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NHS England

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

Evidence for the 2023/24 pay round

11 January 2023

Contents

1. Introduction

1. This is NHS England's submission to the Review Body on Doctors' and Dentists' Remuneration. The evidence covers our key responsibilities for supporting the recruitment, retention and motivation of NHS doctors and dentists. We have covered each of the doctor and dentist groups within the remit of the DDRB: consultants, salaried general practitioners (GPs), the dental workforce, SAS grade doctors, and doctors and dentists in postgraduate training.

2. At the time of preparing our evidence we are in a period of industrial action across the NHS, with successful ballots for strike action over the 2022/2023 pay award by some NHS trade unions. The BMA Junior Doctor Committee will ballot in January 2023.

3. There is a backlog of patients requiring care as a result of the COVID-19 pandemic and overall demand for services, both in the NHS and social care, continues to increase. The winter period is harder than ever this year, with the resurgence of COVID-19 alongside respiratory illnesses such as influenza. Many doctors and dentists are being asked to undertake additional work to meet demand.

4. Vacancy levels across most staff groups are high, including 10,582 medical vacancies according to ESR data, despite the NHS workforce having grown significantly over recent years, with more people employed by the NHS now than at any time in its history. Leaver rates are now climbing, having fallen dramatically during the pandemic. To ensure services remain appropriately staffed and safe, NHS organisations have significantly increased their use of temporary staff, through both bank and agency shifts.

5. The most recent NHS Staff Survey results show that – save for a limited number of measures – staff experience has declined over recent years. Sickness absence rates increased during the pandemic and remain high; in June 2022 NHS Digital data showed the mean average sickness absence among doctors in NHS trusts was 2.4% compared with 1.6% in June 2019. While 7,084 doctors no longer held a licence to practise in 2020 during the pandemic compared to 9,960 in the preceding year, this

rose to 10,206 2021, a 2.5% increase on 2019.[1] The average retirement age for doctors in the NHS Hospital and Community Health Services (HCHS) is 60 years[2] and we know from our engagement that those approaching retirement cite pension taxes, workload, burnout and wishing to move abroad as reasons for retiring early.

6. Of doctors who joined the medical register last year, 61.4% had qualified in other countries, and fewer doctors from overseas are staying in the NHS long term.[3] Therefore, there is a need to increase domestic supply and to retain doctors by better supporting them in the workplace. Given the global shortage of healthcare staff we must make sure that being a doctor in the NHS is an attractive and rewarding job.

7. Delivering the NHS Long Term Plan, improving urgent and emergency care performance and reducing the elective backlog following the COVID-19 pandemic are imperative. To do this, the NHS needs to recruit and retain staff. This evidence sets out the work being undertaken to retain staff and support their physical and mental health wellbeing as they restore services, meet new care demands and reduce the care backlogs due to COVID-19. However, increasing productivity to tackle backlogs built up due to COVID-19 remains a challenge.

8. Work is also underway to develop a Long Term Workforce Plan. This will focus on the actions the NHS must take, working with partners in government, over the next 15 years to grow and transform the workforce, and continue to embed compassionate and inclusive cultures, so that it is on a sustainable footing to deliver the new care models required to meet the ageing population's care needs. The size and shape of the workforce, and the skills of staff, will need to shift to meet these challenges.

9. Staff need to know that they will have the right numbers of staff working alongside them in hospital or the community. To achieve this, pay awards need to be fully funded, so NHS leaders can employ the staff they need to deliver the mandated level of activity and investment in services for the benefit of patients.

10. We know from our discovery work during 2021 that staff are not fully aware of the value of the overall NHS employment offer or that the NHS Pension Scheme offers excellent value for money and important benefits for them and their loved ones. We

[1] https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report-2022#downloads Reference tables about the register of medical practitioners, table 220.
[2] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics
[3] https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report-2022

are exploring the benefits of improving awareness of the overall NHS employment offer by collaborating with our partners on developing an Employee Value Proposition framework that organisations can adopt or adapt as part of their local plans to attract, recruit, retain and encourage staff to return to the NHS.

11. Around 40% of the NHS workforce is over age 50. To maintain and increase capacity, it is vital we retain experienced staff to support recovery and their less experienced colleagues. And when staff do retire, we want to encourage them to return. To do that we need to put in place the right incentives and flexibilities, which address staff concerns over the impact of pensions tax, their ability to return to their previous role after retirement and the potential impact on their pension.

12. The total NHS pay bill accounts for at least £70 billion, around 65% of a provider's expenditure. Each additional 1% of pay for NHS trusts accounts for around £1 billion, allowing for full system costs. The 2022/23 pay award for staff was not supported by additional investment from central government, which led to difficult trade-offs within the existing NHS budget, and affected service delivery.

13. The NHS budget has been set until 2024/25 and includes stretching efficiency targets. The NHS will need to continue to manage the impact of high inflation, which also applies to other areas of spend, eg consumables, drugs and devices, energy costs, etc.

14. Given the ongoing impact of COVID-19 and the need to restore and recover services, additional pay pressure could lead to difficult trade-offs within the current NHS settlement. Pay remains the largest component of NHS costs and therefore pay inflation represents a material cost pressure to the NHS. This pressure, if not supported by additional investment, is again likely to result in difficult trade-offs during the year on staffing numbers, initiatives to support staff, and the ability of the NHS to deliver on its key strategic priorities – reducing the elective backlog, improving emergency care and improving access to primary care.

2. Workforce strategy

15. In July 2020, The NHS People Plan 2020/21[4] and the People Promise[5] were published, and set out the action that everyone in the NHS needs to take so that we have more people, working differently, in a compassionate and inclusive culture. The actions built on steps already being taken in the NHS, including innovative practice as a result of the pandemic, to improve the experience of people working, learning and training in the NHS, so that they are better equipped to lead change, provide high quality, safe services and improve outcomes for patients.

16. On 23 December 2022, NHS England published the 2023/24 priorities and operational planning guidance for the NHS. This includes priority actions relating to the strategic themes established in the People Plan 2020/21, in particular:

    - accelerating plans to grow the substantive workforce and working differently, while keeping our focus on the health, wellbeing and safety of our staff as they 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
    - working 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
    - using 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.

17. Looking to the future, demand for services will continue to grow with demographic and societal shifts. Technology will change how services are delivered and will give patients greater control over their own healthcare. Over the next 15 years, England's population is projected to increase by 4.2%. It is also ageing; over the same period the number of people over 85 is estimated to grow by 55%. An older population, with different health needs, and more empowered patients, means the size and shape of the workforce, and the skills NHS staff have, will need to alter.

18. In February 2022, the Secretary of State commissioned NHS England and Health Education England to develop a long-term workforce plan for the NHS. It will focus on

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

the practical action the NHS must take, working with partners, to grow and transform the workforce, and continue to embed compassionate and inclusive cultures.

19. Guided by a new strategic framework for the health and care workforce, the workforce plan will set out how we ensure the NHS has the right number of people, with the right skills, working in the right areas to deliver high quality care. Combined, the actions recommended in the plan would put the NHS on a sustainable footing over the long term. The NHS Long Term Workforce Plan will be published in Spring 2023.

3. NHS finances

3.1 Financial context

20. NHS England's priorities are to deliver the NHS Long Term Plan, improve urgent and emergency care performance, tackle the elective backlog and continue to respond to the impact of the COVID-19 pandemic. This is taking place within a financial settlement predicated on stretching efficiency targets and a reduction of COVID-19 related costs. As part of the settlement, government has set specific objectives for NHS England for urgent and emergency care, elective recovery and primary care. Government will set out its formal objectives and budgets for 2023/24 in the NHS mandate.

21. The NHS financial settlement was originally agreed with government in the 2021 Spending Review and covered the period up to 2024/25. Funding for the NHS has since been confirmed in the 2022 Autumn Statement. This provides an additional £3.3 billion for 2023/24 and 2024/25 which is required to fund forecast higher inflation.

22. The settlement requires the NHS to deliver annual efficiency savings of at least 2.2% each year, which is significantly higher than the c1% per year the NHS has historically delivered. Covid funding for systems reduces from £5.1 billion in 2022/23 to £2.4 billion in 2023/24, with a further £2 billion reduction in 2024/25. This will be challenging given that we anticipate that Covid demand and costs will now be ongoing issues for services. Furthermore, the NHS is absorbing other costs, including higher inflation in 2022/23 and other responsibilities transferred to NHS England.

Taken together, the NHS budget is estimated to have reduced in real terms by 3.4% in 2022/23 and will increase by 1.8% in 2023/24 and 2.0% in 2024/25.

3.2 Affordability

23. Pay remains the largest component of NHS costs (c65% of total operating costs) and therefore pay inflation represents a material cost pressure the NHS needs to plan for and manage.

24. NHS England funded systems in full to implement the pay award in 2022/23 but it created a recurrent pay inflation pressure as it was above what we had been funded for in the NHS financial settlement. This pressure was met by reducing the funding available to systems to support investment in technology and new diagnostic capacity.

25. Pay awards higher than what is affordable, and which are not supported by additional investment, will put further pressure on the NHS budget. This could impact on staffing numbers and the ability to deliver planned activity or service improvements. These decisions would have a longer term impact on the NHS's ability to restore services and make progress in tackling the elective care backlogs that have grown during the pandemic.

26. We are already reviewing investment in future service improvements and transformation programmes. This requires some planned service expansions to be reprofiled, which will reduce previously planned expenditure in 2023/24 and 2024/25. Separate to system wide expenditure, we are also delivering savings on our own internal management costs, as part of the merger with Health Education England from April 2023 and NHS Digital from January 2023.

4. NHS Staff Survey

27. The NHS Staff Survey[6] remains one of the world's largest staff surveys with nearly 650,000 responses.[7] In 2021 the survey was redeveloped and aligned with the People Promise. The 2022 survey retained Covid-related questions in light of the

[6] https://www.nhsstaffsurveys.com/
[7] https://www.nhsstaffsurveys.com/static/5051c9bf4e3622339dc41f581d4739e7/Core-questionnaire-2021.pdf

pandemic's continued impact, maintaining the opportunity to understand and compare employee experience during this period. The NHS Staff Survey is now being piloted in primary care across seven integrated care systems (ICSs), with an initial focus on inclusion of general practice and primary care network staff.

28. The 2022 survey results are not yet available. We expect them to be published in early 2023 to comply with official statistic requirements. 2021 data shows that scores across all themes were lowest for those staff who worked on Covid wards, were redeployed or who could not work remotely.

Table 1: NHS Staff Survey 2021 themes by Covid working

	Overall results	Covid-specific areas		Redeployed during Covid		Working remotely	
People Promise element	**PP element 2021 average score**	**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**	**Not working remotely**	**Those who have been working remotely due to the pandemic**
We are compassionate and inclusive	7.23	7.03	7.36	7.04	7.28	7.08	7.48
We are recognised and rewarded	5.88	5.59	6.09	5.65	5.95	5.64	6.30
We each have a voice that counts	6.71	6.54	6.82	6.53	6.76	6.54	6.98
We are safe and healthy	5.95	5.55	6.20	5.62	6.03	5.82	6.17
We are always learning	5.27	5.27	5.29	5.27	5.28	5.13	5.52
We work flexibly	6.04	5.66	6.29	5.76	6.12	5.69	6.62
We are a team	6.63	6.44	6.76	6.49	6.67	6.43	6.96

Higher than average score
Same as average score
Lower than average score

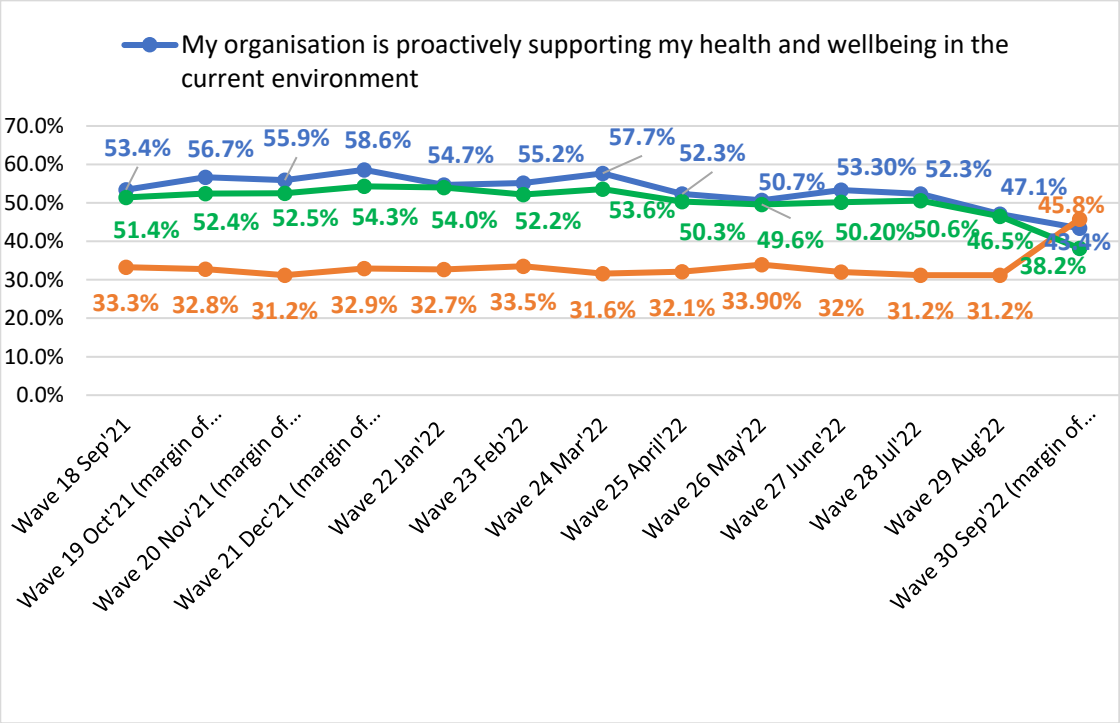
Source: NHS Staff Survey data 2021

29. The People Pulse[8] was introduced to help organisations listen to staff's views throughout the pandemic in a consistent, validated, standardised and more regular

[8] https://www.england.nhs.uk/nhs-people-pulse/

way. It has provided insights into employee experience since July 2020. Trend data from the last 12 months indicates a deterioration in staff feeling their health and wellbeing is supported and feeling they are informed, while anxiety levels have been stable except in September 2022 (Figure 1).

Figure 1: People Pulse analysis

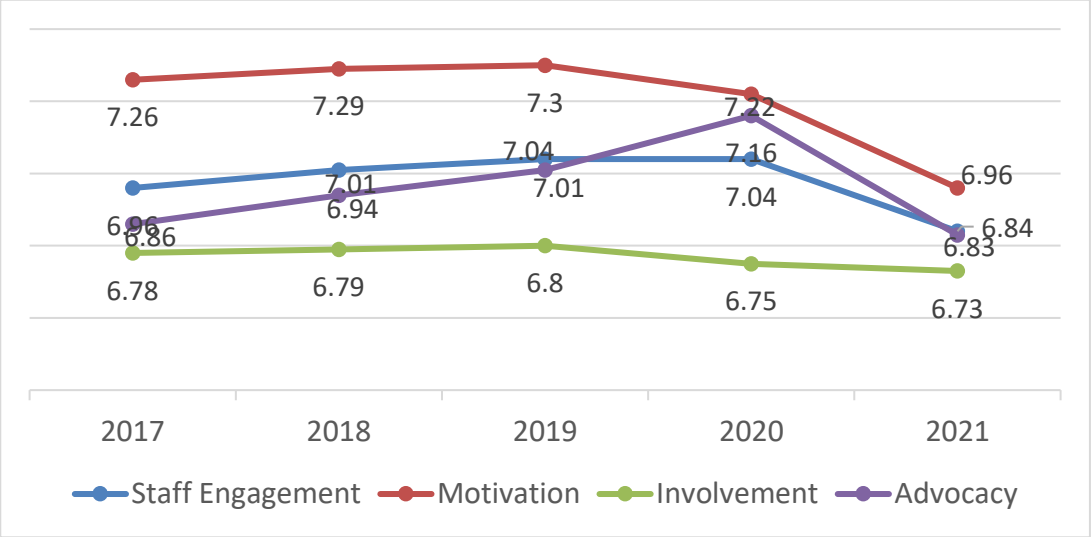


Source: People Pulse

30. The September rise in staff feeling anxious may be explained by September having a lower response rate and higher margin of error, September results were predominately influenced by two organisations scoring over 7 points above the NHS average. Following September, anxiety scores did reduce back to broadly the long-term trend. Quarter four data will be stronger and have a reduced margin of error, but figures will not become available until February 2023.

31. Figure 2 shows the overall engagement theme had been steadily increasing since 2017, and held in 2020 mainly due to an increase in advocacy – the pride our NHS people have for their organisation and service provision. However, it decreased significantly in 2021, with the advocacy, motivation and involvement elements all at their lowest levels for the last five years, substantially so for advocacy.

Figure 2: Staff engagement national average 5-year view



Source: NHS Staff Survey data 2021; National Quarterly Pulse Survey

32. The National Quarterly Pulse Survey[9] (NQPS) was introduced gradually from July 2021. In April 2022 the NHS Standard Contract was amended to require trusts to implement the NQPS. The NQPS uses the employee engagement question set and can be delivered in trusts using the People Pulse platform. Since Quarter 4 2021/22, NQPS has consistently collected over 115,000 responses each quarter, with the highest response numbers collected in Quarter 2 2022/23 (127,021 responses, representing over 10% of the NHS workforce).

33. Trend data from the NQPS show a continuous slight deterioration of the employee engagement score, although the pace of deterioration is slowing. Involvement has seen a slight improvement (+0.02). People Directorate research indicates that involvement, more than other aspects of employee engagement, might have the strongest link with retention.

34. The NHS Staff Survey has been aligned to the People Promise since 2021 to better understand how employee experience compares to what staff have told us is important to them. National support for local listening strategies has increased with the introduction of the monthly People Pulse and NQPS. These provide a consistent and standardised way of understanding employee experience nationally, regionally and locally at more regular intervals than yearly.

35. The Retention Programme explores factors that affect job satisfaction, and the reasons people decide to stay or leave the NHS, including what may trigger staff to

[9] https://www.england.nhs.uk/fft/nqps/

consider leaving. There are several triggers, eg work-related stress, staff shortages, pay, mental health impacts and time pressure. Pay is now in the top five reasons for leaving.

Medical and dental trends

36. As has been the trend for several years, medical and dental staff continue to have a higher level of satisfaction with their pay than any other staff group, although this has declined for all staff in the most recent results including medical and dental staff. The percentage of medical and dental staff satisfied with their level of pay is 49.8%, compared to 32.7% of all staff.

37. Staff are asked if they feel burnt out because of their work; 33.1% of medical and dental staff reported feeling burnt out because of their work, around the same percentage (34.3%) as all staff, but lower than for operational ambulance staff (51%) and registered nurses and midwives (40.5%).

38. The latest results appear to show medical and dental staff are less satisfied with opportunities for flexible working compared to other staff; 45.1% of medical and dental staff are satisfied with flexible working opportunities, compared to 53.9% of staff overall. This has declined for all staff groups over the last year, reversing the trend of overall improvement in satisfaction with flexible working opportunities.

39. Similarly, medical and dental staff also have a worse experience in terms of the percentage saying their immediate manager takes a positive interest in their health and well-being; 58.6% of medical and dental staff compared to 68% of all staff.

5. People Promise work programmes

5.1 The Exemplar Programme

40. The People Promise Exemplar Programme was launched in April 2022 in response to the experience that single interventions have limited efficacy and therefore a ‘bundle’ of actions is needed to deliver sustained gains across the whole workforce. The programme addresses retention factors for all staff groups and consists of 23 trusts covering every region and a range of types and sizes (excluding ambulance trusts).

41. Each trust is implementing a People Promise improvement action plan, addressing its key retention factors and drawing from a standard menu of interventions (eg flexible working, health and wellbeing and line management support). While the programme is in its early stages, we are beginning to see a positive picture for these organisations. Data gathered through the National Quarterly Pulse Survey (NQPS)[10] shows positive results in terms of engagement scores where focused interventions are being delivered, eg 14 of 23 exemplar trusts have improved their quarterly staff engagement scores from Quarter 1 to Quarter 2, with the overall cohort improving by 1.1% versus a deterioration nationally of -0.3%

42. There is a 10% productivity difference between the average of the ten most and ten least engaged acute providers and for those with a combination of high productivity/effectiveness and high engagement their working practices and workforce models can be quite distinctive (e.g., specialist nurses on surgical wards doing the work of trainee doctors in most other models).

43. Figure 3 suggests a positive relationship between operating department practitioner (ODP) NHS Staff Survey engagement scores (2021) and capped theatre utilisation (September 2022). The ODP role is a good representative proxy for theatre staff, ie these staff are easily identified through survey results and always work in theatres.

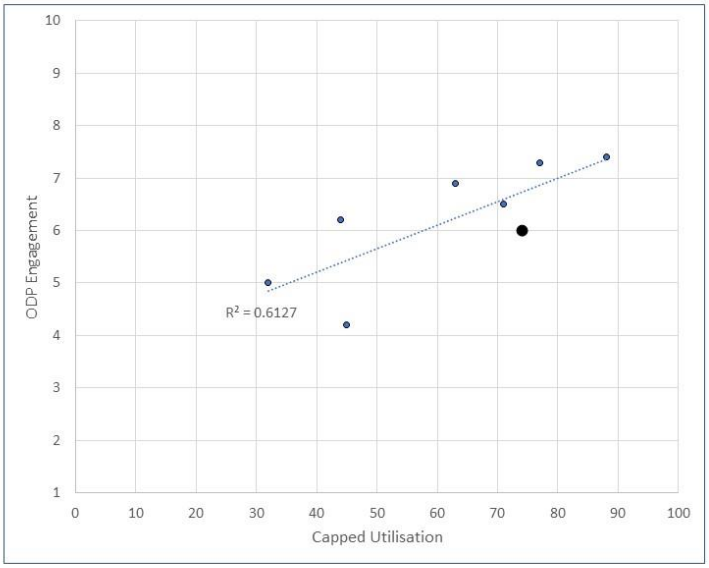
44. Capped theatre utilisation percentage – the touch time within planned session versus planned session time – is one of the key operating theatre efficiency metrics. This indicator improves understanding of the effectiveness of an organisation's operation scheduling processes in comparison to other organisations.

45. This metric represents theatre time utilisation on actual surgery, while touch time represents the time the theatre team were actively engaged in operating. A high level of touch time utilisation could represent effective use of theatre time as well as efficiency in non-surgical activities such as set up and logistics. Touch time utilisation over 85% is considered good practice.

46. Capped theatre utilisation is one of the primary elective recovery metrics that the Getting It Right First Time (GIRFT)[11] programme uses to monitor and measure progress and improvement.

[10] https://www.england.nhs.uk/publication/national-quarterly-pulse-survey-data/
[11] https://gettingitrightfirsttime.co.uk/hvlc/theatre-productivity/

Figure 3: Capped theatre utilisation percentage versus operating department practitioner engagement



- For a selection of trusts there appears to be a correlation between ODP Engagement score (2021 Staff Survey) and Capped Theatre Utilisation (Sept 2022)
- This could be worth expanding to a wider selection of Trusts as well as testing for trends over time

Data sources:

- Operating Department Practitioner Staff Engagement theme scores by Trust – 2021 NHS Staff Survey
- Trust Capped Theatre Utilisation data – Model Health System (Sept 2022)

Source: Operating department practitioner staff engagement theme scores by trust (2021) NHS Staff Survey and trust capped theatre utilisation data – Model Health System (September 2022)

47. Various other retention improvement interventions are being implemented and are informed by:

- Culture and Leadership Programme[12] (CLP) – a structured approach that helps organisations understand their own culture, identify the root causes they need to change and then to address them.
- Workforce Disability Equality Standard[13] (WDES), which is mandated through the NHS Standard Contract to reduce areas of disparity.
- The NHS Health and Wellbeing Framework[14] which defines what organisations and systems need to do to create a wellbeing culture.

[12] NHS England » The Culture and Leadership programme
[13] https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/wdes/
[14] https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/nhs-health-and-wellbeing-framework/#:~:text=This%20framework%20is%20a%20high,interest%20in%20health%20and%20wellbeing

- Messenger Review[15] (2022) which highlighted the difference excellent leadership can make in health and social care.

5.2 Health and wellbeing support

48. From the early stages of the pandemic, the national Health and Wellbeing Programme[16] was developed to support staff and complement what was available locally. The NHS Health and Wellbeing Framework[17] defines what organisations and systems need to do to create a wellbeing culture. This has continued to be rolled out during 2022.

49. The programme shifted from individually led offers, which required staff to recognise they were struggling and access support, to an organisationally-led and designed preventive approach, so that staff health and wellbeing becomes embedded culturally at a local level. Since then, key interventions include:

    - rollout of health and wellbeing conversation training for line managers and peers to enable them to have safe and compassionate conversations with colleagues
    - establishing and supporting the wellbeing guardians – a role to ensure effective, board-level ownership that provides check and challenge to ensure staff health and wellbeing is embedded in organisational culture
    - introduction of the wellbeing dashboard in the Model Health System[18] to provide a consistent dataset for all providers and ICSs to evaluate progress on health and wellbeing, including leading and lagging indicators, and positive and negative indicators
    - rollout of health and wellbeing champions across the NHS – with dedicated support from the national team
    - dedicated support and investment into 26 ICSs to develop locally owned health and wellbeing programmes tailored to local workforce needs and evaluated to share learning and identify which interventions could be scaled nationally

[15] https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future
[16] https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/
[17] https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/nhs-health-and-wellbeing-framework/#:~:text=This%20framework%20is%20a%20high,interest%20in%20health%20and%20wellbeing
[18] https://www.england.nhs.uk/applications/model-hospital/

- development of a national strategy for occupational health[19] with a view to supporting occupational health services to move towards a preventive, integrated service delivery model
- a tailored coaching service for all staff across primary care
- expansion of access routes to Practitioner Health for all primary care staff to self-refer to the service if they are unable to access local mental health services confidentially.

50. The national health and wellbeing programme is working with specific sectors, including maternity, ambulance and critical care, as well as directly supporting regional teams. ICSs participating in the nationally-led enhanced health and wellbeing programme have seen positive impact on leaver rates in comparison to the national average. Reasons for leaving include retirement, work-life balance and pay/reward. It follows that by improving staff experience, we would expect to see an impact on retention rates over time.

51. We continue work to ensure that all primary care staff have easy access to health and wellbeing offers, with the 'Looking After You' suite of accessible, tailored coaching offers continuing to see high levels of uptake and evidence of improved levels of motivation, retention and resilience across all primary care groups taking up the offer. This sits alongside the Practitioner Health service, which is a free, confidential primary care mental health and addiction service for health professionals. Previously aimed primarily at senior clinicians across the NHS, we have recently extended access to all primary care staff to self-refer to the service if they are unable to access confidential care through local mental health services.

52. On 28 September 2022 we launched a cost of living hub, which includes several local resources developed by the NHS for its staff and wider national resources that support health and care staff to make their money go further. We encourage employers to collaborate, sharing best practice with each other. We also developed a cost of living guide informed by interventions developed by employers – this provides a good practice approach to the structure and type of content employers may want to highlight to their workforce, with this support accessible both on and off site, and

19 https://www.nhshealthatwork.co.uk/growingohroadmap.asp#:~:text=Growing%20OHWB%20Together&text=In%202021%2C%20in%20response%20to,strategic%2C%20and%20proactive%20system%20partners.

categorised into key areas such as groceries, accommodation and travel. Colleagues welcome having access to a 'one stop shop' for cost of living resources.

53. We also published cost of living resources/information for staff on our Financial Wellbeing[20] webpage, providing information that NHS and care staff can access, a range of widely available financial wellbeing support and ideas to help any member of health and care staff make their money go further, categorised into key areas, eg deals and discounts, utilities, travel, grocery costs.

54. There is no quick fix to improving staff wellbeing and addressing its determining factors, which include adequate staffing levels to meet demand. It will require long-term investment, culture change, service improvement and, above all, a focus on what drives workforce wellbeing, some of which lies outside the workplace. The COVID-19 wellbeing offer will still be key in supporting staff as the service moves to recovery and living with Covid. It will evolve as part of the wider health and wellbeing offer to reflect staff's ongoing needs.

5.3 Flexible working

55. We know that flexible working is important to our people and a means of attracting and retaining them. In January 2022, we published the guidance Flexible working: Raising the standards for the NHS and in June 2022, Flexible working: toolkit for individuals and line managers[21]

56. Flexible working is encouraged from the point of recruitment, with NHS Jobs and the recruiting system (TRAC) enabling roles to be advertised with flexible working options. Since initial implementation in NHS Jobs in September 2020 and TRAC in March 2021, use of this feature has increased from 11.4% in April 2021 to 21.5% in September 2022.

57. Flexible working is also a key component of the exemplar site programme, with the 23 participating organisations being offered a range of support to focus on five areas:

    - Evidence of communicating and adopting the flexible working policy changes introduced in the NHS Terms and Conditions, including a clearly defined board-

[20] https://www.england.nhs.uk/supporting-our-nhs-people/support-now/financial-support/supporting-our-staff-to-help-money-go-further/
[21] https://www.england.nhs.uk/publication/flexible-working-toolkit-for-individuals-and-line-managers/

level champion. Trusts can also draw on the flexible working definition and principles when reviewing their policies.

- Dashboard or workforce report, which enables the board to monitor progress against defined flexible working metrics, including data relating to clinical staff. A template dashboard with sample metrics has been made available for use.
- Audit of the level to which team rostering and e-rostering are used to facilitate flexible working. Trusts can use tools such as the Level of Attainment checklist to understand their current position and identify gaps in moving to the next level. Interactive sessions, such as regional roadshows that include exploring challenges, are being run.
- Advertising a minimum of 25% of permanent roles with clear flexible working options. A webinar will be hosted to help trusts understand the benefits of advertising flexible roles and to promote use of NHS Jobs and TRAC functionality.
- Clinical leads demonstrate they are playing an active role in designing, implementing and monitoring flexible working arrangements for all staff, and acting on feedback. NHS England will work with the sites to understand how they are engaging with clinical teams and the impact this has in the organisation.

58. Regarding e-rostering, its introduction for medical staff is behind that for other staff groups. The 2022 Workforce Deployment Systems (WDS) survey assesses the extent to which e-rostering and e-job planning is implemented across NHS trusts based on software levels of attainment (LOA) for different staff groups – measured on a scale of 0 to 4. The LOA enable a trust to benchmark its progress towards optimal system use. The national average LOA for e-rostering was 1.6 for nursing and midwifery staff, 1.0 for allied health professionals and 0.6 for medical staff. NHS England has a national programme operating for advancing levels of attainment in e-rostering and e-job planning across all professions, including medical staff.

59. In general practice, flexible pools were introduced in 2020 to support GPs who want to work flexibly while supporting local systems and practices to fill vacant shifts. They enable GPs to access the flexibility of a locum role, with the additional benefits of a salaried position.

60. The NHS Staff Survey has shown a general overall upward trend in staff reporting satisfaction with opportunities to work flexibly, although there is more work to do for medical staff. Apart from a slight decrease in 2021 (53.9%), overall satisfaction increased from 51.2% in 2016 to 57% in 2020. The reason for the decrease is not

known but may partly reflect ways of working and staff experiences during the pandemic.

5.4 Enabling staff movement

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

62. The Enabling Staff Movement Toolkit,[22] developed with partners and published in 2019, helps organisations remove barriers to staff movement, providing sample 'warranty' text, case studies and signposted resources.

63. A digital staff passport[23] is widely accepted as a strategic modern solution to help achieve more efficient deployment of an agile and responsive workforce. In brief, this innovation enables the right people, with the right skills to be safely deployed to the right place, quickly, efficiently and securely, thereby helping in both the recovery period and setting a change in approach to provide a long-term sustainable solution.

64. Digital staff passports enable people to hold a verified portfolio of their qualifications, professional registration, employment history, competence and assessed experience so that they can move between different NHS employing organisations easily and quickly, without the need for repeat form filling, checks and duplicate training.

65. Significant progress has been made towards this ambition with all staff groups in NHS trusts being offered a limited scope, interim digital staff passport during the COVID-19 pandemic to enable temporary staff movements, alongside the extensive use of workforce sharing agreements (often referred to as MOUs). This has effectively acted as a national pilot, testing the use of decentralised ledger technology, the managed service requirements, interoperability with NHS Mail and the Electronic Staff Record (ESR), interim trusted frameworks and the demand for digital staff passports. We have been collaborating with the NHS BSA, HEE and other partners to launch the digital staff passport by August 2023 in 19 early adopter sites. Post-graduate doctors will be the first cohort of the workforce to adopt the digital staff passport towards their rotations in October 2023.

[22] https://www.england.nhs.uk/enabling-staff-movement-toolkit/
[23] https://transform.england.nhs.uk/information-governance/guidance/digital-staff-passport/

5.5 Equality, diversity and inclusion

66. In September 2020, eleven medical Workforce Race Equality Standard (WRES) indicators were developed to measure the experiences, career opportunities and progression of doctors (excluding GPs), a group not currently captured in other WRES data for NHS trusts. The 2020 publication is the first WRES report for the medical and dental workforce across NHS trusts and clinical commissioning groups (CCGs). The data presents a baseline against which future improvements can be measured.

67. Indicators 1 to 4 measure variations in career progression, pay, differential attainment at training, and difference in treatment by regulatory bodies. Indicators 5 to 10 measure treatment by colleagues, employers and patients. Indicator 11 measures representation in councils and boards of medical institutions such as Royal Colleges.

68. The report shows that while the NHS relies on the talents of Black and minority ethnic (BME) doctors and dentists, there is evidence of discrimination in opportunities for progression. Understanding the medical WRES data is the first step in helping organisations to develop evidence-based action plans, to continuously improve on the workforce race equality agenda. If we are to meet the ambitions set out in the NHS People Plan, urgent extra focus is needed on creating workplaces that attract, nurture and retain colleagues. Inequalities in any form are at odds with our NHS values. The fair treatment of staff is directly linked to better clinical outcomes and better experience of care for patients.

Key findings and challenges

69. 41.9% (53,157) of the medical and dental workforce in NHS trusts and CCGs in England were from an ethnic minority background, compared to 14% ethnic minority representation in the population.

70. Compared to 2017, the number of ethnic minority doctors increased by 21.1% (9,263). Over the same period the number of white doctors increased by 4.4% (1,466), confirming the ever-increasing diversity of medical staff in the NHS.

71. In 2020, 26.4% of clinical directors and 20.3% of medical directors were from an ethnic minority background, both considerably lower than the minority ethnic representation in the medical workforce.

72. The number of ethnic minority clinical directors increased by 16 and of ethnic minority medical directors by five between 2019 and 2020.

73. Compared to the overall proportion of doctors in NHS trusts and CCGs, ethnic minority doctors are underrepresented in consultant grade roles, overrepresented in other doctor grades and doctors in postgraduate training, and underrepresented in academic positions.

74. Ethnic minority doctors reported a worse experience than their white colleagues when it comes to harassment, bullying, abuse and discrimination from staff, and examinations (medical school and postgraduate examinations) and regulation (revalidation, referrals/complaints to the General Medical Council (GMC), Annual Review of Competence Progression).

Future ambitions

75. NHS England along with the Royal Colleges are committed to tackling the identified inequalities. Understanding the medical WRES data is the first step in helping institutions, regulatory bodies and organisations to develop evidence-based action plans, to continuously improve the workforce race equality.

76. For our patients to get better care and outcomes, our doctors need to be treated fairly and equitably. If we are to meet the ambitions set out in the NHS Long Term Plan and People Plan, urgent extra focus is needed on creating workplaces that attract, nurture and retain colleagues. If we are to be a model employer and make the NHS the best place to work, we must do better in tackling inequality for those with protected characteristics, including an ethnic minority background.

77. The NHS Long Term Plan set the ambition to increase minority ethnic representation at senior levels across the NHS, and each NHS organisation is now required to set it own target to contribute to this.

78. In primary care, we want to improve equality, diversity and inclusion (EDI) by embedding Freedom To Speak Up across primary care to give the workforce a safe space to speak up. We are working with integrated care boards (ICBs) to support WRES and the Workforce Disability Equality Standard (WDES) implementation across primary care, improving WRES and WDES data through improvements to workforce data collections and implementation of the NHS staff survey across

general practice, and supporting the spread of staff networks to include primary care staff.

Conclusion

79. While progress has been made in some areas, more remains to be done to embed and progress workforce equality. This will require a combination of approaches, including an action-focused EDI workforce plan for all protected characteristics, building on current initiatives such as overhauling recruitment processes and practices to be more inclusive and continuing to use WDES and WRES data to drive organisational and system improvements.

5.6 Retention Programme

80. Established in April 2020, our evidence-based Retention Programme has supported trusts and ICSs to increase workforce capacity by improving retention and staff experience. Structured around the People Promise, the programme is helping to embed a consistent offer to improve the experience of all staff – recognising differences across generations in workplace needs, motivations and influences on intention to stay.

81. The Retention Programme[24] explores factors that affect job satisfaction and the reasons people decide to stay or leave the NHS, including what may trigger staff to consider leaving: work-related stress, line manager support, staff shortages, pay, mental health impacts and time pressure are strong drivers for leaving.

Progress to date

82. In year 1 the programme developed a universal component focusing on flexible working and health and wellbeing, which organisations and systems accessed virtually through the retention hub[25] – a digital repository of practical information, tools and case studies for trusts and systems. The programme also established intensive pathfinder sites in every region (74 trusts in 10 ICSs) with cross-system collaboration.

83. In year 2 the programme delivered:

[24] https://www.england.nhs.uk/looking-after-our-people/
[25] https://www.england.nhs.uk/looking-after-our-people/

- benchmarking tools for retention within the Model Health System,[26] enabling every ICS and organisation to review its own data, track improvement and benchmark against peers to ensure evidence-based improvement
- an updated national retention hub[27] extending the reach of ideas and positive retention practice
- significant engagement with the system, including through focus groups, webinars and masterclasses
- a retention guide for line managers and leaders[28] produced with NHS Employers in March 2022.

Secondary care retention

84. Across all staff groups, fewer people left the NHS throughout the COVID-19 pandemic, but from September 2021 to August 2022 the rolling 12-month NHS leaver rates have been increasing month on month and are now higher than pre-pandemic. We believe the cumulative number of staff leavers since September 2021 exceeds the cumulative gains from the pandemic around the second quarter of 2022.

85. Through the retention, health and wellbeing and other programmes, we developed and introduced a range of interventions to try and help reduce leaver rates, which potentially may have been higher without these interventions.

86. Evidence on retention of primary care staff, including dentists and GPs, is included in sections 8 and 9.

Retention support

87. Retention of doctors in later stage careers is a key concern, particularly given there are signs in NHS trusts that these are increasing. Doctors are choosing to leave the NHS for various reasons: workplace pressures, lack of opportunities to work flexibly and issues relating to pensions taxation. Those in later stage careers are looking for 'healthy' and more fulfilling work, which often means a flexible work model, but also greater fairness and equality, and a more manageable workload.

88. Career conversations, sometimes referred to as 'stay conversations', are a way of supporting our valued NHS people to stay. 'Stay conversations' have been described

[26] https://www.england.nhs.uk/applications/model-hospital/
[27] https://www.england.nhs.uk/looking-after-our-people/
[28] https://www.nhsemployers.org/publications/improving-staff-retention

as conversations held by a leader with their critical talent to reinforce their value and how much the organisation appreciates them, with a view to increasing the probability they will stay.

89. A proactive conversation about what is and is not working enables the employer to build engagement and create a strategy to keep the employee, rather than waiting until they have already decided to leave.

90. Currently seven pilot sites are testing later stage career conversations. These structured conversations with senior consultants about their motivations at work, career and retirement plans, issues that would push them to leave and changes that would encourage them to stay longer will enable team-centred discussions around what changes are possible and better succession planning for the department and trust.

6. Reducing agency spend and temporary staffing

91. Increasing demand and vacancies are driving the increased use of temporary staffing (both agency and bank) – £2.9 billion at the end of 2021/22. Our aim is to increase the substantive workforce by bearing down on expensive agency costs. We are supporting trusts to promote the use of their trust banks, to move towards a more sustainable model of temporary staffing. We want to find the most cost-effective way to ensure the NHS has an effective and affordable flexible staffing solution for all staff groups.

92. The NHS has made progress in optimising temporary staffing spend in NHS trusts despite workforce and capacity shortages. The increase in bank spend reflects the flexibility needed to meet fluctuating demand.

93. The NHS Long Term Plan contains further measures to help improve the quality of care and value for money from the temporary workforce, which includes ensuring all agency staff are supplied using an approved procurement framework.

94. NHS England re-introduced measures in September 2022 to control agency expenditure in NHS trusts, including an ICB agency expenditure limit (agency celling only is monitored within the ICSs). Metrics to monitor agency usage are included in

the NHS Oversight Framework, which reinforce the rules that NHS trusts and foundation trusts should comply with.

95. Total agency spend, through the introduction of the price caps as part of a wider package of agency controls in 2016, has reduced spend by about £600 million from a peak of £3.6 billion in 2015/16 to £3 billion at the end of 2021/22. Despite this £600 million cost reduction, continuing increases in demand for workforce during the pandemic have resulted in an increase in agency spend as a percentage of wage bill from 4.0% in 2019/20 to 4.3% by the end of 2021/22. Total agency spend as a percentage of total wage bill was 7.9% in 2015/16.

96. The reduction from 2015/16 has largely been achieved by reducing the proportion of shifts filled by agency staff across all temporary staffing shifts, from 26% in 2018/19 to 23% in 2021/22. The proportion of agency spend as a share of overall temporary staffing in NHS trusts has fallen from 38% in 2017/18 to 30% in 2020/21, reflecting the percentage rise over this period in temporary shifts procured through a bank.

97. Medical and dental bank shifts in NHS trusts have increased from 43% in 2018/19 to 52% in 2021/22.

98. Bank staff spend as a percentage of temporary staffing spend in NHS trusts has risen from 62% in 2017/18 to 70% in 2020/21, which reflects our strategy to procure more of the NHS's temporary staffing through internal staff banks.

99. Medical and dental agency shifts have decreased from 57% in 2018/19 to 48% in 2021/22.

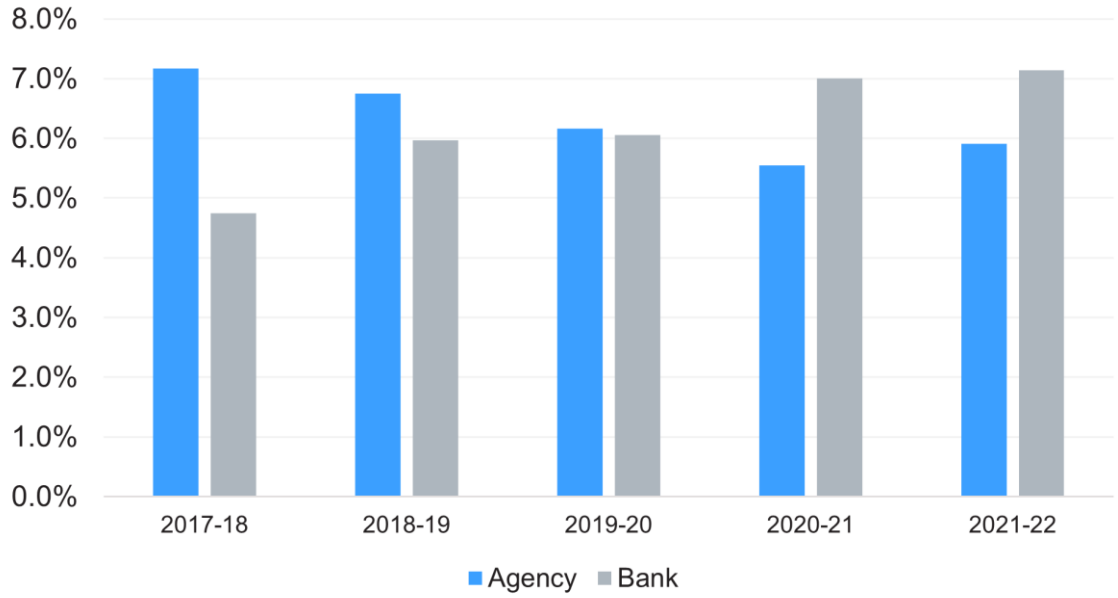
100. There are 77 trusts in a collaborative bank arrangement, with 27 such arrangements set up. This is a 56% increase since the People Plan was published in September 2020. A further 28 trusts are in the planning stage.

101. Of 42 ICSs, 27 have a collaborative bank, with each of the seven regions having one. Collaborative banks enable systems to work in partnership to make the most effective use of available resources. Most established and developing collaborative banks include medical and dental as a staff group.

102. Anecdotal data suggests ICS collaborative banks have since increased in number in the last 12 months. Collaborative bank data is collected annually via the Bank Management Staff Survey. The survey for 2022/23 will be complete in December

2022 and this data will be validated against quarterly bank headcount data. Results for 2022/23 collaborative bank engagement will be available in January 2023.

Figure 4: Medical and dental agency and bank spend as a percentage of total wage bill in NHS trusts



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

103. Work on bank development continues. The Bank Programme will support trusts and ICSs to improve their staff banks and work collaboratively through self-directed learning, face-to-face support and group improvement activities. It aims to help providers 'unblock' any issues that may prevent collaborative working.

104. In general practice, flexible pools were introduced in 2020 to support GPs who want to work flexibly while supporting local systems and practices to fill vacant shifts. They enable GPs to access the flexibility of a locum role, with the additional benefits of a salaried position.

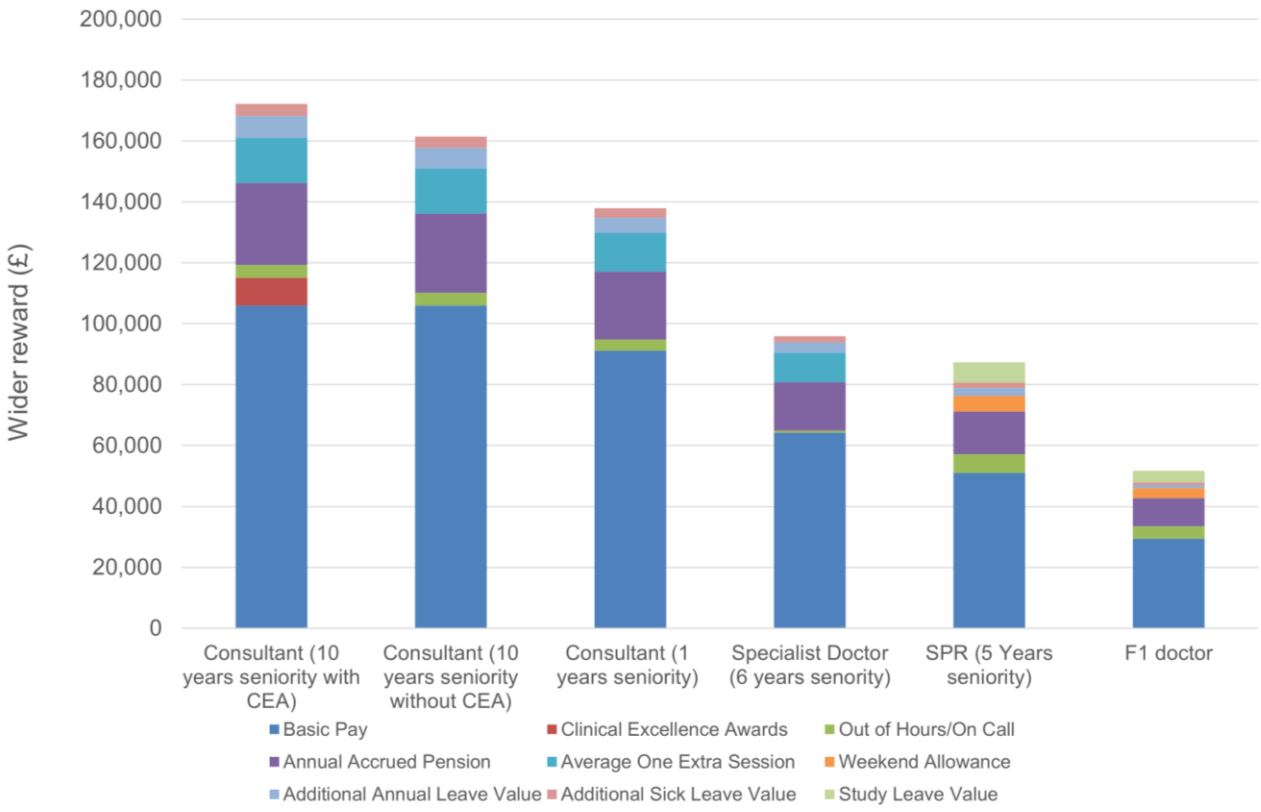
105. The Temporary Staffing Programme contributes to several initiatives described in the NHS Long Term Plan. Workstreams are reducing off-framework supply into the NHS; supporting trusts to improve price cap compliance and helping to accelerate the Bank Programme.

7. The total reward offer

106. The total NHS employment reward offer available to staff is made up of pay and non-pay benefits. The Department of Health and Social Care (DHSC) has set out in successive Review Body on Doctors' and Dentists' Remuneration evidence the value of the NHS reward package, developed by the Government Actuary's Department, the value of basic pay, out-of-hours and on-call payments, annual accrued pension, extra sessions worked and weekend allowances. It also includes additional leave over the statutory minimum and additional sick leave over statutory sick pay.

107. Our aim is to collaborate with our partners to support trusts to raise the profile of the value of the overall NHS employment offer, both the pay and non-pay benefits, including the NHS Pension Scheme, to attract, recruit, retain and encourage staff to return to the NHS after retirement.

Figure 5: Value of employed doctor grades total reward package (£)



Source: Government Actuary's Department.

7.1 Employee value proposition (EVP)

108. In the NHS Constitution, the NHS states its ambition for staff – the rights and obligations it aims to deliver for them, supported by the People Promise values and commitments, which include how staff should feel about working in the NHS, by 2024. EVP goes beyond the total reward elements of pay, pensions and benefits to the core values, mission and aims of an organisation, influencing staff engagement, wellbeing, engagement, culture, learning and development, and leadership.

109. We are drawing on research evidence to develop and test the impact of communicating the value of the NHS employment offer across a career, eg in the early years after recruiting staff when attrition is high in some groups, through to ensuring staff understand how the NHS Pension Scheme can help them work flexibly, wind down into retirement, and retire from and then return to the NHS. We will work with ICSs, ambulance trusts and the People Promise exemplar sites to test how the EVP framework can support organisations.

7.2 Staff recognition framework

110. Drawing on research evidence we are working with NHS organisations and academics to develop a 'staff recognition framework'. We plan to publish the framework in early 2023 and will test it with the exemplar sites. Our aim is to help health and care leaders and managers improve their understanding of and approaches to staff recognition. The aim is to reduce unwanted variation in how staff are recognised at work.

111. While the contractual pay and benefits offer to staff is important and needs to be competitive, this is only one component of the wider employment offer. As important is the value staff place on the experiential and emotional aspects of working in health and care, having a meaningful career and development opportunities, along with a shared sense of belonging, purpose, culture.

7.3 NHS Pension Scheme and reform

112. Our Pensions Response Project was established to identify how the NHS Pension Scheme (NHSPS) could better support the recruitment, retention and return of our NHS staff. The NHSPS has over 1.7 million members, who pay on average 9.8% in employee contributions; the employer contribution rate is 20.6%. It is important that

this significant investment available to staff, guaranteed by government and at a cost that staff would find difficult to outside the NHS, is better communicated to staff and employers.

113. Through focus groups and surveys, we found that most staff understood that the NHSPS is a good scheme but were less clear about why and how it works, and they did not fully appreciate how competitive it is and its value to them and their loved ones.

114. How staff want to receive pension information depends on their career stage. Older staff prefer to speak to a pension expert face to face, while younger staff are happy to rely on digital information provided it is simple and clear. Staff want the opportunity to ask questions about the scheme and have their questions answered on the day.

115. Since 2021, we have led pension seminars to help staff understand the value of NHSPS membership as part of their overall NHS employment offer. We are strengthening links with pension leaders in NHS Business Services Authority Pensions (NHSBSA), an organisation that can use its economies of scale and expertise to help staff better understand how the scheme works, the interaction with pensions tax and the benefits for most if they continue to build pension savings.

116. Our focus has been on retaining clinical staff in late career, those who may choose to retire voluntarily or who have the special right to retire at age 55 without reducing their pension (nurses, midwives and health visitors who retain the reserved rights that were withdrawn from 6 March 1995).

117. Since autumn 2021, over 300 staff pension seminars and pension masterclasses have been offered to over 10,000 staff (nurses, midwives, allied health professionals, consultants and GPs).

118. The seminars ranged from explaining the basics to one-to-one sessions explaining how pensions tax works and, for most, the benefits of paying pensions tax charges.

119. Qualitative evidence is based on a brief questionnaire that staff are asked to complete before and after each seminar. The questions measure improvement in understanding and whether staff might behave differently. Most of those who complete the survey say they have a greater understanding after the seminar. We are also embarking on a smaller study to track the retirement intentions of those who attend the seminars over the longer term.

NHS Pension Scheme reform

120. Work-life balance and flexibility around retirement are key concerns for staff. Encouraging them to prolong their working lives is critical to increasing capacity for patient care. DHSC and NHS England have together explored pension reforms that best position the NHSPS to attract, retain and encourage staff to return to the NHS: introducing strong financial incentives and facilitating a smooth transition that allows staff to remain in work while drawing their pension savings.

121. From 5 December 2002 DHSC began a consultation on changes to the 1995 Section of the NHSPS[29] to incentivise staff to remain in the workforce. New legislation will introduce partial retirement, allowing members to draw between 20% and 100% of their 1995 Section benefits and continue without a break to work as many hours as they wish. To be eligible staff must reduce their pensionable pay by 10%; GPs must reduce their commitment by 10%. Those who return to work in the NHS after retirement, including those who have already done so, will be able to re-join the 2015 Scheme and build further pension benefits. These important reforms are expected to become effective during 2023. Staff will be able to access their pension savings while continuing to work, retaining both their pension and salary. More detail can be found in DHSC's written evidence.

122. In parallel, we and NHS Employers will together explore how best to support employers offer staff greater flexibility over pensionable employment contracts. This additional support could complement new flexible retirement rules and help staff manage anxieties over pensions tax.

7.4 Pensions tax

123. The impact of pension tax charges appears to be influencing staff behaviour. Some staff say they feel they are being penalised for working hard for patients. Some staff may make counter-intuitive decisions to reduce their commitment, retire or leave altogether because they misunderstand the tax rules or feel they should not have to pay a tax charge.

124. Pension tax rules do allow relief on pension growth of up to £40,000 in any one tax year. Tax is payable but only on the excess after £40,000. Members do not have to

[29] https://www.gov.uk/government/consultations/nhs-pension-scheme-proposed-amendments-to-scheme-regulations

pay the tax charge immediately; they can meet the cost through 'scheme pays'.[30] For most NHSPS members, remaining a member and paying the tax charge may be the right decision. However, for the minority, opting out of the NHSPS may be a sound financial decision.

125. NHS England and DHSC, working with NHS Employers at the request of the previous Secretary of State for Health, were asked to develop options on recycling employer pension contributions into the pay of staff for whom opting out of the NHSPS, due to pensions tax, may be a sound financial decision. Employer contribution recycling is already within the gift of employers and is used by some to help retain the staff they need.

126. Working with our key partners, DHSC, NHS Employers and NHSBSA, our aim is to reposition the NHSPS as a valuable part of the overall NHS employment offer. The NHS Pension Response Project is part of wider initiatives that together help attract, recruit, retain and encourage staff to return to the NHS.

127. Learning from the NHS Response Project will inform how we and our partners support ICSs to build reward expertise, helping them create innovative ways to communicate and embed the value of the employment offer, including pensions as part of local people plans.

8. Consultants

8.1 Overview

128. Consultants are an essential part of the medical workforce, overseeing the treatment of the most complex patients. The standard required to gain specialist registration and requirement to demonstrate continuous learning and competence to maintain a licence to practise reflect their unique and valuable contribution to patient care. This skill set cannot be replaced by workforce redesign, so the consultant workforce will remain a critical component of providing high-quality patient care across NHS services.

[30] https://www.nhsbsa.nhs.uk/sites/default/files/2021-03/NHS%20Pension%20Scheme%20Pays%20V4.1%2001.2021.pdf

129. Consultants also provide clinical leadership, and training for the next generation of doctors, and may contribute to research that improves patient care. These skills are critical as the NHS seeks to recover from the pandemic, particularly in elective services.

130. Despite progress toward a multiprofessional workforce, more doctors are needed to meet increasing demand. Demand is driven by an ageing population, new treatments and technologies, public expectations, service improvements committed to in the NHS Long Term Plan, the need for elective recovery and tackling the backlog, and significant short-term winter pressures. Even before the pandemic, the NHS had a shortage of doctors. The OECD indicates the UK has 3 doctors per 1,000 people; the OECD average is 3.6. Our approach to increasing doctor numbers focuses on boosting supply and reducing attrition through retention.

131. According to the GMC, the number of consultants on the medical register is growing, but possibly not fast enough. The GMC predicts that if current trends continue, specialty and associate specialist (SAS) and locally employed doctors will be the largest group on the medical register by 2030, a significant shift from current proportions where consultants outnumber SAS grades by around five to one in England, according to ESR data.

132. Consultants are drawn from domestic supply and from international medical graduates (IMGs), via postgraduate training or specialist doctor and specialist routes. Domestic supply, the primary source of consultants, is limited. While medical student places are growing it will take at least 10 years for this to translate into more senior doctors.

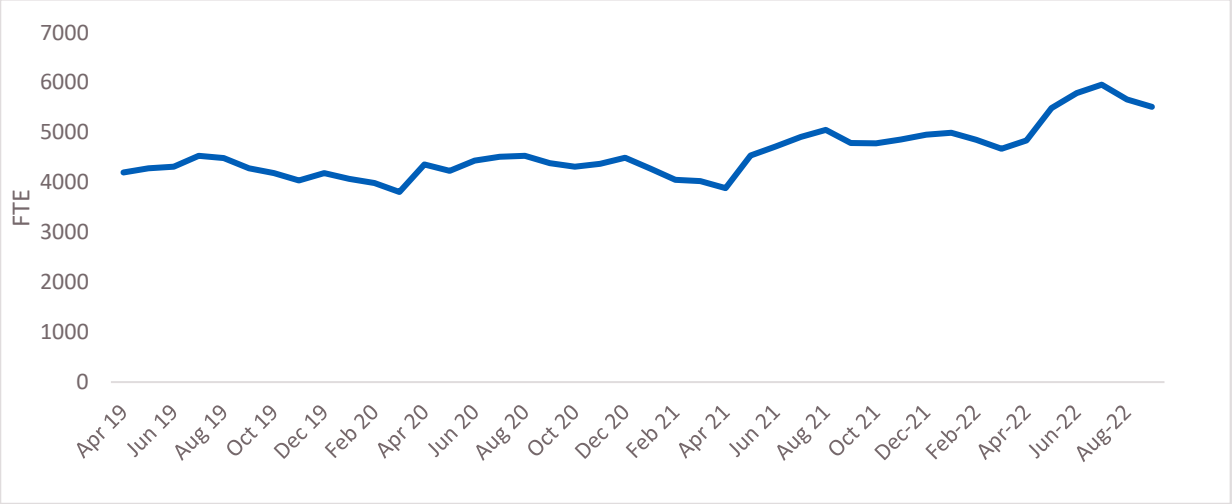
133. Health Education England (HEE) advises on the number and distribution of postgraduate medical training places it can afford from its financial allocation from government. HEE's evidence provides more information on postgraduate medical training.

134. International recruitment is the other source of doctors, including consultants, but the path for doctors who qualify in other countries (IMGs) to obtain medical employment in this country can be difficult.

8.2 Recruitment

135. Recruitment of consultants remains challenging across the country. Vacancies peaked in July 2022 at 5,959, and by September 2022 had fallen marginally to 5,517, still above the medium-term trend (Figure 6).

Figure 6: Consultant vacancies (FTE), April 2019 to September 2022



Source: NHS provider financial returns

136. Some geographies and specialties have difficulties recruiting the consultants they need, which can affect patient care and bank/agency usage. We know of one trust where over 50% of consultant posts are filled by locums or are vacant. Early investigative work suggests that both ESR and Provider Financial Returns (PRF) under-report the actual number of consultant vacancies. Further work is underway to evaluate this more widely.

137. HEE provides evidence on the distribution of specialty training places, which in time may address location-based shortages. In the short term, trusts have existing flexibilities, including in the consultant contract.

8.3 Retention

138. NHS England continues to focus on retention, including of senior clinicians. We provide information on the Retention Programme in section 6. We will shortly publish guidance on retaining doctors in the later stage of their careers by looking at the reasons doctors retire and what motivates them to continue working. We suggest specific actions for employers to help them retain their experienced consultants.

139. We understand anxiety about the impact of pensions tax is influencing our senior doctors' retirement intentions; many feel the pensions tax charge penalises them for working hard for patients. A greater number of staff in the NHS are affected by pensions tax than in other public sector workforces. The large concentration of senior doctors in their late career means employers will come across examples of doctors for whom remaining a member of the NHS Pension Scheme (NHSPS) may no longer be in their financial interests.

140. The risk is that pensions tax forces senior doctors to reduce their commitment to the NHS to lower their exposure to tax, opting out of the NHSPS or leaving the NHS altogether. For some, joining the temporary workforce may be a way to mitigate pension tax but offers poor value for money for the NHS.

141. Doctors in training will be aware of the issues their senior colleagues raise and may make the decision to reduce their commitment to avoid breaching the annual allowance threshold, even though this is not in their financial interest. Doctors continue to cite pensions tax as the most likely reason they will reduce their commitment and/or retire earlier than they may have planned.

142. Section 8 describes the action NHS England is taking with DHSC around the NHSPS.

143. At a national level DHSC's proposed changes could mean a reduction in doctors deciding to leave the workforce because of the impact of the NHSPS on their earnings. However, trusts will still have work to do to ensure that changes are understood and utilised.

144. NHS England will work with DHSC and NHS Employers to explain pension changes to the service and how they can aid retention.

8.4 Total reward

145. The DDRB noted last year that consultants remain in the 99th percentile of earners. This is of course not just because of their base salary, but also significant additional earnings, a component of which is local clinical excellence awards and national clinical impact awards.

146. Although the negotiating parties did not reach agreement on the reform of local clinical excellence awards, they are still being invested in and remain a valuable part of the overall consultant reward package.

8.5 Conclusion

147. Consultants are an essential part of the medical workforce. To meet future demands we will need to grow the consultant workforce both through postgraduate training and other routes. Consultants are our most well remunerated employed doctor group but we face recruitment and retention challenges driven by geographical and speciality-specific shortages, as well as factors pushing consultants to consider leaving the workforce. Significant changes are on the horizon with regards to the NHSPS that could alleviate some of the pension issues.

9. Specialty and associate specialist doctors

9.1 Overview

148. Specialty and associate specialist (SAS) doctors are an important and growing part of the medical workforce. The latest GMC state of medical education and practice workforce report identifies that all groups on the medical register have increased since 2017, but SAS and locally employed doctors (LEDs) more than others. The GMC predicts that if this trend continues, SAS and LED doctors will form the largest part of the medical workforce by 2030.

149. Our evidence last year set out the outcomes of the 2020/21 SAS contract reform and provided an update on implementation of the 2021 SAS contracts. This year we provide a further update, following the 2022/23 pay round.

9.2 SAS contract reform

150. The new SAS contracts were introduced from 1 April 2021 following agreement among all parties. The new grades were linked to a three-year deal including annual pay increases, ending on 31 March 2024. NHS England supports the introduction of the new grades; they provide modernised national grades that are attractive to doctors who do not wish to pursue a career as a consultant or wish to step out of their training

programme to focus on providing NHS services. With flexibility in mind, the grades were designed to closely align with pay points in other medical grades.

151. Between 1 April 2021 and the withdrawal of the national associate specialist grade in 2008 there was no national grade between specialty doctor and consultant. The introduction of the specialist grade gives flexibility to both employers and senior doctors: employers can create specialist roles that best provide the skill mix they require, and doctors have an alternative senior grade to consultant, so long as they meet the entry requirements. As such, the reformed SAS grades have an important role in the medium to long term in continuing to provide attractive flexible career routes as the aspirations of doctors in training change.

9.3 SAS Development Fund

152. In the first and third years of the agreement reached on the new SAS grades, investment is being provided for ongoing development through a specific SAS Development Fund. The intention is for the money to be used to support individual and collective professional development activities.

153. There has been some confusion regarding the allocation of the SAS Development Fund, with some employer and BMA representatives voicing they are struggling to locate available funding. NHS Employers has issued communications to the service on this issue.

154. All trusts received relevant funding in their overall allocations. SAS Development Funding was not specifically identified or separately allocated to trusts. Individuals responsible for allocating this funding to their SAS doctors may wish to work with their trust finance colleagues to ensure its correct allocation, and that the money is used for the intended purpose of supporting SAS doctors.

9.4 Benefits realisation

155. Uptake of the new grades is being monitored and NHS Employers will cover this in its evidence. Entrants to the new grades come from two sources: those joining the SAS workforce and those who chose to transfer from existing to new SAS grades. DHSC and NHS England agreed a benefits realisation approach to look broadly at the implementation of the multi-year deal and the benefits delivered. This work is ongoing and we will update the DDRB in due course.

156. Since the end of formal negotiations, the Joint Negotiating Committee for Specialty Doctor and Specialist grades (JNS SAS) was established jointly with the BMA and continues to meet quarterly.

9.5 Impact of the 2022/23 pay round

157. It has been unfortunate that, owing to the uplifts to the un-reformed SAS grades in the last two pay rounds, the salary scales of these grades have diverged from those of the reformed SAS grades. This means it is not attractive financially in the short term for some SAS doctors to move to the new grades, forgoing the broader benefits of the new contracts over the medium to longer term. We would want to see a coherent set of national grades for this group of doctors.

9.6 Conclusion

158. The changing needs and wants of our medical workforce necessitate a flexible and attractive career structure with alternatives to the direct route from trainee to consultant. The reformed SAS grades are therefore a vital part of our workforce offer.

159. We are keen to make it easier where possible for doctors to move from higher specialty training to the SAS doctor grades, and back into training, and to support the route from specialty doctor to the new specialist grade and to consultant via the Certificate of Eligibility for Specialty Registration (CESR) route. We also want to promote parity of esteem between IMGs, doctors in specialty training and SAS doctors, and to eliminate any inherent discrimination between grades or groups of doctors.

160. Given specialty training places are limited by what HEE can afford, supporting alternative routes into the consultant grade is important as more consultants will be needed in the future. When the graduates of the new medical schools start to qualify as doctors from 2024, we want to ensure there are attractive career structures and job and development opportunities for them in the NHS.

10. General medical practitioners

10.1 Overview

161. Most general medical practitioners (GPs) work under GMS contracts as independent contractors; they are self-employed individuals or members of partnerships running their own practices as small businesses. On 30 September 2022, 19,537 individual GP partners were working in general practice in England (53.1% of the fully qualified workforce); 15,433 doctors (41.9%) were employed as salaried GPs (including 618 GP retainers) and 1,668 as regular locums.[31]

162. As NHS England and the BMA's General Practitioners Committee (GPC England) agreed a five-year funding settlement from 2019/20, DDRB is not seeking a recommendation for independent contractor GP net earnings for 2023/24.

163. Government has asked DDRB to include recommendations on the minimum and maximum pay range for salaried GPs, so we provide evidence around recruitment, retention, motivation and earnings for salaried GPs, but not detailed tables as official statistics are publicly available on the NHS Digital website. Recommendations will need to be informed by affordability and the fixed contract resources available to practices under this deal; this information will also inform GP practice decisions about the pay of their salaried GPs.

164. As of 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.[32]

165. GP appraiser fees are currently included in the DDRB's remit, but we recommend this is removed in future years.

[31] NHS Digital. General practice workforce, 30 September 2022 (bulletin tables, Table 1B). https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-september-2022
[32] NHS Digital. NHS payments to general practice in England (Annex 1, Table 1A). https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2020-21

10.2 Recruitment, retention and motivation

166. On 30 September 2022, 46,283 (37,026 FTE[33]) doctors were working in general practice in England, a 9.3% increase on 2017. Of these, 16,051 (10,117 FTE) were working as salaried GPs (including GP retainers) – an increase of 4,381 doctors (2,400 FTE) in the last five years.

167. Salaried GPs now comprise 43.6% of qualified GPs (36.7% in full time equivalent (FTE) terms), compared to 28.9% in 2015 (23.6%). The proportion of salaried GPs working ≤15 hours per week, >15 hours to <37.5 hours per week, and 37.5 hours and over per week is set out in Table 2, and of GP partners as a comparison in Table 3.

Table 2: Salaried GPs: headcount by work commitment over time

	Sept 2017	Sept 2018	Sept 2019	Sept 2020	Sept 2021	Sept 2022
	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)
Working ≤15 hours per week (≤0.4 FTE)	1,551 (13.7)	1,708 (14.1)	1,836 (14.1)	1,985 (14.0)	2,067 (13.6)	2,045 (13.4)
Working >15 hours to <37.5 hours per week (>0.4 to <1 FTE)	8,231 (72.6)	8,860 (73.0)	9,648 (74.4)	10,676 (75.5)	11,531 (76.1)	11,731 (76.7)
Working 37.5 hours and over per week (≥1 FTE)	1,554 (13.7)	1,541 (12.9)	1,497 (11.5)	1,483 (10.5)	1,554 (10.3)	1,521 (9.9)

Table 3: GP partners: headcount by work commitment over time

	Sept 2017	Sept 2018	Sept 2019	Sept 2020	Sept 2021	Sept 2022
	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)
Working ≤15 hours per week (≤0.4 FTE)	594 (2.6)	586 (2.7)	587 (2.8)	576 (2.9)	591 (3.0)	545 (2.8)
Working >15 hours to <37.5 hours per week (>0.4 to <1 FTE)	12,950 (57.5)	12,477 (58.3)	12,416 (59.5)	12,307 (61.0)	12,313 (62.5)	12,307 (63.5)

[33] NHS Digital. General practice workforce, 30 September 2022 (bulletin tables, Table 1A).https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-september-2022

	Sept 2017	Sept 2018	Sept 2019	Sept 2020	Sept 2021	Sept 2022
Working 37.5 hours and over per week (≥1 FTE)	8,991 (39.9)	8,403 (39.0)	7,865 (37.7)	7,299 (36.2)	6,810 (34.5)	6,515 (33.6)

Recruitment

168. Increasing the number of GP specialty training places is key to sustainable growth in the GP workforce. GP training places have grown year on year, and a record 4,000 people accepted places for GP specialty training in 2021.[34] The Targeted Enhanced Recruitment Scheme was expanded to 800 places from 2022 to encourage more trainee GPs to areas of the country that have a history of under-recruitment or are under-doctored or deprived.

169. The NHS GP International Induction Programme continues to offer a supported pathway for overseas qualified GPs to be inducted safely into NHS general practice. The Return to Practice Programme provides supported routes back into general practice for GPs who have left practice for reasons including caring responsibilities, a career break or to work overseas. In 2022, NHS England implemented changes to the way it manages the England Medical Performers List,[35] streamlining processes and requirements and making it easier for doctors to return to practice.

Retention

170. Work continues on targeted efforts to retain GPs in the workforce, including:

- the two-year General Practice Fellowship Programme to support newly qualified GPs as they move into independent practice
- support for IMGs due to complete GP specialty training to identify practices with visa sponsorship licences, so that they continue to live and work in England once they qualify as a GP
- the Supporting GP Mentors scheme, which provides a pool of trained mentors to support GP fellows and encourages experienced GPs to become mentors
- the national GP Retention scheme, which provides financial and educational support for doctors who may otherwise leave general practice

[34] HEE. A record number of 4,000 GPS accepted a training place (blog) https://www.hee.nhs.uk/news-blogs-events/news/record-number-4000-gps-accepted-training-placements
[35] NHS England (February 2022). Policy for managing applications to join the England performers lists. https://www.england.nhs.uk/publication/policy-for-managing-applications-to-join-the-england-performers-lists/

- the introduction of primary care flexible staff pools, accompanied by a digital provider framework
- the Local GP Retention Fund, which provides extra bespoke interventions based on the specific need of a place or system
- the New to Partnership Payment scheme, which by September 2022 had supported 2,000 GPs to take up partnership positions.

Motivation

171. The GMC's The state of medical education and practice in the UK 2021 reported that, on average, GPs described their workload as 'high intensity' on 76% of their working days and 32% consider themselves at high risk of burnout. Only 21% of the UK GPs surveyed were satisfied or very satisfied with their day-to-day work.

172. The Eleventh National GP Worklife Survey 2021 showed that overall job satisfaction fell between 2019 and 2021; 50.6% of respondents reported being satisfied with their job overall and 30.6% reported being dissatisfied. More than eight in 10 GPs reported experiencing considerable or high pressure from increasing workloads and demands from patients.

173. Activity in general practice now exceeds pre-pandemic levels. In September 2022[36] there were 29.2 million appointments, including those for COVID-19 vaccinations, an increase of 10.4% on September 2019 (adjusted for working days). Over the same time period, the number of qualified GPs fell by 2.2% from 28,182 FTE to 27,556 FTE.

174. In this context, supporting health and wellbeing 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 by September 2022 it had delivered over 19,400 such sessions to over 6,200 primary care staff, including 2,398 GPs. The offer has now been expanded to 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 opened to direct all staff, including those working in primary care, to locally and nationally available health and wellbeing support.

[36] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/september-2022

Conclusion

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

10.3 Wider general practice workforce

176. Between September 2017 and September 2022, total practice staff numbers excluding GPs and doctors in GP training grew by 11.0% in headcount terms (from 131,293 to 145,800) and 16.8% in FTE terms (from 90,830 to 106,099); the FTE increase for clinical staff excluding GPs was 23.8%.

177. Over the same five years, the number of practices[37] has decreased by 12.2%, from 7,354 in 2017 to 6,456 at September 2022, and the average number of patients per practice has risen by 20.3%, from 7,978 to 9,596.

178. The ratio of GPs to patients has increased from 59.0 to 59.8 FTE per 100,000 patients but decreased for fully qualified GPs from 49.7 to 44.5 FTE per 100,000 patients. The ratio for other (non-GP) clinical staff has increased from 44.8 to 52.5 FTE per 100,000 patients. 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 8.5%, from 103.8 to 112.3 FTE, although there is variation across the country.

179. This does not include the contribution of clinical staff working across a primary care network (PCN). By 30 June 2022, NHS England had recruited 19,305 FTE direct patient care staff, [38] meaning that we are on track to deliver the target extra 26,000 FTE primary care professionals by March 2024.

180. General practice teams increasingly comprise a wider range of clinical professionals to support larger patient lists with fewer qualified GPs.

[37] NHS Digital. General practice workforce, 30 September 2022 (bulletin tables, table 5)https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-september-2022
[38] https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-workforce-quarterly-update/30-june-2022

10.4 Renumeration and affordability

Trends in the earnings and expenses of salaried GPs

181. The average income before tax for salaried GPs in England working in either a general medical services (GMS) or PMS (GPMS) practice in 2020/21 was £64,900, compared to £63,600 in 2019/20[39] – a statistically significant increase of 2%. This is below the DDRB recommended uplift for 2020/21 of 2.8%, and below that for the other UK nations whose salaried GP pay uplifts ranged from 8.1% to 9.5%.

182. The average increase for contractor GPs in England was £20,200 (16.6%) from £121,800 in 2019/20 to £142,000 in 2020/21. DDRB has not been asked to provide recommendations on uplifts to independent contractor GP net earnings for 2023/24 as this is covered by a five-year funding settlement.

183. The increase for salaried and contractor GPs includes both an uplift to their average rates of pay as well as pay for any additional hours worked. The additional hours worked during 2020/21 – the first year of the pandemic – included those to open practices over four bank holidays, in the evening and at weekends to deliver the largest vaccination programme in the history of the NHS, and some salaried and contractor GPs worked extra hours to support the pandemic response elsewhere in the NHS too.

184. Table 4 below shows trends in average gross earnings, expenses and net earnings for salaried GPs in England and the ratio of their expenses to gross earnings between 2012/12 and 2020/21.

Table 4: Average salaries for GPMS salaried GPs in England, 2012/13 to 2020/21

Financial year	Average gross earnings (£)	Average expenses (£)	Average net earnings (£)	Expenses as a % 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%

[39] NHS Digital, GP earning and expenses estimates, 2020/21. https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2020-21

2017/18	68,200	9,800	58,400	14%
2018/19	70,100	9,400	60,600	13%
2019/20	71,600	8,000	63,600	11%
2020/21	72,200	7,400	64,900	10%

185. 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, 2012/13 to 2016/17

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

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

186. Table 6 shows the distribution of income before tax (gross income less expenses) for GPs in England on GPMS contracts between 2017/18 and 2020/21.

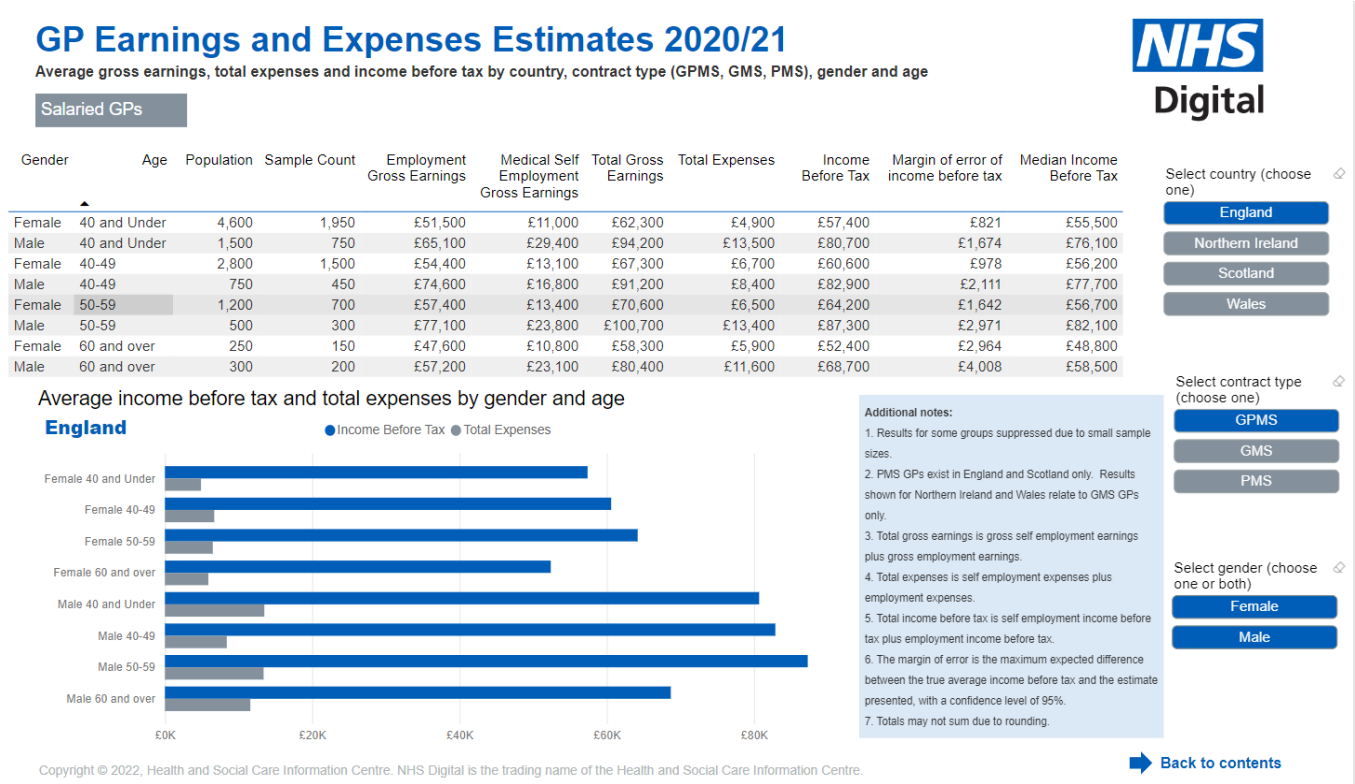
Table 6: Number of GPs on GPMS contracts in England in different income-before-tax brackets, 2017/18 to 2020/21

Financial year	<£25,000	£25,000–£50,000	£50,000–£75,000	£75,000–£100,000	£100,000 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
2020/21	580	3,390	4,480	2,230	1,250

Gender pay gap

187. The Review of the gender pay gap in medicine identified a particularly wide gap for salaried GPs compared to hospital and community health service doctors, clinical academics and contractor GPs. Table 7 highlights the latest position by comparing pay per headcount for male and female salaried GPs in the same age bracket using latest available data. However, this data has accuracy and quality limitations and comparing pay per FTE would facilitate a more robust investigation into the gender pay gap for salaried GPs given the difference in average working hours between male and female. Accurate conclusions can therefore not be drawn from this dataset.

Table 7: GP earning and expense estimates of female and male GPs in England (2020/21)



GP Earnings and Expenses Estimates 2020/21

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

Salaried GPs

NHS Digital

Gender	Age	Population	Sample Count	Employment Gross Earnings	Medical Self Employment Gross Earnings	Total Gross Earnings	Total Expenses	Income Before Tax	Margin of error of income before tax	Median Income Before Tax
Female	40 and Under	4,600	1,950	£51,500	£11,000	£62,300	£4,900	£57,400	£821	£55,500
Male	40 and Under	1,500	750	£65,100	£29,400	£94,200	£13,500	£80,700	£1,674	£76,100
Female	40-49	2,800	1,500	£54,400	£13,100	£67,300	£6,700	£60,600	£978	£56,200
Male	40-49	750	450	£74,600	£16,800	£91,200	£8,400	£82,900	£2,111	£77,700
Female	50-59	1,200	700	£57,400	£13,400	£70,600	£6,500	£64,200	£1,642	£56,700
Male	50-59	500	300	£77,100	£23,800	£100,700	£13,400	£87,300	£2,971	£82,100
Female	60 and over	250	150	£47,600	£10,800	£58,300	£5,900	£52,400	£2,964	£48,800
Male	60 and over	300	200	£57,200	£23,100	£80,400	£11,600	£68,700	£4,008	£58,500

Average income before tax and total expenses by gender and age

England

Income Before Tax Total Expenses

Female 40 and Under
Female 40-49
Female 50-59
Female 60 and over
Male 40 and Under
Male 40-49
Male 50-59
Male 60 and over

£0K £20K £40K £60K £80K

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 is gross self employment earnings plus gross employment earnings.
4. Total expenses is self employment expenses plus employment expenses.
5. Total income before tax is self employment income before tax plus employment income before tax.
6. The margin of error is the maximum expected difference between the true average income before tax and the estimate presented, with a confidence level of 95%.
7. Totals may not sum due to rounding.

Select country (choose one)

England
Northern Ireland
Scotland
Wales

Select contract type (choose one)

GPMS
GMS
PMS

Select gender (choose one or both)

Female
Male

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Affordability

188. 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 practices clarity and certainty.

189. General practice funding flows primarily through ICBs. In 2023/24 commissioner primary medical care allocations will rise by more than 5% in aggregate, through a

combination of funding streams at practice and PCN level, and there will likely be further continued investment in relation to Covid vaccination.

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

191. Funding for the practice contract is increasing by £998 million between 2019/20 and 2023/24. Accordingly, we are not seeking any recommendation for independent contractor GP net income for the duration of the five-year deal, and therefore for 2023/24.

192. NHS England and GPC England agreed that practice staff, including salaried GPs, in England would receive at least a 2.1% increase in 2022/23 – and that the DDRB recommendation for practices to uplift salaried GP pay by 4.5% could be adopted if they chose to. The minimum and maximum pay range for salaried GPs was uplifted by 4.5%, as was the pay for GP educators and trainers.

193. In 2022, we asked government to ask DDRB to continue to make recommendations to practices on salaried GP pay. Government will again decide how it responds to DDRB recommendations. Recommendations will need to be informed by affordability to practices – that is, ultimately, to primary medical care contractors. The practice global sum (usually the main source of funding directly used for practice staff pay) increase in 2023/24 will reflect sufficient funding for a 2.1% for salaried staff, agreed as part of the fixed five-year deal with the sector. We have described above the overall increases to primary care funding.

10.5 GP appraiser fee

194. GPs like other doctors are subject to annual appraisal as part of revalidation requirements. NHS England is responsible for arranging the appraisal of the c60,000 GPs working in England, and for recruitment, training, support and payments for those who appraise GPs. GP appraisers do not need to be a GP or a doctor.

195. There is a set fee for each appraisal; currently £584 as per the DDRB recommendations for 2022/23, and an annual cost of about c£28 million.

196. Time spent preparing for, carrying out and writing up an appraisal can vary greatly but, in most cases, will not be more than the equivalent of a half-day session. It is of concern, therefore, based on this assumption, that time spent on appraisals is being remunerated at the equivalent of an annual salary of about £250,000 pa, considerably in excess of what would be earned delivering clinical work.

197. NHS England submits that the GP appraiser fee is a fee for service which should be subject to periodic review of value for money, particularly in the light of changed appraisal requirements, and should not remain within the DDRB remit for further increases alongside salaries.

11. Dental practitioners

11.1 Overview

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

199. NHS England has continued to regularly meet the General Dental Practice Committee of the British Dental Association (BDA), increasing the frequency during the pandemic to discuss operational issues and the pressures facing primary care dentistry.

200. As announced in our letter to the profession in March 2021, NHS England is now responsible for taking forward dental system reform. In July 2022 we announced some initial contract changes to start to address the current challenges to access and supporting higher needs patients. These include an adjustment to the numbers of units of dental activity (UDAs) accrued to more complex band 2 care; measures to support greater use of the wider dental team; support for those practices that can deliver more NHS care to do so within current budgetary constraints; and steps to address persistent underperformance with the intention of releasing resources to commission other providers. We are now taking the next steps in reform and holding stakeholder engagement events and further focus groups with contractors, associate dentists and the wider dental team in November and December 2022. The uplift for independent contractors overall is best considered as part of such discussions about ongoing improvements in contractual arrangements.

201. Dental services commissioning is expected to move to ICBs as part of delegated commissioning functions from 1 April 2023, which will 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 and promote preventative pathways.

202. For clarity, we define dentists as follows:

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

203. 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 on a self-employed basis. We have no contractual relationship with performer-only dentists; their contractual arrangement is with the contract holder, and therefore we are not involved in how their pay is calculated and distributed.

9.2 Recruitment, retention and motivation

204. Current trends in the dental workforce are difficult to assess. Available data[40] does not detail whole-time or part-time working, which limits our analysis of the workforce capacity. However, we are aware of certain geographical shortfalls limiting service provision, including in rural and coastal areas.

205. In 2021/22, the number of dentists providing NHS activity increased by 2.3% to 24,272 dentists. The increase follows a fall of 4% in 2020/21, possibly because of very low levels of dental activity during the pandemic. However, we are concerned that these dentists are delivering less NHS care than a similar number would have done pre-pandemic.

206. A significant number of dentists enter and leave the NHS within any given year: in 2020/21 no dentist left the NHS Performers List and 1,398 joined, although some on the list did not provide any NHS activity and 5.9% of dentists only worked for the NHS

[40] NHS Digital (August 2022). NHS dental statistics for England, 2021-22, Annual report. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2021-22-annual-report

for part of the year. DHSC's evidence provides an historical breakdown of the number of dentists providing NHS services.

207. DHSC also provides details on motivation in its evidence, and NHS Digital has published Dentists' working patterns, motivation and morale– 2018/19 and 2019/20.

208. NHS England held engagement events in autumn 2021 with providing performers, performer-only dentists and the wider dental team to better understand the issues facing the sector. We heard concerns about recruitment, retention, especially in particular geographies, and the impact of very low indicative UDA values on care delivery. To begin to address geographical variation in UDA rates, we introduced a minimum indicative UDA value of £23 from 1 October 2022. We will monitor the effect of this change at affected practices, gathering data to inform any further action in this area.

209. Our engagement with the profession also revealed that misunderstandings about skill mix are common in dental practices. We are currently taking steps to address some of these. Specifically, we will issue guidance to clarify how skill mix and direct access in NHS practice can be used while working within the framework of existing regulations. We have also started to remove the administrative barriers that have prevented dental therapists and others operating within their scope of practice and competence from opening courses of treatment; by amending the FP17 and other IT systems from 1 October 2022. We will work with the General Dental Council and others to promote good practice in the use of skill mix and to address any concerns and questions contract holders may have.

Conclusion

210. Recruitment and retention of dentists remains an issue in some areas. The changes announced in the first phase of dental system reform are designed to increase sustainability of service provision by more accurately targeting remuneration to reflect the underlying needs of the patient, and supporting practices in areas with low UDA values. We recognise there is more to do and we launched a further round of engagement with the profession in October 2022.

9.3 General dental practitioner recovery from COVID-19

211. Service provision was significantly impacted during the pandemic. Face-to-face routine dental care was paused for several months and, due to infection prevention

and control (IPC) restrictions, income protection remained in place through to the first quarter of 2022/23. Normal contractual terms and tolerances will apply from 1 July 2023 and ahead of this, practices on the prototype contract returned to national core contractual terms and conditions as of 1 April 2022. Ex-prototype practices have been offered ongoing income support through a revised threshold of financial recovery set at 90% of their annual contracted activity, as they readjust to a UDA-based contract.

212. While income protection was in place, practices delivered only a portion of their contracted activity in return for near-normal levels of payment. All dental contracts continued to receive 1/12th of their annual contract value each month, but following consultation with the BDA, these payments were subject to a deduction for variable costs not incurred due to activity levels being below normal. This income protection was designed to secure practice viability and allow the ongoing retention of staff, supporting recovery of access once COVID-19 restrictions were lifted.

213. Urgent dental centres (UDCs) were established during the first COVID-19 wave to care for those with urgent needs, and provided services throughout the pandemic.

214. While 2022/23 delivery is above that in 2020/21 and 2021/22, dental services have not returned to pre COVID-19 levels. The reasons for this are likely to be multi-faceted; reports from sector representatives and commissioning teams reference the recruitment challenges in certain parts of the country, and a greater appetite from dentists to commit higher levels of capacity to private care, at the expense of NHS delivery.

Conclusion

215. Throughout the pandemic the goal was 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. Despite the support given to NHS dental practices and the lifting of IPC constraints, the sector has yet to recover to pre-pandemic levels. Some of the 2022 contract reforms are in place as of October/ November 2022, so we expect to see improvement and are working with the sector to consider further reforms.

9.4 Community dental service

216. Community dental services (CDS) are local services commissioned by NHS England, now under a personal dental services (PDS) agreement in line with local oral health needs assessments. CDS dentists, previously referred to as salaried or special care dentists, 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. CDS also use the wider dental workforce, with dental nurses, hygienists and therapists providing services within their scope of practice to vulnerable patients.

217. NHS England has 75 contracts that provide CDS services across c296 geographical locations; 84% are held with foundation, community and mental health trusts and 16% with community interest companies (CIC). Staff working in CICs may be subject to different rates of pay and wider terms and conditions. Those employed by NHS trusts are remunerated based on nationally agreed pay rates, determined by DHSC.[41] CICs tend to reference the NHS bands for salaried dentists in setting their pay scales, but these will also reflect the individual contract value.

218. During the pandemic NHS England introduced a CDS-specific workforce collection, but it should be noted that response rates are variable and returns not always completed in full. From the data received we understand 2,438 FTE dentists, dental care professionals and support staff currently work in these locations, with six FTE leavers reported.

219. CDS played a key part in our response to the pandemic, standing up as UDCs, but the enhanced IPC measures and lack of access to acute sector theatres during this time has created a backlog in care. Any gaps in workforce now and for the future will compound backlog issues for the management of vulnerable groups, including longer 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

220. CDS services have and continue to play an important role in dental health service provision, particularly for vulnerable groups. Any gaps in CDS provision of access to

[41] Pay award for hospital medical and dental staff, doctors and dentists in public health, the community health service and salaried dental care (England) (Annex A, section 6). https://www.nhsemployers.org/system/files/2022-08/Pay-and-Conditions-Circular-MD-3-2022.pdf

specialists who can manage Tier 2 complex cases will set back recovery, adding to the burden of elective care and failing patients.

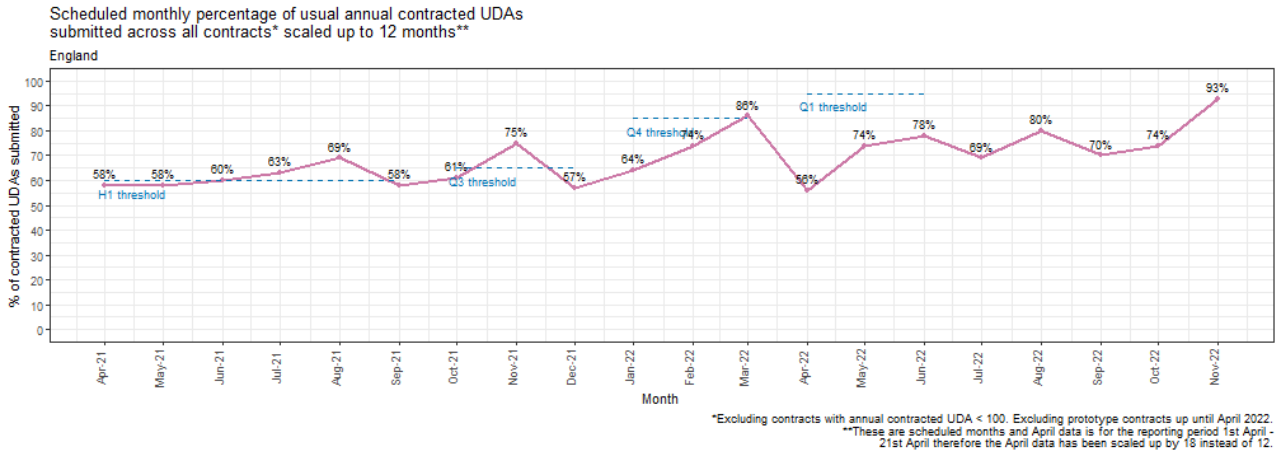
9.5 Access and activity

221. The March 2022 GP Patient Survey[42] identified that 75% 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 79%. This compares with around 96% pre-pandemic.

222. The COVID-19 restrictions will have impacted activity, patient numbers, finances and treatments in the final quarter of 2019/20, 2020/21, 2021/22 and the first quarter of 2022/23. Figure 7 shows the average monthly performance of contracts measured against the delivery thresholds (60% for April to September and 65% for October to December 2021; 85% for January to March and 95% for April to June 2022; and 100% going forward).

223. Delivery of contracted activity in 2022/23 remains below pre-pandemic levels, despite the relaxation of IPC measures.

Figure 7: UDAs delivered as a percentage of contracted UDAs: April 2021 to November 2022



[42] GP patient survey dental statistics, January to March 2022, England. https://www.england.nhs.uk/statistics/2022/07/14/gp-patient-survey-dental-statistics-january-to-march-2022-england/

224. On 14 January HM Treasury agreed that NHS England could invest up to £50 million during the remainder of the 2021/22 contract year to support urgent care delivery, with the following restrictions:

- purchase of non-recurrent activity outside contracted hours for urgent care and subsequent stabilisation
- purchase of non-recurrent activity for CDS to address their growing waiting lists
- other short-term enhancements to the capacity and efficiency of existing urgent care provision
- investment not to be accrued into the 2022/2023 contract year.

The period over which this investment was available coincided with the Omicron wave, which unfortunately resulted in some practices experiencing reduced staff availability.

225. Through this investment:

- 731 general dental services (GDS) contractors delivered 20,748 sessions and 32 CDS providers delivered 591 sessions.
- An extra 60,318 people received care in high street practices, of whom 20% were children.
- CDS services saw an extra 4,138 patients, of whom 55% were children.
- People with urgent care needs were targeted – 67% of courses of treatment in GDS were recorded as urgent care courses. The data indicates some dentists used additional sessions to stabilise patients in clinical priority groups after initial urgent treatment, reducing their need to reattend for urgent treatment.

Patients seen in these additional GDS sessions were more likely to be exempt from charges than those seen in usual care sessions.[43]

226. The proportion of dentists' time spent on NHS work increased from 70.7% in 2017/18 to 73% in 2019/20, the latest data available. We do not have data on how this changed during the pandemic.

[43] NHS Digital. NHS Dental Statistics for England, 2021-22, Annual Report - NHS Digital

9.6 Earnings and expenses

227. 2020/21 saw the introduction of the government Self-Employment Income Support Scheme (SEISS) payments to eligible businesses adversely affected by the pandemic. These are subject to income tax and self-employed national insurance contributions. As these payments are classed as taxable income, we have included them in the dental earnings data for 2020/21. The number of claimants and average payments were: 300 providing performers £15,800 and 4,150 performer-only £14,000.

228. In 2020/21 the gross earnings of providing performer dentists increased in cash terms, while that for performer-only dentists fell. [44] Earnings and expenses data includes income from both NHS and private patients where a contractor provides both services. In 2020/21 NHS England provided a significant level of income protection as described above.

Table 8: Average gross earnings (before deduction of practice expenses and delivery costs) by dentist type, 2017/18 to 2020/21

Year	Provider performer dentist	Performer-only dentist
2017/18	£365,100	£90,300
2018/19	£383,400	£89,000
2019/20	£386,300	£87,500
2020/21	£390,700	£83,800

Source: NHS Digital. Dental earnings and expenses estimates 2020/21[17]

Note: Due to the time needed to collect and compile the data, 2020/21 is the latest year for which data is available.

229. For dentists holding a contract, average taxable earnings (net profit) were £132,200, a 17.4% increase from the previous year's £112,600. Dentists working for providers had an average taxable income of £58,700, a 1% increase from £58,100 in the previous year.

230. New dental contracts are awarded through a procurement process initiated via an invitation to tender document. Contracts are awarded based on factors including, but

[44] NHS Digital. Dental earnings and expenses estimates 2020/21. https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2020-21

not limited to, staffing levels, premises availability, financial due diligence and value for money. All areas are appropriately weighted to allow selection of a preferred provider.

231. The income of performer-only dentists is determined by the contract they hold with the performing provider. NHS England is concerned that benefits and contract uplifts are not always passed on to performer-only dentist, but we currently have no involvement or influence over these contract arrangements.

232. In 2020/21 dentists used almost half (49%) the gross payments they received to meet their expenses, a fall from the consistent 53% since 2013. Our view is that this may be due to the provision of personal protective equipment (PPE) to dental contractors free of charge throughout the pandemic, a practice that will continue until 31 March 2023. In addition, lower activity during the pandemic will have reduced a practice's variable costs, eg material and laboratory costs, which led to NHS England agreeing a variable cost adjustment to the income protection money distributed to dental practices. DHSC's evidence provides historical data on income and net profit.

233. As shown in Table 9, dentists in the under 35-year age group have the lowest taxable income, which is partly explained by only 6% of them being providing performers. The 45–55-age group has the highest taxable income.

Table 9: Self-employed primary care dentists – average earnings and expenses from NHS and private dentistry, by age, England 2020/21

Age	Population	Average gross income	Expenses	Taxable income	Expenses ratio
<35	7,650	£83,800	£26,400	£57,400	31.5%
≥35 to ≤45	5,550	£143,600	£71,600	£72,000	49.9%
≥45 to ≤55	3,950	£207,400	£114,100	£93,400	55.0%
≥55	2,750	£202,400	£116,700	£85,700	57.7%
All	19,950	£141,400	£68,900	£72,500	48.7%

Source: NHS Digital. Dental earnings and expenses estimates 2020/21[17]

234. Table 10 shows earnings by percentage dental time spent on NHS dentistry. The data is based on responses to the dental working hours survey,[45] and as such the population represented is much smaller than in the 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.

235. 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 10: 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[4]

236. 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

[45] NHS Digital. Dentists' working patterns, motivation and morale – 2018/19 and 2019/20. https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2018-19-and-2019-20-working-patterns-motivation-and-morale

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 – that is, is the only dentist working in the practice – no multiple counting can occur."

237. 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 data: mainly the large shift from providing performer dentists to performer-only dentists.

238. 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 changes in pay rates and price. For example, if dentists work longer hours, they have higher gross income – but they may also have higher expenses (and higher net income). The data 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).

239. National Association of Specialist Dental Accountants and Lawyers (NASDAL) and Morris & Co (other non-staffing costs) provide the percentage of gross income spent on certain categories of expenditure for England (see Table 11), the first year it has been separated from that for England, Wales and Scotland combined.

Table 11: Categories of expenses as a percentage of gross income, 2017/18 to 2020/21

	2017/18	2018/19	2019/20	2020/21
Non-clinical staff wages				
NHS practices	20.9%	20.9%	20.6%	21.3%
Private practices	17.9%	17.9%	18.5%	19.8%
Laboratory costs				
NHS practices	5.6%	5.4%	5.7%	2.9%
Private practices	6.8%	7.0%	6.6%	7.2%

Material costs				
NHS practices	6.1%	6.2%	6.2%	4.4%
Private practices	7.4%	7.9%	7.5%	8.2%
Other non-staffing costs (Morris & Co)				
NHS practices	16.1%	15.8%	16.0%	13.4%
Private practices	18.9%	18.9%	20.1%	14.3%

Source: NASDAL

240. Valuations from the NASDAL goodwill survey covering the quarter ending January 2022, the latest available, were higher than in the previous quarter: deals averaged 166% of gross fees – up from 152% in the quarter to 31 October 2021. NHS practices saw the lowest practice goodwill at 141% of gross fees; for private practices it was 155% and for mixed practices 189%.

Gender and ethnicity pay gaps

241. DDRB asked for evidence on the gender and ethnicity pay gaps. We do not hold data on ethnicity. Table 12 provides data from the dental earnings and expenses estimates publications by gender.

242. NHS England procures dental service provision via an open and transparent process and as such applications do not detail gender-specific identifiable information.

Table 12: All self-employed primary care dentists – average taxable income from NHS and private dentistry by gender, 2015/16 to 2021/21

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Total	£69,200	£68,700	£68,100	£68,600	£68,600	£72,500
Male	£81,900	£81,800	£81,900	£82,900	£83,500	£87,800
Female	£55,800	£55,500	£54,700	£55,100	£55,100	£59,100

Source: NHS Digital. Dental earnings and expenses estimates 2020/21[17]

243. 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 provider

performer dentists, a group who have significantly higher income than performer-only dentists (28% vs 10%).

244. 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 13 shows the split by gender in working hours based on the responses to the Dental Working Patterns Survey; 55% of female dentists work fewer than 35 hours a week compared to 26% of male dentists.

Table 13: 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%

Gender	Weekly working hours	Report population	Mean average Gross earnings	Total expenses	Taxable income	Expenses to earnings ratio
	All	2,100	£117,900	£58,400	£59,500	49.5%

Source: NHS Digital. Dental earnings and expenses estimates 2019/20 (Data on working hours was not collected in 2020/21 so this is the latest available)

245. Table 14 shows the marked increase in female dentists in recent years. In 2021/22 59.9% of dentists under 35 were female.[46]

Table 14: Percentage of dentists with NHS activity by gender, 2015/16 to 2021/22

All dentists with FP17	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Male	52.0%	51.2%	50.3%	49.6%	48.7%	48.2%	47.4%
Female	48.0%	48.8%	49.7%	50.4%	51.3%	51.8%	52.6%

Source: NHS dental statistics 2021/22

Performance adjustment

246. 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, in the following financial year we recover the proportion of the contract value commensurate with the undelivered activity and this is used for other local NHS priorities (the money stays in the NHS).

247. When all contracted activity is not delivered patients will have lost access to the NHS. Current rules prevent commissioners in most circumstances from releasing funding quickly from contracts where not all activity will be delivered, and so have limited ability to reinvest this money in-year in practices that can deliver more. Our first step to address this will be to encourage commissioners and contractors to collaborate. Particularly for contracts where 30% of activity has not been delivered in the first half

[46] NHS Digital. NHS dental statistics for England 2021-22, Annual report. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2021-22-annual-report#:~:text=26.4m%20courses%20of%20treatment,compared%20to%20the%20previous%20year

of the year, they should consider reducing the annual activity requirement 5 by 10%, on a voluntary basis only, to make it possible for other practices to use these resources to treat more patients.

248. We have also announced as part of the July 2022 reform package that where a dental contractor has delivered less than 96% of its contracted activity for three consecutive years, and no voluntary plan or reduction can be agreed, commissioners can unilaterally reduce the size of a contract to the highest level of delivery in the preceding three years. The initial three 'consecutive' years are 2019/20 (the last year before the pandemic), 2022/23 and 2023/24. These will then roll forward on an annual basis, always excluding the pandemic period of 2020/21 and 2021/22 to recognise that these years were exceptional. This package has been designed to ensure funding is prioritised to those practices able to deliver NHS activity.

249. NHSBSA has provided a provider assurance service since 2018 to assist NHS England 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 performance adjustment, particularly for contracts that have consistently underperformed year on year. Financial recovery of money for care not provided is necessary to ensure funding is used for the correct purpose and we are not making fruitless payments.

250. In 2020/21 contractors were required to significantly reduce levels of activity but continued to receive near-full contract payments. As a result, performance adjustment in 2021/22 was much lower than usual.

Table 15: Performance adjustment extracted from NHS England's accounting system

	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m
Performance adjustment	71	65	128	123	131	17

The performance adjustment includes underperformance, payments where a contract has exceeded the contract value by up to 2% and any other adjustment to contract values. 2021/22 data is still subject to final audit.

251. Another source of information on dentists' income is the data from NASDAL. Table 16 shows the net profit (ie taxable income) for each contract holder in an NHS dental

practice increased by 25% in 2020/21, compared to an 8% increase in private practices. This demonstrates the level of support NHS England provided to NHS practices during the pandemic.

Table 16: Net profit per principal for the practice, 2015/16 to 2020/21

Type of practice	2015/16 £	2016/17 £	2017/18 £	2018/19 £	2019/20 £	2020/21 £
NHS	134,102	139,698	126,269	124,475	116,284	145,498
Mixed	127,684	130,076	127,676	132,940	134,342	
Private	133,743	139,454	138,806	140,951	133,192	143,418

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.

9.6 Remuneration and affordability

252. Pay recommendations for GDS in 2023/24 will need to be fair to contractors, recognise the significant levels of income protection provided during the pandemic and represent value for money to the taxpayer. However, pay recommendations that are higher than the affordable level, and not supported by additional funding, will require NHS England to make difficult decisions – that is, we may have no choice but to cut back services. A dental contract with NHS England gives several financial benefits that are usually only provided to NHS employees. The Statement of Financial Entitlements (SFE) provides dentists delivering NHS dental services with long-term sick pay, parental pay and access to the NHS Pension Scheme, irrespective of their level of commitment to the NHS. However, NHS England is concerned about the extent to which some of these benefits, eg sickness and maternity payments, are passed on to performer-only dentists, despite this being a requirement in the SFE. NHS England also pays non-domestic business rates for the proportion of premises used for NHS dental services.

253. We continue to face challenges in encouraging dentists to work within NHS contracts in some geographical areas. As mentioned above, only providing performers have a contract with NHS England. 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.

2022/23 settlement

254. For 2022/23, DDRB recommended an uplift in income, net of expenses, of 4.5% from 1 April 2022. The increase was accepted by ministers, and DHSC is progressing the uplift to expenses. Once agreed this will be combined with the income uplift to provide a contract uplift.

255. The national uplift will be 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 NHS England, we cannot say whether the increase will be passed on to performer-only dentist or not.

9.7 Conclusion

256. Ensuring equity of access to primary dental care services remains one of our central goals. The backlog of care that is a direct result of restrictions on activity during the pandemic continues to challenge levels of service and access. NHS dental service provision has not recovered to pre-pandemic levels following the relaxation of IPC restrictions, suggesting recruitment and retention pressures, alongside declining commitment of individual dentists to the NHS, are impacting on delivery of NHS activity.

257. There is significant geographical variation in NHS dental service provision. We are also aware that significant levels of dissatisfaction regarding the contract continue. We have taken first steps to address this as part of phase one of dental system reform, and our ongoing programme of work is dedicated to developing the NHS contract and improving access for patients. Regional teams are addressing recruitment and retention of dentists through schemes such as golden hellos. With support from NHS England throughout the pandemic and up to June 2022, providing performers' 'provider profit' appears to have increased. We are concerned about the disparities in pay along with terms and conditions among performer-only dentists, but have no direct relationship beyond providing performers and are unable to influence this.

12. Doctors and dentists in training

12.1 Overview

258. Doctors and dentists in training provide important service to NHS patients alongside their formal training programme. The NHS Staff Survey showed that they were likely to have been redeployed during the pandemic to support the national response, and they will continue to play an important part in reducing the backlog.

259. There has been unrest from the BMA Junior Doctors Committee which will ballot its members for industrial action. The prospect of industrial action from any staff group causes concern in the service and among patients. NHS England works with DHSC on emergency preparedness in relation to industrial action to try and minimise where possible impacts on the service and patients, and we will continue to closely monitor the situation.

12.2 Multi-year pay and contract reform agreement for doctors and dentists in training (2019/20 to 2022/23)

260. Since 2019, doctors and dentists in training have been subject to a multi-year pay and contract reform deal, agreed by the BMA and the majority of their junior doctor members. This deal set the level of annual pay uplifts to pay scales for the duration of the agreement, and improved several aspects of the contract, such as increasing eligibility for enhanced night pay, increasing the weekend allowance payment and significant investment to create a fifth nodal point.

261. Pay uplifts were only agreed for the four years of the deal but additional contract improvements will of course continue to benefit doctors recurrently. As the pay element of the agreement ends on 31 March 2023, government is now looking to the DDRB to recommend an annual uplift for doctors in training.

262. The total investment over the deal was 11.3%, with 3.3% not spent directly on pay uplifts but on improvements that will continue to benefit doctors in training. For example, the introduction of the fifth nodal point means trainees at ST6 and above going forwards have significantly higher pay than they would have without a multi-year agreement.

263. Doctors' experience of the four-year deal will depend on where they were at the start of the deal and how it has changed their specific pay point, as well as their overall level of pay through beneficial contract changes.

12.3 Workforce supply

264. The pandemic has disrupted the trainee pipeline; however, HEE and DHSC have invested around £26 million to limit any disruption to training programmes. During the pandemic trainees may have missed out on elective experience due to being redeployed or the reduction in elective activity. HEE introduced two new Annual Review of Competence Progression (ARCP) outcomes (10.1 and 10.2). These are no-fault outcomes that relate to COVID-19 disruption. An Outcome 10.2 signals that additional training time will be required. NHS Employers and the BMA, supported by DHSC and NHS England, issued guidance to employers on what to do where an Outcome 10.2 may impact on the pay progression of a doctor in training.

265. While HEE has done everything possible to minimise training delays, the timeline for trainees to achieve their certificate of completion of training (CCT) is still likely to be affected, potentially impacting on consultant supply. HEE's evidence provides data on fill rates to specialty training which remains competitive. There are difficulties in recruiting to certain specialties and geographies. HEE has oversight of the distribution of training places and has incentivised entry into shortage training programmes previously, eg the GP Targeted Enhanced Recruitment Scheme (TERS).

12.4 Training experience

266. NHS England continues to support the HEE Enhancing Junior Doctors' Working Lives programme of work and HEE's evidence provides an update on this. HEE continues to focus on flexibility in training given we know this is what the new generation of doctors want. HEE has introduced the ability for doctors to apply for less than full time training for any reason – complementing the wider work on flexible working led by NHS England to make it a contractual right to request flexible working from day one of employment.

12.5 Conclusion

267. Doctors and dentists in training remain crucial both for their service provision to NHS patients and their role as future NHS SAS doctors and consultants. We need to ensure that being a doctor in training in the NHS is an attractive career choice, one that has embedded flexibility to suit the needs of what doctors want.

13. Locally employed doctors

13.1 Overview

268. Locally employed doctors (LEDs) form an important and growing part of the medical workforce. As stated in section 10, according to the GMC numbers of SAS and LEDs have grown strongly and they could form the largest part of the medical workforce by 2030 if trends continue.

269. LEDs are employed on pay and terms and conditions determined by their employing trust, not on national pay and terms and conditions. However, the pay and terms of LEDs may mirror national pay scales and/or terms and conditions. LEDs may be employed on closed national grades. All previous SAS grades were subsumed by the new specialty doctor and associate specialist contracts in 2008, and in 2021 by the new specialty doctor grade and introduction of the specialist grade. However, some LEDs may be on ‘old’ associate specialist grades or previous SAS grades.

270. Similarly, LEDs may be employed on pay and terms and conditions similar to the 2002 or 2016 contract for doctors and dentists in training. These doctors may not be employed on a formal HEE training programme, but are working broadly at that level. The specialty doctor contract requires at least four years of postgraduate experience, so most ‘F3’ doctors would not meet the entry requirements for a national contract.

271. Because of the make-up of LEDs as described above, national data is unclear. Doctors on national pay codes appear within that group in ESR data, eg LEDs on SAS pay codes show within SAS grades while doctors in training pay codes show as doctors in training. This explains why the number of doctors in approved HEE training is lower than the number of doctors in training shown via ESR. To add to the unclarity, some pay codes from the previous 2002 contract are used for doctors on

the 2016 contract to protect their pay. This makes it difficult to distinguish if a doctor on a 2002 pay code is a LED or a doctor on the 2016 contract being pay protected.

272. Some LEDs have bespoke pay and terms and conditions. These doctors can be identified given they do not appear with other national grades in ESR data. DHSC analysis estimates these doctors make up around 4% of the HCHS medical workforce.

273. These data challenges make it hard to provide an accurate total number of LEDs employed in England.

13.2 2022/23 pay round

274. NHS Employers told us that the DDRB's recommendation on LEDs in last year's pay round caused some confusion. This is understandable given LEDs are not a single group of doctors. The DDRB makes recommendations to government, not directly to employers. Government can accept recommendations that uplift national pay scales, but for the most part ministers have not chosen to intervene over local employment and pay arrangements determined independently by employers.

275. The written ministerial statement did not respond to the DDRB's recommendation on LEDs and, without government accepting a DDRB recommendation, there is no direct link between the recommendation and the actions of employers.

276. We have no information on the consequences of the DDRB's recommendation but where LEDs are paid according to national pay scales, they will have received an uplift alongside their counterparts on the same pay scale. We have no way of knowing what has happened to LEDs on 'bespoke' contracts, although we understand the BMA has asked organisations locally to introduce 4.5% pay uplifts. The picture across the country is likely to be inconsistent.

13.3 Conclusion

277. We understand from NHS Employers that some employers have found it difficult to offer their local terms of employment to overseas doctors, due to bespoke or out of date pay values not being recognised by the Home Office for the purposes of visa applications. This may be driving employers locally to use national pay and contracts where possible. However, there may be other reasons employers are not using national contracts and it is important to understand what these are.

278. We are keen to understand more about LEDs, including reasons for their use and total numbers, and we will work with DHSC and NHS Employers to understand how this group can best be supported.

279. LEDs play an important role in delivering service to patients but they are also a potential future supply of consultants, providing appropriate support and career structures are put in place for them. This is important given the limits on consultant supply from postgraduate training. It is important that the culture in employing organisations does not distinguish between LEDs and doctors on national grades. We are aware that the growth in LEDs could be driven by IMGs and employers must guard against discrimination, particularly where there are differentials in pay and terms and conditions for LEDs.

14. Evidence summary

280. The NHS is now seeing increasing leaver rates after they fell dramatically during the pandemic, and the NHS Staff Survey shows falling positive staff experience results. The People Promise workstreams are looking to address these challenges.

281. Supporting staff health and wellbeing will be essential for the transformation needed to achieve the NHS Long Term Plan's new care models to meet an ageing population's care needs. The size and shape of the workforce and the skills of staff will need to shift to bring these changes.

282. Pay remains the largest component of NHS costs and therefore pay inflation represents a material cost pressure to the NHS. This pressure, if not supported by additional investment, will result in difficult trade-offs during the year on staffing numbers, initiatives to support staff, and the ability of the NHS to deliver on its key strategic priorities –the NHS Long Term Plan ambitions, reducing the elective backlog, bearing down on the increased use of expensive agencies, tackling high sickness absence levels and improving staff experience.

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