



**The Review Body on Doctors' & Dentists'  
Remuneration Review for 2016  
General Medical Practitioners and  
General Dental Practitioners  
September 2015**

# The Review Body on Doctors' and Dentists' Remuneration

## NHS England's Evidence for the 2016 Review

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

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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. Primary medical care commissioning responsibilities were fully delegated to some 63 Clinical Commissioning Groups from 1 April, 2015. However, 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 2016/17 pay for their remit group. In a letter to the Chair of the DDRB which is to follow, a Department of Health Minister will set out the detailed evidence to be provided to you.

### Contract for services

- 0.3 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.
- 0.4 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.
- 0.5 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 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.
- 0.6 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

- 0.7 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.
- 0.8 NHS England's budget for 2016/17 has not yet been set, as the Department of Health's total resource allocation is subject to the outcome of the Spending Review. The Spending Review will be published on 25 November 2015 and we expect that the Department of Health will make decisions on budgets shortly thereafter.

- 0.9 Nevertheless, it is clear that the next five years will continue to require very significant further financial savings and efficiency improvements, similar in scale to those needed over the last five years. Whilst the Government has committed to provide additional real terms funding growth for the NHS over the next five years, NHS England's analysis, set out in the Call to Action<sup>1</sup> and updated in the Five Year Forward View<sup>2</sup> identified funding pressures of around £30 billion by 2020/21.
- 0.10 As a result, it is imperative that all providers in the service make savings and deliver efficiency gains each year.
- 0.11 In June 2010, the coalition Government announced a public sector pay freeze, covering 2011/12 and 2012/13. During the 2011 Autumn Statement, it announced that, for 2013/14 and 2014/15, public sector pay increases would be capped at an average 1%. In March 2014, it announced that the 1% public sector pay cap would be extended by a further year to include 2016/17. This decision was re-affirmed by the Chancellor, who also announced that the 1% pay cap will be extended to cover the next four years in his 8 July 2015 budget.
- 0.12 On the basis of the above, we would urge the DDRB to carefully consider what, if any, uplift is appropriate for 2016/17.

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<sup>1</sup> Available at: [http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs\\_belongs.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf)

<sup>2</sup> Available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

## Chapter 1: General Medical Practitioners (GMPs)

### Introduction

- 1.1 This chapter relates to information on General Medical Practitioners 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 2016/17. 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.
- 1.4 It also sets out the progress being made in delivering on the commitment to invest more in general practice over the next five years, as set out in "A new deal for primary care" on page 18 of the Five Year Forward View<sup>3</sup>.

### Background

- 1.5 Most doctors working under GMS contracts 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 Health and Social Care Information Centre<sup>4</sup>, as at 30 September 2014, there were 7,875 GP practices in England. Of these, around 56% of practices (accounting for 53% of GMPs) operated under the national GMS contract.
- 1.6 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.
- 1.7 In addition, there are a small number of GMPs (1,016) who work under, or hold, contracts under a locally contracted Alternative Provider Medical Services (APMS) arrangement across some 290 practices.

### Recruitment, retention and motivation of GMPs

- 1.8 As at September 2014, in headcount terms, there were 35,819 GMPs - an increase of 258 (0.7%) since 2013 and an estimated increase of 4,296 (13.6%) since 2004 (an annual average increase of 1.4%). In Full Time Equivalent (FTE) terms, there were 32,628 GMPs - an increase of 553 (1.7%) since 2013 and an estimated increase of 4,320 (15.3%) since 2004 (an annual average increase of 1.4%).
- 1.9 Of these, in headcount terms there were 26,183 GMP providers, a decrease of 452

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<sup>3</sup> Available at: <http://www.england.nhs.uk/ourwork/futurenhs>

<sup>4</sup> Available at: <http://www.hscic.gov.uk/catalogue/PUB16934/nhs-staf-2004-2014-gene-prac-rep.pdf>

(1.7%) since 2013, and an estimated decrease of 2,598 (9.0%) since 2004. In FTE terms, there were 23,763 GMP providers, a decrease of 279 (1.2%) since 2013, and an estimated decrease of 2,416 (9.2%) since 2004.

- 1.10 The number of 'other' GMPs (typically salaried practitioners) now stands at 9,885 (8,865 FTEs), an increase of 732 (8.0%) (833 FTEs, representing 10.4%) since 2013 and an estimated increase of 7,143 (261%) (6,736 FTEs, representing 316.4%) since 2004.
- 1.11 The average age of the workforce has reduced slightly since 2013, with 45.2% of practitioners in 2014 under the age of 45 (44.0% in 2013) but the average age still remains higher compared with 46.1% under the age of 45 in 2004 - and 21.9% over the age of 55 in 2014, compared with 20.4% in 2004.
- 1.12 There are now 4,570 GMP registrars, compared with 2,562 in 2004, an increase of 2,008 – 78.4%.
- 1.13 Although the overall cost of locums rose by 32% from £19m in 2012/13 to £26m in 2013/14, it has since only risen by 2% (£0.5m) in 2014/15<sup>5</sup>. (Data on the FTE numbers of locums used in each year is not published).
- 1.14 The Eighth National GP Work Life Survey<sup>6</sup> (to be published on 1 October 2015) conducted by Manchester University in spring and summer 2015, on working conditions and job satisfaction of GMPs, is the most up to date comparable evidence in measuring GMP satisfaction based on the 1,172 responses from 4,000 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, then decreased to 4.5 points in 2012 and further decreased to 4.1 points in 2015.
  - average working hours had, however, reduced slightly from 41.7 to 41.4 hours per week, back to levels in the 2010 survey - which had remained unchanged since the 2008 survey.
  - The proportion of GPs expecting to quit direct patient care in the next five years had increased from 8.9% in 2012 to 13.1% in 2015 amongst GPs under 50 years-old and from 54.1% in 2012 to 60.9% amongst GPs aged 50 years and over. This continued the trend between 2010 and 2012, which reversed the trend in previous years (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).
- 1.15 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

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<sup>5</sup> Available at: <http://www.hscic.gov.uk/pubs/investgp1015>

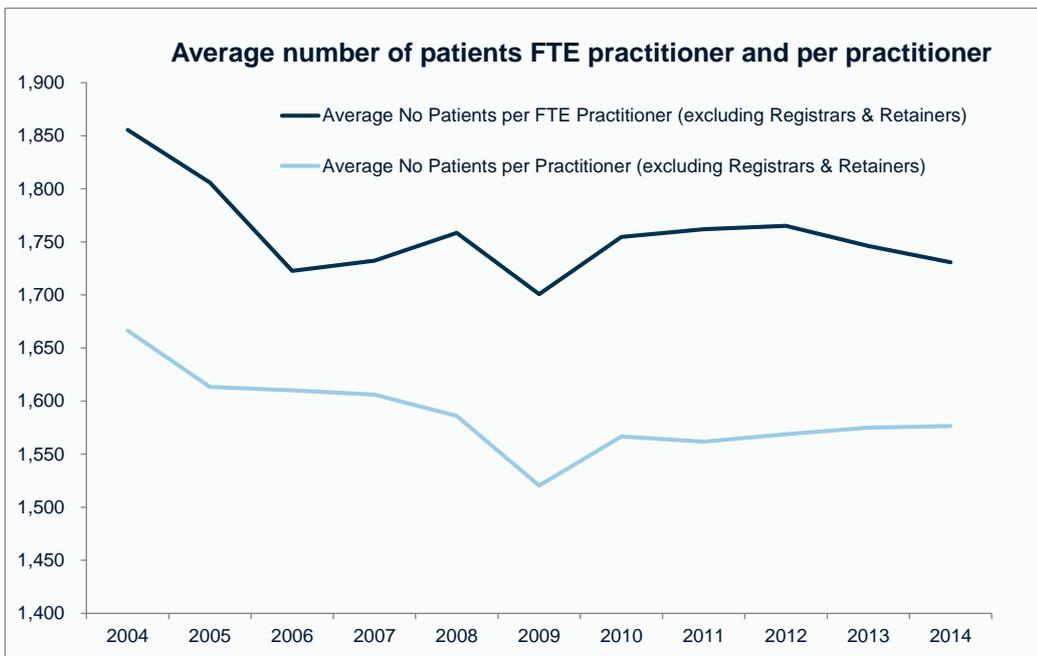
<sup>6</sup> Available at: <http://www.population-health.manchester.ac.uk/health/economics/research/Reports/EighthNationalGPWorklifeSurveyreport/EighthNationalGPWorklifeSurveyreport.pdf>

be noted that, as the DDRB recommendation affects the contract price, salaried GP pay may not be automatically updated (depending on the contract). This could lead to inequity between GMP and salaried GPs with resulting impacts on salaried GP recruitment.

## Workload of GMPs

- 1.16 The average number of patients per medical practitioner in England has fallen from 1,666 (1,856 per FTE) in 2004 to 1,577 (-5.4%) (1,731 per FTE, a reduction of 6.7% since 2004) in 2014, partly because the number of GMPs continues to grow faster than the number of patients. However, whilst it dipped in 2009 to 1,520 per practitioner (1,701 per FTE), it has risen again since, in both headcount and FTE terms. The graph in Figure 1.0 below shows this more clearly (the difference in trend over the past two years is likely to be due to changes to the way FTEs are recorded):

**Figure 1.0**



- 1.17 Whilst the number of patients per FTE GMP have fallen along with a small reduction in the average hours worked, the reduction in job satisfaction and increase in proportions of GPs expecting to quit direct patient care highlighted by the GP Work Life Survey may be explained by workload increases. These are likely to result from an ageing population with more complex health needs, and the fact that long-term health conditions - rather than illnesses susceptible to a one-off treatment - now absorb around 70% of the health service budget<sup>7</sup>.
- 1.18 The number of patients per practice has risen from 6,149 in 2004 to 7,171 in 2014. Over the same period, the number of practices has decreased from 8,542 to 7,875, reflecting a move towards larger practices employing more GMPs. This trend is also evident in the decline of single-handed GMPs (i.e. those with only one practitioner) from 1,949 in 2004 to 843 in 2014.

<sup>7</sup> <http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/>

- 1.19 There remains a significant overall increase in headcount numbers of practice staff between 2004 and 2014, with total practice staff numbers increasing by 27,098 (24%) to 139,352 (which is 88,396 FTEs, an increase of 23%). The overall increase in clinical (non-GP) staff FTEs between 2004 and 2014 was 7,185 to 24,340 (42%) – and the number of patients per FTE fell from 18,499 to 9,836 (47%).
- 1.20 Taken together, the total number of primary care staff (GMPs and practice staff) was 143,777 in 2004 which increased by 31,394 or 22% to 175,171 in 2014. Over the same period, the ratio of patients to primary care staff has decreased by 43 patients (-12%), from one for every 365 patients to one for every 322 patients.
- 1.21 This appears to show that general practice has adapted its skill mix to help meet challenges it has been facing in terms of a changing and increasing workload.

### Five Year Forward View update

- 1.22 In January 2015, the NHS invited [individual organisations and partnerships](#) to apply to become ‘vanguard’ sites for the new care models programme, one of the first steps towards delivering the NHS [Five Year Forward View](#) aim of increasing capacity in primary and community-based services and supporting improvement and integration of services.
- 1.23 Overall, 37 vanguards were selected following a rigorous, two wave process, involving workshops and the engagement of key partners and patient representative groups. Each vanguard site is leading the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.<sup>8</sup>

### Workforce planning issues

- 1.24 NHS England has worked closely with the Royal College of General Practitioners (RCGP), the British Medical Association (BMA) and Health Education England (HEE) to jointly develop and launch a Workforce Action Plan<sup>9</sup> “to ensure that we have a skilled, trained and motivated workforce in general practice” as part of the New Deal for General Practice. Work is underway to implement the plan including, for example, a pilot to test the role of clinical pharmacists in general practice<sup>10</sup> – which was initiated in July 2015. However, it is too early to say whether this has addressed recruitment issues.
- 1.25 This supports the ambition and government manifesto commitment to increase the overall number of doctors in general practice by a further 5,000 and a further 5,000 other practice staff by 2020/21, and extending access to evenings and weekends.
- 1.26 As set out above, we are therefore working to support practices with meeting the challenge of achieving the optimal skill mix to deliver the patient care required in the most cost effective way.

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<sup>8</sup> <http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/>

<sup>9</sup> <http://www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan/>

<sup>10</sup> <http://www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan/cp-gp-pilot/>

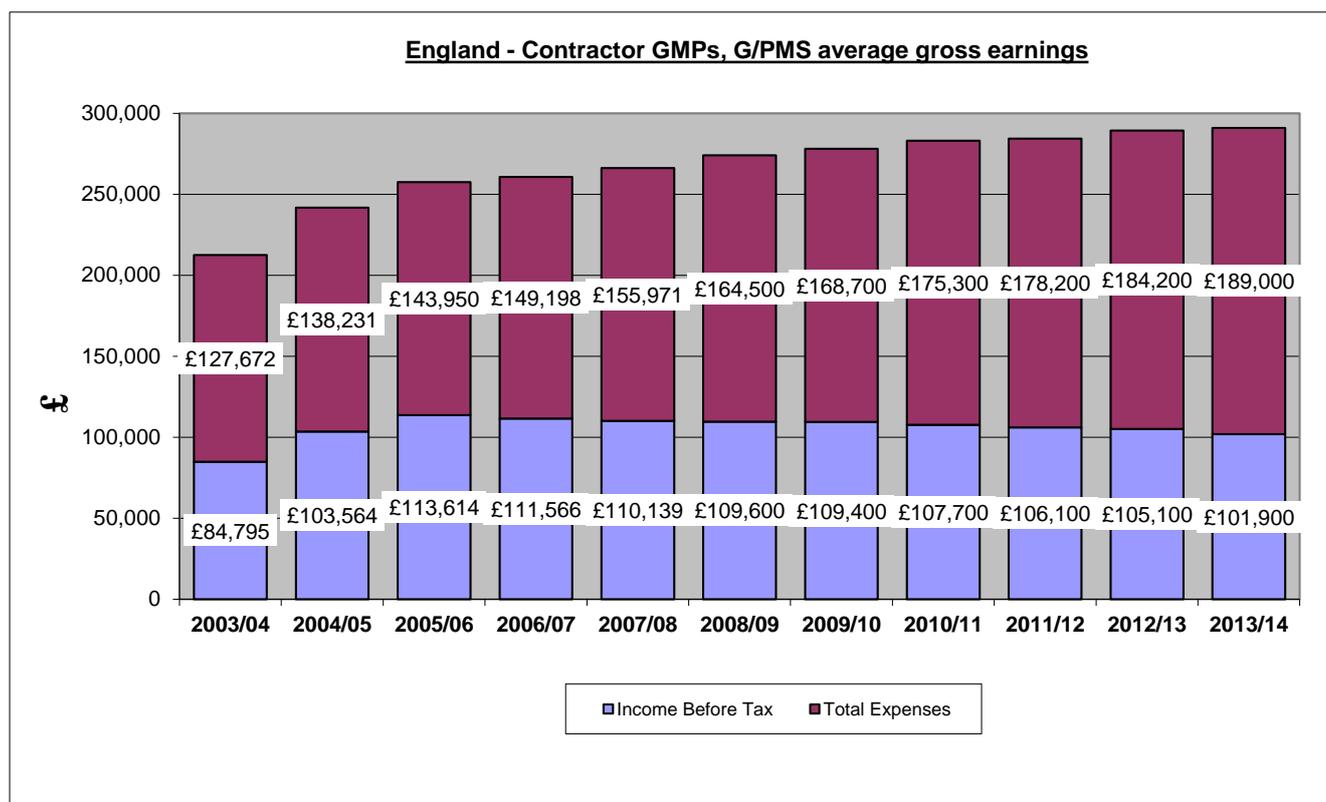
## Trends in the earnings and expenses of GMPs

- 1.27 In 2014/15, the comparable spend for the NHS in England was £9.0 billion<sup>11</sup> on primary medical services compared to £5 billion in 2003/04 - an overall real-terms increase of 20%, and a cash increase of 2.7% compared with 2013/14.
- 1.28 The following points set out the trends in GMP earnings and expenses in England since 2003/04:
- GMP pay has increased in cash and real terms relative to other NHS staff groups. On a cash basis, pay has increased by 20% over the period 2003/04 to 2013/14 – but fallen by 6% in real terms. This compares to an increase of 10% for consultants (a real terms reduction of 14%) and 17% for nurses (a real terms reduction of 8%) over the same period. However, over the same period, the number of GMPs (excluding registrars and retainers) has risen by only 14%, whilst the number of hospital consultants (excluding registrars) has risen by 39%.
  - Increases in GMPs' pay were concentrated in the three years from 2003/04 to 2005/06 following introduction of a new GMS contract. Since the peak in 2005/06 when GP contractors earned £113,614, there have, to date, been year-on-year falls in net income averaging 3.2% p.a. in real terms. This compares to an annual average reduction for consultants of 1.9% and 1.4% for nurses over the same period.
  - It also means that, on average, GMPs who have become contractors since 2005/06 are likely to have only experienced a real terms pay reduction year on year since then.
- 1.29 Figure 1.1 below, based on data provided by Her Majesty's Revenue & Customs (HMRC), shows (cash) increases in gross earnings and net income for the average GMP in England between 2003/04 and 2013/14 (the latest year for which data are available) – though gradual falls in net income since 2005/06.

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<sup>11</sup> <http://www.hscic.gov.uk/pubs/investgp1015>

**Figure 1.1**



1.30 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
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	14,170	12,690	3,030	520	160
2012/13	2,470	14,360	12,550	2,800	470	160
2013/14	2,660	14,710	11,810	2,540	410	150

1.31 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 year-on-year reductions since 2005/06.

1.32 Table 1.3 below sets out actual GMP average net income for 2003/04 to 2013/14.

**Table 1.3**

England GPMS GMPs				
Financial Year	Average Net Earnings £	Year on Year Percentage Cash Change	Cumulative Percentage Cash Change	Cumulative Real Terms Percentage Change Since 2003/04
2003/04	84,795	-	-	-
2004/05	103,564	22.1%	22.1%	18.4%
2005/06	113,614	9.7%	34.0%	26.4%
2006/07	111,566	-1.8%	31.6%	20.8%
2007/08	110,139	-1.3%	29.9%	15.9%
2008/09	109,600	-0.5%	29.3%	12.5%
2009/10	109,400	-0.2%	29.0%	9.4%
2010/11	107,700	-1.6%	27.0%	4.8%
2011/12	106,100	-1.5%	25.1%	1.5%
2012/13	105,100	-0.9%	23.9%	-1.1%
2013/14	101,900	-3.0%	20.2%	-6.0%

1.33 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 Percentage of Earnings
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%
2013/14	290,900	189,000	65%

1.34 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, the latest figures indicate NHS superannuable earnings for GPMS contractor GMPs in the UK was 94.6% of total earnings, suggesting 5.4% 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 £76m of public health services from practices and in 2014/15 £62m (which is the estimated figure calculated by DCLG – the provisional figure of £63m for 2013/14 rose by £13m to £76m once finalised); 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.
- 1.35 However, professional indemnity insurance cost increases are affecting practice expenses nationally – and NHS England is working with the BMA and others to investigate this issue. This includes what the cost drivers are and how it might be possible to help mitigate them.
- 1.36 Data from the NHS Litigation Authority annual report - which largely reflects experiences of Medical Defence Organisations - highlights an expected cost increase to the Clinical Negligence Scheme for Trusts (CNST) of 27% from £1.1bn in 2014/15 to £1.4bn<sup>12</sup> in 2015/16.
- 1.37 The Medical Defence Organisations report a similar position for GPs and Dentists. Drivers for cost inflation include:
- increases in patient numbers being treated by the NHS, increased number of reported incidents resulting in harm;
  - a legal environment that increasingly encourages claims, higher numbers of patients who claim as a proportion of incidents and higher numbers of claims without merit;
  - the emergence of non-specialist lawyers, leading to disproportionate and excessive claimant legal costs for lower value claims; and
  - increasing damages, over and above inflation, for high value claims.
- 1.38 It would be worth noting that, if the trend continues, indemnity costs for employed clinical staff (doctor and nursing) - plus the cost of indemnity for GP locums, will push up expenses for GP performers.

## NHS pension scheme

- 1.39 The NHS pension scheme forms a significant part of the overall GMP and GDP reward package. Uniquely amongst self-employed people, GMPs and GDPs have access to a defined benefit public sector pension scheme, effectively guaranteed by the Exchequer.
- 1.40 GMP and GDP earnings can fluctuate widely from year to year according to the work that they carry out and how much is taken as net NHS income. To take account of these fluctuations in earnings, GMPs and GDPs who are members of the 1995 or 2008 NHS Pension Scheme have a Career Average Revalued Earnings (CARE) NHS pension arrangement in which their pensionable earnings are revalued by an annual uprating (dynamising) factor. The factor is based on the Consumer Prices Index (CPI) plus 1.5%. GMPs and GDPs who are members of the 2015 NHS Pension Scheme accrue a pension account every year (based on 1/54<sup>th</sup> of their pensionable pay) - which is revalued according to Treasury Orders plus 1.5%.
- 1.41 DDRB asked for evidence of the opt-out from the NHS pension scheme. There is

<sup>12</sup> Please see p4 of the Annual Report here:

<http://www.nhs.uk/aboutus/Documents/NHS%20LA%20Annual%20Report%20and%20Accounts%202014-15.pdf>

currently no published data or research on the impact of pension changes on recruitment, retention and motivation of GMPs.

## **Clinical Commissioning Groups (CCGs) and GP income**

- 1.42 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<sup>13</sup>. There are three co-commissioning models that CCGs can take forward:
- Full delegated responsibility for commissioning the majority of GP services;
  - Joint commissioning responsibility with NHS England; and
  - Greater involvement in GP commissioning decisions
- 1.43 Over 70% of CCGs have taken on an increased role in the commissioning of GP services from 1 April, 2015, including 63 CCGs that successfully applied for and have been delegated commissioning responsibilities.
- 1.44 CCGs with an increased role have new powers to improve local health services that give them greater influence over the way NHS funding – especially primary care funding - is being invested for local populations. The potential benefits of co-commissioning for the public and patients include:
- improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
  - high quality out-of-hospitals care;
  - improved health outcomes, equity of access, reduced inequalities; and
  - a better patient experience through more joined-up services.

## **Access to GP Services: the Prime Minister's Challenge Fund/GP Access Fund**

- 1.45 In October 2013, the Prime Minister announced<sup>14</sup> 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.
- 1.46 In December 2013, NHS England invited GP practices to submit their 'expressions of interest' to be one of the pilots, and twenty pilot schemes were selected covering over seven million patients across more than 1,100 practices spread across the country.
- 1.47 The schemes are testing a wide variety of proposals to:
- improve convenience and access to GP services;

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<sup>13</sup> <https://www.england.nhs.uk/commissioning/pc-co-comms/>

<sup>14</sup> <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access>

- improve patient experience to fit around work and family life - with more appointments in the evenings and at weekends,
- offer the option for video, email and telephone consultations and better use of telecare and health apps; and
- develop more integrated services - with a single point of contact to co-ordinate patient services across health and social care.

1.48 In March 2015, a second wave of schemes was announced, with 37 pilots involving over 1,400 practices and covering 10.6m patients. This was backed by investment of over £100 million and a further £25.5m from the Primary Care Infrastructure Fund.

1.49 Taken together, a total of 18m patients in 2,500 practices will have benefited from improved access to general practice through this Fund.

1.50 Delivery of these schemes has been supported by a national innovation support programme. This has included access to policy advice, peer networking, board support for strategic planning and leadership and facilitation for local patient engagement and service redesign. In addition, NHS England is working to share learning from these schemes to spread innovation across the NHS, through published guidance and thematic innovation showcases on topics such as:

- Delivering at pace;
- Innovative use of technology;
- Patient engagement;
- Practice engagement;
- Delivery at scale;
- Collaborating with other providers; and
- Effective leadership.

## **GMS contract changes in 2014/15**

1.51 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 2016;
- 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;
- establishing a working group to develop proposals on how the publication of GP NHS net earnings relating to the contract should be implemented for 2016/17 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.

1.52 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 website<sup>15</sup>.

## **GMS contract changes in 2015/16**

1.53 The 2014/15 contract changes included an increase to the global sum equivalent for all GP providers by an overall 1.16%. 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:

- extending the avoiding unplanned admissions (AUA) enhanced service for a further year from 1 April 2015, with changes to the reporting process and payment structure;
- extending the dementia, extended hours and learning disabilities enhanced services (unchanged) for a further year;
- changing registration regulations to allow armed forces personnel to be registered with a GP practice in defined circumstances;
- practices offering online access to all detailed information within the patient's medical record;
- practices promoting and offering a secure facility for all patients wishing to order online, view and print a list of their repeat prescriptions for necessary drugs, medicines or appliances;
- practices continuing to promote and offer patients the ability to book appointments online and also routinely consider whether the proportion of appointments that can be booked online needs to be increased to meet the reasonable needs of their registered patients, and, if so, take such action accordingly;
- practices providing assurance on out of hours provision to ensure that all service providers are delivering out of hours care in line with the National Quality Requirements (or any successor quality standards);
- ending the patient participation enhanced service and associated funding reinvested into global sum. From 1 April 2015, it is a contractual requirement for all practices to have a patient participation group (PPG);

<sup>15</sup> <http://www.england.nhs.uk/wp-content/uploads/2014/03/gp-contract-letter-at-fin.pdf>

- ending the alcohol enhanced service and associated funding reinvested into global sum. From 1 April 2015 it is a contractual requirement for all practices to identify newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels;
- both parties agreeing to review the Carr-Hill formula with a view to addressing deprivation;
- both parties agreeing to have a strategic discussion about the primary care estate, especially to support the transfer of care into a community setting;
- the following changes to the Quality and Outcomes Framework (QOF):
  - adjusting the value of a value for 2015/16 taking account of population growth and relative changes in practice list size for one year from 1 January 2014 to 1 January 2015;
  - deferring for one year the changes in thresholds planned for April 2015; and
  - the redistribution of the points of a small number of retired indicators across the atrial fibrillation and dementia indicators.
- practices allocating a named, accountable GP, who will take lead responsibility for the co-ordination of all appropriate services required under the contract

## **GMS contract changes in 2016/17**

- 1.54 We will provide an update on the negotiations in NHS England's supplementary evidence, due to be provided to DDRB in November 2015.

## **Conclusion**

- 1.55 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 (GDPs)

### 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 British Dental Association (BDA) in the early Autumn to discuss practice expenses and possible quality and efficiency improvements for 2016/17. 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, 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 local offices 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"<sup>16</sup>.
- 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. However, 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 looked at elements of a new contract based on capitation and quality, which will focus on the treatment patients need and avoid unnecessary treatments.

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<sup>16</sup> Available at: [www.commissioningboard.nhs.uk/files/2012/06/ex-comm-pc.pdf](http://www.commissioningboard.nhs.uk/files/2012/06/ex-comm-pc.pdf)

- 2.7 The learning from the pilots has now been evaluated and a prototype scheme will be launched in Autumn 2015, incorporating learning and developing on the pilot scheme. 62 pilot practices will move to prototypes - with a further 38 Unit of Dental Activity (UDA) practices - making a total of 100 prototypes. The prototypes will follow 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. 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 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.
- 2.9 We want to see a continued improvement in access to NHS dental services. Questions included in the GP Patient Survey covered access to NHS dental services, which showed 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 higher still at 96%.

**Table 2.1: Success rates for patients who tried to get an appointment in the last 6 and 24 months by NHS England regions:**

	Success rate in last 24 months: percentage who succeeded, not including "Can't remembers"	Success rate in last 6 months: percentage who succeeded, not including "Can't remembers"
England	95%	96%
North of England	95%	97%
Midlands and East of England	96%	97%
London	93%	95%
South of England	95%	97%

2.10 In the last year:

- access to NHS dental services has risen: 30.0 million patients (56% of the population) were seen by an NHS dentist in the 24-month period ending June 2015. The number is 108,000 higher than twelve months earlier, and 2.9 million higher than the low point reached in June 2008;
- there has been a slight fall in NHS dental activity, the total movement was from 88.7 million UDAs in 2013/14 to 87.2 million UDAs in 2014/15, however band 1 activity increased by 343,000 UDAs. NHS England regional team commissioning plans at June 2015 for the following twelve months are 294,000 UDAs higher than the previous twelve months, showing the fall is not driven by commissioning intentions. Following a quality checking exercise that contributed to decreases in the reported numbers of UDAs commissioned

compared to the previous year, the increase in commissioned UDAs shown in this quarter suggests that reporting practices have now been stable for at least one year;

- the number of dentists providing NHS services rose by 224 to 23,947 dentists in 2014/15; and
- the proportion of dentists' time spent on NHS work fell from 74.8% in 2011/12 to 72.8% in 2012/13.

## General Dental Practitioners: recruitment, retention and motivation

- 2.11 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, as noted above, the numbers of dentists has also continued to rise, up by 1% last year.
- 2.12 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.
- 2.13 Dentists have achieved a reduction in working hours, with evidence from the Health and Social Care Information Centre (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%.
- 2.14 For the first time, the HSCIC has collected information on motivation and morale of dentists. The results show Performer-only dentists are more motivated and have higher morale than Providing-Performers. Performers have shown a slight increase in in both morale and motivation between 2012/13 and 2013/14 and Providing-Performers have shown a fall in both areas.

**Table 2.2: Motivation and Moral of dentists 2012/13 to 2013/14**

	Providing Performer	Performer only	Providing Performer	Performer only
	Average Motivation (percentage)		Average Morale (percentage)	
2012/13	48.3	48.2	27.3	42.1
2013/14	45.7	48.8	27.2	42.7

- 2.15 The question 'I feel my pay is fair' had the lowest result of the motivation questions with 24.2% of Providing-Performers responding 'agree' or 'strongly agree', and 29.4% of Performer-only dentists.
- 2.16 In answer to the question 'I feel good about my job as a dentist' 64.7% of Performers and 54.4% of Providing-Performers 'agreed' or 'strongly agreed'. This was the highest positive response for Performers. The question ' My job gives me the chance to do challenging and interesting work' provided the highest positive

response for Providing-Performers with 57.8% answering 'agree' or 'strongly agree' (57.9% of Performers).

- 2.17 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

- 2.18 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 the basis of the best evidence available, 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.
- 2.19 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: earnings and expenses

- 2.20 Each year we are seeing a smaller number of Providing-Performers (those who hold a contract to provide dental services) a fall of 375 in 2014/15 to 4,038 and a rise in the number of Performers, whom the Providing-Performer pay to provide the dental services, increasing by 599 in 2014/15 to 19,909. 83.1% of dentists are now Performers compared to 62.4% in 2006/07.
- 2.21 The earnings of the Provider dentists has seen a slight increase for the second year running, and the earnings of performer dentist continued to decrease in 2013/14. The movement of dentists across the European Union may mean we have a larger pool of Performers competing for contracts. A consistent number of UDAs being delivered by a rising number of dentists and shorter working hours suggest fewer UDAs per dentist are being delivered.
- 2.22 The average figures published by the HSCIC<sup>17</sup> cover dentists doing any NHS work in the year. A significant number of dentists come and go within a year. With 22,800 dentists covered by GDS or PDS contracts in 2013/14, there were 1,300 leavers and 1,700 joiners in-year - or 3,000 (13%) working for only part of the year for the NHS.
- 2.23 The numbers of dentists for the years 2006/07 to 2014/15 are set out on table 2.3 below (table 8e from 'NHS Dental Statistics for England 2014/15').

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<sup>17</sup> Available at: <http://www.hscic.gov.uk/catalogue/PUB18376/dent-earn-expe-2013-14-init-rep.pdf>

**Table 2.3: Number and percentage of dentists with NHS activity in the year ending 31 March, by dentist type, 2006/07 to 2014/15**

	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
2014/15	4,038	19,909	23,947	16.9	83.1	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

- 2.24 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.
- 2.25 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 2014/15. Compared to 2013/14, there 8.5% fewer dental contract holders and 3.1% more “dentists who work for others”.
- 2.26 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 earn good income levels. Although the average identifiable net profit after expenses for dentists in 2013/14 fell to £71,700 compared with £72,600 in the previous year, this remains a well remunerated profession.
- 2.27 For dentists holding a contract, earnings were considerably higher at an average of £115,200 - an increase of 1% from the previous year’s £114,100. The data also show some dentists earning considerably more; with 1% earning over £300,000. Dentists working for others still had an average net profit of £60,600, down 0.4% from the £60,800 of the previous year.

2.28 On expenses, the data showed that just over half (53.8%) of gross payments to dentists was to meet their expenses.

**Table 2.4: Gross income and net profit of primary care dentists 2004/05 to 2013/14**

	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
2013/14	21,500	£155,100	£83,400	£71,700	53.8

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

2.29 Information on dentists' income compiled by the National Association of Specialist Dental Accountants and Lawyers (NASDAL) reported an increase in net profit for NHS practices in 2013/14 of 2.4%, to an average profit of £129,000. The first increase since 2008/09. Net profit for NHS practices fell below net profit of private practices, although the difference is marginal. Profits in NHS practices had exceeded those in private practices since 2005/06.

**Table 2.5: Net profit for the practice**

Type of practice	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
NHS	£142,400	£149,500	£148,000	£161,300	£147,800	£133,020	£130,000	£125,958	£129,000
Mixed	£129,600	£147,100	£140,700	£138,600	£143,800	£127,045	-	-	
Private	£131,400	£130,900	£136,500	£130,600	£126,400	£117,552	£117,000	£124,086	£131,000

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

2.30 NASDAL report that average net profit for associate dentists (those dentists with no share of ownership) increased slightly for the second year running, seeing an increase on average of £700 per individual on the 2012/13 figure of £67,770.

## Expenses

2.31 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.*

- 2.32 In looking at expenses we need to continue 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.
- 2.33 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).
- 2.34 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.

- 2.35 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.
- 2.36 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 2013/14 - with the exceptions of other non-staff costs (Morris & Co) in NHS practices, which increased by 2.2%.

**Table 2.6: 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	2013/ 14
Non-clinical staff wages (NASDAL)									
NHS practices	18.2%	17.3%	17.9%	17.7%	18.8%	19.8%	19.9%	21.0%	20.3%
Private Practices	17.2%	17.4%	17.8%	17.6%	18.1%	19.4%	19.5%	19.5%	18.9%
Laboratory costs (NASDAL)									
NHS practices	6.4%	5.6%	6.1%	6.0%	6.5%	6.3%	6.1%	6.4%	6.6%
Private Practices	8.9%	7.8%	7.6%	7.1%	7.9%	7.6%	7.2%	7.3%	7.4%
Materials costs (NASDAL)									
NHS practices	5.6%	5.0%	5.6%	5.4%	5.6%	6.3%	6.6%	6.3%	6.8%
Private Practices	6.7%	7.0%	7.5%	7.1%	7.5%	7.9%	7.4%	7.2%	7.1%
Other Non-Staffing Costs (Morris & Co)									
NHS practices	16.4%	16.8%	15.7%	15.6%	15.1%	16.7%	16.6%	16.4%	18.6%
Private Practices	23.0%	23.2%	23.6%	21.4%	21.2%	21.7%	22.8%	20.4%	19.7%
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.									

## NHS pension scheme

- 2.37 DDRB asked for evidence of the opt-out from the NHS pension scheme. Information on take-up of the NHS pension scheme by dentists from the NHSBSA Data Warehouse based on entries made by NHS England teams on Payments on

Line (POL) shows the number of dentists who are members of the NHS pension scheme fell slightly from 19,365 in 2013/14 to 19,090 in 2014/15. Almost all dentists under the age of 26 are members of the NHS Pension scheme. Although the effect of the most recent changes, including the effect on recruitment, retention and motivation will not be known for some time, this suggests that dentists continue to find the NHS pension scheme attractive.

## **2015/16 settlement**

- 2.38 For 2015/16, DDRB recommended an uplift in pay net of expenses of 1%. The increase was accepted by the Department of Health, and when combined with an increase for staff expenses of 1%, in line with public sector pay cap, and other expenses using RPIX, this resulted in an overall up lift of 1.34%.
- 2.39 The national uplift was applied to gross contract values for GDS contracts and PDS agreements.
- 2.40 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. It included further moves to obtain a nationally consistent approach to contract management.
- 2.41 The 2015/16 package also included a number of measures to improve efficiencies – including:
- introduction of the Friends and Family test for dentists;
  - reduction in unnecessary referrals to secondary care; and
  - reduction in losses through incorrect claims for exemption from patient charges and inappropriate claims for re-attendance with 28 days by contractors, to be achieved through better education, awareness and enforcement of the rules.
- 2.42 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: conclusion**

- 2.43 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.