The Review Body on Doctors' & Dentists' Remuneration

Review for 2019

General Medical Practitioners and General Dental Practitioners

February 2019

The Review Body on Doctors' and Dentists' Remuneration

NHS England's Information and Evidence on GMPs and GDPs for the 2019 Review

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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 8E28 Quarry House
Quarry Hill
Leeds
LS2 7UE
Email: mike.kemp@nhs.net or joanne.lowther@nhs.net

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1.1 This document contains written information and evidence to inform the report by the Review Body on Doctors' and Dentists' Remuneration (DDRB) on 2019/20 pay for their remit group.

1.2 Chapter 2 provides information on primary care finance – including the affordability and funding constraints in relation to GMP and GDP pay.

1.3 Chapter 3 provides information on the outcome of the 2019/20 GP contract negotiations.

1.4 Chapter 4 provides detailed evidence on general dental practitioners (GDPs) providing NHS primary care services and those salaried GDPs on terms and conditions set by NHS organisations in England.

Background

1.5 As the national commissioning board, tasked with ensuring the delivery of health services across England within the financial settlement agreed with the government, there is a clear imperative for NHS England to ensure the NHS workforce is well motivated and able to attract and retain high performing members of staff. However, we must also ensure we are able to grow the total size of the workforce to adequately expand services to manage increasing levels of demand.

1.6 NHS England is also responsible for commissioning primary care services, including primary medical care. These commissioning responsibilities are undertaken by NHS England through its local regional teams and, increasingly, through delegation to Clinical Commissioning Groups (CCGs). Over 91% (178 CCGs) of the total now have delegated responsibility for primary medical care commissioning. 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 changes to the General Medical Services (GMS) contract.

Contracts for GMP and GDP services

1.7 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.

1.8 The take-home pay earned by these contractors from their NHS activities is therefore derived from the profits their practices generate, which are determined by the gross income earned from their NHS contracts less NHS-related practice expenses.

1.9 To an extent, contractors are therefore able to influence the level of profits 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 therefore earn extra income from, delivering Enhanced Services.

Chapter 2 – Primary Care Finance

Overview

GMPs

2.1 The NHS Long Term Plan, which was published on 7 January, 2019[1] underpins the long term funding settlement referred to above and sets out that:

- NHS England is committed to increasing investment in primary medical and community health services as a share of the total national NHS revenue spend from 2019/20 to 2023/24; and
- spending on those services will be at least £4.5bn higher in five years' time.

2.2 NHS England has secured agreement to a five-year framework for contract reform[2] with GPC England that gives clarity and certainty for practices. It confirms the funding intended through national legal entitlements for general practice under the practice and new network contracts. GPC England and NHS England have agreed that they do not expect additional national money for practice or network contract entitlements, taken together, until 2024/25.

2.3 Accordingly, no recommendation is being sought from DDRB for independent contractor GMP net income for the duration of the five-year deal.

2.4 Under this agreement, GPC England is recommending that practice staff, including salaried GPs, receive at least a 2.0% increase in 2019/20, but the actual effect for individuals will depend on how indemnity cover is currently funded within practices. Accordingly, from April 2019, the minimum and maximum pay range for salaried GPs will be uplifted by 2%. The Secretary of State for Health and Social Care has therefore asked that the review body does not provide a recommendation on salaried GMP pay in England for the 2019/20 pay round.

GDPs

2.5 The affordability of pay recommendations for GDPs in 2019/20 has also been carefully considered within the context of the Long Term Plan, the continued financial pressures and the productivity and efficiency requirements required of all providers of NHS services – including GDPs. In line with other staff groups, the maximum affordable pay award for GDPs within an affordable set of national allocations is 2%.

2.6 The evidence suggests that the workforce remains robust with a good supply of dentists who are well remunerated.

2.7 On the basis of the above, we would encourage the DDRB to carefully consider what uplift is appropriate for 2019/20.

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[1] Available at: https://www.england.nhs.uk/2019/01/long-term-plan/

[2] Available at: https://www.england.nhs.uk/publication/gp-contract-five-year-framework/

Chapter 3: General Medical Practitioners (GMPs) – A Five Year Contract for Reform

Key elements of the contract agreement

3.1 NHS England and the British Medical Association's General Practitioners Committee have agreed a five-year GP (General Medical Services) contract framework from 2019/20[3]. The new contract framework marks some of the biggest general practice contract changes in more than a decade and will be essential to deliver the ambitions set out in the NHS Long Term Plan through strong general practice services.

3.2 The contract increases investment and more certainty around funding and looks to reduce pressure and stabilize general practice. It will ensure general practice plays a leading role in every Primary Care Network (PCN)[4], which will include bigger teams of health professionals working together in local communities. It will mean much closer working between networks and their Integrated Care System.

3.3 Core general practice funding will increase by £978 million per year by 2023/24.

3.4 A PCN contract will be introduced from 1 July 2019 as a Directed Enhanced Service (DES). It will ensure general practice plays a leading role in every PCN and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme, which will be centrally funded and locally delivered.

3.5 By 2023/24, the PCN contract is expected to invest £1.799 billion, or £1.47 million per typical network covering 50,000 people. This will include funding for around 20,000 more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers. Bigger teams of health professionals will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.

3.6 A new shared savings scheme for PCNs so GPs benefit from their work to reduce avoidable A&E attendances, admissions and delayed discharge, and from reducing avoidable outpatient visits and over-medication through a pharmacy review.

3.7 A new state backed indemnity scheme is planned to start from April 2019 for all general practice staff, including out-of-hours.

3.8 Additional funding of IT will allow both people and practices to benefit from the latest digital technologies. All patients will have the right to digital-first primary care, including web and video consultations by 2021. All practices will be offering repeat prescriptions electronically from April 2019 and patients will have digital access to their full records from 2020.

3.9 A new primary care Fellowship Scheme will be introduced for newly qualifying nurses and GPs, as well as Training Hubs.

[3] Available at: https://www.england.nhs.uk/publication/gp-contract-five-year-framework/
[4] Available at: https://www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/

3.10 Improvements to the Quality and Outcomes Framework (QOF) will bring in more clinically appropriate indicators such as diabetes, blood pressure control and cervical screening. There will also be reviews of heart failure, asthma and mental health. In addition, there will be the introduction of quality improvement modules for prescribing safety and end of life care.

3.11 Extra access funding of £30 million a year will expand extended hours provision across PCNs and, from 2019, will see GP practices taking same-day bookings direct from NHS 111 when clinically appropriate.

3.12 More detail can be found in the following document: A five-year framework for GP contract reform to implement The NHS Long Term Plan.

Chapter 4 – General Dental Practitioners (GDPs)

Introduction

4.1 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.

4.2 NHS England has already met the General Dental Practice Committee of the British Dental Association (BDA) to discuss possible quality and efficiency improvements for 2018/19, and has also discussed practice expenses. We plan to meet again on several occasions in the near future. 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 the quality and efficiency of services.

Background

4.3 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. Proposals for dental commissioning will build on the single operating model for primary care commissioning described in "Securing excellence in commissioning primary care"[5].

4.4 NHS England has now been commissioning dental services for five years and is committed to improving them to the benefit of patients and providers, in particular by:

- 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.

4.5 We are doing this through the development of, and move towards, a single system with a consistent operating model across the country. NHS England is working to ensure there are clear and consistent outcome measures, indicators and a single accountability framework for NHS primary care dentistry in England, set out in our single operating model for dental commissioning. This is not intended to be at the expense of stifling local innovation in service and quality improvement.

4.6 In 2011, in response to dentists continuing to feedback 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 and Social Care set up new pilot schemes. The pilots looked at elements of a new contract based on

[5] Available at: https://www.england.nhs.uk/wp-content/uploads/2013/02/commissioning-dental.pdf

capitation and quality, intended to focus on better rewarding oral health promotion, and better targeting patients with dental needs, avoiding unnecessary treatments and focusing on long-term care that will give patients the security of continuing care.

4.7 Following learning from the pilots, a prototype scheme was launched early in 2016 incorporating learning from the pilot scheme and testing a blended capitation/activity-based remuneration mechanism.

4.8 This year, the Dental Contract Reform programme is increasing the number of dental practices in the prototype scheme; we hope to add nearly 50 more practices by the end of the 2018/19 financial year. This will mean around 120 practices will be involved, including some who were part of the pilot scheme, alongside new entrants from both 'high street' practices and community dental services. This confirms NHS England's commitment to the reform process. It is notable that our evaluation[6] of the first year of prototypes (published in May) showed that the prototypes are showing promise, in particular through the delivery of the prevention focussed clinical pathway.

4.9 The testing of a potential new dental contract has been measured, in line with the recommendations of the Health Select Committee[7] that any changes to the dental contract are piloted and tested rigorously. We are continuing to test the proposed system and are involving the profession throughout the process. The principles of dental contract reform are the same as those in the Five Year Forward View: prevention, self-care and individually focussed treatment for patients. This is in line with the wider approach we are taking to the health and social care system.

4.10 Oral health has improved enormously in the last 40 years and we now need NHS dentistry to incentivise dentists to work with patients to prevent dental decay, treating it where necessary, to improve the oral health of the population. This should in turn lead to routine patients needing less treatment and less frequent check-ups, and should allow for improved timely access and care for new patients and others with greater dental care needs.

4.11 Along with reform of the dental contract we are working with local commissioners to integrate dental services into the new local care systems including Sustainability and Transformation Partnerships (STP), Integrated Care Systems (ICS) and Primary Care Networks (PCNs). Local Professional Networks established under "Securing excellence in commissioning primary care"[8] are the vehicle for clinically lead integrated commissioning which adds value to care pathways and improve outcomes. The on-going development and maturation of the Local Dental Networks (LDNs) and associated Managed Clinical Networks is key in achieving this locally focussed NHS commissioning and delivery model.

4.12 The current focus of activity is around ensuring dentistry has a firm "seat at the table" to ensure that services fit patient needs and form part of the wider continuum of care provided in the area. In the future we will be exploring how we can increase the local

6 Available at: https://www.gov.uk/government/publications/dental-contract-reform-evaluation-report-2016-to-2017

7 Available at https://publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/289i.pdf

8 Available at: https://www.england.nhs.uk/publication/securing-excellence-in-commissioning-primary-care/

accountability and commissioning of dental services and are currently looking at how they might best fit into the evolving new models of care.

Smile4Life prevention initiatives

4.13 In addition to the development of a new contract, NHS England has developed SMILE4LIFE, a programme of activity which aims to reduce oral health inequalities and promote good oral health in England.

4.14 Within this programme are two complementary initiatives which aim to improve oral health and increase dental access across the population, through creative commissioning, service development and integration with the wider health & social care system.

- Starting Well 13 – a targeted NHS England programme in 13 high priority areas. The programme aims to support the reduction of oral health inequalities and improve oral health in children under the age of five years, through creative use of commissioning expenditure. The objectives of the programme are to:
  - offer evidence-based interventions at individual patient level, practice level and community level to children under the age of five years, with a focus on high-risk groups;
  - increase the provision of preventive advice and interventions by the dental team, as per the evidence base presented in Delivering Better Oral Health;
  - increase the proportion of children under the age of five accessing dental care, with a focus on high-risk groups;
  - increase the integration of the dental team within the community; and
  - provide NHS England dental commissioners with a method of commissioning the programme within the existing dental contract.
- Starting Well Core is a nationwide commissioning opportunity for NHS England dental commissioners to apply across their areas of responsibility, in line with place-based commissioning priorities. The programme is designed to improve dental access and address oral health inequalities in children under two years. Starting Well Core supports the wider ambition to reduce the number of children requiring a general anaesthetic for the removal of decayed teeth. The objectives of the programme are to:
  - increase access to dental care and attendance for children under two years of age on a national level;
  - implement a high profile public awareness programme of “Dental Check by One” to ensure the timely attendance of children under two years;
  - provide cost effective evidence-based interventions and preventive advice - such as fluoride varnish, healthy lifestyle choices and dietary advice; and

- provide NHS England dental commissioners with a method of commissioning the initiative within the existing dental contract.

4.15 In order to increase the effectiveness of the programmes – and to complement existing local initiatives – both initiatives have been developed and delivered in partnership with Public Health England, Health Education England, the dental profession, NHS England Dental Commissioners, Local Dental Networks and Local Dental Committees, British Society of Paediatric Dentistry and Local Authorities.

Access to NHS dental services

4.16 The March 2018 GP Patient Survey[9] covered access to NHS dental services and 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%. However, respondents who had not been to the practice before were less successful (78%) in getting an NHS dental appointment with nine CCG areas having success rates below 60% where respondents had not been to the practice before. Younger adults and ethnic minorities also reported a lower success rate. A lower proportion of younger adults and respondents from ethnic minorities had been to the practice before, compared to other respondents.

4.17 Dental access continues to be relatively stable, dropping slightly for adults in the last dataset but increasing for children, possibly due to an increased emphasis on child oral health and starting the habit of going to the dentist early.

4.18 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 years prior to 2015/16. We are still able to compare access to NHS dental services by adult patients, as reported in NHS Dental Statistics[10] - and this has fallen: 22.1 million adult patients (50.7% of the population) were seen by an NHS dentist in the 24-month period ending June 2018. This is a decrease of 0.1 million compared with the previous twelve months, but 2.6 million higher than the low point reached in June 2008. Please see table 1.1 below.

4.19 In the 12 month period ending June 2018, 6.9 million children (58.6% of the childhood population) accessed NHS dental services, an increase in both the number and proportion of children compared to the previous 12 months when the figures were 6.8 million and 58.2%.

9 Available at:https://www.england.nhs.uk/statistics/2018/08/09/gpps_dent_x1786_239846/

10 Available at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2017-18-annual-report

Table 1.1 Number and proportion of adult and child patients seen by an NHS Dentist

Year	Adult patients seen	Percentage of the adult population	Child patients seen	Percentage of the child population	Total patients seen	Percentage of the total population
2007/08	19,435	48.5%				
2015/16	22,140	51.8%	6,724	58.0%	28,864	53.1%
2016/17	22,159	51.4%	6,799	58.2%	28,958	52.9%
2017/18	22,061	50.7%	6,901	58.6%	28,962	52.4%

4.20 The correct level of NHS dental access is difficult to assess; oral health has improved greatly over the last 40 years. In 1968, as many as 37% of adults had no teeth at all, but by 1998 the figure had fallen to 11% and by 2009 to 6%. In 2017, 77% of 5-year-olds were free from decay. Although this lowers individual need for the younger generation it also means there is a large cohort of older adults with restored teeth requiring maintenance. This results in additional demand for the ongoing maintenance of their oral health. There has also been a marked shift towards private dentistry. Our national patient survey figures suggest that the unmet demand for NHS dentistry is relatively small at around 5% of the adult population, based on the percentage of the adult population who have tried and been unsuccessful in obtaining an NHS dental appointment.

4.21 There has been a slight fall in units of dental activity (UDAs) delivered: 83.2 million UDAs in 2017/18 down 2.5 million (3%) since 2016/17. The smallest reduction is in band 1 activity down by just 125,000 UDAs when compared with 2016/17, with falls in band 2 and band 3 activity of 1.1million each suggesting that the mix of treatment provided is changing. NHS England regional team commissioning plans at June 2018 for the following twelve months show 233,000 UDAs (0.3%) lower than the previous twelve months. This can reflect a number of factors, including the continued removal of undelivered UDAs, cleaning of the dataset and efforts to improve the efficiency of NHS dental services, such as ensuring that claims for activity correctly reflect the treatment required and delivered.

4.22 The majority of dentists' time remains committed to NHS work: in 2017/18 the proportion of dentists' time spent on NHS work remained the same as in 2015/16 at 70.7%.

General Dental Practitioners: recruitment, retention and motivation

4.23 For clarity, the definitions used in the report are as follows:

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

4.24 It is worth noting that, unlike general medical practice, dentists are rarely salaried in primary dental services and the significant majority of these performer only dentists work as an associate within a practice.

4.25 2017/18 saw the number of dentists providing NHS services increase by 1.3% to 24,308 dentists and the number of Performer Only dentists continued to rise at a higher rate, increasing by 3.2% in 2017/18. This may be a factor in the overall NHS remuneration per dentist as activity is spread across more dental performers.

4.26 Current trends in the dental workforce are difficult to assess. Overall workforce numbers appear adequate in order to meet the needs of the population and the numbers have increased in absolute terms.

4.27 In their 46th Report published last summer, DDRB asked for systematic data on GDP motivation. NHS Digital have published this information in Dental Working Hours - 2016/17 and 2017/18: Working Patterns, Motivation and Morale.

4.28 NHS England has been working with the profession - including the BDA - to look for possible solutions, especially to the issue of geographical distribution. This work continues and the outcomes will inform our commissioning intentions. It appears likely that young dentists are attracted to the ways of working in our prototype dental practices which more closely matches the way dentistry is taught in dental schools - with the much larger emphasis on prevention and continuing care.

Future workforce supply

4.29 Health Education England (HEE) commissioned the Advancing Dental Care Review, with the Chief Dental Officer's support in 2017. The report considers the skills and composition of the future dental workforce that will best meet future patient need, and the training structures and funding models that will deliver that workforce. The initial report was published on 16th May 2018[11], alongside 21 recommendations for safeguarding future workforce sustainability and supply for the NHS.

4.30 The Review has now entered its second phase – a three-year programme, which will map current training structures and explore reform options, with the aim of delivering more needs-based workforce planning and increasing training efficiency and flexibility, for both trainees and the service. The Review will work with stakeholders, and particularly the General Dental Council, to consider how existing training pathways are structured, and determine whether they continue to serve current and future patient needs.

4.31 HEE placed all UK graduates into foundation training places in 2018, and works closely with NHS England to administer Performers List Validation by Experience (PLVE) and support dentists from the European Economic Areas acceptance onto the performers list.

[11] Available at https://www.hee.nhs.uk/our-work/advancing-dental-care

General Dental Practitioners: earnings and expenses

4.32 The data from NHS Digital, Dental Earning and Expenses Estimates 2016/17[12] shows gross earnings of Providing-Performers dentists have seen an increase in cash terms in 2016/17. The earnings of Performer Only dentists also increased in cash terms for the fourth year in a row.

Table 1.3: Average gross earnings by dentist type 2006/07 to 2016/17

Year	Provider-Performer dentist	Performer Only dentist
2006/07	£353,869	£104,417
2007/08	£345,651	£99,208
2008/09	£366,500	£104,000
2009/10	£370,900	£101,700
2010/11	£364,300	£98,400
2011/12	£358,400	£96,200
2012/13	£368,000	£96,200
2013/14	£375,000	£99,000
2014/15	£385,600	£99,800
2015/16	£377,800	£103,500
2016/17	£381,200	£106,400

Note Due to the time needed to collect and compile the data, 2016/17 is the latest data available.

4.33 The total number of dentists has continued to increase. Within this there has been an increase in the number of Performer Only dentists and a reduction in the number of Providing-Performer dentists.

4.34 The average figures published by NHS Dental Statistics cover dentists doing any NHS work in the year. A significant number of dentists come and go within a year: in 2016/17 there were 1,520 leavers and 1,547 joiners in-year, or 3,067 (12.8%) working for only part of the year for the NHS.

4.35 The numbers of dentists for the years 2006/07 to 2017/18 are set out on table 1.4 below (table 8b from 'NHS Dental Statistics for England 2017/18').

[12] Available at https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2016-17

Table 1.4: Number and percentage of dentists with NHS activity by dentist type, 2006/07 to 2016/17

	Number			Per cent		
	Providing performer	Performer only	Total	Providing performer	Performer only	Total
	No.	No.	No.	%	%	%
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
2016/17	2,925	21,082	24,007	12.2	87.8	100
2017/18	2,555	21,753	24,308	10.5	89.5	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

4.36 The data from NHS Digital, Dental Earning and Expenses Estimates 2016/17 continues to be difficult to compare with previous years because of changes in the way dentists pay themselves. The main change has been 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. The following extract from the known issues section of the report sets this out:

This report considers only those primary care dentists who have earnings from self-employment which has traditionally been the employment status of the majority of primary care dentists (both Providing-Performer/Principal and Associate). These dentists complete Self Assessment tax returns which, subject to certain exclusion criteria, are used to inform the analyses presented in the Dental Earnings and Expenses Estimates series of reports. Since the introduction of the Dentists Act 1984 (Amendment) Order 2005, it has been possible for both Providing-Performer/Principal and Associate dentists to incorporate their business(es) and to become a director and/or an employee of a limited company (Dental Body Corporate), with the potential to operate in a more tax-efficient manner. In the case of Providing-Performer/Principal dentists, the incorporated business tends to be a dental practice, whereas for Associate dentists, the business is the service they provide as a subcontractor. It is not currently known how many dentists have incorporated their business(es) nor what the precise consequences of incorporation may be for the results presented in this report.

4.37 This is a significant issue, which has an 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. There was no statistically significant change in average identifiable net income after expenses for dentists in 2016/17 compared with the previous year. These income levels are sufficient to recruit and retain the dental workforce.

4.38 For dentists holding a contract, earnings were considerably higher at an average of £115,800, an increase of 0.1% from the previous year's £115,700. The data also show some dentists earning significantly more – with some earning over £300,000. Dentists working for providers still had an average net profit of £60,800, up 1% from £60,200 the previous year.

4.39 On expenses, the data showed that just over half (52.9%) of gross payments to dentists were to meet their expenses. There has been little movement in this ratio since 2006 – as shown in the table below.

Table 1.5: Gross income and net profit of all primary care dentists 2004/05 to 2016/17

	Population	Average gross income[13]	Expenses	Net profit	Expenses ratio
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
2014/15	21,350	£152,500	£82,000	£70,500	53.8
2015/16	21,200	£148,000	£78,900	£69,200	53.3
2016/17	21,200	£145,700	£77,000	£68,700	52.9

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

4.40 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 NHS practices have been increasing since 2012/13 – with NHS practices having an average profit of £139,698 in 2016/17, an increase of £5,596 from 2015/16. Net profits for private practices increased in 2016/17 following a fall in the previous year. NHS practices continue to generate slightly higher profits than private practices. The NASDAL goodwill survey published in July 2018 noted that NHS practices in particular still appear to be in demand with a significant number of sales in the quarter at considerably over 200% of gross fees.

13 Changes in average gross income over time reflect the changing weighting in the numbers of Providing-Performer and Performer Only dentists as shown in table 1.4.

Table 1.6: Net profit per principle for the practice

Type of practice	2006/07 £	2007/08 £	2008/09 £	2009/10 £	2010/11 £	2011/12 £	2012/13 £	2013/14 £	2014/15 £	2015/16 £	2016/17 £
NHS	149,500	148,000	161,300	147,800	133,020	130,000	125,958	129,000	129,265	134,102	139,698
Mixed	147,100	140,700	138,600	143,800	127,045	-	-	-	-	-	-
Private	130,900	136,500	130,600	126,400	117,552	117,000	124,086	131,000	140,129	133,743	139,454

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

Expenses

4.41 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:

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 Providing-Performer/Principal dentists. In some cases, the dental work is performed by an Associate dentist working in the Providing-Performer/Principal's practice and some of that payment will be passed on to the Associate. This means that the same sum of money may be declared as gross earnings by both the Providing-Performer/Principal and Associate and again as an expense by the Providing-Performer/Principal. This is known as 'multiple counting' and its extent is difficult to quantify. However, where multiple counting does occur, it 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 the practice, no multiple counting can occur.

4.42 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.

4.43 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 may also 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).

4.44 Extracts from NASDAL and Morris and Co (Other non-staffing costs) results are in the table below. They show that there have been only slight variations in expenses as a percentage of gross income in 2016/17. Expenses as a percentage of gross income have remained relatively stable since the data was first provided in 2006/07.

4.45 NHS England continues to have productive meetings with the BDA on a number of issues including efficiencies and potential cost pressures such as increasing

indemnity costs, the changes relating to the use of amalgam and the impacts on the cost of restoration work.

Table 1.7: Categories of expenses as a percentage of gross income

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Non-clinical staff wages (NASDAL)											
NHS practices	17.3%	17.9%	17.7%	18.8%	19.8%	19.9%	21.0%	20.3%	20.1%	20.6%	19.7%
Private Practices	17.4%	17.8%	17.6%	18.1%	19.4%	19.5%	19.5%	18.9%	18.2%	17.6%	18.0%
Laboratory costs (NASDAL)											
NHS practices	5.6%	6.1%	6.0%	6.5%	6.3%	6.1%	6.4%	6.6%	6.3%	6.1%	6.0%
Private Practices	7.8%	7.6%	7.1%	7.9%	7.6%	7.2%	7.3%	7.4%	6.8%	7.5%	7.1%
Materials costs (NASDAL)											
NHS practices	5.0%	5.6%	5.4%	5.6%	6.3%	6.6%	6.3%	6.8%	6.0%	6.1%	6.2%
Private Practices	7.0%	7.5%	7.1%	7.5%	7.9%	7.4%	7.2%	7.1%	7.8%	7.4%	7.5%
Premises Costs (NASDAL)											
NHS practices							3.4%	3.7%	3.2%	3.8%	3.6%
Private Practices							4.3%	4.5%	4.4%	4.4%	4.2%
Other Non-Staffing Costs (Morris & Co)											
NHS practices	16.8%	15.7%	15.6%	15.1%	16.7%	16.6%	16.4%	18.6%	17.1%	15.4%	16.1%
Private Practices	23.2%	23.6%	21.4%	21.2%	21.7%	22.8%	20.4%	19.7%	19.7%	16.3%	18.9%

Gender Pay Gap

4.46 DDRB asked for evidence on the gender pay gap and this section provides data from the dental earnings and expenses estimates publications.

Table 1.8: Average taxable income from NHS and private dentistry by gender

	2006/07	2012/13	2013/14	2014/15	2015/16	2016/17
Total	93,135	72,600	71,700	70,500	69,200	68,700
Male	110,747	83,900	84,100	83,300	81,900	81,800
Female	71,093	59,100	57,300	56,500	55,800	55,500

4.47 Regardless of dental type classification, on average, male dentists have higher gross earnings, total expenses and taxable income than their female counterparts. In 2016/17, for all self-employed male primary care dentists, average taxable income was £81,800 compared to £55,500 for all female self-employed primary care dentists. This could be partly explained by the data including a higher proportion of male dentists being Providing-Performers with significantly higher income than the Performer Only (21% compared to 8% female dentists).

4.48 It is important to note this data includes both full-time and part-time dental earnings and expenses, which, given (on average) male dentists tend to work more hours per week than their female counterparts, could be a contributory factor to the differences observed in taxable income by gender. The table below shows split by gender and working hours based on the responses to the Dental Working Patterns Survey. Please note as this data is prepared from a smaller data set, determined by the survey's response rate, the averages are slightly different to those reported in para 5.56 above.

Table 1.9: All self-employed primary care dentists - average earning and expenses from NHS and private dentistry, by gender and weekly working hours, England and Wales 2016/17

			Mean average			
Gender	Weekly working hours	Report population	Gross earning	Total expenses	Taxable income	Expenses to earnings ratio
Male	<35	650	£143,900	£79,500	£64,300	55.3%
	>35<45	1550	£195,500	£108,100	£87,400	55.3%
	>45	450	£303,600	£197,300	£106,300	65.0%
	All	2650	£201,900	£116,800	£85,100	57.8%
Female	<35	1250	£85,900	£36,000	£49,800	42.0%
	>35<45	1100	£120,200	£55,400	£64,800	46.1%
	>45	150	£210,900	£134,100	£76,800	63.6%
	All	2500	£109,200	£51,100	£58,100	46.8%

4.49 Data from NHS Dental Statistics 2017/18 is provided in the table below. This shows a marked increase in female dentists in recent years, in 2017/18, 59% of dentists under age 35 were female.

Table 1.10: Percentage of dentists with NHS activity by gender: 2006/07 to 2016/17

All dentists with FP17	2006/07	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Male	61.2%	54.6%	53.9%	52.9%	52.0%	51.2%	50.3%
Female	38.8%	45.4%	46.1%	47.1%	48.0%	48.8%	49.7%

Clawback

4.50 The term “clawback” can mean a number of different things but is often used to describe an adjustment to a dental contract where there has been under performance of a contract and the amount already paid for the contracted services is deducted from future payments, i.e. an overpayment in one year is ‘clawed back’ in the next year. The current dental contract is based on an expectation that practices deliver the agreed amount of contractual activity either in UDAs or other agreed criteria. Unless an agreed amendment is made in year, practices are paid the full Annual Contract Value (ACV) in 12 monthly payments. When the activity requirements are not achieved NHS England recovers the proportion of the contract value this relates to and it is used for other local NHS priorities (the money stays with the NHS). NHS England local teams have been working with practices to more closely align contract values with overall delivery – so if a practice has continued to under-deliver for a number of years the contract can be rebased and the funds can be redistributed to other practices, re-contracted or used for other priority NHS services.

NHS pension scheme

4.51 Access to the NHS Pension scheme is available to all those dentists who work for the NHS. 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 increased slightly to 18,911 in 2017/18 from 18,730 in 2016/17. The data shows almost all dentists under the age of 26 are members of the NHS Pension scheme and suggests dentists continue to find the NHS pension scheme attractive.

4.52 The BSA has provided data on the number of general dental practitioners who took ‘normal’ age retirement and those who took voluntary early retirement along with the average age at retirement. The data covers dentists with fully protected 1995 Section membership of the NHS Pension Scheme and will cover the majority of NHS dentists. To avoid the possibility of double counting those who may be members of both schemes, it does not include details of NHS dentists who were fully protected 2008 Section members or 2008/2015 transition members.

Table 1.11: General Dental Practitioners claiming their NHS Pension

Year	Age Count	Age Average Age	Voluntary Early Retirement Count	Voluntary Early Retirement Average Age
2008	225	61.05	90	55.58
2009	189	61.14	125	56.14
2010	186	61.16	118	55.61
2011	244	61.32	130	56.34
2012	245	61.42	161	56.53
2013	239	61.43	156	56.56
2014	186	61.43	148	56.80
2015	191	61.12	161	56.33
2016	183	60.98	145	56.26
2017	176	61.10	143	56.46
2018	179	61.06	115	56.47

4.53 The data shows the average age of retirement for both normal age and voluntary early retirement has remained fairly stable in the last eleven years. Since 2015, the number of dentists retiring has fallen for both types of retirement and the number taking age retirement in 2017 and 2018 are lower than in any other year in this data. Voluntary early retirement in 2018 is also at its lowest level for ten years.

4.54 Whilst the figures show the number of dentists who claimed their NHS pension, they do not indicate who has retired completely from the dental profession and who has taken 24 hour retirement and returned to work. The NHS pension rules allow dentists to claim their pension, provided they retire for 24 hours. The introduction by HMRC of the lifetime allowance cap on pensions may have made early retirement more attractive for some dentists who wish to avoid paying the lifetime allowance charges. However, the tables above do not suggest there has been a change in retirement patterns in recent years.

2018/19 settlement

4.55 For 2018/19, DDRB recommended an uplift in income, net of expenses, of 2% from 1 October 2018. The increase was accepted by Ministers, and when combined with an increase for expenses of 3% from 1 April 2018 this provided an annualised uplift of 1.68%.

4.56 The national uplift was applied to gross contract values for GDS contracts and PDS agreements.

4.57 As part of this package, dentists were expected to continue to work closely with the Department of Health and Social Care 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

4.58 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.

4.59 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.

4.60 NHS England believes 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 2019/20

4.61 We are taking forward discussions with the BDA with a view to setting a direction of travel that aligns key contract changes to our objectives for the improvement of dental outcomes.

General Dental Practitioners: conclusion

4.62 This chapter provides information on the latest position on recruitment and retention, earnings and expenses, and other relevant developments for general dental practitioners. The evidence from private sector surveys and practice valuations shows that, the workforce remains robust with a good supply of dentists who are well remunerated.