The Department of Health and Social Care's written evidence to the Review Body on Doctors and Dentists Remuneration (DDRB) for the 2019/20 Pay Round

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Contents

Executive Summary 6

1. NHS Strategy and Introduction 8
   - Workforce 10
   - Staff engagement 10
   - Government Pay Policy, 2018/19 Awards and our Approach to Pay and Contract Reform 10
   - Gender Pay Gap in Medicine Review 15
2. Evidence on the General Economic Outlook 16
   - Introduction 16
   - UK economy 16
   - Public finances 17
   - Labour market 18
   - Public sector pay and pensions 21
   - Conclusion 23
3. NHS Finances 24
   - Funding growth 24
   - Financial position 25
   - Share of resource going to pay 26
   - Demand pressures 27
   - Efficiency 29
   - Productivity in the NHS 30
   - Conclusion 33
4. HCHS Medical and Dental Staff Earnings 34
   - HCHS Earnings & Earning Growth Analysis 34
   - Average Base Pay and Total Allowances 38
   - High Earners Comparison Analysis 42
   - Why has the NHS paybill per FTE grown? 43
   - Recruitment & Retention Premia 45
   - Earnings of doctors at the foundation stage 46
   - Pay Progression 47
5. Workforce Strategy 50

Workforce Strategy ... 50

6. Recruitment, Retention, Motivation and Medical Workforce Planning ... 52

Background ... 52
Exiting the European Union ... 53
Numbers in work ... 54
Skill Mix ... 55
Expansion of Undergraduate Medical Training Places ... 57
Analysis of Joiners and Leavers ... 60
Retention ... 60
Medical staff reasons for leaving ... 62
Vacancies ... 65
Agency staff (All HCHS staff) ... 67
Staff Experience ... 68
Staff Engagement and Wellbeing ... 72
NHS Staff Survey - Engagement Index ... 72
Performance Against Selected Key Findings ... 73
Staff Motivation ... 74
Flexible Working & Additional Hours ... 76
Proportion experiencing Bullying or Harassment ... 78
Other Measures ... 78
Staff Health and Wellbeing ... 80
Sickness Absence ... 82
Gender balance and Gender pay gap ... 83

7. Doctors and Dentists in Training ... 85

Review of 2016 Contract ... 85
Non-contractual issues ... 85
Approach to pay for 2019/20 ... 86
Flexible pay premia ... 86
Background on the introduction of the flexible pay premia (FPPs) ... 87
Effectiveness of these initial flexible pay premia ... 88
Subsequent proposals for use of flexible pay premium to target/support specialty recruitment and retention ... 89

8. Consultants ... 90

Contract reform ... 90

Local Clinical Excellence Awards 91

9. Career grade doctors (SAS grades) 94

10. General Medical Practitioners 96

Spend on General practice 96

NHS Long Term Plan Investment 97

Current GP pay...97

GP Indemnity..98

GP earnings..98

GP Trainers' grants 105

General Medical Practitioner (GMP) Appraisers' rates 106

GP Workforce numbers 106

Part-time working and participation rates 109

GP Locums...111

Staff movement 112

Staff Motivation..113

The GP Forward View 116

GP recruitment and retention...116

Recruitment 117

Retention and Return to practice 117

Workload 118

Older GPs leaving the profession 119

NHS Long Term Plan - primary care workforce 121

GP Partnership Review 122

GP appointments and waiting times 123

Access to General Practice 124

New Care Models 124

Integrated Care Providers (ICPs) 125

GP participation in Integrated Care Providers 126

11. General Dental Practitioners 127

Workforce Numbers and Recruitment and Retention 127

Earnings and Expenses...128

Motivation and Morale 130

Supply of Dentists and status of NHS Contracts 131

Targeting 131

Dental contract reform 132
Community Dental Services 132
12. Ophthalmic Medical Practitioners 134
Background 134
13. Pensions and Total Reward 135
Introduction 135
Pension Scheme Contributions 135
Pension scheme membership 137
Total Reward 141
NHS Trend Analysis 147
Total Reward Statements 148
Annex 1 - Remit letter 150
Annex 2 - Written Ministerial Statement 152
Consultants 153
Doctors and Dentists in Training 153
Specialty Doctors (new grade 2008) and Associate Specialists (closed grade) 154
General Dental Practitioners 154
General Medical Practitioners 154
Annex 3 - Secretary of State’s letter to the BMA 156
Annex 4 – Analysis of Joiners 160
Annex 5 – Analysis of Leavers 166
Leavers by Region 166
Annex 6 - Pension scheme membership and trends 169
References 171

Executive Summary

The key context for evidence for the 2019/20 pay round is NHS England's Long-Term Plan for the NHS published on 7 January 2019. As in the remit letter from the Secretary of State for Health and Social Care (Annex 1), this written evidence asks the Review Body to:

- consider its recommendations within the context of workforce growth assumptions and the importance of making planned workforce growth affordable;
- make recommendations for targeting funding to support productivity and recruitment and retention; and
- set out, in its report to government, how its recommendations take account of affordability and need for workforce growth and improved productivity

As in recent years - and reflecting the roles of the Department, its Arms-Length Bodies and other organisations - the Review Body will be invited to consider, alongside evidence from the trades unions, professional bodies and other stakeholders:

- high-level evidence from the Department, including the strategic policy objectives and the economic and financial (NHS funding) context
- evidence from NHS England on its Long-Term Plan and the implications of that for workforce growth and affordability; including key objectives of primary care reform and negotiations on the GP contract;
- evidence from NHS Improvement on provider issues including provider affordability, recruitment and retention, improving consultant productivity and the contribution of pay to that;
- evidence from Health Education England evidence on doctors and dentists in training, including specialty and geographical issues and potential for pay targeting to address this; and
- evidence from NHS Employers updating on contract reform negotiations, and providing employer views, for employed doctor groups.

This evidence covers:

Chapter 1: Strategic Context; Government Pay Policy; and the Government's response to the DDRB's 46th Report

Chapter 2: Evidence on the General Economic Outlook

Chapter 3: NHS Finances

Chapter 4: HCHS Medical and Dental Staff Earnings

Chapter 5: Workforce Strategy

Chapter 6: Recruitment, Retention, Motivation and Medical Workforce Planning

Chapter 7: Doctors and Dentists in Training

Chapter 8: Consultants

Chapter 9: Career Grade Doctors (Specialty Doctors and Associate Specialists)

Chapter 10: General Medical Practitioners

Chapter 11: General Dental Practitioners

Chapter 12: Ophthalmic Medical Practitioners

Chapter 13: Pensions and Total Reward

1. NHS Strategy and Introduction

1.1 The NHS has seen, and will continue to see, real growth in its budget. In the 2015 Spending Review, the Government committed to backing the NHS with an additional £8 billion in real terms, by 2020/21; subsequent additional funding increases included £2.8 billion of revenue funding for frontline services announced in the Autumn 2017 budget.

1.2 In June 2018 the Prime Minister set out a new multi-year funding plan for the NHS, setting the real terms growth for spending in return for the NHS agreeing a Long-Term Plan with the Government; a plan which determines the direction the NHS will take over the next decade.

1.3 The health and social care system continues to face increasing demand for its services, driven by an increasingly aged and frail population, and meeting this demand and driving up quality in an affordable way is incredibly challenging. The long-term funding settlement gives the NHS the financial security to implement a ten year plan that addresses these challenges in a sustainable manner.

1.4 NHS England was asked to develop its Long-Term Plan against five financial tests to ensure that the service is being put on a more sustainable footing (see Chapter 3). NHS England's Long-Term Plan, published on 7 January 2019, sets out the need to target investment in primary care, and states that NHS England will publish a Workforce Implementation Plan later in 2019. NHS England and NHS Improvement published full planning guidance on 10 January 2019[i]

1.5 We expect the DDRB to make recommendations within an envelope of £250m for substantive HCHS medical staff, taking into account how this envelope can best be targeted.

1.6 This is based on the forecast medical paybill for 2019/20 before the application of any pay awards. It is derived as:

- The 2017/18 substantive HCHS medical paybill (£11.2bn);
- Plus the assumed cost weighted impact of staffing growth in 2018/19 – (2.9% based on in-year data);
- Plus the recurrent impact of the 2018/19 pay award (2.1%);
- Plus the assumed impact of pay drift in 2018/19 (0.1%)

- Resulting in a recurrent pay bill going into 2019/20 of £11.8bn
- Plus the assumed impact of pay drift in 2019/20 (0.1%)
- Plus the assumed impact of the NHS pension scheme revaluation (3.8%);
- Plus the assumed cost weighted impact of staffing growth in 2019/20 (2.75%)
- Resulting in a projected £12.6bn pay bill before pay rises in 2019/20.

1.7 Workforce growth is assumed to be 2.75% for 2019/20, which assumes growth levels continue at broadly the same level as the in-year growth observed in 2018/19.

1.8 This focuses on the impact on substantive staff, but we note that wider financial planning will have to account for knock-on impacts on temporary staffing and the wider system.

1.9 Any recommendations in excess of that would require reprioritisation of NHS England's Long-Term Plan, for example reducing the growth in the workforce.

1.10 For GDPs we expect the DDRB to make recommendations on income and staff costs within an envelope of £37m. The value of all NHS dental contracts in 2017/2018 was £2.8bn and this envelope is based on the weighting of income and staff costs. The table below gives a breakdown of the weighting to each element of the NHS dental contract. Any uplifts on the other costs mentioned below would need to be considered separately.

Figure 1.1 – Weighting to each element of the NHS Dental Contract

Income	50.0%
Staff costs	16.2%
Laboratory Costs	6.1%

Materials Costs	6.6%
Premises Costs	0.0%
Other Non-staffing Costs	21.1%

Workforce

1.11 Ensuring that the NHS has access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care is a fundamental aspect of the Department's overarching strategic programme for the health and care system. The Department works with system partners to ensure there is a highly engaged and motivated workforce delivering NHS services to patients.

1.12 NHS England's Long-Term Plan published on 7 January 2019 sets out a number of specific workforce actions that can have a positive impact now, and that a Workforce Implementation Plan will follow later in 2019. The Department will continue to work with the Home Office to ensure that after we leave the EU, we will have in place an immigration system which works in the best interests of the whole of the UK.

Staff engagement

1.13 Staff engagement is crucial to securing and retaining the workforce that the NHS needs, as is making the most effective use of the entire NHS employment offer - pay and non-pay benefits. We strongly believe that recruitment and retention is not just about pay, it is about creating a culture and environment in the NHS where staff want to work, where staff feel safe to raise concerns and to learn from mistakes; where employers listen to and empower staff, and work hard to keep them safe and ensure bullying and harassment is not tolerated. The Department continues to work in partnership with its arms-length bodies and other organisations to support trusts in their responsibility for improving staff experience.

Government Pay Policy, 2018/19 Awards and our Approach to Pay and Contract Reform

1.14 The Government's public sector pay policy aims to ensure that the overall package for public sector workers is fair to them and that we can deliver

world class public services which are affordable within the public finances and fair to taxpayers as a whole.

1.15 Patients, and their experience of care, must be at the heart of everything that the system does - we want to help ensure that the NHS can continue to deliver world-class patient care, putting patients first and keeping them safe whilst providing the high quality care we all expect. The pay review bodies for the NHS are asked, as part of their standing remits, to give regard to that.

1.16 All of this requires ensuring the right balance between pay and staff numbers through systems of reward that are affordable and fit for purpose. Staff tell us that they want to know they will have the right number of colleagues working alongside them in hospital or in the community.

1.17 We continue to focus on public sector pay reform to ensure that terms and conditions are fit for purpose, affordable and sustainable. The approach taken (including the public sector pay cap that was in place until 2017/18) has been essential to ensuring continued levels of recruitment and retention. The number of employed doctors increased by 9,791 full-time equivalents (9.8%) in the period between March 2013 and March 2018, with consultants (who represent the largest group) increasing by 7,213 (18.3%), from 39,425 to 46,638.

1.18 In September 2017, the Government said that it recognised that, within the context of a continued need for pay discipline to ensure the affordability of public services and the sustainability of public sector employment, more flexibility may be required in some parts of the public sector, particularly in areas of skills shortage, to deliver world class public services, including in return for improvements to public sector productivity.

1.19 Existing spending plans, set through the 2015 Spending Review and budgeting for a 1% average increase in basic pay and progression pay awards for specific workforces, remained in place. For 2018/19, the DDRB was asked to continue to consider affordability and to make recommendations, in relation to the employed medical workforce, for targeting.

1.20 The recommendations in DDRB's 46th report - for basic increases of 2% across all the groups, plus some additional increases targeted at GPs (a further 2%) and SAS doctors (a further 1.5%) - were given very careful consideration by Government, in the context of:

- affordability in 2018/19 in the context of a Spending Review that budgeted for 1 per cent average basic pay awards;

- the importance of prioritising patient care, and the long-term funding settlement which increases NHS funding by an average 3.4 per cent per year from 2019/20, and which will see the NHS receive £20.5 billion a year in real terms by 2023;

- the three-year contract reform agreement on the Agenda for Change pay contract for one million non-medical staff, which delivered significant reforms as part of 3% pay investment per year, including progression pay reforms that end automatic annual increments; and

- the case for contract reform for some of the DDRB's remit groups, in particular for consultants and GPs.

1.21 We understand that the DDRB would find it helpful for this evidence to rehearse the rationale for the Government's response to the DDRB's recommendations, and its decisions on awards for 2018/19.

1.22 The Written Ministerial Statement of 24 July 2018 (Annex 2) sets out that the Government took account of DDRB's approach to targeting its recommendations; and details the Government's decisions to modify, abate and/or stage some awards.

1.23 The decisions taken by Government on the 2018/19 pay awards followed full consideration of the state of recruitment, retention and motivation as well as the necessary budgetary constraints and how that might impact the aims and priorities of the health service and its staff.

1.24 For employed staff, the decision was made to stage awards from 1 October 2018. An alternative approach would have been to backdate the awards to 1 April 2018 at half the value. Staging from October delivered the same in-year payment, but ensured that the recurrent award, for subsequent years, was higher (twice the amount) than if a backdating approach had applied.

1.25 For consultants, the decision was to modify the recommended 2% increase to basic and clinical excellence awards to apply:

- an increase of 1.5% to basic pay

- 0.5% of pay bill to be targeted on the new system of performance pay (with no increase to the value of clinical excellence awards)

1.26 This was informed by: the clearly established need for contract reform, as set out previously by the DDRB; the progress to date on agreeing a new system of performance pay awards to replace local clinical excellence awards; and the intention to seek to agree a multi-year pay and contract reform deal with the BMA.

1.27 For doctors and dentists in training, the Government agreed:

- the recommended 2% increase to basic pay; and
- the introduction, under the 2016 contract, of a flexible pay premium for histopathology training programmes. This recruitment premium was applied, in line with the Terms and Conditions of Service, to those commencing training in the relevant training programmes at ST1.

1.28 For SAS doctors, the Government abated to 3% the recommended 3.5% increase to basic pay. This took account of the facts that:

- the 3% award to Agenda for Change staff was considered to be the ceiling for 2018/19 awards; and
- whilst the significant investment for AfC staff was in return for contract reform, it was recognised that a review of the SAS salary structure was needed (as part of a wider review).

1.29 Moving on to contractors, for General Medical Practitioners, the Government abated the recommended 4% increase in pay, announcing:

- 2% uplift to the value of GP remuneration and practice staff expenses through the GP contract, through the addition of a further 1% to the 1% already awarded from 1 April 2018 through the contract; and
- the potential for up to an additional 1% to be added, from April 2019, conditional on contract reform through a multi-year agreement from 2019/20. This would be in addition to the envelope for contract negotiations for 2019/20 onwards.

1.30 For General Dental Practitioners, the 2% increase in pay recommended by the DDRB was accepted, from October 2018, combined with a 3% uplift for expenses from April 2018. In order to ensure the full effect of the 3% expenses uplift from April and 2% mid-year pay uplift is applied to future years we took the unusual step of implementing a two-staged uplift. A first uplift of 1.68% applied from 1 April 2018 followed by another uplift of 0.65% which will be applied from 1 April 2019.

1.31 For other payments to these staff groups, increases were informed by the principles and rationales above:

- the minimum and maximum of the salaried (employed) GP scales increased by 2% from October 2018 – this was consistent with the 2% increase to GMPs and the staging for employed staff;

- the recommended 4% increase in the GP trainer grant and GP appraiser fees was abated to 3% and applied from October 2018.

1.32 The same approach has been applied to the fees and allowances that are set out in the Pay Circular for medical and dental staff.

1.33 As set out in the remit letter, the affordability of pay recommendations for 2019/20 will have to be considered within the context of the affordability assumptions in NHS England's Long-Term Plan, and the importance of making planned workforce growth affordable.

1.34 We are again asking the DDRB to consider targeting, to ensure the optimal allocation of investment to ensure recruitment and retention issues are properly addressed.

1.35 We set out, in the following chapters, our approach for each of the remit groups, including for contract reform. The Secretary of State covered this, and other issues, in his letter of 18 September to the BMA, which is at Annex 3.

1.36 For employed doctors we are asking the DDRB to look at the case for targeting pay on shortage specialties and geographies based on the evidence that will be provided by HEE. For SAS doctors, we set out the work NHS Employers will take forward with the BMA to reopen a reformed Associate Specialist Grade along with other initiatives. We believe that this work will start to address the longstanding concerns the DDRB have had about morale for this group. For Consultants, we are asking the DDRB to consider targeting pay on increasing the funding available to support the reformed CEA scheme.

1.37 For GMPs, preliminary discussions on changes to the GP contract for 2019/20 are on-going ahead of formal negotiations. The funding envelope will depend upon primary care reforms agreed. Items for discussion in 2019/20 negotiations include primary care networks, reform of QOF payments, indemnity and digital.

1.38 In preparing this evidence, we have taken equalities impacts into consideration – ie, the potential impacts on those who share a protected characteristic (age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation). We would expect the Review Body to be mindful of equalities impacts in considering evidence from all parties and arriving at its recommendations; and Government will consider the recommendations in the context of its Public Sector Equality Duty.

Gender Pay Gap in Medicine Review

1.39 The former Secretary of State announced in 2016 his intention to commission an independent report on how to reduce and eliminate the gender pay gap in the medical profession. In April 2018 the review was officially launched. Professor Dame Jane Dacre, former President of the Royal College of Physicians, is chairing the review, with Professor Carol Woodhams and her team from the University of Surrey undertaking the quantitative and qualitative analysis elements of the review. The Department of Health and Social Care worked with the BMA and other key organisations to establish the review objectives. The review will help identify the causes of gender pay gap and enable the development and delivery of recommendations. The review recommendations, once agreed by the review's stakeholders, are expected to be published in March 2019.

2. Evidence on the General Economic Outlook

Introduction

2.1 The economic and fiscal context in which the Pay Review Bodies make their recommendations was set out in the October 2018 Budget. However, as in previous years this chapter sets out points in the economic and fiscal context which are of particular relevance to the PRB process, notably the latest OBR projections and labour market context, both public and private. This should be considered alongside the rest of the evidence set out in this document.

2.2 In July the Government announced the biggest pay rise in almost 10 years for around one million public sector workers across Britain. This Government recognises that public sector workers deserve to be fairly rewarded for the vital work they do, and seeks to ensure the overall package remains fair and competitive.

2.3 Our flexible approach to pay allows us to recognise areas of skill shortage, and improvements to workforce productivity. The Government continues to take a balanced approach to public spending and it is important that pay awards are considered within the wider fiscal picture. With budgets for 2019-20 already set, it is crucial that Pay Review Bodies consider the more detailed information about affordability set out in this document alongside the economic and fiscal context.

UK economy

2.4 As usual, it is very important that the PRBs take into account the wider fiscal context when making their recommendations. The UK economy has solid foundations and continues to demonstrate its resilience. GDP has grown every year since 2010 and is forecast by the OBR to continue growing over the forecast period. Employment is at a near record high and real wages are rising at the fastest rate for two years.

2.5 There has been a sustained worldwide slowdown in productivity growth since the 2008 financial crisis, but the UK has been affected more than most. Whilst productivity growth has improved since 2016 it remains below pre-crisis levels. Increasing productivity is the only sustainable way to boost economic growth and prosperity, and to deliver better jobs and higher

income for people across the country. The forecast for productivity remains subdued in the medium term but is expected to rise gradually to reach 1.2% per year[ii] by 2023.

2.6 With public services accounting for around 20% of UK GDP, public sector productivity plays an important role in the UK's productivity growth overall. While public sector productivity has increased by 0.8% in the last year, continued improvement is essential for meeting growing demands on our world class public services. Public sector pay awards should reward efforts to modernise workforces and delivery models.

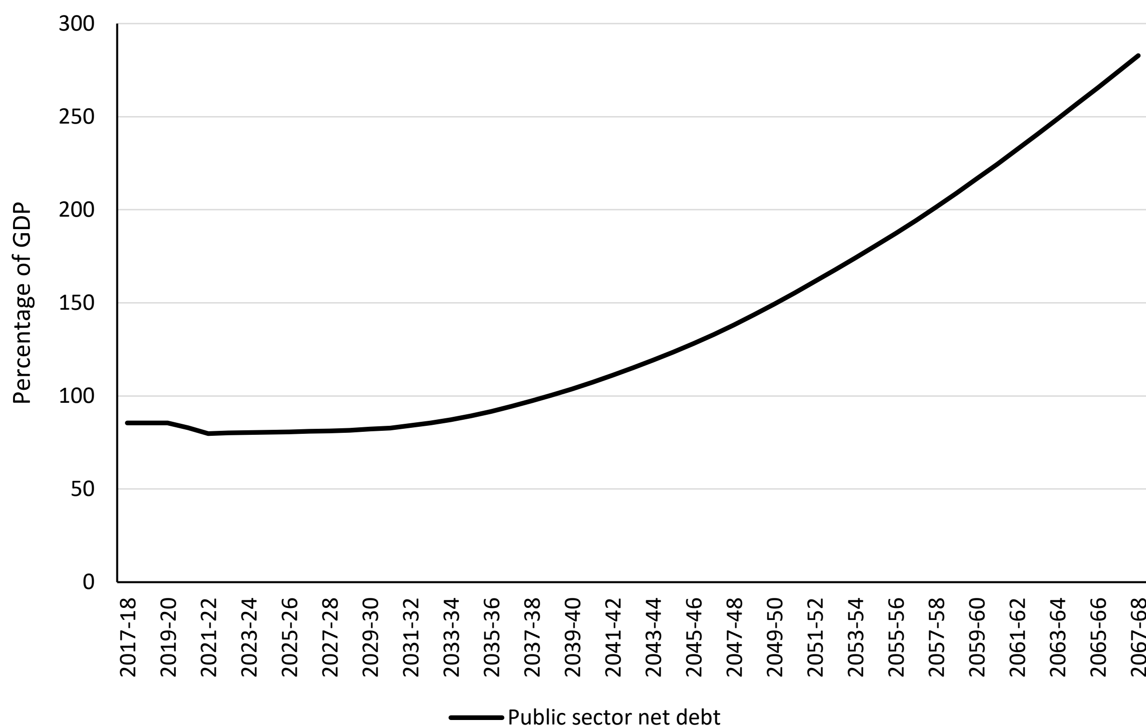
Public finances

2.7 Since 2010 the government has made significant progress in restoring the public finances to health, which have now reached a turning point. The deficit has been reduced by four-fifths from a post-war peak of 9.9% of GDP in 2009-10 to 1.9% in 2017-18. The fiscal rules approved by Parliament in January 2017 commit the government to reducing the cyclically-adjusted deficit to below 2% of GDP by 2020-21 and having debt as a share of GDP falling in 2020-21. These rules will guide the UK towards a balanced budget by the middle of the next decade. The OBR forecasts that the government has met both its near-term fiscal targets in 2017-18, three years early, and will meet them in the target year.

2.8 The need for fiscal discipline continues however as, despite the improvement, debt still remains too high at over 80% of GDP. Continuing to reduce borrowing and debt is important to enhancing the UK's economic resilience, improving fiscal sustainability, and lessening the debt interest burden on future generations.

2.9 The OBR's 2018 Fiscal Sustainability Report (FSR) was published in July and highlighted the long-term pressures and risks to the public finances, underscoring the importance of locking in this hard-won progress. The 2018 FSR projection shows that, left unaddressed, demographic change and non-demographic cost pressures on health, pensions, and social care would push the debt-to-GDP ratio far beyond sustainable levels in the long-term. This would pass an unacceptable burden on to the next generation, and the government is therefore committed to ensuring that debt remains on a sustainable trajectory.

Figure 2.1: Baseline projection public sector net debt (OBR Fiscal Sustainability Report, 2018)[iii]



2.10 Affordable pay awards will be an essential part of keeping borrowing under control: the public sector pay bill was £183.79bn in 2017. This accounts for £1 in every £4 spent by the Government. There continues to be a need to ensure increases in pay are affordable to ensure the delivery of world-class public services remains sustainable. Keeping control of public sector pay supports the Governments fiscal strategy to avoid passing an increasing burden of debt onto future generations. We spend more on debt interest than on the police and Armed Forces combined.

2.11 Existing spending plans set through the Spending Review 2015 remain in place, excepting the NHS, where the Government has announced a five-year funding settlement. The affordability position for each workforce is set out elsewhere in this evidence pack.

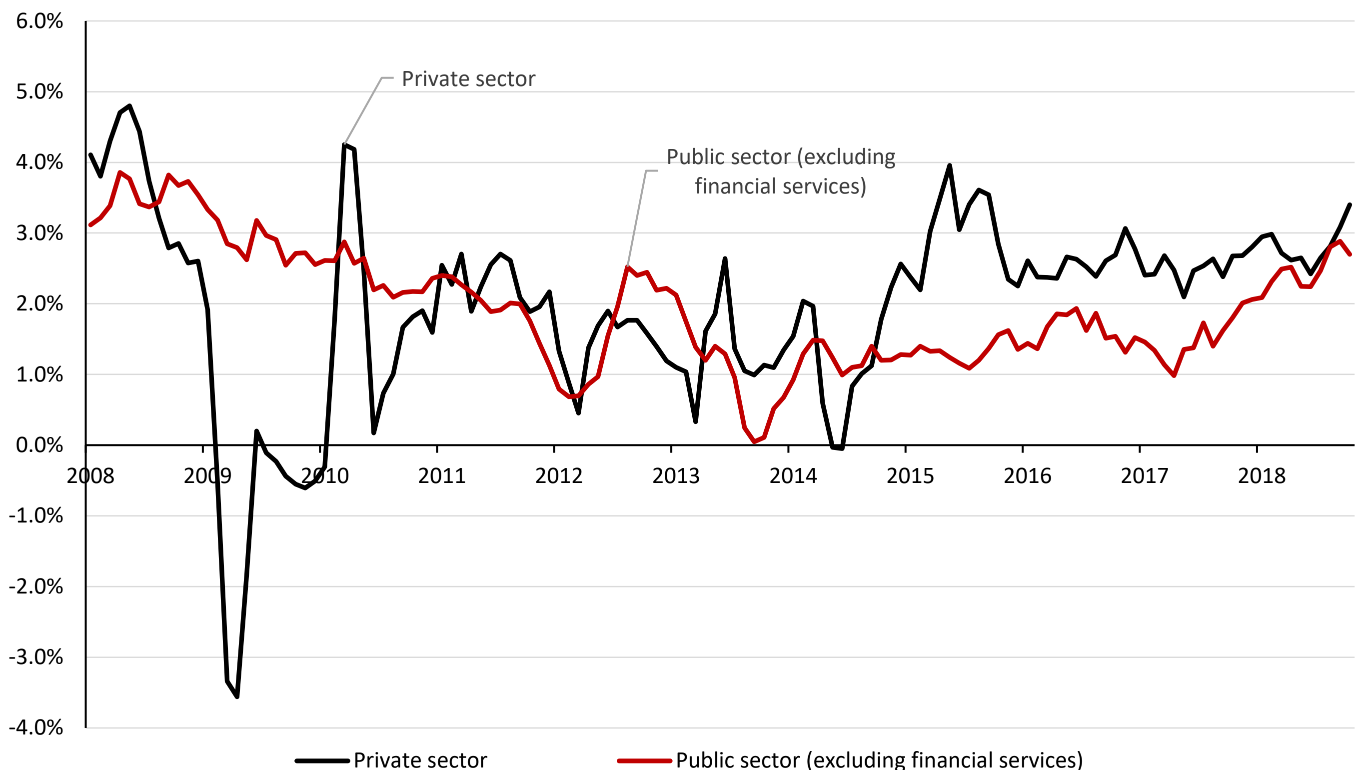
Labour market

2.12 Activity in the UK labour market is an important contextual consideration. Total employment reached a new record high in the 3 months to October 2018, with 32.5 million people in work. In 2018 the unemployment rate has dropped to its lowest since the 1970's, currently at 4.1%, it remains close to its historic low.

2.13 In their most recent Economic and Fiscal Outlook, the OBR revised down their assessment of the equilibrium rate of unemployment from 4.6% to 4.0% at the end of the forecast. The unemployment rate is forecast to reach 3.7% in 2019, before returning to 4.0% by 2023.

2.14 The downward revision to the equilibrium rate of unemployment was accompanied by an upward revision to labour market participation, meaning the number of people available to the labour market has increased. This was partially offset by a fall in average hours worked. Looking ahead, the OBR forecast employment to rise every year to reach 33.2 million by 2023.

Figure 2.2: Public sector (excluding financial services) and private sector average nominal earnings growth (ONS November 2018).



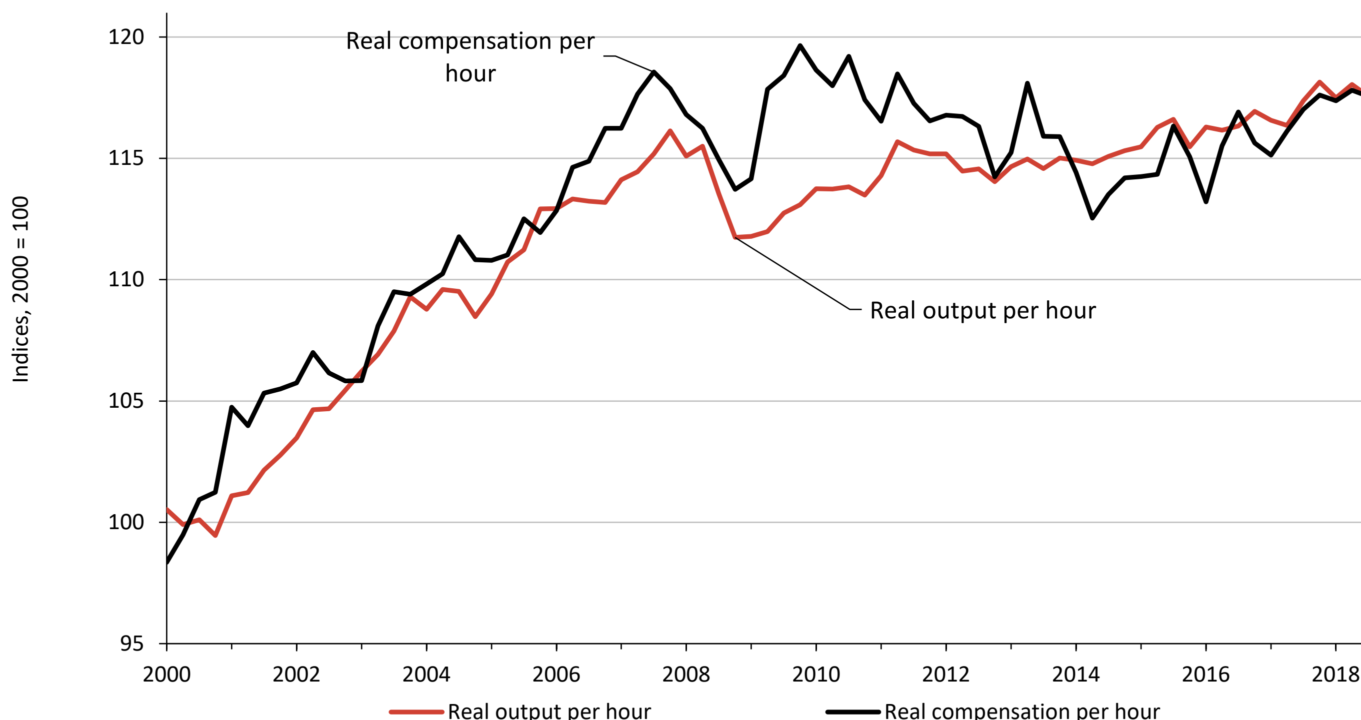
2.15 Total nominal wage growth rose to 3.3% in the 3 months to October[iv] (including bonuses), although wage growth remains lower than averages seen prior to the financial crisis, which reflects sluggish productivity growth. Public sector (excluding financial services) and private sector total wage growth are both above the current rate of inflation, at 2.7% and 3.4% respectively. Both the public sector and the private sector have seen real total pay growth in the three months to October. It should be noted that wage growth as reflected in the ONS Average Weekly Earnings series reflects pay

growth beyond annual settlements, including promotions, incremental increases and compositional changes.

2.16 The OBR forecast average earnings growth for the whole economy to be 2.6% in 2018, 2.5% in 2019, 2.8% in 2020, 3.0% in 2021, 3.1% in 2022 and 3.2% by 2023[v]. Average earnings growth is forecast to remain below the pre-crisis average.

2.17 Ultimately, a pickup in productivity is vital for the recovery of cross-economy wage growth rates to pre-recession levels. Public and private sector wages tend to move in similar directions, both because of pay expectations and the implications of tax receipts on public sector budgets. Despite low unemployment, weak growth in labour productivity has been weighing down on wages and, ultimately, the public finances. The OBR forecasts productivity growth of 0.8% in 2019, 0.9% in 2020, 1.0% in 2021, 1.1% 2022 and 1.2% in 2023.

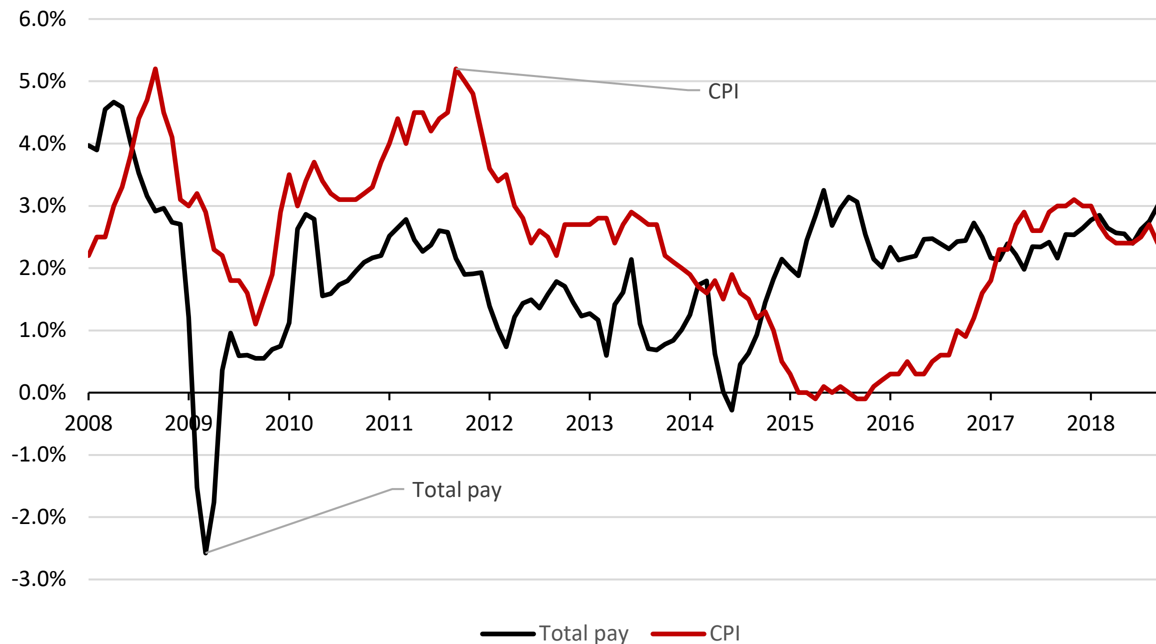
Figure 2.3: Real output per hour and real compensation per hour, year on year growth (ONS November 2018)



2.18 Inflation reached a peak of 3.1% in November 2017, following an increase in import prices after the earlier depreciation of sterling, but has since fallen back to 2.1% in the year to December 2018. The OBR forecasts CPI inflation to be 2.6% in 2018 and it is then expected to be 2.0% in 2019. It remains the view of Government that the appropriate level of public sector pay award is

complex and determined by a variety of factors. Rates of price inflation are important, but not the only consideration.

Figure 2.4: Whole economy average earnings growth and inflation (ONS November 2018)



Public sector pay and pensions

2.19 Public sector pay remains competitive: the median full-time wage in the public sector is £31,414, compared to £28,802 in the private sector. Public sector workers benefit from wider Government measures to support wages and ensure that people take home more of what they earn. The introduction of the National Living Wage marked an increase in pay for approximately one million people across the UK labour market, including in the public sector. Income tax changes mean that a typical taxpayer will pay £1,205 less in tax in 2019-20, compared to 2010-11, an additional support to public sector workers.

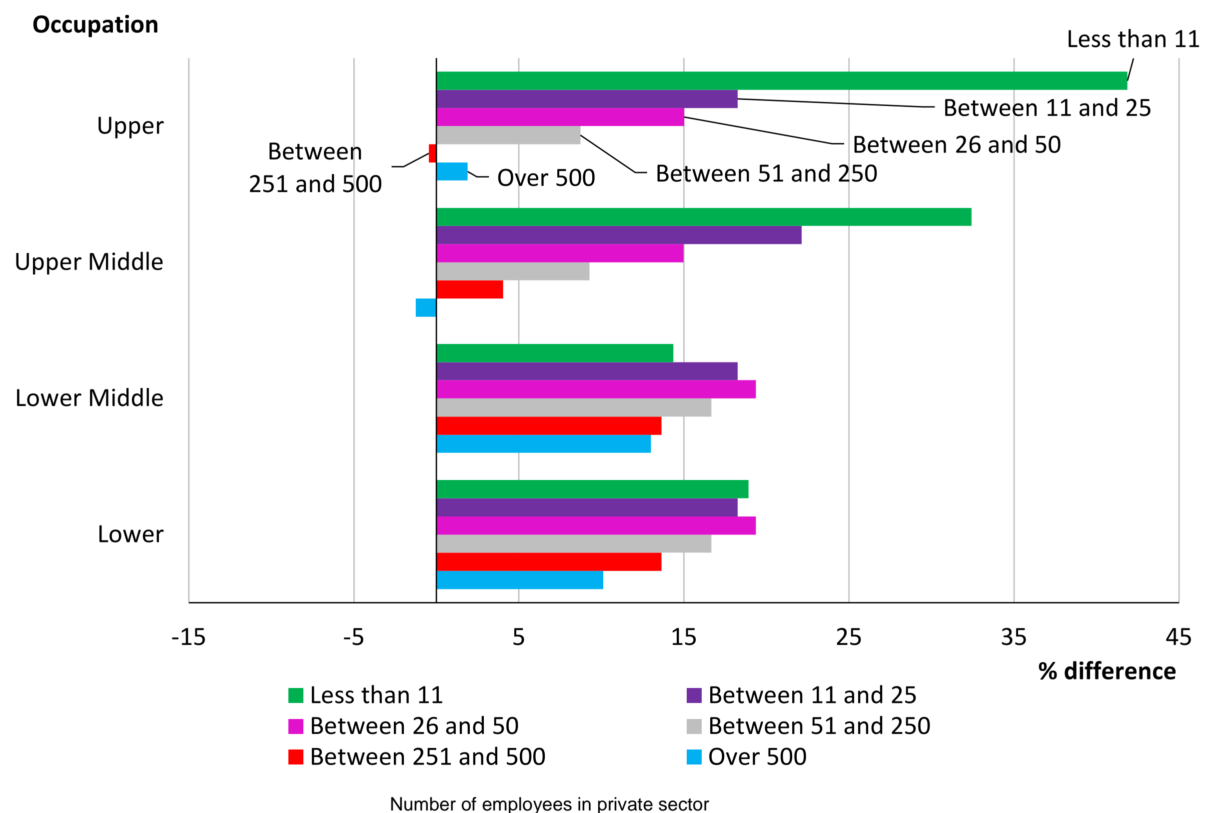
2.20 Following the 2008 financial crisis public sector workers were protected from the sharp drop in wages that was seen in the private sector, though wages subsequently grew at a slower pace. However, during Q3 2018 public and private sector wage growth was similar, and public sector remuneration when pensions are taken into account remains higher than in private sector, as shown in recent ONS analysis (see chart 2.5).

2.21 This analysis shows that after controlling for various individual and job characteristics, on average there is a positive earnings differential in favour of the public sector, when pensions are included. However, as shown in

Chart 5 below, this premium varies considerably by occupational skill level, and by the size of private sector firm being compared to the public sector, which is treated as a single large employer in this analysis. The right-hand side shows the average premium received by public sector workers in comparison to their private sector counterparts, and the left-hand side showing the penalty.

2.22 Key PRB workforces, including teachers, police and NHS staff such as nurses, midwives and GPs are in the upper and upper middle skill categories according to the ONS Standard Occupational Classification.

Figure 2.5: Average percentage difference in mean hourly earnings (includes pensions) of employees, by occupational group and firm size, private sector compared with public sector, UK, 2017[vi]



2.23 When considering changes to remuneration, PRBs should take account of the total reward package including elements such as progression pay, allowances and pensions. Public service pension schemes continue to be amongst the best available and significantly above the average value of pension provision in the private sector. Around 13.3% of active occupational pensions scheme membership in the private sector is in defined benefit (DB) schemes, with the vast majority in defined contribution (DC) schemes. In

contrast, over 92.7% of active members in the public sector are in DB arrangements.

2.24 The Budget confirmed a reduction of the discount rate for calculating employer contributions in unfunded public service pension schemes. The valuations indicate that there will be additional costs to employers in providing public service pensions over the long-term. It is a long standing principle that the full costs of public sector pensions are recognised by employers at the point they are incurred. This is important to ensure that the schemes are affordable and sustainable in the long-term. However, HM Treasury is working with departments to ensure that recognition of these additional costs does not jeopardise the delivery of frontline public services or put undue pressure on public employers.

Conclusion

2.25 This chapter summarises the economic and fiscal evidence which is likely to be relevant to the recommendations of the PRBs. This is intended to inform consideration of the affordability of specific pay awards, and to place these awards in economic context, on top of the workforce specific evidence presented elsewhere in this evidence pack.

2.26 Much of the evidence presented here will feed into retention and recruitment across public sector workforces. Retention and recruitment will vary considerably across geographies, specialisms and grades. As set out in our remit letter, we ask that the PRBs set out what consideration they have given to targeting in their final report, alongside affordability of awards.

3. NHS Finances

3.1 This chapter describes the financial context for the NHS.

Funding growth

3.2 The NHS Five Year Forward View (2014) set out the NHS's plan for delivering transformational changes to meet broad healthcare challenges. The Government signalled its clear support for this plan through the 2015 Spending Review settlement with a commitment to increase NHS funding by more than £8 billion per year by 2020-21 compared to 2015-16 (and £10 billion compared to 2014-15).

3.3 The Government has subsequently continued to provide additional funding increases, including £2.8 billion announced at the 2017 Autumn budget. This provided a significant increase in resource funding for day-to-day spending to support the NHS to put the service on a stronger, more sustainable footing.

3.4 In June 2018, the Prime Minister set out a new multi-year funding plan for the NHS, setting the real terms growth rate for spending in return for the NHS's new Long-Term Plan, which sets out how this money will be spent. This Long-Term Plan now determines the direction the NHS will take over the next decade.

3.5 All of this means that the NHS has, and will continue to see, real growth in its budget. Over the next five years this will average real-terms increases of 3.4%.

3.6 NHS England’s RDEL and real-terms growth figures since 2013/14 will follow this evidence.

3.7 This long-term funding commitment gives the NHS the financial security to implement a ten year plan that addresses challenges in a sustainable manner. Consequently, it is essential that this money is spent wisely, which is why the Government has set five financial tests to ensure the service is being put on a more sustainable footing:

- improving productivity and efficiency;
- eliminating provider deficits;

- reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live;
- getting much better at managing demand effectively;
- making better use of capital investment.

3.8 There will be multiple calls on available funding, including pay, and these will need careful prioritisation in order stay within available funding. More funding put towards pay will mean less funding for other priorities, including the size of the workforce that is affordable.

Financial position

3.9 The Government's Mandate to the NHS includes: a clear objective for the NHS to balance its budget; for NHS England and NHS Improvement (which has responsibility for financial control in NHS providers) to work together to stabilise finances across the system; and, to increase financial sustainability through improved efficiency and productivity in the provision of healthcare.

3.10 The NHS continues to work incredibly hard to manage its finances in a challenging environment. Since the financial re-set of July 2016, significant progress has been made and maintained. NHS providers continue to demonstrate that strong, effective and sustainable financial management is possible.

3.11 However, despite these successes, a small proportion of providers continue to make up the majority of the overall provider deficit. NHS England's Long-Term Plan, published on 7 January 2019, sets out the measures intended to support the most challenged organisations in returning to balance, and commits to reducing year-on-year the number of trusts and CCGs in deficit, so that all NHS organisations are in balance by 2023/24.

Figure 3.2 Provider deficit time series

NHS Providers RDEL Breakdown	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
	£m	£m	£m	£m	£m	£m	£m	£m
Total Provider Deficit	(458)	(476)	(544)	107	842	2,448	791	991
Provisions Adjustment	(106)	(163)	(120)	53	121	74	43	39
Other Adjustments	(183)	3	68	(11)	(47)	27	101	8
Total Revenue DEL	(748)	(636)	(596)	149	916	2,548	935	1,038

3.12 The NHS has been afforded the highest priority by the Government as demonstrated by a further increase of over £20 billion a year in real terms by 2023/24. This will ensure that the NHS is properly funded to meet the growing demands on the service. The NHS's ten-year strategic plan sets out how the money will be best spent to take forward the reforms to deliver a more sustainable NHS with improved care for patients and better health outcomes.

Share of resource going to pay

3.13 Figure 3.3 shows the proportion of funding consumed by NHS provider permanent staff spend over the last 5 years. Note that NHS provider permanent staff spend only covers staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

3.14 On average, between 2013/14 and 2017/18, increases to the HCHS paybill accounted for 44% (£7.0bn out of £15.9bn) of the increases in revenue expenditure.

3.15 Despite many competing pressures, the NHS has managed to increase its permanent staff spend while largely maintaining the proportion of expenditure spent on permanent staff.

Figure 3.3 Increases in Revenue Expenditure and the Proportion Consumed by Paybill

	NHS England RDEL (£bn)	Provider Permanent Staff Spend (£bn)	% of spend on staff	Increase in total spend	Increase in provider permanent staff spend
2013-14	93.7	42.9	45.8%		
2014-15	97.0	43.9	45.3%	3.6%	2.4%
2015-16	100.2	45.2	45.1%	3.3%	2.8%
2016-17	105.7	47.7	45.1%	5.5%	5.6%
2017-18	109.5	49.9	45.6%	3.6%	4.6%

3.16 In line with Government's wider policy, pay rises across the health service have largely stayed around 1%. However, last year the Chief Secretary to the Treasury confirmed a more flexible approach to public sector pay, in return for improvements to productivity.

3.17 Following this, and in recognition of the dedication shown by staff across the NHS, over the course of this year Government has announced a range of pay rises for doctors, dentists, and healthcare professionals on Agenda for Change.

3.18 These deals reflect the Government's continued support for the NHS workforce to deliver excellent care, while reinforcing public sector pay policy that pay flexibility should be in return for reforms that improve recruitment and retention and boost productivity.

3.19 The long-term settlement sets out overall funding available to the NHS from 2019/20, including for pay. The Government has confirmed that funding for the second two years of the Agenda for Change deal will be met from the long-term settlement. This long-term funding settlement runs off a baseline for 2018/19 that includes the £800m of additional funding for the Agenda for Change deal in 2018/19.

Demand pressures

3.20 Demand for services provided in the health and care system continues to rise above what would typically be expected from population growth and demographics alone. To meet this demand the NHS continues to deliver more activity than ever before, as evidenced by the number and growth in

emergency admissions and elective (i.e. non-emergency) treatments over the last 6 years.

3.21 Compared with 2016-17, the NHS managed just over half a million more A&E attendances in 2017-18, an increase of 3.8% in people seen by a specialist for suspected cancer and performed more 528,000 more diagnostic tests.

Figure 3.4 Emergency admissions per calendar day

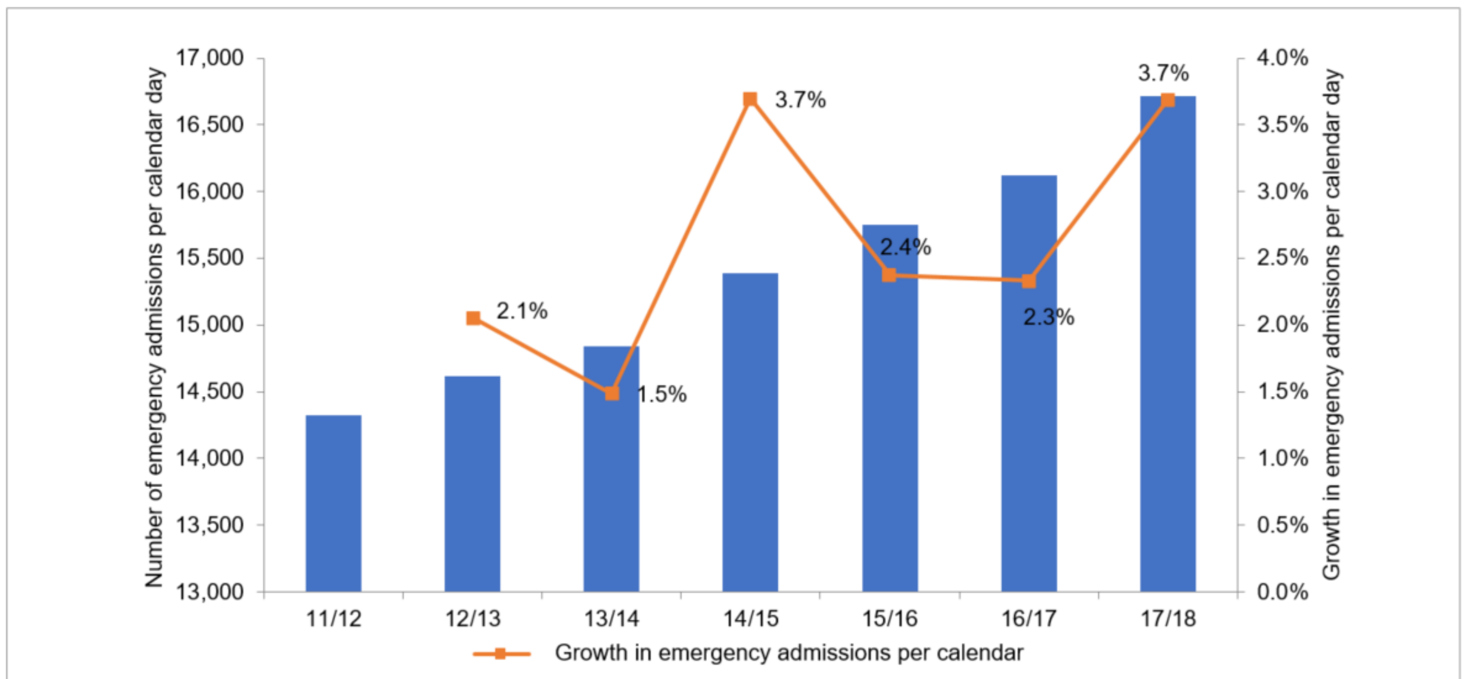
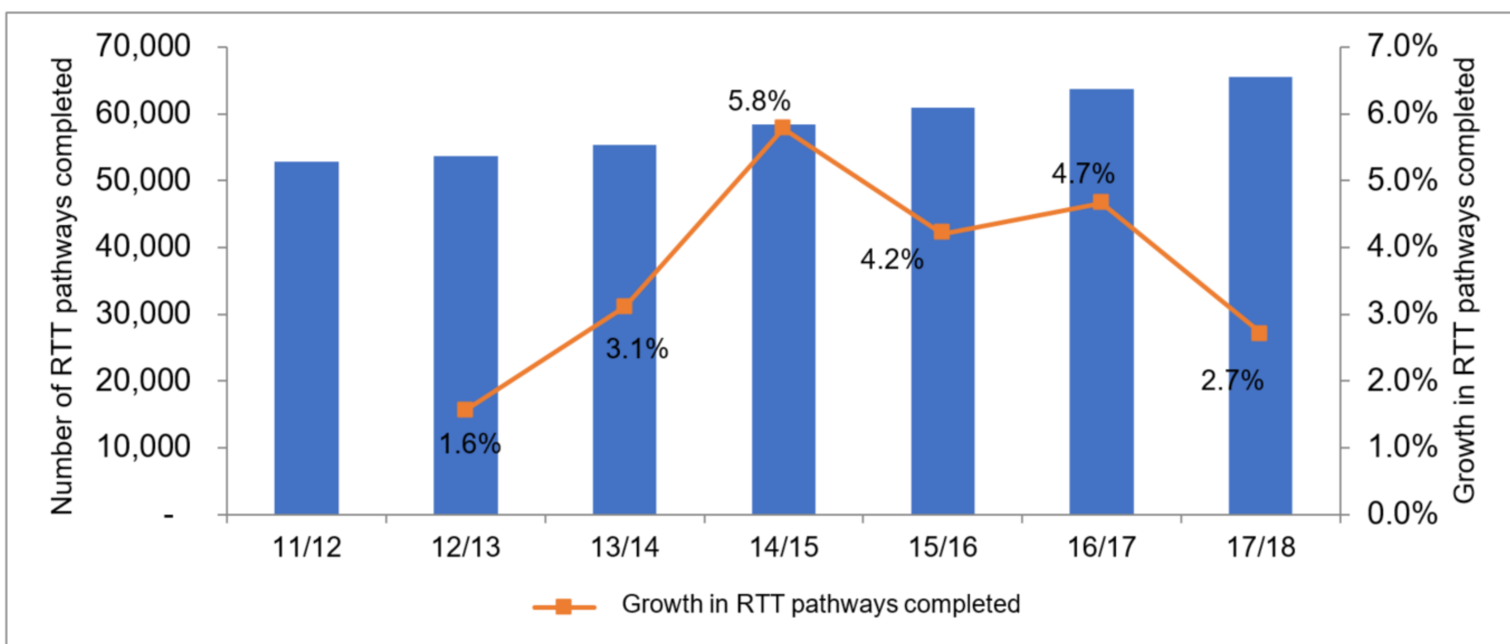


Figure 3.5 RTT pathways completed per working day



3.22 Despite the increasing activity during the year, the NHS balanced its financial budget through continuing focus on financial rigour and efficiency, with the majority of Trusts once again meeting their control totals. Managing demand effectively is one of the five financial tests that Government has set the NHS as part of the long-term funding settlement, while the NHS committed to cutting down avoidable demand in its 10 Point Efficiency Plan.

3.23 This level of rigour will need to be continued in future years, in order to ensure the long-term sustainability of the system.

Efficiency

3.24 To achieve this level of sustainability, the NHS must also continue developing into an increasingly efficient system. This efficiency will ensure that the funding received is used in the most effective manner to achieve the best value and the best possible outcomes.

3.25 The overall efficiency challenge is set out in the joint NHS' 10 Point Efficiency Plan – a single, agreed plan of action as to how the NHS will deliver the necessary savings to ensure it lives within its means. This includes:

- Operational Productivity Programme: reducing variation in clinical practice and improving management of resources in NHS acute, community, mental health, and ambulance providers, following the recommendations of the 2016 Carter Review of operational productivity.

- Getting it Right First Time: driving quality and productivity improvement in over 30 clinical specialities, helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes.

- Other cost improvement initiatives: such as RightCare which is supporting commissioners to reduce unwarranted variations in care; and NHS Improvement's Financial Improvement Programme which is providing central support combined with sharing learning and guidance to help raise levels of achievement against plans.

3.26 NHS England and NHS Improvement have joint oversight over the programme and monitor its progress. They provide expert central support and combine this with the sharing of learning and guidance to help raise levels of achievement against plans. Each NHS organisation has been set a stretching efficiency target as their contribution to this plan.

3.27 Progress is monitored through provider Cost Improvement Programmes (CIPs), and commissioner Quality, Innovation, Productivity and Prevention plans (QIPPs). In 2017/18 total savings delivered through Provider CIPS was £3.2bn while Commissioner QUIPPs delivered a further £3.0bn.

3.28 The system has made progress in implementing the Operational Productivity programme; across 2017-18, this programme has delivered £1.45 billion of efficiency savings for the NHS across the service, including hospital pharmacy and medicines, the clinical workforce, procurement, back-office services and estates. This is a promising start, but the challenge going forward remains ensuring that learning and best practice is spread across the NHS so that the full benefits of this work are felt everywhere.

3.29 Alongside this, progress has been made in reducing the reliance on the use of expensive agency staff within the NHS, reducing spending on agency workers to the targeted level of £2.5 billion, and increasing the use of bank staff, who are typically more committed to their trusts. This represents a cost reduction of £1.2bn over two years.

3.30 However, whilst progress has been made, at this point in time the NHS is not yet seeing the level of sustainable efficiencies that it needs. Organisations will need to address this and deliver more recurrent efficiencies to deliver sustainability as part of the Long-Term Plan.

Productivity in the NHS

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

3.32 The measure of labour productivity we use for the NHS in England is the one developed by the University of York (Centre for Health Economics, CHE). The York measure uses a range of NHS data sources to assess outputs and inputs and also adjusts the output measure to take some account of quality change, including change in waiting times and death rates. Their figures show between 2005/06 and 2015/16 the NHS's average annual labour productivity was 2.5%.

Figure 3.6 Labour Productivity Data from York University (CHE)

	Total Output Growth	Labour Input Growth	Labour Productivity Growth
2005/06	7.1%	3.4%	3.6%
2006/07	6.5%	0.6%	5.9%
2007/08	3.7%	0.7%	2.9%
2008/09	5.7%	4.1%	1.5%
2009/10	4.1%	4.5%	-0.4%
2010/11	4.6%	1.4%	3.2%
2011/12	3.2%	0.1%	3.4%
2012/13	2.3%	-2.0%	4.4%
2013/14	2.6%	0.4%	2.1%
2014/15	2.5%	2.8%	-0.3%
2015/16	2.6%	1.3%	1.3%
Average Annual Growth	4.1%	1.6%	2.5%

3.33 Labour productivity is an important component of efficiency, but labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, for example including drugs. This is called total factor productivity and York University also produce figures on this basis. Their figures show that between 2005/06 and 2015/16 the NHS's average annual labour productivity was 1.2%.

Figure 3.7 Total Factor Productivity Data from York University (CHE)

	Total Output Growth	Total Factor Input Growth	Total Factor Productivity Growth
2005/06	7.1%	7.2%	-0.1%
2006/07	6.5%	1.9%	4.5%
2007/08	3.7%	3.9%	-0.2%
2008/09	5.7%	4.2%	1.4%
2009/10	4.1%	5.4%	-1.3%
2010/11	4.6%	1.3%	3.2%
2011/12	3.2%	1.0%	2.1%
2012/13	2.3%	2.0%	0.4%
2013/14	2.6%	0.4%	2.2%
2014/15	2.5%	1.9%	0.5%
2015/16	2.6%	2.6%	0.0%
Average Annual Growth	4.1%	2.9%	1.2%

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

3.35 It is hard to identify productivity for individual staff groups as each unit of output is generated by a combination of different staff groups, from consultants and nurses, to management and support staff. It is difficult to disaggregate the productivity of these groups when they are contributing to the same unit of output.

3.36 The input factor of productivity can be more easily broken down by staff group. The labour input in York CHE's productivity measure is a weighted combination of different staff groups; the growths for each staff group is summarised in Chapter 6 of this submission.

3.37 As part of the long-term funding settlement, the NHS has committed to achieve cash-releasing productivity growth of at least 1.1% a year.

Conclusion

3.38 The Government has reiterated its commitment to the NHS through the long-term funding settlement that will deliver real terms increases in its budget of over £20 billion per year over.

3.39 Government's continued support for the NHS workforce was further underlined by recently announced pay rises, reflective of the more flexible approach to public sector pay than in previous years. These pay deals have rewarded staff dedication and productivity improvements, as well as encouraging recruitment and retention.

3.40 The long-term nature of the settlement will give the NHS the security to implement its Long-Term Plan for the service, determining the direction of the NHS over the next decade, putting the service on a more sustainable footing to meet the demands of the future.

3.41 Pay forms one part of a wider rewards package that includes pensions, and as a whole is intended to recognise the hard work of the NHS workforce.

4. HCHS Medical and Dental Staff Earnings

4.1 This chapter analyses how medical and dental staff earnings are distributed across the different types of doctors, how they have evolved since 2013/14, and the drivers behind this change. The second half of the chapter discusses how pay compares to that earned in the private sector, to identify potential recruitment and retention risks of medical and dental staff.

4.2 Medical practitioners remain amongst the highest (top 7) earning professions, and, looking broadly at earnings, medicine graduates typically earn at least 30% more than the average graduate[vii]. Whilst average Earnings for HCHS doctors have grown in the last five years, data for last year shows this growth has been at a lower rate than other high-income groups in the private sector. Consultants' pay, the most numerous and highly paid medical and dental staff group, has again grown at a rate significantly lower than average for the economy as a whole.

4.3 Average earnings have increased over the past year at a slightly faster pace than headline pay awards. This has been because of the changing composition of doctors and an increase in consultants in the workforce.

HCHS Earnings & Earning Growth Analysis

4.4 In 2017/2018, total earnings per FTE ranged between an average of £33,675 for a Foundation Doctor Year 1 and £119,112 for consultants who are the largest and most senior staff group. Average earnings for medical staff have increased over the past four years following increases to headline pay rates and an increase in the proportion of consultants.

4.5 Doctors' earnings in each of the medical career grades vary depending on training, experience and length of service; the estimates reported represent average total earnings per FTE. Consequently, these figures do not represent the earnings growth experienced by staff employed within one group throughout the five-year period. Most people will have received pay progression increments and some will have had a pay rise on promotion.

4.6 Changes in earnings over the past four years are generally higher for training grades (including the Foundation Programme and Specialty Training) than for those in Consultant and Career grade positions. The lower rate of increase for the consultant grade may be related to the increase in

the number of consultants over the period leading to more consultants at the lower end of the consultant pay scales. The “Staff Grade” and “Hospital Practitioner” grades are closed to new entrants and so figures should be treated with caution as this reflects the composition of remaining staff.

4.7 Over the past year there have been increases in Earnings per FTE for most medical grades with the largest increases for the Core Training and Specialty Registrar groups. The groups with decreases (Staff Grade and Unknown Grades) are closed grades and hence changes are due to compositional effects.

Figure 4.1: HCHS Medical & Dental Staff Average Cost of Total Earnings per FTE and FTEs by Medical Career Grade

Staff group	2013/14	2016/17	2017/18	Earnings Growth Since 2013-14	Earnings Growth Since 2016-17
HCHS Doctors	£79,047	£81,981	£83,383	5.5%	1.7%
Consultant (including Directors of Public Health)	£116,547	£118,131	£119,112	2.2%	0.8%
Associate Specialist	£94,158	£99,334	£100,841	7.1%	1.5%
Specialty Doctor	£69,791	£73,806	£75,268	7.8%	2.0%
Staff Grade	£72,487	£72,200	£71,137	-1.9%	-1.5%
Specialty Registrar	£56,721	£57,815	£59,521	4.9%	3.0%
Core Training	£47,165	£48,119	£50,514	7.1%	5.0%
Foundation Doctor Year 2	£38,750	£39,480	£39,932	3.0%	1.1%
Foundation Doctor Year 1	£31,657	£32,942	£33,675	6.4%	2.2%
Hospital Practitioner / Clinical Assistant	£96,294	£108,077	£112,646	17.0%	4.2%
Other and Local HCHS Doctor Grades	£71,037	£72,621	£69,656	-1.9%	-4.1%

Source - DHSC Paybill Metrics

4.8 Figure 4.1 shows the overall growth in earnings per FTE for different grades. Figure 4.2 shows the distribution of earnings within different grades over the past year. Across all medical grades the lowest 25% of earners have seen an increase of 3% compared to an increase of 1% for the highest earners. The reduction in earnings for the lowest 25% of Foundation Doctors is caused by compositional change.

Figure 4.2: Earnings for medical and dental by grade, and distribution in 2013/14 and growth to 2017/18, comparison of earnings by medical grade

	25% Earn Less Than	25% Earn Less Than	25% Earn Less Than	Median Average	Median Average	Median Average	25% Earn More Than	25% Earn More Than	25% Earn More Than	Mean Average	Mean Average	Mean Average
	16/17	17/18	Growth	16/17	16/17	17/18	Growth	16/17	16/17	17/18	Growth	16/17
HCHS doctors	59,500	61,000	3%	89,500	59,500	61,000	3%	89,500	59,500	61,000	3%	89,500
Consultant	93,000	93,500	1%	111,000	93,000	93,500	1%	111,000	93,000	93,500	1%	111,000
Associate Specialist	75,500	76,000	1%	89,000	75,500	76,000	1%	89,000	75,500	76,000	1%	89,000
Specialty Doctor	47,500	49,500	4%	67,000	47,500	49,500	4%	67,000	47,500	49,500	4%	67,000
Staff Grade	41,500	41,000	-1%	66,000	41,500	41,000	-1%	66,000	41,500	41,000	-1%	66,000
Specialty Registrar & Core Training*	48,500	50,000	3%	56,500	48,500	50,000	3%	56,500	48,500	50,000	3%	56,500
Foundation Year 2	35,500	33,000	-7%	43,000	35,500	33,000	-7%	43,000	35,500	33,000	-7%	43,000
Foundation Year 1*	25,500	22,000	-14%	29,500	25,500	22,000	-14%	29,500	25,500	22,000	-14%	29,500

Source – NHS Digital Earnings Statistics

Average Base Pay and Total Allowances

4.9 This section considers the current Basic Pay and Total Earnings for HCHS doctors in the 12 months to the end of March 2018 as published by NHS Digital. For all Doctors average earnings in 2017-18 were 1.9% higher than in 2016-17.

4.10 Three measures are provided. Basic Pay per person / per FTE which is based on Basic Pay only and does not include any additional allowances for things like overtime or geography. Total earnings per person includes all payments that are received by the individual – NHS Digital do not publish earnings per FTE.

4.11 Additional Earnings per person add around £20,000 to the earnings of a typical doctor but range from £8,000 For Foundation Year 1 to over £28,000 for consultants.

Figure 4.3: Staff earnings 12 months to March 2018

Staff Group / Medical Grade	Basic Pay per FTE	Basic Pay per Person	Total Earnings per Person	Change in Total Earnings over past year
HCHS doctors	£63,628	£58,263	£78,332	1.9%
Consultant (including Directors of Public Health)	£90,855	£84,906	£112,234	0.6%
Associate Specialist	£82,276	£73,409	£90,212	1.7%
Specialty Doctor	£60,732	£51,119	£64,389	2.4%
Staff Grade	£53,439	£45,155	£60,472	-0.8%
Specialty Registrar	£41,356	£38,951	£57,157	2.7%
Core Training	£36,269	£34,782	£49,639	4.5%
Foundation Doctor Year 2	£30,183	£28,895	£39,689	1.3%
Foundation Doctor Year 1	£26,586	£25,630	£33,537	2.1%
Hospital Practitioner / Clinical Assistant	£103,312	£30,208	£32,720	3.6%
Other and Local HCHS Doctor Grades	£79,801	£49,004	£51,493	0.3%

Source – NHS Digital Earnings Statistics – 12 Months to March 2018. Change compared to the 12 months to March 2017.

4.12 There are a range of additional allowances that Medical staff are eligible to receive based on factors including their location, shifts undertaken or experience. The table below shows these allowances and the proportion of each career grade who received allowances over 2017-18.

4.13 This shows that different career grades typically receive different allowances depending on their situation. Those in the Consultant grades are most likely to receive Medical Awards, including Clinical Excellence Awards, while those in the training grades are most likely to receive payments for Shift Work or Banding Supplements.

4.14 The value of these payments is below, and shows the average payment for those staff who received payment. The highest value allowances are RRP payments but these are paid to a very small number of people.

Figure 4.4: Proportion of Staff in Receipt of Allowances in 12 months to end of March 2018

Staff Group / Medical Grade	Additional Activity	Band Supplements	Medical Awards	Geographical Allowances	Local Payments	On-Call	Overtime	RRP	Shift Work	Other
HCHS doctors	49.4%	24.3%	18.6%	25.8%	14.9%	32.9 %	0.0%	0.2%	18.7%	9.2%
Consultant (including DoPH)	61.0%	0.5%	44.3%	25.5%	19.7%	71.8 %	0.0%	0.3%	0.6%	6.5%
Associate Specialist	48.7%	0.3%	0.4%	22.8%	17.5%	16.5 %	0.1%	0.1%	0.2%	4.9%
Specialty Doctor	47.3%	1.6%	0.0%	22.0%	17.9%	14.6 %	0.1%	0.7%	0.1%	3.8%
Staff Grade	30.6%	20.2%	0.6%	25.6%	18.6%	1.0%	0.2%	0.0%	0.1%	9.8%
Specialty Registrar	26.1%	66.6%	0.0%	29.8%	9.3%	3.7%	0.0%	0.0%	22.9%	9.2%
Core Training	51.9%	42.3%	0.0%	26.3%	10.3%	4.1%	0.0%	0.1%	50.4%	15.8%
Foundation Year 2	55.6%	31.8%	0.0%	23.3%	10.5%	2.1%	0.0%	0.0%	53.2%	17.1%
Foundation Year 1	87.6%	3.4%	0.0%	22.5%	14.7%	0.6%	0.0%	0.0%	86.4%	17.6%
Hospital Practitioner / Clinical Assistant	3.5%	0.3%	0.1%	4.7%	10.2%	0.2%	0.0%	0.2%	0.4%	5.0%
Other and Local HCHS Doctor Grades	5.9%	2.1%	0.6%	12.5%	7.4%	0.6%	0.0%	0.0%	1.5%	10.0%

Source – NHS Digital

Figure 4.5: Average Value of Allowances in 12 months to end of March 2018

Staff Group / Medical Grade	Additional Activity	Band Supplements	Medical Awards	Geographical Allowances	Local Payments	On-Call	Overtime	RRP	Shift Work	Other
HCHS doctors	£15,546	£17,048	£13,940	£1,683	£18,140	£3,745	£15,683	£19,267	£4,669	£5,606
Consultant (including DoPH)	£21,717	£13,168	£13,941	£1,684	£21,399	£3,700	£17,667	£21,836	£2,065	£7,252
Associate Specialist	£22,431	£26,978	£6,446	£1,409	£25,332	£5,199	£18,166	£10,217	-£1,844	£5,359
Specialty Doctor	£17,395	£12,754	£3,368	£1,273	£21,844	£3,019	£7,173	£11,655	£1,757	£3,695
Staff Grade	£18,439	£21,009	£4,300	£1,655	£25,513	£8,739	-£1,307	£0	£197	£7,684
Specialty Registrar	£8,717	£18,098	£0	£1,773	£13,985	£5,461	£19,120	£35,447	£6,047	£7,164
Core Training	£6,821	£14,628	£0	£1,741	£11,190	£4,042	£1,986	£7,623	£5,380	£4,445
Foundation Year 2	£5,248	£11,738	£0	£1,614	£8,864	£4,892	£0	£2,222	£4,878	£3,063
Foundation Year 1	£4,313	£9,457	£0	£1,590	£4,551	£4,161	£0	£0	£2,759	£2,141
Hospital Practitioner / Clinical Assistant	£18,074	£4,252	£30,663	£543	£14,252	£25,589	£0	£4,791	£4,070	£11,223
Other and Local HCHS Doctor Grades	£10,136	£19,810	£23,025	£1,386	£12,599	£6,235	£11,866	£123	£4,020	£2,927

Source – NHS Digital

High Earners Comparison Analysis

4.15 This section compares earnings of different professions from the Annual Survey of Hours and Earnings (ASHE) and how earnings have changed over the past five years. In this case the “Medical Practitioners” group (which includes all types of doctors from foundation, GPs and Consultants) are compared against other high-income occupations such as Airline Pilots, IT directors and members of the Legal profession. This allows comparison between the public and private sectors.

4.16 While there have been some changes over time with an increase in part time working as well as compositional changes, Medical Professionals remain one of the highest paid professions in the UK.

4.17 The results from ASHE data are different to those from DHSC paybill metrics. There are several reasons why this may be the case. ASHE data is based on around 1% of PAYE records from HMRC whereas NHS Digital data is based on data extracted from the Electronic Staff Record. ESR data should provide a more complete record of the workforce and be less subject to sampling errors.

4.18 ASHE data will also include some groups that are not covered by NHS Digital data including GPs. It is possible that the ASHE data is impacted by composition effects such as the proportion of GPs or Part Time workers.

4.19 Figure 4.6 compares the median annual earnings for occupations which had median annual earnings of at least £55,000 in 2013. It shows that the median annual gross pay for Medical Practitioners decreased by 4% between 2013-17 compared to an increase of 16% for Information technology and telecommunications directors and 12% for members of the legal profession. The decrease in median annual pay for Medical Practitioners is mainly due to sample composition effects such as the increase in the share of part time doctors and a shift towards more salaried (lower paid) GPs and fewer practice partners. The relative rank of Medical Practitioners is also shown to have reduced from 5th in 2013 to 7th in 2017 falling behind IT executives and Senior Police Officers.

4.20 The median annual gross pay for Medical Practitioners is around 2.6 times the national average for all staff.

Figure 4.6: Median Annual Gross Pay for High-Earning Occupations in 2013 and 2017

Occupation	ASHE CODE	Median Annual Gross Pay 2013	Median Annual Gross Pay 2017	Percentage Increase	Number of jobs (thousand) 2017
Chief executives and senior officials	1115	£84,374	£86,332	2%	72
Aircraft pilots and flight engineers	3512	£78,667	£83,691	6%	7
Marketing and sales directors	1132	£68,532	£74,153	8%	159
Legal professionals n.e.c.	2419	£63,231	£70,707	12%	35
Information technology and telecommunications directors	1136	£55,426	£64,379	16%	31
Senior police officers	1172	£57,695	£61,699	7%	10
Medical practitioners	2211	£63,676	£61,245	-4%	183
All employees	XXX	£21,837	£23,474	7%	21,992

Source: Office for National Statistics (ONS), Annual Survey of Hours and Earnings (ASHE) for 2013 and 2017 – Gross Annual Pay by Occupation (4-digit SOC 2010)

Why has the NHS paybill per FTE grown?

4.21 The Paybill per FTE increased by 1.8% in 2017/18. The main reasons for this increase are the medical pay award of 1.0% that took effect in April 2017, changes to the Junior Doctor contract and a staff-group effect with more consultants in the medical workforce. The increase in On-Costs was lower in 2017-18 as there were no further changes to regulations surrounding pensions or NI contributions.

4.22 Since 2010-11 the increase in Pay per FTE has been driven by an increase in Basic Pay per FTE as well as an increase in the proportion of consultants creating a more expensive cost-weighted workforce. Additional earnings per FTE have reduced over the period.

4.23 There are multiple factors which can contribute to changes in the cost of the medical workforce. These are related to changes in the composition of the workforce (e.g. more senior staff) or changes in pay rates.

- Headline pay awards & Pay Reform - this is the in-year pay settlement applied to basic pay values and any known impacts from pay reform that has been implemented.

- Changes in band mix - This is caused by a change in the distribution of staff across the different pay bands, and impacts the basic pay per FTE.

- Changes in point mix - This is caused by changes in the distribution of staff across pay points within bands, and impacts the basic pay per FTE (e.g. high recruitment may weigh the distribution towards lower points in the band as people tend to enter at the bottom of the pay range).

- Changes in staff group mix - This is caused by changes in the proportion of staff in specific professions which may be down to high recruitment of a specific staff group e.g. consultants.

- Additional earnings effects - can be caused by changes in other earnings at a different rate to basic pay (this may include the use of bonuses, geographical allowances, medical awards, recruitment and retention premiums etc.)

- On-costs effects - these can be caused by changes in the rules that govern employer pension contribution, or employer national insurance contribution requirements (recent effects here have been caused by introduction of the Single Tier State Pension and Apprenticeship Levy.

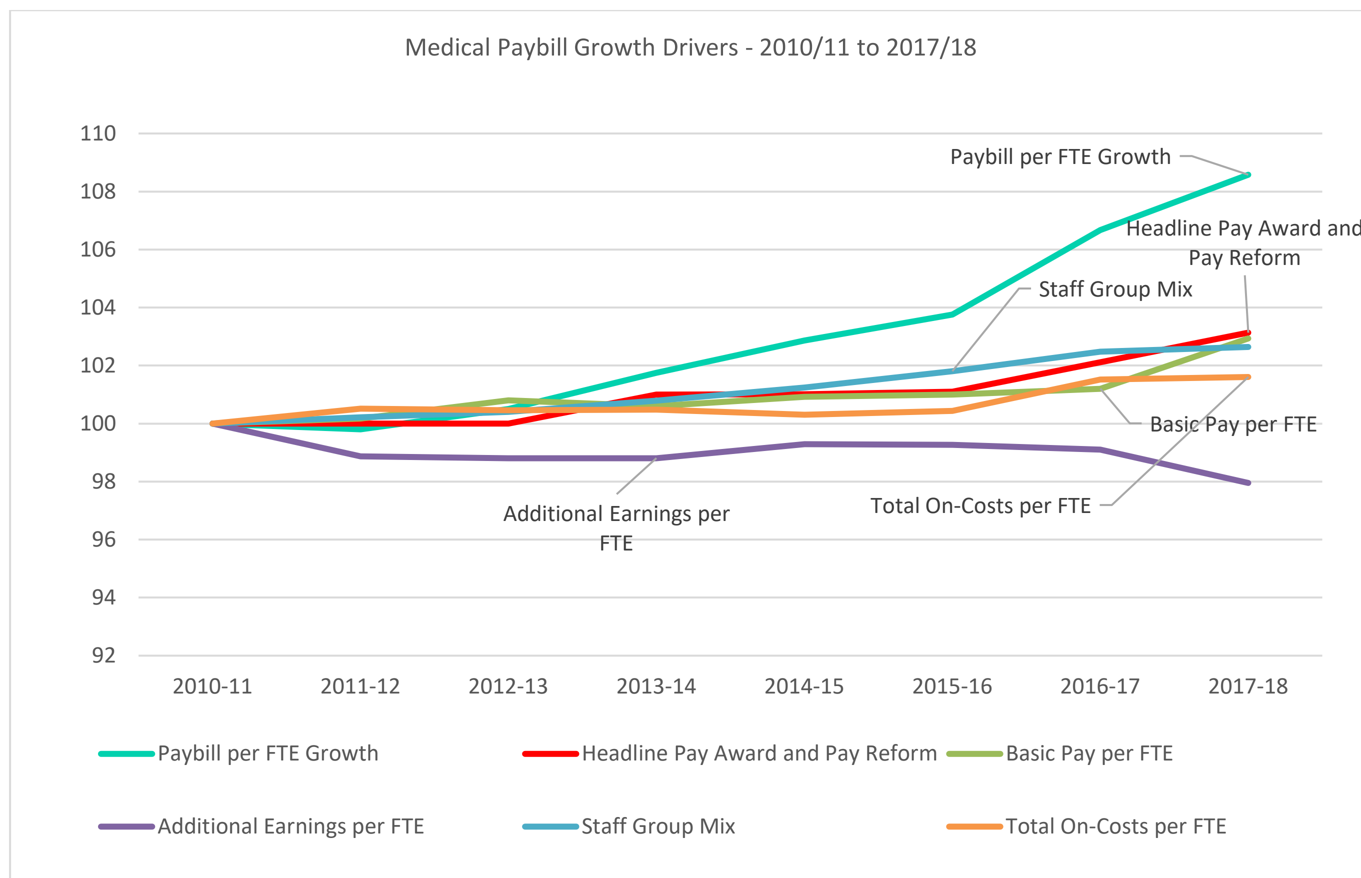
Figure 4.7: HCHS Medical staff pay bill per FTE year on year changes

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Paybill per FTE Growth	-0.2%	0.7%	1.2%	1.1%	0.9%	2.8%	1.8%
Headline Pay Award and Pay Reform	0.0%	0.0%	1.0%	0.0%	0.1%	1.0%	1.0%
Basic Pay per FTE	0.2%	0.6%	-0.2%	0.3%	0.1%	0.2%	1.7%
Additional Earnings per FTE	-1.1%	-0.1%	0.0%	0.5%	0.0%	-0.2%	-1.2%
Staff Group Mix	0.2%	0.2%	0.4%	0.4%	0.6%	0.7%	0.2%
Total On-Costs per FTE	0.5%	-0.1%	0.0%	-0.2%	0.1%	1.1%	0.1%

Source: Department of Health Headline HCHS Paybill Metric Estimates

[Insert title]

Figure 4.8: Movements in HCHS doctors pay bill components



Source: Department of Health Headline HCHS Paybill Metric Estimates

Recruitment & Retention Premia

4.24 Recruitment and Retention Premia (RRP) payments are pay supplements that can be made to individual jobs or groups of roles where labour market pressures can make it difficult to recruit at the standard rates – for example, because of specific skills shortages or local labour market conditions that may be particularly challenging.

4.25 Data from NHS Digital show that only a small number of Doctors receive these payments as shown in the table below. The proportion who receive payments has increased marginally over the past five years but is still around only 0.2% of doctors.

4.26 The average value of RRP payments has fluctuated over time – whilst the average payment in 2017-18 was higher than in 2016-17 it is only slightly higher than was the case in 2013-14

Figure 4.9: Average value and proportion in receipt of RRP payments

Year	Proportion in Receipt of RRP	Average RRP Payment
2013-14	0.1%	£19,015
2014-15	0.1%	£17,632
2015-16	0.1%	£18,634
2016-17	0.2%	£15,687
2017-18	0.2%	£19,267

Source – NHS Digital Earnings Statistics

Earnings of doctors at the foundation stage

4.27 This section provides additional detail on earnings for foundation doctors, and whether the increases seen last year have been sustained.

4.28 Earnings for foundation doctors have shown steady increases in the last five years with larger increases over the past two years. The earnings rate from last year has been sustained in 2017/18

4.29 Over the last five years, mean earnings for F1 doctors have increased by around 4.5%, while it has increased by around 4% for F2 doctors. In the last year, F1 earnings have increased by around 2%, while it has increased by around 1% for F2 doctors. This continues the trend observed in 2016/17.

Figure 4.10: Mean annual earnings per person for foundation year Doctors as at March each year

Grade	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Foundation year 1	£32,073	£31,374	£31,546	£31,879	£32,830	£33,537
Basic pay	£22,429	£21,951	£21,912	£21,885	£22,999	£25,630
Non-basic pay	£9,644	£9,423	£9,634	£9,995	£9,831	£7,907
Foundation year 2	£39,325	£38,451	£38,603	£38,576	£39,191	£39,689
Basic pay	£27,815	£27,067	£27,010	£26,984	£27,138	£28,895
Non-basic pay	£11,510	£11,385	£11,593	£11,592	£12,053	£10,793

Source: NHS Digital earnings estimates

Pay Progression

4.30 This section provides additional information on Pay Progression currently received by Medical staff of different grades.

4.31 Some medical staff will be eligible to receive pay progression as they move through training and gain more experience when a consultant. This reflects an increase in experience and responsibility.

4.32 The following table shows the current “Pay journey” while in training and then at Consultant Level.

4.33 Doctors in Training are eligible to receive increases in pay on completion of F1, F2 and after the first 2 years of Specialty Training

4.34 Consultants are eligible to receive increases in each of the first 4 years after being appointed and then at 5 yearly intervals until they have 19 years of experience as a Consultant.

Figure 4.11: "Pay journey" while in training and at Consultant Level

Year	Stage	Time in Grade	Basic Pay	Increase
	DOCTOR IN TRAINING LEVEL			
1	Foundation Year 1	1 Year	£27,146	
2	Foundation Year 2	1 Year	£31,422	15.8%
3-4	Specialty Training Years 1 – 2	2 Years	£37,191	18.4%
5- 10	Specialty Training Years 3 - 8	Up to 6 Years	£47,132	26.7%
	CONSULTANT LEVEL			
0	Entry to Consultant level	1 Year	£77,913	
1	1 Year Experience	1 Year	£80,352	3.1%
2	2 Years' Experience	1 Year	£82,792	3.0%
3	3 Years' Experience	1 Year	£85,232	2.9%
5 – 9	Between 4 & 8 Years' Experience	5 Years	£87,665	2.9%
10 – 14	Between 9 & 13 Years' Experience	5 Years	£93,459	6.6%
15 – 19	Between 14 & 18 Years' Experience	5 Years	£99,254	6.2%
20 +	19 Years' Experience and Above	Top of Band	£105,042	5.8%

Source: NHS Employers

4.35 Figure 4.12 below shows how the starting basic pay for Doctors in training and consultants changes over five years. It shows a significant increase of over 70% in the first five years in basic pay for new Doctors in training as they move to the latter stages of Specialty Training.

[Insert title]

Figure 4.12: Starting basic pay for Doctors in training and consultants after 5 years

	Starting Basic Pay	6th year Basic Pay
Doctors in Training	£27,146	£47,132 (73.6%)
Consultants	£77,913	£87,665 (12.5%)

5. Workforce Strategy

Workforce Strategy

5.1 Effective workforce policy is critical to the delivery of affordable, high quality care. Ensuring that the NHS has access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care is a fundamental aspect of the Department of Health and Social Care's overarching strategic programme for the health and care system.

5.2 The Department of Health and Social Care is responsible for leading, shaping and funding healthcare in England. The Department works with system partners to ensure there is a highly engaged and motivated workforce delivering NHS services to patients.

5.3 The Department works through its Arms-Length Bodies (ALBs) on the delivery and implementation of workforce policy. NHS England is the ALB responsible for setting the priorities and direction of the NHS and encouraging and informing the national debate to improve health and care. NHS England will be chiefly responsible for delivering a credible workforce plan, with education and training of the workforce being the core functions of Health Education England.

5.4 This year, NHS England and NHS Improvement agreed new joint working arrangements; including the creation of a People directorate led by a new Chief People Officer. The Chief People Officer, working closely with Health Education England, NHS Employers and other national partners, will have responsibility for providing a cohesive approach to improving leadership and management of the NHS workforce.

5.5 Additionally, Health Education England and NHS Improvement have agreed to a number of measures to improve how both organisations work together. These include new governance procedures for the Health Education England mandate. These new arrangements supersede the Workforce Strategy Board, which we established last year and which no longer meets.

5.6 The NHS Long-Term Plan published in January 2019 sets out a vital strategic framework to ensure that over the next ten years the NHS will have the staff it needs so that nurses and doctors have the time they need to care, working in a supportive culture that allows them to provide the expert compassionate care they are committed providing.

5.7 It highlights the following objectives as most important for the workforce:

- ensuring we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well;

- ensuring our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering healthcare;

- strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long-Term Plan will demand.

5.8 Critically, the plan is not just about numbers. It focusses on ensuring that our dedicated staff are supported, valued and empowered to do their best, with clear commitments to tackle bullying, discrimination and violence and a programme of work to sustain the physical and mental health of staff who work under pressure every day and every night.

5.9 To ensure a detailed plan that everyone in the NHS can get behind, the Secretary of State has commissioned Baroness Harding, Chair of NHS Improvement, to lead a rapid and inclusive programme of work to set out a detailed workforce implementation plan to be published in the Spring. The plan will be concise and delivery focussed, detailing what progress can be made on the commitments in the Long-Term Plan, identifying a series of actions to deliver on these commitments.

6. Recruitment, Retention, Motivation and Medical Workforce Planning

Background

6.1 Effective workforce policy is critical to the delivery of affordable, high quality care. Securing the people with the values, skills, experience and expertise which the NHS needs is central to the future of England's health and care system. NHS England's Long-Term Plan published on 7 January 2019 describes the approach to shaping the face of the NHS for the next decade.

6.2 The Department continues to take action to increase the supply of trained medical and dental staff available to work in the NHS and wider health and care system by supporting a world class health education and training system. In conjunction with Health Education England (HEE) and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff.

6.3 The supply of new consultants and the growth in the consultant workforce this generates continues to be consistently high, and the Government's commitment to expanding undergraduate medical training places will not only increase our supply of doctors but will also provide more opportunities for students with the talent, drive and ambition to train as a doctor.

6.4 As set out in the Long-Term Plan, HEE and NHS England will establish a national workforce group which will examine options for growing the medical workforce. These options will include the possibility of increasing part-time study, expanding the number of accelerated degree programmes and greater contestability in allocating the 7,500 medical training places to drive improvements in curricula. Depending on the HEE training budget agreed in the spending review, the number of medical school places could grow further.

6.5 The Department works through its Arms-Length Bodies (ALBs) on the delivery and implementation of workforce policy. Building on recent, constructive joint work to develop workforce priorities for NHS England's Long-Term Plan, HEE, NHS Improvement and DHSC have agreed new, joint working arrangements. These will help ensure that our organisations work much more closely together to support local health systems to recruit, train, develop and retain the staff the NHS depends upon, while enhancing leadership across the service.

Exiting the European Union

6.6 The Department of Health and Social Care is clear that our priority is to ensure that EU staff currently working in the NHS are not only able to stay, but feel welcomed and encouraged to do so.

6.7 The Home Office has launched the EU Settlement Scheme – a simple registration process for EU nationals who arrive in the UK to live before the end of 2020 (or by 29 March 2019 in the event of ‘no deal’) to remain living in the UK, with broadly the same rights as they currently enjoy.

6.8 The Home Office tested this scheme with all health and social care staff from 26 November 2018, giving them earlier access to the rest of the population.

6.9 There are over 4,300 more EU27 nationals since the referendum employed in NHS Trusts and CCGs. This includes almost 600 more EU27 doctors.

6.10 The data so far provides little evidence of an adverse EU exit impact on the employment of EU27 nationals in the NHS, particularly given other factors such as the additional language controls.

6.11 We continue to monitor and analyse overall staffing levels across the NHS and adult social care, and we’re working across Government to ensure there will continue to be sufficient staff to deliver the high-quality services on which patients rely following the UK’s exit from the EU.

6.12 On 18 September 2018 the Migration Advisory Committee published its important review on the patterns of EEA migration, the impacts of that migration on the UK and recommendations for a future migration system.

6.13 In its report, the MAC concludes that they believe the UK should focus on enabling higher skilled migration coupled with a more restrictive policy on lower-skilled migration in the design of its post-EU exit system.

6.14 The Department will continue to work with the Home Office to ensure that after we leave the EU, we will have in place an immigration system which works in the best interests of the whole of the UK.

Numbers in work

6.15 NHS HCHS doctors have increased by 9,791 FTEs (9.8%) in the period between March 2013 and March 2018. Consultants, who represent the largest group in the HCHS doctors' workforce, increased by 7,213 (18.3%), from 39,425 to 46,638. There have been large proportionate changes such as for Specialty Doctors which have seen the largest increase (21.8%) and the two categories which have been phased out: the Associate Specialist and Staff Grade[viii] have decreased by 32.1% and 26.5%, respectively.

Figure 6.1: HCHS doctors FTEs March 2013 to March 2018

Staff Group	March 2013	March 2018	Change in FTE	% Change
Consultant (including Directors of Public Health)	39,425	46,638	7,213	18.3%
Associate Specialist	2,983	2,027	-957	-32.1%
Specialty Doctor	5,509	6,710	1,201	21.8%
Staff Grade	446	328	-118	-26.5%
Specialty Registrar	28,577	29,500	923	3.2%
Core Training	8,429	10,105	1,676	19.9%
Foundation Doctor Year 2	6,485	6,526	41	0.6%
Foundation Doctor Year 1	6,164	6,149	-15	-0.2%
Hospital Practitioner/Clinical Assistant	574	497	-77	-13.4%
Other and Local HCHS Doctor Grades	963	868	-95	-9.8%
HCHS Doctors	99,556	109,346	9,791	9.8%

Source: NHS Digital HCHS monthly workforce statistics

6.16 The total proportion of doctors with a non-UK nationality increased slightly from 24.3% in March 2016 to 25.4% in March 2018. Most staff groups saw some increases over this period.

Figure 6.2: Proportion of non-UK doctors, March 2016-March 2018, headcount

Staff Group	March 2016	March 2018	Change
Consultant (including Directors of Public Health)	19.9%	20.2%	0.3%
Associate Specialist	28%	28.1%	0.1%
Specialty Doctor	45.4%	45.6%	0.2%
Staff Grade	44.4%	44.2%	-0.3%
Specialty Registrar	29.6%	30%	0.4%
Core Training	29.3%	34.9%	5.6%
Foundation Doctor Year 2	16.9%	20.1%	3.2%
Foundation Doctor Year 1	13.9%	15.6%	1.7%
Hospital Practitioner/Clinical Assistant	8.6%	7.2%	-1.4%
Other and Local HCHS Doctor Grades	10.5%	11.8%	1.3%
All HCHS Doctors	24.3%	25.4%	1.1%

Source: NHS Digital Quarterly Workforce Statistics

Skill Mix

6.17 The Department continues to work with NHS England and HEE to consider how skill mix changes can help address workforce shortages.

6.18 The NHS has seen the emergence and increased use of multi-disciplinary teams as part of a continuing drive to provide safe, accessible and high-quality care for patients. The Department is working with its ALBs to address areas of workforce shortage and to consider where appropriate skill mix interventions may be needed.

6.19 As set out in the Long-Term Plan, there will be an increasing focus on accelerating the shift from a dominance of highly specialised roles to a better balance with more generalist ones to meet the needs of an ageing population. There will also be further work to enable trainees to switch specialities without re-starting training, as well work to accelerate the development of credentialing.

6.20 General Practice is an area that has been a focus for the Department; in particular, targeting increased recruitment and retention. This year, HEE recruited the highest number of GP trainees ever (3,473), surpassing their target of 3,250 for the first time.

6.21 Getting the skills mix right in general practice is critical in addressing workload pressures, as well as in delivering appropriate patient care. This will mean bigger teams of staff, providing a wider range of care options for patients and freeing up more time for GPs to focus on those with more complex needs. As of June 2018, there are over 3,000 more clinical staff (excluding GPs) working in general practice since 2015; consisting of 500 more nurses and 2,800 more other direct patient care workers.

6.22 Furthermore, addressing geographical inconsistencies, the five new medical schools, alongside existing medical schools, have demonstrated a commitment to sending more trainees to rural or coastal areas and increasing the number of doctors who go on to train as GPs and mental health specialists.

6.23 The NHS has seen the emergence and increased use of new professional roles within multi-disciplinary teams as part of a continuing drive to provide safe, accessible and high-quality care for patients. Four of these professional roles can be grouped under the Medical Associate Professionals (MAPs) heading as they share some similarities in their career framework and education and training. The four roles are:

- Physician associate (PA)
- Physicians' assistant (anaesthesia) (PA(A))
- Surgical care practitioner (SCP)
- Advanced critical care practitioner (ACCP)

6.24 The use of MAP roles appears to be an acceptable model that could reduce the current skills shortage and provide high-quality patient care in both primary and secondary care settings.

6.25 The further growth of this profession is a key part of the Government's policy to develop a more effective, strong and expanding general practice to meet future need. Secretary of State announced in June 2015 that there will be 1,000 more PAs available in primary care by 2020 as part of the wider commitment to make available 10,000 health care professionals in primary care within this timeframe. HEE has committed to recruit 205 PAs into

training during the academic year 2015-16. Their current projections forecast an over recruitment into training of 75% (358). HEE's current national workforce plan for England sets out the proposal to commission 657 training places during 2016-17 in support of the 1,000 target.

Expansion of Undergraduate Medical Training Places

6.26 In October 2016 the Secretary of State announced plans for an expansion to undergraduate medical education, by funding an additional 1,500 medical school places in England. The first 500 places were allocated to existing medical schools for students starting in 2018-19.

6.27 In March this year, the Secretary of State announced the allocation of 1,000 new medical school places in England - to 17 schools in England, including five brand new medical schools in England all outside of London (in Sunderland, Lancashire, Chelmsford, Lincoln and Canterbury).

6.28 The new schools will help to deliver these places, alongside existing medical schools which have demonstrated a commitment to sending more trainees to rural or coastal areas and increasing the number of GPs and mental health specialists.

6.29 Overall, by 2020 there will be an extra 1,500 medical students entering training each year. Around 630 have taken up places on medical courses in September 2018, bringing the total intake for 2018/19 to 6,701 - the highest on record. A further 690 will be available to students in 2019/20 and the remaining 180 places will be available in 2020/21.

6.30 In terms of entry criteria to medical courses, these remain, as far as the department is aware, similar to previous years. Data showing average scores for those starting on medical and dental degrees is not published by UCAS.

6.31 The number of places under the expansion has now been finalised[ix]. The allocations are shown, along with pre-existing places in Figure 6.3. The expansion takes effect in 2018/19 and is spread over three years until 2020/21. The expansion phasing per year is shown in Figure 6.4.

- Over 500 of the new places have been allocated to seven new schools, all outside of London.
- Lancaster, Plymouth and Exeter universities received the highest percent increase in places.

- London universities generally received the fewest extra places.

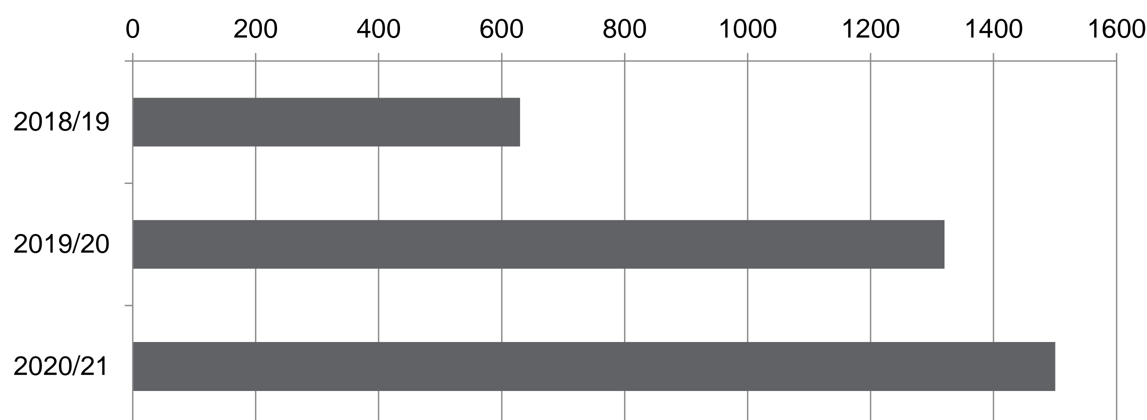
Figure 6.3 - Expansion table – Medical degree places before (6,071) and after the expansion (7,571)

University	2017/18	2020/21	Expansion
Lancaster University	54	129	138.9%
University of Plymouth	86	156	81.4%
University of Exeter	130	218	67.7%
Universities of Hull and York	141	231	63.8%
Universities of Brighton and Sussex	138	203	47.1%
University of Sheffield	237	306	29.1%
Keele University	129	164	27.1%
University of East Anglia	167	208	24.6%
University of Leicester	241	290	20.3%
Queen Mary, University of London	316	371	17.4%
University of Nottingham	327	371	13.5%
University of Warwick	177	193	9.0%
University of Oxford	184	200	8.7%
University of Liverpool	307	332	8.1%
University of Southampton	242	261	7.9%
University of Leeds	258	278	7.8%
St George’s Hospital Medical School	259	279	7.7%
University of Bristol	251	270	7.6%
University of Cambridge	292	313	7.2%
Imperial College	322	345	7.1%
University of Manchester	371	397	7.0%
University of Newcastle	343	367	7.0%
University of Birmingham	374	400	7.0%
King’s College London	403	430	6.7%
University College London	322	334	3.7%

Anglia Ruskin University	0	100
Aston University	0	100
University of Central Lancashire	0	15
Edge Hill University	0	30
Universities of Kent and Canterbury Christ Church	0	100
University of Lincoln	0	80
University of Sunderland	0	100
Total	6,071	7,571

Source – Office for Students (OfS)

Figure 6.4: Cumulative phasing of the 1,500 extra places



6.32 The Government set out its clear intention that widening participation and incentivising social mobility are central to this expansion. The increase will provide more opportunities for people from all backgrounds to study medicine. By widening participation and ensuring fair selection decisions, access to education and employment regardless of age, race, disability and social status will be allowed.

6.33 Over time, it will mean that we are taking fewer doctors from countries overseas where the domestic need is arguably greater than ours, and it will also help reduce reliance on expensive medical agency staff, and ensure the money is better spent on treating more patients.

6.34 A review of postgraduate medical education and training was undertaken under the chairmanship of Professor Sir David Greenaway to ensure that doctors now and in the future, are able to meet the changing needs of

patients, society and health services. The final report, The Shape of Training: Securing the future of excellent patient care was published in October 2013.

6.35 The UK Shape of Training Steering Group was convened by the four UK health departments to provide policy advice and structure to guide implementation of the recommendations from Professor David Greenaway's review

6.36 The Report from the UK Shape of Training Steering Group was published on 11th August 2017. The UK health ministers accepted its recommendations and officials from the 4 health departments are working with the GMC and the medical royal colleges on proceeding with implementation.

Analysis of Joiners and Leavers

6.37 The total increase in HCHS doctors is due to more doctors joining the NHS workforce rather than improved retention. Analysing changes in the number of joiners and leavers across different staff groups, and the reasons behind them, is an important step in identifying potential risks in recruitment and retention of medical and dental (M&D) staff.

6.38 While education and training provide around a third of joiners to the NHS from external sources, new entrants from non-EU countries have also grown to represent a sizeable component of the joining workforce (13%). The leaver rate for HCHS M&D staff was between 14% and 16% per year in the period between 2012/13 to 2017/18.

6.39 This analysis is provided in Annexes 4 and 5.

Retention

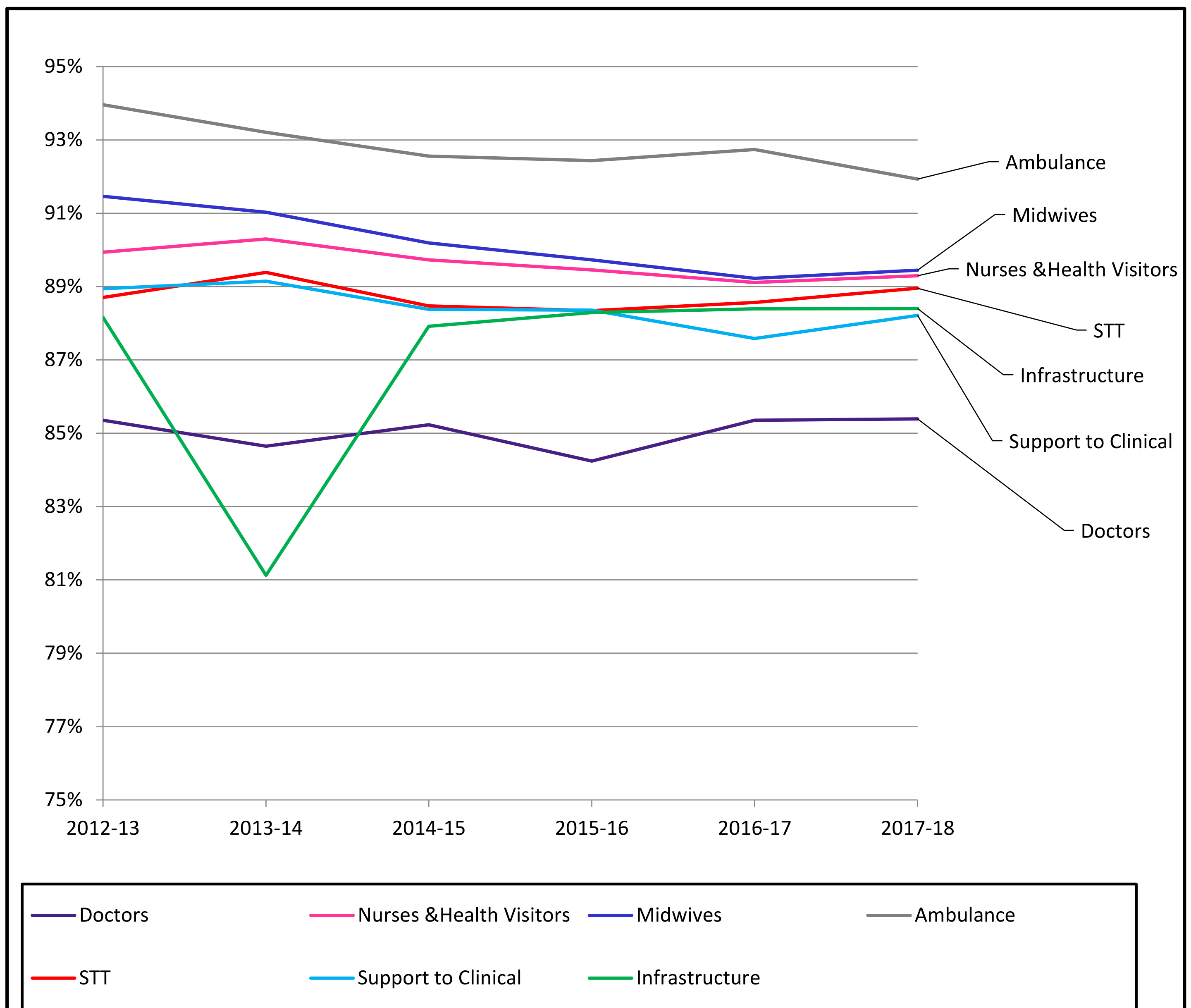
6.40 The stability index[x] captures how successful the NHS is in retaining its staff. The index is computed by NHS Digital on data for England. A comparison between medical and dental staff, nurses and other non-medical staff is presented.

6.41 Consultants have the highest stability index by doctor career grade at 94%. Doctors below consultant level often move and work abroad during their careers, and may well move between sectors. A larger share of doctors taking career breaks may also be influencing this index.

6.42 In the last few years little change in retention of the M&D staff can be observed, with the stability index first decreasing to 84.2% and then returning in 2016-17 to the 2012-13 level of 85.4%, and then remaining the same in 2017-18.

6.43 The most notable change in the stability index has been for infrastructure staff between 2012/13 and 2013/14, where there was a sharp fall, followed by a sharp increase back to original levels. This was driven by a policy to decrease the number of senior managers and managers in 2012/13.

Figure 6.5: Stability index for M&D staff and for non-medical staff in the last six years



Source: NHS Digital

Figure 6.6: Table to show the Stability Index of HCHS Doctors by medical career grades 2017/18

Staff Group	Stability index
Consultant (including Directors of Public Health)	94.0%
Associate Specialist	93.7%
Specialty Doctor	89.8%
Staff Grade	88.1%
Specialty Registrar	78.1%
Core Training	80.3%
Foundation Doctor Year 2	50.2%
Foundation Doctor Year 1	92.6%
Hospital Practitioner / Clinical Assistant	82.5%
Other and Local HCHS Doctor Grades	81.6%
All HCHS Doctors	85.3%

Source: NHS Digital

Medical staff reasons for leaving

6.44 A large proportion of HCHS doctors leave due to the end of fixed-term contracts (23.2% in 2017/18). The average stability index for all HCHS doctors is brought down by the lower stability index of junior doctors. The 2017/18 share of doctors who resigned voluntarily was 17.3%, similar to 17.7% in 2013/14. However, since 2014/15 the proportion of doctors voluntarily leaving appears to have been declining, year-on-year (Figure 6.8).

[Insert title]

Figure 6.7: Stability index for M&D staff and for non-medical staff in the last six years

Staff groups	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Doctors	85.4%	84.6%	85.2%	84.2%	85.4%	85.4%
Nurses &Health Visitors	89.9%	90.3%	89.7%	89.5%	89.1%	89.3%
Midwives	91.5%	91.0%	90.2%	89.7%	89.2%	89.4%
Ambulance	94.0%	93.2%	92.6%	92.4%	92.7%	91.9%
STT	88.7%	89.4%	88.5%	88.3%	88.6%	89.0%
Support to Clinical	88.9%	89.1%	88.4%	88.4%	87.6%	88.2%
Infrastructure	88.2%	81.1%	87.9%	88.3%	88.4%	88.4%

Source: NHS Digital

Figure 6.8: Reasons for leaving among HCHS doctors

Reason for leaving	2013/14	2014/15	2015/16	2016/17	2017/18	2013/14	2014/15	2015/16	2016/17	2017/18
Dismissal	94	102	88	69	65	0.5%	0.6%	0.4%	0.4%	0.4%
Employee Transfer	1904	364	298	169	164	9.6%	2%	1.5%	1%	1%
End of Fixed Term Contract	5567	5645	5986	4026	3855	28.2%	30.6%	29.9%	25%	23.2%
End of Fixed Term Contract – Completion of Training Scheme	1524	1337	1526	985	875	7.7%	7.2%	7.6%	6.1%	5.3%
End of Fixed Term Contract – End of Work Requirement	313	264	306	216	198	1.6%	1.4%	1.5%	1.3%	1.2%
End of Fixed Term Contract – External Rotation	2493	2406	2592	1685	1503	12.6%	13%	12.9%	10.4%	9.1%
End of Fixed Term Contract – Other	627	519	678	413	398	3.2%	2.8%	3.4%	2.6%	2.4%
Mutually Agreed Resignation	43	23	19	9	6	0.2%	0.1%	0.1%	0.1%	0.0%
Others	108	76	89	62	47	0.5%	0.4%	0.4%	0.4%	0.3%
Redundancy	171	58	35	31	25	0.9%	0.3%	0.2%	0.2%	0.2%
Retirement	1027	1060	1059	908	925	5.2%	5.7%	5.3%	5.6%	5.6%
Voluntary Resignation	3502	3608	3883	2817	2870	17.7%	19.6%	19.4%	17.5%	17.3%
Unknown	2371	2993	3481	4746	5668	12%	16.2%	17.4%	29.4%	34.1%
All Reasons for Leaving	19744	18455	20040	16136	16599	100%	100%	100%	100%	100%

Source: NHS Digital

6.45 Among those leaving voluntarily, the three most cited causes were; relocation, work life balance and undertaking further education and training. Work life balance has increased over the last five years, from 5.3% to 8.9%.

Figure 6.9: Top 3 reasons for voluntary resignation among HCHS doctors

Type of Voluntary Resignation	2013/ 14	2014/ 15	2015/ 16	2016/ 17	2017/ 18	2013/ 14	2014/ 15	2015/ 16	2016/ 17	2017/ 18
Relocation	700	709	736	660	702	20%	19.7%	19%	23.4%	24.5%
Work Life Balance	187	221	292	237	256	5.3%	6.1%	7.5%	8.4%	8.9%
Promotion	240	237	221	149	147	6.9%	6.6%	5.7%	5.3%	5.1%

Source: NHS Digital

Note: top 3 reasons excluding “Voluntary resignations – other/not known”

Vacancies

6.46 NHS Improvement perform monthly workforce data collections from NHS trusts and foundation trusts, which contain data on staff in post (including bank and agency), and vacancies. This data has shown that medical vacancies have remained relatively stable over the last five quarters – ranging from between 9,600 FTE to 11,500, which is equivalent to a rate of between 8% and 9.3%. This is a relatively new time series, therefore no long-term trends can be established presently.

6.47 Over the same period, the Midlands and East has had the highest medical vacancy rates at around 10%, while the lowest are in the South at around 6%.

6.48 Vacancy rates for the wider workforce have been between 8% and 9.2% over the past five quarters, which suggests that medical vacancy rates are similar to the wider workforce.

6.49 NHS Trusts use bank and agency staff to fill these vacancies temporarily, in addition to covering sickness absence and long-term leave. Approximately 85% of the 11,500 vacancies in 18/19 Q1 were filled by a combination of bank (45%) and agency (locum) staff (55%).

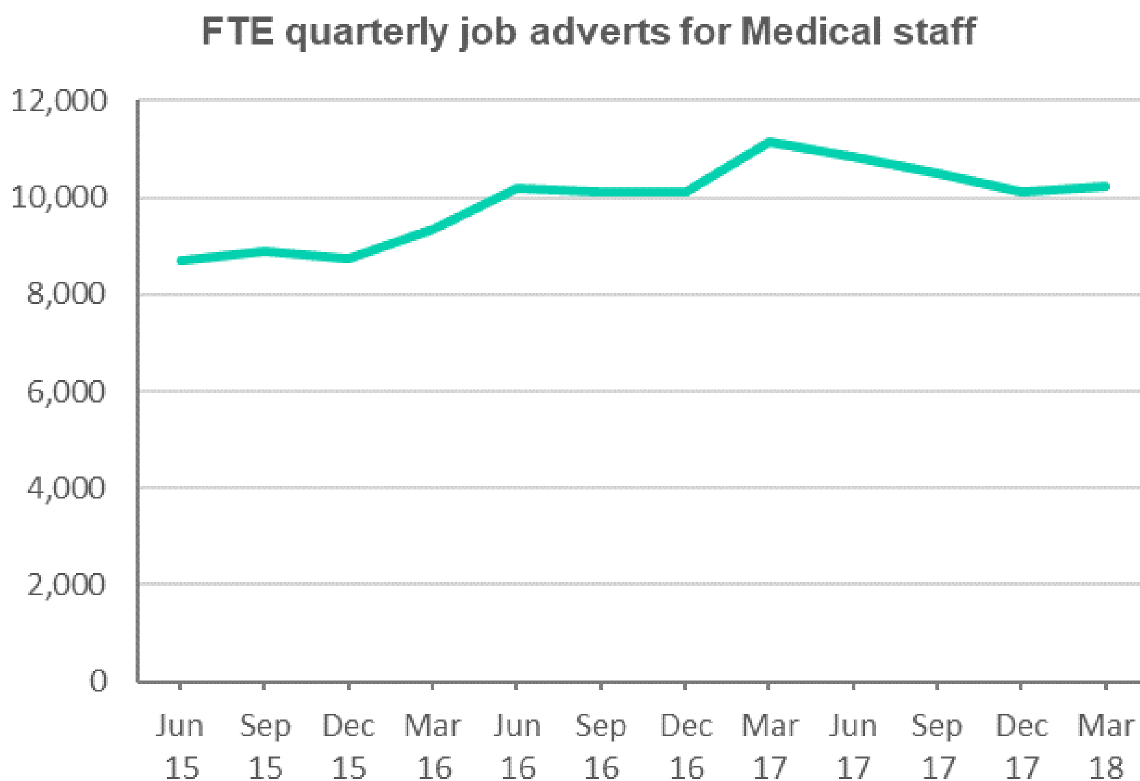
Figure 6.10: Medical vacancies

Medical Staff	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Vacancy rate	9.3%	8.4%	8%	8.2%	9.3%
WTE Vacancies	10,848	10,096	9,676	9,982	11,576

Source: NHS Improvement quarter 1 18/19 performance report

6.50 Separately, NHS Digital publish data on the number of jobs advertised on the NHS Jobs website. This data is a proxy for vacancies. It shows that job adverts for Medical staff have slightly increased in the last three years.

Figure 6.11: Quarterly job adverts for medical staff



Source: NHS Digital bi-annual job advert statistics for the NHS

Agency staff (All HCHS staff)

6.51 The use of Agency and Bank staffing provides some insights and an indication of how the NHS labour market is operating. The available national expenditure figures do not separate NHSPRB Remit from medical and dental staff. They include all expenditure on off-payroll staffing, including agency, self-employed contractors and externally-managed banks.

6.52 NHS Improvement and DHSC have signalled an intent to make greater use of bank staff as an alternative to using agency staff for temporary staffing. An early focus of this work includes a programme aimed at improving trusts' bank offers by providing bank staff with the ability to self-book shifts; allowing them to see those shifts alongside their normal rota using integrated technology; and providing prompter payment and pension flexibility for those shifts.

6.53 Introducing measures to reduce agency spend can only have maximum impact where trusts have a viable alternative temporary staffing solution. Staff banks ensure better quality and continuity of care, while allowing the reduction of unnecessary agency spending.

6.54 Trusts also recognise the importance of attracting staff to work on cost effective banks and have introduced many other initiatives including:

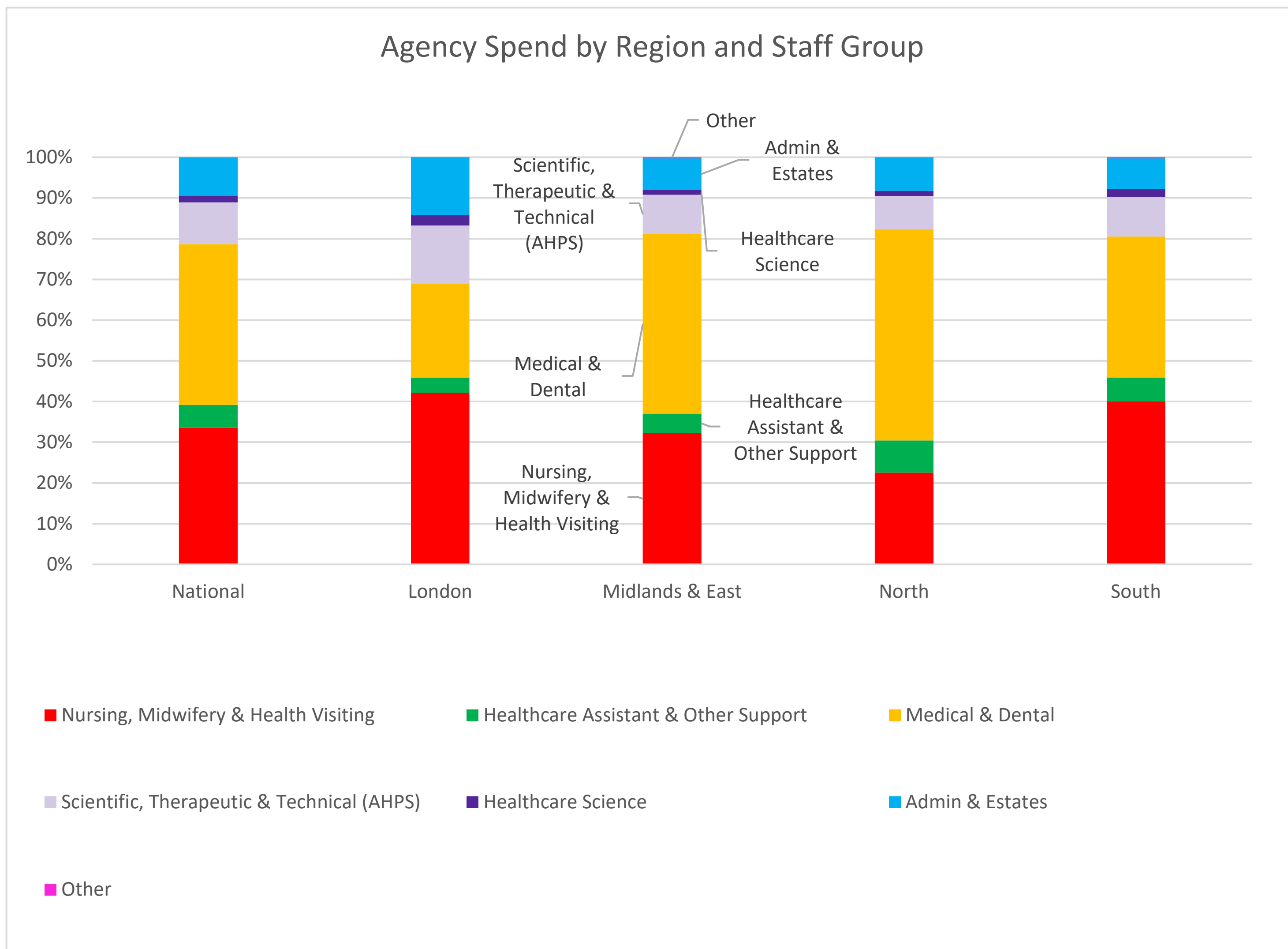
- Being clear about the benefits of NHS employment (i.e. pension scheme, paid training, indemnity cover)
- Making improvements to NHS staff banks including making it easier for substantive staff to choose and be paid promptly for additional shifts
- Making substantive contracts more flexible (for example if a doctor can only work 2 days in a week the trust will give them a contract for 2 days per week).

6.55 NHS Trust spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6bn to £3.7bn). Following the introduction of agency spend controls, expenditure on agency staffing reduced to £2.9bn in 2016/17 and £2.5bn in 2017/18 (a fall of 18% or £550 million across the total workforce in 2017/18 from the previous year).

6.56 NHS Improvement have provided data on the proportion of agency spend that can be attributed to different staff groups and by region. In 2017/18 a total of £950m (39%) was for Medical agency staff.

6.57 The London region had the lowest proportion of its agency spend on Medical staff (23%) while the Northern region had the highest proportion of its agency spend on Medical staff (52%)

Figure 6.12: Agency Expenditure by Staff Group and Region



Source – NHS Improvement

Staff Experience

6.58 The NHS Staff Survey provides useful insight into staff experience of working in the NHS including, for example, their motivation, engagement, satisfaction with flexible working and pay. In the future, results from the survey will take the form of a new set of indicators, or themes rather than the 32 key findings. This will provide organisations with a concise summary of how they are performing across different areas of staff experience relative to their peers and there will be a clearer indicator of staff morale.

6.59 Although staff experience in the NHS has remained relatively stable, there has been a slight decline in a large proportion of Key Findings from the 2017 NHS Staff Survey and the overall engagement score has decreased.

6.60 DHSC and their partners recognise there is no room for complacency and are working in partnership with ALBs and other colleague organisations to support trusts in their responsibility for improving staff experience as follows:

- #TalkHealthandCare gives staff the opportunity to share their views and contribute ideas to improve the experience of people working across health and care supplementing, for example, consultations and staff surveys.
- NHS Improvement has:
  - Its “Staff Experience and Outcomes Explorer” which provides a link between the NHS Staff Survey’s website on-line tool and research establishing links between staff experience and patient outcomes
  - Its Improvement Hub about staff retention where they have developed and collated a collection of resources to help improve staff retention which will include a mixture of: retention improvement guides; government policy documents; case studies on trust initiatives to improve retention. These have been created with support from trust HR directors, directors of nursing, medical directors and NHS providers to help promote best practice and share learning.
  - a staff health and wellbeing collaborative which is working with 73 trusts to develop 10 high impact actions for rolling out across the NHS including options for quicker access to accredited occupational health services. The Collaborative will support the NHS commitment to reduce NHS sickness absence by 1% by April 2020 and to the public services average by 2022.
  - The collaborative and NHS England’s staff health and wellbeing framework (see below) embed “Thriving at Work” principles aimed at improving workplace mental health and developing positive and supportive workplace cultures;
  - a Culture and Leadership Programme with a revised toolkit and guides and continues to share with and gather from trusts working on their culture and exploring use of the toolkit with trusts in special measures.
- NHS Digital publishes NHS sickness absence rates which now provide more information on length and number of episodes;

- CQC provides:
    - inspection reports;
    - publications e.g. "Driving Improvement: Case Studies from eight NHS trusts" which highlights that
    - "Engaging and empowering staff is key to driving improvement in hospital care";
    - 2017/18 State of Care which shows resilience in the workforce has been maintained despite the pressures organisations are facing in their struggles to recruit and retain staff.
    - a revised Well Led Framework which through reviews of leadership and governance identify areas that would benefit from further targeted development to secure and sustain future performance. NHSI is encouraging organisations to carry out, every three to five years, externally facilitated, developmental reviews of their leadership and governance using the well led framework.
- Sustainability and Transformation Partnerships use staff engagement to improve local services. New Care Models and Staff Engagement: All Aboard aimed to help spread learning from the vanguard programme across the health and care sector including:
    - enabling staff across organisations to 'break down the barriers' so people can break out of old working patterns and think differently;
    - recognising that those on the front line of care have the best ideas about how to improve it – but need to feel empowered to do so;
    - recognising that if staff feel their contribution is valued, they will want to do all they can to make new care models a success.
- The NHS Constitution remains the framework for what employers and staff should expect of each other and patients.
- NHS England has:
    - its staff health and wellbeing framework which sets out standards for what organisations in the NHS need to do to help support staff in feeling well, healthy and happy at work. The framework includes organisational enablers of essential leadership, structural, cultural building blocks for

improving staff health and wellbeing and interventions for mental health, musculoskeletal injuries and encouraging healthier lifestyles.

- its 2017/19 Commissioning for Quality and Innovation (CQUIN) incentive scheme which encourages trusts to invest in innovative local solutions for improving staff physical and mental health. To qualify for incentive payments, trusts have to show a 5% improvement in two of the three health and wellbeing questions in the NHS Staff Survey or achieve a 75% positive response rate;

- the Staff Friends and Family Test which assesses the extent to which an employee would advocate their trust as a place to work or receive treatment. It does not separate out different staff groups. Q1 2018/19, shows 66% of staff say they would recommend their organisation as a place to work (up 2% from the previous year) and 81% would recommend their trust as a place to receive treatment (highest since Q1 2017/18).

- NHS Employers provides advice, guidance and good practice and continues to lead negotiations with the BMA to modernise medical and dental pay, terms and conditions of service and work with partners to support implementation of the 2016 contract for doctors and dentists in training;

- Delivering against the Government's NHS workforce manifesto commitments as follows:

    - "We will take vigorous and immediate action against those who abuse or attack the people who work for and make our NHS": via the new NHS Violence Reduction Strategy commissioned by ministers, developed by NHS Improvement and NHS England with the NHS. The Strategy will aim to make appropriate use of the new Assaults against Emergency Workers (Offences) Act

    - "We will strengthen the entitlement for NHS employees to flexible working to help those with caring responsibilities for young children or older relatives": better use of technology (another priority for the Secretary of State) including apps and electronic rostering are being piloted and rolled out aimed at helping organisations make optimum use of their permanent and temporary workforces which should help them offer flexible working to more staff who want that. In respect of e-rostering, the Department is working across Government, with health leaders and trusts, on improving procurement arrangements including better evidence to support its use, easier access to the market for

providers, better interaction with other systems e.g. the Electronic Staff Record/payroll, more user training, better access to data etc.

- "We will introduce new services for employees to give them the support they need including quicker access to mental health and musculoskeletal services": this is being delivered via the health and wellbeing programmes described above following Secretary of State's July announcement about quicker access to services for staff who need help.

- We will act to reduce bullying rates in the NHS, which are far too high: this is being led by the national Social Partnership Forum's (SPF) "Collective Call to Action" which, during its second year has focussed on: support and training for line managers, the impact of bullying on patient care and encouraging sharing of good practice across the health and care system. The SPF is due to review the progress it has made as part of its consideration for third year priorities. DHSC along with the other UK health departments are working with the royal colleges and unions including the BMA to reflect the need for kindness, compassion and respect in staff recruitment as well as in subsequent training and development throughout careers.

Staff Engagement and Wellbeing

6.61 Responses to individual questions in the 2017 NHS Staff Survey are used to derive 32 key findings across 9 staff experience areas including an overall engagement score.

NHS Staff Survey - Engagement Index

6.62 The staff engagement index combines findings from:

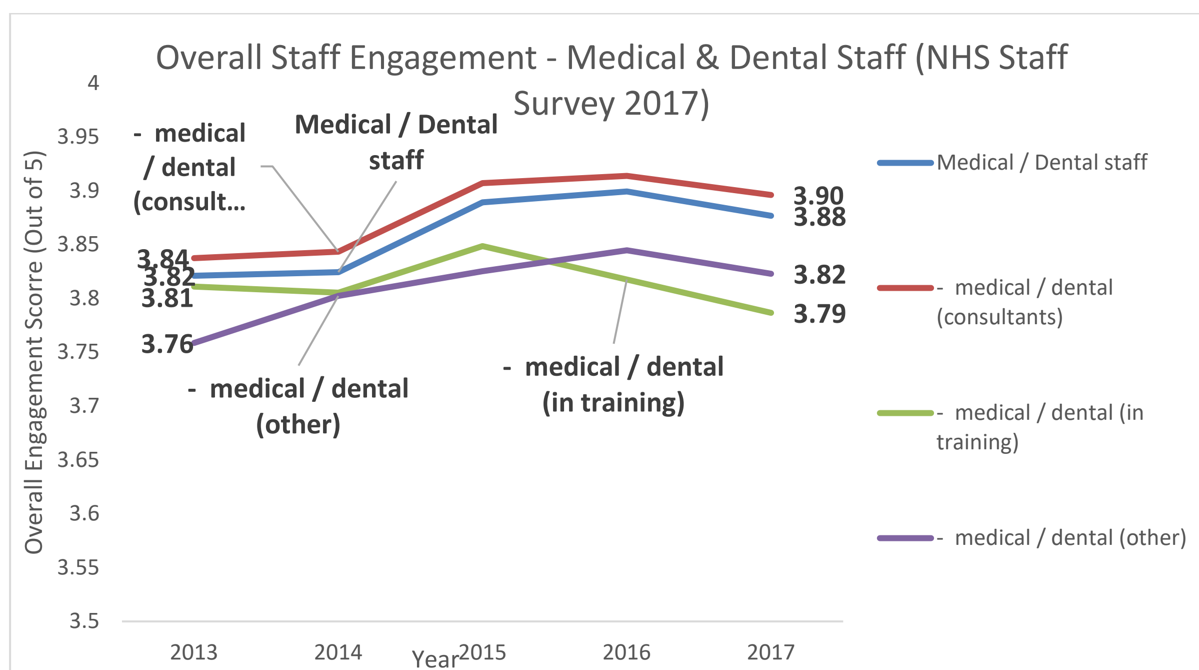
- Recommendation of the organisation as a place to work or receive treatment
- Staff motivation at work
- Staff ability to contribute to improvements at work

6.63 Medical and Dental staff have consistently higher engagement scores compared to other staff groups. In the 2017 survey Medical staff had higher scores than all groups other than General Managers.

6.64 Across all organisations there were increases in the engagement score between 2013 and 2017 but there were small decreases in the past year.

6.65 The graph below shows the engagement index for the different medical and dental staff groups over the past 5 years. For Medical and Dental staff, the engagement index has increased slightly (0.06 points) over the period. Medical and Dental staff in training are the only group of medical staff where the index in 2017 (3.79) is lower than it was in 2013 (3.81)

Figure 6.13: Overall Staff Engagement - Medical & Dental Staff (NHS Staff Survey 2017)



Performance Against Selected Key Findings

6.66 The 2017 NHS Staff Survey reported results against 32 different key findings across elements of staff experience and wellbeing. This section looks at the results of those findings and how many have improved or worsened over time.

6.67 The trends for each of the key findings are shown in the table below. In the period between 2015 and 2017 for all medical and dental staff there have been improvements in 18 of the 33 metrics however for doctors and dentists in training there have only been improvements in 8 of the 33 measurements. Over the past year there were more deteriorations (20) than improvements (13).

Figure 6.14: Key findings trends (improvement and deterioration) between 2015 and 2017 for medical and dental staff

2015 – 2017	Improvement	Deterioration
Medical & Dental Staff	18	15
Medical & Dental (Consultants)	20	13
Medical & Dental (In Training)	8	25
Medical & Dental (Other)	17	16

2016 – 2017	Improvement	Deterioration
Medical & Dental Staff	13	20
Medical & Dental (Consultants)	18	15
Medical & Dental (In Training)	10	23
Medical & Dental (Other)	12	21

6.68 For a few metrics, while the direction of movement has been the same for all medical categories, the change has been larger for some. For example, "Staff Satisfaction" for Doctors in Training has declined by 0.07 points over the past 2 years compared to a reduction of 0.02 points for consultants.

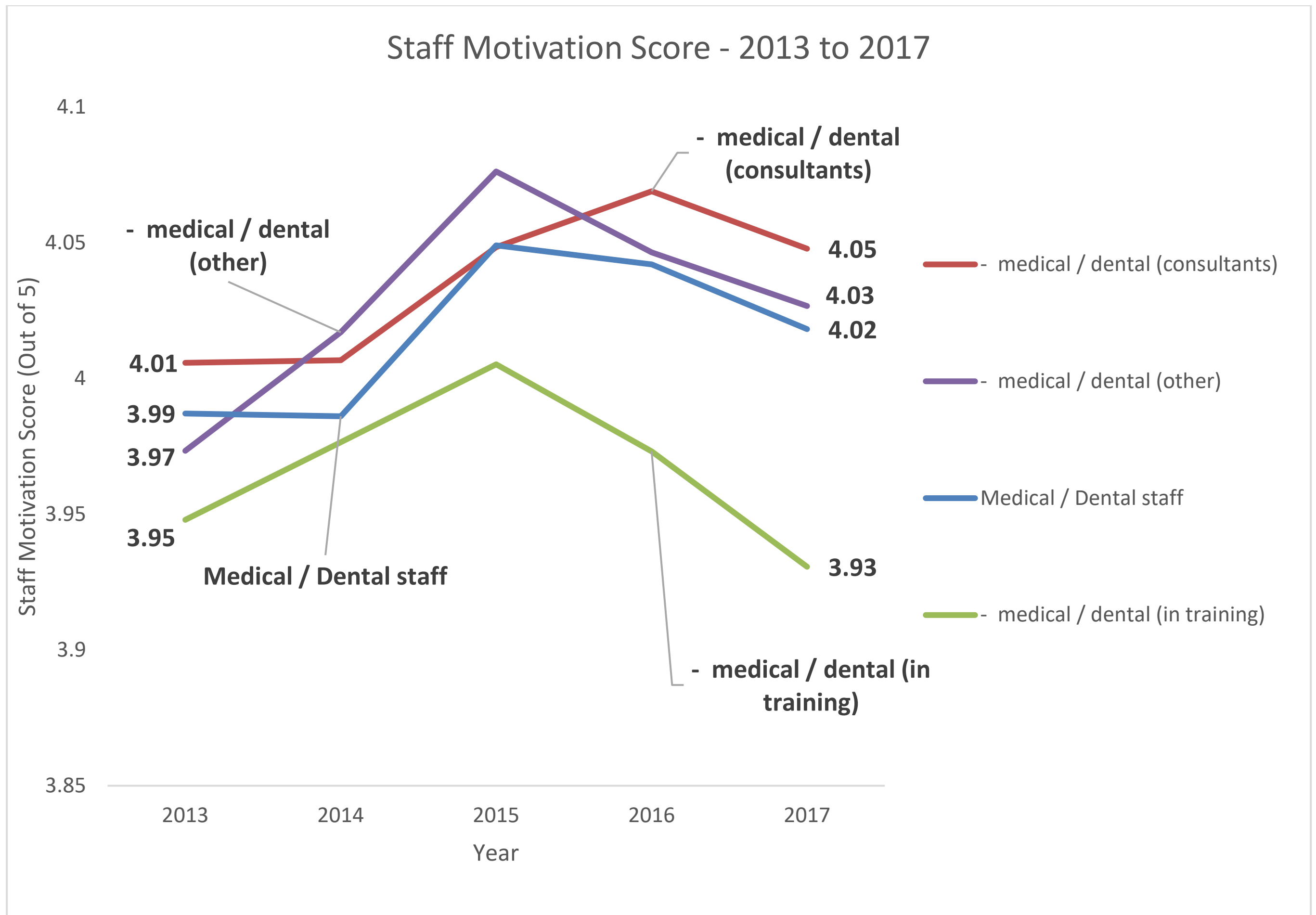
6.69 Across all key findings the staff survey suggests Consultants have a better experience at work when compared to more junior doctors and dentists. In 2017, consultants had better scores than those in training on 25 of the 33 measures.

Staff Motivation

6.70 For all medical and dental staff, motivation has improved slightly between 2013 (3.99) and 2017 (4.02). Despite the overall improvement, the score for Doctors in Training has worsened over the period (3.95 – 3.93) and there have decreases for all medical and dental groups over the past year.

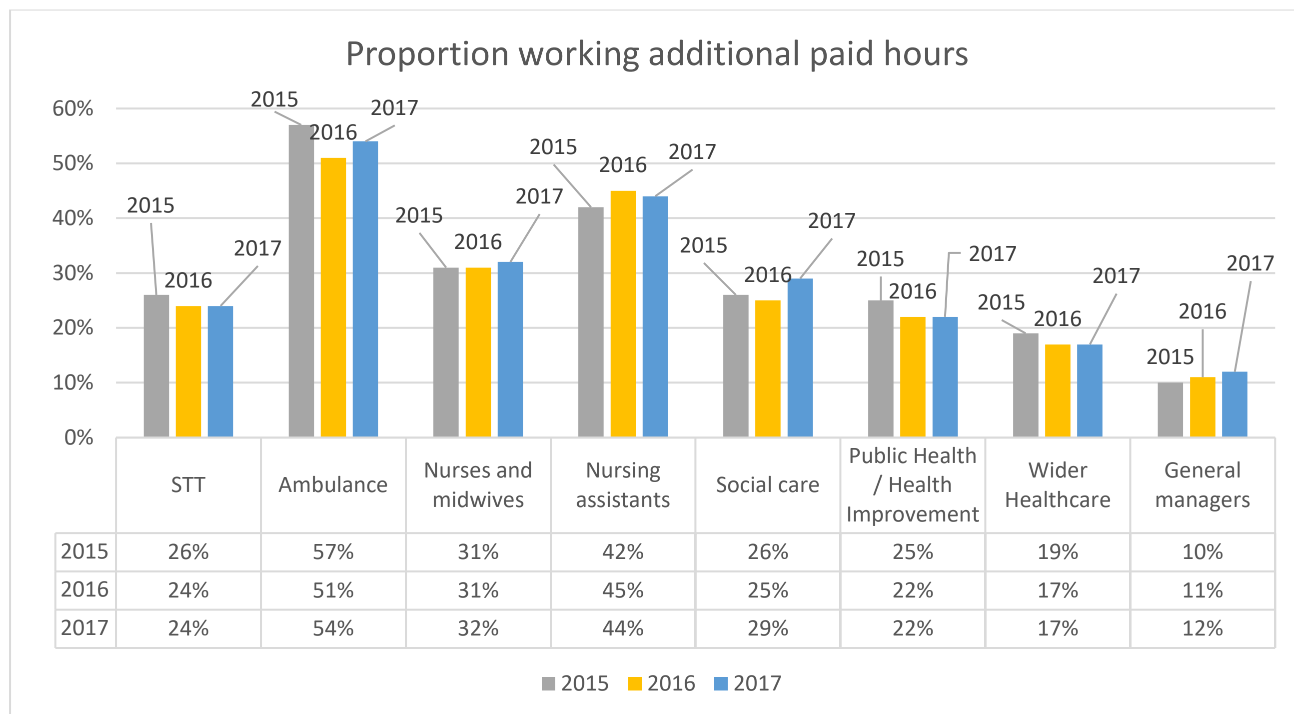
[Insert title]

Figure 6.15: Staff motivation score 2013 to 2017



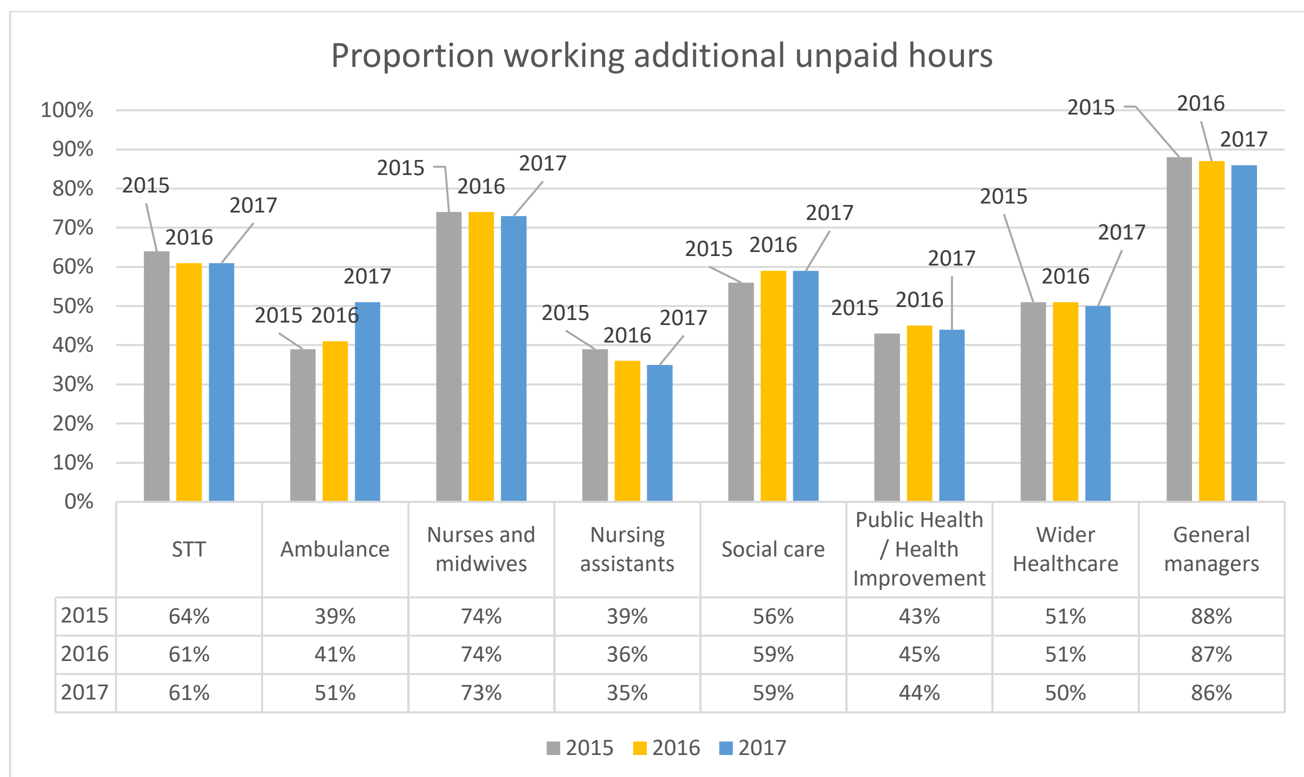
Flexible Working & Additional Hours

Figure 6.16: Proportion of staff working additional paid hours



	STT	Ambulance	Nurses and midwives	Nursing assistants	Social care	Public Health / Health Improvement	Wider Healthcare	General managers
2015	26%	57%	31%	42%	26%	25%	19%	10%
2016	24%	51%	31%	45%	25%	22%	17%	11%
2017	24%	54%	32%	44%	29%	22%	17%	12%

Figure 6.17: Proportion of staff working additional unpaid hours

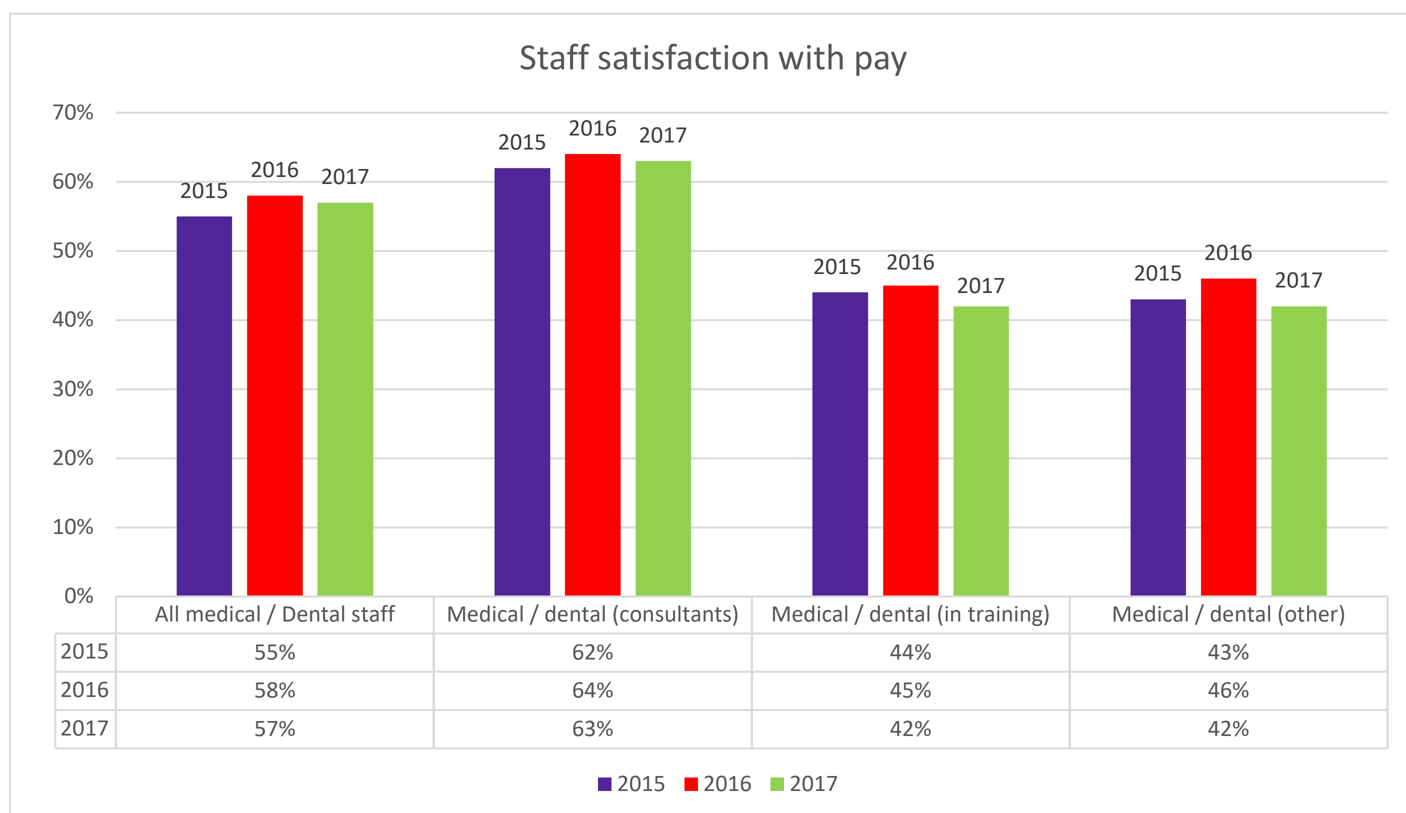


	STT	Ambulance	Nurses and midwives	Nursing assistants	Social care	Public Health / Health Improvement	Wider Healthcare	General managers
2015	64%	39%	74%	39%	56%	43%	51%	88%
2016	61%	41%	74%	36%	59%	45%	51%	87%
2017	61%	51%	73%	35%	59%	44%	50%	86%

6.71 During the last three years, medical and dental staff have been working broadly similar additional hours with some small variation across the different categories. Consultants have the highest proportion, falling slightly in both paid and unpaid additional hours over the period, doctors in training are just behind with more reporting paid additional hours and fewer reporting unpaid; other medical grades have the lowest proportion but increasing slightly in both categories.

6.72 Last year the Pay Review Bodies raised concerns about the challenges facing the NHS and the need to tackle the changing workforce in terms of flexibility and work-life balance. Opportunities for flexible working have improved by between 3 and 5 percentage points since 2013 although there is a clear difference with over 50% of consultants satisfied compared to only 30% of junior doctors. Flexible working is of particular concern to junior doctors and will be explored in the Gender Pay Gap Review in Medicine.

Figure 6.18: Staff satisfaction with pay 2015-2017



	All medical / Dental staff	Medical / dental (consultants)	Medical / dental (in training)	Medical / dental (other)
2015	55%	62%	44%	43%
2016	58%	64%	45%	46%
2017	57%	63%	42%	42%

6.73 Survey Results from the BMA, NHS Employers and the NHS Staff Survey has indicated problems for Staff and Associate Specialty (SAS) doctors around pay, morale, workload, career progression and development. For example, in the 2017 and 2016 Staff Surveys, 63% of consultants have been satisfied with their pay whereas the rate for “Other” doctors (including SAS)

was 42% in 2017down from 46% in 2016. This will also be explored during the Gender Pay Gap in Medicine Review.

Proportion experiencing Bullying or Harassment

Figure 6.19: Proportion of medical and dental staff experiencing Bullying or Harassment

Key Finding 26 - Bullying & Harassment (Staff)	2013	2014	2015	2016	2017
Medical / Dental staff	21.3	21.5	22.4	21.7	21.8
- medical / dental (consultants)	22.4	22.3	23.6	23.0	22.2
- medical / dental (in training)	20.1	20.0	19.9	19.7	22.8
- medical / dental (other)	21.9	22.8	22.7	24.4	22.8

6.74 About 20% of medical staff report bullying and harassment with little difference between the different medical and dental groups, although there has been a significant increase for doctors in training over the past year.

Other Measures

6.75 While there have been some measures where staff experience appears to have worsened since 2013 there are also some measures where scores have improved since 2013. There have been improvements in the quality of appraisals and the quality of non-mandatory training since 2013; however, doctors in training reported slight declines in both of these areas in the last year.

[Insert title]

Figure 6.20: Medical and dental staff scores on quality of appraisals 2015-2017

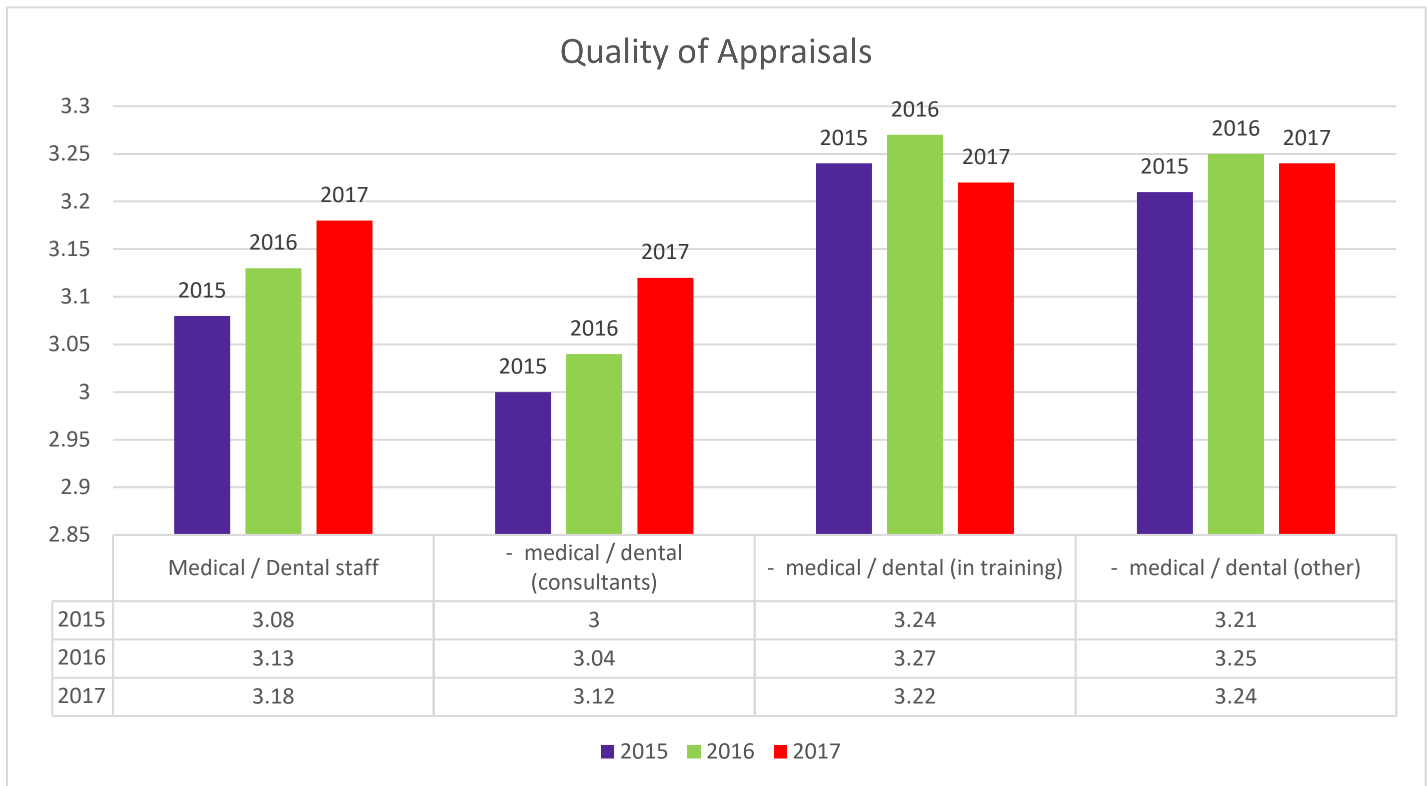
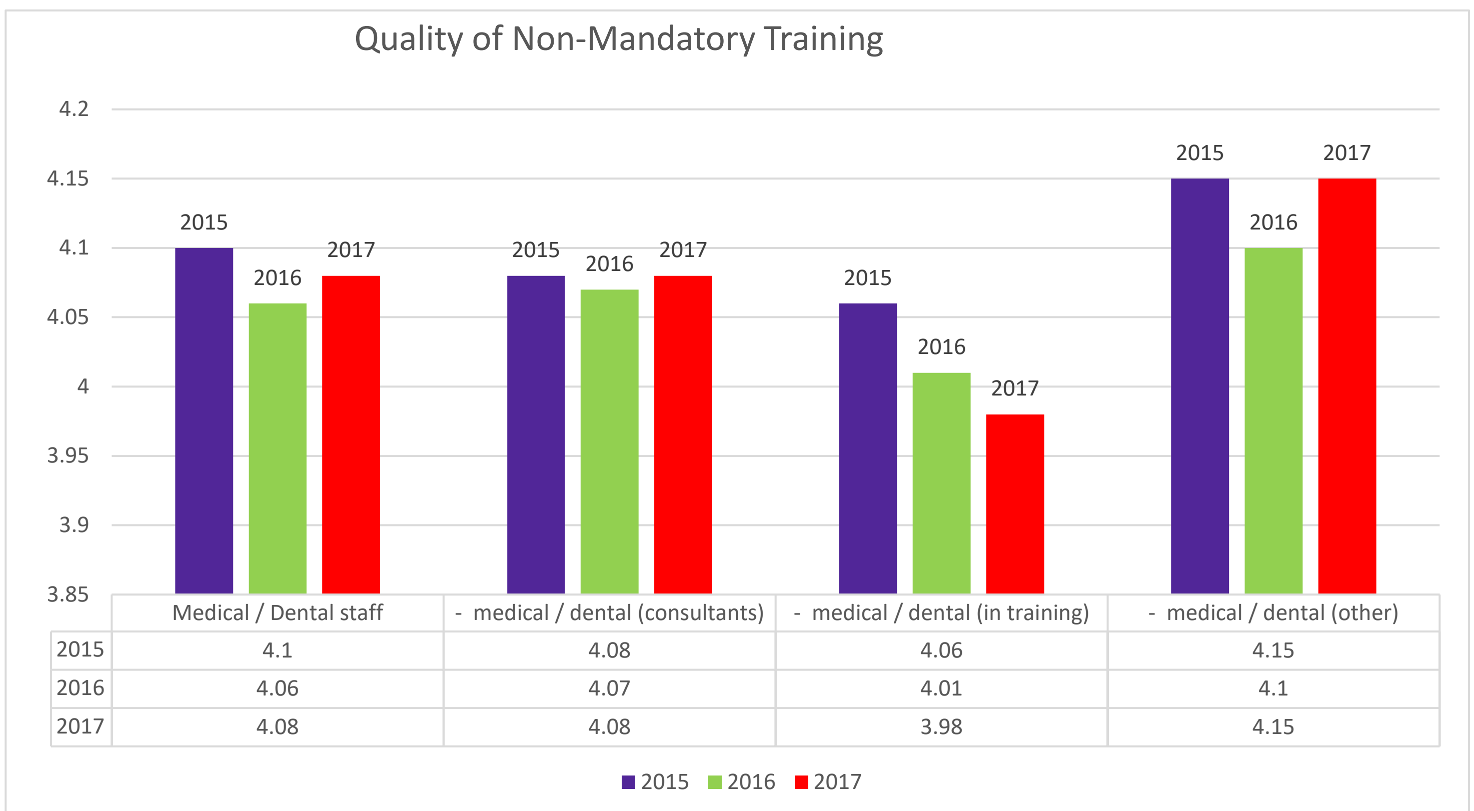


Figure 6.21: Medical and dental staff scores on quality of non-mandatory training 2015-2017



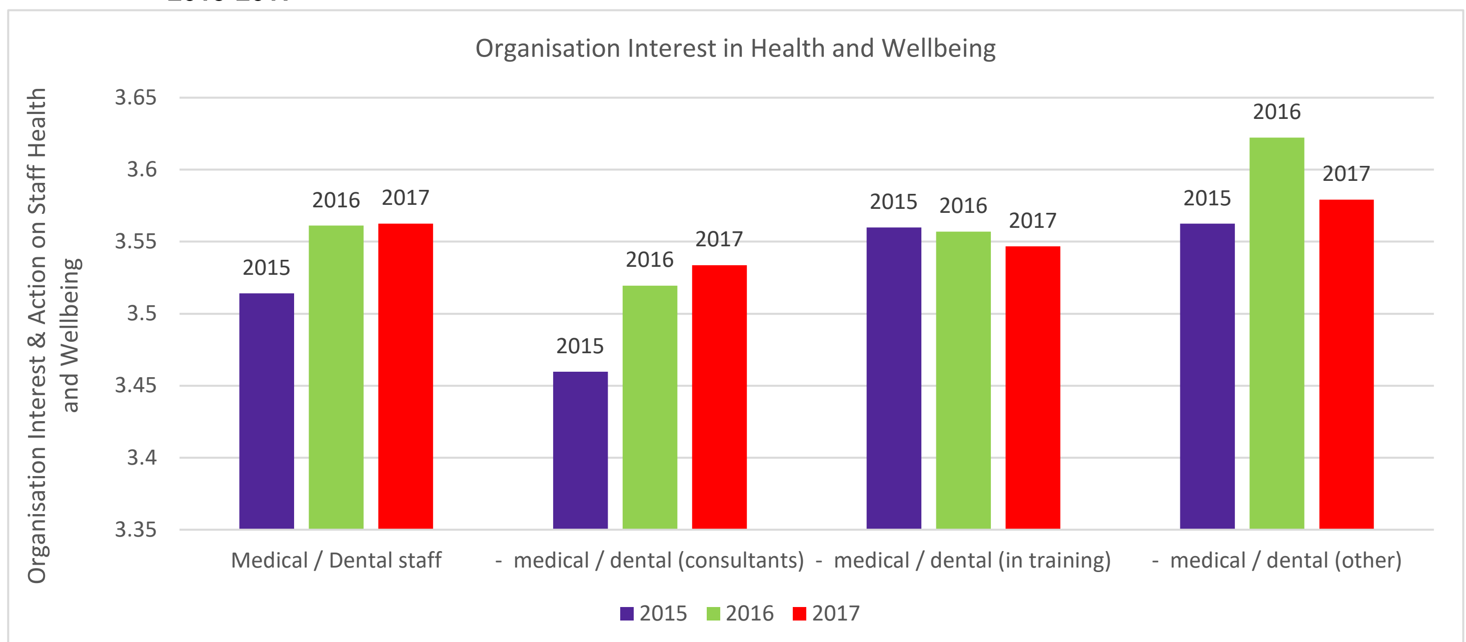
Staff Health and Wellbeing

6.76 The new health and wellbeing initiatives described above should help improve the 2017 NHS Staff Survey finding that 32% of medical and dental staff reported feeling unwell due to work related stress over the previous 12 months (up from 31% in 2016), with consultants staying at 31% but doctors and dentists in training rising to 36% from 32% and “others” to 35% from 32%.

6.77 However, the percentage of doctors and dentists attending work in last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves dropped for consultants to 39% from 41% in 2016, 37% down from 42% for doctors in training and 43% for “other” doctors down from 46% in 2015.

6.78 Organisational and management interest in, and action on health and wellbeing stayed the same overall for medical and dental staff at 3.56 in 2017 and 2016 but improved for consultants to 3.53 in 2017/5 from 3.52 but deteriorated for doctors in training to 3.55 in 2017 from 3.56 and 3.58 in 2017 down from 3.62 for “other” doctors.

Figure 6.22: Medical and dental staff scores on organisation interest in health and wellbeing 2015-2017



[Insert title]

Figure 6.23: Medical and dental staff scores on pressure felt to attend work when ill 2015-2017

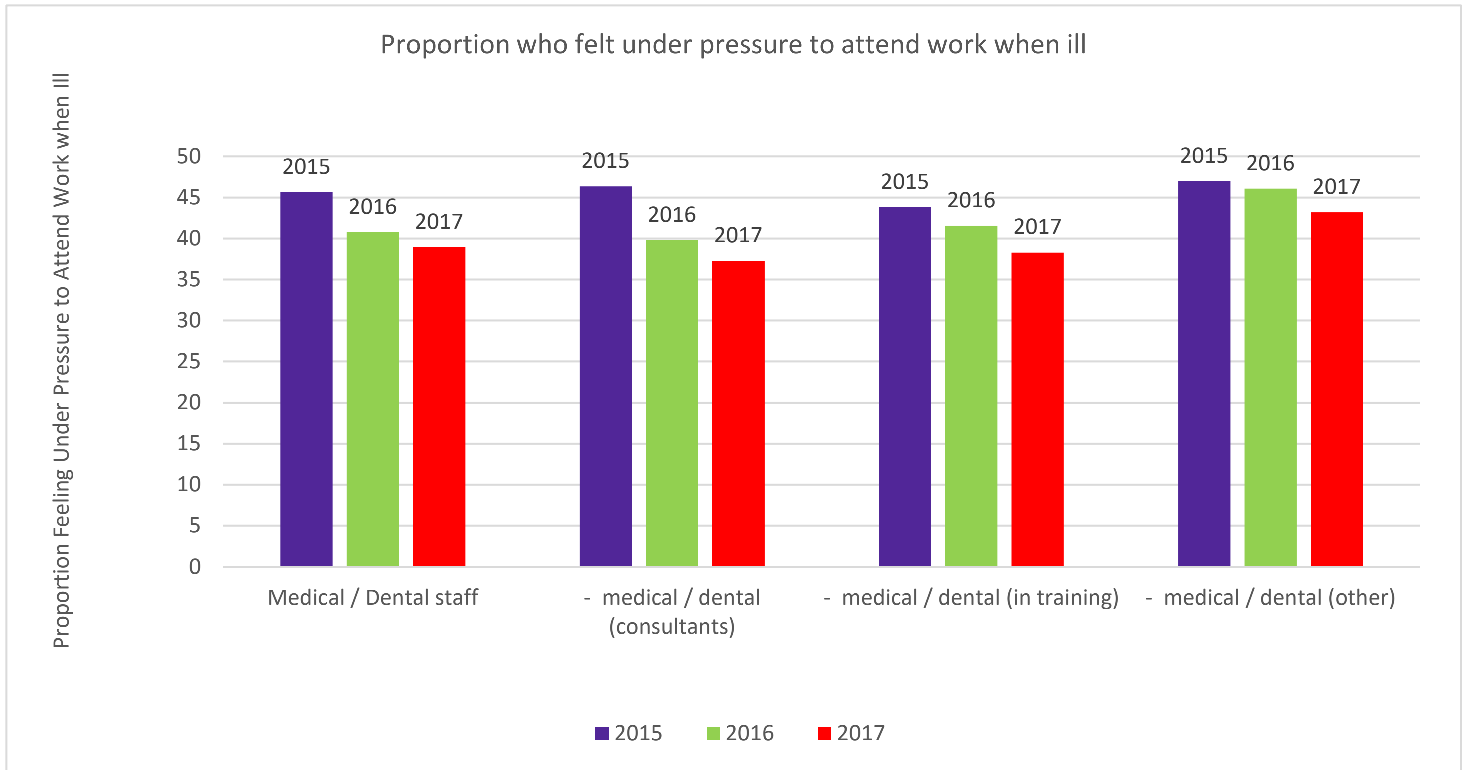
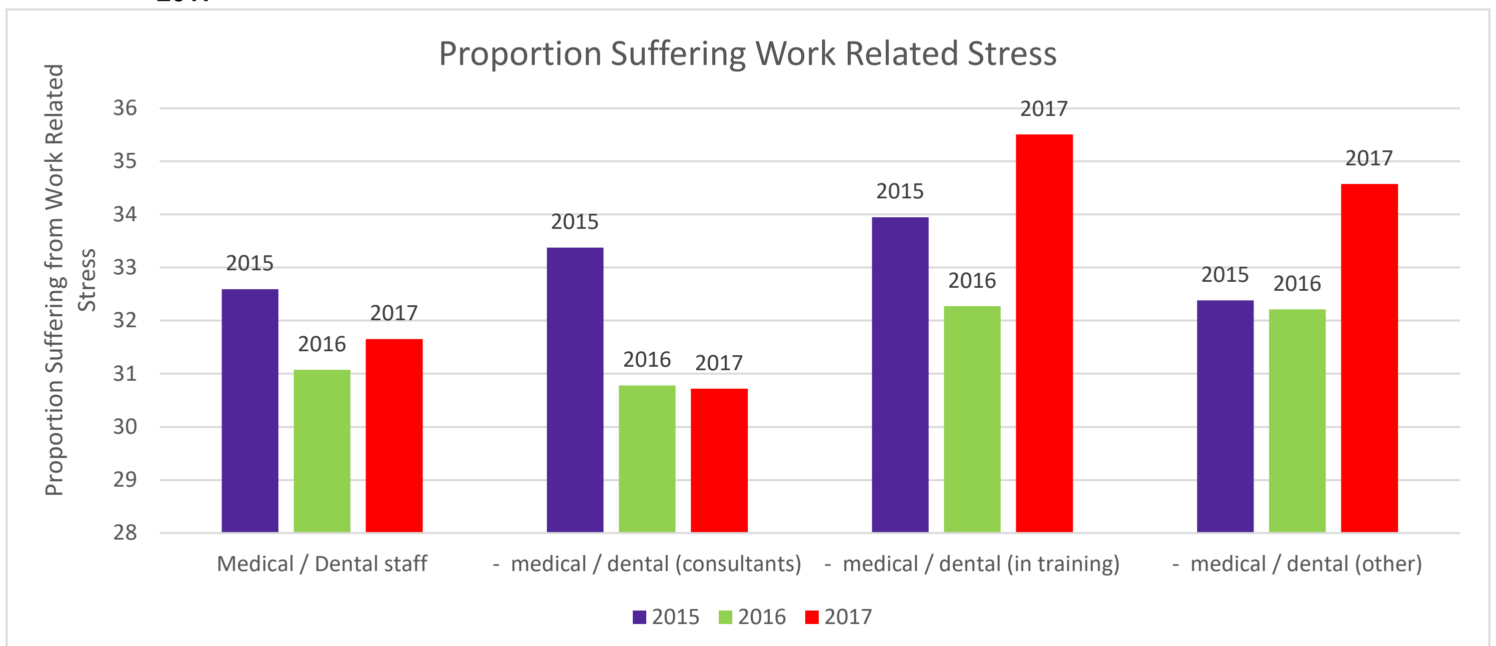


Figure 6.24: Proportion of medical and dental staff suffering from work related stress 2015-2017



Sickness Absence

6.79 Doctors continue to have the lowest (at 1.29%) sickness absence rate compared to other NHS staff groups.

6.80 NHS Digital publishes sickness absence statistics based on information recorded locally in the NHS Electronic Staff Record. The absence rate is calculated as the number of recorded days of absence as a proportion of the total number of calendar days. The table shows the annual sickness absence rate since these data were first collected in 2009/10. Excluding 2009/10 there have been only small changes to the national sickness absence rate with a range of 0.1% between the highest and lowest rates in the series.

Figure 6.25: Sickness absence rate (%) from 2009* to 2018

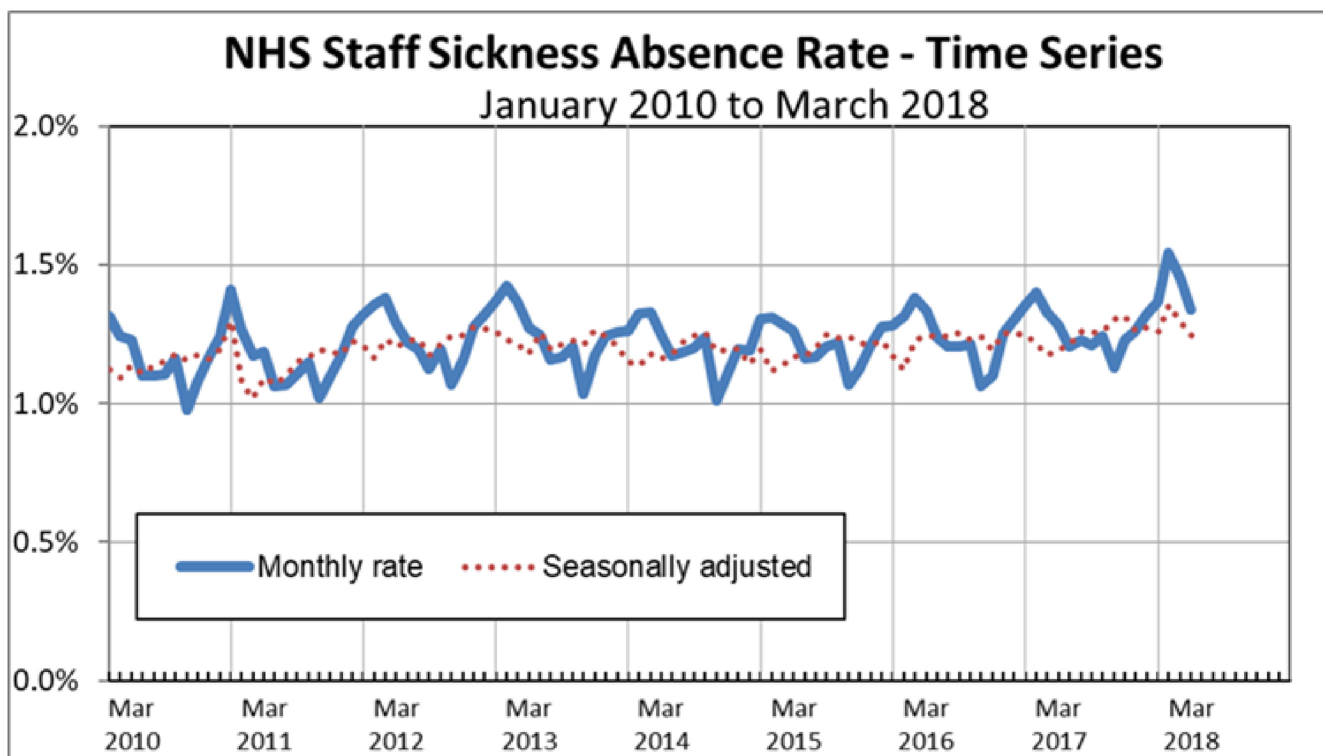
Year	SA Rate %
2009-10*	1.26%
2010-11	1.16%
2011-12	1.19%
2012-13	1.25%
2013-14	1.22%
2014-15	1.21%
2015-16	1.23%
2016-17	1.25%
2017-18	1.29%

*2009/10 data is based on the final 3 months only

Source – NHS Digital Sickness Absence Statistics

6.81 Sickness absence is seasonal with rates higher in winter. The chart below plots a line to remove the seasonal adjustment. There have been no significant changes to sickness absence over the period.

Figure 6.26: NHS Staff Sickness Absence Rates - Time Series January 2010 to March 2018



Source - NHS Digital sickness absence statistics (Medical Staff only)

Gender balance and Gender pay gap

6.82 The equality act of 2010 means that most public sector and medium/large private sector companies would have to publish figures on their gender pay gap at the end of March each year – the first instance being in 2018.

6.83 Over 200 NHS organisations reported in this period – the mean hourly rate gap was -22%; meaning that women earned an average of 22% less per hour than men did across all reporting trusts.

6.84 These figures are for all staff – the reporting guidelines do not allow for a breakdown for medical staff only.

6.85 In 2016, a review was launched to examine how to reduce and eliminate the gender pay gap in medicine. (See Chapter 1).

6.86 Over the past two years, the gender distribution has shown no significant changes; there has been a small increase in the proportion of female staff, increasing by 0.7 percentage points.

6.87 The most significant change is observed at consultant level; there is an increase of almost 2 percentage points for the proportion of female staff over

the last two years. It is important to note that these proportions are based on headcount values – FTE values would give different proportions as more female staff work part time.

Figure 6.27: Gender distribution in male and female staff March 2016 to March 2018

	March 2016		March 2017		March 2018	
Grade	Female	Male	Female	Male	Female	Male
Consultant	34.4%	65.6%	35.2%	64.8%	36.2%	63.8%
Doctor in training	52.9%	47.1%	53.3%	46.7%	53.1%	46.9%
Other	54.1%	45.9%	53.9%	46.1%	54.9%	45.1%
SAS Doctor	44.3%	55.7%	45.1%	54.9%	44.9%	55.1%
Grand total	44.5%	55.5%	45%	55%	45.2%	54.8%

Source: NHS Digital equality and diversity statistics as at March each year

7. Doctors and Dentists in Training

Review of 2016 Contract

7.1 The BMA remains in dispute over the introduction without agreement of the 2016 contract. However, in line with the commitment in the ACAS agreement of 2016, the BMA and NHS Employers agreed to enter into a formal collaborative bargaining process to jointly review the efficacy of the contract and negotiate changes to address the areas for improvement identified. As set out in his letter to the BMA (Annex 3) the Secretary of State is prepared to agree modest additional investment (in addition to recycled resources) as part of a negotiated agreement and in support of improved patient care.

7.2 The first stage is work being undertaken by five Contract Review sub-groups, who will deliver reports to the Joint Negotiating Committee (Juniors), (BMA Junior Doctors Committee and NHS Employers), on 25 January 2019, to inform negotiations between January and April 2019 on changes to the contract, with a view to collectively agreeing it after consultation with BMA members.

7.3 We have previously said that DDRB will be asked to consider, in future rounds as the contract is implemented, how funding freed up during transition has been-invested within the pay structure and informed by the outcome of the 2018 Review. Updates on the Review, including any developments relating to the pay structure will be provided to DDRB as part of supplementary evidence and at the oral evidence sessions.

Non-contractual issues

7.4 Health Education England (HEE) has continued to undertake a wide range of work in consultation with the BMA and other organisations to address some of the non-contractual issues raised during the contract dispute (in addition to those issues addressed through the 2016 contract itself). HEE's latest (2018) report details the progress made across a range of initiatives and the continuing work, on the themes of: deployment; flexible training; recruitment; costs of training; Supported Return to Training; early career support; streamlining; length of placements; whistleblowing; individualised support; and improving training data.

7.5 As set out in SofS's letter to the BMA, £10m is being made available to be spent by Guardians of Safe Working in Trusts, in agreement with junior

doctors locally, to improve working conditions. A sub-group of the EJDWL Working Group (including the BMA, HEE, NHS Employers and NHSI) is agreeing the use and distribution of this funding.

Approach to pay for 2019/20

7.6 As set out in the Secretary of State's remit letter, the Review Body is invited to make recommendations about targeting funding to support productivity and recruitment and retention. In doing so, it should consider whether pay uplifts might be targeted, including through the existing mechanisms of the flexible pay premia, and taking account of views from Health Education England on hard-to-fill training programmes.

Flexible pay premia

7.7 In its 46th Report, the DDRB made observations relating to the flexible pay premia that are part of the 2016 contract for doctors and dentists in training (England). These observations included:

- that the DDRB was not asked to make recommendations on specific proposals before it was decided to introduce the existing premia for general practice, psychiatry and emergency medicine;
- strong support for the introduction of specialty premia in appropriate circumstances, particularly that proposed for histopathology; and
- strong support for the application of appropriately targeted geographic premia.

7.8 The DDRB urged the parties to undertake modelling of shortage specialties and geographic areas, and to produce associated evidence, to inform DDRB's decision making.

7.9 DDRB also stated "We would find it helpful in the evidence next year to receive reports on the impact of those premia already in place". In responding to that, it is helpful to start with a clear understanding of what the impact of the premia was meant to be, i.e. the problems that they were designed to address or avoid.

7.10 In the following sections we set out the origins and purpose of these premia, their use to date and the roles of the parties in making recommendations on their use.

Background on the introduction of the flexible pay premia (FPPs)

7.11 In 2014, following the breakdown of negotiations between NHS Employers and the BMA, the DDRB was given a special remit to make recommendations on contract reform for doctors and dentists in training.

7.12 NHS Employers submitted evidence on the proposals they had been developing as part of the negotiations. This included:

- A proposal to move from broad banding payments to a pay structure that more closely related pay to actual work done;
- Scenarios (A, B and C), based on detailed modelling, which included variations of:
    - level of increase to basic pay;
    - definitions of out-of-hours (unsocial hours) periods; and
    - payment rates for out-of-hours work;
- A proposal (scenario C+) for the use of recruitment and retention premia, giving illustrative examples of hard-to-fill training programmes might require such a payment (depending on the final pay structure):
    - accident and emergency
    - the paediatric group of specialties
    - obstetrics and gynaecology, and
    - the psychiatry group of specialties.

7.13 In its report, published in July 2015, the DDRB:

- supported the use of scenarios C and C+ as the basis for further negotiation/discussion;
- suggested that the additional payments proposed under scenario C+ would serve two purposes:
    - transition payments to compensate some specialties that would lose out with the ending of banding payments; and

    - addressing some current shortage areas;

- proposed that these payments would be more appropriately termed 'flexible pay premia' (FPPs); and

- supported the use of FPPs for other purposes (clinical academics and work for the wider benefit of the NHS).

7.14 DDRB recommended that the new contract should include flexible pay premia to incentivise hard-to-fill specialties and that these payments should be 'paid where required'; and noted that GP trainees would be likely to receive a flexible pay premium, given the current difficulties in recruiting sufficient numbers of GMP trainees in some parts of the UK.

7.15 The DDRB's 2015 recommendations and observations informed the November 2015 'offer to juniors' and the May 2016 deal agreed with the BMA at ACAS. The ACAS deal became the contract that was introduced in 2016 (without the collective agreement of the BMA following a rejection by its members). That deal included:

- transitional pay protection for all juniors;

- the use of flexible pay premia for hard-to-fill training programmes of:

    - accident and emergency; and

    - psychiatry

- a flexible pay premium payable during the general practice based period of GP specialty training, replacing/continuing the GMP trainee supplement that had been payable under the old contract to ensure no financial disincentive (compared to earnings during hospital training) that might impact on recruitment to GP training.

Effectiveness of these initial flexible pay premia

7.16 The pay premia for hard-to-fill training programmes and GP specialty training that were part of the 2016 contract from its introduction were designed to ensure that there are no pay disincentives that would deter trainees from entering these programmes. One way of assessing whether that has had the intended impact is to look at application and fill rates, and HEE's evidence to the DDRB this year will include information on the application and fill rates for these specialties since the contract was introduced.

7.17 The contract has only been in place for two years, and pay is not, of course, the only factor influencing trainees' choices. If analysis were to show a change in applications/fill rates for these or any other programmes, we would want DDRB to consider that, informed by a view from HEE on both the extent to which pay can be identified as a factor and also the whole system perspective of ensuring appropriate recruitment/supply to all specialties as part of the workforce strategy.

Subsequent proposals for use of flexible pay premium to target/support specialty recruitment and retention

7.18 Advice and proposals on the application of FPPs is provided by Health Education England (HEE). In evidence for the 2018/19 pay round HEE set out that recent work on the Cancer Workforce Plan had shown a risk of under-filling of histopathology training programmes. HEE proposed that a premium be applied for histopathology training programmes across the country. DDRB supported this proposal and the premium was introduced for those entering training at ST1 now who are on training programmes for histopathology, forensic histopathology, diagnostic neuropathology, and paediatric and perinatal pathology. (It applied from October 2018).

7.19 Whilst it is likely that it would not be possible to evidence a direct correlation between a pay intervention (separate from other efforts/initiatives) and application/fill rates, it is also the case that it is not possible to establish any evidence of pay interventions working until they have been tried: HEE's evidence will include information on the effectiveness of the GP Targeted Enhanced Recruitment Scheme. It will remain important to understand what the data shows after the application of FPPs, consider that in the light of other interventions, and review the application of FPPs over time.

7.20 For the 2019/20 pay round, HEE will set out a more comprehensive picture of recruitment pressure points for the DDRB to consider, informed by supply data (increases in training numbers/expansion of medical schools), geographical data (under-doctored areas), application and fill rates for training programmes, available data on consultant vacancies and agency spend, and workforce planning.

8. Consultants

Contract reform

8.1 As system leaders, consultants provide direction to take forward transformation, supporting growth in productivity and improvements in patient care.

8.2 The National Audit Office, Public Accounts Committee and the DDRB have all set out recommendations to reform the 2003 national consultant contract.

8.3 The ambition of consultant contract reform is to produce a national contract that values the consultant workforce, is responsive to patients' needs and supports employers and consultants to deliver sustainable improvements in the quality of care. Fair and modern terms should attract, retain and motivate consultants and be affordable for employers.

8.4 Negotiations between NHS Employers and the medical trades unions to reform the consultant contract have been ongoing in some form since 2013, but have moved at a slow pace for several reasons.

8.5 In July 2018 Secretary of State for Health and Social Care confirmed his commitment to negotiations on a multi-year agreement incorporating contract reform for consultants to begin from 2019/20. However, in October 2018 the BMA advised that they will not continue with negotiations on the basis of the investment envelope available. The investment envelope proposed was set in the context of work developing NHS England's Long-Term Plan and proposed a potential investment of 2% per annum over three years.

8.6 Evidence will be provided by NHS Employers on the progress which has been made to date on reform of the consultant contract.

8.7 In the absence of agreement on a reformed national contract, the targeting of pay awards could begin to bring about some of the intended outcomes which the negotiating parties were in broad agreement on.

8.8 The parties had already agreed in principle to a reduction in the number of pay points and shortening progression the top of the consultant pay scale. Currently the consultant contract provides incremental pay increases over a nineteen-year period. Smaller pay increments over a long period of time were beneficial in the context of final salary pension arrangements.

However, the same benefits do not transpose to the current career average pension scheme.

8.9 The negotiators agreed that after five years a consultant should have the competencies, skills and experience to be fully performing at consultant level. Targeting pay awards for instance at those with 4 to 8 years' experience would recognise that they are fully performing the breadth of the consultant role and bring the pay of these consultants closer to the levels paid to those who have been consultants for more years.

8.10 Alternatively targeting of pay can bring about the effect of accelerating progression to the top of the pay scale. Pay could be targeted towards those with 14 years' experience, in the middle of their consultant career, with the effect of reducing the time the reach the top of the pay scale by five years.

8.11 Those with over 14 years' experience as a consultant are more likely to be male, due to the historic gender imbalance within the consultant workforce. Therefore, in the short-term targeting pay at this point in the pay scale would benefit this group in comparison to others. However, in time those with less experience, where there are larger proportions of female and BAME staff, will of course benefit from the shortening of the pay scale.

8.12 The difficulty with targeting pay increases on base pay is that these changes were envisaged as part of contract reform which would link progression more explicitly to performance in the first five years as a consultant and also remove the opt out from delivering planned work outside of 7am to 7pm Monday to Friday. The Department's view is that changes to shorten the pay scale should be linked to reform and modernisation of the contract.

Local Clinical Excellence Awards

8.13 From April 2018, following collective agreement between NHS Employers and the BMA, a new schedule was introduced into the 2003 consultant contract making access to Local Clinical Excellence Awards contractual. The schedule put in place interim arrangements from 1 April 2018 to 31 March 2021 and further arrangements which would apply from 1 April 2021 should a new nationally agreed local performance related pay scheme not be implemented prior to that date.

8.14 The agreement requires all employers to run an annual Local CEA round. All new awards will be time limited and non-pensionable with no associated uplift for Additional Programmed Activities. According to the new terms

employers will commit to an investment ratio of 0.3 CEA points per eligible consultant until 31 March 2021. A reversion mechanism was also introduced for those who unsuccessfully apply to renew a national CEA. Local CEAs awarded prior to April 2018 will be retained and remain pensionable and consolidated, but will become subject to a process of review from 2021.

8.15 It is intended that the new arrangements will ensure a closer link between current excellent performance and reward. The objective is to open up more opportunity for consultants to apply for awards, encouraging equality of access. Employers will be required to produce annual reports setting out the details of their awards rounds to ensure the process is transparent.

8.16 The interim CEA arrangements from 2018 to 2021 are seen as a means of transition to a position where employers have more flexibility to use performance pay innovatively to engage consultants to support reform objectives and motivate them to achieve the highest levels of performance. The aspirations for future arrangements post 2021, or sooner if agreement is reached with BMA, are for greater focus on objective based assessment with more flexibility with regards to award criteria.

8.17 In response to the Review Body's 2018 report the government froze the value of existing Local and National CEAs and targeted 0.5% of the pay bill on new Local CEAs to increase the amount available for performance pay awards. The intention was to enable employers to use performance pay to reward those consultants making the greatest contribution to developing and delivering high quality care and to continuous improvement of the NHS.

8.18 The Department sees the targeting of a proportion of any pay award towards increasing investment in the new arrangements for performance pay as a means to incentivise excellent performance, increase productivity and reward those who make excellent personal contributions. Conversely, the Department sees that increasing the value of consolidated Local CEAs rewards those with historical excellent performance but does not necessarily reward those who are providing the greatest contribution today.

8.19 Last year the Government decided to target 0.5% of pay into new awards plus the savings made from not increasing the value of existing CEAs. This will be reflected in a higher investment ratio for 2019 of 0.8 points per eligible consultant (0.3 carried forward from 2018, a further 0.3 as provided for in the contract agreement and an additional 0.2 funded by the targeted pay.) Looking forward to the introduction of new local performance pay from 2021, this will increase the amount of money available for awards, recognising the continued protection of old style CEAs.

8.20 The Department considers there is more scope for targeting pay awards on increasing funding for new local awards.

8.21 Targeting a proportion of pay towards new arrangements for Local CEAs, together with local initiatives designed to increase participation beyond the majority currently applying for and receiving awards, could have a positive impact on younger consultants, females or those from ethnic minority backgrounds.

8.22 Recommendations relating to previously awarded consolidated CEAs would have the greatest impact on white males over the age of 50 who currently hold a disproportionate majority of these awards, due to the historical makeup of the consultant workforce and to smaller proportions of females applying for Local CEAs in the past.

9. Career grade doctors (SAS grades)

9.1 The term "SAS doctors/grades" is widely used as shorthand to cover a number of career roles (other than consultant). It includes, but its use is not limited to, the main career grade of Specialty Doctor and the closed grades of Staff Grade and Associate Specialist (hence SAS) – there are national contracts for each of those three grades.

9.2 In its 46th report, DDRB:

- welcomed the fact that the draft Workforce Strategy for England recognised this group and the important role they can play in addressing some medical shortages;

- expressed the hope that the final version of the Strategy would address the question of who has overall responsibility for furthering the development of this group; and

- recommended that a review of the salary structure for SAS doctors should be a part of a wider review of their role, their career structure and the developmental support available to them, which was urgently needed.

9.3 DDRB recommended that, in the meantime and in the interests of addressing the motivation of this group, a pay solution was required; and SAS doctors received a higher pay increase that other groups of employed doctors in 2018/19.

9.4 The Secretary of State's letter to the BMA (at Annex 3) made clear that he wants to see the valuable role of SAS doctors recognised in their contract arrangements and the development and support they receive. He set out his expectations that trusts should be: implementing the 2014 SAS Charter (England) that sets out minimum conditions and appropriate support and development for SAS doctors; and accessing the SAS doctor development funding held and allocated by HEE. He gave a commitment to work with the BMA SAS Committee to reform the SAS contractual arrangements, including agreeing in principle that this will include reopening the Associate Specialist grade to extend career development for this important group of doctors. The Department has had early discussions with the BMA as the first stage in a process of negotiating modernised terms and conditions.

9.5 Working with system partners, the BMA and the profession, HEE has led the development of a SAS Doctor Strategy, as part of its Medical Reform Work Programme. The Strategy will be published early in 2019.

9.6 Informed by that Strategy, NHS Employers will hold a series of engagement sessions with employers from January to March 2019. The parties will update the DDRB on the progress of discussions/negotiations and any agreement on revised contractual arrangements. We believe that this work, planned to be completed in relation to associate specialists during 2019/20, will address the concerns leading to the targeted pay recommendation by the DDRB in last year's report.

9.7 We are asking the DDRB to make a recommendation for Specialty Doctors and Associate Specialists, in the usual way, for 2019/20.

10. General Medical Practitioners

10.1 The material in this chapter is intended to provide a background to ongoing developments in general practice. Detailed evidence on general practitioners and general dental practitioners will be provided separately by NHS England.

Spend on General practice

10.2 The total spend on general practice services in England, including the reimbursement of drugs dispensed in general practices, was £10.9 billion (£10.2 billion excluding reimbursement of drugs) in 2017/18**Error! Bookmark not defined.**. This was an increase of 6.7% in cash terms, and 4.9% in real terms, relative to the spend of £10.2 billion in 2016/17. Compared to 2013/14, the 2017/18 total spend was an increase of 23.2% in cash terms and 16.1% in real terms (figure 10.1).

Figure 10.1 Investment in general practice in England in real and cash terms excluding and including reimbursement of drugs dispensed in general practices (£ millions)

	Including Reimbursement of Drugs		Excluding Reimbursement of Drugs	
	Cash Terms	Real Terms	Cash Terms	Real Terms
2013/14	8,830.54	9,374.21	8,234.01	8,740.95
2014/15	9,173.04	9,614.26	8,570.50	8,982.74
2015/16	9,696.56	10,082.37	9,088.46	9,450.08
2016/17	10,193.71	10,367.59	9,603.67	9,767.48
2017/18	10,879.18	10,879.18	10,197.17	10,197.17

Source: NHS Digital, Investment in general practice

10.3 In April 2016, NHS England published the General Practice (GP) Forward View, a package of support for general practice. This included a commitment to invest an extra £2.4 billion a year in general practice services by 2020/21 compared to 2015/16.From 2019/20 this commitment will be superseded by the Long Term Plan commitment, see 10.4.

NHS Long Term Plan Investment

10.4 In June 2018, the government announced a multi-year funding plan for the NHS. The NHS budget will receive increased funding by an average of 3.4% a year in real terms; an extra £20.5 billion a year by 2023/24. This increased funding will support a new 10-year long-term plan developed by the NHS. The NHS Long Term Plan was published on 7 January 2019 and included a commitment to increase investment in primary medical and community health services as a share of the total national NHS revenue spend across the five years from 2019/20 to 2023/24. This commitment will mean spending on these services will be at least £4.5 billion higher by 2023/24. This commitment is a 'floor' level of investment that is being nationally guaranteed, that local Clinical Commissioning Groups (CCGs) and Integrated Care Systems (ICSs) are likely to supplement further. This investment guarantee is set to fund demand pressures, workforce expansion, and new services to meet relevant goals set out across the Plan. Further information is provided in section 10.46 and in NHS England's written evidence.

Current GP pay

10.5 NHS Employers (on behalf of NHS England) and the General Practitioners Committee (GPC) of the BMA negotiated an agreement on the GP contract for 2018/19 before the DDRB reported. This agreement was for investment of £256.3 million, to deliver a pay uplift of one percent and an expenses uplift of 3 percent. The agreement also included implementation of the NHS e-referral Service (October 2018); amendment of regulations to support introduction of Electronic Prescription Service (EPS); replacement of the National Quality Requirements (NQR) with new Key Performance Indicators; commitment to work together to support further use of NHS 111 direct booking into GP practice and agreement that practices must not advertise private providers of GP services that should be provided free on the NHS.

10.6 Following the forty-sixth DDRB report, a further pay uplift of one percent was awarded to GPs and practice staff, backdated to 1st April 2018. From October 2018, the recommended minimum and maximum pay scales for salaried GPs were uplifted by two percent and the GP trainer grant and appraiser fees increased by three percent. Up to a further one percent will be available to be added to the baseline from 1st April 2019, subject to contractual reform in 2019/20. This is on top of the funding envelope agreed for 2019/20, making the total £318m.

10.7 The General Practice Forward View set a commitment to address rising indemnity costs. These are considered to be an expense for GPs, and £60 million funding was included in the contract agreement for 2018/19 to cover indemnity inflation rises.

10.8 Preliminary discussions on changes to the GP contract for 2019/20 are on-going ahead of formal negotiations. Items for discussion include primary care networks, reform of QOF payments, indemnity and digital. We will update you on the outcome of these contract negotiations in supplementary evidence.

GP Indemnity

10.9 In October 2017, the previous Secretary of State for Health and Social Care announced his intention to develop a state backed indemnity scheme for general practice in England. The rising cost of clinical negligence is a great source of concern for GPs. The state-backed scheme is being designed to provide more stable, affordable cover for GPs and patients. We are working with key stakeholders and are committed to implementing the scheme from April 2019.

10.10 The current intention is that the scheme will exclude NHS primary care dentistry and private dentistry, private healthcare and community pharmacy and optometry. The Department of Health and Social Care is currently consulting on the regulation of indemnity cover for professionals who will not covered by a state backed scheme, including dentists. Any changes would apply across the UK. The government wants to ensure that patients can access appropriate compensation; to reduce the risks of professionals facing prohibitive costs; and to ensure that both patients and professionals have greater clarity and confidence about the terms of their cover. The consultation will seek views on whether changes to professional and financial regulation could help to achieve these aims.

GP earnings

10.11 The latest available data from NHS Digital on GP earnings and expenses is for the financial year 2016/17 and is based on a sample from HM Revenue and Customs' (HMRC's) tax self-assessment database. 2017/18 earnings and expenses will be available in September 2019. It is not possible to calculate the split between private and NHS work and therefore the data presented below is a combination of both. The most recent assessment (2014/15) showed the average NHS superannuable income for a GPMS

contractor was 94 per cent before tax. The dataset is divided by contractor (GP partners) and salaried GPs working under both GMS and PMS contracts, however it does not include GPs who work solely as locums. The data show that the average income before tax in 2016/17 for a contractor GP was £109,600 in England, compared to £104,900 in 2015/16, a rise of 4.6% in cash terms. When compared with the latest income distribution figures (2015/16), this puts contractor GPs in the top 97-98th percentile group (£97,100 - £117,000).

10.12 Figure 10.2 shows the change in contractor GP income in England since 2003/4 in both nominal and real terms (2016/17 prices). The data in this table represent average earnings for GP contractors in both GMS and PMS practices and are based on a survey of GPs' actual earnings by headcount and not by FTE.

Figure 10.2 - GMS and PMS contractors in England, Earnings and Expenses – GMS & PMS – all practice types

	Estimated Earnings and Expenses in cash terms			Estimated Earnings and Expenses in real terms (2016/17 prices)		
Year	Gross Earnings	Total Expenses	Income Before Tax	Gross Earnings	Total Expenses	Income Before Tax
2002/03	£191,777	£116,671	£75,106	£253,763	£154,381	£99,382
2003/04	£212,467	£127,672	£84,795	£275,421	£165,502	£109,919
2004/05	£241,795	£138,231	£103,564	£305,218	£174,489	£130,729
2005/06	£257,563	£143,950	£113,614	£316,816	£177,066	£139,751
2006/07	£260,764	£149,198	£111,566	£311,494	£178,223	£133,271
2007/08	£266,110	£155,971	£110,139	£310,196	£181,810	£128,386
2008/09	£274,100	£164,500	£109,600	£311,100	£186,700	£124,400
2009/10	£278,100	£168,700	£109,400	£311,200	£188,700	£122,500
2010/11	£283,000	£175,300	£107,700	£310,900	£192,500	£118,400
2011/12	£284,300	£178,200	£106,100	£308,300	£193,300	£115,000
2012/13	£289,300	£184,200	£105,100	£307,500	£195,800	£111,700
2013/14	£290,900	£189,000	£101,900	£303,600	£197,300	£106,300
2014/15	£302,600	£198,800	£103,800	£311,800	£204,900	£106,900
2015/16	£315,600	£210,800	£104,900	£322,700	£215,500	£107,200
2016/17	£338,300	£228,700	£109,600	£338,300	£228,700	£109,600

Source: GP Earnings and Expenses Estimate Time Series 2016/17 (published August 2018)**Error! Bookmark not defined.**. The conversion has been carried out using Gross Domestic Product (GDP) deflators as at June 2018 available from HM Treasury.

10.13 The corresponding data for salaried GPs in England are shown in figure 10.3 below. The real average pre-tax income of salaried GPs in 2016/17 was £56,600, compared to £55,900 in 2015/16, an increase of 1.2% in cash terms. When compared with the latest income distribution figures (2015/16), this puts salaried GPs in the top 91st-92nd percentile group (£55,800 - £59,000). As before, these figures are based on headcount data so will not take account of part time working. Note that in March 2018, the participation rate for salaried GPs in England was 66%.

Figure 10.3 – GMS and PMS salaried GPs England –Earnings and Expenses – all practice types

Year	Gross Employment Earnings	Gross Self Employment Earnings	Total Gross Earnings	Total Expenses	Total Income Before Tax
2006/07	£47,354	£12,891	£60,245	£6,139	£54,106
2007/08	£49,854	£12,337	£62,191	£6,260	£55,931
2008/09	£50,300	£13,800	£64,200	£6,800	£57,400
2009/10	£50,800	£14,700	£65,500	£7,100	£58,300
2010/11	£50,000	£15,100	£65,100	£7,300	£57,900
2011/12	£49,600	£14,800	£64,400	£7,300	£57,000
2012/13	£49,200	£15,500	£64,700	£8,100	£56,600
2013/14	£48,200	£15,800	£64,100	£9,200	£54,900
2014/15	£50,800 r	£14,700	£65,500 r	£8,700	£56,700 r
2015/16	£51,500	£12,300	£63,900	£7,900	£55,900
2016/17	£51,700	£13,700	£65,300	£8,700	£56,600

Source: GP Earnings and Expenses Estimate Time Series 2016/17 (published August 2018). There are breaks in the time series (each year between 2011/12 and 2014/15) due to the use of unrevised pension contribution rates when calculating adjustments to income before tax.

10.14 The data for 2016/17 for contractor (figure 10.4) and salaried GPs (figure 10.5) by contract type are shown in the tables below.

Figure 10.4 - GP Contractors' earnings and expenses by Contract Type, England, 2016/17 – all practice types

	Gross Earnings	Total Expenses	Income Before Tax
GMS	£328,100	£219,600	£108,500
PMS	£365,500	£252,800	£112,700

Figure 10.5 - Salaried GPs earnings and expenses by Contract Type, England, 2016/17 – all practice types

	Gross Earnings	Total Expenses	Income Before Tax
GMS	£64,200	£8,600	£55,600
PMS	£67,100	£9,000	£58,200

10.15 Mean earnings, expenses and income by age group, gender and (grouped) working hours for GPMS contractors in the UK are set out in figure 10.6. This is the first-time data on GP earnings by weekly working hours (divided into 0 to <22.5, 22.5 to <37.5 and 37.5+ hours) has been published. However, there are known data quality issues which are listed below. These factors may differentially impact male and female workers:

- Contractor GPs' earnings may be affected by the terms of any partnership agreements in effect for their practices.
- It is not possible to calculate the split between private and NHS work and therefore the data presented below is a combination of both.
- GPs may work longer than their contracted hours or may work outside their practice in an alternative setting such as a hospital or extended access hub (their income would be included in this data but not their hours).
- Salaried / partner GPs may undertake locum work outside of their contracted working hours, the pay for these hours would be captured but not the hours worked.

- Working hours are as of 30 September 2016 and could have changed over the course of the year.

- Due to sample sizes, GPs are divided into contracted weekly working hours bands in this report. The data does not present the average working hours for each group and it is possible that female GPs may have weekly working hours at the lower ends of these bands on average, which would reduce their average income compared to males in the same bands.

10.16 Female GPs are more likely to take a career break and therefore have fewer years of reckonable service for their age than men. This could negatively impact pay, for example through a reduced seniority payment.

Figure 10.6 – GMS and PMS GP average earnings and expenses by weekly working hours (contracted), age and gender, England, 2016/17

Contractor GP						
Weekly Hours	Gender	Sample Count	Age	Gross Earnings	Expenses	Income Before Tax
0 to <22.5	Male	50	Under 40	£344,100	£244,200	£99,900
		100	40 to 49	£316,400	£223,700	£92,700
		200	50 to 59	£287,400	£195,700	£91,700
		200	60 and over	£222,300	£145,800	£76,500
	Female	200	Under 40	£199,000	£134,000	£65,000
		400	40 to 49	£220,900	£152,100	£68,800
		400	50 to 59	£233,800	£160,800	£73,000
		100	60 and over	£266,400	£177,700	£88,700
22.5 to <37.5	Male	500	Under 40	£330,800	£220,100	£110,700
		800	40 to 49	£379,600	£260,900	£118,700
		950	50 to 59	£367,700	£247,800	£119,900
		300	60 and over	£350,200	£236,200	£114,000

	Female	650	Under 40	£270,400	£185,000	£85,500
		1,100	40 to 49	£297,600	£202,300	£95,200
		800	50 to 59	£309,300	£213,000	£96,300
		100	60 and over	£307,800	£206,900	£100,800
37.5 and over	Male	600	Under 40	£356,400	£235,400	£121,000
		1,050	40 to 49	£404,100	£271,000	£133,200
		1,350	50 to 59	£408,800	£275,800	£133,000
		350	60 and over	£363,900	£234,600	£129,300
	Female	250	Under 40	£313,500	£209,400	£104,100
		450	40 to 49	£362,600	£248,600	£114,000
		400	50 to 59	£385,500	£262,400	£123,100
		100	60 and over	£353,800	£230,900	£122,900

Salaried GP, England						
Weekly Hours	Gender	Sample Count	Age	Gross Earnings	Expenses	Income Before Tax
0 to <22.5	Male	150	Under 40	£78,000	£9,600	£68,500
		100	40 to 49	£82,000	£9,800	£72,200
		100	50 to 59	£98,100	£10,300	£87,800
		50	60 and over	£61,700	£13,700	£48,000
	Female	750	Under 40	£49,000	£5,600	£43,400
		650	40 to 49	£51,100	£6,400	£44,700
		300	50 to 59	£56,800	£7,000	£49,800
		50	60 and	£47,400	£5,100	£42,300

			over			
22.5 to <37.5	Male	350	Under 40	£78,000	£9,900	£68,100
		150	40 to 49	£88,500	£14,200	£74,200
		100	50 to 59	£95,200	£15,600	£79,600
		50	60 and over	£77,500	£15,800	£61,700
	Female	1,000	Under 40	£60,200	£7,600	£52,600
		450	40 to 49	£67,300	£10,000	£57,300
		200	50 to 59	£67,500	£6,700	£60,800
		C	60 and over	C	C	C
37.5 and over	Male	150	Under 40	£92,200	£14,300	£77,900
		100	40 to 49	£101,300	£15,100	£86,200
		50	50 to 59	£101,400	£11,000	£90,500
		50	60 and over	£92,200	£16,800	£75,400
	Female	150	Under 40	£72,900	£10,900	£62,000
		50	40 to 49	£95,700	£21,900	£73,800
		50	50 to 59	£89,600	£18,000	£71,600
		C	60 and over	C	C	C

c = confidential - figures are suppressed due to small sample sizes

Source: GP Earnings and Expenses Estimate by Gender and Weekly Working Hours, England, 2016/17 – Experimental statistics **Error! Bookmark not defined.**

GP Trainers' grants

10.17 The GP trainer grant, which was previously published in an annex of the Directions to Health Education England, is now published as part of the document containing GP Educator pay scales and from 1 October 2018 is £8,146.

10.18 The Department continues to work with stakeholders to develop a tariff based approach for funding clinical placements in GP practices for medical students and trainees. The Department has collected information from GP practices to better understand the costs incurred from having medical students and trainees on placement. The outcomes of this exercise are being used to determine the timescales and funding to support the introduction of a tariff payment mechanism.

General Medical Practitioner (GMP) Appraisers' rates

10.19 Since 2002, medical appraisal has been a requirement for general practitioners, as part of the revalidation process. In the forty-fifth report, DDRB said that the GMP Appraisers' rate will be kept under review and that DDRB would welcome evidence on the situation in future rounds.

The Department does not have any further evidence on the rate or on recruitment of GMP appraisers.

GP Workforce numbers

10.20 Data on the general practice workforce are now published quarterly with data initially published as provisional and finalised in the next publication. The latest final figures, for September 2018, showed a total of 42,445 headcount GPs working in England (34,205 FTEs). See figure 10.7 for a summary of Workforce Minimum Dataset (wMDS) data on doctors working in general practice by headcount and full-time equivalent. Statistical advice is to compare the workforce data only on a year-on-year basis (September – September) due to seasonality concerns, rather than across quarters, so the main numbers below are presented on this basis.

10.21 All practitioner figures are presented in 10.7 in a time series, however this figure is not comparable across the time series due to changes in locum recording from March 2017 and registrar recording from June 2018.

Figure 10.7 – Doctors in general practice by headcount and FTE

Headcount	September 2015	September 2016	September 2017	September 2018
All Practitioners	41,877	41,865	42,145 42,352+	42,445
GP Providers	24,826	23,937	22,919	22,109
Salaried/Other GPs	10,775	10,988	11,497	12,342
GP Registrars	4,996	5,503	5,412 5,610+	5,986
GP Retainers	155	171	218	320
GP Locums	1,370	1,561	2,631	2,043

Full Time Equivalent	September 2015	September 2016	September 2017	September 2018
All Practitioners	34,592	34,495	34,091 34,426+	34,205
GP Providers	21,937	21,163	20,234	19,387
Salaried/Other GPs	7,292	7,295	7,603	8,047
GP Registrars	4,729	5,273	5,135 5,470+	5,880
GP Retainers	67	72	90	123
GP Locums	567	692	1,029	767

Source: NHS Digital General and Personal Medical Services, England. Figures include estimates for the practices that did not provide fully valid data.
+ Sept 2017 'All practitioners' and 'GP Registrars' rebased to Sept 2018 methodology.

10.22 Overall, the wMDS data show that the number of GP contractors in England has been on a decreasing trend. For example, between September 2017 and September 2018, the GP contractor headcount decreased by 3.5% from 22,919 to 22,109, corresponding to a 4.2% decrease in FTEs, from 20,234 to 19,387. Conversely, the salaried GP headcount increased over the same period by 7.3%, from 11,497 to 12,342; in FTE terms, the increase in

salaried GPs was 5.8%, from 7,603 to 8,047 FTEs. Note, that comparisons with workforce numbers prior to September 2015 are not possible.

10.23 As the most recent figures demonstrate, there continues to be issues around retention of GPs. A number of policy programmes are being undertaken to both boost retention, and increase the FTE GP number. Information on these will be provided later in this chapter and in NHS England's written evidence.

10.24 When comparing the September 2018 and September 2015 figures (excluding locums and registrars), although the GP headcount numbers have dropped (by 1,041), the FTE count has dropped more sharply (by 1,738 FTE), this may in part be due to changes in the workforce demographics. The demographic makeup of the workforce is shown in figure 10.8 by job role and by age split. There are more female GPs by headcount (22,432) than male GPs (17,979) (including registrars, locums and retainers) (unknown 2,050) in September 2018; however, the younger workforce is predominately female whilst the older workforce is predominantly male. Differences in working patterns (see participation rates and part time working in figure 10.8 and 10.9) between male and female workers is likely to impact workforce FTE rates. There are also differences in the proportion of male and female workers in individual job roles.

Figure 10.8 – GP workforce demographics, England (General Practitioner headcount by job role and gender, September 2018)

Headcount	All	%	Male	%	Female	%	Unknown	%
GP Contractors	22,109	52.1%	11726	27.6%	9182	21.6%	1205	2.8%
Salaried/Other GPs	12,342	29.1%	3169	7.5%	8471	20.0%	706	1.7%
GP Registrars	5986	14.1%	2193	5.2%	3792	8.9%	1	0.0%
GP Retainers	320	0.8%	50	0.1%	253	0.6%	17	0.0%
GP Locums	2043	4.8%	990	2.3%	933	2.2%	121	0.3%

Figure 10.9: General Practitioners headcount (excluding Registrars, Retainers & Locums) by age, September 2018*

Headcount	All	%	Male	%	Female	%
Under 30	236	0.7%	0.2%	0.2%	150	0.4%
30-34	3,688	10.7%	3.4%	3.4%	2,520	7.3%
35-39	5,380	15.7%	5.6%	5.6%	3,458	10.1%
40-44	5,653	16.5%	6.8%	6.8%	3,299	9.6%
45-49	5,002	14.6%	6.3%	6.3%	2,843	8.3%
50-54	4,961	14.5%	7.0%	7.0%	2,564	7.5%
55-59	4,407	12.8%	7.5%	7.5%	1,840	5.4%
60-64	1,711	5.0%	3.4%	3.4%	538	1.6%
65 and over	1,313	3.8%	2.9%	2.9%	310	0.9%
unknown	2,004	5.8%	0.2%	0.2%	78	0.2%
All	34,318		14,836		17,583	

Source: NHS Digital General and Personal Medical Services, England. Figures include estimates for the practices that did not provide fully valid data. Headcount totals may vary slightly from the sum of the component values in the tables published by NHS Digital, for example if staff who work in more than one role or more than one practice have been counted twice. For further information on the methodology used by NHS Digital, please refer to the publication General and Personal Medical Services.

Part-time working and participation rates

10.25 Participation rates are used to measure the extent of part-time working in the GP workforce. They are defined as the ratio of full-time equivalents to headcount, and vary by job type, by age and by gender. Participation rates by age, gender and by job role for the whole GP workforce are shown in figure 10.10. Participation rates are lower for female GPs in every age band and job role (except GP retainers). The average participation rate for younger male GPs (under 35) is lower than other (male) age categories.

10.26 The number of sessions GPs report conducting every week (according to the GP worklife survey) is shown in figure 10.11. The percentage of GPs doing 6 or fewer sessions per week increased between 2015 and 2017 and the percentage doing 9 or more sessions increased between 2015 and 2017.

Fig 10.10 - All GPs participation rate by age and gender and job role. Participation rate = ratio of FTEs to headcount (September 2018 participation rate by age/gender excluding locums, registrars and retainers)

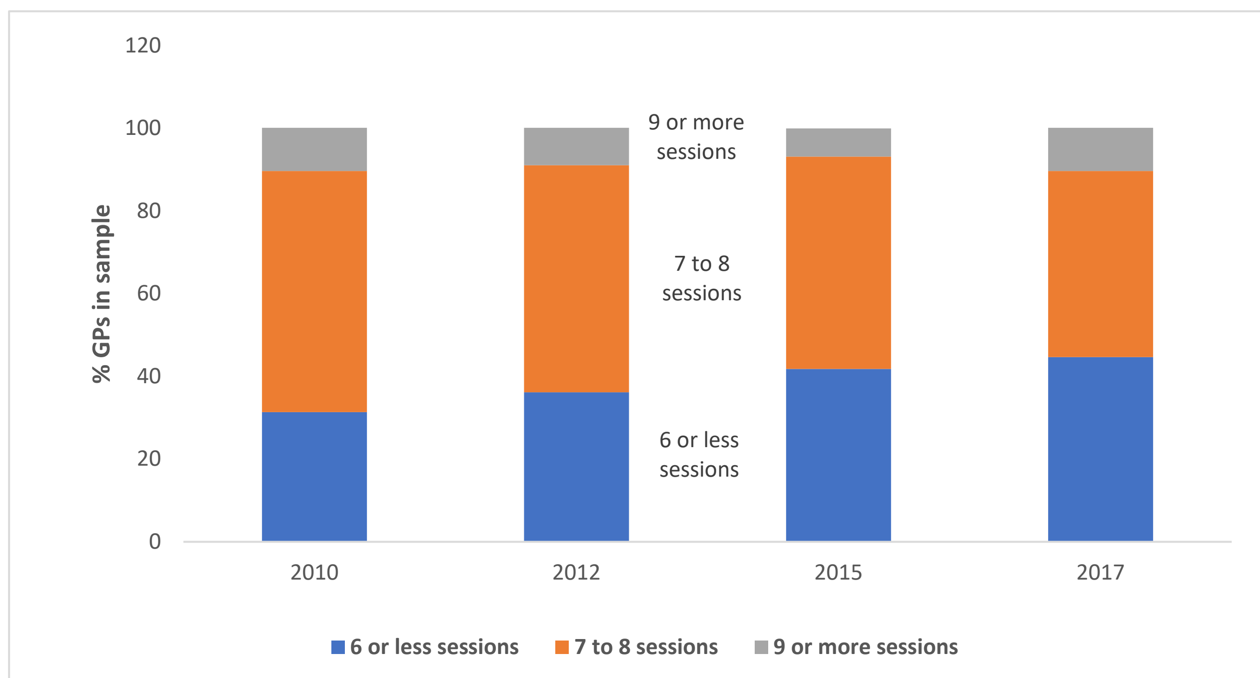
Age Band*	Male	Female	All (including unknown gender)
Under 30	77.1%	76.3%	76.6%
30-34	81.2%	71.4%	74.5%
35-39	88.7%	68.4%	75.6%
40-44	92.5%	68.9%	78.7%
45-49	94.3%	70.8%	80.9%
50-54	95.1%	73.1%	83.7%
55-59	93.5%	73.5%	85.2%
60-64	85.2%	75.3%	82.1%
65 and over	84.5%	74.9%	82.3%
Unknown	79.7%	62.9%	77.3%
All practitioners	90.8%	71.0%	79.9%

	Male	Female	All (including unknown gender)
GP Contractors	95.2%	78.2%	87.7%
Salaried GPs/Other GPs	72.8%	62.5%	65.2%
GP Registrars	104.2%	94.8%	98.2%
GP Retainers	40.4%	38.1%	38.5%
GP Locums	41.4%	33.6%	37.6%
All practitioners	90.0%	73.5%	80.6%

Source: Calculated from NHS Digital General and Personal Medical Services. Figures include estimates for the practices that did not provide fully valid data. GP

registrar participation rates appear to be higher as a registrar's full time contract is 40 hours, compared to the standard full time salaried/partner GP contract which is 37.5 hours.

Fig 10.11 - The average number of sessions worked by a GP. A higher proportion of GPs are working less than 6 sessions year on year (GP worklife survey).



Source: The GP Worklife Survey which received responses from a broadly representative group of around 1,000 GPs in England, excluding registrars (GPs in their 50s are over represented and GPs aged in their 30s and under were underrepresented)

GP Locums

10.27 The quality of GP locum data has been improved. Following new guidance issued by NHS Digital to practices about the recording of all staff, including GP locums, the number of GP locums reported in March 2017 was higher than the number reported in the previous quarter. This rise is likely to be due to improvements in reporting of locums rather than a rise in the number of locums in the workforce. Due to changes in recording methods at practices, recording of locums has improved and hence the figures for locums may not be comparable to previous data.

10.28 Locums were reported in the main figures and in a new "infrequent locum" data table the December 2017 publication (located in the data quality statement) and in the March and September 2018 publications (located in supplementary information). Locums who work regularly in a practice are included in the all practitioner figures.

10.29 Infrequent locums are those that are not regularly working in a single practice. Practices submit data covering the number of hours a locum has worked in the previous quarter and this is converted into FTE and headcount figures. In September 2018 there were 767 FTE GP locums (2,043 headcount) captured in the main publication and 272 FTE (2,918 headcount) infrequent locums (figure 10.11). No estimates were made for the 90.0% of practices that did not submit infrequent locum data. It is not known if practices did not submit data because they did not have any infrequent locums to record or they did not participate in the data collection. Further evidence on locums is provided in NHS England's written evidence.

Figure 10.12 GP locums captured in main publication and supplementary infrequent locum count, September 2018

Locums identified in the main publication	Headcount	FTE
Locum GPs identified in the main September 2018 census	2,043	767

Infrequent locums (supplementary table)	Headcount	FTE
Infrequent locums also identified in September 2018 main census	649	48
Infrequent locums not identified in September 2018 main census	2,269	224
Total infrequent locums	2,918	272

Source: NHS Digital General and Personal Medical Services, England.

Locums identified in the main publication - valid figures were received from 94.6% of practice. Estimates are included for practice not submitting valid data.

Infrequent Locums – valid Infrequent Locum records were received from 90.0% of practices. No estimates are included for practices not submitting Infrequent Locum records.

Staff movement

10.30 GP workforce vacancy rates are published by job role (figure 10.12); however, the data quality is low for this dataset (less than 1,250 practices submitted data each year), no estimates are made for the practices that did not submit data as practices may not have recorded data if they did not have any vacancies in the given period.

Figure 10.13 Recorded GP vacancies by job role, headcount

Job Role	2015/2016	2016/2017	2017/2018
GP Contractors	125	168	123
Salaried/Other GPs	532	499	441
GP Registrars	1	-	9
GP Retainers	-	1	6
GP Locums	17	37	38
Number of Practices that submitted data	1,233	1,218	1,247
Total	675	705	617

Source: NHS Digital General and Personal Medical Services, England. Figures do not include estimates for the practices that did not provide fully valid data.

10.31 Data on GP Joiners and Leavers has been improved through exclusion of staff movement between practices. However, there are still data quality issues, as this data only being based on around 60-70% of GP practices and GPs transferring between practices are excluded if identified by their GMC number, however, if a valid GMC number is not provided at both practices they would be incorrectly recorded as either a joiner or a leaver. For the period 30th September 2017 to 30th September 2018, the headcounts for joiners and leavers (excluding locums and registrars) were 1,203 and 1,502 respectively, implying a net decrease of 299. The actual change in the headcount workforce between those two dates was an increase of 149 GPs.

Staff Motivation

10.32 Staff movement by reason for leaving is also recorded and published (figure 10.14) and this data does include GPs that have transferred between practices. In 2017/18 the most common known reasons for leaving a practice were; end of a fixed term contract (other, and completion of training scheme), voluntary resignation (relocation and other/not known) and retirement (age).

Figure 10.14: GP movement (including movement between practices) by reason for leaving (headcount)

Reason for Leaving	2015-16	2016-17	2017-18
Bank staff not fulfilled minimum work requirement	13	3	4
Death in Service	9	2	4
Dismissal – Capability	2	2	-
Dismissal – Conduct	4	2	4
Dismissal - Some Other Substantial Reason	2	-	1
Dismissal - Statutory Reason	3	1	-
End of Fixed Term Contract - Completion of Training Scheme	609	477	421
End of Fixed Term Contract - End of Work Requirement	79	152	182
End of Fixed Term Contract - External Rotation	229	178	206
End of Fixed Term Contract – Other	460	499	474
Initial Pension Ended	-	-	-
Mutually Agreed Resignation	55	45	46
Pregnancy	38	23	32
Redundancy – Compulsory	3	2	6
Redundancy – Voluntary	13	16	11
Retirement – Age	426	325	274
Retirement - Ill Health	56	23	18
Voluntary Early Retirement - No Actuarial Reduction	44	39	32
Voluntary Early Retirement - With Actuarial Reduction	24	19	25
Voluntary Resignation - Adult Dependants	6	8	1
Voluntary Resignation - Better Rewards Package	65	61	44
Voluntary Resignation - Child Dependants	22	41	19

Voluntary Resignation – Health	16	32	21
Voluntary Resignation - Incompatible Working Relationships	15	16	12
Voluntary Resignation - Lack of Opportunities	5	4	4
Voluntary Resignation - Other/Not Known	502	373	328
Voluntary Resignation – Promotion	162	160	113
Voluntary Resignation – Relocation	545	416	337
Voluntary Resignation - To undertake further education or training	34	31	34
Voluntary Resignation - Work/Life Balance	264	251	215
Unknown	1,900	1,958	1,668
Total	5,605	5,159	4,536

Source: NHS Digital General and Personal Medical Services, England. The figures only include data on staff movement from practices which submitted staff movement data (2015/16 – 82%, 2016/17 – 84%, 2017/18 73%).

10.33 Manchester University published the Ninth National GP Worklife Survey for 2017 in May 2018**Error! Bookmark not defined.**. The survey received responses from a broadly representative group of around 1,000 GPs in England, excluding registrars. It is not possible to distinguish between salaried GPs and GP contractors. Findings included:

- GPs reported most stress with: ‘increasing workloads’; ‘having insufficient time to do the job justice’; ‘paperwork’; ‘changes to meet requirements from external bodies’ and ‘increased demands from patients’.
- Increasing workloads was the top stressor in every survey since 2008.
- In addition, the following statements all saw small increases in reported agreement amongst GPs compared to 2015: ‘have to work very fast’, ‘do not have time to carry out all work’, ‘have to work very intensively’, ‘required to do unimportant tasks preventing completion of more important ones’, ‘relationship at work are strained’.
- Overall satisfaction increased marginally from 4.14 to 4.25 between 2015 and 2017, however it remains lower than 2004-2012. Satisfaction is measured on a 7-point scale where 1 represents the lowest satisfaction rating, and 7 is the top rating. The lowest levels of reported satisfaction were

for ‘hours of work’, ‘remuneration’ and ‘recognition for good work’, although satisfaction in 2017 with these domains were marginally higher than in 2015.

The GP Forward View

10.34 In April 2016, NHS England published the General Practice (GP) Forward View **Error! Bookmark not defined.**, a package of support for general practice. The GP Forward View set out:

- an investment of an extra £2.4 billion a year for general practice services by 2020/21 (a 14% increase in real terms);
- a commitment to an additional 5,000 GPs and 5,000 other staff working in general practice;
- a commitment to tackle practice workload through the General Practice Resilience Programme and changes to the CQC inspection regime;
- investment in practice infrastructure including through the Estates and Technology Transformation Fund;
- a range of measures to support care redesign including extended access and the 10 high impact actions.

10.35 Further detail on progress against the GP Forward View commitments will be provided in NHS England's written evidence.

GP recruitment and retention

10.36 NHS England and Health Education England (HEE) are working together with the profession to increase the GP workforce. This includes measures to boost recruitment into general practice, encourage GPs to return to practice, and address the reasons why experienced GPs are considering leaving the profession.

Recruitment

10.37 The first round of recruitment to specialty GP training for 2018 saw an increase in total accepted posts of 10% compared with the same time in 2017. In total in 2018, there were 3,473 new starters recruited to specialty GP training posts. This is the highest number of GP trainees HEE has ever recorded (figure 10.15). GP trainees are included in the workforce data (GP registrars) when working in a general practice and they usually spend 50% of their training working in a general practice. Health Education England (HEE) and NHS England have a number of schemes in place to attract more doctors to GP speciality training including the "Choose GP" advertising campaign, the Targeted Enhanced Recruitment scheme (TERs) and the Targeted GP Training Scheme. Further detail will be provided in NHS England's written evidence.

Figure 10.15 – Places available, places filled and fill rate of GP speciality training.

	2014	2015	2016	2017	2018
Places available	3,067	3,117	3,250	3,250	3,250
Places filled	2,671	2,769	3,019	3,157	3,473
Fill rate	87%	89%	93%	97%	107%

Source: HEE's recruitment statistics

10.38 To bridge the gap whilst training is ongoing, in August 2017 NHS England announced plans to accelerate its international recruitment to 2,000 GPs. This is an increase from the 500 international GPs which was the original target in the GP Forward View. Further detail will be provided in NHS England's evidence.

Retention and Return to practice

10.39 To improve retention, NHS England has launched a number of schemes including the GP Retention Fund, the GP Retention Scheme, the GP Health Service and the National Induction and Refresher Scheme. Details of these schemes will be provided in NHS England's evidence.

Workload

10.40 Workload is the key factor affecting GP recruitment and retention, and addressing workload includes increasing GP workforce supply through the range of actions described above. NHS England has in place a number of schemes specifically designed to target workload. These include the Releasing Time to Care Programme, the General Practice Resilience Programme and the GP Health Service. Further information will be in NHS England's evidence.

10.41 Increasing the skills mix in general practice will also address workload pressures, as well as deliver appropriate patient care. This will mean larger teams of staff, providing a wider range of care options for patients which will free up more time for GPs to focus on those with more complex needs. As of September 2018, there were 3,738 additional full-time equivalent clinical staff working in general practice, excluding GPs, compared to 2015. This consisted of 639 more nurses and 3,099 more other direct patient care staff, see figure 10.16.

Figure 10.16 All staff working in general practice (Headcount and FTE)

Headcount	September 2015	September 2016	September 2017	September 2018
All Staff	172,392	174,271	173,850	176,548
All Staff excluding GPs	130,515	132,406	131,705	134,103
GPs	41,877	41,865	42,145	42,445
Nurses	23,066	23,141	22,816	23,135
Other Direct Patient Care	14,469	15,326	17,760	18,323
Admin / non-clinical	93,301	94,295	91,455	92,960

[Insert title]

FTE	September 2015	September 2016	September 2017	September 2018
All Staff	122,867	125,666	125,113	127,792
All Staff excluding GPs	88,275	91,171	91,022	93,587
GPs	34,592	34,495	34,091	34,205
Nurses	15,398	15,827	15,800	16,037
Other Direct Patient Care	9,149	10,009	11,610	12,247
Admin / non-clinical	63,728	65,334	63,613	65,303

Source: NHS Digital General and Personal Medical Services, England **Error! Bookmark not defined.**. Figures include estimates for the practices that did not provide fully valid data.

Older GPs leaving the profession

10.42 The proportion of GPs taking their pension for the first time on a Voluntary Early Retirement (VER) basis increased in the 9 years prior to 2016/17 according to analysis of NHS pensions scheme membership; see chapter 12 (and figure 10.16) for further detail. The proportion taking VER dropped slightly in 2017/18, but it still remained high at 57.7% (588 VERs of 1,019) of those taking their pension for the first time (all reasons). However, this is not a measure of retirement, but a measure of GPs taking their pension and anecdotally, we know some GPs will take their pension and return to the workforce (retire and return). We do not have robust data on the number of GPs that retire and return, and if they do return to the workforce, in what capacity this is, including job role. Reaching the pensions lifetime allowance may be a factor in GPs retiring early and in recent years the lifetime allowance has been lowered.

10.43 NHS Digital now report on staff movement by ‘reasons for leaving’ (figure 10.13 and figure 10.17) in the wMDS publications when a valid ‘Termination Date’ is inputted. The overall reported number of retirements is lower than is reported from the pension scheme membership analysis. This is perhaps owing to some practices not submitting data (73% submitted data in 2017/18) and because a high proportion of ‘reasons for leaving’ are recorded as unknown (see figure 10.12). According to the wMDS ‘reasons for leaving’

data, the proportion of GPs taking VER compared to all retirements figure in 2017/18 was 16.3%.

10.44 NHS England have a number of schemes in place aimed at enhancing retention, which may benefit the older age group, for example the GP Retention Scheme. More detail will be provided in NHS England's written evidence.

10.45 Further detail on GP pensions have been outlined further in Chapter 13 on Pensions and Total Reward, including data on GP voluntary early retirements, numbers of opt-outs and those leaving the service.

Figure 10.17 The number of GPs taking their pension (NHS Business Authority analysis of 1995 pensions scheme membership)

Pension year (1 April to 31 March)	*Total number of GPs claiming the VER pensions	**Number of GPs in total claiming NHS pensions	% taking VER
2007/08	198	1,154	17.2
2008/09	265	1,307	20.3
2009/10	322	1,427	22.6
2010/11	443	1,555	28.5
2011/12	513	1,545	33.2
2012/13	591	1,409	41.9
2013/14	746	1,502	49.7
2014/15	739	1,436	51.5
2015/16	695	1,324	52.5
2016/17	721	1,171	61.6
2017/18	588	1,019	57.7

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

Figure 10.18 The number of GPs reported as retiring in staff movement data (wMDS)

Year (1st April – 31st march)	Number of GPs 'reasons for leaving' recorded as VER	Number of GP reason for leaving recorded as retirement	% taking VER
2015/16	68	550	12.4
2016/17	58	406	14.3
2017/18	57	349	16.3

Source: NHS Digital General and Personal Medical Services, England. Figures do not include estimates for the practices that did not provide fully valid data (2015/16 – 82%, 2016/17 – 84% and 2017/18 – 73% of practices submitted staff movement data).

NHS Long Term Plan - primary care workforce

10.46 The NHS Long Term Plan was published on 7 January 2019. In the plan, NHS England committed to boosting "out-of-hospital" care and dissolving the historic divide between primary and community services. The plan included a commitment to increase investment in primary medical and community health services as a share of the total NHS revenue by 2023/24 (see 10.4).

10.47 The additional investment will fund expanded community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices that work together typically covering 30-50,000 people. Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector.

10.48 The NHS Long Term Plan also set out plans to publish a Workforce Implementation Plan later in 2019. For primary care, this plan will build on the General Practice Forward View to increase the number of doctors working in general practice.

10.49 As part of measures to grow the medical workforce, the NHS Long Term Plan set out plans for a two-year fellowship programme for newly qualified doctors and nurses entering general practice. This is a scheme suggested by the GP Partnership Review which was published on 15th January 2019

and aims to increase the number of registrars taking up substantive roles in primary care, and enable qualified nurses to consider primary care as a first destination.

GP Partnership Review

10.50 In February 2018, the former Secretary of State for Health and Social Care, announced a formal review of how the partnership model of general practice needs to evolve in the modern NHS. The GP Partnership Review was published in January 2019 and makes recommendations in the following areas:

- The challenges currently facing partnerships within the context of general practice and the wider NHS, and how the current model of service delivery meets or exacerbates these
- The benefits and shortcomings of the partnership model for patients, partners, salaried GPs, locum GPs, broader practice staff, for example practice nurses, and the wider NHS
- How best to reinvigorate the partnership model to equip it to help the transformation of general practice, benefiting patients and staff including GPs

10.51 The review was independently chaired by Dr Nigel Watson, a managing partner at the Arnewood Practice and chief executive of Wessex Local Medical Committee, and supported by DHSC, NHS England, the RCGP (Royal College of GPs) and BMA.

10.52 The review found the main challenges for the partnership model of general practice to be related to risk, workload, workforce and the status of general practice in relation to the wider healthcare system. Engagement across the review, feeding into both the interim report and the final report, made clear that a key disincentive for GPs to become or remain partners was the financial risk, particularly around premises, that partners must take on. The profession also fed back that rising workloads, worsened by ongoing challenges with recruitment and retention, are causing burn-out and pushing GPs at all stages in their careers away from the front line. Frustration with the role of the GP in the local health ecosystem was another challenge the review sought to address, with practices asking for more of a voice at a system level (e.g. at STP level), and also more autonomy with respect to funding (e.g. out of hours services).

10.53 A summary of the recommendations made in the final report is below:

1. Recommendation 1: There are significant opportunities that should be taken forward to reduce the personal risk and unlimited liability currently associated with GP partnerships.

2. Recommendation 2: The number of General Practitioners who work in practices, and in roles that support the delivery of direct patient care, should be increased and funded.

3. Recommendation 3: The capacity and range of healthcare professionals available to support patients in the community should be increased, through services embedded in partnership with general practice.

4. Recommendation 4: Medical training should be refocused to increase the time spent in general practice, to develop a better understanding of the strengths and opportunities of primary care partnerships and how they fit into the wider health system.

5. Recommendation 5: Primary Care Networks should be established and operate in a way that makes constituent practices more sustainable and enables partners to address workload and safe working capacity, while continuing to support continuity of high quality, personalised, holistic care.

6. Recommendation 6: General practice must have a strong, consistent and fully representative voice at system level.

7. Recommendation 7: There are opportunities that should be taken to enable practices to use resources more efficiently by ensuring access to both essential IT equipment and innovative digital services.

10.54 A government response to the final report of the review will be published in due course.

GP appointments and waiting times

10.55 Data on "appointments in general practice" was published for the first time in December 2018 by NHS Digital. The publication covers the number of appointments delivered by GP practices in England in the twelve months from November 2017 to October 2018, inclusive. NHS Digital estimated that this was equivalent to a total of 307.4 million appointments across all GP practices in England in this twelve-month period. Note that these statistics

are badged as experimental and the results should be treated with caution. The following data are also available in the publication:

- The number of surgery appointments, home visits, telephone and online consultations;
- Type of healthcare professional leading the appointment ('GP', 'Other Practice staff', or 'Unknown');
- The number of appointments where a patient did not attend; and
- The time between the booking of the appointment and its taking place.

Access to General Practice

10.56 In October 2013, the former Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services. That funding was invested in 2014/15. A further £100 million of funding was announced in September 2014 for a second wave which was invested in 2015/16. Bringing both waves together, the GP Access Fund covered more than 2,500 practices and a population of over 18 million people.

10.57 In April 2016, the GP Forward View, building on the learning from the GP Access Fund, committed £500 million by 2020/21 to deliver extended access to primary care. This additional funding is to enable clinical commissioning groups (CCGs) to ensure that by 2020 everyone in England has access to GP services including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services. The Conservative Party Manifesto 2017 set out the ambition that by March 2019 the whole population will be able to get routine weekend or evening appointments at either their own GP surgery or one nearby. This commitment is mirrored in the Government's Mandate to NHS England for 2018/19. The National Health Service planning guidance, issued by NHS England in February 2018, brought forward the deadline for CCGs to provide extended access to general practice to their whole population to 1 October 2018, to ensure additional capacity is in place ahead of winter 2018.

New Care Models

10.58 NHS England's 'vanguard' programme, supported by £329m funding, developed new models of care in 50 sites across England. These new models included the:

- 'multispecialty community provider' (MCP) model that brings together general practice, community health, mental health, social care and public health services; and
- 'primary and acute care services' (PACS) model that also encompasses acute hospital services.

10.59 These new models are designed to integrate services across traditional boundaries so that services are coordinated around the needs of the patient. This means patients only having to tell their story once; it means data is shared appropriately with staff working in different settings; and it means more treatment in the community and in people's homes.

10.60 Currently, these vanguards cover around 9% of the population of England, with Primary Care Home sites (a key building block of the MCP and PACS models, covering a further 15%.

10.61 The emerging evidence from these sites suggests they are improving patient experience of care. Vanguards have also made significant progress in reducing the pressure on A&E. Compared with 2014-15, emergency admissions on average grew by 0.9% in Multispecialty Community Providers and 2.6% in Primary and Acute Care Systems compared with 6.9% in the rest of the NHS. For Enhanced Health in Care Home vanguards, emergency admissions from care home residents in Enhanced Health in Care Homes areas flat lined compared with an increase of 9% for non- Vanguard care homes.

Integrated Care Providers (ICPs)

10.62 A small number of sites are now ready to go further by having a single contract to commission their models to create an ICP, using the draft ICP contract.

10.63 NHS England recently held a public consultation on the contract. The consultation closed on 26 October. The long-term plan announced NHSE's intention to make the contract available for use. We have to amend a set of regulations before the contract can be used. Most of these amendments are

consequential in nature, and seek to ensure that existing rules apply to the ICP contract in the same way as they apply to the standard NHS contracts. In addition, two changes also allow GPs to suspend their contracts to join an ICP contract.

GP participation in Integrated Care Providers

10.64 The active participation of GPs is critical to the successful delivery of integrated care models. But the participation of any individual practice or GP is entirely voluntary, and the manner in which they integrate with an ICP will be for them to decide.

10.65 If the ICP contract is introduced, the opportunities for GPs to be involved in the direction and leadership of the ICP will be central to their engagement and to the success of the care model and contract. To be awarded an ICP contract, a provider will have to demonstrate that it can work closely with general practice providers to offer a joined up set of services to their population. For their part, GPs will wish to take the opportunities presented by integrated care models to play a greater role in population-focused decision-making.

10.66 Full integration involves usual GP services being commissioned with other services under a single ICP Contract. The draft contract has been created to enable this, by including terms and conditions applicable to primary medical services. But in order that usual services can be commissioned under such a contract, existing GMS and PMS arrangements in relation to those services must be set aside, whether permanently (by ending their existing contract) or for the life of the ICP Contract. Changes to secondary legislation have already been proposed and consulted upon by the Department of Health and Social Care which would provide that, where a GP practice decides that it wishes to become fully integrated with an ICP, it may suspend its current contract, allowing the primary medical services to be commissioned through the ICP Contract. GPs would then become either salaried GPs of the ICP or subcontractors. Practices would have the option to reactivate their suspended GMS and PMS contracts at different points throughout the lifetime of the ICP Contract, and this reactivation would otherwise happen by default following the expiry or termination of the ICP Contract.

11. General Dental Practitioners

11.1 This chapter provides an update on general dental practitioners (GDPs) providing NHS primary care services.

Workforce Numbers and Recruitment and Retention

11.2 In England, NHS England commissions NHS primary care dentistry from providers who can be individuals or corporate bodies. NHS dentists can be either provider-performers (holding a contract with the NHS) or performers only (working for practice owners or corporate bodies). Dentists can also offer private care alongside NHS services.

11.3 NHS Digital publishes data on the number of dentists who have delivered NHS dentistry in any given financial year. This is based on data from NHS Business Service Authority who process dental payments and forms. Figures are shown in Table 11.1.

Table 11.1: Number and percentage of dentists with NHS activity by dentist type, 2007/08 to 2017/18

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

Source: see Annex 1 at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2017-18-annual-report

11.4 From 2016/17 to 2017/18 the total number of dentists actively delivering NHS services increased from 24,007 to 24,308. During this period, the number of Provider-Performers fell and they now make up only 10.5% of the workforce. The number of performer only dentists rose from 21,082 to 21,753.

11.5 The percentage of dentists (undertaking NHS activity submitted by FP17[xi]) who are female has increased from 40.1% in 2007/08 to 49.7% in 2017/18). This change is continuing as the proportion of dentists leaving the NHS who

are female was 44.5% in 16/17, while the proportion of females joining the NHS in 16/17 was 55.5%.

11.6 In terms of age groups, the age band that has shown the greatest decline – in proportion – from 2007/08 to 2017/18 is 45-54 (23.6% to 20.7%), while the age group that has increased most is 55 and over (13.0% to 14.5% over the same period)

11.7 This does not indicate a substantial shift towards "generation Y" (i.e. Millennials or the Internet generation) in the dentist population. The relationship between age group and motivation/morale is confounded by the correlation between age of performers and other factors such as weekly hours, amount of annual leave and proportion of NHS work. It is difficult to determine any conclusive Generation Y impact from these demographics.

Earnings and Expenses

11.8 The tax data covers income from all dental sources, including from private dental practice. As a result, the earnings and expenses estimates presented in Dental Earnings and Expenses Estimates cover both NHS Health Service and private dentistry. It is not possible to analyse separately earnings and expenses from NHS and private practice. The gross income, expenses and taxable income for all dentists is not adjusted for inflation.

11.9 The average taxable income for all dentists in 2016/17 was £68,700, down from £69,200 in 2015/16. This reflects a fall in the average gross income to £145,700 in 2016/17 from £148,000. The level of expenses to gross income ("the expenses ratio") has dropped to 52.9%. The expenses ratio remains towards the lower end of the range seen during the last ten years. Table 11.2 has details for the last fourteen years.

Table 11.2: Gross income, expenses and taxable income for all dentists from 2004/05 to 2016/17

	Average Gross Earnings	Average Expenses	Average Taxable Income	Expenses ratio
2004/05	£193,215	£113,187	£80,032	58.6%
2005/06	£205,368	£115,450	£89,919	56.2%
2006/07	£206,255	£110,120	£96,135	53.4%
2007/08	£193,436	£104,373	£89,062	54.0%
2008/09	£194,700	£105,100	£89,600	54.0%
2009/10	£184,900	£100,000	£84,900	54.1%
2010/11	£172,000	£94,100	£77,900	54.7%
2011/12	£161,000	£86,600	£74,400	53.8%
2012/13	£156,100	£83,500	£72,600	53.5%
2013/14	£155,100	£83,400	£71,700	53.8%
2014/15	£152,500	£82,000	£70,500	53.8%
2015/16	£148,000	£78,900	£69,200	53.3%
2016/17	£145,700	£77,000	£68,700	52.9%

Source: See Dental Earnings and Expenses Estimates - England and Wales, Time Series, 2006/07 - 2016/17 at https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2016-17

11.10 In England, the earnings of a dentist are dependent on whether they are a Providing-Performer dentist or a Performer only dentist. Generally, Provider-Performers tend to earn more, however, the changing ratio of Providing-Performers to Performer only dentists (as seen in Table 11.2) has moved the average figure closer to the – lower-earning – Performer only dentists. In 2016/17 Providing-Performer dentists had an average taxable income £115,800 a rise from £115,700 in 2015/16. In contrast, a Performer only dentist saw their average taxable income increase to £60,800 in 2016/17 compared to 2015/16 when it was £60,200

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

Motivation and Morale

11.12 The Dental Working Hours: Motivation and Morale 2016/17 & 2017/18 report was last published by NHS Digital in August 2018. Motivation is regarded as the internal drive of an individual, e.g. inspiration or enthusiasm. The difference in average motivation between 2015/16 and 2017/18 for Provider-Performers is -3.0%, for Performers the difference is -6.0%. This is shown in the table below:

Table 11.3: Average motivation results; Average morale results 2012/13-2017/18

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

Average motivation (%)	Provider-Performer	Performer only
2012/13	48.3	48.2
2013/14	45.7	48.8
2014/15	47.5	44.3
2015/16	45.1	45.3
2016/17	44.6	39.7
2017/18	42.1	39.3

Percentage of dentists who recorded their morale as 'very high' or 'high'

Average Morale (%)	Provider-Performer	Performer only
2012/13	27.3	42.1
2013/14	27.2	42.7
2014/15	22.8	32.9
2015/16	22.2	33.4
2016/17	21.3	24.6
2017/18	20.1	24.9

11.13 In 2017/18, Performer only dentists responded less positively than Provider-Performer dentists with a 39.3% 'strongly agree' or 'agree' response compared to 42.1%.

11.14 Morale generally relates to comfort and satisfaction. Performer only dentists appear to have higher morale than Provider-Performers. In 2017/18, 24.9% of Performer only dentists answered 'very high' or 'high' to the question 'How would you relate your morale as a dentist?' This contrasts to only 20.1% of Provider-Performer dentists. The difference in average morale between 2015/16 and 2017/18 for Provider-Performers is -2.2%, for Performers the difference is -8.5%.

11.15 Comparing the data published by NHS Digital for 2012/13 and the BDA Business Trends Survey for 2012, the BDA data reports a higher motivation score for Provider–Performer dentists (58%) than the NHS Digital published survey (48.3%). However, it is difficult to draw too many conclusions from the differences, as the population groups covered by the survey differ. For example, the BDA only canvassed their members, many of them undertaking private only work.

11.16 The Dental Working Group (DWG) is a technical group with a UK wide remit and membership. Its primary role is to carry out agreed programmes of work to meet the requirements of dentists' remuneration (including the associated Review Body on Doctors' and Dentists' Remuneration (DDRB)). The DWG survey covered individuals undertaking more NHS work and working longer hours.

Supply of Dentists and status of NHS Contracts

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

Targeting

11.18 Targeting is unlikely to be effective because for General Dental Practitioners (GDS contracts and PDS agreements) commissioners already have the ability to target and commission new services where there is need. They have the flexibility to commission services at an appropriate contract value to reflect local circumstances including the cost of service provision, potential service availability and the level of need.

Dental contract reform

11.19 The Government is committed to reforming the current dental contractual framework including a period of prototyping for a potential new contract (see below). This longstanding commitment, reaffirmed by the current Government, is intended to increase access and improve oral health. The reformed approach will move away from the current all activity remuneration system to a part capitation, part activity model. Capitation will provide financial drivers that align with the new clinical approach, focussed on prevention as well as treatment.

11.20 The clinical approach has been tested for a number of years and since April 2016 selected practices have been testing this with the proposed new remuneration system. Two variations of the combined capitation and activity approach are being tested.

11.21 The second full year of results continue to be encouraging both in terms of clinical and contract delivery as work continues to progress towards a potential rollout. The new contract is well liked by those testing it. This year, the Dental Contract Reform programme is increasing the number of dental practices in the prototype scheme, we hope to add up to 50 more practices by the end of the 2018/19 financial year.

Community Dental Services

11.22 Salaried dentists working in Community Dental Services (CDS), which are local services commissioned by NHS England, provide an important service to patients with particular dental needs, especially vulnerable groups.

11.23 NHS England commissions dental services, including community dental services, in line with local oral health needs assessments undertaken in partnership with local authorities and other partner organisations. These assessments identify the level of dental need for a particular community and pay particular attention to both access to local dental services and the dental health of the local population.

11.24 The Department of Health believes that CDS fills an important role in dental health service provision and are not aware of any specific difficulties in filling vacancies faced by Providers.

11.25 Three CDS practices are prototypes participating in the national contract reform programme. They will continue to test the new clinical approach with their specific, and usually vulnerable, patient groups.

11.26 The terms and conditions for salaried dentists directly employed by the NHS are negotiated by NHS employers on behalf of the NHS.

12. Ophthalmic Medical Practitioners

12.1 The Department of Health remains firmly of the view that there should be a common sight test fee for optometrists and Ophthalmic Medical Practitioners (OMPs), which is consistent with previous DDRB recommendations for joint negotiation of the fee. Optometrists carry out nearly 99.9 per cent of NHS sight tests. Commissioning of the NHS sight testing service in England is the responsibility of NHS England. Discussions are to take place with representatives of the professions on fees for 2019/2020.

Background

12.2 Between 31 December 2016 and 31 December 2017, the number of OMPs who were authorised by the NHS England in England to carry out NHS sight tests decreased from 217 to 190, 12.4%, and the number of optometrists increased from 12,241 to 12,951 an increase of 5.8 per cent. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

12.3 In 2017/18, there were 13.0 million NHS sight tests. This was 0.3 per cent more than in 2016/17

Sources:

https://digital.nhs.uk/data-and-information/publications/statistical/general-ophthalmic-services-workforce-statistics/general-ophthalmic-workforce-statistics-31-december-2017

https://digital.nhs.uk/data-and-information/publications/statistical/general-ophthalmic-services-activity-statistics/year-ending-31-march-2018/gosactivity1718

13. Pensions and Total Reward

Introduction

13.1 The NHS Pension Scheme remains a valuable part of the total reward package available to NHS doctors and dentists.

13.2 Eligible members of the NHS workforce will now belong to one of the two existing schemes. The final salary defined benefit scheme consisting of the 1995 and 2008 sections is now closed, other than for a limited group who are eligible for age-related protection. The NHS Pension Scheme 2015 is a career average revalued earnings (CARE) scheme. Self-employed doctors and dentists (practitioner members) also had their benefits in the 1995/2008 sections calculated on a CARE equivalent basis. The key differences between the two schemes, other than the way benefits are calculated, are different normal pension ages (1995 section – 60, 2008 section – 65, 2015 Scheme – state pension age) and accrual rates (1995 section – 1/80th, 2008 section – 1/60th, 2015 Scheme – 1/54th).

13.3 The NHS Pension Scheme 2015 continues to provide a generous pension for NHS staff and remains one of the best schemes available. The Government Actuary's Department calculates that NHS members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed. The NHS Pension Scheme is backed by the Exchequer and is revalued in line with price inflation; providing a guaranteed retirement income.

13.4 A junior doctor commencing employment and membership of the 2015 scheme from August 2018 (retiring at 68) can expect a pension of around £62,400 a year if s/he progresses to be a full-time consultant. A similar junior doctor progressing to be a part-time consultant can expect a pension of around £53,400 a year. Junior doctors progressing to be GPs can expect a pension of around £63,900 a year.

Pension Scheme Contributions

13.5 The employer continues to pay more towards the cost of the scheme than the majority of the workforce, currently contributing 14.3% of pensionable pay. Employee contributions are tiered according to whole-time equivalent earnings, with the rate paid by the lowest earners being 5% and the highest is 14.5% for those earning £111,377 or above.

Figure 13.1: Employee contribution rates

Whole-time equivalent Pensionable Earnings/Pay	Contribution Rate (gross)
≤ £15,431	5.0%
£15,432 - £21,477	5.6%
£21,478 - £26,823	7.1%
£26,824 - £47,845	9.3%
£47,846 - £70,630	12.5%
£70,631 - £111,376	13.5%
≥ £111,377	14.5%

13.6 Member contribution rates and earnings tiers have been frozen since 1 April 2015, and will remain set until 31 March 2019. It is expected that around 10% of members will see their contribution rate increase (by between 0.6% and 3.2% of pensionable pay, depending where they are in the pay range) at some point during the four years 2015-2019. A proportion of members are expected to progress to higher contribution tiers year to year through pay progression.

13.7 The Department commissioned the NHS Pension Scheme's Scheme Advisory Board (SAB) to review the approach to member contributions. The review explored a number of design elements, including whether the rate payable should be determined using whole-time equivalent or actual earnings, the range and number of tiers, and whether tier boundaries should be revalorised to avoid pay awards placing individuals in higher contribution tiers.

13.8 The SAB submitted their review conclusions in July 2018, and reached full agreement that:

- The principles underpinning the current contribution structure should be retained: include protection for the low paid, minimise the risk of opt-outs,

and ensure the scheme remains a sustainable and valuable part of staff reward.

- ‘Cliff edges’ in the contribution structure should be resolved.

- There is a pressing need to explore ways to minimise scheme opt-outs and mitigate other issues caused by the impact of pension taxation.

- A move to use actual pay, rather than whole-time equivalent pay, to determine contribution rates would be appropriate.

13.9 The SAB reached a majority recommendation that the existing contribution structure be retained for a further two years until 31 March 2021. There was a recognition that further discussion was required on a number of areas, including the approach to avoiding ‘cliff edges’, and a desire by the majority of trade union representatives to seek formal mandate from their membership before recommending any move to actual pay as the basis for determining contribution rates. Further, the SAB expressed concern that if a part of the recently agreed Agenda for Change pay deal (which covers the majority of members) is seen to be offset by contribution rate rises, member confidence in both the pay agreement and pension scheme would be undermined.

13.10 The Department has accepted this recommendation. During this transitional period, the SAB will continue developing a recommended contribution structure based on the agreed elements outlined above. The SAB recommendation is made and accepted subject to the outcome of the quadrennial actuarial valuation of the scheme.

Pension scheme membership

13.11 The Department continues to monitor changes in scheme membership using data from ESR. Annex 6 presents the position as of August 2018, and shows the percentage point change over the previous month, the last 12 months and from October 2011.

13.12 Membership amongst employed doctors remains high. 89% of employed doctors are members of the pension scheme. The rate decreased by 2.1 percentage points compared to August 2017, and 1.9 percentage points less than the October 2011 position. On a one-month view, the rate decreased by 0.5 percentage points for the period July 2018 and August 2018.

13.13 The Review Body recommended in its 45th report that evidence be provided on how many doctors and dentists are taking early retirement and the reasons. The following table shows the number of employed doctors, GPs and dental practitioners claiming their NHS pension earlier than their normal pension age. The figures are based on membership data from the NHS Pension Scheme.

Figure 13.2: Numbers claiming their NHS pension on a voluntary early retirement (VER) basis

Hospital Doctors	VER	% of all retirements
Y/E 2008	178	14%
Y/E 2009	142	11%
Y/E 2010	183	13%
Y/E 2011	286	16%
Y/E 2012	315	18%
Y/E 2013	387	24%
Y/E 2014	406	26%
Y/E 2015	453	28%
Y/E 2016	494	31%
Y/E 2017	490	30%
Y/E 2018	424	29%

General Practitioners	VER	% of all retirements
Y/E 2008	198	17%
Y/E 2009	265	20%
Y/E 2010	322	23%
Y/E 2011	443	28%
Y/E 2012	513	33%
Y/E 2013	591	42%
Y/E 2014	746	50%
Y/E 2015	739	51%
Y/E 2016	695	52%

Y/E 2017	721	62%
Y/E 2018	588	58%

Dental Practitioners	VER	% of all retirements
Y/E 2008	92	29%
Y/E 2009	125	37%
Y/E 2010	118	36%
Y/E 2011	131	32%
Y/E 2012	161	37%
Y/E 2013	158	36%
Y/E 2014	149	40%
Y/E 2015	161	41%
Y/E 2016	145	41%
Y/E 2017	143	42%
Y/E 2018	115	37%

13.14 The decision to claim payment of pension is an individual one. The NHS Pension Scheme does not require members at the point of claim to give a reason. It is therefore difficult to assign and give relative weight to specific factors that contribute to early retirements.

13.15 However, claiming an NHS pension does not necessarily mean that individuals have left NHS service permanently. The 'retire and return' employment flexibility enables NHS employers to support skilled and experienced staff who are approaching retirement and may otherwise retire and leave service, to continue working longer with less onerous commitments or fewer hours typically. It is a flexibility well known and used by GPs. There is no additional cost to the taxpayer or employers as the pension has been fully paid for, with any early payment cost recouped by reducing the pension. However, returning to work is not a right: the employer has to agree to re-employ the individual, who must resign in order to draw their pension. The Department has published guidance to NHS employers on the appropriate use of retire and return.

13.16 In addition to early retirements, the following table presents data on the number of GPs, employed doctors and other high earners who opt-out or leave service. This is based on scheme valuation data as of 31 March 2017. The numbers leaving service are gross, and do not account for the fact that some will re-join active service.

Figure 13.3: Number of GPs, consultants and other high earners who opt-out or leave service

All members with final WTE pay over £110k	Opted out	Left service
2012-13	715	1,098
2013-14	801	1,285
2014-15	1,177	1,211
2015-16	801	1,082
2016-17	1,228	1,882

GPs only	Opted out	Left service
2012-13	397	3,472
2013-14	459	3,306
2014-15	867	2,820
2015-16	518	1,558
2016-17	652	739

13.17 There is evidence of high earning individuals opting-out of the scheme or leaving NHS employment through early retirement. Concerns were raised in last year's DDRB report that this could be due the new lower lifetime and annual allowances tax limits which potentially affect some high earners. From 6 April 2018 the allowances are:

- £1.03m for the lifetime allowance, increasing by CPI to £1.055m for 2019-20
- £40,000 for the annual allowance, tapering down to £10,000 at a rate of £1 less allowance per £2 of relevant earnings above £150,000. HMRC calculates relevant earnings to include the value of pension growth over the year.

13.18 Placing these tax measures in context of the 1995 final salary section of the NHS Pension Scheme, individuals who use up the full £40,000 annual allowance would see their annual pension increase by around £2,500. Those who reach the £1.055m lifetime allowance limit will have built up a pension of around £46,000 a year plus a tax free lump sum of £138,000.

13.19 The Department recognises that annual allowance tax charges, particularly for individuals subject to a tapered allowance, reduce the incentive for higher earners to remain in the scheme or increase their pensionable earnings by taking on additional work or responsibilities.

13.20 We are reviewing recruitment and retention of GPs and consultants, of which pensions tax changes will be a factor. We will explore what, if any mitigation might be appropriate in the context of total reward.

13.21 For individuals with an annual allowance tax charge, HMRC offers an alternative payment facility. The 'Scheme Pays' facility allows the individual to elect for the pension scheme to pay the tax charge on their behalf. The scheme then recoups the cost by reducing the value of the individual's pension by an amount equivalent to the tax charge plus interest. It means members can settle their tax charges without needing to pay up front.

13.22 The Department has closed a gap in the Scheme Pays coverage operated by the NHS Pension Scheme, which prevented those with charges arising from the tapered annual allowance or charges under £2,000 from utilising it. The scheme administrator has confirmed that the scope of Scheme Pays has been extend so that from tax year 2017-18 it can be used to meet any pension tax charge of any amount.

Total Reward

13.23 Total reward, the tangible and intangible benefits that an employer offers an employee, remains central to recruiting and retaining staff in the NHS. There is some evidence that more employers across the NHS are developing a strategic approach to reward which may be due to:

- staff demand arising from total reward statements;
- trusts recognising, they need to do more to recruit and retain staff in an increasingly competitive employment market;

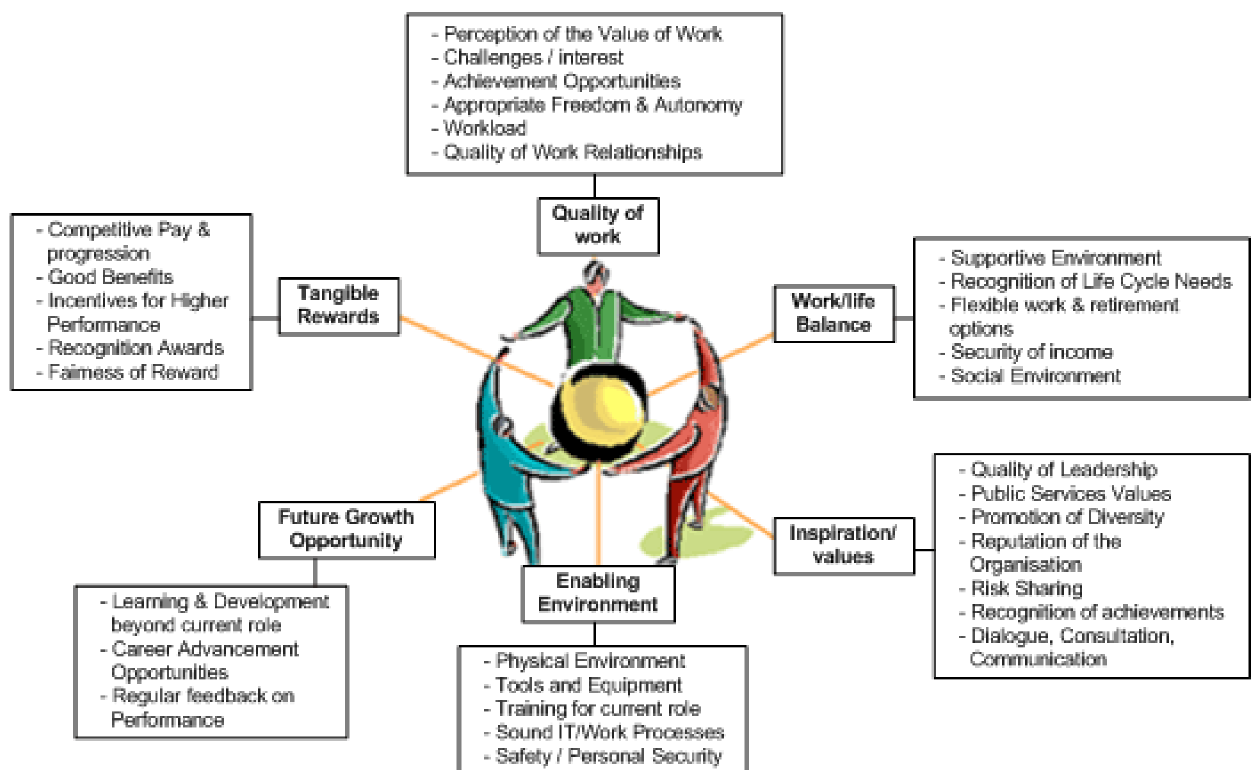
- employers working to reduce staff sickness and other absences by ensuring they are offering the support staff need for their physical, mental and financial wellbeing.

13.24 The Department’s ambitions for the NHS reward strategy remains that employers should develop their capacity and capability to:

- utilise the NHS employment package to recruit, retain and motivate the staff they need to deliver excellent services to patients;
- develop and implement local reward strategies that meet organisational objectives and workforce needs;
- improve staff understanding of their reward package and what options they have to change aspects of it;
- strengthen staff experience of working for the NHS;
- contribute to improvements in workforce productivity and efficiency in use of the NHS workforce pay bill;
- continue to be at the leading edge of innovation in public sector reward, and improve NHS staff satisfaction with pay;
- improve staff financial wellbeing.

13.25 For consultant doctors and dentists, satisfaction with their level of pay is 63% (2017 NHS Staff Survey), the same as 2016. For doctors and dentists in training, satisfaction with pay has fallen to 44%, from 45% in 2017. For ‘other’ doctors and dentists, satisfaction with pay is 43%, falling from 47% in 2016. The department commissions NHS Employers to provide advice, guidance and good practice to the NHS on developing a strategic approach to reward based on the Hay Model (below).

Figure 13.4: Hay Model



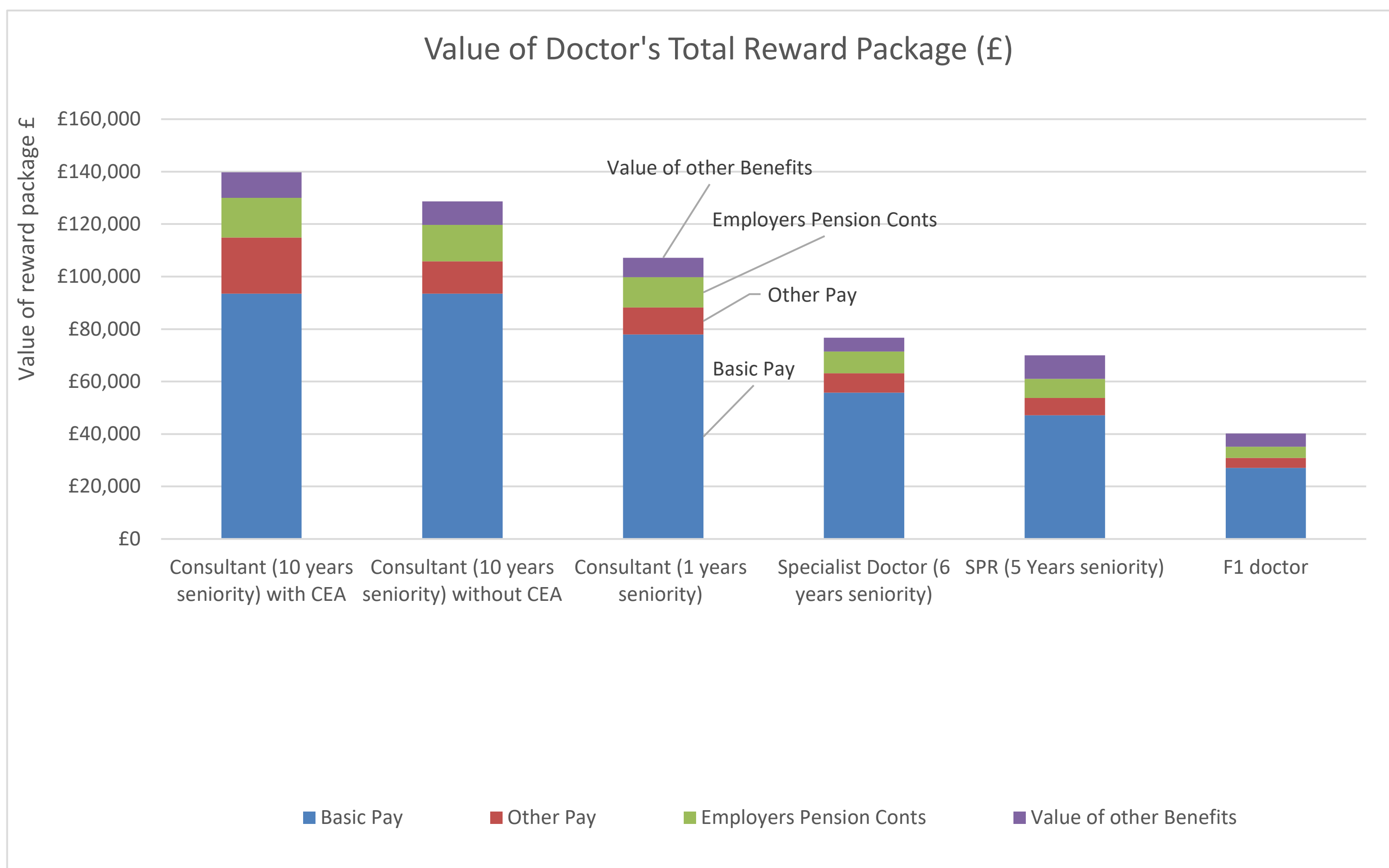
13.26 NHS Employers will provide updates on;

- their work to ensure the strategic context for total reward in the NHS remains 'fit for purpose' and aligned with their other work programmes;
- how their engagement with employers is improving NHS understanding of total reward and why they should be developing their own local reward strategies;
- their promotion of existing and new tools to support trusts in using strategic reward to deliver local workforce priorities;
- the continuing development of their total reward engagement networks to gain and share intelligence about total reward in the NHS;
- their promotion of better uptake and understanding of total reward statements.

13.27 The value of reward packages for doctors is shown in the graph below and includes; basic pay, employer's pension contribution, other pay such as clinical excellence awards for consultants, out of hours/on call payments, weekend allowances (for Specialist Registrars), extra sessions worked. It

also includes additional leave over the statutory minimum, additional sick leave over statutory sick pay and study leave for doctors in training.

Figure 13.5: Value of Doctor's Total Reward Package (£)



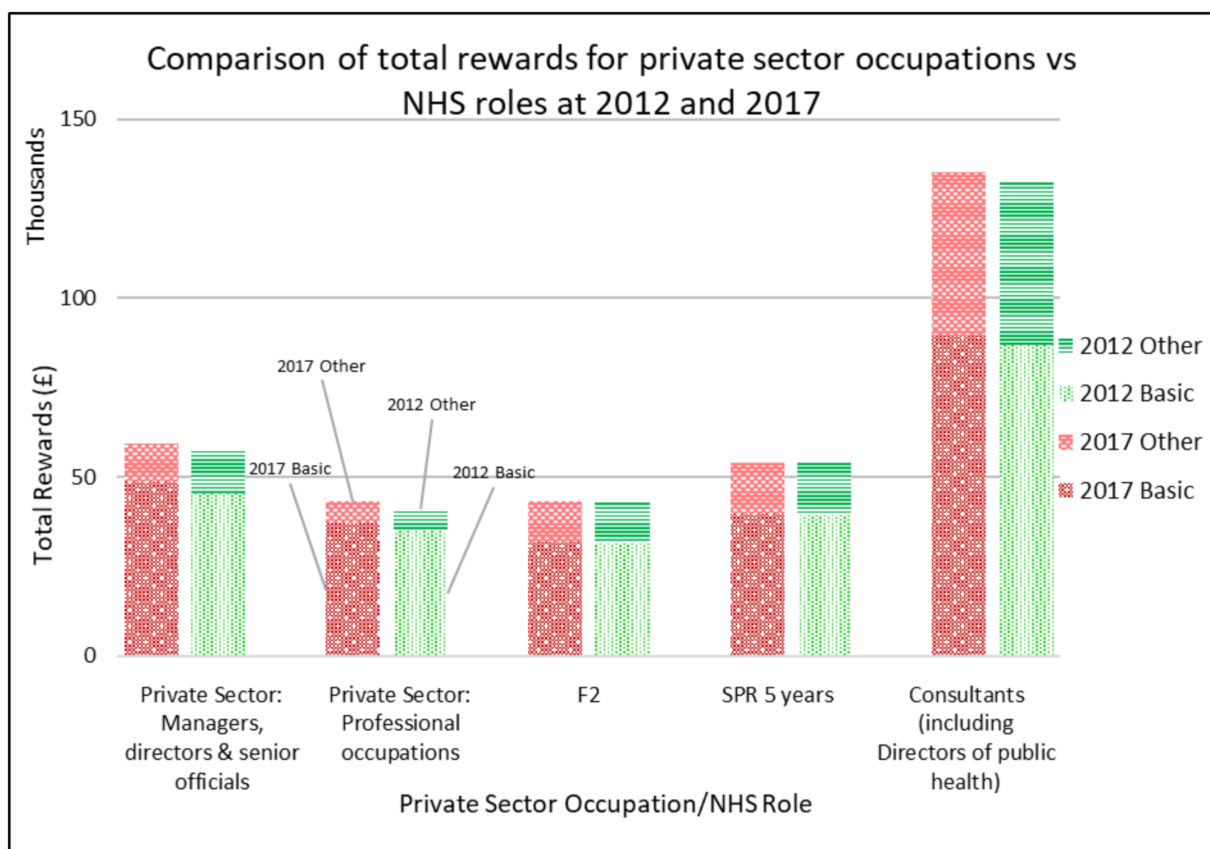
13.28 The Department commissioned the Government Actuary's Department (GAD) to analyse total reward across various private sector occupations, based on Office for National Statistics (ONS) data for salary and pension benefits, and compared them against pay rewards for various NHS staff based on previous GAD analysis for 2012 and 2017.

13.29 A total reward package considers basic pay plus "other" (non-basic pay), the latter including all other pay elements such as overtime, incentives, other elements of pay, and employer pension contributions. The graph below shows the relative change in total reward packages from 2012 to 2017 for each of the identified roles. Registrars, doctors in training and consultants in the NHS are compared to managers, directors and senior officials in the private sector, as well as other private sector professional occupations. This is mainly due to the availability of data and difficulty drawing appropriate comparisons with any one NHS role and other roles. The graph splits basic

and “other” non-basic pay for each of the occupations, at 2012 and 2017, and is based on;

- 2012 basic + 2012 non-basic = 2012 pension/salary data (private sector occupations)
- 2011/12 NHS pay bands
- 2017 basic + 2017 non-basic = 2017 pension/salary data (private sector occupations)
- 2016/17 NHS pay bands

Figure 13.6: Comparison of total rewards for private sector occupations vs NHS roles as at 2012 and 2017



13.30 All roles considered as part of this analysis experienced an increase in pay between 2012 and 2017. Private sector managers, directors and senior officials experienced the highest salary increase at about 5% over this period. Specialist Registrars (SPRs) with 5 years’ experience remained broadly the same with a less than 1% increase over the period.

13.31 Non-basic pay makes up a larger proportion of NHS total rewards across roles analysed relative to private sector occupations, about 34% of consultants' total reward. One driver might be higher employer pension contributions available to members of the NHS Pension Scheme, as well as additional pay elements and awards available to NHS staff, relative to the private sector.

13.32 Although they are not included in the above graph, the additional non-basic pay elements of the total reward package available to NHS staff must be considered as they exceed that available in the private sector. NHS staff are currently entitled to redundancy up to a maximum of £160,000, whereas statutory redundancy has a maximum cap of £15,240. Doctors in the NHS are entitled to uncapped redundancy. NHS staff receive one month's pay for every year of service up to a maximum of 24 months, whilst statutory redundancy provides 0.5 weeks for service below age 22, 1 week for service up to age 41 and 1.5 weeks for service beyond age 41.

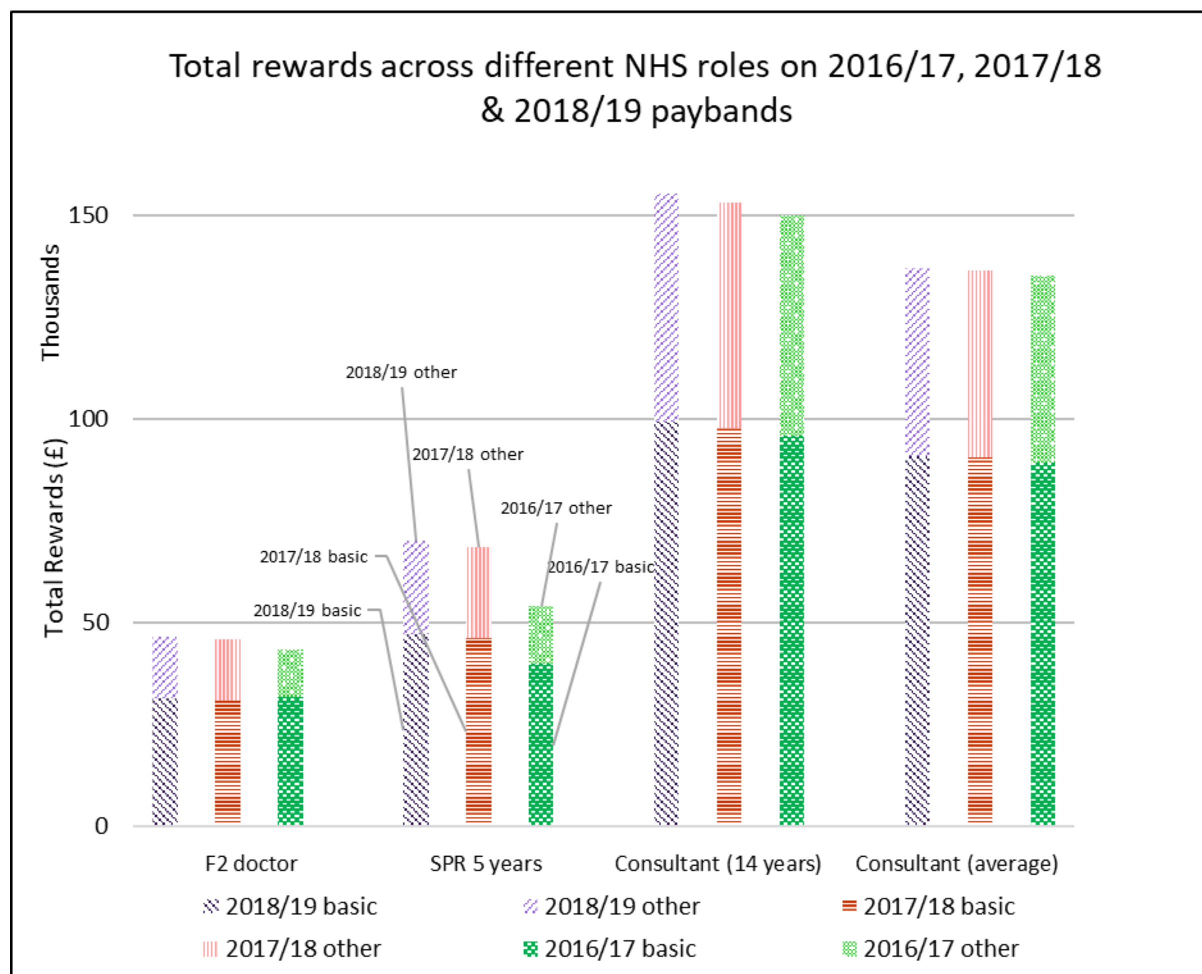
13.33 It is difficult to quantify the value of NHS redundancy benefits as this only applies when an individual is made redundant and would need assumptions about the rate at which members leave under redundancy terms. Eversheds Sutherland conducted a survey of employers in 2016, which found that 1/3 of respondents offer statutory benefits only. 60% of respondents consider enhanced redundancy to be discretionary, unlike the NHS, suggesting that their offer is not as generous as the NHS.

13.34 NHS staff are entitled to above statutory sick pay, receiving up to 6 months full pay and 6 months half pay subject to length of service. Statutory sick pay provides £92.05 per week for 28 weeks.

NHS Trend Analysis

13.35 GAD also carried out trend analysis for different NHS staff, based on the previous total reward analysis in 2011/12 by DHSC, 2015/16, 2017/18 and 2018/19 by GAD.

Figure 13.7: Total rewards across different NHS roles on paybands since 2015/16



13.36 All roles considered as part of this analysis have experienced an increase in total rewards over the period 2016/17 to 2018/19.

13.37 Over the year between 2017/18 and 2018/19, increases were lower than those identified over the previous year. Foundation Year 2 (F2) doctors and SPRs (5 years' experience) had the highest increase between 17/18 and 18/19 at 2%. However, the total reward for the average consultant remained broadly the same between 17/18 and 18/19.

13.38 The new 2016 Doctors in Training contract was in place for the 2017/18 and 2018/19 analysis. F2 doctors experienced an increase of 8% in their total rewards over 2016/17 and 2018/19. SPRs (5 years' experience) had an increase of 30% over the same period. This may indicate the relative impact of the change of contract on each of the roles.

13.39 All doctor roles considered for analysis have over 30% of their total reward made up of non-basic pay.

Total Reward Statements

13.40 Total reward statements (TRS) provide NHS staff with a better understanding of the benefits they have or may have access to as a NHS employee. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer. Local reward offers from NHS organisations might include;

- Recommend a friend scheme
- Affordable accommodation
- Childcare and carer support
- Counselling and support
- Various salary sacrifice schemes
- Discounts
- Education and learning support
- Financial wellbeing
- Physical and mental health and wellbeing
- Members of the NHS Pension Scheme are also provided with an annual benefit statement (ABS), which shows the current value of their NHsPension benefit.
- For consultant medical and dental staff, up to 30 days paid study leave.

13.41 Since 2016, the NHS Business Services Authority (NHSBSA), which is responsible for ABSs, has held TRS engagement events for different types

of employers to help them better understand the role they can play in promoting TRS. These events explain the difference between a TRS and an ABS, as local employers are responsible for TRS whilst NHSBSA creates ABSs.

13.42 The latest access total for this year's TRS is 366,527 compared to 227,930 at the same time last year. Currently there are 2,414,352 TRSs available. Refreshed statements were published in August 2018.

13.43 TRS Improvements include changes to embedded links following the introduction of BSA's new website and an update to branding in line with the rest of the NHS. Work continues to put in place alternative arrangements for those who access their TRS via the Government Gateway which ends in 2018.

Annex 1 - Remit letter

Professor Sir Paul Curran

Chair Review Body on Doctors' and Dentists' Remuneration

Office of Manpower Economics

Fleetbank House

2-6 Salisbury Square

London

EC4Y 8JX

21 November 2018

Dear Professor Curran,

I am writing firstly to express my thanks for your valuable work on the 2018-19 pay round. As you know, the government, had to make some difficult decisions on the awards for 2018-19 against the budgeted one per cent. We did so informed by your considered recommendations on targeting pay and taking into account affordability and the prioritising of patient care.

I write now to formally commence the 2019-20 pay round.

The NHS Long Term Plan and the 2019 Spending Review - on which NHS England will provide written evidence - provide the context for the long-term funding of the NHS. The affordability of pay recommendations will have to be considered within the context of NHS England's affordability assumptions in the Long Term Plan, and the importance of making planned workforce growth affordable. Given the NHS budget is now set for the next five years, there is a direct trade-off between pay and staff numbers and our evidence, and that from NHS England, will set out the balance. The evidence that I will provide in the coming months will also support you in your consideration of affordability and I request that you describe in your final report what steps you have taken to take account of affordability and need for workforce growth and improved productivity. Pay awards will also be considered in the context of planned workforce reform and productivity improvements, which we will cover in our evidence.

I am also seeking your views on the targeting of available funds in pay in 2019-20 to ensure recruitment and retention pressures are properly addressed, and ask that you outline what consideration you have given to targeting in your final report.

You are invited to make recommendations in relation to doctors and dentists in training about targeting funding to support productivity and recruitment and retention. We would like you to consider how resources might be targeted, including through the existing mechanisms of the flexible pay premia in the contract for doctors and

dentists in training and taking account of views from Health Education England on hard-to-fill training programmes.

In relation to the future remuneration of consultants, I have asked NHS Employers to continue exploratory talks with the BMA with a view to reaching a multi-year agreement incorporating contract reform. At present, it seems unlikely that these talks will bear fruit. I am therefore asking you for recommendations in relation to consultants, asking you to consider targeting of pay including to support increased productivity.

I am asking also for your recommendations on Specialty Doctors and Associate Specialists, and our evidence will update you on our approach to a review of the salary structure for these grades as proposed in your 46th Report.

In considering remuneration for General Medical Practitioners, we wish to make the Review Body aware that NHS England are shortly due to begin formal negotiations to reach agreement on a new primary care contract. As I have set out, we are aspiring to negotiate a multi-year agreement on proposed reforms in primary care which will lead to enhanced resources going into primary care.

We invite you to make recommendations as usual for General Dental Practitioners.

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 report by week commencing 6 May 2019

Yours ever,

MATT HANCOCK

Annex 2 - Written Ministerial Statement

Made on: 24 July 2018

Made by: Matt Hancock (Secretary of State for Health and Social Care)

Commons

12. Department of Health and Social Care update

I am responding on behalf of my Rt. Hon. Friend the Prime Minister to the 46th Report of the Review Body on Doctors' and Dentists' Remuneration (DDRB). The report has been laid before Parliament today (Cm9670) and a copy is attached. I am grateful to the Chair and members of the DDRB for their report.

I am today announcing pay rises for Doctors and Dentists working across the NHS.

This is a pay rise that recognises the value and dedication of hardworking Doctors and Dentists, targeting pay as recommended by the DDRB, and taking into account affordability and the prioritising of patient care.

Supporting the NHS workforce to deliver excellent care is a top priority. Following this one year pay rise, we want to open up a wider conversation on pay and improvements. This is the start of a process whereby we will seek to agree multi-year deals in return for contract reforms for consultant and GPs. We want to make the NHS the best employer in the world.

In June this year nurses were awarded a multi-year award as part of a pay and contract reform deal and it is only right that pay rises are targeted at the lowest paid workers.

Including the announcement of today's pay award, from October 2018, a consultant that started in 2013 will have seen a 16.5% increase in their basic pay, rising to a salary of £87,665 from £75,249. Today's pay award is worth:

- Between £1,150 and £1,550 for consultants
- Between £1,140 and £2,120 for Specialty Doctors
- Between £1,600 and £2,630 for Associate Specialists
- Between £532 and £924 for Junior Doctors
- Around £1,052 for a salaried GP with a median taxable income of £52,600

GPs face a significant challenge in numbers and we need to recruit large numbers over a short period, meaning any pay rise needs to be balanced against our aim for a growing number of practitioners. The 2018/19 pay award is worth £2,000 per year to a GP contractor with a median taxable income of £100,000.

The Government's response to the DDRB's recommendations takes account of:

affordability in 2018/19 in the context of a Spending Review that budgeted for 1 per cent average basic pay awards

the importance of prioritising patient care, and the long term funding settlement which increases NHS funding by an average 3.4 per cent per year from 2019/20, and which will see the NHS receive £20.5 billion a year in real terms by 2023

the three year contract reform agreement on the Agenda for Change pay contract for one million non-medical staff, which delivered significant reforms as part of 3% pay investment per year, including progression pay reforms that end automatic annual increments; and

the case for contract reform for some of the DDRB's remit groups, in particular for consultants and GPs.

The Government's response is as follows,

Consultants

I am committing to negotiations on a multi-year agreement incorporating contract reform for consultants to begin from 2019/20.

From 1 October 2018:

a 1.5% increase to basic pay

the value of both national and local clinical excellence awards (CEAs) to be frozen

0.5% of pay bill to be targeted on the new system of performance pay to increase the amount available for performance pay awards from 2019/20. Employers will be able to choose to use the 0.25% of funding available in 2018/19 as transitional funding to manage the costs of running the required CEA round this year or to invest it additionally should they choose to do so.

Doctors and Dentists in Training

As agreed in the May 2016 ACAS agreement, we will discuss changes to the pay structure as part of the 2018 review of the contract, re-investing any existing funding freed up as transition costs reduce.

From 1 October 2018

A 2% increase in basic pay and the value of the flexible pay premia.

Introduction of a flexible pay premium for doctors on training programmes in histopathology of the same value as that currently provided for doctors on training programmes in Emergency Medicine and Psychiatry.

Specialty Doctors (new grade 2008) and Associate Specialists (closed grade)

I take note of the DDRB comments about the particular issues of morale in relation to this group that led to their pay recommendation and their observation on the need for a review of the salary structure for these grades as part of a wider review of their role, their career structure and the developmental support available to them. It is intended that this will follow the agreement of reformed arrangements for consultants.

From 1 October 2018

Increase basic pay by 3%

General Dental Practitioners

From 1 April 2018 (backdated)

Increase expenses by 3%

From 1 October 2018

Increase dental income and staff costs by 2%

General Medical Practitioners

I intend to ask NHS England to take a multi-year approach to the GP contract negotiations with investment in primary care linked to improvements in primary care services.

From 1 April 2018 (backdated)

Add an further 1% to the value of the GP remuneration and practice staff expenses through the GP contract, supplementing the 1% already paid from April 2018 and making a 2% uplift in all. This will enable practices to increase the pay of practice staff.

From 1 October 2018

The recommended minimum and maximum pay scales for salaried GPs will be uplifted by 2%

the GP trainer grant and GP appraiser fees will be increased by 3% and we will apply the same approach to clinical educators' pay; GP and Dental educators.

From 1 April 2019

the potential for up to an additional 1%, on top of the 2% already paid to be added to the baseline, to be paid from 2019/20 conditional on contract reform, through a multi-year agreement from 2019/20. This would be in addition to the funding envelope for

the contract negotiation for 2019/20 onwards. This would be reflected in respect of GP remuneration, practice staff expenses and the recommended minimum and maximum pay scales for salaried GPs.

Annex 3 - Secretary of State’s letter to the BMA

Dr Chaand Nagpaul CBE

BMA Council Chair

British Medical Association

BMA House

Tavistock Square

London WC1H 9JP

18 September 2018

Dear Chaand,

Following my meetings with you and your Heads of Committees, I wanted to write to you to set out my commitment to working with the BMA to address the concerns you have raised.

I absolutely recognise the frustration and disappointment many doctors are expressing in relation to this year’s pay award and the way in which it is phased. I have heard that very clearly and it wasn’t a decision I took lightly. In a tight financial year for our health service, the priority had to be ensuring that we could afford the staff we need to provide the care we need to provide to patients, but I would be deeply concerned if doctors took this as a signal that we do not value the extraordinary dedication and expertise which they continue to show day in day out. We do not and cannot take that commitment for granted and in future, as in any other year, we will endeavor to ensure that is reflected in our discussions and our decisions.

I understand that some of your members have expressed concerns about the DDRB process. I have asked my officials to meet with yours to understand these concerns in greater detail and to report back to me in the light of those discussions.

I am keen to work with you to address the challenges that face us both for employed doctors and GPs. For all groups I want to see agreements reached that give fair reward for the difficult jobs that you do and sort out some of the longstanding shared concerns about your working lives – contractual and non-contractual.

For consultants, I am keen for the Department and employers to get around the table with you as soon as possible to discuss, debate and agree a long term pay deal

including contract reform. I want a frank open discussion about how we can work together to do a deal that pays fairly, improves morale, values doctors – and in doing so meets our shared aim of improving patient care. I understand your negotiators have asked to meet with employers and the Department prior to the full Consultants Committee meeting in October and I hope that you will agree to continue with negotiations. I have asked my officials for advice on what resource envelope could potentially be available for the right long-term agreement, to inform those discussions in October and subsequent discussions with employers.

As part of that we are happy to discuss the pensions issues that you have raised. One issue that you have raised that I can progress is the problem experienced by doctors who are subject to tax charges as a result of the tapering annual allowance, as the NHS Pension Scheme currently does not offer the “scheme pays” facility for this group. I can confirm that we have asked the Business Services Authority that administers the pension scheme to introduce this facility as soon as possible.

Junior doctors are a crucial part of the NHS workforce, not just for the expert care they give day in day out, but as the medical leaders of the future. I’m determined to ensure that their contract fairly reflects the value that we all place on them and that we do everything we can to improve their working lives and their training experience.

I want to ensure that that we have a Junior Doctors Contract that enshrines safe working, supports high quality training, pays fairly and is clear and simple. I am pleased that the terms of reference for the Review of the 2016 Contract have been agreed. They will provide a good framework to iron out some glitches and agree how we can make it safer, fairer and simpler.

I particularly welcome the strong focus in the contract review on safety and training and ensuring that exception reporting works as intended. We really need to work on improving how exception reporting of missed training opportunities works and to ensure that juniors do not miss out on training because of service pressures.

I know that junior doctors are concerned about the distribution of the weekend allowance. I am committed to making sure that this fairly reflects the weekend commitment of doctors. I also want to ensure that we look at how we can better support Less than Full Time trainees.

I look forward to reaching an agreement that allows us to put the past behind us and move forward. To support this, we are prepared to consider modest additional investment (in addition to recycled resources) if that would support improved patient care. It is too early to say what level of investment would be appropriate but I will consider this as the Review progresses.

In addition, I am asking HEE to look at how the programme of improvements in training can be accelerated. For instance, I would like them to look to roll out the pilot of flexible working in Emergency Medicine to other specialties but there are a number of areas where we can build on the significant progress already made working with you.

I recognise your concerns about rota gaps and the pressure they put on juniors. I am keen to ensure visibility of this and that Trust Boards properly address this issue. In future, as part of the Quality Accounts, every Trust must publish a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps, which must be signed off by the trust chief executive.

I also want to ensure every trust is implementing e-rostering for juniors. This should have significant benefits for work live balance. I will be asking NHSI to ensure Trusts are properly implementing e-rostering and addressing rota gaps.

Recognising the importance of simple things to improve the work environment for junior doctors, I am making available to Trusts £10m to be spent by the Guardian of Safe Working in each Trust in agreement with Junior Doctors locally to improve working conditions for Junior Doctors. The DDRB made clear that SAS Doctors have been a neglected group and they have received a higher pay rise at 3% this year than other groups of hospital doctors in recognition of this. Building on this, I want to see the valuable role they do recognised in their contract arrangements and the development and support they receive.

I expect trusts to be implementing the 2014 SAS Charter (England), that sets out minimum conditions and appropriate support and development for SAS doctors. They should also be accessing the SAS doctor development funding held and allocated by HEE.

You have asked me to consider reopening the Associate Specialist grade and I am happy to commit to working with the SAS Committee to reform the SAS contract including agreeing in principle that this will include reopening the AS grade to extend career development for this important group of doctors.

The DDRB also recognised the challenges faced by General Practice in their recommendations.

As you know, I have asked NHS England to look to agree a multi-year contract settlement with the General Practitioners Committee and have announced that, if agreement is reached, GPs will receive an additional 1% in the baseline for 2019/20 on top of the funding agreed in the contract negotiation.

I am committed to seeing investment in primary care. I know negotiations with NHS England are underway and I want to hear from NHS England their views on the level of investment and what will be achieved for it.

We also have a substantial programme of work in place to support General practice that I want to affirm my support for

• establishing a GP indemnity scheme from April 2019 that covers the full range of primary care services;

• the Review of the GP Partnership Model; an independently chaired review due to report by the end of 2018, that will address the current challenges faced by GP partnerships, and make recommendations for how best to reinvigorate the partnership model of general practice;

• exploring how the profession can move to operating at scale to provide a stronger voice and expanded role for general practice in the system;

• the review of primary care premises policy, which is underway and being led by NHS England;

• working together on emerging IT innovations to ensure they work well for GPs and patients I am looking to increase the choice of quality digital services available to practices through the GP IT Futures programme.

• I want the Department and NHS England to work with primary care to bring more pharmacists into General Practice

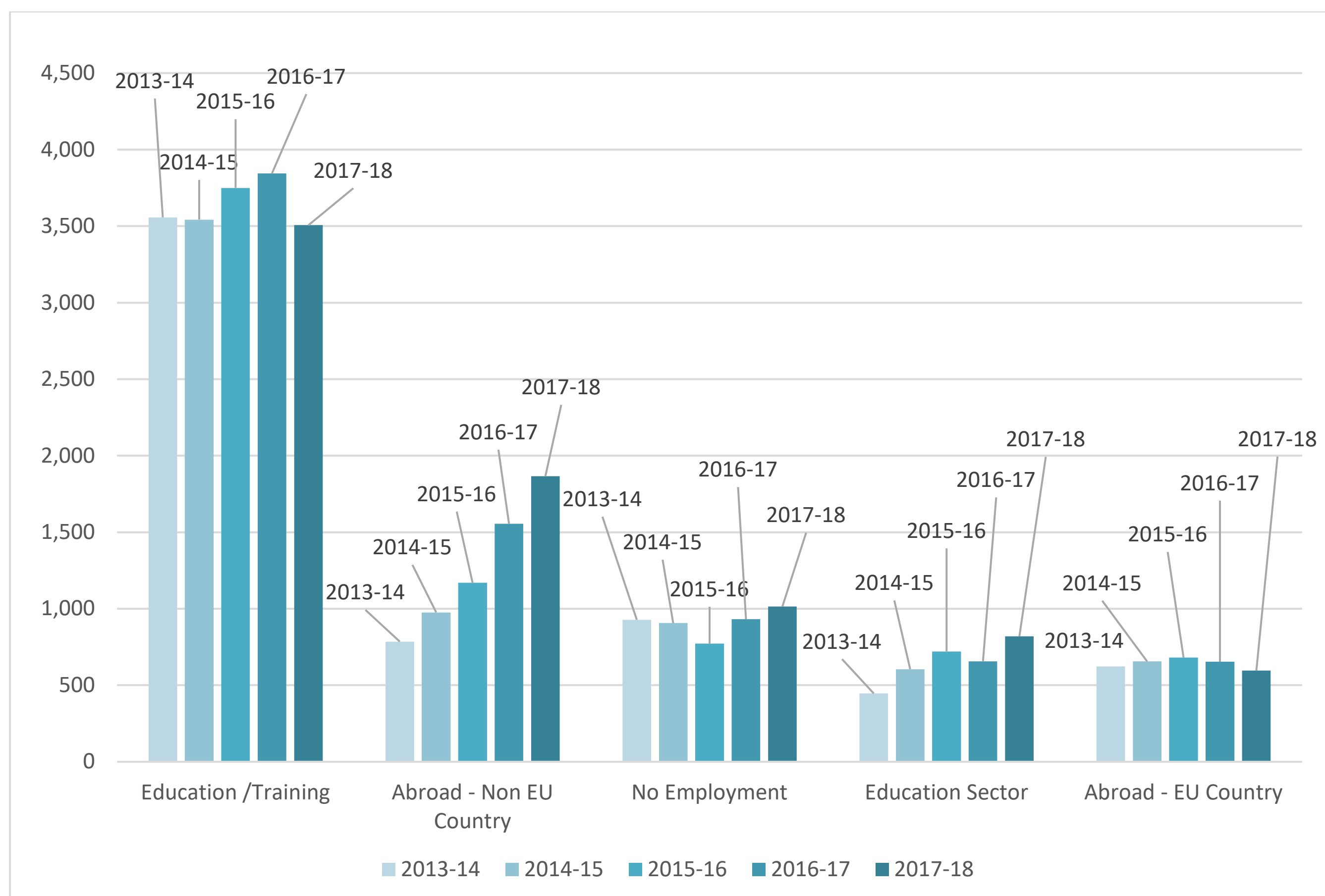
I strongly believe that the Government, employers and Trade Unions need to work together to further our shared commitment to valuing staff and improving the quality of the service we provide to patients. I very much hope that we will be able to move forward together in the way I have set out.

Yours ever,

MATT HANCOCK

Annex 4 – Analysis of Joiners

HCHS Doctors group - Number of NHS Joiners from the Five Largest Sources: Time Series



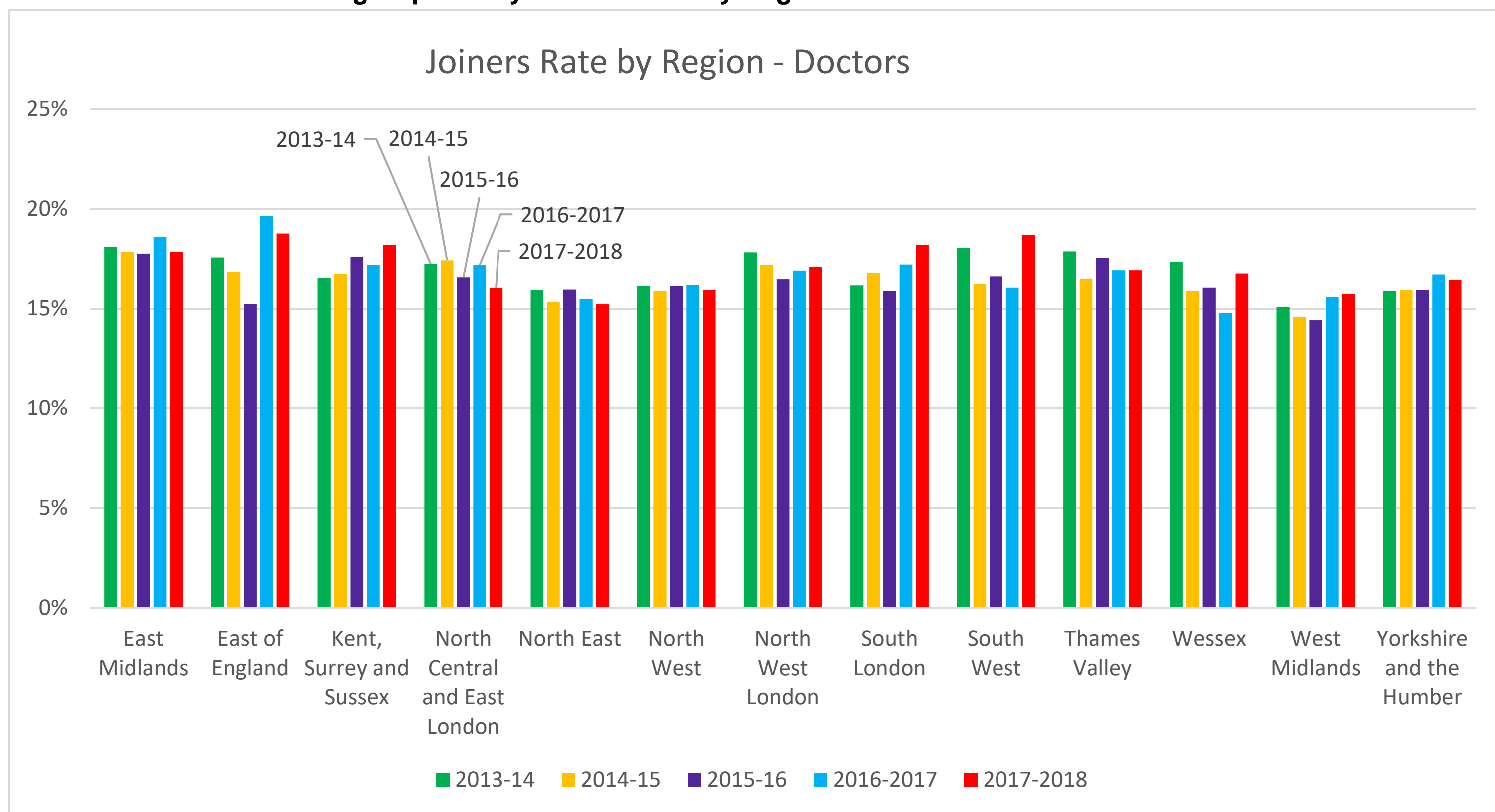
Source: NHS Digital HCHS workforce statistics

Around a third of joiners from external sources[xii] to the NHS medical workforce come from education and training. The number of new entrants from this external source has decreased slightly in the period between 2013/14 and 2017/18. New entrants from non-EU countries have continued to grow year on year, and has more than doubled in the past five years, up by 1,081 (138%) between 2013/14 and 2017/18.

The number of joiners in the HCHS doctors' workforce has grown by 10% in the last 5 years. The number of new entrants has grown at higher rates particularly in terms of new doctors coming from non-EU countries, as well as those coming from the Education Sector.

The number of joiners from EU countries has declined slightly, and there are around 5% less joiners from EU countries than in 2013.

HCHS Doctors group - Analysis of Joiners by Region



The joiner rate is the percentage of the workforce in the HCHS joining their staff group in a year.

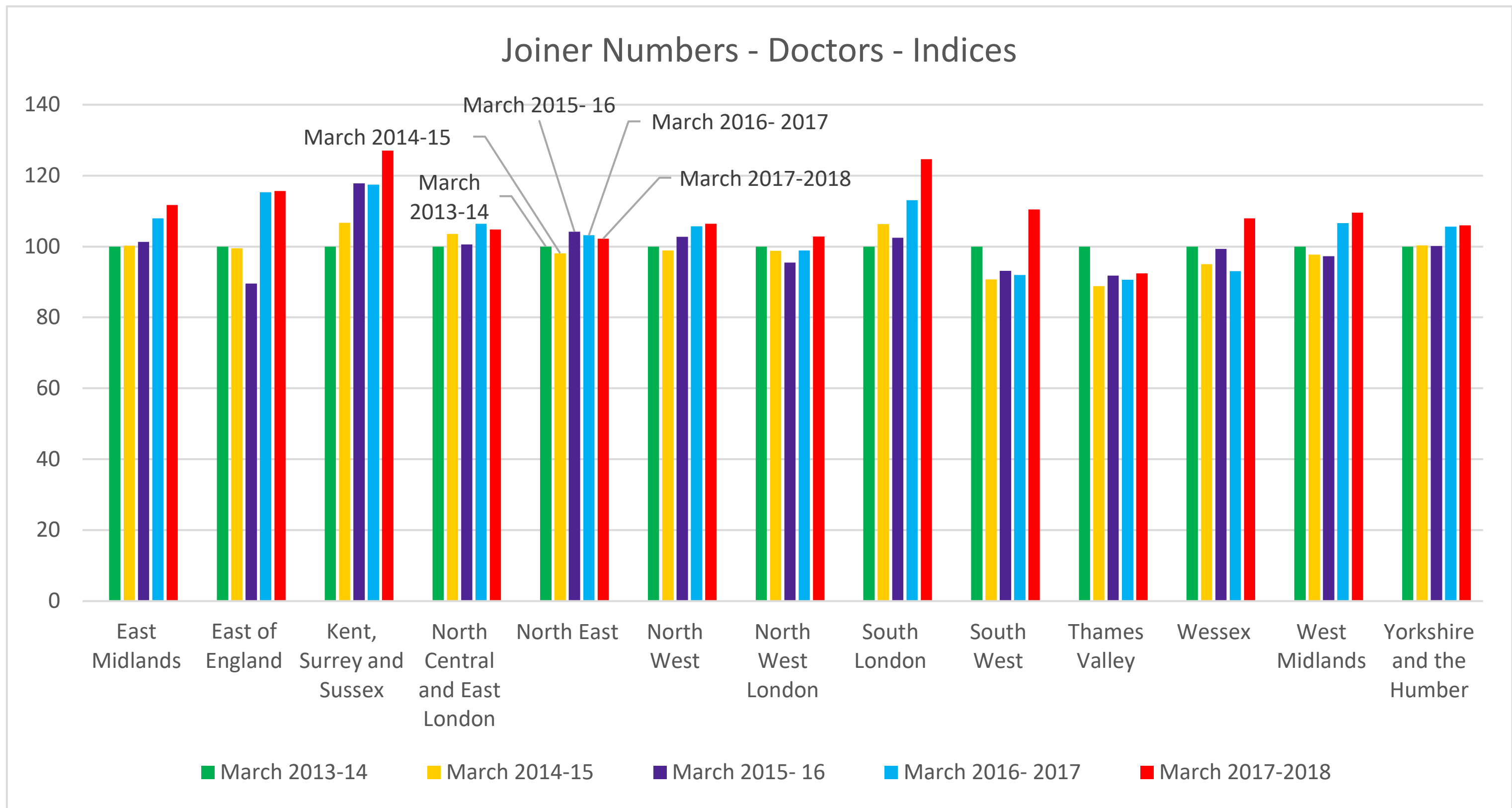
The data collected by NHS Digital provide a general picture of joiner rates in regions across England. For HCHS doctors, joiners' rates vary little between regions, and there are no clear trends. The joiners' rates between all regions vary between 15% and 20% throughout the time series.

12-months joiner rates by region, HCHS Doctors

Region	2013-14	2014-15	2015-16	2016-2017	2017-2018
East Midlands	18%	18%	18%	19%	18%
East of England	18%	17%	15%	20%	19%

Kent, Surrey and Sussex	17%	17%	18%	17%	18%
North Central and East London	17%	17%	17%	17%	16%
North East	16%	15%	16%	15%	15%
North West	16%	16%	16%	16%	16%
North West London	18%	17%	16%	17%	17%
South London	16%	17%	16%	17%	18%
South West	18%	16%	17%	16%	19%
Thames Valley	18%	17%	18%	17%	17%
Wessex	17%	16%	16%	15%	17%
West Midlands	15%	15%	14%	16%	16%
Yorkshire and the Humber	16%	16%	16%	17%	16%

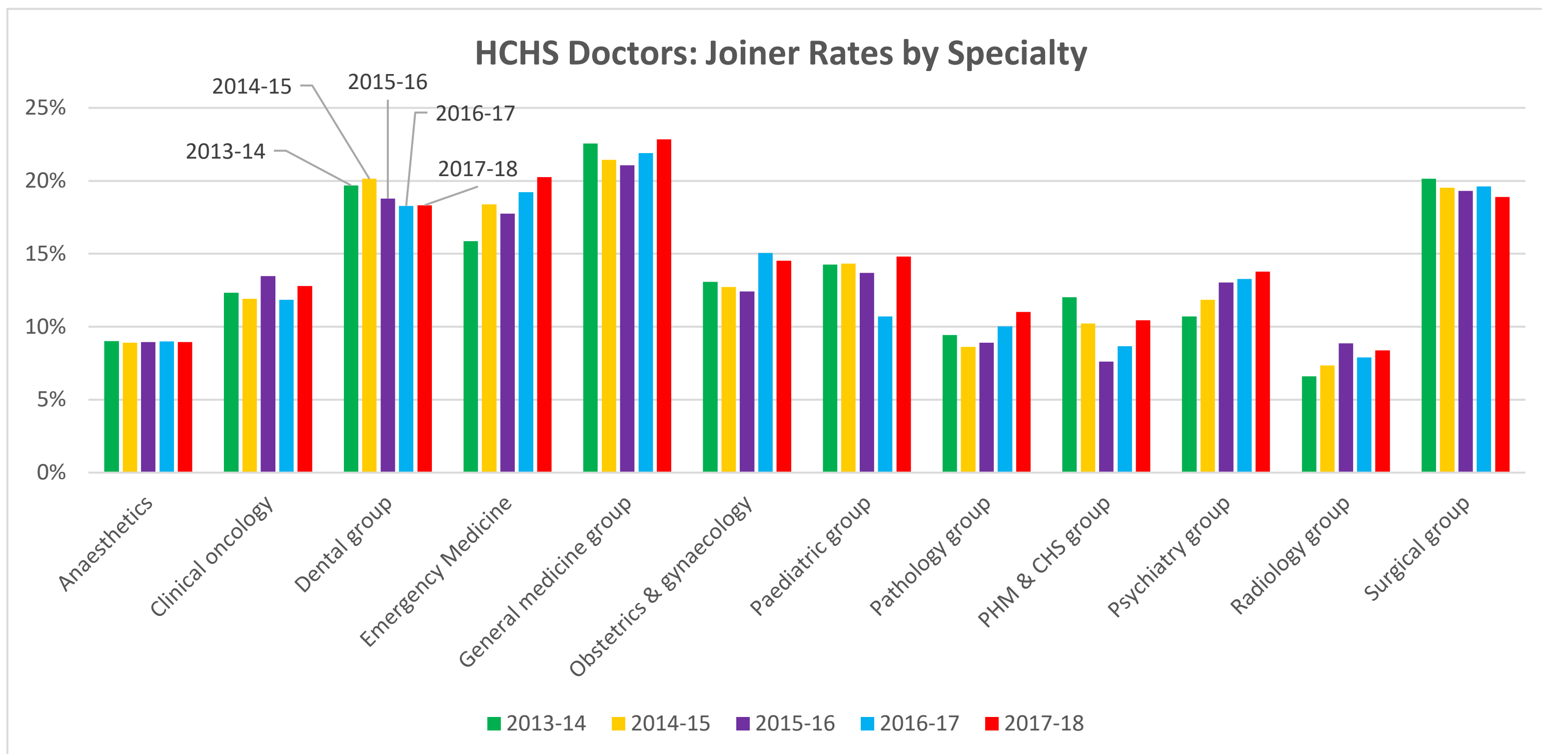
Region	2013-14	2014-15	2015-16	2016-2017	2017-2018
East Midlands	18%	18%	18%	19%	18%
East of England	18%	17%	15%	20%	19%
Kent, Surrey and Sussex	17%	17%	18%	17%	18%
North Central and East London	17%	17%	17%	17%	16%
North East	16%	15%	16%	15%	15%
North West	16%	16%	16%	16%	16%
North West London	18%	17%	16%	17%	17%
South London	16%	17%	16%	17%	18%
South West	18%	16%	17%	16%	19%
Thames Valley	18%	17%	18%	17%	17%
Wessex	17%	16%	16%	15%	17%
West Midlands	15%	15%	14%	16%	16%
Yorkshire and the Humber	16%	16%	16%	17%	16%



Absolute Joiner Numbers

Looking purely at the number of joiners in indices, the Kent, Surrey and Sussex saw the largest increase (27%) between 2013/14 and 2017/18. The number of doctors has increased across all regions, apart from Thames Valley where the numbers decreased by 8% since 2013/14.

M&D Joiners by Specialty



Dental group, emergency medicine, general medicine and the surgical group specialties have the highest joiner rates each year. The number of doctors joining the dental group specialty has decreased over the last 5 years, from a joiner rate of 20% in 2013/14 to a joiner rate of 18% in 2017/18. Meanwhile, the number of joiners to the emergency medicine group has increased at a faster rate compared to all other specialties.

Joiner rates among specialty groups which have remained similar over the past 5 years include anaesthetics, clinical oncology, general medicine, surgical, radiology and pathology specialties. Joiners to the paediatric group remained similar at close to 15% but dropped last year, however returned to its normal rate in 17/18.

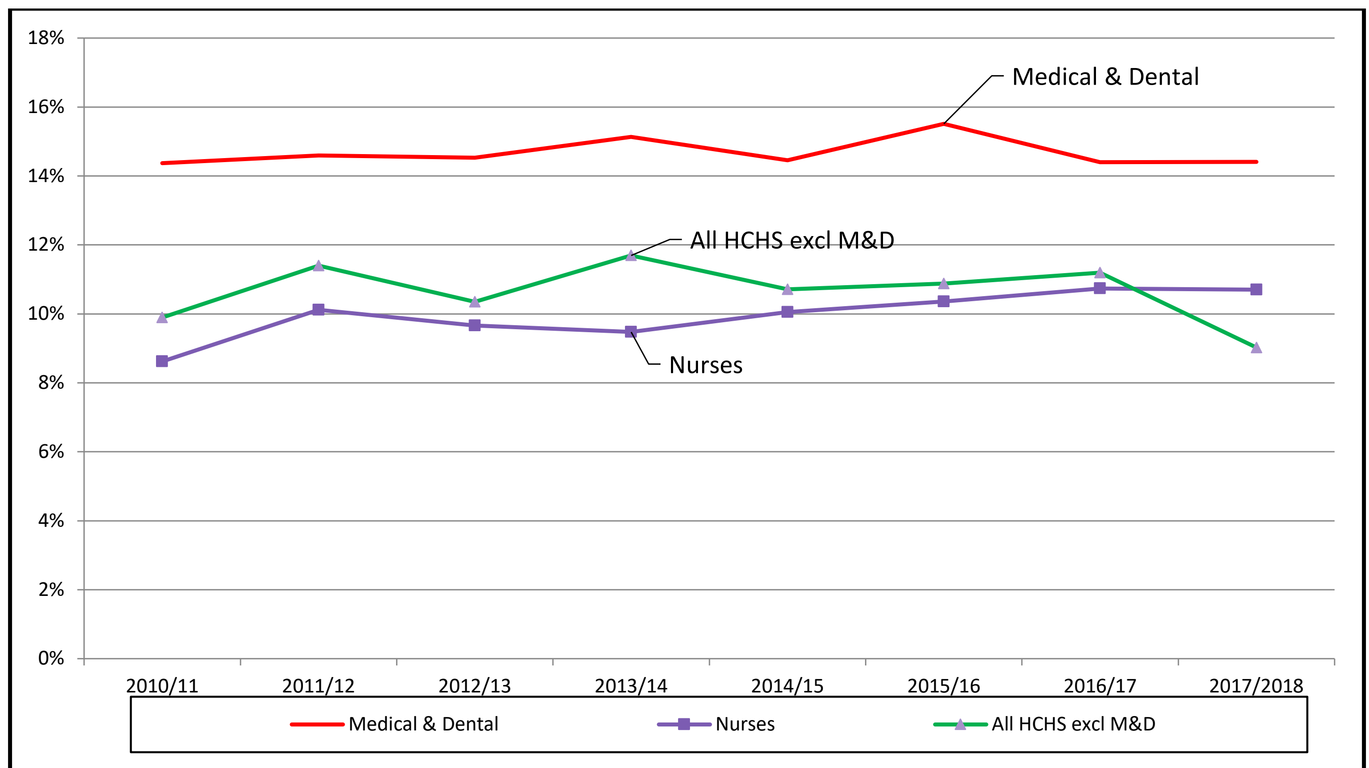
The joiner rates have increased across a few specialty groups over the same period. The emergency medicine group had a joiner rate of 16% in 2013/14, however in 2017/18 the rate had increased to 20%. The number of joiners to the psychiatry specialty group has been increasing by around 1% each year since 2013/14. Other specialty groups which have also seen a rise in the number of joiners compared to previous years are the obstetrics and gynaecology specialty and the radiology specialty group.

PHM and CHS doctors' joiner rate decreased since 2013/14, however it has picked up in the last two years, but still not reached the 2013/2014 levels. The dental group and surgical specialties are the only other group that have decreased since 2013/14.

Annex 5 – Analysis of Leavers

NHS Digital produces turnover statistics based on information in the NHS Electronic Staff Record. The leaver rate is the percentage of the workforce leaving their staff group in the NHS Trusts and CCGs in a year. It excludes staff moving between Trusts, but includes people moving from the Trusts to e.g. a GP Practice. The leaver rate for HCHS medical & dental staff was around 14.5% per year in 2010/11 to 2012/13. There was a one-off temporary increase in 2013/14 during transformation of the health system, including the transfer of some jobs out of the HCHS into Public Health England. The rate increased to 15.5% between 2014/15 and 2015/16, however decreased in 2016/17 to a similar rate of 14.4% in 2014/15, and has remained the same in 2017/2018.

HCHS Staff Leaver Rates: Time Series



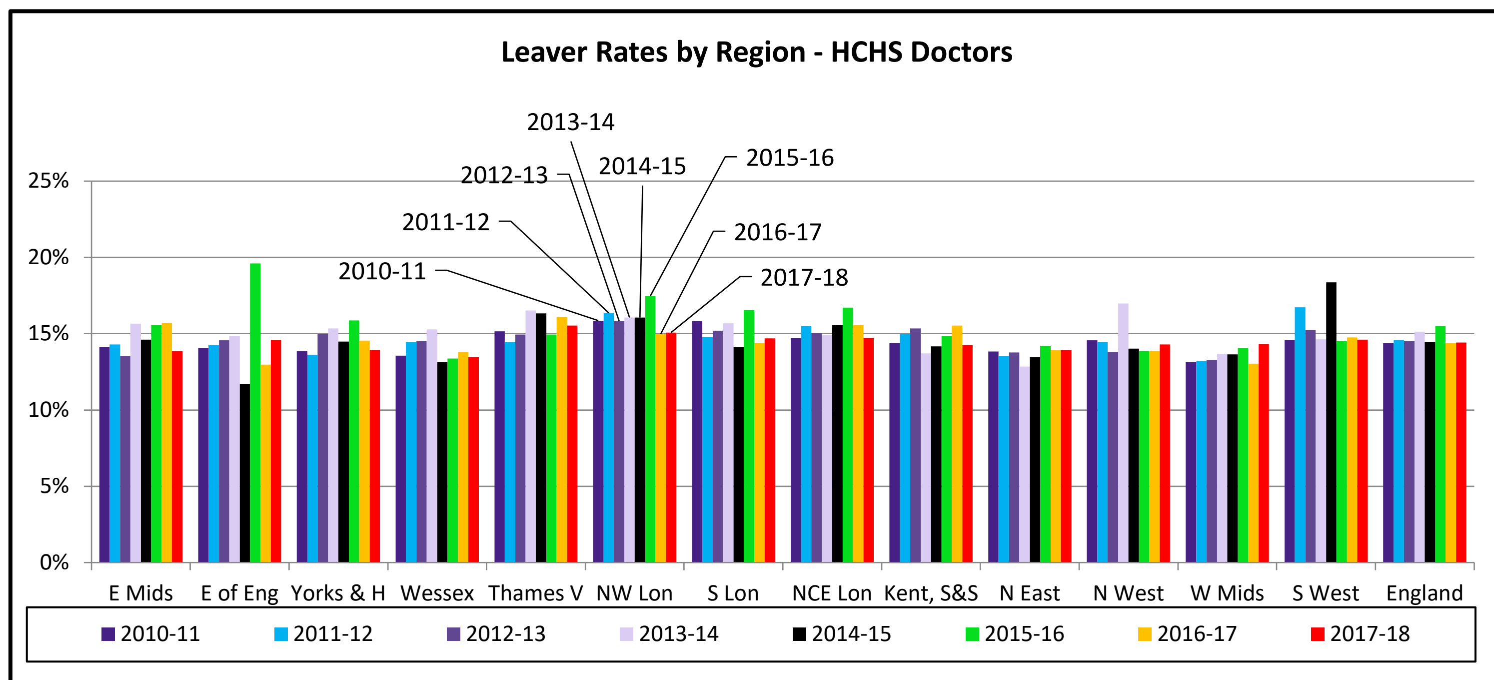
Leavers by Region

The data collected by NHS Digital provide a general picture of leaver rates in regions across England. For HCHS doctors, leaver rates vary between 13 and 20% across regions and time series, but there are no clear trends. There are signs of possible small increases in the West Midlands as well as the East of England. This evidence suggests that regional targeting of pay awards would not be financially efficient.

12-months leaver rates by region, HCHS Doctors

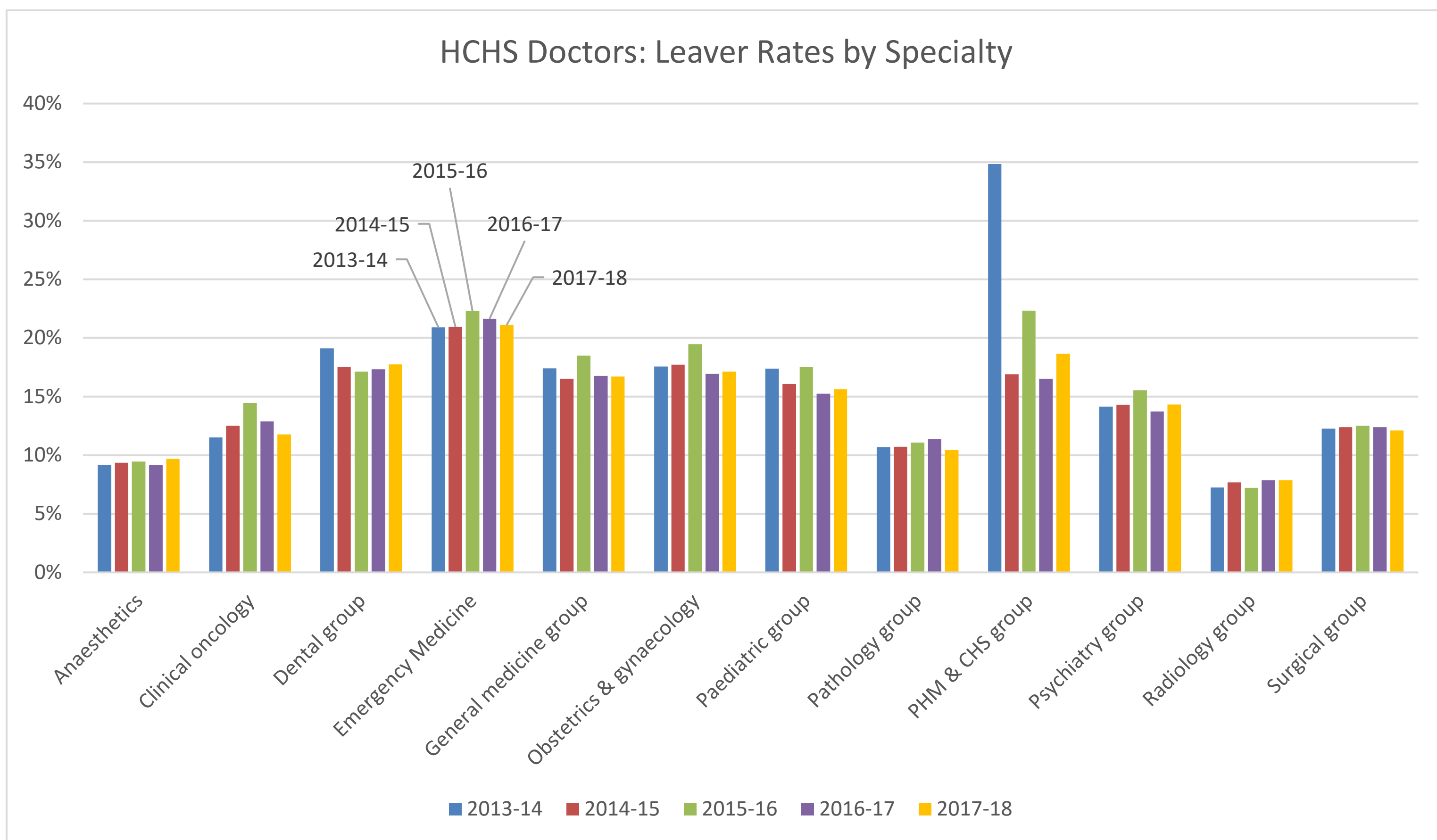
Region	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
E Mids	14.1%	14.3%	13.5%	15.7%	14.6%	15.6%	15.7%	13.9%
E of Eng	14.1%	14.3%	14.6%	14.8%	11.7%	19.6%	13.0%	14.6%
Yorks & H	13.9%	13.6%	15.0%	15.3%	14.5%	15.9%	14.5%	13.9%
Wessex	13.6%	14.4%	14.5%	15.3%	13.1%	13.4%	13.8%	13.5%
Thames V	15.2%	14.4%	14.9%	16.5%	16.3%	14.9%	16.1%	15.5%
NW Lon	15.9%	16.4%	15.8%	16.1%	16.1%	17.5%	15.0%	15.1%
S Lon	15.8%	14.8%	15.2%	15.7%	14.1%	16.5%	14.4%	14.7%
NCE Lon	14.7%	15.5%	15.0%	14.9%	15.6%	16.7%	15.6%	14.7%
Kent, S&S	14.4%	15.0%	15.3%	13.7%	14.2%	14.8%	15.5%	14.3%
N East	13.8%	13.5%	13.8%	12.8%	13.5%	14.2%	13.9%	13.9%
N West	14.6%	14.5%	13.8%	17.0%	14.0%	13.9%	13.9%	14.3%
W Mids	13.1%	13.2%	13.3%	13.7%	13.6%	14.1%	13.0%	14.3%
S West	14.6%	16.7%	15.2%	14.6%	18.4%	14.5%	14.8%	14.6%
England	14.4%	14.6%	14.5%	15.1%	14.5%	15.5%	14.4%	14.4%

12-months leaver rates by region, HCHS Doctors



The chart below shows the leaver rates for HCHS doctors by specialty. This is calculated by dividing the number of leavers by the difference between the staff in post at the start of the year, to the number of staff in post at the end of the year. The leaver rates vary between the different specialties, however, within the specialty groups, there is little variation with no clear trends. On average, the Emergency medicine group has the highest leaver rate every year, while the pathology and radiology groups have the lowest. Most speciality groups have stayed relatively similar from the period 2013-14 and 2017-18. The only group that has declined significantly is the PHM & CHM group from a leaver rate of 35% in 2013-14 to a leaver rate of 19% in 2017-18.

HCHS Doctors: Leavers by Specialty



Annex 6 - Pension scheme membership and trends

Changes in scheme membership as at August 2018, showing percentage point change over the previous month, the last 12 months and from October 2011.

Pension scheme membership changes

		% with pension contributions	% change	% change	% change
	FTE Jul 2018	Headcount Aug 2018	Jul 2018 and Aug 2018	Aug 2017 and Aug 2018	Oct 2011 and Aug 2018
All	1,065,395	90%	0.7%	0.9%	5.1%
Staff Groups					
Doctor	110,622	89%	-0.5%	-2.1%	-1.9%
Qualified nursing, midwifery & health visiting staff	304,143	91%	0.9%	0.9%	3.2%
Qualified Scientific, therapeutic and technical staff	133,701	93%	0.8%	0.5%	2.3%
Qualified Ambulance Staff	20,676	94%	0.8%	0.1%	-1.5%
Support to Clinical Staff	319,209	89%	0.9%	1.7%	9.7%
Central Functions & Hotel, Property & Estates	136,330	86%	0.9%	1.5%	8.7%
Managers	31,773	90%	0.4%	-0.2%	-2.7%
All Non-Medical	954,773	90%	0.9%	1.2%	5.8%
AfC Band					

1	24,439	81%	1.1%	3.4%	18.8%
2	151,875	88%	1.1%	2.1%	12.2%
3	125,342	89%	0.9%	1.7%	8.7%
4	84,175	90%	0.7%	1.2%	5.6%
5	197,367	89%	1.3%	1.3%	3.6%
6	180,409	91%	0.7%	0.4%	2.1%
7	102,500	93%	0.5%	0.2%	0.2%
8a	35,751	93%	0.5%	0.0%	-0.9%
8b	14,342	93%	0.5%	-0.2%	-1.8%
8c	7,527	94%	0.4%	-0.3%	-1.7%
8d	3,703	93%	0.4%	-0.1%	-4.0%
9	1,419	93%	0.4%	-0.3%	-2.9%
Non AfC	136,546	88%	-0.5%	-1.7%	0.5%

References

[i] https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting/
[ii] OBR Economic and Fiscal Outlook, October 2018.

[iii] OBR Fiscal Sustainability Report, July 2018.

[iv] Looking at annual growth rates for total pay (including bonuses), between July to September 2017 and July to September 2018.

[v] The OBR use Wages and Salaries divided by employees to estimate wage growth, and so this will not exactly correspond to the ONS headline AWE measure.

[vi] ONS, Public and private earnings in the UK, November 2018.

[vii] Institute for Fiscal Studies - The relative labour market returns to different degrees, June 2018

[viii] The Associate Specialist grade and the Staff Grade have not been open to new entrants since the introduction of the Specialty Doctor contract in 2008.

[ix] The 1,500 places are found at http://www.hefce.ac.uk/lt/healthcare/#d.en.113195 under "Read more about the allocation of 1,500 additional medical school places". The 2017/18 (prior to expansion) places are under the "Medicine and dentistry intake targets" tab.

[x] The definition of the stability index is provided by NHS Digital at https://digital.nhs.uk/services/iview-and-iviewplus/workforce-monthly-supporting-info-and-documents/iviewplus-workforce-nhs-staff-turnover-definitions

[xi] Dentists submit FP17 forms to NHS BSA detailing dental activity data. The data recorded on the FP17 shows the patient charge collected, the number of units of activity performed and treatment banding information.

[xii] All sources except for joiners from NHS Organisations.

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