Review Body on Doctors' and Dentists' Remuneration

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Forty-Seventh Report 2019

Chair: Professor Sir Paul Curran

CP 148

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Presented to Parliament by the Prime Minister
and the Secretary of State for Health and Social Care

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

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

Presented to the Permanent Secretary of the Department of Health,
Northern Ireland

by Command of Her Majesty

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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 and Social Care, the First Minister and the Cabinet Secretary for Health and Sport of the Scottish Parliament, the First Minister and the Minister for Health and Social Services in the Welsh Government and the First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.

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

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

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 and Social Care, the First Minister and the Cabinet Secretary for Health and Sport of the Scottish Parliament, the First Minister and the Minister for Health and Social Services of the Welsh Government, the First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive and the Prime Minister.

The members of the Review Body are:

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

The Secretariat is provided by the Office of Manpower Economics.

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

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Executive Summary

The DDRB's remit group

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

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

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

Context for our report

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

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

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

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

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

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

Our remits and our process

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

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

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

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

The case for a pay award

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

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

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

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

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

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

Pay policy, productivity and affordability

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

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

Pay uplift

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

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

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

Targeting

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

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

Targeting by grade

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

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

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

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

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

Targeting by specialty or geographically

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

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

Looking ahead

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

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

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

CHAPTER 1: INTRODUCTION

Introduction

1.1 For this pay round we received remits from all four UK countries. The remits differed slightly, reflecting the different priorities and public sector pay policies of each Government. More detail on the remits is provided later in this chapter.

Structure of the report

1.2 We have considered the remits in relation to our standing terms of reference and set out the evidence received from the parties on these matters, together with the conclusions and recommendations we reached based on this evidence.

1.3 This report is divided into eleven chapters.

1. Introduction
2. Economic outlook
3. Affordability, productivity and workforce demand
4. Pay, motivation and workforce supply
5. Doctors and dentists in training
6. Specialty doctors and associate specialists (SAS)
7. Consultants
8. General Medical Practitioners
9. Dentists
10. Pay recommendations and observations
11. Looking forward

1.4 We also include seven appendices.

A. Remit letters from the parties
B. Detailed recommendations on remuneration
C. The number of doctors and dentists in the NHS in the UK
D. Glossary of terms
E. The data historically used in our formulae-based decisions for independent contractor GMPs and GDPs
F. Abbreviations and acronyms
G. Previous DDRB recommendations and the Governments' responses

Key context for this report

1.5 Many of the background issues which had concerned us in previous reports remained unresolved. Some of them appear to be increasing in importance. The UK's future relationship with the EU, which is important to determine the nature and scope for international recruitment by the NHS, is still to be settled. The pension taxation system is having increasing financial impact on the more highly paid, and most experienced, members of our remit group, and is incentivising some of them to reduce their working hours. The challenges of meeting the work-life balance sought by some in the workforce continue to remain, and in particular the problems of managing the process of stepping out temporarily from service by doctors in training. Issues about gender pay also remain. At the same time some other issues no longer represent the same level of concern, for example, efforts being made to control agency spend on medical and dental staff appear to be having an effect.

1.6 Since January 2017 there has not been a fully functioning Northern Ireland Assembly. This has meant a lack of budgetary certainty and ministerial direction, which has had an impact on the ability of public services to plan effectively in Northern Ireland.

Workforce plans

1.7 Our work on this year's report took place against a background of several significant developments in the NHS. A draft health and care workforce strategy was published in December 2017 by Health Education England (HEE), during the course of our previous year's review, and despite being expected in the summer of 2018, a final version was not published. Since then, in January 2019, a Long Term Plan (LTP) for the NHS in England was published by NHS England. The other countries of the UK continued to pursue initiatives which had been set in train at the time of our last report.

1.8 The new plan for England was for a period of ten years, and not the subject of further consultation. However, although the plan contained little about workforce, it was subsequently clarified that this area was to be the subject of a separate and subsequent exercise, to be carried out under the chair of Baroness Harding of Winscombe. Following this commitment, the Interim NHS People Plan for England, an action plan for 2019-20, setting out a vision of how the NHS workforce will be supported to deliver the LTP, was produced by NHS Improvement shortly before this report was submitted, with a fully costed five-year People Plan expected later this year.

1.9 The other nations have also published their own workforce plans and strategies, noting the challenges of future health care provision.

The extent of the DDRB's general role in the pay determination process

1.10 There have been various exchanges of views in the wake of the previous year's round between the unions, principally the British Medical Association (BMA) and the British Dental Association (BDA), and both the Department of Health and Social Care (DHSC) and the DDRB, about the extent of the DDRB's role in relation to pay determination questions. These exchanges were prompted by the Government's decisions on the implementation of the pay award, which did not follow the DDRB's recommendations. In this section, we comment on the main issues raised.

1.11 As is usual for arrangements involving workforces in areas covered by a pay review body, there is scope for negotiations on pay between the remit group and the unions representing the workforce, outside the review body process. Where, for example, the parties have jointly reached an agreement between themselves, the review body would not normally expect to re-examine, or be asked to re-examine, the terms of any such agreement. The chief trade unions in this area, the BMA, the BDA and the Hospital Consultants and Specialists Association (HCSA), all negotiate directly with employer groups in the NHS, and there are issues that have been, and no doubt will continue to be, settled directly between the parties. The breadth and extent of such direct negotiations can be judged by the Secretary of State's letter of 18 September 2018 to the BMA's Council Chair, Dr Chaand Nagpaul, which formed Annex 3 of the DHSC evidence to the review body and which set out the areas where there was such negotiation between the parties.

The breadth of the DDRB's work and remit

1.12 The DDRB's primary focus of concern is pay. But over the course of time there have been periods when the DDRB has been asked to report on issues beyond any narrow consideration of pay uplifts (for example 7 day working). More generally, pay questions can rarely be considered in isolation from other factors which influence recruitment, retention and motivation. To understand the role of pay in addressing these questions, it is often necessary to consider this broader context. In its investigations and its reports, the DDRB tries to make a pragmatic judgement about the need to demonstrate that its central pay-focused recommendations have been informed, as necessary, by due consideration of these wider questions.

The independence of the DDRB

1.13 The question of the DDRB's independence has been raised by the unions. It is not for the DDRB to assert that it is independent: any such judgements will doubtless be made by others. However, it would observe that the way in which the England and Scotland Governments failed to implement the review body's recommendations contained in the previous year's report ought to be reasonably compelling evidence that the body remains at arm's length from government.

The case for 'catch-up' awards and retrospective awards

1.14 An issue raised by the unions generally in this round concerned the case for a 'catch-up' award, and whether the DDRB should be recommending one. This point was addressed in general terms in Paragraph 10.15 of our 2018 report, where we commented that we had not seen sufficient evidence to persuade us of the case for any settlement that would undo the effects of the period of pay restraint. At a general level, it is certainly the case that the salaries of the medical workforce have fallen in real terms, by a considerable margin in some cases. However, many others in the public and private sectors have also seen real-terms falls in salaries since the economic setbacks of 2008 and, in any case, pay relativities are not the only consideration relevant to pay recommendations, and the NHS has experienced considerable change over these years. The review body does not generally seek to undo past decision making and its focus is forward looking, rather than retrospectively tracking just inflation and earnings.

1.15 That said it is worth commenting on the consequences of an incomplete implementation of a previous year's recommendation. Decisions to stage or abate recommendations may generate motivational consequences of less immediate but longer term or cumulative impact. They may be perceived as sending signals to the workforce about the value which the employer (or in this case the Government) puts on their efforts. It is important that those charged with implementing pay determinations are conscious of this aspect of their decision making.

Pensions and pension taxation

1.16 There is no mention in the review body's terms of reference of the need to consider pensions and the pension taxation system. Nor was there anything in the review body's remit for this year to suggest that pension taxation in the medical and dental sector might be an issue requiring consideration. Yet as our enquiries in this pay round proceeded, we found ourselves constantly having our attention drawn to the subject. On the basis of the information presented, there is a serious problem for the NHS workforce.

1.17 Since they were first introduced, the annual and lifetime pension allowances have been reduced significantly. Consequently, more employees, and more relatively lower paid employees, now exceed these allowances. The value of the annual allowances has been further reduced by the introduction of a taper system. A combination of these changes mean that staff are now much more likely than they were before to find themselves having breached annual allowances, and hence to be in receipt of sometimes substantial tax charges.

1.18 We were told by employers that this was most likely to impact upon the large proportion of the remit group who had been or remained members of the now closed final salary NHS pension schemes. Members of the new scheme where pension benefits are calculated on career average rather than final salary were less likely to breach the tax thresholds.

1.19 However, it is clear that, because of the transitional arrangements, there are people who were in final salary NHS schemes for part of their career, but who would have been transferred at some point to new career average schemes. Even though they may no longer be contributors to the final salary scheme, the value of their entitlements under that scheme will probably continue to rise because the value of the accrued pension is a proportion of the final salary at actual retirement, not of the salary when they changed schemes.

1.20 These taxation impacts are likely to have three effects: they may cause staff to retire early in order to avoid building up their pension, to leave the pension scheme either temporarily or permanently, or to slow down the accrual in pension value by reducing the number of programmed activities worked.

1.21 On early retirement, we have noted that the NHS system offers the more highly paid members of the medical and dental workforce opportunities which are not generally available to others in receipt of public sector pensions, namely the ability to return after retirement ("retire and return") and to continue to work in the same area, albeit without accumulating extra pension. It is not clear to us to what extent the retirements visible in the NHS are instances of "retire and return", or are people finally and conclusively quitting the world of medical work.

1.22 A feature of the NHS system is that short of formal retirement, it gives the more highly paid members of the medical and dental workforce the opportunity to reduce their hours selectively. There are options therefore for such people to reduce the accruals in their pension, and hence any tax charges, by working fewer programmed activities.

1.23 The review body's observations on this are as follows. First, it is not clear whether the taxation impacts which have surfaced through progressive reductions in allowances and the introduction of the taper were foreseen for this workforce. This is a matter of tax policy, which is outside the remit of this review body, but the policy may have impacts on retention and motivation, and hence the consequences are of interest to the review body. It is not an issue we feel we can afford to ignore; therefore we note that the government has launched plans to consult[1] on proposals to offer a different pension option[2] to senior clinicians as part of the ongoing discussions to resolve this issue.

[1] https://www.gov.uk/government/news/top-nhs-doctors-to-be-given-more-flexible-pensions
[2] The 50:50 option would allow clinicians to halve their pension contributions in exchange for halving the rate of pension growth.

1.24 Second, it is questionable whether for doctors and dentists the problem can be dismissed as a legacy one, and to assume it will disappear shortly when most or all of them have transitioned fully to career average schemes. For the reasons discussed above it is likely that the problem of tax charges caused by spikes in the value of pensions will continue on for a considerable period in the future, as those with two pensions continue to move through their medical career. In the circumstances, the option of simply waiting for the problem to disappear is not one which commends itself to us, and we welcome the proposals of the Government to try to resolve this issue. We look forward to a speedy resolution, and we should stay alert to any implications of these discussions for pay settlements in future years.

Remits for this report

1.25 The remit letters from each of the four countries are included in full at Appendix A.

Department of Health and Social Care (England)

1.26 The Secretary of State sent his remit letter on 21 November 2018 which invited us to make recommendations in relation to the employed medical workforce, targeting funding to support productivity and recruitment and retention. We were also asked to consider how resources might be targeted through existing flexible pay premia in the contract for doctors and dentists in training.

1.27 On 4 February this year, following the receipt of written evidence from the Department of Health and Social Care in late January, we received a further letter jointly signed by the Secretary of State for Health and Social Care, the Chair of the BMA's General Practice Committee ("the BMA's GPC"), and the National Director of Strategy and Innovation, NHS England, announcing a new five-year funding agreement for general medical practitioners. As part of this agreement, both the BMA's GPC and NHS England agreed to ask the Secretary of State to not ask for our recommendations on independent contractor GMP net income, and the Secretary of State duly asked us not to provide recommendations on independent contractor pay for the duration of the five-year deal.

1.28 It was agreed under the five-year deal that practice staff, including salaried GMPs in England, would receive at least a 2 per cent pay uplift for 2019-20, although the actual effect would depend on indemnity arrangements within practices. The jointly-signed letter of 4 February announced that from April 2019 the minimum and maximum pay range for salaried GMPs would be uplifted by 2 per cent. The letter asked us not to provide recommendations in the 2019-20 round in respect of pay for salaried GMPs in England, but envisaged that the DDRB would be asked to provide recommendations for the pay of salaried GMPs within the review body's remit from the 2020-21 pay round onwards. The DDRB was also asked to continue to make recommendations on pay for GMP trainers, educators and appraisers.

Welsh Government

1.29 The Minister for Health and Social Services wrote to us on 8 March 2019, asking for recommendations that would enable him to determine a fair pay award for medical and dental staff in Wales. His letter indicated that the Welsh Government continued not to support the use of targeted pay to specific specialties within staff groups.

Scottish Government

1.30 The Cabinet Secretary for Health and Sport wrote to us on 7 February 2019 to ask us to make recommendations in this pay round for employed doctors and dentists on a pay uplift for one year only (2019-20), and to consider these recommendations in the context of the Scottish Government's longer term vision on recruitment and retention of medical and dental staff in NHS Scotland; increasing staff morale and ensuring staff felt valued as employees; ensuring all medical and dental staff received appropriate support to carry out their roles and responsibilities; and ensuring improved productivity and efficiency in the Scottish health service. The letter indicated that the Cabinet Secretary would not find it particularly helpful for DDRB to recommend different uplifts for different staff groups in Scotland *per se*, but that it would be helpful if the recommendations could set out how limited financial resources could be targeted more effectively to address the issues set out above.

1.31 The Scottish Government's evidence confirmed that the Scottish public sector pay policy 2019-20 had been agreed in Parliament on 31 January 2019, and that the main features remain unchanged including:

- A guaranteed minimum increase of 3 per cent for public sector workers who earn £36,500 or less
- A limit of up to 2 per cent for those earning above £36,500 and below £80,000
- A flat increase of £1,600 for those earning £80,000 or more
- Flexibility for employers to consider using up to 1 per cent of paybill savings.

1.32 The Cabinet Secretary's letter also asked the DDRB to describe how it had taken account of affordability and need for workforce growth and improved productivity.

1.33 The DDRB were asked to make a recommendation on the pay element only for Scottish GMPs and GDPs. This meant that the review body were not asked for recommendations on expenses for either group, and the Cabinet Secretary's letter indicated that there were separate exercises going on in conjunction with the BMA's Scottish General Practitioners Committee and the BDA Scotland.

Northern Ireland Department of Health

1.34 In the continuing absence of a fully functioning Northern Ireland Assembly the Permanent Secretary of the Department of Health wrote to the review body on 7 January 2019 and submitted evidence to assist the DDRB in the task of providing recommendations for Northern Ireland for the 2019-20 pay round. The Permanent Secretary said that recommendations would be considered in the context of the Northern Ireland public sector pay policy and continued budgetary pressures.

Our comments on the remits

1.35 We noted that the remit letters from the four UK nations set out differing views in relation to whether the DDRB should consider targeting its recommendations based on recruitment and retention or geographical or specialty shortages. The remit from the English Department of Health and Social Care asked us specifically to look at this point. The Scottish Government was not convinced it wanted recommendations on different pay uplifts for different groups other than on the basis of current salary levels, although it did not appear to rule them out entirely. The Welsh Government was against targeting in principle, and the letter from the Department of Health Northern Ireland did not address the issue. None of the other stakeholders involved in the process told us that targeting pay, either geographically or by specialty, would improve recruitment and retention on a long term basis.

1.36 In our previous report we said that we were not convinced by arguments of general principle that geographical shortages are not amenable to pay. There is an important argument that, in a situation of general workforce shortage, the use of targeted pay differentials will incentivise staff to move into prioritised shortage areas, even if this increases the less pronounced shortages in the areas they have vacated. We recognise the force of the argument that non-pay approaches ought to be tried, on the reasonable grounds that the problem with a particular specialism or location may not be resolvable by pay alone. But we had not seen at the time of our last report, and nor have we seen since, any evaluation which suggested that non-pay based approaches could provide an effective substitute for pay-based solutions. We considered then that non-pay measures had been given a more than reasonable time to address issues, and so pay solutions should be explored.

1.37 We also noted that geographic shortages risked being ignored or at best handled piecemeal, unless further work was done on this by the parties. We considered there was more scope for a regularised national targeting scheme operated by agreement: we felt that it was highly desirable that different types of targeted pay and reward incentives should be explored, including some that might be radically new. We recognised the practical difficulties: a nationwide system could be slow to develop, and there is currently no mechanism for enabling new ideas, backed by appropriate resources, to be locally stimulated and tested rapidly. We concluded in our previous report that we should not target our recommendations on the basis of recruitment and retention, as the overall pay uplift was modest and there was a risk of demotivating those whose pay was uplifted least. But we expressed our continued support for the development of a system which could, over time, help address persistent shortages in specific areas.

1.38 The concept of targeting can motivate a wide range of ways of applying pay differentials. Some pay differentials may be in the form of a compensation for an elevated cost of living in a particular area; others are more deliberately applied premia designed to change behaviour and to overcome the negative effects on recruitment or retention which are associated with specific locations or particular specialisms. For example, the differing pay rates emerging in the differing UK nations may not have been intended as targeting as such, but their practical impact may be to create the same effect. Other pay differentials may be related to different pay scales or grades.

1.39 The review body recognises the difficulties of evaluating the case for targeting. Without any empirical evidence to draw upon, it is difficult to know in advance of launch whether pay-based incentives are likely to work. For example, the DDRB has noted that the recruitment and retention premia for general practice, psychiatry and emergency medicine had been introduced without any evident formal evaluation of the likely extent of their impact, and the same was true when histopathology was added to the list. And once a scheme is in operation, evaluation is complicated by the difficulty of controlling for factors other than pay incentives. It can be argued that it would take a very long time, and some very complex analytical work, to construct a realistic value for money case for pay supplements, either existing or prospective.

1.40 Notwithstanding the above, the results concerning the use of targeting in relation to histopathology and other shortage specialties suggests that, in the absence of any other explanation, targeting may be having some effects on initial recruitment. In our view pay incentives could be useful, even if they only redistribute shortages to address the most serious cases, and the DDRB urges the parties to pursue these options further in situations where there are persistently high shortages, relative to other geographies or specialties, encouraging long-term tracking to be put in place to monitor and evaluate the outcomes.

The remit group

1.41 The remit group is essentially the same as we covered in the last report. However, as consideration of the individual remit letters will show, some categories of staff will fall outside the scope of the DDRB's work in this round, notably contractor and salaried GMPs (the latter only for this year) in England. For consistency and clarity, reference to 'the remit group' in this report will imply exclusion of those categories.

Parties giving evidence

1.42 We received written and oral evidence from the organisations listed below:

Government departments and agencies

- Department of Health and Social Care (England)
- NHS England
- NHS Improvement
- Health Education England
- Welsh Government
- Scottish Government
- Department of Health (Northern Ireland)

Employers' bodies

- NHS Employers
- NHS Providers

Bodies representing doctors and dentists

- British Dental Association (BDA)
- British Medical Association (BMA)
- Hospital Consultants and Specialists Association (HCSA)

The evidence-giving process

1.43 We asked the evidence providers to make written submissions by 7 January 2019. We were grateful to the bodies representing doctors and dentists for their helpful evidence, and for their efforts to ensure it was submitted in a timely fashion. Written evidence from DHSC was not received until 18 January 2019 and evidence from the Scottish and Welsh Governments was not received until 8 February 2019 and 8 March 2019 respectively.

1.44 The BMA indicated to us that it would be giving only very limited written evidence, largely reflecting its views on the value of engagement with the review body process. We would observe that the review body process is essentially one which operates with the willing consent of the parties involved. The BMA always has open to it the option of direct negotiation with the employers and/or government, and regularly uses it. The BMA did however engage with the oral evidence session. As always, we found it useful to have their views and insights. The oral evidence process is deliberately a private one, and the evidence given is not shared with the other parties in the same way as the written evidence, and hence cannot be open to comment and challenge in the same way. This means that what we receive solely by way of oral evidence is of potentially less value to us in our formal report. We regret that the BMA decided not to have a fuller engagement with the process on this occasion but, recognising the value and insight that they have brought in their long engagement with the DDRB, we hope that they will reconsider this point for rounds to come.

Last year's recommendations

1.45 In our 46th Report 2018, our main recommendation was for an increase in basic pay of a minimum of 2 per cent to the national salary scales for salaried doctors and dentists across the UK in 2018-19.

1.46 Our other pay recommendations for 2018-19 were:

- a minimum increase in pay, net of expenses, of 2 per cent for independent contractor GMPs and GDPs across the UK;
- an increase of 2 per cent to the maximum and minimum of the salary range for salaried GMPs;
- An increase in the GMPs trainers' grant and rate for GMP appraisers of 2 per cent;
- For SAS doctors an additional increase in pay, of 1.5 per cent, above our minimum pay recommendation;
- For independent contractor GMPs an additional increase in pay, net of expenses, of 2 per cent above minimum pay recommendation;
- An additional 2 per cent recommendation to the maximum and minimum of the salary range for salaried GMPs and to the GMP trainers' grant and the rate for GMP appraisers;
- That the flexible pay premia included in the junior doctors' contract in England increase by 2 per cent;
- That the value of Clinical Excellence Awards, Distinction Awards and Discretionary Points increase in line with recommendation for the basic consultant pay scales.

Responses to our recommendations

1.47 Following receipt of our report, the DHSC, the Welsh Government and the Scottish Government implemented the annual pay uplifts for this remit group as detailed in Table 1.1 below in 2018. It is worth noting again that at the time of submitting this report, the Department of Health (Northern Ireland) had not acted on our recommendations.

Table 1.1 Implementation of 2018 DDRB recommendations.

Group	DDRB 2018 recommendations	England	Wales	Scotland
Consultants (pay scales)	2%	1.5% from October 2018	2% from April 2018	3% (<£80,000), or £1,600 (=>£80,000) from April 2018
Consultants (Clinical Excellence, Distinction Awards)	2%	Value frozen	2% from April 2018	Value frozen
SAS doctors	3.5%	3% from October 2018	3.5% from April 2018	3% (<£80,000), or £1,600 (=>£80,000) from April 2018
Doctors and dentists in training	2%	2% from October 2018	2% from April 2018	3% from April 2018
Independent contractor GMPs	4%	2% from April 2018	4% from April 2018	3% from April 2018
Salaried GMPs range	4%	2% from October 2018	4% from April 2018	3% from April 2018
Independent contractor GDPs	2%	2% from October 2018	2% from April 2018	2% from April 2018
Salaried GDPs	2%	2% from October 2018	2% from April 2018	3% (<£80,000), or £1,600 (=>£80,000) from April 2018
GMP trainers' grant and GMP appraisers	4%	3% from October 2018	4% from April 2018	3% from April 2018

Note: At the time of submission the Department of Health (Northern Ireland) had not acted on our recommendations.

1.48 The Scottish Government said it valued the independent view which the DDRB offered on doctors' and dentists' pay, and recognised the role that the recommendations would play in determining the final pay uplifts in order to ensure that the Scottish health service staff were treated at least as fairly as those in any of the UK nations.

Our comments on responses to our recommendations

1.49 The most notable feature of the follow-up to this round was the abatement and staging of many of the recommendations for England, as detailed in Table 1.1. The DDRB has noted that the BMA, BDA and HCSA all expressed profound disappointment and anger with the outcome of the review body process, and/or the English Government's response to the recommendations. The BMA described in its written evidence the fact that the four Governments were able arbitrarily to reject the DDRB's recommendations as completely undermining the value and purpose of an independent pay review body, and said it had reinforced its members' perceptions that participation in the DDRB was futile, intensifying the calls to the BMA to withdraw from the DDRB process. The BDA described in its written evidence the award as having "baffled and angered the profession". Similar sentiments were expressed by the HCSA.

1.50 The review body itself observes that it had not anticipated that, in addition to abating the recommendations for many groups, the Government also would stage most of the (reduced) uplifts in England, so that they only appeared in pay packets halfway through the year. It appears also that this development was not anticipated by any of the non-governmental parties to the process.

1.51 The review body does not feel it ought to be necessary to stress that the pay recommendations were developed in the expectation that they would be applied for the whole of the relevant pay year. But in view of these developments it feels it should underline the point here that its recommendations are indeed made with the assumption that they are intended to apply to the full year.

The Scottish Government's approach to recommendations

1.52 The review body notes that the Scottish Government treats the recommendations of the DDRB in a slightly different way to other Governments in the UK and uses them as an input to a decision which takes into account a wider set of social policy-based considerations. These considerations produce a somewhat different set of outcomes than might be seen in the other countries, particularly the impact of applying the £80,000 ceiling on percentage recommendations.

1.53 The question of how an economically- or market-determined recommendation might interact with the operation of the social policy considerations leaves policy makers with some choices. The review body's area of operation is in the market-determined recommendations and it does not regard itself as having a remit in applying the relevant social policy factors. However, it believes that the result of a review based on market- or economically-determined factors may nonetheless be useful to policy makers in the Scottish Government, because it should help to identify more clearly the proportion of any settlement which is clearly referable to the social factors.

Future evidence

1.54 Chapter 11 sets out areas where the data available to the review body could be improved or enhanced. Many of the data requests made this year are essentially re-iterations or elaborations of requests made in earlier reports. We are concerned in particular about the continuing differences in the picture of the state of dentistry as presented by the government/employer side, and by the BDA. We would urge the parties concerned, as we did in our previous report, to get together with a view to agreeing on what data are needed in order to present an objective picture of the position in relation to dentistry.

CHAPTER 2: ECONOMIC OUTLOOK

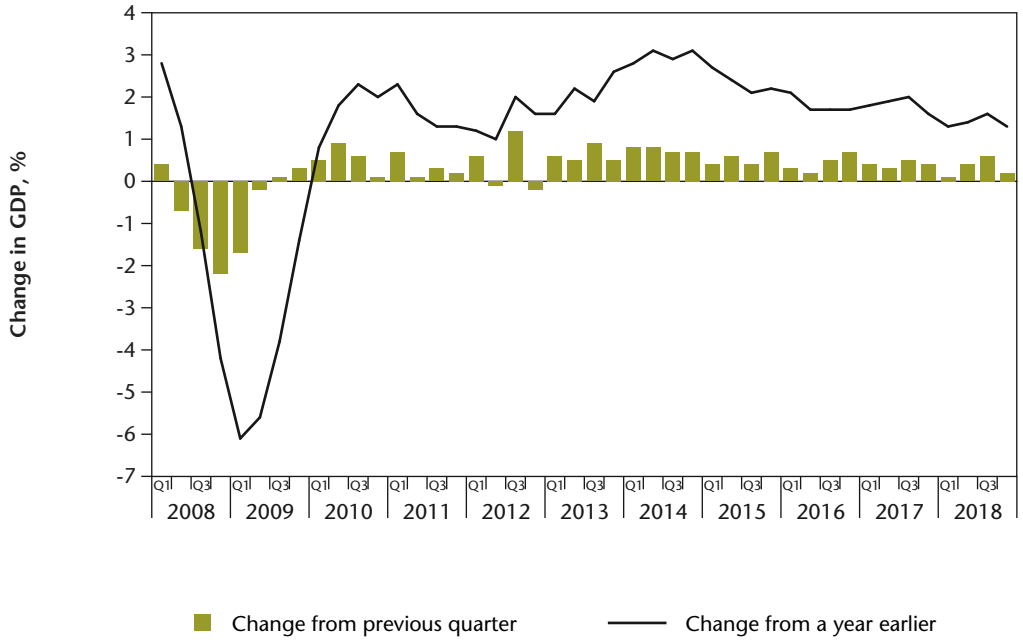
Introduction

2.1 In this chapter we look at the wider economic context, taking account of economic growth, price inflation and the state of the labour market, including average earnings growth and recent pay settlements.

Economic growth

2.2 Gross domestic product (GDP) in the UK grew by 1.4 per cent in 2018, following growth of 1.8 per cent in 2017, with slower growth of between 1.1 and 1.3 per cent forecast for 2019.

Figure 2.1: Gross domestic product (GDP) growth, United Kingdom, 2008 to 2018



Source: ONS (IHYQ, IHYR).
Note: Chained volume measure at market prices, seasonally adjusted.

2.3 In March 2019, the Office for Budget Responsibility (OBR) revised down its GDP forecast for 2019 due to slower growth, both in the UK and globally, since the budget in October 2018. It said that net trade and private investment were markedly weaker than expected, and business investment had fallen for four consecutive quarters – for the first time since the economic downturn of 2008 to 2009. The OBR also said that survey indicators of current activity had weakened materially, in part reflecting heightened uncertainty related to exiting the European Union, so it revised down the forecast for GDP growth for 2019 from 1.6 to 1.2 per cent. It did not alter its assessment of the outlook for potential output, so the medium-term forecast was little changed, with GDP growth forecast at around 1½ per cent a year between 2020 to 2023. These forecasts assumed that the UK made an orderly departure from the EU on 29 March, into a transition period to the end of 2020.

2.4 In its February 2019 Inflation Report, the Bank of England said that UK economic growth slowed in late 2018 and appeared to have weakened further in early 2019. This slowdown mainly reflected softer activity abroad and the greater effects from Brexit uncertainties at home. It expected quarterly GDP growth to recover later in 2019, with four-quarter growth rising to 2 per cent in 2021. These projections are conditioned on a smooth adjustment to the average of a range of possible outcomes for the UK's eventual trading relationship with the EU.

Table 2.1: GDP forecasts, year on year growth, United Kingdom

	Office for Budget Responsibility %	Bank of England central projection %	Treasury independent median* %
2019	1.2	1.1	1.3
2020	1.4	1.7	1.5
2021	1.6	2.0	1.7
2022	1.6	–	1.7
2023	1.6	–	1.7

* 2019 and 2020 are medians of forecasts made in the three months to April 2019. Forecasts for 2021 to 2023 are medians of forecasts made in the three months to February 2019.

2.5 The Scottish Government said that independent forecasters expected growth of between 1.0 per cent and 1.5 per cent in 2019. This compared with growth of 1.4 per cent in 2017 and 1.3 per cent in 2018. The Welsh Government said that it did not publish future growth forecasts for the Welsh economy, but that in the short to medium term its performance would be driven largely by the performance of the wider UK economy.

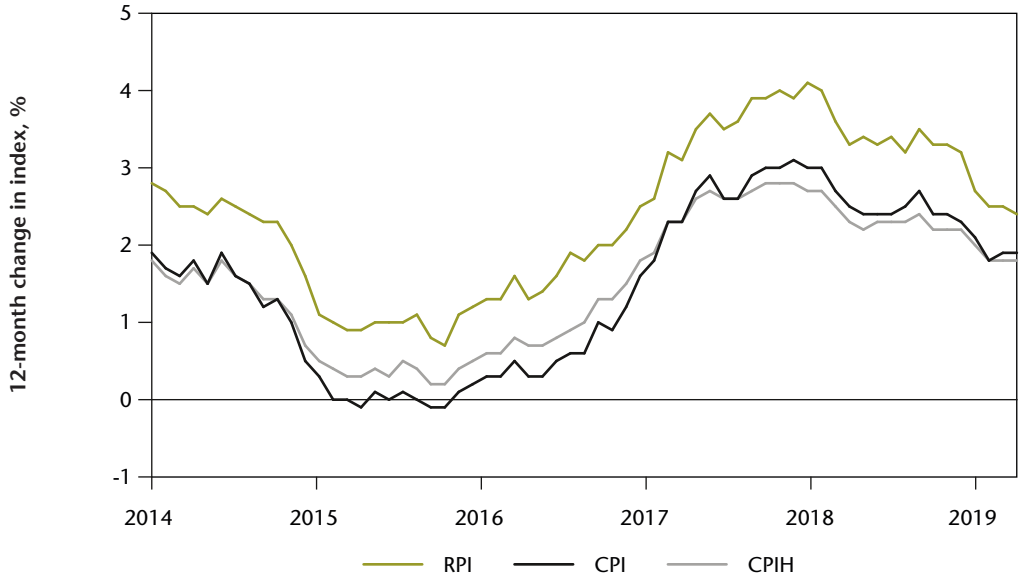
Inflation

2.6 Three measures of inflation are potentially relevant to our work. We note that the Retail Prices Index (RPI) has lost its designation as a national statistic. The Consumer Prices Index (CPI) remains the Government's target measure of inflation and CPIH[1] has been adopted by the ONS as its headline measure of inflation, although CPIH receives relatively little coverage. We refer to each of these measures at different points in this report.

2.7 The latest inflation figures, for March 2019, as measured by CPI, show inflation at 1.9 per cent. CPI has been relatively stable at just under 2 per cent throughout the first quarter of 2019, having fallen through 2018 from a previous peak of just over 3 per cent. The RPI rate of inflation was at 2.4 per cent in March 2019, down from a peak of 4.1 per cent in December 2017. CPIH inflation was at 1.8 per cent in March 2019.

[1] CPIH – The Consumer Prices Index including owner occupiers' housing costs https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpricesindexincludingowneroccupiershousingcostscpihhistoricalseries

Figure 2.2: Price inflation, United Kingdom, 2014 to 2019



Source: ONS, CPI (D7G7), CPIH (L55O), RPI (CZBH), monthly, not seasonally adjusted, UK, January 2014-March 2019.

2.8 The Bank of England said in its February 2019 Inflation Report that CPI inflation was expected to fall to slightly below the 2 per cent target for the first three quarters of 2019, largely reflecting the sharp fall in oil prices since November 2018. As that effect unwinds, the Bank expected CPI inflation to rise above 2 per cent and remain a little above the target for the rest of the forecast period.

2.9 The OBR expected CPI inflation to dip from 2.1 per cent in 2019 to 1.9 per cent in 2020, returning to the 2 per cent target thereafter. The OBR expected the recent fall in oil prices to reduce CPI inflation in the first quarter of 2019, but the announced increase in the Ofgem energy price cap in April 2019 to increase it in the second quarter of the year.

Table 2.2: Inflation forecasts, United Kingdom

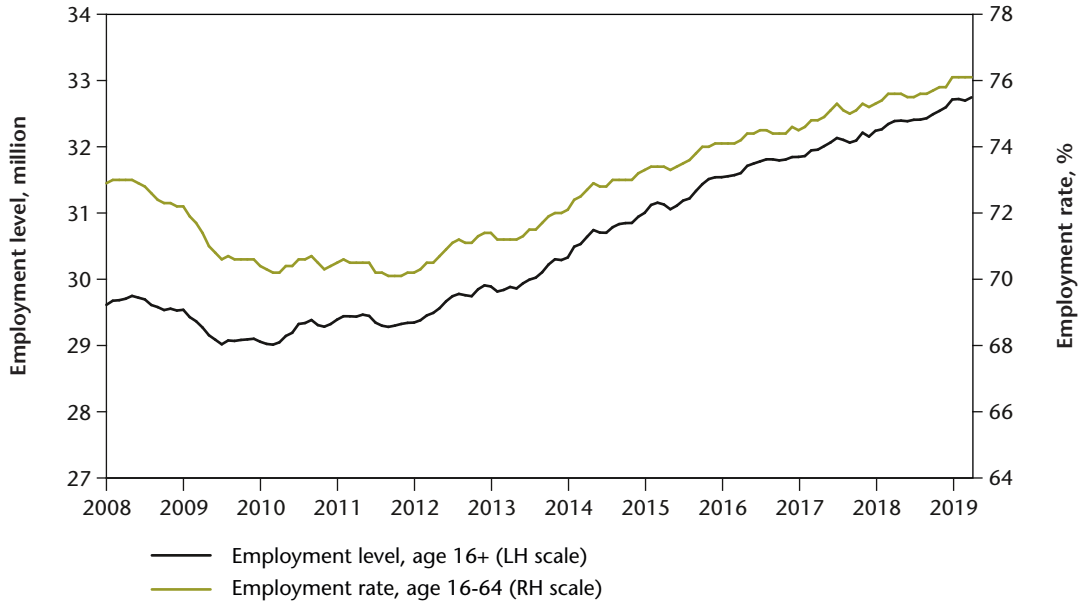
	Office for Budget Responsibility (OBR) %		Bank of England central projection %	Treasury independent median %	
	March 2019		February 2019	February/April 2019*	
Q4	CPI	RPI	CPI	CPI	RPI
2019	2.0	2.9	2.0	1.9	2.6
2020	1.9	2.9	2.1	2.0	2.9
2021	2.0	3.1	2.1	2.0	3.0
2022	2.0	3.1	–	2.0	3.1
2023	2.0	3.1	–	2.0	3.2

*2019 and 2020 are medians of forecasts made in the three months to April 2019. 2021 to 2023 are annual averages (rather than Q4) of forecasts made in the three months to February 2019.

Employment and the labour market

2.10 The employment level continues to show strong growth, with the number of people in employment increasing by 354,000 (1.1 per cent) over the year to March 2019. The employment rate was 76.1 per cent, the highest since comparable records began in 1971.

Figure 2.3: Total employment, level and rate, United Kingdom, 2008 to 2019

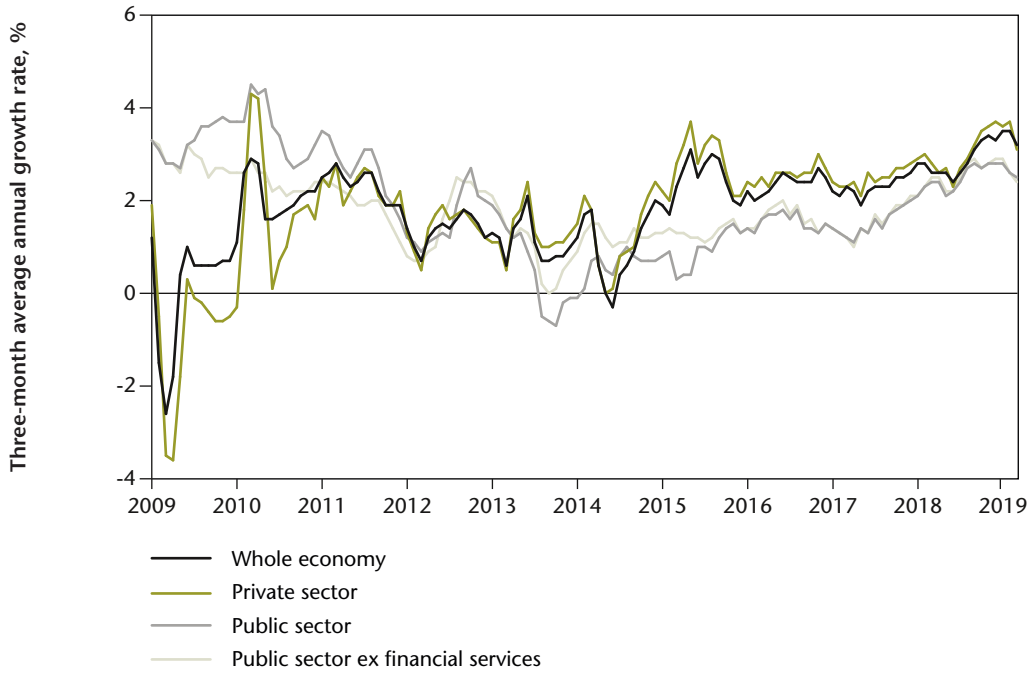


Source: ONS (MGRZ and LF24).

Earnings growth

2.11 The latest data show whole economy average weekly earnings growth was 3.2 per cent in the three months to March 2019. Growth has been above 3 per cent since September 2018. Regular pay growth, pay excluding bonuses, was 3.3 per cent in the three months to March 2019. Public sector average earnings growth (excluding financial services) was at 2.4 per cent in the three months to March 2019. The Bank of England has calculated that much of the 2018 uplift in average earnings growth can be accounted for by changes in the composition of the workforce – i.e., a shift towards higher paying industries and occupations.

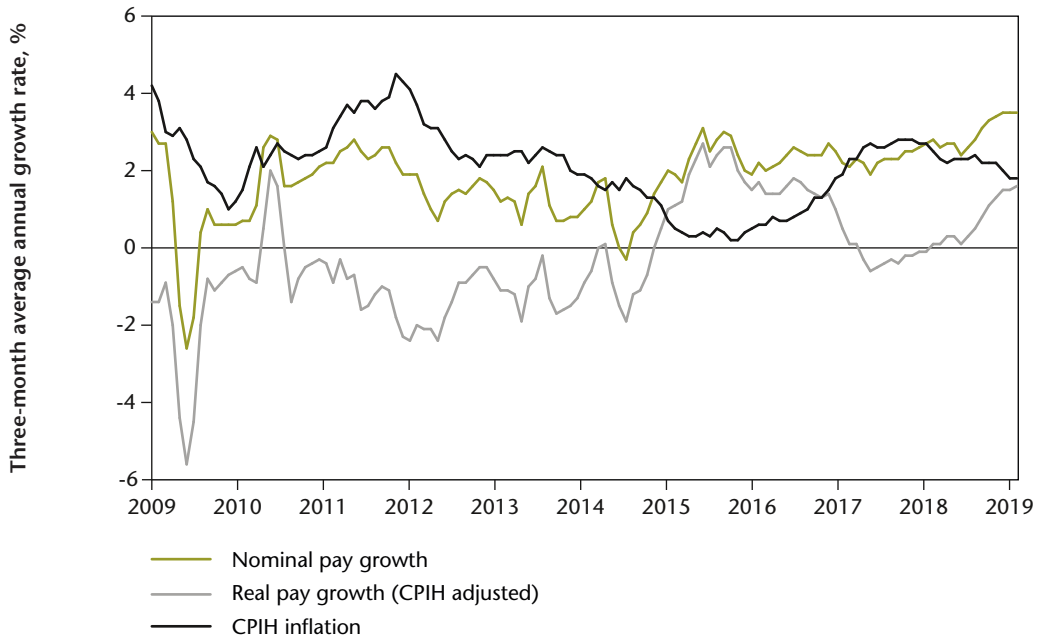
Figure 2.4: Average weekly earnings growth (total pay), three-month average, Great Britain, 2009 to 2019



Source: ONS, average weekly earnings annual three-month average change in total pay for: the whole economy (KAC3); private sector (KAC6); public sector (KAC9); public sector excluding financial services (KAE2); monthly, seasonally adjusted, GB, 2009-2019.

2.12 In the calendar year of 2018, average earnings growth across the economy as a whole was 3.0 per cent, the highest calendar year rate of growth since 2008. Real earnings growth (adjusted for CPIH inflation) averaged only 0.6 per cent across the whole year, but picked up to 1.3 per cent in the three months to March 2019. The level of average regular earnings (i.e. excluding bonus payments) remains 1.7 per cent below its spring 2008 peak in real terms, while real average total earnings (i.e., including bonus pay) are 6.1 per cent below the peak seen in the three months to February 2008.

Figure 2.5: Nominal and real average weekly earnings growth (total pay), three-month average, Great Britain, 2009 to 2019



Source: ONS, CPI 12-month rate, (D7G7), monthly, not seasonally adjusted, AWE whole economy total pay growth (KAC3), real earnings growth (A3WW), annual three-month average change, monthly, seasonally adjusted, GB, 2009-2019.

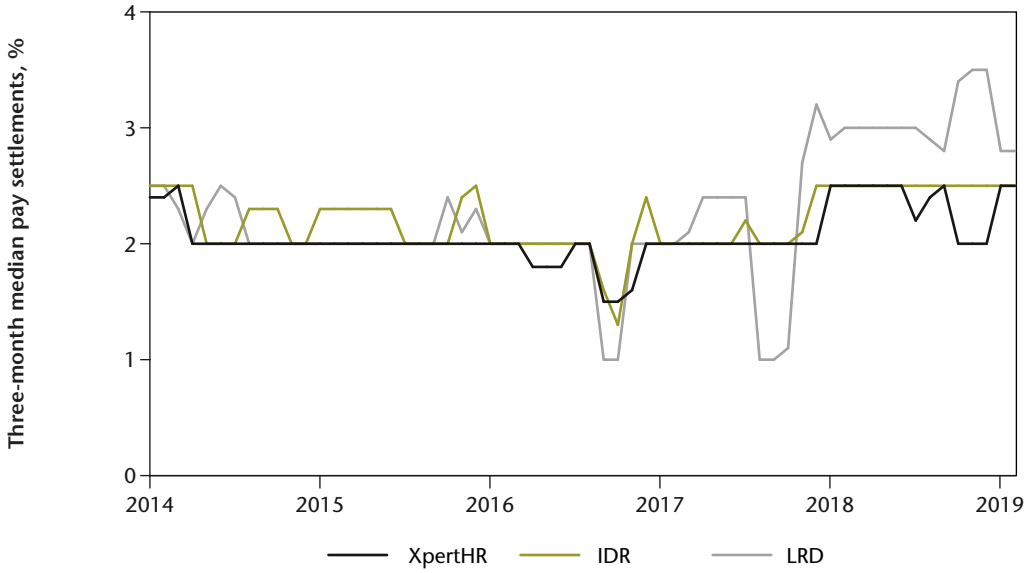
2.13 The DDRB pays particular attention to the movements of earnings at the upper end of the wage distribution, which includes the more highly paid members of our remit group. According to the Annual Survey of Hours and Earnings (ASHE), earnings growth at the top end of the distribution was stronger than at the middle in 2018. Earnings growth for full-time employees across the economy as a whole was 2.8 per cent at the median, 3.2 per cent at the 90th percentile, 4.1 per cent at the 95th percentile, 3.8 per cent at the 97th percentile and 3.6 per cent at the 98th percentile, in the year to April 2018.

2.14 There was a difference in growth between the private and public sector, with gross weekly earnings for full-time employees at the median increasing by 3.0 per cent in the private sector in 2018, and 2.4 per cent in the public sector.

2.15 The OBR assumed that some of the momentum in earnings growth seen in the second half of 2018 was maintained, and was forecasting growth of 3.1 per cent in 2019.

2.16 Median pay settlements in the first quarter of 2019 were at 2.5 per cent, according to XpertHR and IDR, while the LRD reported median awards at 2.75 per cent.

Figure 2.6: Pay settlements, United Kingdom, 2014 to 2019 (three-month average)



Source: XpertHR, IDR and LRD pay databank records, three-month medians, UK, 2014-2019.

Public sector pay policies and finances

England

2.17 The Department for Health and Social Care's (DHSC) evidence included the UK Government's position on public sector pay and its assessment of the economy and labour market as presented to all pay review bodies. These included the economic indicators and forecasts available at the time of submission in January 2019.

2.18 DHSC said that the UK Government's public sector pay policy remained competitive: the median full-time wage in the public sector was £31,414, compared to £28,802 in the private sector. It said that public sector workers benefitted from wider government measures to support wages and ensure that people took home more of what they earned. Following the 2008 financial crisis public sector workers were protected from the sharp drop in wages that was seen in the private sector, although wages subsequently grew at a slower pace. During Q3 2018, public and private sector wage growth was similar, and public sector remuneration, when pensions were taken into account, remained higher than in the private sector. The DHSC provided comparisons to demonstrate that, after controlling for various individual and job characteristics, on average there was a positive earnings differential in favour of the public sector when pensions were included.

2.19 The DHSC evidence referred to the reduction, confirmed in the Budget, in the discount rate for calculating employer contributions in unfunded public sector pension schemes, and said the valuations indicated that there would be additional costs to employers in providing public service pensions over the long term. Although it was a long-standing principle that the full costs of public sector pensions were recognised by employers at the point they were incurred, it said that HM Treasury was working with departments to ensure the recognition of these additional costs did not jeopardise the delivery of frontline public services or put undue pressure on public employers.

Wales

2.20 The Welsh Government said that financial circumstances continued to be very challenging in the context of a service which faced increasing demands.

Scotland

2.21 The Scottish Government said its pay policy was governed each year by the Scottish public sector pay policy (SPSPP), which, provided a guaranteed minimum percentage increase for public sector workers below certain thresholds and maximum increases for those on higher salaries. Elements of the 2019-20 SPSPP include:

- a minimum increase of 3 per cent for public sector workers who earn £36,500 or less;
- a limit of up to 2 per cent on the increase in baseline paybill for those earning above £36,500 and below £80,000 and limiting the maximum pay increase to £1,600 for those earning £80,000 or more;
- continuing the flexibility for employers to consider using up to 1 per cent of paybill savings on baseline salaries for;
  - non-consolidated payments amounting to no more than 1 per cent of salary, but only for employees already on the maximum of their pay range (who no longer benefit from progression) or on spot rates;
  - other affordable and sustainable changes to their existing pay and grading structures where there is clear evidence of equality issues.

2.22 The Scottish Government continued to recognise the role that the DDRB could play in determining the final pay uplifts in order to ensure that health service staff in Scotland were treated at least as fairly as those in any of the UK nations.

Public finances

2.23 DHSC's evidence said that since 2010 the Government had made significant progress in restoring public finances to health – the Government budget deficit had been reduced from a post-war peak of 9.9 per cent of GDP in 2009-10 to 1.9 per cent in 2017-18. The fiscal rules approved by Parliament in January 2017 committed the Government to reducing the cyclically adjusted deficit to below 2 per cent of GDP by 2020-21 and having debt as a share of GDP falling in 2020-21. However, the Government argued that the need for fiscal discipline continued as, despite the improvement, debt still remained too high at over 80 per cent of GDP.

2.24 According to the DHSC's evidence, affordable pay awards were an essential part of managing borrowing – the public sector paybill accounted for £1 in every £4 spent by the UK Government.

Our comments

2.25 The review body noted that, despite recent poor investment levels and economic growth that was well below its long term trend, the UK labour market had been relatively buoyant, with high levels of employment in the economy as a whole and earnings and pay settlements running a little ahead of inflation.

2.26 On the other hand, there was considerable uncertainty on the economic environment in the coming years. At the time of writing this report, the Government had agreed with the EU an extension of the Article 50 period to 31 October 2019. Many medical and dental students, and many substantive NHS doctors and dentists, are EU nationals and are potentially affected by the continuing uncertainty around the UK's future relationship with the EU. This uncertainty may also affect the recruitment of international students and staff from outside the EU. The review body noted that this represented a considerable challenge which cannot be ignored in workforce planning. The review body agreed with many of the parties submitting evidence that, in some respects, the uncertainty served only to magnify and complicate the challenges faced by the NHS current and future workforce. Nevertheless, the review body noted that despite the continued uncertainty, and below long-term trend economic growth, employment, earnings and pay settlements continued to rise.

2.27 The review body was asked in its deliberations to take account of the total reward package, including elements such as progression pay, allowances and pensions. We note that DHSC provided evidence of how total reward had increased recently for specific points on hospital doctors' pay scales, but the BMA questioned whether these comparisons were representative of the profession as a whole.

CHAPTER 3: AFFORDABILITY, PRODUCTIVITY AND WORKFORCE DEMAND

Introduction

3.1 This chapter is concerned with the NHS's plans for its workforce and the opportunities and constraints faced by the NHS, given government funding decisions and departmental expenditure limits, and informed by the public sector financial position discussed in the previous chapter.

Concepts of affordability, productivity and efficiency

3.2 Discussions of NHS plans often make reference to 'productivity', 'efficiency' and 'affordability'. In what follows, we use the term 'productivity' by itself to refer to output per head, not total factor productivity (which measures output for given inputs of all kinds, not just labour inputs). Although productivity is not straightforward to quantify for the NHS, the DHSC in England use a measure developed by the University of York based on health output adjusted for quality change, death rates and changes in waiting times. Because staff have a mix of different skills, it will not necessarily rise if fewer staff are used to deliver the same quality and quantity of outputs. But for a given mix of staff skills, a reduction in overall staff numbers will result in a rise in productivity. Productivity can also be increased through capital investment, new working arrangements and new technologies.

3.3 Government is also concerned about the cash cost of delivering services. 'Cash-releasing' efficiencies arise from reducing the cost of delivering a given quantity and quality of services. This was the focus of Lord Carter's review of efficiency in hospitals[1], which looked at the 136 acute trusts in England and concluded that £5 billion of savings could be made if 'unwarranted variation' were removed.

3.4 For the economy as a whole, output-per-head productivity is the key determinant of average living standards. But for any sector, the 'affordability' of a pay settlement is also driven by other factors affecting the demand and supply for its output. In the case of the NHS, the level of services is limited by the politically determined NHS budget and the costs of inputs as well as by productivity. For a given budget, technologies, efficiencies and staff mix, there is then a trade-off between real pay and overall employment: higher pay is affordable with lower staff numbers and higher output-per-head productivity.

Plans for the NHS

England

3.5 The *NHS Long Term Plan for England*[2] (LTP) was published in January 2019 following the 2018 announcement by the UK Government on increased NHS funding for the next five years, amounting to real terms increases of 3.4 per cent per annum on average. The LTP stemmed from concern around funding, staffing, increasing inequalities, and pressure from a growing and ageing population. It stated that the redesign of patient care must be accelerated to future-proof the NHS for the decade ahead.

[1] https://www.gov.uk/government/publications/productivity-in-nhs-hospitals
[2] NHS England (January 2019), The NHS Long Term Plan. Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

3.6 The LTP is key to any discussion of NHS finances, workforce and productivity. The LTP set out a new service model and referred to better support and properly joined-up care at the right time in the optimal care setting. It contains a long list of actions and targets, of which some of the most relevant to the work of this review body are as follows:

- in five years, every patient would have the right to online digital GP consultations. Hospital support would be redesigned to avoid a third of outpatient appointments;
- GP practices would be funded to work together to deal with pressures and extend services covering community health and social care;
- community health teams would provide fast support to people in their own homes and a ramping up of support for people in care homes;
- within five years, people would benefit from social prescribing[3], a personal health budget and support for managing their own health;
- primary and community services would have increased funding (new investment of £4.5 billion a year for five years); and
- there would be new service channels for emergencies, such as Urgent Treatment Centres, same-day emergency care, and improving outcomes for critical illnesses. Delayed discharges would be cut by building on action with Local Authorities.

3.7 The LTP also said that Integrated Care Systems would be in all areas by 2021, bringing integration of primary and specialist care, physical and mental health services, and health with social care. The Plan would fund specific new evidence-based prevention programmes, with every local area required to set out specific measurable goals, and mechanisms to narrow health inequalities. There were commitments to improving cancer survival, halving maternity-related deaths, increasing the number of planned operations and cutting long waits, increasing mental health funding, and expanding and faster access to community and crisis mental health services. These changes to services were to be backed by action on workforce, technology, innovation and efficiency.

3.8 The LTP stated that the affordability of the phased commitments had taken account of current financial pressures, and that it made realistic assumptions about continuing demand growth from the growing and ageing population. It was said that the underpinning modelling had taken a prudent approach that hospital trends of the past three years would continue.

3.9 NHS Improvement said that in 2018-19 specific efficiency savings linked to workforce productivity, resource optimisation and benchmarking through the Model Hospital[4] were estimated to be £713 million, forecast to rise to £1.9 billion by the end of the year. In 2017-18, the NHS delivered workforce savings, with £445 million recurrent Cost Improvement Programmes (CIPs) reported by providers. It went on to say that it continued to help providers maximise the benefit from efficiency savings, providing national and technical forums for sharing best practice.

3.10 NHS Employers said that the funding increase would not match the increase in demand for services, and other cost pressures. NHS organisations would have to manage these disparities, while continuing to meet public and patient expectations. It went on to say that while the additional investment was welcomed, it was not enough, and would restrict the ability of the NHS to invest in the real transformation of NHS services.

[3] Social prescribing is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. See: https://www.kingsfund.org.uk/publications/social-prescribing

[4] https://improvement.nhs.uk/resources/model-hospital/

3.11 The DHSC said that the LTP increased the focus on the shift from a dominance of highly specialised roles to more generalist ones to meet the needs of an ageing population. The department also said that measures such as enabling trainees to switch specialties without re-starting training, and making improvements to credentialing[5], would be progressed.

3.12 The DHSC said that NHS England and NHS Improvement had agreed new joint working arrangements; including the creation of a People Directorate headed by a Chief People Officer, who would be working closely with Health Education England (HEE) and NHS Employers to provide a more cohesive approach to improving leadership and management of the workforce.

Wales

3.13 In June 2018, the Welsh Government published its plan for health and social care, A Healthier Wales[6] in response to the Parliamentary Review of Health and Social Care which reported in January 2018. In the plan, the government committed to engaging with those who deliver health and care services. The plan was developed to promote the principles of prevention and prudent healthcare to make an impact on health and well-being throughout people's lives. It set out a long-term national transformation programme, underpinned by aims which included a motivated and sustainable health and social care workforce.

3.14 The Welsh Government said that it considered a Wales-wide approach to planning future workforce a priority, and that it would be investing a further £192 million in 2019-20 to implement the plan. Although much had already been achieved, the plan would be further progressed by Health Education & Improvement Wales (HEIW). HEIW would also manage the educational commissioning for all health professional groups, including dentists.

Scotland

3.15 The Scottish Government said that it would deliver an above inflation increase for Health and Sport in 2019-20, against a backdrop of Scotland's fiscal resource budget being reduced by 6.9 per cent in real terms by the UK Government between 2010-11 and 2019-20. It said that the 2019-20 Scottish Budget delivered additional resource funding of almost £730 million (5.5 per cent) for health and care services.

3.16 The Scottish Government published the third part of its National Health and Social Care Workforce Plan in April 2018, which had recommended several measures aimed to bring about improvements in health and primary care. The Scottish Government said that a fully integrated health and social care workforce plan was expected to be produced in 2019, but it was not available at the time of submitting this report.

3.17 The Scottish Government said that its Workforce Vision for NHS Scotland would respond to the needs of the people it cared for, adapt to new ways of working, and utilise new technology.

3.18 The Scottish Government said that a key element of the 2018 GP Contract was that GMPs would become more involved in complex care and system wide activities. It also told us that it would expect GMPs to have less involvement in more routine tasks, which would be delivered by others in the primary care multi-disciplinary team.

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[5] "Credentialing is a process that will recognise expertise and provide approved, regulated training programmes in areas of practice where:
- there may be significant patient safety issues, or
- training opportunities are insufficient or do not provide adequate flexibility to support effective service delivery."

From: https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/credentialing

[6] https://gov.wales/docs/dhss/publications/180608healthier-wales-mainen.pdf

Northern Ireland

3.19 In May 2018, the Department of Health (Northern Ireland) launched The Health and Social Care Workforce Strategy 2026: Delivering for Our People[7]. The strategy set out plans for a workforce that would meet the needs of a transformed health and social care system and tackle the challenges of supply, recruitment and retention of staff.

3.20 The Department of Health (Northern Ireland) said that it planned to set up arrangements for the oversight and accountability for the strategy's implementation. One of the stated aims of the strategy was that by 2026 the health and social care system would have the optimum number of staff with the right skills mix to deliver care, and that the workforce would feel valued and supported. The strategy identified key themes to achieving these aims including: attracting, recruiting and retaining the right people with the right skills mix; effective workforce planning, with a workforce model developed and implemented; and improved workforce communication and engagement.

Our comment on NHS plans

3.21 The four nations have acknowledged that a strong and committed workforce with the right mix of skills is integral to the provision of good quality healthcare.

3.22 The LTP for England recognised that the performance of any healthcare system depended on its people and that NHS staff were feeling the strain due in part to vacancies. It also argued that, in order to deliver the NHS Plan, more staff would be needed, working in rewarding jobs and in a more supportive culture. We note that, despite the focus on workforce, the Plan itself is still dependent on the production of the Workforce Implementation Plan, the subject of a separate and subsequent exercise, to be carried out under the chair of Baroness Harding of Winscombe. Following this commitment, the Interim NHS People Plan for England, an action plan for 2019-20, setting out a vision of how the NHS workforce will be supported to deliver the LTP, was produced by NHS Improvement shortly before this report was submitted, with a fully costed five-year People Plan expected later this year. We look forward in our next round to see the results of the five-year plan in the evidence we receive.

3.23 Healthcare is a significant focus of spending for any government, and control of costs is an important function. At the same time, a failure to plan for and invest in the future risks longer term problems. It is to be welcomed that the LTP, and equivalent work in other countries, has an emphasis on workforce and strategic development. Achieving such longer-term aims will depend however upon continuing political commitment and finance, which can only be supplied by government. What will be important for any such plans is what can be delivered early. To the extent that commitments are scheduled to be delivered further down the line, they are more vulnerable to unforeseeable changes in circumstances. Those involved in implementing the plans will need to pay due heed to the stability and security of the sources of finance they will need if they are to be able to deliver.

Affordability and productivity

England

3.24 For England, the reported figures for the NHS show output rising by around 2.6 per cent per annum over the five years to 2015-16. Output-per-head productivity growth is more variable, rising by 2.2 per cent per annum on average over the same five years but by just 0.5 per cent per annum over the two years 2014-15 to 2015-16.

[7] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-workforce-strategy-2016.pdf

3.25 Workforce growth has continued to be relatively strong, at around 2.75 per cent in 2018-19. If this growth continues at broadly the same rate in 2019-20, as assumed by DHSC, and if outputs continue to grow in line with recent experience, then output-per-head productivity will remain relatively unchanged from last year. At the same time, DHSC propose that wage recommendations lie within an envelope of £250 million. Working from an existing paybill of £12.6 billion, this implies a pay increase of 2 per cent across the sector and, with inflation expected to run at around 2 per cent also, real wage levels that are unchanged from last year.

3.26 The DHSC reported that the NHS has committed to achieve a "cash-releasing productivity growth of at least 1.1 per cent a year", with all savings reinvested in frontline care. It should also be noted that, as described in the LTP, providers with deficit control totals indicating a risk to financial sustainability and the continuity of services will be expected to achieve additional cash-releasing efficiency gains of at least 0.5 per cent per year. It is not clear whether these efficiency gains would be necessary simply to achieve output growth in line with recent experience or whether they would enable yet higher output growth.

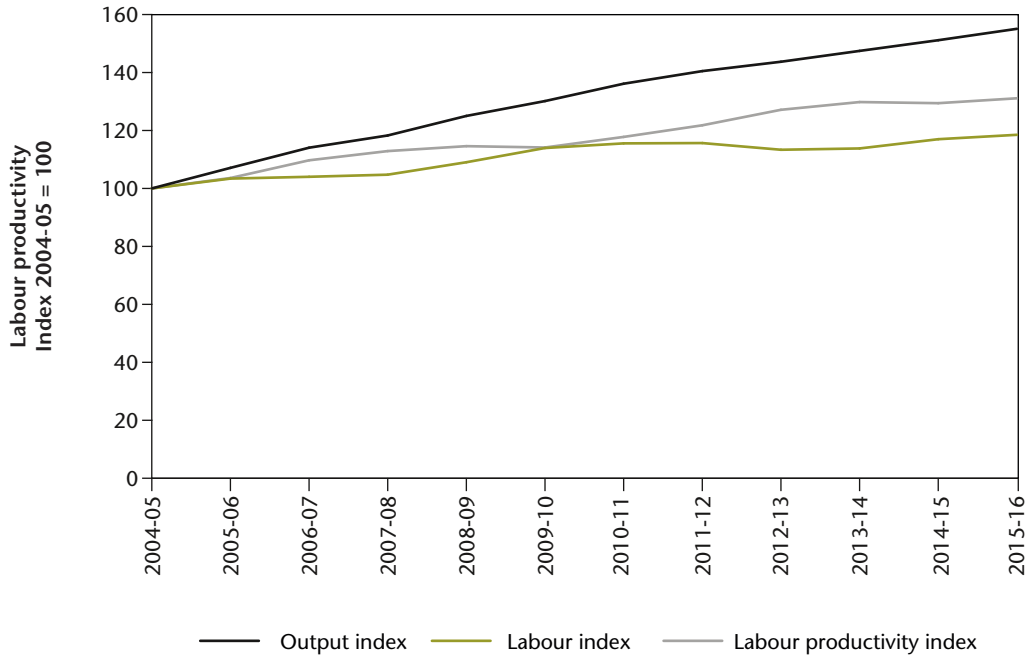
3.27 NHS Employers said that "Productivity in the NHS has grown by an average of around 1.4 per cent a year since 2009, and at a better rate than the economy in general", and that it was assumed that productivity would continue to grow at a similar rate over the next five years.

3.28 Data provided by the DHSC, in Figure 3.1, showed that between 2004-05 and 2015-16 NHS outputs in England had grown by 55 per cent while the volume of labour input, taking into account all those employed by the NHS, had grown by 19 per cent. This suggests average annual growth in output-per-head productivity of 2.5 per cent per annum. By way of comparison, between 2004-05 and 2015-16, output per worker across the economy as a whole grew by just 6 per cent in total[8].

3.29 Figure 3.2 shows a broader measure of productivity (total factor productivity), also developed by the University of York. This considers output growth, but also takes into account the growth of all the inputs into the NHS, including the composition of the workforce, and derives overall total factor productivity growth of 1.2 per cent per year between 2005-06 and 2015-16.

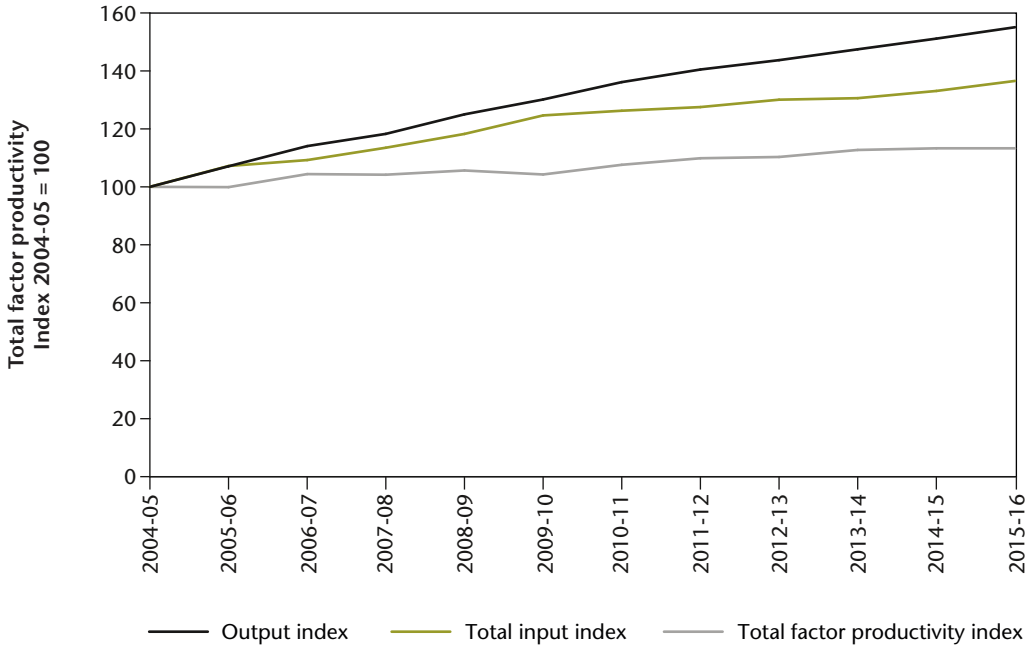
[8] ONS identifier A4YM – Output per worker.

Figure 3.1: Output-per-head productivity in the NHS, England, 2004-05 to 2015-16



Source: DHSC.

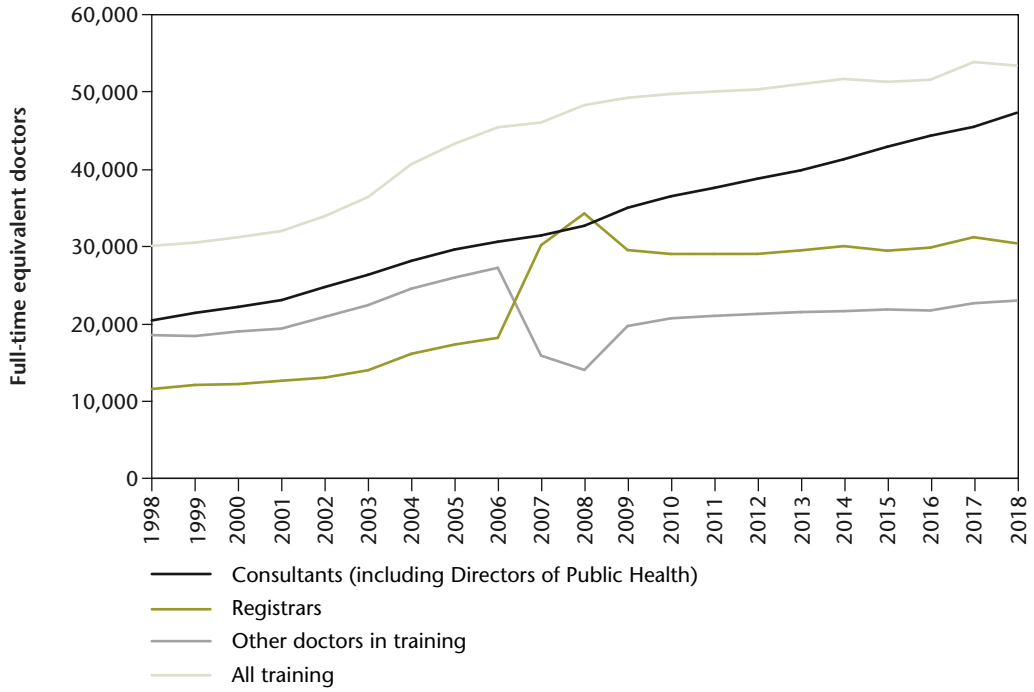
Figure 3.2: Total factor productivity in the NHS, England, 2004-05 to 2015-16



Source: DHSC.

3.30 Figure 3.3 shows the numbers of Hospital and Community Health Service (HCHS) doctors in England between 1998 and 2018. The number of doctors in training (including FY1, FY2 and Registrars) rose by 60 per cent between 1998 and 2008 and by 11 per cent between 2008 and 2018. This represents a growth rate of almost 3 per cent per annum over the period as a whole. Consultant numbers also rose by 60 per cent between 1998 and 2008 and by a further 45 per cent between 2008 and 2018, representing a growth rate of more than 4 per cent per annum over the period as a whole. This growth, outpacing the growth in output and in employment in the NHS overall, reflects the shift in emphasis from a consultant-led service towards a more consultant-provided service over recent decades.

Figure 3.3: Hospital and Community Health Service (HCHS) medical workforce, England, 1998-2018



Source: NHS Digital.

Wales

3.31 The Welsh Government said that it had accepted the findings of the Nuffield Trust which were included in the Health Foundation report, The path to sustainability, Funding projections for the NHS in Wales to 2019/20 and 2030/31[9]. The report analysed the demand and cost pressures facing the NHS in Wales up to 2019-20 and the decade beyond. It found that the NHS in Wales would need to deliver at least £700 million of efficiency savings to close the projected funding gap by 2019-20.

3.32 The Welsh Government also said that the report confirmed that the NHS was financially sustainable and affordable in the long term if it continued to deliver efficiency in line with long term trends and funding continued in line with expected GDP growth.

[9] https://www.health.org.uk/publications/reports/the-path-to-sustainability

Scotland

3.33 In October 2018, the Scottish Government published the Waiting Times Improvement Plan (WTIP), which set out a range of actions that will deliver major change in access to care. It will require a combination of an increase in output from the current workforce resources, a reconfiguring of the way in which resources are utilised and an overall increase in the workforce.

3.34 The Scottish Government said that it was increasing clinical effectiveness and efficiency by implementing targeted action plans in key specialties and clinical areas, and through mainstream and key productivity improvement plans, e.g., rolling out the virtual clinic from December 2018.

Our comments on affordability and productivity

3.35 The LTP set out how putting the NHS in England back onto a sustainable financial path was a key priority and was essential to allow it to develop the service improvements in the Plan. What follows is relevant to the comparable strategies developed by all the UK nations.

3.36 In the NHS environment, measures of productivity are complicated by the difficulties in defining outcomes. For some staff, increasing productivity may be about improving the quality of outputs – better and more intangible patient outcomes, or about making better functioning connections between disparate parts of the system. For others, it may be about reducing the cost of delivering outputs. While both these constitute increased productivity, they may feel quite different to those who are expected to deliver the required outcomes.

3.37 We have been asked to consider the affordability of our recommendations. A principal theme of the Government's evidence on the economy generally is that, with a fixed budget, pay increases can only be met through greater productivity by restricting the growth in employment. The DDRB would observe that, in the public sector, productivity is also influenced by the level of services (determined in turn by political considerations), by the level of investment in capital and new technologies, and by the efficiencies that can be achieved. Any pay recommendation should reflect the service's productivity at the time but productivity itself – and hence the affordability of the recommendation – is the outcome of a wider set of decisions that influence the way employment and pay of doctors and dentists evolve over time.

3.38 We received no proposals which sought to tie pay recommendations to specific productivity improvements. Much of the messaging about productivity from within the NHS stresses that greater productivity is delivered through multi-disciplinary team working, and that the problem is one of measuring (and rewarding) team effort. This seems right: it is self-evident for example that a consultant cannot work effectively at the top of their licence without the assistance of an appropriate supporting team. Under this argument it follows that productivity measurement based on the work of individual doctors, measured in isolation, is unlikely to help a great deal in either motivating the individuals concerned or in helping managers to identify service improvements. This obviously also weakens the link between measured productivity and wages of particular parts of the workforce.

3.39 The review body has also noted one specific aspect of the productivity debate that applies particularly to this remit group, and which is an example of how the productivity challenge may be impacted by related management decisions. The policy of continually increasing the number of consultants over several years has led to a change in the balance within the workforce with proportionately more consultants now than before the policy began. Abstracting from any improvements in services that are achieved, the greater preponderance of consultant-led teams, or of consultant-heavy teams, leads to a decrease in productivity because consultants are relatively highly paid compared to other colleagues in the medical workforce. The policy of increasing the number of consultants exerts a moderating influence on pay settlements over time.

3.40 Having reviewed these issues again, the review body's general conclusion is that the measurement of productivity in this area is important but not straightforward. More detail on NHS output measures, on the contribution to output of different parts of the workforce, and on the benefits of changes in the composition of the workforce would provide a clearer – and more useful – picture of productivity achievements and the affordability of any pay recommendations. The review body referred to this issue in its previous report and invited the interested parties to get together to consider the subject. We have received no evidence in the current pay round that this work has advanced to any appreciable extent.

3.41 The issue of affordability is closely tied to productivity achievement and so the review body takes the data provided very seriously. But the data currently provided relate only to service-level achievements and can provide only a broad and imperfect indication of the affordability constraints informing pay recommendations.

3.42 The review body welcomes the strengthening of both workforce planning and utilisation to ensure that staff across the NHS are more fully utilising their skill set, primarily in terms of job satisfaction but also to generate productivity gains and improve patient outcomes.

Progress with the Carter Review

3.43 NHS Improvement said that in 2018-19 specific efficiency savings linked to workforce productivity, resource optimisation and benchmarking through the Model Hospital[10] were estimated to be £713 million, forecast to rise to £1.9 billion by the end of the year. In 2017-18, the NHS delivered workforce savings, with £445 million recurrent Cost Improvement Programmes reported by providers. It went on to say that it continued to help providers maximise the benefit from efficiency savings, providing national and technical forums for sharing best practice.

Spending on locums, agency and bank staff

England

3.44 In England, NHS Improvement and DHSC have signalled an intent to make greater use of bank staff as an alternative to using agency staff for temporary staffing. They told us that to improve trusts' bank offers, bank staff would be provided with a self-booking system to allow them to manage their shifts better, and the technology would also allow for improved payment processes.

[10] https://improvement.nhs.uk/resources/model-hospital/

3.45 The DHSC said that NHS Trust spending on agency staff rose by 40 per cent between 2013-14 and 2015-16 (£2.6 billion to £3.7 billion). Following the introduction of agency spend controls, expenditure on agency staffing reduced to £3.1 billion in 2016-17 and £2.5 billion in 2017-18 (a fall of 18 per cent or £550 million across the total workforce in 2017-18 from the previous year). NHS Improvement have provided data on the proportion of agency spend that can be attributed to different staff groups and by region. In 2017-18 a total of £950 million (39 per cent) was for medical agency staff. The London region had the lowest proportion of its agency spend on medical staff (23 per cent) while the Northern region had the highest proportion of its agency spend on medical staff (52 per cent).

Wales

3.46 The Welsh Government said that the Medical Workforce Efficiency Group had been set up to tackle the rising agency and locum spend, and that a new control framework had been developed[11] which included caps on the rates to be paid for external agency staff. The Welsh Government said that the total spend on agency and locum medical staff in the last financial year was £30 million lower than the previous year, achieved by the implementation of controls and management process instigated by joint working between Welsh Government and NHS organisations.

Scotland

3.47 The Scottish Government said that the spend on medical locums in secondary care had reduced in NHS Scotland by 8 per cent from £109.2 million in 2016-17 to £100.3 million in 2017-18. It said this was mainly due to actions including expanding the NHS Staff Bank to include medical staff in all acute NHS Boards, and improved governance. The aim of the Scottish Government was to ensure that all doctors would have access to an NHS staff bank, at any point in their career from trainee to consultant, and which could include doctors having technically retired and hence drawn their pension, but who were continuing to practise without having to have a fixed commitment. It said this had been achieved by operating 'Medical Staff Banks', most of which were providing a regional service, and that feedback had been positive.

Northern Ireland

3.48 Northern Ireland told us of rising agency costs within various HSC workforce groups over the last five years, which they said were as a result of a number of factors, including increased demand, vacancy rates in junior doctor training positions, and wider recruitment and retention difficulties.

3.49 Data from the Department of Health Northern Ireland showed agency spend, in 2017-18, on medical and dental staff, of £73.5 million. This was a sharp increase from £68.7 million in 2016-17, which was itself a substantial increase from £46.0 million in 2015-16.

[11] http://www.wales.nhs.uk/sitesplus/documents/863/2c.%20App%201%20WG%20report%20June%20Data%202.docx.pdf

Our comments on spending on locums, agency and bank staff

3.50 At a general level, we welcome the action which has been taken to reduce the level of spend on agency working, and to introduce bank systems. The costs for such additional working by medical and dental staff in England are currently running at almost £1 billion annually, and it is clearly right that the NHS should seek to manage these costs effectively. We had heard from both doctors in the early stages of their training and those nearing retirement that additional salary was one of the attractions of locum work. To that extent, a shift from the use of agency to bank working is an important step in the right direction. At the same time, for many organisations, some reasonable level of flexible working is an important and essential component of managing short-term demand. The aim should be to get the balance right between permanent staff and flexible working. It may be that the NHS has its own understanding of the ideal balance, but we did not hear any evidence that any work had been done to establish what the correct balance might be. In saying this we recognise that the balance might need to be different in different areas, and in different trusts. If so, there needs to be some understanding of why the balance might vary, and by how much it should vary. We had heard that some NHS trusts and hospitals used educational fellowships to enable doctors in training to take time away from routine work but continue on out-of-hours rotas. Such initiatives had removed a previous dependency on agency locums. This is very much the territory of the Carter review, and we hope this might be an area which might be addressed more fully in evidence to us in future rounds.

CHAPTER 4: PAY, MOTIVATION AND WORKFORCE SUPPLY

Introduction

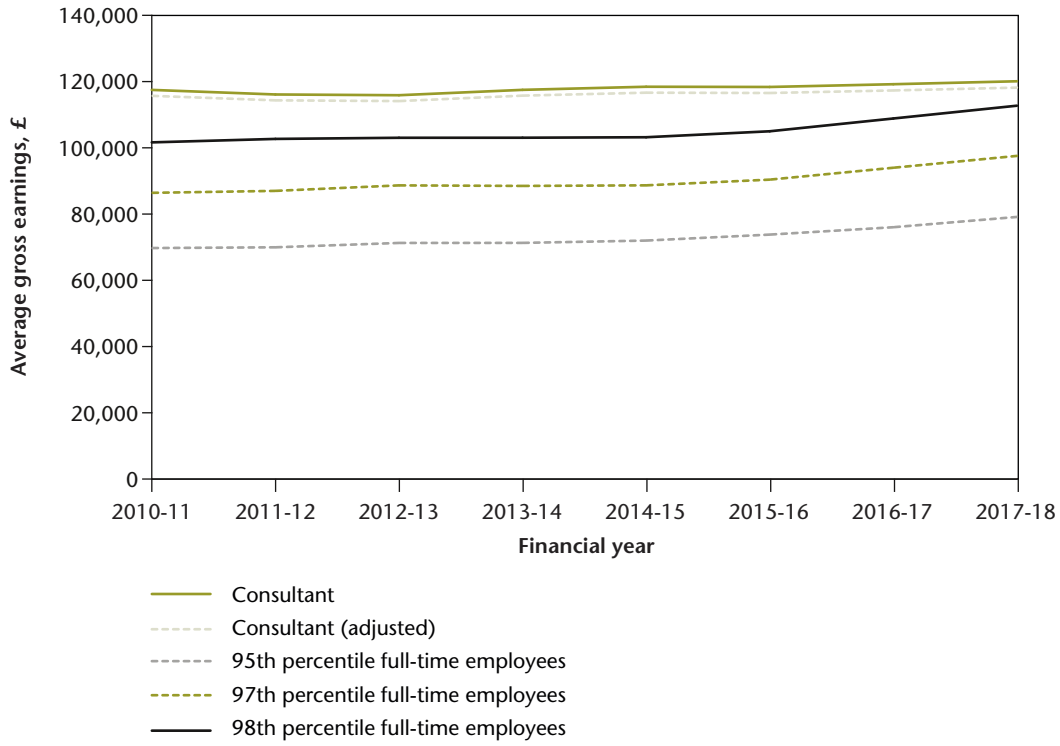
4.1 In this chapter, we consider how doctors' and dentists' pay has changed over time in England (equivalent data are not available for the other countries in the UK). We also consider how doctors' and dentists' pay compares with the distribution of pay across the whole UK economy, and how it compares to the private sector and to comparator groups. We also comment on workforce motivation and make some brief comments on the consequences for workforce supply of retirement trends and outflows/inflows of international doctors and dentists, with particular reference to the EU exit process.

The pay position

4.2 Figures 4.1 to 4.5 show how the average (mean) total earnings of various staff groups compare to the median, 90th, 95th, 97th and 98th percentile of full-time employees' (FTE) earnings in the wider economy, since 2010-11, based on data from the Annual Survey of Hours and Earnings (ASHE). Figures 4.1 to 4.3 include two estimates of mean earnings for Hospital and Community Health Service staff. The first, which we have used for a number of years, adds the mean annual basic pay per FTE to the mean annual non basic pay per person. The second estimate adjusts the non-basic pay per person data by a factor that reflects the ratio between FTE and headcount estimates of basic pay before adding to the FTE estimate of basic pay. We believe this second estimate is a more appropriate comparator to the ASHE data which is based on the earnings of full-time employees. Figure 4.4 also includes two estimates of earnings for GMPs: the data published by NHS Digital on a headcount basis; and the published data adjusted by a factor that reflects the ratio of the number of GMPs on a headcount basis to the number of GMPs on an FTE basis.

4.3 Since 2010-11 consultants' average total earnings have been consistently above the 98th percentile of FTE earnings in the wider economy, although the gap has narrowed since 2015-16 (Figure 4.1). Some part of this change will reflect the fact that the size of the consultant workforce has grown consistently over the recent past. As a result of recruitment at more junior levels exceeding outflow from more senior levels, this will have led to a larger share of the workforce being paid towards the lower end of the consultant pay scale, depressing the average earnings figures.

Figure 4.1: Average gross NHS earnings of consultants in England, compared with the distribution of earnings for full-time UK employees, 2010-11 to 2017-18

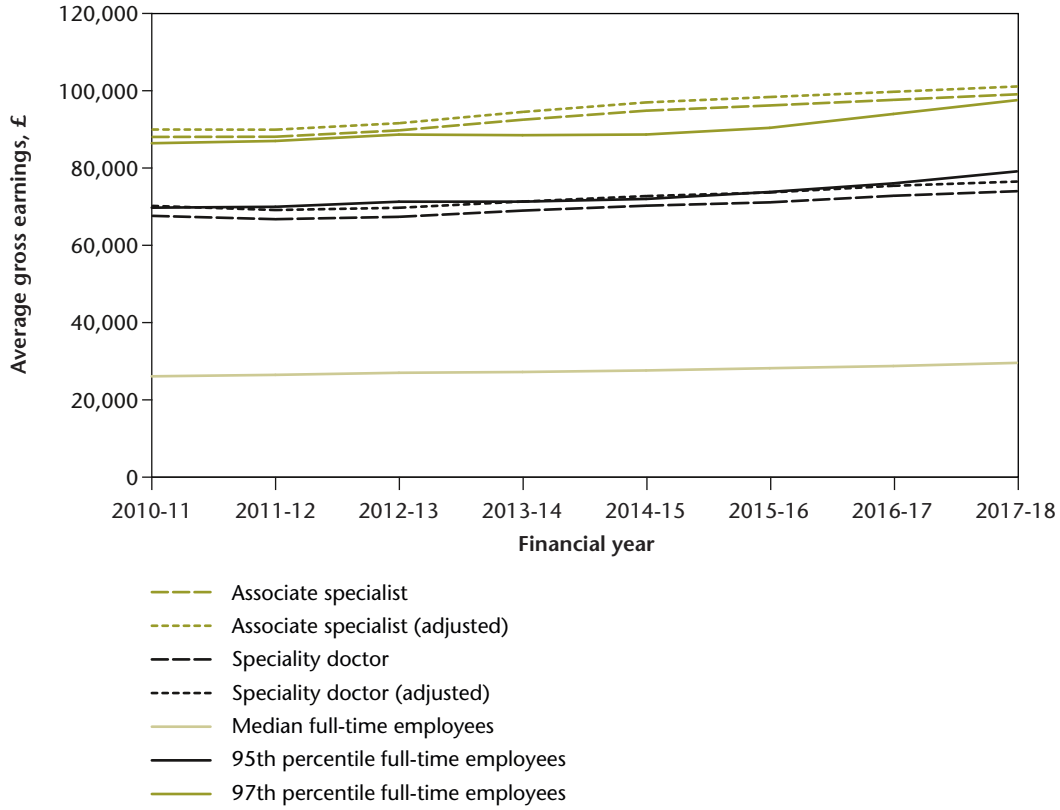


Source: OME estimates, based on data from NHS Digital, ONS.
Note: The consultant series uses basic earnings on an FTE basis and published NHS Digital non-basic earnings data on a headcount basis. The consultant (adjusted series) uses basic earnings on an FTE basis and OME estimates of non-basic earnings on an FTE basis.

4.4 Figure 4.2 shows that associate specialists' average total earnings increased relative to those at the 97th percentile in the wider economy, in 2013-14 and 2014-15, before falling back since 2015-16, while the average total earnings of specialty doctors, relative to the 95th percentile, moved similarly.

4.5 The average total earnings of the registrar group were 8 per cent above the 90th percentile in 2010-11. However, the gap has narrowed consistently, such that by 2017-18 average earnings of the registrar group were in line with those of the 90th percentile (Figure 4.3). For training grades in their first years as doctors (Foundation Year 1 & 2), the average total earnings for both grew over the period, but by less than median earnings of full-time employees. Over the period the earnings of those in Foundation Year 1 grew more quickly than those in Foundation Year 2 (Figure 4.3).

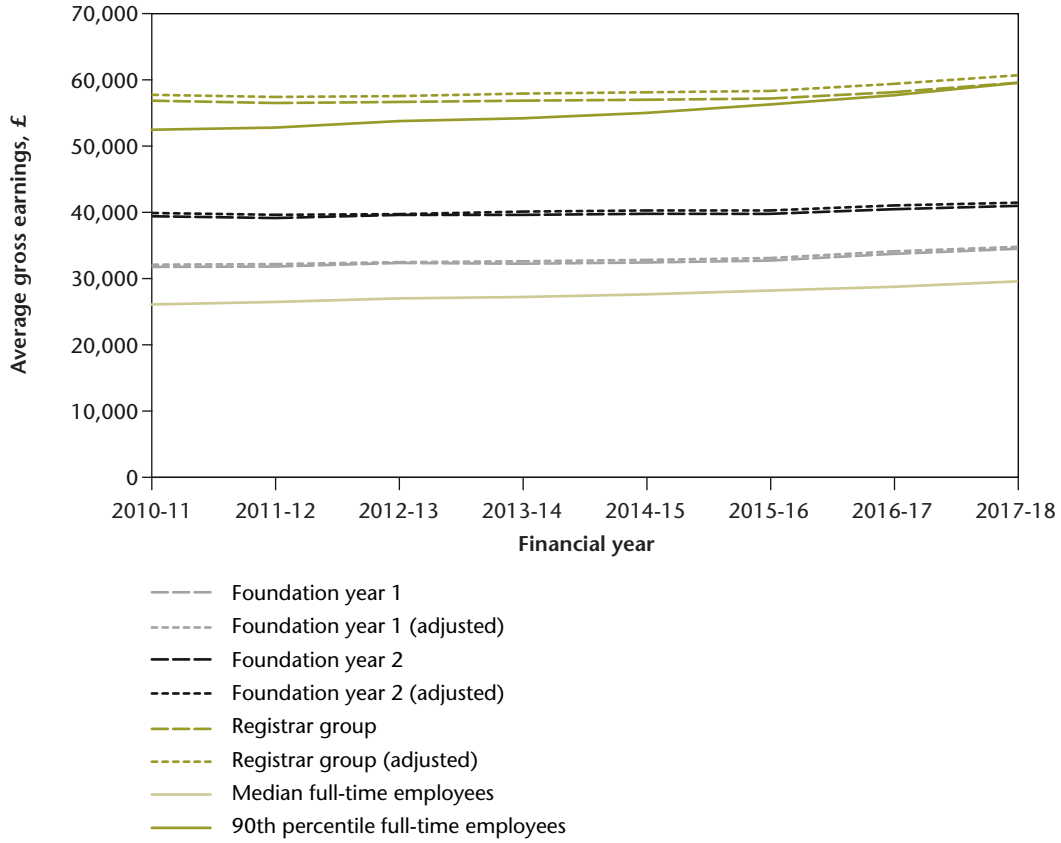
Figure 4.2: Average gross NHS earnings of specialty doctors and associate specialists in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2017-18



Source: OME estimates, based on data from NHS Digital, ONS.
Note: The associate specialist and specialty doctor' series use basic earnings on an FTE basis and published NHS Digital non-basic earnings data on a headcount basis. The associate specialist (adjusted series) and specialty doctor (adjusted series) use basic earnings on an FTE basis and OME estimates of non-basic earnings on an FTE basis.

4.6 Between 2010-11 and 2017-18, with the exception of associate specialists, the average earnings of hospital doctors grew less quickly than the UK median, 90th, 95th, 97th and 98th percentiles.

Figure 4.3: Average gross NHS earnings of doctors in training in England, compared with the distribution of earnings of all full-time UK employees, 2010-11 to 2017-18



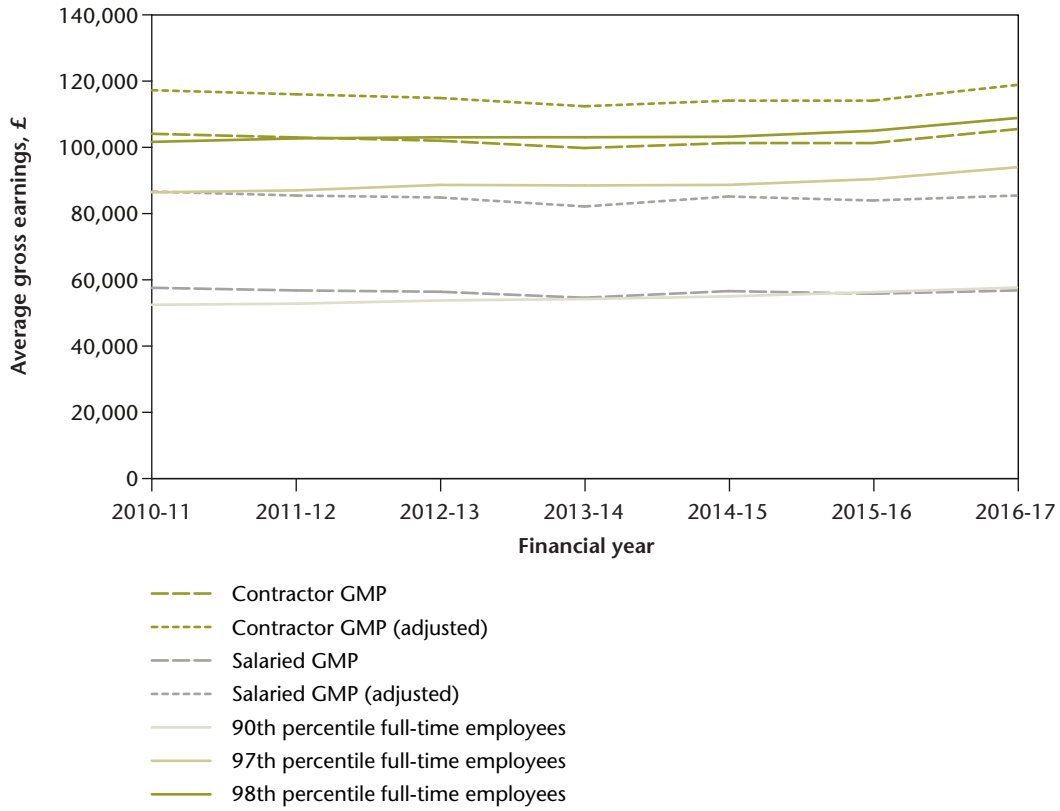
Source: OME estimates, based on data from NHS Digital, ONS.
Note: The Foundation year 1, Foundation year 2 and Registrar group series' use basic earnings on an FTE basis and published NHS Digital non-basic earnings data on a headcount basis. The Foundation year 1 (adjusted series), Foundation year 2 (adjusted series) and Registrar group (adjusted series) use basic earnings on an FTE basis and OME estimates of non-basic earnings on an FTE basis.

4.7 Figure 4.4 shows average income before tax for contractor and salaried General Medical Practitioners (GMPs) based on headcount and FTE equivalent between 2010-11 and 2016-17, the most recent year for which income figures are available.

4.8 On a headcount basis, at the start of the period contractor GMP earnings were 2 per cent above the earnings of those at the 98th percentile of full-time employees, but by 2016-17 their earnings were 3 per cent below those at the 98th percentile. Similarly, salaried GMPs' average income was 10 per cent above that of the 90th percentile of full-time employees at the start of the period, but by 2016-17 salaried GMP earnings had fallen 2 per cent behind those at the 90th percentile.

4.9 NHS Digital publish estimates of the number of GMPs on a headcount basis and an FTE basis. Those figures showed that the ratio of contractor GMPs on an FTE basis to those on a headcount basis was around 0.9 (in March 2017 there were 20,600 FTE GMP partners and 23,100 GMPs by headcount). For salaried GMPs the ratio was around 0.67 (in March 2017 there were 7,500 FTE salaried GMPs and 11,200 salaried GMPs by headcount). We have included in Figure 4.4 a second set of comparisons with GMP income figures adjusted upwards by these ratios. On an FTE basis, at the start of the period contractor GMP earnings were 15 per cent above the earnings of those at the 98th percentile of full-time employees, but by 2016-17 their earnings were 9 per cent above those at the 98th percentile. Similarly, salaried GMPs' average income was in line with the 97th percentile at the start of the period, but by 2016-17 salaried GMP earnings had fallen 9 per cent behind those at the 97th percentile.

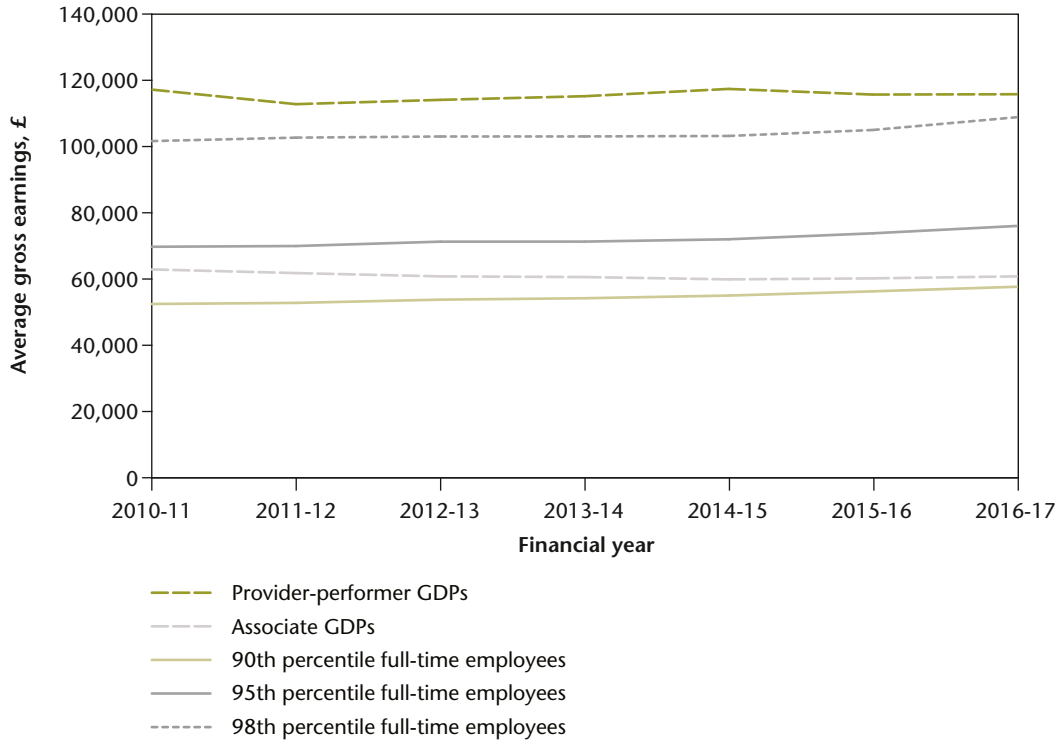
Figure 4.4: Average gross earnings of GMPs in England, compared with the distribution of earnings of all full-time UK employees, 2010-11 to 2016-17



Source: OME estimates, based on data from NHS Digital, ONS.
Note: The Contractor GMP and Salaried GMP earnings series' use published NHS Digital data on a headcount basis. The Contractor GMP (adjusted series) and Salaried GMP (adjusted series) adjust the published earnings series by a factor that reflects the ratio of the number of GMPs on a headcount basis to the number of GMPs on an FTE basis.

4.10 Relative to the 98th percentile, providing-performer General Dental Practitioners' (GDPs') average income, on a headcount basis, retained its value between 2011-12 and 2015-16 but fell back in 2016-17 (Figure 4.5). Performer-only GDPs average income has been between the 95th and the 90th percentiles but has fallen relative to those benchmarks and, since 2012-13 it was closer to the 90th percentile. These figures are based on headcount and take no account of hours worked.

Figure 4.5: Average gross earnings of GDPs in England, compared with the distribution of earnings of all full-time UK employees, 2010-11 to 2016-17



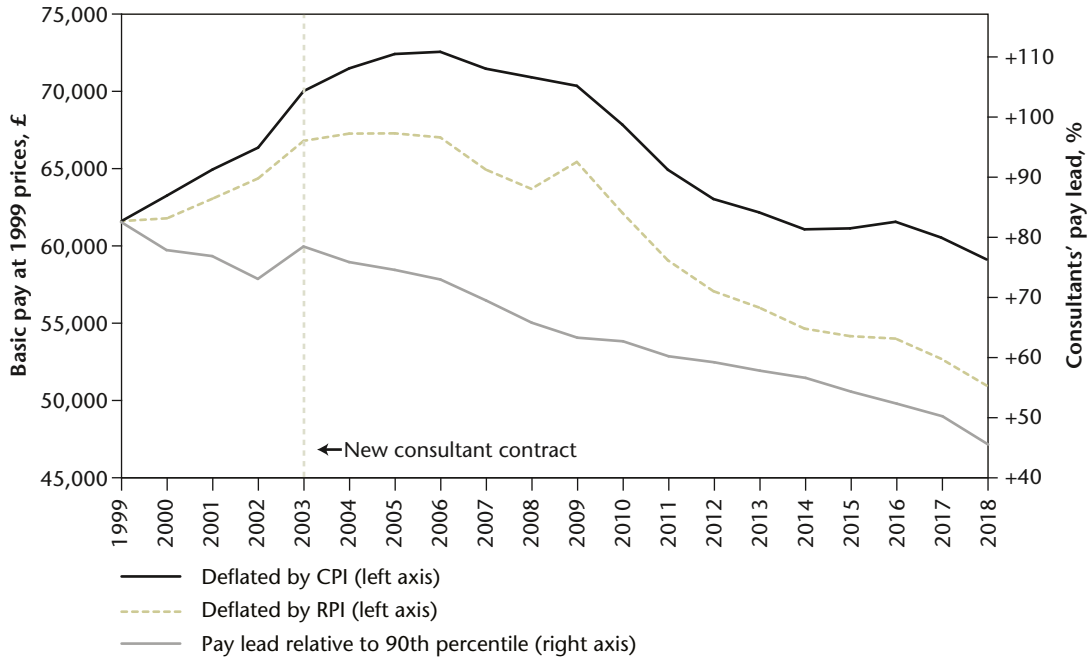
Source: NHS Digital, ONS.
Note: The Provider-performer GDP and Associate GDP earnings series' use published NHS Digital data on a headcount basis.

4.11 Figure 4.6 shows the real terms change from 1999 to 2018 in the 5th point of the consultants' pay scale[1]. This is a useful figure because, unlike the average earnings figures, it is not affected by the changing composition of the consultant workforce but relates only to basic (not total) pay. Compared with CPI inflation, the consultants' pay point increased until 2006 and then decreased until 2014, where it reached roughly the same level as in 1999, and in 2018 was 4 per cent below its 1999 value and 17 per cent below the level in 2008. This contrasts with the fall in real average total earnings (i.e., including bonus pay) across the economy as a whole since 2008 of 6 per cent.

4.12 Between 1999 and 2018, pay for full-time employees in the 90th percentile (including basic pay and other pay) has grown more quickly than the pay point (basic pay only) of a consultant with five years' experience. As a result, the consultants' pay lead has fallen every year since 1999, except in 2003 when the new consultant contract was introduced, from 82 per cent in 1999 to 45 per cent in 2018.

[1] The 2018 award was not implemented until October 2018. The data in Figure 4.6 are based on data at April in each year and so do not include the 2018 mid-year award.

Figure 4.6: Change in the value of the 5th point on the consultants' pay scale, in real terms and as compared to 90th percentile earnings, England, 1999–2018



Source: ONS.

4.13 The British Medical Association (BMA) said that since 2008-09 doctors had experienced a prolonged pay freeze and cap, at a time when inflation was running much higher. It said that doctors had faced an unprecedented cut in their average real-terms income (compared with RPI), after tax and pension deductions, of up to 30 per cent for hospital doctors and 29 per cent for GMPs. It further highlighted changes to the NHS pension scheme from 2015 onwards.

Pay comparability

4.14 Although pay comparability does not form an explicit part of our terms of reference, we believe it is important to assess the pay position of our remit group relative to other groups that could be considered appropriate comparator professions. Changes in pay, relative to price inflation and earnings, may feed through to impact on our terms of reference in areas such as recruitment, retention and the motivation of staff.

4.15 Last year the Institute of Employment Studies reviewed the DDRB pay comparability methodology[2] and recommended that we continue to use the same anchor points (i.e., job weights) as identified and used in previous reports. In this report we have included data for actuaries, legal professions, tax and accounting, pharmaceutical roles, vets and higher education roles.

4.16 Figure 4.7 compares the pay distributions for doctors in training (Foundation years 1 and 2 and specialty registrars), staff grades and specialty doctors in England, to comparator professions. It is important to note that, in this section, the pay for other professions is on a full-time equivalent (FTE) basis, whereas that for doctors and dentists is the average for both full- and part-time, and so may be lower than it would be on an FTE basis.

[2] Review of DDRB Pay Comparability Methodology, 2017, https://www.gov.uk/government/publications/review-of-ddrb-pay-comparability-methodology-2017

- Median total earnings for Foundation doctors in their first year were £31,750. This is 7 per cent more than the median earnings of all employees, and 31 per cent higher than median earnings of all employees ages 22 – 29. Median earnings were similar to those for vets who had just qualified, and for trainee lecturers. However, they were lower than for the other comparator groups.
- Median earnings for Foundation doctors in their second year (£43,250), were 4 per cent higher than the 75th percentile of all UK employees. Median earnings were higher than those for lecturers, vets, tax and accounting, legal and actuarial and similar to those for pharmaceutical.
- The Registrar group's median earnings were £60,750, which was 2 per cent higher than the 90th percentile of all UK employees and 5 per cent higher than the 90th percentile of all UK employees ages 30-39. Median earnings were lower than for actuarial and legal groups, but higher than for the other comparators.
- There was an overlap in the earnings of staff grade and specialty doctor grades, with median earnings of £66,250 and £68,750 respectively. This placed both grades into the top 10 per cent of UK earners. Relative to the comparator groups, median earnings were above those of senior lecturers, vets, pharmaceutical, and tax and accounting comparator groups, but below actuarial and legal earnings.

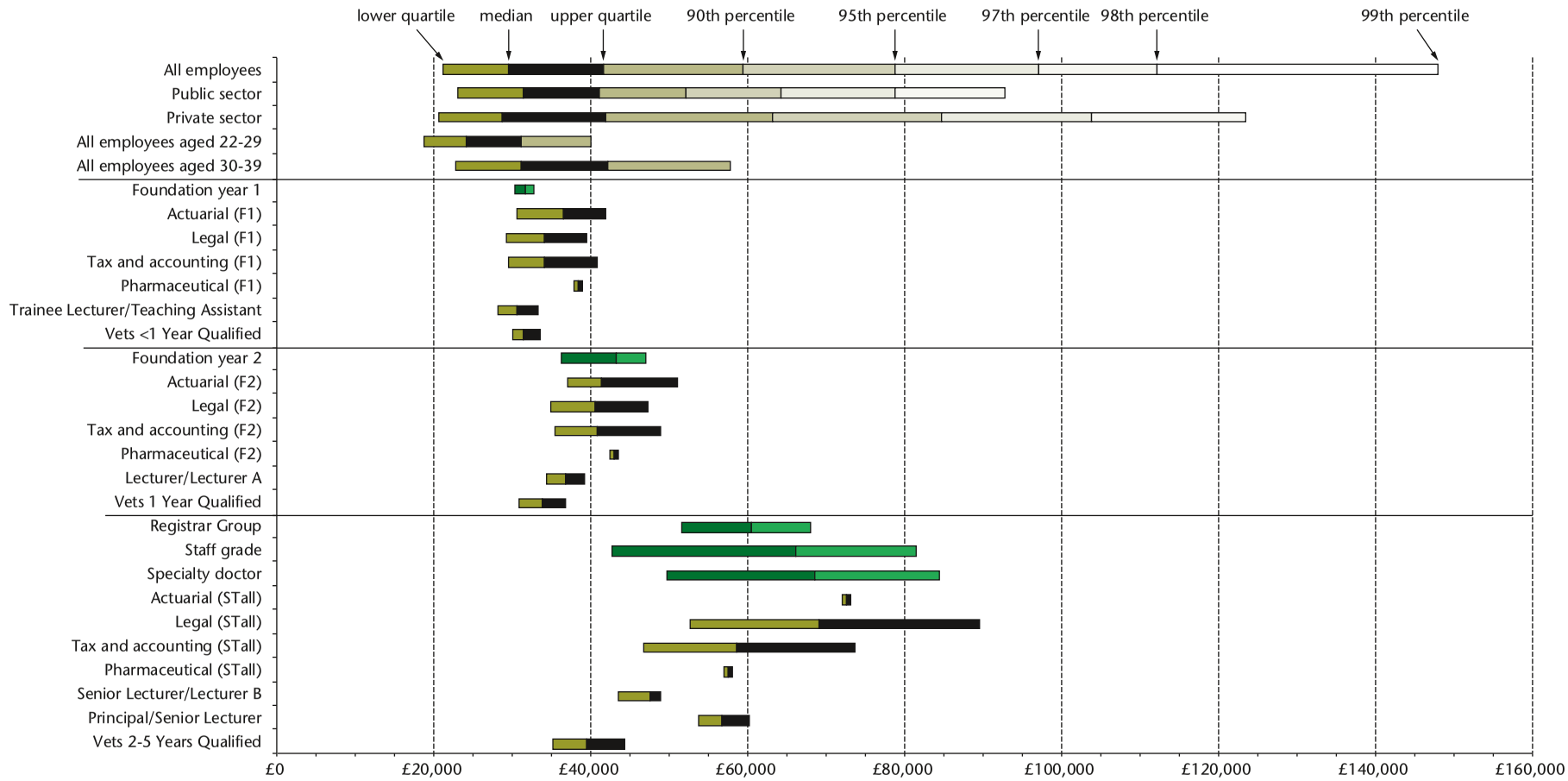
4.17 Figure 4.8 shows comparisons for associate specialists and consultants with the national pay distribution and other professional groups.

- Median earnings for associate specialists (£90,250) were 7 per cent less than the 97th percentile of all UK employees. Although considerably higher than for professors, the head of a subset of an academic area, and for vets, median earnings were much lower than those for actuarial, legal, tax and accounting, and pharmaceutical groups.
- Consultants' median earnings (£111,750) were 1 per cent below the 98th percentile of all UK employees. Median earners were above the highest paid vets and higher education academics, but lower than for tax and accounting, legal and actuarial groups.

4.18 Figure 4.9 shows comparisons for GMPs and GDPs.

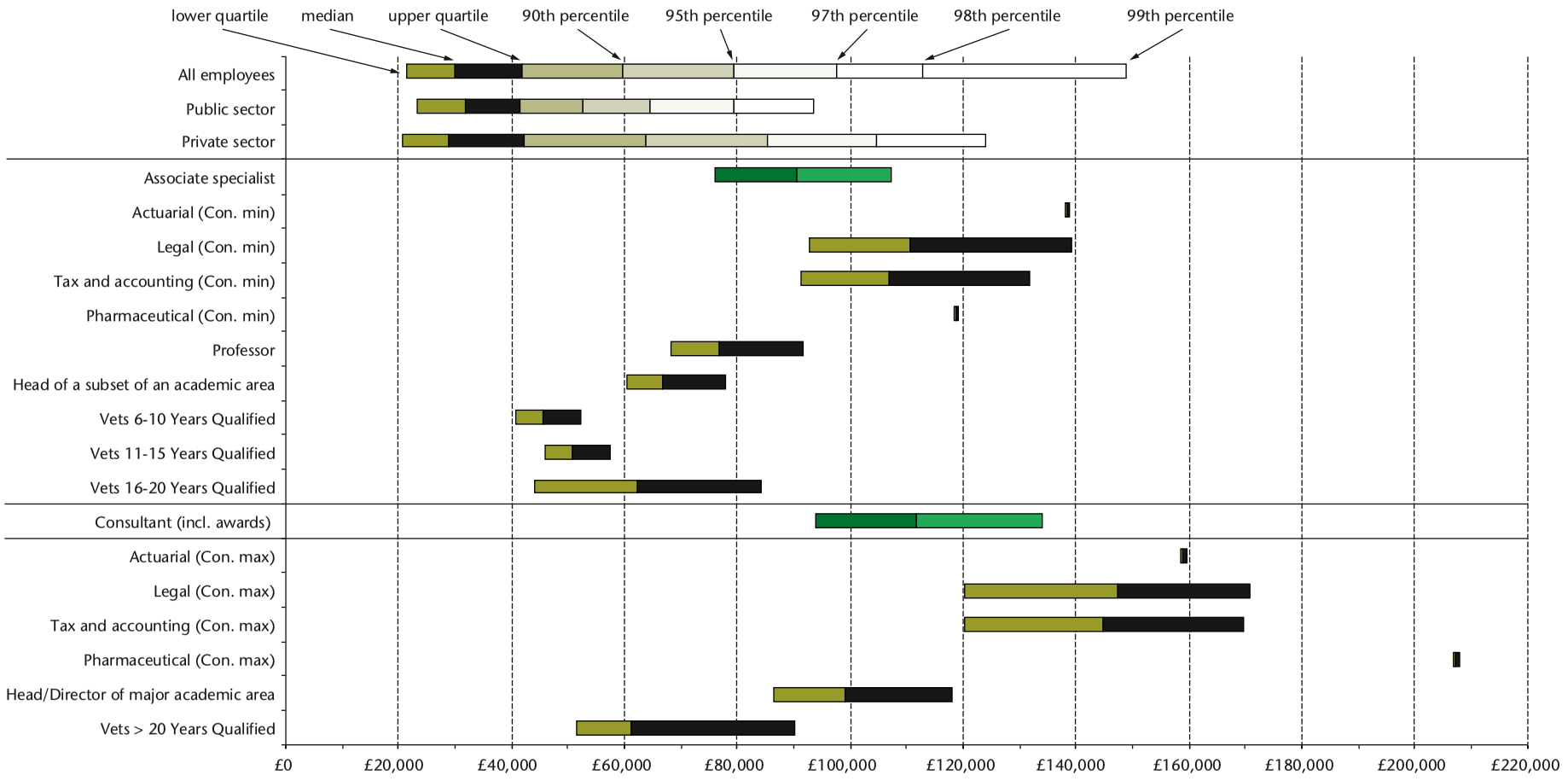
- Salaried GMPs median earnings (£52,700) were 11 per cent less than the 90th percentile of all UK employees. Median earnings for performer GDPs (£54,600) were 8 per cent less than the 90th percentile. Both had earnings higher than vets, but lower earnings than actuarial, legal, tax and accounting groups.
- Contractor GMPs had median earnings of £100,400, which was 3 per cent higher than the 97th percentile of all UK employees. Providing-performer GDPs had median earnings of £97,400, which was similar to the 97th percentile. Median earnings for both groups were higher than median earnings for vets, but less than for actuarial, legal, tax and accounting and pharmaceutical groups.

Figure 4.7: Total earnings inter-quartile ranges of DDRB training grades, staff grades and speciality doctors (England), compared with the national pay distribution and other professional groups, full-time rates, 2018



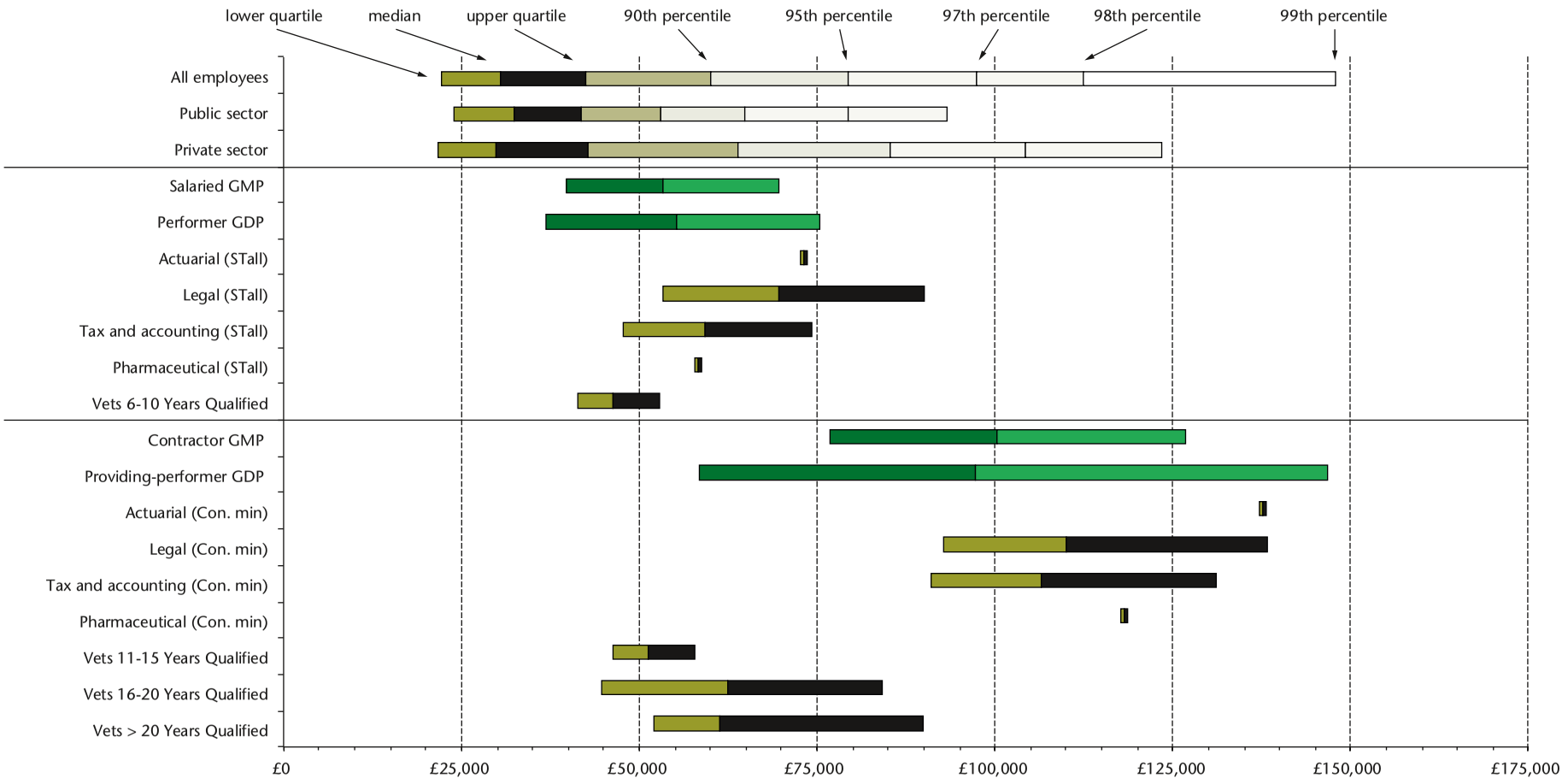
Sources: ONS, NHS Digital, NHS Employers, Hay group, UCEA and SPVS.
(1) Figures for hospital medical grades are average total earnings for full and part time in the year ending June 2018, by headcount.
(2) A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median for these groups.
(3) Vets data are for 2017.

Figure 4.8: Total earnings inter-quartile ranges of consultants and equivalent grades, and associate specialists (England), compared with national pay distribution and other professional groups, full-time rates, 2018



Sources: ONS, NHS Digital, NHS Employers, Hay group, UCEA and SPVS.
(1) Figures for hospital medical grades are average total earnings for full and part time in the year ending June 2018, by headcount.
(2) A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median for these groups.
(3) Vets data are for 2017.

Figure 4.9: Total earnings inter-quartile ranges of GMPs and GDPs (United Kingdom), compared with national pay distribution and other professional groups, full-time rates, 2018



Sources: ONS, NHS Digital, NHS Employers, Hay group, UCEA and SPVS.
(1) Figures for GMPs and GDPs are average total earnings for full and part time in the year ending June 2018, by headcount.
(2) A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median for these groups.
(3) Vets data are for 2017.

Turnover

England

4.19 In 2017-18, joining rates for hospital medical and dental staff in England were higher than the leaving rates by 2.6 percentage points (Figure 4.10). This is the widest gap between rates in the period from 2010-11 to 2017-18. Compared with 2016-17, the leaving rate was unchanged at 14.4 per cent, while the joining rate increased to 17.0 per cent from 16.8 per cent.

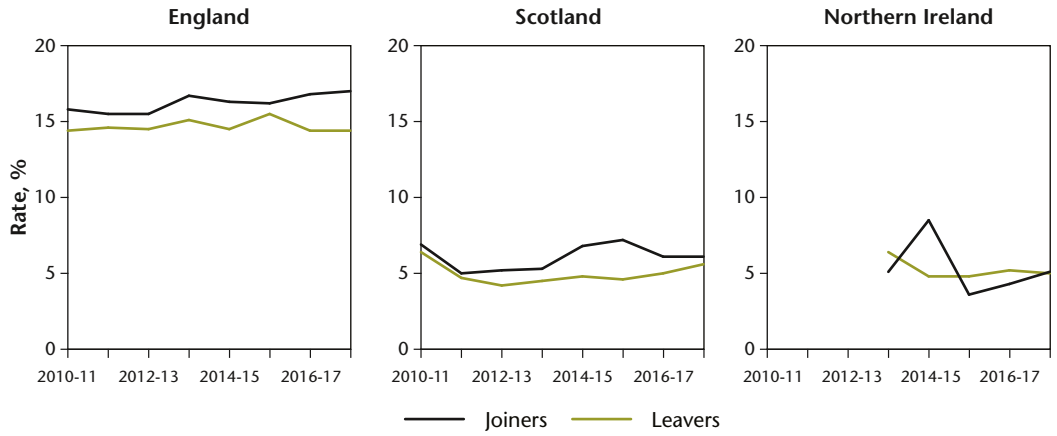
Scotland

4.20 In 2017-18, joining rates for hospital medical and dental staff in Scotland were higher than the leaving rates by 0.5 percentage points. This is the narrowest gap between rates since 2011-12. Compared with 2016-17, the leaving rate increased from 5.0 per cent to 5.6 per cent, while the joining rate was unchanged at 6.1 per cent.

Northern Ireland

4.21 In 2017-18, joining rates for hospital medical and dental staff in Northern Ireland were higher than the leaving rates by 0.1 percentage point. Compared with 2016-17, the leaving rate fell to 5.0 per cent from 5.2 per cent, while the joining rate increased to 5.1 per cent from 4.3 per cent.

Figure 4.10: Joining and leaving rates, by country, 2010-11 to 2017-18



Source: OME calculations, using data from NHS Digital, ISD Scotland, Department of Health (Northern Ireland).

International recruitment

England

4.22 Data from NHS Digital (Table 4.1) show that in 2017-18 12.6 per cent of doctors joining the Hospital and Community Health Services (HCHS) in England were from abroad, comprising of 3.0 per cent from within the EU and 9.5 per cent from outside the EU. The share of joiners to the HCHS from abroad has increased each year between 2010-11 and 2017-18.

4.23 Between 2010-11 and 2015-16, the share of joiners from the EU more than doubled, from 1.7 per cent to 3.8 per cent, before falling back in each of the last two years. The share of joiners from abroad from outside the EU has increased each year between 2010-11 and 2017-18.

Table 4.1: Medical and dental joiners to the NHS in England by source of recruitment, between March 2010 and March 2018, %, headcount, England

	EU (exc. UK) (%)	Non-EU (%)	EU (exc. UK) and Non-EU (%)
2010-11	1.7	3.3	5.0
2011-12	2.3	3.4	5.7
2012-13	3.0	3.7	6.7
2013-14	3.5	4.4	7.9
2014-15	3.7	5.5	9.2
2015-16	3.8	6.6	10.4
2016-17	3.5	8.3	11.8
2017-18	3.0	9.5	12.6

Source: NHS Digital.

4.24 According to data from NHS Digital non-United Kingdom nationals made up just over a quarter of the HCHS medical and dental workforce in March 2018 (Table 4.2), with 9 per cent EU/EEA nationals and 16 per cent from the rest of the world. There are differences by grade, with non-UK nationals making up over 40 per cent of SAS doctors, 30 per cent of doctors in training and 20 per cent of consultants.

Table 4.2: Medical and dental staff by nationality, March 2018, headcount, England

	EU/EEA	Non-EU	EU/EEA/Non-EU
Consultants	4,554 (9%)	5,452 (11%)	10,006 (20%)
SAS Doctors	1,171 (11%)	3,217 (31%)	4,388 (42%)
Doctors and Dentists in Training	5,085 (10%)	10,038 (22%)	15,123 (31%)
Total	10,953 (9%)	18,846 (16%)	29,799 (25%)

Source: NHS Digital.

Retirement trends

England

4.25 The DHSC provided data on numbers in England who were claiming their NHS pension on voluntary early retirement (VER) basis since 2007-08 (Table 4.3). It showed for both hospital doctors and GMPs a sharp increase in the numbers choosing VER over the period as a whole, and that the percentage of retirements they accounted for was increasing. This is particularly the case for GMPs, where since 2013-14 more than half of retirements are on a VER basis. However, the latest data for 2017-18, compared with 2016-17, show a reduction in the number of hospital doctors and GMPs choosing VER, and in the share they represent of all retirements. For dental practitioners the numbers choosing VER have declined since 2014-15, but still account for just over a third of all retirements.

Table 4.3: Numbers claiming their NHS pension on a voluntary early retirement (VER) basis, England, 2007-08 to 2017-18

	Hospital doctors		General medical practitioners		General dental practitioners	
	VER	% of all retirements	VER	% of all retirements	VER	% of all retirements
2007-08	178	14	198	17	92	29
2008-09	142	11	265	20	125	37
2009-10	183	13	322	23	118	36
2010-11	286	16	443	28	131	32
2011-12	315	18	513	33	161	37
2012-13	387	24	591	42	158	36
2013-14	406	26	746	50	149	40
2014-15	453	28	739	51	161	41
2015-16	494	31	695	52	145	41
2016-17	490	30	721	62	143	42
2017-18	424	29	588	58	115	37

Source: DHSC.

4.26 The Hospital Consultant and Specialists Association (HCSA) said that changes to pension taxation were disincentivising additional shifts and incentivising early retirement. It reiterated a point from its evidence for the previous round that there should be a joint task force set up to explore and seek better evidence around early retirement. It said that a survey of its members showed that pension taxation changes had led 42 per cent of respondents to plan to retire earlier, while 13 per cent said they would retire later. The HCSA said that low morale and high stress levels were also leading to senior doctors planning to leave their posts earlier than previously planned.

4.27 The BMA said that doctors now realised that taking on additional work, covering vacancies or receiving clinical excellence awards might actually cost them money because of the nature of the way in which pension benefits were taxed. It said that in a survey of its members 60 per cent said that they planned to retire early, and 50 per cent had reduced or planned to reduce additional programmed activities. It said that the way in which pensions were taxed was undermining the ability of doctors to do additional work and encouraging early retirement, and that urgent reform was required to avert a deepening of what it described as an NHS staffing crisis.

4.28 The British Dental Association (BDA) said that many of those who said that they intended to leave dentistry in the next five years were associate dentists aged 55-64. However, it said that of most concern was that over 60 per cent of associate dentists in the 25-34 age group indicated a desire to leave dentistry. The BDA also said that almost two-thirds of those expressing a desire to leave dentistry were those dentists with an NHS commitment of over 75 per cent and those with very 'high needs' patients.

4.29 NHS Digital statistics show that, between April 2017 and March 2018, of those doctors and dentists who reported their reasons for leaving, reaching retirement age was the third most likely reason (752 people), behind end of fixed term contract (6,864), and voluntary resignation for unknown reasons (1,487). A further 179 people cited one of early retirement, retirement on health grounds or flexible retirement.

Wales

4.30 Evidence from the Welsh Government showed that between April 2017 and March 2018, 104 medical and dental staff had retired (up from 84 in 2016-17), of which seven (down from 15 in 2016-17) were voluntary early retirements.

Scotland

4.31 The Scottish Government included data from the Scottish Public Pensions Agency on the retirements of GMP and GDPs in Scotland. For GMPs, 73 were identified as retiring early in 2017-18, compared with 81 in 2016-17. For GDPs there were 32 identified early retirements (of 61 retirements in total) in 2017-18, compared with 31 (of 67 retirements in total) in 2016-17. The Scottish Government described the retirement rates of GDPs in Scotland as comparatively low.

Northern Ireland

4.32 Data from the Department of Health (Northern Ireland) identified that 130 medical and dental staff had left the system in 2017-18, compared with 2016-17. The data do not identify why staff left the system or whether they were doing so before their normal retirement age.

Motivation, morale and engagement

England

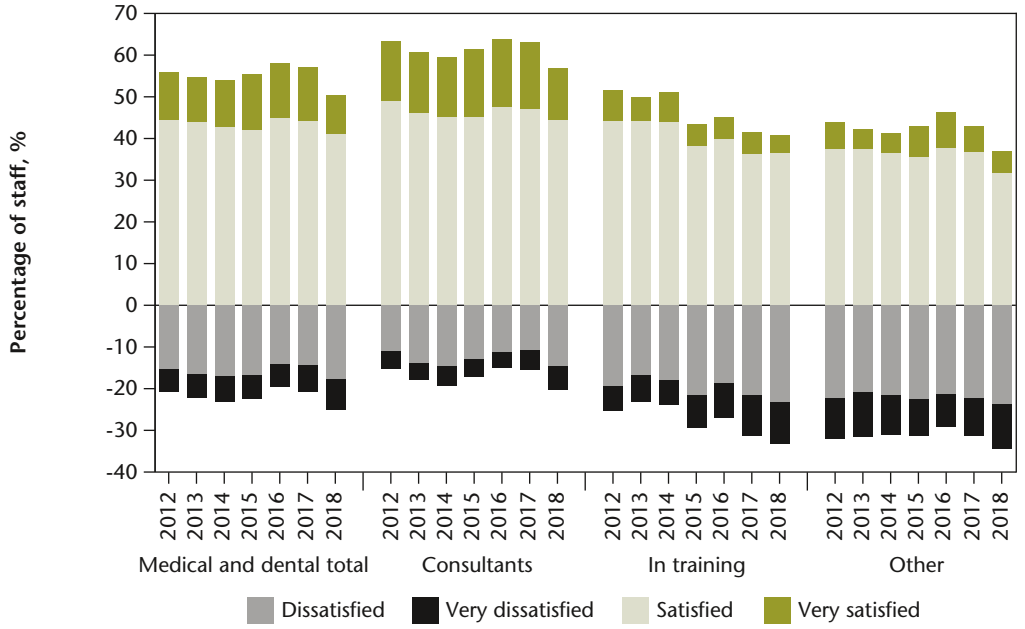
4.33 Since our 2018 Report, the 2018 survey of NHS Staff in England was published. It was conducted in the autumn of 2018, and over 497,000 staff responded (a response rate of 46 per cent, up from 45 per cent in 2017).

4.34 In 2018, 50.5 per cent of medical and dental staff responding said they were satisfied[3] with their pay, a fall of 6.6 percentage points, from 57.1 per cent in 2017 (Figure 4.11) and the lowest recorded since at least 2011. There was a large fall in satisfaction with pay for consultants and specialty doctors and associate specialists, and a more modest fall for doctors and dentists in training.

- A larger proportion of consultants said they were satisfied with their pay than other groups. In 2018, 56.7 per cent said they were satisfied, a fall of 6.5 percentage points from 2017.
- For doctors and dentists in training, in 2018, 40.8 per cent said they were satisfied with pay, a fall of 0.8 percentage points compared to 2017.
- For the 'other' group (comprising mainly specialty and associate specialist (SAS) doctors), 36.8 per cent said they were satisfied with pay, a fall of 6.1 percentage points from 2017.
- Although only 35 per cent of other (Agenda for Change) NHS staff expressed satisfaction with their pay, this represented a 5.5 percentage improvement from 2017.

[3] In each case, satisfied refers to participants answering that they were 'satisfied' or 'very satisfied' with their level of pay.

Figure 4.11: HCHS medical staff satisfaction with level of pay, England, 2012 to 2018

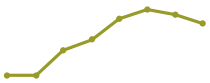
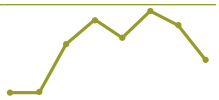


Source: NHS Staff Survey.
Note: The percentage saying "neither satisfied nor dissatisfied" omitted throughout this chart.

4.35 Job satisfaction generally declined for medical and dental staff in 2018 compared to 2017 (Table 4.4).

- There was a decrease of 0.5 percentage points of staff saying they looked forward to going to work, and a decrease of 0.4 percentage points of staff saying they were enthusiastic about their job.
- Respondents said they were less positive about the amount of support they got from immediate managers and colleagues, the ability to use their skills, the recognition they got for good work and the extent to which their organisation values their work.
- The percentage of respondents saying they experienced harassment, bullying or abuse from patients, relatives or the public, increased for the fourth year in a row, to 33.9 per cent in 2018.

Table 4.4: Selected results from the National Staff Survey, medical and dental staff, England, 2011 to 2018

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	Trend[1]
I look forward to going to work	62.0	62.5	64.0	64.4	68.0	68.9	67.2	66.7	
I am enthusiastic about my job	74.0	74.3	75.4	75.2	79.4	78.7	77.4	77.0	
Time passes quickly when I am working	81.7	79.9	81.8	81.8	84.1	83.2	83.0	82.2	
The recognition I get for good work	51.9	51.9	54.3	55.3	57.4	58.3	57.8	57.0	
The support I get from my immediate manager	64.0	64.1	67.0	68.7	67.5	69.2	68.3	66.0	
The support I get from my work colleagues	81.0	82.6	82.9	83.5	86.4	85.8	85.6	84.8	
The amount of responsibility I am given	81.2	83.3	82.7	83.0	82.4	82.2	83.0	81.7	
The opportunities I have to use my skills	76.5	78.3	80.0	80.1	80.6	79.6	79.4	78.3	
The extent to which my organisation values my work	42.8	46.2	49.2	51.4	50.4	52.3	52.1	47.6	
My level of pay	57.1	55.9	54.7	54.1	55.4	58.0	57.1	50.5	
Percentage of staff appraised in the last 12 months	81.9	87.7	89.9	91.5	90.8	91.1	90.8	91.6	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.7	32.8	32.1	33.0	33.4	33.5	33.9	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

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

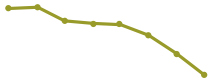
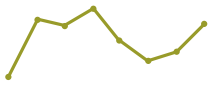
[2] *Lower scores are better in these cases, however, in all other cases, higher scores are better.*

4.36 Workload pressures generally remained high and showed signs of worsening (Table 4.5). In 2018, compared with 2017.

- There was a fall, of 3.2 percentage points, to 36.1 per cent, in staff agreeing they could meet all the conflicting demands on their work.
- There was a large decline in the numbers of staff agreeing that there were enough staff at their organisation, falling 3.1 percentage points to 27.7 per cent in 2017. This measure has declined in each of the last six years.
- There was a 3.6 percentage point increase in the percentage of staff who said they felt unwell as a result of work-related stress.

- There was an increase of 1.7 percentage points, to 38.0 per cent, in the percentage of staff saying they worked paid hours over and above their contracted hours. Meanwhile there was a corresponding reduction of 1.7 percentage points, to 78.0 per cent in the percentage of staff working unpaid hours over and above their contracted hours.

Table 4.5: Selected results from the National Staff Survey, medical and dental staff, England, 2011 to 2018

Workload	2011	2012	2013	2014	2015	2016	2017	2018	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	44.8	44.7	45.2	48.0					
I am able to meet all the conflicting demands on my time at work[4]					38.7	37.2	39.3	36.1	
I have adequate materials, supplies and equipment to do my work	58.1	56.0	56.9	58.9	56.2	56.3	55.9	49.2	
There are enough staff at this organisation for me to do my job properly	35.5	35.5	34.2	33.9	33.7	32.4	30.8	27.7	
During the last 12 months have you felt unwell as a result of work related stress[2]		32.0	32.9	32.3	32.6	31.1	31.7	35.3	
Percentage of staff working PAID hours over and above their contracted hours[2]	35.0	38.7	38.3	39.4	37.4	35.9	36.3	38.0	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	72.5	76.2	77.1	76.3	79.1	80.5	79.6	78.0	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

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

[2] *Lower scores are better in these cases, however, in all other cases, higher scores are better.*

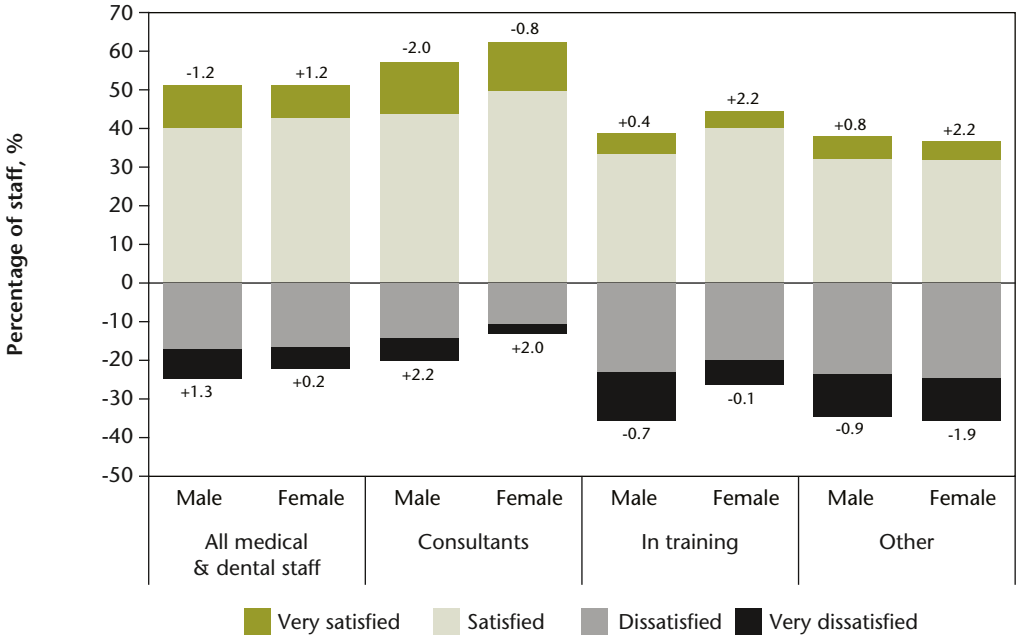
[3] *For 2015, this question was reversed to "I am able to meet…"*

[4] *This question was introduced in 2015.*

4.37 Figure 4.12 shows satisfaction with pay broken down by staff group and gender in 2018. When looking across all medical and dental staff, 52.6 per cent of female staff and 50.2 per cent of male staff expressed satisfaction with pay. Compared with 2017, there was a 1.2 percentage point increase in female staff expressing satisfaction with pay and a 1.2 percentage point decrease in male staff. Female consultants and doctors and dentists in training were more likely than their male counterparts to express satisfaction with pay while there was no difference between male and female in the SAS doctor (other) group.

- Female consultants (61.8 per cent) were more likely to express satisfaction with their pay than male counterparts (55.4 per cent). Similarly, male consultants were more likely to express dissatisfaction with their pay (22.3 per cent) than female counterparts (15.3 per cent).
- There was a 7.7 percentage point gap between the proportion of male and female doctors and dentists in training expressing satisfaction with pay. 46.9 per cent of females expressed satisfaction with pay in 2018, compared to 39.3 per cent among males.
- Across the SAS doctor (other) group 39 per cent of both male and female doctors expressed satisfaction with pay.

Figure 4.12: HCHS staff satisfaction with level of pay by grade and gender, England, 2018



Source NHS Staff Survey data, Picker Institute Europe.
Note: Those answering 'neither satisfied nor dissatisfied' have been excluded from this chart.
Those answering 'prefer to self-identify' or 'prefer not to say' are not shown.
Figures above and below the bars are the change in satisfaction/dissatisfaction compared to 2017.

NHS Staff Survey (Wales)

4.38 In the summer of 2018 NHS Wales conducted a survey of its staff, with 25,500 responding (a response rate of 29 per cent). This follows on from similar surveys in 2013 and 2016. For the first time results have been made available that identify separately the results of the medical and dental workforce. Issues from the 2018 survey, where the results for medical and dental staff were at least as positive as for the workforce as a whole, include:

- 65 per cent of medical and dental staff said that they look forward to going to work (compared with 60 per cent for the workforce as a whole);
- 24 per cent of staff said that during the last 12 months they had personally experienced harassment, bullying or abuse at work from patients or the public (21 per cent); and
- 73 per cent of staff said that they were enthusiastic about their job (73 per cent).

4.39 Issues from the 2018 survey, where the results for medical and dental staff were less positive than for the workforce as a whole, include:

- 63 per cent of staff said that they were satisfied with the support they got from their immediate manager (71 per cent);
- 33 per cent of staff said that during the last 12 months they had been injured or felt unwell as a result of work-related stress (34 per cent);
- 36 per cent of staff said that they could meet all of the conflicting demands on their time at work (49 per cent);
- 46 per cent of staff said that they had adequate supplies, materials and equipment to do their work (57 per cent);
- 18 per cent of staff said that there were enough staff at their organisation for them to be able to do their job properly (32 per cent); and

- 82 per cent of staff said that during the last 12 months they had had a Personal Appraisal and Development Review (PADR) (83 per cent).

Scotland

4.40 Between February and September 2018 Health & Social Care Staff in Scotland were surveyed, with 104,000 responding (a response rate of 59 per cent). This survey uses the same method and questionnaire as 2017 thus allowing comparisons between the two years to be made. The results cover the whole of the workforce and do not separately identify medical and dental staff. Key results include:

- 78 per cent of staff said that they had sufficient support to do their job well, an increase from 77 per cent in 2017;
- 81 per cent of staff said that their work gave them a sense of achievement, unchanged from 2017;
- 74 per cent of staff said that they felt appreciated for the work they do, an increase from 73 per cent in 2017;
- 71 per cent of staff said that their organisation cared about their health and wellbeing, an increase from 70 per cent in 2017; and
- 72 per cent of staff said that they got the help and support from other teams and services within the organisation to do their job, an increase from 71 per cent in 2017.

Our comments

4.41 Earnings for consultants remain above the 98th percentile of full-time earnings across the economy as a whole, while earnings for associate specialists, specialty doctors and registrars remain just above the 97th percentile, just below the 95th percentile and just above the 90th percentile, respectively. On a headcount basis, earnings for GMPs remain just under for the 98th percentile for contractors and in line with the 90th percentile for salaried GMPs, while earnings for providing-performer GDPs remain above the 98th percentile and above the 90th percentile for performer only GDPs. Estimates of GMP earnings on an FTE basis show contractor GMP earnings above the 98th percentile and salaried GMPs earnings just below the 97th percentile. However, compared with 2010-11, the latest data show that those in our remit group have lost ground against the relevant percentile earnings estimate in the most recent year for which earnings data are available.

4.42 We also make comparisons with those in other professional groups. Overall, despite a continued period of pay restraint, the pay levels of those in our remit group were not out of line with the comparator groups.

4.43 Some of the impact of the higher award made in Scotland in 2018 would be reduced by the higher taxation rates and lower income thresholds in Scotland. From April 2019 the higher rate of income tax in Scotland is 41 per cent (40 per cent in the rest of the UK), and applies from £43,430 (£50,000 in the rest of the UK).

4.44 The data on outflow remains mixed. The data for 2017-18 show no change in outflow rates for England, an increase for Scotland and a slight fall for Northern Ireland. We have heard evidence from several of the parties that changes to the NHS pension scheme, and the lowering of the thresholds of the pension annual and lifetime allowances, have led to an increase in the numbers retiring at an earlier age, from the more experienced, higher earning members of our remit group. Although the numbers of voluntary retirements for 2017-18 show an easing, compared with 2016-17, the numbers remain high compared with previous years.

4.45 With a quarter of all HCHS doctors being non-UK nationals and approaching 13 per cent of HCHS doctors joining the NHS in England coming from abroad, the recruitment and retention of international doctors remains important. The continuing uncertainty around the UK's future relationship with the EU has been reported to be having an effect on both the recruitment of future international medical and dental workforce, and retention of the current workforce.

4.46 The Staff Survey results in England for 2018 were generally less positive than in 2017. There was a sharp fall in satisfaction with pay which we believe reflects to some extent the decision taken by Government to stage and abate our 2018 recommendations. We are particularly concerned that the percentage of medical and dental staff experiencing harassment, bullying or abuse from patients, relatives or the public increased for the fourth year in a row, that there was a fall for the sixth year in a row of the numbers saying that there are enough staff at their organisation for them to do their job properly, that there was a sharp increase in the number reporting feeling unwell as a result of work related stress, and a sharp fall in the number saying they are able to meet the conflicting demands on their time at work.

4.47 It was helpful to have for the first time the results of the 2018 Welsh Staff Survey for medical staff only. We look forward to receiving this data again in the future to allow us to track changes over time. However, the value of the survey is diminished by not including a question about satisfaction with pay.

4.48 The results of the 2018 Scottish Staff Survey is of reduced value as it does not identify medical and dental staff separately.

CHAPTER 5: DOCTORS AND DENTISTS IN TRAINING

Introduction

5.1 Doctors in the UK begin their hospital training in Foundation Programmes, normally a two-year, general post-graduate medical training programme, where they are known as foundation doctors (FY1 and FY2). Following this training, doctors can either continue in the hospital sector or enter general practice training. Dentists undertake a training programme of at least five years study at dental school.

5.2 A new junior doctors' contract was introduced in England from October 2016. NHS Employers said that, in line with the commitment made in the 2016 Advisory, Conciliation and Arbitration Service (ACAS) agreement, NHS Employers, the British Medical Association (BMA) junior doctors' committee, and the Department of Health and Social Care (DHSC) formally began in August 2018 a review of the junior doctors' contract in England. As part of that process, negotiations on the outcomes of the review began in early 2019, involving all the parties. Although junior doctors in England are working to the new contract, those working in Scotland, Wales and Northern Ireland are still working on older contracts. Therefore, until the contract review and negotiations process is complete, we will continue to make recommendations for changes to national salary scales that will apply across the UK.

5.3 In September 2018 there were 64,500 doctors and dentists on a full-time equivalent (FTE) basis in hospital training in the UK, an increase of 0.9 per cent from 2017. Comparing September 2018 with 2017 there was an increase in the numbers in training in England (1.1 per cent), Northern Ireland (1.5 per cent[1]) and Wales (4.3 per cent) and a fall in Scotland (2.1 per cent).

Undergraduates

5.4 Graduation from one of the medical or dental schools in the UK is the main entry route to the NHS for doctors and dentists. A typical medical student will complete a 4 – 6-year medical graduate course, before beginning two years of hospital training in Foundation Programmes.

5.5 Tables 5.1 and 5.2 show time series from 2011 to 2018 for the numbers of applications[2], applicants[3] and acceptances[4] on pre-clinical medicine and pre-clinical dentistry courses.

5.6 In 2018 there were 21,570 applicants to study pre-clinical medical degrees in the UK who between them made 75,395 applications (an average of 3.5 applications per applicant). Of these, 8,620 were accepted on a course. Compared with 2017, this represents an increase in students accepted on to courses of 11 per cent and an increase in the number of applicants of 9 per cent.

[1] The figures for Northern Ireland are for March 2018 compared to March 2017.
[2] Number of applications: defined as a choice to a course in higher education through the UCAS main scheme. Each applicant can make up to five choices.
[3] Number of unique applicants: defined as the number of applicants making at least one choice through the main UCAS scheme.
[4] Acceptance: defined as an applicant who has been placed for entry into higher education.

Table 5.1: Numbers of applications, unique applicants and acceptances for medical degrees, UK, 2011-2018

	Number of Applications	Number of Unique Applicants	Number of Acceptances	Applications per Acceptance	Unique Applicants per Acceptance
2011	83,185	22,930	7,800	10.7	2.94
2012	81,260	22,285	7,805	10.4	2.86
2013	82,440	22,685	7,515	11.0	3.02
2014	84,850	23,365	7,680	11.0	3.04
2015	75,665	20,935	7,660	9.9	2.73
2016	74,860	20,815	7,830	9.6	2.66
2017	68,655	19,860	7,750	8.9	2.56
2018	75,395	21,570	8,620	8.7	2.50

Source: OME estimates using UCAS data.

5.7 In 2018 there were 3,040 applicants to study pre-clinical dental degrees in the UK who between them made 9,850 applications (an average of 3.2 applications per applicant). Of these 1,125 were accepted on a course. This represents a ratio of applicants to acceptances of 2.70. The number of applicants peaked at 3,820 in 2011, falling back each year until 2016 before increasing in 2017 and 2018 (by 5 per cent, compared with 2017). Compared with 2017, the number of acceptances in 2018, at 1,125, was little changed. Since 2014 the ratio of applicants to acceptances has fallen from 3.09 to 2.70.

Table 5.2: Numbers of applications, unique applicants and acceptances for dental degrees, UK, 2011-2018

	Number of Applications	Number of Unique Applicants	Number of Acceptances	Applications per Acceptance	Unique Applicants per Acceptance
2011	12,550	3,820	1,195	10.5	3.20
2012	11,630	3,515	1,195	9.7	2.94
2013	11,350	3,455	1,190	9.5	2.90
2014	11,210	3,410	1,105	10.1	3.09
2015	9,875	3,010	1,095	9.0	2.75
2016	9,060	2,810	1,100	8.2	2.55
2017	9,240	2,885	1,135	8.1	2.54
2018	9,850	3,040	1,125	8.8	2.70

Source: OME estimates using UCAS data.

5.8 For at least the last decade, Universities and Colleges Admissions Service (UCAS) data show that there have been consistently more female students than male students on pre-clinical medical and dental courses. In 2018 59 per cent of those accepted on to pre-clinical medical courses were female and 63 per cent of those on pre-clinical dentistry courses were female.

5.9 Table 5.3 shows the ten undergraduate subjects with the largest ratio of applications to acceptances in 2018. This shows that, despite the reduction in applications and applicants over the past four years, there is still a higher ratio of applications to acceptances to study medicine and dentistry than for any other subject.

Table 5.3: Subjects[5] with the highest ratio of applications to acceptances, United Kingdom 2018

Subject	Ratio of applications to acceptances 2018
Pre-clinical dentistry	8.8
Pre-clinical medicine	8.7
Artificial intelligence	8.3
Others in medicine and dentistry	7.2
Pre-clinical Veterinary Medicine	7.2
Anatomy, physiology and pathology	6.8
Biotechnology	6.8
Economics	6.4
Genetics	6.4
Astronomy	6.1

Source: OME estimates using UCAS data.

Junior doctors' contract reform in England

5.10 NHS Employers said that good progress had been made with the implementation of the new junior doctors' contract. Following the contract review which began in August 2018, in early 2019, NHS Employers and the BMA had entered into negotiations to agree the outcomes of the review (referred to in this report as 'the contract review'), and any necessary changes.

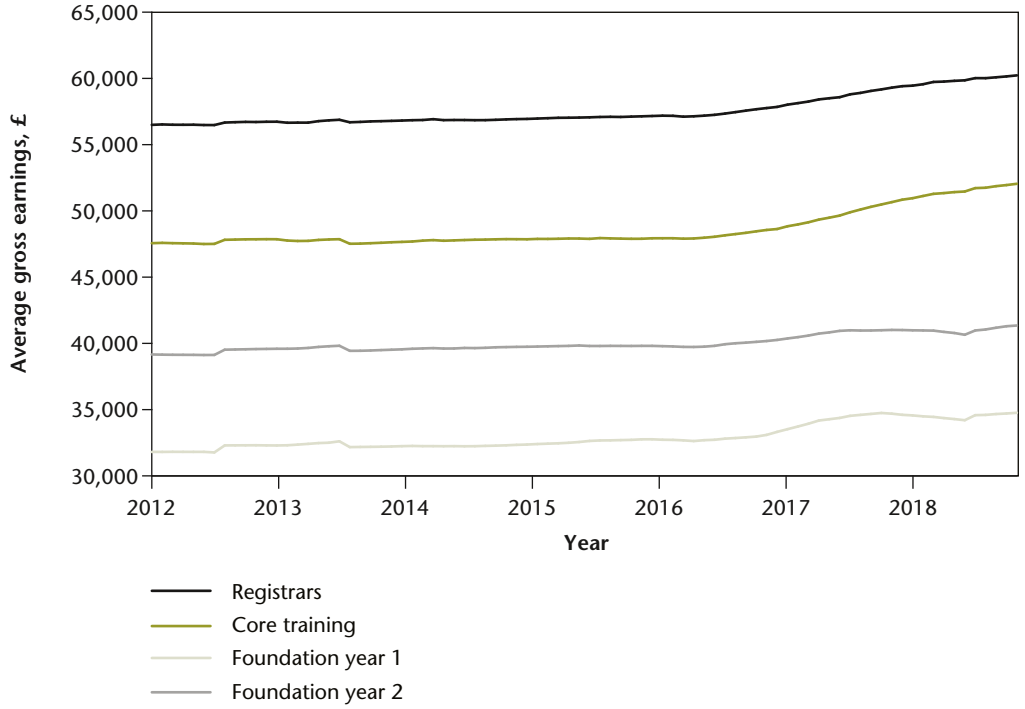
5.11 NHS Employers said that the parties had agreed the areas for consideration and set up sub-groups to consider themes including; pay and transitional arrangements, workforce, well-being and education and training.

5.12 NHS Employers said that the contract review would have a strong focus on safety and training. It recognised that improvement was needed on the reporting of missed training opportunities due to service pressures and that better data collection would be required.

5.13 Figures 5.1 and 5.2 show levels and growth in monthly average gross earnings of doctors in training, on a headcount basis, in England between 2012 and 2018. Figure 5.1 shows that the level of average gross earnings increased at each level since late in 2016, following the introduction of the new contract for doctors and dentists in training in England.

[5] This table only looks at subjects that had at least 100 acceptances in 2018

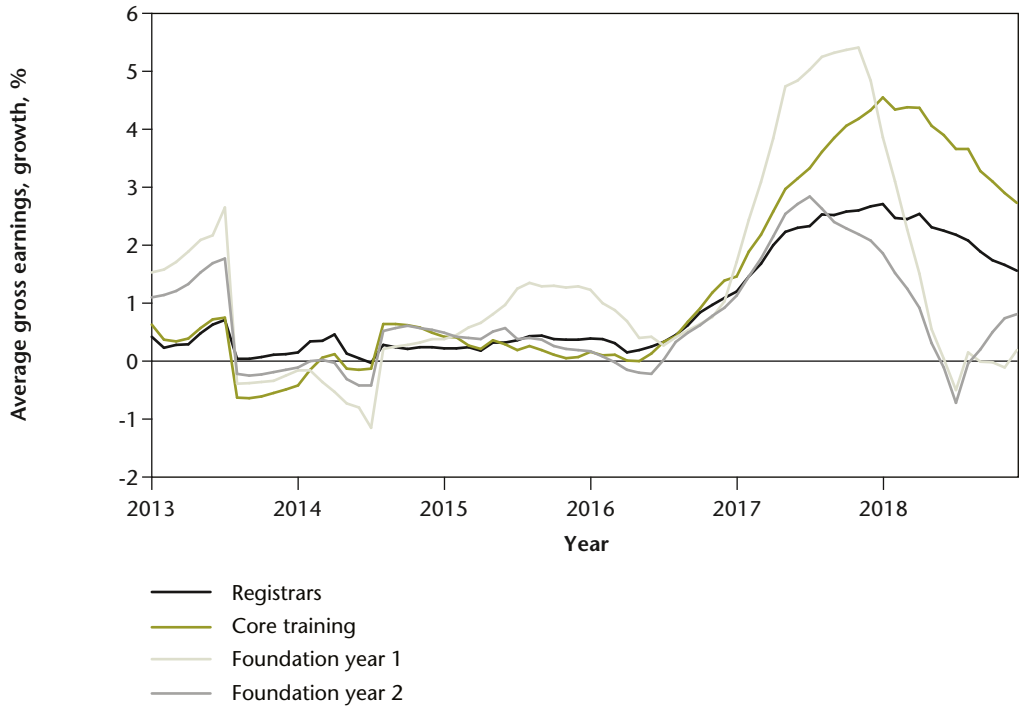
Figure 5.1: Monthly average gross earnings of doctors in training in England, headcount, 2012 to 2018



Source: NHS Digital.

5.14 Figure 5.2 shows that annual growth in monthly average earnings of doctors in training peaked at 5.4 per cent (November 2017) for FY1, 4.6 per cent (January 2018) for core training, 2.8 per cent (July 2017) for FY2 and 2.7 per cent (January 2018) for registrars. However, growth rates have since moderated, especially for FY1 and FY2, where growth rates were at or just below zero for part of 2018. Previously between 2011 and 2016, for both Foundation Years, the average total earnings for both years have moved slightly down, away from the 90th percentile and towards the median across the economy as a whole.

Figure 5.2: Growth in monthly average gross earnings of doctors in training in England, 2013 to 2018



Source: NHS Digital.

Flexible Pay Premia

5.15 The 2016 junior doctors' contract in England included flexible pay premia (FPP) for:

- general practice training, payable only during the practice-based period of GMP specialty training;
- hard-to-fill training programmes, initially emergency medicine and psychiatry;
- oral-maxillofacial surgery;
- clinical academic trainees;
- those taking time out for training for recognised activities deemed to be of benefit to the wider NHS.

5.16 A further pay premium to cover histopathology was introduced from 1 October 2018. The DHSC said that in 2018-19 the combined cost of these premia was forecast to be 1.9 per cent of the junior doctors' paybill, or £67 million, 70 per cent of which was accounted for by those on general practice training programmes. The current values of these flexible pay premia are set out in Table 5.4.

Table 5.4: Flexible pay premia in England, 2018

	Full time annual value (£)
General practice	8,448
Psychiatry core training	3,434
Psychiatry higher training (3 year)	3,434
Psychiatry higher training (4 year)	2,576
Histopathology	4,121
Academia	4,121
Emergency medicine/Oral & maxillofacial surgery: (Length of training programme)	
3 years	6,868
4 years	5,151
5 years	4,121
6 years	3,434
7 years	2,944
8 years	2,576

Source: NHS Employers, Pay and Conditions Circular (M&D) 3/2018.

5.17 NHS Employers said that the pay premia for GMP training and some other hard-to-fill programmes had been established to reduce pay disadvantages that could deter trainees from entering these programmes. They added that the contract had been in place for two years, and an analysis of both fill rates and retention figures would be necessary to assess whether premia were operating as intended. In October 2018, a new premium for histopathology had been introduced.

5.18 NHS England noted that the review body had been asked to consider targeting pay either by extending the current flexible pay premia or establishing new premia to address geographical challenges. In response it said that it did not feel that there was a sufficiently well-developed evidence base to justify targeting pay in this way, particularly within the current pay envelope.

5.19 The DHSC agreed with NHS Employers that the pay premia for hard-to-fill training programmes and GMP specialty training that were part of the 2016 contract had been designed to ensure that there were no pay disincentives to deter trainees from entering those programmes.

Recruitment and training choices

England

5.20 Health Education England (HEE) supplied data showing the fill rates for various training programmes between 2016 and 2018 (Table 5.5). Over the period 94 per cent of post-foundation years' training posts were filled. Fill rates varied by specialty, with the lowest fill-rates in 2018 being in core psychiatry training (68 per cent), histopathology (82 per cent) and paediatrics (88 per cent).

Table 5.5: Fill rates for post-foundation years' training posts, England 2016 to 2018

Training Programme	Posts recruited to (average)	Fill rates (%)
	2016-18	2016-18
Clinical Radiology	228	100
Neurosurgery	28	100
Ophthalmology	64	100
Core Surgical Training	505	100
Public Health Medicine	72	100
Obstetrics and Gynaecology	232	99
ACCS/Core Anaesthetics	537	98
General Practice	3,108	96
ACCS – Emergency Medicine	302	96
ACCS Acute Medicine/Core Medical Training	1,340	94
Paediatrics	367	88
Histopathology	61	82
Core Psychiatry Training	376	68
Total		94

ACCS – Acute Care Common Stem.
Source: Health Education England.

5.21 The Hospital Consultants and Specialists Association (HCSA) expressed its concern that a rising number of trainees were leaving training to fill non-training 'trust grade' or 'clinical fellow' roles, which had no national oversight, and it believed these doctors would not follow the route to becoming future consultants.

5.22 HEE said that it recognised the need for a flexible approach to training and that all trainees progress at different rates. It described its plans to develop a mechanism for assessing competencies at different stages during training, which would allow them to step off training pathways, consolidate training or progress faster when they were gaining competencies and experience.

Wales

5.23 The Train Work Live (TWL) marketing campaign continues to promote the benefits of working as a doctor in Wales, and is currently in its third year of the medical phase, which went live in October 2018. The medical phase retains its focus on GMPs, psychiatrists and core medicine. It has also been extended to included intensive care medicine.

Scotland

5.24 The Scottish Government told us that the recruitment arrangements for 2018 were the same as the previous year. Applications to UK recruited specialties were managed by a national lead for the specialty, either a Royal College, NHS Education for Scotland (NES), Northern Ireland Medical and Dental Training Agency, or HEE on behalf of the UK. The recruitment ran to a nationally agreed timetable to allow the synchronisation of application dates, interviews and offers, providing consistency for candidates. This UK-wide recruitment process provided candidates across the UK with a consistent and fair recruitment process working to nationally agreed processes and timetables.

5.25 There were a small number of vacancies which were only recruited to within Scotland and managed by NES. These included the introduction of the Broad-Based Training programme 12 advertised and filled posts, and the Improving Surgical Training pilot with 100 per cent fill rate of 47 posts. Local processes again resulted in 100 per cent fill rates in Trauma and Orthopaedic Surgery level 1 (15 posts), and 100 per cent in Obstetrics and Gynaecology level 3 (7 posts).

5.26 The Scottish Government also told us that, in line with its aim to support and sustain Scottish General Practice, for the third year running it had taken part in a further round of national GP specialty training (GPST) recruitment. The overall number of GPST places advertised was 347 and this resulted in a fill rate of 84 per cent of the establishment of 1,184.

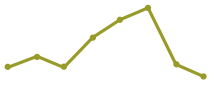
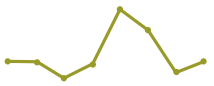
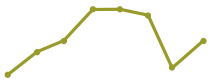
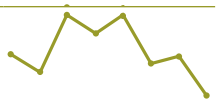
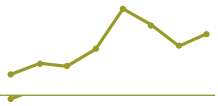
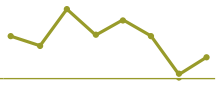
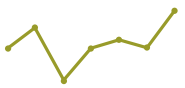
Motivation

England

5.27 In Chapter 4 we reported on the results of the 2018 Staff Survey. It showed that 41 per cent of doctors and dentists in training expressed satisfaction with their pay (compared with 53 per cent in 2011), a greater percentage than SAS doctors but smaller than for consultants. Like doctors overall, the level of satisfaction was at its lowest level since at least 2011.

5.28 Job satisfaction indicators for doctors and dentists in training in 2018, compared to 2017 were mixed (Table 5.6). There were falls in the percentage saying that they looked forward to going to work and the opportunities to use their skills, although there were increases in the percentage saying they were enthusiastic about their job, the amount of responsibility they were given, and the extent to which the organisation valued their work. In addition, the percentage of doctors and dentists in training saying they had experienced harassment, bullying or abuse from patients increased to its highest level since the question was first asked in 2012.

Table 5.6: Selected results from the National Staff Survey, doctors and dentists in training, England, 2011 to 2018

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	Trend[1]
I look forward to going to work	64.2	64.8	64.1	65.8	66.8	67.4	64.4	63.8	
I am enthusiastic about my job	76.7	76.7	75.6	76.4	80.4	79.0	76.0	76.6	
Time passes quickly when I am working	80.6	78.1	79.2	80.7	83.2	79.4	79.1	79.1	
The recognition I get for good work	55.2	57.8	59.3	62.6	62.8	62.0	56.3	59.1	
The support I get from my immediate manager	75.6	73.8	79.4	77.7	79.3	74.5	75.4	71.4	
The support I get from my work colleagues	84.3	85.0	85.1	86.3	89.3	88.2	86.6	87.4	
The amount of responsibility I am given	81.4	80.7	83.4	81.6	82.7	81.6	78.7	80.1	
The opportunities I have to use my skills	78.5	79.0	82.3	80.9	81.9	79.6	79.2	78.5	
The extent to which my organisation values my work	39.4	49.9	51.0	52.4	48.8	50.9	48.8	51.4	
My level of pay	52.9	51.6	50.0	51.0	43.6	45.2	41.6	40.8	
Percentage of staff appraised in the last 12 months	77.7	81.1	82.2	81.5	77.7	81.8	78.4	79.6	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.6	36.8	31.3	34.6	35.3	34.6	38.6	

Source: National NHS Staff Survey.

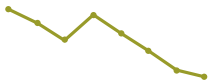
Notes: Data rounded to 1 decimal place.

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

[2] *Lower scores are better in these cases, however, in all other cases, higher scores are better.*

5.29 Junior doctors were generally more negative about work pressures than in 2017 (Table 5.7). There were reductions in the percentage of doctors and dentists in training reporting that they were able to meet all the competing demands on their time, that they had adequate materials, and that there were enough staff at the organisation. Also, there was an increase in the percentage saying that they had felt unwell as a result of work-related stress. There was evidence of improved practice on working hours beyond those that were contracted, with an increasing proportion of junior doctors reporting that these hours were paid, and a decreasing proportion reporting that they were unpaid.

Table 5.7: Selected results from the National Staff Survey, doctors and dentists in training, England, 2011 to 2018

Workload	2011	2012	2013	2014	2015	2016	2017	2018	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	28.5	34.7	34.4	37.3					
I am able to meet all the conflicting demands on my time at work[4]					43.4	45.7	43.8	38.9	
I have adequate materials, supplies and equipment to do my work	71.4	64.7	62.8	67.6	60.5	63.2	60.8	58.4	
There are enough staff at this organisation for me to do my job properly	47.1	44.0	40.2	45.7	42.2	38.6	34.3	32.9	
During the last 12 months have you felt unwell as a result of work related stress[2]		26.5	30.1	30.8	34.0	32.3	35.5	38.1	
Percentage of staff working PAID hours over and above their contracted hours[2]	28.5	33.8	32.8	30.8	36.2	34.1	38.2	41.0	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	68.0	71.9	75.5	72.9	83.1	77.4	75.5	70.8	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

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

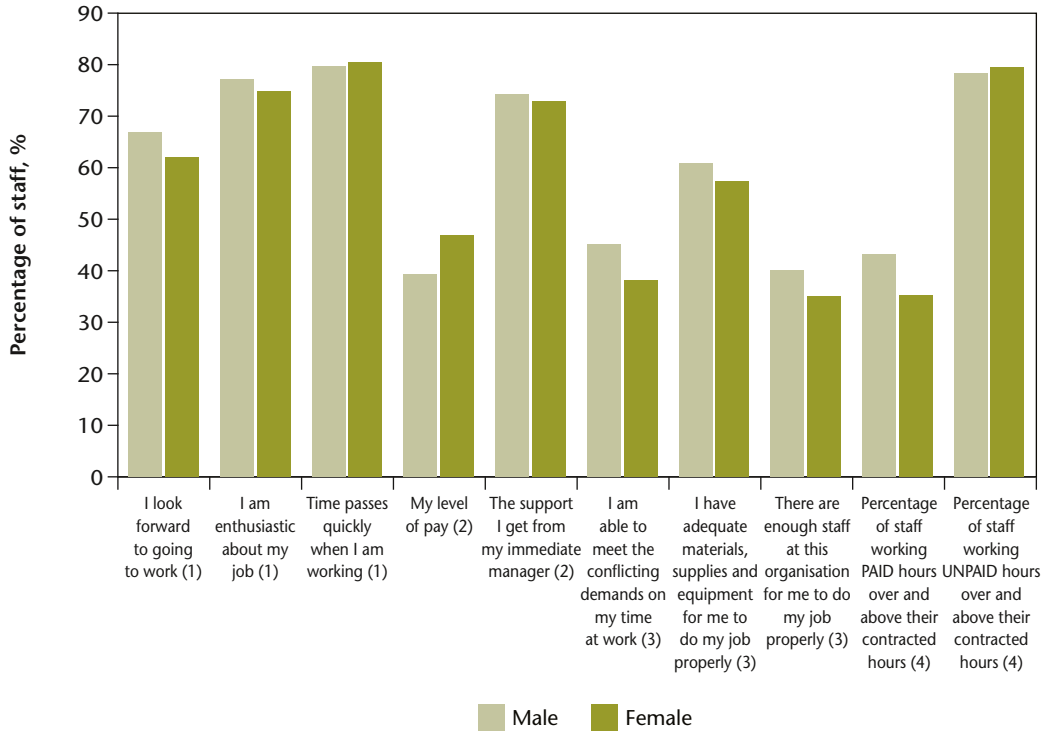
[2] *Lower scores are better in these cases, however, in all other cases, higher scores are better.*

[3] *For 2015, this question was reversed to "I am able to meet…"*

[4] *This question was introduced in 2015.*

5.30 Figure 5.3 shows that female doctors and dentists in training are more satisfied with their pay than their male colleagues. However, compared with female doctors and dentists in training, male doctors were more likely to say that they looked forward to going to work, were enthusiastic about their job, were able to meet the conflicting demands on their time, that they had adequate materials to do their job and that there were enough staff at their organisation. Male doctors and dentists in training were more likely to work paid hours over and above their contracted hours, while female doctors were slightly more likely to work extra unpaid hours.

Figure 5.3: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by gender, England, 2018



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours

Scotland

5.31 The Scottish Government said that it had continued to take action to improve the working lives of junior doctors. Actions had included maintaining compliance with the Working Time Regulation average 48 hour working week, changing rotas to make them safe, and abolishing the practice of junior doctors working seven nights in a row. The Scottish Government said that, in partnership with the BMA and employers, it had implemented a minimum rest period of 46 hours after any period of full night shift working, and achieved an 85 per cent compliance rate by November 2018.

5.32 The most recent staff survey results for Northern Ireland were published before our 45th Report 2017, so there is no new data to report on since our last report. The latest published Wales and Scottish staff surveys, published earlier in 2018, are not available in sufficient detail to identify junior doctor level results.

Our comments

5.33 We have noted that work on the junior doctors' contract review in England started in August 2018, and negotiations on the outcomes are underway. We welcome the fact that negotiations are in progress and we hope that they will lead to a satisfactory outcome. In the meantime, as the review and negotiations process is not complete, we have not sought in this report to make observations about matters which may be subject to negotiation.

5.34 We were heartened to hear that there has been an increase in the number of applicants for pre-clinical medical and dental degrees, although we have no information on the 'A' level scores of entrants to courses to enable an assessment of whether the increasing numbers have adversely affected the quality of the intake. There has also been an increase in non-EU recruitment, and it is not clear whether this is due to recent changes in immigration rules. We have made some general comments elsewhere in this report about the impact of the continuing uncertainty around the UK's future relationship with the EU, and these concerns apply particularly to doctors in training who are EU nationals working in the UK, and the recruitment of future EU nationals.

5.35 The issue of stepping out temporarily from service and training was raised by several of the parties. There appear to be two schools of thought on the value and utility of this practice. The positive arguments are that it reflects the career choices and aspirations of a younger generation that does not want to work in the same way as its predecessors and wants to have a better work/life balance. It is argued that stepping out temporarily from service can be helpful for 'lifestyle' reasons, for example to travel before settling down more permanently, or to enable indebted junior doctors to increase earnings and hence pay off accumulated student debt.

5.36 Alternatively, it has been presented as a mechanism to deal with 'burnout', because workforce shortages have made training too gruelling, or as a result of lack of availability of training places in the desired specialties or locations.

5.37 It was also argued that the practice of stepping out temporarily from service, particularly after the foundation years, deprived the NHS of several crucial years of career work by doctors. Although stepping out temporarily can usually be planned for, it could have an effect on the efficiency of long-term workforce planning, putting additional pressure on trusts and increasing the spend on agency staff. This might be tempered to the extent that – if indeed it is the case – the doctors concerned were operating as locums somewhere within the UK's NHS system.

5.38 We were not clear whether the extent of stepping out temporarily from service represented a genuine problem. We observed that, to the extent that a good proportion of trainees step back in, any problem might be smaller than it is sometimes presented. We also heard an argument that the tendency to step out temporarily may be a recognition of the increasing reluctance of the younger part of the workforce to see their careers in a linear form. For the moment, the area feels under-researched. The review body welcomed the intention of HEE to facilitate the smoother exit and return of trainees by improving the competency validation and assessment process.

5.39 Our attention has been drawn to information published by HEE[6] about the recruitment-rates for specialties, including those that attract FPP, but most particularly the rates for histopathology, to which DDRB gave special attention last year. It indicates that there was a 100 per cent application rate in 2019 (for 75 posts) compared to 47 per cent (39 out of 83 posts) in 2018. These figures must, however, be read in context: they provide a comparison to the applications received at the same stage of the process in 2018. While some specialties complete recruitment after this round, others continue to recruit and therefore the number of trainees in these areas will rise as a result of a further round of recruitment (ACCS Emergency Medicine, Core Psychiatry, General Practice, Internal Medicine, Obstetrics and Paediatrics). However, the figures should be treated with caution, as applicants can – and do – change their preferences during the course of the year. At this stage, they are an indication of how well recruitment has progressed within each specialty, and not as the last word on the final outcomes.

5.40 We discuss dentists in training in more detail in Chapter 9.

[6] https://www.hee.nhs.uk/our-work/medical-recruitment/specialty-recruitment-round-1-acceptance-fill-rate

CHAPTER 6: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS (SAS)

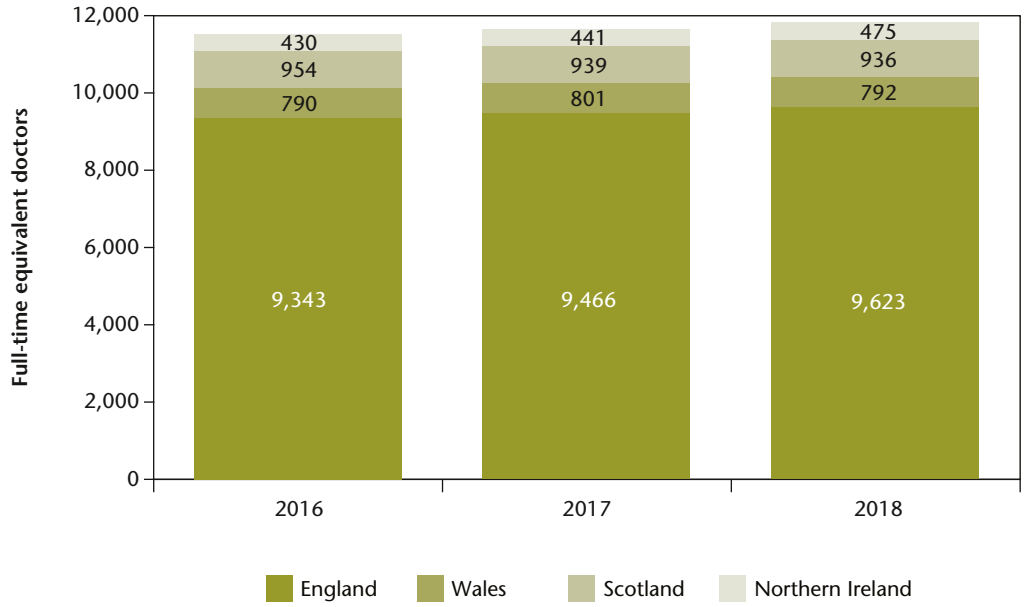
Introduction

6.1 This chapter covers specialty doctors and associate specialists (SAS). This is 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. SAS doctors are important contributors to health service provision across the UK.

6.2 In September 2018[1] there were 11,826 full-time equivalent (FTE) specialty doctors, associate specialists and staff grades (SAS) in the UK, around 11 per cent of the hospital doctor workforce. In 2018, compared with 2017, the number of SAS doctors increased by 1.5 per cent, with increases in Northern Ireland (7.7 per cent), England (1.7 per cent) but fell in Scotland (0.4 per cent) and Wales (1.1 per cent).

6.3 Data from NHS Digital, for England only, give a breakdown of the remit group by gender and ethnicity. The data show that 45 per cent of SAS doctors were female, compared with 36 per cent of consultants. SAS doctors contained a higher proportion of BAME staff, with fewer than 40 per cent identifying as white, compared with close to 60 per cent for consultants.

Figure 6.1: Number of specialty doctors, associate specialists and staff grades in the Hospital and Community Health Services, United Kingdom, 2016 to 2018



Source: NHS Digital, StatsWales, ISD Scotland, Department of Health Northern Ireland.

[1] Northern Ireland data are as at 31 March each year.

Recruitment and retention

6.4 In March 2019, Health Education England (HEE) and NHS Improvement (NHSI) launched their report setting out how SAS doctors in England would benefit from improved support and development opportunities. Maximising the potential: essential measures to support SAS doctors[2] sets out the commitments from stakeholders, including NHS Employers, to improve the opportunities for SAS doctors to advance as clinicians and leaders.

6.5 This strategic approach to SAS development would raise awareness of SAS doctors and provide mechanisms to ensure they would be effectively developed, supported and deployed to deliver high-quality patient care. NHS Employers said that the SAS Charter already set out a range of recommendations around recruitment, contracts, job planning, support, development and involvement in local management and organisational structures.

6.6 NHS Employers said that, of those employers who replied to their survey, 71 per cent thought that a new contract could help with recruitment and retention in the SAS grades, including the potential for career development. Previous survey data showed that employers had difficulties recruiting to SAS posts, particularly in emergency medicine, psychiatry and paediatrics. NHS Employers felt that a new contract would provide important opportunities for SAS doctors to progress their careers.

Career development

6.7 On our visits during 2018 we heard from SAS doctors across the UK. The feeling among SAS doctors had changed little since our report of last year. Despite the recognition given by DDRB in its report, many reported feeling undervalued in their work, with a lack of development opportunities. Some felt marginalised by management from leadership opportunities and overlooked when training was considered. By contrast, we were told by SAS doctors in Scotland that there seemed to be greater recognition of the role and a better work/life balance. Many SAS doctors said they would welcome the reopening of an associate specialist grade, since they felt that there was now no recognition of SAS seniority in either pay or name. SAS doctors wanted recognition of their value and adequate remuneration in their existing grade, rather than being asked to retrain as consultants, which they felt would likely add to already heavy workloads and could adversely affect their work-life balance.

England

6.8 DHSC England said that the Secretary of State's letter of 18 September 2018 to the BMA[3] made clear that he wanted to see the valuable role of SAS doctors recognised in their contractual arrangements, and in the development and support they receive. He committed to working with the SAS Committee to reforming the SAS contract and agreed in principle to reopening the Associate Specialist grade to improve career development prospects.

6.9 HEE acknowledged that many doctors chose a career as a SAS doctor and that they made a significant contribution to patient care and service delivery. However, it also said that some had not seen SAS doctor roles as a separate career pathway. HEE said that doctors increasingly stress the need for greater flexibility in their career structure, and that a typical career pathway could involve moving in and out of training and spending time in SAS grade roles.

[2] https://www.hee.nhs.uk/sites/default/files/documents/SAS_Report_Web.pdf
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746966/matt-hancock-letter-to-dr-chaand-nagpaul-september-2018.pdf

Wales

6.10 The Welsh Government referred again to the SAS Charter for Wales, published in August 2016, which highlighted the commitment of employers in NHS Wales to providing an appropriate agreed job plan relevant to their role within the service and individual specialised skills. A SAS reference group for Wales was reviewing the numbers of SAS staff with job plans.

Scotland

6.11 The Scottish Government said that the SAS grade doctors were an important part of the senior medical workforce and that it ensured that the aims and objectives of the SAS Doctors Development Programme, and the £500,000 per annum financial support it provided, were fulfilled. The funding supported costs such as salary backfill, or completion of training to apply for a Certificate of Eligibility for Specialist Registration (CESR). The funding also enabled the appointment of an Associate Postgraduate Dean (a SAS Doctor) to leadership of the programme, and a national network of SAS doctors and dentists as Educational Advisors to support SAS doctors. The Scottish Government said that the SAS Charter and the SAS Development Programme supported SAS doctors during their ongoing career and professional development.

Motivation

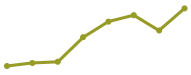
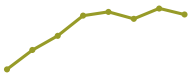
England

6.12 In Chapter 4 we reported on the results of the 2018 Staff Survey. It showed that 37 per cent of SAS doctors expressed satisfaction with their pay, a smaller percentage than for other groups. Like doctors overall, SAS doctors' satisfaction with pay was at its lowest level after a six per cent drop since 2011.

6.13 Job satisfaction generally declined for SAS doctors in 2018, compared to 2017 (Table 6.1). There was an increase in the percentage saying that they looked forward to going to work, were enthusiastic about their job and were satisfied with the recognition they got for good work. However, there were declines in satisfaction with the support received from managers and colleagues, the amount of responsibility given, and opportunities to use their skills. In addition, the percentage of SAS doctors saying they had experienced harassment, bullying or abuse from patients increased for the fourth consecutive year.

6.14 Workload pressures show little sign of improving (Table 6.2). Although in 2018, compared with 2017, there was an increase in the percentage of SAS doctors saying they were able to meet all the conflicting demands on their time at work, there were also reductions in the percentage of SAS doctors saying they had adequate materials to do their job and that there were sufficient staff at their organisation. There were increases in the percentage of SAS doctors saying that they worked extra hours over those contracted for, both paid and unpaid, and an increase in the percentage reporting feeling unwell as a result of work-related stress.

Table 6.1: Selected results from the National Staff Survey, SAS doctors, England, 2011 to 2018.

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	Trend[1]
I look forward to going to work	62.8	63.2	63.3	66.3	68.3	69.0	67.2	69.8	
I am enthusiastic about my job	72.6	75.1	73.8	77.4	79.2	78.3	77.0	79.0	
Time passes quickly when I am working	78.6	78.8	79.8	82.0	83.3	82.7	80.7	80.5	
The recognition I get for good work	51.8	50.7	50.4	55.3	55.4	58.1	56.6	57.7	
The support I get from my immediate manager	64.7	65.3	65.1	70.3	67.8	70.2	67.0	64.4	
The support I get from my work colleagues	78.7	79.7	79.1	81.0	82.1	84.1	84.2	82.1	
The amount of responsibility I am given	77.4	80.1	75.4	77.9	78.0	77.9	77.7	76.9	
The opportunities I have to use my skills	72.6	76.0	71.3	75.4	74.8	73.8	74.1	71.8	
The extent to which my organisation values my work	37.8	45.1	44.4	50.7	46.1	50.3	48.0	48.0	
My level of pay	42.5	43.7	42.4	41.4	42.9	46.2	42.9	36.8	
Percentage of staff appraised in the last 12 months	74.5	79.8	83.7	89.2	90.3	88.3	91.2	89.5	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		33.9	31.1	32.1	30.9	32.6	33.8	33.8	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

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

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

6.15 SAS doctor satisfaction with pay was similar by gender (Figure 6.2). However, compared with female SAS doctors, male SAS doctors were more likely to say that they looked forward to going to work, were enthusiastic about their job, were able to meet the conflicting demands on their time and had adequate materials to do their job. Male SAS doctors were more likely to work hours over and above their contracted hours, especially paid hours, than their female colleagues.

Table 6.2: Selected results from the National Staff Survey, SAS doctors, England, 2011 to 2018.

Workload	2011	2012	2013	2014	2015	2016	2017	2018	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	35.2	36.0	37.9	39.6					
I am able to meet all the conflicting demands on my time at work[4]					45.8	44.8	42.0	44.4	
I have adequate materials, supplies and equipment to do my work	63.4	63.9	64.2	65.0	60.5	61.7	62.6	60.0	
There are enough staff at this organisation for me to do my job properly	38.3	40.4	39.2	38.3	37.2	37.7	34.7	33.5	
During the last 12 months have you felt unwell as a result of work related stress[2]		34.9	36.8	31.3	32.4	32.2	34.6	37.9	
Percentage of staff working PAID hours over and above their contracted hours[2]	27.4	30.7	31.0	33.1	32.0	33.3	33.7	35.6	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	56.9	61.0	62.1	62.4	65.9	67.5	66.8	67.6	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

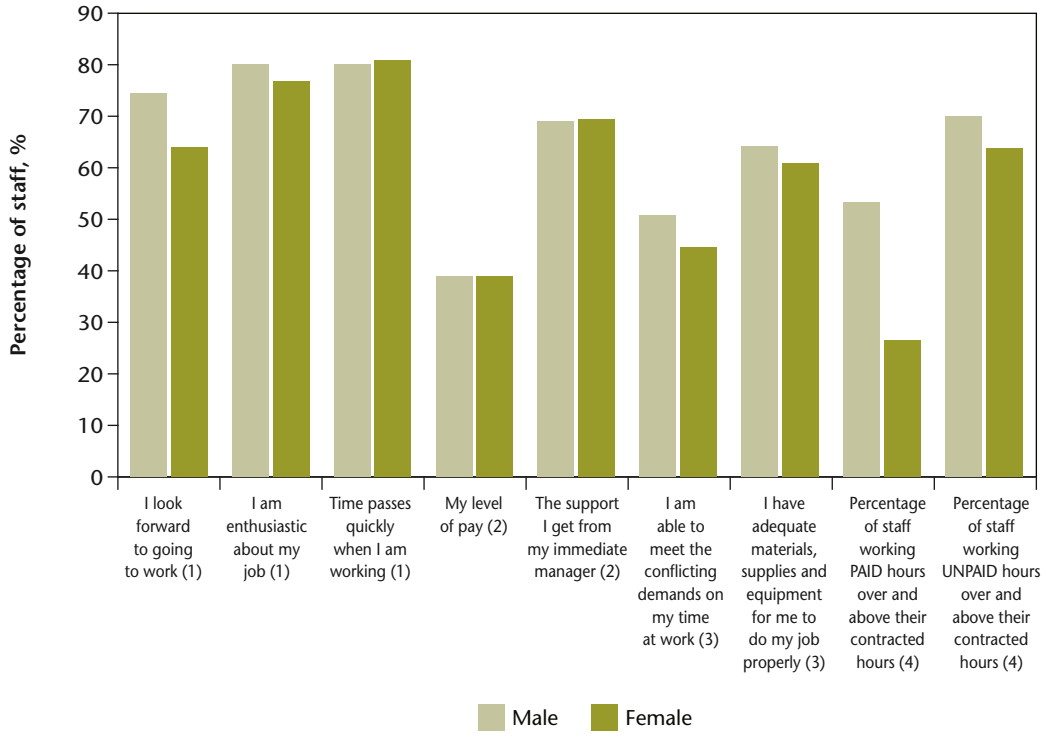
(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) For 2015, this question was reversed to "I am able to meet…"

(4) This question was introduced in 2015.

Figure 6.2: HCHS SAS (other) doctors' satisfaction with aspects of the job and work pressures by gender, England, 2018



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always".
(2) Staff responding "satisfied" or "very satisfied".
(3) Staff responding "agree" or "strongly agree".
(4) Staff indicating one or more additional hours.

6.16 The most recent staff survey results for Northern Ireland were published before our 45th Report 2017, so there is no new data to report on since our last report. The latest published Wales and Scottish staff surveys, published earlier in 2018, are not available in sufficient detail to identify SAS doctor level results.

6.17 NHS Employers told us that recent staff surveys had reported a significant level of dissatisfaction within the SAS grades and in August 2017, it undertook a survey to identify the issues affecting the SAS workforce from an employer perspective. The BMA also carried out a survey of its members from the SAS workforce. The results of both surveys included concerns about:

- bullying and harassment;
- career development and progression;
- morale and job satisfaction;
- job planning and workload;
- pay;
- recruitment and retention; and
- recognition and status.

Contract reform

England

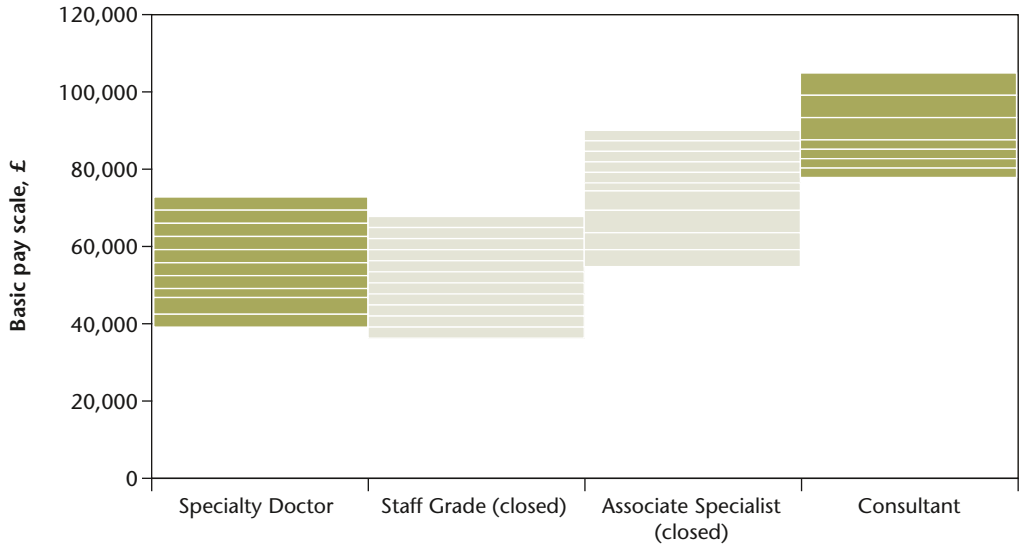
6.18 NHS Employers said that it would be engaging with employers and stakeholders in early 2019, to determine what elements of the contract could be reformed to improve the morale, recruitment and retention of the SAS workforce. It would also be assessing the commitments published in the HEE – NHSI report to determine if they would meet the challenges of improving the employment, development and utilisation of the SAS workforce, or whether the recommendations should form part of wider contract reform.

6.19 The Hospital Consultants and Specialists Association (HCSA) said that it expected the SAS contract review to begin in 2019-20 and would look forward to being engaged in the process.

6.20 NHS Providers said that of the HR directors responding to their survey, 61 per cent said that they would be in favour of reintroducing the associate specialist grade. Greater value for money of the contract, around direct patient care and flexibility to recruit to roles in hard-to-fill specialties where consultant posts were unavailable, were some of the benefits of the grade.

6.21 Figure 6.3 shows the basic pay scales for specialty doctors and consultants in England, from October 2018, compared to the closed staff and associate specialist grades. This shows that the current specialty doctor pay scale is much more in line with the previous staff grade scale than with the associate specialist scale, and that the possible maximum pay point for doctors joining the specialty doctor grade today is £17,300 lower than the maximum pay point of the associate specialist grade, severely limiting the potential earnings of the SAS career path. Today an experienced specialty doctor on the top of the scale will earn £5,100 less in basic pay than a newly appointed consultant, whereas previously the specialty doctors had the potential to generate earnings similar to a consultant with 5 years' experience by being promoted to an Associate Specialist.

Figure 6.3: Specialty doctor, staff grade, associate specialist and consultant basic pay scales, England, 2018



Source: OME analysis of NHS pay scales.

Scotland

6.22 The Scottish Government said that while there were clearly existing mechanisms in place to support SAS grades, it recognised the benefits of discussion on whether more could be done in this area. The Government continued to say that around half of the Scottish respondents to the BMA's SAS Charter survey reported that they had had either no time, or not enough time in recent months, for professional development.

Our comments

6.23 In 2018 the review body recommended that SAS doctors received particular attention, reflected in the award recommendation of 3.5 per cent, although at the time of submitting this present report only the Welsh Government had implemented the recommendations in full. Since the last report there appears to have been some movement on the issues of SAS doctors. This is something on which the DDRB has been pressing for some time, so we welcome this news. We learnt, from the Secretary of State's letter of September 2018 to the BMA, that the DHSC was looking at reopening, or possibly creating a new version of, the associate specialist grade, and that the minister had committed to working with the SAS Committee. Although opinions seemed to differ on how far this work had progressed, it represents a good start on the road to invigorating this small but important group of senior doctors.

6.24 HEE told us that many doctors choose to be a SAS doctor, and provide a significant contribution to patient care and service delivery and that it is committed to improving career and development opportunities for SAS doctors. Moreover, HEE also says there would be a benefit in offering the SAS role as part of a flexible career pathway, and enabling 'step off and step on' training pathways, which, in HEE's view, would help to increase retention.

6.25 The review body noted that SAS roles are often more focused on service delivery than other elements of the medical and dental workforce, and they play an important role in addressing pressures and gaps at multiple levels. Many of the staff in the SAS group are highly experienced and are able to carry out specialist procedures efficiently and effectively in a way that helps towards overall productivity and relieves some of the burden on the consultant workforce. Furthermore, SAS doctors are the most diverse branch of the medical workforce, with over half from a black, Asian or minority ethnic (BAME) background and a large proportion having trained overseas. The review body noted that SAS doctors play a vital role in delivering high quality care within health teams and will be integral to the delivery of the NHS Long Term Plan.

6.26 As a general principle, we welcome anything which might be done to reflect the importance of the work carried out by SAS doctors, and we would urge that appropriate attention is given to pressing forward with the commitments contained in the recent HEE-NHSI guidance. However, we are not reassured by the fact that little seems to have been done to promote and embed the SAS charters. We would urge that such plans are not only given emphasis, but are implemented as soon as possible.

6.27 The review body feel that there remains considerable untapped potential in respect of SAS doctors undertaking duties currently undertaken by consultants, to both boost motivation and increase productivity, and consider further investment is needed to raise the profile and attractiveness of this important and often under-valued group.

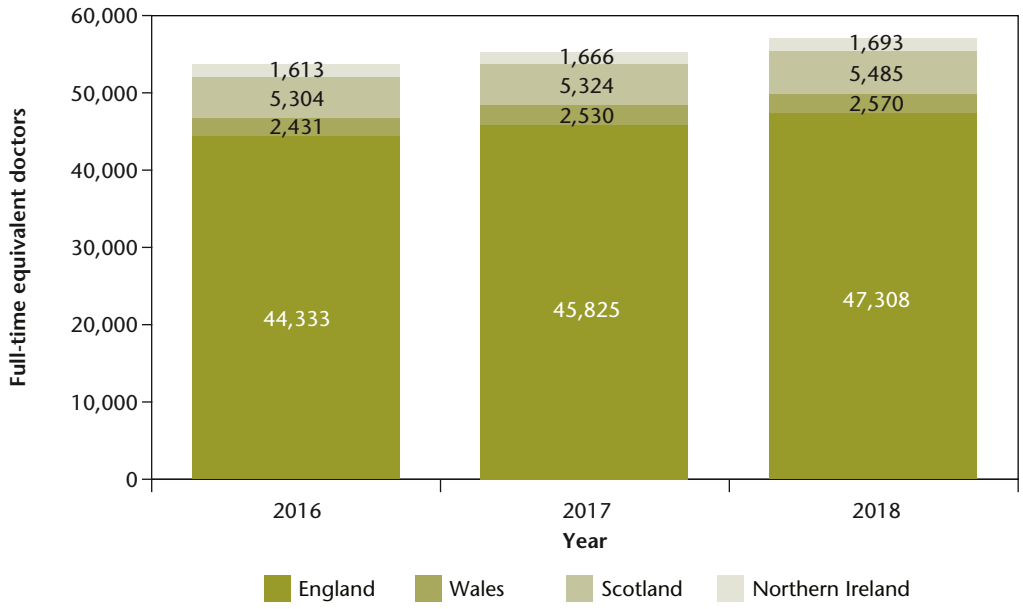
CHAPTER 7: CONSULTANTS

Introduction

7.1 This chapter covers consultants, the main career grade in hospitals.

7.2 In September 2018[1], on a full-time equivalent (FTE) basis, there were 57,056 consultants in the United Kingdom, an increase of 3.1 per cent from a year earlier (Figure 7.1). All countries in the UK experienced an increase: 3.2 per cent in England, 3.0 per cent in Scotland, 1.6 per cent in each of Wales and Northern Ireland.

Figure 7.1: Number of consultants in the Hospital and Community Health Services (HCHS), United Kingdom, 2016 to 2018



Source: NHS Digital, ISD Scotland, StatsWales, Department of Health Northern Ireland.

Recruitment and retention

England

7.3 NHS Providers said that trusts have faced issues attracting doctors within certain specialties. It said that Health Education England (HEE) acceptance and fill rate data from 2017 showed between 8 and 10 per cent of training posts in acute and emergency medicine training programmes were unfilled. The 35 per cent rate of unfilled posts in core psychiatry training was exacerbated by retention issues, and NHS Providers considered that one-third of consultant psychiatrists would be working outside the NHS within five years of completing specialist training. NHS Providers also said that there was an overarching challenge responding to the large-scale retirement of senior doctors.

7.4 NHS Providers said that the age profile of the medical workforce was a challenge for trusts, with 23 per cent of consultants aged over 55, many of whom were seeking to reduce their working hours. It said it hoped that the NHS Long Term Plan, launched in January 2019, would consolidate some of the national retention programmes.

[1] Northern Ireland data are at March 31 for each year.

7.5 The Hospital Consultants and Specialists Association (HCSA) said that changes to the NHS Pension lifetime allowance (LTA) and annual allowances (AA) were affecting the behaviour of senior doctors by disincentivising additional shifts (which it says would become effectively unpaid), and incentivising early retirement plans. HCSA recommended a joint task force, involving the NHS, Department of Health and Social Care (DHSC), HCSA and the British Medical Association (BMA) to investigate the issues surrounding early retirement and those at the start of their careers who may be looking at leaving the NHS earlier than expected.

7.6 HEE provided data that showed, as at September 2017, a total consultant shortfall of 3,756 (7.7 per cent). Table 7.1 focuses on those specialties where the total shortfall identified was equal to or exceeded 50 FTEs *and* the vacancy rate was equal to or exceeded 7 per cent.

Table 7.1: Consultant shortfall by HEE region and specialty, England, September 2017

			Shortfall % of establishment				
Specialty	Establishment FTE	Shortfall FTE	England	North	Midlands & East	London	South
General and acute medicine	1,455	330	23	30	28	12	14
Emergency medicine	2,045	340	17	12	20	21	15
Dermatology	648	98	15	19	12	12	19
Geriatric medicine	1,483	197	13	14	17	9	13
Histopathology	1,398	174	12	16	12	11	10
Clinical radiology	3,224	341	11	12	13	11	6
Psychiatry – general and adult	2,774	301	11	14	12	11	7
Gastroenterology	1,320	132	10	10	8	12	10
Neurology	853	87	10	15	8	6	11
Respiratory medicine	1,104	104	9	10	9	2	14
Intensive care medicine	608	52	9	16	3	10	4
Psychiatry – child and adolescent	680	62	9	11	9	7	9
Endocrinology	723	51	7	7	9	4	6

Source: HEE.

7.7 The three specialties with the largest shortfalls across England as a whole were General and Acute Medicine (23 per cent), Emergency Medicine (17 per cent) and Dermatology (15 per cent). However, there were wide variations across different parts of England. The largest deficits were in the North and Midlands & East for General and Acute Medicine, Midlands & East and the South for Emergency Medicine, and the North and the South for Dermatology.

7.8 HEE told us that some specialties fill regardless of the geographical area, that London generally has greater success than the rest of England and that the extent to which specialties are filled from non-UK sources varies, with London least reliant on non-UK sources, and Midlands & East most reliant.

Wales

7.9 The Welsh Government said that there had been national and international labour shortages which had impacted on recruitment into the NHS in Wales.

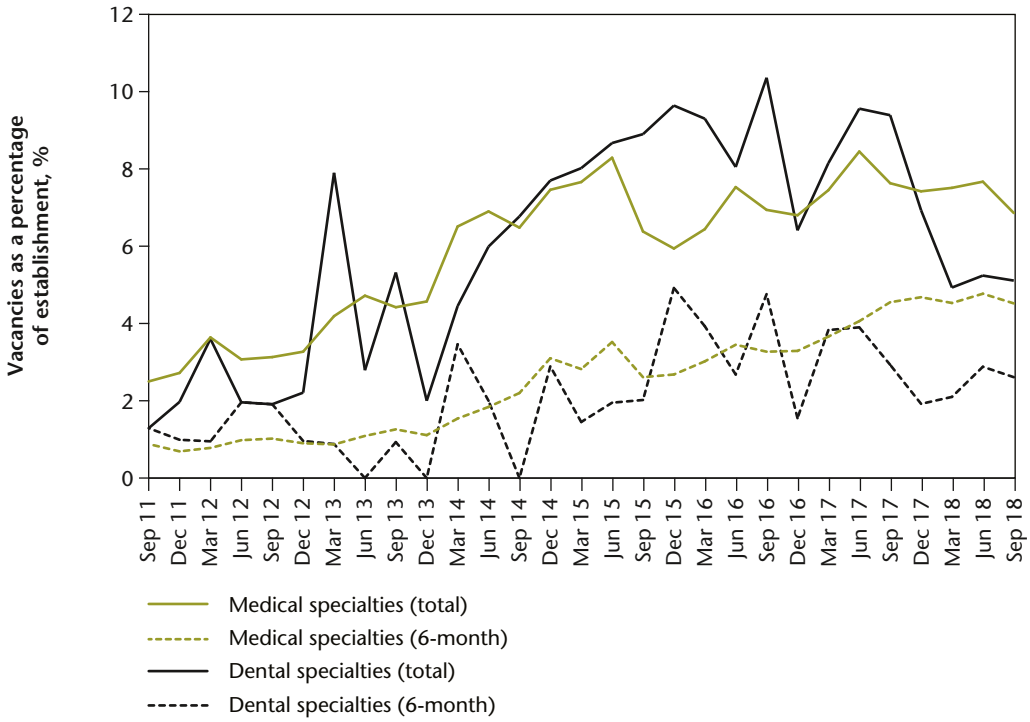
Scotland

7.10 The Scottish Government said that Health Boards could find it challenging to fill certain consultant posts, such as radiology, geriatrics or psychiatry, or in certain areas of Scotland.

7.11 At the end of September 2018 there were 393 FTE vacant posts for medical and dental consultants, a vacancy rate of 6.8 per cent, a reduction from 7.7 per cent a year earlier (Figure 7.2). The specialties with the highest vacancy rates were psychiatric (10.6 per cent) and clinical laboratories (9.9 per cent) (Table 7.2).

7.12 There were 258 posts that had been vacant for at least six months, a rate of 4.5 per cent, a slight increase from 254 a year earlier. The specialties with the highest six-month vacancy rates were clinical laboratories (8.3 per cent) and psychiatric (6.6 per cent).

Figure 7.2: Vacancy rates in Scotland, total and long-term, 2011 to 2018



Source: OME estimates, based on data from ISD Scotland.

Table 7.2: Vacancy rates in Scotland by specialty, September 2018

		Total vacancies		six month vacancies	
	Establishment (FTE)	Vacancy rate (%)	Annual percentage point change	Vacancy rate (%)	Annual percentage point change
All specialties	**5,751**	**6.8%**	**-0.8**	**4.5%**	**0.0**
All medical specialties	**5,655**	**6.9%**	**-0.8**	**4.5%**	**0.0**
Emergency medicine	240	4.6%	-2.7	4.2%	0.0
Anaesthetics	789	3.4%	-0.7	2.2%	-0.5
Intensive Care Medicine	22	9.0%	-10.5	4.5%	-1.1
Clinical laboratory specialties	712	9.9%	-2.1	8.3%	-0.1
Medical specialties	1,433	7.5%	-0.9	5.1%	-0.3
Public health medicine	92	7.6%	-0.4	2.2%	-0.7
Occupational medicine	11	1.9%	-11.4	1.9%	-11.4
Psychiatric specialties	596	10.6%	0.6	6.6%	0.3
Surgical specialties	1,066	6.8%	0.5	3.6%	0.4
Obstetric & gynaecology	266	3.8%	0.3	3.0%	2.2
Paediatrics specialties	367	4.4%	-3.1	2.2%	-0.2
General Practice	13	0.0%	0.0	0.0%	0.0
Not known/other	47				
All dental specialties	**96**	**5.1%**	**-4.3**	**2.6%**	**-0.3**

Source: ISD Scotland.

7.13 The Scottish Government also told us that the Improving Consultants Working Lives Group (involving the Management Steering Group – NHS Scotland employers and the Scottish Government, and the BMA Scotland) agreed and issued guidance[2] in May 2018 on promoting the retention of existing consultants.

Northern Ireland

7.14 In its written evidence, the Department of Health (Northern Ireland) said that there were 100 consultant vacancies actively being recruited to at the end of September 2018, a reduction from 129 at the end of September 2017. Between April 2017 and March 2018 there were 63 (3.5 per cent) consultant joiners and 79 (4.4 per cent) consultants left the Health and Social Care system.

Motivation

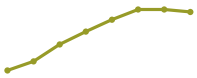
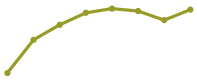
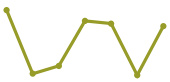
England

7.15 According to the 2018 NHS Staff Survey consultants were more satisfied with their pay than other medical staff groups (covered in Figure 4.12). However, consultants recorded a sharper fall in satisfaction with pay in 2018, compared with 2017, than other staff groups.

[2] https://www.sehd.scot.nhs.uk/dl/DL(2018)07.pdf

7.16 The results for job satisfaction for consultants were generally worse in 2018 than in 2017 (Table 7.3). There were small falls in satisfaction with recognition, management support, and being valued by their organisation, with a small increase in satisfaction with the amount of responsibility given.

Table 7.3: Selected results from the National Staff Survey, consultants, England, 2011 to 2018.

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	Trend[1]
I look forward to going to work	61.8	62.8	64.0	64.3	67.8	69.8	68.4	67.3	
I am enthusiastic about my job	74.2	73.4	75.7	75.1	78.8	79.5	78.0	77.2	
Time passes quickly when I am working	84.0	81.8	84.0	83.6	84.5	85.1	85.2	83.7	
The recognition I get for good work	49.4	50.5	52.6	54.0	55.5	56.6	56.7	56.3	
The support I get from my immediate manager	59.9	59.8	62.3	65.6	64.6	67.2	65.6	64.4	
The support I get from my work colleagues	81.2	82.7	83.6	83.5	86.0	85.3	85.7	84.4	
The amount of responsibility I am given	82.7	85.3	84.9	85.3	83.4	84.2	84.8	83.8	
The opportunities I have to use my skills	77.2	79.7	81.8	81.7	81.2	80.4	79.8	80.3	
The extent to which my organisation values my work	44.3	46.3	49.4	51.0	49.9	52.1	51.6	46.6	
My level of pay	63.4	63.5	60.8	59.5	61.6	63.8	63.2	56.7	
Percentage of staff appraised in the last 12 months	86.8	91.1	93.1	94.8	95.3	94.9	93.8	95.2	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.8	32.3	32.7	34.4	34.3	32.3	34.2	

Source: National NHS Staff Survey.

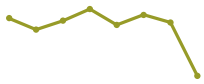
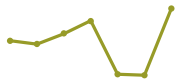
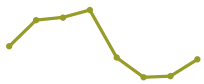
Notes: Data rounded to 1 decimal place.

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

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

7.17 There were sharp falls in the proportion saying they were able to meet the conflicting demands on their time, that they had adequate resources to do their job, and that there were enough staff for them to do their job properly (Table 7.4).

Table 7.4: Selected results from the National Staff Survey, consultants, England, 2011 to 2018.

Workload	2011	2012	2013	2014	2015	2016	2017	2018	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	52.2	52.6	51.3	52.3					
I am able to meet all the conflicting demands on my time at work[4]					33.1	34.1	37.8	33.1	
I have adequate materials, supplies and equipment to do my work	51.8	50.2	51.5	53.1	50.9	52.3	51.2	43.4	
There are enough staff at this organisation for me to do my job properly	30.5	30.5	29.0	29.2	29.7	28.0	28.1	24.1	
During the last 12 months have you felt unwell as a result of work related stress[2]		32.4	32.2	32.8	33.4	30.8	30.7	34.0	
Percentage of staff working PAID hours over and above their contracted hours[2]	41.6	43.5	43.6	44.2	40.8	39.3	39.4	40.6	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	81.1	82.9	83.8	82.9	84.8	85.5	83.4	82.9	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

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

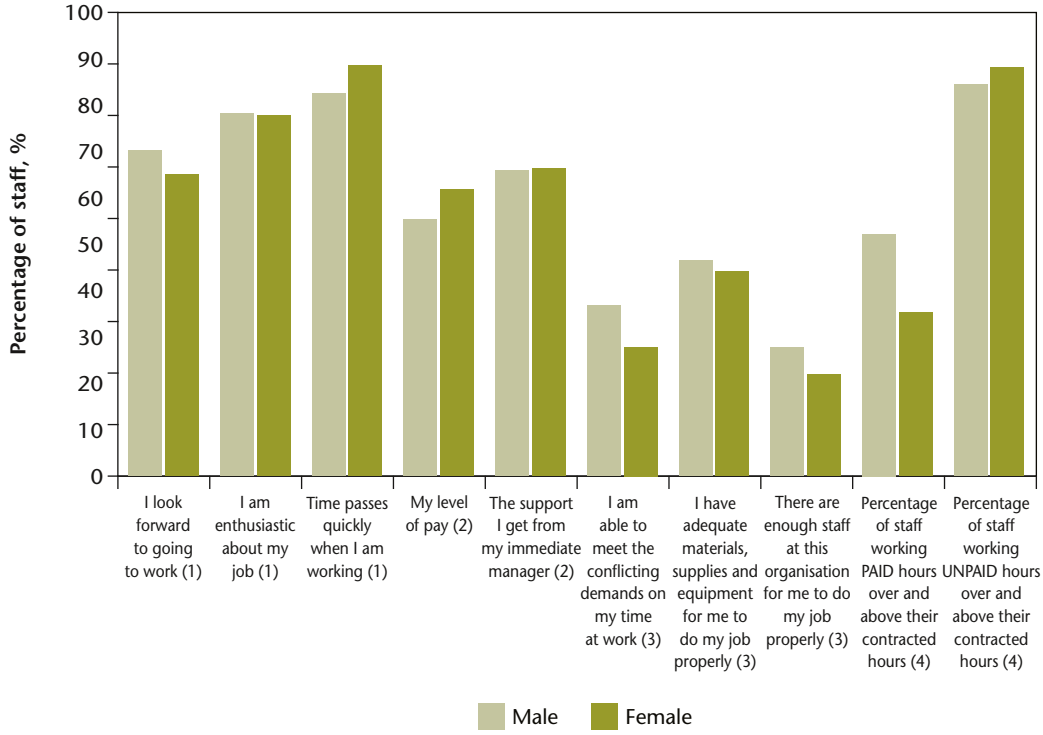
(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) For 2015, this question was reversed to "I am able to meet…"

(4) This question was introduced in 2015.

7.18 Female consultants were more likely to say they were satisfied with their pay than male colleagues (Figure 7.3). However, compared with female consultants, male consultants were more likely to say that they looked forward to going to work, were able to meet competing demands on their time, had adequate materials, and that there were sufficient staff at the organisation. Female consultants were slightly more likely to work extra unpaid hours than male consultants but were far less likely to work extra paid hours than their male colleagues.

Figure 7.3: HCHS consultant satisfaction with aspects of the job and work pressures by gender, England, 2018



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always".
(2) Staff responding "satisfied" or "very satisfied".
(3) Staff responding "agree" or "strongly agree".
(4) Staff indicating one or more additional hours.

Scotland, Wales and Northern Ireland

7.19 The most recent staff survey results for Northern Ireland were published before our 45th Report 2017, so there is no new data to report on since our last report. The latest published Wales and Scottish staff surveys, published earlier in 2018, are not available in sufficient detail to identify consultant level results.

Contract reform

England

7.20 The DHSC told us that the aim of reforming the consultant contract was to produce a contract that would attract, retain and motivate consultants while being affordable for employers. It would value the consultant workforce, be responsive to patients' needs, and support employers and consultants to deliver sustainable improvements in the quality of care. DHSC said that negotiations between NHS Employers and the medical trades unions to reform the consultant contract had been ongoing in some form since 2013, and that in July 2018, the Secretary of State for Health and Social Care confirmed his commitment to negotiations on a multi-year agreement incorporating contract reform to begin from 2019-20. However, the department continued to say that the negotiations had stalled.

7.21 The HCSA expressed concern at the suggestion by the Secretary of State in July that the outcome of the consultant contract could be tied to a new multi-year pay deal, as this could complicate the need to reverse long term pay restraints. HCSA also said that it would continue to engage with NHS Employers over the consultant contract, although there had been no progress.

7.22 NHS Providers told us that, although it had not been involved in consultant contract negotiations, trusts felt it important that the BMA should be in agreement to the terms of any new contract. It also said that the uncertainty was not helping trusts to plan, and was affecting the morale of senior doctors and that, in the circumstances, reaching an agreement should be a priority.

Wales

7.23 In 2018, the Welsh Government said that the Welsh Audit Office had reported that the current consultant contract fell short of securing the intended benefits. Although the Government said it would like to reform the contract, no progress was reported this year.

Scotland

7.24 The Scottish Government said that it would continue to offer an attractive pay package for consultants, along with the guarantee of no compulsory redundancy.

Northern Ireland

7.25 The Department of Health said that it would not be in a position to take any action on contract reform in Northern Ireland without a Minister in place, or without talks with the local BMA.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

England

7.26 The DHSC told us that, following agreement between NHS Employers and the BMA, a new schedule had been introduced for local Clinical Excellence Awards (CEAs). Interim arrangements from 1 April 2018 to 31 March 2021 were implemented, and included further arrangements which would apply from 1 April 2021 should a new performance related pay scheme not be implemented prior to that date. DHSC explained that the agreement required all employers to run an annual local CEA round, and that new awards would be time limited and non-pensionable. Employers would commit to an investment ratio of 0.3 CEA points per eligible consultant until March 2021.

7.27 NHS Employers said that it would intend future arrangements for performance pay to continue to be non-consolidated and non-pensionable, promote the engagement of consultants in the delivery of agreed objectives, and reward those who make an exemplary contribution to the health system. By establishing a closer link to objectives, employers would be able to incentivise performance and reward consultants for meeting their organisational priorities. NHS Employers also told us that a system based on meeting objectives, rather than on applications, would widen access and participation for under-represented groups of consultants, including women and those from black and minority ethnic backgrounds.

7.28 NHS Employers said that it would continue to consult with the BMA and the Universities and Colleges Employers Association (UCEA) about eligible clinical academic consultant contracts, to reflect the revised local CEA scheme.

7.29 HCSA said that it would generally support reform of the awards system to make them fairer, more encouraging of reward for clinical excellence, and more accessible to all specialties and demographics. However, it also said that the Government's decision to boost the quantity of CEA points available instead of increasing the value of CEAs represented a retrograde step for consultants.

Scotland

7.30 The Scottish Government said that its position with regard to arrangements for Distinction Awards and Discretionary Points (DADPs) had not changed. To increase or restore DADPs would be inconsistent with the Scottish public sector pay policy. The Scottish Government also said that while its aim was to attract and retain highly skilled staff, and that it valued their contribution to the health service, there was no evidence that the freezing of the value of DADPs had had an adverse impact. Although DAs had been frozen to new consultants, the availability of new DPs continues to increase in line with the number of consultants in post.

Our comments

7.31 In recent years, the emphasis, at a political level, has been on creating a consultant-provided rather than a consultant-led service. There is evidence that having a higher proportion of consultants on hand leads to better patient care outcomes. However, the focus on increasing consultant numbers, which is continuing at a rate of 3 per cent a year, does have consequences. Consultants are a relatively expensive part of the medical workforce, so an ever-increasing proportion of consultants leads to a more expensive cost-weighted workforce, and exerts a moderating influence on pay settlements over time.

7.32 Set against the increasing cost of the consultant workforce is the tendency for it to become younger (as recruitment to the consultant grade remains strong), and also for it to contain a higher proportion of female workers. The younger workforce is likely to contain a higher proportion of workers at lower points on the consultants' pay scale. The increasing demands for greater career flexibility may create a higher proportion of part-time workers, who earn less overall than their predecessors, largely full-time equivalents, and who will hence tend to reduce the overall average salary levels for the grade. The review body did not see much evidence that enabled it to account quantitatively for the influence of these various competing factors, but it would argue that any rigorous assessment of declining consultant earnings in real terms ought to control for them.

7.33 Although the number of consultants is increasing, consultant vacancy rates are not improving, and the trends do not suggest that this consultant gap will be easily filled. In other words, demand and supply are both rising. Scottish six-month vacancy rates were also noted to be increasing.

7.34 On retention, the review body was made aware of the significant consequences, probably unintended, of the operation of the annual allowance and the taper provision in the pension taxation scheme, particularly for those who are still in, or had switched from, final salary pension schemes. The impact of the taper and the expiration of the shelter of the annual allowance carry-over for some have created circumstances in which relatively highly paid workers experiencing a pay increase, for example on promotion, may find themselves in receipt of large tax bills reflecting the chargeable gains in the value of their pension entitlements. It has been represented to us that consultants were choosing to retire earlier or starting to do fewer programmed activities, refusing promotions or reducing the number of their contracted programme activities in order to avoid pension tax complications.

7.35 The counter-argument is often expressed in terms of total reward: the pension is an accrued and accruing entitlement, and the worker should consider the often substantial value of the pension alongside any less appealing and more immediate adverse cash consequences. The problem as expressed to us however was less to do with the reduced value of the final pension, and more to do with the need to address immediate cash calls required to settle tax bills, which were often substantial – in the tens of thousands of pounds. There would be no immediate cash call if a person used the 'scheme pays' facility, but there would be an effective interest rate charge when calculating the final, and thereby reduced, pension. However, the review body has not been shown evidence that a person utilising the 'scheme pays' facility would be worse off from taking a pay increase for the rest of their working lifetime, and in consequence, having higher pensionable pay.

7.36 This problem is in its relative infancy: we were told that many of the doctors are only now running out of the ability to carry-forward unused annual allowance from previous years. We also understand that the problem could not be avoided by paying some of the income outside the pension scheme, as the overall income still counts for the purpose of calculating the annual allowance taper, whether pensionable or not.

7.37 If the foregoing is correct, and if the consequences are as they have been represented to us, the NHS may be heading for an immediate consultant shortfall problem of some significance. The implementation of any pay uplift recommendations later in this report needs to be considered with an eye to these new complications.

7.38 Consultants, unlike many other public sector workforces have the option to avoid negative pension tax consequences by retiring, reducing their NHS work hours or opting in and out of the pension scheme to maximise their retirement incomes. The ability to be able to retire and then return to the NHS, as well as offering an option to certain staff to avoid the most adverse consequences of the pension taxation system, may mean that the headline level of retirements do not present as large an issue to the NHS, in workforce terms, as might appear from the headline data. This approach however is not without consequence; for the organisation the person returning often works reduced hours and may identify less with the organisation. For the individuals concerned, if they opt out of the pension scheme currently, then apart from losing final benefit (which would be at least partly offset by tax foregone), while still in employment they would lose the advantages of the death-in-service benefits.

7.39 These points raise a general issue of a lack of adequate data on how far retiring doctors are being re-employed elsewhere, in other capacities, within the system, and it is an area on which it would be useful to have better quality, and greater quantity, of data.

7.40 The BMA provided some evidence of the negative effects of the LTA and the AA on consultants' pensions. Pension taxation has undoubtedly had an impact on the actual and perceived benefits, or otherwise, of working patterns and retirement options, and affected the behaviours of doctors towards the end of their careers. The review body acknowledges the impact this is likely to have on the retention of experienced staff. We note that the government has launched plans to consult[3] on proposals to offer a different pension option[4] to senior clinicians as part of the ongoing discussions to resolve this issue. We look forward to a speedy resolution, and we should stay alert to any implications of these discussions for pay settlements in future years.

[3] https://www.gov.uk/government/news/top-nhs-doctors-to-be-given-more-flexible-pensions

[4] The 50:50 option would allow clinicians to halve their pension contributions in exchange for halving the rate of pension growth.

CHAPTER 8: GENERAL MEDICAL PRACTITIONERS

Introduction

8.1 In this chapter we consider issues relating to General Medical Practitioners (GMPs). The traditional role for GMPs is as the family doctor, working in the primary care sector of the NHS. There are several contracting arrangements in place under which primary care services are provided, and GMPs can work as independent contractors, salaried GMPs or as locums.

8.2 During the course of our work this year, a five-year contract was agreed, between the Department for Health and Social Care (DHSC), NHS England, and the General Practitioners Committee (GPC) of the British Medical Association (BMA), in relation to a new GMP contract in England. The parties said that the contract would give clarity and certainty for practices. NHS England and the GPC agreed that there would be no further expectation of additional national funding for practice or contract entitlements until 2024-25. The contract provided for the minimum and maximum pay range for salaried GMPs in England to be uplifted by 2 per cent for the 2019-20 pay round and also aimed to address other significant problems for primary care providers. These included questions of liabilities and responsibilities arising from practice ownership, and the funding of professional medical indemnities. The total financial benefits of these new arrangements for individual contractor GMPs may be considerably more than 2 per cent.

8.3 The parties to the new contract agreed to ask the DDRB to not make recommendations relating to GMP independent contractor pay over the period of the agreement, and not to make recommendations on salaried GMP pay in England for this round. The expectation however is that, starting with our 2020 report, the DDRB will again make recommendations on salaried GMP pay annually over the period of the agreement. DDRB will be making recommendations this year for contractor and salaried GMPs in Wales, Scotland and Northern Ireland only.

8.4 On 7 January 2019, NHS England published its NHS Long Term Plan (LTP), which would underpin the long-term funding settlement for GMPs in England. The LTP set out that:

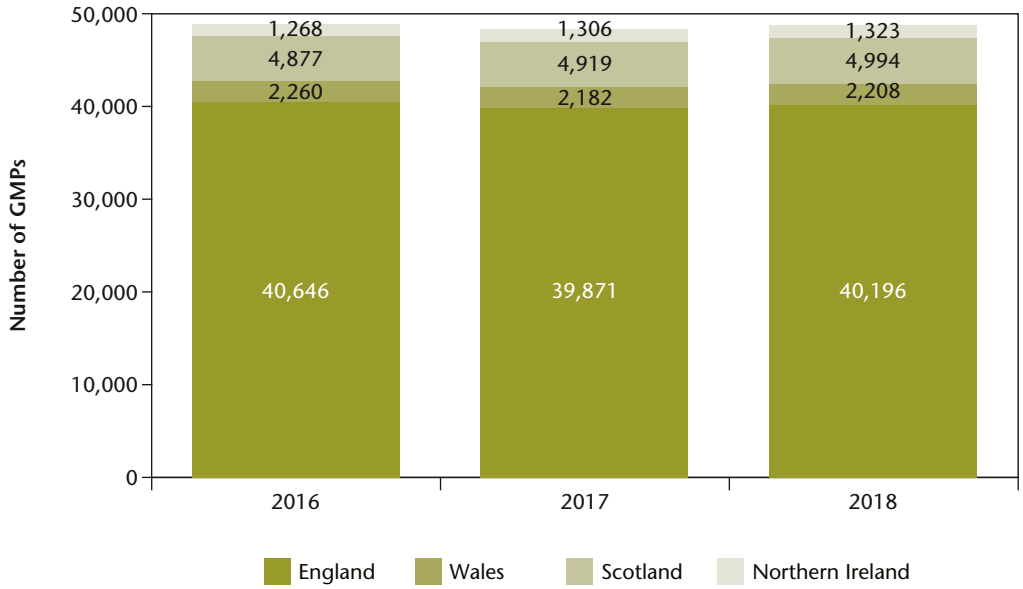
- NHS England was committed to increasing investment in primary medical and community health services as a share of the total national NHS revenue spend from 2019-20 to 2023-24; and
- spending on those services would be at least £4.5 billion higher in five years' time, which would fund pressures of demand and workforce expansion;
- the new investment would fund community multi-disciplinary teams comprising a range of staff including GMPs, pharmacists, community geriatricians and social care staff and the intention would be to create a fully integrated community-based health care provision.

8.5 Although the LTP contained little about workforce, it was subsequently clarified that this area was to be the subject of a separate and subsequent exercise, to be carried out under the chair of Baroness Harding of Winscombe. Following this commitment, the Interim NHS People Plan for England, an action plan for 2019-20, setting out a vision of how the NHS workforce will be supported to deliver the LTP, was produced by NHS Improvement shortly before this report was submitted, with a fully costed five-year People Plan expected later this year.

8.6 In September[1] 2018, there were 48,721 (headcount) GMPs in the UK which was an increase of 443 (0.9 per cent) compared to 2017 (Figure 8.1). There were increases in each country in the UK: of 325 (0.8 per cent) in England, 75 (1.5 per cent) in Scotland, 26 (1.2 per cent) in Wales and 17 (1.3 per cent) in Northern Ireland.

8.7 Although each country recorded an increase in GMP numbers in 2018, compared with 2017, GMP numbers in both England and Wales are lower than in 2016. For England this needs to be seen in the context of a policy objective to increase the number of FTE GMPs by 5,000.

Figure 8.1: Number of General Medical Practitioners (GMPs), headcount, United Kingdom, 2016 to 2018



Source: NHS Digital, ISD Scotland, StatsWales, Northern Ireland Statistics and Research Agency.

Access to GMP services

England

8.8 As explained in Paragraph 8.3, the review body will not be making recommendations for contractor and salaried GMPs in England this year. Therefore, we will not be commenting on access to GMP services in England.

Wales

8.9 The Welsh Government said that the plan published in June 2018, A Healthier Wales: our Plan for Health and Social Care[2] set the overarching strategy for the delivery of health services in Wales and emphasised new ways of working to integrate care. To ensure the management of patients' needs, primary care clusters of multi-professional staff would be created, of which GMPs would form a central role. One of the main challenges would be the need to change cultures and integrate different professionals into a joined up approach.

[1] As of September 2018, for England, Scotland and Wales but March 2018 in Northern Ireland.
[2] https://gov.wales/docs/dhss/publications/180608healthier-wales-mainen.pdf

Scotland

8.10 The Scottish Government said the new GP contract maintained the focus of the patient access review of 2014-15, to support practices and NHS Boards, and was underpinned by the principle of ensuring patients could see the right person at the right place at the right time.

8.11 The Scottish Government also said that the Primary Care Fund supported the development of multi-disciplinary teams for primary care, which would embed long-term, sustainable change within GP services, to address the changing needs and demands of patients.

8.12 The Scottish Government told us that the Primary Care Fund would also support the use of digital services by GP practices, such as the development of a webGP and online appointment booking systems to improve patient access.

Northern Ireland

8.13 The Department of Health (Northern Ireland) said that it acknowledged the pressures on general practice across Northern Ireland and was working to deliver a range of initiatives to support GPs, drive transformation and deliver better care, while attempting to reduce bureaucracy and the pressure on services. The Department told us that in 2018-19, it invested £21.7 million in GMS related services, which reflected the importance of general practice in delivering transformation. In line with the strategic direction set out in the 2016 plan, Health and wellbeing 2026: Delivering together, a transformation fund worth £100 million had been established for 2018-19 to help support reform and change how primary care services would be delivered, including the roll-out of multi-disciplinary teams.

Recruitment and retention

England

8.14 As explained in Paragraph 8.3, the review body will not be making recommendations for contractor and salaried GMPs in England this year. Therefore, we will not be commenting on recruitment and retention in England.

Wales

8.15 The Welsh Government said that the primary care workforce plan published by the Welsh Government in 2015 included several actions intended to stabilise core elements of the workforce, including GMPs, by supporting people who want to return to practice or to work part-time; exploring how training and working in general practice can be encouraged in areas of greatest need and communicating the opportunities afforded by general practice in Wales. The plan was supported by an additional £43 million made available to health boards in 2016-17. Much of this funding had been used to recruit additional members of the wider primary care team, with 400 posts having been recruited to since the funding was made available. These posts include salaried GMPs, nurses, pharmacists, health care support workers and other allied health professionals.

8.16 The Welsh Government also told us that the plan included an expansion of the GMP retainer scheme, which offered flexible working opportunities to encourage professionals thinking of retiring to stay in work part-time and the reimbursement of medical school fees when newly qualified doctors commit to a career in general practice.

8.17 The Welsh Government said that the marketing campaign, Train Work Live (TWL), was in its third year of the medical phase, which went live in October 2018, and promoted the benefits of working as a doctor in Wales. The campaign had a focus on GMPs.

8.18 GMP training had been incentivised through the payment of specified exam fees and an additional targeted incentive, which offered £20,000 to GMP trainees who took up a training place in a specified hard-to-recruit area and who committed to remaining in a targeted area for one year of practice after qualification.

Scotland

8.19 The Scottish Government said that it provided support for better recruitment and retention through an enhanced and expanded Scottish Rural Medicine Collaborative (SRMC) – a partnership of ten rural Health Boards – to target support to recruitment in primary care services in remote and rural areas. SRMC and National Services Scotland (NSS) launched a national GMP recruitment website[3] in October 2018.

8.20 The Government also said that there was a strategy to recruit at least 800 GMPs over the next ten years, including the ScotGEM[4] programme which would introduce 55 graduate places from September 2018 with a particular focus on rural medicine. Administered by NHS Education for Scotland, ScotGEM students would also be offered a 'return of service' bursary of £4,000 per student per annum in return for a year of service up to a maximum of four bursaries and four equivalent years of service. There would also be continued support for GP Specialty Training (GPST) bursaries, where 102 of the 400 posts would attract a £20,000 bursary for hard-to-fill posts, including those in remote and rural practices.

8.21 The Scottish Government said that it would be implementing a package of retention measures (including coaching and mentoring schemes) to support GPs, helping to combat workload pressures and to retain them in the workforce, while improving the skill mix. It also said that Seniority Payments for Scottish GPs, rewarding experience, based on years of reckonable service adjusted for superannuable income, have been made to practices for payment to individual GPs.

8.22 The government said that lump sum payments, in the form of 'Golden Hellos' are made to doctors who become GP performers in certain remote, rural or deprived areas, or if the local Health Board believes the practice has experienced significant difficulties around recruitment and retention.

Northern Ireland

8.23 The Department of Health (Northern Ireland) said that it had continued to work with the Health and Social Care Board and other stakeholders to support GMP recruitment and retention.

8.24 The Department told us that the annual number of GMP training places had increased by 70 per cent over a three-year period and had resulted in an annual commissioned intake of 111 by 2018-19.

8.25 The Department said that the GMP Induction and Refresher Scheme provided an opportunity for GPs who had previously been on the General Medical Council's (GMC) GP Register and on a UK Performers' List to return to general practice following a career break, or time spent working abroad. We were told that at September 2017, 15 doctors had completed the scheme, with a further seven on the scheme at that time. The department also told us about the GP retainer scheme, designed to assist in the retention of GPs, providing stable work in practices and including a continuing professional development programme to assist with appraisal and revalidation.

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[3] https://gpjobs.scot/work-in-scotland/

[4] https://www.scotlanddeanery.nhs.scot/trainer-information/scottish-graduate-entry-medicine-scotgem/

GMP trainers' grant and GMP appraisers

8.26 The DHSC (England) said that it had continued to work with stakeholders to develop a tariff-based approach for funding clinical placements in GP practices for medical students and trainees. The Department had collected information from GP practices to understand better the costs incurred from having medical students and trainees on placement. The outcomes of this exercise are being used to determine the timescales and funding to support the introduction of a tariff payment mechanism.

Independent contractor GMPs

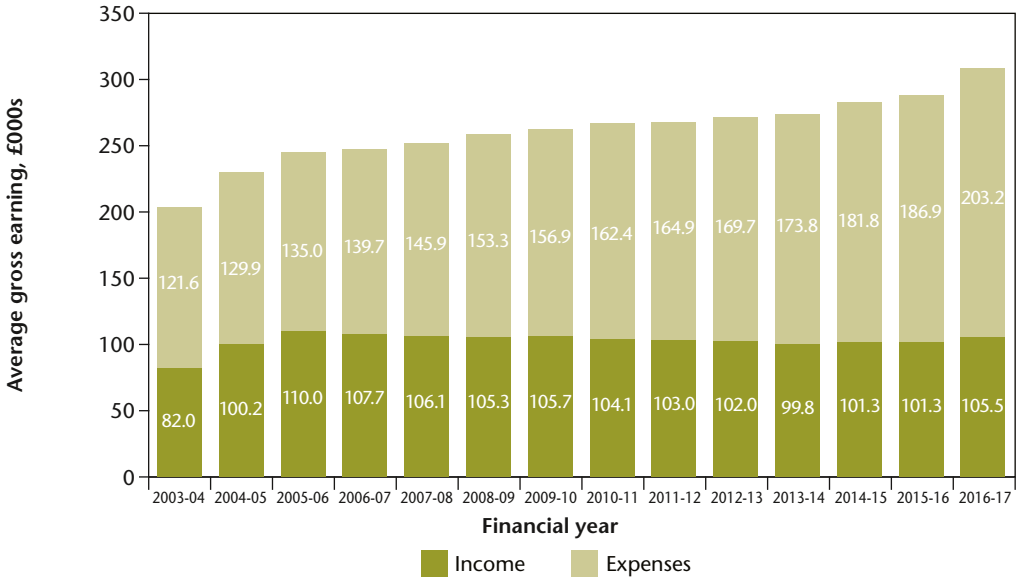
Income

8.27 In 2016-17, on a headcount basis across the UK, average gross earnings of independent contractor GMPs was £308,700. Contractor GMPs had average expenses of £203,200, giving an average income of £105,500, an increase of 4.1 per cent from 2015-16, and the highest level since 2009-10.

8.28 There was variation in income by country, with the average income highest in England (£109,600), followed by Wales (£96,500), Scotland (£90,800) and Northern Ireland (£90,500). Northern Ireland was the only country to see a reduction in income in 2016-17, of 1.7 per cent, while there were increases in England (4.6 per cent), Wales, (3.3 per cent) and Scotland (1.5 per cent).

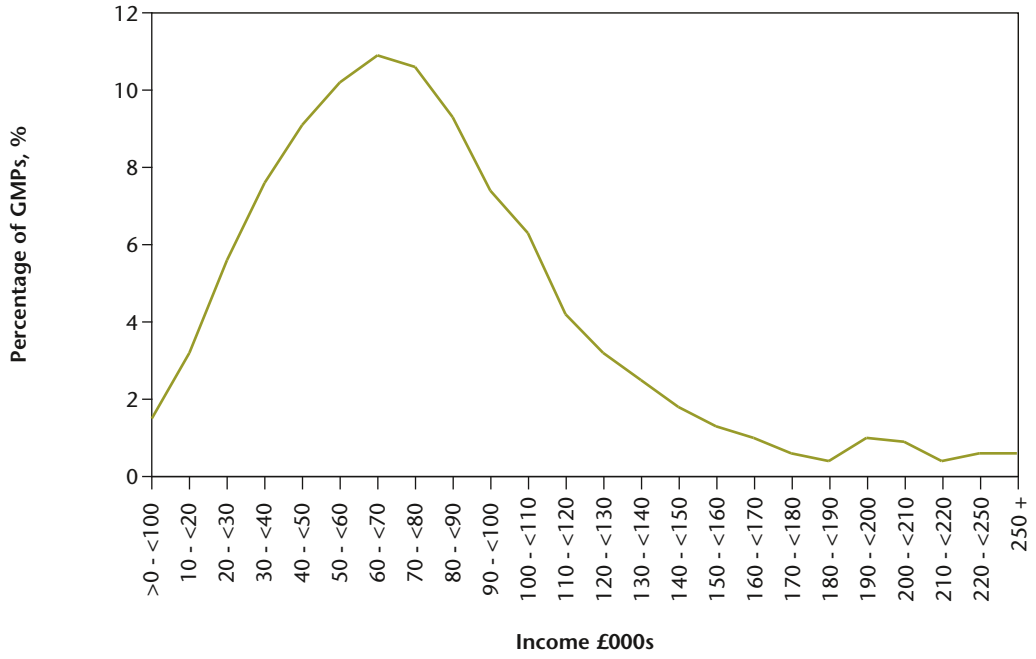
8.29 The distribution of contractor GMP income was largely unchanged from 2015-16, about 1 in 5 GMPs income was less than £70,000, whilst a similar proportion had an income over £130,000 (Figure 8.3). These figures are calculated on a headcount basis, so it is likely that the lowest paid GMPs are working part time.

Figure 8.2: GMP contractors' average gross earnings: income and expenses, United Kingdom, 2003-04 to 2016-17



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

Figure 8.3: Distribution of GMP contractors' income before tax, United Kingdom, 2016-17



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.

Salaried GMPs

England

8.30 As explained in Paragraph 8.3, the review body will not be making recommendations for contractor and salaried GMPs in England this year. Therefore, we will not be commenting on salaried GMPs in England.

Wales

8.31 The Welsh Government said that although it remained committed to the status of independent contractor, over the last decade, GMPs have moved closer to a salaried model and any future pay recommendations would be considered as part of the wider context of contract reform, and would be likely to be tied to contractual changes.

Scotland

8.32 The Scottish Government said that the new GP contract had been designed to make becoming an independent contractor more attractive to younger GMPs, including reducing GMP workload and stabilising GP partner income. However, it recognised that there was an important and continuing role for salaried GMPs.

8.33 The Government also said that the Primary Care Workforce Survey Scotland 2017 estimated that there were 749 salaried GPs (17 per cent) and 81 GP Retainers (2 per cent). The survey recorded a small number of returner GPs, with an estimated headcount of nine across Scotland and a small number of Enhanced Induction GPs, with an estimated headcount of four across Scotland.

8.34 The survey also found that salaried GPs are more likely to work fewer sessions per week than GP partners, with a third working up to four sessions per week, compared to 8 per cent of GP partners.

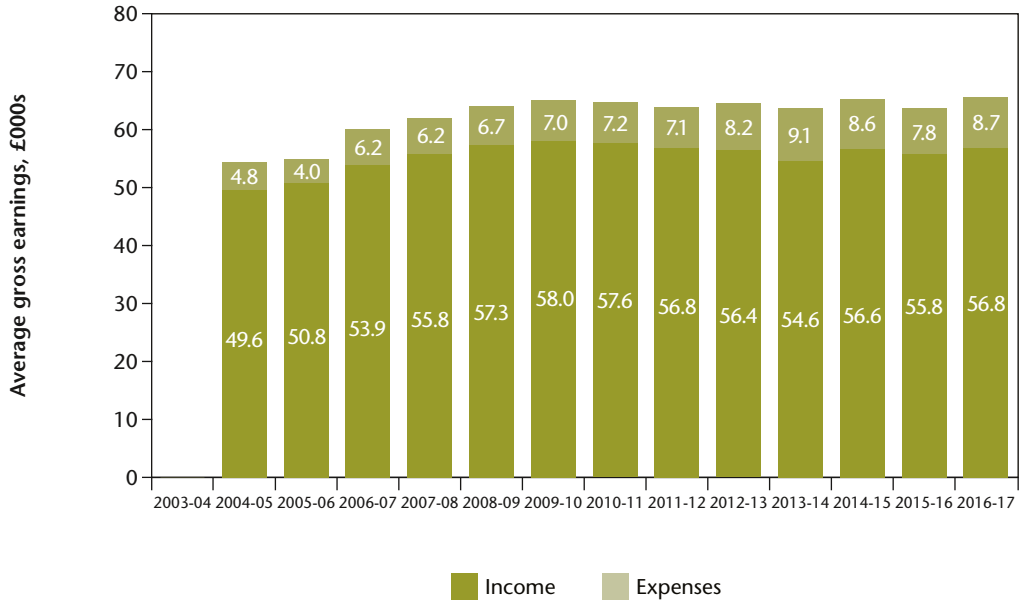
Income

8.35 In 2016-17, on a headcount basis across the UK, average gross earnings of salaried GMPs was £65,400. Salaried GMPs had average expenses of £8,700, giving an average income of £56,800, an increase of 1.7 per cent from 2015-16 (Figure 8.4).

8.36 About a quarter of salaried GMPs had an income below £40,000, whilst a quarter had income above £70,000 and only about 6 per cent had income above £100,000.

8.37 The average income was highest in Scotland (£61,800), followed by England (£56,600), Northern Ireland (£55,300) and Wales (£53,700). All countries saw an increase in salaried GMP income over 2015-16, of 17 per cent in Northern Ireland, 7 per cent in Scotland, 4 per cent in Wales and 1.2 per cent in England.

Figure 8.4: Salaried GMPs' average gross earnings, income and expenses, United Kingdom, 2003-04 to 2016-17



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

Expenses and formula

8.38 In 2016 we took a decision to make recommendations on our intended increase in pay net of expenses. Taking this approach required the parties to discuss expenses in order to ascertain a gross increase. For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs had we used the formula-based approach.

8.39 We note that the increase in employer and employee pension contributions from April 2019 hits contractor GMPs particularly hard and recommend that this is taken into account in discussions about expenses in Scotland, Wales and Northern Ireland.

8.40 The Scottish Government told us that it had reached agreement in principle with the Scottish General Practitioners Committee that the Scottish Government would directly reimburse practices for the increased costs of employing practice staff and contributions for practice partners, depending on the outcomes of discussions between the UK and Scottish Governments.

Our comments

8.41 We have heard from across the UK about the importance placed on primary care and this has been reinforced by an increase in funding for primary care and the aim to increase the number of GMPs providing services. If the targets to expand the GMP workforce are to be met, this will require a combination of increasing the throughput from training, international recruitment, and improving the retention of existing GMPs.

8.42 The Scottish Government's remit letter reiterated the terms of the Scottish public sector pay policy for 2019-20, which might conceivably lead to pay settlements which could differ from our recommendations, and might not be justified by considerations of recruitment, retention, motivation and morale alone. We were asked to make recommendations on the pay element only for GMPs and GDPs.

8.43 International recruitment, which is being undertaken by the services in England, Wales and Scotland, is unlikely to be helped by the continuing uncertainty around the UK's future relationship with the EU and the recent difficulty that some potential employers had with obtaining certificates of sponsorship which allow them to employ international GPs.

8.44 If the challenging workforce expansion plans are to be achieved, it is important that the rewards from working as a GMP in the NHS provide an incentive either to join, or to remain in the service, or both.

CHAPTER 9: DENTISTS

Introduction

9.1 Our remit covers all independent contractor General Dental Practitioners (GDPs) and salaried dentists in England, Wales, Scotland, and Northern Ireland. In England and Wales this includes the salaried dentists working in community dental services (CDS), and the salaried dentists working in the Public Dental Service (PDS) in Scotland and Northern Ireland.

General Dental Practitioners

9.2 In England and Wales, GDPs working for the NHS comprise 'providing-performer' dentists and 'performer-only' dentists. 'Providing-performer' dentists hold a contract with the NHS and also perform as dentists. A 'performer-only' dentist works, as an employee or in self-employment, under a contract held by a practice that may be either providing-performer owned, or owned by a limited company. The equivalents in Scotland and Northern Ireland are 'principal dentist' and 'associate dentist'. For consistency and clarity, the terminology used for 'performer-only' dentists has been changed to 'associate dentists'.

9.3 As with General Medical Practitioners (GMPs), the remit of the DDRB includes making recommendations on the pay of GDPs. Associate dentists will be paid by the practice owner or company concerned. Providing-performer dentists will be paid from the income of the relevant practice (in which they will have an equity interest). In either case their income will be funded from the income from contracts negotiated with the NHS, or from the revenues from private work, or a mixture of both.

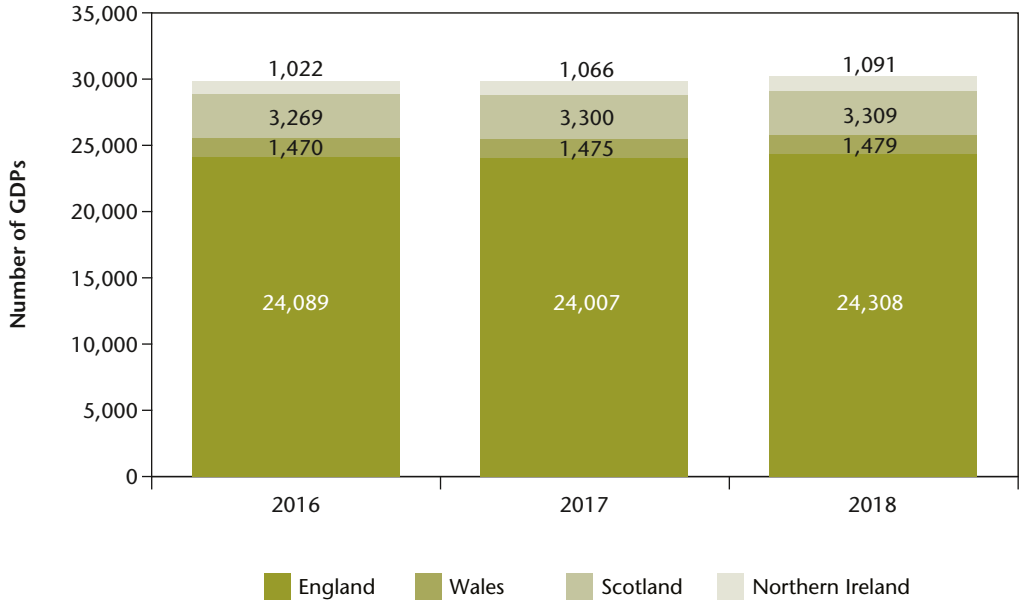
9.4 GDPs differ from GMPs in that, typically, a relatively larger proportion of a dentist's income is based on dental work undertaken outside the NHS, so that the practice income, and hence their own income, is subject to an element of wider market pressure.

9.5 A career in dentistry starts with at least five years undergraduate study and then a further two years in dental foundation training. In the longer-term, earnings differ depending on the route taken, the balance of NHS and private work undertaken, the number of hours worked and the location of the practice, but providing-performer dentists in England and Wales earned on average in the region of £115,800 in 2016-17, while associate dentists earned £60,800 on a headcount basis.

9.6 In September 2018[1] there were 30,187 dentists providing NHS services in the UK, an increase of 339 (1.1 per cent) from a year earlier. There was an increase in each of the countries of the UK: of 301 (1.3 per cent) in England, 25 in Northern Ireland (2.3 per cent), nine (0.3 per cent) in Scotland, and four (0.3 per cent) in Wales. Within the overall total there has been a trend for growth in the number of associate dentists and a decline in the number of providing-performer dentists.

[1] Data for Scotland and Wales are for 30 September 2018. The latest available data for England and Northern Ireland are as at 31 March 2018.

Figure 9.1: Number of General Dental Practitioners, United Kingdom, 2016 to 2018



Source: NHS Digital, ISD Scotland, StatsWales, Northern Ireland Statistics and Research Agency.

Access to dental services

England

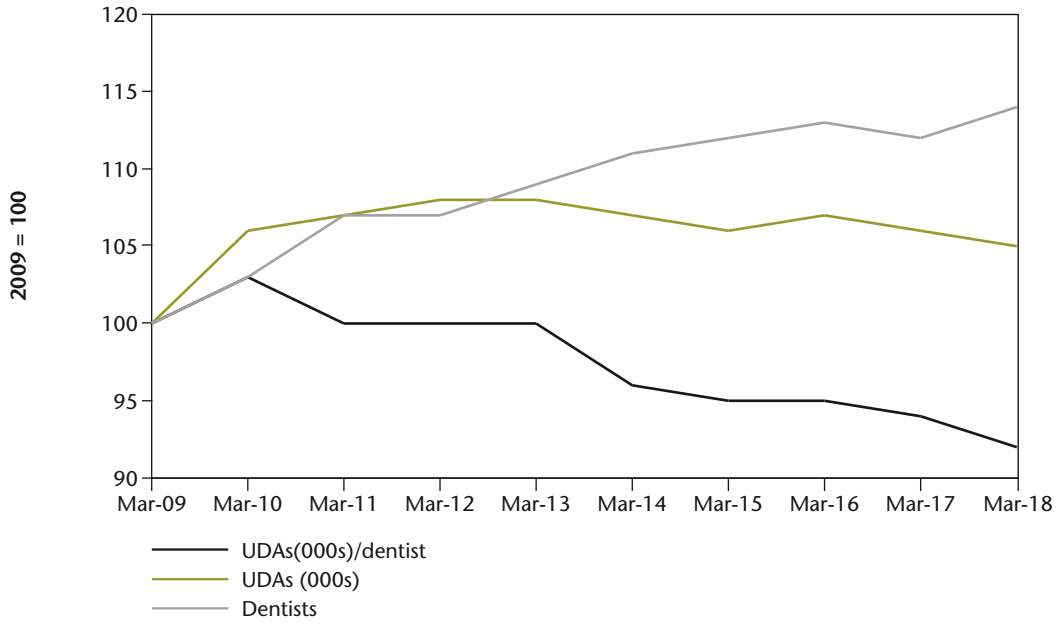
9.7 NHS England said that the GP Patient Survey Dental Statistics for March 2018 showed that 95 per cent of people who tried to get an appointment with an NHS dentist in the past two years were successful, rising to 96 per cent in the six months to March 2018. The latest data[2] for England, to December 2018, show that 22.05 million adult patients (50.4 per cent of the population) were seen by an NHS dentist in the previous 24-months and 6.95 million child patients (58.6 per cent of the population) were seen in the previous 12-months. Compared with the data to December 2017, this represents a decrease of 79,000 in the number of adult patients seen, and an increase of 99,000 in the number of child patients seen. In 2017-18, 83.2 million units of dental activity (UDAs) were carried out, a fall of 2.5 million from 2016-17.

9.8 In August 2018 the Dental Working Hours surveys for both 2016-17 and 2017-18 were published[3]. The results, for England, showed that in 2017-18 dentists worked on average 36.6 hours per week of which 25.7 hours (70.3 per cent) were dedicated to NHS dentistry. Compared with 2016-17, this represents a fall of 0.2 hours worked, and a reduction of 1.0 hours in the number of hours devoted to NHS dentistry.

[2] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics
[3] https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2016-17-and-2017-18-working-patterns-motivation-and-morale

9.9 Although there has been an increase in the number of dentists providing NHS services, the number of UDAs commissioned in England has been slowly declining since 2013 (Figure 9.2). There are several potential explanations as to why the number of UDAs per dentist is declining. The British Dental Association (BDA) thought it might be explained by an increasing amount of administrative effort and general bureaucracy associated with carrying out treatments, charging for them, and recovering the cost. The review body observes that it could also be a reflection of dentists working fewer hours or devoting a greater share of their time to non-NHS work. Alternatively, it could be a feature of improving oral health across the population, and new contracting methods reducing the reliance on UDAs. We were unable to identify any single satisfactory explanation, and we would welcome evidence from the parties in future rounds that might help shed further light on the issue.

Figure 9.2: Dentists providing NHS services, Units of Dental Activity (UDAs) commissioned, England, 2009 to 2018



Source: NHS Digital and NHS England Dental Commissioning Statistics.

9.10 The NHS Long Term Plan[4] (LTP) published in January 2019 by NHS England said that the Starting Well Core Initiative would support 24,000 dentists in England to embed good oral health habits in more young children. The plan also said it would invest over the next five years to ensure children with learning disabilities would have their dental needs met by dental services, and would be supported by easily accessible, ongoing care.

Wales

9.11 The Welsh Government said that a total of 1.72 million patients were recorded as having been treated in the 24-months to December 2018, amounting to 55.1 per cent of the population. This was over 10,000 higher than a year before and some 126,000 more than the low point in March 2008 (These data do not include those patients who attended the Community Dental Service – some 68,000 in 2017-18. Including these patients would increase the percentage of the population treated to 57.3 per cent). Data for 2017-18[5] showed 4.88 million UDAs, compared with 5.02 million in 2016-17, a reduction of 2.7 per cent.

[4] https://www.england.nhs.uk/long-term-plan/
[5] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Dental-Services/Current-Contract/coursesoftreatmentandunitsofdentalactivity-by-localhealthboard-treatmentband

9.12 In August 2018 the Dental Working Hours surveys for both 2016-17 and 2017-18 were published[6]. The results, for Wales, showed that in 2017-18 dentists worked on average 36.5 hours per week, of which 27.0 hours (74.2 per cent) were dedicated to NHS dentistry. Compared with 2016-17, this represented an increase of 0.2 hours worked and a reduction of 0.2 hours in the number of hours devoted to NHS dentistry.

Scotland

9.13 The Scottish Government told us that the percentage of the population registered with an NHS dentist continued to increase. In September 2018, 94.2 per cent of the population were registered, compared with 77.9 per cent in September 2012.

9.14 In August 2018 the Dental Working Hours surveys for both 2016-17 and 2017-18 were published[7]. The results, for Scotland, showed than in 2017-18 dentists worked on average 38.2 hours per week of which 29.4 hours (76.9 per cent) were dedicated to NHS dentistry. Compared with 2016-17, this represents a reduction of 0.1 hours worked and a reduction of 0.5 hours in the number of hours devoted to NHS dentistry.

9.15 The Oral Health Improvement Plan, published by the Scottish Government in January 2018, which it described as having the intention of building on progress made in improving oral health in Scotland and meeting the challenges of the future, including the need to address oral health inequalities and an ageing population, particularly around the provision of oral health domiciliary care. The BDA said that the proposals set out in the plan would require adequate additional funding to implement the plan. As part of the 2018 Programme for Government, the Scottish Government said it would change how NHS Boards provided oral health domiciliary care. The overall aim of the Scottish Government would be to change the approach to dentistry to support better oral and population health, with more emphasis on prevention and anticipatory care.

Northern Ireland

9.16 The Department of Health (Northern Ireland) said that the continued increase in patient numbers, and the resulting increase in treatment provision over recent years, had led to a significant number of dental practices moving to the position where they now provided more Health Service treatment and care for patients.

9.17 The Department also said that while figures collected in recent years had clearly indicated a steady level of growth in patient registrations, the latest statistics indicated that they had slowed down and would now seem to be levelling off.

9.18 In August 2018 the Dental Working Hours surveys for both 2016-17 and 2017-18 were published[8]. The results, for Northern Ireland, showed that in 2017-18 dentists worked on average 36.5 hours per week of which 25.5 hours (69.7 per cent) were dedicated to NHS dentistry. Compared with 2016-17, this represented a reduction of 0.6 hours worked, and a reduction of 0.9 hours in the number of hours devoted to NHS dentistry.

Motivation

9.19 Since our 2018 report the results from the Dental Working Hours Motivation and Morale survey, for 2016-17 and 2017-18 were published by NHS Digital. The survey contained six motivation questions, a leaving question and a question about morale. The motivation questions are set out in the table below.

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[6] https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2016-17-and-2017-18-working-patterns-motivation-and-morale

[7] https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2016-17-and-2017-18-working-patterns-motivation-and-morale

[8] https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2016-17-and-2017-18-working-patterns-motivation-and-morale

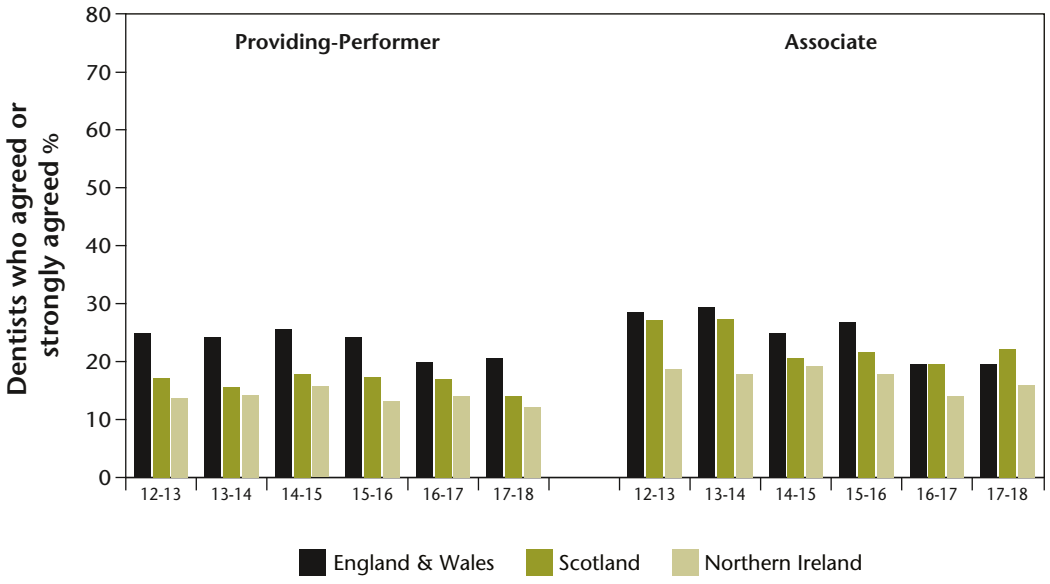
Table 9.1: Dental Working Hours Motivation and Morale Survey questions on motivation

Question	Potential answers
I feel good about my job as a dentist	• Strongly agree • Agree • Neutral • Disagree • Strongly disagree
I receive recognition for the work I do	
I feel my pay is fair	
I have all the equipment and resources I need to do my job properly	
My job gives me the chance to do challenging and interesting work	
There are opportunities for me to progress in my career	

9.20 The main points from the responses to the 2016-17 and 2017-18 surveys were:

- Only 1 in 5 dentists in England & Wales, both providing-performer (21 per cent) and associate dentists (19 per cent), agreed or strongly agreed that their pay was fair (Figure 9.3). For providing-performer dentists the results were even less positive in Scotland (14 per cent agreed that their pay was fair) and Northern Ireland (12 per cent agreed that their pay was fair) than in England & Wales. For associate dentists, those in Scotland (22 per cent) were slightly more positive than their English & Welsh counterparts while the results for associate dentists in Northern Ireland (16 per cent) were less positive than those in England & Wales;

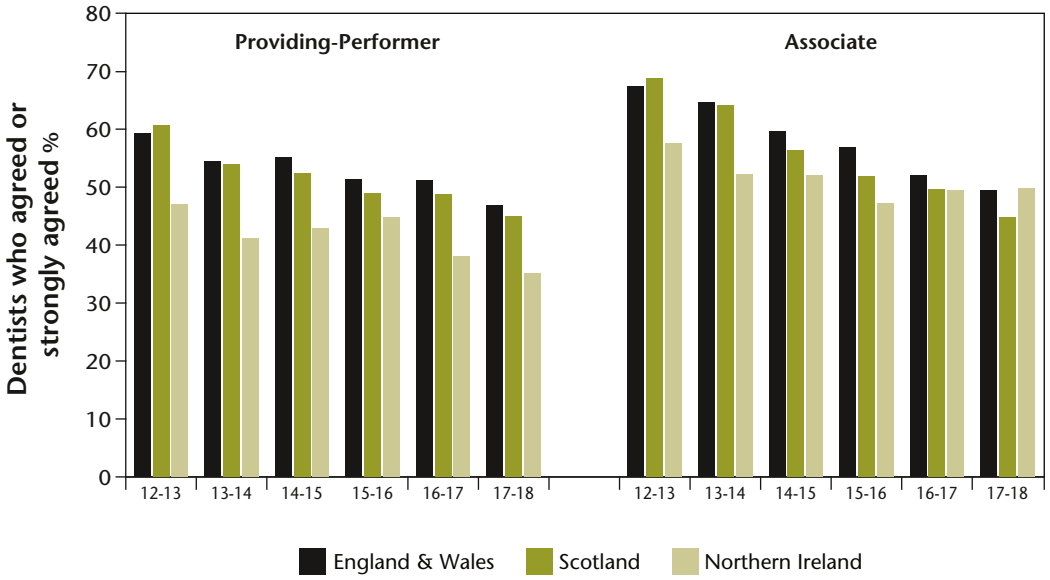
Figure 9.3: Percentage of dentists who 'agreed' or 'strongly agreed' that their pay was fair, 2012-13 to 2017-18



Source: NHS Digital.

- In 2017-18 just under half of all dentists agreed or strongly agreed that they felt good about their job as a dentist, although that fell to just over one-third for providing-performer dentists in Northern Ireland (Figure 9.4). Between 2012-13 and 2017-18, the proportion of dentists giving a positive answer to this question has declined for both providing-performer and associate dentists in each of England & Wales, Scotland and Northern Ireland;

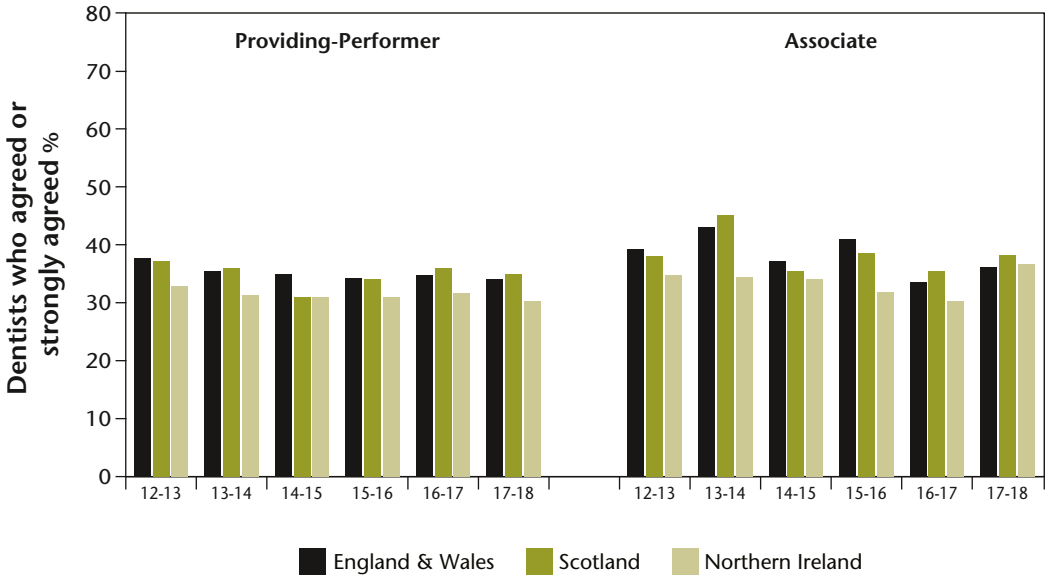
Figure 9.4: Percentage of dentists who 'agreed' or 'strongly agreed' that they felt good about their job as a dentist, 2012-13 to 2017-18



Source: NHS Digital.

- In 2017-18 between 30-40 per cent of dentists, in each of England & Wales, Scotland and Northern Ireland, and for both providing-performer and associate dentists, agreed or strongly agreed that they had opportunities to progress in their career (Figure 9.5). Since 2012-13 the proportion of respondents giving a positive answer has declined, although the results for 2017-18 for associate dentists are more positive in all parts of the UK than in 2016-17;

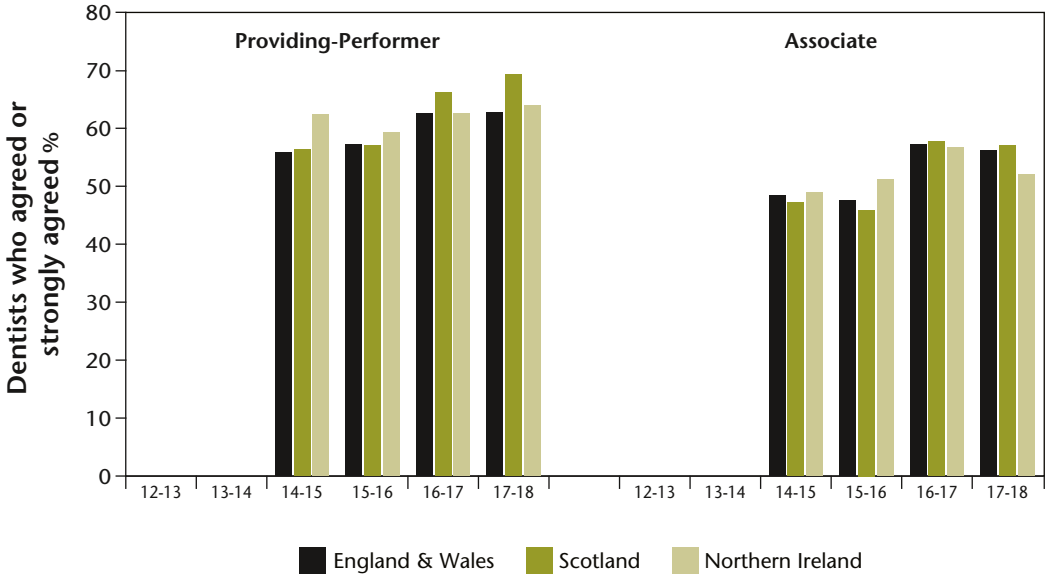
Figure 9.5: Percentage of dentists who 'agreed' or 'strongly agreed' that there were opportunities for them to progress in their career, 2012-13 to 2017-18



Source: NHS Digital.

- Between 2014-15 and 2017-18 the proportion of dentists saying that they agreed or strongly agreed with the statement that they thought about leaving general dentistry increased in each of England & Wales, Scotland and Northern Ireland, and for both providing-performer and associate dentists (Figure 9.6). In 2017-18 over 60 per cent of providing-performer dentists and 50 per cent of associate dentists in all parts of the UK answered in the same way, although for associate dentists the responses were slightly more positive than in 2016-17;

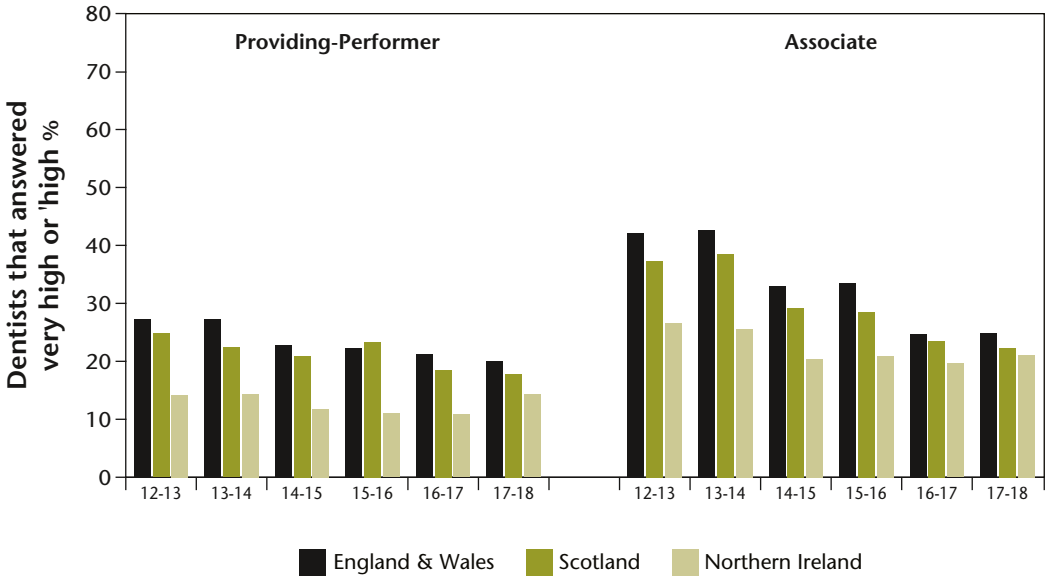
Figure 9.6: Percentage of dentists who 'agreed' or 'strongly agreed' that they thought about leaving general dentistry, 2014-15 to 2017-18



Source: NHS Digital.

- In 2017-18 just 20 per cent of providing-performer dentists in England & Wales rated their morale as high or very high (Figure 9.7). The figures for Scotland (18 per cent) and Northern Ireland (14 per cent) were even less positive. Compared with 2012-13, the latest results for both England & Wales and Scotland are less positive while the results for Northern Ireland are little changed. The results in 2017-18 for associate dentists were slightly more positive than for providing-performers but in all parts of the UK fewer than 25 per cent rated their morale highly. The proportion of positive responses has declined since 2012-13 across all parts of the UK;

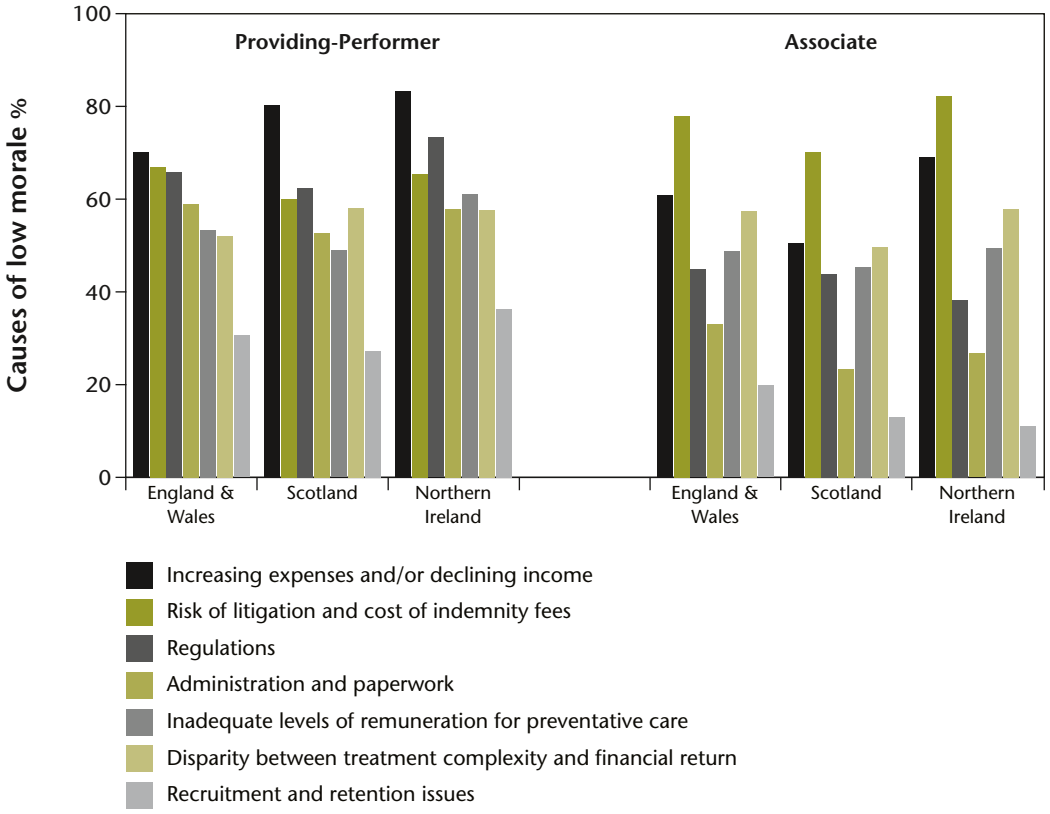
Figure 9.7: Percentage of dentists who rated their morale as 'high' or 'very high', 2012-13 to 2017-18



Source: NHS Digital.

- In 2017-18, for providing-performer dentists in all parts of the UK, the most frequently cited cause of low morale was increasing expenses or declining income (Figure 9.8). The risk of litigation, the cost of indemnity fees and regulations were also cited by more than 60 per cent of those providing-performer dentists responding. For associate dentists the risk of litigation and cost of indemnity fees was the most often cited cause of low morale. Recruitment and retention issues was the cause of low morale least cited by both providing-performer and associate dentists;

Figure 9.8: Causes of low morale amongst dentists, 2017-18



Source: NHS Digital.

9.21 The results from the Dental Working Hours Motivation and Morale survey, for 2016-17 and 2017-18 suggest that the more hours worked and the higher the proportion of work done on NHS/Health Service work, the lower the levels of motivation.

Recruitment and retention

England

9.22 NHS England said that overall workforce numbers appear adequate in order to meet the needs of the population, and that the number of dentists has increased. It said that current income levels are sufficient to recruit and retain the dental workforce.

9.23 However, the BDA said that it believed that their concern about the looming crisis they had identified in general practice recruitment and retention, as reported in last year's report, had not abated and remained an urgent concern. The BDA also said that problems with recruitment and retention of associates in particular, along with a reduction in providing-performers had, resulted in the return or reduction of NHS contracts, sometimes with the closure of NHS practices. It cited data provided to it by NHS England which showed that 231 contracts, with a value of £40 million and covering just over 1 million UDAs, had been terminated by the contract holder between 2015-16 and 2017-18. The BDA said that this stood in stark contrast to the evidence provided by NHS England for our 2018 report that dentists were enthusiastic to undertake NHS contracts.

9.24 The BDA told us that responses to a recent survey of practice owners cited 'few or no applicants' and 'difficulty finding a suitable dentist' when questioned about difficulties in recruiting. The BDA also said that although the reasons for recruitment issues varied between areas across England and the UK, the difficulties faced were acute.

Wales

9.25 The Welsh Government said that some health boards had problems recruiting and retaining dentists, particularly in the rural areas of North, Mid- and West Wales. These included staff movements in the larger corporate bodies from rural to urban areas and a fall in recruitment from Europe, caused by the continuing uncertainty around the UK's future relationship with the EU and a fall in the value of sterling. The Welsh Government said that it was continuing to work with health boards to provide support with incentives and skill mix.

9.26 The BDA said that it had made clear to the Welsh Government that there was a problem with the provision of NHS dental services in Wales, which the Welsh Government had not acknowledged. The BDA went on to say that large corporate chains in Wales were finding that NHS contracts were unworkable and, after suffering clawback and contract reduction were, as a result, closing in ever larger numbers.

Scotland

9.27 The Scottish Government said that EU nationals were very important in the provision of dental services. Around one in ten dentists in Scotland were from the EU, and the Government has been working closely with them, through the EU Dental Network, to protect the workforce from the possible impact of EU Exit.

9.28 The Scottish Government told us that the numbers of dentists in training remained strong, with each yearly cohort constituting around five per cent of the total GDP workforce in Scotland.

9.29 The Scottish Government also told us that there were several incentive payments designed to attract dentists to remote and rural areas. Dentists joining a dental list in certain NHS Board areas within three months of completing their vocational training period could qualify to claim a 'Golden Hello' allowance. These areas were reviewed periodically, to ensure that the allowances were targeted to those areas that required additional incentives for recruitment and retention. The Scottish Government said that there were also payments and incentives to encourage GDPs to work in relatively deprived communities. For example, Childsmile payments had a 'deprivation weighting', where the dentist could qualify for an additional payment.

9.30 The Scottish Government said that the retirement rates of dentists in Scotland were quite low, with just 61 people retiring in 2017-18, representing two per cent of the overall workforce.

9.31 The BDA said that around one in 10 dentists in Scotland is from the EU, and in some NHS Board areas, over 40 per cent. It said that there was a significant risk that parts of Scotland will face a shortage of dentists once the UK leaves the EU. It also said that tighter rules on visas for non-EU dental workers could compound recruitment problems.

Northern Ireland

9.32 In 2018, the Department of Health (Northern Ireland) said that it was content with the number of dentists, and that Northern Ireland was well served. It went on to say that places at dental schools were over-subscribed, but the economic slowdown had meant that the private market for dental treatment had shrunk, potentially reducing overall dental incomes. The department did not present further evidence of recruitment and retention issues for this pay round.

9.33 The BDA said that in a survey of its members, of all the UK countries Northern Ireland reported highest difficulties in finding a suitable dentist when trying to recruit (81.8 per cent). It also said that Northern Ireland dentists suggested difficulties finding appropriate maternity/sickness cover affected around half of those who responded. The BDA attributed this to contractual differences between the four UK countries.

Earnings and expenses for providing-performer and principal GDPs

9.34 NHS Digital, using HMRC data, publishes statistics on the earnings and expenses of primary care dentists who carried out NHS/Health Service work in each part of the UK. The overall picture on earnings is unclear as it is not known how many hours work the statistics were based on, and some dentists choose to take incorporated status, affecting how their income appears in the statistics. It is also difficult to separate earnings attributable to NHS work from those arising from private practice.

England and Wales

9.35 Table 9.2 shows that in 2016-17, providing-performer dentists in England and Wales had average taxable income of £115,800, an increase of 0.1 per cent from 2015-16, and average expenses (employee plus other) of £265,400 (Expenses to Earnings Ratio (EER) of 69.6 per cent). The table also shows that employee expenses for providing-performer dentists increased by 2.6 per cent to £85,800, while non-employee expenses increased by 0.6 per cent, to £179,600.

Table 9.2: Providing-performer GDPs' average gross earnings, income and expenses, England and Wales, NHS and private, headcount, 2008-09 to 2016-17

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2008-09	6,783	366.5	74.7	160.8	131.0	64.3
2009-10	6,250	370.9	77.6	165.3	128.0	65.5
2010-11	5,750	364.3	79.0	168.1	117.2	67.8
2011-12	5,250	358.4	80.7	164.9	112.8	68.5
2012-13	4,750	368.0	80.5	173.3	114.1	69.0
2013-14	4,350	375.0	81.7	178.1	115.2	69.3
2014-15	3,950	385.6	85.5	182.8	117.4	69.6
2015-16	3,450	377.8	83.6	178.5	115.7	69.4
2016-17	3,050	381.2	85.8	179.6	115.8	69.6
Latest change (%)		*+0.9%*	*+2.6%*	*+0.6%*	*+0.1%*	*+0.2pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Scotland

9.36 Table 9.3 shows that in 2016-17 principal dentists in Scotland had average taxable income of £109,000, a decrease of 1.7 per cent from 2015-16, and average expenses (employee plus other) of £268,300 (EER 71.1 per cent). This was the first time average income had fallen, in nominal terms, since 2012-13.

Table 9.3: Principal GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2008-09 to 2016-17

Year	Estimated population	Gross earnings (£000s)	Employee expenses (£000s)	Non-employee expenses (£000s)	Income (£000s)	EER (%)
2008-09	699	343.9	86.7	138.5	118.7	65.5
2009-10	650	337.0	85.8	137.4	113.8	66.2
2010-11	700	334.7	89.3	144.3	101.1	69.8
2011-12	700	332.9	86.2	143.8	102.9	69.1
2012-13	650	319.6	84.0	138.3	97.4	69.5
2013-14	650	330.3	85.0	146.9	98.4	70.2
2014-15	600	347.2	89.9	154.4	102.9	70.4
2015-16	500	377.8	97.8	169.2	110.8	70.7
2016-17	500	377.3	94.3	174.0	109.0	71.1
Latest change		*-0.1%*	*-3.6%*	*2.8%*	*-1.7%*	*0.4pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Northern Ireland

9.37 Table 9.4 shows that in 2016-17, principal dentists had average taxable income of £99,100 and average expenses (employee plus other) of £215,500 (EER 68.5 per cent). Average incomes, in nominal terms, were at the lowest level since at least 2008-09.

Table 9.4: Principal GDPs' average gross earnings, income and expenses, Northern Ireland, Health Service and private, headcount, 2008-09 to 2016-17

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2008-09	319	333.7	66.6	137.5	129.6	61.2
2009-10	350	344.6	73.2	148.5	122.9	64.3
2010-11	300	331.0	79.2	137.6	114.2	65.5
2011-12	350	318.6	77.0	129.1	112.5	64.7
2012-13	300	316.0	79.1	126.1	110.9	64.9
2013-14	300	335.6	76.9	146.2	112.5	66.5
2014-15	250	328.7	76.1	140.9	111.7	66.0
2015-16	250	336.0	78.6	139.8	117.6	65.0
2016-17	200	314.7	80.4	135.1	99.1	68.5
Latest change		*-6.3%*	*2.3%*	*-3.4%*	*-15.7%*	*3.5pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Earnings and expenses for associate GDPs

England and Wales

9.38 Table 9.5 shows that in 2016-17, associate dentists in England and Wales had average taxable income of £60,800, an increase of 1.0 per cent from 2015-16, and average expenses (employee plus other) of £45,600 (EER of 42.8 per cent).

Table 9.5: Associate GDPs' average gross earnings, income and expenses, England and Wales, NHS and private, headcount, 2008-09 to 2016-17

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2008-09	12,853	104.0	5.6	30.7	67.8	34.9
2009-10	14,050	101.7	6.7	29.4	65.6	35.5
2010-11	15,050	98.4	5.9	29.6	62.9	36.0
2011-12	16,050	96.2	5.6	28.9	61.8	35.8
2012-13	16,800	96.2	6.0	29.4	60.8	36.8
2013-14	17,150	99.0	6.7	31.8	60.6	38.8
2014-15	17,400	99.8	6.9	33.0	59.9	39.9
2015-16	17,750	103.5	7.9	35.5	60.2	41.9
2016-17	18,150	106.4	8.3	37.3	60.8	42.8
Latest change		*2.7%*	*5.1%*	*5.1%*	*1.0%*	*0.9pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Scotland

9.39 Table 9.6 shows that in 2016-17, associate dentists in Scotland had average taxable income of £56,400, an increase of 2.1 per cent from 2015-16, and average expenses (employee plus other) of £32,100 (EER of 36.3 per cent).

Table 9.6: Associate GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2008-09 to 2016-17

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2009-10	1,450	91.9	1.1	27.7	63.1	31.3
2010-11	1,450	87.9	1.2	26.6	60.1	31.6
2011-12	1,550	85.0	0.6	26.9	57.6	32.3
2012-13	1,650	84.9	0.8	26.9	57.2	32.6
2013-14	1,650	84.9	0.6	28.1	56.2	33.8
2014-15	1,750	84.7	0.3	29.4	55.0	35.1
2015-16	1,700	86.0	0.4	30.3	55.2	35.7
2016-17	1,750	88.6	0.2	31.9	56.4	36.3
Latest change		*3.0%*	*-50.0%*	*5.3%*	*2.1%*	*0.6pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Northern Ireland

9.40 Table 9.7 shows that in 2016-17, associate dentists in Northern Ireland had average taxable income of £59,100, an increase of 9.0 per cent from 2015-16, and average expenses (employee plus other) of £45,700 (EER of 43.6 per cent).

Table 9.7: Associate GDPs' average gross earnings, income and expenses, Northern Ireland, Health Service and private, headcount, 2008-09 to 2016-17

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2009-10	500	97.9	1.1	34.1	62.7	36.0
2010-11	550	96.2	0.5	36.4	59.4	38.3
2011-12	600	91.6	0.8	35.0	55.7	39.1
2012-13	650	86.7	0.2	33.5	53.0	38.9
2013-14	700	89.7	0.7	34.8	54.2	39.6
2014-15	700	90.2	0.5	35.6	54.0	40.1
2015-16	750	98.9	0.5	44.2	54.2	45.2
2016-17	850	104.8	2.8	42.9	59.1	43.6
Latest change		*6.0%*	*460.0%*	*-2.9%*	*9.0%*	*-1.6pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Contract reform

England

9.41 NHS England said that it has been commissioning primary, community and hospital NHS dental services for five years, and was working towards a single operating model which would provide consistency, efficiency and flexibility as described in Securing excellence in commissioning primary care[9].

9.42 The DHSC told us that the Government had a long-standing commitment to reforming the current dental contractual framework. The approach would be to move to a part-capitation, part-activity model. The capitation model would provide financial drivers which focused on prevention as well as treatment. DHSC also said that two variations of the model had been tested, with encouraging results. It said that the number of dental practices in the programme had been increased and was progressing toward a potential rollout.

9.43 The BDA said that it was still fully engaged in the reform process, but had argued for changes to the current prototype model. It said that the DHSC evaluation of the prototypes provided some evidence to support the BDA's concerns about the financial stability of the prototype model. The BDA also said that it would be working with NHS England and DHSC to produce an alternative to UDAs soon after roll-out begins.

[9] https://www.england.nhs.uk/publication/securing-excellence-in-commissioning-primary-care/

Wales

9.44 The Welsh Government said that 22 dental practices had been taking part in early stages of contract reform, and that early evaluation demonstrated the possibilities of increased access, improved quality and preventative intervention. The Welsh Government said that the need to expand contract reform should be accelerated, and that it had an expectation that a minimum of 20 per cent of dental practices would be taking part in contract reform from April 2019.

Scotland

9.45 The Scottish Government told us that the main aim of the Oral Health Improvement plan was to change the approach to dentistry in Scotland to support better oral and population health, with an emphasis on preventative care and according to patients' oral health needs.

Northern Ireland

9.46 The Department of Health (Northern Ireland) said that it remained committed to the development of a new contract for dentists in Northern Ireland. It also said that it hoped to continue to negotiate with the BDA to develop and implement new contracts which would primarily remunerate practitioners through a capitation type contract for the care and treatment they provide to their patients.

9.47 The BDA said that negotiations towards a new GDS contract in Northern Ireland had stalled as the outcome of an evaluation of GDS pilots was awaited. It said that the results of the evaluation would inform negotiations on a new contract.

Expenses and formula

9.48 In 2016 we decided to make recommendations on our intended increase in pay net of expenses. Taking this approach required the parties to discuss expenses to agree a gross increase. The BDA have said that its preferred position remained that DDRB should recommend on an expenses uplift. For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs, had we continued to use the formula-based approach.

9.49 The BDA in its evidence urged the DDRB to return to the practice of making separate recommendations on expenses. The DDRB has noted that the Scottish Government has asked it not to make recommendations on dentists' expenses, while Northern Ireland, Wales and England do not mention dentists' expenses. We also note that the increase in employer and employee pension contributions from April 2019 hits contractor GDPs particularly hard, and recommend that this is taken account of in discussions about expenses.

Payment recovery

9.50 The BDA again highlighted the issue of what it described as 'clawback'. It said that if providers in England failed to deliver at least 96 per cent of their contracted activity, and providers in Wales failed to deliver at least 95 per cent of their contracted activity, commissioners could recover the payments made for that activity. The BDA said that the amount being recovered was increasing and was £88 million in England in 2017-18, and this could have a significant impact on practice finances.

Salaried dentists

United Kingdom

9.51 GDPs who are employed directly by the NHS will be on a salary directly paid by an NHS organisation. Salaried dentists work in a range of different posts, as community dentists, primary dental services dentists, dental access centre dentists, and as salaried dental practitioners in the NHS.

England

9.52 DHSC told us that salaried dentists working in Community Dental Services (CDS) fill an important role in dental health service provision, particularly for vulnerable patients. NHS England commissions dental services, including community dental services, and were not aware of any specific difficulties in filling vacancies faced by providers.

9.53 However, the BDA told us that across the UK, Community and Public Dental Services are stretched. It said that the CDS across the UK is struggling to recruit, while undergoing the loss of experienced staff and has reached the point of a recruitment crisis. It suggested that for the last two years across the UK, for every three posts vacated, less than two appointments have been made. In a BDA survey, four in five CDS staff said that they had been asked to cover absent colleagues and 50 per cent of responders said that it was a moderate or more frequent event for them to work in excess of their contracted hours.

9.54 The BDA said that morale among CDS dentists was low, and that 45 per cent do not see their future in the CDS within the next five years. The BDA also told us that 66 per cent of CDS dentists had reached the top of their salary scale with no opportunity for progression, that 82 per cent of CDS dentists that it surveyed perceived their workload to be high or very high, and almost half said they felt their current pay was unfair.

9.55 More than half of their members in England reported that they had undergone a tendering exercise[10] in the past year, in some cases the whole practice being put out to tender. Where attempts to re-commission CDS services had failed, this has led to issues with commitments to staff, training and resources. The BDA said that this process had resulted in a decrease in morale.

Wales

9.56 The Welsh Government told us that the 106 full-time equivalent dentists working in the CDS delivered oral health promotion and intervention programmes, including the Designed to Smile child oral health improvement programme, and provided NHS dentistry services to vulnerable patients and those who had difficulty accessing treatment.

9.57 The BDA said that the health boards had had difficulty with recruitment and retention of CDS staff, especially in rural areas, and that the number of FTE staff in the CDS was the lowest since 2011, which in their view was an unsustainable service model, not capable of addressing the growth in the Welsh population.

[10] The process of the commissioning authority seeking to identify a suitable provider of Community Dental Services.

Scotland

9.58 The Scottish Government said that the Public Dental Service[11] (PDS) constitutes about 12 per cent of the NHS workforce in Scotland, and delivers dental care to priority groups such as people with a disability and the homeless. It also said that there were similar challenges to those faced by the GDP service in some of the more remote and rural areas, and there are similar payment regimes, such as an equivalent set of 'Golden Hello' payments to attract dentists to the PDS service in those areas.

9.59 The BDA said that it was concerned about how the PDS in Scotland would meet the growing demands of an ageing population at a time when the number of PDS dentists and clinics was reducing. It was also concerned about the retirement of senior dentists, which it attributed to stress, restructuring of services and the need for retraining to take on new roles.

9.60 The BDA said that it was concerned about changes to PDS management, and the 6 per cent reduction in the number of PDS posts from 2016-17 and 2017-18 due to the transfer of GDS patients to independent GDP clinics. The BDA was also concerned about the lack of long-term investment and the cutting of funding leading to disquiet among the profession about the service.

Northern Ireland

9.61 In March 2019 the Department of Health (Northern Ireland) announced the implementation of the new contract for CDS dentists[12]. The department had said that the new contract for Northern Ireland would meet the needs of practitioners and of the service commissioner, and improve the oral health of patients in Northern Ireland. It added that it hoped that this would provide greater stability for practitioners and hopefully alleviate some of the BDA's concerns.

9.62 The BDA said that the CDS dentists were integral to dental provision for vulnerable and challenging patients in Northern Ireland, because they provided care which could not be delivered by other means. The BDA also said that the CDS dentists were under increasing pressure from a growing elderly population with increasingly complex needs, and that CDS dentists were increasingly frustrated, concerned and demoralised that contract implementation had not yet happened. In BDA's view, workforce planning, and implementation of the new CDS contract, were urgent imperatives.

Our comments

9.63 The review body has noted once again the significant difference between the picture of dentistry as presented by the health departments and as presented by the BDA. DHSC/ NHS England presents a picture of a reasonable balance between supply and demand. This would appear to be backed up by data which suggest that around 95 per cent of individuals who attempt to see an NHS dentist are able to do so.

9.64 The BDA's picture is rather different: in many parts of the country practices are closing, dentists are difficult to recruit and to retain, and there is said to be a general drift into crisis. The results of the Dental Working Hours Motivation and Morale Survey showed a worsening of morale, a fall in satisfaction with pay and an increase in those thinking about leaving general dentistry.

[11] In 2014 the CDS and salaried GDS merged to become the Public Dental Service (PDS). Its main role was to complement independent GDS provision and provide a dental service to people with special needs and those who cannot access care from independent GDPs.

[12] https://www.health-ni.gov.uk/sites/default/files/publications/health/TC8-01-2019.DOCX

9.65 The review body finds it concerning that two such apparently diverse interpretations could be held by the two bodies who, between them, are likely to be best placed to know the reality. The review body has in the past looked to data on the sale of practices to assure itself that supply and demand are not in any serious imbalance. In the light of the continuing differences of opinion, it may be time that the practice closure and transfer data are looked at again to determine whether the national-level picture revealed by the DHSC data is at too aggregated a level, and possibly hides significant local shortcomings in particular areas. The DDRB would urge the DHSC and the BDA to work together to review the position and to arrive at some resolution to the widely differing pictures of dentistry as presented by the parties.

9.66 To the extent that practices are not able to survive on NHS income alone, the review body is conscious that, to an extent not possible in other parts of the NHS, alternatives may exist for dentists to supplement their income through private practice, or to hand back NHS contracts and replace them with private business.

9.67 The review body noted that although the English Government said it was committed to dental contract reform, this has been a long process which, with the hope to add just 50 more practices to reformed contracts by the end of the 2018-19 financial year, is unlikely to be completed in the near future. It is therefore unlikely that the stated intention of increasing access and improving oral health, would be achieved soon. The review body would encourage speedy conclusion of this work.

CHAPTER 10: PAY RECOMMENDATIONS AND OBSERVATIONS

Introduction

10.1 In this chapter we discuss our recommendations on the main pay uplift for our remit group. We also comment on the case for targeting.

A UK-wide labour market

10.2 The market for the medical and dental workforce is UK-wide. While recognising the distinctive approach that the Scottish Government has taken towards public sector pay, we heard nothing to suggest that the medical and dental workforce within the UK currently comprises separate national markets. None of the four UK countries, in their evidence, asked us for differential basic recommendations.

Affordability

10.3 England was the only one of the four UK countries to put a monetary envelope on the figure it considered available for a pay uplift. The DHSC said in its evidence that it expected the review body to make recommendations within an envelope of £250 million for substantive HSCS medical staff, taking into account how the available funding could best be targeted. They provided an equivalent financial envelope for the pay of General Dental Practitioners of £37 million. We noted that the figures for both HSCS and GDP staff would translate into a general increase of 2 per cent. With CPI inflation running at approximately 2 per cent, this would correspond to a zero real pay increase.

10.4 Earlier in this report we have noted that such monetary envelopes reflect judgements, whether by the employer or the government. Each year many assumptions have to be made about potential costs and savings, and decisions to invest or not invest resources are likely to have knock-on consequences over several years. To take a single example, within a total annual NHS budget for England of over £110 billion, the current annual cost of agency expenditure on medical and dental staff is almost £1 billion. Deciding how much money should be invested to try and reduce that cost is a matter of choice and judgement. Such potential trade-offs can be found throughout the NHS. In this context we regard affordability as a factor but not a binding constraint on our recommendations.

Basic pay recommendations

10.5 We noted that, were we to stay rigidly within the envelope set out by the DHSC, and were we also to take up the invitation to target specific groups within that envelope, then some members of the workforce would need to receive a below-inflation basic pay uplift in order to create headroom for targeting.

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

10.7 We have some serious concerns about morale within our remit group, and about the implications for motivation. It appears that a long period of real-terms pay decline over the last decade is starting to have a significant negative impact. This emerged strongly from the tone and content of the written evidence we received from the British Medical Association (BMA), the British Dental Association (BDA), and the Hospital Consultants and Specialists Association (HCSA). It was visible in the sharp fall in satisfaction in pay as reported in the staff surveys described in Chapter 4. We also heard it on our visits within England, where several very negative comments were made about the Government's decision to stage and abate the pay recommendations that we made last year, and about the reductions made to some of our recommendations (for example, the award for consultants was not only staged, but reduced from 2 per cent to 1.5 per cent).

10.8 This concerns us. The NHS has always relied to a considerable extent on goodwill and vocational commitment. Even though unquantifiable, this discretionary effort makes a significant contribution to NHS productivity. It cannot simply be taken for granted. All the UK Governments and NHS leaderships have ambitious plans for the future, and our remit group will have key roles to play. Discussions need to conclude on the consultant contract, and the junior doctors' contract review process, as well as those issues affecting General Dental Practitioners (GDPs) and SAS doctors.

10.9 For all of these, sustainable success requires mutual confidence and reasonable goodwill. In that context, the recent staff survey results, showing declines in almost every measure of engagement and job satisfaction, are very worrying.

10.10 The recently concluded GMP agreement in England provided specifically for a 2 per cent pay uplift for salaried GMPs, while also addressing significant financial issues for contractor GMPs. These include questions of liabilities and responsibilities arising from practice ownership, and the funding of professional medical indemnities. The total financial benefits of these new arrangements for individual contractor GMPs may be considerably more than 2 per cent.

10.11 Recent years have seen a return to economic growth, and an increase in the level of pay settlements in the wider economy. We believe that this should be reflected in the basic pay increase for our remit group. We also believe that an award that is felt to be fair and reasonable will provide a constructive background for the strategic discussions about the future of the NHS which are going on in all parts of the UK.

10.12 Unless otherwise indicated, these recommendations are for England, Wales, Scotland and Northern Ireland.

10.13 **We recommend a 2.5 per cent increase to the national salary scale for the following salaried doctors and dentists included in the 2019 remit group, payable in full from the start of the relevant April 2019 pay year and backdated as necessary in the event of late implementation, namely:**

- **consultants;**
- **doctors and dentists in training;**
- **independent contractor GMPs in Wales, Scotland and Northern Ireland;**
- **salaried GMPs in Wales, Scotland and Northern Ireland;**
- **independent contractor GDPs; and**
- **salaried GDPs including Community Dental Service practitioners;**

10.14 As an illustration of cost, within England we estimate that this would add £316 million to the paybill in 2019-20, compared with what the DHSC described as an envelope of £250 million for substantive HCHS medical staff. For GDPs, it would add around £46 million to the total paybill, against the DHSC envelope of £37 million. We set these figures in the context of other NHS expenditure – for example, the almost £1 billion annual spend for agency expenditure on medical and dental staff in England. We are also conscious of the potential costs and savings associated with future contract negotiations covering different groups within our remit, and of the wider strategic challenges facing the NHS across the country.

Targeting

10.15 We have expressed our support for the principle of specialist and geographical targeting, but we did not receive this year any specific proposals on which we were asked to comment. We were strongly urged by the unions not to take this approach.

10.16 We considered the case for more specific recommendations, targeted at particular groups within our remit. We had some difficulty with the use of the concept of targeting in the evidence we received, which appears to mean different things to different people. In some respects, already divergent pay levels in some parts or countries of the United Kingdom, for example the London allowance, and areas of Wales, Scotland and Northern Ireland, represent examples of *de facto* targeted pay, whether or not that was the original intention. Initiatives on targeting need to take account of the impact which existing *de facto* targeting arrangements may be having.

10.17 We noted a certain ambivalence among employers on the use of targeting for such purposes, with a reluctance to endorse it formally. We heard arguments on the difficulties and problems of using targeting in a sector where the total available workforce was already below the level needed to meet overall demand. However, we believe that, even in these circumstances, targeted pay arrangements have a part to play in ensuring that available resources can be allocated most effectively and efficiently.

10.18 In previous reports we have noted the use of 'Golden Hellos' to attract more people to train as GMPs in certain geographical areas, and in our last report we signalled support for targeting towards training places in histopathology. For this round, we are content to make no further recommendations, since we believe these would not be helpful in establishing the constructive background for future dialogue that our main recommendations are intended to create. In our view, pay incentives could be useful and the DDRB urges the parties to pursue these options further in situations where there are persistently high shortages, relative to other geographies or specialties, encouraging long-term tracking to be put in place to monitor and evaluate the outcomes and make specific proposals to us in the future.

SAS doctors

10.19 Last year we recommended that specialty and associate specialist doctors (SAS) should receive a 3.5 per cent increase in their basic pay from April 2018. The Welsh Government implemented this recommendation in full. In other parts of the UK it was reduced; the English Government implemented a 3 per cent increase. However, we were pleased that the DHSC Secretary of State committed to working with the BMA SAS committee to reform the SAS contract in England and agreed in principle that this will include reopening the Associate Specialist (AS) grade to extend career development for this group.

10.20 This represents a good start on the road to reinvigorating this small but important group of senior doctors. This year, we see a value for money justification for going a little further. Many of the staff in the SAS group are highly experienced and are able to carry out specialist procedures in a way that helps relieve some of the burden on the consultant workforce. They help towards overall productivity by ensuring particular specialist procedures are done effectively but at a lower overall cost. Some 40 per cent of the doctors in the group are qualified international doctors, so there is no long training period before they can be deployed. They are also the group whose pay is most susceptible to international recruitment influences, such as the relative strength or weakness of sterling.

10.21 SAS doctors will have a crucial role in delivering the productivity improvements of the Long Term Plan. We also note that female and BAME staff comprise a higher than average percentage of SAS doctors.

10.22 We recommend that this group should receive an extra 1 per cent in addition to the 2.5 per cent general increase that we are recommending for all groups. The extra cost would be £11 million. We consider this would be a further cost-effective, and justifiable, investment in raising the profile and attractiveness of this important but too often under-valued group of staff.

10.23 **We accordingly recommend 3.5 per cent increase to the national salary scale for all specialty and associated specialist (SAS) doctors, payable in full, from the start of the relevant April 2019 pay year and backdated as necessary in the event of late implementation.**

10.24 **We recommend that the value of Clinical Excellence Awards, Distinction Awards and Discretionary Points, GMP trainers grant and GMP appraisers' grant, and the flexible pay premia included in the junior doctors' contract in England increases in line with our recommendations for the national salary scales, an increase of 2.5 per cent, also from the beginning of the year and backdated as necessary in the event of late implementation.**

Our recommendations

10.25 In view of the staging and abatement applied to our recommendations last year, we have made it explicit in this report our desire to see the recommended uplifts applied in full, from the start of the pay year, and backdated if necessary to ensure that the full annual value is paid.

CHAPTER 11: LOOKING FORWARD

11.1 In this final chapter we look ahead to some of the challenges facing our remit group and what we would expect to see covered in evidence over the next few years.

Our 48th Report 2020

11.2 To recognise the rights of all the parties involved and for the review body process to work effectively, it is important that all the parties strive to work to an agreed timetable and to ensure that evidence is produced and delivered in a timely manner.

Economic outlook

11.3 There is always uncertainty attached to forecasting the outturn of the economy. But at this time, with major changes such as Brexit on the horizon, there is greater uncertainty than usual. In addition to affecting the wider economy this is an issue that has the potential to impact directly on our remit group, as the UK continues to depend heavily on its ability to recruit doctors and dentists internationally.

Affordability and productivity

11.4 Labour productivity in the NHS has grown broadly in line with that of the wider economy. However, identifying the impact of those in our remit group on the overall output of the system is difficult, as the delivery of healthcare is a collaborative effort between those in our remit group and other NHS staff. We would welcome more detailed evidence showing the contribution of the various components of our remit group, and consultants in particular, towards improvements in productivity and the trade-offs between staff numbers and pay, but recognise that the most appropriate place for detailed consideration of productivity issues is probably through contract negotiations.

Workforce planning

11.5 Across the UK, health departments are developing strategies to help them meet the demands of the future, especially the move towards improved integration of health and social care. We do not underestimate the difficulty of this task, especially given the challenges which Brexit poses in relation to international recruitment, and the changing ambitions of the workforce in relation to work/life balance. We look forward to seeing in our evidence next year how these strategies are being developed and implemented, and impacting on the provision of patient care in Wales, Scotland and Northern Ireland. In England, we await with interest the publication of the final version of the NHS Workforce Implementation Plan, led by Baroness Harding of Winscombe, as part of the commitments of the NHS Long Term Plan.

Doctors and dentists in training

11.6 We look forward to hearing about the outcome of the review of the junior doctors' contract in England (to be undertaken in line with an agreement reached at the Advisory, Conciliation and Arbitration Service (ACAS)) and the subsequent contract negotiations. We will also be interested to hear of any reform to the contract arrangements for doctors and dentists in training in other parts of the UK.

11.7 We look forward to receiving evidence about the effectiveness of the flexible pay premia in the junior doctors' contract in England. We would also welcome evidence or proposals that look at extending the range of pay premia to cover other specialties and the introduction of pay premia related to geography.

Specialty doctors and associate specialists

11.8 We look forward to receiving updates on the progress of the reform of the SAS contract in England which will include the possibility of reopening the Associate Specialist (AS) grade.

Consultants

11.9 We have recognised in this report that the consultant contract negotiations in England are ongoing in parallel to our work, but we are disappointed at the lack of progress in this area, over many years. We feel that there have been missed opportunities to resolve some of the issues affecting this group, especially around Clinical Excellence Awards, Distinction Awards and Discretionary Points. We expect to be kept informed of progress made in the consultant contract negotiations.

General Medical Practitioners

11.10 We look forward to hearing about the impact that the new GMP contract has had on the independent contractor GMP and the salaried GMP workforce in England.

11.11 We were told that there had been positive progress in implementing and delivering the anticipated benefits of the first phase of the GP Contract in Scotland. We look forward to hearing about the outcomes and evaluations of the first phase and the progress of phase two.

Dentists

11.12 We have heard again from the British Dental Association (BDA) that NHS dentistry has reached crisis point due to pay and workload issues. However, these reports continue to contrast strongly with the assessments we receive from the health departments, which report improving access for patients and quality of care and an ability to be able to let competitive contracts for NHS dentistry. We are interested in hearing in more detail about the frequency with which dental contracts are returned to those commissioning dental services, and some assessment of the viability of dental practices.

11.13 We would also be interested in seeing the time series data on the morale and motivation results from a succession of staff surveys undertaken by the BDA. They would assist us to better understand the ongoing issues within dentistry.

Pay

11.14 Issues that we will look to see covered in the future include:

- we expect to hear about action to mitigate the impact of the way that pension benefits are taxed, and the outcome of the planned Government consultation on proposals to offer a different pension option to senior clinicians as part of the ongoing discussions to resolve this issue;
- data published since the introduction of the new contract for junior doctors showed an average increase in the earnings of doctors at the Foundation stage. We will look with interest to see if that becomes a trend or if the data starts to show greater variability;
- a full assessment of the impact of the pay premia already introduced as part of the junior doctors' contract and any further premia that are introduced;

- it may not be available until the evidence for our 2021 report, but we will be interested to see if the recommendations we made last year on the pay of GMPs feed through to the income figures for GMPs and if the introduction of the new General Medical Services contract in Scotland have an impact on GMP earnings; and
- attempts to develop a sound methodology that would allow the introduction of pay premia based on specific geographies.

11.15 We would welcome updates on the progress of the parties to consider the issue of the common understanding of NHS productivity. We requested in our previous report that parties consider the issue, but have received no evidence this year that this has advanced. We think that the issue of productivity in the NHS is important, but not straightforward, and that more detail on NHS output measures, on the contribution to output of different parts of the workforce, and on the benefits of changes in the composition of the workforce would provide a clearer – and more useful – picture of productivity increases and the affordability of any pay recommendations.

Future data requirements

11.16 We very much welcome the progress being made on the provision of better pay and workforce data. This is critical to good decision-making by the health system, as well as to our consideration of pay recommendations and the merits of targeting. Several organisations and working groups provide us with such information, for which we are grateful. We noted this year that the fuller evidence provided by DHSC was a significant step forward, and particularly helpful in providing the range and detail of information we needed. We encourage other government departments to emulate this.

11.17 Data gaps have emerged during this round, and Table 11.1 summarises these by UK country. We are interested in these data broken down by staff group, region, gender and age where possible. We would also like to see time series data, which is much more useful and enables us to have a clearer view of the issues.

11.18 Of the data requests in Table 11.1, we would especially appreciate information in the following areas: earnings by full-time equivalent for Salaried GMPs and GDPs and further information about the breakdown between NHS and private income for GDPs; the number of NHS dental contracts returned, and the reasons for their return; time series evidence on morale and motivation among dentists; and the composition of the community dental services workforce by contract type.

Future developments

11.19 We would welcome information about the outcomes of the enhanced commitment to a multi-disciplinary approach to service provision across the wider Primary Care and Social Care teams, as highlighted by the 2018 Scottish Primary Care Plan.

11.20 We look forward to the publication of the findings of the Gender Pay Gap in Medicine review, led by Professor Dame Jane Dacre, later this year. We would welcome updates about the impact the findings, recommendations and planned action are likely to have on our remit group.

Table 11.1 Data gaps by UK country

	England	Wales	Scotland	Northern Ireland
Paybill data (Chapter 3)	Sample career pathways.	Total health expenditure. Total medical paybill. Elements of paybill growth. Sample career pathways		
Locum use and rates (Chapter 3)	Information about the number of hours worked, type of work, pay rates, demographics and why people choose to do locum work.			
Productivity (Chapter 3)		Information about productivity in the NHS.		
Workforce information (Chapter 4)	Annual time series of average total earnings by FTE, nationality of workforce by staff group and median and interquartile ranges of average total FTE earnings by staff group.	Average earnings of medical staff by FTE, staff group, and nationality of workforce. Turnover by staff group.	Average earnings of medical staff by FTE, staff group, and nationality of workforce.	Average earnings of medical staff by FTE, staff group, and nationality of workforce.
Early retirement and pensions (Chapter 4)	Data on the impact of pension tax changes. Information and time series about the number of staff taking early retirement and whether they re-join the workforce, and if they re-join whether on FT or PT basis. Withdrawals from the NHS pension scheme,			
Staff survey results by hospital medical and dental group (Chapters 4, 5, 6, 7)	Breakdown by age, sex and staff group.	Inclusion of question on satisfaction with pay.	Breakdown by staff group.	Breakdown by staff group.
International recruitment and retention (Chapter 4)	Potential impact of EU exit and measures to mitigate the impact. Number, destinations and motivation of international leavers, particularly of those who return overseas. Number of international joiners.			
Career choices for junior doctors (Chapter 5)	Average UCAS scores for those starting on medical and dental degrees. Career paths of junior doctors, understanding of why they make those choices. Data on those who step out temporarily from service and training – at what point in training and motivators especially those who become locums or go overseas. Data on those who do not return after stepping out temporarily from service and training. Impact of FPP (England).			
Vacancy rates (Chapters 4, 5, 6, 7, 8, 9)	Dentists in training. SAS Doctors. GMPs and GDPs.	Vacancy or shortfall rates across remit group. Junior doctor fill rates by region and specialty.	Junior doctor fill rates by region and specialty.	Vacancy or shortfall rates across remit group. Junior doctor fill rates by region and specialty.

	England	Wales	Scotland	Northern Ireland
SAS doctors (Chapter 6)	SAS Doctors recruitment and retention patterns. Use of the SAS Development Fund.			
Consultants (Chapter 7)	Consultant recruitment and retention patterns, including sources of recruitment.			
GMP and GDP motivation data (Chapters 8 and 9)	GMP and GDP motivation. Systematic data on salaried GMPs and GDPs. Time series morale and motivation data on GDPs.			
GMP and GDP earnings by FTE (Chapters 8 and 9)	Earnings by FTE (as well as headcount). Demographic information and working hours of GMPs. Number of consultations carried out. Timeseries of the value of dental clawback. NHS and private earnings split.			
GDP Contracts (Chapter 9)	Number of contracts returned and reasons for returns. BDA time series data			
Gender pay gap (Chapter 10)	Gender pay analysis. Relevant comparator group pay.			

APPENDIX A: REMIT LETTERS FROM THE PARTIES

Department of Health & Social Care

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Professor Sir Paul Curran

Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

21 November 2018

Dear Professor Curran,

I am writing firstly to express my thanks for your valuable work on the 2018-19 pay round. As you know, the government, had to make some difficult decisions on the awards for 2018-19 against the budgeted one per cent. We did so informed by your considered recommendations on targeting pay and taking into account affordability and the prioritising of patient care.

I write now to formally commence the 2019-20 pay round.

The NHS Long Term Plan and the 2019 Spending Review - on which NHS England will provide written evidence - provide the context for the long-term funding of the NHS. The affordability of pay recommendations will have to be considered within the context of NHS England's affordability assumptions in the Long Term Plan, and the importance of making planned workforce growth affordable. Given the NHS budget is now set for the next five years, there is a direct trade-off between pay and staff numbers and our evidence, and that from NHS England, will set out the balance. The evidence that I will provide in the coming months will also support you in your consideration of affordability and I request that you describe in your final report what steps you have taken to take account of affordability and need for workforce growth and improved productivity. Pay awards will also be considered in the context of planned workforce reform and productivity improvements, which we will cover in our evidence.

I am also seeking your views on the targeting of available funds in pay in 2019-20 to ensure recruitment and retention pressures are properly addressed, and ask that you outline what consideration you have given to targeting in your final report.

You are invited to make recommendations in relation to doctors and dentists in training about targeting funding to support productivity and recruitment and retention. We would like you to consider how resources might be targeted, including through the existing mechanisms of the flexible pay premia in the contract for doctors and dentists in training and taking account of views from Health Education England on hard-to-fill training programmes.

In relation to the future remuneration of consultants, I have asked NHS Employers to continue exploratory talks with the BMA with a view to reaching a multi-year agreement incorporating contract reform. At present, it seems unlikely that these talks will bear fruit. I am therefore asking you for recommendations in relation to consultants, asking you to consider targeting of pay including to support increased productivity.

I am asking also for your recommendations on Specialty Doctors and Associate Specialists, and our evidence will update you on our approach to a review of the salary structure for these grades as proposed in your 46th Report.

In considering remuneration for General Medical Practitioners, we wish to make the Review Body aware that NHS England are shortly due to begin formal negotiations to reach agreement on a new primary care contract. As I have set out, we are aspiring to negotiate a multi-year agreement on proposed reforms in primary care which will lead to enhanced resources going into primary care.

We invite you to make recommendations as usual for General Dental Practitioners.

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

We would welcome your report by week commencing 6 May 2019.

Yours ever,

MATT HANCOCK

Department of Health & Social Care

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

4 February 2019

Dear Professor Sir Paul Curran,

Review of Doctors' and Dentists' Remuneration: General Medical Practitioners and the Forty-Seventh Review.

As you are aware we submitted written evidence to you on 18th January 2019. In this, we set out that we would update you in supplementary evidence on the outcome of 2019/20 primary contract negotiations. The outcome of these negotiations has now been finalised and published.

https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/

The contract agreement gives five-year funding clarity and certainty for practices and confirms the funding intended through national legal entitlements for general practice under the practice and new network contracts. British Medical Association General Practitioners Committee (GPC) England and NHS England have agreed that they do not expect additional national money for practice or network contract entitlements, taken together, until 2024/25. Beyond contract funding, investment worth hundreds of millions of pounds will continue to be made in central programmes benefiting general practice.

As part of this agreement, both GPC England and NHS England agreed that they would ask the Secretary of State for Health and Social Care to not ask for the review body's recommendation on independent contractor GMP net income. Following on

from this request, I ask that the review body does not provide a recommendation on independent contractor pay in England for the duration of the five-year deal.

Under this agreement, NHS England and GPC England have agreed that practice staff, including salaried GPs, in England will receive at least a 2.0% increase in 2019/20, although the actual effect will depend on indemnity arrangements within practices. From April 2019, the minimum and maximum pay range for salaried GMPs will be uplifted by 2%. NHS England and GPC England have therefore asked the Secretary of State for Health and Social Care to not ask for the review body's recommendation on salaried GMP pay in England for the 2019/20 pay round. As such, I ask that the review body does not provide a recommendation for salaried GPs in England for the 2019/20 pay round. We envisage continuing to include recommendations on the pay of salaried GMPs within the review body's remit from the 2020/21 pay round onwards. Recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under this deal and will inform decisions by GMP partners on increases to the pay of salaried GMPs. We ask you to continue as usual for this pay round and the following pay rounds to make a recommendation on pay for GMP trainees, educators and appraisers. As now, the Government will decide how to respond to DDRB recommendations.

We attach a summary of the contract agreed and invite the review body to note the new contract.

Ian Dodge
National Director of Strategy and Innovation
NHS England

Dr Richard Vautrey
Chair, General Practitioners Committee
British Medical Association

MATT HANCOCK
Secretary of State for Health and Social Care

Copy list: Ed Waller; Ed Scully; Jonathan Marron; Daniel Hodgson

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health & Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/VG/4602/18

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

Neil.Higginbottom@beis.gov.uk

8 March 2019

Dear Paul,

Doctors and Dentists Remuneration Review Body remit for Wales 2019-20

Thank you for the DDRB work on the 2018-19 pay round. I am writing to formally commence the 2018-19 pay found for medical and dental staff in Wales.

In this pay round I would like you to consider evidence and make recommendations on what would be a fair and affordable pay award for medical and dental staff to help us sustain the NHS in Wales and deliver the priorities set out in *A Healthier Wales: Our Plan for Health and Social Care*?

While we recognised and accepted the DDRB's recommendations during the 2018 pay review round to target pay for GMPs and SAS doctors to address issues around recruitment, retention & moral, Welsh Government continues not to support the use of targeted pay to specific specialities within staff groups.

Your advice and recommendations will enable me to determine a fair pay award for medical and dental staff in Wales, and to seek a sufficient transfer of funding from the UK Government to Wales to enable us to fund that award and protect patient services.

In order to support your work, I have provided written evidence to the Doctors' and Dentists' Review Body and my officials have committed to attend the planned oral evidence session in the spring.

I would like to receive your advice and recommendations in early May 2019 to ensure that payment of any award to hard pressed NHS staff is not unduly delayed.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

As noted in my remit letter last year, the NHS across the four UK nations benefits from a degree of mobility within the workforce, which supports flexibility in recruitment, ease of movement for career development and training and to ensure equity for professional staff working across the UK. This means it is essential that Wales continue to be aware and engaged in any future contractual negotiations.

I look forward to receiving your advice and recommendations in May.

Yours sincerely,

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health & Social Service

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

T: 0300 244 4000
E: scottish.ministers@scotland.gsi.gov.uk

The Scottish Government
Riaghaltas na h-Alba

Professor Sir Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics

By Email.

7 February 2019

Dear Paul

Further to my letter of 9 January 2019, I am now writing to formally set out our remit for the Doctors' and Dentists' Review Body (DDRB) for 2019-20.

As you are aware, the Cabinet Secretary for Finance, Economy and Fair Work announced the draft Scottish Public Sector Pay Policy (SPSPP) for 2019-20 on 12 December 2018. I am pleased to be able to report that the SPSPP was agreed in Parliament on 31 January 2019 and the main features remain unchanged:

- a guaranteed minimum increase of 3 per cent for public sector workers who earn £36,500 or less;
- a limit of up to 2 per cent for those earning above £36,500 and below £80,000;
- a flat increase for those earning £80,000 or more of £1,600;
- continuing the policy commitment to No Compulsory Redundancy.

The SPSPP also continues to provide the flexibility for employers to consider:

- using up to 1 per cent of paybill savings on baseline salaries for additional non-consolidated payments for employees already on the maximum of their pay range (who no longer benefit from progression) or on spot rates; and
- a cash underpin of up to £750 for those employees who earn less than £25,000
- other affordable and sustainable changes to their existing pay and grading structures where there is clear evidence of inequality issues.

It will be necessary to consider the affordability of the Recommendations from the DDRB within the confines of the SPSPP set for 2019-20.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Although we are seeking Recommendations from the DDRB on a pay uplift for one year only (2019-20), it will be necessary to consider these in the context of our longer term vision on:

- retention and recruitment of medical and dental staff in NHS Scotland
- increasing staff morale and ensuring staff in our health service feel valued as employees
- ensuring all medical and dental staff receive appropriate support to carry out their roles and responsibilities
- ensuring improved productivity and efficiency of our health service

Whilst it would not be particularly helpful for the DDRB to recommend different uplifts for different staff groups in NHS Scotland per se, it would be helpful if the Recommendations set out how limited financial resources could be targeted more effectively to address the issues above.

For General Medical Practitioners (GMPs) we are only seeking a recommendation on the pay element. We are in the process of agreeing a separate expenses exercise with the Scottish General Practitioners Committee of the BMA which will help inform our discussions on expenses.

For General Dental Practitioners (GDPs) we are once again seeking a recommendation on the pay element only. We are also intending to conduct a separate expenses exercise which, depending on the level of information received, will help to inform any discussions on expenses with BDA Scotland.

Copies of this letter will be 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.

Kind regards

JEANE FREEMAN

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Professor Sir Paul Curran
Chair of the review Body for
Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

By email: lesley.balkham@beis.gov.uk

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

Tel: 02890520559
Fax: 02890520573

Email: richard.pengelly@health-ni.gov.uk

Our ref: RP3373
SSUB-0008-2019

Date: 7 January 2019

Dear Professor Curran

I am writing to formally commence the 2019/20 pay round for doctors and dentists in Northern Ireland and to submit my Department's evidence. I wish to begin by thanking the Review Body for Doctors' and Dentists Remuneration (DDRB) for its invaluable work on the 2018/19 pay round.

On 22 November 2018, the Department of Finance (DoF) set Northern Ireland's public sector pay policy for 2018/19. Doctors' and dentists' pay in Northern Ireland, however, is yet to be determined. This will be considered in the context of the public sector pay policy and continued budgetary pressures.

This year we would welcome, for consideration, your recommendations on pay for all doctors and dentists working within health and social care in Northern Ireland.

Yours sincerely

RICHARD PENGELLY

APPENDIX B1: DETAILED RECOMMENDATIONS ON REMUNERATION IN ENGLAND

SALARY SCALES[1]

The salary scales that we recommend apply from 1 April 2019 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

The 2018 salary scales reflect those that were implemented from 1 October 2018.

Further recommended pay scales, allowances and fees, including those for previous contracts, can be found on the Office of Manpower Economics' website.

A. Basic pay scales and awards

	2018 £	2019 £
Doctors in training (2016 contract)		
Foundation doctor – year 1	27,146	27,825
Foundation doctor – year 2	31,422	32,207
Core/Run-through training – year 1 & 2	37,191	38,120
Core/Run-through/Higher training – year 3 +	47,132	48,310
Specialty doctor (2008 contract)	39,060	40,428
	42,400	43,884
	46,742	48,378
	49,069	50,787
	52,422	54,257
	55,762	57,714
	59,177	61,248
	62,593	64,784
	66,009	68,319
	69,424	71,854
	72,840	75,389
Associate specialist (2008 contract)	54,764	56,681
	59,167	61,238
	63,568	65,792
	69,380	71,808
	74,418	77,023
	76,508	79,186
	79,235	82,009
	81,963	84,832
	84,690	87,654
	87,418	90,477
	90,147	93,302

[1] Our recommended basic pay uplifts, to be applied from 1 April 2019, are applied to unrounded current salaries (November 2007 is the base year date for most staff groups), with the final result being rounded up to the nearest pound.

	2018	2019
	£	£
Staff grade practitioner	36,187	37,454
(1997 contract, MH03/5)	39,060	40,427
	41,932	43,400
	44,805	46,373
	47,678	49,347
	51,060	52,847
Discretionary points	*Notional scale*	
	53,423	55,293
	56,295	58,265
	59,168	61,239
	62,041	64,212
	64,913	67,185
	67,787	70,159
Consultant (2003 contract)	77,913	79,860
	80,352	82,361
	82,792	84,862
	85,232	87,362
	87,665	89,856
	93,459	95,795
	99,254	101,735
	105,042	107,668
Clinical Excellence Awards (local)		
Level 1	3,016	3,092
Level 2	6,032	6,184
Level 3	9,048	9,276
Level 4	12,064	12,368
Level 5	15,080	15,460
Level 6	18,096	18,552
Level 7	24,128	24,736
Level 8	30,160	30,920
Level 9	36,192	37,104
Salaried General Medical Practitioner range[2]		
Minimum	57,655	58,808
Maximum	87,003	88,743
Dental foundation training	31,982	32,782
Dentists in training (2016 contract)		
Foundation dentist – year 1	27,146	27,825
Foundation dentist – year 2	31,422	32,207
Dental core training – year 1 & 2	37,191	38,120
Dental core & specialty training – year 3 +	47,132	48,310

[2] NHS Employers (on behalf of NHS England) and the General Practitioners Committee (GPC) of the BMA negotiated an agreement on the GP contract for 2019-20 before the DDRB reported. From April 2019, the recommended minimum and maximum pay scales for salaried GPs were uplifted by two percent.

	2018	2019
	£	£
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	39,638	40,629
	44,042	45,143
	50,648	51,914
	53,951	55,300
	57,255	58,686
	59,457	60,943
Band B: Salaried dentist[3]	61,659	63,200
	63,861	65,457
	67,164	68,843
	68,815	70,536
	70,467	72,229
	72,119	73,921
Band C: Salaried dentist[4, 5]	73,770	75,614
	75,972	77,871
	78,174	80,129
	80,376	82,386
	82,578	84,643
	84,780	86,900

B. Pay premia

	2018	2019
	£	£
Flexible pay premia – doctors and dentists in training (2016 contract)		
General practice	8,448	8,659
Psychiatry core training	3,434	3,520
Psychiatry higher training (3 year)	3,434	3,520
Psychiatry higher training (4 year)	2,576	2,640
Academia	4,121	4,224
Histopathology	4,121	4,224
Emergency medicine/Oral & maxillofacial surgery		
3 years	6,868	7,040
4 years	5,151	5,280
5 years	4,121	4,224
6 years	3,434	3,520
7 years	2,944	3,018
8 years	2,576	2,640

London weighting

The value of the London zone payment[6] is unchanged at £2,162 for non-resident staff and £602 for resident staff.

[3] The first salary point of Band B is also the extended competency point at the top of Band A.
[4] The first salary point of Band C is also the extended competency point at the top of Band B.
[5] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.
[6] *Thirty-Sixth Report*. Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 1.64.

APPENDIX B2: DETAILED RECOMMENDATIONS ON REMUNERATION IN WALES

SALARY SCALES[7]

The salary scales that we recommend apply from 1 April 2019 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Further recommended pay scales, allowances and fees, including those for previous contracts, can be found on the Office of Manpower Economics' website.

Basic pay scales and awards

	2018	2019
	£	£
Foundation house officer 1 (2015 contract)	23,553	24,142
	25,023	25,649
	26,494	27,157
Foundation house officer 2 (2015 contract)	29,214	29,945
	31,125	31,904
	33,035	33,861
Specialty registrar (full)	31,219	32,000
	33,128	33,957
	35,796	36,691
	37,410	38,346
	39,354	40,338
	41,301	42,334
	43,247	44,329
	45,194	46,324
	47,140	48,319
	49,087	50,315
Specialty doctor	39,251	40,625
	42,607	44,099
	46,970	48,614
	49,308	51,034
	52,677	54,521
	56,034	57,996
	59,464	61,546
	62,897	65,099
	66,331	68,653
	69,762	72,204
	73,195	75,757

[7] Our recommended basic pay uplifts, to be applied from 1 April 2019, are applied to unrounded current salaries (November 2007 is the base year date for most staff groups), with the final result being rounded up to the nearest pound.

	2018	2019
	£	£
Associate specialist (2008)	55,031	56,958
	59,455	61,536
	63,878	66,114
	69,718	72,159
	74,780	77,398
	76,880	79,571
	79,621	82,408
	82,362	85,245
	85,102	88,081
	87,843	90,918
	90,586	93,757
Staff grade practitioner	36,364	37,637
(1997 contract, MH03/5)	39,251	40,625
	42,137	43,612
	45,023	46,599
	47,911	49,588
	51,309	53,105
Discretionary points	*Notional scale*	
	53,683	55,562
	56,569	58,549
	59,456	61,537
	62,343	64,526
	65,228	67,511
	68,117	70,502
Consultant (2003 contract)	75,881	77,779
	78,298	80,256
	82,340	84,399
	87,034	89,210
	92,395	94,705
	95,452	97,839
	98,515	100,978
Commitment awards[8]	3,336	3,420
	6,669	6,840
	10,004	10,260
	13,337	13,680
	16,670	17,100
	20,005	20,520
	23,338	23,940
	26,671	27,360

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

	2018 £	2019 £
Salaried General Medical Practitioner range		
Minimum	58,787	60,257
Maximum	88,710	90,928
Dental foundation training	31,665	32,457
Dental core training	29,359	30,093
	31,279	32,061
	33,199	34,029
	35,119	35,997
	37,038	37,964
	38,958	39,932
	40,878	41,900
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	39,639	40,630
	44,043	45,145
	50,650	51,917
	53,952	55,301
	57,255	58,687
	59,458	60,945
Band B: Salaried dentist[9]	61,659	63,201
	63,862	65,459
	67,164	68,844
	68,816	70,537
	70,468	72,230
	72,120	73,923
Band C: Salaried dentist[10, 11]	73,772	75,617
	75,973	77,873
	78,175	80,130
	80,378	82,388
	82,580	84,645
	84,781	86,901

[9] The first salary point of Band B is also the extended competency point at the top of Band A.
[10] The first salary point of Band C is also the extended competency point at the top of Band B.
[11] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

APPENDIX B3: DETAILED RECOMMENDATIONS ON REMUNERATION IN SCOTLAND

SALARY SCALES[12]

The salary scales that we recommend apply from 1 April 2019 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Further recommended pay scales, allowances and fees, including those for previous contracts, can be found on the Office of Manpower Economics' website.

Basic pay scales and awards

	2018	2019
	£	£
Foundation house officer 1	24,382	24,991
	25,904	26,551
	27,425	28,111
Foundation house officer 2	30,242	30,998
	32,219	33,025
	34,197	35,052
Specialty registrar (full)	32,157	32,961
	34,125	34,978
	36,873	37,795
	38,534	39,498
	40,538	41,552
	42,544	43,607
	44,549	45,663
	46,553	47,717
	48,558	49,772
	50,563	51,828
Specialty doctor	39,846	41,240
	43,253	44,766
	47,682	49,350
	50,055	51,807
	53,476	55,347
	56,883	58,874
	60,366	62,479
	63,851	66,086
	67,336	69,692
	70,819	73,298
	74,304	76,904

[12] Our recommended basic pay uplifts, to be applied from 1 April 2019, are applied to unrounded current salaries (November 2007 is the base year date for most staff groups), with the final result being rounded up to the nearest pound.

	2018	2019
	£	£
Associate specialist (2008 contract)	55,865	57,820
	60,356	62,469
	64,845	67,115
	70,775	73,252
	75,914	78,571
	78,046	80,778
	80,828	83,657
	82,775	85,672
	85,476	88,468
	88,177	91,263
	90,881	94,061
Staff grade practitioner (1997 contract)	36,915	38,207
	39,845	41,240
	42,775	44,272
	45,706	47,305
	48,636	50,339
	52,087	53,910
Discretionary points	*Notional scale*	
	54,497	56,404
	57,426	59,436
	60,357	62,470
	63,288	65,503
	66,217	68,535
	69,149	71,569
Consultant (2004 contract)	80,653	82,669
	82,356	84,415
	84,808	86,928
	87,260	89,441
	89,705	91,948
	95,528	97,917
	101,352	103,886
	107,170	109,849
Discretionary points for consultants	3,204	3,284
	6,408	6,569
	9,612	9,853
	12,816	13,137
	16,020	16,421
	19,224	19,705
	22,428	22,989
	25,632	26,273

	2018 £	2019 £
Salaried General Medical Practitioner range		
Minimum	58,220	59,676
Maximum	86,898	89,070
Dental core training[13]	35,715	36,607
Dental senior house officer/Senior house officer	30,242	30,998
	32,219	33,025
	34,197	35,052
	36,174	37,079
	38,152	39,106
	40,129	41,133
	42,107	43,159
Salaried primary care dental staff (2008 contract)		
Band A: Dental officer	40,832	41,852
	45,369	46,503
	52,174	53,478
	55,576	56,965
	58,979	60,453
	61,247	62,778
Band B: Senior dental officer	63,516	65,103
	65,784	67,428
	69,186	70,915
	70,888	72,660
	72,590	74,404
	74,290	76,147
Band C: Assistant clinical director	75,992	77,891
	78,260	80,216
	80,528	82,541
Band C: Specialist dental officer	75,992	77,891
	78,260	80,216
	80,528	82,541
	81,985	84,035
Band C: Clinical director/Chief administrative	75,992	77,891
dental officers	78,260	80,216
	80,528	82,541
	81,985	84,035
	84,187	86,292
	86,390	88,550

[13] On completion of Core training employees will move to the nearest point on or above their existing salary on the Dental senior house officer scale.

APPENDIX B4: DETAILED RECOMMENDATIONS ON REMUNERATION IN NORTHERN IRELAND

SALARY SCALES

At the time of submitting this report the Department of Health, Northern Ireland had yet to make an award for 2018. There are no salary scales in place for 2018 and therefore no base from which to apply our 2019 recommendations.

APPENDIX B5: OTHER FEES AND ALLOWANCES[14]

Operative date

1. The levels of remuneration set out below are recommended to apply from 1 April 2019.

Hospital medical and dental staff

2. The annual values of national Clinical Excellence Awards (CEAs) for consultants and academic General Medical Practitioners should be increased as follows:[15]

	England		Wales	
	2018	2019	2018	2019
	£	£	£	£
Level 9 (Bronze)	36,192	37,097	36,915	37,838
Level 10 (Silver)	47,582	48,772	48,534	49,748
Level 11 (Gold)	59,477	60,964	60,667	62,184
Level 12 (Platinum)	77,320	79,253	78,867	80,939

3. The annual values of Distinction Awards for consultants[16] should be increased as follows:

	England		Wales		Scotland	
	2018	2019	2018	2019	2018	2019
	£	£	£	£	£	£
B award	32,601	33,416	33,254	34,086	31,959	33,078
A award	57,048	58,474	58,189	59,644	55,924	57,881
A+ award	77,415	79,350	78,964	80,939	75,889	78,545

General Medical Practitioners

4. The supplement payable to general practice specialty registrars is 45 per cent[17, 18] of basic salary.

5. The value of the GP trainer grant and GP appraiser fee should be increased as follows:

	England		Wales		Scotland	
	2018	2019	2018	2019	2018	2019
	£	£	£	£	£	£
GP trainer grant	8,146	8,350	8,225	8,431	8,228	8,434
GP appraiser fee	515	528	520	533	515	528

[14] At the time of submitting this report the Department of Health, Northern Ireland had yet to make an award for 2018. There are no salary scales in place for 2018 and therefore no base from which to apply our 2019 recommendations.

[15] Awarded by the Advisory Committee on Clinical Excellence Awards (ACCEA).

[16] 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.

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

[18] Doctors employed on the 2016 Junior Doctors contract in England will not receive this supplement but may be eligible for the General Practice Flexible Pay Premia instead.

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN THE NHS IN THE UK[1]

ENGLAND[2]	2017		2018		Percentage change 2017-2018	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[3]						
Consultants	45,825	48,607	47,308	50,275	3.2%	3.4%
Associate specialists	2,088	2,337	1,987	2,215	-4.9%	-5.2%
Specialty doctors	6,528	7,637	6,825	7,933	4.5%	3.9%
Staff grades	365	432	313	375	-14.2%	-13.2%
Registrar group	30,448	31,714	30,407	31,666	-0.1%	-0.2%
Foundation house officers 2[4]	6,510	6,558	5,521	5,560	-15.2%	-15.2%
Foundation house officers 1[5]	6,130	6,163	6,260	6,294	2.1%	2.1%
Other doctors in training	9,737	9,908	11,216	11,426	15.2%	15.3%
Hospital practitioners/Clinical assistants	484	1,722	498	1,727	2.9%	0.3%
Other staff	886	1,349	912	1,394	2.9%	3.3%
Total	**109,002**	**116,040**	**111,247**	**118,510**	**2.1%**	**2.1%**
General Medical Practitioners[6]	**33,437**	**39,871**	**33,327**	**40,196**	**-0.3%**	**0.8%**
GMP partners	20,205	22,791	19,262	21,857	-4.7%	-4.1%
GMP registrars	5,509	5,646	5,880	5,986	6.7%	6.0%
GMP retainers[7]	88	213	121	314	36.5%	47.4%
Other GMPs	7,635	11,465	8,065	12,236	5.6%	6.7%
General Dental Practitioners[8,9,10]		**24,007**		**24,308**		**1.3%**
General Dental Services only		20,046		20,514		2.3%
Personal Dental Services only		1,625		1,536		-5.5%
Mixed		1,542		1,446		-6.2%
Trust-led		794		812		2.3%
Ophthalmic medical practitioners[11]		**190**		**218**		**14.7%**
Total general practitioners		**64,688**		**64,369**		**1.0%**
Total – NHS doctors and dentists		**180,108**		**183,232**		**1.7%**

1 An employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.
2 Data as 30 September unless otherwise indicated.
3 Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.
4 Includes senior house officers.
5 Includes house officers.
6 From 2015 figures are sourced from the workforce Minimum Dataset (wMDS) and include estimates for missing data. Data excludes locums.
7 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.
8 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 meet the criteria for inclusion within the annual reconciliation process.
9 Data as at 31 March of that year.
10 Includes salaried dentists.
11 Data as at 31 December of that year.

WALES[12]	2017		2018		Percentage change 2017-2018	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff[13]						
Consultants	2,530	2,678	2,570	2,732	1.6%	2.0%
Associate specialists	253	291	225	258	-10.9%	-11.3%
Specialty doctors	545	633	564	649	3.6%	2.5%
Staff grades	4	5	3	4	-21.8%	-20.0%
Specialist registrars	2,102	2,212	2,195	2,314	4.4%	4.6%
Foundation house officers 2[14]	504	521	542	561	7.5%	7.7%
Foundation house officers 1[15]	403	429	400	428	-0.6%	-0.2%
Hospital practitioners	1	5	1	3	-12.5%	-40.0%
Clinical assistants	6	26	5	24	-17.0%	-7.7%
Other staff[16]	36	73	33	72	-7.2%	-1.4%
Total	**6,383**	**6,873**	**6,539**	**7,045**	**2.4%**	**2.5%**
General Medical Practitioners		**2,182**		**2,208**		**1.2%**
GMP providers		1,926		1,964		2.0%
General practice specialty registrars		239		230		-3.8%
GMP retainers		17		14		-17.6%
General Dental Practitioners[17]		**1,475**		**1,479**		**0.3%**
General Dental Services only		1,207		1,212		0.4%
Personal Dental Services only		77		72		-6.5%
Mixed				112		10.9%
Ophthalmic medical practitioners[18]		**5**		**4**		**-20.0%**
Total general practitioners		**3,662**		**3,691**		**0.8%**
Total – NHS doctors and dentists		**10,535**		**10,736**		**1.9%**

[12] Data as 30 September unless otherwise indicated.
[13] Some hospital practitioners and clinical assistants also appear as General Medical Practitioners, General Dental Practitioners or ophthalmic practitioners.
[14] Includes senior house officers.
[15] Includes house officers.
[16] Consists of mainly dental officers.
[17] Data as of 31 March that year.
[18] Data as of 31 December of that year.

SCOTLAND[19]	2017		2018		Percentage change 2017-2018	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff						
Consultants	5,324	5,745	5,485	5,938	3.0%	3.4%
Specialty doctors	939	1,271	936	1,252	-0.4%	-1.5%
Registrar group	4,156	4,348	4,110	4,303	-1.1%	-1.0%
Foundation house officers 2[20]	882	914	932	965	5.7%	5.6%
Foundation house officers 1[21]	1,177	1,239	1,040	1,099	-11.7%	-11.3%
Other staff	761	1,270	1,036	1,579	36.2%	24.3%
Total	**13,239**	**14,666**	**13,538**	**15,012**	**2.3%**	**2.4%**
General medical practitioners		**4,919**		**4,994**		**1.5%**
GMP providers		3,491		3,396		-2.7%
General practice specialty registrars[22]		521		564		8.3%
GMP retainers[23]		90		84		-6.7%
Other GMPs		830		970		16.9%
General dental practitioners (non-hospital)[24]		**3,300**		**3,309**		**0.3%**
General Dental Service		3,004		3,052		1.6%
Public Dental Service		403		390		-3.2%
Ophthalmic medical practitioners		**27**		**27**		**0.0%**
Total general practitioners		**8,246**		**8,330**		**1.0%**
Total – NHS doctors and dentists		**22,912**		**23,342**		**1.9%**

[19] Data as 30 September unless otherwise indicated.
[20] Includes senior dental officers.
[21] Includes dental officers.
[22] Formally known as GMP registrars.
[23] 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.
[24] Includes salaried, community and public dental service dentists.

NORTHERN IRELAND[25]	2017		2018		Percentage change 2017-2018	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[26, 27]						
Consultant	1,666	1,770	1,693	1,800	1.6%	1.7%
Associate Specialist/Specialty Doctor/Staff Grade	441	531	475	563	7.7%	6.0%
Specialty/Specialist Registrar	1,309	1,343	1,360	1,405	3.9%	4.6%
Foundation/Senior House Officer	542	544	519	522	-4.2%	-4.0%
Other[28]	140	293	152	310	8.3%	5.8%
Total	**4,098**	**4,481**	**4,199**	**4,600**	**2.5%**	**2.7%**
General Medical Practitioners[29]		**1,306**		**1,323**		**1.3%**
General Dental Practitioners[30, 31]		**1,066**		**1,091**		**2.3%**
Ophthalmic medical practitioners[32]		**11**		**11**		**0.0%**
Total general practitioners		**2,383**		**2,425**		**1.8%**
Total – NHS doctors and dentists		**6,864**		**7,025**		**2.3%**

[25] Data as 30 September unless otherwise indicated.
[26] Some hospital practitioners and clinical assistants also appear as General Medical Practitioners, General Dental Practitioners or Ophthalmic medical practitioners.
[27] As at March that year.
[28] Due to changes the collection of staff groups, the 'other' category is not consistent across year groups and should not be compared with previous years.
[29] Data as October of that year.
[30] Data as April that year.
[31] It is possible for someone to be a dentist in one location and an assistant at another location. The final total will not represent individual people.
[32] Data as at April that year.

APPENDIX D: GLOSSARY OF TERMS

AGENDA FOR CHANGE – the current NHS grading and pay system for NHS staff, with the exception of doctors, dentists, apprentices and some senior managers. The pay structure for staff employed under AfC is divided into nine pay bands. Staff are assigned to one of these pay bands on the basis of job weight, as measured by the NHS Job Evaluation Scheme.

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.*

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

CAVENDISH COALITION – a group of health and social care organisations formed to provide those leading Brexit negotiations with the expertise, evidence and knowledge required on post-EU referendum issues affecting the health and social care sectors.

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

CLINICAL EXCELLENCE AWARDS (CEAs) – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. All levels of Clinical Excellence Awards are pensionable, with the exception of the local Clinical Excellence Awards in England awarded from March 2018 onwards. 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 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, higher education, pharmaceutical and veterinary.

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 remain 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 remain in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable. See also *Clinical Excellence Awards, Discretionary Points.*

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

FOUNDATION HOUSE OFFICER – a trainee doctor undertaking a Foundation Programme, a (normally) two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. 'FY1' refers to a trainee doctor in the first year of the programme; 'FY2' refers to a doctor in the second year.

FOUNDATION SCHOOL – a group of institutions bringing together medical schools, the local deanery, trusts and other organisations such as hospices. They aim to offer training to foundation doctors in a range of different settings and clinical environments and are administered by a central staff supported by the deanery.

GENERAL DENTAL PRACTITIONER – a qualified dental practitioner, registered with the General Dental Council and on the dental list of an NHS England Region (Geography) for the provision of general dental services.

GENERAL MEDICAL PRACTITIONER – more commonly known as a GP, a GMP works in primary care and specialises in family medicine.

GENERAL MEDICAL PRACTITIONER RETAINER – a general medical practitioner, who provides service sessions in general practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

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 *Quality and Outcomes Framework.*

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

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

NHS LONG TERM PLAN – a document published by NHS England on 7 January 2019, which sets out its priorities for healthcare in England over the next 10 years and shows how the NHS funding settlement will be used. The plan builds on the policy platform laid out in the NHS five year forward view which articulated the need to integrate care to meet the needs of a changing population.

PATIENTS AT THE HEART – NHS England and ministerial commitment to 'put patients at the heart' of business planning to improve care and access for all. DDRB's terms of reference state that the Review Body should have reference 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.'

PERFORMER-ONLY DENTISTS (ENGLAND AND WALES) – a performer-only dentist delivers NHS dental services but does not hold a contract. They are employed by a provider-only or a providing-performer. The equivalent in Scotland and Northern Ireland is associate dentist. See also *associate dentists.*

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

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

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

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

SALARIED CONTRACTORS (including salaried GMPs) – 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.*

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 closed.

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.

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.

APPENDIX E: THE DATA HISTORICALLY USED IN OUR FORMULAE-BASED DECISIONS FOR INDEPENDENT CONTRACTOR GMPS AND GDPS

E.1 This appendix supports Chapters 8 and 9 and gives the latest data that would have populated the formulae for both GMPs and GDPs, had we used the formulae-based approach (Table E.1).

E.2 Whilst we are not making formula-based recommendations for independent contractor GMPs and GDPs, we set out below in Table E.1 the data that would have populated the formulae. Given our ongoing concerns with the reliability of the formula, we do not consider it appropriate this year to adjust the weightings of the coefficients in the formula. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work: as noted in our 2012 report, average earnings and expenses for dentists reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound. The parties may wish to consider this point as part of their discussion of expenses and the uplift.

Table E.1: Data historically used in our formulae-based decisions for independent contractor GMPs and GDPs

Coefficient	Value
Income (GMPs) *DDRB recommendation*	2.5%
Staff costs (GMPs) *Annual Survey of Hours and Earnings (ASHE) 2018 (general medical practice activities)*	3.7%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2018*	3.0%
Income (GDPs) *DDRB recommendation*	2.5%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2018 (dental practice activities)*	0.0%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2018*	3.0%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2018*	3.0%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2018*	3.1%
Other costs (GDPs) Scotland *RPIX for Q4 2018*	3.0%

Sources: Annual Survey of Hours and Earnings (Table 16.5a), Consumer Price Inflation Time Series (CDKQ, CZBH).

APPENDIX F: ABBREVIATIONS AND ACRONYMS

ACAS	Advisory, Conciliation and Arbitration Service
ACCEA	Advisory Committee on Clinical Excellence Awards
A&E	Accident and Emergency
APMS	Alternative Providers of Medical Services
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
BAME	Black, Asian and Minority Ethnic
CCG	Clinical Commissioning Group
CDS	Community Dental Service
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
CPIH	Consumer Prices Index including owner occupiers' housing costs
Con.	Consultant
CT 1-3	Junior doctor, later stages in training (Core Training)
DDRB	Review Body on Doctors' and Dentists' Remuneration
DETINI	Department of Enterprise, Trade and Investment in Northern Ireland
DHSC	Department of Health and Social Care (England)
DLHE	Destination of Leavers of Higher Education
DWP	Department for Work and Pensions
EER	Expenses to earnings ratio
FY1	Foundation House Officer Year 1
FY2	Foundation House Officer Year 2
FHO	Foundation House Officer
FPP	Flexible Pay Premia
FTE	Full Time Equivalent
GDC	General Dental Council
GDP	Gross domestic product
GDP	General Dental Practitioner
GDS	General Dental Services
GMC	General Medical Council
GMP	General Medical Practitioner
GMS	General Medical Services
GP	General Practitioner
GPMS	General/Personal Medical Services

GPST	General Practice Specialty Training
HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association
HEE	Health Education England
HESA	Higher Education Statistics Agency
HMRC	Her Majesty's Revenue and Customs
HSCNI	Health and Social Care Northern Ireland
JDC	Junior Doctors Committee
LTP	NHS Long Term Plan
MPIG	Minimum Practice Income Guarantee
MSP	Member of the Scottish Parliament
NAO	National Audit Office
NHS	National Health Service
NI	Northern Ireland
NSS	NHS National Services Scotland
OBR	Office for Budget Responsibility
OECD	Organisation for Economic Co-operation and Development
OME	Office of Manpower Economics
ONS	Office for National Statistics
PA	Programmed Activity
PDS	Public Dental Services
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
RPI	Retail Prices Index
RRP	Recruitment and Retention Premium
SAS	Specialty doctors and associate specialists
SDAI	Scottish Dental Access Initiative
SPA	Supporting Professional Activity
SRMC	Scottish Rural Medicine Collaborative
ST	Specialist Training
UCAS	Universities and Colleges Admissions Service
UCEA	Universities and Colleges Employers Association
UDA	Unit of Dental Activity
UK	United Kingdom
UKFPO	UK Foundation Programme Office

APPENDIX G – PREVIOUS DDRB RECOMMENDATIONS AND THE GOVERNMENT'S RESPONSES

The main DDRB recommendations since 1990 for the general pay uplift are shown in the table below, together with the November or Quarter 4 RPI and CPI inflation figures which were usually the latest figures available at the time of publishing the Review Body's report and the Governments' responses to the recommendations as a whole.

Report year	Main uplift	RPI % (Nov)[1]	CPI % (Nov)[2]	Response to report
1990	9.5%	7.3	5.5	Not accepted. Rejected increases at top of consultants' scale and in the size of the A+ distinction award; staged implementation
1991	9.5% to 11%	10.9	7.8	Accepted, but staged implementation
1992	5.5% to 8.5%	3.7	7.1	Accepted
1993		3.6	2.6	No report following Government's decision to impose a 1.5% pay limit on the public sector
1994	3%	1.4	2.3	Accepted
1995	2.5% to 3%	2.4	1.8	Accepted
1996	3.8% to 6.8%	3.2	2.8	Accepted, but staged implementation
1997	3.7% to 4.1%	2.7	2.6	Accepted, but staged implementation
1998	4.2% to 5.2%	3.7	1.9	Accepted, but staged implementation
1999	3.5%	3.1	1.4	Accepted
2000	3.3%	1.2	1.2	Accepted
2001	3.9%	3.1	1.1	Accepted, but Government suspended the operation of the balancing mechanism (which recovers GMPs 'debt')
2002	3.6% to 4.6%	0.9	0.8	Accepted
2003	3.225%	2.6*	1.5	Accepted
2004	2.5% to 2.9%	2.5	1.3	Accepted
2005	3.0% to 3.4%	3.4**	1.5	Accepted
2006	2.2% to 3.0%	2.2**	2.1	Accepted, although consultants' pay award of 2.2 per cent was staged – 1.0 per cent paid from 1 April 2006 and the remaining 1.2 per cent paid from 1 November 2006
2007	£1,000 on all pay points***	3.9	2.7	Accepted, although Scottish Executive did not implement one of the smaller recommendations relating to the pot of money for distinction awards to cover newly eligible senior academic GMPs. England and Wales chose to stage awards in excess of 1.5 per cent – 1.5 per cent from 1 April 2007, the balance from 1 November 2007
2008	2.2% to 3.4%	4.3	2.1	Accepted
2009	1.5%	3.0****	4.1	Accepted

[1] At November in the previous year, series CZBH.

[2] At November in the previous year, series D7G7.

Report year	Main uplift	RPI % (Nov)[1]	CPI % (Nov)[2]	Response to report
2010	0% to 1.5%	0.3	1.9	Mostly accepted. DDRB recommended: 0% for consultants and independent contractor GMPs and GDPs; 1% for registrars, SAS grades, salaried GMPs and salaried dentists; and 1.5% for FHOs. England and Northern Ireland both restricted the FHO recommendation to 1%.
2011	No recommendation due to public sector pay freeze	4.7	3.3	
2012	No recommendation due to public sector pay freeze	5.2	4.8	
2013	1%	3.0	2.7	Accepted
2014	1%	2.6 Q4	2.1 Q4	Accepted in Scotland. Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales. Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales.
2015	1%	1.9 Q4	0.9 Q4	Accepted. Recommendation only applied to independent contractor GMPs and GDPs in the UK and for salaried hospital staff in Scotland
2016	1%	1.0 Q4	0.1 Q4	Accepted
2017	1%	2.2 Q4	1.2 Q4	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland.
2018	2%	3.7 Q1[#]	2.7 Q1[#]	Staged and abated in England. Accepted in Wales. Accepted in Scotland, except for staff earning at least £80,000 who received £1,600. Northern Ireland yet to respond.
2019	2.5%	2.5 Q1[#]	1.9 Q1[#]	

* Due to the late running of the round, DDRB was also able to take account of the March figures for RPI (3.1%).

** Due to a later round, November to February, DDRB was also able to take into account the December RPI figure.

*** £650 on the pay points for doctors and dentists in training. The average banding multiplier for juniors meant that this would also deliver approximately £1,000.

**** DDRB also took into account the December RPI figure (0.9%).

[#] Due to the late running of the round, DDRB was also able to take account of the Q1 RPI and CPI figures.

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