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

February 2022

Contents

1. Introduction

1. This is the submission from NHS England and NHS Improvement to the Doctors and Dentists' Pay Review Body. The evidence covers our key areas of responsibilities for supporting the recruitment, retention and motivation of doctors and dentists employed on NHS national contracts.

2. On 22 November 2021, the Secretary of State for Health and Social Care announced that Health Education England (HEE), NHSX and NHS Digital will merge with NHS England and NHS Improvement by April 2023, putting long-term planning and strategy for the NHS workforce at the forefront of the national NHS agenda.

3. At the time of preparing our evidence, we are again operating in a Level 4 National Incident in response to the emergence of the Omicron variant.

4. On 24 December 2021, we published the 2022/23 priorities and operational planning guidance for the NHS. This includes the priority actions relating to the strategic themes established in the People Plan 2020/21.

5. In 2022/23 our aim remains to restore services, meet new care demands and reduce the care backlogs due to COVID-19. Supporting and motivating NHS staff, developing new ways of working to improve patient experience and productivity, and recruitment and retention are all critical to increasing capacity while delivering high quality safe care. Sustaining advances made throughout the pandemic, eg. flexible working and a focus on health and wellbeing will be central to our work. Our priorities, set out in our guidance, include:

   - accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff
   - use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies
   - work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to surpass pre-pandemic levels of productivity as the context allows

- use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

2. Workforce strategies

2.1 NHS People Plan

6. The interim People Plan, published in June 2019, set out the action needed for our NHS people and workforce to deliver the NHS Long Term Plan. It described how the NHS would ensure it had more people, working differently in a compassionate and inclusive culture. The first full People Plan, published in July 2020, built on this foundation and set out how the NHS would support staff through the pandemic and beyond by looking after our people, fostering a sense of belonging in the NHS, instituting new ways of working and growing the workforce.

7. Working with NHS systems we have made good progress in implementing the actions set out in both People Plans. We have taken an explicitly improvement-based approach to allow systems to prioritise the actions that will have the greatest impact for their staff and in turn for their patients. Most systems report that they are on track to deliver on priorities across the actions set out in the 2020 People Plan, however there is further work to do in all areas; in particular, ensuring that flexible working opportunities are available to all staff, there is a consistent approach to service transformation and workforce productivity, and the workforce is growing to meet demand.

8. The COVID-19 pandemic has placed unprecedented pressure on healthcare systems globally, including the NHS. NHS staff have cared for over 600,000 people in hospitals with the virus and administered over 115 million COVID-19 vaccine doses, at the same time as delivering non-COVID care for those who needed it urgently. This has inevitably constrained planned service delivery: 6 million people are now waiting for elective care, and there will be others who might need care but who have delayed coming forward for treatment during the

pandemic.[1] The NHS will need to manage the continuing pressure from the pandemic alongside the challenge presented by this backlog of care. A workforce which feels valued, recognised and rewarded for the role it plays will be critical to this endeavour.

9. The NHS will continue to be under pressure for the next few years. In addition to recovering elective care performance by significantly increasing diagnostic and treatment capacity, the restoration of other impacted services – such as primary, community and mental health care – will continue to be a priority, as will making progress on the NHS Long Term Plan ambitions and responding to independent service reviews (such as the Ockenden Review of maternity services).

10. These priorities also need to be delivered in a way that improves the experience staff have at work. We will continue to work with NHS systems to recruit and retain more people, implement new ways of working and build a more compassionate and inclusive culture where staff feel well supported and are empowered to lead service improvement.

11. In practice, this means we will work with systems to implement workforce changes which are well integrated with changes in how services are delivered to patients, including investment in new facilities and technology. In our focused programme of work to support elective recovery, we have sought to rapidly increase workforce capacity. Interventions so far have included growing the number of clinical support staff and international nursing recruits. We are currently working to further increase capacity and deliver effective service transformation in those areas and professions that will have the greatest impact on patient flow and outcomes, including diagnostics (in line with the Richards Review), anaesthetics, critical care, operating theatres and community services.

12. A core component of our approach to supporting our people is the delivery of the People Promise (created by our staff, for our staff) to ensure that all staff experience the NHS as a good place to work and are better able to care for patients and service users as a result. Engagement links to productivity and outcomes for both patients and staff, through applying a continuous improvement methodology. We are also working closely with government to support the Messenger Review of leadership in the NHS as we know strong and effective

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf

leadership and management are critical to the success of the NHS, including improving staff experience.

2.2. Long-term strategic framework for health and social care workforce planning

13. With the conclusion of the Comprehensive Spending Review in December 2021, we now have a much clearer view of the increase in workforce capacity and skills which the commissioned training programmes will deliver in 2024/25. We are working closely with government and HEE to assess the impact of these programmes, and to identify what further action will be required to meet demand.

14. HEE is developing a long-term strategic framework for workforce. This will identify what the future health and social care workforce needs to look like, based on the needs of patients and service users and considering demographic and structural changes, service developments and the views of professionals. This will guide investment and policy choices over the next 10–15 years and inform workforce planning in the short, medium and long term.

15. In developing this framework, HEE will consider what we need to do to ensure that integrated care systems (ICSs) are best equipped to develop one workforce across services, in line with the high level objectives of each ICS People function.

16. The Secretary of State has also commissioned NHS England and NHS Improvement to develop a long-term workforce strategy.

17. Over the coming year, we will continue to work closely with HEE and the Department of Health and Social Care (DHSC) to align these strategies, and capitalise on the opportunities presented by our forthcoming integration to work together across service and workforce priorities. Integrated planning across people, service and finance will be a feature.

2.3 Integrated care systems

18. In November 2020, our publication of Integrating care: Next steps to building strong and effective integrated care systems across England signalled a shift towards more local decision-making in health and care and local collaboration driven by communities' needs.

19. In February 2021 NHS England and NHS Improvement made recommendations to government to establish ICSs on a statutory basis, which were included in the government's White Paper.

20. The Health and Care Bill is expected to establish Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) as the legal structures underpinning each ICS. Through these new structures ICS's will play a critical role in aligning NHS, local government and other local partners' action to achieve shared aims.

21. Statutory ICSs – now expected to be in place from July 2022, are therefore well placed to improve workforce integration and deliver the People Plan ambition to have 'more staff, working differently, in a compassionate and inclusive culture'. ICSs can, for example, widen the opportunities for people in their local communities to work in the NHS, including for those living in areas of greater deprivation, from excluded groups or not in education, employment or training. Through creating employment, volunteering and apprenticeship opportunities, they can make the most of the skills and talent across the whole local area and develop a broader talent pipeline. NHS employers are increasingly seen as anchor institutions in their local economies and communities, with a crucial role to fulfil as employers as well as providers of health and care services.

22. The ICS Design Framework published in June 2021 articulates the expected ICB and ICP functions, governance arrangements at ICS level and a roadmap to implement these new arrangements. It sets out the duty for the ICB and the ICP to collaborate to deliver a set of functions and responsibilities – to achieve the four aims of each ICS and deliver national and local priorities.

23. ICSs will lead the People function. Guidance published in August 2021 sets out the 10 functions of NHS leaders and organisations to, working with partners, deliver the workforce priorities, including those set out in the People Plan, and develop and support the entire workforce in the health and social care system.

24. Each ICB will also be expected to establish strong clinical and professional leadership arrangements at ICS level, working with ICS partners. This will include appointing an ICB medical director and executive chief nurse to involve clinical and care professionals in ICS decision-making. These executive roles will be responsible for: all matters relating to the relevant professional colleagues employed by the ICB; developing and delivering the ICB's long-term clinical

strategy, ensuring multi-professional involvement; and leading areas such as information governance, quality assurance/improvement and safeguarding.

3. NHS finances

3.1 Financial context

25. The NHS Long Term Plan was published in 2019 setting out the priorities and commitments of the NHS over the period to 2023/24, including the planning assumptions for workforce pay.

26. Due to the COVID-19 pandemic in 2020, and to support the NHS through a challenging period, NHS England and NHS Improvement introduced an interim financial regime to recognise pandemic related inefficiencies and lost productivity (eg increased infection prevention and control (IPC), redeployment of staff and higher sickness absence levels).

27. As a result of this temporary arrangement and significant COVID-19 related costs, the NHS has been hindered over the last two years from delivering recurrent efficiencies to the levels it has achieved historically and set out in the NHS Long Term Plan. The NHS is operating with a significantly higher cost base (with the workforce having grown 10% since March 2019) than the plan funding settlement provided for.

28. The government's SR21 multi-year settlement for the NHS covers 2022/23–2024/25. The NHS priorities are to deliver on the NHS Long Term Plan commitments, tackle the elective backlog, continue to provide COVID services and increase the NHS workforce, all of which within a relatively tight financial settlement which is predicated on stretching efficiency targets and reduction of COVID-related costs.

29. For 2022/23, the total NHS resource budget (including COVID costs) is expected to reduce in real terms by c1.9% compared to the previous year. The NHS

resource budget (including COVID costs) in 2023/24 and 2024/25 will see real terms growth on the previous year of c1.4%.[2]

3.2 Pay award affordability

30. Pay remains the largest component of NHS costs (c65% of total operating costs) and therefore pay inflation represents a material cost pressure which the NHS needs to plan and manage. Pay awards that are higher than the affordable level, and which are not supported by additional investment, will result in difficult trade-offs during the year on staffing numbers and the ability to deliver activity volume. These decisions will have a longer-term impact on the NHS's ability to restore services and make progress in tackling the elective care backlogs which have grown during the pandemic.

31. The 2022/23 NHS system financial framework renews emphasis on financial discipline. Systems will need to manage ongoing COVID care needs, while restoring services, making inroads into the elective backlog, and progressing other NHS Long Term Plan commitments. Local budgets will therefore require delivery of a combination of stretching financial challenges:

    - cost reductions required to deliver efficiency
    - convergence adjustment to bring systems gradually towards their fair share of NHS resources
    - reduction in COVID funding
    - delivering a significant increase in volume of activity from the available resource compared to 2021/22 levels.

32. These factors will impact different systems to different extents, but the overall efficiency requirement will be at least double that of the previous national NHS Long Term Plan efficiency requirement. This means it would not be credible to rely on further efficiencies in order to fund headline pay awards.

[2] The government's Spending Review 2021 set out an increase of 3.8% in real terms. This is based on growth above the NHS Long Term Plan baseline excluding COVID funding, whereas the figures set out above include the additional budget funded in 2021/22.

3.3 Ongoing impact of COVID-19

33. The NHS is continuing to incur significant additional costs due to the ongoing impact of COVID-19. Higher costs are driven by several uncontrollable factors including enhanced IPC (which continues to be in place), ward reconfigurations, staff redeployment and cancellations of elective activity as well as increased staff sickness absence. Since the SR21 outcome, the rise in prevalence of the Omicron variant has generated further uncertainty over the ongoing impact that COVID-19 will have on NHS operational needs.

34. The NHS is also managing the challenges of competing workforce and financial pressures from continuing to deliver COVID-19 care, delivering increased capacity for elective recovery to improve waiting times for patients, and ensuring staff are given adequate rest and recuperation after a sustained period of intense pressure, to safeguard the health and wellbeing of the workforce, resulting in both retention of existing staff and attraction of new.

35. In 2021/22 staff sickness absence (in the hospital and community health services (HCHS) workforce) has remained high; for April to August the average was 4.65%, spiking to above this due to the emergence of the Omicron variant, before falling again but remaining high at the end of January 2022. Temporary staffing spend has increased during the pandemic driven by an increase in bank activity, to maintain services while covering higher rates of staff sickness absence.

36. Given ongoing uncertainties and impacts from COVID-19, pay is not the only financial uncertainty for the NHS in 2022/23.

4. Recovery

4.1 Support for staff during COVID-19

37. In April 2020 – very soon after the start of the pandemic – NHS England and NHS Improvement launched a national staff health and wellbeing offer to support staff through the COVID-19 pandemic; this complements support available locally.

38. We refined this offer throughout 2021/22 and it now includes:

- a specialist bereavement support line for health and care staff
- free access to mental health and wellbeing apps (by the end of December 2021 this had been accessed over 47,000 times)
- suicide awareness resources and support for people affected by suicide
- guidance for key workers on how to have difficult conversations with their children
- group and one-to-one support, including specialist services to support our Black and minority ethnic (BME) colleagues
- webinars providing a forum for support from and conversation with experts
- bereavement support for our Filipino nurses via a specific 'Tagalog' speaking service supported by Hospice UK.

The entire national health and wellbeing offer has now been accessed more than 1.5 million times and utilisation remains consistent.

39. We also developed guidance to equip NHS line managers to support and lead their teams during and after COVID-19, emphasising their role in caring for their staff and taking a preventative approach to health and wellbeing. This includes:

- training for line managers to have health and wellbeing conversations
- coaching and mentoring support
- online resources, toolkits and guidance for teams working under pressure.

4.2 Recovering services

40. The pandemic and the NHS response to it have inevitably had an impact on both workforce and availability of services. The NHS workforce responded with unstinting effort and flexibility; over the ensuing waves sickness absence related to anxiety and stress has increased, as well as the leaver rate from the low level seen at the height of the pandemic.

Table 1: Yearly (September to September) NHS leaver rates by professional group, 2014/15 to 2020/21

Staff Group	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
AHPs	7.08 %	7.10 %	7.06 %	6.82 %	6.52 %	5.38 %	6.36 %
HCS	9.49 %	6.55 %	6.70 %	6.55 %	6.76 %	5.61 %	5.90 %
Medical and Dental	10.73 %	10.69 %	10.51 %	10.16 %	10.05 %	9.00 %	9.27 %
NHS Infrastructure and Support	9.55 %	9.20 %	9.27 %	8.79 %	8.18 %	6.90 %	7.20 %
Nursing & Midwifery	7.19 %	7.25 %	7.58 %	7.06 %	6.90 %	5.63 %	6.26 %
Other ST&T	7.78 %	8.08 %	8.09 %	7.92 %	7.48 %	6.44 %	7.53 %
Support to AHPs	7.71 %	7.83 %	8.43 %	8.45 %	7.24 %	6.65 %	7.59 %
Support to HCS	10.48 %	8.84 %	9.01 %	9.09 %	9.39 %	8.05 %	8.70 %
Support to Nursing & Midwifery	9.48 %	9.61 %	9.71 %	9.31 %	8.72 %	7.54 %	8.49 %
Support to Other ST&T	10.59 %	10.76 %	11.30 %	10.79 %	10.03 %	8.56 %	9.44 %
Grand Total	**8.71 %**	**8.57 %**	**8.72 %**	**8.32 %**	**7.94 %**	**6.75 %**	**7.34 %**

Source: Unpublished ESR Data

41. The pivot in the early stages of the pandemic from routine elective work to treating patients with COVID-19 has had an impact on waiting lists for diagnostic and surgical interventions, exacerbated by delays in some patients presenting for initial assessment in primary care during the pandemic. Recovery of elective services to pre-pandemic levels and dealing with the backlog of cases delayed due to COVID-19 is a key priority for NHS England and NHS Improvement, and requires a net increase in the rate patients are treated. Supporting the recovery of NHS staff is also key in the overall elective recovery programme, both to increase workforce capacity and for maintaining staff health and wellbeing. Systems are drawing up plans that prioritise the health and wellbeing of the workforce to ensure we retain existing staff alongside recruiting new colleagues.

42. The pandemic has caused many NHS staff to reflect on their work–life balance. For many the last two years have been the most challenging of their careers and they may be looking to set clearer boundaries between their work and personal lives by not working ‘full time’ hours or taking on additional shifts. Decisions are compounded for some by the hours they work potentially having tax consequences for pension growth, by breaching the annual or lifetime allowance.

These factors are likely to reduce workforce capacity and the discretionary effort which some people are prepared to put in.

43. NHS England and NHS Improvement's delivery plan for tackling the COVID-19 backlog of elective care aims to support local health systems and other partners to address short-, medium- and long-term issues which were either caused by the pandemic response or which were already present prior to March 2020.

44. The short term (next six months) aim of increasing workforce capacity is designed to help reduce the day-to-day pressures on existing staff, allowing them more time to recover, while focusing on recruitment to fill existing vacancies and reducing staff absence. This work will also complement any further requirements for the service to manage short-term or more sustained future waves of COVID-19. Since the pandemic began NHS England and NHS Improvement have demonstrated how they can support frontline health service staff in delivering quality care in challenging circumstances: developing health and wellbeing offers; making progress in agile and flexible working plus recruitment initiatives (eg vaccination workforce). Work is also ongoing to help those affected by pension tax issues make more informed decisions around working additional hours or clinical sessions.

45. Given the length of time needed to train additional medical workforce, it is difficult to expand capacity quickly. But recent initiatives include using returning staff, the Medical Support Worker (MSW) Programme, and encouraging more consultants to delay retirement through the retention programme:

    - Thousands of doctors joined the temporary emergency register set up by the General Medical Council (GMC) in spring 2020 and over 1,000 of these doctors went on to work in vaccination centres or NHS 111. Very few of these doctors were then taken on by trusts, for various reasons including the lack of HR onboarding capacity, concerns about lack of clinical currency due to length of time out of practice, and doctors preferring to offer their time to remote working rather than face to face. Some of these doctors would be willing to work as educators, to free up time for existing consultants to do more clinical sessions.
    - The MSW Programme has found placements for over 400 doctors in 2021/22 to support capacity in both secondary and primary care. Many MSWs have gone on to gain GMC registration and will continue their careers as registered doctors in the NHS, contributing in the longer term. Many more potential MSWs across

the country could not be offered placements this year but could be potential contributors in 2022/23 if this programme is funded again.

- Work is also ongoing to provide practical advice and information to those who may be affected by pension tax issues, allowing them to make more informed decisions around working additional sessions, eg to help reduce waiting lists. Concerns around pension taxation remain a major risk to retention of the consultant workforce.

46. In the medium term (next 18 months) our aim is to optimise the use of the existing NHS workforce by transforming how some services are delivered, both to increase capacity and improve patient outcomes. The need for the NHS to redeploy staff to provide emergency care for COVID-19 patients has increased demand for areas such as diagnostics, outpatient services, critical care, anaesthetics and operating theatres. Workforce redesign can help create more capacity, use workforce more flexibly and ultimately reduce the time patients wait to be treated or followed up, as well as how long they stay in hospital. It can also expand the opportunities for staff by creating new roles and career pathways and improve their experience.

47. For example, the Improvement Directorate is working on improving productivity for high volume, low complexity surgery such as the high flow cataract pathway. This ensures effective, efficient and consistent team working to enable an increased number of cases per list. Systems are also being asked to take a more personalised approach to outpatient follow-ups, including the use of patient initiated follow-up, effective discharge and referral optimisation. This will help make the best use of clinical time as we recover our elective services.

48. Over the longer-term NHS England and NHS Improvement, working alongside their stakeholders and supporting local health systems, aim to create a workforce that is sustainable within the financial resources available, and able to meet the demands placed on it. Increased investment in training places and programmes via HEE would be needed to provide more capacity in existing NHS roles, and in new roles arising from the transformation of services, leading to improved patient access to services.

49. Creating additional higher specialty training posts will benefit the NHS in the long term, by boosting consultant numbers, but also provide immediate- and medium-term benefits. These training grade doctors make a significant service contribution,

and in these posts their competencies increase faster than if they were employed locally, as their training is supported by the system.

50. Role substitution with medical associate professionals (physician associates and anaesthetic associates) may augment middle grade doctor tier; however, at present the number of these associates is small and training capacity for them is limited. Further work and engagement is needed with the medical community to address any concerns about these roles and impact on doctors, and to understand how they can best work within the multi-disciplinary team to make patient care better and more efficient.

Conclusion

51. The pandemic has had – and continues to have – a fundamental impact on both the supply and capacity of the workforce, and on staff health and wellbeing and preferred working patterns. Key to recovering NHS services over the short, medium and long term will be 'people recovery', focusing on initiatives that improve staff experience and promote the retention of staff, and attract new talent into the service in key areas. In parallel work is ongoing to increase the capacity and productivity of the workforce through recruitment, retention and workforce redesign and service transformation, to make the best possible use of existing staff and their skills and time.

5. Our NHS People Promise

5.1. Overview

52. The NHS People Promise was created by staff for staff and sets out how all NHS staff can work together to help make the NHS the best place to work. It represents what would improve NHS staff experience in the workplace the most. All NHS staff should be able to recognise the promise as their experience of work by 2024. From this year, the NHS Staff Survey has been redesigned to align with its themes and moves from an annual survey to quarterly. The NHS Staff Survey will enable teams, departments, organisations and systems to see the progress they are making towards the promise becoming a reality for all staff and help focus efforts on areas where improvements are needed.

5.2 We are compassionate and inclusive

Culture and engagement

53. The People Plan states that to make the NHS the best place to work, we need "compassionate and inclusive leadership behaviours coming to the fore", to create a sense of belonging and unleash potential. Good leaders appreciate that a culture that values our people as individuals is the way we will hold onto our people and recruit the next generation. It also recognises that "inclusive cultures depend on inclusive leaders".[3]

54. The evidence tells us that having 5% more staff working in teams – and teams that demonstrate the practices of what are termed 'real teams' – is associated with a 3.3% drop in patient mortality rates,[4] and lower error rates, hospitalisations and costs.

55. Compassionate and inclusive working environments also positively impact staff engagement. For example, a 0.12 increase in staff engagement scores in the NHS Staff Survey (on a scale from 1 to 10) correlates with a 0.9% decrease in agency spend, saving the average trust £1.7 million per year.[5]

The Culture and Leadership Programme

56. The Culture and Leadership Programme (CLP) was developed in 2015 in response to the findings of the Francis Report and the Berwick Report into failings of care at Mid Staffordshire and other organisations at risk of similar failings. It is a structured framework that helps organisations understand their own culture, identify the root causes they need to change and then to address them. Through the programme, leaders commit to listen more deeply to staff about the things that challenge them; this means that the interventions they then make lead to the difference staff want to see.

57. The CLP has six key lines of enquiry that analyse culture in respect of a strong evidence base.[6]

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[3] West M The King's Fund *If it's about NHS culture, it's about leadership*, 11 December 2020.
[4] Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of Work and Organizational Psychology* 24(6): 929-50.
[5] https://www.england.nhs.uk/publication/employee-engagement-sickness-absence-and-agency-spend-in-nhs-trusts/
[6] https://www.england.nhs.uk/culture/culture-leadership-programme/

58. This year the CLP has reached 1,226 individuals through events, online forums and its community of practice. It directly supports 17 of the most challenged NHS organisations.

59. An analysis of quantitative data from trusts[7] that engaged in the CLP from 2018 to 2020 shows their improvement in key outcome measures:

- staff engagement improved by more than twice the national average (0.03)
- registered nurse turnover reduced by 1.41 percentage points between 2015/16 and 2019/20 (compared to a national average of 0.8 percentage points).

Equality, diversity and inclusion

60. The NHS People Plan's 'Belonging in the NHS' pillar outlines the aim to "foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care," through addressing issues highlighted by the Workforce Race Equality Standard (WRES) report[8] and the Workforce Disability Equality Standard (WDES) report[9] findings, alongside consideration of other protected characteristics, inclusive recruitment and inclusive leadership.

61. Our priority for 2021/22 was to strengthen and accelerate delivery of the Model Employer goals,[10] published in 2018, measuring two strategic areas through the annual data collections for WRES/WDES and supported by a targeted National Quarterly Pulse Survey approach:

- Leadership at trust and system level (ICSs) to increase BME representation and encourage rapid and focused corrective actions, delivered by overhaul of recruitment and promotion practices and enabling a compassionate and inclusive culture.
- Raising the profile and voices of BME staff to contribute to decision-making in their organisation, delivered by empowering staff networks and supporting line managers to hold productive conversations about race.

[7] Affina OD West T, West M, Gosh D (2021) An evaluation of the implementation of the NHS Culture and Leadership Programme
[8] NHS England » NHS Workforce Race Equality Standard
[9] wdes-2020-data-analysis-report.pdf (england.nhs.uk)
[10] wres-leadership-strategy.pdf (england.nhs.uk)

Key findings of the 2020 WRES and WDES

62. The 2020 WRES and WDES annual surveys showed progress towards achieving WRES and WDES performance metrics during 2019/20.

63. The WRES findings show year-on-year reduction in the proportion of BME staff likely to enter a disciplinary process and a small improvement in the percentage of senior BME staff in trusts (6.8% in 2020 vs 6.5% in 2019). However, BME staff reported higher levels of harassment and bullying (28.4%) compared to white staff (23.6%). Fewer BME staff were shortlisted for jobs compared to white staff (1.61 times more likely for white staff).

64. The WDES findings show an increase in the number of staff who declared a disability through ESR, the NHS national payroll system (3.7% in 2020 vs 3.3% in 2019), and an improvement in adverse employee experience compared to non-disabled staff. However, disabled staff are still less likely to be shortlisted, more likely to go through formal capability processes and experience higher levels of bullying and harassment.

Conclusion

65. While progress has been made in some areas, more remains to be done to embed workforce equalities from a race and disability perspective. An action plan is being developed to identify where trusts need to reverse deteriorating key performance indicators (KPIs), while continuing to strive for improvement across all the indicators.

5.3 We are recognised and rewarded

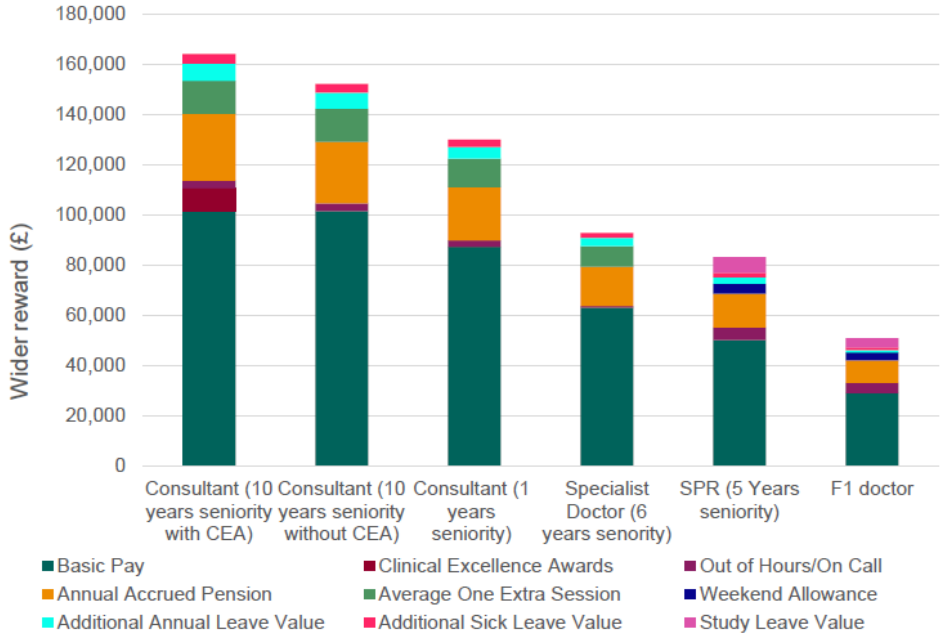
66. The Pension Response Project relates to our People Promise pillars ‘we are recognised and rewarded’ and ‘we work flexibly’.

Total reward

67. DHSC has set out in successive written evidence to the Review Body on Doctors’ and Dentists’ Remuneration the value of the reward package, developed by the Government Actuary’s Department, for medical and non-medical staff: the value of basic pay, out-of-hours and on-call payments, clinical excellence awards (CEAs) for consultants (including dental consultants), annual accrued pension, extra sessions worked and weekend allowances. It also includes additional leave over

the statutory minimum, additional sick leave over statutory sick pay and study leave for doctors and dentists in training.

Figure 1: Wider reward packages for a range of NHS medical staff



Source: Government Actuary's Department

68. Most employed staff have access to their Total Reward Statement (TRS), through the ESR, and NHS Employers has developed a checklist to help organisations develop their local TRS.[11]

Employee Value Proposition (EVP)

69. Employee Value Proposition (EVP) describes the tangible and intangible offer, the psychological contract between staff and their employer, expectations and obligations, which informed the NHS Constitution:[12]

"All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated

[11] https://www.nhsemployers.org/articles/total-reward-statements
[12] https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress."

This is echoed in the People Promise:[13]

"The themes and words that make up Our People Promise have come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace".

70. Some NHS organisations already use the terminology of EVP as part of their local people strategies, which provide a focus on the employee-employer relationship in the context of challenges organisations have been facing such as recovering services and Vaccination as a Condition of Deployment (VCOD). As a result of the policy, qualitative feedback received is that there is a feeling of loss of trust among some staff, and particularly from people who have expressed that they felt concerned about losing their jobs if they did not get vaccinated. This remains a risk to retention while we work to support staff.

71. We are exploring how best to leverage the overall NHS employment offer to inform principles, which could underpin a single high-level value proposition and be adapted and personalised at a local or system level.

NHS Pension Scheme

72. The NHS Pension makes up around 30% of the NHS reward offer and is one of the most comprehensive and generous schemes in the UK. It provides valuable benefits for staff and their loved ones and supports staff through flexible retirement options, such as working differently or retiring gradually through flexible working options, such as reduced hours or change in role.

The Pension Response Project

73. During summer 2021, NHS England and NHS Improvement, working with our pension partners, Isio and behavioural insight specialists, developed Phase One of the Pension Response Project.

74. Phase One is an early example of using EVP techniques to segment the workforce, personalising our offer to those in late career who may be thinking

[13] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/

about retiring earlier (from age 50 or 55) than they had previously planned due to, for example, pandemic fatigue, concerns about pensions tax, higher pension contributions and National Insurance contributions from 1 April 2022, misunderstanding and/or concerns about:

- how the Scheme works, the value to members and their loved ones, implications of the legal ruling in the McCloud case[14] and the move of all NHS Pension Scheme members to the 2015 Scheme from 1 April 2022
- how the Scheme can support flexible working, including those who choose to retire and return to the NHS
- the impact of pensions tax and the tax they may have to pay. Since 2006, HM Revenue and Customs (HMRC) set a Lifetime Allowance limit on tax-free savings in all registered pension schemes.

75. The project found that staff aged 50 or older prefer face-to-face communications about the NHS Pension Scheme and are more likely to secure information about the Scheme from family and friends, rather than from 'official' sources. The complexity of the Scheme, including the different sections/schemes, each with different normal pension ages and multiple, often complex rules, is a barrier to engagement.[15]

76. On 19 November 2021, we launched a series of staff communication materials, designed to explain, as simply as possible, the key benefits of NHS Pension Scheme membership and how staying in work longer could help staff increase their pension savings.

77. These materials – including pension illustrations and a 'Pension Positives' flyer – were promoted through ESR and wage slips and published on NHS England and NHS Improvement's website for staff and organisations to download.

78. Phase One also includes a series of 'proof of concept' staff regional pension seminars, segmented by age (50 and older) and by role:

- senior doctors, GPs and executives – pensions tax and flexible working/retirement

[14] https://www.gov.uk/government/consultations/nhs-pension-scheme-mccloud-remedy-part-1-proposed-changes-to-scheme-regulations-2022/mccloud-remedy-part-1-proposed-changes-to-nhs-pension-schemes-regulations-2022
[15] https://www.nhsbsa.nhs.uk/member-hub/membership-nhs-pension-scheme

- nurses, GP nurses, midwives, AHPs – flexible working and pensions.

Feedback has been encouraging and demand has outstripped supply. The seminars will continue to 31 March 2022.

79. In parallel, we commissioned NHS Employers to develop guidance and training for organisations to help local managers have impactful conversations about the benefits of Scheme membership.[16]

80. As part of NHS England and NHS Improvement's priorities and operational planning guidance, Phase Two of the project during 2022/23 will focus on the most impactful interventions across the career journey for staff in early, mid and late career: "Look after our people: improve retention by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, early/mid/late career conversations and enabling staff to understand their pensions.[17]

Pension Response Project Dashboard

81. We analysed retirement activity to better understand employee behaviour around retirement and what interventions have the greatest impact on staff retention, to improve the employee experience in relation to pension options and life planning.

82. This work is informing the development of a Pension Response Dashboard to help us monitor the outcomes of any interventions and provide an evidence base for the best point to intervene, as well as identify trends across the NHS to support workforce planning by making staff due to retire projections. For example, metrics will include:

- retirement volumes and retirement rates by region, ICS and provider
- annual retirement trends by age, profession and region
- regional hotspots of retirement activity.

Coronavirus Act 2020 – temporary NHS Pension changes

83. The temporary NHS Pension Scheme changes introduced on 24 March 2020 incentivised staff to return to the NHS to care for patients during a national emergency[18] without financial detriment to their pension. The temporary changes

[16] https://www.nhsemployers.org/pensions
[17] https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/
[18] https://www.nhsbsa.nhs.uk/pensioner-hub/covid-19-guidance-support-retired-members

allow staff who retire and return to the NHS (regardless of the hours they work or level of earnings) to retain their entire pension and salary. These temporary changes included:

- 16-hour rule – staff can work more than 16 hours a week in the first calendar month without their pension being suspended. Applies to all members of the Scheme.
- Special class status (SCS) normal pension age (NPA) 55 – staff can retire, return to the NHS, and work additional hours without abatement (their pension is not reduced). Applies to nurses, midwives, health visitors and staff with mental health officer status (MHO).
- Pension draw down staff can take their pension and continue working without abatement, ie ability to increase hours without detriment to their pension. Applies to all members in the 2008 Section and 2015 Scheme.

84. From 15 February HM Treasury and DHSC began a consultation on extending the temporary pension rules in Section 45 of the Coronavirus Act 2020. The consultation asks for feedback on the case for extending the temporary pension rules from 24 March 2022 to 31 October 2022 and beyond 31 October 2022. Any extension will be provided via changes to NHS Pension Scheme regulations and take effect immediately after Section 45 expires on 25 March 2022. We are pleased that government recognises how important the temporary pension rules are, helping leaders increase capacity on the ground, vital to tackling recovery.

85. The temporary pension rules help to increase capacity by incentivising staff to return to work, safe in the knowledge that they can work full time if they wish to do so, without detriment to their NHS pension.

86. We continue to work with the BSA NHS Pensions and NHS Employers to ensure staff have access to simple to understand information to help them make informed decisions about the benefits of returning to work after retirement.[19]

Conclusion

87. The Pension Response Project seeks to leverage the value of the NHS Pension Scheme by providing staff with an opportunity to hear about the Scheme from experts, dispel any myths or misunderstanding about how the Scheme and

[19] https://www.nhsbsa.nhs.uk/coronavirus-act-2020-and-update-end-temporary-suspensions-retire-and-return

pensions tax work, and equip them to make informed decisions about the benefits to them and their loved ones of working longer.

NHS Pension Scheme – dental practitioners

88. All dentists who work for the NHS are entitled to access the NHS Pension Scheme. Information from the NHSBSA Compass system on take-up of the NHS Pension Scheme by dentists shows the number who are members reduced slightly to 18,816 in 2020/21 from 19,524 in 2019/20; however, almost all dentists under the age of 26 are members.

89. Table 2 provides data on the number of general dental practitioners (GDPs) who took 'normal' age and 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, which will be most NHS dentists. It does not include details of NHS dentists who were fully protected 2008 Section members or 2008/2015 transition members, to avoid the possibility of double counting those who may be members of both schemes.

Table 2: General dental practitioners claiming their NHS pension early, 2016 to 2021

Year	Age count	Average age	Voluntary early retirement count	Voluntary early retirement average age
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
2021	208	61.19	185	56.94

Source: NHS Business Services Authority

90. 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.

Conclusion

91. HMRC's introduction of the lifetime allowance cap on pensions may have made early retirement more attractive for some dentists. However, the tables above do not suggest a change in retirement patterns in recent years. We are not aware that the recent changes in pension taxes and provision have had any effect on recruitment and retention, and dentists still find the NHS Pension Scheme attractive.

5.4 We each have a voice that counts

Staff surveys and supporting engagement in the NHS People Plan

NHS staff survey

92. The NHS Staff Survey remains one of the world's largest staff surveys with nearly 600,000 responses.

93. The 2021 NHS Staff Survey has been redesigned to align with the People Promise. This survey will be the principal way teams and departments, as well as whole organisations, can measure their progress and take action to improve.

94. The 2021/22 Staff Survey is not yet available. We expect the results to be published in March. We will provide supplementary evidence to the Pay Review Body as soon as possible.

95. The 2020 NHS Staff Survey was adjusted in light of the COVID-19 pandemic, while maintaining the opportunity to understand and compare employee experience during this period. We know from this data that:

    - 34.2% of staff said they had worked on a COVID-19 specific ward or area at some point
    - 18.5% said they had been redeployed
    - 36.0% said that they had been required to work remotely
    - 10.4% said they had been shielding for themselves and/or a member of their household.

96. Those who worked on COVID wards, were redeployed or who could not work remotely had a significantly poorer working experience across all themes (Table 3).

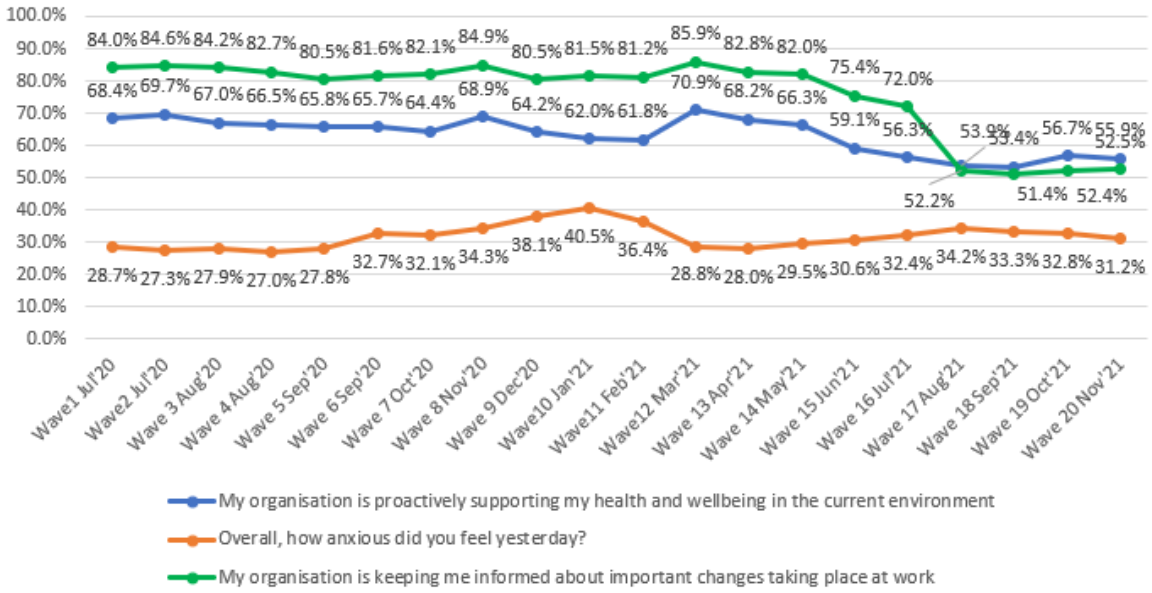
Table 3: NHS Staff Survey themes by COVID working

	Overall results		Covid-specific areas		Redeployed during Covid		Working remotely		Shielding	
Theme	**Theme 2020**	Theme 2019	**Those who worked on Covid specific wards at any time**	**Those who have not worked on Covid specific wards**	**Those who have been redeployed due to the pandemic**	**Not redeployed**	**Those who have been working remotely due to the pandemic**	**Not working remotely**	**Those who have been shielding due to the pandemic**	**Not shielding**
HWB	**6.10**	5.90	5.65	6.35	5.74	6.19	6.49	5.9	6.06	6.12
Morale	**6.23**	6.17	6.03	6.34	6.03	6.28	6.45	6.12	6.20	6.24
Safe Environment Bully and harassment.	**8.07**	8.00	7.51	8.38	7.70	8.17	8.5	7.85	7.96	8.10
Safety culture	**6.80**	6.75	6.74	6.83	6.7	6.82	6.88	6.76	6.84	6.80
Equality, Diversity and Inclusion	**9.00**	9.02	8.63	9.20	8.72	9.07	9.21	8.89	8.7	9.04
Staff Engagement	**7.04**	7.04	6.97	7.09	6.94	7.07	7.24	6.94	7.06	7.04
Teamwork	**6.53**	6.63	6.37	6.62	6.49	6.54	6.95	6.3	6.58	6.53
Immediate Managers	**6.88**	6.91	6.7	7.0	6.8	6.9	7.2	6.7	6.9	6.9
Quality of Care	**7.47**	7.47	7.5	7.5	7.5	7.5	7.4	7.6	7.6	7.5
Safe - violence	**9.45**	9.44	9.0	9.7	9.3	9.5	9.8	9.3	9.5	9.5

Source: NHS Staff Survey data 2020

97. In June 2020, the monthly People Pulse survey was introduced to support organisations in listening to our NHS people's views through COVID in a consistent and standardised way. This was an optional survey which so far has been adopted by over 100 NHS organisations.

Figure 2: People Pulse trend data



Source: People Pulse data (July 2020 to November 2021)

98. Monthly Pulse data shows, from May 2021, increasing levels of anxiety among staff. Analysis of 14,000 free text comments from the quarterly Pulse Survey in July indicates workload is the primary driver behind this trend.

99. Staff engagement is measured annually through the Staff Survey and is now also tracked quarterly by all trusts. It is made up of three components: motivation, involvement and advocacy.

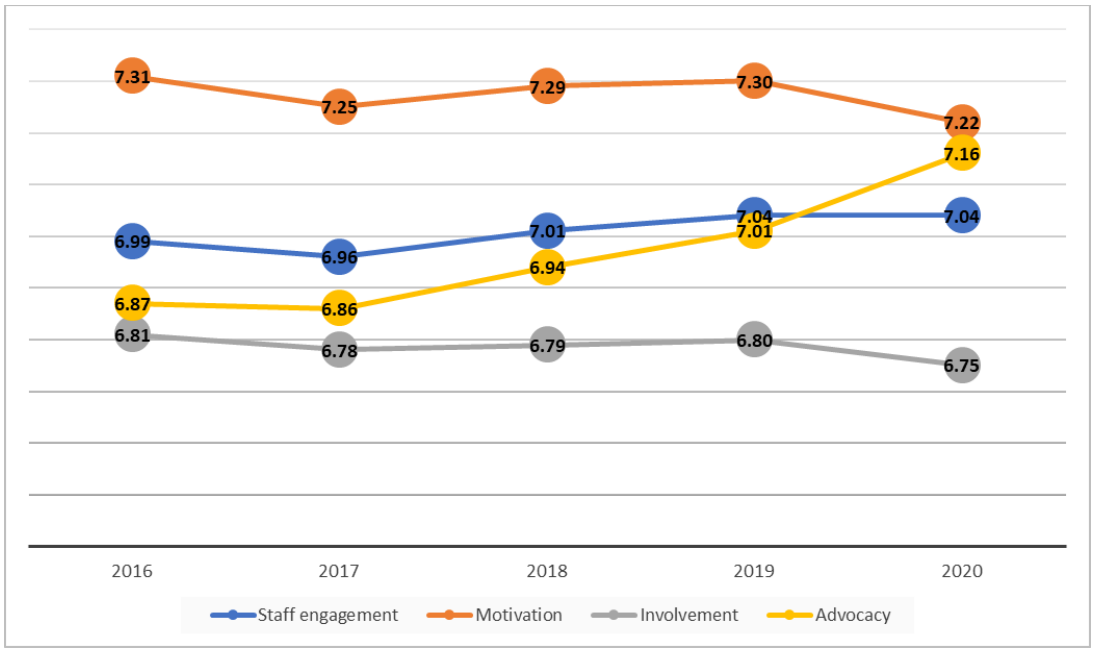
100. Using a fixed effects model, analysis illustrates that staff engagement has a positive and statistically significant impact on NHS trust outcome measures. In particular, trusts with higher levels of staff engagement are likely to have:

- lower sickness absence rate
- lower MRSA rate
- lower mortality rate
- higher recommended rate in the inpatient satisfaction survey
- lower unrecommended rate in the inpatient satisfaction survey.

101. Annually, the response to the engagement theme as a whole has remained stable. For 2020 this was mainly due to an increase in advocacy – the pride our NHS people have for their organisation and service provision. However, the motivation

and involvement scores were at their lowest levels for the last five years (Figure 3).

Figure 3: National Staff Survey engagement score trend data



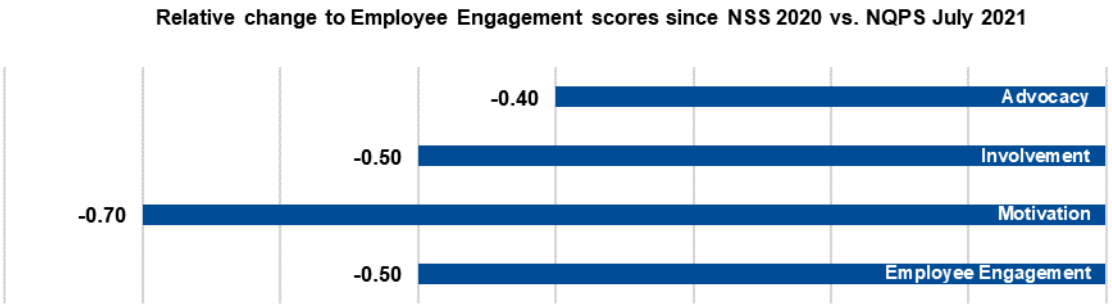
Source: NHS Staff Survey data 2020

National Quarterly Pulse Survey (NQPS)

102. The National Quarterly Pulse Survey (NQPS) was introduced as a requirement for trusts from July 2021. The NQPS uses the Employee Engagement questions from the NHS Staff Survey and can be delivered in trusts using the People Pulse platform.

103. Quarterly Pulse Survey results in July show a drop in staff engagement scores, most markedly for motivation. Tracking engagement quarterly replaces the Staff Friends and Family Test and will take time to interpret, but this drop in engagement scores is concerning (Figure 4).

Figure 4: National Quarterly Pulse Survey trend data, July 2021



Source: National Quarterly Pulse Survey Trend data (July 2021)

Conclusion

104. The NHS Staff Survey has been aligned to the People Promise from 2021 to help us identify how well employee experience matches what our NHS people have told us is important to them. We have increased national support for local listening strategies by introducing the monthly People Pulse and National Quarterly Pulse Surveys. These two tools provide a standardised way of understanding how employee experience nationally, regionally and locally is changing within year, to support decision-making.

5.5 We are safe and healthy

Health and wellbeing

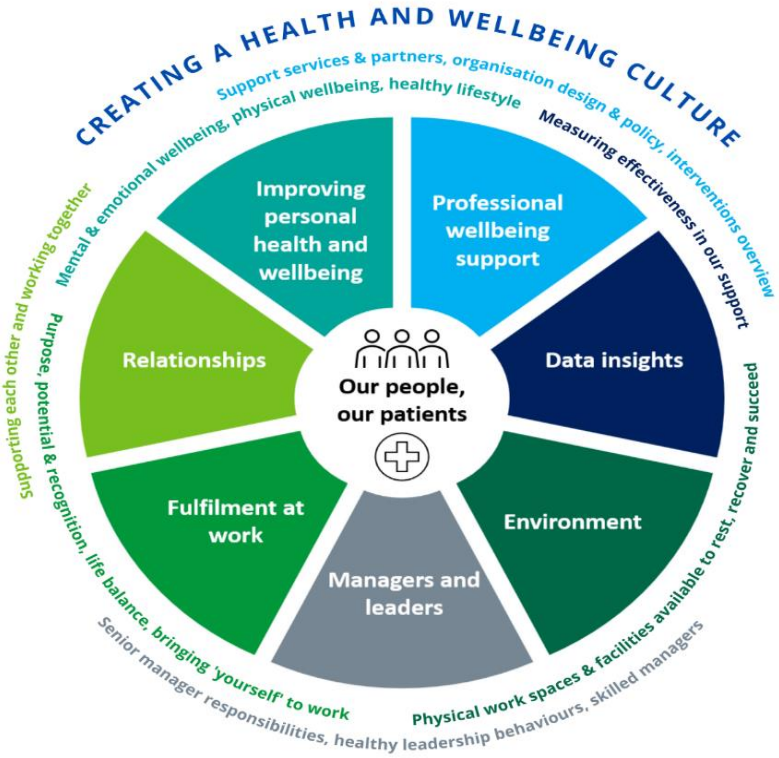
105. NHS England and NHS Improvement have developed a strategy, and supported this with a range of national programmes, to improve the wellbeing of our NHS people and enable NHS organisations and systems to create a culture of wellbeing. These recognise there is no quick fix to improving the wellbeing of our NHS people and addressing the root causes; it will require long-term investment, culture change, service improvement and, above all, a proactive focus on preventing what damages workforce wellbeing.

106. The recently refreshed NHS Health and Wellbeing Framework sits at the heart of this work (see Figure 5). It defines what organisations and systems need to do to improve the wellbeing of our NHS people by creating a wellbeing culture. It was first developed in 2018 and was refreshed during 2021 following large-scale stakeholder engagement and co-design, incorporating the learning from the pandemic.

107. We know:

- focusing on the organisational enablers in the NHS Health and Wellbeing Framework improves the impact of health and wellbeing interventions by creating a culture of wellbeing in which our workforce can thrive and feel cared for, and therefore care for patients more effectively
- using the framework in a targeted, structured way and with specialist guidance improves staff health and wellbeing, reflected in the improved staff wellbeing metrics.

Figure 5: NHS Health and Wellbeing Framework Model (2021 update)



108. Evidence supports moving away from a focus on outcomes (eg reducing sickness absence) to focus on inputs (that is, putting in place the conditions for a culture of wellbeing and focusing on prevention of illness and maintenance of wellbeing). NHS organisations and systems that have developed their health and wellbeing initiatives have been more successful in reducing sickness absence and improving wider wellbeing metrics. Developing and committing to a long-term health and wellbeing strategy that paints a picture of a positive future based on a healthy workplace culture is key to attract and retain the best staff.

109. The Health and Wellbeing Programme had created communities of practice for HR/OD and occupational health (OH) and wellbeing leaders to share learning and good practice in improving wellbeing. Feedback indicates that the opportunity to network and learn from one another about how different approaches can improve staff health and wellbeing is highly valued and is making a difference.

110. OH services are core to improving the wellbeing of our NHS people. They have played an important role in supporting workforce wellbeing during the pandemic. However, this has also exposed long-term underinvestment in this essential service. During 2021/22, NHS England and NHS Improvement worked with the 'Health at Work' network of NHS OH leaders to develop the 'Growing OH' programme with the vision of enabling NHS OH services to fulfil their potential as strategic, integrated and preventative partners in enabling the wellbeing of our NHS people. We are working with stakeholders to invest in growing OH services and people, and also co-designing a five-year service improvement strategy for NHS OH services. This strategy will be released in 2022/23.

111. The evidence gathered as part of the improving wellbeing programmes underlines the key role NHS leaders play in enabling the wellbeing of our NHS people, which is reflected in the refreshed NHS Health and Wellbeing Framework.

112. A new senior leadership role, the wellbeing guardian, was introduced as part of the NHS People Plan. Their role is to champion creating a wellbeing culture and, by sitting on the board of every NHS organisation, ensure that staff wellbeing is a consideration in all aspects of their board's agenda. At least 84% of NHS providers have confirmed that they have appointed a wellbeing guardian (based on a December 2021 audit), and full adoption is predicted by April 2022.

113. We recognise that NHS leaders also need support with their personal wellbeing if they are to act as role models with regard to health and wellbeing for their teams and patients. We have worked in partnership with the NHS England and NHS Improvement Leadership and Lifelong Learning team to offer wellbeing development for our NHS managers[20] and senior leadership[21] communities. Initiatives will continue to be scaled and spread during 2022/23.

[20] https://learninghub.leadershipacademy.nhs.uk/projectm/
[21] https://learninghub.leadershipacademy.nhs.uk/executivesuite/

114. Each ICS needs to develop a health and wellbeing (HWB) offer for its staff. In 2020/21 we supported 14 ICSs with this and in 2021/22 have introduced an enhanced HWB offer and primary care pilots. Both programmes encourage innovation and the piloting of new approaches to improving health and wellbeing, using available data to understand the needs of the local workforce. Twenty-six ICSs are now involved in the enhanced HWB programme.

5.5 We are always learning

115. The People Promise commits to making opportunities to learn and develop plentiful and equally accessible to all, supporting us all to reach our potential, and attracting, developing and retaining talented people from all backgrounds.

116. The NHS Leadership Academy provides a suite of talent and leadership programmes and a network learning hub for staff to learn, reflect and connect.

117. Its support offer for organisations is delivered locally through the regions, each of which has a team of leadership/lifelong learning and talent staff who take an established local leadership academy approach to supporting development in each region tailored to system needs.

118. The NHS Leadership Academy talent and leadership offer covers these themes:

- A talent strategy that takes an 'everyone is talent' approach
- Equality, diversity and inclusion as a golden thread through every programme, continually reinforcing the importance of a diverse workforce to create innovation and equality of opportunity for all
- Recognition that the pandemic has had a more debilitating impact on BME populations, and that social justice has become a cornerstone of the Leadership Academy's work.

119. The talent and leadership offer includes:

- learning spaces – these include #ProjectM and Executive suite
- leadership development programmes
- Stepping Up and Ready Now programmes – aimed at BME colleagues.

120. The NHS Leadership Academy's talent and leadership strategy supports the NHS to develop a diverse talent pipeline, support system leadership, and provide local talent and leadership support, recognising that 'everyone is talent'. This speaks directly to the development of a compassionate and inclusive culture in the NHS.

6.4 We work flexibly

Flexible working

121. The NHS Staff Council consulted on and approved significant changes to the NHS Terms and Conditions, in line with the ambitions of the NHS People Plan. These came into effect on 13 September 2021.[22]

122. The changes include:

- extending the request for flexible working beyond the statutory duty of after 26 weeks of employment to day one of employment
- not requiring staff to provide a reason for flexible working
- no limit on the number of flexible working requests each year (previously restricted to one request per 12 months); staff can make more than one request for flexible working.

123. NHS England and NHS Improvement and Timewise are running NHS Flex for the Future, an online programme delivered over six months. This programme is currently supporting 93 organisations (including two ICSs) across all seven regions to explore what flexible working looks like in their organisation, through to the creation of an action plan to embed changes in their organisation.

124. As part of this programme, we are also exploring additional support, such as definition and principles, a case for change, a series of toolkits aimed at line managers and individuals, and testing a cost calculator designed to enable organisations to explore the potential savings from retaining staff.

125. We have worked with both the NHS BSA (NHS Jobs) and TRAC (a recruitment software provider) to ensure flexible options can be included in advertised roles. The percentage of roles advertised with flexible options has increased from 10% in April 2021 to just under 17% in November 2021 as a result.

[22] https://www.nhsemployers.org/publications/tchandbook

126. Two KPIs have been included in the 2020/21 oversight framework, one relating to the NHS Staff Survey 'satisfaction with opportunities for working flexibly' and the other to 'percentage of roles advertised as flexible'.

127. Many organisations have adopted flexible working and NHS Employers has published best practice case studies.

128. Many flexible working opportunities can be agreed informally or without requiring a contractual change. We are exploring how the ESR can best capture and record informal and formal flexible working requests.

129. We know from the NHS Staff Survey that year on year more and more staff are satisfied with the opportunities to work flexibly (up from 54% in 2019 to 57% in 2020, co-inciding with the publication of the People Plan and the introduction of the People Promise).

Conclusion

130. We have made good progress with our trade unions partners to ensure that staff have access to flexible working from day one and to remove restrictions on how often they can ask to work flexibly. We will continue to track job adverts to ensure these include flexible roles and to work with organisations on both the cultural and practical barriers to staff asking to and being supported to work flexibly.

Enabling Staff Movement Programme

131. The Enabling Staff Movement Programme aims to make it much easier for staff to move around the NHS safely and easily by removing technological, process and cultural barriers, many of which can only be overcome with national interventions and policy changes.

132. NHS staff move for several reasons, and each move typically involves completing multiple forms, repeating employment checks and mandatory training. During COVID-19, staff with the right skills have urgently needed to move between NHS organisations without such barriers, delays or unnecessary administration.

133. Movements include:

- Permanent movements – the NHS has about 250,000 new starters each year.

- Internal movements – there are estimated to be over 300,000 each year, with over 100,000 temporary staff movements for honorary contracts, secondments, and emergency deployment. Junior doctors – who number around 53,000 – typically move eight times over the course of a 10-year programme, sometimes twice in a given year.
- Bank workers – over 800,000 workers are registered on trust banks, 300,000 of whom are actively undertaking bank shifts at more than one NHS organisation.

134. The easier we can make the registration and movement processes, the less the NHS will need to rely on agency workers to fill gaps.

135. The programme is helping overcome these barriers at a national level by setting best practice standards and policy to allow local systems (ICSs) to streamline their inductions and onboarding processes; reducing duplication and recognising previous training and skills 'passported' from previous employers. The work programme areas below represent the interlinking initiatives and priority actions to achieve our aim.

136. The Enabling Staff Movement Toolkit, developed with partners and published in August 2019, gives NHS organisations practical help with removing barriers to staff movement: sample 'warranty' text, case studies and signposted resources. It is in the process of being updated with, for example, new national templates, additional case studies and a template for deploying NHS workers to other care providers when needed for short periods, such as during emergencies.

Connecting the NHS ESR with third-party systems

137. As part of efforts to improve the recruitment processes and the onboarding experience of NHS staff, an interoperability workstream of the Enabling Staff Movement Programme is focusing on the movement of occupational health and training data into ESR. To date this workstream has successfully enabled organisations to automate the transfer of over 200,000 training and immunisations and vaccination data items between NHS trusts.

138. This workstream has the potential to generate substantial savings in manual input and duplication of effort by organisations and staff, and to streamline the onboarding and induction process when staff move.

COVID-19 Digital Staff Passport

139. The COVID-19 Digital Staff Passport removes the need to repeat NHS employment checks for NHS staff who are temporarily moving or being shared to support the COVID-19 response. This saves valuable time and reduces the administrative burden on NHS staff and HR departments, while ensuring staff move with the right safeguards to where patients need them most.

140. The passport is supporting organisations to fully utilise and mobilise their workforce. So far 100 organisations have adopted it and 950 passports have been issued, with the potential to extend it much more widely.

141. The COVID-19 Digital Staff Passport and service, now updated to include a vaccination programme credential for staff working in vaccination centres, has been extended to December 2023.

Digital Staff Passport for doctors in training and temporary staff movements

142. We are working with HEE and NHSX to improve local onboarding processes, including for bank staff, to realise efficiencies, enhance staff experience and release time for clinical activity and patient care, as well as other key priorities, such as training and development time for staff.

Trusted frameworks

143. The programme team are working with key strategic NHS and non-NHS partners (HEE, NHS Employers, DHSC, Department for Digital, Culture, Media and Sport, Disclosure and Barring Service, Home Office and Skills for Health) to define and build 'trusted frameworks', which when fully adopted by all NHS trusts will ensure consistency of and trust in data to aid the transfer of staff between NHS organisations.

Conclusion

144. The Enabling Staff Movement Programme is a key component in simplifying and improving staff experience. The COVID-19 Digital Staff Passport and Enabling Staff Movement Toolkit continue to support the COVID-19 response, as well as elective recovery. In parallel, the programme is making considerable progress in delivering the long-term vision of digital staff passports for all staff, enabling them to move seamlessly from one organisation to another without unnecessary administration and duplicated induction. This will ensure the right staff with the right skills can be deployed where they are most needed easily and quickly.

145. In addition, digital staff passports act as a catalyst to achieve interoperable workforce systems and cultural and process changes by providing modern, easy to use technology that improves staff experience.

Temporary staffing: agency and bank

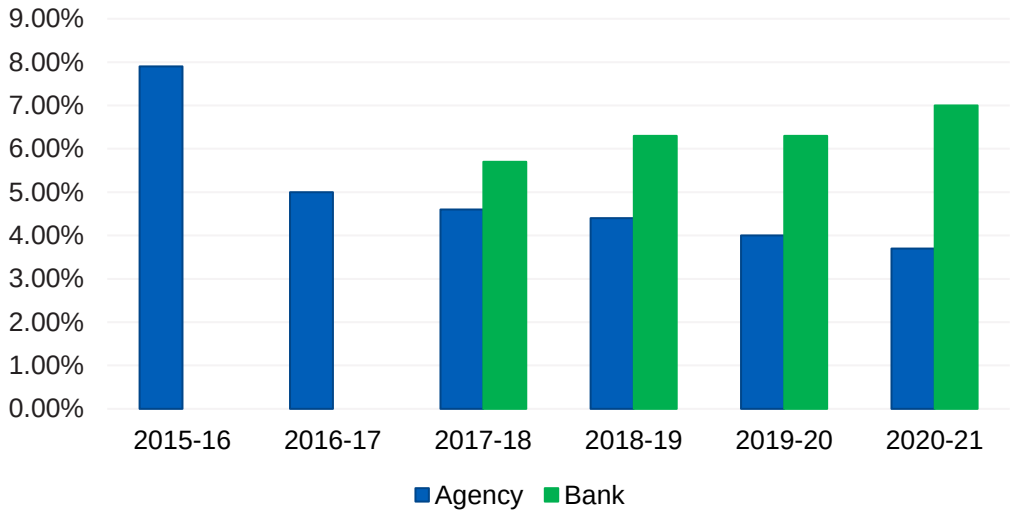
146. The NHS has made progress in optimising temporary staffing spend despite workforce and capacity shortages. Increased bank spend as a proportion of total temporary staffing spend demonstrates greater flexibility in meeting fluctuations in demand, and doing so more economically.

147. The NHS People Plan sets out further measures to improve the quality and value for money from temporary staffing, including an action to ensure that all agency supply is via an approved procurement framework.

148. Through the introduction of the price caps as part of a wider package of agency controls in 2016, total agency spend has reduced by around £1.2 billion, from a peak of £3.6 billion in 2015/16 to £2.4 billion at the end of 2020/21. This is despite continuing increases in demand for workforce and increases in pay.

149. Total agency spend as a percentage of total wage bill has decreased from 7.9% in 2015/16 to 3.7% in 2020/21. The has largely been delivered by the NHS reducing the proportion of shifts filled by agency staff across all temporary staffing shifts from 28% in 2018/19 to 23% in 2020/21.

Figure 6: Temporary staffing as a percentage of total wage bill, 2015/16 to 2020/21

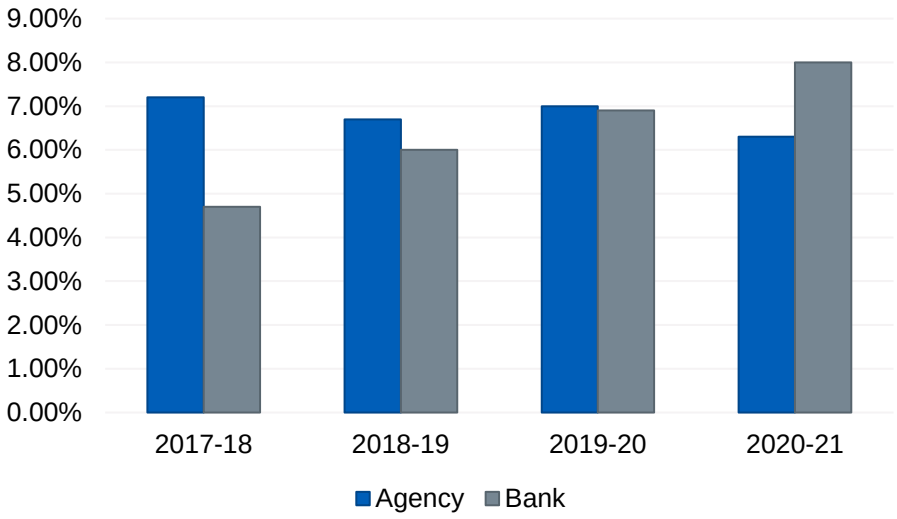


Source: Internal reporting requirements informed by trusts' monthly finance and staffing submissions (Bank data collection started in 2017/18)

150. The proportion of agency spend as a share of overall temporary staffing has fallen from 38% in 2017/18 to 30% in 2020/21 reflecting the falling percentage rise of temporary shifts procured through a bank. Medical and dental bank shifts have increased from 43% in 2018/19 to 52% in 2020/21.

151. Bank staff spend as a percentage of temporary staffing spend has risen from 62% in 2017/18 to 70% in 2020/21, reflecting the increasing procurement of temporary staffing through internal staff banks. Medical and dental agency shifts have decreased from 57% in 2018/19 to 48% in 2020/21.

Figure 7: Temporary staffing (medical and dental) as a percentage of total wage bill, 2017/18 to 2020/21



Source: Internal reporting requirements informed by trusts' monthly finance and staffing submissions)

152. There are 77 NHS trusts in a collaborative bank arrangement, with a total of 23 set up. This is an increase of 56% since the publication of the People Plan, September 2020. A further 28 providers are in the planning stage. Twenty-seven of 42 ICSs have a collaborative bank and there is an arrangement in each of the seven regions. Collaborative banks will allow systems to work in partnership to make the most effective use of the resources available.

Conclusion

153. Work on bank development is ongoing, with the Bank Programme supporting trusts and local systems to improve their staff banks and work collaboratively, through a combination of self-directed learning, face-to-face support and group

improvement activities. The programme aims to support providers to address any issues that may inhibit collaborative working arrangements.

154. The NHS Long Term Plan outlines the national strategy to continue improving on workforce productivity and reduce reliance on agency workers. The NHS has been effective in reducing agency spend despite considerable pressures from COVID-19 and more recently elective recovery.

155. The Temporary Staffing Programme workstreams are reducing off-framework supply into the NHS; supporting trusts to improve price cap compliance; and facilitating the acceleration of the Bank Programme.

5.8 We are a team

156. The first six elements within the People Promises inform how the NHS operates as one team, which is the seventh. The measure of success will be drawn from our ambitions right across the People Promise, including the leadership work led by the NHS Leadership Academy.

157. The response to the pandemic has demonstrated again the importance of teams, and the vital contribution of every member of that team, regardless of their professional status or qualifications. It is important that the NHS continues to value and recognise that teams are the main mechanism through which patient care is delivered and are the natural building block of organisations.

6. Consultants

6.1 Overview

158. The demand for healthcare in the NHS requires an increasing number of doctors, notwithstanding ongoing progress towards a multi-professional workforce in healthcare. The demand is fuelled by demographic changes; new treatments and technologies; patient safety issues and public expectations; the service improvements driven by the NHS Long Term Plan; pressures due to COVID-19 and the need for elective recovery including dealing with the backlog; and finally the short-term winter pressures.

159. The number of doctors in the NHS was insufficient before the pandemic. A 2019 survey found that 40% of consultants and nearly 63% of senior trainee doctors said that there were daily or weekly gaps in hospital medical cover. Overall, there are 2.8 doctors per 1,000 population in the UK compared with the OECD average of 3.7. Our approach to getting more doctors must encompass increased supply, alongside reduced attrition. Consultants are the senior hospital doctors who lead their teams. Consultant supply comes from three sources: postgraduate trainees, specialty and associate specialist (SAS) doctors and international medical graduates.

160. There is a constrained domestic supply pipeline of doctors. While the number of undergraduate medical student places is increasing, it will take at least 10 years before this translates into more senior doctors. HEE controls the number and distribution of postgraduate medical training places, and this is the major consultant supply route. Repeated surveys by medical Royal Colleges and the British Medical Association (BMA), and narrative from national healthcare commentators such as the King's Fund and Health Foundation, show the need to increase the number of consultants as well as GPs.[23] Financial constraints limit the expansion of postgraduate training posts and therefore the domestic supply of consultants.

161. Another source of doctors, including consultants, is international recruitment but the pathway for doctors who qualify in other countries (international medical graduates, IMGs) to obtain medical employment in this country is challenging. This includes doctors who have already moved to England (including some refugees) and are studying for the Professional and Linguistic Assessments Board (PLAB) exams to achieve GMC registration. Our recent work developing the MSW Programme with support from DHSC has funded over 400 of these posts. Early evaluation shows MSWs are a useful addition to the clinical workforce: the first 'graduates' of this scheme have gone on to obtain postgraduate training posts or specialty doctor jobs. An estimated 2,000 IMGs in Britain are interested in applying to an MSW post as a route into working as doctors in the NHS. A further challenged group are UK nationals who graduate from medical schools in other

[23] Buchan J, Charlesworth A, Gershlick B, Seccombe I (2019) A critical moment: NHS staffing trends, retention and attrition. London: The Health Foundation, pp1–38; The King's Fund (2021) NHS workforce: our position.

countries and as such are not eligible for FY1 posts in the UK; they often struggle to obtain a foot on the ladder of postgraduate training.

162. Consultants are a vital component of the medical workforce, particularly in overseeing treatment of the most complex patients. Their unique and valuable contribution to patient care is reflected in the standard they needed to achieve to gain specialist registration and their requirement to demonstrate continuous learning and competence to maintain a licence to practice.

163. This skill set is not replaceable by workforce redesign and the consultant workforce will remain an essential component of delivering high-quality patient care across our services.

164. Consultants also provide clinical leadership to the services that deliver against quality and performance standards for the NHS, they are essential for training the future generation of doctors and many contribute to essential research that improves patient care.

165. A thriving consultant workforce is important as the NHS strives to recover from the pandemic, particularly elective services, and continues to implement the NHS Long Term Plan.

6.2 Recruitment

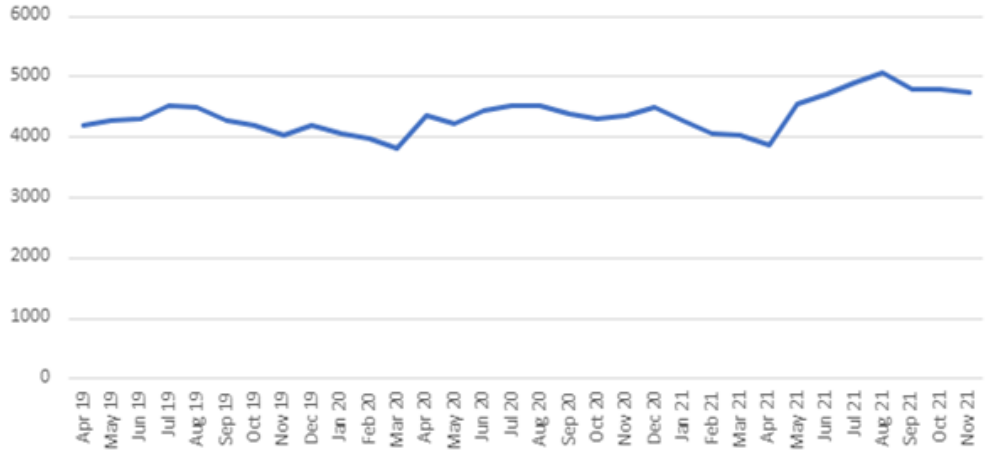
166. Over the past six months consultant vacancies have begun to rise having been relatively constant since 2019 (Figure 8). This could be a combined result of the pandemic curtailing progression of senior trainees and reducing international recruitment. However, vacancies only reflect part of the real demand as positions are only advertised once they have funding; that is, those positions the NHS can afford to fill.

167. The last full census on current consultant workforce was the joint HEE/NHS England and NHS Improvement data collection in 2019. At that time there were 4,600 vacancies (10% of establishment) and the specialties carrying the highest vacancy levels were emergency medicine, psychiatry, the ‘acute take’ specialties, histopathology, radiology and intensive care medicine (ICM). The pandemic has since exposed the need for more ICM and anaesthetic consultants to manage acute respiratory illness needing critical care support. New service developments including virtual wards (community-based management of acute respiratory illness

where this is appropriate for patients) and enhanced care wards (for inpatients needing additional respiratory support but not full critical care) will require more acute physicians and anaesthetists.

168. As well as hard-to-fill specialties, we recognise that posts in remote and rural places can be difficult to recruit to. We are working with HEE to ensure that the distribution of training places helps remote and rural trusts with workforce shortages; both by augmenting numbers of trainees in these areas who can provide significant service contributions in the short and medium term, and by giving trainees experience of working in a rural trust increasing the chances they may remain as consultants in the long term. Consideration of the use of pay premia in certain specialties and geographies could be helpful.

Figure 8: Consultant vacancies (FTE), April 2019 to November 2021



Source: NHS Provider Financial Returns Apr 2019–Nov 21

6.3 Impact of the pandemic

169. The NHS provided around 90% of pre-pandemic levels of activity this year. Our ambition is that in 2022/23 systems deliver over 10% more elective activity than before the pandemic, rising to 30% more activity by 2024/25.

170. Elective recovery, alongside continuing pressure on urgent and emergency care, has compounded workload pressures on doctors at all stages of their training and career, and impacted on the ability of many doctors to provide the service they want to give to their patients: 30% of doctors said they often felt unable to cope with their workload, up from 19% in 2020.[24] These workload pressures are not

[24] GMC State of Medical Practice 2021 Report

new; similar statistics were seen in 2019 and this year's statistics reflect the resumption of services, after a drop in the number of doctors struggling with workload last year.

171. A recent snapshot survey by the Royal College of Physicians showed that 69% of respondents had felt overwhelmed at work, with a fifth feeling that way almost every day.[25] 'High patient numbers and long waiting lists' was the biggest area of concern for specialists (21%) and 64% have found it difficult at some point over the last year to provide a patient with the 'sufficient level of care' they need.

172. The GMC report 'Caring for doctors, Caring for patients' discussed the ABC of doctors' core needs: autonomy/control, belonging and competence.[26] Competence encompasses a doctor's wish to provide high-quality care and the impact on wellbeing when they are unable to do so. Excessive workload is a significant contributor to this and solutions to address it will include increasing the number of doctors, reducing the burden of unnecessary administrative tasks, and ensuring that some tasks can be appropriately delegated to other members of the multi-disciplinary team.

Wellbeing

173. 18% of specialists are at high risk of burnout according to the GMC 2021 barometer survey. There is a strong relationship between burnout, workload pressure and levels of support.

174. There has been a strong focus on staff wellbeing during the pandemic with new initiatives introduced to help all staff (see section 5.4). Despite these positive changes, no wellbeing initiative can substitute for having enough competent staff to do the work.

Conclusion

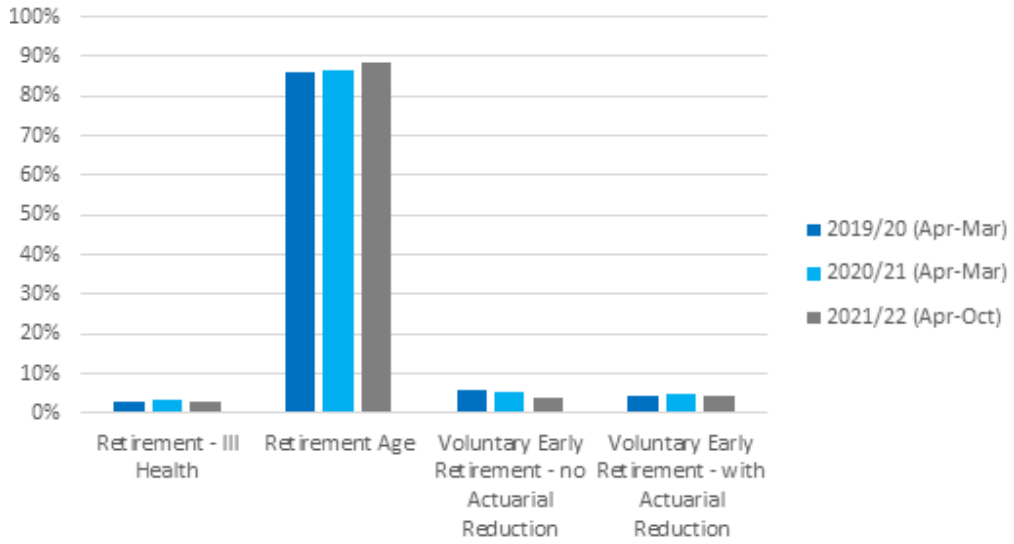
175. The combination of increased elective activity with ongoing pressures on urgent and emergency care related to the pandemic has impacted on an already stretched workforce. Excessive workload is a key contributor to poor wellbeing; it can be mitigated by adequate staffing.

[25] COVID-19 and the workforce: filling gaps, feeling overwhelmed | RCP London
[26] caring-for-doctors-caring-for-patients_pdf-80706341.pdf (gmc-uk.org)

6.4 Retention

176. Fewer medical and dental staff overall left the NHS throughout 2019/20 (9%) and 2020/21 (9.27%), but over the past few months leaver rates have started to approach pre-pandemic levels. The leaver rate for consultants has been relatively constant at ~4% but survey data indicates rising intention to leave among them.

Figure 9: Consultant retirement: Reasons for leaving, 2019/20 to 2021/22



Source: Unpublished ESR data

177. Most consultants who retire do so because they have reached retirement age. Normal pension age is considered to be 60 years for senior doctors in the 1995 Section of the NHS Pension Scheme, or 65 for those in the 2008 Section. Most members of the Scheme have the right to retire voluntarily from age 55. Opportunities exist to encourage senior doctors to continue to work into their sixties by offering them flexible contracts and appropriate remuneration. Data from HEE shows that about 1,100 consultants younger than 55 and 850 older than 55 leave the NHS each year.

178. The GMC's 'Completing the Picture' report showed that two of the top three reasons for doctors leaving the NHS were dissatisfaction with role/place of work/NHS culture (36%) and burnout/work-related stress (27%).

179. In 2021, 23% of doctors said they were planning to leave the profession, with 7% having already taken 'hard steps' towards doing so, up from 19% and 4% respectively in 2020 (GMC SoMEP).

180. A 2021 report from the Royal College of Anaesthetists showed that one in four consultant anaesthetists are planning to leave the NHS within five years, and following the pandemic many more now feel less inclined to stay working in the NHS.[27] Additionally, 14% of consultants have reduced their hours as a result of pension tax changes.

Key challenges

181. Pension taxation is a concern for many consultants and one that can contribute both to the decision to retire early and not to work additional hours.

182. The view from Royal Colleges and through our own staff networks is that the annual allowance and lifetime allowance thresholds in the NHS Pension Scheme have the biggest single impact on retention. Currently, a doctor who does extra work to help their trust in one year can receive an unexpectedly large tax bill the following year.

183. The NHS England and NHS Improvement Pensions Project has sought to dispel myths around pension taxation for consultants and other senior NHS employees, and advise on the circumstances in which working additional hours, delaying retirement or retiring and returning can still benefit doctors financially (see section 5.3). Our offer included:

- communications on the benefits of the Pension Scheme promoted via our website, payslips and a flyer
- pensions seminars
- guidance and training for local managers.

184. We will continue to monitor metrics to understand trends in early retirement and the impact of these interventions. However, the work so far does not address concerns of consultants who receive independent financial advice to reduce sessions or seek early retirement.

Conclusion

185. Retaining the consultant workforce in the current environment remains a challenge. Senior consultants provide important support to new consultants, training to registrars and clinical leadership to the wider multi-professional team. The NHS will realise significant benefits by encouraging consultants close to

[27] Respected, valued, retained. RCoA. Respected_valued_retained2021_0.pdf (rcoa.ac.uk)

retirement to stay on and consider flexible working or retire and return arrangements in doing so.

7. Specialty and associate specialist (SAS) doctors

186. This section sets out the outcomes of the 2020/21 SAS contract reform and provides an update on implementation of the 2021 SAS contracts.

7.1 SAS contract reform

187. Following national contract negotiations over 2020/21, a reformed specialty doctor contract and a new specialist contract were introduced on 1 April 2021, and have been agreed for three years, until 31 March 2024. They apply to new staff entering SAS grades from 1 April 2021 and to SAS doctors employed on new contracts from that date.

188. Contract reform updated and modernised terms and conditions and introduced new benefits for specialty doctors, such as an additional day of annual leave after seven years of service in an SAS grade and improved safeguards. It also shortened the pay scale for SAS grades – in line with recommendations from the Gender Pay Gap in Medicine Review, enabling doctors to reach the top of their pay scale more quickly; and aligned their pay points with other medical grades, to give individuals more flexibility to move throughout their training and career (eg step off and step on).

189. It also introduced a new specialist grade, to help recruit, motivate and retain senior doctors, as well as position SAS grades as a positive and fulfilling career choice. This new grade creates a progression opportunity for experienced specialty doctors and closes a gap that had opened with the withdrawal of the associate specialist grade in 2008.

190. The reformed contract also supports new investment in ongoing development through a SAS Development Fund. Funding is available in years one and three of

the three-year agreement to support individual and collective professional development activities.

191. Overall, contract reform will help meet commitments set out in the Interim NHS People Plan to provide new opportunities for progression within specialty and associate specialist careers, as well as to recognise and make SAS roles more attractive.

192. Following reform, a Joint Negotiating Committee for Specialty Doctor and Specialist grades (JNS SAS) was established to monitor implementation of the contracts and respond to emerging issues relating to implementation, benefits realisation and relevant non-contractual matters.

193. A benefits realisation approach was also agreed by DHSC and NHS England and NHS Improvement to monitor uptake and implementation of the multi-year deal in England, as well as the benefits delivered. Several metrics will be monitored over the three-year period of the deal, as well as any additional information available through JNC (SAS).

194. SAS doctors employed on national SAS terms and conditions of service were able to choose whether to transfer to the new terms and conditions or to remain on their existing terms and conditions. Those transferring are covered by the three-year agreement, whereas those remaining on the old contract remain subject to the government's response to the DDRB's pay recommendations.

195. The DDRB 2021 recommendation of a 3% pay uplift for all doctors not already covered by multi-year deals – which government accepted – created challenges for the implementation of the new contract. Many SAS doctors are in a better financial position if they stay on their existing contracts, rather than transferring to the new 2021 contracts. This may explain why uptake of the new contract has been slower than expected.

196. Furthermore, trade unions, in responding to the introduction of the new contract in 2021, have emphasised the short-term pay implications of switching contracts, not the broader benefits over the medium and longer term.

197. For further information on the number of SAS doctors who have moved to the 2021 contracts and implementation of the SAS advocate role, please refer to DHSC's and NHS Employers' evidence.

Conclusion

198. As a result of contract reform negotiations in 2020/21, a revised specialty doctor contract and a new specialist contract were introduced on 1 April 2021.

199. Despite the benefits of the new contracts to both doctors and the service, uptake has been slower than anticipated.

200. We will continue to work with DHSC, NHS Employers and other colleagues in JNC (SAS) to monitor and support implementation of the 2021 contracts, highlighting their broader and longer-term benefits.

8. Salaried GPs

8.1 Overview

201. While hospital consultant FTE numbers have increased by 19.4% over the past five years,[28] statistics[29] show only a 5.0% increase in doctor FTE numbers in general practice since 2016, despite a headcount increase of 11.5% over the same time period. FTE numbers of fully qualified GPs (ie excluding doctors in training) have decreased by 5.0% since 2016 despite a headcount increase of 3.6% over the same time period.

202. Most GPs work under GMS contracts as independent contractors; they are self-employed individuals or members of partnerships running their own practices as small businesses. As NHS England and the BMA's General Practitioners Committee agreed a five-year funding settlement from 2019/20, no recommendation is being sought from DDRB for independent contractor general medical practitioner (GP) net income for 2022/23.

203. The government has asked DDRB to include recommendations on the minimum and maximum pay range for salaried GPs, so evidence around recruitment,

[28] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/august-2021
[29] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-december-2021. Note that NHS Digital have revised their methodology, so figures provided in previous evidence are not comparable to those in this report.
[29] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2019-20

retention, motivation and earnings for salaried GPs are provided in this section. As official statistics on the general practice workforce are publicly available on the NHS Digital website, we have not included detailed tables of these here.

204. As at 31 March 2021, there were 1,831 Personal Medical Services (PMS) arrangements (26.9% of all contracts). Any uplifts in investment for PMS contracts are a matter for local commissioners to consider. In addition, a small number of GPs work, or hold contracts, under a locally contracted Alternative Provider Medical Services (APMS) arrangement across 177 practices.

Conclusion

205. The salaried GP recommended pay range is in scope of the DDRB's considerations for 2022/23. Recommendations will need to be informed by affordability and the fixed contract resources available to practices under this deal – which will also inform decisions by GP practices on the pay of salaried GPs.

8.2 Recruitment, retention and motivation

206. Statistics show that at 31 December 2021, 45,555 (36,191 FTE) doctors were working in general practice in England, an increase of 10.9% compared to 2016. Of these, 16,043 individuals (10,121 FTE) were working as salaried GPs (including GP retainers) – an increase of 4,809 doctors (2,660 FTE) in the last five years.

207. Salaried GPs now comprise 43% of qualified GPs (36% in FTE terms), compared to 29% in 2015 (24% in FTE terms) and at December 2021 they worked at an average participation rate of 63.1%.

Recruitment

208. Increasing the number of GP speciality training places is key to sustainable growth in the GP workforce. GP training places have grown year-on-year, and a record number of people accepted places for GP speciality training in 2021 with the total intake increasing to 4,000.[30] The Targeted Enhanced Recruitment Scheme has also been expanded to 800 places to encourage more trainee GPs to areas of the country that either have a history of under-recruitment or are under-doctored or deprived.

[30] https://www.hee.nhs.uk/news-blogs-events/news/record-number-4000-gps-accepted-training-placements

209. NHS England and NHS Improvement continue to help trainees from overseas identify practices with Tier 2 visa sponsorship licences, so that they continue to live and work in England once they qualify as a GP.

210. The NHS GP International Induction Programme also provides a supported pathway for overseas qualified GPs to be inducted safely into NHS General Practice and NHS England and NHS Improvement will work with the GMC and Royal College of General Practitioners in 2022/23 to open the programme to GPs from more countries around the world.

211. The Return to Practice Programme provides supported routes back into general practice for GPs who have left practice for a variety of reasons, including caring responsibilities, a career break or to work overseas. One is a streamlined route back for doctors who returned as part of the emergency COVID response. NHS England and NHS Improvement will implement further changes in 2022 to make it easier for former GPs to return to practice.

Retention

212. Work continues on targeted efforts to retain GPs in the workforce, particularly with systems to embed and communicate the enhanced package of GP retention initiatives in Investment and evolution: updates to the GP Contract 2020/21 to 2023/24:

- the two-year fellowship programme supports newly qualified GPs as they transition into independent practice
- the Supporting Mentors scheme provides a pool of trained mentors to support GP fellows, and encourages experienced GPs to become mentors for the younger GP workforce
- the New to Partnership Payment scheme encourages GPs to take up partnership positions; in December 2021 its criteria were revised to allow more healthcare professionals to apply
- the national GP Retention Scheme provides financial and educational support for doctors who may otherwise leave general practice
- the introduction of primary care flexible staff pools will stimulate the creation of additional salaried GP roles that are attractive to practices and locums alike

- the Local GP Retention Fund continues to provide additional bespoke interventions based on the specific need of a place or system.

213. NHS England and NHS Improvement are actively promoting the support available to GPs, and have introduced a new GP Career Support Hub to help GPs navigate the offers available.

Motivation

214. The GMC's report State of medical education and practice in the UK 2021 showed a doubling of the proportion of UK GPs struggling with their workload in 2021: 54% compared to 26% in 2020. On average, GPs described their workload, on average, as 'high intensity' on 76% of their days and 32% consider themselves at high risk of burnout (compared to 17% of doctors surveyed in 2020).

215. The report also showed that in 2021, only 21% of UK GPs surveyed were satisfied or very satisfied with their day-to-day work as a doctor; this compares with 38% in the equivalent report for 2020 and is lower than for other groups of doctors. In summary, 51% of GPs were satisfied overall compared to an average of 70% in 2022 and 39% reported they were dissatisfied overall compared to an average of 22% in 2020.

216. In this context, supporting the health and wellbeing of our GP workforce is more important than ever. The Looking After You Too coaching service, introduced in April 2020, offers rapid access to individual coaching to encourage psychological wellbeing and resilience and at December 2021 had delivered over 10,700 such sessions to over 4,800 primary care staff including 1,900 GPs. The offer has now been expanded to include the Looking After Your Team and Looking After Your Career offers. NHS Practitioner Health continues to provide a free, confidential service for doctors and dentists across England with mental illness and addiction problems, and system-level health and wellbeing hubs have been developed to direct all staff, including those working in primary care, to available health and wellbeing support available locally and nationally.

Conclusion

217. An increasing proportion of GPs are choosing to work as salaried GPs rather than independent contractors. This may reflect their desire for greater flexibility in the way they work to manage increasing workload pressures. NHS England and NHS

Improvement has health and wellbeing support as well as career development offers in place.

8.3 Wider general practice workforce

218. Between September 2016 and September 2021,[31] total practice staff numbers, including GPs, have grown by 8.0% in headcount terms (from 174,469 to 188,476) and 9.5% in FTE terms (from 126,361 to 138,372); the FTE increase for clinical staff excluding GPs was 20.1%.

219. Over the last five years, the number of practices has decreased by 13.2%, from 7,558 in 2016 to 6,522 at December 2021, and the average number of patients per practice has risen by 21.3%, from 7,761 to 9,412. This reflects a move towards larger practices employing more GPs, a trend that is also evident in the decline of single-handed GPs (ie those with only one practitioner) from 21.6% of practices in 2005[32] to 8.6% at December 2021.

220. This trend has meant a significant change in the skill mix within general practice. The ratio of qualified GPs to patients has decreased from 50.5 to 45.4 FTE per 100,000 patients but that for other (non-GP) clinical staff has increased from 44.6 to 50.8 FTE. Overall, the national ratio of clinical staff in a general practice setting (including GPs and doctors in training) per 100,000 patients has increased by 4.7%, from 105.5 to 110.4 FTE, although there is variation across the country.

221. This does not include the contribution of clinical staff working across a primary care network (PCN). Latest NHS Digital statistics[33] show that at 30 September 2021, PCNs had recruited 7,420 FTE clinical staff (based on 78.4% of organisations providing data).

Conclusion

222. The data indicates that general practice is both growing and diversifying to meet the challenges presented by a growing patient population and increasing workload.

[31] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-december-2021
[32] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/1995-2005
[33] https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-network-workforce/30-september-2021

8.4 GP recovery from COVID-19

223. Over the course of the pandemic, general practice has continued to provide high quality care to patients despite increased workload pressures and playing a critical role, through PCNs, in delivering the COVID-19 vaccination programme.

224. Excluding COVID-19 vaccinations appointments, in November 2021[34] there were 1.38 million average appointments per working day compared to 1.28 million in November 2019, an increase of 8.0%. The total appointments including for COVID-19 vaccinations was 34.6 million, an increase of 20.3% compared to November 2019 (adjusted for working days).

225. During the COVID-19 pandemic, general practice changed the way patients contacted their practice and the mode of appointments offered, transitioning rapidly to virtual consultations and remote triage, to reduce the spread of infection and protect both patients and general practice staff. Such changes offer long-term benefits for patients and practices and therefore will continue to be part of general practice going forward. Face-to-face appointments remained available throughout the pandemic with decisions about their use for individual patients based on clinical judgement and patient preference.

226. Patient satisfaction with GP services across England has increased, despite the challenges presented by the pandemic. Based on 850,000 responses, the independent GP Patient Survey 2021[35] showed marked increases in satisfaction across many questions compared to 2020, including overall patient satisfaction with their GP practice (83% compared to 81.8% in 2020).

227. The ongoing COVID-19 vaccination delivery, the treatment of patients with COVID and long COVID, and managing patients on elective waiting lists in addition to maintaining core services will continue to place further demands on general practice.

228. In Our plan for improving access for patients and supporting general practice, NHS England introduced further capacity funding for systems from November 2021 to March 2022 through the Winter Access Fund. This included a commitment to introduce digitally enabled flexible pools of staff to work across a place or system

[34] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/november-2021
[35] https://www.gp-patient.co.uk/surveysandreports

by 31 December 2021, making it easier for practices and PCNs to access available GPs and other professionals and for these professionals to find local opportunities.

229. With the acceleration of the COVID-19 vaccination programme in December 2021, further immediate steps were taken to free up general practice capacity this winter. Income for much of the Quality and Outcomes Framework was protected and GPs encouraged to use their professional clinical judgement to continue to provide effective preventative care and long-term condition management to those with greatest need.

230. In addition, by September 2021 NHS England and NHS Improvement had recruited 10,420[36] of the target additional 26,000 FTE staff to be working in primary care by March 2024. Patients can increasingly expect to be able to see different types of healthcare professionals in general practice, those who have greater expertise or skills to manage particular needs and conditions. These staff include social prescribing link workers, care co-ordinators and health and wellbeing coaches, who can support the health and wellbeing of patients, help people to develop knowledge, skills and confidence to self-manage their condition, and address wider determinants of health by connecting people to community-based support and advice.

Conclusion

231. General practice is facing a 'backlog' of deferred demand that is now presenting after the lifting of COVID-19 restrictions, the need to recover routine activity and manage patients on elective care waiting lists, and continued delivery of the vaccination programme – on top of pre-pandemic workload pressures. Salaried GPs and other primary care professionals will play a vital role in meeting this increased demand.

[36] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-december-2021; https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-network-workforce/30-september-2021

8.5 Remuneration and affordability

Trends in the earnings and expenses of salaried GP

232. The average income before tax for salaried GPs in England working in either a GMS or PMS (GPMS) practice in 2019/20[37] was £63,600, compared to £60,600 in 2018/19 – a statistically significant increase of 4.9%.

233. Table 4 below shows trends in average gross earnings, expenses and net earnings for salaried GPs and the ratio of their expenses to gross earnings.

Table 4: Average salaries for GPMS salaried GPs in England

Financial year	Average gross earnings £	Average expenses £	Average net earnings £	Expenses as a percentage of gross earnings
2012/13	64,700	8,100	56,600	13%
2013/14	64,100	9,200	54,900	14%
2014/15	62,500	8,700	53,700	14%
2015/16	63,900	7,900	55,900	12%
2016/17	65,300	8,700	56,600	13%
2017/18	68,200	9,800	58,400	14%
2018/19	70,100	9,400	60,600	13%
2019/20	71,600	8,000	63,000	11%

Source: Unpublished ESR data

234. Table 5 shows the distribution of income before tax (gross income less expenses) for salaried GPs in the UK from 2012/13 to 2016/17 (data for England is not available for this analysis).

Table 5: Number of UK salaried GPs in different income-before-tax brackets

Financial year	£0–£30k	£30k–£50k	£50k–£70k	£70k–£100k	£100k plus
2012/13	1,100	2,530	2,590	1,490	480
2013/14	1,240	2,890	2,690	1,410	420
2014/15	1,470	3,180	2,830	1,460	470
2015/16	1,030	2,620	2,560	1,440	440
2016/17	1,180	3,040	2,950	1,700	590

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

[37] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2019-20

235. Table 6 shows the distribution of income before tax (gross income less expenses) for GPs in England on GPMS contracts between 2017/18 and 2019/20.

Table 6: Number of GPs on GPMS contracts in England in different income-before-tax brackets

Financial year	0-<£25k	£25k–<£50k	£50k–<£75k	£75k–<£100k	£100k plus
2017/18	690	3,250	3,450	1,320	680
2018/19	660	3,420	3,880	1,680	850
2019/20	620	3,140	4,140	2,010	1,070

Source: Unpublished ESR data

236. The BMA's Review of The Gender Pay Gap in Medicine suggested the gap for salaried GPs is particularly wide.

237. Table 7 highlights this by comparing salaries for male and female salaried GPs within the same age bracket. It is important to note this data has accuracy and quality limitations. The table shows pay per headcount and not pay per whole time equivalent, which would facilitate a more robust investigation into the gender pay gap for salaried GPs. This dataset does therefore not enable accurate conclusions to be drawn.

Table 7: GP earning and expense estimates of female and male GPs in England

GP Earnings and Expenses Estimates 2019/20

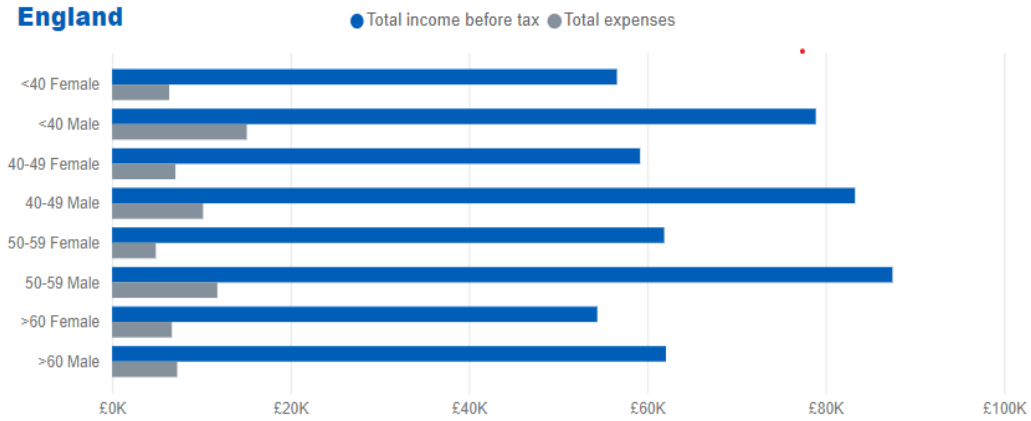
Average gross earnings, total expenses and income before tax by contract type (GPMS, GMS, PMS), country, gender and age

NHS Digital

Salaried GPs

Gender	Age	Population	Sample count	Employment gross earnings	Medical self employment gross earnings	Total gross earnings	Total expenses	Total income before tax	Margin of error of income before tax	Median income before tax
Female	50-59	1,100	650	£56,200	£10,600	£66,800	£4,900	£61,900	£1,390	£55,300
Female	<40	4,300	2,000	£50,300	£12,600	£63,000	£6,400	£56,600	£757	£55,600
Female	>60	200	150	£48,800	£12,400	£61,200	£6,700	£54,400	£3,001	£49,900
Female	40-49	2,550	1,400	£52,100	£14,200	£66,300	£7,100	£59,200	£962	£54,600
Male	>60	300	200	£53,100	£16,300	£69,300	£7,300	£62,100	£3,389	£53,800
Male	40-49	700	450	£72,200	£21,400	£93,500	£10,200	£83,300	£2,150	£77,700
Male	50-59	500	300	£75,000	£24,300	£99,300	£11,800	£87,500	£2,885	£81,500
Male	<40	1,350	700	£62,100	£31,900	£94,000	£15,100	£78,900	£1,497	£75,900

Average income before tax and total expenses by gender and age



Select country (choose one)

England | Northern Ireland | Scotland | Wales

Select contract type (choose one)

GPMS | PMS | GMS

Select gender (choose one or both)

Female | Male

Additional notes:

1. Results for some groups suppressed due to small sample sizes.
2. PMS GPs exist in England and Scotland only. Results shown for Northern Ireland and Wales relate to GMS GPs only.
3. Total gross earnings = gross self employment earnings plus gross employment earnings.
4. Total expenses = self employment expenses plus employment expenses.
5. Total income before tax = self employment income before tax plus

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Affordability

GP contract

238. The NHS Long Term Plan announced that funding for primary medical and community services would 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 GPC England agreed a five-year funding settlement from 2019/20 to give clarity and certainty to practices.

239. Funding for the practice contract is increasing by £998 million between 2019/20 and 2023/24. Accordingly, no recommendation is being sought from DDRB for independent contractor GMP net income for the duration of the five-year deal, and therefore for 2022/23.

240. As part of the five-year GP contact framework, NHS England and NHS Improvement announced that up to £2.355 billion per annum will flow nationally through the Network Contract DES and IIF by 2023/24.

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

Salaried GPs

242. NHS England and NHS Improvement and GPC England agreed that practice staff, including salaried GPs, in England would receive at least a 2.1% increase in 2021/22 – and that the DDRB recommendation for practices to uplift salaried GP pay by 3% could be adopted if they chose to. The minimum and maximum pay range for salaried GPs was uplifted by 3%, as was the pay for GP educators and trainers.

243. In 2021, we asked the government to continue to make recommendations on practice staff pay, including for salaried GPs, in its submission to the DDRB. We also asked it to ensure that DDRB continues to make recommendations on pay uplifts for GP trainees, educators and appraisers. The government will again decide how it responds to DDRB recommendations.

244. Recommendations will need to be informed by affordability and the 2.1% fixed contract resources available to practices under this deal for 2022/23 – which will also inform decisions by GP practices on the pay of salaried GPs.

245. The fixed contract resources for 2021/22/23 allow for pay rises for salaried GPs of 2.1%.

9. Dental practitioners

9.1 Overview

246. This section gives an update on general dental practitioners (GDPs) providing NHS primary care services.

247. We have continued to regularly meet with the General Dental Practice Committee of the British Dental Association (BDA) and during the pandemic, increased the frequency 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 about ongoing improvements in contractual arrangements.

248. 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.

249. For clarity, we define dentists as follows:

- ‘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.

250. Unlike general medical practice, dentists are rarely salaried in primary dental services. A high proportion of performer-only dentists work as an associate within a practice. We have no contractual relationship with performer-only dentists; their contractual arrangement is held with the contract holder, and therefore we are not involved in how pay is calculated and distributed to staff within any practice.

9.2 Recruitment, retention and motivation

251. Current trends in the dental workforce are difficult to assess. Available data[38] does not detail whole-time or part-time working, which limits our analysis of the workforce capacity.

252. In 2020/21, the number of dentists providing NHS services reduced by 4% to 23,733 dentists, having steadily increased in in the previous 10 years. We do not know if this is due to the pandemic-related very reduced levels of NHS activity during 2020/21, or the start of a reversal of an established upward trend.

253. A significant number of dentists enter and leave the NHS within any given year: in 2019/20 2,349 left and 1,806 joined. The number working for only part of the year for the NHS was 4,155 (16.8%). DHSC has provided a historical breakdown of the number of dentists providing NHS services in their evidence.

254. The Primary Care Activity Report (PCAR) collects data from regional teams, including the number of contracts terminated and the associated reason (see Table 8). In total 58 contracts were terminated between 1 April and 30 November 2021, almost the same as between December 2018 and September 2019 (57). Most (38) were voluntary hand-backs, and for 29 of these contracts caretaking arrangements have been established while re-procurement takes place; one contract has been recommissioned. Procurement generally takes over six months, so this does not necessarily reflect the final recommissioned position. Any further reduction in contract numbers reflects activity being distributed across existing contracts.

[38] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2020-21-annual-report

Table 8: NHS dental contracts terminated

Period	Number of contract hand-backs/termination	Reason
April 2021 – November 2021	Total number of contracts terminated or handed back: 58 North East – 5 North West – 8 Midlands – 5 East – 13 London – 2 South East – 13 South West – 12 Number of the above that entered caretaking arrangements: 29 Number of the above that have been recommissioned: 1	Commissioner terminations (1) Contractor termination notices (38) Retirement (2) Other (17)

Source: NHS England Primary Care Activity report

255. DHSC has provided details on motivation in their evidence. NHS Digital also published this information in Dentists' working patterns, motivation and morale– 2018/19 and 2019/20.

Conclusion

256. There are areas where recruitment and retention of dentists remains an issue. The further development of the commissioning framework to allow flexibility in existing contractual arrangements, within the existing financial framework, will help address this. The Interim NHS People Plan: the future dental workforce commits to creating a capable and motivated multi-disciplinary dental workforce of sufficient size to meet population health needs.

9.3 General dental practitioner recovery from COVID-19

257. While service provision has been impacted during the pandemic, face-to-face dental care provision continued to increase across 2021/22.

258. Financial support has been maintained throughout the financial year and activity requirements adjusted appropriately to ensure that the NHS dental contract provides a secure option for dentists. All dental contracts have received 1/12th of

their value each month. During the first COVID wave, urgent dental centres (UDCs) were established to care for those with urgent needs and have continued to provide services throughout the pandemic. As part of the income protection arrangements, dental contractors are not placed in clawback even though they have not delivered their full contractual activity, on the condition of delivering a portion of their contracted activity set by NHS England, reflecting ongoing capacity constraints caused by COVID-19. The protected income offered to practices for this non-delivered activity is adjusted to take account of variable costs not incurred.

Conclusion

259. 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 rebuild capability and capacity, working with their staff to optimise time and resources as well as manage patient expectation.

9.4 Community dental service

260. Community dental services (CDS) are local services commissioned by NHS England, now under a PDS agreement in line with local oral health needs assessments. Dentists working in CDS provide an important service to vulnerable patients with complex health and dental needs, and CDS have traditionally been seen as a vocational specialist route into dentistry. These dentists have previously been referred to as salaried or special care dentists. CDS also use the wider dental workforce, with dental nurses, hygienists and therapists working and delivering services to vulnerable patients within their scope of practice.

261. CDS played a key part in our response to the pandemic, standing up as UDCs. A consequence of this is an increase in CDS waiting times for patients. We have set up a waiting list reporting mechanism to help commissioners and contractors together address the longest waits locally.

Conclusion

262. We believe CDS play an important role in dental health service provision, and we are not aware of providers having any specific difficulties in filling vacancies.

9.5 Data comparisons

Access and activity

263. IPC guidance has had a significant impact on the number of patients that dental practices have been able to see since March 2020. The March 2021 GP Patient Survey[39] identified that 77% of people who sought an appointment with an NHS dentist in the past two years were successful (excluding those who could not remember). For those seeking an appointment in the last six months, the success rate was 75%. This compares with around 96% pre-pandemic.

264. The COVID-19 restrictions will have impacted activity, patient numbers, finances and treatments in the final quarter of 2019/20, 2020/21 and 2021/22, as shown in the data below. In some instances, we have used different comparators than in previous years to make the data more meaningful.

265. Data on delivery of UDAs is not comparable with previous years as routine dental activity paused on 25 March 2020 and some patients were reluctant to attend for treatment from early February. Table 9 therefore provides data for the year to December rather than March as that through to December 2019 is comparable to that through to December in previous years. Activity in December 2020 was heavily constrained by the pandemic.

Table 9: Number/proportion of adult and child patients seen by an NHS dentist

Year ended	Adult patients seen in the previous 24 months '000	Percentage of adult population in the previous 24 months	Child patients seen in the previous 12 months '000	Percentage of child population in the previous 12 months
Dec 2016	22,157	51.4	6,744	57.8
Dec 2017	22,131	50.9	6,855	58.2
Dec 2018	22,052	50.4	6,954	58.6
Dec 2019	21,834	49.6	6,979	58.4
Dec 2020	19,689	44.5	3,579	29.8

Source: GP Patient Survey Dental Statistics; January to March 2021, England.

[39] https://www.england.nhs.uk/statistics/2021/07/08/gp-patient-survey-dental-statistics-january-to-march-2021-england/

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

Earnings and expenses

267. This is the second year that figures are presented separately for England and Wales; the combined averages for England and Wales are no longer available. This coincides with a change in the way we determine dental type: more dentists are now identified as providing-performers and fewer as performer-only dentists. These changes mean that population counts and earnings and expenses estimates are not comparable with those in previous years. This means data before and after the change in methodology cannot be compared, but to add context and allow comparisons, HMRC has calculated the figures for 2017/18 using the new methodology (Table 10).

268. The dental earning and expenses estimates 2019/20 from NHS Digital[40] show that in 2019/20 the gross earnings of providing-performer dentists increased in cash terms. Earnings and expenses data include income from both NHS and private patients where a contractor provides both services.

Table 10: Average gross earnings (before deduction of practice expenses and delivery costs) by dentist type, 2015/16 to 2019/20

Year	Provider-performer dentist	Performer-only dentist
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
2019/20	£386,300	£87,500

Source: NHS Digital. Dental Earnings and Expenses Estimates (2019/20)

[40] https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2019-20

Note: Due to the time needed to collect and compile the data, 2019/20 is the latest year for which data is available.

269. Comparison of dental earning and expenses estimates between years continues to be difficult because of changes in the way dentists pay themselves. The main change has been the move towards personal and practice incorporation. This has impacted our ability to access data on key areas, including the relative level of expenses and earnings.

270. There was no statistically significant change in average identifiable net income after expenses for dentists in 2019/20 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.

271. For dentists holding a contract, average taxable earnings were £112,600, a 0.4% decrease from the previous year's £113,100. Dentists working for providers had an average net profit (taxable income) of £58,100, a 0.9% increase from £57,600 in the previous year.

272. For expenses, dentists used just over half (53%) the gross payments they received to meet their expenses. There has been little change in this ratio since 2013; DHSC provides historical data on income and net profit in their evidence.

273. DDRB asks for data by age, gender and ethnicity. We do not have data on ethnicity. Data on gender is provided later in this section. Table 11 provides a breakdown of pay by age.

274. Dentists under 35 have the lowest pay which is partly explained by only 5% of them being providing-performers. The 45–55 age group has the highest taxable income.

Table 11: Self-employed primary care dentists – average earnings and expenses from NHS and private dentistry, by age, England 2019/20

Age	Population	Average gross income	Expenses	Taxable income	Expenses ratio
<35	8,000	£85,500	£29,800	£55,800	34.8%
≥35 to ≤45	5,750	£145,400	£77,600	£67,900	53.3%
≥45 to ≤55	4,050	£218,500	£131,900	£86,600	60.4%

Age	Population	Average gross income	Expenses	Taxable income	Expenses ratio
≥55	2,950	£203,400	£123,300	£80,100	60.6%
All	20,750	£144,700	£76,100	£68,600	52.6%

Source: NHS Digital. Dentists' Working Patterns, Motivation and Morale – 2018/19 and 2019/20

275. Table 12 shows earnings by the percentage of dental time spent on NHS dentistry. The data is based on responses to the dental working hours survey,[41] and as such the population represented is much smaller than in other tables. The data shows income falls where time spent on NHS dentistry is >75%. These findings could be explained by performer-only dentists retaining a higher percentage of the fees generated from private dentistry than they do from NHS dentistry as the providing-performer dentists might take a lower proportion of the private fees.

276. The services provided by NHS dentists and private dentists may also differ. Private dentists often provide aesthetic care such as implants and adult orthodontics not available on the NHS.

Table 12: Self-employed primary care dentists – average earnings and expenses from NHS and private dentistry, England, 2019/20

Percentage of time spent on NHS dentistry	Population	Average gross income	Expenses	Taxable income	Expenses ratio
>0≤25%	550	£218,900	£132,000	£87,000	60.3%
>25<75%	800	£186,900	£109,600	£77,300	58.6%
≥75%	2,850	£149,300	£79,600	£69,700	53.3%
All responders	4,200	£165,500	£92,100	£73,400	55.7%

Source: NHS Digital. Dentists' Working Patterns, Motivation and Morale – 2018/19 and 2019/20

277. Another source of information on dentists' income is the data compiled by the National Association of Specialist Dental Accountants and Lawyers (NASDAL). Valuations from the NASDAL goodwill survey covering the quarter ending July 2021, the latest available, were higher than in the previous quarter ending April

[41] https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2018-19-and-2019-20-working-patterns-motivation-and-morale

2021: fee income as a percentage of gross fees up from 128% to 144%. NHS practice saw the highest practice goodwill at 161% of gross fees, compared to 146% in the previous quarter. Private practices goodwill values increased considerably between quarters, up to 133% of gross fees, but mixed practices saw a slight reduction, down to 145%.

278. The reason for the higher value of NHS practices could be the robust financial protection NHS dental services were given during the pandemic when safety requirements constrained their ability to provide services.

Table 13: Net profit per principal for the practice, 2015/16 to 2019/20

Type of practice	2015/16 £	2016/17 £	2017/18 £	2018/19 £	2019/20 £
NHS	134,102	139,698	126,269	124,475	116,284
Mixed	127,684	130,076	127,676	132,940	134,342
Private	133,743	139,454	138,806	140,951	133,192

Source: NASDAL. NHS practices are those where NHS earnings are 80% or more of total earnings. Private practices are those where private earnings are 80% or more.

279. The NHS Digital earnings report continues to note the 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 – i.e. is the only dentist working in the practice – no multiple counting can occur."

280. In looking at expenses, we need to continue to take account of the significant ongoing changes in the composition of the dentists in the earnings and expenses figures: mainly the large shift from providing-performer dentists to performer-only dentists.

281. Dentists can also choose to alter the balance between gross and net pay without this having any 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 they may also have higher expenses (and higher net income). The figures may also reflect changes in the type of work undertaken (eg a caseload of more complex and time-consuming treatments that incur higher expenses and fewer time-consuming prevention courses of treatment that incur lower expenses).

282. NASDAL provides the percentage of gross income spent on certain categories of expenditure for England (see Table 14), the first year it has been separated from that for England, Wales and Scotland combined.

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

	2017/18	2018/19	2019/20
Non-clinical staff wages			
NHS practices	20.9%	20.9%	20.6%
Private practices	17.9%	17.9%	18.5%
Laboratory costs			
NHS practices	5.6%	5.4%	5.7%
Private practices	6.8%	7.0%	6.6%
Materials costs			
NHS practices	6.1%	6.2%	6.2%
Private practices	7.4%	7.9%	7.5%
Premises costs			
NHS practices	3.5%	3.8%	4.2%
Private practices	4.4%	3.9%	4.6%

Source: NASDAL

Gender pay gap

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

284. We procure dental service provision via an open and transparent process and as such applications do not detail gender-specific identifiable information.

Table 15: All self-employed primary care dentists – average taxable income from NHS and private dentistry by gender

	2015/16	2016/17	2017/18	2018/19	2019/20
Total	£69,200	£68,700	£68,100	£68,600	£68,600
Male	£81,900	£81,800	£81,900	£82,900	£83,500
Female	£55,800	£55,500	£54,700	£55,100	£55,100

Source: NHS Digital. Dental Earnings and Expenses Estimates 2019/20

285. Regardless of dental type classification, on average male dentists have higher gross earnings, total expenses and taxable income than their female colleagues. This could be partly explained by the data including a higher proportion of male than female provider performer dentists who have significantly higher income than performer-only dentists (29% vs 11%).

286. 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 colleagues, contributes to the differences in taxable income by gender. Table 16 below shows the split by gender in working hours based on the responses to the Dental Working Patterns Survey; 55% of female dentist work fewer than 35 hours a week compared to 26% of male dentists.

Table 16: All self-employed primary care dentists – average earnings and expenses from NHS and private dentistry, by gender and weekly working hours, England 2019/20 (latest available)

			Mean average			
Gender	Weekly working hours	Report population	Gross earnings	Total expenses	Taxable income	Expenses to earnings ratio
Male	<20	100	£103,000	£56,500	£46,500	54.9%
	≥20 to <25	100	£173,700	£103,400	£70,300	59.5%
	≥25 to <30	100	£155,000	£85,000	£70,000	54.8%
	≥30 to <35	250	£169,300	£90,900	£78,300	53.7%
	≥35to <40	450	£173,800	£92,100	£81,700	53.0%
	≥40 to <45	500	£208,700	£115,100	£93,600	55.1%
	≥45	550	£312,500	£206,900	£105,700	66.2%
	All	2,100	£214,000	£126,500	£87,500	59.1%
Female	<20	200	£58,400	£23,700	£34,700	40.6%
	≥20 to <25	300	£60,500	£19,200	£41,200	31.8%
	≥25 to <30	250	£101,800	£46,200	£55,600	45.4%
	≥30 to <35	400	£120,300	£60,400	£59,900	50.2%
	≥35 to <40	400	£114,900	£50,900	£64,000	44.3%
	≥40 to <45	350	£133,800	£63,900	£69,900	47.8%
	≥45	250	£232,400	£147,900	£84,400	63.7%
	All	2,100	£117,900	£58,400	£59,500	49.5%

Source: NHS Digital. Dental Earnings and Expenses Estimates 2019/20

287. Table 17 presents data from NHS Dental Statistics 2020/21 and shows a marked increase in female dentists in recent years: in 2020/21. These statistics also indicate 59.1% of dentists under 35 were female.

Table 17: Percentage of dentists with NHS activity by gender, 2015/16 to 2020/21

All dentists with FP17	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Male	52.	51.	50.	49.	48.	48.
Female	48.	48.	49.	50.	51.	51.

Source: Extracted from FP17 data

Clawback

288. The term 'clawback' can mean different things but is often used to describe an adjustment to a dental contract where there has been underperformance: the amount already paid for the contracted services is deducted from future payments – that is, 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 in the NHS).

289. We continue to ensure that delivery of services is clinically appropriate, within the contractual framework and provides quality care provision. To help achieve this, NHS BSA has since 2018 provided 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 contributed to an increase in clawback, particularly for contracts that have consistently underperformed year on year.

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

	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
Performance adjustment	71	65	128	123	131

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

9.6 Remuneration and affordability

290. The affordability of pay recommendations for GDPs in 2022/23 needs to be carefully considered within the context of the NHS Long Term Plan and the productivity and efficiency requirements of all providers of NHS services – including GDPs.

291. We continue to see challenges with the geographical distribution of dentists willing to work within NHS contracts. As mentioned above, only providing performers have a contract with NHS England and NHS Improvement. Each year we adjust these contracts by the agreed uplift. However, there is no legal requirement for the providing performer to pass on this uplift to their performer-only contractors. We have no power to enforce this; any uplift is a decision for the providing performer.

2021/22 settlement

292. For 2021/22, DDRB recommended an uplift in income, net of expenses, of 3% from 1 April 2021. The increase was accepted by ministers, and when combined with an increase for expenses of 0.5% this provided an uplift of 2.22%.

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

9.7 Key challenges

294. 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 continue to be challenged by the backlog of care that is a direct result of the impact of the pandemic. The geographical and specialty shortfalls in NHS dental service provision are acknowledged and their causes are multi-factorial but largely due to the distribution of dentists.

295. We continue to develop our commissioning framework to provide tools that enable commissioners to flex current contractual arrangements, within the existing financial framework. These will include guidance for the development of existing contracts based on feedback from the dental profession.

296. In January 2022 we announced a £50m short-term funding injection to help address the backlog of urgent care that has been building up throughout the pandemic. This £50m has been distributed to each region and must be spent by the end of March 2022.

297. We have worked with the profession and the BDA to assess how the whole dental team may be better deployed to free capacity for and increase access to dentists, and at the same create a capable and motivated multi-disciplinary team.

10. Doctors in training

10.1 Overview

298. Doctors in training were an integral part of the pandemic response; many were redeployed from their usual specialties for long periods to support treatment of COVID patients. Many are senior decision-makers in their specialty who will be critical in managing the backlog of NHS care.

299. The pandemic has had a significant impact on many doctors in training. They have demonstrated considerable commitment, flexibility and resilience over the past two years. Their changed roles may have affected their mental and emotional wellbeing. They are likely to have seen more patients die than is usual in their specialty. NHS England and NHS Improvement have worked throughout the pandemic to enhance and extend the health and wellbeing offer to all NHS staff, including by improving access to professional wellbeing support and helping organisations create a wellbeing culture (section 5.5).

300. The BMA's Junior Doctors Committee approved reform of the junior doctors contract in June 2019, with members subsequently voting in favour of accepting the amended contract. A four-year pay deal was agreed that gave annual pay uplifts for the years 2020/21 to 2022/23. This agreement will end on 31 March 2023 and therefore the 2023 DDRB submission is the next opportunity to make new recommendations on pay for doctors in training.

301. While we note the tendency for doctors to move out of training posts for a period after completing foundation training, most do return. There continues to be intense

competition for specialist training posts. This year applications to and fill rates for specialty and GP training posts were high, reflecting in part the reduced movement of trainees to overseas posts and higher than usual applications from international medical graduates. As international travel opens up the opportunities for doctors in training to move to medical posts in other countries is likely to increase.

10.2 Workforce supply

302. Training has been disrupted for many; for some this is a result of redeployment out of specialty for many months, others have lost elective training experience, both their specialty's procedures and in the outpatient department.

303. Therefore, some will need training extensions to fulfil curriculum requirements and complete their training programme. While necessary, this means a potential hold-up in the pipeline of available new consultants, especially in procedural specialties, which could impact on the workforce available for elective recovery. Further details on this issue are provided in HEE's evidence submission to the DDRB.

304. Despite the impact of the pandemic, 76% of trainees rated the quality of their teaching as good or very good and 88% gave the quality of their clinical supervision in post a positive rating.[42]

305. The proportion of trainees struggling with their workload remains below pre-pandemic levels (11%) and is lower than that for GPs and specialists.

10.3 Training recovery

306. NHS England and NHS Improvement have worked with HEE to restore training and align training recovery and service recovery as quickly as possible. The elective recovery programme will provide significant educational and training opportunities for trainees, and senior trainees in particular can make a significant contribution to addressing the elective care backlog. We and HEE have engaged with elective centres, including those in the independent sector, to build in training opportunities.

307. We and HEE have set out a shared plan for COVID-19 training recovery and to mitigate risks to future workforce supply.[43] We continue to work with HEE and

[42] National training survey 2021 - results (gmc-uk.org)
[43] COVID-19 PGME Training Recovery: Progress Report (hee.nhs.uk)

DHSC to ensure appropriate funding for training recovery: this is key to the supply of new consultants.

308. There is also ongoing work with HEE and the Academy of Medical Royal Colleges (AoMRC) to ensure there is time for consultants to deliver appropriate educational and clinical supervision to doctors in training. In this year's operational planning guidance, NHS England and NHS Improvement has asked systems to ensure that consultants have adequate time in their job plans for supervision and training.[44] We recognise the contribution of many consultants to support training and the ongoing work on pensions and flexible working seeks to ensure we retain these consultants.

309. NHS England and NHS Improvement are working with DHSC, NHS Employers and HEE to address the issue of financial disadvantage to trainees who have been unable to progress to a higher grade due to the impact of the pandemic on their training.

310. As we work across the system on developing new ways of working and pathways of care to support elective recovery, we will continue to consider education and training needs alongside service recovery. This includes where NHS work is commissioned in the independent sector.

[44] B1160-2022-23-priorities-and-operational-planning-guidance-v2.pdf (england.nhs.uk)

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