



Review Body on Doctors'
and Dentists' Remuneration

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Fiftieth Report 2022

Chair: Christopher Pilgrim



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

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

Presented to the Senedd by the First Minister
and the Minister for Health and Social Services

Presented to the Northern Ireland Assembly by the
Minister of Health

by Command of Her Majesty

July 2022



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Review Body on Doctors' and Dentists' Remuneration

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

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

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

- the need to recruit, retain and motivate doctors and dentists;
- regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;
- the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

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

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

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

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

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The Secretariat is provided by the Office of Manpower Economics.

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Executive summary

Introduction

1. The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the governments of the UK on the remuneration of doctors and dentists employed by, or providing services to, public health services across the UK. Our terms of reference are reproduced in full on page iii.
2. This report is divided into twelve chapters:
 1. Introduction
 2. Wider Context
 3. Affordability, Productivity and Workforce Planning
 4. Workforce Supply and Equalities
 5. Reward and Motivation
 6. Doctors and Dentists in Training
 7. Specialty and Specialist Doctors and Dentists (SAS)
 8. Consultants
 9. General Medical Practitioners
 10. Dentists
 11. Pay Recommendations and Observations
 12. Looking Forward

It also includes eight appendices:

- A. Remit Letters
 - B. Detailed Recommendations on Remuneration
 - C. The Number of Doctors and Dentists in Public Health Services in the UK
 - D. Glossary of Terms
 - E. The Data Historically Used in our Formulae-Based Decisions for independent contractor GMPs and GDPs
 - F. Abbreviations and Acronyms
 - G. Previous DDRB Recommendations and the Governments' responses
 - H. Staff Survey Gender and Ethnicity Data
3. The DDRB's remit group is complex. It is made up of 165,000 Hospital and Community Health Services (HCHS) medical staff (of which there are approximately 67,000 consultants, 14,000 speciality doctors and associate specialists (SAS) and 78,000 doctors and dentists in training), 53,000 General Medical Practitioners (GMPs) and 29,000 General Dental Practitioners (GDPs).

4. For this pay round we received remit letters from all four UK governments. The remits differed slightly, reflecting the different priorities of each government, as well as the multi-year pay deals that are in place for some groups within our overall remit. The UK Government did not seek recommendations from us for doctors and dentists in training, contractor GMPs or SAS doctors and dentists on reformed terms and conditions in England, while the Welsh Government and Northern Ireland Executive similarly did not ask us to make recommendations for SAS doctors and dentists on reformed terms and conditions in Wales and Northern Ireland respectively. We were asked by the governments for recommendations for all other groups of doctors and dentists across the UK.
5. However, in written evidence the BMA also asked us to make recommendations for all groups of doctors and dentists across the UK, including those currently under multi-year deals, and HCSA asked us to make recommendations for doctors and dentists in training in England and SAS doctors and dentists who are subject to the multi-year deal currently in place in England, Wales and Northern Ireland.
6. We received written and oral evidence from the Department of Health and Social Care (England); the Welsh Government; the Scottish Government; the Department of Health (Northern Ireland); NHS England and Improvement; Health Education England; NHS Employers; NHS Providers; the British Medical Association; the British Dental Association; and the Hospital Consultants and Specialists Association.

Wider Context

7. The pandemic and its aftermath has had a direct impact on both overall demand for healthcare services and the availability of and access to specific services. It has also caused care backlogs that will mean that demand is likely to remain at challenging levels for years to come, and further increasing the workload pressure for staff. Medical and dental staff have had to work flexibly and in unfamiliar settings and specialties, often putting themselves in danger as they delivered front-line care. Patient throughput in dentistry has also been significantly reduced, which has led to the governments providing practices with significant financial support.

8. In 2021 as a whole UK gross domestic product was estimated to have grown by 7.4 per cent, offsetting most of the 9.3 per cent that gross domestic product fell in 2020¹. The latest inflation figures from ONS, for April 2022 showed CPI inflation at 9.0 per cent, CPIH inflation at 7.8 per cent, and RPI inflation at 11.1 per cent, each over 12 months². In the three months to March 2022, average weekly earnings growth was stronger in the private sector than the public sector. Year-on-year average weekly earnings in March 2022 were 7.0 per cent higher across the whole economy, 8.2 per cent higher in the private sector and 1.7 per cent higher in the public sector (excluding financial services)³. According to XpertHR, the median pay award across the economy in April 2022 was 4.0 per cent⁴, and according to IDR it was 3.7 per cent⁵.

Affordability

9. DHSC said to us that, in setting the NHS budget, the Government had assumed a headline pay award of 2 per cent for NHS staff, taking into account the multi-year deals that were already in place. They said that higher pay rises than what was affordable would lead to a reduced ability to expand clinical capacity and tackle the elective care backlog. The Scottish Government said that it would be necessary for us to consider the affordability of our recommendations within the confines of the Scottish Public Sector Pay Policy, which they said represented an overall investment of 2 per cent into pay bills, though this investment was intended to be more concentrated towards the lower end of the earnings distribution. The Welsh Government and Northern Ireland Executive did not present us with explicit affordability figures.
10. Our view is that, given existing workforce shortages and continued dependency on temporary staffing, pay awards that are too low have the potential to have significant budgetary downsides, including increased use of temporary staffing, understaffing and worse motivation, which can affect the quality of patient care and efficiency of services and undermine any budgetary benefit that lower pay awards might bring. We therefore view the affordability and budgetary information provided by the governments as critical context for our considerations of pay uplifts, but we do not view government pay policies or affordability figures as an absolute limit on what our recommendations should be.
11. We appreciate that in responding to our recommendations, Ministers and health service leaders must decide how to fund medical and dental pay uplifts. This includes deciding whether to provide additional funding for health services, and how much to provide, as well as how to prioritise funding within overall budgets. We would expect such decision-making to be done appropriately and in consultation with partners in the system, and to be cognisant of the impact that this decision-making may have on services.

¹ <https://www.ons.gov.uk/economy/grossdomesticproductgdp/timeseries/ihyp/pn2>

² <https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation L55O, D7G7, and CZBH>

³ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/latest KAC3, KAC6 and KAE2>

⁴ <https://www.xperthr.co.uk/indicators/pay-awards/16100/>

⁵ <https://www.incomesdataresearch.co.uk/resources/viewpoint/median-pay-award-climbs-to-37>

Pay Recommendations

12. Our recommendations are made in line with our terms of reference, including in particular our considerations of recruitment, retention and motivation. We considered all the pay proposals provided to us by the parties, including the Scottish Public Sector Pay Policy and DHSC's affordability figure of 2 per cent, as well as the three trade unions' proposals that they receive uplifts in excess of RPI inflation. We discuss these in more detail in Chapter 3. We were also cognisant of the current high rates of inflation, which have grown more quickly than was expected at the start of the round. We observe that in the wider economy, pay settlements have increased, and medians are now well above the 2 per cent affordability figure provided to us by DHSC, but the latest data shows that employers across the economy are not matching current high levels of inflation with their pay awards. We do not believe that doctors and dentists should necessarily be exceptionally shielded from these increases to the cost of living faced by the wider population this year.
13. We note that health services remain under considerable strain, as a result of the continuing impact of the pandemic, and the care backlogs that were worsened as a result of pandemic-related disruption. Addressing the backlogs whilst dealing with ever-growing demand for services requires a workforce that is sufficiently large and engaged. It is therefore more essential than ever that staff are retained and motivated to perform.
14. The major recruitment and retention indicators that are included across our report, including vacancy rates, turnover and retirements, have not yet seen the significant deterioration that many of the parties have warned about. However, multiple parties expressed to us concern that this could still take place in the coming months. At the same time, a longer-term context of workforce shortages and high demand remains, which saw measures including vacancy rates at challengingly high levels even prior to the pandemic. These issues have also not yet been adequately addressed in workforce planning for the long-term.
15. Trends in workforce behaviour, including an increase in flexible and less-than-full-time working, affect workforce capacity across our remit group even in the absence of increases in the number leaving the NHS/HSC or retiring. Across the remit group, interest in senior, leadership and contractor roles, including leadership positions in hospitals and partner GMP status, seems to be waning, alongside the more general shift to less-than-full-time working. This may be driven by issues of workload, work-life balance and, for more senior staff, pensions and pensions tax issues. However, regardless of the cause, a decrease in average working hours necessitates a higher absolute number of staff to deliver the same quantity of services, providing a significant challenge to recruitment and retention, and warranting a further re-examination of workforce demand.
16. At the same time the key staff survey results that are available to us, including the NHS Staff Survey and the Dental Working Hours Motivation and Morale Survey, suggest severe and urgent challenges to motivation in general, with NHS Staff Survey results in England declining substantially on every measure, including significant falls in pay satisfaction.

17. Many of these issues are not directly solvable with higher pay awards. However, pay does serve as an important signifier of value and, perhaps more importantly, if it is sensed to be deficient, can exacerbate a feeling amongst the medical and dental workforce that they are neglected and undervalued. This can in turn make staff feel they no longer wish to put in the additional discretionary effort on which the NHS/HSC depends, or that they no longer want to work full-time, or that it is no longer worth staying in the NHS/HSC at all. In order to address this, a pay award is required that is significantly in excess of the 2 per cent proposed to us by DHSC, and the sums proposed to us under the SPSPP.
18. The backdrop to this year's round has been particularly challenging. In making our recommendations, we have balanced the need to ensure that they are affordable and represent an effective use of finite resources to support patient care, with the critical need to ensure that doctors and dentists feel that their vital role in our society is properly respected and that they are treated fairly relative to earnings growth among similar professionals. The issues of recruitment, retention and motivation are central to our recommendations and our view is that pay and reward must be maintained at a level that can, over the long term, retain existing staff and attract high calibre people into the NHS and HSC.
19. **Therefore, we recommend a 4.5 per cent increase to national salary scales, pay ranges or the pay element of contracts for all groups included in our remit letters from the governments for this year, namely:**
- **Consultants**
 - **SAS doctors and dentists in Scotland, as well as those who do not move onto the reformed contracts in England, Wales and Northern Ireland**
 - **Doctors and dentists in training in Scotland, Wales and Northern Ireland**
 - **Independent contractor GMPs in Scotland, Wales and Northern Ireland**
 - **Salaried GMPs**
 - **The GMP trainers' grant and GMP appraisers' grant**
 - **Independent contractor GDPs**
 - **Associate and salaried GDPs including Community Dental Service practitioners**
 - **Doctors and dentists employed by Trusts and Health Boards on locally-determined contracts**

These uplifts should be backdated to 1 April 2022 as necessary so that they would be paid in full for the 2022-23 financial year.

20. These recommendations are made considering the evidence we received, reflecting the need to recruit, retain and motivate staff, while also considering affordability, in line with our terms of reference. As we discuss in Chapter 3, decisions about how to fund pay awards across our remit group, whether through increases to departmental budgets, or to fund them from existing budgets, are a political choice that sits with Ministers. These dynamics also apply to general medical and dental practices, for whom we would expect appropriate funding arrangements to be made so that these recommendations can be passed on to salaried GMPs and associate GDPs.
21. We estimate that this recommendation would add approximately £425 million to the HCHS pay bill in England, against a total DHSC Resource Departmental Expenditure Limit in 2022-23 of £167.9 billion. We estimate that it would add approximately £77 million to the pay bill in Scotland, £52 million to the pay bill in Wales, and £26 million to the pay bill in Northern Ireland.
22. We welcome the progress that has been made towards the development and implementation of the new National Clinical Impact Awards scheme that covers England and Wales, and in the coming year we expect to see evidence of progress towards improving the equity and effectiveness of the scheme, compared to the previous National Clinical Excellence Awards scheme. We also note that DHSC asked us not to make recommendations that their value be increased during the first year of the new scheme's operation.
23. However, we note with concern the lack of progress towards improving the rest of the schemes in place across the UK. As we discuss in Chapter 8, issues of equity and effectiveness for these schemes remain across the UK. The Gender Pay Gap in Medicine Review's findings in relation to these schemes in England further strengthened the case for reform. **Given our concerns, we once again are not making a recommendation that the value of these awards be uplifted this year.** We are concerned, however, that a continuing freeze in the overall value of consultant reward schemes will gradually lead to the schemes' overall value deteriorating relative to the overall consultant pay bill. This could lead to the schemes, which we continue to regard as being important to retaining the most senior and capable consultants, being less effective even as necessary reforms are completed.
24. For this year, the remit letters for England, Wales and Northern Ireland again did not ask us to make recommendations for the three groups currently under multi-year pay deals (MYDs) – contractor GMPs in England, doctors and dentists in training in England, and SAS doctors and dentists who are employed on the reformed Specialty Doctor and Specialist contracts in England, Wales and Northern Ireland. However, the BMA asked us in written evidence to make recommendations for all groups of doctors this year, and HCSA asked us to make recommendations for doctors in training and SAS doctors.

25. The recruitment, retention and motivation concerns that we outlined in our discussion of the overall recommendations apply as much to those who are under MYDs as to those who are not. Indeed, some of the concerns, including declining pay satisfaction amongst doctors and dentists in training in England and recruitment and retention within the GMP workforce, are particularly acutely felt in the workforce groups under MYDs. We also have other concerns that relate to recruitment, retention and motivation for these groups, that we discuss in Chapter 11 and elsewhere in the report.
26. At the same time, we note that all three of the MYDs were agreed before the scale of increases to inflation became apparent, and therefore it cannot be said that they address those increases to inflation. Our wider recommendations this year do not seek to match inflation, but they have been informed by it to some extent, and also by the increases to pay settlements in the wider economy that the inflation increases have precipitated.
27. If action is not taken for those under MYDs, then the relative pay positions of different groups within our overall remit will diverge significantly. We are concerned that doctors and dentists under MYDs would therefore see their pay falling relative to their peers as a result of their having agreed to a MYD. This would have a significant effect on motivation, affecting retention, productivity, and ultimately patient care.
28. We are therefore extremely concerned that the uplifts contained within the MYDs are likely not sufficient to address the issues of recruitment, retention and motivation that we discuss elsewhere in the report.
29. Our view remains that our terms of reference instruct us to set out our independent views and enable us to make recommendations for any part of our remit group as we consider appropriate. However, at the same time, it is crucial that we operate with the consensual agreement of all of the parties. We also would generally wish to respect the MYDs that have been agreed between the governments and trade unions.
30. Therefore, we are not making a formal recommendation for the groups under MYDs this year. However, we would strongly urge the governments to consider the unique economic and workforce context, the need to protect the relative pay position of staff on MYDs, and the issues of recruitment, retention and motivation outlined above, and take action to address these issues. Given the exceptional and unusual nature of the current year, contrary to what DHSC told us, we do not believe that the governments taking action would set a precedent that MYDs can be reopened. In fact, a lack of action would set a different precedent; that workforce groups under MYDs should not expect there to be an appropriate response to exceptional changes to the economic and wider context, should they take place during the period that a MYD is active. This would make entering a MYD less attractive to staff, which would affect the governments' ability to agree contract reforms in future.

CHAPTER 1: INTRODUCTION

Introduction

- 1.1 The Review Body on Doctors' and Dentists' Remuneration (DDRDB) provides advice to ministers in the Governments of the UK on the remuneration of all doctors and dentists employed by, or providing services to, national health services. In this report, we make our recommendations and observations for the 2022 pay round, covering the 2022-23 financial year.
- 1.2 For this pay round we received remit letters from governments in England, Scotland, Wales and Northern Ireland. They differed slightly, reflecting the different priorities of each government, as well as the multi-year pay deals that are in place for some of the remit groups. More detail on the remit letters is provided later in this chapter.
- 1.3 This report is the DDRDB's fiftieth. At this milestone, we would wish to register our thanks to all those who have participated in the DDRDB process over its history, including our predecessors as Chairs and Members of the DDRDB. In particular, we would also like to register with appreciation the extraordinary contribution to our society that doctors and dentists have made during this period, and continue to make throughout the UK.

Structure of the report

- 1.4 We have considered the remit letters in relation to our standing terms of reference and set out the evidence received from the parties on these matters, together with the conclusions and recommendations we reached based on this evidence.
- 1.5 This report is divided into twelve chapters:
 1. Introduction
 2. Wider Context
 3. Affordability, Productivity and Workforce Planning
 4. Workforce Supply and Equalities
 5. Reward and Motivation
 6. Doctors and Dentists in Training
 7. Specialty and Specialist Doctors and Dentists (SAS)
 8. Consultants
 9. General Medical Practitioners
 10. Dentists
 11. Pay Recommendations and Observations
 12. Looking Forward
- 1.6 We also include eight appendices.
 - A. Remit Letters
 - B. Detailed Recommendations on Remuneration
 - C. The Number of Doctors and Dentists in Public Health Services in the UK
 - D. Glossary of Terms

- E. The Data Historically Used in our Formulae-Based Decisions for independent contractor GMPs and GDPs
- F. Abbreviations and Acronym
- G. Previous DDRB Recommendations and the Governments' responses
- H. Staff Survey Gender and Ethnicity Data

Key context for this report

- 1.7 For the third year, our report has been completed against the evolving backdrop of the coronavirus (COVID-19) pandemic and its aftermath. At the time of writing, government action to prevent the spread of COVID-19 continues to evolve, the virus remains present in the UK, and significant numbers are infected by, and require hospital treatment for, the virus. Health services and their staff continue to be under pressure both as a result of the virus itself and the care backlogs that it instigated.
- 1.8 The impact of the pandemic on the economy and on health services going forward will also remain an important contextual factor for years to come. We discuss the pandemic's impact on the economy in Chapter 2 and the evidence provided to us by the parties about the impact of COVID-19 on our remit group across the report.
- 1.9 Doctors' and dentists' working patterns continue to change, with notable trends including falls in the number of partner general medical and providing-performer dental practitioners, concurrent with rises in those working in salaried and associate positions. Increasing numbers of doctors and dentists also now wish to work flexibly or less-than-full-time. Rises in the proportion of the medical and dental workforces who are female and/or from ethnic minority backgrounds continue. We discuss these matters throughout the report.

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

- 1.10 The DDRB is an advisory non-departmental public body that makes recommendations to governments in line with its terms of reference. Our conclusions are based on the evidence that is provided to us by governments, trade unions and other stakeholders, and on our visits programme, during which we meet members of the remit group and health service leaders across the UK. It is then for those governments to decide how to respond to our recommendations.

The breadth of the DDRB's work and remit

- 1.11 Our primary focus is on pay, and its impact on recruitment, retention and motivation, in line with our terms of reference. But over the course of time there have been periods when the DDRB has been asked to report on issues beyond narrow consideration of pay uplifts (for example, seven day services). More generally, pay questions can rarely be considered in isolation from other factors which influence recruitment, retention and motivation. To understand the role of pay in addressing these questions, it is often necessary to consider this broader context. In our reports, we make a pragmatic judgement about pay informed by due consideration of these wider questions.

The independence of the DDRB

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

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

- 1.13 In their evidence submissions, the three trade unions each made reference to the period between 2010 and 2018, where pay awards were lower than inflation, and the consequent impact of this on real-terms pay for doctors and dentists. They also each asked that the remit group receive an increased award explicitly based on the real-terms falls in pay since 2010 that they described.
- 1.14 Our view remains that our recommendations should not be explicitly justified by the need to, or the need to avoid, retrospectively tracking inflation or cross-economy earnings data. Our recommendations are instead based on our independent assessment of recruitment, retention and motivation, considering also the affordability context, in line with our terms of reference. That said, given their importance to recruitment, retention and motivation, long-term trends in real pay and the relative pay position of our remit group are an important part of the evidence we receive.

Remit letters for this report

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

Department of Health and Social Care (England)

- 1.16 The Secretary of State sent his remit letter on 30 November 2021. It asked us to make recommendations for consultants, SAS doctors and dentists who chose not to transfer onto the new contracts, the minimum and the maximum of the pay scales for salaried general medical practitioners (GMPs), and the pay element of remuneration for NHS dentists in England. It asked us not to make recommendations for independent contractor GMPs, doctors and dentists in training and SAS doctors and dentists who chose to move onto the new contracts, since all are currently subject to multi-year pay deals.
- 1.17 The letter noted that the government must balance the need to ensure fair pay for public sector workers while protecting funding for frontline services and ensuring affordability for taxpayers, and that the affordability of a pay award must be taken into consideration to ensure that the NHS is able to recruit, retain and motivate its medical and dental workforce, as well as deliver on other key priorities.

Department of Health (Northern Ireland)

1.18 The Minister of Health wrote to us on 13 December 2021, asking us for recommendations on pay for all doctors and dentists working in health and social care in Northern Ireland not otherwise subject to a negotiated settlement, including SAS doctors and dentists in Northern Ireland who choose not to move onto reformed contracts. He also noted the need for affordability and sustainability to be balanced with the need for fair pay and asked for our views on wider recruitment, retention and motivation factors specific to health labour markets which have land borders across which individuals might reasonably commute.

Scottish Government

1.19 The Cabinet Secretary for Health and Social Care wrote to us on 21 December 2021. He said that it would be necessary to consider the affordability of recommendations within the confines of the Scottish Public Sector Pay Policy (SPSPP) for 2022-23, the main features of which include:

- A basic pay increase of up to £700 for public sector workers earning between £25,000 and £40,000
- A cash uplift of £500 for public sector workers earning above £40,000

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

Welsh Government

1.21 The Minister for Health and Social Services sent us her remit letter on 1 February 2022. It asked us for recommendations for all groups of medical and dental staff in Wales except for SAS doctors and dentists who have chosen to transfer onto new contracts. It asked for our advice on what would be a sufficient pay rise for staff to recognise their dedication and hard work during the pandemic and the work they will continue to undertake to support the recovery efforts. It also noted the increase in national insurance contributions and cost of living increases that many NHS staff would be facing in the coming year.

1.22 The letter also asked us to make observations on the 2003 Welsh Consultant Contract and pay in relation to how the contract and structures have impacted on the equality and diversity of their workforce.

Our comments on the remit letters

1.23 While there are several groups within our overall remit for which we have not been asked for recommendations this year, in line with our terms of reference our overall remit continues to include all groups of doctors and dentists working in the NHS and HSC across the UK.

- 1.24 We note that the DHSC remit letter asked us for our comments and observations on the evidence that we received about doctors and dentists in training. It will also be necessary for us to discuss in detail the GMP workforce in England, and the SAS workforce in England, Wales and Northern Ireland, given that we have been asked for recommendations for some members of these groups. We also discuss doctors and dentists employed in the NHS/HSC on locally-determined contracts, who were not mentioned in the remit letters, in Chapters 6 and 7 and we discuss their inclusion in the scope of our recommendations in Chapter 11.
- 1.25 The BMA and HCSA asked us in their written evidence to make recommendations for all groups of doctors and dentists, including for the groups that the remit letters asked us not to make recommendations for. We discuss this in Chapter 11.
- 1.26 We note the specific asks made of us by the Northern Ireland Executive and the Welsh Government. We address these issues in the relevant chapters of the report, Chapter 4 for those working in border regions and Chapter 8 for terms and conditions for consultants in Wales.
- 1.27 We also note the different approach to pay taken by the Scottish Government, as set out in their remit letter, which included reference to the SPSPP which is more prescriptive than the pay policies of the other governments. If applied for our remit group, it would see all groups of doctors and dentists receive a lower pay uplift than our recommendations. However, we note that the Scottish Government has in previous years shown flexibility in applying the SPSPP to our remit group, and we would welcome them doing the same this year.

Parties giving evidence

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

Government departments and agencies

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

Employers' bodies

- NHS Employers
- NHS Providers

Bodies representing doctors and dentists

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

- 1.29 We also considered evidence from a number of other sources, including NHS staff data and economic and other data prepared by the Office of Manpower Economics (OME).
- 1.30 Ahead of this round starting, the chairs of the BMA committees representing consultants and junior doctors in England wrote to us explaining that due to a lack of confidence in the DDRB process, they would not be participating in this pay round. The BMA written evidence submission therefore did not have specific sections covering consultants and doctors and dentists in training in England, and representatives of these groups did not attend their oral evidence session with us. This weakened the evidence that we received about these groups and made it more challenging for us to make comments, observations and consider the case for making recommendations for these groups. We would urge these groups within the BMA to reconsider this position.

The pay review body process

- 1.31 We would reiterate to all the governments that timely submission of our reports to them is dependent on timely receipt of remit letters and evidence. Following receipt of the first remit letter, for England, and in discussion with the parties, on 30 November 2021 we set a deadline for written evidence of 24 January 2022. We received most written evidence submissions by or close to this date. However, we only received written evidence from DHSC and NHSE/I in late February, and from DoH in early March. These delays have now been happening for several years, and lead to significant delays to our process, and ultimately to the report's completion and therefore to when members of our remit group can expect to receive their pay uplift.
- 1.32 This sends an unhelpful signal to our remit group about the way in which their pay setting process, and our role within it, is viewed. To recognise the rights of all the parties involved and to uphold the integrity of the review body process and enable it to work effectively, it is important that our deadlines are respected.
- 1.33 More generally, we would welcome a return to our process being completed before the start of the financial year, but this is dependent on us receiving remit letters significantly earlier than has been the case in recent years. We would also then need all parties to submit evidence in line with deadlines that were earlier still than the one set this year.

Last year's recommendations

- 1.34 In our 49th Report 2021, our basic recommendation was for a 3 per cent increase to the national salary scales or the pay element of contracts, to be applied for the following:
- Consultants
 - Staff grade, associate specialist and specialty (SAS) doctors and dentists in Scotland, and those in England, Wales and Northern Ireland who do not elect to move onto reformed contracts
 - Doctors and dentists in training in Scotland, Wales and Northern Ireland
 - Independent contractor GMPs in Scotland, Wales and Northern Ireland

- The pay range for salaried GMPs
- Providing-performer and associate GDPs
- Salaried GDPs including Community Dental Service/Public Dental Service practitioners

1.35 We were not asked to make recommendations for doctors and dentists in training and independent contractor GMPs in England, or for SAS doctors and dentists in England, Wales and Northern Ireland who elect to move onto reformed contracts, as all were subject to multi-year pay deals. However, we stressed the importance of recognising their contribution to the pandemic response, as well as responding to the impact of the pandemic on them personally, and on recruitment, retention and motivation, and urged ministers to consider this.

1.36 We also did not make a recommendation that Clinical Excellence Awards, Distinction Awards, Discretionary Points and Commitment Awards for consultants should be uplifted.

Responses to our recommendations

1.37 Following the submission of our report in June 2021, the four governments implemented the annual pay uplifts for this remit group as detailed in Table 1.1 below. DHSC and the Welsh Government announced that they would implement our recommendations in full in July 2021, and the Scottish Government did so in August 2021, whilst in Northern Ireland they were implemented in March 2022.

Table 1.1 Implementation of 2021 DDRB recommendations.

Group	DDRB 2021 recommendations	England	Wales	Scotland	Northern Ireland
Consultants (pay scales)	3%	3%	3%	3%	3%
Consultants (Clinical Excellence Awards, Commitment Awards, Distinction Awards)	No recommendation	Value frozen	Value frozen	Value frozen	Value frozen
SAS doctors and dentists	3% (in England, Wales and Northern Ireland, those on the old contracts only)	3%	3%	3%	3%
Doctors and dentists in training	3% (Scotland, Wales and Northern Ireland only)	n/a	3%	3%	3%
Independent contractor GMPs	3% (Scotland, Wales and Northern Ireland only)	n/a	3%	3%	3%
Salaried GMPs range	3%	3%	3%	3%	3%
Providing-performer and associate GDPs	3%	3%	3%	3%	3%
Salaried GDPs	3%	3%	3%	3%	3%
GMP trainers' grant and GMP appraisers	3%	3%	3%	3%	3%

Our comments on the responses to our recommendations

- 1.38 We welcome that all our explicit recommendations were implemented across the UK. However, the delays to the pay award process in Northern Ireland continue to be unacceptable. Doctors and dentists in Northern Ireland had to wait months longer than their counterparts in England, Scotland and Wales to receive their pay award. During our visits programme, members of the remit group in Northern Ireland told us that they felt less valued by government as a result of these delays. We have also been told by the BMA and on visits that delays to the implementation of pay awards in Northern Ireland beyond the end of the financial year, which has taken place in recent years, have also caused a financial detriment related to the annual pensions tax allowance.
- 1.39 We expect pay awards to be made in a timely fashion following the submission of our reports. We have repeatedly urged the Executive in Northern Ireland to respond to our reports soon after they are submitted, and once again this has not happened. These delays undermine the credibility of the pay determination process amongst the remit group and is likely to have had a negative impact on morale.
- 1.40 We welcome that the Scottish Government showed flexibility in applying its public sector pay policy to the remit group in order to address our recommendations and comments. We would welcome them doing so again this year.
- 1.41 In last year's report, we also urged ministers to consider the need for additional reward to respond to the impact of the pandemic on recruitment, retention and motivation for those under existing multi-year pay deals. We were disappointed that none of these groups subsequently received any additional reward, except SAS doctors and dentists in Wales, for whom pay continuity arrangements were introduced to ensure that those that moved onto new contracts did not end up earning less as a result. DHSC said that the UK Government's position was that it does not reopen pay deals made with trade unions. We also did not get a response to this from the Northern Ireland Executive, or an explanation as to why they chose not to act. We reinforce our position on this matter in Chapter 11.

Future evidence

- 1.42 Chapter 12 sets out areas where the evidence provided to the review body could be improved or enhanced. In particular, we expect to hear of significant progress towards the development and implementation of robust NHS/ HSC workforce plans. We also ask for more data on workforce supply and demand, including how changing working patterns might affect this, as well as parties' views on the long-term impact of the pandemic and its aftermath on retention, progression and motivation in the medical and dental workforces and an explanation for recent trends in earnings and expenses for GMPs and GDPs.

CHAPTER 2: WIDER CONTEXT

Introduction

2.1 In this chapter we discuss wider factors that provide important context for our considerations of recruitment, retention, motivation and affordability, which follow in later chapters. This includes a discussion of the latest economic and labour market indicators, as well as details of public sector pay policies and finances, at the time of this report. We also discuss at a high level the impact of the coronavirus (COVID-19) pandemic on the economy, the public finances and on demand for health services.

The coronavirus (COVID-19) pandemic

2.2 We remain conscious that we have prepared our report and are making our recommendations in the evolving context of the coronavirus pandemic and its aftermath, which have had a major, and in many cases deeply personal, impact on the members of our remit group, as well as millions of people across the UK and beyond. The pandemic has also had a major impact on the economy, the public finances and on demand for health services.

2.3 Since the last report, the UK economy has returned to growth, and according to the Office for Budget Responsibility (OBR), gross domestic product is now larger than before the pandemic¹. We have also seen significant impacts on inflation and labour markets throughout the pandemic, the latest indicators for which we discuss later in this chapter. Public health-related restrictions were relaxed throughout the second half of 2021 and the first part of 2022, and government support initiatives were progressively withdrawn, including the end of the Coronavirus Job Retention Scheme (the furlough scheme) in September 2021.

2.4 Through the pandemic, many NHS/HSC services were disrupted as a result of both infection control measures, and hospitals and other health care settings being reoriented towards caring for patients with coronavirus. This, along with lower referral rates as the way that patients accessed health services changed, has led to significant growth in waiting lists for elective treatments, often referred to as care backlogs. Backlogs have grown across care settings and different parts of the NHS and HSC, including dentistry, mental health and cancer services.

2.5 The pandemic led to significant additional demands being placed on all groups of staff in our remit. Staff have worked in unfamiliar settings and specialties, have been faced with increased demand for their services and have had to adapt to different and in most cases more challenging working conditions. All of this has placed pressure on staff wellbeing and will continue to do so as efforts to clear care backlogs continue. We discuss the impact of the disruption to health services on workforce demand, on training, and on staff themselves, elsewhere in the report.

¹ <https://obr.uk/efo/economic-and-fiscal-outlook-march-2022/>, paragraph 2.8

The economy and the labour market

HMT Economic Evidence

- 2.6 In December 2021, HM Treasury sent economic evidence to the Pay Review Bodies², which sets out their perspective on the economic and fiscal position.
- 2.7 In their submission, they said that there had been a stronger-than-expected recovery in economic activity, and that the strength of the recovery and the effectiveness of government policy mean that the OBR were forecasting the pandemic to have had a smaller long-term effect on the economy than was previously anticipated. They also said that a combination of global supply chain issues, energy price rises and labour market shortages were likely to push up inflation in the near term, and noted that the OBR and the Bank of England expected, at the time of their writing, inflation to peak at between 4 and 5 per cent in 2022, with it falling back towards the 2 per cent target relatively quickly after the peak. However, HM Treasury also warned that ‘were public sector pay increases to exacerbate temporary inflationary pressure, for instance through spilling over into higher wage demands across the economy or contributing to high inflation expectations, then these short-term pressures would become more sustained. In turn, this would exacerbate cost of living pressures, as higher pay awards were offset by higher inflation, and would require significantly tighter monetary policy to address, which would also harm growth.’
- 2.8 In describing the state of the labour market, they said that on average those working in the public sector have a better remuneration package than those in the private sector, and that this difference was most apparent at lower grades. They also said that pay growth figures (at the time of their writing, 3-month annual pay growth as of September 2021 was 4.9 per cent) were affected by changes in the composition of the workforce, and that therefore average pay settlements were the more appropriate measure of earnings growth to consider in setting public sector pay settlements. They added that at the time of their writing, business surveys of private sector employers anticipated that awards would increase slightly, to 2.5 per cent for the 12 months to August 2022.
- 2.9 HMT said that strong recovery and necessary tax rises had put the public finances on a more sustainable footing but borrowing and debt remained at historically high levels. They added that pay rises above affordability could materially impact the Government’s ability to deliver on its commitments to public service improvements, including that the NHS in England would deliver around 30 per cent more elective activity by 2024-25 than it was delivering before the pandemic, and that they felt that public sector pay policy should retain broad parity with the private sector.

² <https://www.gov.uk/government/publications/hmt-economic-evidence-to-review-bodies-2021>

Economic growth

2.10 In 2021 as a whole UK gross domestic product was estimated to have grown by 7.4 per cent, offsetting most of the 9.3 per cent that gross domestic product fell in 2020³. In March 2022 the Office for Budget Responsibility (OBR) said that they expected there to be 3.8 per cent real growth in 2022, slowing further to 1.8 per cent in 2023 as the rebound from pandemic-related restrictions fades⁴. They also said that they expected the economy to face pandemic-related 'scarring' of 2 per cent in the medium term⁵. In their latest Monetary Policy Report, for May 2022, the Bank of England forecast economic growth to slow sharply, with zero growth between the second quarters of 2022 and 2023, revised down from the 1.2 per cent forecast in their February 2022 Report⁶.

Inflation

2.11 The latest inflation figures from ONS, for April 2022 showed CPI inflation at 9.0 per cent, CPIH inflation at 7.8 per cent, and RPI inflation at 11.1 per cent, each over 12 months⁷. Inflation is expected to increase further this year compared to 2021, in part as a result of the war in Ukraine. The OBR said in March 2022 that they forecast CPI inflation to reach 7.7 per cent in the second quarter of 2022 and peak at 8.7 per cent in the last quarter of 2022⁸. In their May 2022 Monetary Policy report, the Bank of England forecast CPI inflation to fall between the second quarters of 2022 and 2023, but to remain at the relatively high level of 6.6 per cent⁹. In May 2022, HM Treasury announced a package of measures to support households through the period of high inflation, including a one-off universal discount on energy bills of £400 for October 2022, and support payments for the most vulnerable households¹⁰.

Employment and the labour market

2.12 The latest official statistics in the labour market showed that employment grew by 390,000 over the year to March 2022, and rose slightly, by 80,000, over the three months to March 2022, to reach 32.57 million. The employment rate was at 75.7 per cent in the three months to March 2022, up 0.9 percentage points over a year previously¹¹.

2.13 The level of unemployment (those looking for and available for work), fell by 400,000 over the year to March 2022, and by 120,000 in the three months to March 2022, to 1.26 million. This gave an unemployment rate of 3.7 per cent in March 2022, down from 4.9 per cent a year previously¹².

³ <https://www.ons.gov.uk/economy/grossdomesticproductgdp/timeseries/ihyp/pn2>

⁴ <https://obr.uk/efo/economic-and-fiscal-outlook-march-2022/>, 1.14 and 1.15

⁵ *Ibid*, 1.15

⁶ <https://www.bankofengland.co.uk/-/media/boe/files/monetary-policy-report/2022/may/monetary-policy-report-may-2022.pdf>

⁷ <https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation> L55O, D7G7, and CZBH

⁸ <https://obr.uk/efo/economic-and-fiscal-outlook-march-2022/>, table 2.22

⁹ <https://www.bankofengland.co.uk/-/media/boe/files/monetary-policy-report/2022/may/monetary-policy-report-may-2022.pdf>

¹⁰ <https://www.gov.uk/government/news/millions-of-most-vulnerable-households-will-receive-1200-of-help-with-cost-of-living>

¹¹ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes> MGRZ and LF24

¹² <https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment> MGSC and MGSX

- 2.14 The number of job vacancies between February and April 2022 rose to a new record of 1.30 million. This was an increase of 630,000 compared to 12 months previous, and an increase of 500,000 from the pre-pandemic level and equated to a ratio of 4.3 vacancies for every 100 employee jobs¹³.

Earnings growth

- 2.15 In the three months to March 2022, average weekly earnings growth was stronger in the private sector than the public sector. Year-on-year average weekly earnings growth in March 2022 was 7.0 per cent across the whole economy, 8.2 per cent in the private sector and 1.7 per cent in the public sector (excluding financial services)¹⁴.
- 2.16 According to IDR, the median pay award across the economy in the three months to the end of April 2022 was 3.7 per cent, with the upper quartile of pay awards 5.1 per cent¹⁵. XpertHR said that the median pay settlement for the three months ending 30 April 2022 was 4.0 per cent¹⁶.
- 2.17 DDRB pays attention to the movements of earnings at the upper end of the wage distribution, which includes the more highly paid members of our remit group. The Annual Survey of Hours and Earnings (ASHE) is produced annually and published in the autumn that follows the end of the financial year, with the latest data currently available covering the 12 months to April 2021. According to this, growth in annual earnings at the top end of the distribution was weaker than the middle in the 12 months up to April 2021, in both the private and public sectors. Growth in annual earnings, between April 2020 and April 2021, for full-time employees in the private sector as a whole was -2.7 per cent at the median, -4.1 per cent at the 90th percentile, -4.1 per cent at the 95th percentile, -3.7 per cent at the 97th percentile and -6.2 per cent at the 98th percentile. Growth in annual earnings for full-time employees in the public sector, over the same period, was 3.3 per cent at the median, 1.0 per cent at the 90th percentile, 0.1 per cent at the 95th percentile, -2.7 per cent at the 97th percentile (there was no data available at the 98th percentile for the public sector in 2020 to make a comparison against). However, this data predates the most recent economic shifts, and more up-to-date data that is likely to reflect more recent increases in whole-economy earnings data is not yet available

Public sector pay policies and finances

- 2.18 As part of the October 2021 Budget and Spending Review, the Chancellor announced that public sector workers would receive pay rises over the next three years as the recovery in the economy and labour market allows a return to a normal pay setting process, and that the Government would be seeking recommendations from the Pay Review Bodies where applicable. In their written evidence, DHSC said that 2 per cent was available in fixed NHS budgets for NHS staff pay awards in 2022-23.

¹³ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/jobsandvacanciesintheuk/may2022> AP2Y. The pre-pandemic level is taken to be the figure for January-March 2020.

¹⁴ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/latest> KAC3, KAC6 and KAC9

¹⁵ <https://www.incomesdataresearch.co.uk/resources/viewpoint/median-pay-award-climbs-to-37>

¹⁶ <https://www.xperthr.co.uk/indicators/pay-awards/16100/>

- 2.19 The 2022-23 Scottish Public Sector Pay Policy was published in December 2021. Its key features were:
- A guaranteed wage floor of £10.50 per hour, going beyond the current real Living Wage rate of £9.90;
 - A guaranteed cash underpin of £775 for public sector workers who earn £25,000 or less;
 - A basic pay increase of up to £700 for those public sector workers earning between £25,000 and £40,000;
 - A cash uplift of £500 for public sector workers earning above £40,000; and
 - Allowing flexibilities for employers to use up to 0.5 per cent of pay bill savings on baseline salaries in 2022 to address clearly evidenced equality or pay coherence issues.
- 2.20 The Northern Ireland Executive did not provide us with details of a public sector pay policy for Northern Ireland, and there is no public sector pay policy in Wales.

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

- 2.21 We are thankful to HMT for providing us with a clear and concise account of their view of the state of the economy. We note that their analysis of reward in the public and private sectors was based on means and medians of both sectors overall, and thus does not account for differences in the composition of the public and private sector workforces. The relevance of these comparisons to doctors and dentists is also limited given they are, along with their comparator groups, generally towards the top of the earnings distribution, where it is far from clear that there is a public sector reward premium. We discuss this in more detail in Chapter 5.
- 2.22 We also recognise what HMT said about higher pay settlements impacting the ability for government to make improvements to public services. However, we would note that it is our role to take a long-term view, and if pay awards were insufficient to support recruitment, retention and motivation, this could also jeopardise planned improvements to public services, particularly given there remain significant medical and dental workforce shortages.
- 2.23 We also note that since the HMT economic evidence was submitted to us, inflation has increased by significantly more than was forecast in their evidence, driven at least in part by external factors including increases in energy prices and the war in Ukraine, with the Bank of England now also forecasting that economic growth will slow significantly in 2022 and 2023¹⁷. We note that pay settlements in the private sector have begun to rise, perhaps in response to the increase to inflation.

¹⁷ <https://www.bankofengland.co.uk/monetary-policy-report/2022/may-2022>, Chart 1.2

- 2.24 We also recognise what HMT told us about the ability for higher public sector pay awards to drive inflation. However, without evidence that can quantify the extent to which this is the case specifically in relation to the DDRB and its remit group, it is not clear how we can factor this into our consideration of pay awards more specifically than as a general contextual point. We would welcome evidence from them or others on this in future years.
- 2.25 We are acutely aware of the impact that the current exceptionally high level of inflation is having on real pay for everyone in our remit group and across the public sector and the wider economy. The extent to which departmental budgets, and therefore affordability, can or should be reassessed in light of this changed context remains a question of Ministerial priorities.

CHAPTER 3: AFFORDABILITY, PRODUCTIVITY AND WORKFORCE PLANNING

Introduction

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

Workforce planning

England

- 3.2 No new workforce plan or strategy has been published for the NHS in England since *We are the NHS: People Plan for 2020/21 – action for us all* was published in July 2020, and which we discussed in last year's report.
- 3.3 However, the Health and Care Act received Royal Assent on 28 April. The Act underpins a major reorganisation of the NHS in England and will see the establishment of Integrated Care Boards to commission and manage services at a local level. NHS England/Improvement (NHSE/I) will also be put on a statutory footing.
- 3.4 It was also announced in November 2021 that Health Education England (HEE), NHSX and NHS Digital would merge with NHSE/I, which DHSC said would put 'long-term planning and strategy for healthcare staff recruitment and retention at the forefront of the national NHS agenda'¹.
- 3.5 DHSC said that they had commissioned HEE to work with partners and review long-term strategic trends for the health and regulated social care workforce, and that this work would review and renew the long-term strategic framework for the health workforce, to help ensure that they have the right numbers, skills, values and behaviours to deliver world-leading clinical services and continued high standards of patient care. They also said that HEE was developing a proposal for an apprenticeship in medicine, working with a range of partners.
- 3.6 NHSE/I said that the Secretary of State had commissioned them to develop a long-term workforce strategy, and that over the coming year, they would continue to work closely with HEE and DHSC to align this strategy and the HEE strategic framework, and to capitalise on the opportunities presented by the forthcoming integration of HEE and NHSE/I.

¹ <https://www.gov.uk/government/news/major-reforms-to-nhs-workforce-planning-and-tech-agenda>

- 3.7 NHS Employers told us that understanding workforce supply needs for the longer term was critical, and that there was a continued absence of a workforce plan, but they welcomed the opportunity to engage with HEE on their long-term strategic framework. NHS Providers said that there was uncertainty as to how the NHS People Plan framework would develop, and whether a next 'phase' or new form of workforce plan through DHSC and NHSE/I might be forthcoming in the near future. They added that the terms of reference of the HEE framework would focus on setting the foundations and principles for future workforce growth, without any specific assessments or projections on required workforce numbers to meet demand for care in the short-, medium- or long-term.

Scotland

- 3.8 In December 2019, the Scottish Government published the *National Health and Social Care Integrated Workforce Plan*, which was developed in partnership with the Convention of Scottish Local Authorities and sets out how health and social care services will meet growing demand and ensure the right numbers of staff, with the right skills, across health and social care services. In August 2021 they also published a consultation on the introduction of a new National Care Service, including seeking views on the development of a consistent approach to integrated workforce planning with health, supported by a national tools framework and an agreed data set.
- 3.9 The Scottish Government said that since the start of the COVID-19 pandemic, all workforce commitments in the Plan had continued to be implemented, with a number of commitments, such as the creation of an additional 100 undergraduate medical places and 100 GMP specialist places now completed, and others progressing towards published target dates.

Wales

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

Northern Ireland

- 3.11 The Department of Health told us that implementation of *Health and Social Care Workforce Strategy 2026* was well underway. They said that the key Objectives of the second Action Plan of the strategy, which would cover 2021-2023, were education and training, strategic workforce planning, and the health and wellbeing of the workforce. They added that going forward, sustainable funding would be key to implementing workforce recommendations.

Our comments on workforce planning

- 3.12 There are a number of important ongoing trends and changes in the medical and dental workforces. These include increasing numbers wishing to train and work flexibly or less-than-full-time or take breaks from training and decreasing numbers of general medical and dental practitioners wishing to take on partner or contractor roles. At the same time, issues relating to pensions taxation and pandemic-related fatigue have the potential to affect retirement behaviour, putting further pressure on recruitment and retention and potentially on workforce demand.
- 3.13 These trends, along with ongoing service and workforce transformation, including the continuing development of multidisciplinary working and workforce planning efforts for wider health and care workforces, as well as the shifts towards community and primary care outlined in *A Healthier Wales: Our Plan for Health and Social Care* and the *NHS Long Term Plan*, will have a material effect on how many doctors and dentists are needed across different parts of health services, and in different specialties. This will in turn have a significant impact on how many undergraduate and postgraduate training places are needed to meet long-term demand.
- 3.14 In this context, it remains critically important that health service leaders across the UK make robust assessments of their medical and dental workforce needs that are informed by service transformation, innovation and development, and act to ensure that they are met. Therefore, we welcome that HEE are developing a new long-term strategic framework in England, and that NHSE/I have been asked to develop a workforce strategy, though the absence of delivery dates for such plans is concerning. We look forward to hearing details of both of these in evidence for the next round. We would also urge governments in Scotland, Wales and Northern Ireland to continue to develop their assessments of their medical and dental workforce needs on this basis. Such assessments are also critical for our considerations of recruitment, retention and motivation.
- 3.15 We also note the passage of the Health and Care Act for England, and the merger of HEE and NHSE/I. We would expect the new, combined organisation to prioritise taking a long-term view to addressing the NHS's workforce needs despite current service challenges, and we would expect it to provide coherent national leadership to the NHS, including in leading the development of robust, costed, comprehensive and workable workforce plans.

Affordability and productivity

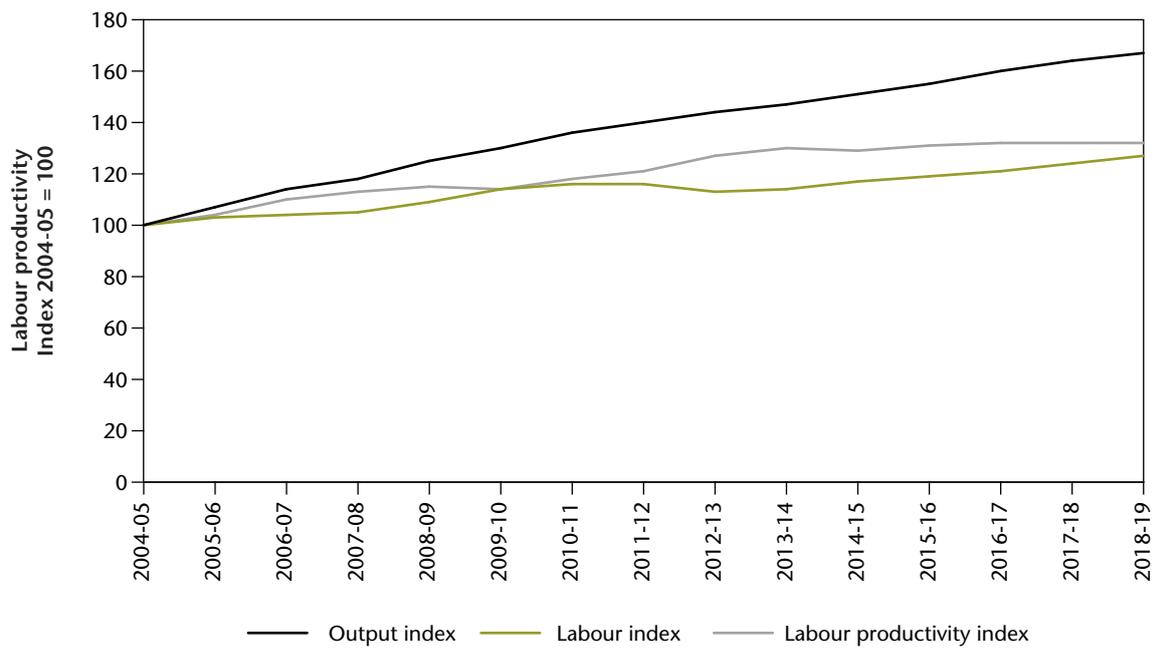
Concepts of affordability, productivity and efficiency

- 3.16 Discussions of NHS plans often make reference to 'productivity', 'efficiency' and 'affordability'. In what follows, we use the term 'productivity' by itself to refer to output per worker-hour, not total factor productivity (which measures output for given inputs of all kinds, not just labour inputs). Although productivity is not straightforward to quantify for the NHS, DHSC for England use a measure developed by the University of York based on health output adjusted for quality change, death rates and changes in waiting times. Because staff have a mix of different skills, it will not necessarily rise if fewer staff are used to deliver the same quality and quantity of outputs. Productivity can also be increased through capital investment, new working arrangements and new technologies.
- 3.17 For the economy as a whole, output-per-head productivity is the key determinant of average living standards. But for any sector, the 'affordability' of a pay settlement is also driven by other factors affecting the demand and supply for its output. In the case of public health services, services are limited by politically-determined budgets and the costs of inputs as well as by productivity. Within a given budget, technologies, efficiencies, and staff mix, there is then a trade-off between real pay and overall employment: higher pay is affordable with lower staff numbers and higher output-per-head productivity.
- 3.18 That said, it is possible that pay policies intended to lower costs can result in a less effective or efficient staff mix. For example, if recruitment and retention is worsened as a result of lower pay and employers become more reliant on more expensive agency work as a result, and/or the quality and safety of services is affected by understaffing, the budgetary benefit of lower pay can be undermined. In an environment of workforce shortages, it is also far from clear that any staffing benefit associated with lower pay can actually be realised.

England

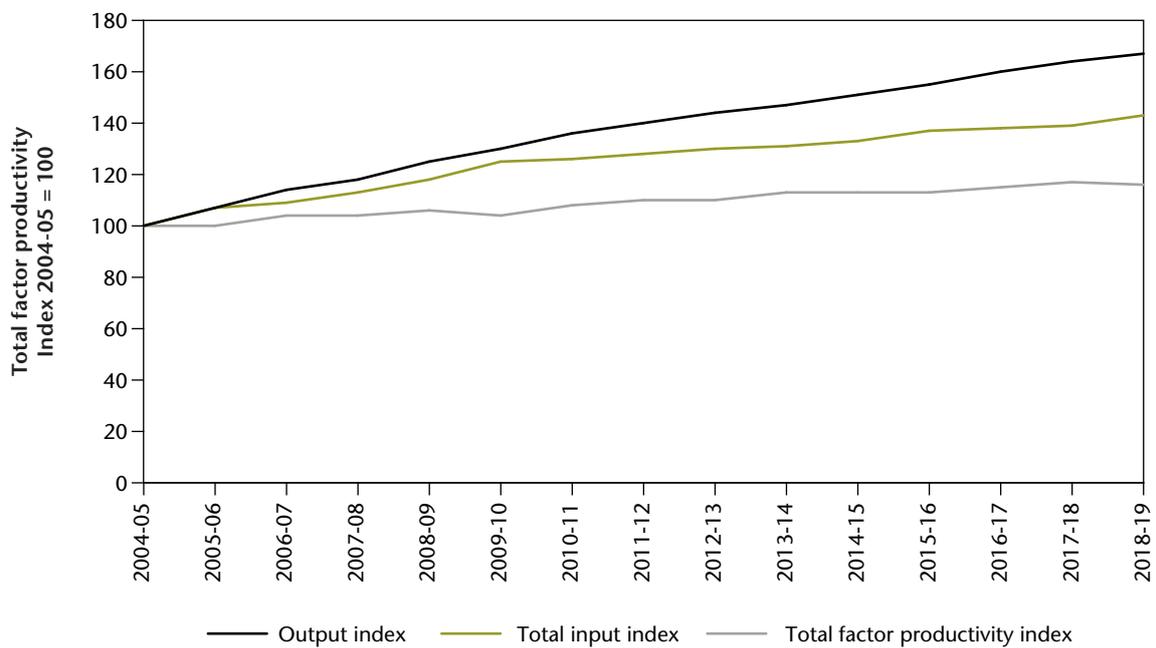
- 3.19 DHSC included information about productivity growth in their written evidence submission, which covered the period from 2005-06 to 2018-19. They showed that labour productivity grew by 0.3 per cent per year on average over the five years to 2018-19, and by 2.0 per cent per year between 2004-05 and 2018-19 (Figure 3.1). The measure of total factor productivity developed by the University of York, which considers output growth and takes into account all the inputs into the NHS, including the composition of the workforce, showed average annual growth of 1.1 per cent between 2004-05 and 2018-19 (Figure 3.2).

Figure 3.1: Labour productivity in the NHS, England, 2004-05 to 2018-19



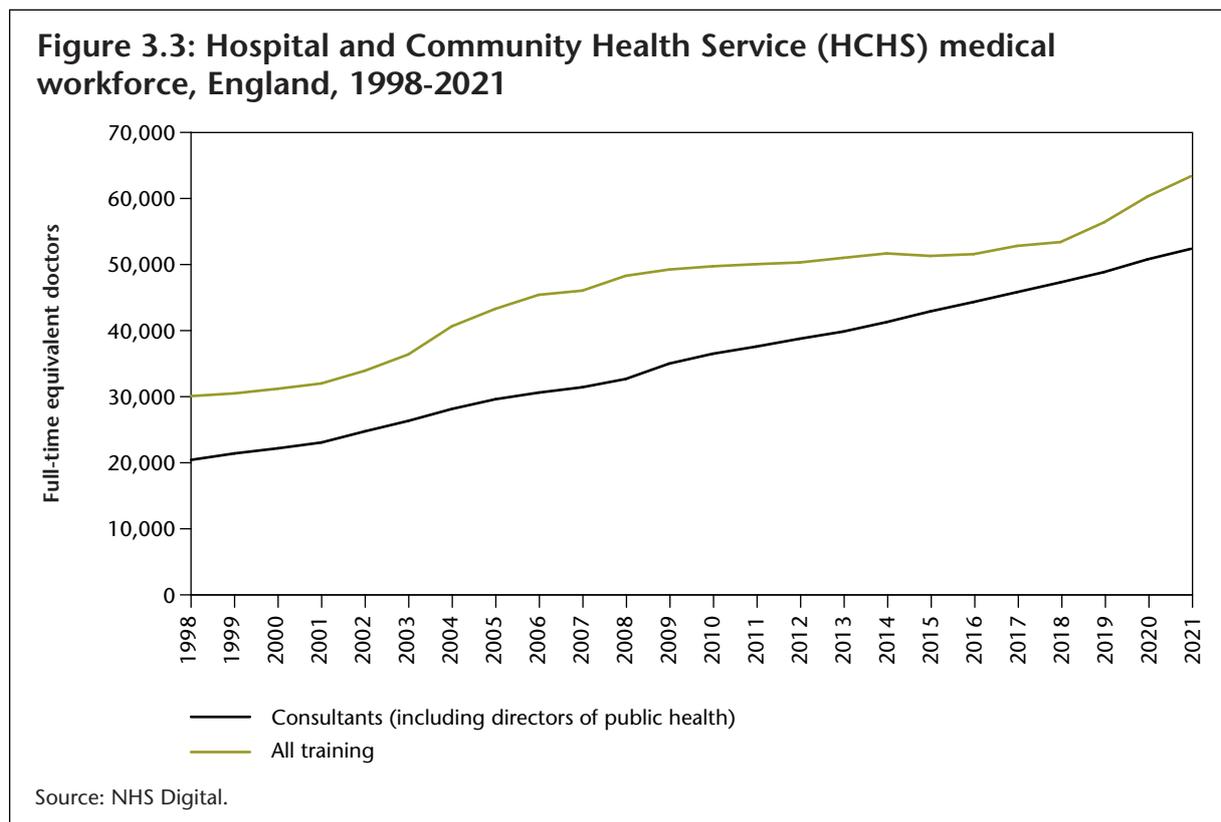
Source: DHSC.

Figure 3.2: Total factor productivity in the NHS, England, 2004-05 to 2018-19



Source: DHSC.

3.20 Figure 3.3 shows the numbers of Hospital and Community Health Service (HCHS) doctors in England between 1998 and 2021. The number of doctors in training rose by 61 per cent between 1998 and 2008 and by 31 per cent between 2008 and 2021. This represents a growth rate of 3.3 per cent per annum over the period as a whole. Consultant numbers also rose by 60 per cent between 1998 and 2008 and by a further 60 per cent between 2008 and 2021, representing a growth rate of 4.2 per cent per annum over the period as a whole. This growth, outpacing the growth in output and in employment in the NHS overall, reflects the shift in emphasis from a consultant-led service towards a more consultant-provided service over recent decades.



3.21 DHSC said that the pandemic had led public sector productivity in general to fall, and that they expected that productivity in the NHS would be similarly affected, due to the cancellation of non-urgent elective work, staff shortages and absences, and enhanced infection prevention and control (IPC) measures. They said that the vaccination programmes and reductions in cases had led to some relaxation of IPC rules, but productivity was, at the time of their writing, yet to recover to pre-pandemic levels. They said that alongside the funding announced at the 2021 Spending Review, NHSE/I had committed to a number of key productivity programmes aimed at returning the NHS to productivity growth, including improving patient pathways, setting up surgical hubs and expanding community diagnostic centres, personalising outpatient care and improving the use of digital productivity programmes including e-rostering and digital staff passports.

- 3.22 DHSC also said that in setting the NHS budget, the Government had assumed a headline pay award of 2 per cent for NHS staff, taking into account the multi-year deals that were already in place. They said that the NHS budget had been fixed to prioritise investments that would enable the NHS to tackle the elective backlog, grow the NHS workforce, continue the fight against COVID-19 and deliver the Long Term Plan, and that there was extremely limited room for any further investment in pay, meaning that financial restraint was needed. They explained that higher pay rises than what was affordable would lead to a reduced ability to expand clinical capacity and tackle the elective care backlog.
- 3.23 NHSE/I said that pay awards that were higher than the affordable level and were not supported by additional investment would result in difficult trade-offs on staffing numbers and the ability to deliver activity volume and would have a long-term impact on the NHS's ability to restore services and make progress in tackling elective care backlogs.
- 3.24 NHS Providers said that if staff pay awards were not fully funded this year, there would be operational impacts, and Trusts would need to make up any shortfall from existing funding. They also added that HM Treasury and DHSC had made it clear that additional funding for pay would not be made available this year.
- 3.25 The BMA said that there was not a direct relationship between pay and staff numbers, and that such a trade-off was a matter of political policy.

Scotland

- 3.26 In their remit letter, the Scottish Government said that it would be necessary for the affordability of our recommendations to be considered within the confines of the Scottish Public Sector Pay Policy (SPSPP). They also said that the transitional 2022-23 Scottish Budget sets out record funding of £18 billion for the Health and Social Care portfolio. This included new investment of over £600 million to support health services. They said that the Budget provides a 3.2 per cent increase in investment in frontline health boards, comprising a baseline uplift of 2 per cent along with further support for increased employer national insurance costs. They said that funding had been allocated to Boards in line with the SPSPP for planning purposes, and that it represented an overall investment of 2 per cent into pay bills, though this investment was intended to be more concentrated towards the lower end of the earnings distribution.

Wales

- 3.27 The Welsh Government said that core investment in the NHS would increase by an additional £1.3 billion, taking total baseline investment in 2024-25 to £9.683 billion.

Northern Ireland

3.28 The Department of Health said that efficiency and productivity improvements would continue to be essential to meet key targets within current resources, given the financial position. They added that the high proportion of Government expenditure accounted for by pay means that trends in public sector pay costs have significant implications for the availability of resources to support staff and deliver public services in Northern Ireland.

Our comments on affordability and productivity

- 3.29 Improving productivity and efficiency continues to be important for ensuring that demand growth for health services can be met. As part of this, it will be necessary for health services to retain any beneficial changes that were instigated by the pandemic, such as through the increased use of digital technology, while resuming the efforts to improve productivity that were interrupted by it. At the same time, as IPC measures are scaled back, we would expect that the pandemic-related hit to productivity described by DHSC to be reversed, at least to some extent.
- 3.30 Services remain challenged by both the continuing need to treat patients with COVID-19 and by the need to address pandemic-related care backlogs. In order to enable health services to address this challenge, it is critical that medical and dental staff numbers are maintained despite ongoing challenges to recruitment, retention and motivation. Given existing workforce shortages and continued dependency on temporary staffing, pay awards that are too low have the potential to have significant budgetary downsides, including increased use of temporary staffing, understaffing and worse motivation, which can affect the quality and efficiency of services and undermine any budgetary benefit that lower pay awards might bring. It is an oversimplification to suggest that there is a simple trade-off between pay and staff numbers, and we do not believe that depressing pay awards would represent an appropriate or effective way to improve staff numbers. Responsibility for improving staff numbers instead falls on employers and health service leaders.
- 3.31 We also note that while DHSC said that 2 per cent was available under current budgets for pay uplifts for doctors and dentists in England, they said that they had made an additional 1 per cent available for staff in the Agenda for Change system in written evidence to NHSPRB, saying that 3 per cent was affordable for those staff groups.
- 3.32 Given this, while we view the affordability and budgetary information provided by the governments as critical context for our considerations of pay uplifts, we do not view government pay policies or affordability figures as an absolute limit on what our recommendations should be – our recommendations are also informed by our considerations of recruitment, retention and motivation, in line with our terms of reference.

- 3.33 We note what NHS Providers said to us about additional funding not being available to fund medical and dental pay awards above the figures provided by DHSC. We appreciate that in responding to our recommendations, Ministers and health service leaders must decide how to fund medical and dental pay uplifts. This includes deciding whether to provide additional funding for health services, and how much to provide, as well as how to prioritise funding within overall budgets. We would expect such decision-making to be done appropriately and in consultation with partners in the system, and to be cognisant of the impact that this decision-making may have on services.

Spending on locums, agency and bank staff

England

- 3.34 DHSC said that during the first wave of the pandemic there was a significant decrease in agency shifts, but demand had rebounded in response to the elective recovery phase and the reinstatement of health services. They said that temporary staff spend overall increased between 2020 and 2021. They said that this was driven by increases in bank spend, and both volume effects and price pressures.
- 3.35 NHSE/I said that they had made progress in optimising temporary staffing spend despite workforce and capacity shortages, and that bank spending as a proportion of overall temporary staffing spend had increased, from 43 per cent in 2018-19 to 52 per cent in 2020-21. They said that there had also been a concomitant fall in agency spending.

Scotland

- 3.36 The Scottish Government said that medical agency spend decreased from £102.9 million in 2019-20 to £87.6 million in 2020-21.

Wales

- 3.37 Medical and dental locum expenditure in Wales was £58.6 million in 2020-21 and was forecast to increase to £63.2 million in 2021-22. Overall medical and dental locum spending has been relatively steady at between £50 million and £65 million in recent years.

Northern Ireland

- 3.38 Data from the Department of Health showed that agency spend in 2020-21 on medical and dental staff was £98.7 million. This was an increase, of 3.6 per cent, from £95.3 million in 2019-20. The Department said that increasing costs were due to the current configuration of services and that changing the model of care was the only solution. They said that they recognised the impact that rising agency costs were having on the HSC budget and that this was not sustainable, and they were examining all potential options as to how to address this.

Our comments on spending on locums, agency and bank staff

- 3.39 While some temporary staffing will always be necessary, increased use of permanent staff can improve care continuity and safety, and in this context we would expect services to improve as the dependency on temporary staffing decreases, ultimately benefitting patients. The use of temporary staffing also has significant cost implications, and therefore we once again welcome the increased use of bank staff, relative to the amount spent on agency staff, given that bank staffing is more cost-effective than agency.
- 3.40 Since permanent staffing provides better, safer and cheaper care, we remain concerned that the overall use of temporary staffing remains at a high level across the UK. Given the challenges that health services face to meet demand in the context of the pandemic and care backlogs, addressing this is ever more important. In order for this to be addressed in the long-term, it is essential that workforce demand is understood and met, as we discuss earlier in this chapter.
- 3.41 While temporary staffing spend is high across the UK, its disproportionately high level in Northern Ireland is of particular concern. We agree with DoH's assessment that such a high level of temporary staffing spend is unsustainable, and we expect to hear details of progress towards reducing temporary staffing spend in Northern Ireland next year.

CHAPTER 4: WORKFORCE SUPPLY AND EQUALITIES

Introduction

- 4.1 In this chapter, we discuss trends in a number of factors that affect workforce supply. This includes rates of staff turnover, international recruitment, and retirements, all of which have a direct impact on the overall size of the medical and dental workforces and therefore comprise important indicators of the state of recruitment and retention. In this chapter we also discuss the changing demographic composition of the medical and dental workforces, and the equalities issues that are associated with this, including gender- and ethnicity-based pay disparities.

Turnover

England

- 4.2 In the year to December 2021, the joining rate, which excludes staff moving between Trusts, for all hospital medical and dental staff in England was 17.9 per cent, a fall from 18.7 per cent in the previous year. In the year to December 2021 the leaving rate, which also excludes staff moving between Trusts, was 14.2 per cent, an increase from 13.0 per cent in the previous year. The stability index, which measures the percentage of staff there at the start of the year who do not leave during the year, was 85.6 per cent in the year to December 2021, down from 86.6 per cent in the previous year.
- 4.3 In the year to December 2021, the leaving rates for consultants and associate specialists in England were 5.0 per cent and 7.0 per cent respectively. These rates represent increases from the same period a year earlier – from 4.6 per cent for consultants and from 6.6 per cent for associate specialists.

Scotland

- 4.4 In 2020-21, the numbers joining the service decreased from 2019-20, while the number of leavers increased over the same period. In 2020-21 the turnover rate was 8.1 per cent, as 602 HCHS medical and dental staff left the service, an increase from 594 in 2019-20. In 2020-21 644 HCHS medical and dental staff joined the service, a decrease from 1,276 in 2019-20.

Northern Ireland

- 4.5 In 2020-21, the joining rate for hospital medical and dental staff in Northern Ireland was higher than the leaving rate. The joining rate was 5.8 per cent, down from 6.6 per cent in 2019-20. The leaving rate was 4.5 per cent, down from 5.4 per cent in 2019-20.

International recruitment

England

- 4.6 Data from NHS Digital (Table 4.1) show that in 2020-21 14.7 per cent of doctors joining the Hospital and Community Health Services (HCHS) in England were from abroad, comprising of 2.0 per cent from within the EU and 12.7 per cent from outside the EU. After increasing each year between 2011-12 and 2019-20, the share of joiners to the HCHS from abroad fell back in 2020-21, possibly as a result of restrictions on international travel as the COVID-19 pandemic developed.
- 4.7 Since 2015-16, the share of joiners from the EU has fallen each year, from 3.8 per cent, to 2.0 per cent in 2020-21. The share of joiners from abroad from outside the EU increased each year between 2010-11 and 2019-20, and despite falling in 2020-21, the number of joiners from outside the EU still accounted for more than twice the share in 2014-15.

Table 4.1: Medical and dental joiners to the NHS in England by source of recruitment, between March 2011 and March 2021, %, headcount, England

	EU/EEA (exc. UK) (%)	Non-EU/EEA (%)	EU/EEA (exc. UK) and Non-EU/EEA (%)
2011-12	2.3	3.4	5.7
2012-13	3.0	3.7	6.7
2013-14	3.5	4.4	7.9
2014-15	3.7	5.5	9.2
2015-16	3.8	6.6	10.4
2016-17	3.5	8.3	11.8
2017-18	3.0	9.5	12.6
2018-19	2.9	12.4	15.2
2019-20	2.4	14.1	16.5
2020-21	2.0	12.7	14.7

Source: NHS Digital.

- 4.8 According to data from NHS Digital non-United Kingdom nationals made up 31 per cent of the HCHS medical and dental workforce in December 2021 (Table 4.2), with 8 per cent EU/EEA nationals and 23 per cent from the rest of the world. This represents an increase from 26 per cent in 2015 (10 per cent EU/EEA and 16 per cent rest of the world). There are differences by grade, with non-UK nationals making up over 50 per cent of staff grades and specialty doctors, 49 per cent of those in core training, and 21 per cent of consultants in 2021. There was a particularly large change in the composition of those in core training, with an increase in the percentage of non-UK nationals from 29 per cent in 2015.

Table 4.2: Medical and dental staff by nationality, December 2021, headcount, England

	EU/EEA	Non-EU/EEA	EU/EEA/ Non-EU/EEA
Consultants	4,967 (9%)	6,593 (12%)	11,560 (21%)
Associate specialists	158 (8%)	494 (25%)	652 (34%)
Specialty doctors	899 (10%)	3,812 (42%)	4,711 (52%)
Staff grade	59 (17%)	147 (43%)	206 (60%)
Registrar	2,729 (8%)	10,063 (29%)	12,792 (37%)
Core training	1,380 (8%)	7,131 (41%)	8,511 (49%)
Foundation year 2	443 (7%)	1,373 (22%)	1,816 (29%)
Foundation year 1	426 (7%)	885 (14%)	1,311 (21%)
Hospital practitioner / Clinical assistant	60 (4%)	70 (4%)	130 (8%)
Other and Local HCHS Doctor Grades	65 (5%)	80 (6%)	145 (11%)
Total	11,165 (8%)	30,599 (23%)	41,764 (31%)

Source: NHS Digital.

Retirement trends

England

4.9 DHSC provided data on numbers in England who were claiming their NHS pension on voluntary early retirement (VER) basis since 2007-08 (Table 4.3). For consultants, the numbers taking voluntary early retirement increased sharply between 2007-08 and 2016-17, fell back between 2016-17 and 2018-19, but rose to a new high in 2019-20, before falling back in 2020-21. For GMPs, voluntary early retirements rose from just under 200 in 2007-08 to more than 700 a year between 2013-14 and 2016-17, fell back to around 600 a year between 2017-18 and 2019-20, but in 2020-21 rose to more than 700 for the first time since 2016-17. For dental practitioners the numbers choosing voluntary early retirement increased from just under 100 in 2007-08 to around 180 a year between 2011-12 and 2015-16, falling back in both 2016-17 and 2017-18, but increasing to an average of just over 200 a year in each of the three years between 2018-19 and 2020-21.

Table 4.3: Numbers claiming their NHS pension on a voluntary early retirement (VER) basis, England

	Consultants		General medical practitioners		General dental practitioners	
	VER	% of all retirements	VER	% of all retirements	VER	% of all retirements
2007-08	178	14	198	17	103	28
2008-09	146	12	264	20	148	36
2009-10	183	13	322	23	126	33
2010-11	286	17	443	29	154	33
2011-12	315	18	513	33	183	36
2012-13	388	24	591	42	185	36
2013-14	404	25	746	50	163	38
2014-15	453	29	739	51	185	39
2015-16	496	31	695	52	188	43
2016-17	492	30	724	61	170	42
2017-18	443	29	587	57	164	40
2018-19	414	28	605	55	204	40
2019-20	525	31	596	54	194	39
2020-21	475	28	704	59	214	41

Source: DHSC Evidence (Tables 58 to 60).

- 4.10 NHS Employers said that retaining senior and experienced doctors was critical. They also said that even before the pandemic, increased workloads and pressures were having an impact on wellbeing, and the ongoing impact of the pandemic and its potential impact on retention was a concern, but also that they felt that it was too early to understand the full scale of its effect.
- 4.11 HCSA said that they were concerned about retention of senior doctors. They said that the percentage of doctors that they had surveyed who said they had made definite plans to leave had risen from 20 to 29 per cent between 2020-21 and 2021-22.
- 4.12 NHS Digital statistics show that, between April 2020 and March 2021, of those doctors and dentists who reported their reasons for leaving the hospital and community health sector, retirement was the third most likely reason (995 people), behind end of fixed term contract (5,427), and voluntary resignation (2,531).

Scotland

- 4.13 The Scottish Government included data from the Scottish Public Pensions Agency on the retirements of GMPs and GDPs in Scotland. For GMPs, 70 were identified as retiring early in 2020-21, up from 63 in 2019-20 but down from 73 in 2018-19. For GDPs there were 14 identified early retirements, down from 19 in 2019-20 and from 15 in 2018-19. The Scottish Government described the numbers for 2020-21 as broadly similar to 2019-20.

Wales

- 4.14 Once again, we did not receive data from the Welsh Government on medical and dental retirements for this year. We would welcome information on the number of retirements, especially voluntary early retirements, from the Welsh Government for the next report.

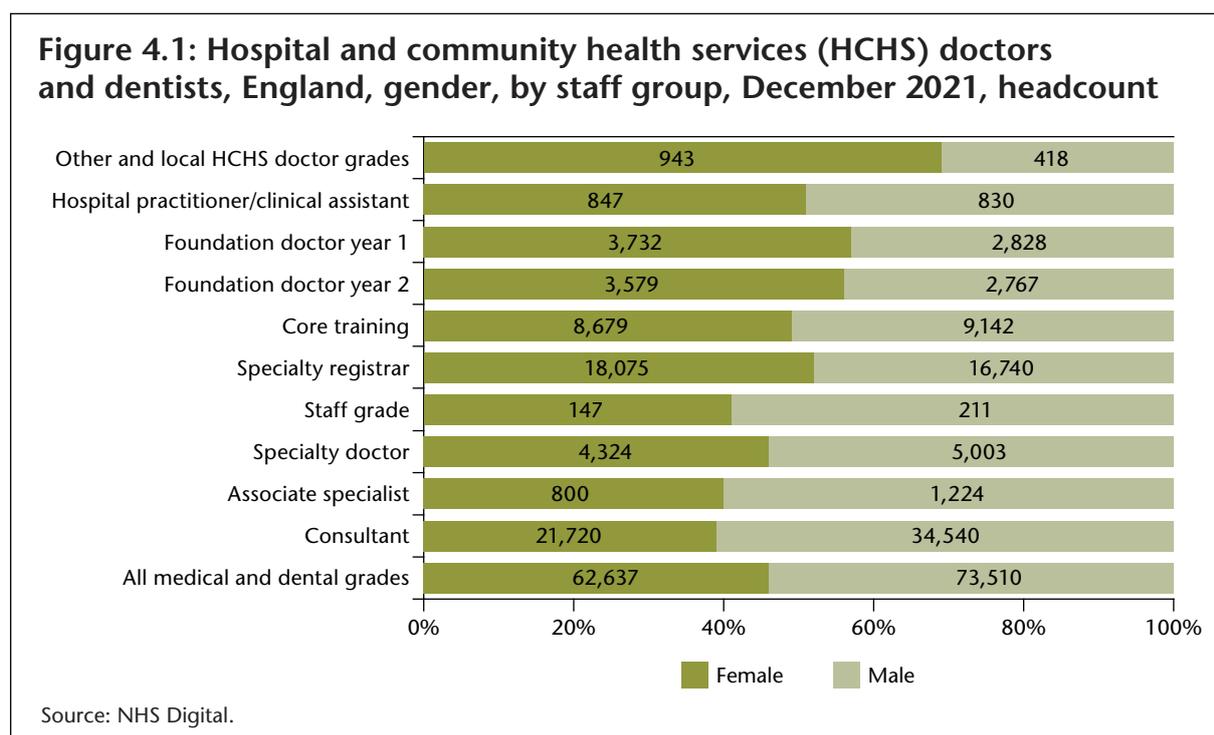
Northern Ireland

- 4.15 Data from the Department of Health (Northern Ireland) identified that 132 (4.5 per cent) medical and dental staff had left the system in 2020-21, compared with 149 (5.4 per cent) in 2019-20 and 141 (5.3 per cent) in 2018-19. The data do not identify why staff left the system or whether they were doing so before their normal retirement age. We would welcome this information being included in evidence in future.

Equalities

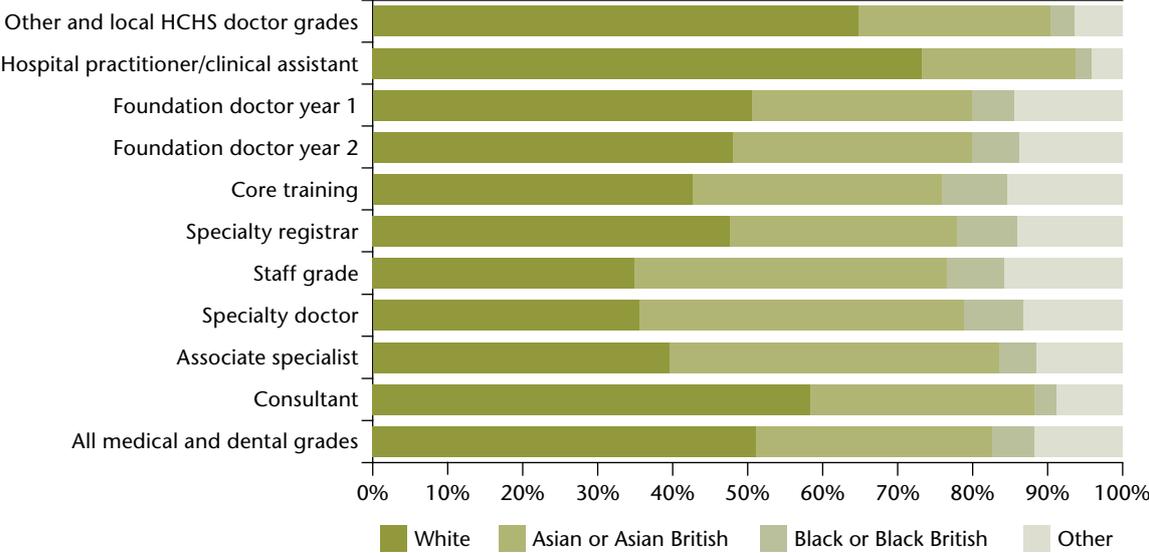
Composition of the medical and dental workforces

- 4.16 Figure 4.1 shows that in December 2021, 46 per cent of HCHS doctors and dentists in England were female. 39 per cent of consultants were female, 45 per cent of SAS doctors were female, and over half of those in training were female.



4.17 Figure 4.2 shows that in December 2021, 51 per cent of HCHS doctors and dentists in England were White, 32 per cent were Asian/Asian British, 6 per cent Black/Black British, and 12 per cent were from other ethnic groups. Almost 60 per cent of consultants were White, while doctors and dentists in the SAS grades were more likely to be Asian/Asian British than any other ethnic group. Of those in training, 47 per cent were White, 31 per cent were Asian/Asian British, 8 per cent were Black/Black British and 15 per cent from other ethnic groups.

Figure 4.2: Hospital and community health services (HCHS) doctors and dentists, England, ethnic group, by staff group, December 2021, headcount



Source: NHS Digital.

Pay gaps

4.18 The report *Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England* (GPG Review) was published in December 2020¹. We discussed its findings and recommendations in last year’s report.

4.19 DHSC said that the Government was committed to eliminating gender and ethnicity pay gaps. They said that gender and ethnicity pay gaps were much smaller within grades than between them, suggesting that pay gaps were associated with the differential gender and ethnic compositions of grades within the overall medical workforce.

4.20 They also said that following the completion of the GPG Review an independent panel had been set up with responsibility for driving forward work to reduce the gender pay gap in medicine in England, and it met for the first time in September 2021, where they agreed an ambitious and wide-ranging work programme.

¹ Department of Health and Social Care (2020) *Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England* <https://www.gov.uk/government/publications/independent-review-into-gender-pay-gaps-in-medicine-in-england>

- 4.21 They also said that they would be commissioning a research project to examine the ethnicity pay gap across the NHS workforce in England, and the research would aim to analyse pay-related data in a manner that gives a clearer picture of where there are ethnic inequalities in pay and making recommendations that would aim to reduce inequalities where they exist.
- 4.22 HCSA said they were a stakeholder in the GPG Review implementation panel. Regarding the ethnicity pay gap, they said that it was multifactorial, and an important factor was institutional racism within the NHS, with both direct and indirect discrimination placing barriers to progression for ethnic minority staff. They said that the pandemic had further exposed and exacerbated existing disparities.
- 4.23 BMA Scotland said that they would welcome hearing from the Scottish Government of progress in considering the applicability of the GPG Review's findings to Scotland and working towards addressing gender pay gaps in the NHS in Scotland. They also said they supported ethnicity pay gap analysis alongside reporting on gender and pay.

Other equalities issues

- 4.24 NHSE/I said their priorities for equality, diversity and inclusion in 2021-22 included to increase the representation of ethnic minority staff in leadership at trust and system level and raise the profile and voices of ethnic minority staff, by empowering staff networks and supporting line managers to hold productive conversations around race. They said that Workforce Race Equality Standard (WRES) surveys in 2020 found that there had been a year-on-year reduction in the proportion of ethnic minority staff entering a disciplinary process and a small improvement in the percentage of senior ethnic minority staff in Trusts. However, they said that ethnic minority staff still reported higher levels of bullying and harassment than white staff and were also less likely to be shortlisted for jobs.
- 4.25 They also said that Workforce Disability Equality Standard data showed an increase in the number of staff who declared a disability in 2020 compared to 2019, and there had been a reduction in the adverse experiences reported by disabled staff, but they were still less likely to be shortlisted and more likely go through formal capability processes and experience bullying and harassment.
- 4.26 NHS Employers said that data collected under the Medical WRES showed that ethnic minority doctors reported a worse experience at work compared to white doctors. These data included that ethnic minority doctors were less likely to be working in consultant roles and have a worse experience with examinations and regulatory processes. They said that employers were playing an active role to drive change, including by reducing regulatory referrals for ethnic minority doctors and improving recruitment processes. They also said that representatives from NHS Employers were included in the GPG Review implementation panel.

- 4.27 NHS Providers said that Medical WRES data showed there was a significant ethnicity pay gap for consultants, and they also said that ethnic minority staff were more likely to be bullied or harassed by other staff members and were more likely to receive referrals to the GMC for investigation. They also said that GMC research had found that disabled doctors were twice as likely to be dissatisfied in their careers and were at a high risk of burnout. They said that gaps between disabled and non-disabled staff on these measures were widening.
- 4.28 HCSA said that childcare and other caring duties had a significant impact on career prospects, and female medics experienced difficulty overcoming career disadvantage caused by taking time out for childcare. They added that they were concerned that the pandemic had worsened this issue, and they were also concerned that menopause was also a factor exacerbating gender pay gaps.
- 4.29 NHSE/I said that male dentists tended to have higher gross earnings than female dentists, but this was to some extent explained by differences in average working hours. The BDA said that pay disparities were driven to some extent by a higher proportion of associates being female, compared to providing-performers.
- 4.30 The Scottish Government said that they were improving data collection and analysis for their staff surveys on the basis of the protected characteristics, including ethnicity. They also said they had facilitated the creation of the NHS Ethnic Minority Forum, and they were developing a platform to bring staff networks together to share resources and best practice. They said they were developing menopause and menstrual health workplace policies to serve as examples of best practice and they were improving training around equalities.
- 4.31 The Welsh Government said that its Race Equality Action Plan included actions specific to the NHS, including the introduction of a WRES for Wales, and a scoping group had been established to make recommendations based on best practice. They also said that by December 2022 they would independently review existing workforce policies and procedures through an anti-racist lens.

Our comments

- 4.32 The data that is included in this chapter does not clearly demonstrate that there has yet been a significant pandemic-related deterioration in recruitment and retention, despite the pressure that has been put on the medical and dental workforces during the pandemic period, and the prospect of high workloads to come. However, we note that all parties have raised concerns that such a deterioration may take place in the coming months, as a result of these factors. We also note that the data included in this chapter do not capture other trends important to recruitment and retention, such as decreasing working hours. We would welcome seeing more data about average working hours in evidence for future years.

- 4.33 Clearly, falling working hours can further exacerbate the challenges faced by services relating to an already-stretched workforce, overall workforce shortages and long-lead in times required to train new staff. This could also lead to an increase in locum spend. There is therefore a clear need for health service leaders to keep a close watch on this, while at the same time addressing some of the other issues that might be affecting retention, including pensions, flexible working and working conditions, that we discuss elsewhere in the report.
- 4.34 However, despite the absence of major short-term pandemic-related changes, we note that the proportion of retirements that are voluntary early retirements remain at historically high levels.
- 4.35 We note the continued high levels of international recruitment, particularly from outside Europe. Understanding what is driving this, and how these numbers might evolve in future years will be critical for our understanding of trends in recruitment, retention and motivation, and is also important context for planning domestic workforce supply.
- 4.36 As the demographics of the medical and dental workforces continue to shift, with higher proportions being female and/or from an ethnic minority every year, it becomes increasingly important that equalities issues are addressed. Doing so is justified for its own sake, but also because issues of inequality and discrimination have a material impact on recruitment, retention and motivation. Improvements can also therefore benefit services through increased motivation, commitment and career aspirations, and we would welcome hearing more about the work that is ongoing to make such improvements across the UK.
- 4.37 Therefore, we welcome that equalities issues were so prominent in the NHS People Plan for 2020-21, and we would urge governments and health service leaders to put considerations of issues of gender, race and disability equality at the heart of all aspects of workforce planning.
- 4.38 We note with concern what HCSA said about institutional racism being a factor that was driving ethnicity pay gaps. This is the second year that they have made this serious claim. We would expect HCSA to work with health service leaders to investigate this claim and address the issues that are uncovered as soon as possible, and to hear more about this from HCSA and other parties next year.
- 4.39 We would also stress the importance of improving data collection, so that equalities issues can be better understood. This includes collecting more data, but also improving the granularity and consistency of the data that is currently collected, such as by seeking to understand any differences between different ethnic minority groups and how issues relating to gender, race and disability inequality interact with each other.

- 4.40 We expect to hear of more progress being made towards implementing the GPG Review's recommendations next year. At the same time, we would again stress the need for more to be done to understand and address pay equalities issues in dentistry, and in Scotland, Wales and Northern Ireland. This should comprise work to understand and address gender and other pay gaps in Scotland, Wales and Northern Ireland, as well as detailed consideration of how the observations and recommendations of the GPG Review apply. For example, many of the issues outlined for GMPs in the review may apply to GDPs, given the similarities between overall career and contractual structures between the two workforces. And given the overall similarities between health services and medical and dental careers in England on the one hand and in Scotland, Wales and Northern Ireland on the other, many of the GPG Review's findings will apply similarly.
- 4.41 We also welcome the progress towards the commissioning of research into the ethnicity pay gap in the NHS in England, and we would stress the need for this work to progress quickly. We expect to hear more about this over the next year, and we would welcome hearing more about work to understand and address other pay equalities issues as well, such as relating to disability. As with the GPG Review, we would encourage governments in Scotland, Wales and Northern Ireland also to work towards understanding issues of ethnicity and pay.
- 4.42 Finally, we note the request from the Department of Health for observations relating to recruitment, retention and staff motivation factors specific to health labour markets for regions which have land borders across which individuals might reasonably commute. While we did not receive much evidence from any of the parties about this issue, we discuss the impact of contractual differences for doctors and dentists in training between England and Wales in Chapter 6, and of different consultant reward structures across the UK in Chapter 8. We would welcome receiving more evidence about this from all parties in future years.

CHAPTER 5: REWARD AND MOTIVATION

Introduction

- 5.1 In this chapter, we consider how doctors' and dentists' pay has changed over time. For hospital doctors and dentists, we present data for England; equivalent data are not available for the rest of the UK. For GMPs and GPs, we present data for the whole of the UK, though time series are shorter in England and Wales owing to a change in how the data was presented. We also consider how doctors' and dentists' pay compares with the distribution of pay across the whole UK economy, and how it compares to the private sector and to comparator groups. It is important to monitor these comparisons because they can have an impact on recruitment, retention and motivation.
- 5.2 We also discuss pensions, and comment on workforce motivation, including the latest staff survey data.

The pay position

- 5.3 In this section, we compare the earnings of doctors and dentists to various points on the overall UK income distribution, before comparing earnings with a number of comparator professions in the next section. As a whole, the workforce's relative pay position compared to the overall income distribution declined during the period of relatively low pay awards from 2010, before stabilising or recovering somewhat from 2018-19 as the DDRB started making relatively higher recommendations. During 2020-21, pandemic-related economic disruption meant that groups across our remit group improved significantly relatively to the overall income distribution.
- 5.4 Tables 5.1 and 5.2 and Figures 5.1 to 5.12 show how the average (mean) total earnings of various staff groups compare to the median, upper quartile, 90th, 95th, 97th and 98th percentile of full-time employees' (FTE) earnings in the wider economy, since 2010-11¹, based on data from the Annual Survey of Hours and Earnings (ASHE).
- 5.5 Tables 5.1 and 5.2 show the percentile position of adjusted mean total earnings for various staff groups compared with the national full-time earnings distribution², from 2010-11 to 2020-21, as set out by ASHE. For example, for consultants in 2010-11, their average total earnings fell between the 98th-99th percentiles of annual earnings for full-time employees in the wider economy, so is listed as 99.

¹ We use 2010-11 as a starting date as it is the earliest year for which comparable data is available

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

Table 5.1: Percentile position of doctors' average earnings in England by grade, 2010-11 to 2020-21

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Change from 10-11
Consultants	99	99	99	99	99	99	99	99	99	99	99	0
Associate specialist	98	98	98	98	98	98	98	98	98	98	98	0
Speciality doctor	96	95	95	96	96	95	95	95	95	95	96	0
Registrars	93	92	92	92	92	91	91	91	91	90	92	-1
Core training	88	88	87	87	87	86	86	86	86	86	88	0
Foundation 1	66	65	64	64	64	63	63	63	61	59	63	-3
Foundation 2	80	79	78	78	78	76	76	75	74	73	77	-3
GMP provider	99	99	99	99	99	99	99	99	99	99		0
GMP salaried	97	97	97	97	97	97	97	97	97	97		0

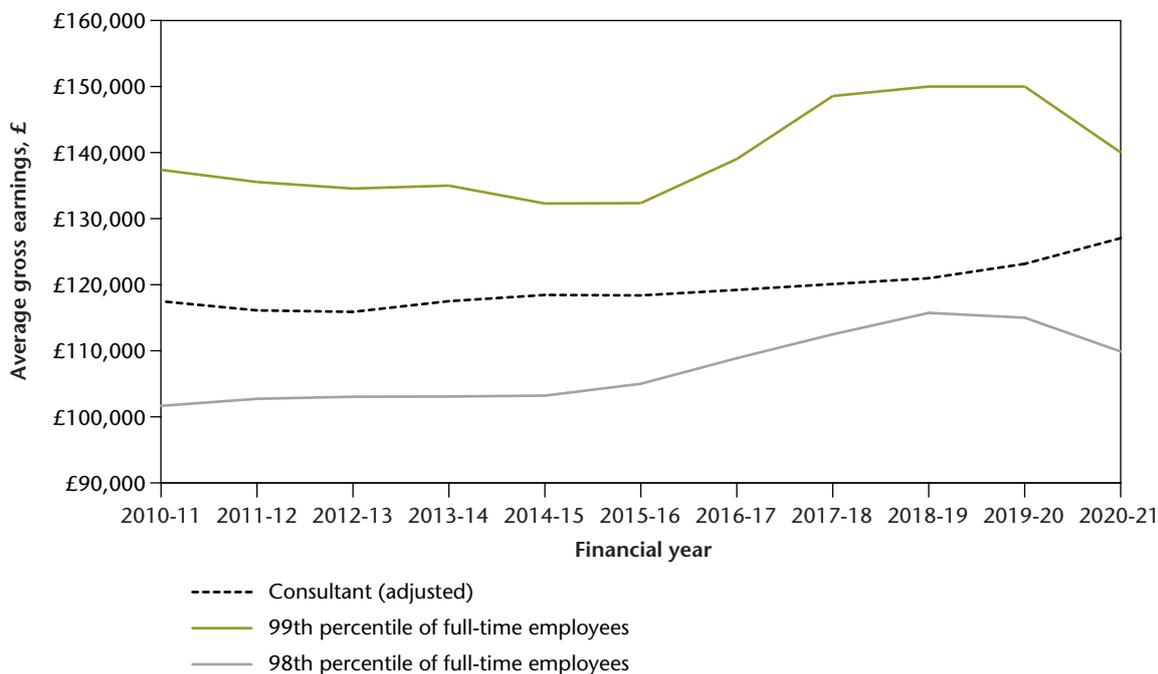
Table 5.2: Percentile position of dentists' average earnings in England, Scotland, Wales, Northern Ireland, 2010-11 to 2019-20

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	Change from 10-11	
GDP provider-performer												
England									98	98	97	
Scotland	98	98	97	97	98	98	98	97	98	97		-1
Wales									96	97		
Northern Ireland	98	98	98	98	98	98	97	98	97	96		-2
GDP associates												
England									90	91	90	
Scotland	95	94	93	92	92	91	91	90	90	90		-5
Wales									91	91		
Northern Ireland	95	93	93	93	93	92	93	90	92	91		-4

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

5.6 Figure 5.1 shows that for consultants, since 2010-11, average total earnings have been consistently between the 98th and 99th percentiles of FTE earnings in the wider economy. Between 2015-16 and 2018-19 consultant average earnings fell back from the 99th percentile and down towards the 98th percentile, although in both 2019-20 and 2020-21 this was reversed as average consultant earnings increased while earnings at the 98th and 99th percentiles were either flat or falling.

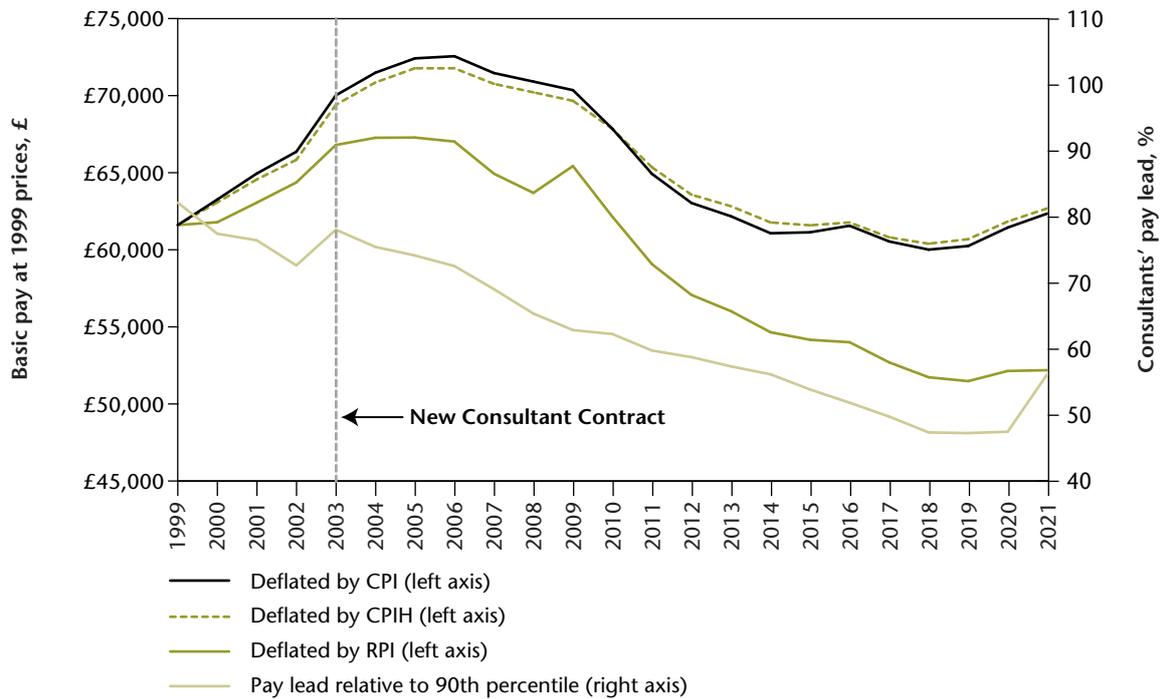
Figure 5.1: Average gross NHS earnings of consultants in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



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

5.7 Looking at the value of the 5th point on the consultants pay scale is helpful, as it is not affected by the changing composition of the consultant workforce but relates only to basic pay. Compared with CPI inflation, the value of this pay point decreased between 2006 and 2018 but has since increased in each year to 2021. In 2021 this pay point was at its highest level since 2012 (Figure 5.2). Compared with average earnings at the 90th percentile, the value of the 5th point on the consultants pay scale lost value between 2003 and 2018, but retained its value between 2018 and 2020 and increased its value in 2021.

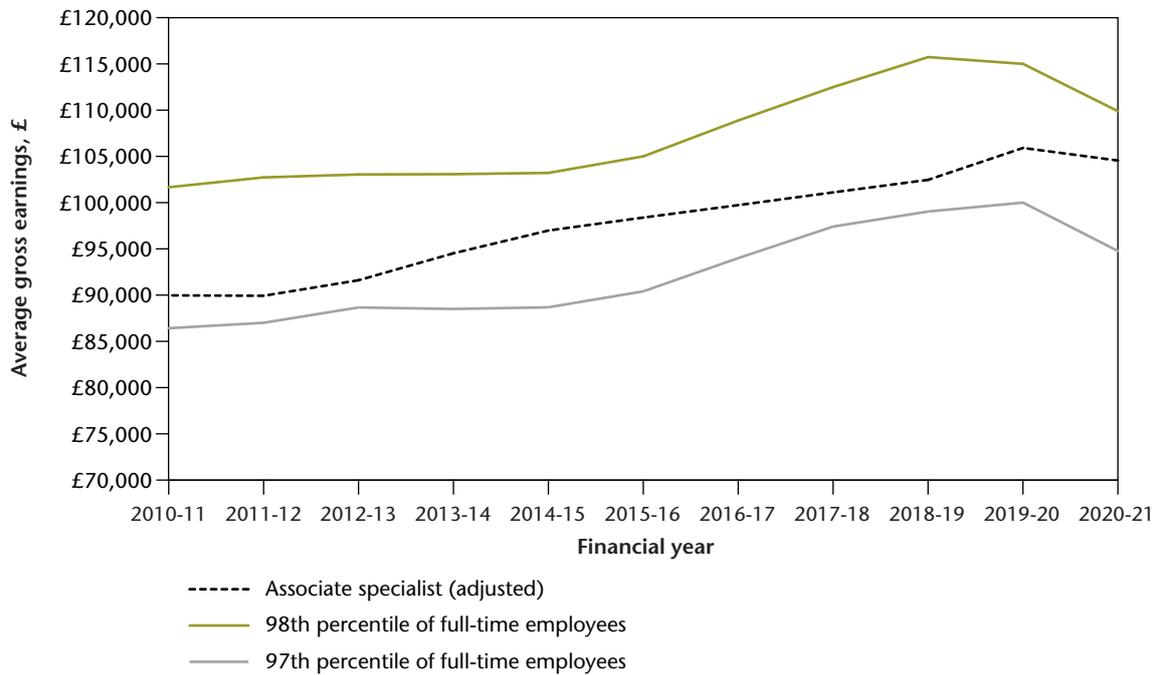
Figure 5.2: Change in the value of the 5th point on the consultants' pay scale, in real terms and as compared to 90th percentile earnings, England, 1999 to 2021



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

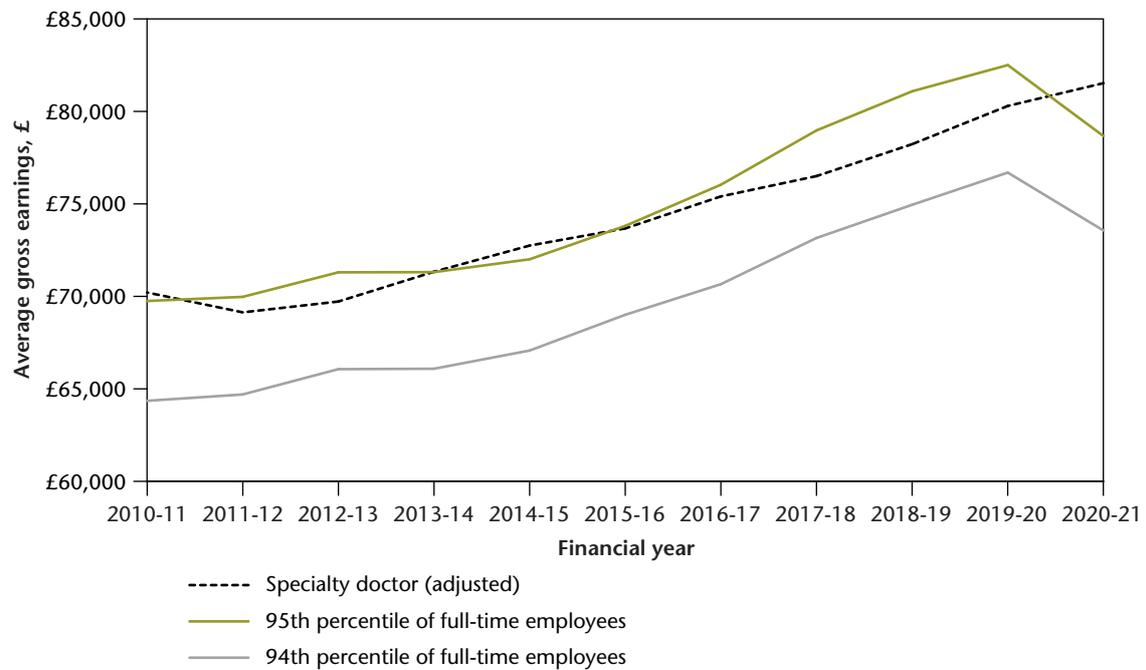
- 5.8 Figure 5.3 shows that associate specialists' average total earnings have been consistently between the 97th and 98th percentile in the wider economy. After falling back towards the 97th percentile between 2015-16 and 2018-19 associate specialists' average earnings moved closer to the 98th percentile in both 2019-20 and 2020-21.
- 5.9 Figure 5.4 shows that average total earnings for specialty doctors were broadly in line with earnings at the 95th percentile between 2010-11 and 2015-16. Average total earnings for specialty doctors fell below earnings at the 95th percentile between 2016-17 and 2019-20, before moving back above that benchmark in 2020-21.

Figure 5.3: Average gross earnings of associate specialists in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



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

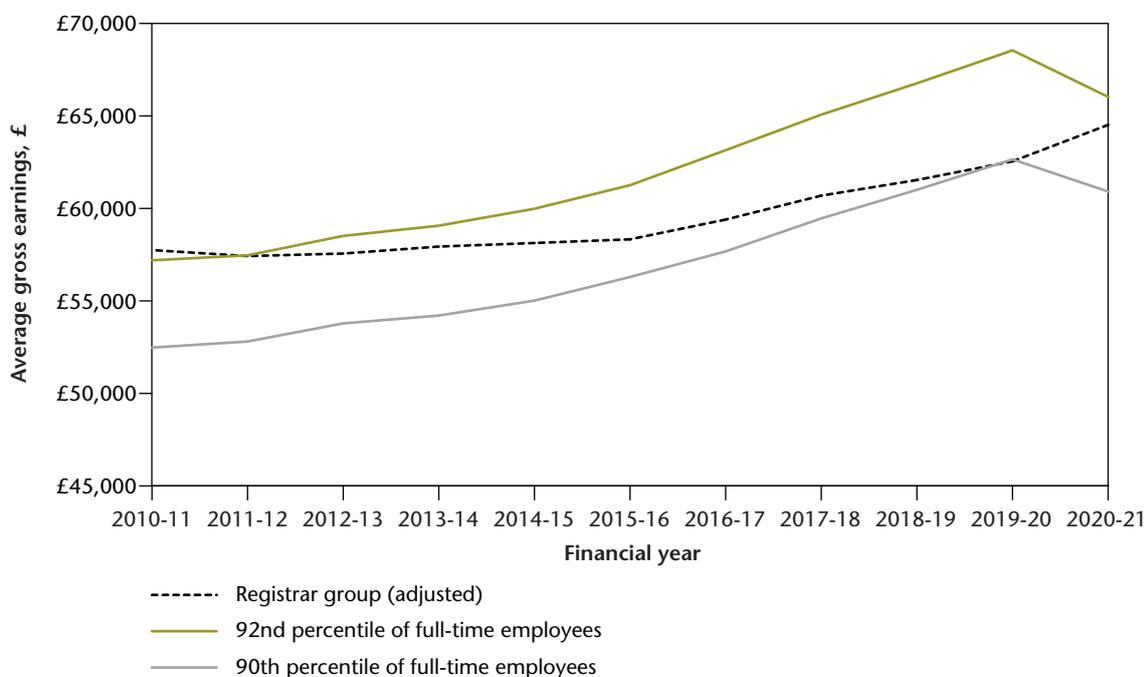
Figure 5.4: Average gross earnings of specialty doctors in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



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

5.10 Figure 5.5 shows that average total earnings of the registrar group were just above the 92nd percentile in 2010-11. However, by 2019-20 average earnings of the registrar group had fallen back in line with those of the 90th percentile, before moving back towards the 92nd percentile in 2020-21.

Figure 5.5: Average gross earnings of the registrar group in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21

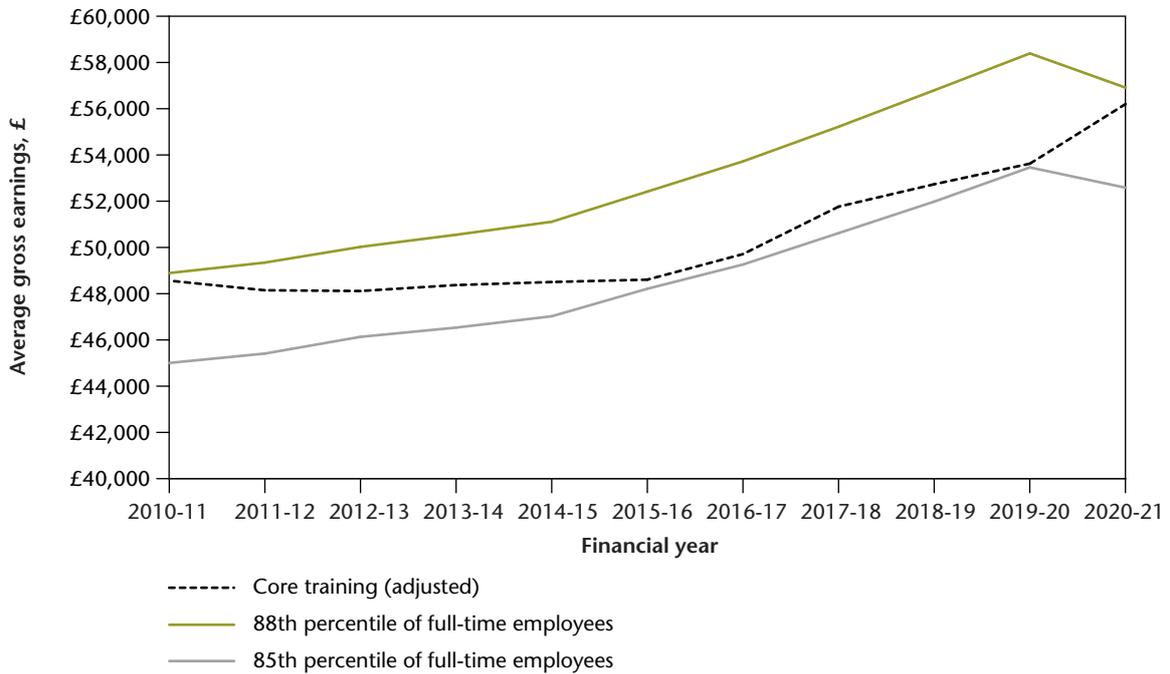


Source: OME estimates, based on data from NHS Digital, ONS.

5.11 Figure 5.6 shows that average total earnings of those in core training fell back from the 88th percentile in 2010-11 to the 85th percentile in 2015-16, maintained that relative position to 2019-20, before moving back towards to the 88th percentile in 2020-21.

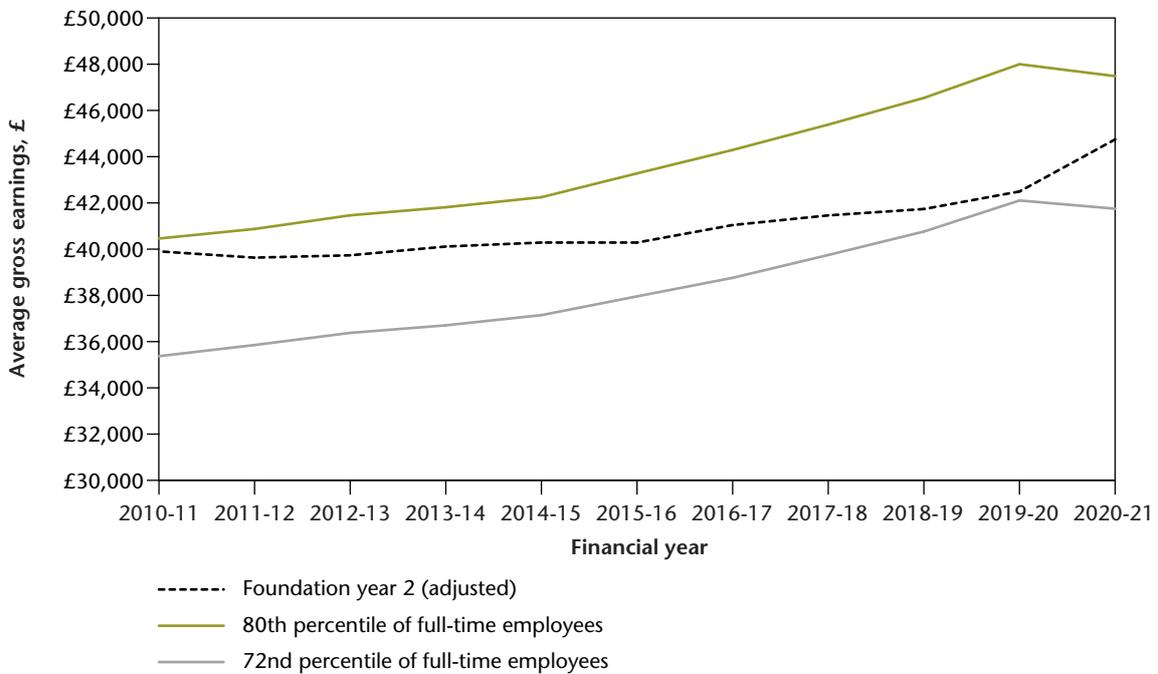
5.12 Figure 5.7 shows that average total earnings for those in the second year of foundation training fell back from just below the 80th percentile in 2010-11 to just ahead of the 72nd percentile by 2019-20, before moving back towards the 80th percentile in 2020-21.

Figure 5.6: Average gross earnings of those in core training in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



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

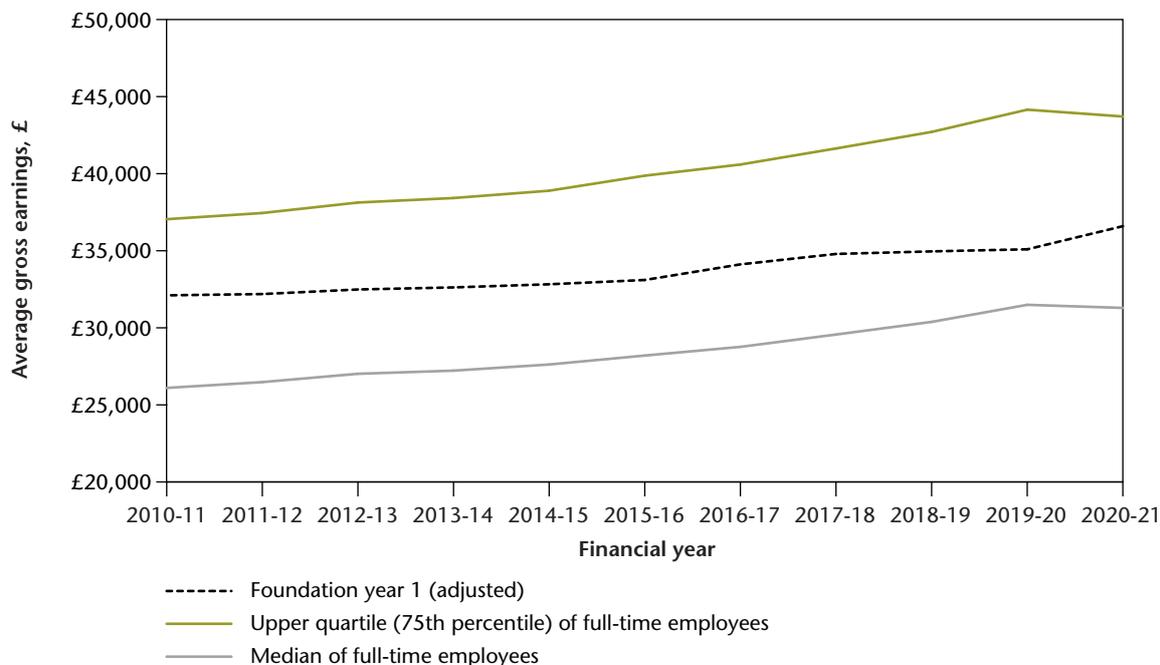
Figure 5.7: Average gross earnings of foundation year 2 trainees in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



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

5.13 Figure 5.8 shows that for those in the first year of foundation training, between 2010-11 and 2020-21, average earnings remained between the median and the upper quartile of earnings across the economy as a whole, although falling away from the upper quartile and towards the median until 2019-20, before moving back towards the upper quartile in 2020-21.

Figure 5.8: Average gross earnings of foundation year 1 trainees in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21

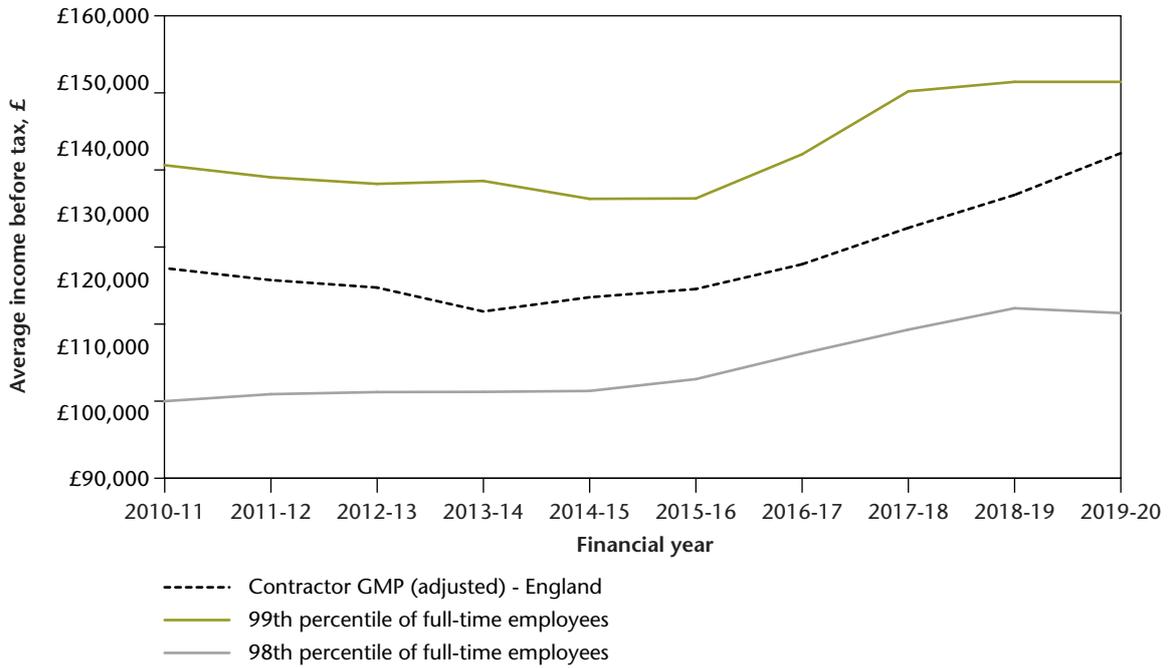


Source: OME estimates, based on data from NHS Digital, ONS.

5.14 Figure 5.9 shows contractor GMP earnings consistently between the 98th and 99th percentiles of earnings for the economy as a whole. Contractor GMP earnings fell back towards the 98th percentile between 2010-11 and 2013-14, but regained some ground against the 98th percentile since that date.

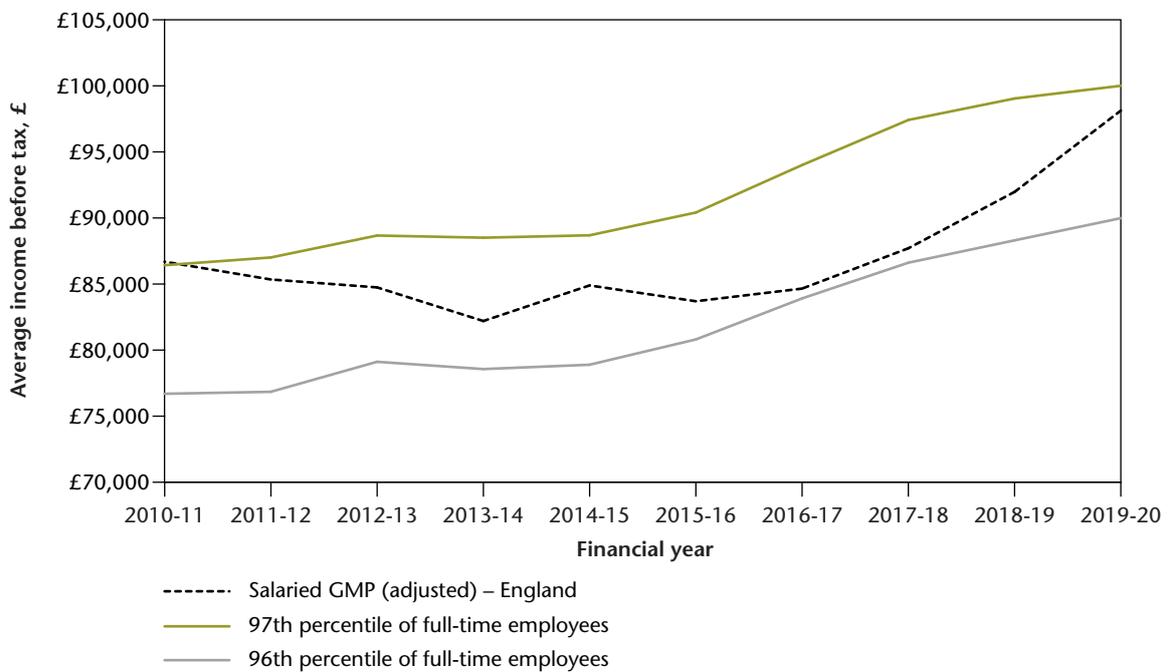
5.15 Figure 5.10 shows in 2010-11 salaried GMP earnings were in line with those of the 97th percentile, but had fallen back to the 96th percentile by 2016-17, before regaining some ground on the 97th percentile in both 2018-19 and 2019-20.

Figure 5.9: Average income before tax of contractor GMPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20



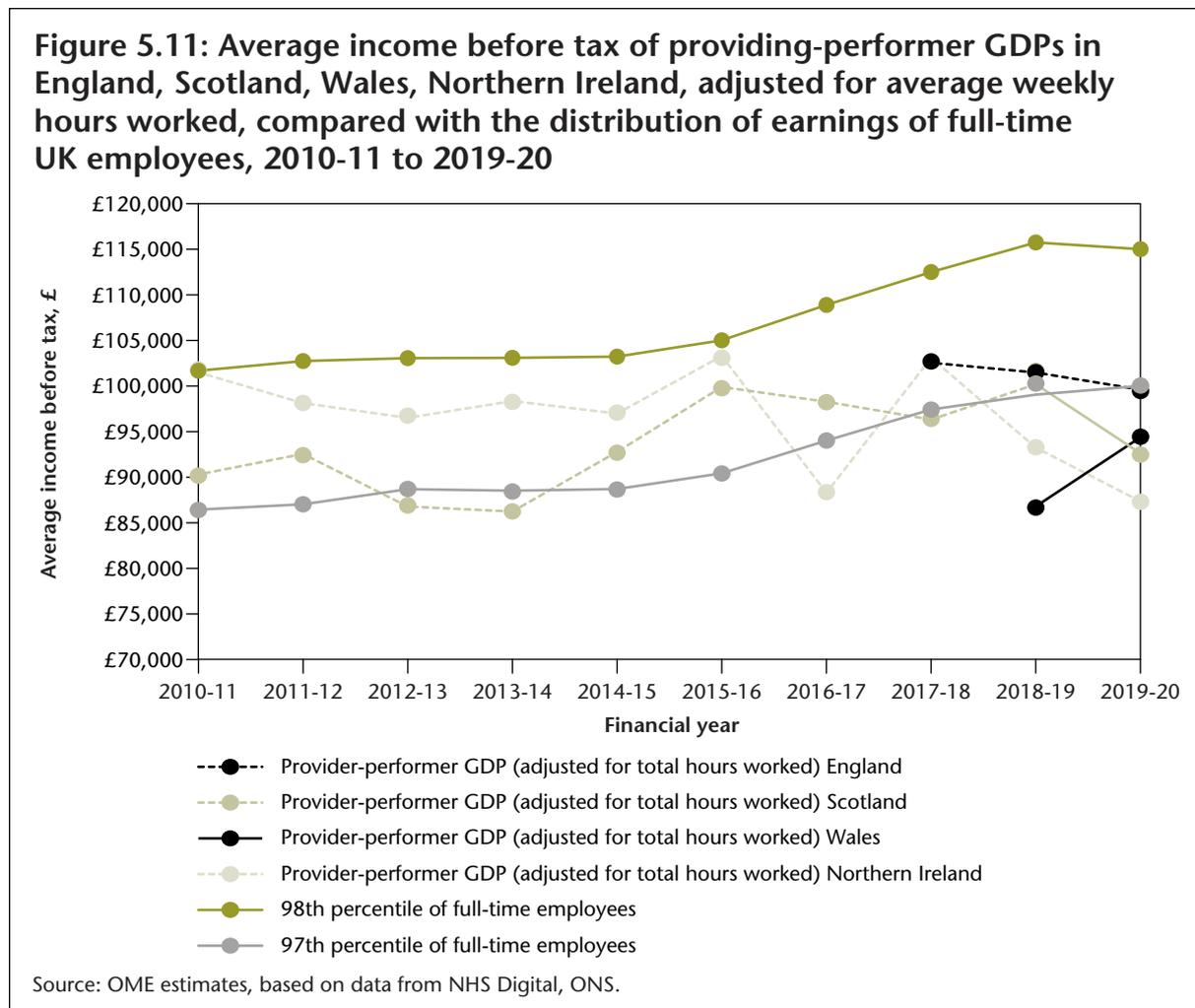
Source: OME estimates, based on data from NHS Digital, ONS.

Figure 5.10: Average income before tax of salaried GMPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20



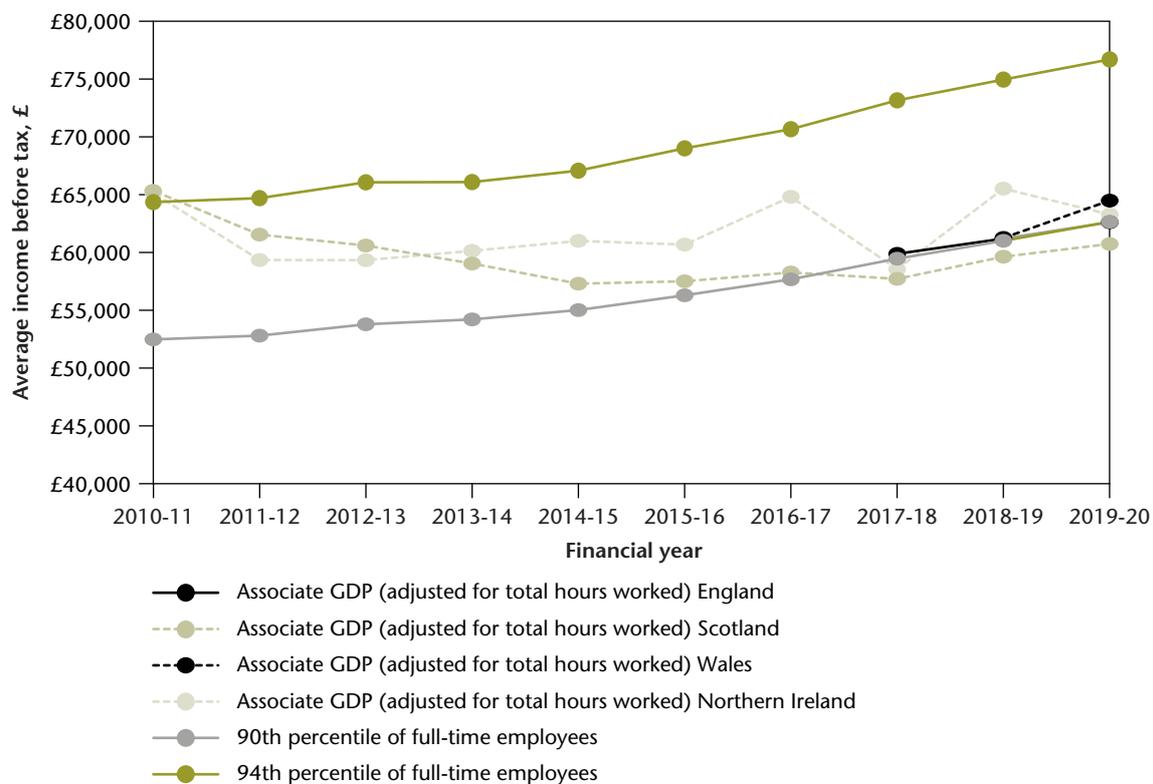
Source: OME estimates, based on data from NHS Digital, ONS.

5.16 Figure 5.11 shows in 2010-11 adjusted providing-performer GDP earnings in Scotland and Northern Ireland were between the 97th and 98th percentiles in the wider economy. In 2019-20, adjusted providing-performer GDP earnings were between the 96th and 97th percentiles in England, Scotland, and Wales and between the 95th and 96th percentiles in Northern Ireland. These figures also include non-NHS income.



5.17 Figure 5.12 shows in 2010-11 adjusted associate GDP earnings in Scotland and Northern Ireland were just above the 94th percentile in the wider economy. In 2019-20, adjusted associate GDP earnings were between the 90th and 91st percentiles in Wales and Northern Ireland, between the 89th and 90th percentiles in England and Scotland. These figures also include non-NHS income.

Figure 5.12: Average income before tax of associate GDPs in England, Scotland, Wales, Northern Ireland, adjusted for average weekly hours worked, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2019-20



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

- 5.18 The BMA once again drew our attention to what they described as ‘pay erosion’, the impact of the period of frozen pay or capped pay awards from 2010. They said that most doctors surveyed felt there was a need to ‘address long-term pay erosion arising from successive below inflationary pay rises’.
- 5.19 HCSA said that real-terms wage deflation devalued the hard work of the profession, and it was not sustainable for the wages of the most experienced doctors to lag behind the rest of the economy, and they were deeply concerned about the role of a declining reward package in incentivising retirement rates among consultants.
- 5.20 The BDA said that compared to 2010-11, the real-terms overall GDS spend was well below the 2010-11 level, meaning that practices were required to do more with less and there were inevitable pressures on dentists’ pay. They said that incomes for providing-performers and associates alike had fallen considerably in cash terms from the levels seen in the late 2000s across the UK, despite DDRB recommendations.

Pay comparability with other professions

- 5.21 As part of our considerations of recruitment, retention and motivation, we consider it necessary to assess the pay position of our remit group relative to other groups that could be considered appropriate comparator professions.

5.22 Figure 5.13 compares the pay distributions for doctors and dentists of different grades, to those for comparator professions. It is important to note that, in this section, the pay for other professions is on a full-time equivalent (FTE) basis, whereas that for doctors and dentists is the average for both full- and part-time, and so may be lower than it would be on an FTE basis.

- Median total earnings for Foundation doctors in their first year were above those for vets, below those in pharmaceuticals but similar to those for other comparator groups.
- Median earnings for Foundation doctors in their second year were higher than those for lecturers and vets, and lower than actuarial and pharmaceutical.
- The Registrar group's median earnings were lower than for actuarial, finance and accounting, pharmaceutical and legal groups, but higher than for academic and veterinary comparators.
- Specialty doctor median earnings were lower than those for actuarial and legal comparators, but in line or higher than for other groups.
- Median earnings for associate specialists were lower than for actuarial, finance and accounting, pharmaceutical and legal groups, but higher than for academic and veterinary comparators.
- Consultants' median earnings were above the highest-paid vets and higher education academics, but substantially lower than for finance and accounting, legal, pharmaceutical and actuarial groups.
- Median earnings for contractor GMPs were higher than median earnings for vets, but less than for actuarial staff. Providing-performer GDPs in England had higher median earnings than vets, but less than for actuarial, legal, finance and accounting and pharmaceutical groups.
- Both associate GDPs and salaried GMPs had earnings higher than vets, but lower earnings than actuarial, pharmaceutical, legal, finance and accounting groups.

Figure 5.13: Total earnings inter-quartile ranges of DDRB grades, (England), compared with professional comparator groups, full-time rates, 2021

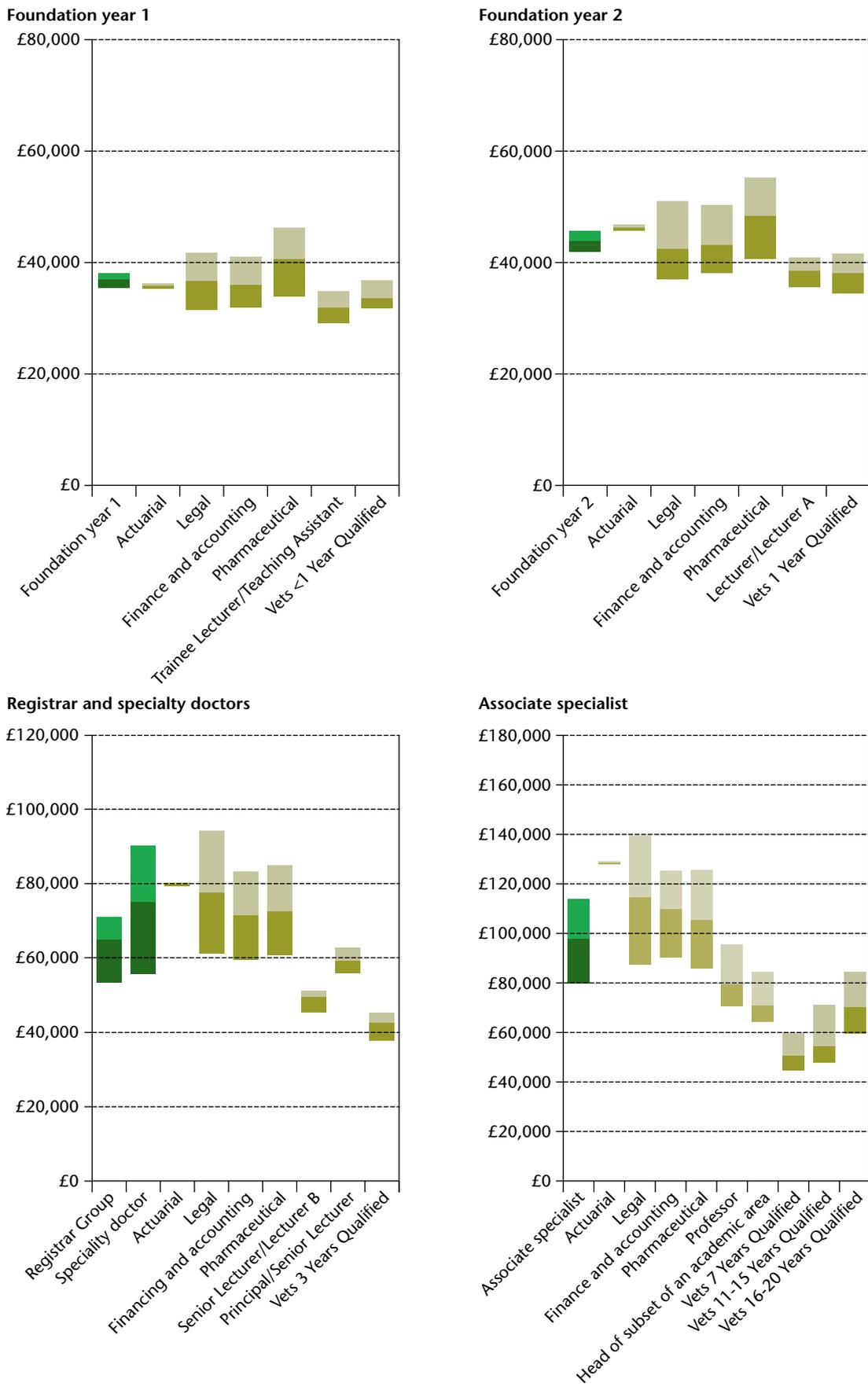
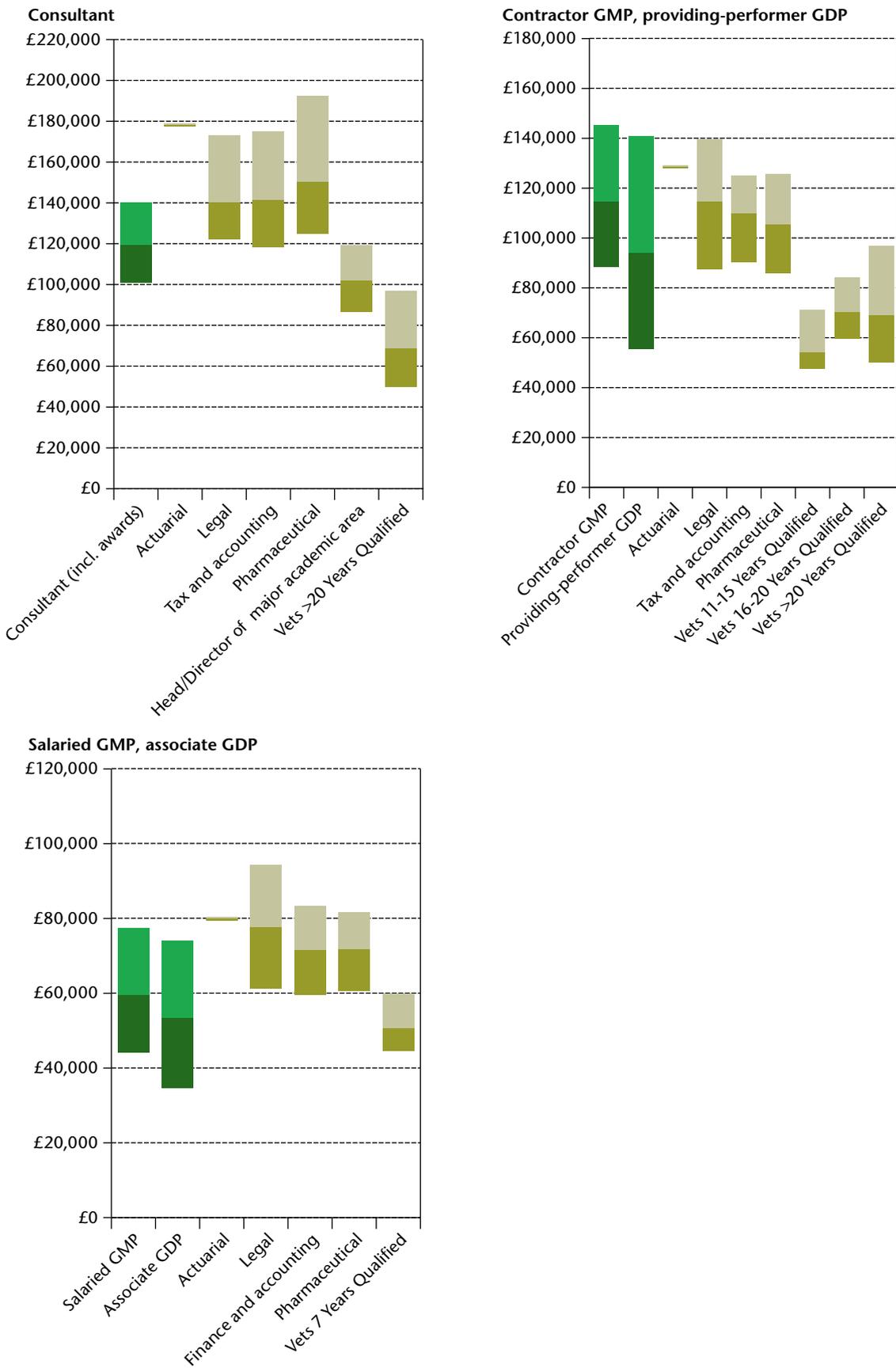


Figure 5.13 (continued): Total earnings inter-quartile ranges of DDRB grades, (England), compared with professional comparator groups, full-time rates, 2021



Pensions and pensions taxation

5.23 While pensions and pensions taxation are outside the formal remit of the review body, as a significant component of total reward, any issues with pensions, including pensions taxation, have the potential to significantly impact on recruitment, retention and motivation. We therefore discuss pensions and pensions taxation in detail in this report, and it featured prominently in the evidence provided to us by the parties.

Employee contributions

5.24 In February 2022, DHSC published a consultation response that outlined proposed changes to the employee contribution structure in place for NHS staff in England and Wales. These proposals included using actual pay, rather than notional whole-time equivalent (WTE) pay to determine contribution rates, partially flattening the contribution structure by increasing contribution rates for the lowest earners while decreasing them for the highest earners and uprating the contribution thresholds annually based on the Agenda for Change pay uplift.

5.25 DHSC said that NHS Pension Scheme members were required to collectively contribute 9.8 per cent across scheme membership, and that tiered contribution rates were originally introduced to reflect that higher earners received proportionally more benefits than lower earners over the course of their retirement, in part as a result of their final salary link. They said that under a career average scheme this advantage no longer exists for higher earners, as all members receive the same proportional benefit for their contributions, and therefore they could no longer justify keeping the cross-subsidy provided by higher earners at the same level. They said that the changes, which would see contributions for the highest earners fall by two percentage points, would be phased in over two years.

Table 5.3: Proposed new employee contribution structure for the NHS pension scheme, England and Wales

Current tiers	Pensionable earnings (rounded down to nearest pound)	Current rate	Rate from 1 April 2022 ³	Rate from 1 April 2023 ⁴	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%	-

Source: DHSC written evidence

- 5.26 DHSC also said that moving to actual pay rather than WTE pay would benefit many part-time doctors and dentists as their contribution rate would be lower, though this would make less of a difference for GMPs and GDPs as their scheme architecture does not use WTE.
- 5.27 NHS Providers said that they felt that the central initiative to flatten the contribution rate structure and increase employee contribution levels for some lower- and middle-banded staff was ill-advised due to the impact on take-home pay for lower- and middle-banded non-medical staff in the NHS, particularly given wider conditions affecting the value of their incomes.
- 5.28 The Scottish Government said that they were similarly reassessing their contribution structure in response to their needing to increase member contribution yields, which had been 0.2 per cent short of the required 9.8 per cent. They also said that they wished to move to basing contribution rates on actual rather than WTE pay. They also said that they similarly intended to flatten their employee contribution structure somewhat.
- 5.29 The Department of Health (Northern Ireland) did not mention any similar plans to flatten employee contribution rates.

³ It was subsequently announced that the changes proposed for 1 April 2022 would instead be implemented from 1 October 2022

⁴ It was subsequently announced that the changes proposed for 1 April 2023 would instead be implemented from 1 October 2023

- 5.30 The BMA said that one of the rationales provided for the use of higher contribution rates for higher earners was that it was an adjustment based on the higher tax relief received by higher earners. They said that on this basis it was unfair that this remained in place alongside the annual and lifetime allowances, which are also designed to claw back tax relief. They said that the DDRB should call for the introduction of a flat employee contribution rate from 1 April 2022 and said that the consultation proposals from the UK Government were welcome, but only represented tinkering around the edges and should go further.
- 5.31 The BDA said that they also said that they wished for there to be a flat employee contribution rate for all NHS Pension Scheme members, and they said that they did not feel that the proposed changes were sufficient to reduce the impact on dentists' total reward. However, they did welcome that contribution rates would be based on actual rather than WTE pay.
- 5.32 HCSA said that the rises in contribution rates for most of those towards earning under £47,846, including some doctors and dentists in training, would have a considerable impact on take-home pay. They also said that asking those on higher salaries to pay more than their fair share, or those on lower incomes to contribute more of their salaries threatens the future viability of the NHS Pension Scheme should individuals opt out, but also lessens the attractiveness of the total remuneration package at a time when the health service can least afford it.

The McCloud judgement and remedy

- 5.33 DHSC said that in December 2018, a Court of Appeal judgement (the McCloud judgement) found that transitional protections that had been in place as career average pension schemes were introduced across the public sector in 2015 gave rise to unlawful discrimination. They said that they had put in place legislation and published a consultation that would implement a remedy for NHS staff in England and Wales, including ensuring equal treatment by moving all members into the new schemes from 1 April 2022 irrespective of age, and removing the effect of transitional protection by offering eligible members a choice over the benefits they would receive for pensionable service between 1 April 2015 and 31 March 2022. The Scottish Government also described similar proposals that were being consulted on ahead of implementation for NHS staff in Scotland.
- 5.34 NHS Employers said they were working with employers to dispel certain misconceptions around the McCloud remedy, as well as to ensure it is rolled out smoothly.
- 5.35 The BMA said that they were concerned that the McCloud remedy might mean that many doctors would be able to retire earlier than planned with less actuarial reduction of their pension, and unless reforms were introduced to address pensions taxation issues, it was likely that many of these doctors would retire in the following 18 months.

Pensions taxation

- 5.36 Since the last report, the overall situation with respect to pensions taxation has not changed, and the parties have continued to discuss both the annual and lifetime allowances as significant factors affecting retention of the most senior doctors and dentists. The lifetime allowance remains frozen at £1.07 million until 2025-26, while the annual allowance remains £40,000, with the taper threshold remaining at £200,000, in line with the £90,000 increase that was introduced as part of the 2020 Budget.
- 5.37 DHSC said that Government Actuary's Department (GAD) analysis showed that the Scheme Pays option for dealing with an annual allowance tax change was proportionate and notwithstanding the reduction to the value of pension accrued, the growth in benefits represented a good return on the contributions made even when this option was used. They also said that they were committed to improving the availability of high-quality information on the pension scheme for members, including commissioning NHS Employers to provide a 'ready reckoner' to help members assess their potential tax liability, which launched in September 2020.
- 5.38 NHSE/I said that they had launched the Pension Response Project, which sought to dispel myths about the NHS Pension Scheme and pensions taxation, and to equip staff to make informed decisions about their pension.
- 5.39 NHS Employers said that they had issued guidance for employers to support them to assess whether the paying of unused employer contribution as salary (recycling) might be appropriate. They also said that over the course of the lifetime allowance freeze, more members of the NHS Pension Scheme would breach the lifetime allowance. They also said that they believed that flexible accrual rates would provide a clear solution to allow higher earners to control their pension growth and mitigate against pension tax charges if it is in their best financial interest to do so, and that it was crucial that higher earners had easy access to independent financial advice and education.
- 5.40 NHS Providers said that while the NHS Pension Scheme provides generous benefits, tax rules had created a situation where senior doctors and managers had received large and sometimes unexpected tax bills. They said that most trusts surveyed said that clinical staff were less willing to take on leadership roles as a result of this, and most clinical directors surveyed said that they had declined or had considered declining additional work due to the impact of annual allowance taxation. They said that the increase to the annual allowance taper threshold had improved the situation, but they had still received isolated reports that challenges remained around the receipt of tax bills associated with promotions.
- 5.41 The Scottish Government said that a scheme to compensate those who had opted out of the pension scheme for pensions taxation reasons remained under active consideration, though this was not a permanent solution and would need a strong justification. They said they would continue to engage with the UK Government on this issue, including to explore the potential for a flexible accrual scheme.

- 5.42 The Department of Health (Northern Ireland) said that HSC employers felt the effect of the pensions tax issue on senior staff, some of whom had retired from the service early, and that there was concern that they would lose more senior staff than normal in 2022. They also said that consultants have expressed concern about staying in HSC or taking on additional sessions and were seeking more flexibility in their working patterns. They also said that they were aware that pensions taxation was a significant disincentive to working additional sessions for GMPs.
- 5.43 The BMA said that at a time of unprecedented pressure within the NHS, the system could ill afford a pensions system that in many cases resulted in penalties for doing additional work or that can make it financially detrimental to continue working rather than taking early retirement. They said that the lifetime allowance was a powerful driver in pushing doctors to consider early retirement, with 72 per cent of doctors surveyed saying they would retire earlier as a result of its freezing. They said that a tax-unregistered top up scheme should be introduced similar to the solution offered to judges, and recycling schemes should be introduced immediately across the UK, noting that its availability in England was patchy despite DHSC saying they supported it. They also said that the full 20.6 per cent employer contribution should be available for recycling, and that partial retirement should be introduced in the 1995 legacy scheme. They said that the late implementation of pay awards in Northern Ireland had also exacerbated this situation for senior doctors there, as receiving backdated pay awards in the following financial year had an impact on their annual allowance.
- 5.44 The BDA said that the increase to the taper threshold had not fully solved the impact the annual allowance tax regime had on dentists.
- 5.45 HCSA said that over a third of doctors they had surveyed outlined improving the annual and lifetime pensions allowances as one of the top three actions that could be taken to increase recruitment and retention. They said that 13 per cent of staff surveyed had made definite plans to leave the NHS primarily because of pensions tax.

Motivation, morale and engagement

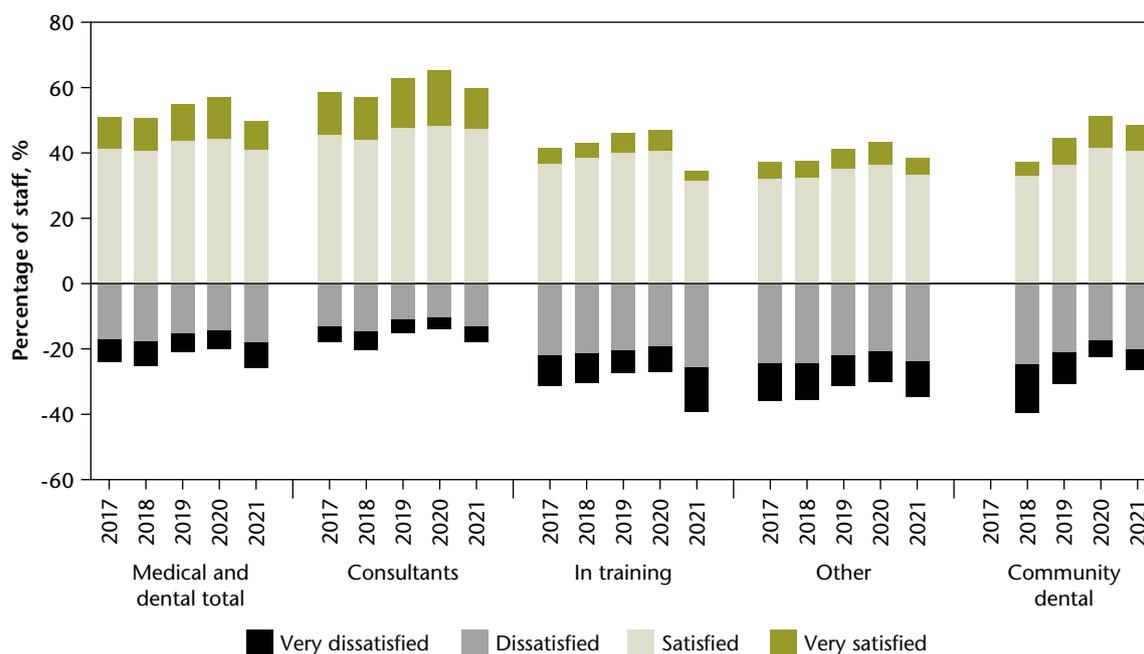
England

- 5.46 Since our 2021 Report, the 2021 survey of NHS Staff in England was published. It was conducted between September and December 2021, and over 47,000 medical and dental staff responded.
- 5.47 In 2021, 49.8 per cent of medical and dental staff responding said they were satisfied⁵ with their pay, a decrease of 7.2 percentage points, from 56.9 per cent in 2020 (Figure 5.14), and the lowest recorded since at least 2017. There was a decrease in satisfaction with pay for consultants, specialty doctors and associate specialists, doctors and dentists in training, and community dentists.

⁵ In each case, satisfied refers to participants answering that they were 'satisfied' or 'very satisfied' with their level of pay.

- A larger proportion of consultants said they were satisfied with their pay than other groups. In 2021, 59.6 per cent said they were satisfied, a decrease of 5.7 percentage points from 2020.
- For doctors and dentists in training, in 2021, 34.5 per cent said they were satisfied with pay, a decrease of 12.5 percentage points compared to 2020.
- For the 'other' group (comprising mainly specialty and associate specialist (SAS) doctors), 38.4 per cent said they were satisfied with pay, a decrease of 4.9 percentage points from 2020.
- For community dentists, 48.5 per cent said they were satisfied with their pay, a decrease of 2.8 percentage points from 2020.

Figure 5.14: HCHS medical staff satisfaction with level of pay, England, 2017 to 2021



Source: NHS Staff Survey data.

Note: The percentage saying "neither satisfied nor dissatisfied" is omitted throughout this chart.

5.48 Looking across a range of measures related to job satisfaction, the results for medical and dental staff as a whole in 2021, were generally worse than in each of the previous four years (Table 5.4).

- The percentage of staff saying that: they looked forward to going to work; were enthusiastic about their job; that time passed quickly at work; they were satisfied with the recognition they got for good work; their line manager valued their work; they would recommend their organisation as a place to work; their organisation values their work; they were satisfied with their pay, was at the lowest level since at least 2017.
- Over one third of respondents said that they experienced harassment, bullying or abuse from patients, relatives or the public, an increase from 2020.
- Just over 20 per cent of respondents said that they were considering leaving the NHS, an increase from 16 per cent in 2020.

Table 5.4: Selected results from the National Staff Survey, medical and dental staff, England, 2017 to 2021

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Engagement and job satisfaction							
I look forward to going to work	2a	66.3	66.8	67.1	65.6	58.1	
I am enthusiastic about my job	2b	77.3	77.4	77.4	75.2	68.2	
Time passes quickly when I am working	2c	82.7	82.8	82.2	80.5	77.1	
The recognition I get for good work	4a	53.1	57.7	60.0	59.0	51.8	
My immediate manager values my work	9e	69.7	69.7	71.1	70.6	66.6	
Considering leaving the NHS ²	22d		19.6	18.4	16.2	20.2	
Recommend my organisation as a place to work	21c	65.1	66.0	67.2	69.7	62.0	
The extent to which my organisation values my work	4b	45.8	48.3	50.4	51.1	42.9	
My level of pay	4c	51.0	50.6	55.0	56.9	49.8	
Percentage of staff appraised in the last 12 months	19a	90.9	91.2	89.9		83.7	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months ²	14a	33.6	36.2	35.8	32.8	34.6	

Source: National NHS Staff Survey

Notes: Data rounded to 1 decimal place

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

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

5.49 In 2021 workload pressures generally remained high and worsened since 2020 (Table 5.5). In 2021:

- The percentage of staff saying that: they were able to meet all the conflicting demands on their time; they had adequate materials, supplies and equipment to do their work; there were enough staff at their organisation for them to do their job properly was at the highest level since at least 2017;
- The percentage of staff saying that they had felt unwell as a result of work related stress, 45 per cent, was at the highest level since at least 2017;
- Compared with 2020, there was an increase in the percentage of staff saying they worked paid hours over and above their contracted hours and an increase in the percentage saying that they were working unpaid hours over and above their contracted hours.
- New questions were added to the survey, covering work-life balance and burnout. 42 per cent of respondents said that they were able to achieve a good balance between work and home life, while 33 per cent said that were feeling burnt out because of work.

Table 5.5: Selected results from the National Staff Survey, medical and dental staff, England, 2017 to 2021

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Workload							
I am able to meet all the conflicting demands on my time at work	3g	37.0	36.5	38.3	41.1	35.3	
I have adequate materials, supplies and equipment to do my work	3h	50.3	50.4	51.4	56.5	50.1	
There are enough staff at this organisation for me to do my job properly	3i	28.9	29.4	30.3	39.0	24.6	
During the last 12 months have you felt unwell as a result of work related stress ²	11c	34.2	37.3	38.0	39.8	45.0	
Achieve a good balance between work and home life	6c					41.5	
Feeling burnt out because of work ²	12b					33.1	
Percentage of staff working PAID hours over and above their contracted hours ²	10b	41.3	42.7	43.6	41.8	45.6	
Percentage of staff working UNPAID hours over and above their contracted hours ²	10c	80.4	80.8	78.8	75.2	78.1	

Source: National NHS Staff Survey

Notes: Data rounded to 1 decimal place

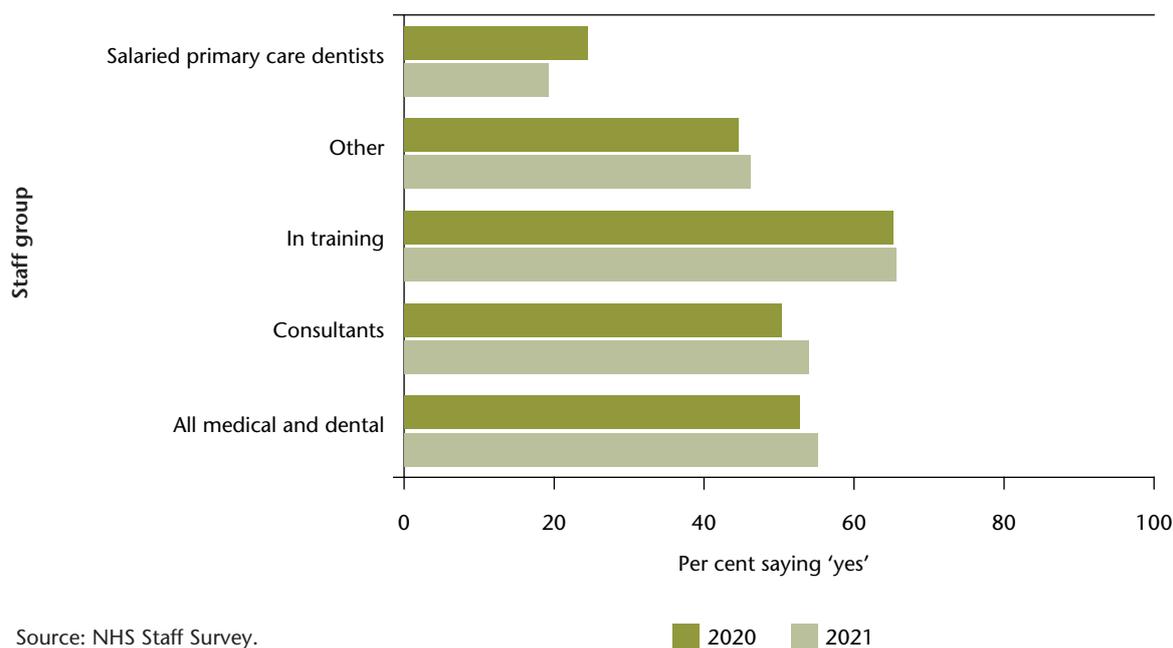
(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure

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

5.50 In addition to the usual range of questions, staff were asked, as part of the 2020 and 2021 surveys, about their experiences during the COVID-19 pandemic (Figures 5.15 to 5.17). In 2021:

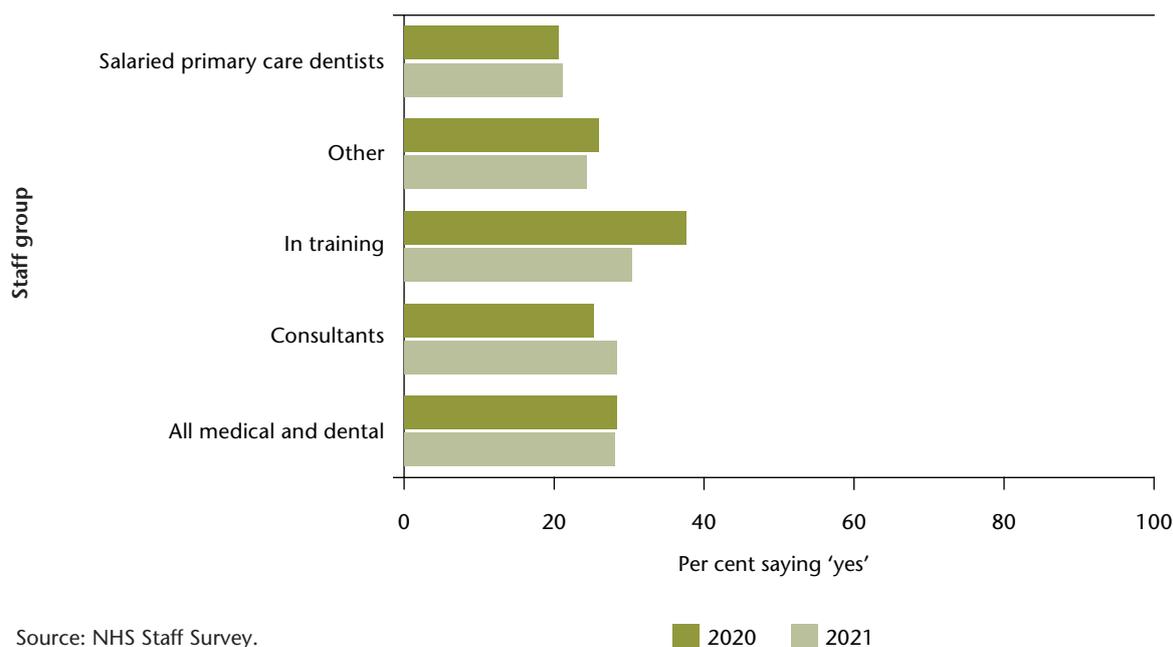
- 55 per cent of medical and dental staff said that they had worked on a COVID-19 ward or area at any time. Doctors and dentists in training (66 per cent) were the group most likely to have done so;

Figure 5.15: COVID-19 related questions from the National Staff Survey, medical and dental staff, England, 2021 – have you worked on a COVID-19 specific ward or area?



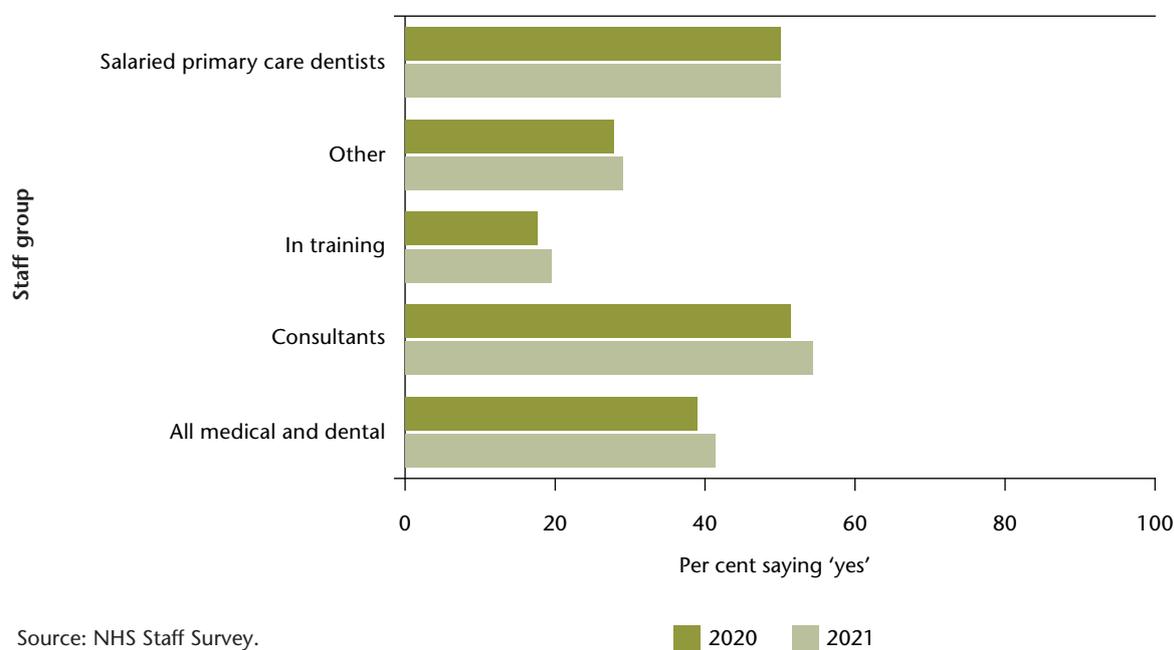
- 28 per cent of medical and dental staff said that they had been redeployed due to the COVID-19 pandemic at any time. Doctors and dentists in training (30 per cent) were the group most likely to have done so;

Figure 5.16: COVID-19 related questions from the National Staff Survey, medical and dental staff, England, 2021 – have you been redeployed due to the COVID-19 pandemic?



- 41 per cent of medical and dental staff said that they had been required to work remotely/from home due to the COVID-19 pandemic. Consultants (54 per cent) were the group most likely to have done so.

Figure 5.17: COVID-19 related questions from the National Staff Survey, medical and dental staff, England, 2021 – have you been required to work remotely/from home due to the COVID-19 pandemic?



NHS Staff Survey (Wales)

5.51 In its evidence the Welsh Government said that the Welsh Partnership Business Committee had agreed to postpone the all-Wales NHS Staff Survey until later in 2022, to ensure that the survey data was not compromised by the winter and pandemic pressures. A survey was conducted in 2020, but did not differentiate medical and dental staff from the rest of the NHS workforce.

Scotland

5.52 The Staff Experience Survey for health and social care staff for 2021 was conducted between 9 August 2021 and 11 October 2021 and had over 108,000 responses from health and social care staff, a response rate of 56 per cent. Within the overall total, there were 6,476 survey responses for 'medical and dental staff'. Key results, with comparisons to 2019, the last time the equivalent survey was conducted:

- 67 per cent of medical and dental staff said that their organisation cares about their health and wellbeing, unchanged from 2019;
- 83 per cent of medical and dental staff said that their direct line manager cares about their health and wellbeing, unchanged from 2019;
- 79 per cent of medical and dental staff, said that their work gave them a sense of achievement, down 3 percentage points from 2019;
- 72 per cent of medical and dental staff said that they felt appreciated for the work they do, down 1 percentage point from 2019;

- 82 per cent of medical and dental staff said that they were treated with dignity and respect as an individual at work, down 1 percentage point from 2019;
- 80 per cent of medical and dental staff said that they were treated fairly and consistently at work, down 1 percentage point from 2019;
- 68 per cent of medical and dental staff said that they got the help and support they needed from other teams and services, down 1 percentage point from 2019.
- 71 per cent of medical and dental staff said that they would recommend their organisation as a good place to work, down 2 percentage points from 2019.

Northern Ireland

5.53 The last survey of Health and Social Care staff was for 2019, which we commented on in our 2020 report.

Our comments

- 5.54 We note the largely positive shifts in the pay position of most groups of doctors and dentists relative to the overall earnings distribution in 2020-21. This is likely a result of distortions associated with the pandemic's impact on the wider economy, and so we would expect that these trends will be reversed, at least to some extent, in the data for 2021-22 and 2022-23. It remains to be seen whether the implementation of our recommendations, combined with the significant economic disruption and recovery associated with the pandemic will lead to an improvement or a deterioration in doctors' and dentists' relative pay position, or how their pay compares to their comparator professions.
- 5.55 We note that in their evidence the trade unions continued to make reference to a fall in the value of earnings for our remit group since 2010, once inflation is taken into account. We also note that our role is limited to examining issues relating to the pay position of and pay comparability for doctors and dentists in respect of recruitment, retention and motivation. However, it has not been in the scope of our remit from the governments to offer a wider view as to where doctors' and dentists' pay should be positioned in wider society and the economy as a whole. As part of longer-term workforce and health service planning efforts, parties may wish to consider whether such an endeavour would be valuable and the extent to which the DDRB could make a contribution to this work.
- 5.56 We note what the parties have told us about pensions and pensions taxation. While it is not our role to make explicit recommendations for pensions, it is clear from the evidence we received, and from what we heard on our visits programme, that the recruitment and retention of senior doctors and dentists is being influenced by these issues, and therefore we would once again underline the importance of them being addressed. This is particularly true given what DHSC said about there being a reliance on the current workforce to supply additional activity or refocus their activity on elective recovery.

- 5.57 Given this, we would urge the governments to consider swift action to address these issues. While it is not our role to advocate for or against particular solutions, we would note that the BMA included a number of proposals for changes to the pensions scheme that would in their view address some of these issues, including the rolling out of recycling of unused employer contribution more widely, though we also heard of some disadvantages of this approach. We would expect national NHS leadership to take charge of this situation.
- 5.58 We also note the new employee contribution structures that will be in place in England and Wales, and Scotland this year, and that the changes are advantageous to higher earners and those that work less-than-full-time. We also welcome the proposal to uplift the contribution thresholds by the Agenda for Change pay uplift each year; this is likely to avoid situations that we have heard about on visits of staff members losing money as a result of their pay uplift moving them into a different contribution tier, though we would note that when there are differences between Agenda for Change and medical and dental uplifts, this issue may return.
- 5.59 We note with concern the staff survey results for 2021. The results are uniformly substantially worse than 2020, which may reflect pandemic-related fatigue and burnout and re-emphasises concerns that staff are under pressure and facing challenging workloads. Demotivated doctors and dentists are more likely to retire early or decrease their working hours, and motivation issues can also impact on the quality of services, ultimately to patients' detriment. It is potentially significant that the falls in pay satisfaction took place despite doctors' and dentists' pay position having improved in the past year.
- 5.60 We are particularly concerned about the survey results that related to recruitment and retention, noting that there were stark falls in the numbers reporting that there were enough staff at their organisation, and who would recommend their place of work to others, as well as rises in the percentages who were working beyond their contracted hours and who were considering leaving the NHS. That these changes happened alongside a significant fall in pay satisfaction suggests that the HCHS workforce feels undervalued and demoralised.

CHAPTER 6: DOCTORS AND DENTISTS IN TRAINING

Introduction

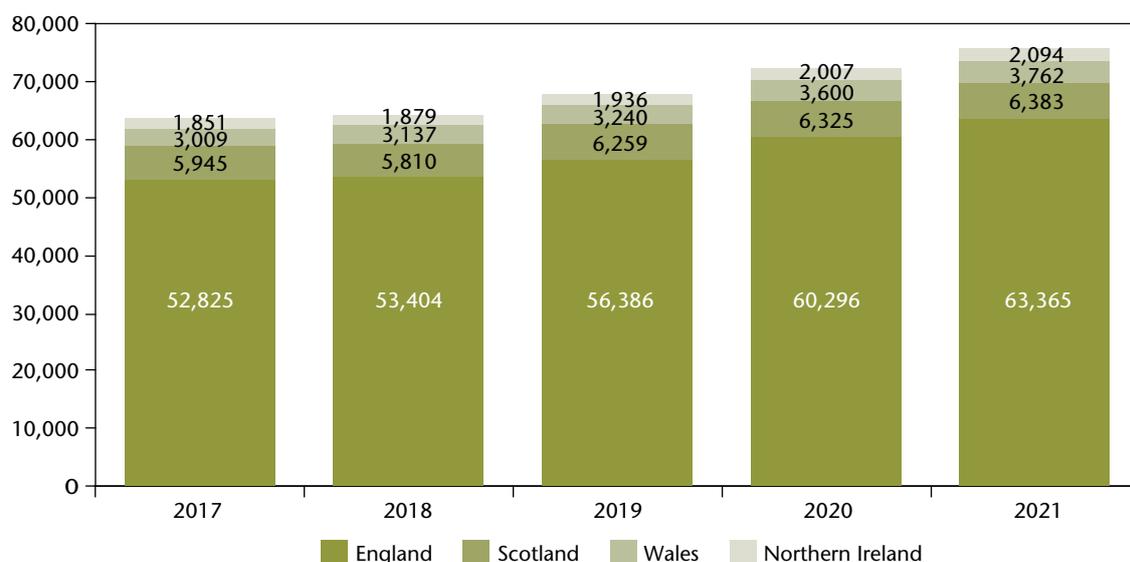
6.1 In this chapter, we examine recruitment, retention and motivation amongst doctors and dentists in training. While doctors and dentists in training in England are entering the final year of a multi-year pay agreement that was agreed in 2019 our remit letter for England asked us to make comments and observations on the evidence we received for this group. We have been asked to make recommendations as usual for doctors and dentists in training in Scotland, Wales and Northern Ireland.

Doctors and dentists in training

- 6.2 After completing medical school, which normally takes around five years, doctors in the UK begin their hospital training in the Foundation Programme, normally a two-year, general postgraduate medical training programme, where they are known as foundation doctors (F1 and F2). Following this training, doctors can either continue in the hospital sector, entering specialty training which, depending on the specialty, may include two or three years' core training, or enter general practice training. Dentists undertake a training programme of around five years' undergraduate study at dental school, after which there is a dental postgraduate training system that includes a one-year foundation programme. After this foundation programme dentists choose whether to stay in the hospital sector or work in primary care dentistry.
- 6.3 Doctors in training, often referred to as junior doctors, comprise doctors undertaking the foundation programme or core, specialty, or general practice training. General practice training takes at least three years, and core and specialty training together at least six. On completion of specialty training, doctors receive the Certificate of Completion of Training (CCT) and become eligible for consultant roles. Doctors may also, if they wish, leave training prior to completion, entering the SAS grades.
- 6.4 In September 2021 there were 75,604 doctors and dentists on a full-time equivalent (FTE) basis in hospital training in the UK (Figure 6.1), an increase of 4.7 per cent from 2020. Comparing September 2021 with 2020 there was an increase in the numbers in training in England (5.1 per cent), Wales (4.5 per cent), Northern Ireland (4.3 per cent¹) and Scotland (0.9 per cent).

¹ The figures for Northern Ireland are for March 2021 compared to March 2020

Figure 6.1: Number of FTE doctors and dentists in training in the Hospital and Community Health Services (HCHS), United Kingdom, 2017 to 2021



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

Undergraduate medical and dental training

- 6.5 Table 6.1 shows the time series from 2012 to 2021 for the numbers of applications², applicants³ and acceptances⁴ on pre-clinical medicine courses. The equivalent figures for dentistry are shown in Table 6.2.
- 6.6 In 2021 there were 30,145 applicants to study pre-clinical medical degrees in the UK who between them made 102,240 applications (an average of 3.4 applications per applicant). Of these, 10,985 were accepted on a course. Compared with 2020, this represents an increase of 3.4 per cent in students accepted on to courses and an increase of 23 per cent in the number of applicants. Since 2017 the number of students accepted on to medical courses has grown by 42 per cent and the number of applicants by 52 per cent.
- 6.7 In 2021 there were also 5,015 applicants to study pre-clinical dental degrees in the UK who between them made 14,135 applications (an average of 2.8 applications per applicant). Of these 1,295 were accepted on a course. This represents a ratio of applicants to acceptances of 3.9. The number of applicants fell each year from 2012 to 2016 before increasing in each of the last five years, and by 13.5 per cent in 2021, compared with 2020. Between 2017 and 2019, the number of acceptances had been little changed, but in 2020 the number of acceptances was 17 per cent higher than in 2019. However, despite the increase in the number of applications and applicants in 2021, compared with 2020, the number of acceptances fell back by 2.6 per cent between 2020 and 2021.

² Number of applications: defined as a choice to a course in higher education through the UCAS main scheme. Each applicant can make up to five choices.

³ Number of unique applicants: defined as the number of applicants making at least one choice through the main UCAS scheme.

⁴ Acceptance: defined as an applicant who has been placed for entry into higher education.

Table 6.1: Numbers of applications, unique applicants and acceptances for medical degrees, UK, 2012-2021

	Number of Applications	Number of Unique Applicants	Number of Acceptances	Applications per Acceptance	Unique Applicants per Acceptance
2012	81,260	22,285	7,805	10.4	2.86
2013	82,440	22,685	7,515	11.0	3.02
2014	84,850	23,365	7,680	11.0	3.04
2015	75,665	20,935	7,660	9.9	2.73
2016	74,860	20,815	7,830	9.6	2.66
2017	68,655	19,860	7,750	8.9	2.56
2018	75,395	21,570	8,620	8.7	2.50
2019	80,995	23,425	9,650	8.4	2.43
2020	84,380	24,580	10,625	7.9	2.31
2021	102,240	30,145	10,985	9.3	2.74

Source: OME estimates using UCAS data.

Table 6.2: Numbers of applications, unique applicants and acceptances for dental degrees, UK, 2012-2021

	Number of Applications	Number of Unique Applicants	Number of Acceptances	Applications per Acceptance	Unique Applicants per Acceptance
2012	11,630	3,515	1,195	9.7	2.94
2013	11,350	3,455	1,190	9.5	2.90
2014	11,210	3,410	1,105	10.1	3.09
2015	9,875	3,010	1,095	9.0	2.75
2016	9,060	2,810	1,100	8.2	2.55
2017	9,240	2,885	1,135	8.1	2.54
2018	9,850	3,040	1,125	8.8	2.70
2019	11,450	3,895	1,140	10.0	3.42
2020	12,220	4,420	1,330	9.2	3.32
2021	14,135	5,015	1,295	10.9	3.87

Source: OME estimates using UCAS data.

6.8 The gender and ethnic composition of those accepted to study for medical and dental degrees has changed between 2012 and 2020. Over that period the share of students accepted onto medical degree courses that were female increased from 53 per cent to 64 per cent. For dentistry, the proportion increased from 61 per cent to 70 per cent. The share of students accepted onto medical degree courses that were from an ethnic minority background increased from 31 per cent to 50 per cent. For dentistry, this proportion increased from 46 per cent to 65 per cent.

6.9 Table 6.3 shows the ten undergraduate subjects with the largest ratio of applications to acceptances in 2021. Pre-Clinical Medicine had the third-highest ratio, behind Pre-Clinical Dentistry and Others in Medicine and Dentistry.

Table 6.3: Subjects⁵ with the highest ratio of applications to acceptances, United Kingdom 2021

Subject	Ratio of applications to acceptances 2021
Pre-clinical Dentistry	10.9
Others in Medicine and Dentistry	9.7
Pre-clinical Medicine	9.3
Statistics	8.4
Artificial Intelligence	8.2
Others in Business & Admin Studies	7.3
Combinations within Mathematical Sciences	7.1
Pre-clinical Veterinary Medicine	6.7
Economics	6.6
Publicity Studies	6.6

Source: OME calculations using UCAS data.

- 6.10 DHSC said that they completed a 25 per cent expansion in the number of medical school places in England, to 7,500, in September 2020, and as part of this, medical schools had been opened in Lincoln, Canterbury, Sunderland, Lancashire and Chelmsford – areas that are ‘under-doctored’. They added that its intention was that the expansion of medical school places would reduce gaps in access for students from lower socio-economic backgrounds. They also said that 800 additional students began medical school during the 2020-21 academic year, compared to pre-planned intakes, as a result of the COVID-19-related disruption to school exams. They said that this growth meant that once these students had passed their medical school licensing examinations, there would be an increase in the number of doctors working in the NHS and a reduction in expensive medical agency staff.
- 6.11 HEE said that the pandemic had functioned as a springboard for innovation in undergraduate medical training, including accelerating the development of online learning, introducing novel ways of assessing students and increased use of simulation software. They also said that intake targets would revert to pre-pandemic levels in 2022.
- 6.12 DHSC also said that HEE were developing a proposal for an apprenticeship in medicine, working with a number of partners, and that Ministerial approval for such a scheme would be sought in the spring of 2022. They said that the intention of this was to widen participation in medicine, and that apprenticeships would be subject to the same rigorous exams as medical undergraduates.

⁵ This table only looks at subjects that had at least 100 acceptances in 2021

Contract reform

England

- 6.13 In June 2019, the BMA, DHSC and NHS Employers announced changes to the contract that was introduced in 2016. As part of the agreement basic pay uplifts of 2 per cent per year were guaranteed until 2023, with a further 3.3 per cent invested into the contract through the lifetime of the deal to provide:
- A new fifth nodal point (pay point) for trainees at ST6 and above, with a staggered introduction from 2020-21
 - An uplift to weekend allowances
 - A £1,000 allowance for those working less than full time
 - Changes to the academic flexible pay premium
- 6.14 The rest and rostering requirements in the contract were also made more robust, including for example a new maximum of eight consecutive shifts rostered or worked over eight consecutive days.

Scotland

- 6.15 The Scottish Government told us they did not currently have plans to reform their junior doctor contract.

Wales

- 6.16 The Welsh Government said that while they had not yet received an official mandate for contract reform negotiations, they had been working informally with the BMA to establish areas for negotiation, and they were considering the applicability of some of the elements of the 2016 contract in place in England to Wales. They said that they wanted their contract to enable the free flow of trainees between England and Wales.
- 6.17 The BMA said that discussions on reforming the junior doctor contract in Wales were well-advanced. They said that an attractive contractual arrangement would include fair pay that recognises the actual work that trainees do while recognising the unique experience that each trainee can bring to their job. They added that the contract must include recognition of the value of flexible training, including out-of-programme experiences and less-than-full-time training.

Northern Ireland

- 6.18 The Department of Health (DoH) said that there was currently no appetite from employers or the BMA to enter into negotiations over reform to the junior doctor contract in Northern Ireland. However, they added that employers were feeling the impact of the difference in pay scales between Northern Ireland and the rest of the UK, as a result of different pay frameworks, and that the option to reform the contract may well be considered in the future.

Recruitment and training choices

6.19 After completing the two-year foundation programme, doctors can choose which specialty they wish to enter, or whether they wish to enter general practice training. However, the number of trainees in the UK deciding not to begin specialty or general practice training immediately after completing the foundation programme, a practice known as stepping out of training, continues to increase. Many doctors who do this choose to work abroad, as locums, or continue to work for the NHS/HSC in alternative roles, sometimes referred to as clinical fellow or trust grade roles. In 2012, one third of trainees stepped out of training for at least a year, but by 2020 that had increased to more than two thirds. Table 6.4 shows the trends in how many trainees have stepped out of training, and for how long.

Table 6.4: Trainees that pause training after F2, and length of pauses

F2 year of completion	No pause	1-year pause	2-year pause	3+ year pause	Not yet returned
2012	66%	17%	7%	4%	6%
2013	62%	20%	8%	3%	7%
2014	57%	22%	8%	5%	8%
2015	51%	25%	10%	6%	8%
2016	46%	25%	13%	7%	10%
2017	41%	29%	13%	5%	11%
2018	38%	29%	16%	n/a	17%
2019	34%	30%	n/a	n/a	36%
2020	31%	n/a	n/a	n/a	69%

Source: General Medical Council: The State of Medical Education and Practice in the UK 2021 (Figure 37).⁶

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

England

6.21 Health Education England (HEE) said that recruitment into specialty training in 2020-21 was successful, with an overall fill rate of 99 per cent, including a 100 per cent fill rate for core psychiatry training. The new, higher target of 4,000 general practice trainees was also met. They also said that the first two rounds of applications for the 2021-22 recruitment cycle had seen them receive over 38,000 applications, compared to 35,000 at the same stage in 2020-21. They added that the main driver of increases in the number of applications came from international medical graduates.

⁶ <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk>

- 6.22 HEE said that they had worked with NHSE/I to develop a robust model for guiding the geographic distribution of training posts, and it was being piloted in three relatively large specialties (Haematology, Cardiology and Obstetrics and Gynaecology), as part of efforts to tackle health inequalities. They said that this had been informed by evidence that had demonstrated a correlation between hospital mortality indices and the number of doctors per head of the population. They also said that this programme would seek to address long-term challenges with attracting, recruiting and retaining trainees in remote, rural and smaller health systems. They added that since in the areas with the most severe shortages the cost of living was generally lower, it was not clear to what extent money is a motivator for choosing to work in certain geographies.
- 6.23 HEE also described work that was ongoing as part of their Medical Education Reform Programme (MERP). MERP comprises a range of aligned initiatives that aim to produce doctors that better meet the needs of patients and services, address health inequalities, and improve the experience of doctors in training. They said that these initiatives were drawn from *The Future Doctor*⁷, which was published by HEE in July 2020. They said that the report's vision was focused around six reform pillars:
- Enhanced generalism;
 - Equality, diversity and inclusion;
 - Accelerating undergraduate supply, bringing forward the current point of registration;
 - Addressing health inequalities;
 - Improving the wellbeing and experience of doctors; and
 - Boosting multi-professional team working, producing more generalist doctors, and supporting service provision to be more efficient.

Flexible Pay Premia

- 6.24 The junior doctors' contract in England included flexible pay premia (FPP) for:
- general practice training, payable only during the practice-based period of GMP specialty training;
 - hard-to-fill training programmes, initially emergency medicine and psychiatry;
 - oral-maxillofacial surgery;
 - clinical academic trainees; and
 - those taking time out of training for recognised activities deemed to be of benefit to the wider NHS.

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

- 6.25 The rates for 2022-23 have already been applied, as part of the 2019 agreement (see para 6.7 above) and are set out in Tables 6.5 and 6.6.

⁷ <https://www.hee.nhs.uk/our-work/future-doctor>

Table 6.5: Flexible Pay Premia in England, 2022-23

Name of premium	Applicable training programme		Full time annual value (£)	
General Practice	General Practice	Payable to ST1, ST2, ST3, ST4 during general practice placements only.	9,144	
Hard-to-fill Training Programmes	Psychiatry Core Training	Payable to Psychiatry Core Trainees.	3,718	
	Psychiatry Higher Training	Payable to Psychiatry Higher Trainees.	3 year higher training programme:	3,718
			4 year higher training programme:	2,789
	Emergency Medicine	Payable to ST4 and above only.	Dependent on length of training programme, see table 6.6 below.	
Dual qualification – OMFS	Oral and Maxillofacial Surgery	Payable to ST3 and above only.		
Histopathology	Histopathology	Payable to ST1 and above only	4,461	
Academia		Upon return to training following successful completion of higher degree.	4,461	

Table 6.6: Flexible Pay Premia in England, 2022-23

Length of training programme	Full time annual value (£)
3 years	7,435
4 years	5,577
5 years	4,461
6 years	3,718
7 years	3,187
8 years	2,789

Source: NHS Employers, Pay and Conditions Circular (M&D) 1/2022.⁸

Targeted Enhanced Recruitment Scheme (TERS)

6.26 TERS is an initiative that offers a one-off payment of £20,000 to general practice trainees committed to working in particular locations where recruitment had previously been challenging. The sum is repayable if the trainees leave the programme during the training period. The sub-regional areas covered by TERS in England saw over 99 per cent fill rates in 2021-22. HEE said that the data appear to show that TERS had been successful, and they were therefore considering whether TERS or a similar scheme should also be considered in psychiatry where there was a similar pressing need to increase recruitment to the training grades, though they said that caution should be exercised in extrapolating the results of TERS in considering the evidence for flexible pay premia more generally, and longitudinal tracking should be used to ascertain if TERS trainees remain in an area following the completion of training. They said that the number of posts available under TERS would increase from 553 to 800 in 2022-23.

⁸ <https://www.nhsemployers.org/articles/pay-and-conditions-circulars-medical-and-dental-staff>

Foundation Priority Programmes

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

Flexible Training

6.28 HEE said that in response to the pandemic they had accelerated the planned rollout of measures to enable trainees to train less-than-full-time (LTFT) as a personal choice, and that a three-year longitudinal study of this was underway. They also described the introduction of the Out Of Programme Pause (OOPP) in 2019 and the SuppoRTT initiative, to help ensure trainees are clinically confident and full supported when they return to training following a sustained period of absence.

Scotland

6.29 The Scottish Government said 51 additional Foundation training places were created and recruited to in 2021, with a further 54 to be added in 2022. They said that these posts would include greater exposure to general practice and psychiatry, with a view to encouraging uptake at a specialty training level.

6.30 They added that the overall medical training recruitment process had been successful, with 92 per cent of training posts filled. Fill rates were close to 100 per cent for Foundation training and training at the ST1 level, with a fill rate of around 80 per cent at the ST3 level.

6.31 They said that a number of actions were underway to improve the attractiveness of postgraduate medical training in Scotland, including:

- Making LTFT available to all grades of trainee in all specialties
- Working to streamline selection and recruitment processes
- Offering Broad Based Training that provides flexibility within training programmes and exposure to shortage specialties
- A Scottish version of the TERS programme, also for general practice trainees in hard-to-fill areas

Northern Ireland

6.32 DoH told us that some specialties did not attract local applicants, and that there were plans to expand the foundation programme in Northern Ireland to facilitate the rotation of trainees through less popular specialties, which could generate more interest in them. They also said that the increasing desire for younger doctors to work and train flexibly and LTFT was causing challenges to the service and exacerbating workforce shortages. They also provided data from the Northern Ireland Medical and Dental Training Agency that showed that over 100 per cent of foundation training places and 91 per cent of specialty training places were filled in 2021.

Retention and progression through training

- 6.33 HEE said that national and local pandemic surges had had a significant cumulative impact on postgraduate trainees' experiential learning and attainment, as a result of trainees having been formally or functionally redeployed to COVID-facing settings or had elective learning opportunities cancelled. They said that this posed a major risk to continued flow in medical workforce supply. They said that work was ongoing to mitigate the length of the training extensions required, to encourage progression by identifying individualised training needs and recovery options, supporting displaced or shielding trainees and aligning service and training recovery. They also said they were working to ensure trainee wellbeing and were continuing to monitor and mitigate against any further disruption. They explained that they had developed new assessment outcomes that reflected that the ability to fulfil progression requirements had been affected by the pandemic through no fault of the trainee, enabling progression where possible and appropriate. However, they warned that these trainees would be at an increased risk of requiring extensions to their training, and so support and investment would continue to be required.
- 6.34 NHSE/I said they were working with DHSC, NHS Employers and HEE to address the issue of financial disadvantage for trainees who had been unable to progress to a higher grade due to the impact of the pandemic on their training.
- 6.35 The Scottish Government said that the vast majority of trainees achieved training competencies and progressed as expected in 2021, despite the challenges of the pandemic, though they added that some specialties had seen a greater impact on progression due to a reduction in training opportunities following the cancellation of elective work. They said while some curriculum requirements could be derogated in this context, the criteria for the awarding of CCTs could not be, and therefore NHS Education for Scotland had developed guidance to give consistency, rigour and transparency to further deployment decisions with an aim of minimising training disruption over the short- and medium-term. They added that trainees nearing the end of their training programmes would be prioritised in terms of being assisted to catch up on lost training time.
- 6.36 The Welsh Government said that they had worked on a four-nations basis to develop the new training outcomes and on how to help trainees catch up, and that craft specialties such as surgery and endoscopy had been impacted the most. They said that it was particularly important to address training deficits as non-progression was also a retention issue.
- 6.37 DoH said that there were lower intakes for some specialties in 2021, which related to the impact of the pandemic in that some specialties did not recruit due to changes in process or uncertainty regarding the progression of current trainees. They also said that DoH and the deanery were working together to understand the impact of the pandemic on training.

Motivation

England

6.38 2021 Staff Survey data showed that 34.5 per cent of doctors and dentists in training expressed satisfaction with their pay, a smaller percentage than for SAS doctors and dentists and consultants. This was a sharp fall compared with 2020, when 47.1 per cent of doctors and dentists and dentists in training said they were satisfied.

Table 6.7: Selected results from the National Staff Survey, doctors and dentists in training, England, 2017 to 2021.

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Engagement and job satisfaction							
I look forward to going to work	2a	63.1	64.2	63.7	62.6	53.4	
I am enthusiastic about my job	2b	75.3	75.8	75.6	74.3	65.6	
Time passes quickly when I am working	2c	79.9	80.0	79.5	77.7	72.9	
The recognition I get for good work	4a	56.3	60.8	61.8	61.5	51.8	
My immediate manager values my work	9e	71.7	72.5	72.6	71.0	63.7	
Considering leaving the NHS ²	22d		14.2	12.5	10.2	14.7	
Recommend my organisation as a place to work	21c	68.2	69.5	69.4	71.1	61.6	
The extent to which my organisation values my work	4b	46.4	50.7	52.9	53.6	40.1	
My level of pay	4c	41.3	43.1	46.0	47.1	34.5	
Percentage of staff appraised in the last 12 months	19a	77.7	78.3	75.9		74.7	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months ²	14a	36.0	38.5	37.2	35.7	36.8	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place

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

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

- 6.39 Job satisfaction indicators for doctors and dentists in training in 2021 were worse than in 2020 (Table 6.7). There were sharp falls in the percentage saying that: they looked forward to going to work (-9.2 percentage points); were enthusiastic about their job (-8.7 percentage points); time passed quickly when they were working (-4.8 percentage points); they were satisfied with the recognition they got for good work (-9.7 percentage points); they were satisfied that their line manager values their work (-7.3 percentage points); they would recommend their organisation as a place to work (-9.5 percentage points); and they were satisfied with the extent to which their organisation values their work (-13.5 percentage points).
- 6.40 There were also increases in the percentage of respondents who said they were considering leaving the NHS (from 10.2 per cent to 14.7 per cent) and that they had experienced harassment, bullying or abuse in the previous 12 months (from 35.7 per cent to 36.8 per cent).
- 6.41 Those in training were also generally less positive about work pressures than in 2020 (Table 6.8). There were sharp falls in the percentage saying that; they were able to meet all the competing demands on their time (-7.7 percentage points); that they had adequate materials (-7.9 percentage points), and that there were enough staff at their organisation (-16.9 percentage points). There was also an increase in the percentage saying that they had felt unwell as a result of work-related stress, to 50.4 per cent in 2021, from 42.3 per cent in 2020. The percentage of staff in training working paid hours over and above their contracted hours continued to increase, reaching 47.2 per cent in 2021, while the percentage working unpaid hours over and above their contracted hours increased for the first time since at least 2017.
- 6.42 New questions were added to the survey covering work-life balance and burnout. 35 per cent of respondents said that they were able to achieve a good balance between work and home life, while 39 per cent said that they were feeling burnt out because of work.

Table 6.8: Selected results from the National Staff Survey, doctors and dentists in training, England, 2017 to 2021.

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Workload							
I am able to meet all the conflicting demands on my time at work	3g	40.2	40.4	41.4	44.2	36.5	
I have adequate materials, supplies and equipment to do my work	3h	58.2	58.8	59.3	61.5	53.6	
There are enough staff at this organisation for me to do my job properly	3i	34.1	36.5	38.0	46.2	29.3	
During the last 12 months have you felt unwell as a result of work related stress? ²	11c	35.5	39.0	41.7	42.3	50.4	
Achieve good balance between work and home life	6c					35.4	
Feeling burnt out because of work ²	12b					39.2	
Percentage of staff working PAID hours over and above their contracted hours? ²	10b	36.2	38.7	42.3	45.2	47.2	
Percentage of staff working UNPAID hours over and above their contracted hours? ²	10c	81.0	79.2	77.0	72.4	76.9	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place

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

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

6.43 In addition to the usual range of questions, doctors and dentists in training were asked, as part of the 2020 and 2021 surveys, about their experiences during the COVID-19 pandemic. In 2021:

- 66 per cent said that they had worked on a COVID-19 ward or area (compared with 55 per cent of all medical and dental staff);
- 30 per cent said that they had been redeployed due to the COVID-19 pandemic (compared with 28 per cent of all medical and dental staff);
- 20 per cent said that they had been required to work remotely/from home due to the COVID-19 pandemic (compared with 41 per cent of all medical and dental staff).

Scotland, Wales and Northern Ireland

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

Locally-employed doctors

6.45 We received evidence from a number of parties about doctors on locally-determined contracts. Some of this evidence noted that some of these doctors were employed on terms and conditions that mirrored those in place for doctors and dentists in training, and that a proportion of those on local contracts were those taking temporary breaks from training. We discuss this group in more detail in Chapter 7.

Our comments

6.46 We note that both the BMA and HCSA asked us to make recommendations for doctors and dentists in training in England who are covered by the multi-year pay agreement that remains in place this year. We will discuss this in Chapter 11, where we set out our recommendations.

6.47 We also note that the BMA chose not to send us evidence relating to doctors and dentists in training in England. As with consultants, this has made it more challenging for us to consider staff perspectives on the issues covered in this chapter and elsewhere, including how such perspectives might inform pay considerations. We would once again urge the relevant committees and groups in the BMA to reconsider this position.

6.48 We welcome the steps that have been made to address the disruption to training caused by the pandemic. This effort will need to continue in the short- and medium-term, as more trainees reach critical points in their training progression, and we expect that the incorporation of training recovery into the efforts to deal with care backlogs will continue. Ensuring that the pipeline of trainees into more senior roles is maintained as far as is possible will be crucial to ensuring that issues of recruitment and retention across all groups in the medical and dental workforces can be addressed.

6.49 Alongside the challenges of the pandemic, it is clear that there are a number of other issues of recruitment and retention amongst doctors and dentists in training. In particular, pandemic-related fatigue and burnout, alongside an increasing desire to work and train flexibly and LTFT, has the potential to significantly challenge workforce availability. We therefore welcome the efforts being made to accommodate doctors and dentists in training that wish to work and train flexibly and LTFT, as doing so will improve retention. In this context, it is critically important that doctors and dentists in training feel engaged and valued, and we note with concern that the results of the 2021 NHS Staff Survey for England for doctors and dentists in training included substantial falls in all job satisfaction measures, including pay satisfaction.

6.50 It is also important that action is taken to address issues of trainee experience, relating to the cost of training and exams and the impact on family life of the way that postings are allocated. Such action would likely represent a cost-effective way to improve retention and motivation and make staff feel valued.

- 6.51 We would also again emphasise the critical need for health systems to understand their workforce demand. Doing so is crucial to addressing long-term workforce shortages. Also essential to this is understanding the impact of changing workforce behaviour, including increasing desire to work and train flexibly and LTFT, increasing numbers taking breaks through training, and evolving specialty and geography preferences.
- 6.52 All of these factors together, alongside consideration of trends in international recruitment, should inform the number of undergraduate and postgraduate medical and dental training places that are made available across the UK, and also inform the need for any efforts to ensure that the calibre of training intakes remains sufficient, and we would welcome hearing from the four governments how they are acting to meet these challenges. This is perhaps the most important aspect of medical and dental workforce planning, and its absence from workforce plans would be a major concern.
- 6.53 In this context, it is also important to understand the effectiveness of the initiatives that are in place to improve recruitment and retention for trainees in particular specialties and geographies. In particular, we would welcome hearing more from the parties about how well flexible pay premia, TERS and the Foundation Priority Programmes are delivering against their objectives, and the extent to which they may inform future developments.
- 6.54 We welcome the progress that is being made towards contract reform in Wales and look forward to hearing of new contracts being implemented. Given what we heard during our visits programme about junior doctors in Wales being incentivised to train and work in England as a result of contractual differences, we would expect that reforms would address this.

CHAPTER 7: SPECIALTY AND SPECIALIST DOCTORS AND DENTISTS (SAS)

Introduction

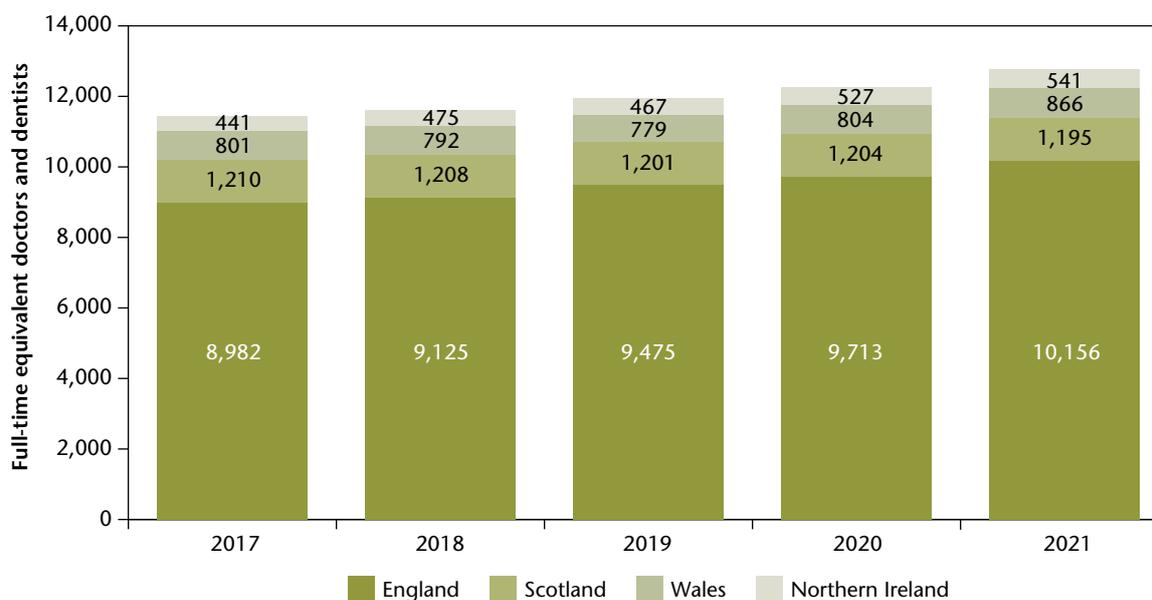
- 7.1 SAS doctors and dentists are a diverse group, consisting of hospital doctors and dentists in non-consultant roles, but who are also not actively undertaking training. They are employed in a number of grades, including: specialty doctors and dentists, associate specialists, specialists, staff grades, senior clinical medical officers, clinical assistants and hospital practitioners. All of these grades are now closed to new entrants except for the Specialty Doctor grade, and the more-senior Specialist grade in England, Wales and Northern Ireland. SAS doctors are experienced and senior doctors who have completed at least four years of postgraduate training, two of which have been in their relevant speciality. SAS doctors and dentists carry out highly specialised roles and often contribute greatly to patient care in addition to being involved with teaching, research and leading service development.
- 7.2 In this chapter, we also discuss hospital doctors and dentists who are employed on locally-determined contracts, often referred to as 'Trust grade' doctors and dentists.

Workforce numbers

- 7.3 In September 2021¹ there were 12,758 full-time equivalent (FTE) SAS doctors and dentists in the UK, around nine per cent of the hospital doctor workforce. In 2021, compared with 2020, the number of SAS doctors and dentists increased by 4.2 per cent, with increases of 7.6 per cent in Wales, 4.6 per cent in England, 2.8 per cent in Northern Ireland, and a fall of 0.8 per cent in Scotland (Figure 7.1).
- 7.4 Data from NHS Digital, for England only, give a breakdown of the remit group by gender and ethnicity. The data show that in December 2021, 46 per cent of specialty doctors, 41 per cent of staff grades, and 40 per cent of associate specialists were female, compared with 39 per cent of consultants. A majority of SAS doctors and dentists, excluding those where ethnic group was not known, identify as being from an ethnic minority group, unlike the rest of the medical and dental workforce. In December 2021, 65 per cent of specialty doctors and staff grades, and 60 per cent of associate specialists identified as being from an ethnic minority group, compared with 42 per cent of consultants. Data from NHS Digital, for England only, showed that SAS doctors and dentists were also more likely to have a non-UK nationality than HCHS doctors and dentists as a whole. In December 2021, of those where nationality data was available, 31 per cent of HCHS doctors and dentists were non-UK nationals, compared with 60 per cent of staff grade doctors and dentists, 52 per cent of specialty doctors and dentists, and 34 per cent of associate specialists.

¹ Northern Ireland data are as at 31 March each year.

Figure 7.1: Number of specialty and specialist doctors and dentists in the Hospital and Community Health Services, United Kingdom, 2017 to 2021



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

Contract reform

England, Wales and Northern Ireland

- 7.5 Two new SAS contracts were introduced in England, Wales and Northern Ireland from the start of the 2021-22 financial year, a reformed Specialty Doctor contract and an entirely new Specialist contract. The new Specialist grade would serve as a more senior grade within the overall SAS workforce. Under the terms of the framework agreement between the three governments, NHS Employers and the BMA, new, shorter pay scales would be introduced over the three years to 2023-24, with 3 per cent investment into the overall pay scales made annually.
- 7.6 The contracts in England, Wales and Northern Ireland will apply to all new staff entering the grade from 1 April 2021. Existing SAS doctors and dentists employed on national terms and conditions of service have had the opportunity to choose to transfer to the new Specialty Doctor contract or remain on their current contract. Similarly, doctors and dentists on national terms and conditions in the closed Associate Specialist grade were able to choose to move onto the new Specialist contract. Under the framework agreement, recommendations would still be sought from us for doctors and dentists who choose to stay on the old contracts.

- 7.7 NHS Employers said that uptake of the new Specialty Doctor contract in England was lower than anticipated, and the main contributing factor to this was that the 3 per cent pay uplift that was applied to the old contracts in 2021 meant that basic pay was higher on the old contracts than the newer ones for most of the pay points, and while the transitional scales were designed so that no doctors would see their pay reduced as a result of transitioning onto the new contract, this was no longer the case. They added that future pay uplifts for SAS doctors should be prioritised onto the new contract and pay system, to encourage movement onto the new contract. They also said that there had been a slow increase in the number of doctors entering the Specialist grade, and they were encouraged by the number of enquiries that they were receiving. However, they noted that there had been some confusion about the new grade, as unlike the old Associate Specialist grade, specialty doctors and dentists cannot regrade into the Specialist grade and must instead go through a competitive recruitment process.
- 7.8 DHSC said that the transitional pay scales had been designed so that most doctors would receive a 1 per cent uplift in 2021, in line with what they had proposed for the rest of the workforce in their evidence to us last year, and that they subsequently implemented our recommendation of 3 per cent meant that most doctors would see an immediate financial detriment by transferring onto the new contract. NHSE/I said that lower-than-expected uptake was also driven by the unions emphasising the short-term pay implications of moving onto the new contract, rather than the broader benefits over the medium- and long-term.
- 7.9 The Welsh Government said that they had introduced pay continuity arrangements to ensure that existing SAS doctors did not lose out by moving onto the new contracts. They said they felt the level of uptake achieved in Wales had been positive.
- 7.10 The Department of Health (Northern Ireland, DoH) said that a consequence of last year's DDRB recommendation was that the pay framework within the new 2021 contract became less attractive in the short-term, and it remains to be seen whether SAS doctors and dentists would choose to move onto the new contract as a result.
- 7.11 The BMA said they were monitoring the number of specialist doctor posts being created, to ensure that they are being used as intended and represented a viable career pathway for SAS doctors in England. They said that in England, as of August 2021, only 473 doctors had chosen to move onto the new Specialty Doctor and Specialist contracts. They also stressed that the lack of pay continuity arrangements in England and Northern Ireland had hampered uptake of the new contracts. They also said that any recommendations for a pay award that were applied to the closed SAS contracts should also be applied to the new contracts.

Scotland

- 7.12 The Scottish Government said they were seeking a Scottish solution to reform of the Specialty Doctor contract, but that work towards reform had paused as a result of the pandemic. They said that negotiations had now resumed, with a view to their concluding in the summer of 2022, and they were looking to develop a senior SAS role with enhanced governance, including potentially a dedicated caseload.

Recruitment and retention

England

- 7.13 DHSC said that they were introducing the SAS Advocate role to support SAS doctors and dentists and improve wellbeing, given existing issues of bullying and harassment. They also said that this would serve as a vehicle for sharing best practice on the treatment and experience of SAS doctors and dentists between different organisations. HEE also said that they had been administering a development fund for SAS doctors and dentists since 2019-20, worth up to £5 million per year.
- 7.14 NHS Employers said that giving SAS doctors and dentists access to an advocate would show an employer's commitment to improving their experience and allow the sharing of good practice across the organisation.

Northern Ireland

- 7.15 DoH said that they had provided funding for the development of SAS doctors and dentists, which had enabled SAS staff to access online leadership, management and other training, as well as wellbeing support. They said that training was well-attended and received excellent feedback.
- 7.16 The BMA said that they were still awaiting progress from DoH on a number of issues, including the appointment of an Associate Dean and the completion of the review of the SAS Charter, which began in 2017.

Motivation

England

- 7.17 2021 Staff Survey data showed that 38.4 per cent of SAS doctors and dentists expressed satisfaction with their pay, a smaller percentage than for consultants, but a larger percentage than for doctors and dentists in training. This was a sharp fall compared with 2020, when 43.3 per cent said they were satisfied.

- 7.18 Job satisfaction indicators for SAS doctors and dentists in 2021, were worse than in 2020 (Table 7.1). There were falls in the percentage saying that: they looked forward to going to work (-4.9 percentage points); were enthusiastic about their job (-4.7 percentage points); time passed quickly when they were working (-2.3 percentage points); they were satisfied with the recognition they got for good work (-5.7 percentage points); they were satisfied that their line manager values their work (-2.9 percentage points); they would recommend their organisation as a place to work (-6.4 percentage points); they were satisfied with the extent to which their organisation values their work (-5.3 percentage points).
- 7.19 There were also increases in the percentage of respondents who said they were considering leaving the NHS (from 14.7 per cent to 17.6 per cent) and that they had experienced harassment, bullying or abuse in the previous 12 months (from 32.4 per cent to 32.9 per cent).

Table 7.1: Selected results from the National Staff Survey, SAS doctors and dentists, England, 2017 to 2021.

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Engagement and job satisfaction							
I look forward to going to work	2a	65.4	68.4	68.8	65.7	60.8	
I am enthusiastic about my job	2b	76.7	78.8	78.6	75.5	70.8	
Time passes quickly when I am working	2c	79.0	80.6	79.2	76.0	73.7	
The recognition I get for good work	4a	52.7	57.7	59.4	58.9	53.2	
My immediate manager values my work	9e	67.7	69.4	69.6	69.5	66.6	
Considering leaving the NHS ²	22d		18.1	16.1	14.7	17.6	
Recommend my organisation as a place to work	21c	62.2	65.4	66.8	69.7	63.3	
The extent to which my organisation values my work	4b	44.7	48.4	50.4	50.3	45.0	
My level of pay	4c	37.3	37.7	41.2	43.3	38.4	
Percentage of staff appraised in the last 12 months	19a	89.1	88.8	87.1		80.5	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months ²	14a	32.1	33.9	33.7	32.4	32.9	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

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

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

- 7.20 SAS doctors and dentists were also generally less positive about work pressures than in 2020 (Table 7.2). There were falls in the percentage saying that: they were able to meet all the competing demands on their time (-3.7 percentage points); they had adequate materials (-4.1 percentage points), and that there were enough staff at their organisation (-14.9 percentage points). There was also a sharp increase in the percentage saying that they had felt unwell as a result of work-related stress, to 45.7 per cent in 2021, from 32.8 per cent in 2020. The percentage of staff in training working paid hours over and above their contracted hours increased to 41.8 per cent in 2021, while the percentage working unpaid hours over and above their contracted hours increased for the first time since 2018.
- 7.21 New questions were added to the survey, covering work-life balance and burnout. 50 per cent of respondents said that they were able to achieve a good balance between work and home life, while 30 per cent said that were feeling burnt out because of work.

Table 7.2: Selected results from the National Staff Survey, SAS doctors and dentists, England, 2017 to 2021.

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Workload							
I am able to meet all the conflicting demands on my time at work	3g	44.9	46.4	46.6	48.8	45.1	
I have adequate materials, supplies and equipment to do my work	3h	60.5	61.6	61.7	66.0	61.9	
There are enough staff at this organisation for me to do my job properly	3i	35.8	36.3	37.4	47.4	32.5	
During the last 12 months have you felt unwell as a result of work related stress? ²	11c	36.0	32.5	33.8	32.8	45.7	
Achieve good balance between work and home life	6c					49.5	
Feeling burnt out because of work ²	12b					29.9	
Percentage of staff working PAID hours over and above their contracted hours? ²	10b	35.1	38.2	40.6	37.4	41.8	
Percentage of staff working UNPAID hours over and above their contracted hours? ²	10c	63.3	66.0	63.9	60.0	62.5	

Source: National NHS Staff Survey.

Notes: Data rounded to 1 decimal place.

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

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

7.22 In addition to the usual range of questions, SAS doctors and dentists were asked, as part of the 2020 and 2021 surveys, about their experiences during the COVID-19 pandemic. In 2021:

- 46 per cent said that they had worked on a COVID-19 ward or area (compared with 55 per cent of all medical and dental staff);
- 24 per cent said that they had been redeployed due to the COVID-19 pandemic (compared with 28 per cent of all medical and dental staff);
- 29 per cent said that they had been required to work remotely/from home due to the COVID-19 pandemic (compared with 41 per cent of all medical and dental staff).

Scotland, Wales and Northern Ireland

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

Locally-employed doctors and dentists (LEDs)

- 7.24 In our report last year, we asked parties to provide us with evidence relating to doctors and dentists employed on locally-determined contracts, after hearing anecdotally of more and more doctors and dentists being employed on them. We are aware that a wide variety of doctors and dentists are employed on local terms, for a variety of different reasons, including those who are taking breaks from training, doctors and dentists from abroad who have yet to be offered employment under one of the national contracts, GMPs working in hospitals and those working under a locally-reintroduced version of the old associate specialist contract.
- 7.25 DHSC said that it was for local employers to determine the detail of contractual arrangements for LEDs, and that they would expect that all doctors should be treated fairly by their employers, regardless of how they were employed. They said that there was a range of different employment models in use, with most employers mirroring the terms and conditions of the 2016 contract for doctors and dentists in training.
- 7.26 NHS Employers said that many doctors who took time out of training, particularly following completion of the Foundation Programme, took on roles on local contracts that mirror arrangements for doctors and dentists in training. Job titles for these doctors included clinical education fellow, clinical specialty fellow, locally employed doctor, junior specialty doctor or trust doctor, and roles can include incentives such as enhanced study leave and research opportunities. They said that employers frequently had to compete for such LEDs, leading to the terms and conditions they were employed on often being more favourable than the national contract for doctors and dentists in training.
- 7.27 The BMA said that they were undertaking work to identify and better support LEDs in England. They said that an audit had so far identified 7,500 doctors who worked on local terms and conditions, and they expected the final total to be significantly higher. They said that many LEDs were international medical graduates who had not been offered employment on any of the national contracts, and that some were placed on working patterns similar to doctors in training, while others were effectively fulfilling the same roles as SAS doctors, but on less generous pay and contractual arrangements.
- 7.28 They said that they were concerned about the use of these contracts, and that those on them were at risk of being placed on less favourable terms and conditions and being pressured into undertaking more onerous working patterns. They also said that they would not automatically receive pay awards that were applied to national contracts without specific local agreement to do so.

Our comments

- 7.29 As with the other groups subject to multi-year deals, we note that the BMA and HCSA asked us to make recommendations for SAS doctors and dentists in England, Wales and Northern Ireland who are subject to the current multi-year deal. We discuss this in Chapter 11.
- 7.30 We also note that multiple parties said that the size of our recommendations relative to the pay uplifts included in the SAS deal in England, Wales and Northern Ireland last year had impacted the attractiveness of moving onto the new contracts, and therefore the ability of the new contracts to improve the recognition and value of the SAS grades. Others, particularly on our visits programme, also cited other factors that were making the new SAS contract less attractive, including the new definition of unsocial hours.
- 7.31 Our view is that if governments temporarily ask us not to make recommendations for certain groups in order to introduce reforms to pay structures, they should be expected to ensure that pay and contract structures remain coherent and incentivise the choices that they wish members of our remit group to make. In this context, we welcome the pay continuity arrangements that were put in place by the Welsh Government and note that the Welsh Government have said that they have therefore seen uptake of the contracts in line with what they were expecting. We were disappointed that no action was taken in England and Northern Ireland; a continued lack of action to address this issue may jeopardise the ability for SAS contract reform to achieve its aims.
- 7.32 We also welcome the progress that is being made towards contract reform for SAS doctors and dentists in Scotland and hope to hear that negotiations have concluded soon.
- 7.33 Beyond contract reform, it remains critically important that efforts to improve the workplace experience of SAS doctors and dentists continue. Given the increased rates of bullying and harassment and sickness absence experienced by this group relative to other parts of the medical and dental workforces, doing so would likely be of significant benefit to recruitment, retention and motivation. We look forward to hearing more about the progress being made towards introducing the SAS Advocate role and SAS development funds in future years.
- 7.34 Given the demographic makeup of the SAS grades, a higher proportion of whom are female and from ethnic minority backgrounds compared to the consultant workforce, it is particularly important that issues relating to the gender and ethnicity pay gaps are addressed in relation to this group, and we would welcome hearing more about this in future years.

- 7.35 In the long-term, a valued and supported SAS workforce can play an important role in the evolving medical and dental workforces. High-quality SAS roles can help to accommodate those that wish to work more flexibly or move into and out of training and enable them to do so while contributing greatly to service provision and patient care. It is therefore important that alongside efforts to reform contracts, wider work is also undertaken to ensure both that the SAS grades are an attractive career destination for those that are suited to them, including through effective use of the new Specialist role and contract, while at the same time supporting the CESR route to consultant and routes back into formal training. We heard on our visits programme that progress had been made on modernising the CESR route and making it more user-friendly, and we welcome this. We would expect to hear more about this from all of the parties in future years.
- 7.36 We are thankful to all of the parties, and particularly the BMA, who gave us the most detail, for providing evidence to us this year about doctors and dentists practising in the NHS on locally-determined contracts. It is clear that these contracts are very widespread, with the number of doctors in England employed on them at least comparable with the number employed on SAS contracts. We would welcome the views of the parties in future years as to why this is the case, and whether efforts should be made to reduce the number employed on these contracts. We would also welcome hearing more from the parties about the use of these contracts in Scotland, Wales and Northern Ireland, where applicable, in future years.
- 7.37 The parties differed in their description of the composition of this group, with some saying they were principally composed of those taking breaks from training, while others said that those from abroad were a significant component – a view that was also reflected during our visits programme. It is important that who these doctors are, how they are distributed amongst the sub-groups described above and others, what roles they play and what needs they fulfil, why they are employed on local contracts, and how they are being treated is properly understood so that any potential equalities concerns can come to the fore, and we and others can understand the dynamics of recruitment, retention and motivation for this group. In particular, we would welcome staff data being collected separately and consistently for LEDs, including in enough detail to better understand the composition of this group. This could in turn enhance other data sources that we receive, including staff survey data.

7.38 We would also welcome information from the parties in evidence next year about the remuneration of LEDs, given some said that they were generally on more favourable terms and conditions than those on the national contracts, and some said that they were generally on less favourable terms. This can also inform what can be done to ensure that this group is treated fairly, including by providing them with routes onto national contracts as appropriate, and could enable any pay equalities issues associated with the use of these contracts to come to the fore. We also discuss the applicability of our recommendations to this group in Chapter 11.

CHAPTER 8: CONSULTANTS

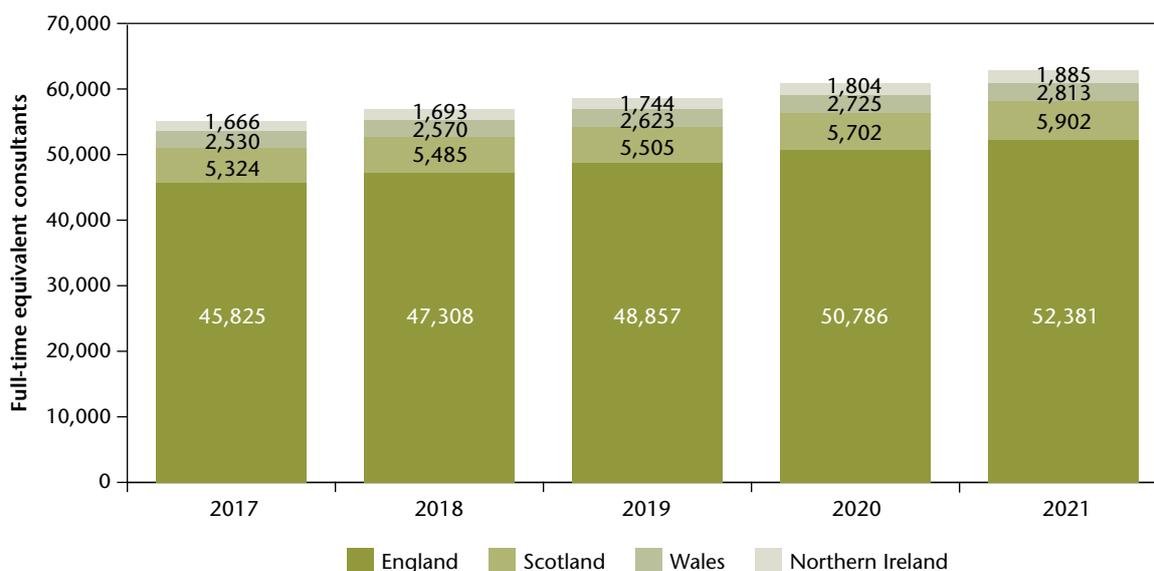
Introduction

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

Workforce numbers

8.2 In September 2021¹, on a full-time equivalent (FTE) basis, there were 62,981 consultants in the United Kingdom, an increase of 3.2 per cent from a year earlier (Figure 8.1). All countries in the UK experienced an increase: 4.5 per cent in Northern Ireland, 3.5 per cent in Scotland, 3.2 per cent in Wales and 3.1 per cent in England.

Figure 8.1: Number of consultants in the Hospital and Community Health Services (HCHS), United Kingdom, 2017 to 2021

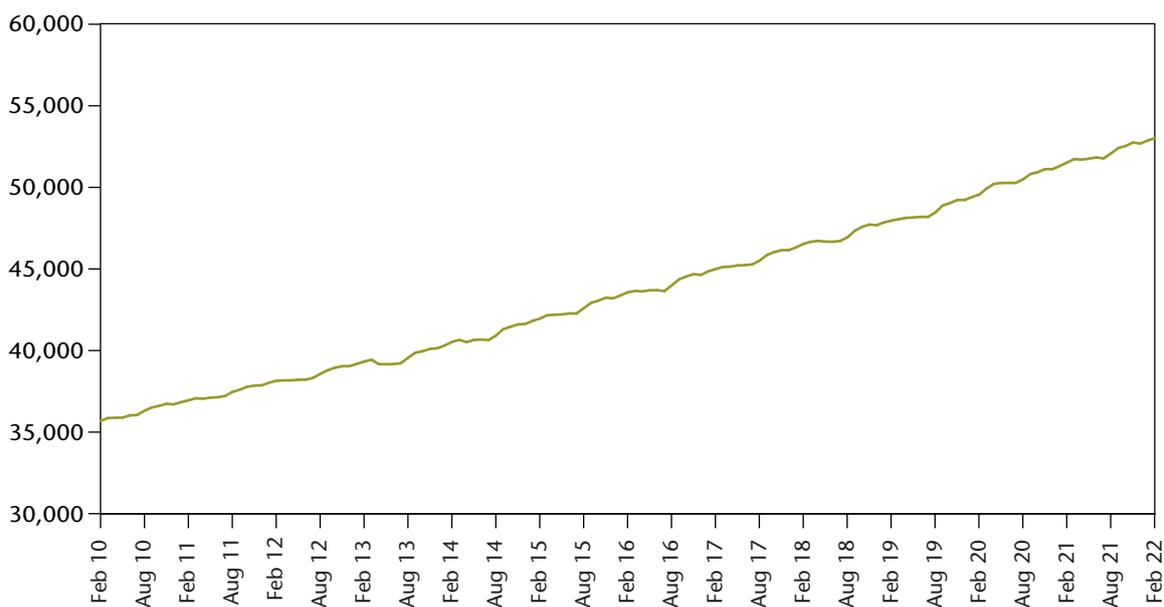


Source: NHS Digital, NHS Education for Scotland, StatsWales, Department of Health Northern Ireland.

8.3 Between February 2010 and February 2022, the number of FTE consultants in England increased from 35,700 to 53,000, an increase of 49 per cent (Figure 8.2).

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

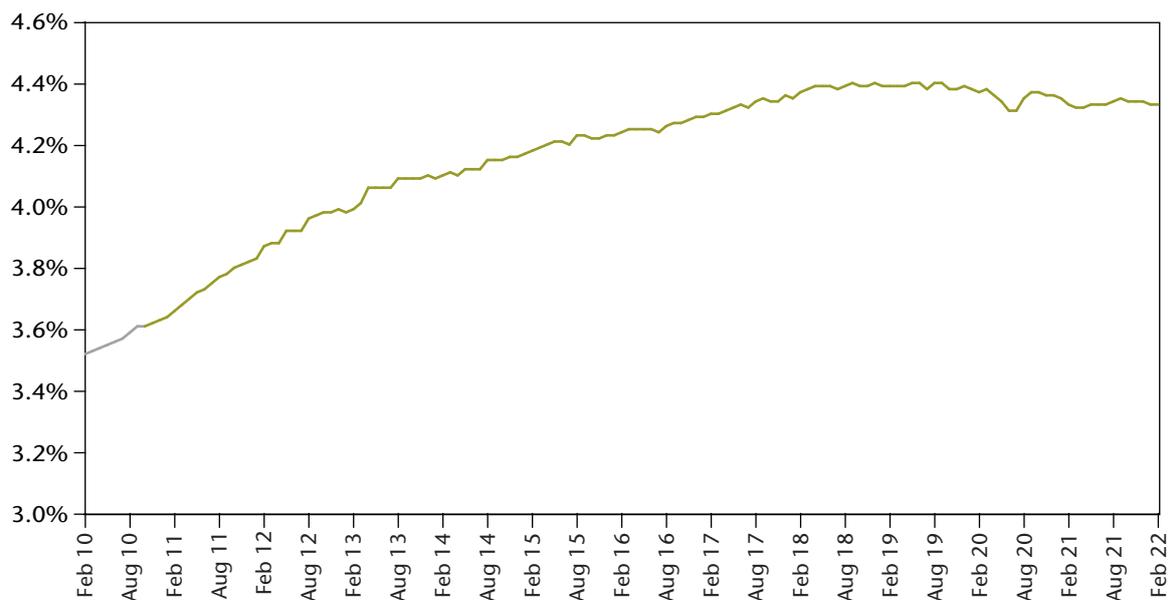
Figure 8.2: Consultants in the Hospital and Community Health Services (HCHS), England, 2010 to 2022



Source: NHS Digital

8.4 For much of the time since 2010, the number of consultants in England has grown more quickly than the HCHS workforce as a whole. In February 2010 consultants accounted for 3.5 percent of the total FTE HCHS workforce², increasing to 4.4 per cent by 2018, before falling back to 4.3 per cent from the middle of 2020, as the wider NHS workforce grew more quickly than the consultant workforce, in response to COVID-19 (Figure 8.3).

Figure 8.3: Consultants in the Hospital and Community Health Services (HCHS), England, percentage of FTE HCHS workforce, 2010 to 2022



Source: NHS Digital

² This includes non-medical and dental staff in the HCHS, such as nurses and healthcare assistants.

Recruitment and retention

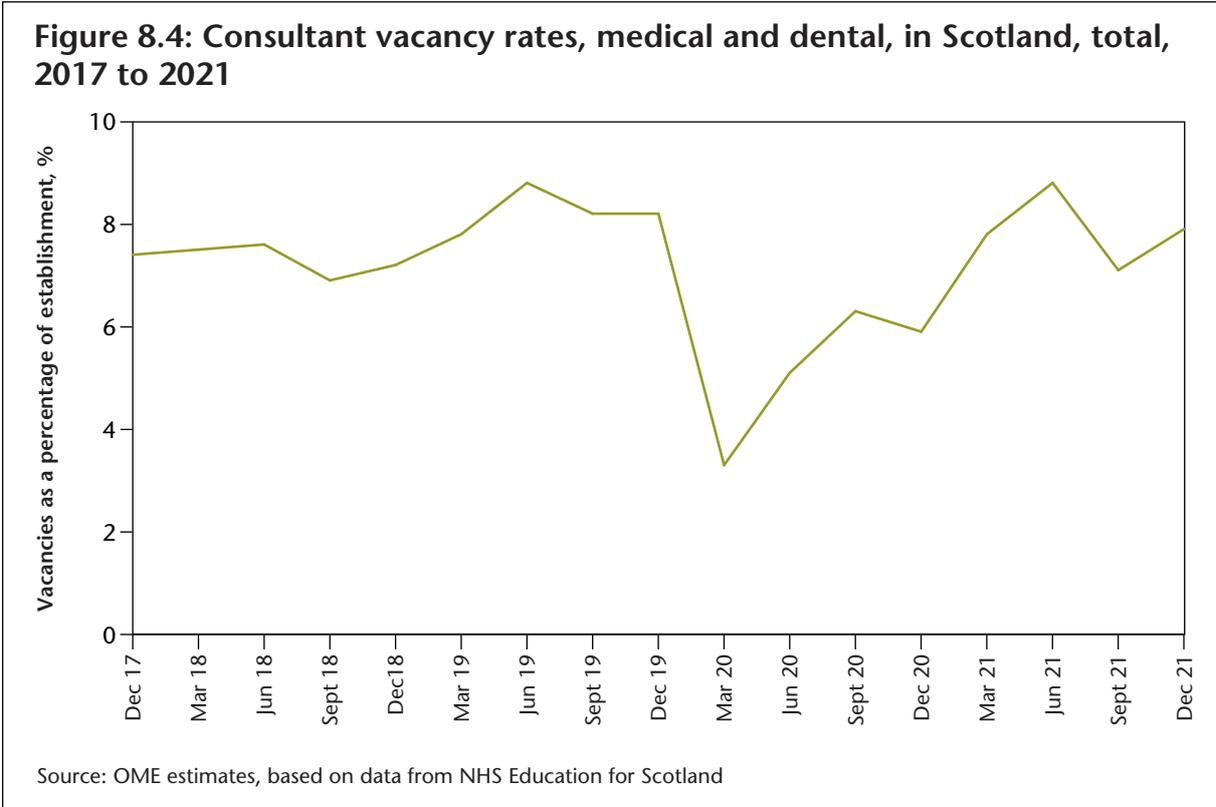
England

- 8.5 DHSC said that it was possible that the trend of increasing consultant numbers may slow over the coming years, and that given that approximately 25 per cent of consultants were aged 55 or over, it was important to target action at retaining highly experienced individuals. They added that due to the relatively long supply pipeline for qualified medical consultants and the smaller proportions being recruited internationally than for other medical workforces, there were unlikely to be significantly more consultants in the short term to deliver the additional output which will be required to address care backlogs.
- 8.6 NHSE/I said that consultants are a vital component of the medical workforce, and that their skill set was not replaceable by workforce redesign, meaning that the consultant workforce would remain an essential component of delivering high-quality care across NHS services. They added that they were essential to providing clinical leadership, training the future generation of doctors and contributing to essential research, and that they would be important as the NHS strives to recover from the pandemic.
- 8.7 They said that consultant vacancies had begun to rise in the six months prior to their time of writing (from August 2021 to February 2022), and that this could be a combined result of the pandemic curtailing progression of senior trainees and reducing international recruitment, though they noted that vacancies only reflect part of the real demand as positions are only advertised once they have funding. They said that the last joint NHSE/I/HEE workforce survey in 2019 found that there was a 10 per cent overall vacancy rate and specialties with the highest vacancy levels were emergency medicine, psychiatry, the 'acute take' specialties, histopathology, radiology and intensive care medicine.
- 8.8 They also said that the combination of increased elective activity and ongoing pressures on emergency and urgent care related to the pandemic had impacted an already-stretched consultant workforce, and that retaining the consultant workforce remained a challenge. They also said that, given the leadership and training roles filled by experienced consultants, the NHS would significantly benefit from encouraging consultants close to retirement to stay on.
- 8.9 NHS Employers said that retaining senior and experienced doctors to deliver against increasing demand for services and catch up with developing care backlogs was critical. They said that increasing flexibility for consultants would be a key factor that could influence their decisions to continue working, though they noted that smaller organisations in particular had challenges in implementing flexible job planning in specialties which required significant on-call commitments. They added that addressing staff wellbeing needs and offering flexible solutions should remain a priority to help retain senior doctors in the NHS.

- 8.10 NHSE/I, NHS Employers and NHS Providers also expressed concern that pensions and pensions taxation were impacting recruitment and retention amongst the consultant workforce in England. We discuss this in more detail in Chapter 5.
- 8.11 The BMA said workforce shortages meant that each FTE doctor in the NHS was doing approximately 1.3 FTE roles, on average, and that this overwork was leading to burnout, and had impacted on morale. They said that action must be taken to ensure that the NHS remains an attractive place to work, and to provide an incentive for doctors who are actively considering changing their career plans to instead remain working in the NHS.
- 8.12 HCSA warned that there was an ever-worsening vacancy crisis, including many hidden vacancies that had been absorbed into the existing staff complement.

Scotland

- 8.13 The Scottish Government said that for certain consultant posts, including in radiology, geriatrics and psychiatry, and in certain parts of Scotland, Boards can find it more challenging to fill vacancies. They said that some specialties, such as radiology, experience international shortages.
- 8.14 Data from NHS Education for Scotland showed that at the end of December 2021 there were 494 FTE vacant posts for medical consultants, a vacancy rate of 7.9 per cent, an increase from 5.9 per cent a year earlier (Figure 8.4).



- 8.15 The BMA said that it must be an absolute priority for the Scottish Government to do everything in its power to retain existing doctors. They said that the way that the Scottish Government collected and recorded its vacancy figures failed to capture the true extent of consultant vacancies across Scotland, saying that their own statistics, obtained using Freedom of Information requests, had that the true consultant vacancy rate in September 2020 was 15.2 per cent, compared to official figures of 6.3 per cent. They added that signs pointed to an ever-growing number of doctors who were considering leaving the profession or reducing their hours of work.

Wales

- 8.16 The Welsh Government said that there were national and international labour shortages that were impacting on recruitment into the NHS in Wales. It also said that the NHS in Wales had 342 advertised vacancies for medical and dental staff in August 2021, up from 238 in August 2020, an increase of 44 per cent. This compares with an increase of 59 per cent in the number of advertised vacancies across all NHS staff groups over the same period.
- 8.17 The BMA said that when they surveyed consultant members in Wales on workforce issues, vacancies were one of the major concerns, and that 77 per cent believed that medical vacancies in their department had a detrimental impact on patient care to some extent, and 67 per cent that they had a detrimental impact on their own wellbeing. They also called for vacancy data to be made more transparent and accessible.

Northern Ireland

- 8.18 The Department of Health (DoH) said that Trusts were experiencing shortages across all specialty groupings. They also said that due to small teams and recruitment difficulties, there was limited flexibility to allow senior doctors to reduce on-call duties, which was contributing to staff burnout.
- 8.19 The BMA said that they were concerned by the high level of vacancies within the consultant workforce in Northern Ireland, and that the methods used by DoH and Trusts to measure vacancies results in a significant undercounting. They said that Freedom of Information requests found that 14.9 per cent of posts across HSC Trusts in Northern Ireland were not filled by a permanent consultant. DoH said that this somewhat overstated the vacancy picture, since this method of counting included some posts that should not be considered as vacancies, such as when a consultant on maternity leave is temporarily covered by a locum.

Motivation

England

- 8.20 2021 Staff Survey data showed that 59.6 per cent of consultants expressed satisfaction with their pay, a larger percentage than for SAS doctors and dentists and doctors and dentists in training. This was a sharp fall compared with 2020, when 65.3 per cent said they were satisfied.

- 8.21 The results for job satisfaction for consultants were worse than in 2020 (Table 8.3). There were sharp falls in the percentage saying that: they looked forward to going to work (-7.7 percentage points); were enthusiastic about their job (-7.0 percentage points); that time passed quickly when they were working (-3.2 percentage points); were satisfied with the recognition they got for good work (-6.7 percentage points); they were satisfied that their line manager values their work (-2.9 percentage points); they would recommend their organisation as a place to work (-7.5 percentage points); they were satisfied with the extent to which their organisation values their work (-6.7 percentage points).
- 8.22 There were also increases in the percentage of respondents who said they were considering leaving the NHS (from 19.2 per cent to 23.3 per cent) and that they had experienced harassment, bullying or abuse in the previous 12 months (from 31.6 per cent to 34.1 per cent).

Table 8.1: Selected results from the National Staff Survey, consultants, England, 2017 to 2021.

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Engagement and job satisfaction							
I look forward to going to work	2a	67.8	67.5	68.2	67.2	59.4	
I am enthusiastic about my job	2b	78.1	77.8	77.8	75.6	68.6	
Time passes quickly when I am working	2c	84.8	84.5	84.3	83.1	79.9	
The recognition I get for good work	4a	52.0	56.8	59.7	58.0	51.3	
My immediate manager values my work	9e	69.5	68.9	70.9	70.7	67.8	
Considering leaving the NHS ²	22d		21.8	21.5	19.2	23.3	
Recommend my organisation as a place to work	21c	64.9	65.0	66.6	69.2	61.8	
The extent to which my organisation values my work	4b	46.0	47.5	49.4	50.2	43.4	
My level of pay	4c	58.6	57.1	62.9	65.3	59.6	
Percentage of staff appraised in the last 12 months	19a	95.9	96.2	96.1		88.2	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months ²	14a	33.2	36.0	35.8	31.6	34.1	

Source: National NHS Staff Survey

Notes: Data rounded to 1 decimal place

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

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

- 8.23 Consultants were also generally less positive about work pressures than in 2020 (Table 8.4). There were sharp falls in the percentage saying that; they were able to meet all the competing demands on their time (-5.6 percentage points); that they had adequate materials (-6.4 percentage points), and that there were enough staff at their organisation (-13.0 percentage points). There was also an increase in the percentage saying that they had felt unwell as a result of work-related stress, to 42.5 per cent in 2021, from 38.0 per cent in 2020. The percentage of consultants working paid hours over and above their contracted hours increased to 46.5 per cent in 2021, while the percentage working unpaid hours over and above their contracted hours increased for the first time since 2018, to 83.5 per cent.
- 8.24 New questions were added to the survey, covering work-life balance and burnout. 42 per cent of respondents said that they were able to achieve a good balance between work and home life, while 31 per cent said that were feeling burnt out because of work.

Table 8.2: Selected results from the National Staff Survey, consultants, England, 2017 to 2021.

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Workload							
I am able to meet all the conflicting demands on my time at work	3g	33.4	32.5	34.7	37.5	31.9	
I have adequate materials, supplies and equipment to do my work	3h	44.3	44.3	45.1	51.3	44.8	
There are enough staff at this organisation for me to do my job properly	3i	24.9	24.8	24.9	33.1	20.1	
During the last 12 months have you felt unwell as a result of work related stress? ²	11c	33.2	36.2	36.2	38.0	42.5	
Achieve good balance between work and home life	6c					41.6	
Feeling burnt out because of work ²	12b					31.4	
Percentage of staff working PAID hours over and above their contracted hours? ²	10b	45.0	45.8	45.4	42.0	46.5	
Percentage of staff working UNPAID hours over and above their contracted hours? ²	10c	85.4	85.7	84.1	81.2	83.5	

Source: National NHS Staff Survey

Notes: Data rounded to 1 decimal place

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

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

8.25 In addition to the usual range of questions, staff were asked, as part of the 2020 and 2021 surveys, about their experiences during the COVID-19 pandemic. In 2021:

- 54 per cent of consultants said that they had worked on a COVID-19 ward or area (compared with 55 per cent of all medical and dental staff);
- 28 per cent of consultants said that they had been redeployed due to the COVID-19 pandemic (compared with 28 per cent of all medical and dental staff);
- 54 per cent of consultants said that they had been required to work remotely/from home due to the COVID-19 pandemic (compared with 41 per cent of all medical and dental staff).

Contract reform

England

- 8.26 DHSC said that they felt that contractual arrangements for consultants should be reformed, with the contract having particular weaknesses that should be addressed, including arrangements for out-of-hours and on-call working, payments for activity out of standard job plans and the structure of the pay scale. They added that the Gender Pay Gap in Medicine Review had shone a light on the impact of these deficiencies. They said they had ambitions to press forward with reforms as soon as circumstances allowed, but the many competing calls on the NHS budget would impact on the availability of funding for reform.
- 8.27 NHS Employers said that while there currently is no mandate from government for reform of the consultant contract, an opportunity to modernise the contract and reform the pay structure would be welcomed by employers. They said that their priorities for reforms would include shortening the pay scale and modernising terms and conditions to provide greater alignment with other staff groups.

Wales

- 8.28 The Welsh Government said that they wished to reassess contractual arrangements in light of changing workforce behaviour and demographics, and so that the contract can reflect service needs.

Northern Ireland

- 8.29 DoH said that no real progress had been made towards consultant contract reform in Northern Ireland.

Clinical Excellence Awards (CEAs), Commitment Awards, Distinction Awards and Discretionary Points

National CEAs (England and Wales)

- 8.30 In March 2022, DHSC, the Advisory Committee on Clinical Excellence Awards (ACCEA) and the Welsh Government published their response to the consultation paper *Reforming the national Clinical Excellence Awards Scheme*³. It outlined final proposals for changes to the national Clinical Excellence Awards (CEA) scheme. Proposed changes included rebranding the awards as National Clinical Impact Awards (NCIAs), increasing the number of awards made while lessening their value, making them non-consolidated and non-pensionable, removing the pro rata element for those working less-than-full-time (LTFT) and removing progression between the award levels. It is also envisaged that it will eventually become possible to hold local and national awards simultaneously in England. Action will also be taken to improve access to awards for female and ethnic minority consultants, as well as those that work LTFT.

³ <https://www.gov.uk/government/consultations/reforming-the-national-clinical-excellence-awards-scheme/outcome/reforming-the-national-clinical-excellence-awards-scheme-response-from-dhsc-and-welsh-government>

- 8.31 DHSC said that the objectives of the reforms were to broaden access to awards, make the application process fairer and more inclusive, and ensure the scheme rewards and incentivises impact across a broader range of work and behaviours.

Local CEAs (England)

- 8.32 In February 2022 it was announced that, despite the best efforts of the parties, it was not possible to reach agreement on the design of a new scheme to replace current local CEA arrangements⁴. Under the arrangement that was agreed in 2018 and that led to the introduction of the interim arrangements that had been in place from then, the changes that were introduced then will remain in place indefinitely. The 2018 changes made local CEAs time-limited, non-consolidated and non-pensionable, but maintained employers' average investment per FTE. Existing consolidated awards would also continue to be paid.
- 8.33 DHSC said that follow-on arrangements for local CEAs allow employers a significant degree of flexibility to run their schemes to suit their own priorities, and that in the absence of a national framework, they would continue to work with NHS Employers to support and encourage best practice. NHSE/I said that progress towards making the existing scheme more effective and equitable could be achieved by ensuring that assessment processes are fair and transparent, panels are diverse, and the composition of recipients of awards is monitored by gender, ethnicity and specialty.
- 8.34 NHS Employers said it was disappointing that a satisfactory outcome for reforms to local CEAs could not be reached with the trade unions. They said that going forward, employers would have to agree any changes or developments in their local CEA schemes themselves. They said that this further underlined the need for a modernised consultant contract more generally.

Distinction Awards and Discretionary Points (Scotland)

- 8.35 The Scottish Government said that there was no evidence to suggest that an adverse impact had resulted from the freezing in value of Distinction Awards (DAs) and Discretionary Points (DPs) since 2010, and that while DAs are closed to new entrants, the number of DPs awarded continue to grow in line with growth in the size of the consultant workforce. They said they were not seeking recommendations from us for DAs and DPs.
- 8.36 The BMA said that the closure of the DA scheme to new entrants had led to significant savings for the Scottish Government that had not been reinvested elsewhere into the overall pay offer for consultants in Scotland. They also said that the closure of the DA scheme meant that historical gender pay gaps remained entrenched, as older, male-dominated cohorts continued to receive their awards while younger, more female cohorts were not eligible to receive them.

⁴ <https://www.nhsemployers.org/articles/new-reward-system-nhs-consultants>

Commitment Awards (Wales)

- 8.37 The Welsh Government said that the Commitment Awards (CA) scheme mainly rewarded older consultants, and that this could potentially be contributing towards the gender pay gap for consultants. They also said that differing reward systems hindered the flow of senior medical staff between Wales and England.
- 8.38 The BMA said that the CA scheme only contributes to the GPG because a greater proportion of women than men who go on to become consultants have undertaken some of their training on a LTFT basis and start on the consultant pay scale at a later stage in life. They said that this could be addressed by allowing those who become consultants in such circumstances to start at a higher point on the consultant pay scale, and if this was done, CAs would no longer contribute to the gender pay gap. They said that CAs should be uplifted in line with basic pay.

CEAs (Northern Ireland)

- 8.39 The Clinical Excellence Awards scheme in Northern Ireland continues to be closed to new entrants, with awards frozen in value. DoH said that they were planning to review their CEA scheme with a view to properly incentivising doctors who perform at the highest level, and that they would look at the changes being made in other jurisdictions to help inform any proposals.
- 8.40 The BMA said that as a result of the closure of the CEA schemes in Northern Ireland to new entrants, many consultants were not being recognised or rewarded for demonstrating excellence. They also said that the closure of the scheme to new applicants had made it harder to recruit consultants from outside Northern Ireland.

Our comments

- 8.41 We welcome the developments that continue to be made across the UK towards the increasing use of multidisciplinary teams. In the long-term, this has the potential to be a change that can help to address concerns about consultant workloads and improve productivity. However, we note that NHSE/I say that consultants' skill sets are not replaceable by workforce redesign, and we would expect that demand for fully trained specialists who can act as the principal clinical decision-maker and lead the overall clinical team will continue to grow for years to come.
- 8.42 It therefore remains crucial for governments and health service leaders to establish their long-term consultant workforce needs and take appropriate action to ensure that they are met. This planning must also factor in changing working patterns and career aspirations amongst the medical and dental workforces; if hospital doctors and dentists increasingly wish to work LTFT, and/or take longer to complete training and become consultants, then there is a clear long-term need for larger university intakes and an increase in the number of training places than would otherwise be the case.

- 8.43 In the shorter term, we remain concerned about the high demands that continue to be placed on the existing consultant workforce, in the context of the pandemic and care backlogs. As DHSC said in their written evidence, health services remain reliant on their current consultant workforce to supply additional activity or refocus their activity on elective recovery. In this light it is crucial that the current vacancy picture is properly understood, and so we would encourage NHSE/I and HEE to resume their vacancy data collection. Action must also be taken to ensure that any pandemic-related impacts on retention are minimised. This in particular includes employers taking appropriate action to accommodate those that wish to work flexibly, given the risks to retention of not doing so. In this context we also continue to be concerned about the risks to retention posed by pensions taxation and other pensions changes, which we discuss in more detail in Chapter 5.
- 8.44 We welcome the proposals that were published for reforms to National Clinical Excellence Awards (CEAs) in England and Wales. Various parties said that these proposals would address some of the concerns that we and others, including the Gender Pay Gap in Medicine Review, expressed about the equity and effectiveness of the scheme. At the same time, particularly given that the new National Clinical Impact Award (NCIA) scheme will continue to be an application-based system, it remains crucial that trends in the gender and ethnic composition of recipients of NCIA are monitored and action continues to be taken to ensure both that more female and ethnic minority consultants and clinical academics apply for the schemes, and that those that do apply have their applications treated equitably.
- 8.45 At the same time, it was disappointing that the negotiations over local CEAs in England did not result in reforms. In the absence of changes, concerns over their equity and effectiveness cannot be fully addressed. That said, given the autonomy given to Trusts under the existing arrangements, we would expect that some progress ought to be made in the absence of substantive reforms, and we would continue to welcome updates on this from NHS Employers, who can spread best practice between Trusts, and others in evidence from the parties in future years.
- 8.46 We welcome that DoH has said that they are looking to re-examine the Clinical Excellence Awards scheme in Northern Ireland, and we look forward to hearing more about any reform proposals in future years. We would also encourage the Scottish Government to consider reforms to DAs and DPs on a similar basis.
- 8.47 We note the request from the Welsh Government, in their remit letter, for our observations on the 2003 Welsh Consultant Contract and pay in relation to how the contract has impacted on equality and diversity of their workforce. Given the similarities in contract structures, terms and conditions and working patterns between health services in England and Wales, most of the observations and recommendations of the Gender Pay Gap in Medicine Review are likely also to apply in Wales, and we would encourage the Welsh Government to examine its findings in relation to hospital doctors closely and consider implementing its recommendations as appropriate.

- 8.48 At the same time, we would note that a crucial distinction in pay, terms and conditions between consultants in Wales and those in England is in Commitment Awards being used in place of local CEAs. Commitment Awards effectively serve as an extension to the consultant pay spine, which is otherwise shorter than in the rest of the UK. Commitment Awards in their current form are available to all consultants who have reached the top of the pay spine, and therefore equalities issues relating to application rates or biases in the assessment of applications are not apparent. However, we also note that the Gender Pay Gap in Medicine Review said that, in the case of hospital doctors, ‘reducing the number of scale points would compress the population in each grade making it easier for women to “catch up” and narrow the gender pay gap. The Equality and Human Rights Commission does not recommend a specific number of scale points within a grade because each industry has its own requirements; however, about six is generally accepted to represent good equality practice.’⁵ The Commitment Awards scheme means that consultants in Wales effectively have a 15-point, 36-year pay spine, and so we would welcome the parties exploring reforms that would address pay equalities issues that may result from this. Given that the proportion of consultants from an ethnic minority background in Wales has also grown in recent years, it is also likely that, as with female consultants, they are more concentrated towards the bottom of the pay spine and so addressing this issue could help to address any ethnicity pay gap in the Welsh consultant workforce in a similar way.
- 8.49 Finally, we note that the BMA did not provide us with evidence specific to consultants in England. This has made it more challenging for us to understand the workforce’s perspective on the issues that we discuss in this chapter, and for us to weigh up these perspectives with the other factors that we must consider when making our recommendations. Given this, we urge the BMA Consultants Committee to re-engage with our process.

⁵ Gender Pay Gap in Medicine Review, 9.3

CHAPTER 9: GENERAL MEDICAL PRACTITIONERS

Introduction

9.1 In this chapter we consider issues relating to General Medical Practitioners (GMPs). The traditional role for GMPs is as the family doctor, working in the primary care sector of the NHS/HSC. There are several contracting arrangements in place under which primary care services are provided, and GMPs can work as independent contractors, salaried GMPs or as locums. Doctors become GMPs after at least five years of postgraduate medical training, comprising the two-year foundation programme and at least three years' general practice training. Doctors in general practice training are junior doctors, and they are covered in Chapter 6.

Contract reform

England

- 9.2 In 2019 a five-year pay and contract reform agreement for England was finalised between the Department for Health and Social Care (DHSC), NHS England/Improvement (NHSE/I), and the General Practitioners Committee of the British Medical Association (BMA). The parties said that the contract would give clarity and certainty for practices. NHSE/I and the BMA agreed that there would be no further expectation of additional national funding for practice or contract entitlements until 2024-25.
- 9.3 The parties to the new contract agreed to ask the DDRB not to make recommendations relating to independent contractor GMP pay in England over the period of the agreement, though the BMA said this year that they would from now on encourage the DDRB to make active recommendations on behalf of all groups of doctors, including contractor GMPs. The agreement also said that the Government would continue to include recommendations on the pay of salaried GMPs in the DDRB remit from 2020 onwards, and our remit letter for England asked us to make recommendations for salaried GMPs again this year.

Scotland

- 9.4 The Scottish Government said that initial changes to their GMS contract were made in 2018, including a new workload formula and a GP Partner whole-time-equivalent earnings expectation. They said that this would be followed by a second phase of reforms, dependent on a further vote from the profession, which would comprise a number of changes, including introducing an income range for partner GMPs that is comparable to consultants and directly reimbursing practice expenses.

Wales

- 9.5 The Welsh Government said that the recovery from the pandemic provided a unique opportunity to reset thinking in terms of the future direction of the GMS contract. They said that its current form was collectively viewed as overly complex, and a unified contract workstream would consider what services should be included in a new, streamlined core contract.

Workforce numbers

- 9.6 For England, in March 2022, the headcount estimate for GMPs was 43,765, an increase of 2.1 per cent from March 2021. The full-time equivalent (FTE)¹ estimate for GMPs in March 2022, was 35,256, an increase of 2.7 per cent from March 2021. Excluding GMP contractors and GMP registrars there were 15,980 salaried GMPs and GMP Retainers on a headcount basis and 10,080 on an FTE basis.
- 9.7 In September 2021, the latest date for which data is available, Scotland had 5,195 GMPs, an increase of 1.4 per cent from September 2020. Within that total the number of performers fell by 0.7 per cent, the number of salaried GMPs increased by 8.2 per cent, and the number of registrars increased by 0.8 per cent.
- 9.8 The most recent data measuring the number of GMPs in Wales, is at 30 September 2021. The data showed Wales had 2,492 GMPs, of which 2,038 were practitioners, 426 registrars and 28 were retainers². Compared with 30 September 2020, the overall number of GMPs increased by 123 (5.2 per cent), of which the number of practitioners increased by 75 (3.8 per cent), the number of registrars increased by 44 (11.5 per cent), and the number of retainers increased by 4 (16.7 per cent).
- 9.9 The latest data for Northern Ireland, from March 2021, showed that Northern Ireland had 1,410 GMPs, an increase of 46 (3.4 per cent) from a year earlier. Within that total there were 1,181 partner GMPs (up from 1,163 in 2020), 205 salaried GMPs (up from 179 in 2020) and 24 retainers (up from 22 in 2020).
- 9.10 The composition of the GMP workforce has changed over recent years, with the share of contractor GMPs having fallen with that of salaried GMPs having increased. In England, between September 2015 and March 2022, the proportion of the GMP workforce headcount made up of contractors had fallen from 61 per cent to 45 per cent, while that of salaried GMPs increased from 26 per cent to 35 per cent. In Scotland, between 2011 and 2021, the proportion of the GMP workforce made up of contractors fell from 77 per cent to 64 per cent, while that of salaried GMPs increased from 11 per cent to 23 per cent.

¹ The four countries of the UK each produce headcount estimates of GMPs. In addition, NHS Digital also publish full-time equivalent estimates of GMP numbers in England.

² GMP retainers in Wales are practitioners on the GP retainer scheme, who are only able to practice a maximum of 4 clinical sessions a week.

- 9.11 The proportion of GMPs who are women has also been increasing. Between 2011 and 2021, the proportion of the general practice medical workforce who are women in Scotland increased from 52 per cent to 62 per cent. In 1985, in Northern Ireland, women made up fewer than 20 per cent of the GMP population, but by 2021 that had increased to 58 per cent. Over a shorter period, between March 2016 and March 2022, in England, the share of the GMP workforce made up of women increased from 53 per cent to 58 per cent.

Access to GMP services

England

- 9.12 DHSC said that the 5-year contract framework aimed to transform general practice with £4.5 billion of additional investment into primary and community care by 2023-24. They said that investment would fund demand pressures, workforce expansion and new services to support growth of more preventive, community-based healthcare. They also said that, through the pandemic, they had sought to provide additional funding for increased capacity and introduce measures to support access to general practice.
- 9.13 They added that they had published a plan to improve access to general practice in October 2021, and measures included a £250 million winter access fund, expansion of the Community Pharmacist Consultation Service, and additional funding to help drive adoption of cloud-based telephony services.
- 9.14 NHSE/I said that during the pandemic, the way that patients contacted their practice and the mode of appointments offered changed, and that these changes offered long-term benefits to patients and practices and would continue to be part of general practice going forward, with decisions over the use of face-to-face appointments to be made based on clinical judgement and patient preference. They said that patient satisfaction with GMP services had increased despite the challenges of the pandemic.

Scotland

- 9.15 The Scottish Government said that a focus on patient access would be maintained under the new contracts, underpinned by the principle of ensuring patients can see the right person at the right place at the right time. They said they were transforming primary care, including through the development of multidisciplinary teams to ensure this, and the Primary Care Fund was also supporting the use of digital services by practices.

Wales

- 9.16 The Welsh Government said that access models had changed as a result of the pandemic, with rapid deployment of digital tools to enable remote consultations where clinically appropriate. They said that an Access Commitment had been agreed and would come into force from 1 April 2022, which would support a blended model of access while taking a forward-looking approach to patient need. It would require practices to adapt current systems to support patient contact and enable advance booking of routine appointments, with a focus on ensuring that patients are informed of next steps at the first point of contact, rather than needing to contact their practice on multiple occasions. They said that this would be supported by £5.2 million of investment for 2022-23.

Northern Ireland

- 9.17 The Department of Health (DoH) said that the pandemic response had accelerated the implementation of innovative ways of working in general practice, including making greater use of technology and telephony. They said that this had helped general practice react quickly to the demands and challenges of the pandemic and maintain the majority of services.

Recruitment, retention and wellbeing

General Practice Training

- 9.18 Recruitment into general practice training again reached a record high in 2021, with the new, higher target of 4,000 doctors entering training in England being met. 321 places were filled in Scotland, close to a 100 per cent fill rate. We cover specific initiatives undertaken in each of the nations to attract trainees into general practice training, as well as the pay and conditions of general practice trainees, in Chapter 6.

England

- 9.19 DHSC said that under the updated GP Contract Framework they had announced a number of new retention schemes for GMPs, including the GP Fellowship Programme, the Supporting Mentors Scheme and the New to Partnership Payment. They said that take-up had been strong, and all newly qualified GMPs had the offer of joining the 2-year GP Fellowship Programme. They said that they continued to work with their partners and the profession to understand further options for improving recruitment and retention of the GMP workforce.

- 9.20 NHSE/I said that they continued to assist trainees from overseas identify practices with Tier 2 visa sponsorship licences to help them live and work in England once they qualify as a GMP. They said that the NHS GP International Induction Programme provided a supported pathway for overseas qualified GMPs to be inducted safely into NHS general practice, and they were working with the GMC and Royal College of General Practitioners to open the programme to GMPs from more countries. They also discussed the Return to Practice programme, which provides supported routes back into general practice for GMPs who had left, including a streamlined route back for those who returned under the response to the pandemic.
- 9.21 They also highlighted the GMC's concerns that a higher proportion of UK GMPs were struggling with their workloads, and that large proportions considered themselves at risk of burnout and were unsatisfied with their day-to-day work as a doctor. They said that in this context supporting the health and wellbeing of the GMP workforce was more important than ever, and they were supporting coaching services and practitioner health services to help GMPs.
- 9.22 The BMA said that survey responses from GMPs suggested that two-thirds had experienced abuse, threatening behaviour or violence directed at them or other members of practice staff, and this was having an impact on morale. They said that many salaried GMPs are seriously considering making alternative career plans as a result, including 65 per cent of those surveyed saying they were more likely to seek to work fewer hours. They said that this was also being driven by a number of other overlapping issues, including workload, worsening personal wellbeing and deteriorating working conditions.

Scotland

- 9.23 The Scottish Government said that they remained committed to increasing headcount numbers of GMPs by at least 800 by 2027. They said that to achieve this they would take forward a number of initiatives to make general practice a more exciting and attractive specialism, including training bursaries, enhancing the role of GMPs via fellowships and increasing the exposure to primary care at undergraduate level. They also said that the NHS Recovery Plan included £8 million in measures to support the wellbeing of the workforce, including £2 million in targeted support for the primary and social care workforces.
- 9.24 They added that seniority payments, for more experienced GMPs, and 'Golden Hellos', for GMPs in their first post in hard-to-recruit, remote or deprived areas, were also available to address specific recruitment and retention difficulties.
- 9.25 The BMA said that GMP numbers in Scotland were increasingly inadequate and an increasing proportion of practices were carrying vacancies. They said that practice capacity had been affected by the pandemic, which had created increased demands on general practice, adding that unmanageable workloads were acting as a barrier to attracting new doctors into general practice, and particularly into partnerships, which in turn led to existing GMPs seeking to reduce their sessional commitment, ultimately impacting patient care.

- 9.26 They also said that the wellbeing and morale of GMPs was an increasing cause for concern, citing surveys that found that majorities of GMPs in Scotland were saying that they were struggling to cope with their work, and that their experience of working during the pandemic had made it more likely that they would take early retirement or leave the profession.

Wales

- 9.27 The Welsh Government told us about their international induction and return to practice programmes, which included induction and support for those coming to work in general practice in Wales from overseas or after having not worked in the NHS for at least two years. Funding and support were also made available for participants in the schemes, including fees equivalent to an ST3 salary and help towards the costs of indemnity and childcare.
- 9.28 The BMA said that there was an increasing trend towards portfolio working amongst GMPs of all ages, with many opting to reduce their number of sessions in favour of other roles. They said that Wales had the oldest GMP workforce in the UK, presenting a sustainability challenge. They also raised concerns about workload and wellbeing, saying that only 6 per cent of respondents to a survey of GMPs in Wales reported that their workload was manageable, and 61 per cent reported that their personal and professional wellbeing was poor.

Northern Ireland

- 9.29 DoH said that they were conscious of the pressures on general practice across Northern Ireland and continued to work with stakeholder partners to address the workforce challenges and support recruitment and retention and decrease bureaucracy and the pressure on services. They told us about a number of initiatives they were undertaking to support the general practice workforce, including introducing GP Federations and induction and refresher, retainer and mentoring schemes.
- 9.30 The BMA said that GMPs in Northern Ireland were the only ones in the UK that had to pay for their own indemnity, which was further adding to the costs of being a GMP.

GMP trainers' grant and clinical placement funding

- 9.31 The GMP trainers' grant, from 1 April 2020, was £8,584. DHSC said that the 2020-21 Education and Training tariff guidance document introduced a new national minimum rate for undergraduate medical placements in general practice of £28,000, and while prices continued to be agreed under local arrangements, no price would be lower than this amount.

Independent contractor GMPs

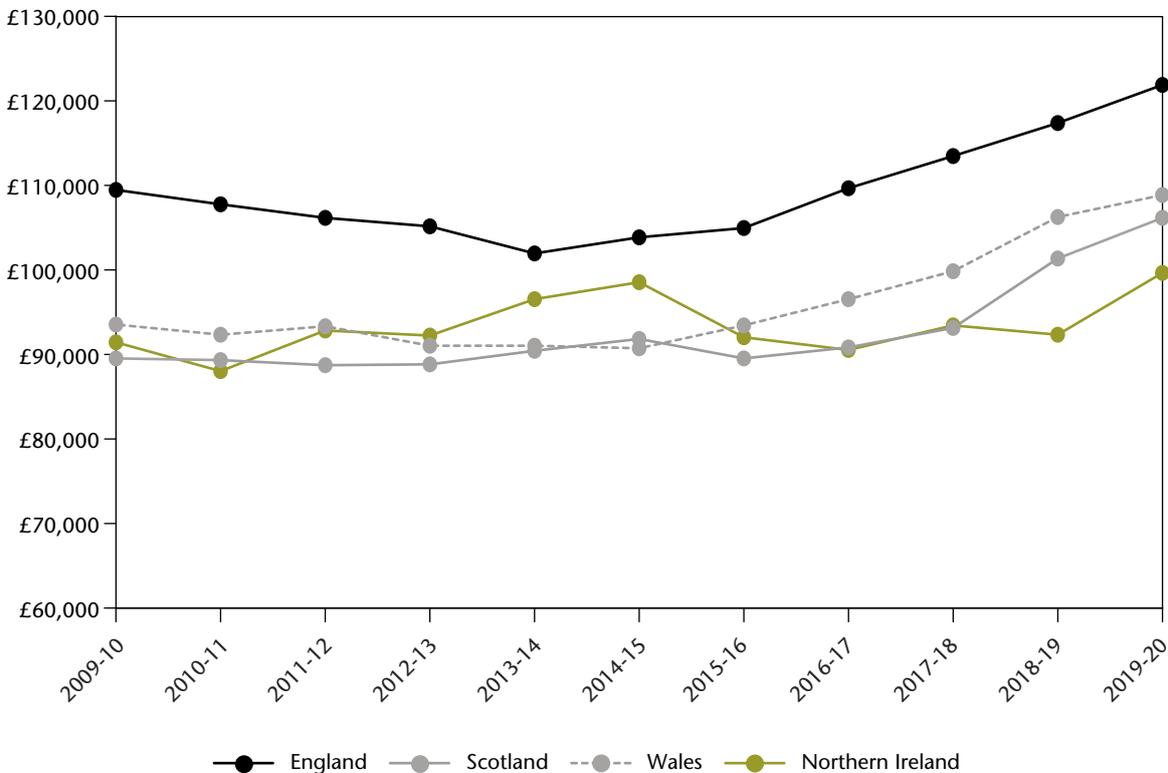
- 9.32 In 2019-20, average taxable income for contractor GMPs in each of the four countries was:
- England – £121,800 (up by 3.8 per cent, from 2018-19 (£117,300))
 - Wales – £108,800 (up by 2.5 per cent, (£106,200))

- Scotland – £106,100 (up by 4.8 per cent, (£101,300))
- Northern Ireland – £99,600 (up by 7.9 per cent, (£92,300)).

9.33 The average earnings estimates are produced on a headcount basis and take no account of hours worked. NHS Digital produce estimates of the numbers of contractor GMPs for England, on both a headcount basis and a Full-Time Equivalent (FTE) basis. This shows that the number of FTE contractor GMPs in September 2019 was 0.875 of the headcount number of contractor GMPs. If the relationship for average earnings, on a FTE basis were calculated in a similar way, this would give a FTE average earnings estimate for 2019-20 of £139,200 rather than £121,800 on a headcount basis, and a 4.6 per cent increase from 2018-19.

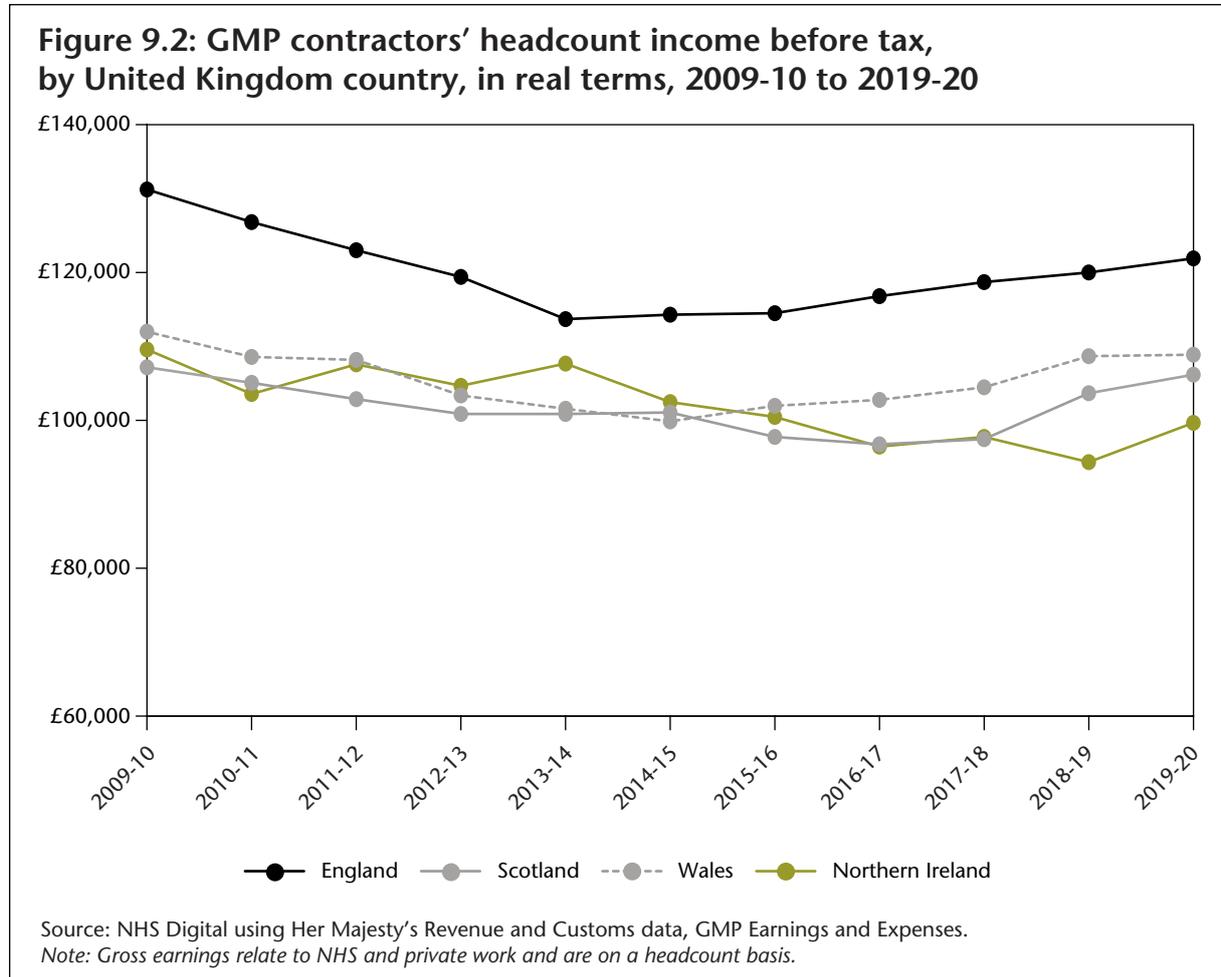
9.34 Figure 9.1 shows GMP contractors’ nominal average income before tax for each country within the UK, since 2009-10. Between 2009-10 and 2013-14 average incomes fell in England, Scotland and Wales but have since grown in each of the last: six years in England; five years in Wales; and four years in Scotland. In Northern Ireland average incomes increased between 2010-11 and 2014-15, before falling back to 2018-19, and then increasing in 2019-20. However, the most recent data for Northern Ireland has been distorted by delays in implementing awards. No uplift was applied during 2018-19, but then the uplifts for both 2018-19 and 2019-20 were applied in time to be reflected in the 2019-20 data.

Figure 9.1: GMP contractors’ headcount income before tax, by United Kingdom country, in nominal terms, 2009-10 to 2019-20



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

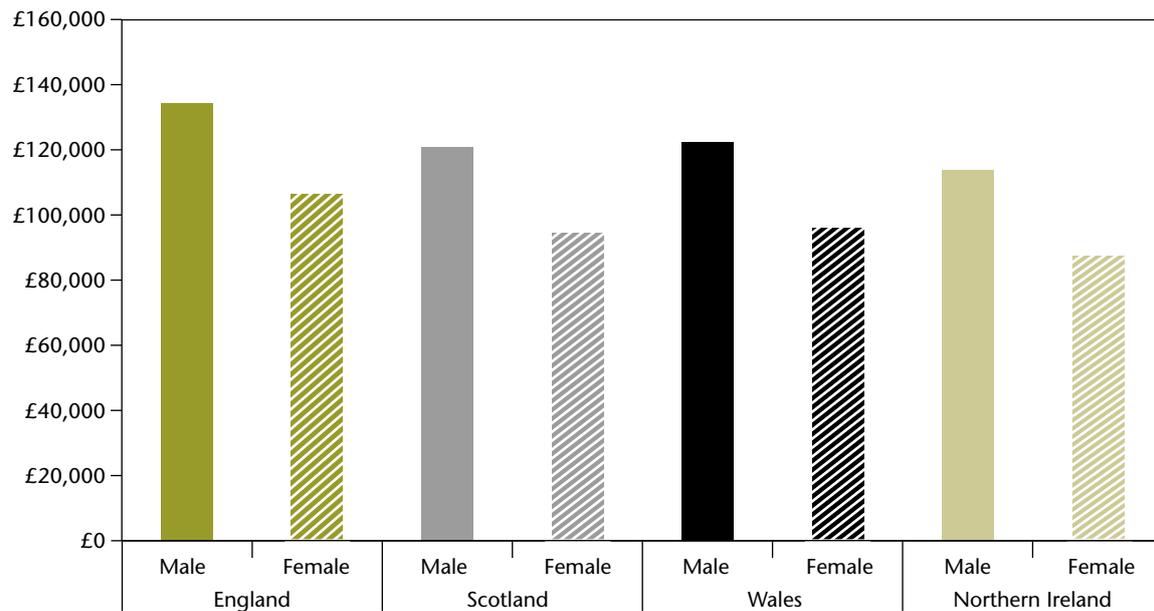
9.35 Figure 9.2 shows GMP contractors' average income before tax for each country within the UK, since 2009-10, adjusted for inflation³. Again, this shows declining incomes at the start of the period but increases in each of the last: six years in England; five years in Wales; and three years in Scotland. In Northern Ireland, average incomes adjusted for inflation were flat between 2009-10 and 2013-14 but have fallen back since that point.



9.36 NHS Digital produce estimates of income before tax for contractors, for each country in the UK, broken down by gender. Figure 9.3 shows that in 2019-20, in each country of the UK, average income before tax was greater for male contractors than for female contractors.

³ The conversion has been carried out using Gross Domestic Product (GDP) deflators as at June 2021 available from HM Treasury.

Figure 9.3: GMP contractors' headcount income before tax, by country, 2019-20, by gender



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

9.37 Table 9.1 shows that in each country average earnings of female contractor GMPs were lower than those of male contractor GMPs, by 21 per cent (Wales and England), 22 per cent (Scotland) and 23 per cent (Northern Ireland). The table also shows that the earnings gap narrowed slightly, compared with the previous year, in England and Scotland, but widened slightly in Northern Ireland.

Table 9.1: GMP contractors’ headcount income before tax, by United Kingdom country, 2017-18 to 2019-20, by gender

Country	Gender	2017-18	2018-19	2019-20	Gender difference		
					2017-18	2018-19	2019-20
England	Male	£125,600	£130,000	£134,300			
England	Female	£97,300	£101,200	£106,400	-23%	-22%	-21%
Scotland	Male	£107,800	£117,200	£120,800			
Scotland	Female	£80,800	£88,700	£94,400	-25%	-24%	-22%
Wales	Male	£111,000	£118,800	£122,300			
Wales	Female	£87,700	£93,300	£96,100	-21%	-21%	-21%
Northern Ireland	Male	£107,900	£104,500	£113,800			
Northern Ireland	Female	£79,600	£81,400	£87,400	-26%	-22%	-23%

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

9.38 In 2019-20 the average taxable income of contractor GMPs in ‘rural’ practices was greater than that of those in ‘urban’ practices, in all countries except Scotland (Figure 9.4). The differences were 6 per cent in Northern Ireland, and 3 per cent in both Wales and England. In Scotland, incomes of contractors in ‘urban’ practices were 2 per cent greater than those in rural practices (Table 9.2).

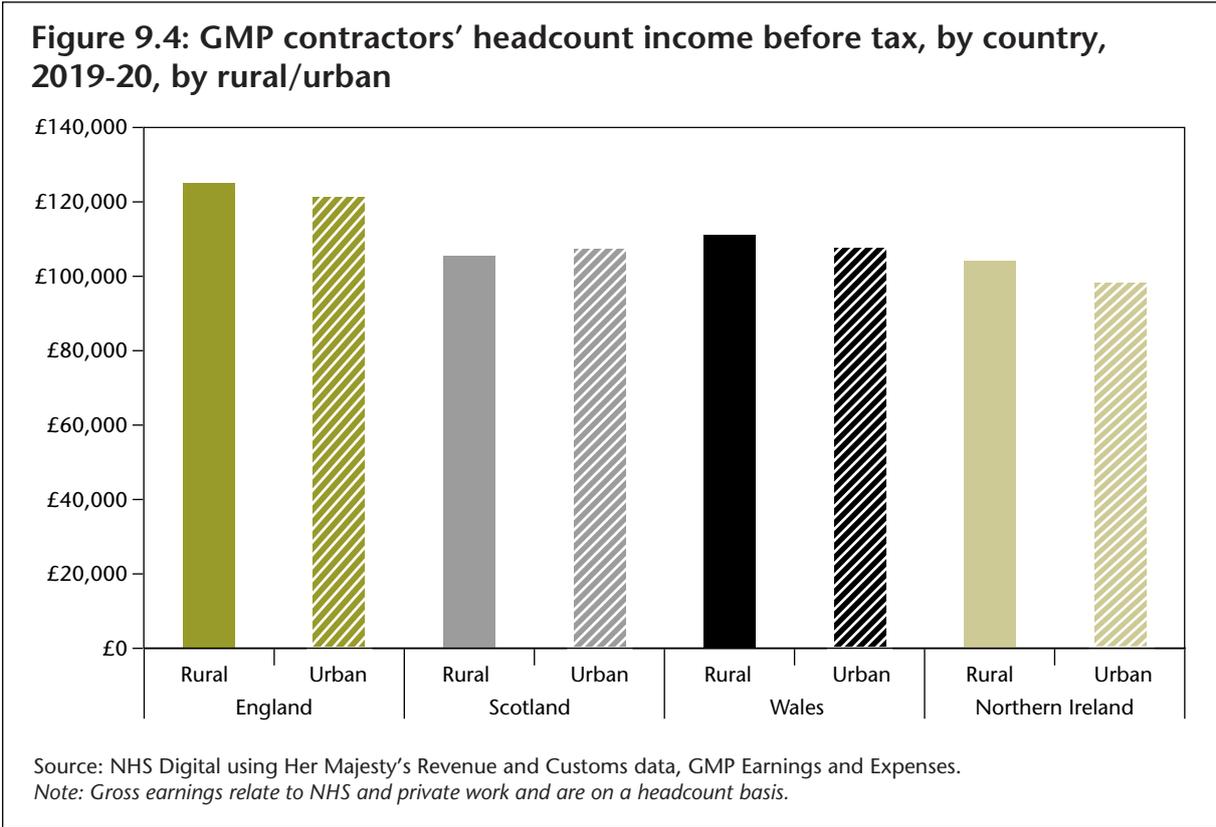


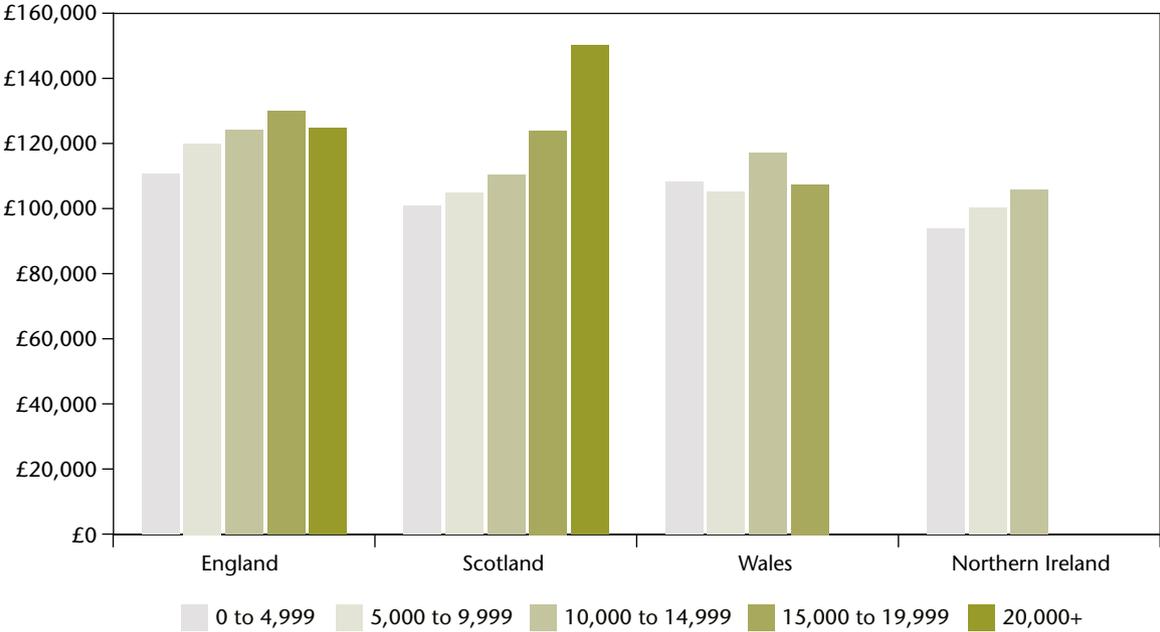
Table 9.2: GMP contractors’ headcount income before tax, by United Kingdom country, 2017-18 to 2019-20, rural/urban

Country	Rurality	2017-18	2018-19	2019-20	Urban/Rural difference		
					2017-18	2018-19	2019-20
England	Rural	£117,800	£120,000	£124,900			
England	Urban	£112,500	£116,700	£121,100	-4%	-3%	-3%
Scotland	Rural	£92,900	£100,700	£105,300			
Scotland	Urban	£93,300	£102,200	£107,300	0%	1%	2%
Wales	Rural	£104,400	£110,700	£111,000			
Wales	Urban	£97,500	£103,800	£107,600	-7%	-6%	-3%
Northern Ireland	Rural	£98,400	£98,000	£104,000			
Northern Ireland	Urban	£91,800	£90,400	£98,100	-7%	-8%	-6%

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

9.39 NHS Digital produce data for each country by practice size. The categories are: 0-4,999 patients; 5,000 to 9,999; 10,000 to 14,999; 15,000 to 19,999; and 20,000+. Figure 9.5 shows that in 2019-20 the average taxable income of contractor GMPs generally increased with practice size. The exceptions were contractors working at the largest practices in England and Wales. It should be noted that there are insufficient contractors working at the largest practices in Wales and Northern Ireland to be able to produce estimates for these groups.

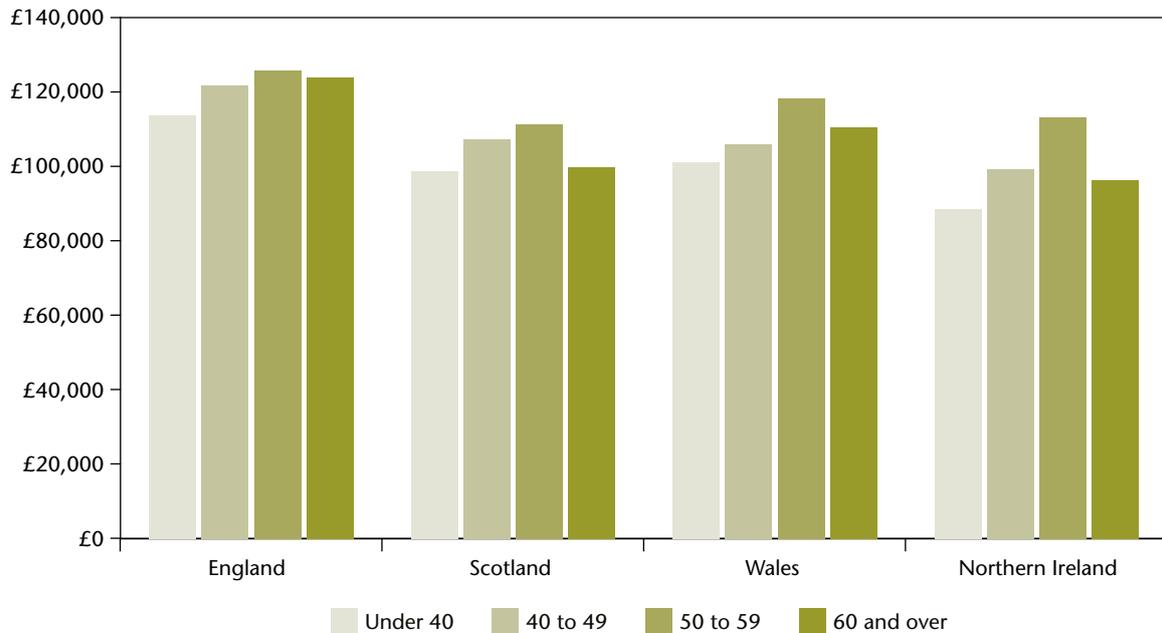
Figure 9.5: GMP contractors’ headcount income before tax, by country, 2019-20, by practice size (number of patients)



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

9.40 NHS Digital produce data for each country by age. The categories are: under 40 years; 40 to 49 years; 50 to 59 years; and 60 years and over. Figure 9.6 shows that in 2019-20 the average taxable income of contractor GMPs generally increased with age up to the 50 to 59 years age range. For the 60 years and over group, compared with the 50-59 years group, income levels off or falls.

Figure 9.6: GMP contractors' headcount income before tax, by country, 2019-20, by age



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

Salaried GMPs

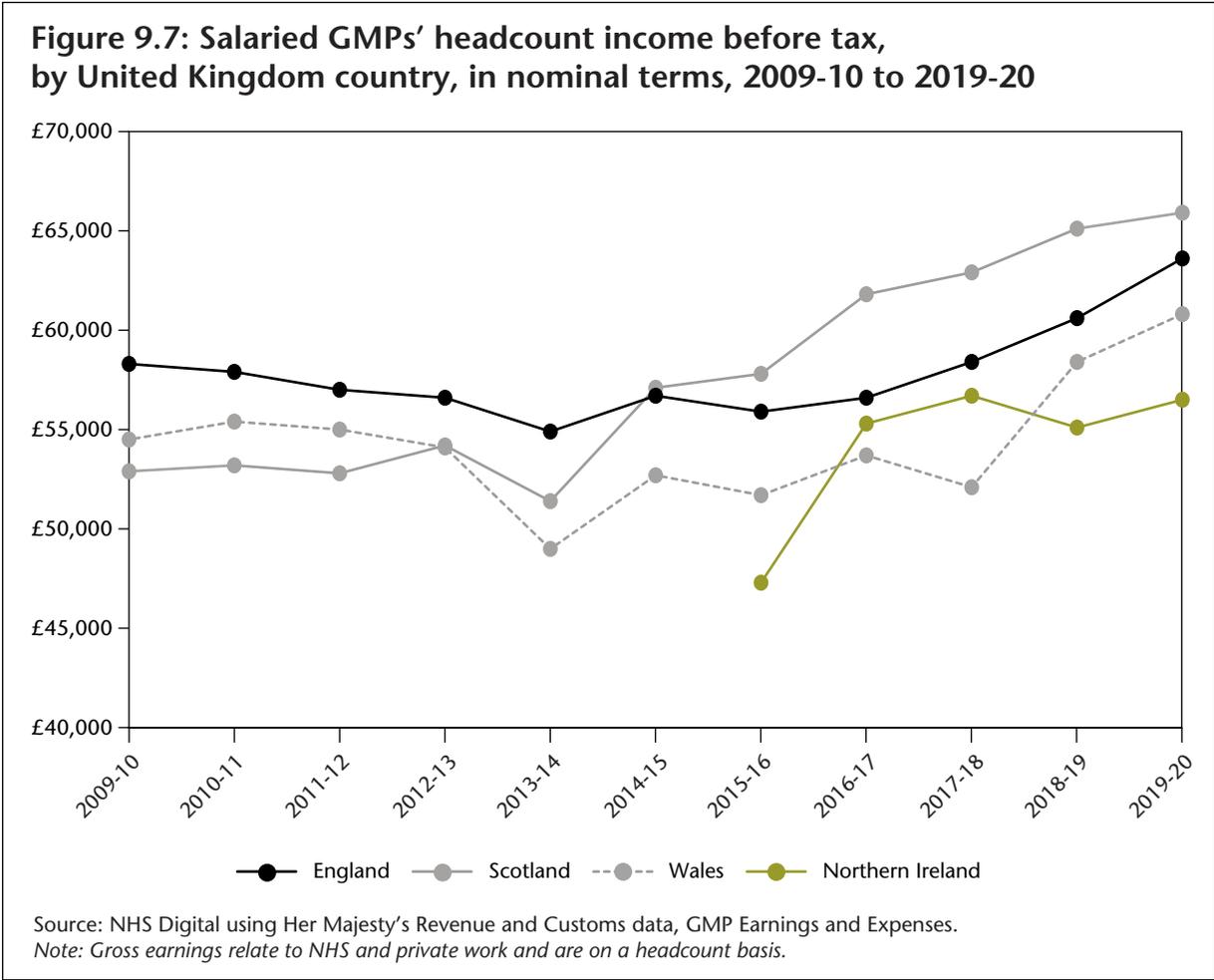
9.41 NHSE/I said that our recommendations for salaried GMPs needed to be informed by affordability, and that the fixed contract resources available under the GMP contract deal in England allowed for pay rises of 2.1 per cent for salaried GMPs in 2022-23.

9.42 In 2019-20, average taxable income for salaried GMPs in each of the four countries was:

- Scotland – £65,900 (up by 1.2 per cent, from 2018-19 (£65,100))
- England – £63,600 (up by 4.9 per cent, (£60,600))
- Wales – £60,800 (up by 4.1 per cent, (£58,400))
- Northern Ireland – £56,500 (up by 2.6 per cent, (£55,100)).

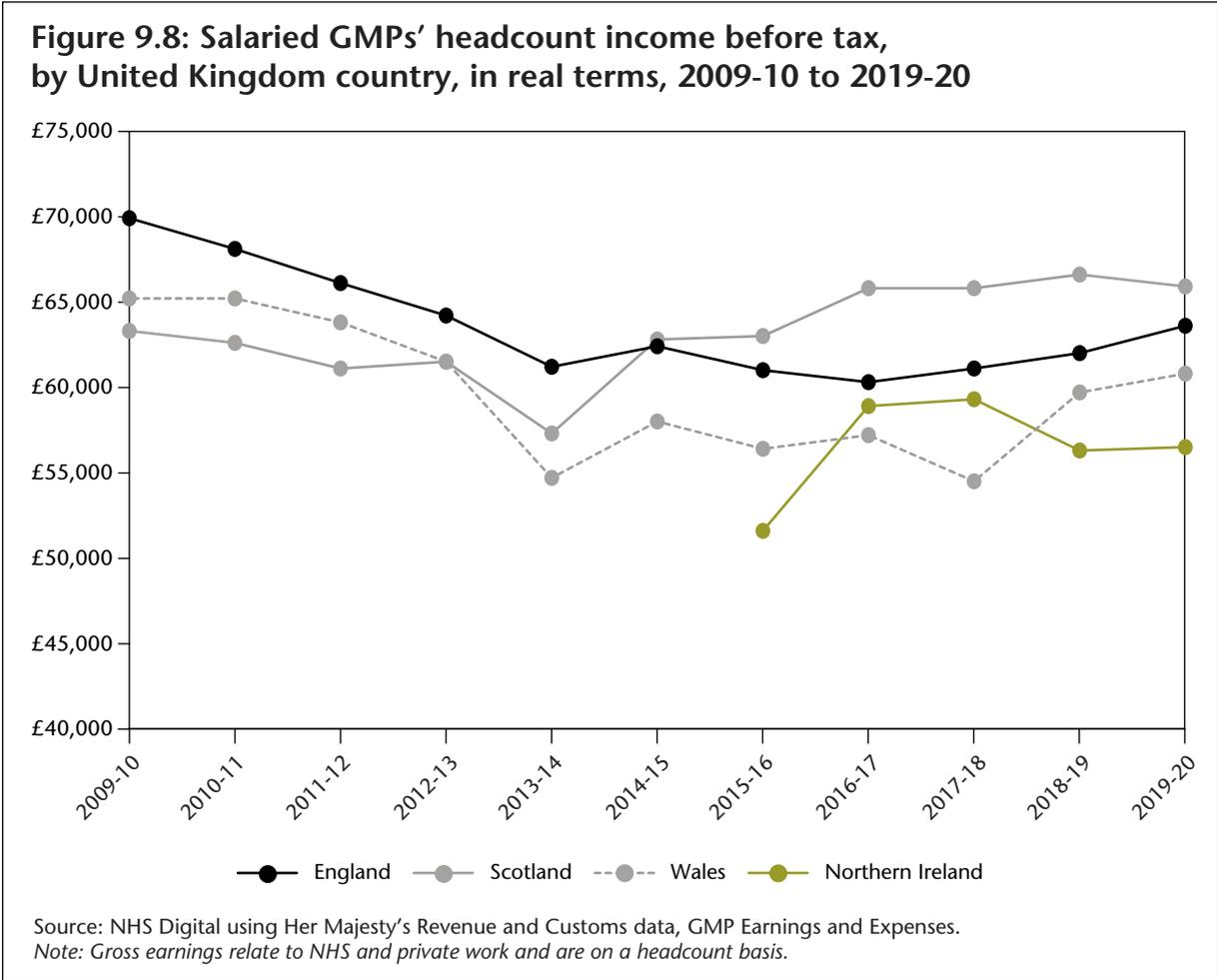
9.43 The average earnings estimates are produced on a headcount basis and take no account of hours worked. NHS Digital produce estimates of the numbers of salaried GMPs for England, on both a headcount basis and a Full-Time Equivalent (FTE) basis. This shows that the number of FTE salaried GMPs in September 2019 was 0.648 of the headcount number of contractor GMPs. If the relationship for average earnings, on a FTE basis were calculated in a similar way, this would give a FTE average earnings estimate for 2019-20 of £98,100 rather than £63,600 on a headcount basis, and a 6.8 per cent increase from 2018-19.

9.44 Figure 9.7 shows salaried GMPs’ **nominal** average income before tax for each country within the UK, since 2009-10 (for Northern Ireland since 2015-16). Average incomes fell between 2009-10 and 2013-14. However, **more recently, average incomes have grown**: in each of the last four years in England; in each of the last six years in Scotland; in the last two years in Wales. In Northern Ireland average incomes grew in both 2016-17 and 2017-18, fell back in 2018-19, but increased again in 2019-20⁴.



⁴ See paragraph 9.34

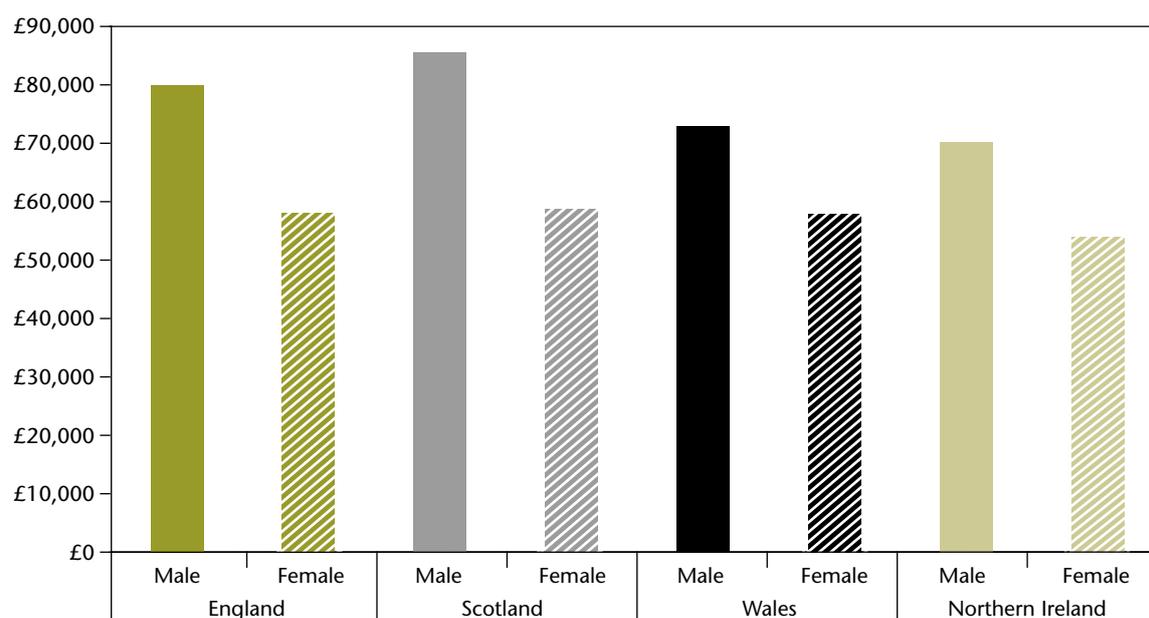
9.45 Figure 9.8 shows salaried GMPs' average income before tax for each country within the UK, since 2009-10 (for Northern Ireland since 2015-16), **adjusted for inflation**⁵. Between 2009-10 and 2013-14 average incomes declined, but there are signs that average incomes have stabilised or grown since that point.



9.46 NHS Digital produce estimates of income before tax for salaried GMPs, for each country in the UK, broken down by gender. Figure 9.9 shows that in 2019-20, in all four countries, average income before tax was greater for male salaried GMPs than for female colleagues.

⁵ The conversion has been carried out using Gross Domestic Product (GDP) deflators as at June 2021 available from HM Treasury.

Figure 9.9: Salaried GMP headcount income before tax, by country, 2019-20, by gender



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

9.47 Table 9.3 shows that in each country average earnings of female salaried GMPs in 2019-20 were lower than those of male contractor GMPs: by 21 per cent in Wales; 23 per cent in Northern Ireland; 27 per cent in England; and 31 per cent in Scotland. However, the gap between female and male incomes narrowed in each country between 2017-18 and 2019-20.

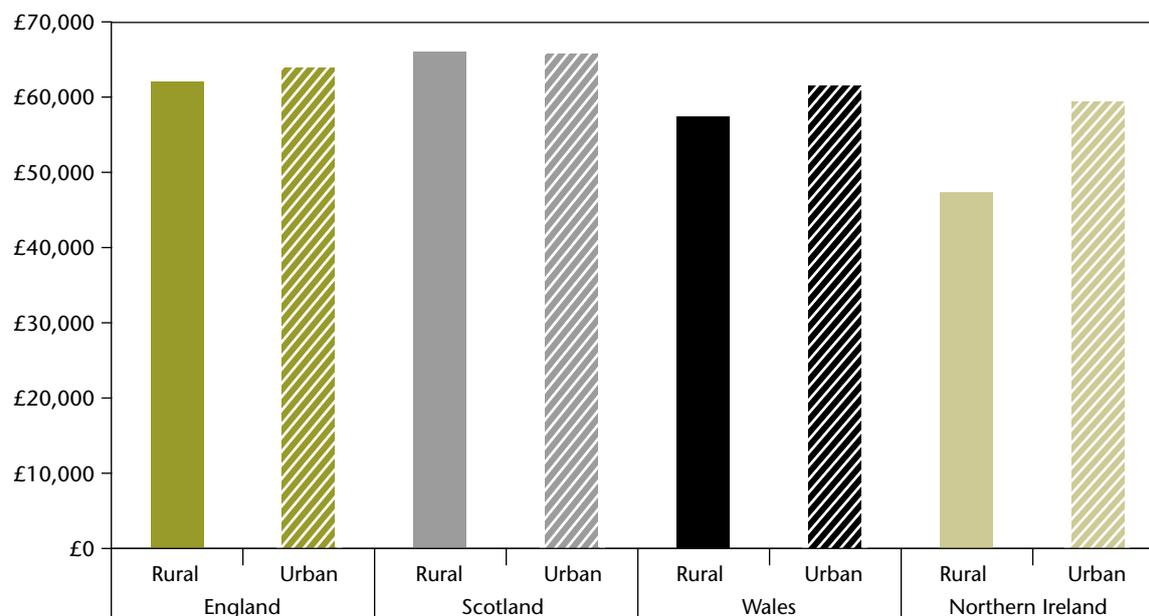
Table 9.3: Salaried GMP headcount income before tax, by United Kingdom country, 2017-18 to 2019-20, by gender

Country	Gender	2017-18	2018-19	2019-20	Gender difference		
					2017-18	2018-19	2019-20
England	Male	£75,100	£76,900	£79,800			
England	Female	£52,600	£55,000	£58,000	-30%	-28%	-27%
Scotland	Male	£85,200	£85,900	£85,400			
Scotland	Female	£55,800	£57,000	£58,600	-35%	-34%	-31%
Wales	Male	£62,800	£68,200	£72,800			
Wales	Female	£49,200	£55,700	£57,800	-22%	-18%	-21%
Northern Ireland	Male	£92,900	not available	£70,100			
Northern Ireland	Female	£51,800	£51,500	£53,900	-44%	not available	-32%

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

9.48 In 2019-20 the average taxable income of salaried GMPs in 'rural'⁶ practices was lower than that of those in urban practices, in all countries except Scotland (Figure 9.10). This is a reversal of the position for contractor GMPs. The differences were 25 per cent in Northern Ireland, 7 per cent in Wales and 3% in England. In Scotland, incomes of contractors in urban practices were in line with those in rural practices (Table 9.4).

Figure 9.10: Salaried GMP headcount income before tax, by country, 2019-20, by rural/urban



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

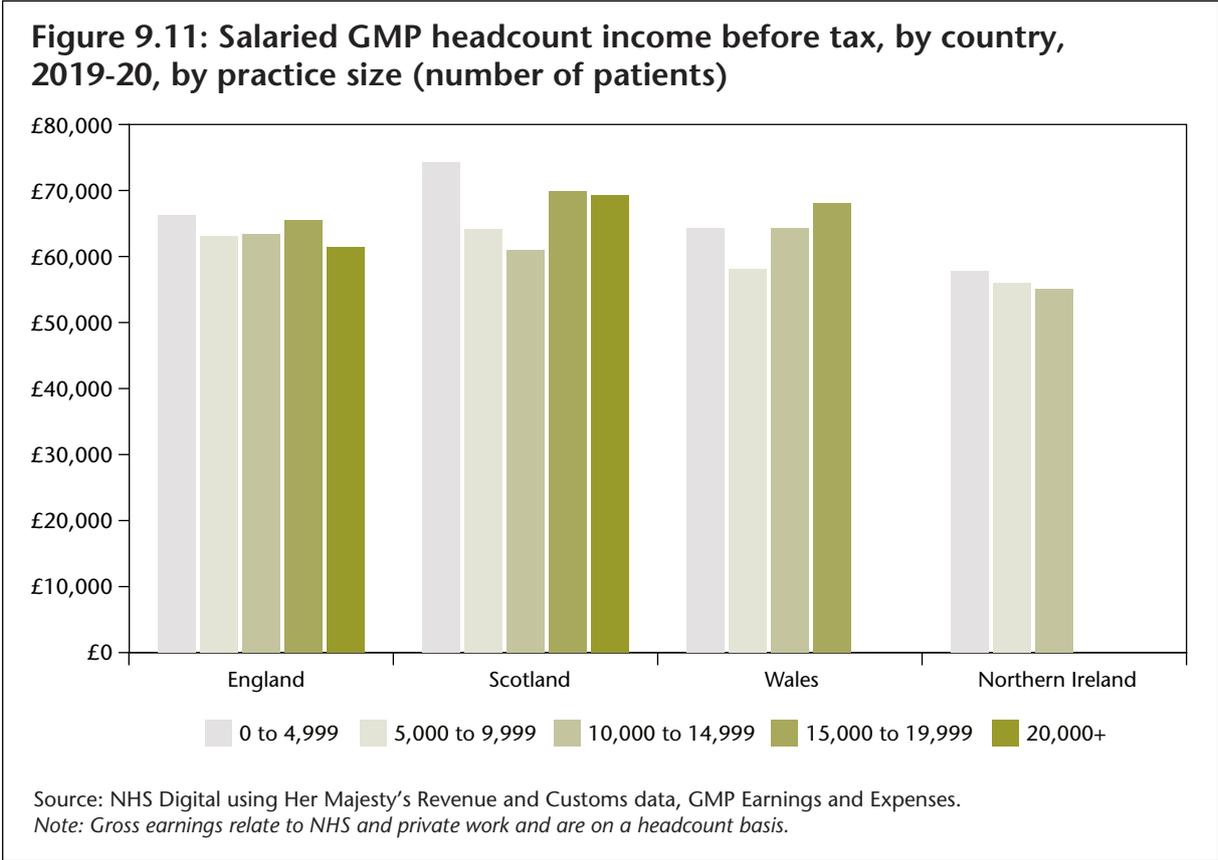
Table 9.4: Salaried GMP headcount income before tax, by United Kingdom country, 2017-18 to 2019-20, rural/urban

Country	Rurality	2017-18	2018-19	2019-20	Urban/Rural difference		
					2017-18	2018-19	2019-20
England	Rural	£57,300	£58,100	£62,100			
England	Urban	£58,600	£61,100	£63,900	2%	5%	3%
Scotland	Rural	£59,900	£63,200	£66,000			
Scotland	Urban	£65,400	£67,200	£65,700	9%	6%	0%
Wales	Rural	£62,200	£69,400	£57,400			
Wales	Urban	£48,600	£55,700	£61,500	-22%	-20%	7%
Northern Ireland	Rural	£56,700	£52,700	£47,400			
Northern Ireland	Urban	£56,700	£55,800	£59,400	0%	6%	25%

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

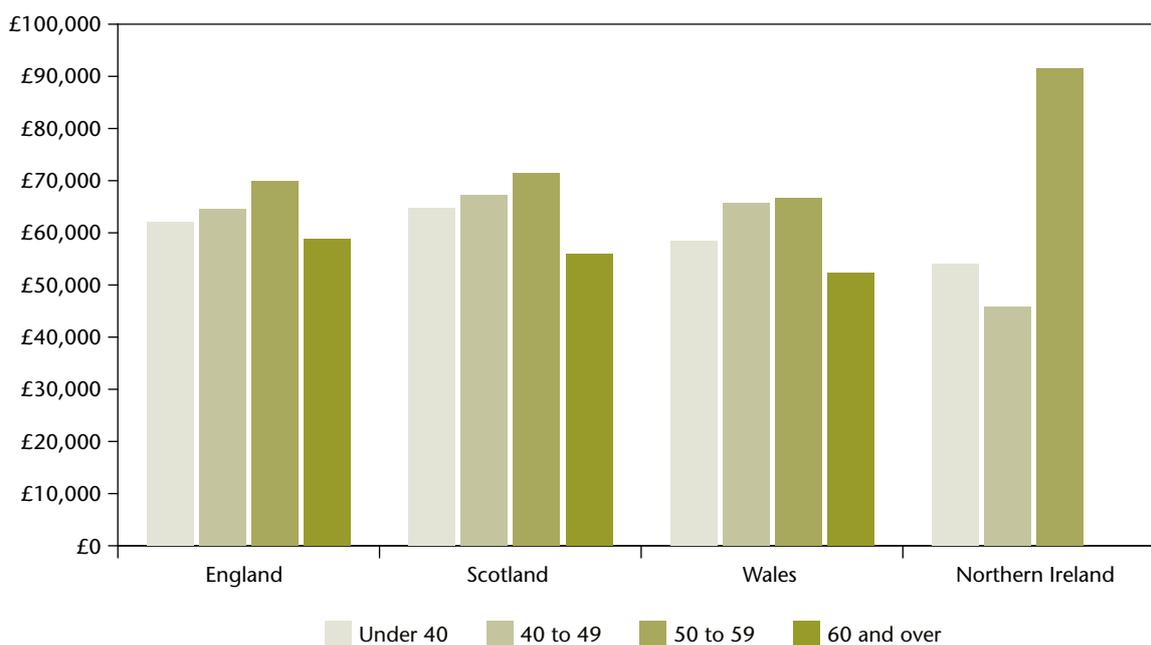
⁶ If more than 50 per cent of patients are classified as rural (based on postcode), the practice is categorised as rural. Likewise, if more than 50 per cent of patients are classified as urban, the practice is classified as urban.

9.49 NHS Digital produce data for each country by practice size. The categories are: 0-4,999 patients; 5,000 to 9,999; 10,000 to 14,999; 15,000 to 19,999; and 20,000+. Figure 9.5 showed that in 2019-20 the average taxable income of contractor GMPs generally increased with practice size. However, Figure 9.11, perhaps not surprisingly, shows no clear relationship between salaried GMP average taxable income and practice size. Indeed, salaried GMPs in the smallest practices in England, Scotland and Northern Ireland had the largest average incomes. It should be noted that there are insufficient salaried GMPs working at the largest practices in Wales and Northern Ireland to be able to produce estimates for these groups.



9.50 NHS Digital produce data for each country by age. The categories are: under 40 years; 40 to 49 years; 50 to 59 years; and 60 years and over. Figure 9.12 shows that in 2019-20 the average taxable income of salaried GMPs generally increased with age up to the 50 to 59 years age range. For the 60 years and over group, compared with the 50-59 years group, income levels off or fall.

Figure 9.12: Salaried GMP headcount income before tax, by country, 2019-20, by age



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

Expenses and formula

9.51 In 2015 we took a decision to make recommendations on our intended increase in pay net of expenses. Taking this approach required the parties to work together to agree on an expenses uplift. For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs had we used the formula-based approach.

Our comments

9.52 As with the other groups subject to multi-year deals, we note that the BMA asked us to make recommendations for contractor GMPs in England who are subject to the current multi-year deal. We discuss this in Chapter 11.

9.53 We welcome the improvements that have been made in recruitment into general practice training that have taken place across the UK over the last few years, and we note what HEE said about improvements having been driven largely by international medical graduates.

- 9.54 We note the continued rise in the proportion of GMPs who are salaried, rather than contractors. The shape of the GMP workforce is shifting, and we have heard in evidence that a greater proportion of GMPs no longer aspire to contractor roles. This is similar to what is happening in dentistry, where the number of providing-performers is falling, which we discuss in Chapter 10. Given this, we note that contractor status and average working hours are correlated. While it is not necessarily the case that there is a causal link between the two, this shift may be part of the reason why the effective size of the GMP workforce has grown more slowly than headcounts in recent years.
- 9.55 Falls in average working hours have the potential to undermine the benefit to the workforce of increased numbers entering and completing general practice training. Given the issues of access and workloads described earlier in the chapter, there remains a clear need for the effective size of the GMP workforce to grow, notwithstanding the improvements to GMP workloads that may take place as a result of the development and greater deployment of multidisciplinary teams in general practice.
- 9.56 We note in this context that a number of initiatives have been introduced to encourage more GMPs to take on contractor roles, as well as the contractual changes that are being developed in Scotland that would remove some of the risks associated with being a GMP contractor which they say are intended to make being a GMP contractor more attractive. We would welcome hearing how effective these initiatives have been in evidence for future years both in encouraging more GMPs to take on contractor roles and in ultimately increasing the effective size of the GMP workforce.
- 9.57 Given that an increasing proportion of the GMP workforce is salaried, we would also again reiterate the importance of contractor GMPs passing on pay uplifts to the salaried GMPs that they employ. Given the role that expenses uplifts play in the affordability of implementing our recommendations for salaried GMPs, we would expect that expenses uplifts for GMPs this year are sufficient for both salaried GMPs and contractor GMPs alike to receive the full value of their pay awards.
- 9.58 We again note that the Gender Pay Gap in Medicine Review found that there was a particularly large gender pay gap in general practice. The Review said that this was driven to some extent by the different compositions of the contractor and salaried GMP workforces by gender, as well as the unstructured way that pay was determined for salaried GMPs. This may also be linked to the passing on of pay awards by partners to the salaried GMPs that they employ. We would welcome hearing more about this issue from the parties next year.
- 9.59 In this context, efforts to improve retention and support GMPs to decide that they wish to take on more sessions are also critically important. We therefore welcome the efforts that are being undertaken to support GMP wellbeing and would encourage governments and health service leaders to continue their efforts.

- 9.60 Another key factor in retaining GMPs is pensions. It is crucial that pensions, which remain a major component of total reward for GMPs, are attractive and incentivise doctors to continue working in the NHS/HSC. We discuss this in more detail in Chapter 5.
- 9.61 We note the earnings growth figures from 2019-20, and that actual earnings growth was generally higher than the 2.5 per cent DDRB recommendation from the 2019 Report. We would welcome hearing more from the parties about how trends in earnings interact with trends in working hours and patterns and the increase in the proportion of GMPs who are salaried.

CHAPTER 10: DENTISTS

Introduction

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

University admissions

10.2 We discuss the numbers and demographics of those applying for and being accepted into dental schools in Chapter 6.

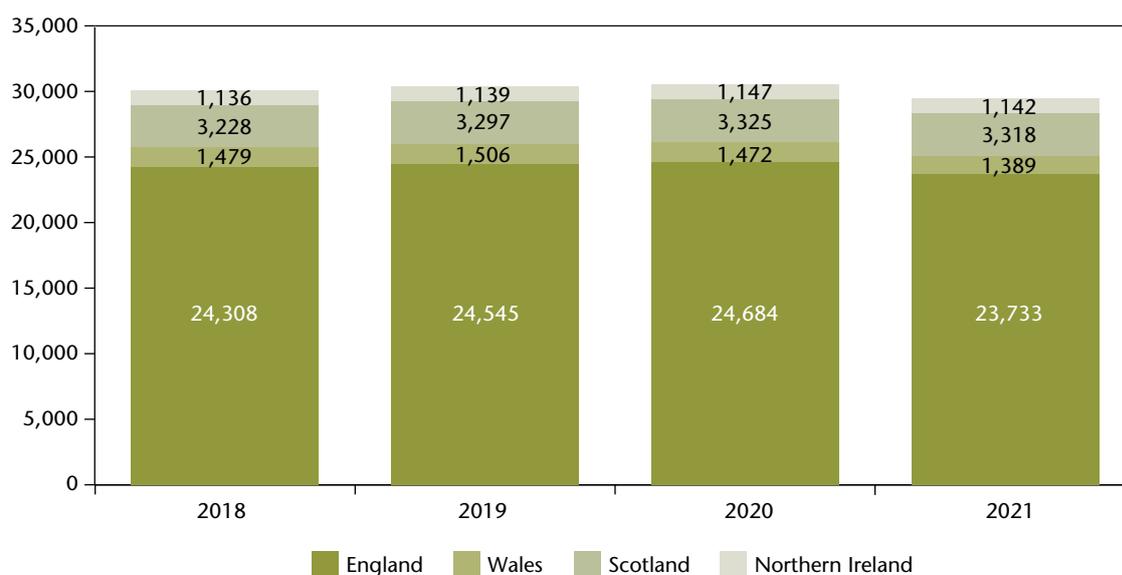
General dental practitioners

10.3 While terminology differs between the nations of the UK, general dental practitioners delivering NHS/HSC services are generally split into two categories. Dentists that hold a contract with the NHS/HSC to provide services are referred to as 'providing-performer' or 'principal' dentists, and typically own their own practices. Practice owners carry the responsibility of procuring, equipping, resourcing and staffing the practice and receiving gross fees from the commissioners in respect of services provided. Dentists that deliver NHS services under a contract held by another body, which can be a limited company or a providing-performer partnership, are referred to as 'performer-only' or 'associate' dentists. Associate dentists usually practice as subcontractors, whose income is usually determined as a proportion of the gross fees received on their behalf by the providing-performers. In this report we will refer to the former group as providing-performers and the latter as associates.

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

- 10.5 Dental contracts in different parts of the UK are structured differently. In England and Wales, contracts are structured around the Unit of Dental Activity (UDA), though some practices in Wales are moving onto reformed contracts based on other activity measures. Different dental treatments are sorted into three bands, which are worth different numbers of UDAs. Those that hold contracts to deliver NHS dentistry are expected to perform a contracted number of UDAs (and, where applicable, units of orthodontic activity, (UOAs)) each year, with provisions for 'clawback' – the recovering of contract values, if UDA/UOA targets are not met. In Scotland and Northern Ireland, remuneration is based on a mix of Item of Service payments, where fixed amounts are recoverable for different treatments; capitation, where a fixed amount is paid per patient registered; and other allowances.
- 10.6 GDPs differ from GMPs in that a significant proportion of GDP practices combine NHS/HSC and private dentistry.
- 10.7 Earnings can vary based on career choices, the balance of NHS/HSC and private work, the number of hours worked and the location of the practice. Calculated on a headcount basis, and including both NHS/HSC and private income, on average in 2019-20 providing-performer dentists in England earned £112,600, while associates earned £58,100. The equivalent figures for Scotland were £103,700 and £58,300; Wales £98,900 and £61,900; and Northern Ireland, £99,200 and £57,200.
- 10.8 In 2021¹ there were 29,582 dentists providing NHS/HSC services in the UK, a decrease of 1,046 (3.4 per cent) from a year earlier. There were decreases of: 951 (3.9 per cent) in England, 83 (5.6 per cent) in Wales, seven (0.2 per cent) in Scotland, and five (0.4 per cent) in Northern Ireland.

Figure 10.1: Number of General Dental Practitioners, United Kingdom, 2018 to 2021



Source: NHS Digital, NHS Education for Scotland, StatsWales, Northern Ireland Statistics and Research Agency

¹ Data for each country are as at 31 March.

Access to dental services, the pandemic and financial support

10.9 Since the start of the pandemic, as a result of coronavirus restrictions and other pandemic-related disruptions to the functioning of dental practices, including the need to address that many common dental procedures generate aerosols, patient throughput in dental practices has been limited. As a result of this, the four governments have each provided financial support to practices, though the level of support differed throughout the course of the pandemic and between the four nations.

England

- 10.10 DHSC said that NHSE/I had monitored dental activity levels to set contractual arrangements that provided NHS dentists with a reasonable activity threshold to meet, taking into consideration restrictions on throughput. They said that once this threshold had been met, dental contractors were reimbursed at 100 per cent of their contract value, though an adjustment had been made to payments to account for the reduction in variable costs which was initially 16.75 per cent, later falling to 12.75 per cent. They also said that the rate of clawback had been lowered to a new, lower activity threshold value. They said that the activity threshold had been set at 65 per cent of pre-pandemic levels for dental activity and 85 per cent for orthodontic activity between October and December 2021, and 85 per cent and 90 per cent respectively between January and March 2022. In April 2022, it was announced that for the first quarter of the 2022-23 financial year, practices would be expected to deliver 95 per cent of their pre-pandemic activity.
- 10.11 The BDA said that the 16.75 per cent abatement for variable costs was arbitrary and they repeatedly contested it. They also said that changes to activity threshold had taken place at short notice, and changes to the standard operating procedures had made them more challenging to meet.
- 10.12 DHSC also said that the activity targets had been set based on what some practices had been able to achieve, and they balanced the need to improve access to dentistry by increasing activity against the need to protect dentists and dental incomes. They said that they were not expecting there to be an increase in clawback as a result of the activity target. However, the BDA said that only a minority of practices were able to meet the 85 per cent activity target that was in place at the start of 2022, and that the new 95 per cent target would lead to hundreds of millions of pounds of clawback.
- 10.13 Data from NHSE/I suggested that clawback in 2020-21 reached a record high level of £131 million, up from £123 million in 2019-20. The BDA, who said that £169 million was clawed back in 2020-21, said that this figure represented 5.7 per cent of overall GDS funds, and 30 per cent of practices had some amount of their contract value clawed back. They said that the leading factor in under-delivery was the inability to recruit associates to deliver NHS activity.

Scotland

10.14 The Scottish Government said that the impact of COVID-19 on NHS dentistry had been prolonged and significant. They said that over the course of the previous year they had seen an increasing amount of care being provided by dentists within the current payment structure, though activity remained significantly below pre-pandemic levels, and they had provided emergency top-up payments to practices that guaranteed 85 per cent of 2019-20 Item of Service income. They said that going forward they were moving back to a blended remuneration model, with an interim multiplier arrangement to incentivise dentists to increase activity, that would be reviewed based on affordability, public health, and actual levels of activity that were achievable. The BDA said that the multiplier would be reviewed after three months, and if it were removed then practices would struggle to remain financially viable.

Wales

10.15 The Welsh Government said that UDA targets had been suspended for 2020-21 and 2021-22 as a result of the pandemic, and all practices, including those not previously part of the reform programme, were collecting data relating to oral health risk and the need of patients treated. They said that practices had been asked to prioritise patients based on need. The BDA said that it would be a huge leap for practices to return to activity targets, whether under the old UDA arrangements or on reformed contracts.

Northern Ireland

10.16 The Department of Health (DoH) said that in response to the disruption to dentistry that had been caused by the pandemic, they had introduced a financial support scheme which provided additional monthly payments to eligible GDPs based on average Item of Service income from 2019-20, with other payments, including capitation, paid as normal. The BDA said that 25 per cent would be added to Item of Service fees for the upcoming financial year, to support increased activity, but that this was not sufficient, and practices would not be able to achieve the levels of activity necessary to achieve sustainable income levels. They also said that this would be reviewed regularly and was not guaranteed to continue beyond the end of the first quarter of the 2022-23 financial year.

Dental Working Hours Motivation and Morale Survey

10.17 Since last year's report, no new Dental Working Hours Motivation and Morale survey has been published, as results are only published every two years. Therefore, instead of including the results and trends in full, we instead summarise some of the key points and takeaways from the motivation and morale questions, that were discussed in last year's report, as follows:

- Only a small proportion of dentists across the UK agreed or strongly agreed that their pay was fair. For providing-performers, 19 per cent in Wales agreed their pay was fair, with 18 per cent doing so in England, 16 per cent in Scotland, and 15 per cent in Northern Ireland. For associates, 26 per cent in Wales agreed their pay was fair, with 23 per cent doing so in England, 21 per cent in Scotland and 13 per cent in Northern Ireland. Since 2012-13, these figures have been consistently below 30 per cent, and for providing-performers have shown a downward trend since 2015-16. For associates, there was a downward trend between 2012-13 and 2017-18, before showing some recovery in 2018-19 and 2019-20
- A minority of dentists agreed or strongly agreed that they felt good about their job as a dentist. For providing-performers, 48 per cent in Scotland agreed they felt good about their job, 47 per cent did so in England, 41 per cent in Northern Ireland and 40 per cent in Wales. For associates, 53 per cent in Scotland agreed they felt good about their job, 52 per cent did so in Wales, 49 per cent in England and 39 per cent in Northern Ireland. For both providing-performers and associates, these figures have trended downwards since 2012-13
- In 2019-20 a majority of dentists said that they 'agree' or 'strongly agreed' that they thought about leaving general dentistry. Across the UK, providing-performers were more likely than associates to say that they thought about leaving general dentistry. For both providing-performers and associates, these figures have trended upwards since 2014-15
- Only a minority of dentists across the UK rated their morale as 'high' or 'very high', with associate dentists were more likely than providing-performers to do so. Results were also a little better in Scotland than the rest of the UK. For providing-performers, 21 per cent in each of Scotland and England rated their morale as high or very high, compared with 17 per cent in Wales and 13 per cent in Northern Ireland. For associates, 31 per cent in Scotland rated their morale as high or very high, compared with 26 per cent in both Wales and England, and 16 per cent in Northern Ireland. For both providing-performers and associates, these figures have trended downwards since 2012-13, though these trends looked to have stabilised in 2018-19 and 2019-20
- In 2019-20 increasing expenses and/or declining income was the most frequently cited cause of low morale by providing-performer dentists in England, Scotland and Northern Ireland. In Wales, although 60 per cent of providing-performers cited expenses and/or income as a cause of low morale they were even more likely to cite administration and paperwork, and regulations. For associates the most frequently cited cause of low morale, in each of the four countries, was the risk of litigation and cost of indemnity fees

10.18 Similarly, the key points from the working hours questions were as follows:

- Providing-performers across the UK on average worked more hours and dedicated more hours per week to NHS/HSC dentistry in 2019-20 compared to 2018-19. Average working hours went up by 0.6 per week in England, 0.9 in Wales and 0.6 in Northern Ireland, with the figures unchanged in Scotland. Average hours per week dedicated to NHS/HSC dentistry went up by 0.5 in England and Scotland, 0.6 in Wales and 0.8 in Northern Ireland. In the long-term, these figures have been broadly stable, though there has been gradual growth in average weekly hours worked since 2014-15
- Except in Northern Ireland, associate dentists on average reduced both their working hours and the number of hours per week dedicated to NHS/HSC dentistry. Average working hours went down by 0.5 per week in England and 0.1 in Scotland but were unchanged in Wales and went up by 0.3 in Northern Ireland. Average hours per week dedicated to NHS/HSC dentistry went down by 0.9 in England, 0.4 in Scotland and 0.6 in Wales, but went up by 0.5 in Northern Ireland. There has been a slight long-term downward trend in the number of weekly hours spent on NHS/HSC work by associates since 2011-12, apart from in Northern Ireland
- Providing-performers across the UK spent a smaller percentage of time on clinical work, though the trends were less clear for associates. The percentage of time spent on clinical work by providing-performers fell by 1.8 percentage points in England, 1.2 in Scotland, 0.9 in Wales and 0.1 in Northern Ireland. The percentage of time spent on clinical work by associates fell by 0.5 percentage points in Scotland and 0.7 in Wales, but increased by 0.2 percentage points in England and 1.0 percentage points in Northern Ireland. In the long term, the percentage of time spent on clinical work by both providing-performers and associates fell significantly between 2010-11 and 2013-14, before recovering between 2017-18 and 2018-19

Recruitment and retention

10.19 NHSE/I said that current trends in the dental workforce were difficult to assess, as available data does not detail whole-time or part-time working. They said that they did not yet know whether the fall in the number of dentists was due to pandemic-related falls in activity or the start of a reversal of the previous upward trend. They also said that there were areas where recruitment and retention of dentists remained an issue, and developments to the commissioning framework to allow for flexibility in contractual arrangements would help to address this. They also said that ongoing work under the NHS People Plan would help to develop a multidisciplinary dental workforce of sufficient size to meet population health needs.

10.20 The BDA said that a survey of practice owners that they had conducted found that 80 per cent had experienced difficulties in recruiting associates, with that figure rising to 93 per cent for practices with over 75 per cent NHS/HSC commitment. They also said that another survey they conducted found that 47 per cent of practice owners and 28 per cent of associates were planning to retire in the next five years. Over the same period, 42 per cent of practice owners and 36 per cent of associates were intending to reduce their working hours; and 22 per cent of practice owners and 39 per cent of associates were planning to increase the proportion of the time they spend on private work. They also said that difficulties in recruiting associates was one of the causes of the increases in clawback.

Earnings and expenses for providing-performer GDPs

10.21 NHS Digital, using HMRC data, publishes statistics on the earnings and expenses of primary care dentists who carried out NHS/HSC work in each part of the UK. The overall picture on earnings is unclear as it is not known how many hours' work the statistics were based on, and some dentists choose to take incorporated status, affecting how their income appears in the statistics. The earnings figures that we have also combine earnings attributable to NHS/HSC work with earnings arising from private work. Due to a change in the methodology used to determine dental type, for dentists in England and Wales, there is now a break in timeseries. The figures published in 2018-19 are not comparable to those of previously published reports. HMRC have recalculated the 2017-18 figures using the new dental type methodology, allowing comparisons to be made from 2017-18 and establishing a new timeseries.

England

10.22 Table 10.1 shows that in 2019-20, providing-performer dentists in England had average taxable income of £112,600, a reduction of 0.4 per cent from 2018-19, and average expenses of £273,700 (Expenses to Earnings Ratio (EER) of 70.8 per cent).

Table 10.1: Providing-performer GDPs' average gross earnings, income and expenses, England, NHS and private, headcount, 2017-18 to 2019-20

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	4,200	365.1	251.9	113.2	69.0
2018-19	4,100	383.4	270.3	113.1	70.5
2019-20	3,950	386.3	273.7	112.6	70.8
<i>Latest change (%)</i>		+0.8%	+1.3%	-0.4%	+0.3pp

Source: NHS Digital using Her Majesty's Revenue and Customs data.

pp: percentage point change.

EER: expenses to earnings ratio.

Wales

10.23 Table 10.2 shows that in 2019-20, providing-performer dentists in Wales had average taxable income of £98,900, an increase of 11.9 per cent from 2018-19, and average expenses of £223,600 (Expenses to Earnings Ratio (EER) of 69.3 per cent).

Table 10.2: Providing-performer GDPs' average gross earnings, income and expenses, Wales, NHS and private, headcount, 2017-18 to 2019-20

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	200	274.5	189.2	85.3	68.9
2018-19	200	294.6	206.1	88.4	70.0
2019-20	200	322.5	223.6	98.9	69.3
<i>Latest change (%)</i>		+9.5%	+8.5%	+11.9%	-0.7pp

Source: NHS Digital using Her Majesty's Revenue and Customs data.

pp: percentage point change.

EER: expenses to earnings ratio.

Scotland

10.24 Table 10.3 shows that in 2018-19 providing-performer dentists in Scotland had average taxable income of £103,700, a decrease of 7.6 per cent from 2018-19, and average expenses of £240,400 (EER 69.9 per cent).

Table 10.3: Providing-performer GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2009-10 to 2019-20

Year	Estimated population	Gross earnings (£000s)	Expenses (£000s)	Income (£000s)	EER (%)
2009-10	650	337.0	223.2	113.8	66.2
2010-11	700	334.7	233.6	101.1	69.8
2011-12	700	332.9	230.0	102.9	69.1
2012-13	650	319.6	222.3	97.4	69.5
2013-14	650	330.3	231.9	98.4	70.2
2014-15	600	347.2	244.3	102.9	70.4
2015-16	500	377.8	267.0	110.8	70.7
2016-17	500	377.3	268.3	109.0	71.1
2017-18	500	367.7	260.0	107.6	70.7
2018-19	500	370.9	258.6	112.2	69.7
2019-20	500	344.1	240.4	103.7	69.9
<i>Latest change</i>		-7.2%	-7.0%	-7.6%	+0.2pp

Source: NHS Digital using Her Majesty's Revenue and Customs data.

pp: percentage point change.

EER: expenses to earnings ratio

Northern Ireland

10.25 Table 10.4 shows that in 2019-20, providing-performer dentists had average taxable income of £99,200, a fall of 5.0 per cent, and average expenses of £213,700 (EER 68.3 per cent). Variations in average incomes, suggest that there is a degree of volatility in these statistics associated with the small sample size.

Table 10.4: Providing-performer GDPs' average gross earnings, income and expenses, Northern Ireland, HSC and private, headcount, 2009-10 to 2019-20

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2009-10	350	344.6	221.7	122.9	64.3
2010-11	300	331.0	216.8	114.2	65.5
2011-12	350	318.6	206.1	112.5	64.7
2012-13	300	316.0	205.2	110.9	64.9
2013-14	300	335.6	223.1	112.5	66.5
2014-15	250	328.7	217.0	111.7	66.0
2015-16	250	336.0	218.4	117.6	65.0
2016-17	200	314.7	215.5	99.1	68.5
2017-18	250	347.1	231.1	116.0	66.6
2018-19	200	334.2	229.7	104.4	68.8
2019-20	200	312.9	213.7	99.2	68.3
<i>Latest change</i>		-6.4%	-7.0%	-5.0%	-0.5pp

Source: NHS Digital using Her Majesty's Revenue and Customs data.

pp: percentage point change.

EER: expenses to earnings ratio

Earnings and expenses for associate GDPs

England

10.26 Table 10.5 shows that in 2019-20, associate dentists in England had average taxable income of £58,100, an increase of 0.9 per cent from 2018-19, and average expenses of £29,400 (EER of 33.6 per cent).

Table 10.5: Associate GDPs' average gross earnings, income and expenses, England, NHS and private, headcount, 2017-18 to 2019-20

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	16,300	90.3	33.3	57.0	36.9
2018-19	16,600	89.0	31.4	57.6	35.3
2019-20	16,750	87.5	29.4	58.1	33.6
<i>Latest change</i>		-1.7%	-6.4%	+0.9%	-1.7pp

Source: NHS Digital using Her Majesty's Revenue and Customs data.

pp: percentage point change.

EER: expenses to earnings ratio

Wales

10.27 Table 10.6 shows that in 2019-19, associate dentists in Wales had average taxable income of £61,900, an increase of 5.3 per cent from 2018-19, and average expenses of £48,100 (EER of 43.7 per cent).

Table 10.6: Associate GPs' average gross earnings, income and expenses, Wales, NHS and private, headcount, 2017-18 to 2019-20

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	850	104.6	46.4	58.3	44.3
2018-19	950	105.3	46.5	58.8	44.2
2019-20	950	110.0	48.1	61.9	43.7
<i>Latest change</i>		+4.5%	+3.4%	+5.3%	-0.5pp

Source: NHS Digital using Her Majesty's Revenue and Customs data.

pp: percentage point change.

EER: expenses to earnings ratio

Scotland

10.28 Table 10.7 shows that in 2019-20, associate dentists in Scotland had average taxable income of £58,300, an increase of 1.6 per cent from 2018-19, and average expenses of £31,500 (EER of 35.0 per cent).

Table 10.7: Associate GPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2009-10 to 2019-20

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2009-10	1,450	91.9	28.8	63.1	31.3
2010-11	1,450	87.9	27.8	60.1	31.6
2011-12	1,550	85.0	27.5	57.6	32.3
2012-13	1,650	84.9	27.7	57.2	32.6
2013-14	1,650	84.9	28.7	56.2	33.8
2014-15	1,750	84.7	29.7	55.0	35.1
2015-16	1,700	86.0	30.7	55.2	35.7
2016-17	1,750	88.6	32.1	56.4	36.3
2017-18	1,800	85.2	29.9	55.4	35.0
2018-19	1,850	90.1	32.7	57.4	36.3
2019-20	1,900	89.8	31.5	58.3	35.0
<i>Latest change</i>		-0.3%	-3.7%	+1.6%	-1.3pp

Source: NHS Digital using Her Majesty's Revenue and Customs data.

pp: percentage point change.

EER: expenses to earnings ratio

Northern Ireland

10.29 Table 10.8 shows that in 2019-20, associate dentists in Northern Ireland had average taxable income of £57,200, a decrease of 2.6 per cent from 2018-19, and average expenses of £39,000 (EER of 40.5 per cent).

Table 10.8: Associate GDPs' average gross earnings, income and expenses, Northern Ireland, HSC and private, headcount, 2009-10 to 2019-20

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2009-10	500	97.9	35.2	62.7	36.0
2010-11	550	96.2	36.9	59.4	38.3
2011-12	600	91.6	35.8	55.7	39.1
2012-13	650	86.7	33.7	53.0	38.9
2013-14	700	89.7	35.5	54.2	39.6
2014-15	700	90.2	36.1	54.0	40.1
2015-16	750	98.9	44.7	54.2	45.2
2016-17	850	104.8	45.7	59.1	43.6
2017-18	850	85.9	33.6	52.3	39.1
2018-19	850	98.1	39.4	58.7	40.2
2019-20	900	96.2	39.0	57.2	40.5
<i>Latest change</i>		<i>-1.9%</i>	<i>-1.0%</i>	<i>-2.6%</i>	<i>+0.3pp</i>

Source: NHS Digital using Her Majesty's Revenue and Customs data.

pp: percentage point change.

EER: expenses to earnings ratio

Gender Pay

- 10.30 Data from NHS Digital shows that incomes of GDPs in England, Scotland, Wales and Northern Ireland varied by gender. In 2019-20 female providing-performer and associate dentists earned less than their male counterparts in each country. Female providing-performer GDPs earned 26 per cent less than their male colleagues in Northern Ireland, 19 per cent less in England, 17 per cent less in Scotland, and 3 per cent less in Wales. In Scotland and Wales the differences had narrowed from 2018-19, by 10 percentage points and 8 percentage points respectively. In England the difference had widened from 2018-19 by 1 percentage point, with little change in Northern Ireland.
- 10.31 For associate GDPs, female GDPs earned 31 per cent less than male colleagues in Northern Ireland, 27 per cent in England, and 23 per cent in both Scotland and Wales. In Scotland and Northern Ireland the differences had narrowed from 2018-19 by 1 percentage point and 7 percentage points respectively. In England and Wales the differences widened from 2018-19 by 1 percentage point and 7 percentage points respectively.

Contract reform

England

- 10.32 DHSC said that the prototype contract reform programme that had been in place since 2016 did not represent a model that could be rolled out across the country for a number of reasons. They said that these included 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, and that the programme would come to a close in March 2022. They said that vital learning and data gained from the prototype programme would be incorporated into plans for future reform. They said that the next phase of contract reform would focus on what improvements could be made under the current system and would aim to make changes that can be implemented in the next 12 months, before looking at developing new proposals with a view to agreeing a mandate for negotiations in 2023-24.
- 10.33 The BDA said that it was a matter of profound regret that a model that was well-liked by dentists and patients and was developed on the basis of advice from leading figures in the field had now been abandoned. They said that it was disturbing that one of the aims of contract reform was to remain under current budgets, since a significant proportion of the public did not receive funded NHS care under current arrangements. They said that their current focus was on working with DHSC and NHSE/I on what improvements can be made under the current arrangements in the coming months.

Scotland

- 10.34 The Scottish Government said that the Cabinet Secretary wrote to the profession in October 2021, setting out that dental services needed to recover and stabilise in the medium term before sectoral reforms were considered, in particular in light of the manifesto commitment to remove patient charges.
- 10.35 The BDA said that there was widespread recognition that the current fee-per-item model was not sustainable for NHS dentistry. They said that they expected the Scottish Government would develop proposals for long-term contract reform during 2022-23.

Wales

- 10.36 The Welsh Government said that the pandemic had led to a pause in progress to increase participation in the contract reform programme to more than 50 per cent of practices, but the pandemic had led to some aspects of the reform programme, including collecting oral health risk and need of patients treated data, being implemented for all practices. They said that the pandemic had not altered the vision for contract reform.
- 10.37 The BDA said that Welsh Government's approach to reform was based on a recognition of the inappropriateness of the UDA and the intention to move away from UDA targets as the contractual measure. However, they stressed that reforms were taking place from within a fixed budget so funding for any new initiatives would come from that previously earmarked for existing patients.

Northern Ireland

- 10.38 DoH said that the Northern Ireland GDS contract had been largely unchanged since the 1990s and it remains the long-term goal to develop and implement a new contract for GDPs, orthodontists and primary care oral surgeons in Northern Ireland. They said that they were initially looking at a capitation-based model, but given pandemic-related care backlogs, a period where the focus is on activity may be necessary before making such a change.
- 10.39 The BDA said that it had taken so long for the previous pilot programme to be evaluated that its findings were no longer of any relevance. They also said that the political situation in Northern Ireland meant that reforms may take longer than might otherwise be the case, which was frustrating.

Expenses and formula

- 10.40 Since 2015 the DDRB has made recommendations on uplifts in pay net of expenses. The 2015 DDRB Report explained that this decision was taken on the basis that the parties were unable to provide them with evidence on income and expenses to the required level of robustness and detail, and recommended that the parties should determine how to deliver the recommended uplift through the annual contract negotiation process. Taking this approach required the parties to discuss expenses to agree a gross increase to overall contract values.
- 10.41 In their remit letter for this year's pay round, DHSC asked us to make recommendations on the pay element of dental contracts only, while the other three remit letters were silent on the matter. In their written evidence, the BDA said that the DDRB should use HMRC data to make a recommendation on expenses, and cited survey data that described a number of expense categories, including consumables, wages and staff costs, utility expenses and clinical waste management, and said that the majority of dentists had observed an increase in those costs compared to before the pandemic.

Community Dental Services/Public Dental Service

- 10.42 The Community Dental Services (CDS) in England, Wales and Northern Ireland and the Public Dental Service (PDS) in Scotland, provide general dental care to people who cannot access care through independent contractor GDPs. This includes those with particular dental needs, including vulnerable groups. DHSC said that the majority of CDS dentists are salaried and are usually managed as NHS Trust employees, and salaried primary care dentists have their own nationally agreed pay, terms and conditions but where applicable, CDS dentists may also have their pay, terms and conditions aligned to other medical staff such as consultants, dependent on their post, grade or seniority. In some locations in England, CDS are provided by private providers. CDS are commissioned by NHSE/I in England. In Scotland, Wales and Northern Ireland, PDS/CDS are provided by Health Boards/Trusts.

England

- 10.43 DHSC said that NHSE/I commission CDS in line with local needs assessments. NHSE/I said that they were not aware of providers having difficulty filling any vacancies.
- 10.44 NHS Employers said that they had surveyed a small group of CDS employers on issues concerning recruitment, retention and morale. They said that the sample size limited the extent to which broad conclusions may be drawn but did provide a snapshot. They said everyone they spoke to reported difficulties in recruiting salaried dentists, with some facing shortages in all grades, and some respondents citing difficulties recruiting to Band A roles, as the salary was insufficient to tempt dentists away from working in practices. Others said that insufficient numbers were progressing through training pathways to fill senior roles. They also said that most respondents reported that retention was less of an issue, but work pressures, including the potential for burnout, was having an effect.
- 10.45 The BDA said that the headcount number of dentists working in the CDS had declined in the last few years. They said that operating procedures during the pandemic meant that CDS dentists had difficulty prioritising within their patient load. They also said that the proportion of CDS dentists surveyed who said that their workload was high or very high increased from 74 to 82 per cent between 2020 and 2021. They also said that stress levels were higher.
- 10.46 NHS Staff Survey data for England for salaried primary care dentists was available from 2018 onwards. In 2021, 48 per cent of dentists were satisfied with their pay, a decrease from 51 per cent in 2020. The results for 2021 were less positive than for consultants, but more positive than those for SAS doctors and dentists and doctors and dentists in training. The results for female dentists, 51 per cent of whom were satisfied with pay, were more positive than for male dentists, 43 per cent of whom were satisfied with pay. There were differences between rates of satisfaction with pay between ethnic groups. 37 per cent of Asian/Asian British dentists were satisfied with pay, compared with 59 per cent of dentists with mixed ethnicity, 52 per cent of White dentists, and 29 per cent of dentists from other ethnic groups.

Scotland

- 10.47 The BDA said that they surveyed PDS dentists in late 2021, and found significant concerns about morale, conditions and capacity within the service. They said that most had said that their job satisfaction had decreased compared to the previous year, and most also rated their morale as low or very low. They said that only 51 per cent said that they planned to continue practicing as a community dentist.

Wales

- 10.48 The Welsh Government told us that their latest data, from March 2020, indicated that the FTE size of the CDS workforce in Wales fell by 3.3 to 104.1 during the previous year. They said that programmes to promote the oral health of children and older people living in care homes would resume during the latter part of 2021-22 as CDS staff return to their usual roles after having played an important role in providing urgent dental services during the pandemic.
- 10.49 The BDA said that they were concerned that a lack of data on the state of the CDS in Wales, and that it was therefore difficult to present formal evidence on the impact of the pandemic on the CDS and their patients.

Northern Ireland

- 10.50 The BDA said that significant numbers of the most experienced CDS dentists in Northern Ireland were approaching retirement, with up to 40 per cent potentially retiring by 2025. They also said that CDS dentists in Northern Ireland were suffering from low morale. They also asked that CDS placements for dental foundation trainees be reintroduced in Northern Ireland, as this could demystify the service, and contribute towards its long-term sustainability.

Our comments

- 10.51 We welcome that financial support continues to be provided to practices in order to help them respond to the demands of the pandemic, and we also acknowledge the need for such support to be structured in such a way that supports levels of activity and throughput to increase back towards pre-pandemic levels. However, given the concerns raised by the BDA, we would stress that practices must remain financially viable, in order for NHS/HSC dentistry to be sustainable in the long-term. We note that DHSC said that they did not expect there to be an increase in clawback in England as a result of the raised activity targets, but the BDA said that they expected there to be a significant increase.
- 10.52 Even before the pandemic, the increases to clawback were a concern; more than 5 per cent of contract values in England had been lost to dentistry as a result of clawback, and we would expect this to both impact and be impacted by issues of recruitment and retention. At the same time, high levels of clawback represent significant amounts of commissioned care not being delivered, which is likely to cause issues of access to dental care. This clearly has a bearing on the sustainability and viability of dental practices in England and Wales and we would welcome hearing more about this from the parties in evidence next year.

- 10.53 We are also concerned about trends in dental earnings, which may factor into recruitment and retention issues and changed workforce dynamics and aspirations. Whilst compositional and working hours factors, including changing levels of private work, may play a role in earnings trends, it appears as though dental earnings have not risen in a manner commensurate with pay uplifts across the UK in the long term.
- 10.54 We would welcome greater understanding of this trend from the parties, including the extent to which earnings trends can be associated with trends in the relative amounts of private and NHS/HSC work done by dentists. We note the BDA have said that a cause of this was that expenses uplifts have not been sufficient to protect take-home pay for NHS/HSC work for providing-performers and associates. This was also a message that we heard during our visits programme, where we heard from practice-owners and associates who said that practices could not afford to uplift associate or other practice staff pay, despite our recommendations and the necessity of doing so from a recruitment and retention perspective.
- 10.55 In this context, we note that DHSC told us that it remained up to practice owners whether to uplift associate pay. They noted that figures from the National Association of Specialist Dental Accountants & Lawyers (NASDAL), who analysed a sample of practices, said that average net profit per providing-performer for the practices they categorise as NHS practices in 2020-21 financial year was higher than for those they categorise as private practices, and that associate average remuneration fell during this period². However, we would also note that NASDAL themselves said that they expected these figures to fall back in 2021-22, and that these figures were still lower in cash terms than they were in 2010, for both providing-performers and associates alike.
- 10.56 We stopped making recommendations on expenses in 2015, and instead expect that expenses uplifts will be agreed between the BDA and the governments as part of annual contract negotiations. Expenses uplifts must address issues such as increased operating and practice staff costs, which fall under practice expenses. We note that performing this exercise this year remains difficult, as levels of activity are difficult to compare year-on-year given the changing levels of activity that have been possible as a result of the pandemic-related disruption to dentistry, and also because of current high levels of inflation and the difficulties in recruiting practice staff described by the BDA. In this context, we note with concern what the BDA highlighted to us in oral evidence, when they quoted what the Northern Ireland Department of Health said in a document sent out to dentists in March 2022³. This said that they expected that ‘fluctuations in operating costs ... will be taken into account in the next publication of the DDRB report’.

² <https://nasdal.org.uk/assets/press-releases/NASDAL%20Annual%20Benchmarking%20Statistics%20-%20Pandemic%20Figures%2014-03-22.pdf>

³ https://hscbusiness.hscni.net/pdf/GDS_RSS-FAQs-V1_110322.pdf, paragraph 17

- 10.57 We would reiterate that our recommendations this year are net of expenses and therefore do not take into account fluctuations in operating costs. Ensuring that dental practices' financial sustainability and dental earnings are not affected by such fluctuations is an important responsibility that lies with the governments, in agreeing expenses uplifts. We also note that DHSC said that they would typically use CPI as a starting point for setting expenses uplifts.
- 10.58 Typical dental remuneration arrangements contain an inherent tension between the interests of providing-performers and associates, relating to pay and pay uplifts. This tension is felt particularly acutely when overall practice uplifts, incorporating the pay uplift that we make recommendations for and the expenses uplift, are not sufficient to enable both providing-performers and associates to receive the pay uplift. It therefore remains our view that expenses uplifts must be sufficient to both deliver dental services and protect dental incomes, ensuring that our pay recommendations are received by providing-performers and associates alike, in order that they can address issues of recruitment, retention and motivation. We are also including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs, had we continued to use the formula-based approach.
- 10.59 Addressing this issue may also be related to addressing gender pay gaps in dentistry. We noted last year that the Gender Pay Gap in Medicine Review's finding that the unstructured way that pay was determined for salaried GMPs exacerbated gender pay gaps was likely to be replicated with respect to associate dentists across the UK. This situation will only be made more acute by a financial climate for practices that makes it harder to apply pay uplifts for associates consistently, and potential localised workforce shortages.
- 10.60 We are also concerned about the state of recruitment and retention in CDS/PDS. We acknowledge that NHSE/I have said that they are not aware of any issues of recruitment and retention in the CDS in England, but NHS Employers' findings suggest that there may be some difficulties. We also note the BDA's position in relation to the CDS/PDS across the UK. We would expect the governments to do more to understand the current state of their CDS/PDS workforces and respond appropriately, again potentially as part of wider workforce planning efforts. The CDS/PDS are a small but important part of health services, and if their workforces were to deteriorate, it would lead to some of the most vulnerable members of society failing to receive critical treatment. This would in turn lead to greater demands on other parts of health services, undermining any short-term financial benefits. We would also welcome health service leaders in England examining the impact of the part-privatisation of the CDS, to understand the impact of this on services, recruitment and retention and pay, terms and conditions.

Long-term issues in dentistry

- 10.61 We are increasingly concerned about access to NHS/HSC dentistry. We are aware that all parties accept there are at least localised issues of access to NHS dentistry, though once again the scale of these issues has been disputed by the parties. We would also again wish to draw parties' attention to Public Health England's March 2021 paper *Inequalities in oral health in England*⁴, which found that oral health behaviours and outcomes were significantly worse amongst those from lower socio-economic backgrounds and from more deprived geographical areas. We also note recent media reports that NHS/HSC dentistry is becoming harder and harder to access⁵. We consider that these findings are likely to apply similarly across the UK. We would welcome hearing more from the parties about what can be done to maintain access to NHS/HSC dentistry, either through the commissioning system in England as described by NHSE/I or via other incentives or initiatives across the UK. From what we have heard, there seems to be a consensus amongst the parties that enough dentists are being trained, but the BDA have also reported that practices are facing difficulties recruiting associates, with those difficulties felt most acutely by practices that primarily do NHS/HSC work. This may be related to the concerning workforce numbers outlined above, which showed a significant fall in the number of dentists providing NHS/HSC dentistry. We would also stress that timely access to NHS/HSC dentistry will ultimately make wider NHS/HSC services more efficient, easier to manage and more financially sustainable; patients would be able to have dental issues addressed before they become more complex and engage with other parts of the system.
- 10.62 This may also be related to what we have heard about falling working hours and changing career aspirations amongst dentists, with younger dentists no longer wishing to become NHS/HSC providing-performers, and instead wishing to work fewer hours and/or do more private work. Current dental systems have also been developed on the basis that NHS/HSC care ought to be delivered by practices owned by partnerships of providing-performers. If the composition of the dental workforce fundamentally changes, then there may be a number of consequences for dental services. For example, dentists who no longer aspire to running an NHS/HSC practice may instead seek career progression through other means, including doing more private work. This would ultimately mean that the same cohort of dentists would, in aggregate, offer less NHS/HSC dentistry than might otherwise be the case. We would stress the necessity of the governments doing more to understand and address these trends, potentially as part of wider workforce planning efforts, which could include the possibility of increasing future dental school intakes as necessary.

⁴ Public Health England (19 March 2021). *Inequalities in oral health in England*. Available at: <https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england>

⁵ See, for example, <https://www.bbc.co.uk/news/uk-england-humber-61384597> and <https://www.thetimes.co.uk/article/nine-out-of-ten-nhs-dental-practices-in-england-closed-to-new-routine-patients-dm0qjxqx5>

- 10.63 While it is not our role to offer a view on contractual structures, or advocate for or against contractual solutions, we note that the basic contractual structure in England and Wales in particular, where contracts are let subject to a competitive bidding process, can lead to practices' profits being squeezed, making it more challenging for pay uplifts to be received by providing-performers and associates alike. Practices operating on thin margins may also face challenges in delivering their activity targets, leading to clawback and further challenges to practice financial viability and sustainability, ultimately leading to patients receiving poorer care. This situation would be further exacerbated when expenses uplifts are insufficient.
- 10.64 Like last year, we are frustrated that contract reform has not been progressing more quickly. We acknowledge there is a tension between the short-term need to boost throughput to help address pandemic-related care backlogs, and the stated longer-term aim of health services across the UK to shift to more preventive models of care. However, reformed contracts have the potential to improve care, whilst delivering a boost to recruitment, retention and motivation, including by reaffirming the attractiveness of providing NHS/HSC care to dentists who may otherwise be considering increasing the amount of private work they do, or leaving dentistry entirely. Contract reform would also present an opportunity to reconsider the incentives the remuneration models place on dentists and practices. We expect to hear of significant progress being made in the coming year.

CHAPTER 11: PAY RECOMMENDATIONS AND OBSERVATIONS

Introduction

11.1 In this chapter we discuss our recommendations on the main pay uplift for our remit group. We also comment on the case for differential awards, and address the requests made by some of the parties that we make recommendations for groups currently covered by multi-year pay deals.

Pay proposals

11.2 In their written evidence, DHSC said that in setting the NHS budget, the Government had assumed a headline pay award of 2 per cent for NHS staff, taking into account the multi-year deals that were already in place, and that higher pay rises than what was affordable would lead to a reduced ability to expand clinical capacity and tackle the elective care backlog. They also told us that the fixed resources available under the multi-year contract deal in place for contractor GMPs were sufficient for a recommendation of 2.1 per cent for salaried GMPs.

11.3 The Scottish Government said that it would be necessary for us to consider the affordability of our recommendations within the confines of the Scottish Public Sector Pay Policy (SPSPP). Its key features this year were:

- a guaranteed wage floor of £10.50 per hour, going beyond the current real Living Wage of £9.90
- A guaranteed cash underpin of £775 for public sector workers who earn £25,000 or less
- A basic pay increase of up to £700 for those public sector workers earning between £25,000 and £40,000
- A cash uplift of £500 for public sector workers earning above £40,000
- Allowing flexibilities for employers to use up to 0.5 per cent of pay bill savings on baseline salaries in 2022 to address clearly-evidenced equality or pay coherence issues

11.4 They said that the SPSPP equated to a 2 per cent investment into pay bills across the public sector, but that this investment was intended to be more concentrated towards the lower end of the earnings distribution.

11.5 The Welsh Government did not present us with a pay proposal or an affordability figure but stressed to us that there were ongoing financial pressures on the NHS in Wales. They also said that health budgets had been set in the autumn of 2021, taking into account the levels of inflation that were forecast at the time.

11.6 The Department of Health (Northern Ireland) also did not provide us with a pay proposal or an affordability figure.

- 11.7 The BMA asked us to recommend a pay award of RPI plus 2 per cent, as an initial step towards closing the real-terms pay erosion that doctors have faced over the last decade that they described.
- 11.8 The BDA asked that we recommend a pay increase of dental inflation plus three per cent, and that we recommend an increase for community dentists of RPI plus 3 per cent. They said that they would wish us to use either the 1 April RPI figure, or the latest RPI figure at the time we finalise our recommendations, as a proxy for dental inflation.
- 11.9 HCSA asked that we make a recommendation of a baseline rise of at least RPI plus the costs of any national insurance rise for all groups, along with a meaningful additional uplift to address what they described as the erosion of pay for doctors at every grade.

Our comments on the pay proposals

- 11.10 We note the difficulties of the current economic situation; most pertinently the steep rises to inflation that have taken place over the last 12 months and continuing economic uncertainty that has seen economic growth estimates for 2022-23 revised substantially in recent weeks. At the same time, pay settlements have started to show significant growth, but at the time of writing are some way below inflation, although it is not yet clear if they will remain this far below inflation in the coming months. We discuss these indicators in more detail in Chapter 2.
- 11.11 As we discuss in Chapter 3, we view the affordability figure provided to us by DHSC and the Scottish Public Sector Pay Policy as important contextual factors rather than strict limits on what our recommendations can be. Given the way that funding is disbursed to the devolved governments through the Barnett formula, the general similarities between health systems across the UK, and the absence of compelling evidence from the governments in Wales and Northern Ireland to the contrary, we view the affordability situations there as similar to England and Scotland.

Our recommendations

- 11.12 Our recommendations are made in line with our terms of reference, including in particular our considerations of recruitment, retention and motivation alongside the pay and affordability proposals put to us by the parties.

- 11.13 We observe that in the wider economy, pay settlements have increased, and the latest data, for April 2022, has that medians are now at 3.7 per cent according to IDR¹ and 4.0 per cent according to XpertHR², well above the 2 per cent affordability figure provided to us by DHSC, but demonstrating that employers across the economy are not matching current high levels of inflation with their pay awards. We do not believe that doctors and dentists should necessarily be exceptionally shielded from the increases to the cost of living faced by the wider population this year. We also do not agree with the trade unions' use of RPI as the principal measure of inflation, nor that it should necessarily be used as a proxy for dental inflation, as the BDA advocates. Dental inflation as a concept seems to us also to be more suited to an expenses uplift, as opposed to pay, which is what our recommendations cover this year.
- 11.14 We recognise the considerable challenges and pressures being put on health budgets, though as we describe in Chapter 3, we are also concerned that a pay award that is too low would have negative budgetary implications related to poor motivation and increases to temporary staffing spend, amongst other things.
- 11.15 We note that health services remain under considerable strain, as a result of the continuing impact of the pandemic, and the care backlogs that were worsened as a result of pandemic-related disruption. Addressing the backlogs whilst dealing with ever-growing demand for services requires a workforce that is sufficiently large and engaged. It is therefore more essential than ever that staff are retained and motivated to perform.
- 11.16 The major recruitment and retention indicators that are included across our report, including vacancy rates, turnover and retirements, have not yet seen the significant deterioration that many of the parties have warned about. However, multiple parties expressed to us concern that this could still take place in the coming months. At the same time, a longer-term context of workforce shortages and high demand remains, which saw measures including vacancy rates at challengingly high levels even prior to the pandemic. These issues have also not yet been adequately addressed in workforce planning for the long-term.
- 11.17 Trends in workforce behaviour, including an increase in flexible and less-than-full-time working, affect workforce capacity across our remit group even in the absence of increases in the number leaving the NHS/HSC or retiring. Across the remit group, interest in senior, leadership and contractor roles, including leadership positions in hospitals and partner GMP status, seems to be waning, alongside the more general shift to less-than-full-time working. This may be driven by issues of workload, work-life balance and, for more senior staff, pensions and pensions tax issues. However, regardless of the cause, a decrease in average working hours necessitates a higher absolute number of staff to deliver the same quantity of services, providing a significant challenge to recruitment and retention, and warranting a further re-examination of workforce demand.

¹ <https://www.incomesdataresearch.co.uk/resources/viewpoint/median-pay-award-climbs-to-37>

² <https://www.xperthr.co.uk/indicators/pay-awards/16100/>

- 11.18 In general medical practice, despite increases in the size of training intakes, the effective size of the workforce seems not to be growing sufficiently quickly, once working hours are taken into account. Despite welcome increases in the use of non-medical clinical staff, general practice services seem to be trapped in a self-fulfilling cycle of higher workloads negatively impacting retention and average working hours, which in turn makes workload pressures more severe for the staff that remain.
- 11.19 Dentists are also facing a number of difficult challenges, which all parties now agree have resulted in at least localised issues of access to NHS/HSC dentistry. Parties have said that the cause of this relates to workforce supply, to some extent, as well as to the profitability of NHS/HSC dentistry and contract structures that are no longer fit for purpose. As we discuss in Chapter 10, this has the potential to severely impact oral health in some of the most deprived areas in the UK. We also note that the BDA have said that these challenges have been exacerbated by expenses uplifts that have not been sufficient to protect dental incomes. In addition, they said that increasing numbers of younger dentists wish to do less NHS/HSC work and more private work.
- 11.20 At the same time the key staff survey results that are available to us, including the NHS Staff Survey and the Dental Working Hours Motivation and Morale Survey, suggest severe and urgent challenges to motivation in general, with NHS Staff Survey results in England declining substantially on every measure, including significant falls in pay satisfaction.
- 11.21 Many of these issues are not directly solvable with higher pay awards. However, pay does serve as an important signifier of value and, perhaps more importantly, if it is sensed to be deficient, can exacerbate a feeling amongst the medical and dental workforce that they are neglected and undervalued. This can in turn make staff feel they no longer wish to put in the additional discretionary effort on which the NHS/HSC depends, or that they no longer want to work full-time, or that it is no longer worth staying in the NHS/HSC at all. In order to address this, a pay award is required that is significantly in excess of the 2 per cent proposed to us by DHSC, and the sums proposed to us under the SPSP. However, this must also be balanced against the financial challenges being faced by health services.
- 11.22 The backdrop to this year's round has been particularly challenging. In making our recommendations, we have balanced the need to ensure that they are affordable and represent an effective use of finite resources to support patient care, with the critical need to ensure that doctors and dentists feel that their vital role in our society is properly respected and that they are treated fairly relative to earnings growth among similar professionals. The issues of recruitment, retention and motivation are central to our recommendations and our view is that pay and reward must be maintained at a level that can, over the long term, retain existing staff and attract high-calibre people into the NHS and HSC.

11.23 Therefore, we recommend a 4.5 per cent increase to national salary scales, pay ranges or the pay element of contracts for all groups included in our remit letters from the governments for this year, namely:

- Consultants
- SAS doctors and dentists in Scotland, as well as those who do not move onto the reformed contracts in England, Wales and Northern Ireland
- Doctors and dentists in training in Scotland, Wales and Northern Ireland
- Independent contractor GMPs in Scotland, Wales and Northern Ireland
- Salaried GMPs
- The GMP trainers' grant and GMP appraisers' grant
- Independent contractor GDPs
- Associate and salaried GDPs including Community Dental Services/ Public Dental Service practitioners
- Doctors and dentists employed by Trusts and Health Boards on locally-determined contracts

These uplifts should be backdated to 1 April 2022 as necessary so that they would be paid in full for the 2022-23 financial year.

11.24 These recommendations are made considering the evidence we received, reflecting the need to recruit, retain and motivate staff, while also considering affordability, in line with our terms of reference. As we discuss in Chapter 3, decisions about how to fund pay awards across our remit group, whether through increases to departmental budgets, or to fund them from existing budgets, are a political choice that sits with Ministers. These dynamics also apply to general medical and dental practices, for whom we would expect appropriate funding arrangements to be made so that these recommendations can be passed on to salaried GMPs and associate GDPs.

11.25 We estimate that this recommendation would add approximately £425 million to the HCHS pay bill in England, against a total DHSC Resource Departmental Expenditure Limit in 2022-23 of £167.9 billion. We estimate that it would add approximately £77 million to the pay bill in Scotland, £52 million to the pay bill in Wales, and £26 million to the pay bill in Northern Ireland.

Consultant reward

11.26 Last year, we discussed our significant concerns about the equity and effectiveness of the Clinical Excellence Awards (CEAs) schemes, as well as the Commitment Awards, Distinction Awards and Discretionary Points systems for consultants, and did not make a recommendation that they be uplifted alongside basic pay.

- 11.27 We welcome the progress that has been made towards the development and implementation of the new National Clinical Impact Awards scheme that covers England and Wales, and in the coming year we expect to see evidence of progress towards improving the equity and effectiveness of the scheme, compared to the previous National Clinical Excellence Awards scheme. We also note that DHSC asked us not to make recommendations that their value be increased during the first year of the new scheme's operation.
- 11.28 However, we note with concern the lack of progress towards improving the rest of the schemes in place across the UK. As we discuss in Chapter 8, issues of equity and effectiveness for these schemes remain across the UK. The Gender Pay Gap in Medicine Review's findings in relation to these schemes in England further strengthened the case for reform. **Given our concerns, we once again are not making a recommendation that the value of these awards be uplifted this year.** We are concerned, however, that a continuing freeze in the overall value of consultant reward schemes will gradually lead to the schemes' overall value deteriorating relative to the overall consultant pay bill. This could lead to the schemes, which we continue to regard as being important to retaining the most senior and capable consultants, being less effective even as necessary reforms are completed.

Locally-employed doctors and dentists

- 11.29 In Chapter 7 we discuss the evidence provided to us by some of the parties on locally-employed doctors and dentists (LEDs). While LEDs are by definition not on pay scales or ranges that are uplifted when our recommendations are implemented, for the avoidance of doubt we would stress that under our terms of reference they are included in our overall remit, and we would expect that employers would uplift their pay in line with our overall recommendations. Were this not to be the case, this is likely to affect recruitment, retention and motivation for this important and large group of doctors and dentists and would also potentially have pay equality implications. We would welcome hearing more from the parties about this in next year's report.

Targeting

- 11.30 Elsewhere in this report, we discuss specialty- and geography-based issues of recruitment and retention, and the potential for these to exacerbate regional health inequalities. We remain supportive of the exploration of the effectiveness of geographic or specialty targeting of pay in order to address localised issues of recruitment and retention. We note that while there are financial incentives in place for various parts of the workforce, none of the remit letters mentioned targeting and we did not receive this year any specific proposals around targeting on which we were asked to comment.
- 11.31 We also considered the case for more specific recommendations targeted at particular groups within our remit.

11.32 We remain particularly concerned about the trends in remuneration, recruitment and retention, and motivation and morale amongst general dental practitioners. In particular, we note what the BDA told us about stagnant pay amongst GPs being caused, at least to some extent, by inadequate expenses uplifts. As we discuss in more detail in Chapter 10, our recommendations are made net of expenses. This means that we expect that the governments and the BDA can agree on an expenses uplift that is sufficient to protect take-home pay for providing-performers and associates alike. Given these concerns, we would expect the governments to provide a comprehensive rationale for the expenses uplifts that they apply to dental contracts in evidence for next year's report.

Multi-year pay agreements

11.33 For this year, the remit letters for England, Wales and Northern Ireland again did not ask us to make recommendations for the three groups currently under multi-year pay deals (MYDs) – contractor GMPs in England, doctors and dentists in training in England, and SAS doctors and dentists who are employed on the reformed Specialty Doctor and Specialist contracts in England, Wales and Northern Ireland. However, the BMA asked us in written evidence to make recommendations for all groups of doctors this year, and HCSA similarly asked us to make recommendations for doctors in training and SAS doctors.

11.34 In our last report we stressed that, for those for whom we were not asked to make recommendations, recognising their contribution during the pandemic period and responding to the impact of the pandemic on recruitment, retention and motivation was as important as it was for other groups in our remit. We note that the UK Government's announcement that the 2021 Report's recommendations would be implemented did not make reference to this ask, and additional reward has not been made available on this basis in England, Wales or Northern Ireland. However, the Welsh Government did guarantee that SAS doctors and dentists who moved onto the new contracts would not see their pay fall as a result of doing so, introducing what they referred to as 'pay continuity arrangements'.

11.35 In oral evidence, DHSC stressed to us that they felt it was an important principle that they should not apply additional pay uplifts for those on MYDs, since doing this would set a precedent that MYDs can be revisited, thereby undermining employer-side confidence in agreeing MYDs. We recognise this perspective, but we were disappointed that no action was ultimately taken.

11.36 The recruitment, retention and motivation concerns that we outlined in our discussion of the overall recommendations apply as much to those who are under MYDs as to those who are not. Indeed, some of the concerns, including declining pay satisfaction amongst doctors and dentists in training in England and recruitment and retention within the GMP workforce, are particularly acutely felt in the workforce groups under MYDs.

- 11.37 At the same time, we note that all three of the MYDs were agreed before the scale of increases to inflation became apparent, and therefore it cannot be said that they address those increases to inflation. Our wider recommendations this year do not seek to match inflation, but they have been informed by it to some extent, and also by the increases to pay settlements in the wider economy that the inflation increases have precipitated.
- 11.38 DHSC also said to us in oral evidence that it was important that there was not differentiation between different groups of doctors and dentists, and said that their 2 per cent affordability figure was linked to the 2 per cent basic pay increases that underpin the MYDs. However, as a result of our concerns about recruitment, retention and motivation, we are making a basic pay recommendation that is 2.5 per cent higher than this.
- 11.39 Therefore, if action is not taken for those under MYDs, then the relative pay positions of different groups within our overall remit will diverge significantly. We are concerned that doctors and dentists under MYDs would therefore see their pay falling relative to their peers as a result of their having agreed to a MYD. This would have a significant effect on motivation, affecting retention, productivity, and ultimately patient care.
- 11.40 All of the groups under MYDs also face critical recruitment, retention and motivation challenges in their own right. While we regret that the BMA did not provide us with evidence for doctors and dentists in training in England, we are aware that they have faced severe pandemic-related disruption to their training and maintaining the pipeline of doctors and dentists into more senior grades during the recovery period will require challenges to motivation and retention, such as trainees' experiences of the training system that we discuss in Chapter 6, to be addressed. During the pandemic, they were also redeployed to front-line services in greater numbers than other groups. We also remain particularly concerned about the potential impact of falling average working hours amongst doctors and dentists in training on workforce availability in the long-term.
- 11.41 Were action not to be taken, uptake of the reformed SAS contracts is again likely to be impacted; the financial incentive to remain on the old contract is likely to be further strengthened. This would significantly undermine the intention that the new SAS contracts would improve the profile and attractiveness of the grade, and offer greater progression, harming the ability of contract reforms, which we welcome, to address long-term issues of recruitment and retention in this group. We would again emphasise that the actions of the Welsh Government last year showed that it is possible to take an innovative approach that can ensure the success of contract reform.
- 11.42 In Chapter 9, we discuss a number of challenges specific to recruitment and retention in the general practice workforce. We are concerned that workload and motivation issues are pushing down average working hours, which is ultimately affecting access to GMP services.
- 11.43 We are therefore extremely concerned that the uplifts contained within the MYDs are likely not sufficient to address the issues of recruitment, retention and motivation that we discuss elsewhere in the report.

- 11.44 Our view remains that our terms of reference instruct us to set out our independent views and enable us to make recommendations for any part of our remit group as we consider appropriate. However, at the same time, it is crucial that we operate with the consensual agreement of all of the parties. We also would generally wish to respect the MYDs that have been agreed between the governments and trade unions, which in normal circumstances we would expect to be sustained in the face of small changes to inflation and the economic context.
- 11.45 Therefore, we are not making a formal recommendation for the groups under MYDs this year. However, we would strongly urge the governments to consider the unique economic and workforce context, the need to protect the relative pay position of staff on MYDs, and the issues of recruitment, retention and motivation outlined above, and work with the trade unions to take action to address these issues. We would also wish to stress the harm that may be caused to recruitment, retention and motivation by not acting. Given the exceptional and unusual nature of the current year, we do not believe that the governments taking action would set the kind of precedent that DHSC told us about. In fact, a lack of action would set a different precedent, that workforce groups under MYDs should not expect there to be an appropriate response to exceptional changes to the economic and wider context, should they take place during the period that a MYD is active. This would make entering a MYD less attractive to staff, which would affect the governments' ability to agree contract reforms in future.
- 11.46 We are concerned that, should the governments not act, the issues of recruitment, retention and motivation that we outline above would not be addressed. The pay positions of groups within our remit will also significantly shift relative to each other. In particular, this would lead to distorted financial incentives resulting from some pay scales being uplifted by significantly more than others. For example, those considering re-entering the workforce via the SAS grades in England, Wales or Northern Ireland, who must do so on the new contracts, may be dissuaded by being paid less than their peers on the old contracts. Similarly, those considering taking on contractor GMP roles in England may be put off from doing so given the smaller uplift that they would receive. Doctors and dentists in training in England may also look to take on locum work rather than substantive training posts. This is likely to further exacerbate the challenges that services face, including making it harder and more expensive for care backlogs to be addressed. At the same time, there will also be significant geographic distortions, given none of the MYDs operate across the whole of the UK.

- 11.47 The disagreements between the parties over what should be in the scope of our recommendations have placed us in a difficult position in making recommendations for this year's round. This difficulty has been exacerbated by the MYD agreements themselves, which we are not a signatory to, failing to present a mutually coherent picture of our continuing role during their lifespan. While we would again reiterate the importance that we place on our operating with the consent of all parties, we would expect that, in agreeing MYDs in the future, governments and unions would ensure that future agreements would be clearer, more consistent and more coherent with respect to this issue, perhaps including reopener clauses, as has been done with MYDs across the public sector in the past.
- 11.48 Next year, the MYD for doctors and dentists in training in England will have come to an end, and we expect to be asked for recommendations by the UK Government for this group as usual. However, the MYDs for SAS doctors and dentists in England, Wales and Northern Ireland, and for contractor GMPs in England, will be in their final year. We would request that all parties, including the governments, provide us with full evidence on these groups next year, to enable us to consider the case for recommendations. We would also expect the governments to provide us with a full and detailed rationale for whatever action they took for those under MYDs, especially if they choose not to act.

CHAPTER 12: LOOKING FORWARD

Introduction

12.1 In this final chapter we look ahead to some of the challenges facing our remit group, as well as some of the key developments that are likely to be important to our consideration of recruitment, retention and motivation in the coming years. We also discuss some of the things we would wish to see covered in the parties' evidence submissions for next year's report.

Out 51st Report 2023

12.2 As we discuss in Chapter 1, we expect that following the receipt of remit letters and the setting of evidence deadlines, all the parties will provide us with written evidence in a timely manner, which would enable our report to be prepared and submitted at an earlier point in the year than has been the case in the last few years.

12.3 We would also welcome a more general shift towards our process being completed prior to the start of the financial year, though this is dependent on us receiving remit letters significantly earlier than has been the case in recent years, and also on the parties submitting evidence in line with earlier deadlines than the one set this year.

The coming year

Wider context

12.4 During the coming months, we would expect to see further developments related to the pandemic, the response to it, and its aftermath. In particular, we would expect to see and hear more about the scale of increases to care backlogs caused by pandemic-related disruption to care, as well as any progress towards addressing and reducing waiting lists.

12.5 We would also expect the recent economic shifts to continue, with uncertainty relating to the changing geopolitical situation and other factors hampering economic growth and leading to high and volatile inflation. It is not clear to what extent inflation will fall back towards the Government's 2 per cent target in the coming 12 months, but this will clearly be a crucial factor in the pay context for our remit group, as well as funding and managing health services. We would also expect there to be continued uncertainty in broader pay settlements, pay growth and the labour market.

Workforce planning and equalities

12.6 If the pandemic were to have a significant impact on the medical and dental workforces, and in particular on retention, we would expect this to be reflected in increasing vacancy rates and/or retirement statistics in the coming year.

- 12.7 We would also expect to hear more about new or updated workforce planning efforts that would seek to determine long-term workforce demand and respond to ensure that it is met, including by considering appropriate expansion to the number of medical and dental school places. Alongside this, we look forward to hearing about more progress being made in implementing the recommendations of the Gender Pay Gap in Medicine Review and in commissioning an ethnicity pay gap review in the NHS in England, as well as hearing more about efforts to address wider equalities issues including in dentistry and in our remit group in Scotland, Wales and Northern Ireland, and some exploration of equalities issues relating to other protected characteristics.

Doctors and dentists in training

- 12.8 We would expect more progress to be made in addressing the impact of the pandemic on training, and therefore on the pipeline of trainees reaching more senior roles. We would also expect progress to be made on contract reform for doctors and dentists in training in Wales.

SAS doctors and dentists

- 12.9 We also expect progress to be made towards contract reform for SAS doctors and dentists in Scotland.

Consultants

- 12.10 While the most recent round of negotiations over reforms to local CEAs in England did not lead to a proposal that will be implemented, we expect that progress will be made towards improving the equity and effectiveness of the scheme at a local level, supported by national NHS bodies including NHS Employers. We also expect new National Clinical Impact Awards to begin to be awarded in England, and to hear of progress being made towards reform of consultant reward schemes in Scotland, Wales and Northern Ireland, and we also hope to hear of progress being made towards wider consultant contract reform.

General medical practitioners

- 12.11 We expect that the larger cohorts that have entered general practice training in recent years will start to have an impact on workforce shortages, though if average working hours continue to fall, this benefit may be undermined. Given what was said in the Scottish and Welsh Government written evidence submissions, we would also expect to hear more about GMS reform in Scotland and Wales.

General dental practitioners

- 12.12 Given that all four governments have expressed their desire to reform dental contracts, we would expect significant progress to be made in dental contract reform across the UK. We would also expect that pandemic-related financial support schemes for dental practices will be wound down over the course of the upcoming year, but this should take place in a manner that does not compromise practices' financial viability or sustainability.

Future data and evidence requirements

12.13 There are also a number of areas where we would welcome additional data or evidence from the parties. This is in addition to what we would expect to receive from them in the coming year or have received from them in previous years, such as the results of annual or periodic surveys. We would generally appreciate receiving data in time series form where applicable and possible.

Chapter	Data and Evidence Requests
2	<ul style="list-style-type: none"> Data that can help us quantify the extent to which our recommendations impact inflation in the wider economy
3	<ul style="list-style-type: none"> More information about ongoing medical and dental workforce planning, in particular assessments of future workforce demand, including that may underpin assessments of potential medical and dental school expansion Delivery dates for full, costed medical and dental workforce plans Details of actions taken to reduce temporary staffing spend, particularly in Northern Ireland
4	<ul style="list-style-type: none"> More information about future workforce supply challenges, including assessments of future levels of international recruitment and how workforce supply is affected by trends in average working hours Data on reasons for leaving in Scotland, Wales and Northern Ireland, and more detailed and accurate data on reasons for leaving in England Medical and dental retirements data for Wales Explanation of the methodology used for official vacancy rates across the UK (and ideally a standardised methodology to be used) Updates on the progress of the Gender Pay Gap Review Implementation Panel More granular and intersectional data on equalities, and data on other protected characteristics including disability Progress towards ethnicity pay gap research in England, and efforts to improve understanding of other pay equality issues across the medical and dental workforces, across all protected characteristics, and across the UK Information about specific recruitment and retention challenges associated with land borders and contractual differences between different parts of the UK, and between Northern Ireland and the Republic of Ireland
5	<ul style="list-style-type: none"> Details of any action taken to address the impact of pensions tax and other pensions changes on retention, and a detailed rationale for the actions being taken. In the absence of any action, a detailed rationale for no action being taken An additional Staff Survey question about whether pensions and pensions tax have affected career decisions Staff survey results in Wales and Northern Ireland that include sufficient detail to identify doctors and dentists separately
6	<ul style="list-style-type: none"> Trends in the numbers progressing through various stages of training, and whether getting to various stages of training is taking longer than previously Postgraduate training fill rates Assessments of the impact of the pandemic on progression through training, and details of further impacts to address this Trends in average working hours for doctors and dentists in training Evaluations of the various financial initiatives in place, including flexible pay premia in England, TERS in England, Scotland and Wales and Foundation Priority Programmes in England Details of actions to improve trainee experience Update on contract reform for doctors and dentists in training in Wales Full BMA evidence on doctors and dentists in training in England
7	<ul style="list-style-type: none"> Detailed data on the trends in uptake of the new SAS contracts, separately for England, Wales and Northern Ireland Trends in the number of Specialist posts created Detailed account from the parties as to how many are on local contracts, what roles they play in hospitals, why they are on local contracts, and how their terms and conditions differ from those on national contracts Trends in average working hours for SAS doctors and dentists
8	<ul style="list-style-type: none"> Trends in the average number of Programmed Activities and Supporting Professional Activities worked (ideally disaggregated by age) Trends in the average age of retirement Update on reforms to local CEAs in England, Distinction Awards and Discretionary Points in Scotland, Commitment Awards in Wales and CEAs in Northern Ireland Detailed equalities data for the existing consultant reward schemes Full BMA evidence on consultants in England

Chapter	Data and Evidence Requests
9	<ul style="list-style-type: none"> • Numbers completing training and becoming GMPs • Trends in numbers taking on contractor roles, and evaluation of the effectiveness of reformed contracts and schemes to encourage GMPs into contractor status • Trends in working-time equivalent size of the GMP workforce, headcounts and average working hours/sessions worked, by contractor status • Average retirement date • Details of the passing on of pay awards from contractors to salaried GMPs
10	<ul style="list-style-type: none"> • The latest version of the Working Hours Survey next year • Detailed breakdown of contractual uplifts, including detailed rationales for expenses uplifts and efficiencies applied, as well as anticipated impact on providing-performer and associate earnings • An explanation of how the bidding process in place in England and Wales may affect remuneration, and identification of any checks and balances in place to ensure that bidders for dental contracts do not undermine their viability by bidding below a sustainable level • Analysis of clawback and any trends that relate to socio-economic or disease profiles of relevant patient bases, case studies of the impact of clawback on practice sustainability and account of how clawed back funds are used by the NHS • Explanation of interaction between pandemic-related practice financial support and clawback, and time series trends for clawback • Explanation for fall in the numbers working as providing-performers • Analysis of the origin, scale and severity of issues of access to dentistry, including how localised issues may or may not correlate with deprivation • Explanations of trends in recruitment and retention in the CDS/PDS

12.14 We expect the parties to work closely with the DDRB secretariat to help them respond to these requests and improve the evidence submissions they send to us in future years.

APPENDIX A: REMIT LETTERS



Department
of Health &
Social Care

*From the Rt Hon Sajid Javid MP
Secretary of State for Health and Social Care
39 Victoria Street
London
SW1H 0EU
020 7210 4850*

Mr Christopher Pilgrim
Chair, Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Level 3, Windsor House
50 Victoria Street
London
SW1H 0TL

30 November 2021

Dear Mr Pilgrim,

I should firstly like to offer my thanks for the Review Body for Doctors' and Dentists' Remuneration's work over the past year on the 2021 report and for the patience you and your members showed during the previous round. The Government appreciates the independent, expert advice and valuable contribution that the DDRB makes.

I write to you now to formally commence the 2022-2023 pay round.

As the NHS budget has already been set until 2024-2025, it is vital that planned workforce growth is affordable and within the budgets set, particularly as there is a direct relationship between pay and staff numbers.

The Government must balance the need to ensure fair pay for public sector workers while protecting funding for frontline services and ensuring affordability for taxpayers. We must ensure that the affordability of a pay award is taken into consideration to ensure that the NHS is able to recruit, retain and motivate its medical and dental workforce. As well as deliver on other key priorities, including ensuring the NHS has 50,000 more nurses by 2025 and tackling elective recovery.

The evidence that my department and NHS England and Improvement will provide in the coming months, will support you in your consideration of all these factors.

We invite you to make recommendations on an annual pay award for consultants.

As you are aware, in 2019 we reached a multi-year agreement for doctors and dentists in training (2019/20-2022/23) so the Government is not asking the DDRB to make a pay recommendation for this group. We would however, welcome your comments and observations on the evidence you receive from the Department of Health and Social Care and other parties, relating to doctors and dentists in training.

For Specialty 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 also remain subject to a five-year pay agreement between NHS England and Improvement and the BMA and therefore, the Government is not seeking recommendations for this group. We do, however, invite you to make recommendations on uplifts to the maximum and minimum of the salaried General Medical Practitioner pay scales. As ever, recommendations will need to be informed by affordability and the fixed contract resources available to practices under the five-year GP contract.

We also invite you to make recommendations on the pay element of remuneration for dentists employed by, or providing services 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 is not asking for a recommendation for this group.

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

We would welcome your reports in May 2022, subject to ongoing conversations with the Office of Manpower Economics.

I would like to thank you again for yours' and the Review Body's invaluable contribution to the pay round and look forward to receiving your 2022 report in due course.

Yours ever,



RT HON SAJID JAVID MP

FROM THE MINISTER OF HEALTH

Mr Christopher Pilgrim
Chair of the Review Body for
Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

By email



Department of
Health

An Roinn Sláinte

Mánnystrie O Poustie

www.health-ni.gov.uk

Castle Buildings
Stormont Estate
BELFAST BT4, 3SQ
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Sub-1350-2021

Date: 13th December 2021

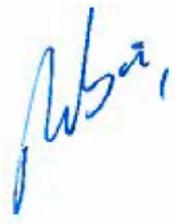
Dear Mr Pilgrim

I am writing to formally commence the 2022/23 pay round for doctors and dentists in Northern Ireland. I wish to begin by thanking the Review Body for Doctors' and Dentists Remuneration (DDRB) for its invaluable work on the 2021/22 pay round. I have accepted the recommendations of the Review Body in full.

In 16 March 2021, the Department of Finance (DoF) set out Northern Ireland's Public Sector Pay Policy for 2021/2022. In line with usual protocols, that Department's approval of the 2021/22 award has been sought, and the relevant revised pay circular will be issued to implement the uplift as soon as this has been secured.

This year we would welcome, for consideration, your recommendations on pay for all doctors and dentists working within health and social care in Northern Ireland not otherwise subject to a negotiated settlement. For doctors on SAS terms and conditions, this should include those who choose not to transfer to the new contractual arrangements. As has been noted by the Secretary of State for Health and Social Care in England, Rt Hon Sajid Javid MP, affordability and sustainability must be balanced with the need for fair pay.

Further, I would be most interested to have the views of the DDRB into wider recruitment, retention and staff motivation factors specific to health labour markets for regions, such as Northern Ireland and northern England, which have land borders across which individuals might reasonably commute.



Robin Swann
Minister of Health

Cabinet Secretary for Health and Social Care
Humza Yousaf MSP



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Mr Christopher Pilgrim (Chair)
Review Body on Doctors' and Dentists'
Remuneration
Office of Manpower Economics
8th Floor
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

By email

21 December 2021

Dear Mr Pilgrim

I am writing to formally set out The Scottish Governments remit for the Doctors' and Dentists' Review Body (DDRb) for 2022-21.

It will be necessary to consider the affordability of the recommendations from the DDRb within the confines of the Scottish Public Sector Pay Policy (SPSPP) set for 2022-23 announced in the Scottish Parliament on 9 December 2021. A copy of the draft Budget, which is subject to parliamentary approval, is available here.

The main features of the SPSPP are:

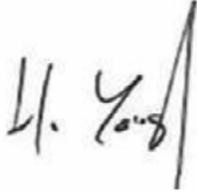
- setting a guaranteed wage floor of £10.50 per hour, going beyond the current real Living Wage rate of £9.90;
- providing a guaranteed cash underpin of £775 for public sector workers who earn £25,000 or less;
- providing a basic pay increase of up to £700 for those public sector workers earning between £25,000 to £40,000;
- providing a cash uplift of £500 for public sector workers earning above £40,000; and
- allowing flexibilities for employers to use up to 0.5 per cent of pay bill savings on baseline salaries in 2022 to address clearly evidenced equality or pay coherence issues.

Although we are seeking Recommendations from the DDRb on a pay uplift for one year only (2022-23), it will be necessary to consider these in the context of our longer term vision on:

- retention and recruitment of medical and dental staff in NHS Scotland
- increasing staff morale and ensuring staff in our health service feel valued as employees
- ensuring all medical and dental staff receive appropriate support to carry out their roles and responsibilities
- ensuring improved productivity and efficiency of our health service

Although the UK Government has entered a multi-year pay deal for General Medical Practitioners (GMPs), we would welcome your recommendations for a pay uplift for this remit group in NHS Scotland.

Copies of this letter will be sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the Staff Side and NHS Employers.

A handwritten signature in black ink, appearing to read 'H. Yousa', with a long vertical stroke extending downwards from the end of the signature.

HUMZA YOUSA

Eluned Morgan AC/AM

**Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services**



Llywodraeth Cymru
Welsh Government

Mr Christopher Pilgrim

Chair Review Body on Doctors' and Dentists' Remuneration
Level 3
Windsor House
50 Victoria Street
London
SW1H 0TL
United Kingdom

ddrb@beis.gov.uk

01 February 2022

Thank you for the DDRBs hard work and independent report and observations which have been invaluable.

I would like to take this opportunity to say I truly value the hard work and commitment of all of our dedicated healthcare workers in Wales, at all times but particularly during this challenging time.

I am now writing to formally commence the 2022-23 pay round for medical and dental staff in Wales including general medical practitioners and general dental practitioners. In this pay round I would like your advice on what would be a sufficient pay rise for staff to recognise their dedication and hard work during the pandemic and, the work they will continue to undertake in the coming year to support the recovery efforts. I am conscious that the pay award should address recruitment and retention issues to ensure the NHS recovers from the pandemic.

In addition, I am aware of the increase in national insurance contributions and cost of living increases many NHS staff will be facing this coming year given the rises in inflation and energy prices and how this impacts on take home pay.

I urge you to make a pay rise recommendation that truly recognises the commitment and hard work of our NHS staff and takes into consideration the significant cost of living increases they face. However affordability is a key issue for Welsh Government, we have to balance rewarding all our public sector within finite budgets set by UK Government and to afford substantial pay increases UK Government need to make available sufficient funding.

I would also like the DDRB to make observations on the 2003 Welsh Consultant Contract and pay in relation to how the contract and structures has impacted on equality and diversity of our workforce.

For Specialty 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.

In order to support your work, I will provide written evidence to the Pay Review Body as soon as possible and I will also plan to attend the oral evidence session in March.

I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed past April 2022.

I look forward to receiving your advice and recommendations.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'M. E. Morgan'.

Eluned Morgan AS/MS

Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

APPENDIX B: DETAILED RECOMMENDATIONS ON REMUNERATION

Appendix B1: Detailed recommendations on remuneration in England

SALARY SCALES

The salary scales that we recommend should apply from 1 April 2022 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff. These figures have been calculated by uplifting 2021-22 values by 4.5 per cent, where applicable.

Unless stated otherwise, the 2021 salary scales reflect those that were implemented from 1 April 2021.

Basic pay scales and awards

	2021 £	2022 £
Doctors and dentists in training (2016 contract)¹		
Foundation doctor – year 1	28,808	29,384
Foundation doctor – year 2	33,345	34,012
Core/Run-through training – years 1-2	39,467	40,257
Core/Run-through/Higher training – years 3-5	50,017	51,017
Run-through/Higher training – years 6+	53,077 ²	58,398
Flexible pay premia (2016 contract)¹		
General practice	8,965	9,144
Psychiatry core training	3,645	3,718
Psychiatry higher training (3 year)	3,645	3,718
Psychiatry higher training (4 year)	2,734	2,789
Academia	4,374	4,461
Histopathology	4,374	4,461
Emergency medicine/Oral & maxillofacial surgery:		
3 years	7,289	7,435
4 years	5,467	5,577
5 years	4,374	4,461
6 years	3,645	3,718
7 years	3,124	3,187
8 years	2,734	2,789

¹ 2022 award already implemented, see <https://www.nhsemployers.org/news/pay-and-conditions-circular-md-12022> Pay and Conditions Circular (M&D) 1/2022

² This pay point was increased to £56,077 from 1 October 2021, under the junior doctor contract deal.

	2021 £	2022 £
Specialty doctor (2021 contract)³		
MC75-01	45,124	50,373
MC75-02	45,124	50,373
MC75-03	49,745	50,373
MC75-04	55,790	56,906
MC75-05	55,790	56,906
MC75-06	58,756	58,756
MC75-07	62,978	64,237
MC75-08	62,978	64,237
MC75-09	62,978	64,237
MC75-10	66,614	71,654
MC75-11	66,614	71,654
MC75-12	70,249	71,654
MC75-13	70,249	75,361
MC75-14	70,249	75,361
MC75-15	73,883	75,361
MC75-16	73,883	75,361
MC75-17	73,883	75,361
MC75-18	77,519	78,759
Specialist (2021 contract)³		
MC70-01	79,894	80,693
MC70-02	79,894	80,693
MC70-03	79,894	80,693
MC70-04	85,286	86,139
MC70-05	85,286	86,139
MC70-06	85,286	86,139
MC70-07	90,677	91,584
Specialty doctor (2008 contract)		
MC46-01	42,393	44,301
MC46-02	46,017	48,088
MC46-03	50,730	53,013
MC46-04	53,255	55,651
MC46-05	56,894	59,454
MC46-06	60,519	63,242
MC46-07	60,519	63,242
MC46-08	64,225	67,115
MC46-09	64,225	67,115
MC46-10	67,933	70,990
MC46-11	67,933	70,990

³ 2022 award already implemented, see <https://www.nhsemployers.org/news/pay-and-conditions-circular-md-12022> Pay and Conditions Circular (M&D) 1/2022

	2021	2022
	£	£
MC46-12	71,640	74,864
MC46-13	71,640	74,864
MC46-14	71,640	74,864
MC46-15	75,346	78,737
MC46-16	75,346	78,737
MC46-17	75,346	78,737
MC46-18	79,054	82,611
 Associate specialist (2008 contract)		
MC41-01	59,436	62,111
MC41-02	64,215	67,105
MC41-03	68,991	72,096
MC41-04	75,299	78,687
MC41-05	80,767	84,402
MC41-06	83,035	86,772
MC41-07	83,035	86,772
MC41-08	85,995	89,865
MC41-09	85,995	89,865
MC41-10	88,955	92,958
MC41-11	88,955	92,958
MC41-12	91,915	96,051
MC41-13	91,915	96,051
MC41-14	91,915	96,051
MC41-15	94,875	99,144
MC41-16	94,875	99,144
MC41-17	94,875	99,144
MC41-18	97,838	102,241

	2021 £	2022 £
Staff grade practitioner (1997 contract, MH03/5)	39,274	41,041
	42,393	44,301
	45,509	47,557
	48,627	50,815
	51,746	54,075
	55,416	57,910
 <i>Discretionary points</i>	 <i>Notional scale</i>	
	57,981	60,590
	61,097	63,846
	64,215	67,105
	67,334	70,364
	70,450	73,620
	73,570	76,881
 Consultant (2003 contract)	 84,559	 88,364
	87,207	91,131
	89,855	93,898
	92,503	96,666
	95,144	99,425
	101,432	105,996
	107,721	112,568
	114,003	119,133
 Clinical Excellence Awards (local, granted prior to 1 April 2018):		
Level 1	3,016	3,016
Level 2	6,032	6,032
Level 3	9,048	9,048
Level 4	12,064	12,064
Level 5	15,080	15,080
Level 6	18,096	18,096
Level 7	24,128	24,128
Level 8	30,160	30,160
Level 9	36,192	36,192
 Clinical Excellence Awards (local, granted since 1 April 2018):		
Unit value	3,092	3,092

	2021 £	2022 £
Clinical Excellence Awards (national)		
Level 9 (Bronze)	36,192	36,192
Level 10 (Silver)	47,582	47,582
Level 11 (Gold)	59,477	59,477
Level 12 (Platinum)	77,320	77,320
Distinction awards for consultants		
B awards	32,601	32,601
A awards	57,048	57,048
A+ awards	77,415	77,415
Salaried general medical practitioner range		
Minimum	62,268	65,070
Maximum	93,965	98,193
General medical practitioner trainer grant	8,842	9,239
General medical practitioner appraisers fee	559	584
Dental foundation training	34,728	36,291
Dentists in training (2016 contract)¹		
Foundation dentist – year 1	28,808	29,384
Foundation dentist – year 2	33,345	34,012
Dental core training – years 1-2	39,467	40,257
Dental core & specialty training – years 3-5	50,017	51,017
Dental core & specialty training – year 6 +	56,077	58,398
Salaried primary care dental staff (2008 contract):		
Band A: Salaried dentist	43,019	44,955
	47,799	49,950
	54,969	57,443
	58,554	61,189
	62,139	64,935
	64,529	67,433

	2021 £	2022 £
Band B: Salaried dentist ⁴	66,919	69,930
	69,309	72,428
	72,894	76,174
	74,686	78,047
	76,479	79,921
	78,271	81,793
Band C: Salaried dentist ^{5,6}	80,063	83,666
	82,453	86,163
	84,843	88,661
	87,233	91,158
	89,623	93,656
	92,013	96,154
London weighting⁷		
Non-resident staff	2,162	2,162
Resident staff	602	602

⁴ The first salary point of Band B is also the extended competency point at the top of Band A.

⁵ The first salary point of Band C is also the extended competency point at the top of Band B.

⁶ The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

⁷ *Thirty-Sixth Report*. Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 1.64.

Appendix B2: Detailed recommendations on remuneration in Wales

SALARY SCALES

The salary scales that we recommend should apply from 1 April 2022 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2021 £	2022 £
Foundation house officer 1 (2015 contract)	25,563	26,713
MN13	27,159	28,381
	28,756	30,050
Foundation house officer 2 (2015 contract)	31,708	33,135
MN15	33,782	35,302
	35,854	37,467
Specialty registrar (full)	33,883	35,408
MN37	35,955	37,573
	38,851	40,599
	40,603	42,430
	42,712	44,634
	44,826	46,843
	46,938	49,050
	49,051	51,258
	51,162	53,464
	53,276	55,673

	2021	2022
	£	£
Specialty doctor (2021 contract)	45,345	50,620
MC75	45,345	50,620
	49,989	50,620
	56,061	57,182
	56,061	57,182
	58,756	58,576
	63,285	64,550
	63,285	64,550
	63,285	64,550
	66,939	72,003
	66,939	72,003
	70,593	72,003
	70,593	75,730
	70,593	75,730
	74,245	75,730
	74,245	75,730
	74,245	75,730
	77,897	79,144
Specialists (2021 contract)	79,894	80,693
MC70	85,286	86,139
	90,677	91,584
Specialty doctor	42,601	44,518
MC46	46,243	48,324
	50,979	53,273
	53,516	55,924
	57,171	59,744
	60,815	63,552
	64,538	67,442
	68,264	71,336
	71,991	75,231
	75,715	79,122
	79,440	83,015

	2021	2022
	£	£
Associate specialist (2008)	59,727	62,415
MC41	64,528	67,432
	69,328	72,448
	75,666	79,071
	81,161	84,813
	83,439	87,194
	86,415	90,304
	89,390	93,413
	92,363	96,519
	95,339	99,629
	98,315	102,739
Staff grade practitioner (1997 contract, MH03/5)	39,468	41,244
	42,601	44,518
	45,733	47,791
	48,865	51,064
	52,000	54,340
	55,130	57,611
<i>Discretionary points</i>	<i>Notional scale</i>	
	58,264	60,886
	61,396	64,159
	64,530	67,434
	67,663	70,708
	70,794	73,980
	73,928	77,255
Consultant (2003 contract)	82,356	86,062
ZM81	84,979	88,803
	89,366	93,387
	94,459	98,710
	100,278	104,791
	103,596	108,258
	106,920	111,731
Clinical Excellence Awards		
Level 9 (Bronze)	36,924	36,924
Level 10 (Silver)	48,533	48,533
Level 11 (Gold)	60,666	60,666
Level 12 (Platinum)	78,866	78,866

	2021	2022
	£	£
Commitment awards⁸	3,334	3,334
	6,668	6,668
	10,002	10,002
	13,336	13,336
	16,670	16,670
	20,004	20,004
	23,338	23,338
	26,672	26,672
Salaried general medical practitioner range:		
Minimum	63,803	66,674
Maximum	96,278	100,611
Dental foundation training	34,380	35,927
Dental core training	31,864	33,298
MN21	33,948	35,476
	36,031	37,652
	38,115	39,830
	40,198	42,007
	42,283	44,186
	44,366	46,362
Salaried primary care dental staff (2008 contract):		
Band A: Salaried dentist	43,021	44,957
	47,802	49,953
	54,972	57,446
	58,556	61,191
	62,141	64,937
	64,532	67,436
Band B: Salaried dentist ⁹	66,920	69,931
	69,311	72,430
	72,895	76,175
	74,688	78,049
	76,481	79,923
	78,273	81,795
Band C: Salaried dentist ^{10,11}	80,067	83,670
	82,456	86,167
	84,845	88,663
	87,236	91,162
	89,626	93,659
	92,015	96,156

⁸ Awarded every three years once the basic scale maximum is reached.

⁹ The first salary point of Band B is also the extended competency point at the top of Band A.

¹⁰ The first salary point of Band C is also the extended competency point at the top of Band B.

¹¹ The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

Appendix B3: Detailed recommendations on remuneration in Scotland

SALARY SCALES

The salary scales that we recommend apply from 1 April 2022 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2021 £	2022 £
Foundation house officer 1	26,462	27,653
	28,114	29,379
	29,766	31,105
Foundation house officer 2	32,822	34,299
	34,969	36,543
	37,116	38,786
Specialty registrar (full)	34,901	36,472
	37,037	38,704
	40,020	41,821
	41,823	43,705
	43,998	45,978
	46,173	48,251
	48,351	50,527
	50,526	52,800
	52,701	55,073
54,879	57,349	
Specialty doctor	43,246	45,192
	46,944	49,056
	51,751	54,080
	54,327	56,772
	58,039	60,651
	61,737	64,515
	65,517	68,465
	69,299	72,417
	73,081	76,370
76,862	80,321	
80,643	84,272	

	2021	2022
	£	£
Associate specialist (2008 contract)	60,632	63,360
	65,506	68,454
	70,378	73,545
	76,814	80,271
	82,391	86,099
	84,705	88,517
	87,725	91,673
	89,837	93,880
	92,770	96,945
	95,701	100,008
	98,635	103,074
Staff grade practitioner (1997 contract)	40,065	41,868
	43,246	45,192
	46,425	48,514
	49,605	51,837
	52,786	55,161
	56,531	59,075
<i>Discretionary points</i>		<i>Notional scale</i>
	59,147	61,809
	62,327	65,132
	65,507	68,455
	68,688	71,779
	71,868	75,102
	75,049	78,426
Consultant (2004 contract)	87,534	91,473
	89,383	93,405
	92,043	96,185
	94,705	98,967
	97,359	101,740
	103,679	108,345
	109,999	114,949
	116,313	121,547
Discretionary points for consultants	3,204	3,204
	6,408	6,408
	9,612	9,612
	12,816	12,816
	16,020	16,020
	19,224	19,224
	22,428	22,428
	25,632	25,632

	2021 £	2022 £
Distinction awards for consultants		
B awards	31,959	31,959
A awards	55,924	55,924
A+ awards	75,889	75,889
Salaried general medical practitioner range:		
Minimum	63,187	66,030
Maximum	94,311	98,555
Dental core training¹²	38,764	40,508
Dental senior house officer/Senior house officer	32,822	34,299
	34,969	36,543
	37,116	38,786
	39,262	41,029
	41,408	43,271
	43,554	45,514
	45,700	47,757
Salaried primary care dental staff (2008 contract):		
Band A: Dental officer	44,315	46,309
	49,241	51,457
	56,626	59,174
	60,318	63,032
	64,011	66,891
	66,473	69,464
Band B: Senior dental officer	68,934	72,036
	71,396	74,609
	75,089	78,468
	76,936	80,398
	78,783	82,328
	80,629	84,257
Band C: Assistant clinical director	82,475	86,186
	84,937	88,759
	87,399	91,332
Band C: Specialist dental officer	82,475	86,186
	84,937	88,759
	87,399	91,332
	88,980	92,984

¹² On completion of Core training employees will move to the nearest point on or above their existing salary on the Dental senior house officer scale.

	2021	2022
	£	£
Band C: Clinical director/Chief administrative dental officers	82,475	86,186
	84,937	88,759
	87,399	91,332
	88,980	92,984
	91,371	95,483
	93,761	97,980

Appendix B4: Detailed recommendations on remuneration in Northern Ireland

SALARY SCALES

The salary scales that we recommend apply from 1 April 2022 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2021 £	2022 £
Foundation house officer 1	25,563	26,713
M220	27,159	28,381
	28,752	30,046
Foundation house officer 2	31,706	33,133
M230	33,778	35,298
	35,853	37,466
Specialty registrar (full)	33,880	35,405
M241	35,955	37,573
	38,849	40,597
	40,601	42,428
	42,712	44,634
	44,825	46,842
	46,938	49,050
	49,049	51,256
	51,161	53,463
	53,273	55,670
Specialty doctor (2021 contract)	45,344	50,485
	45,344	50,485
	49,985	50,485
	56,061	56,850
	56,061	56,850
	58,756	58,576
	63,285	64,150
	63,285	64,150
	63,285	64,150
	66,937	71,550
	66,937	71,550
	70,590	71,550
	70,590	75,430
	70,590	75,430
	74,243	75,430
	74,243	75,430
	74,243	75,430

	2021	2022
	£	£
	77,895	79,000
Specialists (2021 contract)	79,894	80,693
	85,286	86,139
	90,677	91,584
Specialty doctor	42,598	44,515
M215	46,242	48,323
	50,976	53,270
	53,514	55,922
	57,171	59,744
	60,814	63,551
	64,538	67,442
	68,263	71,335
	71,988	75,227
	75,713	79,120
	79,438	83,013
Associate specialist (2008 contract)	59,725	62,413
M090	64,527	67,431
	69,326	72,446
	75,665	79,070
	81,158	84,810
	83,438	87,193
	86,413	90,302
	89,388	93,410
	92,362	96,518
	95,335	99,625
	98,314	102,738
Staff grade practitioner	39,466	41,242
(1997 contract)	42,597	44,514
M211/12	45,730	47,788
	48,865	51,064
	51,997	54,337
	55,686	58,192
<i>Discretionary points</i>	<i>Notional scale</i>	
	58,262	60,884
	61,394	64,157
	64,528	67,432
	67,660	70,705
	70,793	73,979
	73,928	77,255

	2021	2022
	£	£
Consultant (2004 contract)	84,975	88,799
M400	87,637	91,581
	90,299	94,362
	92,958	97,141
	95,611	99,913
	101,933	106,520
	108,253	113,124
	114,567	119,723
Clinical Excellence Awards (local):		
Step 1	2,957	2,957
Step 2	5,914	5,914
Step 3	8,871	8,871
Step 4	11,828	11,828
Step 5	14,785	14,785
Step 6	17,742	17,742
Step 7	23,656	23,656
Step 8	29,570	29,570
Clinical Excellence Awards (national):		
Step 9	35,484	35,484
Step 10	46,644	46,644
Step 11	58,305	58,305
Step 12	75,796	75,796
Salaried general medical practitioner range:		
Minimum	63,170	66,013
Maximum	95,325	99,615
Salaried primary care dental staff:		
Band 1: Salaried dentist	39,485	41,262
	42,679	44,600
	45,872	47,936
	49,068	51,276
	52,262	54,614
	55,455	57,950
	58,651	61,290
	61,845	64,628
Band 2: Senior salaried dentist	56,423	58,962
	60,889	63,629
	65,353	68,294
	69,817	72,959
	74,283	77,626
	73,076	75,268
	74,031	76,252

	2021 £	2022 £
Band 3: Assistant clinical director salaried dentist	74,976	78,350
	76,136	79,562
	77,294	80,772
	78,456	81,987
	79,615	83,198
	80,776	84,411
Band 4: Clinical director salaried dentist	74,976	78,350
	76,136	79,562
	77,294	80,772
	78,456	81,987
	79,615	83,198
	80,776	84,411
	81,937	85,624
	83,118	86,858
	84,278	88,071
	85,438	89,283

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN PUBLIC HEALTH SERVICES IN THE UK¹

ENGLAND ²	2020		2021		Percentage change 2020-2021	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff						
Consultants	50,786	54,218	52,381	55,946	3.1%	3.2%
Associate specialists	1,901	2,126	1,863	2,083	-2.0%	-2.0%
Specialty doctors	7,510	8,648	7,971	9,115	6.1%	5.4%
Staff grades	303	344	322	358	6.3%	4.1%
Specialty registrar	32,801	34,241	33,660	35,142	2.6%	2.6%
Foundation doctor year 2	6,123	6,171	6,247	6,292	2.0%	2.0%
Foundation doctor year 1	6,398	6,424	6,624	6,658	3.5%	3.6%
Core training	14,974	15,261	16,834	17,153	12.4%	12.4%
Hospital practitioners/Clinical assistants	542	1,661	588	1,698	8.4%	2.2%
Other staff	820	1,313	830	1,346	1.2%	2.5%
Total	122,157	129,972	127,319	135,341	4.2%	4.1%
General medical practitioners³						
GMP partners	17,641	20,363	17,059	19,876	-3.3%	-2.4%
GMP registrars	7,454	7,558	8,576	8,664	15.1%	14.6%
GMP retainers ⁴	228	576	254	640	11.4%	11.1%
Salaried GMPs	9,133	14,257	9,752	15,267	6.8%	7.1%
General dental practitioners^{5,6}		24,684		23,733		-3.9%
Providing performers		4,863		4,682		-3.7%
Associates		19,781		19,026		-3.8%
Unknown		40		25		-37.5%
Total general practitioners		67,300		67,903		0.9%
Total general practitioners Total – NHS doctors and dentists		197,272		203,244		3.0%

¹ An employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.

² Data as 30 September unless otherwise indicated.

³ Data excludes locums.

⁴ GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

⁵ This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms.

⁶ Data as at 31 March of that year.

WALES ⁷	2020		2021		Percentage change 2020-2021	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff⁸						
Consultants	2,725	2,925	2,813	3,033	3.2%	3.6%
Associate specialists	187	212	170	194	-8.7%	-9.3%
Specialty doctors and dentists	615	703	692	781	12.6%	10.0%
Staff grades	3	4	3	3	-1.6%	-33.3%
Specialist registrars	2,559	2,695	2,648	2,881	3.5%	6.5%
Foundation house officers 2	572	598	609	632	6.5%	5.4%
Foundation house officers 1	469	500	505	536	7.6%	6.7%
Other staff	81	185	64	166	-21.0%	-11.4%
Total	7,211	7,822	7,505	8,226	4.1%	4.9%
General medical practitioners		2,369		2,492		4.9%
GMP providers		1,963		2,038		3.7%
General practice specialty registrars		382		426		10.3%
GMP retainers		24		28		14.3%
General dental practitioners⁹		1,472		1,389		-6.0%
General Dental Services only		1,205		1,129		-6.7%
Personal Dental Services only		72		60		-20.0%
Trust-led Dental Services contracts		71		48		-47.9%
Mixed		124		152		18.4%
Total general practitioners		3,841		3,881		1.0%
Total – NHS doctors and dentists		11,663		12,107		3.7%

⁷ Data as at 30 September unless otherwise specified.

⁸ Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.

⁹ Data as of 31 March that year.

SCOTLAND ¹⁰		2020		2021		Percentage change 2020-2021	
Hospital and Community Health Services Medical Staff	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount	
Consultants	5,702	6,188	5,902	6,442	3.5%	4.1%	
Specialty doctors and dentists	940	1,219	932	1,195	-0.9%	-2.0%	
Registrar group	4,546	4,761	4,550	4,825	0.1%	1.3%	
Foundation house officers 2 ¹¹	1,022	1,061	983	1,025	-3.8%	-3.4%	
Foundation house officers 1 ¹²	1,022	1,075	1,114	1,174	9.0%	9.2%	
Other staff	1,180	1,781	1,357	2,030	15.0%	14.0%	
Total	14,411	15,924	14,837	16,495	3.0%	3.6%	
General medical practitioners		5,121		5,195		1.4%	
Performers (partners)		3,333		3,311		-0.7%	
Registrar/Specialist trainee		634		639		0.8%	
Retainers ¹³		64		64		0.0%	
Salaried		1,113		1,204		8.2%	
General dental practitioners (non-hospital)¹⁴		3,345		3,207		-4.1%	
General Dental Service		3,081		2,945		-4.4%	
Public Dental Service		367		375		2.2%	
Total general practitioners		8,466		8,402		-0.8%	
Total – NHS doctors and dentists		24,390		24,897		2.1%	

¹⁰ Data as 30 September of that year.

¹¹ Includes senior dental officers.

¹² Includes dental officers.

¹³ GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

¹⁴ Includes salaried, community and public dental service dentists.

NORTHERN IRELAND ¹⁵	2020		2021		Percentage change 2020-2021	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff^{16,17}						
Consultant	1,804	1,919	1,885	2,006	4.5%	4.5%
Associate Specialist/Specialty Doctor/ Staff Grade	527	612	541	627	2.7%	2.5%
Specialty/Specialist Registrar	1,469	1,532	1,547	1,615	5.4%	5.4%
Foundation doctor	539	542	547	552	1.5%	5.8%
Other ¹⁸	164	320	296	451	79.7%	40.9%
Total	4,503	4,925	4,816	5,251	7.0%	6.6%
General medical practitioners¹⁹		1,364		1,410		3.4%
GMP principal		1,163		1,181		1.5%
GMP salaried		179		205		14.5%
GMP retainers		22		24		9.1%
General dental practitioners²⁰		1,147		1,142		-0.4%
Total general practitioners		2,511		2,552		1.6%
Total – NHS doctors and dentists		7,436		7,803		4.9%

¹⁵ As at 30 September unless otherwise specified.

¹⁶ Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.

¹⁷ As at March that year.

¹⁸ Due to changes the collection of staff groups, the 'other' category is not consistent across year groups and should not be compared with previous years.

¹⁹ Data as at 31 March that year.

²⁰ Data as at 31 March that year.

APPENDIX D: GLOSSARY OF TERMS

ADVISORY NON-DEPARTMENTAL PUBLIC BODY – a body whose function is to provide advice to government and which has a role in the processes of national government but is not a government department or part of one, and which accordingly operates to a greater or lesser extent at arm's length from ministers.

AGENDA FOR CHANGE – the pay system used for all NHS/HSC staff except for doctors, dentists and senior managers.

ASSOCIATE DENTISTS– self-employed dentists who enter into a contractual arrangement, that is neither partnership nor employment, with principal dentists. Associates pay a fee for the use of facilities, the amount generally being based on a proportion of the fees earned; the practice owner provides services, including surgery facilities and staff to the associate. They are typically referred to in England and Wales as performer-only dentists. See also *performer-only dentists*.

BARNETT FORMULA – a formula used by HM Treasury to allocate funding to the devolved governments in Scotland, Wales and Northern Ireland, based on the funding allocated to public services in England, England and Wales or Great Britain, as appropriate.

BASIC PAY – the annual salary without any allowances or additional payments.

BRITISH DENTAL ASSOCIATION (BDA) – A trade union that represents all groups of dentists across the UK.

BRITISH MEDICAL ASSOCIATION (BMA) – A trade union that represents all groups of doctors across the UK.

CERTIFICATE OF COMPLETION OF TRAINING (CCT) – A CCT confirms a doctor has completed an approved UK postgraduate medical training programme and is eligible for entry onto the Specialist Register or GP Register, thereby becoming eligible for consultant or GMP roles. CCTs are issued by the GMC.

CERTIFICATE OF ELIGIBILITY FOR SPECIALIST REGISTRATION (CESR) – An alternative to the CCT for doctors who have not completed a GMC-approved programme of training but who can show they have knowledge, skills and experience equivalent to the approved curriculum for their specialty.

CLINICAL EXCELLENCE AWARDS (CEAs) –payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. There are two schemes currently open to new entrants, Local CEAs and National CEAs, a CEA scheme in Northern Ireland is now closed to new entrants. See also *Local CEAs*, *National CEAs*.

COMMITMENT AWARDS – a reward scheme for consultants in Wales, Commitment Awards are paid every three years after reaching the maximum of the pay scale. There are eight levels of Commitment Awards. Commitment Awards replaced Discretionary Points in October 2003. See also *Discretionary Points*.

COMMITMENT PAYMENTS (SCOTLAND) – paid quarterly to dentists who carry out NHS General Dental Services and who meet the criteria for payment.

COMMUNITY DENTAL SERVICES – See *Salaried Dentists*

COMPARATOR PROFESSIONS – groups identified as comparator professions to those in the DDRB remit groups are: legal, tax and accounting, actuarial, higher education, pharmaceutical and veterinary.

CONTRACTOR GMP/PARTNER GMP – A GMP who hold a contract with the NHS/HSC to provide GP services to the public. Contractor GMPs are typically partners in a practice owned by multiple GMPs.

CORPORATE DENTAL PROVIDERS – both providing-performer/principal and performer-only/associate dentists are able to incorporate their business and become a director and/or employee of a limited company (Dental Body Corporate). For providing-performer/principal dentists, the business tends to be a dental practice. For performer-only/associate dentists, the business is the service they provide as a sub-contractor.

COVID-19 (CORONAVIRUS)- an infectious disease that can affect the lungs and airways. This is caused by a newly-discovered coronavirus (a family of viruses) which is referred to as COVID-19 and was discovered in 2019. This virus that causes the disease is referred to as SARS-CoV-2. The outbreak of COVID-19 was declared a pandemic by the World Health Organisation in March 2020, and in this report, the term **PANDEMIC** is generally used to refer to the COVID-19 pandemic.

DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC) – the department of the UK Government responsible for funding and overseeing the NHS in England.

DEPARTMENT OF HEALTH (NORTHERN IRELAND) (DoH) – the department of the Northern Ireland Executive responsible for funding and overseeing Health and Social Care (HSC) services in Northern Ireland.

DISCRETIONARY POINTS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by local Clinical Excellence Awards in England and Northern Ireland, and Commitment Awards in Wales, but remain in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Discretionary Points are pensionable. See also *Clinical Excellence Awards, Commitment Awards, Distinction Awards*.

DISTINCTION AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by national Clinical Excellence Awards in England, Wales and Northern Ireland, but remain in Scotland, though the scheme is closed to new entrants. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable. See also *Clinical Excellence Awards, Discretionary Points*.

EXPENSES TO EARNINGS RATIO (EER) – the percentage of earnings spent on expenses rather than income by a general medical practitioner or a general dental practitioner.

FLEXIBLE PAY PREMIUM – Additional payments made to doctors and dentists in GP practice placements and recognised hard-to-fill training programmes.

FOUNDATION DOCTOR/FOUNDATION HOUSE OFFICER – a trainee doctor undertaking a **FOUNDATION PROGRAMME**, a (normally) two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. ‘F1’ refers to a trainee doctor in the first year of the programme; ‘F2’ refers to a doctor in the second year.

FOUNDATION PROGRAMME – See *Foundation Doctor/Foundation House Officer*

FOUNDATION SCHOOL – a group of institutions bringing together medical schools, the local deanery, trusts and other organisations such as hospices. They aim to offer training to foundation doctors in a range of different settings and clinical environments and are administered by a central staff supported by the deanery.

GENDER PAY GAP – the difference in average pay rates for men and women, as a percentage of men’s earnings.

GENDER PAY GAP IN MEDICINE REVIEW – the independent review, led by Professor Dame Jane Dacre, was commissioned by the Department of Health and Social Care in April 2018 to advise on action to improve gender equality in the NHS. Its report, *Mend the Gap*, was published in November 2020.

GENERAL DENTAL PRACTITIONER – a qualified dental practitioner, registered with the General Dental Council.

GENERAL DENTAL SERVICES CONTRACT (GDS) – the standard national contract under which dental services are commissioned and delivered. Different versions of the GDS are used in England, Scotland, Wales and Northern Ireland.

GENERAL MEDICAL COUNCIL – A public body that maintains the medical register – the list of doctors who are registered to practice in the UK.

GENERAL MEDICAL PRACTITIONER (GMP) – more commonly known as a GP, a GMP works in primary care and specialises in family medicine. See also *Contractor GMP/Partner GMP* and *Salaried GMP*

GENERAL MEDICAL SERVICES CONTRACT – one of the types of contracts primary care organisations can have with primary care providers. It is a mechanism for providing funding to individual general medical practices, which includes a basic payment for every patient, and further payments for specified quality measures and outcomes.

GENERAL PRACTITIONER (GP) – See *General Medical Practitioner*

GMP RETAINER – a general medical practitioner, who provides service sessions in general practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

GMP TRAINER – a general medical practitioner, other than a general practice specialty registrar, who is approved by the General Medical Council for the purposes of providing training a general practice specialty registrar.

GUARDIAN OF SAFE WORKING HOURS (GoSWH) – an individual appointed by an NHS Trust In England whose role is ensure the safeguards outlined in the terms and conditions for doctors and dentists in training are adhered to, to ensure safe and effective care.

HEALTH EDUCATION ENGLAND – an Arm’s Length Body of DHSC that funds and manages the NHS’s workforce training systems, including the medical and dental training systems.

HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS) STAFF – A collective term for the hospital medical and dental workforce, including consultants; doctors and dentists in training; SAS doctors and dentists; and others (including those on locally-determined contracts). General medical practitioners, general dental practitioners and ophthalmic medical practitioners that practice in primary care are excluded from this category.

HOSPITAL CONSULTANTS AND SPECIALISTS ASSOCIATION (HCSA) – A trade union that represents hospital doctors across the UK.

LOCAL CEAs – A reward scheme for NHS consultants and academic GMPs in England. Administered locally by employers, payments are temporary and non-pensionable, under arrangements that will expire in 2022. Some consultants continue to receive pensionable, consolidated payments under the former Local CEA scheme, that was replaced in 2018.

LOCALLY-EMPLOYED DOCTORS AND DENTISTS – Doctors and dentists directly employed by NHS/HSC Trusts or Health Boards, but not on the national contracts for consultants, SAS doctors and dentists, doctors and dentists in training or salaried dentists. Instead, they are employed on locally-determined contracts that are generally agreed on an individual basis.

NATIONAL CEAs – A reward scheme for NHS consultants and academic GMPs in England and Wales. Administered by the ACCEA, there are four levels of award, bronze, silver, gold and platinum. Awards are consolidated and pensionable. The scheme will be replaced by the new National Clinical Impact Award scheme, under which awards will no longer be pensionable or consolidated, but more awards will be made, in 2022.

NATIONAL CLINICAL IMPACT AWARDS (NCIAs) – See *National CEAs*

NHS EMPLOYERS – a national employers’ body that represents NHS Trusts in England.

NHS ENGLAND AND IMPROVEMENT (NHSE/I) – an Arm’s Length Body of DHSC responsible for funding and commissioning NHS services, and overseeing NHS Trusts in England.

NHS LONG TERM PLAN – a document published by NHS England and Improvement, which sets out its priorities for healthcare in England over the 10 years from its publication in January 2019. The plan builds on the policy platform laid out in the NHS Five Year Forward View, which articulated the need to integrate care to meet the needs of a changing population.

NHS PROVIDERS – a membership organisation for NHS acute, ambulance, community and mental health Trusts in England.

OFFICE OF MANPOWER ECONOMICS (OME) – The Office of Manpower Economics is a part of the Department of Business, Energy and Industrial Strategy. Its sole function is to provide an independent secretariat to the 8 Pay Review Bodies, including the DDRB.

PANDEMIC – see *COVID-19*

PARTNER GMP – see *Contractor GMP*

PERFORMER-ONLY DENTISTS (ENGLAND AND WALES) – performer-only dentists deliver NHS dental services but do not hold a contract with the NHS in their own right. They are typically subcontracted to deliver dental services to the public by a providing-performer or by a corporate dental provider. The equivalent in Scotland and Northern Ireland is associate dentist. See also *associate dentists*.

PRINCIPAL DENTISTS (SCOTLAND AND NORTHERN IRELAND) – dental practitioners who are practice owners, practice directors or practice partners, have an arrangement with an NHS board, and provide General Dental Services. The equivalent in England and Wales is providing-performer dentists. See also *providing-performer dentists*.

PROGRAMMED ACTIVITIES (PAs) – under the 2003 contract, consultants have to agree the numbers of programmed activities they will work to carry out direct clinical care; a similar arrangement exists for specialty doctors and associate specialists on the 2008 contracts. Each programmed activity is four hours, or three hours in ‘premium time’, which is defined as between 7 pm and 7 am during the week, or any time at weekends. A full-time consultant typically does 10 PAs, but some do more. A number of PAs are dedicated to **SUPPORTING PROFESSIONAL ACTIVITIES**, during which time consultants carry out training, continuing professional development, job planning, appraisal and research.

PROVIDING-PERFORMER DENTISTS (ENGLAND AND WALES) – dentists who hold a contract with a primary care organisation and also perform NHS dentistry on this or another contract. The equivalent in Scotland and Northern Ireland is principal dentists. See also *principal dentists*.

PUBLIC DENTAL SERVICE – See *Salaried Dentists*

ROYAL COLLEGES – Organisations that set standards for the way that doctors are educated, trained and monitored. They are typically arranged around specialties. See *specialty*.

SALARIED DENTISTS – provide generalist and specialist care, largely for vulnerable groups. They often provide specialist care outside the hospital setting to many who might not otherwise receive NHS dental care as part of the Community Dental Services in England, Wales and Northern Ireland, and the Public Dental Service in Scotland.

SALARIED GMPs – general medical practitioners who are employed by either a primary care organisation or a practice, typically under a nationally agreed model contract.

SAS CHARTER – A document that sets out the support available to SAS doctors and what they can expect from their employers. It includes recommendations around contracts, job planning, development, involvement in organisational structures and recruitment.

SAS GRADES – *see staff grade, associate specialists, specialist and specialty doctors and dentists.*

SPECIALTY – Specialties are divisions of clinical work which may be defined by body systems (dermatology), age (paediatrics), clinical technology (nuclear medicine), clinical function (rheumatology), group of diseases (oncology) or combinations of these factors. Hospital doctors and dentists typically choose one specialty to train and work in.

STAFF GRADE, ASSOCIATE SPECIALISTS, SPECIALIST AND SPECIALTY GRADE DOCTORS AND DENTISTS/SAS GRADES – This group of hospital doctors and dentists comprises specialty doctors and dentists, associate specialists, staff grades, clinical assistants, hospital practitioners and specialists. Roles in the SAS grades do not require the completion of training, but doctors and dentists undertaking them are also not actively seeking to complete training. All but the specialty grade and, in England, Wales and Northern Ireland, the specialist grade, are closed to new entrants.

SUPPORTING PROFESSIONAL ACTIVITIES – *see programmed activities.*

TARGETED ENHANCED RECRUITMENT SCHEME – A scheme under which GMP trainees in certain hard-to-fill locations receive a payment of £20,000 that is refundable under certain circumstances.

UNIT OF DENTAL ACTIVITY (UDA) – the technical term used in the NHS dental contract system regulations in England and Wales to describe weighted courses of treatment. The UOA is an equivalent figure used for orthodontic treatments.

UNIT OF ORTHODONTIC ACTIVITY (UOA) – *see Unit of Dental Activity.*

VOLUNTARY EARLY RETIREMENT (VER) – Refers to clinicians who elect to receive their pension ahead of the normal retirement age defined by their pension scheme.

WE ARE THE NHS: PEOPLE PLAN FOR 2020-21 – a document published by NHSE/I which sets out actions that will be taken by NHSE/I and HEE over 2020-21 to address workforce challenges.

WORKFORCE DISABILITY EQUALITY STANDARD – a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan. Year-on-year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

WORKFORCE RACE EQUALITY STANDARD – a requirement for NHS commissioners and healthcare providers under the NHS standard contract, under which NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

APPENDIX E: THE DATA HISTORICALLY USED IN OUR FORMULAE-BASED DECISIONS FOR INDEPENDENT CONTRACTOR GMPs AND GDPs

- E.1 This appendix supports Chapters 9 and 10 and gives the latest data that would have populated the formulae for both GMPs and GDPs, had we used the formulae-based approach (Table E.1).
- E.2 Whilst we are not making formula-based recommendations for independent contractor GMPs and GDPs, we set out below in Table E.1 the data that would have populated the formulae. Given our ongoing concerns with the reliability of the formula, we do not consider it appropriate this year to adjust the weightings of the coefficients in the formula. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work: as noted in our 2012 report, average earnings and expenses for dentists reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound. The parties may wish to consider this point as part of their discussion of expenses and the uplift.

Table E.1: Data historically used in our formulae-based decisions for independent contractor GMPs and GDPs

Coefficient	Value
Income (GMPs) <i>DDRb recommendation</i>	4.5%
Staff costs (GMPs) <i>Annual Survey of Hours and Earnings (ASHE) 2021 (general medical practice activities)</i>	4.2%
Other costs (GMPs) <i>Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2021</i>	7.0%
Income (GDPs) <i>DDRb recommendation</i>	4.5%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland <i>ASHE 2021 (dental practice activities)</i>	8.6%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland <i>RPIX for Q4 2021</i>	7.0%
Materials (GDPs) England, Scotland, Wales, Northern Ireland <i>RPIX for Q4 2021</i>	7.0%
Other costs (GDPs) England, Wales, Northern Ireland <i>Retail Prices Index (RPI) for Q4 2021</i>	6.9%
Other costs (GDPs) Scotland <i>RPIX for Q4 2021</i>	7.0%

Sources: Annual Survey of Hours and Earnings (Table 16.5a, all, median), Consumer Price Inflation Time Series (CDKQ, CZBH).

APPENDIX F: ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CA	Commitment Award
CCT	Certificate of Completion of Training
CDS	Community Dental Services
CEA	Clinical Excellence Award
CESR	Certificate of Eligibility for Specialist Registration
CPI	Consumer Prices Index
CPIH	Consumer Prices Index including owner occupiers' housing costs
COVID-19	Coronavirus disease 2019
CT 1-3	Core training, years 1-3
DA	Distinction Award
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSC	Department of Health and Social Care (England)
DoH	Department of Health (Northern Ireland)
DP	Discretionary Point
EEA	European Economic Area
EER	Expenses to earnings ratio
EU	European Union
F1	Foundation Year 1
F2	Foundation Year 2
FPP	Flexible Pay Premium
FTE	Full-Time Equivalent
GAD	Government Actuary's Department
GDP	General Dental Practitioner
GDS	General Dental Services contract
GMC	General Medical Council
GMP	General Medical Practitioner
GMS	General Medical Services
GP	General Practitioner
GPG	Gender Pay Gap

HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association
HEE	Health Education England
HMRC	Her Majesty's Revenue and Customs
HMT/HM Treasury	Her Majesty's Treasury
HSC	Health and Social Care (Northern Ireland)
IDR	Incomes Data Research
IPC	Infection Prevention and Control
LED	Locally Employed Doctor or Dentist
LTFT	Less-Than-Full-Time
LTP	NHS Long Term Plan
MERP	Medical Education Reform Programme
NCIA	National Clinical Impact Award
NES	NHS Education for Scotland
NHS	National Health Service
NHSE/I	NHS England and Improvement
NHSPRB	NHS Pay Review Body
OBR	Office for Budget Responsibility
OME	Office of Manpower Economics
ONS	Office for National Statistics
OOPP	Out Of Programme Pause
PDS	Public Dental Service
RPI	Retail Prices Index
SAS	Staff grade, associate specialist, specialist and specialty doctors and dentists
SPSPP	Scottish Public Sector Pay Policy
ST1-9	Specialist Training, years 1-9
TERS	Targeted Enhanced Recruitment Scheme
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity
UOA	Unit of Orthodontic Activity
UK	United Kingdom
VER	Voluntary Early Retirement
WRES	Workforce Race Equality Standard
WTE	Whole-Time Equivalent/Working-Time Equivalent

APPENDIX G: PREVIOUS DDRB RECOMMENDATIONS AND THE GOVERNMENTS' RESPONSES

The main DDRB recommendations since 1990 for the general pay uplift are shown in the table below, together with the November or Quarter 4 RPI and CPI inflation figures, which were until 2014 the latest figures available at the time of publishing the Review Body's report and the Governments' responses to the recommendations as a whole. Since 2014, the latest quarterly RPI and CPI inflation figures at the time the report has been submitted has been included.

Report year	Main Uplift	RPI % (Nov) ¹	CPI % (Nov) ²	Response to report
1990	9.5%	7.3	5.5	Not accepted. Rejected increases at top of consultants' scale and in the size of the A+ distinction award; staged implementation
1991	9.5% to 11%	10.9	7.8	Accepted, but staged implementation
1992	5.5% to 8.5%	3.7	7.1	Accepted
1993		3.6	2.6	No report following Government's decision to impose a 1.5% pay limit on the public sector
1994	3%	1.4	2.3	Accepted
1995	2.5% to 3%	2.4	1.8	Accepted
1996	3.8% to 6.8%	3.2	2.8	Accepted, but staged implementation
1997	3.7% to 4.1%	2.7	2.6	Accepted, but staged implementation
1998	4.2% to 5.2%	3.7	1.9	Accepted, but staged implementation
1999	3.5%	3.1	1.4	Accepted
2000	3.3%	1.2	1.2	Accepted
2001	3.9%	3.1	1.1	Accepted, but Government suspended the operation of the balancing mechanism (which recovers GMPs 'debt')
2002	3.6% to 4.6%	0.9	0.8	Accepted
2003	3.225%	2.6*	1.5	Accepted
2004	2.5% to 2.9%	2.5	1.3	Accepted
2005	3.0% to 3.4%	3.4**	1.5	Accepted
2006	2.2% to 3.0%	2.2**	2.1	Accepted, although consultants' pay award of 2.2 per cent was staged – 1.0 per cent paid from 1 April 2006 and the remaining 1.2 per cent paid from 1 November 2006
2007	£1,000 on all pay points***	3.9	2.7	Accepted, although Scottish Executive did not implement one of the smaller recommendations relating to the pot of money for distinction awards to cover newly eligible senior academic GMPs. England and Wales chose to stage awards in excess of 1.5 per cent – 1.5 per cent from 1 April 2007, the balance from 1 November 2007
2008	2.2% to 3.4%	4.3	2.1	Accepted
2009	1.5%	3.0****	4.1	Accepted
2010	0% to 1.5%	0.3	1.9	Mostly accepted: DDRB recommended: 0% for consultants and independent contractor GMPs and GDPs; 1% for registrars, SAS grades, salaried GMPs and salaried dentists; and 1.5% for FHOs. England and Northern Ireland both restricted the FHO recommendation to 1%.
2011	No recommendation due to public sector pay freeze	4.7	3.3	

¹ At November in the previous year, series CZBH

² At November in the previous year, series D7G7

Report year	Main Uplift	RPI % (Nov) ¹	CPI % (Nov) ²	Response to report
2012	No recommendation due to public sector pay freeze	5.2	4.8	
2013	1%	3	2.7	Accepted
2014	1%	2.6 (Q4 figure)	2.1 Q4	Accepted in Scotland. Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales. Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales.
2015	1%	1.9 Q4	0.9 Q4	Recommendation only applied to independent contractor GMPs and GDPs in the UK and for salaried hospital staff in Scotland Accepted
2016	1%	1.0 Q4	0.1 Q4	Accepted
2017	1%	2.2 Q4	1.2 Q4	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland
2018	2%	3.7 Q1#	2.7 Q1#	Staged and abated in England. Accepted in Wales and Northern Ireland. Accepted in Scotland, except for staff earning at least £80,000 who received £1,600.
2019	2.5%	2.5 Q1#	1.9 Q1#	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards. Additional 1% for SAS not implemented anywhere.
2020	2.8%	2.6 Q1#	1.7 Q1#	Accepted
2021	3%	1.4 Q1#	0.6 Q1#	Accepted
2022	4.5%	8.4 Q1#	6.2 Q1#	

* Due to the late running of the round, DDRB was also able to take account of the March figures for RPI (3.1%)

** Due to a later round, November to February, DDRB was also able to take into account the December RPI figure

*** £650 on the pay points for doctors and dentists in training. The average banding multiplier for juniors meant that this would also deliver approximately £1,000

**** DDRB also took into account the December RPI figure (0.9%)

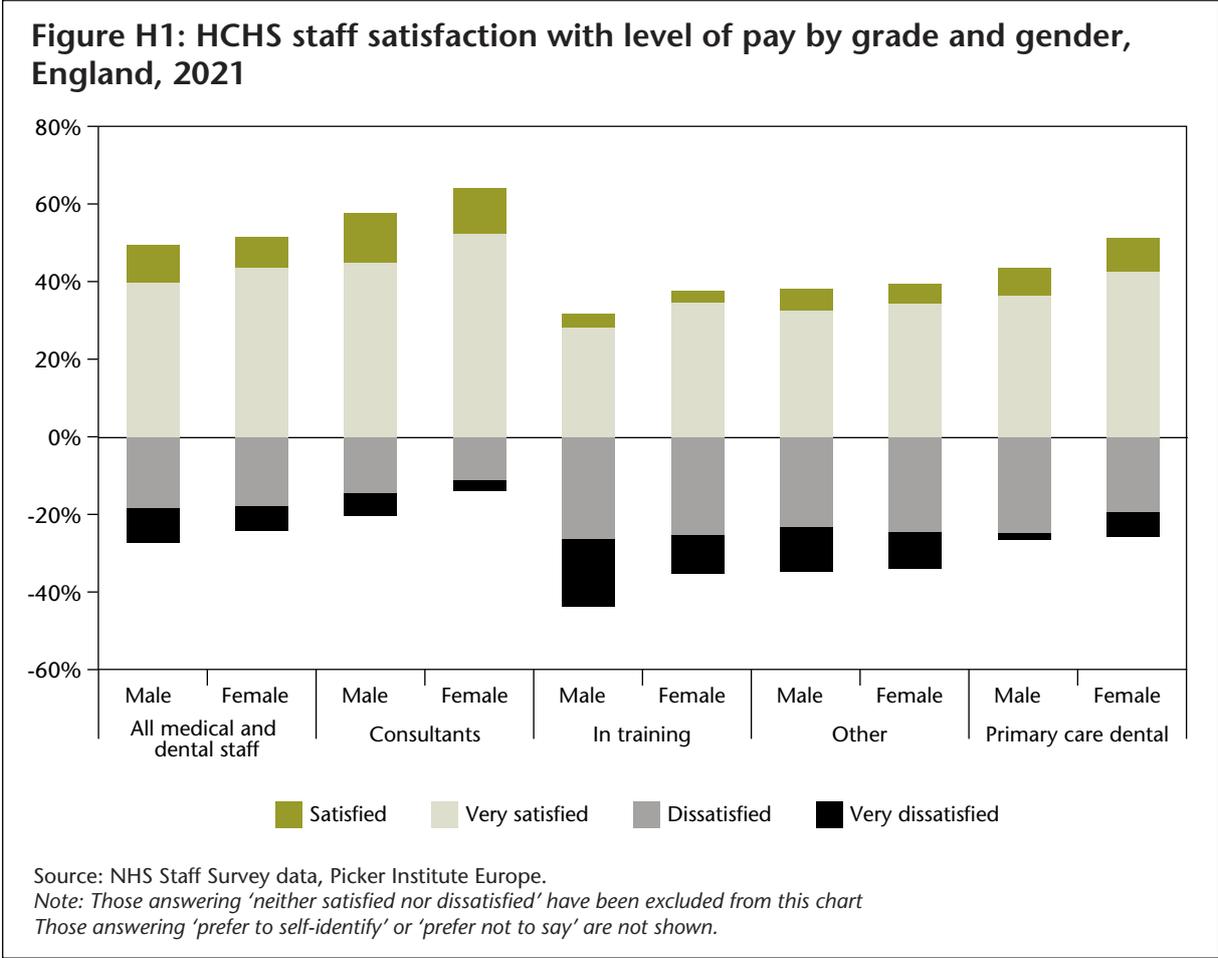
Due to the late running of the round, DDRB was also able to take account of the Q1 RPI and CPI figures.

APPENDIX H: STAFF SURVEY GENDER AND ETHNICITY DATA

H.1 In previous reports, we have included NHS Staff Survey Data for England broken down by gender and ethnicity. This year they have been included in a dedicated Appendix. In the 2021 NHS Staff Survey, data broken down by gender was collected separately for those that identify themselves as non-binary or prefer to self-describe their gender identity. This data has been included alongside male and female data, but we would note that the sample size is relatively small, and so it may be difficult to draw firm conclusions from it.

Cross-HCHS Data

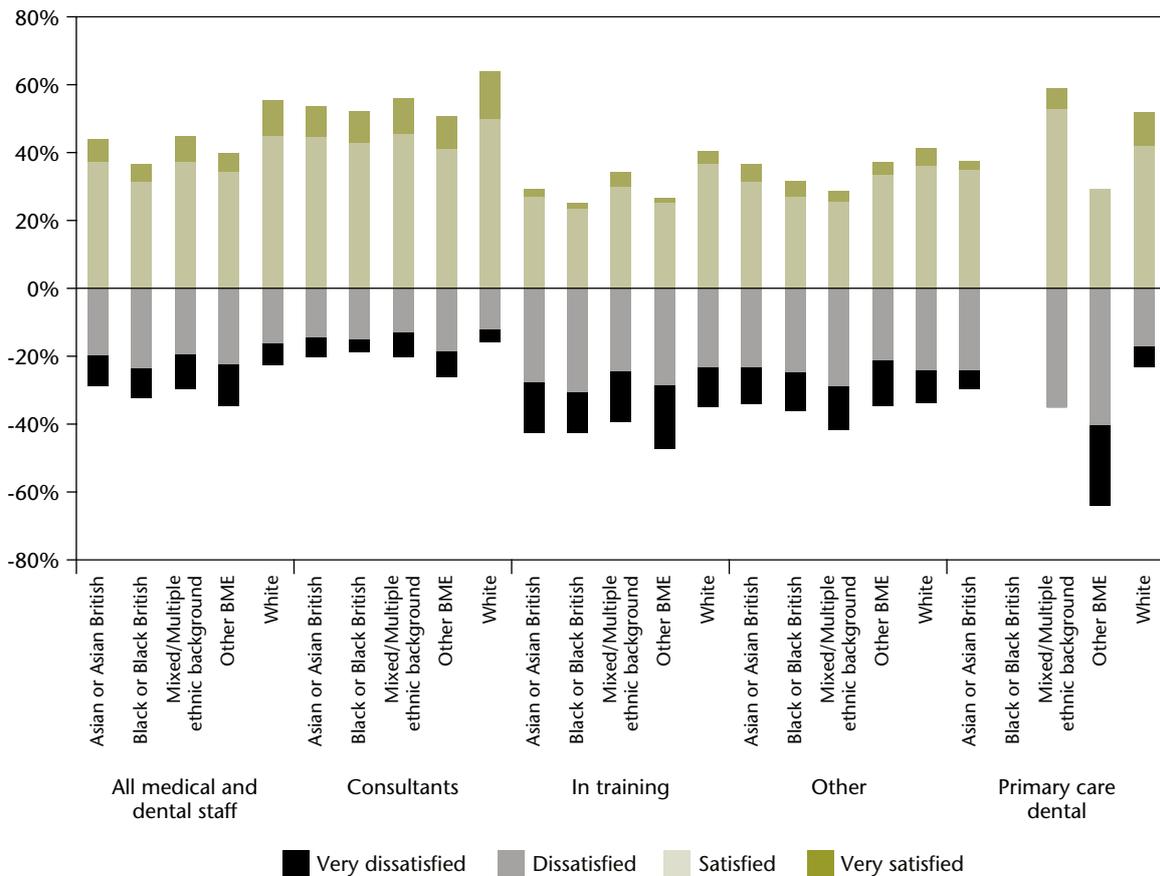
H.2 Figure H1 shows satisfaction with pay broken down by staff group and gender in 2021. When looking across all medical and dental staff, there was a 2.0 percentage point difference between female and male staff. 51.5 per cent of female staff and 49.4 per cent of male staff expressed satisfaction with pay. Female consultants, doctors and dentists in training, SAS doctors and primary care dental staff were all more likely than their male counterparts to express satisfaction with pay.



H.3 Figure H2 shows satisfaction with pay broken down by staff group and ethnic group in 2021. When looking across all medical and dental staff, 55.3 per cent of White staff expressed satisfaction with their pay, compared with 44.8 per cent of staff from a mixed/multiple ethnic background, 43.9 per cent of Asian or Asian British staff, 36.6 per cent of Black or Black British staff and 39.9 per cent of staff from other ethnic groups.

- White consultants (63.8 per cent) were more likely to express satisfaction with their pay than consultants from a mixed/multiple ethnic background (55.9 per cent), Asian or Asian British consultants (53.7 per cent), Black or Black British consultants (52.1 per cent) and consultants from other ethnic groups (50.7 per cent).
- White doctors and dentists in training (40.3 per cent) were more likely to express satisfaction with their pay than colleagues from a mixed/multiple ethnic background (34.3 per cent), Asian or Asian British staff (29.4 per cent), Black or Black British staff (25.3 per cent) and staff from other ethnic groups (26.6 per cent).
- White SAS doctors and dentists (41.4 per cent) were more likely to express satisfaction with their pay than Asian or Asian British staff (36.6 per cent), Black or Black British staff (31.5 per cent), colleagues from a mixed/multiple ethnic background (28.7 per cent), and staff from other ethnic groups (37.0 per cent).
- Salaried primary care dentists from a mixed/multiple ethnic background (58.8 per cent) were more likely to express satisfaction with their pay than White colleagues (51.9 per cent), Asian or Asian British staff (37.4 per cent), and those from other ethnic groups (29.2 per cent).

Figure H2: HCHS staff satisfaction with level of pay by grade and ethnic group, England, 2021

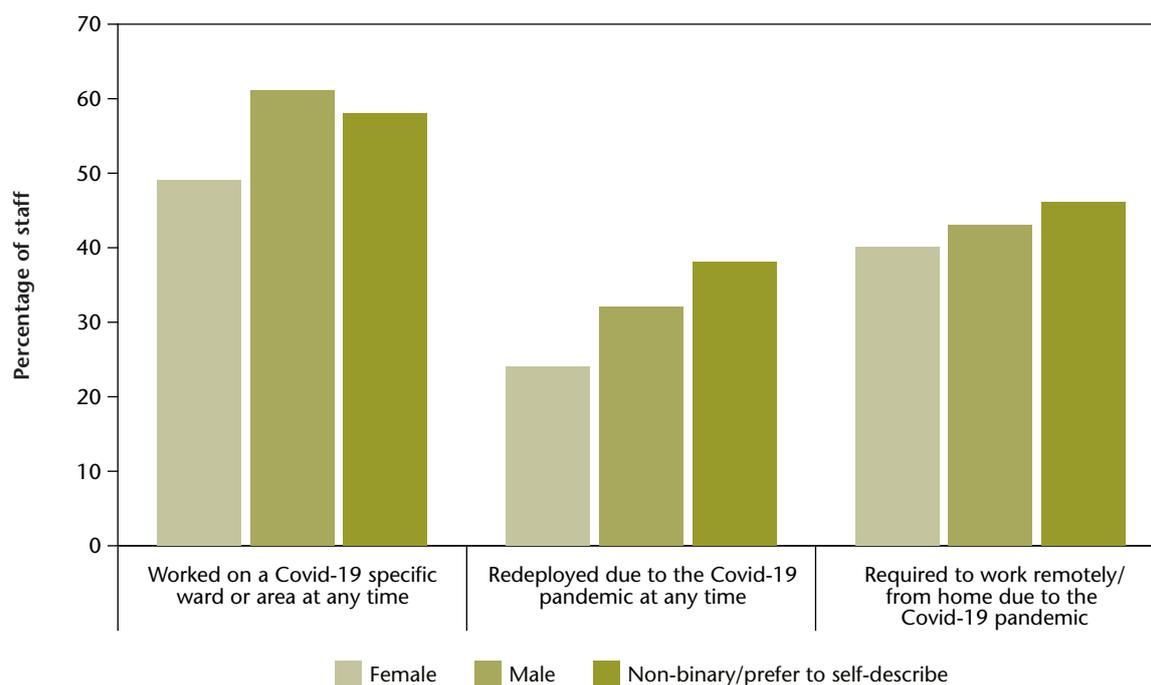


Source: NHS Staff Survey data, Picker Institute Europe.

Note: Those answering 'neither satisfied nor dissatisfied' have been excluded from this chart. Those answering 'prefer to self-identify' or 'prefer not to say' are not shown.

H.4 Figure H3 breaks down the results of the questions about experiences during the COVID-19 pandemic by gender. Male medical and dental staff were more likely than female staff to have said that they: had worked on a COVID-19 ward or area; had been redeployed due to COVID-19; or had been required to work remotely or from home during the pandemic. Staff who were non-binary or preferred to self-describe were more likely to have been redeployed or required to work remotely or from home than female and male staff.

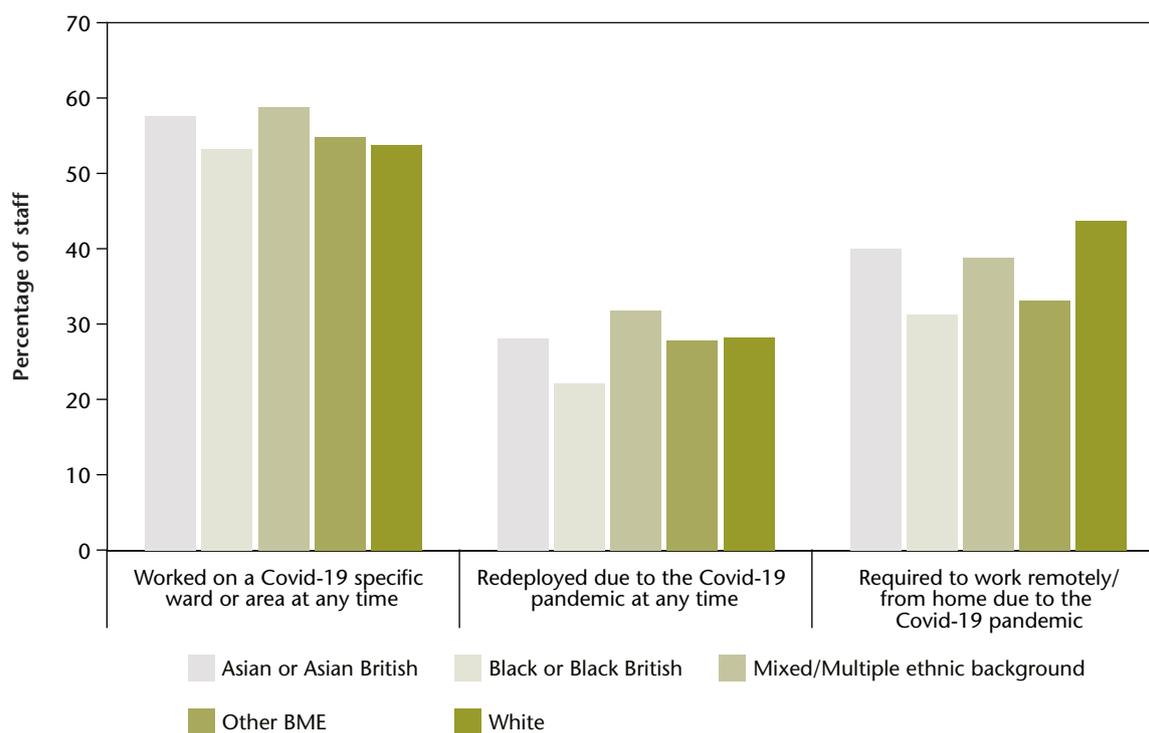
Figure H3: COVID-19 related questions from the National Staff Survey, medical and dental staff, by gender, England, 2021



Source: NHS Staff Survey.

H.5 Figure H4 breaks down the results of the questions about experiences during the COVID-19 pandemic by ethnic group. Medical and dental staff from a mixed/multiple ethnic background (59 per cent) were more likely to say they had worked on a COVID-19 ward or area, although at least 50 per cent of staff in each ethnic group said they had done so. Medical and dental staff from a mixed/multiple ethnic background were also more likely to say that they had been redeployed due to COVID-19 (32 per cent) than staff from other ethnic groups. White medical and dental staff were more likely to say they had been required to work remotely or from home (44 per cent) than staff from other ethnic groups.

Figure H4: COVID-19 related questions from the National Staff Survey, medical and dental staff, by ethnic group, England, 2021

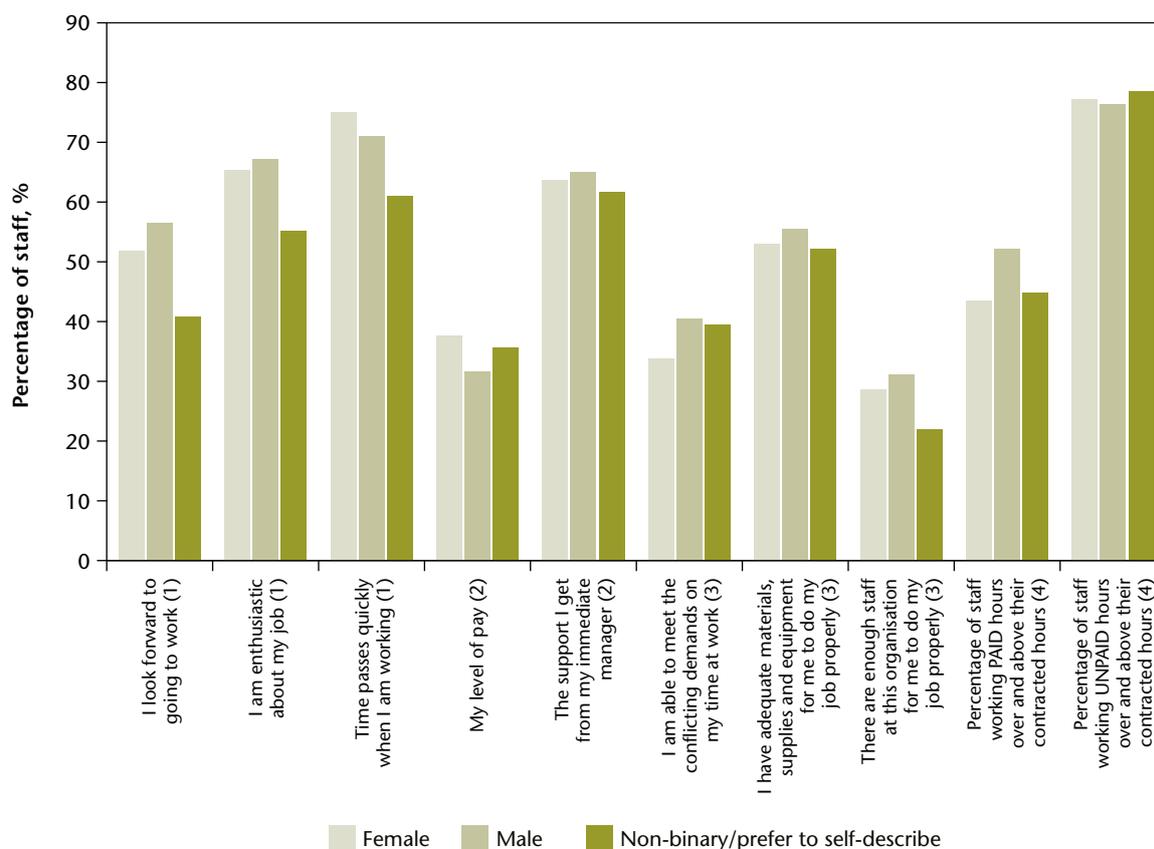


Source: NHS Staff Survey.

Doctors and Dentists in Training

H.6 Figure H5 shows that in 2021 female doctors and dentists in training were more satisfied with their pay than their male colleagues and non-binary/prefer to self-describe colleagues. However, compared with both female and non-binary/prefer to self-describe colleagues, male doctors and dentists in training were more likely to say that they looked forward to going to work, were enthusiastic about their job, were satisfied with the support they received from their line manager, were able to meet the conflicting demands on their time, had adequate materials to do their job and that there were enough staff at their organisation. Male doctors and dentists in training were most likely to work paid hours over and above their contracted hours, while there was little difference by gender in the likelihood of working extra unpaid hours.

Figure H5: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by gender, England, 2021



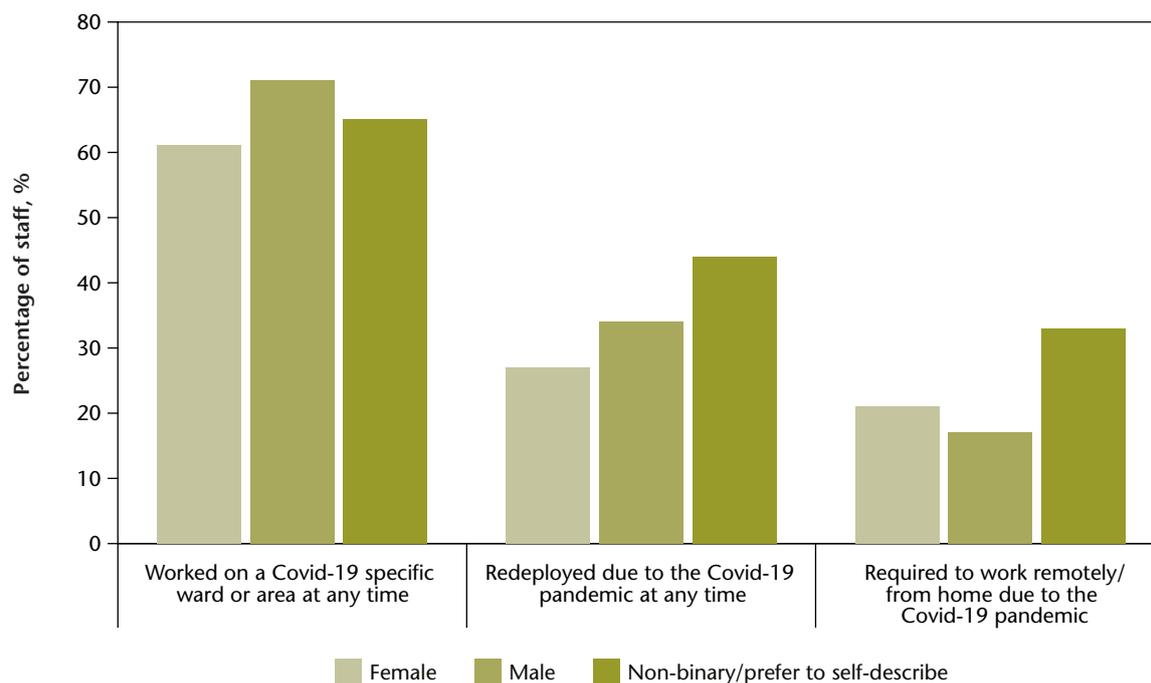
Source: NHS Staff Survey data, Picker Institute Europe.

Notes:

- (1) Staff responding "often" or "always"
- (2) Staff responding "satisfied" or "very satisfied"
- (3) Staff responding "agree" or "strongly agree"
- (4) Staff indicating one or more additional hours

H.7 Figure H6 shows doctors and dentists in training responses to questions about their experiences during the COVID-19 pandemic, by gender. Female trainees (61 per cent) were less likely to say that they worked on a COVID-19 specific ward or area, than male trainees (71 per cent) or non-binary/prefer to self-describe trainees (65 per cent). Female trainees (27 per cent) were also less likely to say that they had been redeployed than male trainees (34 per cent) or non-binary/prefer to self-describe trainees (44 per cent). Female trainees (21 per cent) were more likely to say that they had been required to work remotely or from home due to COVID-19 than male trainees (17 per cent), but less likely than non-binary/prefer to self-describe trainees (33 per cent).

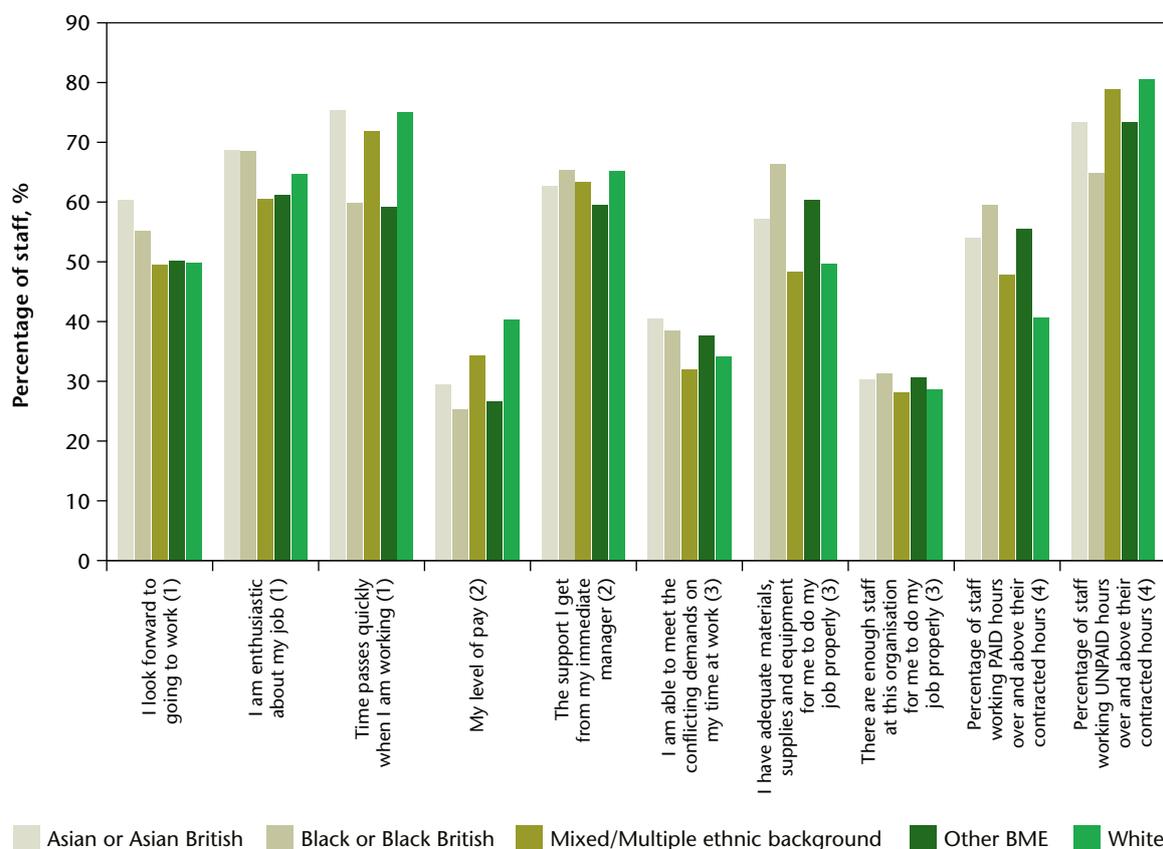
Figure H6: COVID-19 related questions from the National Staff Survey, doctors and dentists in training, by gender, England, 2021



Source: NHS Staff Survey data, Picker Institute Europe.

H.8 Figure H7 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian or Asian British doctors and dentists in training were more likely to say that they looked forward to going to work, were enthusiastic about their job, that time passes quickly when they are working, and that they were able to meet the conflicting demands on their time than those from other ethnic groups. White doctors and dentists in training and those from mixed/multiple ethnic backgrounds were more satisfied with their pay than colleagues from other ethnic groups. White doctors and dentists in training were less likely to say that they worked paid hours in addition to their contracted hours than colleagues from other ethnic groups, while White doctors and dentists in training were more likely to say that they worked unpaid hours in addition to their contracted hours.

Figure H7: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by ethnic group, England, 2021



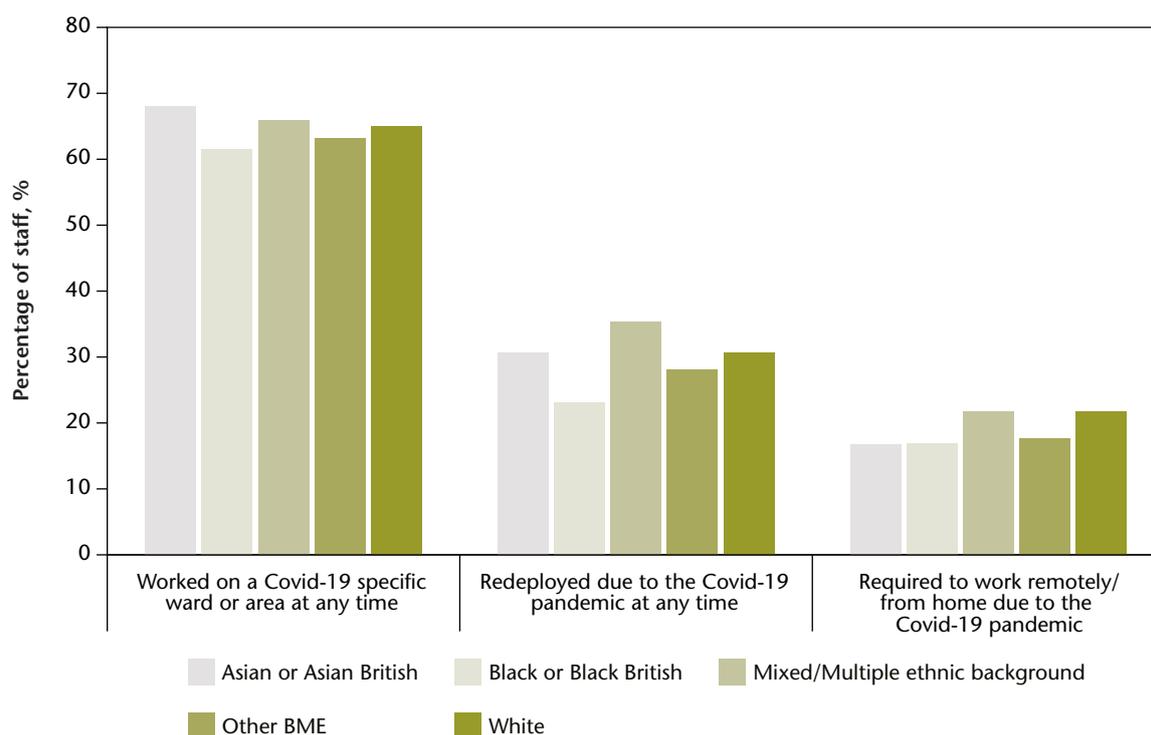
Source: NHS Staff Survey data, Picker Institute Europe.

Notes:

- (1) Staff responding "often" or "always"
- (2) Staff responding "satisfied" or "very satisfied"
- (3) Staff responding "agree" or "strongly agree"
- (4) Staff indicating one or more additional hours

H.9 Figure H8 shows doctors and dentists in training responses to questions about their experiences during the COVID-19 pandemic, by ethnic group. Asian or Asian British doctors and dentists in training (68 per cent) were most likely to say they had worked on a COVID-19 ward or area, although at least 60 per cent of doctors and dentists in training in each ethnic group said they had done so. Doctors and dentists in training from a mixed/multiple ethnic background were more likely to say that they had been redeployed due to COVID-19 (35 per cent) than staff from other ethnic groups. White doctors and dentists in training and those from a mixed/multiple ethnic background were more likely to say they had been required to work remotely or from home (22 per cent) than staff from other ethnic groups.

Figure H8: COVID-19 related questions from the National Staff Survey, doctors and dentists in training, by ethnic group, England 2021

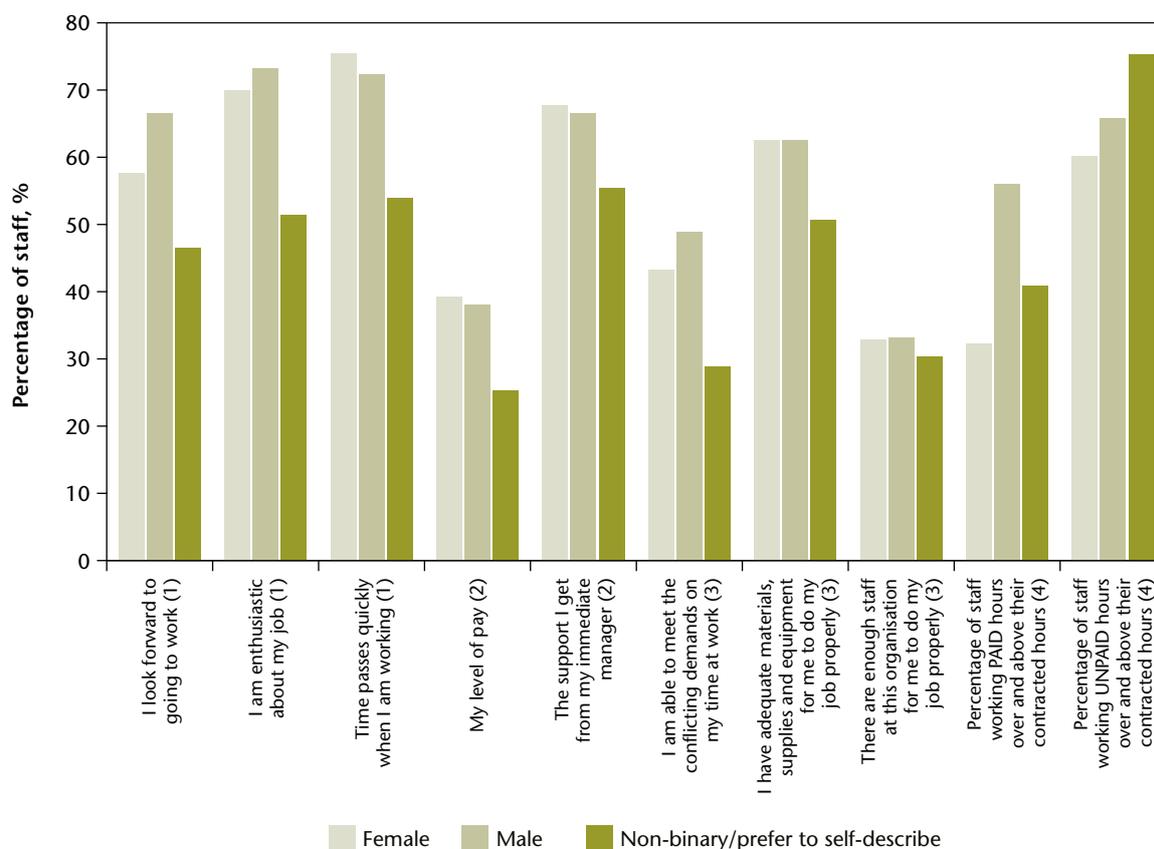


Source: NHS Staff Survey data, Picker Institute Europe.

SAS Doctors and Dentists

H.10 Figure H9 shows that just under 40 per cent of male and female SAS doctors and dentists were satisfied with pay, compared with 25 per cent of non-binary/prefer to self-describe colleagues. However, compared with female and non-binary/prefer to self-describe SAS doctors and dentists, male SAS doctors were more likely to say that they looked forward to going to work, were enthusiastic about their job, and were able to meet the conflicting demands on their time. Female SAS doctors and dentists were less likely to work hours over and above their contracted hours, both paid and unpaid hours, than their male or non-binary/prefer to self-describe colleagues.

Figure H9: HCHS SAS (other) doctors, satisfaction with aspects of the job and work pressures by gender, England, 2021



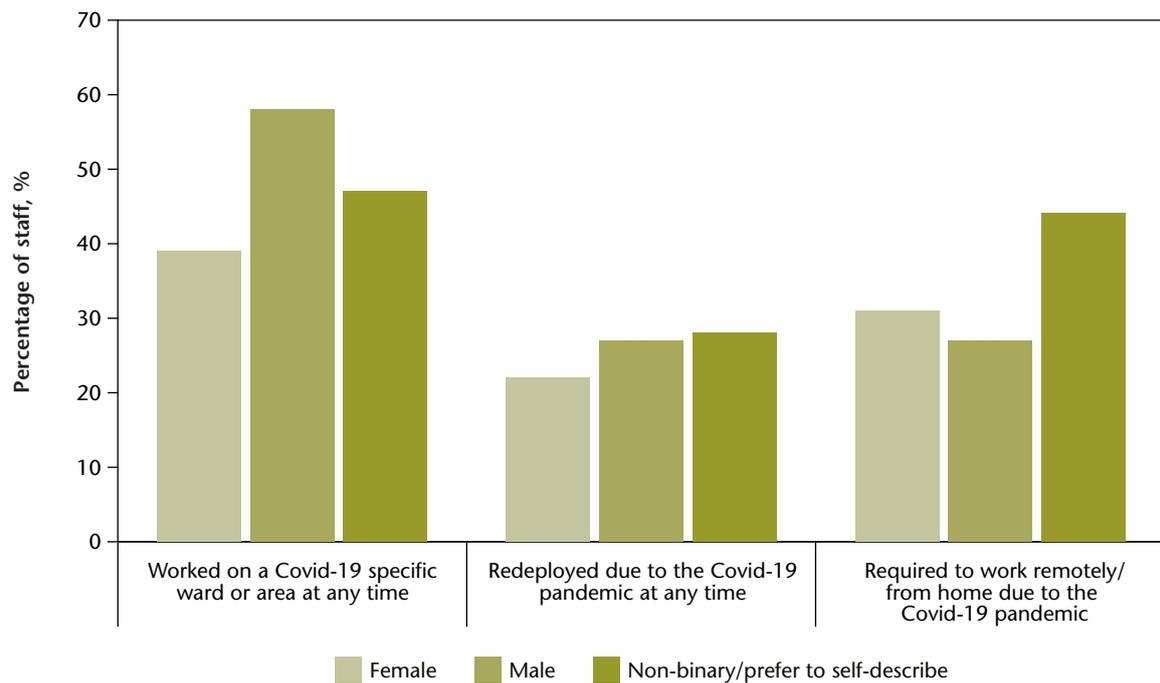
Source: NHS Staff Survey data, Picker Institute Europe.

Notes:

- (1) Staff responding "often" or "always"
- (2) Staff responding "satisfied" or "very satisfied"
- (3) Staff responding "agree" or "strongly agree"
- (4) Staff indicating one or more additional hours.

H.11 Figure H10 shows SAS doctors and dentists responses to questions about their experiences during the COVID-19 pandemic, by gender. Female SAS doctors and dentists (39 per cent) were less likely to say that they worked on a COVID-19 specific ward or area than male SAS doctors and dentists (58 per cent) and non-binary/prefer to self-describe SAS doctors and dentists (47 per cent). Female SAS doctors and dentists (22 per cent) were also less likely to say that they had been redeployed than male SAS doctors and dentists (27 per cent) and non-binary/prefer to self-describe SAS doctors and dentists (28 per cent). Female SAS doctors and dentists (31 per cent) were more likely to say that they had been required to work remotely or from home due to COVID-19 than male SAS doctors and dentists (27 per cent), but less likely than non-binary/prefer to self-describe SAS doctors and dentists (44 per cent).

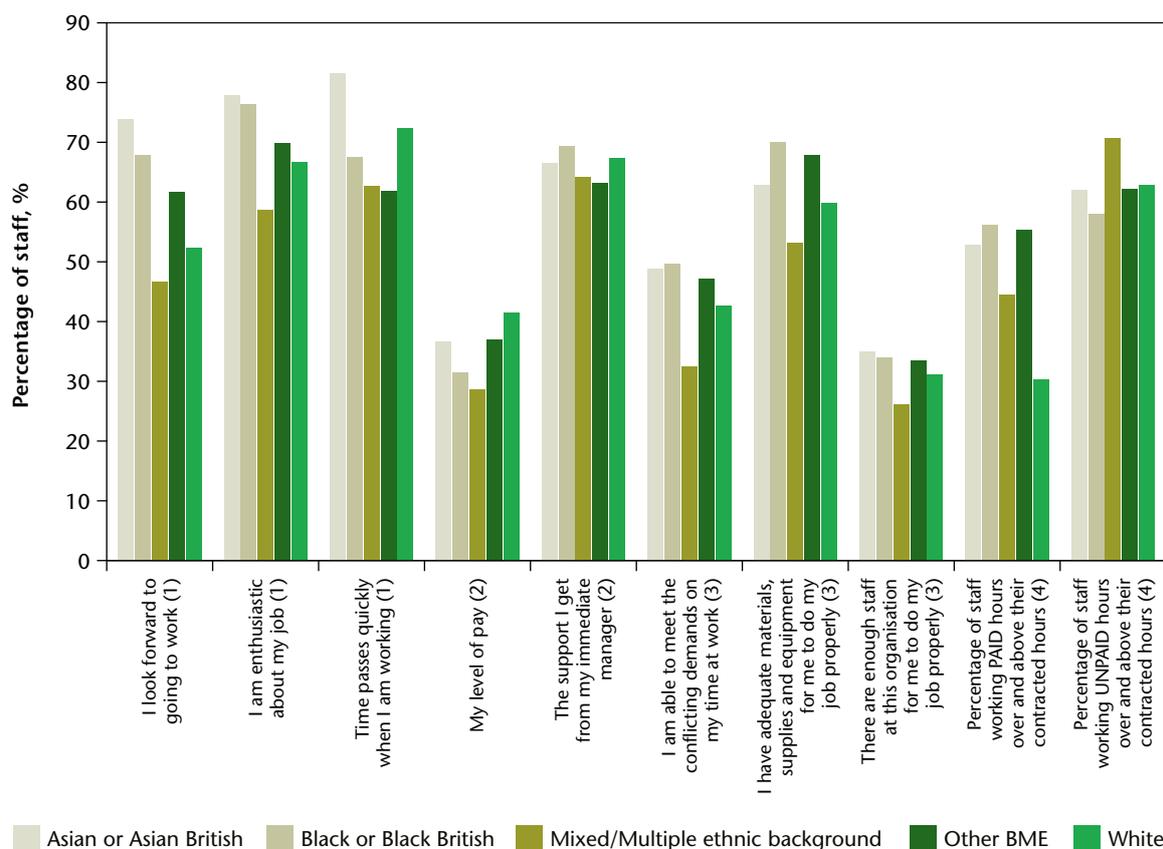
Figure H10: COVID-19 related questions from the National Staff Survey, SAS doctors and dentists, by gender, England, 2021



Source: NHS Staff Survey data, Picker Institute Europe.

H.12 Figure H11 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian or Asian British SAS doctors, compared with those from other ethnic groups, were more likely to say that they looked forward to going to work, were enthusiastic about their job, and said that time passed quickly when they were working. White SAS doctors were less likely to work extra paid hours than colleagues from other ethnic groups.

Figure H11: SAS (other) HCHS doctors training, satisfaction with aspects of the job and work pressures by ethnic group, England, 2021



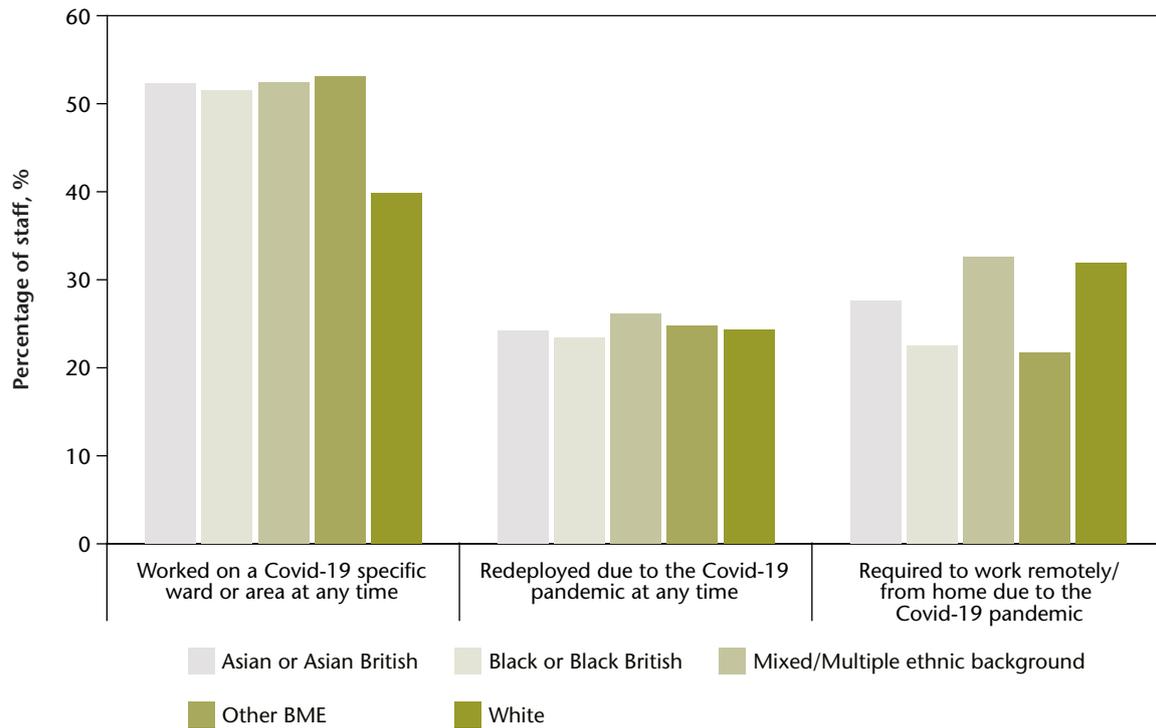
Source: NHS Staff Survey data, Picker Institute Europe.

Notes:

- (1) Staff responding "often" or "always"
- (2) Staff responding "satisfied" or "very satisfied"
- (3) Staff responding "agree" or "strongly agree"
- (4) Staff indicating one or more additional hours.

H.13 Figure H12 shows SAS doctors and dentists responses to questions about their experiences during the COVID-19 pandemic, by ethnic group. Just 40 per cent of White SAS doctors and dentists worked on a COVID-19 ward, compared with over 50 per cent of SAS doctors and dentists from other ethnic groups. White SAS doctors and dentists and those from a mixed/multiple ethnic background were more likely to have been required to work remotely/ from home, with 32 per cent and 33 per cent respectively, having done so, compared with those from other ethnic groups.

H12: COVID-19 related questions from the National Staff Survey, HCHS SAS doctors and dentists, by ethnic group, England, 2021

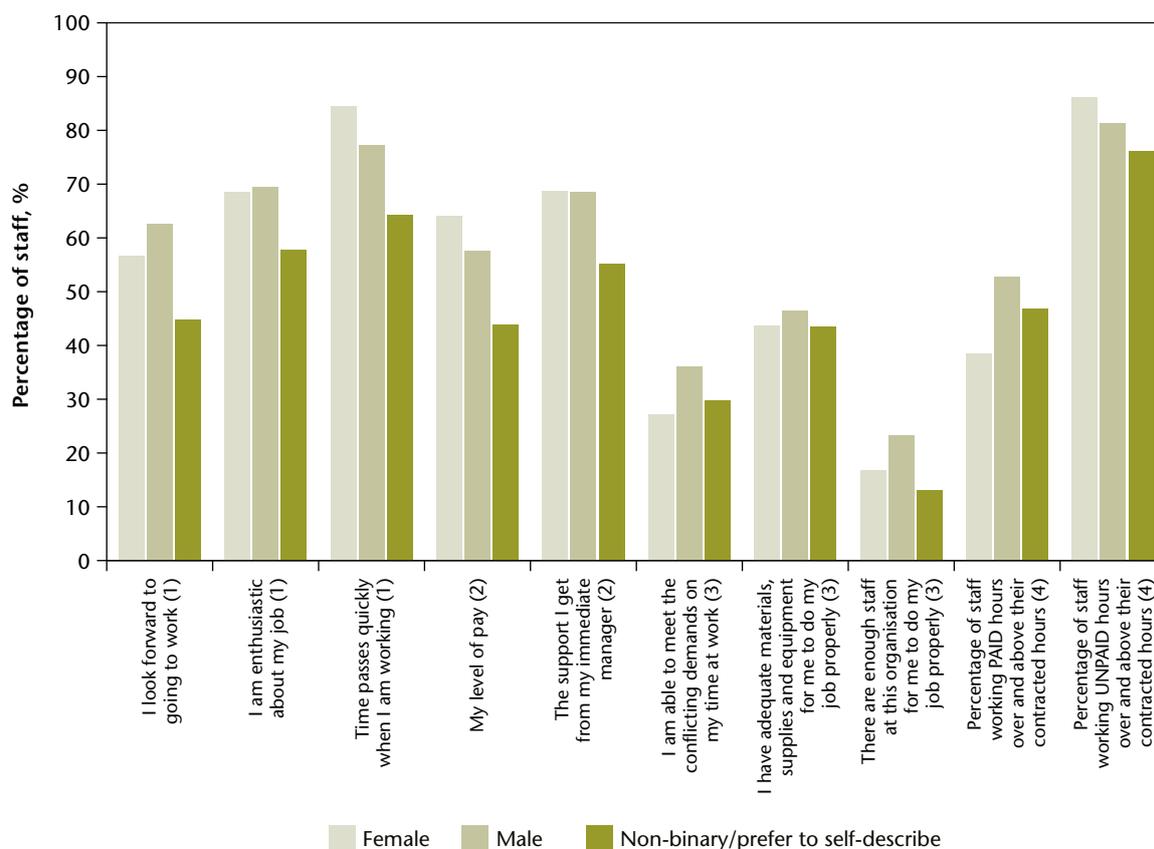


Source: NHS Staff Survey data, Picker Institute Europe.

Consultants

H.14 In 2021, female consultants were more likely to say they were satisfied with their pay than male or non-binary/prefer to self-describe colleagues (Figure H13) and were more likely to say that time passed quickly when they worked. However, compared with female consultants and non-binary/prefer to self-describe colleagues, male consultants were more likely to say that they looked forward to going to work, were able to meet competing demands on their time, had adequate materials, and that there were sufficient staff at the organisation. Male consultants were most likely to work extra paid hours, while female consultants were most likely to work extra unpaid hours.

Figure H13: HCHS consultant satisfaction with aspects of the job and work pressures by gender, England, 2021



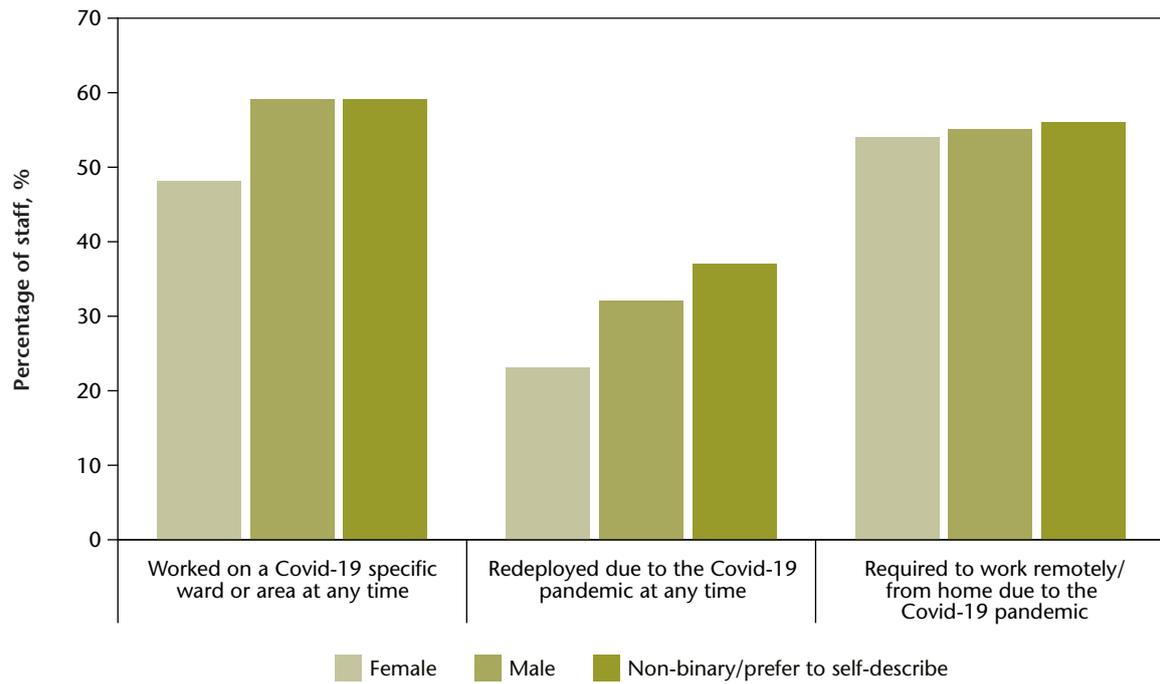
Source: NHS Staff Survey data, Picker Institute Europe.

Notes:

- (1) Staff responding "often" or "always"
- (2) Staff responding "satisfied" or "very satisfied"
- (3) Staff responding "agree" or "strongly agree"
- (4) Staff indicating one or more additional hours.

H.15 Figure H14 shows consultants' responses to questions about their experiences during the COVID-19 pandemic, by gender. Female consultants (48 per cent) were less likely than male consultants (59 per cent) and consultants who are non-binary/prefer to self-describe (59 per cent) to say that they worked on a COVID-19 specific ward or area. Female consultants (23 per cent) were less likely than male consultants (32 per cent) and consultants who are non-binary/prefer to self-describe (37 per cent) to say that they had been redeployed. Just over half of female, male and non-binary/prefer to self-describe consultants said that they had been required to work remotely or from home due to COVID-19.

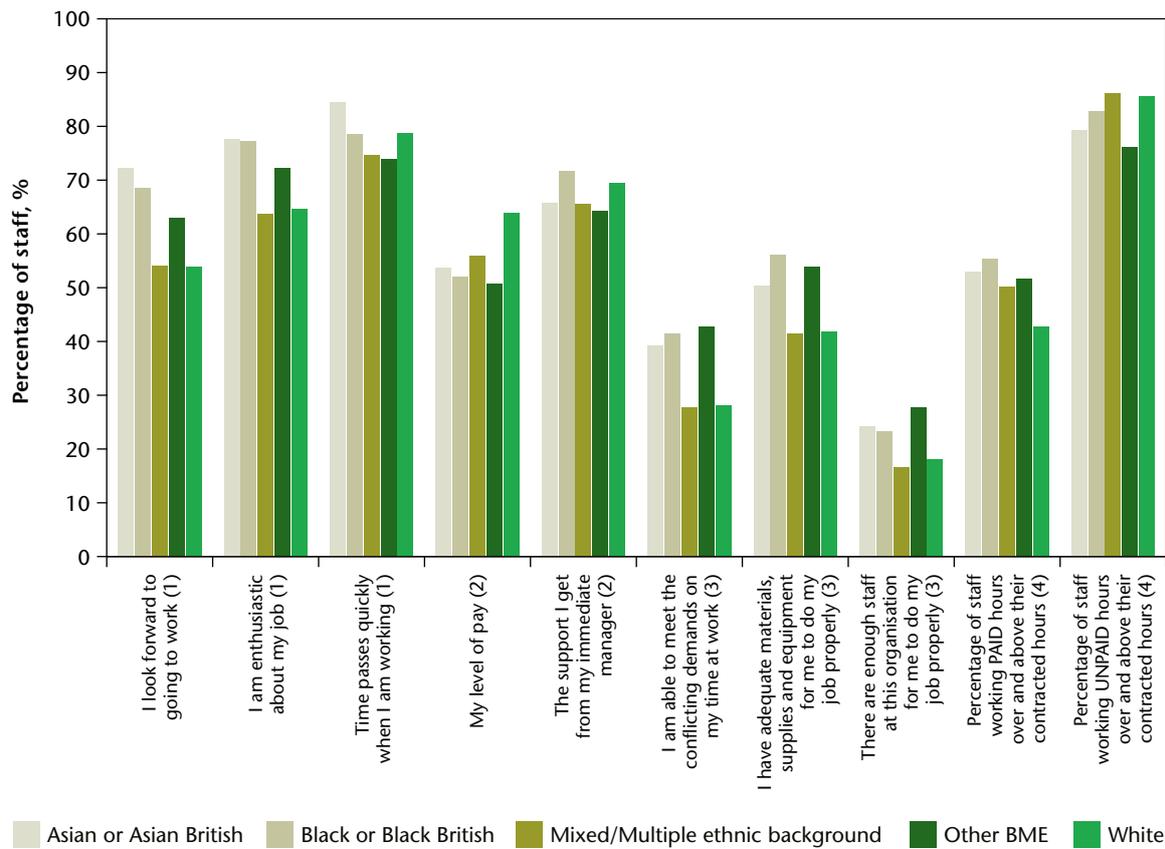
Figure H14: COVID-19 related questions from the National Staff Survey, consultants, by gender, England, 2021



Source: NHS Staff Survey data, Picker Institute Europe.

H.16 Figure H15 shows satisfaction with aspects of the job and work pressures, by ethnic group. For most of the variables, Asian or Asian British and Black or Black British consultants were more satisfied than their White colleagues or those from other ethnic groups. White consultants were more likely to say that they worked paid hours in addition to their contracted hours than colleagues from other ethnic groups.

Figure H15: HCHS consultant satisfaction with aspects of the job and work pressures by ethnic group, England, 2021



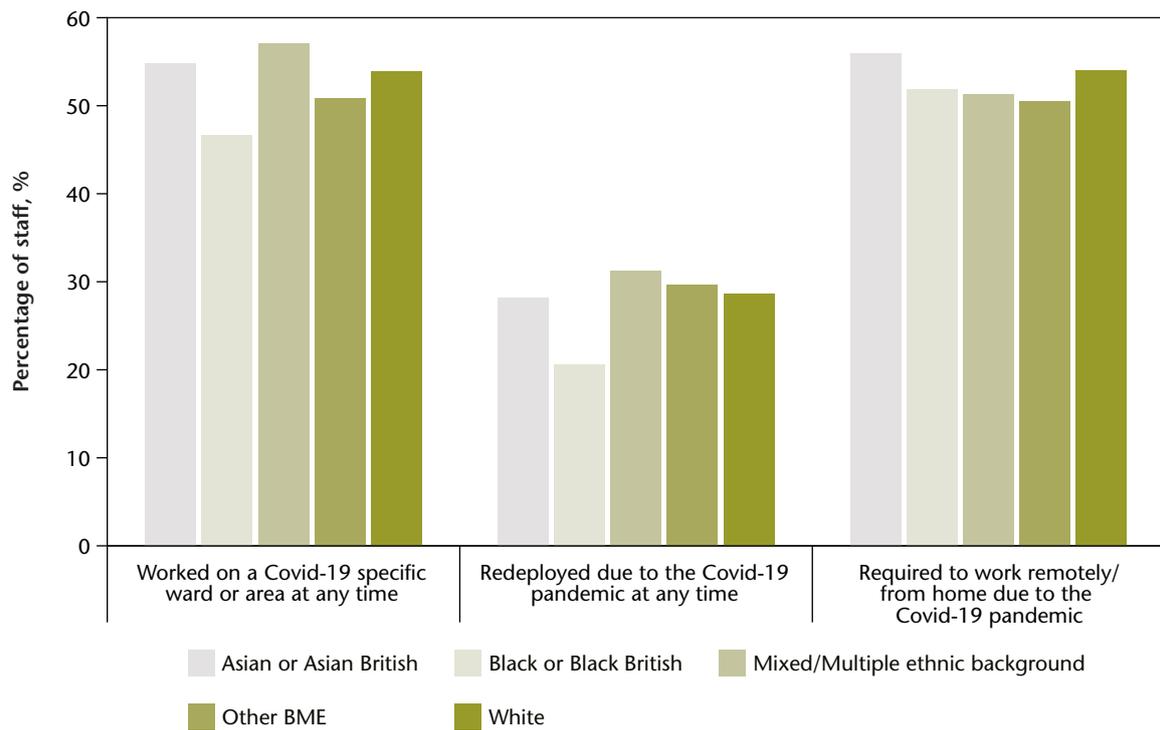
Source: NHS Staff Survey data, Picker Institute Europe.

Notes:

- (1) Staff responding "often" or "always"
- (2) Staff responding "satisfied" or "very satisfied"
- (3) Staff responding "agree" or "strongly agree"
- (4) Staff indicating one or more additional hours.

H.17 Figure H16 shows consultants' responses to questions about their experiences during the COVID-19 pandemic, by ethnic group. There was little difference in the responses, except that a smaller percentage of Black or Black British consultants said that they had worked on a COVID-19 ward or area or had been redeployed due to COVID-19.

Figure H16: COVID-19 related questions from the National Staff Survey, consultants, by ethnic group, England, 2021



Source: NHS Staff Survey data, Picker Institute Europe.

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