Department of Health & Social Care

The Department of Health and Social Care's written evidence to the Review Body for Doctors' and Dentists' Remuneration (DDRB) for the 2022 to 2023 Pay Round

Contents

1. Introduction and NHS strategy

This chapter sets out the wider context for the department's 2022 to 2023 (2022-23) evidence, including the strategic context for NHS pay and the medical and dental workforce. This chapter also provides an overview of this year’s written evidence to the Review Body for Doctors' and Dentists' Remuneration (DDRB).

Autumn budget and spending review 2021

At the Spending Review 2021 (SR21), the Chancellor set out the government's plan for public expenditure for the next 3 years. NHS England's day-to-day budget was given an average of 3.8% real terms growth per year. Part-funded by the new Health and Social Care Levy, this equates to £23.3 billion over three years.

Since SR21, the context within which the NHS operates has been rapidly changing. COVID-19 has already had a considerable impact on the NHS and while the vaccine programme has put the UK in a strong position, there is still a large degree of uncertainty as new COVID variants emerge. HMT set out in their economic evidence that there also remains uncertainty in the economic outlook, and risks that public sector pay increases exacerbate temporary inflation pressures.

The NHS budget has now been set until 2024-25. While this gives the NHS the financial security to address challenges in a sustainable manner, the settlement is tight and there will be a need for careful prioritisation to stay within available funding and make progress towards long-term financial sustainability.

At SR21 the government was clear its priorities were to improve health outcomes for patients by ensuring the NHS can tackle the elective backlog, deliver the long-term plan and have the resources to continue its response to COVID-19 pandemic. This specifically included:

1. More than £8 billion to tackle the elective backlog, which comes on top of £2 billion funding provided for this purpose in 2021-22. This means that the NHS in England can aim to deliver around 30% more elective activity by 2024-25 than was the case before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance.

2. Additional funding to grow the NHS workforce. This will be achieved by progressing existing commitments for 50,000 more nurses and 50 million more primary care appointments, as well as funding the training of some of the biggest undergraduate intakes of medical students and nurses ever.

3. £9.6 billion over the SR period for COVID-19 related health spending so that the NHS can continue to respond to and mitigate the impacts of the virus.

Chapter 2 of our evidence focuses on the impact of SR21 and how NHS finances are being specifically targeted at meeting these priorities.

NHS workforce

The increase in vital budgets through SR21 will ensure that the NHS can meet these key priorities and keep building a bigger and better trained NHS workforce. Chapter 3 of our evidence outlines the Department's current strategy to ensure that the NHS has the workforce it needs, including workforce planning and service transformation and integration. For instance, we are working with system partners to increase supply throughout the nursing workforce, diversifying education and training pipelines for doctors and participating in ethical and sustainable international recruitment. There is also significant reform taking place more widely in the health and care system to improve integration of services around the needs of patients.

Recruitment and retention is not only crucial to meeting objectives like elective recovery but for safeguarding staff health, wellbeing and morale and avoiding burnout. The government recognises that staff are also motivated by their workplace environment and culture, championing inclusion, diversity and prioritising health and wellbeing. Chapter 4 sets out how the workforce has changed in the last year, outlining the current data and analysis on joiners, leavers, vacancies, and temporary staffing in the medical and dental workforce. The chapter outlines that retention remains stable and overall, the workforce continues to grow, however there is more to do, and our evidence outlines the current and additional steps the government and our NHS system partners are taking to increase morale and motivation amongst the workforce.

The NHS total reward offer remains a key recruitment and retention tool and continues to play a key role in ensuring the NHS can grow the workforce it needs. The total package includes a range of benefits beyond basic pay that exceed those offered in other sectors. These benefits include a generous holiday allowance, opportunities for additional earnings and enhanced rates for unsocial hours and access to a much-valued pension scheme to name a few. Chapters 5 and 6 of our evidence provide more detail of the total reward package and describe how earnings for the medical and dental workforce have changed since the last report and have remained broadly competitive with comparable labour markets. Whilst data for NHS earnings growth in 2021-22 is not yet available, based on known changes to the pay system it is reasonable to expect total earnings growth of around 3% in 2021-22. Given the wider public sector pay pause in the 2021-22 pay round for which NHS staff where exempt, we expect the NHS to compare favourably to the rest of the public sector.

In the 2022-23 financial year, the NHS is returning to its pre-pandemic financial regime following temporary arrangements in light of the pandemic. There is a need for greater financial restraint in the context of stretching efficiency requirements and making progress towards long term financial sustainability. NHSEI's evidence provides further information on this.

The government, as ever, has a careful balance to strike between ensuring the NHS has the workforce it needs to deliver health priorities, whilst also ensuring the NHS remains on a sustainable financial footing and delivering value for money for the taxpayer.

As the NHS budget is now set, there are stark trade-offs between pay and other NHS spending. In addition, growing the workforce, however crucial, does come at a cost. There is a direct trade-off between growing the workforce, investing in public services and giving higher pay rises, and this is the careful balance the government must strike to ensure the NHS remains an affordable, value-for-money service for the taxpayer.

Pay rises above affordability could materially impact government’s ability to deliver on these and other commitments. It therefore essential that pay remains affordable to help deliver more frontline staff and expand the clinical capacity of the NHS. It is therefore crucial during this challenging fiscal and economic climate that the DDRB carefully consider the important balance between ensuring that existing funding, which has been set within the NHS budget, can be used to expand the medical and dental workforce, whilst also fairly rewarding staff. We ask that in reaching your recommendation you take into account the NHS' financial position detailed within chapter 2 of this evidence, and within NHS England and Improvement's (NHSEI) evidence. Further information will also be provided at oral evidence.

2022-23 recommendations

In 2021-22, for a pay recommendation for those medical staff groups not in multi-year agreements, the government looked to the DDRB and in July, after careful consideration accepted your recommendation, providing a 3% pay uplift for all medical staff within this remit. As recommended by the DDRB, the value of Local and National Clinical Excellence Awards, Commitment Award, Distinction Awards and Discretionary Points was frozen.

This year, the government is again inviting you to make recommendations on annual pay award for consultants.

As you are aware, in 2019 we reached a multi-year agreement for doctors and dentists in training so the government will not be seeking a pay recommendation for this group. We would, however, welcome your comments and observations on the evidence you receive relating to doctors and dentists in training.

For Speciality Doctors and Associate Specialists (SAS), you will be aware of the multi-year pay and contract reform deal agreed with the British Medical Association (BMA) in 2020. As SAS doctors were given the choice to transfer over to the new contract, we invite you to make recommendations on an annual pay award for those doctors who chose not to transfer.

Independent contractor General Medical Practitioners (GPs) are also subject to a 5-year pay agreement between the BMA and NHSEI, and, therefore, the government is not seeking recommendations for this group. We do, however, invite you to make recommendations on uplifts to the minimum and maximum of the salaried GP pay scales. As ever, recommendations will need to be informed by affordability and the fixed contract resources available to practices under the 5-year GP contract.

We invite you to make recommendations on the pay element of remuneration for dentists employed by, or providing service to, the NHS. As with doctors in training, dentists in training are covered by the multi-year pay and contract reform agreement and therefore, the government will not be asking for a recommendation for this group.

We look forward to receiving your report in May 2022.

2. NHS finances

This chapter describes the financial context for the NHS.

As set out in the SR21 settlement, the focus for the NHS is balancing the priorities of managing the ongoing pandemic response and addressing the elective recovery challenge. Growing the NHS workforce is essential to achieving these objectives.

In 2020-21, the government spent an estimated £45 billion of additional revenue costs across the health and social care system to mitigate the impacts of COVID-19. For 2021-22 the Government has so far approved £34 billion for frontline health services, including £15 billion of day-to-day funding for the NHS. NHS financial sustainability is key to its post-pandemic recovery with increasing productivity crucial to restoring the performance of the NHS. To achieve this, funds have been allocated to put the NHS on a sustainable footing and fund the biggest catch-up programme in NHS history. Part-funded by the new Health and Social Care Levy, SR21 delivers an average 3.8% real terms growth per year for the NHS – equating to £23.3 billion over three years. This includes more than £8 billion to tackle the elective backlog, which comes on top of £2 billion funding already provided for this purpose in 2021-22.

There is an expectation that the NHS can catch-up on some of the lost efficiency and make productivity savings in 2022-23 in order to return to financial balance. It is therefore important that the 2022-23 pay awards support the government's objective to deliver long term financial sustainability in the NHS.

Economic Context

As a result of the underlying resilience of the economy, the vaccination programme and the £378 billion of the pandemic support provided to families and businesses, the UK economy has seen faster than anticipated growth after the largest quarterly decline in GDP since comparable records began in 1955. In November 2021, GDP was estimated to be above pre-pandemic levels for the first time. However, the emergence of the Omicron variant and the tightening of restrictions at the end of 2021 have increased economic uncertainty.

As set out in HMT’s Economic Evidence to Review Bodies 2021, the gradual reopening of the global economy and the rapid return of economic activity has led to a substantial rise in commodity and raw material prices, as demand for inputs has outpaced production. Global supply issues, including increases in transportation and energy costs, have pushed up inflation in the UK. In the 12 months to December 2021, inflation grew to 5.4%, the highest in almost 30 years. The Bank of England now expects it to reach around 6% in April 2022. The OBR expects it to remain elevated across 2022 and 2023 before stabilising towards

the target of 2% in the middle of the decade. If wages were to increase in line with the temporary spike in inflation, this increase could become more permanent. Given that price stability is part of the terms of reference for PRBs, this must be considered as part of their recommendations. The government is committed to price stability and has re-affirmed the Bank of England's 2% consumer price inflation target at the Budget. The pandemic has highlighted the significant value of job security in both the NHS as well as the public sector more widely. Latest Labour Force Survey data for September 2021 shows that the number of people in private sector employment is 690k lower than pre-pandemic levels, whilst employment in the NHS and public sector continues to rise. As set out in SR21, PRBs must be aware that, to ensure fairness and the sustainability of public finances, public sector earnings growth over the next 3 years should retain broad parity with the private sector and continue to be affordable. Whole economy pay growth in average earnings is forecasted to be in line with the pre-pandemic period over the coming years, as the base effects of the pandemic unwind.

Funding growth

The NHS LTP published in January 2019 set out the NHS's 10-year strategy to improve the quality of patient care and health outcomes, ensuring that patients will be supported with world-class care at every stage of their life. The LTP sets out that putting the NHS back onto a sustainable financial path is a key priority and is essential to delivering further improvements in care. The pandemic has understandably impacted on progress towards implementing many elements of the LTP. However, as set out in the Mandate, we are focused on minimising the further adverse impact of the pandemic and then recovering delivery against commitments made in the LTP - including supporting the further expansion of NHS programmes and services and embedding the positive changes brought about by the pandemic such as integration and technology advancements.

Since the beginning of the pandemic, the NHS has risen to the biggest challenge in its history by responding to the threat of COVID-19. In 2020-21, the government spent an estimated £45 billion of additional revenue costs across the health and social care system to mitigate the impacts of COVID-19. For 2021-22 the Government has so far approved £34 billion for frontline health services, including £15 billion of day-to-day funding for the NHS.

As described in chapter 1, SR21 took steps to place the NHS on a sustainable footing and to fund the biggest catch-up programme in NHS history. The increase in funding for elective recovery, growing the workforce and allowing the NHS to continue to respond to the pandemic will further enable the NHS to deliver better service and health outcomes for patients.

This is part-funded by the new Health and Social Care Levy introduced by government, which represents a 1.25% increase to National Insurance contributions with revenue ringfenced to support UK health and social care bodies. The NHS will see the tangible benefits resulting from the Health and Social Care Levy more than most as the additional funds are distributed throughout the system.

The SR21 settlement for Health and Social Care will also ensure that we can keep building a bigger and better trained NHS workforce. The government is committed to delivering 50,000 more nurses and 50 million more primary care appointments by funding some of the biggest undergraduate intakes of medical students and nurses ever. The settlement will also continue to support a strong pipeline of new midwives and allied health professionals, who are key to delivering the full range of NHS services.

Table 1 - Opening mandate for NHS England

NHS England (NHSE)	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £ billion*	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £ billion
2013-14	93.676	0.200
2014-15	97.017	0.270
2015-16	100.200	0.300
2016-17	105.702	0.260
2017-18	109.536	0.247
2018-19	114.603	0.254
2019-20	123.377	0.260
2020-21	149.473	0.365
2021-22	144.365	0.301
2022-23	151.827	0.219
2023-24	157.407	0.219
2024-25	162.678	0.219

Source: 2021-22 Financial Directions to NHS England

Table 1 above shows the opening mandate for NHS England (NHSE) in 2021-22, and indicative amounts for future years, in line with the outcome of SR21. These figures include an increase for pensions revaluation which was provided alongside the LTP settlement. Figures exclude depreciation, AME and technical budget.

The SR21 settlement, and the LTP settlement that underpins it, gives the NHS the financial security to address challenges in a sustainable manner. There will be multiple calls on available funding, including pay, and these will need careful prioritisation in order stay within available funding. As described later in the chapter, more funding put towards pay will mean less funding for other priorities, including the size of the workforce that is affordable, as well as wider non-ringfenced investments required to deliver the NHS LTP and elective recovery.

It is essential that this money is spent wisely and in line with the NHS priorities which will have the most effective impact on delivering high quality care for patients. Therefore, the government has set 5 financial tests alongside the LTP settlement to ensure the service is put on a more sustainable footing for the future. The 5 tests are:

- the NHS (including providers) will return to financial balance
- the NHS will achieve cash releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care
- the NHS will reduce the growth in demand for care through better integration and prevention
- the NHS will reduce variation across the health system, improving providers' financial and operational performance
- the NHS will make better use of capital investment and its existing assets to drive transformation

While the 5 tests remain important to the delivery of the LTP, COVID-19 has meant reporting against the tests has rightly been temporarily put on hold to allow the system to focus on managing and responding to the pandemic.

Financial position

The government's 2021-22 Mandate to the NHS provides clarity on headline objectives for the NHS. The financial directions to NHSE published alongside the Mandate partially reflect further funding to deliver manifesto commitments agreed at Budget 2021 as well as any funding required for the 2021-22 financial year to meet pressures arising due to COVID-19. Given the nature of COVID-19, the Mandate reinforces the importance of public money being spent with care on targeted, timely and time-limited interventions.

2021-22 is the third year of the LTP period and began during the winter COVID-19 peak. Since the start of the 2020-21 financial year, the NHS's financial framework was suspended and replaced with a temporary regime to help deal with the impact of COVID-19. The temporary regime moved to a system of nationally agreed block contracts with retrospective top-ups for reasonable COVID-19 related costs.

The NHS ended the 2020-21 financial year in an overall underspend position against its revised budget, including the additional COVID-19 related funding. Due to the revised financial framework which provided systems with fixed envelopes to operate within throughout 2020-21, in addition to a continuing focus on financial rigour and efficiency, most Trusts reported a year end position that was in surplus or financial balance.

Throughout the 2021-22 financial year, the NHS has been fully supported with the necessary funding at the right time, resulting in all spending pressures being met including those arising due to COVID-19. The NHS is now returning to its pre-pandemic financial regime, and there is a need for greater financial restraint in the context of stretching efficiency requirements. Evidence provided by NHSEI offers further information on this.

The financial impact of COVID-19 will be felt across the health and social care system for years to come.

Table 2 - NHS Providers RDEL Breakdown

NHS Providers RDEL Breakdown (£m)	2016-17	2017-18	2018-19	2019-20	2020-21
NHS providers' RDEL Outturn as per SoPS	935	1,038	826	1,008	-731
Provisions Adjustment	-43	-39	23	50	418
Other Adjustments	-101	-8	-22	-159	-342
Aggregate Net Deficit (Surplus)	791	991	827	899	-655
Unallocated Sustainability Funding	0	-25	0	-144	0
Adjust Net COVID-19 Impact	0	0	0	-85	0
Reported Net Deficit	791	966	827	669	-655

Share of resources going to pay

Table 3 shows the proportion of funding consumed by NHS provider permanent and bank staff spend over the last 8 years. Note that NHS provider permanent and bank staff spend only covers staff working within hospital and community health settings.

Table 3 - Increases in Revenue Expenditure and the Proportion Consumed by Pay bill

Year	NHSE RDEL (£ billion)	NHS Provider Permanent and Bank Staff Spend (£ billion)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2013-14	93.7	42.9	45.8%	n/a	n/a
2014-15	97.0	43.9	45.3%	3.57%	2.37%
2015-16	100.2	45.2	45.1%	3.28%	2.80%
2016-17	105.7	47.7	45.1%	5.49%	5.58%
2017-18	109.5	49.9	45.6%	3.63%	4.64%
2018-19	114.4	52.6	45.9%	4.46%	5.35%
2019-20	120.5	55.7	46.2%	5.35%	5.88%
2020-21	141.5	62.5	44.1%	17.37%	12.22%

Notes:

- 2019-20 and 2020-21 NHSE RDEL excludes £2.8 billion for the revaluation of the NHS pensions scheme

- 2019-20 NHS Provider Permanent and Bank Staff revised since last year's submission due to delays in finalising the accounts of one NHS provider

- 2013-14 to 2019-20 NHSE RDEL represents the budget. 2020-21 NHSE RDEL represents the outturn expenditure (the higher budget of £146.6 billion reflects the high level of uncertainty around the financial pressures arising from the pandemic)

In 2021-22, the government asked the DDRB and NHSPRB for a pay recommendation, for staff groups outside of multiyear pay deals. The Review Body recommended a 3% pay increase, which the government accepted and implemented in full. This was significantly above the government's affordability envelope given pressures related to COVID-19. The NHS received an additional £5.4billion in the second half of the year to support COVID-19 response and tackle the elective backlogs. This injection of funding allowed the 3% pay award to be funded.

Over recent years, DHSC has embarked on pay and contract reform across the NHS workforce as part of our ambition to make the NHS the best employer in the world providing the highest quality care. As these reforms have illustrated, this is not just about headline pay but delivering changes that will help improve the working lives and the physical and mental health and wellbeing of all our dedicated NHS staff.

Doctors and dentists in training are currently in a 4-year pay and reform deal. The deal covers 2019-20 – 2022-23. The investment in the deal was agreed at 2.3% in 2019-20 and 3% in the remaining 3-years. The BMA agreed that headline pay awards should be 2% in every year of the deal, with the remaining investment paying for contract improvements. In April 2021, SAS doctors also entered into a multiyear deal, covering 2021-22 to 2023-24. This agreement sets out increases to pay and amendments to the 2008 Specialty doctor contract and introduced a new Specialist contract. Investment averages at 3% per year of the deal.

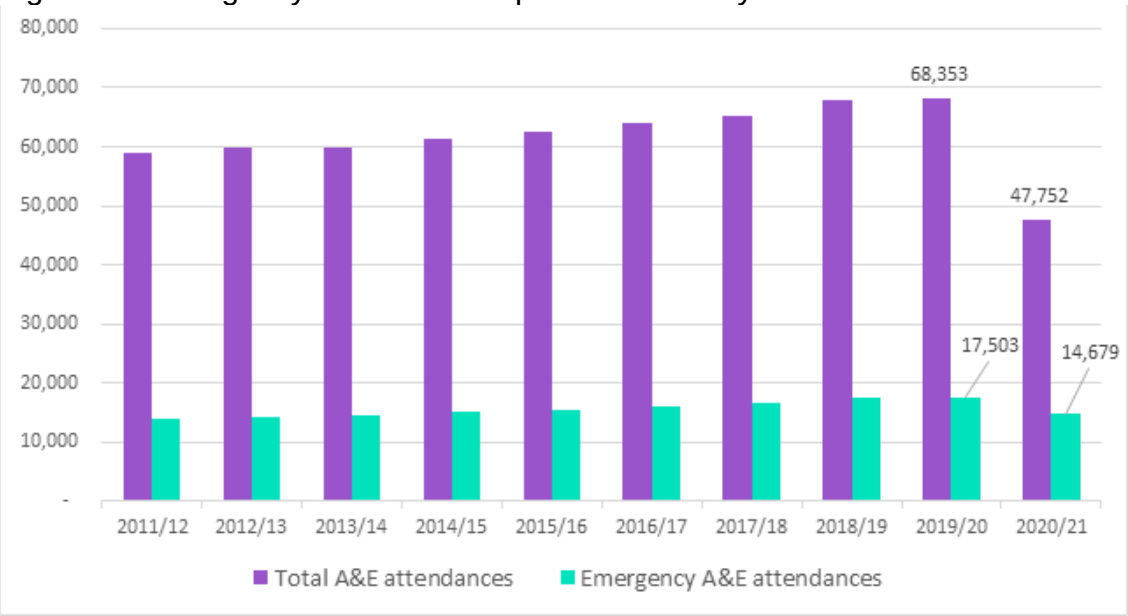
The BMA’s General Practitioners Committee (GPC) and NHSEI agreed a 5-year GP (General Medical Services) contract framework from 2019-20 to 2023-24, which along with £4.5 billion of additional investment of by 2023-24, aims to expand the general practice workforce, transforming the system to address workload and retention issues and better meet patient needs.

Demand pressures

Activity and demand levels in the health system for elective care dropped dramatically in 2020-21, as numbers of self-presenting patients reduced and the NHS freed up capacity to manage COVID-19 demand, including the suspension of all non-urgent elective

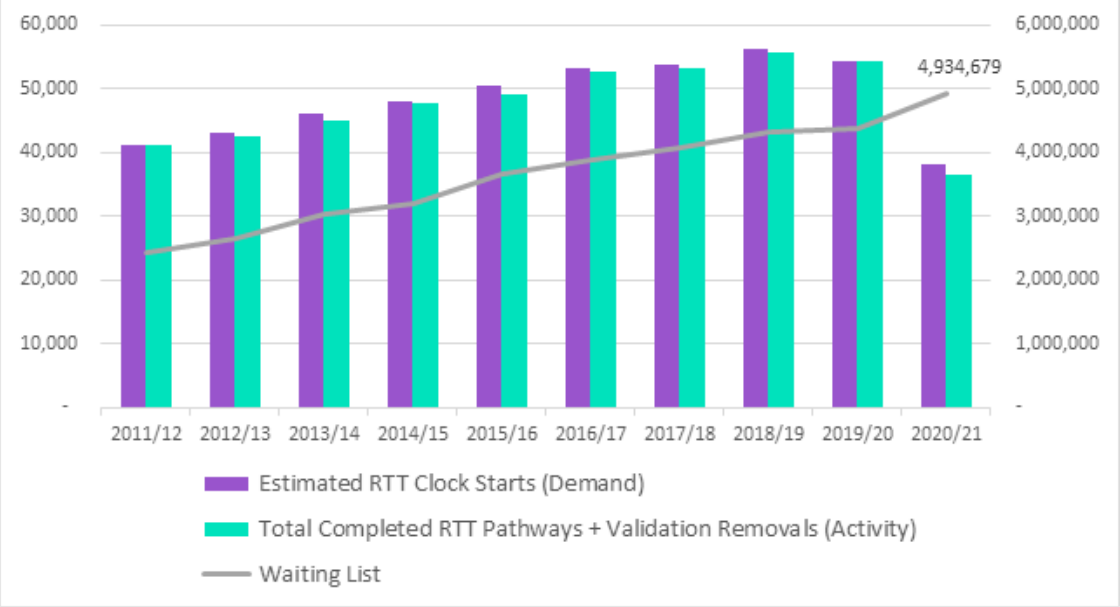
operations. As a result, there was a reduction in the number of patients seen for both elective and non-elective care compared to 2019-20.

Figure 1 - Emergency Admissions – per calendar day



Source: A&E attendances and Emergency Admission Statistics

Figure 2 - Referral to Treatment Pathways Completed per Working Day



Source: NHSE Consultant Led Referral to Treatment Statistics. Data adjusted for non-submitting Trusts and exclusion of sexual health services from 2013

Compared to the year before, in 2020-21 there was a 16.1% reduction in the number of emergency admissions. There was a 32.7% reduction in the number of completed pathways, and the RTT waiting list reached 4.9 million by the end of the financial year as demand continued to outpace activity, as shown in Figures 1 and 2.

Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2020-21. These included A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards.

We have committed in 'Build Back Better: Our Plan for Health and Social Care', to reducing the elective backlog as part of improving NHS services going forwards. As a part of this we have committed £8 billion over the next 3 years to step up elective activity and transform elective services. This funding could deliver the equivalent of around 9 million more checks, scans, and procedures. It will also mean NHS England and Improvement can aim to deliver the equivalent of around 30 per cent more elective activity by 2024-25 than it was before the pandemic.

Calculating productivity in the NHS

Labour productivity is calculated by dividing total NHS output by an appropriate measure of labour input (usually some form of a weighted sum of staff numbers and hours worked). It measures the amount of output generated per 'unit' of labour, and as such, is an important component of efficiency.

The measure of labour productivity we use for the NHS in England is that developed by the University of York (Centre for Health Economics, CHE). Their measure uses a range of NHS data sources to assess outputs and inputs, as well as adjusting the output measure to take some account of quality change, including change in waiting times and death rates. Their figures show that between 2005-06 and 2018-19 the NHS’s average annual labour productivity was 2.0%.

Labour productivity is an important component of efficiency, but labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, for example, including drugs as an input. This is called total factor productivity and is also measured by York University (CHE). Their figures show that between 2005-06 and 2018-19 the NHS’s average annual total factor productivity growth was 1.1%.

Productivity, as formally defined here, does not take into account the costs of inputs, including changes in staff pay. A full measure of technical efficiency would, in addition, factor in changes in pay and the cost of inputs relative to a suitable deflator. If pay increases more quickly than GDP deflator, this would have a negative effect on technical efficiency.

It is hard to identify productivity for individual staff groups as each unit of output is generated by a combination of different staff groups, from consultants and

nurses, to management and support staff. It is difficult to disaggregate the productivity of these groups when they are contributing to the same unit of output.

The input factor of productivity can be more easily broken down by staff group. The labour input in York CHE's productivity measure is a weighted combination of different staff groups; the growths for each staff group is summarised in Chapter 5.

Table 4 - York CHE Total Factor Productivity (Figures are all quality adjusted so take into account changes in quality of care (for example, waiting times)

Year	Quality Adjusted Output	Total Input	Total Factor productivity
2005-06	7.1%	7.2%	-0.1%
2006-07	6.5%	1.9%	4.5%
2007-08	3.7%	3.9%	-0.2%
2008-09	5.7%	4.2%	1.4%
2009-10	4.1%	5.4%	-1.3%
2010-11	4.6%	1.3%	3.2%
2011-12	3.2%	1.0%	2.1%
2012-13	2.3%	2.0%	0.4%
2013-14	2.6%	0.4%	2.2%
2014-15	2.5%	1.9%	0.5%
2015-16	2.6%	2.7%	-0.2%
2016-17	3.0%	1.0%	1.9%
2017-18	2.6%	0.9%	1.7%
2018-19	2.2%	3.0%	-0.8%

Table 5 - York CHE Labour Productivity (Figures are all quality adjusted so take into account changes in quality of care (for example, waiting times)

Year	Quality Adjusted Output	Labour Input	Labour Productivity
2005-06	7.1%	3.4%	3.6%
2006-07	6.5%	0.6%	5.9%
2007-08	3.7%	0.7%	2.9%
2008-09	5.7%	4.1%	1.5%
2009-10	4.1%	4.5%	-0.4%
2010-11	4.6%	1.4%	3.1%
2011-12	3.2%	0.1%	3.1%
2012-13	2.3%	-2.0%	4.4%
2013-14	2.6%	0.4%	2.3%
2014-15	2.5%	2.8%	-0.3%
2015-16	2.6%	1.3%	1.3%
2016-17	3.0%	2.4%	0.6%
2017-18	2.6%	2.4%	0.2%
2018-19	2.2%	2.4%	-0.2%

Even though the annual measures haven't captured this yet, the ONS quarterly measures have explicitly stated that reductions in health output have reduced the total public sector productivity figures (Source: UK productivity introduction - April to June 2020).

It is important to note that infection controls and lockdowns have delivered health benefits (for example, less COVID cases) that aren't captured in our usual measures of productivity.

Productivity and efficiency in the NHS

The government has set out in "Build Back Better" that recovering and increasing productivity will be crucial to restoring the performance of the NHS.

The ONS estimated public service productivity as a whole fell by 32.6% between April and June 2020 and 22.4% between July and September 2020 compared with the same quarter a year earlier, and that even as it recovered productivity was still nevertheless 9.8% lower in Q1 2021 compared with Q1 2019. It is reasonable to expect that the impact on NHS productivity would be similar. NHS productivity will have fallen significantly during 2020-21 because of the cancellation of non-urgent elective work, staff shortages and absences, and enhanced infection prevention and control (IPC). These were combined with rising costs and inputs due to increased critical care and PPE requirements.

The impact of COVID, including enhanced IPC measures, remains a challenge for productivity. Enhanced IPC guidance, which is necessary to protect patients and staff, has reduced productivity by reducing capacity (for example, physical distancing of beds), increasing costs (for example, buying PPE), and reducing throughput (for example, longer gaps between scans for enhanced cleaning).

The vaccination programmes and reductions in cases in 20-21 have allowed for some relaxation of IPC rules, but productivity is yet to recover to pre-pandemic levels. NHS and UKHSA will work together to review IPC rules and determine what adjustments can be made to improve productivity without compromising patient safety. Any adjustments to these measures will be dependent on emerging COVID-19 variants.

As part of the funding announced at the Spending Review, the government will invest in programmes to help the NHS return to productivity growth and achieve an ambitious productivity trajectory while delivering on the elective recovery challenge. Key productivity programmes prioritised by NHS England and NHS Improvement are:

- improving patient pathways – simplifying a patient pathway will ensure patients are seen faster at the right speciality, diagnosed earlier and treated sooner. Improving the skills mix and enhancing digital connections between primary, secondary and

community services in a pathway will reduce unnecessary referrals and encourage treatments closer to or at home

- setting up surgical hubs – increasing surgical productivity will increase efficiency for some of the costliest parts of the NHS. Surgical hubs will provide opportunity for patients to be seen and treated faster which will reduce the number of patients on the waiting list faster

- expanding Community Diagnostic Centres (CDCs) – the NHS will increase the number of CDCs to at least 100 by 2024-25. CDCs separate elective diagnostics from acute hospital settings, reducing the risk of COVID infection, and offering improved productivity by reserving facilities for elective care

- making outpatient care more personalised – the NHS will give patients greater control and convenience over their outpatient appointments by supporting them to initiate follow-up care and to self-manage their conditions. This will also reduce the number of unnecessary or low value follow up appointments

- digital productivity programmes – using digital tools such as single sign-on, e-rostering, digital staff passports, improved communication tools, and shared care records to save clinical staff time that can be better spent caring for patients

The productivity programmes aligned with the elective recovery will build on the achievements of the 2016 Carter Review and the Operational Productivity programmes which saw a saving of £3.57 billion by January 2020, supporting average productivity growth of 1.6% from 2010 to 2019.

Alongside this, the Department and NHSEI have created a Flexible Staffing Strategy that aims to meet fluctuations in demand by building a flexible workforce that is sustainable, high quality and value for money for the NHS. A series of measures have been introduced to bring NHS agency spending under control. These measures and the impact they have had on spending are described in Chapter 5 of this evidence.

Affordability

In chapters 1 and 2, we have described the challenging economic and NHS financial landscape for 2022-23.

With the NHS moving away from temporary COVID-19 arrangements and returning to its pre-pandemic financial regime, there is a need for financial restraint in the context of stretching efficiency requirements the NHS has committed to deliver as part of the 2021 Spending Review, building on the NHS Long Term Plan commitments and delivering value for money for the taxpayer.

When set in January 2019, the Long-Term Plan assumed a headline uplift of 2% for 2022/23. The outcome of SR21 has provided a tight settlement for the NHS, requiring the delivery of a range of priorities and efficiencies which will need careful prioritisation in order to stay within available funding. Since SR21, the emergence of Omicron has placed additional uncertainty on the economy, and could further reduce the NHS's ability to prioritise significant new pay interventions, above that which was accounted for in the SR.

In settling the DHSC and NHS budget, the government assumed a headline pay award of 2% for NHS staff. This takes into consideration what is happening in the wider system for medical and dental staff including:

- the 3% investment per year for junior doctors and SAS doctors which included a minimum pay award of around 2% for 22/23 alongside significant pay and contract reform; and

- that general practice funding for pay is already allocated and fixed through the 5-year GP contract.

As already mentioned earlier in this evidence, the NHS budget has been fixed to prioritise investments which will enable the NHS to tackle the elective backlog, grow the NHS workforce, continue the fight against COVID-19 and deliver the Long-Term Plan. This includes the significant step government has already undertaken to increase National Insurance Contributions by 1.25% to fund the Health and Social Care Levy. This leaves extremely limited room for any further investment in pay and therefore in order to achieve these objectives, financial restraint on pay is needed.

To put this into context, each additional 1% of pay for the whole HCHS workforce costs around £900 million per year allowing for full system costs. This equates to around 16,000 full time nurses or 500,000 Procedures. For dentists and HCHS medics covered by the DDRB recommendations this year, an additional 1% of pay costs around £160 million per year which is equivalent to approaching 1,000 full time consultants or around 100,000 procedures. Although general practice funding is already allocated and fixed through the 5-year GP contract, practices would face similar trade-offs if they faced higher than anticipated pay rises for their staff (see GP finances section below). Pay for this remit group should therefore not been seen in isolation from what is happening in the wider system.

These examples illustrate how more funding allocated towards pay than what is affordable, will lead to reduced ability to tackle the elective care backlog and expand clinical capacity to deliver a more effective health and social care system.

Patients, and their experience of care, must be at the heart of everything that the system does - we want to help ensure that the NHS can continue to put patients first and deliver world class patient care.

Our focus is on ensuring that the overall package of reward helps to recruit and retain the staff we need whilst maintaining affordability. Growing the workforce is crucial, but there is a direct correlation between the size of the workforce and what is affordable in terms of pay. This is the careful balance the government must strike in order to ensure the NHS remains an affordable, value-for-money service for the taxpayer.

It is therefore crucial during this challenging fiscal and economic climate that the DDRB carefully consider the important balance between ensuring that existing funding can be used to expand the medical and dental workforce, whilst also fairly rewarding staff.

DHSC ministers and officials will be able to provide further information on affordability at oral evidence.

General practice finances

In January 2019, NHSEI and the BMA's General Practitioners Committee (GPC) agreed a 5-year GP (General Medical Services) contract framework from 2019-20 – 2023-24. Funding for the core practice contract is therefore agreed and fixed for 2022-23, including for salaried GP pay.

The full package of GP contract reform aims to expand the general practice workforce, transforming the system to address workload and retention issues and better meet patient needs. Throughout the pandemic, the government has sought to support these ambitions by providing additional funding for increased capacity and introducing measures to support access to general practice and delivery of the COVID-19 vaccination and booster programmes (see chapter 3 and 4 for details).

In managing uplifts to staff pay from within the fixed GP contract envelope, there are trade-offs for practices, for example between passing on the full uplifts to all staff, expansion of the general practice workforce and contractor GP earnings. Recommendations should therefore be made in line with resources available to practices under the multi-year contract deal and should take account of affordability in the wider economic context.

Investment in general practice

The 5-year GP contract framework aimed to transform General Practice with £4.5 billion of additional investment by 2023-24. This investment looks to fund demand pressures, workforce expansion, and new services to support growth of more preventative,

community based healthcare and meet the goals set out in the NHS LTP. In 2020, DHSC committed at least an additional £1.5 billion in cash terms for general practice until 2023-24 for additional staff to deliver the Government's general practice workforce commitments.

Data on Investment in General Practice for England is published by NHSEI. The latest available data is from 2019-20 and a timeseries of investment since 2015-16 is shown in Table 6 and 7. Compared to 2015-16, total spend on general practice services in England by 2019-20 including reimbursement of drugs had increased by 27.2% in cash terms and 17.3% in real terms (27.7% in cash terms and 17.8% in real terms if excluding reimbursement of drugs).

Table 6 - Investment in general practice in England in real and cash terms excluding reimbursement of drugs dispensed in general practices 2015-16 to 2019-20 (£ millions)

Year	Excluding reimbursement of drugs, cash terms (£)	Year-on-year change excluding reimbursement of drugs, cash terms	Excluding reimbursement of drugs, real terms (2019-20 prices, £)	Year-on-year change excluding reimbursement of drugs, real terms
2015-16	9,088.46	-	9,853.29	-
2016-17	9,603.67	5.7%	10,171.04	3.2%
2017-18	10,197.97	6.2%	10,617.02	4.4%
2018-19	10,535.89	3.3%	10,739.78	1.2%
2019-20	11,602.26	10.1%	11,602.27	8.0%

Source: NHS England, Investment in General Practice, 2015-16 to 2019-20, in England, March 2021, Table 1 and 2. Real terms figures have been based on unrounded figures.

Table 7 - Investment in general practice in England in real and cash terms including reimbursement of drugs dispensed in general practices 2015-16 to 2019-20 (£ millions)

Year	Including reimbursement of drugs, cash terms (£)	Year-on-year change including reimbursement of drugs, cash terms	Including reimbursement of drugs, real terms (2019-20 prices, £)	Year-on-year change including reimbursement of drugs, real terms
2015-16	9,696.56	-	10,512.56	-
2016-17	10,193.71	5.1%	10,795.93	2.7%
2017-18	10,879.99	6.7%	11,327.06	4.9%
2018-19	11,237.68	3.3%	11,455.15	1.1%
2019-20	12,329.79	9.7%	12,329.79	7.6%

Source: NHS England, Investment in General Practice, 2015-16 to 2019-20, in England, March 2021, Table 1 and 2. Real terms figures have been based on unrounded figures.

Table 8 provides a summary of key investments relating to the transformation of primary care between 2015-16 to 2019-20, including funding agreed via the 5-year GP contract framework (such as the introduction of PCNs), measures to improve access and address workforce and workload pressures and the state-backed scheme for GP indemnity.

Table 8 – Reported investment in general practice in England 2015-16 to 2019-20 (£ thousands)

	2015-16	2016-17	2017-18	2018-19	2019-20
Primary Care Network Participation	-	-	-	-	104,383
Clinical Negligence Scheme for General Practice[1]	-	-	-	-	310,377
PCO Administered Funds[2]	455,560	470,729	664,705	701,733	995,812
Improving Access to General Practice[3]	105,600	122,771	144,316	237,142	220,383
Estates and Technology Transformation Programme[4]	100,201	136,059	159,508	130,867	142,267
General Practice Workforce Programmes	-	47,595	77,328	96,236	140,904
Other General Practice Transformation Programmes[5]	-	79,520	129,634	170,523	186,164
New Models of Care	7,111	13,516	11,433	-	-
Primary Care Network DES	0	0	0	0	243,016

Source: NHS England, Investment in General Practice, 2015-16 to 2019-20 in England, March 2021, Table 3a. Real terms figures have been based on unrounded figures.

Dental finances

The total funding for primary care NHS dentistry in 2019-20 was c.£3 billion which included total Patient Charge Revenue (PCR) of c.£850 million. NHSEI are responsible for commissioning primary care dentistry to meet the needs of the local population. During the pandemic some regions have prioritised commissioning of time limited additional dental activity to improve access which has been restricted by infection prevention and control measures.

[1] These costs are included in the report for the first time in 2019 to 2020, as reported by NHS Resolution. They comprise the £307 million increase in provision for future liabilities in 2019 to 2020 and the £3 million administrative costs of running the Clinical Negligence Scheme for General Practice (CNSGP) and Existing Liabilities Scheme for General Practice (ELGP) schemes.
[2] Figures for Recruitment and Retention are included in the Primary Care Organisation (PCO) Administered Funds line. Additional training costs met by Health Education England were included in the PCO Administered Funds line for the first time in 2016 to 2017.
[3] Improving Access to General Practice includes expenditure in relation to the Prime Minister's Challenge Fund, The Prime Minister's GP Access Fund and the Improving Access to General Practice programme. This is in addition to the investment in extended access via the Directed Enhanced Service.
[4] The Estates and Technology Transformation Fund was formerly known as the Primary Care Infrastructure Fund and Primary Care Transformation Fund.
[5] See General Practice Forward View for details.

Throughout the pandemic, NHSEI have monitored dental activity levels to set contractual arrangements that provide NHS dentists with a reasonable activity threshold to meet. This is designed to take into consideration restrictions on patient throughput as a result of infection prevention and control guidance, whilst still ensuring patient access.

Once this threshold has been met, dental contractors have been reimbursed at 100% of their contract value, minus agreed deductions for variable costs. Clawback of funding for un-delivered activity has not been applied to practices delivering at, or above the set threshold of dental activity. Further, the rate of clawback has then been proportionately reduced to a lower threshold value. Beyond the lower threshold, normal clawback has taken place.

An adjustment to payments to account for the reduction in variable costs associated with face-to-face care not delivered during the pandemic has been in place. NHSEI have reduced the adjustment made to payment for activity not delivered from 16.75% to 12.75% for the second half of the 2021-22 financial year to further help dental contractors.

NHS dentist income has therefore been largely protected, to ensure practices remain stable through the pandemic period, despite the fact that activity in dentistry has been necessarily limited to protect patients and staff from infection.

For their private earnings, dentists have been able to access the full range of financial support from HM Treasury, available to individuals and businesses affected financially by COVID-19.

3. Workforce strategy

This chapter sets out the current strategy for the NHS workforce and provides further information on the NHS People Plan. It includes updates on current manifesto commitments and key priorities including workforce culture, leadership, and workforce planning.

Effective workforce strategy is important for the delivery of safe, affordable, high quality care, both now and in the longer term. Ensuring that the NHS has access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care is a fundamental aspect of the DHSC's overarching programme for the health and care system.

There are currently record numbers of doctors and nurses working in the NHS, and the Department continues to work closely with the various bodies involved in workforce planning to help ensure the NHS continues to recruit and retain staff. This commitment is supported by a robust programme of work including delivery of the Nurse 50k manifesto commitment, investment in international recruitment, the expansion of medical training places, and training grants for nursing, midwifery, and Allied Health Professions students. The Department recognises that in addition to growing the workforce, work must continue to help improve ways of working to increase productivity and efficiency through advancing skills mix and service transformation. The Department is therefore developing proposals to improve the integration of health and social care services around the needs of patients.

In addition to training and recruiting additional workforce and improving ways of working, there is a significant programme of work in place to retain and look after the existing workforce. Initiatives include improving staff wellbeing, fostering an increased sense of belonging, and promoting greater equality, diversity and inclusion.

The Department works through its ALBs on the delivery and implementation of workforce policy. In conjunction with the department, NHSEI is responsible for setting the priorities and direction of the NHS workforce and encouraging and informing the national debate to improve health and care. NHSEI is responsible for delivering the NHS People Plan.

Building on the experience of the pandemic, NHSEI will also be working with HEE to explore the potential of new roles and making best use of skills through multidisciplinary teams, as well as ensuring the workforce can respond to technological change and support new service models to provide high-quality patient care, now and in the future. This work will include developing proposals for medical education reform to improve efficacy and flexibility of our medical education system, guided by the lessons of the COVID response, as well as through HEE's advanced practice programme, expand clinical

practice for nurses, allied health professionals, pharmacists and healthcare scientists to ensure people can practise to their maximum ability, not the top of their capacity.

Education and training of the workforce is the core function of HEE and, subject to parliamentary passage of the requisite powers within the Health and Care Bill, will be merged with NHSEI. The merger will help ensure that workforce is placed at the forefront of the national NHS agenda as it will integrate service, workforce and finance planning in one place, reflecting its importance. It will also simplify the national system for leading the NHS, ensuring a common purpose and strategic direction.

NHSEI/HEE have responsibility for short term workforce planning and the deployment of workforce to meet service need, with each Integrated care systems (ICS) planning workforce requirements for its own service. ICSs are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area, including working to ensure the system is retaining, recruiting and, where required, growing its workforce to meet future need.

The Department retains strategic oversight for the NHS workforce and is delivering longer term strategic workforce planning. It also includes HEE Long Term Strategic Framework (“Framework 15”), commissioned in July 2021, which will review long term strategic trends for the health and regulated social care workforce.

The NHS people plan

'We are the NHS: People Plan 2020-21 – action for us all' was published in July 2020, setting out the actions which will make sure the NHS has the right measures in place to support transformation across the whole system and grow the workforce, acknowledging the impact of the pandemic. The People Plan focuses on building resilience across the NHS workforce with actions to support recruitment and retention. NHSEI is responsible for the delivery of the NHS People Plan and their evidence will cover the People Plan actions for 2021-22.

The 2021-22 NHS operational planning guidance, which sets the priorities for the NHS reaffirms the importance of the 4 pillars of the NHS People Plan – looking after staff and helping them to recover, belonging in the NHS and addressing inequalities, new ways of working and growing the workforce for the future.

The experience of the pandemic has shown, once more, that the NHS is nothing without its exceptional staff. NHS staff have been severely tested by the challenges of dealing with the pandemic and it is vitally important that they are kept safe, supported now and over the months ahead, and able to recover. Investing in staff health and wellbeing is very important. The NHS has strengthened the mental health and wellbeing support offer for

health and social care staff in 2021-22, with £37 million invested in 40 mental health and wellbeing hubs across the country. These provide proactive outreach and clinical assessment, access to evidence-based mental health services and other support where needed. The NHS Retention Programme is working to understand why staff are leaving, resulting in targeted interventions to support staff to stay whilst keeping them well. While much is being done, we are not complacent and both the Department and NHSEI will continue to seek to understand what further action will help support staff in keeping well and feeling supported while doing the difficult jobs that they do.

NHS covenant

The Department is exploring the potential for a Covenant for NHS staff. This could provide an opportunity to ensure there is comprehensive, meaningful and lasting support to those working in the NHS on issues such as health and wellbeing, recognition, bullying, harassment and violence reduction.

We are currently working through the best approach to developing the NHS Covenant with partners including NHSEI, NHS Employers and the Social Partnership Forum. We will engage further with NHS staff and others on how we might shape the NHS Covenant and ensure it is aligned with the staff rights in the NHS Constitution and some of the good work being done through other initiatives such as the NHS People Plan and NHS People Promise.

Leadership review

The Health and Social Care Leadership Review, led by General Sir Gordon Messenger with support from Dame Linda Pollard, will look to strengthen the leadership of health and social care in England, with the aim of reducing regional disparities in efficiency and health outcomes. The Terms of Reference have now been published, which outline further detail on the scope of the review.

Research has shown that leadership plays a significant role in shaping organisational culture. Strong leadership in health and social care will ensure the best outcomes for our key priorities and that the necessary leadership behaviours, strategies and qualities are developed to maximise these efforts - which is vital in ensuring that every pound of investment is spent well.

The move to Integrated Care Boards in April 2022 and the need for ever closer working between NHS organisations and local authorities provides an opportunity to look at what more needs to be done to foster and replicate the best leadership and management and to

address underperformance. It also provides a new focus on how leaders from both health and care work together to provide efficient and integrated care for the people they serve.

The Leadership Review is working closely with stakeholders across health and social care to discuss how to ensure the right pay and incentives are in place to foster good and excellent performance.

The review should report to the Secretary of State for Health and Social Care in early 2022.

International recruitment

Internationally trained staff have been part of the NHS since its inception in 1948 and continue to play a vital role. International recruitment remains an important part of achieving our workforce commitments.

Ethical and sustainable international recruitment is central to our approach, set out in the Department's revised Code of Practice for International Recruitment which aligns with the latest advice from the World Health.

Many international staff benefit enormously from the opportunity to work in the NHS, in terms of professional development and economically. We have made it easier for those wanting to further their career to come to work in the NHS. Since 2016, we have seen increases in joiners of nearly all staff types from the EU and EEA. The growth in Rest of World nationalities has increased by 66% over the last 6 years, now representing about 21% of the total medical workforce.

While some of these professionals will stay in the UK, many return to their home countries, taking with them enhanced experience in new clinical settings and new skills which can help strengthen their country's health system.

Service transformation, integration, and productivity

The government is developing proposals to improve the integration of health and social care services around the needs of patients. These proposals will be published in 2022. The health and social care workforce is central in delivering more integrated care, and the drive to deliver more integrated services will support the health and care workforce to deliver care in a more effective way, working across traditional boundaries. This will both benefit patients and service users and will support professionals to work more effectively.

NHSEI’s evidence will cover this in further detail.

Workforce planning and education

The Heath and Care Bill builds on this work and investment. Publishing a report detailing the roles and responsibilities of the bodies involved in workforce planning and supply, as we are proposing in clause [35] of the Bill, is one part of our commitment to improve workforce planning and supply. The report will set out the role and responsibility of each of the bodies in the system responsible for workforce planning for the first time – to increase accountability and transparency and provide assurance that the system is making this issue a priority. Part of the rationale for this report is that workforce planning in the NHS necessarily requires collaboration between various bodies at different levels of the system – national, regional, and local.

This workforce accountability report will cover the whole of the NHS including primary care, secondary care, and community care. It will also cover where sections of the workforce are shared between health and social care – for example, registered nurses or for the case of public health, doctors and other regulated healthcare professions.

In July 2021, the Department commissioned HEE to work with partners and review long term strategic trends for the health and regulated social care workforce. This will review and renew the long-term strategic framework for the health workforce, to help ensure we have the right numbers, skills, values and behaviours to deliver world leading clinical services and continued high standards of patient care. For the first time ever, the framework will also include regulated professionals working in social care, like nurses and occupational therapists.

Building on this work, the department for Health and Social care has recently commissioned NHS England to develop a workforce strategy and will set out the key conclusions of that work in due course.

Supporting all this is our recent announcement of our intention to formally merge HEE with NHSEI.

Medical workforce planning

To support the government's commitment to secure the right numbers of NHS staff with the right skills, values, and behaviours to meet future population needs, HEE are developing a Framework 15, as mentioned above.

Aiming to establish what the NHS, patients, and public require from 21st century graduates, HEE published the Future Doctor Report in July 2020. With a focus on enhanced generalism, this report sets out the reforms needed in education and training to equip doctors with the skills that the future NHS needs, and which have been much in demand during the COVID-19 response so far. Among these skills, enhanced generalism

for doctors is key to addressing health inequalities by creating locally nurtured doctors serving complex population health needs.

The Department and partners are undertaking a range of actions to increase flexibility and support the medical workforce – this is covered in more detail in a separate submission by HEE.

Medical school places

The government recognises the need for the workforce pipeline to be able to meet the needs of the NHS. To address concerns of several medical bodies that more doctors would be needed in the future, the government has funded additional undergraduate medical school places each year for domestic students in England - a 25% increase over 3 years, from 6,000 to 7,500. This expansion was completed in September 2020.

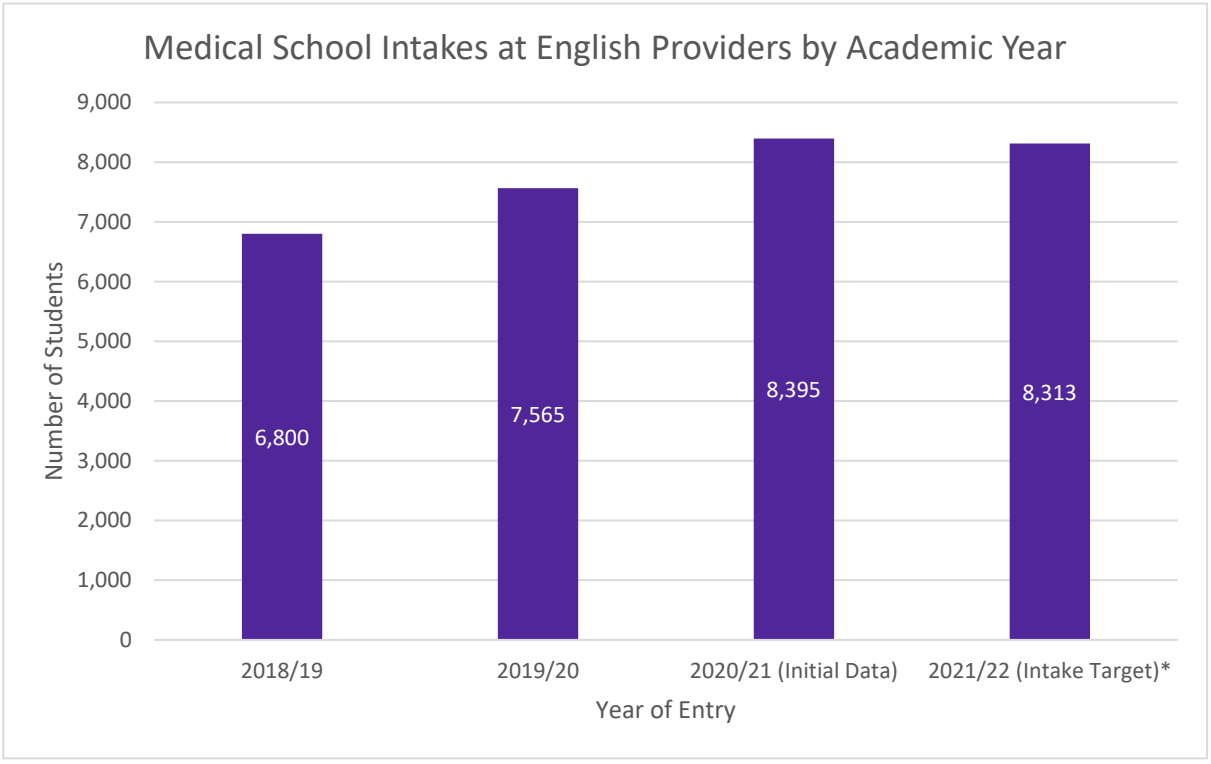
As part of this, 5 new medical schools were opened in Lincoln, Canterbury, Sunderland, Lancashire and Chelmsford - areas that are under-doctored.

During the COVID-19 pandemic school exams were cancelled resulting in a greater number of medical school applicants achieving the required grades for their conditional offers. To accommodate all eligible students in these exceptional circumstances, the government lifted the cap on medical and dental school places for students who completed Year 13 exams in 2020 or 2021. Consequently, initial data shows that 8,395 medical students entered training in the 2020-21 academic year compared to 7,565 the year before (Office for Students Medical and Dental Students Survey 2020). This lift on the cap resulted in over 800 more students beginning undergraduate medical degrees that would normally be allocated.

This growth in medical school places will mean, once these students have passed their medical licensing assessment, there will be an increase in the number of doctors working in the NHS as junior doctors from 2023 onwards and a reduction in expensive medical agency staff. The growth in numbers and reduction in locums helps ensure money is better spent on treating more patients.

The government set out its clear intention that widening participation and reducing gaps in access for students from lower socio-economic backgrounds are central to the planned medical expansion of 7,500 undergraduate places per year. The increase will provide more opportunities for people from all backgrounds to study medicine.

Figure 3 - Entrants to English Medical School by Academic Year 2018-19 to 2020-21
Source: Office for Students Medical and Dental Students Survey (2018 to 2020)



*NOTE: Due to COVID-19 situation and the subsequent changes in A-level grading we expect a higher intake of medical students in the academic year 2020-21 than originally planned.

Medical apprenticeships

HEE is developing a proposal for an apprenticeship in medicine, working with a range of partners. This reform is in the consultation phase and HEE has successfully made a submission to the Institute for Apprenticeships and Technical Education. Funding models have yet to be confirmed for this pathway and the commencement of this route into medicine is subject to ministerial approval, which is due to be sought in Spring 2022.

This medical apprenticeship is designed to encourage widening participation in medicine, offering a new route into the profession and reducing some of the barriers that prohibit talented people entering medicine. Apprentices will be subject to the same rigorous exams as medical undergraduates, taking the Medical Licensing Assessment (MLA).

This pathway will enable employers to recruit apprentices as part of their local workforce plans, supporting the development of apprentices' clinical practice skills while building capacity in the workforce.

Further information on apprenticeships will be in HEE's evidence.

Skill mix

To improve the ability of doctors to work with multi-morbidities, there is a focus on building multi-disciplinary teams. New roles are being created to support these teams and address shortages in specialties such as anaesthetics and general practice.

These roles are Physician Associate (PA), Anaesthesia Associate (AA), Surgical care Practitioner (SCP), and Advanced Critical Care Practitioner (ACCP). These roles will support primary care (in the case of PA) and secondary care.

Further growth of the PA position is a key part of the government's policy to develop a more effective and strong General Practice workforce to meet future patient need.

Since 2014, the PA workforce has grown considerably. At present, there are 36 institutions across the UK running courses leading to the award of a PA qualification, with additional providers working to open a PA programme in 2022. As of October 2021, there are 2,486 qualified PAs and 1,000 student PAs on the Managed Voluntary Register (MVR).

On 29 July 2019 the GMC confirmed that they were content to take on the regulation of these roles and work is currently underway to take this forward, with an expectation that the legislative process will be completed by summer 2023.

Blended learning

To maintain the medical training pipeline during and after the COVID-19 pandemic and mitigate the worst-case scenario of non-progression of up to 50% of trainees, medical education will need to maintain a focus on training recovery and supporting training catch-up.

To support this catch-up, HEE has invested £30 million into the development of individual training recovery plans for each trainee and the development of trust-level solutions. These recovery plans include continuing to realise benefits and efficiencies in using technology, simulation and blended learning to enhance and improve education and training.

Blended learning strategies such as Technology Enhanced Learning (TEL), encompass a wide range of methods to support learning, including e-learning courses, mobile learning, online resources, interactive digital media, videos for learning and reflection, teleconferencing and webinars for virtual workshops and meetings, and simulation using virtual reality.

Through working closely with HEE postgraduate deans, heads of specialty schools, the royal colleges, trainee groups, and national programmes, the TEL project aims to provide

rapid access to simulation and technology-based resources to help address specific training needs and will support both recovery plans and future working.

Specialty doctors, Specialist Doctors and Associate Specialists (SAS)

SAS doctors play a critical role in delivering high-quality care. Their roles are often centred around service delivery and as such are essential for the elective recovery. They provide an important contribution to addressing workforce pressures.

In our written evidence to the DDRB last year we outlined our commitment to negotiate a multi-year pay and contract reform deal for the SAS grades. The aims of reform were to raise the profile and status of SAS roles, enhance pay satisfaction and improve the wellbeing and morale of SAS doctors.

In March 2021 the Department reached a collective agreement with the BMA on a new 2021 Specialty Doctor contract and a contract for the new Specialist grade. The contracts came into force from 1 April 2021. As part of negotiations it was agreed that existing SAS doctors would have a choice on whether to move to the new contract. SAS doctors had a 6-month choice window to decide whether to express an interest in transferring to the new contract. The window originally closed on 30 September 2021. In February 2022 the Department responded to feedback from employers and the BMA and opened the contractual right to express an interest in transferring to the new Specialty contract. We hope this will provide clarity for the service and encourage more doctors to transfer.

Overview of the 3-year deal

The 3-year agreement, covering 2021-22 to 2023-24, sets out increases to pay and amendments to the 2008 Specialty doctor contract. Investment averages at 3% per year of the deal.

The Department has confidence that the 2021 contract delivers on the original objectives of reform. For SAS doctors the deal improves pay and career progression and enhances the experiences of work, which will contribute to improvements in morale, recruitment and retention and to improving the inequalities faced by this group. For employers, the deal improves flexibility to use staff resources in an affordable way to support service provision.

Highlights from the deal include:

- guaranteed meaningful pay increases and faster progression to the top of the pay scale through a reduction in spinal points (moving from an 11 point to a 5 point scale progressing to the top 5 years faster)

- introduction of safeguards to improve health and wellbeing of SAS doctors
- an additional day of annual leave after 7 years' service
- alignment with the consultant on-call availability supplement
- modernised terms and conditions through the adoption of the NHS Staff Handbook, for example, inclusion of Shared Parental Leave

Non-contractual benefits

Specialist grade

One of the main ambitions of reform was to improve career progression for SAS doctors. This has been achieved by the creation of the new Specialist grade which will provide an opportunity for progression for highly experienced Specialty doctors. The introduction of the role will help recruit, motivate and retain senior doctors and contribute to SAS grades being a positive and fulfilling career choice.

The creation of the Specialist grade also creates an alternative pathway for a career in medicine. We know that doctors' expectations of a career in medicine are changing and not all doctors want to progress straight through a formal training programme to become a consultant. Introducing more flexibility into the medical career pathway will provide more opportunity for doctors to create a career which works for them.

SAS advocate role

This is a new role that employers are encouraged to create to support and improve SAS doctors' wellbeing.

We know SAS doctors report experiences of bullying and harassment and difficulties with receiving adequate support for their health and wellbeing. Providing the option of an advocate shows employer's commitment to improving their experience. It is also intended to provide a vehicle for sharing good practice on the treatment and experience of SAS doctors across organisations and between different organisations. The advocate will also help SAS doctors share their experiences and improve their visibility within the organisation. Guidance on the role can be found on the NHS Employers website.

SAS development fund

As part of the deal, it was agreed that funding will be allocated for investment in the professional development of Specialty and Specialist doctors. The additional funding can be used to support SAS doctors create a collaborative, inclusive and learning-focused

culture and working environment. Guidance on the funding is also located on the NHS Employers website.

Challenges to implementation

It was our ambition that as many SAS doctors as possible transferred to the new contract. However, we know that the number of doctors to transfer is low. At the end of September 2021 there were only 824 FTE doctors on the new 2021 Specialty doctor contract and 7049 FTE remaining on the 2008 Specialty doctor contract. This is despite the efforts of individual employers, NHS Employers and the BMA in explaining the benefits of the contract.

The pay scales for the 2021 contracts were devised before the conclusion of the 2021-22 pay round. At the time of negotiations, we were working in the context of wide public sector pay restraint. Therefore, although investment in the deal is an average of 3% per annum, we designed the pay scale so that the majority of doctors transferring would receive a 1% pay uplift in the first year of the deal to ensure parity across the workforce. The context shifted and as you know, the DDRBs recommendation of 3% was accepted in full.

The impact of the 3% uplift awarded to the 2008 closed grades has made it challenging for people to transfer to the new contract. The impact on the pay scale is significant to the extent that the majority of doctors would see an immediate financial detriment by transferring to the 2021 contract in the first year.

NHS Employers have started to capture feedback that the implementation of the 2021 contract is having a negative impact on recruitment. Existing SAS doctors are rejecting roles because they would need to move onto the new Terms and Conditions. It is a significant challenge for the Department that a newly agreed and jointly negotiated contract that brings a number of benefits for SAS doctors and the service has been undermined by the financial treatment of a closed grade.

The Department would ask members to consider the impact of recommending equal uplifts for closed grades. The 2021 deal delivers on the requests from the DDRB to modernise and reform the SAS grades. We would ask that the DDRB considers the benefits the deal brings when making a recommendation.

Consultants

As the most senior hospital doctors, consultants hold overall responsibility for the patients in their care. Leading multidisciplinary teams, consultants are responsible for driving forward the delivery of system priorities.

In 2021 the government accepted the DDRB's recommendations and uplifted pay for consultants by 3%. This increased the consultant pay scales by between £2503 and £3320. As recommended by the DDRB, the value of Local and National Clinical Excellence Awards (CEAs) was not uplifted.

Unlike other hospital staff whose contracts have been modernised, consultants continue to benefit from more or less automatic incremental pay progression. A doctor joining the consultant grade in 2011-12 would have been on a starting salary of £74,504, by 2021-22 they would now be on a basic salary of £101,432. This represents an increase of approximately 36% over 10 years. This does not include additional earnings consultants have access to, including CEAs, additional Programmed Activities and management allowances. Additional earnings make up 23% of total earnings for consultants as a whole.

The last available Staff Survey results, from the survey conducted in Autumn 2020, showed consultants were more satisfied with their pay than other medical staff groups, with 65% of consultant respondents reporting being happy with their pay.

Over recent years the number of consultants has continued to increase steadily. Between 2017 year and 2021 numbers have increased by 14.3%, with 52,381 consultants in September 2021. The majority of consultants are male (61% compared to 43% in Foundation Year 1). The proportion of female consultants has increased by 3% since 2016, we would expect to see this proportion continuing to increase over time given the larger proportion of females within the training grade. The proportion of consultants with a non-UK nationality has remained relatively stable over recent years. 20% of consultants hold a non-UK nationality, lower than the average for all doctors of 30%.

It is possible that the trend of increasing consultant numbers may slow over coming years. As set out in further detail in the Total Reward section of this evidence, with approximately 25% of consultants aged 55 or over, it will be key to target action at retaining these highly experienced individuals and to ensure that the total reward package for all consultants in the NHS remains attractive and is supported by positive experiences of working.

In 2020-21 a number of parties highlighted in their evidence planned activity specifically aimed at retaining older consultants in workforce. We expect NHS England and Improvement and NHS Employers to provide an update on progress within their evidence submissions.

Elective recovery

The key focus for the NHS going forward will be to recover system activity and tackle the significant backlog of elective procedures caused by the pandemic. Consultants will be at the centre of this strategy in terms of driving service reconfiguration, innovation and delivery of clinical care.

Due to the relatively long supply pipeline for qualified medical consultants and the smaller proportions being recruited internationally than for other medical workforces, there is unlikely to be significantly more consultants in the short term to deliver the additional output which will be required. There is likely to largely be a reliance on the current workforce to supply additional activity or refocus their activity on elective recovery.

The consultant contract sets out the arrangements for pay outside of standard job plans which will ensure that consultants are fairly remunerated for any additional activity they supply. However, this additional activity will need to be paid for from the existing overall budget and this will have an impact on funding available for basic pay uplifts.

Contract reform

In their 49th report the DDRB highlighted the increasingly clear need for reform of the consultant contract. This year attentions have been focused on continuing to respond to the pandemic and initiating plans to recover the elective position, leaving limited scope to effect plans for large scale contractual reforms. In relation to reform, the Department and its partners have instead been focused on negotiating the replacement arrangements for Local Clinical Excellence Awards, as set out in more detail below.

We share the DDRBs views in relation to the pressing need to reform the contractual arrangements for consultants. Particular areas of weakness in the contract are around out of hours and on-call arrangements, pay for activity outside of standard job plans and the structure of the pay scale. The Gender Pay Gap in Medicine Review has shone a light on the direct impact of deficiencies within the contract in some of these regards. We also believe that there are changes which could be made to the contract to help build capacity and support service recovery in the longer term. We have ambitions to press forward with reforms as soon as the circumstances allow.

However, we recognise the many competing calls on the NHS budget which will impact on the availability of funding for reform. Additionally, we need to consider whether there is capacity in the system to deliver reforms and whether new contractual arrangements for consultants could potentially disrupt service provision at a time when significant pressures already exist. These factors are likely to impact on our ability to initiate reforms in the very near future. However, we continue to engage positively with the trade unions and welcome discussions on what we may be able to achieve in partnership.

Local Clinical Excellence Awards (LCEA)

In March 2021 the Department was jointly approached by NHS Employers, BMA and HCSA to request approval not to run a Local Clinical Excellence Award (LCEA) round in 2021 and to distribute the funding equally as a one off non-consolidated payment to

eligible consultants. The government had approved a similar request the previous year due to pressures of the COVID response, on the proviso that this did not set a precedent. However, the parties made a case that with employer priorities being to protect staff wellbeing and drive recovery strategies, running an award round in 2021 would not be appropriate or feasible.

Whilst the equal distribution approach does raise some questions around fairness towards those who have performed exceptionally and around value for money, the approach was supported again in 2021 given system capacity pressures. For the 2021 round the parties additionally agreed to include wording in the contract to state that the one-off payment should also be made in full to those working less than full time, those not working due to sickness related to COVID, those absent on maternity leave (or similar), consultant clinical academics and those employed on a fixed term basis.

As highlighted in our evidence last year, the Department, supported by NHSEI, has been working with NHS Employers and the trades unions to negotiate new LCEA arrangements since January 2020. Our overarching aim has always been to increase and diversify the distribution of awards and ensure they encourage engagement and participation. Our intention was that the reformed awards should motivate consultants to achieve the highest levels of performance locally, contributing to the delivery of local priorities whilst role modelling the behaviours which make the NHS a great place to work. We wanted to create a scheme which was simpler to run, less administratively burdensome and effectively tackled issues of inequity.

Discussions have largely been positive and productive but have taken much longer than anticipated due to the complexity of designing and negotiating a new scheme which meets each party's objectives. The parties jointly reached a Framework Agreement in January 2022 which set out details of a new local award scheme for consultants. However, the BMA and HCSA did not secure the approval necessary to take the Framework Agreement forward to a member ballot. This was a disappointing outcome as, although we recognised some transitionary weaknesses, we believed the proposal had clear long-term benefits for both employers and consultants. However, the trades unions have decided not to allow doctors the opportunity to decide for themselves whether they supported the proposals.

As no agreement is reached, the follow-on arrangements already set out within the consultant contract will come into effect from April 2022. These arrangements allow employers a significant degree of local flexibility to run their LCEA schemes to suit their own priorities. In the absence of a national framework, we will continue to work with NHS Employers to support and encourage best practice.

National Clinical Excellence Awards (NCEA)

In March 2021 the Department launched a consultation on reforms to the National Clinical Excellence Awards scheme. The objectives of reform were to broaden access to the scheme, make the application process fairer and more inclusive, and ensure the scheme rewards and incentivises excellence across a broader range of work and behaviours. Key to the reforms are the recommendations made by the DDRB in 2012 and wider evidence including the Gender Pay Gap in Medicine Review.

The consultation received over 400 responses with detailed and constructive input from a range of individuals and organisations, which have been used to formulate the final scheme design.

The joint response to the consultation from the Department of Health and Social Care and the Welsh government, was published on 26 January 2022 and confirms that the awards will be re-branded the National Clinical Impact Awards (NCIAs) from April 2022. The response document sets out the full details of the reforms, including differences in final scheme design between England and Wales. In summary the reforms (in England) will:

- increase the number of available awards. Once the transition process has completed, there will be up to 600 awards granted annually in England
- re-brand the scheme. The awards will be re-branded as the 'National Clinical Impact Awards'
- re-structure the award levels. In England, the new scheme will operate as a 3-level award system: National 1 (lowest), National 2 and National 3 (highest)
- refresh the assessment domains. The current assessment domains will be developed, combining both Domains 1 and 2 and introducing a new fifth domain
- simplify the application process. A single level application process will be introduced with self-nomination being retained
- remove pro-rated awards. Those working Less Than Full Time (LTFT) will no longer have their award payments pro-rated
- remove the renewals process. The renewals process will not continue in the new scheme; awards will be held for a total of 5 years, at which point applicants will need to re-apply
- remove the pensionability of awards. Awards will no longer be pensionable or consolidated

- simplify the process for employers.

Following discussion with NHSEI, we have agreed the budget for the reformed awards over the next 5 years (an increase of approximately 1% per annum). This provides planning certainty for the NHS and for ACCEA.

Table 9 - NCEA annual budgets 2022-23 to 2027-28

Year	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28
Scheme budget (£m)	127	128.5	130	131.5	133	134.5

The NCEA award values will of course be subject to the recommendations of the DDRB and will be kept under review as the reforms are implemented. However, in the last 2 years, the DDRB has not recommended uplifts to NCEAs due to concerns around equalities impacts.

As detailed above and in the consultation response document, the government has set the value of national awards for 2022-23. We therefore ask the DDRB to allow the reformed scheme to be fully implemented and imbedded before any further uplift is recommended.

Doctors and dentists in training

Since February 2020, all doctors and dentists in training in England in approved postgraduate training programmes under the auspices of HEE are covered by the 2016 Contract for Doctors and Dentists in Training. The 2016 contract, following agreement with the British Medical Association Junior Doctor Committee (BMA JDC) in 2019, is currently subject to a 4 year pay and contract reform deal, ending 31 March 2023.

The agreement made the 2016 contract a national collective agreement, subject to collective bargaining. The contract is maintained through partnership working between the relevant employer side and staff side organisations through the Joint Negotiating Committee for Junior Doctors - JNC(J). The JNC(J) is now once again meeting on a regular basis to review contractual arrangements in partnership.

The junior doctor workforce, consisting of the foundation programme and core and specialty training, currently makes up the largest proportion of the medical workforce in England. August 2021 workforce numbers showed just over 63,000 FTEs, although a proportion of doctors within this group will be “trust grade” doctors on local contracts outside of an approved HEE postgraduate training programme.

As a result of the 4-year agreement, our remit letter to the review body set out that we are not looking for a pay recommendation for doctors and dentists in training for the 2022-23 round, but as usual we would welcome comments and observations on the evidence you receive from DHSC and other parties.

Table 10 below shows the basic pay values for the 2016 contract over the course of the 4-year agreement. Pay uplifts for doctors and dentists in training have been agreed at 2% per annum for the years 2019-20, 2020-21, 2021-22, and 2022-23. It is important to take in to account the significant additional investments the deal makes on top of the 2% pay uplifts, and the impact these have on individual doctors. The total investment into the deal is profiled at 2.3% in 2019-20, and 3% in 2020-21, 2021-22, and 2022-23.

Table 10 - 2016 terms and conditions of service, basic salaries 2019-20 to 2022-23

Nodal point / grade	2019-20 (£)	2020-21 (£)	2021-22 (£)	2022-23 (£)
Nodal point 1 / FY1	27,689	28,243	28,808	29,384
Nodal point 2 / FY2	32,050	32,691	33,345	34,012
Nodal point 3 / ST/CT 1-2	37,935	38,694	39,467	40,257
Nodal point 4 / CT3/ST3-5	£48,075	49,036	50,017	51,017
Nodal point 5 / ST6-8	n/a	From October 2020: £52,036	From October 2021: £56,077	58,398

Some of the extra benefits are:

- more pay for those working most frequently at weekends, by increasing their weekend allowance

- more pay for those working in the evenings and nights, by increasing the number of hours eligible for the 37% enhancement

- more pay for any junior doctor who wants to work less than full time, through the introduction of a permanent £1,000 a year allowance

- the introduction of a new, higher pay point for the most senior doctors in training. This fifth nodal point came into effect in 2020-21 by introducing a pay point £3,000 above the existing fourth nodal point. In 2021-22 nodal point 5 increased by a further £3,000 and in 2022-23 will increase by another £1,200. These increases were in addition to the 2% per annum pay uplifts. By the end of the 4-year agreement, around 1 in 8 doctors in training will reach nodal point 5, significantly increasing their basic salary above what they could have expected to earn had the new higher pay point not been introduced.

Progression through the 2016 contract

Over the course of the 4-year deal annual pay awards increase every pay point by at least a cumulative 8.2%. In addition, doctors and dentists in training benefit from significant salary growth as they progress through their training.

The introduction of nodal point 5 means that some doctors can expect to progress from a starting basic salary of £29,384 in 2022-23, to a basic salary of £58,398, almost doubling their salary in as little as 7 years. Those that complete training before reaching nodal point 5 are eligible for consultant posts - with basic salaries starting at £84,559.

Because of the "frontloading" of salaries, which was a BMA preference in initial contract negotiations, junior doctors also benefit from significant increases earlier on in their training. Table 11 below demonstrates this effect:

Table 11 - Progression through the 2016 contract

Grade	Number of years in training	Basic salary	Percentage increase from previous pay point	Cumulative percentage increase from start of training
Foundation Year 1	0 - 1	£29,384	-	-
Foundation Year 2	1 - 2	£34,012	15.8%	15.8%
Core/Specialty Training year 1 and 2	2 - 4	£40,257	18.4%	37%
Core/Specialty Training year 3, 4 and 5	4-7	£51,017	26.7%	73.6%
Specialty Training year 6, 7 and 8	7-9+	£58,398	14.5%	98.7%

Support through the pandemic

The government recognises that in the face of the challenges presented by COVID-19, many doctors and dentists in training showed flexibility and resilience to deliver care in uncertain and rapidly changing circumstances.

Working arrangements through the pandemic were largely managed through the provisions within the 2016 contract which contains a structured system to pay for every additional hour worked. An additional supplement, on top of basic salary, is paid for weekends which increases as weekend frequency increases, for example if frequency of weekend working increased during the pandemic. In addition, some employers came to

local agreements, for example around further premium rates of pay, to recognise the exceptional circumstances at the most challenging times.

COVID-19 has had an impact on trainee recruitment, rotation, assessment and progression, and to tackle this, DHSC have implemented a central programme across the whole health system. Firstly, HEE are investing £30 million to support the development of individual training recovery plans for each doctor in training, and to develop trust-level solutions. The initial £30 million funding allocation has gone to Directors of Medical Education in NHS Trusts, so will benefit all trainees who do part or all of their work in Trusts. HEE are also developing specific specialty solutions for all specialty training recovery.

In addition, HEE have introduced a number of measures including refining the Annual Review of Competence Progression (ARCP) panels, looking at minimum curriculum requirements, identifying where compensatory evidence can be used, defining critical progression points, and introducing new ARCP outcomes.

ARCP outcome 10.1 and 10.2 are no-fault outcomes which recognise that progress of the trainee has been satisfactory but that acquisition of competences / capabilities by the trainee has been delayed by COVID-19 disruption:

- outcome 10.1 is used where trainees are not at a critical progression point, allowing them to progress to the next stage of training where they can obtain the relevant competences / capabilities

- outcome 10.2 is used when a trainee is at a critical progression point in their programme and there has been no derogation to normal curriculum progression requirements given by the relevant Medical Royal College or Faculty. This means that additional training time is required before the trainee can progress to the next stage in their training, or obtain the Certificate of Completion of Training (CCT)

Many junior doctors have been through a very challenging year and we know that the pressures on much of the workforce have been extremely high. The measures taken to address this, in line with the NHS People Plan, are noted earlier in this chapter.

Trust grades

In last year's report, the review body asked us for information on those working on locally determined contracts, typically referred to as "trust grades" or "clinical fellows", and how they can be treated fairly and retained. It is of course for local employers to determine these arrangements, which sit outside of national terms and conditions, however we would expect that all doctors, regardless of how they are employed, are treated fairly by their employer.

We understand that there are a range of employment models, with some organisations "mirroring" the relevant aspects of the 2016 contract, to create an appropriate set of local terms and conditions for locally employed doctors outside of an official training programme. We expect that NHS Employers will provide some further detail on these local arrangements.

GPs

The government is committed to creating an extra 50 million appointments in general practice a year by 2024 through growing the general practice workforce. Despite growth in the overall number of doctors in general practice over recent years (see chapter 4), there remains a high rate of attrition and reduction in working hours among qualified GPs.

Retaining existing expertise and building the future pipeline of GP trainees, along with diversifying the workforce with 26,000 more primary care professionals, is key to reducing GP workload and supporting the government's general practice commitments. The Department continues to work with NHSE&I, HEE and the profession to boost recruitment, address the reasons why doctors leave the profession or reduce their working hours, and encourage them to return to practice.

In support of our general practice workforce commitments, the update to the GP contract agreement 2020-21 - 2023-24 announced a number of new retention schemes alongside continued support for existing schemes for the general practice workforce. An overview of the key schemes was provided in our written evidence to the DDRB for the 2021-22 pay round, including the GP Fellowship Programme, the Supporting Mentors Scheme, the New to Partnership Payment, The GP Retention Scheme and The National GP Induction and Refresher Scheme. Further information on these schemes can be found in chapter 4.

The additional roles reimbursement scheme

The government is working to strengthen existing plans to increase the number of primary care professionals, as part of the transformation to the general practice clinical workforce. The 5-year GP contract framework sought to address workload issues and provide funding towards 26,000 additional staff in PCNs via the Additional Roles Reimbursement Scheme (ARRS). The ARRS enables PCNs to recruit a diverse range of professions directly into primary care with the aim of providing a wider range of care options for patients and multi-disciplinary support according to local needs.

This aims to replicate the model used in hospitals, whereby a consultant leads a multidisciplinary team of professionals. This will help patients to be seen by those who are more expert at dealing with their particular needs, and also help to free up capacity for

GPs to focus on what only GPs can do. We expect this to improve retention of GPs who regularly cite high workloads as reasons for reducing their hours or leaving the workforce.

Since March 2019, over 10,000 of these professionals have been recruited into general practice (see chapter 4 for details of the Direct patient care workforce figures). These additional primary care professionals have immediately made an impact, delivering COVID-19 vaccinations and a wider range of services through PCNs, as well as advanced practitioners and professionals in more senior roles anecdotally taking on some GP workload. The 2021 updates to the contract agreement included an increase to ARRS funding and addition of 3 new roles (paramedics, advanced practitioners and mental health practitioners) from April 2021.

Implementation of the multi-year GP contract agreement

The 5-year framework agreed between DHSC, NHSE/I and the GPC of the BMA guaranteed extra investment in general practice between 2019-20 and 2023-24 to deliver the expansion of services and improvements in care set out in The NHS LTP. In our written evidence to the DDRB last year, the Department set out measures introduced through the update to the GP contract agreement 2020-21 to 2023-24, including enhancements to improve access to general practice and grow the general practice workforce. We also set out a number of contractual easements to free up general practice capacity to support in the response to the COVID-19 pandemic.

Working to implement the 5-year framework and NHS LTP, but recognising the pressures in general practice as a result of COVID-19, and the vaccination programme, government phased the introduction of changes to the GP contract in 2021-22.

This phased approach started with a letter published by NHSE/I in January 2021 confirming the contract arrangements from 1 April 2021 onwards. This interim agreement for 2021-22 allowed a focus on the COVID-19 response (including the COVID-19 vaccination programme), while supporting the recovery of long-term condition management. These arrangements included an increase to ARRS funding from £430 million in 2020-21 to a maximum of £746 million in 2021-22, and 3 new roles (paramedics, advanced practitioners and mental health practitioners) added to ARRS from April 2021. They also reinstated performance-related payment for QOF in 2021-22, and a phased approach to introducing new Impact and Investment Fund (IIF) indicators in 2021-22.

A further letter was published in June 2021.This included further funding for PCN Clinical Director support for the period from July to September 2021 and introduced two new enhanced services (Weight Management and Long COVID). These are set to run from 1 July 2021 to 31 March 2022 and, as with other enhanced services, practices must opt in to delivering them.

In August 2021, a further set of changes were announced, introducing new service requirements and Impact and Investment Fund incentives for PCNs from October 2021 to April 2022 and further changes from April 2022. Recognising pressures on general practice, these service specifications were set to be introduced in a gradual way and focused on key health priorities and system goals to support recovery from the COVID-19 pandemic. To further support PCNs, the package also provided £43 million of leadership and management funding for the remainder of this year.

The Department's written evidence for the 2021-22 pay round set out a number of easements and additional funding that were provided to relieve pressure on GPs and to free up more time for staff in general practice to provide care and deliver the COVID vaccine programme. In March, to support the ongoing response to COVID-19, an extra £120 million funding was provided for extension of the General Practice COVID Capacity Expansion Fund until 30 September 2021 (together with the £250 Winter Access Fund this totals £520 million for general practice over the pandemic period).

In response to updated advice from the Joint Committee on Vaccines and Immunisations (JCVI) following the emergence of the Omicron variant, on 3 December measures were announced to increase general practice capacity as well as financial support to deliver an expanded vaccine programme. This included part income protecting the 2021-22 Quality and Outcomes Framework and Investment and Impact Fund indicators. These are due to recommence in full in April 2022. To deliver the government's scaled-up ambition to ensure all adults can receive a booster by the end of December 2021, further time-limited measures to release capacity were developed with other government Departments and announced on 17 December. These include DWP extending self-certification for sickness for people accessing Statutory Sick Pay from 7 to 28 days and the DVLA suspending requests for medical information for the provision of drivers' licenses (excluding essential workers such as bus and HGV licenses). These measures were considered necessary to support practices to deliver an expanded vaccine programme while practices continue to target and support the most vulnerable patients.

Dentists

In 2021, the Department asked NHSEI to lead the next phase of dental system reform work, recognising the need for reform in the wider dental system, including needing to make the contract more attractive for dentists. As a result, NHSEI and the Department are working closely with the British Dental Association and others to tackle the key challenges in dentistry, which the pandemic has highlighted.

Additionally, HEE published its Advancing Dental Care (ADC) Review Report in September 2021 and is working to implement the proposals over the next 4 years, through their Dental Education and Reform Programme (DERP).

Through these workstreams, the Department is seeking to address both the impact of the pandemic backlog and the longer-term challenges seen in NHS dentistry.

Advancing dental care

HEE's ADC Review Report was published on 21 September 2021 and is the culmination of a 3-year review to identify and develop a future dental education and training infrastructure that will improve recruitment and retention.

HEE have identified ways to improve the use of skill mix of the dental workforce and widen access and participation to training, allowing for more flexible entry routes and developing training places for dental professionals in areas of greatest need. In addition, they are looking to better support modern flexible ways of working, for instance through digital and blended learning opportunities to deliver dental education and training.

HEE are now moving into a programme of implementation via their DERP.

Dental system reform

DHSC has been testing a new approach to delivering NHS dentistry since 2011. The latest approach implemented in April 2016 involved over 100 NHS dental practices following a prevention focussed clinical pathway. The prototype programme did not represent a model that could be rolled out across the country for a number of reasons including a lack of evidence that if implemented the contract would maintain dental access, reduce oral health inequalities and offer overall sustainability within available resources for the NHS. Whilst the programme is coming to a close in March 2022, we will ensure that the vital learning and data gained from the prototype programme will be incorporated into plans for reform.

In March 2021 Ministers commissioned NHSEI to lead the next stage of dental system reform, working with DHSC and key stakeholders -Technical and Advisory Groups have been established. The British Dental Association had representatives on both of these groups and has actively contributed to discussions. A number of engagement events with dentists and their teams, commissioners and patient representatives have also been held to inform the ongoing process and bring forward proposals for implementable change.

The underlying key principles for national contract reform agreed by Ministers are that any redesigned contract be more attractive to and supported by the profession, improve oral health outcomes, incentivise care of highest clinical value, and improve access with a focus on addressing inequalities.

Scoping discussions are now being held with the British Dental Association ahead of formal negotiations.

4. Recruitment, retention, motivation and morale

This chapter describes and discusses the existing size of the workforce and how it has changed with regards to patterns of recruitment, retention and motivation. We have highlighted and discussed where there might be COVID-19 impacts as part of sections if apparent. The remainder of the chapter reflects on key topics of interest as requested.

There are currently a record and growing number of hospital doctors in the NHS, and it continues to become an even more diverse workforce in terms of nationality, ethnicity and gender. Education and training pipelines continue to diversify, bringing in new roles and staff from local areas. Trends in vacancies, temporary staffing, retention rates for staff and the numbers of staff joining and leaving have been impacted by the pandemic. The data shows that less staff have been leaving however there are early signs that leaver rates are now returning to pre-pandemic levels.

COVID-19 and impacts to workforce data

There have been a broad range of workforce changes as part of responding to the COVID-19 pandemic. These have had implications and impacts to workforce data which makes interpreting 2020-21 data more challenging than normal. Therefore, data for this year should be treated with caution. This includes:

- doctors from training were deployed / joined the NHS earlier than would be typical. This meant typical patterns of joiners to the NHS have changed;
- vacancy numbers and rates appear to be artificially suppressed due to NHS Trusts focusing on the COVID-19 response and therefore pausing and / or focusing less on assessing their establishment. We expect there also have been some data quality or coverage issues as also highlighted by NHS Digital;
- whilst the international workforce continues to grow, international recruitment flows were briefly impacted, reduced or paused whilst travel restrictions were in place and
- many people were and continue to work longer hours, but other professions, depending on their specialism may not have seen the same demands as part of the pandemic response. There were also a number of redeployments of staff which make it challenging to understand what care areas they did or did not provide service in at times.

Numbers in work

The number of HCHS medical staff has increased by 18,317 FTEs (16.8%) in the period between September 2017 and September 2021. Between 2017 and 2021, consultants increased by 6,556 (14.3%). There have been large, proportionate changes, such as for doctors in Core Training which have seen the largest increase (72.9%), with the total number of doctors at training grades (Specialty Registrar, Core Training, Foundation Year 1 and Foundation Year 2) increasing by 11,678 (22.6%) since September 2017.

Table 12 - HCHS Doctors FTEs Sept 2017 to Sept 2021 (Source: NHS Digital HCHS monthly workforce statistics)

Staff Group	Sep-17	Sep-18	Sep-19	Sep-20	Sep-21	Change since Sep-17	% Change
Consultant	45,825	47,308	48,857	50,786	52,381	6,556	14.3%
Associate Specialist	2,088	1,987	1,909	1,901	1,863	-225	-10.8%
Speciality Doctor	6,528	6,825	7,251	7,510	7,971	1,443	22.1%
Staff Grade	365	313	315	303	322	-43	-11.8%
Speciality Registrar	30,448	30,407	31,259	32,801	33,660	3,212	10.5%
Core Training	9,737	11,216	13,053	14,974	16,834	7,097	72.9%
Foundation Doctor Year 2	6,510	5,521	5,626	6,123	6,247	-263	-4.0%
Foundation Doctor Year 1	6,130	6,260	6,448	6,398	6,624	494	8.1%
Hospital Practitioner / Clinical Assistant	484	498	500	542	588	104	21.5%
Other ad Local HCHS Doctor Grades	886	912	860	820	830	-56	-6.3%
Total	109,002	111,247	116,079	122,157	127,319	18,317	16.8%

Doctors are a highly skilled workforce, as part of their professional development and the scope of their work, it is common to take career breaks from the NHS or move between employers. The joiner and leaver data reflect this, for example doctors have a higher annual turnover rate than nurses. Doctors in training are increasingly taking career breaks, although we continue to see the vast majority return to the UK to work in the NHS. Despite the high degree of movement within the workforce, longitudinal studies show low rates of loss over the long term and the workforce is inherently stable.

Joiners

The number of joiners to the medical workforce has grown by 29% in the last 5 years. Whilst the number of joiners reflects the higher degree of mobility and rotation of the workforce as well as it increasing size, it is important to note the increases in joiners coming from international recruitment.

The number of entrants coming from non-EU countries has grown rapidly since 2015-16. The number of joiners from EU countries has declined and there are around 33% fewer joiners from EU countries than in 2015-16.

Table 13 - Source of HCHS Doctors (Source: NHS Digital HCHS Workforce statistics)

Absolute Numbers	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Abroad: Non-EU Country	1,169	1,556	1,866	2,639	3,404	2,913
Abroad: EU Country	680	653	596	611	582	459

Until the latest period, new entrants from non-EU countries had continued to grow year on year, up by 2,235 (191%) between 2015-16 and 2019-20.

Around 80% of new entrants from non-EU countries entered into medical training grades (rather than consultant or SAS grades).

Joiner rates are the percentage of the HCHS workforce joining their staff group each year. For medical staff, there isn't much variation in joiner rates between regions, with joiner rates steadily growing in all regions since 2015-16 as the total number of staff increase. The joiner rates between all regions vary between 15% and 21% throughout the time series as shown in Table 14.

For medical staff, there isn't much variation in joiner rates between regions, with rates steadily growing in all regions since 2015-16 as the total number of staff increase.

Table 14 - Joiner rates by region, HCHS Medical Staff (Source: NHS Digital Workforce Statistics)

NHSEI name	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
All NHSEI regions	16.3%	16.2%	16.8%	17.1%	18.2%	19.7%
London	17.1%	16.3%	17.1%	17.3%	17.8%	18.7%
South West	16.0%	16.3%	15.8%	18.2%	18.4%	19.3%
South East	16.4%	17.3%	16.6%	17.5%	18.0%	19.7%
Midlands	15.8%	15.7%	16.8%	16.9%	18.8%	20.2%
East of England	16.9%	15.3%	19.4%	18.7%	19.3%	20.5%
North West	15.8%	16.1%	16.0%	15.7%	18.1%	21.3%
North East and Yorkshire	15.7%	16.0%	16.3%	16.1%	17.3%	18.7%

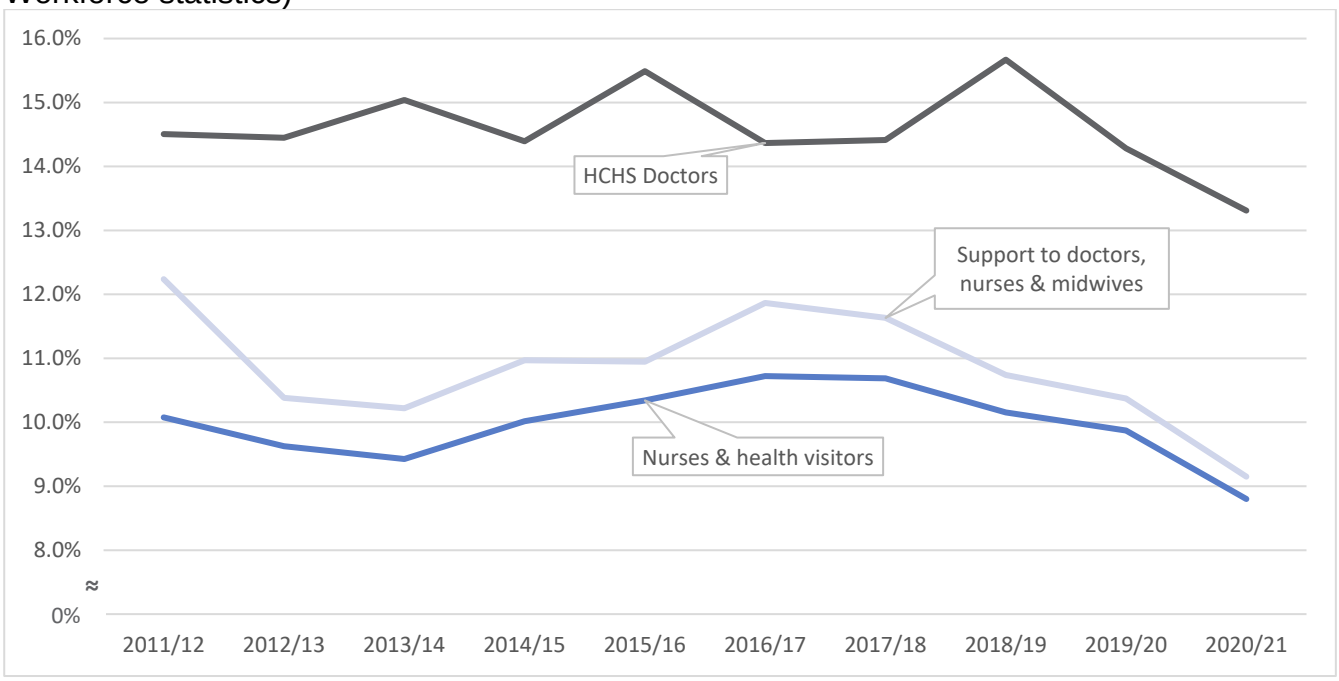
Leavers

The leaver rate for HCHS Medical staff has remained stable over the last 10 years, as shown in Figure 4, except for a clear drop in the latest data during the pandemic. The leaver rate is the percentage of the workforce leaving their staff group in NHS Trusts and CCGs in a year. It excludes staff moving between Trusts but includes movement of doctors from Trusts to other settings such as General Practices, this is important as doctors in training may often leave trusts to work in other settings or countries during their training. Therefore, the leaver rate for all HCHS medical staff is inflated and when excluding doctors in training we observe that medical staff leaver rates are below other non-medical staff groups. NHS Digital produces turnover statistics based on information in the NHS ESR.

The leaver rate for all HCHS medical staff was 14.5% in the year 2010-11. Over the last 10 years, the leaver rate peaked at 15.7% in 2018-19 and reached a low of 13.3% in 2020-21, as more people hesitated to leave during the pandemic. More timely unpublished data shows leaver rates for all staff and nurses are now returning to pre-pandemic levels. For context a thousand additional/fewer doctors leaving the NHS equates to about a 0.8% change in the leaver rate.

The impact of the more common movement of doctors in training grades in and out of hospital settings is shown by the fact the leaver rates for the year to March 2021 for consultants (5.1%) and speciality doctors (8.1%) are below the average for all grades.

Figure 4 - HCHS Leaver Rates by Staff Group: Time Series (Source: NHS Digital HCHS Workforce statistics)



Over time, HCHS medical staff leaver rates have varied between 12% to 19% across regions, with a drop in all regions for 2020-21, again likely due to the pandemic. There is though not a larger degree of variation between rates in regions.

Table 15 - Medical Leaver Rates by Region (Source: NHS Digital HCHS Workforce statistics)

NHSEI name	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
All NHSEI regions	15.5%	14.4%	14.4%	15.7%	14.3%	13.3%
London	16.8%	15.0%	15.0%	15.2%	14.3%	13.2%
South West	14.4%	14.7%	14.1%	15.9%	14.5%	14.1%
South East	14.4%	15.2%	14.5%	16.9%	14.5%	13.0%
Midlands	14.6%	14.1%	14.4%	14.9%	14.8%	13.5%
East of England	19.4%	13.0%	14.4%	15.5%	14.1%	13.5%
North West	13.8%	13.7%	14.2%	16.3%	14.4%	13.5%
North East and Yorkshire	15.2%	14.3%	13.9%	15.4%	13.4%	12.8%

Whilst the number of leavers varies between the different specialties, they appear to be broadly consistent over a number of years within a speciality area. Differences between specialities are likely to reflect the differing levels of doctors in training (who are more likely to rotate out of the HCHS setting represented in a specified period).

GP workforce data

GP workforce shortages are well recognised by government and workload is known to be primary factor in morale and retention of the workforce. This circular relationship underpins our targets to expand and diversify the general practice workforce and trends in workforce data can provide useful insight.

Data on the general practice workforce is published by NHS Digital. General practice workforce numbers are subject to seasonal variation, linked to recruitment and training cycles each year: they historically reach an annual high in September followed by a gradual decline over the rest of the year. Comparisons looking at long term trends in capacity, therefore, should only be made with the same annual time point, for example, September to September. Monthly general practice workforce statistics were introduced from 31 July 2021 to provide insight into workforce patterns between quarters. As the monthly series is less than a year old, we cannot yet compare data to the same point in the previous year. As such, the September 2021 data is presented here.

A range of methodological changes to the data were implemented in the June 2021 publication, including removal of fully estimated records and publication of ad hoc locum GP figures in an annex.

Following stakeholder feedback, NHS Digital have undertaken a review of the changes to the estimation methodology and some form of estimate will be reintroduced for all workforce groups. All published figures remain provisional until the reintroduction of the revised timeseries, which is scheduled to be implemented in December 2021's figures, published in February 2022.

Table 16 and 17 present a summary of doctors by role type working in general practice by headcount and full-time equivalent, since 2015. As at 30 September 2021 there were a total of 36,275 full time equivalent (FTE) doctors in general practice in England (45,681 headcount).

Table 16 - Doctors in general practice in England, FTE, by role, September 2015 to 2021[6]

FTE	Sept 2015[7]	Sept 2016[7]	Sept 2017	Sept 2018	Sept 2019	Sept 2020	Sept 2021
All Doctors in General Practice	33,056	34,537	34,320	33,796	34,433	35,155	36,275
GP Partners	20,732	20,671	19,984	18,948	18,262	17,486	16,922
Salaried GPs	6,565	7,211	7,552	7,933	8,414	9,061	9,678
GPs in Training Grade	4,941	5,692	5,493	5,880	6,547	7,454	8,576
GP Retainers	72	72	87	119	185	226	252
GP Regular Locums	746	890	1,203	917	1,025	929	848

Source: NHS Digital, General Practice Workforce 30 September 2021, November 2021, Table 1a.; NHS Digital, General Practice Workforce 30 June 2021, August 2021, Table 1a.

Table 17 - Doctors in general practice in England, headcount, by role, September 2015 to 2021[6].

Headcount	Sept 2015[7]	Sept 2016[7]	Sept 2017	Sept 2018	Sept 2019	Sept 2020	Sept 2021
All Doctors in General	comparable data not	comparable data not	comparable data not	41,593	43,047	44,298	45,681

[6] Following a methodological change introduced in June 2021, these figures no longer include fully estimated records when a practice provided no or invalid data. These figures still include partially estimated records where working hours were not recorded for an individual by using the national average for their job role.

[7] Figures from September 2015 and September 2016 should be treated with caution as the data submission rates from practices were appreciably lower than for subsequent reporting periods and the reported figures may be lower than the true picture.

Practice 2	available	available	available				
GP Partners	23,415	23,063	22,535	21,492	20,868	20,182	19,714
Salaried GPs	9,817	10,776	11,336	12,029	12,980	14,145	15,152
GPs in Training Grade	5,045	5,761	5,628	5,986	6,686	7,558	8,664
GP Retainers	165	171	211	309	482	572	634
GP Regular Locums 2	comparable data not available	comparable data not available	comparable data not available	2,367	2,501	2,275	2,101

Source: NHS Digital, General Practice Workforce 30 September 2021, November 2021, Table 1b. NHS Digital, General Practice Workforce 30 June 2021, August 2021, Table 1b. Headcount figures are not comparable across the time series due to changes in locum recording prior to March 2017.

Overall, the General Practice Workforce data show the number of doctors in general practice grew by 1,842 FTE from September 2019 to September 2021, an increase of 5.3% (2,634 or 6.1% increase by headcount). This is driven by promising growth among salaried GPs and GPs in training. However, the number of FTE GP contractors has steadily declined over recent years. While this means there has been an overall loss in the number of FTE qualified permanent GPs (187 fewer FTE compared to September 2019), the number of headcount qualified permanent GPs has increased over the same period (a headcount increase of 773). This is due in part to differences in working patterns between partner and salaried GPs (see participation rates and part time working in Figures 19 and 20). A number of policy programmes are being undertaken to boost retention and increase participation, as outlined in the section on GP retention below.

Demographics of the GP workforce

The demographic makeup of the workforce by job role and gender is shown in Table 18. As at September 2021, there were more female doctors in general practice (19,078 FTE) than male (17,161 FTE); however, more males work as GP partners and locums.

Age distribution also varies with role (with salaried GPs and GPs in training making up a higher proportion of the younger workforce) and gender (with female doctors making up a higher proportion of GPs under 45 and a higher proportion of male GPs in older age bands). Differences in working patterns (see participation rates and part time working in Figures 19 and 20) between male and female workers are likely to impact workforce trends in FTE by role.

NHS Digital publishes ethnicity data for general practice. Of those recorded, as of September 2021, 16% of practice staff (36% of GPs) identified themselves as from a BAME background.

Table 18 - Doctors in general practice FTE by job role and gender, September 2021[8]

FTE	All	% of All GPs by type	Male	% of all Male GPs by type	Female	% of all Female GPs by type	Unknown	% of all unknown GPs by type
GP Partners	16,922	46.7%	9,981	58.2%	6,935	36.4%	6	17.1%
Salaried GPs	9,678	26.7%	2,994	17.4%	6,669	35.0%	15	42.9%
GPs in Training Grade	8,576	23.6%	3,668	21.4%	4,895	25.7%	12	34.3%
GP Retainers	252	0.7%	51	0.3%	200	1.0%	0	0.0%
GP Regular Locums	848	2.3%	467	2.7%	379	2.0%	2	5.7%
All Doctors in General Practice	36,275	100%	17,161	100%	19,078	100%	35	100%

Source: NHS Digital, General Practice Workforce 30 September 2021, November 2021, Table 1a.

GP part-time working and participation rates

Participation rates are used to measure the extent of part-time working in the GP workforce. They are defined as the ratio of full-time equivalents to headcount, and vary by job type, age and gender. Participation rates as of September 2021 are shown by role and

[8] Following a methodological change introduced in June 2021, these figures no longer include fully estimated records when a practice provided no or invalid data. These figures still include partially estimated records where working hours were not recorded for an individual by using the national average for their job role.

gender in Table 19 and by age and gender in Table 20. A full-time working week is considered to be 37.5 hours.

Participation rates are lower for female GPs in each job role and in every age band. Contractor GPs and GPs in training have the highest participation rates regardless of gender; regular locums and retainers have the lowest. GPs in Training Grade participation rates appear to be higher as a trainee's full-time contract is 40 hours, compared to the standard full time salaried/contractor GP contract which is 37.5 hours.

Table 19 - General Practitioner participation rate by gender and job role, September 2021[9]

Practitioner type	Male (%)	Female (%)	All (including unknown) (%)
GP Partners	93.1	77.2	85.8
Salaried GPs	70.3	61.3	63.9
GPs in Training Grade	103.8	95.6	99.0
GP Retainers	42.4	39.0	39.7
GP Regular Locums	43.0	37.5	40.3
All doctors in general practice	88.3	72.8	79.4

Source: NHS Digital, General Practice Workforce 30 September 2021, November 2021, Tables 1a and 1b.

Table 20 - Doctors in general practice participation rate (excluding locums and registrars) by age and gender, September 2021[9]

Age Band	Male (%)	Female (%)	All (Including unknown) (%)
Under 30	105.4	102.3	103.5
30-34	88.1	78.3	81.9
35-39	84.0	69.0	74.1
40-44	88.4	66.1	74.9
45-49	89.6	68.3	77.1
50-54	89.5	70.2	79.0
55-59	90.0	71.0	80.9
60-64	80.4	67.0	75.7
65 and over	78.3	69.3	76.0
Unknown	67.6	60.4	63.2
All	88.3	72.8	79.4

Source: NHS Digital, General Practice Workforce 30 September 2021, November 2021, Tables 1a and 1b.

[9] Following a methodological change introduced in June 2021, these figures include partially estimated records where working hours were not recorded for an individual by using the national average for their job role

Staff movement

We have previously included GP workforce vacancy rates by job role. However, data quality is poor, due to low completion rates. As a result, NHS Digital have not published this information since September 2019 and so we are not able to include information on vacancy rates in our evidence submission for this year.

Similarly, NHS Digital's experimental data on the number of joiners and leavers in general practice have not been updated since the publication covering 30 September 2019 to 30 September 2020, due to the ongoing review of changes to the General Practice Workforce data methodology.

GP locums

Whereas many locum GPs work for practices on a long-term or regular basis, for example maternity cover or a regular weekly or monthly session, "ad-hoc" locums are those who work on a less regularised basis, such as covering sessions at short notice.

As part of the methodological changes implemented in the June 2021 publication to facilitate the move to monthly practice workforce reporting, ad hoc locum GP figures were removed from the main publication and instead included in an annex. Figures for ad-hoc locums are collected and calculated differently to the rest of the General Practice workforce which includes regular locums, in that they represent ad hoc locum use across the whole quarter, rather than a snapshot of the general practice workforce.

The number of regular locums, as at 30 September 2021 was 848 FTE (2,101 headcount). There were an additional 270 FTE ad hoc locums working in general practice during September 2021 (1,401 headcount, 394 of whom worked in another general practice role during the reporting period).

Other primary care staff

The 5-year GP contract seeks to address workload pressures and provide full reimbursement of additional staff in PCNs via the ARRS. Growing the general practice workforce with 26,000 more primary care professionals, including clinical pharmacists, social prescribers, physiotherapists and dieticians, will mean bigger teams of staff providing a wider range of care options for patients.

To complement the general practice level workforce data, since March 2020, NHS Digital have separately published quarterly statistics on the workforce in PCNs, which are labelled as "experimental". As at September 2021, there were 2,373 more FTE direct patient care staff, such as physiotherapists, social prescribers and pharmacists working in general practice compared to September 2019. Additionally, as at September 2021, 7,420 FTE

direct patient care staff have been employed in Primary Care Networks since July 2019, though due to data quality issues, this is likely to be an underestimation.

Table 21 - All staff working in general practice by FTE[10].

FTE	September 2015	September 2016	September 2017	September 2018	September 2019	September 2020	September 2021
All Staff	113,288	122,168	123,090	125,693	129,873	132,366	137,119
All Staff excluding GPs	80,232	87,632	88,771	91,896	95,440	97,210	100,844
GPs	33,056	34,537	34,320	33,796	34,433	35,155	36,275
Nurses	14,240	15,155	15,561	15,925	16,261	16,361	16,183
Other Direct Patient Care	8,565	9,653	10,046	10,863	11,980	12,985	14,353
Admin / non-clinical	57,427	62,824	63,164	65,108	67,199	67,865	70,308

Source: NHS Digital, General Practice Workforce 30 September 2021, November 2021, Table 1a.; NHS Digital, General Practice Workforce 30 June 2021, August 2021, Table 1a.

Table 22 - All staff working in general practice by headcount[10].

Headcount	September 2015	September 2016	September 2017	September 2018	September 2019	September 2020	September 2021
All Staff	comparable data not available	comparable data not available	comparable data not available	173,049	178,799	181,394	186,730
All Staff excluding GPs	118,006	127,437	128,257	131,481	135,777	137,131	141,118
GPs	comparable data not available	comparable data not available	comparable data not available	41,593	43,047	44,298	45,681
Nurses	21,228	22,166	22,436	22,884	23,374	23,403	23,071
Other Direct Patient Care	13,463	14,838	15,336	16,224	17,614	18,753	20,480

[10] Following a methodological change introduced in June 2021, these figures no longer include fully estimated records when a practice provided no or invalid data. These figures still include partially estimated records where working hours were not recorded for an individual by using the national average for their job role.

Admin / non-clinical	83,657	90,805	90,882	92,759	95,108	95,310	97,958

Source: NHS Digital, General Practice Workforce 30 September 2021, November 2021, Table 1b.; NHS Digital, General Practice Workforce 30 June 2021, August 2021, Table 1b. GP headcount figures are not comparable across the time series due to changes in locum recording prior to March 2017.

Dental workforce data

DHSC does not hold information on vacancies, supply of dentists or status of contracts. NHSEI, as commissioners of dental services are better placed to respond to this.

NHSEI is responsible for commissioning NHS primary care dental services from providers to meet local dental needs in England. Providers are individuals or corporate bodies who hold a contract with the NHS.

NHS dentists can be either performer only (also known as associates), who subcontract with or are employed by dental contract holders to deliver NHS dentistry) or provider-performers (contract holders who perform NHS dentistry). Dentists can also offer private care alongside NHS services.

NHS Digital publishes data on the number of dentists who have delivered NHS dentistry in any given financial year. This is based on data from NHS Business Service Authority who process dental payments and forms. Figures are shown in Table 23.

Due to a change in methodology used to determine dental type for dentists in England and Wales, figures in this publication are not comparable to results published prior to 2018-19.

Table 23 - Number of dentists with NHS activity by dentist type, 2007-08 to 2020-21

Year	Total	Providing-Performer	Performer only/associates
2007-08	20,815	7,286	13,529
2010-11	22,799	5,858	16,941
2011-12	22,920	5,099	17,821
2012-13	23,201	4,649	18,552
2013-14	23,723	4,413	19,310
2014-15	23,947	4,038	19,909
2015-16	24,089	3,449	20,640
2016-17	24,007	2,925	21,082
2017-18	24,308	2,555	21,753
2018-19*	24,545	4,954	19,550

2019-20*	24,684	4,863	19,781
2020-21*	23,733	4,682	19,026

source: NHS Dental Statistics for England – 2020 to 2021 Annual Report - NHS Digital

*Methodology changed in these years, figures are not comparable to earlier years. The refer to ENGLAND Only. There was a small number of dentists in these years where it was unknown whether they were a providing-performer or associate.

From 2019-20 to 2020-21 the total number of dentists actively delivering NHS services decreased from 24,684 to 23,733 (3.9% decrease). During this period, both the number of providing-performers and the number of performer only (or 'associate') dentists fell. A new methodology for determining dentist type implemented for 2018-19 onward resulted in many dentists being reclassified as Providing-Performer. There are now 3 years of comparable data.

The percentage of dentists (undertaking NHS activity submitted by FP17 forms to NHS BSA detailing dental activity data) who are female has increased from 43.5% in 2010-11 to 51.8% in 2020-21, a slight increase from last year. There are more female dentists than male dentists aged 35 and under (59.1%) and aged between 35 and 44 (57%). However, male dentists disproportionately represent those aged 55 and above, making up 70.4% of dentists in this age group.

In addition, the greatest fall in the number of dentists by age can be seen in the under 35 age group, with 399 (4.2%) fewer dentists in this age range in 2020-21 compared to the previous year.

There has been a 3% decrease in the proportion of dentists aged 45 to 54 from 2010-11 to 2020-21 and a 3% increase in the proportion of dentists aged between 35 and 44 undertaking NHS activity over the last 10 years.

Recruitment and retention

HCHS reasons for leaving

Reasons for leaving are collected within ESR and provide an insight for some aspects of staffing motivation but any conclusions drawn need to be mindful of a continually increasing rate of an 'unknown' reason being recorded, up to over 45% of total reasons for leaving by 2020-21.

The most commonly specified reason for leaving is staff reaching the end of a Fixed Term Contract, making up almost 30% of total reasons for leaving in 2020-21. However, this is linked to doctors in training moving training posts. The number, and proportion, of

voluntary resignations has reduced until the current year, though what effect the level of unknowns has on this figure is unclear. Among those leaving voluntarily the most common reasons are relocation, promotion and work life balance.

The General Medical Council found that over half of doctors who have left (55%) are still working clinically abroad, while around a quarter of doctors are likely to return (24%), however, for the majority (59%) we can be confident they will not return, as they said they are both unlikely and unwilling to return.

Of those who are likely to return, just 10% are currently in the UK, while the remaining 90% are currently abroad, the vast majority of whom are currently working clinically (93%).

The GMC found the reasons for leaving are very varied with a mix of more 'neutral' reasons, such as returning to their country of previous residence (32%) and retiring (26.8%), and more negative reasons, such as burnout (27.2%) and dissatisfaction (35.7%). Other less-common reasons are also noteworthy, including bullying (5.5%) and harassment (3.1%).[11]

Table 24 - Reasons for Leaving among HCHS doctors in percentage and numbers

Reason for leaving (%)	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Dismissal	0.4%	0.4%	0.4%	0.4%	0.3%	0.3%
Employee Transfer	1.5%	1.0%	1.0%	3.7%	1.1%	1.4%
End of Fixed Term Contract	29.9%	25.0%	23.2%	22.6%	19.9%	18.3%
End of Fixed Term Contract - Completion of Training Scheme	7.6%	6.1%	5.3%	5.4%	4.9%	3.8%
End of Fixed Term Contract - End of Work Requirement	1.5%	1.3%	1.2%	1.2%	1.1%	1.0%
End of Fixed Term Contract - External Rotation	12.9%	10.4%	9.1%	6.8%	6.8%	6.2%
End of Fixed Term Contract - Other	3.4%	2.6%	2.4%	1.8%	2.0%	2.2%
Mutually Agreed Resignation	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%

[11] General Medical Council – Completing the Picture Survey October 2020

Others	0.4%	0.4%	0.3%	0.2%	0.4%	0.6%
Redundancy	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%
Retirement	5.3%	5.6%	5.6%	4.8%	5.3%	5.8%
Voluntary Resignation	19.4%	17.5%	17.3%	14.6%	15.9%	14.7%
Unknown	17.4%	29.4%	34.1%	38.4%	42.1%	45.4%
Reason for leaving (numbers)	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Dismissal	88	69	65	71	53	56
Employee Transfer	298	169	164	673	195	245
End of Fixed Term Contract	5,986	4,026	3,855	4,148	3,439	3,144
End of Fixed Term Contract - Completion of Training Scheme	1,526	985	875	993	851	657
End of Fixed Term Contract - End of Work Requirement	306	216	198	218	197	175
End of Fixed Term Contract - External Rotation	2,592	1,685	1,503	1,259	1,182	1,070
End of Fixed Term Contract - Other	678	413	398	324	353	381
Mutually Agreed Resignation	19	9	6	3	3	9
Others	89	62	47	36	66	96
Redundancy	35	31	25	34	26	22
Retirement	1,059	908	925	891	917	995
Voluntary Resignation	3,883	2,817	2,870	2,686	2,750	2,531
Unknown	3,481	4,746	5,668	7,052	7,283	7,791
All Reasons for Leaving	20,040	16,136	16,599	18,388	17,315	17,137

HCHS vacancies

There are multiple measures for vacancies which NHS Digital collate as an experimental statistic. As part of that series, NHSEI undertake a monthly workforce data collection from NHS Trusts, which includes data on staff in post (including bank and agency) and vacancies. This is the considered the best available measure presently and helpful as

represents the variance between the reported whole-time equivalent (WTE) substantive staff in post and planned workforce levels. Tables are published by NHS Digital.

The vacancy rate for medical staff has shown large variation over the last 3 years, ranging from 4.8% to 9.0%, which is equivalent to vacancies of over 6,600 to over 11,600 as shown in Table 25.

NHS Digital also highlight that these experimental statistics should be treated with caution especially considering disruption from the COVID-19 pandemic. NHS Digital say:

> "Due to the COVID-19 pandemic, there has been a significant disruption to recruitment activity within the NHS. This is apparent from the significantly lower reported advertised vacancies between March and June 2020 as the NHS was fully focused on dealing with the pandemic and the typical seasonal pattern not shown.
>
> "Whilst some critical recruitment increased in response to the situation, other elements were significantly reduced – this is particularly the case for certain Staff Groups. However, we believe that the headline figures included in the bulletin remain of immediate use, as they represent the situation as it was at the time, but year on year comparisons should be avoided."

Vacancies should reflect the headroom for sickness absence, maternity leave and temporary staffing which a trust is expecting to require. Bank and agency staff are used to cover some vacancies, in addition to covering sickness absence and long term leave.

Some further information on geographic and specialty specific recruitment for doctors and dentists in training is covered in Chapter 7.

Table 25 - Medical Vacancies (FTE and Rate) 2018-19 Q1 to 2021-22 Q2 (Source NHSEI quarterly vacancy statistics publication)

Medical Staff	Vacancy Rate	WTE Vacancies
18-19 Q2	7.7%	9,743
18-19 Q3	7.1%	8,989
18-19 Q4	7.2%	9,181
19-20 Q1	9.0%	11,630
19-20 Q2	7.0%	9,247
19-20 Q3	6.7%	8,876
19-20 Q4	6.3%	8,338
20-21 Q1	6.0%	8,075
20-21 Q2	5.3%	7,262
20-21 Q3	5.1%	6,954
20-21 Q4	4.8%	6,634

21-22 Q1	7.0%	9,676
21-22 Q2	5.9%	8,333

GP recruitment

To boost recruitment, we have increased the number of GP training places. The highest ever number of doctors accepted a place on GP training this year, a record 4,000 trainees. Table 26 shows the growth in the number of GP training places available and accepted since 2014.

The GP training model is undergoing reform to support better training for GPs and a more balanced distribution of trainee capacity across the NHS. GP registrars have traditionally spent around half of their 3-year training working in general practice, but this proportion is increasing to 2 years in general practice placements, through a phased approach.

HEE and NHSEI have introduced schemes to attract more doctors to GP speciality training including the “Choose GP” advertising campaign and the Targeted Enhanced Recruitment scheme (TERs). TERs is a national incentive scheme that funds a £20,000 salary supplement to attract trainee GPs to work in areas of the country where training places have been unfilled for a number of years. This reflects the fact that trainees who are attracted to these areas by the scheme usually stay on after training. Additional government investment has seen the number of places on the scheme expand to 500 in 2021-22 and this will grow to at least 800 in 2022-23.

Table 26 - GP speciality training places available, accepted and fill rate

GP speciality training	2014	2015	2016	2017	2018	2019	2020	2021
Places available	3,067	3,117	3,250	3,250	3,250	3,250	3,750	4,000
Acceptances	2,671	2,769	3,019	3,157	3,473	3,540	3,793	4,000
Fill rate	87%	89%	93%	97%	107%	109%	101%	100%

Source: Health Education England, General Practice ST1 Recruitment Figures

GP retention

The updated GP Contract Framework announced a number of new retention schemes alongside continued support for existing schemes for the general practice workforce. These include the GP Fellowship Programme, the Supporting Mentors Scheme, the New to Partnership Payment, The GP Retention Scheme and The GP Return to Practice Programmes (formerly combined with the GP International Induction Programme to form the National GP Induction and Refresher Scheme).

Despite the pandemic potentially limiting the capacity of GPs and practices to engage with the schemes, initial take-up has been strong. All newly qualified GPs now have the offer of joining the 2 year the GP Fellowship Programme on qualification, supported by experienced GPs trained as mentors through the Supporting Mentors Scheme. The National GP Retention Scheme had 634 doctors on the scheme as at 30 September 2021 by headcount, contributing 252 FTE. In addition to the GPs who have returned to practice on the Return to Practice Programme, hundreds of retired GPs also signed up to return to work to support the COVID-19 response via the NHS 111 COVID-19 Clinical Assessment Service. The GP Return to Practice programme has simplified the process for these GPs to return to longer-term practice and now offers support for the costs of childcare and caring responsibilities for all returning GPs.

In December 2020, NHSEI launched their primary care flexible staff pool scheme, which aims to increase capacity in general practice and create a new offer for local GPs wanting to work flexibly with the benefits of a salaried position. Integrated Care Systems can receive up to £120,000 each to implement virtual pool arrangements at pace, to engage and deploy local GPs flexibly. There is local autonomy to agree the delivery model, which is supported by NHSEI thorough national guidance, engagement with GPs to promote the scheme and optional enablers (such as a template contract and a digital suppliers framework).

We continue to work with our partners and the profession to understand further options for improving recruitment and retention of the GP workforce.

Older GPs leaving the profession

According to analysis of NHS pensions scheme membership, of the GPs taking their pension for the first time (all reasons), the proportion doing so on a VER basis increased from 17.2% in 2007-08 to a peak of 60.8% in 2016-17 (see Table 27 for further detail). The proportion taking VER has dropped slightly since but has remained high at 58.6% in 2020-21 (704 VERs of 1,201 of all those taking their pension for the first time).

However, this is not a measure of retirement, but a measure of GPs taking their pension and anecdotally, we know some GPs will take their pension and return to the workforce (retire and return). We do not have robust data on the number of GPs that take their pension and remain in the workforce, and if they do stay in the workforce, in what capacity this is, including job role. Further information on pensions is outlined in chapter 6.

Table 27 - The number of GPs taking their pension for the first time (NHS Business Services Authority analysis of 1995 pensions scheme membership)

Pension year (1 April to 31 March)	Total number of GPs* claiming VER pensions	Number of GPs in total claiming NHS pensions**	% taking VER

2007-08	198	1,154	17.2
2008-09	264	1,305	20.2
2009-10	322	1,427	22.6
2010-11	443	1,556	28.5
2011-12	513	1,545	33.2
2012-13	591	1,412	41.9
2013-14	746	1,505	49.6
2014-15	739	1,438	51.4
2015-16	695	1,327	52.4
2016-17	724	1,190	60.8
2017-18	587	1,035	56.7
2018-19	605	1,093	55.4
2019-20	596	1,102	54.1
2021-21	704	1,201	58.6

Source: NHS Business Services Authority analysis of the number of GPs taking their pension for the first time (1995 pension scheme only). *There will be a very small number of Ophthalmic Medical Practitioners included. **Includes all types of NHS pensions awarded to GPs (That is, normal age, VER and ill-health).

HCHS diversity analysis

The NHS Workforce is more ethnically diverse than the wider economy. Across the Medical workforce about 48% of the workforce is White with a further 5% Black or Black British and, 28% Asian or Asian British. There are currently just under 8% of the workforce with Unknown or Not Stated Ethnicity. BAME representation in the workforce has been increasing slightly over the past 5 years.

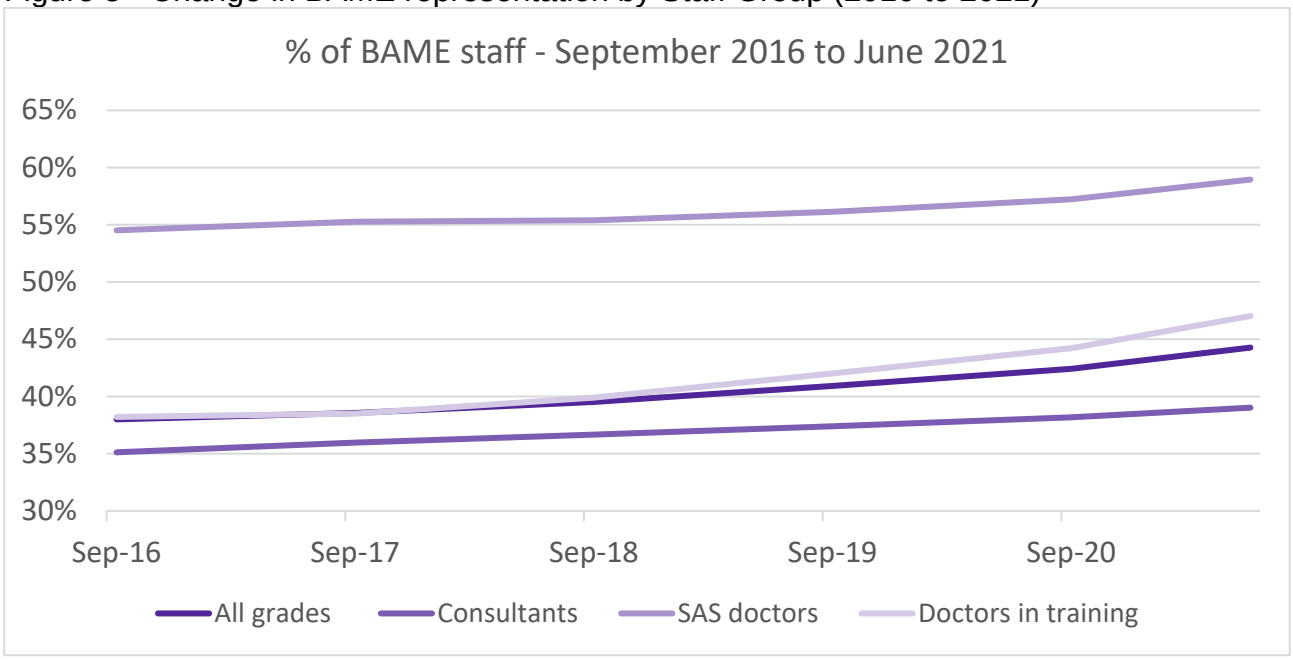
Table 28 - Ethnicity makeup of Medical NHS roles

June 2021 (Headcount)	Asian or Asian British	Black or Black British	Chinese	Mixed	White	Any Other Ethnic Group	Not Stated	Unknown and Discontinued codes
All grades	28.69%	5.15%	2.41%	3.39%	47.86%	4.63%	6.16%	1.71%
Consultant	27.98%	2.89%	2.10%	2.47%	55.33%	3.59%	4.78%	0.86%
Associate Specialist	40.08%	4.49%	0.61%	3.12%	37.30%	7.55%	5.76%	1.09%
Specialty Doctor	40.33%	7.36%	0.85%	3.56%	32.97%	7.75%	5.92%	1.26%

Staff Grade	35.47 %	6.69%	1.16%	4.36%	34.01 %	6.69%	9.59%	2.03%
Specialty Registrar	27.06 %	7.35%	3.10%	4.18%	43.90 %	5.30%	6.86%	2.25%
Core Training	30.30 %	8.06%	2.66%	4.71%	39.23 %	5.77%	6.97%	2.30%
Foundation Doctor Year 2	27.51 %	4.56%	2.73%	3.68%	44.74 %	4.50%	9.74%	2.54%
Foundation Doctor Year 1	24.22 %	4.75%	3.90%	4.11%	47.29 %	3.36%	8.21%	4.18%
Hospital Practitioner / Clinical Assistant	17.95 %	1.72%	0.71%	1.25%	64.39 %	1.49%	8.20%	4.28%
Other and Local HCHS Doctor Grades	22.05 %	2.78%	1.58%	2.33%	60.80 %	1.58%	7.07%	1.81%

Source: NHS Digital HCHS monthly workforce publication - June 2021

Figure 5 - Change in BAME representation by Staff Group (2016 to 2021)



Source: NHS Digital Workforce Statistics

Gender balance in the medical workforce

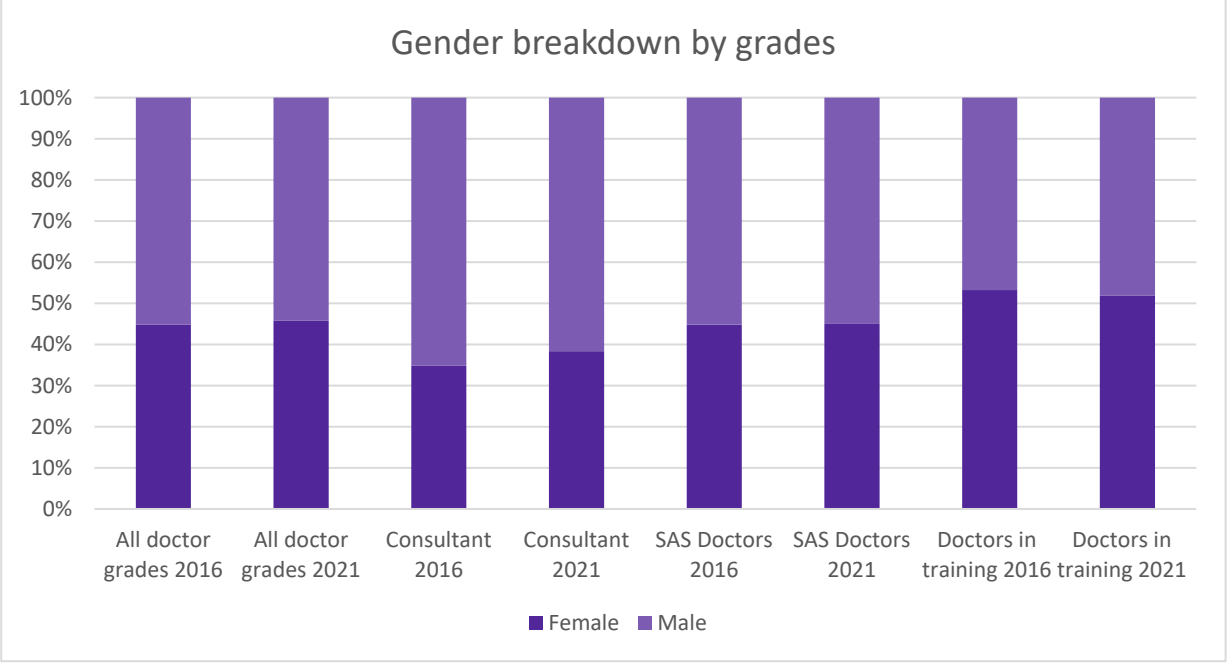
Data from June 2021 shows that just under 46% of the Medical workforce are female. The proportion of female staff varies by grade with higher proportions of female staff in at

Foundation Year 1 (57%), Foundation Year 2 (55%) and Speciality Registrar (52%). Compared to the rest of the Medical grades, Males have higher representation at Consultant grade (61%), and Associate Specialist (60%). The proportion of female staff has slightly increased over the past 5 years.

Table 29 and Figure 6 - Workforce Gender Representation by Doctor Grade (June 2021)

June 2021 (Headcount)	Female	Male
All doctor grades	45.73%	54.27%
Consultant	38.34%	61.66%
Associate Specialist	39.33%	60.67%
Specialty Doctor	46.67%	53.33%
Staff Grade	40.70%	59.30%
Specialty Registrar	51.90%	48.10%
Core Training	47.92%	52.08%
Foundation Doctor Year 2	55.60%	44.40%
Foundation Doctor Year 1	57.12%	42.88%
Hospital Practitioner / Clinical Assistant	51.01%	48.99%
Other and Local HCHS Doctor Grades	68.92%	31.08%

Source: NHS Digital Workforce Statistics



Temporary staffing

NHS Trusts use flexible staffing arrangements to efficiently manage the fluctuating demands of healthcare, which is regularly subject to unavoidable increases in demand. A temporary workforce market allows the NHS to meet demand fluctuations without the need to increase capacity above that which would be required on a sustained basis. Trusts use

their own banks (managed in-house or via management companies) and external agencies to resource extra temporary staff.

In response to an escalation in agency spend (NHS trust spending on agency staff rose by 40% between 2013-14 and 2015-16 from £2.6 billion to £3.6 billion) measures were introduced in 2015 to bring NHS agency spending under control. Price caps limiting the amount a trust can pay to an agency for temporary staff were introduced at 55% above basic substantive pay, as were the mandatory use of approved frameworks for procurement, and the requirement for all trusts to stay within the specified Annual Expenditure Ceilings for agency staff.

In 2019, NHSEI updated the agency rules to include two new policy initiatives requiring trusts to use only substantive or bank workers to fill admin and estates shifts (with exemptions for special projects, shortage projects, shortage specialties and IT staff) and requiring the use of on-framework agency workers to fill non-clinical and unregistered clinical shifts. These changes came into effect on 16 September 2019. For trusts, this will reduce cost and give greater assurance of quality. All of the above measures are regularly monitored for compliance and effectiveness.

The ‘Agency Rules’ have contributed to a reduction in spending on agency workers to £2.38 billion in 2019-20 compared to £3.6 billion in 2015-16. Agency spend in 2019-20 accounted for 4.0% of the overall NHS pay bill, down from 7.8% at its peak in 2015-16. The overall average price per agency shift decreased by 1.3% from 2018-19, resulting in an overall saving of £19 million (0.8%). The continued reduction in the proportion of agency staff costs to total pay bill is a significant achievement in view of the record levels of demand and the extreme pressure on the acute sector.

Data update for 2020-21 expected in NHSEI PRB submission.

Ongoing workstreams

The Department and NHSEI have created a flexible staffing strategy that aims to meet fluctuations in demand by building a flexible workforce that is sustainable, high quality and value for money for the NHS. We aim to support NHS providers to reduce their agency staff bills and encourage workers back into substantive and bank roles. This will help ease the financial pressure by developing and improving the trust’s strategy, procurement and commercial negotiation in their approach to temporary staffing. There are 3 workstreams:

- off-framework: Work in partnership with trusts, systems and our approved framework operators to reduce/eliminate off-framework supply into the NHS in order to give assurance on quality and value for money standards of the staff working via agencies

- price cap compliance: Continue to implement and monitor the Agency Rules with ongoing collection and analysis of data and working with ICSs and trusts to support intervention where necessary

- bank acceleration programme: Develop and deliver the Bank Programme and measure and report key programme outcomes. Increase the number of collaborative banks in England to reduce the reliance on agency by offering increased flexibility to bank staff. Increase transparency and collaborative working within the NHS to reduce competitive behaviours

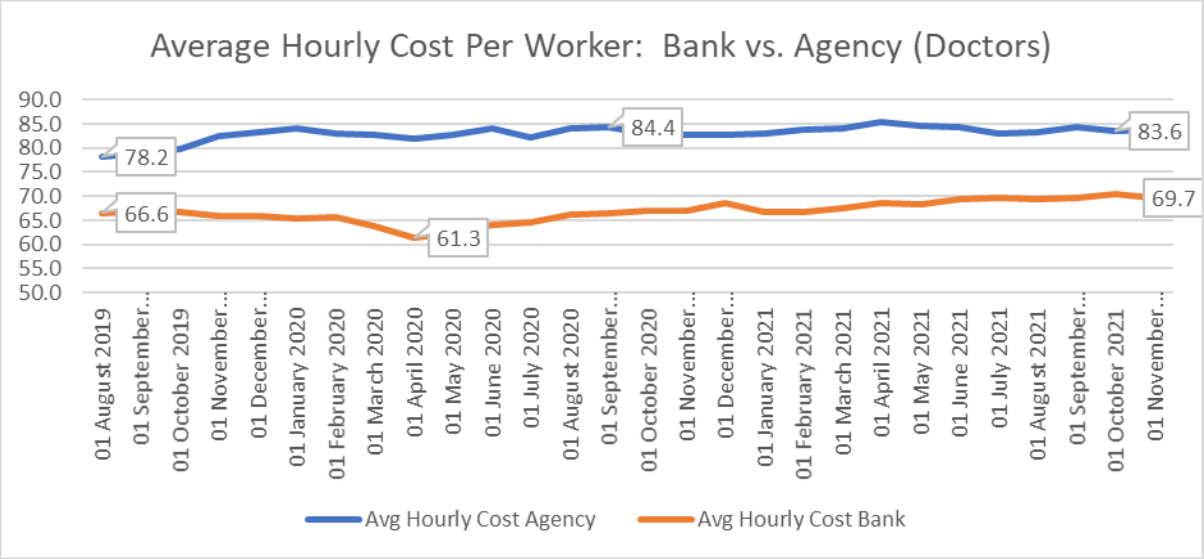
Data on temporary staffing

According to our anecdotal evidence and stakeholder research, doctors who choose to work through agencies cite flexibility, relatively higher pay, improved support systems, culture and a smaller admin burden as the main reasons for doing so. This is opposed to those who choose to work substantive shifts, who tend to cite involvement in teaching and research; learning and development; and predictable pay and hours. For bank shifts, 2 separate pieces of research conducted by NHSP on ‘Doctors Personas’ and ‘Nurses Personas’ revealed that pay and the ability to take control over the time, duration and place of shifts are the biggest attractions to bank work for most persona groups.

Data update for 2020-21 agency spend and shift numbers expected in NHSEI PRB submission.

Data from NHS Professionals (NHSP), who provide a managed bank service and cover more than 20% of the temporary staffing market, gives an indication of market trends. NHSP data on hourly rates of doctors working temporary shifts is shown in Figure 7, and shows that agency rates of pay are increasing faster than bank for this group. Market disruption during COVID-19 makes it hard to determine underlying trends, but the considerable rise in unfilled demand for flexible workers may contribute to agencies attempting to fill this gap by increasing pay rates.

Figure 7 - Average Hourly Cost Per Worker: Bank vs Agency (Doctors)

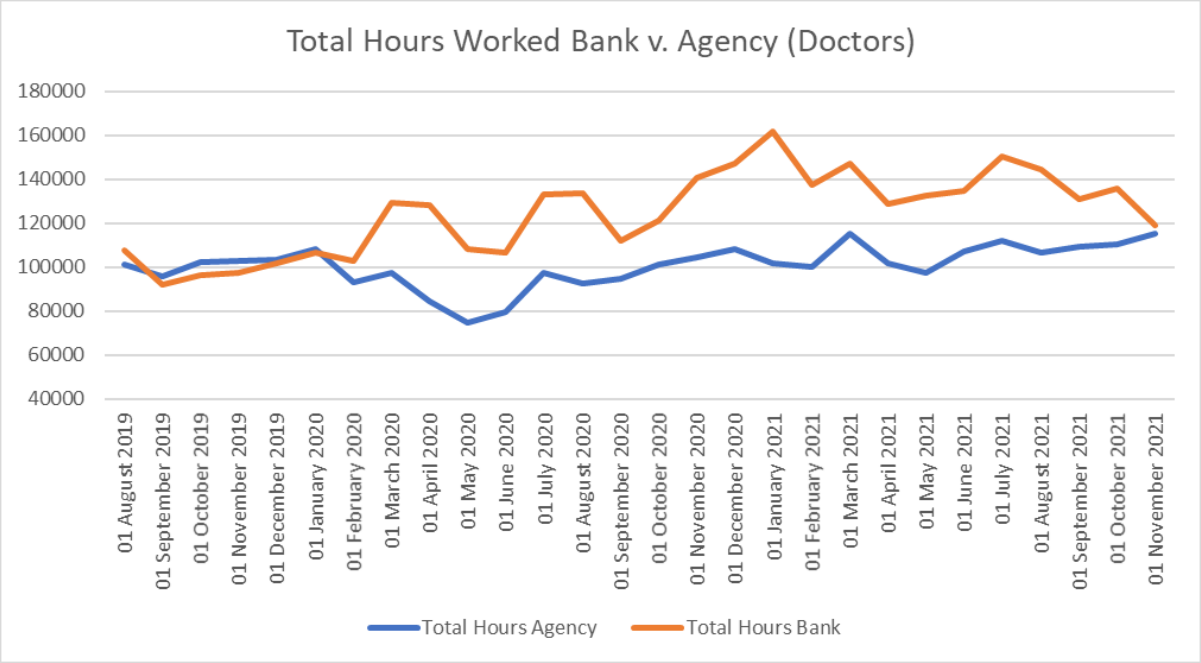


Source: NHSP

Figure 8 shows the total hours worked for doctors working via bank and agency for NHSP. Whilst there are peaks and troughs, there is an underlying upward trend in the total flexible bank hours supplied. There was also a shift from agency to bank, although the current trend suggests that the market may be returning to pre-COVID levels with a similar proportion of bank and agency shifts being supplied.

Trusts are required to procure agency staff via approved frameworks and within price caps, unless there are exceptional circumstances– known as ‘break glass’. Price cap compliance for all staff groups has remained constant at 60% since 2018; However, for the medical and dental staff group compliance is typically around 14%. The national shortages of medics in certain specialities (such as orthopaedics, geriatrics, cardiothoracic oncology and radiology) may contribute to poorer compliance rates amongst this group. This causes greater variability in hourly rates between on and off-framework spending: NHSP data shows that on-framework spending varies from around £85 to £90 an hour, whereas hourly agency costs for off-framework spend ranges from £42.13 in June 2021 to £124.57 in November 2021.

Figure 8 - Total Hours Worked Bank vs Agency (Doctors) (Source: NHSP)



COVID-19 impact on agency and bank

During the first wave of COVID-19 there was a significant decrease in agency shifts. The volume of shifts decreased by 15% in the first 5 months of 2020-21 and during this period trusts spent £0.91 billion on agency staff, which was 10% lower than the same period in 2019-20. Of this £0.91 billion, £0.36 billion related to Medical and Dental agency staff, down 9% from the same time last year. The percentage of medical agency staff paid within price cap between April and August 2020 was roughly the same as the corresponding period the previous year.

However, demand for agency staff has rebounded in response to the elective recovery phase and reinstatement of healthcare services.

Temporary staffing costs overall in 2020 to 2021 increased, mainly driven by increases in bank spend. Higher temporary staffing costs are being driven by both volume effects (more shifts) and price pressures. These are related because higher demand for staff generates a supply shortfall and will result in some price inflation. NHSEI will provide a data update for 2020-21 costs expected in their evidence.

Staff engagement and wellbeing

The NHS Staff Survey gives useful information about many aspects of staff experience at work. The published NHS staff survey results for 2015-20 is available at: http://www.nhsstaffsurveyresults.com/. National and local reports are available with summary briefing on specific themes such as health and wellbeing, staff morale and

bullying and harassment. NHSEI manages the NHS staff survey and will discuss the latest findings in their evidence to the review body.

Engagement

The "Staff Engagement" score in the Staff Survey is based on responses to 3 sections of the survey covering staff motivation and satisfaction, involvement and willingness to be an advocate for the service. This score can then be used to compare between different organisations.

Staff engagement scores have generally remained consistent over the last 5 years. The percentage of staff who would recommend their organisation as a place to work has increased year on year from 59.6% in 2017 to 66.8% in 2020.

Satisfaction with pay

Medical staff satisfaction with level of pay remains positive on balance. From 2016 to 2018 satisfaction fell slightly, however satisfaction with pay has rose in 2019 to 55% and to 56.9% in 2020. Satisfaction with pay has increased amongst Consultants, Junior Doctors, and Other Doctors.

Flexible working and additional hours

Overall, medical staff working any number of additional paid hours (in the average week) has remained fairly steady since 2015, although the percentage working additional paid hours has been increasing since 2016.

Sickness absence - HCHS

For the 12-months to the end of March 2021 the absence rate for medical staff was 1.65% which compares to 4.66% across all staff groups. The rate of sickness absence has been stable over the past decade, with rates between 1.16% and 1.29%. Increases in recent years in a large part due to the impact of the coronavirus pandemic. Data is available for the HCHS sector only (not for primary care).

Table 30 - Annual Sickness Rate for Medical Staff (2010-11 to 2020-21)

Year	Sickness Absence Rate
2010-11	1.16%
2011-12	1.19%
2012-13	1.25%
2013-14	1.22%
2014-15	1.21%

2015-16	1.23%
2016-17	1.25%
2017-18	1.29%
2018-19	1.29%
2019-20	1.49%
2020-21	1.65%

Source: NHS Digital Workforce Statistics

For the last 5 years, data is also available by career grade. In general, changes in individual grades' rates of absence have followed the pattern for the medical workforce as a whole. Where changes have been larger (for example, the Hospital Practitioner grade) these tend to be the staff groups with the smallest staff numbers (though doctors in training grades and consultants do have lower rates than SAS doctors).

Table 31 - Average sickness Absence rate by Staff Group (2016-17 to 2020-21)

Career Grade	2016-17	2017-18	2018-19	2019-20	2020-21
All HCHS doctors	1.25%	1.29%	1.29%	1.49%	1.65%
Consultant	1.18%	1.24%	1.24%	1.40%	1.54%
Associate Specialist	2.38%	2.88%	2.50%	2.79%	3.07%
Specialty Doctor	2.08%	2.11%	2.05%	2.37%	2.61%
Staff Grade	4.44%	3.37%	3.47%	1.97%	1.68%
Specialty Registrar	1.15%	1.19%	1.20%	1.44%	1.57%
Core Training	1.14%	1.09%	1.10%	1.38%	1.56%
Foundation Doctor Year 2	0.98%	0.99%	1.12%	1.22%	1.47%
Foundation Doctor Year 1	0.95%	0.97%	1.02%	1.25%	1.72%
Hospital Practitioner / Clinical Assistant	1.52%	1.38%	2.65%	2.69%	1.00%
Other and Local HCHS Doctor Grades	1.99%	2.20%	2.05%	2.25%	1.95%

Source: NHS Digital Workforce Statistics

Table 32 - Medical Sickness Absence by Region 2018-19 to 2020-21

Region	2018-19	2019-20	2020-21
England	1.3%	1.5%	1.6%
London	0.9%	1.1%	1.6%
South West of England	1.4%	1.6%	1.6%
South East of England	1.2%	1.4%	1.6%
Midlands	1.5%	1.6%	1.6%
East of England	1.3%	1.5%	1.6%
North West	1.5%	1.7%	1.6%
North East and Yorkshire	1.5%	1.6%	1.6%
Special Health Authorities and other statutory bodies	1.5%	1.5%	1.4%

Source: NHS Digital Workforce Statistics

The DDRB has previously requested more granular information on sickness absence for Medical Staff, including the length and reasons for absence. We have consulted with NHS

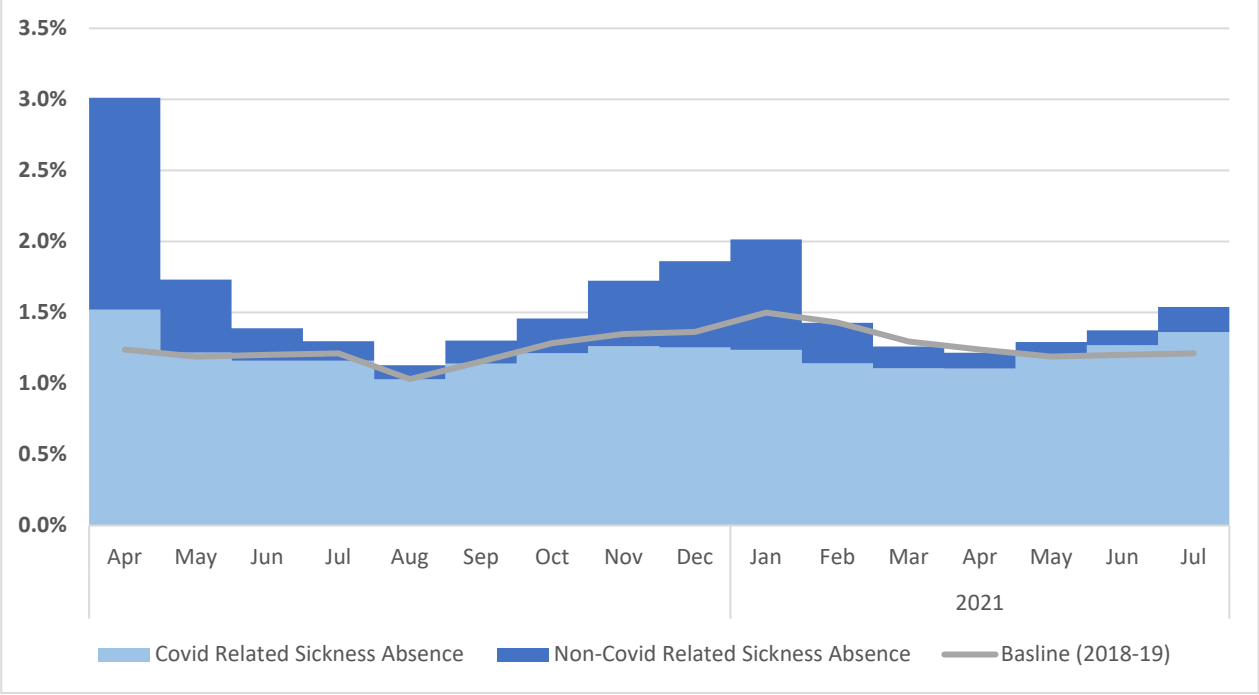
Digital and concluded that the quality and completeness of the data is not sufficiently robust to provide reliable insight to the Review Bodies. In addition, data on "length of absence" is not reliable as ESR only measures the time between the start and end of absence rather than ‘working days’ lost.

COVID-19 related sickness absence

NHS Digital data is available to describe trends in sickness absence during the ongoing response to the pandemic. Additional coding has been made available on the ESR for organisations to record against.

Figure 9 shows the ESR reported rates of absence for medical staff over the period of the pandemic split by those coded as COVID related or not. Peaks matching waves one and two of the pandemic can be seen with the underlying rate of non-COVID absence broadly mirroring that seen in the baseline year of 2018-19.

Figure 9 - Monthly Total Sickness Absence Rates by Staff Group



Source: NHS Digital Monthly Sickness Absence Statistics Publication

GP wellbeing and morale

The National GP Worklife survey is a regular series of studies, commissioned by the Department and carried out by the University of Manchester, that focusses on GPs’ experiences of their working lives, including job satisfaction, sources of pressure and job attributes. The 10th survey ran between November 2019 and April 2020, and showed that:

- overall GP satisfaction scores had increased since the last survey, from 4.25 in 2017 to 4.49 in 2019 (on a scale of 1-7). Each of 9 sub-domains of job satisfaction also increased to varying degrees in, with the biggest increase observed in remuneration. A high proportion of respondents still reported dissatisfaction with a number of aspects of their work, most commonly with their hours of work

- the pressure experienced as a result of common job stressors all decreased but varying amounts, however these all remain high, with increasing workloads the most common stressor

- average working hours (all clinical and non-clinical NHS GP-related work, including out of hours work) were shown to be 40 hours per week, a notable decrease of 1.8 hours per week since 2017. Of those surveyed, 37% said they were likely to quit direct patient care within 5 years. This was 63% among the over 50s and 11% of those below 50. Although the figures for all GPs and the under 50s are a slight reduction compared to 2017, there was a slight increase in intentions to quite for over 50s (+0.7%)

The findings largely precede the COVID-19 pandemic, which has put the NHS including general practice under a lot of pressure. The government is conscious of these pressures and acknowledge the feedback from the profession that this can put a considerable strain on morale across the workforce.

The government is taking action on a number of fronts including to reduce workload pressures, expand and diversify the general practice workforce, and tackle bureaucracy. These include NHSEI's package of GP retention schemes (see section on GP retention, above) and the ARRS scheme, which aims to free up more time for doctors to focus on those with more complex needs by diversifying the workforce (see GP section of Chapter 3).

The government and NHSEI have been undertaking a review of levels of bureaucracy in general practice as part of the 2020-21 GP contract agreement and considering what actions we can take to reduce bureaucracy and streamline existing processes to free up valuable time for patient care. The review is ongoing, and we are working closely with stakeholders such as the Royal College of General Practitioners (RCGP) and the BMA. Solutions to reduce unnecessary bureaucracy are being implemented as they emerge. Some changes have already taken place, for example, in March 2020, we introduced the Isolation Note to reduce the pressures on GP services from a surge in demands for Fit Notes for COVID-19 related absence. The Isolation Note functions as a COVID-19 bespoke alternative to the Fit Note, enabling employees to evidence absence from work.

The government will also reduce administrative burdens on GPs by looking at reforming who can provide medical evidence and certificates such as FIT notes and DVLA checks –

freeing up time for more appointments. In July 2021, the government set out plans to deliver fit note improvements. This includes both removing the requirement to sign fit notes in ink (from April 2022) and enabling a wider range of eligible professionals to sign fit notes (planned for summer 2022).

The provision of mental health services, such as NHSE&I and RCGP's #LookingAfterYouToo and the #LookingAfterYourTeam, is important for building resilience and reducing burnout in general practice. These coaching support services provide access to mental health services to all primary care workers, managers and leaders employed or contracted to deliver work on behalf of the NHS and aim to encourage psychological wellbeing and resilience in teams.

Many patients are unaware of the high administrative workloads GPs face alongside appointments – developing public awareness of GP workloads could foster public support for GPs and improve morale. The government's plan for improving access and supporting general practice aims to address the spread of disinformation around access to GPs and help patients understand how to access the care they need in general practice.

Impact of COVID-19 on the general practice workforce

General practice has played a central role in supporting their patients and communities throughout the COVID-19 pandemic and GPs and their teams have worked incredibly hard to provide care and deliver the COVID-19 vaccination programme.

By necessity, general practice adapted and ways of working changed almost overnight to keep providing vital services during the pandemic. However, recent increasing demand for GP appointments and a desire for more face-to-face appointments has led to pressures in general practice. Workforce shortages and a more complex workload in general practice have been exacerbated by the release of this pent-up demand which accumulated over the pandemic.

We are aware of the knock-on impact this has on workforce morale, which in some cases, has been further reduced by disgraceful and unacceptable incidences of staff facing abuse and violence while trying to do their jobs. We are also aware of the impact of COVID-19 on sickness absence rates amongst general practice staff, affecting capacity within general practice. This has highlighted the need for more robust data on the impact of COVID-19 on the general practice workforce.

Despite these issues, the GP Patient Survey 2021 reported that 83% of patients described their overall experience of their GP practice as good or very good and almost all patients (94%) felt that their needs were met during their last general practice appointment. Appointment numbers have now returned to pre-pandemic levels; excluding COVID-19

vaccinations, in November 2021 there were an estimated 1.39 million average appointments per working day in general practice, an increase of 6.0% from November 2019. The proportion of face-to-face appointments has also been steadily increasing since a low point in April 2020 (46.8%) following the first lockdown. In November 2021, 62.7% of all appointments (excluding COVID-19 vaccinations) were face to face.

In recognition of the challenges facing general practice, the government published 'Our plan for improving access for patients and supporting general practice' on 14th October. Measures include:

- a £250 million Winter Access Fund that can be used to fund more sessions from existing staff, to make full use of the digital locum pool framework, or to fund extra administrative staff. It will be for local commissioners to determine how this funding is distributed, in line with local conditions or issues

- expansion of the Community Pharmacist Consultation Service, which refers patients to highly qualified community pharmacists, on the same-day appointment in a community pharmacy

- additional funding to help NHS England drive full adoption of cloud-based telephony technology across all practices as rapidly as possible

- a £5 million fund to facilitate essential upgrades to practice security measures. We are also working with professional bodies and patient groups to stop the spread of disinformation around access to GPs, by developing communications tools that can help patients understand how to access the care they need in general practice

- expansion of the Access Improvement Programme, which is already working with over 900 practices experiencing the greatest access challenges, to accommodate 200 more practices

General Dental Practitioners (GDPs) wellbeing and morale

The Dental Working Patterns: Motivation and Morale 2018-19 and 2019-20 report was last published by NHS Digital in August 2020. Motivation is regarded as the internal drive of an individual, for example, inspiration or enthusiasm. Dentists were asked 6 motivation questions. For those who answered 'agree' or 'strongly agree', the difference in average motivation between 2018-19 and 2019-20 for Principles is -2.6%, compared to 0.6% for Associates.

They were asked 'How would you rate your morale as a dentist?' For those that answered 'high' or 'very high', the difference in average morale between 2018-19 and 2019-20 for Principles is 0.3%, for Associates the difference is 0.4%. Due to the methodological

changes, these results cannot be compared to previous years and refer to England only. This is shown in the table below:

Table 33 - Average motivation results; Average moral results 2012-13 - 2019-20

	Average motivation (%) Provider-Performer	Average motivation (%) Performer only	Average Morale (%) Provider-Performer	Average Morale (%) Performer only
2012-13	48.3	48.2	27.3	42.1
2013-14	45.7	48.8	27.2	42.7
2014-15	47.5	44.3	22.8	32.9
2015-16	45.1	45.3	22.2	33.4
2016-17	44.6	39.7	21.3	24.6
2017-18	42.1	39.3	20.1	24.9
	Principle	Associate	Principle	Associate
2018-19	43.5	39.8	20.4	25.2
2019-20	40.9	40.4	20.7	25.6

1. Average of 'strongly agree' or 'agree' responses to the motivation questions

2. Percentage of dentists who recorded their moral as 'very high' or 'high'

Morale generally relates to comfort and satisfaction. Associate dentists report higher morale than Principles (4.9% difference in morale between these 2 groups).

The relationship between age group and motivation/morale is confounded by the correlation between age of performers and other factors such as weekly hours, amount of annual leave and proportion of NHS work. It is difficult to determine any conclusive impact from these demographics.

Impact of COVID-19 on the dental workforce

The COVID-19 pandemic has had a significant effect on dentistry, with patient throughput in practices constrained by the specific risk of transmission present in many common dental procedures. These ‘aerosol generating procedures’ (AGPs), which create a fine spray of saliva, present a high risk of infection to those in direct contact with patients and for a short period of time after treatment concludes.

From the 25th March 2020 NHSEI asked all NHS dental practices to suspend all face-to-face routine care, with urgent dental care provided by 600 Urgent Dental Care Centres.

NHSEI continued to remunerate dentists in full through this period for their NHS contracted activity less a planned abatement of 16.75% (reflecting consumables not needed due to the absence of face-to-face care).

Dentists were able to re-open and provide face to face care from 8 June 2020, subject to capacity, availability of PPE and adherence to infection prevention and control (IPC) guidance. During the restart period NHSEI continued to remunerate in full with the expectation that practices would be delivering the equivalent of at least 20% of historic contracted patient activity up until 31 December 2020.

In light of changes to IPC guidance allowing the time needed to rest the room following AGPs to be reduced, NHSEI set a threshold of 45% contracted activity for dentists to receive their full remuneration during the final quarter of the 2020-21 financial year. Revised activity thresholds of 60% dental and 80% orthodontic activity were set for the first half of 2021-22, attainment of which triggered full payment of contractual value.

The activity threshold for quarter 3 was increased to 65% dental and 85% orthodontic activity.

Between January and March 2022 (quarter 4) the activity threshold increased to 85% dental and 90% orthodontic activity following new IPC guidance. No lower threshold applies, although mitigating circumstances, such as the impact of staff sickness, is considered through the exceptions process. For orthodontic contracts clawback is not applied to practices delivering at least 90% of contracted UOAs. The rate of clawback was also reduced linearly down to a lower threshold of 85% of UOAs. Below this lower threshold normal clawback applies.

The Department and NHSE/I recognise the importance of the health and wellbeing of NHS dentists and their teams. In response, NHS England and NHS Improvement have invested in additional mental health support which is available to all NHS dental teams. This includes the ‘Looking After You Too’ service. NHS Practitioner Health is also available to dentists including confidential 24/7 support via a dedicated phoneline and a crisis text service.

International workforce

At March 2021, 30% of doctors have a non-UK nationality (a further 2% have an unknown nationality). Doctors in the Specialty Doctor (50%) and Core Training (46%) grades are the most likely to hold a non-UK nationality while F1s (17%) and Consultants (20%) had lower than average rates of non-UK nationality. Table 34 shows the proportion of staff from different nationality groups are split between the different medical grades. Data is presented on a headcount basis. Data on Nationality is collected via the "Nationality" field on ESR. Nationality is self-declared and may differ from immigration or citizenship status.

Table 34 - HCHS Medical Staff by Nationality Group and Grade March 2021

Doctor Grade	All Nationalities	EU/EEA	Rest of World	United Kingdom	Unknown

All HCHS Doctors	132,113	8.6%	21.1%	68.3%	2.1%
Consultant	55,191	9.1%	11.3%	77.0%	2.7%
Associate Specialist	2,151	7.8%	24.0%	63.7%	4.6%
Specialty Doctor	8,959	10.3%	39.4%	47.3%	3.1%
Staff Grade	331	19.3%	33.8%	43.5%	3.3%
Specialty Registrar	34,223	8.3%	27.8%	63.1%	0.8%
Core Training	15,812	8.4%	37.6%	52.3%	1.7%
Foundation Doctor Year 2	6,282	7.2%	20.2%	71.3%	1.3%
Foundation Doctor Year 1	6,511	7.0%	10.3%	80.7%	2.0%
Hospital Practitioner / Clinical Assistant	1,705	3.6%	3.9%	87.6%	5.1%
Other and Local HCHS Doctor Grades	1,321	4.5%	5.6%	86.4%	3.6%

Source: NHS Digital Workforce Statistics

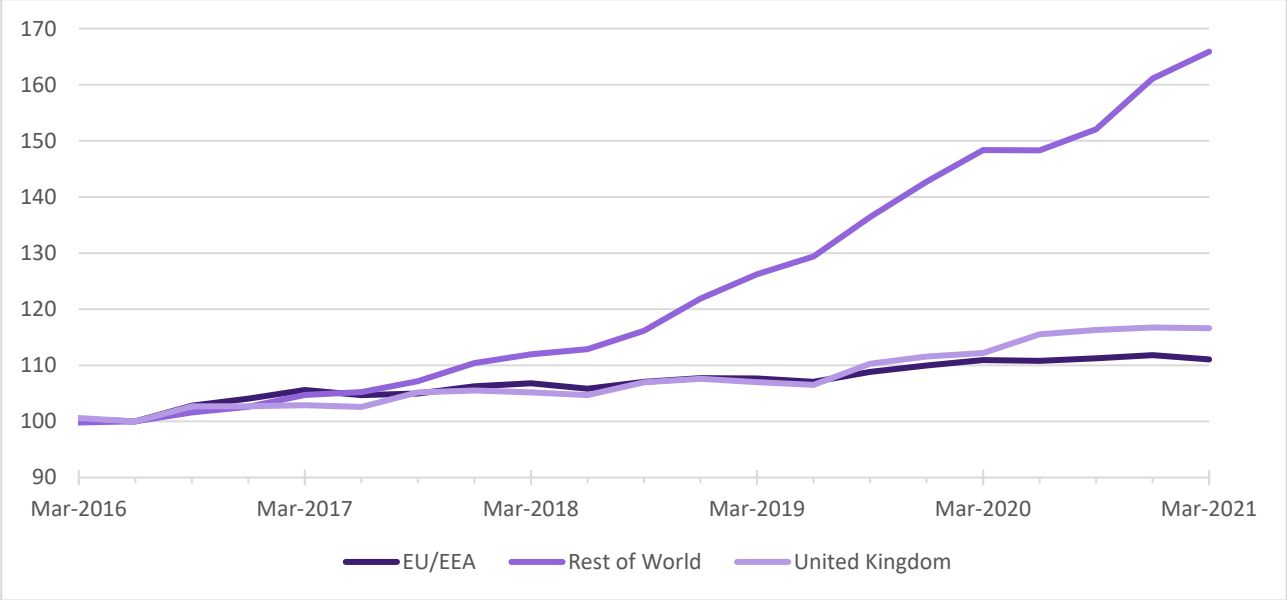
International staff benefit enormously from the opportunity to work in the NHS, both in terms of professional development and economically, and we have made it easier for those wanting to further their career to come to work in the NHS. Since 2015-16 the proportion of non-UK medical staff has increased from 24% in 2016 to 30% in 2021 as shown in Table 35.

Table 35 - Proportion of Doctors with Non-UK Nationality

Doctor Grade	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
All HCHS Doctors	24%	25%	25%	27%	29%	30%
Consultant	20%	20%	20%	20%	20%	20%
Associate Specialist	28%	28%	28%	28%	30%	32%
Specialty Doctor	45%	45%	46%	47%	48%	50%
Staff Grade	44%	48%	44%	41%	48%	53%
Specialty Registrar	30%	30%	30%	32%	34%	36%
Core Training	29%	31%	35%	40%	45%	46%
Foundation Doctor Year 2	17%	18%	20%	23%	25%	27%
Foundation Doctor Year 1	14%	16%	16%	16%	17%	17%
Hospital Practitioner / Clinical Assistant	8%	8%	7%	6%	8%	7%
Other and Local HCHS Doctor Grades	10%	10%	12%	11%	10%	10%

The growth is Rest of World nationalities has increased by 66% over the past 6 years and now represents about 21% of the total medical workforce. The number of medical staff with EU/EEA Nationality has increased by 11%.

Figure 10 – Growth of Medical Workforce by Nationality



Source: NHS Digital Workforce Statistics

Table 36 – Growth of Medical Workforce by Nationality

Date	All Nationalities	EU/EEA	Rest of World	United Kingdom
2015-16	110,732	10,260	16,785	77,843
2016-17	113,508	10,793	17,609	79,594
2017-18	116,605	10,914	18,829	81,365
2018-19	119,597	11,001	21,228	82,779
2019-20	126,286	11,338	24,950	86,795
2020-21	132,113	11,348	27,897	90,204

Source: NHS Digital Workforce Statistics

Internationally trained staff in eligible health and care roles (including doctors, nurses, allied health professionals and social workers) can migrate to the UK on the Health and Care Visa, introduced in August 2020. Applicants for this visa are guaranteed a decision within 3 weeks and pay reduced visa fees (£232). From August 2020 all health and social care staff are exempt from paying the Immigration Health Surcharge (£624 per year).

From January 2021 the UK introduced a new points-based immigration system to replace free movement from the EU. This system is global, meaning overseas recruits face the same immigration control whether they come from the EU or further afield.

Despite the ongoing uncertainty due to the COVID-19 pandemic and travel restrictions in place for some of the year, the internationally trained medical workforce continues to grow.

Table 37 - Proportions of all Medical Joiners by Staff Grade and nationality

Grade and Year	United Kingdom	EU/EEA	Rest of World

HCHS Doctors 2017	64.5%	11.8%	19.9%
HCHS Doctors 2021	60.5%	8.5%	28.7%
Consultant 2017	67.0%	17.3%	11.4%
Consultant 2021	69.7%	13.8%	14.0%
Associate Specialist 2017	54.8%	7.1%	28.6%
Associate Specialist 2021	43.5%	17.4%	37.0%
Specialty Doctor 2017	40.7%	15.9%	39.5%
Specialty Doctor 2021	32.5%	8.1%	54.8%
Staff Grade 2017	23.7%	23.7%	44.7%
Staff Grade 2021	19.1%	29.8%	51.1%
Specialty Registrar 2017	56.6%	14.5%	25.5%
Specialty Registrar 2021	58.2%	9.1%	31.6%
Core Training 2017	55.5%	10.2%	30.3%
Core Training 2021	45.8%	8.1%	43.5%
Foundation Doctor Year 2 2017	45.5%	16.3%	37.2%
Foundation Doctor Year 2 2021	25.5%	7.7%	62.4%
Foundation Doctor Year 1 2017	80.0%	6.9%	8.8%
Foundation Doctor Year 1 2021	81.0%	6.9%	10.2%
Hospital Practitioner / Clinical Assistant 2017	88.1%	3.9%	2.7%
Hospital Practitioner / Clinical Assistant 2021	80.1%	2.9%	4.6%
Other and Local HCHS Doctor Grades 2017	82.6%	4.8%	6.6%
Other and Local HCHS Doctor Grades 2021	89.3%	2.7%	4.7%

Source: NHS Digital Workforce Statistics

Supply and impact of Brexit

DHSC is undertaking preparatory work, planning for the new arrangements. Work continues with the Irish government to ensure cross-border recognition of qualifications is supported, now and after the end of standstill, and we are working closely with BEIS to represent the healthcare position in the upcoming Professional Qualifications (PQ) Bill and new trade negotiations.

Following the end of continued automatic recognition, the UK's regulators of healthcare professionals have in place arrangements to continue to register EEA and Swiss professional qualifications through established recognition routes accessible to international applicants. Regulators will also be able to create recognition agreements and establish specific recognition arrangements with countries around the world as they see fit. There is not currently a legislative mechanism through which it would be possible to offer automatic recognition to EEA/Swiss qualifications awarded pre-standstill.

In addition, the agreement between the UK and the EU includes a framework which supports professional regulators, to co-operate with EU equivalents to agree a process, if

they consider it appropriate, for recognising professional qualifications in one another's territories and form a UK-EU-wide Mutual Recognition Agreement (MRA). Regulators are also free to work with their counterparts in specific EU countries and establish regulator to regulator agreements which further the interests of UK workforce and patient safety.

The DHSC position on all healthcare professions is the same and is consistent with the cross-government position on professional regulation. We aim to avoid creating Mutual Recognition of Professional Qualifications (MRPQ) style arrangements in trade deals, and to create arrangements which provide space and structure for regulator led cooperation with all our trading partners. This is in order to increase regulator autonomy over acceptance of qualifications and to avoid committing regulators to arrangements which might undermine patient safety.

International registration process for dentists

The government recognises that registration processes for some internationally qualified dental professionals can be bureaucratic and inefficient.

The Department is currently working with the GDC on legislative proposals which will allow it greater flexibility to expand on the registration options open to international applicants. We plan to consult on these changes in early 2022.

As a result of the safety restrictions brought in as part of the COVID-19 response, the GDC suspended Parts 1 and 2 of the Overseas Registration Exam (ORE) last year. The Department is aware of the impact that the suspension of the ORE will have had on candidates waiting to sit the exam and has been in regular communication with the GDC regarding the situation.

The GDC recently announced that it plans to hold an ORE Part 2 sitting in January 2022. Current legislative framework restricts the GDC from offering ORE places to candidates where 5 or more years have passed since they attempted Part 1 of the exam, however, we are working with the GDC to develop a solution which will provide these candidates with additional time to take the Part 2 assessment in the future.

5. Earning and expenses

Earning and expenses summary

This chapter includes information on the pay and earnings for Doctors in England and covers staff working in the Hospital and Community Health Sector (HCHS), General Practice and the Dental sector. This covers staff working under the range of contracts that fall under the DDRB remit including Junior Doctors, SAS Doctors, Consultants, Independent Contractor GPs, Salaried GPs, Providing Performing and Associate GDPs and Salaried GDPs working across a range of NHS settings.

The chapter is composed of the following parts:

- an outline of the material that is explored in greater detail in earlier sections.
- the latest data on pay or earnings for different groups of medical staff (HCHS, GPs and Dentists) and how staff progress on different contracts
- comparisons of earnings for medical staff and the wider economy with a particular focus on high income professions.
- latest information on the Gender and Ethnicity Pay Gaps

More information on workforce strategy pertaining to each part of the workforce is in Chapter 3.

Introduction

In 2020-21 average earnings in HCHS increased by 2.7% (to over £82,700) which was slightly higher than increases in basic pay (2.4%) or basic pay per FTE (2.0%). The increase in earnings was seen across most career grades and contracts, is broadly consistent with recent pay awards.

While data for 2021-22 is not yet available we expect most staff will see total growth in earnings of around 3% as a result of existing multi-year agreements and the outcome of the 2021-22 DDRB process. This is expected to compare favourably to the wider public sector as the NHS was exempt from the public sector pay pause.

The latest available data on average earnings for GPs (combined contractor and salaried) showed an increase of 2.8% in 2019-20 compared to the previous year (to £100,700) and exceeds the agreed uplift for that year (negotiated through the GP contract). In 2019-20

(latest data available) the average taxable income of Providing Performer and Associate Dentists remained at £68,600 with no change. Some staff will have seen an increase in earnings during the pandemic if they were required to work additional hours to meet increased demand. This is dependent on the individual doctor and their specialty - other medics may have seen a reduction in activity if working in a specialty impacted by a reduction in elective activity.

There are ongoing multi-year agreements for some sections of the medical workforce in 2022-23:

- Junior Doctors will enter the fourth, and final, year of a multi-year agreement reached in 2019-20

- Specialty and Specialist Doctors on the new contracts introduced in 2021-22 will enter the second year of a 3-year agreement

- contractor GPs are subject to a 5-year agreement between the BMA and NHSEI, (however recommendations are being sought on uplifts to the minimum and maximum of salaried GP pay scales)

Doctors have a reasonable expectation of relatively high salaries and benefit from substantial pay progression and promotion as they develop expertise in their chosen specialty.

Doctors are high earners compared to the wider economy - Median average earnings for medical professionals are more than double the national average and are in the top 10 of occupations when ranked by median average earnings. This is without taking into account the total reward of NHS contracts. Data from the Office for National Statistics suggests earnings have remained competitive with comparator occupations during the pandemic although there are signs that earnings in the wider economy have recovered to pre-pandemic levels. While data for earnings growth in 2021-22 is not yet available we expect to see most staff experience total pay growth of around 3% due to existing multi-year agreements and the outcome of the 2021 DDRB process. This is likely to be favourable compared to the rest of the public sector as the NHS was exempt from the public sector pay pause.

There remains uncertainty about how labour markets will recover from the pandemic and its impacts on current labour market data. This should be borne in mind when interpreting the current evidence.

Pay and earnings for the HCHS workforce

Average earnings and recent growth

Basic pay for Doctors in the Hospital and Community Health Sector (HCHS) ranges from a minimum of £28,808 for Foundation Year 1 Doctors through to £114,003 for the most senior Consultants, with staff also having the ability to earn more if they complete more hours, work unsocial hours or receive Clinical Excellence Awards.

NHS Digital publish information on pay and earnings for the HCHS workforce in England. This data includes substantive staff who are directly employed by the NHS and does not include any locum or private sector earnings.

There are 3 principle measures of earnings which can be used dependent on the context being analysed:

- Total Earnings Per Person - This calculates the average earnings received per member of staff over the period. It does not adjust for part time working and so is effectively the total paid to staff divided by the total headcount

- Total Basic Pay Per Person - This calculates the average basic pay received per person over the period and does not adjust for part time working. It is the total amount of basic pay paid to staff divided by the total headcount

- Total Basic Pay Per FTE - The level of basic pay received is directly proportional to the number of hours worked. As such this measure calculates the average amount of basic pay if it is assumed that all staff were to work on a full time basis

- NHS Digital do not produce a "Per FTE" calculation for total earnings because earnings cannot be assumed to grow in direct proportion with hours worked in the same way as basic pay

Table 38 presents information for the different definitions for basic pay and total earnings, by medical grade, for the 12-month period to the end of March 2021 and growth compared to the previous 12-month period to the end of March 2020.

Table 38 - Average Basic Pay and Earnings for HCHS Medical Staff - 12 Months to March 2021

Grade	FTE (March 2021)	Basic Pay per FTE	Basic Pay per Person	Earnings per Person	Basic Pay per FTE Growth	Basic Pay per Person Growth	Total Earnings Growth
HCHS Doctors	124,078	£68,777	£62,975	£82,709	2.0%	2.4%	2.7%

Consultant	51,701	£98,010	£91,013	£117,981	2.9%	2.8%	3.1%
Associate Specialist	1,923	£89,282	£79,546	£93,147	2.2%	2.3%	-1.2%
Specialty Doctor	7,813	£66,952	£57,261	£69,723	3.1%	3.9%	2.3%
Staff Grade	292	£61,030	£52,395	£67,582	3.3%	6.8%	4.3%
Specialty Registrar	32,723	£45,742	£43,253	£61,002	2.9%	3.4%	3.6%
Core Training	15,511	£40,953	£39,542	£54,261	3.2%	3.7%	5.3%
Foundation Year 2	6,226	£32,388	£31,214	£43,123	2.5%	2.6%	5.4%
Foundation Year 1	6,483	£28,059	£27,130	£35,379	3.0%	1.9%	3.2%
Hospital Practitioners and Clinical Assistants	576	£118,959	£37,250	£39,988	1.5%	12.3%	11.9%
Other and Local HCHS Grades	831	£91,530	£52,909	£55,637	4.1%	4.4%	4.9%

Source - NHS Digital Earnings Statistics

The average increase in earnings for all HCHS Doctors was 2.7% which was slightly higher than the growth in both basic pay per FTE (2.0%) and basic pay per person (2.4%) This "additional earnings drift" is explored in more detail in the "pay drivers" section below.

The growth for individual medical grades ranges from -1.2% for Associate Specialists to 11.9% for the Hospital Practitioner and Clinical Assistant Grade but we stress caution when interpreting these results as the Associate Specialist grade has been closed to new entrants since 2008 and the HP/CA grade is very small (< 600 FTE) with staff employed via sessional contracts data on earnings in 2020-21 will not include the impact of changes to pay from April 2021 which included:

- an increase in basic pay of 3% for Consultants following the 2021 DDRB recommendation. There was no change to Clinical Excellence Awards in 2021-22

- an increase in basic pay of 2% for Junior Doctors following the 2018 Junior Doctor pay agreement and an increase of £3,000 to basic pay for the most experienced Junior Doctors (Nodal Point 5) from October 1st 2021. Combined with the other changes in the 2018 contract this results in total investment for Junior Doctors of 3%

- the new Specialty and Specialist Doctor contracts that came into operation at the start of 2021-22, more detail on the new SAS contract is in Chapter 3). Staff remaining on the old contract received a pay award of 3% in line with DDRB recommendations

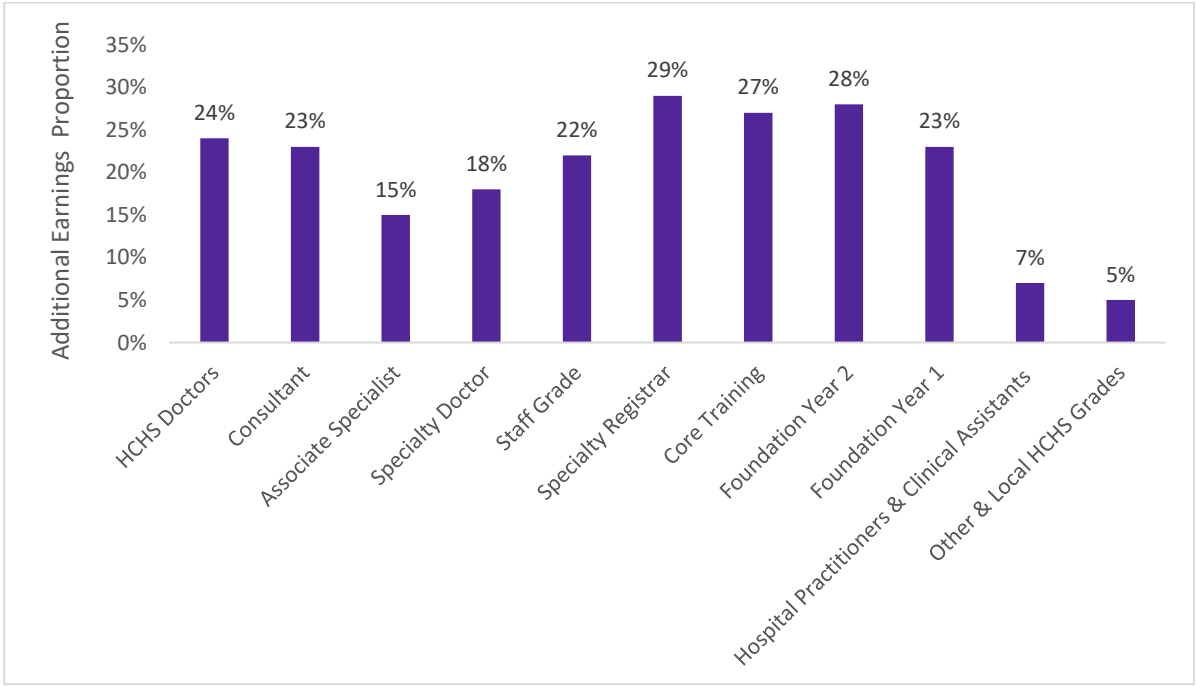
- based on known changes to the pay system it is reasonable to expect average earnings growth of around 3% in 2021-22 which compares favourably to the wider public sector as the NHS was exempt from the public sector pay pause.

Additional earnings

Additional earnings are the difference between basic pay and total earnings and can be earned by staff working additional hours, working at unsocial hours or by being in receipt of Clinical Excellence Awards.

There is additional interest in additional earnings this year due to the impact of Covid on earnings - Some staff will have seen an increase in additional earnings in 2020-21 if the requirements of the pandemic led them to work more hours than usual. However, this will not have been the case for all staff and others will have seen no change, or even a decrease, depending on their specialty due to the impact of the pandemic on elective activity.

Figure 11 - Additional Earnings as Proportion of Total Earnings by Grade - 12 Months to March 2021



Source - NHS Digital Earnings Statistics

Across all medical staff additional earnings account for around 24% of all earnings. The proportion of earnings that do not come from basic pay ranges from 5% for Hospital Practitioners to 29% for Specialty Registrars. The proportion, and type, of additional earnings can often be linked to contractual provisions - Consultants may access additional earnings via Clinical Excellence Awards or Additional Programmed Activities while

Specialty Registrars receive "unsocial hours" payments based on the number of weekends worked.

A small number of doctors are in receipt of Recruitment and Retention Premia - In the 12 months to the end of March 2021 around 0.3% of Doctors received a RRP with Staff Grade and Specialty Doctors being most likely to receive one.

More details on the proportion / distribution of additional earnings can be found in the NHS Digital publication - https://digital.nhs.uk/data-and-information/publications/statistical/nhs-staff-earnings-estimates

Earnings distribution

Earnings can vary within medical grades as well as between them due to differences in seniority, working patterns and ability to access additional earnings.

Table 39 shows the earnings distribution for the 12-months to the end of March 2021. Only those working in the same grade for the entire period are shown - this means that there is no data for F1 / F2 doctors as the training year (Aug - July) does not align with financial years (Apr - Mar).) F1 / F2 doctors will typically spend one-year in each grade and there is less scope for earnings differentials given the requirements of those roles - this means that the figures in Table 39 provide a reasonable estimate for earnings in these grades

As expected, earnings are higher for Consultants and SAS Doctors and lower for Junior Doctors. There are generally relatively small differences between the mean and median averages which suggests there are not large numbers with either very high or very low earnings compared to others in the grade which could impact the mean.

Table 39 - Distribution of Total Earnings by Career Grade - 12 Months to March 2021

Grade	25% Earn Less Than	Median	25% Earn More Than	Mean Average
HCHS Doctors	£50,500	£83,500	£119,500	£82,709
Consultants	£98,000	£117,000	£138,000	£117,981
Associate Specialist	£76,500	£95,500	£111,500	£93,147
Specialty Doctor	£52,500	£73,500	£88,500	£69,723
Specialty Registrar	£32,000	£47,000	£65,000	£61,002
Core Training	£34,500	£51,500	£58,500	£54,261
Foundation Year 2	N/A	N/A	N/A	£43,123
Foundation Year 1	N/A	N/A	N/A	£35,379

Source - NHS Digital Earnings Statistics

HCHS pay drivers

Table 40 presents trends in medical average earnings growth and its component drivers. This is based on the DHSC headline paybill metrics. The Metrics calculate the average

paybill cost of employing different types of staff, and how this changes over time, using data on earnings and workforce published by NHS Digital. This can then be compared with information on pay awards to determine if growth is higher or lower than can be explained via the pay award.

Table 40 - Breakdown of Average Earnings Growth for HCHS Medical Staff

Pay Growth Element	15-16	16-17	17-18	18-19	19-20	20-21
Basic Pay per FTE Growth	0.8%	2.0%	2.8%	2.3%	3.3%	2.2%
Additional Earnings per FTE Growth	0.6%	1.2%	-1.5%	-2.4%	-2.9%	3.5%
Total Earnings per FTE Growth	0.7%	1.8%	1.7%	1.1%	1.8%	2.5%
Of which	-	-	-	-	-	-
(a) Headline Pay Awards	0.1%	1.0%	1.0%	1.0%	3.4%	2.7%
(b) Total Earnings Drift	0.6%	0.8%	0.7%	0.0%	-1.6%	-0.3%
Of which	-	-	-	-	-	-
(b1) Basic Pay Drift	0.2%	0.3%	1.6%	1.2%	0.3%	0.4%
(b2) Additional Earnings Drift Impact	-0.1%	-0.2%	-1.1%	-1.3%	-1.7%	0.1%
(b3) Grade Mix Effect	0.6%	0.6%	0.2%	0.2%	-0.2%	-0.8%

Note: Total Earnings Drift includes grade mix effects; Basic Pay Drift and Additional Earnings Drift Impact are excluding grade mix effects. Grade mix means the distribution of staff across the HCHS medical staff groups presented in NHS Digital published data

Source: DHSC Headline Paybill Metrics

Several factors drive changes in average earnings. Some relate to changes in the composition of the workforce, some relate more specifically to pay rates.

The impact of headline pay awards on average earnings for doctors in 2020-21 compared to 2019-20 was 2.7%, which reflects the combined effect of:

- 2.6% impact for Consultants (average of 2.8% increase to basic pay scales and no change in the value of CEAs, discretionary points and distinction awards)
- 3% impact for Junior Doctors (2% increase to basic pay scales, plus additional changes as part of the multi-year deal agreed in 2019)
- 2.8% impact for Staff Grade and Associate Specialist Doctors

Average total earnings grew by less in 2020-21 than the pay awards impact (2.5% vs 2.7%), implying negative earnings drift. Drift levels are driven by several factors:

- a grade mix effect of -0.8% reflecting a shift in the workforce towards lower earning medical grades for example, Junior Doctors, which is linked to earlier than usual recruitment of Foundation Year doctors as part of the response to the pandemic (see below)

- basic pay drift (excluding grade mix effects) of 0.4% reflecting wider workforce mix effects such as a shift in the distribution of staff within grades towards higher pay points

- positive additional earnings drift impact (excluding grade mix effects) of 0.1%, following several years of negative drift impact. Additional earnings per FTE increased by 3.5% in 2020-21, a reversal from the recent decreasing trend. While increased hours for some doctors during the pandemic will have contributed to additional earnings growth, reduced workload due to a reduction in elective activity will have had an opposing effect. Additional earnings growth in 2020-21 also reflects other factors, including ongoing effects of the phased implementation of the Junior Doctor contract reforms introduced in 2016 and the 2018 Junior Doctor contract refresh

The negative grade mix effect reflects a shift in 2020-21 in the distribution of HCHS medical staff FTEs away from Consultants and towards Junior Doctors. Table 41 shows that both Consultant and Junior Doctor FTEs grew in 2020-21 at a higher rate than in recent years, but the growth in average annual FTE for Junior Doctors (8.1%) was nearly double that for Consultants (4.1%). This is at least partly due to earlier than usual recruitment of Foundation Year 1 doctors in 2020-21 as part of the response to the Pandemic, so the intake of new trainee doctors was in the workforce for longer in 2020-21 than is usually the case.

Table 41 - Annual FTE Growth and Share of HCHS Medical Staff FTE by Medical Staff Group

Staff Group	Measure	15-16	16-17	17-18	18-19	19-20	20-21
Consultants	FTE Growth	3.9%	3.4%	3.4%	3.1%	3.2%	4.1%
Junior Doctors	FTE Growth	0.5%	-0.4%	2.6%	2.1%	4.3%	8.1%
SAS and Other Doctors	FTE Growth	-0.4%	0.0%	1.9%	2.2%	3.0%	3.0%
Consultants	% of Medical FTE	41.1%	42.0%	42.2%	42.5%	42.2%	41.5%
Junior Doctors	% of Medical FTE	49.0%	48.2%	48.1%	47.9%	48.1%	49.1%
SAS and Other Doctors	% of Medical FTE	9.9%	9.8%	9.7%	9.7%	9.6%	9.4%

Based on average monthly FTE over each year

Source: DHSC Headline Paybill Metrics

Pay progression for hospital doctors

Medical staff can expect higher salaries as they both progress within their current medical grade and are promoted to more senior grades. Progression may work differently dependent on their current grade, specialty and working patterns.

- for Junior Doctors progression is linked to the stage of training with separate pay points for Foundation Year 1, Foundation Year 2, ST1-2, ST 3-5 and ST6+. The higher pay at more advanced stages of training reflects the increase in experience and competence. More information on Junior Doctors, including progression routes, is available in Chapter 3 (Workforce Strategy)

- for Consultants progression is linked to time in the consultant grade. Consultants receive pay progression in each of the first 4 years of employment and then every 5 year until they have completed 19 years in post. Progression is automatic and does not depend on FTE

- for SAS Doctors, once the final pay structure is in place as of 1 April 2023, doctors will need to spend a minimum of 3 years on each pay point and evidence achievement against the criteria set out in the pay progression schedule before moving to the next pay point. Due to the nature of the transition, this may vary during the transition period from April 2021 to March 2023. More information on the new SAS contract can be found in Chapter 3 (Workforce Strategy)

- doctors will also experience salary progression as they are promoted into more senior grades - Most noticeably when Junior Doctors complete their training and are eligible to apply for Consultant level posts

- pay progression is on top of any other pay awards that may be made

Table 42 provides information on the current salary ranges for the 4 main contract groups that are open to new joiners as of April 2021 and gives an indication as to the progression that is possible through progression and promotion - the difference between Nodal Point 1 (Foundation Year 1) and 5 (Specialty Training Year 6+) on the Junior Doctor contract is just 95% and Consultants can receive progression of just under 35% over 20 years in post.

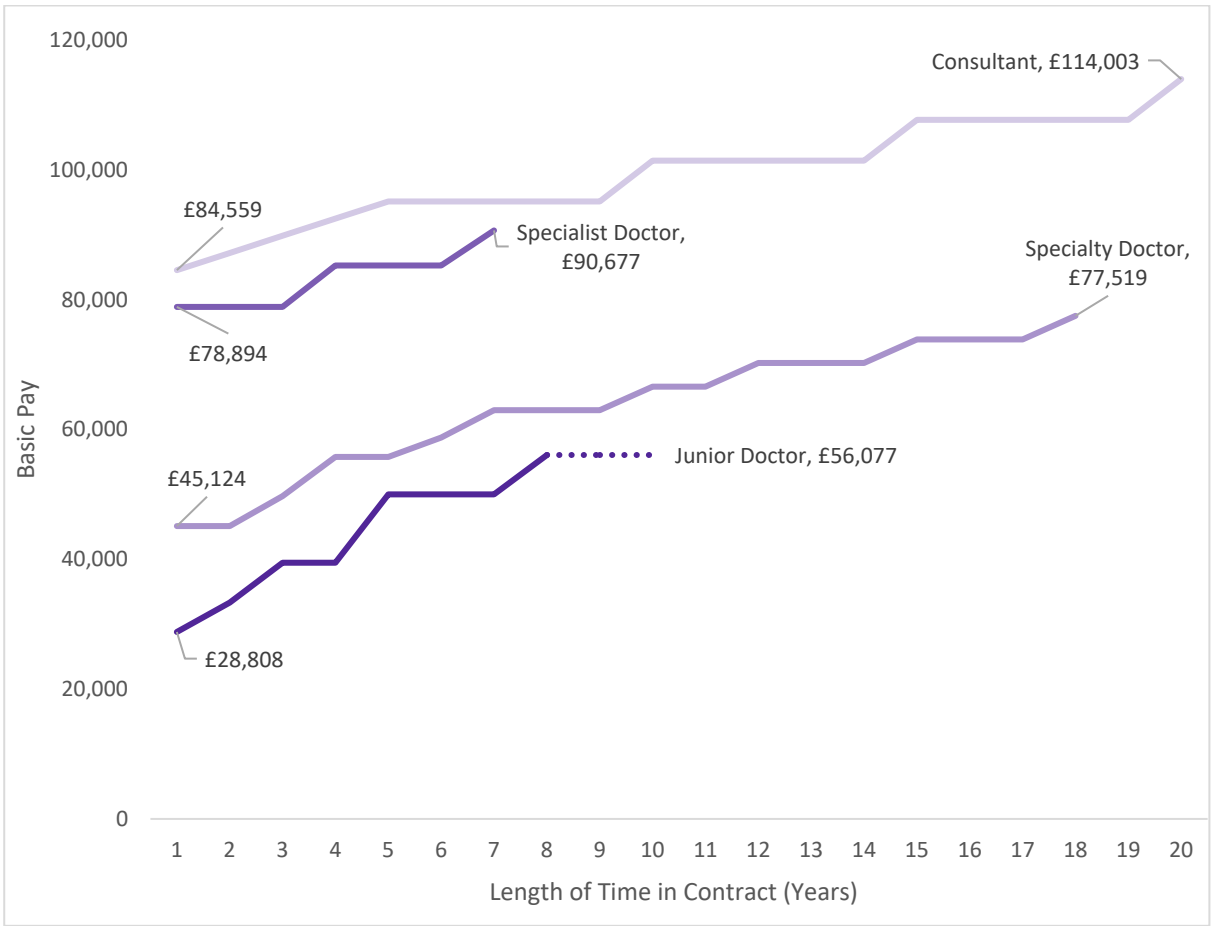
Table 42 - 2021-22 Medical Pay Scales by Contract

Pay Journey	Starting Basic Pay	Maximum Basic Salary	Increase
Junior Doctors	£28,808	£56,077*	94.7%
Specialty Doctor (2021 Contract)	£45,124	£77,519	71.8%
Specialist Doctor (2021 Contract)	£79,894	£90,677	13.5%
Consultants	£84,559	£114,003	34.8%
Pay Route	Starting Basic Pay	Maximum Basic Pay	Increase
F1 - Consultant Maximum	£28,808	£114,003	295.7%

Source - NHS Employers Pay Circulars * - Value applied from 01/10/2021

Figure 12 shows how Doctors can benefit from progression within their current grade based on the 2021-22 pay scales. It shows the differentials in pay between the contracts, how basic pay can change over time and the points at which someone is eligible for progression within their current grade - in order to access higher pay someone would then need to seek promotion to a more senior role.

Figure 12 - Incremental Progression by Contract and Time in Contract – 2021-22 Pay Scales



Source - NHS Employers Pay Circulars * Note the SAS Grades (Specialist Doctor and Specialty Doctor do not reflect the final pay scales from the 2021 SAS Agreement which create a 12 point pay structure by the end of the agreement. Junior Doctor Nodal Point 5 denoted by dashed line as length of time on this point determined by specialty.

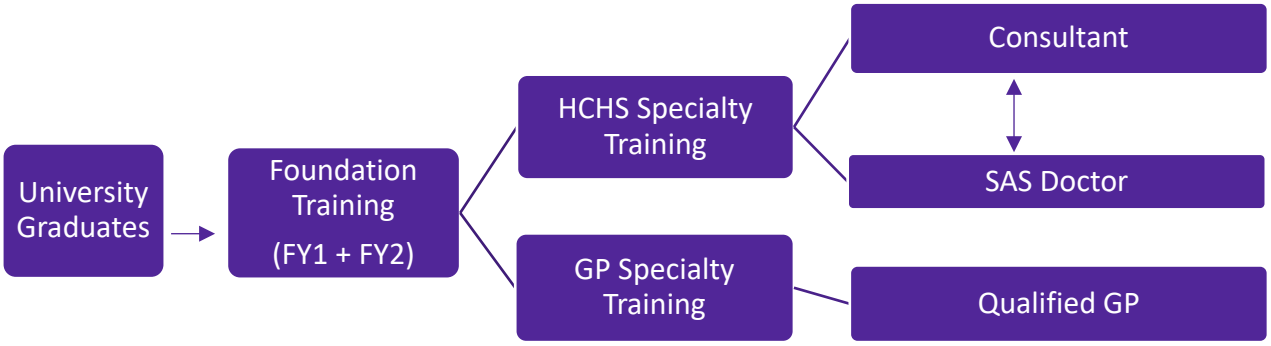
Typical career pathways in the HCHS sector

A medical career can span decades with staff entering as Junior Doctors before developing their expertise and progressing to more senior roles such as Consultants in the HCHS sector or as GPs in Primary Care.

Figure 13 shows the most common career pathways for new medics from UK medical schools. After completing the Foundation Programme most doctors will enter Specialty / Core training on either a "Hospital" or "Primary Care" pathway. Those following a hospital pathway are likely to become Consultants or SAS doctors while those in Primary Care are likely to become GPs.

In addition to this other doctors will enter the UK health system from abroad or other sources (for example, returning from career breaks) and could enter at different levels depending on their qualifications and experience.

Figure 13 - Example Career Pathways



It is possible to use data from ESR to show how staff have transitioned between medical grades in the HCHS sector between March 2011 and March 2021. This can provide some insight on how staff transition between grades over time however will only reflect a 10-year snapshot rather than the totality of a medical career and does not include people who have joined since 2011.

Table 43 shows data for the period March 2011 - March 2021 and shows that:

- for those who were Consultants in 2011 they are either still Consultants in 2021 or have left the HCHS sector. To some extent this will reflect the age profile of Consultants who may have retired

- it is common for SAS doctors to remain in SAS posts although a smaller number have transitioned to Consultant level. The opening of the new Specialist grade will provide additional career progression options for SAS doctors which could result in more staying in the grade or even joining from other grades

- Junior Doctors are likely to progress to more senior grades - mostly at Consultant level. A smaller proportion of Junior Doctors enter the SAS grades

- around 50% of Junior Doctors were not employed in the HCHS sector in 2021. This is not unexpected as ESR does not cover Primary Care and around 50% of Junior Doctors go into GP training each year - While these staff may no longer be in the HCHS sector they are unlikely to be lost to the NHS and healthcare system

- this only covers people who were employed in both 2011 and 2021. Other staff will have joined the HCHS sector between those points including new doctors entering training or more recent international recruits. For example, a relatively high proportion of new international recruits are seen to enter SAS grades

Table 43 - Career Journeys - Medical Grades in 2011 and 2021

-		Grade in 2021					
-		Consultant	SAS Grade	Junior Doctor	Other Grades	Not in HCHS	Total
Grade in 2011	Consultant	62%	0%	0%	0%	37%	100%
	SAS Grade	13%	36%	1%	1%	48%	100%
	Junior Doctor	36%	3%	11%	1%	49%	100%
	Other Grades	6%	2%	1%	21%	69%	100%

Source: DHSC Analysis of Electronic Staff Record. Note - Rows show the Grade in 2011 and the Columns show the Grade in 2021

Longitudinal pay for hospital doctors

Data from ESR, the HR and payroll system used by all Trusts and Foundation Trusts, can be used to analyse pay and earnings for individual members of staff over time. This permits analysis of how employees experience the pay system and goes beyond looking at headline averages which can be impacted by things like grade mix and workforce growth.

Table 44 presents data for just under 52,000 doctors who were employed in the HCHS sector in both March 2011 and March 2021. The median average increase in pay was around 32% (2.8% pa) over the period and over 25% of doctors who saw pay more than double (8.1% pa) usually reflecting promotion to more senior grades. Some staff, especially those at the top of grade throughout will have seen smaller increases.

Table 44 - Change in Basic Pay per FTE for individual staff employed in both March 2011 and March 2021.

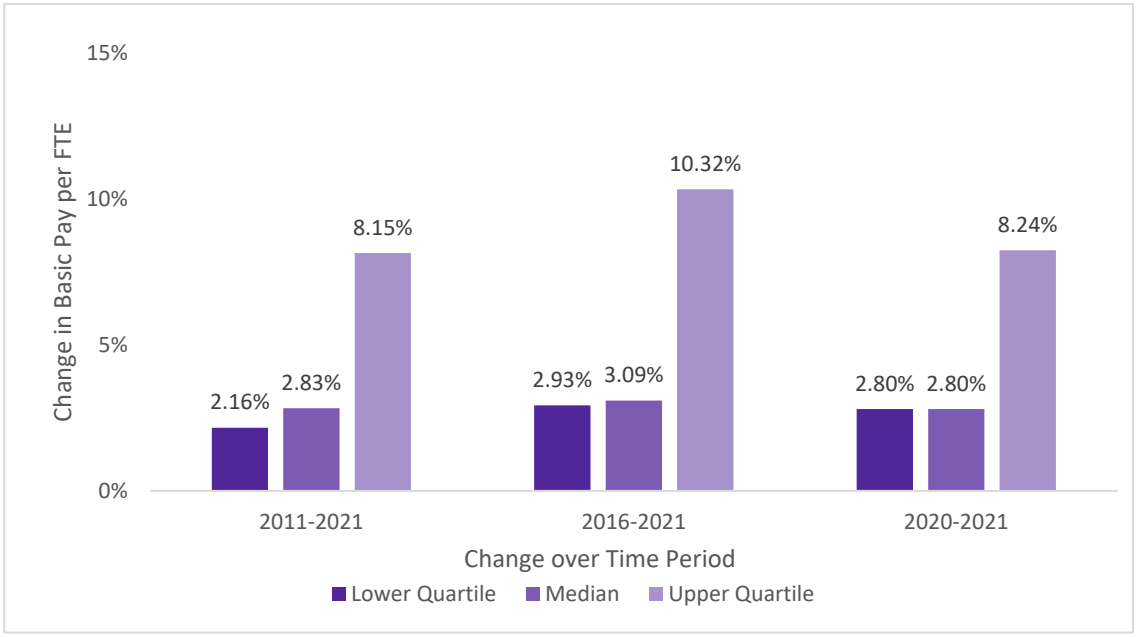
Staff Group	Count	25th Percentile	Median	75th Percentile
HCHS Doctors	51,800	23.8%	32.2%	118.8%
Consultant	40,200	23.8%	28.2%	129.0%
Associate Specialist	1,400	21.2%	27.8%	36.5%

Specialty Doctor	3,100	30.1%	50.4%	85.3%
Staff Grade	100	11.8%	11.8%	11.8%
Specialty Registrar	4,800	49.9%	72.4%	109.8%
Core Training	400	34.0%	65.1%	76.4%
Other and Local Doctor Grades	500	10.7%	18.7%	30.2%

Source: DHSC Analysis of Electronic Staff Record. For people who have changed staff group groups between 2011 and 2021 the 2021 staff group is shown.

Figure 14 shows similar analysis over the past 1, 5 and 10 years with growth given on an annualised basis. Over the last 10 years a median average of 2.8% is equivalent to a total increase of over 32%. Staff with the highest level of growth will have been promoted to more senior grades while those with the smallest growth will have been at "Top of Scale" throughout.

Figure 14 - Annualised Change in Basic Pay per FTE for HCHS Doctors over 1, 5 and 10 Years



Source - DHSC Analysis of Electronic Staff Record

GP earnings and expenses

Data on GP earnings and expenses is published by NHS Digital and is based on a sample from HM Revenue and Customs' (HMRC's) tax self-assessment database. As the data is based on samples with weighting applied, rather than the whole population, it is subject to sampling error and uncertainty. The dataset includes contractor and salaried GPs working under General Medical Services (GMS) and Personal Medical Services (PMS) contracts but does not include GPs who work solely as locums. It is possible that some salaried GPs may not need to complete a Self Assessment tax return. Such individuals do not appear in HMRC's tax Self Assessment database and therefore cannot be included in the sample.

The available data provides information on GP's total earnings by headcount, and it is therefore not possible to calculate the split between private and NHS work or to distinguish between full and part time workers. Due to concerns about the validity and quality of the analysis, NHS Digital no longer publish experimental data on GP earnings estimates by FTE or working hours bands.

The latest available earnings data is for the financial year from 1 April 2019 to 31 March 2020, covering the first year after introduction of the 5-year GP contract deal. This provided funding clarity and certainty to practices and introduced the state-backed indemnity scheme to protect GPs from the rising costs of clinical negligence indemnity.

The average income before tax for combined (contractor and salaried) GPs working in either a GMS or PMS (GPMS) practice in England in 2019-20 was £100,700, an increase of 2.8% since the average in 2018-19. This equated to average earnings increase of 5.0% for salaried GPs and 3.8% for GP partners.

Table 45, below, sets out the average percentage increase in annual earnings for salaried and contractor GPs over recent years, against the uplifts recommended by the DDRB and agreed by government in the corresponding year. There does not appear to be a clear link between agreed government uplifts to pay and changes in average earnings for GPs.

Contractor GPs were stood down from the remit of the DDRB for the duration of the 5-year contract, 2019-2020 to 2023-2024. Salaried GPs were stood down for one year in 2019-20, with a 2% uplift agreed for salaried GPs via contract negotiations.

Table 45 - Average percentage increase in annual earnings for salaried and contractor GPs and the recommended and agreed uplifts for the same year

Year	DDRB recommendation	Government response	Average % earnings increase for salaried GPs	Average % earnings increase for GP contractors
2015-16	1%	1%	-1.4%	1.1%
2016-17	1%	1%	1.3%	4.5%
2017-18	1%	1%	3.2%	3.5%
2018-19	4%	2%	3.8%	3.4%
2019-20	n/a	2% agreed as part of the 2019/20 contract for salaried GPs	5.0%	3.8%
2020-21	2.8% (salaried GPs only)	2.8% (salaried GPs only)	Data to be published Sept 2022	Data to be published Sept 2022
2021-22	3% (salaried GPs only)	3% (salaried GPs only)	Data to be published Sept 2023	Data to be published Sept 2023

Sources: NHS Digital, GP Earnings and Expenses Estimates 2019-20 August 2021, Tables 1a and 7a.

GP contractor earnings

GP Contractors are responsible for meeting the requirements set out in the contract for their practice and they take an income after practice expenses. Contractor GP earnings are therefore intrinsically linked to uplifts to salaried GP pay and other pressures on practice finances. In England, the average pre-tax income for a contractor GP working in either a GMS or PMS practice in 2019-20 was £121,800, an increase of 3.8% compared to 2018-19. Table 46 shows the change in contractor GP income in England since 2006-07 in both nominal and real terms (2019-20 prices). The latest available UK Income distribution figures published by HMRC, are based on total income subject to tax for the year 2018-19 and do not account for hours worked. Contractor GPs were in the 98th percentile group (£99,600 to £121,000) in that year.

As mentioned above, GP earnings data is an average across a sample of full and part time GP workers from HMRC's tax Self Assessment database. The participation rate for contractor GPs in September 2019 was 87.5% (a slight decrease since September 2015 at 88.5%), although this may not accurately reflect actual working hours.

The data in Table 46 represent average earnings for GP contractors in both GMS and PMS practices. The GMS contract is the national standard GP contract and in 2018-19, around 70% of GP practices operated under it. Expenses are split into categories including office and general business, premises, employee, car and travel, interest, net capital allowance and other (for example, cost of drugs for dispensing GPs).

Table 46 - Earnings and expenses for GP contractors in England - GMS and PMS, all practice types, 2006-07 to 2019-20[12]

Year	Reported Population	Estimated gross earnings, cash terms	Total expenses, cash terms	Income before tax, cash terms	Estimated gross earnings, real terms (2019-20 prices)	Total expenses, real terms	Income before tax, real terms
2006-07	27,279	£260,764	£149,198	£111,566	£335,100	£191,700	£143,400
2007-	27,121	£266,110	£155,971	£110,139	£332,600	£194,900	£137,600

[12] The dataset shows total earnings, expenses and income (pre-tax). 'Earnings' is the total that GPs receive; however, expenses come out of this sum, meaning that 'income' is total earnings minus expenses. Mean values are presented for earnings and expenses. Estimates have been rounded to the nearest £100, so numbers presented for taxable income may not equal gross earnings minus total expenses and the sum of numbers in a table may not equal the total.

08							
2008-09	26,712	£274,100	£164,500	£109,600	£333,500	£200,200	£133,300
2009-10	26,400	£278,100	£168,700	£109,400	£333,000	£202,000	£131,100
2010-11	26,300	£283,000	£175,300	£107,700	£332,800	£206,100	£126,700
2011-12	26,350	£284,300	£178,200	£106,100	£329,400	£206,500	£122,900
2012-13	26,200	£289,300	£184,200	£105,100	£328,400	£209,100	£119,300
2013-14	25,700	£290,900	£189,000	£101,900	£324,300	£210,700	£113,600
2014-15	25,500	£302,600	£198,800	£103,800	£332,800	£218,700	£114,200
2015-16	18,300	£315,600	£210,800	£104,900	£344,400	£230,000	£114,400
2016-17	19,850	£338,300	£228,700	£109,600	£360,200	£243,500	£116,700
2017-18	20,350	£357,300	£243,900	£113,400	£373,800	£255,200	£118,600
2018-19	20,300	£380,900	£263,600	£117,300	£389,500	£269,600	£119,900
2019-20	19,250	£402,600	£280,000	£121,800	£402,600	£280,800	£121,800

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2019-20, August 2021, Tables 1a and 1b. The conversion to real terms has been carried out using Gross Domestic Product (GDP) deflators as at June 2021 available from HMT.

The data for 2019-20 for contractor GPs by contract type are shown in Table 47 below.

Table 47 - Earnings and expenses for GP contractors in England by contract type – 2019-20, all practice types[12]

Contract type	Gross Earnings (£)	Total Expenses (£)	Income Before Tax (£)
GMS	394,100	272,800	121,200
PMS	426,400	303,100	123,300

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2019-20, August 2021, Table 1a.

Salaried GP earnings

Salaried GPs should be on a salary no less favourable than the minimum pay range in the model terms and conditions, as set out by NHS Employers and the model salaried GP

contract. In responding to the DDRB's recommendations, government will adjust the minimum and maximum pay threshold accordingly. It is up to practices to determine the pay uplift for their staff following this adjustment.

Table 48 shows the change in salaried GP income in England since 2006-07 in both nominal and real terms (2019-20 prices). The average pre-tax income of salaried GPs working in either a GMS or PMS practice in England in 2019-20 was £63,600, an increase of 5.0% compared to in 2018-19.

The UK Income distribution figures from 2018-19, show that salaried GPs were in the 92nd percentile group (£59,100 to £62,400) for that year. The participation rate for salaried GPs in September 2019 was 64.8% (a decrease since September 2015 at 66.9%), although this may not accurately reflect actual working hours.

Table 48 - Earnings and expenses for salaried GPs England - GMS and PMS, all practice types, 2006-07 to 2019-20[13]

Year	Report population	Gross employment earnings, cash terms	Gross self-employment earning, cash terms	Total gross earnings, cash terms	Total expenses, cash terms	Total income before tax, cash terms	Total gross earnings, real terms (19/20 prices)	Total income before tax, real terms (19/20 prices)
2006-07	4,704	£47,354	£12,891	£60,245	£6,139	£54,106	£77,400	£69,500
2007-08	4,665	£49,854	£12,337	£62,191	£6,260	£55,931	£77,700	£69,900
2008-09	5,991	£50,300	£13,800	£64,200	£6,800	£57,400	£78,100	£69,800
2009-10	6,650	£50,800	£14,700	£65,500	£7,100	£58,300	£78,400	£69,900
2010-11	7,000	£50,000	£15,100	£65,100	£7,300	£57,900	£76,600	£68,100
2011-12	7,050	£49,600	£14,800	£64,400	£7,300	£57,000	£74,600	£66,100
2012-13	7,550	£49,200	£15,500	£64,700	£8,100	£56,600	£73,500	£64,200
2013-14	8,000	£48,200	£15,800	£64,100	£9,200	£54,900	£71,400	£61,200
2014-15	8,750	£50,800	£14,700	£65,500	£8,700	£56,700	£72,000	£62,400

[13] There are breaks in the time series (each year between 2011 to 2012 and 2014 to 2015) due to the use of unrevised pension contribution rates when calculating adjustments to income before tax. ‘Earnings’ is the total that GPs receive; however, expenses come out of this sum, meaning that ‘income’ is total earnings minus expenses. Mean values are presented for earnings and expenses. Estimates have been rounded to the nearest £100, so numbers presented for taxable income may not equal gross earnings minus total expenses and the sum of numbers in a table may not equal the total.

		r[14]		r[14]		r[14]		
2015-16	7,250	£51,500	£12,300	£63,900	£7,900	£55,900	£69,700	£61,000
2016-17	8,550	£51,700	£13,700	£65,300	£8,700	£56,600	£69,500	£60,300
2017-18	9,400	£52,400	£15,800	£68,200	£9,800	£58,400	£71,400	£61,100
2018-19	10,500	£53,700	£16,400	£70,100	£9,400	£60,600	£71,700	£62,000
2019-20	11,000	£55,300	£16,300	£71,600	£8,000	£63,600	£71,600	£63,600

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2019-20, August 2021,Table 8a and 8b.

The data for 2019-20 for salaried GPs by contract type are shown in Table 49 below.

Table 49 - Earnings and expenses for salaried GPs in England by contract type – 2019-20, all practice types[15]

Contract type	Gross Earnings (£)	Total Expenses (£)	Income Before Tax (£)
GMS	72,000	8,500	63,500
PMS	71,000	7,000	63,900

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2019-20, August 2021, Table 7a. The conversion to real terms has been carried out using Gross Domestic Product (GDP) deflators as at June 2021 available from HMT.

GP Trainer Grants

The GP trainer grant, which was previously published in an annex of the Directions to Health Education England, was published as part of the document containing GP Educator pay scales and from 1 April 2020 is £8,584.

The Department continues to work with stakeholders to promote a fair and equitable approach to the funding of clinical placements in GP practices, irrespective of geography and historical arrangements. The 2020-21 annual Education and Training tariff guidance document introduced a new national minimum rate for undergraduate medical placements

[14] (r) 2014 to 2015 Income Before Tax and Gross Earnings figures have been recalculated since the GP Earnings and Expenses Estimates 2014 to 2015 publication using updated adjustments for superannuation contributions.

[15] The dataset shows total earnings, expenses and income (pre-tax). 'Earnings' is the total that GPs receive; however, expenses come out of this sum, meaning that 'income' is total earnings minus expenses. Mean values are presented for earnings and expenses. Estimates have been rounded to the nearest £100, so numbers presented for taxable income may not equal gross earnings minus total expenses and the sum of numbers in a table may not equal the total.

in general practice of £28,000. This means that although prices continue to be agreed under local arrangements, no price will be lower than this amount.

NHSEI submission will contain information on GP appraiser rates.

Dental practitioners earnings and expenses

Data on earnings and expenses is available for self-employed primary care dentists who have completed some NHS work during the financial year, however figures relate to both NHS and private income. Private earnings are determined by the amount of demand from individual patients, which may be in addition to NHS care.

In 2019-20 the average taxable income for all dentists in has remained unchanged from 2018-19 at £68,600. The expenses to earnings ratio has decreased by 0.8 percent, to 52.6%. See Table 50.

A 3% pay uplift was awarded to dentists in 2021 and backdated to 1 April 2021. Whilst each year we recommend that provider-performer dentists apply this to their associate dentists' salaries, as practices are private businesses it falls to them to set employee pay and conditions.

Table 50 - Gross income, expenses and taxable income for all dentists from 2009-10 to 2019-20

	Average Gross Earnings	Average Expenses	Average Taxable Income	Expenses ratio
2009-10	£184,900	£100,000	£84,900	54.1%
2010-11	£172,000	£94,100	£77,900	54.7%
2011-12	£161,000	£86,600	£74,400	53.8%
2012-13	£156,100	£83,500	£72,600	53.5%
2013-14	£155,100	£83,400	£71,700	53.8%
2014-15	£152,500	£82,000	£70,500	53.8%
2015-16	£148,000	£78,900	£69,200	53.3%
2016-17	£145,700	£77,000	£68,700	52.9%
2017-18*	£146,700	£78,100	£68,500	53.3%
2018-19*	£147,100	£78,500	£68,600	53.4%
2019-20*	£144,700	£76,100	£68,600	52.6%

Source: Dental Earnings and Expenses Estimates 2019-20 - NHS Digital

In England, the earnings of a dentist are dependent on whether they are a Providing-Performer dentist or an associate dentist. Providing performer dentists hold a contract with NHS England to provide a given number of Units of Dental Activity or Units of

Orthodontic Activity. Associate dentists work as performers under the contract, they deliver NHS dental services and hold a contract with their provider performer but do not hold a contract with the NHS. Generally, Provider-Performers tend to earn more (higher gross earnings and taxable income). This is true for the 2018-19 figures and is consistent with previous years. However, the changing ratio of Providing-Performers to performer only dentists has moved the average figure closer to the lower-earning Performer only dentists. In 2019-20 Providing-Performer dentists had an average taxable income £112,600 a slight drop from £113,100 in 2018-19. In contrast, an associate dentist saw their average taxable income increase to £58,100 in 2018-19 compared to 2017-18 when it was £57,600.

A number of factors make it difficult to compare the level of earnings and gross income from one year to another. These factors include variations in hours worked, in the balance between NHS and private sector activity, the evolving nature of practice business models, the new methodology used to collect data and the rise of incorporation.

The 2019-20 ‘Dental Earnings and Expenses’ publication reports the results of a longitudinal study over the last 3 financial years from 2017-18 to 2019-20, focusing specifically on dentists who have not changed their dental or contract type during this period. Average taxable income from NHS and private dentistry increased by 3.6% from £72,400 in 2017-18 to £75,000 in 2019-20. Whilst both providing performer dentists and associates saw their income rise, associate dentists had a greater increase (4.7%) in income than providing performer dentists (1.4%) during the same period.

The variation in the findings from the longitudinal study and the main findings highlights the impact that changes to the overall dental population and to contract types can have.

Labour market analysis

In addition to data for the respective parts of the workforce it is possible to use data from the Office for National Statistics (ONS) to assess how earnings for all medical staff compare with those in the wider economy in general and specifically against other high-income occupations.

Comparisons are made using the Annual Survey of Hours and Earnings (ASHE) which provides information about the levels, distribution, and make-up of earnings for employees across the UK and is based on a sample of around 1% of the PAYE registers covering around 180,000 jobs from 60,000 employers. ASHE contains a single "Medical Practitioner" group which covers staff across medical settings including those working in Primary and Secondary care.

Using ASHE, it is possible to make consistent comparisons between occupations but is not directly comparable to the NHS data in earlier parts of this chapter:

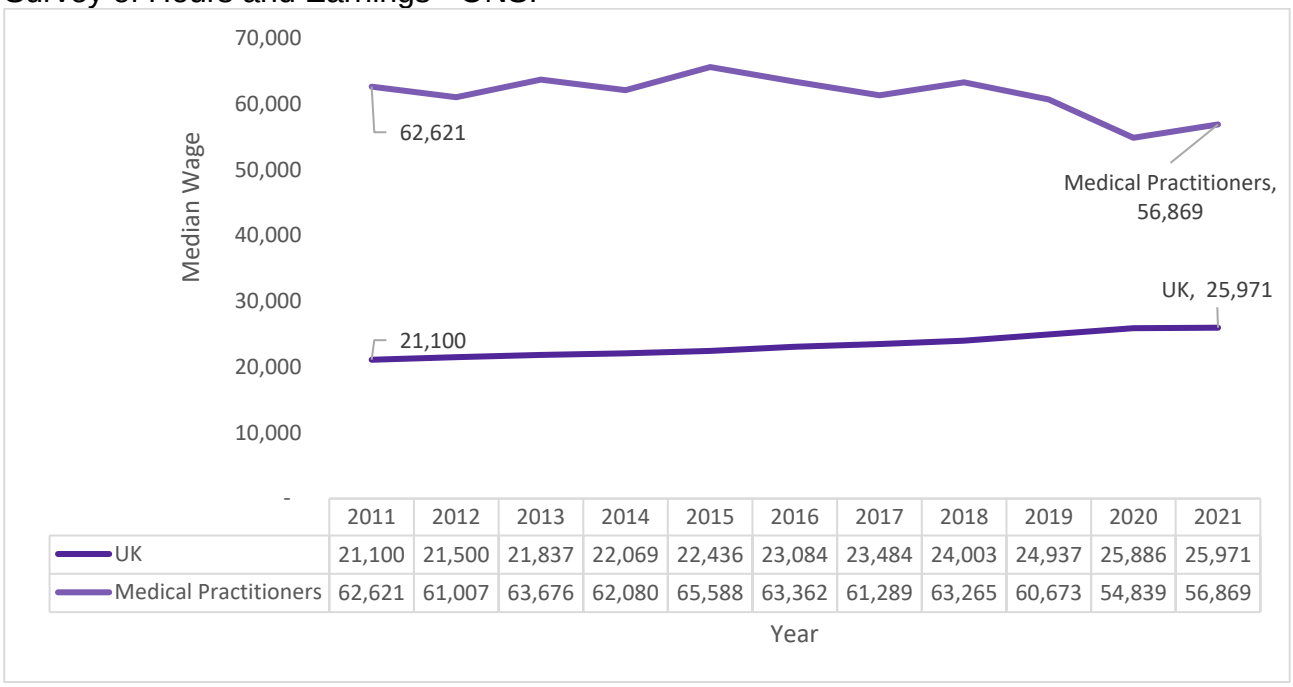
- ASHE data is based on a sample of around 1% of PAYE records while NHS data may be sourced from administrative data sets covering the whole workforce
- as ASHE is based on PAYE data it does not cover people who use the Self-Assessment system (for example, Partner GPs)
- the ASHE data presented here is based on "gross median earnings per person" - other tables in this chapter may have used other definitions (for example, mean earnings per person)

As ASHE is based on data collected in April the ONS have noted the impact that Covid may have had on the data. The composition of the workforce in April 2021 may have been different to previous years and some staff will have been on furlough. As such we may need to be cautious when interpreting a single datapoint and should make conclusions based on all available data sources. This analysis is also only on the basis of total earnings and does not consider wider elements of total reward detailed in Chapter 6.

Comparison with the wider economy

Average earnings for medical professionals are high compared to the wider economy. Figure 15 shows that over the last decade median earnings for medical professionals have consistently been more than double those of the wider economy.

Figure 15 - Median Earnings for Medical Practitioners compared to UK Average - Annual Survey of Hours and Earnings - ONS.



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
UK	21,100	21,500	21,837	22,069	22,436	23,084	23,484	24,003	24,937	25,886	25,971
Medical Practitioners	62,621	61,007	63,676	62,080	65,588	63,362	61,289	63,265	60,673	54,839	56,869

Source - Office for National Statistics

Comparison with high earning professions

While we accept the difficulties in making comparisons across sectors it is useful to consider how earnings for medical staff compare to other professions which require similar levels of skills and where earnings are also high as these are jobs against which medical staff might judge salaries and salary growth. Sector level information from ASHE will have similar limitations to the national data and as some of these professions are very small there may be some variation from year to year depending on the sample frame.

Table 51 shows the median annual pay, and growth over the past 5 years, for occupations with median average earnings of at least £50,000 and shows that medical practitioners have the 9th highest average earnings which is an improvement from 11th place in in 2020. The reduction in median earnings since 2016 in this data is not consistent with data from NHS Digital for the HCHS sector. Potential explanations for this difference may include changes in the composition of the total medical workforce including an increase in the proportion of Junior Doctors or be caused by sampling effects. While the estimates for Medical Practioners are considered by ASHE to be “reasonably precise”, any estimate based on a sample is more uncertain than one based on the entire population as the sample may in advertently over or under represent different grades.

Table 51 - Median Annual Pay for High Earnings Occupations in 2016 and 2021

Occupation	SOC Code	Median Gross Annual Pay (2016)	Median Gross Annual Pay (2021)	Change	Rank 2016	Rank 2021	Number of jobs (000s, 2021)
Chief executives and senior officials	1115	£84,485	£81,102	-4.0%	1	1	92
Marketing and sales directors	1132	£69,720	£69,779	0.1%	2	2	176
Medical practitioners	2211	£63,362	£56,869	-10.2%	5	9	193
Senior police officers	1172	£62,505	£58,734	-6.0%	6	6	11
IT and telecommunications directors	1136	£64,959	£51,637	-20.5%	3	10	64
Advertising and public relations directors	1134	£53,801	£58,948	9.6%	8	5	14
Financial managers and directors	1131	£56,942	£58,028	1.9%	7	8	314
Senior professionals of educational establishments	2317	£52,427	£58,268	11.1%	9	7	107
Train and tram drivers	8231	£49,714	£59,189	19.1%	10	4	28
Legal professionals n.e.c.	2419	£64,014	£69,514	8.6%	4	3	52

Source: Annual Survey of Hours and Earnings. Includes the 10 professions with the highest median earnings in 2021.

Medical practitioners have some of the highest average earnings for any occupation. Unlike most of the other listed professions this covers staff at all levels including those in training grades while other listed professions (for example, senior police officers) are already at the most senior roles in their respective sectors with other staff classified elsewhere.

As outlined in longitudinal analysis the system of training and progression mean that most Doctors have the reasonable expectation of reaching more senior levels and consequently having higher earnings - average earnings for Consultants are over £110,000 in the HCHS sector which would be in the 97% percentile of pre-tax earnings (https://www.gov.uk/government/statistics/percentile-points-from-1-to-99-for-total-income-before-and-after-tax).

Gender and ethnicity pay gaps

The government is committed to eliminating pay gaps which occur when men are paid more than women (Gender Pay Gap) or White staff are paid more than BME colleagues (Ethnicity Pay Gaps).

Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England ("GPG Review") published in 2020, undertook analysis to establish the size of pay gaps in medicine and to better understand the reasons why they develop with a similar piece of work planned for ethnicity across the whole NHS workforce. The findings of the GPG review can be used to explain some of the factors which contribute to the development of a pay gap including:

- differences in Grade Mix - A gap will develop if male / white doctors are more likely to be in more senior grades, gaps across the whole medical workforce are usually indicative of grade mix

- differences in Point Mix - A gap will develop if male / white doctors are more likely to be higher up the pay scale (for example, Consultants with 19 years' experience), gaps within a particular grade are usually indicative of point mix

- differences in Additional Earnings - Male / white Doctors may be more likely to have higher additional earnings - for example they may be more likely to receive Clinical Excellence Awards

The latest data on pay gaps in medicine are presented in the following section.

HCHS Gender and ethnicity pay gaps

Table 52 presents the latest data on the Gender and Ethnicity Pay Gap as of May 2021 and are based on basic pay per FTE. Gender and Ethnicity are shown separately to isolate the impact of either factor.

Table 52 - Gender and Ethnicity Pay Gap for HCHS Doctors using Basic Pay per FTE definition - May 2021.

Staff Group	GPG - White	GPG - BME	EPG - Female	EPG - Male
Description	Comparison of White Female to White Male	Comparison of BME Female to BME Male	Comparison of BME Female to White Female	Comparison of BME Male to White Male
HCHS Doctors	-11% (White Females have pay 11% lower than White Males)	-13%	-12%	-10%
Consultants	-3%	-2%	-2%	-3%
SAS Doctors	-2%	-6%	-4%	0%
Junior Doctors	-1%	-4%	-2%	1%

Source - NHS Digital Earnings Statistics

Overall, male and white doctors are paid more than female and BME doctors' average earnings for white female are around 11% lower than for white males and BME females around 12% lower than for white females.

Gaps are much smaller within medical grades with most gaps being between 0% and 4% - This suggests that the "Grade Mix" effect is much stronger than the Point Mix effect - for example the information on "Gender Balance" in Chapter 4 shows that a higher proportion of Consultants are male, and a higher proportion of Junior Doctors are female.

General Practice pay differences by age and gender

Mean earnings, expenses and income by age group and gender for salaried and contractor GPs in England are set out in Table 53 and 54. The data shows that for both contractor and salaried GPs, men earn more on average than female GPs in each age category, with the difference in average pay reducing in GPs over 60 years old.

GP earnings data does not take account of part time working and average participation rates are lower for female GPs than male, so it is not possible to assess the extent to which differences in working patterns may explain the observed earnings differences between male and female GPs of different ages. For example, female GPs may be more likely to take a career break and have fewer years of reckonable service than male GPs of

the same age. The amount of earnings from outside of general practice or the NHS may also differ between male and female GPs.

The GPG Review found that the mean gender pay gap for net income before tax in the 2016-17 tax year was 22.6% among contractor GPs and 31.1% among salaried GPs. The report found the FTE-corrected mean gender pay gap was substantially lower for contractor GPs at 7.7% but remained high for salaried GPs at 22.3%. However, there are known limitations with the analysis, which used total income figures based on HMRC's self-assessment tax records and contracted hours or average weekly hours taken from NHS Digital's Workforce Minimum Data Set (wMDS). This collection does not capture the actual number of hours worked and any hours worked outside of a general practice setting would not be accounted for.

Table 53 and 54 - Average GP earnings and expenses in England by age and gender – 2019-20, GMS and PMS, all practice types

Contractor GP, England

Age	Gender	Report population	Average total gross earnings	Average total expenses	Average total income before tax	% Comparison of Female to Male
Under 40	Female	1600	£331,300	£231,900	£99,500	-22%
Under 40	Male	1600	£401,000	£273,600	£127,500	
40-49	Female	3550	£362,400	£255,800	£106,600	-22%
40-49	Male	3650	£451,500	£315,500	£136,000	
50-59	Female	2950	£373,800	£265,500	£108,300	-22%
50-59	Male	3900	£455,400	£317,100	£138,300	
Over 60	Female	550	£360,300	£244,500	£115,800	-9%
Over 60	Male	1500	£390,800	£264,200	£126,600	

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2019-20, August 2021, Tables 2a and 2b. Earnings and expenses estimates are only available for England GPs and were calculated for the first time for 2016-17

Salaried GP, England

Age	Gender	Report population	Average total gross earnings	Average total expenses	Average total income before tax	% Comparison of Female to Male
Under 40	Female	4,300	£63,000	£6,400	£56,600	-28%
Under 40	Male	1,350	£94,000	£15,100	£78,900	
40-49	Female	2,550	£66,300	£7,100	£59,200	-29%
40-49	Male	700	£93,500	£10,200	£83,300	
50-59	Female	1,100	£66,800	£4,900	£61,900	-29%
50-59	Male	500	£99,300	£11,800	£87,500	
Over 60	Female	200	£61,200	£6,700	£54,400	-12%
Over 60	Male	300	£69,300	£7,300	£62,100	

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2019-20, August 2021, Table 8. Earnings and expenses estimates are only available for England GPs and were calculated for the first time for 2016-17.

1. The percentage difference is calculated as the mean (average) difference in average total income before tax as a percentage of men's pay.

The gender pay gap implementation panel

The Department published the GPG review in December 2020. In our evidence to the DDRB last year we outlined our plans to establish an independently Chaired Implementation Panel with responsibility for driving forward work to reduce the gender pay gap in medicine.

The Department is pleased to say that the panel has been established and is independently Chaired by Professor Dame Jane Dacre. Membership is wide ranging and includes senior leaders from across the health system, representing among others, NHSE/I, NHS Employers and the Trade Unions.

The panel had their first meeting in September 2021 where they agreed an ambitious and wide-ranging work programme, informed by the recommendations from the GPG review. The plan was subsequently signed off by the Minister of State for Health. Policy teams across the Department are working closely with colleagues in partner organisations to deliver the programme. Quarterly progress updates are submitted to the panel for review.

The work of the panel underpins our ambition to embed pay gap considerations into policy development and we are already seeing successful outcomes for example, through the reduction in pay points agreed in the SAS contract reform.

The ethnicity pay gap review

As members will remember, in our evidence last year we also committed to explore the causes of the Ethnicity Pay Gap (EPG) across the NHS workforce.

As a first step, the previous Minister of State for Care, Helen Whatley chaired a roundtable in late Spring that brought together key stakeholders for a discussion on the causes of the EPG. We concluded from the conversation that before we take action to remedy the problem, we need to better understand the nuances within the EPG.

That is why we will be commissioning a research project examining the EPG across the NHS. The research will aim to analyse pay related data in a manner that gives a clearer and more accurate picture of where there are potential ethnic inequalities in pay and,

presenting recommendations aimed at reducing inequalities where they exist. We are in the final stages of commissioning and anticipate an announcement in the coming months.

6. Total reward

Introduction to total reward

Total reward is the tangible and intangible benefits that an employer offers an employee, and it remains central to recruiting and retaining staff in the NHS. The value of the NHS total reward package remains high, as has been noted in previous rounds of DDRB evidence.

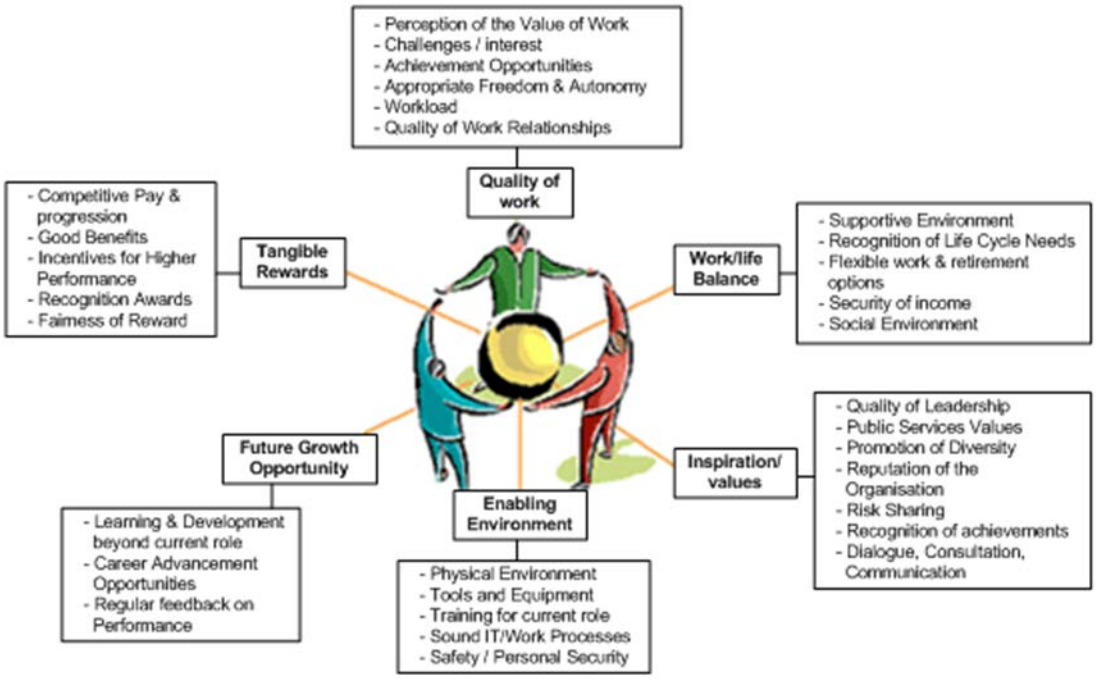
The NHS total reward package includes a range of benefits that are above the statutory minimum and exceed those offered in other sectors. These benefits include a holiday allowance of up to 33 days (plus 8 public holidays), sickness absence arrangements well beyond the statutory minimum, enhanced rates for nights and weekend work, access to a much-valued pension scheme, enhanced parental leave, and support for learning, development and career progression.

As part of the total reward package and to improve the experience of working in the NHS NHSE/I have developed the NHS People Promise, which accompanied the July 2020 People Plan publication. The intention is to make the promise's principles a reality by 2024. It is structured around 7 principles aimed to make the NHS "the best place to work". The 7 principles are: We are compassionate and inclusive; We are recognised and rewarded; We each have a voice that counts; We are safe and healthy; We are always learning; We work flexibly; We are a team.

More detail on the People Promise will be provided in NHSE/I's written evidence.

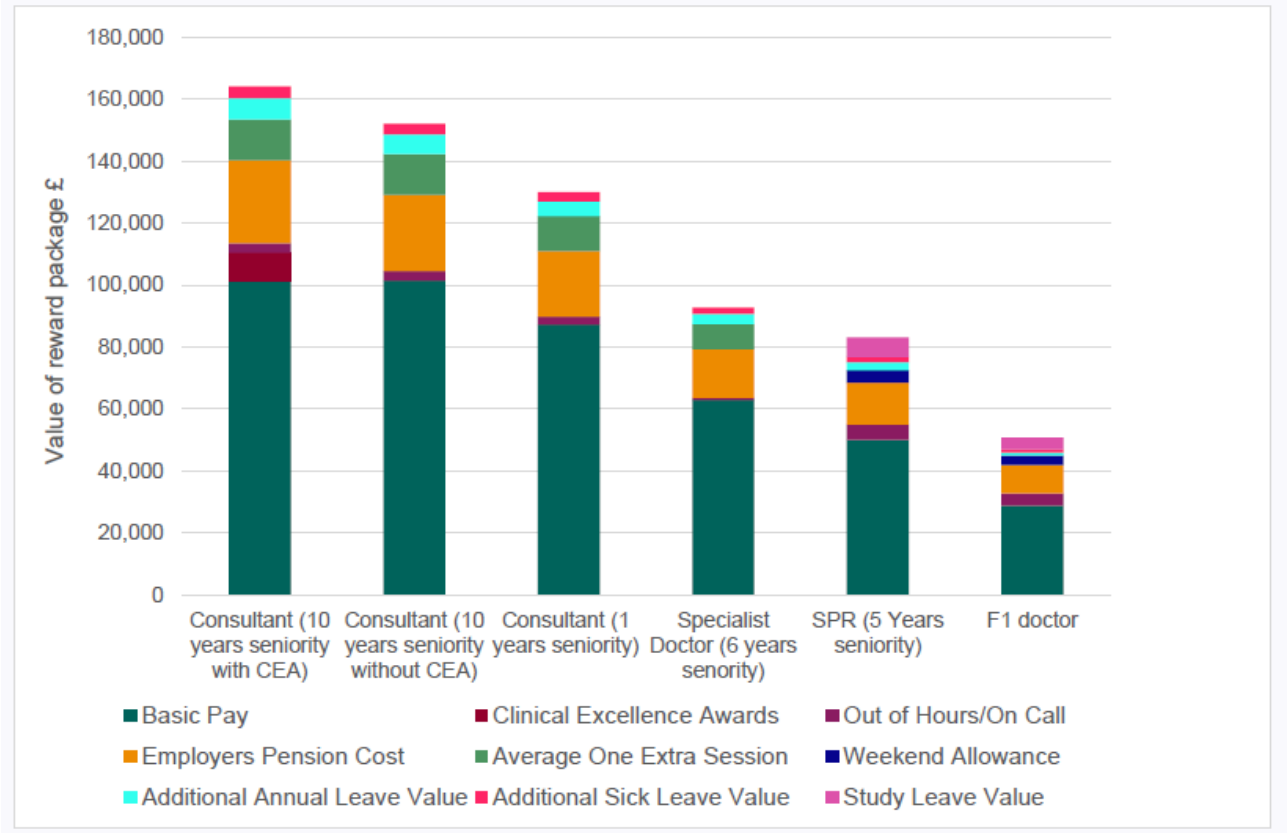
The Department commissions NHS Employers to provide advice, guidance and good practice to the NHS on developing a strategic approach to reward based on the Hay Model (Figure 16). Further information on how individual employing organisations approach reward for their staff will be provided in the written evidence submitted by NHSE/I and NHS Employers.

Figure 16 - The Hay Model



The value of the reward package for doctors is shown in Figure 17 below, which has been produced for the Department by the government Actuary's Department (GAD). It includes basic pay, other pay such as clinical excellence awards (CEAs) for consultants (including dental consultants), out of hours/on call payments, employer pension costs, extra sessions worked and weekend allowances. It also includes additional leave over the statutory minimum, additional sick leave over statutory sick pay and study leave for doctors and dentists in training.

Figure 17- Total Value of Wider Reward Packages 2021-22 (£)



NHS trend analysis

The Department also commissioned GAD to carry out trend analysis for different NHS staff, based on the previous total reward analysis at 2017-18, 2018-19, 2019-20 and 2020-21. This trend analysis for NHS doctors looks at the split of total wider reward packages between basic and other pay over the years 2019-20, 2020-21 and 2021 and 2022.

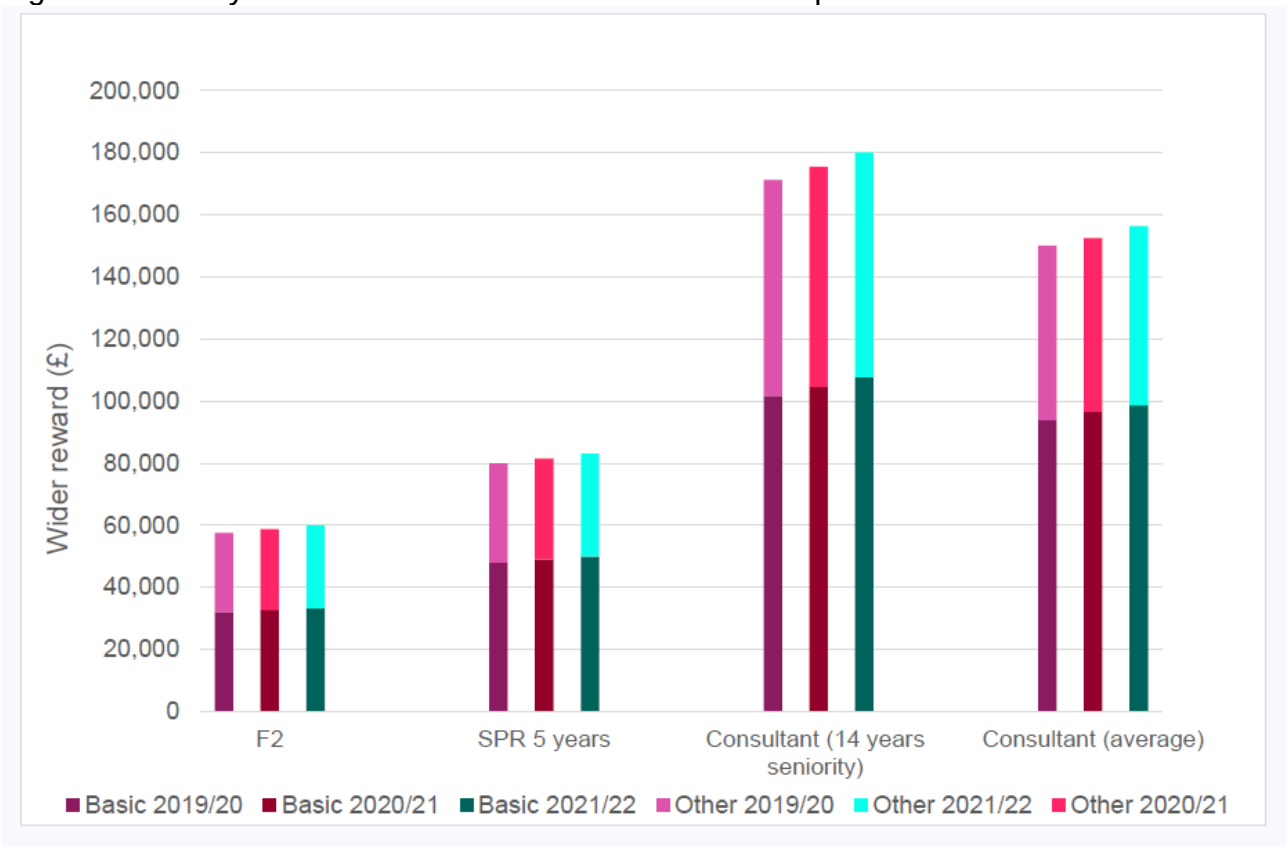
The roles considered are Foundation Year 2 (F2) doctors, Speciality Registrars (SPR) with 5 years' seniority, consultants with 14 years' seniority and average consultants. The chart below compares average rewards at 30 September 2019, 30 September 2020 and 30 June 2021 with pay bands at 2019-20, 2020-21 and 2021-22. GAD believes this is appropriate and will only cause a negligible difference for the purpose of comparison. This is consistent with the approach used in previous years and reflects the availability of the relevant data.

Figure 18 shows that all doctor roles considered as part of the analysis have experienced an increase in total wider reward over the period 2019-20 to 2021-22. F2 doctors and SPR doctors experienced broadly consistent increases of around 2% in each year over the period, meaning total reward increased by around 4% between 2019-20 and 2021-22.

Consultants with 14 years seniority experienced an increase of around 2.5 % in each year over the period, bringing the increase in total wider reward package to around 5% over the total period. The value of reward package for average consultants increased by around 4%

over the period 2019-20 to 2021-22. All doctor roles considered have at least 37% of the total reward made up of non-basic pay.

Figure 18 - Analysis of the trend in wider reward over the period 2019-20 to 2021-22



GAD also analysed total reward across various private sector occupations, based on Office for National Statistics (ONS) data for salary and pension benefits, and compared them against pay rewards for NHS doctors based on their previous analysis from 2012 to 2020.

This analysis of reward is intended to give an approximate indication on how wider reward between roles and occupations change over time; it is not intended to provide a direct comparison between any direct NHS doctor role and other occupation. The roles included in this analysis are F2 doctors, SPRs with 5 years' seniority, and average consultants. The private sector occupations considered are managers, directors and senior officials and professional occupations.

Figure 19 below shows that all roles considered as part of this analysis experienced an increase in reward between 2012 and 2020. The new 2016 Doctors in Training contract was introduced over this period and so the impact of this will be reflected in value of reward over the period from 2012 to 2020. SPR experienced an increase of around 28% over the period from 2012 to 2020. This may be driven by an increase to basic pay following the new 2016 Doctors in Training contract. The value of reward packages for F2

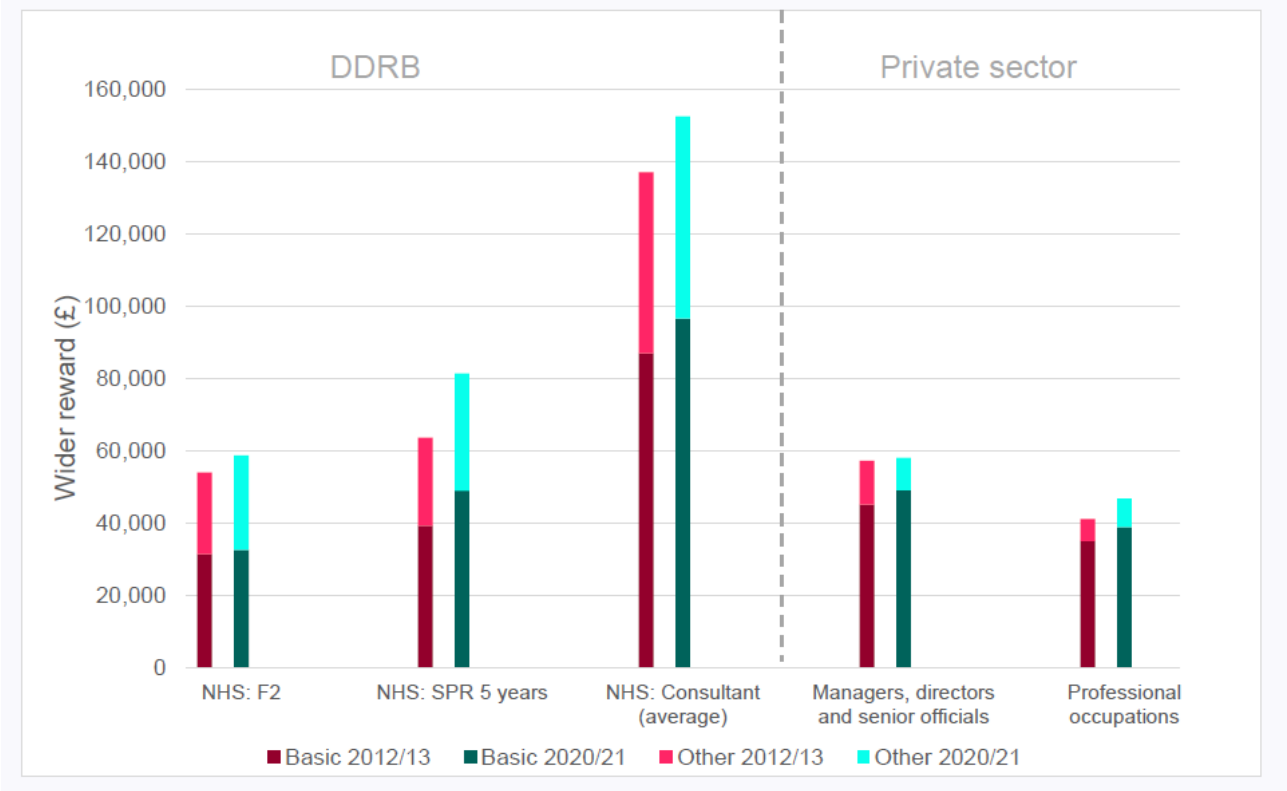
doctors increased by around 9% over this period. The value of reward packages for average consultants increased by around 11% over the period.

Private sector occupations experienced lower increases compared to the public sector. Professional occupations experienced a larger increase than Managers, Directors and Senior Officials with increases of around 14% and just over 1% respectively in total wider reward over the period.

Non-basic pay makes up a larger proportion of NHS total rewards across all roles analysed relative to private sector occupations, with this making about 36% of consultant rewards. One driver for this might be the value of public sector pension benefits available to NHS staff and additional pay elements and awards available, relative to the private sector.

Although they are not included in the chart, the additional non-basic pay elements of the total reward package available to NHS staff should be considered as they usually exceed that available in other sectors. These include benefits available to members of the NHS Pension Scheme (other than the value of pension benefits accrued each year), parental leave and other flexible benefits.

Figure 19 - Comparison of trend of increase of NHS roles relative to private sector over the period 2012 to 2020



Introduction to the NHS Pension Scheme

Doctors and dentists working in the NHS have access to the NHS Pension Scheme ("the Scheme"), which remains a valuable part of the total reward package available to them and one of the best pension schemes available. Membership of the Scheme is high, with around 9 in 10 NHS staff actively participating.

Eligible doctors and dentists will now belong to one of the 2 existing schemes, both of which are defined benefit schemes. The final salary scheme, or legacy scheme, is made up of the 1995 and 2008 Sections and is now closed to new members. All new staff will join the 2015 Scheme, a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career. Benefits in the 1995 to 2008 Sections for self-employed doctors and dentists (practitioner members) are also calculated on a CARE equivalent basis. The key differences between the 2 schemes, other than the way benefits are calculated, are different normal pension ages and accrual rates, as shown in Table 55 below.

Table 55 - Comparison of scheme, retirement age and accrual rate

Scheme or Section	Retirement Age	Accrual rate
1995 Section	60	1/80th
2008 Section	65	1/60th
2015 Scheme	State Pension Age	1/54th

GAD calculates that Scheme members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. A junior doctor with membership wholly in the 2015 Scheme (retiring at 68) can expect a pension of around £62,800 p/a if they progress to be a full-time consultant. A similar junior doctor progressing to be a part-time consultant can expect a pension of around £53,700 p/a. Junior doctors progressing to be GPs can expect a pension of around £53,700 p/a.

The 2015 Scheme was introduced as part of wider reforms implemented by regulations made under the Public Service Pensions Act 2013. As part of these reforms, public service pension scheme members within 10 years of retirement were given transitional protection, and so remained in their legacy pension schemes. In December 2018, a judgement by the Court of Appeal in the cases of McCloud and Sargeant ("the McCloud judgment") found that these transitional protection arrangements gave rise to unlawful discrimination.

The Department set out the Government's proposed response to the McCloud judgment its 2021 evidence. Since then, the Government has laid proposed primary legislation, the Public Service Pensions and Judicial Offices Bill, before Parliament to implement changes in public service pension schemes to remedy the discrimination identified by the McCloud judgment. The bill was introduced into the House of Lords on 19 July 2021. Subject to Parliamentary approval, this puts in place a legal framework which requires departments to

make amendments to pension scheme regulations to facilitate implementation of the remedy as directed by the bill.

The remedy has 2 parts:

- to ensure equal treatment for all members within each of the main public service pension schemes by moving all members into the new schemes on 1 April 2022 irrespective of age

- to remove the effect of transitional protection by offering eligible members a choice over the set of benefits (legacy scheme or new scheme) they wish to receive for any pensionable service during the period 1 April 2015 to 31 March 2022

On 9 December 2021, the Department launched a consultation on a draft Statutory Instrument (SI), which will make changes to the NHS Pension Scheme regulations as part of the first part of the McCloud remedy.

NHS Pension Scheme contributions

The Scheme collects contributions from both employers and members, with employers contributing 20.6% (plus a 0.08% administration charge) of a member's earnings. Members are required collectively to contribute 9.8% across the whole scheme membership. This is the average member contribution rate and is known as the member contribution "yield".

Tiered contribution rates were introduced in 2008, to reflect that higher earners were likely to receive proportionally more benefits than lower earners over the course of their retirement, due in part to their final salary link. To ensure the cost of the Scheme is affordable for all members, these tiered contribution rates ask higher earners to pay proportionally more than lower earners to access the valuable benefits of the Scheme. The Department keeps member contribution rates under review, in dialogue with NHS trade unions and employers through the NHS Pension Scheme Advisory Board (SAB).

The Department launched its consultation on changes to member contributions on 19 October 2021. The consultation set out that whilst the generous cross-subsidy provided by the current tier structure was intended to reduce potential financial barriers and encourage all staff to participate in the Scheme, the Department could no longer justify keeping the cross-subsidy at the same level. In the old final salary scheme, higher earners tended to derive more value from their ultimate pension benefits relative to the amount they contributed over their career, and so they were charged higher contribution rates. However, under a CARE scheme this advantage no longer exists for higher earners, as all members receive the same proportional benefit for their contributions.

Given that all members will be moved to the 2015 Scheme, a CARE scheme, for future accrual from 1 April 2022, the consultation set out a new structure (Table 56), which narrows the range between the lowest and highest contribution rates and ensures that the costs and benefits of the scheme are more evenly shared. Other changes set out in the consultation document include a move to base members' contribution rates on their actual pensionable pay rather than their whole-time equivalent (WTE) earnings, and annual increases to each tier in line with uplifts to Agenda for Change (AfC) pay bands. Whilst AfC does not apply to the DDRB workforce, earnings ranges in the contribution tiers will be increased each year in line with the AfC pay award. This is because AfC is the pay award that applies to the highest number of Scheme members.

Adjustments to contribution tiers will be phased in over 2 years, to dampen the impact on take-home pay for staff and mitigate the risk of staff leaving the scheme on grounds of affordability. For the purpose of determining a member's contribution tier, their pensionable earnings are rounded down to the nearest whole pound. In practice, as the tier thresholds will be increased annually in line with AfC pay awards the figures will be slightly different for future scheme years.

Table 56 - New member contribution structure, as proposed in the consultation document

Current tiers	Pensionable earnings (rounded down to nearest pound)	Current rate	Rate from 1 April 2022	Rate from 1 April 2023	Proposed tiers
-	-	(WTE pay)	(Actual pay)	(Actual pay)	-
Tier 1	Up to £13,231	5.0%	5.1%	5.2%	Tier 1
Tier 1	£13,232 to £15,431	5.0%	5.7%	6.5%	Tier 2
Tier 2	£15,432 to £21,478	5.6%	6.1%	6.5%	Tier 2
Tier 3	£21,479 to £22,548	7.1%	6.8%	6.5%	Tier 2
Tier 3	£22,549 to £26,823	7.1%	7.7%	8.3%	Tier 3
Tier 4	£26,824 to £27,779	9.3%	8.8%	8.3%	Tier 3
Tier 4	£27,780 to £42,120	9.3%	9.8%	9.8%	Tier 4
Tier 4	£42,121 to £47,845	9.3%	10.0%	10.7%	Tier 5
Tier 5	£47,846 to £54,763	12.5%	11.6%	10.7%	Tier 5
Tier 5	£54,764 to £70,630	12.5%	12.5%	12.5%	Tier 6
Tier 6	£70,631 to £111,376	13.5%	13.5%	12.5%	Tier 6
Tier 7	£111,377 and above	14.5%	13.5%	12.5%	Tier 6
-	Expected yield	9.8%	9.8%	9.8%	-

In order to balance clarity for members and a timely move to the new structure with minimising the impact of the new member contribution structure on take-home pay, the Department decided to delay the implementation of the new member contribution structure until 1 October 2022. As set out in the consultation document, the new member contribution structure will be phased in slowly to protect scheme affordability and minimise the risks to take-home pay of increases to member contribution rates.

In October 2022, approximately 40% of members are expected to receive a reduction in their contribution rates compared to the previous contribution rate structure. Senior doctors and dentists, who are some of the highest earning members of the NHS, are particularly likely to see a decrease in their contribution rate as the gap between the lowest and highest contribution rates is narrowed. Members with pensionable pay between £70,631 and £111,376, who currently contribute 13.5%, will contribute 12.5% by the end of the phasing in period. Members with pensionable pay above this amount, who currently contribute 14.5%, will also see this decrease to 12.5% by the end of the same period.

Moving to using actual annual rates of pensionable pay (instead of WTE) will also benefit many part-time doctors and dentists, as their contribution rate will be lower and better reflective of the amount of pension that they are building. Around 40% of the Scheme membership work part-time, and it is estimated that 30% of the whole Scheme membership would pay less in contributions as a result of moving to actual annual rates of pay.

The Department asked GAD to provide examples showing the effect of the new structure on consultants. A consultant earning £114,003 would pay £85 less a month after tax relief. The same consultant working 60% of full-time would pay £51 a month less.

In practice, moving from WTE to actual annual rates of pay will result in very little change for practitioner members - GPs and self-employed dentists. This is because the current scheme architecture for practitioners does not use WTE. Officer members are staff who are employed and have access to the Scheme. These members will have their member contributions based on their previous years' pensionable pay to allow members to have their pension contributions deducted regularly through their payroll, in anticipation of the full year earnings. This is similar to the mechanics of the WTE approach.

The SAB have previously considered that it is important for any tier structure to avoid "cliff edges", whereby members are placed in a higher tier as the result of moving up a pay band, and so see a decrease in their take-home pay. This issue has also been highlighted by the Pay Review Bodies. Whilst the Department has sought to mitigate this in designing the new contribution structure, in a tiered contribution structure some cliff edges will always exist.

It is also common for doctors and dentists to earn supplementary payments for on-call or out-of-hours work, which may increase their pensionable pay. This means that not all members of the Scheme have pensionable pay which matches nationally agreed pay scales. This also contributes to difficulties in designing a tier structure that avoids cliff edges, and makes it hard to predict the impact of any particular change in structure on individual members or groups of members.

Pension taxation

To encourage individuals to plan for their retirement, the government provides tax incentives by allowing pension scheme contributions to be made tax-free. However, the cost of providing this tax incentive is over £50 billion a year. To ensure sustainability, since 2010 there have been progressive restrictions on the amount that individuals can save into their pension tax-free.

As previous DDRB reports have noted, in previous years there has been evidence of high-earning clinicians opting out of the Scheme or retiring early because of issues with the Lifetime Allowance (LTA) and Annual Allowance (AA), which limit the total amount of tax-free pension savings that an individual can make over their career and each year.

The government's manifesto committed to addressing the taper problem in doctors' pensions. This followed a review of the tapered AA commissioned by the Prime Minister before the General Election.

In response to evidence of senior clinicians reducing their working patterns due to the impact of the taper, the Department also completed a consultation on a package of pension flexibilities between September and December 2019. Responses to the consultation were shared with HMT, who led the review of the taper.

However, following the review the government decided that a tax solution was the simplest way to address the issue. At Budget in March 2020, the Chancellor increased the tapered annual allowance thresholds by £90,000 from 6th April 2020. The net income and adjusted income thresholds were increased to £200,000 and £240,000 respectively.

As of 1 April 2021, the allowances are as follows:

- £1.073 million for the LTA; and
- £40,000 for the AA, tapering down to £4,000 at a rate of £1 less allowance per £2 of relevant earnings above £240,000. HMRC calculates relevant earnings to include the value of pension growth over the year

Following these changes, the pension flexibility proposal consulted on in 2019 will not be implemented. The incentive to take on additional work is now restored, and all Scheme members can earn an additional £90,000 before they are affected by the taper. The Department has previously estimated that this takes up to 96% of GPs and up to 98% of NHS consultants outside the scope of the taper based on their NHS income, so they can perform the work that the NHS needs without worrying about tax bills. A small number of GPs and consultants will still experience tapering based on their NHS earnings. These are the very highest earners in the NHS.

The “Scheme Pays” facility allows members to meet the cost of a tax bill from the value of their pension benefits, without needing to find funds upfront. Where a member uses Scheme Pays, the scheme applies an interest rate that will reduce the value of pension benefits at retirement.

Analysis from GAD demonstrates that Scheme Pays is a proportionate means of dealing with an AA charge, and at retirement will have a relatively small impact on the pension accrued that year. The analysis shows that it may be a sound financial decision to incur an AA charge and use Scheme Pays to deal with it. Although Scheme Pays will reduce the value of the pension accrued, the growth in benefits represents a good return on the contributions made.

For example, a 40-year old 2015 Scheme member earning £125,000 with £20,000 additional non-pensionable income would build in the 2022-23 scheme year an annual pension worth £9,521pa at retirement. This would be reduced by 6% to £8,974pa once the Scheme Pays debit is applied. Figure 20 illustrates the progression up to retirement of pension benefits accrued and the annual allowance charges incurred over a single year following the post-April 2020 annual allowance regime for this example member.

The Department is committed to improving the availability of high-quality information on the Scheme for members. As part of this, the Department commissioned NHS Employers to provide a “ready reckoner” to help members assess their potential tax liability. The tool was launched in September 2020 and allows members to input their pay and pension details to get a view on whether their prospective NHS commitments may lead to an AA tax charge.

Figure 20 - Example growth in pension earned over year 2022-23 for a member with 2015 Scheme benefits, Pensionable pay £125,000

Flexibility around retirement

The Department is also aware that older doctors and dentists value the ability to work flexibly, and that employers' ability to make more flexible employment offers is key to retaining experienced staff in the workforce for longer. The Department has therefore been working with NHSEI on a retention initiative focused on employers making flexible employment offers to staff and engaging their higher earners on pension tax issues. These plans include:

- developing pension communications designed specifically for staff, and personal illustrations demonstrating the value of delaying retirement

- staff seminars to explain the value of the scheme and the benefits of delaying retirement, including seminars designed for those affected by pensions tax

The Department is also working with NHS Employers, who are supporting this work by providing guidance and practical examples on actions employers can take. NHS Employers have published a range of communication, guidance, and training materials to support organisations to have impactful conversations with their staff to help them make informed decisions about how the Scheme can help them to retire gradually supported by flexible working options or retire and return.

NHS Pension Scheme membership

The Department continues to monitor Scheme membership rates through ESR, which records staff working in hospitals. Table 57 shows the total number of Scheme members by medical grade at July 2021. It also compares the change in membership rates from July 2020 to July 2021, July 2016 to July 2021 and July 2011 to July 2021.

Table 57 - Pension Scheme Membership Rates by Staff Group

Medical Grade	July 2021 FTE	July 2021 Headcount	July 2021 Membership (Headcount)	1 Year Change 2020-2021	5 Year Change 2016-2021	10 Year Change 2011-2021
Consultant	51,742	55,254	89%	0.2%	-2.8%	-5.3%
Associate Specialist	1,875	2,098	89%	-0.7%	-2.4%	-2.6%
Specialty Doctor	7,884	9,016	84%	-0.6%	-4.3%	-2.2%
Staff Grade	310	347	89%	-0.3%	-1.0%	7.5%
Specialty Registrar	31,838	33,393	85%	-2.2%	-5.6%	-3.8%
Core Training	14,817	15,110	82%	-1.2%	-10.0%	-7.2%
Foundation	6,160	6,207	87%	-0.8%	-5.6%	-6.0%

Doctor Year 2						
Foundation Doctor Year 1	8,346	8,374	89%	-3.1%	-5.6%	-4.5%
Hospital Practitioner/ Clinical Assistant	577	1,683	69%	0.4%	-6.8%	-9.1%
Other and Local HCHS Doctor Grades	827	1,328	91%	0.0%	0.2%	0.4%
HCHS Doctors	124,377	132,445	86%	-1.0%	-4.7%	-4.7%

Membership of the scheme amongst all HCHS doctors is high, at 86%. This is however a reduction of 1.0% compared to July 2020 (the same point the previous year), and a reduction of 4.7% compared to July 2011. Further investigation is necessary to explain the decline in scheme membership rates for doctors since 2011. However, the Department recognises that experience of pension taxation may be a factor.

However, membership rates for the NHS Pension Scheme compare favourably with private sector pension scheme participation. The Department for Work and Pensions published a report in June 2019 comparing the participation rates and savings trends between public and private sector pension schemes. The report studied pension scheme data between 2008 and 2018. Although private sector pension scheme participation has risen since the introduction of auto-enrolment, participation in private sector schemes (85%) is still lower than the public sector (93%). The report also shows that scheme participation for lower earners in public sector schemes is higher than that of lower earners in private sector schemes.

Tables 58, 59 and, 60 show the number of consultants, GPs and GDPs claiming their NHS pension earlier than their normal pension age, taking Voluntary Early Retirement (VER).

Table 58 - The number of consultants claiming their NHS Pension on a voluntary early retirement (VER) basis (1995 pension scheme only). Source - NHS Business Services Authority

Consultants	VER	% of all retirements
Y/E 2008	178	13.9
Y/E 2009	146	11.6
Y/E 2010	183	12.5
Y/E 2011	286	16.5
Y/E 2012	315	17.9
Y/E 2013	388	24.4
Y/E 2014	404	25.4
Y/E 2015	453	28.5
Y/E 2016	496	31.0
Y/E 2017	492	30.1
Y/E 2018	443	29.1
Y/E 2019	414	27.6

Y/E 2020	525	30.8
Y/E 2021	475	28.3

Table 59 - The number of GPs claiming their NHS Pension on a voluntary early retirement (VER) basis (1995 pension scheme only). Source - NHS Business Services Authority

GPs	VER	% of all retirements
Y/E 2008	198	17.2
Y/E 2009	264	20.2
Y/E 2010	322	22.6
Y/E 2011	443	28.5
Y/E 2012	513	33.2
Y/E 2013	591	41.9
Y/E 2014	746	49.6
Y/E 2015	739	51.4
Y/E 2016	695	52.4
Y/E 2017	724	60.8
Y/E 2018	587	56.7
Y/E 2019	605	55.4
Y/E 2020	596	54.1
Y/E 2021	704	58.6

Table 60 - The number of dental practitioners claiming their NHS Pension on a voluntary early retirement (VER) basis (1995 pension scheme only). Source - NHS Business Services Authority

Dental practitioners	VER	% of all retirements
Y/E 2008	103	27.5
Y/E 2009	148	36.0
Y/E 2010	126	33.3
Y/E 2011	154	32.6
Y/E 2012	183	36.0
Y/E 2013	185	36.1
Y/E 2014	163	37.9
Y/E 2015	185	38.9
Y/E 2016	188	43.4
Y/E 2017	170	42.0
Y/E 2018	164	39.6
Y/E 2019	204	40.4
Y/E 2020	194	39.3
Y/E 2021	214	40.8

The data shows that GPs take early retirement at a higher rate than other clinicians. The decision to retire is a personal one and the scheme administrator, the NHSBSA, does not request this when staff choose to retire. Further work is required to determine why this is the case. This is also discussed in more detail in the GP chapter.

However, it is important to note when examining the VER data that it does not necessarily mean that staff have left NHS service altogether. For members of the 1995 Section, there is the option to “retire and return”, by which they can leave service and return to work, providing they meet certain conditions. Under this arrangement members are not permitted

to re-join the Scheme, which explains why they may be absent from data, yet remain part of the workforce.

Trade unions have previously noted that the fear of breaching the LTA is causing many doctors to retire early. Although breaching the LTA may be a contributory factor in doctors deciding to claim VER, it is also important to note that clinicians have well remunerated careers, and many make the choice to retire early as they have built up a substantial level of financial security.

NHS Pension Scheme benefits

Beyond the pension which is payable for life following retirement, the wider scheme benefits for a member of the 2015 Scheme at 1 April 2022 include:

- tax relief on member contributions
- employer contributions, currently 20.6% of members' pay
- death in service lump sum equivalent to 2x salary
- spouse and family benefits, including benefits paid to a spouse following a death in retirement, and children's pensions in some cases
- ill health benefits, including full retirement benefits accrued without reduction under ill health Tier 1, and enhanced benefits for prospective service up to normal retirement age under ill health Tier 2
- options to exchange pension for a tax-free cash lump sum (subject to limits); early and late retirement options (subject to limits) and the option to purchase additional pension

Enhanced parental leave

For medical staff whose contracts have recently been reformed are on modernised terms and conditions, employees with 12 months continuous service with one or more NHS employers are entitled to maternity, adoption, or shared parental leave benefits above the statutory entitlement (enhanced shared parental leave does not apply to consultants or SAS doctors on the pre 2021 contracts). A doctor earning £55,000 would be entitled to earn enhanced parental pay of around £12,000 more than they would be entitled to under the statutory leave allowance. Please note that GAD have refined their approach to calculate maternity pay after revisiting the contract terms and the figures now represent the additional value of NHS staff entitlements in excess of statutory maternity pay (previously, they looked at the value of NHS benefits only, excluding any SMP).

This calculation is provided for illustrative purposes only and represents the additional value of NHS staff entitlement in excess of SMP. Parental pay depends on the member's contractual entitlements and is calculated relative to the current statutory pay entitlements. Details on current statutory maternity pay can be found here.

Salaried GPs are expected to be employed on terms and conditions no less favourable than those set out in the model salaried GP contract. This includes maternity benefits above the statutory entitlement and as set out in the General Whitley Council Handbook. Salaried GPs can negotiate with their employer for terms and conditions more favourable than the model contract. The BMA publish a handbook which contains information on salaried GPs.

Flexible working

The Department is aware that doctors and dentists value the ability to work flexibly. Therefore, NHSEI is working with the NHS Staff Council, a partnership of NHS trade unions and NHS Employers, to create a range of tools and support for organisations to embed flexible working. This includes toolkits aimed at line managers and individuals to support managing flexible working requests. New guidance for HR colleagues is being developed on retire and return.

In addition, there is a national collective agreement to include the right to flexible working from day one within the NHS Terms and Conditions of Service Handbook. As part of the improvements made during contract reform, this section of the Handbook is also applicable to junior doctors and SAS doctors. The NHS Staff Council has jointly agreed revisions to Section 33 of the NHS terms and conditions of service handbook, which will include a new day one right to request flexible working. There will be no limit on the number of applications and regardless of the reasons for a request. There are also new requirements for better centralised oversight of processes to ensure greater consistency of access to flexible working. This includes an escalation stage for circumstances where a line manager is not initially able to agree a request. Employers will be expected to promote flexibility options at the point of recruitment and through regular staff engagement through one-to-ones, appraisals and team discussions. The improvements are designed to support and facilitate a cultural change to ensure flexible working is available to all NHS staff. The contractual changes came into force on 13 September 2021. A programme is also underway to support organisations understand the benefits for staff and patients of flexible working.

Flexible benefits

Other than the reward elements included in the above analysis, many employers also offer a range of flexible benefits, discounts and support offered to staff that may support

recruitment and retention of staff and improve employee engagement. Although the range of flexible benefits offered varies across employers, some popular flexible benefits can include salary sacrifice schemes, options to buy and sell leave and a range of discount vouchers. Employers may offer travel benefits such as season ticket loan and cycle to work scheme, as well as health and wellbeing benefits including discounted gym memberships.

Many trusts have also partnered with third party providers offering staff up to 20% discount on shopping, insurance and travel. NHS employees may also be entitled to cashback on purchases at specified retailers of up to 12% using prepaid cards. Therefore, NHS employees spending around £3,000 per year at a participating supermarket could offset spending by up to £360 (around 1% of basic pay on average). The overall value to staff can vary depending on the specific benefits options offered across employers and the level of benefits taken up but GAD estimates these additional flexible benefits could be valued up to 1% - 3% of basic pay on average across NHS employees.

Total reward statements

Total reward statements (TRS) are provided to NHS staff by their employer and give staff a better understanding of the benefits they have or may have access to as an NHS employee. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer.

Examples of local reward individual NHS employers may offer include recommend a friend schemes, affordable accommodation, childcare and carer support, counselling and support, various salary sacrifice schemes, retail discounts, education and learning support, financial wellbeing support, physical and mental health and wellbeing support, and signposting to pensions advice services.

Annual benefit statements

NHS Pension Scheme members also receive an annual benefit statement (ABS), which shows the current value of their Scheme benefits. On 7 December 2021, the number of statements viewed by staff was 349,349, a slight decrease from 375,457 that had been viewed at around the same point in 2020.

Since 2016, the BSA have held stakeholder engagement events across the country for a range of different NHS organisations to help employers better understand their role in promoting TRS. The workshops also explain the difference between a TRS and an ABS.