Review Body on Doctors' and Dentists' Remuneration

Thirty-Fifth Report 2006

Chairman: Michael Blair, QC

Cm 6733

£17.50

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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
March 2006

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. This 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 Minister[1].

[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 Dolton
Hugh Donaldson
David Grafton[2]

The Secretariat is provided by the Office of Manpower Economics.

[2] David Grafton was appointed to the Review Body by the Secretary of State for Health from June 2005.

Contents

Summary of recommendations and main conclusions

Our recommendations are for implementation on 1 April 2006.

Chapter 1 – Economic and General Considerations

- This has been an unusual round in a number of ways. The focus of the evidence to us on the general issue of affordability has been much more marked than in previous years. We have received submissions, both at the start and later in the course of our deliberations, which show how the topic is now of more critical concern to the Health Departments. While the most recent submissions have highlighted the fall in inflation and the expectation that earnings growth for our remit groups will continue to be strong in 2006-07, a less positive picture has been presented on NHS funding (paragraphs 1.1–1.8).

- We are pleased to note the continuing growth in medical and dental staff in the Hospital Community and Health Service (HCHS) sector, although we also note the variations across each country. We are unable to judge at the moment whether growth in workforce capacity is only meeting increased demand for NHS services, rather than reducing the workload of existing staff (paragraphs 1.28–1.29).

- The results from the latest NHS Staff Survey for 2004 show some improvements in terms of staff satisfaction for our remit groups. However, the lack of any detailed breakdown of results does not allow us to draw anything other than broad conclusions here (paragraph 1.31).

- We have considered it appropriate to look at changes and predicted changes in all the major inflation indicators. We also believe it appropriate to consider inflation on a three-month rolling average basis, rather than considering each month's figures separately. We take the view that this approach ensures that temporary blips in the various measures of inflation do not unduly influence our deliberations (paragraph 1.48).

Chapter 2 – Funding, affordability and pay

- We have no doubt that affordability is a real concern for all the Health Departments, but we are unable to judge from the evidence we have received exactly how the current funding problems faced by some trusts arose or how they will affect overall affordability when considering possible pay uplifts for our remit groups. We think it is right that our consideration of affordability should be taken at the national level and that due weight should be given to the views of NHS trusts which were reported to us by NHS Employers that resourcing for next year will permit a pay uplift relatively close to the various current assessments of inflation (paragraph 2.57).

- Our assessment of pay comparability supports the findings of the British Medical Association (BMA) that the remuneration of our remit groups compares rather well with that of the comparators. Indeed, we note that the pay position of our remit groups has been helped considerably by the new contracts for consultants and general medical practitioners (GMPs). Our analysis of official figures from the Office for National Statistics indicates that they have done well in the last year, showing that doctors' pay has increased at a much faster rate than the average for high earners in the economy (paragraph 2.34).

- We do not believe that in recommending a basic pay uplift we should take account of the Department of Health's estimates of pay drift of 3.6 per cent for next year (paragraph 2.56).

- We recommend for 2006-07 a base increase of 2.2 per cent on national salary scales unless there are reasons to depart from that for specific groups (paragraph 2.62).

- We consider that London weighting is a labour market issue and have made our recommendations on that basis in the light of the available evidence which indicates that there are no comparative labour market difficulties for the medical staff under our remits in London. There is no basis, on labour market grounds, for increasing the current level of payment and indeed, there is an argument for removing it completely. We recognise however that its immediate removal could create considerable problems in morale and motivation terms. We therefore **recommend** (recommendation 1) that supplements for London weighting should remain at their existing levels for 2006-07. Unless the evidence in future years indicates that labour market conditions in London have changed, we do not intend to revisit this decision (paragraph 2.26).

- In view of the limited evidence submitted by the parties and by the Health Departments in particular, we remain unable to give consideration to the output targets part of our remit. Until we are provided with more substantive evidence, we can only view the evidence from the Department of Health as a further broad illustration of the cost pressures faced by the NHS (paragraph 2.16).

- The Department of Health has told us that it is not seeking any regional/local differentiation in doctors' pay for 2006-07, nor are the Scottish Executive Health Department (SEHD) or the National Assembly for Wales. In the light of the Department's evidence, based on the Aberdeen University study, we conclude that there is no need for further consideration of this aspect of our remit (paragraph 2.24).

Chapter 3 – General medical practitioners

- As the additional funding being made available as part of the recent agreement on the General Medical Services (GMS) contract appears to be intended to support the new elements of the contract agreed for 2006-07, we do not intend to change the remuneration for an existing element of the contract without more robust evidence. We therefore **recommend** (recommendation 2) that seniority payments in 2006-07 remain at current values (paragraph 3.18).

- We consider that the salary range for salaried GMPs should be uplifted in line with the uplift for salaried medical staff. We therefore **recommend** (recommendation 3) that the salary range for salaried GMPs is increased by 2.2 per cent in 2006-07, in line with the majority of hospital medical staff (paragraph 3.36).

- The parties have said that for recruitment purposes, they would like the GMP registrars' supplement to remain at the current level of 65 per cent, despite the UK average supplement paid to hospital trainees now being 60 per cent. We are content to support this request in order to assist recruitment into general practice, and therefore **recommend** (recommendation 4) that the supplement for GMP registrars should remain at 65 per cent in 2006-07 (paragraph 3.44).

- The review of GMP trainers will be able to give full and proper consideration to the appropriate levels of remuneration in the light of the forthcoming changes under *Modernising Medical Careers*. In these circumstances we believe that we should do no more than seek to maintain the real value of the trainers' grant and we therefore **recommend** (recommendation 5) that the GMP trainers' grant is uplifted by 2.2 per cent for 2006-07 (paragraph 3.54).

- General practice is integral to the delivery of many of the Health Departments' policies, and so alongside the training of the next generation of general practitioners, we would also expect the Departments to put a high priority on the training and development of new and existing GMPs. We therefore **recommend** (recommendation 6) that the GMP educators' payscales should be uplifted by 2.2 per cent in 2006-07 in line with our recommendation for the trainers' grant (paragraph 3.59).

- For 2006-07, we **recommend** (recommendation 7) that sessional fees for doctors in the community health service and fees for work under the collaborative arrangements between health and local authorities should be set by doctors engaged in this work. We believe that this approach is not out of line with the Government's policy of local commissioning of services and of contestability (paragraph 3.67).

Chapter 4 – General dental practitioners (GDPs)

- We hope that the reforms (*in England and Wales*) will encourage new dentists to commit to the NHS, and existing dentists to retain or enhance their commitment to NHS dentistry. Our recommendations for 2006-07 are intended to support these changes (paragraph 4.42).

- It is our view that we should focus on the most recent information when considering dental expense inflation, rather than forecast what might happen. We intend to continue with the formula approach that we used last year (paragraph 4.52).

- As we have no practical way of resolving the issue of return on capital, we are going to assume that for the present an allowance for the return on capital is embodied in the practitioner's take-home pay but would urge the parties to discuss the issue and bring any relevant evidence to us in the next or subsequent rounds (paragraph 4.58).

- Given that a new system of local commissioning of NHS dentistry is being introduced in England and Wales, we do not think that the introduction of a non-targeted practice cost allowance in these countries is appropriate at this stage in the transition (paragraph 4.64).

- We **recommend** (recommendation 8) that an uplift of 3.0 per cent be applied to the gross earnings base under the new contract for 2006-07 for GDPs. In making our recommendation, we have applied a formula that gives appropriate weight to both the dentists' own remuneration and to the costs they incur. This year we are **recommending** (recommendation 9) that the uplift of 3.0 per cent also apply to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland. We note, however, that if the two systems continue to diverge it may in future years be appropriate for us to consider Scottish dentistry separately and to make a separate recommendation (paragraphs 4.73–4.76).

Chapter 5 – Salaried Primary Dental Care Services (SPDCS)

- Given the proximity of negotiations on new pay, terms and conditions for salaried dentists, we suggest that the parties discuss how any payments to recognise commitment, retention and morale should be integrated into the pay scales (paragraph 5.24).

- We have taken into account the delay in delivering new pay, terms and conditions for this group of dentists and considered how to protect the value of pay against the range of possible inflation and pay indicators before the new arrangements are introduced. Taking these factors into account, we **recommend** (recommendation 10) a 2.4 per cent uplift on salaries and allowances for all dentists in the SPDCS to be applied across the board in 2006-07 (paragraph 5.25).

Chapter 6 – Ophthalmic medical practitioners (OMPs)

- We believe that a unified sight test fee for OMPs and optometrists, set in negotiation between the Health Departments and representatives of both OMPs and optometrists, remains appropriate and **recommend** (recommendation 11) this continues accordingly (paragraph 6.7).

Chapter 7 – Doctors and dentists in training

- We believe that our conclusion from previous years holds true, 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 12) that the percentage values of the current multipliers be rolled forward for another year (paragraph 7.48).

- Our view on the recruitment, retention and morale situation for doctors and dentists in training is generally encouraging, with further improvements in the numbers of applicants to study medicine and dentistry. On pay comparability, we note that the BMA has concluded that medical graduates' earnings compare favourably with comparable professions and that they remain among the higher graduate earners. We have looked at the range of inflation and pay indicators when considering how to protect the value of pay. Taking all of this into account, we **recommend** (recommendation 13) an increase of 2.2 per cent for 2006-07 on the salary scales for all grades of doctors and dentists in training (paragraph 7.80).

Chapter 8 – Consultants

- In order to support recruitment and retention, we wish to maintain a level playing field until the parties have discussed and agreed a replacement merit award scheme for Scotland. The Scottish Advisory Committee on Distinction Awards (SACDA) has made its proposals to us in accordance with the agreed structure of the current distinction awards scheme and we therefore endorse and **recommend** (recommendation 14) SACDA's proposal for an additional two A+ awards, four A awards and nine B awards (paragraph 8.43).

- For 2006-07, we endorse and **recommend** (recommendation 15) the Advisory Committee on Clinical Excellence Awards' (ACCEA's) proposal that the budget for higher awards should be increased in line with the increase in the number of consultants now eligible for an award. We **recommend** (recommendation 16) that the value of Clinical Excellence Awards (CEAs), commitment awards, distinction awards and discretionary points should be uplifted by 2.2 per cent, in line with our main pay uplift recommendation. We also endorse and **recommend** (recommendation 17) ACCEA's proposal that it should continue to retain the flexibility to determine the number of CEAs to be made at each level in 2006-07. We also endorse and **recommend** (recommendation 18) ACCEA's request for £2.9 million for both national and local awards for academic GMPs with an increase in line with the general uplift of 2.2 per cent, together with an increase in line with the increase in the number of academic GMPs. We endorse and **recommend** (recommendation 19) ACCEA's proposal that recommendations for local awards for academic GMPs should be made by the relevant local ACCEA committee and moderated centrally (paragraphs 8.45–8.47).

- In reaching our views on the appropriate level of the pay award for consultants, we have taken into account the available evidence on recruitment, retention and morale, affordability, the pay position of consultants in the labour market and how to protect the value of their current pay. Taking all of these factors into account, we **recommend** (recommendation 20) an increase of 2.2 per cent for 2006-07 on the national salary scales/pay thresholds for the pre-2003 and post-2003 consultant contracts (paragraphs 8.74–8.75).

Chapter 9 – Staff and associate specialists/non-consultant career grades (SAS/NCCGs)

- In reaching our view on the appropriate level of the pay award for SAS/NCCGs, we have taken into account the available evidence on recruitment, retention and morale, affordability and the pay position of our remit groups in the labour market. We are conscious of the need to consolidate the improvements in recruitment and to support continued retention of staff at a time of continuing change within the NHS. Taking all these factors into account, and in recognition that other groups of doctors are already working under revised contracts, we believe that a slightly higher award is merited by this group. We therefore **recommend** (recommendation 21) an increase of 2.4 per cent for 2006-07 on the national salary scales of SAS/NCCGs. In the usual way, our recommendation of a 2.4 per cent increase for SAS/NCCGs will also apply to the payscales for non-GMP clinical assistants and hospital practitioners (paragraphs 9.29–9.30).

Our main recommendations on pay levels are:

	Point on scale[1]	*Recommended scales 1 April 2006 £*
Hospital doctors and dentists – main grades (whole-time salaries):		
House officer	minimum	20,741
	maximum	23,411
Senior house officer	minimum	25,882
	maximum	36,292[2]
Specialist registrar[3]	minimum	28,930
	maximum	43,931[4]
Staff grade practitioner	minimum	31,547
	maximum (normal)	44,924[5]
	maximum (discretionary)	59,968[6]
Associate specialist	minimum	34,977
	maximum (normal)	63,422[5]
	maximum (discretionary)	77,039[6]
Consultant (2003 contract, England and Scotland for main pay thresholds)	minimum	70,822
	maximum (normal)	95,831
	maximum (CEA[7])	34,200
	CEA[8] (bronze)	34,200
	CEA (silver)	44,965
	CEA (gold)	56,206
	CEA (platinum)	73,068
Consultant (2003 contract, Wales)	minimum	68,606
	maximum	89,368
	maximum (commitment award[9])	24,704

[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 in 2004, to be awarded automatically except in cases of unsatisfactory performance, see paragraph 6.61 of the Thirty-Third Report.

[5] Top incremental point extended in 2004, see paragraph 8.42 of the Thirty-Third Report.

[6] Additional discretionary point in 2004, see paragraph 8.38 of the Thirty-Third Report.

[7] A local Clinical Excellence Award (CEA) scheme operates in England, whereby consultants become eligible for an award after one year's service. See footnotes 9 and 10 for the local award systems in Wales and Scotland respectively. The figure presented 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) in England and Wales.

[9] A total of eight commitment awards are awarded (one every three years) once the maximum of the scale is reached.

	Point on scale[1]	*Recommended scales 1 April 2006 £*
Consultant (pre-2003 contract)	minimum	58,632
	maximum (normal)	76,300
	maximum (discretionary[10])	24,704
	distinction award[11] 'B'	30,808
	distinction award 'A'	53,911
	distinction award 'A plus'	73,158
Community health staff – selected grades (whole-time salaries):		
Clinical medical officer	minimum	30,179
	maximum	41,996
Senior clinical medical officer	minimum	43,059
	maximum	61,829
Salaried primary dental care staff – selected grades (whole-time salaries):		
Community dental officer	minimum	32,041
	maximum	50,754[12]
Senior dental officer	minimum	46,215
	maximum	62,810[13]
Clinical director	minimum	61,741
	maximum	70,497[13]

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OFFICE OF MANPOWER ECONOMICS
17 February 2006

[10] Discretionary points are now only awarded in Scotland. Local CEAs have replaced this scheme in England, while commitment awards have replaced it in Wales. Discretionary points remain payable to existing holders in both England and Wales until the holder retires or is awarded a CEA or commitment award.

[11] From October 2003, national Clinical Excellence Awards replaced distinction awards in England and Wales. Distinction awards continue to be awarded in Scotland, and remain payable to existing holders in England and Wales.

[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 1 – ECONOMIC AND GENERAL CONSIDERATIONS

Setting the scene

1.1 *We have decided to include, in the next few paragraphs, an overview of the situation in which we find ourselves as we approach the task of making recommendations resulting from our review. Our main reasons for doing this are twofold, and are linked:*

- *firstly, the focus of the evidence to us on the general issue of affordability has been much more marked than in previous years, although we have had little hard evidence on the current funding problems within the NHS or how we should take them into account when making our recommendations; and*

- *secondly, the evidence on the Government side has changed markedly in the course of the review itself. The changes mainly concern the central submission on the pay uplift, but also the outlook for affordability and inflation. Originally the Government proposed a general pay uplift of no more than 2.5 per cent. It subsequently revised this at oral evidence to 1.0 per cent for the majority of our hospital remit groups in the light of the latest estimates of earnings growth for our remit groups and some trusts' funding deficits. Inflation has also fallen since we first received evidence.*

1.2 *At the start of the review, the early indications were that the review for 2006-07 was likely to be unusual in a number of different ways. In particular:*

- *the expiry of several of the three-year pay deals for some substantial groups of staff (general medical practitioners (GMPs), consultants and salaried dentists) meant that it was possible that we would have to cover them fully in our report for the first time since the 31st Report in early 2002;*

- *the measures of inflation which we need to consider appeared at that time, perhaps unusually, to be converging; this, if sustained, would make the judgement on a figure for the relevant fall in the value of money less problematic;*

- *there had been recent changes in the organisation on the side of the employers. NHS Employers had been recently formed and had taken a more direct role than the NHS Confederation on issues affecting our remit, and also more functions had been devolved to NHS Employers from the Department of Health. In consequence, it was expected that the Government would focus on macroeconomic context, general policy and funding, and central initiatives, while NHS Employers would be in the lead on other matters relevant to our remit, especially recruitment, retention, motivation and affordability at the local level;*

- *the major rationalisation of strategic health authorities (SHAs) and Primary Care Trusts (PCTs) in England[1] might well have consequences for our remit groups and in particular, for general dental practitioners (GDPs), whose services will be commissioned by their local PCT from 1 April 2006;*

- *there were mixed signals about the extent to which negotiations between the parties were likely to make certain decisions of ours either unnecessary or else much simpler. For instance:*

[1] *Commissioning a Patient-Led NHS*, letter of 28 July 2005 from the Chief Executive of the NHS.

a) *negotiations on pay, terms and conditions for staff and associate specialists/non-consultant career grades had finally got under way, some three years after we had first urged this upon the parties;*

b) *the prospects for a negotiated outcome on GMPs looked reasonable; and*

c) *discussions on the new remuneration arrangements for the general dental services (GDS) were not proceeding quickly and it was unclear how matters would develop.*

1.3 *As the review progressed, however, the picture began to change. Some of the points already made remained true, but others did not. For example, inflation fell more sharply than had been anticipated and implementation of the new GDS contract appears to be on course for 1 April 2006. However, these variations were overshadowed by two more fundamental changes which we now seek to address in outline.*

1.4 *The first of these relates to average earnings. A significant disagreement between the parties emerged in the important area of "pay drift" (the extent to which the growth in average earnings exceeds the basic pay uplift). The issue dividing the parties was whether it is legitimate and fair, in considering an annual uplift in pay scales, to take into account:*

- *that those not at the top of the scale will in any event be receiving an increment as well as an uplift; and*

- *that average earnings may have increased through factors such as pay modernisation, overtime or intensity payments.*

1.5 *Since the Government estimates that for hospital doctors, pay drift is 3.6 per cent overall (so that 3.6 per cent would need to be added to any pay uplift to produce a figure for the overall increase in average earnings), this issue is of considerable importance to us.*

1.6 *Secondly, the Government's own position changed significantly in the course of the review. The Secretary of State, who gave evidence to us in person for the first time in recent years, suggested in December 2005 that, for reasons of earnings growth and affordability, the annual uplift should be reduced for the majority of hospital doctors to 1.0 per cent. This followed an earlier letter in November from the Chancellor of the Exchequer urging us to regard the CPI (Consumer Price Index) as having a special and temporary rider related to an unusual and short-term effect derived from the price of oil.*

1.7 *As a result of these changes, we asked the other main parties for their response to the points raised with us. They have taken issue with much of what was put to us by the Government, and we have duly considered all of it with care.*

1.8 *All of the points mentioned above are examined in greater detail in the body of this report. We ask readers to bear in mind, in coming to grips with our analysis and recommendations, that the evidential basis for much of what follows has evolved in the way we have just described.*

Conduct of the 2006 review

1.9 *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.*

1.10 *We were not required to make any recommendations on remuneration for independent contractor GMPs working under the new primary medical care contracting arrangements (General Medical Services) as the parties have been in direct discussions about the arrangements for 2006-07. Certain remit groups finish their three-year pay deals at the end of 2005-06 and so for the 2006 review, we are therefore required to make recommendations on the following groups – all doctors and dentists working within the Hospital and Community Health Service, salaried GMPs, GMP registrars and GDPs. These groups represent some 77 per cent of our total remit group, as shown below and also at Appendix D.*

Remit staff groups under consideration for the 2006 review[1], Great Britain (headcount)

	Being considered	Not being considered	Total
Consultants	35,710		**35,710**
Associate specialists/staff grades	9,047		**9,047**
Registrar group	18,749		**18,749**
Senior house officers	23,753		**23,753**
House officers	5,292		**5,292**
Other[2]	8,366		**8,366**
NHS contracted GPs		34,332	**34,332**
GP registrars	2,959		**2,959**
Other GP staff[3]		4,031	**4,031**
GDPs	22,997		**22,997**
Salaried dentists[4]	2,290		**2,290**
Ophthalmic medical practitioners	613		**613**
Total	**129,776**	**38,363**	**168,139**

1. Source: *NHS Health and Social Care Information Centre*, Medical and Dental Census, September 2004.
2. Includes hospital practitioners, clinical assistants, trust grade doctors and public health and community medical staff not elsewhere specified.
3. Salaried GPs cannot be separately identified within this group.
4. Includes community dental staff and salaried dentists working in the General Dental Services.

1.11 *We said in our last report that we wished to see from experience how the new contractual arrangements were working for consultants and GMPs and we are grateful to the parties for the information they have provided here. As the new arrangements have not long been in place, it seems too early to reach a fully informed view about the true impact of these contracts, both for our remit groups and for the NHS. Therefore, with the lack of a robust evidence base, we have approached this round again on the basis of not wanting to disrupt what has been agreed between the parties.*

1.12 *For this round, we have received written and oral evidence from the three Health Departments for Great Britain; NHS Employers; the British Medical Association (BMA); the British Dental Association (BDA); and the Dental Practitioners' Association (DPA). Oral evidence for the Department of Health was led by the Secretary of State for Health and the Minister of State for NHS Delivery. 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 can be found at Appendix E.*

1.13 *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.*

1.14 *This chapter and chapter two considers our remit issues generally in terms of medical staff. All of the issues raised by the parties concerning dentistry are considered in chapter four on GDPs and in chapter five on the Salaried Primary Dental Care Services (SPDCS). The detailed consideration of the evidence on each medical remit group can be found in the relevant group chapter.*

Scotland and Wales

1.15 The **Scottish Executive Health Department** (SEHD) and the **National Assembly for Wales** said their evidence complemented that from the other Health Departments and the SEHD said it endorsed evidence representing a Great Britain position.

1.16 Evidence from the **BMA** included a separate chapter this year on Wales. Here, the BMA stressed the vital importance of our deliberations and eventual recommendations not adversely affecting doctors in Wales to a disproportionate extent, thereby affecting the principle of health equality across the UK. The BMA believed that GMPs and junior doctors in Wales did not differ significantly from their English counterparts and were best assessed from a UK perspective. However, the effect of the Welsh consultant contract would need to be given appropriate consideration.

Northern Ireland

1.17 *The BMA has updated us on certain developments regarding Northern Ireland and also presented some evidence regarding issues concerning our remit groups in Northern Ireland. We note the BMA's evidence, but at present, issues affecting our remit groups in that country lie outside our terms of reference and therefore our consideration. We would ask the parties to consider any issues of concern.*

The current round

1.18 In setting the context for our consideration of remuneration, the **Department of Health** explained that this year its evidence would provide a high-level strategic overview, reflecting the new roles and relationships created in England by the establishment of NHS Employers from 1 November 2004.

1.19 It its evidence, **NHS Employers** explained that it had taken over responsibility from the Department of Health for much of the NHS human resources' (HR) agenda and that its key roles were negotiating on behalf of employers on issues such as NHS pay and conditions, representing and supporting employers, and promoting the NHS as a good employer. Although NHS Employers was an England-only initiative, it said that a protocol had been developed with the four UK Health Departments and it provided the 'machinery' for on-going negotiations on a UK basis. Its evidence for the current review was based primarily on information collected from employers.

1.20 The **BMA** said that it was an unusual position again this year as the three-year periods covered by the two major contract negotiations had come to an end and the BMA was currently engaged in negotiating a third contract. With the exception of GMPs working in GMS (*discussed further in chapter three*), we were faced with conducting a 'normal' review for the other remit groups.

Recruitment, retention, morale and motivation of our remit groups

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

1.22 The **Department of Health** said there was clear evidence of a continuing healthy position on recruitment and retention within the medical workforce. In 2004, the total numbers of hospital, public health medicine and community health service (HCHS) medical and dental staff in Great Britain had increased by 9.1 per cent (whole-time equivalent (wte)) (*see relevant chapters of the report for details*). In England, the total numbers of HCHS medical and dental staff had grown by 8.6 per cent (wte) in 2004. The Department reported that the second NHS staff survey had reinforced last year's results and shown that in key areas, e.g. job satisfaction, there had been consolidation and in some cases improvement. The Department said that the growth in staff numbers, the increase in new staff roles and encouraging results from the staff survey taken together showed an encouraging picture, and it was clear that the current levels of pay were appropriate to address the recruitment, retention and motivation of doctors in the NHS. Mechanisms were also in place at local level to address any pressures. In future, workforce requirements would be set locally and the Department said that its role now was to provide national models and assumptions where needed, ensure that local plans could deliver national objectives and to provide national support e.g. on regulatory reform.

1.23 The **SEHD** described developments affecting health service priorities in Scotland, workforce planning and development, and HR policies[2]. The total numbers of doctors and dentists in the HCHS in Scotland had increased by 2.7 per cent (wte) in 2004. The SEHD said that pay modernisation had placed NHSScotland in a strong position to recruit and retain doctors. However, Scotland faced particular challenges in remote and rural areas, in some areas outside the larger teaching hospitals, and where there was international and wider UK competition for specialties. Overall, the SEHD said it believed that current recruitment and retention pressures arose from non-pay factors – a misalignment between supply and demand and the availability of posts with sufficiently attractive professional content. Its key focus would be on addressing these issues.

[2] See Appendix E of the report.

1.24 The **National Assembly for Wales** said an additional 400 doctors were to be recruited by 2006 and total HCHS medical and dental staff in Wales had increased by 12.0 per cent (wte) in 2004.

1.25 **NHS Employers** said employers had reported that recruitment and retention was generally improving or remaining stable, helped by a fall in staff turnover in most areas. It considered that recruitment and retention premia were generally only useful where there was widespread competition with non-NHS organisations. This was clearly not the case with medical and dental staff. Non-pay solutions could be as important as pay, especially the introduction of flexible working practices and good line management. Many trusts had cited positive staff survey reports showing that flexible working, education, training and development and childcare provisions were the areas which appeared to have had the most positive effects on staff morale, motivation and retention. NHS Employers presented the results from the second NHS Staff Survey for medical/dental staff covering the areas of flexible working, training, appraisals and job satisfaction and said that the overall results from the Survey had shown improvements in terms of staff satisfaction. Employers had indicated that in the current climate of challenging recovery plans, a higher than expected and unfunded pay award would lead to extended vacancies and freezing of posts, with a subsequent reduction of services and developments.

1.26 The **BMA** considered issues surrounding the recruitment, retention and motivation of medical staff in its evidence on specific groups (*see relevant group chapter*).

1.27 Similarly, evidence from the **British Dental Association** and the **Dental Practitioners' Association** on general dental practitioners and staff in the Salaried Primary Care Dental Services can be found in the relevant group chapters.

Comment

1.28 *We are pleased to note the continuing growth in medical and dental staff in the HCHS sector, although we also note the variations across each country. Scotland's growth is modest compared to England's, whilst Wales saw very significant growth in 2004, after only very modest growth in 2003. We also note the SEHD's comments about its various recruitment and retention challenges which were echoed during our summer visit programme. All three Health Departments face these same issues to varying degrees. We therefore hope that in devolving future workforce planning to a local level, the Department of Health will take into account the need for a strategic approach to issues such as recruitment and retention in remote and rural areas and any national misalignment of supply and demand.*

1.29 *We also need to consider how our pay recommendations in any one year might impinge on the medium and longer-term recruitment, retention and motivation of our remit groups. We note NHS Employers' comment about the importance of non-pay solutions to recruitment and retention issues and also their warning about the effects on recruitment of unfunded pay awards. Vacancy freezes would presumably impact on workload unless overall workload was reduced. We would like to see evidence on how changing roles in the NHS and the growth in workforce capacity is affecting both hours of work and intensity for our remit groups. As we have said in previous reports, we are unable to judge at the moment whether growth in workforce capacity is only meeting increased demand for NHS services, rather than reducing the workload of existing staff. We would ask the Health Departments and NHS Employers to consider what evidence they can provide for the next review to help clarify this issue.*

1.30 *We note that this year the Department of Health has provided information on part-time working in relation to consultants, whereas last year we were also given the latest ratio for the HCHS as a whole. It will be important for us to see the time series data on part-time working for each grade of doctor separately each year so that we can monitor the trends for the different remit groups. We would also ask again for information on how planning assumptions are comparing to outturn. If detailed workforce planning requirements are in future to be considered locally, we assume that the Department of Health will want to maintain an overview of how actual outturn compares with planning assumptions in order to inform national decisions about issues such as planning the number of medical student places. We would ask the Department to provide evidence on this for our next review.*

1.31 *We note the results from the latest NHS Staff Survey for 2004 which shows some improvements in terms of staff satisfaction for our remit groups. However, the lack of any detailed breakdown of results (by grade of doctor or in relation to how pay impacts on the motivation and morale of staff) does not allow us to draw anything other than broad conclusions here. Our secretariat has been in contact with the Healthcare Commission to see whether the next survey (covering 2005) can accommodate some of our information needs and we are grateful for the Healthcare Commission's positive response on some issues. For the 2005 Survey, we welcome that the medical and dental occupational groups have been expanded into three categories: "consultants"; "doctors in training" (e.g. PRHO, SHO, SpRs); and "others" (e.g. staff and associate specialists/non-consultant career grade). This will allow us to consider separately the results for these groups. We also welcome that "pay" has been added to the list of options in the question to those who indicate that they are considering leaving their job. However, we note that the results to this particular question will need to be interpreted with care as the reasons why people are thinking of leaving their job are not the same as why people actually leave their job in the NHS, which is even more important for us to know. We note these useful additions to the 2005 Survey and we see value in keeping these changes in future surveys, in addition to questions on job satisfaction, motivation and morale, so that we can monitor trends over time. In addition to this valuable survey information, we consider that information on the turnover and wastage of our remit groups is important and would ask the Health Departments and NHS Employers to give consideration to collecting such data in the future.*

1.32 *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

1.33 The **Government** evidence said that as Pay Review Body recommendations were forward looking, the economy's future prospects were particularly important. The macro-economy was in a strong position. The economy was expected to grow by 1.75 per cent in 2005, picking up to 2.0-2.5 per cent in 2006 and 2.75-3.25 per cent in 2007 and 2008. Unemployment levels were close to their lowest levels since the 1970s and employment was at a record high. However, this strength in the economy was not resulting in any significant upward wage pressure in the private sector.

1.34 **NHS Employers** said recent evidence showed that the UK economy was experiencing an economic slowdown and as a result pay increases in other sectors were unlikely to rise.

Earnings growth and pay-bill growth

1.35 The **Government** evidence described the pay measures used across the public sector and said it was critical to consider them all when making pay recommendations, given their different strengths and weaknesses. Changes in the *Average Earnings Index* (AEI) measure the speed at which earnings are growing across the whole economy in the public and private sectors. The Government's evidence gave emphasis to considering a measure of 'paybill per head'. This measure is obtained by dividing the total amount paid by the total number of employees paid. The AEI is sensitive to skill and workforce composition and a change in either might produce a mis-leading picture of pay growth. Care is therefore required with any comparisons.

1.36 For a picture of how average earnings of existing employees remaining at the same grade is changing over time, *earnings growth* is a more appropriate measure. This identifies all the elements of increases, including progression increases, bonuses, allowances, overtime and any other elements of take-home pay affecting staff within a grade. It is a good indication of how an individual's pay packet is affected by pay progression and revalorisation.

1.37 We were told that the *headline award/basic settlement* needed to be considered in order to understand how a decision affected revalorisation. This measure is simply the average headline increase in base pay and excludes the other elements of take-home pay, such as performance bonuses and progression.

1.38 Despite their compositional problems, we were told that *paybill* and *paybill per head* should be considered as they give a good measure of affordability by providing an indication of the funding required by the employer to implement the pay deal. Paybill records earnings increases and includes the net effect of all other increases such as bonuses and changes to non-pay elements (pensions, National Insurance Contributions, etc). Aggregate paybill also includes any notional pay-bill savings from staff turnover which are reallocated to pay, as well as reflecting compositional changes. Paybill per head divides the paybill by the total number of full-time equivalent staff.

1.39 The Government evidence said that it considered growth in the AEI for the whole economy of around 4.5 to 4.75 per cent in the medium term to be consistent with the achievement of the Bank of England's CPI inflation target of 2.0 per cent. However, the headline award was only one component of the pay increase. Average earnings in the health sector had grown strongly in 2004-05 at 6.1 per cent, compared with 4.5 per cent in 2003-04. This was significantly above both the private and public sector averages and was largely driven by the growth in consultant medical pay, following the introduction of their new contract. Earnings growth for doctors was likely to be relatively strong again in 2006-07 as consultants on the new contract moved through pay thresholds and staff and associate specialists began to benefit from their proposed reforms. We were provided with tables (*see Appendix G*) showing the growth in the medical paybill, paybill per head and average earnings from 2001-02 to 2003-04, the estimated growth from 2004-05 to 2005-06, and the estimated effect of various settlement levels from zero to 2.5 per cent in 2006-07. The Government evidence suggested that a 2.5 per cent headline award would deliver average earnings growth per head of 6.2 per cent.

1.40 Following the Health Departments' oral evidence session, the Secretary of State for Health in England subsequently wrote to us on 19 December 2005 to update these estimates (*see paragraphs 2.37–2.40 for details of the letter which is also reproduced in full at Appendix F*). She said that latest estimates indicated that even with no uplift, earnings growth would be 3.6 per cent in 2006-07. A 2.5 per cent uplift could see earnings growth exceed six per cent.

1.41 **NHS Employers** said that data from Incomes Data Services (IDS) showed that median pay settlements in the quarter to July 2005 was 3.1 per cent. Data from IDS showed that recently long-term pay deals had provided for much lower annual increases of 2.5 to 3.0 per cent. NHS Employers said that the AEI three-month average showed average earnings to have risen by 3.9 per cent in the year to July 2005. The evidence tended to show that public sector earnings growth remained consistently higher than private sector earnings. NHS Employers observed that this higher rate of growth in the public sector was a consequence of the extra payments and new salary structures to solve recruitment and retention problems for key workers, plus the extra money resulting from pay modernisation. Most staff had witnessed significant increases in their earnings, but it was unrealistic to assume that future pay uplifts would be anywhere near the current level of earnings growth.

1.42 The **BMA's** evidence submitted in October presented data from IDS showing the fluctuation in settlement levels in the year to August 2005. The BMA said that as for last year, the trend in settlements had not been echoed in overall earnings movements. Average earnings in the public sector were still rising more rapidly than in the private sector (5.5 per cent against 3.9 per cent in July 2005). The whole economy AEI was currently rising at 4.2 per cent. Independent forecasters expected the increase in average earnings to reach 4.4 per cent by the fourth quarter of 2006. On this basis, the BMA said an increase in pay of less than 4.5 per cent during 2005 would lead to a relative decline in medical earnings against comparators.

1.43 In response to the Department of Health's estimates of growth in medical earnings, the BMA sent us its own estimates of pay drift (*see Appendix H*). The evidence presented a simple model which assumes an even distribution of staff across the pay scales. The model is illustrative and shows the effect of staff moving through the incremental pay system and of attrition. This model inevitably showed that there was zero pay drift for our remit groups. Responding to the Secretary of State's letter of 19 December 2005 and her revised estimates of pay drift for our groups, the BMA said that to the extent that incremental drift occurred, this was either specifically related to movement through training or to performance-related thresholds negotiated as part of a wider agreement (*see paragraphs 2.46 – 2.50 for details of the BMA's response*[3]).

Inflation

1.44 The **Government** evidence described the various measures of inflation – the CPI, Retail Prices Index excluding mortgage interest payments (RPIX), and the Retail Prices Index (RPI) – and presented data showing the percentage changes in all three measures. It stressed that too much emphasis should not be placed on a single month's inflation figure, but rather underlying trends should be considered.

[3] See http://www.bma.org.uk/pressrel.nsf/wlu/SGOY-6L5GDJ?OpenDocument&vw+wfmms

1.45 **NHS Employers** said that the CPI had risen to 2.4 per cent in August 2005, reflecting movements in crude oil prices. The July IDS pay report showed that RPI inflation was forecast to slow down towards 2.0 per cent by the end of 2005 and then stabilise at around that rate for much of 2006.

1.46 The **BMA** noted that RPI over the year to August 2005 had decreased to 2.8 per cent from 3.2 per cent in the year to August 2004. Independent forecasters expected the rate to fall further in the fourth quarter of 2005 to about 2.4 per cent, rising to around 2.6 per cent by the end of 2006. Forecasts collated by Pay and Benefits Bulletin expected an average of 2.4 per cent for 2006. The BMA said that we were therefore faced with, at worst, a modest rise in inflationary pressure over the review period, which might persist into the medium term. As a measure of movements in the cost of living, the BMA said that it preferred RPI as this drove pay expectations and it felt that even RPIX excluded a major cost pressure experienced by doctors. The BMA said that it appeared that pay increases in excess of 4.0 per cent were eminently sustainable during this review and into the medium term.

1.47 On 23 November 2005, further **Government** evidence was received when the Chancellor of the Exchequer wrote to each of the Pay Review Body Chairs[4] drawing their attention to what was expected to be the temporary impact of oil prices on the CPI inflation rate. Details of the Chancellor's letter can be found in paragraphs 1.47 and 2.38.

Comment

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. The Government evidence emphasises CPI whereas the BMA emphasises RPI. We would repeat our comment from the last report that in our view, there is no perfect measure of inflation as the different indices measure different things and all have their strengths and weaknesses. CPI and RPIX exclude elements of housing costs such as mortgage interest payments, which are a major item of expenditure for many employees, and 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 specific to the expenditure patterns of our remit groups, we must always 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 indicators. We also believe it appropriate to consider inflation on a three-month rolling average basis, rather than considering each month's figures separately. We take the view that this approach ensures that temporary blips in the various measures of inflation do not unduly influence our deliberations.*

1.49 *The figures that the parties provided when their evidence was submitted in the autumn have subsequently been updated as new data are published. The latest macro-economic data on inflation, average earnings and settlements available at the time we reached our recommendations were as follows.*

[4] The Chancellor's letter and accompanying Treasury paper can be found at http://www.hm-treasury.gov.uk

Inflation measures[5]

	Percentage change on the same month a year ago – December 2005	Percentage change on the quarter a year ago – quarter to December 2005
CPI	2.0%[6]	2.1%
RPI	2.2%	2.4%
RPIX	2.0%	2.3%
Average Earnings[7] **– November 2005**		
Whole Economy	3.4%	
Private Sector	3.3%	
Public Sector	4.1%	
Settlements[8] **– November 2005**		
Median	3.0%	
Lower quartile	2.5%	
Upper quartile	3.5%	

1.50 *Over recent months, CPI has moved in the range 2.0 to 2.5 per cent, RPIX has been between 2.0 and 2.5 per cent and RPI has been between 2.2 and 2.7 per cent. The headline earnings growth of 3.4 per cent in the whole economy in the three months to November was the lowest rate recorded so far in 2005.*

1.51 *We comment on the parties' evidence on earnings growth and pay drift at the end of chapter two.*

1.52 *In the next chapter, we consider the parties' evidence on funding, affordability and pay.*

[5] Consumer Price Index (CPI), Retail Prices Index (RPI), and Retail Prices Index (excluding mortgage interest payments) (RPIX). Source: *Office for National Statistics.*

[6] The CPI figure for December 2005 was subsequently revised to 1.9 per cent by the Office of National Statistics on 14 February 2006.

[7] "Headline" rate of increase in the Average Earnings Index (AEI), three-month average including bonus effects. Source: *Office for National Statistics.*

[8] Three-month median of settlements, and upper and lower quartiles. *Industrial Relations Services.*

CHAPTER 2 – FUNDING, AFFORDABILITY AND PAY

Introduction

2.1 *In this chapter, we consider the parties' evidence on funding, affordability, regional/local pay, pay comparability and the parties' general pay uplift proposals. Our pay uplift recommendations are set out at the end of this chapter.*

The funds available to the Health Departments

2.2 The **Government** evidence said that the 2004 Spending Review (SR04) had been significantly tighter than the 2002 Spending Review (SR02) and that within tight affordability constraints, it was important that resources needed for service improvement were not absorbed by pay and that pay rises in the public sector were set at sustainable rates. Within what was affordable, pay increases should be set at levels to improve service delivery by addressing specific recruitment and retention problems, supporting diversity and equal pay, or significant reform.

2.3 In its original written evidence, the **Department of Health** said that the primary argument for this year's recommendation was the healthy recruitment and retention position, but it was also crucial to consider affordability as around two-thirds of NHS spending was on pay. The Department said that the annual paybill increased as staff numbers increased, but also because of the annual settlement, pay reform and pay drift, illustrating this by reference to the new consultant contract. There were current financial pressures and the NHS would end 2004-05 with a deficit of around £250 million. NHS reforms would also create significant new financial risks and this, together with the likely slowdown in overall funding from 2008-09, made it even more important to be cautious in terms of additional spending commitments.

2.4 The Department explained that Primary Care Trusts (PCTs) funded paybills from their overall funding and the Department had assumed a pay award of up to 2.5 per cent in its own pay forecasts. Approximately 60 per cent of a PCT's budget was currently spent on pay and the Department said that any large increases would inevitably affect the amount available for PCT commissioning. As decisions about commissioning were made locally, it was impossible to say what areas would be at risk, but in response to our previous requests about the opportunity cost of relative pay increases, the Department said that each additional 0.1 per cent increase in NHS pay translated into the equivalent of 1,000 nurses, or 525 doctors or 30,000 elective procedures. PCTs could look at the achievement of Public Service Agreement targets, implementation of guidelines from the National Institute for Clinical Excellence and not increasing staff numbers as their response to a large pay deal.

2.5 The Department said that its expenditure plans' growth figures of 10.4 per cent and 9.9 per cent for 2006-07 and 2007-08 respectively were nominal, but in real terms, growth rates were 7.5 per cent and 7.0 per cent respectively. The Department explained the range of things that needed to be funded from overall NHS growth and that much was demand led. The Department said that the NHS had a fixed funding envelope until 2007-08 and there would be no resources over and above this to fund any excess pay costs arising from pay settlements. It was therefore crucial that pay increases were no more than necessary to meet the recruitment and retention needs of the NHS. The Department said that a 2.5 per cent headline award would equate to

a paybill per head increase on average of 6.2 per cent. This was a nominal (cash) growth figure which should be compared with nominal (cash) total expenditure growth of around ten per cent in 2006-07. The real question was whether a 6.2 per cent increase in pay was affordable in the context of ten per cent total funding growth. We were reminded that in his 2001 recommendations for increasing NHS spending by an average of 7.2 per cent in the five years to 2007-08, Derek Wanless[1] had made very clear that this extra spending was to cover a range of improvements to the NHS, notably improving access (including reducing waiting times) and quality of service. The 7.2 per cent had been based on an assumption that no more than a quarter of extra resources would go on pay. In this context, the Department said it was clear that much more was being spent on pay than Derek Wanless' assumption. Unless this was moderated, the Department said that the sustainability of the system as a whole would be put at risk.

2.6 Following her appearance at oral evidence, the Secretary of State subsequently wrote to us on 19 December 2005 emphasising the impact of the financial deficits faced by some NHS organisations on the affordability of pay awards and setting out her revised pay uplift proposals. The details of the Secretary of State's letter are set out at paragraphs 2.37–2.40 below. The letter itself is reproduced at Appendix F.

2.7 In its evidence, the **SEHD** explained the framework within which the costs of pay awards had to be set and said that staffing costs accounted for about 60 per cent of total expenditure on health. The recent significant increases in staff pay had had a major impact on Health Board budgets and the SEHD said that each rise of 0.5 per cent in the paybill equated to £24 million, equivalent to 800 extra nurses or 260 doctors. Increases in staff productivity produced time-releasing savings and allowed for growth in activity, but did not generate cash savings. Significant pay increases however had a direct and major impact on NHS Boards' budgetary positions, given that paybill costs amounted to well over 50 per cent of total Board budgets. Such impacts would affect Boards' ability to invest in meeting key priorities, whether that be investment in health improvement, extended primary care, better diagnosis or more responsive acute services. The SEHD said that the average increase in revenue allocations in 2006-07 for NHS Boards was 7.25 per cent and its own funding provision for 2006-07 showed real terms growth of 5.45 per cent, but stressed this was not a benchmark for pay settlements. The provision had to meet modernisation commitments plus various underlying demand pressures. Pay clearly had an important part to play, but it was only one element.

2.8 The **National Assembly for Wales** said that over recent years NHS pay and price inflation had equated to an average of 4.0 per cent per annum while in any year unavoidable cost pressures could add anything over 5.0 per cent to costs. All NHS Trusts had needed to make additional efficiencies of about 1.0 per cent per annum to meet local pressures, but in 2005-06 because of pay modernisation, there had been a 3.31 per cent funding shortfall equating to approximately £95 million. The next three years would be challenging, and financial discipline and improved productivity were essential. The Assembly reported that its provisional real terms growth figure for health in 2006-07 was 4.9 per cent.

[1] http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm

2.9 **NHS Employers** said that no money within departmental budgets was specifically allocated to spend on annual pay increases, but pay bills were met at a PCT level from their overall allocation of funding. Any further large increases in pay would have an effect on the amount available for PCTs to spend on additional services. Views from NHS trusts indicated their real concerns over the affordability of the current position with a recent survey of chief executives revealing that 93 per cent did not believe that the current workforce reforms were affordable. Recent data from the Healthcare Commission reported that one in three acute trusts and 24 per cent of PCTs had failed to achieve financial balance by the end of 2004-05, resulting in a total overspend of almost £500 million. Future NHS policy developments might also increase the financial pressure, e.g. Payment by Results and new commissioning arrangements. Given the evidence, NHS Employers asked us to consider carefully the impact that any pay increase deemed unaffordable would have on an already difficult financial position.

2.10 The **BMA** said that the Government's existing expenditure plans for 2006-07 and 2007-08 incorporated growth of 9.2 per cent and 9.4 per cent respectively and that the resources available to reward staff could again be supplemented by efficiency gains. The BMA therefore considered that there should be no inherent resource barrier to sustainable increases in NHS pay in 2006-07. NHS affordability was determined by Government funding policies and by competing pressures on resources. The BMA said it believed that the sums necessary to maintain the profession's relative position were affordable within the resources set aside for the NHS and that they need not compromise health outcomes.

2.11 Responding to the Secretary of State's letter of 19 December 2005, the BMA rejected her arguments on the effect on affordability of trusts' financial deficits. The details of the BMA's response are set out below in paragraphs 2.46–2.50.

Comment

2.12 *We note that spending in the NHS will have increased in 2005-06 by almost £7 billion from £69.7 billion to £76.4 billion. By 2007-08 the NHS budget will be £92.6 billion. We fully appreciate that there is a variety of demands on the resources available to support the NHS and that the funding increases in each country are not available purely to reward staff. This year, NHS Employers has emphasised the financial difficulties faced by some trusts and the wider concern amongst employers about affordability issues in the coming year. These financial difficulties and the implications they may have for our pay recommendations are also of concern to us and we consider this issue in more detail at the end of the chapter.*

2.13 *We have said in previous reports that having an adequate number of good quality, well-motivated staff is a very important factor in the overall mix which determines service delivery in the NHS. We note the Department of Health's original argument that "a modest general pay uplift of no more than 2.5 per cent" is required this year in the light of the healthy recruitment and retention position and consideration of the crucial constraints of affordability. We also note the Department's revised position of 1.0 per cent for most of our remit groups in the light of the latest information about the NHS's financial difficulties. The Secretary of State's letter setting out the Department's revised position can be found at Appendix F and is summarised in paragraphs 2.37–2.40 below. We address the Department's changed position and the issue of funding difficulties in more detail at the end of this chapter.*

Output targets for the delivery of services

2.14 The **Department of Health** said again this year that it did not believe it was possible to quantify the impact of our recommendations on pay against the achievement of output targets, though affordability and other cost pressures were crucial factors in considering the links between pay and output targets.

2.15 The **BMA** said it concurred with the view in our last report that output targets should no longer be part of our remit and it had no further evidence to offer on the way that productivity should be treated for pay purposes.

Comment

2.16 *In view of the limited evidence submitted by the parties and by the Health Departments in particular, we remain unable to give consideration to this aspect of our remit. Until we are provided with more substantive evidence, we can only view the evidence from the Department of Health as a further broad illustration of the cost pressures faced by the NHS, i.e. as another aspect of affordability.*

Regional and local variations in labour markets

2.17 In the **Government** evidence on the general context for this round, the benefits of local pay arrangements to the wider economy were set out for us again. The **Department of Health** said that it had commissioned Aberdeen University to conduct research into the effectiveness of regional pay in helping to address localised recruitment and retention issues for various NHS staff groups. The study examined geographic variations in average pay amongst NHS staff and amongst private sector employees to see if differential geographic variations in pay between NHS and private sector employees affected vacancy rates among NHS staff. The research suggests that doctors operate in a national labour market and found no evidence that greater geographic pay differentiation would tackle comparative recruitment and retention difficulties for doctors. The report from the Aberdeen researchers was shared with us and the other remit groups and will be published in due course. The Department said that the attractiveness for consultants of working in different parts of the country was likely to be influenced by a number of non-pay factors including the location of medical schools, opportunities for teaching, research and private practice. The additional medical school places allocated over the last few years were expected to improve the distribution of doctors and to help tackle comparative recruitment and retention problems. Given the provision under the 2003 consultant contract for employers to pay a recruitment and retention premium of up to 30 per cent of salary, plus the payment of London weighting, the Department said that it was not seeking any further regional/local differentiation in doctors' pay for 2006-07.

2.18 In its evidence on regional pay, the **SEHD** said that its position had not changed markedly since last year and therefore it was not currently considering any further measures on that front. Given that the delivery of pay modernisation was still at an early stage, the SEHD said that it was not yet able to measure the effect of new pay systems on pay differentials in addressing local recruitment and retention pressures.

2.19 The **National Assembly for Wales** said that it was not in favour of any form of regional pay specifically for Wales because of the particular problems in attracting people to work in places such as Merthyr Tydfil and Haverfordwest. It said that it had retained the provision which allowed Trusts to advertise a hard-to-fill consultant post up to the maximum of the scale, but this had not been used to any great extent because of the continuing fall in vacancy rates.

2.20 **NHS Employers** told us that it had asked employers whether the majority of resources should be spent on a generic award (a percentage pay uplift to all staff) or a targeted award e.g. as regional pay, national recruitment and retention premia, London weighting, or high cost area payment. Employers had indicated that resources should be spent on a generic award rather than a targeted award with issues of regional pay being dealt with at a local level, where possible. NHS Employers said there was no evidence to suggest that there was a particular requirement for regional pay for doctors. Shortages tended to be related to particular specialties, rather than in particular regions or geographical areas.

London weighting

2.21 The **Department of Health** said that as at September 2004, there were 6.1 consultants per 10,000 population on average in England. In four of the five Strategic Health Authorities (SHAs) for London, consultant numbers were above this mean and were the four highest in England. Three-month vacancy rates in London were below those in other parts of the country with two London SHAs having the second and third lowest rates in England. The evidence therefore suggested that Trusts were able to recruit and retain consultants at the current levels of London weighting and so the Department could see no case for any increase in 2006-07. The Department said that it was not aware of any regional recruitment pressures for any of our other remit groups and it therefore proposed no change to London weighting. We were asked to agree that rates should be held steady in cash terms.

2.22 The **BMA** said it had again been disappointed that we had declined to recommend a substantial increase in London weighting from April 2005. We had asked for its views in our discussion document[2] on the consideration of London weighting as a labour market rather than a cost compensation issue (as argued by the Department of Health), but it said that this argument would be inconsistent with practice elsewhere. The BMA said that there was no evidence that employers paid attention to the nature of the labour market when setting levels of London weighting. Where an explicit allowance was paid, it was generally in recognition of excess costs. The BMA said that this was the rationale behind the market forces factor in resource allocation and behind the continued paying of an allowance throughout the public sector and the NHS. The low level of London weighting paid to doctors and dentists also raised equity issues in relation to other NHS staff. The BMA repeated its view that on the basis of its evidence over the last two years, a figure closer to £5,000 was the appropriate level and that a substantial increase was overdue. The official statistics quoted by the Department of Health showing a continuing decline in vacancies were inconsistent, the BMA said, with the views of the profession on the ground who suggested that vacancies were not being advertised. Like the Health Departments, the BMA said that it did not see regional or local pay as a solution to vacancies. The existing flexibilities were sufficient if used properly. However, the BMA said that the picture on recruitment and retention was a confused one and if it was amenable to a pay solution, it would be a national one.

[2] http://www.ome.uk.com/review.cfm?body=5

2.23 In supplementary evidence, the **Department of Health** said that equal pay considerations arose where, without justification, people of different sexes were paid different amounts for undertaking similar work. London weighting was a regional pay premium, whereas the labour market for doctors was clearly different to the market for other NHS staff and therefore there was a clear case for offering different structures of pay to tackle different labour market issues. The Department said that this would not appear to raise equal pay issues as gender had no bearing whatsoever on whether the weighting was being paid. The significant, real reason for paying London weighting was the recruitment/labour market position.

Comment

2.24 *We are grateful to the Department of Health for its evidence this year on the effectiveness of regional pay in helping to address localised recruitment and retention issues for various NHS staff groups. We were interested to note from the findings of the research by Aberdeen University that there were differences between medical and non-medical staff with vacancy rates for consultants in high cost areas such as London amongst the lowest in the country. We also note the suggestion from the research that doctors operate in a national labour market and that there was no evidence that greater pay differentiation would tackle comparative recruitment and retention difficulties. The Department of Health has told us that it is not seeking any regional/local differentiation in doctors' pay for 2006-07, nor are the SEHD or the National Assembly for Wales. In the light of the Department's evidence, based on the Aberdeen University study, we conclude that there is no need for further consideration of this aspect of our remit.*

2.25 *However, we have been asked to make a recommendation about London weighting. The parties view this from different perspectives – the Department of Health argues that London weighting should be considered on a labour market basis, whereas the BMA argues that London weighting historically has been a cost compensation issue and remains so, as well as possibly being an equity issue in relation to other NHS staff. We have considered both viewpoints. As originally envisaged in the Pay Board report in 1974, London weighting was a cost compensation payment. Employers may have begun by paying staff London weighting to recognise the higher costs involved in working in London, but subsequently these payments have been driven increasingly by the need to recruit and retain staff of sufficient quality to meet business needs. If there were no difficulties recruiting and retaining staff, there would be no need for additional supplements to be paid (and, indeed, research shows many of these payments being either removed or frozen in the private sector). Although the London weighting payments which are made to non-medical NHS staff are called "High Cost Area Supplements" (a term which rather distorts their true purpose), they are paid as additions to national pay scales because of the difficulties in recruiting and retaining non-medical staff in London. The findings from the study by Aberdeen University concluded that there was no evidence of a need for local pay for doctors in London.*

2.26 *Whatever its origins, we consider that London weighting is a labour market issue and have made our recommendations on that basis in the light of the available evidence which indicates that there are no comparative labour market difficulties for the medical staff under our remits in London. There is no basis, on labour market grounds, for increasing the current level of payment and indeed, there is an argument for removing it completely. We recognise however that its immediate removal could create considerable problems in morale and motivation terms.* ***We therefore recommend*** ***(recommendation 1)*** ***that supplements for London weighting should remain at their existing levels for 2006-07****.*

Unless the evidence in future years indicates that labour market conditions in London have changed, we do not intend to revisit this decision. We understand that in freezing the level of London weighting, the real pay relativities between those of our remit groups working in London and those working outside will be changed, and that over time the real relativities for those working in London will deteriorate. However, on labour market grounds, we do not consider that the existing relativities are justified. As we have said, should the labour market evidence in future years indicate any significant change, we will revisit this.

2.27 *The BMA raises the issue of equity with other NHS staff. As High Cost Area Supplements for other NHS staff under Agenda for Change have their basis in the position of the labour market, we do not consider that an equal pay issue arises for our remit groups.*

Pay comparability

2.28 The **BMA** said that a major part of its evidence for this year's review was an assessment of the relative position of doctors' pay in relation to starting salaries and career progression, comparable professions and to doctors in other countries. The reports from its three comparative studies were presented in its evidence to us. To carry out its pay comparisons, the BMA said that it had had to estimate 2004-05 levels of medical remuneration and it explained how it had done so in some detail. The comparative figures used were £83,000 for the net income of GMPs (principals), £94,700 for consultants' NHS earnings, £28,800 for juniors' basic pay and £47,900 for their average total NHS pay.

2.29 The BMA set out its broad conclusions from the three studies. Medical graduates' earnings were in line with those of comparable professions and they remained amongst the higher graduate earners. The BMA said that this seemed appropriate to reflect the cost to the individual of studying medicine. Any comparative reduction in potential earnings would adversely affect the rate of return to a medical education and may deter future applicants. The evidence also showed that pay rises for doctors were falling behind those of other professions at this stage in their careers and if this trend continued, coupled with the reduction in doctors' earnings as a result of reduced working hours forced by the Working Time Directive, then in the longer term, medical graduates would be comparatively worse off. The study of international comparisons had suggested that the earnings of doctors in the UK (both GMPs and consultants) were broadly comparable with their compatriots in other countries. This situation had been helped considerably by the new contracts which had awarded GMPs and consultants significant pay increases. Countries offering higher earnings potential were nations where English-speaking doctors would be able to find work easily – USA, Canada, Australia, Netherlands and Denmark. The study of comparative professional earnings showed that the range in similar professions to medicine was wide at career grade level. The BMA said that the average earnings of GMP principals and consultants were broadly comparable with those in middle to senior positions, but they lagged behind those at the very top, with whom in job weight terms they might consider themselves to be equivalent.

2.30 In conclusion, the BMA said it believed that we ought to ensure by recommending a minimum increase in pay rates for the remit groups of 4.5 per cent from 1 April 2006, that the position described was not immediately eroded. This would at least maintain the relative position of doctors to the wider economy. It would leave it to us to determine the extent to which our recommendations should address any perceived changes in differentials. In response to our query as to what basic settlement would deliver a 4.5 per cent increase in earnings, the BMA said that the interaction between

incremental progression and attrition due to workforce growth and composition in medicine was such that average earnings per doctor would tend to increase only modestly above settlement rates, if at all. Indeed, under some circumstances, the BMA said they would fall. In comparing medical pay increases with those in the wider economy, the BMA said it believed that we should assume a 1:1 relationship between the settlement increase and its impact on average earnings within the profession. As noted earlier, we were provided with its own simple model on pay drift which can be found at Appendix H of this report.

2.31 We asked the BMA to what extent it considered movements in the earnings of other professions as part of our remit and it said this had been implicitly built into our terms of reference by the Royal Commission[3], but had then been removed in recent changes. However, we were still required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others. The BMA said that its evidence provided us with two proxies – one (comparison with other professions and income progression) was a proxy for the market that would exist in the absence of a monopoly employer, and the second (international comparisons) provided an indication of the value placed on doctors elsewhere, including countries where a free market in medical labour did exist. The BMA said that we stood in place of the market for doctors in the UK and these data were thus relevant to our considerations.

2.32 Commenting on the BMA's comparability evidence, the **Department of Health** said that it agreed with the conclusion that "medical graduates' earnings are broadly in line with those of other comparable professions and doctors remain amongst the higher graduate earners.". The Department offered some detailed observations on the BMA's international comparability evidence, concluding that the BMA's argument that UK doctors needed to be paid more than doctors in other countries needed testing. It would like to see the evidence that if they were paid less, there would be migration of doctors from the UK. Commenting on the BMA's comparison of earnings across professions, the Department said that it was drawing together evidence from the Office for National Statistics (ONS) on earnings growth comparators, but the level of detail provided in the BMA's evidence (by grade rather than averages for the whole profession) was not replicated in the ONS data. The Department said that previous analysis of ONS' ASHE (Annual Survey of Hours and Earnings) and NES (National Earnings Survey) data had shown that on average, medical practitioners' pay had grown faster than that of comparator professional groups.

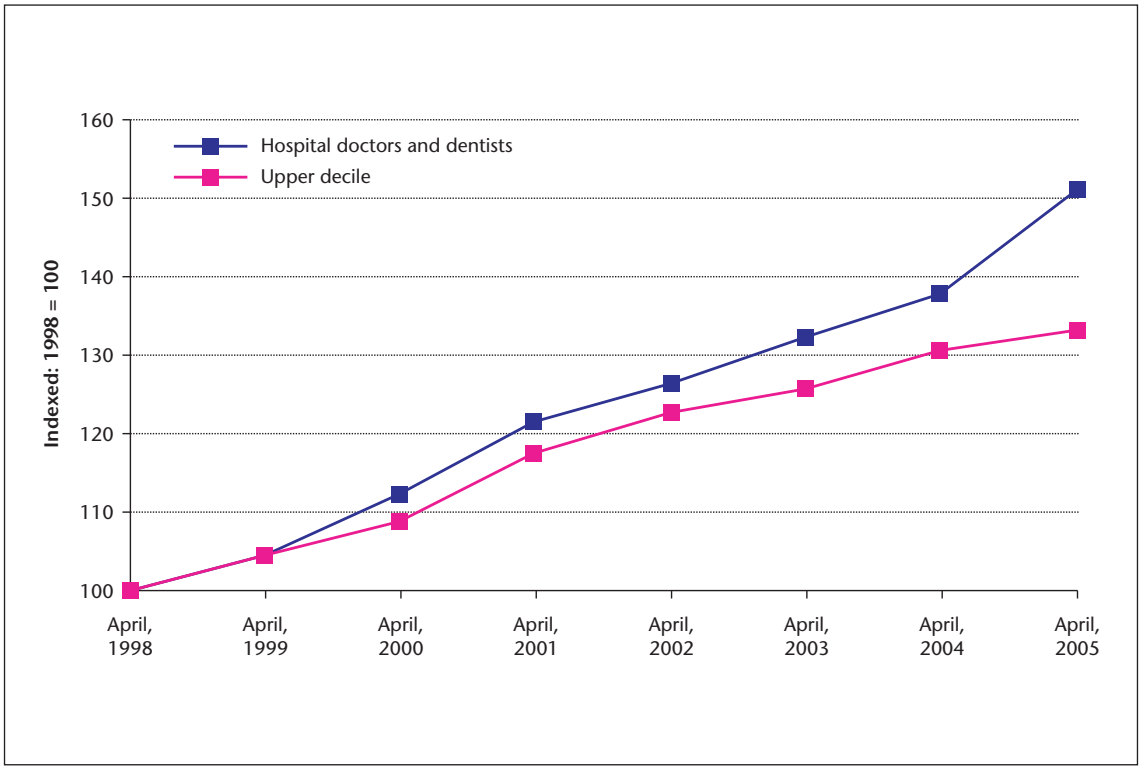
Comment

2.33 *As we have said in previous years, we believe that pay comparability is a relevant factor in our deliberations as it can be an important influence on recruitment and retention and the motivation and morale of our remit groups. In this respect, we note the findings of the pay comparability studies the BMA has carried out for this review. They show that medical graduates' earnings are broadly in line with those of other comparable professions and these doctors remain amongst the higher graduate earners, that the earnings of doctors compare well with middle to senior grade professionals in other sectors in the UK economy and also with other international medical professionals. We continue to 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. We use solicitors, actuaries, chartered engineers, accountants and some public sector staff as comparators. We also look at recent trends in average pay movements across the economy.*

[3] Royal Commission on Doctors' and Dentists' Remuneration of 1957, reporting in 1960.

2.34 *Our assessment supports the findings of the BMA that the remuneration of our remit groups compares rather well with that of the comparators. Indeed, we note that the pay position of our remit groups has been helped considerably by the new contracts for consultants and GMPs. Our analysis of official figures from the Office for National Statistics indicates that they have done well in the last year. Figure 1 gives changes in the gross earnings of hospital doctors and dentists compared with the top ten per cent of earners in non-manual occupations since 1998, which is expressed as an index. It shows that doctors' pay has increased at a much faster rate than the average for higher earners in the economy over the last year.*

Figure 1: Changes in earnings from ASHE, 1998 to 2005



Notes:

1. Upper decile data are average gross weekly earnings including overtime for non-manual males in full time employment on adult rates.
2. Hospital doctors and dentists data are the gross pay of full-time employees.

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

2.35 *The BMA has argued that in recommending a pay uplift we should seek to maintain the relative pay position of doctors, which the BMA believes is now appropriate. In our view given the healthy recruitment and retention picture and the favourable position on pay, we do not believe that pay comparability is an issue for us this year.*

Recommendations for 2006-07

Secretary of State's evidence on the pay uplifts for our remit groups

2.36 In its original written evidence, the **Department of Health** had argued that against a background of strong growth in medical earnings, the overall strong recruitment position and low inflation, a modest general pay uplift of no more than 2.5 per cent would be sufficient to meet NHS needs and ensure continued workforce stability. It would balance recruitment and retention against affordability. In addition to the annual pay uplifts, doctors on incremental payscales who were not yet at the top of their pay scale had the opportunity to progress up the pay scale. However, the Department also acknowledged that salary scales provided a means of pay progression in recognition of experience, ability and knowledge.

2.37 In contrast to the original call for a pay uplift of no more than 2.5 per cent for all of our remit groups, the Secretary of State set out her revised proposals at the Department of Health's oral evidence session. In a letter dated 19 December 2005 (*see Appendix F*), she confirmed her revised position on the level of the uplift for our remit groups in the light of new evidence about earnings growth and other cost pressures. She said that the Department now had a better understanding of the earnings position. Earnings data based upon NHS Trust Financial Returns and the NHS Workforce Census indicated a consistent growth in average earnings for medical staff from 2001-02 to 2003-04. Her Department's estimates showed that, yet again, this was going to be higher than the national average (around 4.0 per cent) at approximately 5.8 per cent for 2005-06. The trend of strong earnings growth looked set to continue into 2006-07, with the Department's latest estimates indicating that even with no uplift, earnings growth would be 3.6 per cent and with a 2.5 per cent uplift, earnings growth could exceed 6.0 per cent.

2.38 The letter of 23 November 2005 from the Chancellor of the Exchequer to the Review Body Chairs had made clear that there was concern that the recent short-term increase in inflation, caused mainly by oil price rises, could become locked-in if employers responded with higher wage rises. This had been followed by his Pre-Budget Report where he had re-iterated that the UK was on course to meet its inflation target of 2.0 per cent. The Secretary of State said it was important that public sector pay settlements did not contribute to inflationary pressure in the economy. Public sector earnings growth in recent years had been above the private sector.

2.39 The Secretary of State told us that in 2004-05 around 170 NHS organisations had finished the year with a combined deficit of £760 million. Overall, the NHS had finished the year in deficit by £250 million. It had become clear that a significant minority of NHS organisations were continuing to struggle to achieve financial balance this year and it was likely that a number would again finish the year in deficit. These deficits would be the first call on resources next year and would therefore impact on the affordability of pay awards. The issue of deficits was a real problem which we were asked to take into account in our recommendations.

2.40 In the light of the emerging deficits, the continued evidence of strong medical earnings growth and the need to keep to the Chancellor's inflation target, the Secretary of State said that she now thought there was a good case for a pay uplift this year for our remit groups of 1.0 per cent, which it was estimated would result in an average earnings growth of around 4.6 per cent. However, there were two

exceptions – staff and associate specialists should receive an award of around 2.0 per cent to maintain stability pending reform next year, while for dentists, an uplift of up to 2.5 per cent was supported (*see later chapters for more detail*). The Secretary of State said that she was not singling out hospital doctors in this respect. An agreement had just been concluded with the BMA for a zero per cent inflation uplift for the GMS contract and the Department of Health's evidence to the Nursing and Other Health Professions Review Body (NOHPRB) had argued for a recommendation of as close as possible to 2.0 per cent on the grounds of last year's outturn for *Agenda for Change*, affordability and the need to keep to the Chancellor's inflation target. The Secretary of State said she believed that this recommendation for NOHPRB's remit groups would deliver around 4.6 per cent earnings growth in 2006-07.

2.41 The **SEHD** said it fully concurred with the Secretary of State's revised pay recommendations and the **National Assembly for Wales** said it supported them.

2.42 In response to the Secretary of State's letter of 19 December 2005 setting out the Department of Health's revised proposals for the pay uplifts for our remit groups, **NHS Employers** said that it had no further comments and its position remained the same. On the grounds of equity, employers had said that all staff should receive the same level of pay award. NHS Employers said its original evidence had called for an uplift of not more than 2.5 per cent and as its representatives had stated during oral evidence, some employers took the view that in the current financial situation, an even lower award would be more appropriate. However, most respondents to NHS Employers' survey had indicated that anything higher would have detrimental consequences and would lead to a deferral of developments coupled with workforce reductions (through natural wastage or vacancy freezes) and service reconfiguration. A minority of employers had indicated that any pay increase would cause significant problems. The figure of not more than 2.5 per cent was used because at the time of the written evidence submission, this was the upper limit of any of the rates of inflation. Inflation had subsequently fallen in the interim and was forecasted to be nearer 2.0 per cent during 2006. NHS Employers said that the general consensus amongst employers had indicated that a pay award of not more than inflation was "affordable". Employers had felt that an uplift of not more than inflation was an appropriate balance between affordability and the need to recruit and retain staff.

2.43 Commenting on the BMA's earlier statement that pay increases in excess of 4.0 per cent were eminently sustainable, NHS Employers said that no money within the healthcare budgets was specifically allocated to spend on annual pay increases. Any cost pressures from pay increases must be met from the overall allocation of funding for PCTs. Annual increments and increasing workforce numbers added to pay bill pressures. By the BMA's own admission, "the earnings of doctors in the UK, both GPs and consultants are broadly comparable with compatriots in other countries" and "the earnings of doctors in the UK are in line with middle to senior grade professionals in other comparator professions". NHS Employers said that given the significant increases in average earnings witnessed in recent years and the future benefits available from new contracts, a pay award in excess of inflation was inappropriate.

2.44 In its original written evidence memorandum, the **BMA** said it concluded that the remit groups would need to receive a minimum increase in pay rates of 4.5 per cent from 1 April 2006 if they were to avoid losing ground against comparators.

2.45 Responding to this proposal of a 4.5 per cent pay uplift, the **Department of Health** said that it had modelled the effect of various settlement levels from zero to 2.5 per cent (*see Appendix G of the report*) and it estimated that a settlement level of 1.0 per cent would deliver a 4.6 per cent increase in average earnings. A zero headline award would see the medical paybill rise to £7.267 billion in 2006-07 and average medical earnings per head would increase by 3.6 per cent.

2.46 The **BMA** wrote to us on 6 January 2006[4], in response to the Secretary of State's letter, saying that it was greatly concerned. The BMA said that the Health Departments' original written evidence had urged us to recommend increases in salaries no greater than 2.5 per cent which was their then estimate of general inflation and less, of course, than both the level of settlements elsewhere and the growth in average earnings. The BMA also noted that in the past, the Treasury had indicated that increases averaging 4.5 per cent were consistent with the 2.0 per cent inflation target that the Chancellor's November letter had emphasised. The BMA said that the Secretary of State's new intervention appeared to be based on different criteria, namely the financial deficits accrued by NHS providers during the current financial year and a reiteration of the misleading mantra that a zero pay increase could generate substantial earnings growth for the profession.

2.47 With regard to deficits, the BMA said that the Department's existing plans for 2006-07 and 2007-08 incorporated growth of 9.2 per cent and 9.4 per cent respectively. The BMA said that the Secretary of State had claimed additionally that the Gershon[5] savings were running £200 million ahead of schedule. It was indefensible therefore to ask doctors to pay for financial mismanagement by a minority of NHS organisations. The Secretary of State had moreover stated that she fully expected the final deficit to be considerably smaller than current forecasts, emphasising that even the estimated shortfall amounted to less than 1.0 per cent of total NHS funding and that two thirds was due to just 37 organisations (7.0 per cent of the total number). Furthermore, for the three years prior to 2004-05, the BMA said that NHS organisations had reported aggregate surpluses of £240 million, which it could not recall our being asked to take into account in favour of the profession.

2.48 The BMA said that it had responded to the issue of pay drift in supplementary evidence and had provided our secretariat with its model and accompanying arguments (*see Appendix H of the report*). The BMA said that to the extent incremental drift occurred, this was either specifically related to movement through training or to performance-related thresholds negotiated as part of a wider agreement.

2.49 The BMA said that it had argued responsibly that the relative earnings position of doctors who had benefited from recent contract change was broadly acceptable, having lagged behind for many years, and it had asked us to make recommendations that would recognise and maintain that position. The effect of the Government's recommendation would be immediately and significantly to erode the levels achieved. The BMA said this would be perceived as a clear demonstration of bad faith in respect of negotiated outcomes which the Government had signed up to fully. For consultants, structured pay progression and payment for additional work done were an integral part of the 2003 contract package, not factors to be deducted from the annual pay awards. For junior doctors, there had not been a recent contractual settlement and total pay levels were already falling significantly as a result of quite

[4] See http://www.bma.org.uk/pressrel.nsf/wlu/SGOY-6L5GDJ?OpenDocument&vw+wfmms

[5] Press release number 2005/0433 from the Department of Health dated 6 December 2005.

modest rota changes, so that the Government's proposal would not even protect current earnings. The BMA said that the comment about the zero per cent inflation uplift for the GMS contract was singularly inappropriate. A complex package of proposals had been agreed with NHS Employers and it was unreasonable to present this package, which included a large number of different elements, as a zero per cent inflation uplift. Whilst the Secretary of State's attempt to prioritise staff and associate specialist/non-consultant career grade doctors (SAS/NCCGs) was, on the face of it, welcome, the BMA said that taken in the context of her overall proposals and ongoing negotiations, it was clearly both inappropriate and inadequate.

2.50 In conclusion, the BMA said that it deeply regretted the pressure that was being brought to bear on us and its members would expect us to ignore such interventions.

Comment

2.51 *We have considered carefully all the evidence from the parties who have urged us towards very different conclusions again this year. We have also, in our usual way, taken account of the economic evidence presented to us by the parties, including taking due account of the Chancellor of the Exchequer's letter and of the more recent data that have been published since the original economic evidence was submitted. We have had particular regard to indicators of inflation, average earnings and pay settlements. Our recommended increase for 2006-07 is set out in summary at the end of this chapter. The detail of the recommended increases for each remit group can be found in the relevant chapter for each remit group.*

2.52 *In December, the Department of Health revised its original proposal that our remit groups should receive what it had described as a modest general pay uplift of no more than 2.5 per cent. The Department originally said that this would balance recruitment and retention against affordability. The Secretary of State has subsequently revised this position, proposing uplifts of up to 2.5 per cent for dentists, of around 2.0 per cent for SAS/NCCGs and a 1.0 per cent uplift for all other groups under our consideration. She argues that the latest information shows firstly, that the growth of earnings of hospital doctors has been well above the average for the economy over recent years, and that earnings growth will remain strong in 2006-07 and, secondly, that there are increased financial pressures on the NHS, as shown by the financial deficits faced by some NHS organisations.*

2.53 *The Government evidence this year has particularly emphasised the growth in medical earnings for our remit groups in recent years arising from pay drift and the Health Departments have factored this growth into account when making their pay uplift proposals to us. They suggest that earnings growth next year will exceed any basic pay uplift by 3.6 percentage points and therefore the uplifts should be held down to ensure that earnings growth does not exceed 4.5 per cent. The BMA on the other hand argues that pay drift other than that arising from incremental progression is not significant and that incremental progression is not relevant to the decision on the pay uplift. We are unclear as to the source of the Departments' pay drift estimate of 3.6 percentage points, but assume that it is the result of a number of factors, most notably the assimilation costs of pay modernisation, overtime and similar payments related to the intensity of work, and the operation of the incremental pay system given the distribution of people within that system. Below we set out our views on the relevance of pay drift to the level of the award.*

2.54 *First, we do not believe that the effects on earnings of overtime and similar payments should constrain the level of the basic pay settlement because such payments represent extra pay for work over and above the contracted amount. Second, we do not believe that the assimilation costs of recently negotiated pay modernisation should be taken into account in setting the level of the basic uplift for future years. These costs were part of the negotiated agreement and should have been taken into account during the negotiations rather than clawed back at a later date. Third, we do not believe that we should take into account the effect on earnings of the incremental pay system when making our pay recommendations each year, as the Government's evidence asks us to do. These increases in earnings for individual employees in our remit groups arise from pay progression within the recently agreed pay structure and should have been factored into account when they were agreed.*

2.55 *As we said last year, the proposal, if strictly followed, would lead to lower pay awards in the short term, but also to a misalignment of the public sector pay structure 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. 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 are 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 their pay scale receive both an increment and a general pay award, with the latter reflecting labour market, inflation and general economic considerations. However, those who have reached the top of their pay scale will only receive the general pay award. Not all of our remit groups will receive incremental pay increases and averaging the increases for all doctors obscures this crucial dichotomy. We are pleased to see that the Government's evidence this year acknowledges that salary scales provide a means of pay progression in recognition of experience, ability and knowledge. Despite this, we are still being asked to take incremental pay growth into account in reaching our general pay uplift recommendations. We do not agree. If we reduced the level of our recommended pay uplifts to take account of the resulting levels of earnings growth, the fundamental principle on which incremental pay scales are based would be undermined. In our view, if the Departments are concerned about the effects of the incremental pay system on the growth of earnings or affordability, they should negotiate some alternative approach to pay progression with the relevant professional bodies, rather than ask us to hold down the level of the basic award.*

2.56 *As we have received no evidence that factors other than the three discussed above are leading to the Department of Health's estimate of pay drift of 3.6 per cent, we do not believe that we should take this estimate into account in making our recommendation on the uplift for basic pay.*

2.57 *Turning to the question of affordability, we note its importance in our remit both in terms of whether our pay uplift recommendation can be funded by the NHS and for the signals that our recommendation send to the wider labour market. We do not doubt that there are always financial pressures on the NHS and we appreciate the impact of pay on the total funding available for the NHS. We note the Secretary of State's evidence on the current funding difficulties being faced by some trusts which is a key factor in the Department of Health's revised position regarding the level of the pay uplifts for 2006-07. She has said that "…These deficits will be the first call on resources next year and will, therefore, impact on the affordability of pay awards. The issue of deficits is a real problem and one that we would ask you to take into account in your recommendations.". We have no doubt that affordability is a real concern for all the Health Departments, particularly in*

view of the current funding problems faced by some trusts, but we are unable to judge from the evidence we have received exactly how the current funding problems faced by some trusts arose or how they will affect overall affordability when considering possible pay uplifts for our remit groups. We believe that our role is to look at the pay structure as a whole and in that context, whether individual trusts are reporting a surplus or deficit in any one year cannot be a factor that we take into account. We think it is right that our consideration of affordability should be taken at the national level. In weighing suggestions for the uplift, we consider that due weight should be given to the views of the NHS trusts, taken as a whole, which were reported to us by NHS Employers, that resourcing for next year will permit a pay uplift relatively close to the various current assessments of inflation. It must be the responsibility of the three Health Departments to ensure appropriate local funding and management of resources.

2.58 *The prevailing rate of inflation is one of the many factors that we take into account in reaching our recommendations on the basic pay uplift. We have also looked at how pay, both settlements and earnings, has been moving elsewhere in the economy in order to consider the relative pay position of our remit groups. The Government's evidence emphasises CPI as the appropriate measure of inflation. Commentators suggest that RPI is more influential with pay bargainers in the private sector than either CPI or RPIX. In practice, 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 and also pay movements elsewhere in the economy.*

2.59 *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 must 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.*

2.60 *In reaching our view on the appropriate level of pay award for hospital doctors, we have therefore taken into account the following factors:*

(i) *Recruitment, retention and morale*

The evidence from the parties on recruitment, retention and morale indicates that:

a. the recruitment situation is generally encouraging for each group, although there are variations in the levels of growth between the remit groups and from country to country;

b. there is no evidence of immediate retention problems; and

c. although evidence on morale and motivation is very limited, there are some signs of improvement over last year.

In reaching these conclusions, we are conscious of the need to consolidate the improvements in recruitment and to support continued retention of staff at a time of continuing change within the NHS.

(ii) *Affordability*

There is serious concern about affordability in 2006-07 on the part of the Health Departments, with NHS Employers stressing that affordable pay settlements are necessary to ensure that the current financial position of the NHS does not worsen. Here we note that although the complex agreement reached by the parties for GMPs working under the GMS contract includes no cost of living or inflationary increase for practices, additional funding of up to 4.4 per cent will be available to support the whole package and that this is affordable within Primary Care Organisations' uplifted budgets for 2006-07.

(iii) *The pay position of our remit groups in the labour market*

Our assessment (discussed earlier under "Pay Comparability") is that the remuneration of our remit groups compares well with that of comparators and that the position of our remit groups has improved over the last year against the top ten per cent of earners in the economy as a whole.

(iv) *The range of possible inflation and pay indicators*

We have considered the need to protect the real value of pay and relative pay position of our remit groups against the range of possible inflation and pay indicators.

2.61 *The Health Departments have urged us to differentiate the pay uplift recommendations this year and we have considered this in the light of the factors discussed above, and also in the light of our views (set out earlier) on the Department of Health's arguments on pay drift. If in future years the parties ask us to recommend differential uplifts for our remit groups, we would ask them to provide clear evidence setting out the basis for doing so.*

Summary of our pay recommendations

2.62 *Taking all these factors into account,* ***we recommend for 2006-07 a base increase of 2.2 per cent on national salary scales*** *unless there are reasons to depart from that for specific groups.*

2.63 *The detailed recommendations for each medical group can be found in the relevant group chapter. Our recommendations on GDPs can be found in chapter four and those for salaried dentists in chapter five.*

Part II: Primary Care

CHAPTER 3 – GENERAL MEDICAL PRACTITIONERS

Introduction

3.1 *Although the three-year pay deal supporting the introduction of the new contractual arrangements for independent contractor general medical practitioners (GMPs) working under the new General Medical Services (GMS) contract finishes at the end of 2005-06, we were told by the parties that we were not required to make recommendations on remuneration for this group as the parties were in discussion about remuneration arrangements for 2006-07. The parties' joint evidence on what has been agreed is summarised later in the chapter. However, the parties have brought to our attention a number of other matters relating to GMPs which lie outside the main GMS contract. These include the salary range for salaried GMPs, GMP registrars, the GMP trainers' grant and GMP educators.*

3.2 *We consider below the various issues which have been raised, after summaries of the parties' evidence.*

The new GMS contract

3.3 The **British Medical Association** (BMA) said that although the period covered by the new contract negotiations for GMPs had now come to an end, the parties were continuing to discuss new arrangements for taking forward the new contractual arrangements. The BMA said that the inequality whereby English GMPs earned 4.1 per cent more for identical work than GMPs in Wales had had damaging effects on recruitment, retention and morale and needed to be fully addressed. It was dealing directly with the Welsh Assembly about this issue, but without success to date and would appreciate our support to correct this anomaly.

3.4 The **Department of Health** said it was envisaged that the outcome of the 2006-07 contract review discussions would not require any remuneration recommendations from us and so we were not required to make recommendations on remuneration for independent contractor GMPs. The Department said that its evidence was therefore focused on updating us on the implementation and review of the contract.

3.5 The Department said that in England, the intention of the current deal had been to give GMPs an increase in their net incomes broadly equivalent to the 36 per cent increase in funding of primary medical care between 2003-04 and 2005-06. Latest forecasts indicated the increase would be over 40 per cent. All things being equal, GMP net incomes overall could reasonably be expected also to increase by over 40 per cent over the same period. Looking across the UK, the Department said that the agreed increase in funding was 33 per cent, but it should be recognised that the position for an individual GMP would depend very heavily on local circumstances. The Department said that it had been in dialogue for the past six months regarding the BMA's concerns about the earnings inequality between GMPs in Wales and England and the damaging effect this was having on recruitment, retention and morale. The Department said that it was continuing to try and find a solution within the current UK contract framework.

3.6 Arrangements for the overall review of the contract were underway, led by NHS Employers based on the changes that the Department wished to see. The Department commented that while there had clearly been considerable financial and workload benefits for practices, it was less clear whether the wider NHS and patients were seeing comparable benefits. The BMA had raised concerns with us last year about enhanced services spend and the Department said that agreement had been reached with the BMA for flexibility for virement of underspends between 2004-05 and 2005-06. The Department reported that it was clear that practices had been scoring highly against the Quality and Outcomes Framework (QOF) and would benefit from its financial incentives. The Department noted that the BMA had also raised concerns last year about equity between GMS and Personal Medical Services (PMS). Such differences between the earnings of GMS and PMS contractors, the Department told us, might be legitimately due to what PCTs had negotiated outside of national agreements.

3.7 The **National Assembly for Wales** confirmed that it was taking part in the overall review of the new GMS contract with NHS Employers.

3.8 The **Scottish Executive Health Department** (SEHD) told us that the guaranteed increase in funding had been significantly exceeded, with a 42 per cent increase between 2002-03 and 2005-06. This had led to significant above-inflation increases in income for GMPs. Scotland was participating in the review of the new GMS contract.

3.9 **NHS Employers** said that it had agreed with the BMA that some changes would be made to the QOF from April 2006 and that work would continue on the review of the global sum allocations formula, but this would not be implemented until 2007-08 at the earliest. This two-stage review would give time to measure the impact of the contract which had only been in operation for just over a year. It would also be able to take into consideration any impact from the White Paper in England on care outside hospitals.

3.10 We subsequently received a tripartite letter from the **BMA**, **NHS Employers** and the **Health Departments** telling us that agreement had been reached, subject to some details outstanding, on the amendments to the national GMS contract that would operate from 2006-07. The agreement included a broadening of the scope of the improvements in patient access for which practices might be rewarded, investment in other Directed Enhanced Services (DESs) and support for practice-based commissioning. The QOF had been reframed and strengthened to secure greater and wider quality of care with new clinical areas agreed, although overall investment in the QOF remained unchanged. There would be no cost of living or inflationary increase for practices. The parties said that the second stage of the GMS contract negotiations would start following publication of the Department of Health's White Paper on care outside of hospital when the impact on primary care and general practice would be clearer.

3.11 The parties told us that NHS Employers and the BMA had agreed, with the full support of the four Health Departments, that the 2006-07 GMS review contract package addressed the perceived value for money issues associated with the original contract. We were told that these would not be revisited in future negotiations. We were also told that funding for all the elements agreed for the 2006-07 GMS contract, amounting to a maximum of 4.4 per cent assuming 100 per cent achievement, were affordable within Primary Care Organisations' (PCOs') average received uplifts to their budgets of over nine per cent for 2006-07.

Comment

3.12 *We note that the parties do not require us to make any remuneration recommendations this year for independent contractor GMPs working under the new GMS contract and that the parties will continue with a review of the global sum allocations formula for implementation from 2007-08 at the earliest. For our next review, we will await the parties' agreement as to whether we are required to make any remuneration recommendations for this group, but would ask the parties for an update on how the review of the global sum allocations formula is progressing and for a further assessment of the impact of the new GMS contract.*

3.13 *We are grateful to the parties for their joint evidence on the agreement for 2006-07. The agreement appears to be complex and although we do not have the full details, it appears that a standstill in basic pay has been agreed alongside acceptance that further adjustments were needed to the QOF, but in return for certain other benefits. We note from the letter to the BMA's GMP members (published on its website when the changes were announced) the beneficial effect on GMPs' pensions of the increases in their income over the first three years of the contract. We also note from the parties' joint evidence that additional funding of up to 4.4 per cent will be available for those GMPs who achieve 100 per cent in all the Directed Enhanced Services. The agreement therefore includes, but is not limited to, the zero per cent uplift indicated by the Secretary of State in her letter of 19 December 2005 (see chapter two).*

3.14 *We note the discussions between the parties about the BMA's concerns regarding the earnings inequality between GMPs in England and Wales and the effect this is having on recruitment, retention and morale in Wales. We hope that there will be a satisfactory outcome and we would ask the parties to report on progress for our next review.*

Seniority payments

3.15 In supplementary evidence, the **BMA** told us that the seniority scale currently used for GMS and PMS principals had been uprated annually for the past three years and had been agreed as part of the GMS contract negotiations in 2002-03. The BMA said that there was no provision for it to be uprated any further from 2006-07 and it was outside the remit of the current negotiations on the GMS contract review. The BMA told us that seniority payments reflected the accumulated experience and knowledge of the practitioner and in this respect, served the same function as salary scales for employed doctors. Given that the GMP principal workforce was approaching a major retirement bulge, the BMA said that there was an urgent need to retain the value of these payments to help retain senior GMPs in the workforce. This bulge particularly affected GMPs who had qualified in South Asia and practised in deprived areas. The BMA said that if GMPs approaching 60 saw the value of seniority payments falling, they would be less likely to stay on or return to general practice after drawing their pensions. The BMA said it considered that it would therefore be appropriate for us to uprate the seniority payments in line with our recommendations for increases in medical salary scales generally.

3.16 In response, the **Department of Health** explained that seniority payments were made to a contractor in respect of individual GMP providers in eligible posts to reward commitment to the NHS based on years of "reckonable service". The Department said that it would be inappropriate for us to uprate seniority payments in line with the recommendations for increases in medical salary scales generally. The Department said that it had no evidence to suggest that GMPs were more or less likely to stay working or to return to general practice after drawing their pension, depending on the value of their seniority payments. This issue had not been raised in the context of the new GMS contract negotiations, where the Department said it would have expected any concerns to be raised and dealt with. The Department said that given that projections for GMP earnings showed a likely profit increase well in excess of the intended 36 per cent, there seemed no good reason to increase seniority payments at this time.

3.17 **NHS Employers** told us that there had been no specific negotiations on seniority payments. We were told that the parties had agreed for the 2006-07 new GMS contract that no element of the existing contract would receive any uplift for inflation or cost pressures. NHS Employers said its view was that seniority payments should be captured within this principle.

Comment

3.18 *We have seen no evidence to indicate that GMPs will leave the workforce any sooner than they might otherwise if the current level of seniority payments remains unchanged. The BMA has told us that there is an urgent need to retain the value of these payments to help retain senior GMPs in the workforce. It seems to us that there are other financial inducements equally likely to retain GMPs nearing retirement, such as maximising earnings under the QOF or undertaking enhanced services work, with the benefits these will eventually have on pension entitlement. The parties' joint evidence on the revisions to the GMS contract told us that there would be no cost of living or inflationary increases for practices and NHS Employers has told us that, in its view, seniority payments are captured within that agreement. As the additional funding being made available as part of the recent agreement on the GMS contract appears to be intended to support the new elements of the contract agreed for 2006-07, we do not intend to change the remuneration for an existing element of the contract without more robust evidence.* ***We therefore recommend*** *(recommendation 2)* ***that seniority payments in 2006-07 remain at current values****. If the parties would like us to revisit this in our next review, we will need evidence covering retention and morale at different levels of experience in the NHS and on affordability.*

Recruitment and retention

3.19 The **Department of Health** said that GMP numbers (excluding GMP retainers and registrars) had increased by 2.1 per cent whole-time equivalent (wte) in Great Britain in 2004. The *NHS Plan* target in England of 2,000 (headcount) extra GMPs by March 2004 over the October 1999 baseline had been achieved in December 2003. The March 2005 census showed this target had been exceeded by 1,727 GMPs.

3.20 The **National Assembly for Wales** said that the data available on numbers of GMPs and vacancies in Wales painted a similar picture to England. The last GMS census showed that the number of wte GMPs per 10,000 population in England and Wales was about the same at between five and six. The growth rate in overall GMP numbers over the previous ten years was also the same at five per cent. The GMP Vacancies Survey for England and Wales 2005 had also shown much similarity between the two countries. The Welsh vacancy rate was 2.1 per cent compared to 2.4 per cent in England. The average number of three-month vacancies per 100,000 patients was 1.3 in Wales and 1.4 in England. Recent research into GMP recruitment and retention in Wales had suggested that initiatives would be more effective if they were designed and implemented locally. There was also a need to offer GMPs career options, use skill-mix effectively, provide personal and developmental support, and extend provision of education and training.

3.21 The **SEHD** said that the number of GMPs working in NHS Scotland was higher proportionately than in England and had shown a consistent year on year average increase between 1994 and 2004 of 0.7 per cent per annum. Between 2003 and 2004, GMP numbers (principals and other) had increased by 0.4 per cent. Remuneration and working conditions had greatly improved in recent years for all the main medical groups, including GMPs, and the SEHD said that it believed the remaining recruitment and retention pressures arose from non-pay, rather than pay factors, and particularly from the misalignment between supply and demand. The key focus now should be on more effective workforce planning. The greatly enhanced benefits for GMPs arising from the new GMS contract (in particular, the removal of the responsibility to provide Out of Hours services) would make general practice much more attractive as a career option for trainee doctors and would address many recruitment and retention pressures affecting general practice.

3.22 **NHS Employers** said that at end-March 2005 there were 32,194 GMPs in England (headcount – excluding retainers and registrars), representing an increase of 1.2 per cent since December 2004 and 3.4 per cent since March 2004. The 2005 estimated three-month GMP vacancy rate from the GMP Practice Vacancies Survey was 2.4 per cent for England. This Survey was conducted for the first time in 2005 and its data were not directly comparable to earlier GMP surveys[1].

3.23 The **BMA** said that the 2004 annual census of the NHS medical workforce in England showed continued growth in the numbers of GMPs in both headcount and wte. The total number of GMPs, excluding registrars and retainers, had grown by 2.5 per cent wte in the year to September 2004, but this was again fuelled by growth in salaried GMPs. The growth in contracted GMPs (both PMS and GMS) being only 0.5 per cent over the same period. The BMA said that it remained too early to assess whether the new GMS contract had had an impact on workforce growth.

[1] The 2005 GP Practice Vacancy Survey collected information from practices, whereas previous surveys were based on PCT data. There were also changes in the vacancy rates from the different types of GPs.

Comment

3.24 *We note the continuing growth in wte numbers for Great Britain, although we suspect this average masks considerable variations across each country, particularly as the SEHD has told us that the annual increase between 2003 and 2004 was just 0.4 per cent. We would welcome comparable year on year figures from each country showing numbers of staff in post in headcount and wte terms. We would also find it useful if information on how the workforce is changing could be produced and would consider data on turnover and wastage, for example, to be valuable for this purpose. It would in particular be helpful to have data from each country on the age profile of its GMP population. The BMA states that the growth in the total numbers of GMPs was again fuelled by growth in salaried GMPs, implying that this is a cause for concern. If this is the BMA's view, we do not share it, but we are concerned that growth in headcount might be masking a reduction in the overall wte so that the overall workforce gain might be less than it appears.*

3.25 *The Government's recently published White Paper, "Our health, our care, our say: a new direction for community services" reinforces the importance of community health services in which GMPs of whatever contractual status are key players. Stability and growth of the GMP workforce will be important elements in the successful delivery of the Government's policy. We are therefore very concerned that data on the GMP workforce should be accurate. We note the view from the SEHD that recruitment and retention pressures do not arise from pay issues and that more effective workforce planning should be the key focus. We would welcome further evidence on this aspect from all three Health Departments for our next review.*

3.26 *We know from the anecdotal evidence that we heard from GMPs during last summer's annual visit programme that the opt out from out of hours provision under the new GMS contract has been welcomed. Like the SEHD, we would expect the various provisions of the new contract to make general practice an attractive career choice for trainee doctors. We wish to monitor this through the data the Health Departments provide on recruitment and retention. We would remind all three countries again that they need to keep their incentive schemes under review to ensure they support recruitment and retention cost effectively.*

Salaried GMPs

3.27 The **Department of Health** said that the salary range (currently £49,248 to £74,816) for salaried GMPs employed by PCOs was designed to be wide enough to cover their range of possible roles, with starting pay, progression and review determined locally. The model terms and conditions of service were intended to be the minimum, with employers free to offer more favourable terms to reflect local needs and circumstances. The Department said that there was, as yet, no information on use of the salary range or recruitment or retention issues for this group of doctors, but it understood that work underway by NHS Employers should help to inform our future rounds. We had asked the parties last year to consider the method for uprating the range in future years. The Department said in its original written evidence memorandum that as it had seen no evidence to suggest that the current range was inappropriate, it asked us to uplift the minimum and maximum by no more than 2.5 per cent, in line with the increases it had proposed for all other salaried doctors and dentists. Following the Secretary of State's oral evidence to us and subsequent letter of 19 December 2005, the Department confirmed that it was now seeking an uplift of 1.0 per cent for the GMP salary range.

3.28 The **National Assembly for Wales** said it was not aware that the present terms and conditions were causing any impediment to recruitment and retention, particularly as the employer was able to offer more favourable terms to reflect local needs.

3.29 The **SEHD** said that there was evidence of the salaried GMP option being taken up by NHS Boards as an effective way of addressing aspects of their service needs, particularly out of hours. The SEHD said it also saw the salaried option as an effective way of delivering services in rural and remote circumstances, for example, in island Boards where salaried GMPs could be deployed to help cover a number of small communities. Boards would be looking at these options as part of their service planning in the light of the future strategy for NHS Scotland, *Delivering for Health*. The SEHD said it fully concurred with the one per cent uplift proposed by the Department of Health for the salary range.

3.30 **NHS Employers** felt that this group of doctors was now becoming established with employers indicating high demand for the services they could provide. Employers had also reported that the pay range was appropriate. As yet NHS Employers did not have sufficiently robust information to be able to report on any specific issues with pay and contractual arrangements for this group. It was trying to address this lack of information in order to inform any national discussions with the BMA. It would also be seeking to introduce more favourable arrangements for maternity leave and pay, and provision for employment breaks to bring arrangements for this group of doctors into line with other directly employed staff. For this round, it was seeking an uplift to the salary range in line with the inflationary uplift sought for all other groups.

3.31 The **BMA** said it fully accepted, agreed with and welcomed our comment last year that a more logical reference point for deciding how the salaried GMP salary range should be uplifted was the uplift for other GMPs. Given that average GMP contractor pay was estimated for pension purposes to have increased last year by 11.3 per cent and by 12.0 per cent in 2005-06, the BMA suggested that the salaried GMP pay range should be uplifted accordingly. A recent BMA survey had shown that some salaried GMPs felt the disparity between their pay and that of GMP contractors had widened unacceptably since the introduction of the new GMS contract. Some GMP contractors were now earning twice the amount of salaried GMPs with the same experience working in the same practice. Other concerns were that current pay did not reflect GMPs' experience, working beyond contracted hours without remuneration, no regular salary increases (cost of living or increment), and non-use by GMS practices and PCOs of the nationally agreed contractual terms and conditions. The BMA said that the salaried workforce was predominantly female and their main concern was the need for flexible working arrangements which meant they were not in a strong negotiating position. It accepted that in an ideal world GMPs should be able to negotiate appropriate arrangements, but it was clear that some were unable to do so. The BMA said that an appropriate uplift to the salaried GMP range would help to ensure that this group were properly remunerated for their work and commitment.

3.32 The BMA said that the minimum pay for salaried GMPs was originally set in 2004 at £46,455 (following our Thirty-Second Report in 2003). Given that the average GMP contractor's pay had increased in 2004-05 by 11.3 per cent, the minimum figure should have risen to £51,704 in April 2005. As the average GMP contractor's pay had increased in 2005-06 by 12 per cent, the minimum salaried GMP figure for this year should be £57,909. The current minimum salaried GMP salary was £49,248, and this year the BMA said that it would like the minimum pay increased by 17.59 per cent.

In response to our query as to what help was available from the BMA locally for salaried GMPs with their contract negotiations, the BMA said that those who were BMA members were able to seek advice about their terms and conditions and to receive general advice on their salary. However, non-BMA members were unable to obtain this advice and the BMA's membership of salaried GMPs was relatively low.

3.33 The BMA's detailed response to the Secretary of State's letter of 19 December 2005 revising the Department of Health's pay uplift proposals for 2006-07 is set out in chapter two, but in summary, the BMA said that it deeply regretted the pressure that was being brought to bear on us by the repeated intervention of Cabinet ministers. The BMA said that this pressure was unacceptable and incompatible with the review body system and its members would expect us to ignore such interventions.

3.34 Responding to the BMA's original evidence, the **Department of Health** said it had no evidence that current salary levels were causing problems with recruitment and more importantly, salaried GMPs were not comparable to independent contractor GMPs in terms of remuneration. The latter were exposed to financial and business risks that salaried GMPs were not and independent contractor GMPs could reasonably expect that an element of their profits would reflect that risk. Net profit was a function of various accounting arrangements and could reflect the personal position of a GMP within a partnership, such as their relative financial investment into the partnership and the expected rate of return. Also the taxation regime under which each type of GMP operated was very different. As a salaried group, the Department said that it would seem more appropriate to make links with other salaried groups within our remit, rather than with independent contractor GMPs.

3.35 **NHS Employers** said that it was not appropriate to compare, for pay purposes, salaried GMPs with contracted GMPs in the manner suggested. Salaried GMPs were directly employed whereas GMPs were independent contractors with a range of roles and responsibilities in addition to, and different from, those held by salaried GMPs. Employers had not indicated that there was a problem with the salary range which NHS Employers said it believed was wide enough to cover the possible roles which salaried GMPs might hold. Any substantial increase above that awarded to other salaried doctors and dentists would present affordability difficulties for employers. NHS Employers said it had no preferred comparator as such, but it wished the salary range to sit comfortably with the scales for other directly employed doctors. Employers had not indicated that either the top or bottom of the range needed increasing. They could appoint where they wished within the range, based on local evaluation of the role.

Comment

3.36 *The evidence on recruitment and retention of salaried GMPs remains very limited, but there is nothing to suggest that the current salary range is deterring the employment of this group of staff. We note the BMA's arguments that the salary range should be uplifted in line with the recent increases in pay enjoyed by GMS principals, but we do not consider the two groups to be equal for pay purposes for the reasons set out by the Department of Health and NHS Employers. We consider that the salary range for salaried GMPs should be uplifted in line with the uplift for salaried medical staff which we considered and commented on in detail in chapter two.* ***We therefore recommend*** *(recommendation 3)* ***that the salary range for salaried GMPs is increased by 2.2 per cent in 2006-07****, in line with the majority of hospital medical staff.*

3.37 *We would ask the parties again for evidence for our next review on the use of the salary range and for more detailed evidence on the recruitment and retention position for salaried GMPs. We would hope that the BMA would consider how best to support individual doctors in their negotiations with their prospective employer, whether it is a GMS principal or a PCO. We have no substantive evidence to suggest that doctors are being exploited, but if the BMA believes they are, the BMA should provide support. As GMPs remain in demand, we would expect individuals, whether they are BMA members or not, wishing to take up a salaried post to be able to negotiate satisfactory remuneration, terms and conditions, if they satisfy the requirements for the particular post.*

GMP registrars

3.38 The **Department of Health** said that GMP registrar wte numbers had increased by 12.3 per cent in Great Britain in 2004. The *NHS Plan* target in England of 550 more GMP registrars by March 2004 over the 1999 baseline had been achieved in June 2003 and in March 2005, the target had been exceeded by 365.

3.39 The Department reminded us that the supplement paid to GMP registrars was intended to ensure that these doctors were not financially disadvantaged in relation to hospital doctors in training. At the current level of 65 per cent of basic salary, the supplement was above the UK average paid to hospital trainees (60 per cent), but below the average for hospital trainees in Scotland (69 per cent). The Department said there was a risk that a reduction in the supplement at this stage would impact on GMP registrar recruitment. In the circumstances, the Department said that it would be content for the supplement to remain at 65 per cent for 2006-07. **NHS Employers** agreed with this analysis and recommendation.

3.40 The **National Assembly for Wales** reported that GMP registrar numbers had increased by 4.5 per cent in 2004. The Assembly said it was content with the Department of Health's proposal that the supplement remain at 65 per cent of basic salary.

3.41 The **SEHD** said that for the period 2003-04 to 2005-06, additional funding had been made available to increase the annual number of GMP registrar places by 30 per annum. In order to align supply and demand, the SEHD said that it was building a better evidence base around the dynamics impacting on the GMP workforce. The SEHD said that it would be content to see the registrars' supplement maintained at 65 per cent for 2006-07. However, current evidence showed that applications for registrar places were buoyant and if this were to continue, the SEHD said that it would see a case for reducing the supplement in subsequent years.

3.42 The **BMA** said that the growth in registrar numbers from the annual census showed early signs of reversing with a fall from 2,439 in March 2004 to 2,435 in March 2005. The lack of growth was a concern, particularly in the light of changing work patterns and increasing demands on GMPs as services were transferred from hospital to community settings. The BMA set out its concerns about a number of issues which it considered would have implications for recruitment to general practice: delays in deaneries receiving their training budget, the cost burden from various new certification charges from April 2006, and the uncertainties of eligibility arising from the new Primary Care Development Scheme which had replaced the Golden Hello Scheme. Although it would like a thorough review of the GMP registrars' payscale, the BMA said that given the considerable changes underway with *Modernising Medical Careers* (*MMC*), it felt it would be best to return to this topic next year when the new arrangements for specialist training were fully in place. It would then be in a better

position to gather robust evidence on the relative job weights for GMP registrars, senior house officers (SHOs) and specialist registrars (SpRs). In conclusion, the BMA said there was real concern about the recruitment and retention of GMP registrars against the background of a stagnation in GMP registrar numbers at a time when there continued to be a chronic shortage of GMPs. At a minimum, the GMP registrar supplement needed to remain at 65 per cent.

Comment

3.43 *We heard reports again during last summer's annual visit programme that general practice was becoming an increasingly attractive career choice for many junior doctors and so we are pleased to note that wte registrar numbers increased strongly in 2004 in Great Britain. Since the overall growth in GMP registrars may hide important differences at country level, it would be helpful if the three Health Departments could provide comparable annual growth figures in headcount and wte so that we may look at the overall picture in Great Britain, and also in the constituent countries, with any significant regional variations within each country also being highlighted. In view of the continuing level of female recruitment into the medical profession and the Government's policy of supporting a better work/life balance in the workplace, we would again urge the Health Departments to keep in mind the retention benefits of enabling employers to support opportunities for part-time working in both the hospital sector and general practice.*

3.44 *The parties have said that for recruitment purposes, they would like the GMP registrars' supplement to remain at the current level of 65 per cent, despite the UK average supplement paid to hospital trainees now being 60 per cent. We are content to support this request in order to assist recruitment into general practice, and therefore* ***recommend (recommendation 4) that the supplement for GMP registrars should remain at 65 per cent in 2006-07****.*

3.45 *We would ask the parties for further evidence on the state of GMP registrar recruitment for our next review as we wish to review the level of the supplement in the light of the latest recruitment position and progress in reducing the hours of doctors in training in the hospital sector. We have commented in previous reports on the oddity in having some degree of linkage between the pay relativities of doctors in training in the hospital sector and those in general practice, but we still accept the Departments' policy and understand that recruitment is the key concern. However, we would expect that at sometime there will be a need to reduce the level of the supplement payable to GMP registrars as hours worked in the hospital sector reduce further in line with the Working Time Directive. As we said in our Thirty-Third Report, we would want to consider the position of those doctors receiving the higher level of the supplement at that time, as fairness suggests that such individuals should mark time, rather than see their pay supplement reduced.*

GMP trainers

3.46 The **BMA** said that it welcomed the recommendation in our last report that all GMP trainers should receive £750 per annum towards the costs of their continuing professional development (CPD), but unfortunately, the payment had not been received. In late September, it had learned that Ministers were considering not awarding the payment in 2005-06 as the Department claimed that it had not accepted our recommendations in full. The BMA said it disputed this as other recommendations not specifically referred to in the statement to Parliament had been implemented and the Department had never formally informed the BMA that it was not implementing the CPD payment. The BMA said it had grave concerns that our status was being undermined.

3.47 The BMA also said that it had written twice to the Department of Health to request a meeting to discuss the remuneration structure for GMP trainers, as we had been urging for the last two years, but the Department had not yet responded. Given this delay by the Department, the BMA said it hoped we would agree that a recommendation from us for a substantial increase to the trainers' grant was necessary in advance of any agreement with the Department. In the meantime, the BMA said that it would endeavour, with the Committee of General Practice Education Directors (COGPED), to discuss this issue with the Health Departments, but warned it would be unfair and potentially disastrous for the recruitment and retention of trainers if the grant continued at the current rate or with only a small increase. To support its case, the BMA presented results from surveys of trainers and of Directors of General Practice Education carried out in August 2005 which it said highlighted the increasingly pressing need to improve the recruitment and retention situation. The results showed that 18 per cent of trainers had either recently stopped or intended to cease working as a trainer in the next 12 months and in 13 deaneries 113 GMP trainers had resigned in the last 18 months. In addition, there was either no or only limited capacity for practices to take on additional GMP registrars or Foundation Year 2 (F2) juniors under *MMC*. Respondents identified two particular measures of importance for their continued retention: first, an overall and significant increase to the trainers' grant to reflect their increasing workload and, second, an appropriate supplement for trainers with a registrar who had special training needs, in recognition of the additional workload. Our intervention and recommendation was sought.

3.48 The **Department of Health** said it accepted that the development of GMP education and training was growing in importance, particularly with the advent of *MMC*. However, the Department said that it had some reservations about our recommendation last year of a £750 supplement for GMP trainers to boost their CPD. For example, it was not clear how the supplement could be linked effectively with the assessment of a GMP's individual development needs and it was difficult to see how a blanket supplement was the best way of targeting support against a GMP's personal development plans. Payment without a supporting and expensive policing system raised problems of accountability. We may have been unaware of the £3 million provision for 2005-06 to address the development needs of new GMPs and that the postgraduate deaneries who administered the fund had some flexibility over its use. Furthermore, the Health Departments had not had the opportunity to submit evidence on this question before we made our recommendation. The Department's position was therefore that it wished to conduct further work on the proposal with a view to submitting evidence (hopefully joint with the BMA) next year on the best way of supporting development in this important area.

3.49 However, in supplementary evidence, the Department told us that the payment of £750 towards the CPD costs of GMP trainers would now be paid in 2005-06 and this had been clarified in a letter of 18 October 2005 from Lord Warner to the BMA. The Department said that payment required accurate information on the number of trainers and their location which was currently being collated in postgraduate deaneries. The Department said that it remained to be convinced that this fixed payment to all trainers, unrelated to the individual's CPD need, was the best way to promote the development of the GMP trainer workforce. In committing this resource long-term, the Department said that it wanted to ensure it was targeted where it was most needed and would be most effective, without creating unnecessary bureaucracy. The Department said it had therefore proposed a broader review of the role and remuneration of GMP trainers and it hoped that the BMA would welcome this and contribute to the review. Specific issues, such as GMP trainers who had registrars with special training needs, would form part of that broader review. The Department acknowledged the valuable role played by GMP trainers and their importance in

supporting *MMC*. It would be important that appropriate arrangements were in place to ensure the GMP trainer workforce for the future, but at the same time, the Department said that it was essential that scarce resources were directed as effectively as possible. Further evidence on recruitment and retention issues and discussion of an appropriate system of remuneration were required and that was why the Department had committed to undertaking a review.

3.50 The Department said that the flat rate grant paid to GMP trainers was currently £7,024 and in its original written evidence memorandum, we were asked to uplift the grant by no more than 2.5 per cent in 2006-07, in line with inflation. Following the Secretary of State's oral evidence and letter to us of 19 December 2005, the Department subsequently confirmed that it was now seeking an uplift of 1.0 per cent for the GMP trainers' grant.

3.51 The **SEHD** said it could confirm that it would be making payment of the £750 allowance towards the CPD costs of GMP trainers in 2005-06. It also endorsed the Department of Health's wish to review the role and remuneration of GMP trainers and fully concurred with the Department's proposal for a 1.0 per cent uplift for the trainers' grant. The **National Assembly for Wales** also said that it agreed with the Department of Health's revised proposal to uplift the trainers' grant by 1.0 per cent. It confirmed that it would be paying the £750 to GMP trainers and supported the proposed review for this group.

3.52 The **BMA's** detailed response to the Secretary of State's letter of 19 December 2005 revising the Department of Health's pay uplift proposals for 2006-07 is set out in chapter two, but in summary, the BMA said that it deeply regretted the pressure that was being brought to bear on us by the repeated intervention of Cabinet ministers. The BMA said that this pressure was unacceptable and incompatible with the review body system and its members would expect us to ignore such interventions.

Comment

3.53 *We are pleased that the Health Departments have now confirmed that they will be paying the £750 we recommended in our last report in recognition of the costs incurred by trainers in maintaining their status. We are also very pleased that the Departments will now be undertaking a broader review of the role and remuneration of GMP trainers and we ask the parties to take this forward as quickly as possible. Given the imminence of the implementation of Modernising Medical Careers, the parties need to consider urgently what will be necessary for the provision of training for trainees working in general practice. What role GMP trainers are to play and their remuneration are key elements of this. General practice is integral to the delivery of many of the Health Departments' policies and we would therefore expect the Departments to put a high priority on support for the training of the next generation of general practitioners. We would ask the parties to report on the progress of the review of GMP trainers for our next review.*

3.54 *As for our recommendation for the coming year, we have no basis on which to make any significant changes to the current remuneration for this group, and we do not intend to prejudice the forthcoming discussions. The review will be able to give full and proper consideration to the appropriate levels of remuneration in the light of the forthcoming changes under MMC. In these circumstances we believe that we should do no more than seek to maintain the real value of the trainers' grant and* ***we therefore recommend*** ***(recommendation 5)*** ***that the GMP trainers' grant is uplifted by 2.2 per cent for 2006-07.*** *The review is also the proper place for the consideration of what, if any, additional remuneration should be provided for GMP trainers who have trainees with particular training needs. We would ask the parties to take this forward, and any other issues of concern to the BMA, as part of the review.*

GMP educators

3.55 The **BMA** said that the pay scale for this group, which had been introduced in 2003-04, had not been uplifted in 2004-05. Furthermore, the Department of Health had not, as expected, discussed the uplift for 2005-06 with the BMA, but had informed it instead that the pay scale had been uplifted by 3.0 per cent with effect from 1 April 2005. The BMA said that the lack of consultation and the uplift were unacceptable. It was not sure why the figure of 3.0 per cent had been chosen and had told the Department that it would be more appropriate to use our recommended salary increase for salaried GMPs which would need to take account of the average increase for this group in 2004-05 of 2.6 per cent and the increase of 3.225 per cent in 2005-06. Based on this, the BMA said it had suggested that GMP educators' pay should have been uplifted in 2005-06 by at least a total of 5.9 per cent. It had not yet received a response from the Department. Now that the parties had agreed that future uplifts should be determined through the review body process, the BMA said it hoped that we would take account of the lack of any pay increases since 2003-04 in England, Scotland and Wales. It would also be helpful if we could highlight the need for the pay scales to be used in Northern Ireland.

3.56 The **Department of Health** said that the GMP educators' payscale had been uplifted by 3.0 per cent from 1 April 2005 and it agreed that future uplifts for this group should be part of our deliberations for GMPs. The payscale had been agreed by the Department, COGPED and the BMA in February 2004 and had been backdated to 1 October 2003. As agreement had been reached less than two months before 1 April 2004, the Department said that it did not consider an uplift had been necessary at that time. An uplift of three per cent had been implemented from 1 April 2005 which the Department said was appropriate in line with our recommendations based upon our estimation of inflation at that time. The 3.225 per cent figure quoted by the BMA was the rate for the final year of the three-year deal agreed with the BMA for GMPs as part of the new GMS contract and was therefore not appropriate for this purpose. The Department acknowledged the vital role of GMP educators, but said it had no evidence there were any recruitment or retention problems that warranted review of the payscale. In its original written evidence memorandum, we were asked to uplift the payscale by no more than 2.5 per cent, in line with its proposed increase for other salaried doctors and dentists. Following the Secretary of State's letter to us of 19 December 2005, the Department confirmed that it was now seeking an uplift of 1.0 per cent in the pay scale for GMP educators. The **National Assembly for Wales** confirmed that the 3.0 per cent uplift was in the process of being implemented in Wales.

3.57 The **SEHD** said that Scotland was uplifting the GMP educators' payscale in line with the uplift agreed by the Department of Health in England. It agreed that future uplifts for this group should be determined through the review body process and fully concurred with the Department of Health's proposal that the pay scale should be uplifted by 1.0 per cent in 2006-07.

3.58 The **BMA's** detailed response to the Secretary of State's letter of 19 December 2005 revising the Department of Health's pay uplift proposals for 2006-07 is set out in chapter two, but in summary, the BMA said that it deeply regretted the pressure that was being brought to bear on us by the repeated intervention of Cabinet ministers. The BMA said that this pressure was unacceptable and incompatible with the review body system and its members would expect us to ignore such interventions.

Comment

3.59 *We note that the parties have agreed that future uplifts for this group should be determined by us as part of our deliberations for GMPs. We also note the parties' conflicting evidence about whether an uplift for 2004-05 was or was not necessary and the BMA's concern about the level of the uplift applied by the Health Departments for 2005-06. As we are now being asked to make recommendations for this group for 2006-07 onwards, we make no comment about past events. We have considered whether our recommendation for this group should mirror the recent agreement between the parties regarding the uplift for the GMS contract for 2006-07. However, we believe this group should be considered as a separate issue from the agreement on the GMS contract. As we noted in our earlier comments on the GMP trainers' grant, general practice is integral to the delivery of many of the Health Departments' policies, and so alongside the training of the next generation of general practitioners, we would also expect the Departments to put a high priority on the training and development of new and existing GMPs.* ***We therefore recommend*** *(recommendation 6)* ***that the GMP educators' payscales should be uplifted by 2.2 per cent in 2006-07 in line with our recommendation for the trainers' grant****. We would ask the parties for evidence for the next review on the recruitment and retention position for this group. We note the BMA's request to highlight the need for the educator pay scales to be used in Northern Ireland, but as we commented earlier in chapter one, Northern Ireland lies outside of our terms of reference. We would therefore ask the parties to consider the issues of concern here.*

GMPs working in community hospitals

3.60 Commenting on the hope we had expressed in our last report that a sensible framework could be agreed within which negotiations could be conducted locally by PCOs and GMPs, the **Department of Health** said as this was a matter for local discussion, there was nothing to negotiate at a national level. The Department reminded us that the NHS Confederation's scoping report had recommended the better use of *existing* mechanisms and there were already national negotiating frameworks for these e.g. new GMS, salaried GMPs etc. The representative organisations for GMPs and PCOs could agree a framework for local negotiations, but it was for local commissioners to determine the service need, in line with Local Delivery Plans, and to make decisions on what services to commission and which commissioning mechanism was most appropriate. The Department said it therefore did not see the need for, or value of, any further guidance or prescription on a national basis. Regarding our recommendation that Ministers give careful consideration to the case for additional funding to meet any increased costs, the Department said that it would only be able to take a view on this issue once there were clear mechanisms for securing these services. The Department said it would review the evidence when available. If the NHS Confederation's view should prove right that there could be savings from implementing new models which could offset the costs involved, it would be entirely inappropriate to allocate additional funding in advance of any assessment of whether additional costs had arisen.

3.61 The **SEHD** said that it had been developing a strategy for the future of community hospitals which was due to be issued for consultation in 2005. This was an important area of work for the NHS in Scotland, particularly given the commitment to take forward the concept of rural general hospitals. The SEHD said that it would be working with NHS Scotland and the professions to take forward this work over the next year.

3.62 **The National Assembly for Wales** told us that because patterns of community hospital and allied services differed throughout Wales, reflecting different needs and circumstances, local Trusts had to take responsibility for negotiating the type and style of treatment to be made available so that the use of community hospitals was based on the care required by local populations. The Assembly said that the question of GMPs' remuneration for working in community hospitals therefore had to be left to individual Trusts and Local Health Boards to resolve.

Comment

3.63 *We note the parties' evidence on community hospitals and in particular, that the BMA has not raised this as an issue for our consideration this year. In the light of the parties' evidence, we would simply say to the Health Departments that we remain concerned about the possibility of new funding pressures arising for PCOs as a result of local commissioning of services to support community hospitals, and as a result of the new GMS contract. Our concern is heightened this year by the Department of Health's evidence on the funding difficulties already faced by some trusts. We note from the Department's recently published White Paper, "Our health, our care, our say: a new direction for community services", that a new generation of community hospitals will be introduced as part of the Government's policy that integrated health and social care services will be provided in local communities and closer to people's homes. If the Health Departments believe that it is important for the whole of the NHS that community hospitals have an integrated role within the NHS, particularly in rural areas, then we would urge all three Departments to maintain strategic oversight of these hospitals and to look for any early warning signs that problems might be developing with service delivery because of funding issues. We would welcome further evidence from the parties next year.*

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

3.64 The **BMA** reminded us again this year of its serious concerns about the level of the various fees payable to doctors under the collaborative arrangements (covering services in the fields of education, social services and public health), particularly since the introduction of the new GMS contract, and how the level of fees was discouraging medical participation in these areas of work. The feedback from the medical profession was that the fee rates were no longer economic and that many doctors had lost confidence in the collaborative arrangements system with a significant number refusing to work within the current fee scales. We were told that there were no contractual obligations for doctors to perform this work, unless they were employed directly by a PCO. As there had been no progress on increasing fees under the collaborative arrangements to realistic levels, the BMA said it would have no option but to issue guidance about doctors' rights to withdraw from the work. It would also invite doctors to consider their options to charge on an individual basis, rather than using our recommended fee increases. The BMA said it believed that this was the last opportunity to correct the poor fee levels and reform the remuneration structure of the collaborative arrangements. It therefore recommended that these fees should in future be based on the BMA's 'Treasury' rate and if we could not recommend this, that doctors should be allowed to charge their own market rate. The BMA said that in 1997 we had stated that these fees were not within our remit and had recommended that they should be established at market rates. The alternative option would therefore be a return to this recommendation.

3.65 The BMA also set out its concerns regarding fees for family planning work. The remuneration provided for this work was well below the commercial rates that doctors had secured for other family planning activities and the BMA said it believed there would be a crisis in recruitment if family planning rates were not increased significantly.

3.66 Asked whether GMPs had any legal obligation to treat patients under these arrangements, the **Department of Health** told us that collaborative arrangements had their basis in Sections 26-28 of the NHS Act 1977. These covered the making available of NHS resources, including staff, to Local Authorities. The resources might include GMS and PMS contractors so far as was reasonably necessary and practical to enable local authorities to discharge their functions relating to social services, education and public health. The Department said it believed that for the most part, payments under collaborative arrangements were probably considered to be outside the GMS contract and it did not see this work as part of enhanced services. There was a structure for paying set fees to GMPs undertaking collaborative arrangements so payment via an enhanced service would seem inappropriate.

Comment

3.67 *Over recent years we have made clear our concern about the lack of progress in reviewing these fees. At the same time, the BMA has argued consistently that we should recommend that its so-called 'Treasury' rate is used as the basis for these fees. We have not been persuaded by the BMA's argument because we have had no evidence on which to make a judgement about the wide-ranging work which is being carried out.* ***We therefore recommend*** *(recommendation 7)* ***that doctors engaged in this work should set their own fees for 2006-07****. We believe that this approach is not out of line with the Government's policy of local commissioning of services and of contestability. We do not intend to revisit this issue in the future unless the parties provide us with better evidence on which we can make a proper judgement.*

CHAPTER 4 – GENERAL DENTAL PRACTITIONERS

Introduction

4.1 *We conduct this review as general dental practitioners (GDPs) are about to transfer to new arrangements for NHS dentistry in England and Wales in April 2006, and dentistry in Scotland is being transformed under the Action Plan[1]. In reviewing the evidence this year, we have noted the emergence of different approaches to NHS dentistry in England and Wales and in Scotland. If in future the two systems continue to diverge, we will need to have full and separate information on each system covering all aspects of our remit.*

4.2 *Turning to the evidence presented to us, it focuses on the reforms that the Government will be making to dentistry in England and Wales, which include local commissioning, a new system of dental charges and payment for dentists who will have contracts with Primary Care Organisations (Primary Care Trusts (PCTs) and Local Health Boards (LHBs)), and the measures that have been introduced in Scotland. The evidence also reflects the concerns of the dental profession as it changes to the new system. The year to which our recommendations apply (2006-07) will be the first year of the new system in England and Wales, and in making our recommendations we have focused on the need to facilitate the transfer to the new arrangements.*

4.3 A number of issues were raised for our consideration this year, covering access to dental services, support for PCTs, recruitment and retention of dentists, practices' expenses, capital support and return on capital and the introduction of a practice cost allowance. We consider these various issues below, after summarising the parties' evidence.

The recommendations in the Thirty-Fourth Report

4.4 While welcoming the more transparent approach used by us last year in formulating the fee uplift, the **British Dental Association** (BDA**)** said our recommendation of a 3.4 per cent uplift on gross fees had done little to inspire the dental profession in the final year before the reform to NHS dentistry. In addition to what was considered an inadequate uplift, considerable disappointment had been expressed on our refusal to recommend a practice allowance, which would go some way towards reimbursing practitioners for their administrative and legislative burden as contractors to the NHS. We had also missed a real opportunity, in the year before the reform to NHS dentistry, in not recommending, or commissioning our own, independent research to explore dental expense inflation.

Progress towards introducing reforms to NHS dentistry

4.5 The **Department of Health** said that the Government had consulted the profession's representative bodies on its proposed reforms and was now completing consultation on the final aspects. Over the past year major changes had been made to the way dentistry was delivered in England with 33 per cent of dentists providing services under the NHS now working under Personal Dental Services (PDS) pilot arrangements. The pilots had been based on principles set out in the consultation *Framework proposals for primary dental services in England from 2005*, and from April 2006, the changes would be consolidated and the benefits made available to all dentists, either through new local General Dental Services (nGDS) contracts, or through permanent nPDS arrangements. The aim was to deliver the Government's vision for NHS dental services which:

- offered improved access to high quality treatment for patients;

[1] Can be viewed at http://www.scotland.gov.uk/library5/health/apioh-00.asp

- reduced the focus on intervention and allowed increased prevention to improve oral health; and

- gave a fair deal to and improved the working lives of dentists and their teams.

4.6 The Department said that it had announced its strategy for reforming NHS dentistry in England in July 2004. In July 2005, the proposed new NHS dental patient charges system had gone out for consultation and draft regulations governing the new GDS contracts and permanent PDS arrangements had been published in August 2005. The Department said that responses so far on the patient charges proposals had shown broad agreement that the current system should be changed and that the new system would offer a better deal for patients and dental professionals, especially regarding increased clarity and reduced bureaucracy.

4.7 The Department said that the new dental reforms would offer benefits both to dentists and NHS patients. For dentists, the reforms would mean:

- no longer being monitored and paid on the basis of the individual treatments provided. They would instead be expected to undertake an agreed number of courses of treatment that were weighted to reflect the complexity of treatment provided;

- freed practice capacity, based on the experience of PDS which indicated that dentists carried out at least ten per cent fewer courses of treatment. Dentists would be expected to undertake 95 per cent of their historic level of weighted courses of treatment;

- a change in behaviour as both a reduction in the expected number of treatments carried out and the average number of interventions within each course of treatment would reduce dentists' workload and allow more time to be spent with patients focused on prevention and health promotion. As a result of fewer and less complex interventions, a reduction in practice expenses would also be likely; and

- delivering services in more innovative ways, with changes in practice skill-mix allowing more straightforward tasks to be undertaken by other dental professionals.

4.8 The Department said that the reforms provided dentists with important guarantees regarding:

- the right to a base contract with a PCT for all dentists currently providing NHS services;

- gross turnover protection for a three year transition period (now 2006-07 to 2008-09) in return for a commensurate level of NHS commitment;

- moving responsibility for arranging out of hours services from dentists to PCTs;

- minimising bureaucracy; and

- ensuring that practices would not bear any financial risk as a result of changes in patients' charges.

4.9 The Department said that GDS contracts would be open-ended and dentists' level of

gross NHS income would initially be guaranteed for three years, which together would support dentists in making business plans. It said that PCTs were only able to terminate contracts where there was a breach of contract.

4.10 The **National Assembly for Wales** said *Routes to Reform, A Strategy for Primary Dental Care in Wales* had acknowledged the need for reform of primary dental care services, and the legislation to enable this to happen had been included in the Health and Social Care (Community Health and Standards) Act 2003. LHBs would have the responsibility for primary dental services in their area and hold the GDS budget locally. It was proposing that dentists could carry out 90 per cent of their historic levels of dental activity in the new arrangements without any loss of income.

4.11 The **Scottish Executive Health Department** (SEHD) said the consultation on *Modernising NHS Dental Services in Scotland* (2004) had resulted in an *Action Plan.* The profession and others consulted had wished to retain a Scotland-wide approach, with some element of local flexibility, rather than go down a path of local contracting, as in England. Over the next three years, the SEHD said that it would invest an additional £150 million to achieve the goals in the *Action Plan*.

4.12 The **BDA** reported slow progress with the Department of Health's plans for reform of NHS dentistry and reminded us of the events leading up to its suspension of discussions with the Department in December 2004. Discussions had been resumed in February 2005. There had been no discussions prior to the publication of the patient charges consultation, the draft GDS and PDS regulations or the policy paper outlining the principles of the Statement of Financial Entitlement. The lack of both joint working and information from the Department had led to uncertainty and anxiety within the profession and a feeling that it had been backed into a corner with their options compromised as the pre-implementation timetable had been compressed. The BDA reminded us that the National Audit Office (NAO) had highlighted the risks associated with this approach in dealing with the profession and had urged the Department to be more transparent.

4.13 The BDA said that it had provided its formal response to the consultation on the new NHS dental charges system and had written to the Department with a range of concerns regarding the new GDS and PDS regulations. These included ensuring that practitioners could continue to prioritise NHS services to children and exempt adults, removing the output-target based system and addressing the increased NHS administrative burden on practices. It was concerned that financial information for practitioners might not be forthcoming until January 2006 and, as certain transitional arrangements would also begin in 2006, the profession would only have a maximum of three months to make properly informed decisions regarding their futures.

Comment

4.14 *We commented in our last report that reform of the current system for general dental services must be the way forward and so we welcome the fact that new arrangements for NHS dentistry will come into effect from April 2006. Despite the professions' continuing concerns, we hope the reforms will begin to deliver the benefits to practitioners and the dental service highlighted to us in evidence.*

4.15 *We note the evidence the Department of Health has given to us on the PDS pilot schemes,*

on which much of the forthcoming changes to NHS dentistry have been based. Some of the benefits that have been observed in the PDS pilots, such as freed-up time as GDPs carry out fewer courses of treatment, should address the issue of the high levels of workload, the so-called "item-of-service treadmill" that has been a key factor in the drift from NHS dentistry. We note also that the gross earnings of dentists in England and Wales will be protected although they will only be expected to carry out 95 per cent (90 per cent in Wales) of their current level of weighted courses of treatment or units of dental activity (UDAs). Whether this reduction in the expected number of treatments carried out, together with the anticipated reduction in the number of interventions within each treatment, will be sufficient to get dentists "off the treadmill" and allow them more time to spend with patients remains to be seen. Indeed, it has been put to us that with dentists having UDA targets to achieve, the Department will just be replacing one treadmill with another. We do not know whether that will be the case and we are therefore taking a neutral view on that for the moment until we see what actually happens. We would hope that the reforms would make it more attractive for dentists to increase their commitment to NHS dentistry.

4.16 *Another feature of the reforms is a new system of patient charges. This has three bands and each band comprises a range of treatments. The higher the band, the higher the charge, but within any one band the charge is uniform although cost and complexity may vary. We have been provided with no evidence on how this new system might impact on the pattern of demand by patients or the pattern of supply by practitioners. The details of the outcome of the consultation exercise[2] on the new system of charges were published in December 2005 and we note the Department of Health says from the consultation that patients and the public are broadly in support of many of the aims of the new system. The response of the profession has been, however, more sceptical, and we believe the Department must do more to explain to dentists and the public how the new system will work and its benefits. While there has been no overwhelming support for the new system from all concerned, we are also taking a neutral view on this for the moment.*

4.17 *We note that in the short time remaining before implementation of the new arrangements, dentists will need to have a clear understanding of their contracts, the new system of charges and the relationship with their PCTs and PCTs will need to know what is required of them to discharge their commissioning role effectively. This is a large change for both dentists and PCTs and its complexity and scale should not be underestimated. Our visits to PCTs last summer suggest that some PCTs will be better equipped to deal with their new responsibilities than others. Overall, our visits left us with the sense that there is uncertainty and anxiety among dentists and PCTs about the change. We were somewhat surprised by the brevity of the evidence given to us on the mechanisms to support dentists and PCTs in the forthcoming change (see paragraphs 4.24 and 4.25) and are concerned about whether the current level of support is sufficient to enable the change to occur across the country to timetable.*

Access to dental services

4.18 The **Department of Health** said the new local commissioning arrangements would free up capacity within dental practices in ways that had already been seen in PDS pilots. The new commissioning relationship would better enable PCTs and dentists to work together to improve patient access. It said it had provided £15 million recurrent revenue funding to PCTs to support the development of dentistry and to buy back extra NHS capacity from existing dentists, and £6 million recurrent funding for 16 PCTs with the most pressing access difficulties.

[2] Can be viewed at http://www.dh.gov.uk/Consultations/ResponsesToConsultations/fs/en

4.19 The **National Assembly for Wales** said that in May 2004, £5.3 million had been made available over three years to prepare for the introduction of the new dental contract in April 2006. Of this funding, £1.9 million had been allocated in both 2005-06 and 2006-07 to improve access and support implementation. The Assembly also reported that 11 new practices had been opened and 37 had expanded over the past two years, and over 10,000 additional NHS patients had been registered as a result of PDS pilots.

4.20 The **SEHD** said that grants were available to dentists wishing to establish new or expand existing NHS practices in areas of high oral health need or unmet demand under the Scottish Dental Access Initiatives (SDAI). The number of grants accepted under the SDAI had increased to 20 in 2005 from 11 in 2004.

4.21 The **BDA** said the continuing problem of access to NHS dentistry was a legacy of poor Government policy and the demand for NHS dental services was outstripping supply so that GDPs were finding that they had to close their books. Quoting from a Healthcare Commission study[3], it suggested that there were around 15 million people in England who would like to be registered with an NHS dentist, significantly more than the Government's estimate of two million people with no access to NHS dentistry.

4.22 The **Department of Health** said that the highest level of NHS registration was 57 per cent for adults and 60 per cent for adults and children in 1993, at a time when the adult registration period was two years as opposed to 15 months now. At that time, there were no significant reported difficulties of patients being unable to register with an NHS dentist. It said it was inconceivable on that basis that the current levels of unmet demand for NHS dentistry were anywhere near the levels extrapolated by the BDA. Even so, the Department said there were continuing access challenges that needed to be tackled.

Comment

4.23 *We note that the new local commissioning arrangements between practitioners and PCTs are expected to be able to deal with problems of access to dentistry more effectively, and we would welcome more analysis on how this has worked next year. We also welcome the various initiatives to improve access to dentistry in areas with the most pressing difficulties. However as last year, the impression we have is that the problem of access to dentistry is widespread and not confined to particular areas. Whether new ways of working will enable PCTs to buy back more of the dentists' time for NHS work remains to be seen, given the competing priorities of PCTs and the financial constraints within which they operate. We would add that expanding commitment to NHS dentistry depends on PCTs having the funding to grow dental services in their area and this may require even more funding than that which has been given to dentistry. As we said last year, the problem of access will not be solved until there are more dentists working in or more fully for the NHS across the country.*

Support for PCTs

4.24 The **Department of Health** said that in 2005 it had run a series of workshops and training events for all PCTs on local commissioning. It had also issued commissioning guidance to PCTs at key points in the process. PCTs had already shown their ability to move significant numbers of dental practices to new working arrangements through PDS pilot schemes, and the Department would continue to ensure that PCTs were well supported in the run up to April 2006 and were able to complete the new contracting process on time.

[3] Healthcare Commission, Primary Care Trust: Patient survey report – primary care (2005).

4.25 **NHS Employers** said it did not believe it would be appropriate to submit evidence on dentistry at the current time, as the overall policy toward dentistry was still under consideration, and it had no remit in respect of dentistry.

Comment

4.26 *We have expressed our concerns about the support being given to dentists and PCTs in paragraph 4.17. We are also concerned about the fact that PCTs will have to contend with their own reorganisation in the future and this will not help them in preparing for their new dentistry responsibilities. We consider it important that the Department of Health not only ensures that PCTs are well supported in the run-up to April 2006 but also in the period after implementation as PCTs adapt to their new functions. Moreover, we were surprised at the limited evidence from NHS Employers who represent the PCTs.*

Recruitment, retention and morale

4.27 The **Department of Health** said that it had shown in its evidence in previous years that although the number of dentists in the GDS had been growing each year, there had at the same time been a downward trend in dentists' overall NHS commitment. Under the current arrangements, dentists could switch from NHS to private work with relative ease and very little notice to the NHS or patients. Private practice, which was relatively less regulated, had been an attractive option for dentists and one with which the NHS found it difficult to compete.

4.28 The Department said that Government had taken a number of steps to try to address these problems, but it had become clear that the current remuneration system had been a major factor in the decline in dentists' NHS commitment. The reforms being introduced from April 2006 would allow a greater focus on prevention and health promotion. They would tackle head-on the traditional concerns raised about NHS dentistry by the profession, by us and by other expert bodies and would make the NHS a much more attractive option for dentists.

4.29 Over the last year, the Department said it had made significant progress in recruiting dentists, expanding workforce capacity and improving access to services. By October 2005, it would have provided the equivalent of an additional 1,000 whole-time equivalent (wte) dentists through:

- 'buying back' extra NHS capacity from existing dentists equivalent to 350 dentists, supported by £50 million central Government funding (£35 million capital grants and £15 million recurrent revenue funding); and

- recruiting 650 dentists from both domestic and international activity.

4.30 The Department said that as a result of the Government's various measures it expected spending in primary care dentistry to be some £250 million a year more in 2005-06 than in 2003-04. Domestic recruitment had been achieved by attracting dentists back from career breaks and through offering more flexible working patterns, and international recruitment had benefited from clearing the backlog of dentists waiting to sit the necessary international qualifying examination. The additional dentists had been targeted to areas where access had previously been most difficult, for example Cornwall, Shropshire, Cumbria and Essex.

4.31 From October 2005, the Department said there would be an extra 170 undergraduate training places in England (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. The Department said that it had taken into account the contextual information from the 2002 Dental Workforce Review when drawing up plans to recruit 1,000 more dentists and fund 170 extra training places for undergraduates. These developments recognised that future workforce planning would need to take into account the positive impact of the forthcoming reforms.

4.32 The Department said it had also continued to invest in expanding PDS, evidenced by the growth in PDS pilots from 3,500 dentists in 1,300 dental practices to over 6,700 dentists in 2,400 practices. It said around 33 per cent of dentists were now in PDS and these dentists were enjoying new ways of working, which were proving very popular with patients.

4.33 The **National Assembly for Wales** said it had implemented a 17 per cent increase in dental undergraduate places at the Cardiff Dental School.

4.34 The **SEHD** reported on the uptake of a number of allowances for GDPs and their effect on recruitment and retention. As a result of the vocational trainee allowance being available to all vocational trainees in 2004-05, there had been increases in numbers of dental graduates taking up posts in Scotland. There had been a 25 per cent rise in 2004-05 in the number of newly qualified dentists claiming the "golden hello" allowance and a 20 per cent increase in 2004-05 in claims for the remote area allowance. It said its *Action Plan* committed it to providing infrastructure support for dentists and the level of support was dependent on the extent of the practice's NHS commitment.

4.35 The **BDA** strongly disputed that in 2003 the undersupply of wte dentists in England was 1,850, as stated in the *Report of the Primary Care Dental Workforce Review,* and considered the undersupply to be around 4,000 wte across the UK. A University of Bath study[4] had suggested that the undersupply was more acute and that the NHS needed to recruit 5,200 more dentists. The Department was actively looking to recruit dentists into England on salary packages that were around £50,000, which was lower than the average net earnings for a committed NHS practitioner and in order to retain these dentists, the Department would either need to increase their earnings or risk losing them to the private dental market.

4.36 The BDA said there was a real risk that the Government's measures to address the under supply of the workforce would fall short, and the situation would continue to be a prominent feature of dental services in England over at least the next two decades. It was imperative for us to make strong recommendations in the first year of the transition period to retain the NHS commitment of those that would be entitled to a new GDS or new PDS contract from 1 April 2006.

4.37 The **Dental Practitioners' Association** (DPA) said that recruitment into the NHS was still difficult and the Government was still advertising for dentists abroad. It said that dentists coming to the NHS from Europe were not required to undergo vocational training, and that practices employing such dentists therefore had to carry the costs of additional training.

[4] Can be viewed at http://www.ij-healthgeographics.com/content/3/1/10

4.38 The DPA said how much work dentists did for the NHS had a greater impact on the supply side than the numbers of dentists in contract, and that was why it was not relevant or useful to quote the number of dentists with NHS contracts, or those qualifying each year.

4.39 The **Department of Health** subsequently told us it had met its target for the recruitment of 1,000 wte dentists by the end of October 2005. It said that in the context of our remit, the position on recruitment was a very important factor for us to take into account, in so far as it measured the likely ability of PCTs to commission additional services in the event of any existing dentists reducing their NHS commitment.

Comment

4.40 *We are glad to note evidence that the number of dentists performing NHS dentistry with GDS and PDS contracts has grown significantly in the last year. We also welcome the steps the Government has taken to increase the size of the workforce. In this respect, we note that the target to recruit 1,000 wte dentists into the workforce has been met through various measures, such as international recruitment and by attracting dentists in the domestic workforce to do more NHS work. We note also that the number of dental student places has increased by over 170 from October 2005. However, we still have no idea of the size of the workforce that would be needed to provide the desired level of NHS dentistry, indeed we are unclear as to what level of dentistry the NHS wishes to supply or the real level of demand for it. We have been told that some of the new international recruits have been trained to work in different ways to the domestic workforce, which means that they do not see as many patients as a UK trained dentist, and that they will take time to get up to speed. Therefore, we are unable to judge whether the steps taken have been enough. The BDA disputes the size of the undersupply of wte dentists, and we remain unclear about the relevance of the 2002 Dental Workforce Review, which suggested there was an undersupply of 1,850 wte dentists. We have not received any evidence on how the Department plans to fill the potential shortfall of 850 wte dentists, but we assume this is expected to be through dentists working in new ways under the new arrangements. We find it difficult to assess the extent to which the NHS is under-provided with GDPs and we would welcome greater clarity about the resources needed or the scale of patient demand so that we might use this as a basis for assessing the issue of recruitment and retention. We would welcome information on the number of wte dentists providing NHS dentistry, if this can be gathered from the new system.*

4.41 *It has been put to us that there is a risk that at the end of their contracts the additional dentists recruited to the workforce from overseas could transfer to more lucrative private practice. We note that the Department states that the reforms are aimed at addressing the problems of recruiting and retaining GDPs, but we have no way of knowing whether the Department is correct in its belief that the new arrangements will make the NHS a much more attractive option for dentists. As dentists are about to transfer over to the new arrangements, recruitment and retention of dentists in the NHS continues to be a concern for us and we would summarise the situation as follows:*

- *despite the measures that have been taken, there continues to be a shortage of dentists working in the NHS and the extent of this is unclear;*
- *it remains to be seen whether the new arrangements will halt and possibly reverse the drift to private practice; and*
- *to address problems of access, more of the average GDP's time needs to be bought back for NHS dentistry.*

4.42 *We hope the reforms will encourage the new dentists to commit to the NHS, and existing dentists to retain or enhance their commitment to NHS dentistry. Our recommendations for 2006-07 are intended to support these changes.*

Practice expenses

4.43 The **Department of Health** said, following our request to review practice expenses, that its initial analysis of the latest expenses data (for 2003-04) suggested that dental expenses had fallen, but it would comment further when the data had been finalised. It had been working with the BDA to assess movements in income and expenses and would be considering with both the BDA and our secretariat at the Office of Manpower Economics (OME) how the analysis might be strengthened in the future. The analysis would need to take account of how expenses were likely to be affected under the new arrangements. It would be important to allow the changes to settle properly before assessing their impact on expenses. It expected practice expenses to fall as a result of the intended shift towards fewer courses of treatment, fewer interventions on average within the typical course of treatment, and greater emphasis on prevention and health promotion.

4.44 The Department said the Health and Social Care Act 2003 gave PCTs a power to assist and support providers and prospective providers of primary dental services. Support and assistance could include financial support and the provision of premises on terms the PCT thought fit. This would give PCTs far greater flexibility to deal directly with local recruitment and retention issues that meant that, at a national level, contract values did not need to increase by more than inflation. The new commissioning framework would give PCTs greater flexibility to deal with practice expenses. For example, PCTs could agree a direct reimbursement of premises costs or contribute to staff wages, as had been the case for some years in general medical services. Commenting on reports about PCTs with financial difficulties, the Department said that the majority of all NHS organisations were delivering service improvements and living within their budgets, and the overall national deficit reported by all NHS bodies in 2004-05 represented only around 0.4 per cent of total resource. It said that the case for additional investment on dentistry would need to be judged on the basis of local circumstances and priorities.

4.45 The **BDA** said the joint working on dental expenses had addressed in part our earlier recommendation, however progress had been slow on developing a mechanism for assessing changes in dental expenses in the transitional year ahead of the new arrangements. It had been encouraged to see that we had used a more transparent approach, which took account of dental expense inflation, to feed into the calculation of the fee scale uplift. It had welcomed our view that fee increases in line with the Government's inflation target would not "ensure stability in the run up to the new contractual arrangements" but would lead to a fall in the real remuneration of GDPs. The BDA urged us to continue considering these principles in the first full year of the new arrangements and to continue to support the parties' joint working. The BDA added that any recommendation on gross earnings that resulted in a real reduction in GDPs' net earnings in 2006-07 would result in many GDPs gradually withdrawing their NHS commitment over the three-year transition period.

4.46 Based on figures[5] for non-associate GDPs' gross earnings, expenses and net income for Great Britain between 1999-2000 and 2003-04, the BDA said that the average annual increase in dental expenses had been 5.6 per cent, compared with an average fee scale increase of 3.5 per cent. Strict infection control guidelines and the resultant move toward single use items had been key factors in the recent driving-up of dental expenses inflation. Its own survey[6] had highlighted insurance costs, training costs, waste management costs and cross infection control costs as key factors that had contributed to rising practice expenses over the previous two years. It said it was very clear that NHS fee scale increases between 1999-2000 and 2003-04 had not kept pace with dental expense inflation and asked us to recognise the significant gap between dental expense inflation and the fee scale uplifts in that period in our recommendation for the 2006-07 uplift.

4.47 Commenting on our use of the Retail Prices Index (RPI) as a measure to reflect rises in dental expenses other than staff costs, the BDA said between 2000 and 2004 the RPI had increased by 9.6 per cent, while over the same period, dental expenses had risen by 22.4 per cent. The BDA believed there was considerable evidence to indicate that salaries and wages of Dental Care Professionals (DCPs) had been growing at a higher rate over the last five years than the Annual Survey of Hours and Earnings (ASHE) measure of 3.8 per cent used by us last year. It cited three separate sources to support its claim. First, based on information between 2001-02 and 2003-04 on the average expense breakdown in Great Britain produced by the Health and Social Care Information Centre (HSCIC), employee expenses had risen by 12 per cent. Secondly, ASHE data between 2001 and 2004 on the mean gross hourly pay for a dental nurse had shown an increase of around 5.25 per cent a year. Thirdly, practitioners would need to continue awarding above average wage increases to DCPs because of the recruitment and retention pressures associated with these staff. The BDA said it concluded that using the RPI as a proxy for all other dental expenses and the hourly wage information for dental nurses (from ASHE) as a proxy for the wages and salaries of DCPs did not address dental expense inflation adequately, though we were not informed of the data series that would be appropriate. We were urged to make a recommendation for 2006-07 that in part considered this historic discrepancy between the feescale uplifts and the rise in dental expense inflation.

4.48 In the first year of the reforms of NHS dentistry, the BDA asked us to undertake our own independent research on dental expense inflation that could feed into the joint working between the BDA, our secretariat and the Department.

4.49 In supplementary evidence, the **Department of Health** said that the ASHE data on gross hourly pay for dental nurses was distorted by a change in occupational classification, which it said probably explained the exceptional increase of nine per cent in 2001. It also said that the fee scale increases did not include the significant boost to dentists' income from commitment payments, and the introduction of Professional Development and Clinical Audit allowances. It said that HSCIC data showed average income after expenses for dentists with a high NHS commitment was almost £80,000. The data also showed dentists' expenses as a percentage of gross income were stable between 1994-05 and 2003-04, and fell by one percentage point between 2002-03 and 2003-04. It said that the expenses to income ratio for the most committed NHS dentists was lower than for less committed dentists, that the expenses ratio decreased as NHS commitment increased. Since private work had a

[5] Health and Social Care Information Centre, General Dental Practitioners' Earnings and Expenses.

[6] BDA Survey of Dental Expenses (2004).

higher expenses ratio and its proportion had been increasing since 1994-95, it said the average expenses ratio for committed NHS dentists had fallen during that period. It added that the data did not take into account the additional amount awarded for expenses in our recommendation last year. Commenting on our formula approach, the Department said the formula used was a general one which could not take into account the factors affecting dentists and their working environment. It did not consider that a formula was needed, given the significant reforms already introduced, which it said were set to reduce expenses further. The Department said that the methodology of the HSCIC had been agreed by the BDA, OME and itself, but that it would be happy to discuss any further ways of reviewing movements in dental expenses.

4.50 The **HSCIC** reported that from the HM Revenue and Customs (HMRC) survey for 2003-04, the detailed breakdown of expenses was: business[7] (10 per cent), premises (9 per cent), salary and wages (30 per cent), car and travel (2 per cent), interest and depreciation (7 per cent), net capital allowances (5 per cent) and other items[8] (37 per cent). The estimated average expenses to income ratio for all dentists was 54.5 per cent for 2003-04 and the average for the period from 1997–98 to 2003-04 was 54.8 per cent.

Comment

4.51 *In making our judgement on the level of award for GDPs, we take into account both the dentists' "take home pay" and their practice expenses. In the absence of any specific comprehensive index of dental expenses, last year we used a formula to derive the expenses element and combined expenses with the dentists' take home pay. We are pleased to note that the parties found this approach more transparent, and that it enabled them to see the reasoning behind our uplift recommendations. We also asked the parties to develop a mechanism for assessing changes in dental expenses and to keep our secretariat informed. Although our request has been in part addressed, real progress in this area has been slow. We are grateful for the work that has been carried out by the HSCIC on the HM Revenue and Customs Survey of Dentists' Income and Expenses, a source that the Department of Health and the BDA have used in evidence this year. We hope this work will continue and we would be particularly interested to see information on GDPs' hours worked and number of patients seen (or UDAs), so that we may be able to monitor the hourly rate of pay and workload for different levels of NHS commitment. We note also that the BDA has asked us to carry out research on dental expense inflation in the first year of the reforms. We do not consider the timing would be appropriate to conduct such a study now, however it would make sense for the parties to monitor this in the transition process.*

4.52 *Concerning the evidence this year, the Department of Health points to the latest year of HMRC data, 2003-04, where the expenses to income ratio fell. We would note in response that our recommendation[9] to increase significantly the level of commitment payments to dentists was included in the 2003-04 HMRC data. This would have distorted the expenses ratio as compared to its historic pattern and so make that year's data less representative. The Department also suggests that the evidence from the PDS schemes, which indicates that dentists will be able to carry out fewer and simpler items of treatment, will lead to a fall in dental expenses. In reply, we would note that the PDS pilot arrangements are different to the contracts that will generally be on offer to dentists from April 2006.*

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[7] Includes repairs and renewal of business premises and machinery, the cost of general office expenses, covering administration, advertising, promotion, legal and professional costs, and bad debts and other finance charges.

[8] Includes cost of sales, i.e. the cost of purchasing raw materials/items sold.

[9] Review Body on Doctors' and Dentists' Remuneration, Supplement to 32nd Report 2003, Paragraph 2.75

These will have Units of Dental Activity targets to be met and, therefore, whether dental expenses will fall and, if so by how much, as a result of working in new ways remains to be seen. The BDA says that historically expenses have increased faster than the fee uplift and are likely to continue to do so in the future. As we said last year, it is our view that we should focus on the most recent information when considering dental expense inflation, rather than forecast what might happen. We intend to continue with the formula approach that we used last year. This is given in more detail at paragraphs 4.73–4.76. We recognise that as dentists move to working under the new arrangements, information on how their expenses have changed will be important new information for us to consider and we will consider how this approach can be adapted as the new arrangements start to bed down.

Commitment and seniority payments under the new contract arrangements

4.53 The **Department of Health** said it remained committed to working with the BDA to devise a longer-term alternative to seniority payments. It said it was keen for the payments to recognise quality. In the meantime, dentists who currently received seniority payments would continue to have them reflected in contract values, and dentists reaching the age of 55 during the transitional period would have their contract values uprated in line with the effect of seniority payments.

Comment

4.54 *We welcome the fact that the value of seniority payments are being retained in the transitional years of the new arrangements, and look forward to seeing the details of any new scheme which aims to recognise quality, and we would hope it will also retain and motivate dentists working in the NHS.*

Capital support and return on capital

4.55 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. It also considered that the new contract seriously eroded the idea of practice goodwill as a saleable resource, since independent contractors had no right to a contract. It also said that many practices were owned outright by dentists and therefore no charge existed in the accounts for rent, and that a notional rent should be built into the funding.

4.56 The **Department of Health** said return on capital was already within the amount of remuneration provided by the existing system. There was no reasonable argument for the subsidy of a private contractor's investment in their own premises by the public body with which they were contracting.

Comment

4.57 *It is certainly the case that in deciding whether to engage in an economic activity, an independent contractor will have regard both to the opportunity cost of his/her time as well as the return on such financial capital as may have to be invested in the activity. This return would include the implicit rent in the case where the principal owned the premises they practiced in.*

4.58 *We accept that all the foregoing applies to GDP principals and when we refer to a dentist's take home pay we mean it to cover these elements. Hence all of these elements should have been built into establishing the appropriate level for a dentist's remuneration at the very outset and allowance should have been made over time for any changes in the elements. The evidence we have received from the parties differs but it is unclear to us whether the disagreement is about whether the baseline was appropriately set at the outset or has been imperfectly adjusted since then. As we have no practical way of resolving this issue, we are going to assume that for the present an allowance for the return on capital is embodied in the practitioner's take home pay, but would urge the parties to discuss the issue and bring any relevant evidence to us in the next or subsequent rounds.*

Practice cost allowance

4.59 The **BDA** said a practice allowance for practitioners would improve NHS dental services for patients and would help to address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support, information collection and provision. The results of the BDA's short email survey in 2005 of 55 committed NHS Dental Practices in Scotland had supported this view. Half of those responding also said that the introduction of the Scottish Dental Practice Allowance and the rise in 2005-06 in the level of the allowance had significantly helped in maintaining their practice viability. The BDA asked us to introduce a practice allowance, similar to that in Scotland, which would be valued at six per cent of a practice's NHS contract value, to address the ever increasing burden of running a dental practice within the NHS. In this regard, it noted a number of new requirements within the draft contract for non-clinical work commitments, such as clinical governance, practice inspection by the PCT and annual and mid-year reviews.

4.60 The **SEHD** said that the Practice Allowance in 2005-06 had increased to six per cent of gross (NHS) earnings. The percentage uptake amongst practitioners had increased by 11 per cent in 2004-05 to 79 per cent, and the number of claims had increased by 95 to 699 in 2004-05. The SEHD said that its take-up did not specifically represent recruitment and retention, but since the intention was to compensate NHS dentists for the rising costs of running a practice, it was an indirect measure of retention. It said that practice owners viewed the allowance as a financial contribution towards their "management time" costs. Although SEHD said it had no robust evidence of the rising costs of running a practice, it said an example of increased costs to dentists was the current demands of decontamination in Scotland. SEHD subsequently told us that with effect from October 2005, it had further increased the general dental practice allowance to 12 per cent of gross NHS earnings. It also announced a number of other measures, including increases to help with decontamination, payments for rent reimbursement, increased payments for continuing care and capitation, a new item-of-service for fissure sealants, and (with effect from April 2006) an allowance of £9,000 for each dentist who served disadvantaged urban areas.

4.61 The **Department of Health** said the new contractual arrangements would reduce the administrative work involved in running a practice. It said the cost of running a practice was already built into the remuneration and expenses taken into account by us, and that a specific allowance would be inequitable when applied to practices of many different sizes and levels of NHS commitment. It said that PCTs could take account of specific needs in agreeing local contracts, and said this was a much fairer and more flexible way of addressing specific requirements than a practice allowance.

Comment

4.62 *Since the practice cost allowance operated in Scotland is calculated as a straight percentage of NHS gross earnings, it can be thought of either as a fee increase (additional to our uplift) or as a cost subsidy. Either way, it is a supplement to the income of Scottish NHS dental practitioners. It has been doubled from six per cent to 12 per cent from October 2005, indicating the importance attached to it by SEHD as a measure for supporting dentistry in Scotland. In its commentary on the allowance, SEHD explain that its intention is to compensate dentists for "the rising costs of running a practice". Since the types of costs indicated look to be the same set as apply in England and Wales and we have been given no evidence that movements in dental costs over time in Scotland have been radically out of line with those elsewhere in Great Britain, the request by the BDA to have this allowance introduced in England and Wales is not particularly surprising, especially as the formal fee scales are currently identical.*

4.63 *SEHD has indicated that, even though this measure was not introduced with recruitment and retention in mind, it may have had an impact on commitment to NHS work. Though plausible, this is a claim that is hard to establish conclusively and we have no way of evaluating the relevant counterfactual: what would have happened in the absence of the allowance. Moreover, the fact that such an allowance exists in Scotland, and does not in England or Wales, is quite consistent given the existence of devolved powers and the emergence of different systems within Great Britain.*

4.64 *We would make the following points. First, the BDA has asked for the introduction of a scheme similar to that in Scotland. Payments under that scheme are, however, proportional to the level of NHS activity, whereas the elements of the new contract identified by the BDA in its request are discrete in nature and not necessarily related to the volume of activity. Secondly, the Government in its evidence has claimed that practice costs will be reduced under the new contract. If this turns out to be the case, this will create headroom to absorb some of the other increases in costs, while leaving practitioners' net income unaffected. In addition, we estimate that the introduction of a uniform allowance related to volume would add around £90 million to the NHS budget in England and Wales, a substantial sum that if recommended would have serious implications for affordability. Therefore, given that a new system of local commissioning of NHS dentistry is being introduced in England and Wales, we do not think that the introduction of a non-targeted practice cost allowance is appropriate at this stage in the transition. We hope that detailed data on practice expenses will emerge in the near future, and when it does, consideration can be given then to whether the level of gross earnings relative to practice costs needs adjustment.*

Pay recommendations for 2006-07

4.65 The **Department of Health** said that the past year had seen major changes in NHS dentistry, with over a third of all NHS dental services now provided under new contracting arrangements (PDS) and a significant change in work patterns for the dentists involved. It was committed to making these benefits available to all dentists from April 2006. The Government had made an unprecedented level of investment in dentistry combined with a strategy to rebuild NHS dentistry through the move to local commissioning and the associated reform of remuneration systems. Recruitment of over 1,000 additional dentists and increases in undergraduate places to increase the future dental workforce would strengthen the changes being made. These changes would take dentists off the treadmill, significantly reduce workload for the same remuneration and ensure that both dentists and patients benefited from freed-up

capacity. Against this background, and taking into account the likely reduction in practice expenses and the position on recruitment and retention, it considered that an increase in gross fees of no more than 2.5 per cent represented a fair deal for dentists. It added that a simple recommended percentage increase that could be applied to 2006-07 contract values was the best way to ensure the smooth delivery of the new contracting system in April 2006. Both the **National Assembly for Wales** and the **Scottish Executive Health Department** asked for a general pay uplift of no more than 2.5 per cent.

4.66 The Secretary of State for the **Department of Health** wrote to us in December 2005 to confirm her position on the level of award for dentists of up to 2.5 per cent. She said that the reforms would reduce practice expenses such that a gross award of up to 2.5 per cent would feed through into an increase in net pay of over 2.5 per cent. Both **National Assembly for Wales** and **SEHD** supported her view of at most a 2.5 per cent uplift for dentists.

4.67 The **BDA** reminded us of the NAO's[10] analysis of expenditure on dentistry, which it said supported its position that NHS dentistry had been historically under funded. Of the additional £250 million for NHS dentistry by 2005-06, announced in July 2004, the BDA estimated that only around £30 million was realistically available to address this underfunding. It was a step in the right direction, but substantially more funding was necessary to deliver the Government's vision of a high quality integrated NHS dental service in England.

4.68 In response, the **Department of Health** said the £250 million represented the growth in the Government's recurrent annual investment in dentistry between 2003-04 and 2005-06, and included the fee scale upratings for these two years, which accounted for some £90 million. The remainder had been used to increase capacity, both through expanding the capacity of existing practices and through recruiting new dentists.

4.69 In the light of the issues raised in its evidence, the **BDA** asked us to recommend at least a 5.8 per cent uplift on gross earnings for GDPs for 2006-07, which would deliver at least a 4.5 per cent increase to the net earnings for GDPs. Its calculation was based on our formula approach from last year and took account of the BDA's forecast growth (of 4.5 per cent) in wages and salaries for DCPs for 2006-07 and a 3.3 per cent rise in all other dental expenses. The BDA said it believed that this would in part address the recent gap between the feescale increases and dental expense inflation. A 5.8 per cent uplift on the feescale, together with the introduction of a practice allowance, would also go some way towards stabilising the workforce in the first year of the transition period, and have a positive impact on retaining both NHS commitment and practice premises and equipment within the NHS.

4.70 The **DPA** said it had estimated the following amounts should be included in the contract funding sum:

- notional rent/return on capital investment – £15,000 per dentist;
- modernisation investment – £5,000 per chair;
- potential loss of private income – £15,000 per dentist;
- training – £10,000 per staff member;
- meeting new regulations – £2,000 per premises;

[10] "Reforming NHS Dentistry: Ensuring effective management of risks", NAO (2004).

- loss of goodwill – £2,000 per annum per dentist; and
- compensation for the increased 'registration' of the Notional List – £6,000 per dentist.

Comment

4.71 *We have received evidence this year on the reforms that the Government will be making to dentistry in England and Wales, and the measures that have been introduced in Scotland. We have noted in the evidence the emergence of different approaches to NHS dentistry in England and Wales and in Scotland and have suggested that, if the two systems continue to diverge, we will need separate information from each system on the different strands of our remit.*

4.72 *We welcome the fact that new arrangements for NHS dentistry will come into effect from April 2006, but we have been provided with no substantive information this year to judge whether the changes are in the right direction or whether they have gone far enough to make NHS dentistry a more attractive option for GDPs, as the Department claims. There has been a significant uptake of PDS contracts by dentists, but we understand that the new GDS and PDS contracts generally on offer from April 2006 will be different to the earlier PDS schemes. These will, for example, have Units of Dental Activity targets to be met. We have also noted that the reforms are designed to address the historical problem of high levels of workload for GDPs working in the NHS, but we do not know whether new ways of working will actually remove the treadmill. From our visits we have noted a lack of readiness among PCTs for the change, and a sense of anxiety among dentists, which makes us believe that matters are rather uncertain on the ground. Furthermore, it is unclear to us how PCTs will tackle access problems in their areas given the funding difficulties they face this year. We note the progress that has been made in recruiting additional dentists to the NHS workforce over the last year, but as we have no information on the level of dentistry the NHS wishes to supply or real demand for it, we are unclear whether the steps taken are sufficient. We are therefore taking a neutral view on the reforms for the moment. However, as dentists are about to transfer to new arrangements for NHS dentistry, we make our recommendation on the uplift for 2006-07 with the intention of supporting this move.*

4.73 *In last year's report, we used a formula to calculate the uplift. This approach was designed to recognise that GDPs are independent contractors and, like any small business, need to cover both the opportunity cost of the practitioner's time and the return to capital invested, as well as the costs of delivering the service. We continue to think that this view is the appropriate one in framing our recommendations for the uplift in NHS dentistry. The formula involved weighting together the increase in the practitioner's personal remuneration and the increase in GDPs' expenses. The weights that were used were derived from the Department of Health's Inland Revenue survey. The increase in expenses was taken to be a weighted average of staff costs and other costs and the weights for these were derived from the BDA's Business Trends Survey. This year the parties have been working jointly on dental expenses under the aegis of HSCIC and it is their report that we have used to provide these weights: 45 per cent to be attached to the personal remuneration figure and 55 per cent to the dental expense figure. Dental expenses themselves involve weighting together staff costs and other costs and, again using the HSCIC data, the weights are 30 per cent and 70 per cent respectively. Hence once we have decided on the appropriate indicators to use for these elements, our uplift is calculated by applying a weight of 45 per cent to the figure for own remuneration, 16.5 per cent (30 per cent of 55 percent) to the appropriate indicator of staff costs and 38.5 per cent (70 per cent of 55 per cent) to our indicator of other practice expenses. The formula is set out as follows:*

*Uplift $_{2006\text{-}07}$ = 0.45 * increase in GDP remuneration + 0.165* increase in staff costs + 0.385*increase in other costs.*

4.74 *In looking for an appropriate indicator for the increase in a GDP's personal remuneration, we believe that they should share the earnings growth enjoyed by the rest of the economy. Unlike our remit groups in the hospital sector, a GDP's personal remuneration contains no built-in pay drift. In the absence of information on an appropriate comparator, we have concluded that the most appropriate indicator to use this year is the latest "headline" earnings growth figure for the whole economy including bonus effects as recorded by the Average Earnings Index (AEI). This figure is 3.4 per cent.*

4.75 *In looking at an appropriate figure for the increase in expenses, we have considered a range of indicators for staff costs and for other costs, including figures that were provided by the parties in their evidence. Last year the indicator that we used for staff costs was the annual change in the hourly rate of pay for dental nurses as recorded in the Annual Survey of Hours and Earnings (ASHE). For the year to April 2005, this was 1.8 per cent. We were troubled by this figure since it was inconsistent both with the evidence we received from the profession and with what we heard about the labour market for dental staff on our visits, which suggested that staff of the right quality were in scarce supply. For this reason, we have chosen to look at a broader measure covering a range of staff, including dental nurses, who would be employed in dental practices. We have used this year the figure for those staff employed in the Healthcare and Related Personal Services (HRPS) sector as recorded by ASHE. Accordingly, the figure we have used for this component is 3.6 per cent for the year to April 2005. For other costs, we recognise that there are no specific measures for the different categories in this component, and we therefore use, as last year, the RPI as the appropriate measure. This is a price index that uses a more general bundle of goods and services than the CPI, which we also considered. Thus the figure for this third component of the formula is 2.4 per cent, the average change in the RPI for the last quarter of 2005.*

4.76 *Using our recommended uplift for GDPs' personal remuneration and our recommended increase for expenses in the uplift formula gives an overall percentage rise of 3.0 per cent.* ***We therefore recommend (recommendation 8) that an uplift of 3.0 per cent be applied to the gross earnings base under the new contract for 2006-07 for GDPs. This year we are recommending (recommendation 9) that the uplift of 3.0 per cent also apply to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland.*** *We note, however, that if the two systems continue to diverge it may in future years be appropriate for us to consider Scottish dentistry separately and to make a separate recommendation.*

CHAPTER 5: SALARIED PRIMARY DENTAL CARE SERVICES

Introduction

5.1 *This year, the parties have provided us with evidence on the way forward following the review of the Salaried Primary Dental Care Services (SPDCS). In addition, the BDA requests that commitment payments should be made available for SPDCS staff.*

The review of the Salaried Services

5.2 The **Department of Health** said that the review of the SPDCS had developed a vision of the contribution to be made by salaried dentists to future dentistry in the light of the reforms contained in the 2003 Health and Social Care Act. It said the review had developed views about the future requirements for education, training, career structures and leadership and management of salaried dentistry. This had led to the development of a set of principles about the underpinning grade and pay structures which would be needed to give effect to those changes. Those principles were the subject of a wide consultation with all key stakeholders which had run from mid-December 2004 to the end of March 2005 under the title *Creating the Future – Modernising Careers for Salaried Dentists in Primary Care*. This included proposals to change the pay and grading structure for all salaried dentists to bring them into line with the structures more generally existing in dentistry and in the wider medical and dental workforce. It said the proposals would require detailed work and negotiation to translate into a new pay and grading structure, with some proposals relevant to dentistry beyond the salaried services.

5.3 The Department said it had commissioned qualitative research about the factors which made salaried employment attractive to identify what factors made a rewarding career in the SPDCS. The research would help to inform decisions about next steps with the career modernisation programme for salaried dentists, both generalists and specialists.

5.4 The Department also reported on the organisational development (OD) programme for salaried dentists for which it had made available £400,000 across England. In helpful discussions with the BDA, it had been agreed that the funds should be applied to a nationally organised OD programme and that the programme should have three elements: awareness raising road-shows, a resource pack for all SPDCS dentists, and the provision of OD facilitators to support local OD work in each salaried dental service in England. The programme was being managed on the Department's behalf by a Strategic Health Authority (SHA) and was intended to assist and support salaried dentists to prepare for the move to local commissioning of all dentistry from April 2006.

5.5 The **National Assembly for Wales** said it had held observer status on the English review of the salaried services. In August 2005, it had published *Bridges to the Future – Proposals for Developing Salaried Primary Dental Care Services in Wales: A Consultation Paper*, which highlighted the key challenges facing the salaried services in Wales and offered suggestions of ways forward. Besides consulting on the future organisational structure of the SPDCS, the Assembly said it was also consulting on issues surrounding education, roles and career pathways for salaried dentists, clinical leadership and principles supporting pay and grading.

5.6 The **Scottish Executive Health Department** (SEHD) said that new grants and allowances for the salaried services had been introduced in April 2004, including allowances for new and returning practitioners, remote area allowances, an allowance for trainers and an out of hours allowance. It did not yet have comprehensive information on their uptake or their impact on recruitment and retention. Its *Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland* included a key principle for there to be a strengthened salaried dental service targeted at those in most need. It said the salaried dental services had a vital role to play in meeting the needs of disadvantaged groups and those with special needs, and NHS Boards might commission salaried services in accordance with their resources to meet local priorities, including the need to complement general dental services (GDS) provision.

5.7 The **British Dental Association** (BDA) noted that the Department of Health had yet to publish its final report that incorporated the responses from the consultation exercise on the review, even though reform implementation was less than six months away. It said it remained extremely disappointed with the slippage in the timeframe of the review. The delay had already severely disadvantaged the ability for SPDCS to compete when local commissioning began in 2006. It was also concerned that the hamstringing of the Service's ability to be immediately involved in local commissioning might make it harder to retain staff.

5.8 The BDA said it had welcomed the publication of *Creating the Future: Modernising Careers for Salaried Dentists in Primary Care* but had been critical of the lack of detail in the document. It was a serious omission that the review had not mentioned Special Care Dentistry, or acknowledged the work done within salaried services by practitioners working with patients with special needs. The BDA said it was surprised and disappointed that the review had not recommended or supported the establishment of a Special Care Dentistry specialism.

5.9 The BDA said that as a consequence of the Department's failure to appreciate both the urgency and impact of the situation for the future of the SPDCS, it regretted its decision not to have submitted detailed evidence on the SPDCS to us over the past two years. It said the SPDCS were inadequately prepared for the upcoming reforms in NHS dentistry, there was considerable anxiety and confusion among SPDCS staff, and the morale within the Service, at already low levels, had been further eroded.

5.10 In response, the **Department of Health** said it was surprised that the BDA claimed that the SPDCS was inadequately prepared for the upcoming reforms. It said that salaried dentistry had been provided within a commissioned environment for the last 15 years and it should therefore be familiar with the organisational requirements of such a system. It said it recognised that it had taken time to complete the review and to agree the next steps on new pay, terms and conditions, but it believed the time and effort invested in the consultation and organisational development programme would pay major dividends in terms of laying the foundations for a successful reform of the pay and career framework for salaried dentists.

5.11 The Department said it recognised the case for modernising pay, terms and conditions, and was inviting NHS Employers to take forward negotiations on new pay, terms and conditions with the BDA. In return for new investment in the SPDCS, it said it was looking to the negotiations to bring commensurate service benefits in terms of factors such as recruitment, career progression and the quality of dentists' working lives. It said it would be entirely inappropriate to make an above-inflation uplift in pay without agreement between NHS Employers and the BDA as to the service modernisation and service benefits that would be secured in return.

Comment

5.12 *We are pleased to note that the Department of Health has asked NHS Employers to take forward negotiations on new pay, terms and conditions for this important group of dentists. The BDA has recorded its disappointment at the delay in the review of the salaried services. The Department of Health acknowledges that it has taken some time but it is clearly important that the outcomes deliver what is required for the service in terms of a new pay and grading structure and service modernisation. Nevertheless, we have taken account of the delay in the review when considering our pay recommendations. We would ask the parties to let us have evidence on the outcomes of the negotiations for our next review. We would, of course, be interested to hear about the findings of the research into the factors which make salaried employment attractive.*

Pay recommendations for 2006-07

5.13 In its original written evidence, the **Department of Health** had said that salaried dentists should receive the same general uplift of salary and associated fees as applied to other groups of doctors and dentists in the NHS, and in view of the review to modernise pay and career structures for salaried dentists, it would not be appropriate to make any changes to existing salary structures and associated fees and allowances other than to apply the general uplift. This approach was supported by the **National Assembly for Wales**, who said it would represent a fair deal for dentists, and by the **SEHD** who said it fairly balanced affordability with the continuing requirement to secure recruitment and retention.

5.14 As noted in chapter two, the Department subsequently wrote to us on 19 December 2005 with a revised position on the uplift for doctors and dentists, but said that it would still support an uplift of up to 2.5 per cent for salaried dentists, but that it could not see any case for a higher award, given the pay reforms that the BDA and NHS Employers would be taking forward separately. It also told us that the financial envelope for the negotiations would be ten per cent of the current paybill, around £7.5 million.

5.15 **NHS Employers** said that pending the publication of the outcome of the *Creating the Future* consultation, salaried dentists should receive the same inflationary uplift as other staff groups.

5.16 The **BDA** said that as the implementation date for reforms of NHS dentistry moved closer, the workload for staff in SPDCS had been mounting. Many PCTs were in debt and even though future funding for NHS dentistry was to be ring-fenced, the burden of debt along with inadequate central funding for pre-implementation planning had created additional pressure on SPDCS staff. It said there was general difficulty in recruiting SPDCS staff. The BDA said there was a national shortage of Dental Public Health staff, and many PCTs were turning to Clinical Directors to provide the knowledge and experience so that PCTs could prepare for reform implementation. In some cases, it said this additional workload could amount to 30–40 per cent of the normal workload of some SPDCS Clinical Directors. This created a 'domino effect' on the workload of SPDCS clinicians. The range of services provided through SPDCS meant that it was ideally placed to provide services that tackled recent political initiatives, such as the various National Service Framework initiatives, or addressing the rising inequalities in children's oral health across the United Kingdom.

5.17 The BDA said the Department was unwilling to recognise the increasing workload of SPDCS staff, nor the new work being undertaken by Clinical Directors. The BDA said that recognising and valuing the increased workload was of primary importance to ensure stability of the workforce. However, the Service was confined to a restrictive pay scale which could not adequately reward increasing workloads, and the future workload was set to rise further. The BDA therefore urged us to recommend an uplift on the salaries and allowances for all SPDCS practitioners of seven per cent from 1 April 2006, which it said would significantly improve retention and would lead to a stabilised workforce as the profession entered a period of uncertainty and radical reform.

5.18 The BDA said that SPDCS salaries were uncompetitive, particularly in relation to salaries offered under PDS arrangements. Under PDS, it said that a full time committed NHS associate with four years' work experience was currently being offered around £70,000 compared with a Senior Dental Officer (SDO) salary scale that started from £45,131 in 2005-06. It emphasised that the majority of SDOs earning £45,131 would have far in excess of four years' experience, a postgraduate qualification and, most importantly, a historically high commitment to delivering NHS care to the population. Salaries of around £50,000 were being offered to international recruits, compared with the Dental Officer (DO) pay scale which started at £31,290. Further still, it said that under PDS arrangements, first year associates were receiving a salary of around £42,500.

5.19 These superior salary packages were said by the BDA to be dramatically undermining recruitment and retention within the SPDCS, and were harming the morale of DOs and SDOs. The reform to the GDS was raising uncertainty about how it would affect the SPDCS patient base. All of this was said by the BDA to be raising concerns about future employment security. The BDA therefore urged us to recommend the introduction of a Commitment Payments Scheme to recognise SPDCS staff for their long-standing commitment in delivering NHS care and more importantly, to retain SPDCS staff and boost morale. It said that a Commitment Payments Scheme should be introduced, pro rata, to SPDCS practitioners, so that five years of experience was rewarded with a payment of £2,500; ten years with £5,000; and fifteen years with £7,500.

5.20 The **Department of Health** said it saw no basis for the assertion that the workload of the service would rise as a result of the move to local commissioning. It also said it was fallacious to make simplistic comparisons between pay in salaried employment and in NHS general dental practice. The former operated within an environment of a wider NHS organisation with its own administrative and managerial infrastructure, while the latter operated within a much smaller business unit with more direct responsibility both for the operation of the premises and staffing, and for delivery of defined levels of clinical activity. It said that it was good practice when recruiting from abroad to pay all recruits the same salary to foster a positive ethos during the training period, and that it had offered dentists recruited from Poland around £49,000 in return for a full-time contract to provide NHS services. It also said that there was no centrally held information on recruitment, retention and vacancies in the SPDCS. The report by Mercer in 2002 (commissioned for us by OME) had found that retention was not a major problem within the SPDCS, but that recruitment was problematic, and was one of the factors which had influenced the decision to agree to a review. It said that the overall expansion in primary care dentists was likely to improve retention across all sectors of dentistry.

5.21 It also said it did not agree that commitment payments were appropriate for salaried dentists, as they would reward 'time served' rather than career development or increases in responsibilities and would not reflect arrangements for other NHS staff. However, it did recognise the case for investment in modernised pay, terms and conditions as part of an overall package of service modernisation and said that this was what it had invited NHS Employers to negotiate with the BDA. Any structural changes to the pay system would pre-empt the outcome of those negotiations.

5.22 In response to the Secretary of State's confirmation of the financial envelope to support the forthcoming pay negotiations, the **BDA** said it was pleased that the Department had finally confirmed the amount of money that was to be made available for the new salary structure for salaried primary care dentists, and was keen that the implementation date of April 2007 was not further delayed. However, as it had outlined in its original submission, there were immediate problems within the SPDCS and the BDA said that it still considered that a seven per cent uplift, combined with the introduction of a Commitment Payments Scheme, would stabilise the workforce over what might be a difficult transitional year. The BDA said that aside from confirming the monies to be available for the new salary structure, the Department had yet to publish its formal response to the review and so the uncertainty for 2006-07 remained.

Comment

5.23 *The BDA has asked us to recommend introducing a Commitment Payments Scheme for salaried dentists. We considered a similar request in 2001, noting in our 2002 Report that "salaried dentists receive payments through their incremental scales which are to an extent a reflection of commitment and we do not consider that the case for introducing further payments along the lines of the GDS Commitment Payments Scheme can be made without reference to the main pay scales". We went on to say that "we would be happy to consider further evidence from the parties on the extent to which the main scales could and should be augmented by separate payments to address retention issues, as part of a wider consideration of the remuneration structure".*

5.24 *We have not been provided with evidence for this round that would lead us to take an alternative view to our 2002 conclusion. Given the proximity of negotiations on new pay, terms and conditions for salaried dentists, we suggest that the parties discuss how any payments to recognise commitment, retention and morale should be integrated into the pay scales.*

5.25 *Turning to the pay uplift for salaried dentists, we have in the normal way taken account of all of the evidence submitted by the parties. The evidence on recruitment, retention, morale and motivation for the SPDCS is somewhat limited, and it is difficult for us to draw conclusions here. We have taken into account the delay in delivering new pay, terms and conditions for this group of dentists and considered how to protect the value of pay against the range of possible inflation and pay indicators before the new arrangements are introduced. Taking these factors into account, we* ***recommend*** *(**recommendation 10**)* ***a 2.4 per cent uplift on salaries and allowances for all dentists in the SPDCS to be applied across the board in 2006-07****. We have calculated 2006-07 salaries on this basis and reproduce these in Appendix A.*

CHAPTER 6: OPHTHALMIC MEDICAL PRACTITIONERS

Introduction

6.1 *This year, the Department of Health reports on a review of the General Ophthalmic Services (GOS) and the parties return to the issue of the setting of the sight test fee for ophthalmic medical practitioners (OMPs).*

Recruitment and retention

6.2 The **Department of Health** said that between December 2003 and December 2004, the number of OMPs registered to provide GOS in Great Britain had decreased from 644 to 613, and the number of optometrists had increased from 9,161 to 9,405. It added that the GOS continued to attract adequate numbers of practitioners of good quality with appropriate training and qualifications. In the period April to September 2004, 5.47 million sight tests were paid for by Primary Care Trusts in England and Local Health Boards in Wales (of which 2.9 per cent were carried out by OMPs), 2.5 per cent more than the total for the period October 2003 to March 2004 and 5.9 per cent more than the period April to September 2003.

6.3 The Department said that its past surveys had shown that the majority of OMPs practised part-time, and that the 2003-04 survey had shown that 52 per cent of practising OMPs also held other appointments, mainly as hospital doctors.

Review of the GOS

6.4 The **Department of Health** said that a review of GOS was being undertaken. The review aimed to consider whether present arrangements met patient need and supported wider Departmental objectives, and would make recommendations for change if necessary. The aim was to complete the review in early 2006. The Department said that it would be working with stakeholder groups to consider the scope for expanding the role of optometrists, OMPs or other professionals in managing eye conditions in primary care and to consider what service arrangements could best facilitate such developments. Any such developments would need to be subject to separate agreements about remuneration.

The sight test and domiciliary visit fees

6.5 The **Department of Health** said that negotiations would take place this year for the fee for 2006-07 – and possibly subsequent years – with the representatives of contractors. The negotiations would also cover the payment which it had been agreed should be made for loss of earnings associated with undertaking continuing education and training. The Department said it remained firmly of the view that there should be a common sight test fee. Optometrists continued to carry out some 97 per cent of NHS sight tests, and it believed our previous recommendations about the joint negotiation of a common fee continued to be relevant for future years.

6.6 The **British Medical Association** (BMA) said it welcomed the fact that the Department was able to offer Continuing Education Training payments, as agreed with optometrists, to OMPs who had no other medical appointments. However, it repeated its arguments from earlier years that OMPs were unable to offset the significant losses resulting from performing NHS sight tests by dispensing spectacles, and again emphasised the expertise that highly trained OMPs brought to the performance of sight tests and their role in reducing hospital referrals. However, the BMA said it would be difficult to demonstrate that the economic viability of optometrist practice would be compromised if they were unable to dispense. It urged us to resume recommending the increase to the sight test fee for OMPs.

Comment

6.7 *For a number of years now, we have stated that we have yet to see evidence that demonstrates the requirement for differentiated fees for sight tests conducted by OMPs and by optometrists respectively. Our view is that the cost of the sight test fee should be covered by the fee and not subsidised by dispensing spectacles. The BMA has said this year that it is difficult to demonstrate that the economic viability of optometrist practice would be compromised if they were unable to dispense. Therefore, in the absence of any evidence that would lead us to take a contrary view, we believe that* ***a unified sight test fee for OMPs and optometrists, set in negotiation between the Health Departments and representatives of both OMPs and optometrists, remains appropriate and recommend*** *(recommendation 11)* ***this continues accordingly****. Unless the BMA believes that it can demonstrate evidence that might lead us to take an alternative view, we would again ask that this issue not be brought to our attention for future years.*

6.8 *We note the current review of the GOS, and look forward to learning of developments, particularly as they might impact on remuneration.*

Part III: Secondary Care

CHAPTER 7: DOCTORS AND DENTISTS IN TRAINING

Introduction

7.1 *This year, the parties have provided evidence on a number of issues concerning doctors and dentists in training. The parties report on access to senior house officer training, the pay implications of Modernising Medical Careers (MMC), progress on complying with both the Working Time Directive (WTD) and the new contract, and the application of pay protection. We return to the issues of the banding multipliers, flexible trainees and pay comparability. We have also been provided with evidence on the availability of free accommodation.*

Recruitment and retention and student debt

7.2 Commenting on the whole-time equivalent workforce numbers in Great Britain for 2004 compared with 2003, the **Health Departments** said that house officer (HO) numbers had increased by 5.5 per cent; senior house officer (SHO) numbers had increased by 9.1 per cent; and numbers in the registrar group (mainly specialist registrars (SpRs)) had increased by 14.5 per cent.

7.3 The Health Departments said that medicine and dentistry continued to remain very attractive careers and attracted high quality candidates with average tariff points considerably higher than the average for all subjects. The number of UK applicants to medical schools had risen more rapidly than the number of available places with an average of 2.1 applicants for every medical school place in 2004. Sixty per cent of applicants were female compared with 62 per cent in 2003.

7.4 The **National Assembly for Wales** said that HOs had increased by 5.1 per cent, SHOs by 10.5 per cent and numbers in the registrar group (mainly SpRs) had increased by 16.7 per cent. It said the number of medical students in training had been increased by 57 per cent since 1999.

7.5 The **Scottish Executive Health Department** (SEHD) said HOs had increased by 0.6 per cent, SHOs by 2.0 per cent and SpRs by 8.6 per cent in the last year. It said SpRs had increased by 30 per cent since 2001 as a result of a Ministerial commitment to increase the number of training posts by 375. It said there was no shortfall in demand for places at medical schools in Scotland.

7.6 The SEHD said it had published its response to Professor Sir Kenneth Calman's report into a review of basic medical education in Scotland. Key elements of the response were:

- the provision of an additional 100 medical graduates in Scotland;
- support for the proposals for universities to review their selection processes and to widen access to medical education;
- support for the introduction of a fast-track graduate entry medical degree course; and

- support for the establishment of a Board of Medical Education for Scotland to co-ordinate activity across the five medical schools.

It said that this would increase Scotland's output of medical graduates from 800 to 900 a year.

7.7 The **British Medical Association** (BMA) said there had been a 19.8 per cent rise in the number of home applicants for places in UK medical schools in 2004. It said that provisional data for 2005 showed an increase of 9.3 per cent, suggesting that the trend would continue albeit at a slower rate. The rise in applicants in 2004 represented an increase in home applicants per place from 1.71 to 1.97, only just below the 1997 level of 2.04, when the current expansion in places began. It said that 60 per cent of successful applicants were women, suggesting that the potential future increase in doctors would be lower in whole-time equivalent terms. It said that whilst the number of applicants remained sufficient and the applicants remained of high quality, potential student debt and the level of remuneration might still be significant factors in deterring future applicants, particularly from the poorest social groups. The BMA also pointed out that the Department's figures for increases in SHO posts included trust grade posts, and therefore gave a false impression of the state of the workforce.

7.8 The **Department of Health** said it shared concerns about the low numbers of applicants from the poorest social groups, but felt it was a complex issue with factors such as low aspiration, low academic attainment and the social/cultural framing of career choices. It said it was very supportive of medical school initiatives such as outreach programmes and the Aimhigher healthcare strand projects.

7.9 The **BMA** drew our attention to a key recommendation of Sir Alan Langland's published report, *Gateway to the Professions*, which was that government should ask pay review bodies to "monitor the impact of the introduction of variable fees and the new student support measures on recruitment and retention and whether additional forms of support (for example bursaries and golden hellos) should be considered, particularly for those who do not receive the full grant of £2,700 plus a bursary of at least £300. Pay review bodies should also be asked to identify instances where the effect of student debt is to strengthen the case for higher starting salaries in key professions". It said that the government had accepted all of the report's recommendations in full. It also said that it was disappointed to learn that graduate medical students might have to pay the total cost of top up tuition fees at the beginning of their course, unlike school leaver counterparts. It said this could mean graduate students starting their course in debt.

7.10 Commenting on the recommendations of the *Gateway to the Professions* report, **SEHD** said it would be discussing how it would take them forward. However, given the extremely competitive salaries that doctors in training commanded, it said it would not see any requirement to raise them further in order to help pay off student debt, and noted that all medical graduates could expect to secure a first hospital post in the UK and therefore to establish financial security almost automatically. It said that the level of applicants to medical school remained very healthy, so there was no evidence of any need to increase paybill costs in order to secure the necessary workforce.

7.11 The **Department of Health** said the Government's response to the report was led by the Department for Education and Skills (DfES), and that the Department of Health would be contributing to the work on implementing the report's recommendations through the Inter-Departmental Group being set up by DfES.

Comment

7.12 *For several years now we have noted the growth in the number of good quality applicants to study medicine, and note that this year the ratio of applicants to those accepted has again risen to almost the 1997 level, when the current expansion in places began. Clearly, medicine and dentistry are seen as attractive careers and we find this very encouraging. We also note that women continue to form the majority of entrants to study medicine and would remind the Health Departments of the possible implications this will have in future years for workforce planning and for policies supporting retention. Although the BMA acknowledges that the applicants to study medicine are both of sufficient number and of high quality, it has raised its concerns that students from the poorest social groups might be deterred from applying, suggesting that potential student debt or the level of remuneration might be factors here. We see no evidence to suggest that the current level of remuneration on offer is affecting recruitment. Our view on student debt is that it is strictly beyond our remit, unless there is evidence that it is affecting recruitment or retention of our remit groups, and it is not, of course, our role to ensure that applicants from all social groups apply to study medicine and dentistry. Nevertheless, we welcome the action taken by the Department of Health to encourage as wide a take-up of medicine and dentistry as possible and hope this will continue.*

7.13 *The BMA has also drawn our attention to the recommendations of Sir Alan Langland's report "Gateway to the Professions". The Department of Health has said that the Department for Education and Skills is taking the lead on this issue, but that it will be contributing to the work on implementing the report's recommendations. In this regard, we note that the Government has accepted the recommendations of the report in full. We look forward to hearing of progress for our next review. In the meantime, we would ask the Department of Health to discuss the recommendations concerning the Pay Review Bodies with our secretariat and to involve them in consideration of how these recommendations can be met.*

House officers

7.14 The **Department of Health** said that in the light of the increase in medical school graduates, funding had been provided for an extra 319 Foundation Programme Year 1 (HO) posts in England in 2005-06.

Senior house officers

7.15 The **Department of Health** said that competition for SHO posts remained extremely high, particularly in popular areas like London. It said there had been no reduction in the combined number of SHO training posts and Foundation Year 2 pilot posts and evidence from the deaneries indicated a small increase. Information from deaneries had indicated that in early August 2005 around 136 HOs did not at that time have a training post to progress to in the NHS. Deaneries had ensured that HOs were made aware of further recruitment opportunities as they arose and the number of HOs seeking training posts had continued to reduce through the following weeks. The Department said that 97.6 per cent of HOs had successfully secured their next training post or taken planned time out of training to increase their experience or travel. The Department said it was not aware that HOs were experiencing significantly greater delays or difficulties this year in obtaining their next SHO post, although it might not always be in their first choice of location or specialty. The Department said it valued highly those doctors in whose training it had invested heavily, and wanted

them to progress and develop their careers in the NHS. In the longer term, it said it was entering the first stages of the *MMC* implementation programme. As a result, the number of SHO posts in the NHS would change as new training programmes were introduced. The Department said it was keeping a close watch on any impact this might have on training.

7.16 **NHS Employers** said that there had been considerable press coverage of junior doctors being unable to obtain jobs. Some Trusts had received hundreds of applications for junior doctor posts, showing evidence of increased competition and it was clear there was not a current problem in recruiting junior doctors. It said it would not expect to see significant numbers of UK trained doctors without posts as the new training system bedded down, although some doctors would not be able to pursue a career in their first choice of specialty.

7.17 The **BMA** said that competition for SHO and HO/FY1 posts had increased dramatically in recent months and that many doctors were known to be out of work as a result. A BMA survey[1] had found that almost one in ten had been unable to find work as a doctor in the UK. It suggested a number of reasons for the increased competition: inadequate workforce planning; a deficit in deanery funding; SHO posts being subsumed into FY2 posts; and more applications from international medical graduates. The BMA was concerned that the problem would be exacerbated during the transition period between the current training system and *MMC* implementation. This uncertainty would only serve to reduce recruitment into medicine and increase the number of doctors leaving the NHS to work elsewhere. It noted that the Department of Health had previously relied on the "guarantee of a post" within medicine in its evidence, and said that if such a guarantee no longer existed, and the savings on accommodation were no longer available (*see later*), medicine's attraction as a career was likely to diminish significantly. The BMA said its survey showed 35 per cent of respondents who had not found a job were no longer looking for work in the NHS, with the same percentage saying they would leave medicine altogether if they were unable to continue their training, and 61 per cent were considering moving abroad to continue training. Ninety per cent expressed concern about the availability of training posts.

7.18 The **Department of Health** said it had commissioned the Dean Director in London to look into the issue of SHO employment, and the results showed that at the beginning of August 2005, four deaneries out of 14 had 136 HOs unemployed with a few more in other parts of the UK. By September, the number of unemployed HOs had reduced to around 100. Deans were aware of this and were looking to help HOs towards suitable future openings. It said the General Medical Council would shortly be undertaking a survey that would provide reliable and independent data about the employment position amongst SHOs. The Departments said the number of HO posts and foundation programmes was reviewed annually to accommodate the forecast number of UK graduates plus a small addition for overseas medical graduates, so that there were more than enough places for all UK qualified graduates. There was no intention to reduce training capacity. More experienced SHOs would be encouraged to compete for training programmes at the level appropriate to their skills, and would not therefore be competing with recently graduated candidates. It said much of the current bottleneck was caused by the large number of SHOs competing for a limited number of higher specialist training programmes, but in the long term, the proposed training and career model would remove the bulge as trainees would progress directly

[1] *Shortage of SHO posts: a report of a survey undertaken by the BMA in August 2005*, HPERU, September 2005.

through training. In the short term, it acknowledged that the period of transition would be complex, but it said it would support and manage the process over a number of years and would encourage close liaison with stakeholders. The Department added that medicine allowed doctors to practise all over the world, and said that the majority of those who went abroad came back to the UK to continue their careers, enriched by their overseas experience.

Specialist registrars

7.19 The **Department of Health** said the *NHS Plan* target in England of 1,000 more SpRs by March 2004 over the September 1999 baseline had been achieved by September 2003. Registrar group numbers had now exceeded the target by 3,141. Central funding had been made available for 117 additional SpR posts in 2004-05 and a further 82 posts in 2005-06. It said the main specialties to benefit were clinical radiology and histopathology.

7.20 The **SEHD** said it was developing a scheme for matching SpRs about to sit their Certificate of Completion of Specialist Training (CCST) with existing/prospective consultant vacancies. It said this would help to improve supply/demand planning, identify shortages and provide advance notice of further development requirements.

Comment

7.21 *The parties have provided conflicting reports on the extent of the problem of trainees finding accredited SHO training posts. It does appear that some difficulties have arisen from the numbers of trainees seeking these posts this year, and we note that the Department of Health intends supporting and managing the process of change to MMC over a number of years. We welcome this, together with the action being taken by Deans in helping HOs towards future openings. A carefully planned career structure for medical and dental students has always been a cornerstone of training and it is clearly in the interest of all parties to ensure that this remains the case within a properly competitive environment. We look forward to receiving evidence in the next round from the survey by the General Medical Council that will provide reliable data on the employment position amongst SHOs and we hope that this survey might be repeated each year or at least while the transition to MMC is underway.*

Modernising Medical Careers

7.22 The **Department of Health** said it had successfully introduced Foundation Programmes (covering the previous HO year and first year of SHO with a new unified curriculum) in August 2005. It said these were two-year structured programmes providing trainees with a basic grounding in clinical and non-clinical skills, as well as providing opportunities to gain broad experience in a range of different specialties and settings. Funding was secured in 2005-06 for deanery infrastructure to support implementation and facilitate provision of career guidance, with further funding for 2006-07 and 2007-08 to support placements in general practice, academic medicine and a number of smaller specialties as part of the second year of Foundation training.

7.23 The Department said it would introduce newly structured specialist training programmes from August 2007, following completion of Foundation Programmes by the first cohort of trainees. This provided an opportunity to organise specialist training to best meet the needs of patients and the NHS, and was now the key focus of *MMC*.

7.24 The Department said training would be shaped by service need and would offer a workforce both of specialists and GMPs trained to Certificate of Completion of Training (CCT) level and doctors who may not have reached CCT-level, but were authorised to perform in defined competences. Those holding CCT would be eligible to enter the Specialist or GMP Registers as appropriate. Appointment to consultant posts would continue to be determined by service need and would not be affected by *MMC* reforms. Where doctors had achieved an authorised level of competence, before the completion of training, they might apply for service jobs outside of the training ladder that they were explicitly competent to perform. This would allow the service to 'draw down' the skills needed. It said that these jobs, linked with the reform of non-consultant career grades, would be competency-defined. This step-off facility would be matched by a 'step-on' route for those wishing to return to training. The Department said that training for specialist and GMP roles would directly follow the Foundation Programme. In effect, this meant that over time the SHO grade would be managed out of existence, although this would be a gradual process that would not begin until 2007 and take some years to complete.

7.25 The Department said that there would be a significant and challenging area of work to develop the arrangements and ensure a smooth transition from the current structure. A key element would be to address issues of pay and terms and conditions, and this would be the focus of evidence to us as early as 2006. It was clear that with a competency-based training and career structure it would be possible to map remuneration to defined levels of competence, a concept that fitted neatly with the current negotiations around the new contract for staff grades and associate specialists. For the time being, the new structures could be run by adapting existing pay and grading arrangements.

7.26 The Department said that in our last report, we had commented that the contract for doctors in training should be reviewed as the working arrangements and the training structure for junior doctors would have altered significantly. It said it believed that the current pay structure for hospital doctors in training met the current needs without amendment, at least for the time being. It would not wish to consider changes to the current pay system for doctors in training until it had seen the effects of the WTD and the SiMAP/Jaeger rulings and was clear about what pay arrangements would be needed to support *MMC*.

7.27 The **BMA** said that now was not the ideal time to begin negotiations on a new contract for junior doctors because of the uncertainty in a number of key areas, such as the future structure of the training grades, the effect of a new contract for staff and associate specialists, proposals to amend the WTD in respect of the definition of working time and the timing of compensatory rest, and the forthcoming review of the NHS staff pension scheme.

7.28 The BMA pointed out a number of problems in England with the introduction of Foundation Year one, such as the varying of training placements without consultation and disputes over responsibility for pay between trusts, and the issuing of unilateral and incorrect advice about pay and contractual matters by the *MMC* team, without consultation with the BMA or NHS Employers. It also said it was very concerned that the Health Departments were advocating a shift towards competency-based remuneration, which is said was a principle it did not support for junior doctors.

7.29 **NHS Employers** said the introduction of a Foundation Programme followed by a single specialist training grade necessitated the introduction of pay scales that facilitated payment on the new grades. It said its approach was to utilise existing pay points and to formulate scales that enabled the new trajectory through training without changing the rate of pay at any point, adding to employer costs or creating a disincentive for junior doctors. It showed us the proposed new scales for the Foundation Programme and a proposal for interim use with pilot schemes in the provisionally titled 'run through' grade alongside existing scales (below), but said that the proposal had not yet been agreed with the BMA. It said it recognised that the senior scale would need further joint discussion and it was envisaged that SHO and SpR scales would be used in parallel for some time until the new pathways were fully embedded.

Proposed pay scales for new grades for doctors in training

GRADE														
Current														
PRHO	20,295	21,601												
SHO			25,324	27,022	28,720	30,418	32,116	33,813	35,511					
SpR					28,307	29,741	31,174	32,607	34,337	36,067	37,796	39,526	41,255	42,985
Proposed														
F1	20,295	21,601												
F2			25,324	27,022										
Run Through				27,022	28,307	29,741	31,174	32,607	34,337	36,067	37,796	39,526	41,255	42,985
		Full Registration												

Figures underlined represent the optimum route through training.

7.30 The **SEHD** gave us details about how *MMC* was progressing in Scotland. It said that over 800 new medical graduates successfully commenced the new two-year Foundation Programme from August 2005. It said it was content to work with NHS Employers on pay scales for Foundation Programme doctors, on the basis that Scotland was able to participate in developing and considering proposals, and to ensure that Scottish needs were addressed.

7.31 The **National Assembly for Wales** said it was content for NHS Employers to lead on the new pay structure for Foundation Programmes.

7.32 The **BMA** said it was engaged in discussions with NHS Employers about new pay scales for the Foundation Year programme and the run-through grade. It said in principle it agreed that salaries for FY1, FY2 and run-through grade pilots should be based upon the existing HO, SHO and SpR pay scales.

Comment

7.33 *Last year, we suggested that the time was right for a review of the contract for junior doctors, given the significant changes to both the working arrangements and the training structure. However, the parties are in agreement that they would not wish to embark on negotiations for a new contract at the present time, given the uncertainties in a number of areas, such as what pay arrangements will be needed to support Modernising Medical Careers and the ongoing implementation of the Working Time Directive. We accept this and hope that the parties can continue to work together to ensure a smooth transition to the new training arrangements. We note that in future there will be opportunities to both 'step-off' and 'step-on' to training routes. We would expect this process to be managed in a robust manner in a properly competitive environment.*

7.34 *NHS Employers has shown us the proposed new pay scales for doctors in training under the Foundation Programme. We offer no comment here, as this is properly a matter for negotiation between the parties, but note that the BMA is in agreement in principle that the new payscales should be based upon those for the existing training grades. We hope that the parties can agree a way forward and would therefore hope to receive joint evidence for our next round.*

Working Time Directive and the Junior doctors' contract

7.35 The **Department of Health** said it was committed to the overall aims of the WTD. The NHS had implemented the WTD for all doctors in training from 1 August 2004, including an interim maximum 58-hour working week. Although implementation was a local matter, the Department had continued to offer help to the NHS with the WTD. The *Hospital at Night* pilots had demonstrated that improving patient care, doctors' working lives and their training was achievable, whilst complying with the WTD. However, the SiMAP and Jaeger rulings had made implementation of the WTD more demanding, as all time spent on-call in hospital counted as work and reduced flexibility regarding the timing of rest breaks. The Department said it was continuing to press in Europe for changes to the Directive. The rulings had virtually ended the traditional resident on-call pattern of working. Some doctors and Royal Colleges had raised concerns about the nature of some of the recently introduced local shift patterns, as they believed that increased night shift working was resulting in overly tired doctors in parts of the NHS, and that doctors were receiving less daytime training opportunities. The Department said it had reminded NHS employers of guidance that supported the implementation of more creative shift patterns. It said working patterns should strike a balance between services designed around patients and services that supported doctors' working lives and their training. It also said that independent research was being funded to look at the possible impact of changing working patterns on medical training.

7.36 The Department said that NHS Employers continued to monitor compliance with the New Deal, and as at March 2005, 98 per cent of junior doctors were fully compliant compared with 96 per cent in September 2004, 88 per cent in March 2004 and 71 per cent in 2001. However, it said that whilst total duty hours for doctors in training had fallen considerably in recent years, there had not been a corresponding drop in earnings. Since the introduction of the new contract in 2001, basic salaries had risen by 13 per cent and overall pay by 16.4 per cent, against overall inflation of 11.5 per cent. It said that the reduction in overall pay over the last year (from £33,616 to £32,537) was a direct result of the reduction in working hours as both the New Deal and WTD impacted on working patterns. It said this was to be expected and would continue as 2009 approached, by when all juniors should be working no more than 48 hours a week. They would then receive a maximum supplement of 50 per cent of basic salary, the actual amount depending on the intensity of work. It said that total pay would continue to reflect actual work done and might well fall further, but any reduction in pay must be considered against the benefits of reduced hours and a more family-friendly working environment. The Department added that the increasing number of junior doctors would have an effect on rotas, further reducing the unsocial hours and intensity elements.

7.37 The **National Assembly for Wales** said that WTD compliance had increased to 92.1 per cent compared with 73.4 per cent in September 2004. It said it was producing a document *Working Towards 2009* which would provide a plan on how WTD compliance could be achieved by that date. NHS Trusts in Wales had continued to make significant progress in achieving New Deal compliance. Overall the compliance rate had increased to 89.3 per cent as at March 2005.

7.38 The **SEHD** said it was fully committed to the WTD. It described seminars and initiatives underway to help in achieving compliance such as *Hospital at Night* and the redesign of various NHS services. There had been significant progress in achieving New Deal compliance. The statistics for January 2005 showed compliance up to 91 per cent. In smaller rural hospitals and smaller specialties the SEHD said it remained challenging to ensure that sufficient amounts of compensatory rest were given promptly, but plans were afoot to address this. Systems were in place to manage non-compliance, including support for Boards with difficult cases of SHO and SpR non-compliance. Support for New Deal implementation had transferred to a local level. This provided an opportunity to integrate the junior doctors' safe hours agenda into a wider 'whole systems' approach by NHS Boards to redesigning the clinical workforce.

7.39 **NHS Employers** said the move to full shift arrangements was to be welcomed, as it meant that doctors were required to be in hospital only when they were actually working, promoting a significant improvement to work-life balance. It said the banding system was sensitive to and took into account the frequency of evening and weekend working, as it had done since its introduction. The contract was designed to take account of different working patterns, including full shifts, and that full shift working in 2005 was the same as it was in 2000. All that had changed was that more doctors were working in that way.

7.40 The **BMA** said it was pleased that, as planned, non-compliance with the New Deal continued to fall. It was also pleased that the Department of Health had decided against reducing the frequency of publishing monitoring returns from twice to once a year. However, the BMA said that rotas were increasingly becoming more anti-social in their structure. The banding system was not designed to be sensitive to such changes, and juniors' pay packets therefore did not fairly reflect the increasing number of weekends and evenings spoiled by shift patterns. It said most junior doctors were working full shift patterns.

Comment

7.41 *The next few years will be very challenging in moving towards full compliance of the Working Time Directive in 2009 when all junior doctors should be working a maximum of 48 hours per week. We would ask that the parties keep us in touch with developments, particularly as the Department of Health presses for changes to the Directive in the light of the SiMAP and Jaeger judgements. We would also be very interested to learn of the outcomes of the independent research looking at the impact of changing working patterns on medical training. While we recognise that the move to shift working has been largely necessitated by the SiMAP and Jaeger judgements, the parties will need to work in close co-operation to ensure that working patterns do not have an adverse effect on the morale of junior doctors.*

7.42 *We have always maintained the importance of the objective of the New Deal, to improve the working conditions of junior doctors by reducing their hours of work, and are therefore pleased to note the continuous progress towards New Deal compliance reported by all three Health Departments. As ever, we will look to the parties to keep us informed on further progress.*

7.43 *The BMA has suggested that juniors' pay packets do not adequately reflect the move to shift working patterns. We have already commented on the need for the parties to work closely together to minimise the risk to junior doctors' morale necessitated by the move to full shift working. NHS Employers has told us that the banding system is fully capable of recognising shift working, as it has done since 2000. We make our recommendation on the banding multipliers in the next section.*

Banding multipliers

7.44 **NHS Employers** said that with the ongoing reduction in hours and the intention to link hours of work and pay, it was intended that average take-home pay would reduce. It noted that the expected reduction in overall pay had started, following a peak in 2003. It said it expected the average supplement to fall further as 2009 approached. The inevitable fall in overall salary must be taken in context. Pay was one factor of the overall reward for undertaking work. Just as important was quality of life, and it said it was entirely right that reduced hours and less onerous working arrangements should be balanced by a reduction in pay. It said an increase in relative pay might be appropriate if there were recruitment difficulties, but there was currently no shortage of applicants to enter medical school, and considerable competition for posts at all levels of training thereafter. Moreover, it said it did not believe that reducing hours with corresponding reducing pay would impact significantly on recruitment and retention. It did not envisage average supplements falling below 50 per cent, and even at that level, it said salaries were extremely competitive.

7.45 The **Department of Health** said that the banding multipliers for compliant bands were set at a level that fully reflected the relativities that the Health Departments and the BMA had agreed to reward different patterns of work intensity and out of hours commitment. It said it remained firmly of the view that those relativities were fair and provided an appropriate financial incentive for Trusts and trainees to manage the workload of junior doctors.

7.46 The **SEHD** said that the average supplement paid to junior doctors for the August 2004 to January 2005 monitoring period was 68.8 per cent of basic salary, a higher average than in England. It said it was working to reduce this as it moved towards further reducing hours of work.

7.47 The **BMA** said an underlying principle of the banded contract was that as hours and intensity reduced, so would pay. Even though there was a long-term expectation of reducing pay, it still impacted upon the pay in juniors' pockets and had a real effect on morale. It said the changing distribution of juniors across the pay bands was impacting significantly on average overall pay. The weighted average multiplier for compliant posts in England stood at 1.57 in March 2005, a sharp decrease from March 2004, when it was 1.63. Take-home pay was only reasonable because juniors worked prolonged periods of compulsory badly paid overtime. It said currently overall pay was reducing, even though overtime pay was at a more appropriate level, so it must be accepted that there was a clear argument in favour of a rise in basic pay. It also said that many lower-banded posts might involve fewer hours, but they also entailed a higher proportion of anti-social duties, and many doctors found themselves with worse work-life balance moving into lower-banded jobs.

Comment

7.48 *The current levels of the banding multipliers are what were negotiated between the parties to fully reflect the different patterns of work intensity and out of hours commitment. The Department has said that it firmly believes this still to be the case, and this year, the BMA has not asked us to consider amending any of the banding multipliers, although it has drawn our attention to the impact that reducing pay is having on morale and to its belief that many doctors working reduced hours for less pay now have a worse work-life balance. The BMA also suggested earlier that juniors' pay packets do not adequately reflect the move to shift working patterns. We commented earlier on the need for the parties to work closely together to minimise the risk to junior doctors' morale necessitated by the move to full shift working. We also have no robust evidence to challenge NHS Employers' evidence*

that the current banding system is fully capable of recognising shift working. We therefore believe that our conclusion from previous years holds true, 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 12)* ***that the percentage values of the current multipliers be rolled forward for another year****. The detail of our recommendation is at Appendix A.*

7.49 *The BMA has acknowledged that an underlying principle of the banded contract was that as hours and intensity reduced, so would pay. NHS Employers also make the point that an increase in pay might be appropriate if there were recruitment or retention difficulties, but that this is not the case. In addition, we would comment that we would not want to see a decline in the quality of the applicants to study medicine and dentistry, but as we have already noted, this is not the case at present, although we will continue to monitor the recruitment and retention situation in the future.*

Pay protection

7.50 **NHS Employers** said pay protection for junior doctors was extremely generous by comparison with other NHS staff groups and could affect Trust pay bills for several years. The value of pay protection to the doctor and the extended period over which it could apply had not only provided a perverse incentive for some doctors to perpetuate the long hours culture and maintain their level of income, they had also not provided an incentive for Trusts to reduce hours. Although the work available from juniors had reduced significantly because of the WTD, costs had been seen to reduce by little as a result of protection. It said that some employers felt that doctors should be aware of the reducing work hours and ought not to be protected from pay reductions, and that even without protection, doctors were paid at BMA agreed rates. Nevertheless, it said that if doctors were appointed to specific posts at known pay bands, the service was contractually obliged to maintain pay at the contracted level while the post was occupied.

7.51 NHS Employers said the service had seen an almost complete elimination of Band 3 posts. The subsequent and continuing reduction in Band 2A numbers needed to move to 2009 WTD compliance suggested that this would be where the bulk of pay protection issues would remain. It anticipated that over time, and certainly after 2009, the majority of doctors would fall into Bands 1A and 1B. Movement to these bands from 2A and 2B would be less costly in terms of pay protection than the move from Band 3 to 2A, and as posts stabilized in Band 1, pay protection would be less of an issue. Regardless of the problems it generated, it said that pay protection existed as part of the collective agreement on the contract for junior doctors, and could not be ignored. It said it was aware that some employers might still be applying protection in ways aimed more at expedience than adherence to the letter of the agreement. NHS Employers said it was developing guidance on implementation in the hope of achieving a better common understanding of the issues.

7.52 The **BMA** said that many employers, on the advice of NHS Employers, were interpreting the pay protection provisions in such a way that denied pay protection to a large number of eligible doctors. Similarly, it said they were also calculating the value of protected pay such that very few doctors benefited from the provisions. It said it was in discussions with NHS Employers to try and agree a reasonable interpretation of the pay protection provisions. The BMA said it was aware of a large number of Employment Tribunals on this issue, and asked for our support in securing a reasonable agreement with NHS Employers.

7.53 In supplementary evidence, **NHS Employers** said it had drawn up a clear guide to pay protection which took account of all available documentation and was supported by legal advice from separate sources. It said the guidance applied to both full-time and flexible trainees. It said that given the overall movement from higher to lower pay bands, and that some trainees would know which specific posts they would be occupying at future stages in their training, it was important that those trainees who had firm commitments from the service as to their future work could plan their future finances without penalty should the band of those known posts reduce before the trainees took them up. It said pay protection was based on the banding and pay scale in place at the time the doctor was offered and accepted the post. A doctor that had not agreed specific future posts could have no expectation of pay at a particular level.

Comment

7.54 *The parties have provided us with conflicting evidence on the application of the pay protection provisions of the junior doctors' contract. The BMA has sought our support in securing a reasonable agreement with NHS Employers. However, we are not in a position to comment on this issue, as the interpretation of the original agreement between the parties and of doctors' individual contracts of employment are ultimately matters for Employment Tribunals or the courts to rule on. Nevertheless, we hope that the parties will be able to work together to bring about a solution to this matter which does not entail recourse to the legal system.*

Flexible trainees

7.55 **NHS Employers** gave us details on the newly agreed pay arrangements for flexible trainees. The new arrangements facilitated access to flexible training, provided clear guidance on eligibility, moved towards integrated rather than supernumerary working and gave an equitable pay structure. From an employer perspective, it made employing a flexible trainee a more attractive proposition and would open up flexible training to doctors who, in the past, might have found difficulty obtaining it.

7.56 The **Department of Health** said that part of the agreement was that funding of £7 million, which was previously used to subsidise flexible training salaries, would be reallocated to incentivise family-friendly practices and expand flexible training. The major benefit was that pay for flexible trainees would become pro rata to pay for full timers. The change would reduce the cost to NHS employers of flexible trainees and it was hoped that the scheme would double the number of flexible trainees over the next three to five years.

7.57 The **SEHD** also welcomed the agreement and hoped it would help with career development and work/life balance.

7.58 The **National Assembly for Wales** said the Deanery had always funded 100 per cent of the salary plus costs for flexible training posts.

7.59 The **BMA** said it was pleased to agree new arrangements for flexible trainees for June 2005 implementation. It noted the £7 million funding from the Department of Health, but said there had been no information about whether additional funding would be provided in Scotland or Wales. The BMA said it was vital that the new arrangements were fully supported, funded and developed by the Health Departments to ensure that the increasingly feminised workforce could continue to train and sustain the NHS.

The BMA said there were problems with the pay protection arrangements for flexible trainees in post when the new arrangements came into force. It said it understood that as part of the agreement, the new arrangements would be brought in under 'no detriment' principles for existing flexible trainees, but NHS Employers apparently disagreed. Under NHS Employers' advice, many trusts were interpreting the pay protection arrangements in such a way as to ensure that the majority of flexible trainees would suffer a considerable pay cut on moving posts. The BMA said it hoped to resolve the problem urgently with NHS Employers and sought our support in securing a fair solution.

7.60 **NHS Employers** said that new terms for flexible trainees were necessary because under the previous arrangements a small number of trainees were being significantly overpaid by comparison to their peers, and this additional cost was deterring employers from taking on flexible trainees. It said it appeared it was this small group that were objecting to the changes. Nevertheless, those trainees were pay protected while their existing contract of employment lasted; current and future posts accepted before June 2005 continued to be protected on the old terms. Future posts contracted under the revised flexible trainee arrangements would be paid under the new terms. NHS Employers said this was fair to all trainees.

Comment

7.61 *We are very pleased to see that agreement has at long last been reached on new pay arrangements for flexible trainees. We hope that the new arrangements will encourage trusts to open up flexible training opportunities so that more trainees who would welcome a move to flexible trainee can be accommodated. We have long supported the importance of flexible training as a retention tool, particularly given the increasing proportion of women in the workforce.*

7.62 *The BMA has also sought our support in securing a fair solution for flexible trainees under the pay protection provisions of their contract. We said earlier that we are not in a position to comment on this issue, as the interpretation of the pay protection provisions of the contract is not a matter for us. However, we would note that the previous arrangements for flexible trainees were clearly deterring some trusts from taking on flexible trainees because of the additional costs involved, pro rata to their full-time colleagues. Having agreed a solution that removed the differential deterrent, it would be a retrograde step if disagreement about the application of the current pay protection provisions of the contract reinstated a deterrent. We hope that the parties can work together to produce a solution that deters neither trust nor potential flexible trainees from adopting this method of training.*

HO/FY1 accommodation

7.63 The **BMA** said it had become aware of several employers around the UK who were not offering free accommodation to HO/FY1 doctors and it was also aware of many employers making substantial 'service' charges for free accommodation. Free accommodation had been unilaterally withdrawn by NHS Glasgow, and it was aware of other employers considering similar action. The requirement for HO/FY1s to work in a resident capacity was set out in the Medical Act and the hospital terms and conditions of service obliged employers to offer appropriate hospital accommodation to HO/FY1s without charge. It said that HO/FY1 basic pay had been kept at a lower rate than otherwise would be appropriate because of the benefit of free accommodation, and quoted the Health Department evidence from last year to support this. The majority of Foundation Programmes would consist of six four-month

placements, and with certain employers, there would be significant distances between hospitals on the Foundation Programme rotation. Concerns had been expressed about the difficulty of finding short-term (i.e. four month) local accommodation and the potential costs of travelling. It said there was a strong argument for a significant uplift in basic pay for HO/FY doctors over and above the uplift it was seeking of 4.5 per cent for other doctors. The BMA asked us to recommend the Health Departments reconfirm the policy position of free accommodation and for SEHD to address the unilateral withdrawal of free accommodation by NHS Glasgow. It said it wanted to ensure free accommodation for HO/FY1s was retained across the UK.

7.64 The **Department of Health** said it was advising trusts to follow the provisions of the Medical Act and to continue to provide accommodation for HOs. Trusts in Wales continued to provide free accommodation for HOs. It said that all Health Departments were in agreement that the free accommodation should not be withdrawn at this stage. The Department said that no monetary value had been placed on HO accommodation, and that it was usually provided at marginal cost by the employer. The cost would depend on the location and local availability of and demand for equivalent rented accommodation. It confirmed that free accommodation was available until registration.

7.65 **NHS Employers** said the unilateral withdrawal of free accommodation was inappropriate and was a breach of terms and conditions. Trusts had a duty to provide free accommodation. It said that doctors had simple redress through formal employment grievance processes if trusts did not provide the expected accommodation. NHS Employers did not agree with the BMA that the provision of free accommodation should extend to services.

7.66 The **SEHD** said it had made it clear that all NHS Boards must comply with their statutory obligations as employers, including those governed by the Medical Act. It said it was also aware that NHS Glasgow had interpreted their obligations under the Act in a way that differed from the view held by the BMA. It said it was currently liaising between the parties to seek a satisfactory resolution to the issue. It later told us NHS Glasgow had ceased charging for accommodation with immediate effect, and confirmed that they would reimburse any charges that had been made for accommodation.

Comment

7.67 *We are pleased that the parties are now all in agreement that free accommodation should continue to be provided for all HO/FY1 doctors, and that NHS Glasgow will be reimbursing any charges that it made for accommodation. The issue has however drawn to our attention this additional benefit for this group of doctors. We would add that if in the future a decision were taken to withdraw the free accommodation, we would want to consider the consequences for those affected.*

Comparability of salary and the pay uplift

7.68 The **Department of Health** said that for graduates entering their first HO post, salaries remained very competitive. The Association of Graduate Recruiters (AGR) Recruitment Survey 2005 showed that over a quarter of employers expected graduate starting salaries in 2006 to rise by less than the cost of living. In the sectors normally compared with medicine, including law, consulting and investment banking, rates were frozen. Median salaries in these areas were said to have remained unchanged for the last four years, although some movement might be anticipated next year.

The average salary for HOs was £32,533 which compared favourably with other professions. It said it did not agree with the suggestion that medical students had longer courses and were starting their careers later than their contemporaries, citing law students training to become solicitors with a six-year training period and a starting salary below HOs, and students in architecture and town planning.

7.69 The Department said it was important to understand the differences in employment prospects between graduates from medical schools and those from business, accountancy and law schools with whom doctors often compared pay. While the AGR survey did not cover all employers, it did cover the principal ones, mainly from the investment banking, consulting and legal sectors, who together were "recruiting over 1,700 graduates in 2005". Even if 1,700 were a low estimate of the better paid openings, it would be reasonable to assume that such opportunities were available only to a small proportion of graduates and that, whilst the earnings of some may be comparable to those of medical graduates, many would earn considerably less. By comparison, the Department said that the number of first hospital posts open to graduates from UK medical schools was in excess of the total number graduating each year. Most graduates would find a suitable post, although some might need to be realistic about location, and they would have the opportunity to progress through a well-established and comparatively well paid career structure. For virtually all medical students this process delivered planned access to training from graduation to consultant status with the consequent benefit that position delivered in terms of status and financial reward.

7.70 The Department said it remained committed to ensuring a continued upward trend in the number of trainees in the NHS. The Department said in its original written memorandum of evidence that given the level of current applications to medical schools and at all levels of training, it believed this could be achieved with an uplift for 2006 of no more than 2.5 per cent.

7.71 Following the Secretary of State's oral evidence to us, and as outlined in more detail in chapter two of this report, she subsequently wrote to us to tell us of the Department's concern that in the light of the emerging trust deficits, the continued evidence of strong medical earnings growth and the need to keep to the Chancellor's inflation target, there was now a good case for a pay uplift of 1.0 per cent for doctors and dentists in training. The Secretary of State said this would result in an average earnings growth of around 4.6 per cent.

7.72 The **National Assembly for Wales** said that in view of the clear evidence of a continuing healthy position on recruitment and retention and growth in average earnings for the health sector, it concurred with the Department of Health's recommendation for a modest general pay uplift and it confirmed that it supported the Department of Health's revised position on the pay uplift.

7.73 The **SEHD** said it also agreed with the Department of Health's revised position on the pay uplift to fairly balance affordability with the continuing requirement to secure sufficient levels of recruitment and retention.

7.74 **NHS Employers** said salaries on graduation remained very competitive and there appeared to be no shortage of qualified applicants to vacancies at all levels of training. It saw no reason for an uplift to basic salaries other than to account for inflation.

7.75 The **BMA** said that its study of graduate pay (*see chapter two*) showed that it was apparent that medical graduates' earnings were in line with those of other comparable professions and that they remained amongst the higher graduate earners. It said this seemed appropriate to reflect the cost to the individual of studying medicine evidenced in part by the higher level of graduate debt for medical students which it said was £19,248 for fifth year medical students. Any comparative reduction in potential earnings would adversely affect the rate of return to a medical education and might deter future applicants. The BMA said that in the five years since 2001, graduate starting salaries had risen by 15.8 per cent in comparison to 13.2 per cent for junior doctors. Pay rises for doctors were therefore falling behind those of other professions and this, coupled with the reduction in salaries as a result of the WTD, meant medical graduates would be comparatively worse off than other graduates.

7.76 The BMA asked us to recommend a significant uplift in basic pay, being a minimum of 4.5 per cent. It summarised the points made in its earlier arguments, that overall pay levels were falling steeply, recruitment and retention were being affected by a shortfall in HO/FY1 and SHO posts, free HO accommodation was no longer widely available, and student debt continued to increase significantly.

7.77 The BMA responded to the Government's revised position (*set out in detail in chapter two*). It said that there had not been a recent contract settlement for junior doctors, and total pay levels were already falling significantly as a result of quite modest rota changes, so that the government's proposal would not even protect current earnings. Any incremental drift was either specifically related to movement through training or to performance-related thresholds negotiated as part of a wider agreement. It said it deeply regretted the pressure that was being brought to bear on us by the repeated intervention of Cabinet ministers, pressure which it said was unacceptable and incompatible with the review body system. It said it expected us to ignore such interventions.

Comment

7.78 *Last year we asked the BMA to make doctors and dentists in training a priority in taking its work forward looking at pay comparability. We are very grateful for the BMA doing so and read the results of its research with much interest. We note its central conclusion that medical graduates' earnings are in line with that of comparable professions and that they remain among the higher graduate earners. The BMA does however flag up a warning that any comparative reduction in potential earnings could affect recruitment. At present, the level of pay available to juniors does not appear to be deterring applicants, but we shall of course wish to continue to monitor this closely for the future.*

7.79 *In considering the pay uplift for doctors and dentists in training, the parties have sought to bring us to widely different conclusions. In its revised position, the Health Departments have urged us to recommend an increase of 1.0 per cent in recognition of affordability concerns and evidence on the growth in average earnings for medical staff in the NHS. The BMA has asked us to recommend an uplift of not less than 4.5 per cent, as it says that overall earnings are falling, recruitment and retention has been affected by a shortfall in posts, free HO accommodation is under threat and student debt is increasing significantly. NHS Employers has suggested an uplift in line with inflation.*

7.80 *We have already commented earlier in this chapter on all of the issues highlighted by the BMA in its request for a 4.5 per cent uplift. We have responded to the Health Departments' request for our recommendation to take account of increases in average earnings for medical staff in detail in chapter two, where we also set out our views on affordability. Our view on the recruitment, retention and morale situation for doctors and dentists in training is generally encouraging, with further improvements in the numbers of applicants to study medicine and dentistry. On pay comparability, we have already noted that the BMA has concluded that medical graduates' earnings compare favourably with comparable professions and that they remain among the higher graduate earners. Finally, we have looked at the range of inflation and pay indicators when considering how to protect the value of pay. Taking all of this into account, we* ***recommend*** ***(recommendation 13)*** ***an increase of 2.2 per cent for 2006-07 on the salary scales of all grades of doctors and dentists in training****. The proposed scales are set out in Appendix A.*

CHAPTER 8 – CONSULTANTS

Introduction

8.1 *As the three-year pay deal supporting the introduction of the new consultant contract finishes at the end of 2005-06, we are once again considering the pay uplift recommendations for all consultants in England, Scotland and Wales. We are also asked to make recommendations on Clinical Excellence Awards (CEAs) and the discretionary points and distinctions 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.*

Recruitment and retention

8.2 The **Department of Health** reported that whole-time equivalent (wte) consultant numbers in Great Britain in 2004 had increased by 7.6 per cent. Consultant numbers in England in 2004 had increased by 6.8 per cent (wte). The *NHS Plan* target in England of 7,500 (headcount) more consultants by March 2004 over the September 1999 baseline had been achieved in December 2004. The manifesto commitment to increase the number of consultants and GMPs in England by 10,000 (headcount) by September 2005 over September 2000 had been achieved in March 2005. Various initiatives were in place to improve recruitment, retention and return to the workforce. The Department said that it did not hold information on the use of recruitment and retention premia and there was very little information available. Anecdotal evidence was that the vast majority of trusts had had little need to award recruitment and retention premia. The Department said this doubtless reflected the fact that the overall number of consultants in post had increased over the last year and that vacancy levels were generally lower. Where such premia had been paid, they tended to be in shortage specialties e.g. psychiatry.

8.3 The **Scottish Executive Health Department** (SEHD) reported that wte consultant numbers had increased by 2.2 per cent in 2004. The most recent vacancy figures showed there were 288 (headcount) consultant vacancies, an increase of just under 18 per cent from September 2003. However, the six-month vacancy rate had decreased to 3.0 per cent from 3.4 per cent in 2003. A number of training grade doctors were English-domiciled and it was a continuing challenge to retain doctors when they gained consultant status, particularly in some shortage specialties. Work was ongoing to support retention rates and meet the target of an additional 600 consultants by September 2006.

8.4 The SEHD reminded us that last year we had raised the issue of recruitment and retention premia for consultants and it repeated that employers had agreed that such premia should only be applied on a collective basis across Scotland to ensure a consistent and fair application. A significant investment had been made in consultant pay and the SEHD said it believed that any recruitment and retention pressures arising from remuneration and working conditions had been fully addressed by the new contract. To date therefore, the premia element of the contract had not been utilised because recruitment pressures had more to do with a lack of available candidates and the professional quality of posts on offer, rather than remuneration.

8.5 The **National Assembly for Wales** reported that wte consultant numbers had increased by 11.2 per cent in 2004, which was in line with achieving its target of 525 extra consultants by 2010. Consultant posts which had remained vacant for three months or more had fallen from 176.4 to 119.3 between September 2003 and March 2005. The Assembly said that the improved vacancy rates were a direct result of robust recruitment and retention and showed that pay was about right at present.

8.6 **NHS Employers** told us that the 2005 vacancy survey figures for consultants had shown an encouraging decrease in the rate from 4.4 per cent in March 2004 to 3.3 per cent in March 2005. There were 31,210 (headcount) consultants in England at March 2005, an increase of 3.4 per cent over the year. Numbers had further increased by 347 in the first quarter of 2005. However, there were some concerns in particular specialties, including national shortages in accident and emergency, psychiatry and radiology. Some examples had been reported to NHS Employers of the use of recruitment and retention premia under the new contract, mostly in areas where there were national shortages (psychiatry, radiology and histopathology). Where premia were used, employers were expected to have first considered non-pay initiatives and consulted other local NHS organisations. No change was being sought by employers to the provisions for these premia. Overall, the premia were not always thought to be appropriate, since the most common cause of difficulty was lack of supply nationally, rather than ability to attract staff to the NHS and so were only useful where there was widespread competition with non-NHS organisations. This was clearly not the case at present with medical and dental staff. NHS Employers also reported a number of other beneficial changes to terms and conditions during 2005 covering maternity leave and pay, employment breaks, public holidays and special leave.

8.7 The **BMA** said that it welcomed the modest increase in consultant numbers of 1.1 per cent since December 2004, as reported by the NHS workforce survey for March 2005. However, it also had evidence that consultants were being offered redundancy in recent months and the BMA said it would be extremely concerned if this anecdotal evidence developed into a clear national trend. In its own survey in September 2004, 44 per cent of respondents had reported that at least one consultant vacancy in their directorate had been vacant for three months or more, overall around one in ten posts were vacant (in certain specialties it was one in five posts) and 28 per cent of respondents reported that their trust was not actively trying to fill some vacancies. Almost half of respondents to the BMA's September 2005 survey of Medical Directors had said that their trust intended to freeze recruitment because of funding shortfalls and a quarter reported that their trusts were considering redundancies, which might affect some consultant posts. A majority (57 per cent) of the Medical Director respondents thought that their establishments were not appropriate to fulfil service needs. On early retirement intentions, over 60 per cent of respondent Medical Directors aged 50-54 intended to retire by 2012 and of those considering early retirement, the most commonly given reason was pressure of work. Nearly one quarter had considered leaving the NHS to work overseas. The BMA said that these figures showed that 79 per cent of consultants had considered early retirement and although it was unlikely that such a percentage would leave, it must be a major concern for the NHS because it highlighted the lack of effective retention policies.

8.8 In Scotland, the BMA reported that the number of wte consultants had increased by 2.2 per cent in the year to September 2004. At the same date, the wte vacancy rate was 7.8 per cent, an increase from 6.8 per cent over the previous year. The consultant headcount as at June 2005 was 3,606, meaning a further 297 consultants were needed to meet the SEHD's target of an additional 600 consultants by September 2006. Currently 15 per cent of consultants were aged 55–59. Given this situation, the BMA said it remained critical of the agreement by employers to place a moratorium on the use of the new contract's recruitment and retention premia. Although the BMA had a good working relationship with the SEHD, the absence of a recognised negotiating structure between it and the employers had also caused difficulty in taking forward issues requiring national negotiation. However, the BMA said that it had also begun discussing initiatives with the SEHD to deliver the consultant expansion programme.

8.9 The BMA reminded us that the top end of the new contract for English consultants was currently £93,768, with clinical excellence awards reaching £33,468[1]. In contrast, the top end in Wales was £87,444, with Commitment awards reaching £21,147. The BMA said this had already translated into a recruitment and retention issue, with 7.7 per cent of all consultant posts in Wales currently vacant, compared to 3.3 per cent in England, and anecdotal evidence suggesting that no attempts were being made to fill vacancies.

8.10 Commenting on the BMA's evidence, the **National Assembly for Wales** said that the vacancy rate quoted (7.7 per cent) was incorrect because the published figures contained a coding error. The correct vacancy rate was 6.8 per cent. This high figure was partly due to the increased number of consultant posts (180+) created by Trusts since September 2004. The overall vacancy total was down from 9.4 per cent in September 2004. The **SEHD** said that a dedicated pay modernisation officer for the consultant contract had now been appointed. During the recent transition to new negotiating and partnership structures, effective negotiations had been taken forward between the Department, employers and the BMA.

8.11 **NHS Employers** commented that it did not have detailed information on doctors being made redundant, however redundancies amongst doctors were extremely unusual.

Comment

8.12 *We are pleased to note again this year the continuing growth in the numbers of consultants across each country, although we also note that the rate varies in each country with Scotland seeing only modest growth in 2004 whilst Wales saw significant growth. In previous years we have asked the Health Departments to tell us their annual target for increasing consultant numbers so that we can judge whether they are on track to meet them. Although the Department of Health has now told us that workforce targets will in future be set locally, we presume that an overview will need to be made by the Department and we would expect this information to be provided to us. We would like to understand how national workforce planning will work in the future and would ask the Department of Health for further information on this for our next review. We must also repeat the request made in previous years for the parties to provide evidence on the impact that any shortfall in workforce has had on the workload of our remit groups and on the achievement of the Health Departments' output targets. Similarly, we would also like to see evidence on the underlying trend in vacancy rates, excluding the effect of growth in posts, so that we can keep this under review.*

[1] This relates to a Bronze or level 9 (local) award. The highest national award in 2005-06 is £71,495 (Platinum). The four national level awards (Bronze, Silver, Gold and Platinum) are also available to consultants in Wales. In Wales, consultants progress onto the commitment awards which are awarded once every three years once the scale maximum is reached.

8.13 *We commented last year on the sharp increase in the six-month vacancy rate in Scotland and so are pleased to note the small decrease in the rate in 2004, although we also note that consultant vacancies increased by just under 18 per cent during this period. We would ask the SEHD for an update on the position for our next review. Given the challenges that Scotland faces retaining consultants who were originally from England and the difficulties the SEHD has told us about elsewhere regarding recruitment in certain areas such as remote and rural locations, we are interested to note Scotland's approach to the use of the recruitment and retention premia under the new contract. We understand the argument, but presumably not all Health Boards face the same degree of difficulty recruiting staff e.g. because of a particularly remote/rural location. NHS Employers' evidence also indicates that where the premia are being used it is to address problems such as national shortages in a specialty, while Scotland seems to have ruled out this approach. There seems to be a mixed message coming from NHS Employers who tell us that use of the recruitment and retention premia is not always appropriate because the difficulty usually stems from lack of supply of a particular specialty at a national level, and yet their evidence also says that employers are reporting that the premia are being used to recruit in specialties suffering from national shortages. As it is still early in the life of the new contractual arrangements, the use of the premia will no doubt evolve further and so we would like to keep developments in both England and Scotland under review and would ask the parties for further evidence next time. We also hope that Scotland can achieve its target of an additional 600 consultants by September 2006 and will await evidence for our next review.*

8.14 *We note the BMA's concern that the pay differential between England and Wales at the top end of the new consultant payscales is having an impact on recruitment and retention in Wales and we also note the Assembly's response. It is still early days for the new contractual arrangements in all three countries and too early to assess fully their impact on recruitment and retention. At this stage, we would only note that whilst there is a pay differential between England and Wales, we would expect that the system of commitment awards in Wales, paid every three years after reaching the new maximum on the pay scale (replacing the former discretionary points scheme), to prove helpful to recruitment and retention in Wales in the longer term. We would ask the parties for further evidence for our next review.*

8.15 *The BMA has expressed concerns about the potential impact of trusts' funding difficulties on recruitment of consultants and concerns about potential redundancies, although we note NHS Employers' comment that redundancies amongst doctors are extremely rare. However, if the BMA's concerns about recruitment or even redundancies prove to be correct, it would be of concern to us and we would ask the parties for evidence for the next review of the impact of trusts' funding difficulties on recruitment and retention. We note here that the Department of Health has said that the level of our pay recommendations for all of our remit groups in 2006-07 is very much a factor in how trusts will solve their funding difficulties in the next financial year. We commented on this in detail in chapter two.*

8.16 *We were interested to see the BMA's evidence on retirement intentions amongst Medical Directors and were disappointed that the Department of Health has not provided us this year with updated data from the NHS Pensions Agency on consultant retirements in England and Wales and reasons for retirement. We have found this data helpful to monitor year on year and would ask the Department (or NHS Employers) to provide it again for us in the next round. We were also disappointed to find that we received no retention evidence this year from the Department of Health showing a revised analysis of data from the HCHS census of the latest and likely future retention trends, plus wastage rates. This data is also very helpful and we would ask the Department to provide it for us again next year. Whilst we welcome the continued increase in consultant numbers in each country, retention remains a very important issue if the manpower gains achieved to date are not to be eroded.*

Morale, motivation and workload

8.17 The **Department of Health** reported that there had been a very good take-up of the 2003 consultant contract, citing a BMA survey from June 2005 which indicated that less than 14 per cent of consultants remained on the old contract. The 2003 contract was designed to provide a 15 per cent average increase in a consultant's career earnings, plus a 24 per cent increase in the maximum basic salary. Job planning was key to the new contract and should enable consultants to better manage their workload and so have a positive impact on morale and retention. The Department's own survey figures published in February 2005 showed that the average number of agreed programmed activities (PAs) was 11.17. The Department said that there was no hard evidence yet to show that the new contract was enabling consultants to manage their workload better, but the key tool to agreeing and controlling workload was the job plan. As employers and trusts became more skilled in preparing these and agreeing objectives, then workloads would become agreed, better defined, more focussed and manageable. This could not happen overnight, but inroads were starting to be made. The Department said that consultants had been covered by the Working Time Directive (WTD) 48 week since 1998 and anybody choosing to work longer should have signed a voluntary opt-out.

8.18 The **SEHD** reported that 96 per cent of consultants had moved onto the new contract as at June 2005. The average number of agreed PAs as at October 2004 was 11.5 and the SEHD said there was a clear understanding that extra PAs were not permanent and were regularly reviewed. A study was being commissioned from Aberdeen University to assess the impact of the contract on both workload and morale which would be completed by Spring 2006. Anecdotal evidence suggested that morale had been positively affected.

8.19 The **National Assembly for Wales** described the various initiatives to achieve rigorous job planning since the introduction of the new contract in December 2003 as this would ensure that the contract realised benefits for the NHS. In addition to the £17 million funding which had already been issued, a further £23 million was being distributed to meet the costs of additional consultant sessions. Some consultants' pay had increased by 35 per cent since April 2003, while the scale maximum had increased by 24 per cent in the same period.

8.20 **NHS Employers** reported results for the second NHS Staff Survey which showed that consultants had largely positive views about appraisals and training, flexible working and job satisfaction. Evidence indicated that some nine out of ten consultants had now moved to the 2003 contract, representing pleasing progress over last year. Job planning was progressing, but failure to agree the number of PAs was a common reason for consultants electing not to transfer. However, many of these disagreements were being resolved via mediation and appeals resulting in further transfers during 2005. A contributory factor to the improving vacancy pattern might be increased flexibility in working arrangements. As employers and consultants became more skilled at tailoring job plans, the resultant arrangements better accommodated the needs of employers, the wider NHS and individual consultants. NHS Employers said it agreed with the BMA that adequate time for supporting professional activities should be incorporated into consultants' job plans.

8.21 The **BMA** said that it was gravely concerned at recent reports that there were significant numbers of trusts with financial difficulties which were failing to replace consultants who had retired, whilst others were considering making consultants redundant as a cost saving measure. The BMA said that results from its September 2005 survey of Medical Directors indicated that trusts were intending to reduce services because of funding shortfalls and that the effects would inevitably increase pressure on existing consultants with consequences on morale and health. The BMA said it was hard to see how job planning would control the resultant impact on workload as this was a funding problem. Job planning could not result in consultants working for free and the BMA said that employers had demonstrated that they expected existing consultants to cope with the workload during additional programmed activities (APAs) or unpaid overtime, if necessary. Employers had also demonstrated repeatedly that they expected overall activity levels to be maintained despite bed closures, redundancies, budget-capping and all other sorts of panic measures which had been introduced or were being considered to limit deficits. The BMA said that the results from its September 2004 survey of 2,000 consultants had shown that 35 per cent of respondents thought their morale had worsened in the past 12 months with the recurrent reasons being an increase in workload, pressure at work, a shortage of consultants, support staff and resources. The BMA said this was a worrying statistic and thought it was important for all concerned to recognise and address it. The BMA noted that amongst those respondents on the new contract, the proportion who said morale had improved was higher than amongst those respondents on the old contract, indicating a strong correlation between improved pay and morale. The BMA said that consequently further pay increases would serve to increase morale further, particularly if applied to all consultants.

8.22 Figures for the average number of agreed PAs from surveys by the Department of Health in October 2004 and the BMA in May 2005 were very similar. Of the average 11.17 PAs, 2.43 were supporting programmed activities (SPAs), slightly below the stipulated 2.5 'norm'. In a small number of trusts, particularly those facing funding difficulties, there remained problems with trusts seeking to limit PAs, despite assurances from the Department that all work should be properly recognised. The BMA said that as additional PAs (APAs) were non-pensionable, they were a low cost way for employers to increase activity without having to expand consultant numbers. The juniors' pay banding system was a good example of where financial incentives could limit working hours and the BMA said it felt that a similar approach, manifested through higher APA payments, would help to reduce consultants' working hours. The BMA suggested that APA payments should be raised with a view to encouraging trusts to take on more staff and reduce workload.

8.23 In Scotland, data from June 2005 showed that 96 per cent of consultants were on the new contract. PAs were generally capped at 12 with workload in excess recognised in some areas by other types of payment. The BMA's view was that PAs should match the workload. At October 2004, the average number of agreed PAs was 11.5. The new contract was a known cost pressure facing the NHS and Audit Scotland was examining its costs and expected benefits (reporting early in 2006).

8.24 The BMA said that regardless of any modest increase in consultant numbers, we should take into account various developments that had or would shortly increase consultant workload – the reduction in juniors' hours under the WTD, the impact of *Modernising Medical Careers* and any new contract agreed for staff and associate specialist doctors.

8.25 Responding to the BMA's evidence, the **SEHD** said it agreed with the BMA that PAs in the job plan should match workload and strategies should be in place to reduce commitments where they exceeded 48 hours per week (unless waivers had been signed under the WTD regulations). The SEHD said it was not aware of evidence that responsibility payments were being paid for work above 48 hours.

Comment

8.26 *We note the parties' evidence on the take-up of the new contract and the average number of agreed PAs. We look forward to receiving evidence from the SEHD for our next review on the findings from the study by Aberdeen University on the impact of the contract on workload and morale. This attempt to produce some robust evidence is most welcome and we would ask the two other Health Departments and NHS Employers to consider what evidence they could provide here. The SEHD has said there is anecdotal evidence that morale had been positively affected by the contract and NHS Employers reported some positive results from consultants in the NHS Staff Survey on certain HR issues. Again, we would welcome a robust assessment from all the parties for our next review on the state of and changes in consultants' morale.*

8.27 *The BMA's evidence about morale and workload from its 2004 survey of consultants will no longer be representative of consultants' views in the light of a further 18 months experience of working under the new contract. As we have said, we would welcome fresh evidence from the parties on the impact of the new contract on morale and workload for our next review. We note with interest the BMA's point that the proportion of consultants on the new contract in September 2004 whose morale had improved was higher than amongst those on the old contract. The BMA concludes that there is a strong correlation between improved pay and morale. This may be true, but it is not the only possibility. Morale may also improve if there is effective discussion between consultants and their managers about job planning so that workload is better understood and managed. The BMA has highlighted its concerns about the potential impact of the current funding difficulties on consultants' morale. We share these concerns, but recognise that unaffordable pay recommendations are likely to increase the pressure on trusts to make savings in the very way that the BMA fears. We consider affordability further below and in the commentary on our pay recommendations at the end of this chapter.*

8.28 *The BMA asks us to support the reduction of working hours using a similar pay approach to that of the juniors' banding system by recommending that APAs are paid at a higher than standard rate. This was not what the parties negotiated and there would be an affordability issue here. The BMA has already said that it is concerned about the impact that trusts' current funding difficulties may have on recruitment, retention, morale and workload. Increasing the cost of APAs would add costs to trusts' paybills and whilst it might encourage trusts to reduce working hours, it would also exacerbate any funding difficulties with unforeseen consequences for recruitment and retention. As it is still relatively early in the life of the new contract, we do not intend to destabilise the existing arrangements without more robust evidence to demonstrate that changes are needed and how any changes might impact on the various aspects of our remit. That said, we believe that employers should be taking action to bring consultants' average workload within the limits of the Working Time Directive as soon as possible. We heard on our visits that some consultants are continuing to work a significant number of hours beyond those agreed in their job plan which in turn were constrained by trusts' financial pressures. We would ask the parties for more robust evidence on consultant workload so that we are able to reach an informed view. We recognise that bringing consultants' average workload within the limits of the Working Time Directive is likely to be achieved only through a combination of*

better job planning, more medical and non-medical staff being in place, and possibly a wider redesign of service delivery. But employers need to keep in mind the potentially adverse consequences for morale and retention if workload concerns remain unaddressed. We want to continue monitoring morale and workload issues and would ask the parties for further evidence for our next review on the outcome of the latest job planning round, its funding implications and how morale is changing.

Clinical Excellence Awards (CEAs), distinction awards and discretionary points

8.29 The **Department of Health** reminded us that the CEA scheme was now in its second year, and that distinction awards and discretionary points awarded under the previous consultant reward schemes remained in payment until award holders retired or were awarded a CEA. The new scheme was open to all consultants with at least one year's service. Work by the BMA and the NHS Confederation on a planned report on the operation of the new scheme after two years was expected to start after completion of the 2005-06 award round and to be completed in time to inform the 2007-08 awards round. For 2006-07, the Department proposed that the value of CEAs, distinction awards and discretionary points should be uplifted in line with the pay uplift it was seeking for consultants.

8.30 The **SEHD** told us that it was committed to conducting a review of the current distinction award and discretionary points schemes. Scottish Ministers were currently considering the parameters for the review with a view to it commencing in early 2006.

8.31 The **BMA** said that it was continuing to work with NHS Employers to ensure that the CEA system was fair and accessible. For the forthcoming round, we were asked to recommend that the total sum of money invested in the national awards should be up-rated pro rata with the increased number of consultants and the pay award, and that local awards should be uprated in line with the pay award. This should also be applied to discretionary points and distinction awards. We were also asked to recommend increases on other fees and allowances that would maintain the present relativities between payments. In Scotland, the BMA considered that the 2006 round would take place under the current arrangements as it had yet to receive a formal approach from the SEHD to begin discussions about a review of the current arrangements. It therefore asked us to recommend that the number of A+, A and B distinction awards should be increased to match consultant expansion in Scotland and that their value should be increased by the same percentage as the general pay award. It also asked that the value of discretionary points be increased by the same percentage. It hoped we would agree that there was no case for changing the basis of the currently agreed schemes in Scotland in advance of the parties reaching agreement about new arrangements.

8.32 The **Department of Health** said it was in broad agreement with the BMA's point that the total sum invested in the national awards should be uprated pro rata with the increased number of consultants and the pay award, that the local awards should be uprated in line with the pay award, and that this should be applied to discretionary points and distinction awards. The **National Assembly for Wales** confirmed that it was seeking the same uplift for CEAs, distinction awards and commitment payments as whatever we recommended for consultants' pay.

8.33 Reporting on the position in Scotland, the Chairman of the **Scottish Advisory Committee on Distinction Awards** (SACDA) said that as at 30 September 2004, there were 479 award holders in Scotland (41 A+, 138 A and 300 B), comprising 13.4 per cent of all consultants. SACDA had approved 65 awards for the 2005 round (including the 15 additional awards that we had endorsed in our last review), comprising four A+, 16 A and 45 B awards. Female consultants formed 27.2 per cent of the consultant population in Scotland, but they held only 11.3 per cent of all the awards granted. As with earlier years, a relatively low proportion of female consultants were nominated in the 2005 round, which SACDA believed was partly due to their being younger, on average, than their male counterparts. Female consultants had accounted for 16.6 per cent of all nominations and 16.9 per cent of awards granted. Although the numbers were very small, SACDA said that there was no evidence of either positive or negative discrimination with respect to nominees from ethnic minorities. For 2006, SACDA said that it was proposing an additional two A+ awards, four A awards and nine B awards.

8.34 In supplementary evidence, the **SEHD** said that in its evidence to us over the last two years, it had indicated that budgetary pressures across the range of the Department's spend were causing it to consider carefully the annual increase in investment that it could reasonably make in the distinction awards and discretionary points schemes. These pressures remained and in the SEHD's view, they argued that the uplift for 2006-07 in Scotland should be made in line with the SEHD's recommendation for the general pay award. The SEHD said that this would recognise the need to release the maximum possible amount of limited resources to NHS Boards for developments in service delivery and the fact that consultants had received substantial increases in salary over the last few years. However, the SEHD said that it did not support the proposal that the number of A+, A and B distinction awards should be expanded in line with total consultant expansion. Whilst there had been a matched expansion in previous years, it was the SEHD's view that this should not be taken as a fixed rule. The purpose of distinction awards was to select for recognition a restricted number of consultants who had made the most outstanding contributions, or were leading in their field well beyond the generality of their profession. The SEHD said it considered that the current number of distinction awards available adequately fulfilled this criterion without the need to expand the numbers further relative to the overall total.

8.35 In evidence from the Chairman of the **Advisory Committee on Clinical Excellence Awards** (**ACCEA**), we were reminded that the scheme existed to reward consultants financially for exceptional achievement and contribution to patient care. The eligibility and assessment criteria for all awards were set nationally. Local Awards Committees (LACs) operated under ACCEA Guidelines and mindful that this new framework had represented important changes for some local committees, ACCEA had allowed the 2004 and 2005 rounds for modifications to be made. The expectation was now that all LACs would have moved to comply with the new requirements for the 2006 round.

Academic GMPs

8.36 The Chairman said that the cost to ACCEA of funding national awards to academic GMPs in 2005 was £2.7 million. In future, ACCEA expected only a modest increase in the number of awards to this small group of potential candidates. In 2005, the sum required for local awards to this group had been based on 0.35 CEAs per eligible GMP. In 2006, ACCEA proposed that recommendations for local awards to this group should be made by the relevant local ACCEA committee and moderated centrally to ensure that they were distributed equitably.

The 2005 Round

8.37 Reporting on the second round of the new scheme, the Chairman said that procedures were now reasonably settled and now needed refining rather than establishing. At the same time, foundations had been laid for the new role of assuring the scheme at local level.

8.38 The Chairman reported that in 2005 there had been an increase in Bronze and Silver awards compared to 2004, but fewer Gold awards. Some oscillation was anticipated year on year in the Silver/Gold balance during the movement from distinction awards to CEAs, but this would stabilise once Silver CEA holders had progressed sufficiently to be considered at Gold level. The second round of national CEAs had broadly established the standards for each national level and these would be kept under consideration year by year. In 2005, there were in total 71 Platinum, 149 Gold, 304 Silver and 636 Bronze CEAs. The Chairman said that despite the increase in award amounts in 2005, better housekeeping arrangements featuring a revised consultant verification process had resulted in savings to the costs for existing A+, A and B distinction award holders compared to 2004. The total adjusted for retirements was in line with ACCEA's agreed budget.

8.39 ACCEA said that the way the CEA scheme operated should ensure that the 'pyramid' shape of the distribution of the level of awards was maintained with modest enhancement. As distinction awards were phased out, the marginal costs of funding an enhanced level CEA would be lower as the differentials between CEAs and distinction awards were lower. These factors should free up funds in year which could be redistributed.

8.40 The Chairman commented that the NHS was making strenuous efforts to ensure that consultants in all specialties and all environments had opportunities to excel and the new award scheme had positioned itself to continue to reflect this year on year. ACCEA was continuing to keep the success rate by specialty under scrutiny to ensure that all groups were properly considered. The numbers on gender and ethnicity would be best assessed over a period of years. It was also still early in the life of the new scheme to compare figures for awards year on year.

The 2006 round

8.41 ACCEA said that it was taking 2006 as another base year for award numbers. Given the pyramidal structure of the higher awards (levels 9 (national) to 12), which it had been asked to create, and the introduction of academic GMPs into the scheme, the Chairman said that ACCEA recommended an uplift which would allow it to maintain award numbers pro rata at the same level for the next round. The budget for the higher awards should be increased in line with the increase in the number of consultants now eligible for an award together with the general uplift recommended by us this year. ACCEA should retain for 2006-07 the flexibility to determine the number of awards to be made at each level. In addition, ACCEA was requesting £2.9 million for both national and local awards for academic GMPs with an increase in line with the general uplift recommended by us this year, together with an increase in line with the increase in the number of academic GMPs (c. five per cent). Apart from this funding for academic GMPs, ACCEA's evidence did not relate to funding for local CEAs (levels 1-9 Local) which were not funded from the dedicated ACCEA budget.

8.42 Both the **Department of Health** and the **National Assembly for Wales** said they had no comments on ACCEA's evidence.

Comment

8.43 *We wish to thank both ACCEA and SACDA for their evidence on the last awards round and for their recommendations for 2006. We note SEHD's view that distinction awards need not be expanded in line with total consultant expansion, but we see no reason for digressing from our previously stated view that there is no case for changing the basis of the current agreed discretionary points or distinction awards scheme in Scotland in advance of the parties commencing their discussions about the new arrangements. The SEHD's evidence under recruitment and retention told us that it was a continuing challenge to retain doctors who originated from England once they had gained consultant status. We would therefore expect any deterioration in the current operation of the distinction awards scheme in Scotland only to lessen the attractions of working there. In order to support recruitment and retention, we wish to maintain a level playing field until the parties have discussed and agreed a replacement merit award scheme. SACDA has made its proposals to us in accordance with the agreed structure of the current distinction awards scheme and* ***we therefore endorse and recommend*** *(recommendation 14)* ***SACDA's proposal for an additional two A+ awards, four A awards and nine B awards****. We hope that the parties can make progress on the review of the current arrangements and would ask for an update for our next round.*

8.44 *Turning to England and Wales, we note that ACCEA believes it to be too early in the life of the new CEA scheme to make an in-depth assessment by comparing figures for awards year on year, but we welcome ACCEA's assessment that the NHS is making strenuous efforts to ensure that consultants in all areas are given opportunities to excel. We would be interested to receive an analysis of the scheme by gender and ethnicity in future years, as outlined by ACCEA.*

8.45 *For the current round, we note that the Department of Health, the National Assembly for Wales and the BMA are in broad agreement on the funding of the CEA scheme, and that the parties have offered no comment on ACCEA's proposals.* ***For 2006-07, we therefore endorse and recommend*** *(recommendation 15)* ***ACCEA's proposal that the budget for higher awards should be increased in line with the increase in the number of consultants now eligible for an award****.*

8.46 *With regard to the annual percentage uplift, we would repeat the comment made last year that all of the 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 16)* ***that the value of CEAs, commitments awards, distinction awards and discretionary points should be uplifted by 2.2 per cent, in line with our main pay uplift recommendation*** *(see end of chapter).* ***We also endorse and recommend*** *(recommendation 17)* ***ACCEA's proposal that it should continue to retain the flexibility to determine the number of CEAs to be made at each level in 2006-07****.*

8.47 ***We also endorse and recommend*** *(recommendation 18)* ***ACCEA's request for £2.9 million for both national and local awards for academic GMPs with an increase in line with the general uplift of 2.2 per cent, together with an increase in line with the increase in the number of academic GMPs. We endorse and recommend*** *(recommendation 19)* ***ACCEA's proposal that recommendations for local awards for academic GMPs should be made by the relevant local ACCEA committee and moderated centrally****.*

Clinical academic staff

8.48 The **BMA** discussed the latest developments affecting this group and the current recruitment and retention difficulties. It highlighted the continuing decline in the number of clinical academic training posts in contrast to the increases in numbers of NHS medical staff. In considering the number of CEA awards to be made available this year, the BMA requested that we increase the number in order to incentivise teaching and research activity, and that we recommend rewarding a higher proportion of academic staff than previously, but without prejudice to NHS consultants. In Scotland, the BMA said that there had been some uncertainty regarding the contractual status of the new contract for clinical academic consultants. The University employers had recently confirmed that the new contract was contractual with the exception of certain procedural aspects covering job plan review and mediation and appeals procedures because the employers were not completely in control of these procedures. The BMA's position remained that these aspects were also contractual. It appreciated that our recommendations did not apply to academics, but we had made helpful observations in the past on the need for academic staff to retain pay parity with their NHS colleagues and our support would be appreciated on this occasion.

8.49 The **British Dental Association** (BDA) explained its concerns about the shortage of clinical academic staff numbers and resources, in the light of increases in dental undergraduate numbers across the UK, and about recruitment and retention, given the inconsistent implementation of the consultant contract for clinical academic staff. The BDA considered that there would be too few staff to handle the influx of students and too little incentive for dental clinical academics to remain in post, with the result that the competence of future dental graduates could not be guaranteed.

8.50 The **SEHD** said that in June 2005 it had received confirmation from the Scottish Universities of their view of the contractual status of (and exceptions from) the new contract which had been helpful in clarifying their position.

8.51 The **Department of Health** reminded us that academic contracts were the responsibility of their employers in the higher education sector and money had been made available for the translation of the 2003 consultant contract for clinical academics. However, it said that it remained concerned about the decline in numbers and was working hard to facilitate entry into clinical academia. Together with the Department for Education and Skills, it had provided £3 million over three years for Academic GMPs to support universities in moving salary levels for these staff closer to those of NHS colleagues and to enable universities to plan to support this in the longer term. As for incentivising academic medicine through use of CEAs, the Department said that Bronze CEAs remained at a higher percentage for academic consultants than NHS consultants and it could see no reason, on this ground, to increase the number of awards available.

Comment

8.52 *As we have noted in past reports, clinical academic staff do not fall within the terms of our remit, but given that we have an interest in the effect that any shortfall in numbers may have on the ability of the NHS to train sufficient numbers of medical and dental staff, we were pleased to note that the Department of Health is concerned about the decline in the numbers of staff in this group. We hope that the Department will continue to work with the Department for Education and Skills in considering how to recruit and retain the required numbers of academics. We would also remind the Health Departments of our*

comments from previous reports. We support the principle of pay parity between clinical academic staff and NHS clinicians. It is important that there are sufficient incentives for doctors and dentists to enter academic medicine or dentistry and that clinical academic staff should be fully considered for the full range of clinical excellence awards, distinction awards and discretionary points to which they may be entitled. We hope that the parties will continue to bear these points in mind in their ongoing consideration of issues affecting this group.

8.53 *We note the BMA's proposal that in considering the number of CEA awards to be made available this year, we should increase the number of CEAs in order to incentivise teaching and research activity, and that we also recommend rewarding a higher proportion of academic staff than previously, but without prejudice to NHS consultants. Since the introduction of the CEA scheme in 2004, we have supported ACCEA having the flexibility to determine how many awards should be made at each of the higher national levels of the scheme. ACCEA has requested this flexibility again this year and we continue to support it. ACCEA is best placed to judge in any particular year the merits of individual applications against the established criteria of the scheme and to determine what number of awards should be made at each level. Our concern is that the CEA scheme in England and Wales and the distinction awards scheme in Scotland should operate effectively so that applications from all eligible consultants, including clinical academic consultants and GMPs, are properly considered against the established criteria for the schemes. We have seen no evidence to indicate this is not happening. Furthermore, we do not consider that either the CEA or distinction awards schemes should be used to address recruitment and retention difficulties amongst particular groups of consultants. To do so would result either in a distortion of the distribution of awards, or require additional funding, neither of which is appropriate. We would however ask both ACCEA and SACDA to report to us next year on the allocation of awards to clinical academic staff and to report on any specific issues arising for this group.*

Public Health Staff

8.54 The **BMA** said there was concern amongst consultants in public health medicine and directors of public health about the implications for their jobs of the Department of Health's recent guidance, *Commissioning a Patient-Led NHS*. The Department was asked to reverse its current policy where there was no recognition for seniority purposes of service at GMP principal level for public health doctors. It also asked that the supplements payable to district directors of public health and regional directors of public health should be uprated in line with the overall award.

8.55 The **BDA** said that over the last year it had received anecdotal evidence indicating that there was a national shortage of Dental Public Health staff. The shortage had also been identified in the *Dental Public Health Workforce in England* status report (January 2005). There had been an increase in part-time working, resulting in an overall reduction of the dental public health workforce, and almost all of the current consultant workforce would retire in the next ten years. The workload of those in post had increased significantly because of the shortage of staff and around a quarter of Primary Care Trusts (PCTs) did not have access to advice from Dental Public Health Consultants. The BDA said that this lack of access was also having negative repercussions on Clinical Directors in the Salaried Primary Dental Care Services who were helping to address this shortage. In the light of this, the BDA asked us to recommend that funding be made available rapidly to support initiatives to increase the number of staff. It also asked that the number of specialist registrar (SpR) training posts in this specialty be increased to maintain the consultant workforce.

8.56 **NHS Employers** said it believed that it was the responsibility of local health economies to decide how healthcare was managed and how resources should best be applied.

8.57 The **Department of Health** said that the public consultation on the proposals for the possible future configuration of SHAs and PCTs was expected to begin in December 2005. With regard to recognising service at GMP principal level for seniority purposes under the consultant contract, the Department and NHS Employers had had continued correspondence with the BMA. The Department said that it had confirmed its policy position to the BMA (that work as a GMP principal did not count as experience equivalent to that of a consultant for seniority purposes) and had no intention of reviewing it. The Department said that the supplements payable to district and regional directors of public health would be uprated in line with the overall award.

Comment

8.58 *We note the BMA's concerns about the potential impact of NHS reorganisation on consultants in public health medicine and directors of public health. We also note the BDA's concerns about the dental public health workforce. Although the organisational structure of the NHS and the size of the workforce needed to deliver services are not matters for us to make recommendations on, we would ask all three Health Departments to consider the impact of any proposed organisational changes on the recruitment, retention and morale of our remit groups. We would also ask the Departments to consider the workload impact resulting from such changes, or from staff shortages, and what effect this might have on recruitment, retention and morale. The BDA has asked us to recommend that funding be made available to support initiatives to increase the number of dental public health consultants and that SpR training posts in the specialty should be increased. We would ask the Health Departments and NHS Employers to consider these requests as part of their workforce planning activities.*

Pay recommendations for 2006-07

8.59 The **Department of Health** reminded us that consultants' pay had increased significantly in recent years and that earnings growth would continue to be strong in 2006-07 as consultants progressed through their pay thresholds towards the new maximum. On the basis of pay reform alone, the Department originally said that growth in consultant earnings was expected to be 2.55 per cent in 2006-07. However, the Department subsequently clarified this statement saying this figure was incorrect as it related to the investment in pay modernisation for consultants over a later period. The Department said that the high earnings growth over the earlier period was partly a consequence of changes to the contract for doctors in training, as well as changes in the composition of the medical workforce. The Department said that a new consultant starting on 1 April 2001 on the minimum of the old contract scale who then transferred to the new contract would, by 1 April 2005, have received an increase in pay of £25,089 or 49.4 per cent over four years. The Department said that the workforce continued to grow and the new contract enabled consultants to better manage their workload. In its original written evidence memorandum, the Department said that for consultants on both the pre-2003 and post-2003 contracts, it believed that a pay uplift of no more than 2.5 per cent would be sufficient in 2006-07 to maintain the current healthy recruitment and retention position and continue to motivate staff. Following the Secretary of State's oral evidence to us, she subsequently wrote on 19 December 2005 to confirm that the Department was now seeking an uplift of 1.0 per cent, as previously outlined in chapter two of our report. The Department said it estimated that this uplift would result in an average earnings growth of around 4.6 per cent. The N**ational Assembly for Wales** concurred with this revised recommendation.

8.60 The **SEHD** said that remuneration and working conditions had greatly improved for consultants and it believed that remaining recruitment and retention pressures were to do with a misalignment between supply and demand and the availability of attractive posts in terms of professional content. The key focus should therefore be on more effective workforce planning that produced a healthy supply of candidates in the future, coupled with service redesign that ensured Scotland could offer sufficiently attractive jobs. It said it fully concurred with the Department of Health's revised position of a general uplift for consultants of no more than 1.0 per cent.

8.61 **NHS Employers** said that some employers had indicated that service developments had already been curtailed to meet the costs of the consultant contract. Any further unfunded pay award would have a serious impact on further service developments and services would have to be cut. It was seeking the same percentage increase this year for those on the 'old' and the 2003 contracts. In its original written evidence, NHS Employers said that a pay uplift of 2.5 per cent "in line with inflation targets" was the most that it could support. In supplementary evidence following the Secretary of State's letter of 19 December 2005, NHS Employers said that it had no further comments, but reminded us that its position was that on grounds of equity, employers had said that all staff should receive the same pay award. Its original written evidence had called for an uplift of not more than 2.5 per cent, but some employers took the view that in the current financial situation, an even lower award than 2.5 per cent would be more appropriate. The figure of not more than 2.5 per cent had originally been used because this was the upper limit of any inflation rates at the time, but inflation had subsequently fallen and was now forecasted to be nearer 2.0 per cent in 2006. There was a general consensus amongst employers (from its survey) that a pay award of not more than inflation was "affordable". Employers felt that an uplift of not more than inflation was an appropriate balance between affordability and the need to recruit and retain staff.

8.62 The **BMA** challenged as misleading the Department of Health's example of the growth in earnings for a new consultant appointed on 1 April 2001. The BMA said that allowing for the pay progression that individual would have received under the old contract, the new contract had only provided an increase of £1,241 (or 1.7 per cent) at 1 April 2005 above the old contract.

8.63 The BMA said that it had discussed the possibility of agreeing a new long-term pay deal for consultants with NHS Employers and that it had been keen to reach such an agreement, which both sides agreed with in principle. However, the BMA's impression was that NHS Employers was uncomfortable with making a deal specifically for consultants and so it had not been possible to make progress. As for our recommendations last year, consultants had been disappointed that we had again recommended a lower increase in pay for those choosing to remain on the old contract and this had prompted calls for the BMA to reconsider its involvement with the review process. The BMA said it felt strongly that this year we should recommend an equal award to all consultants regardless of their contracts, as varying awards only served to lower morale and increase resentment amongst consultants. As stated in its evidence in chapter two, the BMA said that the remit groups (including consultants) would need to receive a minimum increase in pay of 4.5 per cent from 1 April 2006 if they were to avoid losing grounds against comparators.

8.64 We were reminded that the effect of the Welsh consultant contract would need to be given appropriate consideration. Morale amongst Welsh consultants was falling with the situation unlikely to improve. For these reasons, an equal pay rise for consultants in England and Wales was requested.

8.65 The BMA said that consultants were particularly keen that this year we should address the decreasing pay differential between consultant and general practitioner remuneration with a view to avoiding any detrimental effect this could have on recruitment and retention of hospital doctors. Having indicated earlier in its general evidence (*see chapter two*) that pay comparisons were a major part of its evidence for this review, the BMA discussed in some detail the concerns of consultants about their current position, including what they saw as the decreasing pay differential between themselves and GMPs. On whatever basis the comparison was made, the BMA said this differential had narrowed since 2002-03. The relativities had historically recognised the training differences between the two groups and the BMA commented that unlike most GMPs, consultants still retained 24-hour responsibility for their patients.

8.66 The BMA said that this falling differential and the possible overlap with SpR earnings could be addressed in a number of ways. The BMA suggested that removing the lowest two points on the consultant salary scale and adding them to the top would move towards re-establishing the previous GMP/consultant differential. The BMA said it wanted to make clear that removing the two lowest points and introducing a new higher point were not dependent on each other and that either could be done independently. We were also requested to increase the rate payable for additional PAs (APAs) over the standard ten. This would be a financial disincentive to employers taking advantage of the low cost of the APAs worked by a majority of consultants compared to taking on new staff, and act as a stimulant towards further increasing the number of consultants. The BMA said that the banding system for juniors had helped to reduce their working hours and a higher rate for APAs would help reduce consultants' hours. Furthermore, premium time rates for non-medical staff in the NHS under *Agenda for Change* roughly equated to time and a half, whereas consultants received time and a third. Finally, the BMA argued that on-call supplements should be increased to more properly recognise the disruption of being on-call and focus employers on removing all but the most essential consultants from the need to be on-call. It considered that the removal of the obligation on GMPs to work on-call strengthened its case here for consultants. The BMA reminded us that results from its September 2004 survey had shown that around 72 per cent of consultants were on the category A^2 supplement and 26 per cent on category B. The Department of Health's survey on contract implementation carried out in October showed an average of 68 per cent on category A and 25 per cent on category B. The BMA said it was the position of NHS Employers that consultants on category B were required to return to work immediately and if this was their case, there seemed little point in category B existing.

8.67 Asked why the desired level of pay differentials with GMPs had not been achieved in the contract negotiations, the BMA said that it had sought significant improvements to consultant earnings throughout the negotiations, but the extent of the improvement had been restricted by the Department of Health's financial envelope. Although it was possible to identify an historical position where differentials were stable, this was problematical with the present arrangements as the reference points no longer existed in their past form and the nature of the work was different, most obviously so in general practice. As far as GMPs were concerned, gross income now related to the practice and depended on patient demographics and the range of primary care work undertaken – including out of hours and enhanced services. Net profit per GMP then depended on expenses and future incomes were uncertain. The BMA said that for consultants, the restoration of something close to the historic

position was a major objective and we should seek to identify a benchmark equivalent to historic Intended Average Net Income for GMPs to which consultant pay could be compared for this purpose. Consultants felt that it was important that their longer training period and increased specialist knowledge was recognised by an appropriate differential with GMP principals – historically this had been recognised and the BMA said there appeared to be no reason why this should not remain the case.

8.68 The BMA's response to the Department of Health's revised position on the pay uplift for consultants is set out in detail in chapter two of the report. In summary, the BMA said that structured pay progression and payment for additional work done were an integral part of the 2003 contract package, not factors to be deducted from the annual pay awards. The BMA said that it deeply regretted the pressure that was being brought to bear on us by the repeated intervention of Cabinet ministers, pressure that was unacceptable and incompatible with the review body system. The BMA said that its members would expect us to ignore such interventions.

8.69 The **Department of Health** commented that the payscale had been agreed with the BMA as part of the consultant contract package. The 2003 consultant contract had a higher starting salary than the pre-2003 contract and the Department of Health said that neither it nor the other Health Departments saw a case for removal of the lowest two points on the consultant scale or the addition of points to the top of the scale. The new contract already delivered a good level of remuneration which the Department said it believed was an appropriate level for the role undertaken. The BMA was comparing the total pay of SpRs with basic pay for consultants, but SpRs earned in excess of basic pay due to additional hours worked. The consultant contract was based on remuneration for work done – the basic salary for whole-time consultants reflected a commitment of ten PAs per week. The contract and the associated pay arrangements had only recently been implemented – relativities had been known at the time that agreement was reached. The responsibilities of SpRs and consultants had not changed since then. The Department said that premium time rates for consultants had also been agreed with the BMA as part of the consultant contract package.

8.70 The **SEHD** said that it noted the BMA's request that consultants should be awarded a greater than inflation increase. The SEHD said that consultants had received substantial increases in pay since the introduction of the new contract. In Scotland, the most recent survey of the total consultant paybill (excluding employers' costs) had shown an increase of over 30 per cent over two years (2004-05 costs compared with 2002-03) once pay inflation was included. This excluded any increases in discretionary points and distinction awards. The SEHD said it was therefore firmly of the view that the proposed increase outlined in the Health Departments' evidence was fair and balanced affordability with the continuing requirement to secure sufficient levels of recruitment and retention. The SEHD said that it supported the Department of Health's response to the BMA's proposal to remove the lowest two points on the consultant payscale. When comparing like for like with SpRs, there was still a clear differential in pay. With regard to premium time rates, the SEHD said that the rates were very recently agreed with the BMA as part of the overall package of measures comprising the new contract, which had included a substantial increase in pay and other benefits. In considering these premium rates, the SEHD said that it was important to recognise the range of benefits delivered through the overall package.

8.71 **NHS Employers** said that the latest available data on the percentage of consultants working in Category A on-call and category B were from last year's Department of Health survey (68.1 per cent and 24.9 per cent respectively). The next survey results were due in the New Year 2006. The main contract was structured around PAs which had a nominal timetable value of four hours, or three hours for work undertaken in premium time. These arrangements had formed a fundamental part of the contract which had been negotiated and agreed with the BMA. NHS Employers confirmed that it had been uncomfortable about making a commitment to a deal specifically for consultants as employers had made clear their preference for all groups to be included in a multi-year agreement.

Comment

8.72 *We note that the parties wish us to recommend the same pay uplift across all three countries for consultants on both the pre and post-2003 contracts. Beyond that, we have been urged to very different conclusions by the parties this year. In proposing a 1.0 per cent pay uplift for consultants, the Health Departments are asking us to bear in mind the effect of earnings growth for consultants on the post-2003 contract and also the current funding difficulties faced by some NHS trusts. In proposing a 4.5 per cent minimum pay uplift, the BMA is asking us to maintain the improved earnings position of consultants against their comparators by recommending the average earnings increase for the economy as a whole (when the BMA submitted its evidence in October 2005). We noted in chapter two that our own assessment of how the pay of our remit groups compares with that of other professions supported the findings of the BMA that the remuneration of our groups compares well with that of comparators.*

8.73 *We also set out in detail in chapter two our views on the Departments' arguments about pay drift and the basis on which we have considered the pay uplift recommendations for our remit groups this round.*

8.74 *In summary, in reaching our view on the appropriate level of the pay award for consultants, we have taken into account the available evidence on recruitment, retention and morale, affordability, the pay position of consultants in the labour market and how to protect the value of their current pay.*

8.75 *Taking all these factors into account,* ***we recommend*** ***(recommendation 20)*** ***an increase of 2.2 per cent for 2006-07 on the national salary scales/pay thresholds for the pre-2003 and post-2003 consultant contracts.*** *The recommended pay scales and pay thresholds are set out at Appendix A.*

8.76 *The BMA has also made proposals to change various pay elements of the new contract. We said in chapter one that it is still too early to reach a fully informed view about the true impact of the new consultant contract. A strong evidence base is necessary before we consider changing what only began to be implemented in 2003. We do not believe that the available evidence demonstrates a need to make the changes proposed by the BMA and we would have serious concerns about their affordability at this time. Changes might be warranted in the future, but we would need to see robust evidence to support them.*

8.77 *We note the BMA's concern about what it describes as the decreasing pay differential between consultants and GMPs which has resulted from the implementation of their respective contracts. The BMA has also proposed that we should identify a benchmark equivalent to historic Intended Average Net Income for GMPs to which consultant pay could be compared. We have no evidence on which to make a judgement about whether the previous differentials were right and we have been given no evidence on which we could make a proper assessment of the appropriateness of the current level of pay differentiation between GMPs and consultants. We can therefore only make observations for now. If the parties believe that a certain level of pay differentiation between GMPs and consultants is justified, we would ask them to provide evidence to us for our next review, although we would have expected the recent contract negotiations to have addressed this issue, as both contracts link remuneration to work done. As GMPs' incomes now depend very heavily on local circumstances and individual decisions, the notion of establishing a measure of average GMP remuneration is not realistic. Job evaluation is one possible approach to establishing the respective job weights of GMPs and consultants. We would ask the parties for their views on this if the issue remains a concern for the next round.*

CHAPTER 9 – STAFF AND ASSOCIATE SPECIALISTS/NON-CONSULTANT CAREER GRADE DOCTORS AND DENTISTS

Introduction

9.1 *Once again this year, we have adopted "staff and associate specialist/non-consultant career grade" (SAS/NCCG) for the purposes of this chapter while we await the outcome of discussions between the parties about a new generic title. The title "SAS/NCCG" 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 2006-07 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, where appropriate, are set out in chapter three of the report.*

9.2 *The numbers of SAS/NCCG staff in each group as at September 2004 is shown below:*

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

	Full-time equivalent	Headcount
Associate specialists	2,380	2,670
Staff grades	5,820	6,380
Hospital practitioners	350	1,250
Clinical assistants	1,400	4,440
Trust grade doctors	1,250	1,330
Senior clinical medical officers	320	480
Clinical medical officers	210	350
Other medical staff	80	260
Total	**11,810**	**17,160**

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

Source: *Health and Social Care Information Centre*

9.3 *At the time of submitting our report, the parties are continuing their negotiations to introduce new contractual arrangements for the main grades in the SAS/NCCG group. The aim is for these to be in place from 1 April 2006. The parties' evidence on the scope and progress of the negotiations is summarised later in this chapter. We hope that the parties will be able to meet their deadline, but if there is any slippage, that it will not be too great and that the parties will continue to work together to secure a positive outcome for both the practitioners and the NHS.*

9.4 *In view of the current contract negotiations, the evidence submitted by the parties for this review is much briefer than usual as the main issues of concern to the BMA in recent years regarding pay are being discussed as part of those negotiations. Our consideration of the evidence that the parties have submitted is set out below, after summaries of their evidence.*

Recruitment, retention and morale

9.5 The **Department of Health** reported that in Great Britain in 2004, associate specialist and staff grade numbers had increased by 7.2 per cent (whole-time equivalent – wte). This group of staff comprised nearly nine per cent of total wte staff in post in the HCHS population for Great Britain in 2004. In England, numbers had increased by 5.6 per cent (wte) in 2004. There was no evidence of any general recruitment and retention problems in the grades. The implementation of *Modernising Medical Careers* (*MMC*) would offer these doctors more opportunities to undertake further training and progress their careers.

9.6 The **National Assembly for Wales** reported that associate specialist and staff grade numbers had increased by 18.1 per cent (wte) in 2004. SAS/NCCGs comprised approximately 22 per cent of the hospital medical workforce in Wales, in terms of headcount. Associate specialists and staff grade doctors made up the vast majority of whole-time equivalent SAS/NCCGs on National Terms and Conditions. When compared to headcounts, clinical assistants, hospital practitioners and other Community Health Service Staff had relatively small wtes, which indicated that there were a significant number of part-time workers in those grades.

9.7 The **Scottish Executive Health Department** (SEHD) reported that associate specialist and staff grades had increased in 2004 by 1.7 per cent (wte).

9.8 The **British Medical Association** (BMA) reminded us of the underlying problems facing this group of doctors, and of their consequent low morale, which had all been highlighted in the BMA's survey of July 2004. The BMA fully agreed with NHS Employers' report that a key benefit of reform would be improved morale and motivation.

Comment

9.9 *We note the continued growth in SAS/NCCG numbers in 2004, although the rate of growth varied quite considerably across the three countries. At the moment, we are unsure of the exact size of the SAS/NCCG workforce working on national terms and conditions and those working on local contracts, and we would find this breakdown helpful in monitoring the position of this latter group of staff. We would ask the parties to consider how they can provide this information in the future. We note that this year figures for the number of trust grade doctors in Great Britain have been provided from the HCHS census, but we are unsure as to the accuracy of these figures as we understand that census data are collected on the basis of payscale rather than job title and as many trust grade doctors are on similar scales to either a SHO or a specialist registrar they could also be counted in the census in these groups. We consider it important to classify the staffing groups accurately so that everyone can monitor trends in the different staff groups. As we said last year, because there are no recruitment targets for this group of staff, we are unable to judge whether the growth rates from year to year and from country to country give any cause for concern. However, we know from the views heard on our visits and from the oral evidence given by the Health Departments and NHS Employers that SAS/NCCGs are a very important staffing resource. We very much hope therefore that the current negotiations will deliver pay, terms and conditions which support improved service delivery for the NHS and also the recruitment, retention and morale of these doctors and dentists. We would ask the parties to provide further evidence for our next review.*

Reform of SAS/NCCGs and new contractual arrangements

9.10 The **Department of Health** reminded us that up to £75 million had been agreed for a new SAS/NCCG contract and that NHS Employers had been asked to negotiate new contractual arrangements with the BMA to be implemented from April 2006. The negotiations had commenced in May 2005 and were still underway. They did not extend to trust grade (or non-standard grade) doctors who were employed on local contracts. The basic pay and terms and conditions of employment for non-standard grade doctors were broadly similar to comparable training grades. The Department said that it was not aware of any compelling problems with the way these doctors were paid, or with their contracts of employment. The Department had previously suggested that any issues of concern were likely to be addressed by policy initiatives already being put in place – in particular *MMC* and the contractual negotiations for SAS/NCCG doctors. Doctors appointed to SAS/NCCG grade posts would be on the national terms and conditions agreed for those grades. It would continue to remain open to NHS trusts to use local contracts where appropriate to local needs. These contracts, together with remuneration, were entirely local matters. The Department said that our recommendations applied to doctors employed on national terms and conditions of service.

9.11 The Department also reminded us that a key strand of *MMC* was the parallel reform of the SAS/NCCGs and that it was committed to providing greater opportunities for these doctors. However, reform must be closely linked to three initiatives:

- the proposed new competency-based model for specialist training which explicitly mapped the competencies to be acquired through training to the skills required to practise in service (SAS/NCCG) posts, facilitating movement into and out of training;

- the ongoing negotiations over new contractual arrangements for SAS/NCCGs; and

- the impact of the Postgraduate Medical Education and Training Board (PMETB).

9.12 The legislation establishing PMETB provided a new flexibility when assessing a doctor for the Specialist Register (and for the new GMP Register) which would allow the totality of a doctor's experience, training and qualifications to be considered together. PMETB would be able to prescribe "top-up" training in order to overcome any perceived deficiency. The Department noted that there would be workforce planning implications here.

9.13 The **National Assembly for Wales** said that a major consideration of the current review of SAS/NCCGs was that any new agreement should support service modernisation and maximise the contribution and motivation of this group for the benefit of patients.

9.14 The **SEHD** said that it was participating in the UK review of pay, terms and conditions of Staff and Associate Specialist doctors. Scottish Ministers had agreed a funding package of £5 million over three years to underpin this. The SEHD said that it wished to ensure that the review met the SEHD's goals of maximising the contribution of this staff group to the NHS through a clear competency-based career framework. The SEHD and employers were holding regular meetings with the BMA to discuss issues arising from the review.

9.15 **NHS Employers** said that Scotland and Wales were taking part in the SAS/NCCG negotiations, whilst reserving the right to employ some flexibility to accommodate different local circumstances. NHS Employers' negotiating mandate required outcomes which supported service modernisation, met employment law and were compatible with *MMC* within a pre-determined funding envelope. At this stage, NHS Employers said that it was too early to give any indication of the overall shape of a final package as the negotiations were being conducted under a 'nothing is agreed until it is all agreed' protocol. Negotiations between the parties were constructive. NHS Employers said that it estimated there were around 10,000 non-consultant career grades included in the negotiations, with around 8,000 whole-time equivalents. These numbers included the following grades – staff grades, associate specialists, clinical medical officers, senior clinical medical officers and non-GMP practising hospital practitioners and clinical assistants. It did not include trust grade doctors on local contracts as this group were not covered by the Department of Health's mandate. NHS Employers said it was aiming to develop a contract that would encourage more flexible working from doctors and that trusts would recognise the potential benefits of this and would want to offer the contract to their doctors.

9.16 The **BMA** said that the start of the negotiations on a new pay structure and terms and conditions of service for this group heralded the much needed reform of the grade and had been long overdue, as we had acknowledged in previous reports. The BMA reminded us that it had responded positively to the Department of Health's announcement in January 2005 about the negotiations, whilst highlighting the need for a properly funded contract and that negotiations must be UK-wide. The BMA said that the new arrangements must meet the concerns about career progression, lack of recognition of qualifications, skills and experience, lack of financial reward and consequent low morale amongst SAS/NCCGs. The negotiations had to produce an improved structure that was seen as a positive career choice for doctors.

9.17 The BMA said that it was the shared aim of the negotiating parties to reduce the reliance on local contracts by negotiating a sufficiently attractive national contract for adoption in place of trust grades (or equivalent) working at SAS level and non-standard career grades. By creating a flexible, attractive contract that met the needs of both doctors and trusts, it was hoped that the NHS would gain the maximum benefit from this group of doctors and that this would encourage trusts to offer the new national contract to those who were or would otherwise be, offered 'trust-grade' local contracts.

9.18 The BMA said it strongly believed that there must be adequate funding to deliver the new arrangements in each country, but it was too early to know the cost of the package. Two important aspects were to protect the value of the funding and to maintain relativities between SAS doctors and their medical colleagues.

Comment

9.19 *We do not underestimate the complexity and interaction of the various strands of reform affecting SAS/NCCGs – MMC, contractual changes and PMETB. These reforms aim to improve service delivery within the NHS and at the same time, deliver improved opportunities for SAS/NCCGs, not only in terms of pay, but in terms of career development. We very much hope that by the time of our next review, the parties are able to report good progress with each of these reforms and in particular, that new pay, terms and conditions will have been implemented.*

9.20 *Although our pay recommendations only apply to those SAS/NCCGs who are employed on national terms and conditions, we do not want to lose sight of those individuals who negotiate their own local contract with their employer. We have already asked for clarification of the numbers in this group and would also ask the parties for further evidence for our next review on any assimilation of trust grades into new pay arrangements.*

Pay recommendations for April 2006

9.21 The **Department of Health** said that it did not want to pre-judge the outcome of the new contractual arrangements for staff grades and associate specialists. Its original written memorandum of evidence proposed that the payscales for these groups should be uplifted by no more than 2.5 per cent in 2006-07. However, following the Secretary of State's oral evidence to us, she subsequently wrote on 19 December 2005 to confirm that an award of around two per cent was now being suggested for SAS/NCCGs, to maintain stability pending the planned reform in 2006. The £75 million was intended to fund the costs of new contractual arrangements for these doctors, and not their pay uplift. The **National Assembly for Wales** said that it concurred with the Department's recommendation which was also supported by the **SEHD**.

9.22 The **BMA** said that on the assumption that new contractual arrangements were agreed for April 2006 onwards, it asked us to make a pay uplift recommendation for 2006-07 in line with the uplift of at least 4.5 per cent being sought for other groups. This would ensure that the value of the baseline was retained from April 2006. We were also asked to take account of relativities with the consultants' and GMPs' pay awards in future years. Over the last few years, the BMA said that there had been a growing disparity in pay between the SAS group of doctors and their medical and dental colleagues covered by new contracts, with SAS doctors' pay lagging behind. Data was presented to illustrate this point and the BMA said that it had been exacerbated by the delays in completing the SAS review and compounded by the low increases in previous years (2.7 per cent in 2004 and 3.225 per cent from 1 April 2005). The BMA said it was not suggesting that SAS/NCCGs had an equivalent job weight to consultants and GMPs, but its evidence illustrated the historical position of staff and associate specialist doctors relative to their consultant and GMP colleagues. This clearly showed that since implementation of the new consultant and GMS contracts, the relative position of staff and associate specialist doctors had worsened in terms of remuneration. Over the same period, the BMA said that there had been no changes to any individual group of doctors in terms of hours worked or responsibility that would justify this divergence in earnings. The BMA said it was hoped that joint evidence would be submitted on the new arrangements for this group. However, if negotiations did not progress as intended and should this not be possible, the BMA intended to submit evidence to us concerning a separate pay award for this group in 2006-07.

9.23 The BMA confirmed its understanding that the cost of our award for SAS/NCCGs would not come out of the £75 million envelope set aside to fund the new contract and acknowledged that the pay award would have an effect on the cost of certain elements of the contract. Where elements were based on a percentage of basic pay, the cost in real terms would increase as basic pay was uplifted. The BMA said that in England, the £75 million envelope covered £50 million in 2006-07, £65 million in 2007-08 and £75 million in 2008-09, representing from 2008-09 ten per cent of the total pay bill for the number of whole-time equivalent SAS/NCCG doctors in England.

9.24 The BMA's response to the Secretary of State's revised position on the pay uplift for SAS/NCCGs is set out in detail in chapter two. In summary, the BMA said that whilst the Secretary of State's attempt to prioritise SAS/NCCGs was on the face of it welcome, taken in the context of her overall proposals and ongoing negotiations, it was clearly both inappropriate and inadequate. The BMA said that it deeply regretted the pressure that was being brought to bear on us by the repeated intervention of Cabinet ministers, pressure which was unacceptable and incompatible with the review body system. The BMA said that its members would expect us to ignore such interventions.

9.25 **NHS Employers** said that in the light of the work being undertaken on contract reform for this group, it was seeking an uplift to their pay range in line with the inflationary uplift sought for all other groups. Responding to the Secretary of State's revised position on the pay uplift for our remit groups, NHS Employers said that it had no further comments. As it had previously said in its general evidence, on the grounds of equity, employers had said that all staff should receive the same level of pay award. NHS Employers said that it had originally called for an uplift of not more than 2.5 per cent, but that some employers had taken the view that in the current financial situation, an even lower award would be more appropriate. The original figure of not more than 2.5 per cent had been used because at the time, this had been the upper limit of any rates of inflation. Inflation had subsequently fallen and was forecasted to be nearer 2.0 per cent during 2006. The general consensus amongst employers had indicated that a pay award of not more than inflation was "affordable". Employers had also felt that an uplift of not more than inflation was an appropriate balance between affordability and the need to recruit and retain staff.

9.26 The £75 million set aside for the negotiations related to the 2008-09 financial year. The corresponding figure for 2006-07 was £50 million and this money was for pay reform. NHS Employers said that its negotiating mandate did not state that the £50 million should cover the pay uplift for 2006-07. This would be an unreasonable expectation given that the funding for pay awards had always come from central allocations and this would take a sizeable chunk of the available funding for this group. However, NHS Employers said that any pay uplift for 2006-07 would have potential cost implications for the pay reform proposals as any allowances calculated from basic pay would become more expensive. These costs would need to be factored into the £50 million cost envelope. In the event that the negotiations did not progress as intended, NHS Employers said that it expected the BMA to continue negotiations and come to a conclusion a little later than expected. Any pay award outside that outlined in its evidence would have the effect of halting negotiations and limiting the possibility of a new contract for this group of doctors.

Comment

9.27 *The Health Departments have proposed a higher pay award for SAS/NCCGs than for other hospital doctors in order to maintain stability pending the planned contractual reform in 2006. The BMA has proposed an uplift of 4.5 per cent, in line with its proposals for other groups, to ensure that the value of the pay baseline is retained from April 2006. The proposed 4.5 per cent reflects the average earnings increase for the economy as a whole (as at October 2005 when the BMA submitted its evidence).*

9.28 *We have reached our decision about the recommendations for SAS/NCCGs for 2006-07 in the light of the developments on the contract negotiations which commenced in May 2005. We do not wish to impede those negotiations in any way and we are conscious that an award above that recommended by NHS Employers would have potential cost implications for the pay reform negotiations.*

9.29 *We set out in detail in chapter two our views on the Departments' arguments about pay drift and the basis on which we have considered the pay uplift recommendations for our remit groups this round. In summary, in reaching our view on the appropriate level of the pay award for SAS/NCCGs, we have taken into account the available evidence on recruitment, retention and morale, affordability and the pay position of our remit groups in the labour market. We are conscious of the need to consolidate the improvements in recruitment and to support continued retention of staff at a time of continuing change within the NHS.*

9.30 *Taking all these factors into account, and in recognition that other groups of doctors are already working under revised contracts, we believe that a slightly higher award is merited by this group.* ***We therefore recommend*** ***(recommendation 21)*** ***an increase of 2.4 per cent for 2006-07 on the national salary scales of SAS/NCCGs.*** *The recommended pay scales are set out at Appendix A. In the usual way, our recommendation of a 2.4 per cent increase for SAS/NCCGs will also apply to the payscales for non-GMP clinical assistants and hospital practitioners.*

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* those of equivalent full-time staff.

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

	Current scales £	Recommended scales payable from 1 April 2006[1] £
	(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)	
House officer	20,295	20,741
	21,601	22,076
	22,907	23,411
Senior house officer	25,324	25,882
	27,022	27,617
	28,720	29,352
	30,418	31,087
	32,116	32,822
	33,813	34,557[2]
	35,511	36,292[2]
Registrar	28,307	28,930
	29,741	30,395
	31,174	31,860
	32,607	33,325
	34,337	35,092
Senior registrar	32,607	33,325
	34,337	35,092
	36,067	36,860
	37,796	38,628
	39,526	40,395
	41,255	42,163
	42,985	43,931[3]

[1] As agreed with the Department of Health, NHS Employers and the professional associations, the scales for 2006-07 have been calculated as follows. Basic pay uplifts for April 2004 and April 2005 have been applied to the base scales for 2003-04 with no rounding applied at this intermediate stage; our recommended basic pay uplifts for April 2006 are then applied to this calculation and the final result is rounded up usually to the nearest pound.

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

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

	Current scales £	Recommended scales payable from 1 April 2006[1] £
Specialist registrar[4]	28,307	28,930
	29,741	30,395
	31,174	31,860
	32,607	33,325
	34,337	35,092
	36,067	36,860
	37,796	38,628
	39,526	40,395[5]
	41,255	42,163[5]
	42,985	43,931[6]
Consultant (2003 contract, England and Scotland for main pay thresholds)[7]	69,298	70,822
	71,498	73,071
	73,699	75,320
	75,899	77,569
	78,094	79,812
	83,320	85,153
	88,547	90,495
	93,768	95,831
Clinical excellence awards[8]	*Value*	
	2,789	2,850
	5,578	5,700
	8,367	8,550
	11,156	11,400
	13,945	14,250
	16,734	17,100
	22,312	22,800
	27,890	28,500
	33,468	34,200
Consultant (2003 contract, Wales)	67,130	68,606
	69,298	70,822
	72,926	74,530
	77,140	78,837
	81,951	83,754
	84,695	86,558
	87,444	89,368
Commitment awards[9]	*Value*	
	3,021	3,088
	6,042	6,176
	9,063	9,264
	12,084	12,352
	15,105	15,440
	18,126	18,528
	21,147	21,616
	24,168	24,704

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

[7] Pay thresholds and transitional arrangements apply.

[8] Local level CEAs in England. For higher national CEAs, see Part II below.

[9] Awarded every 3 years once the basic scale maximum is reached.

	Current scales £	Recommended scales payable from 1 April 2006[1] £
Consultant (pre-2003 contract)[10]	57,370	58,632
	61,545	62,899
	65,721	67,167
	69,896	71,434
	74,658	76,300
Discretionary points[11]	*Value*	
	3,021	3,088
	6,042	6,176
	9,063	9,264
	12,084	12,352
	15,105	15,440
	18,126	18,528
	21,147	21,616
	24,168	24,704
Associate specialist	34,158	34,977
	37,879	38,788
	41,600	42,598
	45,321	46,408
	49,042	50,219
	52,763	54,029
	57,676	59,061
	61,935	63,422
Discretionary points	*Notional scale*	
	63,703	65,232
	66,009	67,593
	68,315	69,954
	70,620	72,315
	72,926	74,676
	75,233	77,039
Staff grade practitioner	30,808	31,547
(1997 contract, MH03/5)	33,331	34,131
	35,854	36,714
	38,377	39,298
	40,900	41,882
	43,871	44,924
Discretionary points[12]	*Notional scale*	
	45,946	47,049
	48,469	49,632
	50,992	52,216
	53,515	54,800
	56,038	57,383
	58,562	59,968

[10] Closed to new entrants.

[11] From October 2003, local Clinical Excellence Awards (CEAs) in England and Commitment awards in Wales have replaced discretionary points. Discretionary points continue to be awarded in Scotland and remain payable to existing holders in both England and Wales until the holder retires or is awarded a CEA or Commitment award.

[12] See Twenty-Seventh Report, paragraph 2.34.

	Current scales £	Recommended scales payable from 1 April 2006[1] £
Staff grade practitioner (pre-1997 contract, MH01)	30,808	31,547
	33,331	34,131
	35,854	36,714
	38,377	39,298
	40,900	41,882
	43,423	44,465
	45,946	47,049
	48,469	49,632
	(annual rates on the basis of a notional half day per week)	
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,209	4,310
Hospital practitioner (limited to a maximum of 5 half day weekly sessions)	4,119	4,218
	4,358	4,462
	4,596	4,706
	4,835	4,951
	5,073	5,195
	5,312	5,439
	5,550	5,683

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	29,472	30,179
	31,120	31,867
	32,769	33,555
	34,417	35,243
	36,066	36,931
	37,714	38,619
	39,363	40,307
	41,011	41,996
Senior clinical medical officer	42,050	43,059
	44,669	45,741
	47,287	48,422
	49,906	51,103
	52,524	53,785
	55,143	56,466
	57,761	59,147
	60,380	61,829

C. Salaried primary dental care staff[13]

	Current scales £	Recommended scales payable from 1 April 2006[1] £
	(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)	
Band 1: Community dental officer	31,290	32,041
	33,901	34,714
	36,511	37,387
	39,122	40,061
	41,732	42,734
	44,343	45,407
	46,954	48,080[14]
	49,564	50,754[14]
Band 2: Senior dental officer	45,131	46,215
	48,781	49,952
	52,430	53,689
	56,080	57,426
	59,729	61,163
	60,534	61,987[15]
	61,338	62,810[15]
Band 3: Assistant clinical director	60,294	61,741
	61,242	62,712
	62,191	63,683
	63,139	64,654
	64,087	65,625[15]
	65,036	66,597[15]
Band 3: Clinical director	60,294	61,741
	61,242	62,712
	62,191	63,683
	63,139	64,654
	64,087	65,625
	65,036	66,597
	65,984	67,568
	66,948	68,555
	67,897	69,526[15]
	68,845	70,497[15]

[13] These scales also apply to salaried dentists working in Personal Dental Services.

[14] 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).

[15] Performance based increment, see paragraph 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 2006[1] £
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	52,835	54,103
	56,181	57,529
	59,527	60,956
	62,873	64,382
	66,948	68,555
	67,897	69,526[16]
	68,845	70,497[16]
Part-time dental surgeon:	*Sessional fee (per hour)*	
Dental surgeon	25.95	26.57
Dental surgeon holding higher registrable qualifications	34.42	35.25
Dental surgeon employed as a consultant	42.89	43.92

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

[16] 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 2006. The previous levels quoted are those currently in force.

Hospital medical and dental staff

2. The budget for national 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 distinction 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 national Clinical Excellence Awards for consultants and academic GMPs should be increased as follows.

Bronze (Level 9):	from £33,468 to £34,200
Silver (Level 10):	from £43,997 to £44,965
Gold (Level 11):	from £54,996 to £56,206
Platinum (Level 12):	from £71,495 to £73,068

4. The annual values of distinction awards for consultants[1] should be increased as follows.

B award:	from £30,145 to £30,808
A award:	from £52,750 to £53,911
A plus award:	from £71,583 to £73,158

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

Daytime supplement:	from £1,178 to £1,204	
Out-of-hours supplement	(England and Scotland)	(Wales)
Band 1:	from £887 to £907	from £2,046 to £2,091
Band 2:	from £1,769 to £1,808	from £4,092 to £4,182
Band 3:	from £2,645 to £2,703	from £6,138 to £6,273

[1] From October 2003, national Clinical Excellence Awards (CEAs) replaced distinction awards in England and Wales. Distinction awards continue to be awarded to eligible consultants in Scotland and remain payable to existing holders in both England and Wales until the holder retires or is awarded a CEA.

6. A consultant on the 2003 Terms and Conditions of Service working on an on-call rota will be paid a supplement in addition to basic salary in respect of his or her availability to work during on-call periods. This is determined by the frequency of the rota they are working and which category they come under. To determine the category the employing organisation should establish whether typically a consultant is required to return to site to undertake interventions in which case they should come under category A. If they can typically respond by giving telephone advice they would come under category B.

   The rates are set out in the table below.

Frequency of Rota Commitment	**Value of supplement as a percentage of full-time basic salary**	
	Category A	**Category B**
High Frequency: 1 in 1 to 1 in 4	8.0%	3.0%
Medium Frequency: 1 in 5 to 1 in 8	5.0%	2.0%
Low Frequency: 1 in 9 or less frequent	3.0%	1.0%

7. The following non-pensionable multipliers apply to the basic pay of whole-time doctors and dentists in training grades:

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

8. Under the 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.

9. A new payment system was introduced in Summer 2005 for flexible trainees working less than 40 hours of actual work per week, where basic pay is calculated as follows:

	Proportion of full time basic pay
F5 (20 or more and less than 24 hours of actual work)	0.5
F6 (24 or more and less than 28 hours of actual work)	0.6
F7 (28 or more and less than 32 hours of actual work)	0.7
F8 (32 or more and less than 36 hours of actual work)	0.8
F9 (36 or more and less than 40 hours of actual work)	0.9

10. Added to the basic salary identified above in paragraph 9 is a supplement to reflect the intensity of the duties.

$$\text{Total salary} = \text{salary}^* + \text{salary}^* \times \begin{matrix} 0.5 \\ 0.4 \\ 0.2 \end{matrix}$$

* salary = F5 to F9 calculated above.

The supplements will be applied on the basis as set out below

Band	**Supplement payable as a percentage of calculated basic salary**
FA – trainees working at high intensity and at the most unsocial times	50%
FB – trainees working at less intensity at less unsocial times	40%
FC – all other trainees with duties outside the period 8 am to 7 pm Monday to Friday	20%

11. The fee for domiciliary consultations should be increased from £75.55 to £77.21 a visit. Additional fees should be increased *pro rata*.

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

Associate specialist, senior hospital medical or dental officer appointment	from £904.86 to £926.64 per week; from £82.26 to £84.24 per notional half day.
Specialist registrar LAS appointment	from £675.20 to £690.00 per week; from £16.88 to £17.25 per standard hour.
Senior house officer appointment	from £583.60 to £596.40 per week; from £14.59 to £14.91 per standard hour.
House officer appointment	from £414.40 to £423.60 per week; from £10.36 to £10.59 per standard hour.
Hospital practitioner appointment	from £92.71 to £94.96 per notional half day.
Staff grade practitioner appointment	from £760.20 to £778.50 per week; from £76.02 to £77.85 per session.
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)	from £80.72 to £82.66 per notional half day.

13. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

London Weighting

14. The value of the London zone payment[3] is £2,162 for non-resident staff and £602 for resident staff.

Ophthalmic medical practitioners

15. The ophthalmic medical practitioners' gross fee for sight testing should be set in negotiations between the parties.

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

[3] See paragraph 2.26 of this report.

Doctors in public health medicine

16. The supplements payable to district directors of public health (directors of public health in Scotland and Wales) and for regional directors of public health should be increased as follows[4]:

	Current range of supplements £	Recommended range or supplements payable from 1 April 2006 £
Island Health Boards: Band E (under 50,000 population)	1,625 – 3,224	1,661 – 3,295
District director of public health		
(director of public health in Scotland/Wales):		
Band D (District of 50,000 – 249,999 population)	3,224 – 6,447 (Bar); 8,061	3,295 – 6,589 (Bar); 8,239
Band C (District of 250,000 – 449,999 population)	4,044 – 8,061 (Bar); 9,686	4,133 – 8,239 (Bar); 9,899
Band B (District of 450,000 and over population)	4,838 – 9,686 (Bar); 12,494	4,944 – 9,899 (Bar); 12,769
Regional director of public health: Band A:	12,494 – 18,136	12,769 – 18,535

General medical practitioners

17. The supplement payable to GMP registrars for out of hours duties is 65 per cent [5]of basic salary for 2006-07.

18. The salary range for salaried GMPs[6] employed by Primary Care Organisations should be £50,332 to £76,462 for 2006-07.

General dental practitioners

19. The gross earnings base under the new GDP contracts in England and Wales should be increased by 3.0 per cent from 1 April 2006. An uplift of 3.0 per cent also applies to gross fees from 1 April 2006 in Scotland.

20. The sessional fee for practitioners working a 3-hour session under Emergency Dental Service schemes should be increased from £108.74 to £112.01.

21. 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 £76.98 to £79.29.

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

[5] See paragraph 3.44 of this report.

[6] See paragraph 3.36 of this report.

22. The hourly rate payable in relation to the Continuing Professional Development allowance and for clinical audit/peer review should be increased from £59.32 to £61.10.

23. The quarterly payments under the Commitment Payments scheme[7] should be increased as follows:

Level 1 payment	from £40 to £42 per quarter
Level 2 payment	from £336 to £347 per quarter
Level 3 payment	from £434 to £448 per quarter
Level 4 payment	from £521 to £537 per quarter
Level 5 payment	from £607 to £626 per quarter
Level 6 payment	from £692 to £713 per quarter
Level 7 payment	from £780 to £804 per quarter
Level 8 payment	from £867 to £894 per quarter
Level 9 payment	from £953 to £982 per quarter
Level 10 payment	from £1,039 to £1,071 per quarter

Community health and community dental staff

24. The teaching supplement for assistant clinical directors in the CDS should be increased from £2,227 to £2,276 per year.

25. The teaching supplement payable to clinical directors in the CDS should be increased from £2,515 to £2,570 per year.

26. The supplement for clinical directors covering two districts should be increased from £1,625 to £1,661 per year and the supplement for those covering three or more districts should be increased from £2,595 to £2,652 per year.

27. The allowance for dental officers acting as trainers should be increased from £1,780 to £1,819 per year.

28. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

[7] GDPs in Scotland are eligible for these payments. In England and Wales, commitment payments are subsumed in base contract values. To calculate 2006-07 payments, an uplift of 3.0 per cent has been applied to 2005-06 payments and the result rounded up to the nearest pound.

APPENDIX B

NUMBERS OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE[1] IN GREAT BRITAIN

	2003		2004		Percentage change 2003-2004	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital medical and dental staff[2,3]						
Consultants	30,231	32,799	32,443	34,916	7.3%	6.5%
Associate specialists	2,072	2,336	2,377	2,667	14.7%	14.2%
Staff grade	5,572	6,104	5,824	6,380	4.5%	4.5%
Registrar group	15,438	16,069	17,787	18,440	15.2%	14.8%
Senior house officers	21,475	21,744	23,407	23,722	9.0%	9.1%
House officers	5,006	5,016	5,277	5,292	5.4%	5.5%
Hospital practitioners	267	1,230	347	1,254	29.8%	2.0%
Clinical assistants	1,287	4,908	1,401	4,439	8.8%	–9.6%
Trust Grade Doctors	1,170	1,278	1,251	1,331	7.0%	4.1%
Total	**82,518**	**91,484**	**90,113**	**98,441**	**9.2%**	**7.6%**
Public health and community medical staff[2]						
Regional and district directors	244	270	237	249	–2.6%	–7.8%
Consultants	506	654	647	794	27.8%	21.4%
Registrar group	286	313	287	309	0.0%	–1.3%
Senior house officers	36	36	31	31	–13.8%	–13.9%
Senior clinical medical officers	409	593	322	478	–21.4%	–19.4%
Clinical medical officers	230	487	211	351	–7.9%	–27.9%
Other medical staff	45	223	75	264	65.7%	18.4%
Total	**1,756**	**2,576**	**1,810**	**2,476**	**3.1%**	**–3.9%**
Community dental staff[2]						
Regional and district dental officers/clinical director	88	95	90	95	1.8%	0.0%
Assistant district dental officers/clinical director	52	56	47	51	–8.9%	–8.9%
Consultants	48	69	55	74	16.5%	7.2%
Senior dental officers	428	541	498	621	16.4%	14.8%
Dental officers	779	1,078	821	1,082	5.4%	0.4%
Other staff	54	101	68	123	26.9%	21.8%
Total	**1,448**	**1,940**	**1,579**	**2,046**	**9.1%**	**5.5%**

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

	2003		2004		Percentage change 2003-2004	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General practitioners[4,5]						
General medical practitioners:	**35,875**	**40,021**	**36,805**	**41,322**	**2.6%**	**3.3%**
Contracted GPs	31,586	34,239	31,323	34,332	–0.8%	0.3%
GMS Contracted GPs	21,961	23,748	21,747	23,805	–1.0%	0.2%
PMS Contracted GPs	9,625	10,491	9,577	10,527	–0.5%	0.3%
GMS GP registrars[6]	1,731	1,800	1,922	2,011	11.1%	11.7%
PMS GP registrars[6]	793	826	905	948	14.1%	14.8%
GP retainers[7]	399	1,252	357	1,049	–10.6%	–16.2%
GMS Other	603	917	1,164	1,509	93.1%	64.6%
PMS Other	763	987	1,133	1,473	48.5%	49.2%
General dental practitioners:[2]	–	**22,702**	–	**23,241**	–	**2.4%**
principals	–	19,555	–	18,824	–	–3.7%
assistants and vocational practitioners	–	2,146	–	2,002	–	–6.7%
Personal Dental Services[8]	–	806	–	2,171	–	169.4%
salaried dentists[9]	–	195	–	244	–	25.1%
Ophthalmic medical practitioners[10]	–	**644**	–	**613**	–	**–4.8%**
Total	–	**63,367**	–	**65,176**	–	**2.9%**
Total – NHS doctors and dentists	–	**159,367**	–	**168,139**	–	**5.5%**

[1] The table contains full-time equivalent (FTE) 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 FTE) hospital dental staff compared with 2,803 (2,095 FTE) in 2004.

[4] England and Wales FTE data have been estimated using the results from the 1992-93 GMP Workload Survey. For 1994-2003 – Full time = 1.00 fte; three quarter time = 0.69 fte; job share = 0.65 fte; and half time = 0.60 fte.
For 2004 – All GPs: Full time 1.00 fte; Part time = 0.60 fte, and therefore may not be comparable with previous years.
FTE GP Retainers have been estimated using a factor of 0.12 per session for 1994-2004. In 2002, Scottish Non-Principals do not have FTE 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] GMP Registrars were formerly known as GMP trainees.

[7] 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.

[8] In 2003, 390 dentists worked in Personal Dental Services (PDS) but also had a General Dental Services (GDS) contract and in 2004 there were 701 dentists who worked in PDS but also had a GDS contract. Most of these would appear in the general dental practitioner principals row. These are excluded from PDS figures to avoid double counting. There are no PDS schemes in Scotland.

[9] Data as at 30 September except Scotland as at 31 March 2003. As a result of improved data, salaried posts in Scotland not previously recognised as active have now been classified as active. Data includes dentists who hold both salaried and non-salaried list numbers in the GDS.

[10] Data as at 31 December for England and Wales and 31 March for Scotland.

APPENDIX C

THE 2005-06 SETTLEMENT

In our Thirty-Fourth Report we put forward recommendations on the level of remuneration we considered appropriate for doctors and dentists in the NHS as at 1 April 2005. Our main recommendations were:

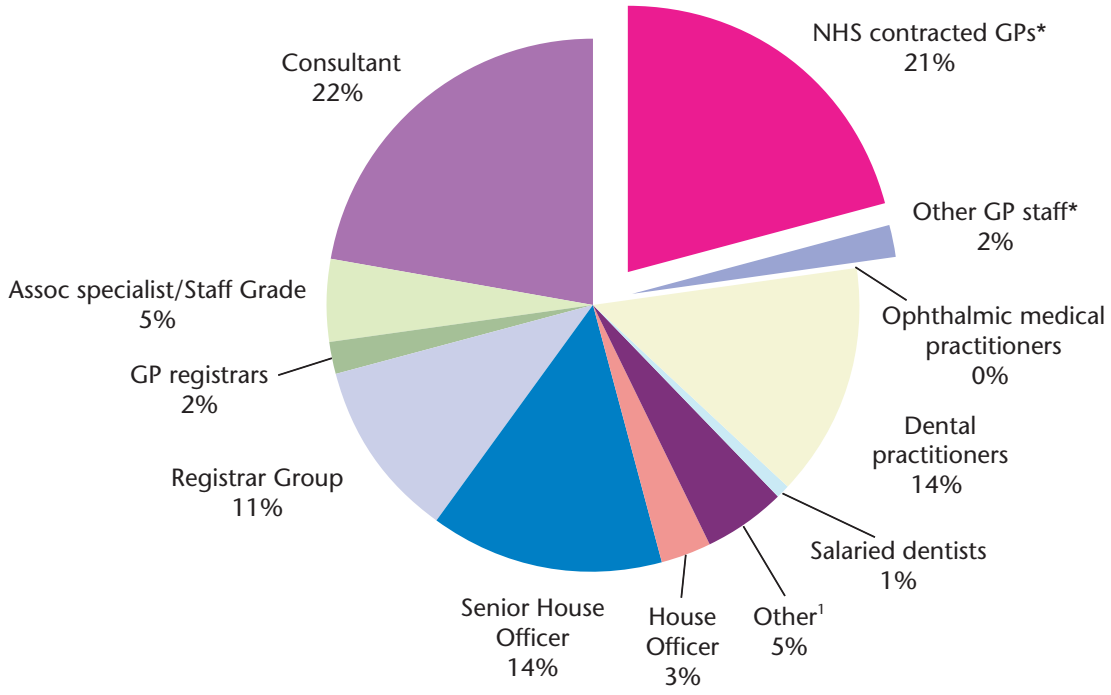
- an increase of 3.0 per cent for all grades of doctors and dentists in training;
- an increase of 3.225 per cent for associate specialists, staff grade practitioners, hospital practitioners and clinical assistants;
- an increase of 3.0 per cent for consultants remaining on the "old" national contract; and
- an increase of 3.4 per cent for general dental practitioners (on gross fees).

The Government accepted in full our recommendations relating to 2005-06.

APPENDIX D

DDRB STAFF GROUPS UNDER CONSIDERATION FOR 2006-07

Total: 168,139 headcount, Great Britain



* Not being considered for 2006-07 Review.

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

Source: *NHS Health and Social Care Information Centre*, Medical and Dental Census. September 2004

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], *HR in the NHS Plan*[2] and *Our health, our care, our say: a new direction for community services*[3] covering England;

    - *Our National Health, A Plan for Action, A Plan for Change*[4], *A Partnership for a Better Scotland: Partnership Agreement*[5], *Building A Health Service Fit For The Future*[6], *Fair to All, Personal to Each – The Next Steps for NHS Scotland*[7], the *National Workforce Planning Framework 2005*[8] and *Healthy Working Lives*[9] covering Scotland;

    - *Improving Health in Wales – A Plan for the NHS with its partners*[10], *Delivering for Patients*[11], the Wanless Report *Implementation Plan*[12], *Building for the Future*[13] and *Designed for Life*[14] in Wales; and

    - *Modernising Medical Careers*[15].

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:

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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 health, our care, our say: a new direction for community services* published by the Department of Health in January 2006.

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

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 Health Service Fit For The Future* published by the Scottish Executive in May 2005.

7 *Fair to All, Personal to Each – The Next Steps for NHS Scotland* published by the Scottish Executive in December 2004.

8 *National Workforce Planning Framework 2005* published by the Scottish Executive in August 2005.

9 *Healthy Working Lives, A Plan for Action* published by the Scottish Executive in August 2004.

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

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

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

13 *Building for the Future* published by the Welsh Assembly in March 1999.

14 *Designed for Life* published by the Welsh Assembly in May 2005.

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

- 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* have 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.

4. In January 2006, the Department published a White Paper, *Our health, our care, our say: a new direction for community services*. It set out proposals for providing people with good quality social care and NHS services in the communities where they live.

5. In Scotland, *Building A Health Service Fit For The Future* set out a framework for service change over the next 20 years, with a health service anchored in communities, built on fully integrated services, more responsive to the healthcare needs of an ageing population. *Fair to All, Personal to Each – The Next Steps for NHS Scotland* outlined enhanced targets for access to health services in Scotland, such as no patient waiting more than 18 weeks from GP referral to outpatient appointment. The *National Workforce Planning Framework 2005* built on the 2004 baseline report, supporting workforce planning at NHS Board and regional level. *A Partnership for a Better Scotland: Partnership Agreement* contained a number of targets relating to the medical and dental workforce. Details of staff governance documents were provided, such as *Healthy Working Lives* which presented an action plan to make NHS Scotland the employer of choice.

6. In Wales, *Designed for Life* set out the vision for the next ten years, continuing along the path set out in *Improving Health in Wales* and *Building for the Future*. It recognised that health services in Wales would in the coming years be more explicitly organised around three regional networks, and required a restructuring of the workforce, new ways of working, changes in practice and improved efficiency, as well as greater support for carers and for supporting service users to do more for themselves.

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

LETTER OF 19 DECEMBER 2005 FROM SECRETARY OF STATE FOR HEALTH TO MICHAEL BLAIR QC, CHAIRMAN OF DDRB

From the Rt Hon Patricia Hewitt MP
Secretary of State for Health

DH Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000

IMC 40515

Mr Michael Blair QC
Chair of Doctors and Dentists Pay Review Body
Office of Manpower Economics
7th Floor Oxford House
76 Oxford Street
London
W1N 9FD

19th December 2005

Dear Mr Blair,

I was pleased to have the opportunity to meet with the review body on the 12th December and to give evidence in person. As promised, I am writing to confirm our position, as I outlined at the session.

There is a great deal in our evidence to be positive about. For example, we have seen the number of doctors increase by 29% since 1997; that is over 24,000 more doctors in the NHS. Vacancy rates are on a downward trend, with a three-month vacancy rate for consultants at 3.3%. In addition, there is an increase in the number of medical students. We are also seeing more dentists recruited to the NHS, with a net increase of 1,100 in the last 12 months.

In our written evidence submitted in September, we recommended an award of no more than 2.5%. This was followed by supplementary written evidence informing you that we were reviewing the appropriateness and affordability of this in the light of further evidence of earnings growth and associated cost pressures.

We now have a better understanding of the earnings position. Following our written evidence in September we looked again at the earnings data (based upon NHS Trust Financial Returns and the NHS Workforce Census) and saw a consistent growth in average earnings for medical staff in the NHS from 2001/02 to 2003/04. Our estimates show that, yet again, this is going to be higher than the national average (around 4%) at approximately 5.8% for 2005/06. The trend of strong earnings growth looks set to continue into 2006/07, with our latest estimates that even with no uplift, earnings growth would be 3.6%, and at 2.5% uplift earnings growth could exceed 6%.

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JE161204

As the Chancellor made clear in his letter to Review Body chairs on 23rd November, there is concern that the recent short-term increase in inflation, caused mainly by oil price rises, could become locked-in if employers respond with higher wage rises. This was followed by his Pre-Budget Report where he re-iterated that the UK is on course to meet its inflation target of 2%.

It is important that public sector pay settlements do not contribute to inflationary pressure in the economy. Public sector earnings growth in recent years has been above the private sector.

In 2004/5, around 170 NHS organisations finished the year with a combined deficit of £760m. Overall, the NHS finished the year in deficit by £250m. Unfortunately, it has become clear that a significant minority of NHS organisations are continuing to struggle to achieve financial balance this year and it is likely that a number will again finish the year in deficit. These deficits will be the first call on resources next year and will, therefore, impact on the affordability of pay awards. The issue of deficits is a real problem and one that we would ask you to take into account in your recommendations.

Turning to dentistry, the issues are somewhat different. A committed NHS dentist earns around £80,000 per year. The BDA has consistently made the point that it is not levels of pay that discourage dentists from working in the NHS, but the 'treadmill' effect of the fee-per-item payment system.

Our reforms will abolish the fee-per-item treadmill once and for all. The evidence of Personal Dental Services pilots show that the average items of service undertaken within each course of treatment have fallen by around 30%. This means a huge change in working practices. It will clearly free up time for dentists to adopt a more preventative approach to dental care and it will reduce workload. We also expect it to reduce practice expenses significantly. This means that a gross award of up to 2.5% (as requested in our evidence) will feed through into an increase in net pay of over 2.5%.

As I indicated, we have also now reached a view on the financial envelope for the negotiations that we have asked NHS Employers to take forward with the British Dental Association to reform pay arrangements for salaried primary care dentists. I am pleased to confirm that the envelope will be 10% of the current pay bill, around £7.5 million.

In the light of the emerging deficits, and the continued evidence of strong medical earnings growth and the need to keep to the Chancellor's inflation target, we now think that there is a good case for a pay uplift this year of 1% which we estimate would result in an average earnings growth of around 4.6%.

Department of Health

However, I would make two exceptions.

- Staff and Associate Specialist Doctors – where I would suggest an award around 2%, to maintain stability pending the planned reform next year.

- Dentists - where we would support an uplift of up to 2.5%. We do not, however, see any case for a higher award than this, given the impact that we can expect from the dental reform programme in changing working practices and reducing practice expenses – and given the pay reforms that the BDA and NHS Employers will be taking forward separately on salaried dentists.

We are not singling out hospital doctors in this respect. We have just concluded an agreement with the BMA for a 0% inflation uplift for the GMS contract, and I have also given evidence to the Nurses and Other Health Professions Review Body also arguing for an award that we believe would deliver around 4.6% earnings growth next year.

I look forward to seeing your recommendations in due course.

Yours sincerely,

PATRICIA HEWITT

UK PRESIDENCY OF THE EU 2005

JE161204

APPENDIX G

DEPARTMENT OF HEALTH: GROWTH IN THE MEDICAL PAYBILL

Table 1 presents growth in the Medical paybill, paybill per head and average earnings from 2001/02 to 2006/07. Table 2 presents the figures from which the growth rates are derived.

Figures for 2001/02 to 2003/04 are derived from historical data on total expenditure by NHS Trusts (the Trust Financial Returns) and on the size of the NHS workforce (the NHS Workforce Census which takes place in September). **From 2004/05, the paybill is estimated on the basis of assumptions about settlement, pay reform and workforce growth which are applied to the 2003/04 base year**. A small adjustment is made to accommodate pay drift. Settlement has been agreed to 2005/06 (see Table 3) – for 2006/07 the tables show the effect of various settlement levels from 0% to 2.5%.

Table 1 Growth in the Medical paybill, paybill per head and average earnings from 2001/02 to 2006/07

	2001/02	2002/03	2003/04	*2004/05*	*2005/06*	*2006/07 (0%)*	*2006/07 (1%)*	*2006/07 (1.5%)*	*2006/07 (2%)*	*2006/07 (2.5%)*
1.1 Growth in Medical Paybill	14.8%	12.5%	19.0%	*3.7%*	*8.2%*	*5.5%*	*6.5%*	*7.0%*	*7.5%*	*8.1%*
1.2 Growth in Medical Paybill Per Head	11.3%	5.5%	12.4%	*6.1%*	*5.8%*	*3.6%*	*4.6%*	*5.2%*	*5.7%*	*6.2%*
1.3 Growth in Medical Earnings Per Head	9.7%	5.6%	11.5%	*6.1%*	*5.8%*	*3.6%*	*4.6%*	*5.2%*	*5.7%*	*6.2%*

Table 2 Medical paybill, paybill per head and average earnings from 2001/02 to 2006/07

	2001/02	2002/03	2003/04	*2004/05*	*2005/06*	*2006/07 (0%)*	*2006/07 (1%)*	*2006/07 (1.5%)*	*2006/07 (2%)*	*2006/07 (2.5%)*
1.1 Medical Paybill (£ billion)	4.589	5.161	6.142	*6.370*	*6.891*	*7.267*	*7.339*	*7.374*	*7.410*	*7.446*
1.2 Medical Paybill Per Head (£)	*71636*	*75604*	85000	*90146*	*95413*	*98871*	*99845*	*100332*	*100819*	*101307*
1.3 Medical Earnings Per Head (£)	60249	63640	*70952*	*75247*	*79644*	*82530*	*83343*	*83750*	*84156*	*84563*

Table 3 DDRB Headline Awards

	2001/02	2002/03	2003/04	2004/05	2005/06
DDRB	3.9	3.6	3.225	2.95 *	3.12 *

* weighted average

Caveats:

- The full effects of pay reform are still not fully understood as the workforce is still being assimilated to the new Agenda for Change system.
- Workforce supply estimates are currently being revised. These – and Trust Financial returns for 2004/05 which are almost complete – will be used to revise paybill forecasts in the near future.

APPENDIX H

BMA: GROWTH IN THE MEDICAL PAYBILL

Pay drift without changes in junior doctor banding

Number of doctors	
New graduates each year	4,500
Trainees at year 1	40,000
Leave training to become consultants each year	2,500
Consultants at year 1	30,000
Retiring consultants each year	1,000
Leave training to become GPs each year	2,000
GPs at year 1	30,000
Retiring GPs each year	1,000

Salary scales					
	PRHO	SHO	SpR	Consultant	GP
Min	19,703	24,587	27,483	55,699	70,000
1	20,972	26,235	28,875	59,753	
2	22,240	27,884	30,266	63,807	
3		29,532	31,658	67,861	
4		31,180	33,337	72,483	
5		32,829	35,016		
6		34,477	36,695		
7			38,374		
8			40,053		
9			41,733		

Bandings	
3	2
2A	1.8
2B	1.5
1A	1.5
1B	1.4
1C	1.2

Weighted average banding
1.64

The weighted average banding multiplier (1.63) was calculated based on the proportion of individuals in each compliant full time band (including basic salary only) at March 2004.

year 1	Year	Number	Salary	Total salary	Total per grade	Total	Average salary
Trainees	1	3,333	32,313	107,709,733			
	2	3,333	40,323	134,408,933			
	3	3,333	43,025	143,418,000			
	4	3,333	45,730	152,432,533			
	5	3,333	48,432	161,441,600			
	6	3,333	51,135	170,450,667			
	7	3,333	51,919	173,063,733			
	8	3,333	54,673	182,242,267			
	9	3,333	57,426	191,420,800			
	10	3,333	60,180	200,599,333			
	11	3,333	62,933	209,777,867			
	12	3,333	65,687	218,956,400	2,045,921,867		
Consultants	1	1,200	55,699	66,838,800			
	2	1,200	59,753	71,703,600			
	3	1,200	63,807	76,568,400			
	4	1,200	67,861	81,433,200			
	5+	25,200	72,483	1,826,571,600	2,123,115,600		
GPs	all	30,000	70,000	2,100,000,000	2,100,000,000	6,269,037,467	62,690

…continued from previous page

year 2

	Year	Number	Salary	Total salary	Total per grade	Total	Average salary		
Trainees	1	4,500	32,313	145,408,140					
	2	3,333	40,323	134,408,933					
	3	3,333	43,025	143,418,000					
	4	3,333	45,730	152,432,533					
	5	3,333	48,432	161,441,600					
	6	3,333	51,135	170,450,667					
	7	3,333	51,919	173,063,733					
	8	3,333	54,673	182,242,267					
	9	3,333	57,426	191,420,800					
	10	3,333	60,180	200,599,333					
	11	3,333	62,933	209,777,867					
	12	2,167	65,687	142,321,660	2,006,985,533				
Consultants	1	2,500	55,699	139,247,500					
	2	1,200	59,753	71,703,600					
	3	1,200	63,807	76,568,400					
	4	1,200	67,861	81,433,200					
	5+	25,400	72,483	1,841,068,200	2,210,020,900				
GPs	all	31,000	70,000	2,170,000,000	2,170,000,000	6,387,006,433	62,312	-0.60%	on previous year

year 3

	Year	Number	Salary	Total salary	Total per grade	Total	Average salary		
Trainees	1	4,500	32,313	145,408,140					
	2	4,500	40,323	181,452,060					
	3	3,333	43,025	143,418,000					
	4	3,333	45,730	152,432,533					
	5	3,333	48,432	161,441,600					
	6	3,333	51,135	170,450,667					
	7	3,333	51,919	173,063,733					
	8	3,333	54,673	182,242,267					
	9	3,333	57,426	191,420,800					
	10	3,333	60,180	200,599,333					
	11	3,333	62,933	209,777,867					
	12	1,000	65,687	65,686,920	1,977,393,920				
Consultants	1	2,500	55,699	139,247,500					
	2	2,500	59,753	149,382,500					
	3	1,200	63,807	76,568,400					
	4	1,200	67,861	81,433,200					
	5+	25,600	72,483	1,855,564,800	2,302,196,400				
GPs	all	32,000	70,000	2,240,000,000	2,240,000,000	6,519,590,320	62,091	-0.35%	on previous year

Pay drift with changes in junior doctor banding

Number of doctors	
New graduates each year	4,500
Trainees at year 1	40,000
Leave training to become consultants each year	2,500
Consultants at year 1	30,000
Retiring consultants each year	1,000
Leave training to become GPs each year	2,000
GPs at year 1	30,000
Retiring GPs each year	1,000

Salary scales					
	PRHO	SHO	SpR	Consultant	GP
Min	19,703	24,587	27,483	55,699	70,000
1	20,972	26,235	28,875	59,753	
2	22,240	27,884	30,266	63,807	
3		29,532	31,658	67,861	
4		31,180	33,337	72,483	
5		32,829	35,016		
6		34,477	36,695		
7			38,374		
8			40,053		
9			41,733		

Bandings	
3	2
2A	1.8
2B	1.5
1A	1.5
1B	1.4
1C	1.2

Weighted average banding	
year 1	**1.64**
year 2	**1.585**
year 3	**1.54**

year 1

	Year	Number	Salary	Total salary	Total per grade	Total	Average salary
Trainees	1	3,333	32,313	107,709,733			
	2	3,333	40,323	134,408,933			
	3	3,333	43,025	143,418,000			
	4	3,333	45,730	152,432,533			
	5	3,333	48,432	161,441,600			
	6	3,333	51,135	170,450,667			
	7	3,333	51,919	173,063,733			
	8	3,333	54,673	182,242,267			
	9	3,333	57,426	191,420,800			
	10	3,333	60,180	200,599,333			
	11	3,333	62,933	209,777,867			
	12	3,333	65,687	218,956,400	2,045,921,867		
Consultants	1	1,200	55,699	66,838,800			
	2	1,200	59,753	71,703,600			
	3	1,200	63,807	76,568,400			
	4	1,200	67,861	81,433,200			
	5+	25,200	72,483	1,826,571,600	2,123,115,600		
GPs	all	30,000	70,000	2,100,000,000	2,100,000,000	6,269,037,467	62,690

The weighted average banding multiplier (1.64) was calculated based on the proportion of individuals in each compliant full time band (including basic salary only) at March 2004. Using the trend from previous years the average pay band was then projected for the 2 subsequent years

…continued from previous page

year 2

	Year	Number	Salary	Total salary	Total per grade	Total	Average salary		
Trainees	1	4,500	31,229	140,531,648					
	2	3,333	38,970	129,901,317					
	3	3,333	41,582	138,608,250					
	4	3,333	44,196	147,320,467					
	5	3,333	46,808	156,027,400					
	6	3,333	49,420	164,734,333					
	7	3,333	50,178	167,259,767					
	8	3,333	52,839	176,130,483					
	9	3,333	55,500	185,001,200					
	10	3,333	58,162	193,871,917					
	11	3,333	60,823	202,742,633					
	12	2,167	63,484	137,548,678	1,939,678,092				
Consultants	1	2,500	55,699	139,247,500					
	2	1,200	59,753	71,703,600					
	3	1,200	63,807	76,568,400					
	4	1,200	67,861	81,433,200					
	5+	25,400	72,483	1,841,068,200	2,210,020,900				
GPs	all	31,000	70,000	2,170,000,000	2,170,000,000	6,319,698,992	61,656	-1.65%	on previous year

year 3

	Year	Number	Salary	Total salary	Total per grade	Total	Average salary		
Trainees	1	4,500	30,343	136,541,790					
	2	4,500	37,864	170,387,910					
	3	3,333	40,402	134,673,000					
	4	3,333	42,941	143,137,867					
	5	3,333	45,479	151,597,600					
	6	3,333	48,017	160,057,333					
	7	3,333	48,753	162,511,067					
	8	3,333	51,339	171,129,933					
	9	3,333	53,925	179,748,800					
	10	3,333	56,510	188,367,667					
	11	3,333	59,096	196,986,533					
	12	1,000	61,682	61,681,620	1,856,821,120				
Consultants	1	2,500	55,699	139,247,500					
	2	2,500	59,753	149,382,500					
	3	1,200	63,807	76,568,400					
	4	1,200	67,861	81,433,200					
	5+	25,600	72,483	1,855,564,800	2,302,196,400				
GPs	all	32,000	70,000	2,240,000,000	2,240,000,000	6,399,017,520	60,943	-1.16%	on previous year

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
Thirty-Fourth Report (2005)	Cm 6463, February 2005

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