Review Body on Doctors' and Dentists' Remuneration

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Forty-Ninth Report 2021

Chair: Christopher Pilgrim

CP 478

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Presented to Parliament by the Prime Minister
and the Secretary of State for Health and Social Care

Presented to the Welsh Parliament by the First Minister
and the Minister for Health and Social Services

Presented to the Scottish Parliament by the First Minister
and the Cabinet Secretary for Health and Social Care

Presented to the Northern Ireland Assembly by the First Minister,
Deputy First Minister and Minister for Health

by Command of Her Majesty

July 2021

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. Its terms of reference were introduced in 1998, and amended in 2003 and 2007 and are reproduced below.

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care of the Scottish Government, the First Minister and the Minister for Health and Social Services of the Welsh Government and the First Minister, deputy First Minister and Minister for Health of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

the need to recruit, retain and motivate doctors and dentists;

regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;

the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;

the Government's inflation target;

the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

The Review Body should also take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care of the Scottish Government, the First Minister and the Minister for Health and Social Services of the Welsh Government, and the First Minister, deputy First Minister and Minister for Health of the Northern Ireland Executive.

The members of the Review Body are:

Christopher Pilgrim *(Chair)*
David Bingham
Helen Jackson
Professor Peter Kopelman
Professor James Malcomson FBA
John Matheson CBE
Nora Nanayakkara

The Secretariat is provided by the Office of Manpower Economics.

Contents

Executive summary

1. We are conscious that we have prepared our report and are making our recommendations in the context of the coronavirus (COVID-19) pandemic, which has had a major, and in many cases deeply personal, impact on millions of people across the UK and beyond. The pandemic has served as a timely reminder of the value of our remit group to society.

The DDRB's remit group

2. The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the Governments of the UK on the remuneration of doctors and dentists employed by, or providing services to, public health services across the UK. Our terms of reference are reproduced in full on page iii.

3. The DDRB's remit group is complex. It is made up of over 140,000 Hospital and Community Health Services (HCHS) medical and dental staff (of which there are approximately 60,000 consultants, 10,000 speciality doctors and associate specialists (SAS) and 70,000 doctors and dentists in training), 50,000 general medical practitioners (GMPs) and 30,000 general dental practitioners (GDPs).

Introduction

4. For this pay round we received remits from all four UK countries. The remits differed slightly, reflecting the different priorities of each Government, as well as the multi-year pay deals that are in place for some groups within our overall remit.

5. The Secretary of State for Health and Social Care's remit letter for England did not ask us for recommendations for independent contractor general medical practitioners and doctors and dentists in training since both groups are currently subject to multi-year deals in England. The Welsh Minister for Health and Social Services, Scottish Cabinet Secretary for Health and Sport, and Minister for Health in Northern Ireland each sought recommendations for all staff groups.

6. The remit letters for England and Wales also requested that our recommendations be informed by progress being made in contract reform negotiations for the SAS grades. In April 2021 the BMA and NHS Employers wrote to us confirming that contract reform packages had been approved in referenda of BMA members in England and Wales, and it was subsequently announced that similar approval had been given by BMA members in Northern Ireland. They added that they no longer expected us to make recommendations for SAS doctors and dentists who chose to move onto the new contracts, but recommendations were still sought for those who chose not to.

7. We received written and oral evidence from the Department of Health and Social Care (England); the Welsh Government; the Scottish Government; the Department of Health (Northern Ireland); NHS England and Improvement; Health Education England; NHS Employers; NHS Providers; the British Medical Association; the British Dental Association; and the Hospital Consultants and Specialists Association. We are grateful to all the parties for working with us during this challenging and uncertain time, though as we discuss in Chapter 1, the late submission of written evidence from some of the parties caused significant delays to the review body process.

Wider context

8. The pandemic has had a significant impact on the economy, labour market and public finances, and on doctors and dentists. Economic output in the UK was estimated to have fallen by 9.9 per cent in 2020. However, the most recent trends are towards recovery. After having fallen to below 1 per cent at times in 2020, the latest inflation figures, for April 2021, showed CPI inflation at 1.5 per cent, CPIH inflation at 1.6 per cent, and RPI inflation at 2.9 per cent, each over 12 months. Employment fell by 529,000 (1.6 per cent) over the year to March 2021 but grew by 84,000 over the three months to March 2021, to reach 32.48 million. Unemployment rose by 258,000 over the year to March 2021, but fell by 121,000 in the three months to March 2021, to 1.62 million. In the three months to March 2021, average weekly earnings growth was strong across the public and private sectors. Year-on-year average weekly earnings in March 2021 were 4.0 per cent higher across the whole economy. According to IDR, the median pay award across the economy in April 2021 was 2.0 per cent.

9. The pandemic has had a direct impact on both overall demand for healthcare services and the availability of and access to specific services. It has also caused care backlogs that will mean that demand is likely to remain at challenging levels for years to come. Medical and dental staff have had to work flexibly and in unfamiliar settings and specialties, often putting themselves in danger as they delivered front-line care. Patient throughput in dentistry has also been significantly reduced.

Productivity and affordability

10. We have set out in our report our views on productivity and affordability. Productivity is an issue we have considered carefully. Measuring it is important but not straightforward. As we said last year, the data we currently receive relates only to the service as a whole and tells us little about the productivity of our remit group. As such, they provide only a broad and imperfect indication of the affordability constraints that might inform pay recommendations.

11. DHSC said to us that any recommendation above 1 per cent would require reprioritisation of resources, as the pandemic had disrupted ongoing work to improve productivity in the NHS. The Scottish Government said that we should view their public sector pay policy[1] as an anchor when making recommendations, rather than an absolute position. The Welsh Government said that Boards already had funding for a 1 per cent increase for doctors and dentists in their allocations for 2021-22, and more money could potentially be available to fund a larger award. The Department of Health (Northern Ireland) said that plans had been made on the basis of 2 per cent pay growth for their medical and dental workforces and that therefore an award of 2 per cent was affordable, and that a higher award than this would require additional funding from the Department of Finance.

The case for a pay award

12. As we discuss in Chapter 3, we do not view the 1 per cent affordability envelope presented to us by the UK Government as a limit on what our recommendations can be for England. We similarly do not view the Scottish Public Sector Pay Policy or the 2 per cent that the Department of Health (Northern Ireland) said they had budgeted for pay awards as limits on what our recommendations can be for Scotland and Northern Ireland.

[1] Scottish Government (24 March 2021). Public sector pay policy 2021 to 2022. Available at: https://www.gov.scot/publications/scottish-public-sector-pay-policy-2021-2022-revised/pages/2/

13. Whilst we recognise the pay and affordability proposals put to us by the parties, our pay recommendations must also recognise the need to recruit, retain and motivate doctors and dentists. Health services have been put under major strain by COVID-19 in the past year and the likelihood of continuing waves of the virus, as well as the pressing need to address care backlogs, mean that health services will remain under pressure for the foreseeable future. In this context, and as services continue to change to meet new challenges, it is crucial that health services support their medical and dental workforces, retaining staff. Doing this requires them to feel valued and motivated and pay is an important contributor to this. Under the current circumstances, given the pressures placed on doctors and dentists by the pandemic, ensuring a sense of value and motivation is maintained is particularly important.

14. While we welcome many of the positive trends in recruitment through the pandemic, it is not yet clear whether these improvements are temporary consequences of the pandemic or will be sustained in the medium and long term. At the same time, all of the parties have expressed concern that the pandemic may precipitate issues of retention. Given the demands of the pandemic, many medical and dental staff will have worked above and beyond their normal working patterns, often in unfamiliar care settings, at personal risk and wearing essential but cumbersome personal protective equipment. This has been reported to have led to widespread fatigue, exhaustion and stress and, given the scale of care backlogs and the likelihood of continuing waves of the virus, is likely to continue to do so, leading to pressing issues of retention as exhausted doctors and dentists leave or decrease their working hours.

15. This has the potential also to interact with and exacerbate a number of existing concerns around retention. These include, but are not limited to:

    - The potential for issues related to pensions taxation, which we discuss in Chapter 4, exacerbating the phenomenon of increasing numbers of senior clinicians deciding that it is in their interest to retire or reduce their commitment. Voluntary early retirements for consultants were at an all-time high in 2019-20.
    - Issues of retention and progression for doctors and dentists in training, including stepping out of training on completion of the foundation programme, which we discuss in Chapter 5.
    - Issues associated with diversity and inclusion, including gender and ethnicity pay gaps, which we discuss in Chapter 4 and elsewhere in the report.
    - Continued change in the composition and demographics of the general practice workforce, which we discuss in Chapter 8.
    - Stagnant take-home pay and structural change to the dental workforce, alongside what the BDA told us about increasing numbers of dentists being attracted to doing private work, which we discuss in Chapter 9. These concerns may also be associated with issues of access to NHS/HSC dentistry that we discuss there.

16. There are also a number of issues of motivation that remain a concern to us. NHS Staff Survey results in England paint a picture of declining job satisfaction, and the results of the Dental Working Hours Motivation and Morale surveys from across the UK paint a troubling picture, with results both low in absolute terms and having fallen consistently in recent years.

Pay uplift

17. **After considering all the evidence, we recommend a general uplift of 3 per cent from the start of April 2021.**

18. This recommendation applies to the national salary scales, pay ranges or the pay element of contracts for all groups included in our remits from the governments this year, namely:

    - Consultants
    - SAS doctors and dentists in Scotland, as well as those who do not move onto the reformed contracts in England, Wales and Northern Ireland
    - Doctors and dentists in training in Scotland, Wales and Northern Ireland
    - Independent contractor GMPs in Scotland, Wales and Northern Ireland
    - The pay range for salaried GMPs
    - The GMP trainers' grant and GMP appraisers' grant
    - Independent contractor GDPs
    - Associate and salaried GDPs including Community Dental Service practitioners

19. This recommendation would add £234 million to the consultant pay bill in England, against a total DHSC Resource Departmental Expenditure Limit in 2021-22 of £169.1 billion, of which £22 billion is additional COVID-19 funding. It would add £50 million to the pay bill for salaried medical and dental staff in Scotland, £33 million in Wales, and £15 million in Northern Ireland.

20. While we welcome the progress that has been made in reforming the National Clinical Excellence Awards (CEAs) scheme that covers England and Wales, reformed consultant reward schemes are not yet in place anywhere in the UK. As we discuss in Chapter 7, issues of equity and effectiveness for these schemes remain across the UK. The Gender Pay Gap in Medicine Review's findings in relation to these schemes in England further strengthened the case for reform. **Given our concerns, we once again do not feel we can make a recommendation for an uplift to CEAs, Distinction Awards, Discretionary Points and Commitment Awards this year, though we will revisit this issue next year as reforms are completed.**

21. We would expect that pay awards would be appropriately funded in order that there would not be a negative impact on service provision.

22. We have not made a targeted recommendation for any part of our remit group this year. Last year, we said that we would revisit the issue of the extra one per cent for SAS doctors and dentists that we recommended in 2019 and had not been implemented anywhere in the UK. We are pleased that reformed contracts are now in place in England, Wales and Northern Ireland, and the BMA and NHS Employers wrote to us confirming that this additional 1 per cent was part of the envelope for contract reform. We therefore consider this matter closed in England, Wales and Northern Ireland. In Scotland, we would similarly expect this additional 1 per cent to be included in any contract reform envelope, and we will revisit this again next year as necessary.

23. We also remain particularly concerned about the trends in remuneration, motivation and morale amongst general dental practitioners. There seems to be evidence of issues of access to dentistry in certain areas across the UK. This may be related to what we heard from the BDA about dentists, and in particular younger dentists, increasingly being attracted to doing more private and less NHS/HSC work. We would welcome hearing more about this in evidence from the parties next year, and how these issues may interact with other trends in the composition and demographics of the dental workforce, including the fall in the number of providing-performers and the increasingly prominent role played by corporate dental providers. In this context it is difficult to know what role our recommendations play in the take-home earnings of associate dentists in particular, and we would also welcome evidence about this from the parties next year, in order to inform our recommendations.

24. Doctors and dentists for whom we have not been asked to make recommendations this year because they are on multi-year pay deals have also made significant contributions to the pandemic response. Our recommendations do not respond to the impact of the pandemic on recruitment, retention and motivation of these groups. Recognising the contribution they have made to the pandemic response in this context is extremely important, and we would urge ministers to consider this.

Looking ahead

25. There are a number of key issues and concerns that we would welcome hearing more from the parties about in evidence in future rounds.

Recruitment, Retention and Motivation

26. It will be important to understand whether and how the positive trends in vacancy rates and international recruitment that took place through the pandemic period will be sustained in future years.

27. There is a critical need to retain medical and dental staff in the context of exhaustion and burnout, significant treatment backlogs and the likelihood of continuing waves of the virus and the unknown impact of long COVID-19. Multiple parties have said that they are expecting an increase in retirements, particularly amongst consultants, during the coming year. There is a risk of a retirement spike over the next 12 months from people who have delayed retirement to support the pandemic response, or for whom COVID has led to a reassessment of their work-life balance. The risk of an increase in early retirements may additionally be exacerbated by issues around pensions.

28. We are concerned about the results of the NHS Staff Survey, which show a decline in job satisfaction compared to last year.

Diversity and Inclusion

29. We look forward to hearing about the work of the Implementation Panel following the publication of the Gender Pay Gap in Medicine Review in England, and what action is taken to address gender pay gaps. We would also welcome hearing about what action is taken to understand and address gender pay gaps in dentistry and in Scotland, Wales and Northern Ireland. We in addition await hearing what action will be taken to understand and address ethnicity pay gaps in the NHS following the roundtable with the Minister for Care that was announced alongside the Gender Pay Gap Review. We would welcome any insight from the parties as to what is driving this and other issues of diversity and inclusion in health services across the UK.

Pensions

30. We discuss in the report our concerns about the potential for issues of retention for the most senior doctors to be exacerbated by changes to the pensions taxation system, most recently the freezing of the Lifetime Allowance until 2025-26. We expect the parties to explain how they anticipate this and other changes to the pensions system to affect retention and what can be done to address this and help to improve retention amongst the medical and dental workforces. This includes changes to the employee contribution structure and the implementation of the remedy to the McCloud judgement. This may include making more timely and easy-to-understand information available to support clinicians' decision making.

Dentistry

31. The pandemic has caused major disruption to dental services, which is likely also to have an effect on oral health. This may exacerbate existing issues of access to NHS/HSC dentistry. In recent years, there has also been a significant change to the composition of dental workforces, as the number of providing-performers falls and the number of associates grows. At the same time, multiple parties told us that the proportion of NHS/HSC dentistry delivered by corporate providers has grown in recent years. Alongside this, further insight into what is driving trends in dental remuneration, including how our recommendations feed through into take-home pay for providing-performers and associates alike, would be helpful to us in determining our recommendations for dentists in future years. We would also expect progress to be made on contract reform in all four nations.

Consultants

32. Reforms to both the Local Clinical Excellence Awards scheme, which covers England, and the National Clinical Excellence Awards scheme, which covers England and Wales, are expected to be completed in the coming year. We expect that the reforms will address concerns about both schemes' equity and effectiveness that we and others, most notably the Gender Pay Gap in Medicine Review, have raised. We also expect governments in Scotland, Wales and Northern Ireland to set out their position on reforms to their consultant reward schemes.

33. We expect all four governments to continue to work towards wider contract reform for consultants. Given both the findings of the Gender Pay Gap in Medicine Review in relation to the length of pay spines, and what we heard during our visits programme and in written evidence about how the contract had performed through the pandemic, the case for contract reform has become clearer still this year. We discuss this in more detail in Chapter 7.

Salaried GMPs and Associate Dentists

34. The Gender Pay Gap in Medicine Review found that the unstructured way that pay is determined for salaried GMPs was an important contributor to gender pay gaps in general practice. We see no reason that these dynamics would be different in Scotland, Wales and Northern Ireland, and we consider that it is likely that the situation would also be similar for associate dentists. We hope that more is done to understand this issue across the UK. In this context, we would also hope to hear more about the dynamics of how pay uplifts are passed on by contractor GMPs and providing-performer dentists to salaried GMPs and associate dentists, and what could be driving any trends.

CHAPTER 1: INTRODUCTION

Introduction

1.1 The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the Governments of the UK on the remuneration of doctors and dentists employed by, or providing services to, national health services. In this report, we make our recommendations and observations for the 2021-22 pay round.

1.2 For this pay round we received remits from all four UK countries. The remits differed slightly, reflecting the different priorities of each Government, as well as the multi-year pay deals that are in place for some of the remit groups. More detail on the remits is provided later in this chapter.

Structure of the report

1.3 We have considered the remits in relation to our standing terms of reference and set out the evidence received from the parties on these matters, together with the conclusions and recommendations we reached based on this evidence.

1.4 This report is divided into eleven chapters:

1. Introduction
2. Wider context
3. Affordability, productivity and workforce planning
4. Pay, motivation and workforce supply
5. Doctors and dentists in training
6. Staff grade, associate specialist, specialist and specialty doctors and dentists (SAS)
7. Consultants
8. General medical practitioners
9. Dentists
10. Pay recommendations and observations
11. Looking forward

1.5 We also include seven appendices.

A. Remit letters from the parties
B. Detailed recommendations on remuneration
C. The number of doctors and dentists in the NHS in the UK
D. Glossary of terms
E. The data historically used in our formulae-based decisions for independent contractor GMPs and GDPs
F. Abbreviations and acronyms
G. Previous DDRB recommendations and the Governments' responses

Key context for this report

1.6 Like last year, our report this year has been completed in the developing context of the coronavirus (COVID-19) pandemic. Both the pandemic and the responses to it from the four governments were evolving throughout the period during which our report process took place, as was the impact on national and regional economies, labour markets, health services and health workforces.

1.7 COVID-19 has had a major impact on the NHS and health and social care more widely, and those working in this sector. Many of the doctors and dentists in our remit group have played a crucial role at the forefront of the national response, across both the primary and acute care sectors. COVID-19 has placed extraordinary demands on members of our remit group, and we are highly sensitive to the fact that throughout the pandemic, doctors and dentists have put themselves at risk from the virus, and that some have lost their lives caring for patients during this time. We discuss the impact of COVID-19 in more detail in Chapter 2, where we examine the evidence the parties provided to us about the impact of COVID-19 on the economy, and elsewhere across all other parts of the report.

1.8 There have been significant developments this year in many of the other key issues that relate to our terms of reference, which had concerned us in previous reports. While the transition period following the UK's exit from the EU has now ended, the impact of EU Exit on recruitment and retention of doctors from overseas is not yet known, nor is it known how any impacts will interact with those of the COVID-19 pandemic. In the context of overall workforce shortages, and given the increasing reliance on international recruitment within the medical and dental workforce in recent years, which we discuss in Chapter 4, this has the potential to impact on staffing, to the detriment of the services they provide and ultimately patient care.

1.9 Doctors' and dentists' working patterns continue to change, with notable trends including falls in the number of partner general medical practitioners and providing-performer general dental practitioners, concurrent with rises in those working in salaried and associate positions, and increasing numbers of doctors and dentists working and training less than full time. Stepping out of training for at least a year on completion of the foundation programme is now the norm rather than the exception for doctors in training.

1.10 The Gender Pay Gap in Medicine Review's report, *Mend the Gap*, whose scope included all parts of the medical workforce in England, was published in December 2020. We discuss the Review and its report in more detail in Chapter 4.

1.11 In early 2021, it was announced that a multi-year pay and contract reform deal had been agreed between governments, employers and the BMA over new contracts for the SAS grades in England, Wales and Northern Ireland. We discuss this in more detail in Chapter 6.

Workforce plans

1.12 There are current workforce plans in place in all four nations, though their scope and timescales differ. Progress towards making and implementing workforce plans has also been affected by the pandemic. We discuss these plans in more detail in Chapter 3.

1.13 For England, *We are the NHS: People Plan 2020/21 – action for us all* was published in July 2020[1].

1.14 On 16 December 2019, the Scottish Government, together with the Convention of Scottish Local Authorities, published *An Integrated Health and Social Care Workforce Plan for Scotland*, Scotland's first integrated national health and social care workforce plan[2].

[1] NHS England (July 2020). *We are the NHS: People Plan for 2020-21 – action for us all.* Available at: https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

[2] Scottish Government and the Convention of Scottish Local Authorities (December 2019). *An Integrated Health and Social Care Workforce Plan for Scotland.* Available at: https://www.gov.scot/publications/national-health-social-care-integrated-workforce-plan/

1.15 NHS Wales, along with Social Care Wales published *A Healthier Wales: Our Workforce Strategy for Health and Social Care* in October 2020[3]. It outlines at a high level a series of actions that they intend to take to deliver an inclusive, engaged, sustainable and flexible workforce in health and social care by 2030.

1.16 In Northern Ireland, *Health and Social Care Workforce Strategy 2026: Delivering for Our People* was published in 2018[4]. The Strategy aimed to see Northern Ireland's health and social care workforce needs met in 2026, and outlined key actions for the period between 2018 and 2020.

The extent of the DDRB's general role in the pay determination process

1.17 The DDRB is an advisory non-departmental public body that makes recommendations to governments based on the evidence that is provided to it by governments, trade unions and other stakeholders, and on its visits programme, during which it meets members of the remit group and health service leaders across the UK. It is then for those governments to decide how to respond to our recommendations.

1.18 Outside of the DDRB process, the parties can and do negotiate with each other about pay and other issues, and the trade unions representing the workforce and the governments can reach agreements on pay between themselves.

The breadth of the DDRB's work and remit

1.19 The DDRB's primary focus of concern is pay, and its impact on recruitment, retention and motivation. But over the course of time there have been periods when the DDRB has been asked to report on issues beyond any narrow consideration of pay uplifts (for example, seven day services). More generally, pay questions can rarely be considered in isolation from other factors which influence recruitment, retention and motivation. To understand the role of pay in addressing these questions, it is often necessary to consider this broader context. In its reports, the DDRB tries to make a pragmatic judgement about the need to demonstrate that its central pay-focused recommendations have been informed, as necessary, by due consideration of these wider questions.

The independence of the DDRB

1.20 As with previous years, the question of the independence of the DDRB has been raised by the trade unions. We would reiterate that our recommendations are based on our independent assessment of all of the evidence provided to us by the parties. We have in the past made recommendations that run contrary to some or all of the parties' positions, including both governments and trade unions, and we do so again this year.

The case for 'catch-up' awards and retrospective awards

1.21 In their evidence submissions, the three trade unions each made reference to the period between 2010 and 2018, where pay awards were lower than inflation, and the consequent impact of this on real-terms pay for doctors and dentists. They also each asked that the remit group receive an increased award explicitly based on the real-terms falls in pay since 2010 that they described. Our view remains that our recommendations should be based on our independent assessment of recruitment, retention and motivation, considering also the affordability context, in line with our terms of reference.

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[3] Health Education and Improvement Wales and Social Care Wales (October 2020). *A Healthier Wales: Our Workforce Strategy for Health and Social Care.* Available at: https://heiw.nhs.wales/programmes/health-and-social-care-workforce-strategy/

[4] Department of Health (May 2018). *Health and Social Care Workforce Strategy 2026: Delivering for Our People.* Available at: https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026

1.22 Our recommendations are therefore not justified explicitly by the necessity of, or the necessity of avoiding, undoing past decision making, or retrospectively tracking inflation or cross-economy earnings data. However, we recognise that such long-term trends in pay can have an impact on recruitment, retention and motivation, and we will continue to keep this under review.

Remits for this report

1.23 The remit letters from each of the four countries are included in full at Appendix A.

Department of Health and Social Care (England)

1.24 The Secretary of State sent his remit letter on 18 December 2020. It asked us to make recommendations for consultants, specialty and associate specialist (SAS) doctors, the minimum and the maximum of the pay scales for salaried general medical practitioners (GMPs), and the pay element of remuneration for NHS dentists in England. It did not ask us to make recommendations for independent contractor GMPs or doctors and dentists in training, since both are currently subject to multi-year pay deals, and it requested that our recommendations be informed by their subsequent updates on progress being made in contract reform negotiations for the SAS grades with the BMA.

1.25 The letter noted the significant impact that the COVID-19 pandemic was having on the economy, labour market and fiscal position. It also said that despite their announced pause of pay awards for the majority of the public sector, the government had committed to provide NHS workers with a pay rise. It asked that our recommendations take account of the fiscal and economic context and consider the affordability of pay awards. It also asked that we describe in our final report what steps have been taken to take account of affordability, the need for workforce growth, and making the best use of funds available to deliver the best care for patients.

Welsh Government

1.26 The then Minister for Health and Social Services sent us his remit letter on 18 January 2021. It asked us to make recommendations on what would be a fair and affordable pay award for all groups of medical and dental staff in Wales, while taking the wider economic situation into consideration. He asked that our recommendations for the SAS grades be informed by the outcome of contract reform talks with BMA Cymru Wales.

Northern Ireland Department of Health

1.27 The Minister for Health wrote to us on 18 January 2021, asking us for recommendations on pay for all doctors and dentists working in health and social care in Northern Ireland.

Scottish Government

1.28 The then Cabinet Secretary for Health and Sport wrote to us on 16 February 2021 asking us to consider the affordability of recommendations within the confines of the Scottish Public Sector Pay Policy for 2021-22, whose main features were[5]:

- A guaranteed cash underpin of £750 for those who earn up to £25,000;
- A guaranteed basic pay increase of 1 per cent for public sector workers who earn £25,000 or more, up to £80,000; and
- A maximum basic pay increase of £800 for those earning £80,000 or more.

[5] This was the version of the Pay Policy that was described in the remit letter. Before being finalised, it was adjusted to the version that is described in Chapter 2.

1.29 The remit letter also asked us to consider our recommendations in the context of the Scottish Government's longer-term vision on: retention and recruitment; increasing staff morale; ensuring medical and dental staff receive appropriate support; and improving the health service's productivity and efficiency.

1.30 For general medical and general dental practitioners, it asked us for recommendations on the pay element of contracts.

SAS contract reform in England, Wales and Northern Ireland

1.31 On 14 April 2021, representatives of the BMA and NHS Employers wrote to us to update us on the state of the SAS grade contract reform negotiations. They said that contract reform packages had been approved at a referendum of BMA members and approved by the UK and Welsh Governments, with a further referendum of BMA members in Northern Ireland due to take place shortly after. On 19 May, it was announced that BMA members in Northern Ireland had also approved the contract deal[6]. They said that the 1 per cent that had been deferred from the 2019-20 pay award was included in the funding for the first year of the deal. However, they also said that for existing SAS doctors and dentists, moving onto the new contract would be voluntary, and for those who do not do so, recommendations are still being sought.

Our comments on the remits

1.32 The remit letter for England did not ask us for recommendations for independent contractor general medical practitioners and doctors and dentists in training, but recommendations are being sought for those staff groups in Scotland, Wales and Northern Ireland. However, we note that the DHSC letter welcomed our comments and observations on the evidence that we received from the parties on doctors and dentists in training, who are discussed in Chapter 5. We have also continued to discuss the GMP workforce in England in detail, given that we have still been asked to make recommendations for salaried GMPs.

1.33 The remit letters for England and Wales both asked us to be mindful of the ongoing talks with the BMA about contract reform for SAS doctors and dentists. We note the correspondence we received in April 2021 confirming that agreements had been reached in England and Wales, and that agreement was also subsequently reached in Northern Ireland.

1.34 We also note that, unlike last year, the remit letter for England did not ask for our views on the targeting of available funds in pay. The other remit letters continued not to ask for our views on this matter, with the Welsh Government adding in their written evidence that they do not support the use of targeted pay to specific staff groups.

1.35 We also note the different approach to pay taken by the Scottish Government, as set out in their remit letter, which included reference to the Scottish Public Sector Pay Policy which, specifically in relation to the DDRB remit group, is more prescriptive than the pay policies of the other governments. The Policy proposes making proportionally higher pay awards to the lowest paid public sector workers and also puts a cap on the size of the award for the highest paid. The £800 cap on increases for those earning over £80,000 would, if implemented for the DDRB remit group, lead to senior clinicians in Scotland receiving a significantly smaller award than our recommendation.

[6] British Medical Association (June 2021). *SAS contract negotiations.* Available at: https://www.bma.org.uk/pay-and-contracts/contracts/sas-doctor-contract/sas-contract-negotiations

The remit group

1.36 Our remit group comprises all doctors and dentists working for or providing services to the NHS in England, Scotland and Wales, and Health and Social Care in Northern Ireland. However, we were not asked to make recommendations for independent contractor GMPs and doctors and dentists in training in England, and the BMA and NHS Employers told us that recommendations were no longer sought for SAS doctors and dentists who have chosen to move on to the reformed contracts in England, Wales and Northern Ireland. All of these groups are currently covered by multi-year pay deals.

Parties giving evidence

1.37 We received written and oral evidence from the parties listed below. These were the same as last year. The organisations were as follows:

Government departments and agencies

- Department of Health and Social Care (England)
- Scottish Government
- Welsh Government
- Department of Health (Northern Ireland)
- NHS England/Improvement (NHSE/I)
- Health Education England

Employers' bodies

- NHS Employers
- NHS Providers

Bodies representing doctors and dentists

- British Dental Association (BDA)
- British Medical Association (BMA)
- Hospital Consultants and Specialists Association (HCSA)

The pay review body process

1.38 We would reiterate to all the governments that timely submission of our reports to them is dependent on timely receipt of remit letters and evidence. Having received our remit letters and the timetables set out within them, we asked that parties submitted their evidence by 18 January. We received most written evidence by or close to this date. However, we only received written evidence from the Scottish Government in mid-February, the Welsh Government in late February, and DHSC and NHSE/I in mid-March. This caused significant delays to the review body process. It is disappointing and these delays have now been happening for several years. They send an unhelpful signal to our remit group about the way in which our role and process is viewed, and ultimately lead to delays in them receiving their pay uplift. To recognise the rights of all the parties involved and to uphold the integrity of the review body process and enable it to work effectively, it is important that evidence is produced and delivered in a timely manner. We welcome the commitment made by the UK Government at oral evidence to improve and expect all the parties to do all they can next year to ensure the round follows a more workable timetable.

Last year's recommendations

1.39 In our 48th Report 2020, our basic recommendation was for a 2.8 per cent increase to the national salary scales, to be applied to the following:

- Consultants
- Staff grade, associate specialist and specialty (SAS) doctors and dentists
- Doctors and dentists in training in Scotland, Wales and Northern Ireland
- Independent contractor GMPs in Scotland, Wales and Northern Ireland
- The pay range for salaried GMPs
- The pay element of contracts for providing-performer and associate GDPs
- Salaried GDPs including Community Dental Service/Public Dental Service practitioners

1.40 We were not asked to make a recommendation for doctors and dentists in training and independent contractor GMPs in England, as both were subject to multi-year pay deals. We also did not make a recommendation to uplift Clinical Excellence Awards, Distinction Awards, Discretionary Points and Commitment Awards for consultants.

Responses to our recommendations

1.41 Following the submission of our report in June 2020, the four governments implemented the annual pay uplifts for this remit group as detailed in Table 1.1. DHSC and the Scottish and Welsh Governments implemented their medical and dental pay awards in July 2020, whilst in Northern Ireland they were implemented in March 2021.

Table 1.1 Implementation of 2020 DDRB recommendations

Group	DDRB 2020 recommendations	England	Wales	Scotland	Northern Ireland
Consultants (pay scales)	2.8%	2.8%	2.8%	2.8%	2.8%
Consultants (Clinical Excellence Awards, Commitment Awards, Distinction Awards)	No recommendation	Value frozen	Value frozen, one-off payment made to consultants at the bottom of the pay band.	Value frozen	Value frozen
SAS doctors and dentists	2.8%	2.8%	2.8%	2.8%	2.8%
Doctors and dentists in training	2.8% (Scotland, Wales and Northern Ireland only)	n/a	2.8%	2.8%	2.8%
Independent contractor GMPs	2.8% (Scotland, Wales and Northern Ireland only)	n/a	2.8%	2.8%	2.8%
Salaried GMPs range	2.8%	2.8%	2.8%	2.8%	2.8%
Providing-performer and associate GDPs	2.8%	2.8%	2.8%	2.8%	2.8%
Salaried GDPs	2.8%	2.8%	2.8%	2.8%	2.8%
GMP trainers' grant and GMP appraisers	2.8%	2.8%	2.8%	2.8%	2.8%

Our comments on responses to our recommendations

1.42 We welcome that all our recommendations were implemented across the UK. However, the delays to the pay award process in Northern Ireland continue to be unacceptable. While the implementation of last year's recommendations in March 2021 represents an advance on previous years, doctors and dentists in Northern Ireland had to wait eight months longer than their counterparts in England, Scotland and Wales to receive their pay award. During our visits programme, members of the remit group in Northern Ireland told us that they felt less valued by government as a result of these delays. We expect pay awards to be made in a timely fashion following the submission of our reports, and we have noted previously that this has not been happening in Northern Ireland for some time, and again this unfortunately remains the case. These delays undermine the credibility of the pay determination process amongst the remit group and are likely to have a negative impact on morale.

1.43 We welcome that the Scottish Government showed flexibility in applying its public sector pay policy to the remit group in order to address our recommendations and comments.

Future evidence

1.44 Chapter 11 sets out areas where the evidence provided to the review body could be improved or enhanced. In particular, we ask for data and evidence from the parties around the long-term implications of the COVID-19 pandemic on health services and medical and dental workforces, so that we will be able to monitor its impact.

CHAPTER 2: WIDER CONTEXT

Introduction

2.1 In this chapter, we firstly summarise at a high level the governments' responses to COVID-19 and then set out the latest economic and labour market indicators, as well as details of public sector pay policies and finances at the time of this report. This forms an important part of our assessment of affordability and the context within which our remit groups are working, when we make recommendations in line with our terms of reference. We also discuss at a high level some of the evidence the parties provided to us about the impact of the pandemic on our remit group, though we cover the impact of the pandemic on specific groups and issues in more detail across the rest of the report.

The coronavirus (COVID-19) pandemic

2.2 We are conscious that we have prepared our report and are making our recommendations in the context of the coronavirus pandemic, which has had a major, and in many cases deeply personal, impact on millions of people across the UK and beyond. Since the UK's first cases of COVID-19 were identified in January 2020 more than 4.5 million people have tested positive for the virus[1]. More than 460,000 people have been hospitalised, more than 120,000 people have lost their lives within 28 days of a positive test, and more than 150,000 have had COVID-19 mentioned on their death certificate. While at the time of writing, case numbers have fallen from their latest peak in January 2021, and the vaccination programme has led to most of the UK population having been immunised, we remain aware of the profound impact that the pandemic has had.

2.3 Below we discuss the implications of the pandemic for the UK economy, and then for health services and workforces.

The economic impact and the governments' responses

2.4 Last year, in this section, we briefly outlined the economic interventions that the government had made during the first phase of the pandemic. These included a scheme to pay up to 80 per cent of the wages of furloughed workers and support for the self-employed, which was announced in March 2020, and at the time of writing had been due to run until October 2020, although it has since been extended to September 2021; increases to Universal Credit and housing benefit; business rates support and grants to small businesses; and additional spending on public services.

2.5 Since then, these measures have remained in place while the economy has continued to be severely impacted by the pandemic and the steps taken to address it. At various times across the UK, these have included stay at home orders, lockdowns, school closures, social distancing measures, the enforced closure of non-essential retail, leisure and hospitality businesses, travel bans, and requirements to self-isolate or quarantine both for those displaying coronavirus symptoms and for those entering the UK from abroad.

2.6 From December 2020, after the start of the second wave and during the second lockdown, COVID-19 vaccinations became approved for use in the general public and new case numbers have fallen. At the time of writing, restrictions are being removed again across the UK. It is hoped that this will represent a permanent relaxation of restrictions, allowing large parts of the economy to begin to recover.

[1] Public Health England (2021). *Coronavirus (COVID-19) in the UK: UK summary.* Available at: https://coronavirus.data.gov.uk/

Impact of COVID-19 on health services and medical and dental workforces

2.7 We will discuss some of the specifics of the impact of COVID-19 on the medical and dental workforces including on particular workforce groups in more detail in other parts of the report, but we present here an overall set of our considerations around its impact.

2.8 The pandemic has placed extraordinary demands on health services and their workforces, and in particular the acute hospital sector. Doctors and dentists across health services have been reprioritised and had their normal working patterns significantly changed. Many have worked in specialties that they are unfamiliar with, often putting themselves in danger as they delivered front-line care, and all will have had to significantly change how they work, including delivering COVID-19 vaccines to members of the public. Some have sadly died as a result of caring for COVID-19 patients. This has also led to a workforce that is exhausted and at great risk of burnout.

Service and workforce demand

2.9 COVID-19 has had a direct impact on overall demand for healthcare services, as well as which parts of health services are utilised, how, and when. It has also meant that parts of the medical workforce have had to work flexibly and in unfamiliar settings and specialties. Patient throughput in dentistry has also been significantly reduced as many dental procedures generate aerosols.

2.10 Many elective medical and dental operations and procedures were cancelled or postponed across the UK. This, alongside the restrictions to the capacity of dental services, is likely to lead to significant backlogs and care needs going unmet across all parts of health services, including dentistry, mental health and elsewhere. It has also led to concerns about referral rates for cancer and other diseases. Addressing these backlogs, as well as the health issues caused by delayed treatments and long COVID, will be a significant and ongoing challenge for health services for years to come.

2.11 All of this together is likely to mean that demands on health services, and therefore their workforces, including on doctors and dentists, are likely to remain at challenging levels in the short and medium term.

Managing health services

2.12 Financial management of health services is likely to remain a challenge throughout the pandemic and its aftermath. While there has been significant additional funding provided to health services since the start of the pandemic, given the likelihood of continued increased demand, budgets are likely to be under pressure for the foreseeable future.

2.13 COVID-19 is also likely to lead to changes in the way health services are delivered in the future. Parties told us about rapid technological changes to the way that services are delivered and managed as a result of the pandemic, which may lead to more effective and efficient services in the future. COVID-19 has also had a major impact on the social care system which in turn may impact on the way that the health and social care systems work together.

2.14 There may also be an impact on the pace and final outcomes of other, longer-term changes. These include contract reform negotiations, including for doctors and dentists in training in Wales and for SAS doctors and dentists in Scotland, as well as reforms to Clinical Excellence Awards in England, which have been delayed to 2022. Similarly, significant strategic decision making for health services, including workforce planning, has been affected, with the scope of last year's NHS People Plan reduced to one year.

Recruitment, retention and motivation

2.15 We discuss trends in vacancy rates, staff survey results and other data relating to recruitment, retention and motivation in more detail elsewhere in the report.

2.16 As a result of the pandemic, doctors and dentists returned to the workforce, providing a boost to workforce numbers. International recruitment, demand for medical school places and recruitment into specialty training have all also been on a positive trajectory.

2.17 Doctors and dentists across the UK have responded to the challenges posed by the pandemic, working extremely hard in stressful and sometimes dangerous settings to deliver care to the public at a difficult time. The potential impact of the pandemic on retention and motivation is a major and pressing concern. Responding to the pandemic and its aftermath is likely to lead to substantial increases in exhaustion and burnout amongst medical and dental staff.

2.18 NHS Providers said that in a survey of Trust HR directors, 99 per cent were concerned about levels of burnout across their workforces. This, alongside what HCSA told us about the pandemic leading to doctors and dentists delaying career choices, has the potential to mean a significantly increased number of doctors and dentists will choose either to retire or decrease their working hours in the near future.

2.19 There may also be significant long-term behavioural changes in the workforce as a result of the pandemic. Doctors and dentists in training may make different career choices based on changed priorities as a result of working through the pandemic, including how many hours a week they wish to work, how quickly they wish to progress through training and which specialty they wish to work in.

2.20 Finally, it is not yet clear what the medium- and long-term impact of the pandemic will be on international recruitment, and how this might interact with changes as a result of the UK's exit from the EU.

The economy and the labour market

2.21 In early January 2021, HM Treasury sent the Pay Review Bodies their written evidence submission[2], which sets out HM Treasury's perspective on the economic and fiscal position.

2.22 HM Treasury said that the COVID-19 pandemic had brought significant disruption to the UK economy, with economic output falling by 25 per cent between February and April 2020. They added that there would be long-term scarring caused by the pandemic, with output at the five-year forecast horizon lying 3 per cent below its pre-pandemic trajectory, though this was highly conditional on the path of COVID-19 and the possibility of a third wave. They also discussed the impact of the pandemic on forecast trends in inflation, productivity and unemployment, explaining that lower productivity had been a key component of the hit to economic output, and that the pandemic had caused inflation forecasts to be revised downwards.

[2] Prior to last year, economic evidence was included in the DHSC written evidence submission. This year, HM Treasury instead decided to prepare one evidence submission for all of the Pay Review Bodies. It was published by them in January 2021 and can be found here: https://www.gov.uk/government/publications/hmt-economic-evidence-to-review-bodies-2020

2.23 HMT also contrasted trends in both public and private sector pay through the pandemic, setting out that during the first phase of the pandemic three-month average wage growth in the private sector had dropped significantly, while the equivalent figures in the public sector had remained broadly on the same trend as before. They also said that the Office for Budget Responsibility's (OBR) November 2020 forecast for whole economy earnings growth for 2021-22 was 1.2 percentage points lower than their March 2020 forecast, as a result of continuing labour market slack, productivity scarring, lower inflation expectations and the need for firms to repair their balance sheets.

2.24 They then outlined the Office for National Statistics' (ONS) analysis of the public sector pay premium between 2011 and 2019, which considered the full remuneration package (including pensions) and controls for individual and job characteristics that affect pay. They said that by 2019, the public sector pay premium had reached 7 per cent, and that as a result of COVID-19, they expected the gap to widen further.

2.25 Finally, they explained that private sector employment fell by 0.2 per cent in the first half of 2020, while public sector employment rose by 0.7 per cent; and that redundancies had significantly increased across the economy through the pandemic.

Economic growth

2.26 In 2020 as a whole UK gross domestic product was estimated to have fallen by 9.9 per cent[3]. Gross domestic product in Q4 2020 was estimated to be 2.8 per cent lower than a year previously[4]. There is still a great degree of uncertainty about the short-term trends in gross domestic product growth, but in March 2021 OBR said that they expect there will be a further contraction in the first quarter of 2021, followed by strong growth for the remainder of 2021[5]. They also said that they expected the economy to face 'scarring' of 3 per cent in the medium term, in line with other economies.

Inflation

2.27 The latest inflation figures from ONS, for April 2021, showed CPI inflation at 1.5 per cent, CPIH inflation at 1.6 per cent, and RPI inflation at 2.9 per cent, each over 12 months[6]. Inflation was expected to increase this year compared to 2020, with the OBR saying in March 2021 that they forecast CPI inflation to be 1.5 per cent in 2021[7], and the Bank of England forecasting it to be 1.7 per cent in the 2021-22 financial year[8].

Employment and the labour market

2.28 The latest official statistics in the labour market showed that employment fell by 529,000 (1.6 per cent) over the year to March 2021, but grew by 84,000 over the three months to March 2021, to reach 32.48 million. The employment rate was at 75.2 per cent in the three months to February 2020, down 1.1 percentage points over the year[9].

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[3] Office for National Statistics (12 May 2021). *Gross Domestic Product: Year on Year growth: CVM SA %.* Available at: https://www.ons.gov.uk/economy/grossdomesticproductgdp/timeseries/ihyp/pn2

[4] Office for National Statistics (12 May 2021). *Gross Domestic Product: Year on Year growth: CVM SA %.* Available at: https://www.ons.gov.uk/economy/grossdomesticproductgdp/timeseries/ihyp/pn2

[5] Office for Budget Responsibility (3 March 2021). *Economic and fiscal outlook-March 2021*. Available at: https://obr.uk/efo/economic-and-fiscal-outlook-march-2021/, table 2.3

[6] Office for National Statistics (March 2021). *Inflation and price indices*. Available at: https://www.ons.gov.uk/economy/inflationandpriceindices

[7] Office for Budget Responsibility (3 March 2021). *Economic and fiscal outlook-March 2021*. Available at: https://obr.uk/efo/economic-and-fiscal-outlook-march-2021/, table 2.8

[8] Bank of England (May 2021). *Monetary Policy Report*. Available at: https://www.bankofengland.co.uk/-/media/boe/files/monetary-policy-report/2021/may/monetary-policy-report-may-2021

[9] Office for National Statistics (June 2021). *Employment and employee types*. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes

2.29 The level of unemployment (those looking for and available for work), rose by 258,000 over the year to March 2021, but fell by 121,000 in the three months to March 2021, to 1.62 million. This gave an unemployment rate of 4.8 per cent in March 2021, up from 4 per cent a year previously[10].

Earnings growth

2.30 In the three months to March 2021, average weekly earnings growth was strong across the public and private sectors. Year-on-year average weekly earnings in March 2021 were 4.0 per cent higher across the whole economy, 3.7 per cent higher in the private sector and 5.6 per cent higher in the public sector[11].

2.31 According to IDR, the median pay award across the economy in April 2021 was 2.0 per cent[12]. XpertHR said that the median pay settlement for the three months ending 30 April 2021 was 1.9 per cent[13].

2.32 We pay particular attention to the movements of earnings at the upper end of the wage distribution, which includes the more highly paid members of our remit group. According to the Annual Survey of Hours and Earnings (ASHE) earnings growth at the top end of the distribution was weaker than the middle in the 12 months up to April 2020. Earnings growth for full-time employees across the economy as a whole was 3.6 per cent at the median, 2.6 per cent at the 90th percentile, 1.4 per cent at the 95th percentile, 0.7 per cent at the 97th percentile and -1.2 per cent at the 98th percentile.

Public sector pay policies and finances

2.33 HM Treasury said that the government had provided one of the largest and most comprehensive packages of measures in the world in response to the COVID-19 pandemic, with the government announcing over £280 billion of support measures since March 2020. They said that the OBR central forecast for public sector net borrowing in 2020-21 was £393.5 billion, seven times higher than the pre-pandemic forecast and, as a proportion of gross domestic product, the highest peacetime level on record. They said that borrowing would fall sharply in 2021-22 but would remain historically high at 7.4 per cent of gross domestic product.

2.34 Since the March 2020 Budget[14], the UK Government has also provided emergency additional funding for the NHS and other public services to tackle the pressures on health and social care. This was in addition to the long-term NHS funding settlement announced in 2018, which runs until 2023-24. The latest figures for additional pandemic spending, which were included in the March 2021 Budget document, said that planned additional funding for health and social care amounted to £58.9 billion in 2020-21 and £22.0 billion in 2021-22[15].

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[10] Office for National Statistics (June 2021). *Unemployment: UK unemployment figures. Information on the labour market, young people and workless households.* Available at: https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment

[11] Office for National Statistics (June 2021). *ARN01: Average weekly earnings.* Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/averageweeklyearningsearn01

[12] Income Data Research (26 May 2021). *Median back to 2.0% as proportion of pay freezes continues to fall.* Available at: https://www.incomesdataresearch.co.uk/resources/viewpoint/median-back-to-20-as-proportion-of-pay-freezes-continues-to-fall

[13] XpertHR (May 2021). *Pay awards*. Available at: https://www.xperthr.co.uk/indicators/pay-awards/16100/

[14] HM Treasury (3 March 2020). *Budget 2020.* Available at: https://www.gov.uk/government/publications/budget-2020-documents/budget-2020

[15] HM Treasury (3 March 2020). *Budget 2020: documents,* Table 1.6. Available at: https://www.gov.uk/government/publications/budget-2021-documents

2.35 As part of the Spending Review in November 2020, the Chancellor announced that pay rises in the public sector would be restrained and targeted in 2021-22[16]. The UK Government would continue to provide for pay rises for NHS workers, including the DDRB remit group, and would prioritise the lowest paid, with those earning less than £24,000 receiving a minimum £250 increase. For the rest of the public sector, there would be no pay rises in 2021-22, which they said would allow the government to protect public sector jobs and investment in public services and avoid further expansion of the gap between public and private sector reward.

2.36 DHSC said that COVID-19 had placed a huge strain on both public and NHS finances, and that the economic outlook for 2021-22 remained uncertain and pay awards must be both fair and affordable. They added that, in settling the DHSC and NHS budget, the UK Government had assumed a headline pay award of 1 per cent for NHS staff, and that anything higher would require reprioritisation.

2.37 The Scottish Public Sector Pay Policy was finalised as part of their 2021 Budget process. Its key features were:

- a guaranteed cash underpin of £800 for those earning £25,000 and below
- a 2 per cent headline pay increase for those earning between £25,000 and £40,000
- a 1 per cent headline pay increase for those earning between £40,000 and £80,000
- a capped increase of £800 for those earning above £80,000.

2.38 The Northern Ireland Executive announced their Public Sector Pay Policy in March 2021. The Policy allowed for pay awards of up to 1 per cent, though this limit would not be applied to health service staff groups, with the recommendations of ourselves and NHSPRB to be taken into account when determining pay awards.

2.39 The Welsh Government did not provide us with details of a public sector pay policy.

Our comments on the economy, labour market and public sector finances

2.40 While the economy experienced a severe shock at the start of the pandemic, the general trend is now towards recovery, as restrictions are lifted and parts of the economy are able to return to operating fully. However, this trajectory remains uncertain and highly dependent on the future course of the pandemic, including the extent to which the vaccine programme is able to prevent future outbreaks. As government support schemes are wound down, there is also the potential for increases in unemployment and redundancies.

2.41 We also note that median pay settlements remained at 1.9 per cent for the three months to the end of April 2021, and the currently-strong growth in weekly earnings figures across the public and private sectors, though some of this growth may be driven by compositional effects.

2.42 This contrast between the potential for a significant spike in unemployment, but businesses continuing to offer pay awards, albeit on average smaller awards than last year, is potentially illustrative of both sectoral differences in the impact of the pandemic and the uncertainty and volatility of the ongoing situation more generally.

[16] The Rt Hon Rishi Sunak MP (25 November 2020). *Spending Review 2020*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/938052/SR20_Web_Accessible.pdf

2.43 We recognise what HM Treasury said to us about contrasts in public and private sector earnings, and note that a similar point was made in the remit letter for England. However, as we will discuss in Chapter 10, we believe that data that compares remuneration across the public and private sectors as a whole is of limited use to us, given where both our remit group and their main comparator groups are situated in the overall earnings distribution. We discuss pay comparability for doctors and dentists in this context in Chapter 4.

2.44 We are aware that the latest inflation figures and forecasts are higher than projected at the start of the year. We also note that when the public sector pay policies in England, Scotland and Northern Ireland are compared to the latest inflation forecasts, their proposed uplifts for some public sector workers, particularly those at the higher end of the earnings distribution, are lower than forecast inflation. However, we would also note that the pay policies include specific carve-outs for health and social care staff, including our remit group.

CHAPTER 3: AFFORDABILITY, PRODUCTIVITY AND WORKFORCE PLANNING

Introduction

3.1 This chapter addresses the plans that the different governments and NHS organisations have for their medical and dental workforces, given the opportunities and constraints they face due to their departmental expenditure limits and other funding decisions. We also discuss affordability and productivity, including the governments' spending on temporary staffing.

Plans for the NHS

England

3.2 The *NHS Long Term Plan* (LTP), which covers England[1], was published by NHS England and Improvement (NHSE/I) in January 2019 following the 2018 announcement by the UK Government on increased NHS funding for the following five years, amounting to average real-terms increases of 3.4 per cent per annum. The LTP stemmed from concern around funding, staffing, increasing inequalities, and pressure from a growing and ageing population. It stated that the redesign of patient care must be accelerated to future-proof the NHS for the decade ahead.

3.3 The LTP outlines how the NHS in England plans to transform itself over the ten years from 2018. It sets out a new service model that includes an increased focus on prevention and community and primary care, as well as improving the use of technology and addressing health inequalities.

3.4 The LTP also included a number of actions associated with the NHS workforce, committing to growing both the nursing and medical workforces, as well as improving retention, productivity and leadership. This included a commitment to publish a comprehensive workforce implementation plan by the end of 2019. An interim People Plan was published in June 2019 to cover immediate actions to be taken during the 2019-20 financial year.

3.5 In July 2020, *We are the NHS: People Plan 2020/21 – Action for us all*, a second one-year workforce plan, was published. It said that to address the increasing pressure that staff have felt since the response to the coronavirus (COVID-19) pandemic began, and the further challenges ahead, the NHS needed more people, working differently in a compassionate and inclusive culture. It focused on four themes:

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future

3.6 In the Queen's Speech in May 2021, it was announced that Ministers would bring forward a new NHS Bill, as part of a significant new reorganisation of the NHS in England.

[1] NHS England (7 January 2019). *The NHS Long Term Plan*. Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

3.7 DHSC said that the COVID-19 pandemic had placed greater focus on the need for transformation across the NHS. They said that health and wellbeing was at the core of the People Plan and that it included a new support package for staff, including measures such as helplines, mental health and wellbeing apps and funding to support mental health support for NHS staff.

3.8 They also said that the People Plan ensured that flexible working was being made a priority, and consisted of actions including making all permanent roles offer flexible working patterns, and supporting organisations to implement e-rostering systems.

3.9 They said that it was urgent that the experiences of NHS people from ethnic minority backgrounds were improved. They outlined a number of actions that would improve the culture in the NHS, including appointing a named equalities champion in every NHS organisation and overhauling recruitment and promotion practices to ensure that staffing reflected the diversity of communities and labour markets.

3.10 Finally, they outlined a number of actions they were taking to build on the increased interest in NHS careers that had resulted from COVID-19 to improve recruitment and retention. This included offering more apprenticeships, increasing ethical international recruitment by launching a new health and care visa to make it easier and cheaper for registered health staff to come from overseas, and improving retention of over-55 staff by ensuring that career conversations are had with line managers.

3.11 NHS Providers said that the only sustainable solution to workforce challenges in the NHS was sufficient focus and investment in both staff pay and recruitment and retention, and that a clear, fully costed workforce plan was vital to the future of the NHS.

Scotland

3.12 In December 2019, the Scottish Government published the *An Integrated Health and Social Care Workforce Plan*, which was developed in partnership with the Convention of Scottish Local Authorities, and sets out how health and social care services will meet growing demand and ensure the right numbers of staff, with the right skills, across health and social care services. This was accompanied by updated guidance on workforce planning for Health Boards and Social Care Integration Authorities in Scotland.

3.13 The Scottish Government said that since the start of the COVID-19 pandemic, workforce planning efforts had reoriented to respond to the widespread disruption to models of service delivery. Providers had to stand down some services and respond to intense pressure on other parts of the system, which necessitated rapid retaining and redeployment of staff.

Wales

3.14 In October 2020, Health Education and Improvement Wales and Social Care Wales launched *A Healthier Wales: A Workforce Strategy for Health and Social Care*. The document was intended to support the delivery of the more seamless models of health and care proposed in *A Healthier Wales*: *Our Plan for Health and Social Care*, which was published in 2018. Included in the Strategy was a commitment to develop workforce plans for key professional and occupational groups, including medicine.

Northern Ireland

3.15 The Department of Health told us that implementation of *Health and Social Care Workforce Strategy 2026* was well underway. They said that the key Objectives of the second Action Plan of the strategy, which would cover 2021-2023, were education and training, strategic workforce planning, and the health and wellbeing of the workforce.

Our comments on workforce planning

3.16 We welcome the publication of workforce plans for England and Wales since our last report, and in particular the focus on staff wellbeing, as it is such a critical factor in retention. However, we are deeply concerned that neither plan included assessments of future medical and dental workforce needs, or specific plans about how to ensure that these needs are met. Given the length of time that it takes to train new doctors and dentists, and the potential for changed international labour market dynamics as a result of EU Exit, COVID-19 and other factors, it is crucial that governments and health service organisations take a long-term view as to their workforce needs and act accordingly. The COVID-19 pandemic will have a significant impact on all aspects of workforce planning, and governments must respond to this challenge proactively. We agree with NHS Providers that comprehensive and fully costed long-term workforce plans need to be published to ensure the sustainability of medical and dental workforces across the UK.

Affordability and productivity

Concepts of affordability, productivity and efficiency

3.17 Discussions of NHS plans often make reference to 'productivity', 'efficiency' and 'affordability'. In what follows, we use the term 'productivity' by itself to refer to output per head, not total factor productivity (which measures output for given inputs of all kinds, not just labour inputs). Although productivity is not straightforward to quantify for the NHS, DHSC in England use a measure developed by the University of York based on health output adjusted for quality change, death rates and changes in waiting times. Because staff have a mix of different skills, it will not necessarily rise if fewer staff are used to deliver the same quality and quantity of outputs. But for a given mix of staff skills, a reduction in overall staff numbers will result in a rise in productivity. Productivity can also be increased through capital investment, new working arrangements and new technologies.

3.18 Governments are also concerned about the cash cost of delivering services. 'Cash-releasing' efficiencies arise from reducing the cost of delivering a given quantity and quality of services. This was the focus of Lord Carter's 2015 review of efficiency in hospitals[2], which looked at the 136 acute Trusts in England and concluded that £5 billion of savings could be made if 'unwarranted variation' was removed.

3.19 For the economy as a whole, output-per-head productivity is the key determinant of average living standards. But for any sector, the 'affordability' of a pay settlement is also driven by other factors affecting the demand and supply for its output. In the case of public health services, the level of services is limited by politically determined budgets and the costs of inputs as well as by productivity. Within a given budget, technologies, efficiencies, and staff mix, there is then a trade-off between real pay and overall employment: higher pay is affordable with lower staff numbers and higher output-per-head productivity.

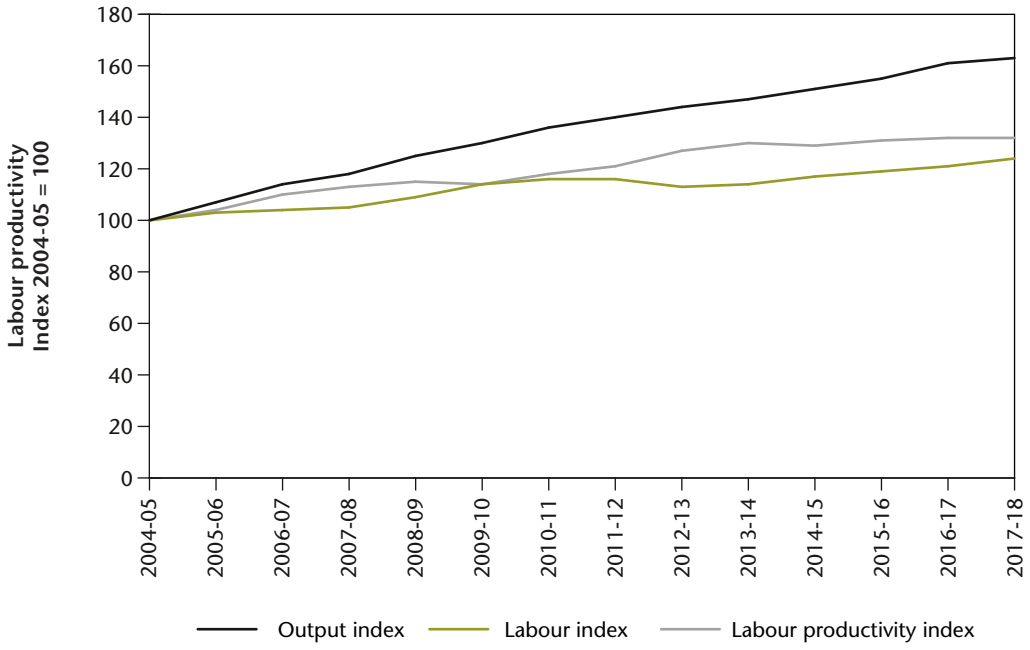
3.20 That said, it is possible that pay policies intended to lower costs can result in a less effective or efficient staff mix. For example, if retention is worsened as a result of lower pay and employers become more reliant on more expensive agency work as a result, the budgetary benefit of lower pay can be undermined.

[2] Department of Health and Social Care (11 June 2015). *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*. Available at: https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

England

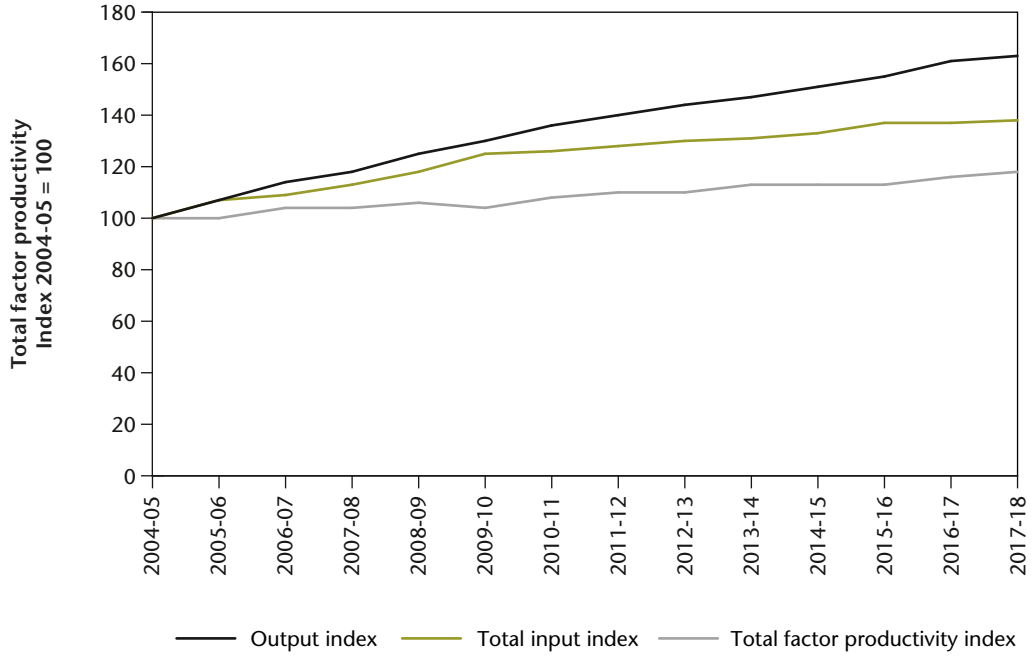
3.21 DHSC included information about productivity growth in their written evidence submission, which covered the period from 2005-06 to 2017-18. They showed that labour productivity grew by 0.8 per cent per year on average over the five years to 2017-18, and by 2.1 per cent between 2004-05 and 2017-18 (Figure 3.1). The measure of total factor productivity developed by the University of York, which considers output growth and takes into account all the inputs into the NHS, including the composition of the workforce, showed average annual growth of 1.3 per cent between 2004-05 and 2017-18 (Figure 3.2).

Figure 3.1: Output-per-head productivity in the NHS, England, 2004-05 to 2017-18



Source: DHSC.

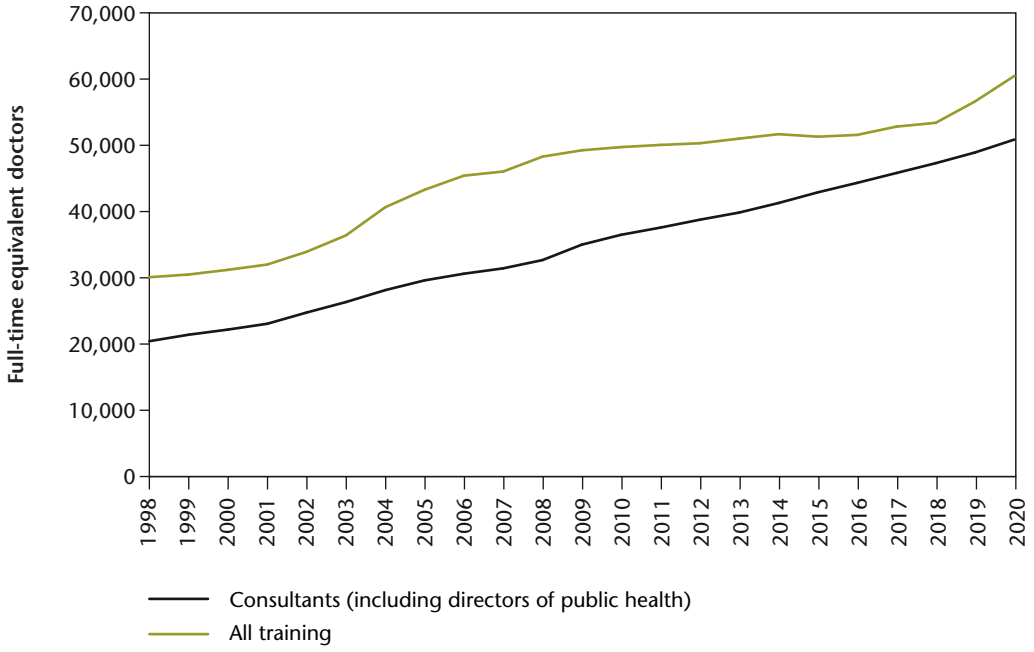
Figure 3.2: Total factor productivity in the NHS, England, 2004-05 to 2017-18



Source: DHSC.

3.22 Figure 3.3 shows the numbers of Hospital and Community Health Service (HCHS) doctors in England between 1998 and 2020. The number of doctors in training (including F1, F2 and Registrars) rose by 60 per cent between 1998 and 2008 and by 25 per cent between 2008 and 2020. This represented a growth rate of 3 per cent per annum over the period as a whole. Consultant numbers also rose by 60 per cent between 1998 and 2008 and by more than 50 per cent between 2008 and 2020, representing a growth rate of more than 4 per cent per annum over the period as a whole. This growth, outpacing the growth in output and in employment in the NHS overall, reflects the shift in emphasis from a consultant-led service towards a more consultant-provided service over recent decades.

Figure 3.3: Hospital and Community Health Service (HCHS) medical workforce, England, 1998-2020



Source: NHS Digital.

3.23 DHSC also said that COVID-19 made improving productivity more important than ever, since improved efficiency would be needed to deal with increased waiting lists and to ensure that patients can be treated while infection control measures remained in place.

3.24 NHSE/I said that one of the five financial tests that underpinned the NHS Long Term Plan was that the NHS would achieve cash-releasing productivity growth of at least 1.1 per cent per year. They also said that the pandemic response had impacted on NHS costs and activity. They said that the NHS People Plan 2020-21 described how staff can be supported to work more productively, including by increasing flexibility and remote and virtual working. They also described a number of other areas where they were supporting the NHS workforce to improve efficiency, including e-rostering and e-prescribing, offering streamlined digital pathways for outpatients and medicine optimisation.

3.25 DHSC said that, in setting the DHSC and NHS budget, the government assumed a headline pay award of 1 per cent for NHS staff, and anything higher than this would require reprioritisation. This figure had been revised downwards compared to the 2 per cent pre-pandemic pay growth assumptions that were included in NHS financial planning[3]. They said that this was as a result of the pandemic leading to missed productivity growth, and that this needed to be counterbalanced in pay so that wider workforce pressures could be addressed.

3.26 Both NHS Employers and NHS Providers said that it was important that fair investment in pay and reward took place to recognise the contribution of staff, but that it was also important that this did not take place at the expense of other priorities, including improving workforce supply. They stressed the importance of any pay award being appropriately funded in order that there would not be a negative impact on service provision.

[3] NHS England and Improvement (3 March 2020). *Submission to the Review Body on Doctors' and Dentists' Remuneration*, Para 30. Available at: https://www.england.nhs.uk/publication/submission-to-the-review-body-on-doctors-and-dentists-remuneration/

Scotland

3.27 The Scottish Government said that the 2021-22 Draft Scottish Budget increased investment in health and care budgets by over £800 million, and would be over £16 billion for the first time. They said that Health Boards would receive a baseline uplift of 1.5 per cent, with another £596 million invested in improving patient outcomes. They said that this was alongside non-recurring additional funding of £869 million for 2021-22 to support the ongoing response to the pandemic. They said that, when considering affordability for medical and dental pay awards, the DDRB should view the Scottish Public Sector Pay Policy[4] as an anchor rather than an absolute position, and they would not want to see doctors and dentists in Scotland disadvantaged compared to their counterparts in the rest of the UK.

Wales

3.28 The Welsh Government said that they were providing more than £385 million of extra funding for core NHS services, taking total NHS funding in 2021-22 to more than £8.4 billion. They said that Boards already had funding for a 1 per cent increase for doctors and dentists in their allocations for 2020-21, and more money could potentially be available to fund a larger award.

Northern Ireland

3.29 The Department of Health's non-ringfenced resource budget grew by 4.7 per cent, to £6.45 billion, for 2021-22. They told us that plans had been made on the basis of 2 per cent pay growth for their medical and dental workforces and that therefore an award of 2 per cent was affordable, and that a higher award than this would require additional funding from the Department of Finance.

Our comments on affordability and productivity

3.30 Improving productivity remains a key challenge for health service leaders and represents an important part of ensuring that demand growth in health services can continue to be met. While the COVID-19 pandemic may have interrupted some of the ongoing long-term efforts to improve productivity, it has also presented new opportunities, particularly in the increased use of digital technology. We look forward to hearing from the parties next year about this, and how the experience of the pandemic can be built on, including in improving health services' emergency preparedness.

3.31 We have seen no evidence from the parties to suggest that the long-term productivity growth trajectory cannot be maintained after the pandemic. And given what the Chancellor has said about the NHS receiving all it needs to respond to the COVID-19 pandemic, we believe that funding should not be diverted away from previously-planned pay growth in order to counteract the pandemic's short-term impact on productivity, given the potential impact on recruitment, retention and motivation, which we discuss elsewhere in the report. We also do not consider that depressing pay growth is necessary to support workforce growth in the current circumstances. We believe that viewing these factors as in direct competition is an oversimplification that does not take into account a number of factors, including the impact of staffing on motivation and retention, and on locum spend, which we discuss below.

[4] We discuss the Scottish Public Sector Pay Policy in Chapter 2.

3.32 We note what DHSC said about any award higher than 1 per cent requiring reprioritisation but, particularly in the context of additional spending for the NHS to address the pandemic, the extent to which the short-term affordability of pay awards is affected relative to pre-pandemic assumptions represents a choice that is to be made by governments. While we understand the impact the pandemic has had on the fiscal and economic position in general and NHS finances in particular, especially in the current context of economic recovery driving improvements to the overall fiscal position, we do not view the 1 per cent affordability envelope presented to us by the UK Government as a limit on what our recommendations can be for England. We similarly do not view the Scottish Public Sector Pay Policy or the 2 per cent that the Department of Health (Northern Ireland) said they had budgeted for pay awards as limits on what our recommendations can be for Scotland and Northern Ireland. We would expect that pay awards would be appropriately funded so that there would not be a negative impact on service provision.

3.33 Given the similar course taken by the pandemic and the responses to it in all four nations, presenting largely the same challenges while affording largely the same opportunities, and the consequentials under the Barnett formula of the additional funding provided by the UK Government to the NHS in England, we view the dynamics of affordability and productivity this year as generally the same in Scotland, Wales and Northern Ireland. However, we note that Trusts and health boards across the UK have different efficiency targets and priorities.

Spending on locums, agency and bank staff

England

3.34 DHSC said that since April 2017 agency costs had been consistently below 5 per cent of overall pay costs, falling to 4.0 per cent in 2019-20. They said that while the number of agency shifts had increased by 0.5 per cent from 2018-19 to 2019-20, the average price per shift fell by 1.3 per cent, resulting in an overall saving of £19 million. They added that there had been a reduction in agency shifts during the first wave of COVID-19.

3.35 NHSE/I said that the NHS had made progress in improving the value for money gained from its agency spend in recent years. They said that while a certain level of agency spend was healthy to ensure flexible staffing and meet fluctuations in demand, the People Plan includes measures to improve the quality and value for money gained from temporary staffing. They said that during the first five months of 2020-21, Trusts' agency spend was 10 per cent lower than in the same period in 2019-20. They also said that during the first part of 2020-21, for the first time, there were more medical bank shifts worked in the NHS than agency.

Scotland

3.36 Data from NHS Education for Scotland showed that medical agency locum spend was £102.9 million in 2019-20. After increasing sharply in both 2015-16 and 2016-17, agency spend fell in both 2017-18 and 2018-19, but increased by 5 per cent between 2018-19 and 2019-20.

Wales

3.37 The Welsh Government said that due to the pandemic, their programme of work to address the deployment of temporary staff in the NHS had been paused, and a pragmatic approach was taken to ensure NHS organisations were sufficiently staffed to meet the acute demands of the pandemic. Agency and locum spending on medical and dental staff was £60.6 million in 2019-20, and was forecast to be £58.2 million in 2020-21.

Northern Ireland

3.38 Data from the Department of Health showed that agency spend in 2019-20 on medical and dental staff was £95.3 million. This was an increase, of 10 per cent, from £86.7 million in 2018-19. The Department said that increasing costs were due to the current configuration of services and that changing the model of care was the only solution, though they said they were working with HSC employers and trade union colleagues on detailed proposals to reduce agency and locum spend.

Our comments on spending on locums, agency and bank staff

3.39 We welcome the increased use of bank staff compared to the overall use of agency staff, and that the total agency spend in England is decreasing. However, the figures for Scotland and Northern Ireland are concerning, with both showing increased spend in 2019-20 compared to 2018-19. The trends in Northern Ireland are a particular concern, given that relative to the size of their medical and dental workforces, locum spend in Northern Ireland was already significantly higher than the rest of the UK.

3.40 The increased number of locum shifts procured in England, despite the decreased overall spend, may also suggest that staffing issues are worsening, and this increased demand may in the long term lead to more upward pressure on locum pay. It may also be associated with issues of retention for doctors and dentists in training, as those who have temporarily stepped out of training take on locum work. The potential for the pandemic to impact recruitment and retention, and the major treatment backlogs that have arisen from the pandemic, mean that it is ever more crucial that health services have their baseline spending on temporary staffing under control.

3.41 We look forward to seeing how the various stages of the pandemic affected demand for temporary staffing, and why, in evidence from parties next year. We would also welcome hearing what lessons can be learned from the transformations that took place to services and how they were delivered as a result of the pandemic in the context of temporary staffing.

CHAPTER 4: PAY, MOTIVATION AND WORKFORCE SUPPLY

Introduction

4.1 In this chapter, we consider how doctors' and dentists' pay has changed over time in England (equivalent data are not available for the other countries in the UK). We also consider how doctors' and dentists' pay compares with the distribution of pay across the whole UK economy, and how it compares to the private sector and to comparator groups. Whilst examining these trends is not an explicit part of our remit, it is important to monitor them because they can have an impact on recruitment, retention and motivation.

4.2 We also discuss pensions, and comment on workforce motivation and the consequences for workforce supply of retirement trends and outflows and inflows of international doctors and dentists. Finally, we discuss issues of equal pay and other equalities issues, which have come to the fore this year as a result of the coronavirus (COVID-19) pandemic and the publication of the Independent Review on Gender Pay Gaps in Medicine in England.

The pay position

4.3 In this section, we compare the earnings of doctors and dentists to various points on the overall UK income distribution, before comparing earnings with a number of comparator professions in the next section, Pay comparability with other professions.

4.4 Tables 4.1 and 4.2 and Figures 4.1 to 4.12 show how the average (mean) total earnings of various staff groups compare to the median, upper quartile, 90th, 95th, 97th and 98th percentiles of full-time employees' (FTE) earnings in the wider economy, since 2010-11, based on data from the Annual Survey of Hours and Earnings (ASHE).

4.5 Until our 2018 report, the calculations for Hospital and Community Health Service staff were based on the NHS Digital mean annual basic pay per FTE, added to the mean annual non-basic pay per head. However, in 2019 we also used a second estimate, which adjusted the non-basic pay per head data by a factor that reflected the ratio between FTE and headcount estimates of basic pay before adding to the FTE estimate of basic pay. In our 2019 report we said that we believed this second estimate was a more appropriate comparator to the ASHE data, which is based on the total earnings of full-time employees. A new earnings estimate for GMPs was also introduced, which adjusted the data published by NHS Digital on a headcount basis by a factor that reflected the ratio of the number of GMPs on a headcount basis to the number of GMPs on an FTE basis. The calculations in this section are based on the adjusted earnings estimates introduced in 2019, unless stated otherwise. For the first time, we have also introduced a new earnings estimate for GDPs, which adjusts the headcount data published by NHS Digital for each of the four UK countries, by factors that reflect the average weekly number of hours worked, as reported in the survey of Dentists' Working Patterns, Motivation and Morale published by NHS Digital[1].

4.6 Tables 4.1 and 4.2 show the percentile position of adjusted mean total earnings for various staff groups compared with the national full-time earnings distribution[2], from 2010-11 to 2019-20, as set out by ASHE. For example, for consultants in 2010-11, their average total earnings fell between the 98th-99th percentiles of annual earnings for full-time employees in the wider economy, so is listed as 99.

[1] NHS Digital (27 August 2020). *Dentists' Working Patterns, Motivation and Morale.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours

[2] Those with the lowest earnings are in percentile 1, percentile 2 etc. Those with the largest earnings are in percentile 98, percentile 99, etc.

Table 4.1: Percentile Position of doctors' average earnings in England by grade, 2010-11 to 2019-20

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	Change from 10-11
Consultants	99	99	99	99	99	99	99	99	99	99	0
Associate Specialist	98	98	98	98	98	98	98	98	98	98	0
Speciality Doctor	96	95	95	96	96	95	95	95	95	95	-1
Registrars	93	92	92	92	92	91	91	91	91	90	-3
Core training	88	88	87	87	87	86	86	86	86	86	-2
Foundation 1	66	65	64	64	64	63	63	63	61	59	-5
Foundation 2	80	79	78	78	78	76	76	75	74	73	-7
GMP Provider	99	99	99	99	99	99	99	99	99	-	0
GMP salaried	97	97	97	97	97	97	97	97	97	-	0

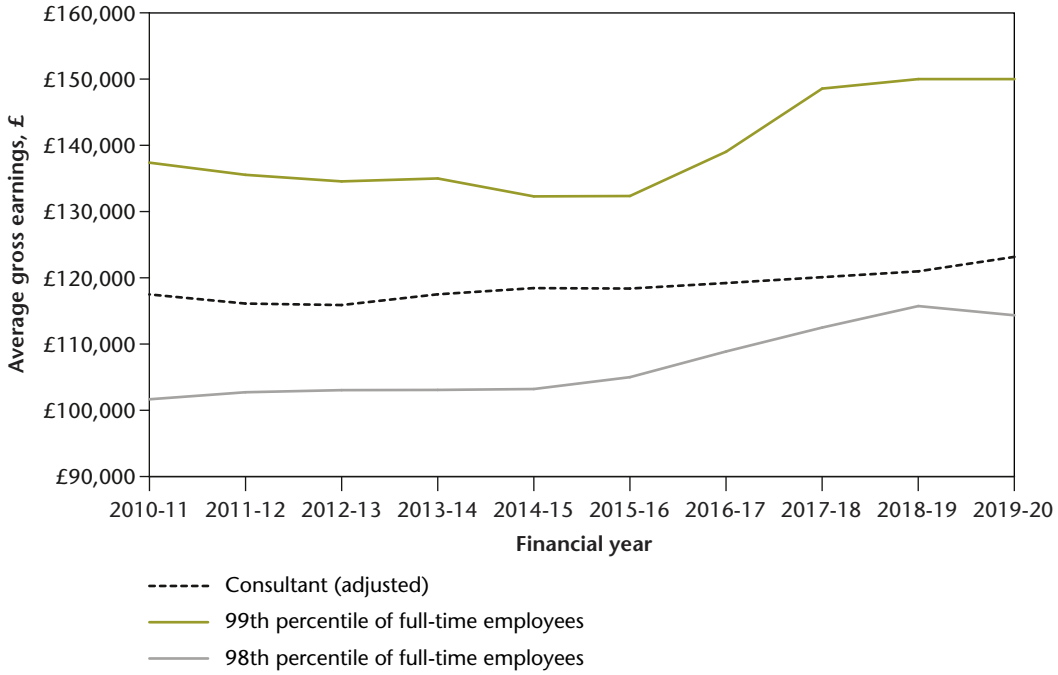
Table 4.2: Percentile Position of dentists' average earnings in England, Scotland, Wales, Northern Ireland, 2010-11 to 2019-20

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	Change from 10-11
GDP provider-performer											
England								98	98		
Scotland	98	98	97	97	98	98	98	97	98	-	0
Wales									96	-	
Northern Ireland	98	98	98	98	98	98	97	98	97	-	-1
GDP associates											
England								90	91	-	
Scotland	95	94	93	92	92	91	91	90	90	-	-5
Wales									91	-	
Northern Ireland	95	93	93	93	93	92	93	90	92	-	-3

Source: OME analysis of data from NHS digital and ONS. Published earnings data adjusted by average hours worked from Dentists' Working Patterns, Morale and Motivation survey.

4.7 Figure 4.1 shows that for consultants, since 2010-11, average total earnings have been consistently between the 98th and 99th percentiles of FTE earnings in the wider economy, although since 2015-16 consultant average earnings have fallen back from the 99th percentile and down towards the 98th percentile. Some part of this change will reflect the fact that the size of the consultant workforce has grown consistently over the recent past. As a result of recruitment at more junior levels exceeding outflow from more senior levels, a larger share of the workforce is being paid towards the lower end of the consultant pay scale, depressing the average earnings figures.

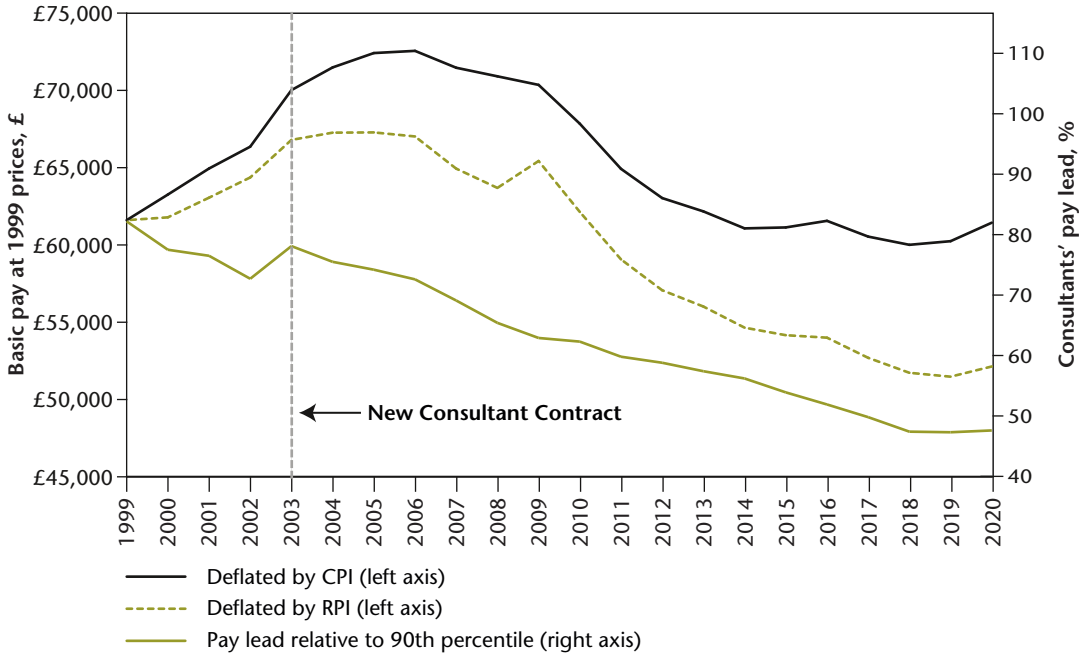
Figure 4.1: Average gross NHS earnings of consultants in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20



Source: OME estimates, based on data from NHS Digital, ONS.

4.8 Looking at the value of the 5th point on the consultants pay scale is helpful, as it is not affected by the changing composition of the consultant workforce, but relates only to basic pay. Compared with CPI inflation, the value of this pay point increased between 1999 and 2006 and then decreased until 2014, where it reached roughly the same value as in 1999. In 2020 this pay point was in line with its 1999 value and 13 per cent below the level in 2008 (Figure 4.2). By contrast, real average regular earnings (i.e., excluding bonus pay) across the economy as a whole fell by 5 per cent between 2008 and 2014, before recovering to be 1 per cent above 2008 levels in 2020. Compared with average earnings at the 90th percentile, the value of the 5th point on the consultants pay scale lost value between 2003 and 2018, but has retained its value between 2018 and 2020.

Figure 4.2: Change in the value of the 5th point on the consultants' pay scale, in real terms and as compared to 90th percentile earnings, England, 1999 to 2020

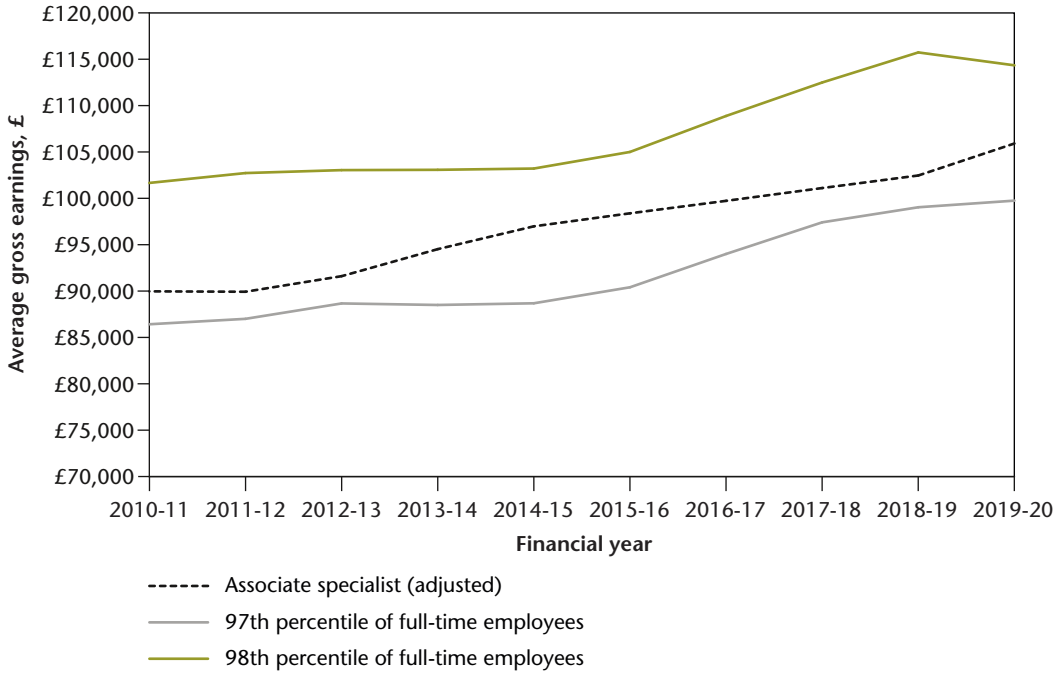


Source: OME estimates, based on data from NHS Digital, ONS.

4.9 Figure 4.3 shows that associate specialists' average total earnings have been consistently between the 97th and 98th percentile in the wider economy. After falling back towards the 97th percentiles between 2015-16 and 2018-19 associate specialists' average earnings moved closer to the 98th percentile in 2019-20.

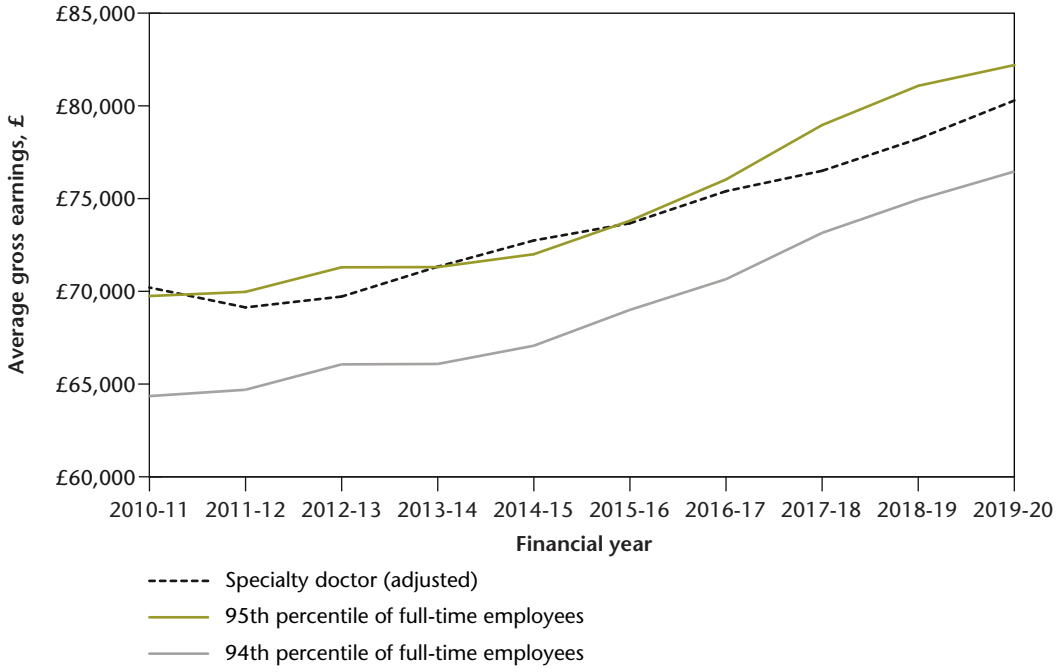
4.10 Figure 4.4 shows that average total earnings for specialty doctors were broadly in line with earnings at the 95th percentile between 2010-11 and 2015-16 before falling back in 2016-17 and 2017-18.

Figure 4.3: Average gross earnings of associate specialists in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20



Source: OME estimates, based on data from NHS Digital, ONS.

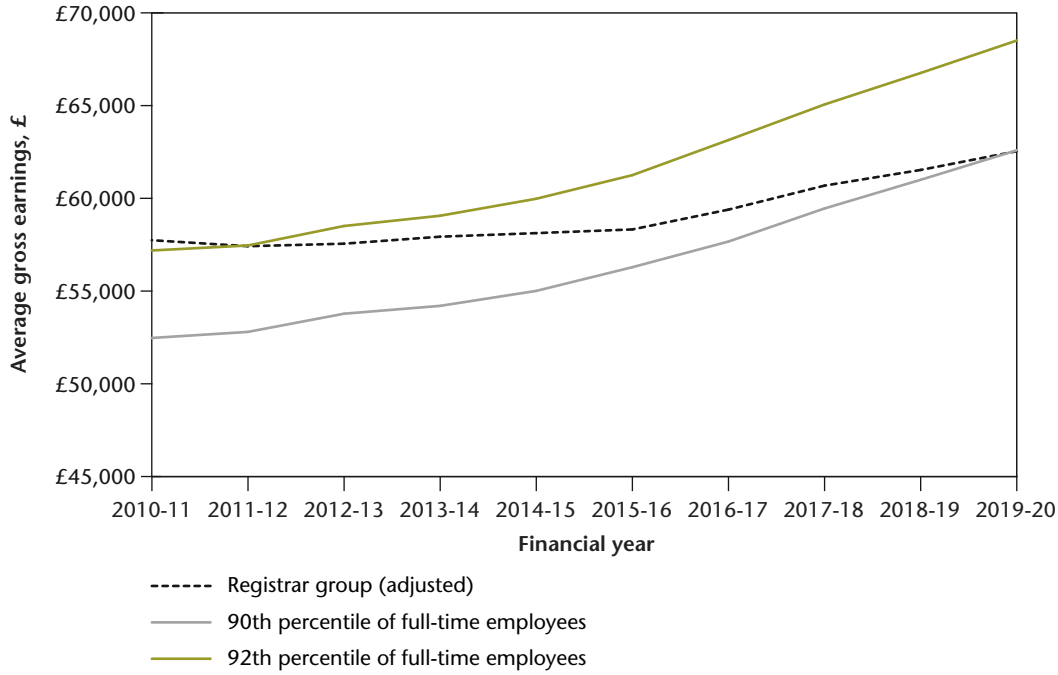
Figure 4.4: Average gross earnings of specialty doctors in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20



Source: OME estimates, based on data from NHS Digital, ONS.

4.11 Figure 4.5 shows that average total earnings of the registrar group were just above the 92nd percentile in 2010-11. However, by 2019-20 average earnings of the registrar group had fallen back in line with those of the 90th percentile.

Figure 4.5: Average gross earnings of the registrar group in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20

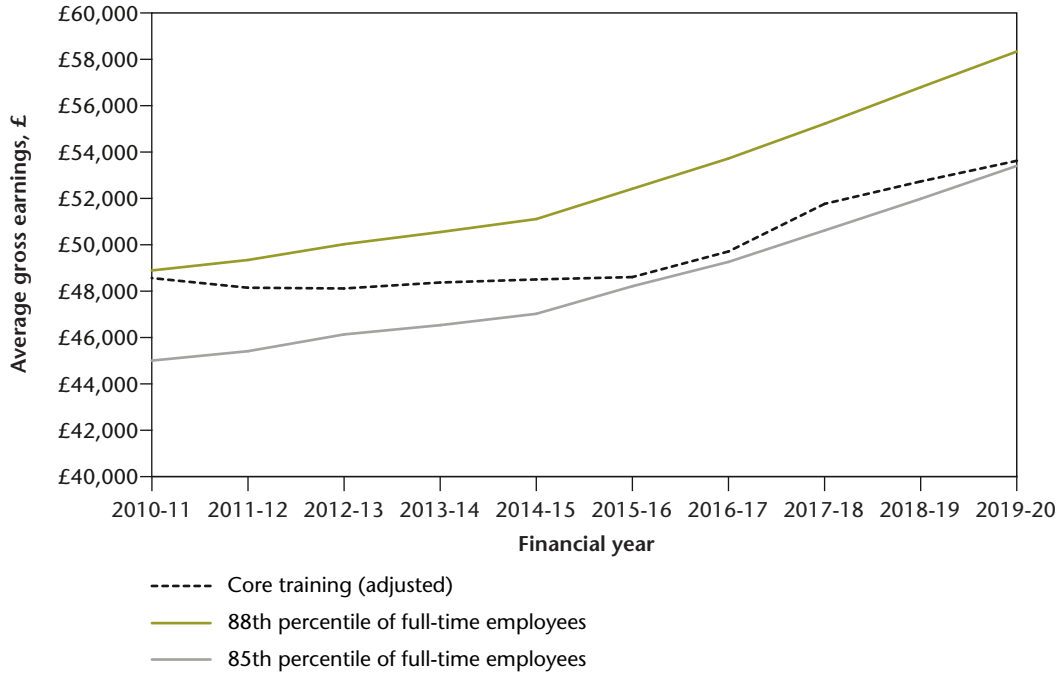


Source: OME estimates, based on data from NHS Digital, ONS.

4.12 Figure 4.6 shows that average total earnings of those in core training fell back from the 88th percentile in 2010-11 to the 85th percentile in 2015-16, and have maintained that relative position since.

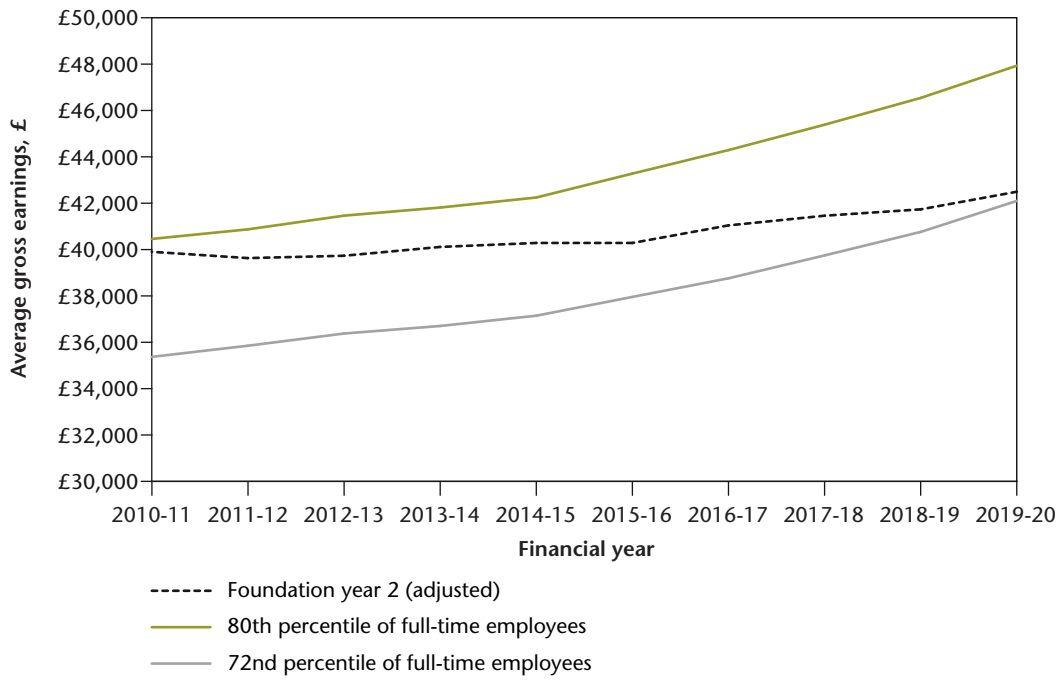
4.13 Figure 4.7 shows that average total earnings for those in the second year of foundation training fell back from just below the 80th percentile in 2010-11 to just ahead of the 72nd percentile by 2019-20.

Figure 4.6: Average gross earnings of those in core training in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20



Source: OME estimates, based on data from NHS Digital, ONS.

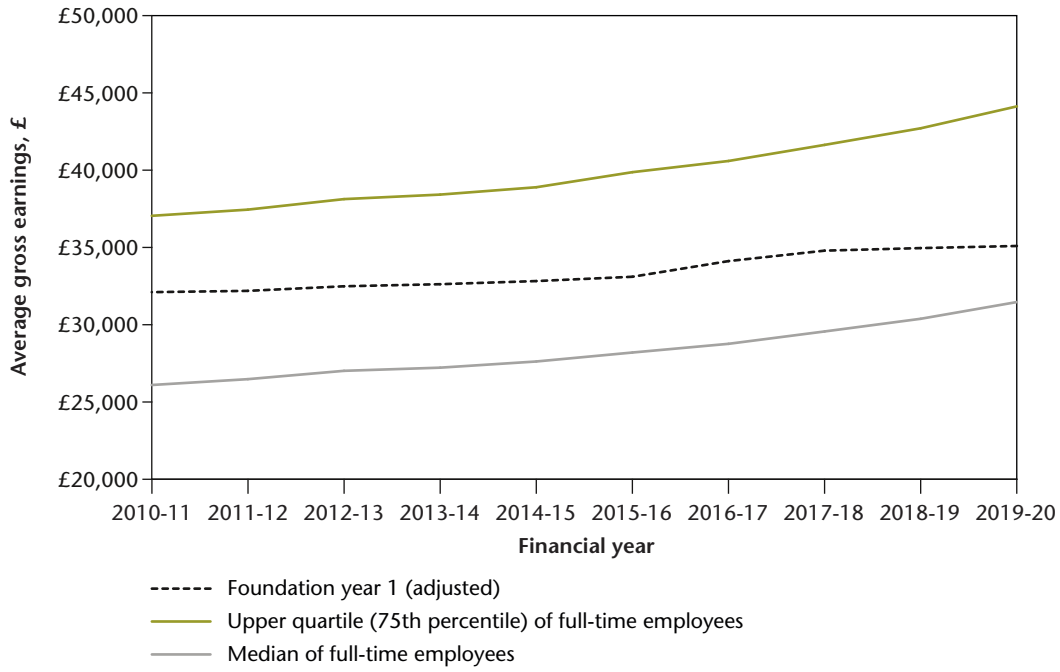
Figure 4.7: Average gross earnings of foundation year 2 trainees in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20



Source: OME estimates, based on data from NHS Digital, ONS.

4.14 Figure 4.8 shows that, for those in the first year of foundation training, between 2010-11 and 2019-20, average earnings remained between the median and the upper quartile of earnings across the economy as a whole, although falling away from the upper quartile and towards the median.

Figure 4.8: Average gross earnings of foundation year 1 trainees in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20

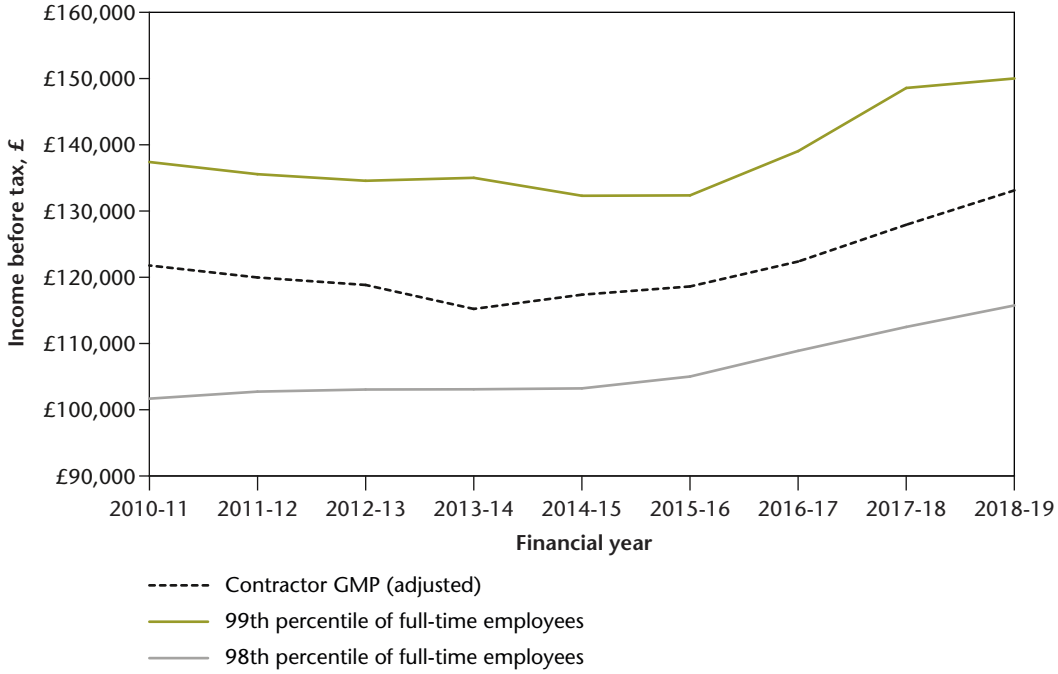


Source: OME estimates, based on data from NHS Digital, ONS.

4.15 Figure 4.9 shows contractor GMP earnings consistently between the 98th and 99th percentiles of earnings for the economy as a whole. Contractor GMP earnings fell back towards the 98th percentile between 2010-11 and 2013-14, but regained some ground against the 98th percentile since that date.

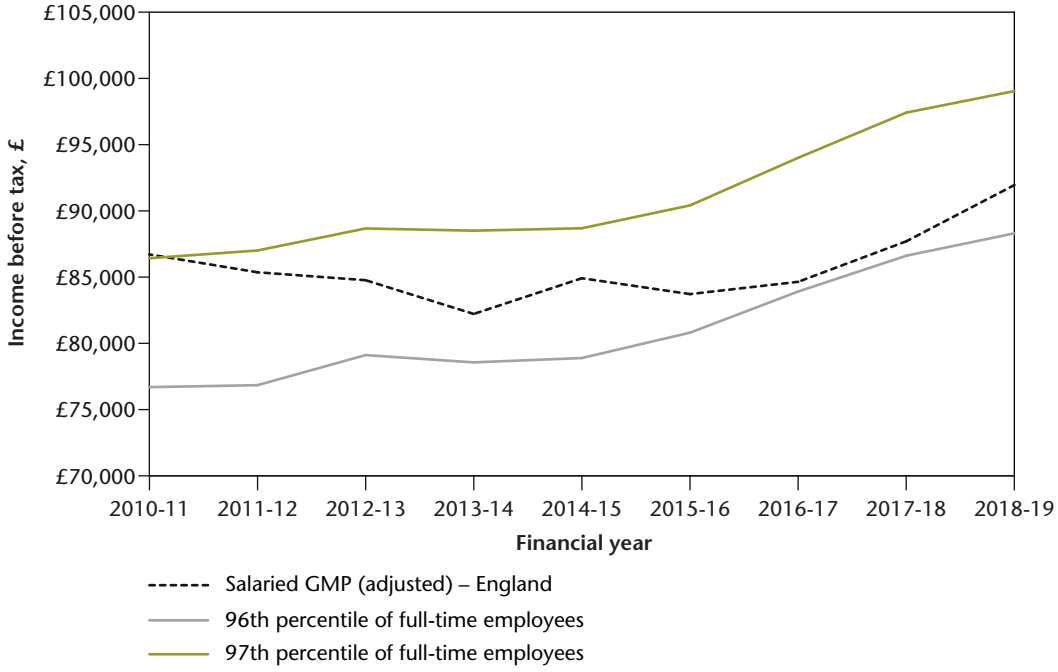
4.16 Figure 4.10 shows in 2010-11 salaried GMP earnings were in line with those of the 97th percentile, but had fallen back to the 96th percentile by 2016-17, before regaining some ground on the 97th percentile in 2018-19.

Figure 4.9: Average income before tax of contractor GMPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



Source: OME estimates, based on data from NHS Digital, ONS.

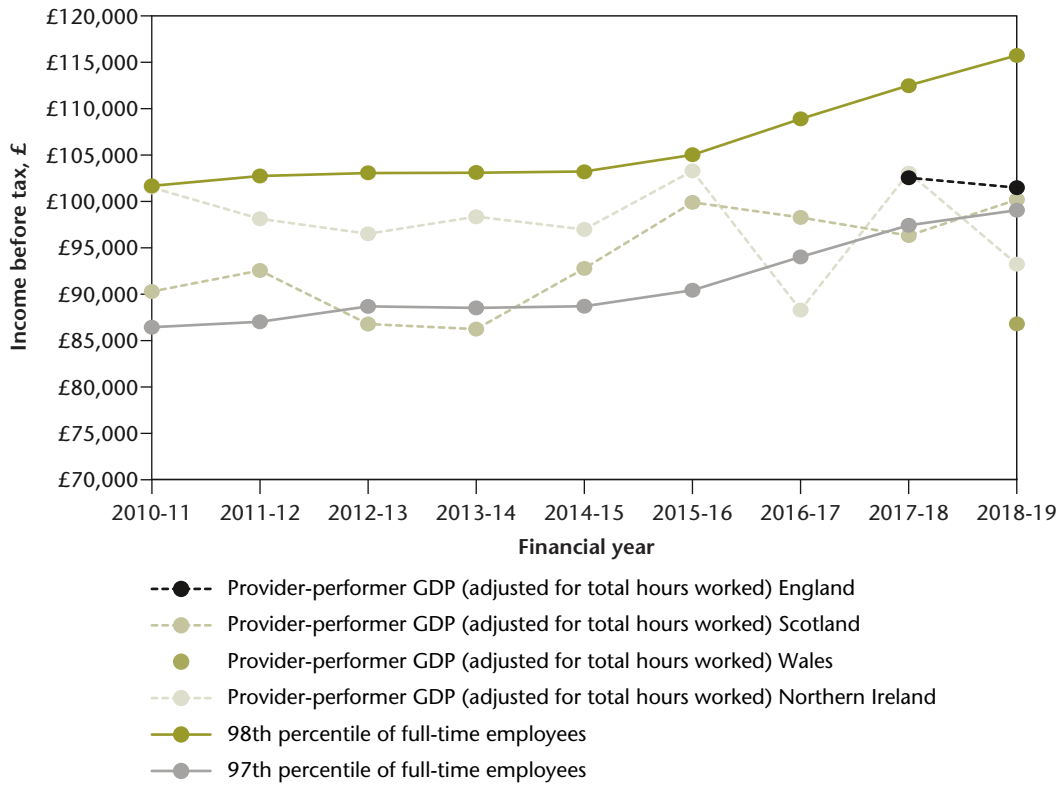
Figure 4.10: Average income before tax of salaried GMPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



Source: OME estimates, based on data from NHS Digital, ONS.

4.17 Figure 4.11 shows in 2010-11 adjusted providing-performer GDP earnings in Scotland and Northern Ireland were between the 97th and 98th percentiles in the wider economy. In 2018-19, adjusted providing-performer GDP earnings were between the 97th and 98th percentiles in England and Scotland, between the 96th and 97th percentiles in Northern Ireland, and between the 95th and 96th percentiles in Wales. These figures also include non-NHS income.

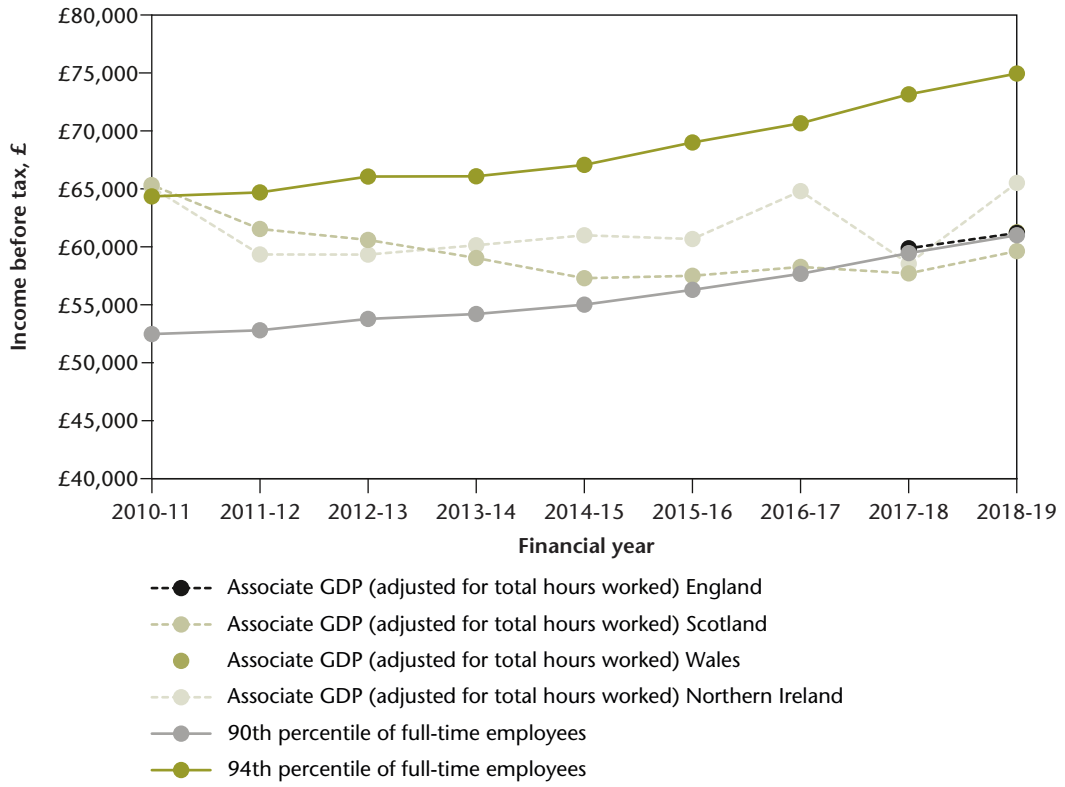
Figure 4.11: Average income before tax of providing-performer GDPs in England, Scotland, Wales, Northern Ireland, adjusted for average weekly hours worked, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



Source: OME estimates, based on data from NHS Digital, ONS.

4.18 Figure 4.12 shows in 2010-11 adjusted associate GDP earnings in Scotland and Northern Ireland were just above the 94th percentile in the wider economy. In 2018-19, adjusted associate GDP earnings were between the 91st and 92nd percentiles in Northern Ireland, between the 90th and 91st percentiles in England and Wales, and between the 89th and 90th percentiles in Scotland. These figures also include non-NHS income.

Figure 4.12: Average income before tax of associate GDPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



Source: OME estimates, based on data from NHS Digital, ONS.

4.19 The BMA said that, since 2008, doctors had experienced a pay freeze followed by a cap on pay awards and that during this period inflation measures had been higher, resulting in some consultants experiencing a near-30 per cent fall in real-terms take-home pay.

4.20 HCSA said the long-term decline of hospital doctors' pay remains sizeable based on historical comparisons. They said that this year's pay award must take into account continued recognition of the legacy issues of corrosive pay erosion which have caused a long-term impact on morale and the perceived value of the profession.

4.21 The BDA said that the UK gross spending on dentistry had fallen dramatically when taking into account the effects of inflation. They said that both practice owners and associates had faced significant erosion in pay that needed to be addressed urgently.

Pay comparability with other professions

4.22 Although pay comparability with other professions does not form an explicit part of our terms of reference, we believe it is important to assess the pay position of our remit group relative to other groups that could be considered appropriate comparator professions. Changes in pay, relative to earnings, may feed through to impact on our terms of reference in areas such as recruitment, retention and the motivation of staff.

4.23 In 2017 the Institute for Employment Studies reviewed the DDRB pay comparability methodology[3] which had previously been reviewed in 2008 by the PA consulting group. Following the 2017 review, the same anchor points (i.e., job weights) used in previous reports were used, while vets and roles in higher education were added to the previous set of professions (actuarial, legal, tax and accounting, pharmaceuticals).

[3] Institute for Employment Studies (15 August 2017). *Review of DDRB Pay Comparability Methodology 2017.* Available at: https://www.gov.uk/government/publications/review-of-ddrb-pay-comparability-methodology-2017

4.24 Figure 4.13 compares the pay distributions for doctors and dentists of different grades to those for comparator professions. It is important to note that in this section the pay for other professions is on a full-time equivalent (FTE) basis, whereas that for doctors and dentists is the average for those working both full and part time, and so may be lower than it would be on an FTE basis. Levels of job security and progression to more senior roles also differ between professions.

- Median total earnings for foundation doctors in their first year were higher than those for vets who had just qualified, and for trainee lecturers. However, they were lower than for the other comparator groups.
- Median earnings for foundation doctors in their second year were higher than those for lecturers, vets and legal, similar to those of tax and accounting and lower than actuarial and pharmaceutical.
- Registrars' and specialty doctors' median earnings were both higher than for academic and veterinary comparators, but lower than for actuarial, pharmaceutical and legal groups. Registrars' median earnings were below those of tax and accounting comparators, while median earnings for specialty doctors were in line with median earnings for this comparator group.
- Median earnings for associate specialists were lower than for actuarial, tax and accounting, pharmaceutical and legal groups, but higher than for academic and veterinary comparators.
- Consultants' median earnings were above the median earnings for vets and higher education academics, but substantially lower than for tax and accounting, legal, pharmaceutical and actuarial groups.
- Median earnings for both contractor GMPs and providing-performer GDPs in England were higher than median earnings for vets, but less than for actuarial, legal, tax and accounting and pharmaceutical groups.
- Both associate GDPs and salaried GMPs had earnings higher than vets, but lower earnings than actuarial, pharmaceutical, legal, tax and accounting groups.

Figure 4.13: Total earnings inter-quartile ranges of DDRB grades, (England), compared with professional comparator groups, full-time rates, 2020

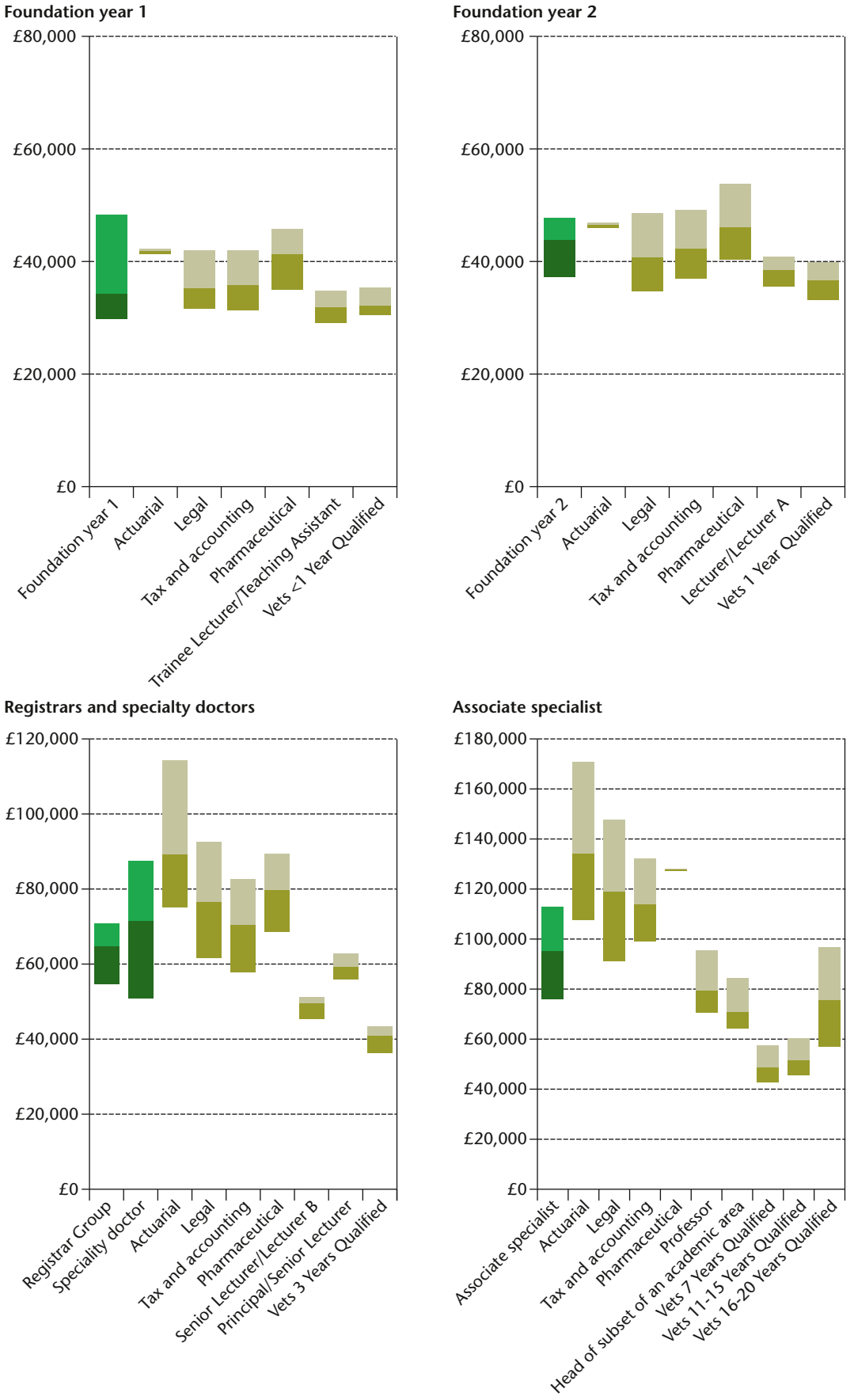
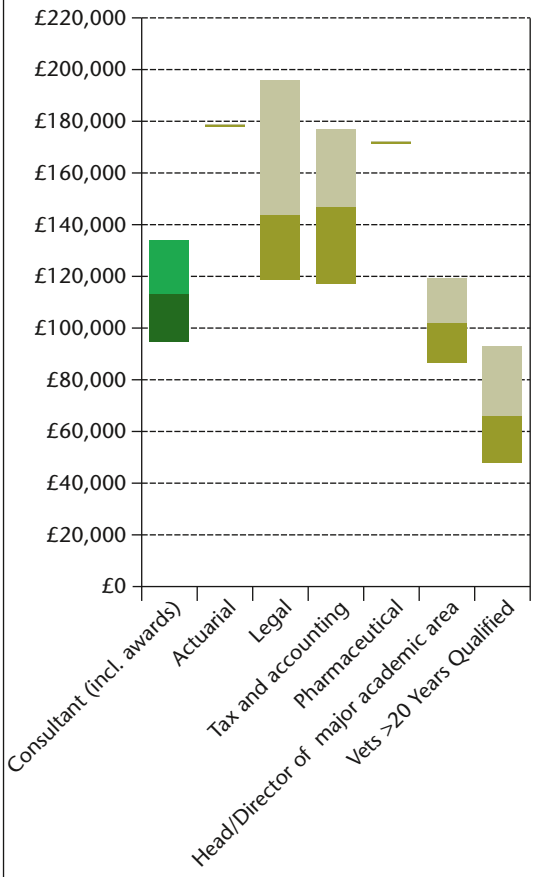
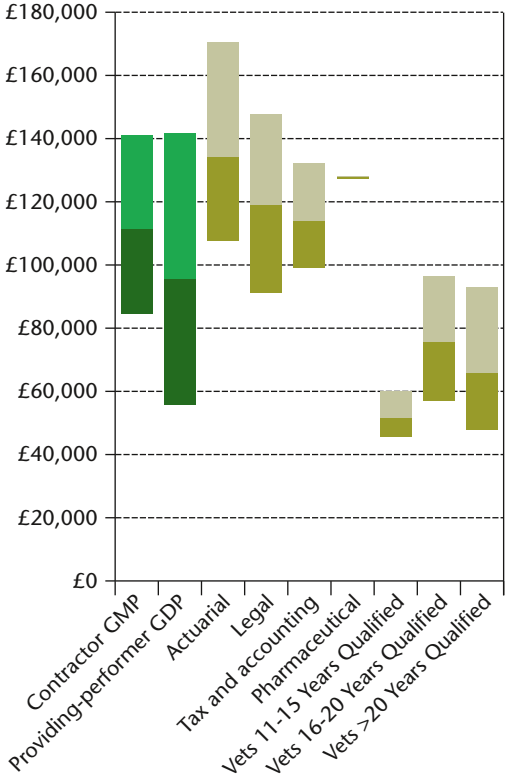


Figure 4.13 (continued): Total earnings inter-quartile ranges of DDRB grades, (England), compared with professional comparator groups, full-time rates, 2020

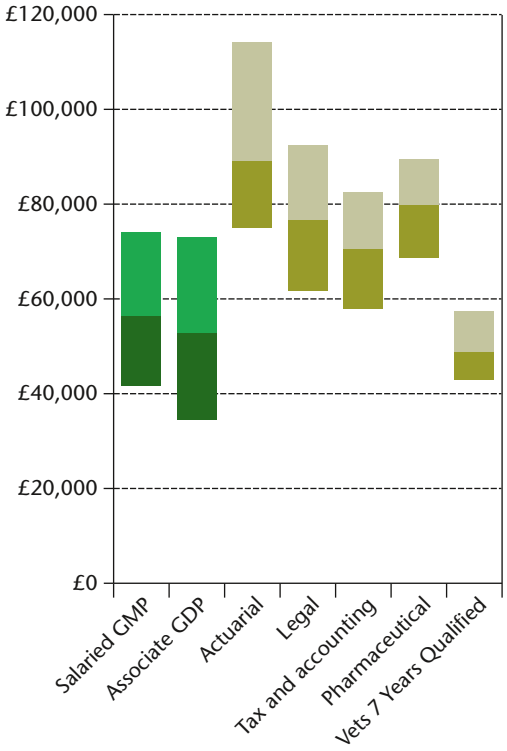
Consultant



Contractor GMP, providing-performer GDP



Salaried GMP, associate GDP



Pensions and pensions taxation

4.25 While pensions and pensions taxation are outside the remit of the review body, pensions taxation has been raised as a key issue in relation to the reward package for doctors and dentists. In recent years changes to the annual and lifetime pensions allowances have been cited by the parties as significant factors affecting retention of the most senior doctors and dentists.

4.26 While the announcement in the 2020 Budget that the threshold at which the annual allowance taper is applied simplified the situation for the majority of doctors and dentists, which we welcomed in last year's report, it was announced in the 2021 Budget that the lifetime pensions allowance would be frozen at £1.07 million until 2025-26.

4.27 Separately, DHSC said that they had commissioned the NHS Pension Scheme's Scheme Advisory Board (SAB) to review member contributions to the NHS Pension Scheme in England and Wales. They said that the SAB had concluded that a move to assessing contributions based on actual earnings (rather than full-time equivalent earnings) was appropriate, and recognised that further discussions were needed to address cliff edges in member contribution tiers.

4.28 They also said that work was underway to remedy pensions schemes in light of the McCloud and Sargeant judgement that the transitional protection arrangements that were awarded to members of final salary schemes gave rise to unlawful discrimination, and that a consultation on options to remove the discrimination was published in July 2020.

4.29 DHSC said that the NHS Pension Scheme remained a generous pension for doctors and dentists, and that membership of the scheme amongst doctors as of July 2020 remained high, at 88 per cent, a reduction of 1.1 per cent compared to July 2019 and 3.4 per cent compared to October 2011. They said that they recognised that experience of the lifetime and annual allowances may have been a factor in the decline in scheme membership since October 2011, though they said that tax charges did not have to be paid in cash and could instead be deducted from members' pension pots on retirement, and that accruing pension net of tax charges could still be in the interest of members. They added that they were supporting employers to engage with high-earning clinicians, and encouraging them to consider the guidance published by NHS Employers, which presented approaches that employers can take locally to address pensions tax issues, including the potential of recycling unused employer contribution into extra pay.

4.30 The Scottish Government said that participation rates in their NHS Pension Scheme remained high amongst doctors and dentists, at 91.8 per cent, though participation was lower amongst GMPs and GDPs, at 81.7 per cent and 75.3 per cent respectively. They said that there was some indication members opt into and out of the scheme during the financial year to restrict pension growth against the annual allowance limit, meaning that a snapshot in any given month may not accurately reflect total participation across the year.

4.31 The BMA said that repeated surveys had demonstrated that pensions taxation was one of the major factors causing doctors to either retire early or reduce their hours, and that the current taxation system was unfair and punitive to doctors working in the NHS. They said that the pension taxation system must be urgently reformed to avoid the NHS further feeling the consequences, and that whilst the changes announced in March 2020 offered some mitigation, the fundamental problems remained. They said that the decision to freeze the lifetime allowance until 2025-26 would exacerbate the already precarious workforce situation, and that the age discrimination remedy proposed by the government added a further layer of complexity to an already complicated pension scheme.

4.32 HCSA said that the proportion of those surveyed who wanted to work fewer hours who cited pensions taxation as the main reason for this fell by more than half in 2020-21 (7.6 per cent) compared to 2019-20 (19.1 per cent). However, they said that amongst those who had made definite plans to leave the NHS, half said that pensions taxation was a factor.

Turnover

England

4.33 In 2019-20, the joining rate, which excludes staff moving between Trusts, for hospital medical and dental staff in England was 19.7 per cent, an increase from 18.4 per cent in 2018-19. In 2019-20 the leaving rate, which also excludes staff moving between Trusts, was 14.1 per cent, a fall from 15.6 per cent in 2018-19. Leaving rates varied by specialty, from 20 per cent for emergency medicine and public health medicine and community health services, to 8 per cent for anaesthetics and 6 per cent for radiology. The stability index, which measures the percentage of staff there at the start of the year who do not leave during the year, was 85.7 per cent in 2019-20, up from 84.2 per cent in 2018-19.

Scotland

4.34 In 2019-20, the numbers joining the service decreased from 2018-19, while the number of leavers increased over the same period. In 2019-20, the turnover rate was 11.2 per cent, as 858 HCHS medical and dental staff left the service, an increase from 9.3 per cent in 2018-19. In 2019-20, 895 HCHS medical and dental staff joined the service, a decrease from 1,014 in 2018-19.

Northern Ireland

4.35 In 2019-20, the joining rate for hospital medical and dental staff in Northern Ireland was higher than the leaving rate. The joining rate was 6.6 per cent, up from 5.6 per cent in 2018-19. The leaving rate was 5.3 per cent, unchanged from 2018-19.

International recruitment

England

4.36 Data from NHS Digital (Table 4.3) show that in 2019-20, 16.5 per cent of doctors joining the Hospital and Community Health Services (HCHS) in England were from abroad, comprising of 2.4 per cent from within the EU and 14.1 per cent from outside the EU. The share joiners to the HCHS from abroad has increased each year between 2010-11 and 2019-20.

4.37 Since 2015-16, the share of joiners from the EU has fallen each year, from 3.8 per cent, to 2.4 per cent in 2019-20. The share of joiners from abroad from outside the EU has increased each year between 2010-11 and 2019-20, and has more than doubled since 2015-16.

Table 4.3: Medical and dental joiners to the NHS in England by source of recruitment, between March 2010 and March 2020, %, headcount, England

	EU (exc. UK) (%)	Non-EU (%)	EU (exc. UK) and Non-EU (%)
2010-11	1.7	3.3	5.0
2011-12	2.3	3.4	5.7
2012-13	3.0	3.7	6.7
2013-14	3.5	4.4	7.9
2014-15	3.7	5.5	9.2
2015-16	3.8	6.6	10.4
2016-17	3.5	8.3	11.8
2017-18	3.0	9.5	12.6
2018-19	2.9	12.4	15.2
2019-20	2.4	14.1	16.5

Source: NHS Digital.

4.38 According to data from NHS Digital non-United Kingdom nationals made up 30 per cent of the HCHS medical and dental workforce in December 2020 (Table 4.4), with 9 per cent EU nationals and 21 per cent from outside the EU. This represents an increase from 25 per cent in 2015 (9 per cent EU and 16 per cent non-EU). There are differences by grade, with non-UK nationals making up over 50 per cent of staff grades and specialty doctors, 45 per cent of those on core training, and 21 per cent of consultants in 2020. There was a particularly large change in the composition of those in core training, with an increase in the percentage of non-UK nationals from 29 per cent in 2015.

Table 4.4: Medical and dental staff by nationality, December 2020, headcount, England

	EU	Non-EU	EU plus Non-EU
Consultants	4,954 (9%)	6,183 (12%)	11,137 (21%)
Associate specialists	162 (8%)	505 (25%)	667 (33%)
Specialty doctors and dentists	910 (11%)	3,451 (40%)	4,361 (51%)
Staff grade	63 (19%)	111 (34%)	174 (53%)
Registrar	2,884 (8%)	9,315 (27%)	12,199 (36%)
Core training	1,337 (9%)	5,646 (36%)	6,983 (45%)
Foundation year 2	438 (7%)	1,251 (20%)	1,689 (27%)
Foundation year 1	440 (7%)	679 (11%)	1,119 (18%)
Hospital practitioner/Clinical assistant	62 (4%)	66 (4%)	128 (8%)
Other and Local HCHS grades	59 (5%)	67 (5%)	126 (10%)
Total	11,284 (9%)	27,091 (21%)	38,518 (30%)

Source: NHS Digital.

Retirement trends

England

4.39 DHSC provided data on numbers in England who were claiming their NHS pension on a voluntary early retirement (VER) basis since 2007-08 (Table 4.5). For consultants, the numbers taking voluntary early retirement increased sharply between 2007-08 and 2016-17, fell back between 2016-17 and 2018-19, but rose to a new high in 2019-20. For GMPs, voluntary early retirements rose from just under 200 in 2007-08 to more than 700 a year between 2013-14 and 2016-17, before falling back to around 600 a year between 2017-18 and 2019-20. For dental practitioners the numbers choosing voluntary early retirement increased from just over 100 in 2007-08 to around 180 a year between 2011-12 and 2015-16, falling back in both 2016-17 and 2017-18, but increasing to around 200 a year in 2018-19 and 2019-20.

Table 4.5: Numbers claiming their NHS pension on a voluntary early retirement (VER) basis, England

	Consultants		General medical practitioners		General dental practitioners	
	VER	% of all retirements	VER	% of all retirements	VER	% of all retirements
2007-08	178	14	198	17	103	28
2008-09	146	12	264	20	148	36
2009-10	183	13	322	23	126	33
2010-11	286	17	443	29	154	33
2011-12	315	18	513	33	183	36
2012-13	388	24	591	42	185	36
2013-14	405	26	746	50	164	38
2014-15	453	29	739	51	185	39
2015-16	496	31	696	52	188	43
2016-17	495	30	723	61	170	42
2017-18	445	29	588	57	164	40
2018-19	416	28	607	56	205	41
2019-20	524	31	591	55	198	40

Source: DHSC Evidence (Figures 4.7 to 4.9).

4.40 HCSA said that many doctors had postponed retirement and other career decisions during the pandemic response, and that this backlog of decisions was likely to have a tangible effect on workforce numbers in the post-pandemic phase. They said that 6.3 per cent of respondents to their Doctors at Work survey said that they had put off retirement during the pandemic.

4.41 The BMA said that while many were choosing to stay within the NHS based on a sense of moral duty to support the response to a national crisis, in a survey in October 2020, 26.7 per cent of respondents said that they were more likely to take early retirement within the next year than previously. They added that understaffing adds strain to the system, which can make it difficult to retain doctors and can be linked to early retirements.

4.42 NHS Digital statistics show that, between April 2019 and March 2020, of those doctors and dentists who reported their reasons for leaving, retirement was the third most likely reason (917 people), behind end of fixed term contract (6,022), and voluntary resignations (2,750).

Wales

4.43 For the second year, we did not receive data for retirements. We would welcome information on the number of retirements, especially voluntary early retirements, from the Welsh Government for the next report.

Scotland

4.44 The Scottish Government included data from the Scottish Public Pensions Agency on the retirements of GMPs and GDPs in Scotland. For GMPs, 63 were identified as retiring early in 2019-20, down from 73 in 2018-19. For GDPs there were 19 identified early retirements, up from 15 in 2018-19. The Scottish Government described the numbers for 2019-20 as broadly similar to 2018-19.

Northern Ireland

4.45 Data from the Department of Health identified that 149 medical and dental staff had left the system in 2019-20, compared with 141 in 2018-19. The data do not identify why staff left the system or whether they were doing so before their normal retirement age.

Motivation, morale and engagement

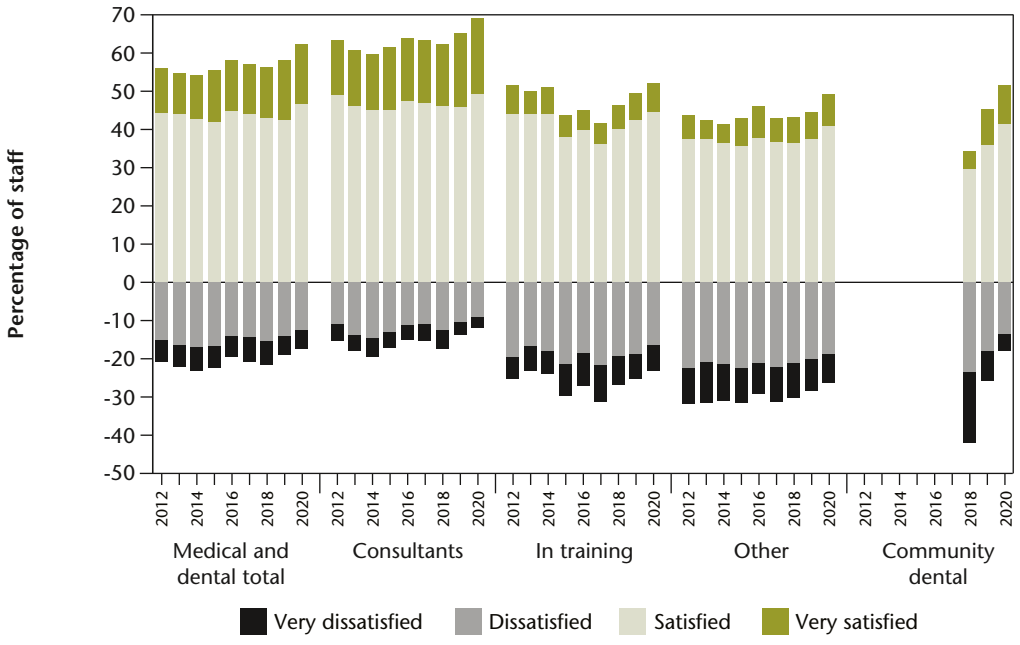
England

4.46 Since our 2020 Report, the 2020 NHS Staff Survey was published. It was conducted in the autumn of 2020, between the first two waves of the coronavirus pandemic, while infections and hospitalisations were relatively low. Over 42,000 medical and dental staff responded.

4.47 In 2020, 62.3 per cent of medical and dental staff responding said they were satisfied[4] with their pay, an increase of 4.0 percentage points, from 58.3 per cent in 2019 (Figure 4.14), and the highest recorded since at least 2011. There was an increase in satisfaction with pay for consultants, specialty doctors and associate specialists, doctors and dentists in training, and community dentists.

- A larger proportion of consultants said they were satisfied with their pay than other groups. In 2020, 69.2 per cent said they were satisfied, an increase of 4.1 percentage points from 2019.
- For doctors and dentists in training, in 2020, 52.0 per cent said they were satisfied with pay, an increase of 2.6 percentage points compared to 2019.
- For the 'other' group (comprising mainly specialty and associate specialist (SAS) doctors), 49.2 per cent said they were satisfied with pay, an increase of 4.6 percentage points from 2019.
- For community dentists, 51.6 per cent said they were satisfied with their pay, an increase of 6.4 percentage points from 2019.

Figure 4.14: HCHS medical staff satisfaction with level of pay, England, 2012 to 2020



Source: NHS Staff Survey data, Picker Institute Europe.
Note: The percentage saying "neither satisfied nor dissatisfied" is omitted throughout this chart.

[4] In each case, satisfied refers to participants answering that they were 'satisfied' or 'very satisfied' with their level of pay.

4.48 Looking across a range of measures related to job satisfaction, the results for medical and dental staff as a whole in 2020 were generally worse than in 2019 (Table 4.6).

- There was a decrease in the percentage of staff saying they looked forward to going to work, were enthusiastic about their job, that time passed quickly at work.
- There was also a decrease in the percentage who said they were satisfied with the recognition they got for good work and the support they got from their immediate manager and from their colleagues, the amount of responsibility they had, and the opportunities they had to use their skills.
- Respondents were more satisfied with their pay, and marginally more positive about the extent to which their organisation valued their work.
- The percentage of respondents saying they experienced harassment, bullying or abuse from patients, relatives or the public fell for the first time since 2014.

Table 4.6: Selected results from the National Staff Survey, medical and dental staff, England, 2011 to 2020

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend[1]
I look forward to going to work	62.0	62.5	64.0	64.4	68.0	68.9	67.2	68.7	68.3	65.0	
I am enthusiastic about my job	74.0	74.3	75.4	75.2	79.4	78.7	77.4	78.7	78.1	74.8	
Time passes quickly when I am working	81.7	79.9	81.8	81.8	84.1	83.2	83.0	83.5	83.1	81.1	
The recognition I get for good work	51.9	51.9	54.3	55.3	57.4	58.3	57.8	63.4	64.7	62.9	
The support I get from my immediate manager	64.0	64.1	67.0	68.7	67.5	69.2	68.3	71.3	71.7	71.4	
The support I get from my work colleagues	81.0	82.6	82.9	83.5	86.4	85.8	85.6	86.1	86.8	85.1	
The amount of responsibility I am given	81.2	83.3	82.7	83.0	82.4	82.2	83.0	82.7	82.4	80.6	
The opportunities I have to use my skills	76.5	78.3	80.0	80.1	80.6	79.6	79.4	80.5	80.8	77.4	
The extent to which my organisation values my work	42.8	46.2	49.2	51.4	50.4	52.3	52.1	55.1	56.2	56.3	
My level of pay	57.1	55.9	54.7	54.1	55.4	58.0	57.1	56.3	58.3	62.3	
Percentage of staff appraised in the last 12 months	81.9	87.7	89.9	91.5	90.8	91.1	90.8	91.6	90.7		
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.7	32.8	32.1	33.0	33.4	33.5	33.9	34.5	32.7	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

4.49 Workload pressures generally remained high but showed signs of improvement (Table 4.7). In 2020, compared with 2019:

- There were increases in the percentage of staff saying that: they were able to meet all the conflicting demands on their time; they had adequate materials, supplies and equipment to do their work; and there were enough staff at their organisation for them to do their job properly;
- There was an increase in the percentage of staff saying that they had felt unwell as a result of work related stress;
- There was a decrease in the percentage of staff saying they worked paid hours over and above their contracted hours and a decrease in the percentage saying that they were working unpaid hours over and above their contracted hours.

Table 4.7: Selected results from the National Staff Survey, medical and dental staff, England, 2011 to 2020

Workload	2011	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	44.8	44.7	45.2	48.0							
I am able to meet all the conflicting demands on my time at work[4]					38.7	37.2	39.3	39.4	41.1	43.2	
I have adequate materials, supplies and equipment to do my work	58.1	56.0	56.9	58.9	56.2	56.3	55.9	57.6	57.7	62.8	
There are enough staff at this organisation for me to do my job properly	35.5	35.5	34.2	33.9	33.7	32.4	30.8	32.6	33.1	41.0	
During the last 12 months have you felt unwell as a result of work related stress[2]		32.0	32.9	32.3	32.6	31.1	31.7	35.3	36.6	39.5	
Percentage of staff working PAID hours over and above their contracted hours[2]	35.0	38.7	38.3	39.4	37.4	35.9	36.3	38.0	39.1	36.2	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	72.5	76.2	77.1	76.3	79.1	80.5	79.6	78.0	74.5	73.5	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) For 2015, this question was reversed to "I am able to meet…"

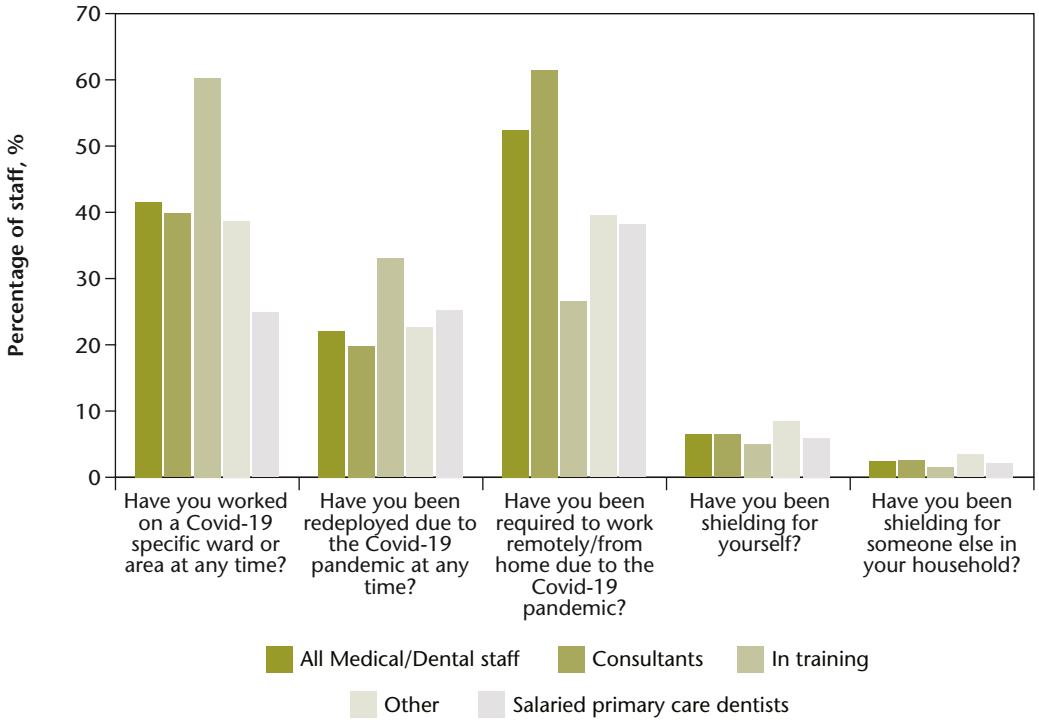
(4) This question was introduced in 2015.

4.50 In addition to the usual range of questions, staff were asked as part of the 2020 survey about their experiences during the COVID-19 pandemic (Figure 4.15). The four areas covered were as follows:

- 41.6 per cent of medical and dental staff said that they had worked on a COVID-19 ward or area at any time. Doctors and dentists in training (60.3 per cent) were the group most likely to have done so;

- 22.1 per cent of medical and dental staff said that they had been redeployed due to the COVID-19 pandemic at any time. Doctors and dentists in training (63.0 per cent) were the group most likely to have done so;
- 52.4 per cent of medical and dental staff said that they had been required to work remotely/from home due to the COVID-19 pandemic. Consultants (61.5 per cent) were the group most likely to have done so; and
- 6.5 per cent of medical and dental staff said that they had been shielding for themselves and 2.4 per cent said that they had been shielding for someone else in their household. Staff in the 'other' group (comprising mainly SAS doctors and dentists) were the group most likely to have done so (8.5 per cent for themselves, and 3.4 per cent for someone else in their household).

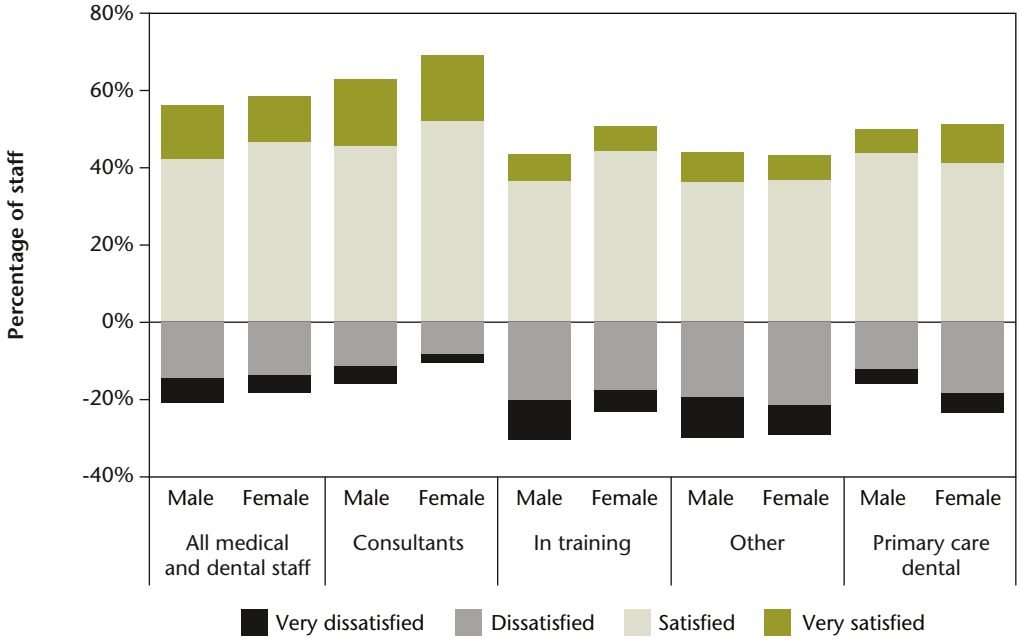
Figure 4.15: COVID-19 related questions from the National Staff Survey, medical and dental staff, England, 2020



Source: NHS Staff Survey data.

4.51 Figure 4.16 shows satisfaction with pay broken down by staff group and gender in 2020. When looking across all medical and dental staff, there was a 2.3 percentage point difference between female and male staff. 58.6 per cent of female staff and 56.3 per cent of male staff expressed satisfaction with pay, a widening of the gap in satisfaction with pay, from 2.0 percentage points in 2019. Female consultants and doctors and dentists in training remained more likely than their male counterparts to express satisfaction with pay. The share of male SAS doctors satisfied with their pay was now 0.6 percentage points higher than that for female SAS doctors, compared with a difference of 0.5 percentage points in 2019. Data for community dental staff shows male community dentists 1.3 percentage points less satisfied with pay than their female colleagues, compared with being 7.2 percentage points more satisfied with their pay than female colleagues in 2019.

Figure 4.16: HCHS staff satisfaction with level of pay by grade and gender, England, 2020

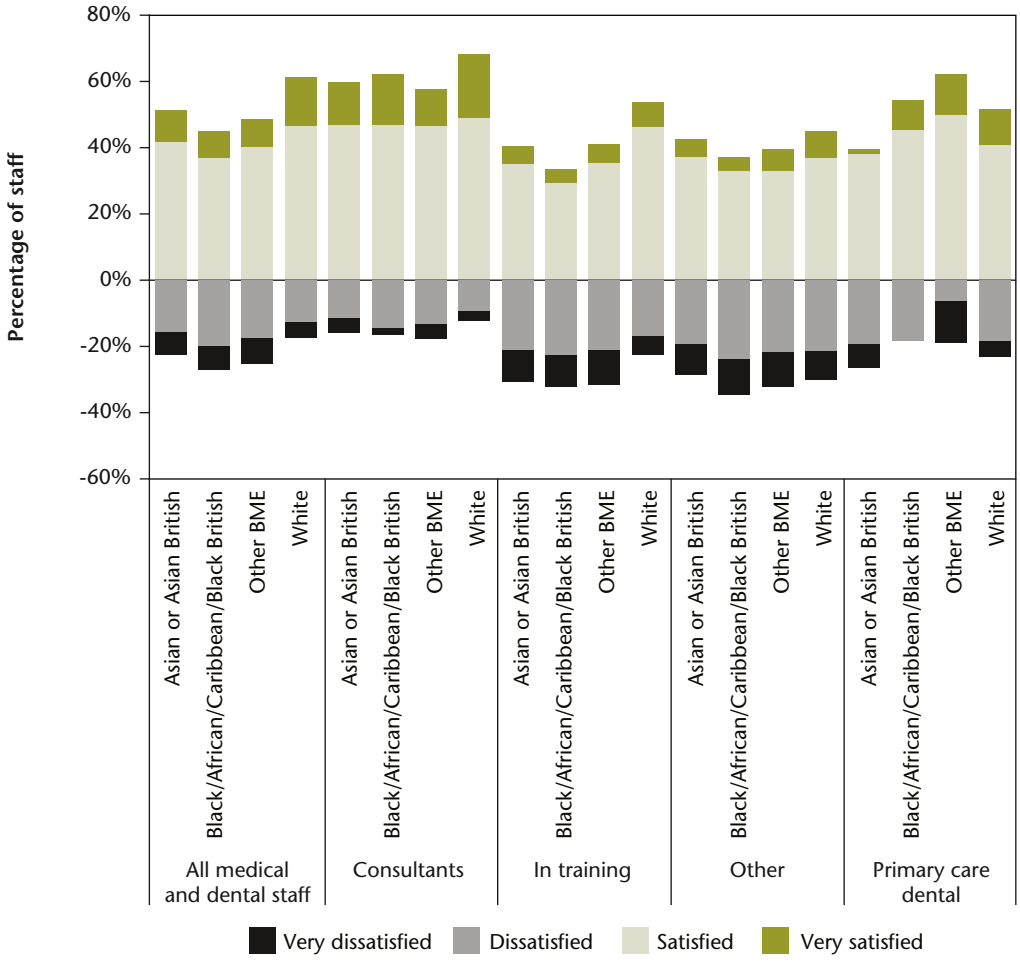


Source: NHS Staff Survey data, Picker Institute Europe.
Note: Those answering 'neither satisfied nor dissatisfied' have been excluded from this chart
Those answering 'prefer to self-identify' or 'prefer not to say' are not shown.

4.52 Figure 4.17 shows satisfaction with pay broken down by staff group and ethnic group in 2020. When looking across all medical and dental staff, 61.5 per cent of White staff expressed satisfaction with their pay, compared with 51.4 per cent of Asian or Asian British staff, 45.1 per cent of Black staff and 48.9 per cent of staff from other ethnic groups.

- White consultants (68.4 per cent) were more likely to express satisfaction with their pay than Asian or Asian British consultants (60.1 per cent), Black consultants (62.5 per cent) and consultants from other ethnic groups (57.8 per cent).
- White doctors and dentists in training (53.9 per cent) were more likely to express satisfaction with their pay than Asian or Asian British consultants (40.5 per cent), Black consultants (33.6 per cent), and those from other ethnic groups (41.1 per cent).
- White SAS doctors and dentists (45.2 per cent) were more likely to express satisfaction with their pay than Asian or Asian British SAS doctors and dentists (42.8 per cent), Black SAS doctors and dentists (37.3 per cent), and those from other ethnic groups (39.8 per cent).
- Asian or Asian British salaried primary care dentists (39.7 per cent) were less likely to express satisfaction with their pay than White colleagues (51.8 per cent), Black colleagues (54.5 per cent), and those from other ethnic groups (62.5 per cent).

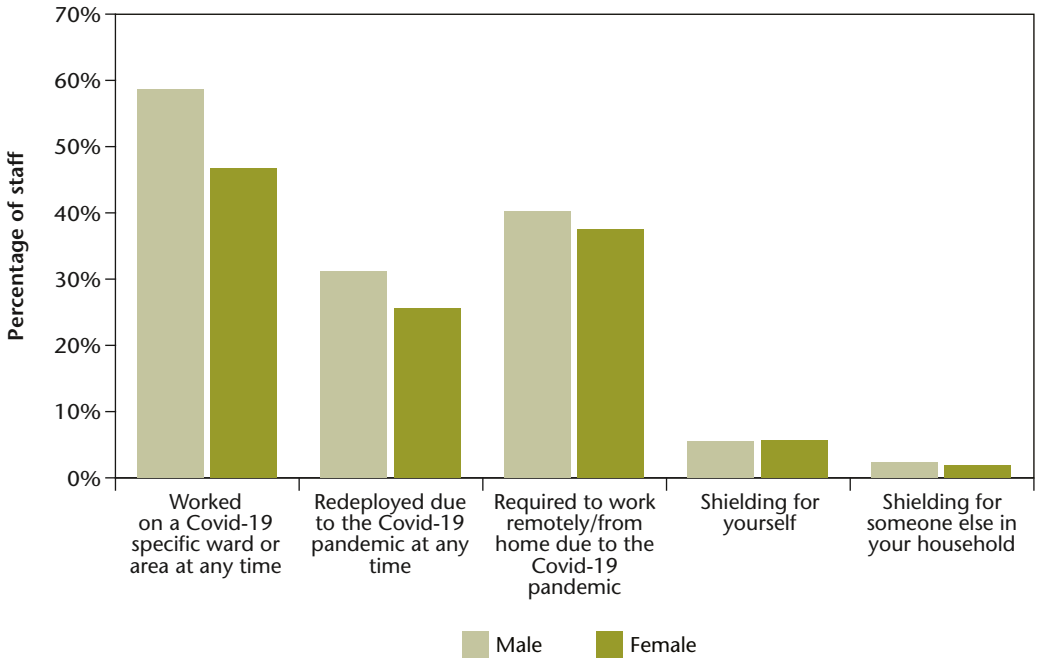
Figure 4.17: HCHS staff satisfaction with level of pay by grade and ethnic group, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.
Note: Those answering "neither satisfied nor dissatisfied" have been excluded from this chart. Those answering "prefer to self-identify" or "prefer not to say" are not shown.

4.53 Figure 4.18 breaks down the results of the questions about experiences during the COVID-19 pandemic by gender. Male medical and dental staff were more likely than female staff to have said that they: had worked on a COVID-19 ward or area; had been redeployed due to COVID-19; or had been required to work remotely or from home during the pandemic.

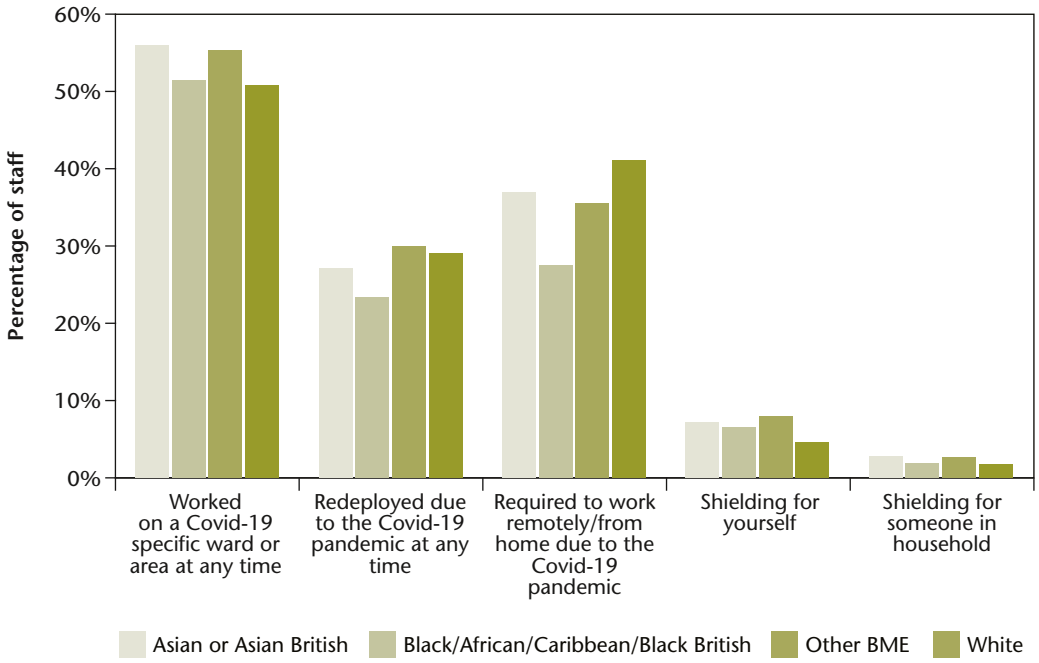
Figure 4.18: COVID-19 related questions from the National Staff Survey, medical and dental staff, by gender, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.

4.54 Figure 4.19 breaks down the results of the questions about experiences during the COVID-19 pandemic by ethnic group. Asian/Asian British medical and dental staff (56 per cent) were more likely to say they had worked on a COVID-19 ward or area than Black staff (52 per cent), White staff (51 per cent) and staff from other ethnic groups (55 per cent). Medical and dental staff from other ethnic groups were more likely to say that they had been redeployed due to COVID-19 (30 per cent) than White staff (29 per cent), Asian/Asian British staff (27 per cent) and Black staff (23 per cent). White medical and dental staff were more likely to say they had been required to work remotely or from home (41 per cent) than Asian/Asian British staff (37 per cent), staff from other ethnic groups (36 per cent) and Black staff (28 per cent).

Figure 4.19: COVID-19 related questions from the National Staff Survey, medical and dental staff, by ethnic group, England, 2020



Source: NHS Staff Survey.

NHS Staff Survey (Wales)

4.55 The Welsh Government said that it was aiming to deliver a more streamlined approach to the national survey for 2020 after it was raised that time pressures on staff could affect completion rates with a larger survey. It conducted a smaller survey in 2020, with 21 questions. The results did not differentiate medical and dental staff from the rest of the NHS workforce.

Scotland

4.56 The Scottish Government said that the Staff Experience Survey for health and social care staff for 2020 was paused in light of the COVID-19 pandemic. However, the Scottish Government went on to say that it was vital to hear from staff about their experiences, so it introduced an 'Everyone Matters' Pulse Survey for 2020 to measure staff experience. The survey was conducted in September 2020 and had 83,000 responses from health and social care staff, a response rate of 43 per cent. Within the overall total, there were 4,945 survey responses for 'medical and dental staff' and 927 responses from 'doctors and dentists in training'. Key results include:

- 67 per cent of medical and dental staff and 69 per cent of doctors and dentists in training said that their organisation cares about their health and wellbeing, compared with 68 per cent of all respondents;
- 77 per cent of medical and dental staff and 75 per cent of doctors and dentists in training said that their direct line manager cares about their health and wellbeing, compared with 79 per cent of all respondents;
- 79 per cent of both medical and dental staff and doctors and dentists in training said that their work gave them a sense of achievement, compared with 78 per cent of all respondents;

- 70 per cent of medical and dental staff and 72 per cent of doctors and dentists in training said that they felt appreciated for the work they do, compared with 69 per cent of all respondents;
- 77 per cent of medical and dental staff and 79 per cent of doctors and dentists in training said that they were treated with dignity and respect as an individual at work, compared with 77 per cent of all respondents;
- 75 per cent of medical and dental staff and 78 per cent of doctors and dentists in training said that they were treated fairly and consistently at work, compared with 75 per cent of all respondents;
- 72 per cent of medical and dental staff and 76 per cent of doctors and dentists in training said that they got the help and support they needed from other teams and services, compared with 73 per cent of all respondents; and
- 71 per cent of medical and dental staff and 74 per cent of doctors and dentists in training said that they would recommend their organisation as a good place to work, compared with 69 per cent of all respondents.

Northern Ireland

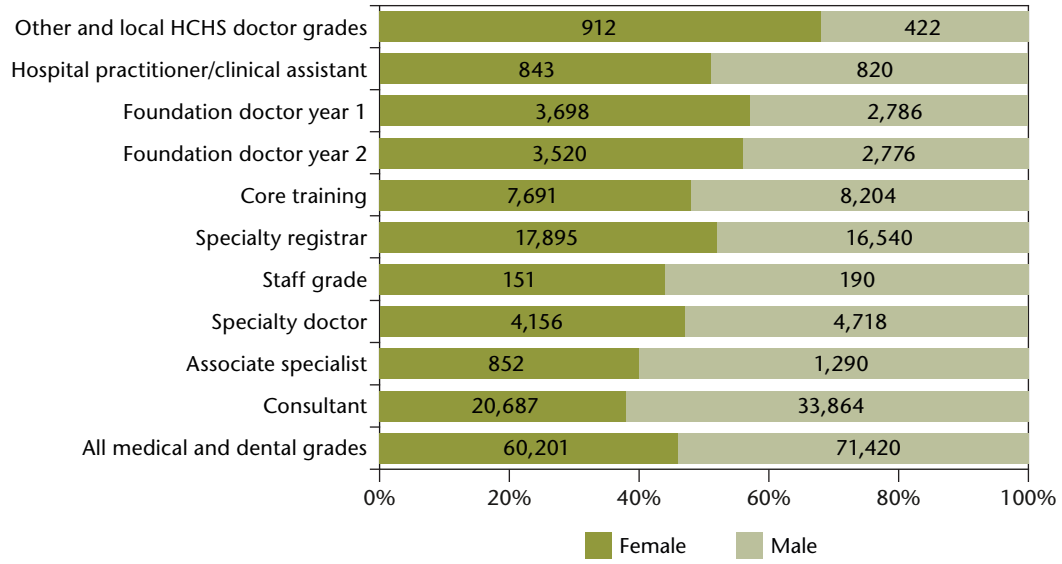
4.57 The last survey of Health and Social Care staff was for 2019, which we commented on in our 2020 report. The Department of Health said that HSC organisations would be taking forward work in response to the results, but that that work had paused as a result of COVID-19 pressures.

Diversity and Inclusion

Characteristics of Remit Groups

4.58 Figure 4.20 shows that in December 2020, 46 per cent of HCHS doctors and dentists in England were female. Although 38 per cent of consultants were female, over 40 per cent of SAS doctors were female, and over half of those in training were female.

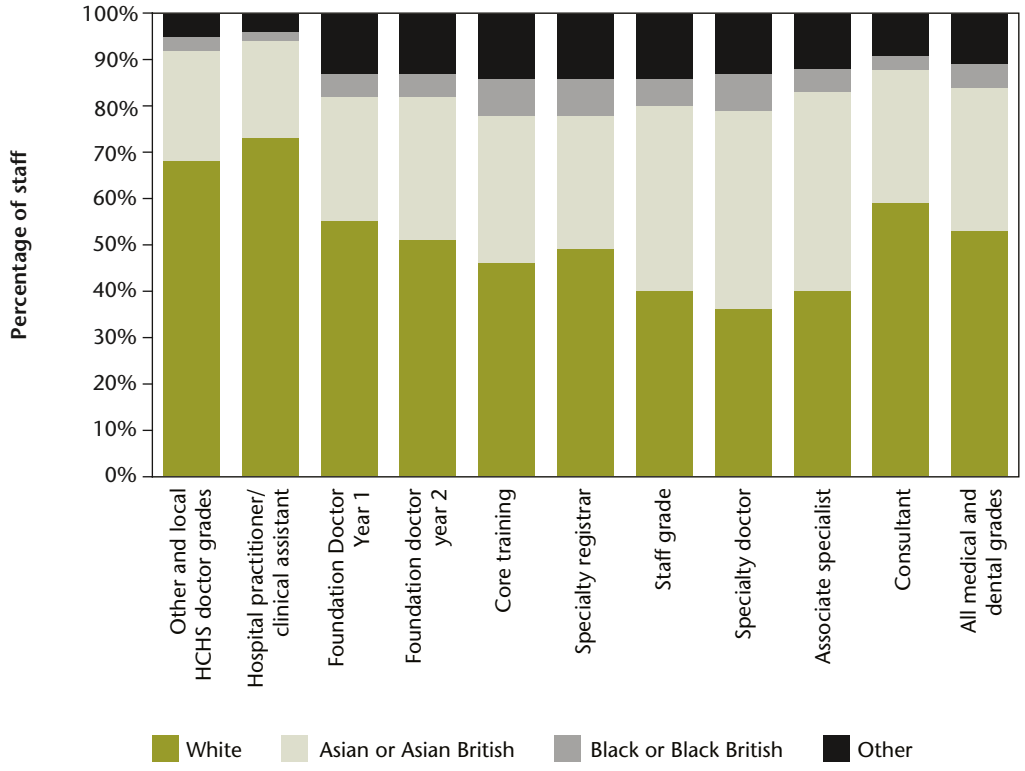
Figure 4.20: Hospital and community health services (HCHS) doctors and dentists, England, gender, by staff group, December 2020, headcount



Source: NHS Digital.

4.59 Figure 4.21 shows that in December 2020, 53 per cent of HCHS doctors and dentists in England were White, 31 per cent were Asian/Asian British, 5 per cent Black, and 11 per cent were from other ethnic groups. More than 50 per cent of consultants were White, while doctors and dentists in the SAS grades were more likely to be Asian/Asian British than any other ethnic group. Of those in training, almost half were White, 30 per cent were Asian/Asian British, 7 per cent were Black and 13 per cent from other ethnic groups.

Figure 4.21: Hospital and Community Health Services (HCHS) doctors and dentists, England, ethnic group, by staff group, December 2020, headcount



Source: NHS Digital.

4.60 We have identified several key trends in the composition of remit groups related to protected characteristics.

- The General Medical Council found that more than half of the doctors joining the medical workforce in 2020 identified as being from an ethnic minority background[5]. The number of international medical graduates joining the medical workforce continues to increase.
- Data from the University and Colleges Admissions Service (UCAS) shows that in 2020 the majority of students accepted to study medicine or dentistry courses were female. Over the last decade the percentage of students accepted to study pre-clinical medical or dental courses from an ethnic minority background has increased.
- Data from NHS Digital for England show that a higher proportion of SAS doctors and dentists are female than consultants, and a majority of SAS doctors and dentists identify as being from an ethnic minority background. The SAS grades are also more likely to experience bullying and harassment, and have higher sickness absence rates than consultants and doctors and dentists in training.

[5] General Medical Council (November 2020). *The state of medical education and practice in the UK: 2020*. Available at: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

- Data from NHS Digital show that female dentists earn less than their male counterparts in England, Scotland, Wales and Northern Ireland. The difference between male and female earnings is larger amongst associates than providing-performers. Women also make up a higher proportion of associates, and now constitute more than half of the general dental practice workforce in England. Data from UCAS show that women represent about 65 per cent of new dental graduates.
- Data from NHS Digital show that the number of female GMPs, relative to the number of male GMPs, is increasing. At the same time, the number of salaried GMPs relative to contractor GMPs is increasing. Salaried GMPs are more likely to be women and on average salaried GMPs also work fewer hours than contractor GMPs.
- The Advisory Committee on Clinical Excellence Awards found that women and doctors from an ethnic minority background are less likely to apply for clinical excellence awards (CEAs)[6]. NHS Employers, the BMA and HCSA have said the CEA system disadvantages groups of consultants because of gender, ethnicity, disability, or because of where they work or their patterns of work.

The Gender Pay Gap in Medicine Review

4.61 The report *Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England* was published in December 2020[7]. The findings from the Review have been explored in written evidence by parties. The Review, which defined gender pay gaps as 'the difference in average pay rates for men and women, as a percentage of men's earnings', presented recommendations to the Government on steps that can be taken to address the gender pay gap in medicine. The Review found that there were gender pay gaps throughout the medical profession. Mean full-time equivalent pay gaps were identified as 18.9 per cent for hospital doctors, 15.3 per cent for general medical practitioners and 11.9 per cent for clinical academics.

4.62 The Review identified several causes for the gender pay gap in medicine, including that:

- The structure of a medical career has not evolved with the changing demographic and working patterns of the workforce. There is an expectation for doctors to work full-time and take on extra commitments, which favours a male workforce and disadvantages women who are more likely to have caring commitments and work less-than-full-time.
- Working less-than-full-time, which at present a higher proportion of women do than men, has implications on the career progression and pay of women.
- Less-than-full-time working is challenging due to the inflexibility of some deaneries and the career structures of some specialties mean that women often take on secondary career paths that are lower paid. Women struggle to complete the training programme which lead them to leave or 'step off' training programmes or join the SAS grades.

4.63 The Review examined the wider causes of the gender pay gap by remit group. It found that the gender pay gap amongst salaried GMPs is significantly higher than that of contractor GMPs. It also found that CEAs are a significant contributing factor to the gender pay gap with women less likely to receive CEAs. We discuss these findings in Chapters 7 and 8.

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[6] Advisory Committee on Clinical Excellence Awards (29 April 2021). *Annual report of the Advisory Committee on Clinical Excellence Awards (ACCEA), covering the 2019 competition for national Clinical Excellence Awards in England and Wales*. Available at: https://www.gov.uk/government/publications/accea-annual-report-2020

[7] Department of Health and Social Care (15 December 2020). *Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England.* Available at: https://www.gov.uk/government/publications/independent-review-into-gender-pay-gaps-in-medicine-in-england

England

4.64 Following the publication of the Review, DHSC said an Implementation Panel will be established to drive forward its recommendations, and that the Implementation Panel is due to begin work in the summer of 2021. The Implementation Panel will include parties consulted in the review, who would be involved in the delivery of recommendations.

4.65 NHS Employers said it will be participating in the Implementation Panel. They said to address the gender pay gap a culture of change that encourages more flexible working and the use of digital systems was needed.

4.66 In addition to the findings in the Review the BMA highlighted the lack of affordable childcare as a barrier to career progression. The BMA said that women were more likely to be disadvantaged by an increase in childcare costs as they said women were more likely to reduce their working hours or leave training to take on caring responsibilities. In line with the findings of the Review the BMA said the long consultant pay scale which takes consultants on average 19 years to reach the top of, disadvantage women and ethnic minority groups who are more likely to be at the bottom of the pay scale.

4.67 HCSA said that the current structure of local clinical excellence awards had driven the gender pay gap and highlighted the importance of flexible working opportunities for women to enable access to work in all specialties and progression into senior roles. They also said paternity pay for male doctors where both parents are doctors can benefit women through greater support.

Wales

4.68 The Welsh Government told us lessons from the Review can be applied to Wales and they would wish to consider these in partnership with the BMA and NHS Employers Wales.

Scotland

4.69 The Scottish Government told us it is working to address gender pay gaps in all sectors and will review the findings and its applicability to NHS Scotland in due course.

Northern Ireland

4.70 The Department of Health told us that findings from the Review are likely to also apply to the medical workforce in Northern Ireland. They also said that they would consider joining consultant contract reform negotiations if the findings from the Review lead to them taking place in England.

Gender Pay Gap in Dentistry

4.71 NHS England and Improvement (NHSE/I) provided us with data relating to the gender pay gap in dentistry in England. The data is difficult to interpret due to additional factors such as the impact of private work and less-than-full-time working. On average, male dentists have higher taxable income than their female counterparts. NHSE/I said that this difference may be as result of a higher proportion of male dentists being providing-performers than female dentists (30 per cent of male dentists compared to 11 per cent of female dentists). They also said that male dentists on average worked more hours per week than female dentists.

4.72 The BDA told us that the gender pay gap in dentistry can to some extent be explained by the composition of the remit group as shown above. They also said that an activity-based remuneration system is likely to contribute to a gender pay gap as male dentists work more hours on average compared to female dentists. They added that data also suggested that pay correlated closely with hours worked.

Ethnicity Pay Gap and Race Inequality

4.73 The Gender Pay Gap in Medicine Review recommended that pay gap research should be expanded to examine other protected characteristics, including an in-depth evaluation of intersectionality. The researchers further examined datasets used in the Review and found that pay gaps are wider for women from an ethnic minority background. They found the groups most affected are Pakistani and Bangladeshi women with pay gaps of 30 per cent or more. They said that factors such as age and less-than-full-time working, do not explain the pay disadvantage, and structural inequalities or discrimination may be a cause of the pay gaps[8].

4.74 DHSC said they planned to organise a roundtable in 2021 that brought together stakeholders from across the health system to understand the causes of the ethnicity pay gap. DHSC also said they will explore how to collate information on the barriers and causes of the ethnicity pay gap across the NHS workforce.

4.75 The BMA said there was evidence of an ethnicity pay gap and discrimination against ethnic minority doctors that affected career progression, and that they supported ethnicity pay gap analysis alongside mandatory pay reporting based on protected characteristics. They said more granular data and analysis on ethnicity is needed to establish experiences and working patterns of staff from different ethnicities.

4.76 NHS Employers told us the Workforce Race Equality Standard (WRES) implemented bespoke indicators for the NHS workforce. Findings from the 2020 survey found white respondents had a 98 per cent chance of being shortlisted after their first application for a post, compared with 91 per cent of ethnic minority respondents. The gap was widened further when examining the likelihood of being offered a post after being shortlisted for the first time. 29 per cent of white respondents were offered a post after being shortlisted for the first time, compared with 12 per cent of ethnic minority respondents[9]. The 2020 survey also found that ethnic minority staff were more likely to be subject to the formal disciplinary process and experience discrimination at work compared to white staff[10].

4.77 NHSE/I have said that the second phase of the WRES will utilise communications and engagement to work to change 'the deep-rooted cultures of race inequality in the system and learn more about the importance of equity'[11]. A focus on accountability will ensure race equality is built into key policies with the aim of making workforce race equality commonplace. The NHS People Plan also outlines the need to address systemic inequalities to improve the experience of ethnic minorities and create an organisational culture where everyone feels they belong[12].

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[8] Dacre. J, Woodhams. C, Parnerkar. I, Sharma. M (15 December 2021) *Pay gaps in medicine and the impact of COVID-19 on doctors' careers.* Lancet. 2021; 397: 79-80. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32671-4/fulltext

[9] NHS England (26 February 2021). *Workforce Race Equality Standard 2020*. Available at: https://www.england.nhs.uk/publication/workforce-race-equality-standard-2020-supporting-data/

[10] NHS England (26 February 2021). *Workforce Race Equality Standard 2020*. Available at: https://www.england.nhs.uk/publication/workforce-race-equality-standard-2020-supporting-data/

[11] NHS England (2021) *NHS Workforce Race Equality Standard: WRES phase two*. Available at: https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

[12] NHS England (July 2020). *We Are The NHS: People Plan for 2020/2021- action for us all.* Available at: https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

4.78 HCSA told us they support a review into the ethnicity pay gap. They said institutional racism was a contributing factor to the ethnicity pay gap and drivers of the ethnicity pay gap are distinct from the drivers of the gender pay gap.

Impact of COVID-19 on Ethnic Minority Doctors and Dentists

4.79 We have drawn attention to the exceptional work carried out by doctors and dentists in response to the pandemic. It is also crucial to highlight that COVID-19 has had a disproportionate impact on ethnic minority staff. Findings from Public Health England shows a higher prevalence of the virus and worse health outcomes for ethnic minorities[13]. The Health Service Journal carried out a preliminary analysis of deaths of NHS staff from COVID-19 during the beginning of the pandemic and found that 63 per cent of deaths were from an ethnic minority background whereas 23 per cent of all staff are from an ethnic minority background, and 95 per cent of doctors who died from COVID-19 were from an ethnic minority background whereas 47 per cent of medical and dental staff are from an ethnic minority background[14].

4.80 The BMA carried out several surveys that examined the impact of COVID-19 on doctors[15]. It found that the increased impact of COVID-19 on ethnic minority staff may be due to the greater number of ethnic minority staff in patient-facing roles, workplace culture and the supply of personal protective equipment (PPE). BMA surveys have found that doctors from an ethnic minority background feel less confident that appropriate adjustments have been made to mitigate risk, feel less confident about PPE provision, feel less safe to report PPE shortages and have experienced higher rates of bullying and harassment during the pandemic.

4.81 NHS Employers published guidance for NHS organisations to take appropriate measures to mitigate the risk of COVID-19. NHS organisations were told by NHSE/I to prioritise risk assurance conversations. This involves conversations with staff to identify the support needed and understand the experience of staff at work to enable organisations to review physical and psychological risk factors[16].

Our comments

4.82 We note a number of key messages from the evidence discussed in this chapter:

- The data on the pay position and pay comparability with our remit group's key comparator professions present a mixed picture, with some groups including consultants and contractor GMPs gaining relative to their comparators in 2019-20, and others, including doctors and dentists in training, falling. Since 2010-11 our remit group has generally lost ground slightly to the wider earnings distribution, a trend which was partially reversed as a result of the pay award last year. These figures should also be viewed in the context of the latest Longitudinal Education

[13] Public Health England (11 August 2020). *COVID-19: review of disparities in risks and outcomes.* Available at: https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes
[14] Health Service Journal (22 April 2020). *Deaths of NHS staff from COVID-19 analysed.* Available at: [h]ttps://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article
[15] British Medical Association (7 January 2021). *COVID-19: the risk to BAME doctors.* Available at: https://www.bma.org.uk/advice-and-support/covid-19/your-health/covid-19-the-risk-to-bame-doctors
[16] NHS Employers (8 January 2021). *Risk assessments for staff.* Available at: https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/supporting-staff-health-and-safety/risk-assessments-for-staff

Outcomes data set, which covers 2017-18, which shows that medical and dental graduates continue to have the highest median earnings for all subject groups 1, 3, 5 and 10 years after graduating[17].

- The complexity of pensions for the most senior clinicians, alongside issues around pension taxation have the potential to exacerbate existing issues of retention. The freezing of the lifetime allowance until 2025-26 may further worsen this situation. It is not yet clear whether the changes to the NHS Pension Scheme that are being made in response to the McCloud judgement will also have an impact.
- The trends to turnover and recruitment, and in particular international recruitment have been positive over the last year, though it is not clear whether or not this is a temporary effect of the pandemic. Health services are becoming increasingly reliant on international recruitment from outside the EU.
- NHS Staff Survey results in England painted a troubling picture of declining job satisfaction, as the proportion of medical and dental staff who said they looked forward to going to work, were enthusiastic about their jobs, were satisfied with the amount of responsibility they had and felt they had sufficient opportunity to use their skills all declined.
- Considering and addressing the Gender Pay Gap in Medicine Review's observations and recommendations will be critical for protecting the future of medical and dental workforces in England, as well as Scotland, Wales and Northern Ireland, alongside action to address other issues of diversity and inclusion, including relating to doctors and dentists from an ethnic minority background. This is increasingly important as the proportion of the workforce that are female, or from an ethnic minority background, or both, continues to increase.

4.83 The above-inflation pay uplifts that were awarded to doctors and dentists in 2019-20 and 2020-21 are likely to be the cause of the partial mitigation of historical decreases in relative pay compared to both comparator professions and the overall earnings distribution. Given the indirect way that our recommendations reach salaried GMPs and associate dentists, we would welcome further insight from the parties about the remuneration of these groups in particular in evidence next year. It is also not yet clear what impact the pandemic will have on the pay comparability situation in 2020-21 and beyond, and how long any effects may last, though in the short term doctors and dentists may receive a boost in their pay position relative to the wider earnings distribution. The pandemic's impact on various comparability groups is also likely to vary greatly by sector of the economy, meaning that interpreting any trends next year will likely be difficult.

4.84 We look forward to hearing about details of the new employee pensions contribution structure, and to seeing what might be done to address contribution tier cliff edges. We would welcome hearing in evidence next year how the parties expect any changes to affect doctors and dentists. We also welcome the proposed change to using actual earnings rather than FTE earnings when calculating contribution tiers. Doing this will help to support the increasing proportion of doctors and dentists who have chosen to work less-than-full-time.

[17] Department for Education (19 March 2020) *Graduate outcomes (LEO): Employment and earnings outcomes of higher education graduates by subject studied and graduate characteristics in 2017/18*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874410/2020_03_HE_LEO_main_text.pdf. These figures remain even after taking account of the longer degree courses that medical and dental students study; the 1-year figure for medicine and dentistry is higher than any of the other 3-year figures, and likewise the 3-year figure for medicine and dentistry is higher than any of the other 5-year figures.

4.85 We are, however, concerned about the freezing of the lifetime pensions taxation allowance until 2025-26. This may combine with existing issues related to pensions taxation, that the government sought to address in the 2020 Budget by raising the annual allowance taper threshold, to once again cause many senior doctors and dentists to conclude that it is in their financial interests to retire or reduce their working hours, exacerbating issues of retention.

4.86 During our visits programme, we also frequently heard of doctors and dentists finding pensions and the pensions taxation system difficult and complex to navigate. Employers and governments should seek to improve the quality and timeliness of the information that doctors and dentists receive about their pensions, enabling them to make informed decisions in a more straightforward manner. They should also consider all options available to them to safeguard retention in the context of the changes to pensions taxation rules. This includes the practice of 'recycling' – paying unused employer contribution as salary to those who opt out of the NHS Pension Scheme as a result of having reached the annual or lifetime allowance. Arrangements enabling this have been in place at times in Scotland and in some Trusts in England. Other options to help doctors and dentists navigate this issue whilst being encouraged to continue working could also be explored.

4.87 We also note the continued increases in the number of international medical and dental joiners to the NHS who do so from outside the EU. It is not yet clear what the combined impact of EU Exit and the pandemic will be on international recruitment but given the increased reliance on doctors and dentists coming to the UK to practice from overseas, it is important to ensure both that these staff are retained, and that there is a clear and funded workforce plan to ensure that staff demand is managed in years to come.

4.88 More generally, it remains critically important to retain all groups of medical and dental staff. All of the parties have expressed concern about the potential for the demands placed on medical and dental staff by the pandemic to precipitate an increase in retirements and leavers in the coming years. We hope that parties act quickly to address this and minimise the impact on retention. In this context, the results of the staff survey, which in general show decreased job satisfaction in the past year, are a pressing concern given the need to retain and motivate staff in the context of the pandemic and care backlogs. This is particularly the case for the most experienced staff, whose role in leading and delivering care, and training and developing more junior staff, is particularly critical at this time.

4.89 We welcome the findings and recommendations from the Gender Pay Gap in Medicine Review. We have highlighted in our reports over a number of years concerns related to our remit groups that have been reflected in the Review's findings. We expect that action will be taken quickly to carry out the recommendations, and we welcome the formation of the Implementation Panel and look forward to receiving more information on the progress of its work. We also look forward to receiving evidence more generally on these issues in future years. Finally, we look forward to seeing in evidence in future years how the governments in Wales, Scotland and Northern Ireland are examining the gender pay gaps in their medical and dental workforces.

4.90 The evidence we have received from the parties suggested that there is a gender pay gap in dentistry as well. Whilst the Review examined gender pay gaps in medicine only, some of the issues raised may be applicable to HCHS dentists who have the same contracts as their medical counterparts. Many of the findings relating to GMPs are also likely to apply to GDPs, and in particular there is likely to be similarities between the salaried GMP and associate GDP workforces in this context. It is important that action is also taken to understand the causes of and address gender pay gaps in dentistry.

4.91 There is also evidence to suggest that there is an ethnicity pay gap. We welcome that the Minister for Care will host a roundtable on this issue. This should be an area of priority as the demography of medicine and dentistry is changing. As outlined, an increasing number of students studying medicine and dentistry are from an ethnic minority background. It is therefore important to understand and address the ethnicity pay gap to ensure doctors and dentists are not disadvantaged and ensure that they feel valued and motivated and remain in the NHS.

4.92 The demography of the remit group may mean that some members of the remit group face additional challenges associated with their protected characteristics such as gender, age and ethnicity. Additionally, the intersectionality of these characteristics is likely to add a further layer of complexity to these issues. Given the increasing proportion of entrants to medicine and dentistry who are female and/or from an ethnic minority background, the importance of understanding these compounding effects is ever more important. It is also important that the information that is collected on issues relating to ethnicity and the medical and dental workforces is captured in sufficiently granular detail to properly examine individual groups, recognising that ethnic minority doctors and dentists are a heterogeneous group.

4.93 We welcome the work that is underway to address race inequalities in the NHS in England, and we hope that similar progress can be made in Scotland, Wales and Northern Ireland. We expect that issues identified, including increased rates of bullying and harassment and differences in staff experiences, can be addressed, and steps are taken to improve the health and wellbeing of staff in this context, including through providing additional support for ethnic minority doctors and dentists as appropriate. We encourage that the work being undertaken to understand the impact of COVID-19 on ethnic minority doctors and dentists is continued and built on post-pandemic.

CHAPTER 5: DOCTORS AND DENTISTS IN TRAINING

Introduction

5.1 In this chapter, we examine recruitment, retention and motivation amongst doctors and dentists in training. While doctors and dentists in training in England are subject to a multi-year pay deal until 2023, and we were therefore not asked by the government for recommendations for this group, in our remit letter for England we were invited to make comments and observations on the evidence we received for this group. We have been asked to make recommendations as usual for doctors and dentists in training in Scotland, Wales and Northern Ireland.

Doctors and dentists in training

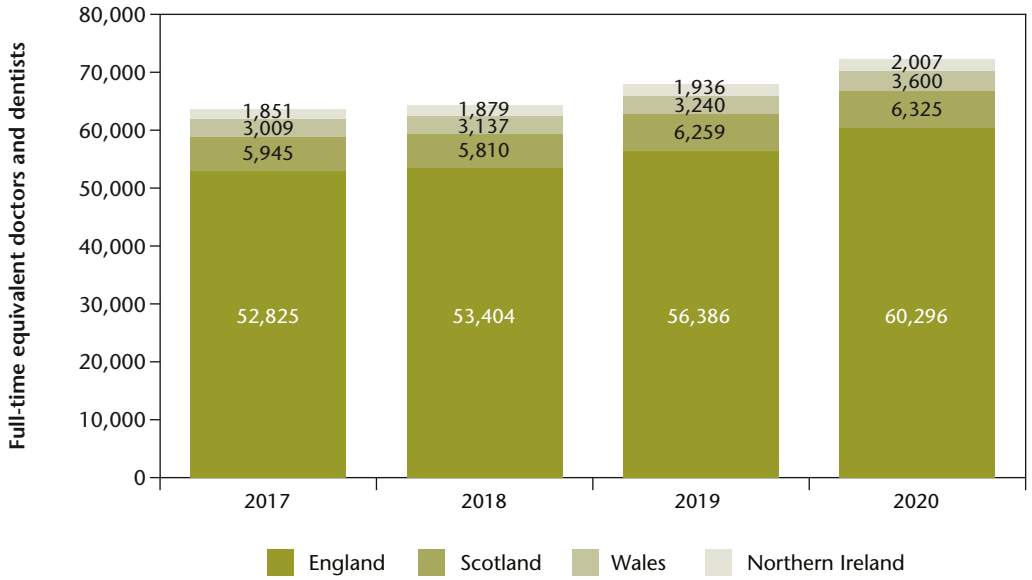
5.2 After completing medical school, which normally takes around five years, doctors in the UK begin their hospital training by undertaking the foundation programmes, normally a two-year, general post graduate medical training programme, where they are known as foundation doctors (F1 and F2). Following this training, doctors can either continue in the hospital sector, entering specialty training which, depending on the specialty, may include two or three years' core training, or enter general practice training. Dentists undertake a training programme of at least five years' study at dental school, after which there is a dental postgraduate training system that includes a one-year foundation programme. After this foundation programme dentists choose whether to stay in the hospital sector or work in primary care dentistry.

5.3 Doctors in training, often referred to as junior doctors, comprise doctors undertaking the foundation programme or core, specialty, or general practice training. General practice training takes at least three years, and core and specialty training together at least six. On completion of specialty training, doctors receive the Certificate of Completion of Training and are eligible to become consultants. Doctors may also, if they wish, leave training prior to completion, becoming SAS doctors.

5.4 In September 2020 there were 72,230 doctors and dentists on a full-time equivalent (FTE) basis in hospital training in the UK (Figure 5.1), an increase of 6.5 per cent from 2019. Comparing September 2020 with 2019 there was an increase in the numbers in training in Wales (11.1 per cent), England (6.9 per cent), Northern Ireland (3.7 per cent[1]) and Scotland (1.1 per cent).

[1] The figures for Northern Ireland are for March 2020 compared to March 2019.

Figure 5.1: Number of doctors and dentists in training in the Hospital and Community Health Services (HCHS), United Kingdom, 2017 to 2020



Source: NHS Digital, StatsWales, NHS Education for Scotland, Department of Health Northern Ireland.

Undergraduate medical and dental training

5.5 Table 5.1 shows the time series from 2011 to 2020 for the numbers of applications[2], applicants[3] and acceptances[4] on pre-clinical medicine courses. The equivalent figures for dentistry are shown in Table 5.2.

5.6 In 2020 there were 24,580 applicants to study pre-clinical medical degrees in the UK who between them made 84,380 applications (an average of 3.4 applications per applicant). Of these, 10,625 were accepted on a course. Compared with 2019, this represents an increase of 10 per cent in students accepted on to courses and an increase of 5 per cent in the number of applicants. Since 2017 the number of students accepted on to medical courses has grown by 37 per cent and the number of applicants by 24 per cent. In 2020 there were also 4,420 applicants to study pre-clinical dental degrees in the UK who between them made 12,220 applications (an average of 2.8 applications per applicant). Of these 1,330 were accepted on a course. This represents a ratio of applicants to acceptances of 3.32. The number of applicants fell each year from 2011 to 2016 before increasing in each of the last four years, and by 7 per cent in 2020 compared with 2019. Between 2017 and 2019, the number of acceptances, had been little changed. However, in 2020, the number of acceptances was 17 per cent higher than in 2019.

[2] Number of applications: defined as a choice to a course in higher education through the UCAS main scheme. Each applicant can make up to five choices.
[3] Number of unique applicants: defined as the number of applicants making at least one choice through the main UCAS scheme.
[4] Acceptance: defined as an applicant who has been placed for entry into higher education.

Table 5.1: Numbers of applications, unique applicants and acceptances for medical degrees, UK, 2011-2020

	Number of Applications	Number of Unique Applicants	Number of Acceptances	Applications per Acceptance	Unique Applicants per Acceptance
2011	83,185	22,930	7,800	10.7	2.94
2012	81,260	22,285	7,805	10.4	2.86
2013	82,440	22,685	7,515	11.0	3.02
2014	84,850	23,365	7,680	11.0	3.04
2015	75,665	20,935	7,660	9.9	2.73
2016	74,860	20,815	7,830	9.6	2.66
2017	68,655	19,860	7,750	8.9	2.56
2018	75,395	21,570	8,620	8.7	2.50
2019	80,995	23,425	9,650	8.4	2.43
2020	84,380	24,580	10,625	7.9	2.31

Source: OME estimates using UCAS data.

Table 5.2: Numbers of applications, unique applicants and acceptances for dental degrees, UK, 2011-2020

	Number of Applications	Number of Unique Applicants	Number of Acceptances	Applications per Acceptance	Unique Applicants per Acceptance
2011	12,550	3,820	1,195	10.5	3.20
2012	11,630	3,515	1,195	9.7	2.94
2013	11,350	3,455	1,190	9.5	2.90
2014	11,210	3,410	1,105	10.1	3.09
2015	9,875	3,010	1,095	9.0	2.75
2016	9,060	2,810	1,100	8.2	2.55
2017	9,240	2,885	1,135	8.1	2.54
2018	9,850	3,040	1,125	8.8	2.70
2019	11,450	3,895	1,140	10.0	3.42
2020	12,220	4,420	1,330	9.2	3.32

Source: OME estimates using UCAS data.

5.7 The gender and ethnic composition of those accepted to study for medical and dental degrees has changed between 2011 and 2020. Over that period the share of students accepted onto medical degree courses that were female had increased from 54 per cent to 63 per cent. For dentistry, the proportion increased from 57 per cent to 66 per cent. The share of students accepted onto medical degree courses that were from an ethnic minority background increased from 28 per cent to 48 per cent. For dentistry, this proportion increased from 46 per cent to 59 per cent.

5.8 Table 5.3 shows the ten undergraduate subjects with the largest ratio of applications to acceptances in 2020. Pre-clinical medicine has the second highest ratio, behind pre-clinical dentistry.

Table 5.3: Subjects[5] with the highest ratio of applications to acceptances, United Kingdom 2020

Subject	Ratio of applications to acceptances 2020
Pre-clinical Dentistry	9.2
Pre-clinical Medicine	7.9
Others in Medicine and Dentistry	7.7
Artificial Intelligence	7.1
Spanish studies	6.3
Economics	6.2
Combinations within Mathematical Sciences	6.1
Combs of phys/math/comp sciences	6.0
Anatomy, Physiology and Pathology	6.0
Ophthalmics	5.9

Source: OME calculations using UCAS data.

5.9 DHSC said that they had expanded the number of undergraduate medical school places by 25 per cent, or 1,500, over the last three years. As a result of the impact of COVID-19 on higher education, the number of students accepted into medical schools in 2020 was larger than expected, with HEE funding approximately 700 additional places in England. HEE said that the Government had committed to ensuring all successful applicants were given places, removing the cap on the number of medical students admitted to universities in 2020, so they had supported the Medical Schools Council to create additional capacity. They also said they were continuing to work with DHSC to secure funding for additional places in 2021 for those deferring from 2020, so as not to disadvantage the cohort of 2021 applicants. Additional places were also made available in Scotland, Wales and Northern Ireland.

Working through the COVID-19 pandemic

5.10 DHSC said that doctors and dentists in training had shown flexibility to deliver care in uncertain and rapidly changing circumstances. They said that working arrangements through the pandemic had been largely managed through the provisions within the 2016 contract that pays an additional supplement for additional and weekend working. They said that they were also aware that some employers had come to local agreements with their doctors and dentists in training where this had been necessary.

5.11 The BMA said that joint statements around working through the pandemic were agreed and published with employer representatives in all four nations. These statements included guidance as to how contractual provisions, such as rules for rotas and out-of-hours work, could be suspended or modified when necessary as part of the pandemic response. The BMA said that the statement for England was withdrawn in July 2020.

5.12 They also discussed their attempts to agree national solutions for rates of pay for additional work undertaken as part of the pandemic response, but they said that they were only able to agree a national solution with the Welsh Government; in England, Scotland and Northern Ireland, employers were expected to implement local solutions.

5.13 HEE said that COVID-19 had generated significant disruption to postgraduate medical and dental education. They said that medical training was disrupted due to loss of teaching time and placements, and that COVID-19 had impacted on clinical training opportunities for dental trainees, as a result of the potential for aerosol-generating procedures to spread the virus.

[5] This table only looks at subjects that had at least 100 acceptances in 2020.

Contract reform

England

5.14 In June 2019, the BMA, DHSC and NHS Employers announced changes to the contract that was introduced in 2016. As part of the agreement basic pay uplifts of 2 per cent per year were guaranteed until 2023, with a further 1 per cent invested annually into the contract to provide:

- A new fifth nodal point (pay point) for trainees at ST6 and above, with a staggered introduction from 2020-21
- An uplift to weekend allowances
- A £1,000 allowance for those working less than full time
- Changes to the academic flexible pay premium

5.15 The rest and rostering requirements in the contract were also made more robust, including for example a new maximum of eight consecutive shifts rostered or worked over eight consecutive days.

5.16 NHS Employers, after having raised some concerns with the operation of the exception reporting system introduced as part of the new contract in 2016 in last year's written evidence, described their engagement with regional guardians of safe working hours (GoSWH). They said that GoSWHs felt that the exception reporting system added value and allowed educational supervisors to be alerted to problems and departments to use the outcomes of exception reports to help establish business cases for tackling staffing issues. They also said that exception reporting had increased as trainees had become more familiar with the process.

5.17 NHS Employers also highlighted that the BDA were preparing a formal case that the fifth nodal (pay) point in the contract should be applied for dentists at ST4, who may gain equivalent competencies to doctors in training at ST6, but who as a result of the structure of their training do not ever reach the ST6 grade.

5.18 DHSC said that all doctors and dentists in training in England were now employed under the new arrangements, though there were still some doctors employed on local contracts (often referred to as trust grade doctors) that mirrored the old 2002 arrangements.

Scotland

5.19 The Scottish Government told us they did not currently have plans to reform their junior doctor contract, and that they were currently working on improvements to the current contract including the ongoing introduction of a single employer model for doctors and dentists in training.

Wales

5.20 The Welsh Government said that they, along with BMA Cymru Wales and NHS Wales Employers, had agreed to work in social partnership to discuss the future of the contract in Wales, adding that they had agreed that any new contract provision agreed through this process should be no less favourable to doctors and dentists in training than the contract in place in England. They said that they would explore with BMA Cymru Wales and NHS Wales Employers the implications of introducing the latest version of the contract in England, as well as considering retaining or improving the existing contract or developing new contractual provisions.

Northern Ireland

5.21 The Department of Health told us that there was no appetite from either employers or the BMA in Northern Ireland to enter into negotiations over the introduction of new terms and conditions, though they were working to introduce a new single employer model to improve the employment experience for all trainees.

Recruitment and training choices

5.22 After completing the two-year foundation programme, doctors choose which specialty they wish to enter, or whether they want to enter general practice training. However, the number of trainees in the UK deciding not to enter into specialty or general practice training immediately after completing the foundation programme, a practice known as stepping out of training, continues to increase. In 2012, one third of trainees stepped out of training for at least a year, but by 2019 that had increased to almost two thirds. Table 5.4 show the trends in how many trainees have stepped out of training, and for how long.

Table 5.4: Trainees that pause training after F2, and length of pauses

F2 year of completion	No pause	1-year pause	2-year pause	3+ year pause	Not yet returned
2012	67%	16%	7%	4%	6%
2013	63%	19%	8%	3%	7%
2014	58%	21%	8%	4%	8%
2015	52%	24%	10%	5%	9%
2016	47%	25%	12%	5%	11%
2017	42%	29%	13%	n/a	16%
2018	39%	29%	n/a	n/a	32%
2019	35%	n/a	n/a	n/a	65%

Source: General Medical Council: The State of Medical Education and Practice in the UK 2020 (Figure 58)[6].

5.23 The majority of doctors that step out of training return to begin core or specialty training. In recent years, around half have done so after one year, and most of the rest after two or three years.

England

5.24 Health Education England (HEE) said that recruitment to CT1/ST1 in 2020-21 was successful with all programmes achieving at least a 95 per cent fill rate, with a majority reaching 100 per cent, including meeting the general practice target, with almost 3,800 beginning general practice training in 2020. HEE went on to say that applications for 2021-22 had increased by 34 per cent compared with 2020-21, including an increase of 84 per cent in the number of core psychiatry applications. HEE acknowledged that the main driver for the increase in applications is applications from international medical graduates.

[6] General Medical Council (November 2020). *The state of medical education and practice in the UK: 2020*. Available at: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

Impact of the pandemic on recruitment

5.25 HEE said that the pandemic necessitated the cancellation of face-to-face recruitment from mid-March 2020. They said that instead a consistent recruitment process based on online testing and self-assessment application forms was negotiated across the majority of specialties, in a process that involved the BMA and the Medical Royal Colleges. They said that 2021 recruitment was underway in a process that had been developed and agreed in a manner that was flexible and able to respond to the course taken by the pandemic.

Flexible Pay Premia

5.26 The junior doctors' contract in England included flexible pay premia (FPP) for:

- general practice training, payable only during the practice-based period of GMP specialty training;
- hard-to-fill training programmes, initially emergency medicine and psychiatry;
- oral-maxillofacial surgery;
- clinical academic trainees;
- those taking time out of training for recognised activities deemed to be of benefit to the wider NHS.

A further pay premium to cover histopathology was introduced from 1 October 2018.

5.27 The rates for 2021-22 have already been applied, as part of the 2019 agreement (see para 5.14 above), and are set out in Tables 5.5 and 5.6.

Table 5.5: Flexible Pay Premia in England, 2021-22

Name of premium	Applicable training programme		Full time annual value (£)
Hard-to-fill training programmes	General Practice	Payable to ST1, ST2, ST3, ST4 during general practice placements only.	8,965
	Psychiatry Core Training	Payable to Psychiatry Core Trainees.	3,645
	Psychiatry Higher Training	Payable to Psychiatry Higher Trainees.	3 year higher training programme: 3,645
			4 year higher training programme: 2,734
	Emergency Medicine	Payable to ST4 and above only.	Dependent on length of training programme, see Table 5.6 below.
Dual qualification – OMFS	Oral and Maxillofacial Surgery	Payable to ST3 and above only.	
Histopathology	Histopathology	Payable to ST1 and above only.	4,374
Academia		Upon return to training following successful completion of higher degree.	4,374

Table 5.6: Flexible Pay Premia in England, 2021-22

Length of training programme	Full time annual value (£)
3 years	7,289
4 years	5,467
5 years	4,374
6 years	3,645
7 years	3,124
8 years	2,734

Source: NHS Employers, Pay and Conditions Circular (M&D) 1/2021[7]

Targeted Enhanced Recruitment Scheme (TERS)

5.28 TERS is an initiative that offers a one-off payment of £20,000 to general practice trainees committed to working in particular locations where recruitment had previously been challenging. The sum is repayable if the trainees leave the programme during the training period. The sub-regional areas covered by TERS in England all saw 100 per cent fill rates in 2020-21. TERS was originally introduced in 2016, and so the first GMP trainees in the programme completed training in 2019. HEE said that the data appear to show that TERS had been successful, and they were therefore considering whether TERS or a similar scheme should also be considered in psychiatry where there was a similar pressing need to increase recruitment to the training grades, though they said that caution should be exercised in extrapolating the results of TERS in considering the evidence for flexible pay premia more generally.

Foundation Priority Programmes

5.29 HEE also told us about a number of local financial incentives that will be introduced and evaluated in 2019-20 and 2020-21 as part of its Foundation Priority Programmes. These included enhanced salary packages and other financial incentives at the Trent, Northern and Wessex Foundation Schools.

Comments from the parties

5.30 DHSC said that pay was not the only factor influencing specialty choice, and a whole-system perspective was necessary to ensure appropriate recruitment and supply to all specialties. They said that doctors are historically attracted to working in areas with high population density and wider case mix, despite higher cost of living, and that doctors are more likely to move to areas where they have lived before. They added that there were still regions and specialties with unfilled posts, including some historically attractive specialties, including paediatrics and genitourinary medicine. They said that if HEE's recent work to analyse the distribution of specialty training posts leads to a redistribution, then there is the potential for greater need for pay incentives or alternatives to pay incentives to ensure that vacancies are filled.

5.31 DHSC also said that the 25 per cent expansion in medical school intakes that took place between 2018 and 2020 prioritised the allocation of places to areas with a shortage of doctors, and that in the longer term this would improve fill rates across all geographies and specialties.

[7] NHS Employers (12 March 2021). *Pay and Conditions Circular (M&D) 1/2021.* Available at: https://www.nhsemployers.org/case-studies-and-resources/2021/03/pay-and-conditions-circular

5.32 HEE also told us about the programme board on geographic and specialty shortages that they were leading. They said that the programme was seeking to address long-term challenges with attracting, recruiting and retaining trainees in remote, rural and smaller health systems. They said that Postgraduate Deans had also been asked to look at the distribution of doctors within their own footprints, with remote and rural systems in mind. They said that there was evidence that specialists are likely to settle and practice near to where they train, with GMC data showing that 49 per cent of specialists who gained their CCT between 2012 and 2019 were based within 10 miles of their specialty training postcode and 80 per cent within 50 miles.

5.33 HEE also described work that was ongoing as part of their Medical Education Reform Programme (MERP). MERP comprises a range of aligned initiatives that aim to produce doctors that better meet the needs of patients and services, address health inequalities, and improve the experience of doctors in training. They said that these initiatives were drawn from *The Future Doctor*[8], which was published by HEE in July 2020. They said that the report's vision was focused around six reform pillars:

- Enhanced generalism;
- Equality, diversity and inclusion;
- Accelerating undergraduate supply, bringing forward the current point of registration;
- Addressing health inequalities;
- Improving the wellbeing and experience of doctors; and
- Boosting multi-professional team working, producing more generalist doctors, and supporting service provision to be more efficient.

5.34 The BMA said that there was no oversupply of trainees and therefore any recruitment and retention FPP introduced for a new specialty would only result in trainees being drawn away from other specialties, leading to workforce issues elsewhere.

Scotland

5.35 The Scottish Government said that the COVID-19 pandemic had, due to travel restrictions and clinician availability, impacted the usual recruitment processes such as face-to-face interviews. They said that despite this, the overall recruitment position was positive, with the overall 2020 fill rate of 96 per cent up from 93 per cent in 2019. While core psychiatry had previously been a problem specialty, 99 per cent of places were filled in 2020, though they said that recruitment in mental health specialties at ST4 level remained a concern. They said that 115 of the 140 places on TERS in Scotland were filled.

Wales

5.36 The Welsh Government said that the *Train Work Live* marketing campaign is now in its fifth year and retains its focus on general practice and psychiatrists. They said that both GMP training and core psychiatry have been incentivised through the payment of specified exam fees, and there was a Welsh version of TERS in place. They said that there had been significant improvements in the fill rates for both general practice training, where the new, higher target of 160 was exceeded, and core psychiatry, where 26 of 27 places were filled. They said that across all specialties, 618 of 671 places were filled, compared to 555 in 2019.

[8] Health Education England (21 June 2020). *The Future Doctor Programme: A co-created vision for the future clinical team*. Available at: https://www.hee.nhs.uk/our-work/future-doctor

Northern Ireland

5.37 Data from the Northern Ireland Medical and Dental Training Agency (NIMDTA) showed that fill rates for specialty training were generally improved in 2020, compared to 2019, and most specialties had fill rates that were at or close to 100 per cent. There was a particular improvement in recruitment to general practice training, which saw 104 of 111 places filled, compared to 94 of 111 in 2019.

Retention and progression through training

5.38 HEE said that COVID-19 had generated significant disruption to postgraduate medical and dental education in England, particularly due to the cancellation of high-stakes examinations required to complete training. They said that this had the potential to disrupt the consultant and mid-grade doctor supply pipeline, and lead to congestion in the training pipeline, at significant cost to HEE. They said that they had worked with the GMC to make adjustments to Annual Review of Competency Progression assessments and decisions, and permit temporary derogations to curricular requirements. They said that these actions would significantly lessen forecast disruptions and requirements for extensions. They said that rotations were paused in April 2020 to support the COVID-19 response, though they were resumed in August 2020.

5.39 The Scottish Government said that the pandemic had impacted postgraduate medical training, though they said that there was limited interruption to trainees progressing in the 2019-20 academic year, and that a comparable number of doctors gained a Certificate of Completion of Training compared to previous years. They added that there was the potential for some trainees to experience further disruption in the 2020-21 academic year. They said that NHS Education for Scotland had developed and issued guidance to mitigate the impact of this disruption, giving consistency, rigour and transparency to further deployment decisions. They said that those nearing the end of training programmes would be prioritised so they can catch up and are prepared for final assessments, and robust and systematic monitoring processes were in place.

Motivation

England

5.40 In Chapter 4 we reported on the results of the 2020 NHS Staff Survey. It showed that 52 per cent of doctors and dentists in training expressed satisfaction with their pay, a greater percentage than SAS doctors but smaller than for consultants. This was an improvement compared with 2019, when 49 per cent said they were satisfied, with satisfaction at its highest level since 2011.

Table 5.7: Selected results from the National Staff Survey, doctors and dentists in training, England, 2011 to 2020.

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend[1]
I look forward to going to work	64.2	64.8	64.1	65.8	66.8	67.4	64.4	67.8	66.1	63.3	
I am enthusiastic about my job	76.7	76.7	75.6	76.4	80.4	79.0	76.0	79.3	77.4	75.0	
Time passes quickly when I am working	80.6	78.1	79.2	80.7	83.2	79.4	79.1	79.7	79.2	77.2	
The recognition I get for good work	55.2	57.8	59.3	62.6	62.8	62.0	56.3	65.2	64.7	65.3	
The support I get from my immediate manager	75.6	73.8	79.4	77.7	79.3	74.5	75.4	77.5	77.6	76.6	
The support I get from my work colleagues	84.3	85.0	85.1	86.3	89.3	88.2	86.6	88.2	88.1	86.9	
The amount of responsibility I am given	81.4	80.7	83.4	81.6	82.7	81.6	78.7	81.4	80.9	81.0	
The opportunities I have to use my skills	78.5	79.0	82.3	80.9	81.9	79.6	79.2	79.4	80.0	77.2	
The extent to which my organisation values my work	39.4	49.9	51.0	52.4	48.8	50.9	48.8	55.8	56.7	57.6	
My level of pay	52.9	51.6	50.0	51.0	43.6	45.2	41.6	46.3	49.4	52.0	
Percentage of staff appraised in the last 12 months	77.7	81.1	82.2	81.5	77.7	81.8	78.4	79.6	77.5		
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.6	36.8	31.3	34.6	35.3	34.6	38.6	35.8	35.2	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

5.41 Job satisfaction indicators for doctors and dentists in training in 2020, were generally worse than in 2019 (Table 5.7). There were falls in the percentage saying that they looked forward to going to work, were enthusiastic about their job, that time passed quickly when they were working, were satisfied with the support they got from their immediate manager and their work colleagues, and the opportunities they had to use their skills. However, there were increases in the percentage saying they were satisfied with the recognition they got for good work, and the extent to which their organisation values their work. In addition, the percentage of doctors and dentists in training saying they had experienced harassment, bullying or abuse from patients fell slightly, but there were still over a third of those in training that experienced such behaviour.

5.42 Those in training were generally more positive about work pressures than in 2019 (Table 5.8). There were increases in the percentage saying that they were able to meet all the competing demands on their time, that they had adequate materials, and that there were enough staff at their organisation. There was also a reduction in the percentage saying that they had felt unwell as a result of work-related stress, albeit only from 40.9 per cent in 2019 to 39.0 per cent in 2020. There was continued evidence of improved practice on working hours beyond those that were contracted, with an increasing proportion of junior doctors reporting that these hours were paid, and a decreasing proportion reporting that they were unpaid, for the fourth consecutive year.

Table 5.8: Selected results from the National Staff Survey, doctors and dentists in training, England, 2011 to 2020.

Workload	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	28.5	34.7	34.4	37.3							
I am able to meet all the conflicting demands on my time at work[4]					43.4	45.7	43.8	44.7	45.1	47.4	
I have adequate materials, supplies and equipment to do my work	71.4	64.7	62.8	67.6	60.5	63.2	60.8	60.5	62.0	64.4	
There are enough staff at this organisation for me to do my job properly	47.1	44.0	40.2	45.7	42.2	38.6	34.3	39.0	39.5	46.4	
During the last 12 months have you felt unwell as a result of work related stress[2]		26.5	30.1	30.8	34.0	32.3	35.5	38.1	40.9	39.0	
Percentage of staff working PAID hours over and above their contracted hours[2]	28.5	33.8	32.8	30.8	36.2	34.1	38.2	41.0	44.1	45.5	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	68.0	71.9	75.5	72.9	83.1	77.4	75.5	70.8	70.5	67.4	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) For 2015, this question was reversed to "I am able to meet…"

(4) This question was introduced in 2015.

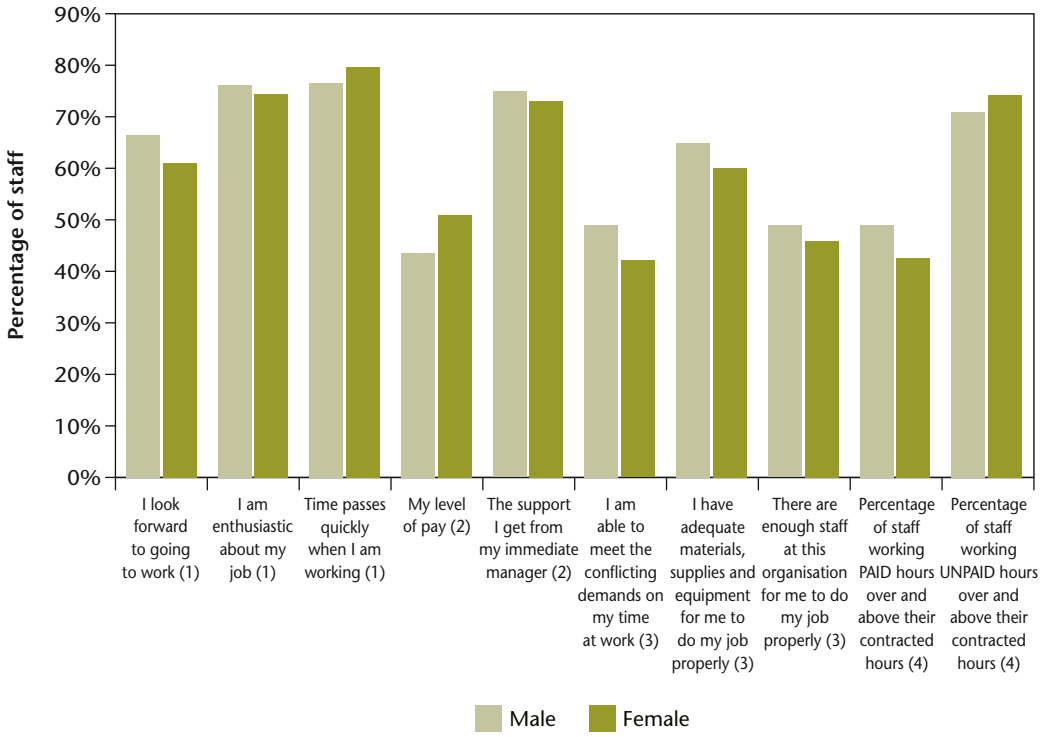
5.43 In addition to the usual range of questions, doctors and dentists in training were asked, as part of the 2020 Survey, about their experiences during the COVID-19 pandemic. The four areas covered were as follows:

- 60 per cent said that they had worked on a COVID-19 ward or area at any time (compared with 42 per cent of all medical and dental staff);
- 33 per cent said that they had been redeployed due to the COVID-19 pandemic at any time (compared with 22 per cent of all medical and dental staff);
- 27 per cent said that they had been required to work remotely/from home due to the COVID-19 pandemic (compared with 52 per cent of all medical and dental staff); and

- 5 per cent said that they had been shielding for themselves and 2 per cent said that they had been shielding for someone else in their household, compared with 6 per cent of all medical and dental staff shielding for themselves and 2 per cent shielding for someone else in their household.

5.44 Figure 5.2 shows in 2020, as in 2019, that female doctors and dentists in training are more satisfied with their pay than their male colleagues. However, compared with female doctors and dentists in training, male doctors and dentists in training were more likely to say that they looked forward to going to work, were enthusiastic about their job, were satisfied with the support they received from their line manager, were able to meet the conflicting demands on their time, had adequate materials to do their job and that there were enough staff at their organisation. Male doctors and dentists in training were more likely to work paid hours over and above their contracted hours, while female doctors and dentists in training were more likely to work extra unpaid hours.

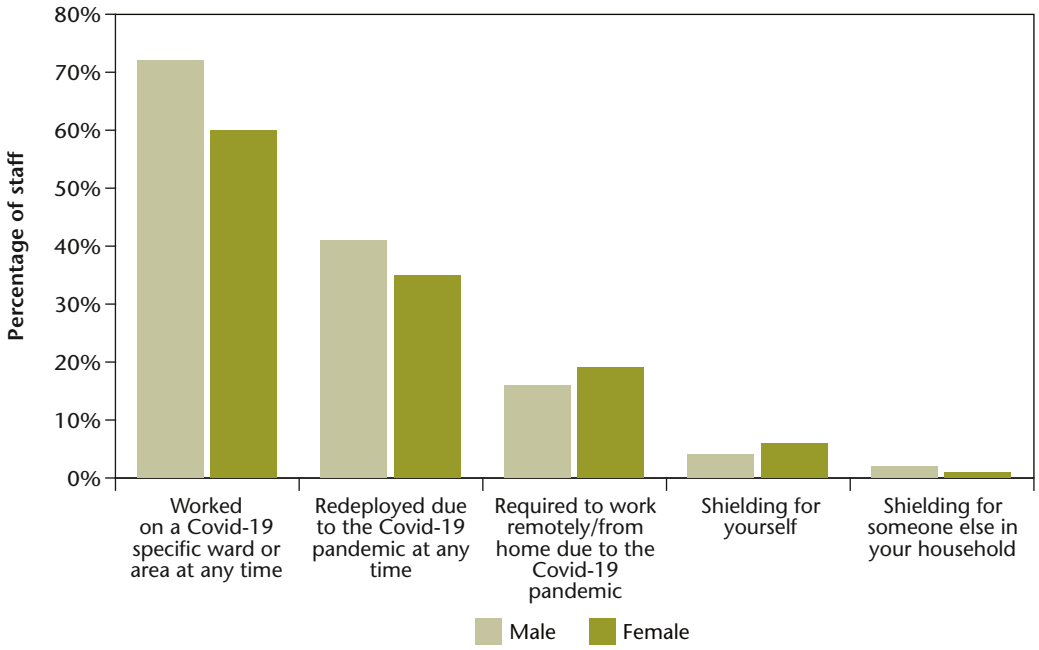
Figure 5.2: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by gender, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

5.45 Figure 5.3 shows doctors and dentists in training responses to questions about their experiences during the COVID-19 pandemic, by gender. Male trainees (72 per cent) were more likely than female trainees (60 per cent) to say that they worked on a COVID-19 specific ward or area. Male trainees (41 per cent) were also more likely to say that they had been redeployed than female trainees (35 per cent). Female trainees (19 per cent) were more likely than male trainees (16 per cent) to say that they had been required to work remotely or from home due to COVID-19.

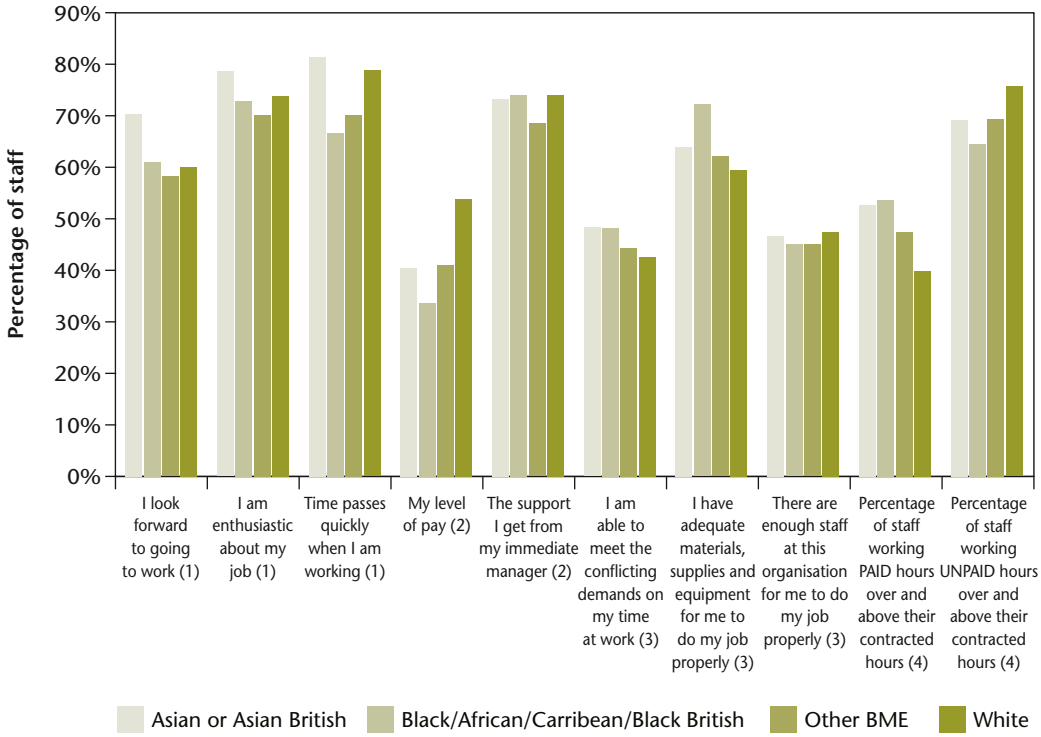
Figure 5.3: HCHS doctors and dentists in training, experiences during the COVID-19 pandemic by gender, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.

5.46 Figure 5.4 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian or Asian British doctors and dentists in training were more likely to say that they looked forward to going to work, were enthusiastic about their job, and that time passes quickly when they are working, than those from other ethnic groups. White doctors and dentists in training were more satisfied with their pay than colleagues from other ethnic groups. White doctors and dentists in training were less likely to say that they worked paid hours in addition to their contracted hours than colleagues from other ethnic groups, while White doctors and dentists in training were more likely to say that they worked unpaid hours in addition to their contracted hours.

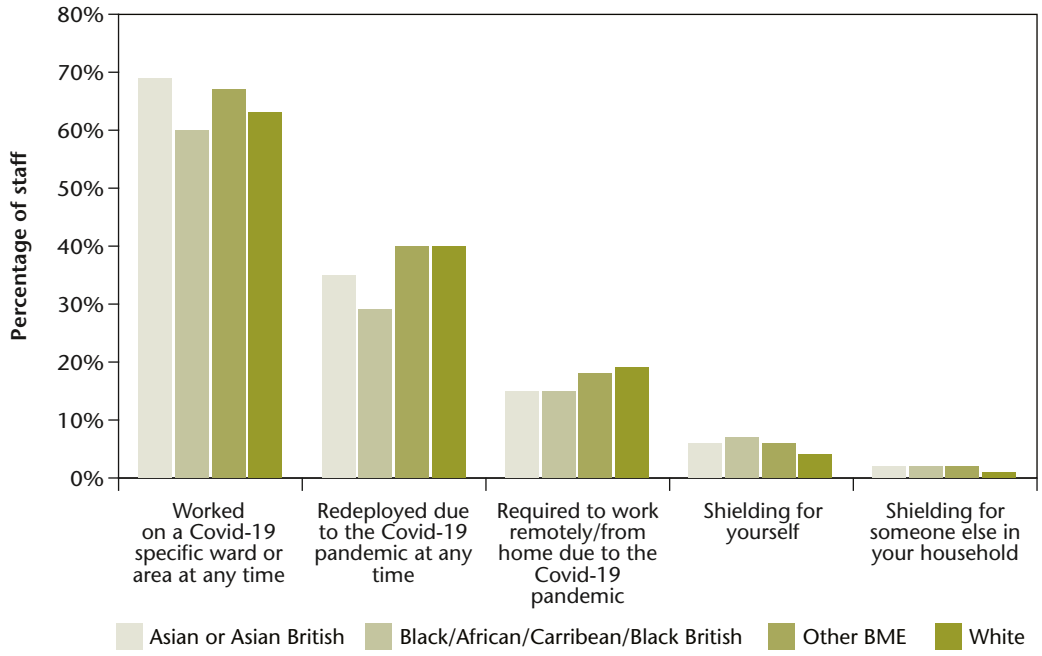
Figure 5.4: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by ethnic group, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

5.47 Figure 5.5 shows doctors and dentists in training responses to questions about their experiences during the COVID-19 pandemic, by ethnic group. Asian/Asian British trainees (69 per cent) and those from 'other' ethnic groups (67 per cent), were more likely to say that they worked on a COVID-19 specific ward or area than Black (60 per cent) and White (63 per cent) trainees. Asian/Asian British and Black trainees were less likely than both White trainees and those from other ethnic groups, to say that they had been redeployed or that they had been required to work remotely or from home, due to COVID-19.

Figure 5.5: HCHS doctors and dentists in training, experiences during the COVID-19 pandemic by ethnic group, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.

Scotland, Wales and Northern Ireland

5.48 In Chapter 4 we reported that the Scottish Government introduced an 'Everyone Matters' Pulse Survey for 2020 to measure staff experience. The survey was conducted in September 2020, and had 927 responses from doctors and dentists in training. Key results of doctors and dentists in training include:

- 69 per cent of doctors in training said that their organisation cares about their health and wellbeing, compared with 67 per cent of medical and dental respondents;
- 75 per cent said that their direct line manager cares about their health and wellbeing, compared with 77 per cent of medical and dental respondents;
- 79 per cent said that their work gave them a sense of achievement, compared with 79 per cent of medical and dental respondents;
- 72 per cent said that they felt appreciated for the work they do, compared with 70 per cent of medical and dental respondents;
- 79 per cent said that they were treated with dignity and respect as an individual at work, compared with 77 per cent of medical and dental respondents;
- 78 per cent said that they were treated fairly and consistently at work, compared with 75 per cent of medical and dental respondents;
- 76 per cent said that they got the help and support they needed from other teams and services, compared with 72 per cent of medical and dental respondents; and
- 74 per cent said that they would recommend their organisation as a good place to work, compared with 71 per cent of medical and dental respondents.

5.49 The staff survey results for Wales and Northern Ireland are not published in sufficient detail to identify doctors and dentists in training.

Our comments

5.50 We note that both the BMA and HCSA explicitly asked us to make recommendations for doctors and dentists in England who are covered by the multi-year pay agreement that remains in place until 2023. We will comment on this in Chapter 10, where we set out our recommendations.

5.51 Doctors and dentists in training have both contributed enormously to the pandemic response and have been particularly affected by the pandemic as a result of its impact on the postgraduate medical and dental training systems. According to staff survey results, more doctors and dentists in training had been redeployed to the front line of the pandemic response than other groups of doctors and dentists, and there has been severe disruption to the delivery of both training and assessments throughout the pandemic, including pauses to rotations. This has had a significant impact on progression through training in the short-term, and we welcome the efforts being made by those leading training systems across the UK to address this, and we hope that the effect on the number of trainees moving through the training pipeline to senior grades can therefore be minimised.

5.52 The pandemic has the potential to interact with existing long-term trends in this workforce, which we have previously outlined. These include the increased number of trainees that wish to train and work less-than-full-time, as well as demographic changes in university intakes, as the medical and dental workforces become increasingly female and ethnically diverse. The experience of the pandemic has the potential to change doctors' and dentists' career priorities, for instance by making temporarily taking breaks from training or working and training less-than-full-time more appealing. This may also exacerbate or interact with pre-pandemic trends in behaviour amongst doctors and dentists in training, such as the increased proportion stepping out of training on completion of the foundation programme. It may also affect the number of doctors that reach certain grades in the future, as well as the rate at which doctors and dentists complete their training. Similarly, the dynamics of which specialties are more popular, and which less so, may be affected by the pandemic, which has the potential to lead to shortages in some specialties in the long-term.

5.53 These trends may also be a factor in the increase in the number of SAS and locally employed doctors that the GMC described in their report *The state of medical education and practice in the UK*[9], as doctors and dentists who have temporarily stepped out of training instead work on locally determined contracts, which we heard described as 'Trust grade' or 'clinical fellow' roles during our visits programme. Ensuring that these doctors and dentists are treated fairly and retained while at the same time facilitating their return to training, should they wish to do so, is becoming increasingly important as their numbers grow.

5.54 At the same time, we welcome the work being done by HEE to gain a stronger understanding of how training places may be redistributed across England to address local workforce shortages. We also welcome the continued progress in increasing the number of medical school places across the UK, which should lessen the dependency on international recruitment into postgraduate medical training in the future.

[9] General Medical Council (November 2020). *The state of medical education and practice in the UK: 2020*. Available at: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk Figure 53 of this report shows significant growth in the combined total of SAS and locally employed doctors since 2018. That this growth was faster than the growth in the number of SAS doctors and dentists described in our reports and elsewhere during this period suggests that it is likely that the number of locally employed doctors has grown significantly in recent years.

5.55 All of these factors together require a robust, transparent and comprehensive workforce planning response. These challenges of retention, progression and changing workforce behaviour must be addressed in order for the investment into the medical workforce that is represented by the increase in medical school places to have the maximum possible benefit to health services, and ultimately patient outcomes. Similarly, in the shorter term, the larger medical school intakes that have resulted from the disruption to higher education that took place in 2020 must be accommodated in the training system, with assurances that there will be adequate capacity at all stages of the undergraduate and postgraduate training systems, so that the benefit to health services that can result from this is maximised and these doctors and dentists are retained.

5.56 It is also important that health service leaders ensure that doctors' and dentists' experiences of the training system are positive, to support motivation and retention. On our visits programme we heard from doctors and dentists in training across the UK who said that they had had negative experiences, including relating to the cost of training and exams, the potential for the way that regional deaneries allocate training placements to impact on family life, and negative workplace cultures. We welcome the initiatives being undertaken to support workforce wellbeing across the UK in this context.

5.57 We also note that the Gender Pay Gap in Medicine Review made a number of recommendations relating to the training system in England, including steps towards reducing the burden of assessment, ensuring consistency of training outcomes across the country, supporting men and women to work more equally across specialties and increasing opportunities for trainees to move between NHS geographical regions to reduce attrition. We hope that these recommendations can be implemented soon. Given the similarities in the structures of the medical training systems across the UK, these recommendations are also likely to apply in Scotland, Wales and Northern Ireland.

5.58 Finally, we welcome that the Welsh Government are exploring possibilities for modernising their contract for doctors and dentists in training. We would encourage governments in Scotland and Northern Ireland to continue to explore the potential benefits and opportunities of reforming their contracts.

CHAPTER 6: STAFF GRADE, ASSOCIATE SPECIALIST, SPECIALIST AND SPECIALTY DOCTORS AND DENTISTS

Introduction

6.1 Staff Grade, Associate Specialist, Specialist and Specialty (SAS) doctors and denitsts are a diverse group comprising those working in multiple grades in the Hospital and Community Health Services (HCHS) across the UK. SAS doctors and dentists are experienced and senior clinicians who have completed at least four years of post graduate training, two of which have been in their relevant speciality. SAS doctors and dentists carry out highly specialised roles and often contribute greatly to patient care in addition to being involved with teaching, research and leading service development.

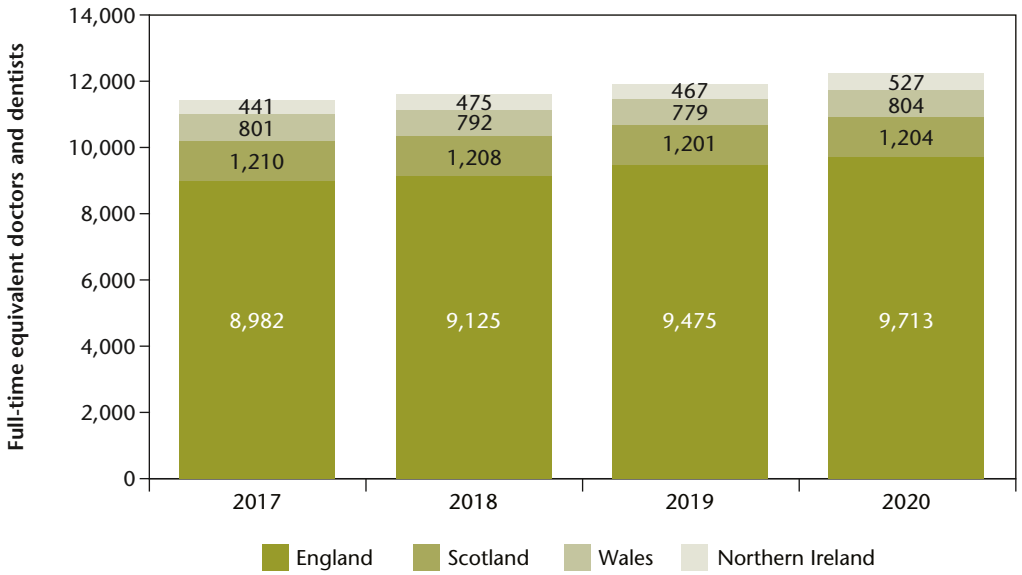
Workforce numbers

6.2 In September 2020[1] there were 12,249 full-time equivalent (FTE) SAS doctors and dentists in the UK, around nine per cent of the hospital medical and dental workforce. In 2020, compared with 2019, the number of SAS doctors and dentists increased by 2.7 per cent, with increases of 12.9 per cent in Northern Ireland, 3.3 per cent in Wales, 2.5 per cent in England and 0.3 per cent in Scotland (Figure 6.1).

6.3 Data from NHS Digital, for England only, give a breakdown of the remit group by gender and ethnicity. The data show that in December 2020, 47 per cent of specialty doctors and dentists, 44 per cent of staff grades, and 40 per cent of associate specialists were female, compared with 38 per cent of consultants. A majority of SAS doctors and dentists, excluding those where ethnic group was not known, identify as being from an ethnic minority group, unlike the rest of the medical and dental workforce. In December 2020, 64 per cent of specialty doctors, 60 per cent of associate specialists and 60 per cent of staff grades identified as being from an ethnic minority group, compared with 41 per cent of consultants. Data from NHS Digital, for England only, showed that SAS doctors and dentists were also more likely to have a non-UK nationality than HCHS doctors and dentists as a whole. In December 2020, of those where nationality data was available, 30 per cent of HCHS doctors and dentists were non-UK nationals, compared with 53 per cent of staff grade doctors and dentists, 51 per cent of specialty doctors and dentists, and 33 per cent of associate specialists.

[1] Northern Ireland data are as at 31 March each year. The new Specialist contract was only introduced from 1 April 2021.

Figure 6.1: Number of specialty doctors and dentists, associate specialists and staff grades in the Hospital and Community Health Services (HCHS), United Kingdom, 2017 to 2020



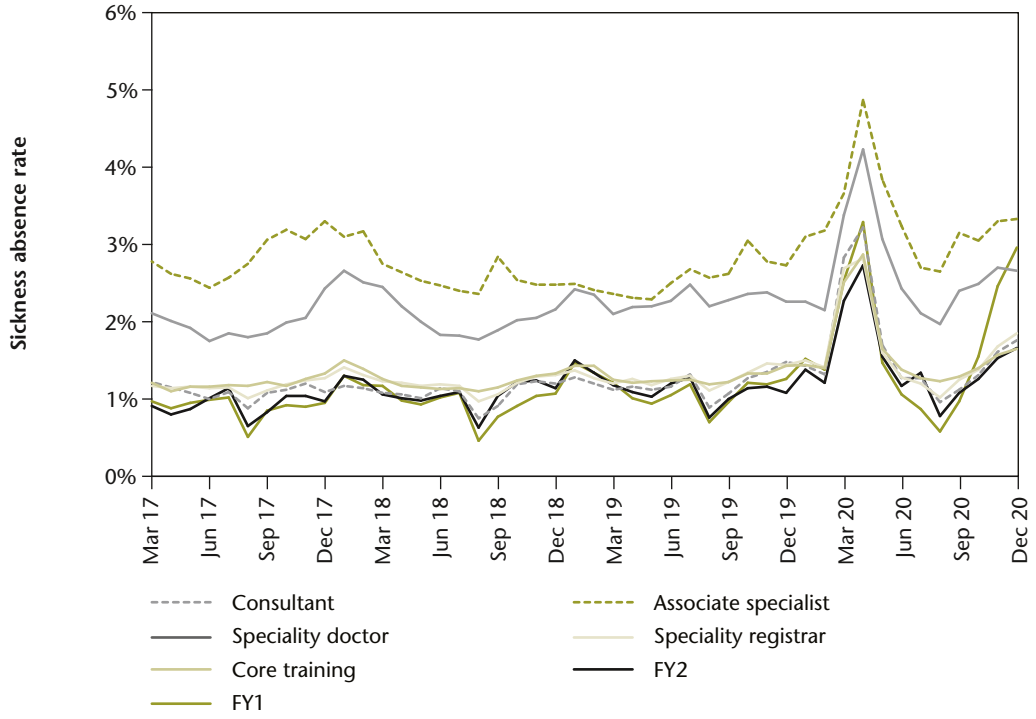
Source: NHS Digital, StatsWales, NHS Education for Scotland, Department of Health Northern Ireland.

Working through the COVID-19 pandemic

6.4 DHSC told us that changes to working patterns and extra work carried out during the pandemic were managed by the standard national contract provisions for the SAS grades. This was used to set out the rates of pay for additional Programmed Activities, out-of-hours work and on call rotas.

6.5 The General Medical Council's Barometer Survey 2020 found that 60 per cent of SAS doctors were not redeployed, 27 per cent were redeployed within their specialty and 12 per cent were redeployed outside their specialty. They also found that 60 per cent of SAS doctors felt they were at risk of burnout. Data from NHS Digital, for England (Figure 6.2) shows that sickness absence rates for associate specialists and specialty doctors and dentists are usually higher than those for other grades, including in March and April 2020, when sickness absence rates spiked at the start of the COVID-19 pandemic.

Figure 6.2: Sickness absence rates, England, by grade, March 2017 to December 2020



Source: NHS Digital.

6.6 The BMA said that, as with consultants, SAS doctors had taken on additional work and duties during the pandemic. SAS doctors had also reported high levels of fatigue, low levels of morale and high burnout. The BMA said that many doctors led new ways of working to provide high levels of care during the pandemic. A BMA Northern Ireland survey found 56 per cent of SAS doctors used more technology to carry out patient consultations.

6.7 The BMA told us that the Welsh Government, NHS Employers Wales and BMA Cymru Wales agreed to an advisory notice on enhanced rates of pay for work carried out outside of agreed working hours. The agreement was implemented during the first wave of the pandemic and re-activated during the second wave.

6.8 The BMA said that SAS doctors in Northern Ireland responded to the pandemic in a similar way as consultants and changed their working hours, location and specialty. A BMA Northern Ireland survey of SAS doctors found that 61 per cent changed their working hours and 17 per cent changed the services they worked in with 1 in 5 SAS doctors redeployed to work at a different site or new service.

Contract reform

England, Wales and Northern Ireland

6.9 In March 2021, we received a letter from NHS Employers and the BMA informing us that national negotiations for two contracts for the SAS grades had concluded in England, Wales and Northern Ireland. The agreement includes a reformed Specialty Doctor contract[2] and a new Specialist contract, creating a new Specialist grade. The contract packages have been approved in England, Wales and Northern Ireland by BMA members and the UK and Welsh governments and Northern Ireland Executive. The new contracts will be introduced over the course of three years from 1 April 2021 to 31 March 2024. In England and Wales the contracts will include annual investment of 3 per cent over 3 years to support reform. DHSC and the Welsh Government said that the additional one per cent the review body recommended for the SAS grades in 2019 was made available as part of a contract reform envelope. NHS Employers and the BMA said the extra one per cent was incorporated into the 3 per cent investment for the first year of the contract in England and Wales. In Northern Ireland, investment is guaranteed for the first year of the contract, and the Department of Health will seek approval from the Department of Finance on an annual basis for the second and third year of the contracts. The Department of Health said the investment for the first year of the contract is 3 per cent[3].

6.10 The contracts in England, Wales and Northern Ireland will apply to new staff entering the grade from 1 April 2021. Existing SAS doctors and dentists employed on national terms and conditions of service will have the opportunity to choose to transfer to the new Specialty Doctor contract or remain on their current contract. Similarly, doctors on national terms and conditions in the closed Associate Specialist grade will be able to choose to move to the Specialist grade. Existing SAS doctors and dentists in England and Wales have until 30 September 2021 to express an interest in moving onto the new contracts. In Northern Ireland, the Department of Health has agreed an extension to this period until 31 October in recognition of the delayed final approval of terms and conditions. NHS Employers and the BMA asked the review body to continue to make recommendations for SAS doctors and dentists on closed national contracts who choose to remain on their existing contracts in England, Wales and Northern Ireland.

6.11 NHS Employers and the BMA said the Specialist and Specialty Doctor contracts will include new pay scales with a reduced number of pay points for faster progression and greater earnings potential. The new pay scale for the Specialty Doctor contract will reduce the time taken to reach the top of the pay scale from 17 years to 12 years. Doctors and dentists on the new Specialist grade contract will typically take six years to reach the top of the pay scale. Automatic incremental pay progression for both contracts will be replaced by pay progression aligned with the development of skills, competencies and experience.

6.12 The BMA said considerations to improve the health and wellbeing of the SAS grades were carefully examined when developing the new contracts. A key element of the health and wellbeing offer is the creation of the SAS Advocate role to help address bullying and harassment that many SAS doctors and dentists have reported experiencing. The SAS Advocate role is encouraged in Trusts in England with the role implemented by employers based on need. The BMA told us the optional nature of the SAS Advocate role in England was as a result of funding difficulties.

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[2] The new and old contracts are referred to as Specialty Doctor contracts, though they cover doctors and dentists. We refer to those on the Specialty Doctor contracts as specialty doctors and dentists throughout this report.
[3] Department of Health (January 2021). *Framework Agreement on SAS Contract Reform in Northern Ireland 2021.* Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-sas-contract-reform.pdf

6.13 DHSC said equalities implications were considered during the development of the new SAS contracts and that recommendations from the Gender Pay Gap in Medicine Review were used to develop the SAS contracts and informed the use of shorter pay scales.

6.14 The Welsh Government said the smaller number of pay points on the Specialty Doctor contract in Wales will enable a higher starting salary that is better aligned with other pay scales and raise the status of the SAS grades. The new SAS contracts will aid the recruitment and retention of existing SAS doctors and dentists and incentivise agency and locum doctors to join the grade as substantive staff. The SAS Advocate role will be mandatory in Health Boards in Wales and the Welsh Government will be developing a role profile for the new Advocate Role as outlined in the Welsh SAS framework agreement.

6.15 The HCSA were not formally engaged with SAS contract negotiations. They told us that doctors in the Specialist grade will need to be carefully monitored to ensure they benefit from additional responsibilities undertaken.

Scotland

6.16 The Scottish Government said they will take a Scotland-specific approach to SAS contract negotiations. This will include a reformed Specialty Doctor contract as well as the potential for a senior Specialty Doctor grade. The BMA said formal contract discussions were paused due to COVID-19 but have now resumed with the aim of reaching a deal by the end of 2021 subject to a mandate being granted by the Cabinet Secretary.

Recruitment and retention

England

6.17 Doctors and dentists in the SAS grades can be on a diverse range of career pathways. NHS England and Improvement (NHSE/I) said the grade includes doctors who have completed specialty training and have joined the grades while seeking a consultant post, doctors who have entered the grades as a permanent career choice, those who 'step-off' training for a short period of time with the intention of returning to training, and doctors recruited internationally into SAS roles.

6.18 Data from NHS Digital showed that in 2019-20 specialty doctors and dentists (91.2 per cent), staff grades (88.5 per cent) and to a lesser extent associate specialists (93.3 per cent), had a lower stability index[4] than consultants (94.6 per cent). Data from NHS Digital showed that between January 2017 and November 2020 SAS doctors had higher sickness absence rates than the overall rate for hospital doctors. In the three months to December 2020, consultants and different grades of doctors and dentists in training had sickness rates of between 1.5 per cent and 2.3 per cent, compared with rates of 3.2 per cent for associate specialists, 2.6 per cent for specialty doctors and dentists and 2.8 per cent for staff grades.

[4] The stability index is the percentage of staff there at the start of the period that do not leave the NHS in England during the period in question. This is useful for looking at staff retention. For example, if the NHS had 100,000 doctors at the start of the year and a year later 90,000 of those doctors remained in post, the stability index would be 90%.

6.19 NHS Employers told us that several programmes to aid the development of the SAS grades were put on hold due to the COVID-19 pandemic. This includes the progress report for *Maximising the Potential: essential measures to support SAS doctors*, a strategy by HEE and NHS Improvement published in 2019 to better the support and development opportunities for SAS doctors in England. *Maximising the Potential* outlines several measures to be implemented by partner organisations, including an NHS Employers-led review of the SAS development guide, which has updated guidance on continued professional development, autonomous working and guidance on how SAS doctors can work as educational and clinical supervisors for doctors in training.

6.20 NHS Employers conducted a survey of employers in March 2020 to better understand the challenges in the recruitment and retention of the SAS grades. The survey found that the majority of respondents (85 per cent) reported difficulties in recruiting SAS roles. The supply of SAS doctors was cited as the main reason for this. Other reasons included career progression, junior doctor vacancies and a lack of mentors. NHS organisations reported particular difficulty in recruiting SAS doctors to emergency medicine, general medicine, anaesthetics and paediatrics. The survey also reviewed the implementation of the SAS charter and found that the majority of respondents (86 per cent) had taken steps to implement the SAS charter.

6.21 The BMA said the non-standard titles of SAS doctors and dentists need to be examined to improve the conditions of the SAS grades. The SAS grades include a range of job titles derived from changing structures and contractual agreements.

6.22 Health Education England (HEE) told us the SAS grades still report concerns regarding limited workplace support. To address this, HEE said that it continues to administer funding for SAS development. The fund is allocated to Trusts to support SAS doctors and dentists with educational development and training. HEE said retention can be improved by making the SAS role a flexible career choice that gives doctors the ability to pursue individualised career pathways and 'step-on' and 'step-off' training. HEE said that many SAS doctors and dentists want to carry out further training but have varied training preferences with some doctors looking to gain extensive training and others wanting some additional training to support their work. They said that greater flexibility within the grade will improve the recruitment of SAS roles and increase the number of SAS doctors and dentists available for service provision.

6.23 NHSE/I said that SAS doctors are vital to service delivery, particularly in smaller Trusts and in remote and rural areas where SAS doctors help to make up for a shortage of consultants and trainees. NHSE/I said the NHS Long Term Plan and the People Plan 2020/21 set out commitments to make the SAS grades more attractive and to provide an alternative career for doctors that do not want to be GMPs or consultants.

6.24 NHS Providers told us that improvements to the recognition of SAS doctors and how valued they feel is needed to help with recruitment and retention. A survey of Trust HR directors by NHS Providers (November 2020) said that the SAS grades are an integral workforce essential to service delivery in Trusts.

Wales

6.25 The Welsh Government said that SAS doctors were critical to filling rotas in Wales. Health Education and Improvement Wales said they were building training to support skills and assist doctors following the Certificate of Eligibility of Specialist Registration (CESR) route. An Associate Postgraduate Dean for SAS grades in Wales was appointed to support doctors and dentists and develop a network of SAS tutors to facilitate training and career progression in Health Boards.

Scotland

6.26 The Scottish Government said that the SAS Development Fund has contributed to the cost of training and aided SAS doctors with the additional training and guidance needed to apply for the CESR. Funding has also enabled the appointment of a SAS Associate Postgraduate Dean to lead the Development Fund and the creation of a network of Educational Advisers to help local SAS doctors and dentists through individual support and guidance. The Fund's impact assessment for 2019-20 found that it led to improved service delivery and clinical care.

Northern Ireland

6.27 The Department of Health said work to embed the SAS charter is ongoing. A SAS development lead for each HSC Trust has been appointed with the role of aiding doctors to access training and development courses. A Regional Associate SAS Dean to support the allocation of the SAS development budget is expected to be recruited to work alongside the development lead to improve the training available with new courses and education and additional development opportunities. The Department of Health said that new courses have been designed in line with the varied needs of the SAS grades and will be accessible for 2021-22.

Motivation

England

6.28 In Chapter 4 we reported on the results of the 2020 NHS Staff Survey. It showed that 49 per cent of SAS doctors expressed satisfaction with their pay, an increase from 2019, but a smaller percentage than for consultants.

6.29 Table 6.1 shows results from the staff survey questions relating to engagement and staff satisfaction. The responses were mixed, but generally worse than those of 2019. There were declines in the percentage saying that they look forward to going to work, that they were enthusiastic about their job and that time passes quickly when they were working. There were also declines in the percentages saying they were satisfied with the support they got from their work colleagues, the amount of responsibility they were given, and the opportunities they had to use their skills. There were increases in the percentages saying that they were satisfied with the recognition they got for good work, the support they got from their immediate manager, and the extent to which their organisation values their work. There was also a fall in the percentage saying that they had experienced harassment, bullying or abuse in the past 12 months, although almost 32 per cent still reported having done so.

Table 6.1: Selected results from the National Staff Survey, SAS doctors and dentists, England, 2011 to 2020.

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend[1]
I look forward to going to work	62.8	63.2	63.3	66.3	68.3	69.0	67.2	68.2	68.3	67.7	
I am enthusiastic about my job	72.6	75.1	73.8	77.4	79.2	78.3	77.0	78.1	77.8	77.1	
Time passes quickly when I am working	78.6	78.8	79.8	82.0	83.3	82.7	80.7	81.4	81.0	79.3	
The recognition I get for good work	51.8	50.7	50.4	55.3	55.4	58.1	56.6	59.6	60.0	61.8	
The support I get from my immediate manager	64.7	65.3	65.1	70.3	67.8	70.2	67.0	70.1	69.3	69.9	
The support I get from my work colleagues	78.7	79.7	79.1	81.0	82.1	84.1	84.2	83.0	83.9	83.6	
The amount of responsibility I am given	77.4	80.1	75.4	77.9	78.0	77.9	77.7	78.4	78.5	76.1	
The opportunities I have to use my skills	72.6	76.0	71.3	75.4	74.8	73.8	74.1	73.3	74.7	71.8	
The extent to which my organisation values my work	37.8	45.1	44.4	50.7	46.1	50.3	48.0	50.9	51.0	53.8	
My level of pay	42.5	43.7	42.4	41.4	42.9	46.2	42.9	43.2	44.7	49.2	
Percentage of staff appraised in the last 12 months	74.5	79.8	83.7	89.2	90.3	88.3	91.2	89.5	88.8		
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		33.9	31.1	32.1	30.9	32.6	33.8	33.8	35.7	31.9	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

6.30 Table 6.2 shows responses to questions about workload pressures. Compared with 2019, the responses are generally more positive. There was an increase in the percentage of respondents saying that they were able to meet all the conflicting demands on their time at work, they had adequate materials and equipment to do their work and that there are enough staff at their organisation for them to do their job properly. There were falls in the percentages saying they had worked extra hours, both paid and unpaid.

Table 6.2: Selected results from the National Staff Survey, SAS doctors and dentists, England, 2011 to 2020.

Workload	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	35.2	36.0	37.9	39.6							
I am able to meet all the conflicting demands on my time at work[4]					45.8	44.8	42.0	45.7	44.9	48.5	
I have adequate materials, supplies and equipment to do my work	63.4	63.9	64.2	65.0	60.5	61.7	62.6	62.0	62.6	67.3	
There are enough staff at this organisation for me to do my job properly	38.3	40.4	39.2	38.3	37.2	37.7	34.7	35.4	36.3	45.9	
During the last 12 months have you felt unwell as a result of work related stress[2]		34.9	36.8	31.3	32.4	32.2	34.6	37.9	37.1	42.4	
Percentage of staff working PAID hours over and above their contracted hours[2]	27.4	30.7	31.0	33.1	32.0	33.3	33.7	35.6	38.1	34.4	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	56.9	61.0	62.1	62.4	65.9	67.5	66.8	67.6	65.2	63.8	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

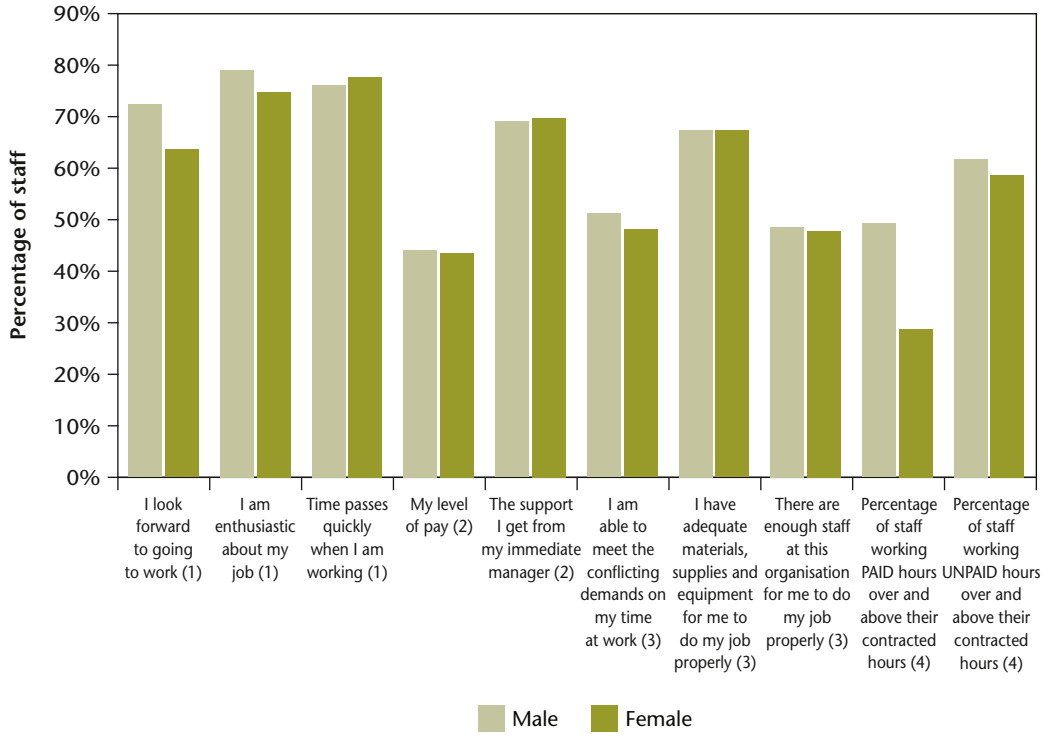
(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

6.31 In addition to the usual range of questions, SAS doctors and dentists were asked, as part of the 2020 survey, about their experiences during the COVID-19 pandemic. The four areas covered were as follows:

- 39 per cent said that they had worked on a COVID-19 ward or area at any time (compared with 42 per cent of all medical and dental staff);
- 23 per cent said that they had been redeployed due to the COVID-19 pandemic at any time (compared with 22 per cent of all medical and dental staff);
- 40 per cent said that they had been required to work remotely/from home due to the COVID-19 pandemic (compared with 52 per cent of all medical and dental staff); and
- 8 per cent said that they had been shielding for themselves and 3 per cent said that they had been shielding for someone else in their household, compared with 6 per cent of all medical and dental staff shielding for themselves and 2 per cent shielding for someone else in their household.

6.32 Figure 6.3 shows that SAS doctors and dentists satisfaction with pay differed little by gender. However, compared with female SAS doctors and dentists, male SAS doctors and dentists were more likely to say that they looked forward to going to work, and were enthusiastic about their job. Male SAS doctors and dentists were more likely to work hours over and above their contracted hours, both paid and unpaid hours, than their female colleagues.

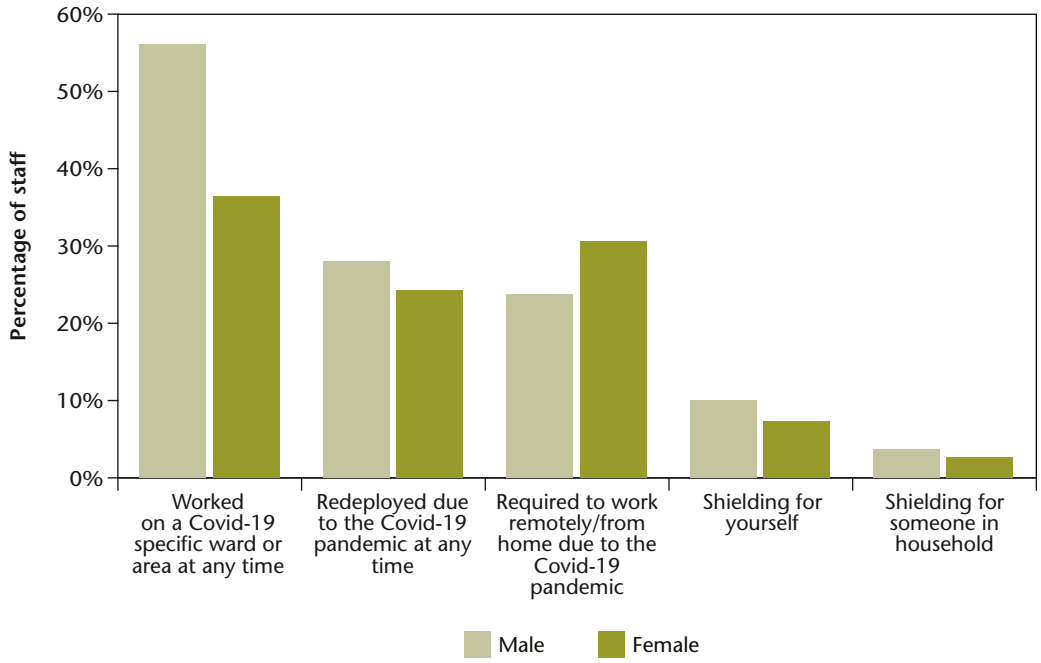
Figure 6.3: HCHS SAS (other) doctors and dentists, satisfaction with aspects of the job and work pressures by gender, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

6.33 Figure 6.4 shows SAS doctors and dentists' responses to questions about their experiences during the COVID-19 pandemic, by gender. Male SAS doctors and dentists (56 per cent) were more likely than female SAS doctors and dentists (36 per cent) to say that they worked on a COVID-19 specific ward or area. Male SAS doctors and dentists (28 per cent) were also more likely to say that they had been redeployed than female SAS doctors and dentists (24 per cent). Female SAS doctors and dentists (31 per cent) were more likely than male SAS doctors and dentists (24 per cent) to say that they had been required to work remotely or from home due to COVID-19.

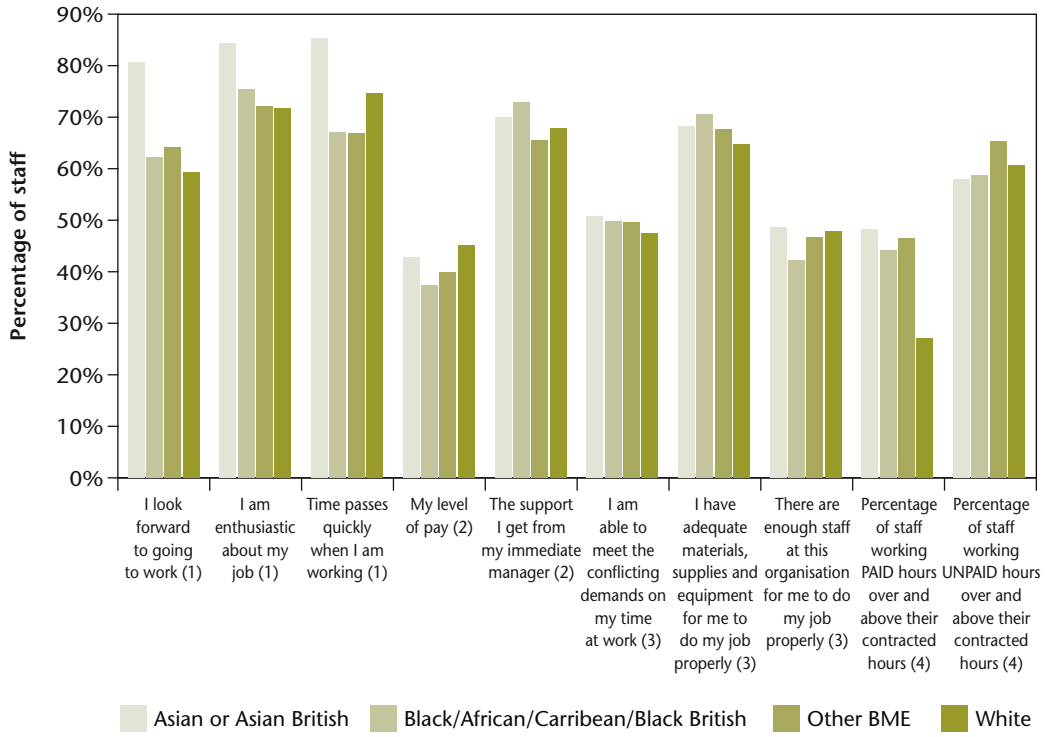
Figure 6.4 HCHS SAS (other) doctors and dentists, experiences during the COVID-19 pandemic by gender, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.

6.34 Figure 6.5 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian/Asian British SAS doctors and dentists, compared with those from other ethnic groups, were more likely to say that they looked forward to going to work, were enthusiastic about their job, and said that time passed quickly when they were working. White SAS doctors and dentists were less likely to work extra paid hours than colleagues from other ethnic groups.

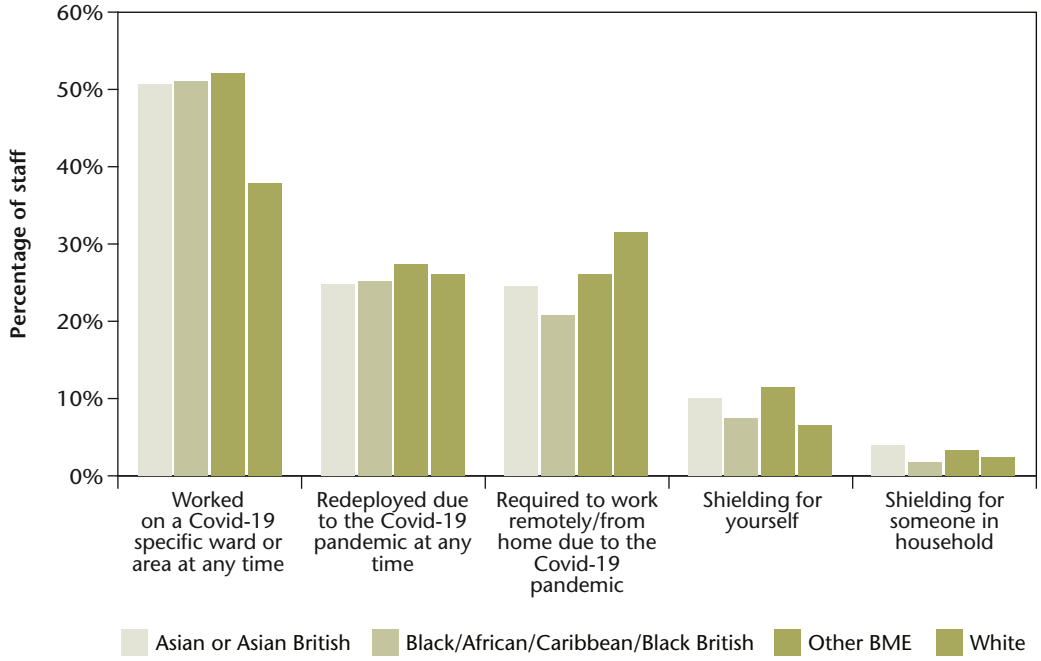
Figure 6.5: HCHS SAS (other) doctors and dentists, satisfaction with aspects of the job a pressures by ethnic group, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

6.35 Figure 6.6 shows SAS doctors and dentists' responses to questions about their experiences during the COVID-19 pandemic, by ethnic group. Just 38 per cent of White SAS doctors and dentists worked on a COVID-19 ward, compared with over 50 per cent of SAS doctors and dentists from other ethnic groups. White SAS doctors and dentists were also more likely to have been required to work remotely/from home, with 31 per cent having done so, compared with between 21 and 26 per cent of those from other ethnic groups.

Figure 6.6: HCHS SAS (other) doctors and dentists, and experiences during the COVID-19 pandemic by ethnic group, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.

Scotland, Wales and Northern Ireland

6.36 The staff survey results for Scotland, Wales and Northern Ireland are not published in sufficient detail to identify SAS doctors and dentists.

Our comments

6.37 We welcome the new Speciality Doctor and Specialist grade contracts in England, Wales and Northern Ireland. We hope the new contracts will provide much-needed career progression and development for SAS doctors and dentists, raise the profile of the SAS grades and subsequently aid recruitment and retention.

6.38 We are concerned that funding for the SAS contracts in Northern Ireland has only be allocated for a year. We hope funding for the full duration of the contract can be secured as soon as possible. This will address concerns that doctors and dentists in Northern Ireland might be left behind in comparison to their counterparts in the rest of the UK.

6.39 We welcome the resumption of SAS contract negotiations in Scotland. We hope that the new SAS contract will enhance the attractiveness of the grade and lead to improved recognition and career progression for SAS doctors and dentists in Scotland.

6.40 In our 2019 report we recommended that the SAS grades receive an additional 1 per cent uplift above the core recommendation of 2.5 per cent. In our last report we noted that we would consider revisiting this if contract negotiations were not complete by April 2021. We note that the BMA and NHS Employers both said that contract reform in England, Wales and Northern Ireland did include this additional 1 per cent as a part of the investment for contract reform.

6.41 We recognise that COVID-19 had led to a pause in SAS contract negotiations in Scotland. Following the resumption of contract negotiations we expect that, as was the case in England, Wales and Northern Ireland, the additional 1 per cent that we recommended in 2019 will be included in the funding envelope for negotiations.

6.42 We are pleased about the continuation of the SAS development fund in Scotland and hope a new SAS contract will help all SAS doctors and dentists gain the skills and training that the SAS development fund has provided.

6.43 We believe the new Advocate role can improve the health and wellbeing of the SAS grades and address issues related to bullying and harassment and hope that that SAS Advocates receive the help they need to support SAS doctors and dentists. A consistent role profile for the Advocate role will set standards in Trusts and Health Boards to ensure support is provided for the SAS grades and work to improve motivation and morale.

6.44 We note, as in our previous reports, that issues related to equality and inclusion need to be examined further as the SAS grades have the highest proportions of staff from an ethnic minority background and a higher proportion of SAS doctors are women compared with consultants. Furthermore, a large proportion of SAS doctors have studied for their primary medical qualification overseas. In addition to these factors, the SAS grades have a high rate of bullying and harassment and high sickness absence rates. In our last report we reported that the demography of the SAS grades means that they are more likely to be impacted by gender and ethnicity pay gaps. We note that the shortened pay scales of the new SAS contracts will work to address the gender pay gap but we hope that more work can be done to understand and address other equalities issues, including the ethnicity pay gap. Doing this will strengthen recruitment, retention and motivation in the long term.

CHAPTER 7: CONSULTANTS

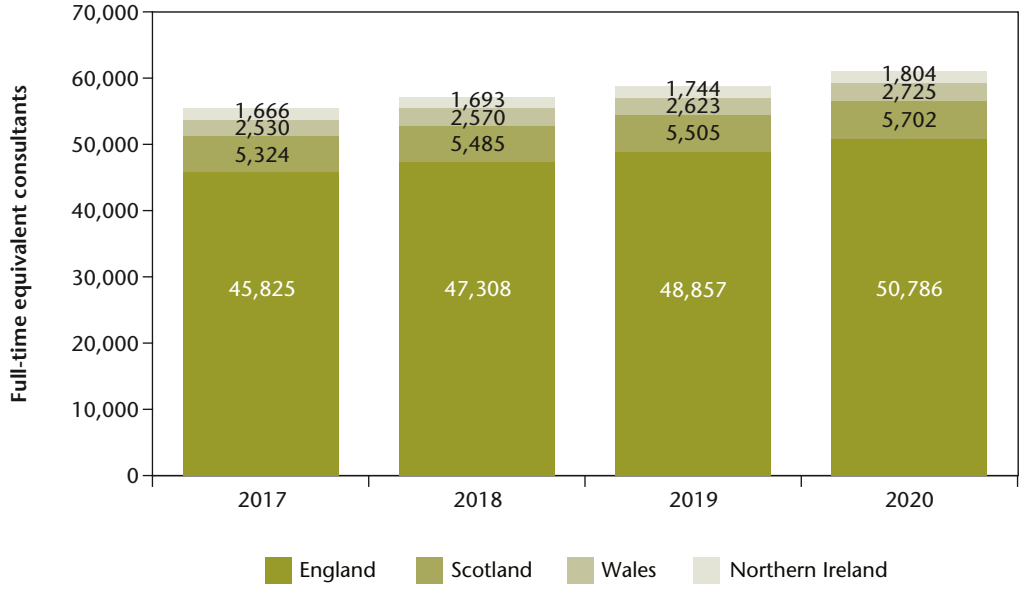
Introduction

7.1 This chapter covers consultants, the most senior grade of hospital doctors. Doctors become eligible for consultant roles on receipt of either a Certificate of Completion of Training (CCT) from the General Medical Council (GMC) after completing postgraduate training, or a Certificate of Eligibility for Specialist Registration (CESR) after demonstrating to the GMC that they have the knowledge, skills and experience necessary to be a consultant.

Workforce numbers

7.2 In September 2020[1], on a full-time equivalent (FTE) basis, there were 61,017 consultants in the UK, an increase of 3.9 per cent from a year earlier (Figure 7.1). All countries in the UK experienced an increase: 3.9 per cent in England, 3.9 per cent in Wales, 3.6 per cent in Scotland, 3.5 per cent in Northern Ireland.

Figure 7.1: Number of consultants in the Hospital and Community Health Services (HCHS), United Kingdom, 2017 to 2020

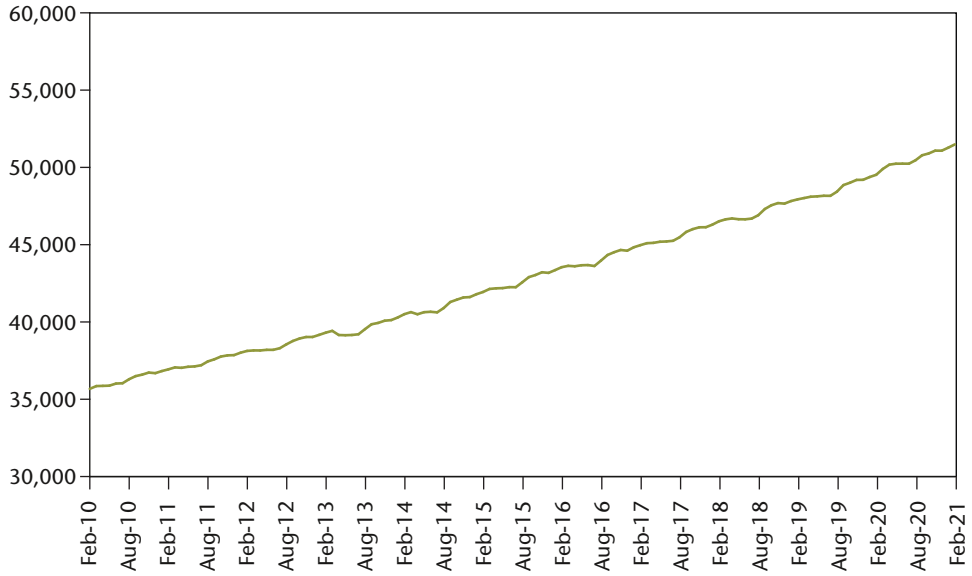


Source: NHS Digital, NHS Education for Scotland, StatsWales, Department of Health Northern Ireland.

7.3 Between February 2010 and February 2021, the number of FTE consultants in England increased from 35,700 to 51,500, an increase of 44 per cent (Figure 7.2).

[1] Northern Ireland data are at March 31 for each year.

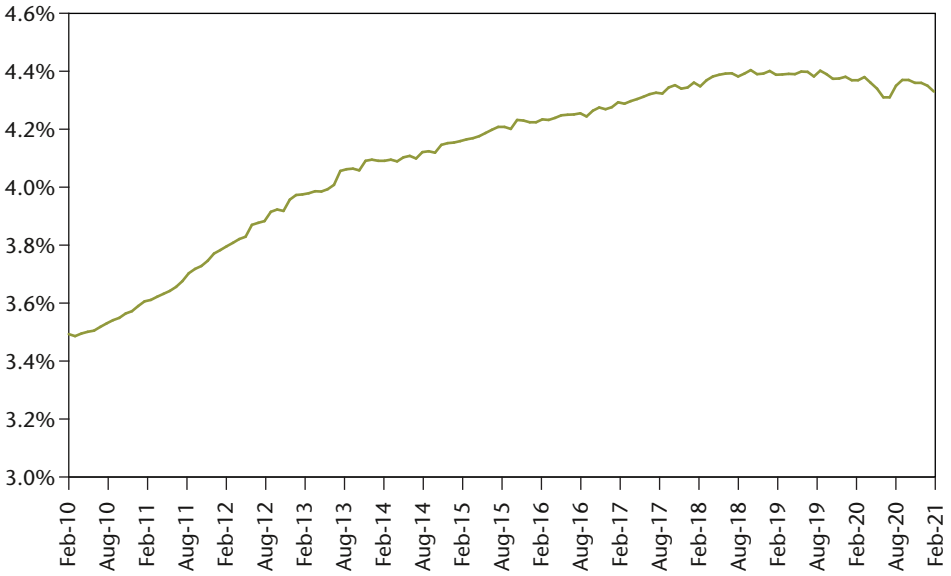
Figure 7.2: Consultants in the Hospital and Community Health Services (HCHS), England, 2010 to 2021



Source: NHS Digital.

7.4 For much of the time since 2010, the number of consultants in England has grown more quickly than the HCHS workforce as a whole. In February 2010 consultants accounted for 3.5 percent of the total FTE HCHS workforce, increasing to 4.4 per cent by 2018, before falling back to 4.3 per cent in the middle of 2020, as the wider NHS workforce grew more quickly than the consultant workforce, in response to COVID-19 (Figure 7.3).

Figure 7.3: Consultants in the Hospital and Community Health Services (HCHS), England, percentage of FTE HCHS workforce, 2010 to 2021



Source: NHS Digital.

Working through the COVID-19 pandemic

7.5 DHSC said that working arrangements for consultants in England through the pandemic had been largely managed through the provisions within the 2003 contract, which allows for local arrangements to be agreed for those working additional unsocial hours or excessive unpredictable emergency work. They said that this enabled employers to maintain comprehensive service provision focused on meeting their most pressing needs.

7.6 The BMA said that they had agreed a number of measures with employers in all four nations around how the additional demands on consultants would be managed through the first wave of the pandemic. However, they said that they had sought to negotiate national solutions for pay for additional hours worked related to the pandemic, but were only able to agree such guidance with the Welsh Government; and that in England, Scotland and Northern Ireland, employers were told to implement local solutions.

7.7 NHS England and Improvement (NHSE/I) said that consultants were among the staff groups in the NHS that had been particularly affected by the pandemic. They described some of the ways that the consultant workforce had been impacted, including increased workforce numbers as a result of the drive for doctors who had recently left the NHS to return, and the opportunities that could be taken to use remote and virtual working to help address issues of recruitment and retention, particularly in remote and rural areas.

7.8 The BMA said that the pandemic had placed unprecedented burdens on consultants, who had to work differently and also above and beyond their contracted hours under intense pressure. They said that the work that consultants had to do during the pandemic was, as a result of changes to job plans and the need to wear personal protective equipment, significantly more tiring.

7.9 HCSA said that the fall in vacancy rates reported by NHSE/I through the pandemic reflected the temporary postponement of career decisions that will be taken later, and that this situation would worsen. They said that for a sizeable minority of doctors, the pandemic would represent 'the straw that broke the camel's back', and they would be pushed into making career decisions that would have an impact on staffing.

Recruitment and retention

England

7.10 According to NHSE/I, before the pandemic there were workforce supply challenges in some specialties, including emergency medicine, psychiatry, clinical radiology, and geriatric medicine. They also said there was variation in the ratio of consultant physicians to population between different geographies, though they said that some of this was due to differences in clinical need. They said that the HEE-led Distribution of Specialty Training Posts in England Programme Board was established in 2019 to begin to address medical distribution issues. They explained that the Board will seek to better align workforce supply with local population health needs and influence the geographical distribution of the future consultant workforce, as medical trainees are likely to remain in the geographical area where they completed specialty training.

7.11 NHSE/I also said that the People Plan 2020/21 described ways consultants and other staff can be supported to maintain their health and wellbeing, leading to better morale and retention. This includes offering consultants more flexible job roles, consideration of team job planning, effective use of e-job planning and e-rostering and providing opportunities for career breaks.

7.12 HEE provided data that showed an estimated overall consultant shortfall in England of 9 per cent, equivalent to 4,628 consultants.

Table 7.1: Estimated consultant shortfall by HEE region and specialty, England

	North East & Yorkshire	North West	Midlands	East of England	London	South East	South West	All
Emergency medicine	15%	7%	23%	15%	16%	27%		16%
Psychiatry	23%	26%	15%	5%	9%	9%	12%	15%
Acute take	14%	14%	18%	12%	11%	13%	9%	13%
Pathology	14%	14%	9%	9%	8%	13%	10%	11%
Clinical radiology	9%	12%	11%	13%	12%	6%	5%	10%
Wider medical	6%	12%	9%	13%	5%	9%	5%	8%
Oncology	11%	14%	8%	2%	1%	11%	5%	7%
Ophthalmology	13%	8%	7%	10%	5%	11%	1%	8%
Infectious diseases	10%	12%	16%	3%	1%	-	11%	7%
Surgery	9%	6%	6%	9%	5%	7%	6%	7%
Anaesthetics and ICM	2%	4%	5%	9%	6%	5%	1%	5%
Obstetrics & gynaecology & CSRH	9%		5%	6%	7%	6%	1%	5%
Paediatrics	1%	0%	6%	6%	5%	2%		3%
Aggregate across specialties	10%	10%	10%	9%	7%	9%	5%	9%

Source: HEE.

7.13 There were wide variations across different parts of England and different specialties. Overall, shortfalls were lower in London and the south, and higher in the north and Midlands. The largest regional deficits for individual specialties were in the North West (26 per cent) and North East and Yorkshire (23 per cent) for Psychiatry, and the South East (27 per cent) and the Midlands (23 per cent) for Emergency Medicine.

7.14 NHS Employers said that some of the Royal Colleges had conducted surveys about what can be done to better retain consultants towards the end of their careers. Recommendations included improving flexibility for job planning, reducing the number of on-call shifts for older consultants, as well as addressing concerns about pensions taxation and utilising older doctors' experience though increased use of mentoring.

7.15 The BMA said that an appropriately sized consultant workforce is essential to look after a growing and ageing population but is unlikely to be delivered by current workforce policies. They added that despite the recent increase in numbers in some specialties in England, overall growth in the consultant workforce had not been keeping pace with increased demand for their services.

7.16 HCSA expressed concern that the current vacancy rate statistics understate the reality in hospitals, and that there were longstanding unacknowledged vacancies that were often absorbed by existing staff.

Wales

7.17 The Welsh Government said that there were national and international labour shortages that were impacting on recruitment into the NHS in Wales.

7.18 The BMA said that most respondents to a recent survey of consultant members in Wales said that they intended to retire early, with the main reasons given in the survey being related to pensions taxation, volume of workload and burnout, stress and anxiety.

Scotland

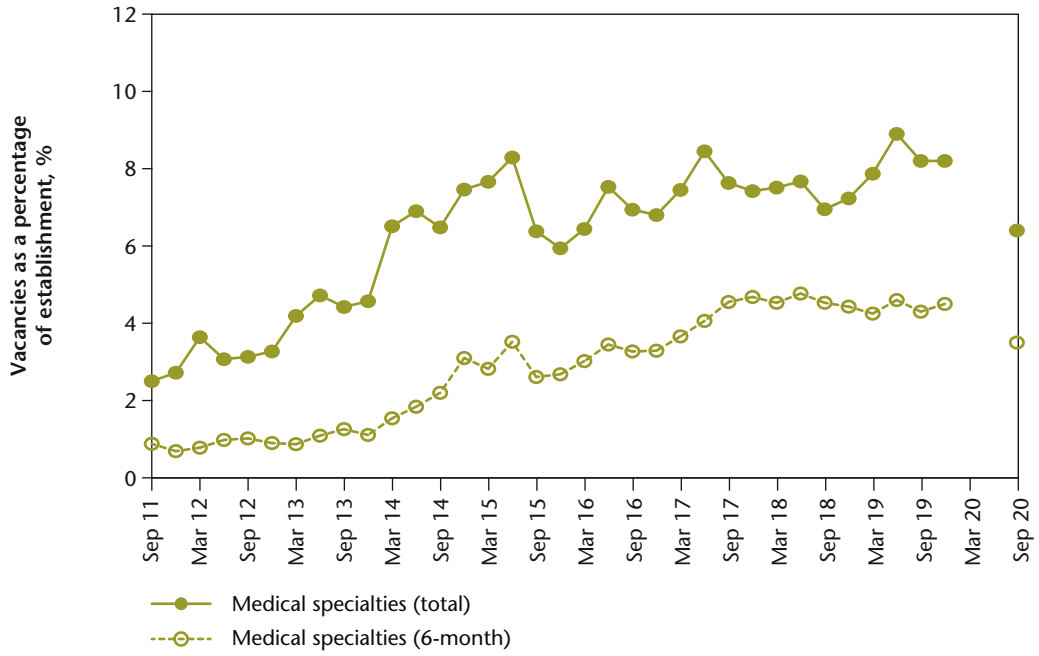
7.19 The Scottish Government said that for certain consultant posts and in certain parts of Scotland, Boards can find it more challenging to fill vacancies. They said that some specialties, such as radiology, experience international shortages.

7.20 NHS Education for Scotland said that due to COVID-19 there was reduced data on vacancies in March, June and December 2020 because of the additional demands this would have placed on staff at NHS Boards. Therefore, the latest data that was available was for September 2020.

7.21 At the end of September 2020 there were 373 FTE vacant posts for medical consultants, a vacancy rate of 6.4 per cent, a decrease from 8.2 per cent a year earlier (Figure 7.4). The specialty, with an establishment of at least 100, that had the highest vacancy rate was psychiatry (11.3 per cent, Table 7.2). In September 2020, there were 4 vacant posts for dental consultants, a vacancy rate of 4.5 per cent, a decrease from 7.9 per cent a year earlier (Figure 7.5).

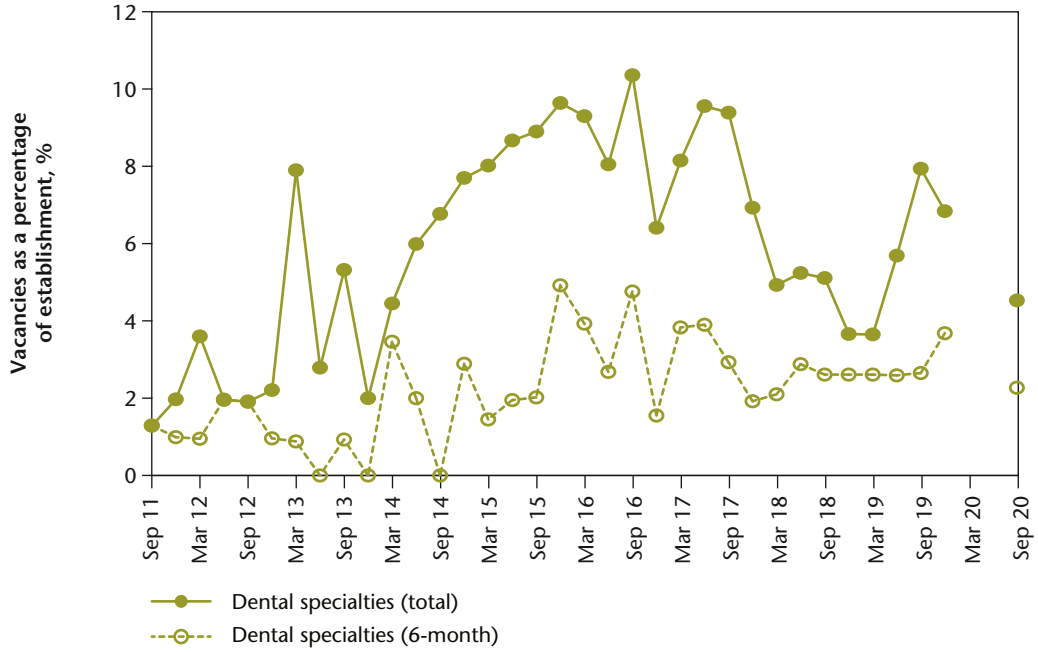
7.22 There were 205 medical posts that had been vacant for at least six months, a rate of 3.5 per cent, a decrease from 251 (4.3 per cent) a year earlier (Figure 7.4). The specialty groups with an establishment of at least 100 with the highest six-month vacancy rates were psychiatry (6.1 per cent), general medical (4.2 per cent) and clinical laboratories (4.1 per cent). In September 2020, there were 2 dental posts that had been vacant for at least six months, a rate of 2.3 per cent, a decrease from 2.6 per cent a year earlier (Figure 7.5).

Figure 7.4: Consultant vacancy rates, medical specialties, in Scotland, total and long-term, 2011 to 2020



Source: OME estimates, based on data from NHS Education for Scotland.

Figure 7.5: Consultant vacancy rates, dental specialties, in Scotland, total and long-term, 2011 to 2020



Source: OME estimates, based on data from NHS Education for Scotland.

Table 7.2: Consultant vacancy rates in Scotland by specialty, September 2020

	Establishment (FTE)	Total vacancies		Six-month vacancies	
		vacancy rate (%)	Annual percentage point change	vacancy rate (%)	Annual percentage point change
All specialties	5,965	6.3%	-1.9	3.5%	-0.9
All Medical specialties	5,877	6.4%	-1.9	3.5%	-0.9
Emergency medicine	271	6.5%	-0.6	2.8%	1.3
Anaesthetics	816	4.3%	-1.2	2.0%	-0.1
Intensive care medicine	25	3.9%	-15.7	3.9%	0.0
Clinical laboratory specialties	707	6.6%	-2.9	4.1%	-3.0
Medical specialties	1,477	7.3%	-1.1	4.2%	-0.9
Public health medicine	90	12.7%	2.8	2.6%	1.5
Occupational medicine	13	0.0%	0.0	0.0%	0.0
Psychiatric specialties	614	11.3%	-1.6	6.1%	-1.8
Surgical specialties	1,104	4.6%	-3.7	2.9%	-1.5
Obstetrics & gynaecology	291	3.1%	-3.2	2.1%	0.8
Paediatrics specialties	380	3.6%	-2.2	1.5%	0.5
General Practice	23	38.4%	38.4	20.0%	20.0
All Dental specialties	88	4.5%	-3.4	2.3%	-0.4

Source: OME estimates, based on data from NHS Education for Scotland.

7.23 The BMA said that in Scotland there had been a sharp increase in the number of consultants choosing voluntary early retirement since 2007. They said that this was due to disillusionment with the job, pensions taxation, work-life balance and personal health and wellbeing.

Northern Ireland

7.24 In its written evidence, the Department of Health said that there were 127 consultant vacancies actively being recruited to at the end of June 2020, a reduction from 145 at the same point during the previous year.

Motivation

England

7.25 According to the 2020 NHS Staff Survey, which was conducted in the autumn of 2020, between the first two waves of the COVID-19 pandemic, consultants were more satisfied with their pay than other medical staff groups (covered in Table 7.3). Over two-thirds (69 per cent) of consultants said that they were satisfied with their pay in 2020, the highest percentage since at least 2011.

7.26 The results for job satisfaction for consultants were worse than in 2019 (Table 7.3). There were falls in the percentage saying they looked forward to going to work, were enthusiastic about their job, that time passed quickly when they worked, and that they felt valued by their employer. The percentages who said that they got enough recognition for their work, support from their immediate manager, support from their work colleagues, responsibility and opportunities to use their skills all also fell. However, there was a fall in the percentage saying they experienced harassment, bullying or abuse in the past 12 months, although this still remains high at 32 per cent.

Table 7.3: Selected results from the National Staff Survey, consultants, England, 2011 to 2020.

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend[1]
I look forward to going to work	61.8	62.8	64.0	64.3	67.8	69.8	68.4	70.0	69.7	66.3	
I am enthusiastic about my job	74.2	73.4	75.7	75.1	78.8	79.5	78.0	79.7	79.0	75.2	
Time passes quickly when I am working	84.0	81.8	84.0	83.6	84.5	85.1	85.2	85.8	84.6	83.3	
The recognition I get for good work	49.4	50.5	52.6	54.0	55.5	56.6	56.7	63.2	65.4	62.9	
The support I get from my immediate manager	59.9	59.8	62.3	65.6	64.6	67.2	65.6	69.0	71.3	71.2	
The support I get from my work colleagues	81.2	82.7	83.6	83.5	86.0	85.3	85.7	86.4	87.1	85.1	
The amount of responsibility I am given	82.7	85.3	84.9	85.3	83.4	84.2	84.8	84.6	84.0	82.9	
The opportunities I have to use my skills	77.2	79.7	81.8	81.7	81.2	80.4	79.8	82.4	82.0	79.3	
The extent to which my organisation values my work	44.3	46.3	49.4	51.0	49.9	52.1	51.6	55.4	57.6	56.3	
My level of pay	63.4	63.5	60.8	59.5	61.6	63.8	63.2	62.1	65.2	69.2	
Percentage of staff appraised in the last 12 months	86.8	91.1	93.1	94.8	95.3	94.9	93.8	95.2	95.2		
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.8	32.3	32.7	34.4	34.3	32.3	34.2	34.3	31.9	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

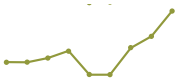
(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) Questions on appraisals not asked in 2020.

7.27 There were increases in the percentage of consultants saying that there were enough staff at their organisation for them to do their job properly, and that they had adequate materials, supplies, and equipment to do their work. However, there was an increase for the third consecutive year in the number of consultants saying that they had felt unwell as a result of work-related stress and a majority of consultants did not agree that they were able to meet all the conflicting demands on their time, although the percentage saying they did increased from 2019. There was a further fall in the percentage of consultants saying that they worked more hours than contracted for, both paid and unpaid (Table 7.4).

Table 7.4: Selected results from the National Staff Survey, consultants, England, 2011 to 2020.

Workload	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	52.2	52.6	51.3	52.3							
I am able to meet all the conflicting demands on my time at work[4]					33.1	34.1	37.8	36.9	39.5	40.7	
I have adequate materials, supplies and equipment to do my work	51.8	50.2	51.5	53.1	50.9	52.3	51.2	53.9	53.6	60.3	
There are enough staff at this organisation for me to do my job properly	30.5	30.5	29.0	29.2	29.7	28.0	28.1	29.1	29.5	36.5	
During the last 12 months have you felt unwell as a result of work related stress[2]		32.4	32.2	32.8	33.4	30.8	30.7	34.0	35.3	37.5	
Percentage of staff working PAID hours over and above their contracted hours[2]	41.6	43.5	43.6	44.2	40.8	39.3	39.4	40.6	39.6	37.3	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	81.1	82.9	83.8	82.9	84.8	85.5	83.4	82.9	80.5	78.4	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) For 2015, this question was reversed to "I am able to meet…"

(4) This question was introduced in 2015.

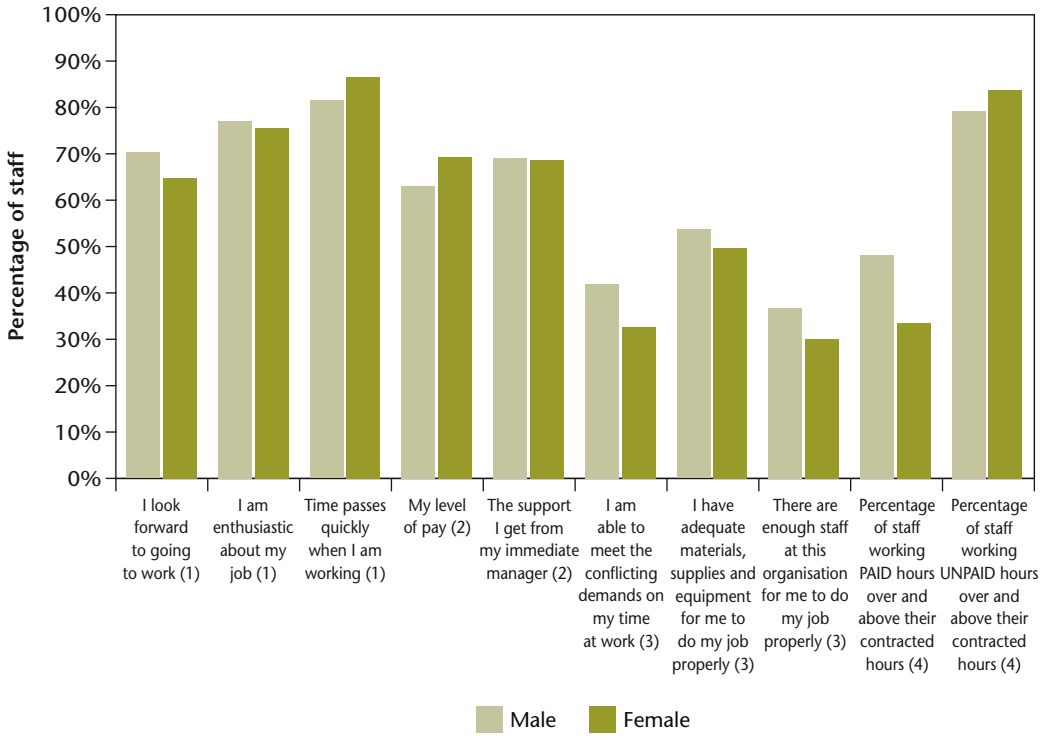
7.28 In addition to the usual range of questions, staff were asked, as part of the 2020 survey, about their experiences during the COVID-19 pandemic. The four areas covered were as follows:

- 40 per cent of consultants said that they had worked on a COVID-19 ward or area at any time (compared with 42 per cent of all medical and dental staff);
- 20 per cent of consultants said that they had been redeployed due to the COVID-19 pandemic at any time (compared with 22 per cent of all medical and dental staff);
- 61 per cent of consultants said that they had been required to work remotely/from home due to the COVID-19 pandemic (compared with 52 per cent of all medical and dental staff); and

- 6 per cent of consultants said that they had been shielding for themselves and 3 per cent said that they had been shielding for someone else in their household compared with 6 per cent of all medical and dental staff shielding for themselves and 2 per cent shielding for someone else in their household.

7.29 In 2020, similarly to 2019, female consultants were more likely to say they were satisfied with their pay than male colleagues (Figure 7.6) and were more likely to say that time passed quickly when they worked. However, compared with female consultants, male consultants were more likely to say that they looked forward to going to work, were able to meet competing demands on their time, had adequate materials, and that there were sufficient staff at the organisation. Female consultants were slightly more likely to work extra unpaid hours than male consultants but were much less likely to work extra paid hours than their male colleagues (34 per cent of female consultants and 48 per cent of male consultants said that they worked extra paid hours).

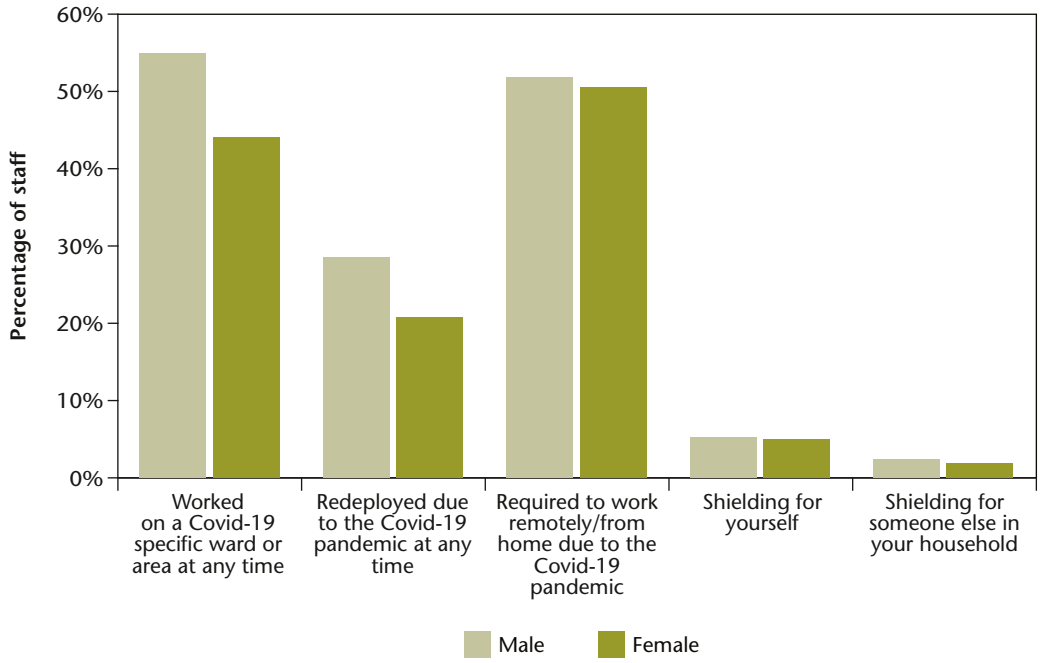
Figure 7.6: HCHS consultants, satisfaction with aspects of the job and work pressures by gender, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always".
(2) Staff responding "satisfied" or "very satisfied".
(3) Staff responding "agree" or "strongly agree".
(4) Staff indicating one or more additional hours.

7.30 Figure 7.7 shows consultants' responses to questions about their experiences during the COVID-19 pandemic, by gender. Male consultants (55 per cent) were more likely than female consultants (44 per cent) to say that they worked on a COVID-19-specific ward or area. Male consultants (29 per cent) were also more likely to say that they had been redeployed than female consultants (21 per cent). Just over half of both male and female consultants said that they had been required to work remotely or from home due to COVID-19.

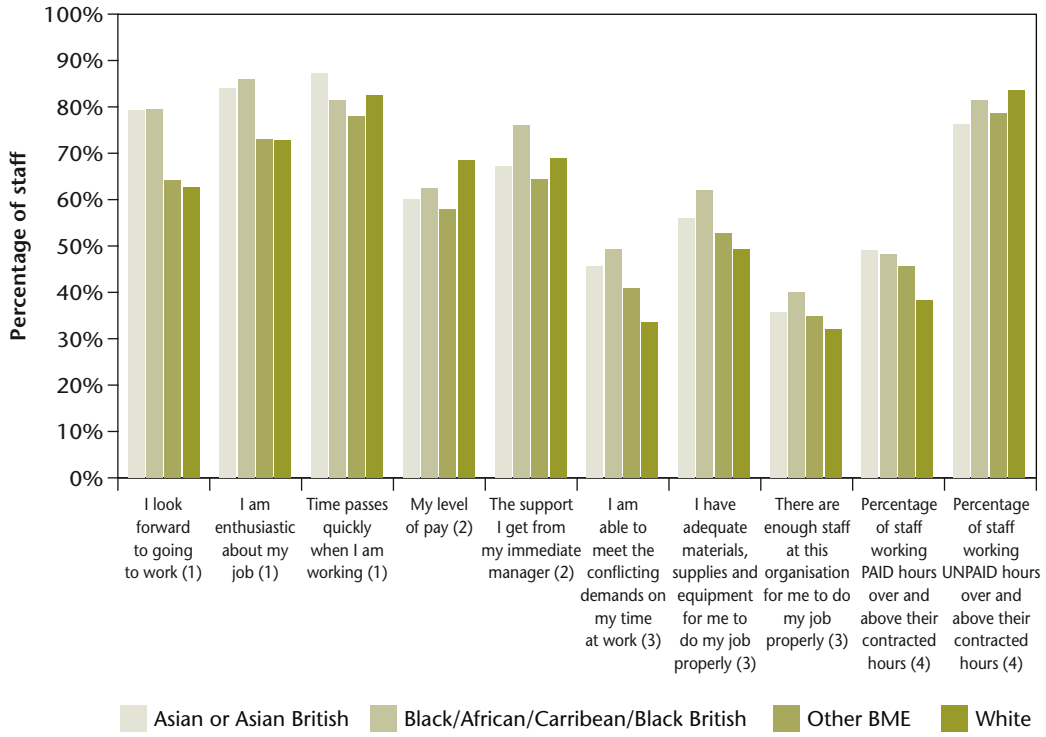
Figure 7.7: HCHS consultants, experiences during the COVID-19 pandemic by gender, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.

7.31 Figure 7.8 shows satisfaction with aspects of the job and work pressures, by ethnic group. For most of the variables, Asian/Asian British or Black consultants were more satisfied than their White colleagues or those from other ethnic groups. However, White consultants were more satisfied with their pay than colleagues from other ethnic groups. A greater percentage of consultants from minority ethnic groups said that they worked paid hours in addition to their contracted hours than White colleagues, while White consultants were more likely to say that they worked unpaid hours in addition to their contracted hours.

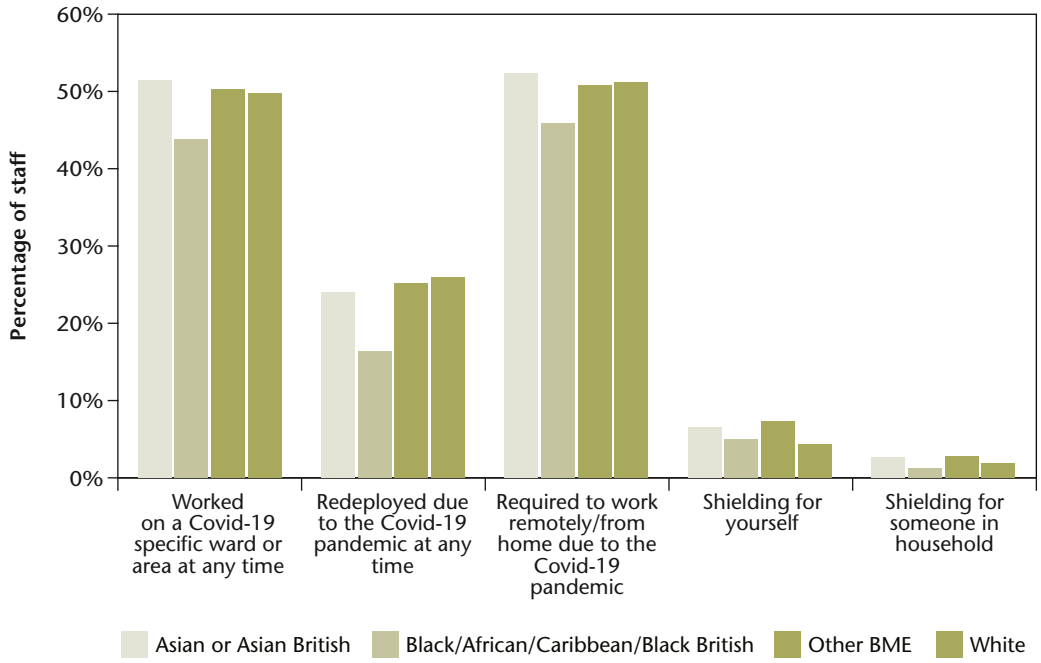
Figure 7.8 HCHS consultants, satisfaction with aspects of the job and work pressures by ethnic group, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

7.32 Figure 7.9 shows consultants' responses to questions about their experiences during the COVID-19 pandemic, by ethnic group. There was little difference in the responses, except that a smaller percentage of Black consultants said that they had worked on a COVID-19 ward or area or had been redeployed due to COVID-19.

Figure 7.9 HCHS consultants, experiences during the COVID-19 pandemic by ethnic group, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe.

Scotland, Wales and Northern Ireland

7.33 The staff survey results for Scotland, Wales and Northern Ireland were not published in sufficient detail to identify consultants.

Contract reform

England

7.34 DHSC said that there remained a strong case for reform of the consultant contract to bring about modernised terms and conditions which attract and retain staff and support service requirements, though there had not been an opportunity to focus on this in the last year due to the pandemic. They added that the pandemic had shone a light on some other contractual elements that could benefit from reform in the future, such as out-of-hours and on-call working.

7.35 They said that previous plans to reform the contract did not progress due to concerns from the BMA about the level of funding available, and the realities of the current fiscal climate limited any potential for investment into contract reform in the short term.

7.36 NHS Providers said that reform to the consultant contract remained desirable, and that this would help restore trust between the government and unions representing senior doctors. They said they supported the prioritisation of this work as soon as possible, alongside reforms to the CEA schemes.

7.37 The BMA said that they had engaged with NHS Employers and DHSC about moving to a 2-point pay scale for consultants, in light of the contribution that longer pay scales can make to gender pay gaps. However, they said that they did not agree with DHSC about how this move would be funded, saying that the cost of doing so should be met from outside of the current consultant pay envelope.

Wales

7.38 The Welsh Government did not tell us about any planned contract reform discussions with the trade unions.

Scotland

7.39 The Scottish Government said that preliminary work on developing contract reform proposals for consultants had been underway prior to the pandemic, but this work had been paused. They added that the pandemic had shone a light on some issues with the contract, and they said they were considering when to resume work developing reform proposals.

Northern Ireland

7.40 The Department of Health said that they had no plans for consultant reform in the short term.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

England and Wales

7.41 In March 2021, DHSC and the Welsh Government published the consultation paper *Reforming the national Clinical Excellence Awards Scheme*[2]. It outlined proposals for changes to the national Clinical Excellence Awards (CEA) scheme. Proposed changes included increasing the number of new national CEAs, making them non-consolidated and non-pensionable, and removing time-based progression between the award levels. Changes are also proposed for the system by which applications are assessed, and views are sought on how to widen access to the scheme. The proposals aim to broaden access to the scheme, make the application process simpler, fairer and more inclusive, and ensure the scheme incentivises excellence across a broader range of work and behaviours. The proposals are based to some extent on the recommendations made by the 2012 DDRB paper *Review of compensation levels, incentives and the Clinical Excellence and Distinction Awards schemes for NHS consultants*[3], which recommended a number of changes to the reward schemes, including that they should be non-consolidated and non-pensionable, temporary, subject to review, and that it should be possible to hold local and national awards simultaneously.

7.42 Separately, a new local CEA scheme for England is being developed by DHSC, NHS Employers and the trade unions to replace the interim scheme that has been in place since 2018 and is due to expire in 2022 after having had its expiration delayed by a year as a result of the COVID-19 pandemic. At the same time, the application system for the interim local CEA scheme for the 2020-21 financial year was suspended, with payments instead equally distributed amongst all eligible consultants[4]. In April 2021 it was announced that this arrangement would remain in place for 2021-22.

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[2] Department of Health and Social Care and the Welsh Government (March 2021). *Reforming the national Clinical Excellence Awards scheme*. Available at: https://www.gov.uk/government/consultations/reforming-the-national-clinical-excellence-awards-scheme/reforming-the-national-clinical-excellence-awards-scheme

[3] Review Body on Doctors' and Dentists' Remuneration (13 August 2013). *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS* consultants. Available at: https://www.gov.uk/government/publications/ddrb-nhs-consultant-compensation-levels-2012

[4] NHS Employers (30 April 2021). *Employer FAQs on the local clinical excellence awards*. Available at: https://www.nhsemployers.org/pay-pensions-and-reward/medical-staff/consultants-and-dental-consultants/local-clinical-excellence-awards-arrangements-from-1-april-2018/local-clinical-excellence-award-employer-faqs

7.43 NHS Providers said that reforms to the CEA schemes must result in simpler schemes that are easy to run, not administratively burdensome and address the issues of gender and racial inequality which result from the current scheme. NHS Employers said that both employers and doctors agree that the current local CEA system is administratively burdensome and exacerbates inequalities for doctors in certain groups, including women and ethnic minorities. They said that the aim was for the new scheme to be in place on 1 April 2022 so that employers can begin their own process for issuing awards in the autumn of 2022. NHSE/I added that they were keen that the local CEA scheme was fit for purpose, rewards doctors in a fair and equitable way, and is accessible by all eligible doctors. They also said that the awards should recognise outstanding performance, incentivise new ways of working in line with the Long Term Plan and the People Plan, and support delivery of organisational goals and local priorities.

7.44 The BMA said that since the Welsh Commitment Award scheme was part of the overall pay structure and open to everyone, in contrast to the rest of the UK, they do not attract the same criticisms over their equity and effectiveness as the other schemes.

Scotland

7.45 The Scottish Government said that there was no evidence to suggest that an adverse impact had resulted from the closing of the Distinction Awards scheme to new entrants, and the freezing in value of both Distinction Awards and Discretionary Points since 2010.

Northern Ireland

7.46 The CEA scheme in Northern Ireland continues to be closed to new entrants, with awards frozen in value. The Department of Health said that they had no plans in place to resume the CEA scheme in Northern Ireland. They also said that they had not experienced an increase in vacancy rates as a result of the closure and freezing of their CEA scheme.

Our comments

7.47 Consultants have in the past year contributed enormously to the pandemic response, leading clinical teams and delivering front-line care at a critical time for health services. Many have worked outside their specialties and have, in caring for the most severely ill patients, put themselves in particular danger from COVID-19, given the correlation between age and mortality from the virus. In this context, and given the lack of national solutions for remuneration for additional work done by consultants through the pandemic in England, Scotland and Northern Ireland, it is critical that employers and others ensure that such work is properly remunerated.

7.48 Despite improvements to vacancy rates through the pandemic, there remains a significant shortfall in consultants across the UK. NHSE/I also said that, compared with other countries outside the UK, England has relatively few doctors in critical care services and we note that per-capita workforce numbers are broadly similar in Scotland, Wales and Northern Ireland. Given this, and the length of time that it takes to train new consultants, retention of the existing consultant workforce is particularly critical.

7.49 Therefore, the measures that are being introduced to help with retention, including flexible job planning and mentoring schemes are welcome. We hope that all measures taken to improve consultant retention are properly evaluated so that they are of the maximum benefit to retention and therefore, ultimately, patient care. We expect details of such evaluations to be included in evidence for future reports.

7.50 However, the potential for the pandemic to precipitate an increase in retirements in the medium term is a critical concern. Similarly, the staff survey results that found decreasing levels of job satisfaction were worrying. Action must be taken proactively to ensure that no opportunity to improve retention is missed.

7.51 Similarly, issues relating to pensions and pensions taxation remain of great importance. The changes made to the way that the pensions tax annual allowance taper is applied appear to have simplified the system for the majority of doctors and dentists, and almost all consultants now do not have their annual allowance tapered. However, the announcement that the lifetime allowance will be frozen in value from this year has the potential to exacerbate issues once more, potentially leading to senior doctors and dentists concluding that it is in their financial interest to retire or decrease their working hours. We also heard during our visits programme that many consultants found navigating the NHS pensions system confusing and overly complex. Therefore, employers should ensure that consultants receive timely, accurate and easy-to-understand information about their pensions, and that action is taken to maximise retention amongst those who are making career decisions in this context.

7.52 During our visits programme and in the evidence we have received we have been told that during the pandemic deficiencies in the consultant contract, including those that we had highlighted in previous reports, had become increasingly apparent. These included the provisions for out-of-hours and on-call responsibility. We also consistently heard on our visits programme that the number of Programmed Activities in consultants' job plans dedicated to Supporting Professional Activities had been eroded over time across the UK, to the detriment of consultants' work-life balance and the quality of leadership and management in hospitals. Alongside the findings of the Gender Pay Gap Review in relation to consultants and the consultant contract, in particular the length of pay spines, these demonstrate the increasingly clear need for contract reform across the UK. We hope that the parties can resume negotiations as soon as possible.

7.53 We welcome DHSC's and the Welsh Government's consultation on reforms to the national CEA system. We hope that these reforms, alongside the reforms to local CEAs that are in development, can address concerns that we and others, in particular the Gender Pay Gap in Medicine Review, have expressed over the equity and effectiveness of the CEA schemes in England ahead of the implementation of reformed schemes in 2022, improving their ability to fulfil their core purpose of incentivising excellence amongst the consultant workforce. We also note that the distribution of local CEA funding to all eligible consultants, in place of running competitions, has taken place for a second consecutive year, though we have also heard of some Trusts instead running their own competitions on a local level.

7.54 We hope that progress can also be made in reforming consultant reward schemes outside England and Wales. Governments, employers and trade unions in Scotland and Northern Ireland should seek reforms to their schemes to ensure that the funds dedicated to them are as effective as possible in encouraging the right behaviours amongst their consultant workforces whilst also promoting equality. Given that the CEA scheme in Northern Ireland and the Distinction Awards scheme in Scotland are both closed to new entrants, they no longer serve to incentivise excellence amongst younger consultants. And given the Gender Pay Gap Review's findings in relation to the length of pay spines for consultants in England, it is highly likely that Commitment Awards in Wales are further contributing to any gender pay gap amongst consultants, given that they effectively serve as an extension to the consultant pay spine.

7.55 Across the UK, the proportion of the NHS workforce who are consultants has continued to grow in recent years, as part of a change from a consultant-led to a consultant-delivered service. Being a relatively expensive part of the workforce, this development increases the average per capita salary cost, which in turn may put additional pressure on staff budgets and impact on the size or composition of the wider healthcare team. It may also be a factor in some of the longer-term work that is being done in all four nations to improve the quantity and quality of workforce outputs within a designated budget. It is perhaps partially in response to the increase in consultant numbers that some of the parties have discussed changed workforce models in hospitals, with a greater focus on the wider clinical team, though it is not yet clear how this will impact growth in the numbers of consultants. In this context, it is critical that governments do all they can to determine their long-term workforce needs and make plans for their hospital medical and dental workforces accordingly.

7.56 Finally, we note that the BMA said that, after adjustment for increased student numbers, the number of clinical academics had fallen by 52 per cent. HEE also told us that they felt that universities could generally fill clinical academic posts, but they were not investing in them as much as they had done previously. Data from the Medical Schools Council[5] showed a decline in the numbers of senior clinical academics at reader or senior lecturer level, although there had been a proportionate increase in the numbers of professors and lecturers. Data from the Dental Schools Council[6] shows a similar pattern of decline for readers, senior lecturers and lecturers with an increase in professors. These reductions in dental academia have been compensated by the appointment of senior clinical teachers whose primary role is teaching rather than research. A robust and sufficiently large clinical academic workforce is essential to maintain the quality of new doctors and dentists, and we would expect those that are responsible for medical and dental training to ensure that this workforce is maintained. This is pivotal to both teaching and clinical research.

[5] Medical Schools Council (2020). *Clinical academic survey.* Available at: https://www.medschools.ac.uk/clinical-academic-survey

[6] Dental Schools Council (2018). *Dental clinical academic staff survey.* Available at: https://www.dentalschoolscouncil.ac.uk/clinical-academia/clinical-academic-staff-survey/

CHAPTER 8: GENERAL MEDICAL PRACTITIONERS

Introduction

8.1 In this chapter we consider issues relating to General Medical Practitioners (GMPs). The traditional role for GMPs is as the family doctor, working in primary care. There are several contracting arrangements in place under which primary care services are provided by the NHS/HSC, and GMPs can work as independent contractors, salaried GMPs or as locums. Doctors become GMPs after five years of postgraduate medical training, comprising the two-year foundation programme and three years' general practice training. Doctors in general practice training are junior doctors, and they are covered in Chapter 5.

Working through the COVID-19 pandemic

8.2 DHSC said that general practice had played a vital role in the response to the COVID-19 pandemic, including identifying and offering proactive care to shielded and high-risk patients while continuing to be there for patients when they had health concerns. They added that due to COVID-19, the primary care sector had significantly increased digital delivery of appointments at unprecedented pace, and that general practice was expected to take a leading role in administering the COVID-19 vaccine to patients across England. A number of bureaucratic and regulatory burdens, such as mandatory reporting to commissioners about the Friends and Family Test, were also relaxed to relieve pressure on GMPs.

8.3 DHSC also said that income protections had been put in place by NHS England and Improvement (NHSE/I) in England, alongside funding to assist with the additional costs of the response, including for COVID-19-related absence cover, bank holiday opening and personal protective equipment. In November 2020, a £150 million General Practice Covid Capacity Expansion Fund was announced, to support expanded general practice capacity until March 2021. The BMA said that they welcomed the commitment to continue many of the changes that were introduced throughout the pandemic, though they added that not all income had been protected by the income protections that had been put in place, and that if the income protections and additional support funding were not maintained, there would be a negative impact on GMP contractors' pay.

8.4 The Welsh Government said that responding to the pandemic had meant that practices had made a number of advances in the few months prior to them sending us their written evidence, in particular adopting remote consultations and collaborating at a cluster level. The BMA said that most GMPs surveyed in September and October 2020 said that workloads were higher than before the pandemic, and that they were being asked to provide services that would usually be provided in secondary care settings.

8.5 The Department of Health (Northern Ireland) said that working arrangements in general practice had changed rapidly in order to cope with the pandemic and protect the public and staff from the virus. Funding was provided to improve telecommunications systems and elements of the General Medical Services (GMS) contract were suspended to free up practice capacity. Practices transitioned to a telephone-first triaging approach and Primary Care COVID-19 centres were established in April 2020 to provide care to patients who had COVID-19 symptoms separately from other patients. The Department added that in the wake of COVID-19, it would be important to ensure that GMP-led services are integrated with the wider health and social care system to improve patients' pathways, increase system capacity, better manage demand and ensure the safety, quality and sustainability of services.

Contract reform

England

8.6 In 2019 a five-year pay and contract reform agreement for England was finalised between DHSC, NHSE/I, and the General Practitioners Committee of the BMA. The parties said that the contract would give clarity and certainty for practices. NHSE/I and the BMA agreed that there would be no further expectation of additional national funding for practice or contract entitlements until 2024-25. The agreement also included a provision for the minimum and maximum pay ranges for salaried GMPs in England to be uplifted by 2 per cent for the 2019-20 pay round, and we therefore did not make recommendations for salaried GMPs in our 2019 report.

8.7 The parties to the new contract agreed to ask the DDRB not to make recommendations relating to independent contractor GMP pay in England over the period of the agreement. However, the agreement said that the Government would continue to include recommendations on the pay of salaried GMPs in the DDRB remit from 2020 onwards, and salaried GMPs were included in our remit for England both last year and this year.

Scotland

8.8 The Scottish Government said that the COVID-19 pandemic had delayed the implementation of Phase 2 of their programme of reforms to the GMS contract, which at the time they were expecting to be fully implemented by April 2022. Phase 2 would comprise a number of changes, including introducing an income range for partner GMPs that is comparable to consultants and directly reimbursing practice expenses.

Workforce Numbers

8.9 At the time of writing, the latest estimate of the number of GMPs in England was from March 2021. The headcount estimate for GMPs, which excludes locums, was 43,191, an increase of 4.7 per cent from March 2020. The full-time equivalent (FTE)[1] estimate for GMPs in March 2021, was 33,982, an increase of 2.6 per cent from March 2021. Excluding GMP contractors and GMP registrars, there were 15,628 salaried GMPs and GMP Retainers on a headcount basis and 9,802 on an FTE basis.

8.10 In September 2020, the latest date for which data is available, Scotland had 5,134 GMPs, an increase of 1.8 per cent from September 2019. Within that total the number of performers fell by 0.3 per cent, the number of salaried GMPs increased by 6.8 per cent, and the number of registrars increased by 7.0 per cent.

8.11 The most recent data measuring the number of GMPs in Wales, is at 30 September 2020. The data showed 2,369 GMPs, of which 1,963 were practitioners, 382 registrars and 24 were retainers[2]. Changes to the way in which the data have been collected mean that care needs to be taken when making comparisons with previous years. However, compared with 30 September 2018, the most recent date for which data were available prior to COVID-19, the overall number of GMPs increased by 161 (4.3 per cent), of which the number of practitioners fell by 1 (-0.1 per cent), the number of registrars increased by 152 (66.1 per cent), and the number of retainers increased by 10 (71.4 per cent).

[1] The four countries of the UK each produce headcount estimates of GMPs. In addition, NHS Digital also publish full-time equivalent estimates of GMP numbers in England.
[2] GMP retainers in Wales are practitioners on the GP retainer scheme, who are only able to practice a maximum of 4 clinical sessions a week.

8.12 The latest data for Northern Ireland, from March 2020, was for 1,364 GMPs, an increase of 30 (2.2 per cent) from a year earlier. Within that total there were 1,163 partner GMPs (down from 1,169 in 2019), 179 salaried GMPs (up from 142 in 2019) and 22 retainers (down from 23 in 2019).

8.13 The composition of the GMP workforce has changed over recent years, with the share of contractor GMPs having fallen, with that of salaried GMPs having increased. In England, between March 2016 and March 2021, the proportion of the GMP workforce headcount made up of contractors had fallen from 60 per cent to 47 per cent, while that of salaried GMPs increased from 26 per cent to 35 per cent. In Scotland, between 2010 and 2020, the proportion of the GMP workforce made up of contractors fell from 77 per cent to 65 per cent, while that of salaried GMPs increased from 10 per cent to 22 per cent.

8.14 The share of the GMP workforce accounted for by women has also been increasing. Between 2010 and 2020, the proportion of the general practice medical workforce accounted for by women in Scotland increased from 51 per cent to 62 per cent. In 1985, in Northern Ireland, women made up fewer than 20 per cent of the GMP population, but by 2020 that had increased to 58 per cent. Over a shorter period, between 2016 and 2021, in England, the share of the GMP workforce made up of women increased from 54 per cent to 58 per cent.

Access to GMP services

England

8.15 DHSC said that the government was committed to improving general practice access for patients by growing the workforce and creating 50 million more appointments in general practice. They said that the 2020-21 update to the GMP contract included measures to improve access to general practice through expanding availability of appointments and increasing the range of healthcare professionals in Primary Care Networks, including by funding additional staff under the Additional Roles Reimbursement Scheme (ARRS). The additional staff covered by the ARRS include clinical pharmacists, social prescribers, physiotherapists and dieticians.

8.16 They said that the COVID-19 pandemic had changed the way that people access general practice, leading to general practice adapting at an unprecedented rate, adopting triaging for all patient contacts and more telephone and online consultations. They said that the number of appointments booked across all GMP practices in England in 2020 was 280.1 million, down 10.3 per cent on 2019.

Scotland

8.17 The Scottish Government provided us with figures from the two-yearly Scottish Health and Social Care Experience Survey from 2019-20, which was published in October 2020, on access to general practice. It found that 85 per cent of those surveyed said that they found it easy to contact their practice in the way that they want, a decrease of 2 percentage points on 2017-18 but an increase of 3 percentage points on the two previous surveys. They also said that 77 per cent were happy with the opening hours of their practice, in line with the responses to this question in previous years.

Wales

8.18 The Welsh Government said that the 2019-20 GMS contract had seen £12 million invested into improving access from March 2019, including money for infrastructure needs such as new telephony systems.

Northern Ireland

8.19 The Department of Health said that one of the aims of the multidisciplinary teams model it was adopting for general practice in Northern Ireland was to make it easier to access vital services at a local level. They said that the number of GMP practices had decreased, with a concurrent rise in average list sizes, and that the trend of practice amalgamations in recent years was likely to continue, particularly in rural areas where there are more single-handed practices and recruitment issues are more acute. However, they also said that 98 per cent of the population still lived within five miles of a practice.

Recruitment and retention

General practice training

8.20 Recruitment into general practice training reached a record high in 2020, with 3,793 doctors entering training in England, 336 in Scotland, 200 in Wales and 104 in Northern Ireland. All were increased when compared to the previous year. We cover specific initiatives undertaken in each of the nations to attract trainees into general practice training, as well as the pay and conditions of general practice trainees, in Chapter 5.

England

8.21 DHSC said that they were working with NHSE/I and HEE to increase the general practice workforce, increasing the primary care workforce by 6,000 doctors. This would include measures to boost recruitment, encourage GMPs to return to practice, and address the reasons why experienced GMPs are considering leaving the profession. They said that the number of GMP training places in England would increase to 4,000 a year from 2021.

8.22 They also described the results of the latest GP Worklife Survey, from 2019, which found that working hours and workloads were the biggest source of job dissatisfaction and stress respectively. It also found that 62.5 per cent of GMPs over 50 and 11.0 per cent of GMPs under 50 said that they intended to quit direct patient care over the next five years. The figure for over-50s was slightly higher than in 2017, but the figure for under-50s was significantly lower.

8.23 DHSC said that they were implementing a number of measures to improve GMP retention, including fellowship programmes and mentoring schemes. They also said that the new contract introduced in 2019 also included the ARRS, which would increase the number of non-medical clinical staff working in general practice, to deal with complex cases outside of hospital.

8.24 NHSE/I said that many GMPs returned to practice to help support the pandemic emergency effort, adding that they were working with clinical and regional leaders and HEE to retain as many of these GMPs as possible.

8.25 The BMA said that COVID-19 had compounded existing GMP retention issues across the UK, and that workload was a factor in GMPs choosing to leave the profession or reduce their commitment. They added that a backlog of work following the pandemic could significantly worsen this situation.

Scotland

8.26 The Scottish Government said that they remained committed to increasing headcount numbers of GMPs to 5,700 by 2027. They said that to achieve this they would need to improve fill rates, as well as valuing, supporting and protecting GMPs already working in primary care. They outlined a number of measures they were taking to support staff wellbeing in primary care, including a national wellbeing hub and a wellbeing helpline. They also offer a number of financial incentives to improve recruitment and retention, including seniority payments to GMPs who have been in work for six years or more, and 'Golden Hellos' – lump sum payments for GMPs who are in their first eligible post in areas that have difficulty recruiting, are remote or rural, or are deprived.

Wales

8.27 The Welsh Government told us about their induction and refresher scheme, aimed at helping encourage into the workforce doctors who had either never worked in general practice in the UK, or who had but not for at least two years.

Northern Ireland

8.28 The Department of Health said that they were conscious of the pressures on general practice across Northern Ireland and continued to work with stakeholder partners to address the workforce challenges and support recruitment and retention. They told us about a number of initiatives they were undertaking to support the general practice workforce, including introducing GP Federations and induction and refresher, retainer and mentoring schemes.

GMP trainers' grant and clinical placement funding

8.29 The GMP trainers' grant, from 1 April 2020, was £8,584. DHSC said they were continuing to work with stakeholders to introduce a fair and equitable approach to the funding of clinical placements in GMP practices, irrespective of geography and historical arrangements. They said that the 2020-21 Education and Training tariff guidance document introduced a new national minimum rate for undergraduate medical placements in general practice of £28,000.

Independent contractor GMPs

England

8.30 As explained in paragraph 8.7, the review body was not asked for recommendations for contractor GMPs in England this year, since they are subject to a multi-year pay and contract reform deal. DHSC said that they had introduced a New to Partnership Payment Scheme from 2020-21, aimed at growing the number of contractors working in primary care. They said that eligible participants would benefit from a £3,000 business training allowance and a guaranteed one-off payment of £20,000.

Wales

8.31 The Welsh Government said that their Partnership Premium Scheme, which was introduced in October 2019, would act as an incentive for GMPs to take up partner roles, with payments based on the number of clinical sessions undertaken.

Income

8.32 In previous years NHS Digital used to produce estimates of GMP earnings for the UK as a whole. However, NHS Digital said that they have stopped publishing such estimates as the contractual arrangements in each country have diverged to the point that comparisons between countries are no longer appropriate.

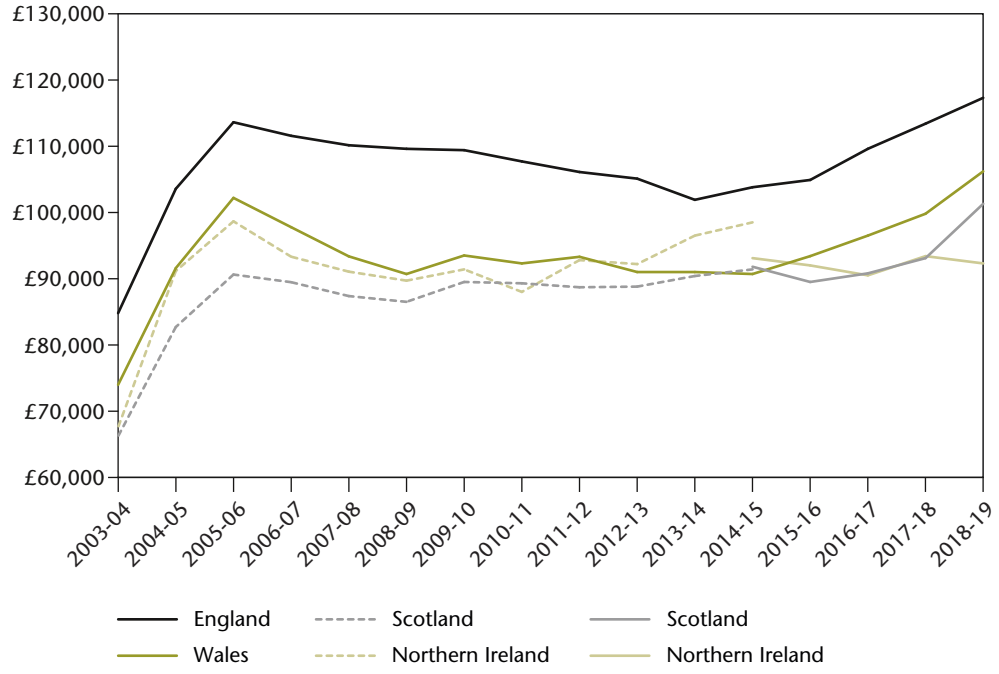
8.33 In 2018-19, average taxable income for contractor GMPs in each of the four countries was:

- England – £117,300 (**up by 3.4 per cent**, from 2017-18 (£113,400))
- Wales – £106,200 (**up by 6.4 per cent**, (£99,800))
- Scotland – £101,300 (**up by 8.8 per cent**, (£93,100))
- Northern Ireland – £92,300 (**down by 1.2 per cent**, (£93,400)).

8.34 The average earnings estimates are produced on a headcount basis, and take no account of hours worked. NHS Digital produce estimates of the numbers of contractor GMPs for England, on both a headcount basis and a Full-Time Equivalent (FTE) basis. This shows that the number of FTE contractor GMPs in September 2018 was 0.88 of the headcount number of contractor GMPs. If the relationship for average earnings on an FTE basis were calculated in a similar way to provide an estimate, this would give an FTE average earnings figure for 2018-19 of £133,100 rather than £117,300 on a headcount basis, and a 4.1 per cent increase from 2017-18.

8.35 Figure 8.1 shows GMP contractors' **nominal** average income before tax for each country within the UK, since 2003-04. Following the introduction of a new GP contract in 2004 average incomes grew sharply in both 2004-05 and 2005-06, in each of the four countries. This was followed by a period of falling or stagnating average incomes. However, more recently, other than in Northern Ireland, average incomes have grown in each of the last: five years in England; four years in Wales; and three years in Scotland. In Northern Ireland income has fallen in three of the last four years.

Figure 8.1: GMP contractors' headcount income before tax, by United Kingdom country, in nominal terms, 2003-04 to 2018-19

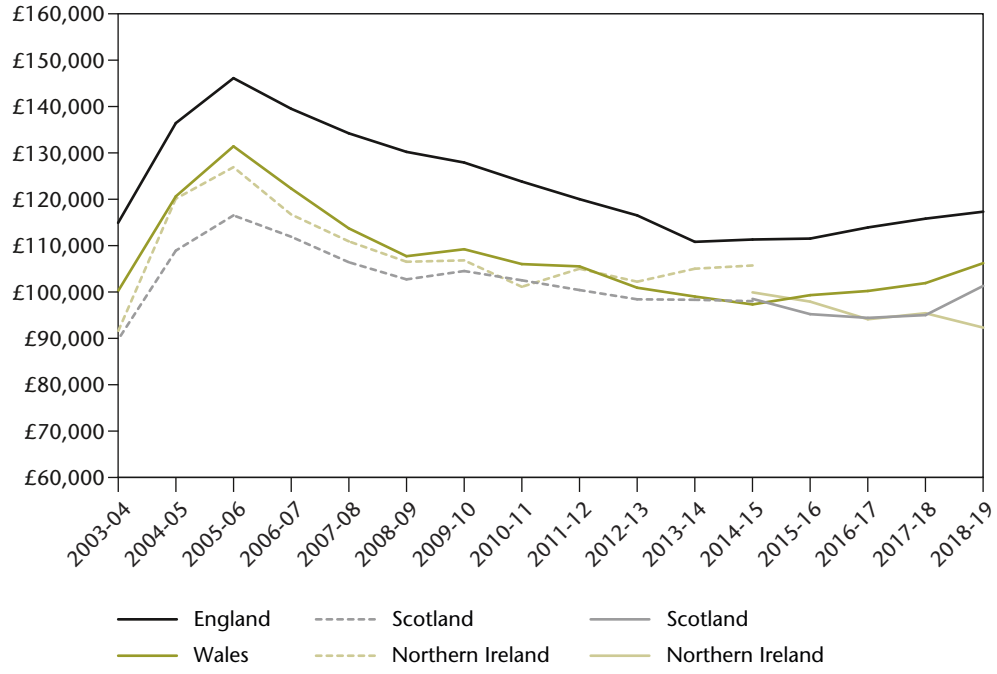


Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis. There are discontinuities in Scotland and Northern Ireland data between 2013-14 and 2014-15.

8.36 Figure 8.2 shows GMP contractors' average income before tax for each country within the UK, since 2003-04, **adjusted for inflation**[3]. Average incomes increased in all four countries in both 2004-05 and 2005-06, but this was followed by a period of decline. However, more recently, average incomes have grown in each of the last: five years in England; four years in Wales; and two years in Scotland. In Northern Ireland average income has fallen in three of the last four years.

[3] The conversion has been carried out using gross domestic product deflators as at June 2020 available from HM Treasury.

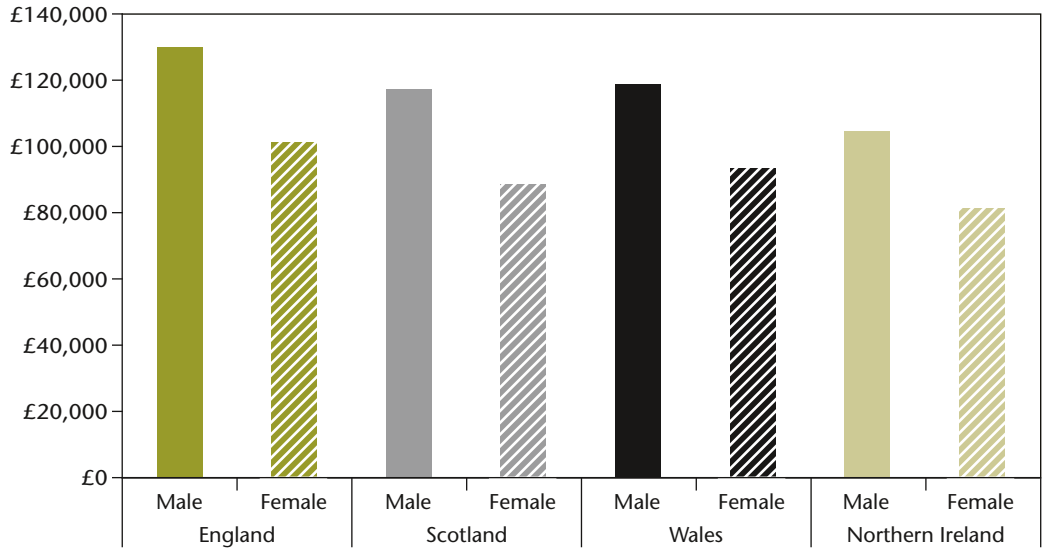
Figure 8.2: GMP contractors' headcount income before tax, by United Kingdom country, in real terms, 2003-04 to 2018-19



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis. There are discontinuities in Scotland and Northern Ireland data between 2013-14 and 2014-15.

8.37 NHS Digital produce estimates of income before tax for contractors, for each country in the UK, broken down by gender. Figure 8.3 shows that in 2018-19, in each country of the UK, average income before tax was greater for male contractors than for female contractors.

Figure 8.3: GMP contractors' headcount income before tax, by country, 2018-19, by gender



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis.

8.38 Table 8.1 shows that in each country average earnings of female contractor GMPs were lower than those of male contractor GMPs, by 21 per cent (Wales), 22 per cent (England and Northern Ireland) and 24 per cent (Scotland). The table also shows that the earnings gap narrowed slightly, compared with the previous year, in England, Scotland and Northern Ireland.

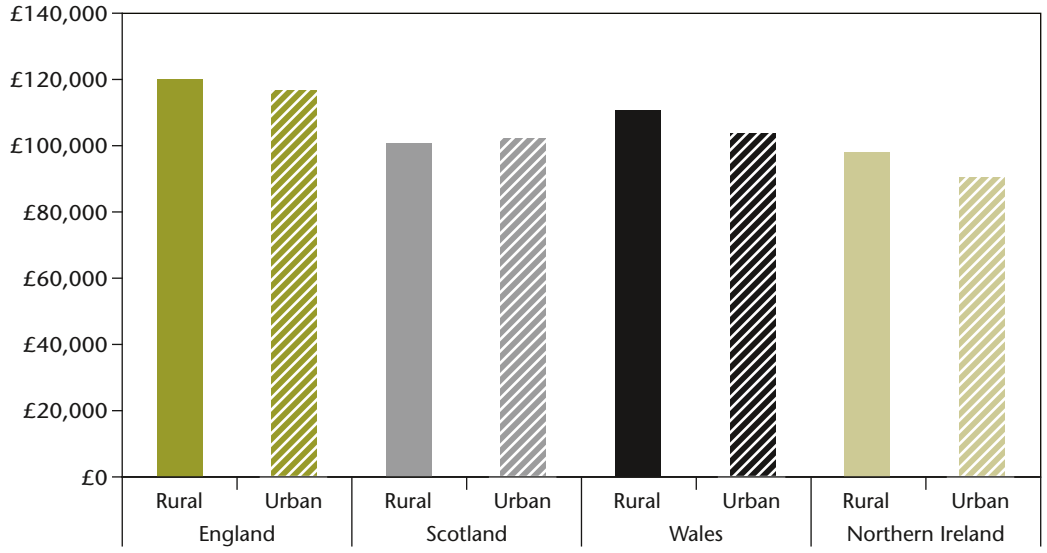
Table 8.1: GMP contractors' headcount income before tax, by United Kingdom country, 2017-18 and 2018-19, by gender

				Gender difference	
Country	**Gender**	**2017/18**	**2018/19**	**2017/18**	**2018/19**
England	Male	£125,600	£130,000		
England	Female	£97,300	£101,200	-23%	-22%
Scotland	Male	£107,800	£117,200		
Scotland	Female	£80,800	£88,700	-25%	-24%
Wales	Male	£111,000	£118,800		
Wales	Female	£87,700	£93,300	-21%	-21%
Northern Ireland	Male	£107,900	£104,500		
Northern Ireland	Female	£79,600	£81,400	-26%	-22%

Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

8.39 In 2018-19 the average taxable income of contractor GMPs in 'rural' practices was greater than that of those in 'urban' practices, in all countries except Scotland (Figure 8.4). The differences were 8 per cent in Northern Ireland, 6 per cent in Wales, and 3 per cent in England. In Scotland, incomes of contractors in 'urban' practices were 1 per cent greater than those in rural practices (Table 8.2).

Figure 8.4: GMP contractors' headcount income before tax, by country, 2018-19, by rural/urban



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis.

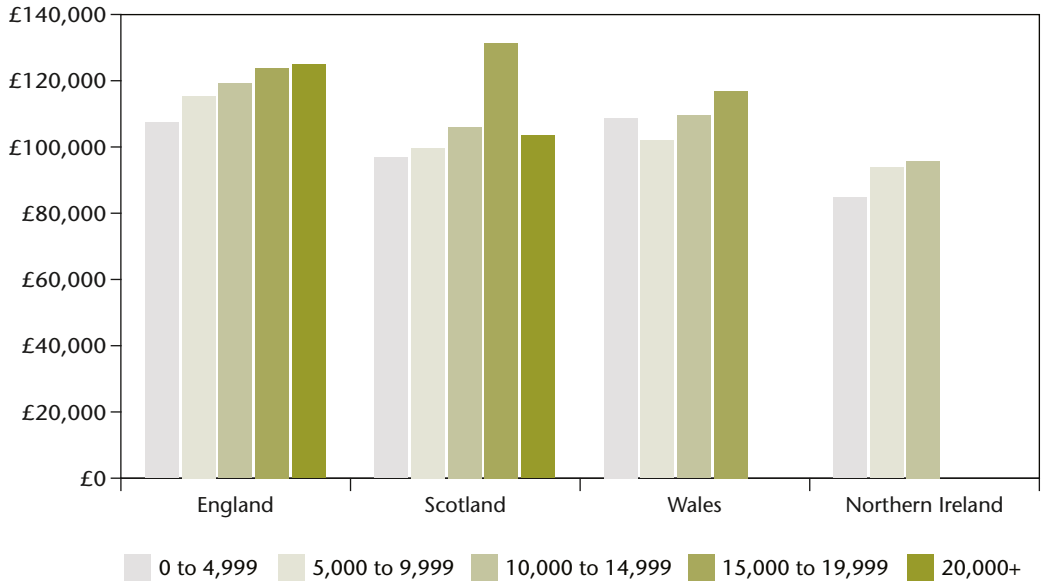
Table 8.2: GMP contractors' headcount income before tax, by United Kingdom country, 2017-18 and 2018-19, rural/urban

				Urban/Rural difference	
Country	**Rurality**	**2017/18**	**2018/19**	**2017/18**	**2018/19**
England	Rural	£117,800	£120,000		
England	Urban	£112,500	£116,700	-4%	-3%
Scotland	Rural	£92,900	£100,700		
Scotland	Urban	£93,300	£102,200	0%	1%
Wales	Rural	£104,400	£110,700		
Wales	Urban	£97,500	£103,800	-7%	-6%
Northern Ireland	Rural	£98,400	£98,000		
Northern Ireland	Urban	£91,800	£90,400	-7%	-8%

Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

8.40 NHS Digital produce data for each country by practice size. The categories are: 0-4,999 patients; 5,000 to 9,999; 10,000 to 14,999; 15,000 to 19,999; and 20,000+. Figure 8.6 shows that in 2018-19 the average taxable income of contractor GMPs generally increased with practice size. The exceptions were contractors working at the largest practices in Scotland and those in Wales working at practices with between 5,000 and 9,999 patients. Note there are insufficient contractors working at the largest practices in Wales and Northern Ireland to be able to produce estimates for these groups.

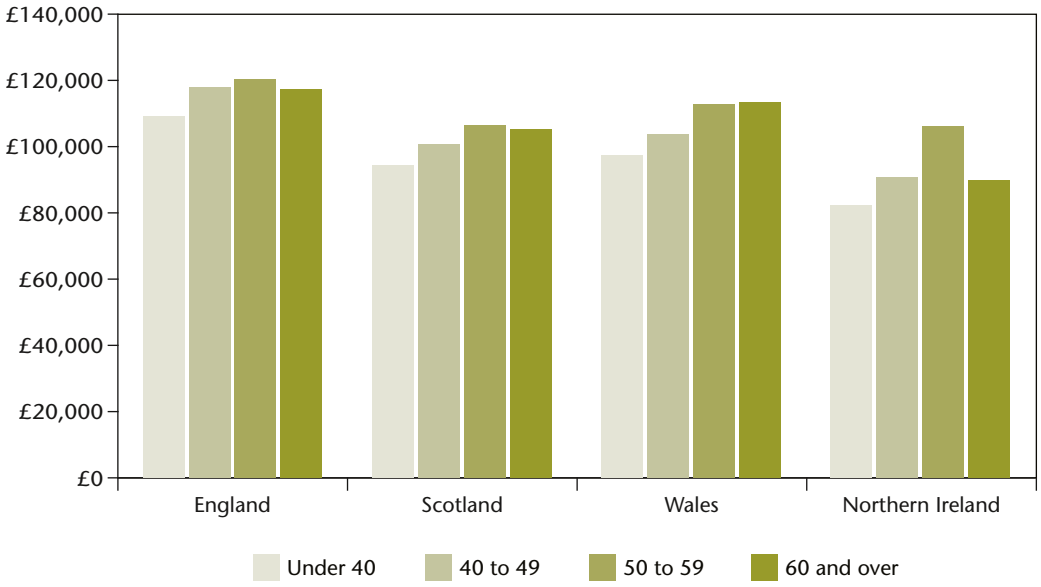
Figure 8.5: GMP contractors' headcount income before tax, by country, 2018-19, by practice size (number of patients)



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis.

8.41 NHS Digital produce data for each country by age. The categories are: under 40 years; 40 to 49 years; 50 to 59 years; and 60 years and over. Figure 8.6 shows that in 2018-19 the average taxable income of contractor GMPs generally increased with age up to the 50 to 59 years age range. For the 60 years and over group, compared with the 50 to 59 years group, income levels off or falls.

Figure 8.6: GMP contractors' headcount income before tax, by country, 2018-19, by age



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis.

Salaried GMPs

England

8.42 NHSE/I said that the headcount number of salaried GMPs increased by 39 per cent between September 2015 and September 2020, while the FTE number of salaried GMPs increased by 33 per cent. Over 70 per cent of salaried GMPs in England are female.

Scotland

8.43 The Scottish Government told us that the Primary Care Workforce Survey Scotland found that salaried GMPs were 17 per cent of the total GMP workforce, and on average they work fewer sessions per week than contractors.

Northern Ireland

8.44 The Department of Health told us that the number of salaried GMPs had increased since 2014-15, but they currently make up less than 10 per cent of the workforce.

Income

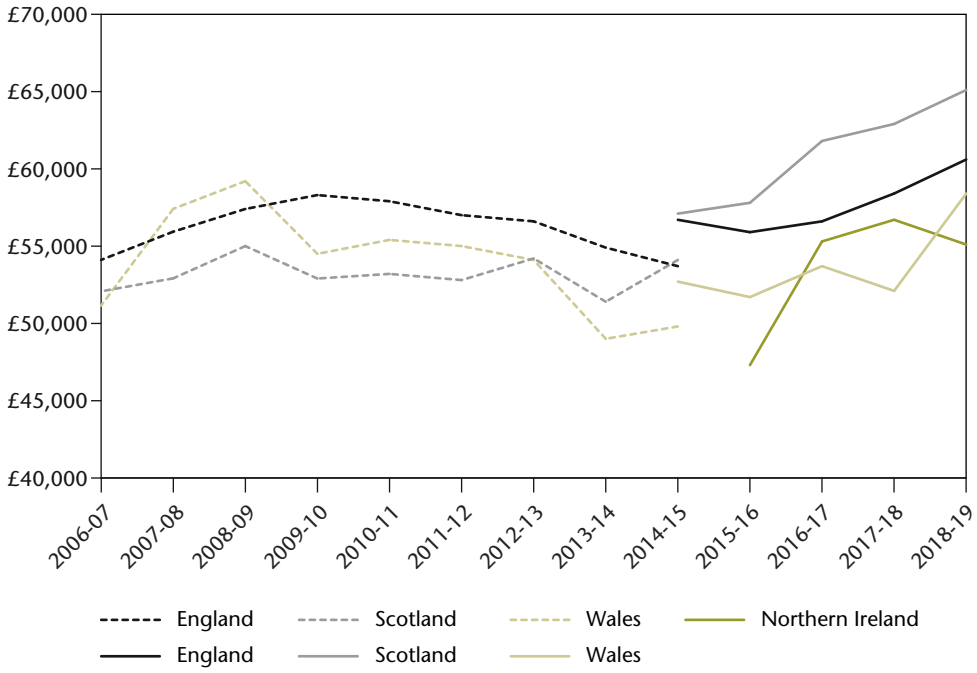
8.45 In 2018-19, average taxable income for salaried GMPs in each of the four countries was:

- Scotland – £65,100 (**up by 3.6 per cent**, from 2017-18 (£62,900))
- England – £60,600 (**up by 3.8 per cent**, (£58,400))
- Wales – £58,400 (**up by 12.1 per cent**, (£52,100))
- Northern Ireland – £55,100 (**down by 2.8 per cent**, (£56,700)).

8.46 The average earnings estimates are produced on a headcount basis, and take no account of hours worked. NHS Digital produce estimates of the numbers of salaried GMPs for England, on both a headcount basis and an FTE basis. This shows that the number of FTE salaried GMPs in September 2018 was 0.66 of the headcount number of salaried GMPs. If the relationship for average earnings on an FTE basis were calculated in a similar way to provide an estimate, this would give an FTE average earnings figure for 2018-19 of £91,900 rather than £60,600 on a headcount basis, and a 4.8 per cent increase from 2017-18.

8.47 Figure 8.7 shows salaried GMPs' **nominal** average income before tax for each country within the UK, since 2006-07 (for Northern Ireland since 2015-16). Average incomes grew between 2006-07 and 2008-09, in each country where data was available. This was followed, between 2008-09 and 2013-14, by a period of falling/stagnating average incomes. However, more recently, average incomes have grown: in each of the last three years in England; in each of the last four years in Scotland; and in two of the last three years in Wales. In Northern Ireland average incomes grew, in both 2016-17 and 2017-18, but fell back in 2018-19.

Figure 8.7: Salaried GMPs' headcount income before tax, by United Kingdom country, in nominal terms, 2006-07 to 2018-19

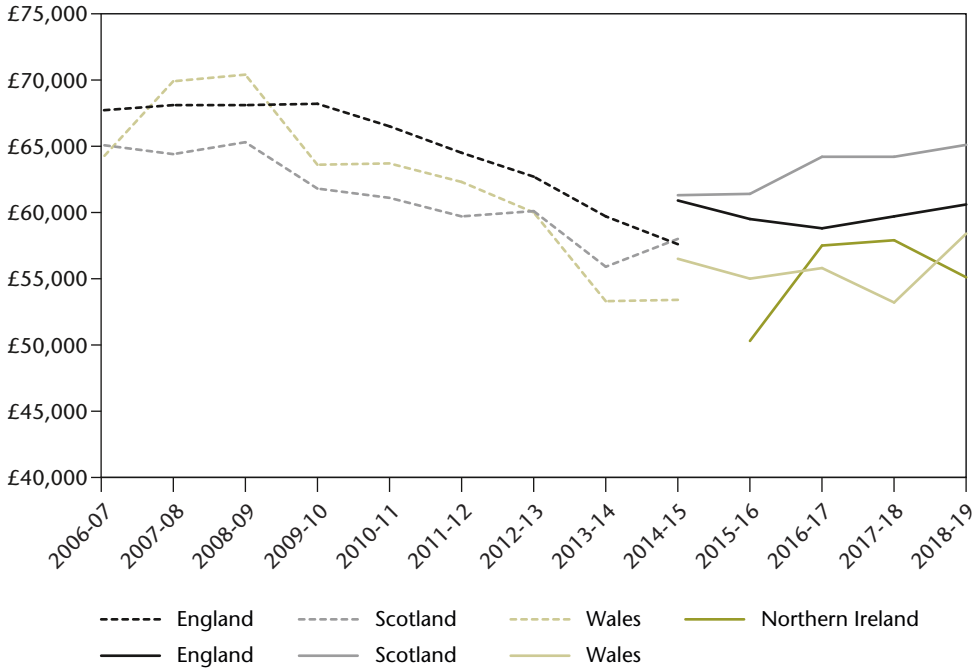


Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis. There are discontinuities in England, Scotland and Wales data between 2013-14 and 2014-15.

8.48 Figure 8.8 shows salaried GMPs' average income before tax for each country within the UK, since 2006-07 (for Northern Ireland since 2015-16), **adjusted for inflation**[4]. Between 2006-07 and 2008-09 average incomes maintained or increased their value, but this was followed by a period of decline, until 2013-14. However, since 2014-15 there are signs that average incomes have stabilised or grown.

[4] The conversion has been carried out using gross domestic product deflators as at June 2020 available from HM Treasury.

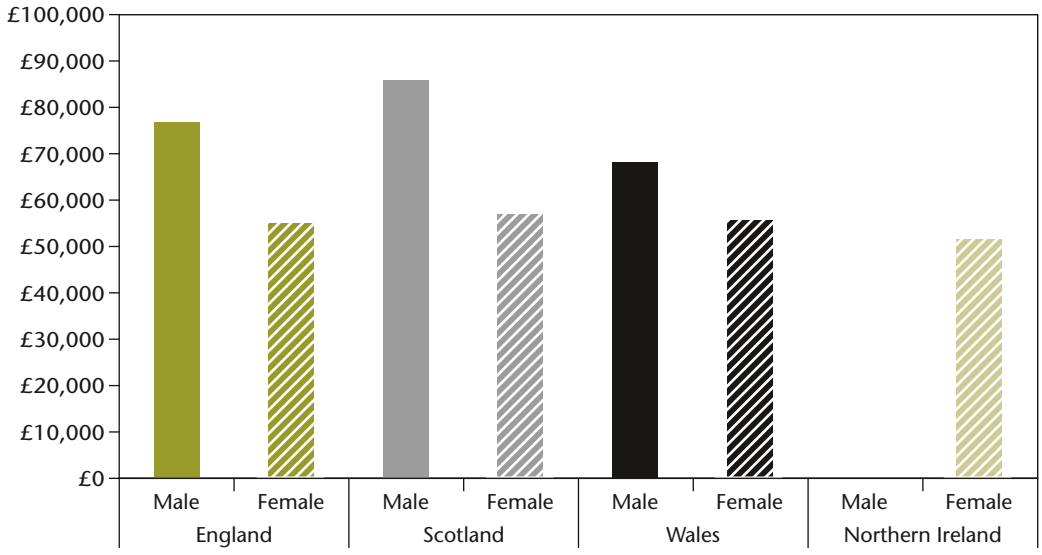
Figure 8.8: Salaried GMPs' headcount income before tax, by United Kingdom country, in real terms, 2006-07 to 2018-19



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis. There are discontinuities in England, Scotland and Wales data between 2013-14 and 2014-15.

8.49 NHS Digital produce estimates of income before tax for salaried GMPs, for each country in the UK, broken down by gender. Figure 8.9 shows that in 2018-19, in England, Scotland and Wales, average income before tax was greater for male salaried GMPs than for female colleagues. Because of the sample size, NHS Digital was unable to produce estimates for male salaried GMPs in Northern Ireland for 2018-19.

Figure 8.9: Salaried GMP headcount income before tax, by country, 2018-19, by gender



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis.

8.50 Table 8.3 shows that in each country in 2018-19 average earnings of female salaried GMPs were lower than those of male salaried GMPs, by 18 per cent in Wales, 28 per cent in England and 34 per cent in Scotland. In 2017-18 the difference in Northern Ireland was 44 per cent.

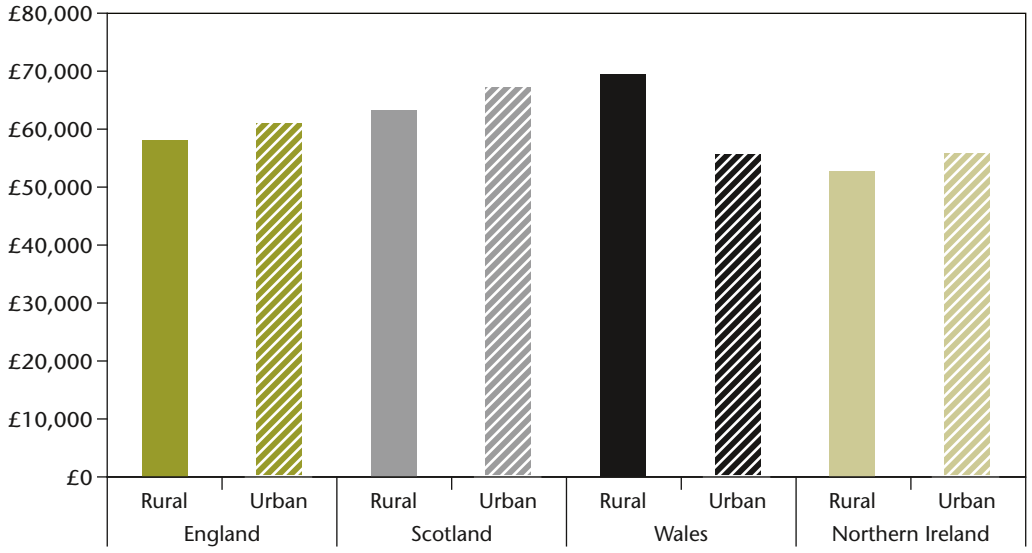
Table 8.3: Salaried GMP headcount income before tax, by United Kingdom country, 2017-18 and 2018-19, by gender

				Gender difference	
Country	**Gender**	**2017/18**	**2018/19**	**2017/18**	**2018/19**
England	Male	£75,100	£76,900		
England	Female	£52,600	£55,000	-30%	-28%
Scotland	Male	£85,200	£85,900		
Scotland	Female	£55,800	£57,000	-35%	-34%
Wales	Male	£62,800	£68,200		
Wales	Female	£49,200	£55,700	-22%	-18%
Northern Ireland	Male	£92,900	not available		
Northern Ireland	Female	£51,800	£51,500	-44%	not available

Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

8.51 In 2018-19 the average taxable income of salaried GMPs in 'rural'[5] practices was lower than that of those in 'urban' practices, in all countries except Wales (Figure 8.10). This is a reversal of the position for contractor GMPs. The differences were 6 per cent in both Scotland and Northern Ireland, 5 per cent in England. In Wales, incomes of salaried GMPs in 'urban' practices were 22 per cent below than those in rural practices (Table 8.4).

Figure 8.10: Salaried GMP headcount income before tax, by country, 2018-19, by rural/urban



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis.

[5] If more than 50% of patients are classified as rural (based on postcode), the practice is categorised as rural. Likewise, if more than 50% of patients are classified as urban, the practice is classified as urban.

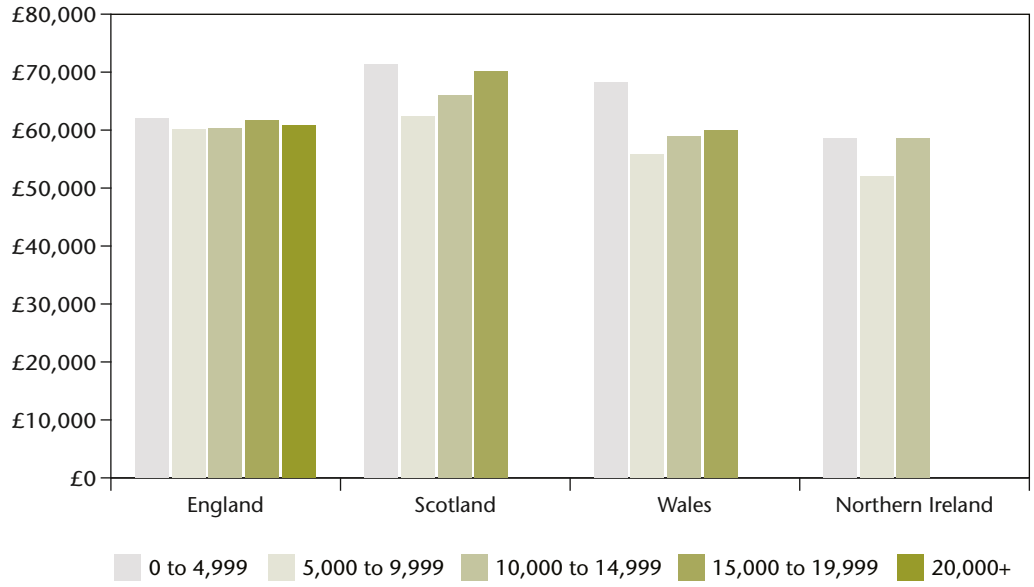
Table 8.4: Salaried GMP headcount income before tax, by United Kingdom country, 2017-18 and 2018-19, rural/urban

				Urban/Rural difference	
Country	**Rurality**	**2017/18**	**2018/19**	**2017/18**	**2018/19**
England	Rural	£57,300	£58,100		
England	Urban	£58,600	£61,100	2%	5%
Scotland	Rural	£59,900	£63,200		
Scotland	Urban	£65,400	£67,200	9%	6%
Wales	Rural	£62,200	£69,400		
Wales	Urban	£48,600	£55,700	-22%	-20%
Northern Ireland	Rural	£56,700	£52,700		
Northern Ireland	Urban	£56,700	£55,800	0%	6%

Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

8.52 NHS Digital produce data for each country by practice size. The categories are: 0-4,999 patients; 5,000 to 9,999; 10,000 to 14,999; 15,000 to 19,999; and 20,000+. Figure 8.6 showed that in 2018-19 the average taxable income of contractor GMPs generally increased with practice size. However, Figure 8.11, perhaps not surprisingly, shows no clear relationship between salaried GMP average taxable income and practice size. Indeed, salaried GMPs in the smallest practices have the largest average incomes. Note there are insufficient salaried GMPs working at the largest practices in Scotland, Wales and Northern Ireland to be able to produce estimates for these groups.

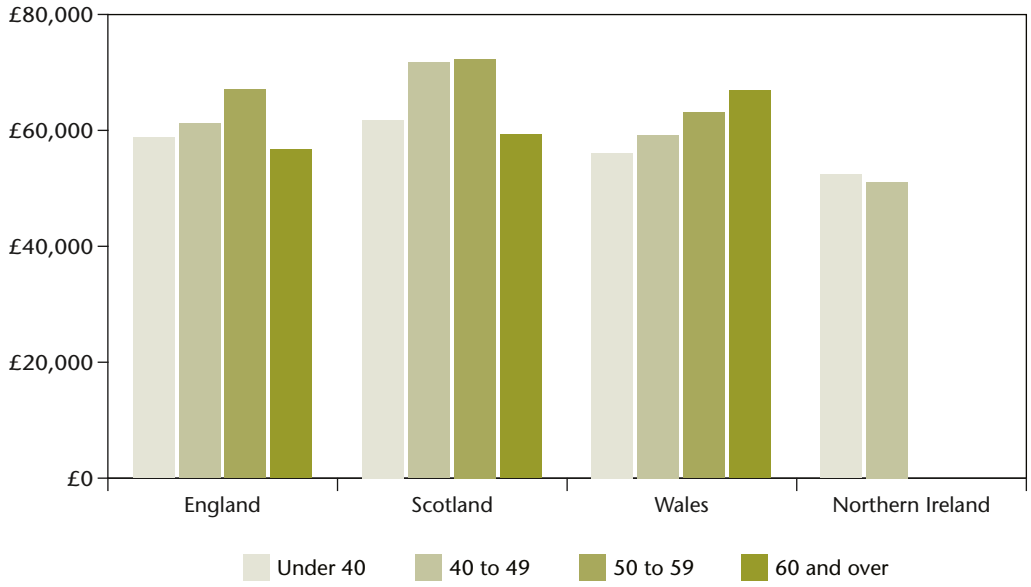
Figure 8.11: Salaried GMP headcount income before tax, by country, 2018-19, by practice size (number of patients)



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis.

8.53 NHS Digital produce data for each country by age. The categories are: under 40 years; 40 to 49 years; 50 to 59 years; and 60 years and over. Figure 8.12 shows that in 2018-19 the average taxable income of salaried GMPs generally increased with age up to the 50 to 59 years age range. For the 60 years and over group, compared with the 50-59 years group, income levels off or falls (except for those in Wales).

Figure 8.12: Salaried GMP headcount income before tax, by country, 2018-19, by age



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Income before tax relates to NHS and private work and is on a headcount basis.

Expenses and formula

8.54 In 2016 we took a decision to make recommendations on our intended increase in pay net of expenses. Taking this approach required the parties to discuss expenses in order to ascertain a gross increase. For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs had we used the formula-based approach.

8.55 The Scottish Government told us that Phase 2 of the new GMS contract, which at the time they expected would be in place from 2022, will include direct reimbursement of practice expenses, and in their remit letter they asked us to make our recommendations net of expenses.

Our comments

8.56 GMPs have played an important part in the pandemic response, including through assisting those who were shielding and the national vaccination programme. This has underlined the critical importance of general practice and primary care more generally. We hope that any positive developments in general practice through the pandemic, such as the increased use of digital technology in delivering some appointments virtually, can be embedded and maintained. We also hope that experiences of the pandemic can be used to support contract reform and development across the UK in the coming years.

8.57 We welcome the continued increase in the number of doctors who are entering general practice training. This shows that it remains an attractive option for newly-qualified doctors when making their career choices. The increasing proportion of international medical graduates entering general practice training will mean that retaining the international GMP workforce will become a more important challenge in future years.

8.58 However, while the headcount size of the GMP workforce is growing, its effective size in England is stagnant as the number of GMPs who are working part-time increases. We would expect this dynamic to apply also in Scotland, Wales and Northern Ireland. This is connected both to the decreasing proportion of GMPs who are contractors, and the decreasing average working hours in the salaried GMP workforce. It is therefore crucial that in the coming years, the increases in the number of general practice trainees translates into an effectively larger workforce which can, alongside developments in the introduction of multidisciplinary teams, maintain and improve access to GMP services.

8.59 Improving retention is also a significant factor in increasing the size of the workforce. We welcome the initiatives being undertaken across the UK to improve retention and look forward to seeing evidence of their effectiveness in future years. Given that an increasing proportion of GMP trainees are international medical graduates, ensuring that GMPs from overseas are retained will also be increasingly important.

8.60 Another key factor in retaining GMPs is pensions. It is crucial that the NHS Pension Scheme, which remains a major component of total reward for GMPs, remains attractive and incentivises doctors to continue working in the NHS. While the overwhelming majority of GMPs will now no longer have their annual allowance tapered, governments should ensure that retention is not impacted by the recently-announced freezing of the Lifetime Allowance. As with other groups of doctors and dentists, it is also important that GMPs can receive timely and easy-to-understand information that would enable them to make informed choices about their pensions.

8.61 Finally, we recognise the findings of the Gender Pay Gap in Medicine Review relating to GMPs in particular, which outlined how the composition of the GMP workforce by gender contributes to gender pay gaps, with female GMPs more likely to be in salaried positions, which on average pay less. The Review also found that the unstructured way that pay is determined for individual salaried GMPs can further widen pay disparities. We see no reason that these factors would not contribute to any gender pay gaps in general practice in Scotland, Wales and Northern Ireland.

8.62 In this context, fair pay for salaried GMPs is a critical part of addressing gender pay gaps, and it is therefore important that pay uplifts are passed on to salaried GMPs, in line with the BMA model contract[6]. This includes both salaried GMPs that work in a practice setting and those employed elsewhere, such as those who work in out-of-hours services or prisons. We therefore welcome the provisions included by the Welsh Government that ensure that pay uplifts are passed on to salaried GMPs and other practice staff and would encourage the other governments to consider acting similarly.

8.63 At the same time, we received evidence from the BMA that a significant proportion of salaried GMPs are earning more than the maximum of our pay range, and that our pay range therefore needed to be updated. We would welcome more evidence from the parties about both how the earnings of salaried GMPs are distributed, and whether and how the pay range needs to be updated, in evidence next year.

[6] British Medical Association (2020). *Salaried GP model contract and model offer letter guidance*. Available at: https://www.bma.org.uk/media/3479/salaried_gp_model_contract_and_model_offer_letter_nov20.pdf

CHAPTER 9: DENTISTS

Introduction

9.1 Our remit covers all general dental practitioners (GDPs) and salaried dentists providing NHS/HSC services in England, Wales, Scotland, and Northern Ireland. This includes dentists working in the Community Dental Services (CDS) in England, Wales and Northern Ireland and the Public Dental Service (PDS) in Scotland.

University admissions

9.2 We discuss the numbers and demographics of those applying for and being accepted into dental schools in Chapter 5.

Access to dental services and COVID-19

9.3 Many common dental procedures generate aerosols. As a result of this, and the need more generally to ensure that practices did not become vectors for the spreading of coronavirus, the four governments each limited the volume of treatments that were able to be performed in dental practices. They also set up remote triaging and centralised urgent dental care centres. The extent of these limits, and the structure of the financial support provided to practices differed throughout the course of the pandemic and between the four nations. In this section we summarise the access and short-term financial situation in each of the four nations through the pandemic.

England

9.4 DHSC said that face-to-face routine NHS care in England was suspended between 25 March and 7 June 2020, as was all urgent care apart from that provided through designated urgent dental centres. Dentists provided remote advice, triage, antibiotics and analgesics and many also volunteered for more direct COVID-19-facing roles. DHSC said that practices were remunerated in full for their contracted activity during this period, less an abatement for consumables not needed. Practices reopened from 8 June 2020, albeit in a limited way due to the need to ensure the safety of patients and practitioners and due to the limited availability of personal protective equipment (PPE). Practices continued to be remunerated in full, though DHSC said that NHS England and Improvement (NHSE/I) intended to reimpose activity targets from 1 January 2021, at a level of 45 per cent of pre-pandemic contracted activity.

9.5 The BDA said that throughout this period, capacity in dental practices had been severely reduced, and dentists had been working under very stressful conditions, both physically and mentally. They said that the new activity targets from January 2021 were not achievable for practices and ran contrary to wider public health advice especially as, subsequent to the virus's resurgence in late 2020 and early 2021, practices had seen widespread patient cancellations. They said that without adequate protections to dentists' incomes, dentists faced financial cliff-edges if they were not able to reach certain levels of activity.

9.6 NHSE/I said that ensuring equity of access to primary dental care services remained a central goal. They added that, prior to the pandemic while service utilisation and access to commissioned care remained high, there were persistent pockets of reduced use and accessibility. They acknowledged that there were geographic and specialty shortfalls in NHS dental service provision. They said that their commissioning framework was being developed to provide tools to flex contractual arrangements, including guidance for using contracts for outreach provision for hard-to-reach groups. They said that March 2020 GP Patient Survey[1] data showed that 94 per cent of people surveyed who had tried to get an appointment with an NHS dentist in the past two years were successful, with the success rate the same for the preceding six-month period.

9.7 In previous years, we also presented the latest figures for the number of UDAs commissioned and delivered in England. However, as a result of the pandemic, this data was not collected in 2020. Had it been collected, it would also not have been comparable to previous years, as a result of the closure of practices and limits on patient volumes described above.

9.8 In March 2021, Public Health England published the report *Inequalities in oral health in England*[2]. It found that oral health behaviours and outcomes were significantly worse amongst those from lower socioeconomic backgrounds and from more deprived geographical areas. It also included evidence that those from ethnic minority backgrounds were less likely to access NHS dentistry.

Scotland

9.9 The Scottish Government said that high street dental practices in Scotland were closed from 23 March 2020, though practices continued to triage patients remotely, with those in need of urgent care being referred to Health Board-run Urgent Dental Care Centres. They said that there was a phased remobilisation during the summer of 2020, which culminated in the return of a full range of treatments available on the NHS from 1 November 2020. However, they said that patient volumes were still significantly reduced even after this date. They said that they had paid £12 million per month in emergency payments, as well as £2.75 million per month of targeted support for practices. They said that top-up arrangements were in place to ensure that practices would receive at least 80 per cent of their average monthly item of service payments from 2019-20 per month, rising to 85 per cent from 1 November 2020.

9.10 The BDA said that while financial support was provided by the Scottish Government, patient charges were not collected between March and November 2020, and dentists' operating capacity had been vastly reduced so income from patients was considerably lower than normal. They said that the Scottish Government had intended to introduce minimum activity levels from March 2021 but had delayed this by at least three months following the tighter restrictions introduced in January 2021.

Wales

9.11 The Welsh Government said that the pandemic had required a change in priorities, with the underlying aim since March 2020 having been the need to keep dental teams, patients and the wider community safe. They said that practices were not closed entirely in Wales, though riskier treatments were centralised. They said that UDA targets were suspended for 2020-21 and the first half of 2021-22, and the reduced throughput of patients had led to practices taking a more considered care-based approach to dentistry.

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[1] NHS England (9 July 2020). *GP Patient Survey Dental Statistics; January to March 2020, England*. Available at: https://www.england.nhs.uk/statistics/2020/07/09/gpps_dent_3758-78929/

[2] Public Health England (19 March 2021). *Inequalities in oral health in England.* Available at: https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england

9.12 The BDA said that practices remained open in Wales for non-aerosol-generating urgent procedures through the first lockdown. They said that for 2020-21, UDA targets were suspended, with a range of alternative performance indicators introduced instead, with the support of the BDA.

Northern Ireland

9.13 The Department of Health (DoH) said that operating constraints meant that at the time of writing, practices were operating at approximately 25 per cent of pre-pandemic activity levels[3], and that in response to the impact on Item of Service payments, they had established the General Dental Services Financial Support Scheme (FSS). They said that patient throughput was expected to remain below normal levels for the foreseeable future, and arrangements for 2021-22 were being considered.

9.14 The BDA said that despite the financial support provided, GDPs' overall HSC earnings had fallen significantly. They also said that dentists in Northern Ireland uniquely had to provide their own PPE, which had exacerbated this situation, despite the abatement present in the FSS being removed.

9.15 DoH said that the access issues which had previously been a problem in Northern Ireland a decade ago had largely been resolved, although the COVID-19 pandemic had resulted in specific access issues and the longer-term impact was being monitored. They said that the number of patients registered with a GDP had grown to 1.219 million, 64 per cent of the total population, compared with 48 per cent in 2008. They said that children were more likely to be registered with a health service dentist than adults (75 per cent compared to 61 per cent), and 94.4 per cent of the population in Northern Ireland lived within five miles of a dental practice.

General dental practitioners

9.16 While terminology differs between the nations of the UK, general dental practitioners delivering NHS/HSC services are generally split into two categories. Dentists that hold a contract with the NHS/HSC to provide services are referred to as 'providing-performer' or 'principal' dentists. Dentists that deliver NHS services under a contract held by another body, which can be a limited company or a providing-performer partnership, are referred to as 'performer-only' or 'associate' dentists. Associate dentists usually practice as subcontractors. In this report we will refer to the former group as providing-performers and the latter as associates.

9.17 The remit of the DDRB includes making recommendations on the pay of GDPs. Associate dentists will be paid by the practice owner or company concerned. Providing-performer dentists will be paid out of the value of their contract. In either case their income will ultimately be funded by the contracts negotiated with the NHS/HSC, often supplemented by additional revenues generated by private work.

9.18 Dental contracts in different parts of the UK are structured differently. In England and Wales, contracts are structured around the Unit of Dental Activity (UDA). Different dental treatments are worth different numbers of UDAs. Those that hold contracts to deliver NHS dentistry are expected to perform a contracted number of UDAs (and, where applicable, units of orthodontic activity, (UOAs)) each year, with provisions for 'clawback' – the recovering of contract values, if UDA/UOA targets are not met. In Scotland and Northern Ireland, remuneration is based on a mix of Item of Service payments, where fixed amounts are recoverable for different treatments; capitation, where a fixed amount is paid per patient registered; and other allowances.

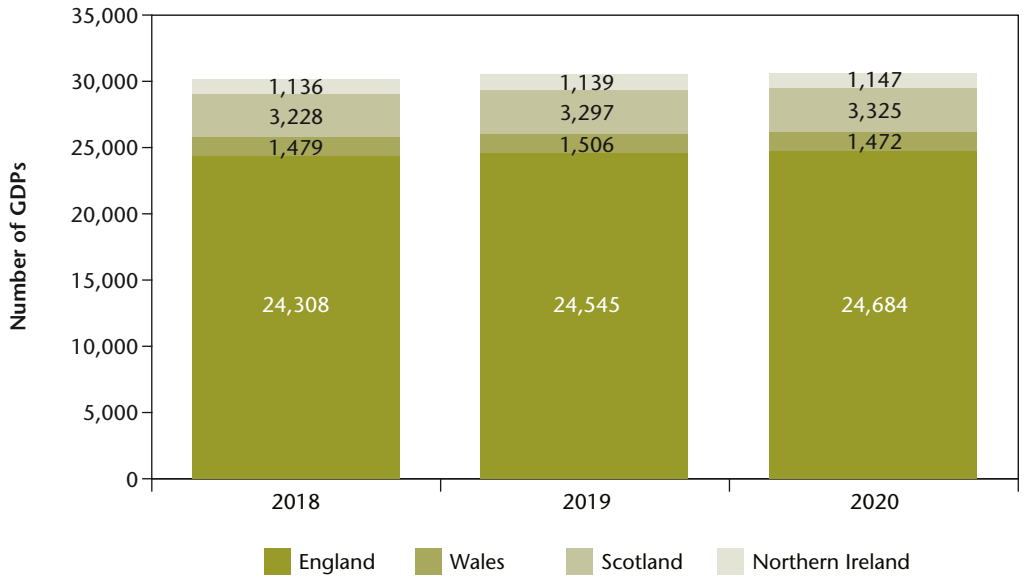
[3] The Department of Health's written evidence was submitted to us in January 2021.

9.19 GDPs differ from GMPs in that, typically, a significant proportion of GDP practices combine NHS/HSC and private dentistry. This means that both practices' and dentists' incomes can often be subject to an element of wider market pressure.

9.20 Earnings can vary based on career choices, the balance of NHS/HSC and private work, the number of hours worked and the location of the practice. Calculated on a headcount basis, and including both NHS/HSC and private income, on average, in 2018-19 providing-performer dentists in England earned £113,100, while associates earned £57,600. The equivalent figures for Scotland were £112,200 and £57,400; Wales £88,400 and £58,800; and Northern Ireland, £104,400 and £58,700.

9.21 In 2020[4] there were 30,628 dentists providing NHS services in the UK, an increase of 141 (0.5 per cent) from a year earlier. There were increases of: 139 (0.6 per cent) in England, 28 (0.8 per cent) in Scotland, and 8 (0.7 per cent) in Northern Ireland. There was a reduction in Wales of 34 (-2.3 per cent).

Figure 9.1: Number of General Dental Practitioners (GDPs), United Kingdom, 2018 to 2020



Source: NHS Digital, StatsWales, NHS Education for Scotland, Department of Health Northern Ireland.

Motivation

9.22 Since our 2020 report the results from the Dental Working Hours Motivation and Morale survey for 2018-19 and 2019-20 were published by NHS Digital. The survey contained six motivation questions, a leaving question and a question about morale. The motivation questions are set out in the table below.

[4] Data for each country are as at 31 March.

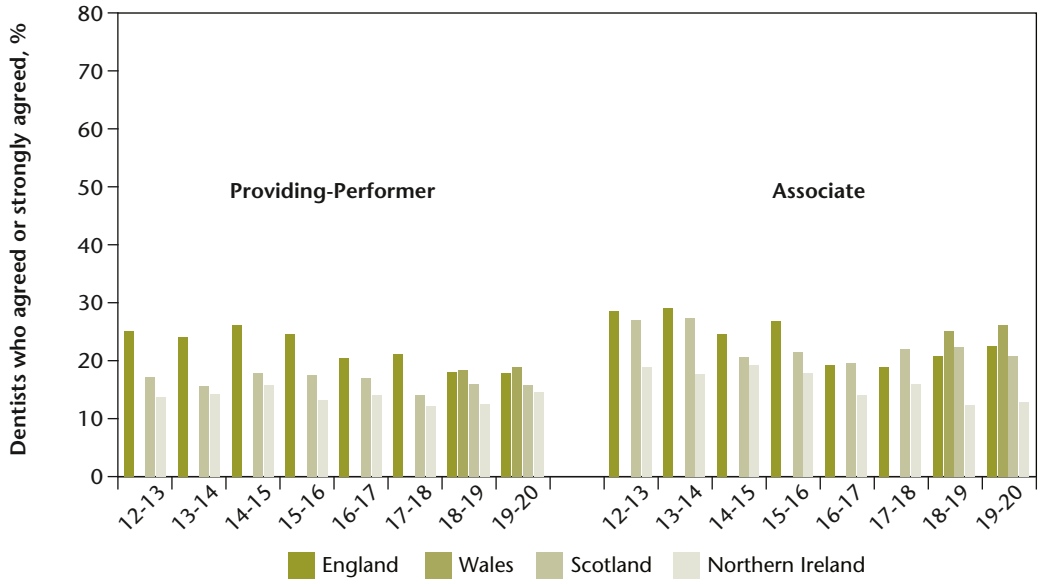
Table 9.1: Dental Working Hours Motivation and Morale Survey questions on motivation

Question	Potential answers
I feel good about my job as a dentist	• Strongly agree • Agree • Neutral • Disagree • Strongly disagree
I receive recognition for the work I do	
I feel my pay is fair	
I have all the equipment and resources I need to do my job properly	
My job gives me the chance to do challenging and interesting work	
There are opportunities for me to progress in my career	

9.23 The main points from the responses to the 2018-19 and 2019-20 surveys were:

- Only a small proportion of dentists across the UK agreed or strongly agreed that their pay was fair. With the exception of Northern Ireland, associates were more likely to agree that their pay was fair. For providing-performers, 19 per cent in Wales agreed their pay was fair, compared to 18 per cent in England, 16 per cent in Scotland and 15 per cent in Northern Ireland. For associates, 26 per cent in Wales agreed their pay was fair, compared to 23 per cent in England, 21 per cent in Scotland and 13 per cent in Northern Ireland.

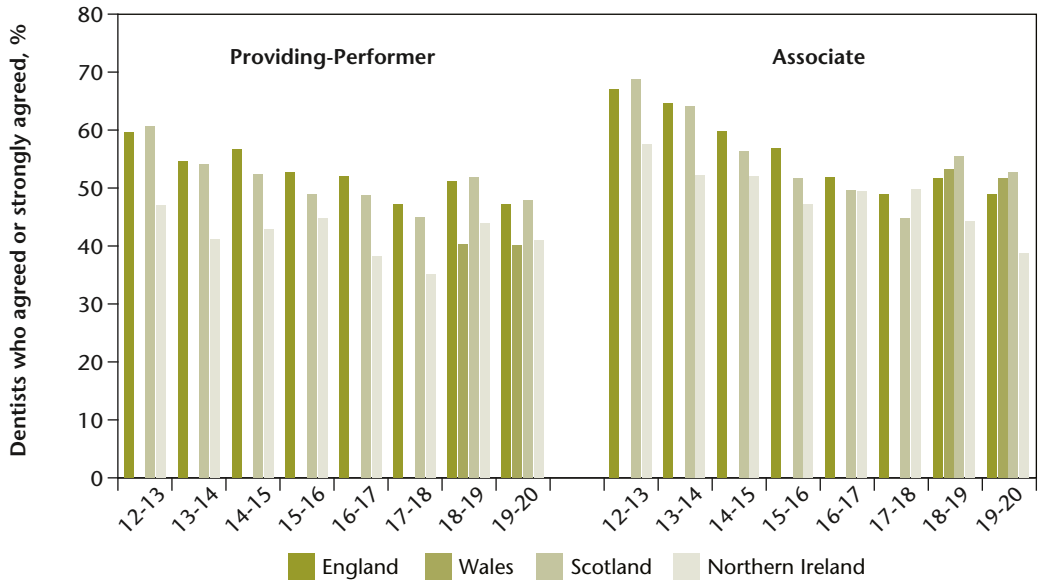
Figure 9.2: Percentage of dentists who 'agreed' or 'strongly agreed' that their pay was fair, 2012-13 to 2019-20



Source: NHS Digital.

- A minority of dentists agreed or strongly agreed that they felt good about their job as a dentist. With the exception of in Northern Ireland associates were more likely to agree that they felt good about their job than providing-performers, and dentists in Scotland were the most likely to say they felt good about their job. For providing-performers, 48 per cent in Scotland felt good about their job, compared to 47 per cent in England, 41 per cent in Northern Ireland and 40 per cent in Wales. For associates, 53 per cent in Scotland felt good about their job, compared to 52 per cent in Wales, 49 per cent in England and 39 per cent in Northern Ireland.

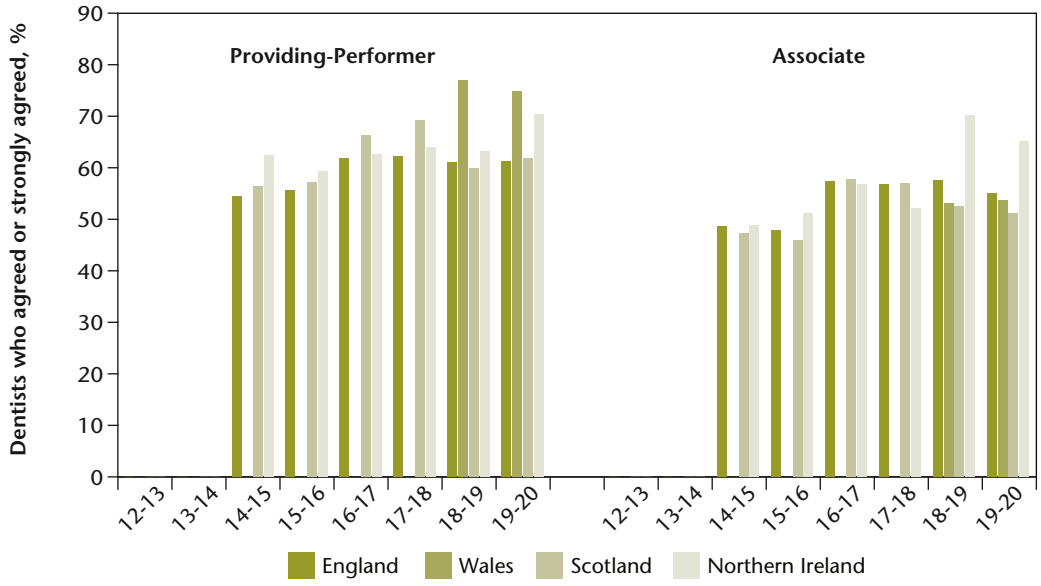
Figure 9.3: Percentage of dentists who 'agreed' or 'strongly agreed' that they felt good about their job as a dentist, 2012-13 to 2019-20



Source: NHS Digital.

- In 2019-20 a majority of dentists said that they 'agree' or 'strongly agree' that they thought about leaving general dentistry. In all countries of the UK providing-performers were more likely than associates to say that they thought about leaving general dentistry. Compared with 2017-18, the period covered when data was previously published, dentists in England and Scotland were less likely to say that they thought about leaving general dentistry, while dentists in Northern Ireland were more likely to have done so.

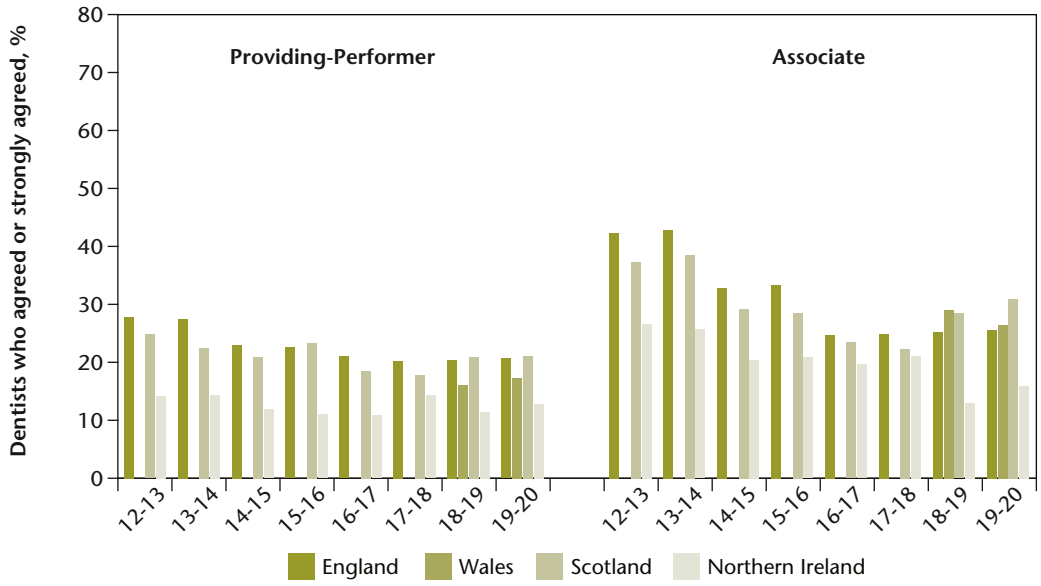
Figure 9.4: Percentage of dentists who 'agreed' or 'strongly agreed' that they thought about leaving general dentistry, 2012-13 to 2019-20



Source: NHS Digital.

- In 2019-20 dentists in Scotland were more likely to rate their morale as 'high' or 'very high' than those in the rest of the UK and associate dentists were more likely than providing-performers to rate their morale as 'high' or 'very high'. For providing-performers: 21 per cent in each of Scotland and England rated their morale as 'high' or 'very high', compared with 17 per cent in Wales and 13 per cent in Northern Ireland. For associates: 31 per cent in Scotland rated their morale as 'high' or 'very high', compared with 26 per cent in both Wales and England, and 16 per cent in Northern Ireland.

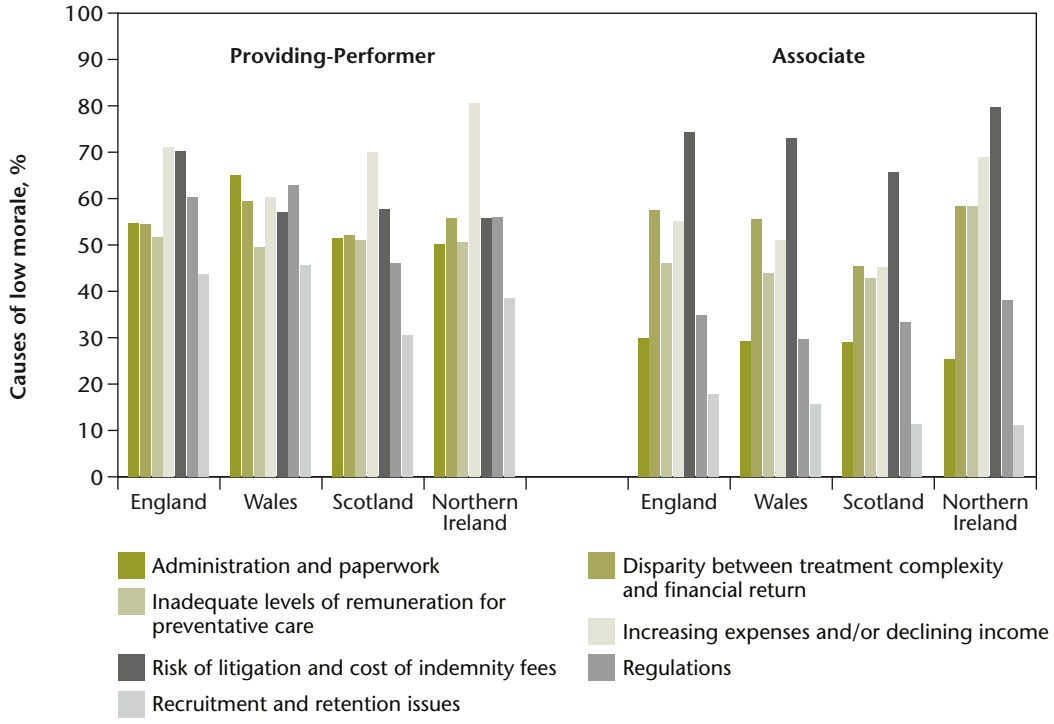
Figure 9.5: Percentage of dentists who rated their morale as 'high' or 'very high', 2012-13 to 2019-20



Source: NHS Digital.

- In 2019-20 increasing expenses and/or declining income was the most frequently cited cause of low morale by providing-performer dentists in England, Scotland and Northern Ireland. In Wales, although 60 per cent of providing-performers cited expenses and/or income as a cause of low morale they were even more likely to cite administration and paperwork, and regulations. For associates the most frequently cited cause of low morale, in each of the four countries, was the risk of litigation and cost of indemnity fees. Recruitment and retention issues was the least cited cause of low morale of those listed, for both providing-performers and associates, across each of the four countries.

Figure 9.6: Causes of low morale amongst dentists, 2019-20



Source: NHS Digital.

Recruitment and retention

England

9.24 NHSE/I said that current trends in the dental workforce were difficult to assess, but overall national workforce numbers appeared adequate to meet the needs of the population. They said their analysis of workforce capacity was limited by the available data not detailing whole- or part-time working, but they were aware of certain geographic shortfalls limiting service provision.

9.25 The BDA said that headcount GDP numbers continued to show steady rises, and that they were working with HEE to understand trends in the full-time equivalent (FTE) size of the workforce. They said that many associates (who comprise the majority of GDPs in England) were choosing to work part-time, but the impact of the pandemic on this was currently unknown, though they had heard anecdotally of associates losing their jobs as practices struggled to make ends meet. They also said that difficulties in recruiting associates was one of the causes of the increases in clawback that took place prior to the pandemic.

Scotland

9.26 The Scottish Government said that 3,081 GDPs were providing NHS dental services in September 2020, slight increases on both March 2020 and September 2018. They said that they were looking to obtain FTE workforce information, which should become available in 2021.

9.27 The BDA said that in a survey of practice owners in Scotland in July 2020 found that the vast majority (91 per cent) of owners of mixed NHS/private practices said they were not confident of maintaining their staffing levels in the coming year. Most owners of largely/exclusively NHS practices (52 per cent) and of mixed practices (86 per cent) said they expected the amount of NHS work they would do in the following 12 months to decrease.

Wales

9.28 The Welsh Government said that recruitment and retention difficulties were being encountered by a number of Health Boards, particularly, but not exclusively, in the more rural areas of North, Mid and West Wales. They said that this was the cause of the closure of a number of practices and was causing difficulties in replacing lost provision. They said that Health Education and Improvement Wales was examining the commissioning of training, and other aspects of the dental training system to consider changed workforce models to improve workloads and make practices more sustainable.

9.29 The BDA said that the headcount number of GDPs practicing in Wales had levelled out, and there had been a significant shift from providing-performers to associates, though they said that as in England, these figures were not necessarily representative of effective workforce capacity.

Northern Ireland

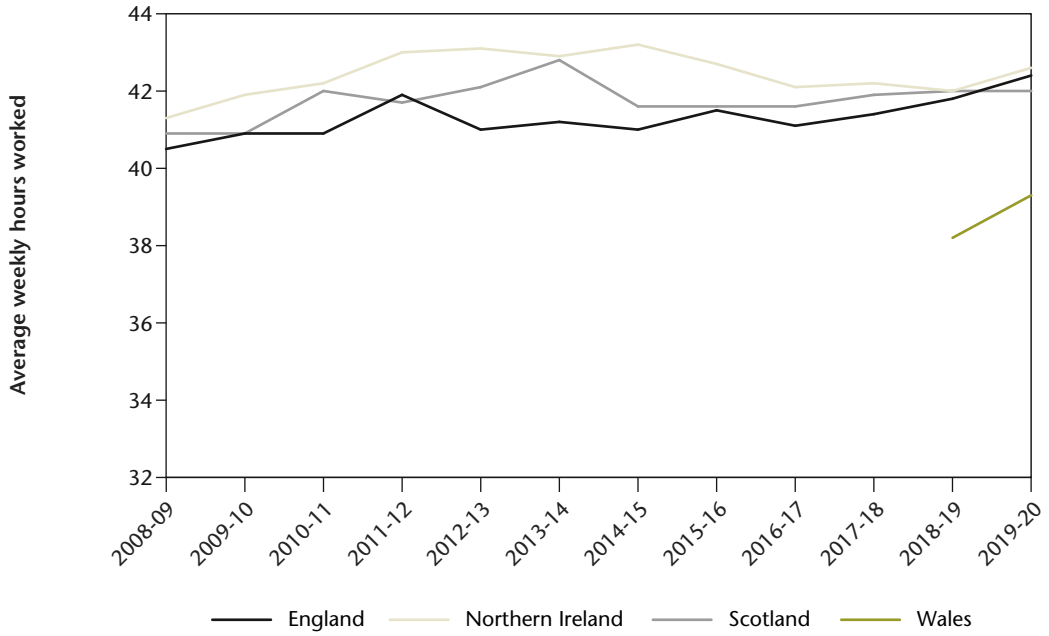
9.30 The Department of Health told us about the Practice Allowance, which was introduced in 2005 to support the provision of HSC dentistry in Northern Ireland by giving financial assistance to dental practices that are most committed to providing HSC dentistry. The Department did not present further evidence of recruitment and retention issues for this pay round.

9.31 The BDA said that while the number of GDPs registered in Northern Ireland had grown, the number of dentists who were actively carrying out HSC dentistry was lower. They said that while overall numbers had been increasing, there was evidence that since the start of the pandemic, more dentists were considering leaving HSC dentistry, with survey results finding that the proportion of providing-performers and associates who said that they often thought about leaving HSC dentistry had increased since 2015-16.

Working hours

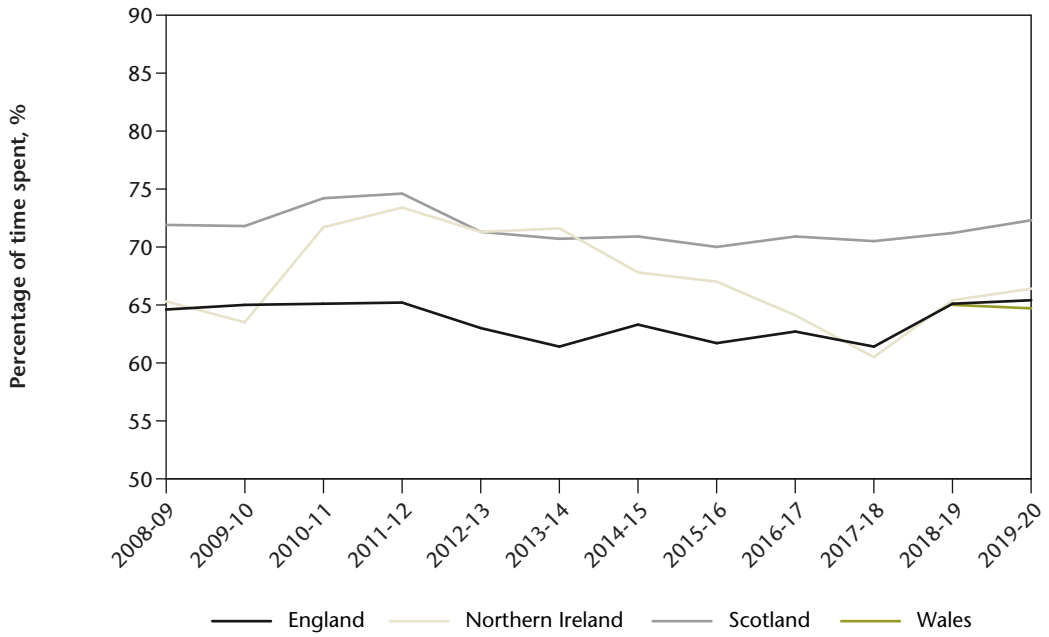
9.32 Since our 2020 report the results from the Dental Working Hours Motivation and Morale survey for 2018-19 and 2019-20 were published by NHS Digital. Figures 9.7 to 9.10 show for providing-performer dentists, in each of the four countries, average weekly hours worked, the percentage of time spent on NHS/HSC work, the percentage of time spent on clinical work, and the average weekly hours spent on NHS/HSC work. The results include all self-employed primary care dentists who provided some NHS/HSC treatment between April 2018 and March 2020.

Figure 9.7: Average weekly hours worked, by providing-performers, 2008-09 to 2019-20, by country



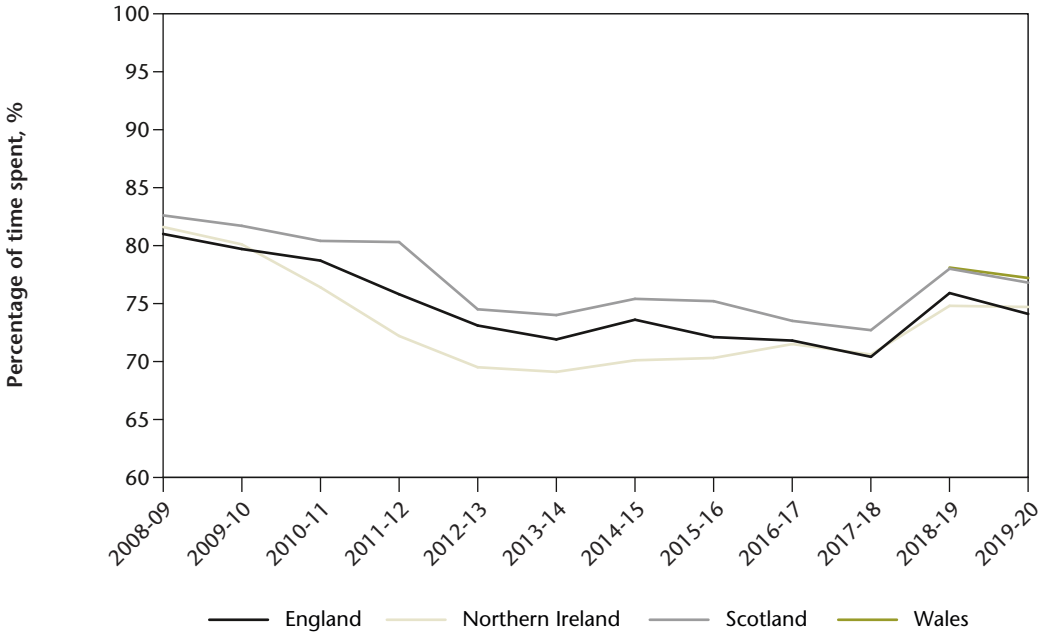
Source: NHS Digital.
Note: Data for Wales only available from 2018-19. There is a discontinuity in the data for England between 2017-18 and 2018-19.

Figure 9.8: Percentage of time spent on NHS/HSC work, by providing-performers, 2008-09 to 2019-20, by country



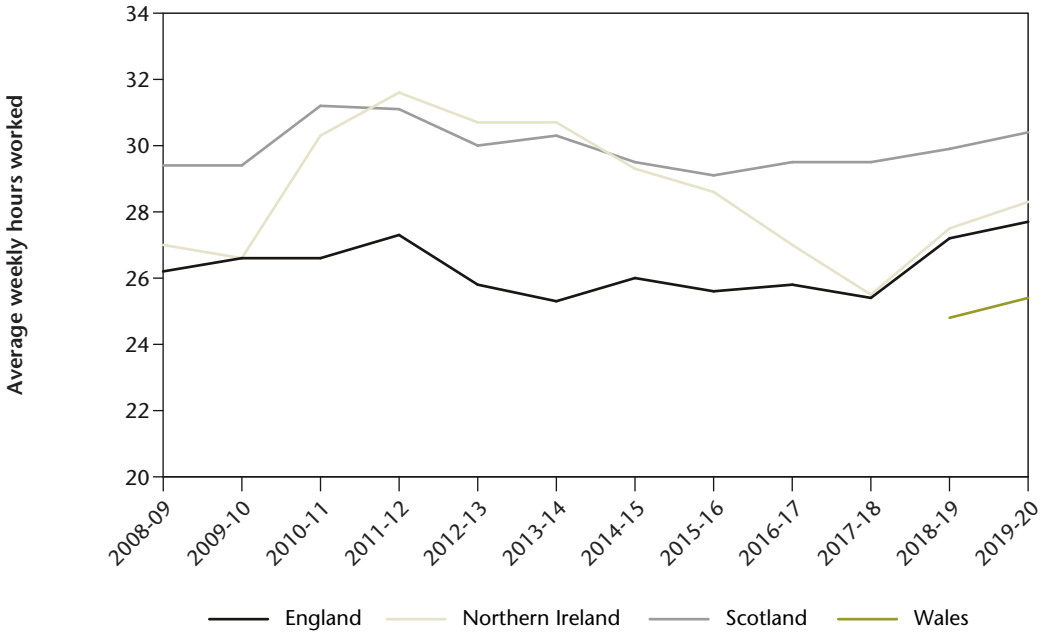
Source: NHS Digital.
Note: Data for Wales only available from 2018-19. There is a discontinuity in the data for England between 2017-18 and 2018-19.

Figure 9.9: Percentage of time spent on clinical work, by providing-performers, 2008-09 to 2019-20, by country



Source: NHS Digital.
Note: Data for Wales only available from 2018-19. There is a discontinuity in the data for England between 2017-18 and 2018-19.

Figure 9.10: Average weekly hours spent on NHS/HSC work, by providing-performers, 2008-09 to 2019-20, by country



Source: NHS Digital.
Note: Data for Wales only available from 2018-19. There is a discontinuity in the data for England between 2017-18 and 2018-19.

9.33 The results for England showed that in 2019-20 providing-performer dentists worked on average 42.4 hours per week of which 27.7 hours (65.4 per cent) were dedicated to NHS dentistry. Compared with 2018-19, this represents an increase of 0.6 hours worked, and an increase of 0.5 hours in the number of hours devoted to NHS dentistry. Providing-performers spent 74.1 per cent of their time on clinical work, a reduction from 75.9 per cent in 2018-19.

9.34 The results for Scotland showed that in 2019-20 providing-performer dentists worked on average 42.0 hours per week of which 30.4 hours (72.3 per cent) were dedicated to NHS dentistry. Compared with 2018-19, this represents no change in hours worked, and an increase of 0.5 hours in the number of hours devoted to NHS dentistry. Providing-performers spent 76.8 per cent of their time on clinical work, a reduction from 78.0 per cent in 2018-19.

9.35 The results for Wales showed that in 2019-20 providing-performer dentists worked on average 39.3 hours per week of which 25.4 hours (64.7 per cent) were dedicated to NHS dentistry. Compared with 2018-19, this represents an increase of 0.9 in the number of hours worked, and an increase of 0.6 hours in the number of hours devoted to NHS dentistry. Providing-performers spent 77.2 per cent of their time on clinical work, a reduction from 78.1 per cent in 2018-19.

9.36 The results for Northern Ireland showed that in 2019-20 providing-performer dentists worked on average 42.6 hours per week of which 28.3 hours (66.4 per cent) were dedicated to HSC dentistry. Compared with 2018-19, this represents an increase of 0.6 in the number of hours worked, and an increase of 0.8 hours in the number of hours devoted to HSC dentistry. Providing-performers spent 74.7 per cent of their time on clinical work, a reduction from 74.8 per cent in 2018-19.

9.37 Figures 9.11 to 9.14 show the results from the Dental Working Hours Motivation and Morale survey for associate dentists, in each of the four countries, for average weekly hours worked, the percentage of time spent on NHS/HSC work, the percentage of time spent on clinical work, and the average weekly hours spent on NHS/HSC work. The results include all self-employed primary care dentists who provided some NHS/HSC treatment between April 2018 and March 2020.

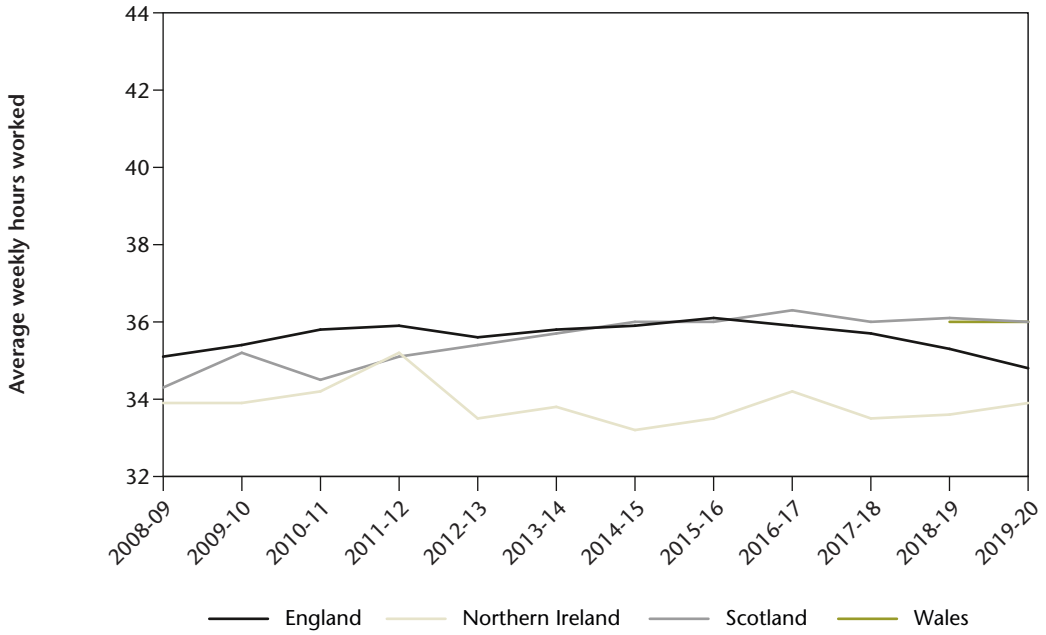
9.38 The results for England showed that in 2019-20 associate dentists worked on average 34.8 hours per week of which 26.4 hours (75.9 per cent) were dedicated to NHS dentistry. Compared with 2018-19, this represents a reduction of 0.5 hours worked, and a reduction of 0.9 hours in the number of hours devoted to NHS dentistry. Associates spent 84.3 per cent of their time on clinical work, an increase from 84.1 per cent in 2018-19.

9.39 The results for Scotland showed that in 2019-20 they worked on average 36.0 hours per week of which 29.2 hours (81.1 per cent) were dedicated to NHS dentistry. Compared with 2019-20, this represents a reduction of 0.1 hours worked, and a reduction of 0.4 hours in the number of hours devoted to NHS dentistry. Associates in Scotland spent 86.6 per cent of their time on clinical work, a reduction from 87.1 per cent in 2018-19.

9.40 The results for Wales showed that in 2019-20 they worked on average 36.0 hours per week of which 27.9 hours (77.6 per cent) were dedicated to NHS dentistry. Compared with 2019-20, this represents no change in the number of hours worked, and a reduction of 0.6 hours in the number of hours devoted to NHS dentistry. Associates in Wales spent 85.3 per cent of their time on clinical work, a reduction from 86.0 per cent in 2018-19.

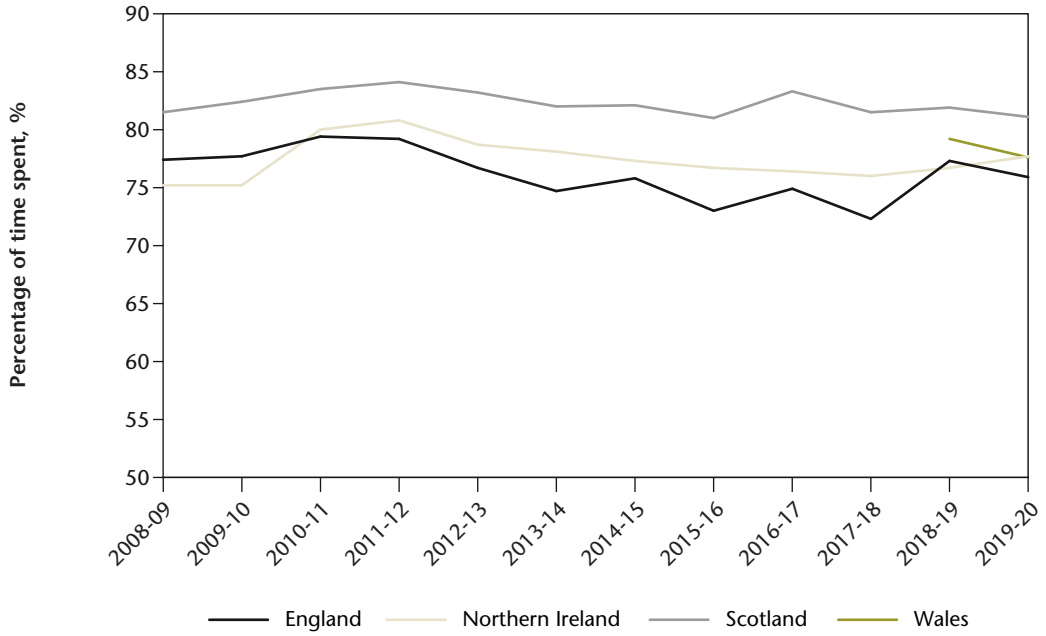
9.41 The results for Northern Ireland showed that in 2019-20 they worked on average 33.9 hours per week of which 26.3 hours (77.7 per cent) were dedicated to HSC dentistry. Compared with 2019-20, this represents an increase of 0.3 hours in the number of hours worked, and an increase of 0.5 hours in the number of hours devoted to HSC dentistry. Associates in Northern Ireland spent 85.9 per cent of their time on clinical work, an increase from 84.9 per cent in 2018-19.

Figure 9.11: Average weekly hours worked, by associates, 2008-09 to 2019-20, by country



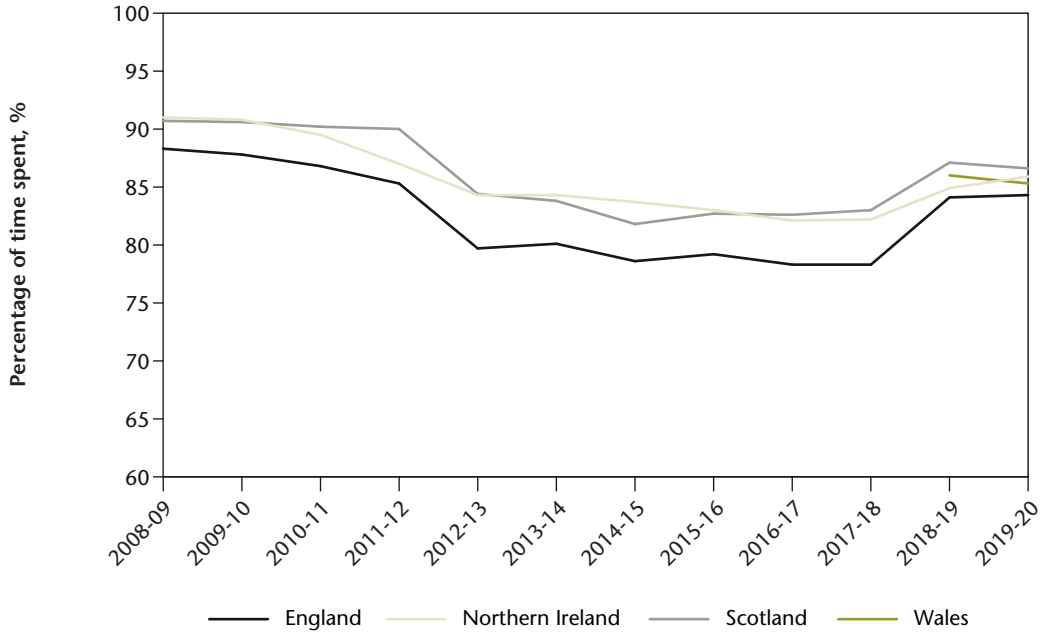
Source: NHS Digital.
Note: Data for Wales only available from 2018-19. There is a discontinuity in the data for England between 2017-18 and 2018-19.

Figure 9.12: Percentage of time spent on NHS/HSC work, by associates, 2008-09 to 2019-20, by country



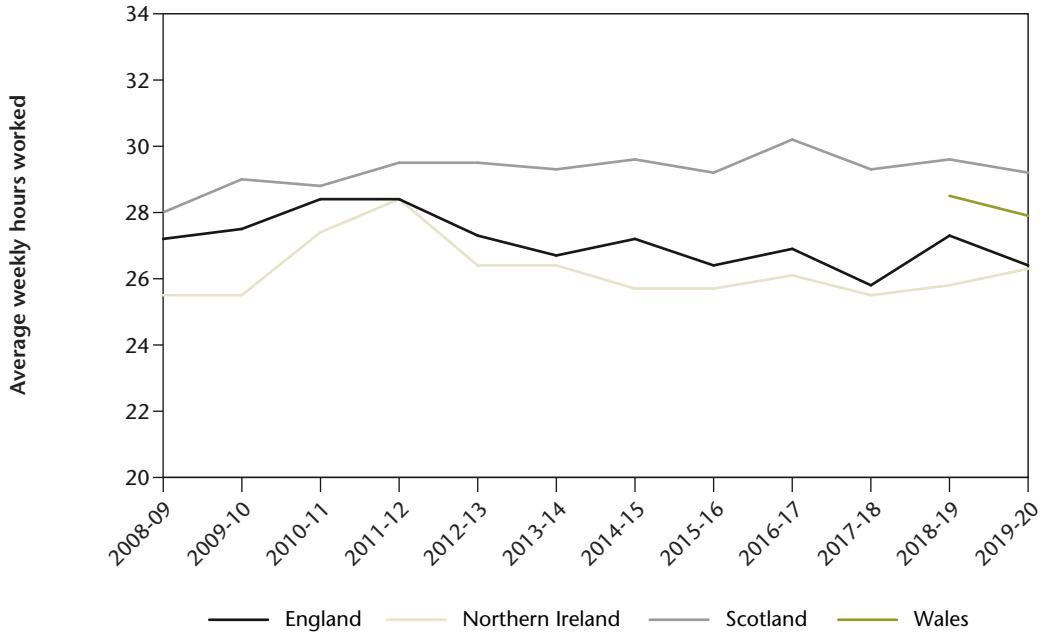
Source: NHS Digital.
Note: Data for Wales only available from 2018-19. There is a discontinuity in the data for England between 2017-18 and 2018-19.

Figure 9.13: Percentage of time spent on clinical work, by associates, 2008-09 to 2019-20, by country



Source: NHS Digital.
Note: Data for Wales only available from 2018-19. There is a discontinuity in the data for England between 2017-18 and 2018-19.

Figure 9.14: Average weekly hours spent on NHS/HSC work, by associates, 2008-09 to 2019-20, by country



Source: NHS Digital.
Note: Data for Wales only available from 2018-19. There is a discontinuity in the data for England between 2017-18 and 2018-19.

Earnings and expenses for providing-performer GDPs

9.42 NHS Digital, using HMRC data, publishes statistics on the earnings and expenses of primary care dentists who carried out NHS/HSC work in each part of the UK. The overall picture on earnings is unclear as it is not known how many hours' work the statistics were based on, and some dentists choose to take incorporated status, affecting how their income appears in the statistics. It is also difficult to separate earnings attributable to NHS/HSC work from those arising from private practice. Due to a change in the methodology used to determine dental type, for dentists in England and Wales, there is now a break in timeseries. The figures published in 2018-19 are not comparable to those of previously published reports. HMRC have recalculated the 2017-18 figures using the new dental type methodology, allowing comparisons to be made between 2017-18 and 2018-19 as well as establishing a new two-year timeseries.

England

9.43 Table 9.3 shows that in 2018-19, providing-performer dentists in England had average taxable income of £113,100, a reduction of 0.1 per cent from 2017-18, and average expenses of £270,300 (Expenses to Earnings Ratio (EER) of 70.5 per cent).

Table 9.3: Providing-performer GDPs' average gross earnings, income and expenses, England, NHS and private, headcount, 2017-18 to 2018-19

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	4,200	365.1	251.9	113.2	69.0
2018-19	4,100	383.4	270.3	113.1	70.5
Latest change (%)		*+5.0%*	*+7.3%*	*-0.1%*	*+1.5pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Wales

9.44 Table 9.4 shows that in 2018-19, providing-performer dentists in Wales had average taxable income of £88,400, an increase of 3.6 per cent from 2017-18, and average expenses of £206,100 (EER 70.0 per cent).

Table 9.4: Providing-performer GDPs' average gross earnings, income and expenses, Wales, NHS and private, headcount, 2017-18 to 2018-19

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	200	274.5	189.2	85.3	68.9
2018-19	200	294.6	206.1	88.4	70.0
Latest change (%)		*+7.3%*	*+8.9%*	*+3.6%*	*+1.1pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Scotland

9.45 Table 9.5 shows that in 2017-18 providing-performer dentists in Scotland had average taxable income of £112,200, an increase of 4.3 per cent from 2017-18, and average expenses of £258,600 (EER 69.7 per cent).

Table 9.5: Providing-performer GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2008-09 to 2018-19

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2008-09	699	343.9	225.2	118.7	65.5
2009-10	650	337.0	223.2	113.8	66.2
2010-11	700	334.7	233.6	101.1	69.8
2011-12	700	332.9	230.0	102.9	69.1
2012-13	650	319.6	222.3	97.4	69.5
2013-14	650	330.3	231.9	98.4	70.2
2014-15	600	347.2	244.3	102.9	70.4
2015-16	500	377.8	267.0	110.8	70.7
2016-17	500	377.3	268.3	109.0	71.1
2017-18	500	367.7	260.0	107.6	70.7
2018-19	500	370.9	258.6	112.2	69.7
Latest change		*+0.9%*	*-0.5%*	*+4.3%*	*-1.0pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio,

Northern Ireland

9.46 Table 9.6 shows that in 2018-19, providing-performer dentists had average taxable income of £104,400, a fall of 10.0 per cent, and average expenses of £229,700 (EER 68.8 per cent). Variations in average incomes, suggest that there is a degree of volatility in these statistics associated with the small sample size.

Table 9.6: Providing-performer GDPs' average gross earnings, income and expenses, Northern Ireland, HSC and private, headcount, 2008-09 to 2018-19

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2008-09	320	333.7	204.1	129.6	61.2
2009-10	350	344.6	221.7	122.9	64.3
2010-11	300	331.0	216.8	114.2	65.5
2011-12	350	318.6	206.1	112.5	64.7
2012-13	300	316.0	205.2	110.9	64.9
2013-14	300	335.6	223.1	112.5	66.5
2014-15	250	328.7	217.0	111.7	66.0
2015-16	250	336.0	218.4	117.6	65.0
2016-17	200	314.7	215.5	99.1	68.5
2017-18	250	347.1	231.1	116.0	66.6
2018-19	200	334.2	229.7	104.4	68.8
Latest change		*-3.7%*	*-0.6%*	*-10.0%*	*+2.2pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Earnings and expenses for associate GDPs

England

9.47 Table 9.7 shows that in 2018-19, associate dentists in England had average taxable income of £57,600, an increase of 1.1 per cent from 2017-18, and average expenses of £31,400 (EER 35.3 per cent).

Table 9.7: Associate GDPs' average gross earnings, income and expenses, England, NHS and private, headcount, 2017-18 to 2018-19

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	16,300	90.3	33.3	57.0	36.9
2018-19	16,600	89.0	31.4	57.6	35.3
Latest change		*-1.4%*	*-5.7%*	*+1.1%*	*-1.6pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Wales

9.48 Table 9.8 shows that in 2018-19, associate dentists in Wales had average taxable income of £58,800, an increase of 1.1 per cent from 2017-18, and average expenses of £46,500 (EER 44.2 per cent).

Table 9.8: Associate GDPs' average gross earnings, income and expenses, Wales, NHS and private, headcount, 2017-18 to 2018-19

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	850	104.6	46.4	58.3	44.3
2018-19	950	105.3	46.5	58.8	44.2
Latest change		*+0.7%*	*+0.2%*	*+0.9%*	*-0.1pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Scotland

9.49 Table 9.9 shows that in 2018-19, associate dentists in Scotland had average taxable income of £57,400, an increase of 3.6 per cent from 2017-18, and average expenses of £32,700 (EER 36.3 per cent).

Table 9.9: Associate GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2009-10 to 2018-19

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2009-10	1,450	91.9	28.8	63.1	31.3
2010-11	1,450	87.9	27.8	60.1	31.6
2011-12	1,550	85.0	27.5	57.6	32.3
2012-13	1,650	84.9	27.7	57.2	32.6
2013-14	1,650	84.9	28.7	56.2	33.8
2014-15	1,750	84.7	29.7	55.0	35.1
2015-16	1,700	86.0	30.7	55.2	35.7
2016-17	1,750	88.6	32.1	56.4	36.3
2017-18	1,800	85.2	29.9	55.4	35.0
2018-19	1,850	90.1	32.7	57.4	36.3
Latest change		*+5.8%*	*+9.4%*	*+3.6%*	*+1.3pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Northern Ireland

9.50 Table 9.10 shows that in 2018-19, associate dentists in Northern Ireland had average taxable income of £58,700, an increase of 12.2 per cent from 2017-18, and average expenses of £39,400 (EER 40.2 per cent). As with the data for providing-performer dentists in Northern Ireland the volatility of this data suggests there is a degree of natural variation in these statistics.

Table 9.10: Associate GDPs' average gross earnings, income and expenses, Northern Ireland, HSC and private, headcount, 2009-10 to 2018-19

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2009-10	500	97.9	35.2	62.7	36.0
2010-11	550	96.2	36.9	59.4	38.3
2011-12	600	91.6	35.8	55.7	39.1
2012-13	650	86.7	33.7	53.0	38.9
2013-14	700	89.7	35.5	54.2	39.6
2014-15	700	90.2	36.1	54.0	40.1
2015-16	750	98.9	44.7	54.2	45.2
2016-17	850	104.8	45.7	59.1	43.6
2017-18	850	85.9	33.6	52.3	39.1
2018-19	850	98.1	39.4	58.7	40.2
Latest change		*+14.2%*	*+17.3%*	*+12.2%*	*+1.1pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio.

Gender Pay

9.51 Data from NHS Digital shows that incomes of GDPs in England, Scotland, Wales and Northern Ireland varied by gender. In 2018-19 female providing-performer and associate dentists earned less than their male counterparts in each country. Female providing-performer GDPs earned 27 per cent less than their male colleagues in Scotland, 25 per cent less in Northern Ireland, 18 per cent less in England and 10 per cent less in Wales. In each country the differences were larger than they had been in 2017-18, except for Northern Ireland where the difference was 2 percentage points smaller. For associate GDPs, female GDPs earned 38 per cent less than male colleagues in Northern Ireland, 26 per cent less in England, 24 per cent less in Scotland and 16 per cent less in Wales. Although the differences in Scotland and Northern Ireland were larger than in 2017-18, there was a narrowing of the gaps in both England and Wales.

Contract reform

England

9.52 DHSC said that a new way of delivering NHS dentistry was being tested in over 100 prototype high street practices, and the underlying principles of contract reform were improving oral health, maintaining or increasing dental access, offering sustainability for practices, and providing value for money for the NHS. They said that the new approach has a prevention-focused clinical pathway at its heart, including offering all patients Oral Health Assessments and diet and hygiene advice. The prototypes included a new remuneration system based on a blend of capitation and non-capitated activity, with two different blends (55 per cent and 80 per cent of payments comprising capitation) being tested. They said that an evaluation covering the three years of prototyping up to 31 March 2022 is expected to be available in early 2022. However, NHSE/I said that contract reform efforts had been paused during the height of the pandemic while resource was redirected to helping practices adapt to new ways of working.

9.53 The BDA said that they have wanted reformed General Dental Services (GDS) contracts to be introduced in England since 2007, but the pandemic had placed discussions on hold. They said that prototype practices had faced more confusion about their remuneration arrangements through the pandemic than other practices. They said that the reintroduction of activity targets was a backwards step, and a missed opportunity to remove the UDA altogether and move towards a more preventive approach.

Scotland

9.54 The Scottish Government said that they had stated in communications to dentists that the payment model had not performed well through the pandemic, and that they would be considering alternative models that offer a more sustainable and predictable income stream for NHS dental contractors. They said that the exact framework and planning for this would take place over the following 18 to 24 months. The BDA said that they had established a working group to contribute to discussions with the Scottish Government and other stakeholders.

Wales

9.55 The Welsh Government said that 40 per cent of all practices were on reformed contracts, which see UDA targets reduced and practices instead expected to spend more time on preventive activity. However, they said that due to the pandemic, the contract reform programme was paused for 2020-21, with the aim to restart it in April 2021. They said that in the COVID-19 recovery period, they were seeking to use lessons from the contract reform programme to support practices to deliver preventive care and treatment to patients, though they said that the pandemic had not altered the vision of contract reform.

Northern Ireland

9.56 The Department of Health said that the Health and Social Care Board were working with the BDA to better understand the various factors influencing GDS payments, though they said that this work had been delayed due to the COVID-19 pandemic. They said that it remained a long-term goal to develop and implement new contracts for dentists in Northern Ireland, and in early 2020 they had published their evaluation of a pilot scheme that was completed in 2016. They said that they would also consider developments in England, Scotland and Wales to inform decisions for Northern Ireland.

9.57 The BDA said that progress towards reform had stalled since the pilot scheme ended in August 2016, despite the activity-based contract model in place no longer being fit for purpose, and their warnings that the GDS and HSC dentistry were facing a sustainability crisis.

Expenses and formula

9.58 Since 2016 we made recommendations on uplifts in pay net of expenses. Taking this approach required the parties to discuss expenses to agree a gross increase to overall contract values. In their written evidence, BDA again asked the DDRB to make separate recommendations on expenses for GDPs. They said that with different treatment of expenses across the four countries, disparities between remuneration levels were widening. The remit letter for England asked us to make recommendations on the pay element of contracts, and the other governments also did not ask us to make recommendations for expenses. For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs, had we continued to use the formula-based approach. We would note that this year, given the disruption to dentistry and reduced patient volumes caused by the pandemic, the potential for increased equipment spend to facilitate social distancing and increased use of PPE, and the abatements applied to contract values that have taken place, year-on-year comparisons of expenses are significantly less straightforward than previous years. We expect that governments and the BDA will work together to ensure that the expenses component of contract values is sufficient to protect NHS/HSC take-home pay for both providing-performers and associates.

Payment recovery

9.59 According to NHSE/I, the amount of contract value recovered in England through 'clawback' increased in 2019-20, from £128 million the previous year to £139 million. In 2015-16, the total amount recovered via clawback was £55 million.

9.60 The BDA said that 2019-20's clawback figure represented 5 per cent of total dental contract values in England, and that 28 per cent of contracts had some amount clawed back from them. They added that the loss of income was a considerable threat to practices' financial sustainability, and that the factors that lead to clawback included difficulties recruiting associates, increased bureaucracy and declining patient attendance.

Community Dental Services/Public Dental Service

9.61 The Community Dental Services (CDS) in England, Wales and Northern Ireland and the Public Dental Service (PDS) in Scotland, provide general dental care to people who cannot access care through independent contractor GDPs. This includes those with particular dental needs, including vulnerable groups. NHSE/I said that CDS are traditionally seen as a vocational specialist route in dentistry. CDS are commissioned by NHSE/I in England. In Scotland, Wales and Northern Ireland, PDS/CDS are provided by Health Boards/Trusts.

Working through the pandemic

9.62 CDS/PDS dentists were essential to the setting up of Urgent Dental Centres and their equivalents across the UK. The BDA said that there were many places where, without the support of CDS/PDS dentists, there would have been no face-to-face dental care taking place at all through the first wave of the pandemic. The BDA said that this, alongside the more general reorientation and redeployment of resourcing and staff towards the pandemic response, meant that across the UK, existing waiting lists for general anaesthetic extractions and other CDS/PDS procedures have increased, leading to care needs for vulnerable patients not being met.

England

9.63 DHSC said that NHSE/I commission CDS in line with local needs assessments, and that they were not aware of any specific difficulties being faced by providers in filling CDS vacancies. They also told us that three CDS practices were participating in the national contract reform programme. NHSE/I agreed, saying that they were also not aware of CDS providers facing difficulties filling vacancies.

9.64 NHS Employers said that they had surveyed a small group of CDS employers on issues concerning recruitment, retention and morale. They said all employers surveyed agreed that there were difficulties recruiting to the CDS, with some citing a lack of progression, and that remuneration was lower than for high street dentistry. Other reasons given included being in a rural location, a lack of senior posts and general workforce shortages. The survey also found that CDS employers felt that capacity was not keeping up with demand, as the workforce had not grown sufficiently, and that while there had been a positive impact through the pandemic, with many CDS dentists taking pride in their roles, CDS dentists were also feeling the pressure of very high demand for urgent and routine care.

9.65 The BDA said that the headcount number of dentists working in the CDS had declined in the last few years. They said that while CDS dentists were likely to stay in the NHS in the short term to ensure their patients get the care they need during the pandemic, those near the end of their careers may leave, causing numbers to drop further. They said that in a BDA survey of CDS dentists in England, high proportions said they intended to reduce their hours or retire from working as a dentist.

9.66 NHS Staff Survey data for England for salaried primary care dentists was available from 2018 onwards. In 2020, 52 per cent of dentists were satisfied with their pay, an increase from 45 per cent in 2019. The results for 2020 were less positive than for consultants, but similar to those for SAS doctors and doctors and dentists in training. There was very little difference, by gender, with 51 per cent of female dentists and 50 per cent of male dentists satisfied with pay. There were greater differences between rates of satisfaction with pay between ethnic groups. 40 per cent of Asian/Asian British dentists were satisfied with pay, compared with 55 per cent of Black dentists, 52 per cent of White dentists, and 63 per cent of dentists from other ethnic groups.

Scotland

9.67 The Scottish Government said that NHS Boards continue to rebalance provision from PDS to independent contractor GDPs for the majority of mainstream patients with routine treatment needs. They said that the redeployment of PDS dentists to Urgent Dental Treatment Centres and away from their usual activities has exacerbated inequalities, making existing challenges more acute. These included challenges to child oral health and delivering procedures involving general anaesthetic.

9.68 The BDA said that they had previously expressed concerns about funding cuts and reductions in the capacity of the PDS. They said that most PDS dentists surveyed felt their morale was low or very low, and only a minority felt their pay was fair. They said that almost a third of those surveyed intended to retire during the next five years.

Wales

9.69 The Welsh Government told us that their latest data, from March 2019, indicated that the FTE size of the CDS workforce in Wales fell by 10.2 to 107.4 during the previous year. The BDA said in their survey of CDS dentists across the UK, a particularly high proportion of respondents in Wales said that their workload, and insufficient time with patients were significant negative factors for morale. They also said that as the CDS in Wales had refocused towards being a referral service only for special needs children and adults, the caseload had become more complex, which had led to dentists working over their contracted hours. They said that this, alongside chronic underfunding and decreasing staffing levels, was putting unsustainable pressure on the CDS workforce in Wales.

Northern Ireland

9.70 The BDA said that demographic change in Northern Ireland was increasing the demand for CDS services, but this was not being matched by an increase in resourcing. They said that a high proportion of CDS dentists were approaching retirement, and if practitioners chose to retire early, the CDS would lose expertise, institutional memory and informal mentoring.

Our comments

9.71 The last year has been an unprecedentedly challenging time for dentists and dentistry. The pandemic has limited dentists' ability to care for their patients and has also led to financial uncertainty for providing-performers and associates alike. The reduction in treatment volumes is likely to have a significant impact on oral health and will likely lead to a difficult and demanding period for dentists in the years to come as they address treatment backlogs and unmet patient need. And while NHS/HSC dental incomes were protected during the pandemic, dentists' ability to supplement NHS/HSC earnings with private work was severely limited.

9.72 While the incidence and overall scale of long-term issues of access to dentistry are contested by the parties, all agree that there are at least some areas where there are difficulties in accessing NHS/HSC dentistry. These long-term issues, alongside the immediate impact of the pandemic, underline the importance of safeguarding NHS/HSC dentistry and the dental workforce. In this context, it is crucial that the BDA and the governments continue to work together to ensure the short-term sustainability of NHS/HSC dentistry through the remaining phases of the pandemic. We strongly encourage all parties to work together to understand the scale of long-term issues of access.

9.73 Given these issues, there is also a critical need to support recruitment, retention and motivation amongst dental workforces longer-term. However, from what we have seen in Working Hours Motivation and Morale survey data and in written evidence, we are becoming increasingly concerned that there are major challenges in post-registration recruitment, retention and motivation amongst dentists across the UK.

9.74 These challenges, alongside stagnant overall earnings and significant changes to the composition of the dental workforce, with an increasing proportion of dentists working as associates and an increasingly prominent role for larger corporate providers, have the potential to fundamentally alter the career plans and aspirations of the dental workforce. We heard during our visits programme and from the BDA that dentists are becoming increasingly attracted to working in the private sector and decreasing their commitment to NHS/HSC dentistry as a result.

9.75 Reformed contracts that put practices on a more sustainable and secure financial footing and reiterate the value of NHS/HSC dentistry and dentists could go some way to addressing these issues. We welcome that all four governments have expressed their intention to reform contracts and move to a more preventive model for dentistry, as well as the progress that has so far been made towards this aim across the UK. However, we would note that the pandemic has also precipitated significant backlogs in interventional dental treatments that will need to be addressed. As we have said in previous years, progress towards contract reform has so far been too slow, particularly in England and Northern Ireland. We expect that in the coming years more tangible progress can be made more quickly across the UK.

9.76 In Chapter 8, we discuss the Gender Pay Gap in Medicine Review's finding that the unstructured way that pay is determined for salaried GMPs in England is a driver of gender pay gaps in that workforce. Given that the way that pay is determined for associate dentists across the UK is similarly unstructured, it is likely that this is therefore contributing to gender pay gaps in dentistry. The parties should seek to explore this issue in more detail and consider what can be done to address any pay disparities. We welcome the data that is provided to us by NHSE/I in this context, and we hope that in future years they can provide us with a better understanding of what is driving these differences. We also hope that the parties consider how the other findings of the Review may reflect parallel issues in dentistry and address any issues accordingly.

9.77 More generally, we heard from the parties that it is difficult to determine the true pay picture for NHS/HSC dentistry, given that many dentists do both private work and NHS/HSC work, and the data that is provided to us does not take account of working hours. It is also not clear how common the phenomenon of providing-performers or corporate dental providers failing to pass on pay uplifts to their associates might be. Without a better understanding of this data, it is difficult for us to know whether our recommendations are feeding through into take-home pay for NHS/HSC dentists. We would welcome the parties, and in particular the governments, doing more to provide us with a more sophisticated understanding of dental pay in this context.

9.78 Finally, we recognise the particular efforts of the CDS/PDS workforce, who have played a critical role in maintaining dental services throughout the pandemic. Given what both the BDA and NHS Employers told us about issues of recruitment and retention in the CDS/PDS workforces, we expect health service leaders, including DHSC and NHSE/I, who said they were not aware of any difficulties, to do more to reach a shared understanding of the scale of any issues and address them, particularly given the crucial work the CDS/PDS do in providing dental care to some of the most vulnerable patients. We look forward to receiving evidence about this during the next pay round.

CHAPTER 10: PAY RECOMMENDATIONS AND OBSERVATIONS

Introduction

10.1 In this chapter we discuss our recommendations on the main pay uplift for our remit group. We also comment on the case for differential awards, and address the requests made by some of the parties that we make recommendations for groups for which governments did not ask for recommendations this year due to the multi-year agreements in place.

10.2 As with last year, our recommendations are made against a backdrop of the evolving context of the coronavirus (COVID-19) pandemic. This has had a major impact on all parts of the health and care system, as well as the economy and the fiscal position more generally. Doctors and dentists across the UK have played a crucial role in both the pandemic response and the effort to maintain health services despite the context of the pandemic. Medical and dental staff have had to work flexibly and in unfamiliar settings and specialties, often putting themselves in danger as they delivered front-line care. We are sensitive to the extraordinary demands placed on our remit group during the course of the pandemic, and in particular the fact that doctors and dentists have fallen ill or lost their lives responding to it. The pandemic has served as a timely reminder of the value of our remit group to society.

Pay proposals

10.3 In their written evidence, DHSC said that any award for doctors and dentists higher than 1 per cent would require reprioritisation of resources. They said that this figure, which was lower than the pay growth assumptions that NHSE/I had told us about in evidence for last year's report[1], had been revised downwards as a result of the pandemic leading to missed productivity growth.

10.4 The Scottish Government said that their approach to public sector pay is governed each year by the Scottish Public Sector Pay Policy. Its key features this year were:

- a guaranteed cash underpin of £800 for those earning £25,000 and below
- a two per cent headline pay increase for those earning between £25,000 and £40,000
- a one per cent headline pay increase for those earning between £40,000 and £80,000
- a capped increase of £800 for those earning above £80,000.

They said that, when considering affordability for medical and dental pay awards, the DDRB should view the Scottish Public Sector Pay Policy as an anchor rather than an absolute position, and they would not want to see doctors and dentists in Scotland disadvantaged compared to their counterparts in the rest of the UK. The Scottish Government also announced in November 2020 that a non-consolidated £500 payment would be made to all health and social care staff in Scotland, including all NHS doctors and dentists.

10.5 The Welsh Government did not present us with a pay proposal or an affordability figure, but stressed to us that there were ongoing financial pressures on the NHS in Wales. They announced in March 2021 that a non-consolidated payment of £735 would be made to all health and social care staff in Wales, including all NHS doctors and dentists.

[1] NHS England and Improvement (3 March 2020). *Submission to the Review Body on Doctors' and Dentists' Remuneration.* Available at: https://www.england.nhs.uk/wp-content/uploads/2020/03/submission-to-the-review-body-on-doctors-dentists-renumeration.pdf

10.6 The Department of Health (Northern Ireland) said that pay growth assumptions of 2 per cent for doctors and dentists were built into their financial planning for 2021-22, and that therefore this size of award was affordable[2]. They announced in February 2021 that a non-consolidated payment of £500 would be made to all health and social care staff in Northern Ireland, including all HSC doctors and dentists.

10.7 The BMA said that there should be a significant and early pay award much higher than RPI inflation that would go some way to addressing the real-terms pay erosion doctors had faced over the last decade. They also said that doctors who had previously agreed multi-year pay deals had gone to extreme lengths to tackle the pandemic and that they should be rewarded accordingly. Separately, they said that they were calling for the DDRB to recommend a pay uplift of at least 5 per cent to consultants' take-home pay in England.

10.8 The BDA asked that we make a pay uplift of 5 per cent to attract and retain dentists to work in the NHS. They also asked that the pay award be implemented in a timely manner.

10.9 HCSA asked that we make a recommendation of a base rise of 3 per cent to properly reflect the value placed on all grades of hospital doctor, both during and after the pandemic. They said that Clinical Excellence and Commitment Awards should increase at the same rate to halt a further reduction to the overall consultant pay envelope, and that there should be an additional award of 0.8 per cent for doctors in training to recognise the shortfall between the value of our 2020 recommendations and their annual award last year[3].

Our comments

10.10 The economy suffered a sharp and deep economic contraction as a result of the pandemic, with GDP estimated to have fallen by 9.9 per cent in 2020 as a whole. However, we note that many economic indicators have started to show some recovery. Inflation measures shifted upwards in April 2021 compared to March 2021 and pay settlements measures from IDR and XpertHR have similarly increased in March and April 2021. However, we note that any economic recovery taking place is highly uncertain and dependent on the trajectory of the pandemic in the coming months and years.

10.11 As we discuss in Chapter 3, we do not view the 1 per cent affordability envelope presented to us by the UK Government as a limit on what our recommendations can be for England. Given the similar budgetary positions, and the similar course taken by both the pandemic and the response to it across the UK, we similarly do not view the Scottish Public Sector Pay Policy or the 2 per cent that the Department of Health (Northern Ireland) said they had budgeted for pay awards as limits on what our recommendations can be for Scotland and Northern Ireland.

10.12 We also note the pay uplifts already implemented for groups within our overall remit as part of multi-year agreements. This includes contractor GMPs in England, whose comprehensive contract deal includes significant investment in general practice and a new, state-backed indemnity scheme. There is also a multi-year agreement in place for doctors and dentists in training in England, for whom a multi-year pay reform deal was agreed in 2019. Most recently, a multi-year pay and reform deal was agreed for SAS doctors and dentists in England, Wales and Northern Ireland, though we note that unlike the other two contract deals, moving onto the reformed contracts is optional.

[2] The Northern Ireland Public Sector Pay Policy's upper limit of 1 per cent does not apply to doctors and dentists.
[3] This consideration applies only in England. Our recommendation in last year's report that the pay scales for doctors and dentists in training in Scotland, Wales and Northern Ireland be uplifted by 2.8 per cent was implemented in all three nations. We discuss the case of doctors and dentists in training in England below.

10.13 We note that the contract agreements for both doctors and dentists in training in England and for SAS doctors and dentists in England, Wales and Northern Ireland include overall investment of 3 per cent in contract values in the 2021-22 financial year. In both cases, this investment includes both basic pay uplifts and reforms to pay scales and other allowances. In practice, some doctors and dentists on the new contracts will receive increases to their basic pay in 2021-22 that are higher than 3 per cent, and some that are lower. For example, doctors and dentists in training on the fifth nodal point, and specialty doctors and dentists towards the bottom of the pay scale will receive basic pay uplifts significantly higher than 3 per cent this year, while doctors and dentists in training on lower nodal points, and some specialty doctors and dentists towards the top of the pay scale will receive less.

Our recommendations

10.14 Whilst we recognise the pay and affordability proposals put to us by the parties, our pay recommendations must also recognise the need to recruit, retain and motivate doctors and dentists. Health services have been put under significant strain by COVID-19 in the past year, and uncertainty over the likelihood of continuing waves of the virus as well as the pressing need to address care backlogs mean that health services will remain under pressure for the foreseeable future. In this context, and as services continue to change to meet new challenges, it is crucial that health services support their medical and dental workforces, retaining experienced staff. Doing this requires them to feel valued and motivated, and pay is an important contributor to this. Under the current circumstances, given the pressures placed on doctors and dentists by the pandemic, ensuring a sense of value and motivation is maintained is particularly important.

10.15 It is therefore welcome that many of the trends in recruitment through the pandemic have been positive. In particular, we are encouraged by the continued increased demand for university places, even as the number of medical school places available has increased, both temporarily in light of the removal of the cap on the number of medical students admitted to universities in 2020, and permanently as new medical schools have opened and existing ones have expanded. We welcome the increased diversity in the medical and dental workforces that is being driven by these and other longer-term trends. We also note the falls in vacancy rates and the increased fill rates in many medical specialties, though it is not yet clear whether these improvements are temporary consequences of the pandemic or will be sustained in the medium and long term.

10.16 However, all the parties have expressed concern that the pandemic would precipitate issues of retention. Given the demands of the pandemic, many medical and dental staff have worked more intensely than their normal working patterns, often in unfamiliar care settings, at personal risk and potentially at risk to their families, and wearing essential but cumbersome personal protective equipment. This has been reported to have led to widespread fatigue, exhaustion and stress and given the scale of care backlogs and the likelihood of continuing waves of the virus, is likely to continue to do so, leading to pressing issues of retention as exhausted doctors and dentists leave or decrease their working hours.

10.17 The risks to retention posed by the pandemic may also interact with and exacerbate a number of existing concerns around retention. These include, but are not limited to:

- The potential for issues related to pensions taxation, that we discussed in Chapter 4, exacerbating the phenomenon of increasing numbers of senior clinicians deciding that it is in their interest to retire or reduce their working hours. Voluntary early retirements for consultants were at an all-time high in 2019-20.
- Issues of retention and progression for doctors and dentists in training, including stepping out of training on completion of the foundation programme, which we discussed in Chapter 5.

- Issues associated with diversity and inclusion, including gender and ethnicity pay gaps, which we discussed in Chapter 4 and elsewhere in the report.
- Continued change in the composition and demographics of the general practice workforce, which we discussed in Chapter 8.
- Stagnant take-home pay and structural change to the dental workforce, alongside what the BDA told us about increasing numbers of dentists being attracted to doing private work, at the expense of NHS/HSC work, which we discussed in Chapter 9. These issues may also be linked to the issues of oral health and access to NHS/HSC dentistry that we discussed there.

10.18 There are also a number of issues of motivation that remain a concern to us. NHS Staff Survey results in England painted a picture of declining job satisfaction, as the proportion of medical and dental staff who said they looked forward to going to work, were enthusiastic about their jobs, were satisfied with the amount of responsibility they had and felt they had sufficient opportunity to use their skills all declined. Similarly, the results of the Dental Working Hours Motivation and Morale surveys from across the UK painted a troubling picture, with results both low in absolute terms and having fallen consistently in recent years.

10.19 We note that pay satisfaction scores for medical and dental staff in the NHS Staff Survey in England were improved compared to last year. However, a pay award that medical and dental staff felt was unfair or did not recognise what we heard from them during our visits programme, and in the evidence that we received, about their contribution to the pandemic response, or their value more generally, would have the potential to severely undermine pay satisfaction. As a result of this, and the factors we outlined above, we consider that our recommendations should represent a real-terms pay increase for all groups of doctors and dentists for which we were asked for a recommendation this year.

10.20 **Therefore, we recommend a 3 per cent increase to national salary scales, pay ranges or the pay element of contracts for all groups included in our remits from the governments for this year, namely:**

- **Consultants**
- **SAS doctors and dentists in Scotland, as well as those who do not move onto the reformed contracts in England, Wales and Northern Ireland**
- **Doctors and dentists in training in Scotland, Wales and Northern Ireland**
- **Independent contractor GMPs in Scotland, Wales and Northern Ireland**
- **Salaried GMPs**
- **The GMP trainers' grant and GMP appraisers' grant**
- **Independent contractor GDPs**
- **Associate and salaried GDPs including Community Dental Service/Public Dental Service practitioners**

These uplifts should be backdated as necessary so that they would be paid in full for the 2021-22 financial year.

10.21 We would expect that pay awards would be appropriately funded in order that there would not be a negative impact on service provision.

10.22 This recommendation would add £234 million to the consultant pay bill in England, against a total DHSC Resource Departmental Expenditure Limit in 2021-22 of £169.1 billion, of which £22 billion is additional COVID-19 funding. It would add £50 million to the pay bill for salaried medical and dental staff in Scotland, £33 million in Wales, and £15 million in Northern Ireland.

10.23 We note that governments in Scotland, Wales and Northern Ireland had announced additional payments for medical and dental staff in recognition of their contribution to the pandemic response.

10.24 Last year, we discussed our significant concerns about the equity and effectiveness of the Clinical Excellence Awards (CEAs), Commitment Awards, Distinction Awards and Discretionary Points systems for consultants, and did not make a recommendation that they be uplifted alongside basic pay.

10.25 While we welcome the progress that has been made for the national CEA scheme that covers England and Wales, reformed consultant reward schemes are not yet in place anywhere in the UK. As we discuss in Chapter 7, issues of equity and effectiveness for these schemes remain across the UK. The Gender Pay Gap in Medicine Review's findings in relation to these schemes in England further strengthened the case for reform. **Given our concerns, we once again do not feel we can make a recommendation for these awards this year**.

Targeting

10.26 Elsewhere in this report, we discuss specialty- and geography-based issues of recruitment and retention, and the potential for these to exacerbate regional health inequalities. While we remain supportive of the exploration of the effectiveness of geographic or specialty targeting by pay, and we note that there are financial incentives in place for various parts of the workforce, none of the remit letters mentioned targeting and we did not receive this year any specific proposals around targeting on which we were asked to comment.

10.27 We also considered the case for more specific recommendations targeted at particular groups within our remit.

10.28 Last year, we said that we would follow the progress of contract reform negotiations for the SAS grades closely and consider again whether there is a case for making a differential award in light of our recommendation for an extra 1 per cent in 2019 not being implemented. We are pleased that reformed contracts are now in place in England, Wales and Northern Ireland, and the BMA and NHS Employers wrote to us confirming that this additional 1 per cent was part of the envelope for contract reform. We therefore consider this matter closed in England, Wales and Northern Ireland. In Scotland, we would similarly expect this additional 1 per cent to be included in any contract reform envelope, and we will revisit this again next year as necessary.

10.29 We also remain particularly concerned about the trends in remuneration, motivation and morale amongst general dental practitioners. We received evidence of issues of access to NHS/HSC dentistry in certain areas across the UK. This may be related to what we heard from the BDA about dentists, and in particular younger dentists, increasingly being attracted to doing more private and less NHS/HSC work. We would welcome hearing more in evidence about this from the parties next year, and how these issues may interact with other trends in the composition and demographics of the dental workforce, including the fall in the number of providing-performers and the increasingly prominent role played by corporate dental providers. Given that many dentists do both private and NHS/HSC work, and the data we have is collected on a headcount basis, it is difficult to know what role our recommendations play in the take-home earnings of associate dentists and we would also welcome evidence about this from the parties next year, in order to inform our recommendations for dentists.

Multi-year pay agreements

10.30 As a result of existing multi-year pay agreements between governments, employers and the BMA, doctors and dentists in training and contractor GMPs in England were not included in the remit given to us by the Secretary of State this year. The BMA and NHS Employers also wrote to us in April 2021 saying that they no longer expected us to make recommendations for SAS doctors and dentists in England, Wales and Northern Ireland who move onto the new contract.

10.31 In their written evidence submissions, the BMA and HCSA both asked us to make recommendations for doctors and dentists in training in England, as well as in Scotland, Wales and Northern Ireland. HCSA said that their recommendation of a basic pay uplift of 3 per cent applied to all grades, including doctors and dentists in training, and that a further 0.8 per cent should additionally be awarded to doctors and dentists in training in England to account for the difference between the basic pay uplift that they received in 2020 and the uplift of 2.8 per cent that other groups received. The BMA, who also asked that we make a recommendation for contractor GMPs in England this year, said that last year it was incredibly unfair and damaging to the morale of these doctors not to be awarded an additional uplift to take into account their contributions during the pandemic. They also said that this year they were asking that we recognise that all doctors, including those doctors who had previously agreed multi-year pay deals, have gone to extreme lengths to tackle the pandemic, and that they should be rewarded accordingly.

10.32 In relation to the BMA and HCSA's comments about our not making a recommendation for doctors and dentists in training and contractor GMPs last year, we would note that, given that it was at that point too early to understand the scale of the impact of COVID-19 on our remit group, and the pandemic had not been reflected in the evidence provided to us by the parties, our recommendations did not seek to take account of the COVID-19 pandemic.

10.33 Looking at the 2021-22 financial year, we note that there is no published figure as to the value of the uplift to the pay element of the contract for contractor GMPs. The overall investment in 2021-22 made as part of the multi-year agreement for doctors and dentists in training in England is 3 per cent, although the basic pay uplift is 2 per cent. This investment figure is the same as that of the deal for SAS doctors and dentists in England, Wales and Northern Ireland in 2021-22, which was made in March 2021 during the pandemic.

10.34 We wish to reiterate our acknowledgement of the contribution of all doctors and dentists to the pandemic response. All groups of doctors and dentists, regardless of whether they are under a multi-year pay agreement or not, have played their part in maintaining and delivering health services during an unprecedentedly challenging period.

10.35 For the groups for which we have been asked to make recommendations we have been able to support the recognition of their contribution during this period. We have also been able to begin to respond to the impact of the pandemic on the recruitment, retention and motivation of these groups of doctors and dentists.

10.36 For those that we have not been asked to make recommendations for, we would stress that recognising their contribution during this period, as well as responding to the impact of the pandemic on them personally and on recruitment, retention and motivation, is as important as it is for other groups. Recognising the contribution they have made to the pandemic response is extremely important, and we would urge ministers to consider this.

CHAPTER 11: LOOKING FORWARD

Introduction

11.1 In this final chapter we look ahead to some of the challenges facing our remit group and what we would expect to see covered in evidence over the next few years. Given the disruption caused by the coronavirus (COVID-19) pandemic, we are thankful to all the parties for providing evidence to us this year, and that some of our requests for additional information were fulfilled.

11.2 Our main priority would be to receive evidence from the parties about how COVID-19, and the disruption to health services associated with it, will affect medical and dental workforces in the short, medium and long term, what the parties are doing about these impacts, and what this will mean for doctors and dentists. This includes the parties' perspectives on how the pandemic has affected health services and workforces, as well as how demand for and access to services will be affected in the context of future waves of the virus and care backlogs. We would also welcome hearing details of how parties expect workforce behaviour, including career and specialty choices, to be affected. We describe our other priorities in more detail below.

Our 50th Report 2022

11.3 After asking the parties to submit their written evidence by 18 January, we only received written evidence from the Scottish Government in mid-February, the Welsh Government in late February, and DHSC and NHSE/I in mid-March. The delays to these written evidence submissions caused serious disruption to our process this year. We hope that we will receive both the remit letters from the governments and the written evidence from all of the parties in a timely manner, enabling our process to work effectively and for doctors and dentists to receive their pay uplifts earlier next year.

Economic outlook and COVID-19

11.4 We would welcome evidence from the governments about how the COVID-19 pandemic has affected the economy and the fiscal position. We would also wish to see insight into what is driving trends in the labour market, inflation, pay settlements, the earnings distribution and pay comparability, particularly in relation to doctors' and dentists' comparator professions and the upper end of the earnings distribution. How these trends drive any government pay policies will also be an important consideration.

Affordability and productivity

11.5 As the additional financial support provided to health services to support the pandemic response is wound down, it will be important for us to understand what the underlying financial positions of the health services are, how they have been affected by the pandemic, and what this means for the affordability of pay awards. This includes any information on productivity and efficiency, given that it is not yet clear how the disruption caused by the pandemic on the one hand, and the opportunities afforded by it on the other, will affect progress towards pre-existing productivity growth targets.

Workforce planning

11.6 It will be helpful for us to understand what is being done to ensure that the medical and dental workforces are able to respond as well as possible to the short-term challenges posed by the pandemic to health services, including responding to care backlogs and the phenomenon of long COVID, while also safeguarding staff wellbeing. As we discuss in Chapter 3, we were dismayed at the lack of information that was provided to us about a robust, costed and strategic transparent workforce planning process to determine long-term workforce requirements across the UK. Receiving this information is essential for us to properly assess trends in recruitment and retention and consider the case for any targeting or other pay initiatives, as part of our evidence-based process. We would particularly welcome more information about what role the use of multidisciplinary teams can play in addressing long-term demand growth. Alongside this, we would also welcome insight into how long-term changes to the medical and dental workforces, including increased ethnic diversity, the increasing proportion who are women, and the continued dependency on international recruitment, as well as the increased number of doctors and dentists that wish to train and work less-than-full-time, are to be addressed and accommodated in workforce planning. This includes what action will be taken to support retention in the context of a changing workforce, including retention of international doctors and dentists, and what will be done to address staff shortages and the related issue of dependency on locums. Details of how issues of pay might play into any strategic workforce planning would also be useful for us to consider.

Diversity and Inclusion

11.7 The Gender Pay Gap in Medicine Review has highlighted multiple important issues with regards to gender and pay across all parts of the NHS in England. We look forward to hearing about the work of the Implementation Panel following the publication of the Review, and what action is being taken to address gender pay gaps. We would also welcome hearing about what action will be taken to understand and address gender pay gaps in dentistry and also in Scotland, Wales and Northern Ireland.

11.8 There is also a need to better understand any pay equality issues relating to other protected characteristics. We therefore await hearing what action will be taken to understand and address ethnicity pay gaps in the NHS following the roundtable with the Minister for Care that was announced alongside the Gender Pay Gap in Medicine Review. We would in addition welcome any insight from the parties as to what is driving this and other issues of diversity and inclusion in health services across the UK, relating to any of the protected characteristics, in particular any further information or insight into any potential ethnicity-based disparities in the experience of staff through the pandemic.

Doctors and dentists in training

11.9 We expect to hear from the parties about how the pandemic has impacted the medical and dental training systems, including how it will affect retention and progression for doctors and dentists in training. This includes parties' expectations as to how the number of medical and dental staff who complete training or reach particular points in the training pipeline in the coming years will be affected. It also includes how this interacts with existing issues of retention and progression.

11.10 We look forward to hearing about any action being taken in England as a result of the work of the Distribution of Specialty Training Board that is being led by HEE, and any similar exercises that may be taking place in Scotland, Wales and Northern Ireland. We also would wish to hear details of evaluations of the initiatives that are underway to attract doctors and dentists in training to work in particular specialties or geographies, including flexible pay premia, the Targeted Enhanced Recruitment Scheme for GMP trainees and the Foundation Priority Programmes.

11.11 We would welcome hearing details of what action is being taken to understand and address concerns about doctors' and dentists' experience of the medical and dental training systems, including concerns about the cost of training and exams, and about the impact on trainees' family lives of the way that training placements are distributed through the deanery system. At the same time we would welcome hearing more about what is being done to ensure that the increasing number of doctors and dentists who have stepped out of training and are working on locally determined 'trust grade' or 'clinical fellow' contracts are treated fairly and retained.

11.12 We would also welcome an update on progress towards contract reform for doctors and dentists in training in Wales, and whether governments in Scotland and Northern Ireland intend to begin negotiations.

Staff grade, associate specialist, specialist and specialty doctors and dentists (SAS)

11.13 We would welcome hearing from the parties about how the new contracts in England, Wales and Northern Ireland are bedding in, including what proportion of existing SAS doctors and dentists have moved onto the new contracts, and how rates of moving over differ by seniority. It would also be useful to hear about how the new SAS Advocate role is working.

11.14 We would expect to hear more about progress towards contract reform for SAS doctors and dentists in Scotland.

Consultants

11.15 We would expect to hear in evidence next year about how the measures that were discussed around encouraging retention amongst the most senior consultants are working.

11.16 We and others, including the Gender Pay Gap in Medicine Review, have expressed concerns about the equity and effectiveness of the consultant reward schemes, leading to us not making a recommendation that they be uplifted this year. We would expect more progress to be made towards reform of the CEA schemes in England and would welcome hearing of progress towards reform of consultant reward systems elsewhere in the UK.

11.17 We would also wish to hear of more progress being made towards consultant contract reform more generally across the UK, the case for which has been strengthened by the findings of the Gender Pay Gap in Medicine Review. We hope that lessons can be learned from the success of the SAS contract reform negotiations in England, Wales and Northern Ireland.

General medical practitioners (GMPs)

11.18 We would welcome hearing more about how demand for and access to GMP services has been affected by the pandemic. Alongside this, it would be helpful to understand how the changing GMP workforce, including a more prominent role for salaried GMPs and other health professionals in practices, will be able to respond to trends in demand for primary care services.

11.19 The BMA presented us with evidence that suggested that a significant proportion of salaried GMPs are earning, on a full-time equivalent basis, more than the maximum of our range. The Gender Pay Gap in Medicine Review suggested that gender pay gaps for salaried GMPs were particularly wide. It would therefore be helpful to us in making our recommendations for salaried GMPs if the parties could provide us with more insight on these matters.

Dentists

11.20 We expect to hear more from the parties about how the disruption to dentistry that was caused by the pandemic has affected oral health, and how this has exacerbated issues of access to NHS/HSC dentistry. We would also welcome insight about how structural change to the dental workforce, which we discuss in more detail in Chapter 9 might affect issues of recruitment and retention, and ultimately access. Alongside this, further insight into what is driving trends in dental remuneration, including how our recommendations feed through into take-home pay for providing-performers and associates alike, would be helpful to us in determining our recommendations for dentists in future years.

11.21 We expect to hear more about progress towards contract reform in all four nations, and how reform can help to address issues of access and recruitment and retention.

11.22 We expect efforts to be made by all parties to determine the extent of any issues of recruitment and retention in the Community Dental Services/Public Dental Service, given the differences in the perspectives presented in the parties' evidence submissions.

Pensions

11.23 We discuss elsewhere in the report our concerns about the potential for issues of retention for the most senior doctors to be exacerbated by changes to the pensions taxation system, most recently the freezing of the Lifetime Allowance until 2025-26. We expect that the parties will explain how they expect this to affect retention, and what can be done to address this, and improve retention for doctors and dentists.

Future data requirements

11.24 We appreciate that, in an exceptional year for managing health services and representing doctors and dentists, the resources available to all parties to develop the data they share with us as part of their evidence submissions may have been limited.

11.25 Last year, we detailed specific key data requests in a table, many of which the parties will again not have been able to provide this year. We would once again ask that the parties consider these and would further stress this year that we would welcome any other new data in relation to the issues mentioned there and above in this chapter as it becomes available.

APPENDIX A: REMIT LETTERS FROM THE PARTIES

Department of Health and Social Care
From the Rt Hon Matt Hancock MP

Secretary of State for Health and Social Care
39 Victoria Street
London
SW1H 0EU

POC_1282869

Mr Christopher Pilgrim
Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square London
EC4Y 8JX

18 December 2020

Dear Mr Pilgrim,

I should first of all like to offer my thanks for the Review Body on Doctors' and Dentists' Remuneration's (DDRB) work over the past year on the 2020 report and your recommendations for pay round 2020-21. The Government continues to appreciate and value the independent expert advice and contribution that the DDRB makes.

The timing of the SR announcement has unfortunately delayed the commencement of Pay Round 2021/22. I am writing now to set out how the Government proposes working with the DDRB in relation to the 2021/22 pay round and to formally begin the Review Body process.

You will have seen that the Chancellor of the Exchequer announced that pay rises in the public sector will be restrained and targeted in 2021/22 at the Spending Review. As the Chancellor set out, Covid-19 is having a very significant impact on the economy, labour market and the fiscal position and has supressed earnings growth and increased redundancies in the private sector and this is reflected across departmental spending settlements. Taken from the latest ONS data, public sector total remuneration in 2019 was already 7% ahead of the private sector, adjusting for characteristics, and it has since been shielded from the pandemic's economic effects[1]. According to ONS Average Weekly Earnings data, in the six months to September the private sector has seen a pay cut of nearly 1% compared to last year, yet public sector earnings were up by almost 4%[2]. Since March, the number of people in employment in the UK fell by 782,000, whilst over a similar period of time public sector employment increased.

Whilst we have announced a pause of pay awards for the majority of the public sector, we recognise the uniquely challenging impact coronavirus is having on the NHS and so have made a commitment to continue to provide NHS workers with a pay rise. This means that for medical and dental staff not already within agreed multi-year deals we would welcome pay recommendations from the DDRB. We expect these recommendations to take account of the extremely challenging fiscal and economic context, and consider the affordability of pay awards. HMT will set out the fiscal and economic context in more detail as the round progresses and my Department will provide you with evidence on the affordability of pay awards.

[1] Public and private sector earnings: 2019, ONS
[2] Average Weekly Earnings: 2020, ONS

It is vitally important planned workforce growth is affordable, particularly given the NHS budget is set until 2023/24 and there is a close relationship between pay and staff numbers. The affordability of pay recommendations will have to be considered within the context of the significant financial and economic pressures that have resulted from the Covid-19 pandemic both within the NHS and wider public finances. The evidence that I will provide in the coming months will support you in your consideration of affordability and I request that you describe in your final report what steps you have taken to take account of affordability, the need for workforce growth and making best use of the funds available to deliver the best care for patients. These considerations must also be balanced with the importance of continuing to recruit, retain and motivate NHS staff.

As you are aware, we reached a multi-year pay agreement (2019/20 – 22/23) for doctors and dentists in training and so we are not asking the DDRB to make pay recommendations for this group. As is usual however, we would welcome your comments and observations on the evidence you receive from the Department of Health and Social Care and other parties on this group.

You are invited as usual to make recommendations on an annual pay award for consultants.

For Specialty Doctors and Associate Specialists we are negotiating a multi-year pay and contract reform deal. Any agreed deal will give valued staff a fair pay rise alongside improving recruitment and retention and developing reforms which better reflect modern working practices, service needs and fairness for employees. We would expect any recommendations to be informed by the outcome of talks with the BMA.

Independent contractor General Medical Practitioners are subject to a five-year pay agreement between NHS England & Improvement and the British Medical Association and therefore no pay recommendation is being sought for this group. You are invited to make recommendations on uplifts to the minimum and maximum of the salaried General Medical Practitioner pay scales. Recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under the five year GP contract.

We invite you to make recommendations on the pay element of remuneration for dentists employed by, or providing services to, the NHS. (As set out above, dentists in training are covered by a multi-year deal and we are therefore not asking you for a recommendation for this group).

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

We are hoping to expediate the process as much as possible this year and would welcome your report in early May 2021, subject to further discussion with the OME.

Finally, I would like to thank you again for your invaluable contribution, and I look forward to continuing our dialogue in future.

Yours ever,

MATT HANCOCK

Llywodraeth Cymru/Welsh Government

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Ein cyf/Our ref: MA/VG/3730/20

Mr Christopher Pilgrim
Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2–6 Salisbury Square London
EC4Y 8JX

18 January 2021

Dear Christopher,

Thank you for the DDRB's hard work on the 2020-21 pay round. I am writing to formally commence the 2021-22 pay round for medical and dental staff in Wales including general medical practitioners and general dental practitioners.

I would like to take this opportunity to say I truly value the hard work and commitment of all of our dedicated healthcare workers in Wales, at all times but particularly during this challenging time

In this pay round I would like you to consider evidence and make recommendations on what would be a fair and affordable pay award for medical and dental staff, whilst taking the wider economic situation into consideration to help us sustain the NHS in Wales and deliver the priorities set out in *A Healthier Wales: Our Plan for Health and Social Care*.

Your advice and recommendations will enable me to determine a fair pay award for medical and dental staff in Wales.

For specialty doctors and associate specialists we are negotiating a multi-year pay and contract reform deal. Any agreed deal will give valued staff a fair pay rise alongside improving recruitment and retention and developing reforms which better reflect modern working practices, service needs and fairness for employees. We would expect any recommendations to be informed by the outcome of talks with the British Medical Association (BMA) Cymru Wales.

In order to support your work, I will provide written evidence to the Pay Review Body and my officials have committed to attend the planned oral evidence session in early March.

I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed.

I look forward to receiving your advice and recommendations. Yours sincerely,

Vaughan Gething AC/AM

Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Riaghaltas na h-Alba /Scottish Government

Cabinet Secretary for Health and Sport

Jeane Freeman MSP

Mr Christopher Pilgrim
Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics

16 February 2021

Dear Christopher

Further to my letter of 22 December 2020, I am writing to formally set out our remit for the Doctors' and Dentists' Review Body (DDRB) for 2021-22.

It will be necessary to consider the affordability of the recommendations from the DDRB within the confines of the Scottish Public Sector Pay Policy (SPSPP) set for 2021-22 announced in the Scottish Parliament on 28 January 2021. A copy of the draft Budget, which is subject to parliamentary approval, is available here.

The main features of the SPSPP are:

- providing a guaranteed basic pay increase of at least 3 per cent for public sector workers who earn up to £25,000, through a guaranteed cash underpin of £750;
- providing a guaranteed basic pay increase of 1 per cent for public sector workers who earn more £25,000 or more, up to £80,000;
- capping the maximum basic pay increase to £800 for those earning £80,000 or more;
- continuing the requirement for employers to pay staff the real Living Wage, set at £9.50 per hour from 1 April 2021

The SPSPP provides discretion for employers to use up to 0.5 per cent pay bill savings on baseline salaries to address clearly evidenced equality issues in existing pay and grading structures. Employers can also carry forward any unused portion of their 0.5 per cent flexibilities from the 2020-21 pay round to provide a cumulative total of up to 1 per cent.

Although we are seeking Recommendations from the DDRB on a pay uplift for one year only (2021-22), it will be necessary to consider these in the context of our longer term vision on:

- retention and recruitment of medical and dental staff in NHS Scotland
- increasing staff morale and ensuring staff in our health service feel valued as employees
- ensuring all medical and dental staff receive appropriate support to carry out their roles and responsibilities
- ensuring improved productivity and efficiency of our health service

For General Medical Practitioners (GMPs) we are only seeking a recommendation on the pay element. We are in the process of agreeing a separate expenses exercise with the Scottish General Practitioners Committee of the BMA which will help inform our discussions on expenses.

For General Dental Practitioners (GDPs) we are also requesting a recommendation on pay. Presently the NHS dental sector is being supported by financial support measures, as dental activity is suppressed item of service payments are significantly reduced. The pay award for 2020/21 was deployed through capitation and continuing care payments.

Copies of this letter will be sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the Staff Side and NHS Employers.

Kind regards

Jeane Freeman

FROM THE MINISTER OF HEALTH

An Roinn Sláinte/ Department of Health
Castle Buildings
Stormont Estate
BELFAST,
BT4 3SQ

Our ref – SUB-0055-2021

Date: 18 January 2021

Mr Christopher Pilgrim
Chair of the Review Body for Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

Dear Christopher,

I am writing to formally commence the 2021/22 pay round for doctors and dentists in Northern Ireland and to submit my Department's evidence. I wish to begin by thanking the Review Body for Doctors' and Dentists Remuneration (DDRB) for its invaluable work on the 2020/21 pay round.

On 02 September 2020, the Department of Finance (DoF) set out Northern Ireland's Public Sector Pay Policy for 2020/21. Within that context, I am pleased to confirm that I accepted, in full, the recommendations contained within your 48th report.

This year we would welcome, for consideration, your recommendations on pay for all doctors and dentists working within health and social care in Northern Ireland.

Robin Swann MLA
Minister of Health

APPENDIX B1: DETAILED RECOMMENDATIONS ON REMUNERATION

SALARY SCALES

The salary scales that we recommend should apply from 1 April 2021 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be pro rata to those of equivalent full-time staff.

Unless stated otherwise, the 2020 salary scales reflect those that were implemented from 1 April 2020.

Basic pay scales and awards

	2020 £	2021 £
Doctors and dentists in training (2016 contract)[1]		
Foundation doctor – year 1	28,243	28,808
Foundation doctor – year 2	32,691	33,345
Core/Run-through training – years 1-2	38,694	39,467
Core/Run-through/Higher training – years 3-5	49,036	50,017
Run-through/Higher training – years 6+[2]	52,036	53,077
Flexible pay premia (2016 contract)[1]		
General practice	8,789	8,965
Psychiatry core training	3,573	3,645
Psychiatry higher training (3 year)	3,573	3,645
Psychiatry higher training (4 year)	2,680	2,734
Academia	4,288	4,374
Histopathology	4,288	4,374
Emergency medicine/Oral & maxillofacial surgery:		
3 years	7,146	7,289
4 years	5,360	5,467
5 years	4,288	4,374
6 years	3,573	3,645
7 years	3,063	3,124
8 years	2,680	2,734

[1] 2021 award already implemented, see https://www.nhsemployers.org/case-studies-and-resources/2021/03/pay-and-conditions-circular Pay and Conditions Circular (M&D) 1/2021.
[2] Introduced with effect from 1 October 2020.

	2020 £	2021 £
Specialty doctor (2021 contract)[3]		45,124
		49,745
		55,790
		58,756
		62,978
		66,614
		70,249
		73,883
		77,519
Specialist (2021 contract)[3]		79,894
		85,286
		90,677
Specialty doctor (2008 contract)	41,158	42,393
	44,677	46,017
	49,252	50,730
	51,704	53,255
	55,237	56,894
	58,756	60,519
	62,355	64,226
	65,954	67,933
	69,553	71,640
	73,152	75,347
	76,751	79,054
Associate specialist (2008 contract)	57,705	59,436
	62,344	64,214
	66,981	68,990
	73,106	75,299
	78,414	80,766
	80,617	83,036
	83,490	85,995
	86,364	88,955
	89,238	91,915
	92,112	94,875
	94,988	97,838

[3] Introduced with effect from 1 April 2021. https://www.nhsemployers.org/case-studies-and-resources/2021/03/pay-and-conditions-circular-for-sas

	2020 £	2021 £
Staff grade practitioner	38,131	39,275
(1997 contract, MH03/5)	41,158	42,393
	44,184	45,510
	47,211	48,627
	50,238	51,745
	53,802	55,416
Discretionary points	*Notional scale*	
	56,292	57,981
	59,318	61,098
	62,345	64,215
	65,372	67,333
	68,398	70,450
	71,427	73,570
Consultant (2003 contract)	82,096	84,559
	84,667	87,207
	87,238	89,855
	89,809	92,503
	92,372	95,143
	98,477	101,431
	104,584	107,722
	110,683	114,003
Clinical Excellence Awards (local, granted prior to 1 April 2018):		
Level 1	3,016	3,016
Level 2	6,032	6,032
Level 3	9,048	9,048
Level 4	12,064	12,064
Level 5	15,080	15,080
Level 6	18,096	18,096
Level 7	24,128	24,128
Level 8	30,160	30,160
Level 9	36,192	36,192
Clinical Excellence Awards (local, granted since 1 April 2018):		
Unit value	3,092	3,092

	2020 £	2021 £
Clinical Excellence Awards (national)		
Level 9 (Bronze)	36,192	36,192
Level 10 (Silver)	47,582	47,582
Level 11 (Gold)	59,477	59,477
Level 12 (Platinum)	77,320	77,320
Distinction awards for consultants		
B awards	32,601	32,601
A awards	57,048	57,048
A+ awards	77,415	77,415
Salaried general medical practitioner range		
Minimum	60,455	62,269
Maximum	91,228	93,965
General medical practitioner trainer grant	8,584	8,842
General medical practitioner appraisers fee	543	559
Dental foundation training	33,715	34,726
Dentists in training (2016 contract)[1]		
Foundation dentist – year 1	28,243	28,808
Foundation dentist – year 2	32,691	33,345
Dental core training – years 1-2	38,694	39,467
Dental core & specialty training – years 3-5	49,036	50,017
Dental core & specialty training – year 6 +	52,036	53,077
Salaried primary care dental staff (2008 contract):		
Band A: Salaried dentist	41,766	43,019
	46,407	47,799
	53,368	54,969
	56,849	58,554
	60,329	62,139
	62,649	64,528

	2019 £	2020 £
Band B: Salaried dentist[4]	64,970	66,919
	67,290	69,309
	70,771	72,894
	72,511	74,686
	74,251	76,479
	75,991	78,271
Band C: Salaried dentist[5,6]	77,732	80,064
	80,052	82,454
	82,372	84,843
	84,693	87,234
	87,013	89,623
	89,333	92,013
London weighting[7]		
Non-resident staff	2,162	2,162
Resident staff	602	602

[4] The first salary point of Band B is also the extended competency point at the top of Band A.
[5] The first salary point of Band C is also the extended competency point at the top of Band B.
[6] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.
[7] *Thirty-Sixth Report.* Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 1.64.

APPENDIX B2: DETAILED RECOMMENDATIONS ON REMUNERATION IN WALES

SALARY SCALES

The salary scales that we recommend should apply from 1 April 2021 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2020 £	2021 £
Foundation house officer 1 (2015 contract)	24,818	25,563
MN13	26,368	27,159
	27,918	28,756
Foundation house officer 2 (2015 contract)	30,784	31,708
MN15	32,798	33,782
	34,810	35,854
Specialty registrar (full)	32,896	33,883
MN37	34,908	35,955
	37,719	38,851
	39,420	40,603
	41,468	42,712
	43,520	44,826
	45,571	46,938
	47,622	49,051
	49,672	51,162
	51,724	53,276
Specialty doctor	41,360	42,601
MC46	44,896	46,243
	49,494	50,979
	51,957	53,516
	55,506	57,171
	59,044	60,815
	62,658	64,538
	66,276	68,264
	69,894	71,991
	73,510	75,715
	77,126	79,440

	2020 £	2021 £
Associate specialist (2008)	57,987	59,727
MC41	62,649	64,528
	67,309	69,328
	73,462	75,666
	78,797	81,161
	81,009	83,439
	83,898	86,415
	86,786	89,390
	89,673	92,363
	92,562	95,339
	95,451	98,315
Staff grade practitioner	38,318	39,468
(1997 contract, MH03/5)	41,360	42,601
	44,401	45,733
	47,442	48,865
	50,485	52,000
	53,524	55,130
Discretionary points	*Notional scale*	
	56,567	58,264
	59,608	61,396
	62,650	64,530
	65,692	67,663
	68,732	70,794
	71,775	73,928
Consultant (2003 contract)	79,957	82,356
ZM81	82,504	84,979
	86,763	89,366
	91,708	94,459
	97,357	100,278
	100,579	103,596
	103,806	106,920
Clinical Excellence Awards		
Level 9 (Bronze)	36,924	36,924
Level 10 (Silver)	48,533	48,533
Level 11 (Gold)	60,666	60,666
Level 12 (Platinum)	78,866	78,866

	2020 £	2021 £
Commitment awards[8]	3,334	3,334
	6,668	6,668
	10,002	10,002
	13,336	13,336
	16,670	16,670
	20,004	20,004
	23,338	23,338
	26,672	26,672
Salaried general medical practitioner range:		
Minimum	61,945	63,803
Maximum	93,474	96,278
Dental foundation training	33,372	34,373
Dental core training	30,936	31,864
MN21	32,959	33,948
	34,982	36,031
	37,005	38,115
	39,027	40,198
	41,051	42,283
	43,074	44,366
Salaried primary care dental staff (2008 contract):		
Band A: Salaried dentist	41,768	43,021
	46,410	47,802
	53,371	54,972
	56,850	58,556
	60,331	62,141
	62,652	64,532
Band B: Salaried dentist[9]	64,971	66,920
	67,292	69,311
	70,772	72,895
	72,513	74,688
	74,253	76,481
	75,993	78,273
Band C: Salaried dentist[10,11]	77,735	80,067
	80,054	82,456
	82,374	84,845
	84,695	87,236
	87,016	89,626
	89,335	92,015

[8] Awarded every three years once the basic scale maximum is reached.
[9] The first salary point of Band B is also the extended competency point at the top of Band A.
[10] The first salary point of Band C is also the extended competency point at the top of Band B.
[11] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

APPENDIX B3: DETAILED RECOMMENDATIONS ON REMUNERATION IN SCOTLAND

SALARY SCALES

The salary scales that we recommend apply from 1 April 2021 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2020 £	2019 £
Foundation house officer 1	25,691	26,462
	27,295	28,114
	28,899	29,766
Foundation house officer 2	31,866	32,822
	33,950	34,969
	36,034	37,115
Specialty registrar (full)	33,884	34,901
	35,958	37,037
	38,854	40,020
	40,604	41,822
	42,716	43,997
	44,828	46,173
	46,942	48,350
	49,054	50,526
	51,166	52,701
	53,280	54,878
Specialty doctor	41,986	43,246
	45,576	46,943
	50,243	51,750
	52,744	54,326
	56,348	58,038
	59,938	61,736
	63,608	65,516
	67,280	69,298
	70,952	73,081
	74,623	76,862
	78,294	80,643

	2020 £	2021 £
Associate specialist (2008 contract)	58,866	60,632
	63,598	65,506
	68,328	70,378
	74,576	76,813
	79,991	82,391
	82,237	84,704
	85,169	87,724
	87,220	89,837
	90,067	92,769
	92,913	95,700
	95,762	98,635
Staff grade practitioner	38,898	40,065
(1997 contract)	41,986	43,246
	45,072	46,424
	48,160	49,605
	51,248	52,785
	54,884	56,531
Discretionary points	*Notional scale*	
	57,424	59,147
	60,511	62,326
	63,599	65,507
	66,687	68,688
	69,774	71,867
	72,863	75,049
Consultant (2004 contract)	84,984	87,534
	86,779	89,382
	89,362	92,043
	91,946	94,704
	94,523	97,359
	100,659	103,679
	106,795	109,999
	112,925	116,313
Discretionary points for consultants	3,204	3,204
	6,408	6,408
	9,612	9,612
	12,816	12,816
	16,020	16,020
	19,224	19,224
	22,428	22,428
	25,632	25,632

	2020 £	2021 £
Distinction awards for consultants		
B awards	31,959	31,959
A awards	55,924	55,924
A+ awards	75,889	75,889
Salaried general medical practitioner range:		
Minimum	61,346	63,186
Maximum	91,564	94,311
Dental core training[12]	37,634	38,763
Dental senior house officer/Senior house officer	31,866	32,822
	33,950	34,969
	36,034	37,115
	38,118	39,262
	40,201	41,407
	42,285	43,554
	44,368	45,699
Salaried primary care dental staff (2008 contract):		
Band A: Dental officer	43,024	44,315
	47,806	49,240
	54,976	56,625
	58,561	60,318
	62,146	64,010
	64,536	66,472
Band B: Senior dental officer	66,926	68,934
	69,316	71,395
	72,901	75,088
	74,695	76,936
	76,488	78,783
	78,280	80,628
Band C: Assistant clinical director	80,072	82,474
	82,463	84,937
	84,853	87,399
Band C: Specialist dental officer	80,072	82,474
	82,463	84,937
	84,853	87,399
	86,388	88,980

[12] On completion of Core training employees will move to the nearest point on or above their existing salary on the Dental senior house officer scale.

	2020 £	2021 £
Band C: Clinical director/Chief administrative	80,072	82,474
dental officers	82,463	84,937
	84,853	87,399
	86,388	88,980
	88,709	91,370
	91,030	93,761

APPENDIX B4: DETAILED RECOMMENDATIONS ON REMUNERATION IN NORTHERN IRELAND

SALARY SCALES

The salary scales that we recommend apply from 1 April 2021 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2020 £	2021 £
Foundation house officer 1	24,818	25,563
M220	26,367	27,158
	27,914	28,751
Foundation house officer 2	30,782	31,705
M230	32,794	33,778
	34,808	35,852
Specialty registrar (full)	32,893	33,880
M241	34,907	35,954
	37,717	38,849
	39,418	40,601
	41,467	42,711
	43,519	44,825
	45,570	46,937
	47,620	49,049
	49,670	51,160
	51,721	53,273
Specialty doctor	41,357	42,598
M215	44,895	46,242
	49,491	50,976
	51,955	53,514
	55,505	57,170
	59,042	60,813
	62,658	64,538
	66,274	68,262
	69,891	71,988
	73,507	75,712
	77,124	79,438

	2020 £	2021 £
Associate specialist (2008 contract)	57,985	59,725
M090	62,647	64,526
	67,306	69,325
	73,461	75,665
	78,794	81,158
	81,007	83,437
	83,896	86,413
	86,784	89,388
	89,671	92,361
	92,558	95,335
	95,450	98,314
Staff grade practitioner	38,316	39,465
(1997 contract)	41,356	42,597
M211/12	44,398	45,730
	47,441	48,864
	50,482	51,996
	54,064	55,686
Discretionary points	*Notional scale*	
	56,565	58,262
	59,605	61,393
	62,648	64,527
	65,689	67,660
	68,731	70,793
	71,774	73,927
Consultant (2004 contract)	82,500	84,975
M400	85,084	87,637
	87,668	90,298
	90,250	92,958
	92,826	95,611
	98,964	101,933
	105,100	108,253
	111,230	114,567
Clinical Excellence Awards (local):		
Step 1	2,957	2,957
Step 2	5,914	5,914
Step 3	8,871	8,871
Step 4	11,828	11,828
Step 5	14,785	14,785
Step 6	17,742	17,742
Step 7	23,656	23,656
Step 8	29,570	29,570

	2020 £	2021 £
Clinical Excellence Awards (national):		
Step 9	35,484	35,484
Step 10	46,644	46,644
Step 11	58,305	58,305
Step 12	75,796	75,796
Salaried general medical practitioner range:		
Minimum	61,330	63,170
Maximum	92,548	95,324
Salaried primary care dental staff:		
Band 1: Salaried dentist	38,334	39,484
	41,435	42,678
	44,535	45,871
	47,638	49,067
	50,739	52,261
	53,839	55,454
	56,942	58,650
	60,043	61,844
Band 2: Senior salaried dentist	54,779	56,422
	59,115	60,888
	63,449	65,352
	67,783	69,816
	72,119	74,283
	73,076	75,268
	74,031	76,252
Band 3: Assistant clinical director salaried dentist	72,792	74,976
	73,918	76,136
	75,042	77,293
	76,170	78,455
	77,296	79,615
	78,423	80,776
Band 4: Clinical director salaried dentist	72,792	74,976
	73,918	76,136
	75,042	77,293
	76,170	78,455
	77,296	79,615
	78,423	80,776
	79,550	81,937
	80,697	83,118
	81,823	84,278
	82,949	85,437

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN THE NHS IN THE UK[1]

ENGLAND[2]	2019		2020		Percentage change 2019-2020	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical and Dental Staff						
Consultants	48,926	52,130	50,875	54,313	4.0%	4.2%
Associate specialists	1,909	2,137	1,901	2,126	-0.5%	-0.5%
Specialty doctors and dentists	7,271	8,416	7,519	8,661	3.4%	2.9%
Staff grades	315	370	305	346	-3.3%	-6.5%
Registrar group	31,467	32,773	32,965	34,426	4.8%	5.0%
Foundation house officers 2	5,630	5,682	6,131	6,179	8.9%	8.7%
Foundation house officers 1	6,450	6,484	6,399	6,426	-0.8%	-0.9%
Other doctors in training	13,085	13,331	14,985	15,273	14.5%	14.6%
Hospital practitioners/Clinical assistants	500	1,684	543	1,662	8.4%	-1.3%
Other staff	862	1,378	824	1,319	-4.4%	-4.3%
Total	**116,416**	**123,979**	**122,446**	**130,293**	**5.2%**	**5.1%**
General medical practitioners[3]	**33,505**	**41,269**	**34,159**	**42,871**	**2.0%**	**3.9%**
GMP partners	18,303	21,161	17,352	20,627	-5.2%	-2.5%
GMP registrars	6,547	6,686	7,454	7,558	13.8%	13.0%
GMP retainers[4]	186	483	228	576	22.7%	19.3%
Other GMPs	8,469	13,076	9,126	14,257	7.8%	9.0%
General dental practitioners[5,6,7]		**24,545**		**24,684**		**0.6%**
General Dental Services only		4,954		4,863		-1.8%
Personal Dental Services only		19,550		19,781		1.2%
Trust-led		41		40		-2.4%
Total general practitioners		**65,814**		**67,555**		2.0%
Total general practitioners Total – NHS doctors and dentists		**189,428**		**197,527**		3.5%

[1] An Employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.
[2] Data as 30 September unless otherwise indicated.
[3] Data excludes locums.
[4] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.
[5] This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms.
[6] Data as at 31 March of that year.
[7] Includes salaried dentists.

WALES[8]	2019		2020		Percentage change 2019-2020	
Hospital and Community Medical and Dental Staff[9]	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Consultants	2,623	2,799	2,725	2,925	3.9%	4.5%
Associate specialists	208	237	187	212	-10.2%	-10.5%
Specialty doctors and dentists	568	650	615	703	8.2%	8.2%
Staff grades	3	4	3	4	0.0%	0.0%
Specialist registrars	2,272	2,394	2,559	2,695	12.6%	12.6%
Foundation house officers 2	561	580	572	598	2.0%	3.1%
Foundation house officers 1	407	434	469	500	15.2%	15.2%
Other staff	52	160	81	185	56.5%	15.6%
Total	**6,693**	**7,258**	**7,211**	**7,822**	**7.7%**	**7.8%**
General medical practitioners[10]		**2,271**		**2,369**		**4.3%**
GMP providers		1,962		1,963		0.1%
General practice specialty registrars		293		382		30.4%
GMP retainers		16		24		50.0%
General dental practitioners[11]		**1,506**		**1,472**		**-2.3%**
Total general practitioners		**3,777**		**3,841**		**1.7%**
Total – NHS doctors and dentists		**11,035**		**11,663**		**5.7%**

[8] Data as at 30 September unless otherwise specified.
[9] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.
[10] Data for 2019 is as at 31 March 2020.
[11] Data as of 31 March that year.

SCOTLAND[12]	2019		2020		Percentage change 2019-2020	
Hospital and Community Health Services Medical and Dental Staff	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Consultants	5,505	5,955	5,702	6,188	3.6%	3.9%
Specialty doctors and dentists	937	1,242	940	1,219	0.3%	-1.9%
Registrar group	4,466	4,662	4,546	4,763	1.8%	2.2%
Foundation house officers 2[13]	1,009	1,048	1,022	1,061	1.2%	1.2%
Foundation house officers 1[14]	1,048	1,107	1,022	1,077	-2.5%	-2.7%
Other staff	780	1,360	1,180	1,782	51.3%	31.0%
Total	**13,746**	**15,241**	**14,411**	**15,929**	4.8%	4.5%
General medical practitioners		**5,045**		**5,134**		1.8%
Performers (partners)		3,339		3,328		-0.3%
Registrar/Specialist trainee		583		624		7.0%
Retainers[15]		72		65		-9.7%
Salaried		1,071		1,144		6.8%
General dental practitioners (non-hospital)[16]		**3,365**		**3,345**		**-0.6%**
General Dental Service		3,088		3,081		-0.2%
Public Dental Service		368		367		-0.3%
Ophthalmic medical practitioners		**17**		**12**		**-29.4%**
Total general practitioners		**8,427**		**8,491**		**0.8%**
Total – NHS doctors and dentists		**23,668**		**24,420**		**3.2%**

[12] Data as 30 September of that year.
[13] Includes senior dental officers.
[14] Includes dental officers.
[15] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.
[16] Includes salaried, community and public dental service dentists.

NORTHERN IRELAND[17]	2019		2020		Percentage change 2019-2020	
Hospital and Community Health Services Medical and Dental Staff[18,19]	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Consultant	1,744	1,857	1,804	1,919	3.5%	3.3%
Associate Specialist/Specialty Doctor/Staff Grade	467	548	527	612	12.9%	11.7%
Specialty/Specialist Registrar	1,420	1,479	1,469	1,532	3.5%	3.6%
Foundation doctor	517	521	539	542	4.3%	4.0%
Other[20]	160	323	164	320	2.5%	-0.9%
Total	**4,307**	**4,728**	**4,503**	**4,925**	**4.5%**	**4.2%**
General medical practitioners[21]		**1,334**		**1,364**		**2.2%**
GMP principal		1,169		1,163		-0.5%
GMP salaried		142		179		26.1%
GMP retainers		23		22		-4.3%
General dental practitioners[22]		**1,139**		**1,147**		**0.7%**
Ophthalmic medical practitioners[23]		**4**		**4**		**0.0%**
Total general practitioners		**2,477**		**2,515**		**1.5%**
Total – NHS doctors and dentists		**7,205**		**7,440**		**3.3%**

[17] As at 30 September unless otherwise specified.
[18] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.
[19] As at March that year.
[20] Due to changes the collection of staff groups, the 'other' category is not consistent across year groups and should not be compared with previous years.
[21] Data as at 31 March that year.
[22] Data as at 31 March that year.
[23] Data as at 31 March that year.

APPENDIX D: GLOSSARY OF TERMS

ADVISORY NON-DEPARTMENTAL PUBLIC BODY – A body whose function is to provide advice to government, and which has a role in the processes of national government but is not a government department or part of one, and which accordingly operates to a greater or lesser extent at arm's length from ministers.

ASSOCIATE DENTISTS – self-employed dentists who enter into a contractual arrangement, that is neither partnership nor employment, with principal dentists. Associates typically pay a fee for the use of facilities, the amount generally being based on a proportion of the fees earned; the practice owner provides services, including surgery facilities and staff to the associate. Associate dentists also have an arrangement with an NHS board and provide General Dental Services. They are typically referred to in England and Wales as performer-only dentists. See also *performer-only dentists.*

BARNETT FORMULA – a formula used by HM Treasury to allocate funding to the devolved governments in Scotland, Wales and Northern Ireland, based on the funding allocated to public services in England, England and Wales or Great Britain, as appropriate.

BASIC PAY – the annual salary without any allowances or additional payments.

BRITISH DENTAL ASSOCIATION (BDA) – A trade union that represents all groups of dentists across the UK.

BRITISH MEDICAL ASSOCIATION (BMA)– A trade union that represents all groups of doctors across the UK.

CLINICAL EXCELLENCE AWARDS (CEAs)– payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. There are two schemes, Local CEAs and National CEAs. See also *Local CEAs, National CEAs.*

COMMITMENT AWARDS – a reward scheme for consultants in Wales, Commitment Awards are paid every three years after reaching the maximum of the pay scale. There are eight levels of Commitment Awards. Commitment Awards replaced Discretionary Points in October 2003. See also *Discretionary Points.*

COMMITMENT PAYMENTS (SCOTLAND) – paid quarterly to dentists who carry out NHS General Dental Services and who meet the criteria for payment.

COMMUNITY DENTAL SERVICES – See *Salaried Dentists*

COMPARATOR PROFESSIONS – groups identified as comparator professions to those in the DDRB remit groups are: legal, tax and accounting, actuarial, higher education, pharmaceutical and veterinary.

CONTRACTOR GMP/PARTNER GMP – A GMP who hold a contract with the NHS/HSC to provide GP services to the public. Contractor GMPs are typically partners in a practice owned by multiple GMPs.

CORPORATE DENTAL PROVIDERS – both providing-performer/principal and performer-only/associate dentists are able to incorporate their business and become a director and/or employee of a limited company (Dental Body Corporate). For providing-performer/principal dentists, the business tends to be a dental practice. For performer-only/associate dentists, the business is the service they provide as a sub-contractor.

COVID-19 (CORONAVIRUS) – an infectious disease that can affect the lungs and airways. This is caused by a newly discovered coronavirus (a family of viruses) which is referred to as COVID-19 and was discovered in 2019. This virus that causes the disease is referred to as SARS-CoV-2. The outbreak of COVID-19 was declared a pandemic by the World Health Organisation in March 2020.

DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC) – the department of the UK Government responsible for funding and overseeing the NHS in England.

DEPARTMENT OF HEALTH (NORTHERN IRELAND) (DoH) – the department of the Northern Ireland Executive responsible for funding and overseeing Health and Social Care (HSC) services in Northern Ireland.

DISCRETIONARY POINTS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by local Clinical Excellence Awards in England and Northern Ireland, and Commitment Awards in Wales, but remain in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Discretionary Points are pensionable. See also *Clinical Excellence Awards, Commitment Awards, Distinction Awards.*

DISTINCTION AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by national Clinical Excellence Awards in England, Wales and Northern Ireland, but remain in Scotland, though the scheme is closed to new entrants. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable. See also *Clinical Excellence Awards, Discretionary Points.*

EXPENSES TO EARNINGS RATIO (EER) – the percentage of earnings spent on expenses rather than income by a general medical practitioner or a general dental practitioner.

FLEXIBLE PAY PREMIUM – Additional payments made to doctors and dentists in n GP practice placements and recognised hard-to-fill training programmes.

FOUNDATION DOCTOR/FOUNDATION HOUSE OFFICER – a trainee doctor undertaking a **FOUNDATION PROGRAMME**, a (normally) two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. 'F1' refers to a trainee doctor in the first year or the programme; 'F2' refers to a doctor in the second year.

FOUNDATION PROGRAMME – See *Foundation Doctor/Foundation House Officer*

FOUNDATION SCHOOL – a group of institutions bringing together medical schools, the local deanery, trusts and other organisations such as hospices. They aim to offer training to foundation doctors in a range of different settings and clinical environments and are administered by a central staff supported by the deanery.

GENDER PAY GAP – the difference in average pay rates for men and women, as a percentage of men's earnings.

GENDER PAY GAP IN MEDICINE REVIEW – the independent review, led by Professor Dame Jane Dacre, was commissioned by the Department of Health and Social Care in April 2018 to advise on action to improve gender equality in the NHS. Its report, *Mend the Gap*, was published in November 2020.

GENERAL MEDICAL COUNCIL – A public body that maintains the medical register – the list of doctors who are registered to practice in the UK.

GENERAL DENTAL PRACTITIONER – a qualified dental practitioner, registered with the General Dental Council and on the dental list of an NHS England Region (Geography) for the provision of general dental services.

GENERAL MEDICAL PRACTITIONER (GMP) – more commonly known as a GP, a GMP works in primary care and specialises in family medicine. See also *Contractor GMP/Partner GMP* and *Salaried GMP*

GENERAL MEDICAL SERVICES CONTRACT – one of the types of contracts primary care organisations can have with primary care providers. It is a mechanism for providing funding to individual general medical practices, which includes a basic payment for every practice, and further payments for specified quality measures and outcomes.

GMP RETAINER – a general medical practitioner, who provides service sessions in general practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

GMP TRAINER – a general medical practitioner, other than a general practice specialty registrar, who is approved by the General Medical Council for the purposes of providing training a general practice specialty registrar.

GUARDIAN OF SAFE WORKING HOURS (GoSWH) – an individual appointed by an NHS Trust In England whose role is ensure the safeguards outlined in the terms and conditions for doctors and dentists in training are adhered to, to ensure safe and effective care.

HEALTH EDUCATION ENGLAND – an Arm's Length Body of DHSC that funds and manages the NHS's workforce training systems, including the medical and dental training systems.

HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS) STAFF – consultants; doctors and dentists in training; specialty doctors and associate specialists; and others (including: hospital practitioners; clinical assistants; and some public health and community medical and dental staff). General medical practitioners, general dental practitioners and ophthalmic medical practitioners are excluded from this category.

HOSPITAL CONSULTANTS AND SPECIALISTS ASSOCIATION (HCSA) – A trade union that represents hospital doctors across the UK.

LOCAL CEAs – A reward scheme for NHS consultants and academic GMPs in England. Administered locally by employers, payments are temporary and non-pensionable, under arrangements that will expire in 2022. Some consultants continue to receive pensionable, consolidated payments under the former Local CEA scheme, that was replaced in 2018.

LONG COVID – Emerging evidence and patient testimony is showing a growing number of people who contract COVID-19 cannot shake off the effects of the virus months after initially falling ill. Symptoms are wide-ranging and fluctuating, and can include breathlessness, chronic fatigue, "brain fog", anxiety and stress.

NATIONAL CEAs – A reward scheme for NHS consultants and academic GMPs in England and Wales. Administered by the ACCEA, there are four levels of award, bronze, silver, gold and platinum. Awards are currently consolidated and pensionable, though a consultation on reforms to the scheme was published in March 2021.

NHS EMPLOYERS – a national employers' body that represents NHS Trusts in England.

NHS ENGLAND AND IMPROVEMENT (NHSE/I) – an Arm's Length Body of DHSC responsible for funding and commissioning NHS services, and overseeing NHS Trusts in England.

NHS LONG TERM PLAN – a document published by NHS England and Improvement, which sets out its priorities for healthcare in England over the next 10 years and shows how the NHS funding settlement will be used. The plan builds on the policy platform laid out in the NHS Five Year Forward View, which articulated the need to integrate care to meet the needs of a changing population.

NHS PEOPLE PLAN – see *We are the NHS: People Plan for 2020-21*

NHS PROVIDERS – a membership organisation for NHS acute, ambulance, community and mental health Trusts in England.

PARTNER GMP – see *Contractor GMP*

PERFORMER-ONLY DENTISTS (ENGLAND AND WALES) – performer-only dentists deliver NHS dental services but do hold a contract with the NHS in their own right. They are typically subcontracted to deliver dental services to the public by a providing-performer or by a corporate dental provider. The equivalent in Scotland and Northern Ireland is associate dentist. See also *associate dentists.*

PRINCIPAL DENTISTS (SCOTLAND AND NORTHERN IRELAND) – dental practitioners who are practice owners, practice directors or practice partners, have an arrangement with an NHS board, and provide General Dental Services. The equivalent in England and Wales is providing-performer dentists. See also *providing-performer dentists.*

PROGRAMMED ACTIVITIES (PAs) – under the 2003 contract, consultants have to agree the numbers of programmed activities they will work to carry out direct clinical care; a similar arrangement exists for specialty doctors and dentists and associate specialists. Each programmed activity is four hours, or three hours in 'premium time', which is defined as between 7 pm and 7 am during the week, or any time at weekends. A full-time consultant typically does 10 PAs, but some do more. A number of PAs are dedicated to **SUPPORTING PROFESSIONAL ACTIVITIES**, during which time consultants carry out training, continuing professional development, job planning, appraisal and research.

PROVIDING-PERFORMER DENTISTS (ENGLAND AND WALES) – dentists who hold a contract with a primary care organisation and also perform NHS dentistry on this or another contract. The equivalent in Scotland and Northern Ireland is principal dentists. See also *principal dentists.*

PUBLIC DENTAL SERVICE – See *Salaried Dentists*

ROYAL COLLEGES – Organisations that set standards for the way that doctors are educated, trained and monitored. They are typically arranged around specialties. See *specialty.*

SALARIED GMPs – general medical practitioners who are employed by either a primary care organisation or a practice under a nationally agreed model contract.

SALARIED DENTISTS – provide generalist and specialist care, largely for vulnerable groups. They often provide specialist care outside the hospital setting to many who might not otherwise receive NHS dental care as part of the Community Dental Services in England, Wales and Northern Ireland, and the Public Dental Service in Scotland.

SAS GRADES, SAS DOCTORS AND DENTISTS – *see staff grade, associate specialists and specialty doctors and dentists.*

SPECIALTY – Specialties are divisions of clinical work which may be defined by body systems (dermatology), age (paediatrics), clinical technology (nuclear medicine), clinical function (rheumatology), group of diseases (oncology) or combinations of these factors. Hospital doctors and dentists typically choose one specialty to train and work in.

STAFF GRADE, ASSOCIATE SPECIALISTS, SPECIALIST AND SPECIALTY GRADE DOCTORS AND DENTISTS/ SAS GRADES – doctors and dentists in the SAS grades work at the senior career-grade level in hospital and community specialties. The group comprises specialty doctors and dentists, associate specialists, staff grades, clinical assistants, hospital practitioners, specialists and other non-standard, non-training 'trust' grades. The associate specialist grade is closed to new entrants.

SUPPORTING PROFESSIONAL ACTIVITIES – see *programmed activities.*

TARGETED ENHANCED RECRUITMENT SCHEME – A scheme under which GMP trainees in certain hard-to-fill locations receive a payment of £20,000 that is refundable under certain circumstances.

UNIT OF DENTAL ACTIVITY (UDA) – the technical term used in the NHS dental contract system regulations in England and Wales to describe weighted courses of treatment. The UOA is an equivalent figure used for orthodontic treatments.

UNIT OF ORTHODONTIC ACTIVITY (UOA) – see *Unit of Dental Activity.*

VOLUNTARY EARLY RETIREMENT (VER) – Refers to clinicians who elect to receive their pension ahead of the normal retirement age defined by their pension scheme.

WE ARE THE NHS: PEOPLE PLAN FOR 2020-21 – a document published by NHSE/I which sets out actions that will be taken by NHSE/I and HEE over 2020-21 to address workforce challenges.

APPENDIX E: THE DATA HISTORICALLY USED IN OUR FORMULAE-BASED DECISIONS FOR INDEPENDENT CONTRACTOR GMPS AND GDPS

E1. This appendix supports Chapters 8 and 9 and gives the latest data that would have populated the formulae for both GMPs and GDPs, had we used the formulae-based approach (Table E.1).

E2. Whilst we are not making formula-based recommendations for independent contractor GMPs and GDPs, we set out below in Table E.1 the data that would have populated the formulae. Given our ongoing concerns with the reliability of the formula, we do not consider it appropriate this year to adjust the weightings of the coefficients in the formula. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work: as noted in our 2012 report, average earnings and expenses for dentists reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound. The parties may wish to consider this point as part of their discussion of expenses and the uplift.

Table E.1: Data historically used in our formulae-based decisions for independent contractor GMPs and GDPs

Coefficient	Value
Income (GMPs) *DDRB recommendation*	3.0%
Staff costs (GMPs) *Annual Survey of Hours and Earnings (ASHE) 2020 (general medical practice activities)*	8.7%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2020*	1.4%
Income (GDPs) *DDRB recommendation*	3.0%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2020 (dental practice activities)*	0.3%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2020*	1.4%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2020*	1.4%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2020*	1.1%
Other costs (GDPs) Scotland *RPIX for Q4 2020*	1.4%

Sources: Annual Survey of Hours and Earnings (Table 16.5a, all, median), Consumer Price Inflation Time Series (CDKQ, CZBH).

APPENDIX F: ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
ARRS	Additional Roles Reimbursement Scheme
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CCT	Certificate of Completion of Training
CDS	Community Dental Services
CEA	Clinical Excellence Award
CESR	Certificate of Eligibility for Specialist Registration
CPI	Consumer Prices Index
CPIH	Consumer Prices Index including owner occupiers' housing costs
COVID-19	Coronavirus disease 2019
CT 1-3	Core training, years 1-3
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSC	Department of Health and Social Care (England)
DoH	Department of Health (Northern Ireland)
EEA	European Economic Area
EER	Expenses to earnings ratio
EU	European Union
F1	Foundation Year 1 junior doctor
F2	Foundation Year 2 junior doctor
FHO	Foundation House Officer
FPP	Flexible Pay Premium
FSS	Financial Support Scheme
FTE	Full Time Equivalent
GDC	General Dental Council
GDP	General Dental Practitioner
GDS	General Dental Services
GMC	General Medical Council
GMP	General Medical Practitioner
GMS	General Medical Services
GoSWH	Guardian of Safe Working Hours
GP	General Practitioner
HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association

HEE	Health Education England
HMRC	Her Majesty's Revenue and Customs
HMT/HM Treasury	Her Majesty's Treasury
HR	Human Resources
HSC	Health and Social Care (Northern Ireland)
IDR	Incomes Data Research
LTP	NHS Long Term Plan
MERP	Medical Education Reform Programme
NES	NHS Education for Scotland
NHS	National Health Service
NHSE/I	NHS England and Improvement
NHSPRB	NHS Pay Review Body
NIMDTA	Northern Ireland Medical and Dental Training Agency
OBR	Office for Budget Responsibility
OME	Office of Manpower Economics
ONS	Office for National Statistics
PDS	Public Dental Service
PPE	Personal Protective Equipment
RPI	Retail Prices Index
SAB	Scheme Advisory Board
SAS	Staff grade, associate specialist and specialty doctors and dentists
ST1-9	Specialist Training, years 1-9
TERS	Targeted Enhanced Recruitment Scheme
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity
UOA	Units of Orthodontic Activity
UK	United Kingdom
VER	Voluntary Early Retirement
WRES	Workforce Race Equality Standard

APPENDIX G: PREVIOUS DDRB RECOMMENDATIONS AND THE GOVERNMENTS' RESPONSES

The main DDRB recommendations since 1990 for the general pay uplift are shown in the table below, together with the November or Quarter 4 RPI and CPI inflation figures which were usually the latest figures available at the time of publishing the Review Body's report and the Governments' responses to the recommendations as a whole.

Report year	Main Uplift	RPI % (Nov)[1]	CPI % (Nov)[2]	Response to report
1990	9.5%	7.3	5.5	Not accepted. Rejected increases at top of consultants' scale and in the size of the A+ distinction award; staged implementation
1991	9.5% to 11%	10.9	7.8	Accepted, but staged implementation
1992	5.5% to 8.5%	3.7	7.1	Accepted
1993		3.6	2.6	No report following Government's decision to impose a 1.5% pay limit on the public sector
1994	3%	1.4	2.3	Accepted
1995	2.5% to 3%	2.4	1.8	Accepted
1996	3.8% to 6.8%	3.2	2.8	Accepted, but staged implementation
1997	3.7% to 4.1%	2.7	2.6	Accepted, but staged implementation
1998	4.2% to 5.2%	3.7	1.9	Accepted, but staged implementation
1999	3.5%	3.1	1.4	Accepted
2000	3.3%	1.2	1.2	Accepted
2001	3.9%	3.1	1.1	Accepted, but Government suspended the operation of the balancing mechanism (which recovers GMPs 'debt')
2002	3.6% to 4.6%	0.9	0.8	Accepted
2003	3.225%	2.6*	1.5	Accepted
2004	2.5% to 2.9%	2.5	1.3	Accepted
2005	3.0% to 3.4%	3.4**	1.5	Accepted
2006	2.2% to 3.0%	2.2**	2.1	Accepted, although consultants' pay award of 2.2 per cent was staged – 1.0 per cent paid from 1 April 2006 and the remaining 1.2 per cent paid from 1 November 2006
2007	£1,000 on all pay points***	3.9	2.7	Accepted, although Scottish Executive did not implement one of the smaller recommendations relating to the pot of money for distinction awards to cover newly eligible senior academic GMPs. England and Wales chose to stage awards in excess of 1.5 per cent – 1.5 per cent from 1 April 2007, the balance from 1 November 2007
2008	2.2% to 3.4%	4.3	2.1	Accepted
2009	1.5%	3.0****	4.1	Accepted

[1] At November in the previous year, series CZBH.
[2] At November in the previous year, series D7G7.

Report year	Main Uplift	RPI % (Nov)[1]	CPI % (Nov)[2]	Response to report
2010	0% to 1.5%	0.3	1.9	Mostly accepted: DDRB recommended: 0% for consultants and independent contractor GMPs and GDPs; 1% for registrars, SAS grades, salaried GMPs and salaried dentists; and 1.5% for FHOs. England and Northern Ireland both restricted the FHO recommendation to 1%
2011	No recommendation due to public sector pay freeze	4.7	3.3	
2012	No recommendation due to public sector pay freeze	5.2	4.8	
2013	1%	3	2.7	Accepted
2014	1%	2.6 (Q4 figure)	2.1 Q4	Accepted in Scotland Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales
2015	1%	1.9 Q4	0.9 Q4	Recommendation only applied to independent contractor GMPs and GDPs in the UK and for salaried hospital staff in Scotland Accepted
2016	1%	1.0 Q4	0.1 Q4	Accepted
2017	1%	2.2 Q4	1.2 Q4	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland
2018	2%	3.7 Q1#	2.7 Q1#	Staged and abated in England. Accepted in Wales and Northern Ireland. Accepted in Scotland, except for staff earning at least £80,000 who received £1,600
2019	2.5%	2.5 Q1#	1.9 Q1#	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards. Additional 1% for SAS not implemented anywhere
2020	2.8%	2.6 Q1#	1.7 Q1#	Accepted
2021	3%	1.4 Q1#	0.6 Q1#	

* Due to the late running of the round, DDRB was also able to take account of the March figures for RPI (3.1%)

** Due to a later round, November to February, DDRB was also able to take into account the December RPI figure

*** £650 on the pay points for doctors and dentists in training. The average banding multiplier for juniors meant that this would also deliver approximately £1,000

**** DDRB also took into account the December RPI figure (0.9%)

Due to the late running of the round, DDRB was also able to take account of the Q1 RPI and CPI figures.

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