Review Body on Doctors' and Dentists' Remuneration

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Forty-Fifth Report 2017

Scotland Supplement

***Chair*: Professor Sir Paul Curran**

SG/2017/31

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Forty-Fifth Report 2017
Scotland Supplement

Chair: Professor Sir Paul Curran

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

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

www.gov.uk/ome

Review Body on Doctors' and Dentists' Remuneration

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

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

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

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

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

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

the Government's inflation target;

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

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

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

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

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

The members of the Review Body are:

Professor Sir Paul Curran (Chair)
David Bingham
Lucinda Bolton
Mehrunnisa Lalani
Professor Kevin Lee
Professor James Malcomson
Lisa Tennant
Nigel Turner, OBE

The Secretariat is provided by the Office of Manpower Economics

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Executive Summary

This supplement contains our consideration of our remit in Scotland, together with our recommendations. It should be read in conjunction with our main 45th report, which covers England, Wales and Northern Ireland and contains UK-wide data, commentary and comparison.

Recommendations for our remit in Scotland 2017-18

Pay

- A base increase of 1 per cent to the national salary scales for salaried doctors and dentists.
- The maximum and minimum of the salary range for salaried GMPs be increased by 1 per cent.
- For independent contractor GMPs, an increase in pay, net of expenses, of 1 per cent.
- For independent contractor GDPs, an increase in pay, net of expenses, of 1 per cent.

Allowances and awards

- An increase in the GMP trainers' grant of 1 per cent.
- No increase in the rate for GMP appraisers which would remain at £500.
- The supplement payable to general practice specialty registrars to remain at 45 per cent of basic salary for those on the existing UK-wide contract.
- We are increasingly concerned that the Scottish Government's policy of no monetary uplift for Distinction Awards and Discretionary Points, and a freeze on new Distinction Awards, may be adversely affecting the attractiveness to consultants of working in Scotland. In the absence of clear evidence either way on that, we are nevertheless clear that recognising performance through pay is an established and important part of the consultants' pay system. We also recognise the Scottish Government's wish that the future of these awards be addressed as part of wider consultant contract reform. However, since this will not be concluded in 2017-18, we therefore recommend that the value of the awards for consultants – Distinction Awards and Discretionary Points – be increased in line with our main pay recommendation of 1 per cent. We would also wish to see the freeze on new Distinction Awards lifted and recommend that the promised review of these awards be brought forward as a matter of urgency.

Targeting

- Better use is made of existing pay flexibilities.
- Recognising what has already been done in Scotland to use pay to address shortages, we recommend that the Scottish Government and workforce planners in Scotland give serious consideration to building on this by developing a new mechanism for enabling targeted pay solutions, backed by extra national resources, to be locally stimulated and rapidly tested. These should aim to address persistent, above average geographic and specialty shortages. We look forward to hearing the results, in evidence next year, and would be happy to assist in developing criteria for payments if evidence is provided to us.

Retention

- The health department and employers in Scotland investigate how many doctors and dentists are taking early retirement and for what reasons, and provide us with evidence on this next year.

Observations 2017-18

A. We observe that a major demographic shift within the UK is taking place within our remit groups associated with the 'Generation Y' cohort (also known as 'millennials') that is now a large part of the workforce and the shift in gender balance of those choosing to train as doctors and dentists. We see this shift as linking closely to career choices to take salaried GMP roles and to locum, and urge the parties to consider the potential impact of this shift on workforce planning assumptions, the nature of the employment offer as well as in terms of pay, including gender pay.

B. We would like to see SAS doctors given equal consideration and reflected more in the quality and quantity of evidence we receive.

C. We note that a key source of frustration for the British Dental Association (BDA) Scotland is the outdated 'fee for item' dental contract, which they find to be legalistic, complicated to understand and burdensome to deal with. Dentists' incomes have declined in Scotland, and access to private practice, and thus to alternative revenue streams, is limited. We therefore have sympathy with this and ask the Scottish Government to give serious consideration to contractual reform in consultation with the BDA Scotland on the basis of fairness, transparency and sustainability.

D. We note that the Scottish Government has recently consulted on the future of oral health in Scotland, demonstrating that it is seeking to modernise NHS dentistry in Scotland. This presents an opportunity for both parties to work together on the future shape of the service and we ask both parties to engage constructively on it and any action plan that follows.

E. We observe that BDA Scotland has concerns about where dentistry fits into the new governance arrangements for health and social care integration. The Scottish Government should address this lack of clarity in order to help build trust.

In our main 45th report we made several observations relating to salaried GMPs. We have no reason to believe that those observations are not equally valid for Scotland – please see Chapter 7 on GMPs in this supplement for these observations in full.

Remits and the pay round process

1. This supplement contains our consideration of matters relating to our remit group in Scotland, together with our recommendations. It should be read in conjunction with our main 45th report, which covers England, Wales and Northern Ireland and contains UK-wide data, commentary and comparison. Given the short time available for our independent consideration of their evidence and factors which affect all four countries, we ask the Scottish Government to submit its evidence to our usual timetable for our next round to enable incorporation into the UK-wide report.

2. Our approach to this round was informed by our standing terms of reference and the remit submitted by the Scottish Government. We received the written evidence on 20 December 2016. The accompanying letter drew attention to the Scottish Government's public sector pay policy for 2017-18, saying that the policy formed the basis of the remit that the Scottish Government wanted us to consider. For this supplement, we considered written and oral evidence from the Scottish Government, the British Medical Association (BMA) and the BDA and held the oral evidence sessions in Edinburgh.

Context to this report

3. Our report comes at a time of change and challenge for the NHS across the UK. Developing new and innovative approaches will be required to meet the needs of an increasing and ageing population, with multiple and complex health requirements which place extra pressure on our remit groups and the wider system. Added to this are the difficulties posed by the wider financial position and the UK Government's public sector finance policies.

4. In Scotland, many of the issues faced echo those for the other countries of the UK. Major NHS reforms are underway with the integration of health and social care services, the National Clinical Strategy and proposals for a new GMP contract. While Scotland has avoided the industrial relations difficulties with junior doctors that have occurred in England, there are other pressure points including some difficulties recruiting into consultant vacancies, the freeze on new Distinction Awards and lack of uplift to both Distinction Awards and Discretionary Points. BDA Scotland stressed to us the low morale of dentists in Scotland, who have the lowest taxable income of dentists in any UK country, and we also observed the difficulty Scottish Government and BDA Scotland have in coming to a bilateral agreement on dental expenses.

Recruitment, retention and motivation

5. As in the rest of the UK, problems remain in recruiting doctors into some specialties (such as emergency medicine, psychiatry and general practice) and into some locations in Scotland. Effective workforce planning based on sound management information is essential to help mitigate. It is clear to us that, as some of the issues are long-running and non-pay solutions have been ineffective so far, pay-related options should be considered. We welcome the steps already being taken in Scotland to use pay options, particularly for remote and rural locations, and look forward to hearing further evidence regarding their effectiveness.

6. We are concerned about the lack of new staff survey data this year to inform our consideration for Scotland. While our remit groups remain intrinsically motivated to deliver high quality patient care, we note that other pressures such as workload are having a negative effect and impacting on motivation and morale in both primary and secondary care. Both the BMA and BDA cited low motivation and morale affecting their members and highlighted that workforce issues are coupled with the wider service aspirations in each country. Pay is seen to be an important signal of personal value in this context.

Economic background, pay comparability and affordability

7. Economic growth in Scotland fell behind the UK as a whole in 2016, having kept pace over the previous three years. Since the first quarter of 2008, just before the recession, the UK economy had grown by 8.1 per cent (to the third quarter of 2016), while the Scottish economy grew by 6.0 per cent. The employment rate in Scotland reached a peak of 74.8 per cent in October 2015, but employment fell by 0.9 per cent over the year, to give a rate of 73.3 per cent in October 2016.

8. Affordability (which we take from our terms of reference to mean the funds available to the health departments as set out in the government's departmental expenditure limits) was at the forefront of evidence provided to us by the Scottish Government. It is apparent that maintaining the public sector pay policy of 1 per cent can offer a way of limiting increases to costs. However, the impact of ongoing pay restraint is wider than just helping to reach fiscal targets. Pay is important and the Scottish Government public sector pay policy could well impact adversely on recruitment, retention and motivation in our remit groups, given the demands on the health service and change programmes underway.

9. We are concerned about the impact of inflation and wider wage growth upon our remit group, particularly when considering recruitment, retention and motivation. We comment fully on this in our main 45th report.

Our recommendations

10. No proposals were put to us for targeting through national pay scales. However, we distinguish between targeting via national pay scales, targeting via differential pay premia informed by nationwide agreement (for example, for particular specialties), and targeting via local pay premia or allowances.

11. We welcome the pay measures already in place in Scotland to mitigate persistent geographic shortages, such as steps taken in the Highlands and Islands area, and look forward to receiving evidence about their effectiveness and applicability to shortages elsewhere. We are not convinced by the general arguments that shortages are not amenable to pay. Shortages tend to persist, and no evaluation of the various non-pay approaches has been provided to us. We wait with interest to see such evaluations. Meanwhile, we consider there is scope for more targeting by nationwide agreement, building on the models that have recently been introduced, recognising that consideration would need to be given on how to fund such schemes.

12. **We recommend:**
    - **that better use is made of existing pay flexibilities;**
    - **recognising what has already been done in Scotland to use pay to address shortages, that the Scottish Government and workforce planners in Scotland give serious consideration to building on this by developing a new mechanism for enabling targeted pay solutions, backed by extra national resources, to be locally stimulated and rapidly tested. These should aim to address persistent, above average geographic and specialty shortages. We look forward to hearing about the results, in evidence next year, and would be happy to assist in developing criteria for payments if evidence is provided to us.**

13. We have several concerns about the evidence we received in relation to this year's pay uplift. We made this point in our main UK-wide report and it applies equally to Scotland. Firstly, the Scottish Government, like the other three UK governments, seems to us to have given little consideration to the possible effects of ongoing pay restraint on the recruitment, retention and motivation of our remit groups in their pay proposals. Should inflation and private sector wages continue to increase, it would be unwise to be complacent here, and we note that consultants have had a relatively larger decrease in take-home pay than others in the NHS. Secondly, we would welcome greater clarity from all parties on what they consider fair and appropriate pay levels would be for our remit groups in relation to any comparators that the parties thought relevant in a "steady state" environment. We will also continue to undertake our pay comparison work.

14. In terms of recruitment, the annual pay award is important in supporting the attractiveness of medical and dental careers. On the other hand, these are relatively highly paid groups and applications by well-qualified students for medical courses appear to be holding up. We note that the Scottish Government's policy of no compulsory redundancy gives a measure of job security for our remit groups, but we are concerned with some of the findings on medical and dental workers from the 2015 NHS Scotland Staff Survey which showed a decline in staff satisfaction, frustration with a perceived lack of autonomy in the workplace, and a sense of being under-staffed. We note again that there is already a general expectation of a 1 per cent increase.

15. We note that Consumer Prices Index (CPI) of inflation at December 2016 was 1.6 per cent, and was forecast to reach 2.5 per cent by the end of 2017. Median gross weekly earnings for full-time private sector employees increased by 3.4 per cent in the year to April 2016, according to the Annual Survey of Hours and Earnings. Whilst forecasts are subject to change and setting the contribution of annual increments aside, the obvious conclusion is that a 1 per cent award would most probably be below inflation.

16. In light of wider economic forecasts, plus the increasing demands being made on the goodwill of our remit groups, we have considered whether our award should be more than 1 per cent. However, we also accept that the affordability of a settlement in Scotland remains weak. In view of the pressures, alleviating workload and fostering job satisfaction rather than increasing pay would still

appear to be the more important priorities for improving motivation. Overall we feel there is a continuing, though diminishing, case for 1 per cent again this year, if this enables more staff to join the service to alleviate workload pressures. We understand that Scotland has assumed 1 per cent in its funding arrangements. We again see no compelling reason for differential awards by country and this recommendation reflects our approach for the other three countries of the UK.

17. **We are therefore recommending a base increase of 1 per cent in 2017-18 to the national salary scales for salaried doctors and dentists in Scotland.** Individuals on incremental pay scales who have not reached the maximum scale point will also be eligible for incremental progression according to the agreed criteria.

18. We make a separate recommendation for salaried GMPs, whose pay falls within a salary range rather than on an incremental pay scale. **We recommend that the minimum and maximum of the salary range for salaried GMPs in Scotland be increased by 1 per cent for 2017-18.**

19. Chapter 6 sets out our reasoning in relation to Distinction Awards and Discretionary Points while Chapter 9 includes our detailed recommendation.

20. We await the outcome of the new approach to GMP contracts in Scotland. We heard from both parties that expenses discussions for GMPs are best done by negotiation, and concluded that we should again this year make a recommendation on pay net of expenses. **For independent contractor GMPs in Scotland, we recommend an increase in pay, net of expenses, of 1 per cent for 2017-18.**

21. In relation to GDPs, whilst we reported fully on the issues in our main 45th report, we wish to raise our concerns with the situation in Scotland given that it has some unique aspects. In particular, dentists in Scotland have the lowest taxable income in all of the four UK countries. We note the current lack of consensus between the parties in Scotland and stress the importance of both parties working together to build better working relationships in future and develop a dialogue, and our observations as set out above are intended as a starting point for this. Our preferred approach is for the parties to negotiate directly on expenses.

22. **For independent contractor GDPs in Scotland, we recommend an increase in pay, net of expenses, of 1 per cent for 2017-18.**

23. There are several topics covered in this report where we would like to receive more or improved information for our next round. We would like to develop further our understanding of areas such as salaried and locum GMPs, gender pay, 'Generation Y' and retirement trends, and need robust evidence to do so.

Looking forward

24. In this final section, we identify some of the challenges facing our remit groups in Scotland over the next few years. It should be read in conjunction with our main 45th report, which draws UK-wide conclusions about future challenges.

25. Scottish public sector pay policy differs slightly from that in other UK countries as it targets boosting pay for the lowest earners and is also for one year only. This policy obviously has implications for our remit groups and we urge the Scottish Government to consider recruitment, retention and motivation of consultants in particular, where the recruitment for certain specialties and in some locations is weak. Pay restraint offers a direct means of limiting increases to costs. However, if real pay levels for our remit group continue to decline at a time when pay in the private sector is rising, this will inevitably affect motivation, and could also damage recruitment and retention. That, in turn, would soon affect workloads, and a vicious circle could be created.

26. While it is too soon to judge the impact of 'Brexit' on our remit groups, all the health departments have made moves to reassure all staff from overseas that they are a valued part of the NHS, and are looking to ensure security of supply. There does, however, need to be a more sophisticated understanding of how the UK-wide market in training doctors operates. There are common issues at play across all four countries, yet it seems to us that each is operating somewhat in isolation, and therefore more collaboration is required.

27. In addition to changes in demands on the NHS, our remit groups are themselves changing. As 'Generation Y' doctors and dentists form an increasing part of the workforce, planners and employers will need to take their different lifestyle and career choices into account. Consideration should also be given on how best to retain experienced staff who may be affected by the changes in public sector pension schemes and to pension rules more widely.

28. Meanwhile, as we say in our UK-wide report, we attach great importance to the motivation of our remit group, across the whole NHS, during a period when staff will continue to be under pressure; when inflation seems likely to rise; and when private sector comparators' earnings are also likely to increase. If there are affordability constraints across the public sector, our remit groups will be affected, but they should not feel singled out. One of our important roles as a Review Body is to advise on this, ensure a fair balance and monitor the sustainability of the recruitment, retention and motivation of our remit groups. This sustainability is clearly being challenged in Scotland as elsewhere in the UK and consideration therefore needs to be given to planning an exit strategy from current pay policy when circumstances allow.

PROFESSOR SIR PAUL CURRAN (Chair)
DAVID BINGHAM
LUCINDA BOLTON
MEHRUNNISA LALANI
PROFESSOR KEVIN LEE
PROFESSOR JAMES MALCOMSON
LISA TENNANT
NIGEL TURNER, OBE

OFFICE OF MANPOWER ECONOMICS 22 March 2017

CHAPTER 1: INTRODUCTION

Introduction

1.1 The Cabinet Secretary for Finance and the Constitution for the Scottish Government confirmed that Scotland would be seeking our recommendations in this pay round, but would be unable to provide evidence until after the Scottish draft budget and public sector pay policy had been published in November 2016. This supplement covers our consideration of Scotland, together with our recommendations. It should be read in conjunction with our main 45th report, which covers England, Wales and Northern Ireland and contains UK-wide data and commentary, and some comparisons between the four countries of the UK.

1.2 Given the short time available for our independent consideration of its evidence and a number of factors which affect all four countries, we ask the Scottish Government to submit its evidence to our usual timetable for our next round to enable incorporation into a UK-wide report.

Structure

1.3 This supplement takes the structure of the main report for ease of reference and is therefore divided into the 10 chapters below. However, to avoid duplication, we do not repeat any data already included in the main report. The 10 chapters are:

1. Introduction
2. Economic outlook and affordability
3. Motivation
4. Workforce planning and future supply
5. Doctors and dentists in training
6. Hospital doctors
7. General Medical Practitioners
8. Dentists
9. Pay
10. Looking forward

1.4 We also include six appendices, although again do not repeat data included in the main report:

A. Remit letter from the Scottish Government
B. Detailed recommendations on remuneration in Scotland
C. Glossary of terms
D. Abbreviations and acronyms
E. Historical formulae values for GMPs and GDPs
F: Letter from the BDA to the Chair of DDRB, 2 March 2017

Key context for this supplement

1.5 Our report comes at a time of substantial change and challenge for the NHS across the UK. New and innovative approaches will be required to meet the demands of an increasing, ageing population with multiple complex health needs placing extra pressure on the system. Added to this are the difficulties posed by the wider economic position and the constraints on public finances.

1.6 Such pressures undoubtedly impact on our remit group. While non-pay issues such as workload are at the heart of our remit group's concerns, pay also has an important role to play in supporting motivation, and ensuring that staff feel valued and fairly treated.

1.7 In Scotland, many of the issues faced echo those for the other countries of the UK. Major NHS reforms are underway with the integration of health and social care services, the National Clinical Strategy and proposals for a new GMP contract. While Scotland has avoided the industrial relations difficulties with junior doctors which occurred in England, there are other pressure points for doctors, including dissatisfaction among consultants regarding the use of 9:1 job plans and the lack of uplift to Distinction Awards, which we discuss later in this report. BDA Scotland stressed to us the low morale of dentists in Scotland, who have the lowest taxable income of dentists in any UK country, and we also observed the difficulty the Scottish Government and BDA Scotland have in coming to a bilateral agreement on dental expenses.

Remit for this supplement

1.8 The remit letter from the Scottish Government is included in full at Appendix A and summarised below.

1.9 The Cabinet Secretary for Finance and the Constitution wrote to us on 30 September 2016 to confirm that Scotland would be seeking our recommendations in this pay round, but would not be able to provide evidence until after the Scottish draft budget and public sector pay policy had been published in November. We received the written evidence on 20 December 2016. The accompanying letter drew attention to the Scottish Government's public sector pay policy for 2017-18, saying that the policy formed the basis of the remit that the Scottish Government wanted us to consider. The pay policy was for one year only, limiting increases to one per cent in total and stated that there would be no compulsory redundancies in the NHS in Scotland for that year. It asked us to take into account the significant financial challenges facing NHS Scotland. The letter requested our recommendations for pay and contractual uplifts for GMPs, adding that the Scottish Government and the British Medical Association (BMA) would commission a review of general practice funding, pay and expenses.

1.10 The BMA noted that the Scottish Government's remit letter drew heavily upon its public sector pay policy. It reiterated previous concerns that such letters effectively over-rode our standing terms of reference to make independent recommendations. It considered that adherence to the public sector pay policy would deliver a further effective pay cut.

Our comment on the remit

1.11 The remit for Scotland outlined a broadly similar approach to those of the other UK countries, albeit with some differences in policies and emphasis. On pay, the UK Government set out a four-year policy, of which 2017-18 is the second year, and expected awards to be targeted to support recruitment and retention. Scotland has a one-year policy to cover 2017-18. The remit for Scotland did not refer to

targeting, nor did it request that we examine salaried GMPs as in our remit for England.

1.12 We regret that it was not possible for Scotland to submit its evidence to our usual timetable as we consider the medical and dental workforce to be a UK-wide labour market and would prefer to make recommendations for our entire remit group at the same time. We welcome the proposed review of general practice finance and hope that this will improve the information that we receive in the future.

Parties giving evidence

1.13 We received written evidence for this supplement from the organisations listed below:

Government departments and agencies

- Scottish Government

Bodies representing doctors and dentists

- British Dental Association
- British Medical Association

1.14 We held oral evidence sessions in February 2017 with the following parties:

- Scottish Government
- British Dental Association
- British Medical Association

Last year's recommendations

1.15 Our main pay recommendations for 2016-17 were set out in our 44th report. In response to those recommendations, the Scottish Government agreed a 1 per cent uplift to basic pay for the remit groups in line with our recommendations. However, it rejected our recommendation to increase the value of Distinction Awards for consultants, so these remained unchanged in 2016-17. We return to this point later. In 2016-17, we also commented on the persistence of hard-to-fill specialties, but in

line with the consensus view of the parties, did not support the use of targeting within pay scales to address this. Our report also emphasised the need to ensure fairness and take a longer-term view of pay policy for the remit group.

CHAPTER 2: ECONOMIC OUTLOOK AND AFFORDABILITY

Introduction

2.1 The wider economic and labour market background, public sector finances and departmental expenditure limits are covered in Chapter 2 of our main 45th report, as the data we received were generally UK-wide. We do, where relevant, set out Scotland-specific evidence and comment where appropriate in this chapter.

General economic and wider labour market context

2.2 The macroeconomic picture, including inflation and employment trends, is covered in the main report and not repeated here, although we highlight several key points relating to Scotland. Economic growth in Scotland fell behind the UK as a whole in 2016, having kept pace over the previous three years. Since the first quarter of 2008, just before the recession, the UK economy had grown by 8.1 per cent (to the third quarter of 2016), while the Scottish economy grew by 6.0 per cent. The employment rate in Scotland reached a peak of 74.8 per cent in October 2015, but the employment level fell by 0.9 per cent over the year, to give a rate of 73.3 per cent in October 2016.

Public sector finances and departmental expenditure limits

2.3 Affordability (which we take from our terms of reference to mean the funds available to the health departments as set out in the government's departmental expenditure limits[1]) was at the forefront of the evidence provided to us by the Scottish Government.

2.4 The Scottish Government told us that the financial position in 2017-18 would be particularly challenging and the first call on additional funding would be meeting anticipated cost pressures within NHS Scotland including pay, pensions, supplies and drug volumes. We were told that the health and social care models for remote

[1] The government budget that is allocated to and spent by government departments is known as the Departmental Expenditure Limit, or DEL. This amount, and how it is split between government departments, is set at Spending Reviews.

and rural areas were under extreme pressure and many seemed unsustainable, even in the short term. The Scottish Government told us it was providing funding of £1.5 million in total from 2013-14 to 2016-17 for testing new ways of working in four areas across NHS Highland. The health budget in Scotland received the full resource under the 'Barnett' arrangements, lifting the resource cash budget by £304 million to £12.7 billion in 2017-18. We were told that funding allocations to NHS territorial boards in 2017-18 would also increase in real terms. However, issues such as the ageing population, new technology and the cost of drugs meant that the NHS would still face considerable budget pressures and boards would be required to contribute an additional £100 million to Integration Authorities to support health and social care integration.

2.5 In its report 'NHS in Scotland 2016', Audit Scotland found that NHS funding was not keeping pace with increasing demand and the needs of an ageing population. NHS boards faced an extremely challenging financial position, with many using 'short-term measures' to break even.

2.6 In oral evidence, the Cabinet Secretary acknowledged continuing pressure on public services and emphasised that the financial position was challenging, with constraints on the public sector pay bill required as a result. She acknowledged the challenge posed by the Audit Scotland report and the need for changes.

Efficiency savings and measuring performance

2.7 The Scottish Government said that the additional pressures arising from demographics, new drugs and technology would require NHS boards to deliver and retain efficiencies. It believed that achieving the efficiency savings would be difficult for NHS Scotland and would require service redesign issues to be closely considered. Increased efficiency would have to be delivered while maintaining and enhancing the quality of care.

2.8 In oral evidence, the Cabinet Secretary noted that boards were expected to deliver supported savings of £107 million, for example by bearing down on agency/locum costs, but that they were being funded for a 1.5 per cent overall uplift

amounting to £136 million. The Cabinet Secretary stated that the Scottish Government felt this represented a challenging but fair settlement.

2.9 BMA Scotland noted that prior to the introduction of austerity policies, healthcare would typically see a 3 to 4 per cent increase in funding per year, which was sufficient to manage health inflation. However, current levels of funding were much lower and would be for the foreseeable future, creating a funding gap. While BMA Scotland supported the aspiration to integrate health and social care in order to provide services more efficiently, it believed that pursuing both austerity and transformational health policies, which required entirely new ways of working and service delivery, was highly challenging.

2.10 BDA Scotland was concerned that in the context of public health finances, dentistry was slipping down the agenda. It cited the example of dental care for the elderly, who could, in some situations, present complex cases requiring home visits including some in remote areas. However, the current funding arrangement meant that domiciliary work – which incurred a fee of £38.70 for home visits at a distance of less than 10 miles – was not financially viable for dentists in Scotland. This was compounded by the fact that in care homes, elderly patients were not required to be registered with a GDP, in contrast to the requirement to be registered with a GMP. BDA Scotland felt that as a result, such vulnerable patients were not getting the necessary care due to a lack of public funds, and termed the situation ‘a national scandal’ in Scotland.

Pay

2.11 The changes in doctors’ and dentists’ pay over time, including Distinction Awards, and how it compares with the distribution of pay across the whole UK economy is included in our main 45th report. It was, of necessity, UK-wide due to data sources at our disposal.

Our comments

2.12 As in the rest of the UK, Scotland is experiencing severe pressures on NHS finances arising from the common challenges posed by an ageing population with multiple, complex healthcare needs. Scotland also has a focus on remote and rural healthcare. In common with other parts of the UK, Scotland is responding to these challenges through a mixture of additional funding, trialling of new healthcare models and the implementation of new workforce strategies. This sets the context in which we considered our recommendations.

CHAPTER 3: MOTIVATION

Introduction

3.1 Information on the motivation of doctors and dentists in Scotland is included alongside that of the other UK countries in Chapter 3 of our main 45th report. This chapter presents the evidence received from the parties relating to Scotland only. The main motivation data we draw upon here relates to 2015 and accordingly we refer back to our conclusions in the 44th DDRB report.[2]

Motivation, morale and engagement

3.2 We do not have new 2016 NHS staff survey data for Scotland, and therefore reprise here the key points on motivation from our 44th report based on the NHS Scotland Staff Survey 2015. This relates only to doctors and dentists working in the hospital sector:

- The survey showed positive results in terms of medical and dental staff saying that they were happy to go the 'extra mile' at work (90 per cent) and getting the help and support needed from colleagues (83 per cent).
- However, we noted declines in the number of staff recommending their workplace as a good place to work (58 per cent, representing a 3 per cent decrease on 2014), and those expressing satisfaction with the sense of achievement they got from work (65 per cent, down 4 per cent from 2014).
- Of concern was the finding that only 34 per cent of medical and dental staff, and 51 per cent of trainees, felt that they could meet the conflicting demands on their time at work, while only 47 per cent of trainees and 25 per cent of medical/dental staff felt there were enough staff for them to do their job properly.
- The percentage of the medical and dental workforce who felt that they had a choice in deciding what they did at work was low, at 31 per cent of those in training, and 41 per cent of other medical/dental staff. This compared

[2] Review Body on Doctors' and Dentists' Remuneration, Forty-Fourth Report 2016, March 2016

unfavourably with the results of a similar survey question to respondents in England. The British Medical Association (BMA) suggested that this showed 'significant discontent' from doctors in Scotland on lack of involvement in decision-making.

3.3 In oral evidence for this round, the Cabinet Secretary acknowledged that workload pressures, combined with public expectations of service delivery, were an issue for our remit group. She told us that significant efforts had been made in Scotland to put in place staff support mechanisms, make provision for caring needs, and make sure there was a clear vision for the service.

3.4 In oral evidence, the BMA Scotland emphasised the need for NHS Scotland employers and new entities such as Integration Joint Boards to show that they valued doctors. BMA representatives said that in secondary care, staff were being set up to fail with unachievable targets, which was highly demotivating. While staff were doing their best with the resources available, they were criticised for not meeting the targets, which in turn led to doctors feeling undervalued. Doctors' capacity to see patients was outstripped by demand, and dealing with this work 'at the coal face' limited doctors' ability to engage with questions of strategy and clinical innovation. Administrative support for consultants in the hospital workplace had been reduced, leaving consultants to do tasks such as producing letters, which put additional pressure on them and also weakened motivation.

'Patients at the heart'

3.5 Our terms of reference require us to have regard to the overall strategy that the NHS should place 'patients at the heart' of all it does and the mechanisms by which that is to be achieved. We received information relating to patients' experience of primary care from the Scottish Government, and summarise this below. While 'patients at the heart' runs through all elements of our remit, we consider it separately here to highlight its importance.

3.6 The Patient Rights (Scotland) Act 2011 provides the basis for patient-centred care in Scotland. The Act aims to improve patients' experiences of using health services and to support people to become more involved in their health and health

care. It gives patients the right to: access healthcare which considers their needs and involves them in decisions; give feedback and raise concerns; and access the Patient Advice and Support Service. It also included a set of principles that those providing NHS healthcare should adhere to, including: patient focus; quality care and treatment; patient participation; communication; patient feedback; and effective use of resources.

3.7 The Scottish Government told us that its most recent health and care experience survey found that, on the whole, the majority (87 per cent) of patients and care users reported a positive experience of their GMP care. However, overall, patients across Scotland were slightly less positive about their experiences than in the previous survey in 2012-13. There continued to be considerable variation in scores between individual GMP practices, suggesting that patients' experiences may be very different depending on which GMP practice they attended.

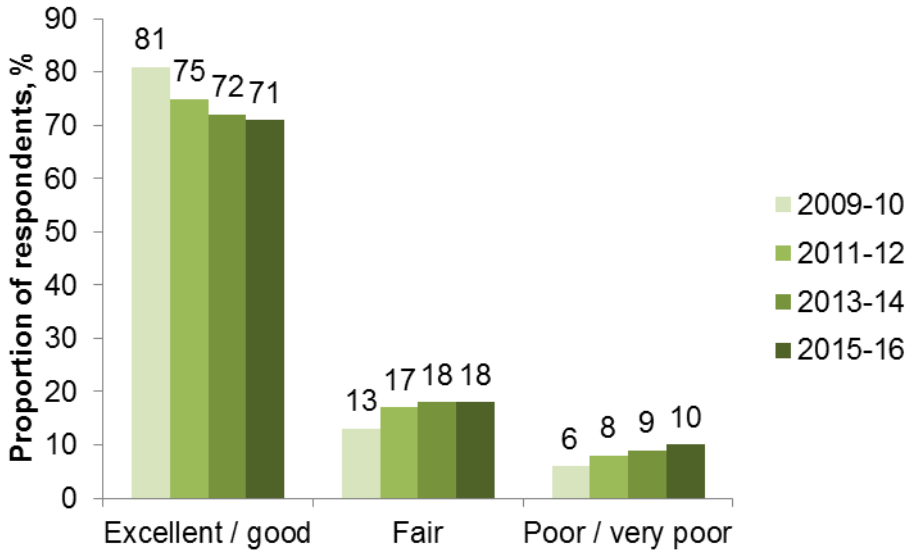
3.8 Most patients reported positive experiences of accessing GMP services. Patients were generally positive about the actual care and treatment they received at GMP practices (Table 3.1), with practice nurses getting particularly positive results. The four most positively answered questions relating to GMP care were all in relation to medicines. However, access continued to be an area of relative concern for respondents. Four of the five most negatively answered GMP questions related to issues of access. These included being able to get through on the telephone, and being able to speak to a doctor or nurse within two working days. Positive ratings for overall arrangements to see a doctor fell to 71 per cent which was 10 percentage points lower than in the 2009-10 survey (Figure 3.1).

Table 3.1: Summary results of questions about GMPs

Statement	Strongly agree/agree (%)	Neither agree nor disagree (%)	Disagree/strongly disagree (%)
The doctor listened to me	95	3	2
I felt that the doctor had all the information needed to treat me	89	7	4
The doctor took account of the things that matter to me	87	10	3
The doctor talked in a way that helped me understand my condition and treatment	90	7	3
I felt confident in the doctor's ability to treat me	90	7	4
I had enough time with the doctor	88	7	5

Source: Health and care experience survey (Scotland).

Figure 3.1: Overall arrangements for getting to see a GMP



Source: Health and care experience survey (Scotland).

3.9 Similarly to the previous survey, the most negative finding for GMP practices related to dealing with mistakes when they occurred. 54 per cent of patients who reported that they had experienced a mistake in their care were unhappy about how it was dealt with. Results also suggested that more could be done to involve patients in their care, with over a third of respondents saying they were not involved as much as they wanted to be in decisions about their care and treatment.

3.10 Audit Scotland reported that NHS boards continued to find it difficult to meet key national performance targets, with NHS Scotland failing to meet seven out of eight key targets (although some were very narrow misses). Audit Scotland also raised concerns over the impact of the increasing use of locums on patient care.

Our comments

3.11 In our main 45th report we note that the staff survey carried out in Scotland in 2015 showed 63 per cent of the workforce felt able to do their job to a standard they were personally pleased with, which was a small decline on the previous year. We remain worried about the impact of heavy workloads on our remit groups' wellbeing and will continue to monitor how changes in the way that our remit groups are working affects their morale, motivation and level of engagement. We note that,

following a recommendation from the Scottish Workforce and Staff Governance Committee, the Scottish Government decided not to commission a staff survey for 2016 in order to embed a new process for staff engagement. We note the impact this will have on our ability and that of other parties to effectively monitor motivation during the transitional period.

3.12 Workload and motivation issues are likely to affect the quality of care that our remit group is able to deliver. While we note that overall patients report positive experiences of GMP services in Scotland, there are clearly issues with patient access to services, and more to be done to increase patient involvement and better manage complaints and errors. We did not receive specific evidence on motivation of secondary care staff or dentists from the Scottish Government, but note the comments made by Audit Scotland on NHS boards finding it difficult to achieve targets. We are also concerned that the increasing use of locums may impact on the quality of patient care, as highlighted by Audit Scotland (see Chapter 4).

3.13 The comments we made in our main 45th report on 'patients at the heart' apply equally to Scotland as they do to the other countries of the UK, in terms of the concerns we have about the impact of heavy workloads on the wellbeing of our remit groups, which in turn may impact upon motivation, engagement and, ultimately, patient outcomes.

CHAPTER 4: WORKFORCE PLANNING AND FUTURE SUPPLY

Introduction

4.1 As we stated in our main 45th report, coherent workforce planning is essential in the face of increasing demand for healthcare, constrained budgets and the need to recruit and retain sufficient, highly-skilled doctors and dentists. Here, we present Scotland-specific evidence and comment where appropriate.

Workforce planning

4.2 The Scottish Government told us that the NHS was Scotland's largest single workforce and planning it was complex, with activity taking place at different levels, over different timescales, and with the involvement of many stakeholders. At local level, health boards were accountable for planning staffing needs in relation to providing high quality, safe and affordable services to the public they serve in their own areas. The Scottish Government aimed to introduce national and regional workforce planning to ensure NHS Scotland had the correct skills mix. The 'National Healthcare Workforce Plan' intended to: strengthen and harmonise workforce planning practice; take full account of the future demand for safe and high quality services for Scotland's people; accurately identify gaps in supply; and help deliver the vision set out in the National Clinical Strategy.

4.3 In oral evidence, the Cabinet Secretary highlighted the Health and Social Care Delivery Plan, published in December 2016, which brought together plans on workforce planning and health and social care integration, and was backed with £125 million in funding in 2017-18. She confirmed that the Scottish Government was consulting key stakeholders in health and social care, with the aim of shifting the focus from acute care to community care. National and regional workforce plans were to be integrated, with boards approaching acute and specialist services on a regional basis.

4.4 Work is underway to better understand the implications for the future training of the medical workforce outlined in Professor Sir David Greenaway's Shape of Training report[3]. In looking at the future sustainability of services, key areas under discussion were supply and demand for NHS workforce, the attractiveness of Scotland as a place for medical (and other) staff to train and work, and the perceived erosion of professionalism in medicine. Measures proposed to address workforce risks included:

- strategic management of gaps in training programmes;
- provision of remote and rural medical workforce;
- a cohesive strategy for non-medical role development, and
- retaining a higher proportion of the current cohort of doctors in training.

4.5 The work outlined above was intended to align with an initiative to attract medical trainees to Scotland. 'Scotland: home of medical excellence' was the key theme underpinning the initiative's marketing strategy. Developments across NHS Scotland include the introduction of an extended visa sponsorship service for all medical trainees, a new specialty-based quality management system for medical training, a performance support unit for trainee doctors in difficulty, and measures aimed at emphasising the positive aspects of working and training in NHS Scotland and optimising recruitment and retention. An increase in the number of government-funded medical undergraduates by 50, to 898 per annum, was brought in for 2016. This intake had previously remained unchanged since 2012.

4.6 The Cabinet Secretary told us in oral evidence that psychiatry and general practice were the specialties most affected by shortages and recruitment issues, while remote and rural recruitment issues posed a particular challenge in Scotland. The Scottish Government was working with medical schools to change the messaging and find out how to make these posts more attractive. Measures included creating opportunities for partners or spouses in rural areas; using 'golden hellos'; and approaching rural medicine as a practice/specialty in itself to create more opportunities.

[3] Shape of training: securing the future of excellent patient care, Final report of the independent review led by Professor Sir David Greenaway, October 2013.

4.7 The Cabinet Secretary said that recruitment challenges needed to be met through new ways of working, enhanced opportunities and skill development, which involved encouraging all healthcare professionals within a multi-disciplinary team to work to the top of their skill level. The Scottish Government was also seeking to be innovative to resolve recruitment difficulties. For example, there was a scheme in place to retrain refugee doctors in Scotland and to enable them to achieve General Medical Council Registration. The Scottish Government was also working with the Royal College of Medicine Edinburgh to further develop the 'Medical Training Initiative' (MTI), the objective of which was to develop mutually beneficial links with a range of countries, including the Malaysian Government, by identifying good postgraduate medical training pathways for overseas specialists to access training posts in Scotland. Early progress was made with the number of MTI trainees rising from 3 in 2014, when the agreement was made, to around 30 in 2017. We were told that Scotland was maintaining a policy of international recruitment, unlike England which we told in evidence from the UK Government aimed to become self-sufficient in the supply of doctors.

4.8 Audit Scotland reported that the NHS workforce in Scotland was ageing and difficulties continued in recruiting and retaining staff in some geographical and specialty areas. Workforce planning was found to be lacking for new models of care to deliver more community-based services. It called for the Scottish Government to provide a clear written plan for implementing the 2020 Vision and National Clinical Strategy.

4.9 The British Medical Association (BMA) Scotland told us in oral evidence that it was working with the Scottish Government on workforce planning, although it felt that the aim to have the first National Workforce Plan ready by spring 2017 was over-ambitious. It stressed that it was important to be realistic about what could be delivered in terms of additional medical staff over the next five years. BMA Scotland noted that only 54 per cent of trained doctors stayed in Scotland, which suggested a UK-wide market. The organisation noted that doctors were also part of a global market, and people were willing to move for lifestyle reasons.

4.10 BMA Scotland expressed concern about the lack of robust vacancy figures for Scotland, particularly for consultants, and felt that there was an apparent lack of concern about this on the part of the Scottish Government. There was still no agreement on how a 'vacancy' should be defined. Officials needed to understand the current situation on the ground clearly for workforce planning purposes, and yet there seemed to be a reluctance to gather the necessary data. While BMA Scotland was confident in NHS Education for Scotland (NES) figures on unfilled training places, other data gaps remained, such as for hospital grade doctors.

'Generation Y'

4.11 We covered issues relating to the new generation of doctors and dentists referred to as the 'Generation Y' cohort in our main 45th report. For our remit group, we have noticed that some of these 'millennials' tended to have a different approach to their careers from their predecessors, valuing, in particular, aspects such as work-life balance, flexibility and variety in the workplace.

4.12 In oral evidence the Cabinet Secretary noted that, while there was a lack of evidence, the trend for foundation year doctors to take career breaks appeared to stem from a desire for more flexibility in working patterns. Officials noted that people were making different choices than previously, and that it would be flexibility and not just pay that would attract people to Scotland.

Views from the British Medical Association

4.13 In its written evidence, the BMA highlighted the findings of the Foundation Year 2 (FY2) career destination survey in Scotland and England, noting that the 2015 UK Foundation Programme Office (UKFPO) report showed a decline in the proportion of FY2 trainees continuing straight into specialty training from 67 per cent in 2012, to 58.5 per cent in 2014 and just 52 per cent in 2015. The BMA referenced research it was undertaking with the University of Edinburgh to look into this further to understand better doctors' early career choices.

4.14 BMA Scotland stated that the reasons for foundation year doctors increasingly taking time out before continuing training were unclear. While for many people it would be a personal choice, there appeared to be a sense that the traditional career structure lacked flexibility. The progression process may have become overly rigid, since people increasingly tended to seek life experience, broader medical exposure, and overseas experience. There was a growing tendency for trainees to take a year off, although it was difficult to factor this in to workforce planning. The BMA was looking into this and would provide more evidence on 'Generation Y' effects next year.

Retirement trends

4.15 As we stated in our main 45th report, recent changes to pension legislation, in particular to the lifetime and annual allowances for pension tax relief, together with changes to the NHS pension scheme, seem to have influenced early retirement rates. During our visits we heard much discontent expressed by consultants about the alterations to their pensions, and that they saw themselves subsidising the pensions of other less well-paid NHS staff as they paid a higher rate of contributions. There were also concerns that this would impact upon the attractiveness of the remuneration package as a whole for younger doctors and those considering a career in the field. This section examines some of the evidence we have heard on retirement trends and its potential impact on the remit group and our recommendations on pay.

4.16 Audit Scotland noted that the NHS workforce was ageing, and that a third of all GMPs and 42 per cent of GMP partners were aged 50 and over in 2015. In oral evidence, the Cabinet Secretary said that the ageing workforce needed to be considered across the board, and it was more pronounced in some areas than others. There was a need to retain the experience and expertise of older workers, which could be encouraged through opportunities to take on different roles and provide more flexibility.

4.17 The impact of pension changes on retirement trends should also be taken into account. Officials undertook to provide data on early retirements, which we look

forward to receiving. While public sector pensions were a matter for the UK government, the Cabinet Secretary said that the possibility of supplementing incomes of those who withdraw from the NHS pension scheme upon reaching the lifetime allowance with employers' contributions could be considered, particularly for consultants, but would require employers' input. Seniority payments existed in Scotland, but the Cabinet Secretary said that there was no information about their effectiveness.

4.18 BMA Scotland said that in terms of the age of the working population, officials should consider whether individuals in their 50s were close to the end of career. People nowadays were expected to work longer, but many people were seeking to do so in a less pressured environment. Changes in the NHS pension scheme and pension tax changes had left colleagues looking at options for early retirement and for returning to work part-time after retirement.

4.19 BMA Scotland thought it likely that more doctors would be leaving medicine in their late 50s/early 60s than expected, although it was very difficult to get reliable figures as many doctors either did not want to say or did not know when they were going to retire. Some older doctors were leaving permanent roles to locum, while others were leaving the workforce due to factors such as rising indemnity costs, and the bureaucracy associated with the appraisal and revalidation process – this was especially true for doctors only wanting to work small amounts of time. In the short term at least BMA Scotland thought the NHS would lose doctors faster in this age group.

'Brexit' and domestically-trained staff

4.20 The implications of the result of the June 2016 EU Referendum were still being worked through as we took evidence. The Scottish Government told us that Scotland's needs were different from those in the rest of the UK due to Scotland's distinctive demographic structure. Migrant workers remained an important labour source. While the UK government remained committed to reducing dependence on migrant workers and tightening the rules around entry to the country, Scotland has some power through the Shortage Occupation List (Scotland only) to facilitate entry

routes for certain skilled migrant workers. There were just over 1,100 EEA-qualified doctors in Scotland (as at December 2014), from a total of approximately 20,000, representing around 6 per cent of the medical workforce, while 2 per cent of dentists in training were from the EU.

4.21 The impact of Brexit on the NHS Scotland workforce would depend on the precise form of withdrawal from the EU. There was concern that continued uncertainty over the long term position of EU nationals working within NHS Scotland and other social care services would have an impact on its ability to continue to attract people from these countries to work and live in Scotland.

4.22 In oral evidence the Cabinet Secretary said that the Scottish Government wished to give certainty to those affected by Brexit, and maintained that EU citizens already living In Scotland should have the right to stay. Scottish supply needs would continue to be met through a mixture of home-grown and international recruitment.

Locums and agency spending

4.23 Audit Scotland reported that difficulties in recruiting and retaining staff and greater use of temporary staff may pose risks to patient safety and quality of care. Such risks could arise from poor continuity of staff, temporary staff being unaware of local systems and processes, or a lack of staff to provide safe care. It also found that one board was using agency medical locums to cover long-term vacancies. BMA Scotland also highlighted this information to us, and linked ongoing recruitment and retention problems to the amounts NHS boards in Scotland spend on temporary staff.

Future delivery of healthcare

4.24 The Scottish Government told us that key to the delivery of its 2020 Vision for Health and Social Care was improved integration across health and social care services. The Public Bodies (Joint Working) (Scotland) Act 2014 aimed to facilitate this. The Act required health boards and local authorities to set up Health and Social Care Partnerships (also known as ‘Integration Joint Boards’) to integrate adult health

and social care services, bringing together the accountability of statutory partners. The Scottish Government told us that the integration of children's health and social care services could be agreed locally. On 15 October 2016, the First Minister made the commitment to increase annual investment in primary care by £500m by 2021-22. The aim was to help to deliver the Scottish Government's vision for general practice in the short and long term.

4.25 In oral evidence, the Cabinet Secretary said that Health and Social Care Partnerships (HSCPs) in Scotland were critical in the planning and delivery of integrated health and social care and aimed to mobilise networks of professionals on a regional basis. GMPs had also been involved in partnership roundtables. Although in operation for under a year, the HSCPs had made some progress in tackling delayed discharge, and it was hoped they would bring cohesion to the patient journey.

4.26 Audit Scotland noted that the NHS in Scotland was going through a period of major reform. A number of wide-ranging strategies proposed significant change, including the National Clinical Strategy, integration of health and social care services and a new GMP contract. These needed to be underpinned by a clear plan for change. While it reported that some progress was being made in developing new models of care, it had yet to translate to widespread change in local areas and major health inequalities remained.

4.27 BMA Scotland noted that Integration Joint Boards (IJBs) had been slow to get up and running, and that they represented a very different form of governance as they included elected councillors. It felt that this introduced a party political dynamic, and that instead of representing local interests, IJBs seemed to have become a proxy for national politics.

4.28 BDA Scotland in oral evidence said there was confusion around governance and who was managing dentistry. It noted that the Scottish Government had policy oversight, while there were 14 NHS boards, and local provision might be devolved to IJBs which did not have dentist representation. BDA Scotland did not want to see dentistry fragmented further, with a resultant loss in the ability to provide dental services flexibly and fluidly. HSCPs were focused on general medical practice and

the multitude of problems in the local health community; as a result, it was difficult to get dentistry on the agenda.

Our comments

4.29 We welcome the focus in Scotland on workforce planning. However, while there appears to be much information on what is intended to be done in this area, we received little evidence on the progress being made at the time of writing this supplement. Better information on training gaps would help underpin the planning process, and as we have previously mentioned, better vacancy data for consultants are also required. We noted a lack of clarity in the Scottish Government's position on workforce planning in terms of Scotland in the UK-wide market, and the balance to be struck between home-grown and international (including EU) recruitment. We encourage the Scottish Government to take action on improving workforce planning, and join up with the other UK countries to develop a coherent UK-wide workforce planning strategy.

4.30 We look forward to hearing more in next year's evidence about the research by the BMA and the University of Edinburgh on training choices. We will need more analysis and evidence on 'Generation Y' behaviours to be able to make any specific recommendations or observations regarding pay and motivation. The potential impacts of the changing career and lifestyle choices of 'Generation Y' need to be fully accommodated in workforce planning. The break at Foundation Year 2, with the latest UK Foundation Programme Office report showing that only half of trainees are now going straight into specialty training[4], and changes in the workforce demographics seem to us to be critical and we would expect workforce planners to be tracking this.

4.31 We recognise that a certain level of locum use is required to provide operational flexibility and to respond to short-term gaps in staffing levels. However, we would be concerned if this had an impact on patient care. We emphasise the need for the parties to understand better the cohort of doctors choosing to locum and we believe that systematic research is needed to understand their motivations and to work out how best the pay and employment package can respond to encourage

[4] UK Foundation Programme Office, Foundation Programme Annual Report 2016.

doctors to remain in direct employment. We look forward to receiving further evidence on locums in the next round, and on retirement trends.

4.32 As for the other UK countries, healthcare delivery in Scotland is undergoing a transformation. Care needs to be taken during this process to ensure not only that patient care standards do not drop, but also that the workload pressure on our remit groups is closely monitored to ensure that it does not cause greater staff stress or adversely affect recruitment and retention.

4.33 We are also concerned over the views expressed by BDA Scotland that there was uncertainty over the future governance of dentistry and that it had moved down the agenda.

CHAPTER 5: DOCTORS AND DENTISTS IN TRAINING

Introduction

5.1 This chapter should be read in conjunction with Chapter 5 in our main 45th report. Here, we set out Scotland-specific evidence and comment where appropriate.

Junior doctor contracts

5.2 In its written evidence, the Scottish Government told us that it would not be implementing the new contractual arrangements as in England, and confirmed to us in evidence that NHS Scotland would continue to service the New Deal contract for junior doctors. However, as it is clear that there will be different contractual and pay arrangements between Scotland and England, the Scottish Government told us that it would review how pay protection would work for trainees who choose to transfer between England and Scotland as part of the inter-deanery transfer process.

5.3 In oral evidence the Cabinet Secretary suggested that part of the attraction of the NHS in Scotland was linked to the good working relationship officials had with the British Medical Association (BMA), and good relations with junior doctors. She reconfirmed that Scotland would maintain the New Deal contract for junior doctors, and would only move on this if and when the time was right. There was no current appetite for a new contract in Scotland, though this would be kept under review.

5.4 The Cabinet Secretary noted that while juniors' basic pay in England had risen, this was offset by lower rates of pay for additional hours and other elements of the contract. She said that so far, the pay differential had no discernible impact. We were told that the referral rates of junior doctor wishing to come to Scotland had increased in 2017, although it was hard to establish the reasons for this.

5.5 BMA Scotland said it was in discussion with the Scottish Government on the junior doctor contract and had been given repeated reassurances that there would be no substantial changes. There was a desire to avoid what had happened in England, although this did not mean there would be no changes, as discussions

were ongoing about ways to amend and improve on the core contract. A priority was to ensure that the overall work pattern was safe for junior doctors, but BMA Scotland was not expecting a root and branch renegotiation of the contract, and was comfortable with the different contractual arrangements in Scotland.

5.6 BMA Scotland also stated that there was no evidence of any changes because of the pay differential with England, noting that banding changes offset some of the difference so that most junior doctors across the UK were earning roughly the same.

Recruitment and training choices

5.7 In September 2015, on a full-time equivalent (FTE) basis, there were 6,187 doctors and dentists in training in NHS Scotland, a decrease of 1 per cent. We provide further information on the numbers and characteristics of doctors and dentists in training in our main 45th report. We also include information on work undertaken to attract medical trainees to Scotland in Chapter 4 of this supplement.

5.8 The Scottish Government provided us with some information on fill rates this year. It told us that the overall fill rate of all medical training posts across all stages and specialties was 96 per cent. Some specialties and geographies remained challenging to fill. Key specialties which did not achieve good fill rates for higher specialty training included acute internal medicine, emergency medicine and, for the first year, general surgery, while core training psychiatry and general practice had even lower fill rates.

Motivation

5.9 While we did not receive updated staff survey results for trainees in Scotland, some information on motivation is available from the General Medical Council's national training survey. The survey reported high satisfaction rates with the overall quality of medical training programmes in Scotland. However, feedback on workload and work patterns was less positive. The Scottish Government told us that it was intending to improve the working lives of junior doctors, and had undertaken some

initial work together with the British Medical Association, including banning working seven nights in a row and agreement on joint monitoring guidance.

Our comments

5.10 As we mentioned in our main 45th report, the ongoing recruitment problems are of concern to us, particularly as we continue to be told that such issues are not pay-related. For our next round, we ask the Scottish Government (alongside the parties in Wales and Northern Ireland) to provide data at a similar level to Health Education England's evidence, which shows both the regional and specialist patterns in fill rates. As we stated in our main 45th report, we would also welcome evidence on the reasons why junior doctors are choosing particular locations or specialties. We note again here that the health departments of Wales and Northern Ireland expressed the desire to see comparability in contracts across all four countries, to ease the cross-border flow of junior doctors. More detailed data on the motivation of trainees in Scotland would also be useful.

CHAPTER 6: HOSPITAL DOCTORS

Introduction

6.1 This chapter considers the consultant group together with speciality doctors and associate specialists who provide secondary care and should be read in conjunction with Chapter 6 in our main 45th report. Here we set out Scotland-specific evidence and comment where appropriate.

CONSULTANTS

Recruitment and retention

6.2 In September 2015, on a full-time equivalent (FTE) basis, there were 4,985 consultants in NHS Scotland, an increase of 2.8 per cent. The Scottish Government told us that while there was difficulty in recruiting consultants to some specialties and locations, it was not a problem unique to Scotland. While staffing levels of units and related recruitment concerns were a matter for individual health boards, it maintained regular contact with all boards on a range of issues including the sustainability of the Scottish workforce. We provide further information on the numbers and characteristics of consultants in our main 45th report.

6.3 Table 6.1 shows the latest vacancy rates by specialty in Scotland (for hospital staff). While there is a large amount of seasonal variation between quarters (Figure 6.1), the trend in the six-month vacancy rate for both medical and dental staff increased, especially since the start of 2014. The total vacancy rate is more volatile, but has also noticeably increased since 2013.

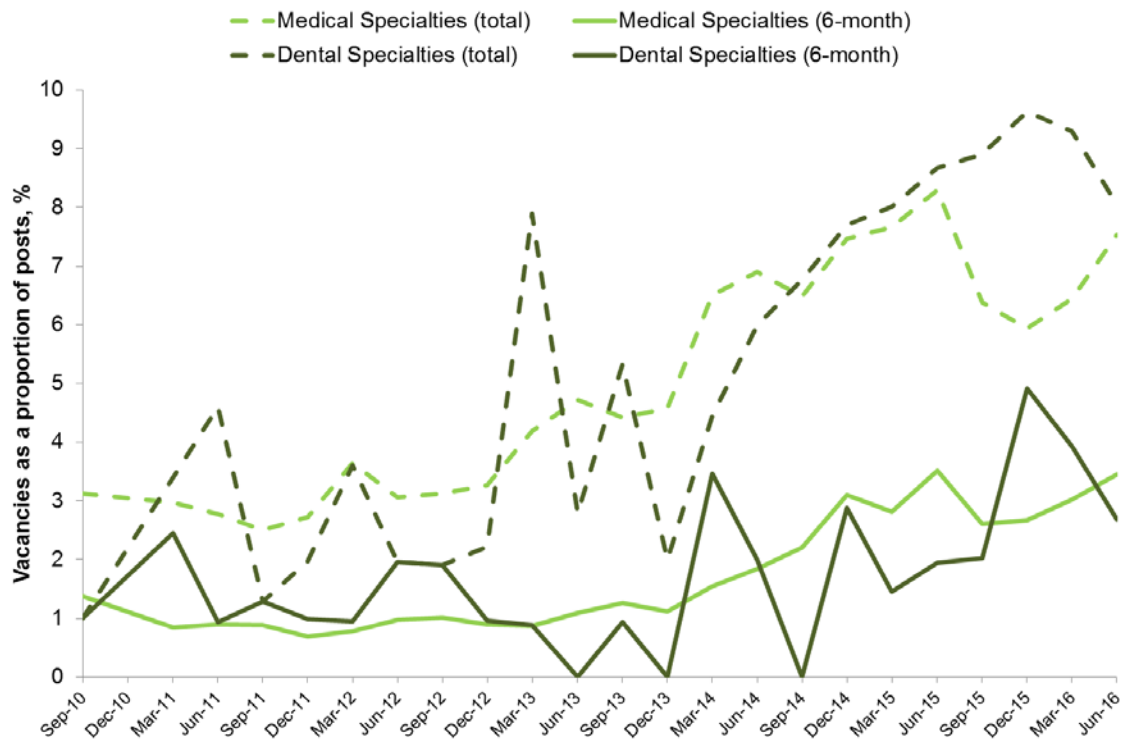
6.4 Of the specialties in Table 6.1, emergency medicine and occupational medicine have the highest six-month vacancy rate, three percentage points higher than the average for all medical specialties. Obstetrics and gynaecology has one of the lowest six-month vacancy rates.

Table 6.1: Vacancy rates in Scotland by specialty, whole-time equivalent, June 2016

		Six-month vacancies		Total vacancies	
	Staff in post	Vacancy rate (%)	Annual percentage point change	Vacancy rate (%)	Annual percentage point change
Scotland (June 2016)					
All specialties	**5,077**	**3.4**	**-0.1**	**7.5**	**-0.8**
All medical specialties	**4,981**	**3.5**	**-0.1**	**7.5**	**-0.8**
Emergency medicine	209	6.5	-0.6	9.7	-0.9
Anaesthetics	722	2.0	0.4	4.8	0.2
Intensive care medicine	10	0.0	0.0	42.4	14.4
Clinical laboratory specialties	625	5.2	1.2	9.9	1.4
Medical specialties	1,193	4.0	-1.5	8.2	-2.5
Public health medicine	88	3.9	1.7	5.7	-2.7
Occupational medicine	12	6.5	0.6	19.5	7.7
Psychiatric specialties	549	4.4	1.1	9.2	0.3
Surgical specialties	952	2.4	0.0	7.0	-1.0
Obstetrics & gynaecology	252	0.8	-0.4	3.5	-2.1
Paediatrics specialties	305	3.1	-0.7	6.0	-2.5
General practice	11	0.0	0.0	8.1	8.1
Not known medical specialty	53	0.0	0.0	0.0	0.0
All dental specialties	**96**	**2.7**	**0.7**	**8.1**	**-0.6**

Source: Information Services Division Scotland.

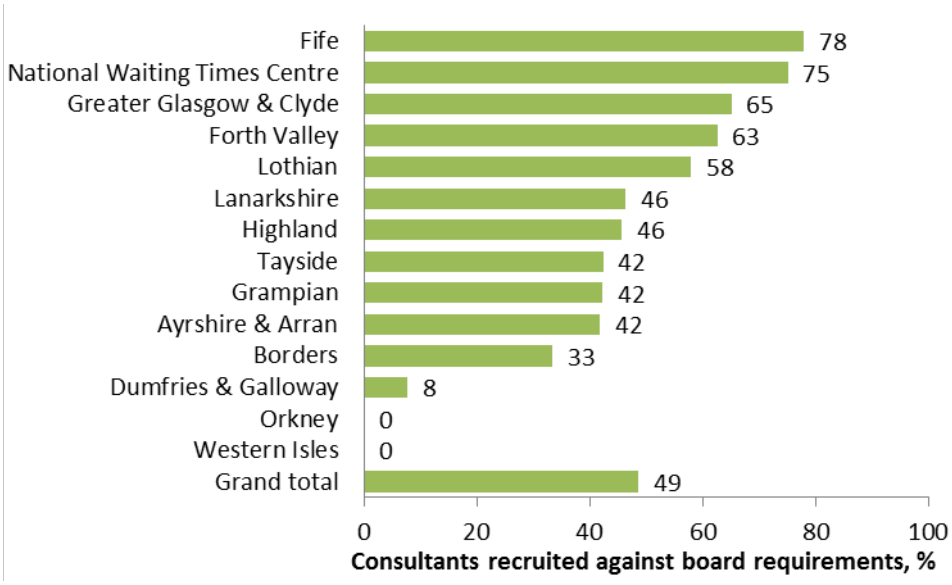
Figure 6.1: Vacancy rates in Scotland, total and long-term, whole-time equivalent, 2010 to 2016



Source: Information Services Division Scotland.

6.5 In oral evidence BMA Scotland said that vacancy figures for consultants were around the highest for any group in NHS Scotland, not even including the unadvertised empty posts. There was a strong sense from small and large hospitals that recruitment of consultants was a problem, and the reduced numbers created severe pressure on remaining colleagues. Many consultant appointment panels were cancelled for lack of applicants. Figure 6.2 illustrates the difficulties in consultant recruitment, showing the percentage recruited against health board requirements.

Figure 6.2: Percentage of consultants recruited against board requirements over a three month period



Source: Scottish Government evidence to DDRB for 2017-18.

6.6 BMA Scotland attributed the failure to attract people to posts to the remuneration and lack of administrative support. There was also dissatisfaction at the failure to implement the full pay award in the last round in relation to Distinction Awards, and 9:1 contracts (discussed below). As a result of these factors, consultants felt less valued.

6.7 The 9:1 job plan refers to the ratio of 'programmed activities' (PAs) for direct clinical care to 'supporting professional activities' (SPAs) upon which the consultant contract is based. BMA Scotland told us that in the original consultant contract, the ratio had been 7.5:2.5, but that this was changed to increase the level of clinical work. As a consequence, however, there was a divided workforce where some

consultants were on 9:1 contracts and others had a more favourable split. This created a sense that teaching the next generation was undervalued and created recruitment difficulties. BMA Scotland said that the use of 9:1 had a highly negative impact and had not helped in the long-term to bring consultants forward and provide career development. Despite BMA Scotland raising this issue repeatedly, the Scottish Government had not changed its policy. According to BMA Scotland, only 5 out of 75 recent consultant appointments in Scotland were offered with 7.5:2.5 job plans.

Contract reform

6.8 We provided details on the contract situation for consultants in our main 45th report. The Scottish Government stated that any changes to the consultant contract in Scotland would be negotiated with the BMA to take account of the need for service delivery models appropriate for the healthcare needs of people in Scotland. However, it was monitoring developments in other UK health departments.

Performance awards

6.9 Schemes to recognise and reward those consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services have existed since the NHS was established in 1948. In Scotland, 'Discretionary Points' are local awards determined by the local health board, while 'Distinction Awards' are national awards. Both are consolidated payments to consultants for exceptional achievements and contributions to patient care. Since the publication of our review of incentives for consultants in December 2012, we have been waiting for the parties to decide how to take forward our proposals on the future of the award schemes.

6.10 On 16 January 2016 health boards and other key NHS stakeholders in Scotland were told by the Scottish Government that Discretionary Points could continue to be awarded and paid at board level and that the freeze on new

Distinction Awards would continue, while the 5 yearly review process continued as normal.

6.11 Last year, we recommended a 1 per cent increase in the value of Distinction Awards and Discretionary Points. The Scottish Government rejected that recommendation as it considered it to be counter to its policy of restraining the pay of high earners in the public sector and inconsistent at a time of continuing public sector pay restraint. The Scottish Government told us that it still intends to reform these schemes, but that such reform would only be considered as part of any potential changes to the consultant contract. It added that it was working with the BMA, the Scottish Academy and NHS Employers in Scotland to consider how recruitment, retention and motivation of the medical and dental workforce could be improved. It had noted the importance of incentives in this regard, but considered that lifting its freeze on these schemes would be contrary to its policy of restraining the pay of high earners in the public sector, and would not be understood by lower-paid staff.

6.12 In oral evidence, the Cabinet Secretary confirmed to us that the Scottish Government would not be changing its policy on Distinction Awards. It was felt that increasing the salaries of the highest paid in this way made the wider principle of pay restraint difficult to justify.

6.13 In its evidence to us, BMA Scotland told us that it remained concerned that governments were able to reject our recommendations, and reiterated its position that the value of Discretionary Points and Distinction Awards in Scotland should be reinstated.

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

6.14 Specialty and Associate Specialist (SAS) doctors are a diverse group comprised of: specialty doctors, associate specialists, staff grades, senior clinical medical officers, clinical assistants, hospital practitioners and doctors working in community hospitals. We gave information on numbers and our detailed consideration of SAS doctors in the UK in our main 45th report.

6.15 In Scotland, in September 2015, there were 1,056 SAS doctors, forming approximately 9 per cent of the Scottish NHS hospital medical workforce.

6.16 In oral evidence BMA Scotland told us that a significant proportion of this group had not made an active choice to be part of the SAS grades, and those who had may have done so for the opportunity to go into the now closed Associate Specialist grade. BMA Scotland considered that there was now a 'glass ceiling' for these doctors, and wanted to see a specific focus on this part of the remit group for next year.

Career development

6.17 The Scottish Government said that it had committed £500,000 per year for SAS career development. A network of regional SAS educational advisors had been established to promote awareness of the development fund and to provide career advice and co-ordination within NHS boards. They had helped to implement local generic educational programmes for SAS doctors as well as enabling them to access national programmes. The fund supported individual professional development and 'CESR' applications.

Our comments

6.18 We are particularly concerned over the recruitment and retention difficulties for consultants in Scotland. There is a wide range of consultant vacancy levels, with evidence suggesting that some boards apparently did not fill any vacancies, while the best-performing were only filling three quarters of their vacancies (although we note that we do not know to which three-month period the data relates). The detrimental impact of 9:1 job plans on recruitment was raised by BMA Scotland as a key issue, and given the seriousness of consultant recruitment difficulties in Scotland we would urge the Scottish Government to consider further action to address this.

6.19 In relation to Distinction Awards and Discretionary Points, the Scottish Government told us that it does not wish to uplift their values as they felt this would be contrary to their pay policy as increasing the salaries of the highest paid in this way would make the wider principle of pay restraint difficult to justify. They noted the importance of incentives to the recruitment, retention and motivation of the medical and dental workforce, and also said that they intended to reform these schemes at the same time as wider contractual reform in Scotland. The BMA were clear that they wished to see the value of Distinction Awards and Discretionary Points reinstated in Scotland. These schemes have not been uplifted since 1 April 2009, which creates a disparity with England and Wales. However there is little evidence regarding the impact of this on recruitment and retention. In 2016-17, the national Clinical Excellence Awards in England, for example, were worth between £35,832 and £76,554; the Distinction Awards in Scotland were worth between £31,959 and £75,889. The consultant salary scales in Scotland are 2 per cent higher than those in England. The evidence is not clear cut therefore, however on balance we believe that it is important to continue to invest in rewarding outstanding performance as this is an established part of the consultants' pay system in all parts of the UK. Our recommendation follows in Chapter 9.

6.20 Please see Chapter 9 of this report and our main 45th report for our recommendations on better use of existing pay flexibilities and a new mechanism for targeted pay solutions.

6.21 We reiterate our comments in our main 45th report that SAS doctors are an important part of the NHS workforce and continue to play a key role in the provision of services. We would like to see this group of doctors given equal consideration and reflected more in the quality and quantity of evidence we receive. Even the term used to refer to SAS doctors – 'Non-Consultant, Non-Training' staff – goes against the notion of an esteemed and valued part of the workforce with a vital role in delivering patient care. We received very little evidence on SAS doctors in Scotland and would like to see more next year. We are pleased to hear that the BMA will be undertaking a substantive project on SAS doctors for the next round and look forward to reviewing this new evidence.

CHAPTER 7: GENERAL MEDICAL PRACTITIONERS

Introduction

7.1 This chapter considers issues relating to General Medical Practitioners (GMPs). In common with the other countries of the UK, there are moves in Scotland to transform the way primary care services are delivered. Further information on the roles, demographics and workforce of GMPs in the UK is included in our main 45th report.

Workforce

7.2 In 2015, on a headcount basis, there were 4,938 GMPs in NHS Scotland, an increase of 0.3 per cent over the previous year.

Access to GMP services and new care models

7.3 The vision for general practice in Scotland was set out by the Cabinet Secretary in June 2015, and will involve a transformation of how primary care services are delivered, enabled by a fund of £85 million over three years from 2016-17. A recruitment and retention fund for GMPs was also announced, together with an increase in the number of GMP training places.

7.4 Some GMP practices in Scotland have approached their NHS board to seek support, which can be given in the form of the board taking over the direct running of the practice, known as '2C' practices, or by some mutually agreed arrangements for managing practice lists. At 1 July 2016, there were 43 '2C' practices in Scotland. In some instances choosing to be managed by the board was a contractual choice rather than a result of the practice being in difficulty. For example half of GMP practices in Orkney use 2C contracts. The Scottish Government does not monitor the reasons for practices becoming 2C as individual circumstances are managed by

the local health boards. However, some boards volunteered this information, and the majority of those cases were due to financial or recruitment issues in 2016. Other reasons included patient list size and retirement of the practice owner.

7.5 In oral evidence the Cabinet Secretary described the aim of primary care policy to move toward a model of cluster working to reduce bureaucracy, and give GMPs a bigger role in population care planning.

Independent contractor GMPs

Contracts

7.6 Most doctors working under contracts to provide primary care services in Scotland, as in the rest of the UK, are independent contractors – who are self-employed individuals or partnerships running their own practices as small businesses, usually in partnership with other GMPs and sometimes others such as practice nurses, managers or companies; while some practices belong to sole practitioners. The main forms of contract in Scotland are: Section 17C arrangements,[5] Alternative Providers of Medical Services (APMS), and Primary Care Trust Medical Services (PCTMS).

7.7 In oral evidence the Cabinet Secretary confirmed that the Scottish Government was working with the British Medical Association (BMA) on a new GMP contract that would help deliver the vision of general practice treatment in a community setting. More GMPs were needed, and a new approach was envisaged for healthcare with multi-disciplinary teams using a range of healthcare professionals with the GMP at the centre.

7.8 In oral evidence, BMA Scotland said that it was looking at redesigning the GMP contract to place focus on the GMP as an expert generalist managing complex care and leading clinical teams to improve patient outcomes. This enhanced role

[5] A 'Section 17C' practice (formerly known as 'Personal Medical Services' or 'PMS' practice) is one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances. Section 17C is in respect of The National Health Service (Scotland) Act 1978, as amended under The Primary Medical Services (Scotland) Act 2004. See: http://www.isdscotland.org/Health-Topics/General-Practice/GPs-and-Other-Practice-Workforce/Glossary.asp

would require GMPs to retrain, to focus more on team leadership, and to channel time away from the high-volume work they were currently doing in order to take on this new agenda. For this to happen, the Scottish Government would need to provide the investment, mainly in additional staff such as pharmacists and other professionals, to support the GMP role. While it was a challenge to ask GMPs to transform their role, it was also necessary for retention in the profession. In the new GMP contract, BMA Scotland was looking to ensure a focus on GMP income for providing GMP services rather than other services. This would include reducing the risks involved in employing larger numbers of staff or running/owning premises.

7.9 While there was a trend toward more salaried GMP employment, the Cabinet Secretary told us that 85 per cent of GMPs still wanted to be independent contractors. Officials also noted that local boards who took on practices found they were two to four times as costly to run as independent contractor-run practices.

Recruitment and retention

7.10 We provide information on the recruitment and retention of GMPs in the UK in our main report. In Scotland, there were a number of recruitment and retention incentives in place to encourage trainees to enter into general practice, and then to take up positions in rural or remote areas. The Scottish Government announced in October 2015 that the number of General Practice Specialty Training (GPST) places had been increased by 100 to 400. Recruitment bonuses of £20,000 had been made available to attract trainees in traditionally harder to fill, remote posts, with 76 training programmes advertised with such bursaries in 2017. The Scottish Government noted that the 2016 GP Year one training recruitment fill rate was up 19 per cent compared to 2015.

7.11 The Cabinet Secretary for Health and Sport announced in March 2017 that the GP Recruitment and Retention Fund would increase five-fold: from £1 million in 2016-17 to £5 million in 2017-18. This investment would support and expand on initiatives such as the establishment of a Scottish Rural Medicine Collaborative involving ten NHS boards and NHS Education for Scotland (NES), to bring together recruitment strategies and support networks for GMPs working in remote and rural

areas. These measures built on the learning from projects in Highland and test sites in Argyll and Bute, where new approaches to sustainable rural healthcare had been successfully trialled. Such projects also explored barriers relating to potential professional isolation and making good use of tele-healthcare where applicable.

7.12 In oral evidence the Cabinet Secretary noted that short-term measures to ease the GMP workload had already been taken, including removing the Quality Outcomes Framework to reduce bureaucracy; improving parental leave; and increasing the use of pharmacists. Scotland was also developing a Scottish Graduate Entry Medical Programme, with a centre of excellence for primary care and a rural working focus.

7.13 The Cabinet Secretary confirmed that the Scottish Government was seeking to address aspects that caused frustration among GMPs, and had introduced a 'goodwill package' as advised by the BMA, investing £20 million in short-term recruitment and retention measures. An out-of-hours review had also been completed to explore how GMP out-of-hours burdens could be reduced by bringing in other professionals, and its recommendations were being implemented[6].

7.14 In oral evidence BMA Scotland noted that the volume of GMP work was increasing. In Edinburgh alone, there were 50 'closed list' practices which were closed to new patients due to recruitment difficulties. The burdens could be eased with the support of healthcare professionals to free up GMP time, but it would be some years before clinical staff were available to meet increased patient demands.

7.15 BMA Scotland considered that the 'job weight' of GMPs could increase as they may be required to become higher-level operatives in the context of future healthcare strategy. The organisation wanted doctors involved in improving patient outcomes and clinical innovation. However, BMA Scotland considered that this should be reflected in pay. BMA Scotland told us that practice closures were happening on an unprecedented scale because GMPs could not be recruited. BMA Scotland felt that doctors should be paid enough to provide the fundamental health services society needed.

[6] Pulling Together – transforming urgent care for the people of Scotland: The Report of the Independent Review of Primary Care Out of Hours Services, Review led by Professor Sir Lewis Ritchie OBE, November 2015:
http://www.gov.scot/Topics/Health/Services/nrpcooh

Earnings and expenses of independent contractor GMPs

7.16 We included information on earnings and expenses for GMPs in the UK in our main report. We have previously called for improved information on GMP expenses, and took the decision in 2016 to abandon the use of a formula to recommend on an increase in expenses, and instead to make recommendations on our intended increase in pay net of expenses. It was therefore incumbent on the parties to discuss expenses in order for them to ascertain what gross increase was necessary in order to deliver our recommended increase in pay (assuming that the Health Departments accepted our recommendation). For 2016-17, the Scottish Government implemented our recommendation to uplift GMP pay net of expenses by 1 per cent. This resulted in a total contract uplift of £11.4 million. We welcome the Scottish Government's recent announcement of a £11.6 million contractual uplift for GMPs, including funding for pay, expenses and population growth, as part of a £71.6 million investment in general practice on pay, premises and workforce measures in 2017-18.[7]

7.17 All parties agree that expenses for GMPs should be settled by negotiation. For this pay round, we therefore again make a recommendation on pay net of expenses. Our main 45th report and Appendix E of this supplement include information relating to the formula we previously used to inform our recommendations on expenses. The Scottish Government told us that it and the BMA's Scottish General Practitioners Committee had agreed in principle that better information was needed to allow more accurate reimbursement of expenses and inform options for the long-term development of GMP pay. Therefore, the parties had agreed to commission jointly a review of general practice funding, pay and expenses, to take place during 2017.

[7] Announcement by Shona Robison, Cabinet Secretary for Health, to the BMA Scottish Local Medicine Committee, 10 March 2017: http://news.gov.scot/news/supporting-general-practice

Salaried GMPs

7.18 In oral evidence, the Cabinet Secretary noted that salaried GMPs made up 16 per cent of the workforce, and had a particular role in rural communities. There was a year-on-year trend of moving to more salaried roles, though the majority of GMPs in Scotland remained contractors.

7.19 BMA Scotland in oral evidence said that the rise in salaried GMPs was not as marked in Scotland as in England, but that there was a trend in GMPs switching from partner positions to salaried roles. There was a wide range of ways in which GMPs were salaried and a range of pay scales, and, given that the salaried route appeared to be a long-term career choice, BMA Scotland considered that a standardised contract may be a way forward.

7.20 We set out here our observations on salaried GMPs from our main report which may also have some relevance to Scotland:

Observation 1

There are signs of a clear trend in the GMP workforce towards salaried employment and away from the contractor-partner model. It is not yet clear if this is a permanent trend. However, broader changes in the economy, particularly with the entry of the 'Generation Y' cohort into the labour market imply that it might be. A systematic data collection exercise is needed to understand properly the profile of the GMP workforce in terms of FTE, geographic, demographic data, and career choices. Understanding FTE would shed further light on how far 'Generation Y' desires for flexibility and a better work-life balance are translating into part-time working patterns and this in turn will be crucial for effective workforce planning.

Observation 2

There is a lack of data on and insight into this trend by the parties. There is also a significant amount of change in the primary care landscape. This implies that there may be a lack of readiness for what may be a fundamental shift in the workforce, in terms of ensuring that the employment offer is as attractive as possible whilst maintaining value for money in primary care provision.

Observation 3

While there is not a great deal of evidence on this group, they are much more likely to be younger and female than GMP partners. Despite generally lower earnings than partners, salaried status appears to be an increasingly popular choice for new doctors, which could be due to the greater flexibility and work-life balance this role can offer. Overall, there is insufficient evidence for us to draw firm conclusions, but we will monitor this group closely, as there could be implications for the future planning and delivery of primary care.

Our comments

7.21 As in much of the rest of the UK, the general practice landscape in Scotland is undoubtedly complex and shifting, with potential impacts on how services are delivered. There are particular concerns over the recruitment and retention of GMPs including in more remote, rural areas. We welcome the measures the Scottish Government has taken to address these concerns and look forward to hearing in due course how successful the measures have been. Achieving the vision for general practice by 2020 will be extremely challenging in the current circumstances of increasing demand for services. We note and welcome that relationships between the Scottish Government and BMA Scotland on GMP issues appear positive. While delivering the 2020 Vision will be a challenge, constructive dialogue between the parties will aid the transition. We look forward to seeing the outcome of the review of general practice funding, pay and expenses to be jointly commissioned by the Scottish Government and BMA Scotland and to hearing of progress on improving general practice provision in remote and rural areas.

7.22 We discuss the GMP trainers' grant and the rate for GMP appraisers in our main 45th report. We received no evidence to suggest that the situation was any different in Scotland from the rest of the UK.

CHAPTER 8: DENTISTS

Introduction

8.1 This chapter considers issues relating to General Dental Practitioners (GDPs). In Scotland, a ‘principal dentist’ is a practice owner, practice director or practice partner who has an arrangement with a health board, whereas an ‘associate dentist’ is a self-employed practitioner who delivers NHS dental services by entering into arrangements with a principal dentist, and also has an arrangement with a health board. Our remit covers all independent contractor GDPs in primary care that are contracted to provide NHS services. In Scotland GDPs are primarily remunerated via item-of-service fees, capitation and some continuing care payments, with some centrally-funded allowances.

GENERAL DENTAL PRACTITIONERS

Workforce

8.2 In 2015, on a headcount basis, there were 3,227 General Dental Practitioners in NHS Scotland, an increase of 0.6 per cent over 2014.

Access to dental services

8.3 The Scottish Government told us that access to NHS dentistry, as measured by the numbers of patients registered, continued to increase. It told us this had been enabled by the substantial increase in the number of GDPs in recent years; for example there was an increase of 11 per cent between 2011 and 2016. We heard that the main policy objective was to balance the supply and demand for NHS dentists, with student numbers remaining ‘buoyant’.

Motivation

8.4 We covered the motivation of dentists in each of the four countries of the UK in our main report. NHS Digital's UK-wide survey on Dental Working Hours[8] suggests that dentists in Scotland generally reported lower motivation and morale than those in England and Wales, but higher than those in Northern Ireland.

8.5 In oral evidence, BDA Scotland described a 'crisis of morale' in dentistry caused by flat-lining incomes and high and growing expense ratios. Other factors contributing to collective stress in the profession included over-regulation and bureaucratic burdens. In particular, the organisation highlighted NHS Digital's survey (see above) which found that more than half of dentists across the UK were thinking of leaving the profession. BDA Scotland suggested that low morale among dentists put dental access in jeopardy and that there had been a collapse in earnings 'without parallel' in the public sector. This was evidenced by the number of GDPs taking voluntary retirement, which BDA Scotland said had doubled over the past two years – although we recognise that the reduction in the pension lifetime and annual allowances may have had an impact on this. It hoped that the DDRB would be able to put forward recommendations which showed an understanding of these issues.

8.6 BDA Scotland described 'a climate of fear' for dentists, who were operating in a context of frequent fitness to practice procedures, complaints and potential loss of licence. There was currently a consultation underway about shifting the perceived balance away from 'punishment' towards prevention, but the current reality remained one of concern, which impacted on motivation.

Recruitment and retention

8.7 In oral evidence, Scottish Government officials reported that there were no recruitment difficulties in Scotland for GDPs. The dental workforce had increased by around a third over the last ten years. While 'golden hellos' and seniority payments were in place, some were only applicable in very remote or island areas. A remote

[8] NHS Digital, Dental Working Hours, 2014/15 and 2015/16 Motivation Analysis, Experimental Statistics, December 2016. See: http://www.content.digital.nhs.uk/catalogue/PUB22526

areas allowance was payable to GDPs working in areas with less than 0.5 persons per hectare.

8.8 BDA Scotland noted that a significant proportion of dentists in Scotland were from overseas, including a prominent group of EU dentists and vocational trainees. Losing these practitioners due to the impact of Brexit would clearly be a serious problem, which was one reason not to reduce the graduate intake.

8.9 BDA Scotland said that golden hellos had been introduced to get round access problems, and had been successful with recruitment, though their effect on retention was uncertain. In more remote areas retention was more challenging, and there were still pockets where it was difficult to get dentists to work and remain, for example the Isles of Lewis and Skye had recruitment difficulties.

8.10 The Scottish Government undertook a consultation on the future of oral health in Scotland[9], to inform the proposed 'Dental Action Plan'. The consultation included a range of proposals regarding General Dental Services, including measures relating to contracts, earnings and expenses, and allowances. We look forward to hearing more about the outcome of the consultation and its impact on our remit group from the Scottish Government.

Earnings and expenses

8.11 The Scottish Government worked with a specialist accountancy firm to produce a report providing more robust information on the expenses of GDPs providing NHS General Dental Services.[10] In oral evidence, Scottish Government officials noted the reduction in dental profits shown by the newly commissioned report which provided new data on expenses. Officials noted that generally there appeared to be a downward pressure on earnings, which could be in part attributable

[9] Scotland's Oral Health Plan: A Scottish Government Consultation Exercise on the Future of Oral Health, September 2016. See: http://www.gov.scot/Publications/2016/09/7679

[10] Henderson Loggie, Analysis of the Accounts of Scottish Dental Practices providing NHS General Dental Services, February 2017: http://www.gov.scot/Topics/Health/NHS-Workforce/Policy/Pay-Conditions/DDRBGDPsandNHSGDSexpenses

to a reduction in private work, and they would expect a more sustainable earnings picture in the future.

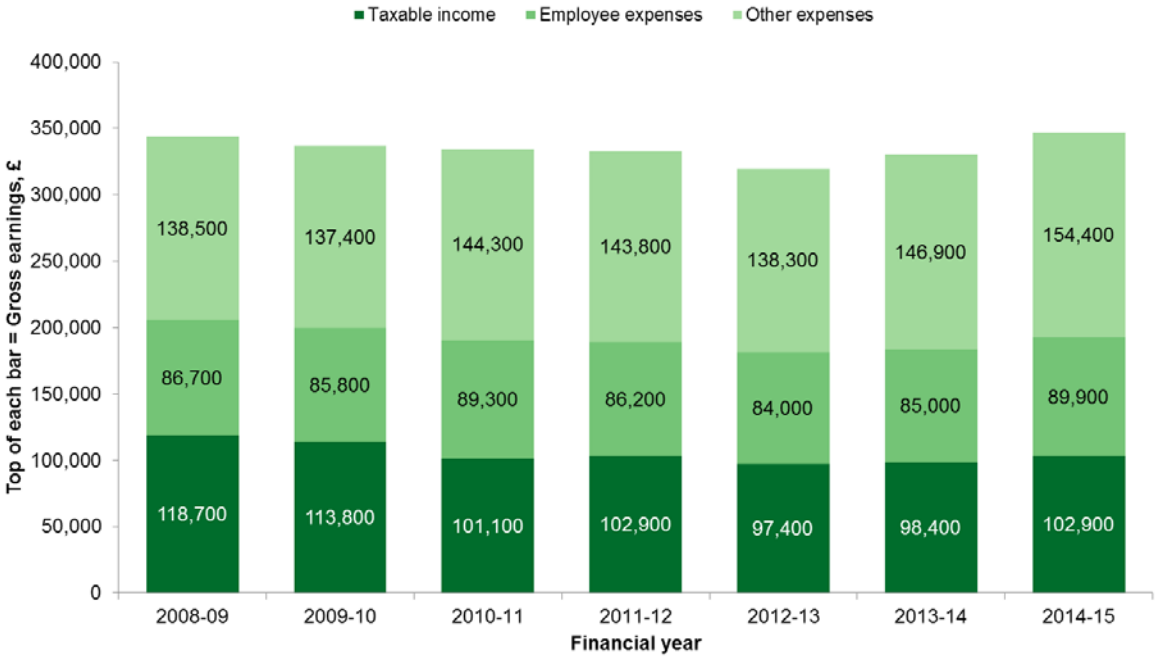
8.12 BDA Scotland stressed the significant and continuing decline in dentists' income which it calculated had fallen by 30 per cent in real terms since 2008, based on NHS Digital data and ONS inflation indices. According to the NHS Digital dental motivation data only 17 per cent of principal dentists thought their pay was fair. BDA Scotland noted that a 1 per cent rise in gross expenses did not equate to a 1 per cent rise in pay.

8.13 BDA Scotland also pointed out that the general running costs of dentistry fluctuated and were influenced by exchange rates. Manufacturers of materials changed prices sometimes daily; for example the price of gold had increased with no additional government funding to mitigate this. BDA Scotland said that the framework within which dentists worked and received payment was very legalistic with 500 items of service, and should be replaced with a simpler and more transparent system of remuneration.

8.14 BDA Scotland noted that there was relatively little private dentistry in Scotland compared with the rest of the UK. In Scotland, there were restrictions on providing private treatment to patients who had already had NHS treatment on the same tooth, which could constrain patient choice and dental earnings. In addition, item of service fees had been kept low when compared with the rate of inflation.

8.15 Table 8.1 shows that in 2014-15 principal dentists had average taxable income of £102,900 and expenses of £244,300 (Earnings to Expenses Ratio or EER of 70.4 per cent) on a headcount basis. Figure 8.1 shows that principal dentist income increased on average in 2013-14 and 2014-15, having noticeably fallen – by over £10,000 – in 2010-11.

Figure 8.1: Principal dentists, mean gross earnings (NHS and private), Scotland, 2008-09 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

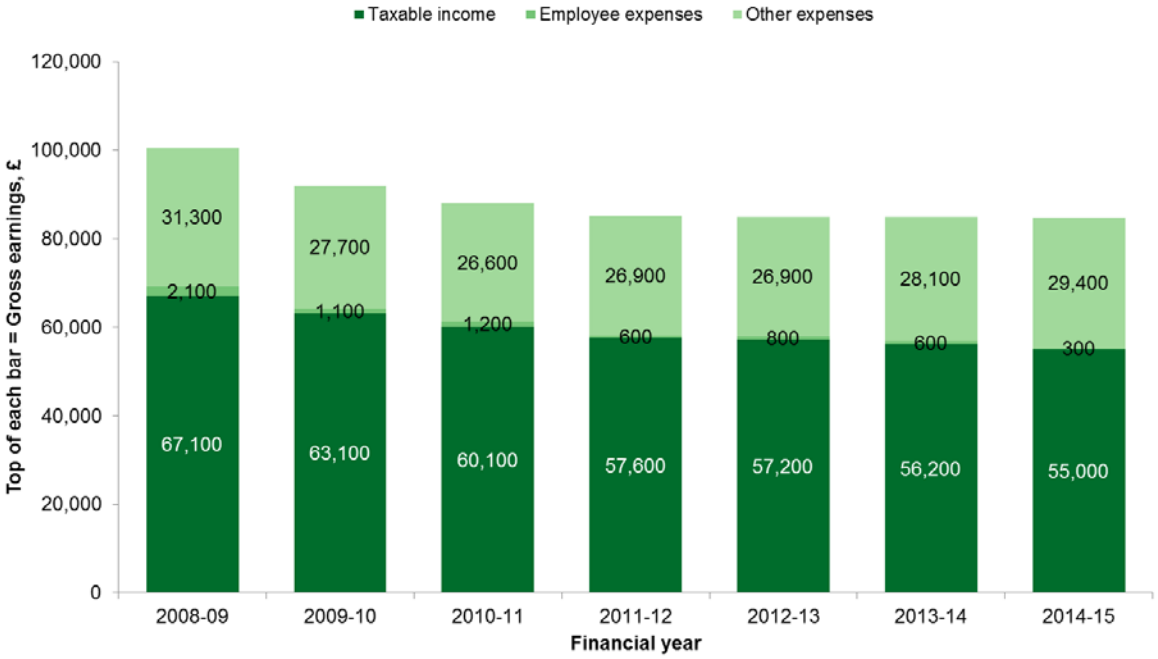
Table 8.1: Mean income and expenses for principal dentists, Scotland, 2008-09 to 2014-15

Dental type	Year	Estimated population[1]	Gross earnings (£)	Employee expenses[1] (£)	Other expenses[1] (£)	Income (£)	Earnings to expenses ratio (EER) (%)
Principal	2008-09	699	343,900	86,700	138,500	118,700	65.5
	2009-10	650	337,000	85,800	137,400	113,800	66.2
	2010-11	700	334,700	89,300	144,300	101,100	69.8
	2011-12	700	332,900	86,200	143,800	102,900	69.1
	2012-13	650	319,600	84,000	138,300	97,400	69.5
	2013-14	650	330,300	85,000	146,900	98,400	70.2
	2014-15	600	347,200	89,900	154,400	102,900	70.4
	Latest change (%)	*-7.7*	*5.1*	*5.8*	*5.1*	*4.6*	*0.2pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
(1) Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by NHS Digital from unrounded figures.
pp: percentage point change.

8.16 Table 8.2 shows that in 2014-15 associate dentists had average taxable income of £55,000 and expenses of £29,700 (Earnings to Expenses Ration or EER of 35.1 per cent) on a headcount basis. Figure 8.2 shows that the pay of associate dentists has been slowly declining over this time period. Employee expenses for associate dentists are very low compared to in England and Wales.

Figure 8.2: Associate dentists, mean gross earnings (NHS and private), Scotland, 2008-09 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Table 8.2: Mean income and expenses for associate dentists, Scotland, 2008-09 to 2014-15

Dental type	Year	Estimated population[1]	Gross earnings (£)	Employee expenses[1] (£)	Other expenses[1] (£)	Income (£)	Earnings to expenses ratio (EER) (%)
Associate	2008/09	1,318	100,500	2,100	31,300	67,100	33.2
	2009/10	1,450	91,900	1,100	27,700	63,100	31.3
	2010/11	1,450	87,900	1,200	26,600	60,100	31.6
	2011/12	1,550	85,000	600	26,900	57,600	32.3
	2012/13	1,650	84,900	800	26,900	57,200	32.6
	2013/14	1,650	84,900	600	28,100	56,200	33.8
	2014/15	1,750	84,700	300	29,400	55,000	35.1
	Latest change (%)	*6.1*	*-0.2*	*-50.0*	*4.6*	*-2.1*	*1.3pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
(1) Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by NHS Digital from unrounded figures.
pp: percentage point change.

Expenses and the formula

8.17 Scottish Government officials told us that there had been discussions with BDA Scotland on expenses, but it was clear that it would be very difficult to come to a bilateral agreement. The Scottish Government felt that BDA Scotland had very high expectations for future increases in compensation for expenses. BDA Scotland's view, however, was that, as could be seen from the available statistics, dentists had been under-compensated for increases in expenses outside their control in recent years, and that a significant correction was therefore needed. The Scottish Government informed us that it had increased item-of-service fees by the following amounts in recent years: 2.51 per cent in 2013-14; 1.71 per cent in 2014-15; 1.61 per cent in 2015-16; and 1.13 per cent in 2016-17.

8.18 In regard to the new evidence on dental practice accounts provided by the Scottish Government, officials felt that while the sample was not statistically representative, it could usefully serve to give context and further concrete information about expenses. Officials suggested the new accounts information could give a fresh perspective and be used to assess the utility of a formula-based

approach. Officials expressed a preference for us to give a recommendation on expenses to help bring the parties closer together in bilateral negotiations.

8.19 In oral evidence BDA Scotland noted that while the new evidence on dental practice accounts provided by the Scottish Government provided data, it was not comprehensive and was very limited in comparison to, for example, HMRC data on dental earnings. BDA Scotland noted there were many caveats around the new data and did not think that it was possible to extrapolate from it given the small sample it was based on.

The General Dental Council Annual Retention Fee and indemnity costs

8.20 BDA Scotland said that dentists in Scotland had not yet felt the effects of actions taken to address rising indemnity costs and the increase in the Annual Retention Fee. Indemnity costs had a knock-on effect with all dentists paying far more; south of the border GDPs had managed to negotiate recompense for this, but not as yet in Scotland. There was no government intervention to say the GDC fee was excessive. BDA Scotland said that the Scottish Government had not acted to restrict indemnity increases, particularly for part-time dentists, and felt that the Scottish Government should be supporting the local resolution of potential fitness to practice referrals to avoid them going to the GDC.

8.21 The BDA has expressed grave concerns about the impact of fitness-to-practice referrals and the knock-on effects in terms of indemnity costs borne by the profession. Additionally, on 2 March 2017, the BDA wrote to us to bring our attention to a change in the discount rate applied to personal injury claims, from 2.5 per cent to -0.75 per cent. It told us that the impact of this would be to increase the size of compensation payments in medical and dental negligence cases, so increasing costs to the NHS and other providers of medical and dental care. This could, in turn, lead to increases in the cost of insurance, increasing expenses and thereby reducing pay. The BDA said that General Medical Practitioners in England would soon benefit

from an indemnity support scheme[11], and that such a scheme should also be available to GDPs across the UK.

Dentists working in the corporate sector

8.22 BDA Scotland noted that several companies such as 'Integrated Dental Holdings' (also known as 'mydentist') undertook NHS work in Scotland and some operated across Europe. Such companies sometimes owned laboratories and other suppliers, so there was a corporate structure not only within dentistry but with the infrastructure around dentistry. This resulted in less transparency, especially on accounting.

Salaried dentists

8.24 We did not receive evidence relating to salaried dentists in Scotland.

Our comments

8.25 We are very grateful for the lengths that the Scottish Government has gone to provide us with extra information on GDP expenses for this round. There is clearly much of value in the data, and while we do not currently see how we can generalise from it to produce a new formula we will be looking at it closely over the summer. We need more time to understand how useful these data may or may not be. The information is however a step in the right direction, and will be needed in any case to support greater understanding of expenses by the parties. Our main 45th report and Appendix E of this supplement include information relating to the formula we previously used to inform our recommendations on expenses.

8.26 Our preferred approach is for the parties to negotiate directly on expenses, for reasons we have set out in detail in our previous reports. We note that dentists in Scotland generally have the lowest taxable income of all of the four UK countries, the difficulty the Scottish Government and BDA Scotland have in coming to a bilateral

[11] See Appendix F: Letter from BDA to Chair of DDRB, 2 March 2017

agreement and the clear mismatch in the information about the situation provided to us this year from them. As a consequence we wish to raise our concerns and stress the importance of both parties working to build better working relationships in future, to avoid for example longer-term risks to recruitment, retention and motivation, and potentially reversal of the gains made in access to NHS dentistry in recent years. We therefore make the following observations intended to provide a starting point for further dialogue between them:

- We note that a key source of frustration for BDA Scotland is the out-dated fee for item dental contract, which they find to be legalistic, complicated to understand and burdensome to deal with. Incomes have declined in Scotland, and access to private practice, and thus to alternative revenue streams, is limited. We therefore have sympathy with this and ask the Scottish Government to give serious consideration to contractual reform in consultation with BDA Scotland on the basis of fairness, transparency and sustainability.
- We note that the Scottish Government has recently consulted on the future of oral health in Scotland, demonstrating that it is seeking to modernise NHS dentistry in Scotland. This presents an opportunity for both parties to work together on the future shape of the service and we ask both parties to engage constructively on it and any action plan that follows.
- We observe that BDA Scotland has concerns about where dentistry fits into the new governance arrangements for health and social care integration. The Scottish Government should address this lack of clarity in order to help build trust.

8.27 Therefore, as last year, we make a recommendation only on pay net of expenses, so the uplift for expenses needs to be determined by the parties. We believe that it is important for the parties to attempt a reasonable dialogue on this and other issues, and encourage them to explore further the differences between their positions and seek to negotiate an outcome that is reasonable for both sides, taking our recommendation into account.

8.28 In relation to indemnity costs and GDC referrals, we note the concerns raised by the BDA but we see this as a matter for all parties, including the regulator, to

discuss respective roles and the most appropriate way forward. On the issue of the potential increases in the cost of insurance that could result from the increase in the size of compensation payments in medical and dental negligence cases that was highlighted to us by BDA, we suggest that the parties across the UK explore what their expectations are here and work towards a common understanding of how the issues can be best addressed.

8.29 We are particularly concerned over the reported low levels of motivation and morale among dentists in Scotland, and the differing views of the Scottish Government and BDA Scotland on recruitment and retention matters. We will continue to keep these issues and the potential impacts on access to NHS dentistry under review, and ask the parties to provide further details on the motivation of dentists in Scotland for our next round.

CHAPTER 9: PAY RECOMMENDATIONS

Introduction

9.1 In this chapter, we set out our recommendations for the main uplift for our remit groups. We have, as always, carefully considered all of the written and oral evidence we received and adhered to our terms of reference. The letter we received from the Scottish Government is at Appendix A.

Targeting: main pay scales

9.2 The Scottish Government's public sector pay policy for 2017-18 was published on 15 December 2016, and the subsequent remit letter highlighted:

- an overall 1 per cent cap on the cost of the increase in the baseline paybill for those earning over £22,000;
- flexibility to use paybill savings to consider meaningful reconstruction of pay and grading systems to address evidenced equality issues; and
- continuing the expectation to negotiate an extension to the no compulsory redundancy agreement as part of constructive, collaborative discussions between employers and the trade unions to make the most effective use of the funding available.

9.3 The letter also asked for our recommendations on GMPs' pay and contractual uplift, and told us that the Scottish Government had agreed to jointly commission with the British Medical Association's (BMA) Scottish General Practice Committee, a review of general practice funding, pay and expenses. We note that the Scottish Government has since announced a contractual uplift of £11.6 million for GMP pay and expenses, and welcome this[12].

9.4 In its evidence to us, the Scottish Government told us that, again, it did not wish to make a case for targeting within the main pay scales. It also told us that there was no doubt that the financial picture in NHS Scotland remained challenging and

[12] Announcement by Shona Robison, Cabinet Secretary for Health, to the BMA Scottish Local Medicine Committee, 10 March 2017: http://news.gov.scot/news/supporting-general-practice

that any pay rise would have to be modest to assist health boards to maintain headcount. The evidence proposed adherence to the Scottish public sector pay policy.

9.5 We gave full consideration to targeting within main pay scales in our main 45th report. Our key conclusions were as follows:

- For 2017-18, we again concluded that we should not target our recommendations on the basis of recruitment and retention. While there are some stubborn shortages in certain specialties, these are more appropriately addressed by nationally agreed flexible pay premia and location-specific recruitment and retention premia than by targeting pay scales.
- However, we are not convinced by the arguments that shortages are not amenable to pay. We welcome the pay measures the Scottish Government has taken to address concerns over recruitment and retention of GMPs in remote and rural areas and look forward to hearing in due course how successful these have been. With regard to other shortage issues, we consider that non-pay measures have been given a more than reasonable time to address these, so pay solutions should now be explored. However, existing local mechanisms are unlikely to be able to respond sufficiently speedily, or on the scale required.

We believe the recommendations made in our main 45th report apply equally to Scotland, for the reasons set out there and as summarised above.

Recommendation 1: We recommend that better use is made of existing pay flexibilities.

Recommendation 2: Recognising what has already been done in Scotland to use pay to address shortages, we recommend that the Scottish Government and workforce planners in Scotland give serious consideration to building on this by developing a new mechanism for enabling targeted pay solutions, backed by extra national resources, to be locally stimulated and rapidly tested. These should aim to address persistent, above average geographic and specialty shortages. We look forward to hearing the results, in evidence next

year, and would be happy to assist in developing criteria for payments if evidence is provided to us.

Targeting: pay premia

9.6 There are several pay premia on offer in Scotland to encourage recruitment and retention of doctors and dentists in certain areas. NHS boards can offer 'golden hellos' as a lump sum for GMPs taking up their first post in an area with significant remoteness/rurality, deprivation, or an area experiencing significant difficulties around recruitment and retention. 186 such payments were made in 2015-16. In August 2016, the Scottish Government announced 100 new GMP training posts, and 37 of these will include a one-off £20,000 bursary for trainees who choose to take up posts in hard-to-fill locations. Dentists can also be eligible for a golden hello, if they join a dental list in certain hard-to-fill areas within 3 months of completing their vocational training.

9.7 The Scottish Government told us that it was aware that targeting additional resources on pay and terms and conditions could help to address gaps in service provision, but was wary of the risks of driving up costs without seeing any actual overall improvement. In addition to the golden hello for GMPs, the Scottish Government told us that it was consulting on the broader issue of how to identify and fill gaps in service provision in priority areas and professions.

9.8 BMA Scotland did not support targeted recommendations to address location or specialty recruitment issues, and did not wish us to investigate applying funds to different approaches than pay to alleviate pressures, unless there was a substantial increase in funding availability.

Pay proposals

9.9 The Scottish Government asked us to consider a pay recommendation within the parameters set out in its remit letter to us.

9.10 In oral evidence, the Cabinet Secretary highlighted that the 2017-18 pay policy was published alongside the Scottish budget, and was a single-year policy which potentially allowed more flexibility. However, she also stressed the importance of continuing restraint on the public sector pay bill to protect jobs while delivering services with increasing demand. The Scottish Government was working within a tight financial envelope, and was committed to maintaining a policy of no compulsory redundancy which constrained pay rises. An enhancement for those on the lowest pay was viewed as a priority, while the Living Wage for care staff had also been introduced and funded.

9.11 The Cabinet Secretary stressed that the Scottish Government considered the fairness of the pay policy across the board; while the one-year pay policy gave some latitude to reconsider in the next round this was dependent on availability of budget, and the outlook for public funds did not seem likely to improve markedly in the near future.

9.12 BMA Scotland noted that DDRB recommendations for 2016-17 constituted less than a cost of living rise, and on top of this, the Scottish Government had made the decision not to raise Distinction Awards and Discretionary Points. This was felt as a ‘double hit’ for doctors in Scotland.

9.13 The BMA did not propose a specific figure for 2017-18, but said that doctors should be treated in line with the wider economy, where pay settlements continued to run at higher than the public sector pay policy cap at around 2 per cent. It noted that if the wider economy was such that employers felt able to offer pay increases in the region of 2 per cent then it was unclear why the public sector should not be able to offer similar uplifts, from a fairness perspective as well as the likely impact on recruitment and retention as private sector jobs became relatively more attractive.

9.14 In oral evidence, BMA Scotland suggested that doctors’ pay should be benchmarked against appropriate comparator groups, for example airline pilots, where there were parallels in terms of taking risks and having responsibility for the health and wellbeing of other people. They noted that pay would not be sufficient to solve the recruitment and retention issues for the remit group but was part of the solution. Better remuneration would encourage people to opt for permanent roles and lead to a reduction in the locum bill.

9.15 The BDA did not suggest a specific figure for the pay uplift. However, it said that GDPs in all four countries had experienced similar reductions in taxable income and should receive the same pay uplift. It said that there was no difference in recruitment and retention issues for community dentists and salaried practitioners in each of the countries and did not wish to create any more differences in pay between the four countries.

Our comments

9.16 We have several concerns about the evidence we received in relation to this year's pay uplift. We made this point in our main UK-wide report and it applies equally to Scotland. Firstly, the Scottish Government, like the other three UK governments, seemed to us to have given little consideration in its pay proposals to the possible effects of ongoing pay restraint on the recruitment, retention and motivation of our remit groups. Should inflation and private sector pay continue to increase, it would be unwise to be complacent here, and we note that consultants, in particular, have taken a relatively larger decrease in take-home pay than others in the NHS, as set out in our main 45th report. Additionally, the Scottish Government's rejection of our recommendations on performance awards for consultants last year may have exacerbated this and we hope that it will not do the same this year. We are concerned about recruitment, retention, and, more especially, motivation, especially in the light of some serious problems in filling consultant vacancies in Scotland.

9.17 Linked to this, as already discussed, the pay proposals given to us do not demonstrate sufficient regard to the need to address some severe ongoing shortages in medical staff in particular specialties, and so do not help to move the situation forward. Lastly, we would welcome greater clarity from all parties on what they consider fair and appropriate pay levels would be for our different remit groups in relation to any comparators that the parties thought relevant in a "steady state" environment. At present the focus is exclusively on the year-on-year increase, which means that the debate is tactical rather than strategic. We will also be undertaking a review of pay comparability in time for the next pay round.

Main pay recommendations: Scotland

9.18 We set out our rationale behind our main pay recommendations in our 45th report. We consider that the justification we explained there, for a continuing, though diminishing, case for a 1 per cent uplift if this enables more staff to join the service to alleviate workload pressures, holds true for Scotland as for the other countries of the UK. As ever, we were guided by the evidence in formulating our pay recommendations. We continue to have in mind additionally the important concept of fairness. We seek to find a balance between the interests of our remit groups, of their employers, of the taxpayer, and of patients. In this context we note two factors that, while relevant throughout the public sector, apply particularly to our remit groups. First, our remit groups have a strong intrinsic motivation to practise their profession, but that does not preclude a perceived sense of unfairness adversely affecting their motivation. Second, they work in a sector where a single employer – the NHS – retains a dominant market position.

Recommendation 3: we recommend for 2017-18 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists in Scotland.

Recommendation 4: we recommend that the maximum and minimum of the salary range for salaried GMPs in Scotland be increased by 1 per cent for 2017-18.

Recommendation 5: for independent contractor GMPs in Scotland, we recommend an increase in pay, net of expenses, of 1 per cent for 2017-18.

Recommendation 6: for independent contractor GDPs in Scotland, we recommend an increase in pay, net of expenses, of 1 per cent for 2017-18.

9.19 Chapter 6 notes our comments and concerns on the consultant award schemes.

Recommendation 7: we are increasingly concerned that the Scottish Government's policy of no monetary uplift for Distinction Awards and Discretionary Points, and a freeze on new Distinction Awards, may be adversely affecting the attractiveness to consultants of working in Scotland. In the absence of clear evidence either way on that, we are nevertheless clear

that recognising performance through pay is an established and important part of the consultants' pay system. We also recognise the Scottish Government's wish that the future of these awards be addressed as part of wider consultant contract reform. However, since this will not be concluded in 2017-18, we therefore recommend that the value of the awards for consultants – Distinction Awards and Discretionary Points – be increased in line with our main pay recommendation of 1 per cent. We would also wish to see the freeze on new Distinction Awards lifted and recommend that the promised review of these awards be brought forward as a matter of urgency.

9.20 Chapter 7 notes that we received no evidence to suggest that the situation regarding the GMP trainers' grant, rate for GMP appraisers and the supplement payable to general practice specialty registrars was any different in Scotland from the rest of the UK:

Recommendation 8: for 2017-18, we recommend that the GMP trainers' grant be increased by 1 per cent in line with our main pay recommendation for GMPs.

Recommendation 9: for 2017-18, we recommend that the rate for GMP appraisers remains at £500.

Recommendation 10: for 2017-18, we recommend that the supplement payable to general practice specialty registrars remains at 45 per cent of basic salary for those on the existing UK-wide contract.

Equality and pay equality

9.21 Our terms of reference require us to take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability. We made a full consideration of equality and pay equality issues in our main report. We would welcome evidence from the parties on equality and pay issues, with regard to gender, ethnicity and age in the next round. For Scotland specifically, we would like to receive information on any potential equality issues related to seniority payments.

Total reward and pensions

9.22 Public sector pension schemes were reformed in April 2015. The Scottish Government stated that while the NHS pension scheme continued to provide significant benefits, our remit groups will be contributing more in the future for somewhat smaller benefits. Given the changes in the limits for the lifetime and annual allowances for pension tax relief, this represents a reduction in total reward. The NHS Pension Scheme (Scotland) Advisory Board (SAB)[13] was considering how the new pension rules applied and what, if any, flexibilities could be introduced to help mitigate the impact of the changes. The Scottish Government also considered whether further flexibilities could be introduced within the reward package to reduce the number of early departures. For example, the employer's pension contribution could be used to fund a salary supplement if and when a member left the pension scheme on reaching the lifetime allowance, subject to employers' input. It undertook to monitor the impact of pension changes on our remit groups.

Our comments

9.23 Total reward packages must be borne in mind when considering remuneration in order to take into account all of the benefits arising from NHS employment beyond basic pay. We recognise that even following reform of pensions, the NHS pension scheme continues to provide significant benefits, although our remit groups will be contributing more than they did and, importantly, more than other staff in the future, for somewhat smaller benefits. We welcome the potential consideration of flexibility in pension arrangements and how these could be used to encourage retention.

Recommendation 11: We recommend that the Scottish Government and employers in Scotland investigate how many doctors and dentists are taking early retirement and for what reasons, and provide us with evidence on this next year.

[13] For more information see: http://www.sppa.gov.uk/index.php?option=com_content&view=article&id=969&Itemid=1653

CHAPTER 10: LOOKING FORWARD

10.1 Chapter 10 of our main 45th report drew together the key themes, and looked ahead to the challenges facing our remit groups over the next few years for the whole of the UK, including Scotland. However, we also include a few Scotland-specific considerations below.

Economic outlook and affordability

10.2 The affordability of the NHS across the UK will continue to be a key consideration and we recognise the scale of the challenges in each country. It is apparent that maintaining the public sector pay policy of 1 per cent over the spending review period would contribute markedly to the health departments' ambitions of meeting their demanding spending targets. Pay restraint offers a direct means of limiting increases to costs. However, if real pay levels for our remit group continue to decline at a time when pay in the private sector is rising, this will inevitably affect motivation, and could also damage recruitment and retention. That, in turn, would affect workloads, and a vicious circle could be created. One of our important roles as a Review Body is to advise on this, ensure a fair balance and monitor the sustainability of the recruitment, retention and motivation of our remit groups. This sustainability is clearly being challenged in Scotland as elsewhere in the UK and consideration therefore needs to be given to planning an exit strategy from current pay policy when circumstances allow.

10.3 Scottish public sector pay policy differs slightly from that in other UK countries as it targets boosting pay for the lowest earners and is also for one-year. This policy obviously has implications for our remit groups and we urge the Scottish Government to take a serious look at long-term recruitment, retention and motivation of consultants in particular, where the recruitment picture is not good for certain specialties and in some locations.

Workforce planning and future supply

10.4 While it is too soon to judge the impact of 'Brexit' on our remit groups, all the health departments have made moves to reassure staff from overseas that they are a valued part of the NHS, and are looking to ensure security of supply. There does, however, need to be a more sophisticated understanding of how the UK-wide market in training doctors operates. There are common issues at play across all four countries, yet it seems to us that each is operating somewhat in isolation, and therefore more collaboration is required. We will need to review the effects of Brexit on our remit group once the position becomes clearer.

10.5 Our main 45th report and this supplement to it also come at a time of substantial change and challenge for the NHS across the UK. New and innovative approaches will be required to meet the demands of an increasing, ageing population with multiple complex health needs who are placing extra pressure on the system. Added to this are the difficulties posed by the wider economic position and the state of the public finances, including NHS finances. These pressures will undoubtedly continue to impact on our remit group. Work will also have to continue to progress on addressing recruitment and retention issues in particular specialties and in remote and rural areas.

10.6 In addition to changes in demands on the NHS, our remit groups are themselves changing. As 'Generation Y' doctors and dentists form an increasing part of the workforce, planners and employers will need to take their different lifestyle and career choices into account and we look forward to seeing further work in this area. Consideration should also be given on how best to retain experienced staff who may be affected by the changes in public sector pension schemes and to pension rules more widely.

GMPs

10.7 We welcome the pay and other measures taken by the Scottish Government to address recruitment and retention of general medical practitioners in remote and rural areas of Scotland. We think a rigorous study of the effectiveness of these measures could provide valuable lessons for Scotland and other countries in the UK.

Also, in our main 45th report, we noted the trend towards salaried or locum GMP roles rather than partnerships, and work that is being undertaken on understanding expenses. We consider that this will have an impact on the future delivery of primary care and would welcome further information from the parties on the situation regarding salaried GMPs in Scotland for our next round.

Hospital doctors

10.8 In relation to geographic shortages, we note that the facility to use Recruitment and Retention Premia (RRP) in the consultant contract is still not widely used by employers in Scotland. While we understand this when there is an overall shortage in the supply of a particular specialty, it should not preclude employers from using RRP to encourage recruitment to address local shortages that may be related to the attractiveness of working in a particular region. We have therefore recommended that better use is made of existing pay flexibilities and recommended that serious consideration is given to developing a new mechanism for enabling targeted pay solutions.

Dentists

10.9 An area of particular concern to us for this supplement has been the gap in the positions of the Scottish Government and the British Dental Association Scotland on expenses. It is important that both parties work together to build relationships and develop a dialogue. We welcome the efforts taken by the Scottish Government to improve the data around dental expenses, and we feel it is a step in the right direction towards developing a greater understanding of actual dental costs.

Future data requirements

10.10 Several gaps have emerged during this round and Table 10.1 summarises these for Scotland. We are interested in these data broken down by staff group, region, gender, age and full-time equivalent where possible.

Table 10.1: Data gaps

	Scotland
Paybill data (Chapter 2)	Total health expenditure; total medical paybill; elements of paybill growth; average earnings; sample career pathways.
Staff survey results by hospital medical and dental group (Chapters 3, 6)	Regular staff survey
Workforce planning assumptions and analysis (Chapter 4)	Evidence of workforce planning; potential impact of Brexit and measures to mitigate the impact.
Retirement trends and pensions (Chapter 4)	Rates of early retirement and returns; withdrawals from pension schemes; data on the impact of pension tax changes.
Locum use and rates (Chapter 4)	Information about the number of hours worked; type of work, pay rates, demographics and why people choose to do locum work.
Career choices for junior doctors (Chapter 5)	Career paths of junior Doctors - understanding of why they make those choices.
Vacancy rates (Chapters 4, 5, 6, 7,8)	Vacancy or shortfall rates across all remit groups; junior doctor fill rates by region and specialism.
Hospital doctors (Chapter 6)	SAS Doctors recruitment and retention patterns; use of the SAS Development Fund.
GMP and GDP motivation data (Chapters 7 and 8)	GMP and GDP motivation; systematic data on salaried GMPs and GDPs.
GMP and GDP earning by FTE (Chapters 7 and 8)	Earnings by FTE (as well as headcount); demographic information and working hours of GMPs and GDPs; NHS and private earnings split.
Pay recommendations (Chapter 9)	Gender pay analysis; relevant comparator group pay.

APPENDIX A: REMIT LETTER FROM THE SCOTTISH GOVERNMENT

Cabinet Secretary for Health and Sport
Shona Robison 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
8th Floor
Fleetbank House
2-6 Salsbury Square
LONDON EC4Y 8JX

20 December 2016

Dear Professor Curran,

Further to the letter my colleague, Derek Mackay, Cabinet Secretary for Finance and the Constitution, sent on 30 September, I am now pleased to present you with further details of our remit and the evidence for employed doctors and dentists for the 2017 pay round which we would like you to consider. I apologise that, for the reasons outlined in Mr Mackay's letter, we are later than we would have liked in sending you this information.

The Cabinet Secretary for Finance and the Constitution announced the Scottish Government's Public Sector Pay Policy for 2017-18 on 15 December 2016 as part of his draft budget announcements. This pay policy provides the basis for the remit we would like you to consider. It is a single year policy and sets out the parameters for pay increases for staff. A copy of the policy is available here.

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

- An overall 1 per cent cap on the cost of the increase in the baseline paybill for those earning over £22,000.
- Flexibility to use paybill savings to consider meaningful reconstruction of pay and grading systems to address evidenced equality issues.
- Continuing the expectation to negotiate an extension to the no compulsory redundancy agreement as part of constructive, collaborative discussions between employers and their trade unions to make the most effective use of the funding available.

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

You will appreciate that all consideration of staff pay by Scottish Ministers must be informed by this policy framework. However, beyond the elements set out above, we would wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland for 2017-18. It is important to take into account the considerable on-going financial challenges facing NHSScotland at the present time and that any pay increase has to be affordable.

For General Practitioners we again seek the DDRB's recommendation in respect of GP pay and contractual uplift. The Scottish Government and the BMA's Scottish General Practitioners Committee have agreed to jointly commission a review of general practice funding, pay and expenses. This should provide better information to inform both accurate recompense of expenses and options for the long term overall development of GP pay in Scotland. This will take place in 2017, and inform options from 2018.

I would again like to take this opportunity to thank the members of the Review Body for their work and assure you that the Scottish Government continues to value the independent voice which the Review Body offers on doctors' and dentists' pay.

Copies of this letter 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.

Yours Sincerely,

SHONA ROBISON

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

APPENDIX B1: DETAILED RECOMMENDATIONS ON REMUNERATION IN SCOTLAND

PART I: SALARY SCALES[14]

The salary scales that we recommend should apply from 1 April 2017 for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

A. Hospital medical and dental, public health medicine and dental public health staff

	2016	2017
	£	£
Foundation house officer 1	23,437	23,672
	24,900	25,149
	26,363	26,626
Foundation house officer 2	29,070	29,361
	30,971	31,281
	32,872	33,201
Specialty registrar (full)	30,911	31,220
	32,803	33,131
	35,444	35,799
	37,042	37,412
	38,968	39,358
	40,896	41,305
	42,823	43,251
	44,750	45,197
	46,677	47,144
	48,605	49,091

[14] Our recommended basic pay uplifts, to be applied from 1 April 2017, are applied to unrounded current salary scales (November 2007 is the base year date), with the final result being rounded up to the nearest unit.

	2016	2017
	£	£
Specialty registrar (fixed term)	30,911	31,220
	32,803	33,131
	35,444	35,799
	37,042	37,412
	38,968	39,358
	40,896	41,305
Senior house officer	29,070	29,361
	30,971	31,281
	32,872	33,201
	34,773	35,121
	36,674	37,041
	38,575	38,960
	40,476	40,880
Specialist registrar[15]	32,250	32,572
	33,847	34,186
	35,444	35,799
	37,042	37,412
	38,968	39,358
	40,896	41,305
	42,823	43,251
	44,750	45,197
	46,677	47,144
	48,605	49,091
Consultant (2003 contract)	77,529	78,304
	79,956	80,756
	82,384	83,208
	84,812	85,660
	87,233	88,105
	92,998	93,928
	98,765	99,752
	104,525	105,570

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

	2016	2017
	£	£
Discretionary points	3,204	3,236
	6,408	6,472
	9,612	9,708
	12,816	12,944
	16,020	16,180
	19,224	19,416
	22,428	22,652
	25,632	25,888
Consultant (pre-2003 contract)[16]	64,370	65,014
	68,976	69,666
	73,583	74,319
	78,189	78,971
	83,442	84,276
Specialty doctor[17]	38,302	38,685
	41,577	41,993
	45,834	46,293
	48,116	48,597
	51,404	51,918
	54,679	55,226
	58,028	58,608
	61,377	61,991
	64,727	65,374
	68,076	68,756
	71,425	72,140

[16] Closed to new entrants.
[17] The specialty doctor pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements.

	2016	2017
	£	£
Associate specialist (2008)[18]	53,701	54,238
	58,018	58,598
	62,333	62,957
	68,033	68,713
	72,973	73,703
	75,023	75,773
	77,697	78,474
	80,371	81,175
	83,046	83,876
	85,720	86,577
	88,397	89,281
Associate specialist (pre-2008)	39,224	39,616
	43,379	43,813
	47,533	48,008
	51,687	52,204
	55,842	56,400
	59,996	60,596
	65,482	66,136
	70,236	70,939
Discretionary points	*Notional scale*	
	72,210	72,932
	74,784	75,531
	77,358	78,131
	79,932	80,731
	82,506	83,331
	85,082	85,933
Staff grade practitioner	35,485	35,840
(1997 contract, MH03/5)	38,302	38,685
	41,118	41,529
	43,935	44,375
	46,752	47,220
	50,069	50,570

[18] The associate specialist (2008) pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements.

	2016	2017
	£	£
Discretionary points	*Notional scale*	
	52,386	52,909
	55,202	55,754
	58,019	58,599
	60,836	61,444
	63,652	64,289
	66,471	67,135
Staff grade practitioner	35,485	35,840
(pre-1997 contract, MH01)	38,302	38,685
	41,118	41,529
	43,935	44,375
	46,752	47,220
	49,568	50,064
	52,386	52,909
	55,202	55,754
Distinction awards		
B award	31,959	32,278
A award	55,924	56,483
A+ award	75,889	76,648
	(Annual rates on the basis of a notional half day per week)	
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,793	4,841
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,691	4,738
	4,962	5,012
	5,235	5,287
	5,506	5,561
	5,778	5,835
	6,049	6,110
	6,321	6,384

B. Community health staff

	2016	2017
	£	£
Clinical medical officer	33,993	34,333
	35,834	36,192
	37,674	38,051
	39,514	39,909
	41,355	41,768
	43,195	43,627
	45,035	45,486
	46,877	47,345
Senior clinical medical officer	48,036	48,516
	50,960	51,469
	53,883	54,421
	56,805	57,374
	59,730	60,327
	62,652	63,279
	65,575	66,231
	68,499	69,184

C. Salaried primary dental care staff

	2016	2017
	£	£
Dental core training 1	34,331	34,674
Public Dental Service pay scales:		
Band A: Dental officer	39,250	39,642
	43,611	44,047
	50,152	50,654
	53,423	53,957
	56,694	57,261
	58,874	59,463
Band B: Senior dental officer	61,055	61,666
	63,235	63,868
	66,505	67,170
	68,142	68,823
	69,778	70,475
	71,412	72,126

	2016	2017
	£	£
Band C: Assistant clinical director	73,048	73,778
	75,228	75,980
	77,408	78,182
Band C: Specialist dental officer	73,048	73,778
	75,228	75,980
	77,408	78,182
	79,589	80,385
Band C: Clinical director/chief administrative dental officers (Western Isles, Orkney and Shetland health boards)	73,048	73,778
	75,228	75,980
	77,408	78,182
	79,589	80,385
	81,769	82,587
	83,950	84,790

	Sessional fee (per hour)	
	2016	2017
	£	£
Dental officer	29.55	29.85
Senior dental officer	39.20	39.59
Dental surgeon employed as part-time hospital consultant	48.36	48.85

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES [19]

1. The fee for domiciliary consultations should be increased from £85.90 to £86.76 per visit. Additional fees should be increased *pro rata*.

2. Weekly and sessional rates for locum appointments in the hospital service should be increased as follows:

	Per notional half day	
	2016	2017
	£	£
Hospital practitioner appointment	105.59	106.65
Part-time medical officer or general dental practitioner	91.92	92.84

	Per week[20]		Per session/programmed activity	
	2016	2017	2016	2017
	£	£	£	£
Staff grade practitioner appointment	869.60	878.30	86.96	87.83
Specialty doctor appointment	879.10	887.80	87.91	88.78
Associate specialist appointment (2008)	1,195.50	1,207.40	119.55	120.74

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

4. The supplements payable to district directors of public health and for regional directors of public health should be increased as follows:[21]

	2016			2017		
	Minimum	Top of range[22]	Exceptional maximum	Minimum	Top of range[9]	Exceptional maximum
	£	£	£	£	£	£
Island Health Boards	1,890	3,748		1,909	3,785	
Band D	3,629	7,255	9,071	3,665	7,328	9,162
Band C	4,551	9,071	10,900	4,597	9,162	11,009
Band B	5,444	10,900	14,059	5,499	11,009	14,200

[19] Our recommended basic pay uplifts, to be applied from 1 April 2017, are applied to unrounded current salary scales, with the final result being rounded up to the nearest unit.
[20] The per session/programmed activity rate multiplied by 10.
[21] Population size is not the sole determinant for placing posts within a particular band.
[22] High performers can go above this as long as they do not exceed the exceptional maximum.

General medical practitioners

5. The supplement payable to general practice specialty registrars is 45 per cent[23] of basic salary.

6. The salary range for salaried GMPs employed by primary care organisations should be increased from £55,965 – £84,453 to £56,525 - £85,298.

General dental practitioners

7. The sessional fee for part-time salaried dentists working six 3-hour sessions per week or less in a health centre should be increased from £88.07 to £88.95.

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

APPENDIX B2: OTHER FEES AND ALLOWANCES

Operative date

1. The levels of remuneration set out below apply from 1 April 2017.

2. Reference should be made to appendix B4 of the main report for details on CEAs, on-call rotas and doctors in training.

Hospital medical and dental staff

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

	2016	**2017**
		£
Daytime supplement:	1,274	1, 287

Scotland

	2016	**2017**
	£	**£**
Band 1:	960	970
Band 2:	1,913	1,932
Band 3:	2,860	2,889

APPENDIX C: GLOSSARY OF TERMS

ASSOCIATE DENTISTS – 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 rate of salary without any allowances or additional payments.

COMPARATOR PROFESSIONS – groups identified as comparator professions to those in the DDRB remit groups are: legal, tax and accounting, actuarial and pharmaceutical.

DISCRETIONARY POINTS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by local Clinical Excellence Awards in England and Northern Ireland, and Commitment Awards in Wales, but remains the current scheme in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Discretionary Points are pensionable. See also *Distinction Awards.*

DISTINCTION AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by national Clinical Excellence Awards in England, Wales and Northern Ireland, but remains the current scheme in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable. See also *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 OR '**FOUNDATION DOCTOR**' – 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. 'F1' refers to a trainee doctor in the first year or the programme; 'F2' 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 local staff which is 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 board 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 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 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.

GENERATION Y – The term used to refer to people born between 1980 and 2000, thought to share certain characteristics and work/lifestyle preferences. Individuals from this generation are also sometimes referred to as ‘millennials’.

HEALTH AND SOCIAL CARE PARTNERSHIPS and **INTEGRATION JOINT BOARDS –** Legislation to implement health and social care integration, passed by the Scottish Parliament in February 2014, came into force on April 1, 2016. This brings together NHS and local council care services under one partnership arrangement in the form of Health and Social care Partnerships, also known as ‘Integration Joint Boards’. These bodies will be jointly responsible for the planning and delivery of services and will be responsible for managing nearly £8bn in resources.

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.

MILLENNIAL – Individual born between 1980 and 2000. See also *Generation Y* definition.

PATIENTS AT THE HEART – NHS 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.’

PRINCIPAL DENTISTS – 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.

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.

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.

SAS DOCTORS – see *specialty doctors and associate specialists.*

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS – doctors in the SAS grades work at the senior career-grade level in hospital and community specialties. The group comprises specialty doctors, associate specialists, staff grades, clinical assistants, hospital practitioners and other non-standard, non-training 'trust' grades. The associate specialist grade is now closed.

SUPPORTING PROFESSIONAL ACTIVITIES – see *programmed activities.*

APPENDIX D: ABBREVIATIONS AND ACRONYMS

A&E	Accident and Emergency
APMS	Alternative Providers of Medical Services
BDA	British Dental Association
BMA	British Medical Association
BAME	Black, Asian and minority ethnic
CCG	Clinical Commissioning Group
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
EER	Expenses to earnings ratio
F1	Foundation house officer Year 1
F2	Foundation house officer Year 2
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
HSCP	Health and Social Care Partnership
HEE	Health Education England
HESA	Higher Education Statistics Agency
IJB	Integration Joint Board
MSP	Member of the Scottish Parliament
NAO	National Audit Office
NES	NHS Education for Scotland
NHS	National Health Service

OBR	Office of Budget Responsibility
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
SPA	Supporting Professional Activity
ST	Specialist training
UK	United Kingdom

APPENDIX E: HISTORICAL FORMULAE VALUES FOR GMPs AND GDPs.

E.1 This appendix supports the Scottish supplement to the 45th report and gives the latest data that would have populated the formulae for both GMPs and GDPs, had we used the formulae-based approach in Scotland (Table E.1).

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

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 in Scotland.

Coefficient	Value
Income (GMPs) *DDRB recommendation in Scotland*	1%
Staff costs (GMPs) *Annual Survey of Hours and Earnings (ASHE) 2016 (general medical practice activities)*	5.1%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2016*	2.5%
Income (GDPs) *DDRB recommendation in Scotland*	1%
Staff costs (GDPs) *ASHE 2015 (dental practice activities)*	1.3%
Laboratory costs (GDPs) *RPIX for Q4 2016*	2.5%
Materials (GDPs) *RPIX for Q4 2016*	2.5%
Other costs (GDPs) *RPIX for Q4 2016*	2.5%

Source: Annual Survey of Hours and Earnings (Table 16.5a), Consumer Price Inflation (CDKQ, CZBH).

Appendix F: Letter from BDA to Chair of DDRB, 2 March 2017

BDA
British Dental Association

2 March 2017

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

Dear Professor Curran,

Discount rate announcement

As you will be aware, the Lord Chancellor, Liz Truss, has just announced a cut to the discount rate applied to personal injury claims from 2.5 per cent to - 0.75 per cent. The effect will be an increase in the size of compensation payments paid in medical and dental negligence cases, leading to significant new costs for the NHS and other providers of medical and dental care. Given that subscription rates charged by medical defence organisations have to reflect their best actuarial estimate of the likely liabilities which they face, rates and costs to dentists are likely to rise substantially.

If rates do rise, this will worsen the already growing retention issue we have in NHS dentistry with many part-time or older more experienced dentists deciding that it is not financially worthwhile to continue to practise. We understand that GPs in England will be benefitting from an indemnity support scheme and we are writing to the Department of Health and NHS England to ask for this for GDPs.

It would be very helpful if the DDRB could comment on this significant expenses development in its forthcoming reports. We intend to focus on this issue in our evidence for 2018/19 in any case, if we haven't achieved any satisfactory resolution from the Department of Health or NHS England and the devolved administrations.

Yours sincerely,

Eddie Crouch
Chair, Review Body Evidence Committee
British Dental Association

British Dental Association 64 Wimpole Street, London W1G 8YS
020 7935 0875 enquiries@bda.org bda.org