# Submission to the Review Body on Doctors’ and Dentists’ Remuneration

**Evidence for the 2024/25 pay round**

26 February 2024



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## 1. Introduction

1. This is NHS England’s submission to the Doctors’ and Dentists’ Review Body (DDRB). The evidence covers our key responsibilities for supporting the education and training of medical and dental staff, and using the total NHS employment offer to help attract, recruit, retain and motivate staff employed by the NHS. We cover each of the doctor and dentist groups within the remit of the DDRB: consultants, GPs, the dental workforce, specialty and specialist (SAS) grade doctors, and doctors and dentists in postgraduate training.
2. From 1 April 2023, NHS England, Health Education England (HEE) and NHS Digital came together with the ambition of creating a high performing organisation to lead NHS services more effectively, including ensuring better alignment of service, financial and workforce planning.
3. Throughout our evidence we refer to NHS England, although before 1 April 2023 some of our evidence relates to work developed and led by HEE.
4. On 30 June 2023, we published the [NHS Long Term Workforce Plan](https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/), a plan to put staffing on a sustainable footing over the next 15 years and improve patient care. Its 3 key themes are to train and grow the workforce, retain the staff we already have, and reform the way we work and train our workforce.
5. Despite government accepting the DDRB recommendations for the 2023/24 pay award in full, at the time of preparing our evidence we are still in a period of sustained industrial action from doctors and dentists in training. The medical and dental consultant workforce have rejected government’s revised pay offer and remain in dispute. SAS doctors are considering a revised government pay deal which will conclude their dispute if accepted.
6. An increasing backlog of patients require care as a result of both the COVID-19 pandemic and impact of industrial action, with an increase in elective cancelations and rescheduling due to the loss of elective capacity on strike days. Overall demand for services, both in the NHS and social care, continues to increase. This winter period looks to be another challenging one, with the resurgence of COVID-19 and respiratory illnesses such as influenza.
7. Vacancy levels across most staff groups are high, including 10,855 medical vacancies according to ESR data (June 2023), 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.
8. The all staff results from the 2022 NHS Staff Survey, the most recent, have seen improvements in 3 areas: ‘we work flexibly’, ‘we are always learning’ and ‘we are a team’ (which includes line management). The score for ‘we are safe and healthy’ remained the same as in 2021 while scores declined for: ‘we are recognised and rewarded’, ‘we are compassionate and inclusive’ and ‘we each have a voice that counts’. The drop in the score for ‘we are recognised and rewarded’ correlates with the decline in staff satisfaction around medical pay. In addition, [sickness absence rates](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/june-2023-provisional-statistics) across the medical workforce have decreased from an average 2.05% in June 2022 to 1.68% in June 2023.
9. Of doctors who joined the medical register in 2022 (the latest year of published data), 61.4% had qualified in other countries, and fewer doctors from overseas are staying in the NHS long term ([The workforce report 2022](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), GMC). This indicates the 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.
10. Around 40% of the NHS workforce are 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 by putting in place the right incentives and flexibilities, which address staff concerns around pension tax and impact on their pension, as well as their ability to return to their previous role.
11. The NHS budget was set up to 2024/25 in the current Spending Review and includes stretching efficiency targets. The NHS will need to continue to manage the impact of high inflation on its non-pay spend; for example, consumables, drugs and devices, energy costs.
12. Given the ongoing impact of COVID-19 and the need to recover services, pay awards need to be fully funded, to deliver the mandated level of activity and investment in services for the benefit of patients. This includes resolving pressures in the current 2024/25 budget and agreeing the final budget with DHSC.
13. If not supported by investment additional to the current NHS settlement, further pay pressures are likely to result in difficult trade-offs during 2024/25 on staffing numbers and initiatives to support staff, and will further impact on 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. Evidence summary

1. In 2023 we published the NHS Long Term Workforce Plan, and work is underway to deliver the ambitions set out in the plan, coupled with the priorities identified in the planning guidance, including the use of agencies, improving urgent and emergency care, elective recovery and access to primary care.
2. Pay remains the largest component of NHS expenditure. The current economic environment means that, in addition to increasing pay costs, the NHS is facing non-pay inflationary costs pressures from higher than expected inflation. Latest GDP deflators for 2022/23 are reported as 6.8% and the forecast for 2023/24 is 6.1%. We calculate this has resulted in a pressure of £1.7bn against the funded level. Taken together, this means the NHS budget will be worth 3.8% less in 2024/25, than in 2021/22, based on the published budget and latest forecast GDP deflators.
3. Financial pressures on NHS services have been exacerbated by ongoing industrial action, which is estimated to have already cost more than £1.5 billion in 2023/24. In addition, we are managing significant pressure on services, with increasing demand, as well as dealing with Covid. In response to the financial and operational pressures of industrial action, we have reprioritised wider health budgets, diverting planned spend away from technology budgets, international recruitment, and wider capital budgets.
4. Against this background, the NHS must 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.
5. Pay awards that are higher than the levels contained in the funding settlement, if not supported by additional funding from government, will put further pressure on the NHS budget given the existing funding pressures. This could impact on staffing numbers and the ability to deliver planned activity or service improvements.
6. The NHS Staff Survey 2022 showed a downward trend in pay satisfaction across all workforce groups. In contrast the trend data for the core metrics indicates that there has been a period of stability for staff feeling their health and wellbeing is supported. The pattern for responses to questions relating to team support and feeling informed is similar.
7. During 2023 we have seen ongoing industrial action across the medical and dental workforce, and over which pay is a key area of dispute. The Pulse survey results show a drop in the positive mood of all staff, which corresponds with the announcements of strike action. At the time of writing the medical and dental workforce remains in dispute and unless this dispute is resolved soon, the ongoing industrial action will further impact the ability of the NHS to reduce the elective backlog resulting from the pandemic.
8. Data from the People Promise Exemplars Programme suggests that, controlling for other variables, the average all staff leaver rate for the exemplar trusts fell by 14.2% more than that for the non-exemplar trusts. We will continue to build the evidence base to support our work on the retention of staff. The expansion of the Exemplar Programme to a further 116 organisations is now underway and provides an opportunity to scale and share best practice.

## 3. Workforce planning

1. The [NHS People Plan](https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/) and the [People Promise](https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/), published in July 2020, set out the action that we need to take collectively in the NHS so that we have more people, working differently, in a compassionate and inclusive culture.
2. NHS England’s [2023/24 priorities and operational planning guidance](https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/) for the NHS includes priority actions relating to the strategic themes established in the People Plan, in particular:

* Accelerating plans to grow the substantive workforce and work differently, while keeping our focus on the health, wellbeing and safety of our staff as they use learning from the pandemic to rapidly and consistently adopt new models of care that exploit 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.

1. The [NHS Long Term Workforce Plan](https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/) published in June 2023 sets out the workforce planning, service and clinical strategies, and financial planning for the long term. The plan builds on [HEE’s Framework 15](https://www.hee.nhs.uk/sites/default/files/documents/HEE%20strategic%20framework%202017_1.pdf), the [NHS People Plan](https://www.england.nhs.uk/ournhspeople/) and [NHS Long Term Plan](https://www.longtermplan.nhs.uk/), and has a focus on improving staff experience and retention by embedding the [NHS People Promise](https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/).
2. The plan is underpinned by actions that need to be taken now to deliver a sustainable NHS workforce that can meet the changing needs of patients over the next 5, 10 and 15 years, and likely continued rise in demand for services with demographic and societal shifts. Technology will change how services are delivered and will give patients greater control over their own healthcare.
3. 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, living with multiple co-morbidities, and more empowered patients means the size and shape of the workforce, and the skills NHS staff have, will need to alter. The modelling in the NHS Long Term Workforce Plan shows that without concerted and immediate action, the NHS will face a workforce gap of 260,000–360,000 staff by 2036/37.
4. To address this, the plan has 3 main themes:
   1. **Train and grow the workforce:** significantly increase domestic education, training and apprenticeships, including alternative routes into professional roles.
   2. **Retain:** keep more of the staff we need through better support, flexible ways of working, and improving the culture and leadership.
   3. **Reform:** improve productivity by working and training in different ways, as well as taking advantage of new technology to increase the capacity of clinicians to care for patients. This includes ensuring that we train the clinicians of the future to work effectively in multidisciplinary teams. The future will see more staff in new and enhanced roles; by being able to maximise their own skill set they will also free up the time of staff in traditional roles to maximise theirs.
5. The plan expands training, changes ways of working and aims to improve our culture, to increase the NHS permanent workforce over the next 15 years with at least 60,000 more doctors and 170,000 more nurses.
6. The plan also sets out:
   * The exploration of a tie-in period to encourage dentists to spend a minimum proportion of their time delivering NHS care in the years following graduation.
   * An increased number and proportion of apprenticeships, as part of widening the opportunity for more people to join the NHS from different backgrounds and a wealth of different experiences.
7. These ambitions will require the integration of education and training with wider workforce planning and finance and service planning.

## 4. NHS finances

### 4.1 Financial context

1. NHS England’s key priorities set out in the [2023/24 business plan](https://www.england.nhs.uk/long-read/our-2023-24-business-plan/) are, for example, 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 pandemic. This work is being done within a financial settlement predicated on stretching efficiency targets and a reduction in COVID-19 related costs.
2. Financial pressures on NHS services have been exacerbated by ongoing industrial action, estimated to have cost more than £1 billion so far in 2023/24. This includes the costs of having to secure staff cover on strike days and catching up on activity that has been rescheduled. Responding to the strike action has impacted on the operational and management capacity to plan and deliver productivity through transformation.
3. The pay rates published by the British Medical Association (BMA) for extracontractual activity are having a noticeable effect on local pay negotiations with doctors. The BMA’s suggested minimum rates are more than triple the estimated basic hourly rate for a consultant and more than what employers typically pay for additional activity.
4. The current NHS financial settlement was agreed with government in the 2021 Spending Review to cover the period up to and including 2024/25. This was predicated on moderate pay and price inflation, and COVID costs reducing to negligible levels by 2024/25, neither of which has been the reality. An additional £3.3 billion was added to this settlement on a recurrent basis in the 2022 Autumn Statement to address higher than planned pay and non-pay inflation (among other financial pressures). Nevertheless, inflation has still been higher than the assumed level, and NHS real terms funding growth into 2024/25 remains low by historical standards.
5. The settlement requires the NHS to deliver annual efficiency savings of at least 2.2% each year, which is significantly higher than the ~1% per year the NHS has historically delivered. In total, integrated care boards (ICBs) are seeking to make £7.8 billion of savings in 2023/24. COVID-19 funding for response to the pandemic will further reduce from £5.1 billion in 2022/23 to £0.4 billion in 2024/25. Latest GDP deflators for 2022/23 are reported as 6.8% and the forecast for 2023/24 is 6.1%. We calculate this has resulted in a pressure of £1.7bn against the funded level. Taken together, this means the NHS budget will be worth 3.8% less in 2024/25, than in 2021/22, based on the published budget and latest forecast GDP deflators.

### 4.2 Affordability

1. Pay is the largest component of NHS costs (c65% of total operating costs) and therefore the NHS must plan for and manage the additional costs resulting from any pay rise.
2. NHS England funded systems in full to implement the pay award in 2023/24. This followed a review of investments in transformation programmes to fund existing financial pressures, including recurrent financial pressures from the 2022/23 pay award. Additional funding was agreed with the Department of Health and Social Care (DHSC) specifically to cover the estimated costs of implementing the 2023/24 DDRB recommendations, which include a request for NHS England to contribute £100 million recurrently from its 2024/25 budget. The final 2024/25 budget, including the additional recurrent impact of pay awards, is still being confirmed with DHSC.
3. Additional non-recurrent funding for ICBs was announced in November 2023 in response to the financial and operational pressures of industrial action. This funding has been generated mostly through central reprioritisation of wider health budgets, which protects patient safety and priority service areas including urgent and emergency care, maternity, neonatal and primary care access. This will mean diverting planned spend away from technology budgets, international recruitment and wider capital budgets – with capital spending switched to resource spending. The elective activity performance targets for earning targeted elective recovery funding have been relaxed to recognise the operational impact that industrial action has had on capacity this year.
4. Pay awards higher than the levels included within the funding settlement, and which are not supported by additional government funding, will put further pressure on the NHS budget. This could impact on staffing numbers and the ability to deliver planned activity or service improvements.

### 4.3 Financial support for education and training

1. NHS England’s long-term investment in education must align to its overall goal of ensuring that the NHS workforce of today and tomorrow have the right numbers, skills, values and behaviours, at the right time and in the right place. Achieving this depends on deploying funding effectively at a strategic level, signalling clearly how this will work in both the short and long term, and ensuring planning, commissioning, contract management and reporting align at both national and regional level. The 2023/24 opening budget (prior to pay awards for 2023/24) for education and training was £5.9 billion, and £2,658 million of this was allocated for postgraduate medical and dental training, £144 million for education support and £361 million for workforce development and transformation.
2. NHS England still commissions some student places directly with higher education institutions (HEIs) within the healthcare system in England, and it has direct and indirect levers to influence the shape of workforce supply. Of the 2023/24 £5.9 billion opening budget (prior to pay awards for 2023/24), £1,033 million was allocated to undergraduate medical and dental education, £1,058 million to clinical (commissioned programmes) and £306 million to clinical (non-commissioned programmes) – see Appendix D.
3. In addition to the reforms set out in this document, two significant changes to the funding policies have impacted on the financial contributions to medical and dental students:

DHSC has introduced policy changes to the [NHS Bursary Scheme rules from the 2023/24 academic year](https://www.gov.uk/government/publications/nhs-bursary-scheme-rules-2023-to-2024) as follows:

* 1. uplift travel and dual accommodation expenses
  2. increase childcare allowance to match Department for Education (DfE) rates
  3. increase means-testing threshold in line with inflation in the last year
  4. simplify Dental Students’ Allowance (DSA) policy, to match DfE policy.

Uplift of the education and training tariffs in 2023/24 to take account of the 2023/24 pay awards, which will increase the study leave funding available for postgraduate doctors in training as that is top sliced from the postgraduate medical tariff.

## 5. Reducing agency spend and temporary staffing

1. Data is drawn from published provider accounts, with those for 2022/23 being the latest available in NHS England’s [financial performance reports](https://www.england.nhs.uk/publications/financial-performance-reports/).
2. As set out in our [2023/24 priorities and operational planning guidance](https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf), a priority has been reducing agency spending across the NHS to 3.7% of the total pay bill. We published toolkits on our FutureNHS platform to support organisations with this.
3. Increasing demand and vacancies are driving the use of temporary staffing (both agency and bank) in NHS trusts – a spend of £6.6 billion at the end of 2022/23 (from the latest [published accounts](https://www.england.nhs.uk/publications/financial-performance-reports/)). Our aim is to increase the substantive workforce by bearing down on expensive agency costs, and move towards a more sustainable model of temporary staffing. We are supporting trusts to promote the use of their own banks and the development of collaborative banks across systems. We want the NHS to have an effective and affordable flexible staffing solution for all staff groups.
4. The NHS has made progress in optimising temporary staffing spend by NHS trusts despite workforce and capacity shortages. The increase in bank spend reflects the flexibility needed to meet fluctuating demand, including seasonal peaks and variations.
5. NHS England reintroduced measures in September 2022 to control agency expenditure in NHS trusts, including a system agency expenditure limit. Metrics to monitor agency usage are included in the [NHS Oversight Framework](https://www.england.nhs.uk/nhs-oversight-framework/), reinforcing the rules that NHS trusts and foundation trusts should comply with.
6. The introduction of price caps as part of a wider package of agency controls in 2016 reduced total agency spend from a peak of £3.6 billion in 2015/16 to £3.5 billion at the end of 2022/23. However, despite this £100 million cost reduction, demand for workforce during the pandemic pushed agency spend as a percentage of the wage bill from 4.0% in 2019/20 to 4.5% by the end of 2022/23; it had been 7.9% in 2015/16.
7. This reduction in agency spend from 2015/16 has largely been achieved by more than halving the proportion of temporary staffing shifts filled by agency staff, from 50% in 2017/18 to 23% in 2022/23.
8. Medical and dental agency spend as a share of overall temporary staffing in NHS trusts has fallen from 60% in 2017/18 to 44% in 2022/23, reflecting the percentage rise over this period in temporary shifts procured through a bank and our strategy to procure more of the NHS’s temporary staffing through internal banks (Figure 5.1).
9. Medical and dental bank shifts in NHS trusts have increased from 18% in 2017/18 to 56% in 2022/23, while agency shifts have decreased from 82% in 2017/18 to 44% in 2022/23.

**Figure 5.1: Medical and dental agency and bank spend as a percentage of the total wage bill in NHS trusts, 2017/18 to 2022/23**

A graph of a number of people

Description automatically generated with medium confidence

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

1. Collaborative bank data is collected quarterly and published yearly through the NHS England submission to the Pay Review Bodies.
2. There are 67 trusts in a collaborative bank arrangement, with 27 such arrangements set up. A further 30 trusts are in the planning stage.
3. Of 42 ICSs, 29 have a collaborative bank, with each of the 7 regions having at least 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.
4. 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 barriers to collaborative working.
5. In general practice, by 2022 all systems had introduced a primary care flexible staff pool supported by a digital solution to help match available GPs to practices with vacant shifts.
6. The NHS Long Term Workforce Plan contains further measures to improve the quality of care and value for money from the temporary workforce, including to ensure all agency staff in NHS trusts are supplied using an [approved procurement framework](https://www.england.nhs.uk/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/agency-rules-list-of-approved-framework-agreements-for-all-staff/).
7. The Temporary Staffing Programme contributes to several of the initiatives described in this plan, including the expansion of new and extended roles to increase the breadth of skills within multidisciplinary teams. These roles can increase productivity by ensuring there is sufficient workforce capacity, making reliance on temporary staffing less likely. Workstreams are eliminating off-framework supply into the NHS; supporting trusts to improve price cap compliance and helping to accelerate bank collaborative arrangements.

## 6. Staff surveys

1. The [NHS Staff Survey](https://www.nhsstaffsurveys.com/) has been aligned to the 7 elements of the People Promise since 2021 to better understand how employee experience compares to what staff tell us matters most to them. National support for local listening strategies increased with the introduction of the monthly [People Pulse](https://www.england.nhs.uk/nhs-people-pulse/) and [National Quarterly Pulse Survey (NQPS)](https://www.england.nhs.uk/fft/nqps/). These provide a consistent and standardised way of understanding employee experience nationally, regionally and locally at more regular intervals than yearly. In particular, the NQPS asks the 9 questions which make up the engagement score in January, April and July. In October, the same questions are asked in the NHS Staff Survey.

### 6.1 NHS Staff Survey

1. The NHS Staff Survey remains one of the world’s largest staff surveys with 636,348 responses (46% of staff) to the [2022 survey](https://www.nhsstaffsurveys.com/static/16b3c5040ef100531faf4350071257d9/NSS22-Core-Questionnaire-FINAL.pdf). Data for surveys up to 2022 can be interrogated using the new interactive [NHS Staff Survey dashboard](https://www.nhsstaffsurveys.com/results/new-interactive-dashboard/) we published in October 2023 on the Staff Survey Coordination Centre website.
2. The 2023 NHS Staff Survey was live for fieldwork during October and November 2023, and as of week 3 the response rate was significantly higher than at the corresponding stage in the previous 2 years. The 2023 survey results are not yet available. They are usually published in March after extensive analysis to comply with official statistic requirements. However, employers can use their own results internally as they become available to them via their survey provider.

#### Overview of NHS Staff Survey 2022

1. 2022 aggregated staff scores for 3 of the People Promise elements were higher than in 2021: ‘we work flexibly', ‘we are always learning' and ‘we are a team’ (which includes line management), and the same as in 2021 for ‘we are safe and healthy'. However, the scores for 3 People Promise elements were lower in the 2022 survey: ‘we are recognised and rewarded', ‘we are compassionate and inclusive' and ‘we each have a voice that counts'. Ambulance and acute community trusts continue to score lower than the average for the whole of the NHS.

**Table 6.1: NHS Staff Survey by benchmarking group**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Promise element/theme** | **2021 national average score** | **2022 national average score** | **2022 acute and acute community trusts** | **2022 community trusts** | **2022 acute specialist trusts** | **2022 MH/LD\* and MH/LD community trusts** | **2022 ambulance trusts** |
| We are compassionate and inclusive | **7.24** | **7.23** | < 7.16 | > 7.67 | > 7.50 | > 7.54 | < 6.61 |
| We are recognised and rewarded | **5.89** | **5.80** | < 5.71 | > 6.27 | > 5.94 | > 6.28 | < 4.96 |
| We each have a voice that counts | **6.72** | **6.68** | < 6.63 | > 7.11 | > 6.93 | > 6.97 | < 5.79 |
| We are safe and healthy | **5.94** | **5.94** | < 5.87 | > 6.26 | > 6.20 | > 6.24 | < 5.32 |
| We are always learning | **5.28** | **5.39** | < 5.33 | > 5.80 | > 5.62 | > 5.73 | < 4.48 |
| We work flexibly | **6.05** | **6.09** | < 5.97 | > 6.71 | > 6.19 | > 6.71 | < 5.00 |
| We are a team | **6.64** | **6.69** | < 6.60 | > 7.11 | > 6.85 | > 7.10 | < 5.94 |
| Employee engagement | **6.84** | **6.79** | < 6.75 | > 7.18 | > 7.24 | > 7.05 | < 5.78 |
| Morale | **5.77** | **5.74** | < 5.67 | > 6.04 | > 5.95 | > 6.04 | < 5.20 |

\*‘MH/LD refers to mental health and learning disabilities

Key: < Lower than the national average, > greater than the national average

1. In 2022 a tailored version of the [NHS Staff Survey was created for bank workers](https://www.nhsstaffsurveys.com/results/bank-worker-results/) in NHS trusts and will be mandated for those organisations with more than 200 bank workers in 2023. This will provide organisations with insight into the working experience of this group to make improvements where necessary as we reduce agency spending.
2. The [NHS Staff Survey 2022 dashboard](https://public.tableau.com/app/profile/piescc/viz/ST22_national_full_data_2023_03_09_FINAL/Aboutthissurvey) data shows that a lower proportion of staff (32.9%) had worked on COVID-19 specific wards than in 2021 (37.7%). Scores across all themes were lowest for those staff who worked on COVID wards, were redeployed or could not work remotely.
3. The score for the People Promise element ‘we are recognised and rewarded’ declined for all NHS staff from 5.9 in 2021 to 5.8 in 2022. This was driven by a 7 percentage point drop in the percentage of staff satisfied with their level of pay to 25.6% (Figure 6.2), and it is now 12.3 percentage points below the pre-pandemic level (38.0% in 2019). In contrast, the percentages of staff feeling that their work is recognised, valued and appreciated all held at a similar level to or improved very slightly on 2021.

**Figure 6.2: NHS Staff Survey % of staff who are “very satisfied” or “satisfied” with their pay for selected occupation groups, 2018 to 2022**

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#### Medical and dental trends

1. As has been the trend for several years, medical and dental staff in NHS trusts continued to have a higher level of satisfaction with their pay than any other staff group, and as for all staff groups satisfaction declined in the 2022 survey (Figure 6.2). This drop in satisfaction to 36.6% for medical and dental staff was prior to a period of sustained industrial action by the medical workforce (doctors in training and consultants) during 2023.
2. The proportion of medical and dental staff reporting feeling burnt out because of their work increased by 2.2 percentage points in 2022 to 35.3%. This is lower than the percentages of operational ambulance staff (49.3%), registered nurses and midwives (39.7%) and nursing and healthcare assistants (37.4%) reporting burnout.
3. The 2022 results appear to show medical and dental staff are less satisfied with their opportunities for flexible working compared to other staff; 43.6% reported they are satisfied with flexible working opportunities, compared to 54.4% of all staff. Medical and dental staff also reported having a worse experience in terms of their immediate manager taking a positive interest in their health and wellbeing; 56.7% of medical and dental staff compared to 69% of all staff.

### 6.2 NHS People Pulse

1. The [NHS People Pulse](https://www.england.nhs.uk/nhs-people-pulse/) survey tool was introduced to help organisations ‘listen’ to staff views through the pandemic in a consistent, validated and standardised way, and more frequently. It is funded nationally and available free to providers, though some have similar, pre-existing arrangements in place. It has provided insights into employee experience since July 2020.
2. Currently 110 trusts use the NHS People Pulse on a quarterly basis, collecting 40,000 to 50,000 responses to feed into the [NQPS](https://www.england.nhs.uk/fft/nqps/), which has a typical equivalent size of around 120,000. Outside those months, the People Pulse collects an average 3,000 responses monthly, providing trend data with a margin of error of 3% at a 95% confidence level.
3. The core metric trend data in Figure 6.3 indicates a period of stability for staff feeling supported with their health and wellbeing, as well as feeling informed and supported by their team.
4. The People Pulse also collects information on mood (Figure 6.4). The top words used to describe positive mood were ‘coping’ and ‘calm’, whereas for negative mood colleagues chose ‘demotivated’ and ‘stressed’.
5. An explanation for the drop in positive mood in December 2022 could be the announcement of nursing and ambulance staff strikes, and for that after March 2023 the start of the doctors in training strikes. Also, the margin of error in December 2022 was higher than from January 2023 onwards due to fewer responses that month (1,129 versus ~3,000 in other months). This could have been due to winter pressures, strike announcements and the fact that the NHS Staff Survey 2022 fieldwork period finished at the end of November 2022.

**Figure 6.3: NHS People Pulse core metric trends, December 2022 to August 2023**

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Source: NHS People Pulse December 2022 to August 2023

**Figure 6.4: NHS People Pulse colleague mood trend data, December 2022 to August 2023**

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Source: NHS People Pulse, December 2022 to August 2023

### 6.3 The National Education and Training Survey

1. To enhance our role in ensuring the quality of education and training, HEE introduced the [National Education and Training Survey (NETS)](https://www.hee.nhs.uk/our-work/quality/national-education-training-survey-nets) in 2019. NETS is the only national survey open to all undergraduate and postgraduate students and trainees undertaking a practice placement or training post in healthcare as part of their education and training programme. The survey gathers opinions from students and trainees about their experience working and training in practice placements and training posts – what worked well and what they think could be improved. The NETS also provides an opportunity to signpost appropriate wellbeing resources to learners, including Freedom to Speak Up guardians and guardians of safe working.
2. The NETS is currently live during October and November 2023. Results are usually published in Spring after extensive analysis and not yet available for the 2023 survey. An interactive reporting tool is available on our [website](https://www.hee.nhs.uk/our-work/quality/national-education-training-survey-nets/nets-2022-reporting) to explore the results at national, regional and organisational level and by profession.
3. The 2022 survey recorded the highest number of responses to date with almost 40,000 learners sharing their experience. The results described a challenging situation for our learners working and training in increasingly pressured environments; the number reporting an overall positive experience has steadily declined since the survey launched in 2019. In 2022, one-third had considered leaving their course or training programme, with most citing stress, workload and feeling overwhelmed as contributing to this. More learners reported experiencing bullying and harassment, with some saying they experienced discrimination by patients but did not wish to report this to their education or placement provider. Furthermore, the NETS results indicate that support and inclusion vary according to learners’ protected characteristics.

#### Medical and dental trends

1. The 2022 NETS survey was completed by 24,496 doctors and dentists in training, and feedback was as follows:

84.5%of doctors and dentists in training reported their overall educational experience as ‘satisfactory’, ‘good’ or ‘outstanding’

88.6%their supervision as ‘satisfactory’, ‘good’ or ‘outstanding’, up from 84.4% in 2021

70.7%would recommend their training post to friends and colleagues as a place to work or train. Of those who would not, 64% cited the rota/staffing as a reason

17%had experienced bullying and/or harassment by other staff in their training post, a slight increase on 15.9%in 2021.

1. In response to NETS feedback and triangulation with existing education quality intelligence, including the General Medical Council (GMC) survey, action taken includes:

Launch of the [National Educator Workforce Strategy](https://www.hee.nhs.uk/sites/default/files/EducatorWorkforceStrategy.pdf) to support the development and wellbeing of educators working across all healthcare professions.

Ensuring mechanisms are in place to support the wellbeing of and educational provision for postgraduate doctors and dentists in training, including through a group chaired by a regional postgraduate dean to review options to improve all education and training.

In January 2022, NHS England published our [inaugural equality, diversity and inclusion annual report](https://www.hee.nhs.uk/EDI_annual_report) and [improvement plan](https://www.england.nhs.uk/publication/nhs-edi-improvement-plan/) to eliminate inequalities in education and training. In 2023 we published [an update on our progress](https://www.hee.nhs.uk/our-work/equality-diversity-inclusion/hee-deans-equality-diversity-inclusion-annual-report-2023) to date and our priorities for the year ahead.

Promotion of the role of local Freedom to Speak Up guardians during 2022/23. The 2022 NETS confirmed that more learners (65%) now know how to raise concerns with their guardian. To further support doctors in training, ‘[Speak Up, Listen Up, Follow Up](https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/)’ is a new e-learning package for everyone working in healthcare.

In 2021 NHS England published the first NHS-wide patient safety syllabus which applies to all NHS employees and means they will receive enhanced patient safety training. The syllabus outlines a proactive approach to identifying risks to safe care, and covers systems thinking and human factors. Levels 1 and 2 are available to all NHS staff on [eLearning for health (ELfH)](https://www.e-lfh.org.uk/).

NHS England seeks solutions to key issues by undertaking additional engagement through national workstreams with partner representatives of trainee associations, such as the NHS England Study Leave Group, Training in the Independent Sector and the inaugural NHS England Equality, Diversity and Inclusion Learner Assembly.

## 7. The Medical Education Reform Programme

1. The Medical Education Reform Programme (MERP) continues to cover a range of aligned initiatives to enhance the structure and delivery of postgraduate medical training, and works in partnership with national stakeholders to facilitate system-wide ownership and delivery of change. The established [Future Doctor](https://www.hee.nhs.uk/sites/default/files/documents/Future%20Doctor%20Co-Created%20Vision%20-%20FINAL%20%28typo%20corrected%29.pdf) initiative sets a clear direction for the next phase of our reforms for medical education and training; to equip future doctors with the right skills to deliver care in an evolving environment. The reform streams focus on:
   1. **Enhanced generalist skills** – ensuring doctors can provide high quality whole person care for patients with multi-morbidities and disease clusters through the development of enhanced generalist skills. This changes how doctors work in local health systems and supports more seamless working across community, primary and secondary care.
   2. **Addressing health inequalities** by ensuring a more even distribution of NHS England’s funded training posts across the country, meaning we better support NHS service priorities across England – this also tackles remote, rural and coastal healthcare challenges.
   3. **Improving the** **wellbeing and experience of doctors** in training through flexible training opportunities, portfolio careers and other initiatives through the [Enhancing Doctors’ Working Lives Programme](https://www.hee.nhs.uk/our-work/doctors-training/enhancing-working-lives), the [People Promise Exemplars Programme](https://www.england.nhs.uk/blog/the-soft-stuff-is-the-hard-stuff-one-year-into-the-people-promise-exemplars-programme/) and the implementation of the [NHS Staff and Learners Wellbeing Commission](https://www.hee.nhs.uk/our-work/mental-wellbeing-report).

Details of the initiatives relevant to the DDRB are described below.

### 7.1 Future workforce – enhanced generalist skills

1. The [Future Doctor Report](https://www.hee.nhs.uk/sites/default/files/documents/Future%20Doctor%20Co-Created%20Vision%20-%20FINAL%20%28typo%20corrected%29.pdf) highlighted the need for a greater proportion of doctors and all other healthcare professionals to have generalist skills. This was reinforced in the learning from the COVID-19 pandemic. Enhancing and maintaining generalist skills will enable clinicians to be more adaptable, and better able to meet patient and population needs and to address health inequity across populations.
2. The [Enhancing Generalist Skills](https://www.hee.nhs.uk/our-work/enhancing-generalist-skills) syllabus covers 6 healthcare domains: person-centred practice, complex multi-morbidity, population health, system working, social justice, and health equity and environmental sustainability. These are supported by four cross-cutting themes: wellbeing, transformative reflection, digital and leadership. Currently, over 500 healthcare workers across more than 25 professions, including over 350 doctors, have undertaken an enhance programme in their region of England via the 7 enhance trailblazers.
3. In August we [expanded the availability of this programme](https://www.hee.nhs.uk/our-work/enhancing-generalist-skills/enhance-foundation-programme) to all foundation doctors in England. This supports early-stage clinicians to understand the clinical, societal and system-wide complexities of health and care services and how to navigate them to provide integrated person-centred care for all.
4. Alongside this expansion we are working to increase partnerships with integrated care systems (ICSs) and bolster opportunities for all health and care staff to learn generalist skills together. This will embed the programme into the wider NHS and maximise benefits for patients, teams and systems.

### 7.2 Medical doctor degree apprenticeship and blended learning medical degree

1. NHS England has confirmed funding support for up to [200 medical doctor degree apprenticeships on a pilot](https://www.hee.nhs.uk/our-work/talent-care-widening-participation/apprenticeships/medical-doctor-degree-apprenticeship), and are aiming for the first of these apprentices to start in 2024. We are engaging with 3 medical schools that have already registered an interest with the GMC in piloting the apprenticeship – Anglia Ruskin University, the University of Central Lancashire and Plymouth University. Medical schools that wish to offer the apprenticeship will need GMC approval that their apprenticeship programme meets the same standards as those required for all medical degrees leading to the award of a primary medical qualification. NHS employers will need to work with medical schools to deliver the apprenticeship. Decisions on employing apprentice doctors will be made at a local level based on local workforce needs. NHS England and medical schools are working with NHS employers to support delivery.
2. The first cohort in the blended learning medical degree programme, delivered by Queen Mary University of London, started in October 2023. The programme blends face-to-face with online and digital learning to develop theoretical and practical knowledge and skills, giving students more flexibility over how they study and a wider choice of where practice placement learning opportunities are provided to complete their training.
3. The flexibility offered by the apprenticeship and blended degree is designed to reduce barriers to higher education and attract applicants from diverse backgrounds.

### 7.3 Addressing health inequalities – distribution of training places

1. This programme seeks to address long-term inequality challenges by helping remote, rural and smaller health systems attract, recruit and retain trainees, consultants and GPs. It has implemented and trialled a range of methods to transition the distribution of training to the future guided position, while maintaining continuity of care and patient quality and safety.
2. The NHS England model for guiding the distribution of training posts has been prioritising 3 high-fill specialties – haematology, cardiology, and obstetrics and gynaecology – to better align with patient need. The first tranche of training posts in these 3 specialties started their first year post movement in August 2022. Addressing distribution for the other medical specialties has been allocated into phases, and will be explored to align with further expansion over the next 10–15 years.
3. There is an opportunity to highlight and promote the educational value of remote and rural clinical placements and to guide the creation, development and support for training posts in these locations. Postgraduate deans are looking at the distribution of doctors within their own footprints, to ensure better regional distribution to remote and rural systems. A network of 6 remote and rural pilot sites has been created to explore how best to support the educational offer and build the required infrastructure.
4. NHS England is aware that trainees in rural Cornwall, for example, have to pay London prices for accommodation but without any upward adjustment of remuneration. This deters trainees from settling in such areas long term.

### 7.4 Flexible pay

1. We note the DDRB would welcome evidence or proposals that look at extending the range of pay premia to cover difficult to recruit to specialties and geographies. We suggest this debate should link to NHS England’s work around the geographical distribution of training places described above.
2. Our experience of introducing pay premia is limited to the [General Practice Targeted Enhanced Recruitment Scheme (TERS)](https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/targeted-enhanced-recruitment-scheme#:~:text=The%20Targeted%20Enhanced%20Recruitment%20Scheme%20is%20an%20initiative,under-recruitment%20or%20are%20in%20under-doctored%20or%20deprived%20areas.). Successful applicants who commit to training for 3 years in TERS areas are offered a one-off £20,000 salary supplement, funded by NHS England. The scheme was designed to test whether additional financial incentives attract trainees to and might provide a workforce supply into areas facing the severest recruitment pressures.
3. The 2020/21 GP Contract agreement committed the then NHS England and NHS Improvement, and HEE to expanding the number of TERS places from 500 to 800 in 2022/23, at which point these would account for 20% of the 4,000 GP specialty training places available nationally. TERS has proved successful in attracting GP trainees to areas with the most significant recruitment challenges. It may also be making GP training more attractive to more prospective trainees, helping NHS England deliver the target of filling all 4,000 training placements. However, caution is exercised in the evaluation of TERS results, as longitudinal tracking is required to ascertain if TERS trainees remain in an area post qualification and this is still a relatively new scheme.

### 7.5 Foundation priority programmes

1. NHS England has maintained support for a range of foundation priority programmes in areas of England that find it difficult to attract and retain trainees through the foundation and specialty recruitment processes. To date, the following local financial incentives have been introduced and evaluated:
   * 1. The Northern Foundation School offers 85 priority programmes with a £7,500 per training year taxable incentive. These include additional educational support for all foundation year 1 and 2 doctors through the F-Docs online education package.
     2. All foundation schools offer programmes that include a fellowship with the Royal College of Psychiatry to support recruitment to core psychiatry programmes.
     3. All foundation schools offer programmes that include a fellowship with the Royal College of Pathology to support recruitment to pathology specialties.

### 7.6 Recruitment incentive – paediatric and perinatal pathology

1. All trainees accepting a paediatric and perinatal pathology training post in England from 2023 will be eligible for a £20,000 recruitment incentive. This is to recognise the need to improve recruitment into the specialty and grow the paediatric and perinatal pathology workforce.
2. Further retention payments will be available to trainees continuing in training, on a sliding scale: ST3 £20,000 – new appointments; ST4 £15,000; ST5 £10,000 and ST6 £10,000.

### 7.7 Specialty and specialist doctors

1. Specialty and specialist (SAS) doctors are a growing cohort who provide a significant service contribution and workforce flexibility, and are significantly over-represented by doctors who trained outside the UK. It is important that SAS doctor roles are seen as a viable and fairly remunerated career choice.
2. Some SAS doctors report concerns about the lack of support they are given in the workplace. NHS England continues to explore and implement initiatives to improve SAS doctors’ overall experience, wellbeing, access to education, training and assessment, and opportunities for career development and progression through:

* enhanced inductions, especially for international medical graduates to support their integration into the NHS
* improved working flexibility
* new professional development offers to support learning and working together across professions
* development of clinical leadership and educator roles to support career development, through implementation of the educator supervision strategy
* exploration of new assessment routes to facilitate career progression and Certificate of Completion of Training attainment for those who wish to work at consultant level.

## 8. People Promise work programmes

### 8.1 The People Promise Exemplars Programme

1. NHS England launched the [People Promise Exemplars Programme](https://www.england.nhs.uk/blog/the-soft-stuff-is-the-hard-stuff-one-year-into-the-people-promise-exemplars-programme/) in April 2022 in response to the understanding that a ‘bundle’ of actions is needed to sustainably improve retention across the whole workforce. There are currently 23 exemplar trusts representing every region and a range of types (excluding ambulance trusts) and sizes, with each implementing a People Promise action plan that draws from a standard menu of interventions (for example, flexible working, health and wellbeing, and line management support). In addition, the NHS Long Term Workforce Plan recommends actions to deliver sustained gains across the whole workforce by addressing the key retention issues identified by partner organisations.
2. We held a People Promise in Action week and convened 21 learning and sharing spaces to showcase best practice examples from our People Promise exemplars and other organisations. Over 4,000 attendees heard from colleagues across the NHS about the practical interventions they are implementing to bring the People Promise to life and improvethe experience of staff within their organisations. This is the start of a commitment to spread and scale at pace what is known to work across the NHS.

**Figure 8.1: Staff turnover and leaver rate impact for People Promise Exemplar organisations**

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Source: Analysis of monthly leaver and turnover data

1. The following are also informing retention improvement interventions:

* [Culture and Leadership Programme](https://www.england.nhs.uk/culture/culture-leadership-programme/) (CLP) – a structured approach that helps organisations understand their culture, identify the root causes of what they need to change and then address them.
* [NHS equality, diversity and inclusion improvement plan](https://www.england.nhs.uk/publication/nhs-edi-improvement-plan/) (June 2023) – sets out 6 high impact actions (HIAs) that organisations must implement to address discrimination and grow an inclusive and equitable workforce.
* [Workforce Disability Equality Standard](https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/wdes/) (WDES) – mandated through the NHS Standard Contract to reduce areas of disparity.
* [NHS Health and Wellbeing Framework](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.) – defines what organisations and systems need to do to create a wellbeing culture.
* [Messenger Review](https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future) (2022) – highlights the difference excellent leadership can make in health and social care.
* [NHS England Fit and Proper Person Test (FPPT) framework for board members](https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/#:~:text=NHS%20England%20has%20developed%20a,and%20proper%20for%20their%20roles.) (August 2023) – we developed this framework in response to the recommendations in the Kark Review (2019), informed by the requirements of the Care Quality Commission (CQC).

### 8.2 Health and wellbeing support

1. In line with the [People Promise](https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/), NHS England has made clear commitments to improve the health and wellbeing of our workforce and support a culture change across systems and organisations to embed an evidence-based, preventative approach to health and wellbeing. We have refreshed the [NHS Health and Wellbeing Framework](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.) to take account of a wider set of factors in defining what organisations and systems can do to create a culture of wellbeing, support staff to feel safe and healthy at work, and deliver an improved experience for our workforce.
2. Supporting the health and wellbeing of staff working across the NHS is a key commitment in strategic policies, including the [NHS Long Term Workforce Plan](https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/), [NHS People Plan](https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/), [2022/23 priorities and operational planning guidance](https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/), [government response to the Health and Social Care Committee Report on workforce burnout and resilience in the NHS and social care](https://www.gov.uk/government/publications/workforce-burnout-and-resilience-in-the-nhs-and-social-care/the-government-response-to-the-health-and-social-care-committee-report-on-workforce-burnout-and-resilience-in-the-nhs-and-social-care) and the [NHS England operating framework](https://www.england.nhs.uk/publication/operating-framework/). The [NHS oversight metrics for 2022/23](https://www.england.nhs.uk/wp-content/uploads/2022/05/B1378_ii_nhs-oversight-metrics-for-2022-23_June-2022.pdf) include specific metrics that we must deliver against to show how we are supporting the health and wellbeing of our NHS workforce.
3. The annual NHS Staff Survey provides important trend data on the self-reported health and wellbeing of staff:

* The percentage of staff reporting that work-related stress had made them feel unwell decreased by 2 percentage points in the 2022 compared to the 2021 staff survey, but at 44.8% it remains above pre-pandemic levels (40.5% in 2019).
* The sub-score relating to ‘health and safety climate’ is unchanged from 2021. However, staff were slightly less likely than in 2021 to say that they have adequate materials, supplies and equipment to do their work.
* The ‘burnout’ sub-score improved slightly in 2022 compared to 2021 (when these questions were introduced) for all staff groups other than medical and dental staff, for whom scores were slightly worse.
* The percentage of staff saying they experienced at least 1 incident of physical violence from patients/service users, relatives or other members of the public in the course of their work over the last 12 months has stayed relatively consistent across the last 5 years, at 14.7% in 2022. This experience is much higher among paramedics (45.3% in 2022).
* The percentage of staff reporting they had experienced at least 1 incident of harassment, bullying and abuse from patients/service users, relatives or other members of the public was also similar in 2022 to that in previous years, at 27.8%.

1. The [national Health and Wellbeing Programme](https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/) was launched early in the pandemic to support staff and complement services available locally, including [occupational health and wellbeing](https://www.england.nhs.uk/publication/growing-occupational-health-and-wellbeing-together-strategy/) and Employee Assistance Programmes.
2. During the early pandemic and since, significant investment has been made in developing national resources and sharing best practice and lessons learnt across ICSs to support systems as we transition into the new NHS England.
3. The national programme has shifted from putting in place offers and support for individuals to access, to encouraging an organisationally-led and preventative approach, where staff health and wellbeing becomes embedded within the culture, including at a local level. Key interventions include:

* Rolling out [health and wellbeing conversation training](https://www.england.nhs.uk/supporting-our-nhs-people/support-now/having-safe-and-effective-wellbeing-conversations/#:~:text=NHS%20England%20co%2Ddesigned%20a,skills%20to%20have%20safe%20and) for line managers and peers to enable them to have safe and effective conversations with colleagues. To date more than 5,300 line managers have attended this training: 76.5% of year 1 respondents and 82% of year 2 respondents to post-course evaluation reported being able to put this training into practice. Furthermore, 85% of participants told us immediately after the training in year 2 that this had contributed to their own wellbeing, with 75% confirming this at 3-month follow-up. Data from the [NHS People Pulse](https://www.england.nhs.uk/nhs-people-pulse/) indicates a strong correlation between supportive wellbeing conversations (especially conversations with a line manager) and a positive view of organisations supporting an individual’s wellbeing. In April 2023, 69.3% of staff who had a wellbeing conversation with their manager said their organisation proactively supports their health and wellbeing, compared with 40% who had not had a wellbeing conversation in the preceding 3 months. Interviews with managers in People Promise exemplar sites suggest this correlation may be attributable to wellbeing conversations creating a more supportive team culture, increasing staff engagement and effectively signposting staff to support.
* Establishing and supporting [health and wellbeing guardians](https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/wellbeing-guardians/) – a role usually fulfilled by a non-executive director to ensure effective board-level ownership. Early impact evaluation demonstrates this role is raising the strategic voice at board level and holding the board to account for investment in health and wellbeing, based on workforce need.
* Rolling out of [health and wellbeing champions](https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/health-and-wellbeing-champions/) across the NHS, with dedicated support from the national team. As of September 2023, a network of over 3,000 champions across the NHS has been established, covering a range of roles, grades, demographics and sectors. Over 30 development sessions have been delivered to champions on topics including menopause, safely signposting staff, financial wellbeing, mental health and looking after yourself.
* Ongoing expert support, in line with the [NHS England operating framework](https://www.england.nhs.uk/publication/operating-framework/), into ICSs to develop locally owned health and wellbeing programmes tailored to local workforce needs.
* Establishing and supporting 6 special interest groups (SIGs) that bring colleagues together from across the NHS to share learning on topics: long COVID, suicide prevention, menopause, men’s health, musculoskeletal and health and wellbeing strategy planning. Shared best practice has contributed to national policy development, including the case studies featured in the [national menopause guidance](https://www.england.nhs.uk/long-read/supporting-our-nhs-people-through-menopause-guidance-for-line-managers-and-colleagues/) and the long COVID guidelines.
* Developing a [national strategy for occupational health](https://www.nhshealthatwork.co.uk/growingohroadmap.asp#:~:text=Growing%20OHWB%20Together&text=In%202021%2C%20in%20response%20to,strategic%2C%20and%20proactive%20system%20partners.), with a view to supporting occupational health services to move towards a preventative, integrated service delivery model.

1. Occupational health and wellbeing is now being integrated in new CQC key lines of enquiry (KLOE) and NHS England (formerly HEE) quality drivers, and is the basis of the NHS annex of the [Safe Effective Quality Occupational Health Service](https://www.seqohs.org/) (SEQOHS) standards.
2. Training is being provided to occupational health and wellbeing leaders through 115 funded places on Leadership Academy programmes.
3. The [national Health and Wellbeing Programme](https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/health-and-wellbeing-champions/) also provides expert support to specific sectors, including primary care, maternity, ambulance and critical care, as well as directly supporting regional teams.
4. The [Ambulance Staff Crisis Phoneline](https://www.theasc.org.uk/crisis?gclid=EAIaIQobChMIpMrC3rOlggMVU8XtCh3NvQGQEAAYASAAEgIGlfD_BwE) was launched on 24 November 2022, run by The Ambulance Staff Charity. It is open to all ambulance staff and volunteers and offers a counsellor-led service to provide immediate and appropriate help.
5. The national Health and Wellbeing Programme also has a focus on reducing violence against staff and has dedicated resource and funding to address this.
6. To support organisations and systems to address violence against staff, the national [Violence prevention and reduction standard](https://www.england.nhs.uk/publication/violence-prevention-and-reduction-standard/) has been refreshed to reflect feedback from 6 ICSs. It now includes a tool that organisations can use to measure their progress against the standard.
7. A violence prevention and reduction strategy toolkit will be published shortly, providing ICSs with a framework to develop a system-level violence reduction strategy.
8. Staff can access the other national support offers, including financial wellbeing support, on the [supporting our NHS people pages](https://www.england.nhs.uk/supporting-our-nhs-people/).

### 8.3 Flexible working

1. ‘We work flexibly’ is one component of the NHS People Promise. Staff should have the opportunity to work flexibly, regardless of role, team, organisation, grade or reason. This offer recognises their diverse needs and responsibilities, and empowers staff to balance and align their professional and personal commitments such as caring responsibilities, health concerns and other life events/circumstances. By embracing flexible working practices, the NHS is demonstrating its commitment to creating a supportive and inclusive workplace culture, one that attracts and retains a talented workforce. When staff feel they cannot secure the flexibility they need, they are more likely to join the temporary workforce, bank or agency, than the substantive workforce.
2. NHS England has made a clear commitment to flexible working, and flexible working is cited as a key enabler/intervention in the following publications:

* [NHS People Plan](https://www.england.nhs.uk/ournhspeople/)
* [NHS People Promise](https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/)
* [Negotiated changes to the NHS Terms and Conditions Handbook](https://www.nhsemployers.org/publications/tchandbook), which extends flexible working to medical and non-medical staff
* [2023/24 priorities and operational planning guidance](https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/)
* [Delivery plan for recovering urgent and emergency care services](https://www.england.nhs.uk/wp-content/uploads/2023/01/B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf)
* [NHS Long Term Workforce Plan](https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/), with a focus on flexibility in training, flexible working as an enabler of retention, and the role flexible working plays in reforming the way the NHS works
* [NHS England 2023/24 business plan](https://www.england.nhs.uk/long-read/our-2023-24-business-plan/).

1. We have developed a [flexible working manager’s guide](https://www.england.nhs.uk/wp-content/uploads/2022/06/flexible-working-toolkit-for-line-managers.pdf) (in partnership with the [NHS Staff Council](https://www.nhsemployers.org/NHSStaffCouncil) and [Timewise](https://timewise.co.uk/)), the guidance [Flexible working: raising the standards for the NHS](https://www.england.nhs.uk/wp-content/uploads/2022/02/B0395-flexible-working-raising-the-standards-for-the-NHS.pdf) and [Flexible working: toolkit for individuals and line managers](https://www.england.nhs.uk/publication/flexible-working-toolkit-for-individuals-and-line-managers/)..
2. Flexible working is encouraged from the point of recruitment, with NHS Jobs and the NHS recruiting system (TRAC) enabling roles to be advertised with flexible working options. As a minimum, 25% of permanent roles should be advertised with clear flexible working options. Since September 2020 (NHS Jobs) and March 2021 (Trac), NHS England has recorded how many adverts offer flexibility, giving us an indication of the availability of flexible working opportunities across the NHS, but not the number of staff engaged on flexible terms. Jobs advertised with some form of flexibility have increased from 11.4% in April 2021 to 24.13% in August 2023.
3. In general practice, flexible pools were introduced in 2020 to support GPs who want to work flexibly, and local systems and practices to fill vacant shifts. By 2022, all systems had introduced a primary care flexible staff pool supported by a digital solution to help match available GPs to practices.
4. In NHS England’s January 2023 [People Pulse Survey](https://www.england.nhs.uk/nhs-people-pulse/), 71% of staff in NHS trusts said they could approach their immediate line manager to talk openly about flexible working, and 41% that their organisation champions flexible working. However, the latest People Pulse survey showed that 45.1% of medical and dental staff in NHS trusts are less satisfied with opportunities for flexible working, compared to 53.9% of other staff. Satisfaction has declined for all staff groups over the last year, reversing the overall improvement trend.
5. ICS retention quarterly returns in August 2023 show that 50% of organisations have a board-level flexible working champion; 79% have communicated flexible working changes to terms and conditions; and 45% track applications for flexible working and outcomes. Tracking applications for flexible working ranges from 33% of organisations in the South West to 61% in the South East.
6. The Medical Education Reform team continue to enhance flexibilities for the medical cohort, with a particular focus on less than full time (LTFT) training. LTFT numbers have increased from 11.8% in March 2018 to 19.63% in March 2023 (Trainee Information System).
7. All doctors in training have access to two flexible training options:
8. **Flexible portfolio training (FPT):** a flexible, individualised opportunity within medical postgraduate specialty training to devote 1 day a week (or 20% full time equivalent, FTE) to additional professional development that supports local educational, academic and service aims. Following a successful pilot run with the Royal College of Physicians (RCP), from August 2023 FPT can be offered in all specialties across England.
9. **Out of programme (OOP):** doctors in training can step out of their training programme for research (OOPR), development experiences (OOPE), approved training (OOPT) or career breaks (OOPC). A further option was introduced in 2019, the out of programme pause (OOPP). The first phase of this initiative was launched in spring 2019, and due to the impact of the pandemic has been extended until the end of July 2024, when a 3-year external evaluation of OOPP is due to be published. Early signs from the pilot are that this is greatly valued by trainees and can keep them in training pathways rather than leaving training. NHS England has secured 4 nation agreement to move forward with the GMC to shift OOPP to business as usual as.
10. Our strategic priorities for 2023/24 include the following interventions:
11. **Flexible working leadership development:** working with boards and senior decision-makers at provider and system level to better understand the benefits of flexible working for their staff and patients. The aim is to support employers to embed flexible working from ‘ward to board’. Planning is underway to develop a ‘proof of concept’ approach, and we will evaluate impact in early 2024/25.
12. **Case studies:** an evidence-based portfolio of case studies showcasing best practice for implementation of the NHS People Promise themes (with a focus on flexible working). Current data from the exemplar sites shows a positive relationship between the delivery of these themes and improved retention rates.
13. **e-Learning:** We will establish an e-learning module available to all NHS staff to develop leaders, managers and teams’ competence and confidence to lead flexible working conversations in their organisations.
14. [Action 5](https://www.england.nhs.uk/future-of-human-resources-and-organisational-development/the-future-of-nhs-human-resources-and-organisational-development-report/turning-the-vision-into-action/) of [NHS England’s Future of HR and OD programme](https://www.england.nhs.uk/publication/the-future-of-nhs-human-resources-and-organisational-development-report/) commits us to develop national policy frameworks that providers, trusts and ICBs can use at a local level, saving time and bringing consistency to local policies across the country. A flexible working policy framework is planned to launch in quarter 4 2024. NHS England will work with trusts that use this policy framework to update or create their own local policy, and identify key performance indicator (KPI) monitoring arrangements.
15. The [2023 workforce deployment systems (WDS) survey](https://www.engage.england.nhs.uk/consultation/workforce-deployment-software-2023/) assesses implementation of e-rostering and e-job planning across NHS trusts, based on measuring software levels of attainment (LOA) for different staff groups on a scale of 0 to 4. The LOA enable a trust to benchmark its progress towards optimal system use. The average LOA nationally for e-rostering was 1.7 for nursing and midwifery staff, 1.1 for allied health professionals and 0.5 for medical staff. Fewer trusts reported LOA level 0 in 2023, demonstrating wider uptake of e-rostering systems.

### 8.4 Enabling staff movement

1. The Enabling Staff Movement Programme is concerned with making 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.
2. The [Enabling Staff Movement Toolkit](https://www.england.nhs.uk/enabling-staff-movement-toolkit/) published in 2019 helps organisations remove barriers to staff movement, by providing sample ‘warranty’ text, case studies and signposted resources.
3. A [digital staff passport](https://transform.england.nhs.uk/information-governance/guidance/digital-staff-passport/) is widely accepted as a strategic modern solution to more efficient deployment of an agile and responsive workforce. This innovation enables the right people with the right skills to be safely deployed to the right place, quickly, efficiently and securely. Digital staff passports hold people’s verified portfolio of qualifications, professional registration, employment history, competence and assessed experience so that they do not need to repeat form filling, checks and training when moving between NHS employing organisations.
4. All staff groups were 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 memorandum of understanding). This has acted as a national pilot to test the use of decentralised ledger technology, managed service requirements, interoperability with NHSmail and the Electronic Staff Record (ESR), interim trusted frameworks and the demand for digital staff passports.
5. We are collaborating with the NHS Business Services Authority (NHSBSA) and other partners to launch the digital staff passport, initially to 5 pilot trusts and then 16 early adopter sites in Spring 2024. Postgraduate doctors will be the first cohort to adopt the digital staff passport for their rotations in February 2024, as well as temporary staff movers (those who have a substantive contract with one NHS organisation and work at another; for example, as part of a clinical network)
6. Subject to the successful completion of the pilot phase, ICSs will be encouraged to adopt the NHS Digital Staff Passport from quarter 1 2024, and subject to public beta assessment roll this out at pace in quarter 3 2024. Full rollout of the digital staff passport is expected by August 2025, as stated in the NHS Long Term Workforce Plan.

### 8.5 Equality, diversity and inclusion

#### NHS equality, diversity and inclusion (EDI) improvement plan

1. The [NHS EDI improvement plan](https://www.england.nhs.uk/publication/nhs-edi-improvement-plan/), published on 8 June 2023, is an action-orientated plan to meet the challenges of EDI in the NHS. The plan focuses on improving the experiences of our workforce, benefiting retention and the attraction of new talent to the NHS, and draws on the growing evidence base in healthcare and from other sectors to make the case for why EDI is a key foundation for creating an efficient, productive and safe NHS. It contains 6 high impact actions (HIAs) covering all protected characteristics, co-produced with staff networks and senior leaders.
2. The plan’s strategic objectives are to:

* Address discrimination so that staff are empowered to use their full range of skills and experience to deliver the best possible patient care.
* Increase the accountability of all leaders to embed inclusive leadership and promote equal opportunities and fairness of outcomes in line with the [NHS Constitution](https://www.gov.uk/government/publications/the-nhs-constitution-for-england), the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents) and the [Messenger Review](https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future).
* Support the levelling up agenda by improving EDI within the NHS workforce to enhance the NHS’s reputation as a modern employer and an anchor institution, thereby attracting diverse talent to our workforce.
* Increase equality of opportunity for progression and growth in the NHS, facilitating social mobility in the communities we serve.

1. The EDI improvement plan sits alongside the NHS Long Term Workforce Plan. Implementation of its 6 HIAs will support NHS organisations to deliver some of the key objectives of the NHS Long Term Workforce Plan.
2. The findings and recommendations of the [Messenger Review](https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future), published in June 2022, reaffirmed the need for the EDI improvement plan; it is a cornerstones of NHS England’s response to recommendation 2. Aligned with the Messenger Review recommendations, future iterations of this plan will respond to the challenges across both health and social care.

#### National EDI repository and EDI dashboard

1. We have been supporting NHS organisations to take an improvement-based approach to delivering the actions in the EDI improvement plan. The [National EDI Repository](https://future.nhs.uk/NationalEDITeam/view?objectId=41622032) on FutureNHS of best practice resources aligned to the 6 HIAs in the EDI improvement plan (for organisations to adapt and use at local level) and EDI dashboard on the [Model Health System](https://www.england.nhs.uk/applications/model-hospital/) underpin our approach to implementation by spreading good practice, reducing duplicative effort and unwarranted variation, and supporting measurable improvement. This helps accelerate the pace of implementation.
2. Resources on the repository include:

* toolkits and best practice exemplar resources for organisations to adapt and adopt
* research and evidence summaries
* case studies from NHS organisations and other sectors.

1. All resources are reviewed and classified according to their effectiveness, impact and scalability.
2. The EDI dashboard provides a suite of aggregated metrics and indicators aligned to the 6 HIAs in the EDI improvement plan, enabling NHS organisations to track the impact of their specific actions.
3. Adopting an agile approach to development of the dashboard, the first release launched alongside the EDI improvement plan included 10 of the 17 success metrics. The second iteration, released in November 2023, added 4 more metrics, and refreshed the datasets on existing metrics.
4. The dashboard aggregates and triangulates multiple workforce datasets, including the:
5. [NHS Staff Survey](https://www.nhsstaffsurveys.com/results/national-results/)
6. [Workforce Race Equality Standard](https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/) (WRES)
7. [Workforce Disability Equality Standard](https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/wdes/) (WDES)
8. [Gender pay gap](https://commonslibrary.parliament.uk/research-briefings/sn07068/)
9. [National Education and Training Survey](https://www.hee.nhs.uk/our-work/quality/national-education-training-survey-nets) (NETS).
10. The [Equalities and Human Rights Commission](https://www.equalityhumanrights.com/) will review the metrics on the dashboard to support its investigations. We have worked closely with the CQC to develop the EDI improvement plan, and it will review organisational performance on EDI using these metrics to inform its well-led assessments.
11. Organisations will be able to benchmark themselves at organisation and system level using data and insights into staff experience and organisational culture for all NHS providers and systems.
12. NHS England will use the dashboard to monitor implementation and impact at a national level, and identify where additional support may be required using quality improvement methodology, in line with the overall improvement approach.

#### Next steps

1. For our patients to get better care and outcomes, all our doctors need to be treated fairly and equitably. While progress has been made in some areas of workforce equality, if we are to meet the ambitions set out in the NHS Long Term Workforce 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 one or more protected characteristics, by implementing the action-focused EDI improvement workforce plan and building on current initiatives, such as overhauling recruitment processes and practices to be more inclusive, and continuing to use WDES and WRES data and other datasets to drive organisational and system improvements.

### 8.6 Retention Programme

1. Established in April 2020, our evidence-based [Retention Programme](https://www.england.nhs.uk/looking-after-our-people/) supports trusts and ICSs to increase workforce capacity by improving staff experience and with this retention. 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.
2. The programme explores job satisfaction and why people decide to stay or leave the NHS, including the triggers for considering leaving. Work-related stress, lack of line manager support, staff shortages, pay, mental health impacts and time pressure are strong drivers for leaving.
3. In year 1 (2020/21) the programme developed a universal component focusing on flexible working and health and wellbeing, which organisations and systems can access through the [retention hub](https://www.england.nhs.uk/looking-after-our-people/) – a digital repository of practical information, tools and case studies. The programme also established intensive pathfinder sites in every region (74 trusts in 10 ICSs) with cross-system collaboration. Unfortunately, the pandemic meant systems and organisations had limited capacity to engage with the programme.
4. In year 2 the programme delivered:

* Retention benchmarking tools within the [Model Health System](https://www.england.nhs.uk/applications/model-hospital/), enabling every ICS and organisation to review its data, track improvement and benchmark against peers to ensure evidence-based improvement.
* An [updated national retention hub](https://www.england.nhs.uk/looking-after-our-people/) (an innovative digital repository of practical information, tools and case studies for trusts and systems to use), extending the reach of ideas and positive retention practice.
* Significant engagement with the system, including through focus groups, webinars, masterclasses, and discussions with staff and their representative bodies, including the medical royal colleges and faculties and the BMA.
* A [retention guide for line managers and leaders](https://www.nhsemployers.org/publications/improving-staff-retention) developed with NHS Employers and published in March 2022.

1. In response to the continued increase in leaver rates and the need to maximise workforce capacity during the extremely challenging winter, in year 3 the programme’s scope was revised to focus on the following priority areas:

* **An all staff approach through the People Promise Exemplars Programme,** working with 23 trusts across all regions to implement a bundle of HIAs selected locally from a standard ‘menu’ to improve all staff experience and retention.
* **Targeted actions for specific professions.** For the medical workforce, these included a focus on retention of those in late-stage career and improving the experience of international medical graduates (IMGs). The latter have been supported with the creation of an IMG ‘Share and Learn’ network and as of October 2023, 24 trusts are members and together these represent all 7 regions.
* Funded dedicated support in every ICS to ensure retention remains a priority across all systems.
* Implementation of a new, quarterly impact tracker with KPIs on progress across all systems against the nursing [5 HIAs](https://www.england.nhs.uk/wp-content/uploads/2022/07/B1711_Retaining-our-nursing-and-midwifery-colleagues-13-July-2022.pdf) and People Promise domains, to be completed by ICS retention leads.
* Visits to various trusts to validate progress achieved on adoption of evidence-based improvement interventions, and to look for opportunities to implement initiatives and the challenges of doing so.

1. The programme continues to spread the adoption of good practice interventions widely across the NHS through the collation and sharing of case studies, communities of practice, locally-led events, updates to the retention hub, publications and media channels.

#### Retention support

1. Retention of doctors in late-stage careers is a key concern, particularly given the signs in NHS trusts that leaver rates for this group are increasing. Doctors are choosing to leave the NHS for various reasons: workplace pressures, lack of opportunities to work flexibly and issues relating to pension taxation (see section 10.3: Consultant retention). Those in late-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.
2. We are testing late-stage career conversations in 7 pilot sites and to date 179 conversations have been conducted. These structured conversations cover a doctor’s motivations at work, career and retirement plans, issues that would push them to leave and changes that would encourage them to stay longer. They enable team-centred discussions around what changes are possible and better succession planning for the department and trust. Initial results from the pilot sites are positive: conversations have been well-received by doctors and have provided organisations with a substantial intelligence around working conditions that better retain doctors in the later stages of their careers.
3. In June 2023, NHS England published [retaining doctors in late stage career guidance](https://www.england.nhs.uk/publication/retaining-doctors-in-late-stage-career-guidance/), developed in collaboration with the Academy of Medical Royal Colleges (AoMRC). The guidance makes 10 recommendations for systems and employers to consider when supporting doctors in late career in secondary care settings to stay and stay well in the NHS. These align to the NHS People Promise and include holding retirement conversations, and supporting flexible working and health and wellbeing. This guidance has had 2,298 webpage views.

## 9. The NHS reward offer

1. The NHS Long Term Workforce Plan sets out our ambition to build on the interventions in the [NHS People Plan](https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/) to ensure that the employment offer is attractive to people across all generations, including those who have yet to join the workforce.
2. This is essential as the NHS seeks to recover services following the pandemic – and help our people to recover. The pandemic has caused many NHS staff to reflect on their career choices and work/life balance. Some may be looking to protect their wellbeing by reducing working hours or discretionary effort, or no longer taking on additional shifts.
3. The DDRB noted last year that consultant earnings remain between the 98th and 99th percentile of UK earners. Each year DHSC commissions the Government Actuary’s Department to assess the value of basic pay, out-of-hours and on-call payments, annual accrued pension, extra sessions worked and weekend allowances, including additional leave over the statutory minimum and additional sick leave over statutory sick pay (Figure 9.1). For example, the total reward package for a consultant with 10 years seniority (without a clinical excellence award) is around £170,000. Further detail on the value of the total reward package is included in the DHSC evidence to the DDRB.

###### Figure 9.1: Value of employed doctor grades total reward package (£)

Source: Government Actuary’s Department

1. To attract and retain the staff the NHS needs, and encourage staff to return and extend their careers after retirement, our aim is to support system leaders to leverage the overall employment offer as part of their local people strategies.

### 9.1 Staff recognition framework

1. The NHS People Promise describes staff recognition as “[a] simple thank you for our day-to-day work, formal recognition for our dedication”. The NHS Staff Survey for 2022 showed that only 52.4% of staff were satisfied with the recognition they get for good work. This has implications for staff retention since pay alone does not determine staff wellbeing, engagement and retention in the long term; praise and recognition are also critical ([Bimpong et al, 2020](https://bmjopen.bmj.com/content/10/7/e034919)). However, recognition is complex in that people’s understanding and experience of it are varied and diverse, influenced by the broader social and macroeconomic environment ([Day et al, 2021](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fonlinelibrary.wiley.com%2Fdoi%2F10.1111%2Fhex.13359&data=05%7C01%7Cangela.walsh12%40nhs.net%7C342e6baeac034681f2c308dbd6f23c7d%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638340108098989356%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=nHahfD6PamUIa%2BJkeZZzC9xMZBl4jxoJaVXdKWqk6Ek%3D&reserved=0); [Cox, 2020](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjme.bmj.com%2Fcontent%2F46%2F8%2F510&data=05%7C01%7Cangela.walsh12%40nhs.net%7C342e6baeac034681f2c308dbd6f23c7d%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638340108099145609%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=RSK6Yn5EMVSk2XGuDJ9yYdM51oiAZ%2FvCGAnza4E%2BKtg%3D&reserved=0)).
2. During 2022/23, we worked with 5 NHS organisations, including system leaders and acute and community trusts, to develop and test a [staff recognition framework](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Flong-read%2Fstaff-recognition-framework%2F&data=05%7C01%7Cangela.walsh12%40nhs.net%7C342e6baeac034681f2c308dbd6f23c7d%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638340108099145609%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=yx9uAixaeX4alETkO0DfTsqOTgzh%2BcZH%2Fhlzvm054kA%3D&reserved=0). The framework, published in October 2023, provides evidence and guiding principles to help health and care leaders improve their understanding of and approaches to staff recognition. It promotes a hierarchy of approaches; encouraging organisations to embed everyday peer-to-peer recognition, followed by manager-led and formal approaches. It emphasises the need for staff-led interventions, underpinned by organisational values and regular evaluation, to ensure recognition is meaningful and has a consistently positive impact on staff.

### 9.2 NHS Pension Scheme (NHSPS) and reform

1. Our [NHS EDI improvement plan](https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/) references the role of the NHSPS in our efforts to reduce the risk of discrimination and to ensure all staff, whatever their protected characteristics, are aware of opportunities to work flexibly and/or prolong their working lives.
2. More staff are returning to work 2 months after retirement, rising from 22.5% in April 2018 to 30.6% in April 2023 (57% of medical staff and 44% of AfC staff).
3. Additionally, the number of retirees rejoining the workforce following flexible retirement has increased slightly, from 91.5% in April 2018 to 92.2% in April 2023. However, those who retire and return to the NHS are working fewer hours, on average by 0.3 FTE.
4. As of July 2023, around 32% of our NHS workforce are aged over 50, with 19% over 55, the earliest age at which most members can choose to retire voluntarily. It is likely that members over 55 and who have worked in the NHS for their entire career will hold most of their benefits in the 1995 Section of the NHSPS.
5. Those in late-stage career have a wealth of skills and expertise critical to supporting the delivery of high-quality, safe services for patients. At a time of workforce shortages across the health and social care sector, pension reform will influence behaviour change, persuading staff to continue working during the later stages of their career.
6. The Spring Budget 2023 announced the abolition of the lifetime pension allowance *(*£1,073,100) and an increase in the annual allowance (AA) from £40,000 to £60,000. This reform came into effect from 1 October 2023 and takes most staff out of pension tax charges, though some will still be subject to these. For example, an NHS employee with pensionable pay over £200,000 may have pension growth during the tax year of over £60,000 and may still be subject to a tax charge on the excess. NHS Employers published a [briefing on what the Spring 2023 Budget means for pension tax and retention,](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.nhsemployers.org%2Fpublications%2Fwhat-spring-2023-budget-means-pension-tax-and-retention&data=05%7C01%7Cangela.walsh12%40nhs.net%7Cd01986eb65824f35b4d908db60ed1028%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638210343535400077%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=CkvDMdmSh26Krzt9Cu%2FXZe7%2FhTgyRk8pfUvqLt1jjFA%3D&reserved=0) to help employers identify those who may still be affected by the AA.
7. On 7 August 2023, we wrote to NHS organisations to remind them about the flexibility they already have locally to operate employer pension contribution recycling schemes for staff who may still be affected by pension tax. Many of these staff will be the experienced senior staff the NHS needs to support recovery and their more junior colleagues. We made clear that local recycling schemes should offer the best value for money for the taxpayer and the best possible outcomes for patients.
8. From 1 April 2023, members of the 1995 Section of the NHSPS who retire and return to the NHS can rejoin the 2015 Scheme. This will allow staff, in particular our female staff who make up 77% of the workforce and tend to have shorter service, to build up additional pension savings. The average annual pension at retirement is set out in the DHSC evidence.
9. From 1 October 2023, the introduction of partial retirement for members of the 1995 Section means they can, with the agreement of their employer, take some or all of their pension and carry on working, keeping both pay and pension, without taking a break in their employment. This is an important financial incentive to help persuade staff to prolong their working lives. Our expectation is that those who partially retire will reduce their working hours by less than those who choose to retire and return.
10. At the time of writing, over 4,500 medical and non-medical staff have either taken or are in the process of applying for partial retirement. The NHSBSA has developed an NHSPS opt-out dashboard. DHSC will provide more detail in their evidence.

## 10. Consultants

### 10.1 Overview

1. 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 estimates the UK has 3.2 doctors per 1,000 people; the OECD average is 3.7.
2. 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 the 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.
3. Consultants also provide clinical leadership and training for the next generation of doctors, and may contribute to research that improves patient care. With the commitment to expand medical training, sufficient consultant workforce capacity must be ensured to support this training.
4. 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, 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 5 to 1 in England, according to [NHS workforce statistics](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics).
5. 2023 has been a challenging year for the consultant workforce who have both undertaken industrial action and provided essential cover to ensure patients remained safe during days of industrial action by doctors in training. At the time of writing, this dispute was still ongoing with the BMA and HSCA, the consultant workforce having rejected a revised government pay deal.

### 10.2 Recruitment

1. Recruitment of consultants remains challenging across the country, and as more consultants want to work less than full time, they may be needed in greater numbers to achieve the same FTE level. Consultant vacancies have tracked similarly to those for other staff groups, with a decrease during the pandemic followed by an increase – but since March 2023, vacancies have grown faster for consultants compared to other staff groups. As of July 2023, consultant vacancies are at their highest level (10.6%) in at least 5 years (Figure 10.1).

**Figure 10.1: Consultant versus all staff vacancies (%), April 2018 to July 2023**

A graph with blue line and black line

Description automatically generated

Source: NHS provider workforce returns

1. Some geographies and specialties find it hard to recruit the consultants they need, which can affect patient care and bank/agency usage. We know of several trusts that have significant agency usage to cover consultant vacancies. Ongoing investigative work suggests that both ESR and provider workforce returns under-report the actual number of consultant vacancies.
2. Consultants are drawn from domestic supply and international medical graduates (IMGs) via postgraduate training or SAS routes. Domestic supply, the primary source of consultants, is finite. While medical student places are growing, it will take at least 10 years for this to translate into more senior doctors.
3. The path for doctors who qualify in other countries (IMGs) to obtain medical employment in this country can be difficult. IMGs often report a poorer workplace experience than those with a UK primary medical qualification. Work to support the induction, onboarding and experience of IMGs is ongoing; see section 8.6.
4. The NHS Long Term Workforce Plan aims for investment in domestic education and training to support the NHS to become less reliant on international recruitment for workforce supply in the medium to long term. However, targeted international recruitment in the short term will be necessary to ease workforce shortages, particularly for the medical workforce.

### 10.3 Consultant retention

1. NHS England continues to focus on retention, including of senior clinicians. We provide information on the Retention Programme in section 8.6.
2. The rate at which consultants are leaving the NHS was around 4% prior to the pandemic and dropped during the pandemic, but then peaked in 2022 at around 4.3%. At the time of writing, it is around 3.7%, slightly below the longer-term trend of around 3.9% (Figure 10.2).
3. Consultants are retiring at an average age of 60 years, 6 years before the current state pension age. This average age has been relatively static since at least 2018/19 (Figure 10.3). Retaining consultants past the age of 60 would help maintain an essential part of the medical workforce, at a point when they have significant experience that can both benefit patients and be shared with colleagues.

**Figure 10.2: Consultant leaver rate (%), 2018 to 2023**

A graph showing the growth of the stock market

Description automatically generated

Source: ESR data

**Figure 10.3: Consultant retirement age profile, 2018/19 to 2022/23**

Source: ESR data

1. In June 2023, we published [guidance](https://www.england.nhs.uk/publication/retaining-doctors-in-late-stage-career-guidance/) on retaining doctors in the later stage of their careers, looking at the reasons doctors retire and what motivates them to continue working. This guidance includes specific actions for employers to help retain experienced consultants. From autumn 2023, recently retired consultant doctors will have a new option to offer their availability to trusts across England, to support delivery of outpatient care, through the NHS Emeritus Doctor Scheme.
2. We understand that concern about the impact of the pension tax charge has influenced our senior doctors’ retirement intentions; many have felt this penalised them if they chose to work for longer.
3. The reform to pension tax charges that government announced in the Spring Budget 2023, and which came into effect from 1 October 2023, looks to address senior doctors’ concern about the impact of the pension tax on their earnings. This will likely mean fewer doctors decide to leave the NHS workforce for this reason as most, but not all, are no longer subject to pension tax charges. Section 9.3 describes the actions NHS England has taken with DHSC and NHS Employers around the NHSPS, in particular government’s recent pension reform, and this will be covered in more detail in DHSC’s evidence.

## 11. Specialty and specialist (SAS) doctors

### 11.1Overview

1. SAS doctors are an important and growing part of the medical workforce. The latest GMC [state of medical education and practice workforce report](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) 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.
2. 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. Below we provide a further update following the 2023/24 pay round.

### 11.2 SAS contract reform

1. The new SAS contracts were introduced from 1 April 2021 following agreement from all parties. The new grades were linked to a 3-year deal including annual pay increases, ending on 31 March 2024. NHS England supported the introduction of these 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.
2. The divergent pay awards for those who chose to remain on the old contracts and the   
   3-year pay deal for those on the new contract means the disincentive remains for some SAS doctors to move onto the new contract. This has impacted on our ability to realise the full benefits of the new contract; see section 11.6.
3. Between the withdrawal of the national specialist grade in 2008 and the introduction of the specialist grade in 2021, 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.
4. In the latest state of medical education and practice report, the GMC recommended that SAS doctors be permitted to work in primary care, potentially increasing career flexibility in this setting. We are in favour of this and recommend that SAS doctors are employed on national SAS terms and conditions of service whether they work in hospitals or primary care.

### 11.3 SAS development fund

1. In the first (2021/22) and third (2023/24) years of the agreement reached on the new SAS grades, investment is being provided through a specific [SAS development fund](https://www.nhsemployers.org/publications/sas-professional-development-funding) to support individual and collective professional development activities.
2. In addition, local opportunities in many regions already exist for SAS doctors, including professional development linked to service need, experience and career aspirations. Of note, potential opportunities for SAS doctors within education, supervision and mentoring of doctors in training could be mutually beneficial, supporting expansion of education and training capacity, and providing attractive career development opportunities for SAS doctors. As discussed in the [SAS Charter](https://www.nhsemployers.org/articles/sas-charter#:~:text=SAS%20Charter%20The%20charter%20for%20specialty%20and%20associate,planning%2C%20development%2C%20involvement%20in%20organisational%20structures%20and%20recruitment.) and the NHS Long Term Workforce Plan, NHS England is committed to working with DHSC, employers and other stakeholders to support SAS doctors to have a better professional experience, by improving equitable promotion and ensuring options for career diversification.

### 11.4 Workplace experiences

1. Currently, SAS and locally employed doctors (LEDs) are grouped together when gathering ESR and NHS Staff Survey data on workforce distribution and workplace experiences. These doctors are significantly more likely to have a non-UK Primary Medical Qualification (PMQ) compared to other groups. They are less likely to feel part of a supportive team, less confident in raising concerns, and less likely to report sufficient access to learning and development opportunities. Work to address these differences in experiences between doctor groups is covered in section 7.7 and section 8.
2. In the most recent 2022 GMC [barometer survey](https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/spotlight-on-sas-doctors-and-le-doctors-analysis-of-barometer-survey-2022-results), SAS doctors (40%) and LEDs (60%) were grouped separately. SAS doctor experiences tend to be more positive; they are more likely to be satisfied at work and less likely to be ‘struggling’ with their workload.
3. As this is the first year in which GMC data for SAS and LED groups have been separated, we cannot yet compare with previous years. We would want to see more LEDs moving to national grades, where experiences tend to be more positive, such as the reformed SAS grade.
4. The feasibility of improving ESR and NHS Staff Survey data quality by separating LED and SAS data is being explored.

### 11.5 Benefits realisation

1. NHS Employers is monitoring uptake of the new grades and 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.
2. Since the end of formal negotiations, the Joint Negotiating Committee for Specialty Doctor and Specialist grades (JNC SAS) was established jointly with the BMA and meets quarterly.

### 11.6 Impact of the 2022/23 pay round

1. It is unfortunate that, owing to the uplifts to the un-reformed SAS grades in the 2021/22 and 2022/23 pay rounds, the salary scales of these grades have diverged from those of the reformed SAS grades. The 2023/24 pay round gave reformed SAS grades an additional 3% uplift on top of the 3% investment increase given as part of their multi-year pay deal. This average 6% uplift (which equated to 4% for specialist doctors and 3–9.3% for specialty doctors) for 2023/24 was in line with the 6% that the un-reformed SAS grades and other doctor groups received, but does not remedy the salary divergence from previous years. This means it remains unattractive 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.

## 12. General medical practitioners

### 12.1 Overview

1. Government asked DDRB to include recommendations on the minimum and maximum pay range for salaried GPs and earnings and expenses uplifts for GP partners. To support this, we have provided evidence around recruitment, retention, motivation and earnings for these GPs. Detailed tables are not provided as official statistics are publicly available on the [NHS England website](https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/). Recommendations will need to be informed by affordability and the contract resources available to practices; this information will also inform GP practice decisions about the pay of their salaried GPs.
2. Most GPs work under General Medical Services contracts as independent contractors; they are self-employed or members of partnerships running their own practices as small businesses. [Published statistics](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2022-23) show that as of 31 March 2023, there were 1,615 personal medical services (PMS) arrangements (24.2% 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 arrangement across 235 practices.
3. [Published statistics](https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-september-2023) show that on 30 September 2023, 46,842 (37,419 FTE) doctors were working in general practice in England, a 10.6% increase on 2018. Of these, 15,914 (10,065 FTE) were working as salaried GPs (including GP retainers) and 19,073 as GP partners (16,342 FTE), an increase of 3,599 salaried GPs (1,951 FTE) and loss of 2,783 GP partners (2,951 FTE) in the last 5 years.
4. Salaried GPs now make up 43.4% of fully qualified GPs (36.9% in FTE terms), compared to 33.9% in 2018 (28.5%), and GP partners 52.0% (59.9% in FTE terms), compared to 60.1% in 2018 (67.7%). 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 shown in Table 12.1, with the same data for GP partners in Table 12.2. The data shows a decrease in the proportion of GPs who are working 37.5 hours and over per week and an increase in the proportion working over 15 and under 37.5 hours per week. More detailed data on GP FTE is available on [our website](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2022-23).

**Table 12.1: Salaried GPs: headcount by work commitment, September 2018 to September 2023**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Sept 2018** | **Sept 2019** | **Sept 2020** | **Sept 2021** | **Sept 2022** | **Sept 2023** |
|  | **No (%)** | **No (%)** | **No (%)** | **No (%)** | **No (%)** | **No (%)** |
| Working ≤15 hours per week (≤0.4 FTE) | 1,708 (14.1) | 1,836 (14.1) | 1,985 (14.0) | 2,067 (13.6) | 2,045 (13.4) | 2,153  (13.6) |
| Working >15 hours to <37.5 hours per week (>0.4 to <1 FTE) | 8,860 (73.0) | 9,648 (74.4) | 10,676 (75.5) | 11,531 (76.1) | 11,731 (76.7) | 12,165  (77.1) |
| Working 37.5 hours and over per week (≥1 FTE) | 1,541 (12.9) | 1,497 (11.5) | 1,483 (10.5) | 1,554 (10.3) | 1,521  (9.9) | 1,457  (9.2) |

Source: NHS England – [General Practice Workforce - NHS Digital](https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services)

**Table 12.2: GP partners: headcount by work commitment, September 2018 to September 2023**

|  | **Sept 2018** | **Sept 2019** | **Sept 2020** | **Sept 2021** | **Sept 2022** | **Sept 2023** |
| --- | --- | --- | --- | --- | --- | --- |
|  | **No (%)** | **No (%)** | **No (%)** | **No (%)** | **No (%)** | **No (%)** |
| Working ≤15 hours per week (≤0.4 FTE) | 586  (2.7) | 587  (2.8) | 576  (2.9) | 591  (3.0) | 545  (2.8) | 512  (2.7) |
| Working >15 hours to <37.5 hours per week (>0.4 to <1 FTE) | 12,477 (58.3) | 12,416 (59.5) | 12,307 (61.0) | 12,313 (62.5) | 12,307 (63.5) | 12,109  (64.0) |
| Working 37.5 hours and over per week (≥1 FTE) | 8,403 (39.0) | 7,865 (37.7) | 7,299 (36.2) | 6,810 (34.5) | 6,515 (33.6) | 6,287  (33.3) |

Source: NHS England – [General Practice Workforce - NHS Digital](https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services)

1. In its 2023 report, DDRB requested information on participation rates by contractor status and how trends in these will affect workforce demand and access in the future. A breakdown of participation rates is included in DHSC’s evidence and therefore not duplicated in our evidence. The NHS Long Term Workforce Plan to build general practice capacity is based on trends in both headcount and FTE loss.
2. DDRB also requested information on trends in numbers taking on contractor roles. In November 2022, NHS England (then NHS Digital) began publishing [experimental data](https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services) exploring the path GPs take into and out of partner and salaried roles, and this is now available on a quarterly basis. Table 12.3 shows annual joiners to the general practice workforce in a GP partner role, and annual joiners to a GP partner role from a different GP role type over the last 6 years.

**Table 12.3: Annual joiners to the general practice workforce in a GP partner role by route, 2017/18 to 2022/23**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
| Joiners to the general practice workforce in a GP partner role | 650 | 699 | 434 | 376 | 903 | 557 |
| Joiners to a GP partner role from a different GP role type | 565 | 756 | 638 | 603 | 670 | 679 |
| Total GP partner joiners | 1,215 | 1,455 | 1,072 | 979 | 1,573 | 1,236 |

Source: NHS England. [Tracking GPs into and out of partner and salaried roles, 30 June 2023 (March to March data used](https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2023)

1. DDRB also requested information on the numbers of doctors completing GP specialty training and joining the GMC’s GP register. The GMC [publishes information](https://gde.gmc-uk.org/postgraduate-training/postgraduate-trainees/entry-to-gp-and-specialist-registers) on number of doctors joining the GP register following completion of postgraduate training. In November 2023, NHS England [published data](https://digital.nhs.uk/supplementary-information/2023/tracking-gps-in-training-into-fully-qualified-general-practice-roles-september-2023) on the number of GPs in ST3 training placements recorded in the Training Information System (TIS) who transition into the fully-qualified general practice workforce as recorded in the National Workforce Reporting Service (NWRS), along with detail of the methodology and advice on interpretation. This data will be published on a quarterly basis in the future.

### 12.2 Access to general practice services

1. Between September 2018 and September 2023, total practice staff numbers excluding GPs and doctors in GP training grew by 10.2% in headcount terms (from 134,050 to 147,682) and 15.9% in FTE terms (from 93,739 to 108,614); the FTE increase for clinical staff excluding GPs was 22.0%.
2. The ratio of GPs to patients has increased from 58 to 60 FTE per 100,000, although for fully qualified GPs it has fallen from 48 to 43 FTE per 100,000. The ratio for other (non-GP) clinical staff has increased from 46 to 53 FTE per 100,000. 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 8.6%, from 104 to 113 FTE, although there is variation across the country.
3. This does not include the contribution of clinical staff working across a primary care network (PCN). Experimental statistics show that by 30 June 2023, the NHS in England had recruited 31,370 FTE direct patient care staff, meaning the target of 26,000 FTE by March 2024 was met and exceeded as of March 2023, a year early ([NHS England. Primary care workforce quarterly update, 30 June 2023](https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-workforce-quarterly-update/30-june-2023)).
4. [Activity in general practice](https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/september-2023) is now at record levels with over 356.6 million appointments, including those for COVID-19 vaccinations, delivered in the 12 months to end of September 2023; 49.6% of these appointments were booked and held on the same or next day.
5. Despite this, there has been a substantial drop in patient satisfaction with general practice services, mostly due to a decline in satisfaction with making an appointment. [General Practice Patient Survey](https://www.gp-patient.co.uk/surveysandreports) data shows that 71.3% of patients had a good overall experience of their GP practice in 2023 compared to 83.0% in 2021. To address this, in May 2023 NHS England published the [Delivery plan for recovering access to primary care](https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/), which sets out measures to make it quicker and easier for patients to contact their practice, and to reduce pressure on general practice teams.
6. In its 2023 report, DDRB requested information on trends in the number of contracts being handed back, and views on what is driving these trends. [Published statistics](https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-september-2023) show that the number of practices has decreased by 11.3% over the last 5 years, from 7,137 in 2018 to 6,334 at September 2023. ICBs collect data on primary medical care commissioning and submit this through NHS England’s annual primary care assurance report. The latest data on practice closures is given in Table 12.4.

**Table 12.4: Practice closures\* reported through the NHS England primary care assurance report**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Commissioner notices | Contractor notices\* | Merger | Not reported | Total | Contractor closures as % of all practices |
| 2017/18 | 20 | 42 | 111 | - | 173 | 0.6% |
| 2018/19 | 14 | 39 | 144 | - | 197 | 0.6% |
| Collection suspended during the pandemic | | | | | | |
| 2022/23 | 7 | 15 | 42 | 4 | 64 | 0.2% |

\* Closures due to ‘contractor notice’ could be for a variety of reasons such as ill-health, retirement or retirement of a single-handed GP, and not all closures result in patient list dispersal.

### 12.3 GP recruitment, retention and wellbeing

#### Recruitment

1. The [Return to Practice Programme](https://www.england.nhs.uk/gp/the-best-place-to-work/returning-to-practice/) 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. From April 2023, NHS England introduced more flexible pathways for GP returners by replacing the fixed set of multiple assessments with an individual pathway based on a personal review. For many GPs, this will provide a quicker and easier route back into practice. For those GPs who would benefit from a placement in general practice, the monthly bursary has been increased from £3,500 to £4,000.
2. The [NHS GP International Induction Programme](https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/international-induction-programme) continues to offer a supported pathway for overseas qualified GPs to be inducted safely into NHS general practice.
3. Information on recruitment to GP specialty training, including the [Targeted Enhanced Recruitment Scheme](https://www.england.nhs.uk/gp/the-best-place-to-work/starting-your-career/recruitment/), is included in section 7.4.

#### Retention and wellbeing

1. The Commonwealth Fund’s [2022 International Health Policy Survey](https://www.commonwealthfund.org/publications/issue-briefs/2022/nov/stressed-out-burned-out-2022-international-survey-primary-care-physicians) of primary care physicians highlighted that 71% of UK GPs said their job is ‘extremely’ or ‘very stressful’ – the highest of the 10 countries surveyed alongside Germany.
2. Similarly, the GMC’s [The state of medical education and practice in the UK 2023](https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk) reported that GPs had the highest risk of burnout (31% compared with the average of 25%), were the register type with the highest proportion of doctors who were struggling (55% compared with the average of 38%), and experienced the highest intensity of work (68% reported that three-quarters or more of their days were high-intensity, compared to an average of 43% of all doctors).
3. The [Delivery plan for recovering access to primary care](https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/) includes measures to reduce pressure on general practice teams, including by increasing the services offered through community pharmacies, reducing workload across the interface between primary and secondary care, and reducing medical evidence requests to practices so that they have more time to meet the clinical needs of their patients.
4. GPs across England with mental illness and addiction problems can continue to access [NHS Practitioner Health](https://www.practitionerhealth.nhs.uk/), a free, confidential service. Further information on support available to all staff, including those working in primary care, is included in section 8.2.
5. In [Investment and Evolution: Updates to the GP Contract 2020/21 to 2023/24](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpublication%2Finvestment-and-evolution-update-to-the-gp-contract-agreement-20-21-23-24%2F&data=05%7C02%7Cjessica.kirk%40nhs.net%7Ce041837eaed148bdbd2e08dc182d2132%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638411829336620982%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=aQyTCfiX3qi80JghZj%2B24vacvx7%2FXeh55Ow%2FnBfnL%2BA%3D&reserved=0), NHS England set out a package of funded GP recruitment and retention initiatives for the period to 31 March 2024, including:

* A 2-year [General Practice Fellowship Programme](https://www.england.nhs.uk/gp/the-best-place-to-work/gp-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](https://www.england.nhs.uk/gp/the-best-place-to-work/supporting-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](https://www.england.nhs.uk/gp/the-best-place-to-work/retaining-the-current-medical-workforce/retained-doctors/), which provides financial and educational support for doctors who may otherwise leave general practice.
* The introduction of [primary care flexible staff pools](https://www.england.nhs.uk/gp/the-best-place-to-work/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 supported 2,939 GPs to take up partnership positions before closing to new applicants on 30 June 2023.

1. NHS England is committed to continued investment in retention of staff in general practice. From 2024/25, ICBs will take on greater autonomy to make decisions that serve the best interests of local people and communities; this means that while the General Practice Fellowship Programme and Supporting Mentors Scheme will no longer operate in their current national form, as referenced in policy guidance, ICBs will put local support in place. GPs who join the General Practice Fellowship Programme before 31 March 2024 will continue to be supported until they complete their 2-year programme.
2. In its 2023 report, DDRB requested information about growth in demand for GPs in the private sector, and whether this has affected recruitment and retention. NHS England does not hold any information on GP activity in the private sector.

### 12.4 Remuneration and affordability

#### Trends in the earnings and expenses of contractor GPs

1. The [average income before tax for contractor GPs in England](https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2021-22) working in either a GMS or PMS (GPMS) practice in 2021/22 was £153,400, compared to £142,000 in 2020/21– a further increase of 8.0% following the 16.6% increase in 2020/21.
2. Again, this is significantly above the maximum uplift of 2.1% agreed in the contract for 2021/22 (1.8% for 2020/21), which is likely due mainly to the additional funding provided during the second year of the pandemic for the delivery of the COVID-19 Vaccination Programme and work done elsewhere in the NHS.
3. Table 12.5 shows trends in average GPMS contractor net earnings, including cumulative cash and real terms growth. Table 12.6 shows trends in average gross earnings, expenses and net earnings for GPMS contractor GPs in England and the ratio of their expenses to gross earnings between 2013/14 and 2021/22.

**Table 12.5: Average net earnings for GPMS contractor GPs in England, 2013/14 to 2021/22**

| **Financial  year** | **Average net earnings (£)** | **Year-on-year percentage cash change since 2013/14** | **Cumulative percentage cash change since 2013/14** | **Cumulative real terms percentage change since 2013/14\*** |
| --- | --- | --- | --- | --- |
| 2013/14 | 101,900 |  |  |  |
| 2014/15 | 103,800 | 1.9% | 1.2% | 0.8% |
| 2015/16 | 104,900 | 1.1% | 2.9% | 1.0% |
| 2016/17 | 109,600 | 4.5% | 7.6% | 3.5% |
| 2017/18 | 113,400 | 3.5% | 11.3% | 5.3% |
| 2018/19 | 117,300 | 3.4% | 15.1% | 7.0% |
| 2019/20 | 121,800 | 3.8% | 19.5% | 8.3% |
| 2020/21 | 142,000 | 16.6% | 39.4% | 18.8% |
| 2021/22 | 153,400 | 8.0% | 50.5% | 29.2% |

**\*** Using GDP deflators per GPEEE time series, Source: [GP earnings and expenses estimates, 2021/22](https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2021-22?key=yXW8f1hXDaMv2Jxnlbi2BZRcCaTDJzKYVdV4TZW1mY0DTcQHL1luF18zyt7Gdoxs)

**Table 11.6: Average gross earnings, expenses and net earnings for GPMS contractor GPs in England, 2013/14 to 2021/22**

| **Financial  year** | **Average gross earnings (£)** | **Average expenses (£)** | **Average net earnings (£)** | **Expenses as a % of gross earnings** |
| --- | --- | --- | --- | --- |
| 2013/14 | 290,900 | 189,000 | 101,900 | 65% |
| 2014/15 | 302,600 | 198,800 | 103,800 | 66% |
| 2015/16 | 315,600 | 210,800 | 104,900 | 67% |
| 2016/17 | 338,300 | 228,700 | 109,600 | 68% |
| 2017/18 | 357,300 | 243,900 | 113,400 | 68% |
| 2018/19 | 380,900 | 263,600 | 117,300 | 69% |
| 2019/20 | 402,600 | 280,800 | 121,800 | 70% |
| 2020/21 | 438,700 | 296,700 | 142,000 | 68% |
| 2021/22 | 482,400 | 329,000 | 153,400 | 68% |

**\*** Using GDP deflators per GPEEE time series, Source: [GP earnings and expenses estimates, 2021/22](https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2021-22?key=yXW8f1hXDaMv2Jxnlbi2BZRcCaTDJzKYVdV4TZW1mY0DTcQHL1luF18zyt7Gdoxs)

1. Table 12.7 shows the distribution of income before tax (gross income less expenses) for GPMS contractor GPs in England between 2013/14 and 2014/15, and Table 12.8 that between 2015/16 and 2021/22.

**Table 12.7: Number of GPMS contractor GPs in England in different income-before-tax brackets, 2013/14 and 2014/15**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Financial year** | **<£50k** | **£50k– 100k** | **£100k– 150k** | **>£150k** | **£150k– 200k** | **£200k– 250k** | **>£250k+** |
| 2013/14 | 2,670 | 14,720 | 11,810 | 3,100 | 2,540 | 410 | 150 |
| 2014/15\* | 2,480 | 14,420 | 11,720 | 3,440 | 2,770 | 490 | 180 |

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

**Table 12.8: Number of GPMS contractor GPs in England in different income-before-tax brackets, 2015/16 to 2021/22**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Financial year** | **£0–<50k** | **£50k–<75k** | **£75k–<100k** | **£100k–<125k** | **£125k–<150k** | **£150k–<175k** | **£175–<200k** | **£200– <225k** | **£225k+** |
| **2015/16** | 1,240 | 3,250 | 4,670 | 4,210 | 4,950 | | | | |
| **2016/17** | 1,120 | 3,080 | 4,820 | 4,700 | 6,150 | | | | |
| **2017/18** | 1,230 | 2,750 | 4,640 | 4,840 | 6,890 | | | | |
| **2018/19** | 1,080 | 2,490 | 4,390 | 4,870 | 7,450 | | | | |
| **2019/20** | 820 | 2,010 | 4,090 | 4,650 | 3,350 | 1,970 | 2,360 | | |
| **2020/21** | 520 | 1,180 | 2,660 | 3,730 | 3,620 | 2,710 | 1,610 | 1,010 | 1,550 |
| **2021/22** | 450 | 910 | 2,190 | 3,370 | 3,310 | 2,720 | 1,930 | 1,270 | 2,190 |

#### Trends in the earnings and expenses of salaried GPs

1. The [average income before tax for salaried GPs in England](https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2021-22) working in either a GMS or PMS (GPMS) practice in 2021/22 was £68,000, compared to £64,900 in 2020/21– a statistically significant increase of 4.8%. This is above the DDRB recommended uplift for 2021/22 of 3.0%, and offsets the 0.8% shortfall in actual uplift against the 2.8% DDRB recommendation for 2020/21.
2. Table 12.9 sets out trends in average GPMS salaried net earnings, including cumulative cash and real terms growth. Table 12.10 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 2013/14 and 2021/22.

**Table 12.9: Average net earnings for GPMS salaried GPs in England, 2013/14 to 2021/22**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Financial  year** | **Average net earnings (£)** | **Year on year percentage cash change since 2013/14** | **Cumulative percentage cash change since 2013/14** | **Cumulative real terms percentage change since 2013/14\*** |
| 2013/14 | 54,900 |  |  |  |
| 2014/15 | 53,700 | (2.2)% | (2.2)% | (3.3)% |
| 2015/16 | 55,900 | 4.1% | 1.8% | 0.0% |
| 2016/17 | 56,600 | 1.3% | 3.1% | (0.9)% |
| 2017/18 | 58,400 | 3.2% | 6.4% | 0.6% |
| 2018/19 | 60,600 | 3.8% | 10.4% | 2.5% |
| 2019/20 | 63,600 | 5.0% | 15.8% | 4.8% |
| 2020/21 | 64,900 | 2.0% | 18.2% | 0.6% |
| 2021/22 | 68,000 | 4.8% | 23.9% | 6.3% |

**\*** Using GDP Deflators per GPEEE time series, 2021-22: [GP Earnings and Expenses Estimates, 2021/22](https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2021-22?key=yXW8f1hXDaMv2Jxnlbi2BZRcCaTDJzKYVdV4TZW1mY0DTcQHL1luF18zyt7Gdoxs)

**Table 12.10: Average salaries for GPMS salaried GPs in England, 2013/14 to 2021/22**

| **Financial  year** | **Average gross earnings (£)** | **Average expenses (£)** | **Average net earnings (£)** | **Expenses as a % of gross earnings** |
| --- | --- | --- | --- | --- |
| 2013/14 | 64,100 | 9,200 | 54,900 | 14% |
| 2014/15 | 62,500 | 8,700 | 53,700 | 14% |
| 2015/16 | 63,900 | 7,900 | 55,900 | 12% |
| 2016/17 | 65,300 | 8,700 | 56,600 | 13% |
| 2017/18 | 68,200 | 9,800 | 58,400 | 14% |
| 2018/19 | 70,100 | 9,400 | 60,600 | 13% |
| 2019/20 | 71,600 | 8,000 | 63,600 | 11% |
| 2020/21 | 72,200 | 7,400 | 64,900 | 10% |
| 2021/22 | 76,900 | 8,900 | 68,000 | 12% |

1. Table 12.11 shows the distribution of income before tax (gross income less expenses) for salaried GPs in the UK from 2013/14 to 2016/17 (data for England is not available for this analysis), and Table 12.12 that for salaried GPs in England between 2017/18 and 2021/22.

**Table 12.11: Number of UK GPMS salaried GPs in different income-before-tax brackets, 2013/14 to 2016/17**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Financial year** | **<£30k** | **£30k–50k** | **£50k–70k** | **£70k–100k** | **£100k+** |
| 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.

**Table 12.12: Number of salaried GPs on GPMS contracts in England in different income-before-tax brackets, 2017/18 to 2021/22**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Financial  year** | **<£25k** | **£25k–£50k** | **£50k–£75k** | **£75k–£100k** | **£100k+** |
| 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 |
| 2021/22 | 630 | 3,140 | 4,870 | 2,630 | 1,610 |

#### Gender and ethnicity pay gaps

1. The [Review of the gender pay gap in medicine](https://www.gov.uk/government/publications/independent-review-into-gender-pay-gaps-in-medicine-in-england) identified a wider gap for salaried GPs compared to hospital and community health service doctors, clinical academics and contractor GPs. Tables 12.13 and 12.14 provide the most recent available data to highlight the latest position by, respectively, comparing pay per headcount for male and female salaried GPs and contractor GP in the same age bracket. However, this data has [accuracy and quality limitations](https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2019-20/gps-included-and-how-to-interpret-the-results), 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 salaried GPs. Accurate conclusions can therefore not be drawn from this dataset.

**Table 12.13: Salaried GP earning and expense estimates for female and male GPs in England, 2021/22**

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**Table 12.14: Contractor GP earning and expense estimates of female and male GPs in England (2021/22)**

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1. In its 2023 report, DDRB requested information on the ethnicity pay gap among GPs and whether this would be exacerbated by relatively fewer ethnic minority GPs achieving contractor status. While no data is available on GP pay by ethnicity, since May 2023 NHS England has [published quarterly data](https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2023) on ethnicity of GPs by job role. Table 12.15 shows the percentage distribution of headcount by ethnicity for salaried GPs and contractor GPs.

**Table 12.15: Percentage distribution of headcount by ethnicity at 30 June 2023**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Role | Asian/ Asian British | Black/ African/ Caribbean/ Black British | Mixed/ multiple ethnic groups | White | Other ethnic group | Not recorded |
| GP partner | 24.2% | 2.5% | 1.6% | 55.4% | 2.9% | 13.9% |
| Salaried GP | 19.0% | 4.2% | 2.1% | 53.4% | 3.8% | 18.7% |

#### Affordability

1. 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 5-year funding settlement from 2019/20, which ends in March 2024. NHS England and DHSC are in consultation with GPC England about the GP contract for 2024/25.
2. Within the NHS settlement, funding is available for a pay uplift of 2% for contractor GPs, salaried GPs and other salaried practice staff.
3. In its 2023 report, DDRB requested information on the process through which GP expenses uplifts are determined and how the views of GPs are represented in this process.
4. Uplifts to contractor GP pay, salaried staff pay (including for salaried GPs) and other practice (that is, non-pay) expenditure are calculated as follows:

* The proportions of the national GP practice contract value attributable to each element to be uplifted (that is, contractor pay, salaried staff costs and other practice expenses) is calculated based on data from the [GP earnings and expenses estimates](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdigital.nhs.uk%2Fdata-and-information%2Fpublications%2Fstatistical%2Fgp-earnings-and-expenses-estimates%2F2021-22%3Fkey%3DyXW8f1hXDaMv2Jxnlbi2BZRcCaTDJzKYVdV4TZW1mY0DTcQHL1luF18zyt7Gdoxs&data=05%7C02%7Cjessica.kirk%40nhs.net%7C5937929785bf4dd6acb408dbfa29e1ca%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638378831804693033%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=Nqk1ttebCQUxNAY6zb42KeUKZyIxk6FKu9EX8sC6iDw%3D&reserved=0).
* The uplifts for each element of the contract are then calculated by multiplying the percentage uplift agreed for that element by the proportion of the contract value. The pay and expenses uplifts agreed under the 5-year contract have been implemented using this approach.

1. Uplifts to contractor GP pay, salaried staff pay and other practice expenses are covered in the GP contract discussions as part of the contract consultation process, and the method used to calculate them and the calculations are discussed with and checked by GPC England before being implemented through increases to global sum payments.
2. Beyond contract funding, significant resources continue to be spent on national staff support programmes that benefit general practice, such as the mental health support programme for GPs.
3. Government agreed with the DDRB recommendation that practice staff, including salaried GPs, in England should receive at least a 6% increase in 2023/24. The contract has been updated accordingly and the additional funding required paid to practices. The minimum and maximum pay range for salaried GPs was uplifted by 6%, as was the pay for GP educators and trainers.

#### GP appraiser fee

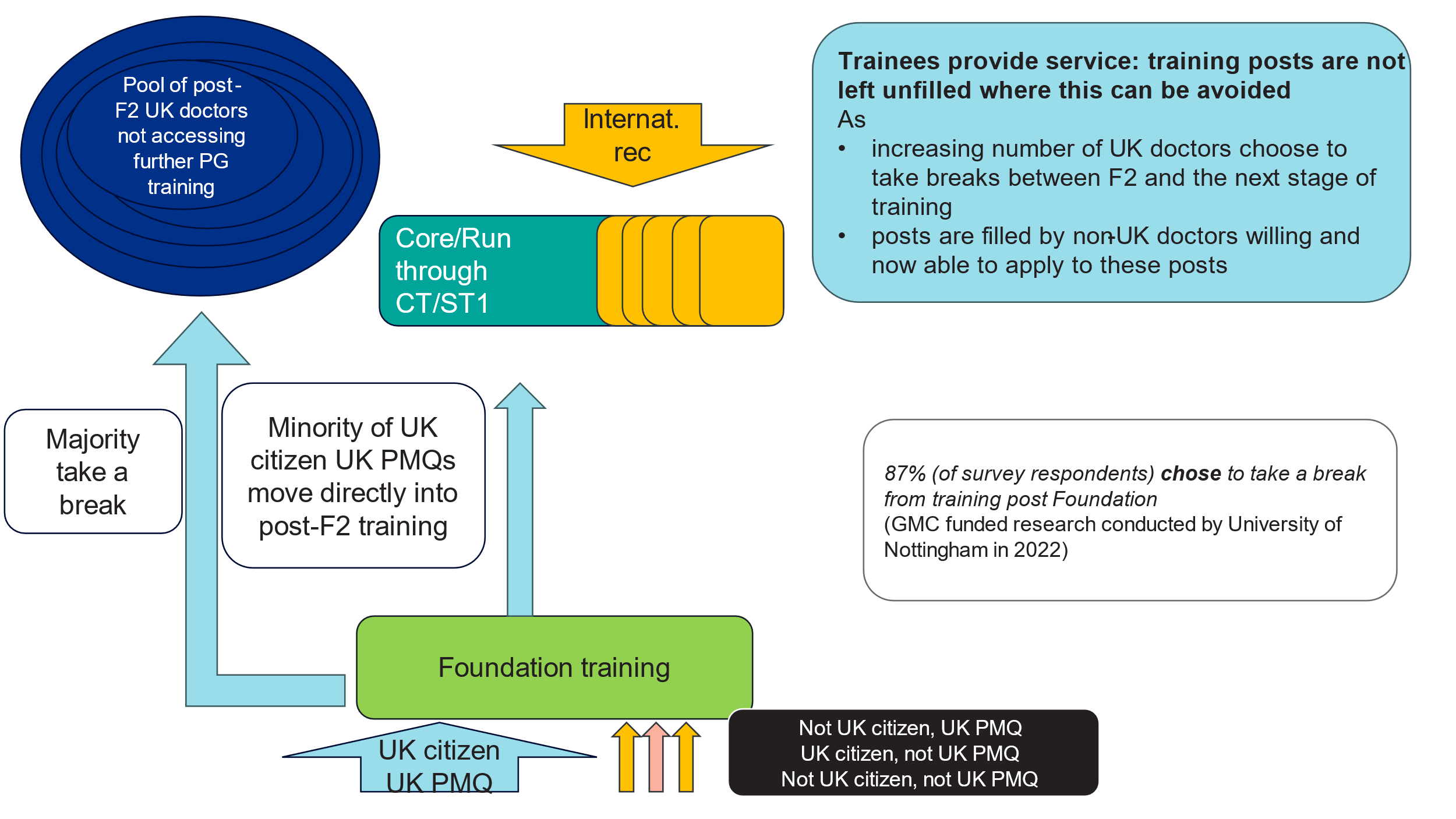
1. In last year’s evidence, NHS England submitted that the GP appraiser fee is a fee for service that should not remain within the DDRB remit for further increases alongside salaries. Further information is included in [last year’s evidence](https://www.england.nhs.uk/publication/submission-to-the-review-body-on-doctors-and-dentists-remuneration-23-24/).

## 13. Doctors in training

### 13.1 Overview

1. The timeline for trainees to achieve their CCT, and therefore short-term consultant supply, is still likely to be affected by the elective experience they missed during the pandemic through being deployed or the reduction in elective activity. This will be impacting on short-term consultant supply.
2. £26 million was invested to limit the disruption to training programmes and the trainee pipeline during the pandemic.
3. Two new Annual Review of Competence Progression (ARCP) no-fault outcomes (10.1 and 10.2) were introduced to indicate delayed progression or acquisition of competencies due to COVID-19 disruption. Outcome 10.2 signalled that additional training time will be required and guidance continues to support employers on what to do where an outcome 10.2 may impact on a doctor in training’s pay progression.
4. NHS England’s evidence provides data on fill rates to specialty training, which remains competitive. Certain specialties and geographies still find it difficult to recruit. NHS England has oversight of the distribution of training places and works to incentivise entry into shortage training programmes.
5. Completion of undergraduate medicine at a university in the UK is referred to as a UK PMQ, while completion of such education outside the UK is referred to as ‘other than UK PMQ’. In recent years, two changes have coincided to alter the balance of UK and other than UK PMQ postgraduate medical trainees in specialty training.
6. First, a growing proportion of UK PMQ doctors are taking a break between completing foundation training and moving into ‘core’ training programmes (which enable trainees to apply to specialty training after 2 or 3 years) and into those specialty training programmes that recruit immediately post-foundation (referred to as ‘run-through’ programmes). Moreover, these breaks are becoming longer. For example, of those UK national UK PMQs completing foundation training in 2013, 62% entered into post-foundation training with no break – that is, in the following year. The corresponding figure for the 2022 completer cohort was 22%. The total drift back to training is broadly the same for those cohorts for whom we have the necessary longitudinal dataset – but the pace has slowed.
7. Second, changes to visa requirements mean that more doctors from overseas are both willing and now able to apply to such training posts. As an indication of the scale of the change, in 2015 the total number of non-UK PMQ new registrants with the GMC was under 5,000, and the most recent figure is closer to 15,000. Note this is data for the UK register: not all of those who register will ultimately work in the UK, or in England or in the NHS in England.
8. As postgraduate medical trainees are vital to service delivery, training posts are not left vacant unless they cannot be filled by either UK PMQ doctors or other than UK PMQ doctors.
9. Figure 13.1 shows the mechanism by which doctors enter post-foundation postgraduate medical training programmes, and Figure 13.2 how the volume and duration of post-foundation breaks has altered for UK PMQs.

**Figure 13.1: Mechanism by which doctors enter post-foundation postgraduate medical training programmes**



Source: NHS England

**Figure 13.1: Cumulative proportion of trainees completing F2 who return to PGME and F2 training; volume and duration of post-foundation breaks has increased for UK PMQs, 2012/13 to 2020/21**



Source: NHS England

1. Table 13.1 shows the impact of this in different specialties. For all specialties recruiting immediately post foundation combined, the proportion of non-UK PMQ doctors has risen steadily. In the academic year 2022/23, they represented 40% of all new starters at the entry level to core or run-through specialty training. In general practice, the other than UK PMQ intake to academic year 202/23 represented 60% of all new starters, and in core psychiatry 51%. At the other end of the spectrum, competition from UK PMQs is much higher for specialties such as ophthalmology and anaesthetics.

**Table 13.1: Impact of post-foundation breaks in different specialties, 2012/13 to 2022/23**

A table with numbers and percentages

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Source: NHS England

### 13.2 Flexibility in training

1. NHS England remains committed to providing flexibility in postgraduate training across all specialties, and continues to support [Enhancing Doctors’ Working Lives](https://www.hee.nhs.uk/our-work/doctors-training/enhancing-working-lives) (EDWL), which enables doctors to progress in their training and supports their longer-term medical careers while maintaining a healthy and balanced personal life.
2. The EDWL programme maintains initiatives such as reforming study leave processes and delivering greater flexibility in medical training. Progress in key areas in 2022/23 includes:
   * 1. Embedding the availability of less than full time (LTFT) training to all doctors in specialty training, meaning eligibility criteria are no longer required for doctors seeking to train flexibly. In the pilot in 2022/23, 1,780 foundation doctors trained LTFT Category 3 for 4 months at 0.8 whole time equivalent, with 100% in year 2 and 99% in year 3 reporting this had an overwhelmingly positive impact on their work/life balance, and 86% saying they are very likely to complete their training. From August 2023 all foundation doctors have been able to apply to train LTFT.
     2. Extending the out of programme pause (OOPP) offer, allowing trainees to step in and out of training without unnecessary burden, and to request that capabilities gained while out of training are recognised on their return. Trainees can apply for OOPP until the end of July 2024, and as of February 2024 580 OOPP placements have been undertaken by doctors in training.
     3. Further developments in the [supported return to training (SuppoRTT) programme](https://www.hee.nhs.uk/our-work/supporting-doctors-returning-training-after-time-out), which support trainee return to programme after a period of absence, for whatever reason and regardless of the specialty. Doctors can step back into training in a safe and supported way, including with an offer of a period of supernumerary time to help them rapidly regain confidence and competence if needed.
     4. Expansion of the [flexible portfolio training (FPT) scheme](https://www.hee.nhs.uk/our-work/doctors-training/flexible-portfolio-training) to all specialties. Trainees can now apply to have 1 day protected time per week for additional personal development within a defined pathway theme, at the discretion of each postgraduate dean.
3. NHS England’s initiatives support female trainees particularly and are helping to address the gender pay gap. Currently, 83% of beneficiaries of the SuppoRTT programme are female; take up of the OOPP is 60% female; and LTFT is now in the Gold Guide, meaning LTFT for personal reasons is now considered mainstream. The high take up of these initiatives by female trainees demonstrates how useful they are in helping women return to and remain in medical training.

### 13.3 Training experience and quality assurance

1. The NHS England [Education Quality Strategy](https://www.hee.nhs.uk/our-work/quality/hee-quality-strategy) outlines our approach to managing and improving the quality of education and training in healthcare services across England. It is underpinned by the multiprofessional [Education Quality Framework](https://nshcs.hee.nhs.uk/publications/health-education-england-hee-quality-framework-from-2021/), which defines the standards for delivering high-quality education and training in a safe, supportive and inclusive learning environment.
2. Postgraduate doctors rotate between different placements. Their feedback on educational experience and the nature of each workplace in terms of patient safety and interpersonal/interprofessional behaviours and culture is often an early warning for potential quality or patient safety concerns. NHS England has a pathway for learners and educators to raise, and where appropriate, escalate concerns regarding the learning environment, complimented by the [National Education and Training Survey](https://www.hee.nhs.uk/our-work/quality/national-education-training-survey-nets) (NETS) which gathers opinions from students and trainees about their time working and training in practice placements and training posts. We continue to work with ICSs to support quality improvement programmes, including by sharing best practice, aligned to national, regional and local priorities.

### 13.4 Cost of training and exams

1. We receive consistent feedback from postgraduate doctors about the personal expense of postgraduate medical training exams. Respondents to a recent AoMRC survey reported that exam part fees ranged from £330 to £1,904.
2. NHS England has facilitated talks with the medical royal colleges and the GMC regarding these costs. We have asked the GMC to carefully consider the added benefit of exams against the cost to trainees, and to consultant time away from work. This has generated an interest in reviewing the place of postgraduate exams in training. We have also encouraged colleges to be open and transparent about cost setting, but some have resisted sharing this information.
3. We reformed the study budget system for doctors in training in 2018 from a notional individual annual funding allocation per trainee, to a pooled resource. No ‘cap’ is imposed on any individual, and every application for study leave is considered on its own merit. This approach is designed to maintain fair and transparent access to educational resources.
4. NHS England also ensures that the costs to individual applicants and to the NHS are minimised by working with the devolved nations to prevent curricula from naming courses, allowing more cost-effective regional or local options to be developed.
5. We have extended the study budget to include trust-funded training posts, to ensure fairness and equity for all postgraduate medical trainees; however, this is putting pressure on the overall study budget, as these posts now make up 20% of all training posts.
6. With this increased pressure, there is the growing risk that the study budget will be insufficient to fund all the essential learning in postgraduate curricula, and that more trainees will have to self-fund their courses to progress through training. These courses can come at significant personal cost to the individual. This is particularly true for practical training in the technical skills required by the ‘craft’ specialties; for example, surgical specialties, obstetrics and gynaecology, ophthalmology and cardiology.

### 13.5 Distance to training placements

1. Placements are distributed across a range of sites to give trainees experience of working in different sized organisations, allow them to cover general and specialist elements of the curricula, and prepare them for consultant or GP practice anywhere in the country. This also ensures trainees are where patients need current and future services. Recognising the strain that movement between placements can cause, postgraduate deans do ask their teams to minimise rotational distance where possible. However, to provide the necessary service for patients across the country, and to cover training requirements, placements at a distance from a trainee’s base need to continue, and NHS England provides financial support for relocation and, for trainees with special circumstances, flexibility in where they train. Since 2020, eligible trainees can claim up to £10,000 to cover relocation and excess mileage costs over the duration of their postgraduate training.
2. NHS England worked closely with the BMA and other stakeholders on the national framework to provide a consistent approach to support all trainees across the country who face the financial costs of moving to take up training, and/or may be financially disadvantaged because their training programme covers a large geographical area.
3. In August 2022, the national Inter-Deanery Transfer (IDT) process introduced Criterion 5, which allows postgraduate doctors in training to apply for a transfer without having to demonstrate any change to personal circumstances (Table 13.2). This criterion gives trainees greater flexibility to be closer to their families (including those who are not a parent/guardian).
4. Applications are reviewed by a national panel following each major round of recruitment, and applicants are entitled to appeal the panel’s decision and given the opportunity to submit additional evidence. There is a limit to how much flexibility can be offered, as available training posts are limited and we are working to improve the opportunity for doctors who move into locally employed doctor posts in other areas to step into training.

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Applications** | **Offers accepted** |
| Criterion 1a – Own disability | 13 | 3 |
| Criterion 1b – Own disability (mental health) | 44 | 15 |
| Criterion 2 – Primary carer | 17 | 3 |
| Criterion 3 – Parental/guardian responsibilities | 190 | 66 |
| Criterion 4 – Committed relationship | 277 | 64 |
| Criterion 5 – Other | 183 | 63 |
| **Total** | **724** | **214** |

**Table 13.2: Number of applications and acceptances by criteria, 2023**

### 

### 13.6 Impact of COVID-19

#### On undergraduate medical education

1. The COVID-19 pandemic disrupted the well-established, traditional structure of undergraduate medical education, but also acted as a springboard for innovations, such as accelerating the development of online learning, introduction of novel ways of student assessment, simulation software, remote consultations, changes to clinical assessment and repurposing elective periods. The return to pre-pandemic A-level standards in summer 2023, coupled with government communications to medical schools that offer-making should be amended to ensure no over-recruitment, reverted intake targets to pre-pandemic levels. Provisional data suggests recruitment caps have been adhered to.

#### On postgraduate medical education

1. The pandemic also significantly impacted postgraduate medical doctors in training (DiT) experiential learning, progression and attainment. Mitigating measures in 2022/23 continue to enable annual review of competency progressions (ARCP) to proceed with more permissive use of outcomes, fully informed by the most up-to-date curricula and decision aids across all specialties, optimising and enabling progression for DiTs. However, at the end of the 2022/23 academic year, all regions recorded DiTs with extensions or with a training backlog in specialties essential for elective recovery and delivery of the NHS Long Term Workforce Plan.
2. NHS England estimates that in the 2022/23 academic year 0.27% (167) DiTs required additional training time (COVID extra time ARCP outcome 10.2) and that 0.22% (138) carried a future extension risk (COVID progress ARCP outcome 10.1), with the same resultant risks of cost, attrition from training programmes, slowed qualification of GPs and consultants, and reduced service from lack of senior grades in training. Recovery interventions have been made for at-risk surgical specialties.

### 13.7 General practice – GP training expansion and reform

1. Trainee GPs currently number 14,950. One of the biggest challenges to the delivery of expansion targets is training placement capacity including estates, which require significant expansion.
2. To deliver the GP specialty training (GPST) reform agenda and meet current and future training targets, we need more placements, which NHS England aims to support using blended learning placements as well as other reform and capacity building initiatives. These learning placements are needed not only to expand GPST training placements, but also the to equip DiTs with generalist, high-quality clinical skills, along with digital, leadership and quality improvement capabilities.
3. A 4-month blended placement ‘proof of concept’ ran between April and August 2023 for 18 DiTs in the West Midlands, and a wider pilot to evaluate effectiveness and potential benefits for learners, educators and the wider NHS is running from December 2023 until April 2024 for 50 DiT in the West Midlands, and another from February to August 2024 involving 3 schools with a total of 60 DiT.
4. GP trainers are included in the [GP educators pay scale](https://www.gov.uk/government/publications/gp-and-dental-clinical-educator-pay-scales-2022-to-2023/gp-educator-pay-scale-2022-to-2023) published annually by DHSC. It is expected that any uplift to this scale would automatically apply to them.
5. A shortage of educators and supervisors will hinder efforts to expand GP numbers. The Royal College of General Practitioners’ survey report [Fit for the Future: Reshaping general practice infrastructure in England](https://www.rcgp.org.uk/getmedia/2aa7365f-ef3e-4262-aabc-6e73bcd2656f/infrastructure-report-may-2023.pdf) (May 2023) gave the following reasons for practices finding it difficult to take on more GP trainees or other learners: a shortage of educators/supervisors (46.8%); a lack of physical space (84.2%) and a lack of headspace or time (61.7%).
6. The GMC’s [The state of medical education and practice in the UK: Workplace experiences](https://www.gmc-uk.org/-/media/documents/somep-workplace-experiences-2023-full-report_pdf-101653283.pdf) (2023) found that “63% of GPs with a training role were struggling compared with 53% of GPs who did not hold such a role”. The [GMC National Training Survey](https://www.gmc-uk.org/education/how-we-quality-assure-medical-education-and-training/evidence-data-and-intelligence/national-training-surveys) (2023) found that 52% of trainers were at high or moderate risk of burnout, the same level as in 2022; and 24% of GP trainers stated that “every working hour is tiring for them”.
7. The expansion of roles across primary care and the increase of GPST places has intensified the role of GP trainers and their workload. Consistent feedback in every region is that the balance of workload to remuneration is the main reason for practices and doctors deciding not to join the training community. Without additional increase in renumeration to retain those in the role and incentivise others to join, the existing issues with training and GP expansion will be compounded.

## 14. Locally employed doctors

### 14.1 Overview

1. Locally employed doctors (LEDs) generally undertake more junior roles, requiring direct or indirect supervision; some may have recently completed their foundation training and could return to formal training, and IMGs can first join the NHS as LEDs. LEDs also work as teaching fellows or postgraduate clinical fellows.
2. Increasing numbers of doctors take a training break for many reasons relating to personal and professional circumstances, such as uncertainty about their training path or wish to gain specialty experience – [the F3 phenomenon](https://www.hee.nhs.uk/sites/default/files/documents/F3_Phenomenon_Final.pdf). This has implications both for how training is delivered and how doctors are supported, and has important implications for the future workforce supply. The productivity of the medical workforce is dependent on their supported progression; learning as they gain experience so that they can provide more complex care. NHS England is now taking forward work to address the need for progression.

### 14.2 Terms and conditions

1. LEDs are employed on local terms and conditions (T&C). Most employers base their local LED employment contracts on the [Doctors and dentists in training terms and conditions (England) 2016](https://www.nhsemployers.org/publications/doctors-and-dentists-training-terms-and-conditions-england-2016), but some still use the 2002 T&C. LEDs may not be employed on a formal NHS England training programme but are working broadly at that level. The specialty doctor contract requires at least 4 years of postgraduate experience, so most ‘F3’ doctors would not meet the entry requirements for a national contract.
2. It is difficult to distinguish between a doctor on a 2002 pay code and an LED or doctor on the 2016 contract being pay protected. However, some LEDs have bespoke pay and T&C and can be identified given they do not appear with other national grades in ESR data. DHSC analysis estimates that doctors on bespoke T&C make up around 4% of the medical workforce.
3. The data challenges make it hard to provide an accurate total number of LEDs employed in England. The growth in LEDs could also be driven by IMGs, and employers must guard against discrimination, particularly where there are differentials in pay and T&C for LEDs.

#### 2023/24 pay round

1. The July 2023 [written ministerial statement](https://questions-statements.parliament.uk/written-statements/detail/2023-07-13/hcws946) on the public sector pay review did not respond to the DDRB’s recommendation on LEDs.
2. 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 the pay of LEDs on ‘bespoke’ contracts, although we understand the BMA has asked NHS organisations locally to introduce a 6% pay uplift, plus £1,250 consolidated (for those on 2016 junior doctors’ contract) back dated to April 2023. The picture across the country is likely to be inconsistent.

## 15. The dental workforce

### 15.1 Overview

1. Most dentists work in primary care and deliver NHS services through General Dental Services (GDS) and Personal Dental Services (PDS) contracts and through the private sector. A small number deliver NHS services in secondary care and community services. As of September 2023, 44,925 dentists in the UK were [registered with the General Dental Council (GDC)](https://www.gdc-uk.org/docs/default-source/registration-reports/registration_reports_september_2023.pdf?sfvrsn=8f263e7f_6), of whom 33,546 were in England,although some might not be practising.
2. During 2022/23, 24,151 dentists were practising under NHS GDS, mixed, PDS and Trust-led Dental Services (TDS) contracts in primary care ([NHS Dental Statistics for England, 2022/23](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2022-23-annual-report), Annual report). This equates to 72% of all registrants. The number of units of dental activity (UDAs) carried out in England in 2022/23 was lower than prior to the COVID-19 pandemic: 70 million in 2022/23 compared to 78.8 million (-12.5%) in 2019/20, 83.9 million (-20.0%) in 2018/19 and 88.1 million (-25.9%) in 2012/13. The effective FTE supply of dentists delivering NHS-commissioned work has therefore declined over the last 10 years.
3. Access to NHS dental services remains an ongoing issue for patients across the country, likely explained by factors including an overall shortage of dentists delivering NHS care and the continuing attractiveness of private practice to dentists. In parts of England patients have no access to an NHS dental practice. NHS England announced reforms to the dental contract in July 2022 to improve access to dental care, along with the recently announced [Dental Recovery Plan](https://www.england.nhs.uk/2024/02/millions-more-dental-appointments-to-be-offered-under-nhs-dental-recovery-plan/).

### 15.2 Dentists in training: workforce supply

#### Undergraduate dental students

1. Government caps undergraduate dentistry student intake numbers for home and international (defined as those from countries outside the European Economic Area) students; more than 800 places are available each year in England (Table 15.1).
2. Following the rise in A-level grades in 2020 and 2021, government lifted the cap on medical and dental school places to ensure a place for every applicant who met the terms of their offer. In 2022, intake targets reverted to pre-pandemic levels, and provisional data suggests these have been adhered to.

**Table 15.1: Applicants and entrants\* to dentistry courses at English providers, 2018/19 to 2022/23**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year of entry** | **2018/19** | **2019/20** | **2020/21** | **2021/22** | **2022/23 (provisional)** |
| UK applicants | 2,365 | 2,765 | 2,860 | 3,185 | 3,440 |
| Intake | 808 | 811 | 898 | 980 | 795 |

\* 28 days after A-level results day in-cycle date

Source: Office for Students. [Medical and dental intakes](https://www.officeforstudents.org.uk/advice-and-guidance/funding-for-providers/health-education-funding/medical-and-dental-intakes/)

1. Teaching of undergraduate dental students has been impacted by the COVID-19 pandemic (particularly due to clinical teaching involving aerosol generating procedures) coupled with ageing estate and infrastructure, and capital and revenue investment has been needed to ensure the delivery of clinical placements is safe for students, supervisors and patients.
2. HEE invested additional non-recurrent revenue funding to support new kit for teaching and staffing, and secured non-recurrent capital funding from HM Treasury via DHSC. The additional revenue funding up to the end of 2022/23 was £32 million. 96% of dental students graduated with the required competencies to begin dental foundation training from September 2022 and 2023 (98% in 2021); without the additional funding few would have graduated in the last 3 years.
3. The impact of COVID-19 on undergraduate dentistry has meant that some dental schools have multiyear plans to support recovery of the training deficit. Progression of students is monitored closely by the Dental Schools Council (DSC) and other stakeholders, including NHS England.

#### Postgraduate training

1. Postgraduate places have consistently been filled, or close to filled, across all training programmes. Appendix C gives recruitment data for dental specialty training posts in 2021 and 2022, and dental core and specialty training in 2023.
2. We are aware that through postgraduate training the numbers of dentists on speciality lists have fallen, particularly in oral surgery/special care dentistry and additional dental specialties (these include dental and maxillofacial radiology, oral and maxillofacial pathology, and oral medicine), and there are very few paediatric posts in some regions. The number of trainees in some specialty training programmes does not keep pace with those retiring from posts, with most specialists having been ‘grandfathered’ onto these lists.

##### Dental foundation training (DFT)

1. Extensions to training nationally in 2023 were in line with those pre-COVID; 1.7% compared to between 1% and 3%.
2. NHS England regions have found it difficult to recruit educational supervisors and training practices for the 2022 and 2023 cohorts, with the number leaving DFT training exceeding the recruitment of trainers, especially in rural and coastal areas. Reasons given for leaving training include workload of training and payment for the service component of training not having been increased since 2013, despite inflationary costs. The latter is a disincentive for practices to carry on as or become a training practice, and requires urgent review from relevant government bodies.

##### Dental core training (DCT)

1. The option to extend training for DCTs was introduced in 2022. No postgraduates completing DCTs in 2023 required an extension to their training, but 1% resigned from post during training.

##### Dental specialty training (DST)

1. In the 2022 reviews of competency progression, 91% of trainees received a satisfactory outcome (266) or completed training (49). 12 trainees (3.5%) required an extension to training for non-COVID related reasons and 2 because of the impact of COVID-19 on their training. Data for 2023 is not yet available but we expect COVID-19 to have had minimal impact on trainee progression in 2023.

### 15.3 Dentistry education and training reform: advancing dental care

1. The Dental Education Reform Programme (DERP) includes work to develop more flexible training experiences in varied settings, build better training pathways for both dentists and dental care practitioners (DCPs) and support more multidisciplinary working. Evidence suggests that dentists could be released for more complex work if other members of the dental team (DCPs) were working to their full scope of practice.
2. The DERP Dental Training Distribution workstream has sought to address lack of access for patients to specialist dental services, through funding additional training posts in oral surgery, special care and paediatric dentistry.
3. Delivery to date includes:
   1. Procurement and implementation of a lead employer model for DFT.
   2. Review of established early years postgraduate dental training programmes and piloting of new curricula. This 2-year programme covers DFT and DCT year 1 and is designed to provide trainees with a wider breadth of experience across sectors within an ICS(s) to enhance their skills and knowledge.
   3. Scoping and review of the middle years postgraduate dental training programme with planned development of a new curriculum. This 2-year training programme spanning DCT years 2 and 3 provides rotational posts across the different dental specialties, and needs to better support trainees to gain enhanced skills and in their career progression to dental specialty training.
   4. Review of the dental therapist foundation training education and funding model.
   5. Review of the return to dental therapy education package, to enable qualified dental therapists who have been working as hygienists to return to the full scope of their therapy qualification.
   6. Development of guided distribution models for DFT and DST across three prioritised specialties – special care dentistry, paediatric dentistry and oral surgery – to inform NHS England’s distribution of training investment.
   7. Funding of an additional 19 new dental specialty training posts in these prioritised specialties.
   8. Setting up of an advisory group of diverse stakeholders to shape the education and training requirement of the dentistry workforce in England using blended learning. The initial focus is dental hygienist training, but this will also examine how a blended approach to learning can impact on other dental care professional groups.

## 16. Dental practitioners

### 16.1 Overview

1. This section gives an update on general dental practitioners (GDPs) providing NHS primary care services and community dental services (CDS).
2. NHS England regularly meets the General Dental Practice Committee of the British Dental Association (BDA) to discuss operational issues and the pressures facing primary care dentistry.
3. Dental services commissioning moved to ICBs as part of delegated commissioning functions on 1 April 2023, which will support local systems to provide more joined-up and sustainable care for patients. In managing and commissioning dentistry, the responsible commissioner aims to improve health outcomes and make best use of NHS resources, maintain access to services, reduce inequalities and promote preventative pathways.
4. For clarity, we define dentists as follows:

* ‘providing performer’ – a dentist who holds a GDS or PDS contract with NHS England and performs dentistry. A provider performer, also known as a contract holder, may be a practice owner, principal or limited company
* ‘performer-only’ – a dentist working for a ‘providing performer’, also known as an associate.

1. 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 GDS/PDS contract holder, and therefore we are not involved in how their pay is determined.
2. Contractors are paid 1/12th of their annual contract value on a monthly basis to deliver an associated set of weighted activity measures, usually but not always, expressed as UDAs. Data for earnings indicates the general trend is increasing NHS practice profits and goodwill in recent years.
3. Most current active contracts transitioned to the 2006 contract, and are held in perpetuity. Any new dental contracts are awarded through an open procurement process under which the applicant is not disclosed. Contracts are awarded based on factors including, but 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.

### 16.2 Recruitment, retention and motivation

1. Current trends in the dental workforce are difficult to assess. [Available data](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2022-23-annual-report) does not detail whole or part-time working, which limits our analysis of the workforce capacity. However, we are aware that certain geographical shortfalls are limiting service provision, including in rural and coastal areas.
2. To improve the available workforce data, NHS England has introduced a new biannual national dental workforce collection from 1 October 2023 onwards. This will provide both cross-sectional and trend data on:

* retention and recruitment of staff
* vacancy rates
* delivery of NHS and private care.

1. In 2022/23, the number of dentists providing NHS activity fell by 0.5% to 24,151. This is not a significant movement, but we are concerned that dentists are delivering less NHS care than the equivalent number would have done pre-pandemic.
2. Typically, 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 for part of the year. DHSC’s evidence provides an historical breakdown of the number of dentists providing NHS services.
3. NHS England held engagement events in autumn 2021 and 2022 with providing performers, performer-only dentists and the wider dental team to better understand the issues facing the sector as part of wider work on ongoing dental contract reform. We heard concerns about the impact of very low indicative UDA values on recruitment, retention and contract delivery, and introduced a minimum indicative UDA value of £23 from 1 October 2022.
4. Our engagement with the profession also revealed misunderstandings about the potential utilisation of skill mix are common in dental practices. We have taken first steps to address these by publishing [guidance and case studies](https://www.england.nhs.uk/long-read/building-dental-teams-supporting-the-use-of-skill-mix-in-nhs-general-dental-practice-long-guidance/) that clarify how skill mix and direct access in NHS practice can be used while working within the current regulatory framework. From 1 October 2022, we also removed the administrative barriers that had prevented dental therapists and others from opening courses of treatment and operating within their scope of practice and competence. We continue to work with the GDC and others to promote good practice in the use of skill mix and to address any concerns and questions contract holders may have.

### 16.3 General dental practitioner recovery from COVID-19

1. All practices were supported across and beyond the pandemic period. Support was designed to secure practice viability, retain staff and promote recovery of access once COVID-19 restrictions were lifted.
2. Income protection remained in place for contractors delivering mandatory services (UDAs) until the end of quarter 1 2022/23, which aligns with the lifting of enhanced infection prevention and control (IPC) requirements. Practices that had exited the prototype programme on 1 April 2022 had separate support arrangements in place as they transitioned to their underlying contract. Contract holders delivering orthodontic services returned to usual contracting arrangements from 1 April 2022.
3. For contractual year 2022/23, we [implemented a reduced performance tolerance of 90% for contractors delivering mandatory services (UDAs)](https://www.england.nhs.uk/wp-content/uploads/2023/06/PRN00549_NHS-dental-year-end-2022-23-arrangements-and-statement-following-GDC-v-Williams-Court-of-Appeal-Judge.pdf) and in line with this, practices that exited the prototype programme were allowed to carry forward undelivered activity of between 80% to 90%. We decided to waive our rights to financial recovery within mandatory services to support practices during the ongoing recovery of dental services, recognising that pandemic measures had continued to affect capacity for many practices in the early part of 2022/23. This meant that more underdelivered activity (10% rather than 4%) could be carried forward to increase capacity in the 2023/24 contract year, maximising access for patients and continuing to address the backlog of care.
4. Access to general dentistry remains a concern. To maximise access for patients in 2022/23, we offered all dental contractors delivering mandatory services (UDAs) remuneration for over-delivered activity up to 110% of their contract value. This arrangement was also available to practices that had exited the prototype programme. In total around 24% of practices received a payment for over-performance equating to c568,000 UDAs (£16.5 million). While the national arrangements excluded contractors delivering orthodontic activity, we agreed that these contractors could also be remunerated for over-delivered activity up to 110% if they had sought advance approval from their local commissioner.
5. Pandemic measures had a significant impact on service provision and capacity. While income protection was in place, practices delivered only a portion of their contracted activity in return for a near-normal level of payment. The reasons for dental services not returning to pre COVID-19 levels of delivery in 2022/23 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. A comparison of activity pre and post COVID-19 is explored in section 16.5.

### 16.4 Community dental services

1. Community dental services (CDS) are local dental services commissioned by ICBs under a PDS agreement in line with local oral health needs assessments. They provide an important service to vulnerable patients with complex health and dental needs, and 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.
2. NHS England has about 70 contracts that provide CDS across 296 geographical locations; most of these are held with foundation, community and mental health trusts and the remainder with community interest companies (CICs). Those employed by NHS trusts are remunerated based on [nationally agreed pay rates](https://www.england.nhs.uk/wp-content/uploads/2022/07/B1802_First-stage-of-dental-reform-letter_190722.pdf), determined by DHSC; those employed in CICs may be subject to different rates of pay and wider terms and conditions. CICs tend to reference the NHS bands for salaried dentists in setting their pay scales and need to comply with the employment protections and payments laid out in the [Statement of Financial Entitlements (SFE)](https://www.gov.uk/government/publications/primary-dental-services-statement-of-financial-entitlements-amendment-directions-2023), but their pay scales will also reflect the individual contract value.
3. The dental-wide workforce collection introduced by NHS England during the pandemic included CDS, but it should be noted that response rates are variable and returns not always completed in full. The new [workforce survey](https://www.england.nhs.uk/long-read/national-dental-workforce-collection/) will provide a much richer source of information.
4. CDS played a key part in our response to the pandemic, standing up as urgent dental centres, 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 in the future will compound backlog issues for the management of vulnerable groups, including longer CDS waiting times for patients. The Getting it Right First Time (GIRFT) team are also supporting CDS providers with demand for services.
5. Data on the activity delivered by and waiting times in CDS services has historically been very limited. To help address this, NHS England has taken steps to [start collecting](https://www.nhsbsa.nhs.uk/national-community-dental-service-cds-waiting-list-collection-2023-24) average wait times across CDS services on a quarterly basis, in order to develop a time series of data.

### 16.5 Access and activity

1. The [March 2023 GP Patient Survey](https://www.england.nhs.uk/statistics/2023/07/13/gp-patient-survey-dental-statistics-january-to-march-2023-england/) identified that 75% of people who sought an appointment with an NHS dentist in the past 2 years were successful (excluding those who could not remember), as were 82% of those in the last 6 months (compared to 96% pre-pandemic). People without an existing relationship with a dental practice were much less successful than those who did: 33% (70.5% pre-pandemic) compared with 84% (96% pre-pandemic).
2. The COVID-19 restrictions impacted activity, patient numbers, finances and treatments in quarter 4 of 2019/20, 2020/21, 2021/22 and quarter 1 of 2022/23. The average monthly performance of contracts measured against the delivery thresholds was 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 (Figure 16.1).
3. Delivery of contracted activity in 2023/24 remains supressed – and has yet to return to pre-pandemic levels – despite IPC measures being lifted and a return to usual contracting arrangements for all dental contractors.
4. The number of unique patients seen in the last 12 months is currently around 86% of pre-pandemic levels, indicating that access remains challenging for some patients (Figure 16.2).
5. The proportion of dentists’ time spent on NHS work increased from 70.7% in 2017/18 to 73% in 2019/20 ([Dentists' working patterns, motivation and morale - 2018/19 and 2019/20](https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours)), but we do not have data on how this changed during the pandemic.

**Figure 16.1: UDAs delivered as a percentage of contracted UDAs, April 2021 to August 2023**

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**Figure 16.2: Unique dental patients seen, April 2018 to August 2023**

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### 16.6 Earnings and expenses

1. 2020/21 saw the introduction of government’s Self-Employment Income Support Scheme (SEISS) payments to eligible businesses adversely affected by the pandemic. These payments are subject to income tax and self-employed national insurance contributions, and as such we include them in the dental earnings data for 2020/21.
2. In 2021/22, the [gross earnings of providing performer dentists and performer-only dentists](https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2021-22) increased in cash terms. Earnings and expenses data includes income from both NHS and private patients where a contractor provides both services. In 2020/21 and 2021/22, NHS England provided a significant level of income protection as described in section 16.3.

**Table 16.1: Average gross earnings (before deduction of practice expenses and delivery costs) by dentist type in England, 2017/18 to 2021/22**

| **Year** | **Providing 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 |
| 2021/22 | £430,100 | £93,700 |

Source: [NHS Digital. Dental earnings and expenses estimates 2021/22](https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2021-22)

Note: 2021/22 is the latest year for which data is available.

1. For dentists holding an NHS contract, average taxable earnings (net profit) in 2021/22 were £135,000, a 2.1% increase from the previous year’s £132,6200. Dentists working for providers had an average taxable income of £64,900, a 10.3% increase from £58,700 in the 2020/21.
2. The income of performer-only dentists is determined by the arrangements they have agreed with the performing provider, but they are typically paid a fixed sum per UDA delivered. NHS England is concerned that maternity/paternity and sick pay benefits along with annual contract uplifts are not always passed on to performer-only dentists, but we do not currently have any involvement or influence over these contract arrangements.
3. In 2021/22, dentists used almost half (50%) of 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 continued until 31 March 2023. In addition, lower activity during the pandemic will have reduced a practice’s variable costs – for example, 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.
4. Dentists aged under 35 have the lowest taxable income (Table 16.2), which is partly explained by only 5% of them being providing performers. Those aged 45–55 have the highest taxable income.

**Table 16.2: Self-employed primary care dentists – average earnings and expenses from NHS and private dentistry by age in England, 2021/22**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Age** | **Population** | **Average gross income** | **Expenses** | **Taxable income** | **Expenses ratio** |
| <35 | 7,750 | £91,100 | £29,000 | £62,100 | 31.8% |
| ≥35 to ≤45 | 5,700 | £157,500 | £81,400 | £76,100 | 51.7% |
| ≥45 to ≤55 | 4,050 | £225,400 | £127,200 | £98,200 | 56.4% |
| ≥55 | 2,850 | £231,700 | £136,000 | £95,700 | 58.7% |
| All | 20,300 | £156,100 | £78,200 | £77,900 | 50.1% |

Source: [NHS Digital. Dental earnings and expenses estimates 2021/22](https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2021-22)

1. [Data from the National Association of Specialist Dental Accountants and Lawyers](https://nasdal.org.uk/nasdal-annual-benchmarking-statistics-increases-not-the-whole-story/) (NASDAL) for 2021/22 indicated a further increase in average net profit per principal from £145,498 to £150,894, and an increase for the first time in a number of years in the average remuneration for an associate from £63,304 to £75,488.
2. 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.
3. The [NHS Digital earnings report](https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2021-22/introduction#known-issues) continues to note the difficulty in separating expenses between performers and providers – and the possible double counting of expenses.
4. 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.
5. Dentists can also choose to alter the balance between gross and net pay without this having any major effect on their earnings. Changes in earnings and expenses reflect more than changes in pay rates and price. For example, if dentists work longer hours, they have a 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; for example, 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.
6. NASDAL and Morris & Co (other non-staffing costs) provide the percentage of gross income spent on certain categories of expenditure for England (Table 16.3).

**Table 16.3: Expense categories as a percentage of gross income for NHS practices and private practices in England, 2017/18 to 2021/22**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **2017/18** | **2018/19** | **2019/20** | **2020/21** | **2021/22** |
| **Non-clinical staff wages** | | | | |  |
| NHS practices | 20.9% | 20.9% | 20.6% | 21.3% | 21.3% |
| Private practices | 17.9% | 17.9% | 18.5% | 19.8% | 17.5% |
| **Laboratory costs** | | | | |  |
| NHS practices | 5.6% | 5.4% | 5.7% | 2.9% | 4.2% |
| Private practices | 6.8% | 7.0% | 6.6% | 7.2% | 7.1% |
| **Material costs** | | | | |  |
| NHS practices | 6.1% | 6.2% | 6.2% | 4.4% | 5.2% |
| Private practices | 7.4% | 7.9% | 7.5% | 8.2% | 8.2% |
| **Other non-staffing costs (Morris & Co)** | | | | |  |
| NHS practices | 16.1% | 15.8% | 16.0% | 13.4% | 15.6% |
| Private practices | 18.9% | 18.9% | 20.1% | 14.3% | 16.7% |

Source: NASDAL

1. Valuations from the NASDAL goodwill survey (end of October 2022, the latest available) were higher than in the previous period: deals averaged 141% of gross fees – up from 135%. NHS practices saw the highest practice goodwill at 152% of gross fees; for private practices there was a fall to 135% and for mixed practices to 143%. Although values of NHS practices were high, their number of sales were low compared to private and mixed practices.

#### Gender and ethnicity pay gaps

1. DDRB asked for evidence on the gender and ethnicity pay gaps. We do not hold data on ethnicity. Table 16.4 provides data by gender from the dental earnings and expenses estimates publications.
2. NHS England procures dental service provision via an open and transparent process and as such applications do not detail gender-specific identifiable information.

**Table 16.4: All self-employed primary care dentists – average taxable income from NHS and private dentistry in England by gender, 2016/17 to 2021/21**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** | **2021/22** |
| Total | £68,700 | £68,100 | £68,600 | £68,600 | £72,500 | £77,900 |
| Male | £81,800 | £81,900 | £82,900 | £83,500 | £87,800 | £95,800 |
| Female | £55,500 | £54,700 | £55,100 | £55,100 | £59,100 | £62,900 |

Source: [NHS Digital. Dental earnings and expenses estimates 2021/22](https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2021-22)

1. 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 providing performer dentists, a group who have significantly higher income than performer-only dentists (28% versus 11%).
2. It is important to note this data includes both full-time and part-time dental earnings and expenses, which, given that on average male dentists tend to work more hours per week than their female colleagues, contributes to the differences in taxable income by gender. Table 16.5 shows the split by gender in working hours based on the responses to the [Dental Working Patterns Survey](https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours); 55% of female dentists work fewer than 35 hours a week compared to 26% of male dentists.

**Table 16.5: All self-employed primary care dentists – average earnings and expenses from NHS and private dentistry, by gender and weekly working hours, in England 2019/20 (latest available)**

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

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

1. Table 16.6 shows the marked increase in female dentists in recent years. In 2022/23 60.6% of dentists under 35 were female ([NHS dental statistics for England 2022/23, Annual report](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2022-23-annual-report)).

**Table 16.6: Percentage of dentists with NHS activity by gender, 2016/17 to 2022/23**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **All dentists with FP17** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** | **2021/22** | **2022/23** |
| Male | 51.2% | 50.3% | 49.6% | 48.7% | 48.2% | 47.4% | 46.4% |
| Female | 48.8% | 49.7% | 50.4% | 51.3% | 51.8% | 52.6% | 53.6% |

Source: NHS dental statistics 2022/23

#### Performance adjustment

1. When practices do not deliver the agreed amount of activity under the dental contract and an agreed amendment has not been made in-year, we recover the proportion of the contract value commensurate with the undelivered activity in the following financial year, and this is used for other local NHS priorities (the money stays in the NHS).
2. Current rules prevent commissioners in most circumstances from releasing funding quickly from contracts where all activity will not be delivered, and so have limited ability to reinvest this money in-year in practices that can deliver more. We will address this by encouraging commissioners and contractors to collaborate to release NHS resources, and are working with DHSC to make appropriate regulatory change.
3. Where 30% of contracted activity has not been delivered in the first half of the year, they should consider reducing the annual activity requirement by 10% on a voluntary basis, to make it possible for other practices to use these resources to treat more patients. Where a dental contractor has delivered less than 96% of its contracted activity for 3 consecutive years, commissioners are encouraged to agree a recurrent reduction to the annual contract value and associated delivery.
4. NHSBSA has provided a provider assurance service since 2018 to assist NHS England regional teams, and from 1 April 2023 ICBs, with end of year contract reconciliation and mid-year reviews. This has ensured a fair and consistent process for contractors delivering UDA and unit of orthodontic activity (UOA) activity and a consistent application of carry forward activity and financial recoveries where these apply.
5. In 2020/21 income protection and pandemic support arrangements resulted in ongoing near-full contract payments for significantly reduced levels of activity, and performance adjustment in 2021/22 was much lower than usual (Table 16.7).

**Table 16.7: Performance adjustment,\* 2017/18 to 2022/23**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **2017/18 £m** | **2018/19 £m** | **2019/20**  **£m** | **2020/21**  **£m** | **2021/22**  **£m** | **2022/23**  **£m** |
| 65 | 128 | 123 | 131 | 17 | 338 |

\* 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

Source: NHS England’s accounting system

1. The net profit (that is, 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 (Table 16.8), again demonstrating the level of support NHS England provided to NHS practices during the pandemic.

**Table 16.8: Net profit per principal for the practice, 2016/17 to 2021/22**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Type of practice** | **2016/17**  **£** | **2017/18**  **£** | **2018/19**  **£** | **2019/20**  **£** | **2020/21**  **£** | **2021/22**  **£m** |
| NHS | 139,698 | 126,269 | 124,475 | 116,284 | 145,498 | 150,894 |
| Mixed | 130,076 | 127,676 | 132,940 | 134,342 | 168,326 | 177,072 |
| Private | 139,454 | 138,806 | 140,951 | 133,192 | 143,418 | 178,513 |

Source: NASDAL. NHS practices are those with NHS earnings ≥80% of total earnings. Private practices are those with private earnings ≥80%

### 16.7 Remuneration and affordability

1. For 2023/24, DDRB recommended an uplift in income, net of expenses, of 6% from   
   1 April 2023. The increase was accepted by ministers and combined with the expenses uplift to provide a contract uplift of 5.13%.
2. 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 and their employment status. NHS England also pays non-domestic business rates for the proportion of premises used for NHS dental services.
3. Each year we adjust contracts with providing performers by the agreed uplift, but there is no legal requirement for them to pass this on to performer-only dentists and we have no power to enforce this. NHS England is concerned that where contractors do not pass on payment uplifts, this has a negative impact on workforce retention, contract delivery and the availability of patient care. NHS England is also concerned that some of the benefits of the SFE – for example, sickness and maternity payments – are not passed on to performer-only dentists, despite this being a requirement in the SFE.
4. Pay recommendations for GDS in 2024/25 will need to be fair to contractors, recognise the significant income protection provided during the pandemic and represent value for money to the taxpayer; as well as ideally appropriately divided between employed and self-employed staff. However, pay recommendations not supported by additional funding may leave NHS England with no choice but to cut back services.

## Appendix A: Recruitment into specialty – fill rates 2019 to 2023

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\* Fill rate trends for the last 4 years. The 2023 data is only part year and only covers those training posts starting from August 2023; further recruitment is underway to fill remaining vacancies with a February 2024 start date.

## Appendix B: 2022/23 – GP Target Enhanced Recruitment Scheme (TERS)

|  |  |  |
| --- | --- | --- |
| **HEE region local office** | **Final allocations of 800 places for 2022/23** | **TERS places filled for 2022/23** |
| East of England | 115 | 118 |
| London | 77 | 75 |
| East Midlands | 81 | 81 |
| West Midlands | 79 | 70 |
| North East | 99 | 99 |
| Yorkshire & Humber | 92 | 83 |
| North West | 86 | 75 |
| Kent, Surrey & Sussex | 27 | 27 |
| Wessex | 62 | 59 |
| South West | 82 | 81 |
| **Total** | **800** | **768** |

## Appendix C: Dental core and specialty training recruitment

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## Appendix D: Education and training opening budget (2023/24)

Note: This data represents opening budgets prior to pay awards for 2023/24.

|  |  |  |
| --- | --- | --- |
|  | **Education and training budget 2023/24** | **%** |
| Postgraduate medical and dental | £2,658m | 45% |
| Clinical (commissioned programmes) | £1,058m | 18% |
| Clinical (non-commissioned programmes) | £306m | 5% |
| Undergraduate medical and dental | £1,033m | 17% |
| Workforce development and transformation | £361m | 6% |
| National activities | £216m | 4% |
| Education support | £144m | 2% |
| NIHR | £66m | 1% |
| Running costs | £62m | 1% |
| **Education and training budget** | **£5.90bn** | **100%** |