



**The Review Body on Doctors' & Dentists'
Remuneration Review for 2017
General Medical Practitioners and
General Dental Practitioners**

September 2016

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The Review Body on Doctors' and Dentists' Remuneration

NHS England's Evidence for the 2017 Review

Version number: 1.0.

First published on 30 September, 2016.

Prepared by:

Mike Kemp, Senior Finance Lead and
Joanne Lowther, Finance Manager
National Primary Care Contracts (GP and Dental respectively)
Strategic Finance
NHS England
Room 8E10 Quarry House
Quarry Hill
Leeds
LS2 7UE
Email: mike.kemp@nhs.net or joanne.lowther@nhs.net

Classification: Official

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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 and a further 51 from 1 April, 2016, taking the total to 114 – i.e. over half. 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 2017/18 pay for their remit group. In his letter of 22nd August, 2016 to the Chair of the DDRB, the Secretary of State for Health set out the evidence to be provided to you.

Contract for services

- 0.3 General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs) 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 Learning Disabilities Enhanced Service. 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

- 0.6 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.
- 0.7 The Government published NHS England's budget for the years to 2020/21 in the Spending Review. NHS England's budget for 2017/18 will be formally set in the Mandate, which will be published later in the year.
- 0.8 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

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from 2010 to 2015. 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 Action¹ and updated in the NHS Five Year Forward View,² identified funding pressures of around £30 billion by 2020/21. This analysis was refreshed in the spending review, and whilst £8bn of pressures have been covered by additional funding, an efficiency challenge of £22bn remains.

- 0.9 As a result, it is imperative that all providers in the service make savings and deliver efficiency gains each year. We estimate that around £7bn of efficiencies against the Five Year Forward View counterfactual cost growth could be nationally delivered. Significantly, £3.5bn of this is predicated on implementing the government's 1% public sector pay cap to 2019/20.
- 0.10 On the basis of the above, we would urge the DDRB to carefully consider what uplift, if any, is appropriate for 2017/18.

¹ Available at: http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

² 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 medical 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 2017/18. An update on the negotiations will be provided in NHS England's supplementary evidence, due 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 the General Practice Forward View³.

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 NHS Digital⁴, as at 31 March 2016, there were 7,613 GP practices in England. Of these, around 64% of practices (accounting for 63% 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 has been undertaking reviews of all PMS contracts.
- 1.7 In addition, there are a small number of GMPs (437) who work under, or hold, contracts under a locally contracted Alternative Provider Medical Services (APMS) arrangement across some 259 practices.

Recruitment, retention and motivation of GMPs

- 1.8 NHS Digital publish data on the number of GPs and staff in general practice each year, and hitherto, with a time series showing the current and preceding ten years. However, NHS Digital have caveated that the latest September 2016 statistics, due to changes in the data source, are 'provisional experimental,' so care needs to be taken when interpreting these figures. In addition, individual tables within the report are footnoted by NHS Digital that due to these changes "figures from 2015 and 2016 are not comparable with previous years." Although the September 2016

³ Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

⁴ Available at: <http://content.digital.nhs.uk/catalogue/PUB21772>

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release uses the same methodology as the March 2016 data. Further detail is provided in the “Data Quality” section of the report.

- 1.9 That said, the NHS Digital data are the best figures available and, in the absence of other data, we have provided changes between September 2015 and March 2016 as the most recent data available. Though as stated above, these need to be treated with caution given their ‘provisional experimental’ status.
- 1.10 As at March 2016, in headcount terms, there were 41,985 doctors working in general practice, taking together GMPs and GP registrars – a slight increase of 108 (0.3%) since September 2015. In Full Time Equivalent (FTE) terms, there were an estimated 34,914 GMPs - an increase of 332 (0.9%) since September 2015.
- 1.11 Within the overall numbers, the new experimental methodology has not been able to identify the roles of some 4,704 GPs, as at March 2016, as to whether they are GP providers, salaried / Other GPs, GP registrars, GP retainers or GP Locums. This means the following paragraphs, which provide details of the split between providers and salaried / other staff, need to be read in this context. This figure has increased by 1,476, from the 3,228 GPs without identifiable roles in the September 2015 data.
- 1.12 This increase makes it difficult to identify any trend in the number of provider and other / salaried GPs, which have both decreased between September 2015 and March 2016, as part of these decreases are likely to be due to the fact that the latest data identifies the roles of 1,476 fewer GPs than the previous report. The main conclusion that can be drawn from the latest workforce figures is that the workforce has increased, as set out in paragraph 1.10.
- 1.13 The average age of the workforce (excluding registrars, retainers and locums – as the NHS Digital figures exclude those categories) has seen an increase in younger doctors since September 2015, with 42.4% of practitioners at March 2016 under the age of 45 (40.3% at September 2015). At the same time, there has been a slight increase in the proportion of GPs aged over 55, increasing from 20.8% in September 2015 to 21.5% in March 2016. However, the data has a category of age “unknown” which stood at 5,084 GPs in September 2015 and has reduced by 1,518 to 3,566 in March 2016. Part of the reason for the increases mentioned above could be due to the fact that NHS Digital had age data on more GPs in the March 2016 data than they did in September 2015.
- 1.14 There are now 5,067 GMP registrars, an estimated increase of 85 (1.7%) since September 2015 and an estimated increase of 2,503 – 97.6%, nearly double the number, compared with 2,564 in 2005. In Full Time Equivalent (FTE) terms, there were an estimated 4,909 GMP registrars - an estimated increase of 190 (4.0%) in just the six months since September 2015 and an estimated increase of 2,474 (101.6%) since 2005 (an estimated annual average increase of 9.2%).
- 1.15 In previous reports, DDRB have referred to whether there was data on the use of GP locums. As context, the overall cost of locum allowances paid to practices rose by 20% from £26.5m in 2014/15 to £31.8m in 2015/16. However, this will not reflect the full costs of locum cover to practices, as practices also incur costs

employing locums that are not covered by allowances and data on the FTE numbers of locums used in each year isn't published. Nevertheless, the National Performers List shows that between 18th January and 24th August 2016, significantly more GP partners became locums (632) than locums that became partners (193). Also, overall numbers of locums increased by 7% from 11,402 to 12,203 in that period⁵.

1.16 The Eighth National GP Work Life Survey⁶ (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 in 2012 to 41.4 hours per week in 2015, 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).

1.17 Salaried GP recruitment and retention is a problem for some areas of England, and would not necessarily be influenced or resolved through a national contract uplift.

1.18 NHS England has, in conjunction with the profession, been developing measures to help improve recruitment and retention. This includes specific workforce schemes (such as changes to the induction and refresher scheme, and increase in funding for the Retained Doctors Scheme) – and also includes the wider package of support set out in the General Practice Forward View. It should be noted that, as the DDRB recommendation only affects the contract price, salaried GP pay may not be automatically updated to reflect any uplift to the contract price that is provided as a result of a DDRB recommendation.

Workload of GMPs

1.19 The average number of patients per medical practitioner in England fell from 1,613

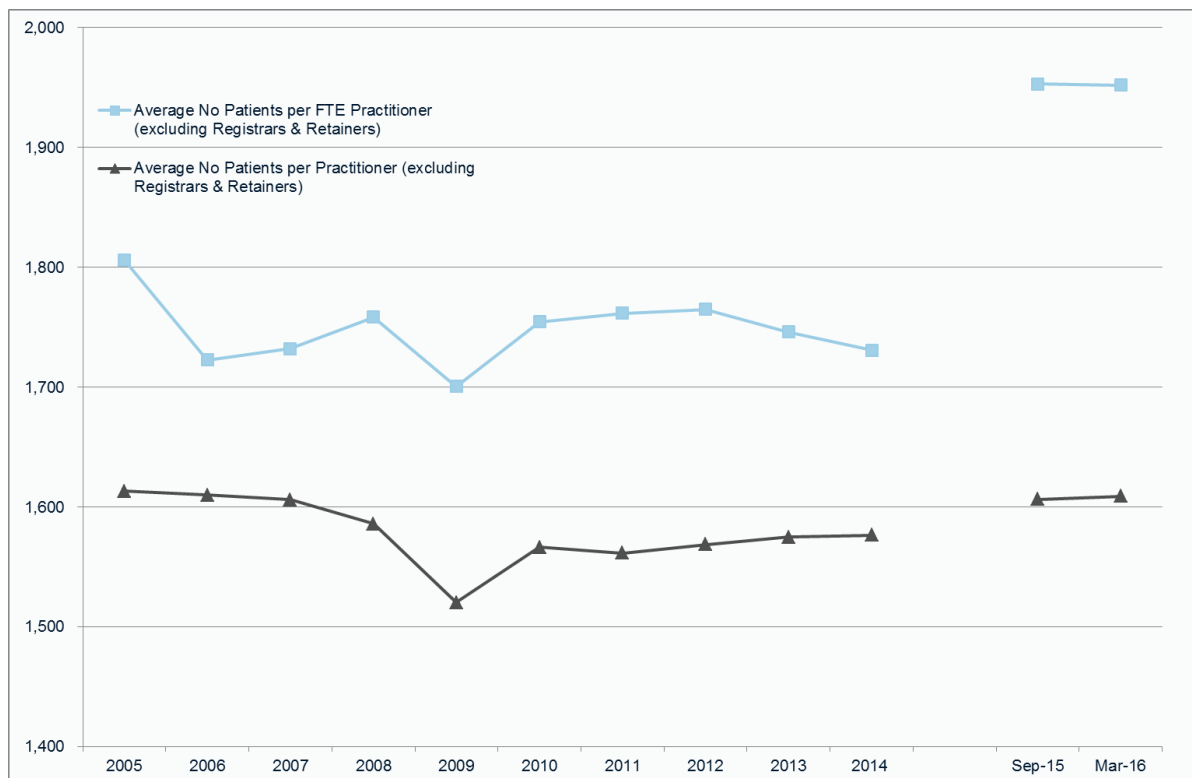
⁵ Source: the National Performers List

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

in 2005 to 1,609 (-0.2%) at March 2016, partly because the number of GMPs grew faster than the number of patients over that period. However, whilst it dipped in 2009 to 1,520 per practitioner, it then rose again since, in both headcount and FTE terms.

1.20 The graph in Figure 1.0 below shows this more clearly (the differences in trend in September, 2015 and March, 2016 are likely to be at least partly due to changes to the way FTEs are recorded – and hence are shown separately in Figure 1.0). The source of the figures changed in 2015 from the Exeter system to the workforce Minimum Dataset and the 2015 figures onwards cannot be compared with previous years).

Figure 1.0 Average number of patients per FTE practitioner and per practitioner



1.21 Whilst the number of patients per FTE GMP has risen slightly, there has been a small reduction in the average hours reported as worked. This may be explained by the fact that the overall ratio of patients to total practice staff has fallen, meaning that more patients are now seen by other (i.e. non-GP) clinical staff.

1.22 Feedback from the profession suggests that the reduction in job satisfaction and increase in proportions of GPs expecting to quit direct patient care, highlighted by the GP Work Life Survey, are driven by concerns over a rising workload. 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 budget⁷. The latest research published by the National Institute of Health Research⁸ suggested

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

⁸ <http://www.sciencedirect.com/science/article/pii/S0140673616006206>

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that general practice has seen demand increase by around 2.5% annually in recent years, based on both the number and length of consultations increasing. The research also indicated that, in 2013/14, the average patient attended 5.16 GP and nurse consultations per person per year which extrapolates to around 300 million across the whole population of England.

- 1.23 The number of patients per practice has risen from 6,250 in 2005 to 7,521 at March 2016. Over the same period, the number of practices has decreased from 8,451 to 7,613, 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 21.6% of practices in 2005 to 9.3% at March 2016.
- 1.24 There remains a significant overall increase in headcount numbers of practice staff between 2005 and 2016, with total practice staff numbers increasing by 19,638 (17.5%) to 131,732 (which is 90,438 FTEs, an increase of 23.9%). Overall headcount has increased by 1,217 since September 2015 (1%), and FTEs have increased by 2,163 (2%). The overall increase in clinical (non-GP) staff FTEs between 2005 and March 2016 was 7,513 to 25,446 (42%) – and over the same period, the number of patients per FTE practice nurse fell from 3,829 to 3,634 (5%) while the patient per FTE of other clinical staff fell from 12,758 to 5,907 (54%).
- 1.25 Taken together, the total number of primary care staff (GMPs and practice staff) was 144,832 in 2005, which increased by 22,478 or 16% to 167,310 at March 2016. Over the same period, the ratio of patients to primary care staff has decreased by 22 patients (6%), from one for every 365 patients to one for every 342 patients.
- 1.26 The data 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, although as stated in paragraph 1.8 caution needs to be taken in comparing the latest data to prior years.

Five Year Forward View update

- 1.27 In 2015, 50 vanguards were selected, following a process involving workshops and the engagement of key partners and patient representative groups. The vanguards are leading the development of new care models that are acting as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system⁹.
- 1.28 During 2015/16, the programme focused on the selection, development and growth of the new care models with increasing emphasis on spreading the new care models across the country. From 2016/17, the programme moved to the next phase of systematic delivery to ensure quantifiable impact - and to support wider spread and the mainstreaming of new care models from 2017/18¹⁰.
- 1.29 The impact of the interventions, integrated workforce models and care model changes being implemented by the vanguards on:

⁹ <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/>

¹⁰ <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/support/>

- health and wellbeing;
- care and quality (including patient experience and staff engagement); and
- efficiency

is being evaluated nationally using a set of national metrics. These high level outcome indicators for each care model type are reported quarterly. Vanguard are also setting up local evaluations which look at the impact of their programmes on key local indicators, and the factors driving any changes.

General Practice Forward View (GPFV) and progress to date

- 1.30 The Five Year Forward View included a “new deal for primary care” and set out an overview of what that would involve. It also included a commitment to invest more in primary care over the next five years.
- 1.31 The General Practice Forward View¹¹ published in April this year – and developed in conjunction with key stakeholders (including the BMA and RCGP) - acknowledged the real pressures facing general practice. It therefore set out the specific, practical and funded steps on investment, workforce, workload, infrastructure and care redesign forming a five year programme that aims to put General Practice on a sustainable footing for the future.
- 1.32 For example, on investment, there is a turnaround package of over £500m, coupled with an estimated increase in recurrent funding £2.4bn a year by 2020/21 to over £12bn – or a 14% increase in real terms. An overview of the steps is included in the introduction¹², with further details on each in chapters 1-5 of the document.
- 1.33 At its public meeting on 28th July, NHS England’s Board went on to set out the progress already made, and launched the detail of a number of specific commitments to strengthen general practice, ease the pressure on GPs and improve services for patients¹³.
- 1.34 They included:
- The release of the first £16m of the new £40 million [Practice Resilience Programme](#), a key part of the five-year General Practice Forward View, to help struggling practices across the country;
 - The first phase of the three-year, £30 million [General Practice Development Programme](#), which will give every practice in the country the opportunity to receive training and development support; and
 - New funding to fully offset the rising cost of [GP indemnity](#), and wider plans to reform indemnity arrangements.

Workforce planning issues

- 1.35 NHS England worked closely with the Royal College of General Practitioners

¹¹ <https://www.england.nhs.uk/ourwork/gpfv/>

¹² See pages 4-5 here: <https://www.england.nhs.uk/ourwork/gpfv/>

¹³ <https://www.england.nhs.uk/2016/07/joined-up-care/>

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(RCGP), the British Medical Association (BMA) and Health Education England (HEE) to jointly develop and launch an initial 10 point action plan – “Building the Workforce - the new Deal for General Practice”¹⁴ (published January 2015) “to ensure that we have a skilled, trained and motivated workforce in general practice”. This work now continues through the delivery of the GPFV, with the aim being to “try to double the growth rate in GPs, through new incentives for training, recruitment, retention and return to practice” - and support initiatives to build capacity and capability in the wider non-medical workforce.

- 1.36 As part of this, a pilot to test the role of clinical pharmacists in general practice¹⁵ has been rolled out and there are now 491 clinical pharmacists supporting 648 practices in 89 pilots across the country. It is too early to say what the impact of these clinical pharmacists has been on GP retention and motivation. Although, an evaluation will take place alongside a further phase of the clinical pharmacist scheme. 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.
- 1.37 To help deliver this commitment, Health Education England has increased the number of GP training places to 3,250 per year. NHS England is also working with Lincolnshire LMC to pilot an overseas recruitment campaign. In addition, NHS England has introduced some specific schemes to make extra funding available for GPs who choose to work in practices that have been identified as hard to recruit to. The existing retained doctor scheme has been revised - with increases in funding. There have been a number of improvements to the induction and refresher scheme to help GPs return to English general practice, with further improvements planned in order to support the goal of attracting back an extra 500 doctors over the next five years. NHS England is working with the profession to consider what further targeted action is needed, for example to support older doctors (as indicated in the RCGP’s recent call for action¹⁶).
- 1.38 This work supports the ambition, and government manifesto commitment, to increase the overall number of doctors in general practice by a further 5,000 along with an additional 5,000 other practice staff by 2020/21. As set out above, we are working to support practices with meeting the challenge of achieving an optimal skill mix to deliver the patient care required in the most cost effective way.

Trends in the earnings and expenses of GMPs

- 1.39 In 2015/16, the comparable spend for the NHS in England was £9.5 billion¹⁷ on primary medical services compared to £5.8 billion in 2003/04 - an overall real-terms increase of 29%, and a 4.6% real terms increase compared with 2014/15.
- 1.40 The following points set out the trends in GMP earnings and expenses¹⁸ in England over the last 10 years:

¹⁴ <http://www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan/>

¹⁵ <http://www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan/cp-gp-pilot/>

¹⁶ <http://www.rcgp.org.uk/news/2016/september/retaining-gps-must-be-as-big-a-priority-as-recruiting-new-ones.aspx>

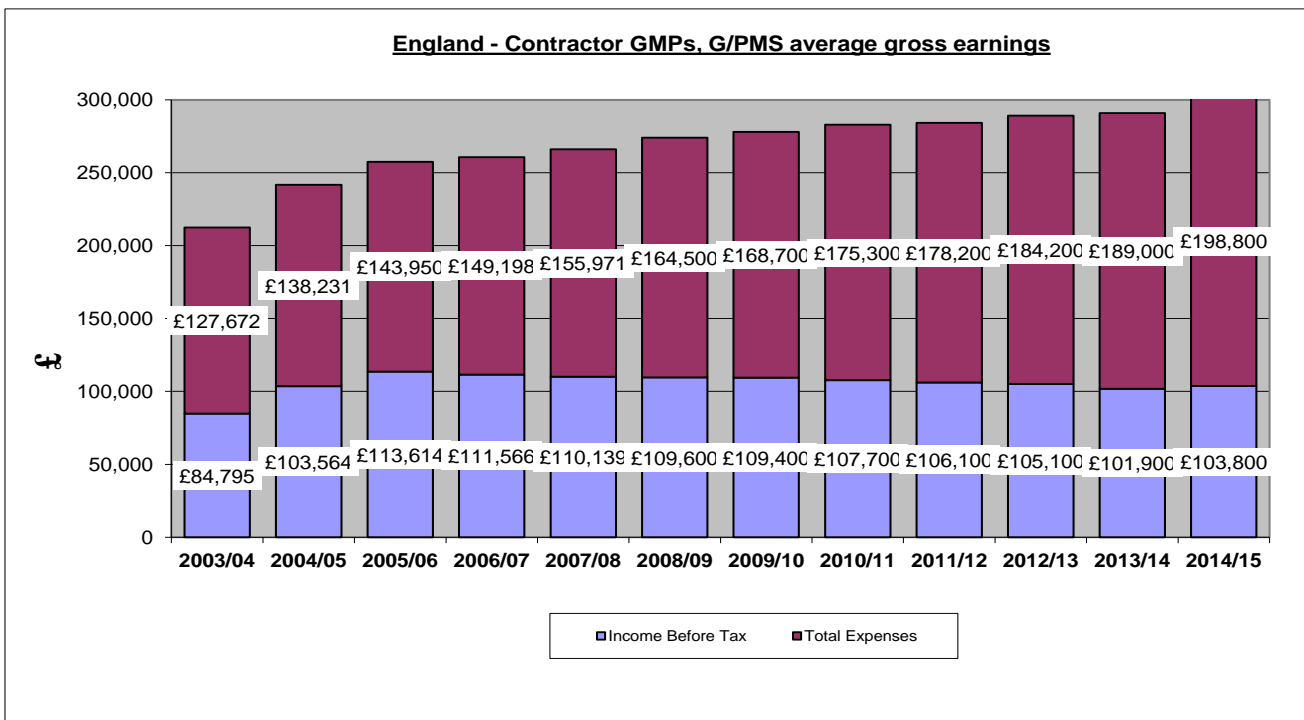
¹⁷ <http://www.digital.nhs.uk/catalogue/PUB21317>

¹⁸ <http://www.digital.nhs.uk/catalogue/PUB21314>

- GMP pay has reduced in cash and real terms and relative to other NHS staff groups. On a cash basis, pay has fallen by 0.2% over the period 2004/05 to 2014/15 and by 18% in real terms. However, over the same period, the number of GMPs (excluding registrars, retainers and locums) has risen by only 13%, whilst the number of hospital consultants (excluding registrars) has risen by around 45% (taking account of the approximate effects of the changing data collection methodology).
- 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 has been an overall fall in net income averaging 2.6% p.a. in real terms. This compares to an annual average real terms reduction for consultants of 1.6% and 1.1% for nurses over the same period. However, in 2014/15, this trend halted and there was a rise of £1,900 (1.9%) in cash terms, 0.3% in real terms.
- Nevertheless, it 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 until 2014/15.

1.41 Figure 2.0 below shows the changes to gross earnings, expenses and the net income (i.e. income before tax) resulting since before the new contract was introduced in 2004/05. It is based on data provided by Her Majesty's Revenue & Customs (HMRC), for an average GMP in England between 2003/04 and 2014/15 (the latest year for which data are available). It shows the gradual falls in net income since 2005/06 until the increase in 2014/15.

Figure 2.0



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1.42 Table 1.1 below sets out actual GMP average net earnings for 2003/04 to 2014/15.

Table 1.1

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%	19.0%
2005/06	113,614	9.7%	34.0%	27.1%
2006/07	111,566	-1.8%	31.6%	21.2%
2007/08	110,139	-1.3%	29.9%	16.8%
2008/09	109,600	-0.5%	29.3%	13.1%
2009/10	109,400	-0.2%	29.0%	11.4%
2010/11	107,700	-1.6%	27.0%	7.7%
2011/12	106,100	-1.5%	25.1%	4.6%
2012/13	105,100	-0.9%	23.9%	1.5%
2013/14	101,900	-3.0%	20.2%	-3.2%
2014/15	103,800	1.9%	22.4%	-2.9%

1.43 The figures in Table 1.2 below show the distribution of net income (i.e. gross income less expenses) 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	2,670	14,720	11,810	2,540	410	150
2014/15	2,470	14,370	11,760	2,790	490	180

- 1.44 There are likely to be several factors affecting the increasing number of GMPs in the higher income brackets, including the fact that a greater proportion of funding for primary care is now channelled outwith the core contract. 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 between 2005/06 and 2013/14, before the number of those earning over £150k rose by over 10% in 2014/15.
- 1.45 Table 1.3 below shows trends in the ratio of practice expenses to gross earnings. 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 1.3

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%

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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%
2014/15	302,600	198,800	66%

1.46 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 (though this will come with increased work) 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. The latest GMP earnings and expenses report by NHS Digital states that it is not possible to provide an NHS/private split of income using HMRC earnings data. However, as a guide, the latest figures indicate that 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; 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; and
 - a greater use of technology.

1.47 However, there are other areas of cost growth which also need to be considered. In particular, professional indemnity insurance cost increases are affecting practice expenses nationally. For 2016/17, these cost increases were addressed directly through the contract uplift. In May, NHS England and the Department of Health established a GP Indemnity Review group to consider proposals to address the rising costs of indemnity in general practice, working with the profession and medical defence organisations.

1.48 The review concluded that the best way to relieve the immediate pressure was through a new and tailored scheme to provide direct financial support to general practice, whilst developing actions to resolve the long-term drivers of increased

costs¹⁹. For 2017/18, addressing the cost increases will be considered in line with the statements set out in the GP Indemnity Review.

NHS pension scheme

- 1.49 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.
- 1.50 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 (or 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 amount every year (based on 1/54th of their pensionable pay) - which is revalued according to Treasury Orders plus 1.5%.

Clinical Commissioning Groups (CCGs) and GP income

- 1.51 NHS England's Chief Executive, Simon Stevens, announced on 1 May 2014, proposals for local CCGs to co-commission primary medical care in partnership with NHS England²⁰. 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.
- 1.52 Over 70% of CCGs took 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. A further 51 successfully applied for delegated commissioning responsibilities from 1 April, 2016 – taking the total to 114 – or over 54%, with 70 of the remaining 95 in joint commissioning arrangements and 25 having greater involvement.
- 1.53 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;

¹⁹ <https://www.england.nhs.uk/ourwork/gp-fv/gp-indemnity/>

²⁰ <https://www.england.nhs.uk/commissioning/pc-co-comms/>

- 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

- 1.54 The Government's Mandate to NHS England²¹ set objectives to 2020, including:
- “...to ensure everyone has easier and more convenient access to GP services, including appointments at evening and weekends where it is more convenient for them.”*
- 1.55 In developing this policy to date, NHS England has focussed on testing approaches to improving and extending access, and has also confirmed the intent to roll out funding to support improved access to general practice across England by 2019/20. Testing approaches to access has been fulfilled by the Prime Minister's Challenge Fund, also known as the General Practice Access Fund. In October 2013, the Prime Minister announced²² 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. By March 2014, twenty schemes were selected - covering over seven million patients across more than 1,100 practices spread across the country.
- 1.56 In March 2015, a second wave of schemes was announced, with 37 pilots involving over 1,400 practices and covering over 10.5m patients. This was backed by further investment of over £125 million.
- 1.57 Taken together, a total of 18m patients in 2,500 practices have benefited from improved access to general practice through this Fund. As well as delivering more appointments during evenings and weekends, the schemes have also tested a broad range of ways of improving and extending channels of access for patients - delivered at scale, with a more diverse workforce - and better use of technology. This approach has also delivered sustainable transformational change in general practice and acted as a key stepping stone to delivering new models of care.
- 1.58 Delivery of these schemes has been underpinned 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 - including through an independent national evaluation²³ and thematic innovation showcases on topics²⁴.

²¹ https://www.england.nhs.uk/wp-content/uploads/2015/12/05.PB_17.12.15-Annex-A-Mandate-to-NHS-England.pdf

²² <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access>

²³ <https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/wave-one/wave-one-eval/>

²⁴ <https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/resources/>

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- 1.59 In 2016/17, Clinical Commissioning Groups (CCGs) have been asked to set out their plans to support general practice, including plans for future cohorts to deliver extended access - with a number of new schemes to go live during 2017/18 and a view to full population coverage of England by 2019. Additional recurrent funding will be made available each year, linked to CCG plans, to support the overall improvements in general practice. This phased increase in investment is designed to match the planned growth in the workforce.

GMS contract changes in 2015/16

- 1.60 The 2015/16 contract changes included an increase to the global sum for all GP providers by an overall 1.16%, which was intended to result in an increase of 1% to GMPs income after allowing for changes in their expenses. The changes to the contract were:

- Extending the avoiding unplanned admissions (AUA) enhanced service for a further year from 1 April 2015, with changes to the reporting process, payment structure and other changes;
- 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 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, with the 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) and that practices must engage with the PPG and confirm that through the practice eDeclaration;
- Ending the alcohol enhanced service, with the 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

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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 the QOF point for 2015/16 to take 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 for all patients (including children), who will take lead responsibility for the co-ordination of all appropriate services required under the contract.

GMS contract changes in 2016/17

1.61 The 2016/17 contract changes included an overall increase to global sum of 5.9% for all GP providers, which incorporated the 1% increase in net income recommended by DDRB. The changes to the contract were:

- Extending the avoiding unplanned admissions (AUA) enhanced service for a further year from 1 April 2016, with minor changes to clarify the timeframe for care plan reviews;
- Retiring the Dementia Enhanced Service from 31 March 2016 and transferring the resources (£42 million) into global sum with no out of hours deduction applied. During 2016, dementia diagnosis rates will be monitored and if necessary the position will be reviewed for 2017/18 if there is a significant change;
- Continuing all other enhanced services unchanged for a further year;
- Continuing all vaccinations and immunisation programmes in 2016/17 with the exception of changes to meningococcal B, meningococcal C and meningococcal ACWY;
- The following changes to Patient Online, with the GP Systems of Choice (GPSoC) programme being the process by which the nationally approved and funded systems necessary to provide the patient online facilities as described below will be made available to GP practices by NHS England:
 - Electronic prescriptions: GP practices will be encouraged to transmit repeat prescriptions only, with at least 80% of repeat prescriptions being transmitted electronically using Electronic Prescription Services (EPS) Release 2 by 31 March 2017 (unless the patient asks for a paper prescription or the necessary legislative or technical enablers are not in place);

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- Electronic referrals: GP practices will be encouraged to make referrals electronically, including at least 80% of elective referrals by 31 March 2017, using the NHS e-Referral Service;
- Summary Care Record: NHS England and GPC will jointly consider ways in which GP practices can be resourced to offer patients the opportunity to add additional information to their Summary Care Record (SCR). Separately, the GMS regulations will be amended to say SCR uploads will be enabled on an 'ongoing' rather than 'daily' basis;
- GP2GP: compliant practices will continue to utilise the GP2GP facility for the transfer of all patient records between practices, when a patient registers or de-registers (not for temporary registration) – subject to known limitations;
- Access to online services: the aim is for at least 10% of registered patients to be using one or more online services by 31 March 2017;
- Apps for patients to access services: GP practices will receive guidance on signposting the availability of apps to patients to allow them to book online appointments, order repeat prescriptions and access their GP record. Apps will be clinically and technically validated through the GPSoC programme during 2016/17 before being made available to patients. Technical support for patients in using the apps will be provided by the app suppliers;
- Online access to clinical correspondence: GP practices will provide patients with online access to clinical correspondence such as discharge summaries, outpatient appointment letters, and referral letters unless it may cause harm to the patient or contains references to third parties;
- Information sharing agreements between practices: NHS England and GPC will jointly develop a national template data sharing agreement, to facilitate information sharing between practices locally for direct care purposes. This will allow formal sharing agreements to be put in place where practices choose to work collaboratively in providing care;
- Shared discharge summaries and event posting: to support the increased use of interoperable records, the NHS Standard Contract requires providers to send their discharge summaries electronically to GP practices from 1 October 2015. From April 2016, GP practices will be required to receive all discharge summaries and subsequent post-event messages, electronically; and
- Cyber security: NHS England and the GPC will continue to promote the completion of the NHS Digital information governance toolkit, including adherence to the requirements outlined within it. GP practices will also continue, under the GMS regulations, to nominate a person with responsibility for practices and procedures relating to the confidentiality of personal data;
- The following changes to data collection requirements:

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- Named GP: NHS England will discuss with GPC during 2016/17 how appropriate and meaningful data relating to the named accountable GP can be made available at practice level through automatic extraction;
- Access survey: GP practices will be required to record data on access and allow it to be extracted or manually reported every six months. The data required and the form in which it is to be collected will be discussed between GPC and NHS England. It will be used to inform NHS England of the availability of evening and weekend opening for routine appointments and is to be collected until 2020/21;
- Extraction of former QOF and ES data: GPC agreed to remind practices to make this data available for extraction, in keeping with the historic agreement on retired QOF indicators and ESs;
- Locum GPs: NHS England propose setting a maximum indicative rate based on a set of rates (which may have some degree of regional variation) for locum doctors pay. NHS England will amend the electronic declaration system to include recording on the number of instances where a practice pays a locum doctor more than the maximum indicative rate;
- Access to healthcare: GPC agreed to work with DH and NHS England to develop arrangements for identifying patients with European Health Insurance Cards (EHIC) and S1 and S2, through patient self-declaration at the point of registration and recording their details with the aim of implementation in December 2016. Discussions will consider how to address any additional workload for GP practices;
- No change to the number of Quality and Outcomes Framework (QOF) points available, the clinical or public health domains, as well as no changes to QOF thresholds. However, the Contractor Population Index (CPI) will be adjusted to reflect the changes in list size and growth in the overall registered population for one year from 1 January 2015 to 1 January 2016.

GMS contract changes in 2017/18

- 1.62 We will provide an update on the negotiations in NHS England's supplementary evidence, due to be provided to DDRB in the coming weeks.

Conclusion

- 1.63 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 has already met the General Dental Practice Committee of the British Dental Association (BDA) to discuss possible quality and efficiency improvements for 2017/18, and has also discussed practice expenses. We plan to meet again on several occasions later this year. 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 where 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"²⁵.
- 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 intended to be at the expense of stifling local innovation in service and quality improvement.
- 2.6 In 2011, in response to dentists continuing to comment that 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 new pilot schemes. The pilots looked at elements of a new contract based on capitation and

²⁵ Available at: www.commissioningboard.nhs.uk/files/2012/06/ex-comm-pc.pdf

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quality, intended to focus on the treatment patients needed and avoid unnecessary treatments.

- 2.7 The learning from the pilots has now been evaluated and a prototype scheme was launched early in 2016. Some 82 prototypes are now live, incorporating learning from the pilot scheme and testing a blended capitation/activity-based remuneration mechanism. Characteristics of the prototypes are 79 high street practices; 3 community dental services; 21 new sites (known as UDA practices); and 58 former pilots.
- 2.8 Of the 79 high street practices 40 are blend A and 39 blend B. The two blends are a combination of payment systems based on capitation and activity. Blend A's capitation covers check-ups and preventative care. Blend B's capitation covers check-ups, preventative care, and routine treatment. All prototypes will follow the preventative clinical pathway designed to support dentists in delivering the best care for patients.
- 2.9 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, drive further improvements in dental health in England, and at least maintain current access as a minimum. The programme will be undertaking a formal evaluation of the prototypes, capturing three high level measures of success:
- Appropriate high quality care;
 - Access; and
 - Value for money.

If the evaluation of prototypes proves successful, additional UDA practices will be rolled out in 2017/18 - with a potential national rollout commencing in 2018/19.

- 2.10 Although it is clear that changes to the current system may be desirable to fit in with our long term aim, as expressed in the Five Year Forward View, of moving towards prevention rather than intervention and encouraging patients to take greater control of their own oral health care, 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 2015/16.

Access to NHS dental services

- 2.11 NHS England wishes 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 two years were successful. For those seeking an appointment in the last six months, the success rate is higher still at 96%.
- 2.12 In the last year:

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- The method of reporting the number of children seen by an NHS dentist changed in 2015/16 from a 24 month period to a 12 month period to reflect NICE recommendations. The data on total access to NHS dental services cannot therefore be compared to previous years. We are still able to compare access to NHS dental services by adult patients and this has risen: 22,104 million adult patients (51.7% of the population) were seen by an NHS dentist in the 24-month period ending June, 2016. The number is 72 higher than twelve months earlier, and 2.7 million higher than the low point reached in June 2008;
- In the 12 month period ending June 2016, 6.7 million children accessed NHS dental services, representing 57.9% of the childhood population;
- There has been a slight fall in NHS dental activity. The total movement was from 87.2 million UDAs in 2014/15 to 86.4 million UDAs in 2015/16. However, band 1 activity increased by 410 UDAs. NHS England regional team commissioning plans at June 2016 for the following twelve months show 474,500 UDAs (-0.5%) lower than the previous twelve months;
- The commissioning statistics show a reduction in the initial level of UDAs commissioned by NHS England. This can reflect a number of factors, including a continued removal of undelivered UDAs and a cleaning up of the dataset. This, and a reduction in delivered UDAs, does not mean that we are commissioning services for fewer patients. The 'patient seen' data continues to show an increase (albeit small) in the number of patients seen - and this reflects our commitment to improve the efficiency of NHS dental services, including ensuring that claims for activity correctly reflect the treatment required and delivered.
- The number of dentists providing NHS services rose by 142 to 24,089 dentists in 2015/16; and
- The proportion of dentists' time spent on NHS work fell from 71.4% in 2013/14 to 70.7% in 2015/16.

General Dental Practitioners: recruitment, retention and motivation

- 2.13 The number of NHS patients seen and the NHS service they receive is the most important measure of delivery, and the numbers of dentists providing NHS services is relatively less important. Nevertheless, it is worth noting that the numbers of dentists has continued to rise, up by 0.6% last year. This may be a factor in the overall NHS remuneration per dentist as activity is spread across more dental performers.
- 2.14 Dentists are still ready, and indeed enthusiastic, to bid for and undertake NHS contracts, including in areas where dentists had previously chosen not to set up or provide NHS services - and NHS access continues to rise.
- 2.15 Dentists have achieved a reduction in working hours, with evidence from NHS Digital's dental working hours survey published in September 2016 showing that

dentists are working an average of 36.9 hours per week in 2015/16 compared to 39.4 hours in 2000, a reduction of over 6%.

2.16 In 2015, NHS Digital collected information on motivation and morale of dentists for the first time. The results show Performer-only dentists are more motivated and have higher morale than Providing-Performers. Performers have shown a slight increase in both morale and motivation between 2012/13 and 2013/14 and Providing- Performers have shown a fall in both areas.

2.17 For clarity, the definitions used in the NHS Digital report are as follows:

- “Providing-Performer”: a dentist under contract with NHS England and also performing dentistry; and
- “Performer Only”: a dentist working for practice owner, principal or limited company.

Table 2.2: Motivation and morale 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

2.18 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.

2.19 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).

2.20 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, we are piloting new dental remuneration systems with prototype practices based more on prevention and quality, and focusing more closely on patient outcomes rather than simply the number of interventions.

Future workforce supply

2.21 The Centre for Workforce Intelligence’s (CfWI) review of dentistry student numbers, commissioned by The Department of Health and Health Education England (HEE), resulted in a decision to reduce the annual dental school intake. The review analysed workforce needs and supply up to 2040.

- 2.22 The review also recommended that HEE commission the CfWI to conduct a stocktake of the multi-professional dental workforce, focusing on Dental Care Professionals (DCP). The resulting DCP Stocktake' report looked at the DCP workforce required to deliver services in both the NHS and the private sector, and focused on the changing dental 'skill mix' in the context of the proposed reform of the NHS dental contract. HEE are taking forward the CfWI's recommendations in reviewing the greater use of DCPs in delivering primary dental care.
- 2.23 Health Education England has informed us that there is a very healthy supply of foundation dentists.

General Dental Practitioners: earnings and expenses

- 2.24 Each year we see a smaller number of Providing-Performers. In 2015/16 there was a fall of 589 to 3,449. We also saw a rise in the number of Performers. In 2015/16, they increased by 731 to 20,640. 85.7% of dentists are now Performers compared to 62.4% in 2006/07.
- 2.25 The earnings of the Providing-Performers dentists have seen a slight increase for the third year running and the earnings of performer dentist continued to decrease in 2014/15. 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.
- 2.26 The average figures published by NHS Digital²⁶ cover dentists doing any NHS work in the year. A significant number of dentists come and go within a year, in 2014/15 there were 1,504 leavers and 1,664 joiners in-year - or 3,168 (13%) working for only part of the year for the NHS.
- 2.27 The numbers of dentists for the years 2006/07 to 2015/16 are set out on table 2.3 below (table 8c from 'NHS Dental Statistics for England 2015/16').

Table 2.3: Number and percentage of dentists with NHS activity by dentist, 2006/07 to 2015/16

	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
2015/16	3,449	20,640	24,089	14.3	85.7	100

²⁶ Available at: <http://www.hscic.gov.uk/catalogue/PUB18376/dent-earn-expe-2013-14-init-rep.pdf>

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

- 2.28 The data from NHS Digital 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.
- 2.29 We do not have precise figures on how many dentists changed their business arrangements in this way, although we do know the changes in the number of self-employed dentists overall in 2015/16. Compared to 2014/15, there are 14.6% fewer dental contract holders and 3.7% more “dentists who work for others”.
- 2.30 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 income after expenses for dentists in 2014/15 fell to £70,500 compared with £71,700 in the previous year, the NHS Digital report notes that this is not statistically significant. These income levels appear to be sufficient to recruit and retain the dental workforce.
- 2.31 For dentists holding a contract, earnings were considerably higher at an average of £117,400 - an increase of 1.8% from the previous year’s £115,200. The data also show some dentists earning considerably more - with 1% earning over £300,000. Dentists working for providers still had an average net profit of £59,900, down 1.1% from the £60,600 of the previous year.
- 2.32 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 2014/15

	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

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	Population	Average gross income	Expenses	Net profit	Expenses ratio
2012/13	21,500	£156,100	£83,500	£72,600	53.5
2013/14	21,500	£155,100	£83,400	£71,700	53.8
2014/15	21,350	£152,500	£82,000	£70,500	53.8

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

2.33 Another source of information on dentists' income, compiled by the National Association of Specialist Dental Accountants and Lawyers (NASDAL), reported that average net profits for all practices have been increasing since 2012/13 - with NHS practices having an average profit of £129,265 in 2014/15, an increase of £265 from 2013/14. Net profits for private practices were, on average, £10,864 higher than for NHS practices in 2014/15. Until 2013/14, when private profits rose slightly above NHS profits, NHS profits had been higher than private practices since 2005/06. However, in the NASDAL April 2016 goodwill survey, they note the market (for dental practices) "...is still very buoyant and there is a huge demand for NHS practices."

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 £	2014/15 £
NHS	142,400	149,500	148,000	161,300	147,800	133,020	130,000	125,958	129,000	129,265
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	140,129

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 has not been provided since 2010/11

2.34 NASDAL report that average net profits for associate dentists (those dentists with no share of ownership) have been stable for over a decade, although average profits decreased slightly in 2014/15, from £68,544 in 2013/14 to £68,024 in 2014/15.

Expenses

2.35 The NHS Digital 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 NHS Digital 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

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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.

- 2.36 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.
- 2.37 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).
- 2.38 As already noted, the changes from year to year are affected by contract holder dentists changing their business arrangements into companies. 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.

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2.39 The issue of multiple-counted expenses is also important as noted by NHS Digital. 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 NHS Digital 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.

2.40 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 2014/15. Other Non-Staffing Costs (Morris & Co) increased at a higher rate than other expenses in 2013/14 and has subsequently seen a fall in 2014/15. For every category of expenditure for NHS practices, the percentage of cost has reduced in 2014/15 compared to the previous year.

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	2014/ 15
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%	20.1%
Private Practices	17.2%	17.4%	17.8%	17.6%	18.1%	19.4%	19.5%	19.5%	18.9%	18.2%
Laboratory costs (NASDAL)										
NHS practices	6.4%	5.6%	6.1%	6.0%	6.5%	6.3%	6.1%	6.4%	6.6%	6.3%
Private Practices	8.9%	7.8%	7.6%	7.1%	7.9%	7.6%	7.2%	7.3%	7.4%	6.8%
Materials costs (NASDAL)										
NHS practices	5.6%	5.0%	5.6%	5.4%	5.6%	6.3%	6.6%	6.3%	6.8%	6.0%
Private Practices	6.7%	7.0%	7.5%	7.1%	7.5%	7.9%	7.4%	7.2%	7.1%	7.8%
Premises Costs (NASDAL)										
NHS practices								3.4%	3.7%	3.2%
Private Practices								4.3%	4.5%	4.4%
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%	17.1%
Private Practices	23.0%	23.2%	23.6%	21.4%	21.2%	21.7%	22.8%	20.4%	19.7%	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. Premises cost are only available from 2012/13										

NHS pension scheme

- 2.41 Access to the NHS Pension scheme is available to all those dentists who work for the NHS. In their last report, DDRB asked for evidence of dentists opting-out from the NHS pension scheme. Information on take-up of the NHS pension scheme by dentists from the NHSBSA Compass system, based on entries made by NHS England teams, shows the number of dentists who are members of the NHS pension scheme fell slightly from 19,090 in 2014/15 to 18,956 in 2015/16. However, the BSA reporting system changed during 2015/16 and the way the data is reported and extracted may have had an effect on the figures when compared year on year. The 2015/16 data still shows that almost all dentists under the age of 26 are members of the NHS Pension scheme. Although, the effect of the most recent changes to the pension scheme, 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.

2016/17 settlement

- 2.42 For 2016/17, DDRB recommended an uplift in income, net of expenses, of 1%. The increase was accepted by Ministers, and when combined with an increase for staff expenses of 1% in line with the public sector pay cap, and other expenses using CPI, resulted in an overall up lift of 0.7%.
- 2.43 The national uplift was applied to gross contract values for GDS contracts and PDS agreements.
- 2.44 As part of this package, dentists were expected to continue to work closely with the Department of Health 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 and we hope to build on this approach further.

Salaried dentists

- 2.45 Salaried dentists working in community dental services (CDS), which are local services commissioned by NHS England, provide an important service to patients with particular dental needs especially vulnerable groups.
- 2.46 NHS England commissions dental services, including CDS, in line with local oral health needs assessments undertaken in partnership with local authorities and other key stakeholders, for example Local Dental Networks and Managed Clinical Networks. These will pay particular attention to the local demography and groups in the population with special or additional needs. The NHS England Commissioning Guide for Special Care Dentistry is particularly relevant when commissioning CDS as it will often be a key provider of more advanced special care services.
- 2.47 NHS England believes that CDS play an important role in dental health service provision and are not aware of any specific difficulties in filling vacancies faced by providers.

Contract changes in 2017/18

- 2.48 We are taking forward discussions with the BDA with a view to setting a direction of travel that aligns key contract changes to the Five Year Forward View.

General Dental Practitioners: conclusion

- 2.49 This chapter provides information on the latest position on recruitment and retention, earnings and expenses, and other relevant developments for general dental practitioners.