

**The Review Body on Doctors' & Dentists'
Remuneration
Review for 2015
General Medical Practitioners and
General Dental Practitioners**

The Review Body on Doctors' and Dentists' Remuneration

NHS England's Evidence for the 2015 Review

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INTRODUCTION

Background

- 0.1 From April 2013, NHS England took over the responsibility for commissioning primary care services, including primary medical care. NHS England continues to have responsibility for developing primary medical care contracts and for the negotiations with the General Practitioners Committee (GPC) of the British Medical Association (BMA) on improvements to the General Medical Services (GMS) contract.
- 0.2 This document contains written evidence from NHS England to inform the Review Body on Doctors' and Dentists' Remuneration (DDRB) report on 2015/16 pay for their remit group.
- 0.3 In his letter¹ of 26th August to the Chair of the DDRB, the Parliamentary Under Secretary of State for Health set out that detailed evidence would be provided to you from:
 - The Department of Health – high level evidence focusing on the economic and financial (NHS funding) context and strategic policy; and
 - NHS England - on primary care contractors.
- 0.4 Further evidence will be provided to you from:
 - NHS Employers – on recruitment, retention, motivation and morale for employed doctors and dentists; and
 - Health Education England – on education, training and workforce capacity.
- 0.5 For NHS England's part, we are therefore providing evidence on those matters where we feel it most appropriate for us to comment on, including affordability and funding constraints.

Contract for services

- 0.6 General Medical Practitioners (GMP) and General Dental Practitioners (GDP) providing NHS care to patients do so under a contract for services. They are not directly employed by the NHS.
- 0.7 The take-home pay earned by these contractors is therefore derived from the profits that their practices generate, which are determined by the gross income earned from their NHS contracts less practice expenses.
- 0.8 To an extent, contractors are therefore able to influence the level of profits that their practices generate by seeking to reduce costs, or looking for opportunities to increase

¹ Available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/348196/Letter_of_26_August_2014_from_Dr_Dan_Poulter_DH_Minister_to_DDRB_Chair_about_remit_for_2015-16_for_independent_contractors.pdf

contractual income. For example, GMPs can choose to participate in, and earn extra income by, delivering Enhanced Services such as the Extended Hours Access Scheme.

- 0.9 In addition, as with other parts of the NHS, GMPs and GDPs will also be expected to deliver efficiency gains which will be offset against any inflationary uplift, unless they can provide evidence that efficiency gains are being delivered by other means.

Affordability and funding constraints

0.10 NHS England is funded by the Department of Health to commission health services as required under the NHS Constitution and the NHS Mandate, with objectives to deliver improved health outcomes.

0.11 In 2014/15, NHS England was allocated £97.95 billion of funding.

0.12 For 2015/16, the Department of Health has indicatively allocated £99.91 billion of revenue funding to NHS England, subject to confirmation in the Mandate during autumn 2014. Whilst the NHS has been protected from real term cuts in funding, the fiscal position and demand pressures mean, by historic standards, the scale of funding growth will be considerably constrained.

0.13 NHS England set out its analysis of what the constrained public finances might mean for the NHS in the period to 2020 in the *Call to Action*². This analysis identified a £30 billion gap between likely available funding and expected demand levels on NHS services by 2020. In addition, page 16 gave an indication showing how projected costs outstrip projected funding from 2014/15 onwards.

0.14 All providers in the service are expected to deliver efficiency gains each year to help reduce the funding gap, including independent contractors. We will ensure the committee is informed of the expected efficiency gains of other parts of the service, and those which have been demonstrated will be delivered by independent contractors through any contract agreements, as this emerges.

0.15 In June 2010, the Government announced a public sector pay freeze, covering 2011/12 and 2012/13. During the 2011 Autumn Statement, the Government announced that, for 2013/14 and 2014/15, public sector pay increases would be capped at an average 1%. In March 2014, the Government announced that the 1% public sector pay cap would be extended by a further year to include 2015/16.

0.16 On the basis of the above, we would urge the DDRB to carefully consider what, if any, uplift is appropriate for 2015/16.

² Available from: <http://www.england.nhs.uk/2013/07/11/call-to-action/>

CHAPTER 1: GENERAL MEDICAL PRACTITIONERS

Introduction

- 1.1 This chapter relates to information on general medical practitioners (GMPs) providing NHS primary care services in England.
- 1.2 NHS Employers is currently in discussion with the GPC over potential improvements to the General Medical Services (GMS) contract for 2015/16. An update on the negotiations will be provided in NHS England's supplementary evidence, due with DDRB later in the year.
- 1.3 The material in this chapter provides background information for DDRB members on recruitment and retention, earnings and expenses and other relevant developments in general practice.

Background

- 1.4 Most doctors working in GMS are independent contractors, who are self-employed individuals or partnerships running their own practices as small businesses. According to the latest figures published by the Information Centre for Health and Social Care³, as at 30 September 2013, there were 7,962 GP practices in England. Of these, around 55% of practices (accounting for 51% of GMPs) operated under the national GMS contract.
- 1.5 Contractors with Personal Medical Services (PMS) arrangements operate within locally agreed contracts, and any uplifts in investment for PMS contracts are a matter for NHS England to consider. NHS England is committed to ensuring an equitable funding approach for Primary Medical Care Contracts, and is undertaking reviews of all PMS contracts.
- 1.6 In addition, there are a small number of GMPs (960) who work under, or hold, contracts under a locally contracted Alternative Provider Medical Services (APMS) arrangement across some 271 practices.

Recruitment, retention and motivation of GMPs

- 1.7 As at September 2013³, in headcount terms, there were 35,561 GMPs - an increase of 112 (0.1%) since 2012 and an estimated increase of 5,203 (17.1%) since 2003 (an annual average increase of 1.7%).
- 1.8 Of these, there were 26,635 GMP providers, a slight decrease of 151 (0.6%) since 2012, and an estimated decrease of 2,011 (7.0%) since 2003.
- 1.9 The number of 'other' GMPs (typically salaried practitioners) now stands at 9,153, an increase of 255 (2.9%) since 2012 and an estimated increase of 7,441 (435%) since 2003.

³ Available at: <http://www.hscic.gov.uk/catalogue/PUB13849/nhs-staf-2003-2013-gene-prac-rep.pdf>

- 1.10 The average age of the workforce has reduced slightly since 2012, with 44.0% of practitioners in 2013 under the age of 45 (43.1% in 2012) but the average age still remains higher compared with 46.7% under the age of 45 in 2003 - and 22.3% over the age of 55 in 2013, compared with 21.3% in 2003.
- 1.11 There are now 4,419 GMP registrars, compared with 2,235 in 2003, an increase of 2,184 – 97.7%.
- 1.12 The Seventh National GP Work Life Survey⁴ conducted by Manchester University in Autumn 2012, on working conditions and job satisfaction of GMPs, is the most up to date comparable evidence in measuring GMP satisfaction based on the 1,189 responses from 3,000 GMPs (in England). This showed:
- on a seven-point scale, overall average job satisfaction had increased from 4.7 points in 2008 to 4.9 points in 2010 and then decreased slightly to 4.5 points in 2012.
 - average working hours were 41.7 hours per week - a slight increase (by 0.3 hours – 0.7%) since the 2010 survey - which had remained unchanged since the 2008 survey.
 - There was no change between 2010 and 2012 in the proportion of GPs reporting undertaking out-of-hours work: in 2012, 21% did so, for a median of 4 hours. However, that was significantly fewer than in 2008, when 32% reported undertaking out-of-hours work.
 - The proportion of GPs expecting to quit direct patient care in the next five years had increased from 6.4% in 2010 to 8.9% in 2012 amongst GPs under 50 years-old and from 41.7% in 2010 to 54.1% in 2012 amongst GPs aged 50 years and over. This reverses the trend in previous years when, in 2010 the proportion of GMPs expecting to quit direct patient care in the next five years fell from 7.1% in 2008 to 6.4% in 2010 amongst GMPs under 50 years old and from 43.2% to 41.7% amongst GMPs aged 50 and over.
- 1.13 The NHS Pension Scheme forms a significant part of the overall GMP reward package. Uniquely amongst self-employed people, GMPs and GDPs have access to a defined benefit pension scheme, effectively guaranteed by the Exchequer. GMP earnings can fluctuate widely from year to year, according to the work that the individual practitioners carry out and how much is taken as net income. To take account of these fluctuations in earnings, GMPs have a Career Average Pension arrangement in which their pensionable earnings are revalued by an annual uprating factor, in a process known as 'dynamisation'. This revalues GMP earnings for pension purposes by the Consumer Prices Index plus 1.5%.
- 1.14 Salaried GP recruitment and retention is a problem for some areas of England, and would not necessarily be influenced or resolved through a contract uplift. It should be noted that, as the DDRB recommendation affects the contract price, salaried GP pay may not be automatically uprated (depending on the contract). This would lead to

⁴ Source: <http://www.population-health.manchester.ac.uk/health/economics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf>

inequity between GMP and salaried GPs with resulting impacts on salaried GP recruitment.

Workload of GMPs

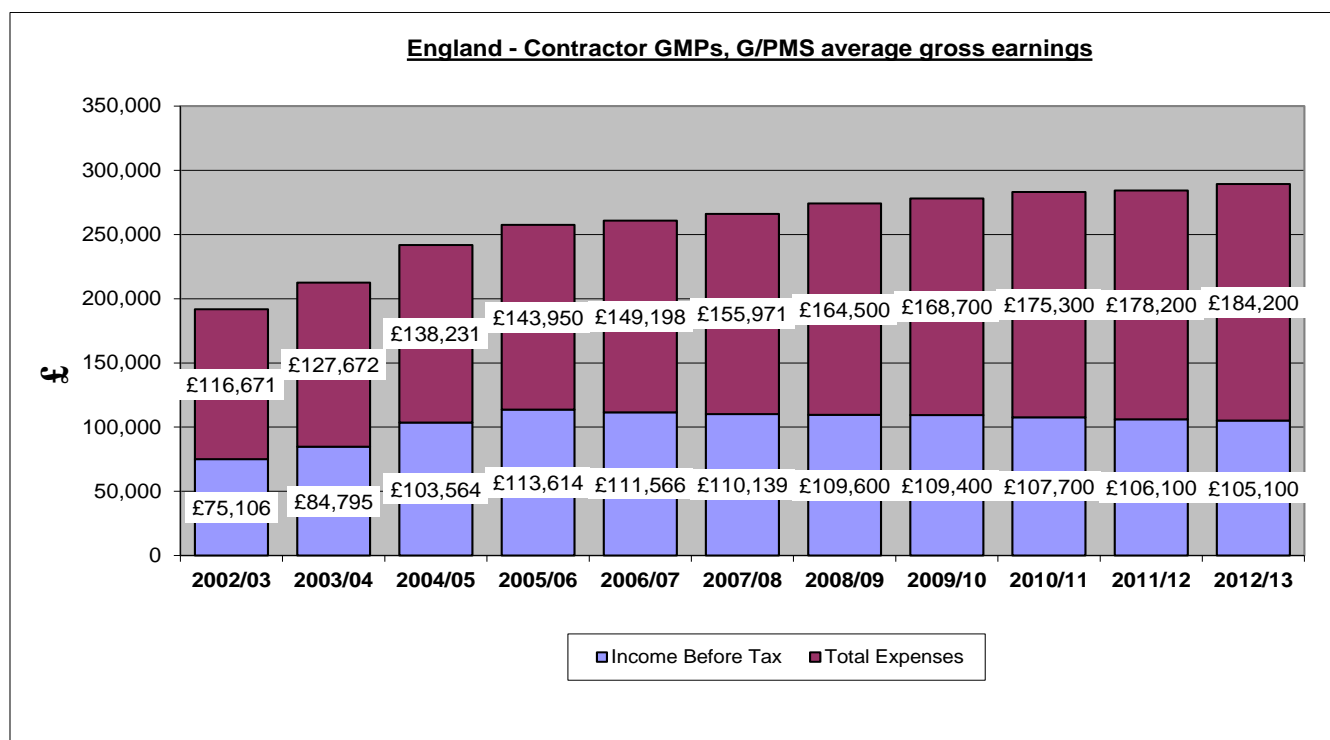
- 1.15 The average number of patients per medical practitioner in England has fallen from 1,672 in 2003 to 1,575 (-5.8%) in 2013, partly because the number of GMPs continues to grow faster than the number of patients.
- 1.16 The number of patients per practice has risen from 5,968 in 2003 to 7,034 in 2013. Over the same period, the number of practices has decreased from 8,833 to 7,962, reflecting a move towards larger practices employing more GMPs. This trend is also evident in the decline of single-handed GMPs from 2,578 in 2003 to 891 in 2013.
- 1.17 There remains a significant overall increase in headcount numbers of practice staff between 2003 and 2013, with total practice staff numbers increasing by 27,965 (25%) to 138,056.
- 1.18 Taken together, the total number of primary care staff (GMPs and practice staff) was 140,449 in 2003 which increased by 33,168 or 24% to 173,617 in 2013. Over the same period, the ratio of patients to primary care staff has decreased by 53 patients (-14%), from one for every 375 patients to one for every 323 patients.

Trends in the earnings and expenses of GMPs

- 1.19 In 2013/14, the comparable spend for the NHS in England was £8.7 billion⁵ on primary medical services compared to £5 billion in 2002/03 - an overall real-terms increase of 37%, and a cash increase of 3.47% compared with 2012/13.
- 1.20 The following points set out the trends in GMP earnings and expenses in England since 2002/03:
- GMP pay has increased in cash and real terms relative to other NHS staff groups. On a cash basis, pay has increased by 40% over the period 2002/03 to 2012/13. This compares to an increase of 24% for consultants and 19% for nurses over the same period.
 - In real terms pay has increased by more than 11% over the same period.
 - Increases in GMPs' pay were concentrated in the three years from 2003/04 to 2005/06 following introduction of a new GMS contract. Since 2005/06, there have, to date, been small year-on-year falls in net income.
- 1.21 Figure 1.1 below, based on data provided by Her Majesty's Revenue & Customs (HMRC), shows increases in gross earnings and net income for the average GMP in England during the period 2002/03 to 2012/13 (the latest year for which data are available).

⁵ <http://www.hscic.gov.uk/catalogue/PUB14900>

Figure 1.1



1.22 The figures in Table 1.2 below represent the position for the average GMP and show the distribution of net income received by groups of contractor GMPs on a UK basis (England figures are not available for this analysis).

Table 1.2

Numbers of UK GPMS GMPs in different net income brackets (before tax)						
Financial Year	Less than £50k	£50k - £100k	£100k - £150k	£150k - £200k	£200k - £250k	More than £250k
2002/03	7,842	20,493	3,875	221	0	0
2003/04	5,138	19,883	6,469	904	222	0
2004/05	3,060	15,442	12,264	2,492	475	154
2005/06	2,001	12,342	14,534	3,876	816	307
2006/07	2,048	13,387	13,832	3,623	739	258
2007/08	2,320	13,610	13,220	3,560	650	260
2008/09	2,310	14,020	12,820	3,280	700	250
2009/10	2,280	13,410	13,180	3,280	680	210
2010/11	2,360	13,780	12,930	3,190	530	200
2011/12	2,390	14,180	12,690	3,020	510	160
2012/13	2,460	14,370	12,550	3,020	480	160

1.23 There are likely to be several factors affecting the increasing number of GMPs in the higher income brackets, including a growing number of GMPs who hold more than one contract to provide medical services. Table 1.2 shows significant movement in the numbers of GMPs in higher income brackets following the introduction of the new GMS contract, followed by some year-on-year reductions since 2005/06.

1.24 Table 1.3 below sets out actual GMP average net income for 2002/03 to 2011/12.

Table 1.3

England GPMS GMPs				
Financial Year	Average Net Earnings £	Year on Year Cash Change	Cumulative Cash Change	Cumulative Real Terms Change
2002/03	75,106	-	-	-
2003/04	84,795	12.9%	12.9%	10.8%
2004/05	103,564	22.1%	37.9%	31.6%
2005/06	113,614	9.7%	51.3%	41.8%
2006/07	111,566	-1.8%	48.5%	35.4%
2007/08	110,139	-1.3%	46.6%	30.4%
2008/09	109,600	-0.5%	45.9%	26.2%
2009/10	109,400	-0.2%	45.7%	22.6%
2010/11	107,700	-1.6%	43.4%	17.6%
2011/12	106,100	-1.5%	41.3%	13.3%
2012/13	105,100	-0.9%	39.9%	11.0%

1.25 Table 1.4 below shows trends in the ratio of gross earnings to practice expenses. The expenses to earnings ratio has traditionally been around 60:40. In 2005/06, when average GMP earnings peaked at £113,614, the ratio was 56:44.

Table 1.4

England GPMS GMPs			
Financial Year	Gross Earnings £	Expenses £	Expenses as a % of Earnings
2002/03	191,777	116,671	61%
2003/04	212,467	127,672	60%
2004/05	241,885	138,321	57%
2005/06	257,564	143,950	56%
2006/07	260,764	149,198	57%
2007/08	266,110	155,971	59%
2008/09	274,100	164,500	60%
2009/10	278,100	168,700	61%
2010/11	283,000	175,300	62%
2011/12	284,300	178,200	63%
2012/13	289,300	184,200	64%

1.26 Unlike many other staff groups, GMP contractors have scope to increase their net income. They can do this by attracting new income from a range of sources and / or looking to reduce their practice expenses. For example:

- additional income could be gained from a variety of professional activities outside their NHS work. Examples include occupational health services, services to the local authority, CCG leadership responsibilities, etc. The latest GMP earnings and expenses report by the NHS Health & Social Care Information Centre (HSCIC) states that it is not possible to provide an NHS/private split using HMRC earnings data. However, as a guide, NHS superannuable earnings for GPMS contractor GMPs in Great Britain were 96.2% of total earnings, suggesting 3.8% was private income;
- additional income could also be gained from NHS and other public sector work. For example, in providing public health services commissioned by Local Authorities, such as smoking cessation. In 2013/14, local Authorities commissioned a total of £63m of public health services from practices (which is the provisional figure they have provided us); and
- expenses could be reduced through seeking greater efficiencies, for example, through:
 - the introduction of federated approaches and sharing of back office functions and staff with other practices;

- appropriate increased delegation to other members of the practice team; and
- partnership working with local pharmacies.

Clinical Commissioning Groups and GP income

- 1.27 In our evidence last year, we summarised those aspects of the role undertaken by Clinical Commissioning Groups (CCGs) which were likely to be of interest and relevance to DDRB.
- 1.28 Since then, NHS England’s Chief Executive, Simon Stevens, announced on 1 May, 2014, proposals for local CCGs to co-commission primary care in partnership with NHS England.
- 1.29 The intention is that CCGs will get new powers to improve local health services under a new commissioning initiative that will give them greater influence over the way NHS funding – especially primary care funding - is being invested for local populations.
- 1.30 CCGs that were interested in an expanded role in primary care were invited to express an interest and outline how new powers would enable them to drive up the quality of care, cut health inequalities in primary care - and help put their local NHS on a sustainable path for the next five years and beyond. Expressions of interest were received from 191 CCGs from a total of 211 CCGs. NHS England is currently reviewing these prior to considering next steps.
- 1.31 We will keep DDRB abreast of any developments in this area that could have a material effect on matters within DDRB’s remit.

Access to GP Services: the Prime Minister’s Challenge Fund

- 1.32 In October 2013, the Prime Minister announced⁶ a £50 million Challenge Fund to improve access to general practice and test innovative ways of delivering GP services. NHS England was asked to lead on selecting and managing the pilot schemes.
- 1.33 In December 2013, NHS England invited GP practices to submit their ‘expressions of interest’ to be one of the pilots, before selecting the final list of schemes.
- 1.34 Twenty GP collaborations have been awarded funds to run pilots for one year, with the aim of transforming primary care services in their areas and improving the patient experience. More than seven million patients across the country will benefit from the pilot schemes that are trialing improvements to GP access
- 1.35 A wide variety of innovative ideas are being trialed – including:
- opening 8 a.m.- 8 p.m. on weekdays and weekends;
 - better use of telecare and health “apps”;
 - more ways for patients to book appointments including e-mail and Skype; and

⁶ <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access>

- new services like care coordinators, to manage care for patients with complex needs.

1.36 NHS England is now working with the pilots as part of a 12-month national development and evaluation programme, sharing learning with all practices across England to spread innovation.

GMS contract changes in 2013/14

1.37 The 2013/14 contract changes announced on 18 March 2013, included an increase to the Global sum equivalent by an overall 1.47%, benefitting the earnings of all GP providers. That was the combined uplift as a result of a 1.32% uplift to the contract value and the transfer of locum superannuation funding into the global sum equivalent, representing a further 0.15%. This was achieved through;

- introducing equitable funding in GMS contractual arrangements from 2014/15 phased over a seven year period, along with the redistribution of correction factor payments between contractors;
- introducing changes to the Quality and Outcomes Framework (QOF), as follows.
 - full implementation of all recommendations made by NICE, although two indicators will be implemented in 2014/15;
 - raising upper thresholds for existing indicators to reflect the current achievement of top performing practices (in line with the 75th centile of achievement). This will be phased in over two years, with the increase being applied to 20 indicators in 2013/14 and the remaining indicators from 2014/15. From 2015/16, thresholds could change on an annual basis in relation to practice achievement;
 - the introduction of a new public health domain;
 - retaining the Quality and Productivity indicators (QP) until 31 March 2014;
 - retiring all remaining organisational domain indicators not retained in QP or moved into the Public Health Domain;
 - removing the current year end overlap for most indicators by changing the indicator timeframe (from 15 to 12 months or 27 to 24 months, including changing the time period for general exceptions);
 - reforming the list size weighting (Contractor Population Index – CPI); and
 - retirement of indicators in the QOF organisational domain.
- Introducing changes to accommodate recommendations made by the Joint Committee for Vaccination and Immunisation (JCVI). These include introducing a new item of service (IOS) fee of £7.63 for a completed course of rotavirus for infants from July 2013, removing one dose of meningitis C from the childhood

vaccination scheme and introducing a new IOS fee of £7.63 for routine shingles vaccination for patients aged 70.

- 1.38 Funding to the value of £120m, through the retirement of indicators in the QOF organisational domain, were used to develop four new enhanced services to facilitate:
- the identification and management of patients identified as seriously ill or at risk of emergency hospital admission;
 - a proactive approach to the timely assessment of patients who may be at risk of dementia;
 - preparatory work to support the subsequent introduction of remote care monitoring for patients; and
 - enabling patients to utilise electronic communications for appointment booking and obtaining repeat prescriptions.
- 1.39 Full details of all 2013/14 contract changes are set out in the '2013/14 GMS Contract Negotiations' letter (Gateway reference 18276) available on the DH website⁷.

GMS contract changes in 2014/15

- 1.40 The 2014/15 contract changes included an increase to the global sum equivalent for all GP providers by an overall 0.28%. That was the combined uplift to the overall value of contract payments intended to result in an increase of 1% to GMPs income after allowing for changes in their expenses. This was achieved through:
- reducing QOF by 341 points (38%) by retiring the Quality and Productivity indicators and, without the Out of Hours deduction applying, reinvesting:
 - 70% (238) of retired points into global sum:
 - 29% (100) in the new Enhanced Service (ES) for Avoiding Unplanned Admissions and Proactive Case Management to improve services for patients with complex health and care needs, who may be at high risk of unplanned admission to hospital; and
 - 1% (3 points) to fund improvements in the Learning Disabilities Enhanced Service.
 - deferring the planned changes in thresholds in QOF from April 2014 to April 2015;
 - introducing a named GP for patients aged 75 and over;
 - introducing a requirement for those practices who have opted out of providing Out of Hours services (i.e. around 90%) to monitor the quality of those services and report any concerns to NHS England;

⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213014/gms-contract-2013-2014.pdf

- establishing a working group to develop proposals on how the publication of GP NHS net earnings relating to the contract should be implemented for 2015/16 as a contractual requirement;
- practices undertaking the Friends and Family Test from December, 2014;
- agreement to introduce Choice of GP Practice on a voluntary basis, working with NHS England and NHS Employers to resolve any practical issues prior to implementation;
- ending seniority payments by March 2020 evenly each year, adding the funding released into global sum with no Out of Hours deduction being applied
- practices publicising their CQC inspection results;
- updating the existing deprivation factors in the Carr Hill formula and working with NHS England to develop formula changes for implementation from April 2015;
- additional patients' information requirements in connection with referral management, electronic appointment booking, online booking of prescriptions and the interoperability of patient records;
- promoting and offering the facility for on-line access to patients' information held on their summary care record (SCR) and working with NHS England in 2014/15 on how practices can:
 - promote and offer patients the opportunity for secure communication with their practice; and
 - permit access to the detailed patient record from other care settings, subject to the satisfaction of required Information Governance controls;
- introducing a new learning disabilities enhanced service for one year in 2014/15 to strengthen the requirements and improve access to the service.
- extending and revising the existing enhanced services for the following
 - patient participation;
 - extended hours access; and
 - dementia.

1.41 Full details of all 2014/15 contract changes are set out in the '2014/15 GMS Contract Negotiations' letter (Gateway reference 01381) available on NHS England's website⁸.

⁸ <http://www.england.nhs.uk/wp-content/uploads/2014/03/gp-contract-letter-at-fin.pdf>

GMS contract changes in 2015/16

- 1.42 NHS England has provided a detailed negotiating remit to NHS Employers, which they are currently discussing with the GPC. We will provide an update on the conclusion of these negotiations in NHS England's supplementary evidence, due to be provided to DDRB in November.

Conclusion

- 1.43 This chapter provides information on the latest position on recruitment and retention, earnings and expenses, and other relevant developments in general practice.

CHAPTER 2 – GENERAL DENTAL PRACTITIONERS

Introduction

- 2.1 This chapter provides an update on general dental practitioners (GDPs) providing NHS primary care services and those salaried GDPs on terms and conditions set by NHS organisations in England.
- 2.2 NHS England will meet the General Dental Practice Committee of the BDA in early Autumn to discuss practice expenses and possible quality and efficiency improvements for 2015/16. We believe that overall levels of uplift for independent contractors are best considered as part of such discussions with the profession's representatives about on-going improvements in contractual arrangements and, provided that it is possible to secure appropriate improvements in quality and efficiency of services.

Background

- 2.3 In April 2013, NHS England became responsible for commissioning all NHS dental services, including primary, community and hospital dental services. NHS England is working towards a single operating model, which provides an opportunity for consistency and efficiency where it is required, and enables flexibility through Area Teams where it is necessary. The proposals for dental commissioning will build on the single operating model for primary care commissioning described in *Securing excellence in commissioning primary care*.⁹
- 2.4 NHS England is committed to designing a commissioning system for dental services that is capable of:
 - improving health outcomes and making best use of NHS resources;
 - reducing inequalities;
 - promoting greater patient and public involvement; and
 - promoting and swiftly adopting innovation that delivers excellence.
- 2.5 This is expected to be delivered through a single system with a consistent operating model across the country. NHS England will ensure there are clear and consistent outcome measures, indicators and a single accountability framework for NHS primary care dentistry in England, but this is not to be at the expense of stifling local innovation in service and quality improvement.
- 2.6 In 2011, in response to dentists continuing to say the current contract leaves them on an “activity treadmill” with no specific rewards for delivering high quality care or for delivering prevention, the Department of Health set up a new pilot scheme. The pilots look at elements of a new contract based on capitation and quality, which will focus

⁹ (www.commissioningboard.nhs.uk/files/2012/06/ex-comm-pc.pdf)

on the treatment patients need and avoid unnecessary treatments. There are currently approximately 90 practices involved in the scheme.

- 2.7 All pilots are trialling and testing the new oral health assessment and clinical pathway designed to support dentists in delivering the best care for patients. The focus on quality is intended to support dentists to improve the oral health of their patients, while the capitation system and the focus on long-term care will give patients the security of continuing care. The current regulations underpinning the pilots will come to an end in 2015. During 2014/15, NHS England - working with DH and the profession, will use the learning from the pilots to develop prototype contracts to be tested over the following year. We expect the proposed new contract will address many of the concerns of the profession and will drive further improvements in dental health in England.
- 2.8 The 42nd report asked parties to consider how DDRB recommendations on pay may fit alongside new contractual arrangements. Developments in England are not sufficiently advanced to provide an answer and a date for completion of the new contract is yet to be decided.
- 2.9 Although it is clear that changes to the current system are necessary, we are pleased to note that the current position on NHS dentistry continues to improve and there has been a further increase in the number of dentists working in the NHS in 2013/14. We want to see a continued improvement in access to NHS dental services. Questions included in the GP Patient Survey tell us about access to NHS dental services. This shows that 95% of people who tried to get an appointment with an NHS dentist in the past three years were successful. For those seeking an appointment in the last six months, the success rate is very high at 96%.

Table 2.1

Success rates for patients who tried to get an appointment in the last 6 and 24 months by Area Team regions:

	Success rate in last 24 months: % who succeeded, not including "Can't remembers"	Success rate in last 6 months: % who succeeded, not including "Can't remembers"
England	95	96
Arden, Herefordshire and Worcestershire	96	98
Bath, Gloucestershire, Swindon and Wiltshire	96	97
Birmingham and the Black Country	96	97
Bristol, North Somerset, Somerset and South Gloucestershire	96	97
Cheshire, Warrington and Wirral	97	98

	Success rate in last 24 months: % who succeeded, not including "Can't remembers"	Success rate in last 6 months: % who succeeded, not including "Can't remembers"
Cumbria, Northumberland, Tyne and Wear	96	98
Derbyshire and Nottinghamshire	95	97
Devon, Cornwall and Isles of Scilly	95	96
Durham, Darlington and Tees	97	98
East Anglia	96	97
Essex	96	97
Greater Manchester	93	95
Hertfordshire and the South Midlands	96	97
Kent and Medway	93	95
Lancashire	95	96
Leicestershire and Lincolnshire	94	96
London	93	94
Merseyside	95	97
North Yorkshire and Humber	95	97
Shropshire and Staffordshire	96	98
South Yorkshire and Bassetlaw	95	97
Surrey and Sussex	94	95
Thames Valley	96	97
Wessex	95	97
West Yorkshire	93	95

2.10 In the last year:

- access to NHS dental services has risen: 29.9 million patients (56% of the population) were seen by an NHS dentist in the 24-month period ending June 2014. The number is 103,000 higher than twelve months earlier, and 2.9 million higher than the low point reached in June 2008;
- there has been a rise in NHS dental activity, from 88.1 million units of dental activity (UDAs) in 2012/13 to 88.7 million UDAs in 2013/14. An overall increase of almost 600k - despite the reduction due to the phasing out of prescription only UDAs. Area Team commissioning plans at June 2014 for the following twelve months are 196,000 UDAs lower than a year ago. However, this is a result of

quality checks that identified CDS/TDS/salaried contracts had been incorrectly included in the dental commissioning figures in previous years;

- the number of dentists providing NHS services rose by 522 to 23,723 dentists in 2013/14; and
- the proportion of dentists' time spent on NHS work fell from 74.8% in 2011/12 to 72.8% in 2012/13.

2014/15 settlement

- 2.11 For 2014/15, DDRB recommended an uplift of 1.8%. This was made up of four elements:
- increases of 1% for dental salaries;
 - 2.5% for staff costs;
 - 2.7% for laboratory and materials costs; and
 - 2.6% for other costs.
- 2.12 The 1% pay cap on increase in public sector salaries meant the Department of Health decided to abate the increase in the staff cost element from the recommended 2.5% to the 1% limit. This resulted in a reduction of the recommendation to an overall increase of 1.6%.
- 2.13 The national uplift was applied to gross contract values for GDS contracts and PDS agreements.
- 2.14 As part of this package, dentists were expected to continue to work closely with the Department and NHS England to prepare for moves to a new national contract based on capitation, quality and registration. This included a further move to fully computerised practice systems and a nationally consistent approach to contract management.
- 2.15 The 2014/15 package also included a number of measures to improve efficiencies – including:
- move to a shorter return cycle for activity and performance data;
 - dental practice computerisation to continue to increase;
 - reduction in unnecessary referrals to secondary care; and
 - changes to maternity and sickness allowances (which are still being discussed before implementation).
- 2.16 As with other NHS efficiencies, every penny saved will be invested back into patient care, and thus will help to improve further the quality of patient services including primary dental care.

General Dental Practitioners: Earnings and Expenses

- 2.17 The average figures published by the Health & Social Care Information Centre (HSCIC) cover dentists doing any NHS work in the year. A significant number of dentists come and go within a year. With 22,180 dentists covered by GDS or PDS contracts in 2012/13, there were 1,130 leavers and 1,680 joiners in-year - or 2,810 (12.7%) working for only part of the year for the NHS.
- 2.18 The numbers of dentists for the years 2006/07 to 2013/14 are set out on table 2.4 below (table 7e from 'NHS Dental Statistics for England 2013/14').

Table 2.4:

Number and percentage of dentists with NHS activity in the year ending 31 March, by dentist type, 2006/07 to 2013/14

	Number			Per cent		
	Providing performer	Performer only	Total	Providing performer	Performer only	Total
2006/07	7,585	12,575	20,160	37.6	62.4	100
2007/08	7,286	13,529	20,815	35.0	65.0	100
2008/09	6,778	14,565	21,343	31.8	68.2	100
2009/10	6,279	15,724	22,003	28.5	71.5	100
2010/11	5,858	16,941	22,799	25.7	74.3	100
2011/12	5,099	17,821	22,920	22.2	77.8	100
2012/13	4,649	18,552	23,201	20.0	80.0	100
2013/14	4,413	19,310	23,723	18.6	81.4	100

Notes

- 1) Dentists are defined as performers with NHS activity recorded by FP17 forms.
- 2) Data consists of performers in General Dental Services (GDS), Personal Dental Services (PDS) and Trust-led Dental Services (TDS).

Net Earnings

- 2.19 The data from the HSCIC continues to be difficult to compare with previous years because of changes in the way dentists pay themselves, especially the move towards personal and practice incorporation, which takes profits out of the self-employed tax system for the individual dentist and moves them into company accounts.
- 2.20 This is a significant issue, which has a serious impact on the ability to access data on key areas including the relative level of expenses and earnings. However, it is clear that dentists continue to receive a good income. Although the average identifiable net profit after expenses for dentists in 2012/13 fell to £72,600 compared with £74,400 in the previous year, this remains a well remunerated profession.

- 2.21 For dentists holding a contract, earnings were considerably higher at an average of £114,100 - an increase of 1.2% from the previous year's £112,800. The data also show some dentists earning considerably more; with 0.9% earning over £300,000. Dentists working for others still had an average net profit of £60,800, down 1.5% from the £61,800 of the previous year.
- 2.22 We do not have exact figures on how many dentists changed their business arrangements in this way, but we do know the changes in the number of self-employed dentists overall in 2013/14. Compared to 2012/13, there were 5.1% fewer dental contract holders and 4.1% more "dentists who work for others".
- 2.23 On expenses, the data showed that just over half (53.5%) of gross payments to dentists was to meet their expenses.

Table 2.2: Gross income and net profit of primary care dentists 2004/05 to 2012/13

	Population	Average gross income	Expenses	Net profit	Expenses ratio
2004/05 GDS only	13,309	£193,215	£113,187	£80,032	58.6
2005/06	18,796	£205,368	£115,450	£89,919	56.2
2006/07	19,547	£206,255	£110,120	£96,135	53.4
2007/08	19,598	£193,436	£104,373	£89,062	54.0
2008/09	19,636	£194,700	£105,100	£89,600	54.0
2009/10	20,300	£184,900	£100,000	£84,900	54.1
2010/11	20,800	£172,000	£94,100	£77,900	54.7
2011/12	21,300	£161,000	£86,600	£74,400	53.8
2012/13	21,500	£156,100	£83,500	£72,600	53.5

Note: some double counting of expenses inflates both gross income and expenses but does not affect reported net profit.

- 2.24 Information on dentists' income compiled by NASDAL reported a decrease in net profit for NHS practices in 2012/13 of 3.1%, to an average profit of £125,958. Net profit for NHS practices still continues to exceed average net profit of private practices, although this difference in 2013/14 is marginal. Profits in NHS practices have exceeded those in private practices since 2005/06.

Table 2.3: Net profit for the practice

Type of practice	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
NHS	£118,000	£142,400	£149,500	£148,000	£161,300	£147,800	£133,020	£130,000	£125,958
Mixed	£100,400	£129,600	£147,100	£140,700	£138,600	£143,800	£127,045	-	-
Private	£124,700	£131,400	£130,900	£136,500	£130,600	£126,400	£117,552	£117,000	£124,086

Source: NASDAL. NHS practices are those where NHS earnings are 80% or more. Private practices are those where private earnings are 80% or more. Data for mixed practices was not provided in 2011/12

- 2.25 NASDAL report that average net profit for associate dentists (those dentists with no share of ownership) increased slightly for the first time since 2008/09 to £67,770 in 2012/13, from £67,027 in 2011/12.

Expenses

- 2.26 The HSCIC earnings report continues to note the increasing difficulty in separating out expenses between performers and providers and the possible double counting of expenses. They state:

Introduction to the HSCIC Report on dental earnings and expenses UK initial analysis

Multiple counting

The results presented in this report reflect earnings and expenses as recorded by dentists on their Self-Assessment tax returns. The majority of payments for NHS dentistry are made to Provider-Performer/Principal dentists. In some cases dentistry is actually performed by a Performer Only/Associate dentist working in the Provider-Performer/Principal's practice and some of that payment will be passed on to the Performer Only/Associate. This means that the same sum of money may be declared as gross earnings by both the Provider-Performer/Principal and Performer Only/Associate and as an expense by the Provider-Performer/Principal. This is known as 'multiple counting'. Its extent is difficult to quantify but, where it does occur, multiple counting will inflate only gross earnings and total expenses values. The resulting taxable income values are not affected. Where a dentist is single-handed (i.e. is the only dentist working in a practice), no multiple counting will occur.

Incorporation

This report only considers those primary care dentists who have earnings from self-employment. Traditionally, the employment status of a vast majority of primary care dentists (both Providing-Performer/Principal and Performer Only/Associate) has been self-employment. As such, these dentists complete Self-Assessment tax returns which, subject to certain exclusion criteria have been used to inform the analyses presented in the dental earnings reports. Since the introduction of the Dentists Act 1984 (Amendment) Order 2005, it has been possible for dentists to incorporate their business(es) and become a director and/or an employee of a limited company (Dental Body Corporate), with the potential to operate in a highly tax-efficient manner. Both Providing-Performer/Principal and Performer Only/Associate dentists are able to incorporate their businesses. For Providing-Performer/Principal dentists, the business tends to be a dental practice. For Performer Only/Associate dentists, the business is the service they provide as a sub-contractor. It is currently not known how many dentists have incorporated their business(es) and what the precise consequences of incorporation may be for the results presented in this report.

- 2.27 In looking at expenses we continue to need to take account of the fact that average earnings and expenses figures are affected by the composition of the population covered. There are significant on-going changes in the composition of the dentists in the earnings and expenses figures: mainly a large shift from Providing-Performer dentists to Performer only dentists.

- 2.28 Dentists can also choose to alter the balance between gross and net pay without a major effect on earnings. Changes in earnings and expenses reflect more than just changes in pay rates and price changes. For example, if dentists work longer hours they have higher gross income but also may have higher expenses (and higher net income). The figures may also reflect changes in the type of work undertaken (e.g. complex treatment with higher expenses vs time consuming with lower expenses).
- 2.29 As already noted, the changes from year to year are affected by contract holder dentists changing their business arrangements into companies. This is tax efficient. Some profit is retained in the company, which in turn makes a self-employment payment to the dentist. The profits retained in the company are no longer covered in these self-employed earnings figures. There is also evidence that many individual performer dentists continue to operate under limited company status - further confusing the self-employed earnings report.
- 2.30 The issue of multiple-counted expenses is also important as noted by the HSCIC. For example, a dental performer pays the laboratory bills associated with treatment out of their gross income. The performer pays the contract holder who in turn pays the laboratory. Both the contract holder and the dental performer show the cost as an expense, with the contract holder showing the payment from the performer as an income. The HSCIC paper (above) indicates that the extent of double-counting may have increased since 2006. This is because gross payments are no longer paid directly to individual dentists.
- 2.31 Extracts from the NASDAL results are in the table below. They show that there have been only slight variations in expenses as a percentage of gross income in 2012/13 - with the exceptions of non-clinical staff costs in NHS practices increasing by 1.1% - and other non-staffing costs in private practice falling by 2.4%.

Table 2.5 Categories of expenses as a percentage of gross income

	2005/ 06	2006/ 07	2007/ 08	2008/ 09	2009/ 10	2010/ 11	2011/ 12	2012/ 13
Non-clinical staff wages (NASDAL)								
NHS practices	18.2%	17.3%	17.9%	17.7%	18.8%	19.8%	19.9%	21.0%
Private Practices	17.2%	17.4%	17.8%	17.6%	18.1%	19.4%	19.5%	19.5%
Laboratory costs (NASDAL)								
NHS practices	6.4%	5.6%	6.1%	6.0%	6.5%	6.3%	6.1%	6.4%
Private Practices	8.9%	7.8%	7.6%	7.1%	7.9%	7.6%	7.2%	7.3%
Materials costs (NASDAL)								
NHS practices	5.6%	5.0%	5.6%	5.4%	5.6%	6.3%	6.6%	6.3%
Private Practices	6.7%	7.0%	7.5%	7.1%	7.5%	7.9%	7.4%	7.2%
Other Non-Staffing Costs (Morris & Co)								
NHS practices	16.4%	16.8%	15.7%	15.6%	15.1%	16.7%	16.6%	16.4%

	2005/ 06	2006/ 07	2007/ 08	2008/ 09	2009/ 10	2010/ 11	2011/ 12	2012/ 13
Private Practices	23.0%	23.2%	23.6%	21.4%	21.2%	21.7%	22.8%	20.4%
Note: 2006/07 figures for NHS practices are affected by temporary increase in income from transition to the new contract. 2005/06 NHS figures include PDS.								

General Dental Practitioners: Recruitment, Retention and Motivation

- 2.32 The numbers of dentists providing NHS services continues to be a relatively weak indicator of supply: it is the number of NHS patients and the amount of NHS service they receive that is more important - and these continue to rise. However, the numbers of dentists has also continued to rise, up by 2.2% last year. Overall, the number of dentists providing NHS services rose by 522 to 23,723 dentists in 2013/14.
- 2.33 Dentists are still ready (and indeed enthusiastic) to bid for and undertake NHS contracts, especially in areas where dentists had previously chosen not to set up or provide NHS services and NHS access continues to rise.
- 2.34 Dentists have achieved a reduction in working hours, with evidence from the HSCIC dental working hours survey published in September 2014 showing that dentists are working an average of 36.9 hours per week in 2013/14 compared to 39.4 hours in 2000, a reduction of over 6%.
- 2.35 There are, however, still a number of key issues with the way dentistry is delivered and managed, which we intend to work with the profession to address. As noted earlier, a new dental contract based on registration, capitation and quality is being piloted, which will benefit dentists and patients by focusing on prevention and outcomes rather than the number of interventions.

Future workforce supply

- 2.36 The situation with respect to supply of dentists in the workforce has changed fundamentally over the last few years. The causes of this are complex, but the Department of Health and Health Education England recently commissioned the Centre for Workforce Intelligence to carry out analysis of workforce needs and supply up to 2040. Although there are many variables, and assumptions have to be made on basis of best evidence, all the scenarios suggested an excess of supply over demand/need. Recommendations will be made soon to allow intakes to dental schools to be adjusted to reflect this new situation.
- 2.37 Health Education England will also be looking to review training requirements for dental care professionals in the coming year to see that full use is made of the opportunities for skill mix and delegation within the dental team.

General Dental Practitioners: conclusion

- 2.38 We are taking forward discussions with the BDA with a view to making appropriate improvements in the contract to secure on-going improvements in quality.