: Data from 2010 in England are not comparable with previous years.

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

2.3 With regard to vacancies in England, the Department of Health reported that while it had experienced difficulties recruiting in some specialties, notably accident and emergency, obstetrics and gynaecology, anaesthetics, paediatrics and psychology, the NHS had had no general difficulty expanding the medical workforce from 2006 to 2010. The Foundation Trust Network noted the impact of the provisions of the Working Time Directive on junior doctors causing an expansion in demand for consultants to cover the resource shortfall. NHS Employers said that recruitment and retention issues were either both locality and specialty specific or part of known labour supply problems. They argued that neither of these types of difficulty could be solved by raising national pay scales. The Foundation Trust Network concurred that there was no evidence that the minor reported

[1] Because of changes made in 2010 to the way in which headcount staff in Hospital and Community Health Services are counted in England – effectively removing instances of double counting – data from 2010 are not comparable with previous years. This does not affect full-time equivalent data or primary care, or other United Kingdom countries.

recruitment and retention problems for doctors and dentists stemmed from pay levels rather than the training pathway outputs. NHS Employers stressed that there was no evidence from employers that any increase in the national scales was necessary for the recruitment and retention of staff. They made the point that in comparison with other professional jobs in the economy, doctors and dentists were in an occupation on which prevailing economic circumstances had a more limited effect since the employment and contracting of doctors and dentists was largely within the NHS. They stated that competition with the wider labour market and the wider economic circumstances were not thought by employers in the NHS to be the primary factors in the recruitment and retention of doctors and dentists.

2.4 The Welsh Government told us that there were 209 medical and dental vacancies across NHS Wales in June 2012, which amounted to just over 3 per cent of all medical and dental staff in NHS Wales and was not considered to be a "huge figure". It reported that a long-term medical campaign, *Work for Wales*, was launched on 1 February 2012, with the aim of ensuring that all doctors were made aware of the potential opportunities and benefits of working for the health service in Wales.

2.5 The Scottish Government said that the positive recruitment and retention picture in the current medical and dental workforce continued to allow health boards to meet their objectives in the provision of healthcare. Vacancy rates had remained at historically low levels over the last 12 months in Scotland, which it said reflected the value placed on job security during difficult times for the wider economy. It told us that during 2011, following evidence of hard-to-fill vacancies, the United Kingdom Border Agency had added certain paediatrics posts to the Scottish Shortage Occupation List, with effect from November 2011. We look forward to hearing in our next report whether this has eased recruitment difficulties.

2.6 The Northern Ireland Executive reported a whole-time equivalent vacancy rate of 3.5 per cent of the medical and dental workforce in March 2012.

2.7 However, the British Medical Association (BMA) told us that it continued to have concerns around recruitment and retention across all parts of the profession, particularly junior doctors and medical students. It had tested the subset of doctors who reported low levels of morale against their career intentions, and this exhibited a very high degree of correlation against outcomes that might suggest a retention problem. The BMA said that given the continuing decline in morale, it was very concerned that the current state of the NHS would lead to an increasing retention problem.

2.8 The British Dental Association (BDA) reported that 2011-12 had seen the smallest increase in the number of dentists in England, and the greatest rate of leaving since the current contract, and told us that its *Dental Business Trends* survey showed that 34.4 per cent of respondents reported problems in recruiting NHS dentists. It added that the level of recruitment of associates for predominantly NHS work suggested a high turnover in this sector, which it interpreted as it being difficult for practice owners to retain staff under difficult economic circumstances.

2.9 Despite these reservations, we think that, in general, the current recruitment and retention picture for doctors and dentists is not a cause for major concern, although there is some evidence of emerging difficulties recruiting doctors for some medical specialties and for general dental practitioners (GDPs) in recruiting associates. However, we recognise that the numbers of Hospital and Community Health Services (HCHS) medical and dental staff have continued to grow year on year and that in England, at least, the NHS medical and dental workforce has increased in 2011 to the highest ever recorded. We are interested as to why, in this time of austerity, the NHS has continued to increase the medical and dental workforces year on year, and we comment on this issue in the section on workload and workforce planning later in this chapter.

Vacancy data

2.10 In our last report, we asked the Health Departments to take steps to ensure that the NHS Information Centre (now known as the Health and Social Care Information Centre) and its equivalents provided up-to-date vacancy information on HCHS staff and general medical practitioners (GMPs), as this is an important measure in our ongoing analysis of the workforce position. However, we continue to be frustrated that it is not possible to compare the vacancy figures across the United Kingdom and that the Health and Social Care Information Centre has suspended the collection and publication of HCHS and GMP vacancy figures in England.

2.11 It is essential that our recommendations are based on robust statistics and evidence, so that they retain the confidence of government, employers, the trade unions and staff. We remain concerned about the continued absence of data on vacancies, which carry weight within the evidence available on recruitment and retention. The *Annual NHS Vacancy Collection* and the *General Practitioners Practice Vacancy Survey* were suspended in 2011 and 2012 pending the outcome of the Department of Health's *Fundamental Review of Data Returns*, and we strongly disagreed with the Review's recommendation to discontinue these collections.

2.12 We are aware that there are plans to introduce an alternative source of data on vacancies, using the re-tendered NHS Jobs website. However, we note with regret that the launch of this service has been substantially delayed, which has had an adverse effect on the breadth of the evidence base available to us. It also seems likely that publicly available data from this new source will take further time to introduce, will not be comparable to the previous survey, and may exclude primary care.

2.13 We expressed the concerns outlined above in a letter to the chairman of the Health and Social Care Information Centre in late 2012. He told us that the *Fundamental Review of Data Returns* was due to report around the end of 2012. He pointed out that concerns had been raised relating to the content and low response rates for both the *Annual NHS Vacancy Collection* and the *General Practitioners Practice Vacancy Survey,* which could potentially have resulted in misleading data. These concerns had led to the suspension of the data collections at a time when resources were reduced. He said that the Health and Social Care Information Centre would look to produce more robust vacancy data from alternative sources to support our future work.

2.14 The absence of robust statistics on vacancies data risks undermining the credibility of our recommendations. These data are also essential to inform long-term strategies for pay and workforce planning, which inevitably affect the quality of patient care. We urge the Department of Health and the Health and Social Care Information Centre to prioritise the publication of vacancy statistics, so that we and the parties to our review process can draw on them in our next round beginning autumn 2013.

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

2.15 We are required by our terms of reference to have regard to regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists. Last year, some of the Review Bodies including the NHS Pay Review Body, were asked by the government to report on how to make pay more market facing, but our remit groups were excluded from this exercise at the time. This may have been because the available evidence,[2] though now some years old, suggested that the market for doctors was likely

[2] R Elliott et al. *Regional pay for NHS medical and non-medical staff: report to the Department of Health*. University of Aberdeen Health Economics Research Unit, 2005.

to be national rather than local or regional. Notwithstanding this, we received evidence from some of the parties on the subject of regional and local pay, which does form part of our standing terms of reference.

2.16 The Foundation Trust Network favoured national frameworks with local flexibilities. In a survey of its members, 68 per cent of respondents thought that there were insufficient local flexibilities for providers in the current national pay frameworks. It told us that respondents had indicated the need for a pay and reward system capable of being responsive to individual performance at the local, organisational level, and many members were beginning to consider seriously the flexibilities available in the system as well as being increasingly keen to see good performance suitably recognised in future.

2.17 On the other hand, the BMA told us that it strongly rejected attempts to introduce local market-facing pay for doctors, and that it continued to believe that a national contract with independent pay recommendations represented the most efficient, effective and beneficial approach for the NHS, for patients and for the profession. NHS Employers believed that there was no compelling evidence for differential awards for different categories of staff either locally or nationally, and little appetite for this given that any possible award was likely to be too little to make a difference.

2.18 We did not receive any evidence indicating specific recruitment issues in London that could be addressed by pay. We have said previously that unless evidence in future years indicated that labour market conditions in London had changed, we did not intend to revisit the decision that London weighting should remain at the existing levels, and we have seen no evidence that recruitment and retention in London are causing major problems or that suggests the need to revisit our previous decision.

The South West Pay, Terms and Conditions Consortium

2.19 We were slightly surprised that the main written evidence contained very little about the South West Pay, Terms and Conditions Consortium, particularly as the Foundation Trust Network had told us that a significant number of respondents to its survey had indicated their strong interest in exploring similar local or regional approaches to the consortium in their own organisations. The consortium was established in June 2012 and now has 19 participants drawn from NHS foundation trusts and NHS trusts. A discussion document[3] on the consortium's website stated that it was set up to produce a full business case by the end of 2012 in order to "quantify the current and future economic, financial and service challenges, and in turn consider how best to create a 'fit for purpose' set of pay, terms and conditions". The website acknowledged that the consortium did not have the authority, responsibility or mandate to engage in negotiations, as sovereignty rested with the individual participating trusts. Although much of its work appeared to be focused on potential changes to the *Agenda for Change* pay system, we noted from the discussion document that some of the "labour cost compressors" being examined by the consortium could have a potential impact on the doctors and dentists in our remit groups.

2.20 We sought the parties' views on the work of the consortium in supplementary questions and during oral evidence. The Department of Health said that the government had made its policy on pay clear in *Equity and Excellence: Liberating the NHS*,[4] which said that individual employers should be free, as foundation trusts already were, to set their own pay, terms and conditions to recruit, retain and motivate staff. This included the freedom to adopt national terms and conditions. It told us that the government expected the

[3] South West Pay, Terms and Conditions Consortium. *Addressing pay, terms and conditions: discussion document.* 22 August 2012. Available from: http://meetingthechallenge.info/wp-content/uploads/2012/08/SWC-Addressing-pay-and-conditions-Final.pdf

[4] Department of Health. *Equity and excellence: liberating the NHS.* Cm 7881. TSO, 2010. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

majority of trusts to remain on national terms and conditions provided these remained fit for purpose and affordable. It said that it would be for each of the consortium's member boards to decide how to proceed with the suggested proposals.

2.21 NHS Employers stressed that NHS trusts and NHS foundation trusts had the legal freedom to determine their own arrangements for pay and conditions, although most trusts had chosen to keep national terms and conditions. In relation to doctors, they told us that all employers in the NHS used the national terms and conditions, but many also employed some doctors on locally established trust grades and conditions, although data on the extent of this was not held centrally. They said that employers would like to see significant reform to the contracts of employment for postgraduate doctors in training and to the arrangements for consultants' Clinical Excellence Awards, and that effective reform of these would significantly reduce the need for employers to move to more local arrangements. They told us that many employers would prefer to stay with the national framework for the bulk of their medical staff as long as it could become more responsive to local needs, affordable and sustainable.

2.22 We note that that the comments made by NHS Employers on consultant reward predated the publication of our report on the *Review of compensation levels, incentives and the Clinical Excellence and Distinction Awards schemes for NHS consultants*.[5] We will follow the developments on local initiatives with interest and ask the parties to report back to us on the outcomes of this and any similar local arrangements for our next report.

Market-facing pay

2.23 We note from the Chancellor's *Autumn Statement*[6] on 5 December 2012 that the government has generally accepted the recommendations on local pay of the four Pay Review Bodies[7] in their reports on market-facing pay. Of particular interest to us were the conclusions of the NHS Pay Review Body and the School Teachers' Review Body. The NHS Pay Review Body[8] recommended that the *Agenda for Change* pay system was the appropriate vehicle through which to make pay more market facing. The government accepted the recommendation that there should be no new centrally-determined local pay rates or zones but that there should be greater use of existing flexibilities. We have previously commented that employers make very little use of the recruitment and retention premia, worth up to 30 per cent of the normal starting salary for consultants.[9] The School Teachers' Review Body[10] recommended greater freedom for individual schools to set pay in line with performance. This is in accord with our own views on consultants' pay, as expressed in our recent *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*, which criticised the fact that the current pay structure rewarded length of service more than contribution or performance.[11]

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[5] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[6] HM Treasury. *Autumn statement.* Cm 8480. TSO, 2012. Paragraph 2.41. Available from: http://cdn.hm-treasury.gov.uk/as2012_chapter_2.pdf

[7] The four Pay Review Bodies that prepared reports on market-facing pay were: the NHS Pay Review Body, the Prison Service Pay Review Body, the Review Body on Senior Salaries, and the School Teachers' Review Body.

[8] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets.* Cm 8501. TSO, 2012. Available from: http://www.ome.uk.com/NHSPRB_Reports.aspx

[9] Review Body on Doctors' and Dentists' Remuneration. *Thirty-ninth report.* Cm 7837. TSO, 2010, Paragraphs 7.11-7.14. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[10] School Teachers' Review Body. *Twenty-first report.* Cm 8487. TSO, 2012. Available from: http://www.ome.uk.com/STRB_Reports.aspx

[11] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Paragraph 4.40. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

2.24 We understand that the parties will be considering a programme of work taking forward the recommendations in the report on market-facing pay made by the NHS Pay Review Body and we have asked for it to be broadened, where appropriate, to cover the NHS medical workforce. In particular, it would be helpful to have a more up-to-date assessment on whether the market for doctors remains a national market and whether there is evidence to support locally differentiated pay for doctors such as London weighting. We ask the parties to keep in touch with our secretariat on this issue and report back to us in the next round.

The Scottish public sector pay policy

2.25 The elements of the Scottish public sector pay policy for 2013-14, which would affect doctors and dentists in our remit groups are: a 1 per cent cap on the cost of the increase in basic pay for staff earning under £80,000; and a pay freeze to apply to all staff earning £80,000 and over. The Scottish Government said in its remit letter that no pay recommendations were sought from us for either medical and dental staff earning £80,000 and over or independent contractor general medical and dental practitioners. The Scottish Government recognised that this was likely to affect around 4,220 staff on the associate specialist, consultant and salaried dentist scales.

2.26 We have reservations about the application of the Scottish public sector pay policy to our remit groups and believe that it could have unintended consequences where the pay scales are currently national, with fairly minor variations across the United Kingdom. For example, the differentials in the pay scales for consultants and some of the specialty doctor and associate specialist (SAS) grades on either side of the threshold would be affected. We also believe that it would be difficult to apply to independent contractor GMPs and GDPs because it is not known whether or not individual practitioners' income falls above or below the £80,000 threshold. We are concerned that if the pay policy continued over a number of years, it would undermine the principles of the current national pay scales. We consider it is for the Scottish Government to determine how to apply our recommendations within the context of its public sector pay policy.

Motivation

2.27 Our terms of reference require us to have regard to motivation. This element of our terms of reference is of particular interest to us because of its effect on recruitment, retention and the quality of patient care.

2.28 We looked at the key results for motivation and morale from the autumn 2011 *NHS Staff Survey*[12] in England and compared results for 2011 with results for the four previous years. Table 2.1 below shows the trends for medical and dental staff, for the five years 2007 – 2011, from the *NHS Staff Survey* in England. It shows that, for medical and dental staff as a whole:

- there was little change in most indicators between 2010 and 2011;
- over a five-year period, most indicators have tended to be on an improving trend, particularly those relating to engagement and job satisfaction;[13]
- there are some signs of increased work pressure, though this has not translated to an increase in work-related stress; and
- there has been a decline in the percentage of staff receiving job-relevant training, learning and development, and the percentage of staff reporting that they had a "well-structured" appraisal remains low.

[12] The 2011 survey for England was the ninth annual survey. Around 135,000 staff responded to the questionnaire, a response rate of 54 per cent, a slight increase on the 2010 survey.

[13] For non-medical staff, most relevant indicators declined between the 2010 and 2011 surveys.

Table 2.1: Summary results from the National NHS Staff Survey, 2007 – 2011, England, medical and dental staff

Measure	2007	2008	2009	2010	2011	Trend[1]
Workload						
Work pressure felt by staff[2,3]	3.09	3.06	3.08	3.06	3.10	
Trust commitment to work-life balance[3]	3.19	3.27	3.27	3.30	3.31	
% staff working extra hours[2]	72.8	75.0	75.3	76.8	79.4	
% staff suffering work-related stress in last 12 months[2]	26.2	22.2	25.0	24.5	23.1	
Training and appraisals						
% staff receiving job-relevant training, learning or development in last 12 months	82.9	85.5	85.2	84.6	82.5	
% staff appraised in last 12 months	76.3	74.4	78.0	79.4	81.4	
% staff having well-structured appraisals in last 12 months	29.1	29.4	31.6	34.0	35.2	
% staff appraised with personal development plans in last 12 months	69.0	69.1	72.0	73.8	76.6	
Engagement and job satisfaction						
% staff feeling valued by their work colleagues			85.5	84.8	87.1	
Support from immediate managers[3]	3.50	3.53	3.55	3.56	3.61	
% staff reporting good communication between senior management and staff		29.4	27.8	31.9	34.1	
% staff able to contribute towards improvements at work		66.6	63.7	66.1	67.4	
Staff recommendation of the trust as a place to work or receive treatment[3]			3.51	3.53	3.51	
Staff motivation at work[3]			3.97	3.94	3.94	
Staff job satisfaction[3]	3.49	3.55	3.57	3.59	3.64	
Staff intention to leave jobs[2,3]	2.46	2.38	2.34	2.41	2.39	

Source: National NHS Staff Survey.

Notes:

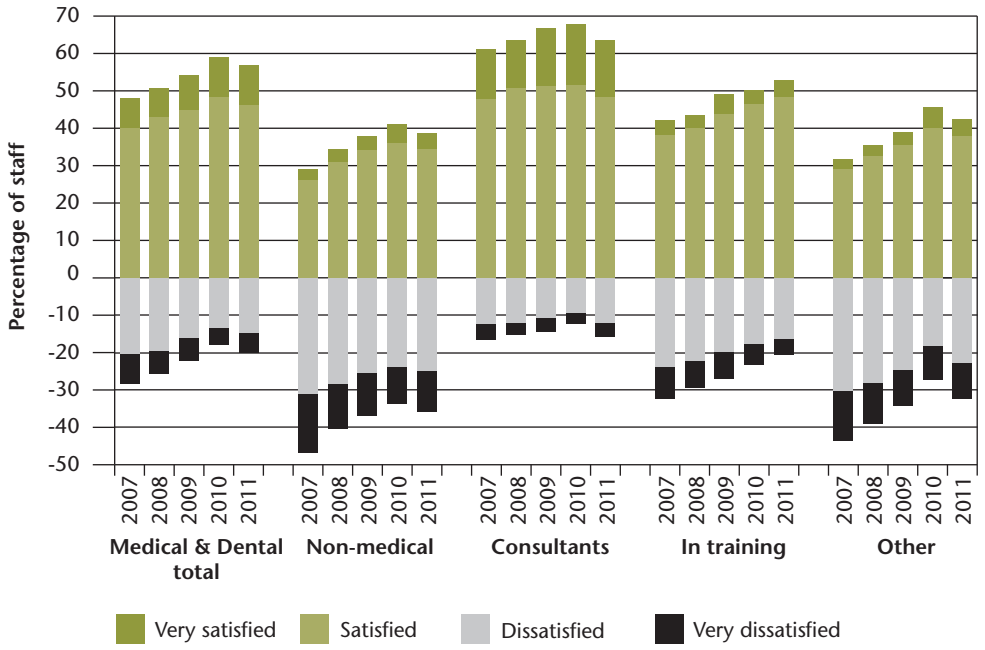
[1] Trend lines do not have a common scale; they each show the general direction of travel of individual key findings (which may exaggerate fairly small, and not statistically significant, changes), and must be viewed both in the context of the data in the preceding columns and the full range of possible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

[2] Lower scores are better.

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

2.29 The 2011 *NHS Staff Survey*, conducted in autumn 2011, was the first to be conducted during the government's two-year pay freeze for our remit groups. Figure 2.2 shows that between 2010 and 2011, there was a decrease in the percentage of consultants and "other"[14] grades reporting that they were satisfied or very satisfied with their level of pay, and an increase in reported dissatisfaction. However, for training grades, a higher percentage of staff reported satisfaction with their level of pay in 2011 compared with 2010. These results pre-date the second year of the pay freeze for our remit groups, and the implementation of higher pension contribution rates from April 2012.

Figure 2.2: Staff satisfaction with their level of pay, England, 2007 – 2011

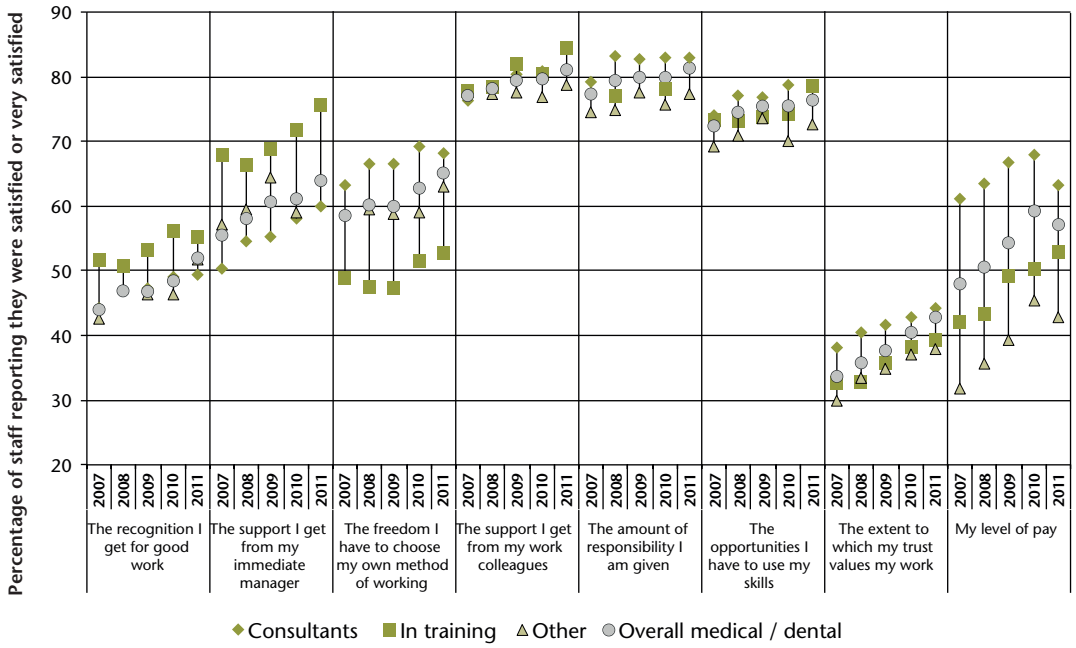


Source: National NHS Staff Survey.

2.30 Figure 2.3 below shows the change in the percentage of staff satisfied or very satisfied with other aspects of their jobs, by grade. There were increases between 2010 and 2011 in the overall percentage of medical and dental staff, and staff satisfied or very satisfied with all listed aspects (but decreases for some grades for some aspects), the exception being satisfaction with their level of pay. This contrasts with the situation for non-medical staff, where there was a decrease in the percentage of staff satisfied with all eight aspects. Among medical and dental staff, consultants tended to be, on average, the grade most satisfied with freedom to choose their own method of working, and level of pay; but tended to be least satisfied with support from immediate managers. Training grades were, on average, most satisfied with recognition for good work and support from immediate managers, but least satisfied with freedom to choose their own method of working. The element of satisfaction that grades were least satisfied with, was the extent to which their trust valued their work.

[14] This category includes specialty doctors, staff grades and associate specialists, as well as other grades such as clinical assistants and hospital practitioners.

Figure 2.3: Staff satisfaction with aspects of their jobs, England, 2007 – 2011



Source: National NHS Staff Survey.

2.31 There were no staff surveys in Wales, Scotland or Northern Ireland during 2011. The next NHS Wales staff survey was to be launched in January 2013, and the next NHSScotland staff survey is due in May 2013. A survey was run in Northern Ireland in September 2012, but the results were not available in time for this report. The Scottish Government told us that it was funding a project to define, improve and measure staff experience, recognising the critical link with organisational performance (and in particular patient experience). We look forward to an update on the Scottish Government project for our next review, as well as some conclusions from the staff surveys in Wales and Northern Ireland.

2.32 The BMA told us that a confidential pensions survey of members in late 2011 showed that one quarter of the over 11,000 doctors who responded would consider taking early retirement if the governments' proposed pension changes were implemented. The BMA also carried out a survey to inform its evidence for this review, although we note that this had a low response rate. It reported that the overall headline level of morale for doctors averaged at 3.3 (on a scale of 1 to 5, where 1 represents very high morale and 5 very low). There appeared to be no significant differences between countries. Respondents to the BMA survey reported a significant decrease in their level of morale compared to a year ago, but with some differences by branch of practice: 75.9 per cent of GMPs reported a decrease in morale, compared with 60.9 per cent of junior doctors. Around half of all doctors responded negatively to the question as to whether they would recommend medicine as a career.

2.33 The BDA said that over 41 per cent of respondents to the *Dental Business Trends* survey in England, with an NHS commitment of 75 per cent or more, said that their morale was low or very low, and that the highest levels of morale were found among those with the lowest NHS commitment.

2.34 We also considered the results of some research carried out by Aston University, linking results from annual NHS staff surveys with various outcome measures for the NHS in England.[15] The overarching conclusion arising from the various supporting reports is that "the more positive the experience of staff within an NHS trust, the better the outcomes for that trust". Higher levels of staff engagement, in particular, were statistically significantly associated with: higher patient satisfaction; lower patient mortality; lower MRSA infection rates; better Annual Health Check scores (quality of services, and quality of financial performance); lower staff absenteeism; and lower staff turnover. Other indicators of good management of NHS staff which were statistically significantly associated with some or all of the above outcome measures[16] included: the percentage of staff receiving well-structured appraisals (and indeed, having no appraisal at all appeared to give better results than having a poor-quality appraisal); staff intention to leave their jobs; the percentage of staff receiving job-relevant training, learning and development; and work pressure felt by staff (which was negatively associated with outcomes).

2.35 We note NHS Employers' view that the staff satisfaction measures, shown by the most recent NHS staff survey in 2011, remained generally good and, for doctors, better than other NHS staff. However, these results are now out of date and the evidence from the BMA and BDA present emerging signs of reducing morale among doctors and dentists, although we have received no clear evidence that this is directly linked to pay. We conclude from this that the issues affecting motivation are more complex than just pay, but we do acknowledge that pay in real terms has declined for our remit groups and that there are a number of ongoing issues surrounding pensions. We address pay comparability later in this chapter and the motivation of GDPs in Chapter 4.

2.36 We would like to pursue the motivation strand of our remit with more rigour, in particular the link between motivation and reward. Given the recent organisational changes within the NHS, the two-year pay freeze, changes to pension arrangements and the quality issues referred to in the Francis report,[17] we think that this is now the right time for the parties to work with us, before the next round, to consider ways of gathering more meaningful evidence.

Workload and workforce planning

2.37 Workforce planning does not directly form part of our terms of reference, but it is very important because of its link to recruitment and retention. This year there are several issues of particular interest to us: the projected oversupply of United Kingdom medical graduates; the move to increase training numbers in general practice and reduce hospital based training; the plans for a service delivered by trained doctors; and the apparent paradox of staff numbers continuing to increase during a time of severe budgetary constraint.

2.38 We heard from NHS Employers that the future shape of the medical workforce was under debate due to an expected oversupply from August 2013 of United Kingdom medical graduates. We also note from NHS Employers that there is to be a greater emphasis on shifting training numbers to general practice from hospital. We address these issues in Chapter 6.

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[15] These reports were drawn together and summarised in August 2011, and published on the Department of Health's website: Aston Business School. *NHS staff management and health service quality: results from the NHS staff survey and related data*. Department of Health, 2011. Available from: http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_129643

[16] These factors were also correlated with overall staff engagement (or with its component factors), so it is unsurprising that they were themselves associated with outcome measures.

[17] Robert Francis QC, chairman. *Report of the Mid Staffordshire NHS foundation trust public inquiry.* HC 947. TSO, 2013. Available from: http://www.midstaffspublicinquiry.com/report

2.39 The Scottish Government told us about its policy objective of moving to a health service predominantly delivered by trained doctors, reducing the reliance on doctors in training for front-line service delivery. It said that a trained doctor service would necessarily consist of a "mixed economy" of consultants, specialty doctors, other existing SAS grades, doctors in training and other healthcare professionals.

2.40 We have observed that staff numbers have continued to rise, despite budget constraints. We asked the parties for an explanation of this apparent contradiction and were told that it was necessary as the demands of the service continued to expand, for example to meet the national agenda to have doctors on site and for more consultant-led workforces. We would find it helpful if the parties would make clear to us in their evidence their roles and responsibilities in relation to workforce planning and their views on the key issues.

General economic context and the government's inflation target

2.41 We are required by our terms of reference to take careful account of the economic and other evidence and of the government's inflation target. We note that the United Kingdom economy did not grow over 2012, despite the forecast of gross domestic product growth of 0.7 per cent made when we last reported. The Office for Budget Responsibility forecasts economic growth of 1.2 per cent in 2013.[18] Inflation fell during 2012: Consumer Prices Index (CPI) inflation fell from a peak of 5.2 per cent in September 2011 to 2.7 per cent in December 2012; and Retail Prices Index (RPI) inflation fell from a peak of 5.6 per cent in September 2011 to 3.1 per cent in December 2012. The Retail Prices Index excluding mortgage interest payments (RPIX) measure of inflation followed a similar path to the RPI rate: it fell from a peak of 5.7 per cent in September 2011 to 2.6 per cent in September 2012, and ended 2012 at 3.0 per cent. This did not match the forecast, however, which expected CPI inflation to reach its 2 per cent target by the end of 2012. The current forecast is for CPI inflation to fall close to, but not reach, the 2 per cent target by the end of 2013. Employment levels have been higher than expected, with employment rising by 552,000 over the year to November 2012, the latest data available to us. The level of employment in the United Kingdom is at an all-time high, and the employment rate has risen for all age groups, except 16 to 17 year olds. The unemployment level fell by 185,000 over the year to November 2012. The employment level is expected to remain stable in 2013, while unemployment is expected to rise slightly. Earnings growth has been modest, and below inflation, at 1.5 per cent in November 2012. Pay settlements have been around 2.6 per cent in the private sector and are expected to remain at similar levels in 2013. The median settlement in the public sector was 0.7 per cent in the 12 months ending December 2012.

Affordability and the Health Departments' expenditure limits

2.42 We are also required by our terms of reference to take account of the funds available to the Health Departments as set out in the government's Departmental Expenditure Limits. Affordability is an important consideration when setting levels of remuneration in any organisation and we give this element of our remit serious consideration during our deliberations on the uplift. However, we think that it cannot be considered in isolation from the other elements of our terms of reference. As always, affordability formed a major theme of the evidence submitted to us. The Health Departments emphasised the need for pay restraint and employer bodies the unaffordability of any pay uplift, a sharp contrast to the views expressed by the BMA. The BDA did not address affordability directly in its evidence.

[18] Office for Budget Responsibility. *Economic and fiscal outlook.* Cm 8481. TSO, December 2012. Available from: http://cdn.budgetresponsibility.independent.gov.uk/December-2012-Economic-and-fiscal-outlook23423423.pdf

2.43 The Department of Health told us that pay was the most significant cost pressure, accounting for more than 40 per cent of NHS revenue expenditure and that from 2001-02 to 2011-12, it had accounted for 45 per cent of the increases in revenue. It said that as pay represented such a large proportion of the NHS budget, managing the pay bill was the key to ensuring that the NHS was able to cope with the future slow-down in funding growth. It pointed out that although the NHS had received a better Spending Review settlement than many other parts of the public sector, including a guarantee of real terms increases in health spending for each year of the current parliament, NHS resources would be under considerable pressure in 2013-14. It argued that the funding available to the NHS was fixed and extremely tight compared with the recent past. Any increases in pay would reduce the funds available for service developments and activity growth and reduce the derived demand for staff. During oral evidence, we were told that the tariff would include a 1 per cent increase for pay, although the Department of Health argued that these funds should not necessarily be used for pay.

2.44 The Welsh Government had estimated that a 1 per cent pay award for NHS employed staff would cost approximately £30 million per annum. The additional cost of an equivalent settlement for General Medical and General Dental Services would be around £8.5 million. It said that any additional costs arising from pay awards would have to be met through further efficiencies and cost reductions.

2.45 The Scottish Government told us that the scale of the real terms total reduction in its budget for the period 2011-12 to 2014-15 had required tough decisions to be taken about expenditure across government and careful consideration of pressures and priorities in all portfolios. It reported that the capital budget for health would reduce significantly over the period 2011-12 to 2014-15 and, based on HM Treasury's gross domestic product deflator, the total budget for health showed an overall real terms reduction in each of these years. It said that pay accounted for a significant section of health board budgets so pay restraint was important within the overall aim of preserving, as far as possible, headcount during these difficult times.

2.46 The Northern Ireland Executive believed that staff costs for medical and dental staff had fluctuated over the last five financial years because of new contract payments. Medical and dental staff gross pay had increased from around £344 million in 2010-11 to around £354 million in 2011-12. It said that in 2011-12, medical and dental staff gross pay had represented around 17 per cent of all staff gross pay.

2.47 NHS Employers told us that affordability of any increases in earnings dominated the thinking of employers in the NHS, in England, due to the risk of negative impacts on patient care. They argued that the current national pay and conditions arrangements were increasingly unaffordable for employers in the NHS, who were faced with the task of meeting growing demand and sustaining the quality of patient care while achieving unprecedented efficiency savings of up to £20 billion by March 2015. They said that restraining pay was essential to protect services and minimise job losses; there was no money available to lift national pay scales from April 2013; and increased pay costs would be unaffordable. They added that additional funding was the only way in which effective, high quality services could be sustained alongside any pay increase. Any increase in pay costs would need to be matched by commensurate increases in the tariff, sufficient to cover the full increase in any employment costs. NHS Employers reported that in an NHS Confederation members' survey in June 2012, 28 per cent of respondents had stated that the financial pressures currently facing their organisation were "the worst they had ever seen". They stressed that earnings restraint was essential for the NHS to meet its financial challenges. They said that pay accounted for approximately 70 per cent of trusts' costs – a total of £22.6 billion in 2011-12, which was £576 million above plan. The financial challenges to the service and the general financial outlook for the United Kingdom suggested to employers that further restraint on pay costs would be needed for some

time ahead. In supplementary evidence, NHS Employers said that while they accepted that we had to strike an appropriate balance in coming to our recommendations, employers believed that in the current circumstances of severe financial stress, the service did not require the national scales to be increased nor did they believe increases to national scales were affordable.

2.48 The Foundation Trust Network added that to award an increase when providers were already struggling with delivering cost containment, protecting jobs and improving care would put providers under severe duress and compromise fiscal sustainability. It believed that given the challenges faced by providers, and the limitations of the current pay system, difficult decisions on pay must be taken now, both to protect jobs and ensure provider sustainability. Containing costs, including pay, was now essential to protecting jobs and investing in the service transformation that the NHS needed to be sustainable. It told us that its members expected revenues to decrease by 1 per cent in 2013-14, which made a pay increase of 1 per cent appear incongruous. It suggested that pay restraint would enable providers better to put patients first (by enabling more activity within the overall financial envelope) and protect jobs (reducing pressure on the efficiency requirement which remained constant). Some respondents to the Foundation Trust Network survey had questioned whether there was discretion to withhold the award, given the scale of the financial challenge.

2.49 In contrast, the BMA argued that an award of higher than 1 per cent could be affordable and further contract erosion could be avoided, at least in England, as the NHS budget to 2015 for England (though not for the other nations), indicated real growth; it pointed out that the Departmental Expenditure Limit of 2.3 per cent in 2013-14, would rise to 2.8 per cent in 2014-15.

2.50 Our view continues to be that affordability must be considered alongside the need to recruit, retain and motivate doctors and dentists. We recognise that the huge financial pressures facing the NHS will continue for a number of years and we have taken this into account when making our decision about what we consider to be the appropriate uplift for 2013-14. Affordability is closely linked to the Health Departments' budgets, and these budgets have been set with assumptions about pay levels having been made. Staff are also likely to be aware of the pay assumptions made by employers, given the public announcements made by the United Kingdom governments on the public sector pay policies for this year. We recognise that our remit groups are only part of the total NHS workforce; for example, in England our remit groups comprise 9.7 per cent of full-time equivalent staff in the NHS and 22 per cent of the HCHS pay bill. We therefore ask the parties to provide an insight into the special factors in relation to our remit groups that impact on affordability, for example, policy objectives for our remit groups, such as seven day working for consultants.

Pay drift

2.51 NHS Employers, the Foundation Trust Network, the Department of Health and the Northern Ireland Executive pointed out that the two-year pay freeze had not frozen earnings or pay costs in the NHS as individual employees had continued to benefit from pay progression as they moved up incremental steps to which they were contractually entitled. NHS Employers told us that on average, these increments resulted in an individual salary increase for doctors of between 3 and 8 per cent per year. However, the actual cost of incremental progression as a percentage of pay roll was unknown. NHS Employers believed that any pay award should be offset by the level of progression pay as the cost of meeting incremental pay progression was a factor which made it more challenging for NHS trusts to achieve the targets. During oral evidence, NHS Employers said that the cost of increments was unaffordable. They estimated that NHS pay costs would grow from 57 per cent of the total expenditure in 2012-13 to 63 per cent by

2014-15; NHS Employers urged us to give consideration, as permitted under the remit, to the level of progression pay provided to doctors and dentists in the NHS and to include this earnings growth in the 1 per cent average referred to in government policy. The Department of Health added that the continuation of pay drift and an uplift of 1 per cent was likely to put considerable pressure on staffing levels and that reductions in clinical posts could not be ruled out. The Foundation Trust Network observed that the risk of pay drift arising from differential awards, which could threaten the integrity of the pay system, was a real issue should differential increases be given to sections of the workforce in recurrent years.

2.52 The Department of Health provided estimates of pay drift[19] for our remit groups in England. In 2011-12, the total pay bill increased by 0.9 per cent compared with the previous year, but the number of full-time equivalent staff increased by 1.6 per cent, leading to negative pay drift of -0.7 per cent. Pay drift was also negative in 2010-11, at -1.0 per cent. The Department of Health's figures relating to the change in average basic pay for our remit groups showed that the effect of incremental progression on pay drift was more than offset by the combined effects of other factors such as staff turnover and changes in the mix of medical grades, though the effects of these individual changes could not be separately identified.

2.53 We have consistently said in our reports that we believe pay drift arising from increased overtime or other payments for higher volumes of work, or from the effects of recently negotiated contracts, including incremental pay scales, should not be offset against the annual award. We think that if we were to offset the earnings growth arising from increments from our recommended pay award, it would undermine the fundamental principle on which incremental pay scales are currently based. Furthermore, both parties agree to the pay increases delivered by increments when staff are employed. We believe that it is therefore inappropriate for us to take account of such increases when considering our general uplift. We also recognise that pay drift is mitigated by the retirement of workers near the top of scales and their replacement by workers near the bottom of scales. In a pay structure which is in steady state, incremental drift will be zero. We believe that if employers find the cost of increments to be unaffordable, then this issue should be addressed through contract negotiations.

2.54 We note that despite increments of between 3 and 8 per cent, pay drift for medical staff was negative, (-0.7 per cent in 2011-12) while the pay bill was growing at a slower rate than staff numbers. We believe that a more rigorous analysis of pay drift and its component parts would be valuable, and ask the parties to address this request in the evidence for our next review. For example, it would be helpful to have a better understanding of the cost of increments and the number of doctors and dentists in receipt of them each year, given that we were asked to take this into account for the current review. We reiterate the need for data that relates specifically to our remit groups rather than the whole NHS workforce.

NHS finances and efficiency savings

2.55 NHS Employers said that cost pressures from increased earnings from whatever source would not be affordable and savings would need to be found elsewhere from efficiencies, or reductions in service, or both. They noted that the NHS would need to achieve unprecedented levels of efficiencies to achieve the £20 billion savings required before the end of 2014-15; some NHS foundation trusts had to achieve cost improvement plans of up to 9 per cent over the coming year. The Foundation Trust Network said that its members were seeking around 60 to 70 per cent of savings to come from pay

[19] Defined by the Department of Health as the increase in pay bill per full-time equivalent in excess of the basic pay uplift.

budgets, with around 20 to 30 per cent from non-pay costs, for example, supplies and procurement. It observed that typically there was only a relatively small role for income generating schemes.

2.56 The Department of Health added that even with a 1 per cent settlement and 1.6 percentage drift (the long run historic average), pay increases consumed approximately £1.1 billion of extra resources. It said that to deliver even moderate increases in activity of £0.7 billion (compared to a previous average of £1 billion) and £0.5 billion spend on service development (compared to a previous average of £1.6 billion) the NHS would need to deliver £1.2 billion of productivity savings (much higher than that delivered in the recent Spending Reviews). It told us that any extra increases in pay over the 1 per cent level would increase this already considerable productivity challenge. A 1 per cent increase for all HCHS staff itself represented a cost pressure of around £430 million. The higher the level of pay growth, the more difficult the balance between staff numbers, productivity and service delivery. The Department of Health said that the higher the levels of pay, the fewer staff would be employed and more productivity improvement was required to meet patient demand.

2.57 We were told by the Welsh Government that NHS funding had been protected in cash terms for the remainder of the current Comprehensive Spending Review period until 2014-15. It said that any additional costs to the NHS arising from pay awards would have to be met through further efficiencies and cost reductions, in addition to those savings required to meet non-pay inflation costs and increases in demand and new technologies. It estimated that NHS organisations in Wales needed to make cash-releasing savings of approximately 5 per cent, i.e. £250 million per annum.

2.58 NHS boards in Scotland estimated that a total of 2.2 per cent cash-releasing efficiency savings would be needed in 2013-14 to achieve financial balance. The Scottish Government said that this would be difficult for NHSScotland and would require service redesign issues to be considered.

2.59 The BMA stated that the NHS had delivered substantial efficiency savings in England of £5.8 billion during 2011-12. It believed that doctors should be recognised for their part in delivering improved clinical quality and outcomes and service innovation, without unsustainable short-term cost-cutting.

2.60 On deficits and surpluses, we note that the Audit Commission[20] found that the number of NHS trusts and foundation trusts in deficit increased from 26 in 2010-11 to 31 in 2011-12. The BMA said that it was alarmed by the government's recent actions to remove funding from the NHS as a whole. It pointed out that England appeared to have revised its spending plans such that not all of the forecast surplus for the NHS as a whole would now be reinvested into the NHS.

2.61 We have consistently expressed in reports our general view that while requiring cash-releasing efficiency savings may be an appropriate way to achieve cost discipline in a government department or public agency that is not subject to market forces, GMPs and GDPs operate small businesses and should have an incentive to achieve whatever efficiency savings are possible. We therefore believe that it is unnecessary and inappropriate to include efficiency savings in our funding formulae for GMPs and GDPs, as the impact of efficiency savings will become apparent, albeit with a time lag, in the data that we use in our formulae. Our last report said that if the Health Departments continued to think it appropriate to impose a requirement on independent contractor GMPs and GDPs to make efficiency savings, then such a requirement should be a

[20] *NHS financial year 2011-12: a summary of auditors' work.* Audit Commission, 20 September 2012. Available from: http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/nhsfinancialyear1112.aspx

contractual matter rather than abating our recommended increases.[21] We are therefore pleased to note that efficiencies for these groups are being delivered through the contracts, although we note that it was not possible for the parties in all countries to reach agreement on the contractual changes. We comment further in Chapters 3 and 4.

Overall NHS strategy – patients at the heart

2.62 Our remit requires us to have regard to the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved. The Department of Health addressed this by stating that placing patients at the heart of everything it does was crucial, particularly when having to make difficult decisions, balancing the needs of NHS staff, patients and the taxpayer. NHS Employers told us that the affordability of any increases in earnings dominated the thinking of employers in the NHS, in England, due to the risk of negative impacts on patient care. They suggested that we should ensure that our recommendations were affordable and sustainable without damaging the quantity and quality of what was done for and to patients. They said that it would be perverse to recommend raising national pay points for doctors and dentists and thus put at risk the quantity or quality of service provided.

2.63 The BMA suggested that a motivated workforce led to enhanced quality of care. Doctors needed time outside of direct patient contact for professional development and to allow time for innovation. It believed that with continuing erosion in real pay and time for supporting activities, there was a real risk that it would not be possible to sustain quality of patient care in future. It also said that doctors should be recognised for their part in delivering improved clinical quality and outcomes and service innovation and that doctors had made significant contributions to the overall performance of the NHS, but that without appropriate recognition of their value, this would not be sustainable.

2.64 The BDA told us that primary care dentists provided an excellent service to patients and that satisfaction with services was high. They said that dental practitioners took the financial burden upon themselves to provide high quality NHS care, thereby saving the NHS and taxpayer the direct capital costs of care, which it considered to be a successful mechanism for providing patient centred care. It believed that we should take into account the threats to practice viability that rising expenses and negligible rises in contract values presented. It added that the salaried services were understaffed and that there was widespread dissatisfaction with inappropriate grading for pay. The BDA asked us to consider the effect of these workforce problems, which impacted on the ability of the NHS to provide quality care to the most vulnerable patients.

2.65 The parties submitted evidence that attempted to address the 'patients at the heart' strand of our remit. The evidence supplied by the BMA partly related to job planning and the balance between Programmed Activities (PAs) and Supporting Professional Activities (SPAs). While we agree that consideration needs to be given to the appropriate weight in job plans for SPAs to allow sufficient time for professional development and innovation, this is clearly a matter for local determination. We note the comments made by the BMA about doctors' contribution to patient care and the performance of the NHS.

2.66 The BDA's evidence asked us to consider the impact of expenses when considering our recommendations on increases to contract values, and this does form part of our usual considerations, although we note that this year the BDA is negotiating directly with the Health Departments, except in Scotland. The BDA also asked us to consider workforce issues for the salaried services: we do, of course, consider the pay scales for salaried dentists, but employment decisions on workforces are taken locally. The evidence from the Department of Health and NHS Employers in essence argued that each pound spent

[21] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report.* Cm 8301. TSO, 2012. Paragraph 1.28. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

on raising doctors' and dentists' pay was a pound that was not being spent on patient services, which we consider to be already covered by the 'affordability' strand of our remit.

2.67 To address this element of our remit in depth remains challenging, although it is clear to us that a focus on patients is a central part of the overall ethos of the NHS. The recently published Francis report[22] concluded that there were systemic failures in the quality of patient care. We ask the parties to address 'patients at the heart' more directly in the evidence for the next round, particularly with regard to any link to our recommendations on pay.

Legal obligations on the NHS including anti-discrimination legislation

2.68 We are also required to take account of the legal obligations on the NHS, including anti-discrimination legislation in relation to age, gender, race, sexual orientation, religion and belief, and disability. The Health Departments have previously told us that they would not expect to submit evidence on this point as a matter of course, although they expect us to take this part of the remit into account when formulating recommendations.

2.69 We are concerned that only the Scottish Advisory Committee on Distinction Awards chose to provide us with meaningful evidence for this aspect of our terms of reference. It reported that it continued to operate without discrimination on grounds of age, gender, ethnicity, belief, type of contract, specialty or area of work, or other relevant factor, although we recognise that the Distinction Awards scheme is currently frozen in Scotland, other than for five-yearly reviews.

2.70 We received evidence on seniority pay for GDPs and comment on the equality aspects of this in Chapter 4.

2.71 Our *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*[23] addressed the governance and operation of the award schemes, including transparency, fairness and equity. We said that we would like to see the awarding bodies continuing to monitor the diversity issues arising from the distribution of the awards and to take appropriate action to address any inequalities. We ask the parties to update us on this for our next review. We also commented upon the length of the consultant pay scale, whereby it takes a consultant 19 years to reach the pay band maximum. We ask the parties to consider whether there are similar age equality issues that apply to other pay scales and to provide evidence for our next review.

Pay comparability

2.72 Pay comparability does not form part of our terms of reference but we believe it is important to assess the pay position of our remit groups relative to other groups that could be considered appropriate comparator professions, and against recent trends in general pay and price inflation measures, to provide a broader context. We look at both pay levels and movements. The specific comparator professions that we use are: legal, tax and accounting, actuarial and pharmaceutical.[24] Further discussion of pay comparability for specific groups within our remit is included in the relevant chapters. Here, we make

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[22] Robert Francis QC, chairman. *Report of the Mid Staffordshire NHS foundation trust public inquiry.* HC 947. TSO, 2013. Available from: http://www.midstaffspublicinquiry.com/report

[23] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Chapters 4 and 9. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

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

some brief general observations about the remuneration of doctors and dentists relative to their comparators, and in the context of the wider United Kingdom economy. We include a more detailed analysis of pay comparability at each anchor point at Appendix F.

Pay levels

2.73 The BMA believed that the relative position of doctors against other workers continued to worsen. It said that the impact of pay freezes and below inflation increases had brought consultant earnings back to their 2003 level in real terms, when the new consultant contract was introduced. It asked us to consider the change in comparator earnings as well as the absolute levels in our pay comparability analysis. It believed that it was important to compare the whole lifetime profile, not just year one earnings.

2.74 The National Audit Office report[25] also noted a real terms drop in consultants' pay and that average (mean) pay in real terms had fallen over the past five years. We comment on this in Chapter 7.

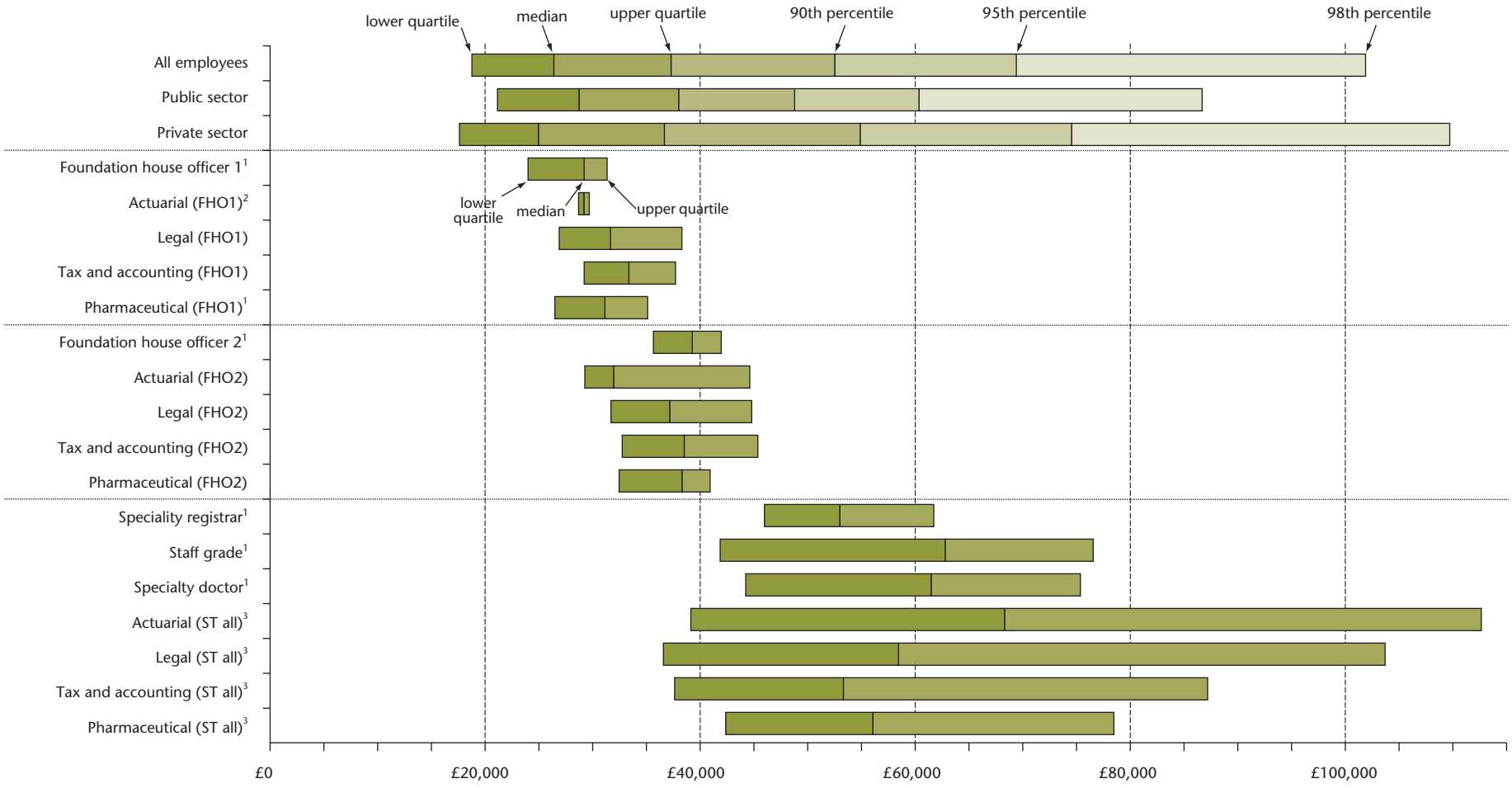
2.75 From our analysis of the data in Appendix F, we note that basic pay for doctors and dentists in training is lower than for their comparator groups at the same stages, but total earnings including banding supplements compare reasonably well with the comparator groups at every stage. Basic pay and total earnings for associate specialists are both lower than for the comparator groups, but those for specialty doctors are broadly comparable. New consultants' earnings are lower than comparator groups, while experienced consultants, at the top of the salary scale and in receipt of awards, have similar total earnings to comparator groups. The earnings position of doctors and dentists in training, specialty doctors and experienced consultants has declined relative to comparator professions since 2011.

2.76 Figures 2.4 and 2.5 compare the distributions of our remit groups' total earnings by headcount with the national distribution for full-time employees in both the public and the private sectors, and for full-time employees in the specific comparator professional groups. Figure 2.4 relates to doctors in training, specialty doctors and staff grades. It shows that median total earnings for foundation house officers in year one is above the national median, but slightly below that of comparators. For foundation house officers in year two, median total earnings are ahead of that of their comparators, and higher than the national upper quartile. Median total earnings of specialty registrars, staff grade doctors and specialty doctors are above the 90th percentile for all employees and broadly in line with comparator medians.

2.77 Figure 2.5 relates to associate specialists, consultants, dentists and general practice. It shows that compared with employees in the wider economy, median total earnings are in excess of the 95th percentile, for associate specialists and consultants. The distribution of incomes for independent contractor GMPs and GDPs is very wide, but median earnings are broadly in line with the comparator groups. Median total earnings for salaried GMPs and Performer-Only GDPs are substantially below that of comparator groups, but this may be because a greater proportion of these individuals work part-time.

[25] National Audit Office. *Managing NHS hospital consultants.* Report by the Comptroller and Auditor General. HC 885. Session 2012-13. 6 February 2013. TSO, 2013. Available from: http://www.nao.org.uk/publications/1213/nhs_hospital_consultants.aspx?utm_source=GovDelivery&utm_medium=email&utm_campaign=naoorguk

Figure 2.4: Total earnings ranges of DDRB training grades and specialty doctors, 2012, compared with the national pay distribution and other professional groups, full-time rates[1]



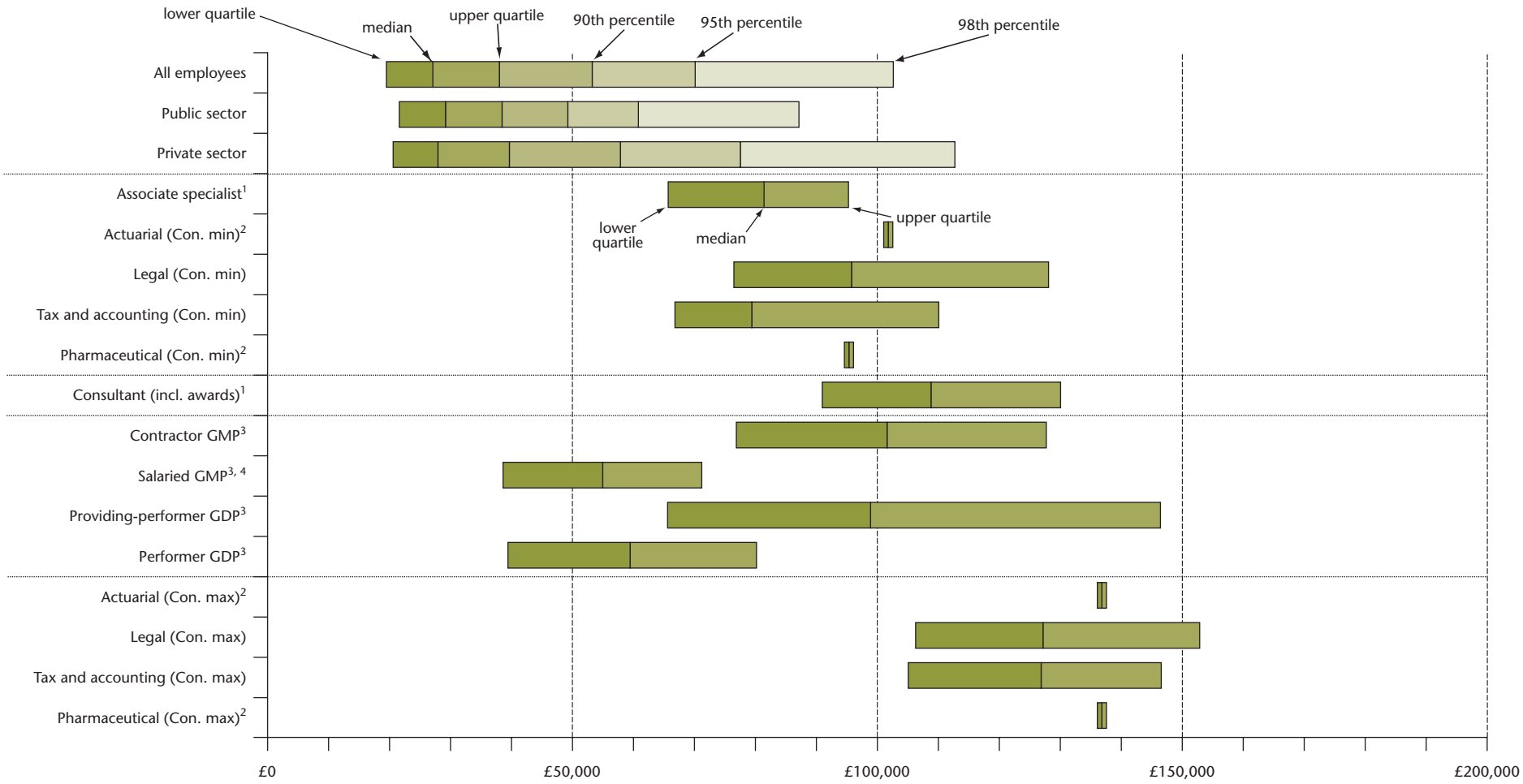
Sources: The Office for National Statistics, Health and Social Care Information Centre, NHS Employers and Hay Group.

[1] Figures for hospital medical grades relate to total earnings in the year ending September 2012, by headcount.

[2] A range is not always available for actuarial posts. A notional range of £1,000 is used to illustrate the median.

[3] The range for specialist training (ST all) covers four distinct reference levels / job weights (among the comparators) and the range given is from the lower quartile of the lowest-paid reference level, through the mid-point between the medians of the two middle level to the upper quartile of the highest-paid reference level.

Figure 2.5: Total earnings ranges of consultants and equivalent grades, 2012, compared with the national pay distribution and other professional groups, full-time rates[1]



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

[1] Figures for hospital medical grades, contractor and salaried general medical practitioners and contractor general dental practitioners relate to total earnings in the year ending September 2012, per headcount.

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

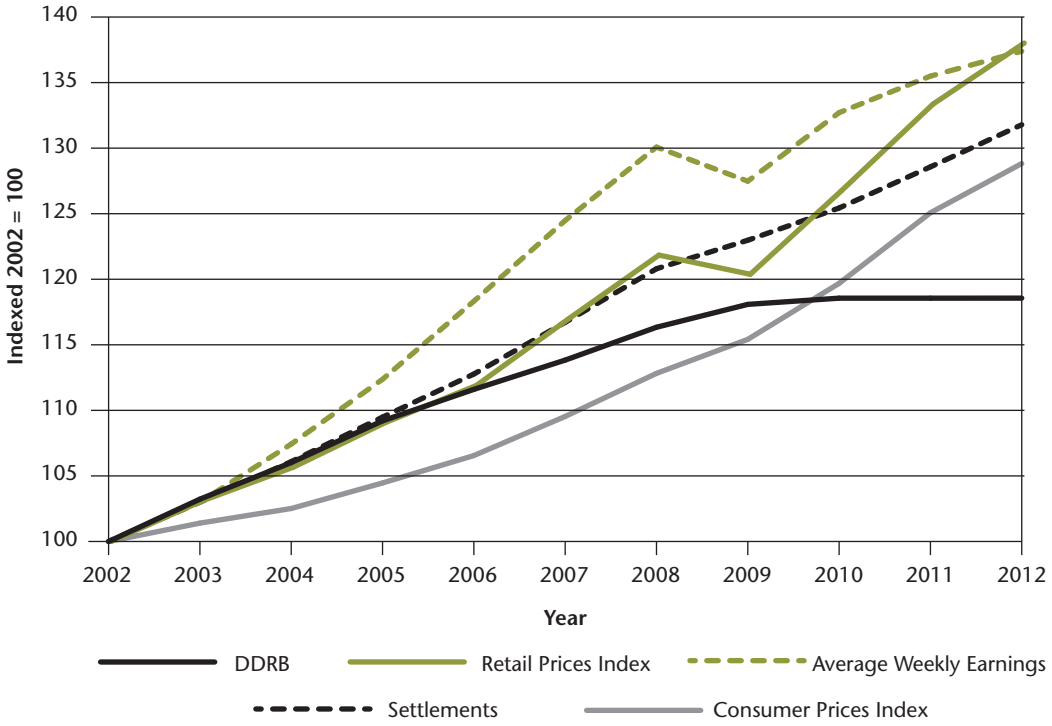
[3] Estimated median incomes (before tax) for 2010-11 for all (both full-time and part-time) general medical practitioners and general dental practitioners (the latest available data).

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

Pay movements

2.78 Figure 2.6 shows the cumulative effects of our main awards over the most recent ten-year period, alongside those for a range of comparable economic measures. Until 2006, our awards were broadly in line with these measures, but tended to be lower towards the end of the decade, so that by 2008 our award was no longer keeping pace with other indicators apart from the CPI. In 2009, the RPI was negative, and growth in Average Weekly Earnings also reversed, but our award remained below the Incomes Data Services whole-economy median for pay settlements. In 2010, the cumulative effect of our award since 2002 was overtaken by the CPI, and is now lower than all these indicators. Strong price inflation since 2011 and a return to consistent growth in earnings and settlements, while our remit groups have been subject to a pay freeze, has widened the gap between the cumulative uplifts for our remit groups and the increases in the other indicators.

Figure 2.6: DDRB main award compared with April movement in the Retail Prices Index, Consumer Prices Index, Average Weekly Earnings and median (whole economy) settlements, 2002 – 2012



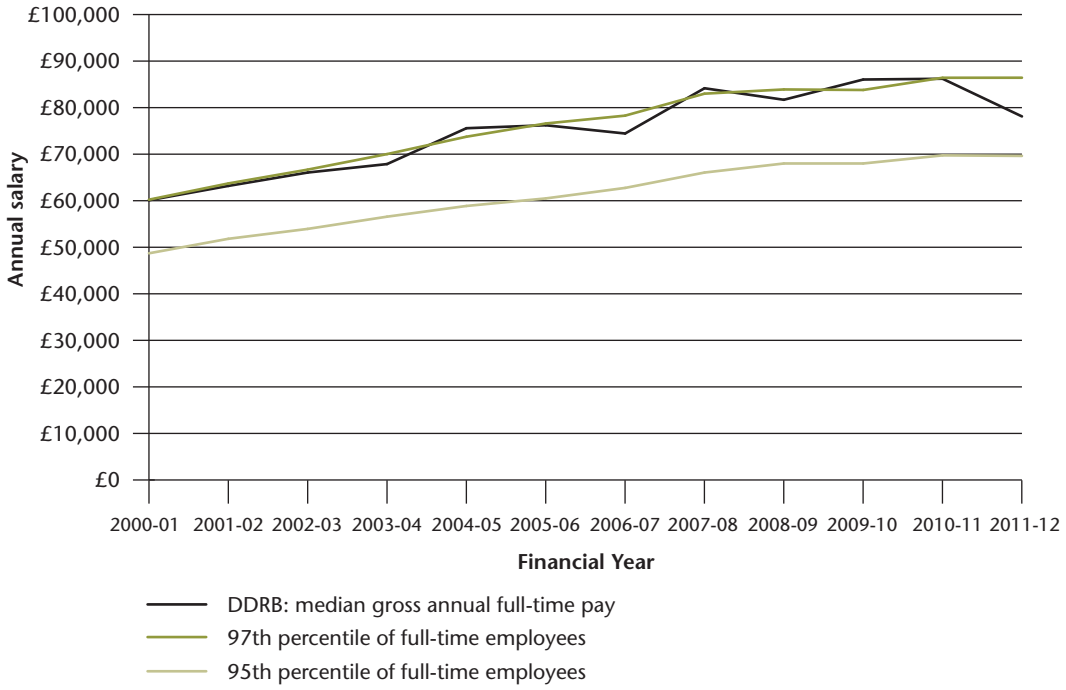
Sources: Office for National Statistics, Incomes Data Services and Office of Manpower Economics.

2.79 Figure 2.7 presents data from the *Annual Survey of Hours and Earnings*, which shows that the median gross annual full-time pay for employed doctors and dentists[26] in the United Kingdom has tended to track the 97th percentile for all full-time employees, though in 2011-12 there appears to be a large drop in average earnings for employed doctors and dentists. This drop does not appear to be borne out by, for instance, the latest statistics from the Health and Social Care Information Centre,[27] which showed a decrease of 0.4 per cent in annual earnings per headcount for non-locum doctors in England in the 12-month period ending March 2012. The much larger decrease in the *Annual Survey of Hours and Earnings* median may be due to a change in the composition of the sample, and we will monitor the position.

[26] The survey includes salaried general medical contractors and dentists, but excludes self-employed contractors.

[27] *NHS Staff Earnings Estimates to September 2012*. Health and Social Care Information Centre, 2012. Table 2b. Available from: http://www.ic.nhs.uk/catalogue/PUB09367

Figure 2.7: Movements in earnings from the Annual Survey of Hours and Earnings, 2000-01 to 2011-12



Source: Annual Survey of Hours and Earnings (Office for National Statistics).

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

Total reward: pensions and fringe benefits

2.80 We recognise that the NHS pension scheme continues to be a valuable recruitment and retention tool and note that, as with other parts of the public sector, the contribution rates increased in April 2012 and are set to see further increases in 2013 and 2014; also that from 2015 the final salary pension scheme will move to career average for most scheme members. GMPs and GDPs are, of course, already members of a career average scheme. We are also conscious of the strong feelings within the profession and that the BMA took strike action over pensions in 2012. We received a substantial amount of evidence from the parties on pensions and fringe benefits, which can be found in the parties' evidence on their websites (see Appendix E).

2.81 The BMA believed that the contributions to the NHS pension scheme were considerably higher than for other public sector professions with similar salary levels. It reported that the contribution rate increase in April 2012 amounted to 2.4 per cent for most doctors, and that the further increases planned in 2013 and 2014 would take contributions to 13.5 per cent for an average consultant (compared with 7.5 per cent before April 2012). It had calculated that hospital doctors moving to the new scheme would see a 30 per cent reduction in value on a like-for-like basis, and this was considered to be a particular concern for junior doctors, as their banding supplements (approximately 30 per cent of income for juniors) were not superannuable, which would have a significant impact on the calculation of pension income in a career average scheme. However, NHS Employers said that as pensions were deferred pay, planned increases to employee contributions to the NHS pension scheme should not be used to justify any additional increase in pay rates. They also reported that changes to tax relief arrangements, from April 2011 affected the annual allowance for tax-privileged saving, which was reduced from the

previous level of £255,000 to £50,000, and would see a further reduction to £40,000 from April 2014. They pointed out that the impact would be greater for NHS pension scheme members because of the number of higher earners.

2.82 With regard to other benefits and total reward, the Department of Health and NHS Employers listed many additional benefits included as part of the total reward package in the NHS. NHS Employers said that the overall value of the NHS reward package was not understood by, or communicated well to, many NHS employees. For this reason, total reward statements would be introduced in 2013 and would demonstrate better what individuals were paid and the additional local employer benefits they received, together with their annual pension benefits statement.

2.83 We are pleased to learn of the introduction of total reward statements. We think this will increase awareness and understanding of the total reward package, which is particularly important in times of pay restraint and could form the basis of a total reward strategy. We would like to be advised of developments in the total reward strategy, so that these can inform our consideration of pay.

2.84 We said previously that we would consider the implications of any changes by the government to pension arrangements for doctors and dentists, including those following from the review of public service pensions by Lord Hutton's Independent Public Service Pensions Commission, which reported in October 2010[28] and March 2011.[29] We would be interested in whether these significant changes to pension arrangements have had an effect on recruitment, retention and motivation and we ask the parties to update us for our next review.

2.85 We are conscious that during recent years, incomes have dropped in real terms for many people, both within and outside our remit groups. While incomes have dropped generally, our pay comparability research has shown that the relative position for our remit groups has worsened. We also recognise that pension contributions have risen and that our remit groups will need to work longer to reach pension age.

Looking forward

2.86 For the future, we believe we should be provided with an unrestricted remit so that the parties' trust and confidence in the independent Review Body process is maintained and we can return to making recommendations on pay and other allowances for the doctors and dentists within our remit groups. The absence of robust data on vacancies risks undermining the credibility of our recommendations. These data are also essential to inform long-term strategies for pay and workforce planning, which inevitably affect the quality of patient care. We ask the parties to update us on these issues for our next review, and to address all elements of our terms of reference, including: recruitment, retention, motivation, affordability, economic evidence, 'patients at the heart' and the legal obligations of the NHS. Our secretariat will be discussing, in detail with the parties, our evidence requirements for the next round.

Conclusions

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

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

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

- in general, the current recruitment and retention picture for doctors and dentists is not a cause for major concern, although there is evidence of some emerging difficulties recruiting doctors for some medical specialties and for GDPs in recruiting associates;
- we have reservations about the application of the Scottish public sector pay policy to our remit groups and believe that it could have unintended consequences for our remit groups, where the pay scales are national, with fairly minor variations across the United Kingdom. For example, the differentials in the pay scales for consultants and some of the SAS grades on either side of the threshold would be affected. We also believe that it would be complex to apply to independent contractor GMPs and GDPs as their earnings are not linked to a pay scale. We are concerned that if the pay policy continued over a number of years, it would undermine the principles of the current national pay scales;
- there is some evidence of reducing morale among doctors and dentists, although we have received no clear evidence that this is linked to pay. We conclude from this that the issues affecting motivation are more complex than just pay, but we do acknowledge that pay in real terms has declined for our remit groups and that there are a number of ongoing issues surrounding pensions;
- affordability must be considered alongside the need to recruit, retain and motivate doctors and dentists. We recognise that the huge financial pressures facing the NHS will continue for a number of years and that affordability is closely linked to the Health Departments' budgets. These budgets have been set with assumptions about pay levels having been made. Staff are also likely to be aware of the pay assumptions built into budgets, given the public announcements made by the United Kingdom governments on the public sector pay policies for this year;
- despite increments of between 3 and 8 per cent, pay drift for medical staff was negative, (-0.7 per cent in 2011-12) while the pay bill was growing due to the increase in staff numbers;
- we are pleased that efficiencies for GMPs and GDPs are being delivered through the contracts, although we note that it was not possible for the parties in all countries to reach agreement on the contractual changes; and
- during recent years, incomes have dropped in real terms for many people, both within and outside our remit groups. While incomes have dropped generally, our pay comparability research has shown that the relative position for our remit groups has worsened. We also recognise that pension contribution rates have risen and that our remit groups will need to work longer to reach pension age.

Future evidence requirements

2.88 We expect the parties to provide us with updates to issues that we have identified in previous rounds, such as any developments on new contractual arrangements for junior doctors and consultants, and the new dental contract pilots. In addition, the evidence requirements that we have identified from this round for our next review are for:

- the parties to address all elements of our remit including recruitment, retention, motivation, affordability, economic evidence, 'patients at the heart' and the legal obligations on the NHS;
- the parties in Scotland to provide an update on whether recruitment difficulties for certain hard-to-fill vacancies have been eased;
- the Department of Health and the Health and Social Care Information Centre to prioritise the publication of vacancy statistics, so that we and the parties to our review process can draw on them in our next round beginning autumn 2013;
- the parties to report back to us on the outcomes of local pay arrangements and initiatives such as the South West Pay, Terms and Conditions Consortium;
- a more up-to-date assessment on whether the labour market for doctors remains a national market and whether there is evidence to support locally differentiated pay for doctors such as London weighting;
- an update on the Scottish Government project measuring staff experience and conclusions from the staff surveys in Wales and Northern Ireland;
- we would like the parties to work with us, before the next round, to consider ways of gathering more meaningful evidence on motivation, in particular the link between motivation and reward;
- the parties to make clear their roles and responsibilities in relation to workforce planning and their views on the key issues;
- an insight into the special factors in relation to our remit groups that impact on affordability, for example, policy objectives for our remit groups, such as seven day working for consultants;
- a more rigorous analysis of pay drift and its component parts, and a better understanding of the cost of increments for our remit groups. We need data that relates specifically to our remit groups rather than the whole NHS workforce;
- the parties to address 'patients at the heart' more directly in the evidence for the next round, particularly with regard to any link to our recommendations on pay;
- the parties to update us on their monitoring of diversity issues arising from the distribution of consultants' awards and on action taken to address any inequalities;
- the parties to consider whether there are age equality issues that apply to remuneration and to provide evidence for our next review;
- we would like to be advised of developments in the total reward strategy, so that these can inform our consideration of pay; and
- the parties to provide an update on whether the significant changes to pension arrangements have had an effect on recruitment, retention and motivation.

Part II: Primary Care

CHAPTER 3: GENERAL MEDICAL PRACTITIONERS

Introduction

3.1 The core traditional role for general medical practitioners (GMPs) is the family doctor, working in the primary care sector of the NHS under one of the contracting routes: General Medical Services (GMS), Personal Medical Services (PMS) in England, Section 17C arrangements in Scotland, Alternative Providers of Medical Services (APMS), or Primary Care Trust Medical Services (PCTMS). The glossary at Appendix H explains these terms further. We are concerned mainly with GMS which is governed by a United Kingdom-wide contract, and we understand that approximately half of GMPs in England have GMS contracts, although in Scotland the figure is 87 per cent, and 100 per cent in Northern Ireland and Wales. Doctors working under PMS, Section 17C arrangements, APMS or PCTMS contract locally with primary care organisations. However, local PMS contracts and Section 17C arrangements tend to follow the main features of the GMS contract, although not obliged to.

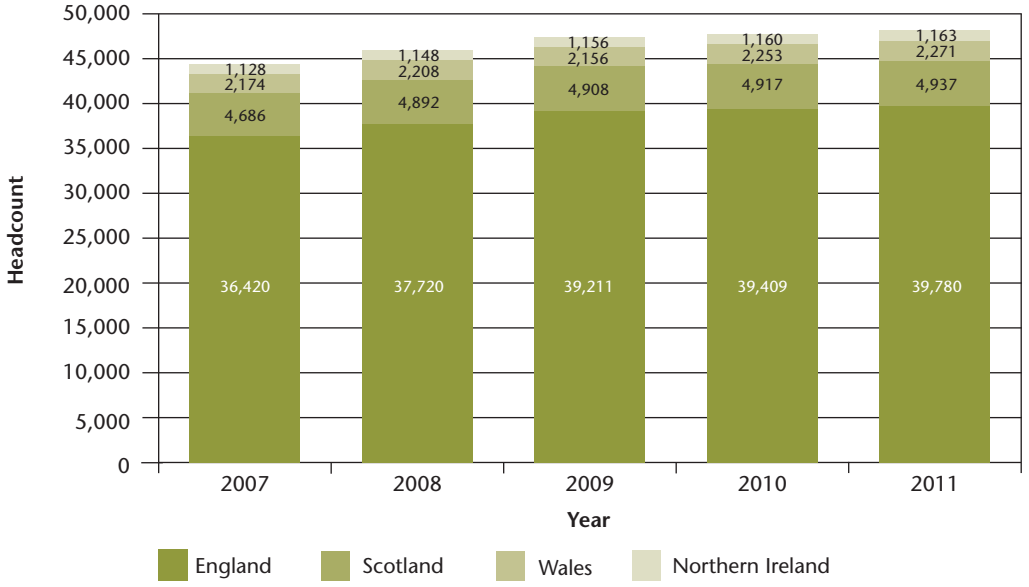
3.2 Most of the doctors working in the GMS are independent contractors – self-employed people running their own practices as small businesses, usually in partnership with other GMPs and sometimes others such as practice nurses; some practices belong to sole practitioners and some to companies which employ salaried doctors to staff them. Around 90 per cent of independent contractor GMPs' earnings come from contracts for the provision of public sector work, i.e. primary medical care services to NHS patients. Whilst the doctors contribute to a defined benefit pension scheme, the balance of the costs of the scheme over members' contributions is funded by the Health Departments and therefore very secure. Such a benefit would not typically be provided by a small business.

3.3 Salaried GMPs are employed either by primary care organisations or by independent contractor practices. The pay range for salaried GMPs is at Appendix C.

Recruitment and retention

3.4 From the evidence received, we do not find any current cause for concern in the recruitment and retention of GMPs. The number of GMPs in the United Kingdom increased by 0.9 per cent between September 2010 and September 2011 to 48,151 (Figure 3.1). The increase in the overall GMP population between 2007 and 2011 has mainly been due to recent increases in the number of general practice specialty registrars, salaried GMPs and GMPs who work flexible arrangements.

Figure 3.1: Number of general medical practitioners, 2007 – 2011, United Kingdom



Sources: Health and Social Care Information Centre, Welsh Assembly Government, Information Services Division Scotland, Health and Social Care Business Services Organisation in Northern Ireland.

3.5 We heard from the Health Departments that while the average age of the workforce has continued to increase, the proportion of GMPs in England expecting to quit direct patient care in the next five years fell from 7.1 per cent to 6.4 per cent amongst GMPs under 50 years old, and from 43.2 per cent to 41.7 per cent amongst GMPs aged 50 and over.

3.6 However, we note the Department of Health's commitment to move towards a 50:50 split between GMP and hospital specialty training, which it says will require an increase in the number of GMP trainees and a reduction in some hospital specialties. We understand from NHS Employers that a general practice taskforce has been created to assist with this and we ask the parties to update us on progress towards the 50:50 goal for our next review.

Motivation

3.7 The British Medical Association (BMA) told us that its latest survey, carried out to inform this year's evidence, showed that GMPs had lower morale than other types of doctor and that 75.9 per cent of respondents had reported a decrease in their morale compared to a year ago, compared to 69.8 per cent overall. It also made reference to the 2011 *GP Opinion Survey*, but we have previously commented on this evidence in our *Fortieth Report*.[1]

3.8 On the other hand, the Department of Health had found that on a seven-point scale, overall job satisfaction for GMPs had increased slightly, from 4.7 in 2008 to 4.9 in 2010. However, we note that this survey was carried out before the impact of the pay freeze, changes to the pension scheme and other recent NHS reforms would have been felt.

3.9 We will continue to monitor closely the impact of the pay freeze and the various NHS reforms on GMPs' motivation and we ask the parties to update us on this issue for our next review.

[1] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report.* Cm 8301. TSO, 2012. Paragraphs 1.42 – 1.44. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

Workload

3.10 The Health Departments observed that the average number of patients per GMP had fallen, but this was partly attributed to an increase in the number of GMPs. At the same time, the number of patients per practice had risen and the number of practices had decreased, which reflected a trend towards larger practices with more GMPs and fewer single-handed practices. The Department of Health also commented that average working hours were 41.4 hours per week and had remained unchanged from the previous 2008 and 2009 surveys. It added that there were significantly fewer GMPs undertaking out-of-hours work in 2010, declining from 32 per cent to 21 per cent. We were interested to note from the Department of Health's evidence that there were moves to use more GMPs in accident and emergency departments to manage minor injuries and illness, which enabled emergency medicine practitioners to attend to cases needing their more specific skills.

3.11 The BMA believed that the average 7.76 half-day sessions per week reported to be worked by GMPs, were a significant underestimate of actual hours worked. It said that the 2011 *GP National Opinion Survey* had estimated that for full-time GMPs the actual number of hours worked was just under 47, including administrative duties. Both its surveys showed a net increase in workload, due to staff shortages, commissioning responsibilities, and as the only way to deliver a quality service. In the BMA survey, GMPs reported higher and increasing intensity and complexity in their work than other doctors.

3.12 In our view, most of these changes in workload reflect changes in the structure of general practice. We also think that working weeks longer than 47 hours are not unusual in the professions we use as comparators for our remit groups. However, we also recognise that many GMPs work part-time and that it is difficult to know how many hours they actually work compared to their contracted hours. We note the disparity between the Department of Health and the BMA in the data for working hours and ask the parties to update us for our next review.

Independent contractor general medical practitioners

3.13 The GMS contract for GMPs was introduced throughout the United Kingdom on 1 April 2004. The contract is with the practice rather than with individual GMPs and allows for gross income under several different headings, including: basic services or global sum; enhanced services; funding administered by primary care organisations; and Quality and Outcomes Framework (QOF) payments. The glossary at Appendix H gives further information on aspects of the GMS contract.

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

3.15 This year, we have found ourselves uncertain as to whether or not we were required to make a recommendation on the uplift to the GMS contract. Initially, the four governments of the United Kingdom were in agreement that they did not require us to make recommendations on the uplift for independent contractor GMPs, as specified in the remit letters available at Appendix A. The BMA disagreed and the Chair of Council wrote to us (Appendix A) stating that the BMA intended to submit full evidence on GMPs and that it wished us to revisit the expenses formula used for GMP contractors to ensure that it was fit for purpose. The BMA said that it did not consider that the Department of Health was able to unilaterally change our remit and that it expected us to make recommendations in the usual way.

3.16 This is not the first time that we have found ourselves in such a position and we see no reason to diverge from the conclusions we reached in our *Thirty-Sixth Report*:

> *Having considered the conflicting positions of the parties, with the BMA asking us to make a recommendation while the government argued that we had no role, we have decided that we should make a recommendation for independent contractor GMPs. We came to this conclusion because our remit covers "the remuneration of doctors and dentists taking any part in the National Health Service". While the parties jointly can – and did – ask us not to make recommendations on remuneration when they have reached a prior agreement, we believe that, as long as independent contractor GMPs remain one of our remit groups, each side is entitled to expect that we will revert to making recommendations once the parties are no longer unanimous in asking us not to do so.*[2]

3.17 The Secretary of State for Health, Jeremy Hunt, subsequently wrote to us on 23 October 2012 to inform us of the potential need for us to make recommendations on the uplift to the GMS contract in England for 2013-14 as negotiators had not yet been able to agree the changes in the contract required by the government in return for a 1.5 per cent uplift in GMP practice income, designed to provide an average 1 per cent uplift in net income. Similar letters followed from the Minister for Health, Social Services and Public Safety in Northern Ireland, Edwin Poots and from the Minister for Health and Social Services in the Welsh Government, Lesley Griffiths. These letters can all be seen at Appendix A. However, Wales and Scotland reached agreement with the BMA on the changes they wished to make to the GMS contract and sought only an uplift recommendation. At the time of submitting this report, no agreement has been reached in either England or Northern Ireland.

The formula

3.18 In deciding the uplift for independent contractor GMPs for 2013-14, we are using a similar approach to last year, using a formula that takes into account our intended net uplift, as well as actual movement in staff costs and other expenses. The BMA asked us to revisit our formula approach to ensure that it was fit for purpose. We have therefore considered each of the coefficients that we use in our formula-based approach for deciding our recommended uplift for independent contractor GMPs for 2013-14.

Earnings and expenses

3.19 The formula coefficients (weights) are derived from figures on GMPs' average earnings and expenses, compiled by the Health and Social Care Information Centre using data from self-assessment tax returns. The most recent iteration of the GMP formula, in our *Thirty-Ninth Report 2010*, assumed an expenses to earnings ratio (EER) of 60 per cent – i.e. GMPs' profit was 40 per cent of their gross earnings. However, evidence from the Department of Health suggested that premises and IT costs, which represented 10 per cent of gross earnings, were fully reimbursed by primary care trusts, which led to an adjustment to the formula coefficients in both 2009 and 2010.[3]

3.20 There have been three annual updates to the GMP earnings and expenses data since the last time we were required to make a recommendation. As shown in Figure 3.2 and Table 3.1 below, the EER has increased each year: 59.3 per cent in 2008-09; 59.8 per cent in 2009-10; and 60.9 per cent in 2010-11 (the latest available figures).

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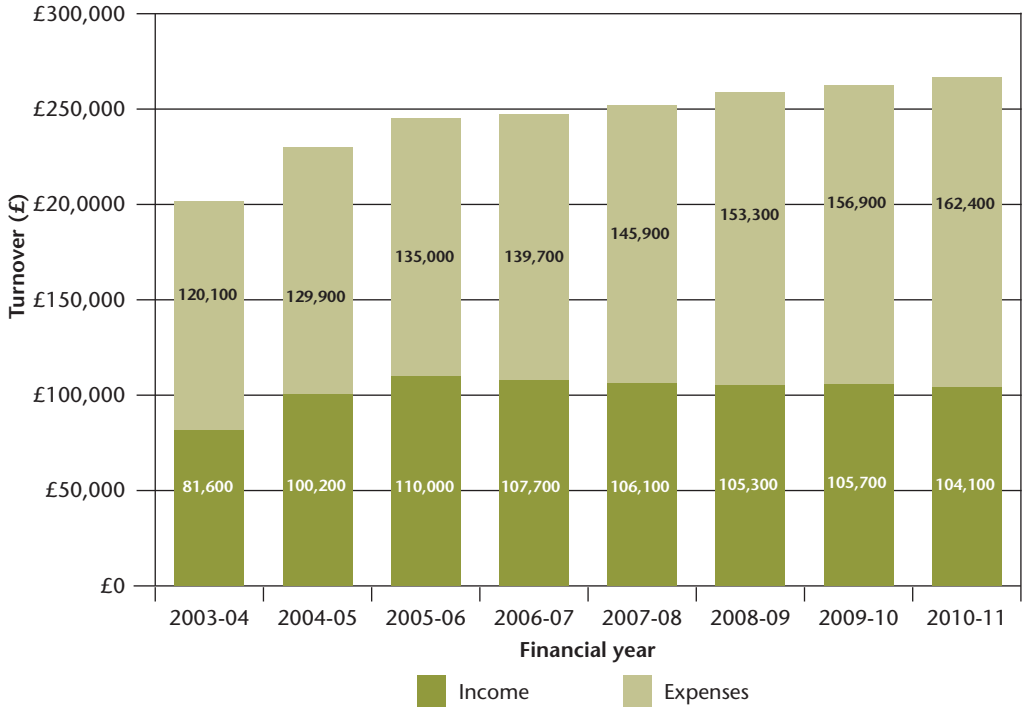
[2] Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth report.* Cm 7025. TSO, 2012. Paragraph 3.28. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[3] For example, the coefficient for income was calculated as 40 per cent divided by (100 – 10) per cent = 44.4 per cent.

Figure 3.2: General medical practitioners' average gross earnings: income and expenses 2003-04 to 2010-11, United Kingdom



Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

Table 3.1: General medical practitioners' average gross earnings, expenses and income by United Kingdom country, 2009-10 to 2010-11

Country	Year	Gross Earnings	Total Expenses	Income Before Tax	Expenses to Earnings Ratio (EER)
England	2009-10	£278,100	£168,700	£109,400	60.6
	2010-11	£283,000	£175,300	£107,700	61.9
	% change	*+1.8*	*+3.9*	*-1.6*	*+1.3pp*
Scotland	2009-10	£192,200	£102,700	£89,500	53.4
	2010-11	£193,600	£104,400	£89,300	53.9
	% change	*+0.8*	*+1.6*	*-0.2*	*+0.5pp*
Wales	2009-10	£227,700	£134,300	£93,500	59.0
	2010-11	£228,200	£136,000	£92,300	59.6
	% change	*+0.2*	*+1.2*	*-1.3*	*+0.6pp*
Northern Ireland	2009-10	£189,200	£97,800	£91,400	51.7
	2010-11	£185,700	£97,700	£88,000	52.6
	% change	*-1.8*	*-0.1*	*-3.7*	*+0.9pp*
United Kingdom	2009-10	£262,700	£156,900	£105,700	59.8
	2010-11	£266,500	£162,400	£104,100	60.9
	% change	*+1.4*	*+3.5*	*-1.5*	*+1.1pp*

Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

pp: percentage point change.

3.21 The BMA has suggested that the formula coefficients should change to reflect the latest data. The offer made by the Department of Health, which took the lead on negotiations for all the Health Departments, was based on the 2010 formula coefficients.

3.22 We believe that the formula coefficients should be changed to reflect the changes in the EER, i.e. an EER of 60.9 per cent, which is the latest available figure from the 2010-11 data.

3.23 With regard to the adjustment for the direct reimbursement of premises and IT costs, the BMA evidence noted an increase in the share of premises costs as a percentage of gross earnings, and said that not all these costs were reimbursed. It said that for GMP contractors, there was a secondary impact of pension contribution rises on their expenses, as employed practice staff on NHS contracts (salaried and locum GMPs, *Agenda for Change*) would also face the rises and seek compensatory pay increases to avoid a further cut in real income. It asked us to consider this in recommendations around the gross uplift for GMP income. The BMA's further supplementary evidence observed that direct reimbursements now comprised "fractionally over 11 per cent" of total investment in general practice – though this related to GMS contracts only, whereas the uplift formula had in the past used data for all GMPs including those on PMS and other contracts. The equivalent figure for direct reimbursements for all GMPs is 10.2 per cent.

3.24 After careful consideration, we have decided that it would be most appropriate to use an adjustment for reimbursements that relates to all GMPs, across all four countries of the United Kingdom, regardless of the type of contract; this is consistent with our approach for the other formula coefficients.[4]

3.25 Accordingly, the formula coefficients are as follows:

- GMPs' average taxable income is 39.1 per cent of total gross earnings which represents 43.5 per cent of non-reimbursed gross earnings;
- staff costs are 36.4 per cent of total gross earnings which represents 40.6 per cent of non-reimbursed gross earnings; and
- other costs are the remaining 15.9 per cent of non-reimbursed gross earnings.

Income uplift

3.26 Government pay policy is for an average of up to 1 per cent increase in basic pay, while the BMA regarded this as an "absolute minimum". The Department of Health's offer in negotiations included a 1 per cent uplift for net income.

3.27 The BMA said that the necessary use of historic earnings and expenses data meant that significant shifts in current and future expenses would not be reflected in the gross earnings recommendation until three years later. It suggested that the solution was to make a retrospective adjustment to the formula where it had failed to deliver the recommended net income, and that following this argument, an additional "catch up" uplift factor of 1.4 per cent should be applied to the net income element of the formula. The Department of Health disagreed. It suggested that if we were to introduce a new, retrospective element into the formula, this should take account of over-delivery of uplifts as well as under-delivery, and that any retrospective adjustment should be considered back to 2003, so that it was applied to the full period of the new GMS contract. As it is not our usual practice to make adjustments for previous recommendations, we believe that we should discount both of these suggestions. We reiterate that our annual recommendations are made in the light of the best available data at that time.

[4] However, we note that had we used General Medical Services only data for both the baseline earnings and expenses data and for reimbursements, there would have been very little difference to the outcome.

3.28 The BMA argued that the fees related to the requirement for GMP providers to be registered with the Care Quality Commission by April 2013 and for revalidation should be taken into account when we considered the income uplift element of the formula. The Department of Health observed that in line with HM Treasury guidance on regulatory fees, it was an accepted principle that those who were regulated should meet the cost of regulation and that the BMA was free to respond to the Care Quality Commission's consultation on the level of fees; and that it would be inappropriate to provide an uplift to a contract for the provision of services (such as GMS) to cover specific costs for individuals to provide the services commissioned from that contracting organisation. Moreover, our established line is that we do not forecast future costs, and that future outturn data on practice earnings and expenses will show trends that can then be taken into account when considering future recommendations.

3.29 Our recommendation this year is for the same uplift across our remit groups. Our recommendation for the intended uplift to income for independent contractor GMPs is 1 per cent: our rationale for this is in Chapter 9.

Staff costs uplift

3.30 Our 2009 and 2010 formulae used the increase in *Agenda for Change* pay scales that was expected to apply from April in those years. These increases were part of a three-year pay agreement reached by the parties to the *Agenda for Change* Agreement. Our 2008 formula treated all expenses equally, increasing them in line with the Retail Prices Index excluding mortgage interest payments (RPIX).

3.31 For 2013, *Agenda for Change* staff are subject to the same government pay policy as doctors and dentists, and the uplift for these staff will not be known until the government publishes the NHS Pay Review Body's Report, i.e. after we have submitted this report. The Department of Health's offer to the BMA in negotiations has allowed for a 1 per cent uplift for staff costs. The BMA told us that actual average expenditure on staff had exceeded the *Agenda for Change* uplift for several years, and that our increase did not account for automatic increments. It suggested that the formula should incorporate an *Agenda for Change* factor of 1 per cent intended uplift, plus 2.5 per cent for increments.

3.32 There is, however, no evidence that all practice staff are being paid on *Agenda for Change* pay scales: indeed, in supplementary evidence, the Department of Health said that only a very small minority of general practice staff were employed on *Agenda for Change* terms. It said that the results of the 2011 *Practice Nurse Survey* indicated that only 1.3 per cent of practices provided the same pay and conditions as those received by nurses working for the NHS. Based on this evidence, we have concluded that usage of an *Agenda for Change* figure to represent the change in staff costs would be inappropriate.

3.33 Accordingly, we have considered alternative options for the uplift to the staff element of the formula. For our dental formula, we have for several years used data from the *Annual Survey of Hours and Earnings* to reflect increases in staff costs, and it is possible from this dataset to examine the change in median gross hourly pay for employees identified as being employed in general medical practices. Although this is a backward-looking measure, it is focused on all employees (i.e. excluding self-employed contractors) within general medical practices, rather than directly-employed NHS staff. It therefore relates to practice nurses, receptionists, practice managers, other practice staff and salaried GMPs. This measure, in our view, is the most appropriate source of data to inform the uplift for the staff element of the formula, and is also consistent with the approach taken for

general dental practitioners in Scotland in our *Fortieth Report*.[5] The increase in median gross hourly pay for employees working in general medical practices was 3.4 per cent between April 2011 and April 2012.

3.34 We note that this figure is higher than typical pay settlements[6] and certainly higher than the uplift we might expect from an organisation essentially working within the public sector, given the pay freeze. However, it is the best estimate available of the actual increase in the staff costs borne by GMPs. A number of factors could be driving this increase, for example pay progression for individuals, or a change in the composition of the practice workforce to include, for example, more specialist nurses, or to deal with the consequences of commissioning. We invite the parties to provide their views on our use of the *Annual Survey of Hours and Earnings* (general medical practice activities) data to reflect increases in staff costs in the formula. We invite views on whether there is a better approach to capturing appropriate information on the increase in staff costs and the deployment of staff in general practices.

Uplift for other expenses

3.35 The 2010 formula used the latest available quarterly figure for the RPIX, because the evidence suggested that premises costs were reimbursed. The BMA noted that in the absence of any clearly preferable alternative, it believed that RPIX should continue to be used. We are not persuaded by the evidence that there should be any change from using RPIX and we therefore intend to continue to use RPIX to represent other expenses, using actual rather than forecast data. The RPIX annual increase for the last quarter of 2012 was 3.0 per cent.

Adjustment for volume changes and efficiencies

3.36 The BMA criticised the formula for not taking account of volume changes and argued that the increasing primary care workload had generated additional expenses (both staff and other expenses), and/or had led to GMPs being forced to deliver these expenses out of their personal income. It said that at a national level, GMPs were not being remunerated for the increase in workload due to an ageing population, and that the gap between remunerated and actual worked consultations was around 1.1 per cent per annum, which it believed should be included as an additional factor in a revised formula: as only the global sum element of the resource allocation is weighted and normalised, this equates to 0.56 per cent to reflect the share of global sum in total practice income. However, the Department of Health commented that it was not aware of the figures on structural changes in the population being presented by the BMA during negotiations, or in the Global Sum Formula Working Group that the negotiators established.

3.37 We suggest that the parties should address any issues relating to structural changes in population and its impact on the global sum through the Global Sum Formula Working Group.

Efficiency savings

3.38 Our longstanding position on efficiency savings is that we believe it is both unnecessary and inappropriate to include them in our funding formula, as the impact of efficiency savings will become apparent, albeit with a time lag, in the data used in our formula. We commented in our last report that if the Health Departments continued to think it appropriate to impose an efficiency requirement on independent contractor GMPs

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[5] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report.* Cm 8301. TSO, 2012. Chapter 2. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[6] The Incomes Data Services median pay settlement for the 12 months ending December 2012 in the United Kingdom is: 2.5 per cent (all settlements); 2.6 per cent (private sector); and 0.7 per cent (public sector).

to make efficiency savings, then we believed that any such requirement should be a contractual matter, rather than abating our recommended increases. We are pleased to note that a contractual approach to efficiency savings is being sought, although we recognise that the BMA has withdrawn from negotiations in some countries on the contractual changes that would deliver efficiency savings. We do not think it is for us to consider the level of efficiencies being sought from changes to the contract, nor to make any adjustment to the formula to take this into account. However, we would wish to track any consequent effects on recruitment, retention and motivation to inform future recommendations.

The formula for 2013-14

3.39 Putting all this information into our formula for calculating the gross uplift to contract values gives the following:

Table 3.2: Uplift formula for general medical practitioners, 2013-14

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Net income	43.5%	1%	0.43%
Staff costs	40.6%	3.4% *Annual Survey of Hours and Earnings (general medical practice activities) 2012*	1.38%
Other costs	15.9%	3.0% *RPIX 2012 Q4*	0.48%
		Total	**2.29%**

3.40 Our recommendation for independent contractor GMPs is in Chapter 9.

Salaried general medical practitioners

3.41 Data from the Health and Social Care Information Centre showed that the average taxable income for salaried GMPs was £57,600 in 2010-11, a decrease of 0.7 per cent compared with the previous year. However, we recognise that many salaried GMPs work part-time. Last year, we observed that figures for the average amount of part-time work per week were not current. The BMA reported that its 2011 *GP Opinion Survey* had found that for practice-employed salaried GMPs the mean was 25.1 hours per week, which shows an increase from the 23.8 hours in the 2006-07 workload survey.

3.42 The BMA said that the vast majority of salaried GMPs had received no pay increase, and had experienced an erosion in remuneration in real terms. In the light of the pay freeze this is not surprising. The BMA argued that there were increasing professional costs from the increase in pension contributions (an additional 2.4 per cent from April 2012), increases in fees for medical defence organisations and the General Medical Council, and increasing costs for continuing professional development which by and large were personally funded by these GMPs. It said that salaried GMPs were also affected, along with their principal colleagues, by the increased workload. It sought the same uplift for this group of doctors as for the rest of the profession.

3.43 NHS Employers believed that the salaried GMP pay range remained fit for purpose and presented no recruitment and retention issues for employers. They said that any recruitment issues were location specific labour market supply issues.

3.44 Our recommendation this year is for the same uplift across our remit groups and can be found in Chapter 9.

Clinical commissioning groups

3.45 Last year we asked the parties to update us on how the proposed new system of Clinical Commissioning Groups (CCGs) in England would operate in practice, what it would mean to be a 'member' of the groups and the effect on income streams for GMPs. However, we did not receive this information in any depth. The BMA said that it was too early for it to have collected evidence on the impact of CCGs (and other new organisations such as Local Education and Training Boards) on practice and individual GMP income and workload; it had concerns about the involvement of GMPs in CCGs and the impact of that on time to undertake patient contact and other practice duties, and cost in additional use of locum cover, but it was unable to quantify this at this stage. The Department of Health told us that CCGs would be responsible from April 2013 for commissioning most healthcare services for local populations. The BMA and NHS Employers had agreed that it would be a contractual duty for practices holding primary medical services contracts in England to be members of CCGs. The Department of Health said that with the exception of the running costs allowance, the annual budget allotted to CCGs would have to be spent wholly on healthcare services for patients. It would be distinct from the NHS income that general medical practices received under their primary medical services contracts. We ask the parties to update us on this issue for the next review, in particular the effect on income streams for GMPs.

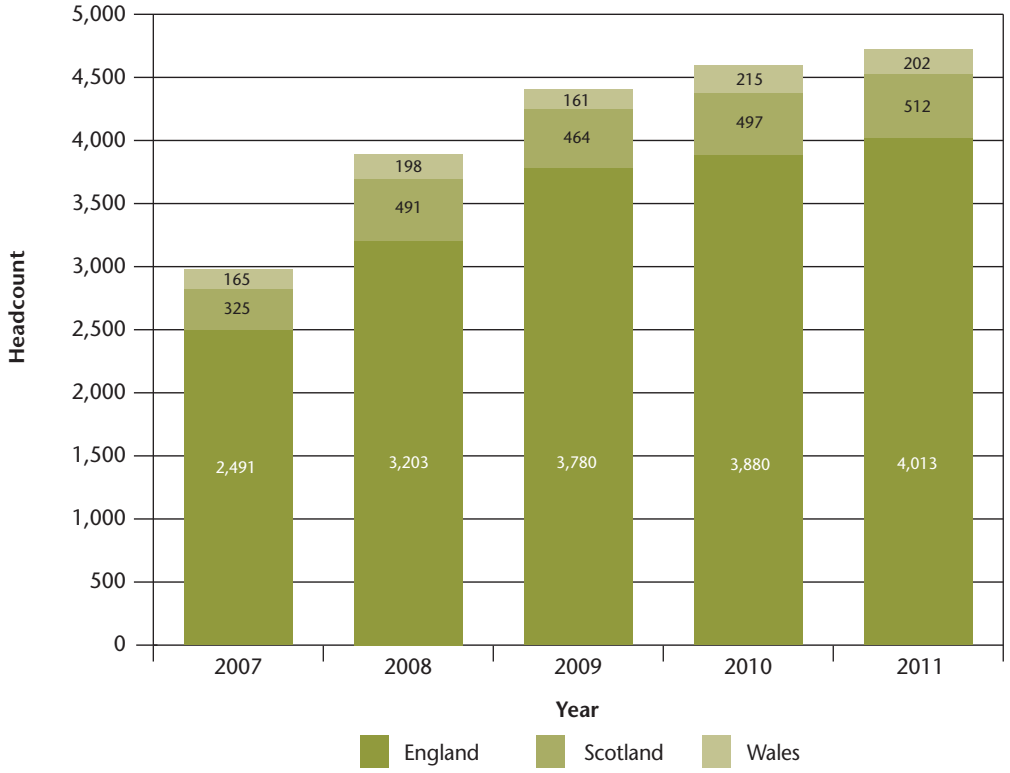
Locally determined contractual arrangements

3.46 Our recommendations for independent contractor GMPs apply solely to the United Kingdom-wide GMS contract; other contractual arrangements including PMS, APMS and Section 17C arrangements are all locally determined. Nevertheless, our recommendations do inform the awards given to contractors working under locally determined contractual arrangements. For example, we note from the Scottish Government its commitment to maintaining fair and equitable funding for all GMPs, and that funding allocations to health boards for 2012-13 were adjusted to reflect consistent treatment of all contractual arrangements, and that this approach would continue in the future.

General practice specialty registrars

3.47 The number of general practice specialty registrars has increased year on year in England, but, as can be seen in Figure 3.3, this has not been the case in Wales and Scotland where the numbers have fluctuated, with dips in 2009 for both countries, and in 2011 for Wales.

Figure 3.3: Number of general practice specialty registrars, 2007 – 2011, Great Britain[1]



Sources: Health and Social Care Information Centre, Welsh Assembly Government, Information Services Division Scotland.

Note:
[1] Northern Ireland does not produce separate figures for general practice specialty registrars.

3.48 The Department of Health told us of the need to continue the move towards a 50:50 ratio between GMP and hospital specialty training. This would require an increase in numbers of GMP trainees and a reduction in some hospital specialties. NHS Employers reported that the 2013 planning assumptions represented an expansion of GMP training posts to 3,000 with Local Education and Training Boards aiming to achieve their share of 3,250 general practice specialty training 1 posts by 2015.

3.49 In the past, we have made recommendations on the GMP registrars' supplement – this was introduced at a time when recruitment into general practice was poor and was paid to ensure that doctors who opted to train for a career in general practice were not financially disadvantaged compared to hospital doctors in training. The supplement currently stands at 45 per cent. We have not been asked by any of the parties to make a recommendation on this supplement. We ask the parties to make it clear for the next round whether any recommendation on this supplement is required, particularly given the desire to increase the number of trainees choosing a career in general practice rather than within hospitals.

General medical practitioner trainers' grant

3.50 The Department of Health pointed out that as growing numbers of GMP training practices moved onto PMS contracts, and since the introduction of the new GMS contract from April 2004, the GMP trainers' grant was no longer treated at local level as an individual GMP's remuneration. Instead, it was generally treated as a practice income stream, the allocation of which was decided collectively by the practice. Frequently, the GMP trainer was responsible for overseeing a trainee's progress for the whole of the

three-year Specialty Training in General Practice programme, not just the period they were on placement in a practice, and a significant number of deaneries were making payments to practices from the Multi Professional Education and Training (MPET) budget, in addition to the GMP trainers' grant, to reflect this wider responsibility. However, there was widespread agreement among stakeholders that the existing MPET funding arrangements lacked transparency and were not fit for purpose, and these were now under review. The Department of Health aimed to introduce a tariff based funding system for education and training in primary care from April 2014 which would incorporate the GMP trainers' grant. The review was led by the Department of Health and included the BMA. The Department of Health believed that it would not be appropriate to increase the GMP trainers' grant while plans were under development for the introduction of an education and training tariff.

3.51 The BMA argued that the role of the GMP trainer was important in general practice, and would become increasingly so with the extension to GMP specialist training to four years. Its survey had indicated that 15.9 per cent of respondents received a training grant and on average they were providing more time for training than they considered reasonable. Furthermore, just over half indicated that the hours actually worked had increased over the previous year. The BMA said that 85.5 per cent of respondents indicated that the level of grant was now insufficient for the workload, and we note that with the planned expansion of GMP trainee numbers, this workload was expected to rise further. The survey also highlighted concerns that GMP trainers might actively resist attempts to introduce additional unresourced work or resign if the level of the grant was not significantly increased. The BMA believed that its survey results indicated a strong case for an uplift in the GMP trainers' grant, and the additional payment towards GMP trainer continuing professional development costs, and asked us to make a specific recommendation on this.

3.52 We have sympathy with the views expressed by the BMA regarding the trainers' grant and we have commented in previous reports about the apparent inertia over the completion of the various reviews, most recently in our *Thirty-Ninth Report*.[7] The trainers' grant has been under review for several years and in expectation of a conclusion we have repeatedly held off recommending anything other than an increase for the trainers' grant in line with other fees and allowances. As the various reviews are still not complete, we believe that the GMP trainers' grant should be uplifted by the same amount as basic pay, which for 2013-14 would represent an increase of 1 per cent. Our recommendation for the pay uplift for 2013-14 is in Chapter 9. We urge the parties to give priority to resolving this issue and to update us for our next review.

General medical practitioner educators

3.53 The BMA said that reforms taking place in education and training would continue to increase the workload and need for GMP educators, as would the introduction of revalidation and the consequent expectation of more doctors requiring remediation. It said that it had previously referred to the fact that remuneration for primary care medical educators was lower than GMP clinical pay and that there was anecdotal evidence that some primary care organisations had been deducting income for educator work from the NHS profits that were used to calculate eligibility for seniority payments, which further increased the differences in reward for the two types of work. The BMA also drew our attention to a report by the Committee of General Practice Education Directors,[8] which noted a small decline in the number of GMP educators employed by Deaneries coupled with a decline in recruitment.

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[7] Review Body on Doctors' and Dentists' Remuneration. *Thirty-ninth report.* Cm 7837. TSO, 2010. Paragraph 3.45. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[8] Committee of General Practice Education Directors. *Educator Workforce Report.* Spring 2012. Paragraph 2.

3.54 We have previously said that as GMP educators are not self-employed, we believe it is appropriate to draw a parallel with other salaried GMPs and that they should receive the same pay uplift as salaried GMPs. Our recommendations are in Chapter 9.

Future evidence requirements

3.55 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to provide an update on progress towards the goal of a 50:50 split between GMP and hospital specialty training;
- evidence on the impact of the pay freeze and the various NHS reforms on GMPs' motivation;
- evidence of GMPs' working hours and of the impact on the recruitment, retention and motivation of GMPs;
- the parties to provide their views on our use of the *Annual Survey of Hours and Earnings* (general medical practice activities) data to reflect increases in staff costs in the formula. We invite views on whether there is a better approach to capturing appropriate information on the increase in staff costs and the deployment of staff in general practices. We also need to achieve a better understanding about staff costs in general practices;
- the parties to provide an update on CCGs, in particular the effect on income streams for GMPs;
- the parties to make it clear whether any recommendation on the general practice specialty registrar supplement is required, particularly given the desire to increase the number of trainees choosing a career in general practice rather than within hospitals; and
- the parties to give priority to reviewing the GMP trainers' grant and to provide an update on progress.

CHAPTER 4: GENERAL DENTAL PRACTITIONERS

Introduction and remit

4.1 For the 2013-14 round, we received a number of remit letters from the four countries, which are reproduced in Appendix A:

- in his letter of 3 July 2012, the then Secretary of State for Health, Andrew Lansley, told us that there was no need for us to make recommendation on uplift for general dental practitioners (GDPs) for 2013-14. The government had already decided that public sector pay increases would be capped at an average 1 per cent increase for 2013-14, and our formula provided a well-established basis for calculating the gross uplift needed to deliver a 1 per cent increase in net income after allowing for expenses;
- in her letter of 8 August 2012, the Minister for Health and Social Services in Wales, Lesley Griffiths, concurred that there was no requirement to make a recommendation for GDPs in Wales;
- the Minister for Health, Social Services and Public Safety in Northern Ireland, Edwin Poots, wrote to us on 25 September 2012, outlining that there was no need for us to make recommendations for GDPs; and
- the Cabinet Secretary for Health and Wellbeing, Alex Neil MSP, confirmed in a letter of 11 October 2012 that there was no need for us to make recommendations on uplift for GDPs in Scotland for 2013-14.

4.2 We were told subsequently by the British Dental Association (BDA) on 12 October 2012 that it would not submit evidence on earnings and expenses for England and Wales, and on 22 October 2012 it again wrote to ask us to treat as information only, the evidence it had already submitted on earnings and expenses for GDPs in Northern Ireland. We understand that, in these countries, the parties are negotiating uplifts to contract values and fee scales, alongside other contractual discussions.

4.3 On 7 November 2012, however, the BDA told us that it would submit evidence on earnings and expenses for GDPs in Scotland, and sought a recommendation on the uplift to fee scales.

4.4 As the parties were not in agreement that we should not make a recommendation on the uplift for GDPs in Scotland, we have therefore considered the evidence on earnings and expenses for GDPs in this country. We also summarise the information we received from England, Wales and Northern Ireland around the recruitment, retention and motivation of dentists, along with the latest statistics on dentists' earnings and expenses.

Uplift for general dental practitioners in Scotland in 2011-12 and 2012-13

4.5 For our *Fortieth Report*,[1] we were asked by the Cabinet Secretary for Health and Wellbeing and Cities Strategy in Scotland to carry out a detailed assessment of all the changes that had been made to GDPs' earnings and expenses in Scotland and make recommendations as appropriate for both 2011-12 and 2012-13. In arriving at our recommendations, we noted that dentists in Scotland benefitted from a range of allowances and reimbursements; and that earnings and expenses statistics could be affected by "multiple counting".[2] Accordingly, we made adjustments to our formula, and made recommendations for uplifts to fee scales for 2011-12 and 2012-13 that were

[1] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report.* Cm 8301. TSO, 2012. Chapter 2. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[2] Multiple counting is described in paragraph 4.44, and in the glossary to this report (Appendix H).

intended to deliver a freeze in dentists' taxable income while allowing for movement in their expenses.

4.6 The Cabinet Secretary wrote to us on 8 March 2012 thanking us for our recommendations and observations, and told us that our comments would be carefully considered and acted upon as appropriate, and that the Scottish Government would work with us and the other parties to take forward the issues highlighted in our report.

4.7 At the time of submitting this report, our recommendations for 2011-12 and 2012-13 were still being considered by the Scottish Government.

4.8 The Scottish Government noted that we recommended an uplift of 1.0 per cent for 2011-12 and 1.38 per cent for 2012-13, but considered that, due to rent payments which had no English or Welsh equivalents, the formula used by us was inappropriate for GDP calculations in Scotland. It also emphasised that our calculations made no provision for efficiency savings, and in the Scottish Government's view it might be fair and reasonable to build these in as part of their response. Options for responding to the 2012-13 recommendations together with wider consideration of General Dental Services (GDS) were being taken forward in consultation with the profession and ultimately Ministers.

4.9 The BDA welcomed the analysis of expenses in Scotland in our *Fortieth Report*, but was disappointed that we chose to alter the methodology applied to the formula used to derive the uplift. Nonetheless, it urged the Scottish Government to implement our recommendations in full for both 2011-12 and 2012-13 as soon as practicable.

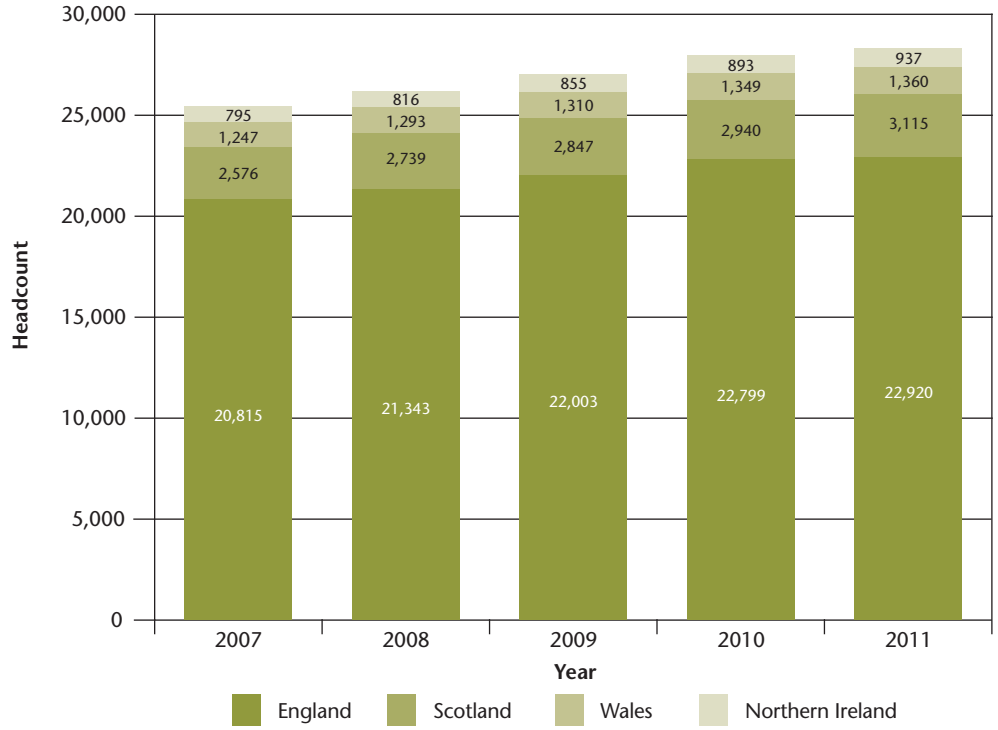
4.10 We agree that a decision on the 2011-12 and 2012-13 uplifts should be taken as soon as practicable. We note the Scottish Government's views on efficiency savings. Our views have not changed and are set out in Chapters 2 and 3, and we note that such savings are now being pursued on a contractual basis for general medical practitioners.

4.11 We note the Scottish Government's concerns that previous uplifts have not taken into account the allowances and reimbursements paid to dentists in Scotland, and we believe this issue has been rectified under our formula for 2011-12 and 2012-13. We understand from our discussion during oral evidence with the Chief Dental Officer that the Scottish Government is attempting to calculate a new 'baseline' for item-of-service fees, to remove the historic effect of allowances and reimbursements from the uplifts. Our recommendations for 2010-11 and earlier were made using the best available data, and the Scottish Government was able to reflect on our recommended uplifts, in the event that it considered that the application of an England and Wales-based formula was inappropriate. In our view, such retrospective action, coupled with the delay in responding to our more recent recommendations, risks damaging the Scottish Government's partnership working with the profession.

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

4.12 In September 2011, there were 28,332 GDPs in the United Kingdom, an increase of 1.3 per cent on September 2010 (Figure 4.1).

Figure 4.1: Number of general dental practitioners, 2007 – 2011, United Kingdom



Sources: Health and Social Care Information Centre, Welsh Assembly Government, Information Services Division Scotland, Health and Social Care Business Services Organisation in Northern Ireland.

4.13 The Department of Health told us that 95 per cent of people who tried to get an appointment with an NHS dentist in England in the past two years had been successful. Access to dental services had risen, with increases in the number of patients seen, the number of Units of Dental Activity (UDAs) provided, and the number of dentists providing NHS services. The proportion of dentists' time spent on NHS work had also increased. The Department of Health also noted that the number of dental school graduates had risen to 933 in 2012, a 39 per cent increase since 2004. There had been a corresponding increase in vocational training places and an increase in practices wishing to participate in the scheme. The Department of Health's estimates of future workforce supply suggested that the supply of dentists would be able to meet demand for new services.

4.14 The Department of Health considered that dentists in England remained willing to bid for and undertake NHS contracts, especially in areas where dentists had previously chosen not to set up or provide NHS services; in the Department of Health's view this was evidence that levels of NHS income were not acting as a bar to recruitment and retention or to growth in NHS services.

4.15 The Welsh Government told us that in 2011-12, 2.4 million dental courses of treatment by dentists in Wales were recorded, 5.1 million UDAs were recorded, and there were more GDPs in the NHS in Wales than at any time in the past. Additional investment in dental undergraduate training in Wales had seen the number of dental foundation 1 posts funded by the Welsh Government increase to 74 in 2011, compared with 55 in 2003.

4.16 The Scottish Government said there had been a significant increase in the number of NHS dentists in general and NHS general dental practitioners in particular, since the publication of the *Dental Action Plan*[3] in 2005.

4.17 The Northern Ireland Executive said the number of dentists in Northern Ireland had risen from 735 in 2007 to 1,049 in 2012. The access issues which were previously a problem had been resolved and the number of patients registered with a GDP had grown to over 1.1 million. The Northern Ireland Executive told us that the increase in the number of patients and the resulting increase in treatment provision could be explained both by the efforts of the Department of Health, Social Services and Public Safety and the Health and Social Care Board to address access issues, along with the financial downturn which had led to a significant number of previously private dental practices, providing Health Service treatment and care again.

4.18 The BDA highlighted that 2011-12 had seen the smallest increase in the number of dentists in England, and greatest rate of leaving, since the introduction of the current contract. The proportion of dental practice owners had dropped from 37.6 per cent in 2006-07 to 22 per cent in 2011-12. Some 40 per cent of practice owners who responded to the BDA's *Dental Business Trends* survey had attempted to recruit an associate, and of these 35.7 per cent encountered a problem with that recruitment. The BDA considered that the level of recruitment of associates for predominately NHS work suggested that there was a high turnover in this sector, and that it was difficult for practice owners to retain staff under difficult economic circumstances.

4.19 The BDA told us that the application system to dental foundation training had been changed in 2011 for England. The new centralised system had been welcomed by the BDA and by students in general who had found the previous system complicated and stressful. The troubled introduction of the new system, however, resulted in a great deal of extra stress and concern for many students. The BDA's survey of vocational dental practitioners found that 78 per cent had found a post at the time of the survey, comparable with earlier surveys.

Motivation and workload

4.20 The Department of Health said that dentists in England and Wales had achieved a reduction in working hours, working an average of 37.5 hours per week in 2011-12 compared to 39.4 hours in 2000. There were, however, still a number of key issues with the way dentistry was delivered and managed which the Department of Health intended to work with the profession to address.

4.21 The Northern Ireland Executive noted the comments raised by the BDA in previous evidence about issues of low morale and motivation within the dental workforce and told us it was cognisant of the potential impact of the current economic climate on independent practitioners. The Northern Ireland Executive said that, whilst it valued the contribution that dental practitioners made in terms of improving and maintaining oral health and as employers, it had extremely limited means to address the concerns of the profession within this budget period and under the current contractual arrangements. The BDA added that the proposals to deliver savings of 10 per cent of the GDS budget in Northern Ireland from 2012-13 were likely to have a serious effect on the morale and motivation of GDPs as well as affecting the ability of businesses to function effectively.

4.22 The BDA told us that over 41 per cent of respondents to the *Dental Business Trends* survey in England with an NHS commitment of 75 per cent or more said their morale was low or very low, and the highest levels of morale were found among those with the lowest NHS commitment. The BDA said the survey showed that the recent pay cuts

[3] *An action plan for improving oral health and modernising NHS dental services in Scotland.* Scottish Executive, 2005. Available from: http://www.scotland.gov.uk/Resource/Doc/37428/0012526.pdf

had a very negative impact on dentists, with 66 per cent of respondents with an NHS commitment of 75 per cent or more saying that pay was not fair. In the BDA's view, it was unreasonable to expect a profession that took a significant personal financial risk to provide NHS services to have to accept disproportionate reductions in pay, while increasing the amount of care for patients.

4.23 The BDA told us that the amount of clinical work being undertaken by dentists with more than 75 per cent NHS commitment had increased slightly according to the *Dental Business Trends* survey, while the amount of time spent on administration was increasing dramatically. The BDA was disappointed that administration appeared to be taking up more and more time at the expense of valuable patient-facing activity, and linked low morale with increased regulation.

Contractual and policy changes

4.24 The Department of Health told us that dentists continued to say that the current contract left them on an "activity treadmill". The aim of the new contract in England would be to improve quality of patient care and increase access to NHS dental services, with an additional focus on improving the oral health of children. Three different aspects of a new system were being piloted in 70 locations across the country. The learning from the pilots would define and feed into the broader work currently underway to design a new dental contract. The Department of Health highlighted that the other major change in the dental environment was the move of dental commissioning in April 2013 from primary care trusts to the NHS Commissioning Board, which would be responsible for commissioning all NHS dental services. The NHS Commissioning Board would have a single operating model, which the Department of Health considered would provide an opportunity for consistency and efficiency where it was required, but enable flexibility through local area teams where it was necessary. The NHS Commissioning Board would ensure there were clear and consistent outcome measures, indicators and a single accountability framework for NHS primary care dentistry in England, but not at the expense of stifling local innovation in service and quality improvement.

4.25 The Welsh Government told us that it was testing new systems of payment and delivery of dental services in Wales. There were two models being piloted which commenced on 1 April 2011 and would run for two years:

- quality and outcome pilot – practices would no longer be paid for meeting a UDA target. In order to meet 100 per cent of their current contract value, practices would need to meet certain pilot indicators based around access, prevention, governance, patient experience and patient care; and
- children and young people pilot – proposed to take all children out of the UDA system. It aimed to encourage preventative treatment and would test the introduction of quality and access indicators.

4.26 The Northern Ireland Executive told us that negotiations on a new stand alone contract for Northern Ireland were ongoing and, while progress had been slow, the general outline of the contract had been agreed, though remuneration was still to be agreed. Pilots would be in three stages: oral surgery; orthodontics; and the GDS. The proposed new dental contracts would incorporate block payments to remunerate dentists for the preventative care and treatment provided to their patients and also for their skills and the quality of their practice. There would be a reduced item-of-service element, which would state clearly which treatments would be funded by the Health and Social Care Board and which would be available through private arrangements. The new arrangements also envisaged the Health and Social Care Board being able to commission services according to need rather than solely on demand. The Northern Ireland Executive said that this would allow the Health and Social Care Board greater control over the GDS budget

and eventually the size of the dental market in Northern Ireland, but would also afford practitioners greater stability and freedom from the treadmill of "drill and fill".

4.27 The BDA said that, although the new contract was not expected to be generally rolled out across England until 2015, many practices would begin to invest in new ways of working and new hardware to support it in advance. The BDA's focus groups for pilot practices had key themes including concerns over associate employment status and unemployment and the increased cost of providing care under the pilot systems. The initial start-up costs required to be involved in the pilots such as IT and software had been partially or fully funded in most cases, but there was a consensus that if practice incomes had not been protected practices would not have embarked on the pilots. Associates felt their positions were threatened by the increased use of hygienists and therapists. The BDA said that, despite these concerns, there was a general consensus that the way of working that was encouraged by the pilot system was an improvement on the existing contractual arrangement for both dentists and patients.

4.28 The BDA told us that the policy landscape for NHS dentistry in Scotland had remained relatively stable, in contrast to the position in England. It told us that the Scottish Government intended to conduct a fundamental review of the GDS allowances, and the BDA would take part in this work; though the BDA highlighted the importance of the General Dental Practice Allowance, which rewarded the NHS commitment of both solely-NHS and mixed practices. In the BDA's view, the allowance was a lifeline to these practices, for which NHS fees alone were insufficient to enable them to meet the costs of decontamination and other regulatory requirements, employing staff, covering practice expenses and overheads and maintaining the high standards required to deliver quality patient care.

4.29 The BDA highlighted that the Welsh Government had issued a Ministerial letter to health boards reminding them that the primary care dental budget was protected and should not be used to support other elements of healthcare. The BDA had welcomed this as it was apparent that health boards were not using their full allocation for dentistry and that any remaining funds were being used in other areas of healthcare. The BDA also noted that the Welsh Government was consulting on a *National Oral Health Action Plan*. A main focus was on the *Designed to Smile* project which was being piloted at present but which would be rolled out into general dental practices.

4.30 The BDA told us that in November 2011, the Northern Ireland Executive had advised it of proposals that it intended to make in order to deliver savings of at least 10 per cent from the GDS budget from 2012-13 onwards. The BDA had rejected these proposals as being damaging to the provision of GDS in Northern Ireland. The BDA also noted that from 30 November 2012, the Northern Ireland Executive would expect practices to meet decontamination requirements which were in excess of other parts of the United Kingdom, and which would place additional mandatory capital and revenue costs and financial and administrative burdens on practices.

Seniority payments

4.31 The BDA said that the refusal to pay seniority pay to new applicant dentists in England from April 2011 because of claims that it breached the *Equality Act* had been received very badly by the profession. Dentists had been paying into the scheme through tacit fee scale/contract value reductions since 1968 but, unlike other professions with similar payment mechanisms, dentists in England had their payments stopped without warning for new entrants, while others continued to receive them. The BDA told us it had tried to work with the Department of Health to develop a new scheme which would allow dentists to continue to receive payments, but no progress had been made.

4.32 The Department of Health told us it was continuing to work with the BDA on ways of rewarding quality and experience within NHS dentistry, but was clear that no direct replacement for the previous Seniority Scheme was possible or desirable. It noted that funding previously used for this scheme remained in the NHS dental budget for future use.

4.33 Our long-standing view is that, if the parties decide that an additional experience-based allowance is necessary, they should consider its compliance with age discrimination legislation, and we regard this issue as a matter for the parties to resolve.

Dental incorporation

4.34 The Department of Health noted that it was difficult to make year-on-year comparisons of dentists' earnings and expenses because of changes in the way dentists paid themselves, especially the move towards personal and practice incorporation,[4] which took profits out of the self-employed tax system for the individual dentist and moved them into company accounts.

4.35 The Department of Health did not have figures on how many dentists changed their business arrangements in this way, but noted that in 2010-11 there were 8 per cent fewer dental contract holders and 7.1 per cent more dentists who worked for others than there had been in 2009-10. It was working with the Health and Social Care Information Centre and its working group on dental income and expenses to try and reduce the effect of dental incorporation on the data. The Department of Health believed that the main effect was to make it more difficult to estimate remuneration (profits) for individual dentists as they were, instead, included in a broader company report and may be spread amongst a number of individuals. The Department of Health had clarified the rules relating to the incorporation of individual dental performers and their membership of the NHS Pension Scheme, in that an incorporated performer may not be a member of the scheme, and it believed that this had reduced the pace of incorporation.

4.36 The Scottish Government was considering the question of incorporation through its working group with the BDA looking at the data gaps we identified in our *Fortieth Report*.

4.37 The Northern Ireland Executive could not identify any benefits to dentists incorporating their business, as the regulatory framework for the provision of GDS in Northern Ireland only permitted arrangements between the Health and Social Care Board and registered dental practitioners and not corporate bodies.

4.38 The BDA told us that since 2005, there had been a steady growth in the number of dentists operating as dental companies, which had coincided with the corporatisation of the dental market with the large corporate chains buying dental practices in England, Wales and Scotland. The net effect had been to reduce the number of self-employed dental practice owners and increase the proportion of associates. The BDA's *Dental Business Trends* survey 2012 gave the configuration of the respondents' main practice and showed that 22 per cent of dentists were working for a corporate body. From 2005 to 2011, the number of Performer-Only dentists who had incorporated increased, but the BDA believed that the introduction of regulations in England, that meant that these dentists were no longer able to be members of the NHS Pension Scheme, had promoted a move away from incorporated status in this group.

[4] Further information on this is provided in the glossary in Appendix H.

Earnings and expenses

England and Wales

4.39 In 2010-11, GDPs on average had taxable income of £77,900 and reported expenses of £94,100, giving a reported average expenses to earnings ratio (EER) of 54.7 per cent (Table 4.1). Providing-Performer dentists[5] had average taxable income of £117,200 and reported expenses of £247,100 (EER 67.8 per cent); for Performer-Only dentists[6] the figures were £62,900 and £35,500 respectively (EER 36.0 per cent). Average taxable income decreased for both Providing-Performer and Performer-Only dentists between 2009-10 and 2010-11,[7] and reported expenses increased.

Table 4.1: Average income and expenses for general dental practitioners, England and Wales, 2009-10 to 2010-11

Dental type	Year	Estimated population	Gross earnings (£)	Employee expenses (£)	Other expenses (£)	Taxable income (£)	EER (%)
Providing-Performer	2009-10	6,250	370,900	77,600	165,300	128,000	65.5
	2010-11	5,750	364,300	79,000	168,100	117,200	67.8
	% change	*-8.0*	*-1.8*	*+1.8*	*+1.7*	*-8.5*	*+2.4pp*
Performer-Only	2009-10	14,050	101,700	6,700	29,400	65,600	35.5
	2010-11	15,050	98,400	5,900	29,600	62,900	36.0
	% change	*+7.1*	*-3.3*	*-11.9*	*+0.7*	*-4.2*	*+0.6pp*
All dentists	2009-10	20,300	184,900	28,600	71,400	84,900	54.1
	2010-11	20,800	172,000	26,100	68,000	77,900	54.7
	% change	*+2.5*	*-7.0*	*-8.7*	*-4.8*	*-8.2*	*+0.6pp*

pp: percentage point change.

Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

4.40 The Health and Social Care Information Centre also presented changes in average taxable income and reported expenses for the longitudinal cohort of dentists that had not changed dental type or contract type over the period 2008-09 to 2010-11. For this cohort, taxable income had also decreased over this two-year period, but by a lesser amount than for the entire sample, suggesting that some of the change in taxable income was due to movement within the dental population and changes within the sample.

Northern Ireland

4.41 In 2010-11, GDPs in Northern Ireland on average had taxable income of £78,900 and reported expenses of £101,200, giving a reported average EER of 56.2 per cent (Table 4.2). Principal dentists had average taxable income of £114,200 and reported expenses of £216,800 (EER 65.5 per cent); for Associate dentists the figures were £59,400 and £36,900 respectively (EER 38.3 per cent). Average taxable income has decreased for both Principal and Associate dentists, and overall, since 2009-10. Reported expenses have decreased for Principal dentists and increased for Associates, but the reported EER has increased for both types of dentist.

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[5] Further information on this is provided in the glossary in Appendix H.

[6] Further information on this is provided in the glossary in Appendix H.

[7] Note that the change in income for "all dentists" is affected by a marked change in the composition of the workforce: in 2010-11 there were estimated to be 8 per cent fewer Providing-Performer dentists, and 7.1 per cent more Performer-Only dentists, compared with 2009-10. This may be reflective of dental contract holders choosing to incorporate their businesses, thereby taking their earnings out of the self-employment data.

Table 4.2: Average income and expenses for general dental practitioners, Northern Ireland, 2009-10 to 2010-11

Dental type	Year	Estimated population	Gross earnings (£)	Employee expenses (£)	Other expenses (£)	Taxable income (£)	EER (%)
Principal	2009-10	350	344,600	73,200	148,500	122,900	64.3
	2010-11	300	331,000	79,200	137,600	114,200	65.5
	% change		*-3.9*	*+8.2*	*-7.3*	*-7.1*	*+1.2pp*
Associate	2009-10	500	97,900	1,100	34,100	62,700	36.0
	2010-11	550	96,200	500	36,400	59,400	38.3
	% change		*-1.7*	*-54.5*	*+6.7*	*-5.3*	*+2.3pp*
All dentists	2009-10	850	195,300	29,500	79,300	86,500	55.7
	2010-11	900	180,100	28,600	72,600	78,900	56.2
	% change		*-7.8*	*-3.1*	*-8.4*	*-8.7*	*+0.5pp*

pp: percentage point change.

Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

Scotland

4.42 In 2010-11, GDPs in Scotland on average had taxable income of £73,300 and reported expenses of £94,000, giving an average reported EER of 56.2 per cent (Table 4.3). Principal dentists had average taxable income of £101,100 and reported expenses of £233,600 (EER 69.8 per cent); for Associate dentists the figures were £60,100 and £27,800 respectively (EER 31.6 per cent). Average taxable income has decreased for both Principal and Associate dentists since 2009-10, and average reported expenses have increased.

Table 4.3: Average income and expenses for general dental practitioners, Scotland, 2009-10 to 2010-11

Dental type	Year	Estimated population	Gross earnings (£)	Employee expenses (£)	Other expenses (£)	Taxable income (£)	EER (%)
Principal	2009-10	650	337,000	85,800	137,400	113,800	66.2
	2010-11	700	334,700	89,300	144,300	101,100	69.8
	% change		*-0.7*	*+4.1*	*+5.0*	*-11.1*	*+3.5pp*
Associate	2009-10	1,450	91,900	1,100	27,800	63,600	31.3
	2010-11	1,450	87,900	1,200	26,600	60,100	31.6
	% change		*-4.3*	*+9.1*	*-4.3*	*-4.8*	*+0.3pp*
All dentists	2009-10	2,100	170,200	28,200	62,700	79,300	53.4
	2010-11	2,150	167,300	29,500	64,500	73,300	56.2
	% change		*-1.7*	*+4.6*	*+2.9*	*-7.6*	*+2.8pp*

pp: percentage point change.

Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

4.43 GDS dentists in Scotland receive a range of direct payments, including fees, the General Dental Practice Allowance, rent reimbursement and commitment payments (see Table 4.4). Nearly 80 per cent of GDS payments were item-of-service and other fees, and some other payments, for example the General Dental Practice Allowance and commitment payments, are driven by dental activity. In order to be eligible for the whole range of allowances a practitioner needed to meet a commitment of registering 500 patients (of whom 100 had to be fee-paying adults) and have gross annual NHS earnings of at least £50,000.

Table 4.4: Direct payments and benefits in kind for General Dental Services dentists, Scotland, 2006-07 to 2011-12

	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000	2011-12* £000
Fees (item-of-service, continuing care, capitation)[1, 2]	188,320	198,713	219,804	229,830	242,916	266,790
General Dental Practice Allowance[1, 2]	21,644	22,832	25,578	28,029	29,094	30,232
Rent reimbursement[1, 4]	7,901[6]	6,637	6,147	7,458	8,140	9,006
Commitment[1, 4]	4,305	4,943	5,402	5,639	5,651	5,668
Seniority[1, 4]	1,627	1,624	1,701	1,634	1,695	1,694
Reimbursement of non-domestic rates[1, 4]	1,614	1,661	1,457	1,558	1,639	1,860
Recruitment and retention[1]	1,145	1,328	1,320	1,535	1,635	9,635
Long term sickness, maternity and paternity[1, 4]	701	941	906	909	1,207	1,091
Continuing professional development[1, 4]	960	967	1,191	1,168	1,020	1,101
Remote areas[1]	645	662	668	979	769	759
Vocational training practice[1]	902	1,045	720	635	582	581
Sedation practice[1]	101	127	106	103	107	101
Clinical audit[1]	68	118	301	108	68	483
Deprived areas[1]	2,750	2,900	-	-	-	-
Scottish Dental Access Initiative[1]	1,298	1,283	3,449	3,374	5,460	3,779
NHS Education for Scotland (Vocational Training Recruitment Allowance[1] and START[3])	597	597	751	762	874	856
NHS Boards clinical and special waste[3]	984	1,038	1,055	857	841	957
NHS National Services Scotland (General Dental Services information management and technology system)[3]	1,969[8]	1,777[8]	557[8]	319	422	407
Practice improvements[1]	2,500	2,500	-	-	-	-
Decontamination practice improvements[1]	-	5,000	5,000	-	-	-
Vocational Training (trainee salaries and trainer grant)[1, 5]	7,038	7,768	8,161	8,260	8,553	9,175
Total	**247,069**	**264,461**	**284,274**	**293,157**	**310,673**	**344,175**

Source: Scottish Government.

Notes:

* Data for 2011-12 are provisional.

[1] Direct payment.

[2] Payments directly affected by changes in the fee scale.

[3] Benefits in kind.

[4] Payments indirectly affected by changes in fees.

[5] Estimate.

[6] Includes 2005-06 rent reimbursement reconciliation payments made in 2006-07.

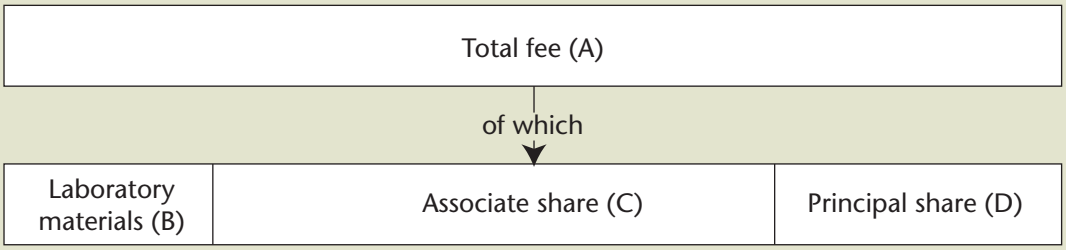
[7] Reduced as incorrectly included general practice improvement funding which is now recorded in practice improvements line.

[8] Includes initial start up costs, for example, provision of equipment, and some NHS National Services Scotland support costs which could not be identified and removed in the time available.

Multiple counting of expenses

4.44 We noted in our *Fortieth Report*[8] that transactions between Principal dentists and Associates occurred frequently, and that the same sums of money could be recorded on two tax returns. An example transaction is shown in Figure 4.2. These transactions, accounting practices and tax returns are valid for the individual dentist, but when aggregated cause estimates of gross earnings and gross expenses, and consequently the expenses to earnings ratio, to be artificially inflated. In our *Fortieth Report,* we set out our approach to estimating the magnitude of such "multiple counting" and used the estimates in our revised formula, and we asked the parties to provide their views on our approach, and to provide better estimates of the EER.

Figure 4.2: Illustrative transaction between Principals and Associates



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

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

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

4.45 The Scottish Government told us that, to address the points we raised, including about multiple counting, BDA Scotland and the Scottish Government had been undertaking some joint working through a short-life Dental Expenses Working Group commissioned by the Chief Dental Officer. The group's remit was to consider and respond to the gaps in evidence highlighted by us; to consider the options for improving data, covering estimates, timescales and costs; and to make recommendations to the Chief Dental Officer for options for improving the data. The group had agreed that a large amount of work would be necessary to identify and consider populating the data gaps that could enable a more robust formula to be applied to Scotland, and to determine the extent of multiple counting and the impact this may have on the practice expense ratio. We understand that the group is considering conducting a survey of practice accounts, and we would like to be kept informed of progress.

4.46 The BDA had attempted to quantify the extent of multiple counting through the *Dental Business Trends* survey. It estimated that the extent of multiple counting in England and Wales was between 33.1 per cent and 35.3 per cent. The BDA recommended that working groups be established in the other countries of the United Kingdom to determine if multiple counting was an issue and, if so, how best to manage it. The BDA did not consider it appropriate for action to be taken on the formula or uplift values until this work had been done and a full evaluation had established what effect, if any, it had. The BDA considered that any action taken to manage any impact of multiple counting must be in proportion to its effect and prevalence.

[8] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report.* Cm 8301. TSO, 2012. Chapter 2. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

4.47 The BDA Scottish Dental Practice Committee reiterated its belief that the formula should not be adjusted to take account of any multiple counting, as more research was needed to understand its impact on the EER. It subsequently told us that payments made to Associates by Principals (or vice versa) should be treated as an expense of those individuals.

4.48 The Department of Health was interested to see the outcome of the approach being taken for Scotland but noted the substantive differences in reimbursement and commissioning arrangements in England and Wales. This, along with the Department of Health's planned reform of the current system of activity based contracts and agreements in England suggested that a cautious approach should be maintained for the present. The Department of Health highlighted that the Health and Social Care Information Centre continued to note the increasing difficulty in separating out expenses between performers and providers and the possible multiple counting of expenses. It said that the extent of multiple counting may have increased since 2006, because gross payments were no longer paid directly to individual dentists.

4.49 The Department of Health was working with the Health and Social Care Information Centre and its working group on dental income and expenses to try and produce a better estimate of dental net income and expenses between providers and performers and to reduce the current risk of multiple counting expenses which it believed had inflated previous estimates of dental expenses.

4.50 The Northern Ireland Executive said that it had not been possible to quantify the impact of multiple counting on the gross earnings and expenses of dentists in Northern Ireland.

4.51 We disagree with the BDA Scottish Dental Practice Committee's view that the income of Associates paid by Principals, or the share of income paid by Associates to Principals, are an expense for the purposes of our formula. We define the costs associated with providing GDS as including those relating to employing staff, laboratory work, materials, decontamination, premises, utilities and other practice expenses. Payments made between Principals and Associates which recognise the agreed 'share' for each individual are, wholly or partly, ultimately taxable income for the recipient, and should be treated as such in our formula.

Our approach to quantifying multiple counting

4.52 Our remit this year relates solely to dentists working in Scotland; however we are taking the opportunity this year to examine multiple counting across the United Kingdom, and we invite views from the parties regarding the approach we have followed below. Our approach differs from that which we followed in our *Fortieth Report*:[9] our starting point this year has been to attempt to estimate a representative EER for practice owners (Providing-Performers in England and Wales, or Principals in Scotland and Northern Ireland).

4.53 Intuitively, the EER for sole traders (without help)[10] should be the highest of all types of business arrangement: dental practices with more than one dentist should benefit from lower (per head) premises costs, and the ability to employ more administrative staff and dental care professionals to deal with lower-level tasks, thus freeing dentists for income-generating activities. Figure 4.3 shows that, in fact, the reported EER for sole traders (without help) in England and Wales in 2010-11 was the lowest of all types of business arrangement, whereas the reported EER for sole traders (with help)[11] was the highest.

4.54 The Health and Social Care Information Centre notes in its earnings and expenses publication that dentists operating either as sole traders (without help), or in expenses

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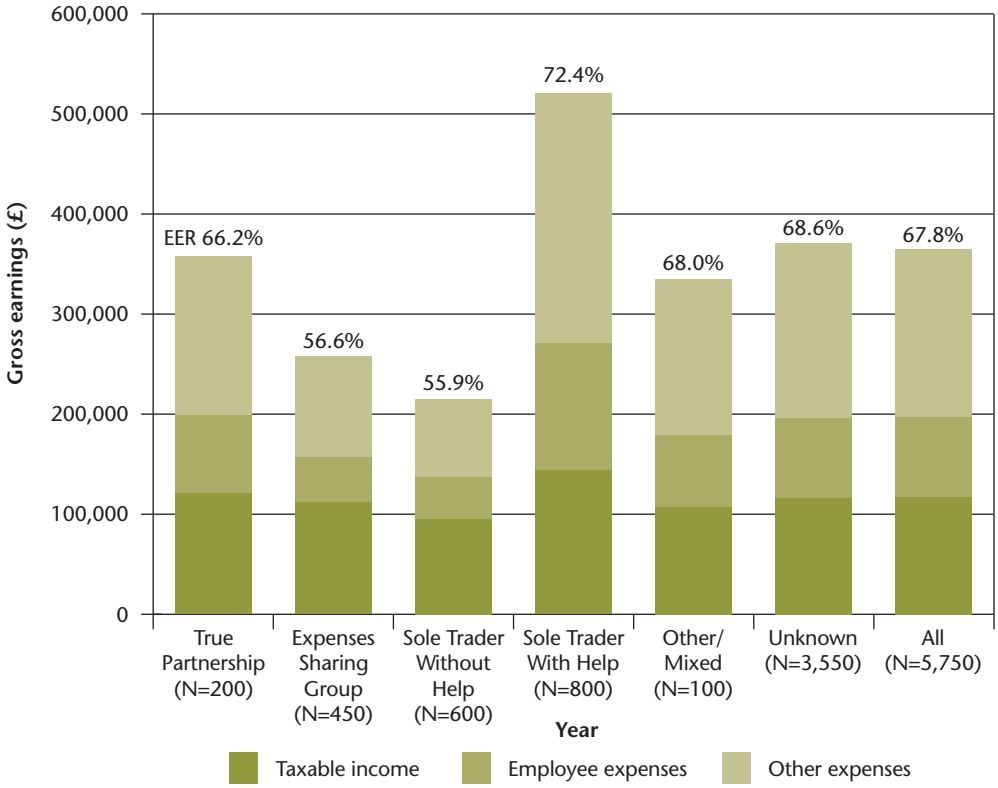
[9] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report.* Cm 8301. TSO, 2012. Paragraphs 2.26-2.32. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[10] Further information on this is provided in the glossary in Appendix H.

[11] Further information on this is provided in the glossary in Appendix H.

sharing groups,[12] should not have any multiple counted expenses. The EER for these dentists on average in 2010-11 was 55.9 per cent and 56.6 per cent respectively. The difference in the reported EER for sole traders with help compared to those without help, in our view, can only be explained by the impact of multiple counting.

Figure 4.3: Gross earnings (NHS and private) for self-employed Providing-Performer dentists, by business arrangement, 2010-11, England and Wales



Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

4.55 In our view, the most appropriate figure for the average EER for Providing-Performer dentists should be close to that for sole traders (without help); indeed, arguably, the average EER for Providing-Performer dentists should be lower than this figure. Taking into account that dentists who did not respond to the business arrangements survey had, on average, a higher EER, and that under this method we cannot be overly precise in our estimate, we suggest a figure of 60 per cent be used as the EER for Providing-Performer dentists. We considered using a lower figure, but on balance we consider this adjustment to be proportionate in the absence of better data.

4.56 To estimate the EER for all dentists, including Performer-Only dentists, we calculate a weighted average using the figure of 60 per cent for Providing-Performers,[13] and 36 per cent for Performer-Only dentists. This is the figure published by the Health and Social Care Information Centre, and is not adjusted to take into account any flows of money from Performers to Providers. In our view, the figure of 36 per cent is likely also to be an overestimate, but we are not minded to make any adjustments in the absence of data.

[12] Further information on this is provided in the glossary in Appendix H.

[13] The "Revised EER" is naturally sensitive to the choice of expenses to earnings ratio for Providing-Performers: each percentage point change in the figure of 60 per cent leads to a change of around 0.6 to 0.7 percentage points for all dentists.

Table 4.5 shows that under this method, the revised EER for all dentists in England and Wales is 48.8 per cent – nearly 6 percentage points lower than the published figure.[14]

Table 4.5: Estimated expenses to earnings ratio for dentists, assuming an expenses to earnings ratio for Providing-Performer dentists of 60 per cent, England and Wales, 2010-11

Dental type	No. dentists	Average taxable income	Published EER	Aggregate £m			Revised EER
				Gross earnings	Total expenses	Taxable income	
Providing-Performer[1]	5,750	£117,200	67.8%	1,684.8	1,010.9	673.9	60.0%
Performer-Only[2]	15,050	£62,900	36.0%	1,480.9	534.3	946.6	36.0%
All dentists[3]	20,800	£77,900	54.7%	3,165.7	1,545.1	1,620.5	**48.8%**

Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

[1] Aggregate gross earnings and total expenses are calculated using the "Revised EER".
[2] Figures are not adjusted.
[3] Aggregate figures and the EER are based on the sum of figures for Providing-Performer and Performer-Only dentists.

4.57 Data on average earnings and expenses broken down by business arrangement are published for Scotland, but the sample sizes for sole traders (without help) and expense sharing groups are too small and the results have therefore been suppressed to avoid the risk of disclosure of personal identifiable data. For those business arrangements with sufficiently large sample sizes, the average EER is a percentage point or two higher than for England and Wales, so an EER of 60 per cent for sole traders is appropriate in our view. Table 4.6 shows the calculations for Scotland using the same method as above: the revised EER is 48.1 per cent.

Table 4.6: Estimated expenses to earnings ratio for dentists, assuming an expenses to earnings ratio for Principal dentists of 60 per cent, Scotland, 2010-11

Dental type	No. dentists	Average taxable income	Published EER	Aggregate £m			Revised EER
				Gross earnings	Total expenses	Taxable income	
Principal[1]	700	£101,100	69.8%	176.9	106.2	70.8	60.0%
Associate[2]	1,450	£60,100	31.6%	127.4	40.3	87.1	31.6%
All dentists[3]	2,150	£73,300	56.2%	304.3	146.4	157.9	**48.1%**

Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

[1] Aggregate gross earnings and total expenses are calculated using the "Revised expenses to earnings ratio".
[2] Figures are not adjusted.
[3] Aggregate figures and the EER are based on the sum of figures for Principal and Associate dentists.

4.58 While data on average earnings and expenses broken down by business arrangement are not published for Northern Ireland, these data are separately published for single-handed and all other practices. The EER for the former in 2010-11 was 59.0 per cent, slightly higher than the figure of around 56 per cent for sole traders in England and Wales but still near to the assumed 60 per cent. Table 4.7 shows the calculations leading to the revised EER for Northern Ireland: the revised EER is 51.7 per cent.

[14] Using the method described in our *Fortieth Report*, the revised expenses to earnings ratio in England would be 47.8 per cent.

Table 4.7: Estimated expenses to earnings ratio for dentists, assuming an expenses to earnings ratio for Principal dentists of 60 per cent, Northern Ireland, 2010-11

Dental type	No. dentists	Average taxable income	Published EER	Aggregate £m			Revised EER
				Gross earnings	Total expenses	Taxable income	
Principal[1]	300	£114,200	65.5%	85.7	51.4	34.3	60.0%
Associate[2]	550	£59,400	38.3%	52.9	20.3	32.7	38.3%
All dentists[3]	900	£78,900	56.2%	138.6	71.7	66.9	**51.7%**

Source: Health and Social Care Information Centre using data from HM Revenue and Customs.

[1] Aggregate gross earnings and total expenses are calculated using the "Revised EER".
[2] Figures are not adjusted.
[3] Aggregate figures and the EER are based on the sum of figures for Principal and Associate dentists.

4.59 As noted in our *Fortieth Report*,[15] the revised estimate of the EER is subject to a number of caveats, including the unknown effects of sampling error, dental incorporation, earnings and expenses associated with private practice, and (in some countries) reimbursement of specific expenses. These same caveats also apply to the original reported data published by the Health and Social Care Information Centre. We remain confident that the EER implied by the aggregated data from dentists' tax returns is too high. In all countries, there appears to be a convergence towards an EER of around 50 per cent, though as noted above this assumes no flows of money from Performers or Associates to Providers or Principals, so the true figure is likely to be lower. Nonetheless, in the absence of better information, we believe that an EER of 50 per cent should be used for all countries.

4.60 We are conscious that the BDA has reservations about making changes to the formula in advance of such changes being evaluated. We are convinced that it is preferable in the short term to estimate the impact of multiple counting in our formula, rather than use an unadjusted formula with an artificially inflated EER as its basis. We also consider that our current adjustment is modest, given the arguments for the use of even lower figures for the average EER both for practice owners and Associates.

The formula for 2013-14

4.61 Our formula represents an approach that was designed to recognise that GDPs, as independent contractors, need to generate gross revenues that cover the opportunity cost of the practitioner's time, the return on capital invested (capital costs) and the costs of service delivery. However, since the coefficients and the input prices used in the formula are based on published data, they are by nature retrospective. This means that there is a time lag between the change in input prices or input coefficients, and the impact on the uplift figure. This should provide an incentive to practices to pursue cost-effective delivery. It is of course the case that our approach may under or over-estimate what has actually been happening to the true level of expenses. However, in the long run, we expect under and over-estimates to feed through the data on income and expenditure and therefore to be taken into account in future years.

4.62 The BDA Scottish Dental Practice Committee said that for 2013-14, a formulaic approach should be used to calculate an uplift for item-of-service fees that reflected rising practice expenses. It was disappointed that we had decided to adopt a different formula to the one recommended by the BDA, but agreed that there was a need to develop a Scotland-specific formula. It had been working jointly with the Scottish Government on the development of an agreed formula that took account of the different system in Scotland, but as the work had not concluded, it had not been possible to produce a formula

[15] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report.* Cm 8301. TSO, 2012. Paragraph 2.31. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

tailored for Scotland. In view of this, the BDA Scottish Dental Practice Committee had based its calculations on the formula that it had applied in previous evidence.

4.63 The BDA Scottish Dental Practice Committee proposed that the historic EER figure of 56.1 per cent should be used this year thus allowing baseline stability to be maintained. It noted that the Health and Social Care Information Centre report on *Dental Earnings and Expenses, Scotland, 2010-11*[16] showed an average EER of 56.2 per cent.

4.64 The BDA Scottish Dental Practice Committee said that the latest data on earnings and expenses in Scotland showed that the largest cost for practice owners was "Other" expenses, at almost 42 per cent of overall expenses. This included direct costs such as laboratory and material costs which dentists in Scotland had reported through the BDA *Dental Business Trends* survey to have increased by 6.25 per cent and 8.1 per cent respectively over the past year. The BDA Scottish Dental Practice Committee said that because the Scottish Government had not applied the uplifts we recommended for 2011-12 and 2012-13, the fees that dentists received for the making of crowns, dentures and other appliances had remained static and were insufficient to meet the rising costs.

4.65 The BDA Scottish Dental Practice Committee said that most staff employed by dental practitioners typically fell under the protected category of those public sector employees who would receive a pay award of £250. Consequently, practice owners would be under pressure to award at least £250 to their staff, and fund the additional National Insurance contributions. The earnings and expenses data showed that employee costs for dentists in Scotland were higher than elsewhere in the United Kingdom at just over 38 per cent of expenses for Principal dentists.

4.66 For 2013-14, the BDA Scottish Dental Practice Committee proposed a compounded increase of 5.17 per cent, on top of our recommendations for 2011-12 and 2012-13, to the expenses element of the item-of-service fee was necessary for this year, to ensure that dentists did not receive a cut in their net taxable income. It said that this would restore the drop in average taxable income of 7.6 per cent for dentists in Scotland in 2010-11, as outlined in the Health and Social Care Information Centre report on *Dental Earnings and Expenses, Scotland, 2010-11.*[17] In oral evidence, the BDA Scottish Dental Practice Committee told us that, as the dental workforce in Scotland had expanded, some dentists reported their appointment books as being "quiet". The drop in workload had led to a consequent drop in average income.

Formula coefficients

4.67 The Scottish Government has again highlighted the allowances and reimbursements paid to GDPs in Scotland, as shown in Table 4.4 above. We continue to believe that these should be offset in our formula, and in 2010-11 they accounted for 10.6 per cent of all expenditure on GDS in Scotland.[18] Expressing dentists' income as a percentage of non-reimbursed gross earnings gives 50 per cent ÷ 0.894 = 55.9 per cent.

4.68 The *Dental Earnings and Expenses, Scotland, 2010-11*[19] statistical report provides information on employee expenses, which we calculate to be 40.7 per cent of revised

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[16] *Dental earnings and expenses, Scotland, 2010-11.* Health and Social Care Information Centre, 26 October 2012. Available from: http://www.ic.nhs.uk/catalogue/PUB07908

[17] *Dental earnings and expenses, Scotland, 2010-11.* Health and Social Care Information Centre, 26 October 2012. Available from: http://www.ic.nhs.uk/catalogue/PUB07908

[18] We have discounted all items in Table 4.4 with the exceptions of GDS fees, the General Dental Practice Allowance, and Commitment Payments, in line with the approach in our *Fortieth Report*.

[19] *Dental earnings and expenses, Scotland, 2010-11.* Health and Social Care Information Centre, 26 October 2012. http://www.ic.nhs.uk/catalogue/PUB07908

total expenses,[20] equivalent to 20.3 per cent of revised gross earnings or 22.8 per cent of non-reimbursed gross earnings.

4.69 For the coefficients for laboratory and materials costs, in the absence of Scotland-specific data we again turn to that produced by the National Association of Specialist Dental Accountants and Lawyers (NASDAL), which relates to practices in England and Wales. For 2010-11, laboratory and materials each comprised 6.3 per cent of gross income, which equates to 7.0 per cent of non-reimbursed gross earnings. Other costs are the remaining 7.3 per cent of non-reimbursed gross earnings.

Pay and price measures

4.70 Our recommendation this year is for the same uplift across our remit groups. Our recommendation for the intended uplift to taxable income for independent contractor GDPs is 1 per cent: our rationale for this is in Chapter 9.

4.71 For the pay and price measures for the expenses elements in the formula (staff costs, laboratory costs, materials and other costs), we use the most recent pay and price data for the 2013-14 uplift:

- for staff costs, we again use data from the *Annual Survey of Hours and Earnings*, for the dental practice activities industrial classification. The change in median gross hourly pay between April 2011 and April 2012 was 1.3 per cent;
- for laboratory and materials costs, we again use the Retail Prices Index excluding mortgage interest payments (RPIX), as these elements of dental expenses do not include premises costs. The RPIX annual increase for the last quarter of 2012 was 3.0 per cent; and
- for all other costs, we also use RPIX, because dentists in Scotland receive reimbursements for rent and non-domestic rates, and these elements have already been accounted for by expressing the formula coefficients as a percentage of non-reimbursed gross earnings.

4.72 Taking all these factors into account, the formula calculation is set out in Table 4.8.

Table 4.8: Dental formula for Scotland, 2013-14

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Net income	55.9%	1%	0.56%
Staff costs	22.8%	1.3% *Annual Survey of Hours and Earnings (dental practice activities) 2012*	0.30%
Laboratory costs	7.0%	3.0% *RPIX 2012 Q4*	0.21%
Materials	7.0%	3.0% *RPIX 2012 Q4*	0.21%
Other costs	7.3%	3.0% *RPIX 2012 Q4*	0.22%
		Total	**1.49%**

Note: individual items do not sum to the total because of rounding.

[20] Multiplying average employee expenses of £89,300 for Principals, and £1,200 for Associates, by the number of dentists gives aggregate employee expenses of £64.25 million. Revised total expenses are assumed to be equal to aggregate taxable income of £157.9 million.

4.73 Our recommendation for independent contractor GDPs is in Chapter 9.

4.74 We note that, this year, we are not required to make recommendations on the uplift for GDPs in England, Wales and Northern Ireland, and have therefore not received full evidence from all the parties on this issue. Nonetheless, we set out below the formula coefficients for each country based on an estimated EER of 50 per cent, and invite the parties to provide their views on the method, and suggest alternative approaches if appropriate. In particular, we would welcome evidence of reimbursements provided to meet specific expenses. The coefficients for England and Wales, and Northern Ireland, have not been adjusted for any such reimbursements.

4.75 For England and Wales, the estimated coefficient for income is 50 per cent. Employee expenses comprise 33.5 per cent of revised total expenses, or 16.7 per cent of revised gross earnings. Laboratory and materials, using data from NASDAL, each account for 6.3 per cent of revised gross earnings. Other expenses are the remaining 20.7 per cent of revised gross earnings.

4.76 For Northern Ireland, the estimated coefficient for income is 50 per cent. Employee expenses are 38.5 per cent of revised total expenses, or 19.2 per cent of revised gross earnings. Laboratory and materials costs, as for England and Wales, are each 6.3 per cent of revised gross earnings. Other expenses are the remaining 18.2 per cent of revised gross earnings.

Future evidence requirements

4.77 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the Scottish Government to update us on its response to our recommendations for the 2011-12 and 2012-13 uplifts to fee scales;
- the parties in Scotland to update us on progress made by the Dental Expenses Working Group to address the evidence gaps we identified in our *Fortieth Report*;[21]
- the parties in all countries to provide their views on our methodology for adjusting the expenses to earnings ratio to reflect multiple counting, and suggest alternative approaches if appropriate; and
- the parties to provide evidence of reimbursements provided to dentists to meet specific expenses in England, Wales and Northern Ireland.

[21] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report*. Cm 8301. TSO, 2012. Paragraph 2.43. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

CHAPTER 5: SALARIED DENTISTS

Introduction

5.1 Salaried dentists work in a range of different posts, as community dentists, salaried Primary Dental Services dentists, Dental Access Centre dentists and as salaried general dental practitioners in the NHS. The parties indicated that there were 1,353 salaried dentists in England, 162 in Wales, 514 in Scotland and 111 in Northern Ireland.

Recruitment and retention

5.2 As in previous years, we received conflicting evidence on recruitment issues: the British Dental Association (BDA) in Scotland's *Salaried Services Morale Survey* recorded that most dentists did not feel that there was an opportunity for career progression; whilst the Scottish Government told us that there had been considerable progress in developing promoted posts within the service, with senior dentist posts increasing over the last ten years from 20 to 91, and the creation of 14 Assistant Clinical Director and 16 Specialist Dentist posts. The BDA in England and Wales both voiced their concerns about job security for salaried dentists; but NHS Employers said that it had not heard of employers cutting back on salaried services that might give rise to such fears, and that even if work was commissioned in a different way, the skills of salaried dentists would continue to be needed. The lack of Band C posts was also a concern for the BDA, although it is not clear to us whether or not any sort of expectation on the number of Band C posts was raised during the negotiations on the new salaried dental contract. Clearly, decisions on the number of posts are a matter for local employers.

Motivation and workload

5.3 Across the United Kingdom, the BDA said that 52.8 per cent of respondents to its survey had stated that their morale was low or very low. In England, 48.5 per cent of dentists reported that their caseload was excessive, and the BDA remained concerned that low levels of pay and increasing workload would continue to cause a deterioration in morale. It said that salaried dentists felt unappreciated and unimportant compared to other services. The BDA in Northern Ireland said that the absence of developments towards a new contract had further exacerbated the problems of low morale. The Health Departments did not provide us with any evidence on the motivation of salaried dentists, so we would again urge them to consider the issues raised by the BDA when developing future policy. Chapter 2 includes our detailed analysis of motivation.

New contractual arrangements

5.4 The Scottish Government said that formal negotiations on a new pay and terms and conditions of service package had begun, with the BDA in Scotland telling us it was encouraged by the progress. The Northern Ireland Executive said that a submission was with Ministers seeking approval to enter into negotiations on a new contract. The BDA also told us that it was working with England on developing a new contract, and that it eagerly awaited the announcement of pilot studies. We welcome these developments in all countries, and hope that any new arrangements will go some way to address the motivation issues raised by the BDA. We ask the parties to update us for our next review.

Inappropriate banding

5.5 The BDA claimed that many clinical specialists were being employed at an inappropriate band, commenting that despite the introduction of a contract supporting Band C posts, 75 per cent of registered specialists were still working at Band B level. NHS Employers

said that the grade of posts was a matter for local employers, and was generally decided by reference to the required competencies for any particular job in terms of both clinical and managerial responsibility. The Department of Health said that if individual dentists felt their work was not correctly graded or rewarded, they should discuss the matter with the employing organisation and use the normal established mechanisms to seek job evaluations. We would encourage the parties to adopt this approach as this is clearly an issue for local determination.

Pay recommendation

5.6 Our recommendation this year is for the same uplift across our remit groups and can be found in Chapter 9.

Future evidence requirements

5.7 The specific evidence requirements that we have identified in this chapter for our next review are for:

- evidence on the motivation of salaried dentists; and
- an update on the new contractual arrangements.

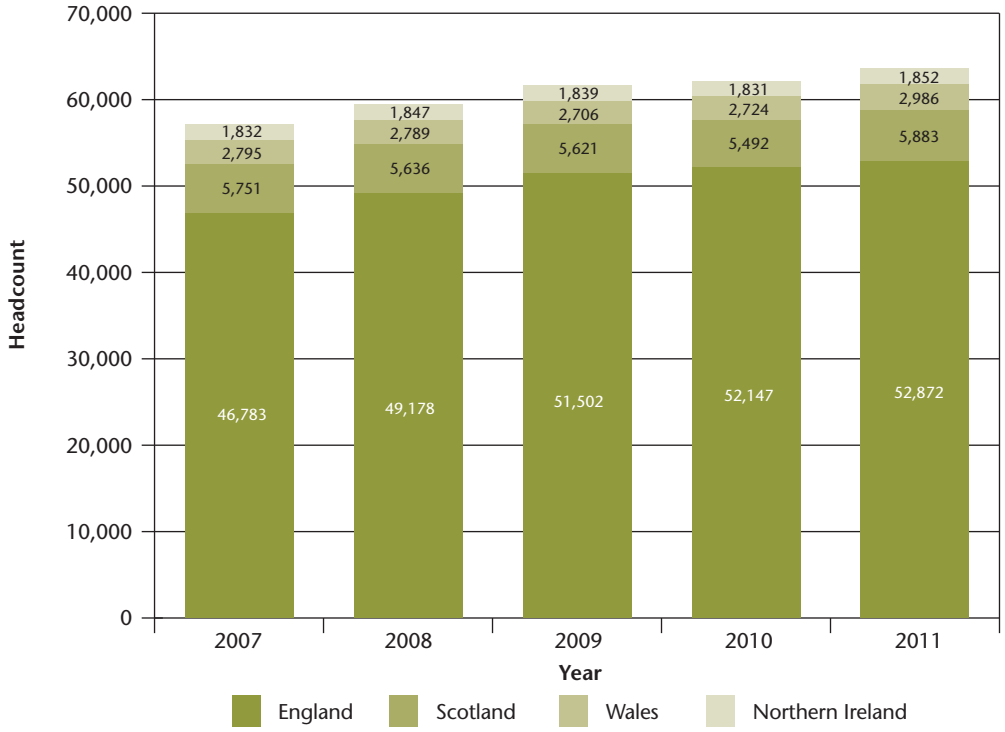
Part III: Secondary care

CHAPTER 6: DOCTORS AND DENTISTS IN HOSPITAL TRAINING

Introduction

6.1 Doctors begin their hospital training in Foundation Programmes, a (normally) two-year, general postgraduate medical training programme, where they are known as foundation house officers. Doctors then face a choice of remaining in the hospital sector as a specialty registrar, or choosing to enter general practice via the general practice specialty registrar route. In September 2011, there were 63,593 doctors and dentists in hospital training (Figure 6.1), an increase of 2.2 per cent in the United Kingdom as a whole since September 2010, with increases in all countries.

Figure 6.1: Number of doctors in training in the Hospital and Community Health Services, 2007 – 2011, United Kingdom



Note: Data from 2010 for England are not comparable with previous years.

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

Recruitment and retention

6.2 We said last year that we would be monitoring closely the number of applicants to medical schools, as the British Medical Association (BMA) suggested last year that the increase in applicants in 2010 may have been due to the forthcoming rise in tuition fees. We are therefore pleased to note that in 2011, there were 2.8 applicants for each United Kingdom medical school place, up from 2.6 the previous year. We interpret this as strong evidence that medicine continues to be seen as an attractive career, although we also note that the average Universities and Colleges Admissions Service (UCAS) tariff points score held by home domiciled accepted applicants has remained this year at 406 after a long period of year-on-year increases, though this is significantly above the average UCAS tariff point score across all subjects of 222, as calculated by NHS Employers. Women

accounted for 55 per cent of accepted applicants, so we welcome the assurances given by NHS Employers that any related workforce planning issues for England are being addressed, and ask the other countries to also bear this in mind when developing their own workforce plans.

6.3 The Department of Health told us that it had not encountered any general difficulties in expanding the medical workforce from 2006 to 2010. It said that it had set up taskforces to review the underlying causes where specialty training posts were hard to fill and then to tailor solutions for the particular causes. It believed that recruitment problems were often related to the attractiveness of the training and development opportunity, rather than the provision of additional pay. Table 6.1 below shows the fill rates for specialty training 1 level in England after the initial round of recruitment and re-advertisement.

Table 6.1: Fill rates for specialty training 1, 2011 and 2012, England

	Fill rate (%)	
Specialty	**2011**	**2012**
Anaesthesia and acute care common stem anaesthesia	95	100
Clinical radiology	96	100
Neurosurgery	100	100
Obstetrics and gynaecology	100	100
Paediatrics	100	100
General practice	99	99
Core medical training and acute care common stem acute medicine	99	98
Core surgical training	98	98
Acute care common stem – emergency medicine	96	94
Core psychiatry	78	86
Histopathology	86	84
Public health	99	83

Source: NHS Employers.

6.4 The Scottish Government said its established selection and recruitment process had proved to be robust and complaint free, and that it continued to be enhanced year-on-year with well-established partnership working between all parties. The Welsh Government told us it was the only United Kingdom country to offer free accommodation to trainee doctors and that it was looking at other opportunities to encourage doctors to work in Wales. The Northern Ireland Executive said that it was working with trusts to address any vacancies, but that the investment in medical school places had started to impact on the trainee workforce and would impact further in 2013.

6.5 Our report last year asked the parties to give consideration to whether recruitment premia for hard-to-fill specialty training posts might be beneficial and to update us on whether trusts were currently using flexibilities to introduce such payments. None of the parties indicated that such freedoms were currently being used for trainees. The BMA said that although it did not believe that there was a significant specialty and location misalignment at present, it could become an issue in future years. The BMA also pointed us to its evidence that showed that the majority (60 per cent) of cohort doctors who responded to a 'snapshot' survey indicated that their choice of specialty had not changed since graduation, and that there was no substantial evidence to suggest career choices had changed to reflect the needs of undersubscribed or oversubscribed specialties. While we note that the Department of Health's preferred approach is to use taskforces to identify and solve particular specialty recruitment issues, we ask the parties to give consideration as to whether recruitment premia for individual specialties experiencing

problems might be a useful recruitment tool, and to keep us updated on recruitment issues for our next report.

6.6 The parties also addressed the future shape of the workforce, and said that it was subject to work by the Centre for Workforce Intelligence. NHS Employers told us that an oversupply of United Kingdom medical graduates was predicted from August 2013. They said that a small planned oversupply in the medical workforce was desirable to enable a flexible response to changing staff and patient demographics, and that the future NHS would not require all doctors to progress to the current role of consultant. The Department of Health said it was focused on rebalancing the number of doctors and was working towards an annual 50:50 split at entry to general practice and hospital specialty training. Given the BMA's earlier comments about the resistance to changing specialties, there will clearly be a role for all the parties in better managing the career expectations of trainees.

Motivation

6.7 The BMA told us that its 2011 survey of junior doctors' morale and career intentions showed that almost two-thirds of respondents were satisfied with their job. NHS Employers said that the *NHS Staff Survey* (carried out in autumn 2011) had also shown a small improvement in the job satisfaction score for trainee doctors, increasing from 3.62 in 2010 to 3.64 in 2011 (on a scale from 1 to 5). We note that satisfaction with level of pay for doctors in training has improved every year since 2007, in contrast with other NHS staff groups, where satisfaction with pay has dropped between 2010 and 2011. Chapter 2 includes our detailed analysis of motivation.

Banding supplements and other allowances

6.8 The BMA highlighted a number of costs for junior doctors that it said had been increased but were not fully reimbursed, including travel costs, reduced study budgets and increased registration, examination and membership fees. However, we agree with the Department of Health when it says that the payment of examination, registration and membership fees should be met from salaries. We will, of course, continue to monitor the impact of all costs to junior doctors on recruitment and retention. With regard to the level of the banding supplements that are applied to basic pay to reflect the hours and intensity of posts, we have not received any evidence from the parties this year that these need amending and so have not considered any related adjustments.

Comparator groups

6.9 The BMA said that the relative position of doctors against other workers continued to worsen, while NHS Employers said that the Association of Graduate Recruiters 2012 survey showed that the total earnings for medical graduates entering their first post remained very competitive. Our own research on pay comparability shows that basic pay for doctors and dentists in training is lower than for their comparator groups at the same stages in their careers, but total earnings including banding supplements compare reasonably well with the comparator groups at every stage. However, the total earnings position for doctors and dentists in training has declined relative to comparator professions since 2011. A more detailed analysis of pay comparability is in Chapter 2 and Appendix F.

New contractual arrangements

6.10 We have long commented in our reports on the need to restructure the contract for junior doctors to shift the balance away from the banding supplements towards basic pay, and to ensure that starting salaries do not fall behind those of other graduate-entry

professions. As far back as in our *Thirty-Eighth Report*,[1] we noted that NHS Employers were undertaking a scoping study for reforming the junior doctors' contract.

6.11 We were therefore pleased to note that the *Scoping report on the contract for doctors in training*[2] was finally published in December 2012. The report notes that the parties are broadly in agreement that the current contract is no longer suitable, although we note that the BMA were not signatories to the final report. The report sets out a vision and principles for a new contract that emphasises:

- better patient care and outcomes;
- doctors in training feeling valued and engaged;
- affordability;
- producing the next generation of medical professionals; and
- improving relationships (particularly between doctors, employers and deaneries).

6.12 The BMA said that talks on the future of the junior doctors' contract could be an opportunity to recognise the vital contribution of trainees to the NHS, and we note that the aim is for the parties (the four Health Departments, the BMA and NHS Employers) to reach an outline agreement on a new contract by spring 2013. We subsequently learned that the BMA had agreed to begin initial talks. We welcome this progress.

6.13 As banding supplements are currently non-pensionable, we note that there will be pension cost implications for both employees and employers if such payments are consolidated into basic pay, although there will be an associated benefit for employees with the move to a career average pension, albeit in the long term.

6.14 We look forward to learning of the outcome of these discussions and ask the parties to keep us informed on how the discussions are impacting on the motivation of trainee doctors. We note from the Francis report[3] the finding that all doctors, whether fully qualified or in training, work in environments where there is a duty to protect patients; that good practical training should only be given where there is good clinical care; and that absence of care to that standard will mean that training is deficient. We expect the parties will want to take account of the relevant findings of the inquiry when considering new contractual arrangements for trainee doctors. For our part, we support a contract that strengthens the link between pay and better quality patient care and outcomes. As ever, we stand ready to assist in any of the deliberations on the new contract, if required.

Pay recommendation

6.15 Our recommendation this year is for the same uplift across our remit groups and can be found in Chapter 9.

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[1] Review Body on Doctors' and Dentists' Remuneration. *Thirty-ninth report*. Cm 7579. TSO, 2009. Paragraph 7.14. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[2] *Scoping report on the contract for doctors in training – June 2011*. Department of Health, December 2012. Available from: https://www.wp.dh.gov.uk/publications/files/2012/12/FINAL-PDF-revised-for-DH.pdf

[3] Robert Francis QC, chairman. *Report of the Mid Staffordshire NHS foundation trust public inquiry.* HC 947. TSO, 2013. Available from: http://www.midstaffspublicinquiry.com/report

Future evidence requirements

6.16 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to keep us updated on any issues relating to recruitment, including the use (if any) of recruitment premia for problem specialties, and the impact on recruitment of costs for trainee doctors;
- the parties to consider if the levels of the banding supplements require any adjustment; and
- an update on the discussions relating to new contractual arrangements, and any implications for the motivation of trainee doctors.

CHAPTER 7: CONSULTANTS

Introduction

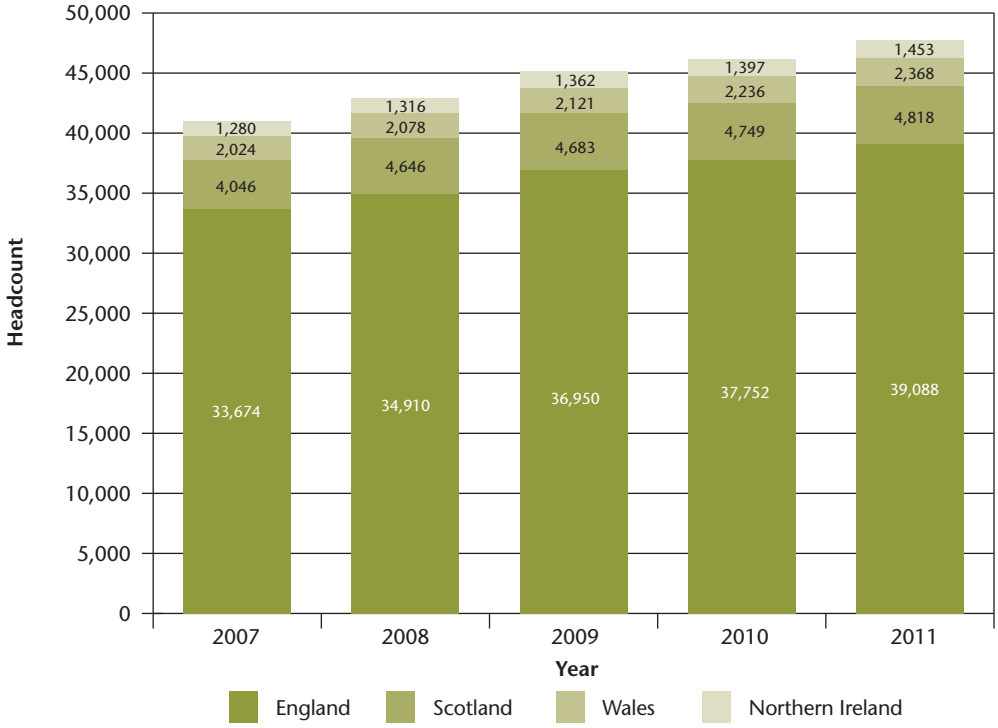
7.1 The consultant grade is the main career grade in the hospital and public health service. The most recent contracts were agreed in October 2003 and differ somewhat in each of the devolved countries. The contract was optional in England, Scotland and Northern Ireland, although all new appointments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

7.2 Under the 2003 contract, consultants have to agree the number of Programmed Activities (PAs) they will work. Further information on PAs is contained in the glossary at Appendix H. Total pay is composed of five elements: basic pay on an eight-point scale; additional PAs; on-call supplements; Clinical Excellence Award/Discretionary Point/Distinction Award payments; and other fees and allowances. The current levels of payments are in the green pages at Appendix C. The main differences for the 2003 contract in Wales are: a basic 37.5 hour working week (compared to 40 hours in the rest of the United Kingdom); a salary structure with seven incremental points; and a system of Commitment Awards to be paid every three years after reaching the maximum of the pay scale, which replaced the former Discretionary Points scheme, although consultants in Wales are also eligible for national level Clinical Excellence Awards.

Recruitment and retention

7.3 In September 2011, there were 47,727 consultants, an increase of 3.5 per cent on the previous year, with the number of consultants increasing in each United Kingdom country each year between 2007 and 2011 (Figure 7.1). We note from the Department of Health and NHS Employers that these were the highest numbers of consultants ever recorded in England.

Figure 7.1: Number of consultants in the Hospital and Community Health Services, 2007 – 2011, United Kingdom



Note: Data from 2010 for England are not comparable with previous years.

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

7.4 NHS Employers reported that the September 2011 workforce census had indicated that 38 per cent of the consultant headcount of 39,088 (full-time equivalent) working in the NHS in England were aged 50 or over, and 8 per cent were aged 60 or over. These proportions were around the same as those in September 2009 and 2010.

7.5 The Health Departments reported that consultant vacancies in Wales accounted for 23 per cent of all medical staff vacancies, giving a vacancy rate for consultants of 2 per cent. Scotland had seen an overall decline in vacant medical and dental consultant posts, although there was a slight rise in the number of posts vacant for over six months; the overall consultant vacancy rate as at 30 June 2012, was 3.0 per cent, a decline of 0.6 per cent from March 2012. In Northern Ireland there were 82 current vacancies for consultants in March 2012, giving a whole-time equivalent vacancy rate of 5.4 per cent. We received no vacancy data for England, and we reiterate our comments in Chapter 2 that we continue to be frustrated that it is not possible to compare the vacancy figures across the United Kingdom and that the NHS Information Centre has suspended the collection and publication of Hospital and Community Health Services vacancy figures in England. We also note that some consultants receive recruitment and retention premia, but that these are not widely used, even in Northern Ireland where remuneration is higher across the border in the Republic of Ireland.

7.6 The Scottish Government did not believe that a pay freeze for staff earning in excess of £80,000 per year would have a significant impact on consultant recruitment and retention. It said that while there could be recruitment and retention issues in relation to specific posts, it did not accept that these issues related to pay, and were more likely to be related to geographical and other workforce factors.

7.7 NHS Employers' evidence drew on the work of the Centre for Workforce Intelligence, which estimated that, based on current trends, and assuming that all eligible doctors became consultants within the current grade structures and terms and conditions, the number of fully trained hospital doctors in England would increase by over 60 per cent to 60,000 by 2020. This would result in an estimated £6 billion annual spend on consultant salary costs, an increase of £2.2 billion on the 2010 spend. NHS Employers said that these figures were not projections of the size of workforce that would be needed, but predictions based on the current shape of the workforce. They told us that this level of expansion was neither necessary nor affordable. However, as referred to in Chapter 6, they believed that a small, planned oversupply in the medical workforce was desirable to enable a flexible response to changing staff and patient demographics. NHS Employers said that the future NHS would not require all doctors to progress to the current role of consultant. They said that new roles and structures must be developed that would meet the needs of employers and patients with the flexibility to adapt the structure to suit local circumstances.

7.8 The evidence does not give us cause for concern on the recruitment and retention of consultants, although we recognise that there are some specialties where it is more difficult to fill posts than others. In such cases there is the facility to use recruitment and retention premia, although we are aware that in practice they are not widely used. We have commented in Chapter 2 on the fact that the numbers of consultants has continued to increase, year on year, despite budgetary constraints.

Motivation

7.9 The 2011 *NHS staff survey*[1] for England, conducted in autumn 2011, showed, as in previous years, that consultants tended to be, on average, the grade most satisfied with freedom to choose their own method of working and with their level of pay, but they tended to be least satisfied with support from immediate managers. In addition, consultants, on average, had higher feelings of work pressure than other grades and were most likely to be working extra hours. Unfortunately no staff survey data were available for Wales, Scotland or Northern Ireland. From the staff survey results for England, we do not have any major cause for concern regarding the motivation of the consultant group, although we note that there was a decrease in consultants reporting that they were satisfied or very satisfied with their level of pay. We recognise that this is the first survey to have taken place after the pay freeze had begun to take effect and it predated many of the proposed changes to the NHS Pension Scheme and the various NHS reforms across the United Kingdom.

7.10 The BMA told us that 70.4 per cent of consultants who responded to their survey reported that their morale had decreased in the last year. This was a similar figure to specialty doctors and associate specialists, but below that of general medical practitioners.

7.11 We will continue to monitor closely the impact of the changes mentioned above on consultants' motivation, and ask the parties to find more rigorous evidence on motivation, for all United Kingdom countries, with which to update us for our next review. Chapter 2 includes our detailed analysis of motivation.

Consultant contract and pay scales

7.12 In our last report, we asked for an update on negotiations in Scotland on consultant terms and conditions. We note that no further progress appears to have been made. The Scottish Government told us that negotiations with the BMA were unable to proceed

[1] *2011 NHS staff survey.* National NHS Staff Survey Coordination Centre, March 2012. Available from: http://www.dh.gov.uk/health/2012/03/nhsstaffsurvey/

because of significant uncertainties over pay and pensions. However, there had been "talks about talks", with a view to moving service delivery away from doctors in training towards a service delivered predominantly by trained doctors. NHS Employers told us that the recommendations from the interim report of the Emergency Medicine Taskforce for England included increased consultant numbers to ensure a consultant presence for 16 hours a day, seven days a week in all emergency departments and 24 hours a day in larger departments or major trauma centres.

7.13 However, changes to the consultant contract are now in prospect, following the publication of our own *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*[2] and the government's acceptance of a "compelling case" for changes to the consultant contract. We note also the announcement by the Secretary of State for Health that doctors' pay arrangements needed to be affordable and sustainable in the longer term, and that he would be seeking to agree changes to doctors' contracts to better support seven day working in the NHS alongside better availability of community services and primary care.[3] Our report recommended an integrated package of local and national awards, changes to pay scales with progression based on performance, and a new principal consultant grade. It said:

> *It is our view that the current system pays increments for a consultant continuing to carry out their basic job, rather than reflecting the evidence of job growth that a progression system should reward. We believe that the current structure rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. Near-automatic progression is not typically a feature of any of the professional roles we use for comparators at this level.*[4]

7.14 We believe that pay scales cannot be looked at in isolation. There need to be opportunities for consultants to achieve promotion and we also have concerns about the consistent application of performance appraisal, and incremental scales not linked to performance.

7.15 The National Audit Office published its study of how far the expected benefits of the consultant contract had been realised.[5] The report found that the contract had increased the cost of employing consultants. It noted that between 2002-03 and 2003-04, the bottom of the consultants' pay band had increased by 24 per cent and the top by 28 per cent, and that as a result, between these dates total earnings per full-time equivalent consultant had increased by 12 per cent in real terms. In addition, trusts stated that they now paid for work which was previously not paid for under the old contract. However, the National Audit Office acknowledged that the contract had had a number of positive impacts, including a reduction in the speed of pay progression. It said that, overall, most of the expected benefits of the contract had been either fully or partially realised, which had improved the value for money of consultants to the NHS; but it could not conclude that value for money had been fully achieved.

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[2] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[3] Department of Health. Written Ministerial Statement: review of awards for NHS consultants and publication of NHS Employers report on junior doctors' contracts. *Hansard,* 17 December 2012, column 74WS-76WS. Available from: http://www.parliament.uk/documents/commons-vote-office/December_2012/17-12-12/8.HEALTH-Review-awards-NHS-consultants.pdf

[4] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Paragraph 4.40. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[5] National Audit Office. *Managing NHS hospital consultants.* Report by the Comptroller and Auditor General. HC 885. Session 2012-13. 6 February 2013. TSO, 2013. Available from: http://www.nao.org.uk/publications/1213/nhs_hospital_consultants.aspx?utm_source=GovDelivery&utm_medium=email&utm_campaign=naoorguk

7.16 The report from the National Audit Office observed that pay progression was not linked to performance in most trusts: less than a third of trusts stated that pay progression for all or most consultants either depended on achieving objectives set out in job plans or achieving objectives from appraisals, even though the contract explicitly linked pay progression with performance. However, trusts reported that 19 per cent of consultants had not had an appraisal in the last 12 months. It also found that 97 per cent of consultants now had a job plan, although 16 per cent of these had not been reviewed in the last 12 months. The report recommended that consultants should be held to account for meeting the objectives and activity levels agreed in job plans through the appraisal process and pay progression. It also recommended that consultants' financial rewards should reflect performance and that pay progression should be linked to consultant performance.

7.17 A number of the concerns that we raised in our *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*[6] are echoed by the National Audit Office report, in particular the weak link between pay and appraised performance. We ask the parties to update us for our next review on progress towards changes in the consultant contract.

7.18 NHS Employers reported that employers were increasingly asking for pay and conditions arrangements to be better aligned to performance and productivity and to be more responsive to local needs. We asked them the extent to which increments were withheld when job planning or appraisals had not taken place, as these are mandatory in the consultants' contracts. NHS Employers told us that any withholding of pay progression could only apply where the doctor could be shown to have failed to participate satisfactorily or to meet other criteria. Where job planning or appraisal had not happened for reasons beyond their control, the consultant contract required pay progression to take place. They added that appraisal and job planning systems needed to be robust if employers were to withhold increments, but that the quality of appraisal could vary. They expected improvements in the quality and quantity of appraisals with the introduction of revalidation. We heard from NHS Employers that data on the withholding of increments was not collected centrally but that anecdotally the withholding of increments was very rare.

7.19 We were pleased to see the introduction of the medical revalidation regulations in December 2012. We would like to see an increase in the quality and quantity of appraisals taking place and a stronger link to pay. This was echoed in the findings of the National Audit Office report and should be assisted by the new revalidation process and any contractual changes. We understand that where there are still increments in the private sector, or even within the public sector, it might not be unusual for the pay system to allow increments to be withheld when appraisal does not take place. We would expect modern contracts to have such mechanisms in place, with appropriate protection for employees. We ask the parties to update us for our next review on the impact of the revalidation process on the quality and quantity of appraisals.

Geographical variation in consultants' pay

7.20 We were concerned that there might be an upward bias in pay for consultants in London. Such a bias was identified for *Agenda for Change* staff by the NHS Pay Review Body in its report on *Market-Facing Pay* which found that as a whole, and for certain individual occupations, basic salaries were significantly higher in inner and outer London than they

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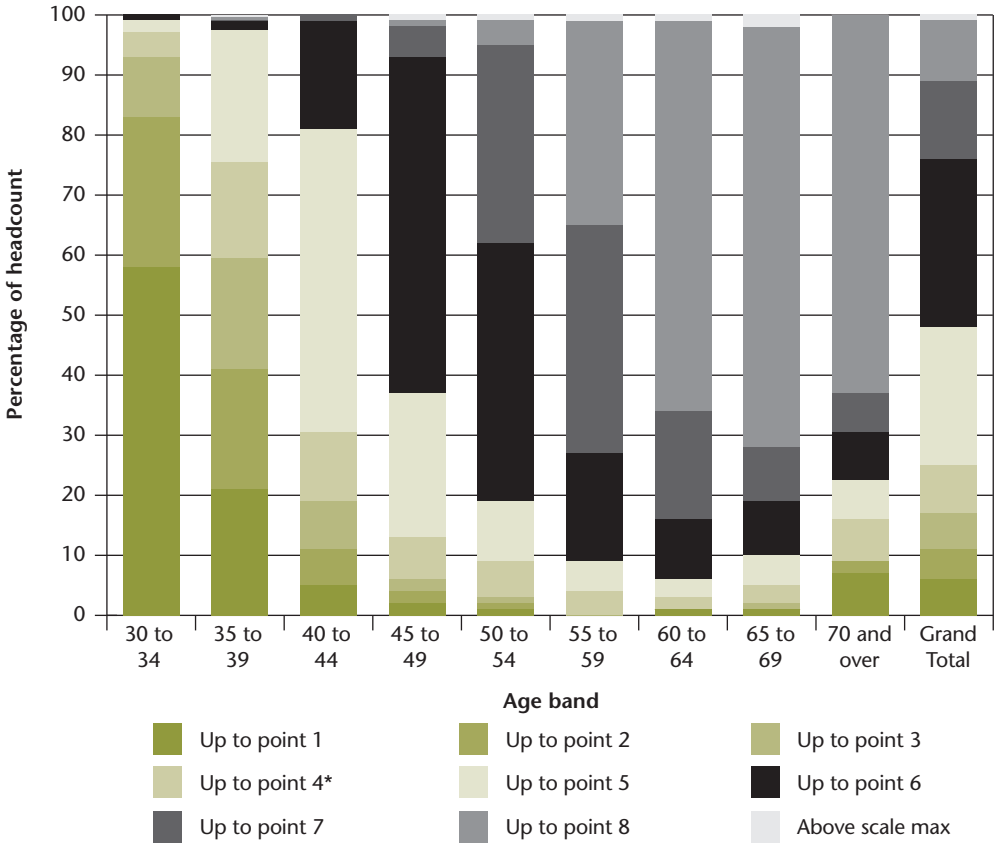
[6] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

were in the rest of England.[7] We therefore conducted some analysis on the distribution of consultants' basic pay for England as a whole, as well as geographical variation.

7.21 We looked at data showing consultants' basic pay, provided by the Health and Social Care Information Centre, from which scale points could be inferred. We found that in the distributions of pay by age band, at national level (Figure 7.2):

- 58 per cent of consultants aged 30 – 34 had basic pay of £75,000 (scale point 1), with a further 23 per cent on £77,000 (scale point 2);
- consultants aged 35 – 39 were nearly uniformly distributed on the first five scale points;
- there were large peaks for the 40 – 44 and 45 – 49 cohorts at £84,000 and £90,000 respectively (scale points 5 and 6); and
- most consultants aged 50 – 54 had basic pay of £90,000 or £95,000 (scale points 6 and 7), while most consultants aged 55 – 59 had basic pay of £95,000 or £101,000, with those aged 60 or over generally paid on the top point of the scale.

Figure 7.2: Distribution of consultants' basic pay by age band, England, June 2012



* Includes some staff paid £81,000 – the top point of the scale under the pre-2003 contract.

Source: Health and Social Care Information Centre.

7.22 Looking at the organisation-level data, although there is some variation in consultants' average pay by age band, this variation appears to be broadly consistent with normal incremental progression for consultants, with no evidence of an upward bias in average basic pay in London. From the data available, there does not appear to be any firm evidence of artificial movement of consultants up the scales or starting above the minimum, though isolated cases may occur. These results give us no cause for concern

[7] NHS Pay Review Body. *Market-Facing Pay*. Cm 8501. TSO, 2012. Chapter 6, in particular paragraphs 6.6 and 6.38 – 6.55. Available from: http://www.ome.uk.com/NHSPRB_Reports.aspx

and we are satisfied that the peaks in distribution fall where we would expect for consultants at different stages of their careers.

Workload

7.23 The National Audit Office report[8] stated that the average paid PAs across trusts was over 11, with most trusts using locally agreed rates of pay for additional work outside that agreed in job plans.

7.24 The BMA reported the continuing increase in the number of worked unremunerated PAs for consultants. It said that both the number of contracted PAs and those actually worked had gone up. It observed that, most critically, this increase had been in direct clinical contact, which had forced doctors to undertake their Supporting Professional Activities (SPAs) in what was previously personal time. It told us during oral evidence that it expected the requirements of revalidation would be 1.5 SPAs per week, and that the pressure on SPAs meant that consultants had little time to develop services of the type that would lead to the award of Clinical Excellence Awards. The BMA believed that the continuing increase in workload, and pressure to deliver more direct clinical contact at the expense of non-clinical SPAs, would have a detrimental effect on both doctors' morale and ultimately career choices, but also on service innovation, continuing professional development, research and education, clinical contributions to organisational change in doctors' employing organisations and the wider NHS, and ultimately limit scope to improve quality of care. It added that it did not believe that crude measures of productivity based solely on direct patient contact were an appropriate reflection of the value of doctors in improving health outcomes.

7.25 We asked NHS Employers about pressure on SPAs. During oral evidence they told us that ultimately, SPA time formed part of the one-to-one discussions on job plans, but they acknowledged that there was now a greater requirement to justify the need for SPAs.

7.26 We note the BMA's concern over this trend, but our view continues to be that the arguments about additional unpaid PAs must be set against senior professional comparators who tend also to work long hours, many of which are unpaid and who carry out much of their continuing professional development in their own time. We also believe that work developing services that is paid for through SPAs should not be additionally rewarded with Clinical Excellence Awards, unless the work carried out was significantly above normal expectations.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

7.27 We were pleased to see publication of our *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*[9] in December 2012 and that the recommendations we had made were generally accepted. We will follow the progress towards the implementation of new award schemes with interest.

7.28 Schemes to provide consultants with some form of financial reward for exceptional achievements and contribution to patient care have been in existence since the beginning of the NHS in 1948. The glossary at Appendix H contains information on Clinical Excellence Awards, Distinction Awards and Discretionary Points.

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[8] National Audit Office. *Managing NHS hospital consultants.* Report by the Comptroller and Auditor General. HC 885. Session 2012-13. 6 February 2013. TSO, 2013. Available from: http://www.nao.org.uk/publications/1213/nhs_hospital_consultants.aspx?utm_source=GovDelivery&utm_medium=email&utm_campaign=naoorguk

[9] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

7.29 We note with interest that the National Audit Office report[10] found that while most trusts thought Clinical Excellence Awards reflected exceptional performance, less than half of consultants agreed.

7.30 We did not receive any requests to recommend on the number and value of awards for consultants in this review. This may have been because the parties submitted their written evidence prior to publication of the review. But we are also conscious that over the period of the pay freeze and the preparation of our review the schemes had been frozen in Scotland and Northern Ireland, and curtailed in terms of both the number and value of awards in England and Wales. We note NHS Employers' view that there is no justification for any increases to the value of any awards or for any new awards to be made. Given the lengthy delay in the publication of our review of the award schemes, we urge the parties to implement the recommendations in our report as soon as possible. We ask the parties to update us on the status of all the consultant award schemes for our next review.

7.31 Our remit requires us to take account of the legal obligations on the NHS, including anti-discrimination legislation regarding ages, gender, race, sexual orientation, religion and belief and disability. We ask the parties to continue to report to us for future rounds whether there are any issues with the award schemes that may raise concerns about discrimination.

England and Wales

7.32 The Advisory Committee on Clinical Excellence Awards (ACCEA) reported that the Health Minister had delayed the decision on whether there would be a 2012 round for Clinical Excellence Awards until May 2012, but that it expected to make 300 new awards for 2012, with a predicted distribution of 21 Platinum awards, 34 Gold, 97 Silver and 148 at Bronze level, subject to the quality of applications. Both the number and the proportion of consultants who held a national award had dropped significantly since 2010. This was likely to be the result of three main factors: an increase in the number of senior consultants leaving the scheme; the decision to reduce and fix the number of awards; and an increase in the overall number of consultants employed in the NHS. Since 2010, ACCEA had been asked to make 300 awards each year in England. This represented a significant reduction from the previous pattern of numbers of awards, based on maintaining a consistent proportion of the overall eligible consultant body.

7.33 ACCEA highlighted anomalies with the current scheme: Distinction Awards held by consultants who had retired and returned to work and retained their awards; and the resources allocated to pay protection, where consultants had had their awards withdrawn, but retained the financial benefit on a 'mark time' basis under the current framework document. We addressed these anomalies in our review of the schemes[11] and we note that the government intends to launch a specific consultation about discontinuing these two anomalies.

7.34 We also note that the National Audit Office report[12] recommended that national Clinical Excellence Awards should be reviewed more often than every five years, and that local employer-based awards should be reviewed regularly.

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[10] National Audit Office. *Managing NHS hospital consultants.* Report by the Comptroller and Auditor General. HC 885. Session 2012-13. 6 February 2013. TSO, 2013. Available from: http://www.nao.org.uk/publications/1213/nhs_hospital_consultants.aspx?utm_source=GovDelivery&utm_medium=email&utm_campaign=naoorguk

[11] Review Body on Doctors' and Dentists' Remuneration. *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Cm 8518. TSO, 2012. Chapter 6. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

[12] National Audit Office. *Managing NHS hospital consultants.* Report by the Comptroller and Auditor General. HC 885. Session 2012-13. 6 February 2013. TSO, 2013. Available from: http://www.nao.org.uk/publications/1213/nhs_hospital_consultants.aspx?utm_source=GovDelivery&utm_medium=email&utm_campaign=naoorguk

7.35 We observe from its website that ACCEA is in the early stages of planning a 2013 awards round and that this would be carried out according to the 2012 business rules. Now that our report on the review of the award schemes has been published, we hope that proposals for a revised scheme can be developed quickly. Our report noted our belief that variable award schemes continue to be required to reward, recognise and provide incentives for those consultants who perform significantly beyond expectations. We ask the parties to update us on progress towards a revised scheme for England and Wales for our next review.

7.36 The BMA asked for our consideration, in the light of any evidence from the Welsh Government, of the issue that clinical academics in Wales have had less access to Commitment Awards, which should be an automatic process. The Welsh Government provided no comment on this matter and we feel unable to follow it up as clinical academics are outside our remit. However, we hope that this and other issues relating to Commitment Awards may be addressed as a result of the overall changes to the awards system following our review. We ask the parties to update us on the status of Commitment Awards.

Scotland

7.37 The Scottish Advisory Committee on Distinction Awards (SACDA) reported that at 30 September 2011, there were 494 Distinction Award holders in Scotland (44 A+, 132 A and 318 B) comprising 10.6 per cent of all consultants. The number of award holders had dropped substantially due to the decision taken by the Deputy First Minister and Cabinet Secretary for Health and Wellbeing that there should be no new Distinction Awards, no increase in their value and no progression through the awards scheme in 2011-12 or 2012-13. Since awards were last granted in 2010, the number of Distinction Award holders had reduced by 24.4 per cent. We note with concern that this reduction in award holders was now making it increasingly difficult for SACDA to perform the five-yearly review process as it relied heavily on higher award holders to carry out peer assessments, and there were now significant numbers of specialties with no senior award holders. SACDA argued that the continued uncertainty over the future of the scheme left many NHS consultants despondent about career progression.

7.38 We acknowledge that the Scottish Government said that it was not asking us to review Distinction Awards or Discretionary Points, nor for any uplift to be recommended. However, we are concerned about the large drop in the number of Distinction Award holders that has come about because of the freezing of the schemes pending publication of our report on the review of the award schemes. Now that this has been published, we hope that proposals for revised schemes can be developed quickly. Our report noted our belief that variable award schemes continue to be required to reward, recognise and provide incentives for those consultants who perform significantly beyond expectations. We ask the parties to update us on progress towards a revised scheme for Scotland for our next review.

Northern Ireland

7.39 The Northern Ireland Executive told us that it was keen to develop proposals for a revised scheme following publication of our review of the schemes. It reported that following the introduction of the pay freeze in June 2010, Ministers took the decision that no new higher or lower Clinical Excellence Awards would be paid to consultant doctors and dentists in the 2010-11 or 2011-12 financial year. It said that the decision was strongly opposed by the BMA which brought a Judicial Review.

7.40 We note that the judgement on the Judicial Review was issued on 16 Nov 2012, that all claims were dismissed and the decision not to hold an award round was upheld.

Now that our report on the review of the award schemes has been published, we hope that proposals for a revised scheme can be developed quickly, along with a decision on the 2012-13 awards round. Our report noted our belief that variable award schemes continue to be required to reward, recognise and provide incentives for those consultants who perform significantly beyond expectations. We ask the parties to update us on progress towards a revised scheme for Northern Ireland for our next review.

Pay comparability

7.41 The BMA told us that the impact of the pay freezes had brought consultant earnings back to their 2003 level in real terms, i.e. when the new consultant contract was introduced. The National Audit Office report[13] stated that between 2002-03 and 2003-04, total earnings per full-time equivalent consultant increased by 12 per cent in real terms. However, it also noted a real terms drop in pay and said that average (mean) pay in real terms had fallen over the past five years, and that between 2006-07 and 2011-12, earnings per full-time equivalent consultant fell by 9 per cent in real terms, mainly due to recent pay restraint.

7.42 Our analysis of pay comparability, using the system of comparators outlined in Chapter 2, concluded that median basic salary and total earnings for newly qualified consultants were both lower than those seen in the comparator groups. The change in the relative position against comparators has been mixed since 2011: doctors' earnings have been flat, while they increased for actuaries and lawyers, but decreased for those in pharmaceutical, and tax and accounting. For an experienced consultant with at least 19 years' experience (and therefore at the scale maximum), with a level five Clinical Excellence Award (worth £14,785, and considered to be the upper quartile number of Clinical Excellence Awards): the basic salary is higher than those for the comparator groups with similar job weights, and total earnings are similar to those of the comparator groups, though as with other grades their relative position has worsened since 2011. We address pay comparability more fully in Chapter 2 and our detailed analysis of pay comparability at each anchor point can be found at Appendix F.

Pay recommendation

7.43 Our recommendation this year is for the same uplift across our remit groups and can be found in Chapter 9.

[13] National Audit Office. *Managing NHS hospital consultants.* Report by the Comptroller and Auditor General. HC 885. Session 2012-13. 6 February 2013. TSO, 2013. Available from: http://www.nao.org.uk/publications/1213/nhs_hospital_consultants.aspx?utm_source=GovDelivery&utm_medium=email&utm_campaign=naoorguk

Future evidence requirements

7.44 The evidence requirements that we have identified from this round for our next review are for:

- the parties to find more substantial evidence on motivation, for all United Kingdom countries, with which to update us for our next review;
- the parties to provide an update on progress towards changes in the consultant contract;
- the parties to update us on the impact of the revalidation process on the quality and quantity of appraisals;
- the parties to provide us with evidence for the next report on how they have taken forward the relevant findings of the National Audit Office report;
- the parties to report on the status of all the consultant award schemes;
- the parties to report any issues with the award schemes that may raise concerns regarding equality legislation;
- the parties to provide an update on progress towards revised award schemes for England and Wales, Scotland and Northern Ireland; and
- the parties to update us on the status of Commitment Awards in Wales.

CHAPTER 8: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

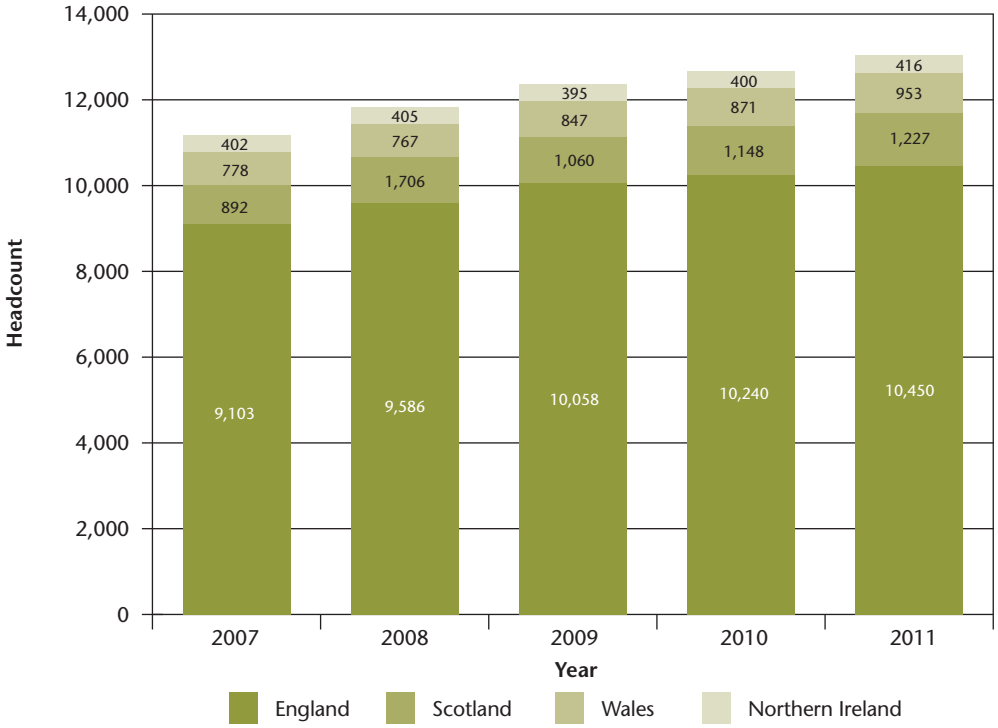
Introduction

8.1 The specialty doctor and associate specialist (SAS) grades are a diverse group comprised of: specialty doctors, associate specialists, staff grades, senior clinical medical officers, clinical assistants, hospital practitioners and doctors working in community hospitals.

Recruitment and retention

8.2 In September 2011, there were 13,046 associate specialists, staff grades and specialty doctors, an increase of 3.1 per cent on September 2010 levels for the United Kingdom as a whole, and numbers increased in all countries (Figure 8.1).

Figure 8.1: Number of staff grades, associate specialists and specialty doctors in the Hospital and Community Health Services, 2007 – 2011, United Kingdom



Note: Data from 2010 for England are not comparable with previous years.

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

8.3 The Northern Ireland Executive said that there was currently a shortage of SAS grade doctors, and that while trusts continued to advertise vacancies, there simply was not the supply. It said that the number of SAS posts had increased, so the service was playing 'catch up' in filling the vacancies. The Foundation Trust Network also commented on recruitment and retention problems for middle-grade doctors.

Costs of the new contracts

8.4 The Department of Health told us that the cost modelling that underpinned the new SAS contract had been robust and that the contract had been implemented as intended. Accordingly, the signatories to the new SAS contract all confirmed to us that it was no

longer necessary for us to take into account the costs of implementing the new contract when recommending our uplift for SAS doctors.

Motivation

8.5 The BMA said that its survey showed that SAS doctors had the lowest level of motivation of all doctors, although it also cautioned us that the sample size for the survey was relatively small. Pressure on the time allocated in job plans for Supporting Professional Activities (SPAs) was highlighted by the BMA. We note from the BMA's survey that the average number of SPAs contracted is 1.43 (more than the minimum 1 SPA stipulated in the contract agreement), but that the average number of SPAs worked is 1.36, with additional time being given to direct clinical care. Chapter 2 includes our detailed analysis of motivation.

Career development issues

8.6 Last year, we commented on the importance of funding for SAS doctors to support career development. We are already aware of the £12 million recurrent funding in England (uprated for inflation) for specialty doctor career support, training and continuing professional development. This year, the Department of Health told us that the General Medical Council (GMC) was taking forward work to consider the concept of credentialing within medical education and careers, whereby capabilities are formally recognised at defined points of the medical career, and it also updated us on the GMC's work looking at alternative routes to general medical practitioner and specialist registration. The Welsh Government reported that the Associate Dean for SAS doctors ran annual programmes of development activities with specific funding from the Deanery, and was piloting a surgical training programme with the Royal College of Surgeons for SAS doctors. An SAS tutor post had also been created within each health board/trust, centrally funded via the Deanery, to lead and focus development activities locally. The Scottish Government reported a new funding stream of £1.4 million over three years from 2012-13, for Scottish SAS doctors' continuing professional development needs. The Northern Ireland Executive told us that it would explore career development opportunities through dialogue with the British Medical Association (BMA), and that a group entitled *Choice and Opportunity* had been tasked with the development of SAS doctors via mentoring and shadowing. It also said that funding for SAS development was available where a clear business case was identified. We welcome this progress, and remind all countries of the importance of investing in the new SAS contract so that its benefits can be realised in full, and ask the parties to update us for our next review.

Pay comparability

8.7 Our pay comparability research shows that basic pay and total earnings for associate specialists are both lower than for the comparator groups, but those for specialty doctors are broadly comparable. Relative to comparator groups, the earnings position for specialty doctors has largely declined since 2011; while the position since 2011 for associate specialists is more mixed, with a decline in relative earnings for both the tax and accounting and pharmaceutical comparators we examine, but a relative gain for the legal and actuarial comparators. A more detailed analysis of pay comparability is in Chapter 2 and Appendix F.

Appraisals

8.8 NHS Employers told us that only 53 per cent of SAS doctors had received an appraisal in the last year. Given NHS Employers' comments about the affordability of increments, we asked whether any increments were being withheld from doctors when appraisal had not taken place, but were informed that withholding of pay progression could only apply

where the doctor could be shown to have failed to have participated satisfactorily or to meet other criteria. We were told that withholding of increments was very rare. Given the large number of doctors without appraisal, this seems to us to be somewhat surprising, but perhaps indicative of the culture within the NHS. We understand that where there are still increments in the private sector, or even within the public sector, it might not be unusual for the pay system to allow increments to be withheld when appraisal does not take place. We would expect modern contracts to have such mechanisms in place, with an appropriate level of protection for employees, as regular quality appraisal should be a cornerstone of both incremental pay and career development.

8.9 Revalidation came into force across the United Kingdom on 3 December 2012. Doctors are now legally required to show they are keeping up to date and are fit to practise. Regular appraisals will now be a requirement in order to remain licensed as a doctor. The BMA told us that Royal College guidance suggested that secondary care doctors would require 1.5 SPAs per week for revalidation. We ask the parties to keep us informed on the incidence of appraisals.

Pay recommendation

8.10 Our recommendation this year is for the same uplift across our remit groups and can be found in Chapter 9.

Future evidence requirements

8.11 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to update us on the funding made available for career development for SAS doctors; and
- the parties to keep us informed on the incidence of appraisals.

CHAPTER 9: MAIN PAY RECOMMENDATIONS FOR 2013-14

The parties' proposals

9.1 The parties have included, as part of their evidence to us, their proposals on pay increases for the year 2013-14. For some of our remit groups, they have offered detailed proposals on the uplifts, and given justifications for their views; we discuss these considerations in depth in the relevant chapters. In this chapter, we outline the parties' principal proposals for the main uplift to be awarded to each group, along with our recommendations, which we have made following careful consideration of all the evidence. The letters from the parties relating to the remits are at Appendix A. Chapter 1 covers the remits in more detail and issues specific to certain groups are addressed in the relevant chapters.

9.2 The Chief Secretary to the Treasury wrote to us noting the need for continued pay restraint across the public sector. He said that the government would limit uplifts to an average of 1 per cent in each workforce and that we should focus on considering how the 1 per cent would be divided within the remit groups. He suggested that we might additionally want to consider the level of progression pay provided to the workforce and the potential for payments to be more generous for certain groups of staff. The 1 per cent average uplift should be applied to basic salary based on the normal interpretation of basic salary in each workforce and did not include overtime or any regular payments such as London weighting, recruitment and retention premia or other allowances.

9.3 The remit letter from the Department of Health stated that public sector pay increases would be capped at an average of 1 per cent. The Department of Health made clear that we would have to be given a remit to add specific allowances if we were to consider them. Its evidence said that NHS pay had to be viewed in the context of wider public sector pay and fiscal policy. There had been a two-year pay freeze and there was now the prospect of average pay increases of up to 1 per cent per annum over the next two years. In oral evidence, the Parliamentary Under Secretary of State for Health stressed that the pay envelope was for up to 1 per cent. The Department of Health argued that recruitment, retention, morale and motivation remained strong and that the majority of employed doctors and dentists received regular increments of between 3 per cent and 8 per cent. It said that any element of these funds not used for pay would be retained in the NHS where it believed it might be better employed on other issues such as increasing staff numbers or improving patient services. We were asked to make recommendations for the distribution of the available funds of up to 1 per cent, balancing the public's aspirations for continuing NHS service improvements, with the pay levels necessary to deliver a workforce of the required size, skill, motivation and morale.

9.4 The Welsh Government's remit letter noted the government's intention to cap public sector pay increases at 1 per cent for 2013-14 and its evidence did not consider that there was any compelling reason to move away from the recommended 1 per cent award advocated in the autumn budget in view of the continuing healthy recruitment and retention position for staff; nor was it persuaded that differential awards should be made for different categories of staff.

9.5 The public sector pay policy for 2013-14 for the Scottish Government differed from that of the United Kingdom government. The relevant pay features for our remit groups were: a 1 per cent cap on the cost of the increase in basic pay for staff earning under £80,000; and maintaining a pay freeze (zero per cent basic award) for staff earning £80,000 and above. The Scottish Government recognised that this was likely to lead to differences for staff on the associate specialist, consultant and salaried dentist scales. It said that there were approximately 4,220 directly employed medical and dental staff who earned over the £80,000 threshold and it did not expect us to recommend a pay increase for this

group of staff. It acknowledged that medical and dental staff had already experienced a two-year pay freeze and sought a maximum 1 per cent uplift for those earning less than £80,000. However, during oral evidence the Cabinet Secretary for Health and Wellbeing acknowledged that he understood that it would be for the Scottish Government to decide how to apply the Scottish public sector pay policy to our recommendations.

9.6 The Northern Ireland Executive advised us that we were not required to make any recommendations on uplifts. Increases for salaried doctors and dentists would be limited to an average of 1 per cent as per the United Kingdom government's public sector pay policy.

9.7 NHS Employers made it clear that they did not believe that increases in national pay rates from April 2013 were either necessary or affordable. They said that earnings had continued to grow for individuals during the freeze of national pay scales, due to the effect of pay progression and incremental step increases as they moved through their careers. In addition, recruitment and retention in the NHS was generally satisfactory, and wider solutions were being implemented where specific supply issues had been identified. However, if any pay award was made, it should be as low as possible, not necessarily as much as 1 per cent and paid equitably to all staff groups. NHS Employers did not favour differential increases in pay between staff groups or within medical staff groups. They also urged us to give consideration to the level of progression pay provided to doctors and dentists in the NHS and to include this earnings growth in the 1 per cent average referred to in government policy. They argued that higher national pay scales would not help to deliver the necessary local level changes that were needed and said that the forthcoming shift of posts from hospital specialties to general practice suggested that an increase in pay for hospital doctors was not required.

9.8 Evidence from the Foundation Trust Network said that there was a clear need for changes to the pay, terms and conditions for doctors and dentists. It strongly believed that the current national pay system was too rigid and could no longer adapt sufficiently to reflect the financial and service challenges. It was necessary to tackle what it perceived as the rigidity of embedded annual pay increases created by incremental progression and other awards. It said that the pay award should be determined in the context of the whole pay system and the unprecedented financial challenge. The Foundation Trust Network believed that there should be no pay increase for doctors and dentists in 2013-14, but that 1 per cent was the absolute maximum that could be tolerated. It also said that most of its membership believed that any award should be allocated equally across all staff groups.

9.9 The British Medical Association (BMA) regarded the government's proposal for a 1 per cent uplift as a minimum, and asked that any uplift be applied equally to the net incomes of all doctors. It argued that general inflation and changes to the NHS Pension Scheme, had resulted in a continued decline in the value of doctors' contracts and asked us to take into account the impact of increased contributions on net pay. It disputed the statements made by the Department of Health and NHS Employers that the majority of medical staff had received annual increments over 3 per cent, as there was no modelling to support this, other than examples of growth for the first five years of various staff groups. It argued that general medical practitioners (GMPs) did not receive automatic increments; and neither consultants nor specialty doctors and associate specialists (SAS) doctors received annual increments; there was a significant number of doctors at the top of the scale, for example, 7 per cent of consultants, who received no increments.

9.10 The British Dental Association (BDA) sought no recommendations from us for general dental practitioners (GDPs) in England, Wales or Northern Ireland as it was negotiating directly with the Health Departments. However, it sought an uplift of at least 1 per cent for salaried dentists throughout the United Kingdom.

9.11 The BDA's Scottish Dental Practice Committee requested a compounded increase of 5.17 per cent to the expenses element of the item-of-service fee, on top of the recommendations made by us for 2011-12 and 2012-13. It said that this would ensure that dentists did not receive a cut in their net taxable income and would restore the average drop in taxable income of 7.6 per cent for dentists in Scotland in 2010-11, which had been identified in the *NHS Information Centre Report on Dental Earnings and Expenses, Scotland, 2010-11*.[1]

Main pay recommendations

9.12 In making our recommendations for this pay round, we have been mindful of our standing terms of reference[2] as well as the governments' public sector pay policies. We have noted the Chancellor's announcement in the *Autumn Statement* for 2011 that public sector pay awards would average 1 per cent for the two years following the pay freeze and the subsequent letter from the Chief Secretary to the Treasury describing the United Kingdom government's public sector pay policy for 2013-14 limiting uplifts to an average of 1 per cent. We have also noted the letters from the Department of Health and the devolved administrations outlining the application of the 1 per cent pay policy cap to our remit groups. These letters are described in the preceding paragraphs and shown in Appendix A.

9.13 As in previous years, we have considered the usual range of economic and labour market evidence, as well as that provided by the parties. In our view, the parties' evidence for this round has been reduced in its scope and quality; this may or may not have been in response to the context provided by governments' pay policies and changing responsibilities for providing evidence. The absence of satisfactory evidence on a number of fronts has limited our ability to exercise our judgement to fulfil our terms of reference and consider a full range of options: some evidence was sparse or did not address all parts of our remit groups; some of the data, for example on pay costs, was too general and applied to the whole NHS rather than being specific to our remit groups; and there was an absence of robust statistics on vacancies.

9.14 Doctors and dentists have been subject to a pay freeze for two years, in common with much of the rest of the public sector; indeed, consultants and independent contractor GMPs and GDPs have had three years of frozen pay, and may now have expectations of a return to the established norm of annual pay reviews. We also note that pay settlements in the wider economy have picked up in the last two years during the public sector pay freeze, to around 2.6 per cent in the private sector during 2012, that the median settlement in the public sector was 0.7 per cent in the 12 months ending December 2012, and that the available data show that the earnings position of our remit groups has deteriorated relative to comparator professions. The latest staff survey data for England show a decline in the percentage of doctors and dentists reporting satisfaction with their pay, with the exception of those in training, and an increase in reported dissatisfaction, following a period when satisfaction had increased year on year. We believe that there is a need to maintain the motivation of doctors and dentists to address quality and care issues and help bring about the many proposed changes in the NHS, noting the comment from the BMA that doctors have made significant contributions to the overall performance of the NHS. A 1 per cent award is the minimum sought by the BMA and the BDA. The factors above would provide support for a reasonable increase in basic pay.

9.15 In contrast, we note the evidence we received on the financial situation in the NHS. Although we understand that financial provision has been made for a 1 per cent pay uplift, employers also have to make substantial efficiency savings. We are conscious

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[1] *Dental earnings and expenses, Scotland, 2010-11.* Health and Social Care Information Centre, 26 October 2012. Available from: http://www.ic.nhs.uk/catalogue/PUB07908

[2] Our terms of reference can be found at the beginning of this report.

that in oral evidence the Department of Health encouraged us towards making a recommendation for no uplift, and that zero is what NHS Employers and the Foundation Trust Network would prefer. Though there is a continuing lack of vacancy data for England, we are assured that the recruitment and retention situation for our remit groups in general remains healthy; indeed, staff numbers have continued to rise, despite budgetary constraints. We are also mindful of the expectations raised by the announcement in the Chancellor's *Autumn Statement* in 2011, of an average 1 per cent pay uplift for public sector workers following the pay freeze. These factors provide support for either no increase or a modest increase in pay. However, we believe that a zero uplift, in the light of these expectations, could be demotivating.

9.16 Weighing all these factors, our judgement is that there should be an increase of 1 per cent in basic pay for our remit groups.

9.17 We have considered the possibility of giving employers freedom on how to spend the 1 per cent allocated in the tariff and other budgets. While this would allow money to be directed to where local employers considered it was needed most, we think that it could be perceived to be unfair as some of our remit groups could potentially do better than others. In addition, it might also be seen that we were abdicating our responsibility to recommend on an uplift. We discussed this option with the parties during oral evidence but did not get clear support or sufficiently developed thinking from the parties who sought an across-the-board uplift.

9.18 We have also given consideration to recommending a non-consolidated uplift, which would mean that costs would only apply for the current financial year and would not attract employers' pension contributions. However, none of the parties have asked for this and we received no evidence to suggest it would be appropriate.

9.19 The Chief Secretary to the Treasury suggested that we might want to consider the level of progression pay and the potential for payments to be more generous for certain groups of staff. We have considered this carefully. With regard to progression pay, we are not persuaded by the argument that many in the workforce will receive increments, as we know that there are many who will not. Furthermore, increments are contractual. We do need to know the cost of pay progression so that we can engage in the issue of its affordability, but the Health Departments were unable to provide data on the cost of increments for doctors and dentists. We have considered the possibility of focusing our award on those salaried doctors and dentists not in receipt of increments, but we do not think that this would be appropriate as it could distort pay scales. We have also considered whether payments should be more generous for some groups of staff. All of the parties said that they did not want a differential award. In the absence of any evidence to the contrary, we are recommending that the 1 per cent increase should apply across the board.

9.20 We have also given thought to the public sector pay policy of the Scottish Government, which placed a 1 per cent cap on the cost of the increase in basic pay for staff earning under £80,000; whilst maintaining a pay freeze (zero per cent basic award) for staff earning £80,000 and above. We are not persuaded that our evidence base would support such a recommendation in line with this policy, on either a United Kingdom basis or a Scotland only basis. We note, however, that the Scottish public sector pay policy has been drawn up to take account of the whole of its public sector, and is partly intended to favour those public sector workers who earn £21,000 or less. Our evidence base is, by definition, not concerned with such staff, as all doctors and dentists earn more than £21,000 on a full-time equivalent basis. We are also mindful that it would be difficult to apply this pay policy to independent contractor GMPs and GDPs because it is not known whether or not individual practitioners' income falls above or below the £80,000 threshold.

9.21 Having considered carefully all the evidence, we have concluded that the most appropriate uplift for 2013-14 is 1 per cent on basic pay, across the board. We consider that it is for the Scottish Government to determine how to apply our recommendations within the context of its public sector pay policy. Although the Northern Ireland Executive did not require us to make recommendations, we note that our proposed increase of 1 per cent is in line with its intended uplift.

Recommendation 1: We recommend for 2013-14 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists.

9.22 We make a separate recommendation for salaried GMPs whose pay falls within a salary range rather than an incremental pay scale.

Recommendation 2: We recommend that the minimum and maximum of the salary range for salaried general medical practitioners be increased by 1 per cent for 2013-14.

9.23 Our recommendation for independent contractor GMPs is intended to provide a net income uplift of 1 per cent after allowing for movement in their expenses. We use a formula to calculate the gross uplift and the rationale for our recommendation is given in Chapter 3.

9.24 Using 1 per cent for GMPs' income uplift along with our estimated increase for expenses, our medical formula gives an overall percentage rise of 2.29 per cent (Table 9.1).

Table 9.1: Uplift formula for general medical practitioners, 2013-14

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Net income	43.5%	1%	0.43%
Staff costs	40.6%	3.4% *Annual Survey of Hours and Earnings (general medical practice activities) 2012*	1.38%
Other costs	15.9%	3.0% *Retail Prices Index excluding mortgage interest payments 2012 Q4*	0.48%
		Total	**2.29%**

Recommendation 3: For independent contractor general medical practitioners, we recommend that the overall value of General Medical Services contract payments be increased by a factor intended to result in an increase of 1 per cent to general medical practitioners' net income after allowing for movement in their expenses. Using our formula, we recommend that an uplift of 2.29 per cent be applied to the overall value of General Medical Services contract payments for 2013-14 for general medical practitioners.

9.25 This year, we are required to make a recommendation for independent contractor GDPs only in Scotland. Our recommendation for independent contractor GDPs in Scotland is intended to provide a net income uplift of 1 per cent after allowing for movement in their expenses. We use a formula to calculate the gross uplift to be applied to the item-of-service fees and the rationale for our recommendation is given in Chapter 4.

9.26 Using 1 per cent for GDPs' income uplift along with our estimated increase for expenses, our dental formula gives an overall percentage rise of 1.49 per cent (Table 9.2).

Table 9.2: Dental formula for Scotland, 2013-14

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Net income	55.9%	1%	0.56%
Staff costs	22.8%	1.3% *Annual Survey of Hours and Earnings (dental practice activities) 2012*	0.30%
Laboratory costs	7.0%	3.0% *Retail Prices Index excluding mortgage interest payments 2012 Q4*	0.21%
Materials	7.0%	3.0% *Retail Prices Index excluding mortgage interest payments 2012 Q4*	0.21%
Other costs	7.3%	3.0% *Retail Prices Index excluding mortgage interest payments 2012 Q4*	0.22%
		Total	**1.49%**

Note: individual items do not sum to the total because of rounding.

Recommendation 4: For independent contractor general dental practitioners in Scotland, we recommend that the overall value of item-of-service fees be increased by a factor intended to result in an increase of 1 per cent to general dental practitioners' net income after allowing for movement in their expenses. For independent contractor general dental practitioners in Scotland, we recommend that an uplift of 1.49 per cent be applied to item-of-service fees in Scotland in 2013-14. This increase should be compounded with the outstanding uplifts for 2011-12 and 2012-13.

9.27 We also make the following observation on the GMP trainer's grant, which has been under review for several years. In expectation of a conclusion, we have repeatedly held off recommending anything other than an increase for the trainers' grant in line with other fees and allowances.

Observation 1: In view of the ongoing delay in reviewing the general medical practitioner trainers' grant, we believe strongly that the general medical practitioner trainers' grant should be uplifted by the same amount as basic pay, which for 2013-14 would represent an increase of 1 per cent.

The cost of our recommendations

9.28 We estimate that the cost of our recommendations will be approximately £180 million per annum on pay bill. Appendix C (the green pages) sets out the detailed pay scales arising from our recommendations.

9.29 There is a full summary of our conclusions and recommendations at the beginning of this report.

APPENDIX A – REMIT LETTERS FROM THE PARTIES

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

POC1_711130

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Ron Amy OBE
Chair, Review Body on Doctors' and Dentists' Remuneration
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WC1B 4AD

– 3 JUL 2012

Dear Ron,

REVIEW BODY ON DOCTORS' & DENTISTS' REMUNERATION (DDRB)

The Chancellor of the Exchequer, George Osborne, wrote to you on 7 December, setting out the general context for the 2013-14 pay round, and indicated that I would write to you subsequently in line with normal process.

As the Chancellor indicated, the Government continues to be grateful for the expert and independent work that DDRB undertakes, a view that is shared by both employers and staff side representatives.

As always, while DDRB's remit covers the whole of the United Kingdom, it is for each of the UK administrations to make its own decisions on its approach to this year's pay review round and to communicate this to you.

We continue to keep in close touch with our counterparts in the other countries and my officials will do all they can to support you in handling any consequences that may arise as a result of different approaches taken by each country.

For England, we will send you as much information as possible by the end of October, in time for your planned first DDRB meeting in November, and my officials will work with your secretariat to finalise the details.

On the question of independent primary care contractors (General Medical Practitioners and General Dental Practitioners) in England, the

Government has decided that there is no need for the Review Body to make recommendations on uplift for 2013/14. The Government has already decided that public sector pay increases will be capped at an average 1% increase for 2013-14 – and the DDRB's formulae for these two groups provide a well-established basis for calculating the gross uplift needed to deliver a 1% increase in net income after allowing for expenses.

There are other issues that the Government will need to resolve for GPs and dentists, namely the quality and efficiency gains that should be expected and any decisions about apportionment of uplift, but these are matters for the contract discussions with the BMA General Practitioners Committee and BDA General Dental Practice Committee.

Following discussion with the GPC and GDPC, therefore, the Government will make final decisions on the overall gross uplifts to apply to contract prices in England. This mirrors the approach taken in the last two years, when pay was frozen but decisions were needed in relation to expenses uplift.

We will naturally provide evidence as usual, for information, on the position on earnings and expenses and recruitment and retention for GPs and dentists.

I am copying this letter to Danny Alexander (Chief Secretary at the Treasury), Nicola Sturgeon (Scottish Government), Lesley Griffiths (Welsh Assembly), Edwin Poots (NI Assembly), Dr Laurence Buckman (Chair of BMA General Practitioners Committee) and John Milne (Chair of BDA General Dental Practitioners Committee).

Yours ever,

ANDREW LANSLEY CBE

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

Ron Amy OBE, Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
6th Floor
Victoria House
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16 July 2012

Dear Ron,

PUBLIC SECTOR PAY 2013-14

The Government greatly values the contribution of the Doctors' and Dentists' Review Body in delivering robust, evidence-based pay outcomes for public sector workers.

2. At the 2011 Autumn Statement, the Government announced that public sector pay awards will average 1% for the two years following the pay freeze. The Government has also asked certain Review Bodies to consider how to make public sector pay more responsive to local labour markets in their remit groups- who will be reporting from July 2012. I am now writing to set out how the Government proposes that the Doctors' and Dentists' Review Body approach the 2013-14 round.

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

- Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market

position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.

- Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services.

3. The Government recognises the Review Bodies role in providing independent advice on pay uplifts. In 2013-14, the Government will limit uplifts to an average of 1% in each workforce. The Review Body should therefore focus on considering how the 1% will be divided within their remit group. When considering their recommendations, Review Bodies may additionally want to consider the level of progression pay provided to the workforce and the potential for payments to be more generous for certain groups of staff.

4. The 1% average uplift should be applied to the basic salary based on the normal interpretation of basic salary in each workforce. This definition does not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

5. I would like to express my gratitude to the Doctors' and Dentists' Review Body once again and look forward to continued dialogue with you in the future.

Best wishes

DANNY ALEXANDER

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/LG/2227/12

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

8 August 2012

Dear Ron,

Review Body on Doctors' and Dentists' Remuneration (DDRB): 2013/14 remuneration of General Medical Practitioners and General Dental Practitioners in Wales

The Welsh Government values greatly the independent and expert advice provided by the DDRB. However, given the current financial and economic conditions together with the UK Government's already stated intention for public sector pay increases to be capped at an average of 1% for 2013/14, the Welsh Government has decided there is no requirement to ask the DDRB to make recommendations on pay or expenses uplifts for independent contractors and salaried General Medical Practitioners and General Dental Practitioners in Wales .

I am copying this letter to Danny Alexander (Chief Secretary at the Treasury), Nicola Sturgeon (Scottish Government), Edwin Poots (NI Assembly), Dr Laurence Buckman, Chair (Chair of BMA General Practitioners Committee), John Milne (Chair BDA General Dental Practitioners Committee) and Cheryl Gillan MP, Secretary of State for Wales.

Regards

Lesley Griffiths

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

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Chair of Council

Our Ref: MPfn

30 August 2012

Dear Ron

GMPs and the review body on doctors and dentists' remuneration (DDRB)

You have received a letter from the Secretary of State in England dated July 2012 stating that the government has decided that for independent primary care contractors "there is no need for the Review Body to make recommendations on uplift for 2013/14".

Whilst acknowledging the Treasury's cap on average public sector pay increases, we do not believe that this should be allowed to constrain the DDRB's important and historic role of acting as an independent arbitrator between NHS doctors and the government. The government has tried to restrict the remit of the DDRB on numerous occasions over recent years, particularly in relation to general practitioners.

In 2006, the Department of Health asserted that the DDRB no longer had a role in making recommendations for independent contractor GMPs. The DDRB's 2007 report concluded that, "as long as independent contractor GMPs remain one of our remit groups, each side is entitled to expect that we will revert to making recommendations once the parties are no longer unanimous in asking us not to do so". (paragraph 3.28)

The review body's role remains vitally important for GMPs. Rising practice expenses since the introduction of the new contract have not been matched by increases in gross income resulting in significant net reductions in the take home pay of independent contractors. We do not accept that the Department of Health can unilaterally change the remit of the DDRB. Furthermore, we believe there is a need this year to revisit the expenses formula used for GP contractors to ensure that it is fit for purpose.

We intend therefore to submit full evidence to the DDRB on GMPs this year. We trust that you will give this evidence full consideration and make recommendations in the normal way.

Best wishes

Mark.

Dr Mark Porter
Chair of Council

Chief Executive/Secretary: Tony Bourne

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STANDING UP FOR DOCTORS

Lesley Griffiths AC / AM
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Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf /Our ref : SF/LG/227/12

Ron Amy OBE
Chair, Review Body on Doctors' and Dentists' Remuneration
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12 September 2012

Dear Ron

Review Body on Doctors' and Dentists' Remuneration (DDRB): 2013/14 remuneration of General Medical Practitioners and General Dental Practitioners in Wales

I wrote to you on 8 August asking DDRB not to make recommendations on pay or expenses uplifts for 2013/14 for independent General Medical Practitioners, salaried General Medical Practitioners and General Dental Practitioners.

I write to clarify that reference to salaried General Medical Practitioners should not have been included in this letter given the separate contractual arrangements for salaried General Medical Practitioners.

Regards

Lesley Griffiths

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

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FROM THE MINISTER FOR HEALTH,
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Edwin Poots MLA

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Our Ref: SUB/920/2012

Date: 25 September 2012

Dear Ron,

Doctors' and Dentists' Review Body 2013/14

In his letter to you of 3rd July 2012 the Rt Hon Andrew Lansley CBE, the then Secretary of State for Health outlined his position in relation to providing evidence to the DDRB for the 2013/14 pay round. He also indicated it was up to each of the UK Administrations to make their own decision on their approach to this year's pay review round and to communicate this to you.

The two-year pay freeze for public sector workers earning over £21k per annum announced by the Coalition Government in 2010 is now nearing an end having applied to staff in Health and Social Care in Northern Ireland (HSC), including doctors and dentists, in 2011/12 and 2012/13. In Northern Ireland the Executive of the NI Assembly has not agreed the funding arrangements for 2013/14 but I can confirm it will adhere to public sector pay policy as outlined by the Government.

HSC Salaried Doctors and Dentists
As health and social care staff did not enter the pay freeze until 2011/12 the one per cent increase for staff in post limit will apply in 2013/14. The Department of Finance and Personnel (DFP) in Northern Ireland has indicated its agreement to our proposals, accordingly DDRB is not required to make recommendations on pay or expenses uplifts for 2013/14.

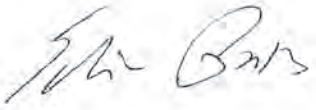
General Medical Practitioners
For General Medical Practitioners I have decided there is no need for the Review Body to make recommendations on the uplift for pay or expenses for 2013/14. This is in line with the UK Government's publicly stated intention for public sector pay increases to be capped at an average of 1% for 2013/14. I will make the final decision on the overall gross uplift to apply to General Medical Practitioners' contract prices for Northern Ireland. This will be exactly the same approach taken in the last two years when pay was frozen but decisions needed to be taken in regard to the uplift for expenses.

General Dental Practitioners
For General Dental Practitioners I have agreed to an increase of 0.5% to the expenses element only of the Statement of Dental Remuneration. This is to take account of the effect of the £250 pay uplift for those earning less than £21k per annum during the two year pay freeze as this impacted on the cost of running dental practices. The uplift applied to the majority of ancillary staff in dental surgeries including receptionists, dental nurses etc.

I noted with interest the conclusions to the DDRB review of earnings and expenses for dentists in Scotland in your Fortieth Report in 2012 and would welcome a similar assessment for Northern Ireland. I would find it helpful if DDRB would carry out such a review for proposed implementation in 2014/15 when the current restrictions on public sector pay end. My Department will provide further details in the information we submit to DDRB by the deadline date of 28th September.

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

I am copying this letter to Jeremy Hunt (Secretary of State for Health), Nicola Sturgeon (Scottish Government) and Lesley Griffiths (Welsh Assembly) and to Sammy Wilson, Minister for Finance and Personnel in the NI Assembly.



Edwin Poots MLA
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The Scottish Government

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Ron Amy OBE
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11 October 2012

Dear Ron

Andrew Lansley, the then Secretary of State for Health wrote to you in July outlining the Department of Health's position in relation to providing evidence to the Doctors' and Dentists' Review Body (DDRB) in the 2013-14 pay round. He indicated that each of the Devolved Administrations would write to you separately confirming their own approach. I am now in a position to provide you with this information for Scotland.

The Cabinet Secretary for Finance, Employment and Sustainable Growth announced the Scottish Government's public sector pay policy for 2013-14 on 20 September 2012. I would ask that the DDRB uses the key features of this policy as its remit for considering the pay and terms and conditions for doctors and dentists in Scotland.

The key features of the Scottish public sector pay policy for 2013-14 are as follows:

- a one per cent cap on the cost of the increase in basic pay for staff earning under £80,000;
- a pay freeze to apply to all staff earning over £80,000;
- a commitment to the Scottish Living Wage, currently £7.20 per hour but set to increase by April 2013;
- all staff earning less than £21,000 per annum should receive a minimum basic pay increase of £250;
- the commitment to no compulsory redundancies will apply in 2013-14.

I recognise that this remit while broadly in line with what has been announced across the rest of the UK, provides a distinctively Scottish dimension with a clear commitment to a pay policy that is fair, protects jobs and services and supports the lowest earners. By continuing the pay freeze for the highest earners and capping the level of basic pay to one percent we would wish to continue our commitment to the Scottish Living Wage and ensure that any employee earning less than £21,000 receives a basic pay increase of at least £250.

We therefore will not be seeking any pay recommendations from the DDRB for 2013-14 for medical and dental staff earning over £80,000.

On the specific question of general medical practitioners (GMPs) and general dental practitioners (GDPs), I can confirm that, as for England, there is no need for the Review Body to make recommendations on uplift for 2013-14.

I can also confirm that we hope to be able to submit our evidence to DDRB as soon as possible and by mid-October at the latest in time for the DDRB's first meeting in November. The evidence will include information on recruitment, retention and other issues which affect medical and dental staff covered by the DDRB. My officials will work with your Secretariat to finalise the details.

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

ALEX NEIL

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INVESTOR IN PEOPLE

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12 October 2012

Dear Ron,

Attached is the British Dental Association's evidence on morale, motivation, recruitment and retention to the Review Body on Doctors' and Dentists' pay for your consideration.

Following the announcements from the Secretaries of State for Health in England and Wales that they would not ask the DDRB to make recommendations on contract value uplifts we have not submitted evidence to you on earnings and expenses for consideration in these countries. No announcements have been made in Northern Ireland or Scotland, so we are submitting earnings and expenses evidence for you to consider for our colleagues in Northern Ireland, for which you kindly agreed an extension to our submission deadline.

My colleague Andrew Lamb wrote to you at the end of September to request an extension to the submission deadline for Scotland as we are unable to provide evidence on expenses for Scotland as data from the NHS Information Centre is not available until later in October. In the letter he also explained that colleagues in Scotland working with the Scottish Government to consider and respond to the gaps highlighted by the DDRB in your last report. In order to provide the most robust evidence for your consideration we would ask if it is possible for DDRB to revise timetables for submission to relate more closely with the publication of information from the NHS Information Centre. We are also going to ask the NHS IC if it is able to bring forward publication of its reports for Northern Ireland and Scotland.

Although we are not including evidence on expenses for England and Wales for your consideration as part of this submission, we would welcome the independent scrutiny and assessment of a contract value uplift based on our submission to the Department of Health in England and Welsh Assembly Government. We will send this evidence to you once we have submitted it to the Department of Health and Welsh Assembly Government, which we anticipate will be before the end of the October.

Yours sincerely

Robert Kinloch

Chair,
Review Body Evidence Committee

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From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

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Mr Ron Amy OBE
Chair, Review Body on Doctors' and Dentists' Remuneration
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23 OCT 2012

Dear Mr. Amy,

GENERAL MEDICAL SERVICES (GMS) CONTRACT 2013/14

My predecessor, Andrew Lansley, wrote to you on 3 July setting out the Government's proposals for handling uplift in the value of NHS contracts for general medical services and primary dental care services for 2013/14.

I am now writing to update you on developments in the GMS contract negotiations, to set out the proposals that the Government is now putting to the BMA General Practitioners Committee (GPC) in the light of those negotiations, and to flag up the potential need for the DDRB to make recommendations on uplift for GMS contracts in England for 2013/14.

As part of the negotiations with the GPC, NHS Employers has indicated that the Government is willing to provide for a 1.5% uplift in GP practice income in England. This would allow an average pay increase of up to 1% for GPs and practice staff, in line with wider public sector pay policy for 2013/14, and a wide margin for increases in non-staff expenses.

Given the significant efficiency savings that will continue to be expected of all other NHS healthcare providers, the Department regards it as essential, in return for this investment, to secure improvements in the GMS contract that will help support continuous improvements in quality of care and health outcomes.

Unfortunately, negotiators have not yet been able to agree changes to the contract that in the Government's view meet this objective. My Department is therefore writing today to the Chairman of the GPC to set out proposals for the changes that we would wish to make to the GMS

contract for 2013/14 in order to secure such improvements. We very much hope that the GPC and NHS Employers will continue discussions and that it will be possible to reach a negotiated settlement. If this does not prove possible, the Department intends to consult the GPC formally in November on the changes to the Statement of Financial Entitlements and any associated legislation needed to give effect to these changes.

As part of a negotiated settlement, the Department remains content to include a 1.5% uplift in GP practice income. If, however, it is not possible to reach a negotiated settlement, we would – as the GPC have proposed – invite the DDRB to make recommendations on uplift. The Government would then make final decisions in the light of the DDRB's recommendations.

I appreciate the uncertainty that this creates in terms of the expectations being placed on the Review Body. I have asked my officials to speak to your secretariat to discuss the implications that this will have for the timing of evidence and to do everything they can to support you in handling the process. We will also quickly assess any implications for decisions on uplift in relation to primary dental care contracts.

The Department's proposals to the GPC are outlined further in the attached note but the key proposals are:

- delivering equitable 'core' funding between GP practices over a seven year period starting in April 2014 to reflect proposals that the BMA and NHS Employers have developed;
- making changes to the Quality and Outcomes Framework (QOF) to incorporate all the new or replacement clinical indicators recommended by the National Institute for Health and Clinical Excellence (NICE) and raising QOF thresholds so that more patients benefit from evidence-based care that enhances quality of life and reduces mortality;
- discontinuing QOF organisational indicators, on the basis that they reflect basic standards of good organisational practice that should not need financial incentives;

- using the expenditure freed up from these organisational indicators to help pay for the new QOF indicators recommended by NICE and to introduce new enhanced services that support quality improvement and promote innovation, for instance in relation to diagnosis and care for people with dementia, care for frail or seriously ill patients, enabling patients to have on-line access to services, and helping people with long term conditions monitor their health.

I will be encouraging the BMA and NHS Employers to continue discussions with a view to reaching a negotiated settlement. In the meantime, officials will ensure that we provide the DDRB with the information and evidence that you will need in order to make recommendations on uplift, if this becomes necessary.

I am copying this letter to Danny Alexander (Chief Secretary to the Treasury), Alex Neil MSP (Scottish Government), Lesley Griffiths AM (Welsh Government), Edwin Poots MLA (NI Assembly), Dr Laurence Buckman (Chair of BMA General Practitioners Committee) and John Milne (Chair of BDA General Dental Practice Committee).

Yours sincerely,

Jeremy

JEREMY HUNT

Department of Health

GMS CONTRACT 2013/14

The Department's proposals are set out below. If a negotiated settlement cannot be reached, the Government will make final decisions in the light of the BMA's response to consultation on these proposals.

Increases in investment

The Department proposes that, if it is possible to reach a negotiated settlement, overall investment in the GMS contract should increase by 1.5%, which we consider would allow for an average pay increase of up to 1% for GPs and practice staff and increases in non-staff expenses. If a negotiated settlement cannot be reached, the Doctors and Dentists Review Body would be invited to make recommendations on uplift.

Equitable 'core' funding

The Department proposes to invite the NHS Commissioning Board to take forward proposals that the BMA and NHS Employers have developed for phasing out the Minimum Practice Income Guarantee (MPIG) and achieving equitable 'core' funding.

This would involve calculating a single weighted capitation price, based on current average expenditure on 'global sum' payments, correction factor payments (under MPIG) and basic elements of PMS funding. GMS practices would then move over a seven-year period to that common capitation price. We understand that the NHS Commissioning Board, which will take over responsibility for PMS agreements on the abolition of PCTs, would wish to follow the same approach for PMS agreements, subject to consultation with the individual contractors involved.

This would mean moving in a controlled and phased way towards equitable funding for all GP practices, based on the numbers of patients they serve with an appropriate weighting for demographic factors that affect relative patient needs and practice workload. Given the work needed to prepare for these changes, these changes would begin from April 2014 and would not affect the 2013/14 contract.

The Department intends that these changes should include appropriate adjustments to the capitation formula to ensure that sufficient weight is given to deprivation factors.

Quality and Outcomes Framework: clinical indicators

The Department proposes to implement in full the recommendations made by NICE for new clinical indicators for the QOF and for retiring or replacing some existing indicators. This will help ensure that the QOF reflects the most up-to-date evidence on those interventions that have the greatest impact on quality of care, particularly in relation to people with complex health and care problems and people with conditions that put them at greater risk of premature mortality.

The Department proposes to raise the upper thresholds for QOF indicators so as to promote improvements in the numbers of patients who benefit from the evidence-based care reflected in the QOF. At present, these upper thresholds (i.e. the % of patients with a given condition or risk factor for whom practices have to offer the relevant interventions to get maximum QOF payments) are below average achievement levels. Independent research has shown that, when the QOF was first introduced in 2004, it is likely that it reduced mortality by 11 lives per 100,000 people, but that providing the same interventions for all relevant patients could save 56 lives per 100,000 people each year. The Department proposes to raise upper thresholds over a two-year period so that they are in line with the upper quartile of current performance and maintain that link in setting future thresholds.

QOF organisational indicators and Quality and Productivity indicators

The Department proposes to:

- retain the existing Quality and Productivity indicators for a further year in 2013/14
- discontinue the organisational domain of the Quality and Outcomes Framework, on the basis that the areas for which it rewards GP practices (e.g. record-keeping, staff training) should be regarded as standard practice and should not require financial incentives

- propose to reinvest fully into the contract the money released from the organisational domain, with some used to help fund the new clinical indicators recommended by NICE and the remaining money used for enhanced services to support practices in providing better care and support to patients.

The Department would propose to design these enhanced services in ways that will:

- support general practice to make most effective and efficient use of resources to improve quality of care in certain priority areas, such as in relation to diagnosis and care for people with dementia, care for frail or seriously ill patients, enabling patients to have on-line access to services, and helping people with long term conditions monitor their health
- ensure that the arrangements also support GP practices in working collaboratively and with peer support – through their clinical commissioning group – to achieve these improvements and to help improve overall use of NHS resources
- support practices to achieve the desired improvements over a phased two-year implementation period.

Correcting QOF anomalies

The Department proposes to amend the QOF indicator wording and business rules to reflect better the annual nature of most QOF interventions, thereby preventing the unintended anomaly of some practices being rewarded for two years for interventions only carried out (or offered) in one.

The Department also proposes to correct an anomaly in relation to the Contractor Population Index that is used to adjust QOF payments to reflect comparative list size. Its proposal is that the Index should be based on the actual average practice list size at the start of the final quarter before the financial year in question. This would ensure that there is a clear, transparent relationship between QOF payments and relative list size and that year-to-year changes in the Index reflect actual changes in average list size. The face value price per point in 2013/14 would be increased by 13% in 2013/14 to recognise the price that is actually paid to the average practice.

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

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Our Ref: SUB/1069/2012

Date: 29 October 2012

Dear Ron,

GENERAL MEDICAL SERVICES (GMS) CONTRACT 2013/14

I wrote to you on 25 September setting out the Government's proposals for handling uplift in the value of NHS contracts for general medical services and primary dental care services for 2013/14.

I am now writing to update you on developments in the GMS contract negotiations, to set out the proposals that the Government is now putting to the BMA General Practitioners Committee (GPC) in the light of those negotiations, and to flag up the potential need for the DDRB to make recommendations on uplift for GMS contracts in NI for 2013/14.

As part of the negotiations with the GPC, NHS Employers has indicated that the Government is willing to provide for a 1.5% uplift in GP practice income in England. This would allow an average pay increase of up to 1% for GPs and practice staff, in line with wider public sector pay policy for 2013/14, and a wide margin for increases in non-staff expenses.

Given the significant efficiency savings that will continue to be expected of all other NHS healthcare providers, the Department regards it as essential, in return for this investment, to secure improvements in the GMS contract that will help support continuous improvements in quality of care and health outcomes.

Unfortunately, negotiators have not yet been able to agree changes to the contract that in my view meet this objective. My Department is therefore writing today to the Chairman of the GPC to set out proposals for the changes that we would wish to make to the GMS contract for 2013/14 in order to secure such improvements. I very much hope that the GPC and NHS Employers will continue discussions and that it will be possible to reach a negotiated settlement. If this does not prove possible, the Department intends to consult the GPC formally in November on the changes to the Statement of Financial Entitlements and any associated legislation needed to give effect to these changes.

As part of a negotiated settlement the Department remains content to include a 1.5% uplift in GP practice income. If, however, it is not possible to reach a negotiated settlement, we would – as the GPC have proposed – invite the DDRB to make

INVESTORS

recommendations on uplift. I would then make final decisions in the light of the DDRB's recommendations.
I appreciate the uncertainty that this creates in terms of the expectations being placed on the Review Body.
The Department's key proposals to the GPC are:

- delivering equitable 'core' funding between GP practices over a seven year period starting in April 2014 to reflect proposals that the BMA and NHS Employers have developed;
- making changes to the Quality and Outcomes Framework (QOF) to incorporate all the new or replacement clinical indicators recommended by the National Institute for Health and Clinical Excellence (NICE) and raising QOF thresholds so that more patients benefit from evidence-based care that enhances quality of life and reduces mortality;
- discontinuing QOF organisational indicators, on the basis that they reflect basic standards of good organisational practice that should not need financial incentives; and
- using the expenditure freed up from these organisational indicators to help pay for the new QOF indicators recommended by NICE and to introduce new enhanced services that support quality improvement and promote innovation, for instance in relation to diagnosis and care for people with dementia, care for frail or seriously ill patients, enabling patients to have on-line access to services, and helping people with long term conditions monitor their health.

I will be encouraging the BMA and NHS Employers to continue discussions with a view to reaching a negotiated settlement. My officials have already provided DDRB with the full level of information and evidence that you will need in order to make recommendations on uplift, if this becomes necessary.
I will write to you again in November prior to any consultation on our proposed changes confirming whether we wish DDRB to make a recommendation or not.
I am copying this letter to Jeremy Hunt MP (Secretary of State for Health) Alex Neil MSP (Scottish Government), Lesley Griffiths AM (Welsh Government) and Dr Paul Darragh (Chairman of BMA NI Council).

Edwin Poots MLA
Minister for Health, Social Services and Public Safety

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Dear Mr Amy

General Medical Services Contract 2013/14

Since the Summer NHS Employers has discussed with the General Practitioners Committee (GPC) a number of potential changes to the General Medical Services (GMS) contract for 2013/14.

Discussions have focused on improvements to patient care delivered through implementing the NICE recommendations to the Quality and Outcomes Framework (QOF) as well as reducing the variability in funding between practices.

I will not repeat the detail in this letter as I know a fuller description of the areas we have discussed with the GPC has been forwarded to you by the Department of Health.

While much of our discussion on the 2013/14 GMS contract with the GPC has been positive, it is disappointing to report that we have been unable to reach an agreement on a negotiated settlement.

You will be aware that the Department wrote to the GPC on 23rd October to set out proposals for changes that they would wish to make to the GMS contract for 2013/14.

Notwithstanding this letter, the hope remains that a negotiated settlement can be reached, and in this respect NHS Employers remains available and willing to further discuss potential changes to the GMS contract with the GPC. We will keep you updated on the progress of any such discussions.

If a negotiated settlement is not reached, we understand that it would be the Department of Health's intent to consult the GPC formally in November on the changes it wishes to make to the Statement of Financial Entitlements and any other associated legislation needed to give effect to these changes.

Yours sincerely

G Bellord

Gill Bellord
Director of Employment Relations & Reward
NHS Employers

CC Catriona Hunter
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Our Ref: MP/fn

15 November 2012

Dear Mr Amy

General Medical Services Contract 2013/14

I am writing to you to clarify a couple of points on the GMS contract negotiations for 2013/14.

The GPC spent almost five months earlier this year negotiating potential changes to the GMS contract with NHS Employers. We held seven plenary meetings over this time, including a two day meeting in October, alongside numerous meetings of our QOF subgroup which examined in detail the changes to QOF proposed by NICE. Further meetings were planned at the time the UK governments announced their intention to impose changes.[1]

We were clear from the start of negotiations that we believe GP practices have reached a point of workload saturation and are simply unable to deliver substantial further efficiencies without putting patient care at risk. Notwithstanding this, we entered negotiations in good faith and were able to accommodate many of the governments' requests. The intention of both parties was to reach the best negotiated agreement possible in early October for final approval from the wider GPC committee and health departments. Negotiations were amicable and constructive. By the time of our last negotiating meeting on 11 October 2012, GPC negotiators believed they had offered enough to accommodate the health departments' agendas including:

- the introduction of some major new clinical indicators recommended by NICE
- appropriate QOF indicator retirements and amendments
- a new risk profiling scheme to be included in QOF
- a considerable reduction in the size of the organisational domain to fund the new clinical work
- an agreement in principle to reduce variability in practice funding
- an increase of 5% across nine QOF indicator thresholds

Some NICE proposals for QOF were excluded from our joint proposals for good reason – where for example they would have been unworkable for some practices or have taken so much time that access for other patients would be compromised.

We were therefore extremely disappointed to hear that the Department of Health intended to disregard our progress and threaten to vary the contract without our agreement. The current proposals include several elements – including new enhanced services and changes to the Contractor Population Index in England and

[1] The changes proposed to the contract vary across the four nations. In Scotland, discussions between GPC and the health department are still ongoing

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STANDING UP FOR DOCTORS

Wales and the redistribution of funding between practices outside England - which were not even raised during negotiations.

Although NHS Employers have said that they hope a negotiated settlement can still be reached, it is clear to us that the threat of imposition would make it impossible for a fair and meaningful agreement to be reached in further negotiations. We have made our position clear over the past five months and see no point in discussing what appears to be a pre-determined outcome.

The health departments' contract proposals for next year have been designed to extract more work from GPs within an already constrained funding envelope. We will analyse the likely impact of these changes for practices when we have received further details from the departments and will present further evidence to you in December. At this point however, we expect the proposed changes to lead to the biggest income cut yet for GPs.

Yours sincerely,

Mark Porter
Chair, BMA Council

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19 November 2012

Dear Mr Amy

General Medical Services Contract 2013/14

The BMA has shared with NHSE the letter sent to you from Mark Porter dated 15 November 2012 (attached).

We agree that negotiations were amicable and constructive. However, in view of the nature of the discussions over the period of the negotiations, and in particular at our meeting on 11 October 2012, we are astonished that GPC negotiators could have believed that they had moved sufficiently in our negotiations at that point to have achieved a position which would prove acceptable to the four Health Departments.

Yours sincerely

G Bellord

Gill Bellord
Director of Employment Relations & Reward
NHS Employers

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

Llywodraeth Cymru
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Ein cyf/Our ref / MB/LG 5521/12

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9 January 2013

Dear Ron,

General Medical Services Contract (GMS) 2013/14

Further to my letter of 8 August setting out the Welsh Government's proposals for handling the uplift in the value of NHS contracts for general medical services and primary dental services, I wish to update you on discussions with General Practitioners Committee (GPC) Wales and the need for the DDRB to make recommendations on uplift for GMS contracts in Wales for 2013/14.

My officials wrote to GPC Wales on 24 October setting out our proposals for imposed changes to the GMS contract, should an agreement not prove possible. The proposed changes included an increased investment in general practice of 1.5%, which I consider would allow for an average pay increase of up to 1% for GPs and practice staff, in line with public sector pay policy for 2013/14 and a margin for increases in non-staff expenses.

Following GPC Wales' response on 29 October which highlighted a number of concerns relating to workload and potential loss of income, the Welsh Government has had several constructive meetings with GPC Wales to discuss the proposals in detail. On 20 December, my officials wrote to GPC Wales setting out details of the proposed changes which included:

- An increase in investment in general practice of 1.5%, however, consideration would also be given to recommendations from the Review Body on Doctors' and Dentists' Remuneration (DDRB) should their recommendations be in excess of 1.5%.
- Implementing the majority of the NICE recommendations but deferring implementation of two hypertension indicators, retaining the 2012/13 thresholds for two blood pressure indicators and ensuring GP practices will not suffer a loss of income if Health Boards are unable to provide the required programmes of care.
- Increasing QOF payment thresholds for 20 specified indicators.
- Discontinuing a number of QOF Organisational Domain indicators. These points will be used to partly fund new NICE recommendations and new QOF Quality and Productivity Indicators.

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- Discontinuing QOF Quality and Productivity indictors relating to A&E attendances, applying these points to Global Sum equivalent (weighted) and introducing new indicators aimed at patients who have a chronic condition and who are at significant risk of unscheduled hospital admission.
- No changes to QOF review dates.
- The elimination of Minimum Practice Income Guarantee (MPIG) over a 7 year period starting from 2014/15 and
- Amendments to the Contractor Population Index.

I believe these proposals are fair and reasonable and address substantially the concerns raised by GPC Wales in relation to workload and loss of income. The Welsh Government remains hopeful an agreement with GPC Wales can be reached on changes to the contract. Further discussions in relation to the elimination of MPIG are on-going and I will update you on progress in due course. However, if an agreement cannot be reached, these proposals will form the basis of our consultation.

I am copying this letter to Danny Alexander, (Chief Secretary to the Treasury), Rt Hon Jeremy Hunt MP (Secretary of State for Health), Alex Neil MSP (Scottish Government), Edwin Poots MLA (NI Assembly), Dr Laurence Buckman (Chair BMA General Practitioners Committee) , John Milne (Chair BDA General Dental Practice Committee) and Rt Hon David Jones MP (Secretary of State for Wales)

Regards

Lesley Griffiths

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

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

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Our Ref: SUB/89/2013

Date: 30 January 2013

Dear Mr Amy,

GENERAL MEDICAL SERVICES (GMS) CONTRACT 2013/14

I wrote to you on 29 October 2012 setting out my proposals for handling uplift in the value of NHS contracts for general medical services for 2013/14.
I am now writing to update you on developments in the GMS Contract negotiations and specifically to advise that it has not been possible to reach an agreeable settlement with BMA General Practitioners Committee NI (GPC NI) and to request that DDRB make a recommendation on the uplift for GMS contracts in NI for 2013/14.

My Department has written to the Chairman of the GPC NI formally consulting on the proposed changes that we would wish to make to the GMS contract for 2013/14. As part of the proposed changes my Department had included an offer of up 1.5% uplift in GP practice income. However, since it has not been possible to reach a negotiated settlement, we would, as the GPC have proposed, invite the DDRB to make recommendations on uplift. I would then make final decisions on any uplift in the light of DDRB's recommendations.
My Department's key proposals as part of the consultation with GPC are:

- delivering equitable core funding between GP practices over a seven year period starting in April 2014 to reflect proposals that the BMA and NHS Employers have developed;
- making changes to the Quality and Outcomes Framework (QOF) to incorporate the majority of the new or replacement clinical indicators recommended by the National Institute for Health and Clinical Excellence (NICE) and raising QOF thresholds for 23 indicators so that more patients benefit from care that enhances quality of life and reduces mortality;

- discontinuing the majority of the QOF organisational indicators, on the basis that they reflect basic standards of good organisational practice that should not need financial incentives; and
- using the resources freed up from these organisational indicators to help pay for the new QOF indicators recommended by NICE and any balance of funding directed towards Global Sum.

My officials have already provided DDRB with the full level of information and evidence that you will need in order to make recommendations on uplift.

I am copying this letter to Jeremy Hunt MP (Secretary of State for Health) Alex Neil MSP (Scottish Government), Lesley Griffiths AC / AM (Welsh Government) and Dr Paul Darragh (Chairman of BMA NI Council).

Edwin Poots MLA
Minister for Health, Social Services and Public Safety

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref / MB/LG 5521/12

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and Dentists' Remuneration
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7 February 2013

Dear Ron,

General Medical Services Contract (GMS) 2013/14

Further to my letter of 9 January, I wish to update you on Welsh Government discussions with General Practitioners Committee (Wales) on changes to the GP contract for 2013/14.

The Welsh Government has reached agreement with the General Practitioners Committee (GPC) Wales on changes to the GP contract for 2013/14.

The agreed changes to the contract include an increase in current levels of investment in general practice by 1.5%. This increased investment will allow for an average pay increase of up to 1% for GPs and practice staff, in line with public sector pay policy, for 2013/14 and a margin for increases in non- staff expenses. The Welsh Government has indicated to GPC Wales it will be mindful of DDRB recommendations on GP pay and expenses should DDRB recommendations be in excess of 1.5%.

Accordingly, in line with my letter of 9 January 2013 the Welsh Government will require DDRB to make recommendations on uplifts for independent contractor General Medical Practitioners in Wales for 2013/14.

I am copying this letter to Danny Alexander, (Chief Secretary to the Treasury), Rt Hon Jeremy Hunt MP (Secretary of State for Health), Alex Neil MSP (Scottish Government), Edwin Poots MLA (NI Assembly), Dr Laurence Buckman (Chair BMA General Practitioners Committee) , John Milne (Chair BDA General Dental Practice Committee) and David Jones MP (Secretary of State for Wales).

Regards

Lesley Griffiths

Lesley Griffiths AC / AM
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Minister for Health and Social Services

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APPENDIX B – CORRESPONDENCE ON THE ROLE OF THE PUBLIC SECTOR PAY REVIEW BODIES

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OFFICE OF MANPOWER ECONOMICS

Rt Hon. Danny Alexander MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
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27 September 2012

Dear Chief Secretary

THE ROLE OF THE PUBLIC SECTOR PAY REVIEW BODIES

Those of us who were able to meet you on 19 September were grateful for the opportunity of a full and frank exchange of views about a range of important issues affecting our various remit groups. We appreciated your words about the value of the work done by the PRBs, and the importance of confidence in the system.

The most important issue we raised was the impact of the Government's current approach to pay policy on the independence of the Review Body system. Since this is an issue which applies to all the Review Bodies that are now embarking on their annual pay rounds, we thought it might be helpful to record our views on this particular point more formally in this letter.

We believe that the PRBs add more value, and operate with the trust and confidence of all parties, when they produce their reports under their normal terms of reference, without the Government attempting to place specific restrictions on the scope of their recommendations. These terms of reference do of course include the need to take account of affordability, the Government's inflation target, and economic and other evidence submitted by Government. These are factors that PRBs consider carefully along with other factors such as recruitment and retention, and the state of labour markets, before making their evidence - based recommendations. We all accept that the Government has the right to reject or modify our recommendations, although

naturally we would hope that, in view of the independent, evidence - based nature of our work, this would not be a decision reached routinely or lightly.

We all understand the exceptional circumstances which led to the Government's initial decision to announce a two-year public sector pay freeze. We believe our remit groups understand this too. We also appreciate that the Government is concerned about the affordability of changes to pay beyond the pay freeze, and why it therefore believes a further period of pay restraint is necessary. We expect to receive clear evidence on this and on, inter alia, the recruitment and retention position for this and future years, and will of course consider it carefully.

The issue concerning us is not the Government's decision to have a policy on public sector pay, but that our remit has been expressed in a way which has led to our independence being increasingly questioned by our remit groups. We believe that, as a result, the trust and confidence they have in us, which is the cornerstone of our role, is at risk. This is in no-one's interest. We would therefore have much preferred that all the PRBs had been given unrestricted remits, since we believe that would have led to greater trust in the system. We urge you to consider that approach in future remits.

Yours sincerely,

Geoff Dart

P.P.	W S Cockburn CBE TD	Chair, SSRB
	Prof Alasdair Smith	Chair, AFPRB
	Ron Amy OBE	Chair, DDRB
	Dr Peter Knight CBE	Chair, PSPRB
	Jerry Cope	Chair, NHSPRB

(Agreed by the Chairs, and signed on their behalf)

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

Geoff Dart, Office of Manpower Economics Director
Prof Alasdair Smith, AFPRB Chair
Ron Amy OBE, DDRB Chair
Jerry Cope, NHSPRB Chair
Dr Peter Knight CBE, PSPRB Chair
Bill Cockburn CBE, SSRB Chair

19 October 2012

Dear Geoff

THE ROLE OF THE PUBLIC SECTOR PAY REVIEW BODIES

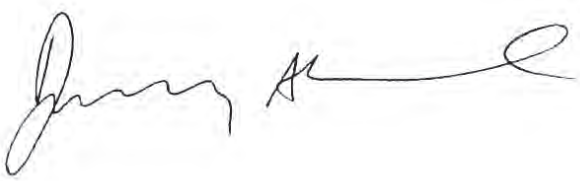
Thank you for your letter of 27 September following up our meeting of the 19 September. I would like to echo your comments on our discussion; I too appreciated the opportunity for a frank discussion. Going forward, I am confident in our ability to continue to work positively together.

2. In particular, I agree that the independence of Review Bodies is of paramount importance. It is necessary to maintain a robust, evidence-based approach to pay policy and is central to cooperative industrial relations.

3. As you have mentioned, we are in an exceptional period of economic consolidation and rebalancing. The pressures that we are currently faced with create once in a generation challenges. In making these difficult choices however, it is important that we do not lose sight of our long term objectives.

4. The chairs of pay review bodies are vital to their effective operation. I therefore valued the opportunity to hear and listen to your views on this year's

pay remit process and will take these views fully on board when considering future remits.



DANNY ALEXANDER

APPENDIX C – DETAILED RECOMMENDATIONS ON REMUNERATION

PART I: SALARY SCALES[1]

The salary scales that we recommend should apply from 1 April 2013 for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* those of equivalent full-time staff.

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

	England and Northern Ireland[2]		Scotland and Wales	
	2012 £	2013 £	2012 £	2013 £
Foundation house officer 1	22,412	22,636	22,523	22,748
	23,811	24,049	23,928	24,168
	25,209	25,461	25,334	25,587
Foundation house officer 2	27,798	28,076	27,936	28,215
	29,616	29,912	29,763	30,060
	31,434	31,748	31,589	31,905

	United Kingdom	
	2012 £	2013 £
Specialty registrar (full)	29,705	30,002
	31,523	31,838
	34,061	34,402
	35,596	35,952
	37,448	37,822
	39,300	39,693
	41,152	41,564
	43,003	43,434[3]
	44,856	45,304[3]
	46,708	47,175[3]

[1] Our recommended basic pay uplifts, to be applied from 1 April 2013, are applied to unrounded current salary scales (November 2007 is the base year date), with the final result being rounded up to the nearest unit.

[2] In England and Northern Ireland, the governments abated our 2010-11 recommendation for a 1.5 per cent uplift to 1 per cent for foundation house officers 1 and 2, house officers and senior house officers. In Scotland and Wales, the 1.5 per cent uplift was applied in full.

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

	United Kingdom	
	2012 £	2013 £
Specialty registrar (fixed term)	29,705	30,002
	31,523	31,838
	34,061	34,402
	35,596	35,952
	37,448	37,822
	39,300	39,693

	England and Northern Ireland[2]		Scotland and Wales	
	2012 £	2013 £	2012 £	2013 £
House officer	22,412	22,636	22,523	22,748
	23,811	24,049	23,928	24,168
	25,209	25,461	25,334	25,587
Senior house officer	27,798	28,076	27,936	28,215
	29,616	29,912	29,763	30,060
	31,434	31,748	31,589	31,905
	33,251	33,584	33,416	33,750
	35,069	35,420	35,243	35,595
	36,887	37,256[4]	37,070	37,440[4]
	38,705	39,092[4]	38,896	39,285[4]

	United Kingdom	
	2012 £	2013 £
Specialist registrar[5]	30,992	31,301
	32,526	32,852
	34,061	34,402
	35,596	35,952
	37,448	37,822
	39,300	39,693
	41,152	41,564
	43,003	43,434[6]
	44,856	45,304[6]
	46,708	47,175[6]

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

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

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

	England, Scotland and Northern Ireland	
	2012	**2013**
	£	**£**
Consultant (2003 contract, England, Scotland and Northern Ireland for main pay thresholds)	74,504	75,249
	76,837	77,605
	79,170	79,961
	81,502	82,318
	83,829	84,667
	89,370	90,263
	94,911	95,860
	100,446	101,451

	England and Northern Ireland[7]	
	2012	**2013**
	£	**£**
Clinical Excellence Awards[8]	2,957	2,957
	5,914	5,914
	8,871	8,871
	11,828	11,828
	14,785	14,785
	17,742	17,742
	23,656	23,656
	29,570	29,570
	35,484	35,484[9]

	Scotland[10]	
	2012	**2013**
	£	**£**
Discretionary Points[11]	3,204	3,204
	6,408	6,408
	9,612	9,612
	12,816	12,816
	16,020	16,020
	19,224	19,224
	22,428	22,428
	25,632	25,632

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

[8] Local level CEAs in England and Northern Ireland. For national CEAs, see Part II of this Appendix.

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

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

[11] From October 2003 in England, and from 2005 in Northern Ireland, local CEAs have replaced Discretionary Points. From October 2003 in Wales, Commitment Awards have replaced Discretionary Points. Discretionary Points are the current scheme in Scotland. They remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a CEA or Commitment Award.

	Wales	
	2012	**2013**
	£	**£**
Consultant (2003 contract, Wales)	72,205	72,927
	74,504	75,249
	78,350	79,134
	82,818	83,646
	87,918	88,798
	90,827	91,735
	93,742	94,679

	Wales[12]	
	2012	**2013**
	£	**£**
Commitment Awards[13]	3,204	3,204
	6,408	6,408
	9,612	9,612
	12,816	12,816
	16,020	16,020
	19,224	19,224
	22,428	22,428
	25,632	25,632

	United Kingdom	
	2012	**2013**
	£	**£**
Consultant (pre-2003 contract)[14]	61,859	62,477
	66,285	66,948
	70,712	71,419
	75,138	75,890
	80,186	80,988

[12] Commitment Awards for levels 2 – 8 are multiples of the level 1 award (x2, x3, x4, x5, x6, x7 and x8).

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

[14] Closed to new entrants.

	United Kingdom	
	2012 £	2013 £
Specialty doctor[15]	36,807	37,176
	39,955	40,354
	44,046	44,487
	46,239	46,701
	49,398	49,892
	52,546	53,071
	55,764	56,321
	58,983	59,572
	62,201	62,823
	65,419	66,074
	68,638	69,325
Associate specialist (2008)[16]	51,606	52,122
	55,754	56,312
	59,901	60,500
	65,378	66,032
	70,126	70,827
	72,095	72,816
	74,665	75,412
	77,235	78,008
	79,805	80,603
	82,375	83,199
	84,948	85,797

[15] The specialty doctor pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements. For further details see *Transitional pay and incremental arrangements* http://www.nhsemployers.org/SiteCollectionDocuments/Transitional%20pay%20increases%2018.06.09.pdf

[16] The associate specialist (2008) pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements. For further details see *Transitional pay and incremental arrangements* http://www.nhsemployers.org/SiteCollectionDocuments/Transitional%20pay%20increases%2018.06.09.pdf

	United Kingdom	
	2012	**2013**
	£	**£**
Associate specialist (pre-2008)	37,694	38,071
	41,687	42,103
	45,678	46,135
	49,670	50,167
	53,663	54,199
	57,655	58,231
	62,927	63,556
	67,496	68,171
Discretionary Points	*Notional scale*	
	69,392	70,086
	71,866	72,584
	74,339	75,083
	76,813	77,581
	79,286	80,079
	81,762	82,580
Staff grade practitioner	34,100	34,441
(1997 contract, MH03/5)	36,807	37,175
	39,514	39,909
	42,221	42,643
	44,928	45,377
	48,115	48,596
Discretionary Points	*Notional scale*	
	50,342	50,845
	53,048	53,578
	55,755	56,313
	58,462	59,047
	61,169	61,780
	63,877	64,516
Staff grade practitioner	34,100	34,441
(pre-1997 contract, MH01)	36,807	37,175
	39,514	39,909
	42,221	42,643
	44,928	45,377
	47,634	48,111
	50,342	50,845
	53,048	53,578

	United Kingdom *(Annual rates on the basis of a notional half day per week)*	
	2012 **£**	**2013** **£**
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,606	4,652
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,508	4,553
	4,769	4,816
	5,031	5,081
	5,291	5,344
	5,552	5,608
	5,813	5,871
	6,074	6,135

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

B. Community health staff

	United Kingdom	
	2012 **£**	**2013** **£**
Clinical medical officer	32,667	32,994
	34,435	34,780
	36,204	36,566
	37,972	38,352
	39,741	40,138
	41,509	41,925
	43,278	43,711
	45,048	45,498
Senior clinical medical officer	46,161	46,623
	48,971	49,461
	51,780	52,298
	54,589	55,135
	57,399	57,973
	60,208	60,810
	63,017	63,647
	65,827	66,485

C. Salaried primary dental care staff[17]

	England and Wales	
	2012 £	2013 £
Band A: Salaried dentist	37,718	38,095
	41,909	42,328
	48,195	48,677
	51,338	51,851
	54,481	55,026
	56,576	57,142
Band B: Salaried dentist	58,672	59,259[18]
	60,767	61,375
	63,910	64,550
	65,482	66,137
	67,054	67,724
	68,625	69,311
Band C: Salaried dentist[19]	70,197	70,899[20, 21]
	72,292	73,015
	74,387	75,131
	76,483	77,248
	78,578	79,364
	80,674	81,480

	Scotland and Northern Ireland	
	2012 £	2013 £
Dental Foundation Year 1	30,324	30,628
Dental Foundation Year 2	32,991	33,321

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

[18] Salary point is the entry level to Band B but is also the extended competency point at the top of Band A.

[19] Managerial dentist posts with standard service complexity are represented by the first four points in the Band C range, those with medium service complexity are represented by points two to five of the range, and those with high complexity by the highest four points of the Band C range.

[20] Salary point is the entry level to Band C but is also the extended competency point at the top of Band B.

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

	Scotland and Northern Ireland	
	2012 £	2013 £
Band 1: Community dental officer[22]	34,618	34,964
	37,418	37,792
	40,219	40,621
	43,020	43,450
	45,821	46,279
	48,621	49,107
	51,422	51,936[23]
	54,223	54,766[23]
Band 2: Senior dental officer	49,468	49,962
	53,383	53,917
	57,298	57,871
	61,214	61,826
	65,129	65,780
	65,992	66,652[23]
	66,854	67,523[23]
Band 3: Assistant clinical director	65,734	66,392
	66,752	67,419
	67,769	68,447
	68,786	69,474
	69,804	70,502[23]
	70,822	71,530[23]
Band 3: Clinical director	65,734	66,392
	66,752	67,419
	67,769	68,447
	68,786	69,474
	69,804	70,502
	70,822	71,530
	71,839	72,558
	72,874	73,602
	73,891	74,630[23]
	74,908	75,657[23]

[22] Points 2 – 8 on this scale form the Advanced Practitioner Training Grade in Scotland.

[23] Performance-based increment.

	Scotland and Northern Ireland	
	2012	**2013**
	£	**£**
Chief administrative dental officer of Western Isles,	57,732	58,309
Orkney and Shetland Health Boards	61,322	61,935
	64,912	65,561
	68,501	69,186
	72,874	73,602
	73,891	74,630[23]
	74,908	75,657[23]

Part-time dental surgeon	*Sessional fee (per hour)*	
	2012	*2013*
	£	*£*
Dental surgeon	28.40	28.68
Dental surgeon holding higher registrable qualifications	37.67	38.05
Dental surgeon employed as a consultant	46.48	46.94

[23] Performance-based increment.

PART II: FEES AND ALLOWANCES

Operative date

1. The new levels of remuneration set out below should operate from 1 April 2013. The previous levels quoted are those currently in force.

Hospital medical and dental staff

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

	2012 £	2013 £
Bronze (Level 9):	35,484	35,484
Silver (Level 10):	46,644	46,644
Gold (Level 11):	58,305	58,305
Platinum (Level 12):	75,796	75,796

3. The annual values of Distinction Awards for consultants[24] should remain at current levels.

	2012 £	2013 £
B award:	31,959	31,959
A award:	55,924	55,924
A+ award:	75,889	75,889

4. The annual values of consultant intensity payments should be unchanged:

	United Kingdom	
	2012 £	2013 £
Daytime supplement:	1,274	1,274

	England, Scotland and Northern Ireland		Wales	
	2012 £	2013 £	2012 £	2013 £
Band 1:	960	960	2,213	2,213
Band 2:	1,913	1,913	4,426	4,426
Band 3:	2,860	2,860	6,637	6,637

[24] From October 2003 in England and Wales, and from 2005 in Northern Ireland, national CEAs have replaced Distinction Awards. Distinction Awards are the current scheme in Scotland. They remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a CEA.

5. A consultant on the 2003 Terms and Conditions of Service working on an on-call rota will be paid a supplement in addition to basic salary in respect of his or her availability to work during on-call periods. This is determined by the frequency of the rota they are working and which category they come under. To determine the category, the employing organisation should establish whether typically a consultant is required to return to site to undertake interventions, in which case they should come under category A. If they can typically respond by giving telephone advice, they would come under category B.

The rates are set out in the table below.

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

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

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

7. Under the contract agreed by the parties, 1.0 represented the basic salary (shown in Part I of this Appendix) and figures above 1.0 represented the total salary to be paid, including a supplement, expressed as a multiplier of the basic salary. However, from 1 April 2010, 1.05 represented the basic salary for foundation house officer 1 trainees and 1.00 represented the basic salary for all other training grades.

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

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

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

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

* salary = F5 to F9 calculated above.

The supplements will be applied as set out below.

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

10. The fee for domiciliary consultations should be increased from £82.54 to £83.37 per visit. Additional fees should be increased *pro rata.*

11. Weekly[25] and sessional rates for locum appointments[26] in the hospital service should be increased as follows:[27]

	Per week		Per notional half day	
	2012 £	2013 £	2012 £	2013 £
Associate specialist, senior hospital medical or dental officer appointment	990.88	1,000.78	90.08	90.98
Hospital practitioner appointment			101.47	102.49
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			88.34	89.22

	Per week		Per standard hour	
	2012 £	2013 £	2012 £	2013 £
Specialty registrar (higher rate) appointment	883.20	892.32	18.40	18.59
Specialty registrar (lower rate) appointment	801.60	809.76	16.70	16.87
Specialist registrar appointment	883.20	892.32	18.40	18.59
Foundation house officer 2 appointment:				
England and Northern Ireland	681.60	688.80	14.20	14.35
Scotland and Wales	684.96	692.16	14.27	14.42
Senior house officer appointment:				
England and Northern Ireland	765.60	773.28	15.95	16.11
Scotland and Wales	769.44	777.12	16.03	16.19
Foundation house officer 1 appointment / House officer appointment:				
England and Northern Ireland	548.16	553.44	11.42	11.53
Scotland and Wales	551.04	556.32	11.48	11.59

	Per week		Per session	
	2012 £	2013 £	2012 £	2013 £
Staff grade practitioner appointment	835.70	844.10	83.57	84.41

	Per week		Per programmed activity	
	2012 £	2013 £	2012 £	2012 £
Specialty doctor appointment	844.80	853.20	84.48	85.32
Associate specialist appointment (2008)	1,148.80	1,160.30	114.88	116.03

[25] The hourly rates given for junior doctors are the basic rate (the midpoint of the current salary scale) divided by 365, multiplied by 7 and divided by 40, rounded up to the nearest penny. The weekly rates are the hourly rates multiplied by 1.2 and multiplied by 40. Hourly and weekly rates have not been adjusted for banding.

[26] For locum rates under the 2003 consultant contract, refer to Schedule 22 of the contract's Terms and Conditions of Service.

[27] Figures relate to the United Kingdom except where specified.

12. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

London weighting

13. The value of the London zone payment[28] is £2,162 for non-resident staff and £602 for resident staff.

Doctors in public health medicine

14. The supplements payable to district directors of public health (directors of public health in Scotland and Wales) and for regional directors of public health should be increased as follows:[29]

	2012			2013		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Island Health Boards: Band E (under 50,000 population)	1,816	3,601		1,835	3,638	
District director of public health (director of public health in Scotland/Wales):						
Band D (District of 50,000 – 249,999 population)	3,487	6,972	8,717	3,522	7,042	8,804
Band C (District of 250,000 – 449,999 population)	4,374	8,717	10,474	4,418	8,804	10,579
Band B (District of 450,000 and over population)	5,232	10,474	13,511	5,284	10,579	13,646
Regional director of public health: Band A	13,511	19,612		13,646	19,808	

Notes:

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

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

General medical practitioners

15. The supplement payable to general practice specialty registrars is 45 per cent[30] of basic salary.

16. The salary range for salaried GMPs employed by primary care organisations should be increased from £53,781 – £81,158, to £54,319 – £81,969.

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

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

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

General dental practitioners (Scotland and Northern Ireland)

17. The sessional fee for part-time salaried dentists working six 3-hour sessions per week or less in a health centre should be increased from £84.63 to £85.48.

Community health and community dental staff (Northern Ireland)

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

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

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

21. The allowance for dental officers acting as trainers should continue to be £1,949 per year.

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

ENGLAND[1]	2010		2011		Percentage change 2010 – 2011	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[2]						
Consultants	35,128	37,016	36,301	38,330	3.3	3.5
Associate specialists	3,222	3,634	3,170	3,571	-1.6	-1.7
Specialty doctors	4,008	4,687	4,698	5,478	17.2	16.9
Staff grades	1,173	1,362	674	808	-42.5	-40.7
Registrar group	37,055	37,672	37,641	38,380	1.6	1.9
Foundation house officers 2[3]	7,068	7,120	7,055	7,102	-0.2	-0.3
Foundation house officers 1[4]	6,179	6,212	6,185	6,225	0.1	0.2
Other doctors in training	63	139	48	124	–	–
Hospital practitioners/Clinical assistants	509	2,147	402	1,782	-21.0	-17.0
Other staff	162	374	136	313	-16.2	-16.3
Total	**94,566**	**99,877**	**96,310**	**101,681**	**1.8**	**1.8**
Hospital and Community Health Services Dental Staff[2]						
Consultants	653	736	664	758	1.6	3.0
Associate specialists	121	176	116	170	-4.2	-3.4
Specialty doctors	154	311	191	372	23.6	19.6
Staff grades	40	70	27	51	-32.1	-27.1
Registrar group	473	486	492	511	4.2	5.1
Foundation house officers 2[3]	532	547	523	542	-1.7	-0.9
Foundation house officers 1[4]	28	28	49	49	75.0	75.0
Other doctors in training	0	0	0	0	–	–
Hospital practitioners/Clinical assistants	52	317	46	276	-10.9	-12.9
Other staff	1,017	1,442	976	1,386	-4.0	-3.9
Total	**3,070**	**4,035**	**3,085**	**4,030**	**0.5**	**-0.1**

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

[2] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[3] This includes senior house officers.

[4] This includes house officers.

ENGLAND[1]	2010		2011		Percentage change 2010 – 2011	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners	**39,409**		**39,780**		**0.9**	
GMP providers	27,036		27,218		0.7	
General practice specialty registrars[5]	3,880		4,013		3.4	
GMP retainers[6]	419		365		-12.9	
Other GMPs	8,319		8,585		3.2	
General dental practitioners[7, 8, 9]	**22,799**		**22,920**		**0.5**	
General Dental Services only	17,287		17,834		3.2	
Personal Dental Services only	2,164		2,151		-0.6	
Mixed	1,997		1,826		-8.6	
Trust-led	1,351		1,109		-17.9	
Ophthalmic medical practitioners[10]	**330**		**324**		**-1.8**	
Total general practitioners	**62,538**		**63,024**		**0.8**	
Total – NHS doctors and dentists	**166,450**		**168,735**		**1.4**	

5 General practice specialty registrars were formerly known as GMP registrars.

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

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

8 Data as at 31 March of the following year.

9 Data include salaried dentists.

10 Data as at 31 December.

WALES[11]	2010		2011		Percentage change 2010 – 2011	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[12]						
Consultants	2,080	2,179	2,167	2,311	4.2	6.1
Specialty doctors	292	362	357	448	22.2	23.8
Associate specialists	40	47	13	41	-66.4	-12.8
Staff grades	364	412	352	404	-3.2	-1.9
Specialist registrars	1,794	1,832	1,855	2,030	3.4	10.8
Foundation house officers 2[13]	468	469	438	526	-6.4	12.2
Foundation house officers 1[14]	341	342	340	345	-0.3	0.9
Hospital practitioners	5	23	4	21	-16.0	-8.7
Clinical assistants	16	80	14	157	-10.9	96.3
Other staff	5	10	4	28	-8.7	180.0
Total	**5,404**	**5,756**	**5,546**	**6,311**	**2.6**	**9.6**
Hospital and Community Health Services Dental Staff[12]						
Consultants	51	57	50	57	-2.0	0.0
Specialty doctors	14	32	17	41	20.5	28.1
Associate specialists	6	7	5	7	-18.2	0.0
Staff grades	9	11	8	12	-7.1	9.1
Specialist registrars	27	28	23	25	-16.9	-10.7
Foundation house officers 2[13]	53	53	58	60	9.4	13.2
Foundation house officers 1[14]	0	0	0	0	–	–
Hospital practitioners	0	2	0	1	-33.3	-50.0
Clinical assistants	2	18	2	18	-15.4	0.0
Other staff	88	122	105	140	19.6	14.8
Total	**250**	**330**	**267**	**361**	**6.9**	**9.4**

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

[12] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[13] This includes senior house officers.

[14] This includes house officers.

WALES[11]	2010		2011		Percentage change 2010 – 2011	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General practitioners						
General medical practitioners	**2,253**		**2,271**		**0.8**	
GMP providers	1,991		2,022		1.6	
General practice specialty registrars[15]	215		202		-6.0	
GMP retainers[16]	47		47		0.0	
General dental practitioners[17, 18]	**1,349**		**1,360**		**0.8**	
General Dental Services only	967		968		0.1	
Personal Dental Services only	201		204		1.5	
Mixed	127		117		-7.9	
Ophthalmic medical practitioners[19]	**16**		**12**		**-25.0**	
Total general practitioners	**3,618**		**3,643**		**0.7**	
Total – NHS doctors and dentists	**9,704**		**10,315**		**6.3**	

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

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

[17] Data include salaried dentists.

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

[19] Data as at 31 December.

SCOTLAND[20, 21]	2010		2011		Percentage change 2010 – 2011	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[22]						
Consultants	4,303	4,599	4,374	4,669	1.7	1.5
Associate specialists	276	320	330	380	19.3	18.8
Staff grades	204	260	89	117	-56.2	-55.0
Specialty doctors	355	507	460	654	29.7	29.0
Registrar group	3,624	3,744	3,931	4,077	8.5	8.9
Foundation house officers 2[23]	819	825	738	748	-9.9	-9.3
Foundation house officers 1[24]	824	827	955	956	15.9	15.6
Hospital practitioners	22	104	20	103	-7.5	-1.0
Clinical assistants	67	267	49	198	-27.6	-25.8
Other staff	239	537	291	640	22.0	19.2
Total	**10,732**	**11,887**	**11,237**	**12,446**	**4.7**	**4.7**
Hospital and Community Health Services Dental Staff[23]						
Consultants	131	150	131	149	-0.2	-0.7
Associate specialists	14	18	17	22	16.8	22.2
Staff grades	12	16	4	7	-63.1	-56.3
Specialty doctors	18	27	26	47	47.8	74.1
Registrar group	42	48	46	50	7.5	4.2
Foundation house officers 2[24]	43	47	47	51	8.2	8.5
Foundation house officers 1[25]	1	1	1	1	0.0	0.0
Hospital practitioners	1	3	1	1	-35.8	-66.7
Clinical assistants	0	0	0	1	–	–
Other staff	446	575	451	583	1.3	1.4
Total	**708**	**871**	**724**	**892**	**2.2**	**2.4**

[20] Data as at 30 September.

[21] An employee can work in more than one board / region / specialty or grade and is presented under each group but counted once in the total.

[22] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[23] This includes senior house officers.

[24] This includes house officers.

[25] General practice specialty registrars were formerly known as GMP registrars

SCOTLAND[20, 21]	2010		2011		Percentage change 2010 – 2011	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General practitioners						
General medical practitioners	**4,917**		**4,937**		**0.4**	
GMP providers	3,779		3,754		-0.7	
General practice specialty registrars[25]	497		512		3.0	
GMP retainers[26]	159		147		-7.5	
Other GMPs	490		533		8.8	
General dental practitioners[27]	**2,940**		**3,115**		**6.0**	
General dental practitioners	2,742		2,912		6.2	
Vocational dental practitioners	185		198		7.0	
Assistant dental practitioners	62		60		-3.2	
Ophthalmic medical practitioners	**24**		**22**		**-8.3**	
Total general practitioners	**7,881**		**8,074**		**2.4**	
Total – NHS doctors and dentists	**20,639**		**21,412**		**3.7**	

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

[27] Data include salaried dentists.

NORTHERN IRELAND[28]	2010		2011		Percentage change 2010 – 2011	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical and Dental Staff[29]						
Consultants	1,317	1,397	1,371	1,453	4.1	4.0
Associate specialists	108	125	117	135	8.4	8.0
Staff grades	157	190	85	103	-46.3	-45.8
Specialty doctors	74	85	147	178	99.0	109.4
Registrar group	1,288	1,311	1,291	1,316	0.2	0.4
Foundation house officers 1 and 2[30]	520	520	532	536	2.2	3.1
Hospital practitioners	88	159	84	150	-5.1	-5.7
Other staff	79	121	82	125	2.9	3.3
Total	**3,632**	**3,908**	**3,708**	**3,996**	**2.1**	**2.3**
General practitioners						
General medical practitioners[31]		**1,160**		**1,163**		**0.3**
General dental practitioners[31, 32]		**893**		**937**		**4.9**
Ophthalmic medical practitioners[31]		**22**		**22**		**0.0**
Total general practitioners		**2,075**		**2,122**		**2.3**
Total – NHS doctors and dentists		**5,983**		**6,118**		**2.3**

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

[29] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

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

[31] Data as at 31 October.

[32] Data include salaried dentists.

APPENDIX E – THE INFORMATION/EVIDENCE

We received written information and evidence from: the Health Departments, comprising the Department of Health, the Welsh Government, the Scottish Government Health and Social Care Directorates and the Northern Ireland Executive Department of Health, Social Services and Public Safety; NHS Employers; the Foundation Trust Network; the Advisory Committee on Clinical Excellence Awards; the Scottish Advisory Committee on Distinction Awards; the British Medical Association; the British Dental Association and its Scottish Dental Practice Committee; and Healthcare Audit Consultants. The main evidence can be read in full on the parties' websites.

Evidence from the Department of Health
http://www.dh.gov.uk/health/2012/11/further-evidence-ddrb-2013/

Evidence from the Welsh Government
Contact: Kay.Hannigan@wales.gsi.gov.uk

Evidence from the Scottish Government Health and Social Care Directorates
http://www.scotland.gov.uk/Topics/Health/NHS-Workforce/Policy/Pay-Conditions/EvidenceSGtoDDRB2013-14

Information from the Northern Ireland Executive Department of Health, Social Services and Public Safety
http://www.dhsspsni.gov.uk/index/hrd/pay_and_employment-medical_terms_conditions/ddrb-pay-review-body.htm

Evidence from NHS Employers
http://www.nhsemployers.org/PayAndContracts/AnnualPayReview/Pages/201314DoctorsandDentists.aspx

Evidence from the Foundation Trust Network
http://www.foundationtrustnetwork.org/influencing-and-policy/workforce/

Evidence from the Advisory Committee on Clinical Excellence Awards
http://www.dh.gov.uk/health/2013/02/annual-evidence-ddrb/

Evidence from the Scottish Advisory Committee on Distinction Awards
http://www.shsc.scot.nhs.uk/upload/file/national_committee_services/sacda/foi/class_3/ddrb_evidence/2012/2012_sacda__ddrb_evidence_41st_report_final.pdf

Evidence from the British Medical Association
http://bma.org.uk/working-for-change/negotiating-for-the-profession/pay-negotiations

Information/evidence from the British Dental Association and its Scottish Dental Practice Committee
http://www.bda.org/dentists/policy-campaigns/research/workforce-finance/ddrb/index.aspx

Evidence from Healthcare Audit Consultants
Contact: enquiries@healthcareaudit.co.uk

APPENDIX F – PAY COMPARABILITY

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

Table F.1: Anchor points used for pay comparability

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

Source: Office of Manpower Economics.

* In 2011 this was a level 5 local Clinical Excellence Award.

Data issues

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

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

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

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

Pay comparability by anchor point

Foundation house officer 1

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

F.6 The median basic salary for foundation house officers in year 1 is well below that of the median basic salary of comparator groups. Median total earnings are broadly comparable to comparator groups, as a result of banding supplements, but the relative position has worsened since 2011.

Figure F.1: Foundation house officer, year 1 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2012

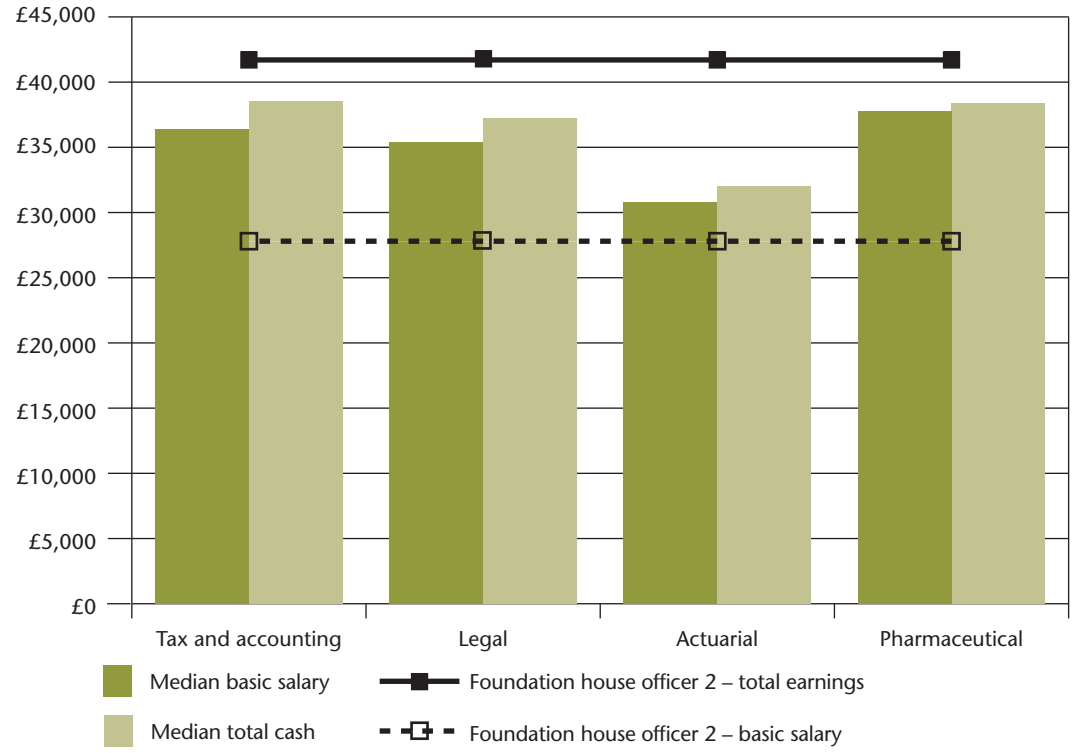
Sources: Health and Social Care Information Centre and Hay Group.

Foundation house officer 2

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

F.8 Total earnings for foundation house officers in their second year put them well ahead of their comparators: although their median basic salary is still below that of the other professions, banding supplements provide them with a median total income greater than that of their private sector comparators, but the gap has narrowed each year since 2009.

Figure F.2: Foundation house officer, year 2 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2012

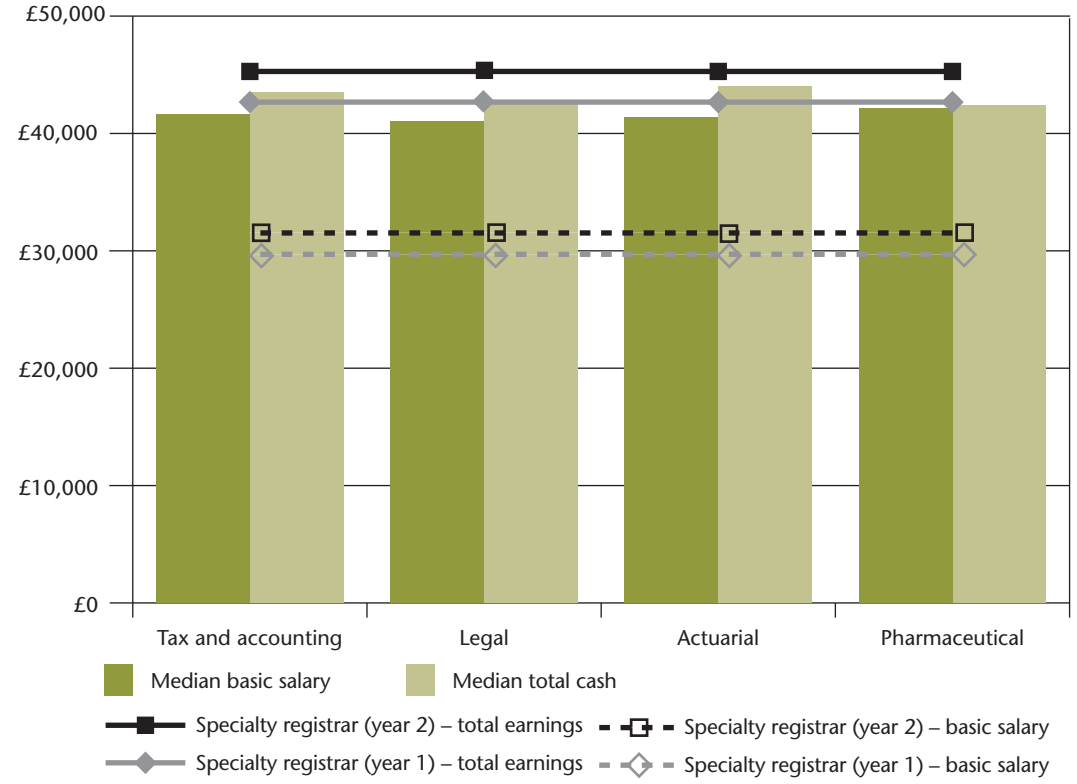


Sources: Health and Social Care Information Centre and Hay Group.

Specialty training 1 and 2

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

Figure F.3: Specialty training years 1 and 2 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2012

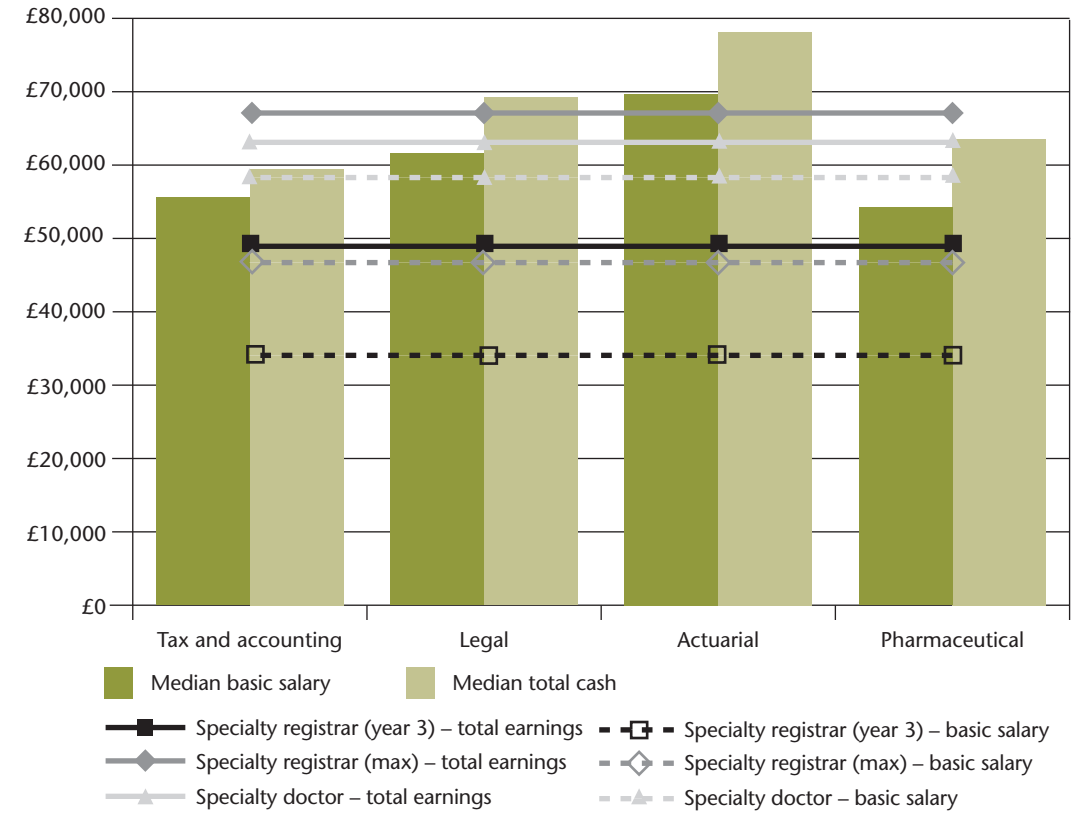


Sources: NHS Employers and Hay Group.

Specialty training 3 and onwards

F.10 Registrars in their third year of specialty training are required to complete Royal College membership exams; this year is also used as the anchor point for the new specialty doctor grade. Salaries and total earnings for comparator occupations cover a wide range.[2] Median total earnings of specialty training 3 doctors are lower than for comparators, but at the scale maximum for specialty trainees, and for specialty doctors, total earnings typically compare well with those of the private sector comparators (Figure F.4), though as for other training grades the relative position has worsened in recent years.

Figure F.4: Specialty training year 3 and onwards and specialty doctors – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2012



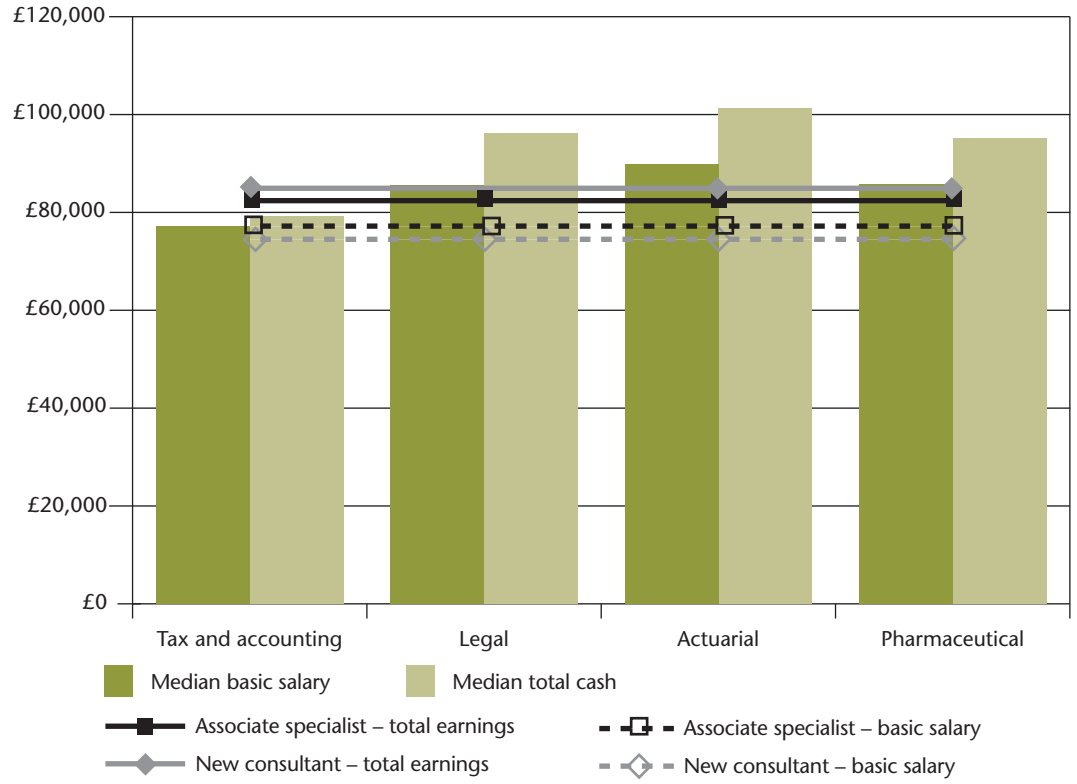
Sources: NHS Employers, Health and Social Care Information Centre and Hay Group.

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

Consultant (minimum)

F.11 Entry to the consultant grade requires a formal qualification (i.e. membership of one of the Royal Colleges). Median basic salary and total earnings for newly qualified consultants are both lower than those seen in the comparator groups. Associate specialists, who are also linked to this anchor point, also have lower median incomes than employees in the comparator groups (Figure F.5). The change in the relative position of both grades against comparators has been mixed since 2011: doctors' earnings have been flat, while they increased for actuaries and lawyers, but decreased for those in pharmaceutical, and tax and accounting.

Figure F.5: Newly qualified consultant (on the minimum of the scale), and associate specialist – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2012



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

Consultant (maximum)

F.12 There is a (generally) accepted gap between the skills and responsibilities of newly qualified consultants and their more experienced counterparts. The final anchor point identified by PA Consulting is a consultant with at least 19 years' experience (and therefore at the scale maximum), with a level five Clinical Excellence Award – worth £14,785, and considered to be the upper quartile number of Clinical Excellence Awards. An experienced consultant's basic salary is higher than those for the comparator groups with similar job weights, and total earnings are similar to those of the comparator groups (Figure F.6), though as with other grades their relative position has worsened since 2011.

Figure F.6: Experienced consultant (at the scale maximum, with level 5 Clinical Excellence Award) – basic salary and total earnings against median basic salary and median total cash for comparator professions, 2012

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

APPENDIX G – PREVIOUS REPORTS BY THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

1971	Cmnd. 4825, December 1971
1972	Cmnd. 5010, June 1972
Third Report (1973)	Cmnd. 5353, July 1973
Supplement to Third Report (1973)	Cmnd. 5377, July 1973
Second Supplement to Third Report (1973)	Cmnd. 5517, December 1973
Fourth Report (1974)	Cmnd. 5644, June 1974
Supplement to Fourth Report (1974)	Cmnd. 5489, December 1974
Fifth Report (1975)	Cmnd. 6032, April 1975
Supplement to Fifth Report (1975)	Cmnd. 6243, September 1975
Second Supplement to Fifth Report (1975)	Cmnd. 6306, January 1976
Third Supplement to Fifth Report (1975)	Cmnd. 6406, February 1976
Sixth Report (1976)	Cmnd. 6473, May 1976
Seventh Report (1977)	Cmnd. 6800, May 1977
Eighth Report (1978)	Cmnd. 7176, May 1978
Ninth Report (1979)	Cmnd. 7574, June 1979
Supplement to Ninth Report (1979)	Cmnd. 7723, October 1979
Second Supplement to Ninth Report (1979)	Cmnd. 7790, December 1979
Tenth Report (1980)	Cmnd. 7903, May 1980
Eleventh Report (1981)	Cmnd. 8239, May 1981
Twelfth Report (1982)	Cmnd. 8550, May 1982
Thirteenth Report (1983)	Cmnd. 8878, May 1983
Fourteenth Report (1984)	Cmnd. 9256, June 1984
Fifteenth Report (1985)	Cmnd. 9527, June 1985
Sixteenth Report (1986)	Cmnd. 9788, May 1986
Seventeenth Report (1987)	Cm 127, April 1987
Supplement to Seventeenth Report (1987)	Cm 309, February 1988
Eighteenth Report (1988)	Cm 358, April 1988
Nineteenth Report (1989)	Cm 580, February 1989
Twentieth Report (1990)	Cm 937, February 1990
Twenty-First Report (1991)	Cm 1412, January 1991
Supplement to Twenty-First Report (1991)	Cm 1632, September 1991
Second Supplement to Twenty-First Report (1991)	Cm 1759, December 1991
Twenty-Second Report (1992)	Cm 1813, February 1992
Twenty-Third Report (1994)	Cm 2460, February 1994
Twenty-Fourth Report (1995)	Cm 2760, February 1995
Supplement to Twenty-Fourth Report (1995)	Cm 2831, April 1995
Twenty-Fifth Report (1996)	Cm 3090, February 1996
Twenty-Sixth Report (1997)	Cm 3535, February 1997
Twenty-Seventh Report (1998)	Cm 3835, January 1998
Twenty-Eighth Report (1999)	Cm 4243, February 1999
Twenty-Ninth Report (2000)	Cm 4562, January 2000

Thirtieth Report (2001)	Cm 4998, December 2000
Supplement to Thirtieth Report (2001)	Cm 4999, February 2001
Thirty-First Report (2002)	Cm 5340, December 2001
Supplement to Thirty-First Report (2002)	Cm 5341, December 2001
Thirty-Second Report (2003)	Cm 5721, May 2003
Supplement to Thirty-Second Report (2003)	Cm 5722, June 2003
Thirty-Third Report (2004)	Cm 6127, March 2004
Thirty-Fourth Report (2005)	Cm 6463, February 2005
Thirty-Fifth Report (2006)	Cm 6733, March 2006
Thirty-Sixth Report (2007)	Cm 7025, March 2007
Thirty-Seventh Report (2008)	Cm 7327, April 2008
Thirty-Eighth Report (2009)	Cm 7579, March 2009
Thirty-Ninth Report (2010)	Cm 7837, March 2010
Fortieth Report (2012)	Cm 8301, March 2012
Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants (2011)	Cm 8518, December 2012

APPENDIX H – GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

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

COURSE OF TREATMENT – an examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment; and the provision of any planned treatment (including any treatment planned at a time other than the initial examination) to that patient.

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL MEDICAL PRACTITIONER EDUCATOR – a generic term for course organisers, general medical practitioner tutors and associate general medical practitioners; these are salaried doctors, employed by the deaneries.

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

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

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

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

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

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

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

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

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

NHS COMMITMENT – see *NHS share.*

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

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

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

PROGRAMMED ACTIVITIES – under the 2003 contract, consultants have to agree the numbers of programmed activities they will work to carry out direct clinical care; a similar arrangement exists for specialty doctors and associate specialists on the 2008 contracts. Each programmed activity is four hours, or three hours in 'premium time', which is defined as between 7 pm and

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[2] Review Body on Doctors' and Dentists' Remuneration. *Fortieth report.* Cm 8301. TSO, 2012. Chapter 2. Available from: http://www.ome.uk.com/DDRB_Reports.aspx

7 am during the week, or any time at weekends. A number of **SUPPORTING PROFESSIONAL ACTIVITIES** are also agreed within the job planning process to carry out training, continuing professional development, job planning, appraisal and research.

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

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

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

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

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

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

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

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

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

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

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

SUPPORTING PROFESSIONAL ACTIVITIES – see *programmed activities.*

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

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

APPENDIX I – ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
APMS	Alternative Providers of Medical Services
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CCG	Clinical Commissioning Group
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
EER	expenses to earnings ratio
GDP	general dental practitioner
GMC	General Medical Council
GMP	general medical practitioner
GMS	General Medical Services
GP	general practitioner
HCHS	Hospital and Community Health Services
IT	information technology
MPET	Multi Professional Education and Training
MSP	Member of the Scottish Parliament
NASDAL	National Association of Specialist Dental Accountants and Lawyers
NHS	National Health Service
PA	Programmed Activity
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
RPI	Retail Prices Index
RPIX	Retail Prices Index excluding mortgage interest payments
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	specialty doctors and associate specialists
SPA	Supporting Professional Activity
TSO	The Stationery Office
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity

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