Pay in the NHS

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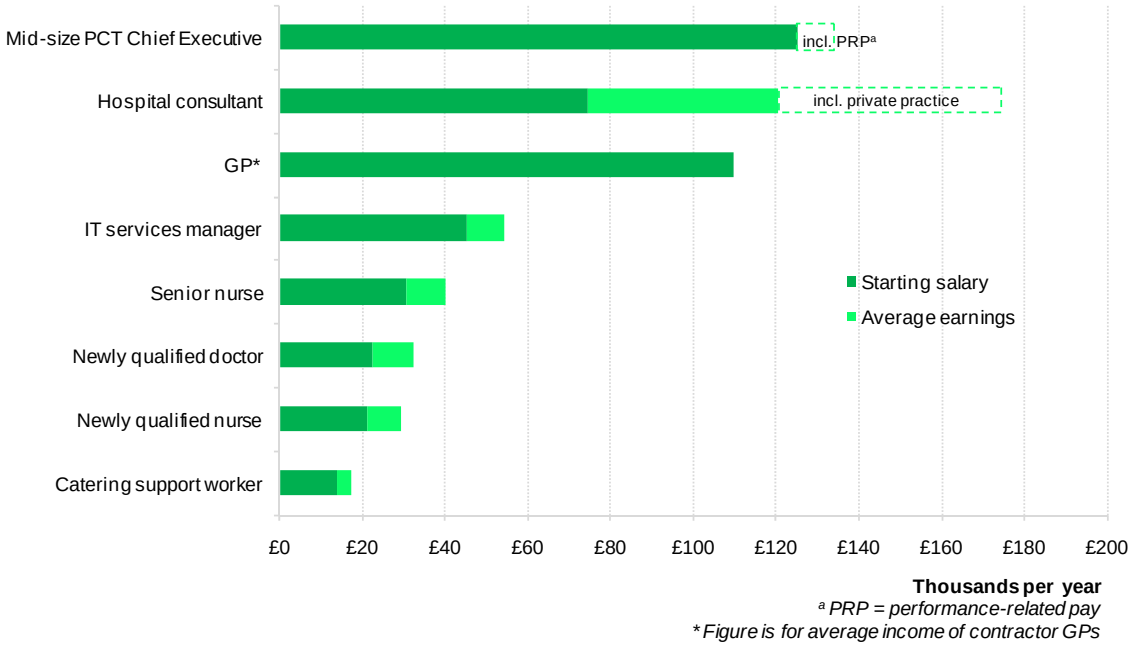
Social and General Statistics

The NHS in England employs 1.4m individuals and in 2010/11, their pay will account for three-fifths of its £106bn annual expenditure. Earnings in the NHS span the full range of public sector pay. At the very top of the distribution, the top ten highest earners are doctors – eight GPs and two consultants – with an average NHS income of £370,000 in 2009/10. At the bottom, an entry-level heath records assistant outside London would have earned £13,233 in the same year.

Pay for almost all directly-employed NHS staff is subject to annual analysis and recommendation by one of three pay review bodies. These recommendations are laid before Parliament, with the Government making the final decision on pay arrangements.

There have been significant contractual changes for NHS employees in recent years. The Agenda for Change framework has harmonised pay structures in the NHS across all staff groups except doctors, dentists and the most senior managers. Meanwhile, new contracts for GPs and consultants have resulted in large increases in remuneration, although these have levelled off more recently. Training and career progression for junior doctors has been reformed, and their hours are gradually being reduced in line with the European Working Times Directive. These changes are described in full in the main text of the note.

Some staff groups, in particular nurses and doctors in training, supplement their basic pay by working significant amounts of overtime. The starting salary and the average total pay of selected staff groups is summarised in the table below.



[a] *PRP = performance-related pay*

** Figure is for average income of contractor GPs*

Contents

1 Pay for hospital consultants

1.1 Contractual framework

Apart from minor changes in 1980, hospital consultants' contracts had remained largely unchanged from the inception of the NHS until 2003. Then, after three years of negotiations, a new contract was agreed between the UK Health Departments, the NHS Confederation and the British Medical Assocation[1]. The new contract introduced, among other things, job plans and specified rewards for on-call work, and work outside the hours of 7am to 7pm. The aim was to improve recruitment and retention of consultants, increase incentives for NHS work and raise productivity. Its success in these respects was examined by the Public Accounts Committee in its 2007 report *Pay Modernisation: A new contract for NHS consultants in England*

96 per cent of consultants are now on the new contract. In terms of earnings, the effect of the contract in its first three years was to increase consultants' pay by an average of 27 per cent.

Since 1971, consultants' salaries and performance-related pay have been subject to annual analysis and recommendations by Review Body on Doctors' and Dentists' Remuneration (DDRB). Its recent reports are available on its website.[2] For 2010/11, it recommended that there be no change to consultants' pay or to the value of clinical excellence awards; the Government accepted this[3].

1.2 Pay scales

The basic consultant pay scale consists of eight pay points, ranging from £74,504 per year to £100,446pa. Consultants can earn additional money through clinical excellence awards, which are paid annually once the individual reaches the required standard. The award is subject to a five-year performance review, but it can only be removed in name; once annual payments start, they cannot then be withdrawn[4]. Twelve different levels of award are paid, ranging from £2,957 to £75,796[5]. The chart below shows the basic salary for each of the eight pay points, and the additional amounts collectable through excellence awards. 52 per cent of consultants received an award in 2009/10, with 13 per cent receiving awards over £35,000. The DDRB is to make recommendations on the future of clinical excellence awards in the summer of 2011.

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[1] Fewer than 10 per cent of consultants in England remain on the pre-2003 contract (*Thirty-Ninth report of the Review Body on Doctors' and Dentists' Remuneration,* p.3)

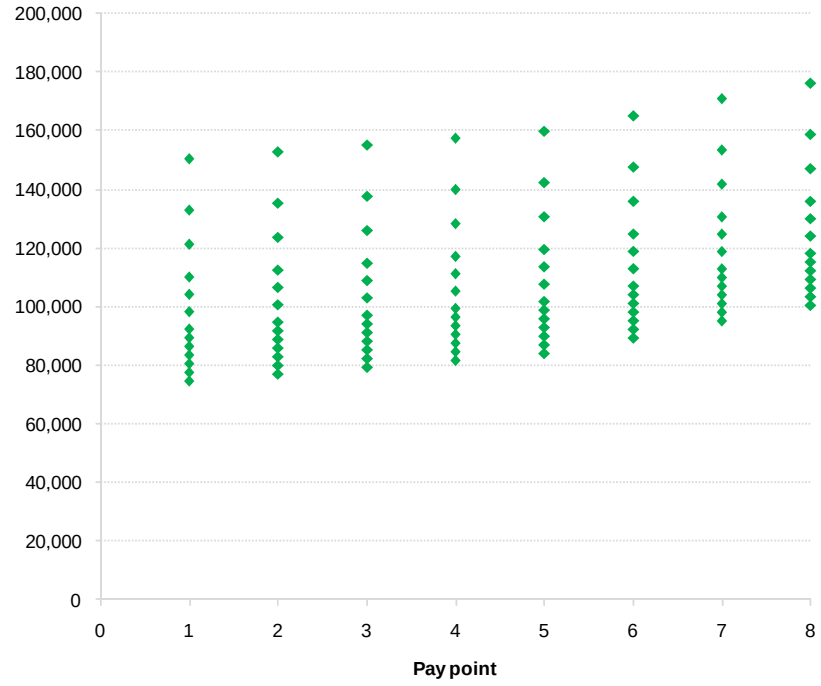
[2] The Library holds older editions in hard copy.

[3] HC Deb 10th March 2010 c17WS

[4] See, for instance, BBC News 13th October 2010 *Q&A: NHS Consultant Bonuses*

[5] More information and statistics on reward allocation can be found on the website of the Advisory Committee on Clinical Excellence Awards

Figure 1: Consultant 8-point pay scale (lowest point in each vertical series) and additional amounts earnable through clinical excellence awards (higher points), 2010/11

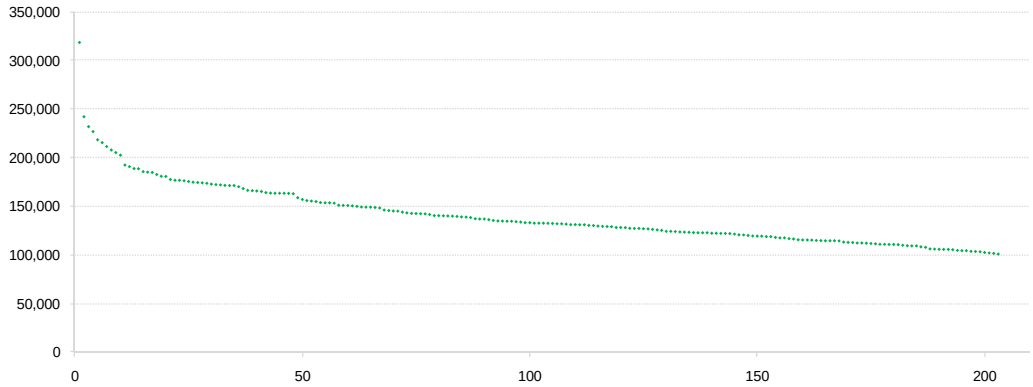


1.3 Actual earnings

NHS Earnings

Consultants' median annual NHS earnings for the period April to June 2010 were £111,700[6]; mean earnings were £120,400[7]. This suggests that it is typical for consultants to earn in excess of their basic pay through overtime and performance awards. As an example of the distribution of pay, the chart on the right below shows the total NHS earnings for consultants paid over £100,000 per year in North Staffordshire NHS Trust (around 80% of the Trust's total consultant workforce). Each dot represents an individual consultant's pay. Of the 255-strong workforce, 207 are paid over £100,000, 60 over £150,000, and 10 over £200,000.

Figure 2: Consultants' pay, North Staffordshire NHS Trust[8]



[6] NHS Information Centre *Staff Earnings Estimates Apr-Jun 2010*

[7] The median is the income of the earner in the middle of the earnings distribution; the mean is the sum of earnings divided by the number of earners.

[8] Source: Bureau of Investigative Journalism/BBC Panorama Public Pay Database

Private earnings

Under the 2003 contract, there is no restriction on the income consultants can earn from practising privately, although it can affect NHS pay progression. It has been argued by the Public Accounts Committee and elsewhere[9] that the contract has had little effect on the incentive to engage in private practice.

HM Revenue and Customs conduct periodic analyses of the private practice income of consultants by linking tax return data with information from the NHS workforce census. These are used to inform PCT funding allocations. The most recent detailed analysis of consultants' private income took place in 2003/04[10]. It found that the ratio of average (mean) private income to NHS income was 0.45; that is, on average, consultants supplement their NHS income by an additional 45% through private practice.

Applying this ratio to mean NHS earnings for April-June 2010 implies consultants earn on average £54,000 per year through private practice and a total of £174,000 per year.

Private earnings vary significantly by specialty; plastic surgeons on average earn an additional 190% on top of their NHS income through private practice, whilst paediatricians supplement their income by just 14%.

2 Pay for hospital doctors other than consultants

2.1 Contractual framework

Doctors in training

Pay for junior doctors is determined centrally following recommendations by the Doctors and Dentists Review Body (DDRB). Since December 2000, junior doctors[11] have operated on a contract and under regulations that seek to reduce their hours to a level that is compliant with the European Working Time Directive. They are contracted to work 40 hours per week, but will typically do significant hours of overtime. From August 2003 all junior doctors were limited by contract to 56 hours of active work per week; from August 2009, the limit is 52 hours; from 2012 it is expected that hours will be limited to 48 per week. The 2000 contract abolished hourly rates of pay for overtime work; instead, junior doctors now receive a fixed supplement to their salary according to the length, timing and intensity of their overtime work, ranging from 20% to 100% of their basic pay.

Since the publication of *Modernising Medical Careers* in 2004, the way in which doctors aretrained has changed. The grades of Foundation House Officer and Specialty Registrar have replaced the older training grades (House Officers, Registrars and Senior Registrars). The grade of Specialty Registrar encompasses the upper end of the older Senior House Officer pay scale, and those of Registrar and Senior Registrar.

Specialist and Associate Specialists (SAS)

Doctors in the SAS grades work at the senior career-grade level in hospital and community specialties. The group comprises, amongst others, staff grades, associate specialists, clinical assistants, hospital practitioners A new contract was implemented for this group of doctors from April 2008 which closed the associate specialist grades to new entrants and

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[9] *Reforming the consultant contract again?* BMJ 2004; 329 (7472): 929-30

[10] See *Analysis of consultants' NHS and private incomes in England in 2003/4*, Journal of the Royal Society of Medicine, 2008; 101(7): 372-80

[11] The term 'junior doctors' here refers to doctors in training grades, specifically, house officers and registrars.

introduced a new grade, the ‘specialty doctor’. Around 56% of SAS doctors are now working on the new contract.

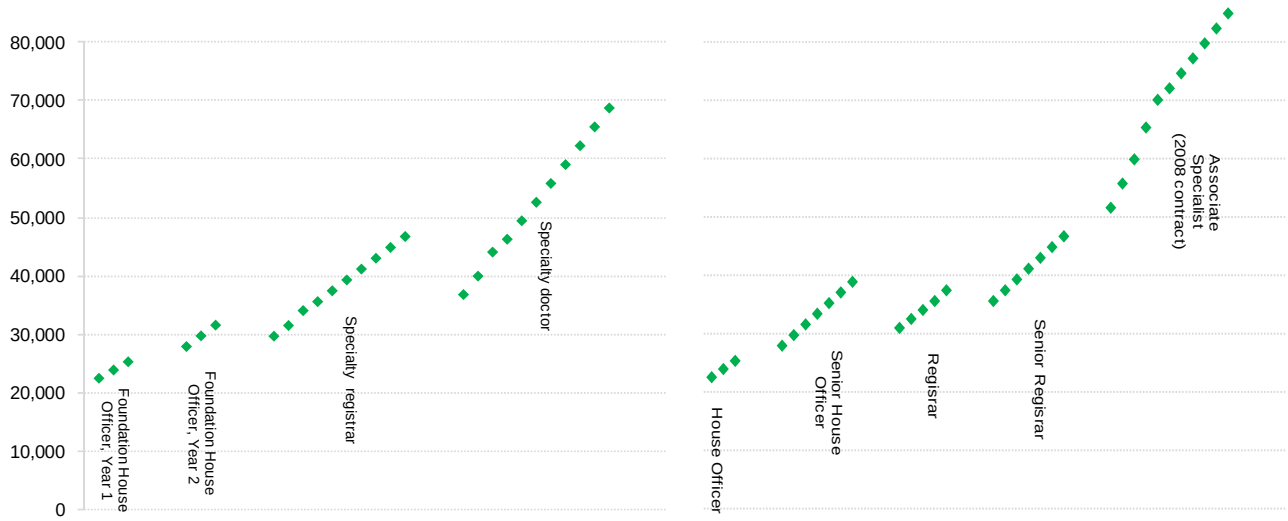
Training grade and SAS doctors’ pay is subject to annual analysis and recommendations by the Review Body on Doctors' and Dentists' Remuneration. In 2010/11 it recommended a pay increase of 1.5% for junior doctors, which the Government rejected in favour of a 1% award. For SAS doctors, it recommended an increase of 1%; the Government accepted this[12].

2.2 Pay scales

Below, the chart on the left shows the pay scales applicable to new entrants to the medical profession; the chart on the right shows pay scales under older arrangements; both are valid from April 2010.

The basic starting pay for a new junior doctor (a Year 1 Foundation House Officer) from April 2010 is **£22,523pa**. Doctors normally progress to the Year 2 scale on their second year, and to the Specialty Registrar scale by their third year.

Figure 3: pay scales of doctors at training and specialist grades under new (left) and old (right) grading, 2010/1



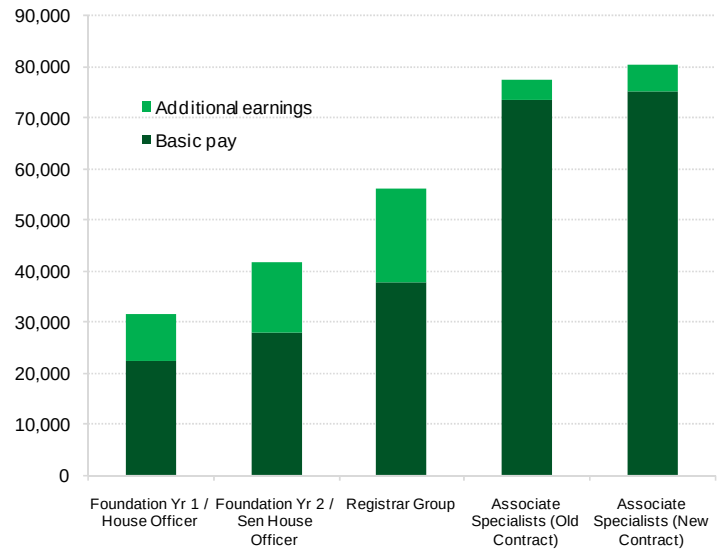
London weighting for 2010/11 for all doctors is £2,162 per year for doctors non-resident in hospital and £602 for residents.

[12] HC Deb 10th March 2010 c17WS

2.3 Actual earnings

The chart below shows average (median) basic and total earnings doctors at training and specialist grades. Doctors in training grades supplement their basic pay, on average, by an additional third through overtime-related payments.

Figure 4: annual average (median) earnings of training and specialist-grade doctors, June 2010



3 Pay for General Practitioners

3.1 Contractual framework

Contractor GPs and salaried GPs

NHS GPs who own and run practices (often termed 'contractor' GPs) are generally independent practitioners who have a contract with the local Primary Care Trust. It is the Practice (which can contain one or many more GPs) that holds the contract, not with the individual GP, unless they operate a single-handed practice. It is common for practices to be organised as partnerships of contractor GPs who may employ other GPs who are not partners (known as 'salaried' GPs) as well as other health and/or administrative staff. Around 15% of GPs (6,000) are salaried GPs[13].

Since April 2004 GP practices have been mainly operated under two contracts; the nationally negotiated General Medical Services (GMS) contract or the locally negotiated Personal Medical Services (PMS) contract. The General Medical Services (GMS) contract was agreed in 2004 following two years of negotiations. In practice, PMS contracts are local permutations of GMS, rather than entirely different funding mechanisms. Of the 34,000 contractor GPs, 55% are on GMS contracts.

Funding to practices is allocated on the basis of population need, with additional money available under a performance-related pay system known as the Quality and Outcomes Framework. Aims of the 2004 GMS contract included a reduction in geographical funding inequalities, increased recruitment and retention, better working practices, and improved access to services through flexible working practices. Its success in these respects was examined by the Public Accounts Committee in its 2008 report *NHS Pay Modernisation: new contracts for General Practitioners in England*.

[13] NHS Information Centre *GP Earnings and Expenses Provisional Report 2008/09*

Under the new contract, GP practices were able to opt out of responsibility for 24 hour care (by foregoing an average of £6,000 per year income). Over the five years to March 2008, *contractor* GPs received an average pay increase of 58 per cent. Compared with 1992, they worked an average of 7 hours per week less in 2006 (36.3 hours per week in 2006 43.1 in 1992)[14].

The GMS negotiations also led to an agreed model contract and minimum terms and conditions for salaried GPs employed by practices and PCTs.

Since 1971, GPs' income has been subject to annual analysis and recommendations by Review Body on Doctors' and Dentists' Remuneration (DDRB). Its recent reports are available on its website.[15] Because payments to GPs under GMS/PMS contracts come from a number of sources, the Review Body generally makes recommendations framed in terms of the contract's overall value, rather than specific payments; the 'carve-up' of any uplift is then determined later. For salaried GPs, the DDRB makes recommendations on the minimum salary range to feature in the model contract. For 2010/11, it recommended that contractor GPs receive a 1.34% increase in their contract value; the Government rejected this and decided on a 0.8% uplift instead. The recommendation for salaried GPs was a 1% increase in pay; this was accepted by the Government[16].

3.2 Pay scales

Contractor GPs

The mechanism by which funding is allocated to practices, and hence the determination of pay for contractor GPs, is complicated. Under GMS, practices get an amount, known as the global sum, allocated according to a needs -based formula (taking into account e.g. number, sex, age and health status of patients) adjusted for geographic differences in cost. Practices also receive a minimum practice income guarantee that ensures this global sum is no lower than it would have been under the previous contract. Practices are also paid for providing additional care, such as out-of-hours and enhanced services, and for dispensing prescription items. PMS practices do not receive a global sum, but instead receive a baseline allocation. This is determined locally and is likely to include mechanisms for calculating the price of opting-out of out-of-hours and taking on additional patients.

In either case, it is not generally possible to construct pay scales for contractor GPs.

There is no explicit London weighting for contractor GPs, but they will have the effect of geographical cost differences taken into account in the needs-based formula used to determine their global sum (for GMS contractors), or through local negotiation (for PMS contractors).

Salaried GPs

The minimum recommended pay scale in salaried GPs' model contract for 2010/11 is **£53,781** to **£81,158**. Salaried GPs benefit from the same London weighting as non-resident hospital doctors (£2,162 per year).

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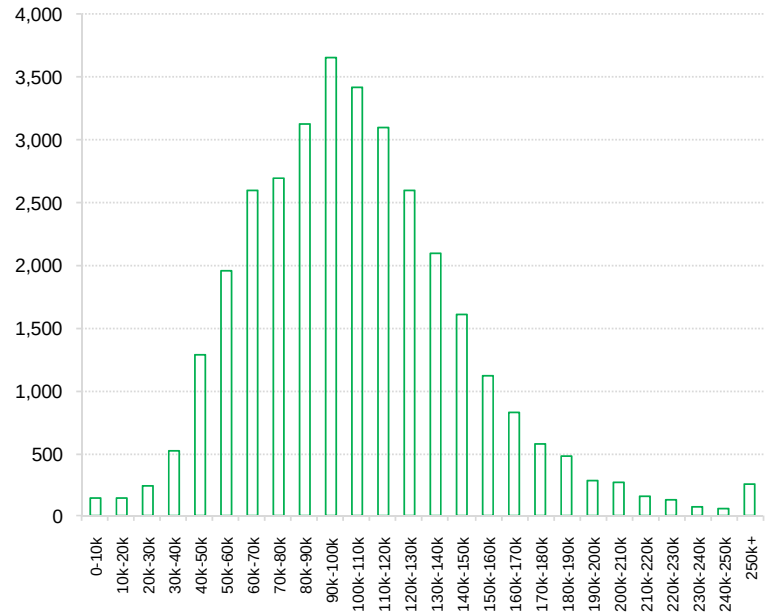
[14] See p.10 of the Public Accounts Committee report
[15] The Library holds older editions in hard copy.
[16] HC Deb 10th March 2010 c17WS

3.3 Actual earnings

Contractor GPs

GP earnings and expenses are analysed each year by the NHS Information Centre using the HMRC tax self-assessment database[17]. The average after-tax personal income of contractor GPs on both PMS and GMS contracts in 2008/09 was **£109,600pa**. Practitioners on 'local' PMS contracts earned more on average (£116,900pa) than those on the 'national' GMS (£103,900pa). The earnings distribution of contractor GPs (that is, the number of practitioners in each £10,000 salary band) is shown in the chart below:-

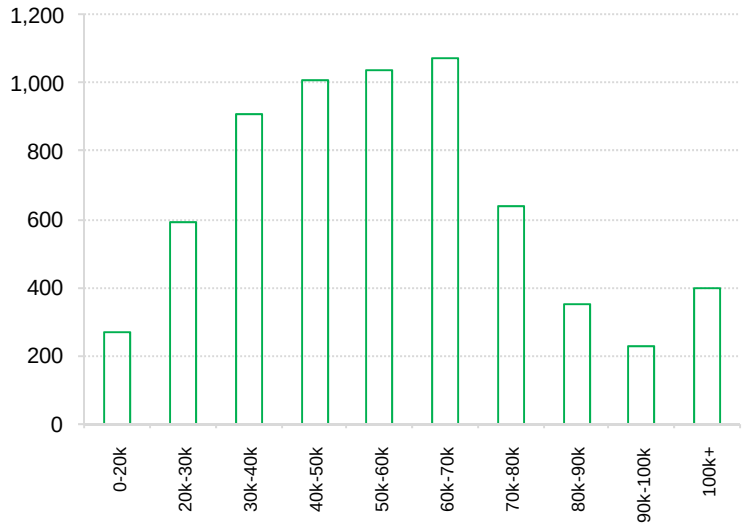
Figure 5: Distribution of contractor GPs' income before tax, 2008/09



Salaried GPs

The average income before tax of salaried GPs in 2008/09 was **£57,400pa**. The distribution of earnings in this group is shown in the chart below.

Figure 6: Distribution of salaried GPs' income before tax, 2008/09



[17] See, for instance, the *GP Earnings and Expenses Provisional Report 2008/09*

4 Pay for senior management

4.1 Contractual framework

Pay for top-level management (known as 'very senior managers', or VSMs) in the NHS is either determined centrally, following annual recommendations made by the Senior Salaries Review Body (SSRB), or through local negotiation, depending on the type of organisation they are working for. VSMs in NHS Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts are subject to a national framework; those in Acute Trusts, Foundation Trusts and Mental Health Trusts have local pay settlements.[18]

The number of VSMs covered by the national framework was estimated in 2009 to be 1,120. The SSRB's analysis and recommendations on levels of pay for VSMs are published as part of their annual report on senior salaries, available from their website. The national framework for VSM pay is published on the Department of Health website. For 2010/11, the SSRB recommended no increase for VSMs earning £81,800 or more; the Government accepted this. For VSMs earning less than £80,000, it recommended a 2.25% increase, and for those earning between £80,000 and £81,799, it recommended an increase to £81,800; the Government did not accept either of these recommendations, and so there was no base pay increase for any VSMs in 2010.11[19].

4.2 Pay scales

Trust chief executives are paid a fixed salary that depends on the type of organisation they work for (PCT, SHA etc.) and its characteristics. PCTs and SHAs are banded according to the size of their population, weighted for age and deprivation, such that chief executives in larger and/or more needy areas receive higher pay. Ambulance trusts are banded according to their expenditure and activity.

Other VSMs are then paid a fixed percentage of their chief executive's salary, ranging from 55% and 75%, depending on the role. Thus, there is no pay scale for VSMs as such[20].

The chart below shows the basic salary of VSMs in each type of organisation for 2010/11. Pay ranges from £57,293 per year for a corporate affairs director in a Band 1 PCT to £204,048 per year for the chief executive of London Strategic Health Authority. VSMs may also receive an additional 7% of salary in performance-related pay, and a supplement of up to 10% of base salary in return for taking on additional responsibilities.

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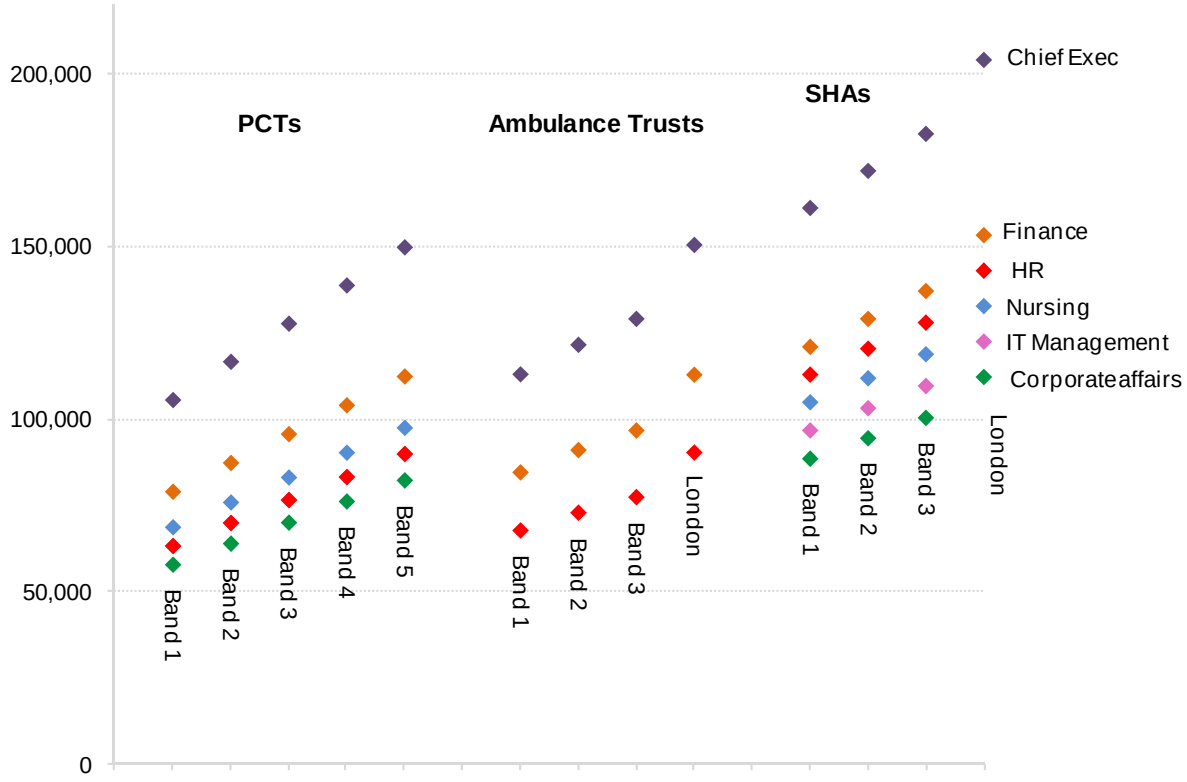
[18] Note that managers with backgrounds as NHS consultants may remain on the consultants' contract and are not classified as VSMs for these purposes, even though they may hold directorial positions.

[19] HL Deb 10th March 2010 cWS23

[20] For further details, see DH *Pay Framework for Very Senior Managers, April 2009*

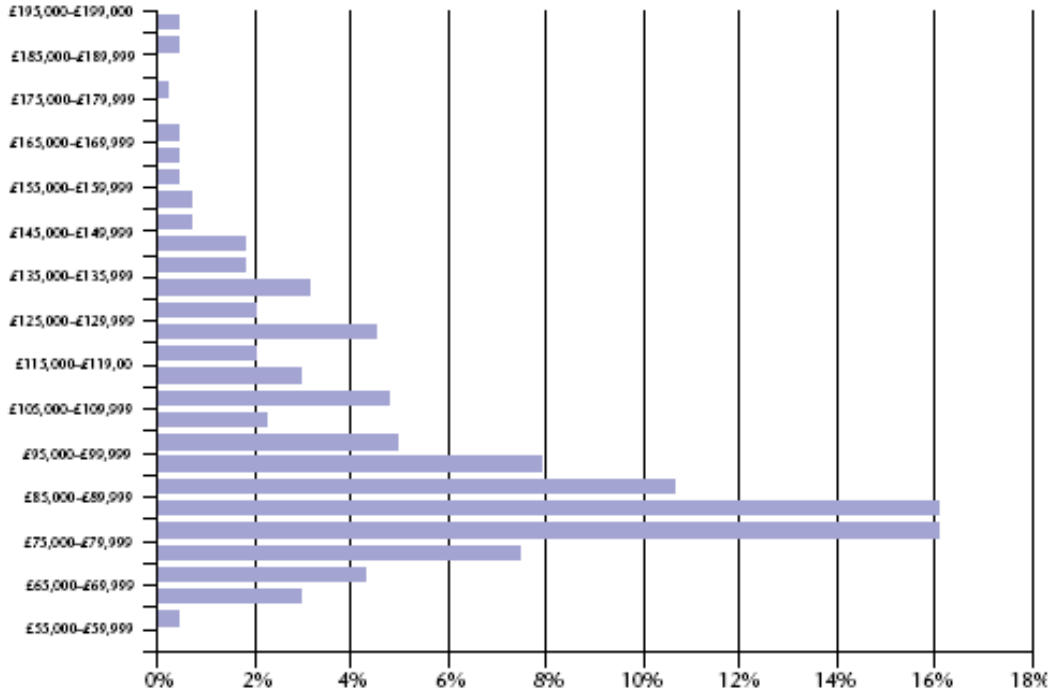
Figure 7: basic pay for 'very senior managers' in the NHS, 2010/11[21]



4.3 Actual earnings

The chart below, produced by the SSRB for its 2010 report (p.51), shows the distribution of earnings of a sample of VSMs. Based on this, median earnings of VSMs in the organisations covered by the national framework are between £90,000 and £95,000pa.

Figure 8: distribution of earnings of a sample of very senior managers in the NHS



[21] Source: SSRB Thirty-second report on Senior Salaries (2010)

5 Pay for staff other than doctors and senior managers[22]

5.1 Contractual framework

All NHS staff apart from doctors dentists and the most senior managers are now paid according to the Agenda for Change (AfC) framework, implemented between December 2004 and December 2006. AfC harmonised the 12 separate pay structures that existed for different staff groups into a single set of pay bands that now cover 1.1m employees (over 80% of the NHS workforce).

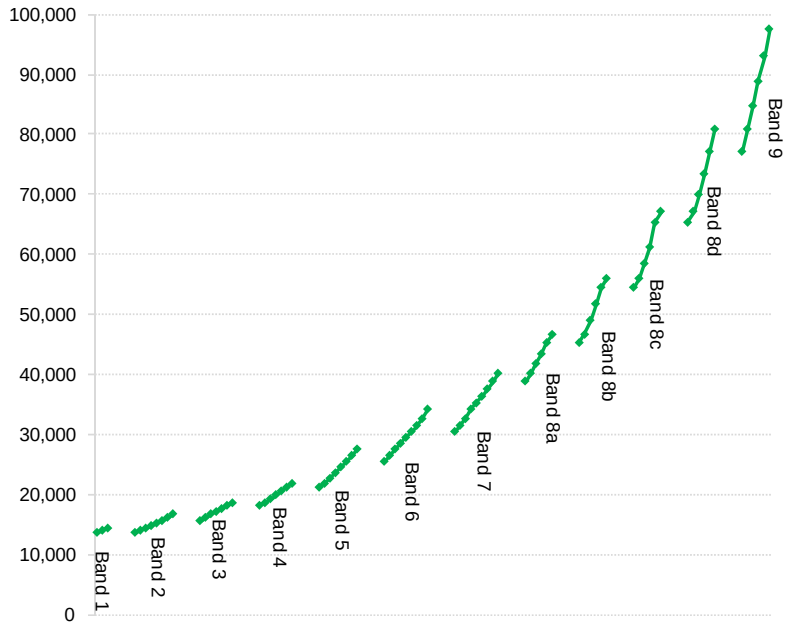
The objectives of the AfC were to reduce administrative complexity, generate productivity savings and break down the historical division of roles and responsibilities perpetuated by separate pay arrangements. Its success in these respects was examined in the 2009 Public Accounts Committee Report *NHS Pay Modernisation in England: Agenda for Change*. Looking at broad staff groups, the AfC does not appear to have had a significant impact on levels of pay.

Since 2007, all staff on AfC salaries have been covered by the NHS Pay Review Body (formerly the Review Body for Nursing and other Health Professions). Its annual analysis and recommendations on pay are published on its website. 2010/11 is the final year of a three-year agreement worth 7.99% over its lifespan.

5.2 Pay scales

The AfC pay scale is divided into twelve bands, each of which have between three and nine pay points, giving a total of 81 points from the bottom of the scale (£13,653 per year in 2010/11) to the top (£97,478pa). These are illustrated in the chart below. Examples of typical roles in each pay band, and the percentage of AfC staff within each band are shown in the nest table.

Figure 9: Agenda for change pay points from April 2010, £ per year [23]



[22] This group includes nurses, allied health professionals, healthcare science professionals (e.g. pharmacists, optometrists), clinical support workers, technicians, and ancillary, maintenance and estates staff

[23] NHS Careers Agenda for Change pay rates from 1st April 2010

Table 1: Agenda for change – examples of typical roles

Agenda for change pay bands - examples of typical roles and percentage of full-time equivalent staff in each band

Pay band	Typical role	Percentage of all AfC full-time equivalent staff	Starting salary
Band 1	Catering support worker; health records assistant	3.3%	13,653
Band 2	Telephone operator; cook; A&E receptionist	15.6%	13,653
Band 3	Estates maintenance; clinical coding officer	13.3%	15,610
Band 4	Medical/legal secretary; nurse associate	9.2%	18,152
Band 5	Newly qualified nurse, allied health professional, technician etc.	22.9%	21,176
Band 6	Specialist nurse, allied health profesional, technician, administrator etc.	17.0%	25,472
Band 7	Advanced/specialist allied health professional, technician etc.; emergency services area manager; nurse team manager; commissioning manager	11.3%	30,460
Band 8a-b	Midwife/nurse/allied health professional consultant; IT service manager	5.7%	38,851
Band 8c-d	Optometrist consultant; higher level nurse/midwife consultant; Head of HR	1.5%	54,454
Band 9	Director of estates/facilities; professional manager of clinical services	0.2%	77,079

Source: NHS Employers *National Job Profiles* ; NHS Information Centre *NHS Staff Earnings, June 2010*

London weighting

The pay scales described above ignore the effect of the London weighting. From April 2010, AfC staff working in and around London receive the following additions to their salary:-

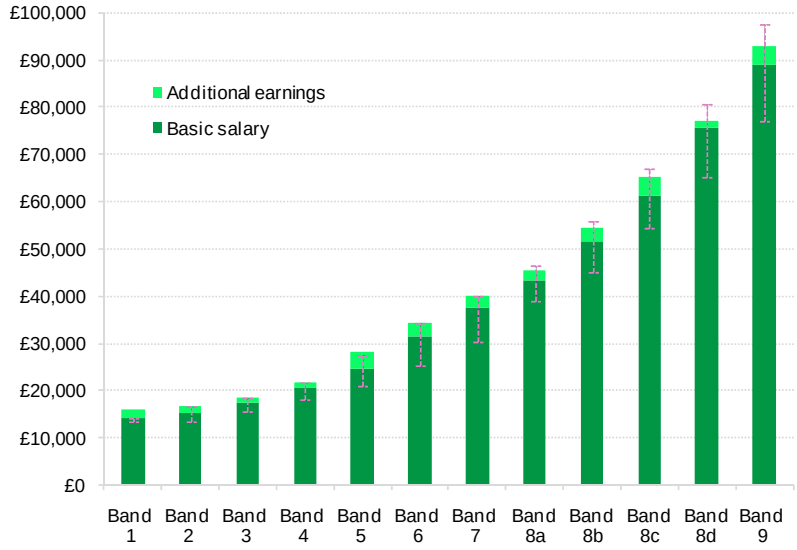
Inner London	20% basic salary, subject to a minimum of £4,036 and a maximum of £6,217
Outer London	15% basic salary, subject to a minimum of £3,414 and a maximum of £4,351
Fringe	5% basic salary, subject to a minimum of £933 and a maximum of £1,616

Source: NHS Employers *Pay Circular (AfC) 1/2010*

5.3 Actual earnings

The chart below shows average (median) basic and total earnings of NHS staff by AfC band. The pink bars show the pay scale within each band. Through overtime work and/or bonuses, it is common for employees, particularly those in lower pay bands, to earn in excess of the top of their pay scale. Average total earnings of newly qualified (Band 5) nurses, for instance, are £28,100pa, but the top of the Band 5 scale is £27,534.

Figure 10: Annual average (median) earnings of NHS staff by AfC band, June 2010[24]



Note: pink brackets show pay scale within each band

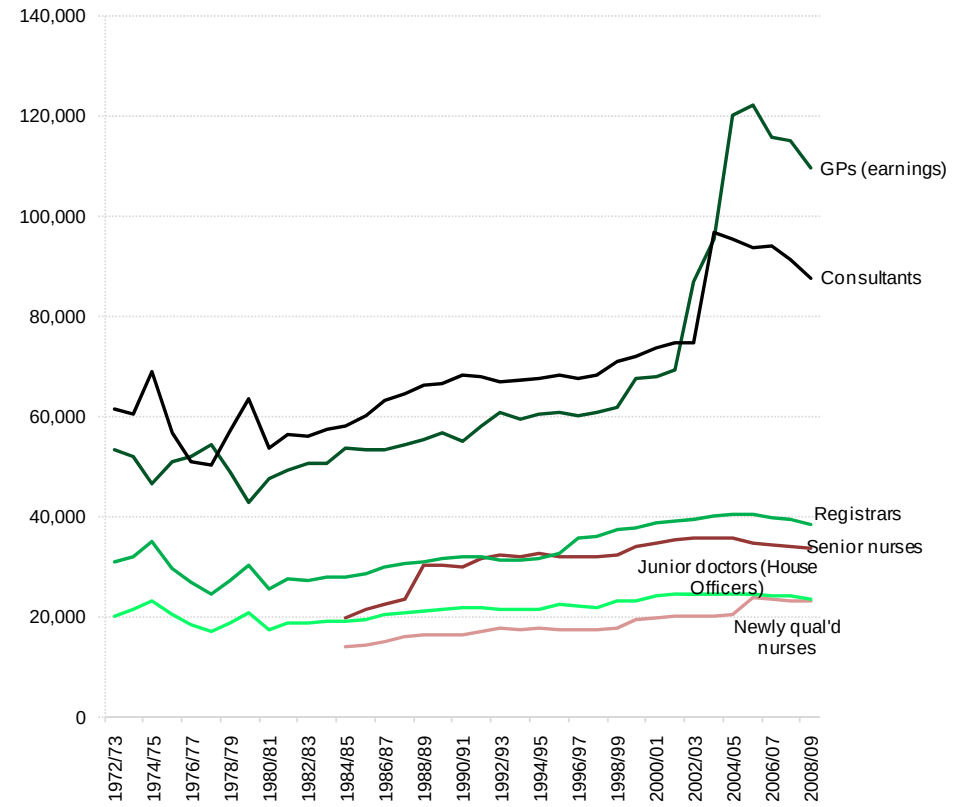
[24] NHS Information Centre *Staff Earnings Estimates Apr-Jun 2010*

6 Changes in pay scales and earnings over time

6.1 Pay scales

The midpoint of the pay scales of key NHS staff groups, and the net earnings of GPs from 1972/73 onwards is shown in the chart below, adjusted for inflation over the period. In real terms, junior doctors' basic pay has remained largely unchanged. That of registrars and senior nurses has risen slightly. Basic pay of consultants and earnings of GPs rose dramatically following the introduction of new contracts in 2003 and 2004 respectively.

Figure 11: basic pay of key NHS staff groups, 1972/73 to 2008/09



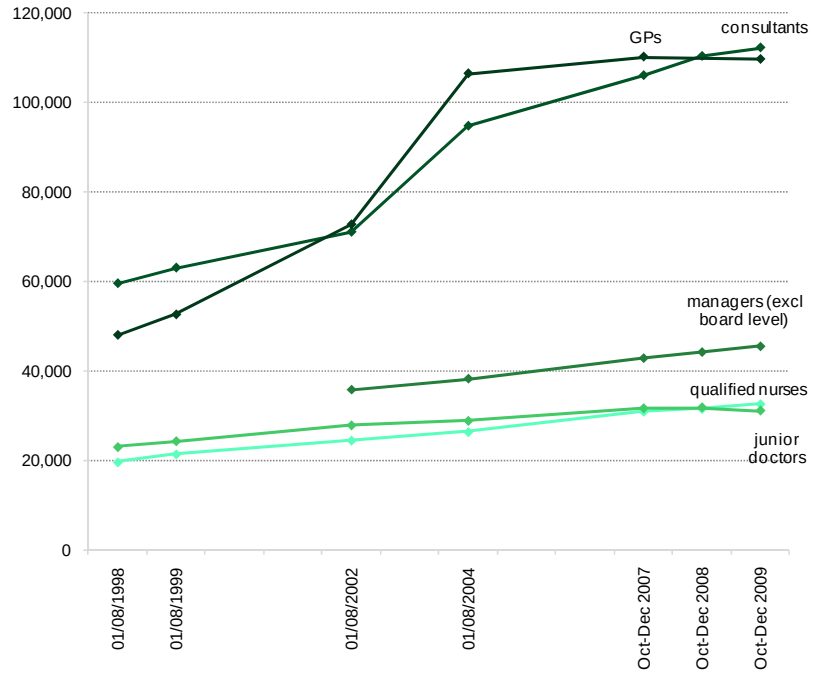
Notes: figures for GPs refer to intended average remuneration from 1972/73 to 1978/79, to actual average remuneration from 1979/80 to 2001/02, and to estimated average annual net income from 2002/03. For all other roles, the chart is based on the midpoint of each year's pay scale. From 2003, the payscale midpoint of the new consultants' contract is used. Newly qualified nurses are those on Grade D of the Whitley Scale (1984-2004) and Band 5 of the Agenda for Change framework (post 2004); Senior nurses are those on Grade I of the Whitley Scale (1984-2004) and Band 7 of the Agenda for Change framework (post 2004).

Sources: Reports of the NHS Pay Review Body (and predecessor organisations), and the Doctors' and Dentists' Review Body, and the corresponding Government responses (Hansard written Ministerial statements).

6.2 Actual earnings

The first NHS staff earnings survey took place in 1998. Average earnings are now surveyed quarterly using the Electronic Staff Record. A similar trend to the chart above is in evidence, with a widening gap between 'senior' doctors, and nurses and junior doctors.

Figure 12: average earnings of key NHS staff groups, 1998-2009[25]



Very Senior Managers (VSMs) in London Ambulance Trust and London Strategic Health Authority are allocated to special pay band (see Figure 7); for PCT VSMs, there is no explicit London weighting; and for VSMs in organisations not covered by the national framework (e.g. hospital trusts), pay is determined locally.

7 A note on pay in Wales, Scotland and Northern Ireland

The figures in this note refer to the pay bands and earnings of NHS staff in England. However, the remit of the pay review bodies (the NHSPRB, the DDRB and the SSRB) that submit recommendations on salaries for nearly all directly-employed NHS staff covers the whole of the UK. There may thus be similarities between the 'English' pay bands described in the note, and those prevailing in the rest of the UK. In particular, the Agenda for Change programme covers the whole of the UK, and so recommendations made by the NHSPRB will apply to Wales, Scotland and Northern Ireland, too. Final decisions on pay, though, rest with the Governments of the devolved administrations, and so bands may differ if, say, one administration accepts the review body's recommendations, and another does not. Moreover, where contractual arrangements differ, country-specific recommendations may be made by the review body[26] (e.g. the consultant contract in Wales differs from that in other parts of the UK, so a separate set of recommendations are made by the DDRB for this group).

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[25] DH and NHS Information Centre Staff Earnings Estimates (various edns.)