



Department
of Health

Supplementary Evidence for the Review Body on Doctors' and Dentists' Remuneration (DDRB): Review for 2017

Supplementary Evidence from the Health
Department for England

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1. Economic and General Considerations

Question 1: How do you respond to BMA's suggestion that there is no credible plan for the £22bn efficiency savings required, and NHS Employer's evidence stating that 96% of NHS leaders had little or no confidence that the efficiency savings set out in the Five-Year Forward View would be possible? Is it reasonable to expect pay restraint to carry the burden of the efficiency savings?

In May 2016 NHS England set out a further breakdown of the efficiency opportunities against the modelled £22 billion. This showed that total efficiencies of £21.6 billion are expected to be delivered by 2020–21.

Of this, £6.7 billion of efficiencies against the Forward View counterfactual cost growth could be nationally delivered. These include: implementing the 1% public sector pay policy to 2019–20; renegotiating the community pharmacy contract with the pharmacy sector and a variety of other nationally delivered cost efficiencies; implementing income generating activities overseen by the Department as agreed in the Spending Review; and, reducing NHS England central budgets and administration costs.

Local health economies therefore need to find around £15 billion in efficiencies. There is already a line of sight to £1 billion of efficiencies from non-NHS provider contracts and Clinical Commissioning Group running cost reductions. This leaves £14 billion to find over the period, the vast majority of which will be delivered through improvements in secondary care provider productivity, including reducing reliance on costly agency staff; and, moderating levels of activity growth.

The Department, NHS England and NHS Improvement have taken significant steps, with further work ongoing, to set out the contribution that local health bodies need to make in these areas and how they can achieve this.

Question 2: It has been suggested that labour productivity has increased at a rate of 2% per annum since 1998-89, given higher outputs per input. With recent reports of medical staff burnout and overwork, do you think that this can be realistically maintained?

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). As presented in our initial evidence, their figures show that in 2013/14 NHS outputs were 89% higher than in their base year of 1998/99, while volume of labour input was 41% higher. This suggests an average growth in labour productivity of 2.0% per annum. Delivering workforce productivity requires a sustainable change to existing ways of working, for example advances in medical technology leading to the switch of treatments from ordinary admissions to day cases, rather than simply working harder. In his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations', published in February 2016, Lord Carter identified £5bn of efficiency opportunities. Potential gains in workforce productivity represent roughly half of this overall opportunity.

Question 3: There is relatively little about productivity in the evidence documents. Do you think it would be reasonable to include productivity achievements as an element for benchmarking pay, and if so, are there any measures that would be sensible to use?

Measurement of productivity in the NHS is complex as health output is complex. The quantum of output may be measured over time based on standard aggregations of activity, e.g. for day cases, elective admissions, non-elective admissions, at both organisation and national level. This will provide some insight into changes in the volume of output for comparison with changes in the volume of inputs. However, it is important to note that the comparison is crude. The measurement is limited by the accuracy, level of granularity, and coverage of measurement (e.g. very limited data on community and mental health services activity). For these reasons it would not be appropriate to, for example, link productivity to pay. In addition, this could lead to perverse incentives, e.g. to treat more where there is little benefit, to skew activity towards less complex cases, or away from activity that is more difficult to measure.

Question 4: What was the reasoning behind the comparators for doctors' pay you made in sections 4.33-4.37? Do you think that matching doctors' pay to some position in the pay distribution serves as a useful element for benchmarking?

The aim of the analysis was to compare the recent growth of pay for doctors with that of other high-earning occupations in the economy. We think that this is a useful comparison, in addition to looking at average earnings growth for the whole economy and the public sector. Pay comparators for medics/dentists will inevitably be imperfect and subject to a nuanced interpretation. However, it is reasonable to expect that pay satisfaction depends on the wider context. Arguably, dissatisfaction among medics and dentists would be greater if the experience of other professions was very different. This analysis shows this is not the case. The comparison indicates that doctors have broadly maintained their rank position amongst the very highest earners, although relative gaps have been modestly affected by pay restraint. Some shift in NHS versus private sector pay differentials is expected in a period of pay restraint, but the statistics do not suggest this has fundamentally altered the attractiveness of medical careers, in terms of earnings compared with other high-earning professions. Although doctors' average earnings have grown less than other high-earning occupations, they remain one of the very highest-earning groups, despite being the only such group to include junior trainees. There are other pay comparisons which could be made. One might be with other professions such as law or science: the Annual Survey of Hours and Earnings (ASHE) statistics show that these groups have significantly lower average earnings than doctors.

Question 5: Do you agree with BMA analysis that real terms doctors' incomes have dropped significantly over past 5 years?

No. We estimate that real average earnings of Hospital and Community Health Services (HCHS) doctors have decreased by 3.5% in the last 5 years between 2010/11 and 2015/16. This is based on using the Gross Domestic Product (GDP) Deflator: using the Consumer Prices Index (CPI) gives a decrease of 6.7%. However our recent longitudinal study shows that while average earnings increased by 2.4% between March 2010 and March 2015 (a real terms decrease of 5.0%), the experience of doctors, including incremental progression and promotion, was a much higher increase. The earnings of doctors with a record of payment in both March 2010 and March 2015 increased by 16.6% over the 5 years, 17.6% after adjustment for full time equivalent (FTE) changes (in real terms, growth of 8.1%, and 9.1% after adjustment for FTE change).

Question 6: Do you think it is meaningful to use broad public sector pay data as a comparison given the specific role of medics/dentists?

Yes. Broad public sector pay statistics provide contextual background for the growth of doctors' and dentists' pay, given recent pay restraint. This is just one comparison, alongside those with the whole economy and with other high-earning occupations. We have also looked at more direct measures of recruitment and retention issues and dissatisfaction such as leaving rates and the staff survey. No one measure is perfect, but a variety of measures can be used together to give a richer understanding of the situation for medics.

Question 7: What are the workforce and pay implications of STPs? How do you plan to ensure that STPs involve clinical staff in reconfiguration plans?

Health Education England (HEE) are creating Local Workforce Advisory Boards (LWABs) to map Sustainability and Transformation Plan areas (STPs) so that the workforce aspect of any STP work remains joined up with the HEE national planning process. Workforce planning would then build up from this level in to the national requirement picture.

Most employers prefer to use national pay frameworks developed through national collective bargaining and we expect that employers will want to continue to rely on collective bargaining to determine the terms and conditions, including pay, of the staff they employ.

2. Security of Supply and Workforce Planning

Question 8: How do you plan to develop your evidence base for recruitment/retention?

This year we have expanded our evidence for recruitment/retention to include analysis of a range of published statistics. We have also presented a new longitudinal study of HCHS doctors' earnings. We have begun work to improve data sharing with our arms' length bodies, including Health Education England and NHS Improvement, and hope to develop more evidence on vacancies and agency use. We have also for the first time drawn all these together in a comprehensive Data Pack for ease of use.

Question 9: What solutions can you suggest for coping with Brexit?

The precise way in which the government will control the movement of EU nationals to the UK following our exit from the EU is yet to be determined. We are considering very carefully the options that will be open to us following our exit from the EU and as part of that process it is important that we understand the impact on different sectors of the economy, including the healthcare sector, from any changes. As a result we are keen to engage and listen to all sides of the debate.

We have also been clear that we want to protect the status of EU nationals already living in the UK. The only circumstance where this would not be possible was if British citizens' rights in European member states were not protected in the same way.

But given the existing challenges faced we have already taken bold steps to ensure that we lay the foundations now for future self-sufficiency for Doctors with up to 1500 additional training places and up to 10,000 additional training places across Nursing and the Allied Health Professions. We will continue to monitor recruitment and retention issues across all staff groups so that we can respond as necessary.

Question 10: Were all of the work schedules completed in the stated 8 weeks' target time for those who have been placed on the new juniors' contract?

We understand NHS Employers are providing an answer to this question which relates to the draft Code of Practice they are developing with Health Education England.

Question 11: Do you have any further information on the Dame Sue Bailey review of non-pay issues for junior doctors?

On 19 May 2016, Dame Sue Bailey, Chair of the Academy of Medical Royal Colleges issued this statement on the review of the well-being of junior doctors:

"As part of the welcome agreement between the Government and the BMA on the junior doctors contract, new measures were agreed to help improve the working conditions and quality of life of junior doctors. As a consequence of these measures it was agreed not, at this time, to take forward the review into junior doctors well-being which I had been asked to conduct. The preliminary work that I have already undertaken will be incorporated into these wider measures. I will, of course, be very happy to play any part in that process. I do believe it is important that

we do not lose sight of addressing these wider underlying and cultural issues which impact on the well-being of junior doctors as we have consistently argued.”

Question 12: Please confirm that any uplift that we recommend will apply to all contracts.

That will be a decision for cross-government agreement in the usual way, in considering the review body's recommendations.

Question 13: You are implementing the new contract for junior doctors, the terms of which were agreed between DH and BMA at ACAS in May, but subsequently rejected by the relevant BMA membership. One of the features of that agreement was a 3-year pay deal of ‘at least’ 1% in 2017-18, 0.9% in 2018-19, and 0.8% in 2019-20, with the difference from the 1% pay cap being used to help fund the government’s national living wage for some Agenda for Change staff. What is the status of this 3-year pay deal?

As set out in our written evidence, this approach to pay for 2017-18, 2018-19 and 2019-20 was envisaged, at the time of the ACAS agreement, in the context of reaching a collective agreement on the proposed contract. In the absence of that collective agreement, there is no three-year pay deal. Our written evidence for this year covers 2017-18 only.

Question 14: Although it is very early days, is there any evidence on the effectiveness of the Guardian role?

It is for other parties to update the review body on this. However, we understand that: NHS Employers and NHS Improvement have identified examples of good working, respect for Guardians and engagement with juniors and that this information will be used to inform good practice guidance and to evidence examples of good practice.

Question 15: Have the agency cap controls have affected quality of care (due to recruitment issues arising in providers)?

We do monitor safety across the system, for example through the National Reporting and Learning System (NRLS) central database of patient safety incident reports.

We have not noticed any increase in safety incidents, or any changes in care quality measures, coincident with the introduction of the Agency Cap.

3. Pay, morale and motivation

Question 16: Your evidence gave little consideration to targeting by geography. What are you doing to address recruitment and retention in areas that have such difficulties?

This is covered in our answer to Question 17

Question 17: How will you address the concerns that financial incentives for working in less popular areas simply move staff shortages around the country without addressing the underlying problem?

Health Education England's (HEE) written evidence covers shortfall, including by geography. However, it carries the caveat that the data is for March (the high point for shortages, being the point at which 'establishment' is set for financial purposes) and that information on trend would be more useful but is not currently available.

HEE's evidence also includes 'underfill' rates for training programmes and reports on incentives introduced by NHS England to incentivise GP training in geographical areas that have historically been hardest to fill. It notes that:

- this has increased recruitment in those areas and is being replicated elsewhere;
- there is some evidence that this might be at the expense of adjacent programmes, which needs to be investigated further; and
- the scheme has yet to be fully evaluated.

As has been noted in previous years, pay is not necessarily the answer to geographical issues; this probably explains why little use continues to be made of Recruitment and Retention Premiums for consultants. Where it is considered an appropriate mechanism, it is important that evaluation establishes its success, including whether it simply shifts the problems to other areas.

Question 18: Can you give further details about how flexible pay premia are intended to operate?

We understand NHS Employers will cover this in supplementary evidence.

Question 19: What consideration have you made of the possible unintended consequences of offering financial incentives to enter hard-to-fill training programmes?

The provisions in the 2016 terms and conditions¹ (and accompanying Pay Circular for 2016/17²) are intended to ensure that there is no pay disincentive to entering hard-to-fill training programmes and to retain the existing incentive of the GP trainee supplement (and also apply in

¹ <http://www.nhsemployers.org/case-studies-and-resources/2016/07/junior-doctors-terms-and-conditions-of-service-july-2016>

² <http://www.nhsemployers.org/-/media/Employers/Documents/Need%20to%20know/Pay%20and%20Conditions%20Circular%20MD%202201625072016.pdf>

other circumstances – see the categories and provisions at Schedule 2, paragraphs 18-44 of the terms and conditions of service).

The discussion, development, design and application of these provisions was informed by DDRB's observations in its 2015 report on contract reform, and undertaken in subsequent negotiations with the BMA. DDRB had commented that flexible pay premia could serve two purposes: (i) to compensate some specialties that would lose pay as a result of moving from banding payments to a system of pay for actual work done; and (ii) to address current shortage areas. To some extent (i) is provided for by the provisions for pay protection during transition – with senior trainees remaining on 'old contract' pay terms, and protection of a cash-floor applying to the rest.

Question 20: What do you foresee our role to be in relation to flexible pay premia?

The review body suggested - in its 2015 report on contract reform - that the use of premia needs to be able to respond to recruitment problems on a more prompt basis than its annual reports would allow, but made clear it would take an ongoing interest in shortage specialties. We were, and remain, content with the review body's proposal that the parties should submit evidence setting out what advice has been put forward to the relevant bodies on shortage specialties and what action has subsequently resulted, so that the review body is able to review retrospectively the effective use of premia and make recommendations as appropriate.

Question 21: Please provide an update on the gender pay review announced by the Secretary of State in July.

We are not yet in a position to provide any further detail but will be happy to provide an update when details are confirmed.

Question 22: Your evidence states that the majority of trained doctors will receive an annual increase of between 3-10% because of the current incremental pay structures. Do you have further details on the numbers of doctors you are referring to here?

To clarify:

- the majority of doctors are progressing through incremental points;
- not all incremental points carry an increase in pay - some pay increases are earned after 2, 3 or 5 years rather than one year;
- the value of incremental pay increases (ie the difference between one pay point and the next), on the pay scales, ranges from 3-10%;

The Table below shows the estimated number of HCHS doctors and dentists, together with the range of *annualised* value of next increment. The current pay scales for Consultants, Specialty Doctors and Associate Specialists include points (in the upper part of the scale) where the next increment becomes payable after 2-5 years rather than one year. In these cases, the increment value has been annualised. For example, if the increment becomes payable after two years, the increment value has been divided by two. The figures exclude Foundation Trainees, because they normally move after a year to a new pay scale. They also exclude staff on Unknown pay scales.

Pay, morale and motivation

Annualised Value of Next Increment	Headcount	% of HCHS M&D (excl FP)
More than 7%	600	1%
6% to 7%	7,500	8%
5% to 6%	4,200	4%
4% to 5%	19,100	20%
3% to 4%	5,700	6%
2% to 3%	12,000	12%
1% to 2%	34,400	35%
None	13,400	14%
Total	96,900	100%

Progression pay systems for doctors mean that the majority will receive an annualised increase of over 2% - detailed as in the table provided above.

Question 23: You note that the Engagement Index suggests that morale has remained constant. However evidence from the BMA and others suggests otherwise. How do you reconcile this?

Although we don't compare results from the NHS Staff Survey with those from other surveys given the different timeframes, sample sizes, methodologies and questions asked, we do welcome surveys conducted by other organisations such as the BMA as they offer a different perspective, an alternative view, all of which help inform our policy development.

In the 2015 NHS Staff Survey, 63% of trusts undertook a census approach, the rest selected a random sample of their staff in line with the survey's eligibility criteria. National results are weighted to account for the number of staff that work at each organisation and also the staff group proportions, to ensure that the national results are accurate and that year on year comparisons are appropriate. Staff engagement for medical staff improved slightly in the 2015 staff survey based on almost 40 000 medical responses.

BMA and other surveys tend to be smaller scale and because of the way they are collected may not be random in selection but they may be more timely than the NHS Staff Survey. The Staff Friends and Family test (next results due at the end of November), although not identifying different staff groups, is also a helpful indicator of staff morale.

The various sources of data we review mean we have no room for complacency about the morale of doctors and other NHS staff groups. As we set out in our evidence, that is why we continue to commission NHS Employers to ensure they are providing up to date advice, guidance and good practice to help trusts, who are responsible for the morale of their staff, continuously improve engagement.

4. General Medical Practitioners

Question 24: BMA points out that current datasets provided by NHS Digital are inadequate, including on basic aspects such as the definition of a FTE GP and the number of locum GPs. What are you doing to improve the evidence base?

A FTE (Full Time Equivalent) member of staff as defined in all NHS Digital guidelines is a standardised measure of the workload of an employed person. An FTE of 1.0 means that the hours a person works is equivalent to a full time worker; an FTE of 0.5 signals that the worker is half time. This measure allows for the work of part-time staff to be converted into an equivalent number of full time staff. It is calculated by dividing the total number of hours worked by staff in a specific staff group by 37.5.

The difficulty in using FTE classification for general practitioners (GPs) is that session lengths and the definition of how many hours constitute full-time and part-time working vary according to regional understanding. In other words, some practices contract staff to work 35 hours; other practices contract staff to work 37.5 hours; others 39 hours, with all of them being classified as 1 FTE.

It is for these reasons that the data is collected in weekly hours on the workforce Minimum Dataset (wMDS), which is then converted into a decimal centrally by NHS Digital using the NHS workforce standard of 37.5 hours being equal to 1 FTE.

With regard to the data available on locum GPs collected on the wMDS, NHS Digital provides the following guidance:

- GP Locums are practitioners who provide service sessions in general practice on a temporary and ad hoc basis. This group includes: Locums – covering vacancy; Locums – covering sickness/maternity/paternity; Locums – other.
- The direction that the practices who input the data are given states that they are to include any GPs who were working in their practice on the day of the census return. This includes all locum staff and trainees.

Question 25: There appears to be a move away from the traditional general practice model towards alternatives such as multi-practices, corporates and the delivery of primary care services by secondary care organisations. How do you see this progressing? What are the likely workforce implications and are the current contractual arrangements for salaried GMPs going to be appropriate for these different models of service provision?

The Five Year Forward View sets out a number of new care models that can meet the changing needs of patients, unlock efficiency savings and maximise the opportunities presented by new technologies and treatments. NHS England is, through its New Care Models programme, supporting the creation of those care models across 50 vanguard sites. These models will act as blueprints for the rest of the NHS and the future of the health and care system.

The overall aim is to make services more accessible, more responsive and more effective. The new models of care encourage communities and individuals to take more responsibility for their health and for planning any care they require. They also provide incentives, such as capitated budgets, for services to be more proactive in managing problems, and give clinical staff the tools they need to help people lead healthier lives.

General Medical Practitioners

The Five Year Forward View sets out a radical approach to care outside hospitals which allows GPs to work more closely with other services and makes greater use of the wider primary and community workforce, and GPs will understandably want to know what any new contract arrangements would mean for their practices and terms of service. We recognise that while some GPs may be attracted by the option of working as employees of a Multispecialty Community Provider (MCP), for example, others will be keen to retain their independent contractor status. That is why NHS England has been clear that the MCP contract - which will be published in draft for consultation before Christmas - will be entirely voluntary, and no GP will be obliged to give up their General Medical Services/Personal Medical Services contractual arrangements. Further, NHS England and DH have jointly reviewed each part of the Alternative Provider Medical Services Directions to determine which provisions should be reflected in the MCP contract, those which are not relevant to the MCP model, and those provided for already in the NHS Standard Contract from which the MCP contract is derived.

Question 26: Please give us more detail on the Terms of Reference of the working group on GP expenses, and what it is seeking to achieve (10.12)? Has there been any progress since you prepared the evidence?

The group – which includes members from the General Practitioners' Committee (GPC) of the British Medical Association, NHS England, NHS Employers and the Department of Health – has been looking at sourcing more detailed analysis of actual practice expenses to develop a dataset that could inform the basis for consideration of practice expenses in future contract negotiating rounds. Subject to identifying a funding source, the group will commission a data collection exercise and keep NHS England and GPC informed of progress.

Question 27: How will the significant increase in the number of registered patients at GPs surgeries be paid for/managed within the current staffing and pay envelope?

The calculation of the funding available for GP contracts includes an appropriate element for population growth each year, based on Office for National Statistics population forecasts.

Question 28: With the promised increase in the number of GPs, will there be an increase in capitation to ensure incomes do not fall?

Reimbursement is based on the number of patients and not the number of GPs, as calculated in line with the Statement of Financial Entitlements (SFE).

Payments under the SFE are negotiated annually as part of the overall contract negotiations between NHS Employers, on behalf of NHS England, and the General Practitioners' Committee (GPC) of the British Medical Association.

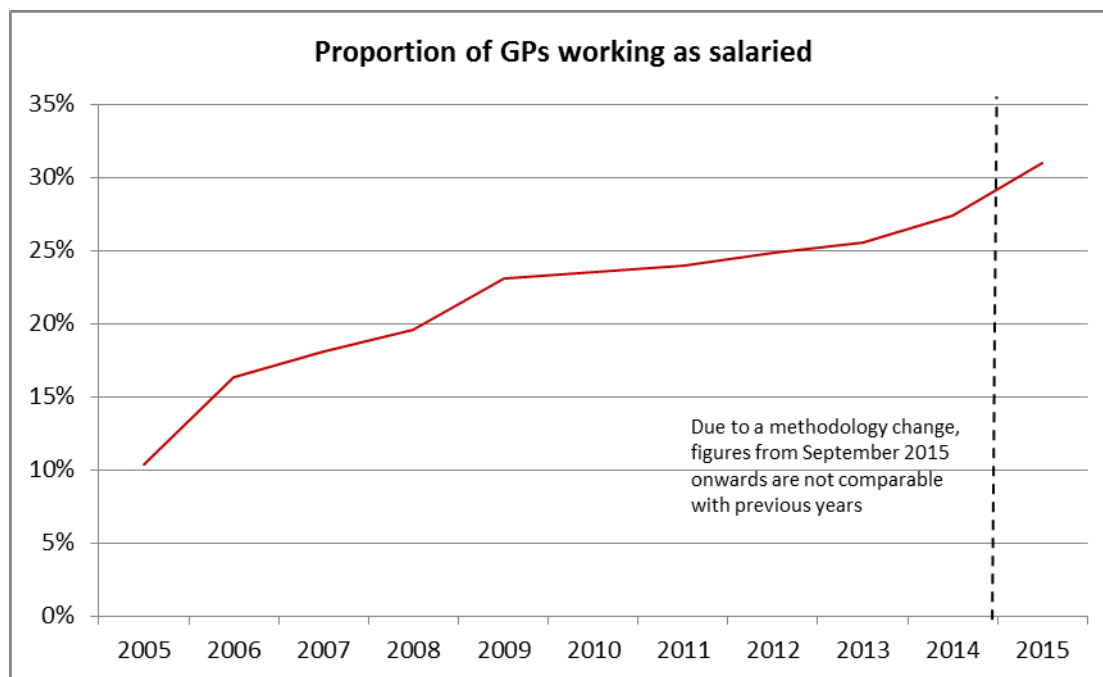
Question 29: What are your specific concerns regarding the recruitment and retention of salaried GPs, per the remit set out in the Department's letter?

The Department does not have specific concerns regarding the recruitment and retention of salaried GPs. It does, however, want to understand the reasons behind the expansion of the salaried model in general practice.

Question 30: What evidence will you provide us with on which to base our analysis of the growing trend for GPs to work on a sessional basis? (10.21)

NHS Digital provide data

() on the number of GPs in the workforce. Data goes back to 2005; however, a methodology change means that data from 2015 onwards is not directly comparable with previous years. There are only two data points after this change (September 2015 and March 2016).

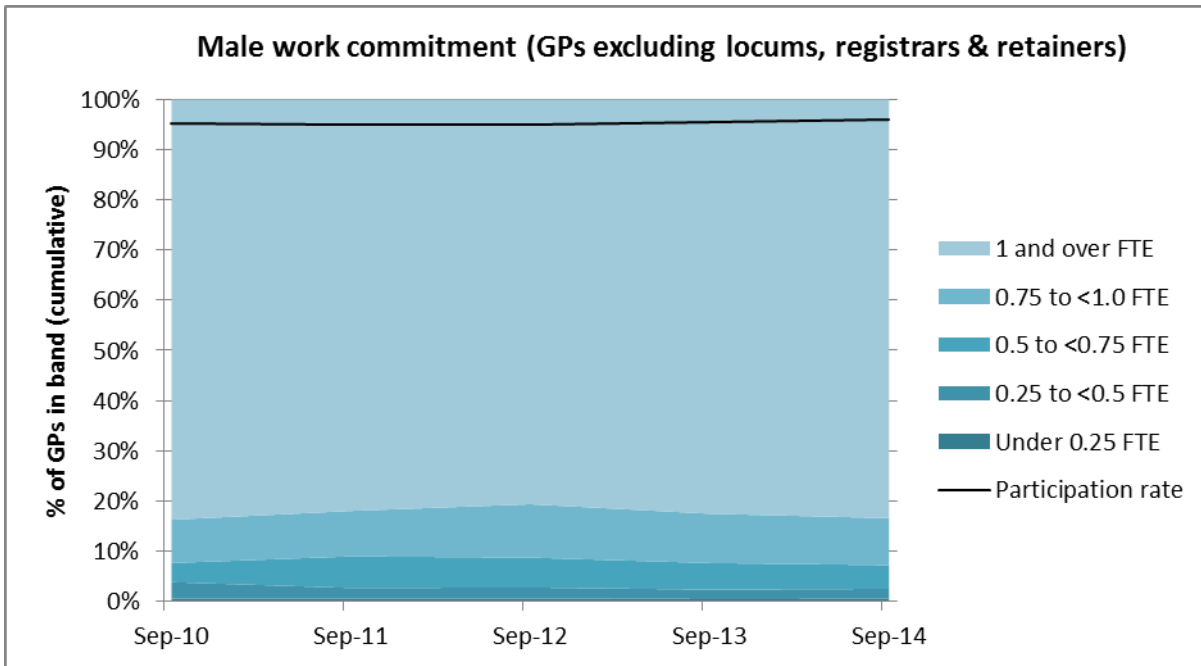


The data shows that the number of GPs working as salaried GPs (who might be more likely to work on a sessional basis) has increased, whilst the number of GP providers has decreased.

However, the data on the work commitment of GPs shows that there does not appear to have been an increase in part-time working, despite this increase in salaried GPs.

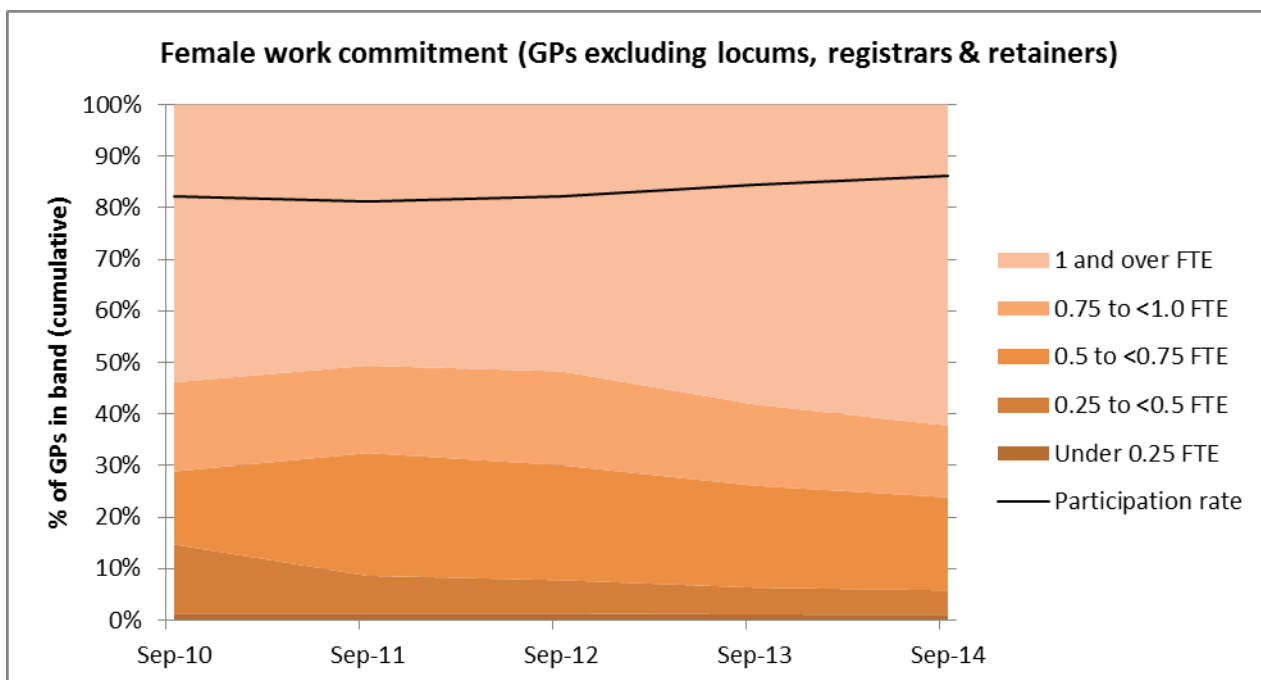
The data shows the number and proportion of GPs in different work commitment bands relative to working full-time-equivalent (FTE) (<0.25 FTE, 0.25-0.5 FTE, 0.5-0.75FTE, 0.75-1FTE & >1FTE), split by male and female, going back to 2010. It is also possible to calculate the overall average participation rate, as the proportion of full-time-equivalent GPs to the headcount.

General Medical Practitioners



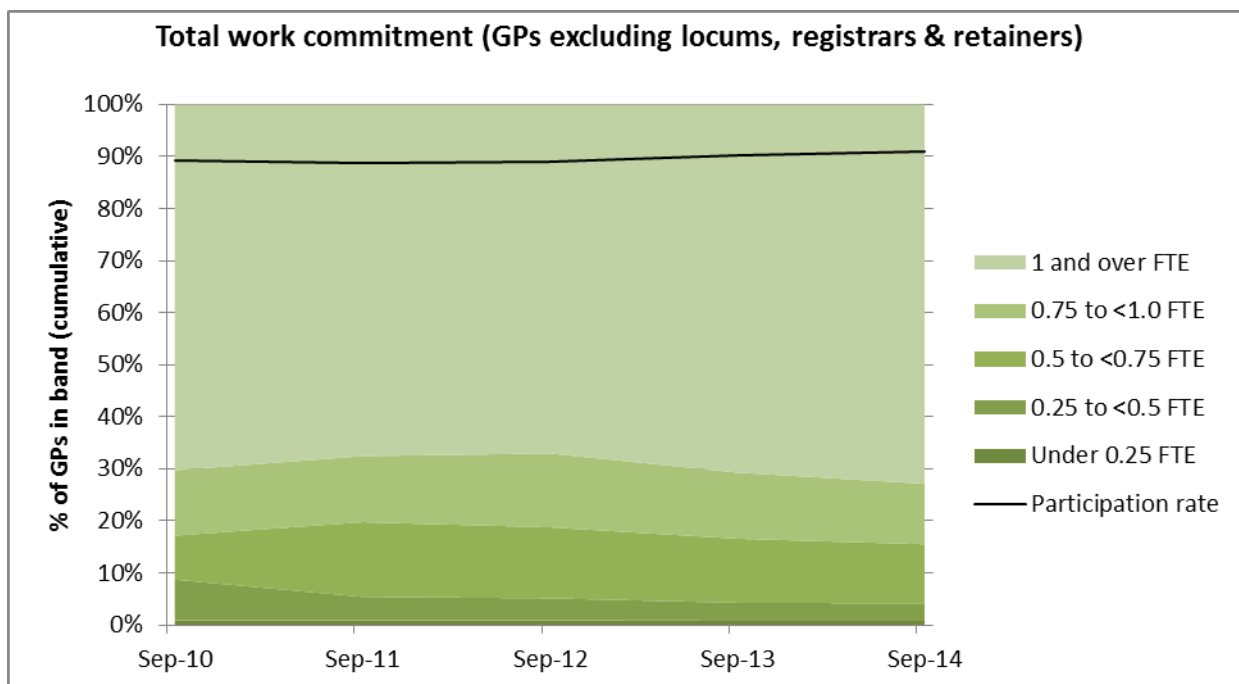
There was little change in male work commitment from 2010 to 2014:

- The proportion working <0.25 FTE remained at around 0.5% throughout.
- The proportion working 0.25-0.5 FTE declined from about 3% to 2%.
- The proportion working 0.5-0.75 FTE increased initially before declining again to 5%.
- The proportion working 0.75-1 FTE increased initially before declining again to 9%.
- The proportion working >1 FTE decreased initially before increasing again to 83%.
- The participation rate (total FTE to headcount proportion) similarly remained steady throughout the period at around 95%.



For female GPs work commitment increased over the period, although it remains lower than that of males:

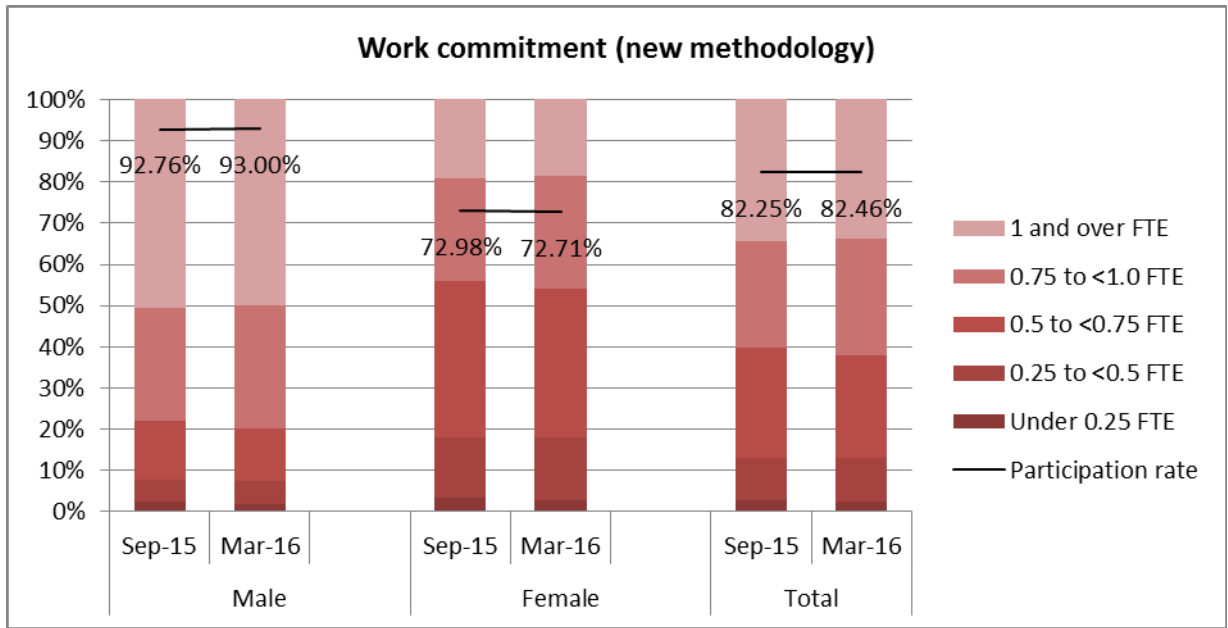
- The proportion working <0.25 FTE remained at around 1% throughout.
- The proportion working 0.25-0.5 FTE declined substantially from about 13% to 5%.
- The proportion working 0.5-0.75 FTE increased from 14% to 24% before decreasing again to 18%.
- The proportion working 0.75-1 FTE decreased slightly from 17% to 14%
- The proportion working >1 FTE increased from 54% to 62%
- The participation rate decreased slightly at first, before increasing to 86%.



Total work commitment has only increased slightly, despite the increasing work commitment of female GPs. This is because the proportion of female GPs, who on average have lower work commitment than male GPs, has increased (from 45% in 2010, to 52% in 2016)

- The proportion working <0.25 FTE remained at around 1% throughout.
- The proportion working 0.25-0.5 FTE declined from about 8% to 3%.
- The proportion working 0.5-0.75 FTE increased from 8% to 14% before decreasing again to 11%.
- The proportion working 0.75-1 FTE decreased slightly from 13% to 12%
- The proportion working >1 FTE increased slightly from 70% to 73%
- The participation rate decreased slightly at first, before increasing to 91%.

General Medical Practitioners



Looking at the latest data points for September 2015 and March 2016, which were calculated under the new methodology, participation rates are much lower than previously recorded as a result of this methodology change. In March 2016, for male GPs the participation rate was 93% (up from 92.8% in September 2015), for female GPs it was 72.7% (down from 73% in September 2015) and overall it was 82.5% (up from 82.3% in September 2015).

If the proportion of female GPs continues to increase, then total work commitment will become more skewed towards female work commitment, which tends to be lower. Therefore, unless female work commitment increases, there may be a decrease in total work commitment.

Locums, retainers and registrars are not included in the above data. Locums and retainers on average have much lower work commitment (47% and 43% respectively in March 2016) but combined they represent only 4% of the GP workforce. Therefore increasing numbers of locums or retainers in the workforce would be likely to exert a downward pressure on overall work commitment. The number of locums wasn't collected before 2015, however from September 2015 to March 2016, the headcount declined from 1,321 to 1,291. The number of GP retainers has been declining since 2005.

Registrars on the other have higher work commitment on average, at 97% in March 2016. Registrars represent 12% of the GP workforce. Increasing numbers of registrars would therefore exert an upward influence on overall work commitment. The number of registrars has been increasing since 2005 and, with increasing numbers entering training this year and next year, it is likely that registrar numbers will continue to increase in coming years.

5. Hospital doctors

Question 31: What lessons from the handling of the new junior doctors' contract will you take into that for the consultants?

The DDRB's July 2015 report 'Contract reform for consultants and doctors & dentists in training – supporting healthcare services' set out a number of observations and recommendations, which the government accepted. We were disappointed when the BMA Junior doctors' committee refused to return to talks, which was contrasted by the consultants' committee's own decision to return to negotiations. We remain focused on engaging with the BMA consultants' committee as we continue constructive discussions.

Question 32: Why are SAS doctors still unable to progress their personal development plans due to work pressures?

The reasons for this, which is an issue for individual employers, may vary – the BMA survey does not report on the detail.

Question 33: NHS Staff Survey results show SAS doctors to be by far the most dissatisfied group, and this is borne out by what we heard during our visits. At the same time it is clear from our visits that significant areas of service delivery rely on them (and will do so for the foreseeable future) and, that some doctors are deliberately opting for SAS roles because of the greater flexibilities they can offer. What are you doing to get a handle on this nationally?

These findings may reflect the mix of staff in the different SAS grades. The Specialty Doctor grade might be seen as a viable alternative (to consultant) career grade by many doctors. Together with the (closed) Associate Specialist grade it is likely to include those who aspire to the consultant grade, including some already on the specialist register. The BMA survey reported 27% of SAS doctors surveyed planned to become a consultant or apply for certificates of eligibility for specialist registration (allowing them to apply for consultant posts) in the next five (now four) years.

NHS Employers have been undertaking substantial joint work with the BMA, Health Education England and the Academy of Medical Royal Colleges on SAS development. Those parties will be able to provide further detail.

6. Dentists

Question 34: Why have you not engaged with BDA on the use of the formula?

Throughout the year, DH officials and colleagues from NHS England have had an ongoing dialogue with representatives from the British Dental Association (BDA) on pay uplifts and efficiencies. Whilst all parties are happy to discuss the formula and inflators the BDA have not been able to provide robust evidence (beyond anecdotal) to support their position.