



Review Body on Doctors' and Dentists' Remuneration

Thirty-Fourth Report 2005

Chairman: Michael Blair, QC



Review Body on Doctors' and Dentists' Remuneration

Thirty-Fourth Report 2005

Chairman: Michael Blair, QC

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

**Presented to the Scottish Parliament by the
First Minister and the Minister for Health and Community Care**

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

**by Command of Her Majesty
February 2005**

© Crown Copyright 2005

The text in this document (excluding the Royal Arms and departmental logos) may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading context. The material must be acknowledged as Crown copyright and the title of the document specified.

Any enquiries relating to the copyright in this document should be addressed to The Licensing Division, HMSO, St Clements House, 2-16 Colegate, Norwich, NR3 1BQ. Fax: 01603 723000 or e-mail: licensing@cabinet-office.x.gsi.gov.uk

Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. The review was conducted under the terms of reference introduced in 1998, amended in 2003 and 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 Secretary of State for Scotland and the Secretary of State for Wales 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 Health Departments' output targets for the delivery of services as set out by the Government;

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

the Government's inflation target.

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.

Reports and recommendations should be submitted jointly to the Secretary of State for Health, the Secretary of State for Scotland, the Secretary of State for Wales and the Prime Minister¹.

¹ Under the Scotland Act 1998 and the Government of Wales Act 1998 responsibility for health matters, including the pay of NHS staff in Scotland and Wales, has passed to the Scottish Executive and the National Assembly for Wales respectively. In addition to our usual addresses, our recommendations are therefore addressed to the First Minister and the Minister for Health and Community Care of the Scottish Executive and to the First Minister and the Minister for Health and Social Services of the National Assembly for Wales.

The members of the Review Body are:

Michael Blair, QC (*Chairman*)
Professor John Beath
Professor Frank Burchill
Dr Margaret Collingwood
Professor Peter Dolton²
Hugh Donaldson, Esq
Dr Gareth Jones

The Secretariat is provided by the Office of Manpower Economics.

² Professor Peter Dolton was appointed to the Review Body by the Secretary of State for Health from June 2004.

Contents

	Summary of recommendations and main conclusions	vi
<i>Chapter</i>	1: Economic and general considerations	1
	2: General medical practitioners	22
	3: General dental practitioners	40
	4: Salaried Primary Dental Care Services	57
	5: Ophthalmic medical practitioners	59
	6: Doctors and dentists in training	60
	7: Consultants	76
	8: Staff and associate specialists/non-consultant career grades	97
<i>Appendix</i>	A: Detailed recommendations on remuneration	111
	B: Numbers of doctors and dentists in the National Health Service	122
	C: The 2004-05 settlement	124
	D: DDRB staff groups under consideration for 2005-06	125
	E: The Policy Framework	126
	F: Executive Summary of SAS Discretionary Points Research	128
	G: Pay of SAS/NCCGs grades relative to consultant pay 1984-2004	133
	H: A note on the expense ratio	135
	I: Previous Reports	138

Summary of recommendations and main conclusions

Our recommendations are for implementation on 1 April 2005.

Chapter 1 – Economic and General Considerations

- We have considered it appropriate to look at changes and predicted changes in all the major inflation indicators, focusing particularly on RPI and RPIX, and also pay movements elsewhere in the economy. We believe that when considering inflation, it is best considered on a three month average basis, rather than one month's figures (paragraphs 1.48 and 1.97).
- We have taken careful note of the economic evidence put to us, but inflation, earnings and settlement data are only part of the evidence we need to consider. Our aim is to make balanced recommendations, against all the provisions of our terms of reference, about what is necessary in pay terms to deliver and retain adequate numbers of good quality, motivated staff (paragraph 1.50).
- Given the difficulties of linking pay in any precise way to the achievement of output targets, the parties might like to consider whether output targets should remain in our remit (paragraph 1.63).
- We are not in a position to do more than recommend a general pay uplift to London weighting this year and our aim has been to protect its real value. In doing so, we have considered a range of inflation and pay indicators. We **recommend** (recommendation 1) an increase of 3.0 per cent on the value of London weighting (paragraph 1.81).
- Our conclusion on pay comparability is that the remuneration of our remit groups remains broadly in line with that of the comparator groups (paragraph 1.84).

Chapter 2 – General medical practitioners (GMPs)

- For salaried GMPs, although the original salary range was set by reference to the mid point of the associate specialist payscale and the top point of the old consultant payscale, we consider that these initial range maxima and minima were artificial and are no longer appropriate for deciding how the salary range should be uplifted each year. A more logical reference point is the uplift for other GMPs and we therefore **recommend** (recommendation 2) that the salary range for salaried GMPs is increased by 3.225 per cent in 2005-06. For 2006-07 onwards, we would like the parties to consider the formulation for uprating the salary range and to make proposals for our next review (paragraph 2.28).
- We **recommend** (recommendation 3) that the out-of-hours supplement for GMP registrars should remain at 65 per cent of basic salary during 2005-06 (paragraph 2.41). We believe that GMP registrars' basic pay should remain aligned to the SHO payscale for the time being but proper consideration of the pay relativities between juniors working in general practice and those in the hospital sector should be taken forward by the parties as part of *Modernising Medical Careers* (paragraph 2.42).

- As we are very concerned to support the retention of GMP trainers while the parties take forward their discussions about a more appropriate remuneration structure, we **recommend** (recommendation 4) that all approved GMP trainers should receive a separate payment towards their CPD costs of £750 per annum, in recognition of the value of a GMP trainer's work and the costs incurred in maintaining that status. This sum should continue to be paid to the trainer for one year even if no trainee is allocated to the trainer. In addition, we **recommend** (recommendation 5) that the GMP trainer's grant is uplifted by 3.225 per cent for 2005-06 (paragraph 2.53).
- We **recommend** (recommendation 6) that the remuneration rates for GMPs working in community hospitals, and for GMPs working in acute trusts, should be increased in accordance with the general uplift for GMPs in 2005-06 of 3.225 per cent (paragraph 2.64).
- We **recommend** (recommendation 7) that Ministers give careful consideration to the case for providing appropriate additional funding for PCOs to meet any increased costs for medical staffing cover for community hospitals (paragraph 2.65).
- We **recommend** (recommendation 8) that sessional fees for doctors in the community health service and fees for work under the collaborative arrangements between health and local authorities are increased by 3.225 per cent for 2005-06. We also urge the Department of Health to get discussions about these fees underway with other Government departments (paragraphs 2.82 and 2.83).

Chapter 3 – General dental practitioners (GDPs)

- It has been our concern that NHS dentistry should be properly funded and we are pleased to note that there will be additional funding from 2005-06 to facilitate the new arrangements, provide for pay awards and support service growth. Whether it will be sufficient both to improve access and to encourage GDPs to return to the NHS remains to be seen, bearing in mind the difference in potential earnings from NHS and private work. We are also pleased that the Department has provided £9 million for a structured change management programme. We would welcome more details for our next review on how the extra funding is actually being allocated (paragraphs 3.28 and 3.29).
- We consider the current information base for expenses weak and as we said last year, expenses need to be given proper consideration under the new regime. We therefore **recommend** (recommendation 9) that in this transitional year ahead of the new arrangements the parties jointly develop a mechanism for assessing changes in expenses and that this be done for a representative cross section of practices across the country (paragraph 3.63).
- We do not consider it appropriate to recommend the national introduction of a practice allowance, without seeing such an allowance tested or any evidence of its effect on recruitment and retention (paragraph 3.78).
- We **recommend** (recommendation 10) that gross fees for items of service and capitation payments should be increased by 3.4 per cent for 2005-06 for GDPs. In making our recommendation, we have applied a formula that gives appropriate weight to the three main components of dentists' costs. We have used relevant general price indicators as measures in part of the expenses component of the

formula, in absence of specific data on dental expenses. We would urge the parties to take forward work on this as set out in recommendation 9. We also **recommend** that commitment payments (recommendation 11) and sessional fees for taking part in emergency dental work (recommendation 12) be increased by 3.4 per cent (paragraph 3.89).

Chapter 4 – Salaried Primary Dental Care Services (SPDCS)

- As the final year of the three-year pay deal, we note that the parties have agreed to a 3.225 per cent uplift on salaries and allowances for all dentists in the SPDCS to be applied across the board in 2005-06. We therefore endorse and **recommend** (recommendation 13) this (paragraph 4.10).

Chapter 5 – Ophthalmic medical practitioners

- We are pleased to see that agreement on a three-year pay deal covering the years 2003-04, 2004-05 and 2005-06 has been reached, and that the sight test fee and domiciliary visit fees for each of these years has been agreed as part of the deal (paragraph 5.6).

Chapter 6 – Doctors and dentists in training

- We believe that our conclusion from last year stands, that the current levels of the banding multipliers are now set at a rate that fully reflects the out-of-hours commitment and intensity of posts, and we **recommend** (recommendation 14) that the percentage values of the current multipliers be rolled forward for another year (paragraph 6.41).
- It seems to us right and timely that the basic contract introduced in 2000 should be reviewed as the working arrangements and the training structure for junior doctors will have altered significantly within the next few years. We would expect any review to address the key question of basic pay and the role, if any, of supplements once hours are significantly reduced. The aim should be to ensure that pay is sufficient to attract good quality individuals to continue to enter into and remain in medicine. We therefore hope that the parties will agree on a way forward and can report progress to us for our next review and come forward with proposals, given the proximity of the final stages of implementation of the WTD (paragraph 6.42).
- The data on recruitment to medical schools does not suggest to us that the prospect of student debt is currently acting as a deterrent to entering the medical or dental professions. However, we would ask the parties in future rounds to provide us with evidence on the levels of student debt so that we can continue to monitor the situation, particularly as it might begin to impact on recruitment (paragraph 6.64).
- We conclude that once we allow for the effect of the banding multipliers, then pay of house officers is not out of line with comparators. We note, however, that medical courses are longer than courses for most other graduates, and that the average age of a first year house officer is likely to be older than that of other graduate entrants, and that we may not be comparing like with like. We intend to monitor this carefully for our next round, but given the current healthy recruitment and retention situation, we do not feel it appropriate this year to recommend a change to the starting salary for house officers (paragraph 6.69).

- This year, given the healthy recruitment and retention situation, our aim has been to protect the real value of the pay of doctors and dentists in training and their relative pay position. In doing this, we have considered a range of inflation and pay indicators and we **recommend** (recommendation 15) an increase of 3.0 per cent for 2005-06 on the salary scales of all grades of doctors and dentists in training (paragraph 6.75).

Chapter 7 – Consultants

- We note the Department of Health's evidence that an allocation of £150 million has been made available for 2005-06 to take account of the latest estimates of the cost of the contract. This funding is from existing PCT allocations, but is part of funds freed up by savings elsewhere in PCT budgets. We hope that it will play a part in enabling the finalisation of outstanding job plans. We would ask the Health Departments for evidence in the next round that the funding arrangements are indeed sufficient to support the new contract (paragraph 7.40).
- Our recommendation for consultants remaining on the pre-2003 contract is designed to protect the real value of their earnings and takes into account our current considerations of the various rates of inflation and pay movements. We **recommend** (recommendation 16) an increase of 3.0 per cent for 2005-06 on the national salary scale for the pre-2003 consultant contract (paragraphs 7.62 and 7.64).
- We endorse and **recommend** (recommendation 17) SACDA's proposals for 15 new distinction awards at the following levels: two A+ awards, four A awards and nine B awards (paragraph 7.86).
- For 2005-06, we endorse and **recommend** (recommendation 18) ACCEA's proposal that the budget for higher awards should be increased in line with the increase in the number of doctors now eligible for an award (including academic GMPs). We **recommend** (recommendation 19) that the value of CEAs, commitment awards, distinction awards and discretionary points should be uplifted by 3.225 per cent, in line with the pay uplift for consultants on the new contract. Finally, we endorse and **recommend** (recommendation 20) ACCEA's proposal that it should retain the flexibility to determine the number of CEAs to be made at each level in 2005-06 (paragraphs 7.88 and 7.89).

Chapter 8 – Staff and associate specialists/non-consultant career grades (SAS/NCCGs)

- We have made clear in our recent reports that any consideration of pay needed to follow on from a review of SAS/NCCGs' role, career progression and training opportunities. We therefore very much welcome the opportunities which will be opened up to SAS/NCCGs once PMETB becomes fully operational this year. We hope that the other work which needs to be carried out to facilitate career progression, and which is linked to the implementation of *Modernising Medical Careers*, can be taken forward quickly. We very much hope that the deadline of April 2006 set by the Minister for the implementation of new contractual arrangements will be met (paragraphs 8.32, 8.33 and 8.57).

- We do not intend at this stage to recommend any new pay arrangements which would place additional administrative burdens on both employers and their staff and which would pre-empt elements of the contract negotiations. The issue of workload and how work beyond conditioned hours and out-of-hours is rewarded must be properly addressed in those forthcoming pay negotiations. We would also ask the BMA to consider what it can do at a local level to support SAS/NCCGs seeking pay recognition from their employers for regular excess hours and out-of-hours commitments (paragraph 8.42).
- Now that contract negotiations have been announced, we do not intend to make any further changes to the current optional and discretionary point schemes. However, we would expect the parties to discuss what part schemes for recognising exceptional contribution to the NHS will have to play in the future contractual arrangements for SAS/NCCGs. We would hope that any new scheme or schemes would be operated consistently by all employers, and that this can be demonstrated to the satisfaction of all interested parties (paragraph 8.51).
- We have reached our decision about the recommendation for SAS/NCCGs in the light of the developments since our last report and from the standpoint that we do not wish to impede the forthcoming negotiations in any way. We therefore consider that the simplest approach is to recommend a flat rate percentage increase which will benefit all SAS/NCCGs and which will also be pensionable, easy to implement and not complicate the existing pay structures. We therefore **recommend** (recommendation 21) an increase of 3.225 per cent for 2005-06 on the national salary scales of SAS/NCCGs in recognition that other groups who are already working under revised contracts will receive this figure in 2005-06 and that there has been a delay in negotiating a new contract for this group (paragraph 8.59).
- In the usual way, our recommendation of a 3.225 per cent increase for SAS/NCCGs will also apply to the payscales for clinical assistants and hospital practitioners who are not also GMPs (paragraph 8.61).

Our main recommendations on pay levels are:

	<i>Point on scale¹</i>	<i>Recommended basic scales 1 April 2005 £</i>
<i>Hospital doctors and dentists – main grades (whole-time salaries):</i>		
House officer	minimum	20,295
	maximum	22,907
Senior house officer	minimum	25,324
	maximum	35,511 ²
Specialist registrar ³	minimum	28,307
	maximum	42,985 ⁴
Staff grade practitioner	minimum	30,808
	maximum (normal)	43,871 ⁵
	maximum (discretionary)	58,562 ⁶
Associate specialist	minimum	34,158
	maximum (normal)	61,935 ⁵
	maximum (discretionary)	75,233 ⁶
Consultant (2003 contract, England and Scotland)	minimum	69,298
	maximum (normal)	93,768
	maximum (CEA)	33,468 ⁷
	CEA ⁸ (bronze)	33,468
	CEA (silver)	43,997
	CEA (gold)	54,996
	CEA (platinum)	71,495
Consultant (2003 contract, Wales)	minimum	67,130
	maximum	84,695 ⁹
	maximum (commitment award ¹⁰)	24,168

¹ Salary scales exclude additional earnings, such as those related to banding multipliers for doctors in training.

² To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth Report, paragraph 3.21.

³ The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.

⁴ Additional incremental point, to be awarded automatically except in cases of unsatisfactory performance, see paragraph 6.61 of the Thirty-Third Report.

⁵ Top incremental point extended, see paragraph 8.42 of the Thirty-Third Report.

⁶ Additional discretionary point, see paragraph 8.38 of the Thirty-Third Report.

⁷ Eligibility for Clinical Excellence Awards (CEAs) is after one year's service as a consultant. The figure represents the value of the maximum CEA awarded by local committee.

⁸ Higher national CEAs awarded by the Advisory Committee on Clinical Excellence Awards (ACCEA).

⁹ Until December 2005 (See Appendix A).

¹⁰ A total of eight commitment awards are awarded (one every 3 years) once the maximum of the scale is reached.

	<i>Point on scale¹</i>	<i>Recommended basic scales 1 April 2005 £</i>
Consultant (pre-2003 contract)	minimum	57,370
	maximum (normal)	74,658
	maximum (discretionary)	98,826 ¹¹
	distinction award 'B'	30,145
	distinction award 'A'	52,750
	distinction award 'A plus'	71,583
<i>Community health staff – selected grades (whole-time salaries):</i>		
Clinical medical officer	minimum	29,472
	maximum	41,011
Senior clinical medical officer	minimum	42,050
	maximum	60,380
<i>Salaried primary dental care staff – selected grades</i>		
Community dental officer	minimum	31,290
	maximum	49,564 ¹²
Senior dental officer	minimum	45,131
	maximum	61,338 ¹³
Clinical director	minimum	60,294
	maximum	68,845 ¹³

MICHAEL BLAIR QC (*Chairman*)
PROFESSOR JOHN BEATH
PROFESSOR FRANK BURCHILL
DR MARGARET COLLINGWOOD
PROFESSOR PETER DOLTON
HUGH DONALDSON
DR GARETH JONES

OFFICE OF MANPOWER ECONOMICS
11 February 2005

¹¹ The figure represents a notional salary where the value of the maximum discretionary point has been added to the maximum of the scale.

¹² Performance based increment, see paragraphs 4.21, 4.30 and 4.38 of the Thirty-First Report.

¹³ Performance based increment, see paragraphs 4.21 and 4.38 of the Thirty-First Report.

Part I: Overview

CHAPTER ONE – ECONOMIC AND GENERAL CONSIDERATIONS

Conduct of the 2005 review

- 1.1 *Our review was conducted under the terms of reference introduced in 1998, as amended in July 2003, and which are reproduced at the beginning of the report. The outcome of the last review is set out at Appendix C.*
- 1.2 *Once again this year we were not required to make recommendations on consultants working under the new consultant contract, on independent contractor general medical practitioners (GMPs) working under the new General Medical Services contract (GMS) or dentists working in the salaried primary dental care services (SPDCS). These groups of staff are covered by the third year of a three-year pay deal. In addition, a three-year agreement is now in place between Ophthalmic Medical Practitioners (OMPs), optometrists and the Health Departments on the sight-test fee and the year 2005-06 is covered by this agreement.*
- 1.3 *For the 2005 review, we are therefore required to make recommendations on the following groups – doctors and dentists working within the Hospital and Community Health Service who are not covered by a longer term pay deal, salaried GMPs, GMP registrars, and general dental practitioners (GDPs). These groups equate to around 58 per cent of our total remit group, as shown below. A chart showing these groups for whom we are required to make a recommendation is also shown at Appendix D.*

Remit staff group under consideration for the 2005 review¹

	Being considered	Not being considered	Total
Consultants ²	5,800	27,650	33,450
Associate specialists/staff grades	8,500		8,500
Registrar group	16,900		16,900
Senior house officers	22,460		22,460
House officers	5,030		5,030
Other ³	7,720		7,720
GMS principals		34,150	34,150
GP registrars	2,630		2,630
Other GMS staff ⁴		3,230	3,230
GDPs	22,510		22,510
Salaried dentists ⁵		2,140	2,140
Ophthalmic medical practitioners		640	640
Total	91,550	67,810	159,360

1. From Health Department's censuses, at September 2003.
2. The proportions of consultants who have signed up to or are on the new contract have been used to calculate the number of consultants not being considered in this review.
3. Includes clinical assistants, hospital practitioners and public health and community medical staff not elsewhere specified.
4. Excludes GP registrars, whose pay is linked with senior house officers.
5. Includes community dental staff and salaried dentists working in the General Dental Services (GDS).

- 1.4 *We said in our last report that having agreed new contractual arrangements with a supporting three-year pay deal, we expected those new arrangements for consultants and GMPs to be implemented, as agreed. We also said that we wished to see from experience how the new arrangements were working in practice and we are grateful to the parties for the information they have provided here. As the new arrangements have not long been in place, we have again approached this round on the basis that we do not intend to disrupt what has already been agreed between the parties, and accepted by our remit groups in their contract ballots.*
- 1.5 *For this round, we have received written and oral evidence from the three Health Departments for Great Britain, the representatives of which were led by the Minister of State for Health and the Minister of State; the NHS Confederation/NHS Employers; the British Medical Association (BMA); the British Dental Association (BDA); and the Dental Practitioners' Association (DPA). Written evidence was also received from the Advisory Committee on Clinical Excellence Awards (ACCEA) and the Scottish Advisory Committee on Distinction Awards (SACDA). The evidence from the Health Departments was set in the context of various policy documents, details of which are set out in Appendix E.*
- 1.6 *As part of our preparation for this review, we continued our programme of visits in England, Scotland and Wales to NHS Trusts and Primary Care Organisations (PCOs), and to medical and dental practitioners. As always, we found the visits and discussions to be valuable and would like to thank all those who helped to arrange the programme, and who gave their time to participate in it.*

Our terms of reference

- 1.7 The **BMA** told us that it had now reached agreement with the Health Departments on a memorandum of understanding on the best way to incorporate the principle of equal pay for work of equal value into our remit. The BMA said it still considered that this might prove unworkable, but it awaited our own judgement. On this occasion however, the BMA said that it would not be presenting evidence on any equal pay issues.
- 1.8 In supplementary evidence, the **Department of Health** told us that following the change to the Review Bodies' remits to include a reference to their having regard to equal pay issues in the NHS, the Department had proposed a 'Memorandum of Understanding' setting out in high level terms how the two health review bodies should work to their new remits and including some generic text on equal pay and regional/local pay. The Department said that the memorandum needed to be agreed by all the parties to the process (Health Departments, NHS Confederation, BMA, BDA and NHS Joint Unions). A number of drafts of the memorandum had been circulated, but the Department said that the text to which the BMA had referred had not been agreed by all the parties. The Department said that as part of the overall programme of NHS pay modernisation, it was important to strengthen the arrangements to reduce the risk of Review Body recommendations giving rise to equal pay problems. The Department said that these strengthened arrangements would only need to be used when one of the parties thought there was prima facie evidence of equal pay problems. It said it did not intend to submit any evidence on equal pay in the current round.

Comment

- 1.9 *We await the outcome of the Government's continuing discussions with the professional bodies about a further change to our remit which would require us to have regard to the principle of equal pay for work of equal value in the NHS. When the parties have reached agreement, we would welcome their views on the practical implications of these changes for the way we carry out our work. We will need to consider any such implications and discuss them further, as necessary, with the parties. Although we are still awaiting the outcome of the current discussions, we asked the parties if they wished to raise any particular equal pay issues with us, but none have been raised.*

Scotland and Wales

- 1.10 The **Scottish Executive Health Department** (SEHD) confirmed that it endorsed the evidence of the Health Departments that represented a Great Britain-wide position. Its evidence set out where circumstances, initiatives and policies within NHSScotland were distinct from elsewhere in Great Britain. The **National Assembly for Wales** said its evidence complemented the evidence from the other Health Departments and highlighted the main differences in the NHS in Wales.
- 1.11 The **BMA** confirmed that, unless otherwise stated, its evidence covered the United Kingdom as a whole and that where appropriate, it dealt with issues affecting the constituent countries in the relevant remit group chapter.

The current round

- 1.12 The **Department of Health** said that the recently concluded Spending Review (SR04) had set out government targets and expenditure plans for the next three years for the whole public sector, including the sectors covered by the Pay Review Bodies (PRBs). The role of the PRBs was to make recommendations about the appropriate resource allocation to pay in the context of the government objectives and the recruitment, retention and motivation situation for the PRBs' sectors, taking into account the constraints of SR04.
- 1.13 We asked the Department whether this meant it was asking us to recommend a sum for pay, or whether we were merely being asked to allocate a previously determined fixed sum and if so, what was the fixed sum. In supplementary evidence, the Department said that we were reading too much into its original evidence. It said it was not asking us to recommend differently from the past (i.e. it was still looking for us to make recommendations for pay increases for different groups of staff). It said that its statement had just meant to be a description of what, "at a philosophical level", the Pay Review Bodies should be taking into account when they made their pay recommendations.
- 1.14 The Department said its strategy for changes to the health workforce, set out in *HR in the NHS Plan*¹, provided important context for our recommendations. The Department told us that the government considered it important that pay rises in the public sector were set at sustainable rates and were justified by productivity. The Department said that the Government was looking to the PRBs to take a firm and fair approach to public sector pay, facilitating the recruitment and retention of suitable staff, increasing their motivation and supporting diversity and equal pay within the boundaries of affordability determined by SR04.

¹ *HR in the NHS Plan*, published in July 2002. See www.dh.gov.uk

- 1.15 In supplementary evidence, the Department said that “justified by productivity” referred to the productivity of the staff in question i.e. those receiving the pay increase. The Department said it wanted to get across the idea that it would want to see relatively high pay awards being connected with reform leading to productivity improvements. The Department also said that it was not exclusively concerned with the short-term recruitment and retention situation; the medium and long-term position was also important and in support of this, the Department pointed us to its evidence on the medium term prospects for earnings growth. It said it believed that, in the medium term, public sector pay growth should be broadly in line with the sustainable level of earnings growth for the economy as a whole. However, it said that in some instances, it may be appropriate for earnings growth to be above or below these levels in the shorter term, depending on the evidence of recruitment and retention and the labour market conditions prevailing at that time.
- 1.16 The Department said that this was getting across the point that the public sector must be able to offer earnings growth in line with the economy as a whole in the medium term, reflecting a concern that the relative public sector position could not be allowed to move too far away from the rest of the economy as the inevitable result, in the medium/long term, would be problems in recruiting, retaining and motivating staff of sufficient quality.
- 1.17 The **NHS Confederation**² said that in practical terms, it was not in a position to produce the detailed evidence this year that it might wish to submit in future as NHS Employers, when it took on this responsibility from 1 November 2004.
- 1.18 The **BMA** said that this year was again atypical as a significant proportion of the remit group was covered by long-term pay arrangements and the start of major pay negotiations were awaited for a further large group of doctors. The BMA said that the emphasis this round was therefore inevitably on the maintenance of pay levels, the correction of anomalies and on meeting the expectations of the remaining groups. In its written evidence, the BMA said that it was concentrating on four areas: the overall amount of any pay increase designed to prevent further deterioration in the profession’s position (which it said it had assessed at 4.5 to five per cent); the impact of the Working Time Directive on the overall pay of junior doctors; the position of consultants on the old contract; and how best to bring up the pay of staff and associate specialist/non-consultant career grades (SAS/NCCGs) to a more appropriate level, pending major contractual change. The BMA said it was disappointed that last year we had not recommended that the groups not covered by new contractual arrangements should receive at least the same uplift in pay levels as was implicit in the new contracts with some recognition that they faced the same pressures.
- 1.19 The **BDA** said that the BMA would be submitting evidence on behalf of all hospital staff and asked us to note that the issues raised by the BMA were applicable to those working in the Hospital Dental Service.

² See page 1 of the NHS Confederation’s written evidence.

Comment

1.20 *We note the BMA's disappointment with our recommendations last year and comment further on this in the relevant chapters. We also note the parties' comments regarding the current round and are grateful for the Department of Health's further clarification of the Government's views on how the Pay Review Bodies should approach their task, and for confirmation that the Department is also concerned about the medium to longer term position for recruitment and retention, as, indeed, are we. The Department of Health has raised the link between pay and productivity in its evidence, and we would ask it for more detailed evidence on this issue if it wishes us to take the productivity of our remit groups into account in reaching our recommendations. We comment later in this chapter on the Department's continuing difficulties in providing us with meaningful evidence on the link between pay and output targets and we would anticipate that the Department may find similar difficulties in providing us with meaningful evidence on the link between pay and productivity. We are aware of the difficulty of measuring productivity in the NHS and the plans to improve the measurement of NHS output following the Atkinson Review. We would invite the parties, and particularly the Health Departments, to submit further evidence for our next review.*

Recruitment, retention, morale and motivation of our remit groups

1.21 *Detailed summaries of the parties' evidence on the recruitment, retention, morale, motivation and workload of each of our remit groups are given under the relevant chapters of this report.*

1.22 The **Health Departments** described the latest position on the recruitment, retention and motivation of our remit groups. Overall, there had been further increases in Great Britain in 2003. The total number of hospital, public health medicine and community health service medical and dental staff had increased by 4,340 (wte) or 5.3 per cent, with faster growth than in any previous years in respect of hospital doctor and dentist numbers.

1.23 The **Department of Health** reported that in England, the total number of staff in this group had increased by 4,000 (wte) or 5.9 per cent in 2003. The Department described how part-time working was taken into account in its workforce models. Across the whole of the Hospital and Community Health Service (HCHS) sector in England, the ratio of part-time to whole-time equivalent (WTE) was unchanged in the year to September 2003 at 1:0.89. Working patterns were changing as a result of a range of factors, including the increasing number of female doctors, and the Department said it was committed to ensuring the modern NHS operated more flexibly. The development of Flexible Career Schemes (FCS) was an example of a tailored response to this trend aimed at recruiting and retaining people.

1.24 The Department described the progress of a number of HR initiatives, including:

- *Flexible Careers Scheme (FCS)* – by the end of 2003, the number of doctors (including GMPs) on the FCS had exceeded the April 2004 target of 1,000. By end August 2004, 259 doctors had been through the scheme, 1,426 were currently on it and a further 839 were preparing to join; and
- *Flexible Retirement* – the Flexible Retirement Campaign had helped 55 hospital doctors and 64 GMPs to take flexible retirement.

- 1.25 With regard to morale and motivation, we were told that the Healthcare Commission's national NHS Staff Survey 2003 had sought to identify factors having the greatest impact on staff attitudes and intentions to leave. The survey had many positive findings, including staff feeling they had support to achieve a good balance between their work and private lives. However, the Department said there were no plans to introduce a programme of systematic exit interviews because mechanisms already existed to gauge staff opinion about working in the NHS, but there was no reason why exit interviews should not be used locally. The staff survey had covered issues of overall staff satisfaction with the job and the 2003 results showed this was higher in the NHS than in other sectors. When the Department had received the results from the 2004 survey, it would be in a better position to gauge if this was changing over time. The 2004 survey would also ask staff expecting to leave to provide their reasons for leaving.
- 1.26 In response to our query as to whether our remit groups could be separately identified in the NHS Staff Survey, the Department said that the Survey undertaken by the Healthcare Commission only collected information by 'consultant grade' and 'other', which included all hospital grades. The Department said that it did not have access to local exit interviews.
- 1.27 In conclusion, the Department said that over the period September 2001 to September 2003, the medical workforce had grown by 9,542 WTE (10.3 per cent) with further increases planned. Recruitment, retention and return policies were working, but there was no room for complacency.
- 1.28 The **SEHD** reported that the total number of doctors and dentists employed in the HCHS in Scotland had increased by 195 (wte) or 2.2 per cent in 2003. In a shrinking labour market, attracting staff into the NHS in the face of competing sectors would become increasingly important and there were particular challenges in recruiting and retaining staff in rural and remote areas. Pay modernisation provided financial incentives to join and stay in the NHS and also created non-financial incentives, such as flexible working conditions, but further pressure was exerted at UK level where Scotland was competing with proactive recruitment from England of nurses and doctors.
- 1.29 The **National Assembly for Wales** reported that the total number of HCHS doctors and dentists employed in Wales had increased by 50 (wte) or 1.2 per cent in 2003. The Assembly said that it was committed to increasing the number of qualified doctors and gave details of the increases across our remit groups (see relevant chapters). The new consultant contract, NHS pay modernisation and the European Working Time Directive (EWTD) provided a unique opportunity to review and modernise working and employment practices across the whole of the workforce. A new HR Strategy would be published in April 2005, designed around service delivery.
- 1.30 The **BMA** said it contended that the demand for doctors' services had never been higher and continued to exceed supply. It said that retention and the need to reflect the shortfall in supply must therefore drive any pay increase in the current round. The BMA said that it considered it was too early to assess the impact of the new contracts on workforce growth and that the seasonal pattern of workforce change was, as yet, undetermined. It hoped that the impact of the new contracts would be to make medical practice more attractive both to new recruits and potential returners. However, the workload implications of a continuing shortfall between the demand and supply were such that we must recognise the contribution of those doctors who had yet to negotiate new contracts, or who remained on pre-existing contractual terms.

Comment

- 1.31 *We note that recruitment within the Hospital and Community Health Service has continued its upward trend. We welcome the latest reported growth, but note the considerable variation in growth rates across England, Scotland and Wales and the particular challenges faced by Scotland and Wales. We have heard anecdotally about the challenges of recruiting in rural areas during our visits to Scotland and Wales and we would welcome further evidence from the parties on the rural/urban divide and how they are addressing this issue. We will continue to monitor progress across all three countries and hope to see evidence that the new contracts for consultants and GMPs are playing their part in supporting recruitment and retention.*
- 1.32 *We also wish to keep track of trends in part-time working and are grateful for the Department of Health's evidence on this. It is helpful of the Department to provide a time-series to help us monitor trends and as we said in our last report, we would also like to know how outturn working patterns are compared to planning assumptions and would ask for evidence on this in the next round. The Health Departments need to keep looking ahead, given the changing demographics of the medical and dental workforces, and we would like to know how the reality of workforce participation has compared to the original workforce planning assumptions. We were pleased to see that the number of people participating in the Flexible Career Scheme (FCS) had exceeded the April 2004 target, but we would also ask the Health Departments to keep in mind that flexible working options such as the FCS will be increasingly important in years ahead, given the changing demographics of the medical and dental workforce. We consider it important to retain and to attract back to the NHS as many staff as possible, given the demand for medical and dental staff, and we hope that the Health Departments keep in mind retention needs when funding for flexible working options is being considered. Flexible retirement options are another important retention tool and we hope the Health Departments will make appropriate representations about the importance of retention of medical and dental staff when the proposals for changes to the NHS Pension Scheme are under consideration.*
- 1.33 *We are unable to judge whether the increasing numbers of medical staff is having any effect on workload as the Health Departments have presented no substantive evidence on this. We have commented in previous reports, and must do so again, that increases in the medical workforce may simply be soaking up the extra demand for NHS services leaving existing workloads unchanged, or they may have resulted in an actual reduction in workload. We have received no evidence here on which we can make a judgement. We therefore ask the parties and the Health Departments in particular to consider what evidence they can provide for our next review to help clarify this issue.*
- 1.34 *As workload is likely to have an effect on the current state of our remit groups' morale, we remain concerned to establish a reliable baseline from which morale and motivation can be measured on a consistent basis. We were therefore pleased to see that the annual NHS Staff Survey has at last been launched, but are disappointed that the broad scope of its results do not provide the detailed baseline for each of our remit groups that we were expecting. We have asked our secretariat to discuss our information needs with the Healthcare Commission, but would ask the Department of Health to support our request for any changes in order to meet our information needs in this important area. We note that the 2004 survey will ask staff expecting to leave their reasons for doing so, and we also note that systematic exit interviews are not carried out by employers and that the results from those that are carried out are not collated centrally. Whilst it is helpful for employers locally to know why staff may be leaving, we would expect the Health Departments to want to form a wider perspective and to monitor trends year on year. It will be helpful to know from the 2004 NHS Staff Survey why people are thinking of leaving the NHS. However, it is even more important for us*

to know why members of our particular remit groups are actually leaving the NHS and where they are going to work. We therefore consider that a systematic form of exit interview across the NHS would be useful and would ask the Health Departments and NHS Employers to give careful consideration to introducing this in the future.

- 1.35 We comment in more detail on the recruitment, retention, morale and workload evidence provided by the parties for each remit group in the relevant chapters of the report.

Economic context and the Government's inflation target

- 1.36 The **Government** evidence on the economic context said that the macro-economy was in a strong position with the UK benefiting from its longest period of sustained low and stable inflation since the 1960s. Economic growth was expected to remain strong with the Pre-Budget forecast putting GDP growth at 3.25 per cent in 2004, and between 3 and 3.5 per cent in 2005. Unemployment levels were close to their lowest levels since the 1970s and this strength in the economy was not resulting in any significant upward wage pressure in the private sector.

Earnings growth and pay-bill growth

- 1.37 The **Government** evidence said that it was critical to consider the earnings growth, pay-bill growth and pay bill per head when looking at the level of the settlement. Pay-bill growth reflected the cost to the employer and earnings growth reflected the impact of the decision on individuals' pay packets. Earnings growth was a measure of how much the average earnings of existing employees who remained in the same grade increased over the year, including progression increases, bonuses, allowances, overtime and any other elements of take-home pay. It was different from the headline award which was simply the average headline increase in base pay and excluded those other elements of take-home pay. The growth in pay-bill per head (PPH) included the net effect on pay-bill of all these increases and also reflected the effects of changes in workforce composition. The PRBs were encouraged to focus on the earnings growth impact of their pay recommendations.
- 1.38 The Government said it believed that, in the medium term, public sector pay growth should be broadly in line with the sustainable level of earnings growth for the economy as a whole. However, in the short-term, it might be appropriate for earnings growth to be above or below these levels, depending on evidence on recruitment and retention and the labour market conditions prevailing at that time. We were referred to the specific evidence on the current recruitment and retention position for our remit groups.
- 1.39 The **BMA** said that settlement levels, which had been rising steadily throughout 2003, had now stabilised at around 3.1 per cent on an unweighted basis. The BMA's own analysis of settlements reported over the year to Income Data Services showed an increase averaging 3.3 per cent on an unweighted basis and 3.7 per cent weighted by the numbers of employees covered for this same period. At the time of submitting its evidence in October 2004, the BMA said it considered that the upturn in RPI inflation (discussed below) might well fuel an upward trend in months to come.
- 1.40 The trend for public sector settlements to exceed those in the private sector had been a consistent one over the last two years and the BMA argued this indicated an acceptance by public sector employers that a relative adjustment of public sector pay levels against private sector equivalents was necessary. The trend in settlements was echoed in overall earnings movements. Average earnings in the public sector were now rising at broadly comparable levels in the public and private sectors, the former having previously risen at a higher rate.

- 1.41 The BMA said that the prospect for earnings movements during 2005 was again for growth to pick up slowly, with the rate of increase of average earnings expected to reach 4.5 per cent by the fourth quarter of 2005. The New Earnings Survey had departed from its past practice by no longer analysing separately movements in manual and non-manual earnings and so the BMA's preferred indicator was no longer available. It was inevitable, in the BMA's view, that doctors would look to higher paid non-manual earners as their comparator group and expect their own earnings to reflect that comparison. The absence of traditional data in this respect was something the BMA wished to address in its comparative earnings study. The BMA said it would expect that increases in pay of less than 4.5 per cent during 2005 would lead to a relative decline in medical earnings against comparators and that something closer to five per cent might be necessary to reflect earnings movements at the higher end of the earnings distribution.

Inflation

- 1.42 The **Government** said in its evidence that while close attention should be paid to the earnings growth impact of any pay recommendations, cost of living was a factor that PRBs might also wish to take into account. The new CPI measure of inflation was said to have certain clear strengths for pay purposes over the old RPIX measure because of the way it was calculated, and because "the new target will make clearer how much of an increase in money earnings represents a real rise in living standards". The RPIX series would however remain available. The Government said that the "PRBs should consider the new target along with RPIX, regional price indices and all other relevant factors, such as developments in the local market, recruitment and retention, motivation and reform, in determining their public sector pay recommendations".
- 1.43 The Government presented data³ showing that CPI and RPIX inflation had been controlled at low levels over the last 12 months. Looking forward, the Pre-Budget forecast for the fourth quarter of 2004 was for CPI inflation to average 1.25 per cent, rising to 1.75 per cent in 2005, and thereafter to rise and remain at the target of two per cent.
- 1.44 The **NHS Confederation** commented that there was a question of what was meant by the inflation rate and which measure should be favoured. It said it was aware that the Government had made clear that it believed that the CPI should be used and that it was basing its inflation targets on CPI. However, the Confederation said that the three year pay deals agreed for a large proportion of remit group staff included sensitivity to movement in RPI(X). The Confederation said that the forecast CPI for 2005-06 was two per cent whilst the RPI(X) forecast was 2.75 per cent. In supplementary evidence, the NHS Confederation said that the award should be at the level of inflation and it was for us to determine what we believed to be the appropriate and relevant measure.
- 1.45 The **BMA** noted that the RPI inflation rate over the year to August had increased to 3.2 per cent. Independent forecasters expected the rate to rise further in the fourth quarter of 2004 before dropping back to around 2.9 per cent by the end of 2005. The headline rate drove pay expectations and the BMA therefore expected an increase in settlement sizes during the next pay round. The most recent Treasury survey of independent forecasters for the medium term showed that they expected RPIX inflation to increase steadily to reach an average of 2.6 per cent per annum by 2008. The BMA had said before that health service non-pay costs historically increased by less than RPI inflation. A modest rise in inflationary pressure was being faced over the review period which might persist into the medium term, but the NHS should still benefit from low overall levels of non-pay inflation.

³ See Annex A of the Health Departments' written evidence for the Review for 2005.

- 1.46 In supplementary evidence, the BMA commented that the inclusion of the Government's inflation target in our terms of reference always ran the risk that it would be redefined from time to time to exclude the more volatile items. The BMA said that for this reason, it had insisted that the remit should also require us to "take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others." The BMA said that included in this were consideration of the cost of living, as measured by RPI inflation, and the pressure this exerted on pay settlements. The BMA said that the Government's inflation targets had been included in our terms of reference at the Government's insistence, but it had now redefined them. The BMA said that CPI (the Government's preferred measure) differed from its predecessor (RPIX) in two main respects. One was mainly technical and related to the way in which the sub-indices were combined, and the other was coverage. The exclusion of owner-occupier housing costs and council tax affected the index by 0.7 percentage points and ignored major drivers of living costs and thus pay increases. The BMA said that it considered the most appropriate index for consideration of cost of living increases remained the RPI.

Comment

- 1.47 *The Health Departments proposed pay uplifts for 2005-06 in line with anticipated inflation for those remit groups who are not currently in a long-term pay deal. This focus on "anticipated inflation" is new and we have sought clarification from the Health Departments as to precisely what they meant by the term. We are aware that our remit requires us to have regard to the Government's inflation target, but the Departments have provided no clear guidance on how to interpret "anticipated inflation" beyond drawing our attention to CPI and the continuing availability of the RPIX series. As we have received no definitive view, we have, in our usual way, taken account of the economic evidence presented to us by the parties, and of the more recent data that has been published since that evidence was submitted. We have had particular regard to indicators of inflation, average earnings and pay settlements.*
- 1.48 *The prevailing rate of inflation is one of the many factors we have taken into account in reaching our recommendations and in doing so, we have considered the rate of inflation over the last twelve months and the various forecasts for the next twelve months. A number of inflation measures are available, but the key ones are CPI, RPIX and RPI. The Government's evidence emphasises CPI as the appropriate measure, but also notes that RPIX will continue to be available. The NHS Confederation notes that the three-year pay deals which are in place for some of our remit groups include a sensitivity to movement in RPIX. The BMA, on the other hand, places the emphasis on RPI. In our view there is no perfect measure of inflation – the different indices measure different things, and all have their strengths and weaknesses. We note that both CPI and RPIX exclude elements of housing cost such as mortgage interest payments, which are a major item of expenditure for many employees, and that Incomes Data Services and other commentators suggest that neither CPI nor RPIX are influential with pay bargainers in the private sector. As we do not have access to measures of inflation which are particularly relevant to the expenditure patterns of our remit groups, we therefore have to fall back on general measures of inflation. For these reasons, we have considered it appropriate to look at changes and predicted changes in all the major inflation indicators, focusing particularly on RPI and RPIX. We also believe that when considering inflation, it is best considered on a three month moving average basis, rather than one month's figures.*

- 1.49 *Over recent months, CPI has moved in the range 1.1 to 1.6 per cent, RPIX has been between 1.9 and 2.5 per cent, and RPI has been between 3.0 and 3.5 per cent. Reflecting the low and stable inflation experienced by the economy, commentators appear agreed that median pay settlements in the three months to November have been around 3.0 per cent, within an inter-quartile range of 2.5 per cent to 3.5 per cent for that period. This is similar to the situation we observed this time last year. Headline earnings growth in the whole economy was 4.2 per cent per annum in the three months to November, very similar to the rates seen earlier in the year. Earnings growth in the public sector generally exceeded that in the private sector, the latest annual rates being 4.7 per cent and 4.1 per cent respectively.*
- 1.50 *We have taken careful note of the economic evidence put to us, but inflation, earnings and settlement data are only part of the evidence we need to consider. Our aim is to make balanced recommendations. We exercise our judgement independently against all the provisions of our terms of reference about what is necessary, as far as pay is concerned, to deliver and retain adequate numbers of good quality, motivated staff.*

The funds available to the Health Departments

- 1.51 The **Department of Health** said that in SR04, the Chancellor had confirmed the five year NHS settlement announced in the 2002 Budget. For the period 2003-04 to 2007-08, expenditure on the NHS in England would increase on average by 7.2 per cent a year over and above inflation. However, the Department said that the increase in demand for NHS services and the delivery of the targets set out in the *NHS Plan* needed to be considered in the use of the Departmental Expenditure Limit (DEL), together with pay for NHS staff. The more resources that were used to fund pay bills, the less Primary Care Trusts (PCTs) would be able to take on initiatives such as National Service Frameworks.
- 1.52 The Department told us that no money was specifically earmarked for pay. The pay bills were met at PCT level from the overall funding for PCTs which covered nearly 80 per cent of the total DEL. Any large increases in pay would inevitably have an effect on the amount available for PCTs to spend on commissioning new services. If excessive pay awards were agreed, there would be an inevitable impact upon the cost of patient services and PCTs would have to consider such increased costs when determining their commissioning strategies. Exactly what service areas would be at risk from a large pay deal was impossible to say as decisions would be made locally, but it was clear that PCTs would need to consider slowing down some priorities and changing others. The Department stressed that its cash growth and real terms growth were not a benchmark for pay settlements. Growth in revenue funding (to fund pay amongst other things) was less than the overall average growth of 7.2 per cent in real terms. It was crucial that pay increases were no more than necessary to meet the recruitment and retention needs of the NHS, in order to ensure resources were available to deliver growth in capacity, service improvements and pay modernisation.
- 1.53 The **SEHD** said that a substantial and sustained injection of new resources had been invested in health services in Scotland and this investment should allow NHSScotland to recruit and retain well trained and motivated staff. However, staffing costs accounted for about 60 per cent of total expenditure on health and a substantial portion of the additional funding would go towards staff costs. The costs of pay awards for NHSScotland staff had to be set within a framework which considered the totality of funding set for the SEHD, the Scottish Executive's commitment to deliver the key national priorities and standards in *Building a Better Scotland*, and inflation.

- 1.54 The **National Assembly for Wales** said that most of what the NHS and its partners would achieve over the next three years would not come from additional resources, but from targeting differently the existing financial allocations and the available staff and resources. The level of resources for the next three years would challenge commissioners and providers to run services at the current level and make changes. Financial discipline was essential and existing deficits must be contained and reduced, and eliminated by March 2006.
- 1.55 The Assembly set out its Departmental Expenditure Limits for Health, though figures for 2005-06 were provisional until December 2004. Key points were:
- unlike England, there had not been a five-year settlement for health. Budgets were set annually;
 - there was a significant increase in funding for health, but this was lower than in England;
 - the Assembly had a higher level of expenditure on NHS manpower than England – 6.6 per cent of England’s compared with a population share of some 5.9 per cent;
 - the Assembly was committed to introducing pay modernisation for all groups of NHS staff, and had its own targets for growth of NHS staff in Wales;
 - Wales faced the same underlying demand pressures as England, and had relatively greater health needs; and
 - because of these factors, the Assembly had relatively less funding available as growth on revenue than England. Accordingly, the NHS in Wales found it more difficult to fund pay awards than in England.
- 1.56 The **BMA** noted that cash growth would average ten per cent per annum over the period 2005-06 to 2007-08, representing some 7.3 per cent per annum in real terms. The resources available to reward staff could again be supplemented by efficiency gains of the order of 2.7 per cent per annum⁴. The BMA remained disappointed that the Government had not provided us with data on the achievement of planned efficiency savings, since these affected both affordability and the perception of NHS productivity.

Comment

- 1.57 *We note the Health Departments’ evidence regarding the various demand pressures and the policy objectives which the available NHS funding must satisfy. We also note the BMA’s view that the resources are available to reward staff. We understand that there are a variety of demands on the resources available to the Health Departments and that the whole of the funding increase for the NHS cannot be made available to reward staff. Service delivery within the NHS is dependent on many factors, but having an adequate number of good quality, well-motivated staff to deliver services is a very important one. In reaching our decisions this round, we have taken account of affordability, in accordance with our terms of reference, and we have exercised our judgement about what is necessary, as far as pay is concerned, to recruit, retain and motivate our remit groups.*

⁴ The ‘Gershon’ review set a target of 2.7 per cent per annum efficiency gain – paragraph 1.12 BMA’s evidence.

Output targets for the delivery of services

- 1.58 The **Department of Health** said it was continuing to move the emphasis towards outputs rather than process measures. The Department referred us to its latest published progress reports on its Public Service Agreement (PSA) targets and on NHS service improvement⁵. It set out its new PSA and described the new national Planning Framework, plus local planning mechanisms⁶.

Links between pay and output targets

- 1.59 The Department said that output targets provided a clear focus for planning and delivery and for measuring the return on the unprecedented levels of Government investment. Our remit required us to have regard to the targets which formed part of the wider context within which we considered our recommendations. However, the Department did not believe it was possible to quantify in any precise way the impact which our recommendations on pay in one year would have had on the achievement of output targets in the next, and to attempt to do so would not be meaningful, given the complex factors at play.
- 1.60 The **SEHD** described how its evidence was set in the context of the challenging agenda for the Scottish Executive's policy priorities and commitments to delivering improvements to NHSScotland, as set out in *A Partnership for a Better Scotland: Partnership Agreement* (May 2003).
- 1.61 The **National Assembly for Wales** summarised its response to the Wanless Health and Social Care Review, explaining how action was being taken forward to meet the Wanless objectives and deliver improvements in the priority areas.
- 1.62 The **BMA** commented that it was difficult to see how the targets impacted on an annual review of pay rates. If they were to form part of the process of setting remuneration, this was surely a matter for pay structures, designed to provide appropriate incentives – these were already in place for GMPs and consultants and would be in due course for staff and associate specialists/non-consultant career grades (SAS/NCCGs). It was not clear that increases in remuneration would jeopardise the achievement of output targets – the BMA said it thought quite the contrary. A well-motivated workforce was essential to the achievement of more health benefit to more patients, and since pay systems would increasingly link individual or practice income to quality criteria, our role should be to recognise overall workload and workforce changes and to reflect these in pay.

Comment

- 1.63 *We understand the difficulty that the Health Departments have had in linking the impact which our pay recommendations would have on the achievement of output targets. Pay is not the only factor in the recruitment, retention and motivation of the staff needed to deliver output targets, but it does have a part to play in sending a positive message to the staff who are working to meet the Government's demanding health targets. Staff are not the only resource required to meet output targets, but the targets will not be met without them. At least until the extra numbers of staff coming into the medical workforce start to deliver a demonstrable reduction in workload, we believe that retention is a very important factor,*

⁵ See 14th annual *Departmental Report* (April 2004) and *Chief Executive's Report to the NHS* (May 2004), both available on the Department of Health website at <http://www.dh.gov.uk>

⁶ See Annex B & paragraphs 3.3-3.5 of the Health Departments' written evidence for further details.

and that the Health Departments' output targets are more likely to be met if our recommendations take account of the current conditions under which the groups are working. Given the difficulties of linking pay in any precise way to the achievement of output targets, the parties might like to consider whether output targets should remain in our remit.

Regional and local variations in labour markets

- 1.64 The **Government** evidence on the general context for the round explained the rationale of increasing the flexibility and responsiveness in public sector pay systems. We were told that the Pay Review Bodies should consider ways of introducing local pay by differential awards within the same overall pay-bill envelope. In general, the Government said that it would expect higher targeted pay for areas with significant and persistent recruitment/retention issues and lower targeted pay for those areas with little or no recruitment/retention difficulties.
- 1.65 In its specific evidence in relation to medical and dental staff, the **Department of Health** said that historically, the only nationally agreed provision for regional variation in doctors' and dentists' pay had been the system of London weighting that was paid to all HCHS doctors and dentists, GMP Registrars and salaried GMPs. The principal allowance in the London Zone for 2004-05 was £2,098 for non-resident staff and £584 for resident staff.
- 1.66 *The Department's remaining evidence on the regional and local dimension focuses solely on consultants, but it is included in this chapter as it forms the basis on which the Department has addressed this aspect of our remit.*
- 1.67 As for last year, the Department said that the evidence suggested comparatively greater problems of recruitment and retention of consultants in parts of the North and Midlands, rather than London, with the differences in vacancy rates becoming more pronounced for particular specialties. The Department said that there was also likely to be substantial variation in vacancies between Trusts within each Strategic Health Authority (SHA). Possible factors likely to explain these variations included the location of medical schools, opportunities for teaching and research, opportunities for additional work outside the NHS (e.g. in private practice), and consultants' preferences about where they wished to live. A reduction in the degree of variation between localities was expected as new medical schools were created and consultant supply expanded.
- 1.68 However, there was a clear need to investigate more closely the reasons for current variations. The Department said that a project had been established and work was progressing to identify evidence and develop proposals to meet the following issues:
- the reasons for variations in staffing and vacancy levels between different localities, including analysis by specialty;
 - the extent to which NHS employers were already using pay or non-pay measures to address recruitment and retention problems; and
 - the effectiveness of such measures and their impact on the distribution of consultants.

- 1.69 The Department said it was exploring the economic factors that might be affected by local variations and this included drawing on experience from the private sector as well as other public sector areas. Once this information had been collected, the Department said the intention was to determine an appropriate response commensurate with NHS needs. The expectation was that recommendations on the likely effectiveness of greater local pay differentiation and the ways in which this could be implemented would be available for our consideration next year. We were invited to endorse this programme of work. In supplementary evidence, the Department said that it would undertake an assessment of the likely effectiveness and cost-effectiveness of greater pay differentiation in addressing comparative recruitment and retention difficulties for all groups of staff within the NHS. It said it would involve stakeholders, including our secretariat at the Office of Manpower Economics, in its considerations of this area of work.
- 1.70 The **SEHD** said given that the delivery of pay modernisation was still at an early stage, it was not yet able to measure the effect of new pay systems on recruitment and retention and what impact these would have on any requirement for pay differentials in addressing local recruitment and retention pressures. The SEHD said it would monitor the situation with a view to reporting in next year's evidence on whether additional action was required to address vacancy variations.
- 1.71 In supplementary evidence, the **National Assembly for Wales** told us that it wished to maintain the stance it had taken in last year's evidence of not wanting Wales to be treated differently on pay from any other part of the UK. It said that it had no evidence yet that there was a need for differential pay within Wales, but that this would be considered as part of its further research into the high vacancy rates in certain areas of Wales, and it would be looking at the extent to which employers were using pay/non pay measures to address recruitment problems.

London weighting

- 1.72 The **Department of Health** reported that three of the five London SHAs had three-month vacancy rates for consultants below the mean, with two SHAs having the lowest three-month vacancy rates in England. The Department said that the current evidence therefore strongly suggested that NHS Trusts in London found it easier to attract doctors than most other parts of the country and it could see no case for an increase in London weighting. It would be investigating factors affecting recruitment of consultants in London, but at this stage, the Department's view was that there should be no change to the current arrangements for London weighting and it was seeking our agreement that London weighting should remain at its existing value in cash terms for 2005-06.
- 1.73 In response to our query about whether there was any evidence on the use of the recruitment and retention premium for consultants on the new contract, the Department said that it had issued advice to employers on approaches to recruitment and retention premia, but it did not yet have evidence on usage and uptake. The Department said however that the formal survey of NHS employers, currently underway, would provide some information.
- 1.74 The Department provided a note⁷ on the market forces factor (MFF) element of the resource allocation formula which the BMA had suggested last year could be regarded as a proxy for the excess costs met by London doctors. The Department stressed that the MFF was certainly not intended to read across directly to levels of pay. Pay levels in

⁷ See Annex F of the Health Departments' written evidence.

London or elsewhere should take into account, not living costs per se, but the ability to attract doctors and dentists to work in those areas. The Department also explained why some of our remit groups did not receive London weighting and why the introduction of London weighting for GDPs would be disruptive⁸.

- 1.75 In supplementary evidence, the Department said that London weighting was originally a cost compensation to reflect the higher cost of living in London. The Department said that the uplift was modest in percentage terms, reflecting the fact that London and the South East did not have the same difficulties recruiting doctors as other groups of staff such as nurses and health care assistants. The Department also said that the MFF element of the resource allocation formula was intended to compensate for non-medical pay staff costs. With regard to its vacancy data, the Department said that it had figures on consultants and on other doctors (excluding doctors in training). In response to our question as to whether there were any equal pay issues arising from this year's evidence generally, and specifically, in relation to London weighting, the Department replied that there were none.
- 1.76 The **BMA** said it had been disappointed that we had declined to recommend a substantial increase in London weighting to £5,000 from April 2004 on the grounds that it had not provided detailed arguments to support this precise figure. The BMA said that there were many comparisons which could be used to justify an increase over existing levels including equity with other NHS staff, the extent to which the service received resources which reflected higher pay costs and failed to pass these to the staff, and comparison with other staff working in high cost areas. It had marshalled arguments and data on these three aspects last year and the figure of £5,000 was an attempt to identify a more appropriate figure than the present one. The BMA considered that clearly it had been insufficient, in the light of its arguments, merely to increase the existing level by the amount of the Government's inflation target and also inappropriate because it proceeded from a demonstrably inadequate base. The BMA said it was therefore asking us again to recommend a substantial increase to recognise the cost pressures facing doctors working in London.
- 1.77 In supplementary evidence, the BMA noted that in rejecting the case last year for an increase in London weighting, we had been critical of its lack of precision, but the BMA considered this was inevitable bearing in mind that there were any number of potential measures of excess cost in support of a cost compensation argument. It said that bearing in mind the current very low level of London weighting, some of the more extreme measures would involve very substantial increases. The figure of £5,000 had been chosen, the BMA said, as a rounded figure having some broad measure of comparability with the position of other NHS workers. Any further precision would have been spurious bearing in mind the crude nature of the weighted average between Inner and Outer zones used to obtain it. The BMA also said that the staff MFF was designed to compensate PCOs for the differential costs of employing staff. It directly reflected the higher pay levels of employees in London and the BMA said it was a valuable addition to the armoury of cost compensation measures.

⁸ See paragraphs 5.16 & 5.17 of the Health Departments' written evidence.

Comment

- 1.78 *We note that the Department of Health has established a project to investigate the reasons for current variations in recruitment and retention and to develop proposals and we look forward to receiving its evidence on the outcomes from this for our next review. For this review, we are in no better position than in the last round to make any further comments about regional and local variations in the labour markets for our remit groups. However, we would remind the Health Departments of the suggestions we made in our last report as to the kind of evidence base that we would find helpful in considering this aspect of our remit – paragraphs 1.66 to 1.70 of the Thirty-Third Report refer. We hope that the Departments will draw on these suggestions as they consider this issue further and will consult with our secretariat. We also remind the Health Departments that we expect this aspect of our remit to be addressed in the context of each of our remit groups, rather than solely in relation to consultants. We would particularly welcome further evidence in the next round from the Scottish Executive Health Department and the National Assembly for Wales on how they are taking forward work to address this aspect of our remit and of their developing views.*
- 1.79 *With regard to London weighting, we said in our last report that we were not in a position to do more than recommend a general pay uplift to London weighting. This remain the case this round as the Department of Health has again only presented labour market evidence for consultants. We do not want to find ourselves in the same position in the next round as we wish to give proper consideration to the need for and, as necessary, the level of London weighting for our remit groups.*
- 1.80 *As regional and local pay is now included in the remits of other Pay Review Bodies, as well as ours, the Office of Manpower Economics (OME) has commissioned research at the request of the Pay Review Bodies to build on its earlier research⁹ which looked at the approaches of private sector companies to geographic pay differentiation. This new research will examine the degree to which pay varies geographically by job responsibility level and the formal and informal levels of geographical variation that exists in commercial organisations. We will be very interested to see the findings from this work and to see what practices are being followed by other organisations as we have heard anecdotally a number of times on our visits to high cost areas that there is a case for a London weighting-type payment in other areas of the country. We have asked our secretariat to discuss the results from the OME research with the parties. We therefore expect to be able to give proper consideration to the issue of London weighting in the next round, informed by the findings from this research and other evidence which the parties put before us.*
- 1.81 *For this year, as we said earlier, we are in no better position to make a proper judgement and so we are only recommending a general pay uplift to London weighting. Our aim has been to protect the real value of London weighting and in doing so, we have considered a range of inflation and pay indicators. **We recommend (recommendation 1) an increase of 3.0 per cent for 2005-06 on the value of London weighting.** The detail of our recommendation is set out at Appendix A.*

Pay comparability

- 1.82 The **BMA** said that in last year's evidence, it had declared its intention to conduct a detailed study of the comparative position of doctors and to report its findings to us as part of its written evidence for this review. However, it had decided to postpone the study until it was in a position to include some estimate of the impact of the two new contracts on medical pay.

⁹ See <http://www.ome.uk.com>

Comment

- 1.83 *We continue to believe that pay comparability is a relevant factor in our deliberations as it is an important factor in considering recruitment and retention difficulties among our remit groups. We make our own assessment of how the pay of our remit groups compares with that of other professions, both in terms of pay movements over recent years and of pay levels. From the private sector, we use solicitors, actuaries, chartered engineers, accountants, taxation professionals, and architects in both the public and private sectors. We also looked at some public sector figures. In selecting these comparators, we have due regard to the following criteria: similar entry requirements, training qualifications, and intellectual rigour. These are careers that might reasonably be thought of as possible alternative careers by individuals joining the medical and dental professions, and that have clearly defined career progression. We have also looked at recent trends in average pay movements across the economy.*
- 1.84 *Our conclusion is that the remuneration of our remit groups remains broadly in line with that of the comparator groups. Within that assessment, however, we note that by comparison to graduate starting pay, the starting basic pay of house officers is broadly in line with the median starting salary of £20,000 reported by Incomes Data Services, but below the median of £21,000 reported by the Association of Graduate Recruiters. We are aware of the difficulties of making such comparisons, given that medical undergraduate degrees are longer than most others and that nearly all junior doctors receive pay supplements so that their earnings are considerably greater than basic pay. The current situation with recruitment and retention of junior doctors, however, appears to be healthy. We would be interested in seeing the findings of fresh research into how the pay of our remit groups compares with that of other professions, and would ask the BMA to consult with our secretariat when it takes forward its own pay comparability study.*

Recommendations for 2005-06

- 1.85 Leaving aside consultants on the new contract, GMPs working within General Medical Services (GMS) and salaried primary care dentists, the **Department of Health** said that for all other groups within our remit, it was seeking pay uplifts for 2005-06 in line with anticipated inflation. We were asked to consider the low and stable inflation as measured by the CPI and RPIX, the Government's inflation target for the CPI of two per cent and other relevant factors, such as the recruitment and retention situation. The Department said that a pay uplift in line with inflation would equate to an above-inflation increase in earnings for doctors who were not yet at the top of their pay scale, for example, without any pay uplift, the average incremental increase in pay of a specialist registrar was around 4.9 per cent. The Department offered to provide further illustrations of the impact on earnings growth of different pay recommendations in supplementary evidence.
- 1.86 In supplementary evidence, the Department said that it was for us to take a view on a precise figure for the pay uplift, and repeated that it was asking us to consider the low and stable inflation, as measured by the CPI and RPIX, and the Government's inflation target for the CPI of two per cent. The Pre-Budget 2004 forecasts were for CPI inflation to average 1.25 per cent in the fourth quarter of 2004 and thereafter to rise and remain at the target of two per cent from 2006. The Department repeated that it believed that the new CPI measure of inflation had certain clear strengths for pay purposes over the old RPIX measure because of the way it was calculated – in particular, it took account of consumer behaviour in terms of substitution away from more expensive goods and brands. The Department also repeated that the RPIX series remained available and that we might wish to take it into account.

- 1.87 In response to our request to clarify the purpose of salary scales, the Department said that they provided a means of pay progression in recognition of experience, ability and knowledge.
- 1.88 The **SEHD** and the **National Assembly for Wales** supported the Department of Health's proposed pay uplift for all groups other than consultants on the new contract and salaried dentists.
- 1.89 The **NHS Confederation** said that at a time of sustained low inflation and if there was no evidence of pay structure problems, it did not seem appropriate to give the same level of above inflation awards to those who had not agreed to a package of pay modernisation, as to those who had. The Confederation said it did not believe there were any reasons to make changes to the pay structures or real pay levels for the groups not covered by the three-year pay deal. These staff should receive an uplift at the level of inflation. We asked whether the Confederation was arguing that pay modernisation was the sole criterion for a pay uplift above inflation and it told us that criteria such as recruitment and retention issues could justify a call for above inflation awards. However, it said it did not believe that at present there were recruitment, retention or morale issues for the remit group that required pay uplift as the solution. In addition, it said that the ten per cent deal was tied to pay modernisation and therefore giving the same award without modernisation or any alternative justification would send the wrong signal.
- 1.90 The **BMA** considered that those remit groups not covered by long-term agreements bound up in contractual change would need to receive a minimum increase in pay rates of 4.5 per cent from April 2005 if they were to avoid losing further ground against comparators. It said it reiterated its view that these groups were exposed to the same workload and pressures as the groups covered by such agreements and it would be inequitable to deny them access to appropriate levels of remuneration.
- 1.91 We asked what basic pay uplift would deliver 4.5 per cent earnings growth and the BMA said in supplementary evidence that 4.5 per cent was a forecast of average earnings growth. It reminded us that it no longer had access to its preferred comparator in the New Earnings Survey, which had previously analysed separately movements in manual and non-manual earnings, to determine what increase in earnings might have taken place at the upper end of the earnings distribution. In the absence of this, the BMA said that it might be that an increase in basic pay of 4.5 to 5.0 per cent could deliver the appropriate (higher) increase necessary in total earnings to maintain comparability with those at higher levels in the earnings hierarchy.
- 1.92 However, the BMA said that it was much harder to answer what impact a given basic pay increase might have on average medical earnings, including incremental and other drift. First, not all the remit groups were involved in this round and for a substantial number of doctors, there would be actual reductions in pay levels this year consequent on movement between pay bands. For example, a senior house officer on point 3 moving from band 2A to band 2B would lose around ten per cent of income, even after allowing for incremental progression. Furthermore, the BMA said that any consideration of pay drift must also take into account the impact of attrition on average earnings – the process whereby the highest earners retired and were replaced by lower earners in increasing numbers. The BMA said it might therefore be the case that, for the limited group of doctors covered by this review, drift was negligible or even negative.

- 1.93 The BMA said that the Health Departments' focus on the difference between basic pay and earnings increases and the issue of pay drift was a narrow approach, concentrating on the impact of incremental progression for the individual doctor. The BMA said that there were, of course, two sides to any comparison. The increase in earnings in the economy as a whole could reflect negative factors as well as positive ones. Thus a decline in bonus payments, which had been evident for a while now, meant that a comparison of average earnings increases with increases in the pay of the profession was not without risk. The BMA said that as it had pointed out, earnings at the upper end of the pay spectrum had reflected a long-term trend towards increasing differentials and so the average earnings increase understated the comparative position. Turning to the profession itself, the BMA said that the impact of attrition was such that over time, both we and the BMA had, in the past, concluded that drift was small and for GMPs was non-existent. Furthermore, the BMA said that incremental scales had been present in the pay structure since the inception of the NHS, let alone the Review Body system, and incremental drift, provided it was stable, should play little or no part in ongoing comparisons.

Comment

- 1.94 *We have considered carefully all the evidence from the parties who have urged us towards very different conclusions once again this year. The detail of our recommended increases for 2005-06 for the remit groups for whom we are required to make recommendations this round is set out in the following chapters.*
- 1.95 *The Government's evidence asked us in recommending pay rates to take account of the increases in earnings for individual employees in our remit groups that arise from pay progression within the pay structure. We understand the argument. We must, however, register our concerns with what is suggested. The proposal, if strictly followed, would lead to lower pay awards in the short term, but also to a misalignment of public sector pay with the wider market, giving rise to recruitment and retention problems in the future. This would inevitably lead to the need for catch-up awards, and, in turn, to unnecessary and damaging volatility in pay levels and movements. Moreover, the comparatively large annual increases in pay for individual remit staff already within the pay structure are a feature of incremental pay systems. These systems, which are used in parts of both the private and the wider public sector, are normally designed to move staff to the appropriate market rate over time as their experience in post develops. Such systems mean that employees who have not reached the top of the pay scale receive both an increment and a general pay award, with the latter reflecting labour market, inflation and general economic considerations.*
- 1.96 *In making pay recommendations for our remit groups, we believe our concern should be the general pay award, not the operation of the pay increment system. It would be helpful, therefore, if in its evidence for the next round the Government would make it clear what is intended when it asks us to take account of the existence of increments in recommending a general pay uplift. If affordability is the concern, it seems to us that the key issue for employers is the effect that the pay awards have on their total payroll. Moreover, the savings that arise automatically from mature incremental payment systems, as more experienced and hence more expensive employees are replaced by ones earning less, are also relevant and should be taken into account. In the meantime, we make our recommendations on the uplift in pay rates in our usual way.*

1.97 *As we said earlier, the prevailing rate of inflation is one of the many factors we take into account in reaching our recommendations on the basic uplift to pay. We have also looked at how pay, both settlements and earnings, has been moving elsewhere in the economy to consider the relative pay position of our remit groups. The Government's evidence emphasises CPI as the appropriate measure of inflation, but also notes that RPIX will continue to be available. Commentators suggest that RPI is more influential with pay bargainers in the private sector than either CPI or RPIX. Over the cycle, RPI and RPIX produce similar estimates of inflation, but RPI is much more volatile because it is very sensitive to interest rate changes. In our view, there is no perfect measure of inflation – the different indices measure different things, and all have their strengths and weaknesses. For all these reasons, we considered it appropriate to look at changes and predicted changes in all the major inflation indicators, focusing particularly on RPI and RPIX, and also pay movements elsewhere in the economy.*

Part II: Primary Care

CHAPTER 2 – GENERAL MEDICAL PRACTITIONERS

Introduction

- 2.1 *We are not required to make recommendations on remuneration for independent contractor general medical practitioners (GMPs) working under the new General Medical Services (GMS) contract, as the uplift for 2005-06 was agreed by the Health Departments and the British Medical Association (BMA) as part of the new contractual arrangements. However, the parties have brought to our attention a number of other matters relating to GMPs which lie outside the main contract. These include the salary range for salaried GMPs, GMP registrars, GMP trainers and GMPs working in community hospitals. Since the parties originally submitted their evidence last October, the report by the NHS Confederation to Ministers on the pay, terms and conditions for staff and associate specialists/non-consultant career grades has been published. This report also makes recommendations on GMPs who are clinical assistants (CAs) and hospital practitioners (HPs) and on GMPs working in community hospitals.*
- 2.2 *We consider below the various issues which have been raised, after the summaries of the parties' evidence. The parties have also updated us on progress with the implementation of the new GMS contract and a summary of their evidence is also set out below.*

The new GMS contract

- 2.3 The **Department of Health** said that by 1 April 2004, 4,910 (99.9 per cent) of the new GMS contracts had been signed by practices and Primary Care Trusts (PCTs). It said this was an excellent result and had exceeded its expectations. The Department said however that the service still faced big operational and strategic challenges around ensuring all practices got paid, agreeing actual practice budgets, managing the quality framework and in finalising the new out-of-hours arrangements.
- 2.4 The Department gave us details of the quality payments that were available through the new GMS contract via the Quality and Outcomes Framework (QOF). It said that all practices using the QOF would be paid the same amount of money for the same amount of work. It would be up to practices to decide for themselves how much of the QOF they wished to take on.
- 2.5 The **National Assembly for Wales** said that by 1 April 2004, 495 practices had signed the new GMS contract, whilst 13 practices were being managed by Local Health Boards.
- 2.6 The **Scottish Executive Health Department (SEHD)** said that all GMS practices in Scotland had signed the new GMS contract with their Health Board. It said that each NHS Board area had established an implementation team to develop a local framework for delivering the new contract in a way that was best suited to local circumstances.
- 2.7 The **BMA** told us that overall, it was pleased with the process of implementation of the new GMS contract and it appreciated the extraordinary amount of effort expended by many people to achieve a smooth and successful transition. Given the size of the change-management project that this represented for general practice, the BMA said that it was extremely grateful to all concerned nationally in the Departments of Health and locally in primary care organisations (PCOs), Local Medical Committees and practices for all the hard work to achieve this.

- 2.8 The BMA also set out for us a number of problem areas, such as continuing issues over the spending of enhanced services funding, but said that it continued to support the new contract fully and to regard its implementation thus far as a guarded success. The difficulties it had described did however illustrate how problematic the implementation process had been on some issues. The BMA also told us that the negotiating parties were now in the process of determining the future negotiations required for reviewing the contract. It was looking forward to working with the new NHS Employers organisation and the Departments of Health on the next stage of the development of the new GMS contract.

Comment

- 2.9 *We are grateful to the parties for their evidence on the progress they have made in implementing the new GMS contract. We have no doubt that all concerned have put considerable effort into getting the arrangements up and running and that this effort will need to be sustained as the new arrangements continue to bed in and the process of review gets underway. From the evidence presented by the BMA, we were pleased to learn that, despite various issues of concern, it still views the contract positively. However, we note these points of concern and would ask the parties to engage positively in seeking to resolve them. The outcome may not always be completely to any one party's liking, but we hope that the parties will work together to resolve any outstanding matters quickly. We would not wish to see GMPs in any part of the UK becoming disillusioned with the new contract because issues remain unresolved.*

Recruitment and retention

- 2.10 The **Department of Health** said that the *NHS Plan* target in England of 2,000 extra GMPs by March 2004 over the October 1999 baseline had now been exceeded by 748 GMPs. There had been an increase of 857 GMPs (excluding GMP retainers, GMP registrars and locums) (644 whole-time equivalent (wte)) between September 2003 and June 2004, compared to an increase of 1,156 (791 wte) during the year to September 2003. There had also been an increase of 176 GMP registrars (155 wte) between September 2003 and June 2004 compared to an increase of 255 (246 wte) during the 12 months to September 2003. The Department said that numbers of GMP registrars in England had risen steadily in recent years to 2,411 in June 2004 and were now 1,068 (80 per cent) more than in 1997. This was the most ever recorded, and the Department said it expected further growth this year and beyond. The *NHS Plan* target in England of 550 more GMP registrars by March 2004 had been exceeded by 341.
- 2.11 However, the Department said that holding on to these gains was critical and it had a number of initiatives in place aimed at maintaining them, including the Flexible Career and Golden Hello Schemes. The Department quoted the BMA's Cohort study which had noted "there has been an increase in the number of doctors planning to enter general practice, with a contrasting decline in the proportion of the cohort planning to enter hospital specialties such as general medicine and surgery. An important factor underlying this shift is the perceived greater flexibility of general practice".
- 2.12 The **National Assembly for Wales** said that there had been a small increase of 14 GMPs (0.7 per cent), excluding GMP retainers and GMP registrars and locums, during the year to September 2003. It said that future recruitment and retention initiatives would focus on GMPs to ensure the additional 175 GMPs target was achieved by 2010.

- 2.13 The **SEHD** said total numbers of GMPs in Scotland had increased by 78 (wte) or 1.9 per cent in 2003. It said it believed the new GMS contract would help attract and retain GMPs in future years, particularly the ability to drop out-of-hours and the improved seniority scheme. It also said that new and most returning GMPs would receive the £5,000 Golden Hello payment, and a further payment of between £2,500 and £7,500 if the practice they joined was in a remote, rural or one of the most deprived areas. It said that the Scottish Allocation Formula for allocating funds under the contract gave additional weighting to reflect the extra costs incurred in providing GMS in remote and rural areas. The SEHD said that Health Boards had the flexibility to employ salaried GMPs and deploy them as necessary, to manage particular difficulties.
- 2.14 In its evidence, the **BMA** said that although the headcount *NHS Plan* total increased by 4.0 per cent in the year to September 2003, the number of GMS unrestricted principals and their PMS equivalents (UPE) had increased by only 537 (1.9 per cent). It said that most of the growth was in the 'other' GMP category – mostly salaried doctors. The estimated increase in whole-time equivalent terms was 344 (1.3 per cent). In Scotland, it said that GMP growth had been slower, the growth in all practitioners being 1.6 per cent over the year to September 2003 and in UPE 1.0 per cent. In future years, the BMA said the contractual arrangements which permitted WTE to be estimated would no longer exist and it would be difficult to assess the impact of headcount increases in general practice. However, it said it expected the disproportionate increase in salaried doctors to represent a much smaller increase in WTEs since this group would in future contain a larger proportion of women and others wishing to work part-time.

Comment

- 2.15 *We are pleased to note that the Department of Health has met and exceeded its NHS Plan target for England to recruit an extra 2,000 GMPs (headcount) by March 2004 over the October 1999 baseline. We are grateful for the whole-time equivalent (WTE) as well as headcount figures from the Department of Health and the SEHD showing the more recent increases in GMP numbers and would ask all three Health Departments to provide these figures for us in the future so we can monitor trends. We note here the BMA's comment that the new contractual arrangements will not permit WTE to be estimated in future years and would ask the Department of Health to comment on this for our next review. We would be concerned if there were no means of estimating WTE as growth in headcount can mask an increase in part-time working and the genuine workforce gain from an increasing headcount may be far lower than it appears. We also welcome the increase in GMP registrar numbers and note that the Department of Health exceeded its NHS Plan target for this group.*
- 2.16 *We note also the smaller increases in GMP numbers recorded in Scotland and Wales and await evidence for our next round on whether the growth has accelerated.*
- 2.17 *We are pleased that the Department of Health recognises the need to hold onto the gains in recruitment of both qualified GMPs and GMP registrars and we hope that it will keep its incentive schemes under review to make sure they support GMP recruitment and retention.*

Salaried GMPs

- 2.18 The **Department of Health** said that the salary range for salaried GMPs employed by PCOs was currently £47,710 to £72,478, with starting pay, progression and review determined locally. For 2005-06, it asked us to uprate the salary range in line with the Government's inflation target. It said that the model terms and conditions of service for

salaried GMPs employed by either a GMP practice or by a PCT were intended to be the minimum, with employers free to offer more favourable terms as they saw fit. The Department said that it believed that such a framework was flexible enough to enable local employers to amend it to reflect local needs and circumstances.

- 2.19 The **NHS Confederation** said it would recommend an uplift in line with inflation.
- 2.20 In its evidence, the **BMA** said that salaried GMPs were an important and ever increasing part of the workforce. It said that the salaried GMP option should be used as a primary care recruitment and retention tool and should be financially appealing to those working less than full time. It said that the salary range should take account of the earnings of GMP providers, notwithstanding the risks and responsibilities that GMP providers must undertake because of their independent contractor status. The BMA noted that we had highlighted last year that it might be more appropriate for the top end of the salary range for salaried GMPs to be amended in line with the new consultant scale. The BMA said it felt this amendment would be entirely appropriate. It said it would welcome a recommendation from us to this effect to apply from 2005-06.
- 2.21 The BMA said that some salaried GMPs had experienced difficulties in negotiating an appropriate salary to reflect their previous experience and skills, let alone securing the annual uplift recommended by us. It said that many had also had problems negotiating incremental scales as part of their pay arrangements and said this was of great concern given that no mechanisms such as seniority payments existed for salaried GMPs. The BMA said it would welcome our support calling for employers to take heed of employees' experience and skills, as well as incorporating pay progression arrangements and our annual uplifts, when negotiating remuneration arrangements. The BMA said it would welcome a recommendation from us to uplift the salary range for 2005-06 to a level that would help to attract and retain this group of GMPs.
- 2.22 We asked the BMA why it was seeking our support for salaried GMPs in their remuneration negotiations with employers when GMPs were in demand and were therefore in a very strong negotiating position with their PCOs. In response, the BMA said market forces did not yet fully apply to this group of doctors. Many salaried GMPs were finding it difficult to negotiate a salary which was commensurate with their skills, experience and the work that they were required to undertake. There were a number of reasons for this. The minimum terms and conditions for GMPs employed by a GMS practice or PCO had only recently been introduced, and the concept of a salaried GMP post was also new following the implementation of the new GMS contract. Many salaried GMPs had not had to negotiate a salary before. Female GMPs in particular had family commitments and wished to work around these. The BMA said that in some areas there were a limited number of vacancies offering suitable work and/or hours for these GMPs. As the market was still developing, the BMA said that it would assist salaried GMPs, and help to recruit new doctors into general practice, if we would support the need for employers to take heed of salaried GMPs' experience and skills, as well as incorporating appropriate pay progression arrangements and our annual uplifts when negotiating remuneration arrangements. The BMA said that this would allow market forces to develop while in the mean time providing protection for salaried GMPs.
- 2.23 We asked the BMA why it was now asking for our support on pay progression, annual uplifts and recognising skills and experience when the parties' joint evidence for the Thirty-Second Report had asked us to make no recommendation beyond support for this to be determined locally. The BMA said that it was particularly seeking our support this year because it was aware anecdotally that there were salaried GMPs who had not

received an annual pay uplift and/or incremental pay progression. Furthermore, the new terms and conditions of service for these doctors had only come into force on 1 April 2004 and so it was only since then that the BMA had received reports about problems salaried GMPs were experiencing negotiating an appropriate starting salary. The BMA confirmed that it did not as yet have any formal data on the use of the salaried range.

- 2.24 In conclusion, the BMA said that as yet it did not have the data to support claims about the impact of the salary range on recruitment and retention. Nevertheless, it said that alignment of the top end of the range with the new consultant scale would be appropriate. It was extremely concerned at the growing evidence of difficulties faced by individual salaried GMPs seeking to negotiate appropriate starting salaries, annual pay progression and incremental scales with their employer. This area would be a higher priority in due course as further evidence became available.
- 2.25 In supplementary evidence, the **Department of Health** said that taking heed of employees' experience and skills, and incorporating pay progression arrangements and the annual Review Body uplifts were a matter for local discussion. The Department said that although the top of the salary range for salaried GMPs agreed in May 2003 was close to the top of the incremental range for consultants, as it then stood, it did not accept that there was a linkage between the two. As it had reported last year, the Department did not believe that the pay thresholds for consultants on the new contract would form an appropriate comparator on which to base the top of the salary range for salaried GMPs. The Department said that the thresholds for consultants were linked to demonstrating a range of new criteria for performance and commitment and were part of an investment-for-reform package designed to achieve fundamental reforms in the way that consultant services were managed. The salary range for salaried GMPs agreed in May 2003 was designed to be wide enough to cover the range of possible roles that salaried GMPs might be required to undertake, and the Department said it had no evidence to suggest that this was no longer the case.
- 2.26 In supplementary evidence, the **NHS Confederation** said it believed there was absolutely no justification for aligning the top of the salary range with the top of the payscale under the new consultant contract. It said this would represent a very substantial potential increase and stressed that such a move would cause real problems.

Comment

- 2.27 *As we have received no evidence this round either on the use of the current salary range or on the position regarding the recruitment and retention of salaried GMPs, we do not consider that we have any evidence to support an adjustment to the top of the salary range at this stage. We would ask the parties, and particularly the Health Departments, to submit evidence on both these issues for our next review.*
- 2.28 *Although the original salary range was set by reference to the mid point of the associate specialist payscale and the top point of the old consultant payscale, we consider that these initial range maxima and minima were artificial and are no longer appropriate for deciding how the salary range should be uplifted each year. A more logical reference point is the uplift for other GMPs and **we therefore recommend (recommendation 2) that the salary range for salaried GMPs is increased by 3.225 per cent in 2005-06. For 2006-07 onwards, we would like the parties to consider the formulation for uprating the salary range and to make proposals to us for our next review.***

2.29 *We note the BMA's concerns that employers are not taking heed of employees' skills and experience in agreeing starting salaries, and the concerns that employers are not incorporating pay progression arrangements and our annual uplifts into remuneration arrangements. We consider that the job requirements rather than the particular skills and experience of the potential employee must define the starting salary and any progression arrangements, unless the employer agrees that the job should be expanded to match the skills and experience being offered by the candidate. As the parties originally agreed that local job evaluation should be the basis for assigning individuals to an appropriate point on the pay range, we would ask the parties again for evidence on how this is being used in practice. We would be surprised to find that contracts are being entered into which do not provide for some form of annual pay review, and would expect GMPs to ensure that this aspect was covered in their contractual arrangements. As GMPs remain in demand, we consider that they should be able to negotiate appropriate arrangements when agreeing their terms and conditions.*

GMP registrars

- 2.30 The **Department of Health** said the supplement for practitioners entering GMPR training was currently set at a level calculated to facilitate movement between hospital and general practice training, and to provide incentives to recruitment. It said this was clearly having an effect, with GMPR numbers up by over 15 per cent in the year to March 2004. It said that the current supplement of 65 per cent of basic salary could be considered somewhat high by comparison with that of hospital trainees who averaged some 60 per cent, but it would be a matter for careful consideration whether it was appropriate to reduce the supplement to retain trainees in the hospital service whilst continuing to maintain some expansion in GMP numbers. The Department also said that one of the unresolved issues from last year's Report – an uplift to the motor vehicle allowance for GMP registrars – was now under discussion.
- 2.31 The **BMA** also noted the discussions on uplifting the motor vehicle allowance and said it was pleased with progress. It was working with the Department of Health to rewrite the Directions for GMP registrars, which it also welcomed. However, the BMA said it was concerned that despite the Government's commitment to maintain and recruit to general practice, a planned decrease in GMP registrar recruitment had been planned in some areas on account of an apparent reduction of £50 million to the increase in funding for deaneries. It said it would welcome our support for sufficient, continuing funding to ensure GMP registrar recruitment could remain a priority and thus continue to expand at the necessary rates that had been previously planned. The BMA was also concerned that the Department was optimistic in believing that the number of GMP registrars had been increasing and would continue to increase steadily. It noted that its Cohort Study had found that 14 per cent of GMP registrars did not plan to enter general practice immediately upon gaining certification. Although it welcomed recent increases in GMP and registrar numbers, the BMA said it was concerned that the increases were not keeping pace with the expansion of available positions in primary care or with the increasing move towards part-time working. The BMA gave details of the General Practitioner Recruitment, Retention and Vacancy Survey 2003 for England and Wales which showed that the current shortage of GMPs was more apparent in inner-city areas and in areas that had a higher cost of living.
- 2.32 The BMA said that a large disparity remained between the average pay for doctors working less than full time in hospital posts compared to those in GMP registrar jobs. It said it would welcome our support for additional funding to be provided to ensure that part time opportunities were maximised in order to aid recruitment and retention in general practice.

- 2.33 The BMA said that it welcomed the effect that the 65 per cent supplement had had on reducing the pay differential between GMP registrars and junior hospital doctors, but unfortunately, a differential still existed. It said that 43 per cent of hospital juniors continued to be paid an 80 per cent supplement and the average supplement for full-time hospital juniors was 68 per cent. The BMA said it was important to ensure doctors did not ignore general practice in favour of hospital medicine for financial reasons. To this end, it said it was important that the supplement was further increased to 70 per cent to provide appropriate parity. The BMA said that GMP registrars should in fact be better remunerated in the light of the increased levels of responsibility which they faced. It said they were required to practise with a level of autonomy and clinical independence that was not often seen amongst their SHO hospital colleagues, with whom their pay scale was aligned. The BMA asked us to recommend a substantial increase to the level of basic pay for GMP registrars to be more closely aligned with specialist registrars. It said that this would put GMP registrars' salaries on a more appropriate basis for the future and would be better than relying so heavily on a changing supplement to deliver financial parity for recruitment purposes.
- 2.34 In supplementary evidence, the BMA said that although GMPs could opt out of providing out-of-hours services, out of hours was still a core component of GMP registrars' training and the supplement was an important recruitment tool to deliver pay parity with hospital doctors in training. It explained that although there should not be junior doctors in the non-compliant band, a proportion were still in it and so for pay parity purposes, it was important those in the non-compliant band were taken into account.
- 2.35 In conclusion, the BMA said that recruitment into general practice remained a pressing concern and it was essential that everything possible was done to increase the number of trainees going into general practice. It was imperative not only that pay parity with hospital trainees was achieved, but that prospective GMP registrars were not deterred by the perception that general practice was a financially less attractive option. The BMA said it believed that different methods could be used to achieve this aim, especially considering the combined impact of the salary scale and the supplement.
- 2.36 The **Department of Health** said in supplementary evidence that doctors on Foundation programmes under *Modernising Medical Careers* were expected to remain employees of their host trust during their secondment into general practice, and as such provisions already existed to establish their pay supplement by reference to the total hours worked and the duration and frequency of out-of-hours working. It said that it recognised this was not the same principle as used to determine the pay of GMP Registrars where the pay supplement was determined by recruitment and retention pressures rather than intensity of work or responsibilities. The Department said that it would be seeking to address this anomaly properly within the review of terms and conditions of service for GMP Registrars. The Department explained that work was in hand to review the Schedule attached to the Directions to Strategic Health Authorities Concerning GP Registrars. This Schedule set out the principal terms and conditions of service for GP registrars. Some aspects of it had been superceded or were clearly dated and were being reviewed so that the Schedule could better reflect current practice elsewhere in the service. The Department said that preliminary work was being carried out by the BMA; when they had completed this exercise, NHS Employers, working closely with the General Practitioners Committee of the BMA, would determine what further action and change was necessary.

- 2.37 The Department said that the supplement to GMP Registrars was a recruitment and retention incentive, rather than being a recognition of the duties of the post. The Department said that given the average hospital supplement was 68 per cent (March 2004) and that there appeared to be no indication that trainees were being discouraged from applying to train in general practice, it would ask that the supplement for GMP Registrars to be left at 65 per cent.
- 2.38 The Department said that the differences in pay between part-time GMP Registrars and those in hospital posts would be addressed following the ongoing negotiations on part-time pay for hospital trainees. It would form an element of the review of terms and conditions of service for GMP Registrars. The Department also said that the concept of a 'funding shortfall' in Deaneries' budgets was somewhat misleading. The Department said it recognised that shifting demography dictated that more doctors would need to work less than full time for childcare reasons, but it felt that this was as much a service planning issue as one of resources. Equitable pay for full and part-time workers would go a long way to resolving this, the Department said; the rest was in the hands of deaneries and local employers.
- 2.39 Commenting on the BMA's proposal to improve GMP Registrars' salaries, the Department said that there was little evidence that an improved salary (unless it was significantly raised) helped recruitment. What did help, the Department said, was a programme of educational support and mentorship being included in targeted interventions to encourage young GMPs to work in more challenging areas. The Department considered that issues of pay parity between general practice and hospital trainees (and indeed doctors in the non-consultant career grades) would have to be addressed as it looked to implement the reforms to postgraduate medical training through *Modernising Medical Careers (MMC)*. However, decisions had not, and could not, be made until the plans for specialist training were more refined.
- 2.40 In supplementary evidence, the **SEHD** said that it would wish to leave the supplement at its existing level for this year and look at it again next year in the light of continuing GPR and hospital trainee recruitment and retention. If, at that point, there was continuing evidence that recruitment and retention was less of a cause for concern, the SEHD said it would see that as a basis for reducing the supplement.

Comment

- 2.41 *We were interested to hear anecdotal reports during our 2004 visit programme that general practice was proving to be an increasingly attractive career option and so we are pleased to note from the Health Departments' evidence that the number of GMP registrars has indeed continued to grow and that the BMA has welcomed this growth. As the GMP registrar supplement is intended to be a recruitment incentive, then, considered against the background of this continuing growth, we find no case for increasing the supplement in 2005-06. This view is reinforced by the latest available data on the average supplement paid to hospital junior doctors working in compliant posts which shows that as at September 2004, the average supplement paid was 58 per cent. This suggests that if the supplement should be revised, it should in fact be decreased, but **we are content to recommend (recommendation 3), as the Health Departments have requested, that the supplement for GMP registrars should remain at 65 per cent in 2005-06.** We would ask the parties for further evidence on the state of GMP registrar recruitment for our next review. We would also hope that sufficient funding continues to be made available to support training for general practice, in accordance with workforce planning requirements.*

2.42 *The BMA has asked us to align the level of basic pay for GMP registrars more closely with that for SpRs, but, as we said in the Supplement to our Thirty-Second Report, it is not possible for us to make a judgement on whether GMP registrars and SpRs are equivalent in terms of responsibility as we have received no evidence on the relative job weight of either grade. We therefore believe that GMP registrars' basic pay should remain aligned to the SHO payscale for the time being. Proper consideration of the pay relativities between junior doctors who have chosen to specialise in general practice and those choosing a hospital specialty must be a matter for the work which will be taken forward by the parties as part of the implementation of Modernising Medical Careers. We note that it is the Health Departments' intention to address the issue of pay parity between general practice and hospital trainees as they look to implement the reforms to postgraduate medical training through MMC. We would ask the parties to report progress here for our next review. We would also hope that the Health Departments will continue to keep in mind the retention benefits of supporting opportunities for part-time training in both the hospital sector and in general practice.*

GMP trainers

2.43 The **BMA** said that it had held two focus groups of GMP trainers, and that its report¹ of the issues discussed lent further weight to the arguments for increasing the trainers' grant and highlighted the problems of recruitment. Workload was increasing and becoming more demanding and was displacing more and more surgery time. The focus group participants had felt that because of the increased demands on trainers and registrars, the registrar's contribution to the practice was much reduced. It took a long time for registrars to gain the necessary confidence and abilities to take on larger caseloads, especially to that equivalent of a GMP. In order to retain trainer status, GMP trainers typically attended six to eight workshops a year, for which there was no set remuneration, work cover or expenses arrangements. The BMA said that the recruitment of trainers was becoming increasingly urgent. It outlined many deterrents to becoming a trainer: the volume of work; the stricter requirements needed to become a trainer; the upkeep of the practice to maintain the standards of a training practice; and the poor status of being a trainer compared to better rewarded alternatives. It said that trainers wanted better recognition of the demands on them, in particular the practical changes that affected them and their practices.

2.44 The BMA said that trainers felt that the flat rate grant of £6,835 per annum was far too low. Trainers also felt it was unfair to remove all of the grant when a trainee was not in place as they still needed to maintain standards in the practice and keep themselves current with training methods and examination standards. Trainers were content that the demands involved in training should be costed and for the remuneration package to reflect the costs. The level should also take into account the amount of time needed and should compensate for displaced surgery time. The BMA said that the administrative costs of supervising doctors in training equated to £4,500 per practice for the first doctor, and approximately £2,500 per annum for each subsequent doctor. Locum costs were around £16,000 per annum to backfill time for training registrars. The BMA noted that there were alternative opportunities for GMPs to develop special interests which might frequently be better remunerated than being a trainer². It was suggested that GMP trainers might "vote with their feet" in 2005 if their contribution was not explicitly valued at a higher rate. The BMA said that its evidence supported the need for a dramatic increase in the trainers' grant, at least threefold, in order to meet adequately

¹ See Appendix I of the BMA's written evidence.

² In supplementary evidence, the BMA explained that these included those undertaking specialised enhanced services, such as minor surgery, working as a GMP with a Special Interest, and other external work.

the costs to GMP trainers of training GMP registrars and to ensure that recruitment improved as demand increased. It said that such a recommendation from us would be a clear recognition of the need to provide adequate financial support and to encourage more GMPs to become trainers.

- 2.45 The BMA said that it was keen to develop the concept of a training payment which would allow for flexibility, within national guidelines, in terms of the level of remuneration received by trainers according to the responsibilities they had been asked to assume. This might resemble the arrangements for GMP educators in terms of structure and experience. This idea had received unanimous support from trainers, which included a retention bursary to ensure that trainers kept up to date in a fallow period. The BMA suggested that the term "training payment" replaced the term "trainers' grant". It said it would prefer that a payment envelope was made available to encompass the different training scenarios and that a payment to the trainer would be agreed for each doctor under supervision prior to the placement. The BMA said that it was keen to arrange meetings with the Department of Health and the new NHS Employers to discuss further arrangements for the trainers' grant. In supplementary evidence, the BMA said that it wished to take forward discussions with the Department about more appropriate ways of delivering the grant, but it was asking for a recommendation from us that the level of the grant, as currently applied, was uplifted very significantly.
- 2.46 In further supplementary evidence, the BMA said that it had asked the Chairman of the Committee of General Practice Education Directors (COGPED) for his views on the issue of the trainers' grant. The Chairman had said that "Many GP Directors have expressed concern that the GP trainer grant has been too low for too long. COGPED has built a significantly larger training force since the publication of the *NHS Plan*. The latest census (August 2004) showed that there are 3,452 trainers with 2,814 currently 'active' i.e. supervising doctors. This compares with the census in 2001 confirming 2,825 trainers with 2,111 'active'. Thus in three years the trainer base has increased by 22 per cent and active trainers by 33 per cent. The increase in GPR numbers allocated through the Workforce Numbers Advisory Board amount to 178 in England for 2005-06. If all doctors rotate through GP foundation programmes by August 2006 we will need to supervise about 1,700 F2 doctors at any one time (assuming four month rotations). These figures make it patently clear that training capacity must not be compromised if MMC is to deliver.
- 2.47 "The successful development of the new pay scale and job description for GP educators was essential to build morale and increased retention of doctors dedicated to train tomorrow's workforce. However, GP trainers feel left out and undervalued and have many opportunities, now, to earn significantly more income through the n[ew]GMS contract and to subcontract with other service providers. I have been informed by Wessex and Leicestershire and Rutland deaneries that an inadequate uplift in the trainers grant for 2005 will cause trainers to resign. I have been approached frequently in my own trainers' workshops since 2000 with enquiries about when the trainers' grant might be increased and indeed, modernised, to reflect the content and responsibility of the job. Course organisers – who play an essential part in recruiting new trainers – report that many practices will not engage unless the training payment is uplifted to compensate the absence of experienced partners and assistants from service delivery. I feel that it is a great shame that this very large section of the GP workforce consider themselves to be undervalued by the Department of Health yet still enjoy excellent relationships with the deaneries."

2.48 In conclusion, the BMA said that it had been concerned at the diminishing adequacy of the trainer's grant. As the pattern of training changed, as the costs of being a trainer increased, as there was an increasing need to recruit more registrars, as more financially attractive options presented themselves to GMPs, and as new initiatives such as MMC meant more trainees spending time in general practice, the BMA said that it was now extremely urgent that the trainer's grant was very significantly increased in order to ensure current trainers were retained and new trainers were recruited. The BMA said that the importance and urgency of tackling this could not be over-stressed and had the full support of the COGPED.

2.49 In supplementary evidence, the **Department of Health** said that as it was not qualified to comment on what time commitment deaneries were specifying for GMP trainers, it had sought advice from a leading Director of General Practice Education who had said:

"The Joint Committee on Postgraduate Training for General Practice (JCPTGP) expects no less than four hours of protected time teaching GMRs per week. This is a minimum and in fact most deaneries expect more (ours is 5 hours). In addition there needs to be preparation time for tutorials, admin and especially time for assessment and regular completion of the trainers report, teaching logs, etc. The BMA quote is not an exaggeration....All trainers are expected to:

- a) attend and contribute to trainer workshops (most deaneries expect at least 6 hours per year with a desirable commitment of 12+ hours)
- b) keep active CPD by attending courses, updates etc...(minimum 8 hours/year with desirable 16 hours+/year).

Thus a minimum level ("a + b") would be a total of 14 hours/year with most achieving the desirable level of 28 hours (7 full sessions)."

2.50 The Department commented that the implementation of *Modernising Medical Careers* was likely to result in increased demand for GMP trainers, but the extent of that demand could not be accurately assessed as yet and would not necessarily be of the magnitude suggested by the BMA. Commenting on the BMA's statement that trainers felt it was unfair to remove all of the grant when a trainee was not in place, the Department said that it was aware of the discussions with the COGPED about a more flexible payment range and it was considering a way forward. The Department said it would engage with the BMA on this matter, but it did not believe that it would be appropriate to pre-empt this with any uplift in the flat rate GP trainer grant at this stage.

Comment

2.51 *In our last report, we urged the Department of Health not to delay its consideration of the remuneration of GMP trainers as we considered the recruitment and retention of these trainers to be of continuing importance, given the Government's primary care agenda. This very much remains our view and we are concerned that the Health Departments should now make speedy progress in taking forward discussions with the BMA and with COGPED on how the remuneration for GMP trainers should be more appropriately structured. We are very concerned that slow progress here will indeed deter potential recruits and may lead to some of the current corps of trainers abandoning this work in favour of pursuing the other more attractive opportunities which are available under the new GMS contract, such as GMP appraisal. It seems clear from the parties' evidence that the demand for trainers will increase with the changes being introduced under MMC, even though the parties do not agree on the scale of the additional demands. Retention of the current corps of trainers to meet that*

increased demand therefore seems the foundation on which the Health Departments must build capacity and we would strongly urge the Health Departments not to allow a crisis of recruitment or retention to develop because of a lack of progress in agreeing appropriate remuneration for this work. We hope the parties can make good progress here in the coming months and can report agreement for our next review.

- 2.52 *We have considered carefully the BMA's request that the current trainer's grant should be increased threefold, but we have received insufficient evidence to allow us to make a definitive judgement about the appropriate level of remuneration for the trainer's grant. We also consider that we cannot make any significant changes to the level of remuneration for work which may vary considerably in the near future with the introduction of MMC. The parties must discuss and agree the way forward on this, as we have already said.*
- 2.53 *However, the parties' evidence has highlighted for us a need to consider the continuing professional development (CPD) demands which are being made of GMP trainers. We have also noted the lack of any payment for trainers who find themselves without an allocated trainee, but for whom there is an expectation that they will continue to undertake various CPD activities. As we are very concerned to support the retention of GMP trainers while the parties take forward their discussions about a more appropriate remuneration structure, **we therefore recommend (recommendation 4) that all approved GMP trainers should receive a separate payment towards their CPD costs of £750 per annum, in recognition of the value of a GMP trainer's work and the costs incurred in maintaining that status. This sum should continue to be paid to the trainer for one year even if no trainee is allocated to the trainer. In addition, we recommend (recommendation 5) that the GMP trainer's grant is uplifted by 3.225 per cent for 2005-06.***

GMP educators

- 2.54 The BMA told us that in February 2004, it had negotiated new pay scales with the Department of Health for GMP educators, backdated to October 2003. It said the intention was that the pay scales would be reviewed annually to ensure parity with GMPs as they embarked on the new GMS contract. The BMA said it was disappointed to bring to our attention the fact that the Department had yet to respond to the need for an uplift from 1 April 2004 and an annual review mechanism for the GMP educators' pay scales.
- 2.55 In supplementary evidence, the **Department of Health** said that it noted the BMA's comments and it would be contacting the BMA to discuss a way forward. The Department also provided us with a summary of the GP educators' pay scale negotiated with the GPC and COGPED in February 2004. It said that GP educators were defined as:
- Course Organisers – responsible for the organisation of vocational training within an area;
 - GP Tutors – responsible for the organisation of continuing professional development for established GMPs in an area; and
 - Associate GP Directors – responsible for supporting the GP Director in the delivery of deanery-wide training functions.

Comment

2.56 *We are pleased to note that the Department of Health intend to discuss this matter with the BMA and we hope the parties can quickly reach an agreement. We would ask them to report progress for our next review.*

GMPs working in community hospitals

2.57 The **BMA** said that the current pay of GMPs working in community hospitals did not reflect their workload, skills, commitment, clinical responsibility and the clinical leadership they brought to the job. This had resulted in depressingly low morale and was leading to a recruitment and retention crisis. It provided the results of a recent survey³ which showed that many doctors felt that community hospital work was an area that had been badly neglected, and that their work had been under-resourced. Doctors felt undervalued in the face of increasing demands from PCOs and Trusts and of improved earning opportunities both within and outside their practices. The survey also showed that they were working long hours and that the work was disruptive to practice commitments and personal life. The BMA said the work was clearly onerous and required a significant commitment from the doctors. The survey had also found that neither the nature of the work and its intensity, nor the skill level and responsibility were reflected in the remuneration package. The survey noted that some doctors had management responsibilities, clinical governance duties or teaching duties, and were often not remunerated for these tasks.

2.58 The BMA said that evidence was starting to mount that GMPs were walking away from providing out-of-hours services in community hospitals if the rewards were not sufficient, given that they would soon no longer be obliged to provide out-of-hours primary medical services through their GMS or PMS contracts. It said that it was also likely that some would cease all services to the community hospital due to the inadequate remuneration, particularly compared to the new earning opportunities in the GMS and PMS contracts. The BMA said that to prevent a recruitment and retention crisis occurring to both in-hours and out-of-hours services, the remuneration of community hospital doctors needed to be uplifted as a matter of urgency, and it called on us to help.

2.59 The BMA said that the prospect of UK-wide negotiations for these doctors had stalled. It said that the Department of Health wished to consider community hospital doctors as part of the Staff and Associate Specialist doctors' negotiations. However, it said the NHS Confederation would prefer to decouple the negotiations for these two groups as it recognised that there were significant differences between them and that there was an urgent need to resolve the community hospital GMP issues. In Wales, it said that negotiations had commenced and initially looked promising, but these too had stalled with no national agreement in sight. In Scotland, it said talks had recently begun. In conclusion, the BMA said again that in advance of formal negotiations to review the pay and career structure for this important group of doctors, a recommendation from us for a significant uplift for 2005-06 would help to prevent a recruitment and retention crisis occurring in the short term.

2.60 The **National Assembly for Wales** said that a national framework of principles to assist local negotiations for GMPs working in community hospitals had been issued to Trusts. It set out a series of criteria against which future services in community hospitals were to be provided and remunerated.

³ See Appendix II of the BMA's written evidence.

- 2.61 The **SEHD** said that a national review of the role of community hospitals was underway. It also said that discussions with the BMA were underway, with the aim of developing a national framework for contractual arrangements for GMPs working in community hospitals which should be sufficiently flexible to recognise local variations. The aim was to produce an initial framework by April 2005. In supplementary evidence, the SEHD said that the current discussions were focussed on developing a set of principles around which a contractual framework could be built. These principles would have to be agreed before discussions moved onto a more detailed level. The intention was that more detailed discussions would address GP recruitment and remuneration, but no prior decisions had been taken as to whether national agreements on remuneration would be advisable.
- 2.62 In announcing, on 6 January 2005, the Minister of Health's decision to mandate NHS Employers to negotiate new contractual arrangements for staff and associate specialists/non-consultant career grades, the **Department of Health** said in its press release that the decision had come after a report by the NHS Confederation which has also recommended that:
- non-GMP qualified clinical assistants and hospital practitioners should be brought into the new contractual arrangements to be negotiated for staff grades and associate specialists; and
 - that the issues (including their remuneration) relating to GMPs undertaking work in hospitals and community hospitals were matters for local negotiation.
- 2.63 The **NHS Confederation's** report to Ministers said that its recommendations on GMPs undertaking work in hospitals and community hospitals would need to be discussed with the BMA with a view to reaching agreement about the way forward.

Comment

- 2.64 *We have commented consistently in recent reports on the need for a survey into the quantum and complexity of the work performed by GMPs working as clinical assistants in community hospitals, and that until such a survey was completed, we had no basis on which to make recommendations about the level of remuneration for this work. We are grateful to the BMA for its efforts to address our information needs, but we have been provided with no evidence by the Health Departments and so have no agreed basis from which to make a judgement. However, now the issue has moved on with the recommendation in the NHS Confederation's recent report to Ministers that issues relating to GMPs undertaking work in hospitals and community hospitals should be matters for local negotiation. We would ask the parties to tell us for the next round whether we therefore still need to make any recommendations for these GMPs. Meanwhile, **we recommend (recommendation 6) that the remuneration rates for GMPs working in community hospitals, and for GMPs working in acute trusts should be increased in accordance with the general uplift for GMPs in 2005-06 of 3.225 per cent.***
- 2.65 *As it appears that there will in future be local negotiation of the remuneration for GMPs working in community hospitals, we have two concerns. First, the remuneration arrangements for these GMPs is complex and need updating, but we would hope that a sensible framework can be agreed by the parties within which negotiations can then be conducted locally by PCOs and GMPs. Second, we are very concerned that PCOs should not be expected to bear additional costs without additional funding, a concern which the NHS Confederation obviously shares as it said in its report to Ministers that "It can not be acceptable to have considerably greater expectations of NHS organisations without resourcing them appropriately." It seems to us important for the whole of the NHS that community hospitals have an integrated role within the NHS, particularly in rural areas.*

If PCOs decide that GMPs are needed to support these hospitals, but the cost of their services increases as a result of the new GMS contract, PCOs should not be expected to bear the resulting financial brunt. We therefore recommend (recommendation 7) that Ministers give careful consideration to the case for providing appropriate additional funding for PCOs to meet any increased costs for medical staffing cover for community hospitals.

Academic GMPs

- 2.66 The BMA said that as with other groups of academic staff, academic GMPs holding a substantive university contract were outwith our remit, but it believed that clinical academic practice was increasingly influenced by the conditions prevalent in the NHS. It said that any changes in the clinical academic workforce as a result of recruitment and retention difficulties would impact in some way on the expectations and workload of the NHS medical workforce, and so, the BMA suggested, consideration of the situation of academic GMPs was relevant to our deliberations. The BMA said that it had been custom and practice for senior academic GMPs to be offered a salary equivalent to their clinical academic consultant colleagues. However, with the introduction of the 2003 clinical academic consultant contract and the new GMS contract, senior clinical academic GMPs had been left outside both the new contracting arrangements. The BMA said that there was a danger that academic general practice would be widely perceived as an unattractive career option, and was concerned that a lack of resources for appropriate contracts would compromise the advances being made in respect of career pathways for academic primary care under *Modernising Medical Careers*. The BMA said that discussions were underway with the university employers on new model documentation appropriate for senior academic GMPs. It was likely that a contract equivalent to that available to clinical academic consultants would be offered to Higher Education Institutions for use in respect of this group. However, the BMA said that the government had yet to take responsibility for resourcing a new contract for this group. The funding required was likely to be in the region of £2 million. The BMA said that it was collecting data on the specific sums required for a UK-wide implementation and would be liaising with the Health Departments. The BMA invited our comments.
- 2.67 The BMA said that in 2004, salaried academic GMPs for the first time became eligible for NHS Clinical Excellence Awards (CEAs). It said it was concerned over local awards, both in terms of the mechanisms for consideration of a local award, and the funding of an award once granted. The BMA said that it hoped we would agree the importance of maintaining confidence in the CEA scheme and asked for our support of clarity in the applications and award process. In determining the number of national awards to be made under the CEA scheme in 2005, the BMA asked us to take account of the fact that larger than usual numbers of academic GMPs would meet or exceed the criteria for higher level national awards, given that they had not previously had access to a merit award scheme. In order to ensure that the scheme did not overlook high levels of excellence amongst this cohort, the BMA asked us to recommend a higher number of national awards than we would do normally.
- 2.68 In supplementary evidence, the **Department of Health** said that academic contracts were the responsibility of their employers, the higher education sector. It was true that academic GMPs were not covered by the academic consultant contract or the new GMS contract. The Department said that, as the BMA evidence stated, it understood that the Universities and Colleges Employers Association (UCEA) were considering a new model contract for senior academic GMPs. Universities could use whatever model they wished to pay academic GMPs and it would be for UCEA to lead any discussion on contractual

arrangements. However, the Department said that the money available for the translation of the new consultant contract for consultant clinical academics was never intended to be used to increase the salary of academic GMPs. The responsibility for funding academic GMPs' pay lay with the higher education sector. The Department said that it was for UCEA to agree GMP academic pay and for individual universities to pay them as they wished.

Comment

- 2.69 *As the BMA notes, this group lies outside our remit. We would only comment that if the remuneration arrangements for academic GMPs begin to have an adverse effect on their recruitment and retention which in turn begins to have an adverse effect on the ability of the NHS to train the next generation of doctors, we would of course be concerned and we would expect the Health Departments to be similarly concerned. We therefore hope that the Health Departments will monitor developments as UCEA takes forward its consideration of a new model contract for senior academic GMPs. We would also encourage the Departments to discuss with the Department for Education and Skills the need to recruit and retain sufficient numbers of academic GMPs to enable the NHS to meet its training requirements in the future.*
- 2.70 *We comment on the BMA's evidence on CEAs for academic GMPs in Chapter 7 of the report.*

Personal Medical Services GMPs

- 2.71 The **BMA** said that it was continuing to monitor the prospect of different payment arrangements between GMS and PMS for practices participating in the QOF, although it was too early to say what, if any major differences were emerging. Of greater concern this year was the disparate way in which PMS practices had been treated in relation to their funding. One of the main issues had been the attempt by PCTs in England to reclaim some of the growth monies that were available previously for PMS practices when PCTs were keen to expand the PMS option. The BMA said this merely proved to GMPs the more cynical purpose for which growth monies were originally available to PMS practices only, and did little to inspire confidence in resourcing that was genuinely focused on patients' needs and the resources GMPs needed to provide health care.
- 2.72 The second main issue concerned funding to cover additional costs. The BMA said that when additional money had been made available for GMS and PMS practices nationally, this had been distributed to PCTs as part of their PMS baseline allocations. Little or no guidance was then provided for how this money was to be transferred to PMS practices. The BMA gave examples of this happening with seniority payments and with additional funding to cover the increase in employer superannuation costs. The BMA said that many PCTs had failed to pass on the additional funding to practices and this was unacceptable.
- 2.73 In conclusion, the BMA said that it was increasingly frustrated at the needless difficulties caused by lack of appropriate guidance and direction to PCOs with regard to funding for PMS practices. In relation to local contractual matters, the BMA said that it was appropriate that such difficulties were resolved locally. But with regard to funding for national entitlements, for example employer superannuation costs for members of the NHS Pension Scheme, the BMA said that it was inexcusable that PCOs were allowed, inadvertently or willingly, to fail in their obligation to pass on that funding, negotiated nationally, to PMS practices.

- 2.74 Responding to the BMA's points, the **Department of Health** said that PMS practices did have the ability, with the agreement of their PCT, to adjust the national QOF to make it more suitable for their local circumstances. This had been done, for example, for practices with a high population of asylum seekers. The Department said it was pleased that some practices and PCTs had taken up the freedoms inherent in PMS and agreed local QOFs. It said it hoped that more would do so in future. The Department said it believed this would reward equal effort by practices with very different populations and prevent practices with atypical populations from losing out under the QOF. The Department said that any local QOFs must be agreed by the local Director of Public Health as being equivalent to the national QOF.
- 2.75 Responding to the BMA's evidence about some PCTs attempting to reclaim growth monies, the Department said that at the time changes to PMS were introduced in April 2004, existing local contracts already included certain quality payments in the baseline. In order that practices were not paid twice for providing the same service, i.e. through the baseline and through QOF payments, a deduction in QOF points was made, equivalent to the resources in the baseline. The Department said it had made it clear to PCTs that any quality money included in the baseline over and above that equivalent to the points value to be offset should be used for quality improvements that went beyond those in the QOF. It was therefore right, the Department said, that PCTs should identify what quality payments in the baseline figure were now covered by the QOF, agree this with practices and agree the amount payable for quality above this figure, and agree what extra quality improvements the practice would provide for this money.
- 2.76 Responding to the BMA's evidence about funding to cover additional costs, the Department said that it was not aware that PCTs were failing to pass on additional funding to PMS practices. However, as the transfer of money was subject to local negotiation and was therefore a contractual matter between the PCT and the practice, the Department said it would be inappropriate for it to get involved in this matter. It said it could however confirm that all appropriate funding had been transferred to PCTs.

Comment

- 2.77 *We note what the parties have told us regarding GMPs working under PMS arrangements. We would expect the funding arrangements for both GMS and PMS practices to be equitable, both to the practices and to the tax payer, even if funding is delivered in different ways, and would expect the parties to be able to resolve any concerns quickly. We would ask the parties for further evidence on any PMS issues for the next round.*

Sessional fees for doctors in the community health service and fees for work under the collaborative arrangements between health and local authorities

- 2.78 The **BMA** said that in previous years it had highlighted that the low level of payment for sessional work in the community health service had made it increasingly difficult for the agencies involved to secure doctors' services, and this year was no exception. It said it had received reports from the British Association for Adoption and Fostering that the level of payment was seriously discouraging medical participation. The BMA said that such problems would only be exacerbated as GMPs would be incentivised to undertake other work that was more financially rewarding, such as for their local out-of-hours provider. The BMA noted that last year we had stated that "the work for which these fees relate covers a range of Departmental issues and it seems right for each individual Department or Agency to review the matter with the BMA." However, the BMA said that despite efforts to initiate discussions, Departments had been reluctant to enter negotiations. The BMA asked us to recommend that these fees for GMPs should in future be based on the BMA "Treasury" rate for the work for central government departments and agencies.

- 2.79 For other fees, which were not within our remit, the BMA said it had been seeking to agree increases in line with the interim dynamising factors for 2003-04 and 2004-05. It said that, as yet, an interim figure for 2005-06 had not been estimated, but nevertheless said it would welcome a recommendation from us to uplift sessional fees for 2005-06 in line with the interim dynamising factor for that year. The BMA also said that new Department of Health guidance in respect of looked-after children had meant that clinical requirements and information requirements for adoption and fostering had increased. The BMA said it would welcome our support for the new health assessment forms issued by the British Association for Adoption and Fostering in September 2004 to be included within the collaborative arrangements.
- 2.80 In supplementary evidence, the **Department of Health** said that this was a matter between the BMA and other Government departments and it would not be appropriate for the Department to comment. As individual Departments were responsible for negotiating their own fees with the BMA, the Department said that the BMA "Treasury" rate had no basis.

Comment

- 2.81 *We are dismayed at the Department of Health's position on this issue. Having told us in its evidence for our Thirty-First Report that it was working with the BMA on an enquiry into sessional fees for doctors in the community health service and fees for work under the collaborative arrangements, and that it was hoped they would be able to present agreed proposals for our subsequent review, it now appears unwilling even to encourage other departments to enter into discussions with the BMA. We are aware from the Department's evidence for our previous two reviews that it saw the solution for consultants carrying out work under the collaborative arrangements lying in including such work within consultants' job plans. However, that does not address the BMA's ongoing concerns about other doctors involved in this work or the sessional fees payable to doctors working in the community health service. The BMA argued for our last two reviews that its so-called 'Treasury' rate should be the basis for these fees and we were not persuaded of this because we had received no evidence on which to make a judgement about the wide-ranging work carried out under these two headings.*
- 2.82 *Although we expected the BMA to initiate discussions about reviewing these fees with the relevant Government Departments and Agencies, we would like to make clear that we also expect the Department to support and encourage these discussions, particularly as the Department had intended in 2001 to carry out a review of these fees itself jointly with the BMA. We consider that it has some continuing responsibility for facilitating proper consideration of these fees by the BMA and the relevant Government organisation. We would therefore urge the Department of Health to get these discussions underway. We would ask the parties to report progress for our next review.*
- 2.83 *In the meantime, we must continue to recommend an uplift and **we therefore recommend (recommendation 8) that these fees are increased by 3.225 per cent for 2005-06.***

CHAPTER 3: GENERAL DENTAL PRACTITIONERS

Introduction

- 3.1 *Progress towards the new arrangements for NHS dentistry has provided the backdrop for our review this year. A major announcement was made last Summer, which included additional new investment for dentistry, plans to recruit extra dentists by October 2005 and to expand the number of undergraduate training places supported by additional capital and revenue funding. The National Audit Office report¹, published in November, drew attention to the fact that the move to local commissioning in England was a major change for NHS dentistry and was not without risks, and since then plans to implement in full the new contract in England and Wales from October 2005 have been put back to April 2006 to allow a longer lead-in time for dentists and Primary Care Trusts (PCTs). The year to which our recommendations apply (2005-06) will therefore be a transitional year before the new arrangements are expected to come into effect. In making our recommendations for this round, we have focused on the need to facilitate the move to the new system and the need to support dentists currently working within the NHS.*
- 3.2 *The parties' evidence was presented against a background of limited progress being made with the new arrangements and a number of issues were raised by the dental profession for our consideration, including the size of the workforce, dental expense inflation, pay comparability, capital support and return on capital and the introduction of a practice cost allowance. We consider these various issues below, after the summaries of the parties' evidence.*

The recommendations in the Thirty-Third Report

- 3.3 The **Department of Health** said that it had introduced a new Statement of Dental Remuneration from 1 May 2004 to implement the increase of 2.9 per cent in item-of-service fees, capitation payments and commitment payments recommended by us in our Thirty-Third Report. It had also accepted our recommendation that additional funding should be made available and targeted locally as part of a structured change management programme to prepare dentists and their staff for the change to local commissioning, for which £9 million had been announced on 16 July 2004.

Progress towards the new arrangements for NHS dentistry

- 3.4 The **Department of Health** said that it had been working with the British Dental Association (BDA) to develop a base contract to underpin the move to local commissioning of dentistry and to provide certainty and security to dentists. It said that in January 2004, the Chief Dental Officer had written to dentists to set out the Underpinning Principles of the new contractual arrangements, which provided guarantees in respect of:
- the right to a base contract for all dentists in contract with a PCT immediately before the change;
 - gross turnover protection for a three year transition period (2005-2008) in return for a similar level of NHS commitment;
 - the ability for dentists to manage their own workload, and to offer a more preventative approach to patient care and to be able to move off the so called item-of-service treadmill; and

¹ *Reforming NHS Dentistry: Ensuring Effective Management of Risks*, House of Commons Paper Number 25, 2004-05, National Audit Office, November 2004.

- out-of-hours services ceasing to be the dentist's responsibility and instead becoming the responsibility of PCTs.
- 3.5 The Department said that it had published *Framework proposals for primary dental care services in England from 2005* for consultation in February 2004. The Department said the BDA, the Dental Practitioners' Association (DPA), British Orthodontic Society, British Association for the Study of Community Dentistry and the Faculty of General Dental Practitioners were consulted on the framework proposals document and there was unanimous support for the direction of travel and the proposal to move away from the item-of-service remuneration system. It said that there was concern, however, that time was short for a 1 April 2005 start and that PCTs might not have the capacity to manage this.
- 3.6 The Department said its response was announced in a statement to Parliament on 16 July 2004. The Secretary of State for Health announced:
- that the new arrangements would come in from October 2005, allowing six more months to prepare for the change;
 - the equivalent of an additional 1,000 whole time dentists by October 2005 through securing extra NHS capacity from existing dentists, attracting dentists back from career breaks and through flexible working, plus international recruitment;
 - 170 extra undergraduate training places in England from October 2005 – a 25 per cent increase – supported by capital investment of up to £80 million over four years starting from 2005-06 and additional revenue funding rising to £29 million a year by 2010-11;
 - additional new investment of £250 million by 2005-06 compared to 2003-04, an increase of 19.3 per cent, to provide for reasonable pay awards and significant service growth. The Department said this would take Government investment in dentistry up from £1.3 billion in 2003-04 to £1.6 billion in 2005-06;
 - the financial resources for dentistry would be devolved to PCTs from October 2005; and
 - the issuing of proposed 2005 contract values for dentists would be based on their most recent gross earnings.
- 3.7 The Department said the statement also made clear that arrangements for moving into Personal Dental Services (PDS) would be streamlined so that dentists who wished to move to the new arrangements in advance of October 2005 could do so speedily with a turnaround time of 12 weeks from application to approval.
- 3.8 The Department said that for dentists who had not already moved to alternative local contractual arrangements, the base contract (based on the PDS model) would be introduced for all practices on 1 October 2005. The contract currency, i.e. what was measured under the contract, would be courses of treatment weighted to reflect the complexity of treatment provided. Based on PDS experience, the total number of courses of treatment would be fewer than under general dental services (GDS) arrangements, freeing up capacity in the practice. At the time of submitting its written evidence in October 2004, the Department said it was having discussions with the BDA on how this additional capacity could be shared fairly between dentists and the NHS so

that dentists could spend more time with their patients and better manage their clinical work. It said the remaining issues under discussion included weighting of the contract currency and performance monitoring arrangements. As soon as those issues were resolved, the Department said that the base contract details would be published.

- 3.9 The **National Assembly for Wales** said that in May 2004 the Minister had announced proposals for a major reform of dental services and the introduction of new contractual arrangements for dentists providing NHS care, which included £5.3 million over the next three years to improve access to NHS dentistry and support implementation of the new contract and associated reforms. It said the announcement included a 17 per cent increase in dental training places in Wales, and details of how the first £1.5 million tranche of the £5.3 million would be allocated.
- 3.10 The Assembly said it was agreed that it would follow the same timetable for implementation as in England.
- 3.11 The **Scottish Executive Health Department (SEHD)** said it had completed its consultation on *Modernising NHS Dental Services in Scotland* on 2 April 2004. It said it expected to respond with policy proposals in the Autumn.
- 3.12 The **BDA** said that over the last 18 months it had met regularly with the Department of Health to discuss the programme for reform of NHS dentistry. In early 2004, the BDA had undertaken a consultation exercise with the profession on the Department's *Framework proposals for primary dental services in England from 2005* and in response to the feedback from its consultation, the implementation date for the reform of NHS dentistry had been delayed by six months.
- 3.13 The BDA said that while it welcomed the funding package announced by the Secretary of State in July 2004 and considered it a positive first step, it was keen to ensure that the additional funding went to the 'frontline' of patient care, and not on administration at the PCT level. It said that the pay award recommendations, made by us for this round, would be coming from the funding allocation announced in July. It estimated that more than half of the funding had been allocated for practitioners that were not yet part of the GDS workforce. This sent a strong signal to the current GDS workforce that historical commitment to the NHS was not appreciated or acknowledged by the Government. The BDA said it had estimated that from the additional funding of £250 million, the real growth in funding was £30 million, assuming expanding the workforce cost £140 million and the annual uplifts accounted for £80 million. It also said that the funding package offered no return on capital employed, or reward for the additional administrative burden facing practice owners to address ever increasing legislative requirements.
- 3.14 In supplementary evidence, the BDA said it was surprised to learn that the Department considered that 'freed up' capacity under the new system and the reduction in practice administration associated with a simplification of the payment system would address the ever growing administrative burden on practitioners. It said that in its discussions with the Department, it had been led to believe that 'freed up' capacity was to be used for treating new patients, to offer more preventative advice and information to patients, to devote more time to practice management, to maintain and improve clinical governance, to pursue additional continuous professional development, and to generally improve the quality of practitioners' working lives. The BDA said it was difficult to see how all these issues could be addressed simultaneously through 'freed up' capacity.

- 3.15 In supplementary evidence, the **Department of Health** commented that at an average cost of £140,000 per dentist, the BDA's estimate of the cost of expanding the workforce seemed more representative of the possible gross cost, rather than the net cost after taking account of charge income from the additional patients treated. It said it was not clear what assumptions the BDA had used to calculate the cost of pay uplifts and that by excluding the cost of workforce expansion and pay uplifts, the BDA had chosen a surprisingly narrow and contentious definition of "real growth funding". It added that dentists who were already working in the GDS would have the opportunity to benefit from the new investment by taking part in local service developments by increasing their commitment to the NHS.
- 3.16 The **BDA** said in its discussions with the Department, there remained some unresolved key issues including valuing NHS commitment, expectations on workload changes and dealing with new patients. It said the fact that the new charges regime had not yet been announced, even though the recommendations were submitted to Ministers on 31 March 2004, had already undermined the profession's confidence in the Department and the Government. It said the Department's claim of an expected work reduction of five per cent would do little truly to free the dentists from the treadmill.
- 3.17 In supplementary evidence, the **Department of Health** said Ministers were considering the Cayton report on the charging regime. Any new system would be simpler to understand and administer and more transparent, and there would be a guarantee that practices would not bear any financial risk from any possible fluctuations in charge revenue.
- 3.18 In Wales, the **BDA** said that to date, none of the extra funding of £5.3 million, announced by the Welsh Health Minister, had yet come down to practices. It said dental practitioners in Wales were also concerned that they had not had the opportunity to develop NHS practice through PDS as no field sites in general practice had been set up in Wales.
- 3.19 In supplementary evidence, the **National Assembly for Wales** said that in recent months there had been renewed interest in PDS schemes from individual dentists, practices and Local Health Boards (LHBs). The Welsh Assembly had asked those practitioners who wished to consider transferring to PDS to express an interest with their LHB. It said that Assembly officials together with a team from the Dental Practice Board (DPB) had been meeting with LHBs to provide a background on how PDS schemes operated. It said it was in the process of arranging similar meetings with dentists and other interested parties and it was likely that there would be a number of new PDS schemes in Wales within the next few months.
- 3.20 In its evidence, the **DPA** said that some of the extra £250 million funding did not come from the Government, but came from patients in the form of dental charges and that it also included any increase recommended by us and the money required to pay for the 1,000 new dentists. It claimed that this left £60 million among 330 PCTs, assuming that our recommendation accounted for approximately £40 million (equivalent to a three per cent increase in fees) and the 1,000 extra dentists accounted for a further £150 million. Responding in supplementary evidence, the **Department of Health** said that the £250 million did not include any contribution from patient charges, which it said would be "on top" of the £250 million, but that the £250 million would support service development, improve access and increase the workforce equivalent to 1,000 dentists.

- 3.21 The **DPA** questioned the flexibility that would be provided with PCTs commissioning dentistry services. It said currently a practice that was experiencing high demand could take on an extra dentist and a new service could be commissioned as and when it was required. It said the new system would be much less responsive to local variations with a greater lead time before the PCT granted a contract extension. Responding in supplementary evidence, the **Department of Health** said that the DPA's comments were not borne out by experience in other areas of local contracting. It said that payments to dentists would continue to be handled by the DPB or its successor body.
- 3.22 The **DPA** argued that although it agreed with the Department's aim to break the link between workload and earnings, it was not clear how this might be achieved. Output, however it was measured under the new arrangements, would remain high while dentists were in competition with each other for contracts. The DPA said it was concerned about the lack of clarity regarding the indicators on which the Department would rely when assessing the success or failure of the new contract.
- 3.23 The DPA commented that under the new arrangements, dentists would be expected to complete around 95 per cent of the courses of the treatment that they carried out in the base year. In return, dentists would be expected to see five per cent more patients. It said this would somewhat alleviate dental access problems, but a newly-registered patient would find that a "weighted course of treatment" would contain less and would occur less often.
- 3.24 In supplementary evidence, the **Department of Health** said that details of the weightings to be used were still very much work in hand with the BDA. It said it was intended that the weightings would be derived from the data submitted to the DPB and its successor body, for the purpose of verification of patient charges.
- 3.25 In November, the **National Audit Office** published its report into the Government's plans for reforming NHS dentistry, *Reforming NHS Dentistry: Ensuring Effective Management of Risks*. The Report highlighted a number of concerns, such as PCTs' lack of experience with dentistry and risks relating to capacity, and the size of the workforce that would realistically be needed for NHS dentistry.
- 3.26 In supplementary evidence, the **BDA** provided a copy of a letter it had sent to the Department of Health in December 2004 suspending further talks on the new base contract. It said that it had engaged with the Department in order to try and establish a base contract which was attractive to dentists in that it allowed them to spend more time with patients, to adopt a more quality-driven and preventative approach to their oral health and improve the working lives of the dental team. However, it said that the base contract that the Department now wished to offer the profession contained many elements that diametrically opposed the advice it had given, and was at complete variance with the 'principles' previously discussed.
- 3.27 In a written ministerial statement made in January 2005 by the Secretary of State for the **Department of Health**, he said that he now believed more time was needed to ensure a complete system reform, and that he had therefore decided that full implementation of the new contract would now take place by April 2006. He said that a longer lead-in time would allow many more dentists to move to new ways of working, would enable public consultation on key aspects and the Parliamentary process to be fully observed, and would allow PCTs to prepare for their new roles. He also confirmed the Department's intention to publish for consultation the new regulations for local commissioning and dental charging in the summer of 2005.

Comment

- 3.28 *We said in our last report that we agreed that reform of the current system for general dental services must be the way forward and that is still our view. It has been our concern that NHS dentistry should be properly funded and we are pleased to note that there will be additional funding from 2005-06 to facilitate the new arrangements, provide for pay awards and support service growth. Whether it will be sufficient both to improve access and to encourage GDPs to return to the NHS remains to be seen, bearing in mind the difference in the potential earnings from NHS and private work. We would welcome more details for our next review on how the extra funding is actually being allocated.*
- 3.29 *We are also pleased that the Department of Health has provided £9 million for a structured change management programme, following our recommendation last year that funding be provided to prepare dentists and their staff for the change. We would ask the Department to provide an update for the next review on how this funding is being used.*
- 3.30 *This year we have noted that discussions between the parties over the new contract's value and how it will operate in terms of the work required have been difficult. Given the continued drift of GDPs away from NHS dentistry, these two important aspects of the reform must be got right, so that benefits are realised for the dental service and dentists. We are concerned about the effect that disagreement between the two sides is likely to have on dentists' morale and motivation, and dentists' decision on whether to stay in the NHS. We hope that the parties can resolve these issues and that practitioners can be reassured that the new arrangements will improve their working lives within the NHS.*
- 3.31 *However, as 2005-06 will be a transitional year in which GDPs continue to work under arrangements which everyone has agreed must be reformed, we are concerned that the NHS should strive to retain the level of service of as many GDPs as possible so that the new arrangements can build on a stable base. We have taken this consideration into account in making our recommendations.*

Recruitment, retention and morale

- 3.32 The **Department of Health** said that it had acknowledged in its evidence in previous years that although the number of dentists in the GDS had been growing each year, there had continued to be a drop in their overall NHS commitment. It said that under the current arrangements, dentists could switch from NHS to private work with relative ease and very little notice to the NHS. It said that private practice had been an attractive option for dentists and one with which the NHS found it difficult to compete.
- 3.33 The Department said that it had previously reported on a number of initiatives taken by Government to try to address this decline and, while many had shown some return, it had been clear that the current remuneration system had been a major factor in the decline in dentists' NHS commitment. The Department said that with the unprecedented increase in funding for dentistry, the planned change to local commissioning and abolition of the item-of-service fees, Government had acted to address all of the concerns raised about NHS dentistry by the profession, and to make the NHS an attractive option for dentists.
- 3.34 The Department said the Government statement of 16 July 2004 included a substantial programme of action to increase dental workforce capacity. It said the 2002 Dental Workforce Review, published on 23 July 2004, had sought to identify the dental workforce (dentists and professionals complementary to dentistry) required to deliver future services within the NHS and the private sector.

- 3.35 The Department said that recent developments since the modelling for the dental workforce review was done suggested that the review had overestimated the undersupply of dentists. The Secretary of State for Health had announced plans in July 2004 to recruit the equivalent of 1,000 more dentists and fund 170 extra training places for dental undergraduates – a 25 per cent increase on current student intakes. It said that this represented a substantial increase in the dental workforce.
- 3.36 The Department said that interest in PDS had grown significantly since January 2004. At the end of August 2004 there were 156 practices working under PDS and the Department knew of more than 800 practices that were in discussion with their local PCTs about PDS arrangements. It said that PDS arrangements were proving popular with all types of practices and some PCTs had already worked with local dentists to move most or all practices into PDS. In supplementary evidence, the Department said that given expressions of interest to PCTs, it expected 25 per cent of practices to move to PDS by April 2005.
- 3.37 The Department said that the *Options for Change* programme was now working with around 243 practices across England covering 72 PCTs. It said that whilst learning from the remuneration field sites was still at an early stage, common outcomes across sites showed an increase in time spent with patients; improved working lives; a decrease in laboratory work; more ability to plan financially; and potential for providing ‘open access’ sessions.
- 3.38 The **National Assembly for Wales** said that the Welsh Dental Initiative, designed to attract NHS dentists to areas where there was a shortage, continued to be a success. Part of the £5.3 million announced in May 2004 would be used to improve access prior to implementation of the new contract.
- 3.39 Commenting on the size of the workforce, the **BDA** said that many of its predictions in evidence provided to us in the past had been accurate. The BDA said that there was a significant shortage of dental personnel in the UK and the *Report of the Primary Care Dental Workforce Review*² supported this point. It said the report concluded that under-supply was projected to increase over the next two decades, with under-supply estimated to be around nine per cent of demand in 2003 growing to around 27 per cent of demand in 2021, in the gravest scenario. As the report was written some two-and-a-half years ago, the BDA pointed out that conclusions on the under-supply of whole-time equivalent (WTE) dentists were biased downwards. It said that its recent evidence to us had indicated that the shortfall was in the region of 4,000 WTE dentists and the recent independent research by the University of Bath had indicated a workforce shortage of 5,200 WTE dentists, although the Bath study had not taken into account dentists in the PDS or the salaried services and so would be biased upwards.
- 3.40 The BDA said that the Workforce Review had finally established the Department’s estimate for the number of WTE dentists, which showed in the most likely scenario that the number of WTE dentists in England was 18,820 in 2001 and would be 18,570 in 2006. It said that an extrapolation of this data indicated that there were 18,620 WTE dentists in England in 2004. Its own estimate for 2003-04 showed that there were 16,941 WTE dentists in England, but its estimate excluded therapists and hygienists. The BDA said it estimated that the NHS component of the GDS comprised of around three-quarters of the total workforce which equated to 12,487 GDS WTE dentists in England, and gave a population to NHS dentist ratio of almost 4,000 for England.

² *Report of the Primary Care Dental Workforce Review*, Department of Health, July 2004.

- 3.41 The BDA said the Workforce Review had stated that in 2003 the under supply of WTE dentists in England would be 1,850, and with the Government's planned recruitment of 1,000 WTE dentists into the GDS over the next year, this was still at least 850 less than was needed to bridge the gap in the workforce. Additionally, the extra 170 undergraduate places, which would become available in England, would not enter the workforce for another six years.
- 3.42 The BDA said that the MORI research *Proposals for Dentistry in England* (2004) had found that 60 per cent of dentists' income on average was derived from NHS work in 2004 and this was predicted to fall to 37 per cent in five years time. This would seriously undermine the ability of the Department of Health to recruit and/or retain 1,000 WTE dentists into the GDS by October 2005. The BDA said that as highlighted in its evidence last year, organisations such as Denplan, DPAS and Practice Plan, which had assisted in private practice conversion, had converted around 260 dental practices to largely private practices in 2003 and that further research indicated that these trends had continued and accelerated in 2004. It said that since January 2003, some 1.2 million adults (in England) were no longer registered with an NHS dentist, and of that number, at least 250,000 were now being seen privately, which implied that the majority of the adults were now unable to access NHS dental care.
- 3.43 In conclusion, the BDA said that there was a real risk that the measures announced by the Government to address the under-supply of the workforce would fall short. It said that the inflow of practitioners had continued to lag behind the outflow and its evidence indicated that this would continue well beyond October 2005. In this final year before the reform of NHS dentistry, the BDA said that supplemental measures were still needed to stabilise and retain current levels of NHS commitment in time for the reforms to possibly arrest the decline of NHS dentistry.
- 3.44 In supplementary evidence, the BDA said again that the increase in undergraduate places would not come to fruition for some six years and in that time the under-supply of practitioners could only continue to increase, even if the Department managed to attract 1,000 WTE practitioners into the GDS by October 2005.
- 3.45 Commenting on the BDA's arguments, the **Department of Health** said that the BDA had extrapolated current activity under the GDS into the new ways of working, which it said was misleading. Based on six years of PDS pilots, it said it expected that practices would free up capacity within the contract value. In the period October 2005 – September 2006, it said it anticipated practices would be able to free up capacity of a minimum of ten per cent of weighted courses of treatment. In response, the **BDA** said that the Department's statement was based only on the first wave of PDS pilots. It said that the first wave of PDS pilots had an emphasis on high quality, and a high trust working environment that truly removed practitioners from the 'treadmill'. Since then, it said newer PDS schemes had introduced more rigorous monitoring/performance management systems.
- 3.46 The **DPA** said that recruitment into the NHS was still difficult and for the first time the Government was advertising for dentists in national newspapers and Sunday supplements. It also said that in a survey it had carried out of 741 dentists in November 2003, over 90 per cent of dentists said that they would be doing less NHS work in five years.

3.47 The DPA said that dentists were expected to have less clinical time in the future due to an increase in bureaucracy, which meant that more dentists were needed. It said that it was not relevant for the Workforce Review to estimate the supply of dentists based on the number of dentists with NHS contracts or the number qualifying each year, but that the relevant measure was how much work done by dentists in the NHS. It said that motivation within the profession to carry out NHS work remained poor and the current level of fees ensured that where NHS treatment was carried out, it was done as quickly as possible, using the cheapest material and laboratories. It said working in this way provided an absolute minimum of job satisfaction.

Comment

3.48 *This year we remain concerned about the uncertainty over the size of the workforce that would be needed to provide the desired level of NHS dentistry. The Department of Health and the BDA have both submitted evidence on this but their views differ. Consequently we are still no nearer to understanding what the actual position is. In our last report we said that we would welcome greater clarity about the resources needed for NHS dentistry so that we might use this as a basis for assessing recruitment and retention issues. We also mentioned that we would find it useful to receive evidence from the Department on the size of the workforce needed to deliver the level of dental care that it felt appropriate. In view of these requests, we welcome the fact that the Department has published its Dental Workforce Review, although we note that this Review was undertaken in 2002 and so is already three years old. The Review suggests that there is an under-supply of 1,850 whole time equivalent (WTE) dentists in England, and the Department plans to recruit the equivalent of 1,000 WTE dentists into the GDS over the next year. We would welcome a report on the progress in recruiting the additional dentists in the next round. However, we note that, even if completely successful, this leaves on the basis of the Department's own figures, a potential shortfall of 850 WTE dentists. We are aware that the Department believes that this gap will be filled by NHS dentists "working in new ways", although we have not had any detail on the mechanism involved and just how it will achieve its objective. We note that the Department intends to have an additional 170 undergraduate students starting a degree in Dentistry by October 2005, for graduation in 2010. We note that this evidence on workforce has been disputed by the BDA and the DPA. In view of this, we repeat our earlier comment that we find it difficult to judge the extent to which the NHS is under-provided with GDPs.*

3.49 *Again in this round, the Department acknowledges that retention is a problem for the GDS and that under the current arrangements, dentists can switch from NHS to private work with relative ease, little risk and with very little notice to the NHS. The drift of GDPs away from the NHS continues to be a concern for us and we have no way of knowing whether the Department is correct in its belief that the new working arrangements will halt and possibly reverse it. Taking the evidence on recruitment and retention into account, it would seem to us that the position is as follows:*

- *there is a shortage of NHS dentists, but the extent of the shortage is unclear;*
- *there is a problem of retention, as dentists continue to drift to private practice; and,*
- *to meet the targets for access, more of the GDP's time needs to be bought back for NHS work.*

3.50 *The Department says that it plans to review the position on the dental workforce in 2005-06 to check if the assumptions on which the recruitment plans are based need revisiting and we would welcome evidence on this review for the next round. Our concerns for 2005-06 are first, whether the current remuneration arrangements are likely to make more dentists work in the NHS and second, whether those arrangements are likely to retain the current level of NHS commitment. We have taken these considerations into account in making our recommendations.*

Access to NHS dentistry

3.51 The **Department of Health** said that it had set up an NHS Support Team, backed by £9 million over two years 2003-04 and 2004-05, to work with the hardest pressed PCTs to improve access. Additionally, £35 million capital over the same two years was being allocated to PCTs to support improved access, choice and quality and this was increased by a further £15 million revenue allocated to PCTs for 2004-05. The Department said the Dentistry Support Team had to date worked with 16 PCTs to agree robust dental action plans that addressed their dental access problems. The Team was now starting to work with a second tranche of 15-16 PCTs.

Comment

3.52 *We welcome this initiative to improve access to NHS dentistry in the hardest pressed areas, but our impression is that the problems of access are widespread and not confined to particular areas. The problem of access will not be solved until there is an increase in the number of dentists working in or more fully for the NHS. The new ways of working may allow the current corps of NHS dentists to treat more patients. The problem of access will not be solved, however, until there are more dentists devoting more of their time to NHS patients.*

Expenses

3.53 The **Department of Health** said it had offered, as part of a three-year deal covering the years 2003-04 to 2005-06, to develop with the BDA a mechanism for assessing movements in expenses in order to predict any significant changes. However, as a major change in the way dentists were remunerated was only a year away, and new clinical patterns and less emphasis on the volume of treatment might alter treatment-related costs, the Department said it believed that what was needed now was time to allow the changes to settle so that the effect on expenses could be properly assessed.

3.54 The Department said that a key feature of the new arrangements was the provision for PCTs to assist and support providers and prospective providers of primary dental services. This support and assistance included financial support and the provision of premises on such terms as the PCT thought fit. Once the PCT held the total financial resources, there would be a greater degree of flexibility to deal with expenses. For example, in high cost areas, the PCT could agree a direct reimbursement of premises costs or contribute to staff wages, as had been the case in general medical practices. It also said it would expect PCTs to agree with their dentists any adjustment to reflect local factors, such as any higher costs in the South East.

3.55 The **BDA** said its analysis last year for looking at dental expense inflation had been undermined by the Department who had stated "... that the BDA's assertion that dental inflation was higher than general inflation was based on the results of the BDA's Professionals Complementary to Dentistry (PCD) Survey (2003) ... PCDs were mainly therapists and hygienists and there were relatively few in the GDS". The BDA said that this statement was misleading and undervalued the contribution made by the 35,000

plus dedicated professionals, which included dental nurses, practice managers and receptionists that operated as front line NHS dental staff. It said its approach to dental expense inflation was built on the recommendations outlined in the Ernst & Young report *Review of the Dental Rates Study Group* (1991), which had advocated the use of simple models to represent and forecast dental expenses and which stated "...the RPI ... and average earnings seem, to us, to provide a fully adequate basis for specifying the limits of plausible [dental expense] expenditure forecasts".

- 3.56 The BDA said that the use of the RPI for dental expenses had become outmoded because the shortage of available PCDs and the approaching necessity of registration of PCDs had meant that recruitment had had to tap into a pool of higher academically qualified people, thus driving wages inflation at significantly above average rates. In addition, the BDA said that strict infection control guidelines and the resultant move toward single use items (i.e. disposables) were currently driving and would in the future drive up dental expenses inflation. It said it considered the benefit of further research to be an invaluable exercise in establishing a robust baseline for addressing dental expense inflation over the transition period and beyond and asked us to recommend that independent research be undertaken to establish and understand this. The BDA also asked us to recommend that a pilot impact assessment be undertaken to establish the costs that would be faced by an average practitioner to provide the quality of care demanded to achieve the standards outlined by the Disability Discrimination Act (DDA), cross infection control requirements, outreach training and placement of PCDs. In supplementary evidence, the BDA said that the SEHD had carried out a pilot premises survey in Grampian and Lanarkshire Health Boards during 2004. It said it was expected that the report would show a low valuation of the practices and that most of the practices would find it difficult to make reasonable adjustments to comply with the DDA. The BDA asked us to undertake a similar audit of dental practices in England and Wales so as to inform us of the financial pressures being placed upon GDS practitioners in the context of morale and retention within the GDS.
- 3.57 The BDA said the basis for its analysis of dental expense inflation recognised that salaries and wages of PCDs comprised, by and large, the largest component of dental practice expense. Its measure of the rate of dental expense inflation therefore used published forecasts for economic indicators (i.e. RPI) and other sources for the rate of average earnings growth for salaries and wages of PCDs. It said it was clear from a comparison of the New Earnings Survey data on dental nurse earnings and GDS gross fee increases over the period 2001-2003 that practitioners had been rewarding their dental staff with wage increases that were significantly higher than GDS gross fee increases and that the tightness of the labour market for PCDs was also driving upward pressure on wages and salaries. On the basis of its formula, where 40 per cent weight was given to wages and salaries and 60 per cent weight given to other practices expenses, the BDA projected that dental expenses would rise by 4.2 per cent in 2004 and by 3.7 per cent in 2005.
- 3.58 In supplementary evidence, the BDA said that there had been no independent work done to suggest any link between the consumer price index and the rate of dental expense inflation. It said that the results from the Dental Business Trends Survey 2002 reported that total practice expenses were comprised: wages and salaries, 41 per cent; laboratory costs, 16 per cent; dental consumables, 14 per cent; premises costs, 11 per cent; and other non capital expenditure, 18 per cent. It presented its analysis from its PCD Pay Survey 2002 which suggested that the PCD wage bill was around 45 per cent of total expenses, and noted that this figure was very close to the actual reported percentage of 41 per cent taken from the BDA Dental Business Trends Survey 2002, suggesting that the results from the various BDA surveys dovetailed and were robust.

It also said that the derived PCD wage bill excluded significant other costs such as employers' national insurance contributions, holiday pay, pension contributions, bonuses and staff training. It said it was its contention that many of these costs were classified into the other non capital expenditure heading, and as such total PCD costs might be as high as 59 per cent of total practice expenditure. This revised weighting of costs led the BDA to suggest that the dental expense inflation in 2004-05 would be 4.2 per cent.

- 3.59 The BDA also presented information from Mr. Ledingham of Morris & Co. Chartered Accountants, which showed that between 2001 and 2003, total gross fees for NHS practices had risen by 5.5 per cent, whilst for private practices (i.e. those with 90 per cent of income generated from private sources) total gross fees had risen by 21 per cent. The BDA said its contention was that the ever-growing burden of practice expenses was eroding NHS practice profitability, more and more NHS practices and practitioners were moving out of the NHS and action needed to be taken now to stem the haemorrhaging.
- 3.60 In supplementary evidence, the **Department of Health** said that its annual income and expenses Inland Revenue survey indicated that dentists' income to expenses ratio was relatively stable, with the estimate for all dentists for 2002-03 of 55.5 per cent compared with 55.6 per cent for 2001-02. It also showed that the expense ratio, weighted to give more weight to the amount of GDS work dentists did, was 53.8 per cent – almost two percentage points lower than the results covering all dental work. It confirmed that the composition of practice expenses derived from the BDA's Dental Business Trends Survey was broadly consistent with the information from the Inland Revenue Survey for 1994-95, which showed that the breakdown of expenses was: laboratory charges (15 per cent), dental consumables (18 per cent), premises (11 per cent), salaries and wages (35 per cent), net capital allowances (4 per cent) and other items (17 per cent).
- 3.61 The **DPA** said that based on a survey of members in 2004, it estimated dental expense inflation would be four per cent during the 12-month period 2005-06.

Comment

- 3.62 *In our deliberations on the fee uplift, we must consider the dentist's own remuneration and expenses, including an appropriate return on capital invested. In our last report we commented that the question of whether expenses were being correctly recompensed was a considerable concern to us and that remains the case this year. Following the last review when the parties provided conflicting evidence on the impact of dental expenses, our secretariat met with the parties to discuss whether any better or agreed dental expense data could be provided from existing administrative or survey sources of information. Unfortunately, neither side has so far provided us with substantive and mutually agreed data on this. We have, therefore, used a formula for expense inflation in order to establish our recommendation for an uplift that takes account of changes in dental expenses. We deal with this more explicitly in paragraph 3.85.*
- 3.63 *Turning to the evidence this year, we have noted that the Department's Inland Revenue survey shows a relatively stable expenses ratio, but we have considerable concerns about the usefulness of the ratio and whether much can be inferred about the movement of NHS expenses from it. Our analysis of the ratio is set out in Appendix H. The BDA has provided an estimate of dental inflation based on a model that takes account of staff costs and uses forecast data. In the absence of specific dental expenses data, the BDA's approach has merit and we believe that the percentage shares of costs on which the BDA's model is based are reasonable, although it is our view that we should look at actual price information rather than forecast data. We consider the current information base for expenses weak and as we said last year, expenses need to be given proper consideration under the new regime.*

We therefore recommend (recommendation 9) that in this transitional year ahead of the new arrangements the parties jointly develop a mechanism for assessing changes in expenses and that this be done for a representative cross section of practices across the country. We expect the parties to report back to us with progress for the next round and would ask the parties to keep our secretariat involved in the work. The BDA has also drawn to our attention the impact that compliance with the Disability Discrimination Act may have on practice expenses. We would ask to see further information from the impact assessment in Scotland in the next review before forming our views.

- 3.64 *We note in the Department's evidence that under the new arrangements, it will be possible for PCTs to agree with their dentistry providers more sensitive ways to reimburse expenses which better reflect regional expense pressures. As we said last year, this may be a solution, providing PCTs have sufficient scope within their funding envelope to address expense pressures. However, as we commented last year and as the National Audit Report has highlighted, we are concerned that PCTs in reality are likely to have many competing demands for funding. We would ask the parties for further evidence about developments here.*

Commitment and Seniority payments under the new contract arrangements

- 3.65 As the Base Contract value would include payments currently made separately to dentists, such as commitment payments and seniority payments, the **DPA** considered this unfair to the dentists not in receipt of these payments. It gave the example of seniority payments which it said the Department of Health argued were designed to compensate practitioners aged over 55 from falling income due to a decreasing work rate. It said for those dentists over 55, removing the link between remuneration and workload should mean that their salaries would continue at the pre-55 rate despite the decrease in the work rate and therefore seniority payments would not be necessary. This meant that dentists over 55 would effectively have a ten per cent up-rating locked in their monthly payments and the bulk of the profession contributing to this scheme would be locked out at varying stages of their contribution history.
- 3.66 In supplementary evidence, the **Department of Health** said that under local commissioning, the gross earnings of older dentists, no longer on a "treadmill" of item-of-service, would not reduce in the same way as under the GDS. It said there was therefore no longer any logical reason to compensate older dentists. However, it said that seniority payments remained under discussion with the BDA because they had symbolic value to the profession and could provide reassurance to experienced dentists and the feeling of being valued by the NHS, during the transitional period.

Comment

- 3.67 *We welcome the fact that seniority payments remain under discussion between the parties and would ask them to report on these discussions for the next round.*

Pay comparability, capital support and return on capital

- 3.68 The **BDA** said there were no 'comparator' professions because dentists had to deploy their own capital in order to establish a practice and had to run a commercial risk. The BDA said there was no reward offered by the Department for this capital at risk, who had use of the estate entirely free. The BDA said that in recent years, the general profitability of practice had been severely eroded.

- 3.69 The **DPA** argued that in a system where dentists were responsible for the provision of their own premises and capital equipment, a return on capital should form part of their remuneration.
- 3.70 The DPA argued that NHS primary dental care had no equivalent to the low-interest loans, assistance with house purchase, subsidised meals, profit-sharing schemes and share options that comparable groups could expect in the private sector. It said the average value of significant fringe and non-cash benefits at comparable levels elsewhere was the appropriate figure for comparison, and not the minimum.
- 3.71 In supplementary evidence, the **Department of Health** said that it did not believe an adjustment for return on capital was appropriate. It said there were two aspects to the use of capital. Firstly, the inclusion of capital allowances in the expenses provided compensation over time for the capital employed in the purchase of buildings and equipment. It said that capital allowances had risen for single-handed practices from an average of £2,317 in 1994-95 (just under four per cent of expenses) to £4,830 in 2002-03 (about five per cent of expenses). Secondly, return on capital provided a proxy measure of the “worth” of an investment and of the overall return. Because dentists were self-employed, it was difficult to separate their income from what might be a return on capital. NHS dentistry was a low risk investment providing security and generous pension benefit. It said that where investment was made in premises, this was often with a view to the appreciating market and return on the investment through the future sale of the property.
- 3.72 Responding to the Department of Health’s suggestion that NHS dentistry was a low risk investment, the **BDA** said that in its evidence last year, it had identified 40 NHS dental practices that had closed down in the last two years through an inability to sell them. It said that this suggested there had been at least 100 NHS dental practices that had had to close down in the last two years across England and Wales due to an inability to sell them on. It said that NHS dentistry was a low risk to the Government as the (capital) risk had been transferred to the level of the practice owner.

Comment

- 3.73 *We note the BDA’s and DPA’s evidence regarding the rate of return on dental practices, and the DPA’s evidence on the levels of benefits available to GDPs. We also note the Department of Health’s evidence that GDPs already receive some compensation for capital employed in the purchase of buildings and equipment in the form of capital allowances, and that it is difficult to partition a GDP’s net earnings into its two component parts – income from work and return on capital. It seems to us important that GDPs should be rewarded fairly for any capital they may have invested to provide NHS services. We would therefore ask the parties jointly to take forward work to look at the feasibility of developing a mechanism for rewarding dentists appropriately for the capital invested in NHS dentistry, and that this be considered in the work on expenses.*

Practice cost allowance

- 3.74 The **BDA** asked for a practice allowance of up to £4,500 to be introduced, pro rata to their NHS commitment, to GDS practitioners. It said this was to address increasing requirements in relation to the provision of high quality premises, information, health and safety, clinical standards and practice staff training.

- 3.75 Last year in supplementary evidence the BDA said that “the Department of Health reported that the National Assembly for Wales has discussed practice allowances with the Welsh General Dental Practice Committee, and although no decisions had been made, negotiations would continue”. The BDA said it was disappointed to report that to date, the Welsh Assembly had not made contact to explore those issues.
- 3.76 Responding in supplementary evidence, the **National Assembly for Wales** said it accepted that this issue had not been formally tabled with the Welsh GDPC. However, the Assembly said it was happy to discuss practice allowances at the next meeting with the GDPC, although it would need to be considered in the context of the new contractual arrangements.
- 3.77 In supplementary evidence, the **Department of Health** said that the circumstances in England were different from those in Scotland and many of the Scottish grants and allowances were aimed at addressing issues of rurality. It said that its experience from earlier initiatives and expert opinion had all pointed to a fundamental overhaul of the system in order to address the long-standing concerns of dentists. It believed that its central conclusion of local commissioning remained the best way forward for England, coupled with the abolition of item-of-service fees. In response, the **BDA** refuted the statement that Scotland differed from England because of ‘rural’ issues, as it said the General Dental Practice Allowance in Scotland and the Practice Improvement Grant were aimed at all practitioners.

Comment

- 3.78 *We commented on the issue of practice cost allowances last year and are disappointed to note here that no additional information has been presented on this issue for this review. Last year we said that we did not consider it appropriate to recommend the national introduction of a practice allowance without seeing such an allowance tested, or any evidence of its effect on recruitment and retention. This remains our view. We have been provided with no substantive evidence of how a practice cost allowance would be used and received no further evidence from Scotland of its impact on recruitment and retention since its introduction.*

Level of fees increase

- 3.79 The **Department of Health** said that the past year had seen significant developments on NHS dentistry. The Government had announced an unprecedented level of new investment in dentistry and had set out a comprehensive strategy to rebuild NHS dentistry through reform of the remuneration system on the move to local commissioning and through plans to address the workforce shortfall. It said the planned changes would remove dentists off the so-called treadmill and ensure that dentists as well as the NHS benefited from freed-up capacity under the new arrangements. Against this background, it considered that an increase in gross fees set at a level which was in line with the Government’s inflation target to maintain comparability with similar groups, was the best way to ensure stability in the run-up to the new contractual arrangements. It said that it fully expected dentists to benefit from the increased investment it had provided by working with their PCTs to increase commitment. It said dentists would have freed up capacity to spend more time with patients, on clinical quality and practice management and would not be required to provide out-of-hours cover. It said this was a reduction in workload for a guaranteed income and generous pension and other benefits.

- 3.80 In the light of the issues raised in its evidence, the **BDA** asked us to recommend an increase in the fee scale of at least 3.8 per cent for 2005-06. It said this would have a positive impact on retaining commitment within the NHS workforce to deliver high quality NHS care to patients when the reforms were implemented. In supplementary evidence, it said that it now calculated that even a fee scale uplift of 4.2 per cent might result in no real uplift for the vast majority of the profession.
- 3.81 The **DPA** said that the correct level of remuneration for dental surgeons was at the top decile of the New Earnings Survey or equivalent survey data, which it considered represented the minimum level of remuneration that was sufficient, under all the circumstances, to recruit, retain and motivate dentists to work in the NHS. It said a closer tie to Survey data would increase the profession's confidence in our recommendations.

Comment

- 3.82 *We have made our deliberations this round against a background of:*
- *delayed progress towards the new arrangements;*
 - *the Government's announcement of additional funding for NHS dentistry and its plans to increase the size of the workforce;*
 - *difficulties with access to NHS dentistry; and*
 - *a shortage of NHS dentists and a continuing reduction in GPs' commitment to the NHS.*
- 3.83 *We have noted the conclusions of the National Audit Office report and the concerns expressed about the new contracting arrangements. The Government announced in January that plans to implement in full the new contract in England and Wales from October 2005 have been put back to April 2006 to allow GPs and PCTs a longer time to prepare. We have also noted that contract discussions between the BDA and the Department of Health have been slow and difficult. This year, therefore, is a transitional year before the new arrangements are expected to come into effect in April 2006 and we see a need to facilitate the move to the new system and support dentists currently working within the NHS through our pay recommendation.*
- 3.84 *The Department of Health has asked us to recommend a fee increase in line with the Government inflation target (CPI). In our view, this would not "ensure stability in the run-up to the new contractual arrangements" as the Department wants. As we said last year, in considering the fee increase, we must have regard to the fact that there is no pay drift for GPs because they are not paid on an incremental pay scale and that GPs have to meet their expenses out of the fee income. An inflation target award would lead to a fall in the real remuneration of GPs. This suggests that an award for GPs ahead of the inflation target is necessary. The BDA has asked us to recommend a fee increase of at least 3.8 per cent on the basis that this is the minimum necessary to cover dental expense inflation. Whilst this approach has merit, the BDA has not been able to supply us with detailed information on dental expenses and we note that it has considered only the expenses element of a GP's costs and not the GP's own remuneration.*
- 3.85 *For the fee uplift this year, we have considered the GP's own remuneration and expenses separately. We have considered the survey information available to us on the composition of dental costs which the parties appear to agree reflect dental costs fairly. We believe this gives a reasonable basis for establishing a simple formula for deriving a fee increase. The formula is*

set out as follows:

$\text{Increase in fee}_{2005-06} = 0.44 * \text{increase in GDP remuneration} + 0.56 * \text{increase in GDP expenses};$

where $\text{increase in GDP expenses} = 0.41 * \text{staff costs} + 0.59 * \text{other costs}$ ³.

Therefore the effect of the overall fee increase formula is to give weights of 44 per cent to **GDP's remuneration**, 23 per cent to **staff costs** and 33 per cent to **other costs**.

- 3.86 *The weights for the fee formula (0.44 and 0.56) have been derived from the Department's Inland Revenue survey and the weights for the expenses component (0.41 and 0.59) have been derived from the BDA's Business Trends survey. Having fixed on a formula, we must now decide which of the various measures might be used for the different components.*
- 3.87 *In looking at an appropriate uplift for the GDP's remuneration, we have sought to protect the real value of their earnings and to treat them in line with appropriate comparators. In this run up to the new arrangements, we consider that GDPs should receive an increase in their remuneration equivalent to the increase agreed for GMPs under the new GMS contract in 2005-06. We therefore recommend that 3.225 per cent is used in the formula to represent the GDP's remuneration.*
- 3.88 *In looking at an appropriate increase for expenses, we have considered indicators for staff costs and other costs separately. For staff costs, we feel the measure that best represents the earnings growth of staff in dental practices is that given by the change in the hourly rate of pay of the full sample of dental nurses as recorded in the Annual Survey of Hours and Earnings. The change in the hourly rate of pay in the year to April 2004 was 3.8 per cent, and therefore we recommend that 3.8 per cent is used in the expenses component of the formula to represent staff costs. For other costs, we recognize that there are no specific measures for the different categories in this component. We therefore recommend that the RPI is used as a measure reflecting general price rises. We have used for other costs the average change in the RPI for the last quarter of 2004, which was 3.4 per cent.*
- 3.89 *Using our recommended uplift for the GDP's remuneration and our recommended increase for expenses in the fee formula gives a percentage rise of 3.4 per cent. We therefore **recommend (recommendation 10) that gross fees for items of service and capitation payments should be increased by 3.4 per cent for 2005-06 for GDPs.** In making this recommendation, we would wish to make clear that we have applied a formula for the fee increase this year, in absence of any specific data on the change in NHS dental expenses. We would urge the parties to take forward work on this as set out in recommendation 9. We also **recommend that commitment payments (recommendation 11) and sessional fees for taking part in emergency dental services (recommendation 12) be increased by 3.4 per cent.***

³ This comprises laboratory costs, dental consumables, premises costs and other non-capital expenditure costs.

CHAPTER 4: SALARIED PRIMARY DENTAL CARE SERVICES

Introduction

- 4.1 *This year, the parties have provided us with evidence on the final year of the three-year pay deal that was agreed for staff within the Salaried Primary Dental Care Services (SPDCS) and an update on the review of the SPDCS.*

Three-year pay deal and the review

- 4.2 The **Department of Health** said that 2005-06 represented the third and last year of the three-year pay deal and that inflation remained within the agreed parameters. It asked us to recommend an uplift across all pay bands and allowances for the SPDCS, including salaried general dental practitioners employed by Primary Care Trusts (PCTs) under General Dental Services Regulations, of 3.225 per cent for the coming year.
- 4.3 The Department said that as part of the pay agreement, it had made available a capital sum of £5 million for use by PCTs in supporting the modernisation of SPDCS in preparation for the 2005 model of primary dental care. Following discussions with the British Dental Association (BDA) about its use and distribution, it said it had apportioned the funds on a weighted capitation basis to Strategic Health Authorities, who were then required to target the funds particularly to those PCTs and services which had not previously received central capital modernisation support through the salaried Personal Dental Services pilot process. In agreement with the BDA, release of the funds was delayed into the current financial year to permit proper planning. The funds were issued to the NHS during September 2004.
- 4.4 The Department said it was also undertaking a major review of the SPDCS, involving the BDA, grass roots clinicians from primary care, senior NHS managers and patient representatives. The review had commenced by visioning the likely shape of primary dental care in about ten years time, and concluded that PCTs would continue to want to be able to directly employ salaried dentists. It had gone on to consider the role of salaried dentists and the education and training and career pathways necessary to enable them to fulfil their roles. It had then considered what kind of pay principles would need to underpin those career pathways and roles. Also considered were issues of service leadership and service size. The Department said it intended to publish the high-level proposals developed in the review for wider input. Subsequently, the Department told us it had published the consultation document *Creating the Future: Modernising careers for salaried dentists in Primary Care* in December 2004. Following the communication period, it said the principles of the changes required would be finalised and detail developed in each of the areas addressed by the review. The Department anticipated making a major submission on the implementation of the review to us for our next round.
- 4.5 The Department said that it had commissioned qualitative research about the factors which made salaried employment attractive. It said that with the assistance of the BDA, all salaried dentists would be surveyed during the autumn. The results of the survey would help to inform the final review principles.
- 4.6 The Department said that as part of the review process, it had undertaken to consider for possible early implementation any affordable actions which would help to support the direction of the review. It said a number of ideas had been proposed, many of which had failed the test of adequately supporting the direction of travel. However, it said it was recognised that there was a need for organisational development work to support the transition of salaried dentists and services into the world of PCT commissioning of

dentistry and therefore into the right contextual position for implementing the review outcomes. It said it had therefore made £400,000 available nationally during 2004-05 to fund an organisational development programme aimed specifically at SPDCS clinicians and was currently in discussions with the BDA about the content of the programme. In supplementary evidence, the Department said that the programme would have three strands: a resource pack (a booklet and a CD-ROM) for each dentist in the SPDCS; a series of day-long road-shows; and the provision of external facilitation to teams of salaried dentists to help them work through the change process locally. It said it had agreed with the BDA it would be sensible to deliver much of the programme in the first part of 2005-06. The road-shows were planned to run in the period April – June 2005, with facilitation to run through into the autumn of 2005.

- 4.7 The **National Assembly for Wales** said that it had commissioned a review of the Community Dental Services (CDS) in Wales. It said that it expected to submit a final report to the Minister in November 2004, and that it intended that consultation on the review's findings would then be carried out.
- 4.8 The **NHS Confederation** confirmed that the SPDCS were covered by the final year of the three-year ten per cent pay deal and it therefore did not expect us to make any recommendations in respect of this group. It also said that it had contributed to the review of the SPDCS and was awaiting the outcome of that review and the consultation on the recommendations. If the review did call for changes to the pay structure, the Confederation said it was likely that it would be the responsibility of NHS Employers to conduct the negotiations, although that agreement had not been finalised.
- 4.9 The **BDA** said it was disappointed that the review had been unable to keep to its timetable, noting that the consultation document on the English review had originally been scheduled for "late summer". It said this had caused considerable anxiety among SPDCS staff and had further dented morale. The BDA said it had put forward evidence to the review covering Clinical Excellence Awards and Clinical Director Multi-PCT Allowances for consideration under the terms of an exchange with the Department of Health that they constituted "pay issues around the margins where it would be practical and desirable to make progress for the pay year 2004-05, over and above the standard 3.225 per cent". It had asked the review to factor consideration of the potential for progress on these issues into its work. The BDA said that the Department had turned down its proposals. It said it was disappointed that the Department had not considered the proposals sufficiently persuasive. The BDA said it now awaited the consultation document with considerable interest and hoped that its concerns would be addressed by the conclusions of the review.

Comment

- 4.10 *As the final year of the three-year pay deal, we note that **the parties have agreed to a 3.225 per cent uplift on salaries and allowances for all dentists in the SPDCS to be applied across the board in 2005-06. We therefore endorse and recommend (recommendation 13) this and have calculated 2005-06 salaries on this basis and reproduce these in Appendix A.***
- 4.11 *We note the BDA's comments about the slippage in the timetable for the review, and are pleased to see that the Department has now published its consultation document on the future of the salaried services. We will, of course, be very interested to receive evidence next year on the outcomes of the consultation, particularly if, as the NHS Confederation has suggested, there are to be changes to the pay structure for salaried dentists.*

CHAPTER 5: OPHTHALMIC MEDICAL PRACTITIONERS

Introduction

- 5.1 *This year, the Department of Health reports on agreement to a three-year pay deal covering the sight test fee and domiciliary visit fees for ophthalmic medical practitioners (OMPs).*

Recruitment and retention

- 5.2 The **Department of Health** said that between December 2002 and December 2003, the number of OMPs registered to provide General Ophthalmic Services (GOS) in Great Britain decreased from 674 to 644, and the number of optometrists increased from 8,812 to 9,161. It added that the GOS continued to attract adequate numbers of practitioners of good quality with appropriate training and qualifications. Demand for NHS sight tests had increased by two per cent, with 11.4 million sight tests paid for in Great Britain by primary care trusts and health boards. Within those figures, the proportion of sight tests carried out by OMPs was around three per cent.
- 5.3 The Department said that its past surveys had shown that the majority of OMPs practised part-time, and that the 2003-04 survey showed that 52 per cent of practising OMPs also held other appointments, mainly as hospital doctors. It said that the first report of the Eye Care Services Steering Group had been launched in May 2004, and that the group continued to meet and consider proposals to improve ophthalmic services.

The sight test and domiciliary visit fees

- 5.4 The **Department of Health** asked us to note that the sight-test fee for 2005-06 was covered by a three-year agreement as its offer to OMPs of a three-year ten per cent pay offer covering the years 2003-04, 2004-05 and 2005-06 had been accepted. Sight test fees of £17.26, £17.82 and £18.39 had been agreed for the three respective years, together with corresponding increases in domiciliary sight-test fees. It said that the agreement included making a payment towards loss of earnings while undertaking mandatory continuing education and training, and that the payment had been agreed at £270 for 2004-05 and £425 for 2005-06. It said that in respect of OMPs, it had been agreed that the payment would only apply to practitioners who had no other medical appointment. Future payments would be considered as part of the normal negotiations between the Department and the professions.
- 5.5 The Department said that it remained firmly of the view that there should be a common sight test fee and that our previous recommendations about joint negotiation of this fee would continue to be relevant for future years.

Comment

- 5.6 *Last year, the BMA voiced its concern about the delay in agreeing the NHS sight test fee payable to OMPs and optometrists for 2003-04. We are therefore pleased to see from the evidence submitted by the Department of Health that agreement on a three-year pay deal covering the years 2003-04, 2004-05 and 2005-06 has been reached, and that the sight test fee and domiciliary visit fees for each of these years has been agreed as part of the deal.*
- 5.7 *We note that the Eye Care Services Steering Group continues to meet, and will be particularly interested to learn in future years how any of its proposals to improve ophthalmic services might affect the remuneration of any of our remit groups.*

Part III: Secondary Care

CHAPTER 6: DOCTORS AND DENTISTS IN TRAINING

Introduction

- 6.1 *This year, the parties have provided evidence on a number of issues concerning doctors and dentists in training. The parties report on the implications of the Working Time Directive (WTD), as well as updating us on progress with implementation of the new contract. We have been asked to consider a significant uplift in junior doctors' basic pay, and have again been asked to consider the levels of the pay banding multipliers which apply to junior doctors' basic pay. The parties also comment on the pay implications of Modernising Medical Careers and the issue of clinical academics in training. We have also been asked to consider the position of flexible trainees and student debt.*

Recruitment and retention

- 6.2 Commenting on the workforce numbers for 2003, the **Health Departments** said that house officer (HO) numbers had increased by 19 (wte) or 0.4 per cent; senior house officer (SHO) numbers had increased by 1,700 (wte) or 8.3 per cent; and numbers in the registrar group (mainly specialist registrars (SpRs)) had increased by 1,070 (wte) or 7.1 per cent.
- 6.3 The Health Departments said that medicine and dentistry continued to remain very attractive careers and attracted high quality candidates. They said that the average Universities & Colleges Admissions Services (UCAS) tariff points for accepted applicants to medicine and dentistry were 403.5 and 373.1, considerably higher than the average tariff points for all subjects of 278.3. The number of UK applicants to study medicine at UK universities had increased again over last year, with 18.7 per cent more UK applicants to medical schools for 2004 entry. They said that this indicated that the number of UK applicants was rising more rapidly than the number of available places. The female proportion of UK applicants had increased from 51.2 per cent for 1994 entry to 59.4 per cent for 2003 entry, and of UK accepted applicants from 52.1 per cent for 1994 entry to 61.6 per cent for 2003 entry. The provisional UK medical school intake figure in autumn 2003 was 7,559. The Departments said that this was 2,497 more than in autumn 1997, an increase of 49.3 per cent and 807 more than in autumn 2002, an increase of 12 per cent. Over autumn 2004 and 2005, six medical schools were due to create at least 200 further new places between them.
- 6.4 The Departments said they were keen to reinforce this upward trend in applicants and to increase the diversity of applicants to medical school.
- 6.5 The **NHS Confederation** said that recruitment and retention were not problems in terms of this group of staff.
- 6.6 The **Health Departments** said that the reform of postgraduate medical training under *Modernising Medical Careers* would give better focused, structured and streamlined training with greater opportunities for flexible career pathways for doctors, and would boost the drive to increase consultant numbers as well as the flexibility of the medical workforce.

- 6.7 The **Department of Health** said that as a result of increases in medical school intakes, there would be 203 extra funded HO posts in 2004-05. A Foundation Years Steering Group was currently considering the appropriate number of HO/F1 and F2 posts that needed to be created in the future and how they would be distributed around England.
- 6.8 The Department said the number of doctors taking the Professional and Linguistic Assessment Board (PLAB) Test exceeded the number of SHO vacancies and steps were being taken to address the issue. It said that entry into SHO posts was extremely competitive. It said that at present, doctors who had gained PLAB could only gain limited registration. Subject to consultation and Parliamentary approval, it would abolish this by the end of 2005.
- 6.9 The Department said that as *Modernising Medical Careers* was implemented, SpR numbers would be increasingly driven by inputs into the training system. It said that the latest census data showed that by September 2003, it had already exceeded the *NHS Plan* target in England by increasing SpR numbers by 1,939 since September 1999. The Department said that in 2004-05, Strategic Health Authorities had been given freedom to agree as many additional SpR training opportunities as were necessary to achieve WTD compliance, subject to obtaining educational approval and local funding. To date, it said that NHS Trusts had expressed an interest in taking up 1,258 SpR posts. A survey was planned to find out how many of these posts had been implemented.
- 6.10 The **National Assembly for Wales** said that medical students in training had increased by 52 per cent over the last few years and would eventually support the recruitment of more consultants and general medical practitioners (GMPs). It said it was committed to increasing the number of qualified doctors. As a result of increases in medical school intakes, HO numbers increased by 11.4 per cent in 2003 and SHO numbers went up by 5.9 per cent. Since April 2001, a total of 80 extra SpR posts had been approved with central funding while a further 39 had been funded by NHS Trusts.
- 6.11 The **Scottish Executive Health Department** (SEHD) said that HO numbers had decreased by 5.8 wte (0.7 per cent), SHOs had increased by 150.3 wte (six per cent) and registrars had increased by 19.4 wte (1.3 per cent). It said that the drop in HO numbers was marginal, and reflected the routine fluctuations in numbers, up or down, which occurred year to year, depending on the flows of medical graduates, both in and out of the profession and across UK borders. It said that with its strong medical school/teaching hospital base, Scotland generated a healthy supply of doctors in training. However, it said that many training grade doctors were English-domiciled and therefore looked south of the border when they reached the consultant grade. It was a continuing challenge to retain doctors when they reached consultant status, but work was ongoing to improve retention.
- 6.12 The **British Medical Association** (BMA) said that the rise in applications for medical school places needed to be placed in the context of an increased number of medical school places. It said that the rise in applicants in 2003 represented an increase in home applicants per place from 1.5 to 1.7, still significantly below the 1997 level, when the current expansion in places began. Fifty-nine per cent of home applicants and 62 per cent of successful applicants to medical school were now women, which suggested that the potential future increase in doctors would be lower in whole-time equivalent terms.

Comment

- 6.13 *Last year, we commented on the encouraging growth in the number of applicants to study medicine. From the evidence provided by the Health Departments this year, we are pleased to note the large increase in the number of applicants to study medicine and dentistry over last year's figures. With the expansion in medical school places, we hope that this upward trend can continue, and that medicine and dentistry can continue to attract high quality candidates. We look forward to receiving further evidence on this for our next review.*
- 6.14 *The BMA notes that the number of applicants per place is below the 1997 level, when the current expansion in places began. We are grateful to the Health Departments for providing data on how the number of applicants per university place has varied in recent years, as we requested last year. The data shows that the ratio of applicants to accepted applicants continues to increase. The large number of applicants in 2004 suggests that the ratio is now very near to the 1997 level. We will, of course, be keen to monitor this in the future.*

Working Time Directive

- 6.15 The **Department of Health** said that the Government took the WTD very seriously. It said that by making sure that no NHS employees worked excessive hours, it would not only improve their working lives, but also ensure that no patients were treated by tired staff. The Department said that it had provided the NHS with the tools and support for local implementation, including details of best practice from the WTD pilot sites. It said that the vast majority of NHS Trusts had achieved compliance across all specialties by August, but implementation of the WTD had resulted in a handful of Trusts experiencing teething problems in a small number of specialties. It said that difficulties were largely the result of the SiMAP and Jaeger European Court of Justice judgements which had ruled that all the time spent resident on call was working time, and changed the rest entitlements. The European Commission had published proposals to address the difficulties from the judgements, but any changes to the WTD would not come into force before early 2006. It said that all NHS Trusts had locally agreed WTD action plans to ensure maximum compliance and that the Department, the Modernisation Agency, the BMA and the Academy of Medical Royal Colleges were continuing to work together to support the NHS.
- 6.16 The Department said numerous types of working patterns could be adopted in achieving WTD compliance, some concerning innovative ways of providing services involving a wide range of staff. It said that if a working pattern was to be sustainable in the long term, then it had to take account of the impact it had on staff. It noted that, as was outlined in 'Guidance on working patterns for junior doctors' (jointly signed by the BMA, Department of Health, NHS Confederation and the National Assembly for Wales), the emphasis was on creating a good working pattern, which was considered such if it "delivers training, meets service needs and WTD hours and rest requirements whilst allowing junior doctors a satisfactory quality of life".
- 6.17 The **NHS Confederation** said the SiMAP and Jaeger judgements posed real challenges for NHS organisations to be compliant whilst maintaining safe services. It said it was pleased to report that the NHS had been remarkably successful in achieving compliance by the August deadline and that the hard work and initiative of NHS organisations should be acknowledged.

- 6.18 The **National Assembly for Wales** said that it had been evident for some time that meeting the WTD by maintaining existing service configuration whilst modifying the current staffing establishment was not an option because of the inability to recruit or train sufficient junior doctors to meet the relevant work pattern. It said that it would also escalate the cost of the provision of secondary care across Wales. As a result, it said it had become imperative for other ways to be explored to meet the WTD whilst maintaining standards of care and training. It said that NHS Trusts in Wales had been advised to continue to plan acute residential service provision around 13 hour shift systems. This allowed Trusts to be certain of meeting the WTD without the need for compensatory rest while also meeting the New Deal. It said that currently 71 per cent of all training grade doctors complied fully with the requirements of the WTD. It said that all flexible trainees were both New Deal and WTD compliant.
- 6.19 The **SEHD** said that meeting the requirements of the WTD for doctors in training was an integral part of modernising and improving services. It said that a recent survey showed an overall compliance rate of 85.5 per cent based on the number of junior doctors assessed as being compliant by 1 August 2004. It said this represented a significant achievement for NHSScotland, and was a strong platform to tackle the remaining 14.5 per cent. The SEHD said it was working with other UK Health Departments to develop solutions for small and isolated sites where it was more difficult to achieve compliance.
- 6.20 The **BMA** said that the redefinition of working time within the WTD brought by the SiMAP judgement required all time spent resident in the hospital to be classified as working time for the purposes of the Directive. It said that this had forced Trusts to introduce new and often unpopular working patterns. Traditionally a majority of doctors worked on-call rotas, and these included a normal working week and a number of weekends and nights on-call in the hospital for emergencies. It said that this type of working pattern was no longer time efficient as the time spent resident in the hospital and not working counted toward the weekly hours limit and reduced the time available for actual work at other times. It said that for this reason, Trusts had introduced full shift working patterns or non resident on-call rotas. A full shift would often divide the total working week into definitive time blocks with doctors rotating around the shift pattern. It said that the criteria determining bands for those on shift patterns meant that those on full shift, where all time was actual work and there was no additional duty, found it very difficult to get into the A bands. It said that the effect was that whilst pay was dropping, junior doctors were working increasingly antisocial patterns which were not conducive to a good family life. In supplementary evidence, it said that its concern was that whilst working conditions were becoming increasingly anti-social, recognition of this through pay was not possible because employers could ensure that the work pattern fitted in with the lower banding criteria.
- 6.21 The **BMA** said that there had been huge changes in distribution across the bands in the six months to March 2004 in comparison with previous periods, in particular a significant decrease in Band 2A, and much larger increases in the numbers in Bands 2B, 1A and 1B than had been seen previously. It said that the changes in the number of people in bands must be attributed, at least in part, to the effects of the preparations for the implementation of the WTD in August 2004. It expected even greater changes in the September monitoring figures. The BMA said this served to demonstrate that the total salary of doctors was falling year on year as doctors became compliant with the WTD. It said it expected the trend to continue as more Trusts made changes to working patterns to ensure compliance with the WTD, and as hours were cut even further in the period to August 2009. The BMA said that if the trend continued, it was likely to have a significant effect on recruitment and retention. It said that hours would be cut even further in the period to August 2009, and junior doctors would be facing salaries of close to 50 per cent of their contemporaries in other professions. The BMA therefore asked us to consider a significant uplift to junior doctors' basic salaries.

- 6.22 In supplementary evidence, the **Department of Health** said that the BMA's request to uplift juniors' basic salaries significantly followed evidence that showed moves of only some three per cent between bands. It said that while there might well be some downward movement of overall average pay over future years, this would not happen immediately and it saw no pressing reasons to revise the basis of the salary structure at this point in time. It said that at March 2004, the average supplement paid to junior doctors was 68 per cent. Logically, as 2009 approached and trainees worked shorter hours, performing less of their duties at unsocial times their pay would properly reduce, but they would benefit from a better work-life balance. The Department added that it was clear that the basis on which the existing contract was drawn up, with working patterns that had a major on-call and out-of-hours component, was unlikely to be representative of the full shift working becoming increasingly prevalent as the restrictions of the WTD came into play. It said it saw a review and renegotiation of the existing contract to reflect the changing workplace and the introduction of *Modernising Medical Careers*, rather than a simple pay uplift, as the most appropriate way forward, and it said it had already raised this informally with the BMA with a view to starting this process in the near future. The Department said that a shift to lower bands would be shown up by future monitoring rounds, but this had not yet happened. It said that the current banding system was designed to work with all types of working pattern, including full shift, to compensate each working pattern appropriately.
- 6.23 The **BMA** commented that to date, there had been no monitoring to determine the extent of compliance or otherwise with the WTD. It said that strong anecdotal reports appeared to imply that many Trusts were not compliant with the WTD, despite reporting more positive messages to their Strategic Health Authorities.

Comment

- 6.24 *Both the Welsh Assembly and the Scottish Executive have reported excellent progress on becoming Working Time Directive compliant, with the English Health Department noting that the "vast majority" of Trusts are compliant, which we are pleased to note. We commented last year on the likely impact of the SiMAP and Jaeger judgements in the European Court of Justice on the working lives of junior doctors and hope that the parties can continue to work together to come up with solutions that do not have a negative impact on the morale of junior doctors. We would ask the parties to keep us in touch with any Working Time Directive developments and for next year, for the English Health Department to provide figures on compliance in the same way as the other Health Departments so that we can monitor the situation year on year.*
- 6.25 *The BMA has asked us to consider a significant uplift to junior doctors' basic salaries to take account of the drop in salary suffered by doctors as they are placed into bands to become Working Time Directive compliant and to accommodate shift working patterns. The Department of Health has stated that the current banding system that was negotiated between the parties is capable of recognising all patterns of work, including full shift working, although it also comments that the basis for the contract is unlikely to be representative of full shift working. We note this point but have seen no substantive evidence to suggest that the WTD has resulted so far in a significant number of junior doctors moving down the pay bands, or to show that the more antisocial shift patterns are not being adequately recognised in pay. We commented last year that we believed the current levels of the pay banding multipliers fully reflected the out-of-hours and intensity of posts, and that the parties were aware that junior doctors' earnings would fall as hours reduced. We did not, however, intend to lose sight of the fact that the levels of basic pay must be kept under review as the effect on earnings of the pay banding multipliers begins to decrease. We conclude from the Department's evidence that the average salary paid to junior doctors (as at March 2004)*

was 168 per cent of the basic salary. Our analysis of the evidence does not indicate that there has yet been a dramatic shift to lower bands and we do not therefore consider that any action on basic pay is currently warranted on this basis. We will continue to monitor this issue as we are concerned that once junior doctors' hours are further reduced in order to comply with the WTD limits of 56 hours from August 2007 and 48 hours from August 2009, their basic pay may no longer be set at the right level. The Departments have already confirmed (see Chapter 1) that the recruitment and retention position of our remit groups in the medium to longer term is something we need to consider, and basic pay has a part to play here.

- 6.26 *We note that the Department of Health has approached the BMA with a view to a review and renegotiation of the existing contract. Negotiation between the parties must be the best way to resolve such difficulties and we would ask that the parties keep us in close touch with developments.*

Junior doctors' contract

- 6.27 The **Department of Health** said that the new contract was now fully established and that it had been successful in improving the working lives of junior doctors. It said that the use of banding supplements had acted as a financial incentive to encourage NHS Trusts to reduce hours and develop less intensive shift patterns, while at the same time rewarding junior doctors for the hard work and the dedication they showed. Monitoring of compliance with the New Deal, currently carried out every six months, showed continuous improvement. The most recent monitoring round carried out in March 2004 revealed that: 88 per cent of all juniors were fully compliant with the hours and rest limits; 94 per cent of all juniors worked less than 56 hours per week (i.e. met the hours limit but not the rest limits); and 43 per cent of Trusts reported all junior doctors were in contractually compliant posts.
- 6.28 The Department said that establishing improvements to working patterns had continued to prove difficult in places, partly as a result of a lack of recognition by some junior doctors of their contractual obligation to monitor their working patterns and to work with their employers to improve compliance, and partly because of a failure on the part of some Trusts to implement monitoring properly. It said that this continued to be addressed at a national level by both the Department and the BMA.
- 6.29 The **National Assembly for Wales** said that NHS Trusts in Wales had made significant progress in achieving New Deal compliance with the overall rate currently standing at 80 per cent (HOs: 100 per cent; SHOs: 84 per cent; and SpRs: 65 per cent). It said that emphasis had switched to the need for Trusts to be WTD compliant.
- 6.30 The **SEHD** said that there had been significant progress in achieving New Deal compliance and the July 2004 figures showed an increase from 82 per cent to 85 per cent. It said it was urging NHSScotland to continue its efforts to achieve full compliance. It said it had been in discussions with the BMA and NHSScotland to agree a national approach to managing non-compliant rotas for SHOs and SpRs. It also said that the New Deal Implementation Support Group was helping Boards to achieve compliance.
- 6.31 The **BMA** said it was pleased to see that the proportion of junior doctors in non-compliant posts had continued to fall. However, it said it was of some concern that at March 2004, 12 per cent of juniors remained in Band 3 posts, despite New Deal compliance being a contractual requirement for all junior doctors from August 2003. The BMA said it was concerned about the delay in publishing monitoring results. It said it believed strongly that frequent monitoring and the requirement on Trusts to submit

monitoring returns was an essential driver for New Deal compliance. It was also the only method available for maintaining a check on changes in working patterns on a national level. It said it was very uneasy about proposals from the Department to reduce the frequency of monitoring submissions to once per year, and asked us to support the maintenance of biannual submission and publication of monitoring results. It said that it was clear that a stable position had not yet been reached, and it expected significant changes to continue as the WTD was implemented. It said that annual reporting of monitoring results would also mean that the figures seen by us might be as much as 18 months out of date.

- 6.32 The BMA also asked for our support in requesting that the Healthcare Commission maintain New Deal compliance as a balanced scorecard performance indicator for determining the star rating of Trusts. The BMA said that it believed that the data was both a reliable and extremely important indicator, and felt strongly that removing it from the balanced scorecard would send the dangerous message to Trusts that ensuring safe working hours for key medical staff was not a priority.
- 6.33 In supplementary evidence, the **Department of Health** said that the monitoring of junior doctors' hours was a central collection of internal management information carried out on a six-month basis, which it had in the past chosen to publish. It said there were no proposals to reduce the frequency of contractual monitoring, which was set within the contract of employment at twice a year, and currently collated centrally in March and September each year. It said it was currently reviewing as a management issue the need to place this burden of central data collection on the service at this frequency. Whilst it recognised the BMA's concerns over this potential lack of access to this information, it was also of the view that our review of pay was an inappropriate forum in which to raise what was a purely management issue.

Comment

- 6.34 *We are pleased to note the continuous progress towards New Deal compliance recorded by all three Health Departments. We have always maintained that the objective of the Deal, to improve the working conditions of doctors by reducing their hours of work, is very important. We note that the Department believes there has been failure on both sides in establishing improvements in working patterns, and hope that the parties can work together to try and reach full compliance. We will, of course, continue to monitor the situation.*
- 6.35 *The BMA has asked for our support for the maintenance of biannual submission and publication of monitoring results, and that the Healthcare Commission should maintain New Deal compliance as a balanced scorecard performance indicator for determining the star rating of Trusts. Clearly, this latter request is outside our remit, and we would not wish to comment. With respect to the first request, we note that the Department of Health says that there are no proposals to reduce the frequency of contractual monitoring, which is currently collated centrally in March and September each year. Whilst we note that this is a management issue, we would add that we also need to have access to the results from the monitoring, particularly the March monitoring, as the results from this period are usually available in the autumn, around the time we are considering evidence from the parties. This information allows us to monitor not only the changing distribution across each pay band, but also to see what effect these changes are having on overall earnings. As the Health Departments continue to argue that total earnings remain very competitive, the distribution of juniors across the pay bands is key data for our deliberations on pay. We would therefore ask the Department to take this information need into account and to ensure that the published data is the most up-to-date for the start of our review each autumn.*

Banding multipliers

- 6.36 The **BMA** said it felt that the Band 2B multiplier did not adequately reflect the workload as shown by the hourly rates of pay. It said that under the current banding system, doctors working a Band 2B rota received the same banding multiplier as those working a Band 1A rota. A doctor working a Band 2B rota worked between 48 and 56 hours a week, whereas a doctor on a Band 1A rota worked less than 48 hours a week, a difference of up to eight hours each week. It said that although the intention was that Band 1A should reflect a greater number of antisocial hours despite the fewer total hours, it could be the case that a doctor working 56 hours a week on a full or partial shift involving one weekend in four would receive the same multiplier as a doctor working 48 hours a week (or less) and also working one weekend in four. It also felt that the Band 1C hourly rates of pay were disproportionately low in comparison with the A and B multipliers. Although it accepted that some variation between the A, B and C multipliers was acceptable to allow for intensity of work and the antisocial nature of that work, some amendments were needed to the multipliers to ensure consistency. The BMA said that increasing the multiplier for Band 2B from 1.5 to 1.68 would bring the upper limit of the hourly rates of pay for 2B in line with those for 1B, as was the case for the hourly rates of pay for 2A and 1A. Increasing the multiplier for Band 1C to 1.3 would make the step from Band 1C to Band 1B the same as the step from Band 1B to Band 1A. It therefore asked us to recommend uplifting the banding multiplier for Band 2B from 1.5 to 1.68 and for Band 1C from 1.2 to 1.3.
- 6.37 The **Department of Health** said that the multipliers for compliant bands were set at a level that fully reflected the relativities that it had agreed with the BMA in 2000 to reward different patterns of work intensity and out-of-hours commitment. It said that it remained firmly of the view that the relativities were fair and that they provided an appropriate financial incentive for Trusts and trainees to manage the workload of doctors in training. The Department said that it had been suggested that it might be necessary to revise the banding multipliers as moves to lower bands as a result of reduced hours could reduce overall earnings. However, monitoring carried out in March 2004 had shown no evidence of a significant change in average bandings from the previous year, and while it might be true that some doctors could earn less as hours reduced, this was to be expected as a consequence of the current contract that had as its basis a relationship between hours worked and pay. It said that it considered that to revise banding multipliers to address overall pay when the agreed purpose of the multipliers was properly to reflect hours and intensity would be to distort the principles behind the contract, and it said it would firmly oppose such an approach. If overall pay were to fall as a result of reducing hours and if it was seen as appropriate to address this in some way, it said that a more fundamental review would be necessary. The Department said that it believed that the focus of such a review should be the impact of *Modernising Medical Careers*. This would enable the parties to take a fresh view of the appropriate levels of pay for a pathway from trainee to trained doctor in an environment where hours had been significantly reduced. It said that where hours reduced, the presumption must be that, in line with the banding system, higher levels of pay were no longer justified (subject to the agreed safeguards for individuals). To do otherwise would undermine the principle of matching levels of pay to relative work intensity and out-of-hours commitments.
- 6.38 In supplementary evidence, the Department of Health said that there was no ideal or target distribution of juniors across pay bands. It said the reality was that by 2009, all full-time juniors should be in Band 1 to meet the WTD, with the distribution between categories A, B and C reflecting the reality of the workload at local level rather than any specific overall strategy. Until 2009 or such time as the medical workforce increased, it

said it expected that many trusts would need to make best use of their juniors, and would employ them in Band 2 to avail themselves of the longer working hours available in that Band, and as a consequence average salaries would not fall as quickly as some might predict.

- 6.39 The Department said that doctors in non-compliant posts were paid an enhanced supplement, with the stated intent of penalising the employer to encourage them to make posts compliant. It said that non-compliance was now down to 12 per cent overall and there would inevitably be some Trusts, particularly in the early stages of implementation of the WTD, who would find it challenging to make all posts compliant despite the best efforts of all parties. The Department suggested this would be some five per cent of the total. It said it would be singularly inappropriate to impose further penalties on those Trusts in order to penalise an equally small number of employers who might not be compliant for other reasons. It said it saw no reason to increase the Band 3 multiplier as an incentive towards compliance. Increasing the multiplier would risk providing a perverse incentive for doctors to maintain non-compliant working. The Department said that it expected Band 3 payments to wither further over the next year.
- 6.40 The Department said that it firmly opposed any suggestion that multipliers for either compliant or non-compliant posts should be raised. Rather, if change was considered necessary the whole system should be reviewed to prevent further distortion of pay differentials between doctors in training and other medical grades. It said that it would support maintaining the current value of the multipliers in percentage terms for this year, alongside consideration of the interaction of the new foundation programme with the existing HO and SHO scales to take account of the impact of *Modernising Medical Careers*. It said that it would welcome our support for such an approach.

Comment

- 6.41 *The BMA has set out its case for increasing the value of the Band 1C and 2B multipliers in order to reflect workload better as shown by the hourly rates of pay. We have considered this matter carefully. While looking at any one particular doctor can throw up what appear to be inconsistencies, we note that the banding system was intended to be a very broad tool, with a wide range of working arrangements encompassed in each band. In our view, it continues to provide a reasonable way of compensating a disparate group of doctors, working a variety of hours, with different degrees of intensity and unsocial hours working patterns. Furthermore, the banding system as it stands is what was negotiated and agreed between the parties. We therefore believe that our conclusion from last year stands, that the current levels of the banding multipliers are now set at a rate that fully reflects the out-of-hours commitment and intensity of posts, and we **recommend (recommendation 14) that the percentage values of the current multipliers be rolled forward for another year.** The detail of our recommendation is at Appendix A.*
- 6.42 *We have already noted our concern that basic pay needs to be set at the right level, particularly as the effect of the banding multipliers decreases in response to the WTD. The key issue appears to be, what is the rate for the job if junior doctors are working normal (WTD compatible) hours. Over recent years, the Department has argued its case for junior doctors on the basis of total earnings, rather than basic pay. We infer from this that the Department agrees that basic pay will need reviewing in due course. We also note the Department's earlier evidence that a review and renegotiation of the existing contract to reflect the changing workplace and the introduction of *Modernising Medical Careers* was the appropriate way forward and that it had raised this informally with the BMA. It seems to us right and timely that the basic contract introduced in 2000 should be reviewed as the working arrangements and the training structure for junior doctors will have altered*

significantly within the next few years. We would expect any review to address the key question of basic pay and the role, if any, of supplements once hours are significantly reduced. The aim should be to ensure that pay is sufficient to attract good quality individuals to continue to enter into and remain in medicine. We therefore hope that the parties will agree on a way forward and can report progress to us for our next review and come forward with proposals, given the proximity of the final stages of implementation of the WTD.

Pay implications of *Modernising Medical Careers*

- 6.43 The **BMA** said that it welcomed our recommendation last year that an additional point be included on the SpR scale.
- 6.44 The **Department of Health** said that it was aware of the possibility of a small number of SpRs who were at the top of the payscale and working in the most intensive bands who could earn more in total in the SpR post than they would receive as a newly appointed consultant. However, the Department said that the new consultant contract had already reduced the number of SpRs whose total pay might fall in the short term on promotion, by raising the starting salary of a new consultant. It said that it believed that the longer-term benefits such as an immediately increased pension provision, access to a considerably extended pay system, greater autonomy of practice and control over working time far outweighed the perceived short-term cash advantage. The Department said that it agreed with our suggestion last year that the current pay structure could accommodate a reduction in the number of years spent in training, as envisaged under *Modernising Medical Careers*. It noted that were the period of training to be shortened, it would reduce the number of trainees on the higher pay points, remove any remaining overlap between SpR and consultant pay, and would reverse the trend of adding additional points to the top of the scales as trainees should no longer spend an extended time in the grade.
- 6.45 The Department said that as all new graduates would embark on Foundation programmes from September 2005, it suggested that a new scale should be introduced to run alongside (and eventually replace) the existing HO scale. There had been some concerns about the pay arrangements for trainees in the second year (F2) of the new Foundation programme, and to avoid financially disadvantaging trainees entering F2 in comparison with colleagues who had followed the traditional HO/SHO route, they were paid a salary equivalent to the first point of the SHO scale. A new scale would clarify the arrangements without affecting pay. The Department asked us to consider the following proposal:

F1 (=HO 0)	F2 (=SHO 0)	F3 (=SHO 1)
Starting point for all new graduates	Subject to achieving Full Registration	In the event of a delay in completing F2

- 6.46 In supplementary evidence, the Department said that the first trainees would be leaving Foundation Programmes in 2007, when it expected many of them to enter new, integrated, programme-based specialist and GP training. It said that the curricula for such programmes were being reviewed with the Royal Colleges on a specialty-by-specialty basis, but that at the outset not all of the new programmes might be available, and there might be a mixed economy of old and new training arrangements for a limited period.
- 6.47 In supplementary evidence, the **BMA** said that the Department's inclusion of pay proposals for Foundation Programmes was inappropriate, and was properly the business of the Joint Negotiating Committee.

Comment

6.48 *We note the Department of Health's proposals for Foundation Programmes, but agree with the BMA that this is properly a matter for negotiation between the parties. We therefore offer no comment at this stage, but given the imminence of the introduction of Foundation Programmes, we expect the parties to treat this as a matter of urgency. The Department said earlier that it had raised informally with the BMA the need to review and renegotiate the existing contract to reflect the changing workplace and introduction of Modernising Medical Careers and this seems the right way forward. We hope the parties can report good progress for our next review.*

Flexible trainees

6.49 The **BMA** said that access to flexible training remained a major problem for many junior doctors and described the problems with the current system. The BMA said it remained committed to improving access to flexible training and had been in negotiation with the Department of Health to determine guaranteed improvements in access whilst ensuring equity of pay with full timers. It asked for our support in this.

6.50 The **Department of Health** said that it remained convinced that the contract was flawed in respect of flexible trainees, with employers still resisting the concept of paying a part-time trainee a salary based on a full salary plus a supplement. It said that this approach had significantly damaged the [flexible] employment opportunities of junior doctors, and a contract that could be seen by employers to be founded on a pro-rata basis would ease the problem greatly. It said that the basis for flexible working and its availability differed fundamentally for doctors in training from other health workers. Whereas workers in other staff groups could ask to work reduced hours and could reasonably expect to be allowed to do so, doctors wishing to train flexibly were required by European legislation to have individual personal reasons that actually prevented them from training on a full-time basis. Even so, the Department said that it believed that most doctors who needed to train flexibly, for reasons of maternity, personal illness or care of elderly relatives for example, were able to do so.

6.51 The Department said that the legislation applicable to part-time medical training required such trainees to participate in the full range of the activities of the department in which they were working. As part-time trainees were required to undertake at least half of all the duties of a full-time trainee and as most contracted for 0.6 of the training of a full-timer, the Department said it would seem reasonable to base pay on a system which reflected the actual amount of work undertaken. It said that it believed that this would remove most of the barriers to the acceptance of flexible trainees by employers. The Department said it was currently in discussions with the BMA over ways in which the contract might be amended to make the pay system more fair and transparent, and with deaneries to develop guidance for the service to ensure that, in conjunction with changes to the pay system, those doctors who needed to train flexibly were enabled to do so. Allied to those stands, the Department said that it agreed with the BMA that demand for, and supply of, flexible training required monitoring.

6.52 The **NHS Confederation** said that whilst employers supported the concept of flexible training, it was hard to justify the level of payment of flexible trainees and this acted as a major disincentive to Trusts to promote flexible training. It said that the Department of Health was in discussion with the BMA and said it was keen to see a sensible resolution of the issue.

- 6.53 In supplementary evidence, the **BMA** said that it felt strongly that improved access to flexible training was vital to support the current medical workforce and would become increasingly more important with the changes to the demographic make up of the workforce. It said that simply changing the system of pay to pro rata would not, in itself, solve the problems associated with flexible training and there needed to be a wholesale change in attitudes within the NHS so that flexible trainees were no longer perceived as a difficulty.

Comment

- 6.54 *At the time of writing, we understand that the parties are continuing to negotiate on this matter with the possibility of an agreement in the near future. We therefore offer no comment but would ask the parties to update us for our next review. It is, however, worth adding our comments from previous rounds, that we hope the Department will consider carefully both the need to minimise retention difficulties and its commitment to promoting flexible working arrangements when re-negotiating the application of the contract to flexible trainees, particularly given the increasing proportion of women in the workforce.*

Clinical academics in training

- 6.55 The **BMA** described the decline in the number of clinical academics in training. It noted that academic training was outwith our remit, but said that our view on clinical academics in training and the importance of pay parity would be very welcome.
- 6.56 In supplementary written evidence, the **Health Departments** also noted that academics in training were outwith our remit, and said it would not be appropriate for them to comment on their pay.

Comment

- 6.57 *As both parties have noted, our remit does not extend to making specific recommendations for clinical academics in training. Nevertheless, our comments in earlier reports about our support for pay parity between clinical academics and NHS clinicians would appear to be equally appropriate for clinical academics in training and we hope that the parties concerned will bear this in mind in their ongoing consideration of this group.*

Student debt

- 6.58 The **BMA** said that the average current level of debt across medical students in all years had risen to £11,500, an increase of five per cent on the previous year. Fifth year medical students had an average debt of £16,547. The BMA said that medical students would be graduating with much higher levels of debt than their colleagues from previous years and would be starting work on significantly lower take home salaries due to the changes in working patterns and the subsequent impact on banding. It also said that the proportion of applications for medicine from the poorest groups remained low and suggested that the prospect of above average debt was a significant factor. It said that this would be exacerbated by the government drive to increase the level of tuition fees (in England and Wales) through the Higher Education Act 2004, and that this disparity needed to be addressed in order to fulfil the Government's pledge to attract a broad socio-economic mix of students into medical education, to provide a diverse medical workforce in the future. The BMA asked us to remove the lowest point on the HO scale. It said that the effect of this would be to narrow the disproportionately large jump in basic salaries from HO to SHO, and to go some way to lessening the pressure on HOs due to the impact of the increased levels of student debt. In supplementary evidence, the BMA added that the longest a HO would stay in the grade was two years as a flexible trainee, and as such no HO should move onto the third point of the HO scale.

- 6.59 The **Dental Practitioners' Association** said that total student debt in the UK had risen by 18.7 per cent to just over £14.6 billion last year. It said that dental courses at five years were two years longer than the average and all dental schools were in major towns where accommodation and living costs were high. Whilst it felt it might be some time before training costs were a deterrent, it was unlikely that robust demand for places was a consequence of the opportunity to go into NHS practice on qualification.
- 6.60 Commenting on the BMA's proposal, the **Department of Health** said that the large jump between HO salaries and the start of the SHO scale took into account the fact that HOs were not yet doctors, having not completed their training and met the conditions for full registration. It said that there were three points on the HO scale to allow for some flexibility on starting salary for individuals with appropriately recognised previous relevant experience and to accommodate those who had their training delayed. It estimated that less than one per cent were on the third point of the HO scale, with the vast majority (over 95 per cent) on the first. It said it could see no justification for removing the first point which it said would be tantamount to awarding house officers a pay rise of 6.4 per cent.
- 6.61 The Department of Health said that when the value of the free accommodation provided in the first year of training was taken into consideration, the position of medical graduates was rather better than graduates in other professions. It said that after taking into consideration the longer university course and the consequent potential for higher levels of student debt, the savings on accommodation and travel to work (because most HOs were housed in or close to their base hospital) combined with the guarantee of a post and a salary at the top end of the graduate spectrum still left medicine as an attractive career choice.
- 6.62 The Department noted that it had said last year that it would consider, in consultation with the Department for Education and Skills, measures necessary to safeguard the supply, retention, diversity and quality of students on health professional training courses, once the full implications of the new arrangements for tuition fees could be assessed. The Department said that on 10 August 2004, it had announced that it would meet the full cost of variable tuition fees from their introduction in September 2006 for medical and dental students in years five and six of the standard undergraduate courses, and years two, three and four of fast-track courses. The Department also said it was also taking action to widen the diversity of students in the healthcare profession through the Aimhigher healthcare strand. This would provide £9 million over five years for nine schemes around England which would look at ways of encouraging a wider range of young people to train in the healthcare professions.
- 6.63 In supplementary evidence, the **BMA** said that the payment of tuition fees for medical students in years five and six of standard undergraduate courses and years two, three and four of fast-track courses by the Department was welcomed. It also welcomed the announcement that the full cost of variable tuition fees (covering the same period) would be met by the Department from their introduction in September 2006. However, it said that the average amount of debt for medical students continued to rise despite the introduction of the NHS bursary. Its view was that the announcement would result in neither a loss nor a gain in the years the NHS bursary was payable, and as significant costs remained in other years, there would be no reduction in the levels of medical student debt.

Comment

- 6.64 *The BMA has asked us to recommend removing the bottom point on the house office payscale to help address the problem of student debt. Our view is that the issue of student debt is strictly beyond our remit, although because of its potential effect on recruitment, we would expect the Department of Health to remain vigilant to any adverse signs that student debt is beginning to deter people from entering into medicine. Having said that, the likelihood of higher levels of debt for medical students is a matter for our consideration in looking at the comparability of junior doctors' earnings with those of graduates entering alternative professions, since medical courses are typically longer than those for most other graduates. We welcome the action taken by the Department on variable tuition fees, as well as its action to encourage young people from a wide range of backgrounds to train in the healthcare professions. The data on recruitment to medical schools does not suggest to us that the prospect of student debt is currently acting as a deterrent to entering the medical or dental professions. However, we would ask the parties in future rounds to provide us with evidence on the levels of student debt so that we can continue to monitor the situation, particularly as it might begin to impact on recruitment.*

Comparability of salary and basic salary

- 6.65 The **BMA** said that the salaries of junior doctors fell far behind other professions of equivalent standing. It said that compared to City law firms with 50+ partners, a junior doctor in their sixth year post qualification earned on average 22 per cent less than an accountant and 31 per cent less than a lawyer of the same experience. In supplementary evidence, it said that it recognised the limitations of the comparison with City law firms because of the London bias, and provided data for large law firms in Manchester as a comparison. The BMA said that it felt strongly that the disparity in pay between the most recognised professions was unsustainable in the long term and that without a significant increase to the basic salary of junior doctors, improved working conditions and better access to flexible working, many juniors would leave the profession, and fewer young people would choose to study medicine. The BMA said its Cohort study indicated that of those who had left medicine permanently as a career, 35 per cent gave NHS pay and working conditions as the reason for their decision.
- 6.66 The **Department of Health** said that for graduates entering their first HO post, salaries were already very competitive. It said that almost two-thirds of employers questioned in a recent survey (*AGR Recruitment Survey 2004*, Association of Graduate Recruiters) expected graduate starting salaries to increase in 2005 by no more than the cost of living, with a further quarter predicting that salaries would be frozen at 2004 levels. The same survey suggested that in 2005 salaries would remain stable, indicating that the days of escalating starting salaries for graduates was over. The Department said that it was significant that in the sectors normally compared with medicine, including law, consulting and investment banking, rates had been frozen and median salaries in those areas had remained unchanged for the last three years, whilst the typical starting pay in medicine had risen by some 28 per cent over the same period. The Department said that the average starting pay for HOs in 2004 was £33,494, with 67 per cent earning £35,435 or more. It said that this compared very well with other professions, exceeding even the starting salary for investment banking. In addition to pay, the Department said there was a further factor to take into account that worked to the advantage of medical students. It said that competition between graduates for posts was intense, particularly in those organisations where starting pay was at the upper end of the range, with an average of 37.6 applicants for each post in all the organisation types in the AGR survey. Competition for public sector posts was even harder, with 46.3 applications for each vacancy. Medical school graduates, on the other hand, had been assured of a position on some of the highest pay available to any graduate.

- 6.67 In supplementary evidence, the Department of Health said that it made comparisons between the earnings of a junior doctor and the basic pay of other professions because it believed this was a broadly accurate reflection of take-home pay. It said that other professions might have some supplementary payments but none were as large as those payable to junior doctors, nor as consistently applied. It said that the concept of 'basic salary' as far as junior doctors was concerned was misleading as under the current contract almost without exception (99.95 per cent) full-time HOs received at least basic salary plus 20 per cent, the average supplement being 71 per cent.

Comment

- 6.68 *The BMA has provided evidence on pay comparability for which we thank it. Our own analysis of pay comparability is contained in Chapter 1 and concludes that the remuneration of our remit groups remains broadly in line with that of comparator groups.*
- 6.69 *We have given particular attention to the starting salary for house officers. We note that the median starting salary for graduates as given by the Association of Graduate Recruiters is £21,000, somewhat higher than the current house officer starting salary of £19,703. The Department argues that if we look at earnings, rather than basic pay, then the remuneration of house officers is very competitive compared to equivalent professions. We conclude that once we allow for the effect of the banding multipliers, then pay of house officers is not out of line. We note, however, that medical courses are longer than courses for most other graduates, and that the average age of a first year house officer is likely to be older than that of other graduate entrants, and that we may not be comparing like with like. We intend to monitor this carefully for our next round, but given the current healthy recruitment and retention situation, we do not feel it appropriate this year to recommend a change to the starting salary for house officers. We said in Chapter 1 that we would like the BMA to involve our secretariat in its planned study on pay comparability and we would ask the BMA to make doctors and dentists in training a priority group in taking that work forward.*

The pay uplift for 2005-06

- 6.70 The **Department of Health** said that following the acceptance of our recommendations last year, it saw no reason for increases over and above the cost of living for trainee salaries in 2005. As a result of the WTD this year, hours spent resident on-call were gradually falling so that total duty hours would have fallen for many doctors, from a maximum of 72 to 58 at most, without a corresponding drop in salary. The Department said that it continued to believe it was important to ensure a continued upward trend in the number of trainees in the NHS, and said this could be achieved with an inflation only award for 2005.
- 6.71 The **National Assembly for Wales** said it supported the suggested pay increase in line with anticipated inflation for this group.
- 6.72 The **SEHD** also said that for this group, the pay uplift for 2005-06 should be in line with inflation.
- 6.73 The **NHS Confederation** said it recommended us to make an award at the rate of inflation for doctors in training and believed that graduate salaries in medicine remained competitive.

6.74 The **BMA** said that remit groups not covered by long-term agreements bound up in contractual change would need to receive a minimum increase in pay rates of 4.5 per cent if they were to avoid losing further ground against comparators.

Comment

6.75 *This year, given the healthy recruitment and retention situation, our aim has been to protect the real value of the pay of doctors and dentists in training and their relative pay position. In doing this, we have considered a range of inflation and pay movement indicators and we **recommend (recommendation 15) an increase of 3.0 per cent for 2005-06 on the salary scales of all grades of doctors and dentists in training.** The proposed scales are set out in Appendix A.*

CHAPTER 7 – CONSULTANTS

Introduction

7.1 *Once again this year, we are primarily considering the pay uplift recommendation for consultants remaining on the pre-2003 contract (the old consultant contract) in England and Scotland as consultants on the post-2003 contract (the new consultant contract) will receive a pay uplift of 3.225 per cent under the terms of the three-year pay deal agreed by the parties in support of contract reform. We are also asked to make recommendations on the Clinical Excellence Awards scheme, and the discretionary points and distinction awards schemes. The British Medical Association (BMA) and the Health Departments have brought various other issues to our attention and our consideration of these is set out below, after summaries of the parties' evidence.*

The Thirty-Third Report 2004

- 7.2 The BMA said that our recommendations for consultant pay from April 2004 were poorly received and that consultants were extremely disappointed, angry and frustrated at our decision to award 2.5 per cent to those on the old contract. The BMA said that this had precipitated a review of the BMA's interaction with us, as it was deemed an unacceptable breach of DDRB process. Consultants had been surprised that we had been convinced by the Department of Health's shift in position from clear support for the same pay rise for both groups of consultants, to believing that consultants on the old contract were now in the same position as all other staff groups and should receive a lower award. Our decision was felt to be especially surprising in light of the NHS Confederation's strong view that any differential award could be extremely disruptive, divisive and damaging. The BMA said that it had found it difficult to understand the reasoning behind our decision, and felt that our printed explanation was inadequate.
- 7.3 In its evidence for last year, the BMA said it had reported that consultants were suspicious that the pay award for 2003-04 had been exactly the same as for other NHS staff groups, and so our 2004 recommendations had added to the growing sense of feeling that the BMA's evidence had not been receiving due consideration. Consultants had experienced a loss of faith in the Review Body processes and a debate at the BMA's Annual Representative Meeting in July 2004 had called for the BMA to consider withdrawing from the review process altogether.
- 7.4 In supplementary evidence, the BMA said that it felt that the process by which the Department of Health's recommendation was made to us last year was highly unusual and outside normal practice. There was a sense that the BMA had not been in a position to convey to us properly the unhappiness that an acceptance of this proposal would cause, because it had come so late in the process. The BMA said that those consultants remaining on the old contract clearly perceived that they had been subjected to detrimental treatment by us and this was reflected in the correspondence received from members who were "angry", "frustrated" and "outraged" by our actions. The BMA said that it had surveyed a random sample of 2,000 consultants in the UK in September 2004 (response rate of 44 per cent). The results had shown lower levels of morale amongst those consultants remaining on the old contract, with 69 per cent of this group indicating that morale had declined. The BMA said that it had no doubt that issues of pay, and in particular the signal given by our award, had contributed to this low morale.

Comment

- 7.5 We note the BMA's concerns about our recommendation in our last report for consultants remaining on the pre-2003 contract. We comment on this in more detail later in the chapter.

Recruitment and retention

- 7.6 The **Health Departments** set out the latest position on consultant recruitment and retention. Consultant numbers in Great Britain in 2003 had increased by 1,690 (wte) or 5.8 per cent. The **Department of Health** said that the 2004 NHS staff vacancy survey for England showed that the three-month vacancy rate for consultants was 4.4 per cent in March 2004, compared with 4.7 per cent in March 2003. The Department said it was important that its measure of vacancies reflected posts where there was a genuine intention to recruit, rather than a notional view of establishment. The Hospital and Community Health Service (HCHS) vacancy survey captured details of vacancies that had been unfilled for three months or more otherwise the survey would show large increases in vacancies when large numbers of additional staff were being recruited, even if there were no difficulty filling the posts. It was not possible to expand the workforce without advertising vacancies and the three-month condition gave a useful working measure of posts that were notionally 'hard to fill'. In supplementary evidence, the Department confirmed that information on vacancy rates excluding growth in posts was not collected. The Department also said that it was currently undertaking a survey of employing organisations which would show the use of recruitment and retention premia under the new consultant contract.
- 7.7 The Department said it was disappointing that the formal *NHS Plan* target in England to recruit 7,500 more consultants over the October 1999 baseline had not yet been met. The total targets for consultants and GMPs was 9,500¹ and by June 2004, the NHS had delivered aggregate growth of 9,598. There would be no let up in the drive to increase consultant numbers and the Department said it expected that the NHS would deliver the target of 10,000 extra doctors (consultants and GMPs) in England by 2005 with various initiatives underway or planned to support recruitment.
- 7.8 The Department reported that the 'wte to headcount' ratio for consultants in England since 1999 had remained largely stable at around 0.92. The Department explained how it took into account the effects of part-time working in its workforce models, using analysis of historic data and judgement about future trends. More generally, the Department said that its workforce models for the whole medical workforce implicitly took into account the effects of changes in participation rates. The development of the Flexible Careers Scheme (FCS) was an example of a tailored response to the trend of changing working patterns.
- 7.9 The Department said it had put in place a range of measures to encourage higher rates of retention, including the FCS, which enabled flexible working, supported return to the NHS after a career break and offered flexible retirement options. As in previous years, the Department explained in some detail² how it modelled retirement rates and it also provided data³ from the NHS Pensions Agency and an analysis of wastage rates. The Department said it concluded that on balance, there were no large shifts in retirement patterns and the number of retirements were consistently moderate, manageable and within planning parameters.

¹ By March 2004.

² See Annex D of the Health Departments' written evidence.

³ See Annex D of the Health Departments' written evidence.

- 7.10 The **Scottish Executive Health Department** (SEHD) reported that numbers of consultants had increased by 89.9 (wte) or 2.8 per cent in 2003. The most recent vacancy figures at 30 September 2003 showed there were 245 consultant vacancies, an increase of 43 from 202 in September 2002. The six-month vacancy rate had increased to 3.4 per cent from 1.9 per cent in 2002. As many training grade doctors were English-domiciled, the SEHD said that it was a continuing challenge to retain doctors when they gained consultant status, particularly in some shortage specialties. However, work was ongoing to improve retention rates in support of the commitment to recruit an extra 600 consultants by 2006. The SEHD said that pay modernisation provided financial incentives to join and stay in the NHS and also created a platform for a number of non-financial incentives such as flexible working conditions, the opportunity for self-development and a high calibre professional environment.
- 7.11 In recent years, the SEHD said that consultant numbers had seen an average annual growth of three per cent, but this would need to increase to respond to pressures arising from the Working Time Directive (WTD), changes to doctors' training and the consultant contract. There were current problems with the recruitment and retention of some consultants, but strategies were being developed to address these issues. It was too early to identify if the new contract had made an impact on recruitment and retention, but no recruitment and retention premia had been adopted and their use was currently subject to approval by a Pan-Scotland NHS Employers Reference Group for the contract. No applications had been approved to date and the employers had determined that the premia should be avoided in order to retain a "level playing field" in the consultant labour market across Scotland.
- 7.12 The **National Assembly for Wales** reported that consultant numbers had increased by 40 (wte) or 2.9 per cent over the 12 months to September 2003, and this was in line with achieving its target of 525 extra consultants by 2010. In the twelve months to March 2004, the three-month vacancy figures had fallen from 153.1 (headcount) to 135.1. It was anticipated that the new contract in Wales would lead to further reductions in the current vacancy levels.
- 7.13 The **BMA** said it welcomed the increase in hospital doctor numbers in England announced in July 2004, although it was disappointed that the Government's target of 7,500 extra consultants had not been met by the original April 2004 deadline. It said consultant recruitment appeared to be stalling with the first ever fall (of five consultants) in consultant numbers between March and June 2004. The figures for the year to June 2004 showed an increase in both headcount and WTE of 6.4 per cent, but with the increasing number of women doctors, it was concerned that the rate of increase was not fast enough to allow for any increase in part-time working, or for the knock-on effect of any reduction in junior doctors' hours as a result of the WTD.
- 7.14 The BMA said its concern remained that consultants currently working in the NHS were being expected to deliver service increases which should have been provided by a greater number of consultants. Its recent survey of consultants had indicated that over 60 per cent of departments in the UK had had at least one post vacant for three months or more, and nearly one third of respondents said their employer was doing nothing to actively fill the vacancies.

- 7.15 The BMA said there was likely to be two waves of consultant retirements in 2006 and 2007 when a significant number of doctors would be able to retire with pension benefits based on the top point of the new scale. This might be increased by the retirement of consultants remaining on their original contract if they continued to perceive discrimination in successive pay awards. The BMA asked us to consider this potential problem and review the retention packages currently available to consultants. The current review of the NHS Pension Scheme would also be crucial in determining the recruitment and retirement rates of future consultants and the BMA had serious concerns about some of the proposals.
- 7.16 The BMA said that in Scotland in the year to September 2003, the consultant headcount had increased by three per cent (2.9 per cent wte), vacancy rates increased from 5.7 per cent to 6.7 per cent, and the over six month vacancy rate increased from 2.0 per cent to 3.5 per cent. The BMA was therefore critical of the moratorium among NHS employers on the use of the recruitment and retention premia available under the new contract. The BMA called on the SEHD to introduce recruitment and retention initiatives to enable the target of 600 additional consultants by 2006 to be achieved and bettered.
- 7.17 In Wales, the consultant vacancy rate was nine per cent compared with 3.8 per cent in England. However, the BMA said that there was very early evidence that the new contract might have improved the position slightly. The BMA said that in Wales, very few consultants derived significant income from private practice and this had a direct effect on Wales' ability to recruit consultants. As the final pensionable salary pay scales for the new contract were £6,000 lower than the English equivalent, this was making it difficult to retain consultants in Wales beyond the age of 60, and a large exodus was likely in March 2006 when they reached the top of the payscale under the new contract.
- 7.18 In response to our query as to whether the availability of private practice was therefore key to recruitment, the BMA said that it was not key, but a relevant factor in some specialties and locations. The BMA said that there were clearly a number of factors that impacted upon recruitment and those geographical areas and specialties with traditionally high levels of private income were often not without their recruitment difficulties.
- 7.19 Commenting on the SEHD's evidence, the BMA said it agreed that pay modernisation provided financial incentives to join and stay in the NHS and it therefore found it curious and disappointing that Scottish employers had declared a moratorium on the use of the recruitment and retention bonuses available within the new terms and conditions of service. The BMA said it was concerned that the employers had taken a policy decision not to operate a provision of the agreed terms and conditions. It strongly supported the SEHD target of increasing the number of consultants by 600 by 2006, however it said that the increase in 2003 was only 89.9 WTE which suggested that the target might not be reached. The BMA said it could identify no clear plan within the SEHD's evidence on the recruitment of consultants, but the SEHD seemed content that employers were taking the negative step of refusing to use recruitment and retention bonuses.

Comment

- 7.20 *We are pleased to note the continuing growth in the numbers of consultants across each country, but note that the rate of growth varies considerably in England, Scotland and Wales. We also note from Table 5 of the Health Departments' written evidence that consultant numbers in England in the year to 30 September 2003 had increased by 1,580 (wte) or 6.4 per cent, compared to an increase of 1,700 (wte) or 7.4 per cent in the preceding twelve-month period. This only serves to highlight the need for us know each Health Department's annual target increases so that we can see whether they are on track to meet their planned growth. This in turn will allow us to take a view about the extent of any shortfall in the planned workforce. We have made this request before and it seems particularly relevant in the light of the Department of Health missing its 2004 NHS Plan target for consultants. We would also ask again for evidence on the impact that any shortfall in manpower has had on our remit groups, and on the achievement of the Health Departments' output targets. As the Departments know, we have previously requested data showing the underlying trend in vacancy rates (excluding the effect of growth in posts) so that we can keep this under review and we would make this request again.*
- 7.21 *We are grateful for the Department of Health's evidence on retention and retirements, including its modelling of retirement rates, rates for part-time working, and its analysis of wastage rates. We hope it will continue to provide this information, but we would again stress that we would find it helpful to identify voluntary early retirements separately in the NHS Pensions Agency data in order to monitor trends. We hope that the Department can continue to provide updated data from the Medical Careers Research Group on early retirement intentions. Our concern in looking at the parties' evidence on retention is whether there is any sign of an adverse trend developing or a significant deterioration in any of the key indicators.*
- 7.22 *We note from the SEHD's evidence that the six-month vacancy rate in Scotland has almost doubled and that vacancies have increased by 21 per cent in the 12 months to September 2003. We wish to monitor this and would ask for updated evidence for our next round. We would ask both the Department of Health and the SEHD for evidence on the use of the recruitment and retention premia agreed under the new contract. We understand that this facility may be in use in England, though we have no details as yet, but note that Scottish employers have agreed that they will not use the recruitment and retention premia at the moment. We understand that Scottish employers wish to maintain a level playing field, but we also wonder why, when it was an agreed facility within the new contract, and when the SEHD tells us that it is a continuing challenge to retain English-domiciled training grades once they become consultants, that one possible means of retaining staff remains unused. We would ask the SEHD for further evidence here for our next review and also for an update on progress against its target to recruit an additional 600 consultants by 2006. We also want to monitor progress with recruitment and retention in Wales and would ask for evidence on whether the new contract is having a positive impact here. We note the BMA's comments about a potential wave of early retirements in 2006 and 2007. We expect NHS employers to be alert to any such indications and would ask the parties for further evidence for our next review.*
- 7.23 *We note the BMA's concerns about pensions. The review of the NHS Pension Scheme is of course being driven by the Government's wider agenda on public sector pensions and its policy considerations here do not fall within our remit. However, we would expect the Health Departments to make representations about the impact on the retention of current medical staff which might result from any planned changes to the scheme.*

- 7.24 *For our next review, we would remind the Health Departments that we will want to see any evidence of the benefits of the new contract for retention, and also for further evidence about the availability of flexible working patterns.*

Morale, motivation and workload

- 7.25 The **Department of Health** reported that support measures were in place for doctors making the transition to, or who were looking for, their first consultant post. The Department said that the Government took the WTD very seriously. Employers and consultants should work together to ensure compliance with the regulations, but career grade doctors could choose to work more than 48 hours a week over a 26-week reference period. The Department said that one of the key aims of the new contract was to help address the desire for flexible working patterns, and the contract was intended to help better prioritise NHS work and better manage consultant workload, via the job planning process. The Department hoped that more effective job planning would enable better prioritisation of work and reduction of excessive workload and therefore long hours. Early evidence of the effect on workload would be obtained from its planned survey of employing organisations.
- 7.26 The **SEHD** told us morale was reportedly high among consultants, but there were reports that the new contract had given rise to reduced flexibility in some working practices. The SEHD said it was clear that while the contract rightly recognised consultants' commitment through more transparent and systematic job planning, their professional ethos should not be undermined by an extreme time sensitive "minute by minute" approach to job planning, and reasonable flexibility should be preserved. Implementing the new contract had assisted NHS Boards in clarifying gaps in service provision and through the awarding of extra programmed activities.
- 7.27 In supplementary evidence, the SEHD said that many consultants had been working in excess of the WTD limit of 48 hours per week under the old contract. In order to prevent a reduction in clinical activity being delivered to patients, the SEHD said that many employers had found it necessary at this initial stage to pay extra Programmed Activities (PAs) to sustain the existing level of clinical activity. The SEHD said that it had never been expected that reform through redesign would be immediate and the use of extra PAs was a tool to ease delivery of the initial stages of the new contract. Employers were clear that extra PAs should not be treated as permanent additions either to workload or pay and that they should be reviewed regularly to determine when/how they could be removed. The SEHD said this had also been made clear to consultants. Employers were expected to make service redesign a high priority in order to reach compliance with the WTD. The new contract provided the mechanism (through job plan reviews) to change consultants' workload in a way which met these limits. The SEHD said that the amount of PAs being undertaken was being assessed to help highlight compliance with the WTD and to assist employers in benchmarking specialities.
- 7.28 The **National Assembly for Wales** said there were major concerns that implementation of the new consultant contract would have significant financial implications, particularly in the short term, as a result of having to fund additional sessions, over and above the contracted ten per week, in order to maintain current levels of activity. Piloting of the contract at two Trusts had shown a need to fund an average of 1.4 and 1.2 extra sessions per consultant respectively. However, this was simply based on the hours consultants reported they were currently working and did not include any assessment of the appropriateness of the activities, or to what extent there were variations between consultants in the time taken to undertake similar activities. It had been agreed with the

BMA that job plans would be subject to independent audit, prior to agreement to fund the sessions indicated, and the Audit Commission in Wales would undertake a substantive review of the implementation of the contract, focusing on job planning and its projected impact on funding additional sessions.

- 7.29 Commenting on how implementation of the new consultant contract had been a difficult process, the **NHS Confederation** said that many trusts had also found they had insufficient funding to pay for what they believed to be the right number of PAs for consultants. Trusts had had to make difficult choices between jeopardising relations with their consultant workforce or overspending to a significant degree. The Confederation said that although the problem had largely been tackled for this year, trusts still faced significant difficulties and would face further pressures next year. Despite these problems, most trusts believed that the contract could bring real benefits to the service and could see how the contract could enable better management of consultants, leading to more effective and productive use of their time.
- 7.30 The **BMA** told us that it hoped that the new contract would improve consultants' work/life balance, but more than half the respondents to its September 2004 survey had felt that it would not. Responses also indicated that the contract had yet to reduce overall workload. The BMA said that this was an area where intervention by us could potentially be very helpful, perhaps by enabling a financial penalty on trusts for excessive workload by increasing the value of additional PAs in future years.
- 7.31 In considering the state of consultant morale and satisfaction with their work, the BMA detailed some of the unfavourable perceptions amongst consultants from the 2003 NHS Staff Survey. These included organisational climate and leadership, support from supervisors, team structure, job design, job satisfaction, harassment, bullying and abuse from patients and/or relatives, working extra hours, work pressure, and lack of support for flexible working. However, the BMA said that the new contract might be helping to improve morale with its recent consultant survey showing that 25 per cent of those had transferred to the new contract saying morale had improved and 51 per cent that it had stayed the same. Although consultants scored well in having had appraisal and personal development, the BMA concluded that these alone could not improve morale and motivation. It suspected that the prolonged contract negotiations and sometimes stressful implementation had had a negative effect on perceptions of management and the wider NHS as a working environment which only placed further importance on valid job planning.
- 7.32 The BMA highlighted its concerns about funding of the new contract and its effect on job planning and on consultant workload. It said that in all the nations of the UK, implementation of the new contract had demonstrated that additional funding to that set aside had been required to recognise the contribution of consultants to the NHS. Many trusts were said to be limiting the number of PAs in job plans, but not expecting consultants to alter their workload, or not signing off job plans because of financial constraints. The BMA said its recent survey of consultants showed that the main reason why 23 per cent of consultants in England wanting to move to the new contract had not yet been able to do so was the failure of the employer to offer a job plan. The BMA said it would welcome our comments on this. The survey had indicated that of those full-timers who had transferred, 8.5 per cent were being paid for ten PAs, 22.8 per cent were on 11 PAs, 49 per cent were on 12 PAs, and 7.2 per cent were on 13 PAs or more. Around one third of consultants said they were not being paid for the number of PAs that adequately reflected their hours of work. There was also concern that important responsibilities for the wider NHS, such as clinical director or work for Royal Colleges, were going unrecognised, contrary to the BMA's agreement with the Department of

Health. The BMA said it would be very interested to receive our comments on this funding shortfall, given the expectation that the contract would reward all workload appropriately. However, the BMA also reported that overall, the majority of respondents were satisfied with the contract, with only 11 per cent being dissatisfied or very dissatisfied.

- 7.33 The BMA said that employers in Scotland were understood to be capping PAs at 12, but workload in excess of this was being recognised, in some instances, by other types of payment. Consultants in specific specialties/locations were reported to be showing a willingness to continue to undertake excessive workloads in the short term, on the understanding that serious attempts were made to reduce workload and recruit additional consultants.
- 7.34 The BMA was concerned that the reduction in juniors' hours because of the WTD could lead to consultants working more hours instead. The recent BMA survey had shown that of those full time consultants moving onto the new contract, 64 per cent were being paid for 12 or more PAs, representing a paid workload at the limit of, or in excess of, the WTD. Given that 40 per cent of consultants working 12 PAs or more had said that the number of paid PAs did not reflect their hours of work, it was clear to the BMA that large numbers of consultants were still working excessive hours.
- 7.35 In response to our request for clarification on whether both consultants and SAS/NCCGs were having to work more hours to cover the decrease in juniors' hours resulting from the WTD, the BMA said that it was still too early to judge the impact of the implementation of the WTD for juniors. Clearly the work would still need to be done and if trainees were working fewer hours, then other staff would pick up the slack. The BMA said the indications from its survey returns were that consultants were still working high numbers of hours.
- 7.36 In supplementary evidence, the **Department of Health** said that funding for the consultant contract, based on the methodology agreed with the BMA during the contract negotiations, was allocated to PCTs in December 2002 as part of main allocations. The Department said that this included funding for extra activity over and above the standard full-time commitment of ten weekly PAs in the new contract. In the contract negotiations, the Department of Health, the BMA and the NHS Confederation had agreed a shared methodology for costing the impact of the contract. The Department said that this methodology had explicitly taken into account the shared objective of better prioritising NHS work and better management of consultant workload. In response to our queries regarding the BMA's evidence that there were funding pressures for the new contract, the Department said that the national tariff for 2005-06 had been revised by £150 million to take account of the latest estimates of the contract's cost. This was not new money, but was already in PCTs' allocations for 2005-06. The higher costs of the consultant contract were offset by savings in other areas such as the Pharmaceutical Price Regulation Scheme agreement, which the Department said would save around £300 million from PCT allocations in 2005-06.
- 7.37 In agreeing job plans and the number of PAs for consultants, the Department said that Trusts would need to reflect accurately the level of activity that commissioners wished to commission, rather than reflecting the previous activity of consultants. The Department said that it did not yet have accurate information on the final implementation costs as this depended critically on how many PAs on average Trusts had contracted. The results of its survey of employing organisations should provide more information.

Comment

- 7.38 *We look forward to receiving evidence for the next round on the outcome of the job planning process in each country and the funding implications of what has been agreed. One of the benefits of the new contract was the expectation that it would help consultants to manage their workload better through more effective job planning. We do not expect the contract necessarily to have an impact on workload straight away, particularly as part of the overall solution may be having more medical and non-medical staff in place, plus a wider redesign of service delivery. However, we will be looking for early indications of improvement and in the longer term, we do expect to see evidence of a reduction in excessive workload and long working hours. We would expect the requirements of the WTD to play their part in helping the drive to reduce consultants' working hours, as well as the working hours of other medical staff.*
- 7.39 *The impact of workload on morale remains a concern to us and so we wish to monitor carefully the impact of the new contract on both workload and morale and would ask the parties for evidence accordingly in the next round. As an early indication, we are pleased to note the BMA's finding from its survey that overall the majority of respondents were satisfied with the contract, with only 11 per cent dissatisfied or very dissatisfied. The sample was only based on 2,000 consultants across the UK, but it is a welcome early indicator of progress.*
- 7.40 *The BMA invited our comments on the failure of employers to offer a job plan to a number of consultants wishing to move to the new contract and on the funding shortfall for agreeing additional PAs. We hope the job planning process can be concluded quickly so that consultants and employers can begin to see the benefits of the new arrangements. We note the BMA's evidence that some consultants are working hours in excess of those for which they are paid and we have heard this on our visits to Trusts. We would ask the parties for further evidence on this for the next round. We would be concerned if the body of evidence over the next year or so appeared to demonstrate that consultants were regularly working a significant number of hours in excess of their agreed job plans, as this would be undermining a key principle of the contract. We note here the Department of Health's evidence that an allocation of £150 million has been made available for 2005-06 to take account of the latest estimates of the cost of the contract. This funding is from existing PCT allocations, but is part of funds freed up by savings elsewhere in PCT budgets and we hope that it will play a part in enabling the finalisation of outstanding job plans. We would ask the Health Departments for evidence in the next round that the funding arrangements are indeed sufficient to support the new contract. We note the BMA's concerns about the funding of PAs for those consultants who undertake duties external to the work of their employer, but which are seen as being of wider benefit to the NHS. We would expect equitable arrangements to be made regarding the funding of such activities and would ask the Health Departments for further evidence on this for the next round.*
- 7.41 *We note the concerns expressed in particular by the National Assembly for Wales on the costs of the new contractual arrangements and as we said earlier, we would ask the Assembly for further evidence on the cost of the new arrangements, and its implications, for our next review.*

Implementation of the new contract

- 7.42 The **Department of Health** reminded us that we had already endorsed the 3.225 per cent pay uplift figure for 2005-06 for consultants on the new contract to give effect to year three of the agreed ten per cent three-year pay deal. The Department said its latest information showed that by August 2004, 95 per cent of consultants who had given a formal commitment to the contract by 31 October 2003 (around 85 per cent of consultants), had received final job plan offers. The Department said that it was too early to assess how the new contract was operating in practice, but it planned to survey employing organisations to provide detailed information on job plans and to provide baseline information for a longer-term study of the impact of the contract. This would also provide information on the total number of consultants on the new contract, including their geographical spread and specialty profile. Its results would be shared with us when available. The Department said it expected the results to show at least 80 per cent acceptance.
- 7.43 The **SEHD** said that the contract had been implemented from 1 April 2004. The total number of consultants on the new contract as at September 2004 was 2,895. Currently, 486 consultants remained on the old contract while job plan offers were agreed. A total of 65 consultants had elected to remain on the old contract.
- 7.44 The **SEHD** said that specific detail on the consultants choosing to remain on the old contract were not yet available as the job planning process was still continuing. Evidence so far from NHS Boards suggested that consultants choosing not to move to the new contract were either those near the end of their career who had elected not to transfer for pension related reasons, or those whose earning potential through private practice under the old contract could not be matched by the new contract. Once the job planning process had been completed, a more detailed assessment of this group would be undertaken.
- 7.45 The **National Assembly for Wales** reminded us that a revised contract had been negotiated for Wales which differed from the rest of the UK and that it had received a high level of backing, with over 94 per cent of consultants voting to accept it.
- 7.46 The **NHS Confederation** said that consultants on the new contract were covered by previously agreed three-year pay deals and they should receive awards of 3.225 per cent, as agreed. It did not expect us to depart from this or to make any changes to the pay structure. Offers had been made to almost all consultants who had expressed an interest in the new contract and these had now been agreed by the large majority.
- 7.47 The **BMA** reported that implementation of the contract had not progressed quickly and that by end January 2004 (the notional deadline for completion of the job planning process), not a single job plan had been signed off. It said that respondents to its September 2004 survey of consultants indicated that around 87 per cent of consultants either had moved or intended to move onto the new contract, with 13 per cent intending to remain on the old contract. There was no significant difference between the percentage of former whole-time, maximum part-time and part-time consultants looking to move. Implementation in Scotland was significantly better overall than in England. In Wales, all consultants had had their terms and conditions amended on 1 December 2003 and job planning would be completed by 1 December 2004, with payment of extra sessions made early in 2005.

- 7.48 The BMA said it would like us to confirm that for 2005-06, pay under the new contract for England and Scotland should be uplifted by 3.225 per cent. The BMA reminded us that this would be the final year in which the three-year deal applied and requested that consideration be given as early as possible to us resuming our role in making recommendations for the new contract for 2006-07. Under the terms of the Consultant Contract in Wales, the BMA said that consultants would receive 3.225 per cent in April 2005, and it trusted that we would endorse this settlement.
- 7.49 Responding to the SEHD's evidence, the BMA said that another important reason for consultants delaying a decision to transfer was to maximise seniority and this might represent a larger number than those with large private practice earnings.

Comment

- 7.50 *We note the progress being made in each country with the implementation of the new contract and in agreeing job plans. As we said earlier, we hope this process can be completed as quickly as possible so that consultants and their employers can start to see the benefits from the new arrangements. We would expect to see more detailed evidence for the next round on the take up of the contract in England and Scotland and the number of programmed activities or sessions being agreed under job plans in England, Scotland and Wales. We would also expect to see more detailed evidence from the Department of Health and the Scottish Executive Health Department on those consultants who have opted not to take up the new contract.*
- 7.51 *As the BMA is aware, in our last report we endorsed a 3.225 per cent pay uplift in both 2004-05 and 2005-06 for those consultants on the new contract, but we are happy to endorse again the uplift for 2005-06.*

Consultants on the old contract

- 7.52 The **Department of Health** said that, as it had reported last year, the new contract was a 'something for something' deal and it had worked hard with the BMA to pitch the benefits for consultants, compared with the current contract, at a level that could be justified by the benefits for patient care. For consultants remaining on the old contract, the Department said it could see no justification for a pay uplift of more than the anticipated rate of inflation.
- 7.53 The **SEHD** said it supported the Department of Health's recommendation that for this group, the pay uplift for 2005-06 should be in line with inflation.
- 7.54 The **NHS Confederation** said that it saw no need for any changes to the pay structure for consultants on the old contract and no justification for any increases in pay levels beyond the expected level of inflation. It accepted that this position was a change from previous years, but it now felt that parity of awards for equity purposes was not sustainable. A very large proportion of the medical and non-medical workforce in the NHS had now agreed to substantial pay modernisation and major changes to their pay structures. The Government had invested very substantial sums of money into pay reform and the commitment to longer-term pay deals above the rate of inflation had been part of that investment. At a time of sustained low inflation, it did not seem appropriate to give the same level of above inflation awards to those who had not agreed to a package of pay modernisation. However, the Confederation said that the earnings of consultants on the old contract should keep pace with inflation, but it saw no reason to make real increases to the salaries of this group. There was no recruitment issue as new consultants would be employed on the new contract and there was no

evidence of specific problems to justify changes to the pay system. The new contract, with its significant pay advantages, was available to consultants on the old contract and there was no rationale for employers to want to see further improvements to the old contract.

- 7.55 The **BMA** said again that it had been surprised and extremely disappointed with our decision last year to recommend a lower award for consultants choosing to remain on the old contract. In the light of its earlier arguments and the results of its recent survey of consultants, the BMA urged us to recommend an award of at least 3.95 per cent for consultants on the old contract, to bring old-contract holders back in line with their colleagues on the new contract. In order to reverse the detriment suffered during the last year by consultants remaining on the old contract, the BMA also requested that a one-off backdated payment of 0.725 per cent on 2004-05 rates of pay should be paid to old contract holders. The BMA said it felt that the increased pay differential under the two contracts could perversely encourage trusts to try to keep consultants working under the old terms and conditions, effectively letting them do the same amount of work, but for less pay. The BMA also urged us to consider carefully the arguments summarised in Chapter 1 on economic and general considerations regarding a 4.5 per cent pay uplift for doctors not covered by long-term agreements.
- 7.56 The BMA said that its recent survey had demonstrated that around 13 per cent of consultants were likely to remain on the old contract and it was important that their interests were protected. The survey had asked this group their reasons for doing so (more than one reason could be given):
- 57 per cent of respondents were concerned that their professional status might be affected;
 - 48.9 per cent were waiting to see how the contract was working in practice before moving;
 - 45.2 per cent did not trust management to implement the new contract fairly;
 - 31.9 per cent believed private practice arrangements were more flexible under the existing contract; and
 - 14.8 per cent had intended to move but changed their mind.
- 7.57 The BMA said that, as these results demonstrated, private practice appeared to have been a reason for around 32 per cent of consultants – a far lower figure than those with concerns about independent status, for example. The BMA said it had no breakdowns by specialty, geography or age in relation to the above figures.
- 7.58 Responding to our question as to whether there were rules governing fair implementation of the contract by management, the BMA told us that there was an established process which employers and consultants were meant to follow when agreeing a job plan under the new contract – there was meant to be a ‘partnership approach’ to job planning. Where agreement could not be reached, there was also an agreed mediation and appeals process. The BMA said that its information indicated that the majority of employers were working with their consultants and that fair agreements were being reached. However, the BMA said that not all consultants would trust their employers to act fairly and reasonably in pursuing them. In many areas there remained an atmosphere of mistrust which had emerged at the time of the original new contract proposals. The BMA said that where progress remained slow and employers were not adopting a partnership approach, this mistrust would naturally remain in place.

- 7.59 We asked the BMA for its views on parity between consultants on the old and new contracts and why, if the new contract gave ‘something for something’, those on the old contract should receive parity. In response, the BMA said that it was not clear what was meant by parity between the old and new contract. Assuming it meant parity of pay uplift, then clearly this did not result in parity between two different pay scales. The BMA said that the same pay award for the two contracts would serve to increase the differences between the relative pay scales. So the BMA said it was not asking for ‘parity’ in terms of pay, rather for fair and equitable treatment for those consultants who chose to remain on their existing terms of service. The BMA said that nobody appeared to doubt that those consultants on the old contract were equally committed and made the same valuable contribution to the NHS as consultants on the new contract. They should therefore receive a fair pay award. The BMA said that the phrase “something for something” was a political sound bite and did not have a basis in any agreed documentation.
- 7.60 In conclusion, the BMA said that the position of those consultants in England and Scotland choosing to remain on the old contract were its prime concern this year. Whilst information indicated that this would be a minority group (around 15 per cent of consultants), it was nevertheless vital that these doctors were treated fairly. Our recommendations last year to give a lower pay award for this group had been received very badly by the profession and the BMA said it was looking to us to address this in 2005. Consultants were remaining on the old contract for a variety of reasons – principally because they were concerned for their professional status, they had a lack of trust in their management and/or a desire to wait and see how implementation developed. The BMA said that these consultants were no less committed to the NHS than consultants on the new contract and there was no reason to punish them with a lower pay award. Giving them the same uplift as consultants on the new contract did not equate to pay parity – rather it simply signalled that they were being treated equitably. Giving a lower pay award to old contract holders would increase the incentive for employers to keep consultants on the old contract by widening the pay differentials further.
- 7.61 In supplementary evidence, the **Department of Health** said that it had invested substantial resources into pay reform, part of which had been the commitment to longer-term pay deals above the rate of inflation. The Department said that all existing consultants had been given the opportunity to transfer to the new contract – which had been offered as a ‘something for something’ deal – and it could see no justification for a pay uplift beyond the anticipated rate of inflation for those who chose not to enter into that deal. The Department said that, as we knew, 2005-06 was the third year of the ten per cent over three years pay deal for consultants on the new contract and this increase was an integral part of the pay reform package. It said that it was not yet in a position to say what level of uplift it would be seeking for consultants in future rounds. The **SEHD** confirmed that it endorsed the Department of Health’s evidence.

Comment

- 7.62 *The BMA has made clear its disappointment with our recommendation in the last round for those consultants opting to remain on the pre-2003 contract and reports that there is a growing sense amongst consultants that the BMA’s evidence is not receiving due consideration. We must make clear that this year, as in every year, we have given the parties’ evidence our full consideration. In the last round, we took the view that consultants on the old contract should not benefit from the pay uplift available to consultants who had opted for the new contract because they had not accepted the new ways of working. We made a*

recommendation designed to protect the real value of their earnings and intend to make a similar recommendation this year. We note that this is the last year of the three-year pay deal for consultants on the new contract and we would make no assumption that there should be differentiated pay awards in future years for the two groups. We expect to receive evidence on both groups in future rounds.

- 7.63 *Last year the Government asked us to recommend a pay uplift in line with its then inflation target of 2.5 per cent, based on RPIX. This year it asks us to recommend an increase in line with “anticipated inflation”. We have looked at a range of inflation and pay indicators to determine a pay increase which would, in our view, protect the real value of consultants’ pay. In reaching our decision, we have also considered the available evidence on retention. There appears to be no indications of any deterioration here. However, we will wish to monitor carefully the situation on retention and would ask the parties for further evidence in the next round on the retention of consultants on both the pre-2003 and post-2003 contracts. We have also considered morale and the BMA’s evidence that the results of its recent survey indicated lower levels of morale amongst consultants remaining on the old contract. The BMA said it had no doubt that pay and our award last year had contributed to this low morale. We believe that our pay recommendations are likely to be only one of many factors which will influence consultants’ morale. Workload remains a key factor. We said last year that the old contract did not appear to be able to offer consultants the means of controlling their workload and this was in turn affecting morale. We therefore consider that our conclusion last year still holds: that the new contract offers the means of better controlling workload and that in turn this should improve morale over time.*
- 7.64 *Taking all these factors into account and our current considerations of the various rates of inflation and pay movements, **we recommend (recommendation 16) an increase of 3.0 per cent for 2005-06 on the national salary scale for the pre-2003 consultant contract.** The recommended payscales are set out at Appendix A.*

Clinical Excellence Awards, Distinction Awards and Discretionary Points

- 7.65 The **Advisory Committee on Clinical Excellence Awards (ACCEA)** said that it had succeeded the Advisory Committee on Distinction Awards (ACDA). ACCEA told us that this had been the first year of the new Clinical Excellence Awards (CEA) scheme which had replaced the national Distinction Awards scheme. Such a scheme, in one form or another, dated from the inception of the NHS in 1948 to reward consultants financially for exceptional achievement and contribution to patient care. ACCEA told us that the new scheme was a single spine, with clear criteria and transparent processes which rewarded doctors who conspicuously contributed to the development of the NHS. The eligibility and assessment criteria for all awards were set nationally. ACCEA said that it would process approximately 5,000 applications for new awards each year and managed the CEA process via its regional and local committees.
- 7.66 Since this had been the first round of the new scheme, ACCEA told us that it had no comparative figures for awards year on year. It said that its report therefore took this as the base year for award numbers and, given the pyramidal structure of higher awards (levels 9-12) which it had been asked to create, and the introduction of academic general medical practitioners (GMPs) into the scheme, it said it was recommending an uplift which would allow ACCEA to maintain numbers, pro rata, at the same level for the next round.

- 7.67 Reporting on the 2004 CEA Round, ACCEA said that last year it had been advised of the sum required to support the entry of academic GMPs into the CEA Scheme and this was included in the amount it had requested from us. It said that it was now clear, however, that this sum covered only the likely amount required for locally nominated awards (levels 1-8) and took no account of the national levels (9-12). As this had been the first year in which this group could apply for awards, ACCEA said that some very distinguished consultants from the specialty clearly had to be accommodated at the highest levels. ACCEA told us that the cost to the scheme had been some £1.6 million. Having achieved this base position, numbers of awards within the specialty would from now on reflect its modest size and the fact that these doctors had already been brought into the scheme at all levels. ACCEA said that all its committees had reported that the integration of academic GMPs was being successfully achieved.
- 7.68 For the 2004 round, ACCEA said that it had been invited to create a 'pyramid' of national Bronze, Silver, Gold and Platinum awards which had allowed the creation of a broad base at Bronze level with sufficient higher level awards to permit recognition of each level of higher achievement. ACCEA said that awards at these levels demanded a "step change" in achievement from that which had earned the existing ACDA award. This first round of national CEAs had broadly established the standards for each national level of award which would be kept under consideration year by year. ACCEA told us that there were two changes in the way the award scheme operated which would ensure that this 'pyramid' was maintained with modest enhancements. Firstly, unlike Distinction Awards, CEAs would automatically end at retirement, releasing funds. ACCEA said that it was working hard to identify accurately exactly when awards were vacated. Secondly, as ACDA awards were phased out, the marginal costs of funding an enhanced award level would be somewhat lower since the financial differences between national ACCEA levels were lower than was the case between ACDA awards. These factors should free up funds in year, which could be redistributed.
- 7.69 ACCEA told us that there had been 311 Bronze, 150 Silver, 89 Gold and 37 Platinum awards in 2004. The numbers on gender and ethnicity would be best assessed over a period of years and ACCEA said that the NHS was making strenuous efforts to ensure that consultants in all specialties and all environments had opportunities to excel. ACCEA said that the new award scheme had positioned itself to continue to reflect this year on year. A recently published paper⁴ analysing ACDA national awards over the last five years had shown that there was no statistically significant difference in the awards achieved by male or female or white or ethnic minority consultants. ACCEA said that it would continue to monitor awards so that this outcome was maintained in the new scheme.
- 7.70 ACCEA told us that it would review CEA award holders every five years to ensure that they continued to perform at the high level required. Some consultants continued to hold ACDA awards and over time, some of these would move to the new scheme and some would retire. In the meantime, ACCEA said that it would continue to review awards in the old scheme, as before, every five years.
- 7.71 ACCEA said that the single spine from level 1 to level 12 was governed by the same criteria (albeit displayed in different ways at the different levels) throughout the scheme, by the same guidance, and required all consultants to fill out a common application form. Local Awards Committees (LACs) operated under ACCEA Guidelines which lay down the roles and responsibilities of the LACs, the template for membership, and the

⁴ Lambert et al BMJ.2004 5;328:1347.

required contents of their annual reports. ACCEA said that, mindful of the fact that this framework represented important changes for some local committees, it had allowed the 2004 round for such modifications to be made. The expectation, specified in the guidance, was that all LACs would have moved to comply with these requirements for the 2005 round.

- 7.72 In its proposals to us for additional awards and resource for the 2005 round, ACCEA said that the budget for higher awards should be increased in line with the increase in the number of doctors now eligible for an award (including academic GMPs), together with the NHS uplift. ACCEA said that it should retain for 2005-06 the flexibility to determine the number of awards to be made at each level.
- 7.73 In evidence from the Chairman of the **Scottish Advisory Committee on Distinction Awards** (SACDA), it was reported that SACDA had completed its fifth (2003) awards round in September 2003 and had issued its Annual Report in March 2004. As at 30 September 2003 there were 455 award holders in Scotland (39 A+, 131 A and 285 B) comprising 13.1 per cent of all consultants. SACDA had agreed in September 2004 the final allocation of awards in Scotland for the 2004 round and the Committee had approved 76 awards, including the 24 additional awards endorsed by us in our Thirty-Third Report.
- 7.74 SACDA set out its proposed number of new awards for 2005⁵. In the year to 30 September 2004, SACDA said that the consultant population had increased by 2.9 per cent. It therefore proposed an additional two A+ awards, an additional four A awards, and an additional nine B awards.
- 7.75 The **Department of Health** reminded us that distinction awards and discretionary points would remain in payment until award holders retired or were awarded a new Clinical Excellence Award (CEA). For 2005-06, the Department said it was proposing that the value of CEAs, distinction awards and discretionary points should be uplifted by 3.225 per cent, in line with the pay uplift for consultants on the new contract.
- 7.76 The **SEHD** confirmed that it supported the Department of Health's recommendation in relation to the uplift of 3.225 per cent for distinction awards and discretionary points.
- 7.77 The **National Assembly for Wales** also confirmed that it supported the Department of Health's recommendations in relation to the uplift of 3.225 per cent for CEAs and distinction awards, and also for consultant commitment awards in Wales.
- 7.78 The **BMA** said that its on-going concerns about the new CEA system in England had not been eased by its observations of the first round in practice. In terms of the application and awards process, it continued to have concerns in some areas including clarity of the guidance, reports of improper use of local CEAs to reward extra routine work, whether trusts were actually investing appropriate funding in the local element of the system during the transitional phase, and evidence of imposed limits on eligibility for national levels. The BMA said that it maintained a dialogue with ACCEA on these issues, but it would be interested in hearing our views. It would also be taking these issues forward with the Department of Health and NHS Employers. The BMA said that it looked to the major review of the system due in 2005-06 to address its concerns.

⁵ See SACDA's evidence for the detailed calculations.

- 7.79 In Scotland, the BMA said that the start of formal negotiations on changes to the distinction awards and discretionary points systems had been delayed by the SEHD. The 2005 distinction awards round and the allocation of discretionary points for 2005 would take place under current arrangements and we were asked to make recommendations. The number of A+, A and B distinction awards should be increased to match consultant expansion in Scotland and their value should be increased by 3.225 per cent. There was no case for changing the basis of the current scheme in advance of the negotiations about new arrangements. The value of discretionary points should also be increased by 3.225 per cent.
- 7.80 Responding in supplementary evidence to the BMA's concerns about academic GMPs, **ACCEA** said that it had already implemented national awards for academic GMPs on the basis that the high levels of excellence amongst this cohort should not be overlooked. With regard to the process for local awards for this group, ACCEA said that it would take at least another year for arrangements for local awards to be fully in place. ACCEA told us that it was the view of the academic GMPs and their Royal College that local awards should be evaluated by ACCEA local committees. ACCEA also told us that it shared the view that the local awards scheme should be operated to the standards ACCEA applied nationally. In its guidance, ACCEA said that it had laid down the basis for this and it was actively developing structures to monitor local processes. ACCEA said that it expected to work closely with employers and the professions in these developments. Trusts had been provided with a template upon which they were required to specify their use of delegated resources. ACCEA said that its criteria made it perfectly clear that CEAs were awarded for over and above activity in the specified domains, which included the delivery of service as well as development management, training and research activities.
- 7.81 In supplementary evidence, the **Department of Health** said that the policy framework for the CEA scheme had been agreed with the BMA as part of the new contract agreement. The operation of the scheme was the responsibility of ACCEA. The Department said that it expected the NHS Confederation and the BMA to review the operation of the scheme in 2005 when issues such as those raised in the BMA's evidence would be considered.
- 7.82 In supplementary evidence, the **SEHD** said that the start of formal negotiations had been delayed at different times by both SEHD and the BMA. With regard to the BMA's request for an increase of 3.225 per cent in the value of discretionary points and distinction awards, the SEHD said that this was an uplift tied to an investment-for-reform package delivered by the new consultant contract. There was no linkage between that package and the distinction awards and discretionary points schemes, which were a continuation of previous arrangements. The SEHD said it was therefore firmly of the view that these schemes should attract an annual uplift in line with inflation.
- 7.83 With regard to the BMA's proposal to increase investment to match consultant expansion, the SEHD said that it did not believe that such an increase would be appropriate just prior to the commencement of a fundamental review of the schemes. The SEHD said it was firmly of the view that such investment decisions should not preempt the review, but should form part and parcel of its deliberations.
- 7.84 In supplementary evidence, the **BMA** said that having had sight of the SEHD's evidence, it was very unhappy with the SEHD's recommendation on distinction awards and its understanding was that the value of distinction awards (and discretionary points) had risen in line with consultant pay awards, rather than inflation. They were a key element of remuneration and should not be downgraded prior to the anticipated fundamental review of the systems in Scotland. Likewise, the BMA said that the number of awards

must retain the same proportionality to the total number of consultants in Scotland and the BMA said that it understood that SACDA had submitted evidence to that effect. The BMA said that failure by us to recommend on that basis would result in a relative diminution of the discretionary points and distinction awards schemes, and it reiterated that it saw no case for changing the basis of the current scheme in advance of the negotiation about new arrangements. The BMA pointed out that the Department of Health had proposed a 3.225 per cent uplift for CEAs in England and Wales for 2005-06. It was essential to recruitment and retention of consultants of the highest quality that the monetary value of Scottish distinction awards should retain parity with the highest level of CEAs in England.

- 7.85 We sought further clarification from the **SEHD** on its position regarding the uplift for discretionary points and distinction awards, and also on the increase in the number of distinction awards for 2005-06. In response, the SEHD said that in relation to the annual uplift, it had signalled last year that it had budgetary pressures across the range of its spend which were resulting in a funding re-prioritisation exercise. The SEHD said that this was causing it to consider carefully the annual increase in investment that it could reasonably make in the schemes. These pressures remained and in the SEHD's view, they argued that the uplift for distinction awards and discretionary points for 2005-06 in Scotland should be made in line with the annual inflation rate, bearing in mind the need to release the maximum possible amount of limited resources to NHS Boards for developments in service delivery, and the fact that consultants would enjoy a 3.225 per cent uplift in their basic pay in 2005-06. As for the increase in the number of distinction awards, the SEHD said that the number of A+, A and B awards should be expanded in line with total consultant expansion. However, the SEHD added a caveat that it would agree to no further increase in numbers until the review of the distinction awards scheme had been completed.

Comment

- 7.86 *We are grateful to ACCEA and to SACDA for their evidence on the last awards rounds and for their recommendations for 2005. As we said in our last report, we see no case for changing the basis of the current agreed discretionary points or distinction awards schemes in Scotland in advance of the parties commencing their discussions about new arrangements. We note that SACDA has made its recommendations to us in accordance with the agreed structure of the current distinction awards scheme and **we therefore endorse and recommend (recommendation 17) SACDA's proposals for 15 new distinction awards at the following levels: two A+ awards, four A awards and nine B awards.** We note the SEHD's stance that after this year, no further increase in the number of distinction awards in Scotland will be agreed until the review of the current distinction awards scheme has been completed. We will have to consider this further in the next round if it falls to us to make recommendations again on the basis of the current agreed distinction awards scheme. In the next round, we would hope to hear the outcome of the review of the current arrangements in Scotland.*
- 7.87 *With regard to England and Wales, we note that the BMA has some concerns about the new CEA scheme and are pleased to note that it is maintaining a dialogue with ACCEA and that it will also be taking forward its concerns with the Department of Health and with NHS Employers. With the implementation of any new scheme, we would expect there to be some issues arising which need to be discussed further and addressed as necessary. We would also expect confidence to be maintained in the way the scheme is operating at local and national levels and for any difficulties to be resolved in order to maintain that confidence. As there has been only one round since the CEA scheme was implemented, it is still very early days to make any judgements about its effective operation, but we would ask all the parties – ACCEA, the Department of Health, the National Assembly for Wales and the BMA – to*

provide us with further evidence on this for consideration in our next review. ACCEA is best placed to form a judgement about all the aspects of the scheme and we would look to it to advise us in the next review of any changes on which we are able to recommend and which it considers necessary for the long-term effective operation of the scheme. We would also welcome ACCEA's evidence on the distribution of awards across the various criteria for the CEA scheme as we have heard anecdotal accounts from consultants when we have been on visits in the past of their dissatisfaction with the criteria by which distinction awards used to be awarded.

- 7.88 **For 2005-06, we endorse and recommend (recommendation 18) ACCEA's proposal that the budget for higher awards should be increased in line with the increase in the number of doctors now eligible for an award (including academic GMPs).**
- 7.89 *With regard to the annual percentage uplift, only the SEHD is seeking an inflation uplift in the value of discretionary points and distinctions awards, while the Department of Health and the National Assembly for Wales have asked us to recommend an uplift of 3.225 per cent in the value of CEAs, distinction awards, discretionary points and commitment awards, in line with the uplift for consultants on the new contract. All of these different merit awards form part of the consultant pay structure and we think it would be wrong to deviate from the accepted approach of recommending the same percentage uplift for these payments as we recommend for basic pay. **We therefore recommend (recommendation 19) that the value of CEAs, commitment awards, distinction awards and discretionary points should be uplifted by 3.225 per cent, in line with the pay uplift for consultants on the new contract. Finally, we endorse and recommend (recommendation 20) ACCEA's proposal that it should retain the flexibility to determine the number of CEAs to be made at each level in 2005-06.***

Collaborative Fees

- 7.90 The **Department of Health** said that for consultants on the new contract, regular work undertaken on behalf of a local authority or Government Department should generally be planned as part of NHS programmed activities, with no fee payable to individual consultants unless agreed with the employer. For consultants on the old contract, and for any such work undertaken outside PAs by consultants on the new contract, the Department said it was seeking a fee increase in line with inflation. The **SEHD** said it strongly supported this recommendation on consultants' collaborative fees.

Comment

- 7.91 *We note the evidence from the Department of Health and the SEHD on this matter and also note that the BMA has addressed this issue in terms of GMPs. Our recommendation on collaborative fees is set out earlier in Chapter 2 of the report.*

Clinical academic staff

- 7.92 The **BMA** said that, as in previous years, it would welcome a statement from us supporting the proper recruitment and retention of clinical academic consultants. It explained the difficulties in respect of 2003 contract implementation for this group whereby in England, backdated pay for "academic" additional PAs had only been available in the majority of institutions from April 2004, and not from April 2003. This approach provided an incentive for clinical academic staff to agree job plans weighted against teaching and research activity. The loss of remuneration suffered as a

consequence of only being guaranteed a contract of ten PAs backdated to April 2003 could be significant and compromised the principle of parity to which all stakeholders had signed up. The BMA asked for our support to reaffirm the importance of full parity with the NHS. In Scotland, the BMA said it would welcome our support in reinforcing the benefits of the new contract for clinical academic consultants.

- 7.93 The **British Dental Association** (BDA) said that it welcomed our comments about recruitment and retention of clinical academic staff and our continued positive support of pay parity. However, it too was concerned about the implementation for the new consultant contract for clinical academics in England and was anxious that differing interpretation amongst dental schools might lead to even more recruitment and retention difficulties.
- 7.94 In supplementary evidence, the **Department of Health** said that this issue did not fall within our remit. The Department said it had provided significant funding to the Department for Education and Skills – of £4.4 million, £15 million and £17.8 million in 2003-04, 2004-05 and 2005-06 respectively – to enable pay comparability in higher education for clinical academic consultants. Funding had been calculated on the same basis as that given to PCTs for non-academic consultants and was based on actual numbers of whole-time equivalent clinical academics. The Department said it had no responsibility for implementation of contracts for clinical academics employed by higher education institutions (HEIs); this was an individual HEI responsibility.
- 7.95 In supplementary evidence, the **SEHD** said that it had been engaged in discussions with the universities earlier in 2004 on funding arrangements for the clinical academic consultant contract, but these had not delayed the implementation and both parties had agreed joint funding arrangements before its commencement in April 2004. This agreement remained in place. The SEHD said this had been a complex exercise, given the number of stakeholders involved and the variety of funding arrangements which existed for clinical academic posts, but it was a purely operational matter which did not affect the clear commitments made by the SEHD and the universities to funding and to the benefits of the clinical academic consultant contract. The SEHD said that the National Partnership Steering Group had recently discussed and agreed measures to ensure that the consultant contract was applied consistently across the universities as well as across the NHS, and also to ensure that clinical academics who were eligible for the contract were able to access it.

Comment

- 7.96 *We are aware that clinical academic staff do not fall within our remit, but we are concerned that any significant deterioration in the remuneration or terms and conditions for this group compared to NHS clinicians which subsequently affects their recruitment or retention might have a knock-on effect on the ability of the NHS to train sufficient numbers of medical staff. We therefore believe that the Health Departments should monitor the situation regarding the new contract for clinical academic staff and be prepared to play an active role in helping to resolve any difficulties that might arise. We said in our last report that we hoped the new contract would prove to be a useful aid to the recruitment and retention of this important group of staff and this remains our view. Funding is important to the successful implementation of the contract and the Department of Health has explained how it has calculated the funding provision for the contract. We are sure that the Department will be keeping itself informed about the progress of implementation and of any issues that might arise in view of its wider interests in clinical academic staff.*

7.97 *Although our remit does not extend to making recommendations about clinical academic staff, we would repeat our comments from previous reports. We support the principle of pay parity between this group and NHS clinicians, it is important that there are sufficient incentives for doctors and dentists to enter academic medicine or dentistry, and clinical academic staff should be fully considered for the full range of clinical excellence awards to which they may be entitled. We hope that the parties will continue to bear these points in mind in their ongoing consideration of this group.*

Dental Public Health Staff

7.98 The **Department of Health** said that dental public health staff represented an increasingly important resource for PCTs and Strategic Health Authorities as they prepared for the introduction of local commissioning of dentistry. However, the Department said that it had concerns about the adequacy of the current size of workforce for the task in hand and it had already increased the number of training places available in the specialty in England. The Department would be considering the outcome of the review commissioned by the Chief Dental Officer of dental health capacity and capability in the NHS and would draw any relevant matters to our attention in the next round. Meanwhile, the Department considered it appropriate to maintain the principle of exact parity for dental public health staff with their public health medicine and hospital medical and dental staff colleagues and asked us to recommend the same uplifts for dental public health staff as for other consultants and training grades.

7.99 The **BDA** reported that the assimilation of Dental Public Health staff onto the terms and conditions of service for Hospital Medical and Dental and Public Health Medicine Staff had been completed. The BDA said that, together with the BMA, it would be discussing with the new Employers' Organisation, future joint negotiating mechanisms for this group.

Comment

7.100 *We note the BDA's evidence about the assimilation of dental public health staff into the terms and conditions of service for Hospital Medical and Dental Staff and Public Health Medicine Staff. We therefore do not expect to receive any separate evidence on this particular group in future rounds unless the parties wish to bring a specific issue to our attention.*

CHAPTER 8 – STAFF AND ASSOCIATE SPECIALISTS/NON-CONSULTANT CAREER GRADE DOCTORS AND DENTISTS

Introduction

- 8.1 *Once again this year, we have adopted “staff and associate specialist/non-consultant career grade” (SAS/NCCG) for the purposes of this chapter as there has been no progress in agreeing a generic title for this group of doctors and dentists. We hope that the forthcoming negotiations on the pay, terms and conditions of these grades will also be able to consider and propose a more appropriate title.*
- 8.2 *The generic title “SAS/NCCGs” covers a disparate group of doctors and dentists which includes associate specialists, staff grades, senior clinical medical officers, clinical medical officers, clinical assistants (CAs), hospital practitioners (HPs) and doctors working in community hospitals. Our recommendations for 2005-06 will apply to all these groups. Clinical assistants, hospital practitioners and doctors working in community hospitals can be qualified as general medical practitioners (GMPs) and our recommendations for these doctors are set out in Chapter 2 of the report.*
- 8.3 *The numbers of SAS/NCCG staff in each group as at September 2003 is shown below:*

Staff Grades and Associate Specialists/Non-consultant career grade doctors and dentists¹, Great Britain

	Whole-time equivalent	Headcount
Associate specialists	2,070	2,340
Staff grade	5,620	6,160
Hospital practitioner	270	1,230
Clinical assistant	1,290	4,910
Senior clinical medical officer	410	590
Clinical medical officer	230	490
Other medical staff	40	220
Total	9,930	15,940

Note: the figures in the table have been rounded to the nearest 10.

1. Source: the Health Departments’ medical censuses for 2003.

2. Those SAS/NCCGs on local contracts are not separately identified in the censuses.

- 8.4 *When the parties originally submitted their written evidence in October 2004, the Health Departments and the British Medical Association (BMA) were awaiting the submission and publication of a report, commissioned by the Secretary of State for Health from the NHS Confederation, on the scope for a review of the pay and terms and conditions for SAS/NCCGs. In response to this report, the Minister for Health announced on 6 January 2005 that up to £75 million would be available to fund new contracts for NHS doctors in the staff and associate specialist grades. He had asked NHS Employers to negotiate these new contractual arrangements for implementation from April 2006. The negotiations will proceed in parallel with the separate work which the Department of Health has told us is underway to look at career development and training opportunities for SAS/NCCGs.*

- 8.5 *Over the last few years we have been urging the Health Departments to take forward the work needed to review the role of these grades, their career progression and training opportunities, and for any consequent changes to the remuneration system to be made as soon as possible. We are therefore pleased to note that the Department of Health has now been able to report some significant progress. We comment further on this in the relevant sections below, but we very much hope that both strands of this work, the consideration of career development and the review of pay, terms and conditions, can be completed and implemented as quickly as possible. We also hope that England, Scotland and Wales can work together so that SAS/NCCGs across Great Britain can benefit simultaneously from any changes which are introduced.*
- 8.6 *Against this background, the BMA has raised several pay issues which we have considered against the background of the forthcoming review of SAS/NCCGs' pay, terms and conditions. Our comments are set out below, after summaries of the parties' evidence.*

Recruitment, retention and morale

- 8.7 The **Health Departments** reported that in Great Britain in 2003, numbers had risen an average of 9.8 per cent a year since 1997 and increased by 2.7 per cent between 2002 and 2003. The Departments said there was no evidence of any general recruitment and retention problems in these grades. The **National Assembly for Wales** reported that SAS/NCCG numbers had remained stable in the last two years due mainly to its policy of converting SAS/NCCG grades to training posts. The **Scottish Executive Health Department (SEHD)** reported that associate specialist and staff grades had increased by 1.3 (wte) or 0.2 per cent in 2003.
- 8.8 The **British Medical Association (BMA)** said that it had conducted a survey in July 2004 of SAS/NCCG opinion, in anticipation of the forthcoming negotiations. A total of 2,596 completed responses had been received (28 per cent response rate) and a copy of the results had been sent to our secretariat at the Office of Manpower Economics. The BMA said that the survey had shown:
- 36 per cent of respondents rated their morale as fairly low, 21 per cent as very low and only 26 per cent as very high or fairly high. 60 per cent reported that their morale had decreased in the last five years; and
 - less than one third (31 per cent) of respondents would recommend a career as an SAS/NCCG to an undergraduate or junior doctor with the reasons including lack of career progression, low pay, high workload, and poor working conditions. Frequent descriptions of the SAS/NCCG grade were 'dumping ground', 'dead end', 'second class', and 'slave labour'.
- 8.9 The BMA said decreasing morale was particularly relevant to retention given the age profile of SAS/NCCGs. The age of respondents had ranged from 28 to 75 years with an average age of 48 years. An increasing proportion of the cohort was reaching the age when retirement was a possibility and around a fifth of respondents said they were considering retirement in the next five years.

- 8.10 In Scotland, the BMA said that at September 2003, there were 1,225 SAS/NCCGs (staff, associate specialist and clinical assistant) which represented a decrease of seven per cent since September 2002. Whole-time equivalent figures had decreased by 3.2 per cent over the same period. However, the BMA said it believed that a higher number of non-standard grade posts had been created instead, although there was no official data on these posts. The BMA considered that the creation of 89 posts it had seen advertised between April and September reflected pressures to achieve compliance for junior doctors and the need to recruit doctors at better than national conditions in order to staff the service. Research carried out by NHS Education for Scotland on recruitment and retention issues, published in December 2003, indicated that the vast majority of SAS/NCCG respondents believed patient care would benefit from an improved SAS/NCCG career structure, and that a significant percentage wished to become a consultant. The BMA said this message was reinforced in the Temple report *Securing Future Practice: Shaping the New Medical Workforce for Scotland*¹.
- 8.11 In conclusion, the BMA said that it was aware of problems in recruiting to the grades, particularly in some specialties or geographic areas, contrary to the evidence from the Departments of Health. This was despite the fact that the overall numbers in the grade were expanding, making it difficult to demonstrate any recruitment difficulties. The BMA repeated that morale was low and there would be major implications for service provision if action was not taken to retain those who were considering retirement in the next five years. The BMA said that the growing disparity between the SAS/NCCG group and other medical colleagues was just not acceptable.

Comment

- 8.12 *We note that the increase in SAS/NCCG numbers in Great Britain was a more modest 2.7 per cent in 2003, compared to the 13.3 per cent increase in 2002 which was reported by the Health Departments for our last review. We also note that numbers have remained stable in Wales and that there was a very small increase in Scotland, which the BMA in fact disputes. As no targets are set by the Health Departments for these grades, we have no means of judging whether the fluctuations in the levels of increase should be a cause for concern, but we assume that the Health Departments do not wish to see a sudden or significant deterioration in the retention of these grades because of the impact on service delivery. The BMA has drawn our attention to the survey it conducted. We have reservations about the representativeness and validity of survey results which are based on only 28 per cent of respondents because we have no way of knowing whether these respondents accurately represent the population as a whole. We were also surprised by some of the survey results e.g. the very large number of excess hours being worked by part-timers. Bearing in mind our doubts, the survey does suggest that morale is very low for this group because of poor career development opportunities and the effect of the new pay arrangements for doctors and dentists in training and for consultants, views which we have also heard anecdotally when we carry out our annual visit programme. We consider that morale amongst this group should be a matter of concern to the Health Departments, and should act as a spur for them to complete the various work strands on career development and the review of pay, terms and conditions as quickly as possible.*

Postgraduate medical training reform and career progression

- 8.13 The **Department of Health** summarised the current obstacles faced by SAS/NCCGs to career progression and the link to pay reform.

¹ See paragraph 3.23 of the BMA's written evidence and paragraphs 9.43, 9.45-9.47 of the Health Departments' written evidence.

8.14 The two main obstacles currently faced by SAS/NCCGs were:

- *Legislative* – only those doctors on the Specialist Register could be appointed to a consultant post. Entry on the Specialist Register currently required the holding of the UK Certificate of Completion of Specialist Training (CCST) or for those trained overseas to possess qualifications considered equivalent to a CCST. Current UK legislation did not allow “top-up” training for those with skills close to that of the CCST.
- *Perception and lack of support* – SAS/NCCGs have been regarded as a professional cul-de-sac and although their contribution to the NHS was undoubted, they had been seen as lacking in status and recognition. There was no consistent framework for progress through the grades or external review to quality assure their work and ensure proper career development. Many SAS/NCCGs would like to move back into and complete training, but found limited opportunities to do so.

8.15 The Department said that in 2005, the newly established Postgraduate Medical Education and Training Board (PMETB) would assume its full responsibilities as the competent authority for postgraduate medical education in the UK. PMETB would reform the regulation of training and be responsible for evaluating applications for entry onto the Specialist Register. A change in legislation meant that PMETB would now be able to consider experience, formal training and qualifications in deciding whether such applications had met the standard for inclusion, and if they did not, PMETB would be able to prescribe the training required. This would remove the current legal obstacles and significantly increase opportunities for doctors stuck in the SAS/NCCG grades. Ministers had agreed that PMETB should go live from September 2005 and PMETB had agreed that it would invite applications from SAS/NCCGs in advance of that date for assessment for inclusion on the Specialist Register.

8.16 As well as this change, the Department said that opportunities for SAS/NCCGs would increase as a result of the acceptance by the Government in May 2004 of the recommendations in the 2003 consultation paper *Choice and Opportunity: Modernising Medical Careers for Non-Consultant Career Grade doctors*. This document (part of the *Modernising Medical Careers* initiative for doctors and dentists in training) aimed to ensure that SAS/NCCGs were not left behind by reforms of medical training. It set out the problems and identified the key principles for reform of the SAS/NCCGs:

- proper entry to, progress through and exit from a career structure linked with opportunities for development; and
- the chance to return to training, supported by good career advice.

8.17 The Department said that the proposed SAS/NCCG reforms were linked to implementation of *Modernising Medical Careers*, and in particular:

- both assumed the introduction of a competency-based assessment applied both to SAS/NCCGs and doctors in training to aid movement between the two structures;
- having established the competencies required for progression, a new system needed to be developed to make sure “top-up” training was available in a fair and organised way; and

- to understand the scale of the changes required, work was required to scope the numbers. Producing an accurate picture of the SAS/NCCG population, including those employed on local contracts, was not straightforward. The published data showed around 12,500 (headcount) SAS/NCCG doctors, but separate analysis showed there were around 5,000 SAS/NCCGs on local contracts.
- 8.18 The Department said that it would be difficult to address developmental and career issues without making a link with pay reform (as reflected in *Choice and Opportunity*). However, any new pay arrangements would need to take account of the revised structure to ensure that it could:
- meet the new system's needs, reflecting the new structure and providing appropriate rewards linked to the level of competency of the doctors and weighting of posts;
 - enable, rather than hinder, movement into training; and
 - include effective and fair transitional arrangements which would see existing SAS/NCCGs move into the new structure.
- 8.19 The Department said that this offered the longer-term prospect of a much improved, fairer and more transparent structure, both in terms of career development and financial reward. Pay reform should reflect structural reform and the detail of any reformed pay system would have to be agreed in the light of emerging proposals for structural reform. The Department said that it would not be in a position to agree the detail of any new pay system by April 2005.
- 8.20 The **BMA** reminded us that the lack of career progression for SAS/NCCGs and the acceptance that their experience and qualifications were not properly recognised or rewarded had been apparent for some time. The BMA said its aspirations for the negotiations were to improve morale, to make SAS/NCCG service a positive career choice with clear entry and exit points, and to incentivise the acquisition and development of specialist skills and knowledge. The BMA commented that many of the reforms in *Choice and Opportunity* were dependent on outside bodies and progress had been slow. In particular, PMETB had had to announce an indefinite delay to the start of its vital work assessing SAS/NCCGs' experience and qualifications for entry to the Specialist Register. The BMA asked us to note that as PMETB had not taken up its full powers in October this year (2004) as expected, SAS/NCCGs' career progression had been dealt a further blow. The BMA said its pessimistic assumptions about the time these reforms would take were not over-stated and the further delays had strengthened the case for substantial additional remuneration to compensate for the current lack of recognition and career opportunities.

The SAS/NCCG review and the Department of Health's announcement about contract negotiations

- 8.21 The **BMA** said that reform of the SAS/NCCGs to create a structure for career progression, clarify the contribution to the NHS of SAS/NCCGs, facilitate access to training opportunities and to recognise and reward this group appropriately, was long overdue. Ministers, NHS employers and the profession were all agreed that it was vital to improve the reward and recognition of SAS/NCCGs to encourage them to continue to provide valued specialist and clinical services. We were also reminded of our own comments in our last four reports about the need for a review of SAS/NCCGs.

- 8.22 The BMA asked us to consider the implications of the ongoing delay in starting formal negotiations. At the time of submitting its evidence, a clear timetable and process had yet to be agreed by the parties and, most crucially, funding in NHS budgets could not be secured until the very earliest implementation date of April 2006. It therefore urged us to look again at our stance that the differentials between SAS/NCCGs and others should be allowed to grow while negotiations had yet to start. It reminded us that SAS/NCCGs had waited for many years in anticipation of a new contract which appropriately recognised their contribution to the NHS. Given the track record of other recent contract negotiations, the BMA said that it could potentially be years before SAS/NCCGs actually saw the benefits of improved career progression and a rationalised pay structure. The BMA said it believed that this ongoing delay should be recognised in the form of an uplift in basic pay now.
- 8.23 The **NHS Confederation** said it had consistently recognised that SAS/NCCG staff provided a vital service to the NHS and that their role had been generally undervalued. However, as was recognised in *Choice and Opportunity*, many of the solutions to the problems faced by SAS/NCCGs did not relate to pay, but the Confederation accepted that reform of the pay structure could play a part in an overall approach. As for what we should recommend for 2005-06, it said that we had rightly wanted to see progress with this group for some time and it also appreciated that SAS/NCCGs themselves were impatient for change. However, the Confederation said that any changes now would impact on negotiations and that additional costs incurred at this stage would leave less scope later. Therefore, whilst the provision of some benefit as a “gesture of goodwill” was understandable and superficially attractive, in practical terms, it was likely to cause more problems than it solved.
- 8.24 The **Department of Health** told us that as a first step in taking forward the reforms, it had commissioned the NHS Confederation to scope the need for a detailed review of SAS/NCCG pay and terms and conditions of service, and to make recommendations for further consideration. As part of its work, the NHS Confederation had considered the appropriateness of the current arrangements for SAS/NCCGs in respect of discretionary points, job planning and appraisal, and payment for hours of work beyond the standard contracted week. The Department said that the scoping work also included a review of the arrangements for the employment of clinical assistants and hospital practitioners. The Department said that the widespread support for the recommendations of *Choice and Opportunity* had given it a clear mandate to explore linking pay to competence and further development work was to be agreed to develop systems for measuring individuals’ competence and job weighting. Where any reformed grades would “fit” in the medical career structure would also need to be determined. Pay for SAS/NCCGs must be appropriately pitched, the Department said, between the scales for doctors in training and consultants, taking account of *Modernising Medical Careers* and structural reform of the training grades. A new contract would offer increased opportunity to support personal development and, when linked to PMETB, would enable SAS/NCCGs to work towards the grade of consultant, thus significantly improving their pay and career prospects. The Department said that while a simple pay solution might alleviate a problem in the short term, it would not provide for a long-term solution.
- 8.25 The latest developments were that on 6 January 2005, the Health Minister for England announced that up to £75 million would be available to fund new contracts for NHS doctors in the staff and associate specialist grades. The Minister said that he had asked NHS Employers to negotiate new contractual arrangements for these staff for implementation from April 2006. The reforms would include a stronger link between

pay and competences, incentives for out of hours working, and a degree of local flexibility to meet patient needs, including availability of recruitment and retention premia. The Minister said the issues and problems faced by these grades had been recognised and the Department was determined to tackle them. The new contractual arrangements were intended to ensure that pay was linked to competencies and the responsibilities of the job, with opportunities to develop and progress.

- 8.26 **NHS Employers** said it was delighted to accept the mandate to negotiate a new contract for SAS/NCCGs. The **Department of Health's** announcement also said that Ministers' decision came after the submission of the NHS Confederation's scoping report² which, as well as recommending that there should be negotiations on a new contract for staff grades and associate specialists, had also recommended that:
- non-GMP qualified clinical assistants and hospital practitioners should be brought into the new contractual arrangements; and
 - issues relating to GMPs undertaking work in hospitals and community hospitals should be matters for local negotiation.
- 8.27 The Department said that the contractual negotiations would build on the enhanced professional development opportunities being taken forward by PMETB, which was enabling senior SAS/NCCG doctors to move onto the specialist register. The Department also said that the announcement of funding assumed that our recommendations for staff grades and associate specialists in 2005-06 were affordable.
- 8.28 The **SEHD** said that it welcomed the UK review of SAS/NCCGs by the NHS Employers' Organisation, and noted that the make-up and operation of the SAS/NCCG grade in Scotland was different to England because:
- Scotland had relatively few "trust doctors" and retained a formal policy that such appointments should not be made;
 - most of Scotland's SAS/NCCGs were female (65 per cent);
 - most of Scotland's SAS/NCCGs were UK graduates (65 per cent) compared to only 33 per cent in England;
 - Scotland's terms and conditions of service varied from those elsewhere, e.g. in Scotland, promotion to associate specialist was by personal regrading; and
 - Scotland had tighter workforce controls on these grades.
- 8.29 In supplementary evidence, the SEHD reported that Ministers had agreed that the Scottish Executive should participate in the UK level review of SAS/NCCG pay and terms and conditions, on the basis of a funding envelope of ten per cent of the SAS/NCCG paybill over three years from 2006, in line with the position taken by the Department of Health.

² Available at http://www.nhsemployers.org/PayAndConditions/non-consultant_career_grade_doctors.asp

- 8.30 The **National Assembly for Wales** told us it had established a Reference Group to provide a discussion forum with BMA Wales to encourage best practice and make appropriate changes to SAS/NCCG working conditions, to share ideas about development of new terms and conditions and feed these into the main negotiating arena. In supplementary evidence, the Assembly said that it recognised the desirability of contractual reform being undertaken on a UK-wide basis and it would ensure that there would be appropriate representation on the new NHS Employers organisation from Wales when negotiations commenced with the BMA. Its Reference Group of NHS Trust representatives would act as a sounding board for the changes emanating from the main negotiations. The Assembly said that resources had been identified for 2006-07 onwards to meet the anticipated costs of pay reform estimated by the NHS Confederation.
- 8.31 In response to the Department of Health's announcement, the **BMA** said that it was very pleased that the government had given the go-ahead for contract negotiations to begin and it looked forward to working with NHS Employers to achieve a better deal for SAS/NCCGs and for their patients. The BMA said it was encouraging that the Department was committed to addressing the frustration being caused by lack of recognition and career progression and to providing opportunities to allow SAS/NCCG doctors to develop their skills. However, the BMA said that there was still a long way to go. It was crucial that negotiations had a sound foundation and a new contract must be properly funded. This was not just about fair pay. A new deal must take into account the need to provide training opportunities for SAS/NCCG doctors so that patients benefited fully from their skills. Until further discussion on such fundamental issues had taken place, the BMA said that it was difficult to attach a price tag to the new contract. The BMA also emphasised that it was crucial that negotiations were UK-wide.

Comment

- 8.32 *We have made clear in our recent reports that any consideration of pay needed to follow on from a review of SAS/NCCGs' role, career progression and training opportunities. We therefore very much welcome the opportunities which will be opened up to SAS/NCCGs once PMETB becomes fully operational this year. We hope that the other work which needs to be carried out to facilitate career progression, and which is linked to the implementation of Modernising Medical Careers, can be taken forward quickly. We understand the BMA's frustration with what it considers the slow progress in taking forward many of the reforms outlined in Choice and Opportunity and we would urge the Health Departments to keep the current momentum going. We expect to receive reports of good progress for our next review.*
- 8.33 *We also welcome the Health Minister's recent announcement that he has mandated NHS Employers to negotiate new contractual arrangements for SAS/NCCGs. We note that he has set NHS Employers a deadline of April 2006 for implementation of the new arrangements. Whilst we had hoped last year that new pay, terms and conditions would have been in place for April 2005, we very much hope that there will be no slippage in the proposed implementation date of April 2006 and will expect to receive reports of good progress being made for our next review. We are pleased to hear that the BMA has welcomed the Minister's announcement, but note its caveat about the funding for the new contract. We would expect the Health Departments to support career development opportunities which in turn support the recruitment and retention requirements of the NHS. We also hope that the Health Departments in England, Scotland and Wales will continue to move forward together in considering SAS/NCCGs' career progression and pay, terms and conditions.*

- 8.34 *We have taken the Department of Health's recent announcement and the three Health Departments' support for new contractual arrangements into consideration in reaching our recommendations for SAS/NCCGs this year, which are set out at the end of this chapter.*

Pay comparisons

- 8.35 The **BMA** said that the delay in completing the SAS/NCCG review had led to an ever-increasing disparity of remuneration between SAS/NCCGs and their medical and dental colleagues³ and the consequent belief that their contribution was not valued. Last year's increase of 2.7 per cent had only compounded the problem and done nothing to improve morale. We were asked to look again at current SAS/NCCG pay rates.

Comment

- 8.36 *We note the BMA's comments on the pay comparisons between SAS/NCCGs and their hospital colleagues. Since 2001, we have taken some action on pay, including recommending additional discretionary/optional points to enable the recognition to service delivery of those SAS/NCCGs working at the very highest level. These recommendations have delivered an additional pay benefit to a significant majority of staff grades and associate specialists (see Appendix G). Whilst we understand the effect on SAS/NCCG morale of seeing other hospital groups benefit from improved pay, terms and conditions, we would repeat our view that changes to the pay structure for SAS/NCCGs must follow on from a review of their role, career progression and training opportunities.*

Work intensity, hours of work and out-of-hours work

- 8.37 The **BMA** said it had received an increasing number of reports from SAS/NCCGs that full shift patterns were being imposed to enable employers to implement the European Working Time Directive (WTD) for junior doctors and dentists. Such arrangements might result in increased intensity of work without necessarily increasing SAS/NCCGs' hours of work as there were fewer junior colleagues to share the workload during the day. Current contractual arrangements did not allow any consideration of intensity of work and we were requested to recommend, as an interim measure, that intensity payments should be paid to SAS/NCCGs at the same level as those received by consultants under the pre-2003 contracts, and backdated to April 2004.
- 8.38 On hours of work, the BMA said it was very concerned about the long hours which respondents to its recent survey had reported were being worked outside contracted hours:
- contracts for full-timers averaged 44 hours per week, but actual hours worked were almost double at 73 hours per week;
 - contracts for part-timers averaged 24 hours per week, but actual hours worked averaged 65 hours per week;
 - 60 per cent of respondents reported their job complied with the WTD, 25 per cent said they did not, and 16 per cent were unsure; and
 - only 11 per cent of respondents had a separate contract for out-of-hours payments, but participated in on-call rotas on average 3.3 times per month and were more likely to share their on-call rota with SpRs or other SAS/NCCGs.

³ See paragraph 3.10 of the BMA's written evidence for the detailed figures.

- 8.39 In supplementary evidence, the BMA said that it believed excess hours were worked by the SAS group to fulfil the demands of the service. It said that its survey showed that, in many cases, the hours that SAS doctors were contracted to undertake did not accurately reflect the needs of the service and that the flexibility within the associate specialist and staff grade (on-call) contracts enabled trust management to exploit the contracts resulting in doctors working excessive hours. Out-of-hours services were contracted and, therefore, compulsory and SAS doctors were also being asked to undertake more out-of-hours and on-call work to help hospitals reduce junior doctors' hours to become compliant with the WTD.
- 8.40 The BMA said that with the implementation of the WTD and the more time-sensitive contracts being implemented for consultants, SAS/NCCGs needed to be protected from exploitation by having out-of-hours work imposed without appropriate reward. SAS/NCCGs were vulnerable to such exploitation because of the disparity between their remuneration for out-of-hours and that of junior colleagues who received banded payments. The BMA asked us to recommend that SAS/NCCGs sharing an out-of-hours rota with junior colleagues be given access to the same out-of-hours banding payments. This would be an interim measure until new contractual arrangements were implemented.
- 8.41 In supplementary written evidence, the **Department of Health** said that there was only limited provision for rewarding excess hours under current arrangements. It said that work intensity, hours worked and adherence to job plans were all issues that would be considered in the light of the NHS Confederation's report.

Comment

- 8.42 *We noted earlier that we had some concerns about the BMA's survey results which are used here in support of its arguments on workload. We have no doubt that SAS/NCCGs are committed to meeting the demands of the service, but the evidence that the BMA has presented suggests that NHS employers are exploiting this group of staff to an extent which then raises the question as to whether the BMA could do more in the future to address these matters at a local level. We note that NHS Employers' recent report to Ministers indicated that better job planning should reduce total hours of work and that this group of doctors worked a wide variety of working patterns. We also note that in its evidence, the Department of Health agreed there was only limited provision for rewarding excess hours under current arrangements. The BMA has asked us to recommend as an interim measure that intensity payments should be paid to SAS/NCCGs at the same level as those paid to consultants under the pre-2003 contract, and that SAS/NCCGs sharing an out-of-hours rota with junior colleagues should also be given access to the same out-of-hours banding payments. We do not intend at this stage to recommend any new pay arrangements which would place additional administrative burdens on both employers and their staff and which would preempt elements of the contract negotiations, but clearly the issue of workload and how work beyond conditioned hours and out-of-hours work is rewarded must be properly addressed in those forthcoming pay negotiations. We would also ask the BMA to consider what it can do now at a local level to support SAS/NCCGs seeking pay recognition from their employers for regular excess hours and out-of-hours commitments.*

Optional and discretionary points

- 8.43 The **BMA** noted that we were seeking information on the operation of the discretionary and optional points schemes for SAS/NCCGs and said it fully supported this work. Its recent survey had found:

- only 42 per cent of respondents had been awarded these points;
- 69 per cent reported applying for points in the last five years;
- a third of those had done so three or more times in the last five years and a quarter of these had been unsuccessful;
- in two-thirds of these cases, reasons were not given for the lack of success, in many cases despite requests for feedback. Others were told they were ineligible and were discouraged from re-applying. Several respondents said they had felt discriminated against; and
- 78 per cent of respondents felt the system was not effective.

8.44 The BMA said it was very disturbing that its survey had found only 42 per cent of respondents had received optional or discretionary points as it was now the ninth year since introduction of discretionary points and seven since the introduction of optional points. The poor compliance of employers clearly demonstrated the Health Departments' lack of central control. For these reasons, the BMA said it requested that we ourselves should take action where local management had failed to reward SAS/NCCGs for their extraordinary service. As its survey had confirmed previous findings regarding lack of access to these points, the BMA therefore asked us **not** to make further use of the schemes as a way to target funding. Furthermore, it requested again that all optional and discretionary points be transferred to an automatic scale, as this would go some way in remunerating senior SAS/NCCGs on the top of the incremental scales before a new contract could be implemented in April 2006.

8.45 In supplementary evidence, the BMA said that the essential difference between the discretionary points scheme under the old consultant contract and the optional and discretionary points schemes for staff grades and associate specialists was that there was a compulsory number of points that employers had to allocate for consultants based on the number of eligible consultants employed. It said that this did not mean, by definition, that every eligible doctor or dentist was awarded points but ensured applications were sought, considered and points awarded as appropriate. The reality was, it said, that without a compulsory minimum number of points, some employers consistently awarded no points at all.

8.46 The BMA said it appreciated the thinking behind our recommendations last year⁴ to award SAS/NCCGs on the top point of the incremental scale who may have been unable to avail themselves of the optional or discretionary points systems. However, it did not agree on the benefits of the award:

- it could be argued that those on the top incremental point had been awarded part of a future optional/discretionary point, but this did not resolve the issue of non-compliant employers denying SAS/NCCGs the opportunity to be remunerated appropriately;
- unless we continued this trend of a higher award for those on the top of the incremental pay scales, it had only benefited those on that top point in 2004. In addition, it had offset the value of the first optional point on the staff grade scale (and likewise for associate specialists), representing an 18 per cent decrease on the value of the first point, and incurring a cost for future SAS/NCCGs moving to that first point; and

⁴ See paragraph 8.42 of the Review Body's Thirty-Third Report 2004.

- awarding the first point was now 18 per cent more cost effective to employers, and 18 per cent less rewarding for SAS/NCCGs, despite the same eligibility and extraordinary service to the NHS for a successful award.

- 8.47 In Scotland, the BMA reported various contractual problems in certain areas and said there was a widespread problem with schemes not being in place which earlier this year had given rise to the SEHD writing twice to all employers reminding them of their obligations. Even where schemes had been set up in response, these included no backdating of awards.
- 8.48 In conclusion, the BMA said that some employers had not implemented optional and discretionary points. There was another group of employers who had a scheme in place but who, without a minimum requirement, did not award points. The BMA said that SAS/NCCGs working for these employers would not receive any points no matter which criteria they fulfilled. Therefore, the BMA said it had asked us again to consider converting these points to an incremental scale. In order to preserve equity, the BMA said that some points on the scale might need to be of greater value than others.
- 8.49 The SEHD told us that it had become aware of concerns in relation to the application of current terms and conditions of service for SAS/NCCGs and it had issued two letters in 2004 to NHS Boards reminding employers about the effective operation of the discretionary points schemes, and about employers' responsibilities to conduct effective job planning and appraisal.

Comment

- 8.50 *We asked our secretariat to carry out a survey of all NHS Trusts employing staff grade doctors and associate specialists and this was identified to be 387 organisations in Great Britain. The purpose of the survey was to examine the extent to which optional and discretionary points were being awarded to this group of doctors. The survey was conducted last autumn and 53 per cent of the Trusts responded to the survey. The survey found that 85 per cent of responding Trusts had a formal scheme for awarding optional points to staff grade doctors and 87 per cent of responding Trusts had a formal scheme for awarding discretionary points to associate specialists. It also showed that at September 2004, 52 per cent of staff grade doctors held optional points and 46 per cent of associate specialists held discretionary points. Although the survey found a high percentage of Trusts with optional/discretionary point schemes and a reasonable percentage of doctors with optional/discretionary points, it remains unclear to us whether the situation would be the same in the 47 per cent of Trusts that did not respond to the survey. The survey's executive summary is to be found at Appendix F and the full report is available on the Office of Manpower Economics' website⁵.*
- 8.51 *We have taken the results from the study commissioned by our secretariat into account in reaching our decision on the recommendations for SAS/NCCGs this round. Now that contract negotiations have been announced, we do not intend to make any further changes to the current schemes. However, we would expect the parties to discuss what part schemes for recognising exceptional contribution to the NHS will have to play in the future contractual arrangements for SAS/NCCGs. We would hope that any new scheme or schemes would be operated consistently by all employers, and that this can be demonstrated to the satisfaction of all interested parties.*

⁵ Office of Manpower Economics web site address: www.ome.uk.com.

Clinical assistants who are not general practitioners

8.52 The **BMA** said that clinical assistants working in acute hospitals who were not general practitioners were included in the review and reform of the SAS/NCCGs, although it understood that the Employers' Organisation report to Ministers might recommend a different course for this group. The BMA said it still maintained that this group should have access to both an incremental payscale and optional points as it would be easier to integrate them within new contracts. The BMA therefore asked us to recommend the introduction of an incremental payscale and optional points for these clinical assistants. In supplementary written evidence, the BMA said that it believed non-GP clinical assistants should have the option to regrade as staff grade or associate specialist.

Comment

8.53 *Our views on this group remain unchanged from last year; a fundamental review of clinical assistants working in acute Trusts is needed and consideration of changes to the current pay structure should follow on from that review. We note the recommendation made by the NHS Confederation in its report to Ministers that this group should be brought within any new contractual arrangements for SAS/NCCGs. We would ask the parties to report on progress here for our next review.*

Recommendations for April 2005

8.54 The **Department of Health** told us it did not believe that it would be either prudent, or justifiable simply to increase the pay of SAS/NCCG doctors above the anticipated rate of inflation for 2005-06. Any pay reform would be taken forward with regard to the Government's key principle for public sector pay reform – namely, investment in return for modernisation. The Department said there would also be a need for clear and identifiable benefits for NHS services and patients. The Department said it now had a clear way forward and had made significant progress through the NHS Confederation's report. In advance of the outcome of the review, the Department said again that it was seeking an uplift in line with the Government's inflation target for SAS/NCCGs.

8.55 The **SEHD** confirmed that it supported the Department of Health's recommendation that for this group, the pay uplift for 2005-06 should be in line with inflation. The **National Assembly for Wales** also said it supported the Department of Health's suggested pay increase in line with anticipated inflation for this group.

8.56 The **BMA** said that SAS/NCCGs had been awaiting the outcome of a review of their grades for a number of years. In the light of the fact that negotiations were yet to get underway, the BMA asked us to consider recommending an appropriate uplift in pay to improve the fragile morale of the group, and the increasing disparity with their colleagues while negotiations get underway. The BMA said it had also asked us to protect SAS/NCCGs from being expected to work an increasing number of hours outside their normal contracts and having to take on greater intensity of work as a result of the implementation of the WTD for junior colleagues, through the interim measures of intensity payments and out-of-hours banding.

Comment

- 8.57 *We have much sympathy with the frustration that has been expressed to us many times by SAS/NCCGs on our visits and by the BMA through the formal evidence processes at the time it has taken the Health Departments to address SAS/NCCGs' concerns about career progression and pay, terms and conditions. We therefore very much welcome the progress which is now being made here and would hope that the momentum can be maintained. We have consistently said over the last few years that a review of this group's role, career progression and training opportunities was the necessary foundation on which to conduct a review of pay. We very much hope that the deadline of April 2006 set by the Minister for the implementation of new arrangements will be met.*
- 8.58 *We do not intend, given the impending contract negotiations, to make any recommendations which will change or further complicate the existing pay arrangements for this group. However, we would expect the issues which the BMA has been bringing to our attention over recent rounds – payment for work beyond contracted hours, work undertaken in out of hours, intensity of work, methods of recognising exceptional contribution to the NHS, etc – to be properly addressed by the forthcoming negotiations. We would ask the parties to report progress here for our next review. We also hope that the parties will consider in their negotiations those SAS/NCCGs who are not currently employed on national contracts and we hope that this group can be integrated into new national terms and conditions.*
- 8.59 *We have reached our decision about the recommendation for SAS/NCCGs in the light of the developments since our last report and from the standpoint that we do not wish to impede the forthcoming negotiations in any way. We therefore consider that the simplest approach is to recommend a flat rate percentage increase which will benefit all SAS/NCCGs and which will also be pensionable, easy to implement and not complicate the existing pay structures. **We therefore recommend (recommendation 21) an increase of 3.225 per cent for 2005-06 on the national salary scales of SAS/NCCGs in recognition that other groups who are already working under revised contracts will receive this figure in 2005-06 and that there has been a delay in negotiating a new contract for this group.***
- 8.60 *In reaching our decision, we also considered various other ideas involving possible one-off adjustments or schemes for discretionary and optional points. However, now that contract negotiations have been announced, we consider that our chosen route is the simplest, particularly in the light of the results of our study on the operation of the discretionary/optional points schemes.*
- 8.61 *In the usual way, our recommendation of a 3.225 per cent increase for SAS/NCCGs will also apply to the payscales for clinical assistants and hospital practitioners who are not also GMPs and we note the NHS Confederation's proposal that this group should be brought within any new contractual arrangements for SAS/NCCGs. Our recommendation for clinical assistants and hospital practitioners who are GMPs are set out in Chapter 2 of the report.*

APPENDIX A

DETAILED RECOMMENDATIONS ON REMUNERATION

PART I: RECOMMENDED SALARY SCALES

The salary scales that we recommend for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be pro rata that of equivalent whole-time staff.

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

	Current scales £	Recommended scales payable from 1 April 2005 ¹ £
	<i>(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
House officer	19,703 20,972 22,240	20,295 21,601 22,907
Senior house officer	24,587 26,235 27,884 29,532 31,180 32,829 ² 34,477 ²	25,324 27,022 28,720 30,418 32,116 33,813 35,511
Registrar	27,483 28,875 30,266 31,658 33,337	28,307 29,741 31,174 32,607 34,337
Senior registrar	31,658 33,337 35,016 36,695 38,374 40,053 41,733 ³	32,607 34,337 36,067 37,796 39,526 41,255 42,985

¹ The current scales have been calculated from the 2003-04 scales, with cumulative recommended awards being applied to the 2003-04 figures. The resultant calculation is rounded up to the nearest pound.

² To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth Report, paragraph 3.21, and paragraph 6.46 of the Thirty-First Report.

³ To be awarded automatically except in cases of unsatisfactory performance, see paragraph 6.61 of the Thirty-Third Report.

	Current scales £	Recommended scales payable from 1 April 2005 ¹ £
Specialist registrar ⁴	27,483	28,307
	28,875	29,741
	30,266	31,174
	31,658	32,607
	33,337	34,337
	35,016	36,067
	36,695	37,796
	38,374 ⁵	39,526
	40,053 ⁵	41,255
	41,733 ⁶	42,985
Consultant (2003 contract, England and Scotland) ⁷	67,133	69,298
	69,264	71,498
	71,396	73,699
	73,528	75,899
	75,654	78,094
	80,717	83,320
	85,780	88,547
	90,838	93,768
<i>Clinical excellence awards⁸</i>	<i>Value</i>	
	2,702	2,789
	5,404	5,578
	8,106	8,367
	10,808	11,156
	13,510	13,945
	16,212	16,734
	21,616	22,312
	27,020	27,890
	32,424	33,468
Consultant (2003 contract, Wales) ⁹	65,032	67,130
	67,133	69,298
	70,648	72,926
	74,730	77,140
	79,391	81,951
	82,049	84,695
	84,712	87,444 ¹⁰
<i>Commitment awards¹¹</i>	<i>Value</i>	
	2,927	3,021
	5,854	6,042
	8,781	9,063
	11,708	12,084
	14,635	15,105
	17,562	18,126
	20,489	21,147

⁴ The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.

⁵ To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth Report, paragraph 3.21.

⁶ See paragraph 6.61 of the Thirty-Third Report.

⁷ Pay thresholds and transitional arrangements apply.

⁸ Local level CEAs. Eligibility for CEAs is after one year's service as a consultant. For higher national CEAs, see Part II below.

⁹ From 1 December 2003.

¹⁰ From 1 December 2003.

¹¹ Awarded every 3 years once the maximum on the scale is reached.

	Current scales £	Recommended scales payable from 1 April 2005 ¹ £
Consultant (pre-2003 contract)	55,699	57,370
	59,753	61,545
	63,807	65,721
	67,861	69,896
	72,483	74,658
<i>Discretionary points</i> ¹²	<i>Value</i>	
	2,927	3,021
	5,854	6,042
	8,781	9,063
	11,708	12,084
	14,635	15,105
	17,562	18,126
	20,489	21,147
	23,416	24,168
Associate specialist	33,090	34,158
	36,695	37,879
	40,300	41,600
	43,905	45,321
	47,510	49,042
	51,114	52,763
	55,874	57,676
	60,000 ¹³	61,935
<i>Discretionary points</i>	<i>Notional scale</i>	
	61,713	63,703
	63,947	66,009
	66,180	68,315
	68,414	70,620
	70,648	72,926
	72,882 ¹⁴	75,233
Staff grade practitioner (1997 contract, MH03/5)	29,845	30,808
	32,289	33,331
	34,734	35,854
	37,178	38,377
	39,622	40,900
	42,500 ¹⁵	43,871
<i>Discretionary points</i> ¹⁶	<i>Notional scale</i>	
	44,511	45,946
	46,955	48,469
	49,399	50,992
	51,843	53,515
	54,288	56,038
	56,732 ¹⁷	58,562

¹² Eligibility for discretionary points is after five years' service as a consultant.

¹³ Incremental point increased, see paragraph 8.42 of the Thirty-Third Report.

¹⁴ See the Thirty-Third Report, paragraph 8.38.

¹⁵ Incremental point increased, see paragraph 8.42 of the Thirty-Third Report.

¹⁶ See Twenty-Seventh Report, paragraph 2.34.

¹⁷ Additional discretionary point, see the Thirty-Third Report, paragraph 8.38.

	Current scales £	Recommended scales payable from 1 April 2005 ¹ £
Staff grade practitioner (pre-1997 contract, MH01)	29,845	30,808
	32,289	33,331
	34,734	35,854
	37,178	38,377
	39,622	40,900
	42,066	43,423
	44,511	45,946
	46,955	48,469
<i>(annual rates on the basis of a notional half day per week)</i>		
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,078	4,209
Hospital practitioner (limited to a maximum of 5 half day weekly sessions)	3,990	4,119
	4,221	4,358
	4,453	4,596
	4,684	4,835
	4,915	5,073
	5,146	5,312
	5,377	5,550

Details of the supplements payable to public health medicine staff are set out in Part II of this Appendix.

B. Community health staff

*(salary scales excluding earnings from
additional sources, such as out-of-hours
payments for training grades)*

Clinical medical officer	28,551	29,472
	30,148	31,120
	31,745	32,769
	33,342	34,417
	34,939	36,066
	36,536	37,714
	38,133	39,363
	39,730	41,011
Senior clinical medical officer	40,736	42,050
	43,273	44,669
	45,810	47,287
	48,347	49,906
	50,883	52,524
	53,420	55,143
	55,957	57,761
58,493	60,380	

C. Salaried primary dental care staff¹⁸

	Current scales £	Recommended scales payable from 1 April 2005 ¹ £
	<i>(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
Band 1: Community dental officer	30,313	31,290
	32,842	33,901
	35,371	36,511
	37,900	39,122
	40,429	41,732
	42,958	44,343
	45,487 ¹⁹	46,954 ¹⁹
	48,016 ¹⁹	49,564 ¹⁹
Band 2: Senior dental officer	43,721	45,131
	47,257	48,781
	50,792	52,430
	54,328	56,080
	57,863	59,729
	58,643 ²⁰	60,534 ²⁰
	59,422 ²⁰	61,338 ²⁰
Band 3: Assistant clinical director	58,410	60,294
	59,329	61,242
	60,248	62,191
	61,166	63,139
	62,085 ²⁰	64,087 ²⁰
	63,004 ²⁰	65,036 ²⁰
Band 3: Clinical director	58,410	60,294
	59,329	61,242
	60,248	62,191
	61,166	63,139
	62,085	64,087
	63,004	65,036
	63,923	65,984
	64,857	66,948
	65,775 ²⁰	67,897 ²⁰
	66,694 ²⁰	68,845 ²⁰

¹⁸ These scales also apply to salaried dentists working in Personal Dental Services.

¹⁹ Performance based increment, see paragraphs 4.21, 4.30 and 4.38 of the Thirty-First Report. See also Twenty-Eighth Report, paragraph 8.9 (community dental officers) and Twenty-Ninth Report, paragraph 7.61 (salaried general dental practitioners).

²⁰ Performance based increment, see paragraphs 4.21 and 4.38 of the Thirty-First Report. See also Thirtieth Report, paragraph 8.15.

	Current scales £	Recommended scales payable from 1 April 2005 ¹ £
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	51,185 54,426 57,667 60,908 64,857 65,775 ²¹ 66,694 ²¹	52,835 56,181 59,527 62,873 66,948 67,897 ²¹ 68,845 ²¹
Part-time dental surgeon:	<i>Sessional fee (per hour)</i>	
Dental surgeon	25.14	25.95
Dental surgeon holding higher registrable qualifications	33.35	34.42
Dental surgeon employed as a consultant	41.55	42.89

Details of the supplements payable to community dental staff are set out in Part II of this Appendix.

²¹ Performance based increment, see paragraph 4.48 of the Thirty-First Report.

PART II: DETAILED RECOMMENDATIONS ON FEES AND ALLOWANCES

Operative date

1. The new levels of remuneration set out below should operate from 1 April 2005. The previous levels quoted are those currently in force.

Hospital medical and dental staff

2. The budget for higher clinical excellence awards should be increased in line with the increase in the number of consultants now eligible for an award (including academic GMPs) in England and Wales. In Scotland, the number of A plus awards should be increased by two, the number of A awards should be increased by four, and the number of B awards should be increased by nine.
3. The annual values of higher national clinical excellence awards for consultants and academic GMPs should be increased as follows:

Bronze (Level 9):	from £32,424 to £33,468
Silver (Level 10):	from £42,622 to £43,997
Gold (Level 11):	from £53,278 to £54,996
Platinum (Level 12):	from £69,261 to £71,495

4. The annual values of distinction awards for consultants¹ should be increased as follows.

B award:	from £29,203 to £30,145
A award:	from £51,102 to £52,750
A plus award:	from £69,347 to £71,583

5. The annual values of intensity payments should be increased to the following amounts:

Daytime supplement:	from £1,143 to £1,178	
Out-of-hours supplement	(England and Scotland)	(Wales)
Band 1:	from £861 to £887	from £1,982 to £2,046
Band 2:	from £1,717 to £1,769	from £3,964 to £4,092
Band 3:	from £2,568 to £2,645	from £5,946 to £6,138

¹ For 2005-06 applies to existing consultants currently in receipt of a distinction award in England, Scotland and Wales and to eligible consultants in Scotland.

6. Under the agreement reached between the Health Departments and the BMA on the new contract for doctors and dentists in training, the following non-pensionable multipliers apply to the basic pay of whole-time doctors and dentists in training grades (and flexible trainees working 40 hours or more a week or in New Deal non-compliant posts):

	December 2002 onwards²
Band 3	2.00
Band 2A	1.80
Band 2B	1.50
Band 1A	1.50
Band 1B	1.40
Band 1C	1.20

7. Under the new contract agreed by the parties, 1.0 represents the basic salary (shown in Part I of this Appendix) and figures above 1.0 represent the total salary to be paid, including a supplement, expressed as a multiplier of the basic salary.
8. Under the new contract agreed by the parties, the following multipliers will apply to the basic pay of flexible trainees working less than 40 hours of actual work per week:

	December 2000 onwards
Band FA	1.25
Band FB	1.05
Band FC	*

* Flexible trainees with no duty outside the period 8 a.m. to 7 p.m. Monday to Friday will be paid according to the following formula: (hours of duty/40) x basic pay.

² See paragraph 6.41 of this report.

9. The fee for domiciliary consultations should be increased from £73.19 to £75.55 a visit. Additional fees should be increased *pro rata*.
10. Weekly and sessional rates for locum appointments³ in the hospital service should be increased as follows:
- | | |
|--|---|
| Associate specialist, senior hospital medical or dental officer appointment | from £876.59 to £904.86 a week;
from £79.69 to £82.26 a notional half day. |
| Specialist registrar LAS appointment | from £655.60 a week to £675.20;
from £16.39 to £16.88 per standard hour. |
| Senior house officer appointment | from £566.80 a week to £583.60;
from £14.17 to £14.59 per standard hour. |
| House officer appointment | from £402.40 a week to £414.40;
from £10.06 to £10.36 per standard hour. |
| Hospital practitioner appointment | from £89.05 to £92.71 a notional half day. |
| Staff grade practitioner appointment | from £712.80 to £760.20 a week;
from £71.28 to £76.02 a session. |
| Clinical assistant appointment
(part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service) | from £78.88 to £80.72 a notional half day. |
11. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

London Weighting

12. The value of London weighting where applicable should be increased as follows:
- | | |
|---------------------|------------------------|
| Non-resident staff: | from £2,098 to £2,161; |
| Resident staff: | from £584 to £602. |

³ For locum rates under the 2003 consultant contract, refer to Schedule 22 of the contract's Terms and Conditions of Service.

Ophthalmic medical practitioners

13. The ophthalmic medical practitioners' gross fee for sight testing should be negotiated between the parties.

Doctors in public health medicine

14. The supplements payable to district directors of public health (directors of public health in Scotland and Wales) and for regional directors of public health should be increased as follows⁴:

	Current range of supplements £	Recommended range or supplements payable from 1 April 2005 £
Island Health Boards: Band E (under 50,000 population)	1,575 – 3,123	1,625 – 3,224
District director of public health (director of public health in Scotland/Wales):		
Band D (District of 50,000 – 249,999 population)	3,123 – 6,246 (Bar); 7,809	3,224 – 6,447 (Bar); 8,061
Band C (District of 250,000 – 449,999 population)	3,918 – 7,809 (Bar); 9,384	4,044 – 8,061 (Bar); 9,686
Band B (District of 450,000 and over population)	4,687 – 9,384 (Bar); 12,104	4,838 – 9,686 (Bar); 12,494
Regional director of public health: Band A:	12,104 – 17,569	12,494 – 18,136

15. From 1 December 2000, no supplement will be payable to trainees in public health medicine or dental public health for out-of-hours commitments. Under the new pay system, trainees will receive the banding supplement applicable to their hours and working arrangements.

General medical practitioners

16. The supplement payable to GMP registrars for out-of-hours duties is 65 per cent⁵ of basic salary for 2005-06.
17. The salary range for salaried GMPs⁶ employed by Primary Care Organisations should be £49,248 to £74,816 for 2005-06.

General dental practitioners

18. The gross fee for each item of service and capitation payment should be increased by 3.4 per cent from 1 April 2005.
19. The sessional fee for practitioners working a 3-hour session under Emergency Dental Service schemes should be increased from £105.17 to £108.74.

⁴ Population size is not the sole determinant for placing posts within a particular band.

⁵ See paragraph 2.41 of this report.

⁶ See paragraph 2.28 of this report.

20. The sessional fee for part-time salaried dentists working six 3-hour sessions a week or less in a health centre should be increased from £74.45 to £76.98.
21. The hourly rate payable in relation to the Continuing Professional Development allowance and for clinical audit / peer review should be increased from £57.37 to £59.32.
22. The quarterly payments under the Commitment Payments scheme⁷ should be increased as follows:

Level 1 payment	from £38 to £40 a quarter
Level 2 payment	from £324 to £336 a quarter
Level 3 payment	from £419 to £434 a quarter
Level 4 payment	from £503 to £521 a quarter
Level 5 payment	from £587 to £607 a quarter
Level 6 payment	from £669 to £692 a quarter
Level 7 payment	from £754 to £780 a quarter
Level 8 payment	from £838 to £867 a quarter
Level 9 payment	from £921 to £953 a quarter
Level 10 payment	from £1,004 to £1,039 a quarter

Community health and community dental staff

23. The teaching supplement for assistant clinical directors in the CDS should be increased from £2,158 to £2,227 a year.
24. The teaching supplement payable to clinical directors in the CDS should be increased from £2,437 to £2,515 a year.
25. The supplement for clinical directors covering two districts should be increased from £1,575 to £1,625 a year and the supplement for those covering three or more districts should be increased from £2,514 to £2,595 a year.
26. The allowance for dental officers acting as trainers should be increased from £1,724 to £1,780 a year.
27. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

⁷ See paragraph 3.89 of this report. Calculated from 2004-05 payments, with the recommended uplift being applied to the 2004-05 figures.

APPENDIX B

NUMBERS OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE¹ IN GREAT BRITAIN

	2002		2003		Percentage change 2002-2003	
	Whole-time equivalents	Headcount	Whole-time equivalents	Headcount	Whole-time equivalents	Headcount
Hospital medical and dental staff^{2,3}						
Consultants	28,561	31,067	30,231	32,799	5.8%	5.6%
Associate specialists	1,856	2,099	2,072	2,336	11.7%	11.3%
Staff grade	5,564	6,105	5,620	6,160	1.0%	0.9%
Registrar group	14,869	15,680	15,908	16,596	7.0%	5.8%
Senior house officers	20,422	20,670	22,109	22,422	8.3%	8.5%
House officers	5,004	5,025	5,023	5,033	0.4%	0.2%
Hospital practitioners	268	1,185	267	1,230	-0.3%	3.8%
Clinical assistants	1,519	5,503	1,287	4,908	-15.2%	-10.8%
Other	4	5	-	-	-	-
Total	78,066	87,339	82,518	91,484	5.7%	4.7%
Public health and community medical staff²						
Regional and district directors	190	194	244	270	28.2%	39.2%
Consultants	528	653	506	654	-4.1%	0.2%
Registrar group	261	278	286	313	9.7%	12.6%
Senior house officers	28	30	36	36	26.8%	20.0%
Senior clinical medical officers	474	673	409	593	-13.7%	-11.9%
Clinical medical officers	269	532	230	487	-14.6%	-8.5%
Other medical staff	152	396	45	223	-70.0%	-43.7%
Total	1,902	2,756	1,756	2,576	-7.6%	-6.5%
Community dental staff²						
Regional and district dental officers/clinical director	83	90	88	95	5.9%	5.6%
Assistant district dental officers/clinical director	48	52	52	56	7.9%	7.7%
Consultants	54	72	48	69	-12.3%	-4.2%
Senior dental officers	410	515	428	541	4.2%	5.0%
Dental officers	777	1,068	779	1,078	0.3%	0.9%
Other dental staff	40	61	54	101	33.8%	65.6%
Total	1,413	1,858	1,448	1,940	2.5%	4.4%

NUMBERS OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN GREAT BRITAIN (*continued*)

	2002		2003		Percentage change 2002-2003	
	Whole-time equivalents	Headcount	Whole-time equivalents	Headcount	Whole-time equivalents	Headcount
General practitioners^{4,5}						
General medical practitioners:⁶34,915	38,650	35,877	40,011	2.8%	3.5%	
Unrestricted Principals and Equivalents	31,153	33,578	31,507	34,152	1.1%	1.7%
General Medical Services						
Unrestricted Principals	24,895	26,785	21,890	23,669	-12.1%	-11.6%
Personal Medical Services GPs ⁷	6,258	6,793	9,617	10,483	53.7%	54.3%
Restricted principals	83	92	79	86	-5.3%	-6.5%
Assistants ¹⁰	343	495	360	505	-5.0%	2.0%
GMS GP registrars ⁸	1,797	1,861	1,730	1,799	-3.7%	-3.3%
PMS GP registrars ⁸	506	525	794	827	56.8%	57.5%
Associates	17	44	16	43	-1.6%	-2.3%
GP retainers ⁹	503	1,371	399	1,250	-20.5%	-8.8%
Salaried doctors (para 52 SFA)	100	127	128	149	27.3%	17.3%
Personal Medical Services other ^{10,11}	414	558	751	969	81.7%	73.7%
Flexible Career Schemes	-	-	52	175	-	-
GP Returners	-	-	60	62	-	-
General dental practitioners:²	-	22,393	-	22,702	-	1.4%
principals	-	19,336	-	19,555	-	1.1%
assistants and vocational practitioners	-	2,202	-	2,146	-	-2.5%
Personal Dental Services ¹²	-	656	-	806	-	22.9%
salaried dentists ¹³	-	199	-	195	-	-2.0%
Ophthalmic medical practitioners^{14,15}	-	686	-	644	-	-6.1%
Total	-	61,729	-	63,357	-	2.6%
Total – NHS doctors and dentists	-	153,682	-	159,357	-	3.7%

¹ The table contains whole-time equivalent (WTE) and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

² Data as at 30 September.

³ Figures include hospital dental staff – in 2003 there were a total of 2,754 (1,981 WTE) hospital dental staff compared with 2,764 (1,944 WTE) in 2002.

⁴ England and Wales GP WTE data has been estimated using the results from the 1992-93 GMP Workload Survey. Full time = 1.00 wte; three quarter time = 0.69 wte; job share = 0.65 wte; half time = 0.60 wte. In 2002 Scottish Non-Principals do not have WTE so factors of 0.65 are applied to all except GP Registrars where a factor of 0.96 is applied.

⁵ Data as at 30 September for England and Wales, as at 1 October for Scotland. Headcount is the number of staff in post.

⁶ The General Medical Practitioner total is one fewer than the sum of its parts in 2002 and six fewer in 2003 due to General Medical Practitioners in Scotland who have two posts in separate categories.

⁷ PMS UPEs comprise Independent contractors and Salaried GMPs (with a patient list).

⁸ GMP Registrars were formerly known as GMP trainees.

⁹ GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the session as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of 4 sessions of approximately half a day per week.

¹⁰ In 2002 includes one assistant in Scotland who has a post both in a GMS and PMS practice.

¹¹ PMS others total contains PMS assistants plus 'other' PMS GPs in Scotland of an unspecified 'GP type' which do not fall into any of the other GP categories.

¹² In 2002 and 2003, a further 341 and 390 dentists respectively worked in Personal Dental Services but also had a General Dental Services contract. Most of these would appear in the general dental practitioner principals row. These are excluded from Personal Dental Services figures to avoid double counting. There are no PDS schemes in Scotland.

¹³ Data as at September except Scotland as at March 2003.

¹⁴ At 31 December 2003 for England and Wales and 31 March 2004 for Scotland.

¹⁵ Figures have been revised from previously published data.

APPENDIX C

THE 2004-05 SETTLEMENT

In our Thirty-Third Report we put forward recommendations on the level of remuneration we considered appropriate for doctors and dentists in the NHS as at 1 April 2004. Our main recommendations were:

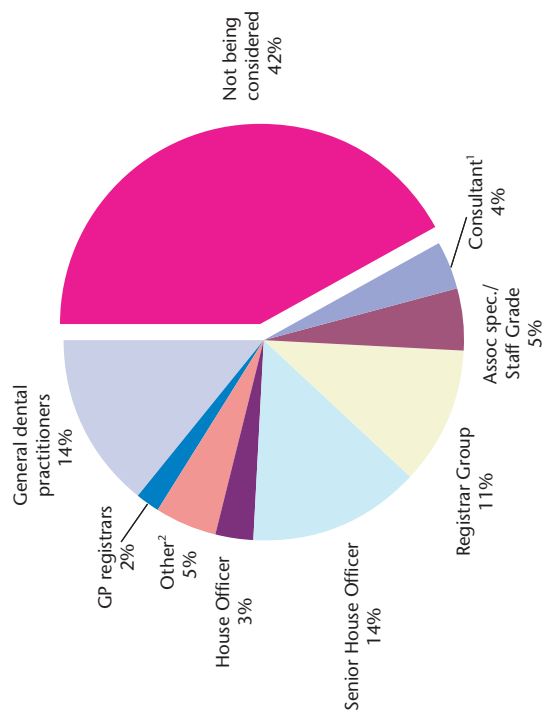
- an increase of 2.7 per cent for all grades of doctors and dentists in training;
- an increase of 2.7 per cent for associate specialists, staff grade practitioners, hospital practitioners and clinical assistants;
- an increase of 2.5 per cent for consultants remaining on the “old” national contract; and
- an increase of 2.9 per cent for general dental practitioners (on gross fees).

The Government accepted in full our recommendations relating to 2004-05.

APPENDIX D

DDR B STAFF GROUPS UNDER CONSIDERATION FOR 2005-06

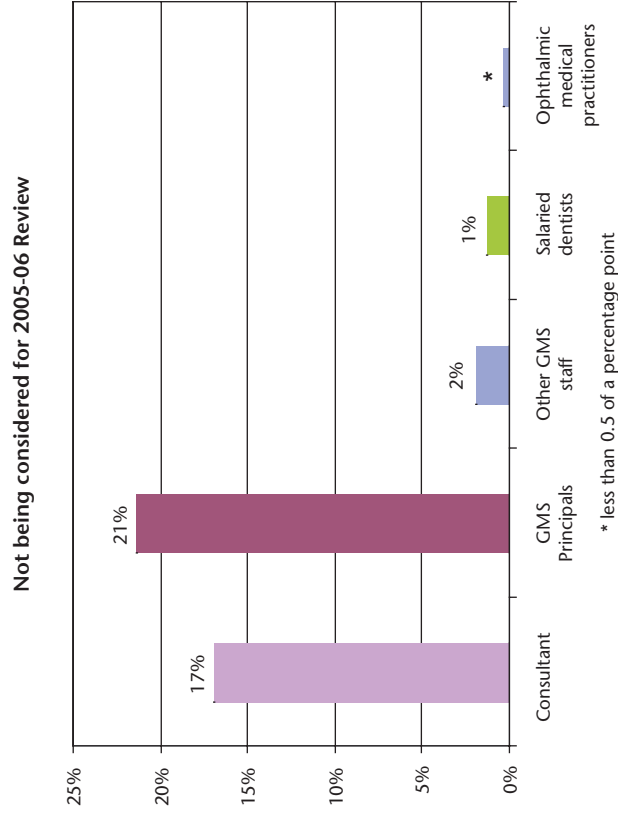
Total: 159,360 headcount, Great Britain



1. For England and Scotland, based on the proportion of consultants who are yet to sign up to the new contract.

2. Hospital Practitioners, Clinical Assistants, Clinical Medical Officers and other medical staff.

Percentages of those not being considered are affected by rounding



APPENDIX E

THE POLICY FRAMEWORK

1. The evidence we have received from the three **Health Departments** was set in the context of the following policy documents:
 - The *NHS Plan*¹ and *HR in the NHS Plan*² covering England;
 - *Our National Health, A Plan for Action, A Plan for Change*³, *Working for Health, the Workforce Development Action Plan for Scotland*⁴, *A Partnership for a Better Scotland: Partnership Agreement*⁵ and *Building a Better Scotland*⁶ covering Scotland;
 - *Improving Health in Wales – A Plan for the NHS with its partners*⁷, *Delivering for Patients*⁸ and the *Wanless Report Implementation Plan*⁹ in Wales; and
 - *Modernising Medical Careers*¹⁰.
2. The objective of the *NHS Plan* was to modernise the NHS in England through a combination of investment and reform. It committed the Government to increases in key staff groups over the period to 2004 alongside a range of Human Resource (HR) initiatives designed to complement the increases in numbers and improve working lives. The key targets in the *NHS Plan* affecting our remit groups were for:
 - 1,000 more medical school places;
 - 1,000 more specialist registrars;
 - 7,500 more consultants; and
 - 2,000 more general medical practitioners.
3. By 2008, the **Department of Health** expected the NHS to have net increases of 15,000 doctors (consultants and GMPs) over the September 2001 baseline. The HR initiatives in the *NHS Plan* had now been strengthened by *HR in the NHS Plan* which outlined a five-year strategy aimed at delivering increased numbers of staff with jobs designed around the needs of patients.

¹ *The NHS Plan* published by the Department of Health on 27 July 2000.

² *HR in the NHS Plan* published by the Department of Health in July 2002.

³ *Our National Health, A Plan for Action, A Plan for Change* published by the Scottish Executive on 14 December 2000.

⁴ *Working for Health, the Workforce Development Action Plan for Scotland* published in August 2002.

⁵ *A Partnership For A Better Scotland: Partnership Agreement*, May 2003, produced by the Labour/Liberal Democrat coalition following the Scottish Parliament elections in May 2003.

⁶ *Building a Better Scotland* published by the Scottish Executive in 2004.

⁷ *Improving Health in Wales – A Plan for the NHS with its partners* published by the National Assembly for Wales on 2 February 2001.

⁸ *Delivering for Patients*, the Human Resources Strategy for NHS Wales launched in June 2000.

⁹ *Wanless Report Implementation Plan*, developed by the National Assembly for Wales in November 2003.

¹⁰ *Modernising Medical Careers; the next steps* published by the Department of Health 15 April 2004.

4. In Scotland, *Our National Health, A Plan for Action, A Plan for Change*, set out the **Scottish Executive Health Department's** (SEHD's) long-term plans for improving Scotland's health. These focused on a more patient-centred approach and lasting investment in Scotland's health workforce. *Working for Health, the Workforce Development Action Plan for Scotland* was published in August 2002 setting out the SEHD's proposals for better workforce planning and development. Both policies emphasised the need to integrate the planning of services with the planning of the workforce needed to support them, and called for multidisciplinary development of the workforce to support service delivery.
5. *A Partnership for a Better Scotland: Partnership Agreement* set out a number of targets and commitments relating to the medical and dental workforce, including: the aim of increasing the number of consultants in the NHS by 600 by 2006, and continuing to build on that thereafter; further measures to attract and retain GMPs; and the options for addressing the shortfall in the number of dentists in some areas of Scotland. The need for further measures for the medical and dental workforce would be informed by work underway to improve workforce development and workforce planning. *Building a Better Scotland* set out the SEHD's commitment to deliver the key national priorities. Among its priorities were to meet the growing demand for health services, to develop, improve and meet the costs associated with the demand-led primary care services, and to secure a more flexible workforce.
6. In Wales, the key objective of *Improving Health in Wales – A Plan for the NHS with its partners*, launched in 2001, was to deliver patient-centred care of the highest quality for the people of Wales. The **National Assembly for Wales'** new workforce planning process was based on need, taking into account national and local strategies, policies and initiatives, rather than affordability. Based on the 2001 Workforce Planning process, the Assembly planned to have almost 9,000 more professional staff in NHS Wales by 2010, including 700 more hospital consultants and GMPs. The Wanless Report Health and Social Care Review, published in June 2003, highlighted the need for a change in the balance between preventing and treating problems and between acute and other forms of care, and called for a radical redesign of services, supported through greater use of information and information technology. The Assembly's response, the *Implementation Plan*, was aligned to four main themes: prevention; optimising service delivery; involving people; and performance and accountability.
7. *Modernising Medical Careers*, prepared under the auspices of all four UK home countries, looked at the future shape of Foundation, Specialist and General Practice Training Programmes, and examined opportunities for streamlining the training of doctors and dentists, and ways of providing greater flexibility.

APPENDIX F

Overview of the Research Survey on the Access to and Award of Optional or Discretionary Awards to Staff Grade Practitioners and Associate Specialists

Executive Summary

Survey Response/Representation

Survey respondents represent over 53% of the 387 NHS organisations identified in the Medical & Dental Census for 2003 as employing associate specialists and staff grade practitioners (ASSGs).

These survey respondents employ:

- 1,275 associate specialists (54% of the 2,351 employed in 2003);
- 3,265 staff grade practitioners (53% of the 6,168 employed in 2003).

Results for Staff Grade Practitioners

Optional Points Schemes/Awards

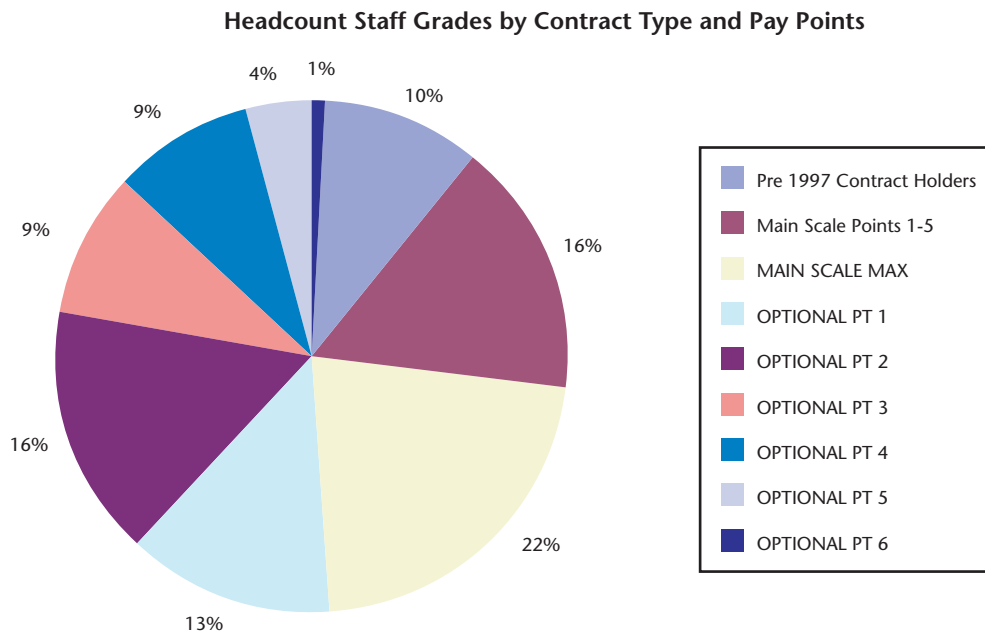
- 189 participating organisations employed staff grade practitioners at 30 September 2004 (this represents 93% of the total of 204 respondents employing ASSGs in 2003/2004).
- 161 organisations (85%) have a formal scheme for awarding optional points but 26 (14%) do not have a scheme (2 organisations did not indicate whether they had a scheme).
- The 26 organisations without a scheme employ 190 staff grade practitioners (by headcount) or nearly 6% of staff grades employed by survey respondents.
- 11 of the organisations (42%) without a scheme for awarding optional points also did not have a scheme for awarding discretionary points to associate specialists.
- The most common reasons given by organisations for not having a scheme were that they were developing one (11 organisations or 42% of those without a scheme) or they did not employ staff grade practitioners eligible for optional points (10 organisations or 38% of those without a scheme). Five organisations had only recently recruited staff grades and three organisations had incorporated optional points into salary scales. (Note: four organisations did not give reasons and some organisations provided more than one reason).
- 137 organisations employed staff grade practitioners in receipt of optional points at 30 September 2004. This is equivalent to:
 - 72% of the organisations employing staff grade practitioners.
 - 85% of the organisations with schemes for awarding optional points.
- 92 organisations received applications/nominations for optional points from 1 April 2004 (57% of those with schemes) but 69 organisations did not receive applications/nominations.

- 61 organisations had awarded optional points from 1 April 2004 (66% of those receiving nominations). 31 organisations had yet to award optional points with 26 organisations saying their panel/committee was due to decide on awards for 2004.

Analysis by Contract Held & Salary/Optional Points

Data on staff grades employed at 30 September 2004 was collected from a sub-sample of 137 respondents employing a total of 2,122 staff grades.

The data shows nearly 52% of staff grade practitioners employed were in receipt of optional points at 30 September 2004.



The data collected does not show how many staff grades employed by respondents were eligible for points at 1 April 2004 but it shows that just over a quarter of staff grade practitioners were not eligible for optional points:

- 10% of staff grade practitioners were still employed on pre-1997 contracts at 30 September 2004 and were not eligible for optional points.
- Nearly 16% of staff grade practitioners were employed on post-1997 contracts but were on a main scale point below the maximum at 30 September 2004 and not, therefore, eligible for points from April 2004.
- The 23% of all staff grades (25% of post-1997 contract holders) on the maximum point of the main scale at 30 September 2004 are eligible for optional points in the future, and many of these post holders were also likely to have been eligible for points from 1 April 2004.
- The 52% of staff grades (57% of post-1997 contract holders) in receipt of optional points at 30 September 2004 were also likely to have been eligible for optional points from April 2004 – apart from the small number of post holders already receiving the maximum number of optional points.
- Over half (56%) of staff grades receiving optional points are on points 1 and 2; just over one third (35%) are on points 3 and 4; and less than 8% are on points 5 and 6 at 30 September 2004.

It should be noted that a number of organisations had yet to award optional points from April 2004.

Analysis by Gender, Ethnic Origin, Contract Status, Country of Primary Qualification

The analysis of the proportions of staff grade practitioners receiving optional points is broadly in line with the profile of all staff grade practitioners employed when analysed by:

- Gender
- Ethnic Origin
- Contract Status
- Country of Primary Qualification

The data provides no evidence of discrimination on these grounds.

Years in Present Grade

Analysis of staff grades employed by the numbers of years in present grade shows that those in receipt of optional points generally have spent longer in the grade than those on the main scale points. Around two-thirds of those on the main scale points (including the maximum) have spent up to 12 months or 1 to 2 years in the present grade while over two-thirds in receipt of optional points are spent between 3 and 15 years in the present grade.

Results for Associate Specialists

Discretionary Points Schemes/Awards

- 180 participating organisations employed associate specialists at 30 September 2004 (88% of the 204 respondents employing ASSGs in 2003/4).
- 157 organisations (87%) have a formal scheme for awarding discretionary points but 21 (12%) do not have a scheme. Two organisations (1%) did not indicate whether they had a scheme.
- The 21 organisations without a scheme employ 58 associate specialists (headcount), which represent less than 5% of all associate specialists employed by survey respondents.
- 11 of these organisations (52%) also did not have a scheme for awarding optional points to staff grade practitioners.
- The most common reasons given for not having a formal scheme were that they were in the process of developing a scheme (8 organisations or 38% of those without a scheme) or they had only recently employed associate specialists (5 organisations or 24%) or they did not have any associate specialists who were eligible for discretionary points (3 organisations or 14%). Some organisations did not give a reason for not having a scheme.
- 130 organisations employed associate specialists in receipt of discretionary points at 30 September 2004. This is equivalent to:

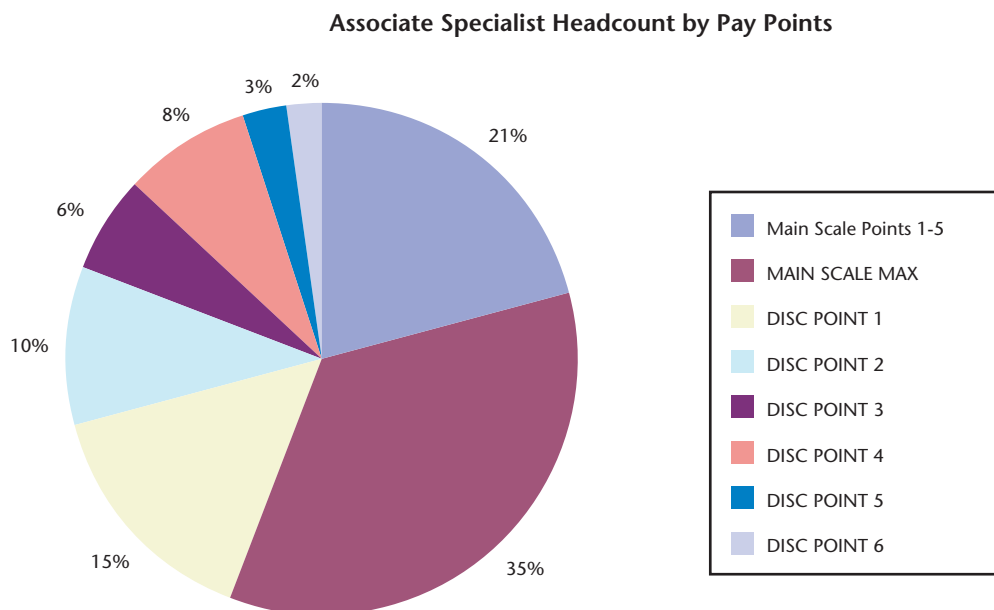
- 72% of the organisations employing associate specialists;
- 83% of the organisations with formal schemes for awarding discretionary points.
- 93 organisations received applications/nominations for discretionary points from 1 April 2004 (59% of those with schemes) but 64 organisations did not receive applications/nominations.
- 63 organisations had awarded discretionary points from 1 April 2004 (68% of those receiving nominations). 30 organisations had yet to award discretionary points with 18 organisations saying their panel/committee was due to decide on awards for 2004.

Analysis by Main Scale Salary/Discretionary Points

Data on associate specialists employed at 30 September 2004 was collected from a sub-sample of 127 respondents employing 920 associate specialists:

This data shows 46% are in receipt of discretionary points at 30 September 2004.

The data does not show how many associate specialists employed by respondents were eligible for points at 1 April 2004 but it shows that just over one-in-five associate specialists would not have been eligible for discretionary points from April 2004 because they were employed on main scale points below the maximum at 30 September 2004.



35% were on the maximum point of the main scale at 30 September 2004 and many of these were likely to have been eligible for points from April 2004. Those on discretionary points (apart from the few already receiving the maximum number) would have also been eligible.

Over half (57%) of associate specialists receiving discretionary points are on points 1 and 2; slightly less than one third (31%) are on points 3 and 4; and 12% are on points 5 and 6.

Analysis by Gender, Ethnic Origin, Contract Status, Country of Primary Qualification

The analysis of the proportions of associate specialists receiving discretionary points is broadly in line with the profile of all associate specialists employed when analysed by:

- Gender
- Ethnic Origin
- Contract Status
- Country of Primary Qualification

The data provides no evidence of discrimination on these grounds.

Years in Present Grade

Analysis of associate specialists employed by the numbers of years in present grade shows that those in receipt of discretionary points generally have spent longer in their present grade than those on the main scale points.

Over two-thirds of those on the main scale points (including the maximum) have spent up to 5 years in the present grade while around two-thirds of those in receipt of discretionary points have spent between 6 and over 16 years in the present grade.

APPENDIX G

PAY OF SAS/NCCGS RELATIVE TO CONSULTANT PAY¹ 1984–2004

Chart 1

Pay as a % of the top consultant pay point (pre-October 2003 contract)

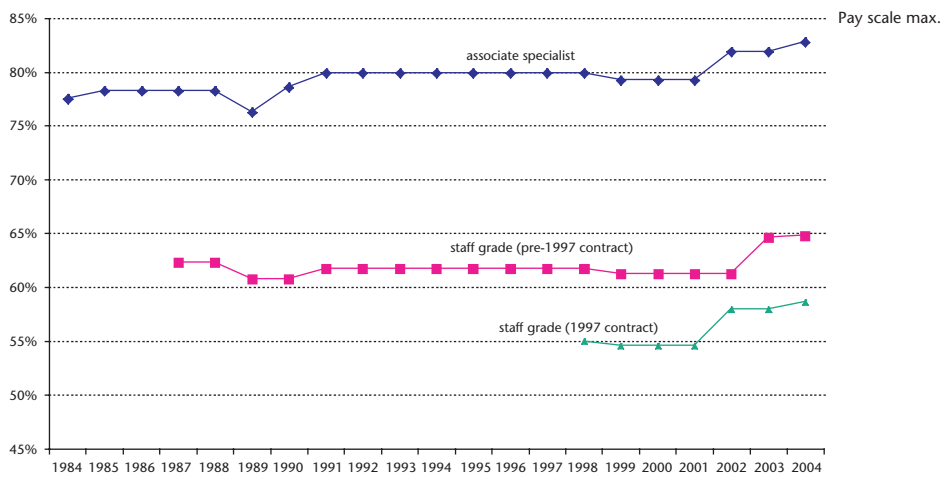


Chart 2

Pay as a % of the consultant mid pay point (pre-October 2003 contract)

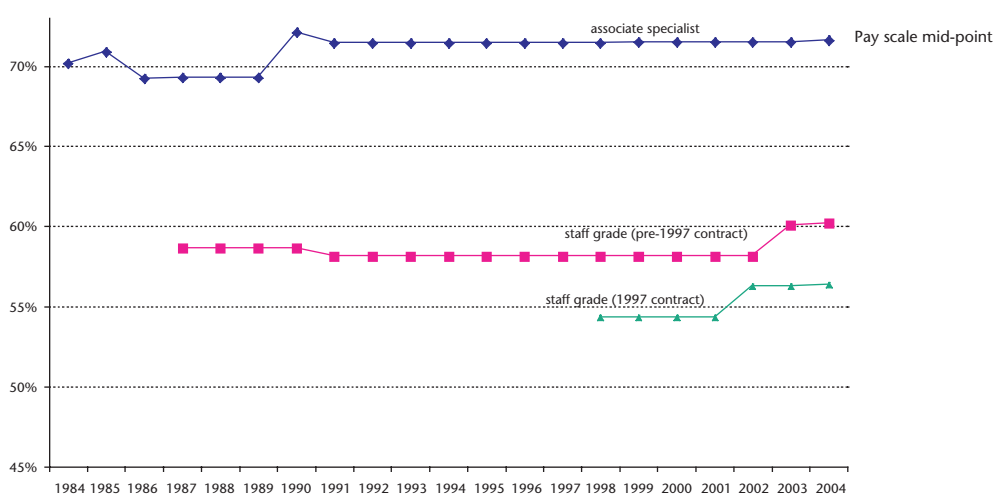


Chart 3

Pay as a % of the consultant bottom pay point (pre-October 2003 contract)



* Pay scale minimum is the same for staff grade contract in 1997 and staff grade contract before 1997.

¹ Basic pay which excludes discretionary points and intensity payments.

Table A: Percentage distribution of associate specialists and staff grades by pay scale 1999 – 2002

	Year	1998	1999	2000	2002
Associate specialist	Headcount	1,720	1,800	1,870	2,100
	Discretionary	28%	33%	34%	40%
	Top	48%	45%	48%	44%
	Intermediate	20%	18%	14%	15%
	Bottom	0%	0%	0%	0%
	Not classified	4%	4%	4%	1%
	Total	100%	100%	100%	100%
Staff grade (1997 contract)	Headcount	310	1,210	2,160	4,270
	Discretionary	45%	48%	49%	55%
	Top	24%	29%	34%	21%
	Intermediate	24%	20%	14%	22%
	Bottom	6%	2%	2%	2%
	Not classified	0%	–	–	–
	Total	100%	100%	100%	100%
Staff grade (pre-1997 contract)	Headcount	3,590	3,280	3,110	1,840
	Top	67%	64%	62%	61%
	Intermediate	26%	27%	25%	26%
	Bottom	1%	1%	1%	1%
	Not classified	6%	7%	12%	12%
	Total	100%	100%	100%	100%

Source: NHS Earnings Surveys, the Department of Health

Note: some distributions may not sum to 100 per cent because of rounding.

- less than 0.5 of a percentage point

Notes: Table A above shows the percentage distribution of associate specialists and staff grades according to four categories on their pay scales: discretionary, top, intermediate and bottom. The data are based on the last four NHS Earnings survey results of hospital medical and dental staff, with 2002 being the latest year for which such data were collected. The survey collects information on pay by occupation and by pay scale and covers about 50 per cent of Trusts in England. The pay period for the data in each respective survey is August.

Headcounts are GB figures from Health Departments' censuses. In the case of staff grades on the 1997 contract and those on the pre-1997 contract, headcounts have been estimated on the basis of the Earnings survey.

APPENDIX H

A Note on the Expense Ratio

1. One of the pieces of evidence that DDRB receives from the Department of Health (DoH) is the Dental Expenses ratio calculated by the Inland Revenue (IR).¹ Since the data is collected for tax purposes, it covers the entire income of the practice and does not distinguish between private and NHS income. From this it also follows that the IR ratio is a weighted average of the NHS and private expense ratios, where the weights are the fractions of total practice income accounted for by NHS and private work.² A natural question of interest is whether the two components in the aggregate differ in a systematic way. The purpose of this note is to show that they do.
2. It has been claimed that nothing can be inferred from the IR data about whether the ratio for NHS work differs from that for private work and, if it does, in what direction it diverges. In fact, this is not correct. If we make use of what is known about how dentists behave, it turns out that there is a robust and definite result: the NHS ratio must exceed the IR ratio.³ Indeed a sufficient condition for this to be so is that the margin over cost in private practice exceeds that in NHS work. Furthermore, the extent to which the NHS ratio lies above the IR ratio depends on the relative size of the margins of the two types of work.
3. It can be shown⁴ that following relationship holds:

$$E_n = \frac{\left(\frac{y}{y_n}\right)}{\left(1 + k \frac{n_p}{n_n}\right)} E, \quad (1)$$

where E_n is the NHS expense ratio, E the IR expense ratio, y is total income, y_n the income from NHS work, n_p the number of private patients in the practice, n_n the number of NHS patients and k is the ratio of the average cost of treating a private patient relative to an NHS one – and so will be greater than one.

4. This expression can be reduced to something far simpler by taking account of the relative margins of price to cost for private and NHS patients. This is useful since that seems to be a piece of evidence on which evidence can be obtained and where there is broad agreement between the parties. The fee earned from treating a patient can be considered as a mark-up on the cost of that treatment. This just indicates the “profit” earned from treating the patient. The evidence points to private patients being more profitable than NHS patients.⁵ Specifically we may say that the profit mark-up for private patients is $(1 + \gamma)$ times the mark-up for NHS patients: $\mu_p = (1 + \gamma)\mu_n$, where μ is the mark-up. Denote by F_p the fraction of practice expenses attributable to private patients. Thus F_p will lie between zero (all NHS) and one (all private). With this notation the formula (1) can be written more simply as

$$E_n = (1 + \gamma F_p) E \quad (2)$$

¹ Since it is based on Inland Revenue analysis of income tax data (for single-handed) dental practices, this data is always going to be a couple of years old. Thus in 2004, we get data based on the analysis of 2002 tax returns.

² The formula is: $\frac{e}{y} = \left(\frac{e_n}{y_n}\right) \frac{y_n}{y} + \left(\frac{e_p}{y_p}\right) \frac{y_p}{y} = \left(\frac{e_n}{y_n}\right) \theta + \left(\frac{e_p}{y_p}\right) (1 - \theta)$.

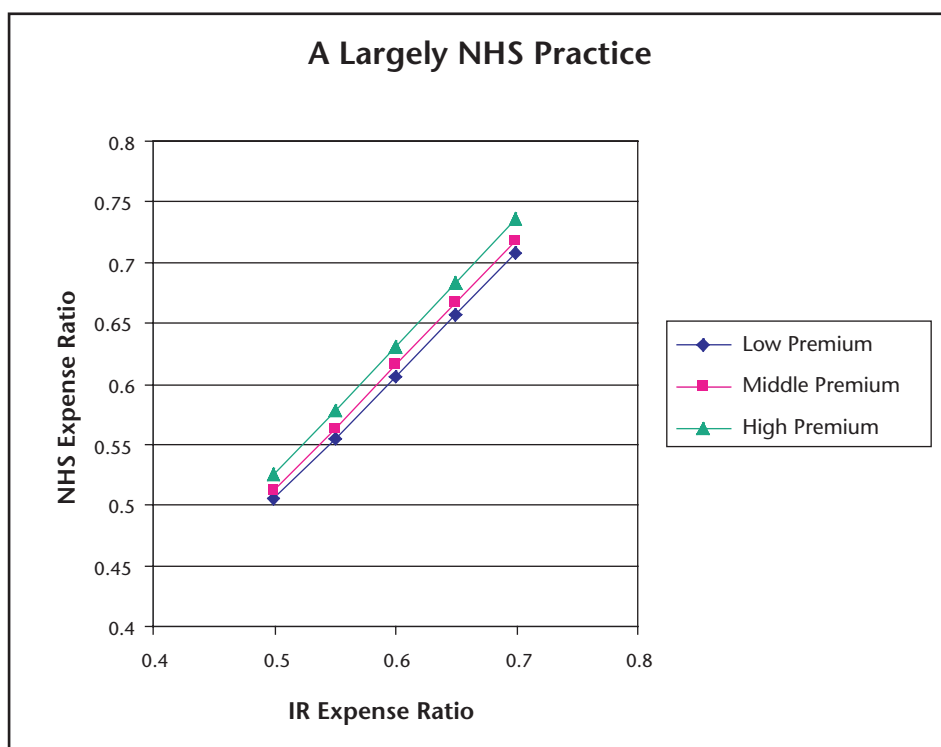
³ Hence the private ratio must be less than IR ratio.

⁴ A technical note showing this is available.

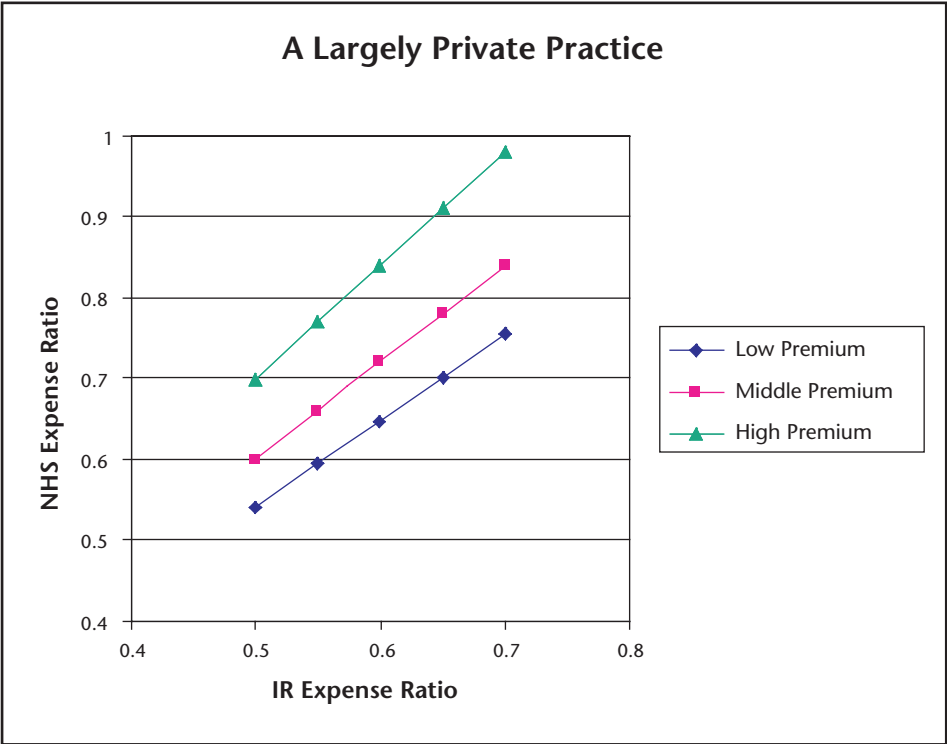
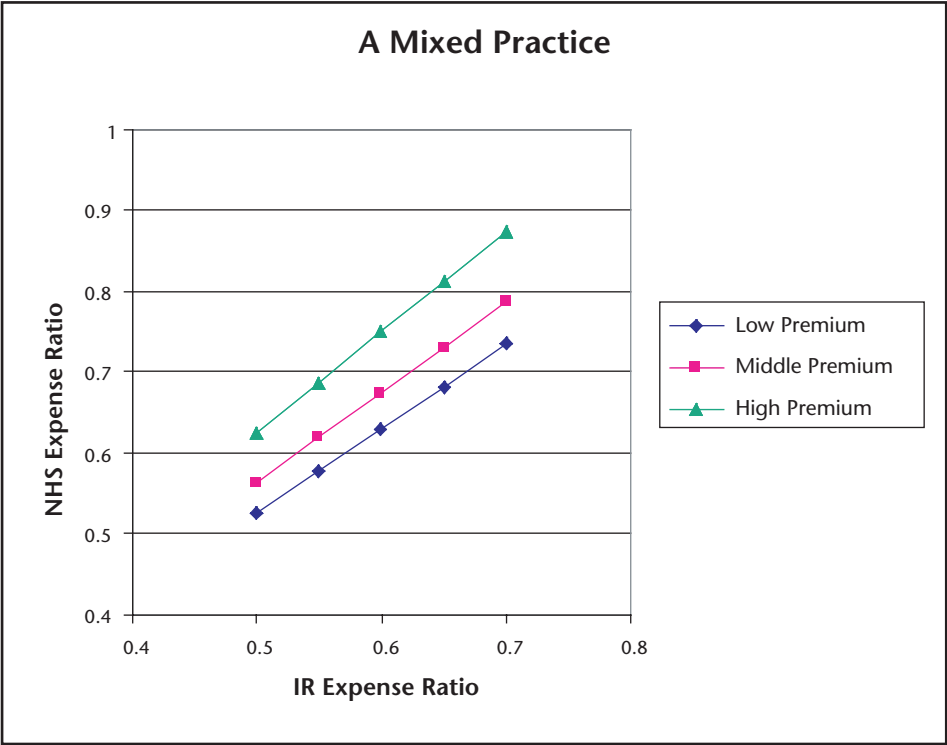
⁵ This is what lies behind the “drift” away from the NHS over the last fifteen years.

5. There are two things to note about this relationship. The first is that since both γ and F_p are greater than or equal to zero, it follows that $E_n \geq E$. In other words, the NHS expense ratio will always be at least as large as the IR ratio and generally will exceed it, with the excess being a function of the relative profitability and the importance of private work in the practice. This substantiates the claim made in paragraph 2 above. The second is that this is a simple relationship to calculate and graph out. Results from doing so are contained in paragraph 6 below.

6. The charts below look at three “types” of practice: Largely NHS (where $F_p = 0.1$), a Mixed Practice ($F_p = 0.5$), and Largely Private ($F_p = 0.8$). In each case the term γ (which can be called the “premium”) is allowed to take on three values (0.1, 0.25 and 0.5). Given this, what the NHS expense ratio would be as the IR ratio runs from 0.5 to 0.7 is calculated.⁶ The three cases are then graphed out and, as can be seen, the graphed line always lies above the 45-degree line. In other words, the NHS expense ratio always exceeds the IR ratio and the higher the premium, the greater is the divergence.



⁶ Considering a wider range of values would be a simple matter but this range encompasses the actual data available.



APPENDIX I

PREVIOUS REPORTS BY THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

1971.....	Cmnd. 4825, December 1971
1972.....	Cmnd. 5010, June 1972
Third Report (1973).....	Cmnd. 5353, July 1973
Supplement to Third Report (1973).....	Cmnd. 5377, July 1973
Second Supplement to Third Report (1973).....	Cmnd. 5517, December 1973
Fourth Report (1974).....	Cmnd. 5644, June 1974
Supplement to Fourth Report (1974).....	Cmnd. 5849, December 1974
Fifth Report (1975).....	Cmnd. 6032, April 1975
Supplement to Fifth Report (1975).....	Cmnd. 6243, September 1975
Second Supplement to Fifth Report (1975).....	Cmnd. 6306, January 1976
Third Supplement to Fifth Report (1975).....	Cmnd. 6406, February 1976
Sixth Report (1976).....	Cmnd. 6473, May 1976
Seventh Report (1977).....	Cmnd. 6800, May 1977
Eighth Report (1978).....	Cmnd. 7176, May 1978
Ninth Report (1979).....	Cmnd. 7574, June 1979
Supplement to Ninth Report (1979).....	Cmnd. 7723, October 1979
Second Supplement to Ninth Report (1979).....	Cmnd. 7790, December 1979
Tenth Report (1980).....	Cmnd. 7903, May 1980
Eleventh Report (1981).....	Cmnd. 8239, May 1981
Twelfth Report (1982).....	Cmnd. 8550, May 1982
Thirteenth Report (1983).....	Cmnd. 8878, May 1983
Fourteenth Report (1984).....	Cmnd. 9256, June 1984
Fifteenth Report (1985).....	Cmnd. 9527, June 1985
Sixteenth Report (1986).....	Cmnd. 9788, May 1986
Seventeenth Report (1987).....	Cm 127, April 1987
Supplement to Seventeenth Report (1987).....	Cm 309, February 1988
Eighteenth Report (1988).....	Cm 358, April 1988
Nineteenth Report (1989).....	Cm 580, February 1989
Twentieth Report (1990).....	Cm 937, February 1990
Twenty-First Report (1991).....	Cm 1412, January 1991
Supplement to Twenty-First Report (1991).....	Cm 1632, September 1991
Second Supplement to Twenty-First Report (1991).....	Cm 1759, December 1991
Twenty-Second Report (1992).....	Cm 1813, February 1992
Twenty-Third Report (1994).....	Cm 2460, February 1994
Twenty-Fourth Report (1995).....	Cm 2760, February 1995
Supplement to Twenty-Fourth Report (1995).....	Cm 2831, April 1995
Twenty-Fifth Report (1996).....	Cm 3090, February 1996
Twenty-Sixth Report (1997).....	Cm 3535, February 1997
Twenty-Seventh Report (1998).....	Cm 3835, January 1998
Twenty-Eighth Report (1999).....	Cm 4243, February 1999
Twenty-Ninth Report (2000).....	Cm 4562, January 2000
Thirtieth Report (2001).....	Cm 4998, December 2000
Supplement to Thirtieth Report (2001).....	Cm 4999, February 2001
Thirty-First Report (2002).....	Cm 5340, December 2001
Supplement to Thirty-First Report (2002).....	Cm 5341, December 2001
Thirty-Second Report (2003).....	Cm 5721, May 2003
Supplement to the Thirty-Second Report (2003).....	Cm 5722, June 2003
Thirty-Third Report (2004).....	Cm 6127, March 2004



Published by TSO (The Stationery Office) and available from:

Online

www.tso.co.uk/bookshop

Mail, Telephone, Fax & E-mail

TSO

PO Box 29, Norwich, NR3 1GN

Telephone orders/General enquiries: 0870 600 5522

Order through the Parliamentary Hotline Lo-call 0845 7 023474

Fax orders: 0870 600 5533

E-mail: book.orders@tso.co.uk

Textphone 0870 240 3701

TSO Shops

123 Kingsway, London WC2B 6PQ

020 7242 6393 Fax 020 7242 6394

68-69 Bull Street, Birmingham B4 6AD

0121 236 9696 Fax 0121 236 9699

9-21 Princess Street, Manchester M60 8AS

0161 834 7201 Fax 0161 833 0634

16 Arthur Street, Belfast BT1 4GD

028 9023 8451 Fax 028 9023 5401

18-19 High Street, Cardiff CF10 1PT

029 2039 5548 Fax 029 2038 4347

71 Lothian Road, Edinburgh EH3 9AZ

0870 606 5566 Fax 0870 606 5588

TSO Accredited Agents

(see Yellow Pages)

and through good booksellers

ISBN 0-10-164632-1



9 780101 646321