Submission to the Review Body on Doctors' and Dentists' Remuneration

February 2020

NHS England and NHS Improvement

Contents

1. Introduction

Overview

1. NHS England and NHS Improvement started working to a single operating model in April 2019 and are therefore now jointly submitting evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB). We continue to work closely with Health Education England (HEE) and the Department of Health and Social Care (DHSC) to ensure there is an aligned national approach for creating and supporting a sustainable workforce for the NHS.

2. Our patients and service users across England are served by 1.3 million dedicated staff working in the NHS and in NHS-commissioned services. They in turn work alongside millions of dedicated staff working in social care, public health services and other non-NHS providers. Demand for health and care services is rising as a result of a growing and ageing population and the ever-increasing possibilities of medical science.

3. The Interim NHS People Plan, published in June 2019, set out the vision and actions we need to begin to take to meet that demand. We will need more people working in the NHS over the next 10 years across multiple disciplines, and we need to transform the way our entire workforce works together. The NHS needs to be an agile, inclusive and modern employer to attract and retain the people we need to deliver the NHS Long Term Plan.

4. Work is already underway through activity set out in the Interim People Plan, and further action will be taken in response to the full NHS People Plan, to be published in 2020. In particular, we are taking action to make the NHS the best place to work and to improve the leadership culture in the NHS, as well as taking steps to increase the supply of new staff both domestically and from overseas – including to support the government's commitment to create an additional 6,000 doctors working in general practice. Appropriate remuneration, including our medical staff, is an important factor in achieving these ambitions.

Scope of this submission

5. The medical workforce makes up an important part of the diverse overall NHS workforce. This submission focuses on the following groups of the medical workforce:

    - consultants
    - staff, associate specialist and specialty (SAS) doctors
    - primary care – salaried general practitioners (GPs)
    - dental practitioners
    - doctors and dentists in training.

6. This submission is confined to areas directly relevant to the work of NHS England and NHS Improvement. It should be read in conjunction with submissions from the DHSC and the other arm's length bodies.

2. Supporting the medical workforce to deliver high quality patient care

7. This chapter sets out how NHS England and NHS Improvement are contributing to addressing some of the most urgent challenges facing our NHS workforce, and doctors in particular.

8. The approach being taken, as set out in the Interim People Plan, will take time as well as investment at different levels of the system. We need to find a balanced approach that supports delivery of joined-up high quality care for patients and gives our people the careers they want, as well as assuring taxpayers that we are working efficiently to ensure that the growing demand for health and social care is affordable for society as a whole.

Context

9. The NHS is operating in an environment of unprecedented and continually growing patient demand for services, and 2019 was another record year in terms of services delivered. For example:

- in 2018/19 roughly 68,000 people per day attended accident and emergency (A&E) services, an increase of 4.1% on 2017/18
- general practice delivered an estimated 307 million consultations between November 2017 and October 2018, which is 21 million more than three years prior to that
- there are around 60,000 completed pathways for consultant-led treatment per day, with 16.6 million completed referral to treatment pathways in the 12 months to September 2019, an increase of 2.7% on the previous year
- in 2018/19 there were over 6,000 cancer referrals per day, an increase of 16% on 2017/18, and double the level of 2011/12.

10. Our NHS staff are vital for delivering high quality care for patients, and the medical workforce play a hugely important role in this. We want to ensure that the medical workforce, alongside other staff groups, is supported and engaged to join and remain in the NHS for the future. We want the medical workforce to feel able to play their part in the multidisciplinary teams that are needed to provide safe and effective modern care, and to feel supported to progress in their careers and promote an inclusive leadership culture.

11. As the NHS needs to be able to deliver year-on-year increases in the volume of activity, it is important to make a balanced allocation that provides for funding:

    - to increase the number (volume) of staff, to deliver the increased activity
    - to remunerate existing staff fairly in a way that reflects their central role in delivering patient care, supports workforce morale and underpins a desire for experience and skilled existing staff to continue working within the NHS.

12. Given the NHS operates within a fixed funding envelope – and is accountable to the government for financial performance – a balance needs to be achieved between these two objectives.

NHS People Plan

13. The Interim People Plan – and, when published, the full NHS People Plan – form part of the overall implementation plan for the NHS Long Term Plan. The interim plan lays the foundations for the workforce transformation we need to bring about to deliver the new service models and ways of working set out in the Long Term Plan, with a focus on immediate actions for 2019/20.

14. The plan focuses on five main themes:

    - **Making the NHS the best place to work:** action to make the NHS an employer of excellence – valuing, supporting, developing and investing in our people. This is based on extensive engagement with staff, staff representatives and employers to develop a new offer, setting out explicitly the support staff can expect from the NHS.

- **Improving the leadership culture:** a new NHS leadership compact that will establish the cultural values and leadership behaviours we expect from NHS leaders, and the support and development leaders should expect in return.

- **Taking immediate action in 2019/20 to tackle the nursing challenge:** increase numbers of undergraduate nurses, reduce attrition from training, develop additional entry routes through the nursing associate qualification and apprenticeships, improve retention of our current workforce, support return to practice and increase international recruitment.

- **Delivering 21st century care:** action to transform ways of working, releasing more time for care and enabling health professionals to make best use of the full range of their skills. Targeted actions to secure the right current and future workforce supply, including workforce analysis to inform workforce and resourcing decisions.

- **Developing a new operating model for workforce:** cohesive and collaborative approach to leadership and workforce, with clarity about who does what at national, regional, local system and organisational levels and with more workforce and people activities carried out by integrated care systems.

15. It is important we recognise the value of supporting our staff in the workplace to be able to create a more engaged and sustainable workforce.

16. Therefore, as part of our work to ensure the NHS is the best place to work, work is underway to address staff sickness absence – which is currently around 2.3% higher across the workforce than other sectors – and high levels of turnover (with one in 11 NHS staff leaving every year).

17. The People Plan will also set out actions to address growing workload pressures felt by all staff groups and address cultures of bullying and harassment in the workplace to create an inclusive and compassionate culture.

18. Work is also underway to address the critical workforce supply challenge, including for the medical workforce, through:

- establishing new medical schools and 1,500 additional medical undergraduate student places

- increasing GP trainee intake to 3,500, concurrent with expanding the wider primary care workforce (an additional 26,000 staff working in primary care networks by 2023/24) to free GP capacity

- boosting international recruitment to secure more undergraduate and postgraduate staff from overseas

- reforming medical careers to ensure that they are more flexible and therefore improve retention and reduced rates of attrition from training.

Tackling the most significant workforce challenges for specific groups

19. In addition to the NHS People Plan, contract reform has been a priority for specific staff groups – including doctors and dentists in training and GPs – and DHSC and NHS England and NHS Improvement have set out to support contract reform with the relevant bodies in these instances.

20. At the same time, we have made specific investments to address critical issues where most urgently needed, including:

    - **Pensions**: annual allowance tax charges and concern about such charges have impacted on the availability of senior clinicians during 2019/20, with knock-on impacts on NHS operational capacity. On 22 November 2019, NHS England and NHS Improvement announced exceptional action for 2019/20 to address this issue and ensure that clinicians who exceed their NHS pension annual allowance in this financial year are not left out of pocket. The costs of this provision are being funded nationally. More broadly, we are supporting the government in considering wider flexibilities through the recent consultation on the NHS Pension Scheme.

    - **GP indemnity:** as part of the five-year contract reform agreed with the British Medical Association (BMA), a state-backed clinical negligence scheme for general practice has been introduced from April 2019.

3. Medical workforce: financial considerations

3.1 NHS five-year funding settlement

21. In June 2018, the government announced a funding settlement for the NHS of an additional £33.9 billion funding (in cash terms) a year by 2023/24.

22. In January 2019, NHS England and NHS Improvement published the Long Term Plan for the NHS. Putting the NHS back onto a sustainable financial path is a key priority and is essential to enabling the NHS to deliver the service improvements in the Long Term Plan. This includes improving productivity and efficiency (achieving at least 1.1% productivity growth per year) and returning the NHS to financial balance.

23. To ensure financial sustainability is prioritised, NHS England and NHS Improvement carried out a rigorous financial planning exercise to underpin the Long Term Plan and have set out funding allocations for the period 2019/20 to 2023/24.

24. While pay is a major component of spend, the NHS needs to allocate funding across a range of areas to optimise patient outcomes. The allocations set by NHS England and NHS Improvement ensure we are:

    - protecting funding for existing commitments
    - appropriately funding commissioning streams for price pressures
    - funding a realistic and sustainable level of activity
    - reducing running costs, while prioritising funding for transformation and service development.

Trust deficits and financial management

25. The financial position for NHS providers is challenging, and pay awards need to be consistent with provider plans to meet financial trajectories. The LTP sets

out our commitment to reduce trust deficits and achieve financial sustainability within the NHS.

26. Recent financial pressures have resulted in NHS providers recording aggregate financial deficits of £791 million in 2016/17, £960 million in 2017/18, and £571 million in 2018/19.

27. As noted further above, demand for services continues to grow and this will exert further pressures on providers during 2019/20 and beyond, so this illustrates the scale of the financial challenge ahead.

28. To ensure that financial sustainability is achieved, the NHS has set each sustainability and transformation partnership (STP) and integrated care system (ICS) a 'system control total' to control expenditure. Financial recovery plans and trajectories have been agreed with providers in deficit, who will be eligible for support funding (through the Financial Recovery Fund). Providers will be required to meet an efficiency challenge of at least 1.1% per year, with a higher efficiency requirement for providers currently in deficit.

Pay assumptions in NHS planning

29. For financial planning at national and local level, we have allocated funding and set out assumptions on pay awards for medical staff groups.

30. The planning assumptions for 2020/21 and beyond were published in the Long Term Plan Implementation Framework (June 2019). For the purposes of financial planning – and to ensure that sufficient funding is available to increase the size of the workforce to meet growing demand and activity – the NHS has made plans on the basis of 2.0% pay growth for consultants, dentists and SAS doctors in every year from 2020/21 to 2023/24 inclusive.

31. Additional funding has been made available on top of this to support the contract reforms for staff under the junior doctor contract and the Agenda for Change contract. Investment in contract reform was agreed on the basis that the reforms would generate a return on investment and provide benefits to the NHS. A commitment has also been made regarding SAS contract reform.

3.2 Salary

Remuneration

32. For NHS staff, a valuable remuneration package is available. This is calibrated to take a number of factors into account:

    - the trade-off between the need for fair pay that rewards staff and maintains morale, versus the need to grow the workforce
    - the need to ensure that nominal salaries are broadly aligned with inflation, such that real incomes are broadly stable
    - the fact that public sector pay is – on average – slightly higher than the average private sector pay
    - the fact that the NHS Pension Scheme provides valuable benefits to its members, and is supported by the government: eg the government recently funded an increase in the employer contribution rate from 14.38% to 20.68%
    - the relative stability of public sector employment
    - the wider investments that the NHS makes in staff recruitment and retention, which are discussed in more detail in the following sections.

    In addition, there is recognition of the value that comes from enhancing the support packages which exist to ensure staff feel supported to work to the top of their licences and have fulfilling and engaging careers in the NHS. These measures include:

    - flexible working opportunities to support a better work-life balance.
    - greater investment in career development for staff, both through greater flexibility and opportunities in scope of work: eg research/teaching but also through greater support for continuing professional development.

33. We have made 2.0% available for annual pay growth in 2020/21 for consultants, dentists and SAS doctors. This is in line with the Office for Budget Responsibility (OBR) forecast for consumer price index (CPI) inflation in 2020/21. This includes SAS doctors because, although there is a government

commitment to discussions on contract reform, these discussions are unlikely to have concluded in time for the 2020/21 pay award.

34. For these groups, a pay award higher than 2.0% would require reprioritisation of funding away from other key areas, such as workforce growth and transformation, and would constrain our ability to make the investments necessary to deliver the NHS Long Term Plan.

Benchmarking: inflation – historic and forecasts

35. DHSC's evidence sets out recent trends in inflation.

36. In summary, CPI inflation has been consistently lower in 2019/20 than in the previous financial year, and the OBR forecasts that CPI inflation will run below 2% during the financial year 2020/21.

37. Given the recent trend in inflation, DHSC and NHS England and NHS Improvement believe that a 2.0% uplift for pay awards in 2020/21 is sufficient to provide an appropriate real-terms pay award.

Additional benefits

38. NHS staff receive a number of benefits (in addition to base salary rises) that would not necessarily be available in the private sector. These benefits are tailored to specific staff groups and include:

- increased employer pension contributions from 2019/20 to secure continued benefits from the NHS Pension Scheme
- from 2019/20, the introduction of a scheme support to ensure that clinicians (who are members of the NHS Pension Scheme) will not be affected by annual allowance tax charges generated from work in 2019/20 in relation to their NHS pension
- wider financial support outside of basic pay: eg junior doctor contract reform included measures such as an additional senior nodal point; and GP contract reform included the introduction of a state-backed indemnity scheme.

Contract reform

39. Additional investment made as part of contract reform – such as for junior doctors and GPs – as well as the Agenda for Change contract for the non-medical workforce were not made in isolation, but rather were balanced against benefits for the NHS in terms of recruitment and retention, productivity and service delivery.

40. **Junior doctors**:

- In 2019 the BMA agreed a deal with NHS Employers and DHSC for a £90 million investment for junior doctors over the next four years (on top of 2% basic pay growth).
- The collective agreement reached in 2019 was based on reforms to the 2016 contract, which had previously been introduced by the Secretary of State in 2016.
- The 2019 agreement was important in terms of supporting staff morale and retention, while also delivering wider benefits to the NHS as contained in the 2016 contract.

41. **GPs**:

- A five-year GP (General Medical Services) contract framework was agreed, starting in 2019/20.
- The contract was put in place to stabilise general practice through increased investment and workforce expansion.
- The contract reform ensures that general practice will play a leading role in primary care networks (PCNs), which are an important part of the Long Term Plan. They will include bigger teams of health professionals working together in local communities, and closer working across health systems.
- The community teams working across PCNs will provide tailored care for patients and will allow GPs to focus more on patients with complex needs.
- Contract reform included expansion of extended hours provision across PCNs, with GP practices taking same-day bookings direct from NHS 111 when clinically appropriate.

3.3 Wider pay and investments

42. In addition to investing in pay growth, the NHS is investing to support the current and future workforce in several ways, including a high level of investment across a number of areas, as described below.

43. The People Plan – once published – will set out the full range of investments proposed for the coming years across the various staff groups, which will provide benefits in addition to basic pay.

44. **Investment in initiatives to support specific workforce groups.** For example:

- Time for Care: this is a £30 million programme to help general practice teams manage their workload, adopt and spread innovations that free clinical time for care, and develop the skills and confidence to lead local improvement.
- GP indemnity support scheme: a state-backed clinical negligence scheme for general practice (CNSGP) that began in April 2019, covering clinical negligence liabilities arising from NHS patient care. Investment for this scheme is about £33 million per year
- General Practice Resilience Programme: around £40 million over four years (until 2020) to support GP practices and to build resilience into the system.
- National GP retention scheme: a package of financial and educational support to help doctors who might otherwise leave the profession remain in clinical general practice. Over £10 million was invested in 2018/19.
- An extra £1 million a year investment in the Workforce Race Equality Standard to extend its work to 2025.
- An expanded Practitioner Health Programme, which will help all NHS doctors access specialist mental health support, providing a safe, confidential, non-stigmatising service when they are struggling and need help.

45. **Investment in non-salary remuneration:** the NHS Pension Scheme employer contribution rates have increased significantly in 2019/20, while employee contributions will remain fixed until April 2021 at the earliest.

46. **Investment in individuals who support the NHS workforce:** the Long Term Plan specified £2.3 million towards the Helpforce programme to scale successful volunteering programmes across the country and double the number of NHS volunteers over the next three years.

3.4 Workforce productivity

Productivity trends and future requirements

47. As stated in the Long Term Plan, providers will need to deliver at least 1.1% productivity growth per year over the course of the Plan – and in many cases, additional savings as part of deficit recovery.

48. NHS productivity has been relatively high in recent years relative to the wider economy, and a higher-than-expected pay rise would increase the pressure on providers to generate even further efficiencies.

Recent trends

49. According to the University of York's Centre for Health Economics, NHS productivity in England has increased significantly over the last decade:

    - The NHS delivered 16.5% more care pound for pound in 2016/17 than it did in 2004/05, compared to productivity growth of only 6.7% in the economy as a whole.

    - Some 5.2 million more patients received planned or emergency hospital treatments in 2016/17 than in 2004/05 – an increase of about 42%.

    - Separately, outpatient activity has increased significantly – by 131% since 2004/05 – with over 60 million more attendances in 2016/17 compared to 2007/08.

50. These productivity gains have occurred against a background of increased activity and patient care, as discussed in Chapter 2.

51. In 2018/19 alone:

- NHS England and clinical commissioning groups delivered £3 billion of productivity and efficiency improvements
- NHS provider productivity increased by an implied 2.3% – even higher than productivity improvements of 1.2% last year
- providers spent less on temporary agency staff, both overall and as a proportion of workforce spend (4.4% in Quarter 4, relative to 4.7% last year).

52. Action taken in recent years by NHS England and NHS Improvement to improve efficiency includes:

- support to trusts to implement e-rostering and e-job planning to facilitate better capacity/demand matching; by July 2018, 59% of the NHS clinical workforce was deployed via an e-rostering system,[1] and the NHS Long Term Plan commits to supporting all NHS trusts and foundation trusts to deploy electronic rosters or e-job plans by 2021
- introducing a cost-per-hour cap on agency staff from November 2015
- curbing prescribing of medicines that have little or no benefit, which will over time help save up to £200 million a year
- stopping the routine commissioning of 17 procedures where less invasive, safer treatments are available and just as effective, over time saving up to an estimated £200 million a year.[2]

Summary

53. Given the relatively high rates of efficiency achieved in recent years by the NHS, as well as the stretching future efficiency challenge in the NHS Long Term Plan, it is important the pay award for 2020/21 ensures the efficiency requirement on NHS organisations remains feasible.

[1] NHS England and NHS Improvement (June 2019) *E-rostering the clinical workforce: levels of attainment and meaningful use standards*.
[2] https://www.england.nhs.uk/2019/04/staff-praised-as-nhs-productivity-grows/

Temporary staffing: agency and bank

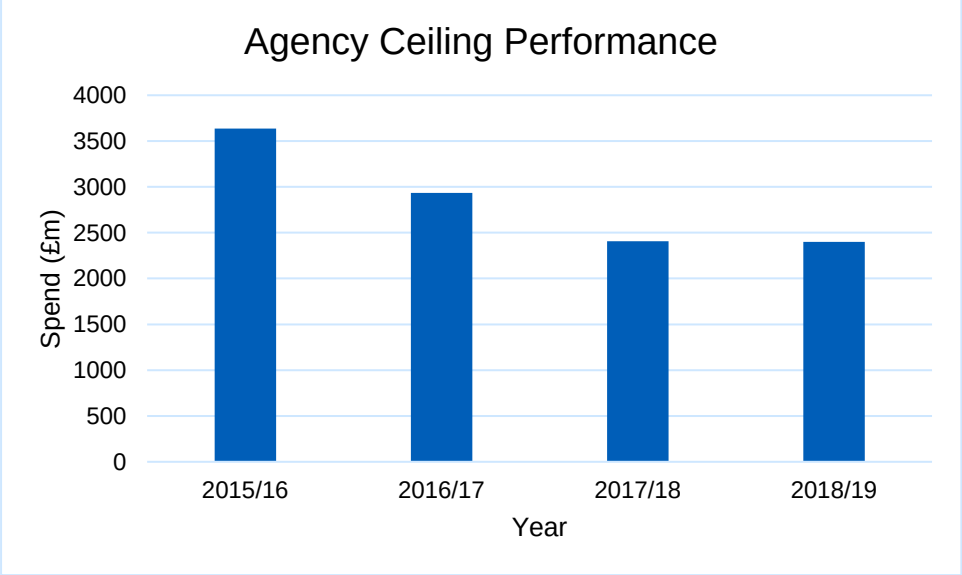
54. The NHS has made progress in controlling agency spend in recent years, with further measures planned. While some use of agency staffing helps ensure the NHS workforce remains flexible to meet demand, we are seeking to make further progress in reducing agency spending relative to current levels.

Agency staff

55. New rules were introduced in April 2016 to support trusts to reduce their agency expenditure and move towards a more sustainable level of temporary staffing. Since then, trusts have successfully reduced agency spend by over £1 billion. There has been a significant reduction in agency spend as a proportion of the total pay bill, from 8.2% at its peak in 2015 to just 4.4% at September 2019.

56. The proportional spend on agency staff, as a percentage of staff costs, also decreased year on year from 4.5% at Month 6 of 2018/19 to 4.1% at Month 6 of 2019/20. This is a considerable reduction on the 7.2% reported in April 2015 – before the 2016 initiatives to manage agency performance.

Figure 1: Agency spend (full year) April 2015 to March 2019



57. In the first six months of 2019/20, trusts have spent £1.19 billion on agency staff, which is 1% lower than the same period in 2018/19. Spend on agency medical locums in the first six months of 2019/20 was £468 million, £8.8 million

lower than at month six in 2018/19. The percentage of medical locums paid in line with the agency price cap fell by 2% year on year.

58. The forecast outturn for 2019/20 is £2.29 billion, and the target for agency spend in 2020/21 is £2.2 billion.

59. In 2019/20, NHS England and NHS Improvement introduced two measures to help trusts bring down agency spend in non-clinical areas:

    - a restriction on using off-framework agency workers to fill non-clinical and unregistered clinical shifts; off-framework shifts on average cost more and have less assurance of quality

    - a restriction on using admin and estates agency workers, with exemptions for special projects and shortage specialties.

Bank staff

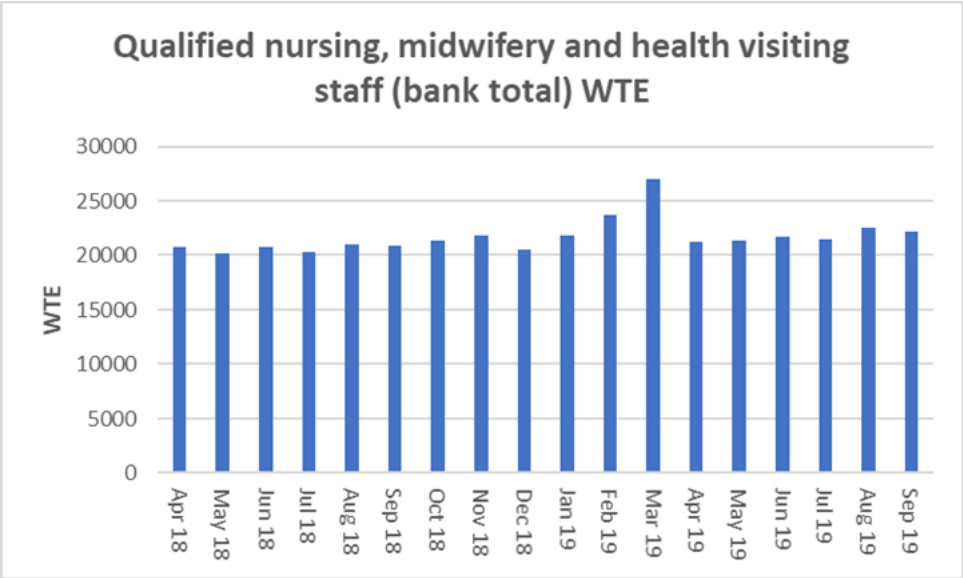
74. NHS staff banks help provide flexibility for staff and employers. Bank arrangements are more cost-effective than using agencies and provide better continuity of care for patients.

75. The percentage of temporary staffing spend through bank arrangements has risen from 58% at Month 6 in 2018/19 to 61% at Month 6 this year; the temporary staffing team is embarking on a programme of improvement activities which will increase this further.

76. Figure 2 below shows the most recent increases in bank staffing.

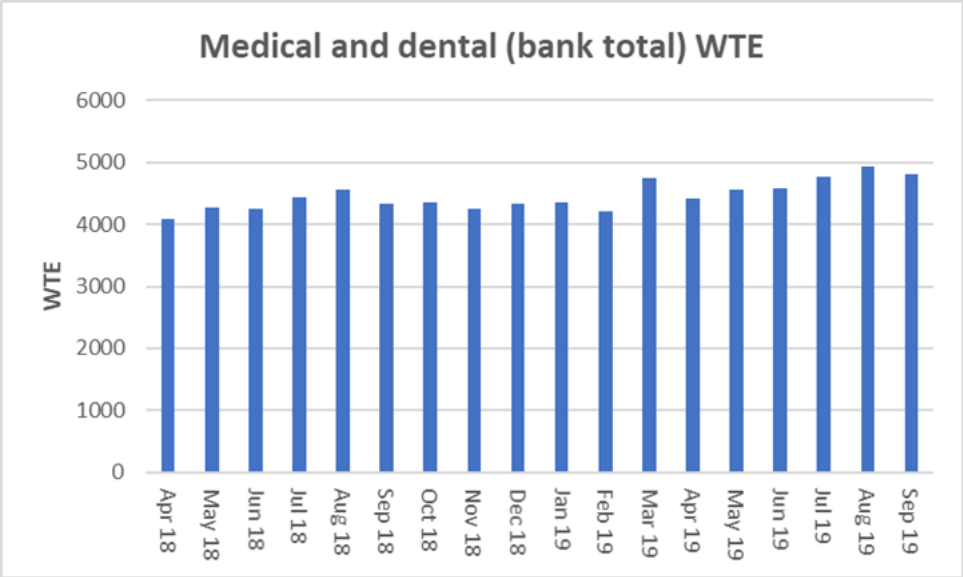
77. As part of the NHS People Plan, we will support providers and STPs to make the most of their banks and allow NHS staff to move flexibly between providers through collaborative banks.

Figure 2: Nurses and health visitors working as bank staff (FTE) in the NHS in England



Source: NHS Improvement, monthly workforce return – September 2019

Figure 3: Medical and dental staff working as bank staff (FTE) in the NHS in England



Source: NHS Improvement, Monthly Workforce return – September 2019

Note: The March peak is due to substantive staff using their annual leave before financial year end.

3.5 Gender pay gap

78. A 2019 update from the Gender Pay Gap in Medicine Review showed that the gender pay gap for doctors is 17%, based on their total pay, compared to a gender pay gap of 23% in the overall NHS.

79. The initial findings from the review found:

- the general practice gender pay gap is 33% – far higher than the average in medicine
- women are not yet represented in equal proportions in senior medical grades – there are nearly 32,000 male consultants to 18,000 female
- two-thirds of doctors in training grades are women, but within consultant grades this drops to under half
- women are over-represented in lower-paid specialties, such as public health and occupational health, but under-represented in the highest-paying specialties, such as urology and surgery
- there is variation across medical specialties, with male-dominated specialties such as urology showing a higher gender pay gap.

80. The review's recommendations will inform NHS England and NHS Improvement's programme on equality, diversity and inclusion.

81. More detailed figures on the gender pay gap for specific medical workforce groups are included in the sections below.

4. Evidence on consultants

4.1 Introduction

82. This chapter provides information on consultants providing medical services in England.

83. It provides information on recruitment and retention of consultants, salary and other relevant developments in the consultant workforce.

84. This chapter also covers specific measures being taken to address challenges for this group, such as pensions and distribution of the consultant workforce.

85. Consultants are a vital component of the medical workforce. While there are some justified concerns regarding retention of consultants, particularly of senior consultants, broadly speaking this is a relatively stable component of our medical workforce, which continues to show good growth in numbers.

86. In addition to supporting retention of consultants through pension reform, it will be important to ensure there is greater flexibility offered to consultants both in terms of working hours as well as working options: eg greater focus on activities of choice such as research, teaching or clinical activity.

87. Alongside these reforms and balancing considerations regarding affordability, it will be important to consider how we better support staff morale through our Best Place to Work offer as part of the People Plan. The considerations for this are detailed below.

4.2 Background

88. Consultants are the senior decision-makers in hospital services and oversee treatment of the most complex patients. They provide a unique and highly valuable contribution to patient care, and this is reflected in the standard that must be achieved to gain specialist registration and in the demonstration of continuing learning and competence needed to maintain a licence to practise.

89. Consultants provide clinical leadership to the services that deliver against quality and performance standards for the NHS: access for emergency

admissions, cancer patients and elective care as well as the provision of seven-day services in hospitals. Consultants' particular expertise includes being able to assess undifferentiated patients who have multiple morbidities and guide them onto an appropriate pathway of care.

90. Consultants take overall responsibility for patients under their care, and this is reflected in the way hospital patient care is always ascribed to individual consultants.

91. Therefore, given the length of training and the resources that go into supporting the development of consultants, it is imperative that consultants are supported to perform the work that only they can deliver, and to continue to do this throughout their career.

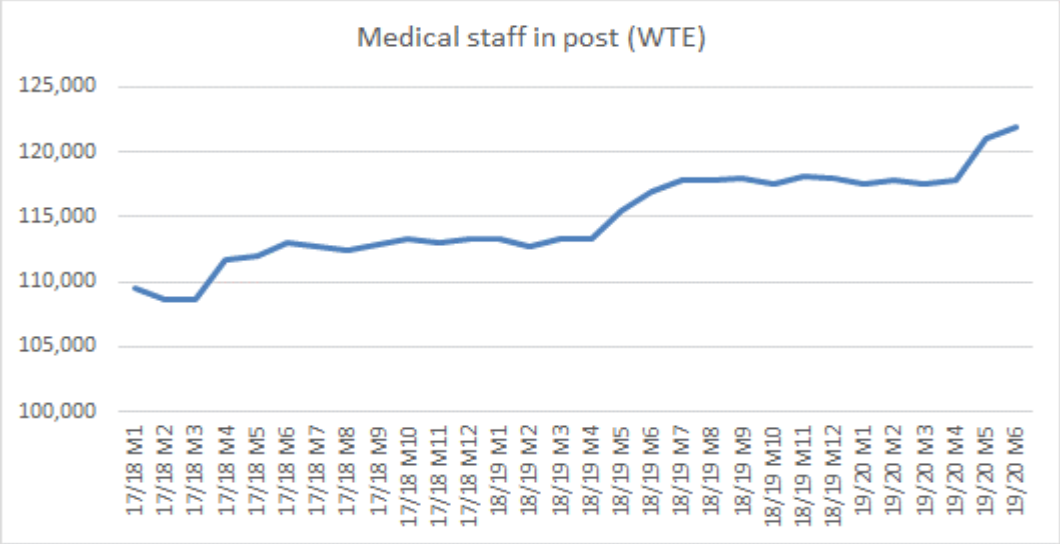
4.3 Statistical publications and data comparisons

92. There are around 150,000 doctors working in the UK, around 12% of the NHS workforce. Of these, approximately 50,000 of the doctors are consultants working in hospital or community services.[3]

93. Data for the last few years shows that the medical workforce in secondary care continues to grow at a healthy rate, with vacancies showing a slight decline. Medical staffing numbers in post – based on full-time equivalent (FTE) – have continued to increase in recent years. This includes consultants, doctors in training (junior doctors), SAS doctors and trust doctors. Using data from to the beginning of 2017/18 (see Figure 4),[4] medical staff FTEs have increased by 3.8% per year on average.

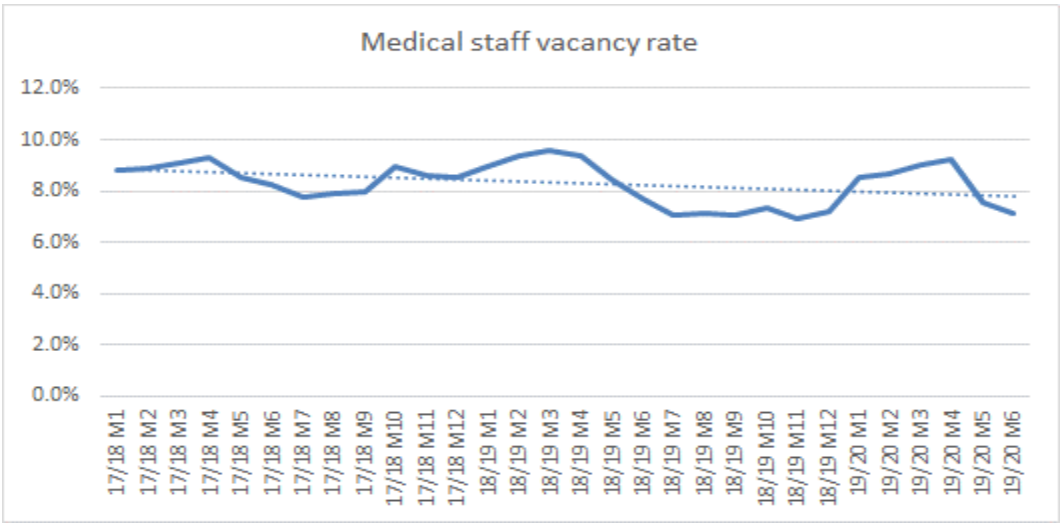
[3] Data source: NHS Digital.
[4] Data source: NHS Digital.

Figure 4: Medical staff in post (FTE)



94. Over the same period, the vacancy rate for medical staff in secondary care has shown a slight downwards trend, albeit with seasonal fluctuations. In Figure 5, the solid line shows the actual vacancy rate, while the dotted line shows the trend over the period.

Figure 5: Medical staff vacancy rate[5]

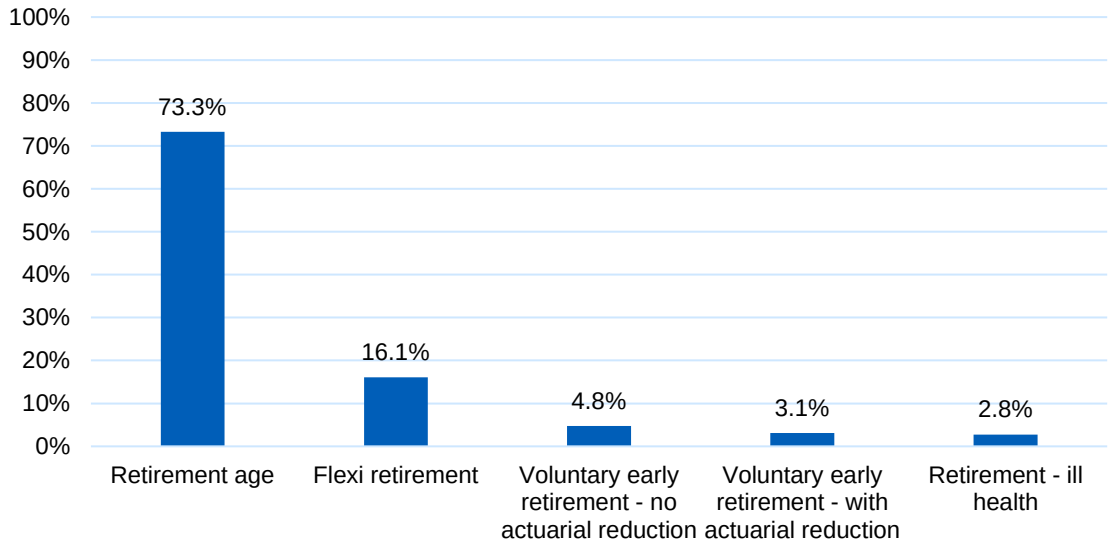


95. In 2019/20 so far, over 2% of consultants (approximately 1,117 FTE) retired, which is in line with retirement figures from 2018/19 for this group. Among those who retired, most did so because they reached retirement age,[6] with around 16% of doctors retiring and returning with flexible arrangements (ie

[5] Data source: NHS provider returns.
[6] Normal pension age is considered as 60 years old in the 1995 section of the NHS Pension Scheme, or 65 in the 2008 section. Staff enrolled in the scheme can opt for voluntary early retirement from age 55.

working fewer days, stepping down into a less demanding role, working flexible days as part of a staff bank). Nearly 8% of consultants chose to retire early (see Figure 6).

Figure 6: Consultant retirement: reasons for leaving (2019/20)



Source: ESR, January 2020

96. Given that the medical workforce in secondary care continues to grow at a healthy rate, with vacancies showing a slight decline, there are not the same overall concerns with this workforce as there are with other staff groups (such as nurses). However, there are still concerns and challenges in specific areas – such as the pensions tax annual allowance issue for senior consultants – and our actions in this area are discussed elsewhere.

97. The total number of consultants has risen by 67% since 2004 (NHS Digital workforce statistics) and there has been a significant increase in the number of specialists registered with a licence to practise over the last five years.[7]

98. In addition, the consultant workforce grew from 40,637 FTE in March 2014 to 48,018 FTE in March 2019, an increase of 18.2% and an average annual increase of 3.4%.

99. In terms of specialties over the same period, medicine has increased by 25%, surgery 13%, paediatrics 24%, radiology 16% and obstetrics and gynaecology

[7] General Medical Council (2019) *The state of medical education and practice in the UK*. https://www.gmc-uk.org/-/media/documents/somep-2019---full-report_pdf-81131156.pdf?la=en&hash=B80CB05CE8596E6D2386E89CBC3FDB60BFAAE3CF.

13%. Numbers of training-grade posts have also increased in some specialties (medicine, paediatrics, radiology) but fallen in others (such as pathology).

4.4 Recruitment, retention and motivation

100. There is continued healthy growth in numbers of consultants outlining the unique appeal of the consultant grade and the value with which this group is seen by doctors in training, who continue to rely on senior doctors for training and supervision support on their path to becoming consultants.

101. Within the context of this overall positive trend, there are some specific issues, such as in certain geographical areas, in shortage specialties, and more generally as a result of specific issues in relation to pensions which can be addressed to ensure continued growth in numbers in the future.

102. This section sets out these specific challenges and the following section sets out the actions that we are undertaking to address these issues.

Geographical shortages

103. In certain areas there are difficulties in recruiting sufficient consultants to meet the rising demands of the NHS at a local population level. Consultants are not evenly distributed in relation to the population, and unfilled vacancies are most prominent in the parts of the country that already have fewer consultants.

104. The ratio of consultants to population varies from around 1:2,500 in South London to 1:5,000 in places such as East of England and Kent, Surrey and Sussex, where rates of unsuccessful consultant appointments are also higher. The Royal College of Physicians' 2019 census[8] shows that, overall, half of all advertised medical consultant posts were unfilled either due to no applicants or a lack of suitable applicants.

Specialty shortages and rising demand in specific clinical areas

105. The 2019 Royal College of Radiologists' census report shows that demand has risen significantly, particularly in certain specialties: for example, requests for computerised tomography (CT) scans have risen by 54% in the last five years, and requests for magnetic resonance (MR) scans have gone up by 48%. We

[8] RCP (2019) *Focus on physicians*. Available https://www.rcplondon.ac.uk/projects/outputs/focus-physicians-2018-19-census-uk-consultants-and-higher-specialty-trainees.

are aware of difficulties in filling vacant consultant radiology posts (six out of 10 of these posts have been vacant for more than a year).

106. Another example of shortages in certain specialties is elderly care medicine. Our own analysis of medical workforce supply variation in 2018 has shown that geriatrics is a nationally undersubscribed specialty, with many trusts facing significant challenges attracting and recruiting doctors. Models of care leading to the development of the new hospital 'front door' geriatrician skills profile, as well as competition between neighbouring trusts in terms of recruitment further compound these challenges. Through work with Health Education England (HEE) we are exploring possible solutions to address them.

107. There is evidence from the General Medical Council (GMC) that some consultants are leaving their posts earlier than expected and that the rate of doctors retiring early has increased since 2000[9]. For example, half of clinical radiologists now retire before age 61[10].

Staffing levels and rota gaps

108. Analysis from the Royal College of Physicians[11] suggests that 40% of consultants work in teams where there are rota gaps at least weekly, and that some consultants have been asked to act down to fill gaps in the trainee rota.

109. There are wider issues for consultants in relation to pensions tax issues and a high work burden[12]. Some staff have sought to reduce their hours as a result.

4.5 Actions to address the challenges

110. Work is already underway across many of these areas, as outlined in more detail in this section.

[9] GMC (2019). *The state of medical education and practice in the UK*. Available https://www.gmc-uk.org/-/media/documents/the-state-of-medical-education-and-practice-in-the-uk---workforce-report_pdf-80449007.pdf
[10] Royal College of Radiologists (2018). Clinical radiology: UK workforce census 2018 report. Available https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-uk-workforce-census-report-2018.pdf
[11] RCP (2019). *Focus on physicians*. Available https://www.rcplondon.ac.uk/projects/outputs/focus-physicians-2018-19-census-uk-consultants-and-higher-specialty-trainees
[12] RCP (2019). *Focus on physicians*. Available https://www.rcplondon.ac.uk/projects/outputs/focus-physicians-2018-19-census-uk-consultants-and-higher-specialty-trainees

Addressing geographical shortages

111. HEE has established a Distribution of Specialty Training Programme Board to address geographical distribution of doctors in training. The group aims to "oversee the review, agreement and delivery of the equitable distribution of post-foundation medical training posts in England". As part of the board's work – and, in particular, its rural and remote working group – NHS England and NHS Improvement will be working with HEE to identify issues and explore solutions to improve distribution, recruitment and retention, both of doctors in training and the trained medical workforce (including consultants). The group will consider a wide variety of initiatives, including using training incentives to drive recruitment in understaffed areas.

Increasing medical workforce numbers to meet demand

112. The recent expansion of 1,500 medical undergraduate places is part of a series of measures to increase future medical workforce numbers. While this is a long-term measure, it is anticipated that many of these medical students will progress to senior medical positions such as consultants. In addition, new medical schools have been established in areas that have been traditionally difficult to recruit to, building on evidence that senior staff such as consultants very often remain in locations where they have undergone their training.

Pensions taxation flexibilities

113. The impact of pensions taxation annual allowance tax charges on senior clinicians has been identified as a key issue for retention and workforce supply among this group.

114. In December 2019, NHS England and NHS Improvement announced an exceptional action to ensure that clinicians who are members of the NHS Pension Scheme do not have to worry about annual allowance tax charges generated from work in 2019/20 in relation to their NHS pension. More broadly, we have been supporting the government in considering wider flexibilities through potential reform of the NHS Pension Scheme, as well as potential reform to the wider national tax framework.

Consultant skill-mix

115. As the needs of the population change, the mix of consultants to support these needs will need to change.[13] There is a need for more expert generalists to deal with rising numbers of patients with multiple long-term conditions.

116. We will build on our existing commitment in the Long Term Plan to accelerate the shift from a dominance of highly specialised roles to a better balance with more generalist ones, which will better meet the needs of an ageing population.

117. At the same time, in some specialties such as radiology, demand for consultants continues to rise. This increased demand will be met by investing in new equipment and staff which is underpinned by a new model of diagnostic provision. This will be delivered in part by pathology and imaging networks to improve the accuracy and turnaround times on tests and scans to make better use of the workforce and reduce unit costs.

Improve the working conditions of all staff

118. The GMC's 2019 report, *Caring for doctors caring for patients*,[14] states that it is essential to improve the wellbeing of doctors faced with high workloads whose own health impacts on patient care. The report makes recommendations for compassionate leadership, giving doctors more say on the culture of their workplace, adopting minimum standards for food and rest facilities, and standardising rota designs that take account of workload and available staff. Implementing these recommendations should improve staff wellbeing, reducing sickness absence and increasing retention of doctors.

119. Developing and implementing the NHS People Plan will improve the working conditions for all staff, including consultants, by making the NHS the best place to work. This builds on the compelling evidence that the more engaged our staff are, the more effective and productive they are and the higher quality of care they deliver to patients. Alongside the NHS People Plan we will publish a new NHS people offer setting out how the NHS will support, develop and empower

[13] GMC (2019) *The state of medical education and practice in the UK* https://www.gmc-uk.org/-/media/documents/the-state-of-medical-education-and-practice-in-the-uk---workforce-report_pdf-80449007.pdf
[14] West M, Coia D (2019) *Caring for doctors caring for patients* https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf.

everyone who works in it. The offer will contain guiding principles that all NHS organisations will be expected to implement, structured around these themes:

- a positive, inclusive and compassionate working culture
- a voice, influence and value
- an effective, healthy and safe working environment
- an ability to learn, develop and achieve
- a flexible and predictable working pattern
- recognition of and reward for your contribution.

120. Part of the actions in the NHS People Plan to make the NHS the best place to work will focus on ensuring the wellbeing of doctors. This will manifest as increased investment, aiming to produce more manageable workloads. There will be a greater focus on mental as well as physical health. This also builds on work already initiated such as 24/7 access to NHS Practitioner Health – a confidential advice and support line for doctors and dentists working in the NHS.

Shift to new models of care

121. Through our work to develop and implement the NHS People Plan we are defining how modern multiprofessional teams can support patient care outside the acute hospital in line with the Long Term Plan. These multidisciplinary teams will redefine how organisations can work together to better support their workforce by ensuring staff are deployed to work to their strengths and make use of clinical and technological advances and can better adapt to changing population health needs. As part of these new care models, consultants will be better supported to work at the top of their licence and have more time to make the biggest impact on patient outcomes. This will, in part, be achieved by releasing time for consultants to focus on those activities that require their specialist skills by reallocating tasks to appropriately skilled team members.

122. This will also include changing the focus from organisational employment to a working environment where employees can work across organisational boundaries for health systems to ensure best possible patient care. This will

ensure more joined-up care for patients and can address the frustrations often encountered by doctors not being able to follow the complete patient journey.

123. In addition, we recognise that some consultants may wish to take opportunities linked to portfolio careers: eg research in higher education or other organisations closely aligned to NHS priorities.

Flexible careers

124. Consideration of team job planning (only reported by 31% of consultant physicians in England), annualised contracts (30% of consultant physicians), effective use of e-job plans and e-rostering, and opportunities for career breaks can all help to provide flexible career options and support retention.

125. The importance of consultant job planning to explore opportunities for career progression in areas other than clinical care cannot be underestimated. The forthcoming NHS People Plan sets out our intention to create more structured career progression for consultants to ensure they can continue to develop and learn, work flexibly and enjoy a diverse career – for example, through research, teaching and/or taking up leadership positions. The NHS People Plan will contain other commitments to improve retention of senior consultant staff, including offering consultants further flexibility regarding the scope of their clinical work – whether that focuses on flexible working hours, reducing participation in on-calls/night shifts or opportunities to refocus on specific aspects of the job – as well as improving ‘retire and return’ schemes.

Improved retention of senior consultants

126. Measures such as reasonable adjustments for age (eg moving from nights on call to day-time on-call periods) and flexible job plans to enable individuals to fulfil caring responsibilities may help to retain senior consultants. Some consultants retire because of the pressure they feel from a specific part of their work. Enabling an older consultant to negotiate a change to a more focused job plan – for example, being able to concentrate on specialised outpatient care or on teaching and training – may help retain them in the workforce. Work is already underway to review the consultant appraisal process to reduce the administrative burden on consultants, especially those working less than full time, while retaining the value of experienced staff.

Professionalising medical leadership

127. Medical directors are doctors, but many have not been trained or accredited in this role. Educating medical directors in what they can do to support a positive culture among their consultants and wider medical workforce is a valuable approach and is supported by the opportunity offered by the Faculty of Medical Leadership and Management for medical leaders to study for a fellowship. This can enable doctors to develop the skills and competencies to take on senior leadership positions, such as medical director and chief executive roles.

128. NHS England and NHS Improvement are also investing in medical leadership programmes like the 'Aspiring medical leadership' programme and the tailored development programme to equip medical directors of trusts in special measures or receiving intensive support to lead continuous improvement.

129. The NHS People Plan will include a leadership compact that outlines the values and behaviours that leaders in the NHS should demonstrate.

4.6 Remuneration and affordability

130. As discussed in Chapter 3, there is a need to balance financial constraints with ensuring proper remuneration of consultants.

131. In light of inflation forecasts for the financial year 2020/21, we view a basic pay uplift of 2.0% (which would increase real wages) to be an appropriate increase in headline pay.

132. Pay growth of 2.0% has been allocated as part of NHS financial planning and is affordable alongside other demands on funding. A higher pay award would reduce trusts' ability to increase the volume of staff hired, and at a national level would require reprioritisation of funding away from other investments necessary to deliver the NHS Long Term Plan – both related to the workforce and more generally.

133. It is also important to consider the pay recommendations in the context of the other considerations outlined above, both financial and measures that support a better working environment. Part of this consideration is the benefits received by staff enrolled in the NHS pension scheme and the exceptional actions taken in 2019/20 in relation to the pension tax annual allowance. This will ensure

senior consultants are supported in continuing to work within the NHS and address one of the main causes of early consultant retirement.

4.7 Conclusion

134. This chapter outlines the latest updates on recruitment and retention, earnings and expenses and other relevant developments for consultants. While consultant numbers have grown steadily in recent years, key work for this group continues to be pension reform to ensure continued steady growth in consultant numbers. Work as part of the People Plan and continued commitments from the Long Term Plan will ensure that key challenges for this group – such as distribution of consultants, both in terms of geography and specialty – are addressed, as well as offering increased flexibility of working, particularly for senior consultants to ensure we retain this vital component of our workforce.

5. Evidence on SAS doctors

5.1 Introduction

135. This chapter provides information on staff grade, associate specialist and specialty (SAS) doctors providing medical services in England.

136. It includes information on recruitment and retention of SAS doctors, salary and other relevant developments in the SAS workforce.

137. Key work for this group this year will include NHS England and NHS Improvement working with NHS Employers and DHSC in engaging with the BMA as part of negotiations for reforming the SAS contract in England and Wales.

138. This chapter also covers specific measures being taken to address challenges for this group such as retention and relatively high predicted retirement rates over the next few years.

139. Finally, we will detail our intention to improve conditions for SAS doctors, to make this grade an alternative career of choice for doctors while recognising the huge value this group provides to the medical workforce. This will include better opportunities for doctors in this group who wish to explore options outside clinical practice and greater working flexibility.

5.2 Background

140. SAS doctors make a significant contribution to delivering patient care across the NHS and are an essential group in the current workforce model. Their roles are predominantly focused on service delivery, and in many trusts they are vital to delivering services and fill important rota gaps. Anecdotal evidence suggests this is particularly true in smaller trusts and hard-to-recruit-to areas. In some trusts SAS doctors make up around 25% of the total medical workforce (NHS Digital data, March 2018).

141. In addition to providing vital patient care, there is huge potential in this group to explore opportunities alongside clinical activities, such as teaching and research. However, as a group they have historically been undervalued and

under-recognised – both in terms of professional status and access to career development and progression opportunities. Our work as part of the People Plan will explore these opportunities for SAS doctors as part of enhanced portfolio careers and greater working flexibility.

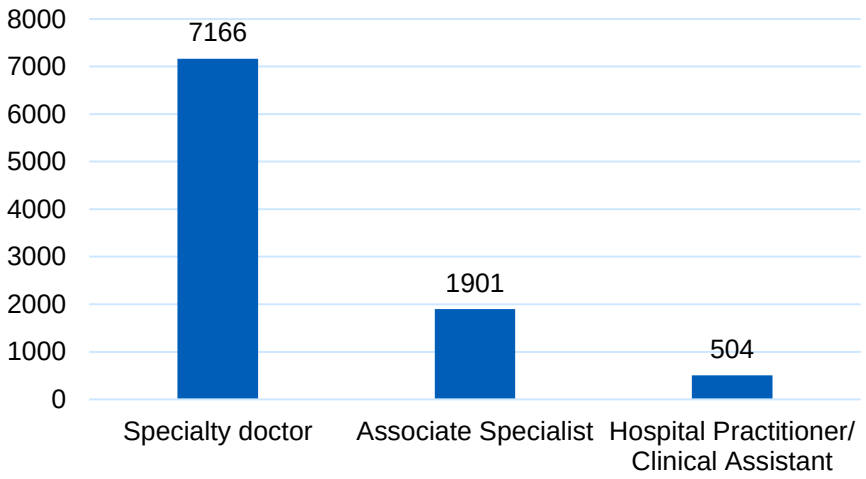
142. Retention of SAS doctors remains challenging. SAS doctors have had consistently higher leaver rates than doctors in training or consultants (NHS Digital data, March 2018). In a 2017 NHS Employers survey, 41% of employers said they experienced difficulties recruiting to SAS posts and 16% said they had challenges retaining them, with career progression and pay cited as the top reasons for SAS doctors leaving.

143. Lack of flexibility in medical training and careers means that some doctors are choosing to leave the NHS at different points in their training and career, resulting in high levels of attrition. Investing in reforming SAS-doctor grades to make them more attractive roles and to create a genuine alternative career that doctors can more easily step into and out of would help stem attrition and improve retention of doctors.

5.3 Workforce figures

144. Estimates of the number of SAS doctors in the NHS workforce vary, although NHS Digital data from 2019 suggests there are around 9,572 SAS doctors (FTE). This represents over 8% of the total medical workforce (see Figure 7 below).

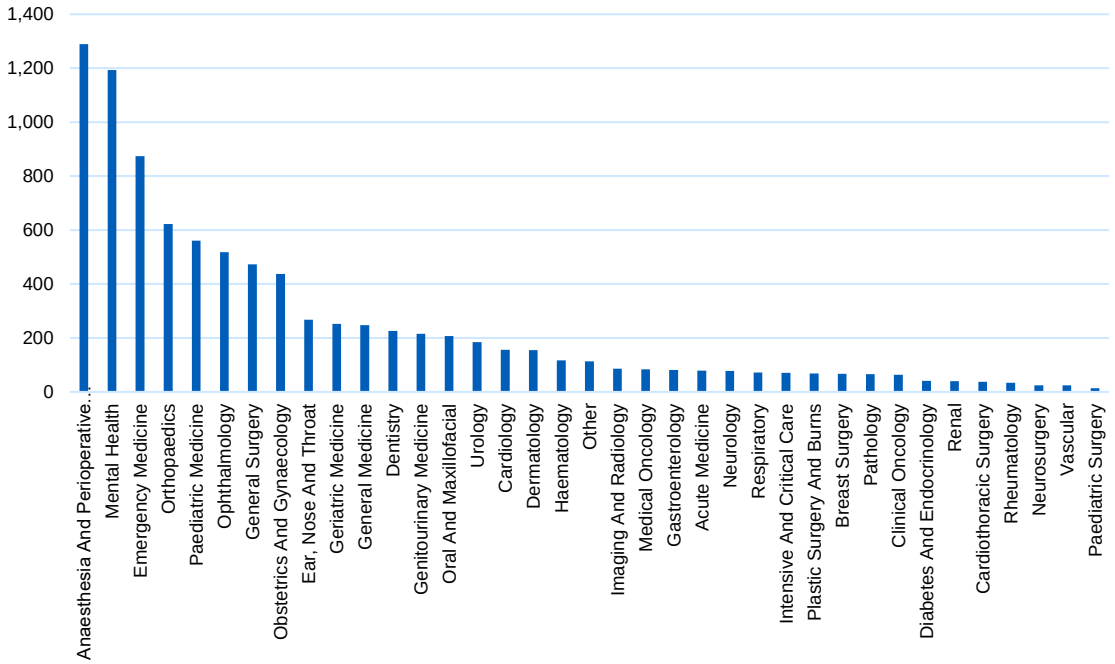
Figure 7: Number of SAS doctors (FTE)



Source: NHS Digital, August 2019

145. Some specialties are particularly reliant on SAS doctors. While they make up a relatively small proportion of all the medical workforce across different specialties, anaesthetics, mental health and emergency medicine have a higher concentration of SAS doctors (see Figure 8).

Figure 8: Distribution of SAS doctors by specialty



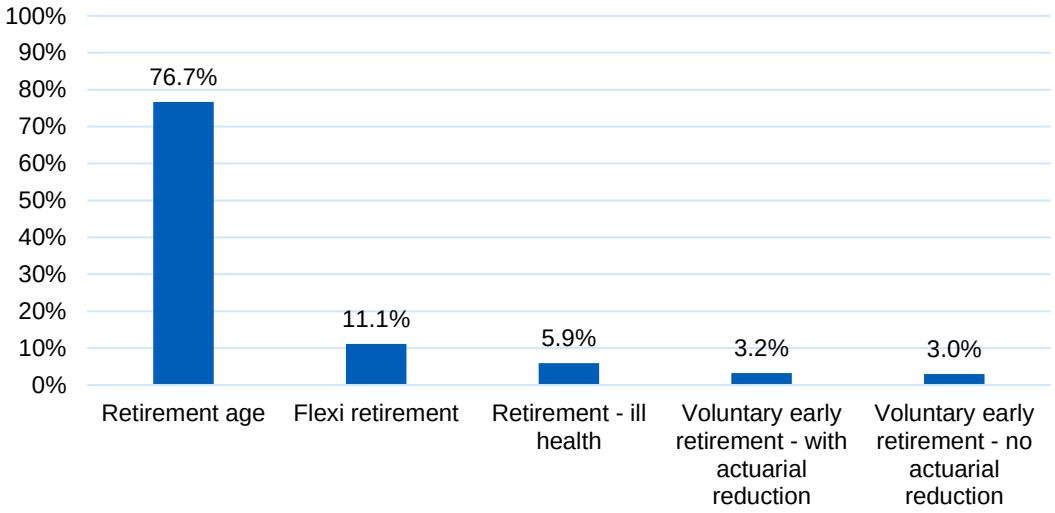
Source: Electronic staff record (ESR), January 2020

146. Between 2018/19 and 2019/20 the SAS doctor workforce grew 2.7% (ESR). However, NHS Digital data (July 2018) shows that nearly 20% of SAS doctors are aged 51 to 60 years and around 7% are 61 years old or more and might, therefore, choose to retire over the next few years. We have heard concerns from trusts that this could potentially create vacancy gaps if there isn't a future pipeline of SAS doctors to replace them.

147. In 2019/20 so far, around 1.9% of SAS doctors (approximately 178 FTE) retired, which is in line with retirement figures from 2018/19 for this group. Among those who retired, most did so because they reached retirement age.[15] Around 11% of SAS doctors retired and returned with flexible arrangements (i.e. working fewer days, stepping down into a less demanding role) and just over 6% chose to retire early (see Figure 9).

[15] Normal pension age is considered as 60 years old in the 1995 section of the NHS Pension Scheme, or 65 in the 2008 section. Staff enrolled in the scheme can opt for voluntary early retirement from age 55.

Figure 9: SAS doctor retirement – reasons for leaving (2019/20)



Source: ESR, January 2020

5.4 Actions to address challenges for this group

148. In July 2019 the government's response to DDRB recommendations committed to negotiations on a multi-year pay agreement, incorporating contract reform for the entire SAS grade, to begin in 2020/21, as an investment in raising the profile and attractiveness of SAS doctor roles. This follows from a commitment in 2018 by the Secretary of State to work with the BMA to reform the SAS contract and an agreement in principle that this will include reopening the associate specialist (AS) grade to improve career development opportunities for this group of doctors.

149. In the Interim People Plan we set out a commitment to "making [SAS] roles a more attractive career choice for doctors who may not wish to become consultants or GPs and a more fulfilling option for those who wish to pause their training". This was linked to a commitment to introduce a reformed 'associate specialist' grade to provide opportunities for progression within SAS grades. The plan also committed to exploring options for recognising expertise gained by doctors while not in a formal training role.

150. During 2020 NHS England and NHS Improvement will continue to work with national partners to address issues with morale, recruitment and retention among SAS doctors. This will include work with HEE and NHS Employers to continue to implement the commitments set out in the *Maximising the potential: essential measures to support SAS doctors* guidance document to improve the

experience, recognition and career development and progression opportunities for SAS doctors and dentists.

151. At the same time, the NHS People Plan will set out actions to improve flexibility in medical training and careers. This will include facilitating step-on/step-off measures to enable doctors in training to pause training while still delivering clinical care, which will create more flexible options for SAS doctors and help make these roles a genuine alternative career.

152. The People Plan sets out additional actions to improve staff engagement, experience and morale across the whole of the NHS workforce, including action on health and wellbeing and flexible working.

5.5 Remuneration and affordability

153. As discussed in Chapter 3, there is a need to balance financial constraints with ensuring proper remuneration of SAS doctors.

154. In light of inflation forecasts for the financial year 2020/21, we view a basic pay uplift of 2.0% (which would increase real wages) to be an appropriate increase in headline pay, in the absence of reaching agreement on contract reform.

155. Pay growth of 2.0% has been allocated as part of NHS financial planning and is affordable alongside other demands on funding. As noted further above, a higher pay award would reduce trusts' ability to increase the volume of staff hired, and at a national level would require reprioritisation of funding away from other investments necessary to deliver the NHS Long Term Plan.

156. However, the NHS is willing to make additional investment available to accompany contract reform in future years, following similar investments in the junior doctor and GP contracts. In addition, the government announced the potential for an additional 1% pay envelope, subject to the outcomes of the forthcoming contract reform.

5.6 Conclusion

157. This chapter outlines the latest updates on recruitment and retention, earnings and expenses and other relevant developments for SAS doctors. The central focus for this staff group is the government commitment to reform the SAS contract. This will include a focus on improving the perception of the SAS

grade, to ensure this vital group are supported and appropriately remunerated to ensure a sustainable pipeline of SAS doctors. Work as part of the People Plan will also be key to improve morale and flexibility in this group.

6. Salaried GPs

6.1 Scope

158. A five-year GP (General Medical Services) contract framework was agreed, starting in 2019/20. As such, no recommendation is being sought from DDRB for independent contractor general practitioners' (GPs) net income for the duration of the five-year deal, including, therefore, 2020/21.

159. However, the government has asked DDRB to include recommendations on the pay of salaried GPs, in its remit for 2020/21 onwards. This is discussed further in Section 6.8.

6.2 Introduction

160. While hospital consultant numbers are up 19.8% over the past five years, permanent GP numbers – ie excluding registrars and locums – have fallen slightly (0.8%) since September 2015, suggesting a bigger workforce challenge for GPs, particularly in retention. However, overall numbers have increased (see Table 1 below).

161. Most doctors working under GMS contracts are independent contractors, who are self-employed individuals or partnerships running their own practices as small businesses.

162. According to NHS Digital's latest figures, as at 30 September 2019[16] there were, in addition, 1,796 Personal Medical Services (PMS) arrangements (26.2% of all contracts) and 7,500 (28.1%) full-time equivalent (FTE) GPs operating within these locally agreed contracts. Any uplifts in investment for PMS contracts are a matter for NHS England and NHS Improvement to consider. NHS England and NHS Improvement are committed to ensuring an equitable funding approach for primary medical care contracts, and NHS England and NHS Improvement local offices have undertaken reviews of all PMS contracts.

[16] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-30-september-2019

163. In addition, a small number of GPs (311 FTEs) work under, or hold, contracts under a locally contracted Alternative Provider Medical Services (APMS) arrangement across some 143 practices.

6.3 Statistical publications and data comparisons

164. NHS Digital publishes official data on primary care workforce, which NHS England and NHS Improvement compare with data from other sources – such as the National Performers List – to explore its limitations. The data is published quarterly, with a time series showing the changes from September 2015. A change in the data source for GP registrars since June 2018 has enabled NHS Digital to produce more timely and accurate information for the latest (September 2019) publication. That has removed the need to release provisional and then final figures.

165. In addition, NHS Digital has continued to work to improve the capture of GP locum data and the 'all practitioners' figures are therefore not directly comparable with previous information. Further detail is provided in the 'Data quality' section of its publication.

166. Detailed changes to the general practitioner workforce between September 2015 and September 2019 are shown in Table 1. We have chosen to use the September 2015 figures because they are the baseline data for the General Practice Forward View (GPFV) measures.

Table 1: Number of GPs compared to September 2015 baseline

Number of GPs	September 2015	September 2019	Increase/ (decrease)	Percentage change
Headcount – all	41,230	45,625	4,395	10.7%
Headcount – salaried	10,283	13,076	2,793	27.2%
FTE – all	34,429	34,862	433	1.3%
FTE – salaried	6,867	8,469	1,602	23.3%

167. While we have included the data reported by NHS Digital[17] in Table 1, we are aware of data quality issues that may affect the comparison. The issues have arisen due to the low levels of reporting. The table shows that, at September 2019, in headcount terms, there were 45,625 doctors working in general practice, taking GPs, GP registrars and GP locums together – an increase of 4,395 (10.7%) since September 2015. In FTE terms, there were an estimated 34,862 GPs – an increase of 433 (1.3%) since September 2015.

168. NHS Digital also collects information on practice vacancies. Based on the 1,398 practices that submitted vacancy data, it reported that there were 246 FTE GP vacancies from October 2018 – March 2019. That compares with 263 FTE GP vacancies from October 2017 – March 2018 (a 7% reduction).

6.4 Recruitment, retention and motivation

169. NHS England and NHS Improvement acknowledged the workload, pressures and recruitment and retention challenges in the GPFV[18], the NHS Long Term Plan[19] and recent GP contract arrangements. We have, with the profession, been developing measures to help improve recruitment and retention. These measures have been further enhanced in recent changes announced in the GP Contract Deal published on 6th February. These constitute a package of recruitment and retention initiatives to deliver on the Government's commitment to 6,000 additional doctors working in primary care and the contract commits significant new investment provided by the Government (£94 million in 2020/21).

170. We support GP retention nationally through the National GP Retention Scheme. It was successfully relaunched in April 2017 to provide financial and educational support to help GPs remain in clinical practice where they cannot undertake a regular part-time role and might otherwise leave the profession. As of September 2019, 489 GPs were being supported on this scheme. The new GP contract announces that the scheme may undergo further reform, for example to increase the number of sessions participants can provide.

[17] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-30-september-2019
[18] See pages 4 to 7: https://www.england.nhs.uk/ourwork/gpfv/
[19] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

171. Last year, we invested £3 million to establish seven GP retention intensive support sites in areas with specific retention issues to test ways of maximising impact. An independent evaluation showed that:

- where workload issues are tackled and
- GPs have opportunities to work with greater flexibility or with greater variety and
- with additional support to help them in their role through mentoring or peer support, then
- increasing job satisfaction and remaining in general practice as a result is significantly more likely.

172. In addition, we invested a total of nearly £15 million in the Local GP Retention Fund, which supported individual GPs through a variety of locally designed retention support initiatives. Around 220 local schemes were reported at May 2019.

173. Alongside activity on GP retention, the recent GP contract agreement announced new two-year fellowships for newly qualified GPs (and nurses) The scheme will include funded mentorship, CPD and rotational placements across one or more PCNs to develop their experience and transition into the workforce in a local area.

174. As announced in the new GP contract, GPs new to partnership will be eligible for a 'new to partnership' payment of £20,000 for a full-time GP, promoting the move to take on partnership.

Training new GPs

175. The GPFV committed to the number of trainee places increasing to 3,250 a year from 2016. The fill rate has been steadily increasing over recent years, with the target first exceeded in 2018. In 2019, 3,538 trainees accepted GP specialty training places – an increase of 65 compared with 2018. This is the second consecutive year that HEE has exceeded its target.

176. Given the success, a further 3,500 places have been made available for the 2020 recruitment round, with applications opening in November 2019. The GP contract published on 6th February described that from 2021 HEE will increase

the number of GP training places to 4,000 a year and that from 2022 GP trainees will spend 24 rather than 18 months in general practice over the period of their training.

Recruitment and return programmes

177. In addition, the Targeted Enhanced Recruitment Scheme provides salary supplements to attract GP trainees to areas that are hard to recruit to. Due to the scheme's success, the number of places available has increased from 144 in 2017 to 265 in the 2019 recruitment round, of which nearly 100% were filled. A further 265 places are being advertised for 2020. The new GP contract announces an expansion of the scheme to at least 800 by 2022.

178. The international GP recruitment programme has also been expanded and is seeking to attract an additional 2,000 doctors from overseas to work in general practice in England, although recruitment to date has been challenging. So far, we have recruited over 170 doctors from overseas. We are working with partner organisations including HEE, the Royal College of General Practitioners and the GMC to expand routes for doctors trained outside the European Economic Area (EEA) to work in general practice in England. We also introduced financial support with Tier 2 visas for non-EEA nationals planning to remain in England on completing their GP training. The new GP contract describes that from 2020/21 all international medical graduates entering general practice training will be offered a fixed five-year NHS contract.

179. There have been several improvements to the induction and refresher scheme to help GPs return to general practice, with further improvements planned to support the goal of attracting back an extra 500 doctors by 2020. Of these, 391 GPs have completed the scheme and are now able to work in practice without conditions. A further 182 are currently on the scheme either undertaking assessments or placements. The new GP contract announces a further enhancement of the scheme. From April 2020, GPs on the scheme with children aged under 11 will each be able to claim up to £2,000 towards the cost of childcare for each child whilst on the scheme.

180. We also continue to invest in support for GPs who might otherwise leave general practice, with a strong focus on retention being encouraged in local workforce plans. Last year, we supported this agenda by investing £10 million to help areas that were struggling most. The new GP contract announces a new national 'supporting mentors' scheme, which will offer highly experienced

GPs the opportunity to mentor newly qualified GPs entering the workforce whilst carrying out at least three other clinical sessions a week.

181. These areas implemented a range of interventions that offer greater flexibility and support to keep hold of the vital skills and experience of GPs on the verge of leaving general practice. We captured the learning from this initiative into the GP retention toolkit. To support the implementation of the toolkit, we invested £24 million over two years to STPs/ICSs this year, alongside additional funding for other GPFV programmes. These range from a 'floating' salaried GP role to portfolio working schemes for newly qualified GPs.

6.5 Salaried GPs

182. The salaried GP headcount has increased by 2,793 (27.2%) from 10,283 to 13,076 from September 2015 to September 2019. Similarly, salaried GP FTEs have increased by 1,602 (23.3%) from 6,867 to 8,469 over the same period. That represents a participation rate of 64.8% in September 2019 (see tables 2 and 3 below).

Table 2: Salaried GPs by gender (headcount)

	Male		Female		Unknown		Total
	Number	%	Number	%	Number	%	Number
Sept 2015	2,696	26.2%	7,107	69.1%	480	4.7%	10,283
March 2016	2,779	26.3%	7,524	71.2%	266	2.5%	10,565
March 2017	2,972	26.6%	7,996	71.5%	211	1.9%	11,174
March 2018	3,213	26.9%	8,575	71.7%	170	1.4%	11,956
March 2019	3,336	26.2%	9,131	71.8%	256	2.0%	12,710
Sept 2019	3,531	27.0%	9,396	71.9%	155	1.1%	13,076

Table 3: Salaried GPs by gender (FTE)

	Male		Female		Unknown		Total
	Number	%	Number	%	Number	%	Number
Sept 2015	2,031	29.6%	4,523	65.9%	313	4.5%	6,867
March 2016	2,109	29.8%	4,805	67.8%	172	1.4%	7,086

March 2017	2,245	30.0%	5,094	68.2%	136	1.8%	7,475
March 2018	2,385	30.2%	5,413	68.5%	107	1.3%	7,905
March 2019	2,434	29.3%	5,702	68.7%	163	2.0%	8,299
Sept 2019	2,546	30.0%	5,825	68.8%	98	1.2%	8,469

GP practice staff

183. There remains a continued increase in headcount numbers of practice staff – including GPs – between September 2015 and September 2019, with total practice staff numbers increasing by 8,176 since September 2015 (6.2%). The overall increase in clinical (non-GP) staff FTEs between September 2015 and September 2019 was 4,014 to 30,138 (15.4%) – and over the same period, the number of patients per FTE clinical (non-GP) staff fell from 2,329 to 1,991 (14.5%). See tables 4 and 5 below. For context, the new GP contract announces that the scheme to fund new workforce roles through the Primary Care Network DES in general practice will be extended to deliver an additional 26,000 new non-GP staff.

Table 4: Practice staff numbers (headcount)

	September 2015	September 2019	Change	% change
Total GPs (headcount)	41,230	45,625	4,395	10.66
Total nurses and other direct patient care staff (headcount)	39,908	43,807	3,899	9.77
Total admin/non-clinical (headcount)	91,932	96,187	4255	4.63
Total practice staff excluding GPs (headcount)	131,498	139,674	8,176	6.22
Total GPs and practice staff (headcount)	172,728	185,299	12,571	7.28

Table 5: Practice staff numbers (FTE)

	September 2015	September 2019	Change	% change

Total GPs (FTE)	34,429	34,862	433	1.26
Total nurses and other direct patient care staff (FTE)	26,124	30,138	4,014	15.37
Total admin/non-clinical (FTE)	63,069	67,952	4,883	7.74
Total practice staff excluding GPs (FTE)	89,193	98,090	8,897	9.97
Total GPs and practice staff (FTE)	123,622	132,952	9,330	7.55

Work life surveys

184. The Ninth National GP Work Life Survey[20] (published on 31 May 2018) conducted by Manchester University on GPs' working conditions and job satisfaction, is the most up to date, comparable evidence in measuring GP satisfaction; 18% of respondents were salaried GPs. This showed that for the GP workforce:

- overall job satisfaction increased since the last survey in 2015; on a seven-point scale, overall average job satisfaction was 4.25 points in 2017, compared to 4.1 points in 2015
- average working hours per week increased slightly from 41.4 hours per week in 2015 to 41.8 hours in 2017; in 2008, the average number of hours was 42.1
- the proportion of GPs reporting a considerable or high intention to leave direct patient care within five years increased slightly to 13.4% among GPs under 50 years old (13.1% in 2015) and 61.8% among GPs aged 50 years and over (60.9% in 2015).

[20] http://blogs.lshtm.ac.uk/prucomm/files/2018/05/Ninth-National-GP-Worklife-Survey.pdf

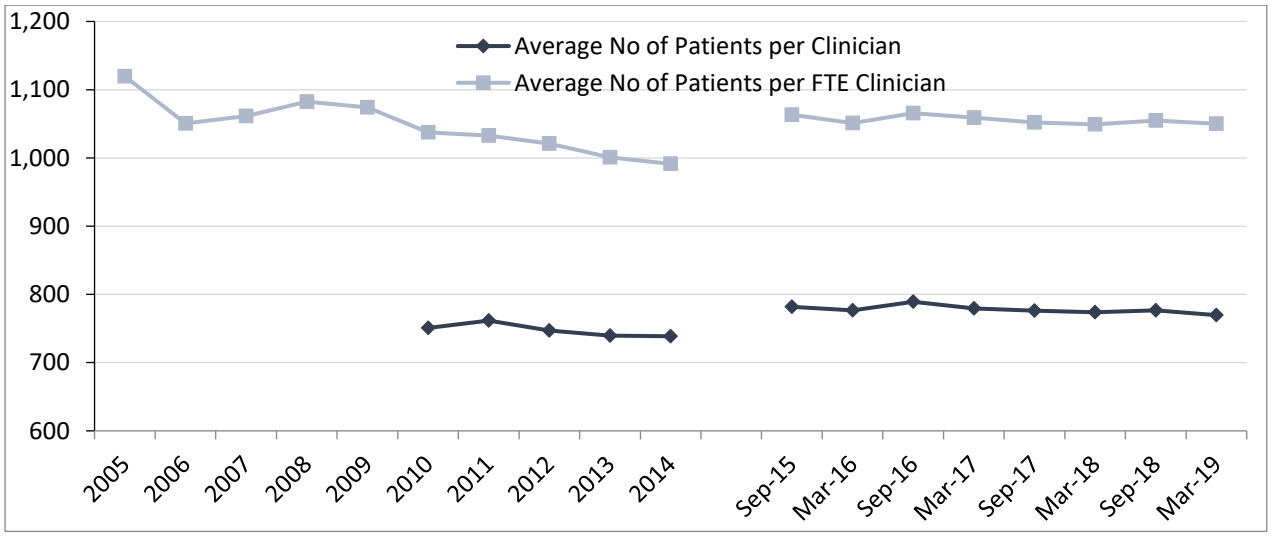
6.6 Workload of GPs

Patients per practitioner and the changing skill mix in general practice

185. The average number of patients per medical practitioner (excluding locums) in England rose from 1,656 in 2005 to 1,735 (an increase of 4.7%) at September 2019. Although GP numbers have changed, it is also because the skill mix in general practice changed significantly over that period – ie up to and beyond 2015. That has meant that, as practices have on average increased the proportion of other clinical practice staff (such as practice nurses) compared with GPs, the ratio of patients to GPs has increased. That explains why the average working hours of GPs have only increased by 1% since 2015.

186. The graph in Figure 10 below shows the trend in the number of patients per practice clinician more clearly. The data in Figure 10 from September 2015 onwards is from the workforce minimum dataset, whereas before this it was from the Exeter (NHAIS) system. Therefore, while the data shows consistent trends of falling numbers of patients per clinician, the absolute values are different and therefore not directly comparable. The data is therefore shown separately in Figure 10.

Figure 10: Average number of patients per FTE clinician and per clinician



187. General practice delivered an estimated 307 million consultations between November 2017 and October 2018, which is 21 million more than three years

earlier.[21] With an average 2% growth per year in workload, general practice could be delivering around 320 million routine consultations by 2020/21.

188. The number of patients per practice has risen from 6,250 in 2005 to 8,737 at September 2019. Over the same period, the number of practices has decreased from 8,451 to 6,867, reflecting a move towards larger practices employing more GPs. This trend is also evident in the decline of single-handed GPs (ie those with only one practitioner) from 21.6% of practices in 2005 to 10.0% at September 2019.

189. Taken together, the total number of primary care staff (GPs and practice staff) was 165,927 in 2015, which increased by 8,609 or 5.19% to 174,536 at September 2019.

190. The data appears to show that general practice is adapting its skill mix to help meet the challenges it has been facing in terms of a changing and increasing workload although caution needs to be taken in comparing the latest data to previous years.

191. The results of the GP patient survey provide patient views on the performance of practices and how well they are coping with workload. The results of the 2019 survey, published by Ipsos MORI[22] (2018 results in brackets), were:

- 82.9% (83.8%) described the overall experience of their GP surgery as good
- 67.4% (68.6%) of patients rated their overall experience of making an appointment as good
- of those who had a preferred GP, just under half – 48.0% (50.2%) said that they saw or spoke to them a lot of the time, almost always or always
- 93.4% (93.5%) of patients felt involved in decisions about their care and treatment
- 87.4% (87.4%) felt their healthcare professional was good at treating them

[21] Derived from the data in the article by Hobbs et al for *The Lancet* in April 2016: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00620-6/fulltext
[22] https://gp-patient.co.uk/about

- 77.0% (78.3%) of patients who had tried to use their GP practice website found it easy to access information or services

- Almost seven in 10 patients – 69.5% (68.7%) – reported a good experience of NHS services when they wanted to see a GP but their GP practice was closed

- 91.1% (91.2%) of patients had confidence and trust in all the people they saw or spoke to when their GP practice was closed.

6.7 Workforce planning issues

192. The aims of *Investment and evolution: a five-year framework for GP contract reform to implement the NHS Long Term Plan*[23] cannot be delivered without sufficient recruitment and workforce expansion, a view also recognised in the NHS Long Term Plan. Accordingly, NHS England and NHS Improvement and HEE will be supporting the government commitment to double the rate of growth of the medical workforce and create an extra 6,000 additional doctors working in general practice as soon as possible and an additional 26,000 staff working in primary care networks. As demonstrated through earlier statistics, there has been good progress in developing the wider workforce in general practice and the number of doctors working in general practice continues to gradually increase.

Developing the wider workforce

193. In the absence of sufficient levels of GP and nurse supply, practices have been creating other roles faster than anticipated: over 5,000 extra in the past three years, achieving NHS England's target two years early.

194. The five-year framework agreement for GP contract reform seeks to address the workload issues.

195. Through a new additional roles reimbursement scheme, PCNs will now be guaranteed funding for 26,000 additional staff. The scheme funds new roles for which there is both credible supply and demand.

[23] www.england.nhs.uk/publication/gp-contract-five-year-framework/

196. The roles have been chosen by NHS England and NHS Improvement and the General Practitioners Committee (GPC) England for four pragmatic reasons:

- we estimate that we can get enough supply
- we see strong practice demand
- the tasks they perform help reduce GP workload, improve practice efficiency and deliver NHS Long Term Plan objectives
- they are relatively new roles, where it is possible to demonstrate additional capacity, unlike GPs and practice nurses.

197. The scope of the scheme increases year on year. This reflects available supply and funding.

Trends in the earnings and expenses of salaried GPs

198. The figures in Table 6 show the distribution of income before tax (ie gross income less expenses) received by groups of salaried GPs on a UK basis (England figures are not available for this analysis).

Table 6: Number of UK salaried GPs in different income - before tax brackets

Financial year	Less than £30,000	£30,000 - £50,000	£50,000 - £70,000	£70,000 - £100,000	£100,000 plus
2012/13	1,100	2,530	2,590	1,490	480
2013/14	1,240	2,890	2,690	1,410	420
2014/15	1,470	3,180	2,830	1,460	470
2015/16	1,030	2,620	2,560	1,440	440
2016/17	1,180	3,040	2,950	1,700	590
2017/18	1,240	3,120	3,290	1,940	770

Income-before-tax 2014/15 figures have been recalculated since the GP earnings and expenses 2014/15 publication, using updated adjustments for superannuation contributions.

199. The average income before tax for salaried GPs in England in 2017/18 was £58,400 for those working in either a GMS or PMS (GPMS) practice compared to £56,600 in 2016/17, an increase of 3.1%, which is statistically significant.

Table 7 below shows trends in gross earning, expense and net earnings for salaried GPs and the ratio of their expenses to gross earnings.

Table 7: England GPMS salaried GPs

Financial year	Gross earnings £	Expenses £	Average net earnings £	Expenses as a percentage of earnings
2012/13	64,700	8,100	56,600	13%
2013/14	64,100	9,200	54,900	14%
2014/15	62,500	8,700	53,700	14%
2015/16	63,900	7,900	55,900	12%
2016/17	65,300	8,700	56,600	13%
2017/18	68,200	9,800	58,400	14%

6.8 Remuneration and affordability

GP contract

200. NHS England and NHS Improvement's Long Term Plan 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
- spending on those services will be at least £4.5 billion higher in real terms in five years' time.

201. We secured agreement to a five-year framework for contract reform,[24] underpinned by the funding for primary medical and community services that was set out in the Long Term Plan. This was agreed within the context of the affordability assumptions in the Long Term Plan and the importance of making planned workforce growth affordable.

[24] www.england.nhs.uk/publication/gp-contract-five-year-framework/

202. The contract agreement with GPC England gives five-year funding clarity and certainty for practices. Though edited through the GP contract agreement reached in February 2020, GPC England and NHS England and NHS Improvement have agreed that they do not expect additional national money for practice or network contract entitlements until 2024/25. Beyond contract funding, investment worth hundreds of millions of pounds continues to be made in central programmes benefiting general practice.

203. Accordingly, no recommendation is being sought from DDRB for independent contractor GP net income for the duration of the five-year deal, including, therefore, 2020/21.

Salaried GPs

204. Under the agreement, NHS England and NHS Improvement and GPC England agreed that practice staff, including salaried GPs, in England would receive at least a 2.0% increase in 2019/20. Although the actual effect will have depended, among other things, on indemnity arrangements within practices. Similarly, the minimum and maximum pay range for salaried GPs was uplifted by 2%. No recommendation was therefore sought on salaried GP pay in England for the 2019/20 pay round.

205. Earlier this year, we asked the government to continue to include recommendations on the pay of practice staff, including salaried GPs, in the DDRB remit from this pay round onwards.

206. We have similarly asked the government to ensure that DDRB continues to make recommendations on pay uplifts for GP trainees, educators and appraisers. As now, the government will decide how to respond to DDRB recommendations.

207. Recommendations will need to be informed by affordability and, in particular, the fixed contract resources available to practices under this deal – which will also inform decisions by GP practices on the pay of salaried GPs.

208. The fixed contract resources for 2020/21 allow for pay rises for salaried GPs of 2%.

6.9 Conclusion

209. The fixed contract resources will allow for 2020/21 pay uplifts for salaried GPs of 2%.

7. Evidence on dental practitioners

7.1 Introduction

210. 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.

211. NHS England and NHS Improvement have already met the General Dental Practice Committee of the British Dental Association (BDA) to discuss operational issues and pressures facing primary care dentistry and plan to continue to work collaboratively over the coming 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 ongoing improvements in contractual arrangements, provided that it is possible to secure appropriate improvements in the quality and efficiency of services.

7.2 Background

212. Since the beginning of the NHS, dental care has been an integral element of the NHS offer and remains a valued service. From the introduction of free NHS dental care in 1948, (primarily treating active dental disease, placing fillings and extracting teeth), the past 70 years have seen a transformation in NHS dental care which emerged into the 21st century and the era of integrated care with a renewed demand and focus for prevention alongside the challenges of managing legacy dental disease. The need for NHS-funded dental care remains, although the modalities of care have changed.

213. Acknowledging that oral health has improved regarding dental decay, NHS service delivery is increasingly focused on intervention with incentives to maintain the trend in reduced population experience of tooth decay. The improvements to date are driving a change in patient profile, with 'routine regular attenders' needing less treatment and – in line with the NICE clinical risk assessment – less frequent check-ups for tooth decay. However, there is an increasing oral health burden for maintaining and managing the mouth and

dentition of the current ageing population. People living longer require clinical support to maintain/replace legacy restorations, repair tooth surface loss (erosion/abrasion) and treat/prevent periodontal disease (gum disease). Recall for 'check-ups' is increasingly associated with lesions of the mouth, such as oral cancer risk assessment and iatrogenic disease associated with polypharmacy and/or type 2 diabetes.

214. In April 2013, NHS England became responsible for commissioning all NHS dental services, including primary, community and hospital dental services. Since the publication of *Securing excellence in commissioning NHS dental services*[25] in 2013, NHS England and NHS Improvement have moved towards a national framework, including the publication of a suite of commissioning policies and guides to ensure clarity and consistency in commissioning dental services to address the new care profiles for the different generations of patients. By applying these policies and procedures, commissioners should be able to ensure optimisation of place-based commissioning that responds to local issues.

215. Dental services are commissioned via NHS England and NHS Improvement's seven regions who support local systems to provide more joined-up and sustainable care for patients. In managing and commissioning dentistry, we aim to:

- improve health outcomes and make best use of NHS resources
- reduce inequalities
- promote greater patient and public involvement.

216. NHS primary care dental contractors are remunerated based on the number of units of dental activity (UDAs) they deliver plus payments for any additional services they provide, such as domiciliary or sedation services. Unlike GP patients, dental patients are not registered to a particular practice, so most contract value is based on activity. Dental care is provided in a course of treatment. There are three courses of treatment that increase in complexity. The lowest level, Band 1, is a basic service including a check-up and attracts one UDA; Band 2 includes Band 1 work plus other treatment such as fillings and extractions, and it attracts three UDAs; Band 3 includes Band 1 and 2 work

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

plus complex dental care such as bridges; this attracts 12 UDAs. Most contract values are legacy arrangements from before 2006, when this contract was introduced. Orthodontists are paid for the number of units of orthodontic activity (UOAs).

217. In 2011, in response to dentists continuing to feed back that the current contract leaves them on an 'activity treadmill' with no specific rewards for delivering high quality care or for delivering prevention, DHSC set up pilot schemes. The pilots looked at elements of a new contract based on 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.

218. 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.

219. The objectives of the Dental Contract Reform Programme are to:

- maintain or improve access
- improve oral health
- remain within existing resources (the current financial envelope) in a way that is financially sustainable for dental practices, patients and commissioners.

220. During 2018/19, the Dental Contract Reform Programme increased the number of dental practices in the prototype scheme; we now have over 100 practices involved, including some that were part of the pilot scheme, alongside new entrants from 'high street' practices. Three community dental service practices are prototypes. Our evaluation[26] of the first year of prototypes found they were showing promise, in particular by delivering the prevention-focused clinical pathway.

221. The testing of a potential new dental contract has been measured in line with the Health Committee's recommendations[27] that any changes to the dental

[26] www.gov.uk/government/publications/dental-contract-reform-evaluation-report-2016-to-2017
[27] /publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/289i.pdf

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 Long Term Plan: prevention, self-care, individually focused treatment for patients and a service fit for the future. This aligns with the wider approach we are taking in the health and social care system.

222. Along with reform of the dental contract we are working with local commissioners to integrate dental services into the new local care systems STPs, ICSs and PCNs. Local professional networks established under *Securing excellence in commissioning primary care*[28] are the vehicle for clinically led integrated commissioning, which adds value to care pathways and improves outcomes. The ongoing development and maturation of the local dental networks and associated managed clinical networks is key in achieving this locally focused NHS commissioning and delivery model.

223. The current focus of activity is around ensuring dentistry has a firm 'seat at the table' to ensure services fit patient needs and form part of the wider continuum of care provided in the area. In the future we will explore how we can increase the local accountability and commissioning of dental services, and we are currently looking at how they might best fit into the evolving new care models.

Smile4Life prevention initiatives

224. The Chief Dental Officer for England launched Smile4Life in 2017: this programme of oral health activities is designed to reduce inequalities and promote good oral health in England. The programme includes two NHS England commissioning initiatives to increase access and improve oral health in children – known as 'Starting Well'.

225. Throughout the past year, NHS England has delivered the two Starting Well initiatives targeted at improving oral health of children living in socio-economic deprived areas. Starting Well 13 targets 13 high priority areas across England. The programme's objectives are to:

[28] https://www.england.nhs.uk/publication/securing-excellence-in-commissioning-primary-care/

- 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
- increase the proportion of children under five accessing dental care, with a focus on high-risk groups
- increase the integration of the dental team within the community
- provide NHS England dental commissioners with a method of commissioning the programme within the existing dental contract.

To date, our commissioners have funded the participation of approximately 300 practices. Through engagement with local communities and other health, social and educational services, new ways of reaching children most at risk of dental disease and least likely to be visiting a dentist regularly are being realised.

226. The complementary initiative, Starting Well Core, enables areas not involved in the original scheme to commission additional access for children under two years of age – for a 'Dental Check by One'. Commissioners have agreed a Starting Well Core offer with approximately 1,400 NHS England dental practices in these local commissioning areas: London, West Midlands, Shropshire and Staffordshire, Cheshire and Merseyside, and Greater Manchester.

227. Following initial implementation in September 2017, Starting Well Core is now supported with a statement of financial entitlement that enables regional teams with available resources to increase local access for children under two years. The objectives of the programme remain focused on:

- a high-profile public awareness programme of Dental Check by One to ensure the timely attendance of children under two years
- provision of cost-effective evidence-based interventions and preventive advice, such as fluoride varnish, healthy lifestyle choices and dietary advice
- innovative NHS England commissioning models to deliver the Long Term Plan commitment on prevention.

Access to NHS dental services

228. Ensuring equity of access to primary dental care services remains a central goal for NHS England and NHS Improvement. Current levels of service utilisation and access to commissioned care remain high, but there are persistent pockets of reduced use and accessibility in parts of the country. The geographic and specialty shortfalls in NHS dental service provision are acknowledged, and the causes are multi-factorial and concern the distribution of dentists.

229. Alongside this, NHS England and NHS Improvement's commissioning framework is being further developed to provide tools that enable commissioners to flex current contractual arrangements, within the existing financial framework. This will include guidance for using contracts for outreach provision targeted at hard-to-reach groups and developing existing contracts based on feedback from the dental profession.

230. The March 2019 GP Patient Survey[29] covered access to NHS dental services and showed that 94% 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 (77%) in obtaining an NHS dental appointment, with seven CCG areas having success rates below 60% when respondents had not been to the practice before. Younger adults and ethnic minorities also reported a lower success rate.

231. The trend in dental attendance has been relatively stable, but there has been another slight drop for adults in the last dataset. There is a continuing trend in increased attendance for children. This may reflect the increased emphasis on child oral health and increase in parental awareness of starting the habit of going to the dentist early.

232. 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 before 2015/16. We are still able to

[29] https://www.england.nhs.uk/statistics/2019/07/11/gpps_dent_8492_822742/

compare access to NHS dental services by adult patients, as reported in NHS Dental Statistics[30] — and this has fallen slightly: 21.9 million adult patients (50.2% of the population) were seen by an NHS dentist in the 24-month period ending June 2019. This is a decrease of 0.2 million compared with the previous 12 months, but 2.4 million higher than the low point reached in June 2008 (see Table 8).

233. In the 12-month period ending June 2018, 7 million children (59% 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 6.9 million and 58.6%.

Table 8: Number and proportion of adult and child patients seen by an NHS dentist

Year	Adult patients seen '000	Percentage of the adult population	Child patients seen '000	Percentage of the child population	Total patients Seen '000	Percentage of the population
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%
2018/19	21,960	50.2%	7,001	59.0%	28,961	52.1%

234. Balancing access to the right services, meeting both needs and expressed demand, relies on contemporaneous needs assessments. While dental health surveys demonstrate a fall in dental caries/decay and a reduced demand for fillings in the younger generations (in 2017, 77% of five-year olds were free from decay) there remains the ongoing support to prevention in this cohort. Overlaid is the increasing demand for maintaining dentitions in the ageing population, which is manifesting itself as complex care in patients with co-morbidities.

235. While there has been a shift towards private dentistry, this is predominantly for aesthetic care and for treatment modalities not routinely available within an NHS course of treatment (eg implants, adult orthodontics). Our national patient survey figures suggest that the unmet demand for NHS dentistry is relatively

[30] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2018-19-annual-report-pas

small at around 6% of the adult population, based on the percentage of the adult population who have tried and been unsuccessful in obtaining an NHS dental appointment.

236. There has been a slight fall in UDAs delivered: 83.1 million UDAs in 2018/19, down 0.1 million (0.2%) since 2017/18. Band 1 activity increased by 0.5 million UDAs when compared with 2017/18; the falls in UDAs were across Band 2 and Band 3 activity, suggesting that the mix of treatment provided is changing. NHS England and NHS Improvement regional team commissioning plans at June 2019 for the following 12 months show 804,000 UDAs, 0.8% lower than the previous 12 months. This can reflect several 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.

237. Most 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%.

238. Data has been collected from regional teams on the number of contacts terminated and the reason. Three contracts were terminated due to under-delivery, the remainder were voluntary handbacks. Seven contracts have been recommissioned. Full results are shown in Table 9.

Table 9: NHS dental contracts terminated

Period	Number of contracts handbacks/termination	Reason
December 2018 – September 2019	57 contracts terminated or handed back Midlands and East – 20 North – 11 South – 22 London – 4	Voluntary termination, no reason (21) Death (1) Retirement (9) Under-delivery/inability to resolve longstanding delivery issues (4) Personal Dental Services contract closed down/expired (4) Recruitment (7) Financial viability (3) Provider no longer wanted to provide NHS services (5) Change in personal circumstances/relocation (3)

7.3 Recruitment, retention and motivation

239. For clarity, the definitions used in the report are:

- ‘providing performer’ – a dentist under contract with NHS England and NHS Improvement and performing dentistry
- ‘performer only’ – a dentist working for a ‘providing performer’ who may be a practice owner, principal or limited company.

240. 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.

241. Current trends in the dental workforce are difficult to assess. Overall national workforce numbers appear adequate to meet the needs of the population, and the numbers have increased in absolute terms. However, available data does not detail whole-time or part-time working, which limits our analysis of the workforce capacity. However, we are aware of geographic shortfalls limiting service provision, with reports from rural and coastal areas of the difficultly in recruiting and retaining dentists.

242. In 2018/19, the number of dentists providing NHS services increased by 1% to 24,545 dentists. Due to changes in the NHS Business Services Authority (NHSBSA) system, we are unable to separate the number of performer-only and providing performers in 2018/19. However, there is nothing to suggest the trend seen in previous years of a move to a higher number of performer-only dentists and a decrease in the number of provider performers has changed. This may be a factor in the overall NHS remuneration per dentist, as activity is spread across more dental performers.

243. The further development of the commissioning framework to allow flexibility in existing contractual arrangements within the existing financial framework will help to address this issue. *The Interim NHS People Plan: the future dental workforce*[31] commits to creating a capable and motivated multidisciplinary dental workforce of a sufficient size to meet population health needs.

31 www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/

244. In its 46th report published last summer, DDRB asked for systematic data on GDP motivation. NHS Digital published this information in *Dental working hours – 2016/17 and 2017/18: working patterns, motivation and morale*.

245. NHS England and NHS Improvement have been working with the profession – including the BDA – to look for possible solutions to the issue of geographical distribution. This work continues, and the outcomes will inform our commissioning intentions. It appears likely that young dentists will be 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.

7.4 Future workforce supply

246. HEE's Advancing Dental Care (ADC) review team is carrying out Phase II of the ADC review; Phase I culminated in the *Advancing dental care* report of spring 2018, which made 21 recommendations to be taken forward as a three-year programme of work: ADC review Phase II.

247. Phase II aims to develop an education and training infrastructure for the dental workforce that can respond to the changing needs of patients and services. During Phase II, the ADC review team has conducted further focused research across several workstreams to:

- collate a robust evidence base on the population's oral health needs and model the most appropriate dental workforce for meeting those needs
- identify and evaluate new and existing innovative training approaches and develop or upscale exemplars within the funding envelope
- understand the CPD requirements of the existing workforce and identify best practice.

248. A series of engagement events took place in autumn 2019 with a variety of stakeholders including learners, dental practitioners, educators, commissioners, patients, and professional and regulatory bodies. These engagement activities will inform the planning and development of several training initiatives which will be piloted in 2020. The pilot programme will be evaluated to consider how future training commissioning by HEE can support multidisciplinary teams and a greater workforce skill mix across dental services.

249. HEE was able to offer all UK dental graduates a foundation training place in 2019 and works closely with NHS England and NHS Improvement to administer Performers List Validation by Experience (PLVE) and support dentists from the EEA to join the performers list.

7.5 Earnings and expenses

250. The data from NHS Digital, *Dental earning and expenses estimates 2017/18*[32] shows that gross earnings of providing-performer dentists increased in cash terms in 2017/18. The earnings of performer-only dentists fell slightly in 2017/18 after four years of growth.

Table 10: Average gross earnings (before deduction of practice expenses and delivery costs) by dentist type, 2012/13 to 2017/18

Year	Provider-performer dentist	Performer-only dentist
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
2017/18	£388,700	£103,000

Note: Due to the time needed to collect and compile the data, 2017/18 is the latest data available.

251. 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 2017/18 there were 1,516 leavers and 1,821 joiners in-year, or 3,337 (13.7%) working for only part of the year for the NHS.

252. The numbers of dentists for the years 2012/13 to 2017/18 are shown in Table 11 below (Table 8b from *NHS dental statistics for England 2017/18*). Due to changes in the NHSBSA system, this data is not available for 2018/19. However, we have no reason to believe the trend seen in previous years of

[32] https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2017-18

more performer-only dentists and fewer providing performers has not continued.

Table 11: Number and percentage of dentists with NHS activity by dentist type, 2012/13 to 2017/18

	Number			Per cent		
	Providing performer	Performer only	Total	Providing performer	Performer only	Total
	No.	No.	No.	%	%	%
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

253. The data from NHS Digital, *Dental earning and expenses estimates 2017/18*, 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 most 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.

254. 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. There was no statistically significant change in average identifiable net income after expenses for dentists in 2017/18 compared with the previous year. These income levels are sufficient to recruit and retain the dental workforce in some but not all areas of England.

255. For dentists holding a contract, taxable earnings were considerably higher at an average of £116,700, an increase of 0.7% from the previous year's £115,800. Dentists working for providers had an average net profit (taxable income) of £59,700, down 1.8% from £60,800 the previous year.

256. On expenses, the data showed that just over half (53%) of gross payments to dentists were to meet their expenses. There has been little movement in this ratio since 2013, as shown in Table 12 below.

Table 12: Gross income and net profit of all primary care dentists, 2012/13 to 2017/18

	Population	Average gross income[33]	Expenses	Taxable Income	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
2015/16	21,200	£148,000	£78,900	£69,200	53.3
2016/17	21,200	£145,700	£77,000	£68,700	52.9
2017/18	21,550	£144,800	£76,800	£68,100	53.0

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

257. Another source of information on dentists' income, compiled by the National Association of Specialist Dental Accountants and Lawyers (NASDAL), the NASDAL goodwill survey reported a fall in the value of NHS practices during the year, but this recovered in the final quarter at 149%, although not reaching the level of the high in July 2018 (200%). Private practice goodwill remains stable at 120%.

258. Profits for all practices fell in 2017/18. However, profits for NHS practices have seen a sharper fall than private practices. NASDAL tells us income has increased for all but mixed practices, and the reduction in profits is driven by an increase in expenses particularly the rise in associate income. Associates have been used to their earnings flatlining for more than a decade, but 2017/18 has seen that turn around.

[33] 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 7.4.

Table 13: Net profit per principal for the practice

Type of practice	2012/13 £	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £
NHS	125,958	129,000	129,265	134,102	139,698	126,269
Mixed	-	-	-	127,684	130,076	127,676
Private	124,086	131,000	140,129	133,743	139,454	138,806

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

259. The NHS Digital earnings report continues to note the increasing difficulty in separating expenses between performers and providers – and the possible double counting of expenses. It states:

The results presented in this report reflect earnings and expenses as recorded by dentists on their self-assessment tax returns. Most 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 – ie is the only dentist working in the practice – no multiple counting can occur.

260. 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 ongoing 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.

261. 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 (eg increased caseload of complex treatment, time-consuming treatment incurring higher expenses versus time-consuming prevention courses of treatment with lower resource expenses).

262. Extracts from NASDAL and Morris & Co (other non-staffing costs) results are shown in Table 14. There were only slight variations in expenses as a percentage of gross income in 2017/18. Expenses as a percentage of gross income have remained relatively stable since the data was first provided in 2006/07.

263. NHS England continues to have productive meetings with the BDA on a number of issues, including operational issues and potential cost pressures.

Table 14: Categories of expenses as a percentage of gross income

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Non-clinical staff wages (NASDAL)						
NHS practices	21.0%	20.3%	20.1%	20.6%	19.7%	20.3%
Private practices	19.5%	18.9%	18.2%	17.6%	18.0%	17.9%
Laboratory costs (NASDAL)						
NHS practices	6.4%	6.6%	6.3%	6.1%	6.0%	6.0%
Private practices	7.3%	7.4%	6.8%	7.5%	7.1%	6.8%
Materials costs (NASDAL)						
NHS practices	6.3%	6.8%	6.0%	6.1%	6.2%	6.4%
Private practices	7.2%	7.1%	7.8%	7.4%	7.5%	7.5%
Other Non-staffing costs (Morris & Co)						
NHS practices	16.4%	18.6%	17.1%	15.4%	16.1%	15.8%

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Private practices	20.4%	19.7%	19.7%	16.3%	18.9%	18.9%

7.6 Gender pay gap

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

Table 15: Average taxable income from NHS and private dentistry by gender

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total	£72,600	£71,700	£70,500	£69,200	£68,700	£68,100
Male	£83,900	£84,100	£83,300	£81,900	£81,800	£81,900
Female	£59,100	£57,300	£56,500	£55,800	£55,500	£54,700

265. Regardless of dental type classification, on average, male dentists have higher gross earnings, total expenses and taxable income than their female counterparts. In 2017/18, for all self-employed male primary care dentists, average taxable income was £81,900 compared to £54,700 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 performer-only dentists (23% of male dentists compared to 7% of female dentists).

266. 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 dataset determined by the survey's response rate, the averages are slightly different to those reported in paragraph 268.

Table 16: All self-employed primary care dentists – average earnings and expenses from NHS and private dentistry, by gender and weekly working hours, England and Wales 2017/18

Mean average						
Gender	**Weekly working hours**	**Report population**	**Gross earning**	**Total expenses**	**Taxable income**	**Expenses to earnings ratio**
Male	<20	150	£104,400	£54,900	£49,400	52.6%
	≥20<25	100	£153,600	£93,400	£60,200	60.8%
	≥25<30	150	£168,000	£91,400	£76,600	54.4%
	≥30<35	300	£176,700	£97,100	£79,600	54.9%
	≥35<40	600	£158,500	£79,500	£79,000	50.2%
	≥40<45	700	£214,500	£124,600	£89,900	58.1%
	≥45	700	£305,100	£195,500	£109,500	64.1%
	All	2,700	£209,600	£122,600	£87,000	58.5%
Female	<20	250	£66,600	£30,800	£35,900	46.2%
	≥20<25	350	£71,800	£28,400	£43,300	39.6%
	≥25<30	300	£104,100	£47,700	£56,400	45.8%
	≥30<35	450	£98,600	£43,300	£55,300	43.9%
	≥35<40	500	£112,000	£49,300	£62,700	44.0%
	≥40<45	450	£123,500	£58,600	£64,900	47.5%
	≥45	300	£182,400	£109,100	£73,300	59.8%
	All	2,600	£109,600	£52,300	£57,300	47.7%

Data from NHS Dental Statistics 2018/19 is provided in Table 17 below. This shows a marked increase in female dentists in recent years: in 2018/19, 59.1% of dentists under 35 were female.

Table 17: Percentage of dentists with NHS activity by gender, 2012/13 to 2018/19

All dentists with FP17	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Male	54.6%	53.9%	52.9%	52.0%	51.2%	50.3%	49.6%
Female	45.4%	46.1%	47.1%	48.0%	48.8%	49.7%	50.4%

Clawback

267. The term 'clawback' can mean different things but is often used to describe an adjustment to a dental contract where there has been underperformance, and the amount already paid for the contracted services is deducted from future payments: ie 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 and NHS Improvement recover 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 and NHS Improvement regional teams have been working with practices to more closely align contract values with overall delivery – so if a practice has continued to underdeliver for several years, the contract can be rebased and the funds can be redistributed to other practices, recontracted or used for other priority NHS services.

Table 18: Performance adjustment extracted from NHS England's accounting system

	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Performance adjustment	37	73	37	71	65	128

The performance adjustment will include 'clawbacks' for underperformance, payments where a contract has exceeded the contract value by up to 2% and any other adjustment to contract values.

NHS Pension Scheme

268. Access to the NHS Pension Scheme is available to all 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 and NHS Improvement regional teams, shows the number of dentists who are members increased slightly to 19,949 in 2018/19 from 18,911 in 2017/18 and almost all dentists under the age of 26 are members. This suggests dentists continue to find the NHS Pension Scheme attractive.

269. The BSA has provided data on the number of GDPs 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 most 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 19: General dental practitioners claiming their NHS pension

Year	Age count	Age average age	Voluntary early retirement count	Voluntary early retirement average age
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
2019	204	60.88	165	56.45

270. The data in Table 19 shows that the average age of retirement for both normal age and voluntary early retirement has remained fairly stable in the last seven years. There was an increase in both categories of retirement in 2019. However, this is no higher than retirements seen in earlier years and follows several years of low retirement numbers. It does not suggest that there is a surge in dentists wishing to retire.

271. While 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. HMRC's introduction 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.

7.7 Remuneration and affordability

272. As discussed in Chapter 3, there is a need to balance financial constraints with ensuring proper remuneration of dental practitioners.

273. In light of inflation forecasts for the financial year 2020/21, we view a basic pay uplift of 2.0% to be an appropriate level of remuneration.

274. The affordability of pay recommendations for GDPs in 2020/21 has 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 similar NHS pay awards, the maximum affordable pay award for GDPs would be 2%.

275. The evidence suggests that a good supply of GDPs is available to support NHS England in delivering dental care, albeit there are geographic shortfalls. Dental practitioners, contracted to deliver NHS England's commissioned dental care, are considered to receive a level of remuneration comparable with NHS England managerial and NHS England professional health cadres.

276. Based on the above, we urge the DDRB to carefully consider what uplift is appropriate for 2020/21, noting the 2.5% awarded and agreed for 2019/20.

7.8 2019/20 settlement

277. For 2019/20, DDRB recommended an uplift in income, net of expenses, of 2.5% from 1 April 2019. The increase was accepted by ministers, and when combined with an increase for expenses of 2.27% this provided an uplift of 2.42%.

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

279. As part of this package, dentists were expected to continue to work closely with DHSC and NHS England and NHS Improvement 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.

Community dental services

280. Dentists working in community dental services (CDS), which are local services commissioned by NHS England and NHS Improvement, provide an important service to patients with particular dental needs – especially vulnerable groups. This cohort was referred to as salaried dentists in the past, when primary care trusts and NHS care trusts were responsible for CDS, and the dentists were employed by the trust. CDS are now commissioned under a GDS or PDS contract. CDS are traditionally seen as a vocational specialist route in dentistry and tend to recruit dentists with a certain set of values.

281. NHS England and NHS Improvement commission 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. NHS England and NHS Improvement's *Commissioning guide for special care dentistry*[34] is particularly relevant when commissioning CDS as it will often be a key provider of more advanced special care services.

282. NHS England and NHS Improvement believes CDS play an important role in dental health service provision, and we are not aware of any specific difficulties in filling vacancies faced by providers.

[34] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-specl-care-dentstry.pdf

7.9 Contract changes in 2020/21

283. 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.

7.10 Conclusion

284. This chapter provides information on the latest position on recruitment and retention, earnings and expenses, and other relevant developments for GDPs. The evidence from private sector surveys and practice valuations shows that there is a workforce and infrastructure available to the NHS which will allow the NHS to fulfil its statutory commitment for the provision of dental care.

8. Doctors in training

285. Reform of the junior doctor contract was approved by the BMA's Junior Doctors Committee in June 2019, with members subsequently voting in favour of accepting the amended contract. The agreement ensures that the 2016 contract (which now includes the 2019 reforms) provides a single nationally agreed contract for doctors and dentists in training.

286. The four-year pay deal – agreed with NHS Employers and DHSC – consists of a 2% pay award per year, plus additional investment of £90 million to fund the changes to the contract.

287. A number of changes were included to support staff safety, morale and remuneration, including increases to weekend and night shift pay, a fifth nodal point on the pay scale, limits on consecutive shifts, and a third paid break introduced for 12-hour night shifts.

288. The investment in contract reform was also made in view of the benefits provided to the NHS, such as the extension of standard working hours, as well as wider impacts on staff morale and retention.

289. Overall, the contract reform supports recruitment, retention and the delivery of high quality patient care through the NHS Long Term Plan.

290. The contract reform aligns with work by NHS England and NHS Improvement to support improved working conditions for staff as part of our interventions to make the NHS the best place to work. This includes measures as part of the People Plan to ensure an effective, healthy and safe working environment for all staff, including ensuring the safety of junior doctors.

291. In addition to contract reform, the government has made available £10 million to NHS trusts to improve the working environment for junior doctors through upgrading or installing rest areas or other facilities.

9. Conclusion

The medical workforce makes up an important part of the diverse overall NHS workforce, and NHS England and NHS Improvement are committed to working together to continuously seek improvements in retention, recruitment, productivity and morale of the workforce. The vision in the Interim NHS People Plan – led by our new Chief People Officer – seeks to ensure a supportive and caring environment for staff, combined with high quality, compassionate leadership, and resulting in high quality patient-centred care.

This submission provides our view of an appropriate pay award for consultants, SAS doctors, salaried GPs and dentists, taking into account a range of factors:

- the need to deliver financial sustainability within a fixed funding envelope
- the benefits of pay in supporting morale, retention and recruitment
- the level of inflation
- the need to afford an increase in the size of the medical workforce, to meet the pressures from rising demand with high quality patient care
- wider financial planning and investments, both related to workforce (including non-pay investments to improve staff morale and retention, as signalled in the Interim NHS People Plan), and other areas of expenditure, including investments required to deliver the NHS Long Term Plan
- recent examples of contract reform which have involved both investment by the NHS but also benefits for the NHS.

We have made 2.0% available for annual pay growth in 2020/21 for consultants, dentists and SAS doctors. This is above the OBR forecast for CPI inflation in 2020/21. This includes SAS doctors because, although there is a government commitment to discussions on contract reform, these discussions are unlikely to have concluded in time for the 2020/21 pay award.

Consultants continue to provide highly specialised medical services. Continued growth of the consultant workforce provides confidence for this staff group overall.

The main concern is around the annual allowance tax charges in relation to pensions, and how such charges can affect the availability of senior clinicians and NHS operational capacity. However, NHS England and NHS Improvement announced exceptional action for 2019/20 and are supporting the government in considering wider flexibilities through the recent consultation on the NHS Pension Scheme to take effect from 2020/21 and beyond.

SAS doctors make a significant contribution to delivering patient care across the NHS. Their roles are predominantly focused on service delivery, and in many trusts, they are vital to delivering services and fill important rota gaps. The government has committed to negotiations on a multi-year pay agreement, incorporating contract reform for the entire SAS grade, and the government's submission will provide more detail.

For salaried GPs, the five-year contract agreement with GPC England gives funding clarity and certainty overall to practices. This fixed contract will allow for 2020/21 pay uplifts for salaried GPs of 2%. Beyond contract funding, investment worth hundreds of millions of pounds continues to be made in central programmes benefiting general practice, and while the NHS faces a challenge in terms of GP numbers, there remains a continued increase in headcount numbers of total practice staff, combined with additional investment recently announced to increase doctors working in primary care.

The evidence suggests that there is currently a steady supply of general dental practitioners supporting NHS England in delivering dental care despite geographic shortfalls. Dental practitioners are considered to be well remunerated with levels of remuneration comparable with NHS managerial and NHS healthcare professional cadres. Overall, the evidence shows that there is a dental workforce and infrastructure available to the NHS which will allow the NHS to fulfil its statutory commitment for the provision of dental care.

Our aim is that the evidence, considerations and pay recommendations in this document will ensure our medical workforce is valued and secure a sustainable and engaged workforce to better support the long-term delivery of healthcare in England.

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Publishing approval reference: