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

March 2021

Contents

1. Introduction

1. In July 2020 we published the *People Plan 2020/21 – action for us all*, which sets out agreed actions for 2020/21, with a particular focus on how the NHS can support staff through the pandemic.

2. This document sets out some data relevant to doctors and dentists, including the challenges identified for the different groups within this workforce and the actions we are taking to address them.

Scope of this submission

3. The medical workforce makes up an important part of the total NHS workforce. This submission focuses on the following groups of the medical workforce:

   - consultants
   - specialty and associate specialist (SAS) doctors
   - primary care – salaried general practitioners (GPs)
   - dental practitioners.

4. This submission is confined to areas directly relevant to the work of NHS England and NHS Improvement.

2. Context for the 2021/22 pay round

5. 2020/21 has been an exceptional year in the NHS, with services and staff having to respond to unprecedented urgent demand and pressures as a result of the COVID-19 outbreak.

6. NHS staff deliver high quality care for patients, and the medical workforce is essential to achieving this, through its critical role in clinical decision-making, service development and delivery across primary, secondary and community care.

7. We want to ensure that the medical workforce, alongside other staff groups, is fairly and properly rewarded, and supported and engaged to join and remain in the NHS for the future. We want members of 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.

8. The NHS needs to continue to be able to deliver routine activity, while continuing to respond to immediate and unforeseen demand. Therefore, it is important:

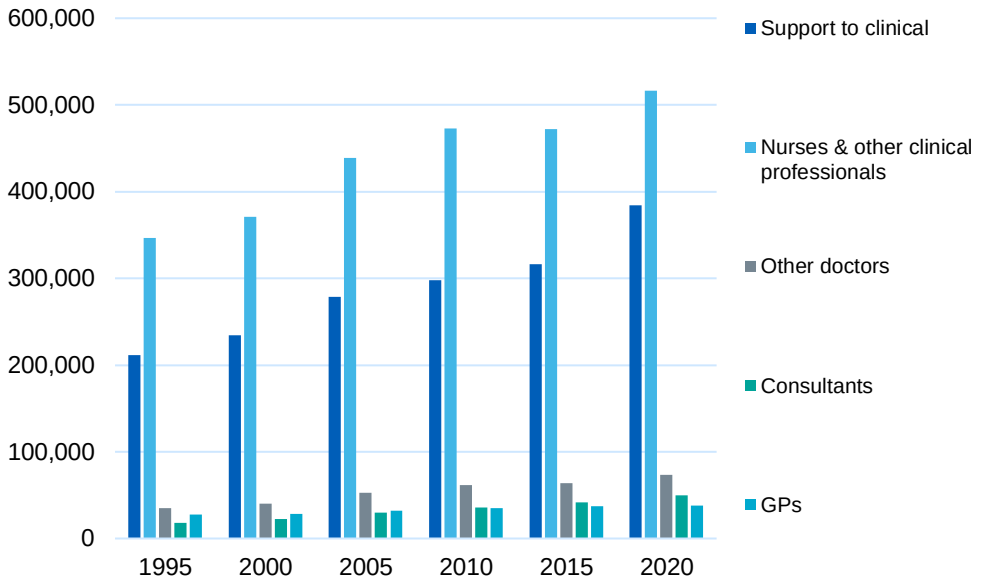
   - to increase the number of staff, to ensure a sustainable pipeline and deliver necessary activity levels
   - to remunerate existing staff fairly in a way that reflects their central role in delivering patient care, supports workforce morale and helps retain experienced and skilled staff within the NHS.

2.1 Overview: medical and dental workforce

9. Between April 2018 and September 2020, we saw an 11.4% increase in the number of full-time equivalent (FTE) staff in substantive posts in England, showing steady growth in our workforce.[1]

[1] Source: ESR.

Figure 1: Clinical staff numbers over time



Source: Health Education England, 2020

10. Growth in the number of FTEs picked up from March 2020, as organisations moved to increase their workforce to support the COVID-19 response and participation rates among current staff increased.

11. At the same time, leaver rates across the NHS have fallen between June 2019 and June 2020 across all professions.[2] The 2019 NHS Staff Survey showed that over half of all medical and dental respondents (57.5%) declared that they were not considering leaving their current job, with 2.7% expressing a wish to move to a job outside healthcare.

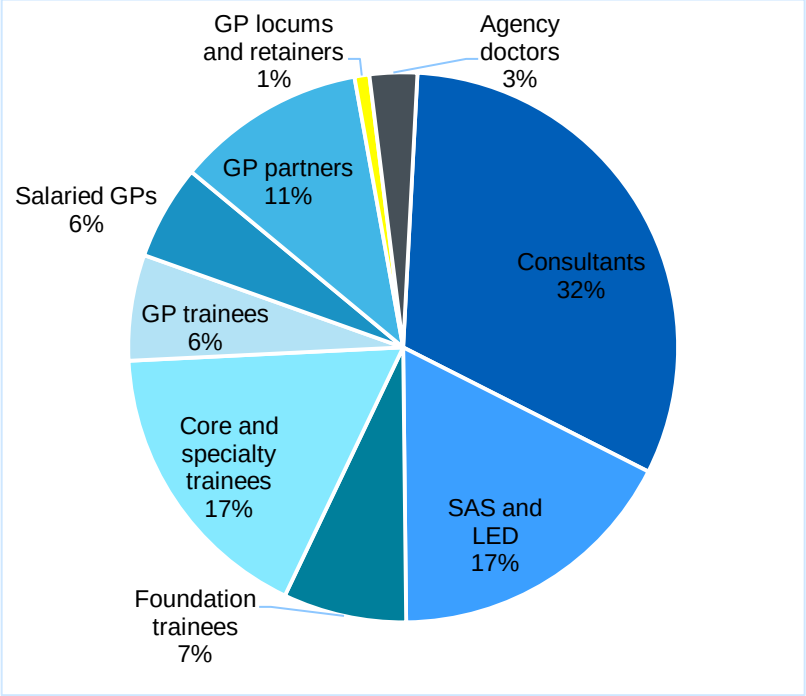
12. Nationally, vacancy rates are falling. Between April 2018 and September 2020, we saw a 7.1% decrease in vacancies nationally.[3]

13. Consultants make up the largest proportion of the total medical workforce (32%), followed by postgraduate medical education (PGME) trainees, who account for about one third (30%) of the medical workforce (Figure 2).

14. Figure 3 shows that the medical workforce in secondary care – including consultants, doctors in training, SAS doctors and locally employed doctors – continues to grow. Over this period FTE medical staffing numbers in post have increased 3.1% per year on average.

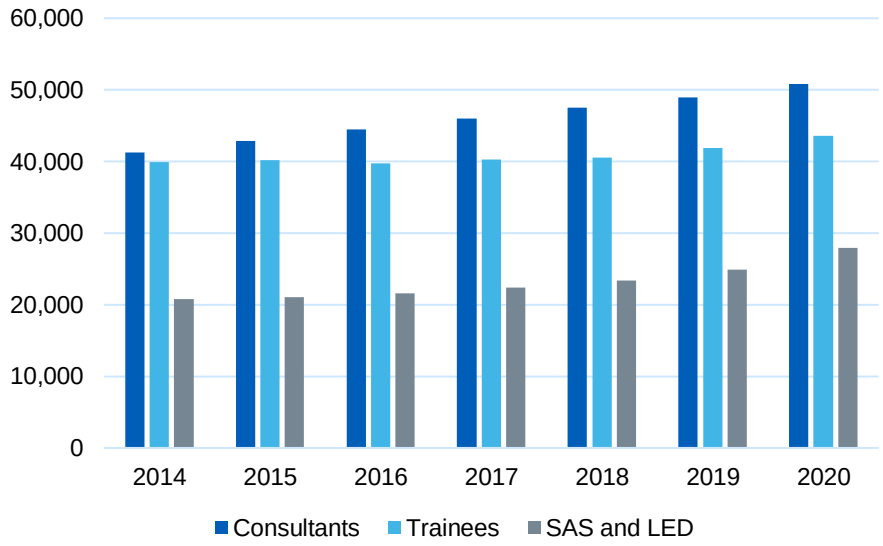
[2] This does not include GPs.
[3] Source: NHS England and NHS Improvement, National Workforce Returns. This does not include primary care.

Figure 2: The medical workforce in primary and secondary care (FTE)



Source: Health Education England, 2020

Figure 3: Total number of doctors (FTE) across medical grades over time

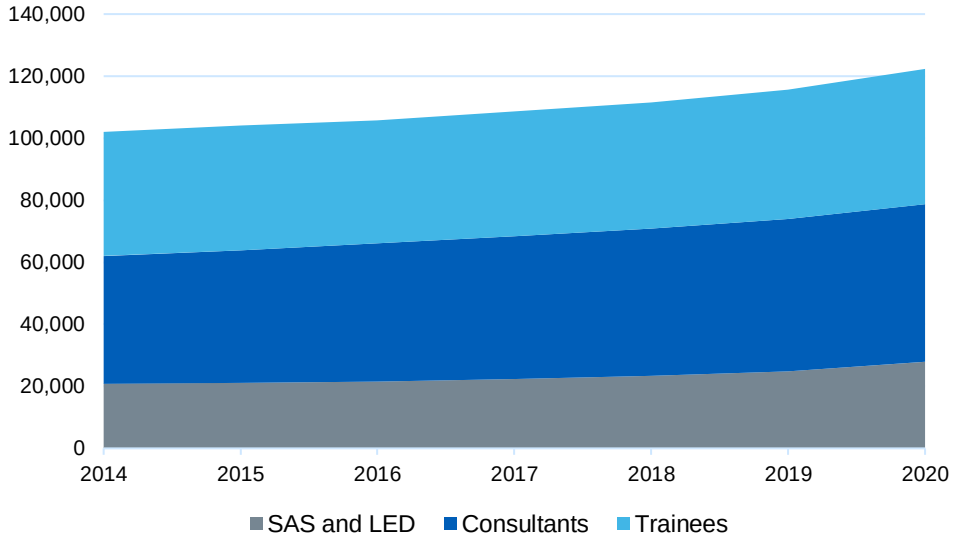


Source: Health Education England, 2020

15. The number of PGME trainees working in the NHS (excluding GP trainees working in primary care settings) has grown at an average of around 1.5% per year, reflecting increased recruitment to training. This is a combination of increases in training posts and improved 'fill' of those posts.

16. Over the same period, total numbers of SAS doctors and locally employed doctors – those employed on local terms and conditions rather than on national contracts – have expanded. This is partially due to the emergence of the 'Foundation Year 3' role – where trainees take an additional year after their Foundation Year 2 before progressing to specialty training – as well as recruitment of medical staff from overseas, who often step into these roles.

Figure 4: Shifting medical workforce structure (FTE) over time



Source: Health Education England, 2020

International doctors

17. Between 2014 and 2020 the proportion of doctors reporting UK nationality has seen a slight decrease across all medical grades. At the same time, and over the same period, we have seen a steady increase in the proportion of doctors with EU/EEA and rest of the world nationalities, highlighting the importance of international recruitment as a source of workforce supply.

18. As of January 2020, out of 169,000 NHS staff with non-British nationality, over 67,000 are nationals of EU countries.[4]

19. At June 2020, 9% of doctors and 4% of nurses in England are nationals of other EU countries.[5] There are 32 trusts (mostly in London and the South East) where over 10% of staff are nationals of other EU countries.

[4] Baker C (2020) Briefing paper: NHS staff from overseas: statistics. https://commonslibrary.parliament.uk/research-briefings/cbp-7783/
[5] Baker C (2020) Briefing paper: NHS staff from overseas: statistics. https://commonslibrary.parliament.uk/research-briefings/cbp-7783/

2.2 EU exit

20. The UK left the EU on 31 January 2020 and the transition period ended on 31 December 2020. The government has negotiated the terms of the UK's exit with the EU.

21. The main changes that impact on the NHS workforce include:

- The Immigration and Social Security Co-ordination (EU Withdrawal) Bill received Royal Assent on 11 November and is now an Act of Parliament. The Bill removes the free movement rights of EU, EEA and Swiss citizens in the UK, which derived from the UK's EU membership. In future, EU citizens who do not hold pre-settled or settled status will be subject to the same immigration rules as other nationalities.
- Following the end of the transition period, a mutual recognition of the statutory mechanism for professional qualifications will allow continued automatic recognition of qualifications for key healthcare professions for up to two years after our EU Exit, followed by the Secretary of State's review of further extension.
- There continues to be no limit on the number of international students who can come to the UK to study.
- The EU settlement scheme allows EU, EEA or Swiss citizens and their families to apply to continue living in the UK after 30 June 2021. There has been a large number of applications by NHS staff.

22. Although it is not possible to predict with certainty the impact of exit from the EU, some circumstances and measures put in place may help mitigate the impact on the NHS workforce, including:

- The fact that EU workers make up a relatively small proportion of the NHS workforce in most NHS organisations (compared to both domestic staff and those trained in other countries).
- The fact that the healthcare surcharge – as part of individuals' immigration application – does not apply to registered health and care professionals and their family members, and NHS staff from the EU already working here will be able to apply to the EU settlement scheme until June 2021.

23. We continue to track staff supply and, including monitoring and mitigating risks to workforce availability through our regional teams; monitoring uptake of staff with EU settled status (following the introduction of an electronic staff record (ESR) field to enable the recording of EU settled status in July); and monitoring leavers through the retention programme.

2.3 COVID-19 and our response

Workforce supply and trends

24. When a Level 4 national incident was declared, infrastructure was rapidly created to enable former NHS staff to return to the NHS, where they could be deployed to different services to boost the emergency response. NHS staff numbers have been bolstered by clinicians returning from academia, retirement and other industries, with over 40,000 clinicians expressing an interest in returning.

25. As part of the work to bring back staff, students have also stepped out of training to increase their direct support to patient care, and some staff have been redeployed to areas experiencing pressure. We published guidance to support the safe and appropriate deployment of staff which, alongside changes in emergency legislation, terms and conditions and ways of working, has provided greater flexibility for NHS staff.

26. We have been engaging with returners to continue to match them with opportunities to support priority work across the NHS, as well as potentially retain them in the service on a longer-term basis.

27. We surveyed those who returned for feedback on the process and to understand their intentions to remain in NHS employment. Non-GP doctors made up 26% of the total number of responses. Most of these were aged 61 to 70 years old. Of all non-GP doctor survey respondents, 47% (515) expressed an interest in returning to the NHS and wider health and social care system in some capacity in the medium to longer term.

28. During the first and second waves of COVID-19, the NHS has seen higher rates of staff absence as a result of both COVID-related sickness and shielding and self-isolation requirements.

29. However, COVID-19 probably also played a part in reducing NHS leaver rates in 2020 because many felt committed to support the NHS and patients during this challenging period.

30. At the same time, the first wave of COVID-19 saw public visibility of the work of the NHS reach an all-time high, with an accompanying surge in interest in NHS careers. In March 2020, applications to jobs through NHS Jobs across all staff groups reached 407,000, up by 21,400 compared to the previous month, and up just over a quarter compared to March 2019.

Support for staff during the response to COVID-19

31. Throughout the pandemic we have worked with DHSC and other national partners to co-ordinate an integrated response across the NHS. We established several aligned cells to support work led by other government departments, provide input on behalf of the NHS and facilitate joint working.

32. Over the course of the pandemic we also took comprehensive action to support staff. This included:

- **Supporting staff health and wellbeing** through a comprehensive national health and wellbeing offer for all NHS staff, including a helpline and text line, free access to mental health and wellbeing apps and self-help modules, and publication of support resources on the #OurNHSPeople health and wellbeing website. We also introduced the #lookingafteryoutoo coaching offer for primary care staff, and a financial wellbeing offer in partnership with the Money Advice Service (based on emerging evidence about the impact financial concerns can have on employees' mental health).
- Increasing workforce supply by '**bringing back staff**' on a temporary basis.
- Enabling **flexible staff deployment** by implementing new guidance, developed with trade unions and employers, and accelerating a staff digital passport to facilitate staff moving across NHS organisations.
- **Supporting vulnerable staff** through a dedicated programme to understand and address the disproportionate impact of COVID-19 on black, Asian and minority ethnic (BAME) communities and staff. Among the medical workforce, more than half (54%) of the doctors joining the register in 2020 identified as black and minority ethnic.[6] As part of this programme we worked with the Faculty of Occupational Medicine to develop a risk reduction framework. This was published with accompanying guidance from NHS Employers, which encouraged employers to conduct individual risk and workplace assessments of their staff and consider actions to mitigate risk.
- Working with national partners to introduce **temporary changes to NHS terms and conditions**, to reflect the unprecedented pressures placed on staff and give them flexibility and support to maintain their health and wellbeing. Benefits introduced included full pay during isolation and sickness absence, additional flexibility to carry over annual leave, and non-contributory benefits for staff deceased in service.

33. At the same time, employers, the industry and the public also took extensive action to support and recognise the NHS workforce, including, for example: services establishing dedicated shopping hours for NHS staff; services giving staff offers and discounts; the public clapping weekly for NHS staff.

[6] GMC (2020) *The state of medical education and practice in the UK*. https://www.gmc-uk.org/-/media/documents/somep-2020_pdf-84684244.pdf

34. We have also been monitoring the health and wellbeing of staff during the pandemic by running a regular NHS coronavirus 'pulse' listening survey since July 2020. The survey includes eight questions about staff health and wellbeing, changes to work patterns and the national and employer support available to staff.

35. Our 'pulse' survey results as of 28 October also show that staff generally report feeling well supported, with 64.4% saying their organisation is proactively supporting their health and wellbeing, 82.1% that they feel well informed, and 58.4% that they are able to balance their work and personal life.

36. Through our interactions with staff via helplines and other channels, we have heard they were feeling pressure from work, but also from 'secondary stressors' – the financial, relationship and physical impacts of COVID-19. The health and wellbeing offer now also includes a pilot offering counselling services to support relationship difficulties, and a joint offer with the Money Advice Service to provide support for pension, saving and financial issues.

37. Our COVID-19 health and wellbeing support offer has received significant external recognition for providing a range of evidence-based interventions to staff across the NHS at scale and at pace. This was recognised through an occupational health and wellbeing award in October 2020 for the 'Best Wellbeing Initiative' and three 2020 Personnel Today awards in November 2020: overall winner, HR impact award winner, and health and wellbeing award.

Continuing to support staff

38. Staff morale and wellbeing, retention and workforce expansion remain key areas of focus for our work.

39. We will continue to engage with and listen to the NHS workforce and continue to monitor their morale, health and wellbeing through regular surveys and through the NHS Staff Survey. Last year we worked with experts to develop new questions for the 2020 national Staff Survey, to capture the pandemic's impact on NHS staff.

40. Through winter we have been investing in mental health and wellbeing support interventions for staff, including:

- setting up system-wide mental health and wellbeing hubs providing proactive outreach to staff most at risk, enabling staff to rapidly access evidence-based mental health treatment and psychosocial support
- establishing a complex case service to support staff presenting with complex needs, such as complex addictions and co-occurring mental health problems

- delivering psychological and mental wellbeing training for critical care nursing staff over the winter.

41. We are piloting an enhanced occupational health and wellbeing support offer across 14 systems, covering 700,000 NHS staff and, in many cases, extending to social care staff. Each system has designed a package of support tailored to its local workforce health needs, such as targeted support for vulnerable groups, local campaigns to support staff to access the national health and wellbeing offer, and dedicated development support for line managers.

42. We are focused on responding to these challenges based on what we learned from the first and second waves of the response to COVID-19. We set up the Beneficial Changes programme in May 2020 to learn from and embed positive changes, and identify innovations that have improved care, safety, patient experience, staff health and wellbeing, and efficiency.

43. The changes we have seen in the NHS during this period bring beneficial changes to the medical profession and enable delivery of our strategic aims around increasing flexibility, ensuring sustainable supply, fostering multidisciplinary and cross-boundary working. Initiatives that support these include, for example:

    - enabling the NHS to retain a talent pool of doctors who have returned to the NHS after previously leaving the medical register
    - increasing the use of technology for outpatient consultations and multidisciplinary team meetings, enabling doctors to work from home (eg radiology reporting, NHS 111 service) and offering doctors greater flexibility to work remotely, more generally
    - flexibility of job plans for doctors in secondary care to meet the initial high demand for treating COVID-19 patients.

44. These insights directly informed the development of the People Plan 2020/21. We will continue to capture learning about our workforce during the ongoing response to COVID-19 and aim to progress and embed beneficial changes in the longer term.

2.4 The NHS People Plan 2020/21

45. In June 2019 the NHS published the Interim People Plan, which forms part of the overall implementation plan for the NHS Long Term Plan. This laid the foundations for the workforce transformation needed to deliver the new service models and ways of working set out in the Long Term Plan.

46. In July 2020 we published *We are the NHS: People Plan for 2020/21: action for us all*, which builds on the direction of travel set out in the Interim People Plan

and describes the action that will be taken at every level of the NHS to support our staff through the ongoing COVID-19 pandemic, winter pressures and in the lead-up to EU exit. These actions contribute to deliver the NHS Long Term Plan, through:

- more people in training and education, and recruited to ensure that our services are appropriately staffed
- people working differently by embracing new ways of working in teams, across organisations and sectors, and supported by technology
- a compassionate and inclusive culture, by building on the motivation at the heart of the NHS to look after and value staff, create a sense of belonging and promote a more inclusive service and workplace, so that staff will want to stay.

47. This Plan includes the NHS People Promise, which describes what people should expect from an NHS career and from the NHS as an employer. It sets out how the NHS will support, develop and empower everyone who works or is learning in the NHS – framed around seven key principles – with clear expectations for all NHS organisations to meet these standards within the next four years.

2.5 Financial context and outlook

NHS Long Term Plan

48. The NHS Long Term Plan set out important commitments aimed at putting the NHS back onto a sustainable financial path. This included five financial tests described as stretching but feasible, which were that the NHS will:

- return to financial balance (including providers)
- achieve cash-releasing productivity growth of at least 1.1% per year
- reduce the growth in demand for care through better integration and prevention
- reduce unjustified variation in performance
- make better use of capital investment and its existing assets to drive transformation.

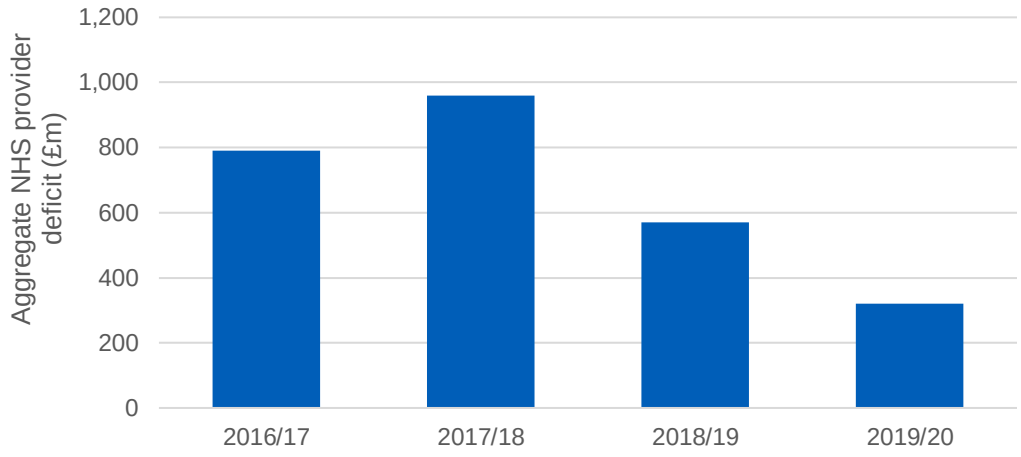
Progress in 2019/20

49. Progress was made against these tests in 2019/20. The NHS continued to balance the books nationally across providers and commissioners, while the

aggregate provider deficit almost halved.[7] The number of individual providers in deficit also halved.

50. Important changes to the NHS payment system moved funding away from activity-based payments.[8] A blended payment approach was introduced for non-elective services that included a fixed and variable element, which provided greater certainty for commissioners and providers.

Figure 5: Aggregate financial deficits of NHS providers[9]



Source: Annual accounts

51. Nonetheless, significant challenges remain. Many NHS providers reported in 2019/20 that their costs exceeded the income they received, even though the total deficit reported was reduced. Some of these organisations have reported financial deficits for several years and they (and their system) may require targeted support in the coming years.

2.6 Impact of COVID-19

52. The response to the COVID-19 pandemic has impacted on NHS costs in 2020/21. In March 2020, temporary financial arrangements were introduced to remove routine burdens on NHS organisations and free them up to devote maximum operational efforts to COVID-19 readiness and response.[10] These included the suspension of usual payment and contract arrangements, with

[7] See: https://committees.parliament.uk/oralevidence/433/html/
[8] See: https://improvement.nhs.uk/documents/4980/1920_National_Tariff_Payment_System.pdf
[9] https://www.england.nhs.uk/wp-content/uploads/2017/06/financial-performance-report-q2-2019-20.pdf
[10] This was set out by Sir Simon Stevens and Amanda Pritchard in a letter to the service. See: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200317-NHS-COVID-letter-FINAL.pdf

block contract payments for all NHS trusts and foundation trusts. The FRF was also suspended.

53. The national block payments included the expected impact of pay uplifts, as set out in the tariff cost uplift. Arrangements were also made for national top-up payments to reflect differences between actual costs and guaranteed income, which included evidence of increases in staffing costs due the COVID-19 pandemic.

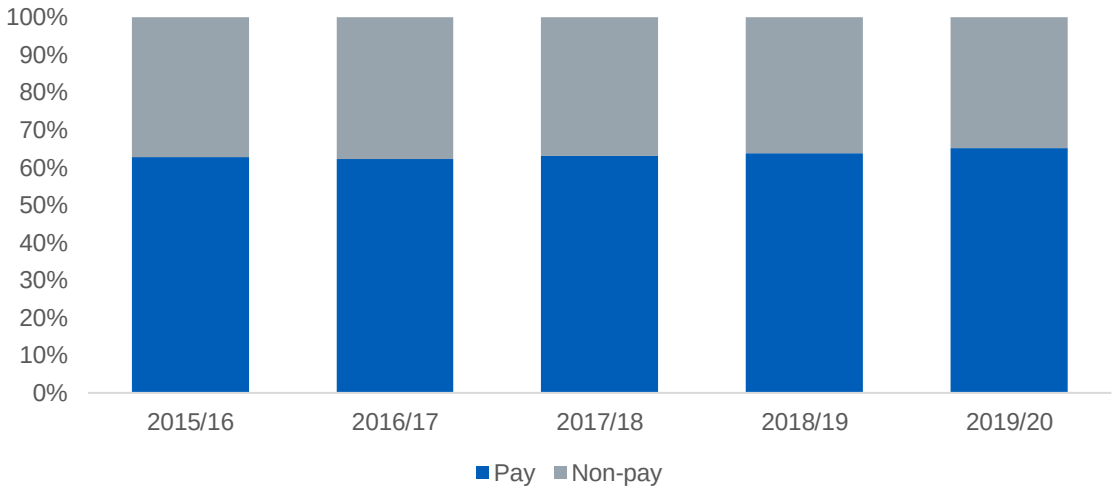
54. From 1 October 2020, systems (STPs and ICSs) have been issued with fixed funding envelopes equivalent in nature to the previous block, prospective top-up payments and a system-wide COVID-19 funding envelope. There is no retrospective payment mechanism for the second half of 2020/21.[11]

55. Overall, the COVID-19 pandemic has required the NHS to have additional resources to maintain and increase capacity. Expenditure has increased significantly in 2020/21 and this has been met on a temporary basis by government on top of the NHS Long Term Plan settlement. The NHS settlement for 2021/22 has not yet been confirmed.

2.7 Staff costs

56. Staff costs are a significant proportion of the total expenditure of NHS providers which has been relatively stable over recent years. Around a quarter of the additional COVID-19 spending in the first half of 2020/21 related to staff costs.

Figure 6: Staff costs and other expenditure of NHS providers, 2015/16 to 2019/20

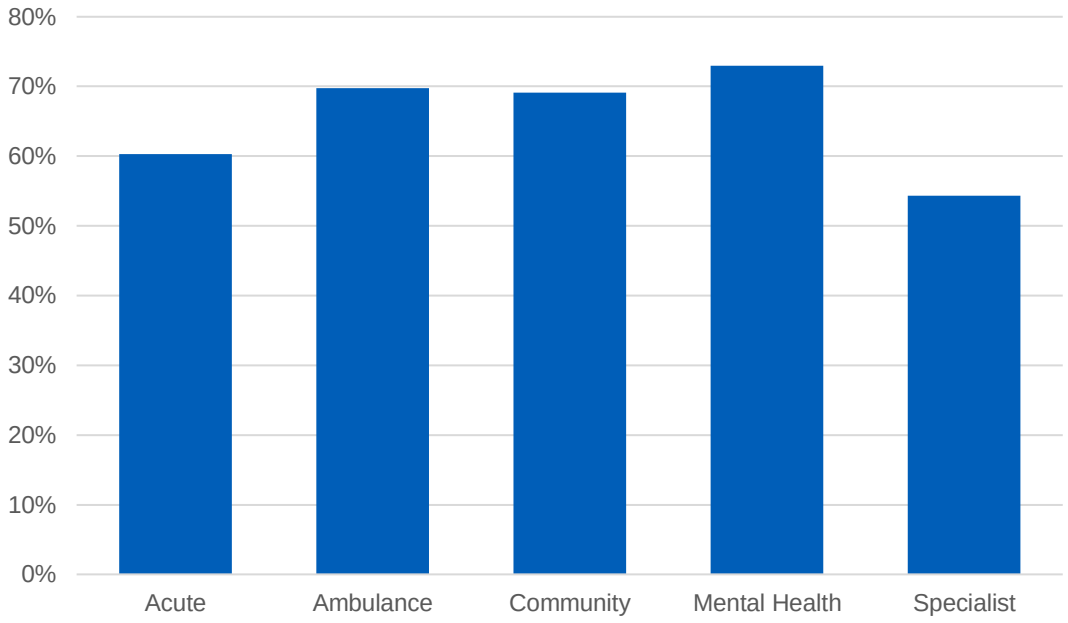


Source: Annual accounts.

[11] See: https://www.england.nhs.uk/wp-content/uploads/2020/09/C0768-finance-guidance-with-annex-3-added-23-september-2020-.pdf

57. Pay as a proportion of total expenditure depends on the type of provider as shown in Figure 7.[12]

Figure 7: Staff costs as a proportion of operating expenditure by provider type

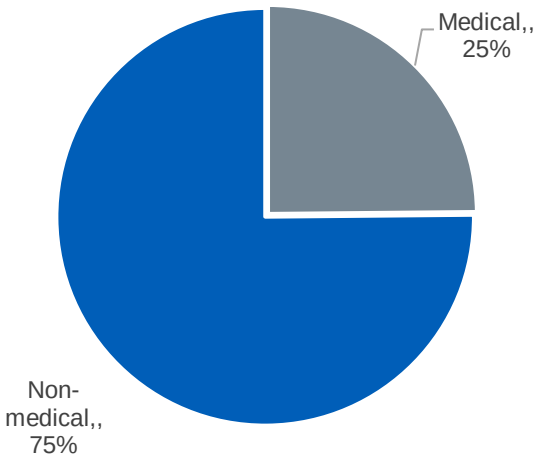


Source: Annual accounts

58. Non-medical and nursing staff account for three-quarters of staff costs. This compares to these staff representing 89% of whole-time equivalents (WTEs), according to annual financial accounts in 2018/19. The proportion of non-medical and nursing staff varies by provider type, with non-acute providers reporting more than 95%.

Figure 8: Breakdown of staff costs by group, 2019/20

Source: Annual accounts (non-medical includes the nursing workforce)

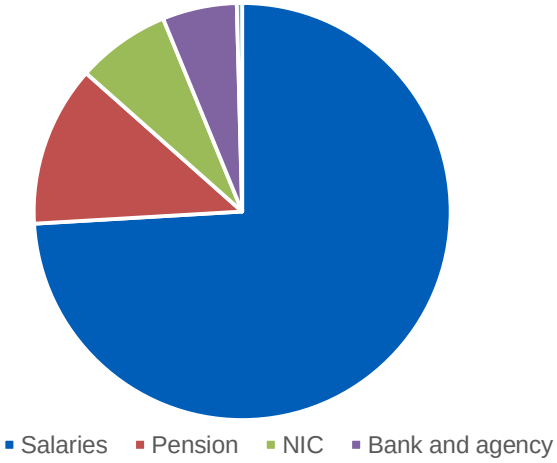


[12] Provider type does not account for a specific type of provider providing services outside that type, eg community or mental health services delivered by acute providers.

59. Around three-quarters of NHS provider staff costs relate to salaries. Employer national insurance contributions and pensions costs account for a further 20% of costs. These proportions do not change much by provider type, except for ambulance trusts which spend much less on agency and bank staff, so a higher proportion of their staff costs are on pay and on-costs.

Figure 9: Breakdown of staff costs, 2019/20

Source: Annual accounts



60. Salaries as a proportion of all staff costs vary by provider; range 65% to 83%. This is mostly driven by different proportions of spending on temporary staff.

61. In 2019/20, the NHS Pension Scheme employer contribution rate increased from 14.3% to 20.6%. The additional costs of this change are currently being met centrally by NHS England and NHS Improvement for employers receiving funding from NHS England and NHS Improvement budgets or from the NHS to deliver services. Additional funding was included in the NHS funding settlement and represents an investment to maintain current benefits from the scheme; it totals a little under £3 billion a year. Employee contributions remained unchanged.

62. Pay awards for some NHS staff groups are already committed to increase in 2021/22. Pay growth for most of the 39,000 doctors and dentists in training in England will increase by 2% (on top of 1% additional investment in other terms) in 2021/22. Some Agenda for Change (AfC) staff in bands 5, 6 and 7 (about 100,000 staff) will also move to a higher pay step in 2021/22, as part of the remaining implementation of the 2018 deal. A significant number of AfC staff earn below £24,000, for whom the Spending Review has committed to providing a £250 pay rise to (worth between 1.1% and 1.4% of their salary).

2.8 Workforce productivity and spend

63. Efficiency gains are partly operationalised through the efficiency factor in the National Tariff Payment System. Additional efficiency is also agreed by NHS providers in financial recovery plans.

64. Furthermore, NHS England and clinical commissioning groups are expected to have delivered around £3 billion a year of productivity and efficiency improvements in 2018/19 and 2019/20.[13] This is in addition to the provider efficiency delivered through the national NHS payments.

65. The pandemic response has naturally impacted on NHS costs and activity. New measures on social distancing and infection prevention and control place additional burdens on staff and capacity.

66. The NHS is also managing COVID-19's impact on increased sickness and other absences which has led to up to 50,000 staff off at the peak of COVID hospitalisations.

67. Nonetheless, NHS staff have responded superbly. Many have trained to support the acute COVID response. They are also leading innovations in digital technology, supporting people at home and advancing solutions that save clinical staff time.

68. The NHS People Plan 2020/21 describes how staff can be supported to work more productively.[14] This includes increasing flexibility and remote working, enabling teams to run virtual multidisciplinary team meetings, case presentations and handovers, and teaching sessions.

69. Further areas where we continue to support the NHS workforce to improve efficiency include:

- workforce deployment systems[15] – utilising e-rostering and e-job planning to facilitate better capacity and demand matching
- outpatients[16] – offering a streamlined digital pathway to support patients to manage their own conditions
- pathology and imaging[17] – transforming services by bringing together expertise to deliver better value and high quality care

[13] https://www.england.nhs.uk/wp-content/uploads/2019/10/financial-information-4th-quarter-2018-19.pdf and https://www.england.nhs.uk/wp-content/uploads/2017/06/financial-performance-report-q2-2019-20.pdf
[14] https://www.england.nhs.uk/wp-content/uploads/2020/07/We_Are_The_NHS_Action_For_All_Of_Us_FINAL_24_08_20.pdf
[15] https://www.england.nhs.uk/workforce-deployment-systems/
[16] https://www.england.nhs.uk/blog/transforming-outpatient-care/
[17] https://improvement.nhs.uk/resources/pathology-networks/ and https://improvement.nhs.uk/resources/transforming-imaging-services-in-england-a-national-strategy-for-imaging-networks/

- general practice[18] – improving access to GP services, including enough routine appointments at evenings and weekends

- electronic prescribing – supporting the rollout of electronic systems to make the most effective use of medicines

- medicines optimisation[19] – looking at the value medicines deliver, making sure they are clinically and cost-effective.

70. As part of the NHS People Promise – which sets out a commitment to improve the experience of working in the NHS for everyone. NHS staff should receive a fair salary rewarding and recognising their amazing contribution including during the COVID pandemic.

71. NHS staff receive several benefits in addition to base salary rises. Those benefits are tailored to specific staff groups, including the following:

- Increased employer pension contributions from 2019/20 to support the financial sustainability of future pension drawdown from the NHS Pension Scheme. This has seen employer contributions increase from 14.3% to 20.6%.

- In the case of recent contract reform for GPs and junior doctors, this has provided multi-year certainty around pay growth.

2.9 Temporary staffing: agency and bank

72. The NHS has made progress in improving the value for money gained from its agency spend in recent years. While a certain level of agency spend is healthy to ensure flexible staffing to meet fluctuations in demand, the People Plan includes further measures to improve the quality and value for money gained from temporary staffing, including action to ensure that all agency supply is via an approved procurement framework.

Agency staff

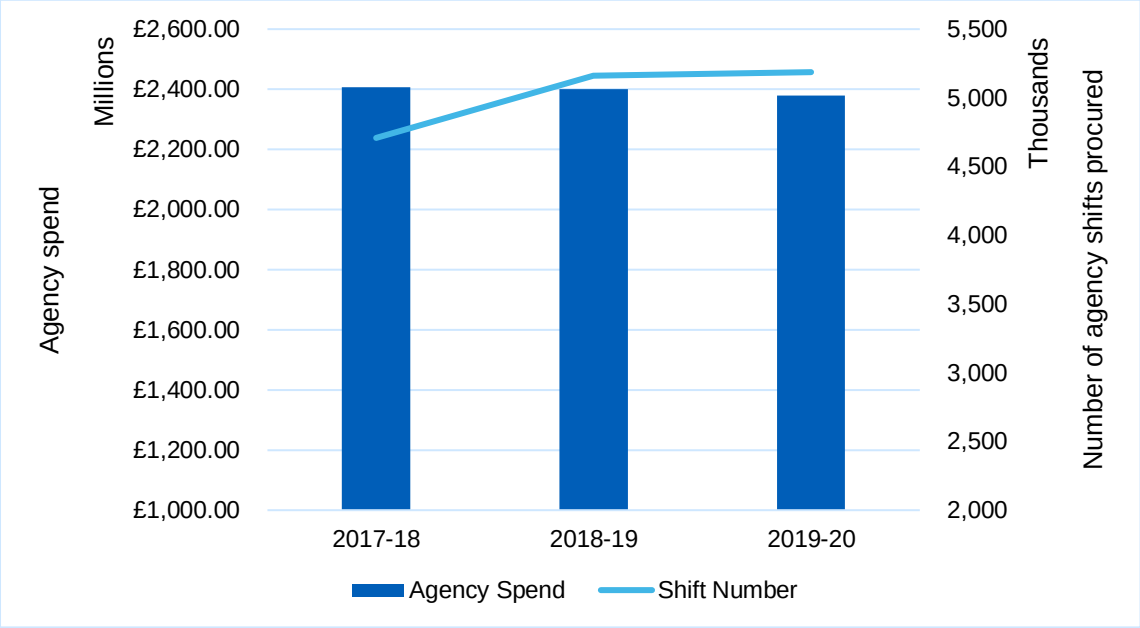
73. 'Agency rules' were first introduced in April 2016 to support trusts to reduce agency expenditure and move towards a more sustainable level of temporary staffing spend. Since then, trusts have successfully reduced agency spend by over £1.2 billion per year, with this reduced level of spend maintained over the last three years despite inflationary pressures and shift volume increasing by 10% between 2017/18 and 2019/20. There has been a significant reduction in agency spend as a proportion of the total NHS pay bill, from 8.2% at its peak in

[18] https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/
[19] https://www.england.nhs.uk/medicines-2/medicines-optimisation/

2015 to just 4.0% in 2019/20. The average cost of an agency shift procured has also fallen from an average of £511 in 2017/18 to £459 in 2019/20, with medical shifts falling from £910 to £849.

74. The proportion of agency shifts as a share of overall temporary staffing has fallen from 29% in December 2017 to 22% in August 2020, which reflects our strategy to procure more of the NHS's temporary staffing needs via staff banks.

Figure 10: Agency spend and volume of shifts



75. During the first five months of 2020/21 trusts have spent £0.91 billion on agency staff, which is 10% lower than the same period in 2019/20. Of this £0.91 billion, £0.36 billion related to medical and dental agency staff, down 9% on the same time last year. The percentage of medical agency staff paid in line with the price cap between April and August 2020 was roughly the same as the corresponding period last year.

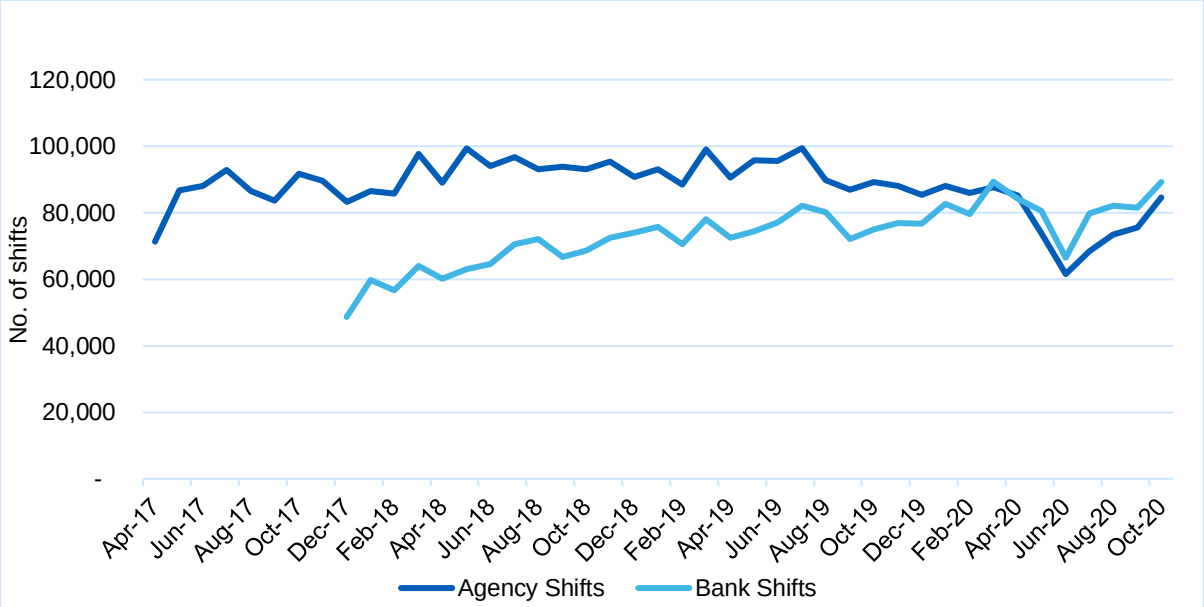
Bank staff

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

77. As mentioned above, the NHS's strategy around temporary staffing is based on further increasing bank usage compared to agency. The percentage of temporary staffing spend through banks has risen from 60% at Month 5 in 2019/20 to 65% at Month 5 in 2020/21, reflecting a rise in this period of the percentage of overall temporary shifts procured through staff banks.

78. For the first time since measurement began there were more medical bank shifts worked than agency in the first part of this financial year, which demonstrates that the 'bank first' strategy is taking effect.

Figure 11: Medical and dental temporary shift numbers 2017-20



79. The bank pilots that were run during 2019 tested out certain methods of running collaborative banks and were successful in improving a number of measures of bank performance in the areas where they ran. This learning is being taken forward in a national programme on improving staff banks.

People Plan 2020/21 commitments

80. The People Plan 2020/21 includes specific commitments to:

- **Reduce the percentage of agency shifts that are procured off-framework**
- **Increase the proportion of temporary staff shifts delivered through staff banks**.
- **Increase the number of staff signed up to banks**.

3. Consultants

81. Consultants are a vital component of the medical workforce. They oversee treatment of the most complex patients. Their particular expertise includes being able to assess undifferentiated patients who have multiple morbidities and guide them onto an appropriate pathway of care.

82. Consultants' unique and valuable contribution to patient care is reflected in the standard that must be achieved to gain specialist registration and the requirement to demonstrate continuing learning and competence to maintain a licence to practise.

83. Consultants also 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.

84. Given the length of training and the resources that go into the development of consultants, we must support them to perform the work that only they can deliver, and to continue to do this throughout their career.

85. We must also ensure there are sufficient numbers of consultants now and in the future to continue to deliver high quality patient care, while also providing the educational and supervision capacity required to train our doctors of the future.

86. There continues to be net growth in consultant numbers and we are supporting retention of consultants by encouraging and supporting employers to offer their staff greater work flexibility; and, more broadly, through our retention programme, which aims to improve staff experience for all staff groups, including addressing issues experienced by doctors.

3.1 Overview

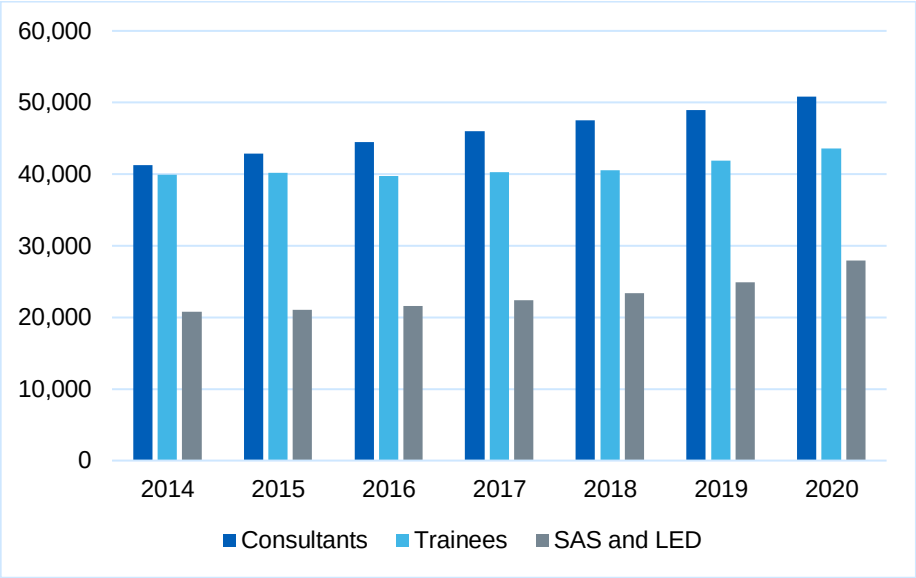
87. There are around 180,000 doctors (headcount) working in the UK. Of these, around 79,000 are doctors working in hospital or community services, not including trainees – of whom nearly 51,000 are consultants – and nearly 28,000 are doctors working in primary care (excluding trainees).[20]

88. The consultant workforce has accompanied the general growth in the aggregate medical workforce (Figure 12). Between March 2014 and March

[20] Data source: Health Education England.

2020, the total number of consultants (FTE) increased from 41,242 to 50,821, an average annual increase of 3.5%.

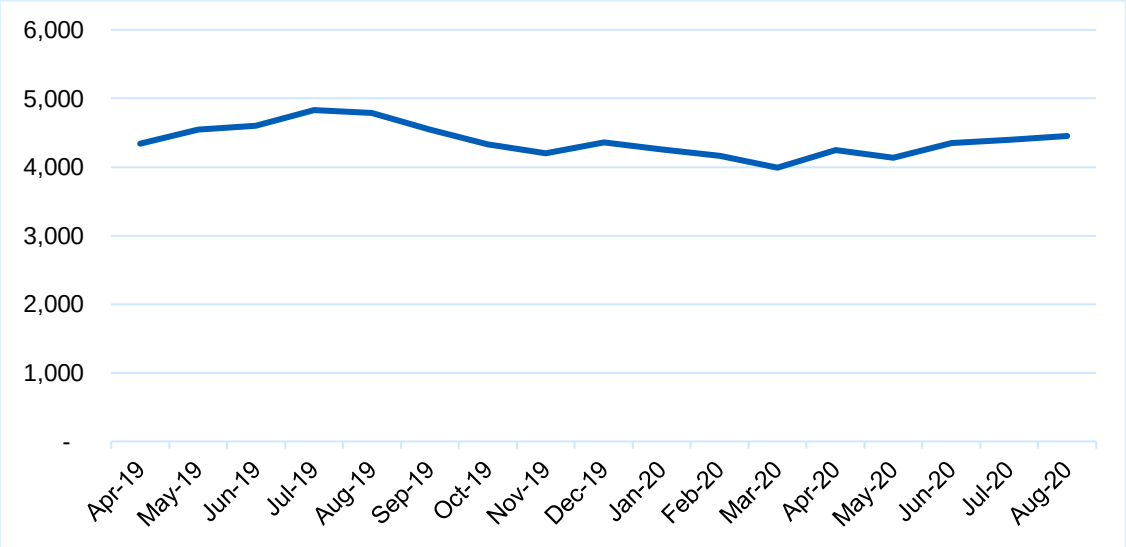
Figure 12: Workforce growth across medical grades (FTE) over time



Source: Health Education England, 2020

89. Between April 2019 and August 2020 consultant vacancies remained relatively stable, albeit with seasonal fluctuations (Figure 13).

Figure 13: Consultant vacancies (FTE)

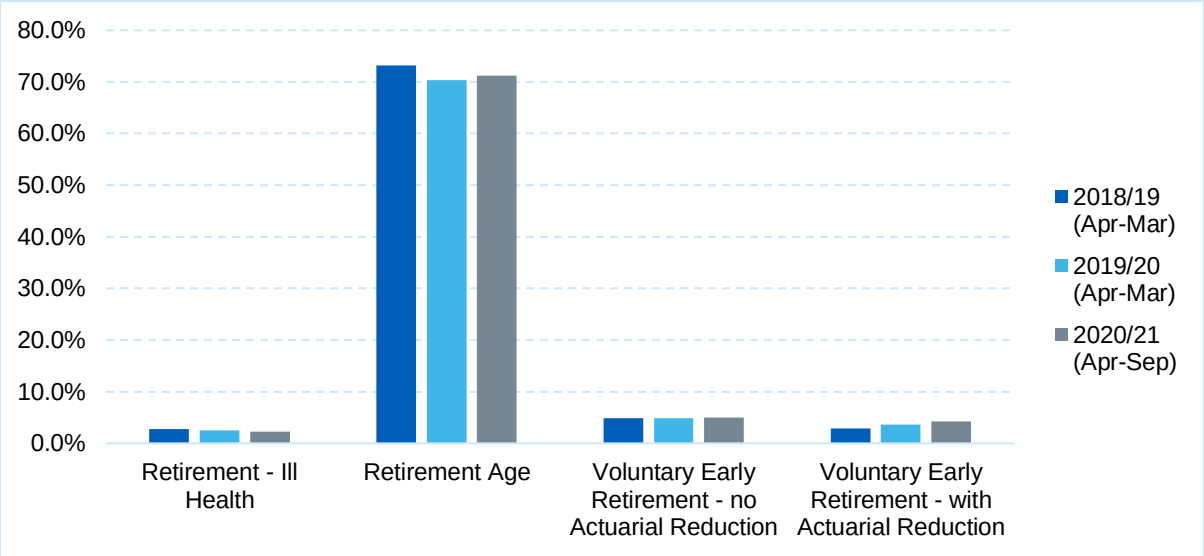


Source: NHS England and NHS Improvement, NHS provider returns

90. In 2020, 37% of the consultant workforce was female and around 22% of consultants were 55 years old or older.[21]

91. Among those who retired, most did so because they reached retirement age,[22] with around 17% of doctors retiring and returning with flexible arrangements (eg working fewer days, stepping down into a less demanding role, working flexible days as part of a staff bank). Around 9% of consultants chose to retire early (Figure 14).

Figure 14: Consultant retirement: reasons for leaving



Source: ESR, September 2020[23]

92. In recent years the proportion of consultants leaving due to 'retirement age' has fallen slowly and flexi-retirement has increased. This reflects changes in the pension scheme eligibilities over time. In 2020 retirement numbers are also likely to be lower as a result of COVID-19, as some consultants delayed their retirement to support the NHS with the response to the pandemic.

93. Although the consultant workforce continues to grow at a steady rate, there are still supply shortages across specialties and in certain geographies, as well as wider challenges and concerns from doctors in specific areas.

[21] Source: Health Education England.
[22] 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.
[23] Although this data provides a useful measure of why individuals leave the service, there is no consensus among analysts that this represents a 'full picture' of staff retirement in the NHS.

3.2 Key challenges

94. The continued growth in numbers of consultants over the last few years suggests the grade continues to appeal to doctors in training as a career option.

95. However, there is a set of specific challenges in maintaining sufficient consultant numbers, including geographical distribution, retention and morale.

Geographical and specialty distribution

96. Before the COVID-19 pandemic there were already workforce supply challenges in some specialties, in particular in specialties such as emergency medicine, psychiatry, clinical radiology[24] and geriatric medicine.

97. In addition to variation in numbers and fill rates across specialties, there is also variation in geographical distribution of the medical workforce and in the ratio of consultant physicians to population. Some of this will be due to differences in clinical need.

98. The Distribution of Specialty Training Posts in England Programme Board, led by HEE, was established in 2019 to begin to address medical distribution issues, as articulated in the NHS Long Term Plan and in the Interim People Plan. The Programme Board set out to review and achieve a more equitable distribution of post-foundation medical training posts in England to:

    - better align workforce supply with local population health needs

    - influence the geographical distribution of the future consultant workforce (as evidence indicates postgraduate medical trainees are likely to remain in the geographical area where they complete specialist training).

Consultant retention

99. The pandemic has both created mounting urgent pressures on services and a backlog of non-COVID patient care, which created and compounded workload pressures for doctors at all stages of their training and career.

100. The People Plan 2020/21 describes ways in which consultants and other staff can be supported by their employers to maintain and enhance their health and

[24] RCR (2020). *Clinical radiology UK workforce census 2019 report*. Clinical radiology UK workforce census 2019 report (rcr.ac.uk)

wellbeing, leading to better staff morale and retention, and improving the quality of patient care.

101. One of these interventions is offering consultants more flexible job roles, to keep consultants in the workforce for longer. This can include, for example, making reasonable adjustments for older consultants who may need them, through flexible working hours, reducing participation in on-calls/night shifts or opportunities to refocus on specific aspects of the job.

102. Consideration of team job planning, annualised contracts, effective use of e-job plans and e-rostering, and opportunities for career breaks are also designed to provide flexible career options and support retention.

103. A systematic approach to career development conversations with consultants may support more of a portfolio approach that enables consultants at different stages of their professional life to focus on areas other than clinical care, such as teaching and training, management, research or audit. This approach ensures consultants can continue to develop and learn, work flexibly and enjoy a diverse career, and it may reduce burnout and enable the NHS to retain these experienced professionals in the workforce.

3.3 Consultants and the response to COVID-19

104. Consultants are among the staff groups in the NHS that have been particularly affected by the pandemic. In this section we describe some of these impacts.

Workforce numbers

105. At the start of the pandemic, the GMC created a temporary emergency register (TER) and brought onto it (on an opt-out basis) all the doctors who had relinquished their registration in the previous three years.

106. A number of medics – including former doctors who retired and final-year medical students – offered to return to the NHS to support with the COVID-19 response through our national workforce cell.

107. As at 25 January 2021, around 2,400 medics (including medical support workers) were ready to deploy, deployed or employed – the majority in support of national programmes and acute services.

Ways of working

108. Remote working and increased use of technology was one of the areas that saw rapid acceleration in response to the COVID-19 epidemic. Many consultants who were unable to work face-to-face with patients due to their own (or family members') medical conditions could work from home doing virtual

outpatient clinics, multidisciplinary team meetings or reporting images. The GMC's barometer survey 2020 showed 41% of respondents thought the pandemic had a positive impact on their ability to provide consultations or clinics remotely.[25]

109. The potential to continue some of this work in the long term might attract some doctors who would otherwise feel unable or unwilling to work in an acute hospital setting. Remote working, especially on a networked basis, may also help deal with some of the geographic shortages of consultants. It could also help with the introduction of community diagnostic hubs, as set out in Sir Mike Richards' Review of Diagnostic Services.

110. Doctors also reported a positive impact of the pandemic in other areas, including teamwork between doctors (62% of respondents), speed of implementing change (49%) and teamwork across the multidisciplinary team (48%).[26]

111. Some consultants have expressed concern about the perceived burden associated with preparing for their annual appraisal. During the early phase of the pandemic, the GMC allowed a delay in the timing of doctors' revalidation recommendations. At the same time NHS England modified the required content of doctors' appraisal written content to reduce the associated burden[27]. The modified 'Appraisal 2020' for doctors is designed to focus on individual doctors' wellbeing.

3.4 Remuneration and total reward

112. An important part of improving the experience of working in the NHS for everyone is to ensure people are recognised and rewarded, as described in Our NHS People Promise. As part of a broad NHS total reward package for staff – including employee assistance programmes, annual leave, parental leave – this includes ensuring staff have a fair salary, competitive pension and an attractive package of benefits, and that they feel supported to work to the top of their licence and have fulfilling and engaging careers in the NHS.

113. According to the 2019 NHS Staff Survey, 54.8% of all medical and dental respondents were satisfied or very satisfied with their level of pay. This level of satisfaction was highest among consultants (62.6%) in comparison to doctors in training (45.9%) and salaried primary care dentists (44.9%).

[25] GMC (2020) The state of medical education and practice. https://www.gmc-uk.org/-/media/documents/somep-2020_pdf-84684244.pdf
[26] GMC (2020) *The state of medical education and practice*. https://www.gmc-uk.org/-/media/documents/somep-2020_pdf-84684244.pdf
[27] NHS England and NHS Improvement (2020). COVID-19 and professional standards activities. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/09/C0757-restarting-appraisals-letter-2-sep-2020.pdf

114. Consultants are the highest-earning professionals in the NHS, which reflects the level of experience, skills and responsibility expected of them. However, there is a set of pay-related issues for this group of doctors.

Pensions taxation

115. The impact of pensions taxation annual and lifetime allowance (which limits the amount of pension savings that benefit from tax relief) charges on senior clinicians has been identified as an issue for retention and workforce supply among this group.

116. These have been an issue for consultants in recent years and have led some consultants to stop taking on additional sessions for their employer – which many services rely on to cover clinical rotas – and, in some cases, to take early retirement.[28]

117. In November 2019, we announced an exceptional single-year 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. The government additionally changed pension tax rules, taking effect for the 2020/21 tax year, to ensure that NHS staff whose income is less than £200,000 can work additional hours for the NHS without their annual allowance being reduced.

118. Temporary measures introduced in 2019/20 had a positive impact on the number of hours worked, and specifically additional sessions for the highest earners.

119. The People Plan 2020/21 sets out specific actions for employers to communicate recent pension taxation changes to their staff, including signposting to financial advice, to give senior clinicians confidence that they can take on additional work and leadership opportunities without incurring additional pension tax.

Gender pay gap in medicine

120. The recent report of the Gender Pay Gap in Medicine review exposes a significant gender pay gap for consultants. The review sets out some of the underlying reasons for pay disparities between men and women makes recommendations to address these.

121. The review identified that the gender pay gap between men and women in medicine is 24.4% for hospital doctors, 33.5% for GPs and 21.4% for clinical academics. However, among hospital doctors, gaps in total pay – including

[28] BMA (2020) *Consultant workforce shortages and solutions: now and in the future*. bma-consultant-workforce-shortages-and-solutions-oct-2020.pdf

clinical excellence awards, allowances and money from additional work – are larger than gaps in basic pay alone.

122. National partners are taking collective action to narrow the gender pay gap, including through SAS contract reform and through potential reform of the national and local clinical excellence award schemes, although the impact is likely to take some time to feed through.

123. We will work with DHSC and other national partners to take action to address the review's recommendations and the pay gap.

National clinical excellence awards

124. National clinical excellence awards (CEAs) are financial awards available to consultants, dentists and academic GPs via an annual competition.

125. We recognise the value and potential of these awards in acknowledging doctors' outstanding work and contributions. We support introducing changes to modernise the scheme, to ensure it reflects the medical workforce demography, addresses recommendations from the Gender Pay Gap in Medicine review, and overcomes any inequities in access to and allocation of awards among eligible doctors.

126. We are keen that reform of national CEAs:

- widens access to the awards from all eligible doctors
- ensures this investment is used in the most effective way to achieve benefits for individuals and the service
- recognises and rewards outstanding achievements, including work that contributes to delivering national priorities
- reflects the changing context in which doctors operate as part of the wider workforce.

Local clinical excellence awards

127. In 2018 an 'interim deal' was agreed between the government and trade unions for local CEAs for 2018-21, giving doctors a contractual right to apply for local awards each year and setting an annual minimum investment level for employers to meet.

128. We are taking part in negotiations with NHS Employers and the BMA to explore changes to local CEA arrangements as part of a potential future reformed successor scheme.

129. We are keen that the local CEA scheme is fit for purpose, rewards doctors in a fair and equitable way, and is accessible by all eligible doctors. Awards should recognise outstanding performance and contributions from individuals; incentivise new ways of working in line with the Long Term Plan and the People Plan; and support delivery of organisational goals and local priorities.

Remuneration and affordability

130. Several factors are important when assessing the remuneration of consultants, including considering salary and the wider range of additional benefits and earnings they may receive.

131. Headline consultant salary scale growth between 2015/16 and 2020/21, as implemented in response to previous DDRB reports, has averaged 1.8% a year.[29] This compares to 1.7% growth in the top pay points for AfC pay over the same period.[30] ONS data on earnings (between 2015/16 and 2019/20), which includes more than salaries, suggests that average annual growth was 1.2% for public sector workers and 3.2% for private sector workers.[31] Inflation (between April 2015 and September 2020) has grown by around 1.8% on average each year.[32]

[29] https://www.nhsemployers.org/pay-pensions-and-reward/medical-staff/pay-circulars
[30] https://www.nhsemployers.org/pay-pensions-and-reward/agenda-for-change/pay-and-conditions-circulars/archived-pay-and-conditions-circulars/agenda-for-change-pay-and-conditions-circulars-2017-2012
[31] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/publicandprivatesectorashetable13
[32] https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation

4. SAS doctors

4.1 Overview

132. There are just under an estimated 10,000 specialty and associate specialist (SAS) doctors in the NHS workforce. The number of SAS doctors has remained relatively stable over time.[33]

133. This workforce group is heterogenous and includes:

- doctors who have completed specialty training and are seeking a consultant post
- doctors who have completed specialty training and chosen, either for the time being or permanently, to work in SAS roles
- doctors who have 'stepped off' training, with the intention of returning at some future point
- doctors recruited from overseas into SAS roles – as of March 2020 just under half of SAS doctors had gained their primary medical qualification outside the UK.[34]

134. SAS doctors are an essential group in the current workforce model and are vital to delivering services. Anecdotal evidence suggests this is particularly true in smaller trusts and hard-to-recruit-to areas. One of the reasons for this is that employers often create SAS posts in response to a shortfall of trainees, consultants or both.[35]

135. As of March 2020, the majority of SAS doctors (80%) were employed on permanent contacts.[36]

[33] Health Education England.
[34] Data source: Health Education England.
[35] Health Education England.
[36] Data source: Health Education England.

4.2 SAS contract reform

136. In 2019 the government's response to DDRB recommendations committed to negotiations on a multi-year pay agreement for SAS doctors, including contract reform for SAS grades to begin in 2020/21.

137. Overall, this contract reform aims to:

- ensure fair remuneration and improved opportunities for career development and progression for SAS doctors and dentists, to improve morale, recognition, recruitment and retention of this group and establish SAS roles as a genuine alternative career pathway to becoming a consultant or a GP

- modernise SAS contracts to offer an additional pathway for a career in medicine, with opportunities for flexible career progression outside of standard routes and comparable roles for doctors moving in and out of training, therefore reducing training attrition.

138. The NHS Long Term Plan, the Interim People Plan and the People Plan 2020/21 outline challenges for the medical workforce and set out commitments to address these, deliver a 21st century care workforce and help our clinical professions have fulfilling careers. One of these commitments was to make SAS roles a more attractive career choice for doctors who may not wish to become consultants or GPs.

139. The aims of SAS contract reform are in line with broader strategic aims for the medical workforce, which include valuing and recognising our workforce and their skills and experience; increasing flexibility and opportunities for progression over medical training and career; and addressing known pay inequities.

140. This contract reform is being negotiated across England, Wales and Northern Ireland. We have been taking part in the negotiations since January 2020, with other national partners.

141. A contract deal has been agreed between negotiating parties, in advance of reformed SAS contracts being introduced from April 2021.

5. Salaried GPs

5.1 Scope

142. 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 medical practitioner (GP) net income for the duration of the five-year deal, including, therefore, 2021/22.

143. However, the government asked DDRB to include recommendations on salaried GPs in its remit for 2020/21 onwards. This is discussed further in Section 5.7.

5.2 Introduction

144. While hospital consultant FTE numbers[37] are up 19.5% over the past six years, qualified permanent GP FTE numbers[38] – ie excluding registrars and locums – have risen by 2.9% since September 2015, with an overall headcount increase of 13.6% (see Table 1 below).

145. This indicates a relatively bigger workforce challenge for GPs, particularly in retention and increasing participation. To meet this challenge, the government's goal is to recruit a further 6,000 doctors in general practice and a further 26,000 staff from wider professional groups.

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

147. According to NHS Digital's latest figures, as at 31 March 2020[39] there were 1,794 Personal Medical Services (PMS) arrangements (25.6% of all contracts) and 7,409 (28.1%) FTE GPs operating within these locally agreed contracts. Any uplifts in investment for PMS contracts are a matter for local commissioners to consider. We are committed to ensuring an equitable funding approach for primary medical care contracts, and our local offices have undertaken reviews of all PMS contracts.

[37] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/june-2020
[38] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-september-2020
[39] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2019-20

148. In addition, a small number of GPs (290 FTE) work under, or hold, contracts under a locally contracted Alternative Provider Medical Services (APMS) arrangement across some 180 practices.

5.3 Statistical publications and data comparisons

149. NHS Digital publishes official statistics on the general practice workforce, which we compare with data from other sources – such as the National Performers List – to explore its limitations. The data is published quarterly (monthly from October 2020) with a time series showing the changes from September 2015.

150. Changes to the GP workforce between September 2018 and September 2020 are shown in Table 1. We have chosen to use the September 2018 figures as earlier data is not directly comparable due to changes in locum recording; see the NHS Digital data quality report for more details.

Table 1: Number of GPs compared to September 2015

Number of GPs	September 2018	September 2020	Increase/ (decrease)	Percentage change
Headcount – all	44,378	46,821	2,443	5.5%
Headcount – salaried	12,236	14,257	2,021	16.5%
FTE – all	34,534	35,434	900	2.6%
FTE – salaried	8,065	9,126	1061	13.2%

151. Table 1 shows that, at September 2020, in headcount terms, there were 46,821 doctors working in general practice, taking GP partners, salaried GPs, GP registrars, GP retainers and GP locums together – an increase of 2,443 (5.5%) since September 2018. In FTE terms, there were an estimated 35,434 GPs, an increase of 900 (2.6%) since September 2015.

5.4 Recruitment, retention and motivation

Impact of COVID-19

152. We recognise that our frontline primary care colleagues involved in the delivery of primary care services – both clinical and non-clinical – are facing unprecedented challenges through the ongoing pandemic. Practices and primary care networks (PCNs) have had to rapidly develop new ways of working and delivering care – including delivering remote total triage and more

online appointments. It means a focus on retention and support is more vital now than ever.

153. The COVID-19 Support Fund was announced on 4 August 2020 to assist with the legitimate additional costs of the response borne by GP practices.[40] It covered specific and net additional costs incurred for bank holiday opening over Easter and on 8 May. Practices were also be able to claim for the additional costs incurred in delivering additional services to care homes, following our letter of 1 May 2020.

154. The COVID-19 Support Fund also covered the cost of clinical and non-clinical sickness cover where practices offered full pay to staff absent for COVID-19 related reasons.

155. The new General Practice COVID-19 Capacity Expansion Fund was announced on 9 November 2020: £150 million of revenue has been allocated to expand general practice capacity until the end of March 2021. Systems are encouraged to use the fund to stimulate the creation of additional salaried GP roles that are attractive to practices and locums alike. The fund can also be used to employ staff returning to help with COVID-19, or to increase the time commitment of existing salaried staff.

156. Financial support of up to £120,000 per ICS/STP (in addition to the £150 million) is also available to support the implementation and running costs of flexible pools of employed GPs.

157. In addition, the #lookingafteryoutoo offer of coaching support for primary care staff has been introduced, and the Practitioner Health Service continues to provide support to GPs.

158. Work continues on wider targeted efforts to retain GPs in the workforce, with a specific focus on returning GPs and implementation of the enhanced package of GP recruitment and retention initiatives in Investment and evolution: updates to the GP Contract 2020/21 to 2023/24. This includes:

- new two-year fellowships to help newly qualified GPs transition into independent practice
- an improved process for GPs to return to practice, including childcare support (beyond emergency period)

[40] Further details on eligible costs available at https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0651-COVID-support-fund-letter-aug-2020.pdf.

- continuing offer of the GP retention scheme for GPs whose personal circumstances prevent them from undertaking a regular part-time role
- support for GPs to train as mentors for newly qualified GPs
- increased local flexible working opportunities (eg portfolio contracts, remote working)
- a New to Partnership Payment scheme to encourage more GPs into partnership positions.

Training new GPs

159. Increasing the number of GP specialty training places is key to creating sustainable growth in the GP workforce, alongside reform of the training programme to distribute the trainee workforce more fairly and ensure they spend more time in the general practice setting.

160. More new GPs are now being trained than ever before. In 2019, 3,540 doctors entered GP specialty training against a target of 3,250. In 2020, 3,793 doctors accepted training offers against a target of 3,500. To create further capacity in the workforce, an additional 4,000 training places have been advertised for 2021 recruitment.

161. Out of their three-year training programme, GP registrars currently spend half their time – or 18 months – working in a hospital setting. The proportion of time that GP registrars spend in general practice during their training will increase from the current 18 months to 24 months from 2022.

162. The Targeted Enhanced Recruitment Scheme has been expanded in parallel to encourage more of these trainees into under-doctored areas, with 500 places now advertised for 2020/21.

163. On qualification, the two-year GP Fellowship Programme now offers further support to newly qualified GPs to help them become independent practitioners. To support local planning, current GP registrars will be auto-enrolled into local opportunities from 2021, with the opportunity to opt out.

Recruitment and retention programmes

164. We continue to support local systems to implement the expanded GP recruitment and retention offer and promote available support through our networks. The pandemic has affected recruitment, in some areas more than others. To support the development of local opportunities, funding continues to be made available to systems through the Local GP Retention Fund.

165. Practices and PCNs are encouraged to consider how they can promote and encourage take-up of available support among their teams. This includes the Supporting Mentors Scheme for experienced GPs, which offers an opportunity for experienced GPs to take on a more varied role as a mentor for the younger GP workforce. GPs are provided with funded training, leading to a recognised mentoring qualification and can then be reimbursed to conduct one session of mentoring a week. This scheme is being delivered locally and, it is hoped, will provide much valued support during the pandemic.

166. GPs for whom local opportunities are not yet available or who have greater support needs, can apply to the national GP Retention Scheme. This is for GPs whose personal circumstances prevent them from undertaking a regular part-time role. The scheme provides a package of financial and educational support to doctors who may otherwise leave general practice. As at September 2020, 576 GPs were being supported through this scheme (393 additional doctors on the scheme since its relaunch in 2017).

167. In July 2020, we launched a New to Partnership scheme to encourage and support more registered healthcare professionals into partnership opportunities, with a key aim of encouraging more younger GPs into partnership. Through the scheme, new partners can access up to £20,000 (pro rata, plus on-costs) to support them in their new role, as well as up to £3,000 in a training fund to develop their non-clinical partnership skills. It is open to all GPs (and other healthcare professionals) who have not been a partner before in England and can commit to remaining in the role for a minimum of five years (or repay a proportion of the loan).

168. Many GPs have returned to practice through emergency powers to support the emergency effort. A proportion of these GPs have signalled a desire to stay longer term but to work in a different way. Increased flexibility and remote working means that roles can fit around other commitments in a way we could not previously have achieved. We are working with GP clinical leaders, HEE and regions to retain as many of these GPs as possible.

169. Beyond the emergency period, many GPs who have left practice for a variety of reasons will also want to return. This will include GPs who have taken time out of practice to raise their family, for example, or to have a career break. Recognising that this can be a daunting process, the Return to Practice Scheme provides a package of educational and financial support for returning GPs. From July 2020, GPs can now additionally claim up to £2,000 towards the costs of caring for children or family members while they complete the placements necessary to return to work.

5.5 Salaried GPs

170. The salaried GP headcount has increased by 3,974 (38.6%) from 10,283 to 14,257 from September 2015 to September 2020. Similarly, salaried GP FTEs

have increased by 2,259 (32.9%) from 6,867 to 9,126 over the same period. That represents a participation rate of 64% in September 2020 (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%	481	4.7%	10,283
Sept 2016	2,942	26.7%	7,825	70.9%	266	2.4%	11,029
Sept 2017	3,072	26.8%	8,255	72.0%	141	1.2%	11,465
Sept 2018	3,257	26.6%	8,714	71.2%	268	2.2%	12,236
Sept 2019	3,531	27.0%	9,396	71.9%	155	1.2%	13,076
Sept 2020	3,928	27.6%	10,208	71.6%	127	0.9%	14,257

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%	312	4.5%	6,867
Sept 2016	2,214	30.0%	4,989	67.6%	172	2.3%	7,375
Sept 2017	2,303	30.2%	5,242	68.7%	90	1.2%	7,635
Sept 2018	2,395	29.7%	5,499	68.2%	171	2.1%	8,065
Sept 2019	2,546	30.1%	5,825	68.8%	98	1.2%	8,469
Sept 2020	2,783	30.5%	6,262	68.6%	80	0.9%	9,126

GP practice staff

171. Headcount numbers of practice staff – including GPs – continued to increase between September 2015 and September 2020, with total practice staff numbers increasing by 15,112 to 187,813 (8.8%). See Table 4 below.

172. An increasing number of health professionals are working alongside GPs and play a vital role in delivering high quality, safe and effective care for patients. The new five-year GP contract will invest up to around £3.4 billion by 2023/24

to recruit 26,000 more health professionals to work within PCNs under the Additional Roles Reimbursement Scheme.

173. Practices are reimbursed 100% of actual salary costs plus employer on-costs (up to the maximum levels set out in the scheme). Support for staff recruitment and deployment is available from clinical commissioning groups and other community services partners; the PCN development funding for 2020/21 will enable support for staff induction and retention.

174. The overall increase in clinical (non-GP) staff FTE between September 2015 and September 2020 was 5,105 to 31,229 (19.5%) and over the same period, the number of patients per FTE clinical (non-GP) staff fell from 2,178 to 1,934 (-11.2%). See table 5 below.

Table 4: Practice staff numbers (headcount)

	September 2015	September 2020	Increase/ (decrease)	Percentage change
Total GPs (headcount)	41,230	46,821	5,591	7.2%
Total nurses and other direct patient care staff (headcount)	39,908	44,912	5,004	12.5%
Total admin/non-clinical (headcount)	91,932	96,454	4,522	4.9%
Total practice staff excluding GPs (headcount)	131,498	141,031	9,533	7.2%
Total GPs and practice staff (headcount)	172,701	187,813	15,112	8.8%

Table 5: Practice staff numbers (FTE)

	September 2015	September 2020	Increase/ (decrease)	Percentage change
Total GPs (FTE)	34,429	35,434	1,006	2.9%
Total nurses and other direct patient care staff (FTE)	26,124	31,229	5,105	19.5%
Total admin/non-clinical (FTE)	63,069	68,645	5,577	8.8%
Total practice staff excluding GPs (FTE)	89,193	99,875	10,682	12.0%

Total GPs and practice staff (FTE)	123,621	135,309	11,688	9.5%

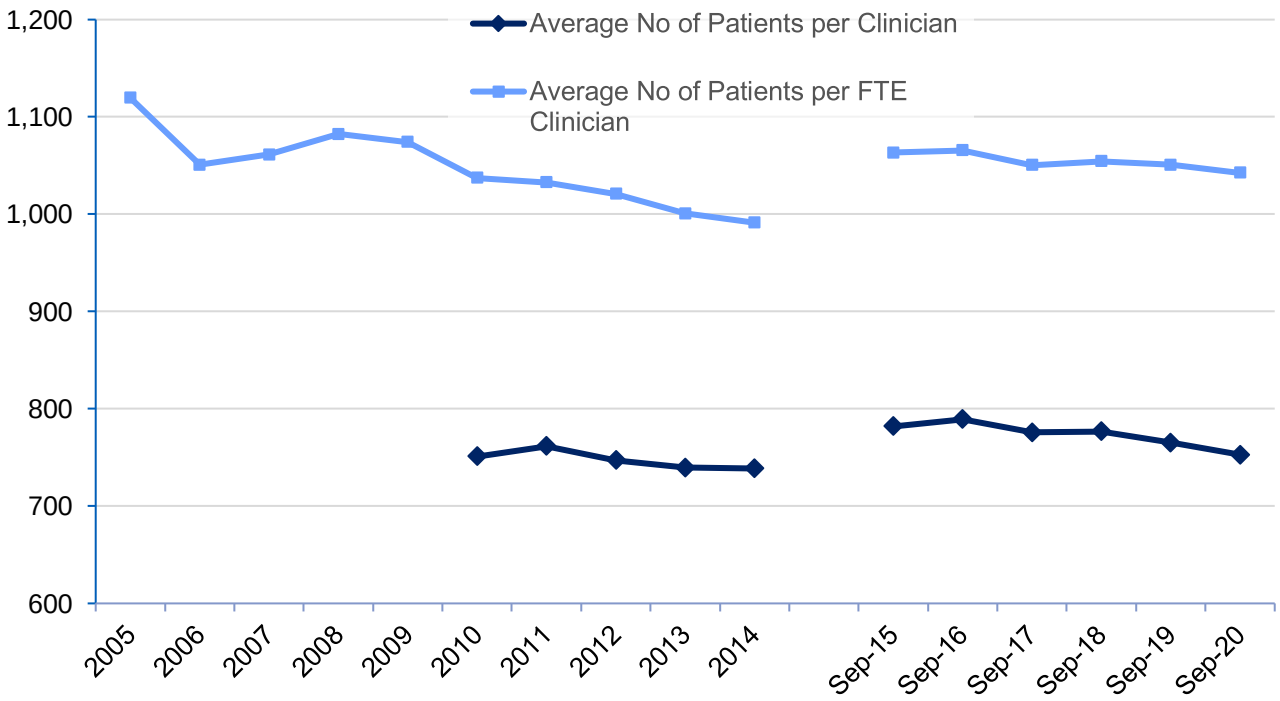
5.6 Workload of GPs

Patients per practitioner and the changing skill mix in general practice

175. The average number of patients per FTE clinician (excluding registrars and locums) in England fell from 1,063 in 2015 to 1,042 (a decrease of 0.13%) at September 2020. The skill mix in general practice has also changed significantly over that period as practices have on average increased the proportion of other clinical practice staff compared with GPs.

176. The graph in Figure 15 below shows the trend in the number of patients per practice FTE clinician. The data in Figure 15 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 15.

Figure 15: Average number of patients per FTE clinician and per clinician



177. The number of patients per practice has risen from 6,250 in 2005 to 9,081 at September 2020. Over the same period, the number of practices has

decreased from 8,451 to 6,650, 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 5.0% at September 2020.

178. Taken together, the total number of primary care staff (GPs and practice staff) was 172,701 in 2015, which increased by 15,112 or 8.8% to 187,813 (headcount) at September 2020. The average number of patients per practice staff (headcount) fell from 349 in 2015 to 321 in 2020 (a decrease of 8%).

179. 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.

GP experience

180. The GMC's report, *State of medical education and practice in the UK 2020*,[41] showed that in 2019, 9% of UK GPs surveyed were 'managing' their workload; in 2020, this is 35%. There has been a decrease in the proportion of doctors 'struggling'; in 2020, this is 26% of GPs, rather than 50% in 2019. The GMC's caveat is that this is likely to be temporary as it was based on feedback in the early stage in the pandemic.

181. A feasibility study has been commissioned to consider extending the NHS Staff Survey to primary care.

Trends in the earnings and expenses of salaried GPs

182. The average net earnings for salaried GPs in England in 2018/19 (latest available data) was £60,600 for those working in either a GMS or PMS (GPMS) practice compared to £58,400 in 2017/18, an increase of 3.8%, which is statistically significant.

183. Table 6 below shows trends in gross earning, expense and net earnings for salaried GPs and the ratio of their expenses to gross earnings.

Table 6: 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%

[41] https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

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%
2018/19	70,100	9,400	60,600	13%

5.7 Remuneration

GP contract

184. The NHS Long Term Plan announced that funding for primary medical and community services will increase by £4.5 billion in real terms from 2019/20 to 2023/24 and rise as a share of the overall NHS budget. NHS England and the BMA's General Practitioners Committee (GPC) agreed a five-year funding settlement from 2019/20 to give clarity and certainty to practices.

185. Funding for the practice contract will increase by £998 million between 2019/20 and 2023/24. Accordingly, no recommendation is being sought from DDRB for independent contractor GP net income for the duration of the five-year deal, including, therefore, 2021/22.

186. As part of the five-year GP contact framework, we announced that up to £2.355 billion per year will flow nationally through the Network Contract Direct Enhanced Service and Investment and Impact Fund by 2023/24.

187. Beyond contract funding, investment worth hundreds of millions of pounds continues to be made in national programmes benefiting general practice such as the mental health support programme for GPs.

Salaried GPs

188. Under the agreement, NHSE and the GPC agreed that practice staff, including salaried GPs, in England would receive at least a 2.0% increase in 2020/21 – and that the DDRB recommendation for practices to uplift salaried GP pay by 2.8% could be adopted if they chose to. The minimum and maximum pay range for salaried GPs was uplifted by 2.8% accordingly, as was the pay for GP educators and trainers.

189. In 2020, 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.

190. We 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.

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

6. Dental practitioners

6.1 Introduction

192. This chapter provides an update on general dental practitioners (GDPs) providing NHS primary care services.

193. We have continued to regularly meet with the General Dental Practice Committee of the British Dental Association (BDA). During the pandemic, the frequency of meetings was increased to discuss operational issues and the pressures facing primary care dentistry. 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.

194. Service provision has been impacted during the pandemic, but services are remobilising, and the face-to-face dental care has resumed in practices across England.

195. Financial support has been maintained throughout and activity requirements adjusted appropriately, and the NHS dental contract provides a secure option for dentists. All dental contracts have received 1/12th of their contract value each month. During the first COVID wave, dentists were required to provide remote triage services to help those in need and Urgent Dental Centres (UDCs) were established to care for those with urgent needs. Following agreement with the BDA, dentists who were not part of a UDC will have an amount deducted from their contract payments for variable costs not incurred during this period.

196. Throughout the pandemic the goal has been to deliver the safe and effective provision of the full range of care in all practices. Having resumed face-to-face care, practices will need to re-build capability and capacity, working with their staff to optimise time and resources as well as manage patient expectation.

6.2 Background

197. Dental services are commissioned via our seven regions, which 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
- maintain access to services

- reduce inequalities
- promote preventative pathways.

198. The testing of a potential new dental contract has been carried out in line with the Health Committee's recommendations[42] that any changes to the dental contract are piloted and tested rigorously. 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.

199. 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.

200. The Dental Contract Reform programme has been paused during the height of the pandemic while resource is redirected to helping practices adapt to new ways of working.

201. We are also working with local commissioners to integrate dental services into the new local care systems STPs, ICSs and PCNs.

Access to NHS dental services

202. Ensuring equity of access to primary dental care services remains one of our central goals. Current levels of service utilisation and access to commissioned care remain high, but there are persistent pockets of lower 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.

203. Alongside this, our 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.

[42] /publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/289i.pdf

204. The March 2020 GP Patient Survey[43] 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 (excluding those that can't remember). For those seeking an appointment in the last six months, the success rate is the same. However, there is some variation for respondents who had not been to the practice before.

205. Due to the COVID-19 restrictions the totals regarding activity, patient numbers, finances and treatments, will have been impacted for the final quarter of 2019-20 and 2020-21. The data that follows may have been affected by this, and in some instances, we have used different comparators than in previous years to give more meaningful data.

206. The trend in dental attendance has been relatively stable, but there has been a slight drop for adult attendance. There is a continuing trend in increased attendance for children which may reflect the increased emphasis on child oral health.

207. 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 compare access to NHS dental services by adult patients, as reported in NHS Dental Statistics[44] – and this has not fallen significantly compared with a year previously: 21.8 million adult patients (49.6% of the population) were seen by an NHS dentist in the 24-month period ending December 2019. This is 2.5 million higher than June 2008 (see Table 7).

208. Due to the COVID-19 pandemic data on delivery of UDAs is not comparable with previous years. Routine dental activity paused on 25 March 2020 some patients were more reluctant to attend for treatment from early February. We have therefore provided data for the year to December rather than March in Table 7 as December 2019 is comparable to December data in previous years.

209. In the 12-month period ending December 2019, 7 million children (58.4% 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 7.0 million and 58.6%.

[43] https://www.england.nhs.uk/statistics/2020/07/09/gpps_dent_3758-78929/

[44] https://www.gov.uk/government/statistics/nhs-dental-statistics-for-england-2019-20-annual-report

Table 7: Number/proportion of adult and child patients seen by an NHS dentist

Year ended	Adult patients seen in the previous 24 months	Percentage of adult population in the previous 24 months	Child patients seen in the previous 12 months	Percentage of child population in the previous 12 months
	£000	%	£000	%
December 2016	22,157	51.4	6,744	57.8
December 2017	22,131	50.9	6,855	58.2
December 2018	22,052	50.4	6,954	58.6
December 2019	21,834	49.6	6,979	58.4

210. The majority of dentists' time collectively remains committed to NHS work although this is not necessarily true for individual dentists/dental practitioners. The proportion of dentists' time reportedly spent on NHS work increased from 70.7% in 2017/18 to 73% in 2019/20.

211. Data has been collected from regional teams on the number of contracts terminated and the reason. No contracts were terminated due to under-delivery or recruitment. The main reason for termination is that 31 Personal Dental Service contracts – which were predominantly orthodontic contracts – have closed or expired. Voluntary hand-backs and retirements account for a further 30 contracts. In total 41 contracts have already been recommissioned and five have entered caretaking arrangements. The bulk of orthodontic activity has been maintained. However, the reduction in contract numbers reflects the activity being delivered across fewer contract holders. Full results are shown in Table 8.

Table 8: NHS dental contracts terminated

Period	Number of contract hand-backs/termination	Reason
January 2020 – September 2020	Total number of contracts terminated or handed back: 77 Midlands and East – 47 North – 14 South – 12	Voluntary termination, no reason (15) Death (2) Retirement (15)

	London – 4 Number of the above that entered caretaking arrangements: 5 Number of the above that have been recommissioned: 41	Under-delivery/inability to resolve longstanding delivery issues (0) Personal Dental Services contract closed down/expired (31) Recruitment (0) Financial viability (3) Provider no longer wanted to provide NHS services (8) Change in personal circumstances/relocation (2) Removal from GDC list (1)

6.3 Recruitment, retention and motivation

212. For clarity, the definitions used in this 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.

213. It is worth noting that, unlike general medical practice, dentists are rarely salaried in primary dental services. There is a significantly higher proportion of performer-only dentists who work as an associate within a practice. We have no contractual relationship with performer only dentists. The contractual arrangement for performer-only dentists is held with the contract holder, and to that end we are not involved in how pay is calculated and distributed to staff within any practice.

214. 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 certain geographic shortfalls limiting service provision, including in some rural and coastal areas.

215. 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[45] commits to creating a capable and motivated multidisciplinary dental workforce of a sufficient size to meet population health needs.

216. In 2019/20, the number of dentists providing NHS services increased by 1% to 24,684 dentists.

217. In its 48th report published last summer, DDRB asked for systematic data on GDP motivation. NHS Digital published this information in *Dentists' working patterns, motivation and morale– 2018/19 and 2019/20*.

218. We have worked with the profession and the BDA to assess how the whole dental team may be better utilised to enable dentists to free capacity and increase access. We continue to develop the commissioning framework to allow flexibility in existing contractual arrangements that incorporates the full skill mix of all disciplines within the dental team thus creating a capable and motivated multidisciplinary dental workforce.

219. We are also working closely with Health Education England (HEE) on phase II of their The Advancing Dental Care (ADC) review. This review aims to develop an education and training infrastructure for the dental workforce that can respond to the changing needs of patients and services.

6.4 Earnings and expenses

220. This is the first time that figures have been presented separately for England and Wales, and the combined averages for England and Wales are no longer available. This coincides with a change in the way we determine dental type which has resulted in increases in the number of dentists identified as providing-performers and decreases in the counts of performer-only dentists. These changes mean that population counts, and earnings and expenses estimates are not comparable with those from previous years. The change in methodology means there is a break in the timeline of the figures and only data before or after the change in methodology should be compared. To add context and allow comparisons to be made HMRC has retuned the figures for 2017/18 using the new methodology.

221. The data from NHS Digital, *Dental earning and expenses estimates 2018/19*[46] shows that in 2018/19 gross earnings of providing-performer dentists increased in cash terms.

[45] www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/
[46] https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2018-19

Table 9: Average gross earnings (before deduction of practice expenses and delivery costs) by dentist type, 2012/13 to 2018/19

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
Change in methodology		
2017/18	£365,100	£90,300
2018/19	£383,400	£89,000

Note: Due to the time needed to collect and compile the data, 2018/19 is the latest data available.

222. 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 2018/19 there were 1,667 leavers and 1,753 joiners, or 3,420 (13.9%) working for only part of the year for the NHS.

223. The numbers of dentists for 2014/15 to 2019/20 are shown in Table 10 below (Table 8b from *NHS dental statistics for England 2019/20*). Due to changes in the NHSBSA system, the methodology for determining this data has changed as noted below. Comparable figures for 2018/19 and 2019/20 are shown below the break in Table 10.

Table 10: Number and percentage of dentists with NHS activity by dentist type, 2014/15 to 2019/20

	Number				Per cent			
	Providing performer	Performer only	Unknown	Total	Providing performer	Performer only	Unknown	Total
	No.	No.	No.	No.	%	%	%	%
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
Change in methodology								
2018/19	4,954	19,550	41	24,545	20.2	79.6	0.2	100
2019/20	4,863	19,781	40	24,684	19.7	80.1	0.2	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

224. The data from NHS Digital, *Dental earning and expenses estimates 2018/19*, 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.

225. This 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 2018/19 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.

226. For dentists holding a contract, taxable earnings were an average of £113,100, a decrease of 0.01% from the previous year's £113,200. Dentists working for providers had an average net profit (taxable income) of £57,600, an increase of 1% from £57,000 the previous year.

227. 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 11 below.

Table 11: Gross income and net profit of all primary care dentists, 2012/13 to 2018/19

	Population	Average gross income[47]	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
Change in methodology					
2017/18	20,500	£146,700	£78,100	£68,500	53.3
2018/19	20,650	£147,100	£78,500	£68,600	53.4

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

228. DDRB ask for data by age, gender and ethnicity, we do not have data on ethnicity and data on gender is provided below in the section on the gender pay gap. Table 12 provides a breakdown of pay by age. Those in the under 35 category have the lowest pay which will be partly explained by only 5% of dentist in this category being providing-performers. The 45-55 age group have the highest taxable income.

[47] 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 11.

Table 12: All self-employed primary care dentists - average earnings and expenses from NHS and private dentistry, by age England, 2018/19

Age	Population	Average gross income	Expenses	Taxable Income	Expenses ratio
<35	7,950	£85,600	£30,400	£55,200	35.5%
≥35≤45	5,750	£146,400	£79,100	£67,400	54.0%
≥45≤55	4,000	£226,900	£139,100	£87,800	61.3%
≥55	2,950	£206,400	£125,500	£80,900	60.8%
All	20,650	£147,100	£78,500	£68,600	53.4%

229. Table 13 shows earnings by the percentage of dental time spent on NHS Dentistry. The data is based on reposes to the dental working hours survey. As the data relies on those responding to the survey the report population is much smaller than in other tables. The data shows income falls where time spent on NHS Dentistry is >75%. A potential explanation for these findings could be that performer-only dentists may retain a higher percentage of the fees generated by performing private dentistry than they do for NHS dentistry as the providing-performer dentists might take a lower proportion of the private fees.

230. The service provided by NHS dentists may also differ from the services of private dentist, which is often for aesthetic care such as implants and adult orthodontics not provided by the NHS.

Table 13: All self-employed primary care dentists – average earnings and expenses from NHS and private dentistry, England, 2018/19

Percentage of time spent on NHS dentistry	Population	Average gross income	Expenses	Taxable Income	Expenses ratio
>0≤25%	550	£230,500	£141,700	£88,800	61.5%
>25<75%	750	£227,700	£142,500	£85,200	62.6%
≥75%	2900	£142,300	£74,200	£68,200	52.1%
All responders	4200	£169,400	£95,400	£74,000	56.3%

231. Another source of information on dentists' income is data compiled by the National Association of Specialist Dental Accountants and Lawyers (NASDAL). The NASDAL goodwill survey in January 2020, the latest data available, saw a big rise in valuations – up from an average goodwill value of 132% of gross

fees in the quarter ending 31 October 2019 to 157% of gross fees. Valuations of NHS, private and mixed practices were all up in the quarter with particularly big rises in the valuations of mixed and private practices.

Table 14: Net profit per principal for the practice

Type of practice	2012/13 £	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £	2018/19 £
NHS	125,958	129,000	129,265	134,102	139,698	126,269	124,475
Mixed	-	-	-	127,684	130,076	127,676	132,940
Private	124,086	131,000	140,129	133,743	139,454	138,806	140,951

Source: NASDAL. NHS practices are those where NHS earnings are 80% or more. Private practices are those where private earnings are 80% or more. Data for mixed practices was not provided for the years 2012/13 to 2014/15.

Expenses

232. 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."

233. 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.

234. 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).

235. Extracts from NASDAL and Morris & Co (other non-staffing costs) results are shown in Table 15. There were only slight variations in expenses as a percentage of gross income in 2018/19, the most notable being the increase in non-clinical staff wages in NHS practices. Expenses as a percentage of gross income have remained relatively stable since the data was first provided in 2006/07.

Table 15: Categories of expenses as a percentage of gross income

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Non-clinical staff wages (NASDAL)							
NHS practices	21.0%	20.3%	20.1%	20.6%	19.7%	20.3%	22.0%
Private practices	19.5%	18.9%	18.2%	17.6%	18.0%	17.9%	17.9%
Laboratory costs (NASDAL)							
NHS practices	6.4%	6.6%	6.3%	6.1%	6.0%	6.0%	6.0%
Private practices	7.3%	7.4%	6.8%	7.5%	7.1%	6.8%	6.9%
Materials costs (NASDAL)							
NHS practices	6.3%	6.8%	6.0%	6.1%	6.2%	6.4%	6.6%
Private practices	7.2%	7.1%	7.8%	7.4%	7.5%	7.5%	8.0%
Other Non-staffing costs (Morris & Co)							
NHS practices	16.4%	18.6%	17.1%	15.4%	16.1%	15.8%	16.0%
Private practices	20.4%	19.7%	19.7%	16.3%	18.9%	18.9%	20.1%

6.5 Gender pay gap

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

237. We procure dental service provision via an open and transparent procurement process with applications detailing no gender-specific identifiable information.

Table 16: Average taxable income from NHS and private dentistry by gender

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	£72,600	£71,700	£70,500	£69,200	£68,700	£68,100	£68,600
Male	£83,900	£84,100	£83,300	£81,900	£81,800	£81,900	£82,900
Female	£59,100	£57,300	£56,500	£55,800	£55,500	£54,700	£55,100

238. Regardless of dental type classification, on average, male dentists have higher gross earnings, total expenses and taxable income than their female counterparts. In 2018/19, the latest available data, for all self-employed male primary care dentists, average taxable income was £82,900 compared to £55,100 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 (30% of male dentists compared to 11% of female dentists).

239. It is important to note this data includes both full-time and part-time dental earnings and expenses, which, given that on average male dentists tend to work more hours per week than their female counterparts, is a contributory factor to the differences observed in taxable income by gender. Table 17 below shows split by gender and working hours based on the responses to the Dental Working Patterns Survey, 55% of female dentist work less than 35 hours a week compared to 26% of male dentists. Please note, this data is prepared from a smaller dataset determined by the survey's response rate.

Table 17: All self-employed primary care dentists – average earnings and expenses from NHS and private dentistry, by gender and weekly working hours, England 2018/19 (latest available)

Mean average						
Gender	**Weekly working hours**	**Report population**	**Gross earning**	**Total expenses**	**Taxable income**	**Expenses to earnings ratio**
Male	<20	100	£111,700	£61,700	£50,000	55.2%
	≥20<25	100	£147,900	£87,200	£60,600	59.0%
	≥25<30	100	£162,200	£85,700	£76,500	52.8%
	≥30<35	250	£216,000	£134,100	£81,900	62.1%
	≥35<40	450	£164,000	£85,200	£78,900	51.9%
	≥40<45	550	£200,800	£109,600	£91,300	54.6%
	≥45	600	£323,300	£216,600	£106,700	67.0%
	All	2,100	£219,300	£131,900	£87,400	60.1%
Female	<20	200	£59,100	£24,700	£34,400	41.8%
	≥20<25	300	£71,500	£27,700	£43,700	38.8%
	≥25<30	250	£86,900	£36,900	£50,000	42.5%
	≥30<35	400	£133,100	£67,800	£65,300	50.9%
	≥35<40	350	£114,900	£52,100	£62,800	45.3%
	≥40<45	350	£131,300	£63,200	£68,100	48.1%
	≥45	250	£208,700	£124,500	£84,100	59.7%
	All	2,100	£118,400	£58,200	£60,200	49.2%

240. Data from NHS Dental Statistics 2019/20 is provided in Table 18 below. This shows a marked increase in female dentists in recent years: in 2019/20, in data addition to that provided in the table below the publication also tells us 59.3% of dentists under 35 were female.

Table 18: Percentage of dentists with NHS activity by gender, 2012/13 to 2019/20

All dentists with FP17	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Male	54.6%	53.9%	52.9%	52.0%	51.2%	50.3%	49.6%	48.7%
Female	45.4%	46.1%	47.1%	48.0%	48.8%	49.7%	50.4%	51.3%

Clawback

241. 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: 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, we 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).

242. We continue to ensure that delivery of services is clinically appropriate, delivered within the contractual framework and provide quality care provision. To help achieve this NHS BSA has been providing since 2018 a provider assurance services to assist our regional teams with the end of year contract reconciliation process. This has ensured a fair and consistent process across the country and has contributed to an increase in clawback, particularly in contracts that had consistently underperformed year on year.

Table 19: Performance adjustment extracted from NHS England's accounting system

	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m
Performance adjustment	71	65	128	123

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

243. 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 our regional teams, shows the number of dentists who are members reduced slightly to 19,524 in 2019/20 from 19,949 in 2018/19 and almost all dentists under the age of 26 are members. This suggests dentists continue to find the NHS Pension Scheme attractive.

244. 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 20: General dental practitioners claiming their NHS pension

Year	Age count	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
2020	203	60.84	164	56.87

245. The data in Table 20 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 2020. 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.

246. 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.

6.6 Remuneration

247. The affordability of pay recommendations for GDPs in 2021/22 needs to be carefully considered within the context of the Long Term Plan and the productivity and efficiency requirements required of all providers of NHS services – including GDPs.

248. The evidence suggests that a good supply of GDPs is available to support us in delivering dental care, albeit there is some geographic variation. Dental practitioners, contracted to deliver our commissioned dental care, are considered to receive a level of remuneration comparable with other equivalent health roles.

6.7 2020/21 settlement

249. For 2020/21, DDRB recommended an uplift in income, net of expenses, of 2.8% from 1 April 2020. The increase was accepted by ministers, and when combined with an increase for expenses of 1.9% this provided an uplift of 2.5%.

250. The national uplift was applied to gross contract values for GDS contracts and PDS agreements. As performer only dentist hold a contract directly with the performing providers and not with us, we cannot say whether the increase was passed on to performer only dentist or not.

Community dental services

251. Dentists working in community dental services (CDS), which are local services commissioned by us, provide an important service to vulnerable patients with complex health and dental needs – especially vulnerable groups. This cohort of dentists have previously been referred to as salaried or special care dentists. CDS are now commissioned under a PDS agreement, in line with local oral health needs assessments. CDS are traditionally seen as a vocational specialist route in dentistry and tend to recruit dentists with a certain set of values.

252. We believe 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.

6.8 Contract changes in 2021/22

253. We are continuing discussions with the BDA with a view to setting a direction that aligns key contract changes to our objectives for improving dental outcomes.

7. Doctors in training

254. 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.

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

256. The *Improving people practices – enabling staff movement* programme aims to enable the movement of staff around the NHS safely and with ease, by identifying and working with systems to address technological, process and cultural barriers.

257. Doctors in training are a priority group of focus for the programme, given they are among the staff who rotate most frequently and have a historically poor experience.

258. The programme is jointly led by us and HEE and is being developed in partnership with other national organisations.

Doctors in training passport

259. The programme team is working with HEE and NHSX to define the precise user needs and scope the detailed requirements that would enable doctors in training to use digital staff passports. This will improve the experience of rotation for doctors and remove the need for them to unnecessarily repeat employment checks and core skills training.

260. A business case for developing and delivering an 'alpha' passport will be submitted for approval in March 2021. This will build on the learning from the COVID-19 Digital Staff Passport – developed by the team during 2020 – and on intensive work with four lead employer organisations and with doctors to understand issues with current processes.

Trusted frameworks

261. In 2019, the programme team stabilised the core skills training framework, by securing its future management within the NHS.

262. The nationally agreed framework sets out agreed requirements for learning outcomes, training standards and frequency of refresher training for NHS trusts in England.

263. The framework has been refreshed to improve standardisation and to support the movement of more consistent and reliable data on doctors in training as they rotate.

264. The NHS Employment Checks Standards will be reviewed to ensure they best support the movement of staff across NHS settings, in light of changes to practice as a result of COVID-19 and in light of digital/technological advances.

Interoperable workforce systems

265. The programme is working with key partners including HEE (for the Trainee Information System), NHS Business Services Authority (for ESR), NHS Digital and NHSX to design, test and implement system enhancements and interfaces to reduce the fragmentation of workforce IT systems.

266. This works aims to increase interoperability, using digital technologies to ensure data is owned and entered at the appropriate source and moved seamlessly with staff as they move around the NHS, to prevent the unnecessary repeating of employment checks and training.

8. Conclusion

267. 2020/21 has been an exceptionally challenging year for the NHS, with services and staff having to respond to unprecedented demand and pressures as a result of the COVID-19 pandemic.

268. Staff are vital for delivering high quality care for patients through their critical role in clinical decision-making, service development and delivery across primary, secondary and community care.

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