THE REVIEW BODY ON DOCTORS' & DENTISTS' REMUNERATION

(DDRB)

REVIEW FOR 2013

General Medical Practitioners and General Dental Practitioners

Further Written Evidence from the Health Department for England

First published November 2012
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

Contents

Executive summary

Pay uplifts for doctors and dentists, who work for the NHS, are determined by the Government in light of recommendations made by the independent review body on doctors and dentists remuneration (DDRB). This body takes evidence from the four UK governments, trade unions and NHS Employers before making their recommendations.

The original pack of evidence from the Department of Health was published on 26th October 2012 and is available on the Department of Health website:

http://www.dh.gov.uk/health/2012/10/evidence-ddrb-2013

This further evidence follows on from the above publication, and contains the Department of Health evidence to DDRB on General Medical Practitioners and General Dental Practitioners.

CHAPTER 1: GENERAL MEDICAL PRACTITIONERS

Introduction

1.1 This chapter relates to information on general medical practitioners (GMPs) providing NHS primary care services and to a small number of salaried GMPs directly employed by NHS organisations in England.

1.2 In June 2010, the Government announced a public sector pay freeze covering 2011-12 and 2012-13. During the 2011 Autumn Statement, the Government announced that for 2013-14 public sector pay increases will be capped at an average 1%.

1.3 The Secretary of State for Health wrote to the Chair of DDRB on 3rd of July to say that the Government had decided there was no need for the Review Body to make recommendations on uplift for 2013-14. This was on the basis that the Government proposed to provide up to a 1% uplift in net income for self-employed contractor GMPs and that the DDRB's formula provided a well-established basis for calculating the gross uplift needed to deliver this increase in net income after allowing for expenses.

1.4 NHS Employers has been in discussion with the General Practitioners Committee (GPC) of the BMA over potential improvements to the General Medical Services (GMS) contract for 2013-14. As part of those discussions, NHS Employers has indicated that, subject to agreeing appropriate changes in the contract to support improvements in quality of patient care, the Government would be prepared to offer a 1.5% uplift in funding for GP practices in England. This would allow for both an average pay increase of up to 1% for GMPs and practice staff, in line with wider public sector pay policy, and a wide margin for increases in non-staff expenses.

1.5 Despite discussions over a number of months it has not yet, however, proved possible to reach agreement on changes to the GMS contract for 2013-14. The Department of Health therefore wrote to the Chairman of the GPC on 23rd October, setting out the Government's proposals for the GMS contract in England and indicating that, if necessary, the Government will consult the GPC in November on the necessary legislative changes to give effect to these proposals.

1.6 The Department hopes that a negotiated settlement with the GPC can still be reached and it has indicated that, as part of a negotiated settlement, it would remain willing to offer a 1.5% uplift in gross income. If, however, a negotiated settlement cannot be reached, the Department will invite the DDRB to make recommendations on uplift.

1.7 In light of these developments, the Department intends to present separate evidence to the DDRB on the question of uplift as part of the supplementary evidence round.

1.8 The material in this chapter provides background information for DDRB members on recruitment and retention, earnings and expenses and other relevant developments in general practice.

Background

1.9 Most doctors working in GMS are independent contractors: self-employed individuals or partnerships running their own practices as a small business. According to the latest figures as at September 2011published by the Information Centre for health and social care[1], there were 8,316 GP practices in England in 201, and of these around 55% of practices (51% of GMPs) operated under the national GMS contract.

1.10 Contractors with Personal Medical Services (PMS) arrangements operate within locally agreed contracts, and any uplifts in investment for PMS contracts are currently a matter for Primary Care Trusts to decide. DH remains committed to ensuring an equitable approach for PMS and other local primary medical care contracts. In addition, there are a small number of GMPs (961) who work under (or hold) contracts under a locally contracted Alternative Provider Medical Services (APMS) arrangement (276 practices).

Recruitment, retention and motivation of GMPs

1.11 As at September 2011[1], in headcount terms (as opposed to whole time equivalent figures), there were 35,415 GMPs, an increase of 295 (0.8%) since 2010 and an estimated increase of 6,613 (22.9%) since 2001 (an annual average increase of 2.1%).

1.12 Of these, there were 27,218 GMP providers, a slight increase of 182 (0.7%) since 2010 and an estimated decrease of 720 (2.6%) since 2001.

1.13 The number of 'other' GMPs (typically salaried practitioners and locums) now stands at 8,585, an increase of 266 (3.2%) since 2010 and an estimated increase of 7,721 (894%) since 2001.

1.14 The average age of the workforce continues to grow, with 42.7% of practitioners in 2011 under the age of 45 compared with 48.2% in 2001 and 22.5% over the age of 55 in 2011 compared with 18% in 2001.

1.15 There are now 4,114 GMP registrars, compared with 1,883 in 2001, an increase of 2,231 or 119%.

1.16 There were 5,800 applicants for 2,658 GMP training places in 2010 with the ratio of applications to posts ratio remaining stable at 2:1.

1.17 The Sixth National Work Life Survey conducted by the National Primary Care Research & Development Centre in June 2011, on working conditions and job satisfaction of GMPs, remains the most up to date comparable evidence in measuring GMP satisfaction based on the 1,633 responses from 3,000 GMPs (in England). This showed:

- On a seven-point scale, overall job satisfaction had increased slightly, from 4.7 points in 2008 to 4.9 points in 2010.
- Average working hours were 41.4 hours per week and had remained unchanged from the previous 2008 and 2009 surveys. There were also significantly fewer GMPs undertaking out-of-hours work in 2010, declining from 32% to 21%.

[1] Available at: http://www.ic.nhs.uk/webfiles/publications/010_Workforce/NHS%20STAFF%20ANNUAL%202001-11/NHS_Staff_General_Practice_2001_2011_Bulletin.pdf

- The proportion of GMPs expecting to quit direct patient care in the next five years fell from 7.1% to 6.4% amongst GMPs under 50 years old and from 43.2% to 41.7% amongst GMPs aged 50 and over.

1.18 The Department has commissioned Manchester University to continue to undertake the GP National Work Life Survey but results will not be available before summer 2013.

1.19 The NHS Pension Scheme forms a significant part of the overall GMP reward package. Uniquely amongst self-employed people, GMPs have access to a defined benefit pension scheme effectively guaranteed by the Exchequer. GMP earnings can fluctuate widely from year to year, according to the work that the individual practitioners carry out and how much is taken as net income. To take account of these fluctuations in earnings, GMPs have a Career Average Pension arrangement in which their pensionable earnings are revalued by an annual uprating factor, in a process known as 'dynamisation'. This revalues GMP earnings for pension purposes by the Consumer Prices Index plus 1.5%.

Workload of GMPs

1.20 The average number of patients per medical practitioner in England has fallen from 1,780 in 2001 to 1,562 (12.2%) in 2011 partly because the number of GMPs is growing faster than the number of patients.

1.21 The number of patients per practice has risen from 5,753 in 2001 to 6,651 in 2011. Over the same period the number of practices has decreased from 8,910 to 8,316, reflecting a move towards larger practices employing more GMPs. This trend is also evident in the decline of single-handed GMPs from 2,626 in 2001 to 1,147 in 2011.

1.22 There remains a significant increase in numbers of practice staff between 2001 and 2011, with total practice staff numbers increasing by 12,570 (19.3%) and numbers of practice nurses increasing by 2,410 (21.6%). Nevertheless, there have been fluctuations in the numbers of practice staff. In 2001 there were 64,998 staff which gradually increased to 76,977 in 2006. There was a decrease over subsequent years to 72,153 in 2009 before increasing again to 77,568 in 2011, a 5.8% increase over 2010.

Trends in the earnings and expenses of GMPs

1.23 In 2011-12, the NHS in England spent £8.4 billion on primary medical services compared to £5 billion in 2002-03, an overall increase of 44%.

1.24 The following points set out the trends in GMP earnings and expenses in England since 2002-03:

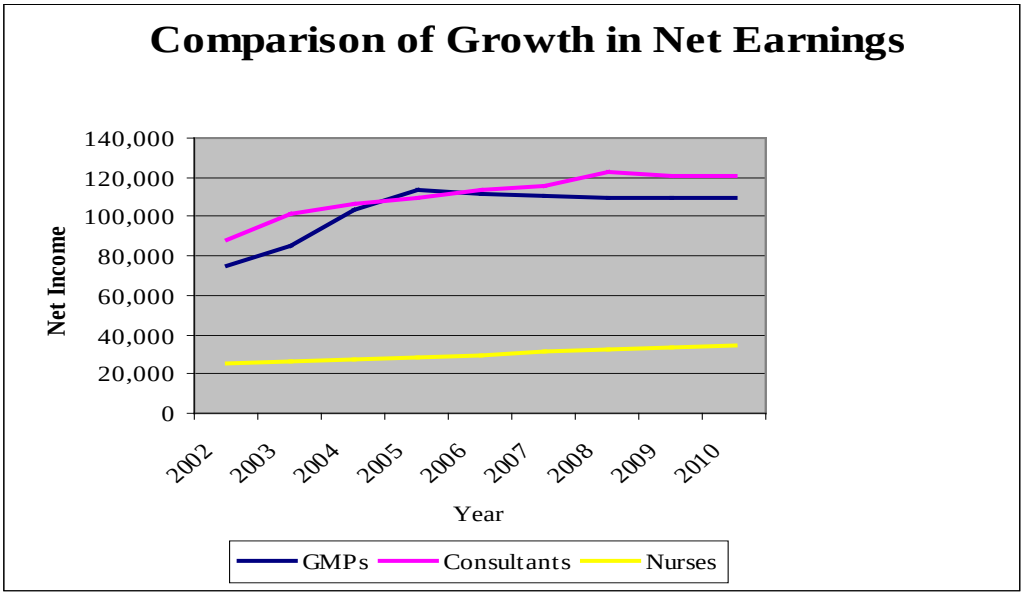
- GMP pay has increased in cash and real terms relative to other NHS staff groups. Figure 1.1 shows the comparison of pay growth between GMPs, nurses and consultants. On a cash basis, pay has increased by 46% over the period 2002-03 to 2009-10 (the latest year for which figures are available). This compares to an increase of 36.4% for consultants and 29.9% for nurses over the same period.

- In real terms pay has increased by more than 24% over the same period, compared to 16.1% for consultants and 10.5% for nurses.

- Based on the Department's forecasts of GMPs', consultants' and nurses' earnings for 2009-10 and 2010-11, GMP real terms pay has increased by 22% for England over the period 2002-03 to 2010-11, compared to 19.7% for consultants and 10.7% for nurses.

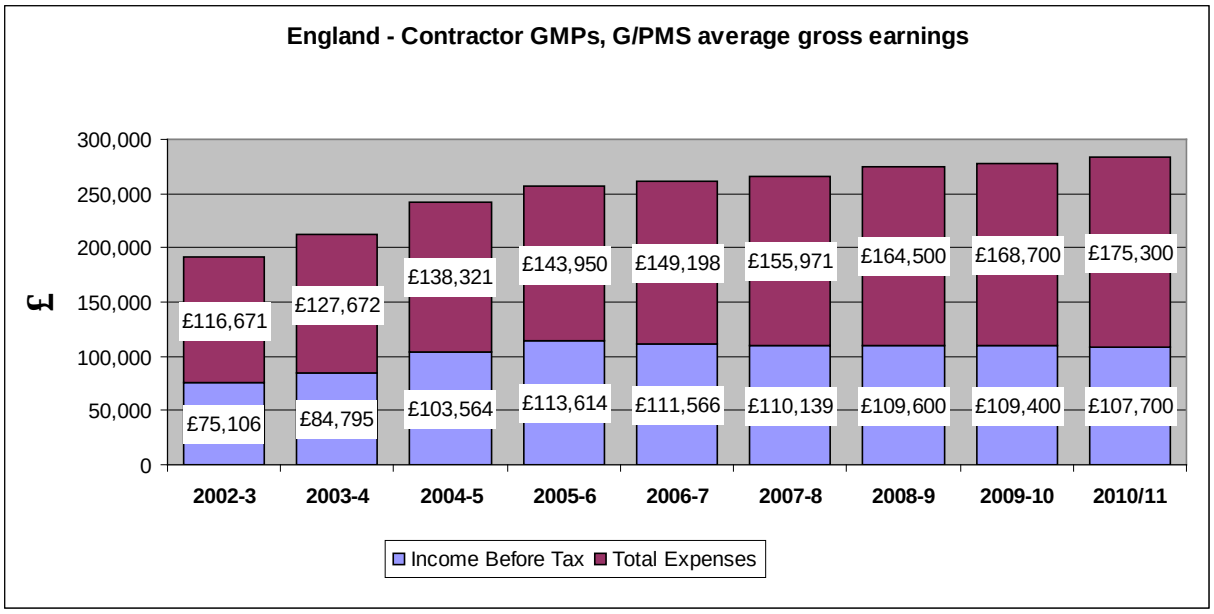
- Increases in GMPs' pay were concentrated in the three years from 2003-04 to 2005-06 following introduction of a new GMS contract. Since 2005-06, there have been small year-on-year falls in net income.

Figure 1.1



1.25 Figure 1.2 below, based on data provided by Her Majesty's Revenue & Customs (HMRC), shows increases in gross earnings and net income for the average GMP in England during the period 2002-03 to 2010-11 (the latest year for which data are available).

Figure 1.2



1.26 The figures in Table 1.3 below represent the position for the average GMP and show the distribution of net income received by groups of contractor GMPs on a UK basis (England figures are not available for this analysis).

Table 1.3

Numbers of UK GPMS GMPs in different net income brackets (before tax)						
Financial Year	**Less than £50k**	**£50k - £100k**	**£100k - £150k**	**£150k - £200k**	**£200k - £250k**	**More than £250k**
2002/03	7,842	20,493	3,875	221	0	0
2003/04	5,138	19,883	6,469	904	222	0
2004/05	3,060	15,442	12,264	2,492	475	154
2005/06	2,001	12,342	14,534	3,876	816	307
2006/07	2,048	13,387	13,832	3,623	739	258
2007/08	2,320	13,610	13,220	3,560	650	260
2008/09	2,310	14,020	12,820	3,280	700	250
2009/10	2,280	13,410	13,180	3,280	680	210
2010/11	2,360	13,780	12,930	3,190	530	200

1.27 There are likely to be several factors affecting the increasing number of GMPs in the higher income brackets, including a growing number of GMPs who hold more than one contract to provide medical services. Table 1.3 shows significant movement in the numbers of GMPs in higher income brackets following the introduction of the new GMS contract, followed by some year-on-year reductions since 2005-06.

1.28 Table 1.4 below sets out actual GMP average net income for 2002-03 to 2010-11 and current Departmental estimates for GMP earnings in 2011-12 and 2012-13.

Table 1.4

England GPMS GMPs				
Financial Year	**Average Net Earnings £**	**Year on Year Cash Change**	**Cumulative Cash Change**	**Cumulative Real Terms Change**
2002/03	75,106	-	-	-
2003/04	84,795	12.9%	12.9%	10.5%
2004/05	103,564	22.1%	37.9%	31.0%
2005/06	113,614	9.7%	51.3%	40.5%
2006/07	111,566	-1.8%	48.5%	34.4%
2007/08	110,139	-1.3%	46.6%	29.5%
2008/09	109,600	-0.5%	45.9%	25.4%
2009/10	109,400	-0.2%	45.7%	25.2%
2010/11	107,700	-1.6%	43.4%	23.2%
Estimates:				
2011/12	107,700	0.0%	43.4%	21.4%
2012/13	107,700	0.0%	43.4%	18.0%

1.29 Table 1.5 below shows trends in the ratio of gross earnings to practice expenses. The expenses to earnings ratio has traditionally been around 60:40. In 2005-06, when average GMP earnings peaked at £113,614, the ratio was 56:44.

Table 1.5

England GPMS GMPs			
Financial Year	**Gross Earnings £**	**Expenses £**	**Expenses as a % of Earnings**
2002/03	191,777	116,671	61%
2003/04	212,467	127,672	60%
2004/05	241,885	138,321	57%
2005/06	257,564	143,950	56%
2006/07	260,764	149,198	57%
2007/08	266,110	155,971	59%
2008/09	274,100	164,500	60%
2009/10	278,100	168,700	61%
2010/11	283,000	175,300	62%

1.30 Unlike many other staff groups, GMP contractors have scope to increase their net income from sources other than their main contract payments. These include:

- additional income from a variety of professional activities outside their NHS work. The latest GMP earnings and expenses report by the NHS Information Centre states that it is not possible to provide an NHS/private split using HMRC earnings data. However, as a guide, NHS superannuable earnings for GPMS contractor GMPs were 90.7% of total earnings, suggesting 9.3% was private income

- additional investment in local enhanced services. Over the three years to 2010-11, investment by PCTs in local enhanced services has grown by 14%, from £323 million in 2008-09 to £367 million in 2010-11.

GMP trainers' grant

1.31 As growing numbers of GMP training practices moved onto PMS contracts, and even more so, since the introduction of the new GMS contract from April 2004, the GMP trainers' grant is no longer treated at local level as an individual GMP's remuneration. Instead, it is generally treated as a GP practice income stream, the allocation of which is decided collectively by the GP practice.

1.32 Since implementation of Modernising Medical Careers in 2007, virtually all GMP trainees enter three-year training programmes. This is a significant change from before, when less than half the doctors undertaking GMP Registrar training had been on a three-year GMP vocational training scheme. Many such trainees are now referred to as General Practice Specialty Trainees (GPSTs) throughout their training programme and are only infrequently referred to as GMP Registrars.

1.33 The Department understands that in a significant number of SHAs/deaneries, the GMP trainer is now responsible for overseeing a trainee's progress for the whole of the three-year Specialty Training in General Practice programme, and not just the period they are on placement in a GP practice. The Department is aware through information

emerging as part of the Multi-Professional Education and Training (MPET) Review, and its associated review of primary care training funding, that a significant number of deaneries are making payments to GP practices from the MPET budget, in addition to the GMP Trainers' Grant, to reflect this wider responsibility.

1.34 The White Paper, 'Liberating the NHS: Developing the Healthcare Workforce' set out the Government's commitment to the principle of "tariffs for education and training as the foundation to a transparent funding regime that provides genuine incentives within the health sector and minimises transaction costs". There is widespread agreement among stakeholders that the existing MPET funding arrangements lack transparency and are not fit for purpose.

1.35 The Department considers that the GMP Trainers' Grant should fall within the ambit of this review. A work stream has been set up to look at the funding arrangements for education and training across all aspects of primary care. The Department continues to work with the NHS, staff organisations and other partners to consider the implications of changes to current funding arrangements. If supported, the Department will begin the introduction of these tariffs from April 2013 at the earliest, with appropriate transitional arrangements. We will provide details of the impact on the GMP Trainers' Grant, once the future funding model is confirmed.

NHS commissioning reforms

1.36 Clinical commissioning groups (CCGs) will be responsible from April 2013 for commissioning most healthcare services for local populations. The BMA and NHS Employers agreed last year that it will be a contractual duty for holders of primary medical services contracts (i.e. each GP practice) in England to be members of CCGs.

1.37 Clinical commissioning will enable GMPs, working closely with patients, the public and a range of other health and care professionals and with local authorities, to use their understanding of local health needs to ensure that the services commissioned for patients meet those needs and contribute to better health outcomes.

1.38 CCGs will be statutory public bodies and will be accountable to the NHS Commissioning Board for how they use the resources allotted to them to commission high-quality services. CCGs will have a running costs allowance to meet the administration costs that they incur in commissioning services, whether by employing staff themselves or by buying in external commissioning support. With the exception of this running costs allowance, the annual budget allotted to CCGs will have to be spent wholly on healthcare services for patients. It will be distinct from the NHS income that GP practices receive under their primary medical services contracts.

1.39 The NHS Commissioning Board will be able to give payments to CCGs to reward them for the quality of the services they commission and the contribution that these services make to improving health outcomes and reducing inequalities. Regulations due to be made under the Health and Social Care Act early next year will make provision for how CCGs can use any quality payment awarded to them.

1.40 From April 2013 the NHS Commissioning Board will take over the responsibilities of primary care trusts (PCTs) for commissioning primary care services, including primary medical care. The NHS Commissioning Board will then have responsibility for

developing primary medical care contracts and for the negotiations with the GPC on improvements to the GMS contract.

Contract agreements for 2011–12 and 2012-13

Investment levels

1.41 The changes to the GMS contract agreed with the GPC for 2011-12 and 2012-13 were intended to deliver a freeze in GMPs' net income, in line with Government policy on public sector pay, whilst delivering service improvements in quality and efficiency. The overall value of contract payments to GMP contractors was increased by 0.5 per cent in both years to cover expected increases in expenses.

1.42 In both years, this uplift was delivered through an increase in the value of QOF points (a 2.53 per cent increase in 2011-12 and a 2.49 per cent increase in 2012-13).

GMS contract changes agreed 2011-12

1.43 The 2011-12 changes to the GMS contract included a number of improvements to quality and productivity of provision, in particular:

- QOF indicators worth 116.5 points ended. The freed-up resources were used to:
  - fund new quality and productivity indicators (96.5 points)
  - pay for the implementation of new clinical indicators recommended by NICE for epilepsy, learning disability and dementia (12 points)
  - support improvements to existing clinical indicators (8 points).
- The Quality and Productivity indicators were designed to support improvements in quality of care through the review of current practice by GMPs in three areas:
  - prescribing
  - first outpatient referrals
  - emergency admissions.

1.44 Full details of all 2011/12 contract changes are set out in the '2011/12 GMS Contract Negotiations' letter (Gateway reference 15500) available on the DH website:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125039.pdf

1.45 Coupled with the agreed 0.5% increase in gross funding, the changes delivered an estimated efficiency gain to the NHS of around 4 per cent.

GMS contract changes agreed in 2012-13

1.46 The 2012-13 agreement reached with the GPC, announced on 2 November 2011, included further improvements to quality and productivity, in particular:

- Two indicators, worth in total 17 points, were retired and a further 26 points were released from existing indicators.

- Seventeen of the NICE recommendations for new or replacement indicators were implemented (covering 141 QOF points, funded by 40 of the points released above, and 101 points from existing indicators being replaced).

- The Quality and Productivity prescribing indicator, worth 28 points, introduced in 2011-12 was stopped on the basis that the activities that it rewarded were sufficiently well embedded within routine GP practice activities.

- The funding released from the prescribing indicator (28 points) was combined with three other released QOF points to develop a new Quality and Productivity indicator that incentivises practices to review Accident and Emergency (A&E) data with the aim of identifying avoidable attendances. The new A&E indicator is worth 31 QOF points.

- A number of small changes to the thresholds for QOF clinical indicators:
    - Raising lower thresholds for those indicators currently 40-90% to 50-90%
    - Raising lower thresholds for indicators with an upper threshold of 70-85% to 45%
    - Raising upper threshold changes for 10 indicators
    - Raising lower and upper threshold for 3 indicators.

1.47 In addition, some £1m was invested into Global Sum payments as a result of discontinuing the Directed Enhanced Service for osteoporosis. This, along with released correction factor payments through corresponding reductions in the Minimum Practice Income Guarantee (MPIG), uplifted Global Sum funding from £64.59 to £64.67 per weighted patient in 2012-13, thereby reducing the number of practices on MPIG from 61.4% to 61.0%.

1.48 Full details of all 2012/13 contract changes are set out in the '2012/13 GMS Contract Negotiations' letter (Gateway reference 16837) available on the DH website: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130951.pdf

1.49 Taken together with the 0.5% increase in gross funding, the agreement reached with the GPC delivered an estimated efficiency gain of around 3.5 per cent.

Conclusion

1.50 This chapter provides information on the latest position on recruitment and retention, earnings and expenses, and other relevant developments in general practice. In view of the latest developments in the GMS contract negotiations, the Department will submit separate evidence on gross uplift for 2013-14, as part of our supplementary evidence, in case there is a need for the DDRB to make recommendations.

CHAPTER 2 – GENERAL DENTAL PRACTITIONERS

Introduction

2.1 This chapter provides an update on general dental practitioners (GDPs) providing NHS primary care services and those salaried GDPs on terms and conditions set by NHS organisations in England.

2.2 This is the third year of the Government's public sector pay policy. The Government has announced that public sector pay increases will be capped at an average 1% increase for 2013/14.

2.3 The Secretary of State for Health wrote to the Chair of DDRB on the 3rd of July to say that the Government had decided there was no need for the Review Body to make recommendations on uplift for 2013-14. This was on the basis that the Government proposed to provide up to a 1% uplift in net income for self-employed contractor GDPs and that the DDRB's formula provided a well-established basis for calculating the gross uplift needed to deliver this increase in net income after allowing for expenses.

2.4 The Department has met, and had constructive discussions with, the General Dental Practice Committee of the BDA over practice expenses and possible quality and efficiency improvements for 2013/14. The Government believes that overall levels of uplift for independent contractors are best considered as part of such discussions with the profession's representatives about ongoing improvements in contractual arrangements and, provided that it is possible to secure appropriate improvements in quality of services, the Government is willing to make provision for a pay uplift of up to 1% in line with the rest of the public sector, and to include appropriate provision for expenses based on the application of the DDRB's formula.

2.5 The Department hopes that an acceptable settlement can be found but, if not, the Department may invite the DDRB to make recommendations on uplift and will present separate evidence to the DDRB.

2.6 The material in this chapter is to provide an update on the continuing background to developments in general dental practice.

Background

2.7 Dentists continue to say that the current contract leaves them on an "activity treadmill" with no specific rewards for high quality care or for delivering prevention. The profession has welcomed our commitment to bring in a new contract based on capitation and quality, which will focus on the treatment patients need and avoid unnecessary treatments. This should free up time for more preventative care and - by ensuring the right treatments are delivered - to improve oral health. The aim of the new contract will be to improve the quality of patient care and increase access to NHS dental services, with an additional focus on improving the oral health of children. Three different aspects of a new system are being piloted in the 70 locations around the country.

2.8 All pilots are trialling and testing the new oral health assessment and clinical pathway designed to support dentists in delivering the best care for patients. The focus on quality is intended to support dentists to improve the oral health of their patients, while the capitation system and the focus on long-term care will give patients the security of continuing care. The learning from the pilots will define and feed into the broader work currently underway to design a new dental contract, which will be fully discussed with the profession and with patient organisations. We hope that the proposed new contract will address many of the concerns of the profession and will drive further improvements in dental health in England.

2.9 The other major change in the dental environment is the move of dental commissioning in April 2013 from PCTs to the NHSCB. The NHSCB will be responsible for commissioning all NHS dental services, including primary, community and hospital dental services. The NHSCB will have a single operating model, which provides an opportunity for consistency and efficiency where it is required, but enables flexibility through local area teams where it is necessary. The proposals for dental commissioning will build on the single operating model for primary care commissioning described in Securing excellence in commissioning primary care.[2]

2.10 The NHSCB is committed to designing a commissioning system for dental services that is capable of:

- improving health outcomes and making best use of NHS resources;
- reducing inequalities;
- promoting greater patient and public involvement;
- promoting and swiftly adopting innovation that delivers excellence.

2.11 This is expected to be delivered through a single system with a consistent operating model across the country. The NHSCB will ensure there are clear and consistent outcome measures, indicators and a single accountability framework for NHS primary care dentistry in England, but this is not to be at the expense of stifling local innovation in service and quality improvement.

2.12 Although it is clear that changes to the current system will be necessary, we are pleased to note that the current position on NHS dentistry continues to improve and there has been a further increase in the number of dentists working in the NHS in 2011/12. We want to see a continued improvement in access to NHS dental services. Questions included in the GP Patient Survey tell us about access to NHS dental services. This shows that 95% of people who tried to get an appointment with an NHS dentist in the past two years were successful. For those seeking an appointment in the last six months, the success rate is 96%.

[2] (www.commissioningboard.nhs.uk/files/2012/06/ex-comm-pc.pdf)

Table 2.1: Success rates for patients who tried to get an appointment in last 6 and 24 months by former SHA regions:

	Success rate in last 24 months: % who succeeded, not including "Can't remembers"	Success rate in last 6 months: % who succeeded, not including "Can't remembers"
England	95	96
North East	96	98
North West	94	96
Yorkshire & the Humber	94	96
East Midlands	95	97
West Midlands	96	97
East of England	96	97
London	93	94
South East Coast	94	96
South Central	94	97
South West	95	97

2.13 In the last year

- Access to NHS dental services has risen. 29.6 million patients were seen by an NHS dentist in the 24-month period ending June 2012, 56.6% of the population. The number is 402,000 higher than twelve months earlier, and 2.6 million higher than the low point reached in June 2008.

- NHS dental activity has risen, up from 87.5 million units of dental activity (UDAs) in 2010/11 to 88.2 million UDAs in 2011/12. PCT commissioning plans at June 2012 for the following twelve months are 87,000 UDAs higher than a year ago.

- The number of dentists providing NHS services rose by 121 to 22,920 dentists in 2011/12.

- The proportion of dentists' time spent on NHS work is rising. It rose from 74.4% in 2010/11 to 74.8% in 2011/12. By region, the NHS proportion ranges

from 66.3% in the former South Central and South East Coast SHA regions, to 82.3% in the North East.

- The number of new dental graduates has risen to 933 in 2012 (taken from Dental School estimates), a 39% increase since 2004; this will help to sustain the healthy workforce position.

- There was a corresponding increase in Vocational Trainee places in 2011/12 and an increase in practices wishing to participate in the scheme.

2012/13 settlement

2.14 As part of the wider Government policy the DDRB was not asked to make recommendations on dentists' pay for 2011/12 and 2012/13. Instead, officials from DH discussed dental expenses with representatives of the profession. In doing this we continued to use the formula approach to expenses that had previously been used by DDRB. The Government indicated that it expected the primary care sector to deliver the same improvement in efficiency and productivity that was required from the rest of the NHS and this was incorporated in the discussions.

2.15 We had a series of useful and informative discussions and meetings with the BDA, which led us to a determination as follows. Existing contract values were increased by 0.5% backdated to 1 April 2012. In addition, as part of this package, dentists were expected to:

- work closely with local commissioners of care to prepare for moves to a national contract based on capitation, quality and registration, including further moves to fully computerise their practice systems.

- work with PCTs and the NHSCB to move to a nationally consistent approach to contract management.

2.16 The package also included the phasing out of Units of Dental Activity credits for prescription only courses of treatment, which are increasingly difficult to justify from a clinical perspective. Together, these measures secured an efficiency and productivity gain from primary dental care in line with the requirement for the rest of the NHS.

General Dental Practitioners: Earnings and Expenses
Net Earnings

2.17 The data from the NHSIC this year continue to be hard to compare with previous years' because of changes in the way dentists pay themselves, especially the move towards personal and practice incorporation, which continues to take profits out of the self employed tax system for the individual dentist and moves them into company accounts. This is a significant issue, which has a serious impact on our ability to access the data on key decisions including the relative level of expenses and earnings and we wish to find a way to address it. However, despite these changes, it is clear that dentists continue to receive a good income. Although the average identifiable net profit after expenses for dentists in 2010/11 fell to £77,900 compared with £84,900 in the previous year this remains a well remunerated profession. For dentists holding a contract earnings were considerably higher at an average of £117,200, down 8.5% from the

previous year's £128,000. The data also show some dentists earning considerably more; with just over 1% earning over £300,000. Dentists working for others still had an average net profit of £62,900, down 4.2% from the £65,600 of the previous year.

2.18 We do not have exact figures on how many dentists changed their business arrangements in this way, but we do know the changes in the number of self-employed dentists overall in 2010/11. Compared to 2009/10 there were 8.0% fewer dental contract holders and 7.1% more "dentists who work for others".

2.19 On expenses, the data showed that just over half (54.7%) of gross payments to dentists was to meet their expenses.

Table 2.2: Gross income and net profit of primary care dentists 2004/05 to 2009/10

	Population	Average gross income	Expenses	Net profit	Expenses ratio
2004/05 GDS only	13,309	£193,215	£113,187	£80,032	58.6
2005/06	18,796	£205,368	£115,450	£89,919	56.2
2006/07	19,547	£206,255	£110,120	£96,135	53.4
2007/08	19,598	£193,436	£104,373	£89,062	54.0
2008/09	19,636	£194,700	£105,100	£89,600	54.0
2009/10	20,300	£184,900	£100,000	£84,900	54.1
2010/11	20,800	£172,000	£94,100	£77,900	54.7

Note: some double counting of expenses inflates both gross income and expenses but does not affect reported net profit.

2.20 Information on dentists' income compiled by the National Association of Specialist Dental Accountants (NASDA), which represents more than 20% of self-employed dentists, reported a decrease in net profit for NHS practices in 2010/11 of nearly 10%, to an average profit of £133,020. Net profit on NHS practices of £133,020 exceeds average net profit of private practices of £117,552, a reversal of the situation before 2005/06.

Table 2.3: Net profit for the practice

Type of practice	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
NHS	£104,000	£118,000	£142,400	£149,500	£148,000	£161,300	£147,800	£133,020
Mixed	£98,800	£100,400	£129,600	£147,100	£140,700	£138,600	£143,800	£127,045
Private	£113,000	£124,700	£131,400	£130,900	£136,500	£130,600	£126,400	£117,552

Source: NASDA. NHS practices are those where NHS earnings are 80% or more. Private practices are those where private earnings are 80% or more.

2.21 NASDA report that average net profit for associate dentists (those dentists with no share of ownership) reduced to £68,000 in 2010/11 from £71,000 in 2009/10.

Expenses

2.22 The NHSIC earnings report continues to note the increasing difficulty in separating out expenses between performers and providers and the possible double counting of expenses. They state:

NHS IC Report on dental earnings and expenses 2010/11, paragraphs 1.18 to 1.22.

"The results presented in this report are estimates which accurately reflect earnings and expenses as recorded by dentists on their self assessment tax returns. However, it should be noted that flows of money between dentists (for example, between a Providing-Performer and a Performer Only working in the former's practice) mean that gross earnings and expenses can be counted more than once across the tax returns of the dental population. This 'multiple counting' will cause estimates of gross earnings and expenses for the dental population as a whole (i.e. all self-employed primary care dentists) to be artificially inflated, but estimates of taxable income are not affected.

The extent of this multiple counting is difficult to quantify, but may have increased since the introduction of the new dental contractual arrangements on 1 April 2006. Under the new system, payments for NHS dentistry are made to the Providing-Performer dentist (or in some cases to a corporate body) who holds the contract under which the dentistry is performed; if the Providing-Performer has sub-contracted this work, then some of the payment will be passed on to a Performer Only dentist. A single sum of money can be declared as gross earnings by both the Providing-Performer and Performer Only dentist, and also as an expense by the Providing-Performer. Where a dentist is a sole-trader (i.e. the only dentist working in a practice), multiple counting will not occur, and where dentists operate in an Expenses Sharing Group, multiple counting is likely to be kept to a minimum.

This report only considers those primary care dentists who are self-employed (i.e. they have earnings from self-employment). Traditionally, the employment status of a vast majority of primary care dentists (both Providing-Performer and Performer Only) has been self-employment. As such, these dentists complete self assessment tax returns which, subject to certain exclusion criteria[3] have been used to inform the analyses presented in the dental earnings reports.

Since the introduction of the Dentists Act 1984 (Amendment) Order 2005 (SI 2005/2011), it has been possible for dentists to incorporate their business(es) and become a director and/or an employee of a limited company (Dental Body Corporate), with the potential to operate in a highly tax-efficient manner. Both Providing-Performer and Performer Only dentists are able to incorporate their businesses (for Providing-Performer dentists, the business tends to be a dental practice; for Performer Only dentists, the business is the service they provide as a sub-contractor).

It is currently not known how many dentists have incorporated their business(es) and what the precise consequences of incorporation may be for the results presented in this report.

[3] See *Dental Earnings and Expenses, England and Wales: Methodology*, shown the in 'Other Publications' section of this report.

HSCIC and DWG are working towards gaining greater understanding of this issue with a view to including further information in each subsequent edition of the report. Some potential arrangements and their likely effects are discussed in Dental Earnings and Expenses, England and Wales: Methodology."

2.23 In looking at expenses we continue to need to take account of the fact that average earnings and expenses figures are affected by the composition of the population covered. There are significant changes going on in the composition of the dentists in the earnings and expenses figures, mainly a large shift from Providing-Performer dentists to Performer only dentists. Dentists can also choose to alter the balance between gross and net pay without a major effect on earnings. Changes in earnings and expenses reflect more than just changes in pay rates and price changes. For example, if dentists work longer hours they have higher gross income but also may have higher expenses (and higher net income). The figures may also reflect changes in the type of work undertaken (eg complex treatment with higher expenses vs time consuming with lower expenses).

2.24 The averages cover dentists doing any NHS work in the year. A significant number of dentists come and go within a year. With 21,400 covered by GDS or PDS contracts in 2010/11, we have 1,000 leavers and 1,900 joiners in a year ie 2,900 or 14% working for only part of the year.

2.25 The numbers of dentists for the years 2006/07 to 2011/12 are set out on the facing page. (Table 7b from 'NHS Dental Statistics for England 2011/12').

Table 2.4: Number and percentage of dentists with NHS activity in the year ending 31 March, by dentist type, 2006/07 to 2011/12

	Number						Per cent					
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Total	20,160	20,815	21,343	22,003	22,799	22,920	100	100	100	100	100	100
Providing performer	7,585	7,286	6,778	6,279	5,858	5,099	37.6	35	31.8	28.5	25.7	22.2
Performer only	12,575	13,529	14,565	15,724	16,941	17,821	62.4	65	68.2	71.5	74.3	77.8

Notes:

1. Dentists are defined as performers with NHS activity recorded by FP17 forms.

2. Data consists of performers in General Dental Services (GDS), Personal Dental Services (PDS) and Trust-led Dental Services (TDS).

2.26 As already noted, the changes from year to year are affected by contract holder dentists changing their business arrangements into companies. This is tax efficient. Some profit is retained in the company, which in turn makes a self-employment payment to the dentist. The profits retained in the company are no longer covered in these self-employed earnings figures. There is also evidence that many individual performer dentists continue to operate under limited company status - further confusing the self-employed earnings report.

2.27 The issue of multiple counted expenses is also important as noted by the NHSIC. For example, a dental performer pays the laboratory bills associated with treatment out of their gross income. The performer pays the contract holder who in turn pays the laboratory. Both the contract holder and the dental performer show the cost as an expense with the contract holder showing the payment from the performer as an income. The NHSIC paper (above) indicates that the extent of double counting may have increased since 2006. This is because gross payments are no longer paid directly to individual dentists.

2.28 Extracts from the NASDA results are in the table below. They show, for two categories of expenses that expenses as a percentage of gross income increased for both mainly NHS and mainly private dentists in 2010/11. A slight reduction was seen in the 'laboratory costs' and there has been an increase in all other categories.

Table 2.5 Categories of expenses as a percentage of gross income

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Non-clinical staff wages (NASDA)						
NHS practices	18.2%	17.3%	17.9%	17.7%	18.8%	19.8%
Private Practices	17.2%	17.4%	17.8%	17.6%	18.1%	19.4%
Laboratory costs (NASDA)						
NHS practices	6.4%	5.6%	6.1%	6.0%	6.5%	6.3%
Private Practices	8.9%	7.8%	7.6%	7.1%	7.9%	7.6%
Materials costs (NASDA)						
NHS practices	5.6%	5.0%	5.6%	5.4%	5.6%	6.3%
Private Practices	6.7%	7.0%	7.5%	7.1%	7.5%	7.9%
Other Non-Staffing Costs (Morris & Co)						
NHS practices	16.4%	16.8%	15.7%	15.6%	15.1%	16.7%
Private Practices	23.0%	23.2%	23.6%	21.4%	21.2%	21.7%
Note: 2006/07 figures for NHS practices are affected by temporary increase in income from transition to the new contract. 2005/06 NHS figures include PDS.						

General Dental Practitioners: Recruitment, Retention and Motivation

2.29 The numbers of dentists providing NHS services continues to be a relatively weak indicator of supply: it is the number of NHS patients and the amount of NHS service they receive that is more important and these continue to rise. However, the numbers of dentists has also continued to rise, up by 0.5% last year. Overall, the number of dentists providing NHS services rose by 121 to 22,920 dentists in 2011/12.

2.30 Dentists are still ready (and indeed enthusiastic) to bid for and undertake NHS contracts, especially in areas where dentists had previously chosen not to set up or provide NHS services and NHS access continues to rise. For example, a recent procurement for dental services in Kent received over 80 expressions of interest. This is evidence that levels of NHS income are not acting as a bar to recruitment and retention or to growth in NHS services.

Future workforce supply

2.31 In the short to medium term, the position on workforce supply has been enhanced by the 25% increase in undergraduate training begun in October 2005 and the increase in training places for dental therapists. As a result, over 933 dentists are expected to qualify in summer 2013, over a third more than the 2004 baseline. DH estimates of future workforce supply strongly suggest that the supply of dentists will be able to meet demand for new services, even taking account of the dental procurements in train. The Dental Programme Board of Medical Education England plans to further review dental workforce requirements, taking account of the reduction in the complexity of treatment and gradual implementation of NICE guidelines for longer recall intervals and growth in skill mix. These changes are gradually allowing greater value for money (quality and productivity) to be obtained from existing investment in dental services and from the existing dental workforce, rather than having to rely mainly on new procurements to increase capacity.

Motivation

2.32 Dentists have achieved a reduction in working hours, with evidence from the NHSIC dental working hours survey published in August 2012 showing that dentists are working an average of 37.5 hours per week in 2011/12 compared to 39.4 hours in 2000. (Source: Dental Working Hours England and Wales 2008/09 and 2011/12 published by The NHSIC)

2.33 There are, however, still a number of key issues with the way dentistry is delivered and managed which we intend to work with the profession to address. As noted earlier, the Government is piloting aspects of a new dental contract based on registration, capitation and quality, which will benefit dentists and patients by focusing on prevention and outcomes rather than the number of interventions.

Vocational trainees and trainers

2.34 The increase in dental graduates referred to at paragraph 9.29 will create a need for a corresponding increase in places for vocational trainees. (Newly qualified dentists may not work in the NHS until they have completed one year's vocational training.) The DH works with Postgraduate Dental Deans to identify the areas in which the additional training places should be provided. Although the numbers are challenging, DH does not anticipate

difficulties because of increased interest from dental practices in applying to take vocational trainees.

General Dental Practitioners: Conclusion

2.35 We are taking forward discussions with the BDA with a view to making appropriate improvements in the contract to secure ongoing improvements in quality. We have indicated that, provided such improvements can be made, the Government is willing to agree an overall uplift for 2013/14 that allows up to a 1% increase in net pay for dentists and practice staff and an appropriate uplift for expenses in line with the formula used by DDRB.

Other Dental Staff Groups

Salaried Primary Dental Care Dentists

2.36 There are over 1,100 salaried dentists (latest headcount: NHSIC data) working in salaried primary dental care services in England, delivering a range of dental public health programmes and providing dental patient care, including specialised care, for a range of priority and at-risk patient groups. They may also work in Dental Access Centres. As part of implementation of the Department's Transforming Community Health Services initiative, these dentists are now employed by a range of different organisations including Social Enterprises, Community Trusts and acute NHS Trusts. These dentists are an important and valued part of the overall dental workforce, whose services will be commissioned by the NHSCB.

2.37 Following the decision of the GDC to recognise a new speciality of Special Care Dentistry, a small number of consultant posts and specialist training posts are being created, typically based within the salaried primary dental care service but with close links with other branches of dentistry. Appointments to those posts are being made on the relevant generic doctors and dentists Terms and Conditions of Service. Consultant and training grade staff in special care dentistry will therefore automatically receive the same uplift to pay and allowances as other medical and dental staff in those grades. For this year, as with other staff groups at this salary point, we expect there will be an average pay rise of 1%.

Dental Public Health Staff

2.38 Consultants in dental public health and trainees are employed on the generic terms and conditions of service for hospital and public health doctors and dentists. The review of capacity and capability in dental public health was published in March 2012 under the title Improving oral health and dental outcomes: Developing the dental public health workforce in England. The review shows how dental public health staff can improve oral health, reduce oral health inequalities, ensure patient safety and improve quality in dentistry. These staff will transfer to PHE where there will need to be a further review of functions and numbers of posts. For this year, as with other staff groups at this salary point, we expect there to be a pay increase.