Review Body on Doctors' and Dentists' Remuneration

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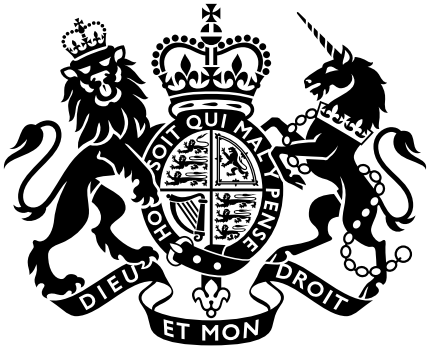
Forty-Eighth Report 2020

Chair: Christopher Pilgrim

CP 259



Review Body on Doctors' and Dentists' Remuneration

Forty-Eighth Report 2020

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

Presented to the Welsh Parliament by the First Minister
and the Minister for Health and Social Services

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

Presented to the Northern Ireland Assembly by the First Minister,
Deputy First Minister and Minister for Health

by Command of Her Majesty

July 2020

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Review Body on Doctors' and Dentists' Remuneration

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

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

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

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

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

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

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

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

The members of the Review Body are:

> Christopher Pilgrim *(Chair)*
> David Bingham
> Helen Jackson
> Professor Peter Kopelman
> Professor James Malcomson FBA
> John Matheson CBE
> Nora Nanayakkara
> Jane Williams

The Secretariat is provided by the Office of Manpower Economics.

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Executive summary

The DDRB's remit group

1. The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the governments of the UK on the remuneration of doctors and dentists employed by, or providing services to, the National Health Service.

2. The DDRB's remit group is complex. It is made up of over 140,000 Hospital and Community Health Services (HCHS) medical and dental staff (of which there are approximately 60,000 consultants, 10,000 staff grade, associate specialist and specialty (SAS) doctors and dentists and 70,000 doctors and dentists in training), 50,000 general medical practitioners (GMPs) and 30,000 general dental practitioners (GDPs).

Our remits

3. For this pay round we received remits from all four UK countries. The remits differed slightly, reflecting the different priorities of each government, as well as the multi-year pay deals that are in place for some groups within our overall remit.

4. The Secretary of State for Health and Social Care did not ask us for recommendations for independent contractor GMPs and doctors and dentists in training since both groups are currently subject to multi-year pay deals in England. The Welsh Minister for Health and Social Services, Scottish Cabinet Secretary for Health and Sport, and Minister for Health in Northern Ireland sought recommendations for all staff groups.

5. The remit letter for England also requested that our recommendations be informed by progress being made in contract reform negotiations for the SAS grades. The remit letter for Wales indicated that the Welsh Government had joined the contract reform talks for SAS doctors and dentists that were taking place between the British Medical Association and government and NHS bodies in England.

6. We received written and oral evidence from the Department of Health and Social Care (England, DHSC); the Welsh Government; the Scottish Government; the Department of Health (Northern Ireland); NHS England/Improvement; Health Education England; NHS Employers; NHS Providers; the British Medical Association; the British Dental Association (BDA); and the Hospital Consultants and Specialists Association. As part of our evidence gathering process, we went on a programme of visits, during which we spoke to local health service leaders and members of the remit group from across the UK. Our report this year has been completed during the coronavirus (COVID-19) pandemic and we are extremely grateful to all the parties for providing oral evidence to us during this immensely challenging time.

Context for our report

7. The evolving context of COVID-19, within which our report has been written, has had a major impact across the whole of society, as well as the NHS and health and social care and those working in this sector. Many of those in our remit group have played a crucial role at the front line of the UK's response. COVID-19 has placed extraordinary demands on members of our remit group, and we are highly sensitive to the fact that some have been made seriously ill and have lost their lives caring for patients during the pandemic.

8. While recognising the immediate impact of COVID-19 on doctors and dentists in our remit group, we have endeavoured to consider the remits in our usual way through our evidence-based process. In future years, we will seek to understand the short-term and longer-term impacts of COVID-19 on the recruitment, retention and motivation of doctors and dentists as more data becomes available.

9. COVID-19 has, however, served as a significant reminder of the critical importance of our remit group to society and its health and well-being, and highlights the continuing need to ensure that medical and dental careers remain attractive and motivating, both for prospective students and for those already in the workforce.

10. We are in an unprecedented position at the time of this report, at the start of a period that will have significant impacts on the economy, labour market and public finances. The data and information to understand many of the effects may take some time to emerge. That said, it is clear that the UK economy will contract significantly in the short term, and many of the economic indicators will reflect this.

11. Gross domestic product was estimated to have fallen by 10.4 per cent in the three months to April 2020, with a 20.4 per cent fall in April 2020 alone.

12. The latest inflation figures, for April 2020, showed increases in CPI at 0.8 per cent, CPIH at 0.9 per cent, and RPI at 1.5 per cent over 12 months. Inflation is expected to fall further this year, with the Bank of England predicting that CPI inflation will fall to zero at the end of 2020.

13. Short-term indicators suggest that the labour market took a sharp downturn at the end of March. Average weekly hours of work fell from 31.6 to 24.8 in the last two weeks of March, while the number of people claiming unemployment-related benefits increased by 856,000 between March and April 2020. The Bank of England expects the unemployment rate to rise to nine per cent in the second quarter of 2020, which would be the highest rate recorded since 1994. Average weekly earnings growth has fallen back to 2.4 per cent in the three months to March 2020, from a peak of 4.0 per cent in mid-2019. Early HMRC/ONS estimates for April 2020 suggest that median monthly pay was 0.9 per cent lower than a year earlier.

14. There have been developments this year with issues that had concerned us in previous reports. The issue of pensions taxation featured extensively in the evidence we received this year. Changes that apply across the UK were made in the 2020 Budget and, consequently, the majority of senior clinicians will not have their annual allowance tapered. We welcome this. However, we note that pensions taxation, particularly through the lifetime allowance, will remain an issue for many doctors and dentists. Likewise, we note the risk of a long-term impact from this; during our visits programme several consultants told us that, after reducing their workloads to avoid pensions taxation charges, they were now enjoying an improved work-life balance and did not intend to return to previous working patterns. The lasting impact of pensions taxation issues as a result of the changes of behaviour and bad feeling they precipitated may continue to be felt going forwards. This could lead to shortages amongst the most senior doctors.

15. Looking forward, the UK has now exited the EU, though the future relationship between the UK and the EU is yet to be settled. Uncertainty as to the impact on the medical and dental workforce therefore remains, particularly in relation to international recruitment and retention. This may be compounded by the effects of COVID-19 on resourcing, leading to shortages of doctors and dentists to the detriment of the services they provide and ultimately patient care.

Productivity and affordability

16. We have set out in our report our views on productivity and affordability. Productivity is an issue we have considered carefully. Measuring it is important but not straightforward. As we said last year, the data we currently receive relates only to the service as a whole and tells us little about the productivity of our remit group. As such, they provide only a broad and imperfect indication of the affordability constraints that might inform pay recommendations.

17. Much of the messaging about productivity from within the NHS stresses that greater productivity is delivered through multi-disciplinary team working. This would imply that productivity measurements based on the work of individual doctors are unlikely to be very helpful. Productivity is a system-wide imperative, and it is likely to be aided, or impeded, by the general levels of commitment, morale and motivation within the NHS, including our remit group. Productivity enhancements would be best addressed through contract negotiations in which specific groups can be rewarded financially for changes in their working practices.

The case for a pay award

18. In making our pay recommendation we have considered the pay and affordability proposals put to us by the parties, alongside the need to recruit, retain and motivate doctors and dentists, and the evidence provided to us on these matters.

19. It is welcome that more students are entering medical school, and that there are more applicants wishing to study medicine and dentistry at university. However, there is a need to ensure that groups across the remit feel there is sufficient incentive for them to either stay in or return to the workforce. As health services change to meet new challenges and demands, it is crucial that they achieve the most with their workforce. This requires doctors and dentists to feel valued and that their contribution to society is recognised appropriately. Retention and motivation must therefore also remain a priority.

20. There are a number of issues of retention and motivation that are a concern and need to be addressed to ensure that groups across the remit feel there is sufficient incentive for them to either stay in or return to the workforce:

    - It is now the norm for doctors in training to step out of training on completion of the Foundation Programme, so it is crucial they feel they have sufficient incentive to return to training and substantive positions in the NHS.
    - For GMPs and GDPs, there are continued signs that partner and providing-performer positions, once roles to which newly qualified doctors and dentists would aspire, are becoming less attractive, and there are a number of programmes in place across the UK to incentivise GMPs to become partners.
    - SAS doctors and dentists continue to be a crucial but undervalued part of the workforce in hospitals. They deliver critical services alongside the consultant workforce, and as the group with the highest proportion who qualified outside the UK, are most susceptible to international labour market movements – including restrictions on movement such as those that occurred during the COVID-19 pandemic.
    - As consultants become an increasingly prominent proportion of the workforce, their retention becomes ever more critical for patients. The persistently high proportion of voluntary early retirements, which have comprised more than a quarter of all retirements every year since 2014, are worrying. We welcome the changes made to the pensions tax annual allowance taper, and any consequent falls in such retirements given the importance of retaining consultants in the NHS and enabling them to contribute the maximum hours possible.

21. Across the whole remit group, there a number of issues that are affecting morale, some very serious. Staff survey results for England show that less than one-third of those responding believed that there were enough staff present in their organisation for them to do their job properly, and three-quarters reported working excess unpaid hours. The rates of those who had experienced harassment, bullying or abuse from patients, relatives or the public remain high and the rates of those who had felt unwell as a result of work-related stress continue to rise. The results from the most recent staff surveys for Northern Ireland and Wales both show high numbers having experienced harassment, bullying or abuse or feeling unwell as a result of work-related stress.

22. Members of our remit group are highly committed to their professions. However, over the last decade, average incomes have fallen in real terms (as measured against CPI inflation) and relative to earnings in the wider economy, especially at more junior levels. During our visits programme, we frequently heard from doctors and dentists who said that they felt less valued by employers, governments and society as a whole than they had been previously. Consultants, in particular, told us that they felt their pay had fallen relative to their private sector professional comparators, and that this impacted negatively on their sense of being valued.

Pay uplift

23. We were struck this year, from both the evidence provided to us and from the conversations we had during our visits, at the strength of feeling in our remit group that their vocational commitment had been taken for granted and their contribution to society was not being recognised, and that their pay sat poorly relative to other professions.

24. We also note the pay uplifts already implemented for independent contractor GMPs and doctors and dentists in training in England, as part of multi-year agreements. Contractor GMPs' comprehensive contract deal includes significant investment in general practice and a new state-backed indemnity scheme. Doctors and dentists in training will receive base pay uplifts of two per cent per annum during the lifetime of the deal, and once reforms to the pay structure are taken into account, a total of three per cent will be invested in this staff group in 2020-21.

25. **After considering all the evidence, we recommend a general uplift of 2.8 per cent, to be applied across all groups included in our remits this year, from the start of April 2020.**

26. Applied to those in our remit in England, this would add £370 million to the pay bill in 2020-21, compared with what DHSC described as an envelope of £310 million for substantive HCHS medical and dental staff. For GDPs, it would add around £52 million compared to the DHSC-quoted envelope of £37 million. We have set these figures in the context of other NHS costs, such as agency expenditure of almost £940 million in 2018-19 on medical and dental staff in England, and the overall annual NHS Resource Departmental Expenditure Limit in England of over £120 billion.

27. We have not made a targeted recommendation for any part of our remit group this year. Last year, we recommended that SAS doctors and dentists should receive an extra one per cent, on the basis that it would be a cost-effective and justifiable investment in raising the profile and attractiveness of the SAS grades. Our recommendation has not been implemented by any of the governments, though we were told that the additional one per cent (which would have been an extra cost of £11 million in England) would be available to help fund contract reform in England and Wales. This followed our 2018 recommendation that SAS doctors and dentists should receive a 3.5 per cent increase in their national salary scales. Other than in Wales, this was not fully implemented.

28. We welcome the SAS contract negotiations in England and Wales, which we have been told it is the intention to complete in time for implementation in April 2021. However, our 2019 recommendation for this important but too-often undervalued group of staff was not made dependent on contract reform. While we have not recommended a differential award this year, we will follow the progress of negotiations closely. We expect the contract to be in place for April 2021 and the savings from the extra one per cent to be added to the funding envelope. If the new contract is not agreed for April 2021, we will consider again next year whether there is a case for an additional award.

29. We have significant concerns about the equity and effectiveness of the Clinical Excellence Awards (CEAs), Commitment Awards, Distinction Awards and Discretionary Points systems for consultants in their current forms.

30. We have been waiting for reform of the award schemes since our review of incentives for consultants in 2012[1] and we also note our report in 2015[2]. We are not convinced that these awards, in their current form, necessarily reward all those who are currently contributing most towards the delivery of high-quality services and patient care. In particular, we consider that they are an exacerbating factor in pay equalities issues for consultants. As this review body has previously outlined, there is a gender and ethnicity pay gap in medicine with women and black, Asian and minority ethnic (BAME) doctors being disadvantaged. There is a disproportionately lower number of applications for these awards from women and BAME candidates. The increasing diversity of the consultant workforce including in relation to gender, ethnicity, and flexible working intensifies the problems with the award systems and the very slow pace of reform.

31. We recognise that work has started to reform these awards in England with planned changes to both the local and national CEA schemes, which DHSC has told us will be based on our 2012 proposals. **However, given our concerns, we do not feel that we can recommend an uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points this year.**

32. It is too early for the review body to understand the full impact of COVID-19 on our remit group and our recommendations do not seek to take account of COVID-19. However, separately, we would urge governments to consider the role that members of our remit group have played and whether any additional recognition should be given to acknowledge this contribution.

Looking ahead

33. The final part of our report looks ahead to some of the challenges facing our remit group and to what we would expect to see covered in evidence over the next few years. We have a number of priorities for additional evidence next year.

34. The Gender Pay Gap in Medicine Review, for England, is expected to be published soon. We particularly look forward to its publication and anticipate that its findings will have significant relevance for our considerations next year. We would welcome views from the parties in all the nations as to whether they intend to perform similar exercises to explore other pay and equalities issues in the medical and dental professions and across the four nations.

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[1] Review Body on Doctors' and Dentists' Remuneration (9 August 2013), *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Available at: https://www.gov.uk/government/publications/ddrb-nhs-consultant-compensation-levels-2012

[2] Review Body on Doctors' and Dentists' Remuneration (16 July 2015), *Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week.* Available at: https://www.gov.uk/government/publications/contract-reform-for-consultants-and-doctors-and-dentists-in-training-supporting-healthcare-services-seven-days-a-week

35. We welcome data from the parties on the short-term and long-term implications of the COVID-19 pandemic on the NHS and its workforce and workforce strategies, such as the forthcoming NHS People Plan for England. This will allow us to monitor its impact on recruitment, retention and motivation of the medical and dental workforces.

36. We look forward to hearing about the progress of contract reform for SAS doctors and dentists and the embedding of SAS charters across the UK.

37. This is the third consecutive year that we stress the widely differing pictures of dentistry presented by the parties. This needs a resolution. The BDA have again told us that NHS dentistry has reached crisis point due to pay and workload issues. However, these reports continue to contrast strongly with the assessments we receive from DHSC and NHS England/Improvement. It will become increasingly challenging for us to make a considered pay recommendation on the basis of such divergent positions. The trends in dentists' earnings are also a concern, and we would welcome an explanation for factors causing these trends, as well as a more detailed breakdown of dental earnings by working hours and by split between NHS/Health Service and private dentistry. We would urge progress on contract reform across the UK and for an update on developments to be provided to us next year.

38. We would find details of any emerging trends in retention of the consultant workforce valuable. This would include evidence as to whether there has been any longer-term impact of the issues associated with pensions taxation; data on the levels of senior consultants looking to reduce their commitments or take voluntary early retirement; and any renewed contract reform efforts. We would also welcome an update on the progress of the Government's planned reform of local CEAs in England and the ACCEA's forthcoming consultation on national CEAs in England and Wales, as well as any plans to reform the discretionary reward systems for consultants in Scotland, Wales and Northern Ireland.

39. There are other areas in which further data would be welcome, which are set out in our report. These include details of the impact of incentives for doctors to join GMP partnerships, given their decreasing appeal, data as to how our recommendations for salaried GMPs are ultimately reflected in their pay, and consideration within workforce planning of changing aspirations and ambitions of doctors and dentists in training in relation to work-life balance and flexibility.

CHAPTER 1: INTRODUCTION

Introduction

1.1 The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the governments of the UK on the remuneration of doctors and dentists employed by, or providing services to, national health services. In this report, we make our recommendations and observations for the 2020-21 pay round.

1.2 For this pay round we received remits from all four UK countries. The remits differed slightly, reflecting the different priorities of each government, as well as the multi-year pay deals that are in place for some of the remit groups. More detail on the remits is provided later in this chapter.

Structure of the report

1.3 We have considered the remits in relation to our standing terms of reference and set out the evidence received from the parties on these matters, together with the conclusions and recommendations we reached based on this evidence.

1.4 This report is divided into eleven chapters:

1. Introduction
2. Wider context
3. Affordability, productivity and workforce planning
4. Pay, motivation and workforce supply
5. Doctors and dentists in training
6. Staff grade, associate specialist and specialty (SAS) doctors and dentists
7. Consultants
8. General medical practitioners
9. Dentists
10. Pay recommendations and observations
11. Looking forward

1.5 We also include seven appendices.

A. Remit letters from the parties
B. Detailed recommendations on remuneration
C. The number of doctors and dentists in the NHS in the UK
D. Glossary of terms
E. The data historically used in our formulae-based decisions for independent contractor GMPs and GDPs
F. Abbreviations and acronyms
G. Previous DDRB recommendations and the governments' responses

Key context for this report

1.6 Our report this year has been completed in the evolving context of the coronavirus (COVID-19) pandemic. The effect of the governments' responses on the UK economy, labour market and the NHS and its workforce emerged after we had received our remits from the UK Government and Devolved Administrations, and after the parties submitted their written evidence to us.

1.7 The evolving context of COVID-19, within which our report has been written, has had a major impact across the whole of society, as well on the NHS and health and social care, and those working in this sector. Many of those in our remit group have played a crucial role at the front line of the UK's response. COVID-19 has placed extraordinary demands on members of our remit group, and we are highly sensitive to the fact that some have been made seriously ill and have lost their lives caring for patients during the pandemic.

1.8 We discuss the impact of COVID-19 in more detail in Chapter 2.

1.9 COVID-19 inevitably changed the context for this report, but it was clear that the parties wanted the DDRB process to continue this year. While recognising the changed context, we have endeavoured to consider the remits in our usual way through our evidence-based process. We are extremely grateful to the parties for providing oral evidence to us during this challenging time.

1.10 In this report, we comment on the broad effects we might expect to see as a result of COVID-19, as they relate to matters in our remit in relation to the economy, the labour market, public finances, the NHS, and members of its workforce in our remit group. However, given that the situation was, at the time of writing, still developing, the full impacts of COVID-19 on the economy and workforce are not yet known and so we do not present definitive observations or recommendations based on its impact. We will seek to monitor the impacts of COVID-19 on the recruitment, retention and motivation of doctors and dentists, including on international recruitment and retention, in future reports as data become available.

1.11 There have been significant developments this year in many of the other key issues that relate to our terms of reference, which had concerned us in previous reports. The UK has now exited the EU, but the future relationship with the EU is yet to be settled. Uncertainty as to the impact on the medical and dental workforce therefore remains, particularly in relation to international recruitment and retention. This may be compounded by the effects of COVID-19 on resourcing, leading to shortages of doctors and dentists to the detriment of the services they provide and, ultimately patient care.

1.12 Doctors' and dentists' working patterns continue to change, with notable changes including falls in the number of partner general medical and dental practitioners, concurrent with rises in those working in salaried and associate positions, and increasing numbers of doctors and dentists working and training less-than-full-time. Stepping out of training for at least a year on completion of the medical Foundation Programme is now the norm rather than the exception for doctors in training. The Gender Pay Gap in Medicine Review is ongoing and is expected to publish its recommendations this year. In response to the issue of pensions taxation, which featured prominently in the evidence that we received, the UK Government made a change to the pensions taxation rules in the 2020 Budget.

1.13 In January 2020, the Northern Ireland Assembly was restored, bringing an end to a three-year period without an Executive. We hope that this will mean a greater level of certainty for budget planning and direction in Northern Ireland, enabling public services to be administered and planned more effectively.

Workforce plans

1.14 We are expecting the NHS People Plan, which covers England, to be published later this year. It builds on the Interim NHS People Plan that was published in June 2019, with the intention of outlining a fully costed workforce strategy for the NHS in England for the next five years.

1.15 On 16 December 2019, the Scottish Government, together with the Convention of Scottish Local Authorities, published 'An Integrated Health and Social Care Workforce Plan for Scotland', Scotland's first integrated national workforce plan, which includes high-level actions for the medical and dental workforce.

1.16 Similarly, Health Education and Improvement Wales on behalf of NHS Wales submitted its final draft of 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' to the Welsh Government in December 2019. It outlines at a high level a series of actions that they intend to take to deliver an inclusive, engaged, sustainable and flexible workforce in health and social care by 2030.

Pensions and pensions taxation

1.17 While pensions and pensions taxation are outside the remit of the review body, pensions taxation has been raised as a key issue in relation to the reward package for doctors and dentists. It has been considered by some parties as a significant factor in the overall challenges being faced by health services across the UK, as a result of its impact on recruitment, retention and motivation. This issue of pensions taxation featured extensively in the evidence that we received for this round and in the conversations we had with doctors and dentists during our visits programme. We heard that this issue was both impacting retention and exacerbating Trusts' issues in resourcing roles.

1.18 As a result of changes to the size and operation of the annual and lifetime pensions allowances made in 2016, senior clinicians were much more likely to be in receipt of tax charges as a result of their membership of the NHS Pensions Scheme than previously. We were told that concern about these tax charges has been cited as reason for senior clinicians retiring early, opting out of membership of the Scheme or reducing their workloads, in order to decrease their earnings and accrual rate to avoid tax charges.

1.19 All parties to the review body have acknowledged this issue and were concerned about the impact it was having on clinicians and the services they provide. Several different remedies for this issue have been implemented or proposed across the UK over the past year.

1.20 The Department of Health and Social Care (DHSC) issued two consultations on pensions in 2019, *NHS Pension Scheme: proposed flexibility*, which was published in July 2019, and *NHS Pension Scheme: increased flexibility*[1], which was published in September 2019, and superseded the first consultation. The latter proposed a number of measures to help to address issues relating to pensions taxation, including allowing eligible clinicians to adjust their pensions accrual rate in increments of 10 per cent.

1.21 Also in September 2019, NHS Employers released *Pensions Tax Guidance for Employers: Local measures to support staff and service delivery during the 2019/20 financial year.* This guidance document outlined a number of measures that employers could take locally in response to these issues. Included was guidance on whether and how employers might pay unused employer contributions as salary to those who opt out of the pensions scheme, a practice known as 'recycling'. In November 2019, NHS Scotland announced a similar initiative, where all clinicians who could demonstrate that they had a reasonable expectation of receiving an annual allowance tax charge could choose to receive recycled employer contributions as salary.

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[1] Department of Health and Social Care (September 2019) *NHS Pension Scheme: increased flexibility.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/830862/NHSPS_flexibility_consultation_document.pdf.
Department of Health and Social Care (July 2019) *NHS Pension Scheme: proposed flexibility* is no longer available

1.22 In December 2019, NHS England/Improvement (NHSE/I) announced another initiative to support staff. They committed to paying a pension supplement on retirement to any clinicians that use the Scheme Pays facility to pay an annual allowance tax charge during the 2019-20 financial year. This, in essence, meant that clinicians could use Scheme Pays without it causing a deduction to their accrued pension. Later in December the Welsh Government announced a similar scheme for clinicians working for NHS Wales.

1.23 Finally, as part of the Budget in March 2020, the thresholds associated with the annual allowance taper were both uplifted by £90,000. This meant that from the 2020-21 financial year onwards, the overwhelming majority of senior clinicians will not have their annual allowance tapered. Some clinicians will continue to breach the annual allowance, and some of those will receive pensions tax bills, including those who hold a significant amount of final salary accrued pension and receive a base pay increment. However, this will take place in a more predictable and straightforward manner as, for all but a small number of the highest earners, the annual allowance will be fixed at £40,000. These measures will apply across the United Kingdom. As part of the Budget announcement, it was also confirmed that the changes proposed in the consultation would not be implemented.

Our comments

1.24 We welcome that governments and NHS stakeholders have been willing to recognise this issue. It is evidently one of major importance both to our remit group and to health services more generally.

1.25 The Budget announcement will have simplified the situation for the overwhelming majority of doctors and dentists, since their annual allowance will no longer be tapered. We welcome this, and we note that the British Medical Association (BMA) were supportive of this measure. However, we also note that pensions taxation, particularly through the Lifetime Allowance, will remain an issue for many doctors.

1.26 We remain concerned that the complexity of NHS pensions can make them difficult for clinicians to navigate. On our visits, we frequently heard from clinicians who said that they felt that they needed to get expensive financial advice, or had simply erred on the side of caution and had reduced their working hours by more than may have been strictly necessary to avoid a tax charge. It is important that the NHS pensions are not too complicated to navigate, and information that can inform decision-making should be made readily available to clinicians. This would ultimately reduce the risk that clinicians decrease their commitment to the NHS for fear of a tax charge.

1.27 We also note the risk that there may a be long-term impact from this issue. During our visits programme several consultants told us that, after reducing their workloads to avoid pensions taxation charges, they were now enjoying an improved work-life balance and no longer intended to return to previous working patterns, regardless of the measures that may be put in place to address the pensions taxation issue. If this pattern is replicated across the UK, it could lead to shortages amongst the most senior doctors.

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

1.28 The DDRB is a body that makes recommendations to governments based on the written and oral evidence that is provided to it by governments, trade unions and other stakeholders. We also make a series of visits, during which we speak to local health service leaders and members of the remit group from across the UK. It is then for those governments to decide whether and how to respond to our recommendations.

1.29 Outside of the DDRB process, the parties can and do negotiate with each other about pay and other issues, and the trade unions representing the workforce and governments can reach agreements on pay between themselves.

The breadth of the DDRB's work and remit

1.30 The DDRB's primary focus of concern is pay, and its impact on recruitment, retention and motivation. But over the course of time there have been periods when the DDRB has been asked to report on issues beyond any narrow consideration of pay uplifts (for example, seven day services). More generally, pay questions can rarely be considered in isolation from other factors which influence recruitment, retention and motivation. To understand the role of pay in addressing these questions, it is often necessary to consider this broader context. In its reports, the DDRB tries to make a pragmatic judgement about the need to demonstrate that its central pay-focused recommendations have been informed, as necessary, by due consideration of these wider questions.

The independence of the DDRB

1.31 As last year, the question of the independence of the DDRB has been raised by the trade unions. We would reiterate that our recommendations are based on our independent assessment of the evidence. We would note that the basic recommendation of 2.5 per cent for 2019-20 was higher than the 2.0 per cent outlined as affordable for doctors and dentists in England in the evidence provided to us by NHS England and NHS Improvement and was implemented by the governments. Similarly, our basic recommendation for Scotland was implemented, which required the Scottish Government to be flexible in applying the 2019-20 Scottish Public Sector Pay Policy.

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

1.32 In their evidence submissions, the three trade unions each made reference to the period of pay freezes or below-inflation pay awards between 2010 and 2018, and the consequent impact on real-terms pay for doctors and dentists. They also each recommended that the remit group receive an increased award explicitly based on the real-terms falls in pay since 2010 that they described. Our view remains that our recommendations and observations are not explicitly intended to undo past decision making, nor do we feel that our recommendations should explicitly intend to retrospectively track inflation and earnings. However, we do consider the impacts of long-term trends in pay on recruitment, retention and motivation.

Remits for this report

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

Department of Health and Social Care (England)

1.34 The Secretary of State, Matt Hancock MP, sent his remit letter on 16 October 2019. It invited us to make recommendations in relation to consultants, staff grade, associate specialist and specialty (SAS) doctors and dentists, salaried general medical practitioners (GMPs) and dentists in England. It did not ask us to make recommendations for independent contractor GMPs or doctors and dentists in training, since both are currently subject to multi-year pay deals, and it requested that our recommendations be informed by their subsequent updates on progress being made in contract reform negotiations for the SAS grades with the BMA. It asked us to take into consideration the workforce growth assumptions contained in the *NHS Long Term Plan*, that the overall NHS budget has now been set until 2024 and planned workforce reform and productivity improvements. It also asked us to consider targeting of available funds to help address recruitment and retention pressures.

1.35 On 5 May 2020, representatives of the BMA and NHS Employers wrote to us to update us on the state of the SAS grade contract reform negotiations. They said that a mandate had been received from the UK Government and Heads of Terms had been agreed between the two parties, with any joint proposals for revised terms and conditions expected to come into effect from April 2021. They said that due to COVID-19, the negotiating teams were meeting virtually, and that they would review the progress being made and how this will impact on the timetable, and that they would continue to keep us updated on the progress of the discussions.

Welsh Government

1.36 The Minister for Health and Social Services, Vaughan Gething AM, wrote to us on 6 January 2020, asking for recommendations that would enable him to determine a fair and affordable pay award for medical and dental staff in Wales. His letter indicated that the Welsh Government had joined the contract reform talks for SAS doctors and dentists that were taking place between the BMA and government and NHS bodies in England.

Northern Ireland Department of Health

1.37 The Minister for Health, Robin Swann MLA, wrote to us on 24 February 2020 to ask us for recommendations on pay for all doctors and dentists working in health and social care in Northern Ireland.

Scottish Government

1.38 The Cabinet Secretary for Health and Sport, Jeane Freeman MSP, wrote to us on 25 February 2020 to ask us for recommendations for all groups within the DDRB remit. She asked us to consider the affordability of recommendations within the confines of the Scottish Public Sector Pay Policy for 2020-21, whose main features are:

- A guaranteed pay increase of three per cent for public sector workers who earn below £80,000;
- Continuing the requirement for employers to pay staff the real Living Wage, now set at £9.30 per hour;
- Providing a guaranteed cash underpin of £750 for public sector workers who earn £25,000 or less;
- Limiting to £2,000 the maximum basic pay increase for those earning £80,000 or more; and
- Allowing flexibilities for employers to use up to 0.5 per cent of pay bill savings on baseline salaries for addressing clearly evidenced equality issues in existing pay and grading structures.

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

1.40 For general medical and general dental practitioners, it asked us for recommendations on the pay element of contracts only since separate exercises on expenses were ongoing with the BMA Scottish General Practitioners Committee and the British Dental Association (BDA) Scotland respectively.

Our comments on the remits

1.41 The remit letter for England did not ask us for recommendations for independent contractor GMPs and doctors and dentists in training, but recommendations are being sought for those staff groups in Scotland, Wales and Northern Ireland. However, we noted that the DHSC letter welcomed our comments and observations on the evidence that we received from the parties on doctors and dentists in training.

1.42 The remit letter for England also asked us for our views on targeting of available funds in pay, and that we outline what consideration we have given to targeting in this report. None of the other remit letters explicitly asked for our views on this issue, although the Welsh Government said in their written evidence that they do not support the use of targeted pay to specific staff groups. They also said that they did not wish to consider the use of targeting pay to aid recruitment to particular specialties until they had evaluated the impact of some of their wider measures designed to address the underlying causes of recruitment challenges.

1.43 A number of different financial incentives are already in place for various parts of the remit group, whether by specialty or by geography. While we will say more about each of these in the relevant chapter of the report, they include flexible pay premia for certain specialties for doctors and dentists in training in England; the Targeted Enhanced Recruitment Scheme for general practice trainees, which incentivises trainees to work in shortage geographies and operates in England, Wales and Scotland; Recruitment and Retention Premia for consultants and SAS doctors and dentists; and the Partnership Premium, which is intended to incentivise GMPs to become partners in England. The general dental practice commissioning system's tendering model is also capable of providing financial incentives for providing dental care in areas with higher demand and lower workforce supply.

1.44 Our position remains supportive of governments exploring the potential for a more substantial system of targeting pay, including by geography, particularly since workforce shortages in remote and rural areas remain a pressing concern. We also note the comment made by NHS Providers that it is important that further recruitment incentives based on geography are designed carefully to avoid unhelpful competition between employers. That said, we remain unconvinced by the arguments put forward by some parties that targeting has no role to play in addressing local shortages. If one or more of the governments wishes to consider targeting pay in this way, then we would welcome seeing the evidence underpinning such considerations.

1.45 We would also welcome evidence from governments as to the utilisation and effectiveness of the financial incentives already in place, to support future decision making. This includes the longer-term impact of these incentives on retention and, ultimately, in achieving their aims. We also note that in England, as part of efforts to address shortages of doctors in remote and rural areas, the recent expansion in undergraduate medical school places has been focused on such areas of shortage – a topic that was also frequently discussed during our visits programme. We would welcome seeing evidence as to the effectiveness of this as it becomes available.

1.46 The remit letters for England and Wales both asked us to be mindful of the ongoing talks with the BMA about contract reform for SAS doctors and dentists. In May 2020 we received joint correspondence from the BMA and NHS Employers that confirmed that a mandate had been received and Heads of Terms had been agreed, with revised terms and conditions expected to come into effect from April 2021. Therefore, all parties still expect us to make a recommendation in this year's report.

1.47 We also note the different approach to pay taken by the Scottish Government, as set out in their remit letter, which included reference to the Scottish Public Sector Pay Policy. The Policy proposes making proportionally higher pay awards to the lowest paid public sector workers and also puts a cap on the size of the award for the highest paid. The £2,000 cap on increases for those earning over £80,000 would, if implemented for the DDRB remit group, lead to senior clinicians in Scotland receiving a significantly smaller award than our recommendation.

The remit group

1.48 The remit group is broadly similar to that of the last report. However, we will not be making recommendations for independent contractor GMPs and doctors and dentists in training in England. Neither was included in DHSC's remit as both groups are currently covered by multi-year pay deals. Salaried GMPs were included in the remit for England, unlike last year when the uplifts to the salary range were agreed as part of the contract deal that underpinned the multi-year pay deal for contractor GMPs. The Scottish, Welsh and Northern Irish governments asked us to make recommendations for all groups of doctors and dentists.

Parties giving evidence

1.49 We received written and oral evidence from the organisations listed below. The parties are the same as last year, except that this year NHSE/I submitted evidence as one organisation. The organisations were as follows:

Government departments and agencies

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

Employers' bodies

- NHS Employers
- NHS Providers

Bodies representing doctors and dentists

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

The evidence-giving process

1.50 We asked the evidence providers to make written submissions by 13 January 2020, although most parties did not meet this deadline, in part as a result of delays associated with the 12 December 2019 general election. The restoration of the Northern Ireland Executive, which took place in January, and the Scottish Budget in February also factored into delays to the submission of written evidence by the Northern Ireland Executive and Scottish Government respectively, though the timings of both of these were also affected by the general election.

1.51 We welcome the BMA's renewed full participation and active engagement in the evidence-giving process and thank them for their submission of written evidence this year alongside that of the other parties.

Last year's recommendations

1.52 In our 47th Report 2019, our basic recommendation was for a 2.5 per cent increase to the national salary scales, to be applied to the following:

- Consultants
- Doctors and dentists in training
- Independent contractor GMPs in Wales, Scotland and Northern Ireland
- Salaried GMPs in Wales, Scotland and Northern Ireland
- Providing-performer and associate general dental practitioners (GDPs)
- Salaried GDPs including Community/Public Dental Service practitioners

1.53 We recommended an additional one per cent for SAS doctors and dentists, meaning that our overall recommendation for the SAS grades was for a 3.5 per cent increase in pay. We also recommended that the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points, GMP trainers' grant and GMP appraisers' fee, and the flexible pay premia included in the contract for doctors and dentists in training in England increase in line with our recommendations for the national salary scales, an increase of 2.5 per cent.

Responses to our recommendations

1.54 Following receipt of our 2019 report, DHSC, the Welsh Government and the Scottish Government implemented the annual pay uplifts for this remit group as detailed in Table 1.1 below. It is worth noting again that at the time of submitting this report, the Department of Health (Northern Ireland) had not acted on our recommendations.

Table 1.1 Implementation of 2019 DDRB recommendations.

Group	DDRB 2019 recommendations	England	Wales	Scotland
Consultants (pay scales)	2.5%	2.5%	2.5%	2.5%
Consultants (Clinical Excellence Awards, Commitment Awards, Distinction Awards)	2.5%	Value frozen, except new interim-system local Clinical Excellence Awards, which were uplifted by 2.5%	Value frozen (money retained for spending on consultants elsewhere)	Value frozen
SAS doctors and dentists	3.5%	2.5%, with the remaining 1% conditional on contract reform	2.5%, with the remaining 1% conditional on contract reform	2.5%
Doctors and dentists in training	2.5%	n/a*	2.5%	2.5%
Independent contractor GMPs	2.5% (Wales, Scotland and Northern Ireland only)	n/a	2.5%	2.5%
Salaried GMPs range	2.5% (Wales, Scotland and Northern Ireland only)	n/a	2.5%	2.5%
Independent contractor GDPs	2.5%	2.5%	2.5%	2.5%
Salaried GDPs	2.5%	2.5%	2.5%	2.5%
GMP trainers' grant and GMP appraisers' fee	2.5%	2.5%	2.5%	2.5%

Note: At the time of submission the Department of Health (Northern Ireland) had not acted on our recommendations.

*A multi-year pay and contract reform deal for doctors and dentists in training in England was made between DHSC and the BMA in June 2019, prior to the publication of the 2019 DDRB report.

Our comments on responses to our recommendations

1.55 We welcome the acceptance of the majority of our recommendations in England, Scotland and Wales, in contrast to the recommendations in the 2018 report, and that they were fully backdated. However, it was disappointing that some of our recommendations were not implemented.

1.56 We were disappointed that the additional one per cent that was recommended for SAS doctors and dentists was not awarded anywhere. However, in his ministerial statement announcing last year's uplift for England, the Secretary of State said that there was potential for this additional one per cent to be added to pay in 2020-21 conditional on contract reform through a multi-year agreement. While we welcome the commitment to contract reform, the additional one per cent would have been a cost-effective and justifiable investment in this important group of staff, and our recommendation was not contingent on contract reform. It has subsequently been confirmed to us that reformed contracts will be implemented in April 2021 at the earliest, meaning that the recommended investment in pay will not take place during the 2020-21 financial year. This is the second year in which our recommended award for this group has been only partially implemented.

1.57 The delays to the pay award process in Northern Ireland continue to be unacceptable. The pay award for 2018-19 was only made in November 2019, more than halfway through the following financial year, and almost 18 months after the DDRB made its recommendations. That the 2019-20 financial year's pay award has, at the time of writing, still not been implemented is similarly unacceptable. We expect pay awards to be made in a timely fashion following the submission of our reports, and this has unfortunately not been happening in Northern Ireland for some time. This in turn undermines the credibility of the pay determination process amongst the remit group and is likely to have a negative impact on morale.

1.58 Finally, we welcome that the Scottish Government showed flexibility in applying its public sector pay policy to the remit group in order to address our recommendations and comments.

Future evidence

1.59 Chapter 11 sets out areas where the data available to the review body could be improved or enhanced. Many of the data requests made this year are essentially re-iterations or elaborations of requests made in earlier reports. We also ask for data and evidence from the parties around the short- and long-term implications of the COVID-19 pandemic on the NHS and the workforce, so that we will be able to monitor its impact.

1.60 We are particularly concerned about the continuing differences in the picture of the state of dentistry as presented by the government/employer side, and by the BDA. We would urge the parties concerned, as we did in our previous report, to come together with a view to agreeing what data are needed in order to present an objective picture of the position in relation to dentistry. The trends in dentists' earnings are also a concern, and we would welcome an explanation for these trends, as well as a more detailed breakdown of dental earnings by working hours and by split between NHS/Health Service and private dentistry.

CHAPTER 2: WIDER CONTEXT

Introduction

2.1 In normal circumstances we would assess the latest and forecast economic indicators to inform our conclusions. However, as a result of the coronavirus (COVID-19) pandemic and the measures taken to address it, there is a very high degree of uncertainty over the future performance of the economy.

2.2 In this chapter, we firstly summarise the governments' responses to COVID-19 and then set out the latest economic and labour market indicators, as well as details of public sector pay policies and finances at the time of this report. Following that, we discuss the initial impacts that COVID-19 is having on our remit group.

COVID-19 and the governments' responses to it

2.3 In April 2020, HM Treasury wrote to us confirming that, in the context of COVID-19, it would not be submitting economic evidence to the Pay Review Bodies in the normal way. HM Treasury asked that, despite the level of uncertainty, the Pay Review Bodies should take note of the changing economic situation as it emerged in forming their recommendations.

2.4 HM Treasury pointed to the measures to support public services and the economy during COVID-19, including: support to the NHS and other public services through a £5 billion emergency response fund; the Job Retention Scheme to help firms continue to keep people in employment; the Self-Employed Income Support Scheme to support self-employed individuals; and welfare measures.

2.5 HM Treasury said that the UK was facing significant economic disruption, but it expected the underlying causes to pass. The actions the UK Government has taken, along with measures taken by the Bank of England, were intended to ensure that the effects did not have a permanent "scarring" effect on the economy. HM Treasury commented that public sector pay rises should be responsive to the wider economic backdrop, which influenced recruitment and retention needs, and the UK Government's wider fiscal position. It expected a weaker labour market to benefit public sector retention, and increase the pool of available candidates for employment, making it easier to hit recruitment targets in some cases. It was not yet clear how the key economic indicators would evolve and therefore HM Treasury asked that the Pay Review Bodies paid attention to unemployment, average weekly earnings in the private sector and inflation as the economic situation changed.

2.6 HM Treasury said that public finances were well placed to deal with the challenges posed by COVID-19 but the impact on the economy and the UK Government's necessary response would lead to a significant increase in borrowing this year compared to the Office for Budget Responsibility's (OBR) forecast. HM Treasury expected this spike in borrowing to be temporary and said that the medium-term impact on borrowing was likely to be limited. It added that the evidence on the affordability of pay awards set out in departmental evidence submissions remained its best current assessment of the position for public sector pay for 2020-21.

2.7 HM Treasury commented that public sector workers play a pivotal role in keeping the population healthy and safe, both during COVID-19 and in the future. It said that it was right that public sector workers benefitted from enhanced job security and stability, including at a time of economic uncertainty. It added that many also received other benefits, such as generous sick pay and flexible working arrangements. HM Treasury noted that inflation was 1.7 per cent in the year to February 2020, lower than forecast a year ago, which meant that the public sector pay awards in 2019-20 were substantive real terms pay increases. HM Treasury asked that Pay Review Bodies take these factors into account when forming recommendations and added that the UK Government's principles used to agree pay awards remained unchanged by the outbreak. These were that awards should be: led by public sector productivity improvements, particularly when considering real terms rises; and funded from within existing budgets, which were set out in departmental evidence submissions. HM Treasury also asked that the Pay Review Bodies continued to refer to the UK Government and departmental recruitment targets in making their recommendations, albeit that COVID-19 introduced some uncertainty over staffing supply and demand.

2.8 At the time of writing, the OBR and the Bank of England had both constructed scenarios to illustrate the effect of COVID-19 on the economy. The impact is centred on the second quarter of 2020, with expected contractions of 25 to 35 per cent in the size of the economy. Economic activity is expected to pick up from the third quarter of 2020, as lockdown restrictions are lifted. Overall, the OBR has modelled a contraction of 13 per cent in the size of the economy in 2020, with the Bank of England suggesting a contraction of 14 per cent. Under these scenarios, the economy regains its pre-recession size by the end of 2021.

2.9 The governments have announced a number of significant measures to support the economy and public services, including the NHS.

2.10 To help the economy, the UK Government has introduced temporary measures to support businesses, employees and the self-employed. These included a scheme to pay 80 per cent of the wages of furloughed workers and the self-employed, which was announced in March 2020, and at the time of writing was due to run until October 2020; increases to Universal Credit and housing benefit; business rates support and grants to small businesses; and additional spending on public services.

2.11 In the March 2020 Budget[1], the UK Government provided an emergency fund for the NHS and other public services to tackle the pressures on health and social care. The Budget also provided an additional £34 billion per year by 2023-24 as part of the NHS funding settlement, which was previously confirmed in the 2019 spending round. Following the budget, further financial measures were announced for the NHS, including that £13.4 billion of provider debt would be written off as part of a major financial reset for NHS providers[2].

[1] HM Treasury (March 2020), *Budget 2020.* Available at: https://www.gov.uk/government/publications/budget-2020-documents/budget-2020

[2] Department of Health and Social Care (April 2020), *Press release.* Available at: https://www.gov.uk/government/news/nhs-to-benefit-from-13-4-billion-debt-write-off

2.12 The UK Government subsequently put in place mechanisms to expand the health and social care workforce. The UK Government announced[3] that NHS staff would have their visas extended beyond October 2020. To combat COVID-19, around 2,800 doctors, nurses and paramedics would automatically have their visas extended, free of charge, for one year, where their visa was due to expire before 1 October. The extension would apply to their family members. In May 2020, the UK Government announced that health and social care workers would also be exempted from the Immigration Health Surcharge. The Home Office also lifted the restriction on the amount of hours international student nurses and doctors could work in the NHS. As well as this, final year medical students graduated early so that they could join the workforce, and thousands of retired NHS staff temporarily returned to the workforce to help deal with service pressures.

2.13 In April 2020, as a result of COVID-19, the Health Secretary announced a new life assurance scheme[4] for frontline NHS workers in England. Families of eligible workers who died from COVID-19 in the course of their frontline work would receive a £60,000 payment. The scheme covered staff that provided hands-on personal care for people who had contracted COVID-19 or worked in health or care settings where the virus was present. Those eligible were full, part-time or locum NHS and public health workers, including general medical practitioners, dentists and retired staff who had temporarily returned to the workforce. Funding was also provided to the Devolved Administrations to support similar schemes in Scotland, Wales and Northern Ireland.

2.14 On 31 March 2020, the Northern Ireland Finance Minister made a budget statement for 2020-21, influenced by COVID-19. The statement included that the health budget was £6.16 billion, an increase of 6.9 per cent from the baseline, compared with an overall increase in departmental allocations of 8.1 per cent.

The economy and the labour market

2.15 Each year we consider our recommendations in the context of the current and expected economic climate. As a result of COVID-19, and the measures taken to address it, we can expect a sharp and deep economic contraction. There is a very high degree of uncertainty over the eventual impact on the economy.

Economic growth

2.16 In 2019 as a whole, UK gross domestic product grew by 1.4 per cent, in line with EU and G7 averages. Gross domestic product was estimated to have fallen by 10.4 per cent in the three months to April 2020, compared with the previous three months, with a 20.4 per cent fall in output in April 2020 alone, with widespread monthly declines in output across the services, production and construction industries.

Inflation

2.17 Inflation has been on a broad downward path through 2018 and 2019. The latest inflation figures, for April 2020, showed increases in CPI at 0.8 per cent, CPIH at 0.9 per cent, and RPI at 1.5 per cent, each over 12 months. Inflation is expected to fall further this year, with the Bank of England predicting that CPI inflation will fall to zero at the end of 2020.

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[3] Home Office (31 March 2020), *NHS frontline workers visas extended so they can focus on fighting coronavirus*. Available at: https://www.gov.uk/government/news/nhs-frontline-workers-visas-extended-so-they-can-focus-on-fighting-coronavirus

[4] Department of Health and Social Care (27 April 2020), *New guarantee on death in service benefits for frontline health and care staff during pandemic.* Available at: https://www.gov.uk/government/news/new-guarantee-on-death-in-service-benefits-for-frontline-health-and-care-staff-during-pandemic

Employment and the labour market

2.18 The latest official statistics in the labour market showed that employment rose by 448,000 (1.4 per cent) over the year to March 2020, and by 211,000 over the three months to March 2020, to reach 33.14 million. The employment rate was at 76.6 per cent in the three months to March 2020, up 0.6 percentage points over the year.

2.19 The level of unemployment (ie those looking for and available for work), rose by 58,000 in the three months to March 2020, and by 50,000 over the year, to 1.35 million. This gave an unemployment rate of 3.9 per cent in March, up from 3.8 per cent at the end of 2019.

2.20 However, short-term indicators suggest that the labour market took a sharp downturn at the end of March. Average weekly hours of work fell from 31.6 to 24.8 in the last two weeks of March. The number of people claiming unemployment-related benefits increased by 856,000 between March and April 2020. Her Majesty's Revenue and Customs indicated in mid-May that eight million workers were covered by the UK Government's Coronavirus Job Retention Scheme, which pays 80 per cent of wages up to £2,500 per month. The Bank of England expects the unemployment rate to rise from 3.9 per cent in the first quarter of 2020 to nine per cent in the second.

Earnings growth

2.21 Average weekly earnings growth has fallen back, from a peak of around 4.0 per cent at the mid-point of 2019, to 2.4 per cent in the three months to March 2020. There was a difference in growth between the private sector, at 2.2 per cent, and the public sector (excluding financial services), at 3.4 per cent. Early HMRC/Office for National Statistics (ONS) estimates[5] for April 2020 suggest that median monthly pay was 0.9 per cent lower than a year earlier.

2.22 Median pay settlements were at 2.4 to 2.5 per cent in the three months to March 2020. However, forecasting future earnings growth is difficult, especially given the number of furloughed workers. Surveys indicate that many employers may postpone decisions on pay awards. Some employers with front-line workers, especially in the retail sector, have paid temporary pay increases, while other companies have cut executive pay during the shutdown to reduce costs.

2.23 The DDRB pays particular attention to the movements of earnings at the upper end of the wage distribution, which includes the more highly paid members of our remit group. According to the Annual Survey of Hours and Earnings (ASHE), earnings growth at the top end of the distribution was marginally weaker than in the middle of 2019. Earnings growth for full-time employees across the economy as a whole was 2.7 per cent at the median, 2.4 per cent at the 90th percentile, 2.5 per cent at the 95th percentile, 1.5 per cent at the 97th percentile and 2.7 per cent at the 98th percentile. Early HMRC/ONS estimates for March 2020 suggest that pay growth for those at the 90th percentile and above was lower than for those elsewhere in the distribution.

[5] Office for National Statistics (16 June 2020), *Earnings and employment from Pay As You Earn Real Time Information, UK: May 2020*. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/earningsandemploymentfrompayasyouearnrealtimeinformationuk/may2020

Public sector pay policies and finances

2.24 The Department of Health and Social Care said that the UK Government aims to ensure that the overall remuneration package for public sector workers is fair to them and that world class public services that are affordable within the public finances and fair to taxpayers as a whole can be delivered. They asked us to make our recommendations within an envelope of £310 million for Hospital and Community Health Services medical and dental staff (of which £120 million covers the 2020-21 element of the pay and reform deal agreed for doctors and dentists in training), and within an envelope of £37 million for general dental practitioners.

2.25 The Scottish Public Sector Pay Policy includes a guaranteed three per cent increase for public sector workers earning less than £80,000 and a maximum basic pay award of £2,000 for those earning more than £80,000. It also includes flexibility for employers to add up to 0.5 per cent of pay-bill savings on baseline salaries for addressing clearly evidenced equality issues in existing pay and grading structures.

2.26 The Welsh and Northern Irish governments did not provide us with details of any public sector pay policies for 2020-21.

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

2.27 Prior to the COVID-19 outbreak, early in 2020 the economic indicators were mixed. Economic growth, at 1.4 per cent for 2019 as a whole, with zero growth in the final quarter of the year, was sluggish. There was also uncertainty about the impact of our exit from the EU on our trade with the EU and the rest of the world, as well as on immigration to the UK. However, employment growth remained strong and price inflation had been on a downward trend through 2018 and 2019. Average earnings growth had picked up through 2018 and the first half of 2019, peaking at 4.0 per cent in June 2019, before falling back since the final quarter of 2019.

2.28 At the time of writing, there was uncertainty over the length and depth of the economic downturn and the nature of the recovery in the UK and the rest of the world. It was unclear what the long-term economic effects will be, though it was clear that the economy and public finances would suffer a large shock as a result of COVID-19[6].

2.29 In response to the impact of COVID-19 and the governments' responses on the economy, employers have used a range of strategies, including: reduced working hours; reduced staffing levels; temporary layoffs of staff; and staff working from home.

2.30 There have also been temporary pay uplifts announced by employers in some areas of the private sector, especially the major food retailers.

2.31 There have also been some effects on executive pay[7], with 37 per cent of FTSE 100 companies cutting executive pay. A third of FTSE 100 companies had withdrawn or withheld dividend payments.

2.32 There is uncertainty over the length and depth of any economic downturn and this could have implications for government finances and affordability of pay awards in future years.

2.33 The impact on the labour market could be volatile for some time to come and may impact the public and private sectors in different ways. The public sector offers more security of employment than the private sector, though those working in frontline services and support roles might be more pressurised or at risk.

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[6] Office for Budget Responsibility (22 May 2020), *Commentary on Public Sector Finances: April 2020*. Available at: https://obr.uk/download/commentary-public-sector-finances-april-2020/

[7] High Pay Centre (2020), *Corporate Response to the Economic Shutdown.* Available at: http://highpaycentre.org/pubs/high-pay-centre-briefing-corporate-response-to-the-economic-shutdown

2.34 Key workers in the private sector have also experienced increased work pressures and risk and some have been given temporary pay increases. However, significant numbers of private sector employees have been furloughed and face uncertainty about their future pay and employment prospects.

Impact of COVID-19 on the medical and dental workforce

2.35 As we discuss earlier, at the time of writing, the major disruption to the economy and health services as a result of COVID-19 and the government response to it is ongoing. Therefore, the overall impact of it on the medical and dental workforce is not yet known, though we are able to present some initial considerations of its impact. Some of the parties also contacted us presenting their perspectives.

2.36 COVID-19 has placed extraordinary demands on the medical and dental workforce. Many of our remit group will have worked in unfamiliar environments and in unfamiliar ways and we are highly sensitive to the fact that some have been made seriously ill and have lost their lives caring for patients during the pandemic. COVID-19 clearly serves as a reminder of the critical importance of the doctors and dentists in our remit group to society, across both primary and secondary care.

Recruitment, retention and motivation

2.37 The workforce's morale and motivation is very likely to be impacted, both by the widespread displays of public support and appreciation on the one hand, but also by the experiences that clinicians will have been exposed to in delivering health services. Many doctors will have experienced increased stress, trauma and fatigue as a result of COVID-19, and this may be exacerbated by the continuing need to reduce waiting lists and clear treatment backlogs in the medium term. These impacts will not be uniform across the workforce and will vary significantly by specialty, grade and geography.

2.38 These changes may precipitate behavioural changes across the workforce. Priorities may shift, and therefore clinicians may make different career decisions: potential applicants to study medicine at university may feel encouraged or discouraged; doctors' training choices may be affected; and more senior doctors may retire early or reduce their workloads ahead of retirement. Rates of international recruitment may also change, both in the short-term, due to the global nature of COVID-19, but also in the longer-term as priorities shift and other governments and health systems respond. They also have the potential to interact with changes brought about by the UK's exit from the EU.

Service and workforce demand

2.39 COVID-19 has had a direct impact on overall demand for healthcare services, as well as which parts of health services are utilised, how, and when. The rapid expansion in both supply of and demand for ventilator and intensive care capacity was a well-documented part of the government response, as was the need to expand testing capacity. This also led to governments calling on retired clinicians, and others working outside of health services, to return to the NHS workforce in order to provide additional capacity during the height of the outbreak. It has also meant that parts of the medical workforce have had to work flexibly and in unfamiliar settings and specialties.

2.40 In addition to this, many elective medical and dental operations and procedures were cancelled or postponed across the UK. This will lead to significant backlogs and has also led to concerns about referral rates for cancer and other diseases. Altogether these, along with any potential second spike in virus cases, may lead to changes in the composition of services, including in how overall service demand is distributed across specialties and different parts of health services in the short-, medium-, and long-term.

Managing health services

2.41 There may also be a significant impact on finances and in both the strategic and short-term decision making of those that manage health services. While the UK Government has cancelled all £13.4 billion of NHS provider debt in England, and in his Budget Speech the Chancellor said that "whatever extra resources our NHS needs to cope with coronavirus – it will get"[8], financial management of health services is likely to remain a challenge through this period and beyond.

2.42 Dentists have faced a unique set of challenges. Practices have had to cope with major restrictions on what treatments they can offer. For example, all routine dental care in England was suspended between 25 March and 8 June, with many practices closing entirely. While some financial support from NHS organisations has been available to contract holders across the UK, practices and associates have faced uncertainty as to their ability to practice and their NHS and private incomes. This disruption to dental practice may affect the way that services are provided in the future, as well as dental incomes and oral health amongst the wider population.

2.43 COVID-19 may also lead to changes in the way health services are delivered in the future. There have already been reports of rapid technological transformation in the delivery of services and we hope that any potential opportunities to improve health services in the longer term are taken, including in implementing some of the recommendations of the Topol review[9]. COVID-19 has also had an impact on the social care system which in turn may impact on the way that the health and social care systems work together in the future.

2.44 There may also be an impact on the pace and final outcomes of other, longer-term changes. These include contract reform negotiations and reforms to local Clinical Excellence Awards in England, which have now been delayed to 2022. Similarly, significant strategic decision making for health services, including workforce planning such as through the NHS People Plan, will have been affected.

Our comments

2.45 The evidence we received this year was submitted before the full extent of COVID-19 was clear, and so at the time of writing we are not in a position to fully understand, nor to comment authoritatively in detail on, its impact on the remit group. However, it highlights the continuing need for sufficient numbers to want to both join and remain in these professions.

2.46 In future years, we will look to receive data from the parties in evidence about the short- and long-term implications of the COVID-19 pandemic and the response to it for the NHS and its workforce, so that we will be able to monitor how recruitment, retention and motivation has been impacted.

[8] HM Treasury and The Rt Hon Rishi Sunak MP (11 March 2020), *Budget Speech 2020.* Available at: https://www.gov.uk/government/speeches/budget-speech-2020

[9] Health Education England (2019), *The Topol Review: Preparing the healthcare workforce to deliver the digital future.* Available at: https://topol.hee.nhs.uk/

CHAPTER 3: AFFORDABILITY, PRODUCTIVITY AND WORKFORCE PLANNING

Introduction

3.1 This chapter addresses the plans that the different governments and NHS organisations have for their medical and dental workforces, given the opportunities and constraints they face due to their departmental expenditure limits and other funding decisions.

Plans for the NHS

England

3.2 The *NHS Long Term Plan* (LTP), which covers England[1], was published by NHS England/ Improvement (NHSE/I) in January 2019 following the 2018 announcement by the UK Government on increased NHS funding for the next five years, amounting to real-terms increases of 3.4 per cent per annum on average. The LTP stemmed from concern around funding, staffing, increasing inequalities, and pressure from a growing and ageing population. It stated that the redesign of patient care must be accelerated to future-proof the NHS for the decade ahead.

3.3 The LTP outlines how the NHS in England plans to transform itself over the ten years from 2018. It sets out a new service model that includes an increased focus on prevention and community and primary care, as well as improving the use of technology and addressing health inequalities.

3.4 The LTP also included a number of actions associated with the NHS workforce, committing to growing both the nursing and medical workforces, as well as improving retention, productivity and leadership. This included a commitment to publish a comprehensive workforce implementation plan by the end of 2019. An interim People Plan was published in June 2019 to cover immediate actions to be taken during the 2019-20 financial year, ahead of the publication of the full NHS People Plan. At the time of writing, the NHS People Plan had not yet been published.

3.5 The interim People Plan said that it proposed a focused set of immediate actions, some of which are intended to make a difference in 2019-20, and others that are intended to lay the groundwork for improved recruitment and retention across the NHS in future years. It is structured into five themes:

- *Making the NHS the best place to work* – this includes improving staff engagement and experience and tackling bullying and harassment
- *Improving our leadership culture* – addressing how they intend to develop and spread a positive, inclusive, person-centred leadership culture across the NHS
- *Addressing urgent workforce shortages in nursing* – including improving retention and significantly increasing the number of newly qualified nurses joining the NHS
- *Delivering 21st century care* – transforming the workforce into one that is more flexible and adaptive, with a different skill mix, in order to deliver the LTP vision and keep pace with advances in science and technology. This includes developing new roles and changing existing roles, and increasing multidisciplinary team working
- *A new operating model for workforce* – ensuring that workforce activities are undertaken at the optimal level – whether national, regional, system or organisational, beginning to set out what functions can be carried out at which levels, including integrated care systems

[1] NHS England (January 2019), *The NHS Long Term Plan*. Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

3.6 The Department of Health and Social Care (DHSC) said that the full NHS People Plan will set out a clear framework for collective action on workforce priorities over the next five years, and a fuller range of specific targeted actions to address shared challenges. This includes a new core offer for NHS staff, to improve staff experience; setting out how the workforce can be redesigned to better reflect patient needs and models of care, contribute to better outcomes, deliver more rewarding careers for those who work in the NHS, and more sustainable patterns of workforce growth; and how a new operating model for workforce will be implemented.

3.7 NHSE/I said that the People Plan would also set out actions to address growing workload pressures felt by all staff groups and address cultures of bullying and harassment in the workplace to create an inclusive and compassionate workforce. They also said that work was already underway to address the critical workforce supply challenge, including for the medical workforce, by:

- Establishing new medical schools and 1,500 additional medical undergraduate student places per year
- Increasing general practice training intake to 3,500
- Boosting international recruitment
- Reforming medical careers to make them more flexible, improve retention and reduce rates of attrition through training

3.8 NHS Providers said that they were aware of the need for investment attached to the NHS People Plan proposals but were optimistic that a strong framework would be put in place to improve the experience of people working in the NHS over time. NHS Employers said that the Plan would contain a number of actions to grow the workforce, including through increasing international recruitment in the short- and medium-term and, in the longer term, through improving staff retention and domestic supply.

Scotland

3.9 In December 2019, the Scottish Government published the National Health and Social Care Integrated Workforce Plan, which was developed in partnership with the Convention of Scottish Local Authorities, and sets out how health and social care services will meet growing demand and ensure the right numbers of staff, with the right skills, across health and social care services. This was accompanied by updated guidance on workforce planning for all health and social care organisations across Scotland, including NHS Boards.

Wales

3.10 In December 2019, Health Education and Improvement Wales, along with Social Care Wales, submitted its final draft of *A Healthier Wales: A Workforce Strategy for Health and Social Care* to the Welsh Government. The document is intended to support the delivery of the more seamless models of health and care proposed in *A Healthier Wales*: *Our Plan for Health and Social Care*, which was published in 2018. Included in the Strategy is a commitment to develop workforce plans for key professional and occupational groups, including medicine.

Northern Ireland

3.11 The Department of Health told us that implementation of *Health and Social Care Workforce Strategy 2026* was well under way, and that a Programme Board and Reference Group had been established with progress being made across all themes of the strategy.

Our comments on NHS plans

3.12 We note that workforce strategies are at different stages of development in the four nations. While at the time of writing the NHS People Plan for England has not yet been published, and *A Healthier Wales: A Workforce Strategy for Health and Social Care* has yet to be formally published by the Welsh Government, final workforce strategies have been published for both Scotland and Northern Ireland. The coronavirus (COVID-19) pandemic could have an impact on the dynamics of recruitment and retention within our remit group, and the wider NHS. We therefore recognise that service leaders may choose to review their workforce plans. Demand for services, and the way they are delivered, is also likely to be affected, which will in turn impact workforce requirements.

3.13 Improving domestic workforce supply and retention are both necessary to address workforce shortages in the long-term. Workforce planning should also continue to respond to developments, including the increasing demand for flexible training and working. In this light, we welcome the five themes of the interim NHS People Plan for England, and we anticipate the publication of the full NHS People Plan later this year.

Affordability and productivity

Concepts of affordability, productivity and efficiency

3.14 Discussions of NHS plans often make reference to 'productivity', 'efficiency' and 'affordability'. In what follows, we use the term 'productivity' by itself to refer to output per head, not total factor productivity (which measures output for given inputs of all kinds, not just labour inputs). Although productivity is not straightforward to quantify for the NHS, DHSC uses a measure developed by the University of York based on health output adjusted for quality change, death rates and changes in waiting times for England. Because staff have a mix of different skills, it will not necessarily rise if fewer staff are used to deliver the same quality and quantity of outputs. But for a given mix of staff skills, a reduction in overall staff numbers will result in a rise in productivity. Productivity can also be increased through capital investment, new working arrangements and new technologies.

3.15 Governments are also concerned about the cash cost of delivering services. 'Cash-releasing' efficiencies arise from reducing the cost of delivering a given quantity and quality of services. This was the focus of Lord Carter's 2015 review of efficiency in hospitals[2], which looked at the 136 acute Trusts in England and concluded that £5 billion of savings could be made if 'unwarranted variation' was removed.

3.16 For the economy as a whole, output-per-head productivity is the key determinant of average living standards. But for any sector, the 'affordability' of a pay settlement is also driven by other factors affecting the demand and supply for its output. In the case of public health services, the level of services is limited by politically determined budgets and the costs of inputs as well as by productivity. Within a given budget, technologies, efficiencies, and staff mix, there is then a trade-off between real pay and overall employment: higher pay is affordable with lower staff numbers and higher output-per-head productivity.

3.17 That said, it is possible that pay policies intended to lower costs can result in a less effective or efficient staff mix. For example, if retention is worsened as a result of lower pay and employers become more reliant on more expensive agency work as a result, the budgetary benefit of lower pay can be undermined.

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[2] Department of Health (5 February 2016), *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, An independent report for the Department of Health by Lord Carter of Coles*. Available at: https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

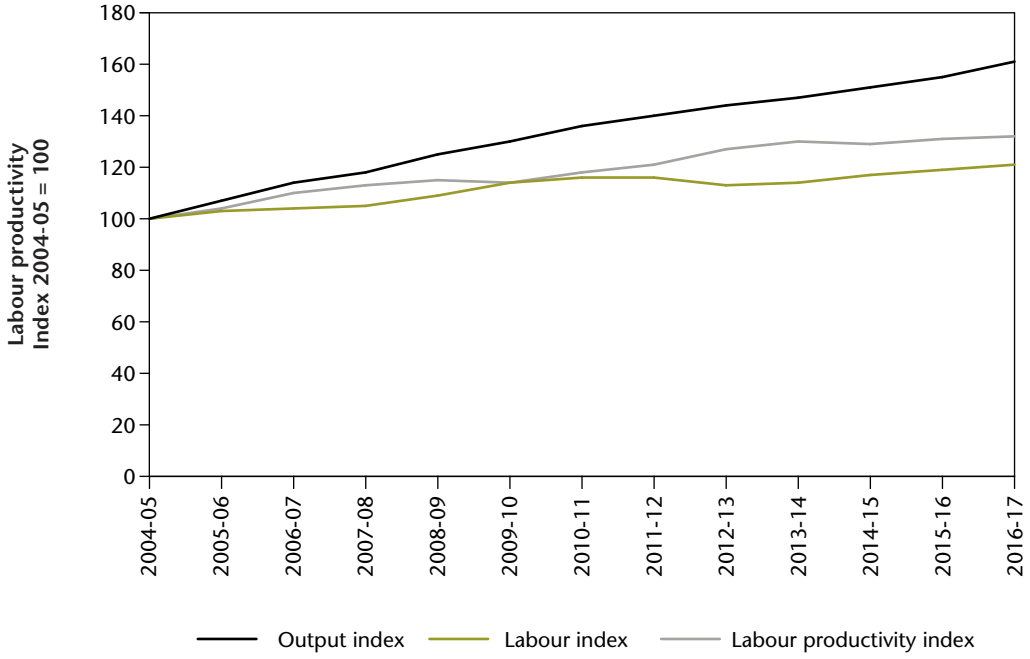
England

3.18 For England, the reported figures for the NHS show quality-adjusted output rising by around 2.7 per cent per annum over the five years to 2016-17. Labour productivity growth is more variable, but rose by 1.8 per cent per annum on average over the same five years.

3.19 Data provided by DHSC, in Figure 3.1, showed that between 2004-05 and 2016-17 NHS outputs in England had grown by 61 per cent while the volume of labour input, taking into account all those employed by the NHS, had grown by 21 per cent. This suggests average annual growth in output-per-head productivity of 2.4 per cent per annum. By way of comparison, between 2004-05 and 2016-17, output per worker across the economy as a whole grew by just eight per cent in total[3].

3.20 Figure 3.2 shows a broader measure of productivity (total factor productivity), also developed by the University of York. This considers output growth, but also takes into account the growth of all the inputs into the NHS, including the composition of the workforce, and derives overall total factor productivity growth of 1.3 per cent per year between 2004-05 and 2016-17.

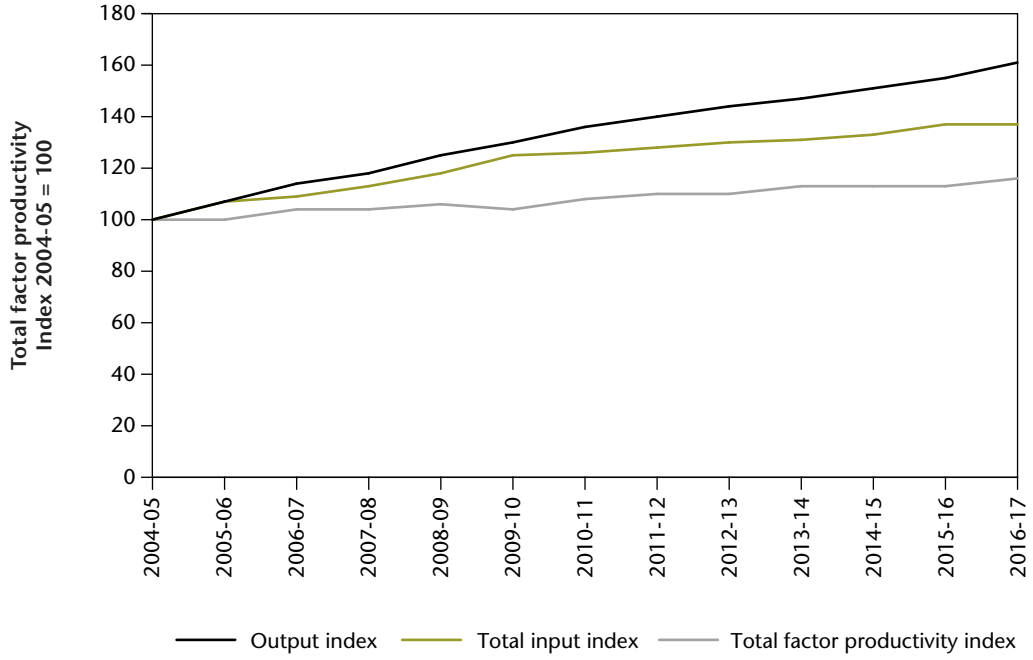
Figure 3.1: Output-per-head productivity in the NHS, England, 2004-05 to 2016-17



Source: DHSC.

[3] ONS identifier A4YM – Output per worker.

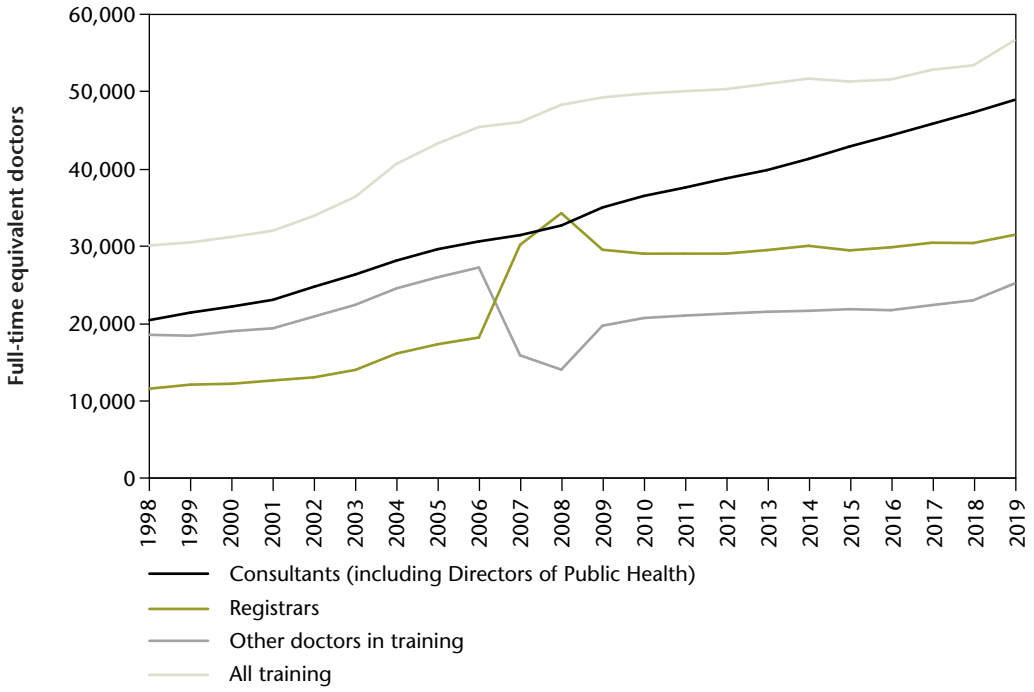
Figure 3.2: Total factor productivity in the NHS, England, 2004-05 to 2016-17



Source: DHSC.

3.21 Figure 3.3 shows the numbers of Hospital and Community Health Service (HCHS) doctors in England between 1998 and 2019. The number of doctors in training (including F1, F2 and Registrars) rose by 60 per cent between 1998 and 2008 and by 17 per cent between 2008 and 2019. This represents a growth rate of three per cent per annum over the period as a whole. Consultant numbers also rose by 60 per cent between 1998 and 2008 and by a further 50 per cent between 2008 and 2019, representing a growth rate of more than four per cent per annum over the period as a whole. This growth, outpacing the growth in output and in employment in the NHS overall, reflects the shift in emphasis from a consultant-led service towards a more consultant-provided service over recent decades.

Figure 3.3: Hospital and Community Health Service (HCHS) medical workforce, England, 1998-2019



Source: NHS Digital.

3.22 NHSE/I told us that providers will need to deliver at least 1.1 per cent cash-releasing productivity growth per year over the course of the LTP, adding that these improvements had taken place against a backdrop of increased activity and patient care. DHSC added that demand for services continued to rise above what would typically be expected from population growth and demographics alone, with emergency admissions increasing by 5.9 per cent between 2017-18 and 2018-19 and referral-to-treatment pathways completed per working day by 2.0 per cent in the same period.

3.23 NHS Employers said that the additional funding announced as part of the funding settlement would allow for activity growth of 2.3 per cent per year, which they said contrasted with the Health Foundation's projection that hospital activity would need to increase by 2.7 per cent per year to meet demand, without any improvement in the quality and range of services.

3.24 DHSC requested that our recommendations are made within an envelope of £310 million for substantive HCHS staff, of which £120 million will be used for the 2020-21 pay elements of the pay and reform deal agreed for doctors and dentists in training. This envelope would allow for a pay increase of two per cent for all HCHS staff in our remit. The equivalent figure for general dental practitioners, £37 million, would similarly allow for a pay increase of two per cent.

Scotland

3.25 The Scottish Government said that the 2020-21 Draft Scottish Budget increases investment in health and care budgets by over £1 billion, and is over £15 billion for the first time. They said that this was more than £100 million above the Barnett formula consequentials of the funding increase for England. They said that NHS Boards, like every public body in Scotland, are expected to deliver efficiency savings of at least three per cent during 2020-21, and that their operating plans suggest that savings are expected to exceed this level, with all efficiency savings available to be reinvested in the body that generates the saving.

Wales

3.26 The Welsh Government said that the Health Foundation report *The Path to Sustainability* indicated that funding would need to rise by 2.2 per cent in real terms, and efficiency by one per cent annually to ensure that cost and demand growth can be managed over the medium term. They added that demand pressures continued to grow, with emergency admissions growing year on year since 2012-13, and that they would continue to examine all the options available to ensure that the service is capable of meeting the demands placed on it with the ongoing reality of continued public austerity and the financial challenges that lay ahead.

3.27 The Welsh Government told us that NHS organisations already had funding for a one per cent increase for doctors and dentists in their allocations for 2020-21, and more money could potentially be available to fund a larger award.

Northern Ireland

3.28 The Department of Health did not present us with any affordability envelopes or proposals in evidence. The Department of Health's non-ringfenced resource budget for 2020-21 was £6.16 billion, an increase of 8.0 per cent on 2019-20.

Our comments on affordability and productivity

3.29 In the NHS context, measures of productivity are complicated by the difficulties in defining outcomes. In particular, improving the quality of outputs and reducing the costs of delivering outputs can be considered increasing productivity. In the context of outcomes that are intangible, difficult to measure and potentially impacted by a wide number of factors, productivity can be particularly difficult to measure.

3.30 We note the multidisciplinary approach being taken to workforce planning across the UK in both primary and secondary care. By diversifying the staff mix and ensuring that more staff spend more of their time working 'at the top of their licence', this is likely to improve productivity. Therefore, it is important that workforce planning anticipates the changed demand for various roles. Similarly, a reinvigorated SAS contract, with improved opportunities for development and improved recognition, could improve the staff mix in hospital trusts, and thereby improve productivity.

3.31 While we note the cancellation of £13.4 billion of historical provider debt in England, financial sustainability remains a critical challenge, and we are aware of the need for further measures to improve efficiency across health services.

3.32 We have again been asked by DHSC to consider the affordability of our recommendations and the impact that they have on productivity. We also note that, like last year, we received no evidence that explicitly tied pay recommendations to productivity improvements. We agree with this – greater productivity is delivered through multidisciplinary team working, and doctors and dentists cannot work effectively in their roles leading the delivery of clinical care without the assistance of their supporting teams. We therefore are not in a position to assess the productivity of any one group of staff. Given this, attempting to measure productivity of doctors or dentists in isolation is also unlikely to help motivate any of the individuals involved or help to identify service improvements.

Spending on locums, agency and bank staff

England

3.33 NHSE/I told us that progress had been made in controlling agency spend in recent years, and further measures were planned. They said that by September 2019, total[4] agency spend as a proportion of total pay bill had fallen from its 2015 peak of 8.2 per cent to 4.4 per cent. The total medical agency spend in 2018-19 was £938 million and the spend on agency medical locums in the first six months of 2019-20 was £468 million, £8.8 million less than a year earlier. They also said that NHS staff banks are a more cost-effective way of providing temporary staff than using agencies, and the percentage of temporary staffing spend through banks had increased three percentage points to 61 per cent in the year to October 2019.

3.34 DHSC said that total NHS Trust spending on agency staff rose by 40 per cent between 2013-14 and 2015-16 (£2.6 billion to £3.7 billion). Following the introduction of agency spend controls, expenditure on agency staffing had reduced to £2.4 billion in 2018-19. There was wide variation between regions. Between 2017-18 and 2018-19 there were sharp falls in agency spend in the North East and Yorkshire (8.8 per cent) and London (8.5 per cent) but increases in the Midlands (6.9 per cent) and the South West (4.3 per cent).

Scotland

3.35 Data from NHS Education for Scotland showed that medical agency locum spend was £98.0 million in 2018-19. After increasing sharply in both 2015-16 and 2016-17, agency spend has fallen in each of the last two years, by nine per cent in 2017-18 and two per cent in 2018-19. The Scottish Government said that this reduction had taken place as a result of ongoing long-term actions. These include expanding the NHS Medical Staff Bank, implementing bank pay rates equivalent to double time for hospital doctors, and ensuring that agency staff are used only as a last resort.

Wales

3.36 The Welsh Government said that in response to increases in temporary staffing spend between 2013 and 2016, they set up a new national control framework in collaboration with NHS Wales organisations. They also said that after a Welsh Audit Office report into medical agency staff spend, they were undertaking a series of actions to improve data collection, deploy the workforce more efficiently and improve workforce planning, in order to reduce expenditure.

3.37 Agency spending on medical and dental staff was £54.6 million in 2018-19. After increasing sharply in both 2015-16 and 2016-17, agency spend has fallen in each of the last two years, by 22 per cent in 2017-18 and nine per cent in 2018-19.

[4] This figure also includes non-medical agency spend, including nurses.

Northern Ireland

3.38 Data from the Department of Health showed agency spend in 2018-19, on medical and dental staff, of £86.7 million. This was an increase, of 18 per cent, from £73.5 million in 2017-18. The Department said that increasing costs were the result of a number of factors, including increased demand, vacancy rates in medical training positions, and wider recruitment and retention difficulties.

Our comments on spending on locums, agency and bank staff

3.39 Across the UK as a whole, medical agency spend was £1.18 billion in 2018-19. This represents a fall of 0.6 per cent from the previous year. Agency spend reduced in England, Scotland and Wales, but continued to grow sharply in Northern Ireland. We welcome the falls in agency spend, in particular in Wales where medical and dental locum spend has fallen by almost a third over the last two years, and we hope that best practice can be shared between employers and across the UK. However, the situation in Northern Ireland is of significant concern – its agency spend is significantly higher in proportion to the other three nations and rising.

3.40 We note the progress being made with staff banks, which represent a more cost-effective way than using agencies to manage temporary staffing issues. At the same time, we continue to believe that more may be done across the UK both to increase the proportion of temporary staffing which is supplied through banks and also to decrease the dependency on temporary staffing.

CHAPTER 4: PAY, MOTIVATION AND WORKFORCE SUPPLY

Introduction

4.1 In this chapter, we consider how doctors' and dentists' pay has changed over time in England (equivalent data are not available for the other countries in the UK). We also consider how doctors' and dentists' pay compares with the distribution of pay across the whole UK economy, and how it compares to the private sector and to comparator groups. Whilst examining these trends is not an explicit part of our remit, it is important to monitor them because they can have an impact on recruitment, retention and motivation. We comment on workforce motivation and make some brief comments on the consequences for workforce supply of retirement trends and outflows and inflows of international doctors and dentists.

The pay position

4.2 In this section, we compare the earnings of doctors and dentists to various points on the overall UK income distribution, before comparing earnings with a number of comparator professions in the next section, Pay Comparability.

4.3 Table 4.1 and Figures 4.1 to 4.12 show how the average (mean) total earnings of various staff groups compare to the median, upper quartile, 90th, 95th, 97th and 98th percentiles of full-time equivalent (FTE) earnings in the wider economy, since 2010-11, based on data from the Annual Survey of Hours and Earnings (ASHE).

4.4 Until our 2018 report, the calculations for Hospital and Community Health Service (HCHS) staff were based on the NHS Digital mean annual basic pay per FTE, added to the mean annual non-basic pay per head. However, in 2019 we also used a second estimate, which adjusted the non-basic pay per head data by a factor that reflected the ratio between FTE and headcount estimates of basic pay before adding to the FTE estimate of basic pay. In our 2019 report we said that we believed this second estimate was a more appropriate comparator to the ASHE data, which is based on the total earnings of full-time employees. A new earnings estimate for general medical practitioners (GMPs) was also introduced, which adjusted the data published by NHS Digital on a headcount basis by a factor that reflected the ratio of the number of GMPs on a headcount basis to the number of GMPs on an FTE basis. The calculations in this section are based on the adjusted earnings estimates introduced in 2019, unless stated otherwise. Earnings estimates for general dental practitioners (GDPs) are still on a headcount only basis and take no account of hours worked.

4.5 Table 4.1 shows the percentile position of adjusted mean total earnings for various staff groups compared with the national full-time earnings distribution[1], from 2010-11 to 2018-19, as set out by ASHE. For example, for consultants in 2010-11, their average total earnings fell between the 98th-99th percentiles of annual earnings for full-time employees in the wider economy, so is listed as 99.

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

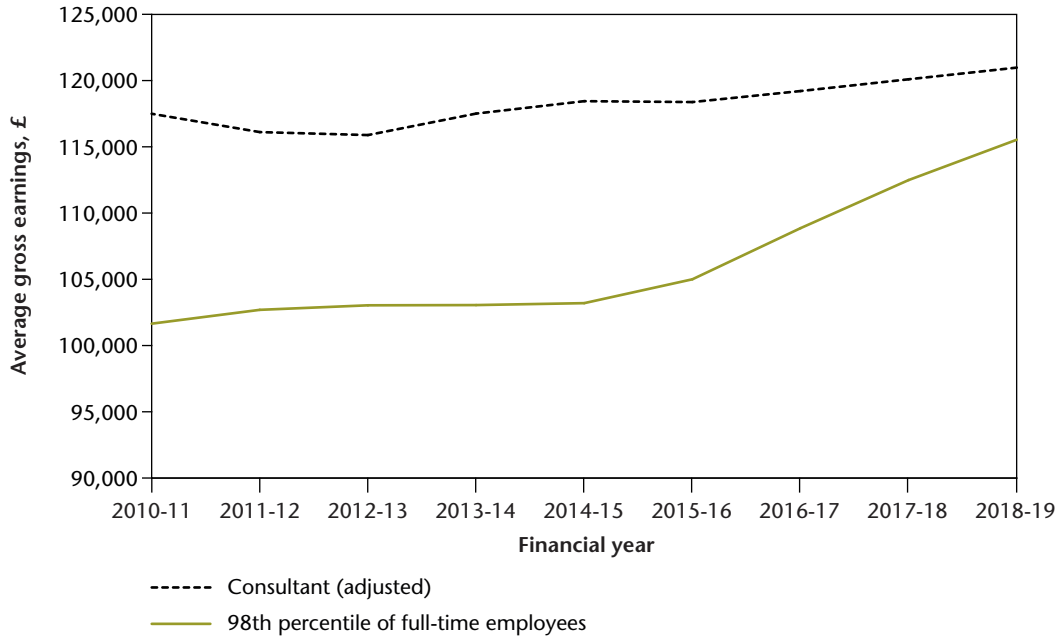
Table 4.1: Percentile Position of doctors' and dentists' average earnings in England by grade, 2010-11 to 2018-19

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Change from 10-11
Consultants	99	99	99	99	99	99	99	99	99	0
Associate specialist	98	98	98	98	98	98	98	98	98	0
Specialty doctor	96	95	95	96	96	95	95	95	95	-1
Registrars	93	92	92	92	92	91	91	91	91	-2
Core training	88	88	87	87	87	86	86	86	86	-2
Foundation 1	66	65	64	64	64	63	63	63	61	-5
Foundation 2	80	79	78	78	78	76	76	75	74	-6
	2010-11	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**Change from 10-11**
GMP provider	99	99	99	99	99	99	99	99	-	0
GMP salaried	97	97	97	97	97	97	97	97	-	0
GDP providing-performer*	99	99	99	99	99	99	99	99	-	0
GDP-associates	94	94	93	93	92	92	92	91	-	-3

Source: OME analysis of data from NHS Digital and ONS.
*GDP earnings calculated on a headcount basis, and take no account of hours worked.

4.6 Figure 4.1 shows that for consultants, since 2010-11, average total earnings have been consistently above the 98th percentile of FTE earnings in the wider economy, although the gap has narrowed since 2015-16. Some part of this change will reflect the fact that the size of the consultant workforce has grown consistently over the recent past. As a result of recruitment at more junior levels exceeding outflow from more senior levels, this will have led to a larger share of the workforce being paid towards the lower end of the consultant pay scale, depressing the average earnings figures.

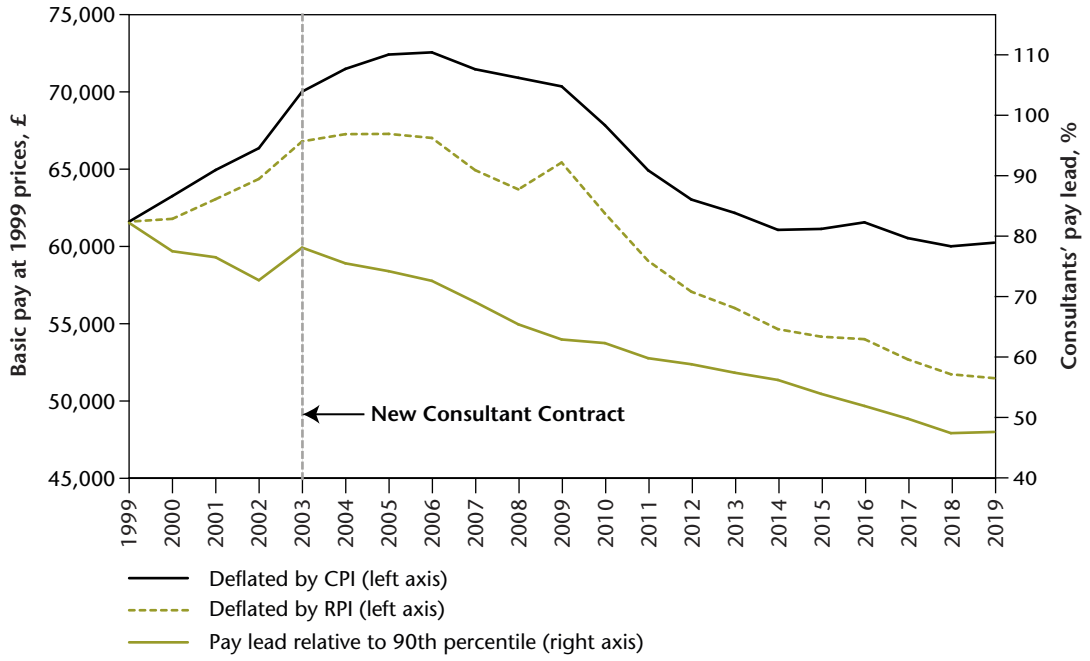
Figure 4.1: Average gross NHS earnings of consultants in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



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

4.7 Looking at the value of the 5th point on the consultants pay scale is helpful, as it is not affected by the changing composition of the consultant workforce, but relates only to basic pay. Compared with CPI inflation, the value of this pay point increased between 1999 and 2006 and then decreased until 2014, where it reached roughly the same value as in 1999, and in 2019 was two per cent below its 1999 value and 15 per cent below the level in 2008 (Figure 4.2). By contrast real average regular earnings (ie excluding bonus pay) across the economy as a whole fell by five per cent between 2008 and 2014, before recovering to 2008 levels in 2019.

Figure 4.2: Change in the value of the 5th point on the consultants' pay scale, in real terms and as compared to 90th percentile earnings, England, 1999 to 2019

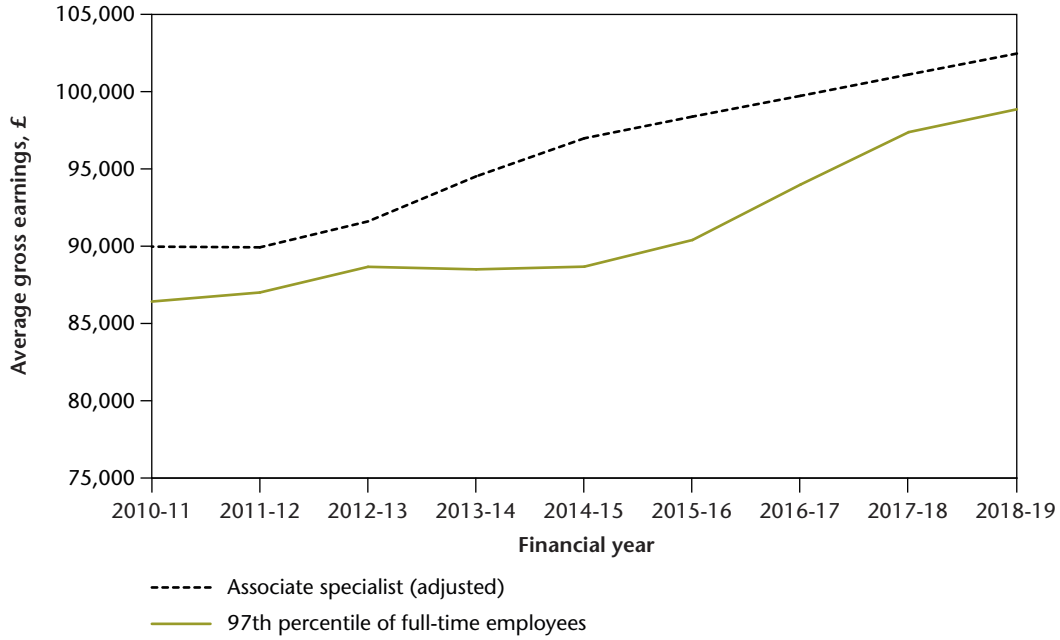


Source: OME estimates, based on data from NHS Digital, ONS.

4.8 Figure 4.3 shows that associate specialists' average total earnings increased relative to those at the 97th percentile in the wider economy, in 2013-14 and 2014-15, before falling back since 2015-16.

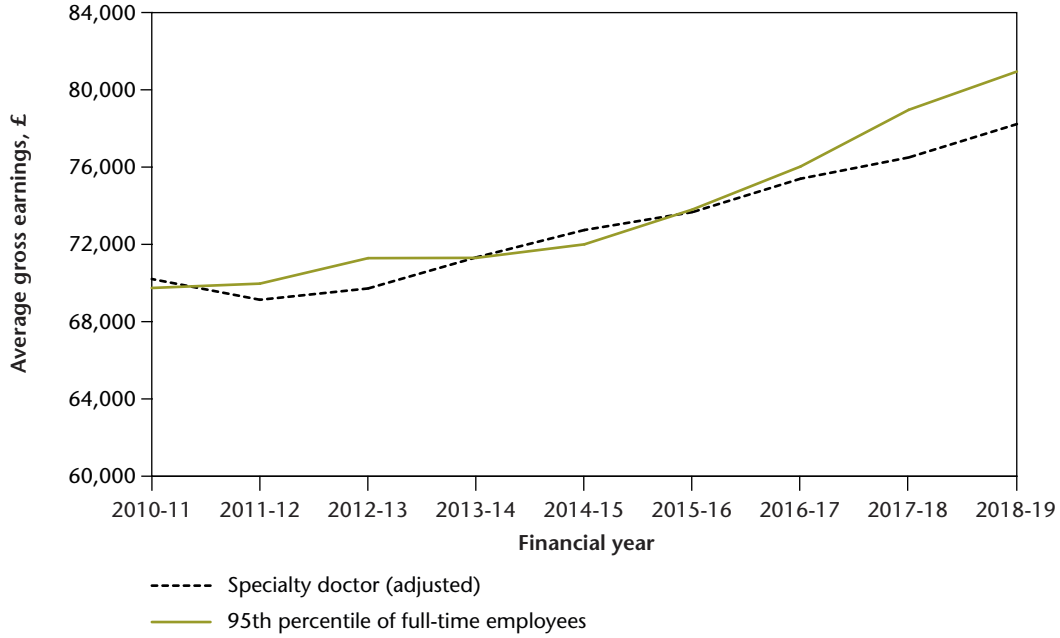
4.9 Figure 4.4 shows that average total earnings for specialty doctors were broadly in line with earnings at the 95th percentile between 2010-11 and 2015-16 before falling back since.

Figure 4.3: Average gross earnings of associate specialists in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



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

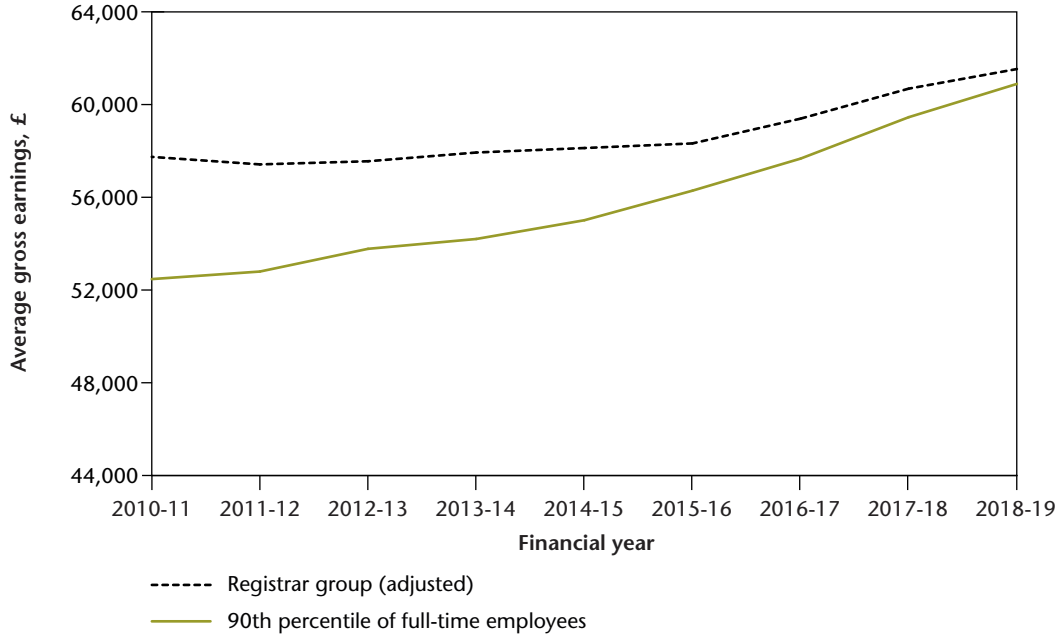
Figure 4.4: Average gross earnings of specialty doctors in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



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

4.10 Figure 4.5 shows that average total earnings of the registrar group were around 10 per cent higher than the 90th percentile in 2010-11. However, the gap has narrowed consistently, such that by 2018-19 average earnings of the registrar group were broadly in line with those of the 90th percentile.

Figure 4.5: Average gross earnings of the registrar group in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19

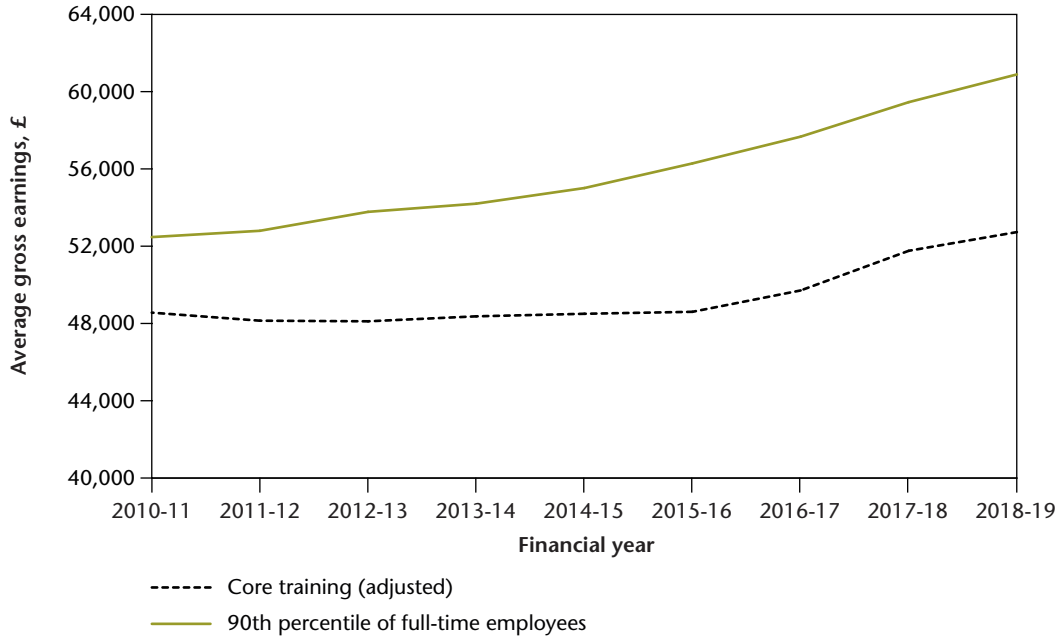


Source: OME estimates, based on data from NHS Digital, ONS.

4.11 Figure 4.6 shows that average total earnings of those in core training fell relative to the 90th percentile between 2010-11 and 2016-17, but have recovered slightly over the last two years.

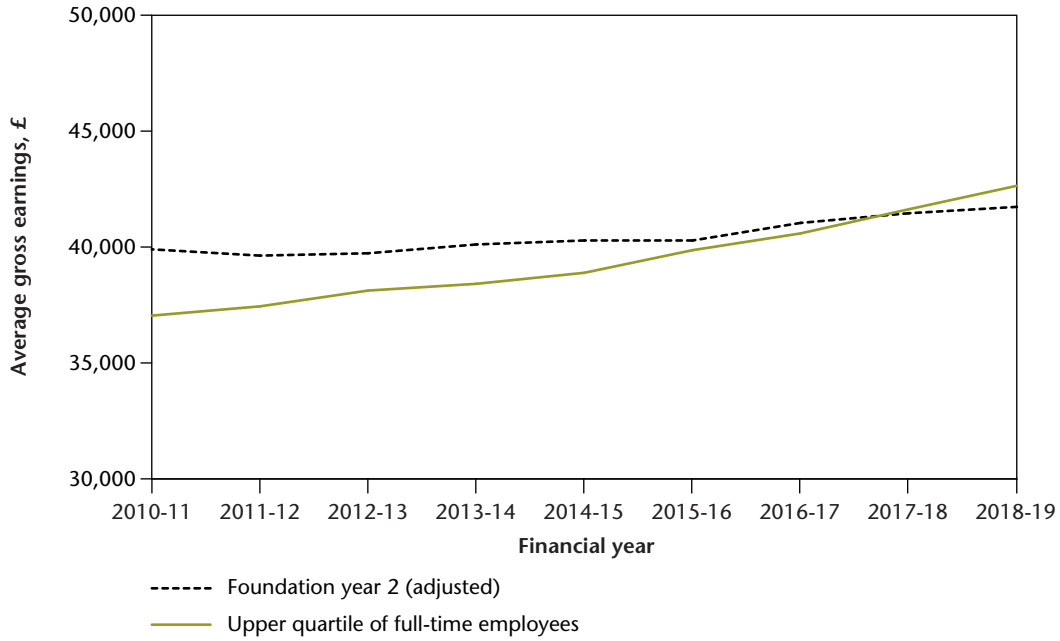
4.12 Figure 4.7 shows that for those in the second year of foundation training, average earnings in 2018-19 were below upper quartile earnings for the economy as a whole, having been ahead of that mark in 2010-11.

Figure 4.6: Average gross earnings of those in core training in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



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

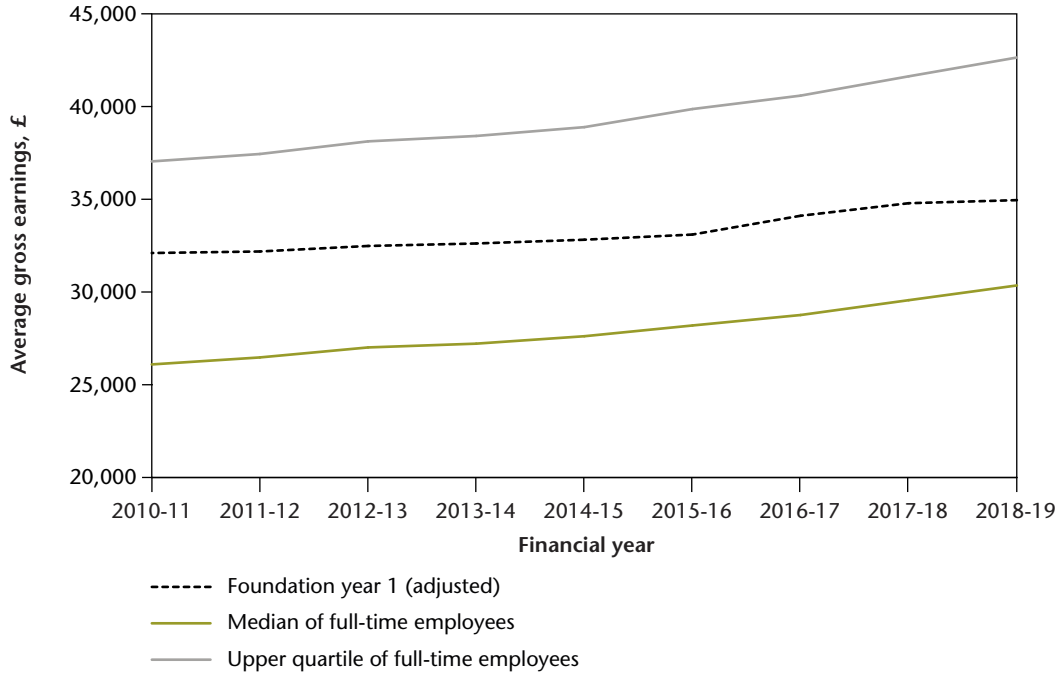
Figure 4.7: Average gross earnings of foundation year 2 trainees in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19



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

4.13 Figure 4.8 shows that for those in the first year of foundation training, between 2010-11 and 2018-19, average earnings remained above median earnings across the economy as a whole, but by a decreasing amount.

Figure 4.8: Average gross earnings of foundation year 1 trainees in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2018-19

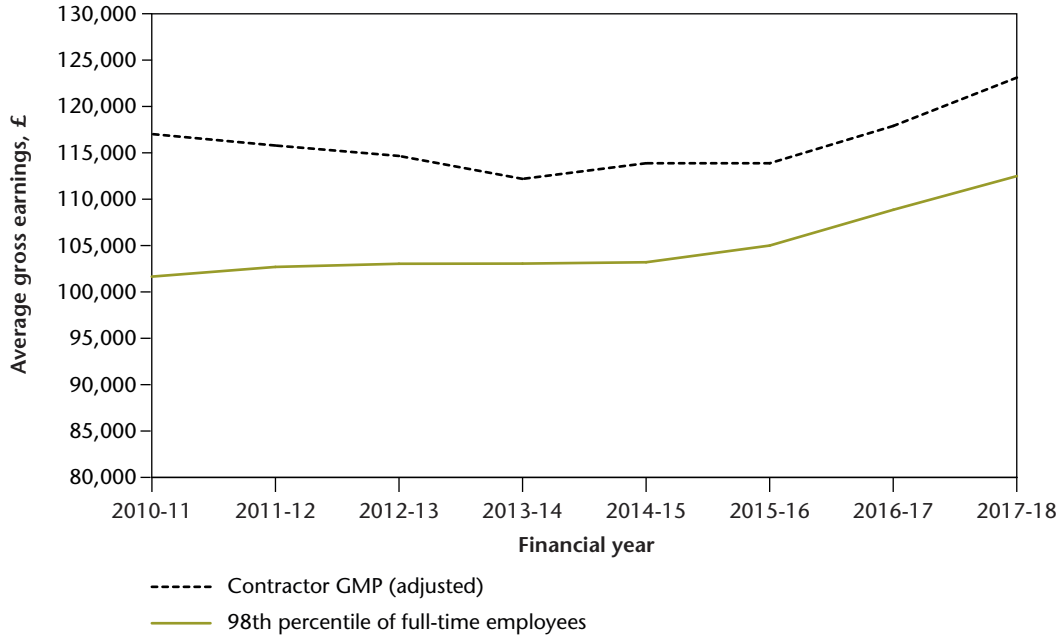


Source: OME estimates, based on data from NHS Digital, ONS.

4.14 Figure 4.9 shows in 2010-11 contractor GMP earnings were 15 per cent above earnings of the 98th percentile in 2010-11. This gap narrowed to around nine per cent by 2013-14 and has remained at a similar level since that date.

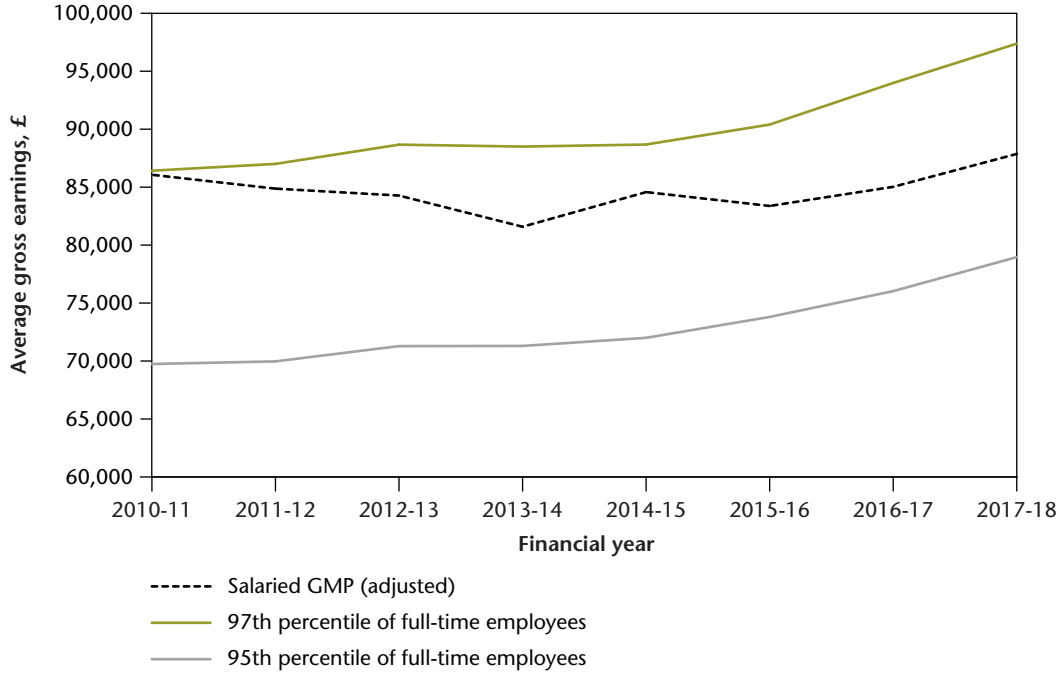
4.15 Figure 4.10 shows in 2010-11 salaried GMP earnings were in line with those of the 97th percentile in 2010-11. Since then, salaried GMP earnings have fallen below the 97th percentile and by 2017-18 were 10 per cent below that comparator.

Figure 4.9: Average gross earnings of contractor GMPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2017-18



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

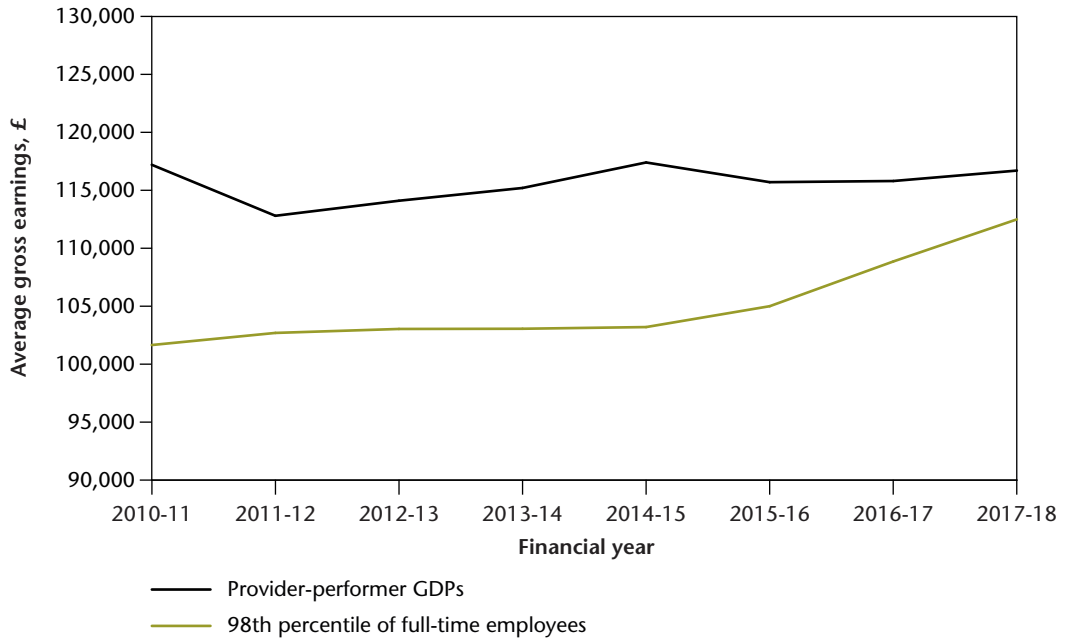
Figure 4.10: Average gross earnings of salaried GMPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2017-18



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

4.16 Figure 4.11 shows in 2010-11 providing-performer GDP earnings were 15 per cent above those of the 98th percentile in the wider economy. That gap closed to 10 per cent and remained around that level until 2015-16, but closed to four per cent by 2017-18. These figures are based on headcount, rather than FTE, and also include non-NHS income.

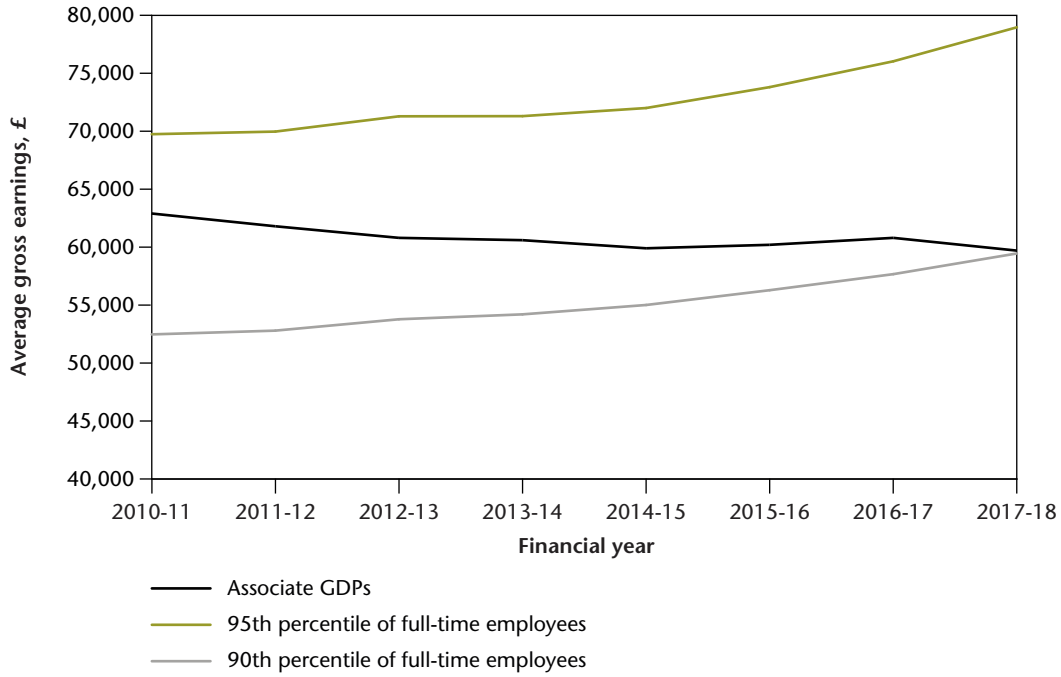
Figure 4.11: Average headcount gross earnings of providing-performer GDPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2017-18



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

4.17 Figure 4.12 shows in 2010-11 associate GDP earnings were 20 per cent above those of the 90th percentile in the wider economy. That gap steadily closed over the period and by 2017-18 associate GDP earnings were in line with those of the 90th percentile. These figures are based on headcount, rather than FTE, and also include non-NHS income.

Figure 4.12: Average headcount gross earnings of associate GDPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2017-18



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

4.18 The British Medical Association (BMA) said that since the last recession in 2008, doctors have experienced a prolonged pay freeze, followed by a cap on pay awards through a period when inflation has often run much higher. They said that pay settlements in the wider economy run at 60 per cent higher than those for doctors' awards, and that consultants in the UK are paid significantly less compared to their international counterparts, both in the EU and internationally.

4.19 The Hospital Consultants and Specialists Association (HCSA) said that they had commissioned research from the Labour Research Department that examined trends in doctors' pay since 1980. They said that this research found that both the maximum and minimum of the consultant pay scales, as a percentage of full-time male upper decile earnings, had fallen by around 40 percentage points. They added that after adjusting for RPI inflation, pay for specialty registrars had not increased since 1980. They said that if the DDRB is to fulfil its core purpose as a surrogate for the market, then it is imperative that the diminution in doctors' remuneration against both inflation and comparator professions is addressed.

4.20 The British Dental Association (BDA) said that across the country there had been a dramatic fall in net profitability in both nominal and real terms for high street dentists, and that adjusting for inflation using RPI, both practice owners and associates have seen massive decreases in taxable income across the UK.

Pay comparability

4.21 Although pay comparability does not form an explicit part of our terms of reference, we believe it is important to assess the pay position of our remit group relative to other groups that could be considered appropriate comparator professions. Changes in pay, relative to earnings, may feed through to impact on our terms of reference in areas such as recruitment, retention and the motivation of staff.

4.22 In 2017 the Institute for Employment Studies reviewed the DDRB pay comparability methodology[2] which had previously been reviewed in 2008 by the PA Consulting Group. Following the 2017 review, the same anchor points (ie job weights) used in previous reports were used, while vets and roles in higher education were added to the previous set of professions (actuarial, legal, tax and accounting, pharmaceuticals).

4.23 Figure 4.13 compares the pay distributions for doctors and dentists in training (Foundation years 1 and 2 and specialty registrars), staff grades and specialty doctors in England, to comparator professions. It is important to note that, in this section, the pay for other professions is on an FTE basis, whereas that for doctors and dentists is the average for both full- and part-time, and so may be lower than it would be on an FTE basis.

- Median total earnings for Foundation doctors in their first year were £31,250. This is three per cent more than the median earnings of all employees, and 25 per cent higher than median earnings of all employees aged 22-29. Median earnings were similar to those for vets who had just qualified, and for trainee lecturers. However, they were lower than for the other comparator groups.
- Median earnings for Foundation doctors in their second year (£42,250), were one per cent lower than the 75th percentile of all UK employees. Median earnings were higher than those for lecturers, vets and legal, similar to those of tax and accounting and lower than actuarial.
- The Registrar group's median earnings were £62,750, which was three per cent higher than the 90th percentile of all UK employees and five per cent higher than the 90th percentile of all UK employees aged 30-39. Median earnings were lower than for actuarial and legal groups, but higher than for the other comparators. Staff grade median earnings were similar, at £63,250.
- Specialty doctor grades had median earnings of £72,750. This placed them well into the top 10 per cent of UK earners. Specialty doctor median earnings were higher than all but the actuarial comparator group.

4.24 Figure 4.14 shows comparisons for associate specialists and consultants with the national pay distribution and other professional groups.

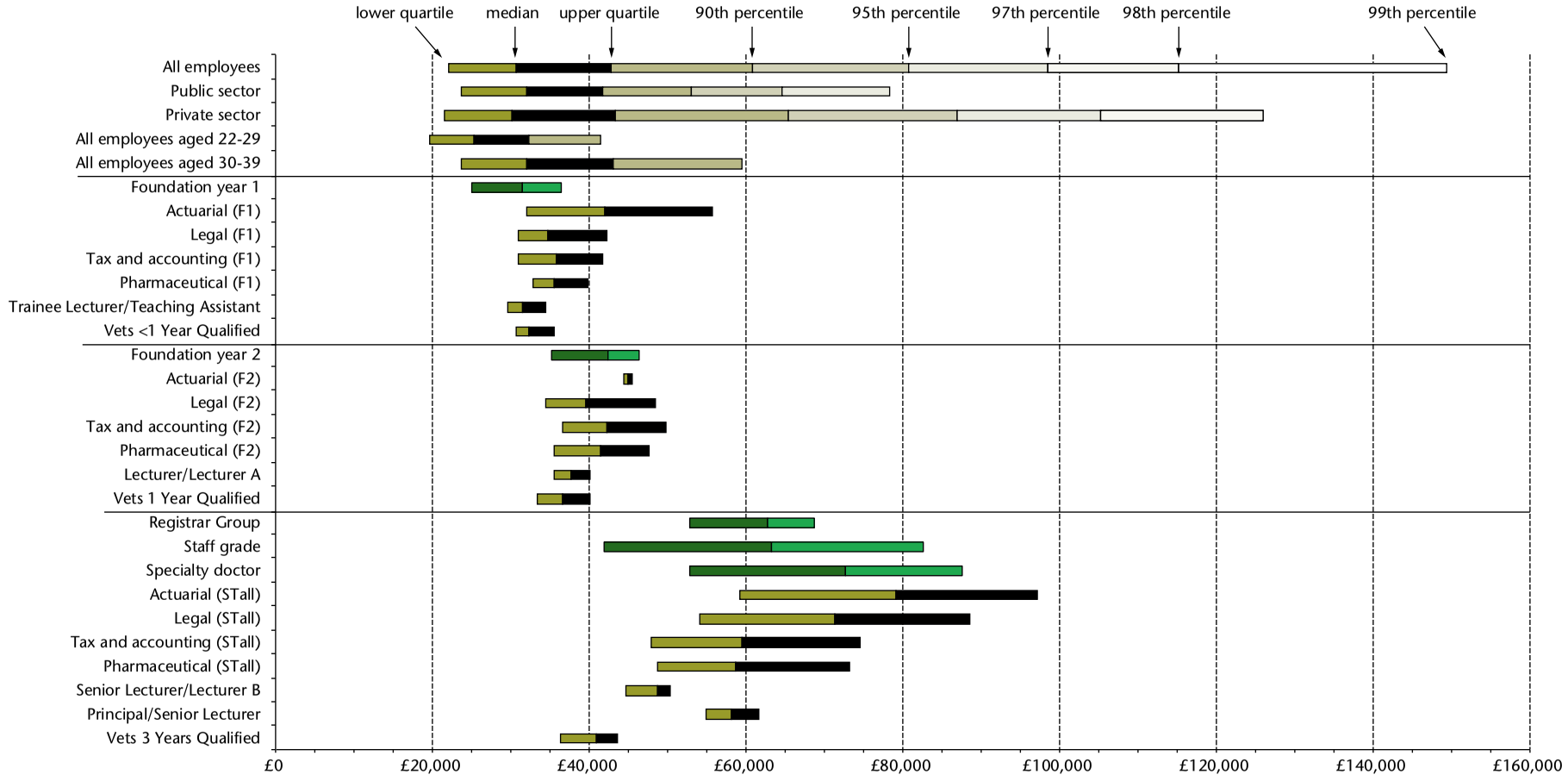
- Median earnings for associate specialists (£95,750) were three per cent less than the 97th percentile of all UK employees. Although considerably higher than for professors, heads of a subset of an academic area and vets, median earnings were much lower than those for actuarial, legal, tax and accounting, and pharmaceutical groups.
- Consultants' median earnings (£113,750) were two per cent below the 98th percentile of all UK employees. Median earners were above the highest paid vets and higher education academics, but substantially lower than for tax and accounting, legal and actuarial groups.

[2] Review Body on Doctors' and Dentists' Remuneration (15 August 2017), *Review of DDRB Pay Comparability Methodology 2017.* Available at: https://www.gov.uk/government/publications/review-of-ddrb-pay-comparability-methodology-2017

4.25 Figure 4.15 shows comparisons for GMPs and GDPs.

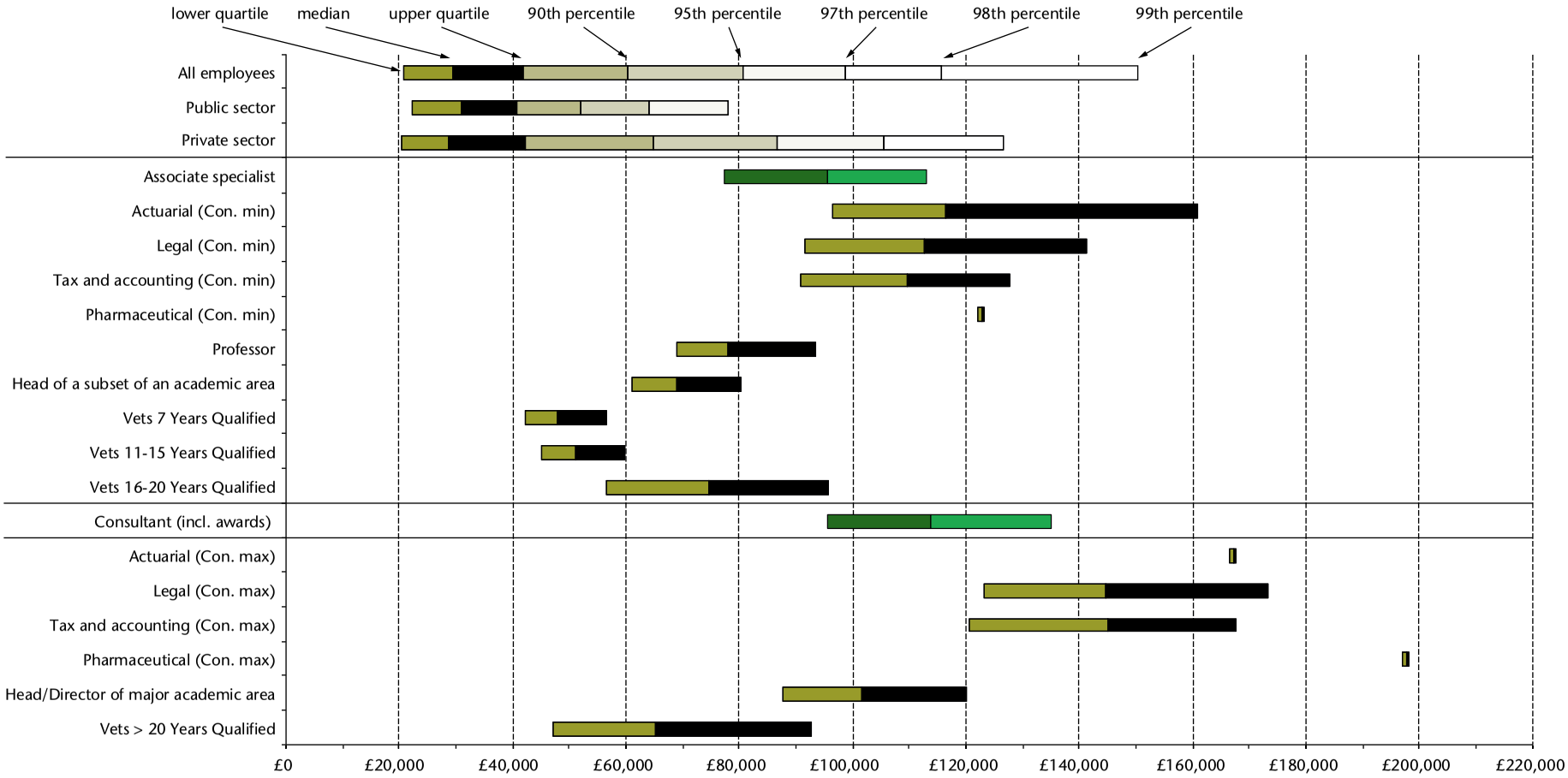
- Salaried GMPs' median earnings (£54,100) were 11 per cent less than the 90th percentile of all UK employees. Median earnings for associate GDPs (£53,300) were 12 per cent less than the 90th percentile. Both associate GDPs and salaried GMPs had earnings higher than vets, but lower earnings than actuarial, pharmaceutical, legal, tax and accounting groups.
- Contractor GMPs had median earnings of £103,400, which was five per cent higher than the 97th percentile of all UK employees. Providing-performer GDPs had median earnings of £96,800, which was two per cent lower than the 97th percentile. Median earnings for both groups were higher than median earnings for vets, but less than for actuarial, legal, tax and accounting and pharmaceutical groups.

Figure 4.13: Total earnings inter-quartile ranges of DDRB training grades, staff grades and specialty doctors (England), compared with the national pay distribution and other professional groups, full-time rates, 2019



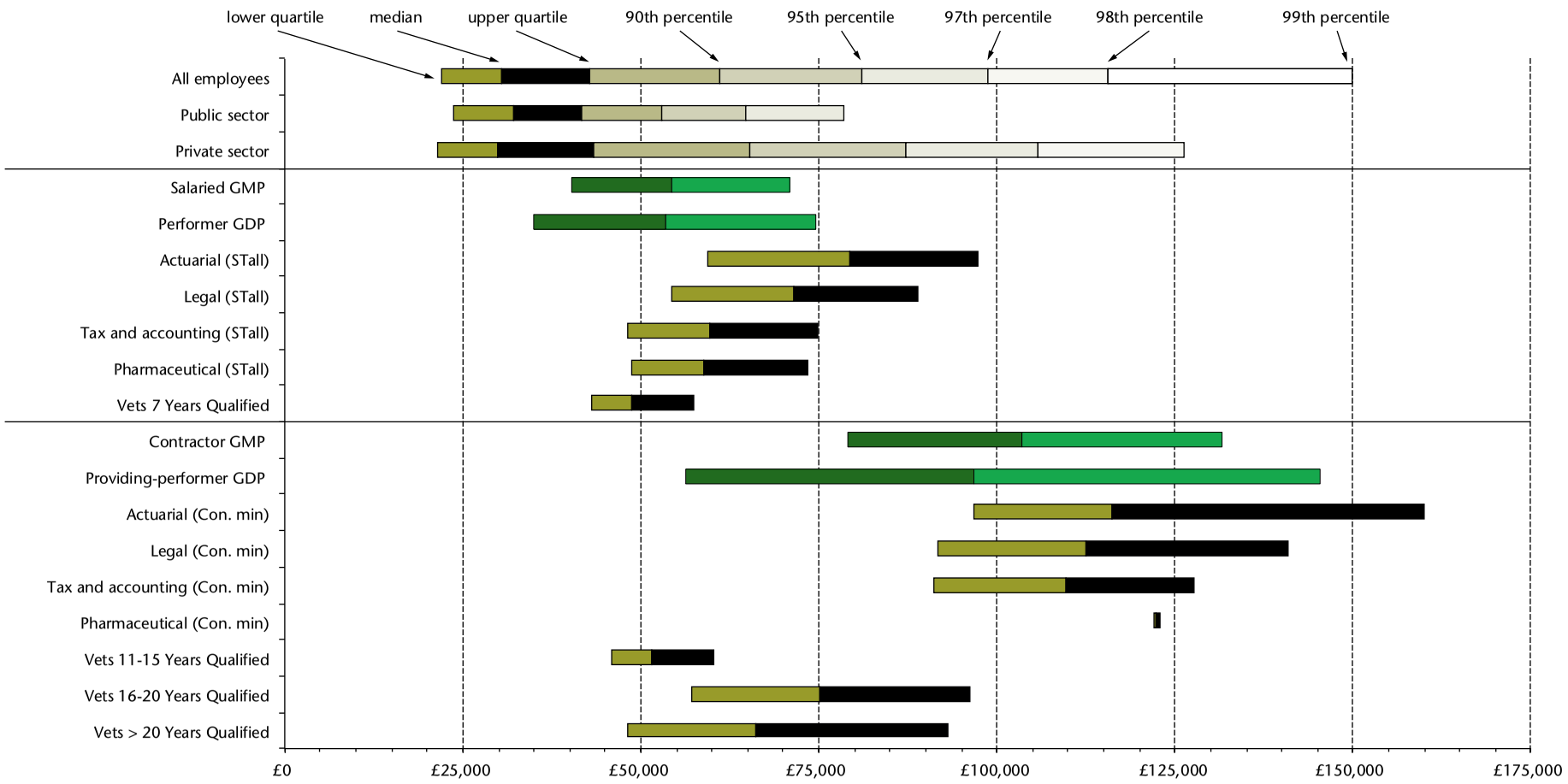
Sources: ONS, NHS Digital, NHS Employers, Hay Group, UCEA and SPVS.
(1) Figures for hospital medical grades are average total earnings for full and part time in the year ending December 2019, by headcount.
(2) A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median for these groups.
(3) Vets data are for 2018.

Figure 4.14: Total earnings inter-quartile ranges of consultants and equivalent grades, and associate specialists (England), compared with national pay distribution and other professional groups, full-time rates, 2019



Sources: ONS, NHS Digital, NHS Employers, Hay Group, UCEA and SPVS.
(1) Figures for hospital medical grades are average total earnings for full and part time in the year ending December 2019, by headcount.
(2) A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median for these groups.
(3) Vets data are for 2018.

Figure 4.15: Total earnings inter-quartile ranges of GMPs and GDPs (United Kingdom), compared with national pay distribution and other professional groups, full-time rates, 2019



Sources: ONS, NHS Digital, NHS Employers, Hay Group, UCEA and SPVS
(1) Figures for GMPs and GDPs are average total earnings for full and part time in the year ending March 2018, by headcount
(2) A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median for these groups.
(3) Vets data are for 2018.

Turnover

England

4.26 In 2018-19, the joining rate, which excludes staff moving between Trusts, for hospital medical and dental staff in England was 18.2 per cent, an increase from 17.1 per cent in 2017-18, and the highest rate since at least 2010-11. In 2018-19 the leaving rate, which also excludes staff moving between Trusts, was 15.7 per cent, an increase from 14.4 per cent in 2017-18 and the highest rate since at least 2010-11. The gap between the joining and leaving rates in 2018-19 was slightly narrower than in 2017-18.

Scotland

4.27 In 2018-19, although the numbers joining and leaving the service both increased from 2017-18, the number of joiners increased by more than the number of leavers. In 2018-19 the turnover rate was 9.3 per cent, as 682 HCHS medical and dental staff left the service, an increase from 8.7 per cent in 2017-18. In 2018-19, 1,014 HCHS medical and dental staff joined the service, an increase from 749 in 2017-18.

Northern Ireland

4.28 In 2018-19, the joining rate for hospital medical and dental staff in Northern Ireland was slightly higher than the leaving rate. The joining rate was 5.6 per cent, up from 5.1 per cent in 2017-18. The leaving rate was 5.3 per cent, up from 5.0 per cent in 2017-18.

International recruitment

England

4.29 Data from NHS Digital (Table 4.2) show that in 2018-19, 15.2 per cent of doctors joining the HCHS in England were from abroad, comprising of 2.9 per cent from within the EU and 12.4 per cent from outside the EU. The share of joiners to the HCHS from abroad has increased each year between 2010-11 and 2018-19.

4.30 Between 2010-11 and 2015-16, the share of joiners from the EU more than doubled, from 1.7 per cent to 3.8 per cent, before falling back in each of the last three years. The share of joiners from abroad from outside the EU has increased each year between 2010-11 and 2018-19, and has more than doubled since 2014-15.

Table 4.2: Medical and dental joiners to the NHS in England by source of recruitment, between March 2010 and March 2019, %, headcount, England

	EU (exc. UK) (%)	Non-EU (%)	EU (exc. UK) and Non-EU (%)
2010-11	1.7	3.3	5.0
2011-12	2.3	3.4	5.7
2012-13	3.0	3.7	6.7
2013-14	3.5	4.4	7.9
2014-15	3.7	5.5	9.2
2015-16	3.8	6.6	10.4
2016-17	3.5	8.3	11.8
2017-18	3.0	9.5	12.6
2018-19	2.9	12.4	15.2

Source: NHS Digital.

4.31 According to data from NHS Digital, non-United Kingdom nationals made up 27 per cent of the HCHS medical and dental workforce in March 2019 (Table 4.3), with nine per cent EU/EEA nationals and 18 per cent from the rest of the world. There are differences by grade, with non-UK nationals making up over 40 per cent of SAS doctors and dentists, 30 per cent of doctors and dentists in training and 20 per cent of consultants.

Table 4.3: Medical and dental staff by nationality, March 2019, headcount, England

	EU/EEA	Non-EU	EU/EEA/Non-EU
Consultants	4,728 (9%)	5,641 (11%)	10,369 (20%)
SAS doctors and dentists	1,161 (11%)	3,426 (32%)	4,587 (43%)
Doctors and dentists in training	4,996 (9%)	12,049 (22%)	17,045 (31%)
Total	11,029 (9%)	21,251 (18%)	32,280 (27%)

Source: NHS Digital.

Wales

4.32 The Welsh Government said that health boards and trusts look to overseas recruitment to fill gaps in medical staff and nursing. It cited as an example the NHS Wales and British Association of Physicians of Indian Origin (BAPIO) recruitment as part of the medical training initiative (MTI) programme which aims to attract doctors based in India to apply for an MTI post in Wales. The MTI is a scheme designed to allow a small number of doctors to enter the UK from overseas, for a maximum of 24 months, so that they can benefit from training and development within the NHS before returning to their home countries. NHS Wales and BAPIO went to India in November 2019 to recruit doctors as part of the annual recruitment campaign.

Retirement trends

England

4.33 The Department of Health and Social Care (DHSC) provided data on numbers in England who were claiming their NHS pension on voluntary early retirement (VER) basis since 2007-08 (Table 4.4). It showed for both hospital doctors and GMPs a sharp increase in the numbers choosing VER over the period as a whole, and that the percentage of retirements they accounted for was increasing. This is particularly the case for GMPs, where since 2013-14 more than half of retirements are on a VER basis. However, the latest data for hospital doctors for each of the last three years shows a small fall in the number of early retirements and the percentage of all retirements that they account for, though these numbers remain high when compared to pre-2010 levels. For dental practitioners there has been much less variation in VER numbers although the numbers choosing VER had declined between 2014-15 and 2017-18, but rose to a new high in 2018-19.

Table 4.4: Numbers claiming their NHS pension on a voluntary early retirement (VER) basis, England

	Hospital doctors		General medical practitioners		General dental practitioners	
	VER	% of all retirements	VER	% of all retirements	VER	% of all retirements
2007-08	178	14	198	17	92	29
2008-09	142	11	265	20	125	37
2009-10	183	13	322	23	118	36
2010-11	286	16	443	28	131	32
2011-12	315	18	513	33	161	37
2012-13	387	24	591	42	158	36
2013-14	406	26	746	50	149	40
2014-15	453	28	739	51	161	41
2015-16	494	31	695	52	145	41
2016-17	490	30	721	62	143	42
2017-18	424	29	588	58	115	37
2018-19	416	28	606	53	165	42

Source: DHSC.

4.34 The HCSA said that the impact of pay restraint, pension tax changes, and the constant strain under which the workforce is operating was contributing to a vicious circle, resulting in an increase in early retirements, as well as the proportion of the workforce wishing to reduce their hours.

4.35 The BMA said that in a recent survey that they had conducted, half of doctors suggested they intend to retire before the age of 60.

4.36 The BDA said that in their most recent survey of practice owners and associates, 23 per cent said that they intend to retire within the next five years, with 50 per cent of those in the 50-59 age bracket and 83 per cent of those over 60 saying this.

4.37 NHS Digital statistics show that, between April 2018 and March 2019, of those doctors and dentists who reported their reasons for leaving, retirement was the third most likely reason (914 people), behind end of fixed term contract (6,942), and voluntary resignation for unknown reasons (1,289).

Wales

4.38 We did not receive data for retirements in 2018-19. We would welcome information on the number of retirements, especially voluntary early retirements, from the Welsh Government for the next report.

Scotland

4.39 The Scottish Government included data from the Scottish Public Pensions Agency on the retirements of GMPs and GDPs in Scotland. For GMPs, 73 were identified as retiring early in 2018-19, unchanged from 2017-18 and down from 81 in 2016-17. For GDPs there were 15 identified early retirements (of 67 retirements in total), down from 32 in 2017-18 and 31 in 2016-17.

Northern Ireland

4.40 Data from the Department of Health (Northern Ireland) identified that 141 medical and dental staff had left the system in 2018-19, compared with 130 in 2017-18. The data do not identify why staff left the system or whether they were doing so before their normal retirement age.

Motivation, morale and engagement

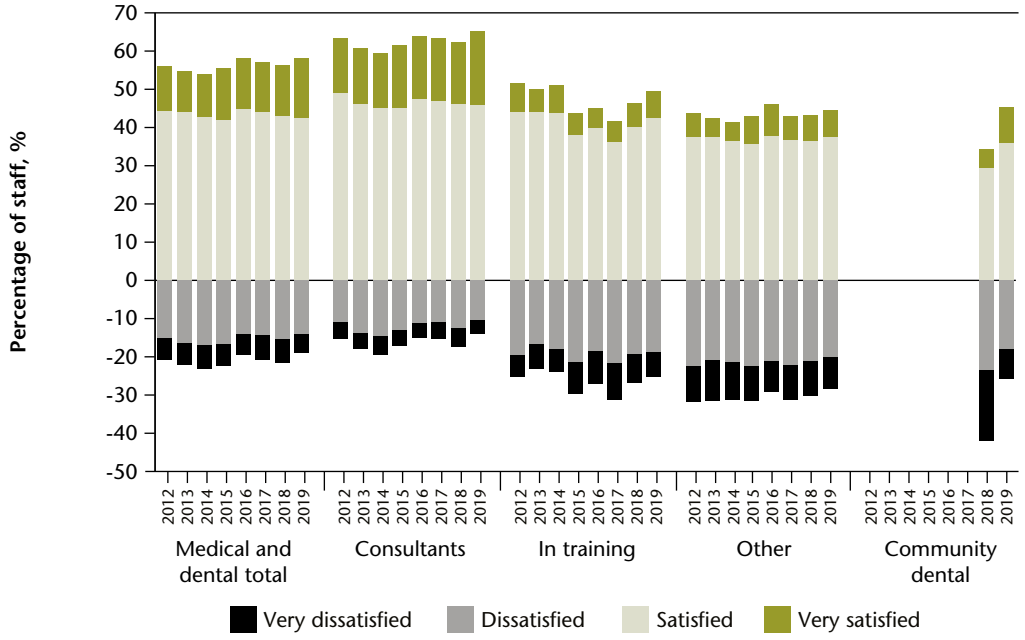
England

4.41 Since our 2019 Report, the 2019 survey of NHS Staff in England was published. It was conducted in the autumn of 2019, and over 41,000 medical and dental staff responded.

4.42 In 2019, 58.3 per cent of medical and dental staff responding said they were satisfied[3] with their pay, an increase of 2.0 percentage points, from 56.3 per cent in 2018 (Figure 4.16) and the highest recorded since at least 2011. There was an increase in satisfaction with pay for consultants, SAS doctors and dentists, doctors and dentists in training, and community dentists.

- A larger proportion of consultants said they were satisfied with their pay than other groups. In 2019, 65.2 per cent said they were satisfied, an increase of 3.0 percentage points from 2018.
- For doctors and dentists in training, in 2019, 49.4 per cent said they were satisfied with pay, an increase of 3.1 percentage points compared to 2018.
- For the 'other' group (comprising mainly SAS doctors and dentists), 44.7 per cent said they were satisfied with pay, an increase of 1.4 percentage points from 2018.
- For community dentists, 45.2 per cent said they were satisfied with their pay, an increase of 10.8 percentage points from 2018.

Figure 4.16: HCHS medical staff satisfaction with level of pay, England, 2012 to 2019



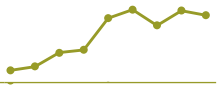
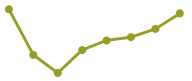
Source: NHS Staff Survey.
Note: The percentage saying "neither satisfied nor dissatisfied" is omitted throughout this chart.

[3] In each case, satisfied refers to participants answering that they were "satisfied" or "very satisfied" with their level of pay.

4.43 Looking across a range of measures related to job satisfaction, there is a mixed picture for medical and dental staff as a whole in 2019, compared with 2018 (Table 4.5):

- There was a decrease in the percentage of staff saying they looked forward to going to work, were enthusiastic about their job, that time passed quickly at work, felt satisfied with the amount of responsibility they had, and whether they had had an appraisal in the last 12 months.
- Respondents were more positive about the amount of support they got from immediate managers and colleagues, the ability to use their skills, the recognition they got for good work, their pay and the extent to which their organisation values their work.
- The percentage of respondents saying they experienced harassment, bullying or abuse from patients, relatives or the public increased for the fifth year in a row, to 34.5 per cent in 2019.

Table 4.5: Selected results from the National Staff Survey, medical and dental staff, England, 2011 to 2019

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I look forward to going to work	62.0	62.5	64.0	64.4	68.0	68.9	67.2	68.7	68.3	
I am enthusiastic about my job	74.0	74.3	75.4	75.2	79.4	78.7	77.4	78.7	78.1	
Time passes quickly when I am working	81.7	79.9	81.8	81.8	84.1	83.2	83.0	83.5	83.1	
The recognition I get for good work	51.9	51.9	54.3	55.3	57.4	58.3	57.8	63.4	64.7	
The support I get from my immediate manager	64.0	64.1	67.0	68.7	67.5	69.2	68.3	71.3	71.7	
The support I get from my work colleagues	81.0	82.6	82.9	83.5	86.4	85.8	85.6	86.1	86.8	
The amount of responsibility I am given	81.2	83.3	82.7	83.0	82.4	82.2	83.0	82.7	82.4	
The opportunities I have to use my skills	76.5	78.3	80.0	80.1	80.6	79.6	79.4	80.5	80.8	
The extent to which my organisation values my work	42.8	46.2	49.2	51.4	50.4	52.3	52.1	55.1	56.2	
My level of pay	57.1	55.9	54.7	54.1	55.4	58.0	57.1	56.3	58.3	
Percentage of staff appraised in the last 12 months	81.9	87.7	89.9	91.5	90.8	91.1	90.8	91.6	90.7	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.7	32.8	32.1	33.0	33.4	33.5	33.9	34.5	

Source: National NHS Staff Survey.

Notes: Data rounded to one decimal place.

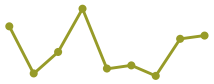
(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

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

4.44 Workload pressures generally remained high but showed signs of improvement (Table 4.6). In 2019, compared with 2018:

- There were increases in the percentage of staff agreeing that they could meet all the conflicting demands on their time at work, that they had adequate materials, supplies and equipment to do their work and that there were enough staff at their organisation for them to do their job properly;
- There was an increase in the percentage of staff saying that they had felt unwell as a result of work related stress;
- There was an increase in the percentage of staff saying they worked paid hours over and above their contracted hours. Meanwhile there was a fall in the percentage saying that they were working unpaid hours over and above their contracted hours.

Table 4.6: Selected results from the National Staff Survey, medical and dental staff, England, 2011 to 2019

Workload	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	44.8	44.7	45.2	48.0						
I am able to meet all the conflicting demands on my time at work[4]					38.7	37.2	39.3	39.4	41.1	
I have adequate materials, supplies and equipment to do my work	58.1	56.0	56.9	58.9	56.2	56.3	55.9	57.6	57.7	
There are enough staff at this organisation for me to do my job properly	35.5	35.5	34.2	33.9	33.7	32.4	30.8	32.6	33.1	
During the last 12 months have you felt unwell as a result of work related stress[2]		32.0	32.9	32.3	32.6	31.1	31.7	35.3	36.6	
Percentage of staff working PAID hours over and above their contracted hours[2]	35.0	38.7	38.3	39.4	37.4	35.9	36.3	38.0	39.1	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	72.5	76.2	77.1	76.3	79.1	80.5	79.6	78.0	74.5	

Source: National NHS Staff Survey.

Notes: Data rounded to one decimal place.

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

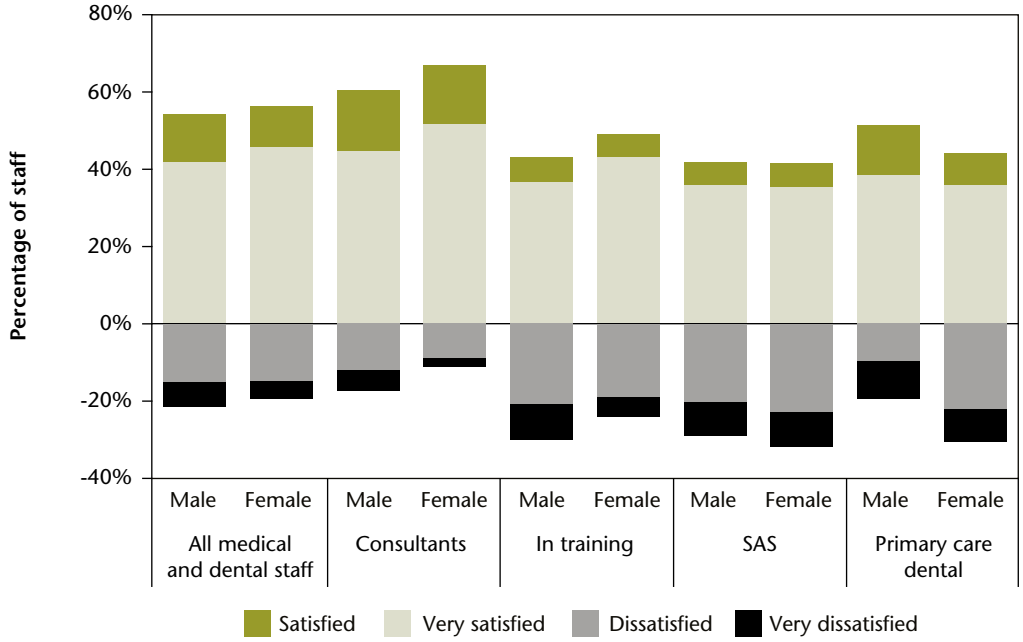
(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) For 2015, this question was reversed to "I am able to meet…"

(4) This question was introduced in 2015.

4.45 Figure 4.17 shows satisfaction with pay broken down by staff group and gender in 2019. When looking across all medical and dental staff, there was a 2.0 percentage point difference between female and male staff. 56.5 per cent of female staff and 54.5 per cent of male staff expressed satisfaction with pay, a narrowing of the gap in satisfaction with pay, from 2.4 percentage points in 2018. Female consultants and doctors and dentists in training remained more likely than their male counterparts to express satisfaction with pay. The share of male SAS doctors and dentists satisfied with their pay was 0.5 percentage points higher than that for female SAS doctors and dentists, compared with no difference in 2018. Data available for primary care dental staff (which includes only primary care dentists employed by Trusts in the Community Dental Services) which shows male community dentists 7.2 percentage points more satisfied with pay than their female colleagues.

Figure 4.17: HCHS staff satisfaction with level of pay by grade and gender, England, 2019

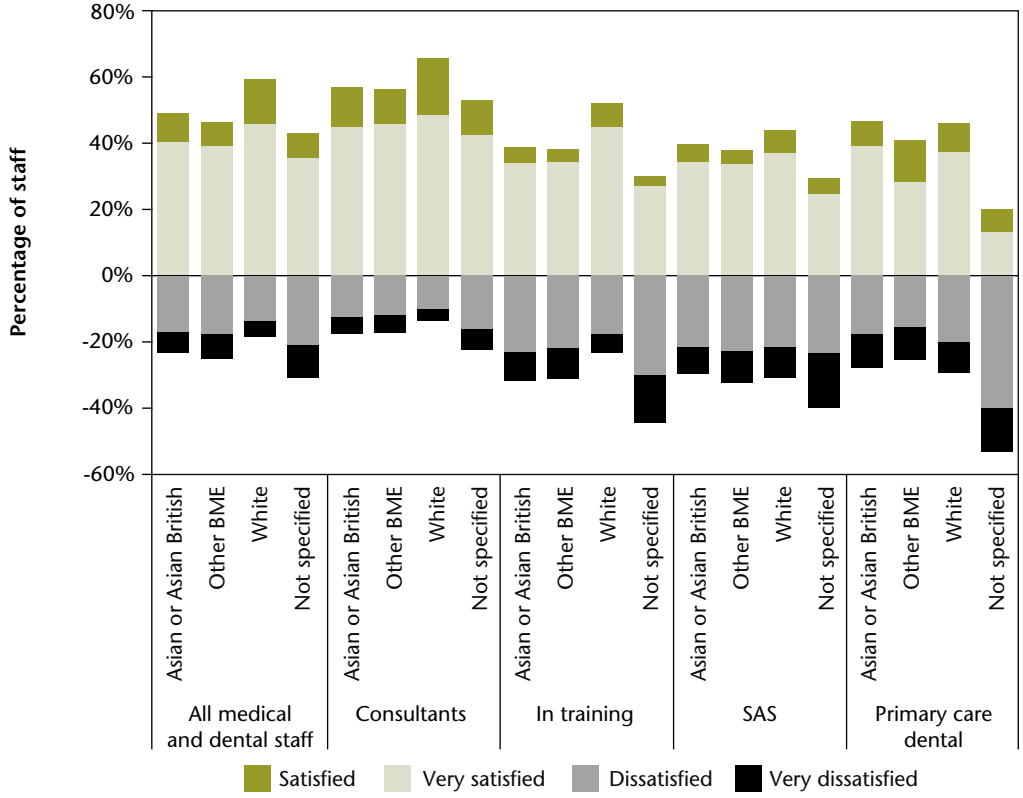


Source: NHS Staff Survey data, Picker Institute Europe.
Note: Those answering "neither satisfied nor dissatisfied" have been excluded from this chart.
Those answering "prefer to self-identify" or "prefer not to say" are not shown.

4.46 Figure 4.18 shows satisfaction with pay broken down by staff group and ethnic group in 2019. When looking across all medical and dental staff, 59.5 per cent of White staff expressed satisfaction with their pay, compared with 49.3 per cent of Asian or Asian British staff, 46.4 per cent of other black and minority ethnic (BME) staff and 43.3 per cent of staff where ethnic group was not specified.

- White consultants (66.0 per cent) were more likely to express satisfaction with their pay than Asian or Asian British consultants (57.2 per cent), other BME consultants (56.6 per cent) and consultants where ethnic group was not specified (52.9 per cent).
- White doctors and dentists in training (52.2 per cent) were more likely to express satisfaction with their pay than Asian or Asian British colleagues (39.0 per cent), those from other BME groups (38.3 per cent) and those where ethnic group was not specified (30.1 per cent).
- White SAS doctors and dentists (44.2 per cent) were more likely to express satisfaction with their pay than Asian or Asian British colleagues (39.9 per cent), those from other BME groups (38.1 per cent) and those where ethnic group was not specified (29.6 per cent).
- Asian or Asian British primary care dentists employed by Trusts (46.8 per cent) were more likely to express satisfaction with their pay than White colleagues (46.1 per cent), those from other BME groups (41.0 per cent) and those where ethnic group was not specified (20.0 per cent).

Figure 4.18: HCHS staff satisfaction with level of pay by grade and ethnic group, England, 2019



Source: NHS Staff Survey data, Picker Institute Europe.
Note: Those answering "neither satisfied nor dissatisfied" have been excluded from this chart.
Those answering "prefer to self-identify" or "prefer not to say" are not shown.

NHS Staff Survey (Wales)

4.47 The most recent staff survey for Wales was for 2018, the results of which we included in our 2019 report. In the summer of 2018 NHS Wales conducted a survey of its staff, with 25,500 responding (a response rate of 29 per cent). This follows on from similar surveys in 2013 and 2016. For the first time results have been made available that identify separately the results of the medical and dental workforce. Issues from the 2018 survey, where positive results for medical and dental staff were at least as common as for the workforce as a whole, include:

- 65 per cent of medical and dental staff said that they look forward to going to work (compared with 60 per cent for the workforce as a whole);
- 24 per cent of medical and dental staff said that during the last 12 months they had personally experienced harassment, bullying or abuse at work from patients or the public (21 per cent); and
- 73 per cent of medical and dental staff said that they were enthusiastic about their job (73 per cent).

4.48 Issues from the 2018 survey where the results for medical and dental staff were less positive than for the NHS workforce as a whole, include:

- 63 per cent of staff said that they were satisfied with the support they got from their immediate manager (71 per cent);
- 36 per cent of staff said that they could meet all of the conflicting demands on their time at work (49 per cent);

- 46 per cent of staff said that they had adequate supplies, materials and equipment to do their work (57 per cent);
- 18 per cent of staff said that there were enough staff at their organisation for them to be able to do their job properly (32 per cent); and
- 82 per cent of staff said that during the last 12 months they had had a Personal Appraisal and Development Review (PADR) (83 per cent).

4.49 The Welsh Government said that it was conducting a review of the questions asked in the survey with a view to increasing uptake and developing quality data. It said that discussions were ongoing about the frequency of future surveys but that annual surveys were likely to be implemented from 2020 onwards.

Scotland

4.50 Between February and September 2019 health and social care staff in Scotland were surveyed, with 111,500 responding (a response rate of 62 per cent, up from 59 per cent in 2018). Helpfully, for the first time, the results separately identify medical and dental staff. Key results for medical and dental staff include:

- 75 per cent said that they had sufficient support to do their job well, compared with 78 per cent of all respondents;
- 82 per cent said that their work gave them a sense of achievement, compared with 81 per cent of all respondents;
- 73 per cent said that they felt appreciated for the work they do, compared with 74 per cent of all respondents;
- 67 per cent said that their organisation cared about their health and wellbeing, compared with 70 per cent of all respondents;
- 69 per cent said that they got the help and support from other teams and services within the organisation to do their job, compared with 71 per cent of all respondents;
- 79 per cent said that they would be happy for a friend or relative to access services within their organisation, compared with 78 per cent of all respondents; and
- 73 per cent said that they would recommend their organisation as a good place to work, compared with 74 per cent of all respondents.

Northern Ireland

4.51 The results of a survey of Health and Social Care (HSC) staff for 2019 identified medical and dental staff separately, of whom 934 responded. This is a response rate of 16 per cent. A summary of the results for medical and dental staff, compared with the results from the 2015 survey, where available, are set out below. For most questions the responses were less positive in 2019 than in 2015. Key results include:

- 69 per cent said that they were enthusiastic about their job, down from 73 per cent in 2015;
- 50 per cent said that they looked forward to going to work, down from 59 per cent in 2015;
- 46 per cent said that they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This was an increase from 30 per cent in 2015. In 2019 only ambulance staff were more likely to experience harassment from patients, relatives or the public;
- 28 per cent said that they had experienced harassment, bullying or abuse from staff in the past 12 months. This was an increase from 20 per cent in 2015;
- 25 per cent said that they had reported the most recent experience of harassment, bullying or abuse, compared with 52 per cent of all HSC staff. Medical and dental staff were less likely to report harassment, bullying or abuse than any other staff group;

- 25 per cent said they were able to meet all the conflicting demands on their time at work, down from 32 per cent in 2015;
- 50 per cent said they felt unwell as a result of stress in the past 12 months, up from 32 per cent in 2015;
- 21 per cent said that there were enough staff for them to do their job properly, down from 25 per cent in 2015;
- 79 per cent said that they worked additional unpaid hours, down from 93 per cent in 2015;
- 42 per cent said that they worked additional paid hours, up from 33 per cent in 2015; and
- 35 per cent said that they often think about leaving their organisation, in line with HSC staff as a whole. Of those medical and dental staff who said they often thought about leaving, 61 per cent said it was because they were not valued for their work and 21 per cent said that they would like more pay. For HSC staff as a whole who said they thought about leaving, 58 per cent said it was because they were not valued for their work and 42 per cent said that they would like more pay.

Our comments

4.52 We note that earnings for consultants remain above the 98th percentile of full-time earnings across the economy as a whole, while earnings for associate specialists, specialty doctors and registrars remain just above the 97th percentile, just below the 95th percentile and just above the 90th percentile, respectively. Adjusted earnings for contractor GMPs are also above the 98th percentile, while adjusted earnings for salaried GMPs are roughly midway between the 95th and 97th percentiles. Earnings for providing-performer GDPs, calculated on a headcount basis, remain just above the 98th percentile, while those of associate GDPs, also calculated on a headcount basis, are almost identical to the 90th percentile, having been significantly above it in the early part of the last decade. Our remit group has in general lost ground relative to the wider earnings distribution since 2010-11. These falls have been particularly apparent for associate GDPs and foundation doctors. However, because earnings for associate GDPs are on a headcount basis, we do not know the extent to which this fall may be the result of changing working hours or the changing ratio of NHS and private work.

4.53 We also make comparisons with those in other professional groups. Overall, despite a continued period of pay restraint, the pay levels of those in our remit group were not out of line with the comparator groups.

4.54 The data for 2018-19 show modest increases in both joiner and leaver rates for medical and dental staff in England, Scotland and Northern Ireland. While we heard evidence from some of the parties that changes to the NHS pension scheme led to an increase in the numbers retiring early, we note that this is not necessarily reflected in the data presented to us by DHSC for England. This showed that the numbers of voluntary early retirements amongst HCHS doctors and dentists, GMPs and GDPs were broadly similar to last year. If the trends in joiner and leaver rates continue to increase, we would welcome an explanation from the parties as to why this is the case.

4.55 With a quarter of all HCHS doctors being non-UK nationals and over 15 per cent of HCHS doctors joining the NHS in England coming from abroad, the recruitment and retention of international doctors remains important. We expect that the coronavirus (COVID-19) pandemic will have had a significant impact on international recruitment, potentially reducing both the rate of international doctors and dentists coming to the UK and the rate of doctors and dentists already practicing in the UK leaving to take up positions overseas. Our exit from the EU may also have an impact on international recruitment and retention. We would welcome evidence on any trends from the parties in future rounds.

4.56 While the staff survey results in England for 2019 generally showed modest improvements, they demonstrate that there is still much improvement to be made. We are particularly concerned that the rates of medical and dental staff that report experiencing harassment, bullying or abuse from patients, relatives or the public continues to rise, as did the number who said that they had felt ill as a result of work-related stress. At the same time, the amount of staff who responded positively to a number of questions around feeling positive about their work environment, such as saying they looked forward to going to work, fell somewhat from 2018, though this particular statistic remained at a higher level than it had been in the period 2011-15. Together these results suggest that the morale and motivation of the workforce as a whole may be deteriorating.

4.57 We welcome that the results of the staff surveys in Scotland separately identified medical and dental staff for the first time. We look forward to examining trends in this data in future years.

4.58 We note that there was no 2019 Welsh staff survey, and we look forward to seeing the results of the 2020 survey. We also support the principle of there being annual staff surveys.

4.59 The survey for Northern Ireland raises significant concerns, with the results generally worse than in 2015 across a wide variety of measures. The response rate was particularly low, which is also a concern.

4.60 It is possible that COVID-19 will have a significant impact on staff survey results next year. We look forward to hearing from the parties about how staff engagement and satisfaction is being affected by COVID-19, though we also are aware that this may make examining longer-term trends in the data more difficult next year.

4.61 We would welcome staff survey data around pay in Scotland, Wales and Northern Ireland, since pay satisfaction is not included in any of the surveys.

CHAPTER 5: DOCTORS AND DENTISTS IN TRAINING

Introduction

5.1 In this chapter, we examine recruitment, retention and motivation amongst doctors and dentists in training. While doctors and dentists in training in England are subject to a multi-year pay deal until 2023, and we are therefore not making recommendations for this group, in our remit letter for England we were invited to make comments and observations on the evidence we received for this group.

Doctors and dentists in training

5.2 After completing medical school, which normally takes around five years, doctors in the UK begin their hospital training with the Foundation Programme, normally a two-year, general postgraduate medical training programme, where they are known as foundation doctors (F1 and F2). Following this training, doctors can either continue in the hospital sector – entering specialty training which, depending on the specialty, may include two or three years' core training – or enter general practice training. Dentists undertake a training programme of at least five years' study at dental school, after which there is a dental postgraduate training programme.

5.3 Doctors in training, commonly referred to as junior doctors, comprise doctors undertaking the Foundation Programme or core, specialty, or general practice training. General practice training takes at least three years, and core and specialty training together at least six. On completion of specialty training, doctors receive the Certificate of Completion of Training and are eligible to become consultants. Doctors may also, if they wish, leave training prior to completion, becoming specialty or staff grade doctors.

5.4 In September 2019 there were 68,100 doctors and dentists on a full-time equivalent (FTE) basis in hospital training in the UK, an increase of 6.0 per cent from 2018. Comparing September 2019 with 2018, there was an increase in the numbers in training in Scotland (7.7 per cent), England (6.0 per cent), Wales (3.3 per cent) and Northern Ireland (3.0 per cent[1]).

Undergraduates

5.5 Table 5.1 shows the time series from 2011 to 2019 for the numbers of applications[2], applicants[3] and acceptances[4] on pre-clinical medicine courses.

5.6 In 2019 there were 23,425 applicants to study pre-clinical medical degrees in the UK who between them made 80,995 applications (an average of 3.5 applications per applicant). Of these, 9,650 were accepted on a course. Compared with 2018, this represents an increase of 12 per cent in students accepted on to courses and an increase of nine per cent in the number of applicants. Since 2017 the number of students accepted on to medical courses has grown by 25 per cent.

[1] The figures for Northern Ireland are for March 2019 compared to March 2018.
[2] Number of applications: defined as a choice to a course in higher education through the UCAS main scheme. Each applicant can make up to five choices.
[3] Number of unique applicants: defined as the number of applicants making at least one choice through the main UCAS scheme.
[4] Acceptances: defined as the number of applicants who have been placed for entry into higher education.

Table 5.1: Numbers of applications, unique applicants and acceptances for medical degrees, UK, 2011-2019

	Number of Applications	Number of Unique Applicants	Number of Acceptances	Applications per Acceptance	Unique Applicants per Acceptance
2011	83,185	22,930	7,800	10.7	2.94
2012	81,260	22,285	7,805	10.4	2.86
2013	82,440	22,685	7,515	11.0	3.02
2014	84,850	23,365	7,680	11.0	3.04
2015	75,665	20,935	7,660	9.9	2.73
2016	74,860	20,815	7,830	9.6	2.66
2017	68,655	19,860	7,750	8.9	2.56
2018	75,395	21,570	8,620	8.7	2.50
2019	80,995	23,425	9,650	8.4	2.43

Source: OME estimates using UCAS data.

5.7 The gender and ethnic composition of those accepted to study for a medical degree has changed since 2011. Over that period the share of students accepted that were female has increased from 54 per cent to 62 per cent, while the share of students accepted that were black, Asian and minority ethnic increased from 28 per cent to 46 per cent.

5.8 Table 5.2 shows the ten undergraduate subjects with the highest ratio of applications to acceptances in 2019. Pre-clinical medicine has the third highest ratio, behind dentistry and artificial intelligence.

Table 5.2: Subjects[5] with the highest ratio of applications to acceptances, United Kingdom 2019

Subject	Ratio of applications to acceptances 2019
Pre-clinical dentistry	10.0
Artificial intelligence	8.7
Pre-clinical medicine	8.4
Pre-clinical Veterinary Medicine	7.2
Spanish studies	6.9
Anatomy, physiology and pathology	6.8
Astronomy	6.6
Others in Business & Admin Studies	6.6
French studies	6.5
Economics	6.4

Source: OME calculations using UCAS data.

Contract reform

England

5.9 In June 2019, the British Medical Association (BMA), the Department of Health and Social Care (DHSC) and NHS Employers announced changes to the contract for doctors and dentists in training that was introduced in 2016. As part of the agreement pay uplifts of two per cent per year were guaranteed until 2023, with a further one per cent invested each year from 2020-21 to 2022-23 into the contract to provide:

[5] This table only looks at subjects that had at least 100 acceptances in 2019.

- A new fifth nodal point (pay point) for trainees at ST6 and above, with a staggered introduction from 2020-21
- An uplift to weekend allowances
- A £1,000 allowance for those working less-than-full-time
- Changes to the academic flexible pay premium

5.10 The rest and rostering requirements in the contract were also made more robust, including for example a new maximum of eight consecutive shifts rostered or worked over eight consecutive days.

5.11 NHS Providers told us that they were pleased that the UK Government and the BMA had reached a new multi-year contract agreement. However, they added that trusts were concerned about the practical difficulties involved with early implementation of certain elements of the deal, including the new rest and rostering requirements, though they reiterated that this did not represent a philosophical rejection of the contract terms.

5.12 NHS Employers said that there had been several challenges around implementing the deal, particularly regarding the rest and rostering requirements. They said these included the administrative burden of implementing the changes, cost pressures for employers and difficulties filling rota gaps. They also told us of systemic issues with the exception reporting system introduced when the previous contract was introduced in 2016, and that there were endemic cultural problems with the practice of exception reporting. They said there were several barriers that trainees needed to overcome when submitting exception reports, including a fear that reporting will damage working relationships and that reports would be used against them in performance management meetings.

5.13 The BMA told us that they were aware of some issues with exception reporting, and with the rostering changes, but felt these were as a result of the changes bedding in.

Scotland

5.14 The Scottish Government told us they did not currently have plans to reform their contract for doctors and dentists in training.

Wales

5.15 The Welsh Government said that they were exploring the possibility of contract reform for doctors and dentists in training with the BMA, considering whether changes to the contract akin to those that have been made in England in recent years would suit the workforce in Wales. They stressed that any changes made would be agreed in social partnership with the trade unions, and that the effect of differing terms and conditions with other parts of the UK on recruitment and retention was a priority.

Northern Ireland

5.16 The Northern Ireland Executive told us that there was limited appetite to update the current contract, which dates back to 2002, though they added that they may reconsider this position once the new contract in England had embedded further.

Recruitment and training choices

5.17 At the end of the two-year Foundation Programme, doctors choose which specialty they wish to enter, or whether they want to enter general practice training. However, the number of trainees in the UK deciding not to enter into specialty or general practice training immediately after completing the Foundation Programme, a practice known as stepping out of training, continues to increase. Almost two-thirds of trainees now step out of training for at least a year. Table 5.3 shows the trends in how many trainees have stepped out of training, and for how long.

Table 5.3: Trainees that pause training after F2, and length of pauses

F2 Cohort year	No pause	1-year pause	2-year pause	3+ year pause	Not yet returned
2012	66%	17%	7%	3%	7%
2013	62%	20%	8%	3%	7%
2014	57%	22%	8%	4%	9%
2015	51%	25%	10%	4%	10%
2016	46%	25%	13%	n/a	16%
2017	41%	29%	n/a	n/a	30%
2018	37%	n/a	n/a	n/a	63%

Source: General Medical Council: The State of Medical Education and Practice in the UK 2019.

5.18 The majority of doctors that step out of training do return to begin core or specialty training. Around half do so after one year, and most of the rest after two or three years.

England

5.19 Health Education England (HEE) supplied data showing the fill rates for various training programmes in 2019 (Table 5.4). Fill rates were at or close to 100 per cent for most categories of specialty, with the main exceptions being core psychiatry (87 per cent), paediatrics (83 per cent), and general practice training (108 per cent).

Table 5.4: Fill rates for post-foundation years' training posts, England, 2017 to 2019

	Filled			Fill Rates			Percentage point change
	2017	2018	2019	2017	2018	2019	2018-19
Total	**7,039**	**7,685**	**7,746**	**92%**	**98%**	**101%**	**2.8**
General Practice	3,093	3,415	3,512	95%	105%	108%	3.0
Core Internal Medicine, Core Anaesthetics, ACCS, Emergency Medicine	2,092	2,252	2,131	92%	99%	99%	0.8
Core Surgery	500	508	515	100%	100%	100%	0.4
Core Psychiatry	327	423	481	68%	74%	87%	12.6
Paediatrics	336	346	347	88%	82%	83%	1.0
Clinical Radiology	226	234	249	100%	100%	100%	-0.4
Obstetrics & Gynaecology	237	231	223	100%	98%	97%	-1.8
Opththalmology	55	72	79	100%	100%	100%	0.0
Histopathology	60	64	76	71%	77%	100%	22.9
Other	113	140	133	97%	99%	100%	1.4

ACCS – Acute Care Common Stem.
Source: HEE.

5.20 There has been a general increase in fill rates over the last two years. The HEE data show that this has been primarily driven by an increase in the number of doctors whose primary medical qualification comes from outside the UK entering specialty training in England. This increase is particularly apparent in general practice training, where an increase in general practice training fill rates, which are now over 100 per cent for the second consecutive year, has been achieved despite the number of trainees who studied at a UK medical school entering general practice training remaining stable. Almost 40 per cent of the 2019 general practice training intake studied for their primary medical qualification outside the UK.

Flexible Pay Premia

5.21 The contract for doctors and dentists in training in England included flexible pay premia (FPP) for:

- general practice training, payable only during the practice-based periods of training;
- hard-to-fill training programmes, initially emergency medicine and psychiatry;
- oral-maxillofacial surgery;
- clinical academic trainees; and
- those taking time out of training for recognised activities deemed to be of benefit to the wider NHS.

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

5.22 The rates for 2020-21 have already been applied, as part of the 2019 agreement (see para 5.7 above), and are set out in Table 5.5.

Table 5.5: Flexible Pay Premia in England, 2020-21

Flexible Pay Premium	Full-time annual value (£)
General practice	8,789
Psychiatry core training	3,573
Psychiatry higher training (3 year)	3,573
Psychiatry higher training (4 year)	2,680
Histopathology	4,288
Academia	4,288
Emergency medicine/Oral & maxillofacial surgery: (Length of training programme)	
3 years	7,146
4 years	5,360
5 years	4,288
6 years	3,573
7 years	3,063
8 years	2,680

Source: NHS Employers, Pay and Conditions Circular (M&D) 1/2020.

Targeted Enhanced Recruitment Scheme (TERS)

5.23 TERS is an initiative that offers a one-off payment of £20,000 to general practice trainees committed to working in particular locations where recruitment had previously been challenging. The sum is repayable if the trainees leave the programme during the training period. The sub-regional areas covered by TERS largely saw 100 per cent fill rates in 2019-20. TERS was originally introduced in 2016, and so the first general medical practitioners (GMPs) to take part in the programme completed training in 2019. We therefore do not yet know how successful it will be in encouraging GMPs to remain in those areas once they have completed training.

Foundation Priority Programmes

5.24 HEE also told us about a number of local financial incentives that will be introduced and evaluated in 2019-20 and 2020-21 as part of its Foundation Priority Programmes. These would support specific areas that have historically found it difficult to attract and retain trainees through the foundation and specialty recruitment processes. These include enhanced salary packages in the Trent and Northern Foundation Schools, as well as a financial incentive for foundation trainees on the Isle of Wight.

Comments from the parties

5.25 NHS Employers said that while numbers entering GMP, emergency medicine and psychiatry training had increased since the flexible pay premia had been introduced, it was not clear whether those increases had taken place as a result of them, or as a result of other specialty-based recruitment initiatives. They said that they thought it would be helpful if research were undertaken to assess whether they have had any impact separate to these initiatives before extending them to other shortage specialties. HEE agreed, saying that the pay incentives came in at the same time as the royal colleges making a significant effort to convey the benefits of those specialties to potential new trainees, and therefore it was difficult to say whether FPPs were the only factor in the improved fill rates.

5.26 In contrast, DHSC said that trends in application rates and fill rates for specialty training would provide an indicator of the success of FPPs. HEE's fill rate data for 2019 showed that acceptances into general practice, histopathology and emergency medicine training had all increased and were close to or above 100 per cent. The fill rate for psychiatry also improved on 2018 but remains relatively low at 87 per cent.

5.27 HEE also told us about the programme board on geographic and specialty shortages that they were leading. They said that this board was examining the distribution of specialty training places in order to address inequities in the distribution of doctors. They said they were considering the data, the actions available to them to incentivise doctors to move to areas with shortages, and what needed to be done to accommodate the changes in trainee doctor numbers in both the areas that would receive additional trainees and those that would need to adapt to having smaller numbers. At the time of writing, this work was ongoing. NHS Employers commented that it was crucial that the geographical distribution of trainees in the UK better matched the geographical and population demand for consultants, given the way that trainees prioritise geographical location. They added that only 23 per cent of medical CCT holders report applying for consultant posts outside their deanery.

5.28 HEE also described work that was ongoing to expand opportunities for training less-than-full-time and to develop a facility for doctors and dentists in training to take an 'Out Of Programme Pause' as a first step to establishing a more flexible training system. They also described their Medical Education Reform Programme (MERP), which covers a range of aligned initiatives to enhance the structure and delivery of postgraduate medical training. They said it was established in response to issues around recruitment and retention, changing expectations amongst doctors in training, both around their careers and when and how training is delivered, and societal, demographic and workforce changes. MERP comprises a number of initiatives, including changes to the Foundation Programme and the structures of some of the specialty training programmes, as well as a new credentialing framework.

Scotland

5.29 The Scottish Government told us that the overall recruitment position in 2019 was positive, with an overall fill rate of 92 per cent, up from 85 per cent in 2018, although they also said that fill rates in some specialties and geographies remained challenging. There were improvements in fill rates for both psychiatry (70 per cent, up from 63 per cent in 2018) and general practice (96 per cent, up from 84 per cent in 2018). They also said that they had increased the undergraduate medical school intake to 1,038 for 2020-21. A Scottish TERS is also available in certain areas. Finally, the ScotGEM programme for graduate entry medical students, which includes a focus on primary care and remote and rural working, funded 55 students starting in 2018-19.

Wales

5.30 The Train Work Live marketing campaign is now in its fourth year and retains its focus on general practice and psychiatrists. As part of Train Work Live, financial incentives are available for general practice and psychiatry trainees, consisting of exam cost subsidies. Targeted incentives are available for general practice trainees in some hard-to-recruit areas.

5.31 The Welsh Government said that for 2019-20, 186 general practice training places were filled, 137 per cent of the original target of 136, and all 21 core psychiatry training places were filled.

5.32 The Welsh Government told us that the FPPs available in England were putting pressure on recruitment into some specialties in Wales. They said that while other financial incentives could be effective in addressing shortages in other specialties, they were concerned that within a limited pool of potential trainees, incentivising too many different specialties would be counterproductive.

Northern Ireland

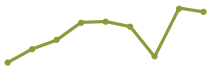
5.33 The Northern Ireland Executive told us that they were increasing the number of general practice training places as a result of increased demand and ageing populations. They also told us that they were concerned that doctors stepping out of training into locum work was a cause of their high locum spend.

Motivation

England

5.34 In Chapter 4 we reported on the results of the 2019 Staff Survey. It showed that 49 per cent of doctors and dentists in training expressed satisfaction with their pay (compared with 46 per cent in 2018), a greater percentage than SAS doctors and dentists but smaller than for consultants. This was an improvement compared with 2018, with the level of satisfaction at its highest level since 2014.

Table 5.6: Selected results from the National Staff Survey, doctors and dentists in training, England, 2011 to 2019.

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I look forward to going to work	64.2	64.8	64.1	65.8	66.8	67.4	64.4	67.8	66.1	
I am enthusiastic about my job	76.7	76.7	75.6	76.4	80.4	79.0	76.0	79.3	77.4	
Time passes quickly when I am working	80.6	78.1	79.2	80.7	83.2	79.4	79.1	79.7	79.2	
The recognition I get for good work	55.2	57.8	59.3	62.6	62.8	62.0	56.3	65.2	64.7	
The support I get from my immediate manager	75.6	73.8	79.4	77.7	79.3	74.5	75.4	77.5	77.6	
The support I get from my work colleagues	84.3	85.0	85.1	86.3	89.3	88.2	86.6	88.2	88.1	
The amount of responsibility I am given	81.4	80.7	83.4	81.6	82.7	81.6	78.7	81.4	80.9	
The opportunities I have to use my skills	78.5	79.0	82.3	80.9	81.9	79.6	79.2	79.4	80.0	
The extent to which my organisation values my work	39.4	49.9	51.0	52.4	48.8	50.9	48.8	55.8	56.7	
My level of pay	52.9	51.6	50.0	51.0	43.6	45.2	41.6	46.3	49.4	
Percentage of staff appraised in the last 12 months	77.7	81.1	82.2	81.5	77.7	81.8	78.4	79.6	77.5	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.6	36.8	31.3	34.6	35.3	34.6	38.6	35.8	

Source: National NHS Staff Survey.

Notes: Data rounded to one decimal place.

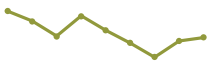
(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.

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

5.35 Job satisfaction indicators for doctors and dentists in training in 2019 were generally worse than in 2018 (Table 5.6). There were falls in the percentage saying that they looked forward to going to work, were enthusiastic about their job, were satisfied with the recognition they got for good work or with the amount of responsibility they were given, and that they had had an appraisal in the last 12 months. However, there were increases in the percentage saying they were satisfied with the opportunities they had to use their skills and the extent to which their organisation values their work. In addition, the percentage of doctors and dentists in training saying they had experienced harassment, bullying or abuse from patients fell, but there were still over a third of those in training that experienced such behaviour.

5.36 Those in training were generally more positive about work pressures than in 2018 (Table 5.7). There were increases in the percentage of doctors and dentists in training reporting that they were able to meet all the competing demands on their time, that they had adequate materials, and that there were enough staff at the organisation. However, there was also an increase in the percentage saying that they had felt unwell as a result of work-related stress. There was evidence of improved practice on working hours beyond those that were contracted, with an increasing proportion of doctors and dentists in training reporting that these hours were paid, and a decreasing proportion reporting that they were unpaid.

Table 5.7: Selected results from the National Staff Survey, doctors and dentists in training, England, 2011 to 2019.

Workload	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	28.5	34.7	34.4	37.3						
I am able to meet all the conflicting demands on my time at work[4]					43.4	45.7	43.8	44.7	45.1	
I have adequate materials, supplies and equipment to do my work	71.4	64.7	62.8	67.6	60.5	63.2	60.8	60.5	62.0	
There are enough staff at this organisation for me to do my job properly	47.1	44.0	40.2	45.7	42.2	38.6	34.3	39.0	39.5	
During the last 12 months have you felt unwell as a result of work related stress[2]		26.5	30.1	30.8	34.0	32.3	35.5	38.1	40.9	
Percentage of staff working PAID hours over and above their contracted hours[2]	28.5	33.8	32.8	30.8	36.2	34.1	38.2	41.0	44.1	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	68.0	71.9	75.5	72.9	83.1	77.4	75.5	70.8	70.5	

Source: National NHS Staff Survey.

Notes: Data rounded to one decimal place.

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

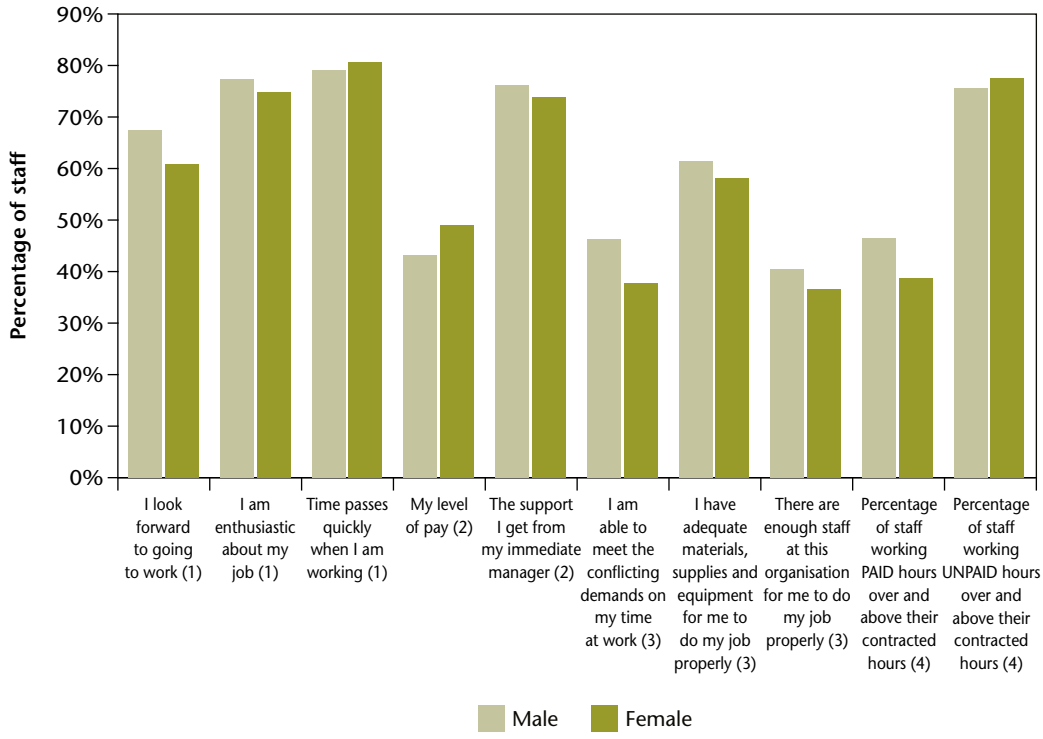
(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) For 2015, this question was reversed to "I am able to meet…"

(4) This question was introduced in 2015.

5.37 Figure 5.1 shows that female doctors and dentists in training are more satisfied with their pay than their male colleagues. However, compared with female doctors and dentists in training, male doctors were more likely to say that they looked forward to going to work, were enthusiastic about their job, were satisfied with the support they received from their line manager, were able to meet the conflicting demands on their time, that they had adequate materials to do their job and that there were enough staff at their organisation. Male doctors and dentists in training were more likely to work paid hours over and above their contracted hours, while female doctors were more likely to work extra unpaid hours.

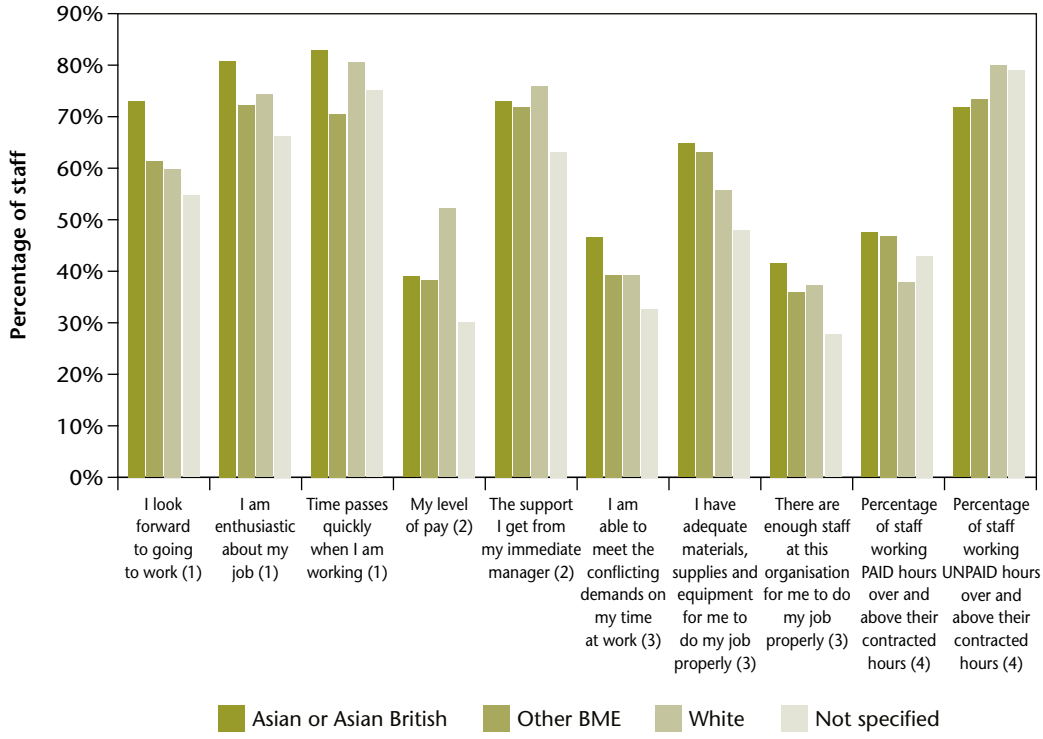
Figure 5.1: Hospital and Community Health Services (HCHS) doctors and dentists in training, satisfaction with aspects of the job and work pressures by gender, England, 2019



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

5.38 Figure 5.2 shows satisfaction with aspects of the job and work pressures, by ethnic group. For most of the variables, Asian or Asian British doctors and dentists in training are more satisfied than their White colleagues or those from other black and minority ethnic (BME) groups. However, White doctors and dentists in training are more satisfied with their pay than Asian or Asian British colleagues or colleagues from other BME groups. A greater percentage of Asian or Asian British doctors and dentists in training and those from other BME groups said that they worked paid hours in addition to their contracted hours than White colleagues, while White doctors and dentists in training were more likely to say that they worked unpaid hours in addition to their contracted hours.

Figure 5.2: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by ethnic group, England, 2019



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

Scotland, Wales and Northern Ireland

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

Our comments

5.40 We note the agreement made by DHSC, NHS Employers and the BMA over the contract for doctors and dentists in training in England. We also note that some parties have brought to our attention issues with the exception reporting system that forms an important part of the contract. This was also mentioned as a concern by doctors and dentists in training during our visits programme. However, we also have heard about the system working as it should; in a visit to one Trust, we were made aware of an outstanding Guardian of Safe Working Hours who had made a significant improvement to the working lives of the doctors and dentists in training working for that Trust. We would welcome evidence next year on how the system is working and what is being done to improve it.

5.41 We also note that some parties mentioned difficulties implementing the new rest and rostering requirements contained in the contract deal, though others said that these difficulties were simply teething problems. Again, we would welcome an update on this issue from the parties in evidence next year.

5.42 We welcome the enhanced provisions for flexible training that are being developed in England, and hope that more can be achieved in this area going forward – more flexible training will be necessary to accommodate, retain and make the most of a more diverse workforce with different needs and priorities. This will need to be a key element of medical workforce planning.

5.43 We note the differing views on contract reform in the Devolved Nations. While the Welsh Government says that they are now exploring the prospect for contract reform, potentially based to some extent on the changes made to the contract in England, neither the Scottish Government nor the Northern Ireland Executive said that there was much appetite to do so.

5.44 We welcome the increase in the number of applicants to study medicine at university last year. This means that there seems to be no immediate prospect of the additional undergraduate medical training capacity that is being introduced across the UK remaining unfilled.

5.45 We note that we were provided by most parties with little or no evidence specific to hospital dentists in training. We hope that we will receive more information about this group in future years.

5.46 We once again note the phenomenon of trainees stepping out of training for at least a year between completion of the Foundation Programme and beginning core, specialty or general practice training. As we discussed last year, this might be taking place as a result of changing career choices and priorities, or as a response to increasing levels of fatigue and burnout caused by staff shortages making training more gruelling. The pay position may also be a factor, as some doctors may be choosing to spend a period doing more lucrative or flexible locum work before resuming training. Those that complete the Foundation Programme may also wish to take a break from formal training, and the coronavirus (COVID-19) pandemic may also play a role in decision making. The efforts underway to make training more flexible may play a role in addressing these challenges.

5.47 Whatever the causes of this phenomenon, we note the statistics from the GMC that indicate that the majority of those that step out of training will return, with data over several years indicating that around half return to training after a year, and most of the rest after two or three years.

5.48 While this trend is not necessarily a good or bad thing, we think it is unlikely that it will be reversed in the short- or medium-term, and therefore it is important that it be factored into workforce planning. Projections of workforce availability should take into account both the fact that doctors will on average complete training more slowly as a result of stepping out, and that the number of years worked for the NHS at the beginning of doctors' careers, to the extent they are not working for the NHS in some other capacity, will be affected.

5.49 We note the improvements in post-foundation years' training fill rates across the UK, especially for general practice training. Targets for recruitment into general practice training were exceeded in England and Wales and close to being met in Scotland and Northern Ireland in 2019, and fill rates in all four nations were significantly increased compared to 2018. In England, this has taken place in part as a result of an increase in the number of doctors whose primary medical qualification is from outside the UK. It is possible that retaining these doctors on completion of their training will prove difficult, and we would welcome evidence that the parties might have on this issue in future years, as well as evidence as to whether a similar change is taking place in Scotland, Wales and Northern Ireland.

5.50 Improvements in fill rates have also taken place in England for the specialties covered by a flexible pay premium, including general practice. Since some of the parties disagreed as to whether the FPPs were the direct cause of the improvements, we hope that they are evaluated, and we would welcome details of this in evidence for future reports.

5.51 Similarly, for the other financial incentive initiatives that are in place, such as TERS in England, Scotland and Wales and the incentives being introduced by the foundation schools in England, we would welcome details of the evaluation of these measures in evidence for future rounds, as well as evidence as to whether they could potentially be expanded to help to address shortages in other parts of the workforce and potentially in other geographies.

5.52 On our visits, morale amongst doctors and dentists in training was said to be low, with a number of factors being raised. Bureaucracy, the pressure of remaining in training, and the strain that the allocation of posts within the deanery system can put on family life were frequently cited as significant exacerbating factors. Also frequently cited were the financial costs of training, which doctors and dentists in training can be expected to fund from personal income in certain circumstances. In future years, we would welcome more evidence from the parties on both retention of doctors and dentists in training within the NHS and attrition rates through training, so that we can examine any trends.

CHAPTER 6: STAFF GRADE, ASSOCIATE SPECIALIST AND SPECIALTY DOCTORS AND DENTISTS

Introduction

6.1 Staff grade, associate specialist and specialty (SAS) doctors and dentists are a diverse group, comprised of: specialty doctors and dentists, associate specialists, staff grades, senior clinical medical officers, clinical assistants, hospital practitioners and doctors working in community hospitals. SAS doctors and dentists are experienced and senior middle-grade clinicians who have at least four years of post-graduate training, two of which have been in their relevant specialty. SAS doctors and dentists are often involved with teaching and research as well as leading service development and are very important contributors to health service provision across the UK.

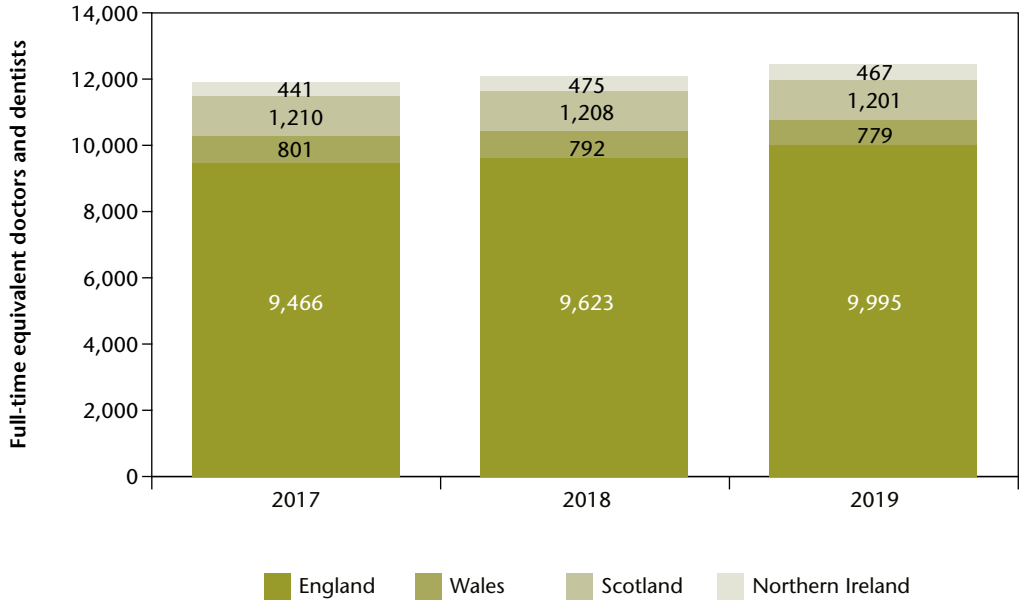
Workforce numbers

6.2 In September 2019[1] there were 12,442 full-time equivalent (FTE) SAS doctors and dentists in the UK, around nine per cent of the hospital doctor workforce. In 2019, compared with 2018, the number of SAS doctors and dentists increased by 2.8 per cent, with an increase in England (3.9 per cent), but falls in Scotland (0.5 per cent), Wales (1.7 per cent) and Northern Ireland (1.8 per cent) (Figure 6.1).

6.3 Data from NHS Digital, for England only, give a breakdown of the remit group by gender and ethnicity. The data show that in March 2019, 47 per cent of specialty doctors, 40 per cent of staff grades, and 39 per cent of associate specialists were female, compared with 37 per cent of consultants. A majority of SAS doctors and dentists identify as being from a black, Asian and minority ethnic (BAME) background, unlike the medical and dental workforce as a whole. In March 2019, 56 per cent of specialty doctors, 55 per cent of associate specialists and 52 per cent of staff grades identified as BAME, compared with 37 per cent of consultants. The evidence from the Department of Health and Social Care (DHSC), for England, showed that SAS doctors and dentists were also more likely to have a non-UK nationality than Hospital and Community Health Services (HCHS) doctors as a whole. Twenty-seven per cent of HCHS doctors were non-UK nationals, compared with 41 per cent of staff grades and 48 per cent of specialty doctors.

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

Figure 6.1: Number of SAS doctors and dentists in HCHS, United Kingdom, 2017 to 2019



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

Recruitment and retention

England

6.4 NHS England and Improvement (NHSE/I) said that the retention of SAS doctors and dentists continues to remain a challenge. Data from NHS Digital showed that in 2018-19 specialty doctors (89.9 per cent), staff grades (90.8 per cent) and, to a lesser extent, associate specialists (93.6 per cent), had a lower stability index[2] than consultants (94.2 per cent). Data from NHS Digital showed that SAS doctors and dentists had higher sickness absence rates than the overall rate for hospital doctors. In the year to January 2020, consultants and different grades of doctors and dentists in training had sickness rates of between 1.4 per cent and 1.5 per cent, compared with rates of 3.1 per cent for associate specialists, 2.3 per cent for specialty doctors and 2.1 per cent for staff grades. NHSE/I told us that while SAS doctors and dentists make up a small proportion of the HCHS medical and dental workforce, in some specialties, services are particularly dependent on them. These include anaesthetics, mental health and emergency medicine, which have also played a significant role during the coronavirus (COVID-19) pandemic.

6.5 While the total number of SAS doctors and dentists has increased, NHSE/I said that Trusts are concerned that the growing number of SAS doctors and dentists that are eligible for retirement may exacerbate workforce shortages in the coming years. NHSE/I said it is necessary to make SAS roles more attractive by greater flexibility of training and career development. SAS doctors and dentists are able to become consultants through the CESR (certificate of eligibility for specialist registration) route. However, NHSE/I said that the SAS role should also be an attractive career pathway for those that do not want to be consultants or General Practitioners, and that this would help to reduce attrition and improve retention.

[2] The Stability Index is the percentage of staff there at the start of the period that do not leave the NHS in England during the period in question. This is useful for looking at staff retention. For example, if the NHS had 100,000 doctors at the start of the year and a year later 90,000 of those doctors remained in post, the Stability Index would be 90/100 expressed as a percentage: 90%.

6.6 Health Education England (HEE) told us that many doctors choose careers in the SAS grades, but they lack support and opportunities for progression. To address these issues, in March 2019, HEE and NHS Improvement launched *Maximising the Potential: essential measures to support SAS doctors*, a strategy to improve support and development opportunities for SAS doctors and dentists in England. NHS Employers said that national stakeholders had begun to make progress on the commitments set out in *Maximising the Potential*, providing greater support in implementing the SAS charter, increasing e-portfolio access for SAS doctors and dentists, applying more consistent funding for SAS doctors and dentists and recognising them as supervisors in guidance by HEE and the Gold Guide. NHSE/I said the NHS People Plan will include initiatives to enable SAS doctors and dentists to have fulfilling careers with greater flexibility and new opportunities.

6.7 The British Medical Association (BMA) told us that difficulties in recruitment and retention have been caused by the removal of financial and professional progression for SAS doctors and dentists. The SAS charter, designed by the BMA and NHS Employers, was intended to improve these opportunities for SAS doctors and dentists. The BMA and NHS Employers continue to work to support the SAS charter with the development of new guidance and resources to assist employers. NHS Employers are leading on the update of the SAS development guide which includes good practice examples of development. A survey by NHS Employers found that 85 per cent of employers were taking steps to implement the charter with approximately 40 per cent saying they had implemented most recommendations.

6.8 The Hospital Consultants and Specialists Association (HCSA) told us that the implementation of the SAS charters has been inconsistent throughout the country.

6.9 NHS Providers told us that an improvement in the recognition of SAS doctors and dentists is needed to help with recruitment and retention. A survey of Trust HR directors by NHS Providers (December 2019) found that Trusts struggled both to recruit at the SAS level and to improve feelings of recognition amongst the SAS group.

Wales

6.10 The Welsh Government told us about the importance of SAS doctors and dentists to service delivery with rotas in Wales relying heavily on them. The Welsh Government are looking to improve the terms and conditions for SAS doctors and dentists with the aim of reducing the reliance on agency and locum staff. The Welsh Government said that they continue to work to embed the SAS Charter for Wales, which commits employers to provide job plans specific to the role and skills of SAS doctors and dentists. The SAS reference group for Wales are reviewing the number of SAS doctors and dentists with job plans, in support of the Charter.

Scotland

6.11 The Scottish Government established the SAS Development Fund to fund SAS doctors' and dentists' training and development to support clinical services.

Northern Ireland

6.12 The Northern Ireland Department of Health established the Health and Social Care transformation fund in 2018. As part of the workforce strategy, *Health and Social Care Workforce Strategy 2026,* the Department of Health is working with the BMA and HSC employers to make SAS roles more attractive through training which will enable SAS doctors and dentists to continue to deliver high quality care and contribute to education, management and clinical governance.

Contract reform

England and Wales

6.13 As part of his written statement to the House of Commons responding to the DDRB's recommendations last year, the Secretary of State for Health and Social Care said that he was looking to negotiate a reformed contract for SAS doctors and dentists in England. In their remit letter, the Welsh Government told us that SAS contract negotiations were taking place on an England and Wales basis. The negotiating partners are the BMA who are representing SAS doctors and dentists and NHS Employers who are representing employers.

6.14 We received a letter from the co-chairs of the SAS contract negotiations detailing the progress of negotiations in May 2020. We understand that a mandate from the UK Government to enter negotiations for SAS doctors and dentists in England and Wales was received on Monday 24 February 2020 and talks began in March 2020 with the intention of joint proposals for revised terms and conditions coming into effect from April 2021. Talks are continuing to take place virtually during the COVID-19 pandemic. The progress made and the impact of COVID-19 on the timeline of negotiations will be reviewed by the negotiating committees. A recommendation for this group is still sought for this year in England and Wales.

6.15 The BMA and NHS Employers have informed us of the Heads of Terms for contract negotiations. Areas for negotiation include the introduction of a new senior SAS grade to replace the closed associate specialist grade, a review of the pay structure to adopt fewer pay spines, a review of pay progression to align progression with the development of skills and expertise, modernised terms and conditions to align staff safety and wellbeing with maximum benefit to the NHS and opportunities to support flexible career development.

6.16 The HCSA is not formally engaged with SAS contract negotiations. They told us that the demographics of the SAS grade should be taken into consideration during contract negotiations. They said that a review into the ethnicity pay gap is needed to examine issues related to ethnicity that may affect BAME SAS doctors and dentists.

6.17 DHSC said that SAS contract reform will improve the status of the SAS grade and the recognition of SAS doctors and dentists. The reformed SAS grades will support career flexibility, with doctors able to pause their training through the ability to 'step on and step off' training. Expertise gained when not on a formal training role will be recognised to help doctors achieve a fulfilling career from a variety of career pathways. A new senior SAS grade to replace the closed associate specialist grade will aid career progression for senior SAS doctors and dentists who do not want to become consultants. DHSC have said SAS contract reform combined with work by NHS Employers, NHSE/I, HEE, and the BMA to develop SAS guidance and the development of career opportunities will help to recruit and retain SAS doctors and dentists through a greater degree of choice.

Scotland

6.18 The Scottish Government said they are working with BMA Scotland and NHS Scotland employers to agree Heads of Terms for contract reform, including the potential development of a Senior Specialty Doctor grade. This will be used to seek a mandate to enter formal discussions to reform the SAS contract. They said that these conversations had paused due to COVID-19, but they would be looking to resume them soon.

Northern Ireland

6.19 The Department of Health in Northern Ireland have an observer role to the SAS contract negotiations in England and Wales. They said that they were interested in reforming the SAS contract to provide greater opportunities for progression.

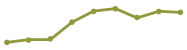
Motivation

England

6.20 In Chapter 4 we reported on the results of the 2019 Staff Survey. It showed that 45 per cent of SAS doctors and dentists expressed satisfaction with their pay, an increase from 2018, but a smaller percentage than for consultants and doctors and dentists in training.

6.21 Table 6.1 shows results from the staff survey questions relating to engagement and staff satisfaction. Generally, the responses were similar to those in 2018, with changes of less than a percentage point. Those questions that did see improvements of greater than a percentage point were satisfaction with pay and the opportunities that people had to use their skills. However, the percentage saying that they had experienced harassment, bullying or abuse in the past 12 months increased to almost 36 per cent.

Table 6.1: Selected results from the National Staff Survey, SAS doctors and dentists, England, 2011 to 2019.

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I look forward to going to work	62.8	63.2	63.3	66.3	68.3	69.0	67.2	68.2	68.3	
I am enthusiastic about my job	72.6	75.1	73.8	77.4	79.2	78.3	77.0	78.1	77.8	
Time passes quickly when I am working	78.6	78.8	79.8	82.0	83.3	82.7	80.7	81.4	81.0	
The recognition I get for good work	51.8	50.7	50.4	55.3	55.4	58.1	56.6	59.6	60.0	
The support I get from my immediate manager	64.7	65.3	65.1	70.3	67.8	70.2	67.0	70.1	69.3	
The support I get from my work colleagues	78.7	79.7	79.1	81.0	82.1	84.1	84.2	83.0	83.9	
The amount of responsibility I am given	77.4	80.1	75.4	77.9	78.0	77.9	77.7	78.4	78.5	
The opportunities I have to use my skills	72.6	76.0	71.3	75.4	74.8	73.8	74.1	73.3	74.7	
The extent to which my organisation values my work	37.8	45.1	44.4	50.7	46.1	50.3	48.0	50.9	51.0	
My level of pay	42.5	43.7	42.4	41.4	42.9	46.2	42.9	43.2	44.7	
Percentage of staff appraised in the last 12 months	74.5	79.8	83.7	89.2	90.3	88.3	91.2	89.5	88.8	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		33.9	31.1	32.1	30.9	32.6	33.8	33.8	35.7	

Source: National NHS Staff Survey.

Notes: Data rounded to one decimal place.

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

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

6.22 Table 6.2 shows responses to questions about workload pressures. Again, compared with 2018, most questions show a change in responses of less than a percentage point. The questions where there was a larger change in responses were for those relating to working extra hours. There was an increase in the percentage of respondents saying that they had worked extra paid hours and a decline in the percentage saying that they had worked unpaid hours.

Table 6.2: Selected results from the National Staff Survey, SAS doctors and dentists, England, 2011 to 2019.

Workload	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	35.2	36.0	37.9	39.6						
I am able to meet all the conflicting demands on my time at work[4]					45.8	44.8	42.0	45.7	44.9	
I have adequate materials, supplies and equipment to do my work	63.4	63.9	64.2	65.0	60.5	61.7	62.6	62.0	62.6	
There are enough staff at this organisation for me to do my job properly	38.3	40.4	39.2	38.3	37.2	37.7	34.7	35.4	36.3	
During the last 12 months have you felt unwell as a result of work related stress[2]		34.9	36.8	31.3	32.4	32.2	34.6	37.9	37.1	
Percentage of staff working PAID hours over and above their contracted hours[2]	27.4	30.7	31.0	33.1	32.0	33.3	33.7	35.6	38.1	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	56.9	61.0	62.1	62.4	65.9	67.5	66.8	67.6	65.2	

Source: National NHS Staff Survey.

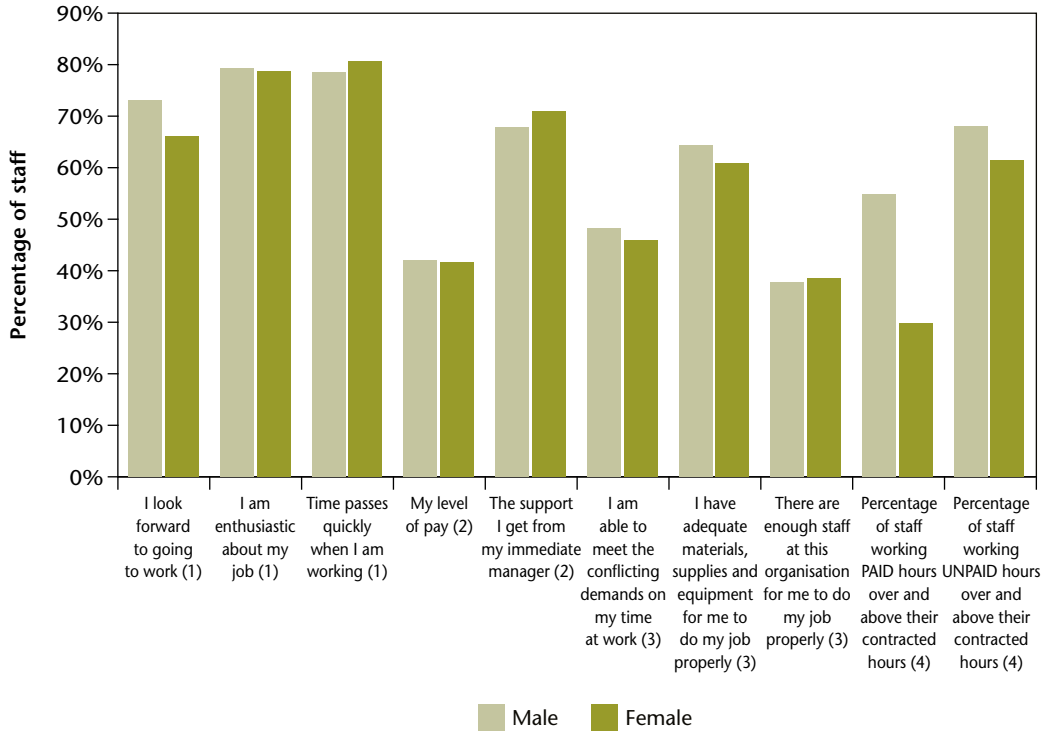
Notes: Data rounded to one decimal place.

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

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

6.23 Figure 6.2 shows that SAS doctor satisfaction with pay differed little by gender. However, compared with female SAS doctors and dentists, male SAS doctors and dentists were more likely to say that they looked forward to going to work, were able to meet the conflicting demands on their time and had adequate materials to do their job. Male SAS doctors and dentists were more likely to work hours over and above their contracted hours, both paid and unpaid hours, than their female colleagues. Female SAS doctors and dentists were more likely to say that time passed quickly when they were working, that they were satisfied with the support they got from their immediate manager and that there were enough staff at their organisation for them to do their job properly.

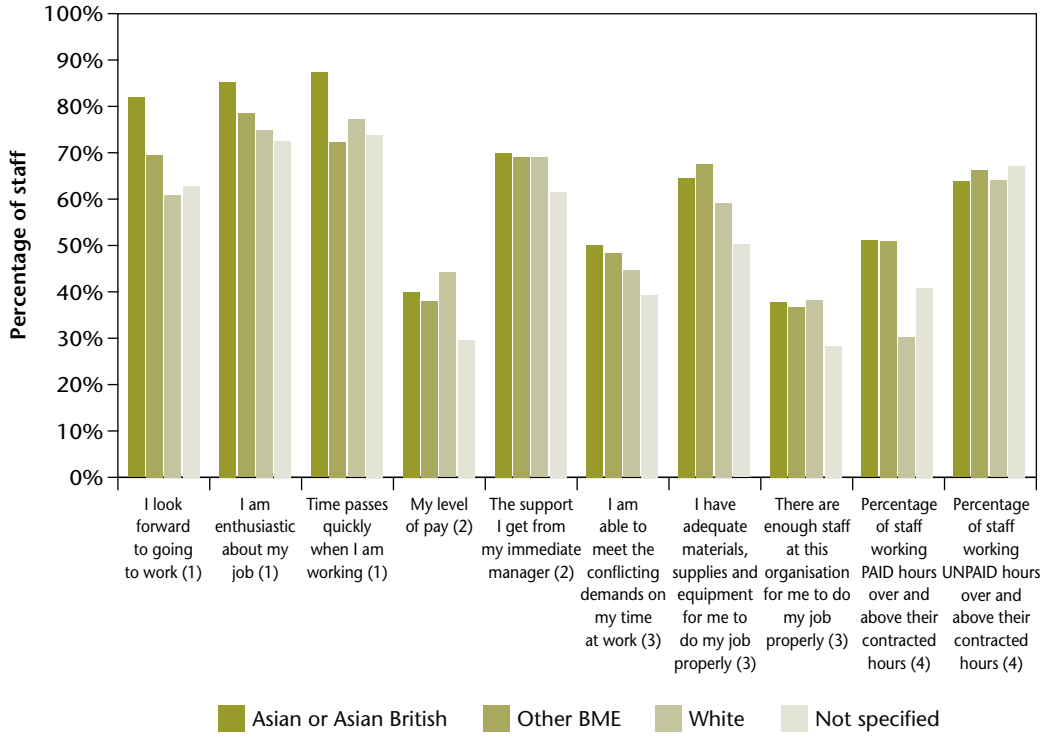
Figure 6.2: HCHS SAS (other) doctors, satisfaction with aspects of the job and work pressures by gender, England, 2019



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

6.24 Figure 6.3 shows satisfaction with aspects of the job and work pressures, by ethnic group. For most of the variables, Asian or Asian British SAS doctors and dentists are more satisfied than their White colleagues or those from other black and minority ethnic (BME) groups. However, White SAS doctors and dentists are more satisfied with their pay than Asian or Asian British colleagues or colleagues from other BME groups. A greater percentage of Asian or Asian British SAS doctors and dentists and those from other BME groups said that they worked paid hours in addition to their contracted hours than White colleagues, while there was little difference by ethnic group in the percentage saying they worked unpaid hours in addition to their contracted hours.

Figure 6.3: HCHS SAS (other) doctors training, satisfaction with aspects of the job and work pressures by ethnic group, England, 2019



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

Scotland, Wales and Northern Ireland

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

Our comments

6.26 We note, as in our previous reports, the important role that SAS doctors and dentists play in the NHS. SAS doctors and dentists are highly experienced with a wide range of skills that are integral to service delivery and patient care. Their skills and expertise mean that they can carry out specialist procedures alongside the consultant workforce and they can play an important role in teaching. However, further investment is needed in the grades to raise their profile and attractiveness. We therefore welcome that contract reform negotiations are underway for England and Wales, and that governments in Scotland and Northern Ireland are also actively considering contract reform.

6.27 In 2019, the review body drew particular attention to the SAS grades, recommending an additional one per cent uplift over and above the core recommendation of 2.5 per cent. The additional uplift was not conditional on contract reform and was intended to raise the profile and attractiveness of the SAS grades and acknowledge a group that is often under-valued and under-recognised. While our core recommendation was accepted in England, Scotland and Wales, our additional recommendation for SAS doctors and dentists was not implemented. However, DHSC and the Welsh Government said that this one per cent would be available as part of a contract reform envelope.

6.28 We maintain that improved recognition and career development is needed for the SAS grades. We affirm that quick progress of SAS contract negotiations is required to address the issues raised. We will closely follow the development of SAS contract negotiations in England and Wales. We expect the contract to be in place for April 2021 and the savings from the extra one per cent to be added to the funding envelope. If the new contract is not agreed for April 2021, we will consider again next year whether there is a case for an additional award.

6.29 We welcome that SAS contract negotiations will be examining areas vital to the advancement of SAS doctors and dentists including improved terms and conditions, a review of the pay structure and the possibility of promotion to a modernised associate specialist grade. However, we believe that negotiations should also address the limited involvement SAS doctors and dentists currently have in management decisions. Our visits programme found that SAS doctors and dentists are often excluded from management decisions and decisions related to service delivery. This means that the considerable expertise and experience of the SAS grades is not fully utilised. A greater involvement of SAS doctors and dentists in decision making will help address historic under-recognition of the grades and add value to the role.

6.30 In addition to contract reform there are other factors necessary to the development of the SAS grades and challenges that need to be addressed. We note that work to implement the SAS charter by employers has been ongoing for several years. We acknowledge that NHS Employers and the BMA are working to improve awareness of the SAS charter and inform employers of the guidance available to them. Governments in Wales and Scotland have also told us that they are continuing with their efforts to implement their versions of the SAS charter. Nevertheless, the slow progress in promoting and embedding these is a concern, since many of the recommendations that they contain play a significant role in realising the potential of SAS doctors and dentists, and would help address issues of recruitment and retention through recognition and career development. We would like further information on the progress and timescales involved in embedding the SAS charters.

6.31 We note that the SAS grades have the highest proportions of staff identifying as BAME and a higher proportion of SAS doctors and dentists are women compared with the consultant grade. Furthermore, a large proportion of SAS doctors and dentists have studied for their primary medical qualification overseas. A recent GMC survey found that over a third of SAS doctors and dentists have experienced bullying in the past and bullying related to race was the most frequently cited of the nine protected characteristics. The NHS Staff Survey also shows a large and increasing number of SAS doctors and dentists who reported experiencing bullying and harassment. We would also welcome more information on the impact of protected characteristics such as gender and ethnicity on SAS doctors and dentists, including data on ethnicity and gender pay gaps and on bullying and harassment.

6.32 Flexibilities in the SAS grades that may be introduced through contract reform have the potential to make the grades more attractive to doctors and dentists that wish to work less-than-full-time. The recognition and opportunities available to these doctors and dentists must be a prominent factor in the contract reform negotiations. The interim findings for the Gender Pay Gap in Medicine Review indicate a significant gender pay gap which is likely to be greater for women that work less-than-full-time. Similarly, due to the demographics of the grades, SAS doctors and dentists are more likely to experience an ethnicity pay gap. Consequently, we believe that it is essential that the impact of protected characteristics such as gender and ethnicity are taken into consideration during the contract negotiations.

CHAPTER 7: CONSULTANTS

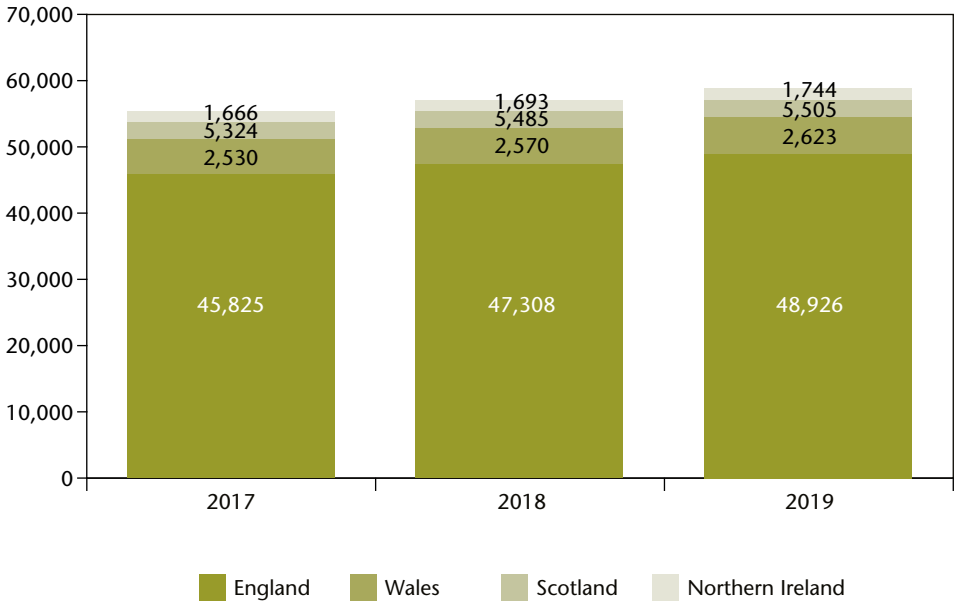
Introduction

7.1 This chapter covers consultants, the most senior grade of hospital doctors. Doctors become eligible for consultant roles on receipt of their Certificate of Completion of Training from the General Medical Council.

Workforce numbers

7.2 In September 2019[1], on a full-time equivalent (FTE) basis, there were 58,797 consultants in the United Kingdom, an increase of 3.1 per cent from a year earlier (Figure 7.1). All countries in the UK experienced an increase: 3.4 per cent in England, 3.0 per cent in Northern Ireland, 2.0 per cent in Wales and 0.4 per cent in Scotland.

Figure 7.1: Number of FTE consultants in the Hospital and Community Health Services (HCHS), United Kingdom, 2017 to 2019

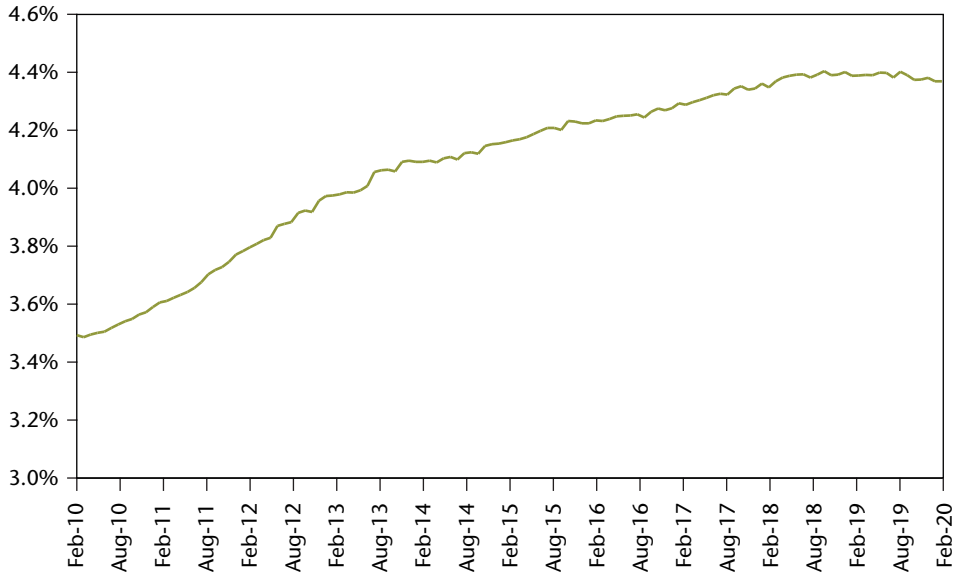


Source: NHS Digital, NHS Education for Scotland (NES), StatsWales, Department of Health (Northern Ireland).

7.3 In February 2020, consultants accounted for 4.4 per cent of the total FTE HCHS workforce in England, including nurses and allied health professionals, compared with 3.5 per cent a decade earlier (Figure 7.2).

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

Figure 7.2: Consultants in the Hospital and Community Health Services (HCHS), England, percentage of FTE HCHS workforce, 2010 to 2020



Source: NHS Digital.

Recruitment and retention

England

7.4 NHS England/Improvement (NHSE/I) said that there was continued healthy growth in the numbers of consultants, although there are also some specific issues in certain geographical areas, in shortage specialties and more generally as a result of specific issues in relation to pensions. They said that consultants were not distributed evenly in relation to the population, and that unfilled vacancies are more prominent in parts of the country that already have fewer consultants.

7.5 In order to address these challenges, NHSE/I described a number of courses of action that they and other parties were taking. These included the following:

- A new Distribution of Specialty Training Board established by Health Education England (HEE) to address the geographical distribution of doctors in training
- Increasing the number of medical undergraduate places to increase medical workforce numbers in the long-term
- Implementing the NHS People Plan to improve working conditions for staff, reducing sickness absences and improving retention
- Supporting more flexible careers, including improving 'retire and return' schemes, as well as improving retention for senior consultants by giving them more control over their job plans

7.6 HEE provided data that showed, as at March 2019, a total consultant shortfall of 10 per cent. Compared with the position at September 2017, the date at which HEE based its evidence to us for our 2019 report, this represents an increase in the vacancy rate from 7.7 per cent. Table 7.1 breaks the latest HEE data down between specialties and HEE regions.

Table 7.1: FTE Consultant shortfall by HEE region and specialty, England, March 2019

	Shortfall, % of establishment							
Specialty	England	North West	Midlands	East of England	London	South East	South West	North East & Yorks
Psychiatry	18%	27%	16%	5%	7%	11%	11%	23%
Emergency Medicine	15%	6%	24%	15%	15%	27%		12%
Acute Medicine	14%	16%	18%	12%	11%	13%	10%	11%
Histopathology	12%	13%	12%	9%	8%	12%	12%	11%
Clinical Radiology	11%	11%	11%	13%	11%	6%	5%	10%
Wider Medicine	10%	17%	11%	14%	7%	10%	6%	10%
Clinical and Medical Oncology	9%	14%	8%	2%	1%	11%	5%	13%
Ophthalmology	8%	9%	8%	10%	5%	11%	1%	9%
Surgery	8%	5%	5%	9%	5%	7%	6%	7%
Obstetrics and Gynaecology	6%	0%	3%	6%	5%	6%	1%	4%
Anaesthetics and ICM	6%	5%	5%	9%	6%	5%	1%	3%
Paediatrics	5%	2%	6%	6%	5%	2%		3%
All	10%	12%	11%	10%	7%	9%	6%	14%

Source: HEE.

7.7 The three specialties with the largest shortfalls across England as a whole were psychiatry (18 per cent), emergency medicine (15 per cent) and acute medicine (14 per cent). However, there were wide variations across different parts of England. Overall, shortfalls were lowest in London and the south, and highest in the north. The largest regional deficits for individual specialties were in the North West (27 per cent) and North East & Yorkshire (23 per cent) for psychiatry, and the South East (27 per cent) and the Midlands (24 per cent) for emergency medicine, and the Midlands (18 per cent) and the North West (16 per cent) for acute medicine.

7.8 The British Medical Association (BMA) told us that the combination of insufficient staffing levels per head of the population, punitive changes to the NHS pension scheme and other workforce issues were having a detrimental impact on the consultant workforce. They added that this was resulting in low levels of consultant staffing, and that the consequent poor working conditions were damaging consultants' emotional wellbeing, their morale, and rates of retention.

7.9 The Hospital Consultants and Specialists Association (HCSA) said that high levels of vacancies over a prolonged period was having a significant impact on services, adding that the data was likely to underestimate the true vacancy rate as jobs may be vacant but not advertised or advertised through other routes, and job adverts may reflect multiple vacancies.

Wales

7.10 The Welsh Government said that there were national and international labour shortages that were impacting on recruitment into the NHS in Wales. The medical phase of the 'Train Work Live' marketing campaign, which promotes the benefits of working as a doctor in Wales, and is currently in its fourth year, includes a particular focus on psychiatrists.

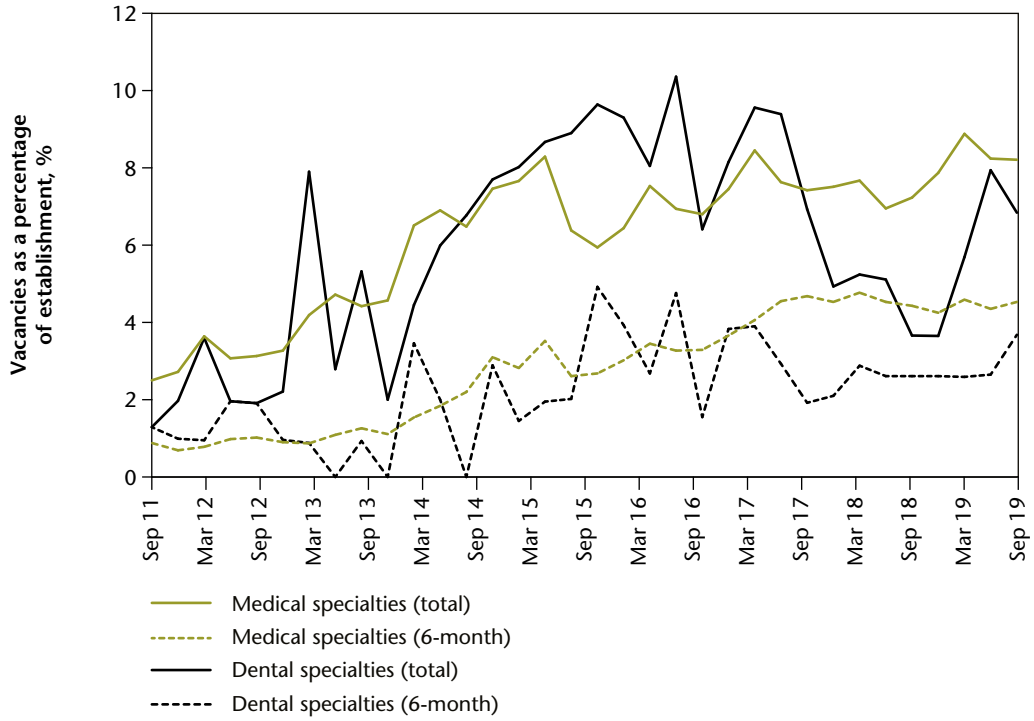
Scotland

7.11 The Scottish Government said that for certain consultant posts and in certain parts of Scotland, Boards can find it more challenging to fill vacancies. They named radiology, geriatrics and psychiatry as particularly challenging specialties.

7.12 At the end of December 2019 there were 481 FTE vacant posts for medical and dental consultants, a vacancy rate of 8.2 per cent, an increase from 7.2 per cent a year earlier (Figure 7.3). The specialty groups with the highest vacancy rates were psychiatry (11.8 per cent) and clinical laboratories (9.1 per cent) (Table 7.2).

7.13 There were 265 posts that had been vacant for at least six months, a rate of 4.5 per cent, an increase from 255 (4.4 per cent) a year earlier. The specialty groups with the highest 6-month vacancy rates were psychiatry (7.9 per cent) and clinical laboratories (6.4 per cent).

Figure 7.3: Vacancy rates in Scotland, FTE, total and long-term, 2011 to 2019



Source: OME estimates, based on data from NHS Education for Scotland.

Table 7.2: Consultant vacancy rates in Scotland by specialty, December 2019

		Total vacancies		Six month vacancies	
	Establishment (FTE)	vacancy rate (%)	Annual percentage point change	vacancy rate (%)	Annual percentage point change
All specialties	5,873	8.2%	1.0	4.5%	0.1
All Medical specialties	5,778	8.2%	1.0	4.5%	0.1
Emergency medicine	254	6.5%	2.6	2.4%	-0.2
Anaesthetics	818	7.1%	2.5	3.1%	0.7
Intensive Care Medicine	24	16.4%	7.3	4.1%	-0.4
Clinical laboratory specialties	710	9.1%	0.0	6.4%	-0.5
Medical specialties	1,427	8.4%	-0.2	5.7%	0.5
Public health medicine	95	8.7%	3.1	4.2%	0.9
Occupational medicine	12	0.0%	0.0	0.0%	0.0
Psychiatric specialties	600	11.8%	-0.3	7.9%	0.3
Surgical specialties	1,111	8.0%	1.4	3.8%	0.3
Obstetric & gynaecology	285	6.4%	3.0	2.1%	-0.1
Paediatrics specialties	374	5.0%	0.4	0.7%	-1.4
General Practice	23	27.1%	27.1	0.0%	0.0
Not known/other	45				
All Dental specialties	95	6.8%	3.2	3.7%	1.1

Source: OME estimates, based on data from NHS Education for Scotland.

Northern Ireland

7.14 In its written evidence, the Department of Health said that there were 98 consultant vacancies actively being recruited to at the end of December 2019, a reduction from 122 at the end of December 2018. Between April 2018 and March 2019 there were 77 (4.2 per cent) consultant joiners and 74 (4.0 per cent) consultants left the Health and Social Care system.

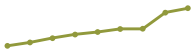
Motivation

England

7.15 According to the 2019 NHS Staff Survey consultants were more satisfied with their pay than other medical staff groups (covered in Figure 4.16). Almost two-thirds (65 per cent) of consultants said that they were satisfied with their pay in 2019, the first increase for two years.

7.16 The results for job satisfaction for consultants were generally mixed, compared with 2018 (Table 7.3). There were falls in the percentage saying they looked forward to going to work, were enthusiastic about their job, that time passed quickly when they worked, were satisfied with the amount of responsibility they were given and the opportunities they had to use their skills. However, there were increases in the percentage saying they were satisfied with the recognition they got for good work, support from management and colleagues, and being valued by their organisation. There was little change in the percentage saying they experienced harassment, bullying or abuse in the past 12 months, and this remains worryingly high at over 34 per cent.

Table 7.3: Selected results from the National Staff Survey, consultants, England, 2011 to 2019.

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I look forward to going to work	61.8	62.8	64.0	64.3	67.8	69.8	68.4	70.0	69.7	
I am enthusiastic about my job	74.2	73.4	75.7	75.1	78.8	79.5	78.0	79.7	79.0	
Time passes quickly when I am working	84.0	81.8	84.0	83.6	84.5	85.1	85.2	85.8	84.6	
The recognition I get for good work	49.4	50.5	52.6	54.0	55.5	56.6	56.7	63.2	65.4	
The support I get from my immediate manager	59.9	59.8	62.3	65.6	64.6	67.2	65.6	69.0	71.3	
The support I get from my work colleagues	81.2	82.7	83.6	83.5	86.0	85.3	85.7	86.4	87.1	
The amount of responsibility I am given	82.7	85.3	84.9	85.3	83.4	84.2	84.8	84.6	84.0	
The opportunities I have to use my skills	77.2	79.7	81.8	81.7	81.2	80.4	79.8	82.4	82.0	
The extent to which my organisation values my work	44.3	46.3	49.4	51.0	49.9	52.1	51.6	55.4	57.6	
My level of pay	63.4	63.5	60.8	59.5	61.6	63.8	63.2	62.1	65.2	
Percentage of staff appraised in the last 12 months	86.8	91.1	93.1	94.8	95.3	94.9	93.8	95.2	95.2	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]		34.8	32.3	32.7	34.4	34.3	32.3	34.2	34.3	

Source: National NHS Staff Survey.

Notes: Data rounded to one decimal place.

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

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

7.17 A majority of consultants did not agree that they were able to meet all the conflicting demands on their time and that there were enough staff at their organisation, although the percentage responding positively had increased. There was also a further increase in the percentage of consultants saying that they had felt unwell as a result of work-related stress. There was a fall in the percentage of consultants saying that they worked more hours than contracted for, both paid and unpaid (Table 7.4).

Table 7.4: Selected results from the National Staff Survey, consultants, England, 2011 to 2019.

Workload	2011	2012	2013	2014	2015	2016	2017	2018	2019	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	52.2	52.6	51.3	52.3						
I am able to meet all the conflicting demands on my time at work[4]					33.1	34.1	37.8	36.9	39.5	
I have adequate materials, supplies and equipment to do my work	51.8	50.2	51.5	53.1	50.9	52.3	51.2	53.9	53.6	
There are enough staff at this organisation for me to do my job properly	30.5	30.5	29.0	29.2	29.7	28.0	28.1	29.1	29.5	
During the last 12 months have you felt unwell as a result of work related stress[2]		32.4	32.2	32.8	33.4	30.8	30.7	34.0	35.3	
Percentage of staff working PAID hours over and above their contracted hours[2]	41.6	43.5	43.6	44.2	40.8	39.3	39.4	40.6	39.6	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	81.1	82.9	83.8	82.9	84.8	85.5	83.4	82.9	80.5	

Source: National NHS Staff Survey.

Notes: Data rounded to one decimal place.

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

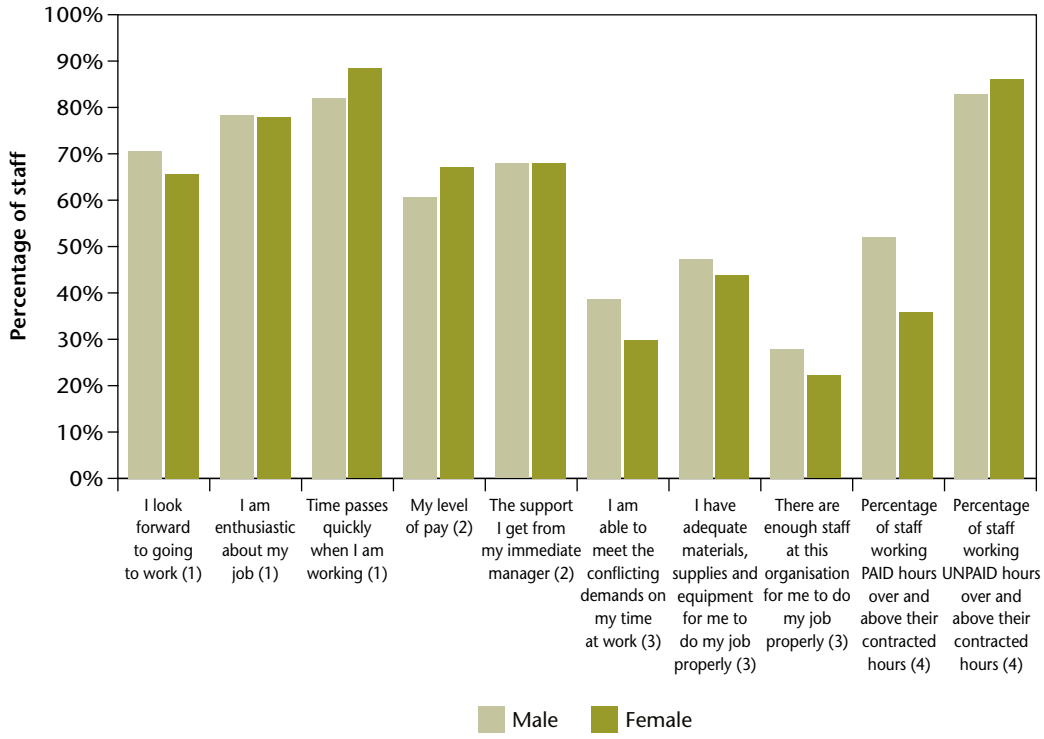
(2) Lower scores are better in these cases, however, in all other cases, higher scores are better.

(3) For 2015, this question was reversed to "I am able to meet…"

(4) This question was introduced in 2015.

7.18 Female consultants were more likely to say they were satisfied with their pay than male colleagues (Figure 7.4) and were more likely to say that time passed quickly when they worked. However, compared with female consultants, male consultants were more likely to say that they looked forward to going to work, were able to meet competing demands on their time, had adequate materials, and that there were sufficient staff at the organisation. Female consultants were slightly more likely to work extra unpaid hours than male consultants but were less likely to work extra paid hours than their male colleagues.

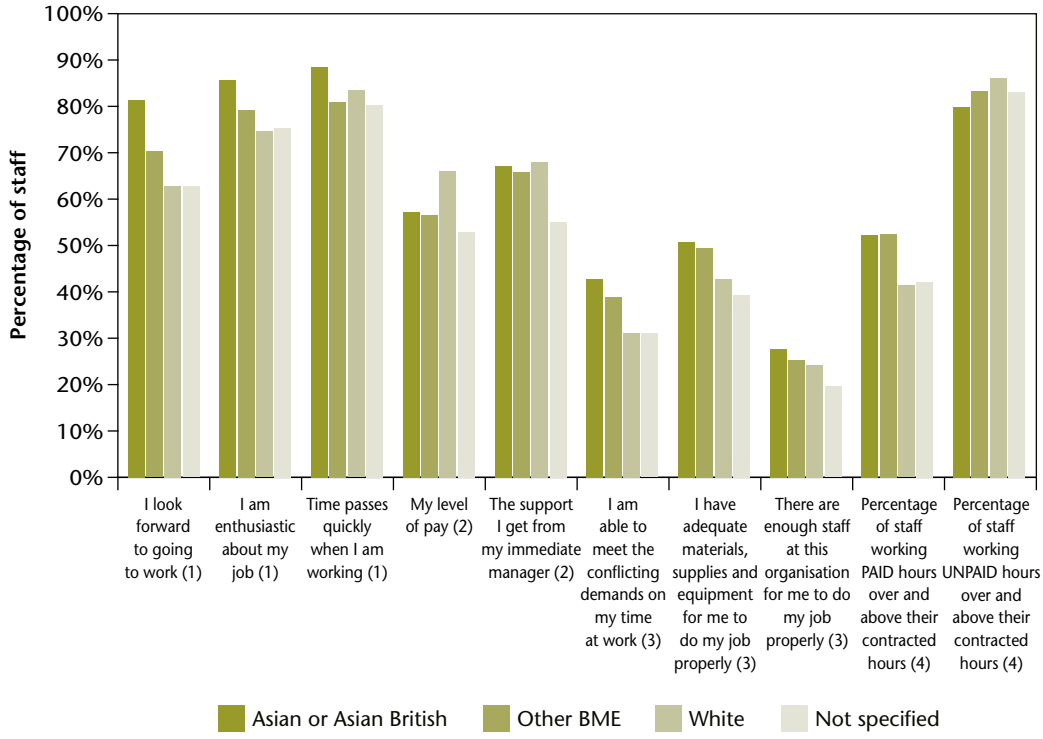
Figure 7.4: HCHS consultant satisfaction with aspects of the job and work pressures by gender, England, 2019



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always".
(2) Staff responding "satisfied" or "very satisfied".
(3) Staff responding "agree" or "strongly agree".
(4) Staff indicating one or more additional hours.

7.19 Figure 7.5 shows satisfaction with aspects of the job and work pressures, by ethnic group. For most of the variables, Asian or Asian British consultants were more satisfied than their White colleagues or those from other black and minority ethnic (BME) groups. However, White consultants were more satisfied with their pay than Asian or Asian British colleagues or colleagues from other BME groups. A greater percentage of Asian or Asian British consultants and those from other BME groups said that they worked paid hours in addition to their contracted hours than White colleagues, while White consultants were more likely to work unpaid hours in addition to their contracted hours.

Figure 7.5 HCHS consultant satisfaction with aspects of the job and work pressures by ethnic group, England, 2019



Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours.

Scotland, Wales and Northern Ireland

7.20 The staff survey results for Scotland, Wales and Northern Ireland are not published in sufficient detail to identify consultants.

Contract reform

England

7.21 The Department of Health and Social Care (DHSC) told us that there is a well-documented case for contract reform that would provide consultants with refreshed terms and conditions that reflect modern working practices and support developing service requirements. They said that negotiations have been ongoing for several years and agreement had been reached in principle on some of the key aspects.

7.22 However, they also said that the resource envelope available to fund reform was unchanged from that presented to the BMA in 2018, which was rejected by them as insufficient. In their evidence, NHS Employers reiterated that contract reform discussions have paused pending any announcement that further funding might be available, noting that consultant contract reform was not one of the immediate priorities set out in the *NHS Long Term Plan* or interim NHS People Plan.

7.23 NHS Providers similarly said that it does not appear that agreement over a new consultant contract is on the horizon, nor does a resumption of meaningful talks seem to be a priority.

7.24 The BMA told us that there was still appetite for contract reform amongst consultants, who recognise that the current contract is outdated and does not reflect working patterns. However, they also said that they would not be interested in contract reform where the financial envelope available was not sufficient. The HCSA said that they felt that most of the changes that need to be made to consultants' terms and conditions could be made within the current contract framework, and therefore there needs to be clarity over what the parties would seek to achieve in making another attempt to achieve contract reform.

Wales

7.25 The Welsh Government told us that they felt the consultant contract does not reflect current priorities, and that they would like to reform the contract. However, they did not tell us about any ongoing contract reform discussions with the trade unions.

Scotland

7.26 The Scottish Government said that they currently had no active plans for contract reform for consultants.

Northern Ireland

7.27 The Department of Health said that they would consider participating in contract reform negotiations for consultants if they were to take place for England.

Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points

England

7.28 On 27 March 2020, the Advisory Committee on Clinical Excellence Awards (ACCEA) announced that the 2020 competition for new and renewed national Clinical Excellence Awards (CEAs) would be suspended as a result of the coronavirus (COVID-19) pandemic. ACCEA said they would further update stakeholders on its plans for the 2020 and 2021 rounds after the pandemic had subsided. Similarly, on 27 April, NHS Employers, the BMA and the HCSA issued a joint statement that the local CEA round for 2020-21 would not be going ahead, with the money that would have been distributed in new local CEAs that year instead distributed equally amongst eligible consultants. This would include funds rolled over from previous years.

7.29 The announcement also confirmed that interim arrangements for local CEAs in England that were due to remain in place until a new scheme was introduced from April 2021 will now be in place until April 2022 instead. Under the interim local CEA arrangements, new awards are time limited, and employers must invest the value of at least 0.3 CEA points per eligible consultant per year.

7.30 DHSC said in their pay award announcement for 2019 that, while the value of a CEA point under the interim arrangements was uplifted in line with the uplift to basic pay scales for consultants, older, consolidated local CEAs were frozen under the 2019 pay award.

7.31 In their written evidence they said that the interim arrangements for local CEAs are a means of beginning the transition to a performance pay system that gives employers more flexibility, with the new system broadly based on recommendations set out in *Review of the compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*, which was published by the DDRB in 2012[2].

7.32 NHS Employers told us that the local CEA system in its current form was presenting several challenges for employers. They said that the requirement to spend a growing pot of money, combined with a drop in the number of applications (in large part due to issues of pensions taxation) was causing employers to roll over funds from year to year. Some employers felt compelled to allocate the money to almost all who apply, undermining the principle that the scheme exists to reward excellence. They also said that they were concerned that, despite the efforts they were making to increase applications from female or black, Asian and minority ethnic (BAME)-identifying consultants, most employers were not seeing an increase, and some other subgroups, including those who work less-than-full-time, were also less likely to put themselves forward. NHS Providers said that most HR Directors see reform to the local CEA system as an important priority, with many saying that the system is currently not fit for purpose.

7.33 In the evidence they submitted as part of the DHSC submission, ACCEA said that they plan to consult on changes to the national CEA scheme that would also be based on some of the recommendations of the 2012 DDRB review. These changes include making awards non-pensionable and without a progression element. More awards would be paid, but individual awards would be worth less.

7.34 The BMA said that the freezing of CEAs in 2019 was disappointing, but also that they felt that the way current CEA systems were operating could be a contributing factor to the gender pay gap in medicine. The HCSA said that they were also disappointed that the 2019 recommendation to uplift CEAs alongside basic pay was not implemented. When asked about the potential reforms to CEAs, they said that there was a tension between the CEAs' original intention, to reward excellence, and their apparent change of emphasis towards being a tool for performance management.

Scotland

7.35 The Scottish Government said that since 2010, no new Distinction Awards have been made and the only consultants still receiving these are those who were successful prior to the freeze being imposed. They added that they had been clear that that existing arrangements for Distinction Awards and Discretionary Points would remain in place but that their position since 2010 had been that to increase or restore Distinction Awards and Discretionary Points would go against the Scottish Public Sector Pay Policy.

Wales

7.36 The Welsh Government told us that they felt that it was possible that significant reform to Commitment Awards was required, and they wanted to have an open conversation with the BMA about the total reward package for consultants – they said that they felt that all decisions about Commitment Awards should be made in partnership with the trade unions.

[2] Review Body on Doctors' and Dentists' Remuneration (9 August 2013), *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Available at: https://www.gov.uk/government/publications/ddrb-nhs-consultant-compensation-levels-2012

Northern Ireland

7.37 CEAs in Northern Ireland have been frozen in value and closed to new applicants since 2013.

Our comments

7.38 Across the UK, the proportion of the NHS workforce who are consultants has consistently risen over an extended period of time, as part of a change from a consultant-led to a consultant-delivered service. Being a relatively expensive part of the workforce, this development increases the average per capita salary cost, which in turn may put additional pressure on staff budgets and impact on the size or composition of the wider healthcare team. It may also be a factor in some of the work that is being done in all four nations to improve the quantity and quality of workforce outputs within a particular budget. It is perhaps partially in response to the increase in consultant numbers that some of the parties have discussed changed workforce models in hospitals, with a greater focus on the wider clinical team, though it is not yet clear how this will impact growth in the numbers of consultants.

7.39 However, despite the increase in consultant numbers, we note that vacancy rates across the UK remain high. This situation has not been helped by the high rate of voluntary early retirement, with around 30 per cent of hospital doctors in England who have retired over the last five years doing so before their normal retirement age. We were told issues of consultant retention had been exacerbated by issues associated with changes to the pensions taxation rules, in particular the introduction of the annual allowance taper from 2016, which may have led to some senior clinicians reducing their workloads or retiring early in order to mitigate pensions tax charges. The changes to the annual allowance taper thresholds announced in the 2020 March Budget will mean that although some consultants will still be affected by the annual allowance threshold the overwhelming majority of consultants will no longer be affected by the taper. That said, pensions taxation rules, including the lifetime allowance, may continue to impact older consultants' career choices, as may the fact that those who choose to opt out of the pension scheme lose their eligibility for death in service payments. Similarly, the differential income tax position in Scotland has the potential to lead to differences in take-home pay with the rest of the UK. We would welcome more detailed data from the parties on the reasons consultants are giving for leaving the NHS, so that we can examine whether pensions taxation and the differential income tax position in Scotland are having an impact on retention.

7.40 During our visits programme, the consultants that we spoke to consistently said that they felt that they and the medical profession as a whole were undervalued and unappreciated. The long-term falls in real pay that took place as a result of the period of pay restraint in the years after 2010 may be a factor in their thinking. While pay restraint was also experienced by the rest of the public sector, many of the consultants we spoke to felt that their pay had fallen behind that of the groups that they compare themselves to, such as lawyers and accountants.

7.41 While the Gender Pay Gap in Medicine Review has, at the time of writing, not yet been published, we note that many parties feel that the current pay structure for consultants, in particular the very long pay spines where base pay is based on time in role, exacerbate the gender pay gap, and also the discretionary reward systems currently in place in all four nations. While we await the findings and recommendations of the review, the scope of which covers England only, we expect that issues will be highlighted that also resonate in Scotland, Wales and Northern Ireland. We also hope that this can trigger renewed contract reform efforts.

7.42 We also note the delay to the introduction of reformed local CEAs in England to 2022, though we welcome that changes will be broadly based on the 2012 DDRB paper *Review of the compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*. Given that some parties have expressed significant concern about the workability of the system and have said that the awards as they are currently constituted do not fulfil their stated purpose of rewarding excellence, we hope that reforms that address parties' concerns can progress without further delay. The discretionary reward systems for consultants in Scotland, Wales and Northern Ireland are similarly in need of re-evaluation, particularly in Northern Ireland, where the system is closed to new applicants. Given the changing way that consultants work as part of wider and multidisciplinary teams, we hope that reform to the discretionary award systems across the UK will appropriately reward excellence in this context.

7.43 We also consider that CEAs, Commitment Awards, Distinction Awards and Discretionary Points are an exacerbating factor in pay equalities issues for consultants. We have previously said that we believe that women and BAME doctors are being disadvantaged. There is a disproportionately lower number of applications for these awards from women and BAME candidates[3]. Given the increasing gender and ethnic diversity of the consultant workforce, it is increasingly important that these issues are addressed.

[3] For example the ACCEA's 2019 annual report details the gender and ethnic makeup of those who applied for and received national CEAs in the 2018 awards round. This report is available at: https://www.gov.uk/government/publications/accea-annual-report-2019

CHAPTER 8: GENERAL MEDICAL PRACTITIONERS

Introduction

8.1 In this chapter we consider issues relating to general medical practitioners (GMPs). The traditional role for GMPs is as the family doctor, working in the primary care sector of the NHS. There are several contracting arrangements in place under which primary care services are provided, and GMPs can work as independent contractors, salaried GMPs or as locums. Doctors become GMPs after five years of postgraduate medical training, comprising the two-year Foundation Programme and three years' general practice training. Doctors in general practice training are covered in Chapter 5.

Contract reform in England

8.2 In 2019 a five-year pay and contract reform agreement for England was finalised between the Department for Health and Social Care (DHSC), NHS England/Improvement (NHSE/I), and the General Practitioners Committee of the British Medical Association (BMA). The parties said that the contract would give clarity and certainty for practices. NHSE/I and the BMA agreed that there would be no further expectation of additional national funding for practice or contract entitlements until 2024-25. The agreement also included a provision for the minimum and maximum of the pay range for salaried GMPs In England to be uplifted by two per cent for the 2019-20 pay round.

8.3 The parties to the new contract agreed to ask the DDRB not to make recommendations relating to independent contractor GMP pay in England over the period of the agreement. However, the agreement said that the UK Government would continue to include recommendations on the pay of salaried GMPs in their DDRB remit from 2020 onwards, and salaried GMPs were included in our remit for England for this report.

Workforce numbers (excluding locums)

8.4 At the time of writing, the latest estimate of the number of GMPs in England was from March 2020. The headcount estimate for GMPs was 41,267, an increase of 1.4 per cent from March 2019. The full-time equivalent (FTE)[1] estimate for GMPs in March 2020, was 33,135, a fall of 0.9 per cent from March 2019. Excluding GMP contractors and GMP registrars, which fell outside our remit this year, there were 13,980 salaried GMPs and GMP retainers[2] on a headcount basis and 8,883 on an FTE basis.

8.5 In September 2019, the latest date for which data is available, Scotland had 5,049 GMPs, an increase of 1.1 per cent from September 2018. Within that total the number of contractors fell by 1.8 per cent, the number of salaried GMPs increased by 9.7 per cent, and the number of registrars increased by 6.6 per cent.

8.6 The most recent data measuring the number of GMPs in Wales was at 29 February 2020. The data showed 2,283 GMPs, of which 1,972 were practitioners, 296 registrars and 15 were retainers. Changes to the way in which the data have been collected mean that care needs to be taken when making comparisons with previous years. However, compared with 30 September 2018, the previous date for which data were available, the overall number of GMPs increased by 3.4 per cent, of which practitioners had increased by 0.4 per cent and the number of registrars by 28.7 per cent.

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

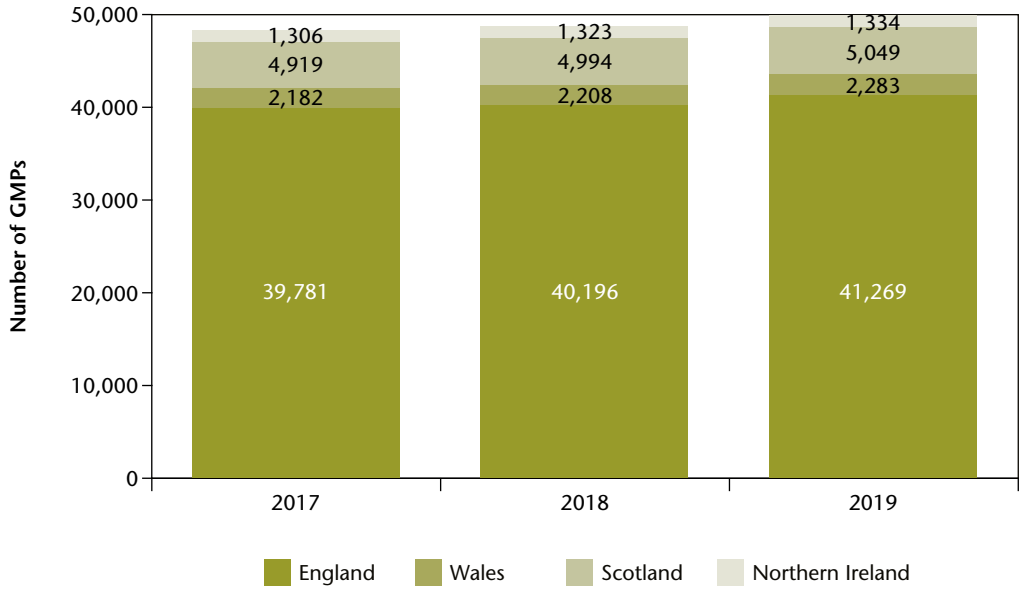
[2] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

8.7 The latest data for Northern Ireland, from March 2019, was for 1,334 GMPs, an increase of 0.8 per cent from one year earlier.

8.8 The composition of the GMP workforce has changed over recent years, with the share of contractor GMPs having fallen and that of salaried GMPs having increased. In England, between September 2015 and March 2020, the proportion of the GMP workforce headcount made up of contractors had fallen from 61 per cent to 51 per cent, while that of salaried GMPs increased from 26 per cent to 33 per cent. In Scotland between 2009 and 2019, the proportion of the GMP workforce made up of contractors fell from 78 per cent to 66 per cent, while that of salaried GMPs increased from 10 per cent to 21 per cent.

8.9 The share of the GMP workforce accounted for by women has also been increasing. Between 2009 and 2019, the proportion of the general practice medical workforce accounted for by women in Scotland increased from 51 per cent to 61 per cent. In 1985, in Northern Ireland, women made up fewer than 20 per cent of the GMP population, but by 2019 that had increased to 56 per cent. Over a shorter period, between 2015 and 2019, in England, the share of the GMP workforce made up of women increased from 54 per cent to 57 per cent.

Figure 8.1: Number of GMPs, headcount, United Kingdom, 2017 to 2019



Source: NHS Digital, NHS Education for Scotland, StatsWales, Northern Ireland Statistics and Research Agency.
Note: Wales data for 2019 is at February 2020.

Access to GMP services

England

8.10 NHSE/I told us that the number of patients per practice has increased from 6,250 in 2005 to 8,737 in 2019. Over the same period the number of practices has decreased, reflecting a trend towards larger practices employing more GMPs. Results from the 2019 GP Patient Survey found that 67.4 per cent of patients rated their overall experience of making an appointment as good and 82.9 per cent described their overall experience of the GMP surgery as good.

8.11 DHSC said that access to GMP services had been supported by the GP Forward View, which provided funding to Clinical Commissioning Groups (CCGs) around the country to improve access to GMP services by 2020. This includes ensuring access to appointments at evenings and weekends to meet locally determined demand, as well as to out-of-hours and urgent care. DHSC said that the GP Forward View had led to greater choice for patients and additional capacity to reduce the pressure on general practice. The GP Forward View built on the work of the GP Access Fund, the first two waves of which saw £150 million invested in plans to innovate primary care services between 2014-2016.

Scotland

8.12 The Scottish Government told us that the number of GMP practices has decreased by nine per cent since 2009 due to a trend for larger practices with a greater number of GMPs serving more patients, but access to GMP practices remained good. They noted that there were more GMPs per head in Scotland than elsewhere in the UK. The Scottish Health and Social Care Experience Survey for 2017-18 found that 87 per cent of people found it easy to contact their GMP practice and 76 per cent were happy with the opening hours of their GMP practice.

8.13 They also said that their transformation of primary care, which included the development of multidisciplinary teams, would put in place long-term, sustainable change within GMP services so that they can better meet changing needs and demands, to ensure that patients can access the right person at the right time.

Northern Ireland

8.14 The Department of Health told us that there had been a decrease in the number of GMP practices and an increase in the number of patients per GMP practice between 2014 and 2019. In this same period the headcount number of GMPs has increased. They told us that the move to fewer but larger GMP practices was likely to continue, particularly in rural areas where a greater number of practices are run by a single partner and recruitment challenges are greater.

8.15 The Department told us that for 2019-20, it had invested £26.76 million in GMS-related services. The funds would in part be used to support the development of multi-disciplinary teams, which they said would play a key role in improving population health and wellbeing, as well as developing care pathways and services to meet population needs, providing access to specialised and appropriate care at the earliest stage.

Recruitment and retention

8.16 Recruitment into general practice training reached a record high in 2019, with 3,512 doctors entering training in England, 325 in Scotland, 186 in Wales and 108 in Northern Ireland. All were significant increases on 2018. We cover specific initiatives undertaken in each of the nations to attract trainees into general practice training, as well as the pay and conditions of general practice trainees, in Chapter 5.

England

8.17 DHSC said that NHSE/I was working with Health Education England (HEE) to increase the size of the general practice workforce, including measures to boost recruitment into general practice, encourage GMPs to return to practice, and address the reasons why experienced GMPs are considering leaving the profession. They said that they had committed to growing the workforce by 6,000 doctors. They also said that NHSE/I had launched a number of schemes to improve retention, including a GP Retention Fund to support doctors to stay in the workforce by promoting new ways of working and offering additional support; a GP Retention Scheme to provide financial and educational support for doctors who work four or fewer sessions per week; and a National Induction and Refresher Scheme to provide a safe, supported and direct route for qualified GMPs to return to or join NHS general practice in England. NHSE/I said that 391 GMPs had completed the scheme, with a further 182 on the scheme as of February 2020.

8.18 NHSE/I said in their written evidence, which was finalised before the coronavirus (COVID-19) pandemic, that their international GMP recruitment programme had been expanded and they were seeking to attract an additional 2,000 doctors from overseas to work in general practice in England, with 170 doctors recruited at the time of writing.

Scotland

8.19 The Scottish Government told us that recruitment and retention is a particular challenge in rural areas. They said they had accepted recommendations by the Remote and Rural Working Group which produced the report *Shaping the Future Together: Remote and Rural General Practice Working Group*[3] to examine how primary health care can be improved and how the new GMS contract can be supported in rural areas. Recommendations for the Scottish Government and Scottish General Practitioners Committee include initiatives to support the contract in rural areas with a commitment to maintain the income and expenses of GMPs and ensure that the terms and conditions outlined in Phase Two of the GMP contract takes into consideration the diversity of remote and rural practice. Other initiatives include the improvement of infrastructure to support multidisciplinary working and the development of criteria for the use of the Rural Fund.

8.20 They also said that they had 'Golden Hello' payments available for new GMPs if the Health Board believes that the practice is experiencing significant difficulties regarding recruitment and retention. Higher payments than the £5,000 minimum are available in remote and rural and deprived areas.

Wales

8.21 The Welsh Government told us that the total GMP workforce (GMPs, GMP registrars, GMP retainers and GMP locums) had increased by 1.7 per cent between 2017 and 2018. They said that the increase in the number of GMP locums, by 3.2 per cent to 778, was a pressing issue. The latest data, for February 2020, shows a fall of 1.2 per cent in the number of GMP locums since 2018.

8.22 As part of the introduction of the state-backed Scheme for General Medical Practice Indemnity, the All Wales Locum Register was introduced in April 2019 for GMP locums who want to access the new scheme. The Welsh Government said that they hope that the register will provide a greater understanding of the support needed by locums and the service they provide to general practice.

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[3] Scottish Government (16 January 2020), *Shaping the Future Together: Remote and Rural General Practice Working Group report.* Available at: https://www.gov.scot/publications/shaping-future-together-report-remote-rural-general-practice-working-group/

Northern Ireland

8.23 The Department of Health said that it had continued to work with the Health and Social Care Board and other stakeholders to support GMP recruitment and retention.

8.24 The Department said that the GMP Induction and Refresher Scheme provided an opportunity for GMPs who had previously been on the General Medical Council's (GMC) GP Register and on a UK Performers' List to return to general practice following a career break, or time spent working abroad. They said that as of November 2019, seven doctors had completed the scheme, with a further two currently on the scheme. The Department also told us about the GP Retainer Scheme, designed to assist in the retention of GMPs, providing stable work in practices and including a Continuing Professional Development (CPD) programme to assist with appraisal and revalidation. At November 2019, 21 doctors were currently on the GP Retention Scheme with two applications in progress.

GMP trainers' grant and clinical placement funding

8.25 The GMP trainers' grant, from 1 April 2019, was £8,350. DHSC said they were working with stakeholders to introduce a fair and equitable approach to the funding of clinical placements in GMP practices, irrespective of geography and historical arrangements, and any changes for the 2020-21 financial year would be communicated as part of the annual Education and Training tariff guidance document.

Independent contractor GMPs

England

8.26 As explained in paragraph 8.3, the review body will not be making recommendations for contractor GMPs in England this year, since they are subject to a multi-year pay deal. Therefore, we will not be commenting on contractor GMPs in England.

Scotland

8.27 The Scottish Government told us that a new GP contract was being introduced in two phases, the first having been introduced in April 2018, and the second to be introduced in 2021. The contract aims to improve access and address health inequalities, as well as increase the support provided to GMPs (including decreasing the risk assumed by owning a practice) and expanding multidisciplinary teams.

8.28 Both phases of contract reform also include changes to GMPs' incomes and reimbursement. Phase One introduced a whole-time-equivalent minimum earnings expectation of £80,000 per year (including pension contributions), subsequently £84,360 per year, and Phase Two includes introducing an income range for partners that is comparable to consultants.

Wales

8.29 The Welsh Government told us that as well as the DDRB uplift for earnings, the General Medical Services contract agreed for 2019-20 included an uplift of three per cent for expenses. It also included a new Partnership Premium Scheme, which has up to £5 million of funding, to incentivise partnership working and encourage new GMPs to take up partner roles.

8.30 From 1 April 2019 contractor GMPs will also benefit from the new Scheme for General Medical Practice Indemnity, which provides clinical negligence indemnity for providers of general practice services in Wales. The Scheme is aligned with the scheme introduced in England.

Northern Ireland

8.31 The Northern Ireland Executive told us that they were making good progress with the implementation of the Multi-Disciplinary Teams model, with over 200 new staff working in 61 practices under the new model. They added that they were also investing money into Practice-Based Pharmacists and Advanced Nurse Practitioners, into premises and into the development of GP Federations to aid resilience and support smaller and rural practices.

8.32 They said that they were also continuing their work towards phasing out the Minimum Practice Income Guarantee in favour of a more equitable system of core funding for practices, and that work in partnership with the BMA Northern Ireland General Practice Committee towards reviewing GMS arrangements was ongoing.

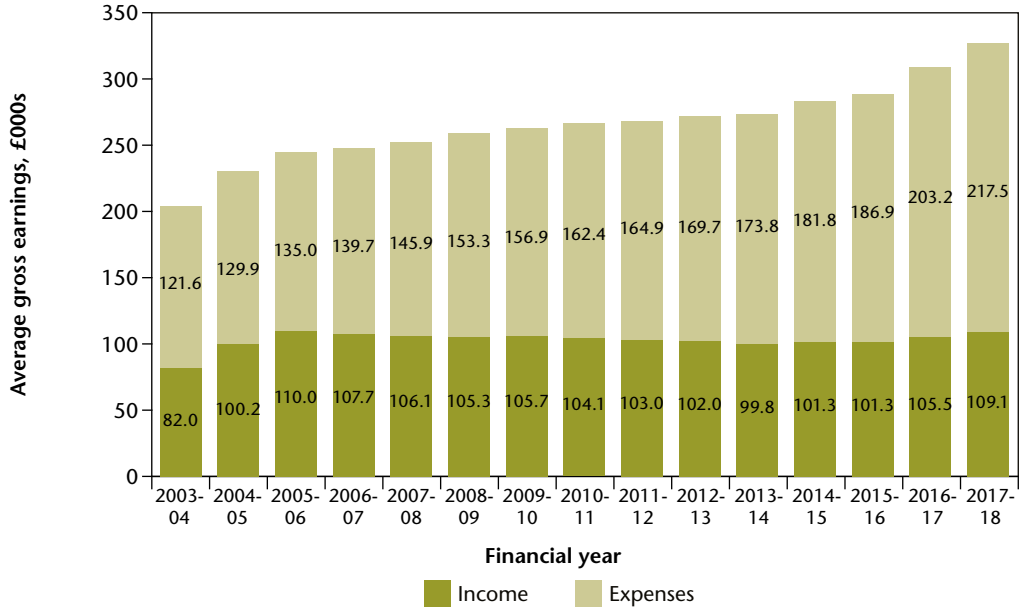
Income

8.33 In 2017-18, on a headcount basis across the UK, average gross earnings of independent contractor GMPs was £326,600. Contractor GMPs had average expenses of £217,500, giving an average income of £109,100, an increase of 3.5 per cent from 2016-17, and the highest level since 2005-06. These trends are illustrated in Figure 8.2.

8.34 There was variation in income by country, with the average income highest in England (£113,400), followed by Wales (£99,800), Northern Ireland (£93,400) and Scotland (£93,100). There were increases in income in each of the four countries; 3.4 per cent in England, 3.4 per cent in Wales, 3.1 per cent in Northern Ireland and 2.5 per cent in Scotland.

8.35 The average earnings estimates are produced on a headcount basis, and take no account of hours worked. NHS Digital produce estimates of the numbers of contractor GMPs for England, on both a headcount basis and an FTE basis. This shows that the number of FTE contractor GMPs in September 2017 was 89 per cent of the headcount number of contractor GMPs. If the relationship for average earnings on a FTE basis were calculated in a similar way, this would give an FTE average earnings estimate for 2017-18 of £127,900 rather than £113,400 on a headcount basis.

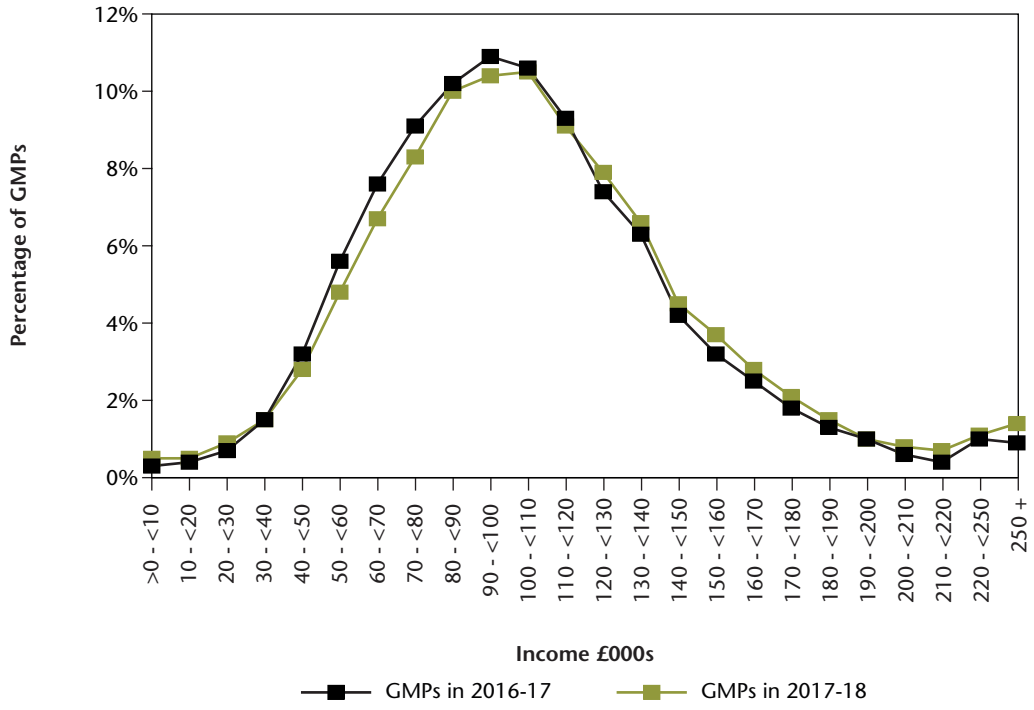
Figure 8.2: GMP contractors' average gross earnings: income and expenses, United Kingdom, 2003-04 to 2017-18



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

8.36 The distribution of contractor GMP income across the UK was largely unchanged from 2016-17. About one in four GMPs earned less that £80,000, whilst a similar proportion earned over £130,000 (Figure 8.3). These figures are calculated on a headcount basis, so it is likely that the lowest paid GMPs are working part time.

Figure 8.3: Distribution of GMP contractors' income before tax, United Kingdom, 2016-17 and 2017-18



Source: NHS Digital using HMRC data, GMP Earnings and Expenses.

Salaried GMPs

England

8.37 NHSE/I said that the number of salaried GMPs increased by 27 per cent (headcount) between September 2015 and September 2019, compared to a 10.7 per cent increase across all GMPs. Salaried GMPs comprise 29 per cent of all GMPs on a headcount basis and 24 per cent on an FTE basis. Therefore, salaried GMPs work, on average, fewer hours per week than contractors, and so as the proportion of salaried GMPs increases, overall workforce availability may increase slightly more slowly than headcount increases might suggest.

8.38 NHSE/I told us in their evidence that the fixed contract resources available under the multi-year pay and contract agreement in place for contractor GMPs from 2019 would allow for pay rises for salaried GMPs of two per cent per year.

Scotland

8.39 The Scottish Government told us that the Primary Care Workforce Survey Scotland found that salaried GMPs were 17 per cent of the total GMP workforce, and on average they work fewer sessions per week than contractors.

Wales

8.40 The Welsh Government told us that the remuneration of salaried GMPs is beyond their control, but that there is a concern that they are not always sharing in the uplifts that are being given to contractor GMPs.

Income

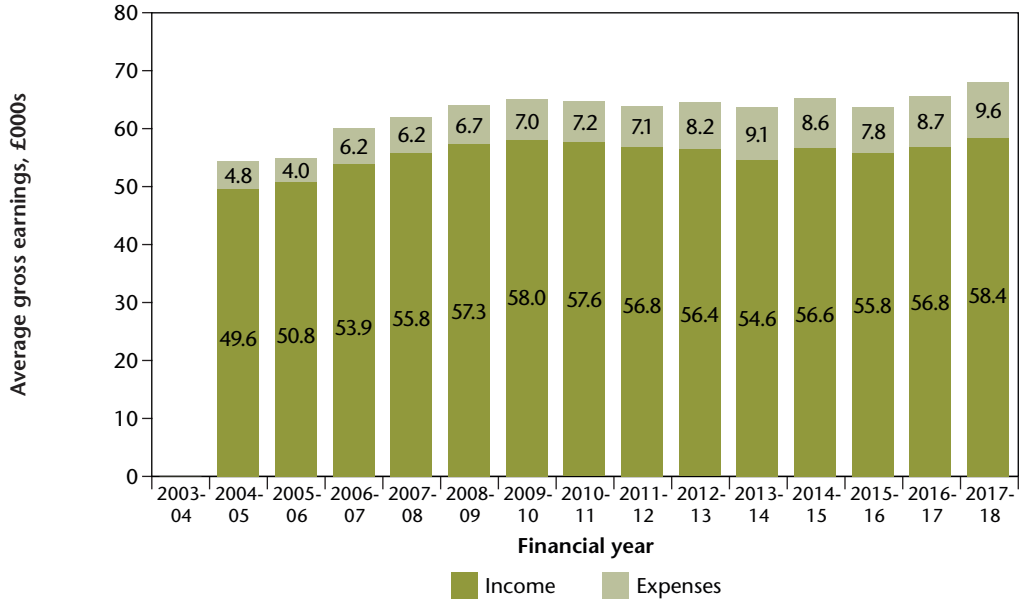
8.41 In 2017-18, on a headcount basis across the UK, average gross earnings of salaried GMPs was £68,100. Salaried GMPs had average expenses of £9,600, giving an average income of £58,400, an increase of 2.9 per cent from 2016-17 (Figure 8.4).

8.42 A quarter of salaried GMPs had an income below £40,000, whilst a similar share had income above £70,000 and seven per cent had income above £100,000.

8.43 The average income in 2017-18 was highest in Scotland (£62,900), followed by England (£58,400), Northern Ireland (£56,700) and Wales (£52,100). There was an increase in salaried GMP income over 2016-17 of 3.2 per cent in England, 2.5 per cent in Northern Ireland and 1.7 per cent in Scotland, while incomes fell in Wales by 3.0 per cent.

8.44 The average earnings estimates are produced on a headcount basis, and take no account of hours worked. NHS Digital produce estimates of the numbers of salaried GMPs for England, on both a headcount basis and an FTE basis. This shows that the number of FTE salaried GMPs in September 2017 was 67 per cent of the headcount number of salaried GMPs. If the relationship for average earnings, on an FTE basis were calculated in a similar way, this would give an FTE average earnings estimate for 2017-18 of £87,700 rather than £58,400 on a headcount basis.

Figure 8.4: Salaried GMPs' average gross earnings, income and expenses, United Kingdom, 2003-04 to 2017-18



Source: NHS Digital using HMRC data, GMP Earnings and Expenses.
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

Expenses and formula

8.45 In 2016 we took a decision to make recommendations on our intended increase in pay net of expenses. Taking this approach required the parties to discuss expenses in order to ascertain a gross increase. For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formulae for both GMPs and general dental practitioners had we used the formula-based approach.

8.46 The Scottish Government told us that Phase Two of the new GP contract, which will be in place from 2022, will include direct reimbursement of agreed practice expenses.

Our comments

8.47 We note that all four nations have, in different ways, dedicated more funding and resource to general practice. In particular, in England and Wales an enhanced and more capable general practice is central to the strategic direction of the NHS in both countries. Given this, the increase in recruitment into general practice training is welcome. We would also welcome evidence from the parties as to whether this transformation is having the desired effect.

8.48 At the same time, the GMP workforce is changing. Salaried GMPs make up an ever-larger proportion of the overall workforce. The latest figures, for March 2020, show that salaried GMPs in England work on average 0.65 FTE, compared to 0.85 FTE for contractor GMPs, so the effective size of the workforce has not increased as quickly as the total headcount. We would welcome more data on the impact of changes to the numbers of contractor and salaried GMPs on workforce availability in Scotland, Wales and Northern Ireland, including in particular whether the increasing number of salaried GMPs is affecting the average FTE worked by the GMP workforce. Given this change, we would also welcome data from the parties on how our recommendations for salaried GMPs are ultimately reflected in their pay.

8.49 These changes are taking place alongside changes to how practices are staffed, with a focus on increasingly multidisciplinary teams, including introducing new roles, such as physician associates, paramedics and pharmacists, all of whom can perform some functions traditionally carried out by doctors, to allow general practice to become more effective and to provide more joined-up care.

8.50 It seems as if the appeal of partnership is decreasing for newly qualified GMPs, who may prefer the flexibility of salaried work or may be discouraged by the business responsibilities and potential financial risks involved in being a practice partner. We note that in response to these trends, some governments have sought to incentivise GMPs becoming partners, and have also sought to reduce the financial risks. We would welcome evidence on the effectiveness of these measures, including those intended to decrease the financial risks associated with being a GMP partner, in future rounds.

8.51 We await with interest the Gender Pay Gap in Medicine Review, which will explore how these dynamics interact with issues related to gender pay, given that the general practice workforce is increasingly female. We hope that this can also lead to exploration of pay gap issues for other groups with protected characteristics. We would also welcome evidence from the parties about how the new incentive schemes to encourage more GMPs to become partners might be impacting gender pay gaps.

8.52 There are still issues of recruitment and retention in general practice. In particular, there continue to be difficulties in remote and rural areas, despite the efforts being made across the UK. On one of our visits we heard from NHS leaders in one such area who described acute difficulties in attracting GMPs to the area. Additionally, we note that the NHS seems to struggle with retaining older GMPs who are towards the end of their careers. In England, in each of the last five years, the number of GMPs claiming their NHS pension on a voluntary early retirement (VER) basis accounted for more than half of all GMP retirements.

8.53 We also note with interest the creation of the All Wales Locum Register, and the Wales National Workforce Reporting System, which the Welsh Government told us would be used to improve their understanding of the general practice workforce. We would welcome receiving details of the insights these initatives generate in future years.

8.54 Finally, we welcome the investment in general practice as it plays such a critical part in the strategic direction of health services across the UK, as underlined by publications such as *A Healthier Wales: Our Plan for Health and Social Care* and the *NHS Long Term Plan*. However, further work is needed to improve recruitment and retention in areas with continuing shortages of GMPs.

CHAPTER 9: DENTISTS

Introduction

9.1 Our remit covers all general dental practitioners (GDPs) and salaried dentists providing NHS/Health Service dentistry in England, Wales, Scotland, and Northern Ireland. This includes dentists working in the Community Dental Services (CDS) in England, Wales and Northern Ireland, and the Public Dental Service (PDS) in Scotland.

University admissions

9.2 A career in dentistry starts with at least five years' undergraduate study and then a further year in dental foundation training. In 2019 there were 3,895 applicants to study pre-clinical dental degrees in the UK who between them made 11,450 applications (an average of 2.9 applications per applicant). Of these 1,140 were accepted on a course. This represents a ratio of applicants to acceptances of 3.42. The number of applicants fell each year from 2011 to 2016 before increasing in each of the last three years, and by 28 per cent in 2019, compared with 2018. The number of acceptances, between 1,125 and 1,140 have been little changed in the last three years.

Table 9.1: Numbers of applications, unique applicants and acceptances for dental degrees, UK, 2011-2019

	Number of Applications	Number of Unique Applicants	Number of Acceptances	Applications per Acceptance	Unique Applicants per Acceptance
2011	12,550	3,820	1,195	10.5	3.20
2012	11,630	3,515	1,195	9.7	2.94
2013	11,350	3,455	1,190	9.5	2.90
2014	11,210	3,410	1,105	10.1	3.09
2015	9,875	3,010	1,095	9.0	2.75
2016	9,060	2,810	1,100	8.2	2.55
2017	9,240	2,885	1,135	8.1	2.54
2018	9,850	3,040	1,125	8.8	2.70
2019	11,450	3,895	1,140	10.0	3.42

Source: OME estimates using UCAS data.

9.3 The gender and ethnic composition of those accepted to study for a dentistry degree has changed since 2011. Over that period the share of students accepted that were female had increased from 57 per cent to 64 per cent, while the share of students accepted that were black, Asian and minority ethnic (BAME) increased from 46 per cent to 58 per cent.

9.4 Table 9.2 shows the 10 undergraduate subjects with the largest ratio of applications to acceptances in 2019. This shows that pre-clinical dentistry remains the subject with the highest ratio of applications to acceptances.

Table 9.2: Subjects[1] with the highest ratio of applications to acceptances, United Kingdom 2019

Subject	Ratio of applications to acceptances 2019
Pre-clinical dentistry	10.0
Artificial intelligence	8.7
Pre-clinical medicine	8.4
Pre-clinical Veterinary Medicine	7.2
Spanish studies	6.9
Anatomy, physiology and pathology	6.8
Astronomy	6.6
Others in Business & Admin Studies	6.6
French studies	6.5
Economics	6.4

Source: OME calculations using UCAS data.

General dental practitioners

9.5 While terminology differs between the nations of the UK, GDPs delivering NHS services are generally split into two categories. Dentists that hold a contract with the NHS to provide services are referred to as 'providing-performer' or 'principal' dentists. Dentists that deliver NHS services under a contract held by another body, which can be a limited company or a providing-performer partnership, are referred to as 'performer-only' or 'associate' dentists. Associate dentists usually practice as subcontractors. In this report we will refer to the former group as providing-performers and the latter as associates.

9.6 The remit of the DDRB includes making recommendations on the pay of GDPs. Associate dentists will be paid by the practice owner or company concerned, though in Scotland associates are paid through Practitioner Services, and depending on the nature of the associate agreement, they may have to give a proportion of the contract value to the practice owner. Providing-performer dentists will be paid out of the value of their contract. In either case their income will be funded by the contracts negotiated with the NHS, often supplemented by additional revenues generated by private work.

9.7 Dental contracts in different parts of the UK are structured differently. In England and Wales, contracts are structured around the Unit of Dental Activity (UDA). Different dental treatments are worth different numbers of UDAs. Those that hold contracts to deliver NHS dentistry are expected to perform a set number of UDAs (and, where applicable, units of orthodontic activity (UOAs)) each year, with provisions for 'clawback' – the recovering of contract values, if UDA/UOA targets are not met. In Scotland and Northern Ireland, remuneration is based on a mix of Item of Service payments, where fixed amounts are recoverable for different treatments; capitation, where a fixed amount is paid per patient registered; and other allowances.

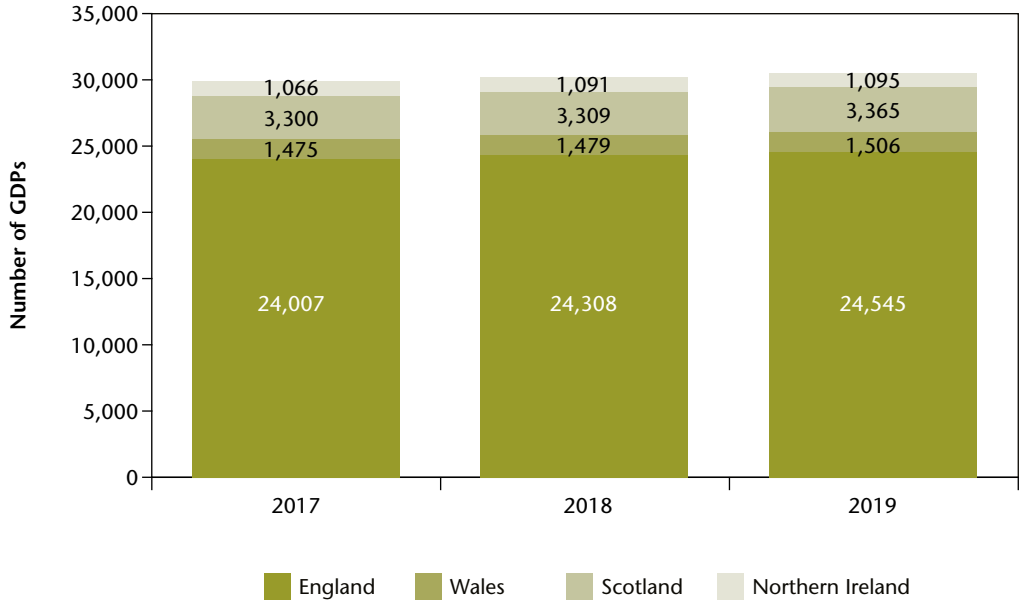
9.8 GDPs differ from general medical practitioners (GMPs) in that, typically, a significant proportion of GDP practices combine NHS and private dentistry. This means that both practices' and dentists' income can be subject to an element of wider market pressure.

9.9 Earnings can vary based on career choices, the balance of NHS and private work, the number of hours worked and the location of the practice. Calculated on a headcount basis, and including both NHS and private income, on average, in 2017-18 providing-performer dentists in England and Wales earned £116,700, while associates earned £59,700. The equivalent figures for Scotland were £107,600 and £55,400, and for Northern Ireland, £116,000 and £52,300.

[1] This table only looks at subjects that had at least 100 acceptances in 2018.

9.10 In 2019[2] there were 30,511 dentists providing NHS services in the UK, an increase of 324 (1.1 per cent) from a year earlier. There was an increase in each of the countries of the UK: of 237 (1.0 per cent) in England, 56 (1.7 per cent) in Scotland, 27 (1.8 per cent) in Wales, and four (0.4 per cent) in Northern Ireland.

Figure 9.1: Number of GDPs, United Kingdom, 2017 to 2019



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

9.11 Within the overall total there has been a trend for growth in the number of associate dentists and a decline in the number of providing-performer dentists[3]. In England and Wales the share of the GDP population accounted for by providing-performer dentists has decreased from 35 per cent in 2008-09 to 15 per cent in 2017-18, while in Scotland the share of the GDP population accounted for by providing-performer dentists decreased from 35 per cent to 22 per cent over the same period. Northern Ireland has also experienced a decline, with the share of the GDP population accounted for by providing-performer dentists declining from around 40 per cent in 2009-10 to less than a quarter in 2017-18. This change has taken place alongside continued growth in the proportion of dentists who are women and BAME. In all four countries of the UK, there are now more female than male dentists.

Access to dental services

England

9.12 NHS England/Improvement (NHSE/I) said that ensuring equity of access to primary dental care services is a central goal. They added that while service utilisation and access to commissioned care remains high, there are persistent pockets of reduced use and accessibility.

[2] Data for Scotland and Wales are for 30 September 2019. The latest available data for England and Northern Ireland are as at 31 March 2019.

[3] NHS Digital (29 August 2019), *Dental Earnings and Expenses Estimates 2017/18*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/dental-earnings-and-expenses-estimates/2017-18

9.13 They said that March 2019 GP Patient Survey[4] data showed that 94 per cent of people surveyed who had tried to get an appointment with an NHS dentist in the past two years were successful, rising to 96 per cent in the six months to March 2019. They also said that dental attendance figures are relatively stable, with adult attendance dropping slightly and child attendance increasing.

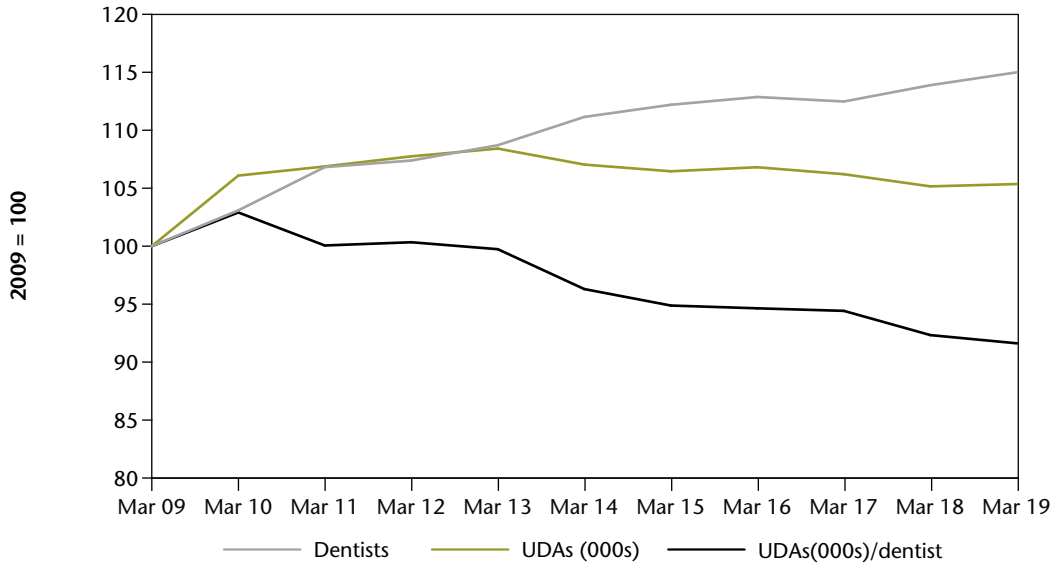
9.14 In our 2019 report we discussed the results from the most recent surveys of dental working hours, for both 2016-17 and 2017-18, which were published[5] in August 2018. The results for England, which included all self-employed primary care dentists who provided some NHS treatment between April 2016 and March 2018, showed that in 2017-18 dentists worked on average 36.6 hours per week of which 25.7 hours (70.3 per cent) were dedicated to NHS dentistry. Compared with 2016-17, this represents a fall of 0.2 hours worked, and a reduction of 1.0 hours in the number of hours devoted to NHS dentistry.

9.15 Despite the number of dentists providing services increasing, the number of UDAs commissioned in England has been slowly declining since 2013. NHSE/I said that this was as a result of changed commissioning models, since some initiatives, such as the Starting Well programme for children, have seen UDAs exchanged for preventive activity within fixed contract envelopes. The British Dental Association (BDA) said that dentists are being forced to spend a greater proportion of their time on administrative tasks, which reduces the time GDPs can spend on fee-paying clinical activity. It is also possible that the fall in commissioning numbers can be linked to dentists' changing working patterns, including potentially increased part-time working and dentists devoting a greater share of their time to non-NHS work. It could also be as a result of improved oral health, though it is not clear that such an improvement has taken place. The apparent conflict between an increasing number of dentists providing NHS services and a decline in the number of UDAs commissioned has not been fully resolved. It would be useful, in future rounds, if this was examined more fully by stakeholders and also if regard was given to the way that the value of UDAs was calculated.

[4] NHS England (11 July 2019), *GP Patient Survey Dental Statistics; January to March 2019, England*. Available at: https://www.england.nhs.uk/statistics/2019/07/11/gpps_dent_8492_822742/

[5] NHS Digital (30 August 2018), *Dental Working Hours – 2016/17 and 2017/18: Working Patterns, Motivation and Morale*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2016-17-and-2017-18-working-patterns-motivation-and-morale

Figure 9.2: Dentists providing NHS services, Units of Dental Activity (UDAs) commissioned, England, 2009 to 2019



Source: NHS Digital and NHSE/I Dental Commissioning Statistics.

Wales

9.16 The Welsh Government said that access to NHS dental services in Wales had risen. 1.73 million patients were treated in the 24 months to September 2019, which was 11,100 higher than a year before and 131,000 higher than the low point in March 2008 (though these data do not include those that are treated by Community Dental Services). The proportion of the Welsh population who were treated by a dentist was 55.15 per cent in the 24 months to September 2019, up from 54.79 per cent in the 24 months to September 2018. As a result of significant numbers of practices in Wales now operating under reformed contracts with reduced numbers of UDAs, it does not make sense to examine trends in the number of UDAs commissioned in Wales.

9.17 The BDA told us that population growth was negating the increases in the number of patients being seen by an NHS dentist in Wales. They also said that their own research had found only a small minority of practices were accepting new NHS patients (15.5 per cent for adults and 27 per cent for children). When asked about these findings, the Welsh Government said that this data represents only a snapshot, and the true access position was being improved by the contract reform programme.

9.18 In August 2018 the Dental Working Hours surveys for both 2016-17 and 2017-18 were published[6]. The results for Wales, which included all self-employed primary care dentists who provided some NHS treatment between April 2016 and March 2018, showed that in 2017-18 dentists worked on average 36.5 hours per week, of which 27.0 hours (74.2 per cent) were dedicated to NHS dentistry. Compared with 2016-17, this represented an increase of 0.2 hours worked and a reduction of 0.2 hours in the number of hours devoted to NHS dentistry.

[6] NHS Digital (30 August 2018), *Dental Working Hours – 2016/17 and 2017/18: Working Patterns, Motivation and Morale*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2016-17-and-2017-18-working-patterns-motivation-and-morale

Scotland

9.19 The Scottish Government told us that the percentage of the population registered with an NHS dentist continued to increase. In September 2019, 95.7 per cent of the population were registered, compared with 94.2 per cent in September 2018 and 77.9 per cent in September 2012. They also told us that the National Dental Inspection Programme, which reports on the oral health status of primary school children in Scotland, found that 80 per cent of primary 7 children had "no obvious decay experience" in 2019, compared to 64 per cent in 2009, and for primary 1 children in 2018, 71 per cent had "no obvious decay experience", compared to 58 per cent in 2008.

9.20 In August 2018 the Dental Working Hours surveys for both 2016-17 and 2017-18 were published[7]. The results for Scotland, which included all self-employed primary care dentists who provided some NHS treatment between April 2016 and March 2018, showed that in 2017-18 dentists worked on average 38.2 hours per week of which 29.4 hours (76.9 per cent) were dedicated to NHS dentistry. Compared with 2016-17, this represents a reduction of 0.1 hours worked and a reduction of 0.5 hours in the number of hours devoted to NHS dentistry.

Northern Ireland

9.21 The Department of Health said that access issues that had been a problem a decade ago had now largely been resolved and the number of patients registered with a GDP in March 2019 stood at 1.213 million, or 64 per cent of the total population, compared with 48 per cent in 2008. However, they also said that the level of GDS contract activity, in respect of fillings, extractions and crowns, fell by 3.2 per cent between 2016-17 and 2018-19, although the BDA said that this statistic presents an unfair impression of GDP activity in Northern Ireland. They added that data from the Business Services Organisation demonstrates that activity had in fact increased by one per cent during this period.

9.22 In August 2018 the Dental Working Hours surveys for both 2016-17 and 2017-18 were published[8]. The results for Northern Ireland, which included all self-employed primary care dentists who provided some Health Service treatment between April 2016 and March 2018, showed that in 2017-18 dentists worked on average 36.5 hours per week of which 25.5 hours (69.7 per cent) were dedicated to NHS dentistry. Compared with 2016-17, this represented a reduction of 0.6 hours worked, and a reduction of 0.9 hours in the number of hours devoted to NHS dentistry.

Motivation

9.23 The latest results from the Dental Working Hours Motivation and Morale survey were for 2016-17 and 2017-18, and we referenced them in last year's report. This survey covers the whole of the UK. The main points of the responses to the survey were:

- Only a small proportion of dentists in England and Wales agreed or strongly agreed that their pay was fair (21 per cent of providing-performers and 19 per cent of associates). The proportions in Scotland and Northern Ireland were similar or lower (14 and 22 per cent for providing-performers and associates respectively in Scotland, and 12 and 16 per cent in Northern Ireland).

[7] NHS Digital (30 August 2018), *Dental Working Hours – 2016/17 and 2017/18: Working Patterns, Motivation and Morale*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2016-17-and-2017-18-working-patterns-motivation-and-morale

[8] NHS Digital (30 August 2018), *Dental Working Hours – 2016/17 and 2017/18: Working Patterns, Motivation and Morale*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2016-17-and-2017-18-working-patterns-motivation-and-morale

- In 2017-18 just under half of all dentists agreed or strongly agreed that they felt good about their job as a dentist. Between 2012-13 and 2017-18, the proportion of dentists giving a positive answer to this question has declined for both providing-performer and associate dentists in each of England and Wales, Scotland and Northern Ireland.
- In 2017-18 between 30-40 per cent of dentists, in each of England and Wales, Scotland and Northern Ireland, and for both providing-performer and associate dentists, agreed or strongly agreed that they had opportunities to progress in their career.
- Between 2014-15 and 2017-18 the proportion of dentists saying that they agreed or strongly agreed with the statement that they thought about leaving general dentistry increased across the UK and for both providing-performer and associate dentists. In 2017-18 over 60 per cent of providing-performer dentists and 50 per cent of associate dentists in all parts of the UK answered this way.
- In 2017-18 just 20 per cent of providing-performer dentists in England and Wales rated their morale as high or very high. The figures for Scotland (18 per cent) and Northern Ireland (14 per cent) were even less positive. Compared with 2012-13, the latest results for both England and Wales, and Scotland were less positive while the results for Northern Ireland are little changed. The results in 2017-18 for associate dentists were slightly more positive than for providing-performers but in all parts of the UK less than 25 per cent rated their morale highly. The proportion of positive responses has declined since 2012-13 across all parts of the UK.

Recruitment and retention

England

9.24 NHSE/I said that overall workforce numbers appeared adequate in order to meet the needs of the population, and that the number of dentists has increased in absolute terms, although they added that available data does not detail working hours, and therefore limits their ability to analyse workforce provision. They also said that they were aware of reports of difficulties in recruiting and retaining dentists in rural and coastal areas.

9.25 The BDA said that despite the rising number of dentists, practices' difficulties in recruiting associates are worsening. They quoted the results of a 2019 survey of 747 of its members with over 75 per cent commitment to the NHS, which found that 65 per cent of dentists in England intended to leave the NHS or reduce their commitment to it, down from 67 per cent in 2018. When asked about recruiting dental associates, 68 per cent of respondents who had sought to recruit had had difficulty doing so, down from 71 per cent in 2018. They said that these issues of recruitment were having a knock-on effect on service provision.

9.26 They said that the difficulty recruiting was partly explained by increasing numbers of dentists, including male and female dentists, choosing to work part-time in clinical dentistry. They also said that the shift in the balance of providing-performer and associate dentists was leading to fundamental changes in the capacity, interests and aspirations of the workforce.

Wales

9.27 The Welsh Government said that Health Boards in the more rural areas of North, Mid and West Wales were facing recruitment and retention difficulties, and that this was a growing issue particularly within larger corporate providers. They added that this had resulted in the closure of a small number of practices and was causing difficulty in filling some vacancies. They said that Health Education and Improvement Wales were looking at the commissioning of training numbers and considering whether more effective workforce models should be used to improve dentists' workloads and make practices more sustainable.

9.28 The BDA said that while the UDA commissioning process could be used to address local issues of recruitment and retention, this was not typically done in Wales. They also said that practices working on reformed contracts did not seem to find it easier to recruit or be profitable.

Scotland

9.29 The Scottish Government said that dental workforce growth is reflected in the increasing numbers of people registered with an NHS dentist, and the increase in the amount of care and treatment being provided under General Dental Services contracts. They said that their intention was to grow the workforce in the short term, in order to meet policy commitments such as expanding domiciliary care provision. However, they said that they had also taken steps to limit workforce growth by setting a dental student intake limit of 135 students from Scotland, the rest of the UK and the EU combined, in order to reduce the rate of growth in the dental workforce and ensure that the overall workforce position is sustainable.

9.30 They also described the work they were doing in areas that they considered had particular recruitment and retention needs. First, for remote and rural areas, they said that arrangements were in place for a system of recruitment and retention 'golden hello' payments, worth up to £25,000 for new dentists and £15,000 for dentists returning to the workforce, to incentivise working in these areas. They added that they were working with partners in NHS Education for Scotland and NHS Boards to consider further actions for improving recruitment and retention in these areas going forward. For more deprived areas, they described how payment arrangements for GDPs include deprivation weightings for patients whose postcodes of residence are in such areas. They provided data on how dentists are distributed across deprivation category areas, demonstrating that dentists are more likely to work in the poorest areas.

9.31 The BDA said that around one in 10 dentists in Scotland is from the EU, and in some NHS Board areas such as Dumfries and Galloway, over 40 per cent. It said that there was a significant risk that parts of Scotland will face a shortage of dentists as a result of the UK leaving the EU. It also said that tighter rules on visas for non-EU dental workers could compound recruitment problems, and that there was already some evidence that some practices – particularly in rural areas – were struggling to fill vacancies.

Northern Ireland

9.32 The Department of Health told us about the Practice Allowance, which was introduced in 2005 to support the provision of Health Service dentistry in Northern Ireland by giving financial assistance to the dental practices that are most committed to providing Health Service dentistry. The Department did not present further evidence of recruitment and retention issues for this pay round.

Earnings and expenses for providing-performer GDPs

9.33 NHS Digital, using data from Her Majesty's Revenue and Customs (HMRC), publishes statistics on the earnings and expenses of primary care dentists who carried out NHS/ Health Service work in each part of the UK. The overall picture on earnings is unclear as it is not known how many hours' work the statistics were based on, and some dentists choose to take incorporated status, affecting how their income appears in the statistics. It is also difficult to separate earnings attributable to NHS work from those arising from private practice.

England and Wales

9.34 Table 9.3 shows that in 2017-18, providing-performer dentists in England and Wales had average taxable income of £116,700, an increase of 0.7 per cent from 2016-17, and average expenses (employee plus other) of £272,000 (Expenses to Earnings Ratio (EER) of 70.0 per cent). The table also shows that employee expenses for providing-performer dentists increased by 0.1 per cent to £85,900, while non-employee expenses increased by 3.6 per cent, to £186,100.

Table 9.3: Providing-performer GDPs' average gross earnings, income and expenses, England and Wales, NHS and private, headcount, 2008-09 to 2017-18

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2008-09	6,783	366.5	74.7	160.8	131.0	64.3
2009-10	6,250	370.9	77.6	165.3	128.0	65.5
2010-11	5,750	364.3	79.0	168.1	117.2	67.8
2011-12	5,250	358.4	80.7	164.9	112.8	68.5
2012-13	4,750	368.0	80.5	173.3	114.1	69.0
2013-14	4,350	375.0	81.7	178.1	115.2	69.3
2014-15	3,950	385.6	85.5	182.8	117.4	69.6
2015-16	3,450	377.8	83.6	178.5	115.7	69.4
2016-17	3,050	381.2	85.8	179.6	115.8	69.6
2017-18	3,150	388.7	85.9	186.1	116.7	70.0
Latest change (%)		*+2.0%*	*+0.1%*	*+3.6%*	*+0.7%*	*+0.4pp*

Source: NHS Digital using HMRC data.
pp: percentage point change.
EER: expenses to earnings ratio.

Scotland

9.35 Table 9.4 shows that in 2017-18 providing-performer dentists in Scotland had average taxable income of £107,600, a decrease of 1.2 per cent from 2016-17, and average expenses (employee plus other) of £260,000 (EER 70.7 per cent). This was the second consecutive year that average nominal incomes had fallen.

Table 9.4: Providing-performer GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2008-09 to 2017-18

Year	Estimated population	Gross earnings (£000s)	Employee expenses (£000s)	Non-employee expenses (£000s)	Income (£000s)	EER (%)
2008-09	699	343.9	86.7	138.5	118.7	65.5
2009-10	650	337.0	85.8	137.4	113.8	66.2
2010-11	700	334.7	89.3	144.3	101.1	69.8
2011-12	700	332.9	86.2	143.8	102.9	69.1
2012-13	650	319.6	84.0	138.3	97.4	69.5
2013-14	650	330.3	85.0	146.9	98.4	70.2
2014-15	600	347.2	89.9	154.4	102.9	70.4
2015-16	500	377.8	97.8	169.2	110.8	70.7
2016-17	500	377.3	94.3	174.0	109.0	71.1
2017-18	500	367.7	93.4	166.6	107.6	70.7
Latest change		*-2.6%*	*-1.0%*	*-4.3%*	*-1.2%*	*-0.4pp*

Source: NHS Digital using HMRC data.
pp: percentage point change.
EER: expenses to earnings ratio.

Northern Ireland

9.36 Table 9.5 shows that in 2017-18, providing-performer dentists in Northern Ireland had average taxable income of £116,000 and average expenses (employee plus other) of £231,100 (EER 66.6 per cent). Average incomes, in nominal terms, recovered almost to the level seen in 2015-16, before a sharp drop for 2016-17, suggesting that there is a degree of volatility in these statistics associated with the small sample size.

Table 9.5: Providing-performer GDPs' average gross earnings, income and expenses, Northern Ireland, Health Service and private, headcount, 2008-09 to 2017-18

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2008-09	319	333.7	66.6	137.5	129.6	61.2
2009-10	350	344.6	73.2	148.5	122.9	64.3
2010-11	300	331.0	79.2	137.6	114.2	65.5
2011-12	350	318.6	77.0	129.1	112.5	64.7
2012-13	300	316.0	79.1	126.1	110.9	64.9
2013-14	300	335.6	76.9	146.2	112.5	66.5
2014-15	250	328.7	76.1	140.9	111.7	66.0
2015-16	250	336.0	78.6	139.8	117.6	65.0
2016-17	200	314.7	80.4	135.1	99.1	68.5
2017-18	250	347.1	76.6	154.5	116.0	66.6
Latest change		*+10.3%*	*-4.7%*	*+14.4%*	*+17.0%*	*-1.9pp*

Source: NHS Digital using HMRC data.
pp: percentage point change.
EER: expenses to earnings ratio.

Earnings and expenses for associate GDPs

England and Wales

9.37 Table 9.6 shows that in 2017-18, associate dentists in England and Wales had average taxable income of £59,700, a decrease of 1.8 per cent from 2016-17, and average expenses (employee plus other) of £43,200 (EER of 42.0 per cent).

Table 9.6: Associate GDPs' average gross earnings, income and expenses, England and Wales, NHS and private, headcount, 2008-09 to 2017-18

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2008-09	12,853	104.0	5.6	30.7	67.8	34.9
2009-10	14,050	101.7	6.7	29.4	65.6	35.5
2010-11	15,050	98.4	5.9	29.6	62.9	36.0
2011-12	16,050	96.2	5.6	28.9	61.8	35.8
2012-13	16,800	96.2	6.0	29.4	60.8	36.8
2013-14	17,150	99.0	6.7	31.8	60.6	38.8
2014-15	17,400	99.8	6.9	33.0	59.9	39.9
2015-16	17,750	103.5	7.9	35.5	60.2	41.9
2016-17	18,150	106.4	8.3	37.3	60.8	42.8
2017-18	18,400	103.0	7.6	35.6	59.7	42.0
Latest change		*-3.2%*	*-8.4%*	*-4.6%*	*-1.8%*	*-0.8pp*

Source: NHS Digital using HMRC data.
pp: percentage point change.
EER: expenses to earnings ratio.

Scotland

9.38 Table 9.7 shows that in 2017-18, associate dentists in Scotland had average taxable income of £55,400, a decrease of 2.0 per cent from 2016-17, and average expenses (employee plus other) of £29,900 (EER of 35.0 per cent).

Table 9.7: Associate GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2009-10 to 2017-18

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2009-10	1,450	91.9	1.1	27.7	63.1	31.3
2010-11	1,450	87.9	1.2	26.6	60.1	31.6
2011-12	1,550	85.0	0.6	26.9	57.6	32.3
2012-13	1,650	84.9	0.8	26.9	57.2	32.6
2013-14	1,650	84.9	0.6	28.1	56.2	33.8
2014-15	1,750	84.7	0.3	29.4	55.0	35.1
2015-16	1,700	86.0	0.4	30.3	55.2	35.7
2016-17	1,750	88.6	0.2	31.9	56.4	36.3
2017-18	1,800	85.2	0.1	29.8	55.4	35.0
Latest change		*-3.9%*	*-50.0%*	*-6.6%*	*-2.0%*	*-1.3pp*

Source: NHS Digital using HMRC data.
pp: percentage point change.
EER: expenses to earnings ratio.

Northern Ireland

9.39 Table 9.8 shows that in 2017-18, associate dentists in Northern Ireland had average taxable income of £52,300, a decrease of 11.5 per cent from 2016-17, and average expenses (employee plus other) of £33,600 (EER of 39.1 per cent). As with the data for providing-performer dentists in Northern Ireland the volatility of this data suggests there is a degree of natural variation in these statistics.

Table 9.8: Associate GDPs' average gross earnings, income and expenses, Northern Ireland, Health Service and private, headcount, 2009-10 to 2016-17

Year	Estimated population	Gross earnings (£000)	Employee expenses (£000)	Non-employee expenses (£000)	Income (£000)	EER (%)
2009-10	500	97.9	1.1	34.1	62.7	36.0
2010-11	550	96.2	0.5	36.4	59.4	38.3
2011-12	600	91.6	0.8	35.0	55.7	39.1
2012-13	650	86.7	0.2	33.5	53.0	38.9
2013-14	700	89.7	0.7	34.8	54.2	39.6
2014-15	700	90.2	0.5	35.6	54.0	40.1
2015-16	750	98.9	0.5	44.2	54.2	45.2
2016-17	850	104.8	2.8	42.9	59.1	43.6
2017-18	850	85.9	1.0	32.6	52.3	39.1
Latest change		*-18.0%*	*-64.3%*	*-24.0%*	*-11.5%*	*-4.5pp*

Source: NHS Digital using HMRC data.
pp: percentage point change.
EER: expenses to earnings ratio.

Contract reform

England

9.40 NHSE/I said that reformed contracts based on capitation and quality had been in development since 2011. In 2016, a prototype scheme was launched, called the Dental Contract Reform Programme. Its three aims were to maintain or improve access, improve oral health and remain within existing resources in a way that is financially sustainable. The prototype contracts use a blended capitation and activity-based remuneration mechanism. During 2018-19, the Programme increased the number of practices participating in the prototype scheme to over 100. Alongside this, they said they were also working with local commissioners to integrate dental services into new local care systems.

9.41 The Department of Health and Social Care (DHSC) added that the clinical approach of the reforms was widely accepted by the profession as being the right approach, and that they are expecting prototype practices to continue on the new contracts into 2020-21 ahead of decisions being taken regarding the wider roll out of the new approach.

9.42 The BDA said that they were supportive of the need for contract reform, that the clinical pathway being tested is appropriate and has the potential to deliver preventive-based dentistry, and that it was envisaged that roll out may start in April 2021 on a voluntary basis. However, they also said that they were concerned about the sustainability of the prototype practices long-term, and that the reformed contracts should move away from using the UDA as the measure of dental activity.

Wales

9.43 The Welsh Government is currently undertaking a programme of dental contract reform, with a third of practices already on reformed contracts, with a target of 50 per cent uptake by October 2020. Reformed contracts contain fewer UDAs for the same contract value, with practices expected to therefore spend more time on preventive dentistry and assessing patient need. The Welsh Government told us that access was being improved by the contract reform programme. The BDA said that they were supportive of the contract reform programme, though they were concerned that the reforms could make dentists' targets and incentives overcomplicated.

Scotland

9.44 The Scottish Government told us about the wide-ranging consultation exercise that they had undertaken as part of the publication of the Oral Health Improvement Plan. They said that the exercise found that the present administration and payment arrangements were a bar to the practice of modern dentistry and were seen as complex and daunting by newly qualified dentists. They said that they were addressing these concerns by bringing forward the development work on the New Model of Adult Oral Health Care, and that the intention was to have a model that was more intuitive, allowed clinicians to exercise more discretion and use the most up-to-date dental techniques. They said that the provisional timetable would see the new model rolled out to early adopter practices in early 2022.

Northern Ireland

9.45 The Department of Health said that they were continuing to engage with parties on implementing new contracts for GDPs, and that the results of their Dental Contract Pilots would be available in early 2020. The BDA said that they were hopeful that negotiations could start soon, since they believe that the current system of remuneration is outdated and needs reform. However, they said that the process had stalled since the pilot schemes ended in August 2016.

Expenses and formula

9.46 In 2016 we made recommendations on uplifts in pay net of expenses. Taking this approach required the parties to discuss expenses to agree a gross increase. The BDA have said that its preferred position remained that the DDRB should recommend on an expenses uplift.

9.47 In their written evidence, the BDA again asked the DDRB to make separate recommendations on expenses for GDPs. They said that with different treatment of expenses across the four countries, disparities between remuneration levels were widening. In the remit letters for England, Wales and Northern Ireland, expenses for GDPs were not mentioned, and in the remit letter for Scotland, we were explicitly asked not to make recommendations on expenses. For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs, had we continued to use the formula-based approach.

Payment recovery

9.48 According to NHSE/I, the amount of contract value recovered in England through 'clawback' increased in 2018-19, from £65 million the previous year to £128 million. The BDA said that 31 per cent of practices were affected, and that this was a clear indication of the difficulties that practices were facing in delivering their contracts, issues that were related to recruitment problems and low morale. For Wales, they said that they had not received data from all seven Health Boards at the time of writing, but based on the figures they had received, clawback totals were higher in 2018-19 than 2017-18.

Community Dental Services and the Public Dental Service

9.49 Community Dental Services (CDS) provide general dental care to people who cannot access care through independent contractor GDPs. This includes those with particular dental needs, including vulnerable groups. NHSE/I said that CDS are traditionally seen as a vocational specialist route in dentistry. CDS are commissioned by NHSE/I in England. In Wales and Northern Ireland, CDS are provided by Health Boards/Trusts. The Public Dental Service (PDS) in Scotland performs a similar role, combining community dental services with salaried dental services.

England

9.50 DHSC said that NHSE/I commissions CDS in line with local needs assessments, and that they were not aware of any specific difficulties being faced by providers in filling CDS vacancies. They also told us that three CDS practices were participating in the national contract reform programme.

9.51 However, the BDA told us that while CDS dentists in England are experienced and highly capable, they are concerned that their workloads are high and there are staff shortages. They quoted NHS Staff Survey figures that found that a significant proportion of CDS dentists felt that they were subjected to unrealistic time pressure, and that most were reporting that they were working unpaid overtime.

9.52 The BDA said that this meant that CDS dentists were working more hours with fewer colleagues, and much of this work is unpaid. They said that the NHS should do more to get the most out of the skills and experience that CDS dentists possess, particularly as the care provided by CDS dentists to the most vulnerable in society often means that more acute, and therefore expensive, issues can be avoided.

9.53 They also presented data from the 2018 survey of CDS dentists in England. Of the respondents to a question about age, almost 40 per cent said they were between 51 and 65, and around 35 per cent said they were between 41 and 50.

9.54 NHS Staff Survey data for England for salaried primary care dentists was available for 2019 and 2018. In 2019, 45 per cent of dentists were satisfied with their pay, an increase from 34 per cent in 2018. The results for 2019 are less positive than for consultants and doctors and dentists in training, but similar to those for SAS doctors and dentists. Male dentists (52 per cent) were more satisfied with pay than female dentists (44 per cent) on average. Asian or Asian British dentists (47 per cent) and White dentists (46 per cent) reported similar levels of satisfaction with pay and both groups were more satisfied than those from other Black and Minority Ethnic (BME) groups (41 per cent).

Wales

9.55 The Welsh Government told us that their latest data, from March 2018, on staffing levels in CDS had 114.6 full-time equivalent (FTE) dentists working in CDS in Wales, up 8.5 FTE on a year previously. The BDA told us that despite the apparent increase in FTE CDS dentists, the number of patient contacts in the CDS was gradually decreasing, and that this was because dentists with minimal clinical duties were being included in the total.

Scotland

9.56 The Scottish Government said that the increase in the number of independent contractor GDPs that has taken place since 2011 has led to a rebalancing of provision away from the PDS and back towards independent contractor GDPs for the majority of mainstream patients with routine treatment needs, especially since they have introduced new arrangements to enhance GDPs' skills in domiciliary care provision. They said that their vision for NHS oral health care services in Scotland is for services for the majority of patients to be provided by independent contractor GDPs. The PDS would continue to have an important role in providing more complex dentistry in a primary care setting.

9.57 The BDA said that they were concerned that funding cuts and staff reductions were having an impact on patient access and continued reductions in PDS capacity were jeopardising the long-term viability of the service.

Our comments

9.58 We note the increase in applicants to study dentistry at university in the last year. It is clear that dentistry remains an attractive choice for those who are considering which course to apply for at university. However, given that earnings are falling and morale amongst dentists is very low, as demonstrated by the Dental Working Hours Motivation and Morale survey[9], we remain concerned about whether dentistry can continue to attract new entrants at the current rate and retain its existing workforce.

[9] See paragraph 9.21.

9.59 The makeup of the GDP workforce is changing rapidly, with the number of providing-performers having fallen by more than half in the last ten years. And despite the size of the dental workforce continuing to grow, we continue to hear from the parties of localised issues of workforce supply. However, the parties disagree on the depth and breadth of these issues, with the BDA saying that there are widespread difficulties recruiting dental associates, while NHSE/I said only that they were aware of geographic shortfalls limiting service provision in certain places, with reports from rural and coastal areas of the difficulty in recruiting and retaining dentists. That the BDA cited recruitment and retention issues as a cause of the increase in clawback last year is also a concern. We would welcome further evidence next year from the parties about these issues and whether these developments are having an impact on oral health. We would again urge the parties to come together to review this position and reach some agreement as to the scale of any issues.

9.60 The trends in dentists' earnings are also cause for concern. In particular, the falling average earnings figures for associate dentists in cash terms, which cannot be fully explained by trends in working hours, as shown by the Dental Working Hours survey[10], are worrying, particularly as the proportion of the general dental practice workforce that works as associates continues to increase. It is clear that whichever model of remuneration is used for dentists, whether it is the UDA system used in England and Wales, or the Item of Service and capitation model in place in Scotland and Northern Ireland, overall earnings are not keeping pace with DDRB recommendations for NHS earnings, and this has the potential to impact on the attractiveness of continuing to work in the dental profession. We would welcome the parties providing more detailed data on trends in remuneration next year, including a more detailed breakdown of earnings by working hours and by split between NHS/Health Service and private dentistry. This would allow us to better understand the dynamics that are driving these trends in dentists' earnings.

9.61 We note that the proportion of the dental workforce who are providing-performers continues to fall, with a commensurate rise in the number of associates. None of the parties fully explained the reasons for this shift. We recognise the BDA's reflections that this change in composition of the workforce has the potential to lead to fundamental changes in the capacity, interests and aspirations of the workforce. We also recognise that, in practice, there is no way for health service leaders to ascertain that pay uplifts are passed on to associates. We would welcome further evidence on the changing shape of the dental workforce and its impact on NHS dentistry in the next round.

9.62 We note that contract reform is progressing at different rates in the four nations, but given the difficulties described above, we urge the parties to continue to make progress. In particular, in England it is disappointing that so little progress seems to have been made and we urge the programme of reform, which dates back to 2011, to progress more quickly, so that improved contracts can be implemented soon.

9.63 At the same time, we are concerned by the descriptions of issues of recruitment and retention in CDS and in academic dentistry that we received in our evidence submissions and on our visits. Given the critical contribution of both these groups, we hope that these can be addressed quickly. We also note that the data the BDA provided us with suggests that the CDS workforce in England is on average significantly older that the wider GDP population. We would therefore welcome further information from the parties on whether retirements within the CDS and PDS workforces are a concern, and whether action needs to be taken to ensure that this workforce, which delivers critical care to those who are hard-to-reach and vulnerable, remains sustainable in the long term.

[10] See paragraphs 9.13, 9.17, 9.19 and 9.21.

CHAPTER 10: PAY RECOMMENDATIONS AND OBSERVATIONS

Introduction

10.1 In this chapter we discuss our recommendations on the main pay uplift for our remit group. We also comment on the case for differential awards.

10.2 The evolving context of the coronavirus (COVID-19) pandemic, within which our report has been written, has had a major impact on the NHS and health and social care more widely, and those working in this sector. Many of those in our remit group played a crucial role at the front line of the UK's response. COVID-19 has placed extraordinary demands on members of our remit group, and we are highly sensitive to the fact that some have been made seriously ill and have lost their lives caring for patients during the pandemic.

10.3 While recognising the immediate impact of COVID-19 on doctors and dentists in our remit group, we have endeavoured to consider the remits in our usual way through our evidence-based process. In future years, we will seek to understand the short-term and longer-term impacts of COVID-19 on the recruitment, retention and motivation of doctors and dentists as more data becomes available.

10.4 COVID-19 has, however, served as a significant reminder of the critical importance of our remit group to society and its health and well-being, and highlights the continuing need to ensure that medical and dental careers remain attractive and motivating, both for prospective students and for those already in the workforce.

Pay proposals

10.5 In their written evidence, the Department of Health and Social Care (DHSC) asked that we make our recommendations within an envelope of £310 million for HCHS doctors and dentists, of which £120 million will be used to cover the 2020-21 element of the multi-year pay and reform deal in place for doctors and dentists in training. They also asked that our recommendation for general dental practitioners (GDPs) be made within an envelope of £37 million. Both these envelopes would be sufficient for a general uplift of two per cent, which DHSC confirmed was the case in oral evidence. Similarly, the NHS England/Improvement (NHSE/I) written evidence explained that the NHS has made plans on the basis of 2.0 per cent pay growth for consultants, dentists and specialty, associate specialist and staff grade (SAS) doctors for every year from 2020-21 to 2023-24 inclusive. They also said that for general medical practitioners (GMPs), the fixed contract resources for 2020-21 allow for pay uplifts for salaried GMPs of two per cent.

10.6 The Scottish Government said that their approach to public sector pay is governed each year by the Scottish Public Sector Pay Policy. Its key features are:

- A guaranteed basic pay increase of three per cent for public sector workers who earn below £80,000
- A guaranteed cash increase of £750 for public sector workers who earn £25,000 or less
- Limiting to £2,000 the maximum basic pay increase for those earning £80,000 or more

10.7 Neither the Welsh nor the Northern Irish governments detailed their approach to public sector pay. The Welsh Government said in their remit letter that they would seek a sufficient transfer of funding from the UK Government to Wales to enable them to fund awards and protect patient services.

10.8 The British Medical Association (BMA) proposed an uplift in line with Retail Price Index (RPI) inflation for 2020-21, plus a mechanism to address what they described as the pay depreciation that doctors have experienced since 2008, saying that this would go some way towards addressing the worsening morale and wellbeing of their members.

10.9 The British Dental Association (BDA) proposed a pay uplift of at least five per cent to attract dentists to work in the NHS. This included both GDPs and dentists working in Community Dental Services (CDS).

10.10 The Hospital Consultants and Specialists Association (HCSA) proposed that base pay and Clinical Excellence Awards increase by 4.1 per cent, comprising RPI as at November 2019, plus 1.9 per cent to begin to address historical erosion of pay. They also proposed that SAS doctors and dentists receive an additional one per cent and doctors in training an additional 1.5 per cent. Finally, they asked for a non-consolidated bonus for doctors and dentists in training who missed out on pay protection when the new contract for England was introduced in 2016, but who will also not benefit fully from the new pay elements of the 2019 contract deal.

Our comments

10.11 In our 2019 report, we said that we had serious concerns about morale within the remit group. We said it seemed that the long period of real-terms pay decline over the previous decade had started to have a negative impact, and that given that recent years had seen a return to economic growth and increased pay settlements in the wider economy, this should be reflected in the basic pay increase for the remit group. We therefore, at that time, recommended a basic pay increase of 2.5 per cent.

10.12 At the time of writing there is a very high degree of uncertainty over the long-term impact of COVID-19 on the economy.

10.13 Prior to COVD-19 economic growth was subdued, with zero growth in the final quarter of 2019. Inflation was on a downward trend through the second half of 2018 and 2019 while employment continued to grow and remained at record levels. Earnings growth had peaked at 4.0 per cent in the middle of 2019, had fallen back to 2.4 per cent by the end of the year, but was still growing in real terms.

10.14 As we said in Chapter 2, the latest short-term indicators suggest we can expect a sharp and deep economic contraction. Gross Domestic Product was estimated to have fallen by 10.4 per cent in the three months to April 2020, compared with the previous quarter, with a 20.4 per cent fall in output in April 2020 alone. The OBR modelled an economic contraction of 13 per cent in 2020 while the Bank of England expects CPI to be zero by the end of 2020, with unemployment at nine per cent in the second quarter, the highest rate since 1994. The OBR scenario models a fall in average earnings of 7.3 per cent in 2020.

10.15 The affordability envelope put to us for England reflected a judgment made by NHSE/I and DHSC about the costs and benefits of increasing pay both within fixed medium-term NHS budgets and within the overall fiscal position as set out in their evidence. There are trade-offs made by governments in setting the size of pay envelopes, including in improving recruitment, retention and motivation and addressing locum spend. Therefore, as we said in our 2019 report, we regard these affordability envelopes as a factor in our considerations but not a binding constraint on our recommendations. Similarly, whilst we note the Scottish Public Sector Pay Policy and the priorities and judgments that underpin it, and it was a factor in considering our recommendations, we do not view it as a constraint on our recommendations for Scotland.

10.16 We also note the pay uplifts already implemented for groups within our overall remit in England, as part of multi-year agreements. This includes contractor GMPs, whose comprehensive contract deal includes significant investment in general practice and a new, state-backed indemnity scheme, and doctors and dentists in training, for whom a multi-year pay reform deal was agreed in 2019. In particular, we note that while doctors and dentists in training will receive base pay uplifts of two per cent per annum during the lifetime of the deal, once reforms to the pay structure are taken into account, a total of three per cent will be invested in this staff group in 2020-21.

Our recommendations

10.17 Whilst we recognise the pay and affordability proposals put to us by the parties, our pay recommendations must also recognise the need to recruit, retain and motivate doctors and dentists. As services change to meet new challenges, it is crucial that health services achieve the most with this workforce, and this requires them to feel valued and for recruitment and retention to be improved. Given this, it is welcome that more students are entering medical school, and that there are more applicants wishing to study medicine and dentistry at university. However, the training pipeline is long and so for improvements to be felt across the workforce, retention and motivation must also remain a priority.

10.18 There are a number of issues of retention and motivation across our remit group that are a concern. There is a need to ensure that groups across the remit feel there is sufficient incentive for them to stay in the workforce.

- It is crucial that doctors in training who had stepped out of training on completion of the Foundation Programme find they have sufficient incentive to return to training and to substantive positions in the NHS.
- There are continued signs that partner and providing-performer positions for GMPs and GDPs respectively, once roles that newly-qualified doctors and dentists would aspire to, are becoming less popular, and there are a number of programmes in place across the UK to incentivise GMPs to become partners.
- SAS doctors and dentists continue to be a crucial but undervalued part of the workforce in hospitals, as they deliver critical services alongside the consultant workforce, and as the group with the highest proportion who qualified outside the UK, are most susceptible to international labour market movements.
- As consultants become an increasingly prominent proportion of the workforce, their retention becomes ever more critical for patients. The persistently high proportion of voluntary early retirements, which have comprised more than a quarter of all retirements every year since 2014, are worrying. While we welcome the changes made to the annual allowance taper, and any consequent falls in such retirements, the impact of issues relating to pensions taxation on consultants both as a result of the changes of behaviour that they precipitated and the bad feeling generated by them may continue to be felt going forwards.

10.19 There are also a number of issues that may be affecting morale, with staff survey results for England saying that less than one-third believed that there were enough staff present in their organisation for them to do their job properly, and three-quarters having reported working excess unpaid hours. Both rates of those who said they had experienced harassment, bullying or abuse from patients, relatives or the public and of those who said they had felt unwell as a result of work-related stress had risen. The results from the most recent staff surveys for Northern Ireland and Wales both showed high numbers reporting having experienced harassment, bullying or abuse or feeling unwell as a result of work-related stress.

10.20 Over the last decade, average incomes have fallen in real terms as measured against CPI inflation and relative to earnings in the wider economy, especially at more junior levels. During our visits programme, we frequently heard from doctors and dentists who said that they felt less valued by employers, governments and society as a whole than they had been previously. Consultants in particular told us that they felt their pay had fallen relative to their private sector professional comparators, and this impacted negatively on their sense of being valued.

10.21 **Therefore, we recommend a 2.8 per cent increase to national salary scales, pay ranges or the pay element of contracts for all groups included in our remits for this year, namely:**

- **consultants;**
- **SAS doctors and dentists;**
- **doctors and dentists in training in Scotland, Wales and Northern Ireland;**
- **independent contractor GMPs in Scotland, Wales and Northern Ireland;**
- **salaried GMPs;**
- **the GMP trainers' grant and GMP appraisers' fee;**
- **independent contractor GDPs; and**
- **associate and salaried GDPs including Community Dental Service practitioners.**

These uplifts should be backdated as necessary so that they would be paid in full for the 2020-21 financial year.

10.22 We have significant concerns about the equity and effectiveness of the Clinical Excellence Awards (CEAs), Commitment Awards, Distinction Awards and Discretionary Points systems for consultants in their current forms. We have been waiting for reform of the award schemes since our review of incentives for consultants in 2012[1] and also note our report in 2015[2]. We are not convinced that these awards, in their current form, necessarily reward all those who are currently contributing most towards the delivery of high-quality services and patient care. In particular, we consider that they are an exacerbating factor in pay equalities issues for consultants. As this review body has previously outlined, there is a gender and ethnicity pay gap in medicine with women and black, Asian and minority ethnic (BAME) doctors being disadvantaged. There is a disproportionately lower number of applications for these awards from women and BAME candidates. The increasing diversity of the consultant workforce including in relation to gender, ethnicity, and flexible working intensifies the problems with the current award systems and the very slow pace of reform.

10.23 We recognise that work has started to reform these awards in England with planned changes to both the local and national CEA schemes, which DHSC has told us will be based on our 2012 proposals. **However, given our concerns, we do not feel that we can recommend an uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points this year.**

10.24 It is too early for the review body to understand the full impact of COVID-19 on our remit group and our recommendations do not seek to take account of COVID-19. However, separately, we would urge governments to consider the role that members of our remit group have played and whether any additional recognition should be given to acknowledge this contribution.

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[1] Review Body on Doctors' and Dentists' Remuneration (9 August 2013), *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.* Available at: https://www.gov.uk/government/publications/ddrb-nhs-consultant-compensation-levels-2012

[2] Review Body on Doctors' and Dentists' Remuneration (16 July 2015),*Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week.* Available at: https://www.gov.uk/government/publications/contract-reform-for-consultants-and-doctors-and-dentists-in-training-supporting-healthcare-services-seven-days-a-week

Targeting

10.25 While we remain supportive of the exploration of the effectiveness of geographic or specialty targeting by pay, and we note that there are financial incentives in place for various parts of the workforce, we did not receive this year any specific proposals around targeting on which we were asked to comment.

10.26 Our view remains that geographic and specialty targeting has the potential to help address shortages caused by the uneven geographic distribution of all groups of doctors and dentists, particularly in remote and rural areas, which frequently suffer from workforce shortages. Financial incentives similarly have the potential help to address shortages in particular specialties, and we discuss the Flexible Pay Premia in place in England for doctors and dentists in training in Chapter 5.

10.27 We therefore encourage governments to continue to evaluate the effectiveness and utilisation of the measures that are already in place, and proactively to consider how these programmes can be altered to ensure they are as effective as possible in addressing shortages; whether and how they can be expanded to address other workforce shortages; and whether they inform the case for a more wide-ranging system of targeting by pay. We would welcome seeing such an evaluation in evidence for future rounds.

10.28 We also considered the case for more specific recommendations targeted at particular groups within our remit and set out our considerations below.

10.29 We have not made a targeted recommendation for any part of our remit group this year. In 2019, we recommended that SAS doctors and dentists should receive an extra one per cent, on the basis that it would be a cost-effective and justifiable investment in raising the profile and attractiveness of the SAS grades. This recommendation was not implemented in full by any of the governments, though we were told that the additional one per cent would be available to help fund contract reform in England and Wales.

10.30 This followed our 2018 recommendation that SAS doctors and dentists should receive a 3.5 per cent increase in their national salary scales. Other than in Wales, this was not fully implemented.

10.31 We believe that the issues we raised then, in support of our recommendation, still apply across the UK. Our recommendation was not dependent on progress in agreeing contract reform. Our view remains that SAS doctors and dentists are in need of greater recognition and career progression. We welcome the SAS contract negotiations in England and Wales, which we have been told it is the intent to complete in time for implementation in April 2021. However, our recommendation for this important but too-often undervalued group of staff was not made dependent on contract reform. While we have not recommended a differential award this year, we will follow the progress of negotiations closely and consider again next year whether there is a case for this.

10.32 We are also particularly concerned about the trends in remuneration, motivation and morale amongst GDPs. Overall earnings for dentists have stagnated, and while the earnings figures we have for GDPs include private earnings, and the figures we have reflect headcounts, rather than full-time equivalent (FTE), these statistics remain a concern. Additionally, the long-term decline in the number of providing-performers that has taken place may reflect changing dynamics of motivation and commitment to NHS dentistry. We note that many of the parties have expressed a desire for reform in this area but aside from in Wales, progress has been unacceptably slow. Contract reform can begin to address some of these issues, and we hope that across the UK the parties can work together to agree to reforms.

10.33 We would again highlight, as we have for the last two years, the need for a resolution to the widely differing pictures of the state of dentistry that have been presented by the parties. We have again heard from the BDA that NHS dentistry is close to crisis point due to pay and workload pressures, in contrast with the assessments we receive from DHSC and NHSE/I. It will become increasingly challenging for us to make considered pay recommendations on the basis of such divergent positions. The trends in dentists' earnings are also a concern, and we would welcome an explanation for these trends, as well as a more detailed breakdown of dental earnings by working hours and by split between NHS/Health Service and private dentistry.

CHAPTER 11: LOOKING FORWARD

Introduction

11.1 In this final chapter we look ahead to some of the challenges facing our remit group and what we would expect to see covered in evidence over the next few years. Our priorities for additional evidence next year include: details of progress towards contract reform for specialty, associate specialist and staff grade (SAS) doctors and dentists across the UK; further data on the trends in recruitment and retention and composition of the general dental practitioner (GDP) workforce and a more detailed breakdown of dental earnings by working hours and by split between NHS/Health Service and private dentistry, as well as an explanation for these trends; and details of any emerging trends in retention in the consultant workforce, including whether the issues associated with pensions taxation detailed earlier in the report will have a lasting impact. We would also wish to see parties' perspectives on the impact of the coronavirus (COVID-19) pandemic on recruitment, retention and motivation in the medical and dental workforces.

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11.2 To recognise the rights of all the parties involved and for the review body process to work effectively, it is important that all the parties strive to work to an agreed timetable and to ensure that evidence is produced and delivered in a timely manner.

Economic outlook

11.3 The COVID-19 pandemic has created a greater deal of uncertainty with forecasting the outturn of the economy. However, it is highly likely that the economy will contract in the short-term and there will be a major impact on public finances. We expect that evidence next year will provide us with the data and information to understand the short-term and potential longer-term impacts of COVID-19 on the UK economy, including on inflation, the labour market, earnings and pay settlements, though we appreciate some evidence may take some time to emerge.

Affordability and productivity

11.4 Identifying the impact of those in our remit group on the productivity and overall output of the system is difficult, as the delivery of healthcare is a collaborative effort between those in our remit group and other NHS staff. If it is available, we would welcome more detailed evidence showing the contribution of the various components of our remit group, and consultants in particular, towards improvements in productivity and the trade-offs between staff numbers and pay, but recognise that the most appropriate place for detailed consideration of productivity issues is probably through contract negotiations.

Workforce planning

11.5 We look forward to seeing in our evidence next year how workforce strategies are being developed and actioned and how strategies are changing as a result of the learnings from COVID-19. We welcome data from the parties on the short- and long-term impact of the COVID-19 pandemic on the NHS and its workforce so we can monitor the impact on recruitment, retention and motivation. We will also seek to understand how the impact of COVID-19 on recruitment, retention and motivation will interact with that of the UK's exit from the EU.

11.6 In England, we await with interest the publication of the NHS People Plan and further detail on how the NHS workforce strategy in England will affect the remit group.

11.7 We note that there is a balance between decreasing locum spend and having the flexibility required to deal with workforce shortages. We would like further information on agency and locum spending within each country and the efforts that have been taken to reduce spending in these areas.

Doctors and dentists in training

11.8 Following the agreement reached on the contract for doctors and dentists in training in England we look forward to receiving further information on insight gained from the exception reporting system and how the exception reporting system is developing.

11.9 We have seen improvements in specialty training fill rates this year, partly due to places taken by doctors whose primary medical qualification is from outside the UK. We welcome further information on measures to retain these doctors as their training continues and after training.

11.10 The cost of training and exams and the effect of the allocation of training posts through the deanery system have frequently been cited as issues that influence morale during our visits. We welcome more evidence on the retention of doctors and dentists in training in the NHS and data on the attrition rates through training.

11.11 We look forward to receiving evidence about the effectiveness of the flexible pay premia in the contract for doctors and dentists in training in England and whether the existing coverage remains appropriate.

Staff grade, associate specialist and specialty (SAS) doctors and dentists

11.12 We welcome the SAS contract negotiations in England and Wales and look forward to hearing about the progress of negotiations, which we have been told are intended to be completed in time to allow for implementation by April 2021. We also look forward to receiving more information on the progress of SAS contract reform in Scotland and Northern Ireland.

11.13 The slow pace of embedding SAS charters continues to be a concern. We are of the view that successfully developing and embedding the charters would have a positive impact on the motivation of SAS personnel. We look forward to hearing, from across the UK, on further progress made in this area.

11.14 We have noted that the gender and ethnicity composition of the SAS grades is different to that of consultants and doctors and dentists in training. We would welcome further information as to whether there are any equalities issues associated with this difference.

Consultants

11.15 Problems with recruitment and retention for some specialties and by geographical area have been highlighted again this year. We would like further information on these trends and the progress and effectiveness of initiatives to address these issues.

11.16 We understand that the 2020 competitions for national and local Clinical Excellence Awards (CEAs) has been suspended due to COVID-19. We look forward to being updated by stakeholders on the competition for new and renewed national CEAs, as well as the progress of the planned reform to this system. Likewise, we look forward to hearing details of the proposed reforms to local CEAs for England, for which the interim arrangements are now due to expire in 2022. We would also welcome hearing from the Scottish, Welsh and Northern Irish governments about any plans to reform their counterpart systems.

General medical practitioners (GMPs)

11.17 We look forward to hearing about the impact the GMP contract has had on the independent contractor GMP workforce in England, as well as whether the transformation programmes for general practice in all four nations are having the desired effect.

11.18 We were told that there had been positive progress in implementing and delivering the anticipated benefits of the first phase of the GMP contract in Scotland. We look forward to hearing about the outcomes and evaluations of the first phase and the progress of phase two.

11.19 We would welcome an update on the progress and insight gained from the All Wales Locum Register and the Wales National Workforce Reporting Tool.

11.20 We would welcome more data on the earnings of GMPs on a full-time equivalent (FTE) basis and the breakdown of this data by age, ethnicity and gender.

11.21 We would welcome details of the impact that the incentives available for new GMP partners that were introduced in 2020 are having on recruitment and retention in the GMP workforce.

Dentists

11.22 We have heard again from the British Dental Association (BDA) that NHS dentistry has reached crisis point due to pay and workload issues. However, these reports continue to contrast strongly with the assessments we receive from the health departments.

11.23 The number of Units of Dental Activity (UDAs) commissioned in England has continued to decline while there is an increase in the number of dentists providing services. We welcome further information on why this has happened and an assessment of whether this trend is likely to continue. We wish to see a comprehensive assessment of the number of dental contracts that are returned to those commissioning dental services, the size of those contracts, and an understanding of why they have been returned.

11.24 We note a long-term change in the ratio of providing-performers to associate dentists. We would welcome an assessment of why this has happened and whether this is a change that we should be concerned about.

11.25 We would also like an assessment of the ability of practices to recruit and retain dental associates and the impact of any shortages on oral health.

11.26 Current estimates of dental earnings are calculated on a headcount basis. We ask that the parties continue to look at the feasibility of producing FTE estimates of earnings and also continue to look at ways of distinguishing between earnings for providing NHS services and private earnings. At the same time, we would welcome a comprehensive explanation of the trends in dental incomes.

11.27 As well as seeing the latest BDA data on morale and motivation of dentists, it is also important to understand how that has changed from previous periods. It would be helpful if the BDA could supply us with time series data from the surveys that they undertake.

Pay

11.28 Issues that we will look to see covered in the future include:

- The impact of pension taxation changes on retention and motivation of the remit group including the results of NHS organisations promising to reimburse clinicians that make use of Scheme Pays in England and Wales in 2019-20, raising the annual allowance taper threshold, and modifications to the taper mechanism announced in the March 2020 Budget, and existing concerns over the impact of the annual and lifetime allowance thresholds;
- A full assessment of the impact of the pay premia introduced as part of the contract for doctors and dentists in training and whether the coverage remains appropriate;
- How our recommendations for salaried GMPs are ultimately reflected in their pay;
- The impact on GMP earnings of the introduction of the General Medical Services contract in Scotland;
- Whether and how our recommendations for GDPs feed through into the earnings of associates; and
- Details of attempts to develop a sound methodology that would allow the introduction of pay premia based on specific geographies.

Future data requirements

11.29 We very much welcome the progress being made on the provision of better pay and workforce data. This is critical to good decision making in the health system, as well as to our consideration of pay recommendations. Several organisations and working groups provide us with such information, for which we are grateful.

11.30 Data gaps have emerged during this round, and Table 11.1 summarises these by UK country. The Gender Pay Gap in Medicine Review has highlighted gender as an issue and we would like to receive data on this and other protected characteristics, such as age and ethnicity, to examine equalities issues concerning the remit group. We would also like to see time series data, which is much more useful and enables us to have a clearer view of the issues.

11.31 Of the data requests in Table 11.1, we would especially welcome information in the following areas: earnings on an FTE basis for GMPs and GDPs and further information about the breakdown between NHS/Health Service and private income for GDPs; the number of NHS dental contracts returned, and the reasons for their return; time series evidence on morale and motivation among dentists; and the composition of the Community Dental Services (CDS) workforce by contract type. We requested this information last year, but did not receive it for this round.

Future developments

11.32 We would welcome information about the outcomes of the enhanced commitment to a multidisciplinary approach to service provision across the wider Primary Care and Social Care teams.

11.33 We would like to hear details of the parties' responses to the Gender Pay Gap in Medicine Review, which we expect to be published soon. We anticipate that the Review's findings will be significant to contract reform and the proposed changes to CEAs. We would welcome the parties' views on whether they intend to perform similar exercises to explore other pay and equalities issues in the medical and dental professions, including with relation to ethnicity.

11.34 We would additionally welcome further evidence from the parties on gender pay and other equalities issues outside the Review's formal scope. This includes evidence about these issues for Scotland, Wales and Northern Ireland, and evidence about dentistry.

Table 11.1: Data gaps by UK country

	England	Wales	Scotland	Northern Ireland
Paybill data (Chapter 3)	Sample career pathways.	Total health expenditure. Total medical paybill. Elements of paybill growth. Sample career pathways.		
Locum use and rates (Chapter 3)	Information about the number of hours worked, type of work, pay rates, demographics and why people choose to do locum work.			
Productivity (Chapter 3)		Information about productivity in the NHS.		
Workforce information (Chapter 4)	Annual time series of average total earnings by FTE, nationality of workforce by staff group and median and interquartile ranges of average total FTE earnings by staff group.	Average earnings of medical staff by FTE, staff group and nationality of workforce. Turnover by staff group.	Average earnings of medical staff by FTE, staff group and nationality of workforce.	Average earnings of medical staff by FTE, staff group and nationality of workforce.
Equalities and pay comparability (Chapter 4)	Analysis related to age, ethnicity, gender and other protected characteristics, and the intersection between these groups.			
Early retirement and pensions (Chapter 4)	Data on the impact of pensions tax changes. Information and time series about the number of staff taking early retirement and whether they re-join the workforce, and if they re-join whether on a full-time or part-time basis. Withdrawals from the NHS pension scheme.			
Staff survey results by hospital medical and dental group (Chapters 4, 5, 6, 7)	Breakdown by age, ethnicity, gender and staff group.			
		Inclusion of question on satisfaction with pay.		
International recruitment and retention (Chapter 4)	Number, destinations and motivation of international leavers, particularly of those who return overseas. Number and source of international joiners.			
Career choices for doctors and dentists in training (Chapter 5)	Average UCAS scores for those starting on medical and dental degrees. Career paths of doctors and dentists in training, understanding of why they make those choices. Data on those who step out temporarily from service and training – at what point in training they do so, and what motivates them, in particular those who become locums or go overseas. Data on those who do not return after stepping out temporarily from service and training. Impact of FPP (England).			

	England	Wales	Scotland	Northern Ireland
Vacancy rates (Chapters 4, 5, 6, 7, 8, 9)	Dentists in training. SAS doctors and dentists. GMPs and GDPs.	Vacancy or shortfall rates across remit group. Junior doctor fill rates by region and specialty.	Junior doctor fill rates by region and specialty.	Vacancy or shortfall rates across remit group. Junior doctor fill rates by region and specialty.
SAS doctors and dentists (Chapter 6)	SAS doctors' and dentists' recruitment and retention patterns. Implementation of SAS charter. Use of the SAS Development Fund. Progress of SAS contract negotiations in England and Wales. Impact of protected characteristics on pay, recruitment, retention and morale.			
Consultants (Chapter 7)	Consultant recruitment and retention patterns, including sources of recruitment. Progress of competition on national CEAs and reform of local CEAs in England.			
GMP and GDP motivation data (Chapters 8 and 9)	GMP and GDP motivation. Systematic data on salaried GMPs and GDPs. Time series morale and motivation data on GDPs.			
GMP and GDP earnings by FTE (Chapters 8 and 9)	Earnings by FTE (as well as headcount). Demographic information and working hours of GMPs. Number of consultations carried out. Timeseries of the value of dental clawback. NHS and private earnings split.			
GDP contracts (Chapter 9)	Number of contracts returned and reasons for returns. BDA time series data. UDA trends.			

APPENDIX A: REMIT LETTERS FROM THE PARTIES

Department of Health & Social Care

From the Rt Hon Matthew Hancock MP
Secretary of State for Health

39 Victoria Street
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SW1H 0EU

Mr Christopher Pilgrim

Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

16 October 2019

Dear Mr Pilgrim,

I am writing firstly to express my thanks for the valuable work of the Review Body on Doctors' and Dentists' Remuneration (DDRB) on the 2019-20 pay round and to welcome you as the new Chair.

I write now to formally commence the 2020-21 pay round.

The NHS Long Term Plan and the 2019 Spending Review 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 the affordability assumptions underpinning the NHS Long Term Plan, the importance of making planned workforce growth affordable and other financial risks facing the NHS. Given the NHS budget has been set for five years (2019/20 – 2023/24), there is a direct trade-off between pay and staff numbers and our evidence, and that from NHS England and NHS Improvement, 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 2020-21 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.

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

You are invited to make recommendations on an annual pay award for consultants.

For Specialty Doctors and Associate Specialists we are embarking on exploratory talks with the BMA with a view to negotiating a multi-year pay and contract reform deal. Any agreed deal would need to be one that gives valued staff a fair pay rise alongside improving recruitment and retention and developing reforms which better reflect modern working practices, service needs and fairness for employees. This does not prejudge the role of the DDRB in recommending the level of pay award that these staff should receive, but we would expect your recommendations to be informed by these talks with the BMA and we will update you on progress.

Independent Contractor General Medical Practitioners are subject to a five-year pay agreement between NHS England and the British Medical Association and therefore no pay recommendation is being sought for this group. You are invited to make recommendations on uplifts to the minimum and maximum of the salaried General Medical Practitioner pay scales, recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under the five year GP contract.

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.

Yours ever,

MATT HANCOCK

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA/VG/5602/19

Mr Christopher Pilgrim
Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
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6 January 2020

Dear Mr Christopher Pilgrim,

Thank you for the DDRB work on the 2019-20 pay round. I am writing to formally commence the 2020-21 pay found for medical and dental staff in Wales including general medical practitioners and general dental practitioners.

In this pay round I would like you to consider evidence and make recommendations on what would be a fair and affordable pay award for medical and dental staff to help us sustain the NHS in Wales and deliver the priorities set out in *A Healthier Wales: Our Plan for Health and Social Care*.

Your advice and recommendations will enable me to determine a fair pay award for medical and dental staff in Wales, and to seek a sufficient transfer of funding from the UK Government to Wales to enable us to fund that award and protect patient services.

In his letter to you date 16 October 2019, the Rt. Hon. Matthew Hancock MP, Secretary of State for Health, DHSC, made you aware of talks taking place with the BMA around contract reform for Specialty and Associate Specialist doctors; I would ask you to be mindful when preparing your report and recommendations that these talks are taking place on a joint England and Wales basis.

In order to support your work, I will provide written evidence to the Doctors' and Dentists' Review Body and my officials have committed to attend the planned oral evidence session in the spring.

I would like to receive your advice and recommendations in early May 2020 to ensure that payment of any award to hard pressed NHS staff is not unduly delayed.

As noted in my remit letter last year, the NHS across the four UK nations benefits from a degree of mobility within the workforce, which supports flexibility in recruitment, ease of movement for career development and training and to ensure equity for professional staff

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working across the UK. This means it is essential that Wales continue to be aware and engaged in any future contractual negotiations.

I look forward to receiving your advice and recommendations in May.

Yours sincerely,

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Cabinet Secretary for Health and Sport
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Mr Christopher Pilgrim (Chair)
Review Body on Doctors' and Dentists'
Remuneration
Office of Manpower Economics

By Email.

25 February 2020

Dear Christopher

Further to my letter of 27 January, I am now writing to formally set out our remit for the Doctors' and Dentists' Review Body (DDRB) for 2020-21.

It will be necessary to consider the affordability of the recommendations from the DDRB within the confines of the Scottish Public Sector Pay Policy (SPSPP) set for 2020-21 announced in the Scottish Parliament on 6 February 2020. A copy of the draft Budget is available here, this is subject to parliament approval. The main features of the SPSPP are:

- providing a guaranteed basic pay increase of 3 per cent for public sector workers who earn below £80,000;
- continuing the requirement for employers to pay staff the real Living Wage, now set at £9.30 per hour;
- providing a guaranteed cash underpin of £750 for public sector workers who earn £25,000 or less
- limiting to £2,000 the maximum basic pay increase for those earning £80,000 or more
- allowing flexibilities for employers to use up to 0.5 per cent of pay bill savings on baseline salaries for addressing clearly evidenced equality issues in existing pay and grading structures.

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The SPSPP also continues to provide the flexibility for employers to consider using up to 1 per cent of paybill savings on baseline salaries for:

- non-consolidated payments, but only for employees already on the maximum of their pay range (who no longer benefit from progression) or on spot rates; and
- other affordable and sustainable changes to their existing pay and grading structures where there is clear evidence of inequality issues.

It will be necessary to consider the affordability of the Recommendations from the DDRB within the confines of the SPSPP set for 2020-21.

Although we are seeking Recommendations from the DDRB on a pay uplift for one year only (2020-21), it will be necessary to consider these in the context of our longer term vision on:

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

For General Medical Practitioners (GMPs) we are only seeking a recommendation on the pay element. We are in the process of agreeing a separate expenses exercise with the Scottish General Practitioners Committee of the BMA which will help inform our discussions on expenses.

For General Dental Practitioners (GDPs) we are once again seeking a recommendation on the pay element only. We are also intending to conduct a separate expenses exercise which, depending on the level of information received, will help to inform any discussions on expenses with BDA Scotland.

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

Kind regards

JEANE FREEMAN

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FROM THE MINISTER OF HEALTH

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Mr Christopher Pilgrim
Chair of the Review Body for
Doctors' and Dentists' Remuneration
Office of Manpower Economics
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By email: lesley.balkham@beis.gov.uk

Date: 24th February 2020

Dear Christopher,

I am writing to formally commence the 2020/21 pay round for doctors and dentists in Northern Ireland and to submit my Department's evidence. I wish to begin by thanking the Review Body for Doctors' and Dentists Remuneration (DDRB) for its invaluable work on the 2019/20 pay round.

On 31 October 2019, the Department of Finance (DoF) set Northern Ireland's Public Sector Pay Policy for 2019/20 . Doctors' and dentists' pay in Northern Ireland for 2019/20, however, is yet to be determined. This continues to be considered in the context of the public sector pay policy and continued budgetary pressures.

This year we would welcome, for consideration, your recommendations on pay for all doctors and dentists working within health and social care in Northern Ireland.

Yours sincerely

Robin Swann MLA
Minister for Health

APPENDIX B1: DETAILED RECOMMENDATIONS ON REMUNERATION IN ENGLAND

SALARY SCALES

The salary scales that we recommend should apply from 1 April 2020 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

The 2019 salary scales reflect those that were implemented from 1 April 2019.

Basic pay scales and awards

	2019 £	2020 £
Doctors and dentists in training (2016 contract)[1]		
Foundation doctor – year 1	27,689	28,243
Foundation doctor – year 2	32,050	32,691
Core/Run-through training – years 1-2	37,935	38,694
Core/Run-through/Higher training – year 3 +	48,075	49,036
Flexible pay premia (2016 contract)[1]		
General practice	8,617	8,789
Psychiatry core training	3,503	3,573
Psychiatry higher training (3 year)	3,503	3,573
Psychiatry higher training (4 year)	2,628	2,680
Academia	4,204	4,288
Histopathology	4,204	4,288
Emergency medicine/Oral & maxillofacial surgery:		
3 years	7,006	7,146
4 years	5,255	5,360
5 years	4,204	4,288
6 years	3,503	3,573
7 years	3,003	3,063
8 years	2,628	2,680

[1] 2020 award already implemented, see https://www.nhsemployers.org/pay-pensions-and-reward/medical-staff/pay-circulars Pay and Conditions Circular 1/2020.

	2019 £	2020 £
Specialty doctor (2008 contract)	40,037	41,159
	43,460	44,677
	47,911	49,253
	50,296	51,705
	53,733	55,238
	57,156	58,757
	60,656	62,355
	64,158	65,955
	67,659	69,554
	71,159	73,152
	74,661	76,752
Associate specialist (2008 contract)	56,133	57,705
	60,646	62,345
	65,157	66,982
	71,115	73,107
	76,279	78,415
	78,421	80,617
	81,216	83,491
	84,012	86,365
	86,807	89,238
	89,603	92,112
	92,401	94,989
Staff grade practitioner	37,092	38,131
(1997 contract, MH03/5)	40,037	41,159
	42,980	44,184
	45,925	47,211
	48,870	50,239
	52,337	53,803
Discretionary points	*Notional scale*	
	54,759	56,293
	57,702	59,318
	60,647	62,346
	63,592	65,373
	66,535	68,398
	69,481	71,427

	2019 £	2020 £
Consultant (2003 contract)	79,860	82,097
	82,361	84,668
	84,862	87,239
	87,362	89,809
	89,856	92,372
	95,795	98,478
	101,735	104,584
	107,668	110,683
Clinical Excellence Awards (local, granted prior to 1 April 2018)		
Level 1	3,016	3,016
Level 2	6,032	6,032
Level 3	9,048	9,048
Level 4	12,064	12,064
Level 5	15,080	15,080
Level 6	18,096	18,096
Level 7	24,128	24,128
Level 8	30,160	30,160
Level 9	36,192	36,192
Clinical Excellence Awards (local, granted since 1 April 2018)		
Unit value	3,092	3,092
Clinical Excellence Awards (national)		
Level 9 (Bronze)	36,192	36,192
Level 10 (Silver)	47,582	47,582
Level 11 (Gold)	59,477	59,477
Level 12 (Platinum)	77,320	77,320
Distinction awards for consultants		
B awards	32,601	32,601
A awards	57,048	57,048
A+ awards	77,415	77,415
Salaried general medical practitioner range		
Minimum	58,808	60,455
Maximum	88,744	91,229
General medical practitioner trainer grant	8,350	8,584
General medical practitioner appraisers fee	528	543

	2019 £	2020 £
Dental foundation training	32,796	33,715
Dentists in training (2016 contract)[1]		
Foundation dentist – year 1	27,689	28,243
Foundation dentist – year 2	32,050	32,691
Dental core training – year 1 & 2	37,935	38,694
Dental core & specialty training – year 3 +	48,075	49,036
Salaried primary care dental staff (2008 contract):		
Band A: Salaried dentist	40,629	41,767
	45,143	46,408
	51,914	53,368
	55,300	56,849
	58,686	60,330
	60,943	62,650
Band B: Salaried dentist[2]	63,200	64,970
	65,457	67,290
	68,843	70,771
	70,536	72,512
	72,229	74,252
	73,921	75,991
Band C: Salaried dentist [3, 4]	75,614	77,732
	77,871	80,052
	80,129	82,373
	82,386	84,693
	84,643	87,014
	86,900	89,334
London weighting[5]		
Non-resident staff	2,162	2,162
Resident staff	602	602

[2] The first salary point of Band B is also the extended competency point at the top of Band A.
[3] The first salary point of Band C is also the extended competency point at the top of Band B.
[4] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.
[5] Thirty-Sixth Report. Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 1.64.

APPENDIX B2: DETAILED RECOMMENDATIONS ON REMUNERATION IN WALES

SALARY SCALES

The salary scales that we recommend should apply from 1 April 2020 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2019 £	2020 £
Foundation house officer 1 (2015 contract)	24,142	24,818
	25,649	26,368
	27,157	27,918
Foundation house officer 2 (2015 contract)	29,945	30,784
	31,904	32,798
	33,861	34,810
Specialty registrar (full)	32,000	32,896
	33,957	34,908
	36,691	37,719
	38,346	39,420
	40,338	41,468
	42,334	43,520
	44,329	45,571
	46,324	47,622
	48,319	49,672
	50,315	51,724
Specialty doctor	40,233	41,360
	43,673	44,896
	48,145	49,494
	50,541	51,957
	53,994	55,506
	57,435	59,044
	60,951	62,658
	64,470	66,276
	67,990	69,894
	71,507	73,510
	75,025	77,126

	2019 £	2020 £
Associate specialist (2008)	56,407	57,987
	60,942	62,649
	65,475	67,309
	71,461	73,462
	76,650	78,797
	78,802	81,009
	81,612	83,898
	84,422	86,786
	87,230	89,673
	90,040	92,562
	92,851	95,451
Staff grade practitioner	37,274	38,318
(1997 contract, MH03/5)	40,233	41,360
	43,191	44,401
	46,149	47,442
	49,109	50,485
	52,592	54,065
Discretionary points	*Notional scale*	
	55,026	56,567
	57,984	59,608
	60,943	62,650
	63,902	65,692
	66,859	68,732
	69,820	71,775
Consultant (2003 contract)	77,779	79,957
	80,256	82,504
	84,399	86,763
	89,210	91,708
	94,705	97,357
	97,839	100,579
	100,978	103,806
Clinical Excellence Awards		
Level 9 (Bronze)	36,924	36,924
Level 10 (Silver)	48,533	48,533
Level 11 (Gold)	60,666	60,666
Level 12 (Platinum)	78,866	78,866

	2019 £	2020 £
Commitment Awards[6]	3,334	3,334
	6,668	6,668
	10,002	10,002
	13,336	13,336
	16,670	16,670
	20,004	20,004
	23,338	23,338
	26,672	26,672
Distinction awards for consultants		
B awards	33,253	33,253
A awards	58,189	58,189
A+ awards	78,963	78,963
Salaried general medical practitioner range:		
Minimum	60,257	61,945
Maximum	90,928	93,474
Dental foundation training	32,460	33,369
Dental core training	30,093	30,936
	32,061	32,959
	34,029	34,982
	35,997	37,005
	37,964	39,027
	39,932	41,051
	41,900	43,074
Salaried primary care dental staff (2008 contract):		
Band A: Salaried dentist	40,630	41,768
	45,145	46,410
	51,917	53,371
	55,301	56,850
	58,687	60,331
	60,945	62,652

[6] Awarded every three years once the basic scale maximum is reached.

	2019 £	2020 £
Band B: Salaried dentist[7]	63,201	64,971
	65,459	67,292
	68,844	70,772
	70,537	72,513
	72,230	74,253
	73,923	75,993
Band C: Salaried dentist [8, 9]	75,617	77,735
	77,873	80,054
	80,130	82,374
	82,388	84,695
	84,645	87,016
	86,901	89,335

[7] The first salary point of Band B is also the extended competency point at the top of Band A.
[8] The first salary point of Band C is also the extended competency point at the top of Band B.
[9] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

APPENDIX B3: DETAILED RECOMMENDATIONS ON REMUNERATION IN SCOTLAND

SALARY SCALES

The salary scales that we recommend apply from 1 April 2020 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2019 £	2020 £
Foundation house officer 1	24,991	25,691
	26,551	27,295
	28,111	28,899
Foundation house officer 2	30,998	31,866
	33,025	33,950
	35,052	36,034
Specialty registrar (full)	32,961	33,884
	34,978	35,958
	37,795	38,854
	39,498	40,604
	41,552	42,716
	43,607	44,828
	45,663	46,942
	47,717	49,054
	49,772	51,166
	51,828	53,280
Specialty doctor	40,842	41,986
	44,334	45,576
	48,874	50,243
	51,307	52,744
	54,813	56,348
	58,305	59,938
	61,875	63,608
	65,447	67,280
	69,019	70,952
	72,590	74,623
	76,161	78,294

	2019 £	2020 £
Associate specialist (2008 contract)	57,262	58,866
	61,865	63,598
	66,466	68,328
	72,544	74,576
	77,812	79,991
	79,997	82,237
	82,849	85,169
	84,844	87,220
	87,613	90,067
	90,382	92,913
	93,153	95,762
Staff grade practitioner	37,838	38,898
(1997 contract)	40,842	41,986
	43,844	45,072
	46,848	48,160
	49,852	51,248
	53,389	54,884
Discretionary points	*Notional scale*	
	55,859	57,424
	58,862	60,511
	61,866	63,599
	64,870	66,687
	67,873	69,774
	70,878	72,863
Consultant (2004 contract)	82,669	84,984
	84,415	86,779
	86,928	89,362
	89,441	91,946
	91,948	94,523
	97,917	100,659
	103,886	106,795
	109,849	112,925
Discretionary Points for consultants	3,204	3,204
	6,408	6,408
	9,612	9,612
	12,816	12,816
	16,020	16,020
	19,224	19,224
	22,428	22,428
	25,632	25,632

	2019 £	2020 £
Distinction awards for consultants		
B awards	31,959	31,959
A awards	55,924	55,924
A+ awards	75,889	75,889
Salaried general medical practitioner range:		
Minimum	59,675	61,346
Maximum	89,070	91,564
Dental core training[10]	36,608	37,634
Dental senior house officer/Senior house officer	30,998	31,866
	33,025	33,950
	35,052	36,034
	37,079	38,118
	39,106	40,201
	41,133	42,285
	43,159	44,368
Salaried primary care dental staff (2008 contract):		
Band A: Dental officer	41,852	43,024
	46,503	47,806
	53,478	54,976
	56,965	58,561
	60,453	62,146
	62,778	64,536
Band B: Senior dental officer	65,103	66,926
	67,428	69,316
	70,915	72,901
	72,660	74,695
	74,404	76,488
	76,147	78,280

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

	2019 £	2020 £
Band C: Assistant clinical director	77,891	80,072
	80,216	82,463
	82,541	84,853
Band C: Specialist dental officer	77,891	80,072
	80,216	82,463
	82,541	84,853
	84,035	86,388
Band C: Clinical director/Chief administrative dental officers	77,891	80,072
	80,216	82,463
	82,541	84,853
	84,035	86,388
	86,292	88,709
	88,550	91,030

APPENDIX B4: DETAILED RECOMMENDATIONS ON REMUNERATION IN NORTHERN IRELAND

SALARY SCALES

At the time of submitting this report the Department of Health, Northern Ireland had yet to make an award for 2019. There are no salary scales in place for 2019 and therefore no base from which to apply our 2020 recommendations. For information, we have included the 2018 salary scales, which have been introduced since publication of our 2019 report.

Basic pay scales and awards

	2018 £
Foundation house officer 1	23,553
	25,023
	26,492
Foundation house officer 2	29,214
	31,123
	33,034
Specialty registrar (full)	31,217
	33,128
	35,795
	37,409
	39,354
	41,301
	43,248
	45,193
	47,139
	49,085
Specialty doctor	39,250
	42,607
	46,969
	49,307
	52,676
	56,033
	59,464
	62,897
	66,329
	69,761
	73,193

	2018 £
Associate specialist (2008 contract)	55,030
	59,455
	63,876
	69,717
	74,779
	76,879
	79,620
	82,361
	85,101
	87,841
	90,585
Staff grade practitioner	36,363
(1997 contract)	39,249
	42,136
	45,023
	47,909
	51,308
Discretionary points	*Notional scale*
	53,682
	56,568
	59,456
	62,341
	65,228
	68,116
Consultant (2004 contract)	78,296
	80,748
	83,200
	85,651
	88,096
	93,920
	99,743
	105,561
Clinical Excellence Awards (local):	
Step 1	2,957
Step 2	5,914
Step 3	8,871
Step 4	11,828
Step 5	14,785
Step 6	17,742
Step 7	23,656
Step 8	29,570

	2018 £
Clinical Excellence Awards (national):	
Step 9	35,484
Step 10	46,644
Step 11	58,305
Step 12	75,796
Salaried general medical practitioner range:	
Minimum	58,205
Maximum	87,831
Salaried primary care dental staff:	
Band 1: Salaried dentist	36,380
	39,323
	42,265
	45,210
	48,153
	51,096
	54,040
	56,983
Band 2: Senior salaried dentist	51,987
	56,102
	60,216
	64,329
	68,444
	69,352
	70,259
Band 3: Assistant clinical director salaried dentist	69,082
	70,151
	71,218
	72,288
	73,357
	74,426
Band 4: Clinical director salaried dentist	69,082
	70,151
	71,218
	72,288
	73,357
	74,426
	75,496
	76,584
	77,653
	78,722

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN THE NHS IN THE UK[1]

ENGLAND[2]	2018		2019		Percentage change 2018-2019	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical and Dental Staff						
Consultants	47,308	50,275	48,926	52,130	3.4%	3.7%
Associate specialists	1,987	2,215	1,909	2,137	-3.9%	-3.5%
Specialty doctors	6,825	7,933	7,271	8,416	6.5%	6.1%
Staff grades	313	375	315	370	0.5%	-1.3%
Registrar group	30,407	31,666	31,467	32,773	3.5%	3.5%
Foundation house officers[2]	5,521	5,560	5,630	5,682	2.0%	2.2%
Foundation house officers[1]	6,260	6,294	6,450	6,484	3.0%	3.0%
Other doctors and dentists in training	11,216	11,426	13,085	13,331	16.7%	16.7%
Hospital practitioners/Clinical assistants	498	1,727	500	1,684	0.5%	-2.5%
Other staff	912	1,394	862	1,378	-5.4%	-1.1%
Total	**111,247**	**118,510**	**116,416**	**123,979**	**4.6%**	**4.6%**
General medical practitioners[3]	**33,327**	**40,196**	**33,505**	**41,269**	**0.5%**	**2.7%**
GMP partners	19,262	21,857	18,303	21,161	-5.0%	-3.2%
GMP registrars	5,880	5,986	6,547	6,686	11.3%	11.7%
GMP retainers[4]	121	314	186	483	54.0%	53.8%
Other GMPs	8,065	12,236	8,469	13,076	5.0%	6.9%
General dental practitioners[5,6,7]		**24,308**		**24,545**		**1.0%**
General Dental Services only		20,514		20,915		2.0%
Personal Dental Services only		1,536		1,501		-2.3%
Mixed		1,446		1,342		-7.2%
Trust-led		812		787		-3.1%
Ophthalmic medical practitioners[8]						
Mixed		**218**		**193**		**-11.5%**
Total general practitioners		**64,722**		**66,007**		2.0%
Total general practitioners Total – NHS doctors and dentists		**183,232**		**189,986**		3.7%

[1] An Employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.
[2] Data as 30 September unless otherwise indicated.
[3] Data excludes locums.
[4] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.
[5] This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms.
[6] Data as at 31 March of that year.
[7] Includes salaried dentists.
[8] Data as at 31 December of that year.

WALES[9]	2018		2019		Percentage change 2018-2019	
Hospital and Community Medical and Dental Staff	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Consultants	2,570	2,732	2,623	2,799	2.0%	2.5%
Associate specialists	225	258	208	237	-7.7%	-8.1%
Specialty doctors	564	649	568	650	0.7%	0.2%
Staff grades	3	4	3	4	0.0%	0.0%
Specialist registrars	2,195	2,314	2,272	2,394	3.5%	3.5%
Foundation house officers 2[10]	542	561	561	580	3.5%	3.4%
Foundation house officers 1[11]	400	428	407	434	1.7%	1.4%
Other staff	40	99	52	160	28.6%	61.6%
Total	**6,539**	**7,045**	**6,693**	**7,258**	**2.3%**	**3.0%**
General medical practitioners[12]		**2,208**		**2,283**		**3.4%**
GMP providers		1,964		1,972		0.4%
General practice specialty registrars		230		296		28.7%
GMP retainers		14		15		7.1%
General dental practitioners[13]		**1,479**		**1,506**		**1.8%**
Ophthalmic medical practitioners[14]		**4**		**3**		**-25.0%**
Total general practitioners		**3,691**		**3,792**		**2.7%**
Total – NHS doctors and dentists		**10,736**		**11,050**		**2.9%**

[9] Data as at 30 September unless otherwise specified.
[10] Includes senior house officers.
[11] Includes house officers.
[12] Data for 2019 is as at 29 February 2020.
[13] Data as of 31 March of that year.
[14] Data as of 31 December of that year.

SCOTLAND[15]	2018		2019		Percentage change 2018-2019	
Hospital and Community Health Services Medical and Dental Staff	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Consultants	5,485	5,938	5,505	5,955	0.4%	0.3%
Staff and associate specialist grades	1,208	1,605	1,201	1,593	-0.5%	-0.7%
Registrar group	4,110	4,303	4,466	4,662	8.7%	8.3%
Foundation house officers 2	852	859	927	934	8.7%	8.7%
Foundation house officers 1	848	852	867	870	2.2%	2.1%
Other staff	1,036	1,579	780	1,360	-24.7%	-13.9%
Total	**13,538**	**15,012**	**13,746**	**15,241**	1.5%	1.5%
General medical practitioners		**4,994**		**5,049**		1.1%
Performers (partners)		3,396		3,336		-1.8%
Registrar/Specialist trainee		564		601		6.6%
Retainers[16]		84		69		-17.9%
Salaried		970		1,064		9.7%
General dental practitioners (non-hospital)[17]		**3,309**		**3,365**		**1.7%**
General Dental Service		3,052		3,088		1.2%
Public Dental Service		390		368		-5.6%
Ophthalmic medical practitioners		**27**		**17**		**-37.0%**
Total general practitioners		**8,330**		**8,431**		**1.2%**
Total – NHS doctors and dentists		**23,342**		**23,672**		**1.4%**

[15] Data as 30 September of that year.

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

[17] Includes salaried, community and public dental service dentists.

NORTHERN IRELAND[18]	2018		2019		Percentage change 2018-2019	
Hospital and Community Health Services Medical and Dental Staff[19,20]	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Consultant	1,693	1,800	1,744	1,857	3.0%	3.2%
Associate Specialist/Specialty Doctor/Staff Grade	475	563	467	548	-1.8%	-2.7%
Specialty/Specialist Registrar	1,360	1,405	1,420	1,479	4.4%	5.3%
Foundation doctor	519	522	517	521	-0.5%	-0.2%
Other[21]	152	310	160	323	5.8%	4.2%
Total	**4,199**	**4,600**	**4,307**	**4,728**	**2.6%**	**2.8%**
General medical practitioners[22]		**1,323**		**1,334**		**0.8%**
General dental practitioners[23 24]		**1,091**		**1,095**		**0.4%**
Ophthalmic medical practitioners[25]		**9**		**4**		**-55.6%**
Total general practitioners		**2,423**		**2,433**		**0.4%**
Total – NHS doctors and dentists		**7,023**		**7,161**		**2.0%**

[18] As at 30 September unless otherwise specified.
[19] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.
[20] As at March that year.
[21] Due to changes the collection of staff groups, the 'other' category is not consistent across year groups and should not be compared with previous years.
[22] Date as October of that year.
[23] Date as April that year.
[24] It is possible for someone to be a dentist in one location and an assistant at another location. The final total will not represent individual people.
[25] As at April that year.

APPENDIX D: GLOSSARY OF TERMS

AGENDA FOR CHANGE – the current NHS grading and pay system for NHS staff, with the exception of doctors, dentists, apprentices and some senior managers. The pay structure for staff employed under AfC is divided into nine pay bands. Staff are assigned to one of these pay bands on the basis of job weight, as measured by the NHS Job Evaluation Scheme.

ASSOCIATE DENTISTS (SCOTLAND AND NORTHERN IRELAND) – self-employed dentists who enter into a contractual arrangement, that is neither partnership nor employment, with principal dentists. Associates pay a fee for the use of facilities, the amount generally being based on a proportion of the fees earned; the practice owner provides services, including surgery facilities and staff to the associate. Associate dentists also have an arrangement with an NHS board and provide General Dental Services. The equivalent in England and Wales is performer-only dentists. See also *performer-only dentists.*

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

CLINICAL COMMISSIONING GROUPS – the groups of general medical practitioners and other healthcare professionals that took over commissioning from primary care trusts in England.

CLINICAL EXCELLENCE AWARDS (CEAs) – payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. National CEAs, and Local CEAs awarded before 2018 are consolidated and pensionable, while Local CEAs awarded after April 2018 are time-limited and non-pensionable. See also *Commitment Awards, Distinction Awards, Discretionary Points.*

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

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

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

COVID-19 (CORONAVIRUS) – an infectious disease that can affect the lungs and airways. This is caused by a newly discovered coronavirus (a family of viruses) which is referred to as COVID-19. The virus that causes the disease is referred to as SARS-CoV-2.

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

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

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

FOUNDATION HOUSE OFFICER – a trainee doctor undertaking a Foundation Programme.

FOUNDATION PROGRAMME – a (normally) two-year, general postgraduate medical training programme which forms the bridge between medical school and specialty/general practice training. 'F1' refers to a trainee doctor in the first year or the programme; 'F2' refers to a doctor in the second year.

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

GENERAL DENTAL PRACTITIONER – a qualified dental practitioner, registered with the General Dental Council and , in England, on the dental list of an NHS England Region (Geography) for the provision of general dental services.

GENERAL MEDICAL PRACTITIONER – more commonly known as a GP, a GMP works in primary care and specialises in family medicine.

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

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

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

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

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

HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS) STAFF – consultants; doctors and dentists in training; specialty doctors and associate specialists; and others (including: hospital practitioners; clinical assistants; and some public health and community medical and dental staff). General medical practitioners, general dental practitioners and ophthalmic medical practitioners are excluded from this category.

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

NHS LONG TERM PLAN – a document published by NHS England/Improvement, which sets out its priorities for healthcare in England over the next 10 years and shows how the NHS funding settlement will be used. The plan builds on the policy platform laid out in the NHS Five Year Forward View which articulated the need to integrate care to meet the needs of a changing population.

NHS PEOPLE PLAN – a document to be published by NHS England/Improvement, which sets out how NHS staff will deliver the **NHS LONG TERM PLAN** through an agenda to tackle workforce challenges.

PERFORMER-ONLY DENTISTS (ENGLAND AND WALES) – performer-only dentists deliver NHS dental services but do not hold a contract with the commissioning body in their own right. The equivalent in Scotland and Northern Ireland is associate dentist. See also *associate dentists.*

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

PROGRAMMED ACTIVITIES – under the 2003 contract, consultants have to agree the numbers of programmed activities they will work to carry out direct clinical care; a similar arrangement exists for specialty doctors and associate specialists on the 2008 contracts. Each programmed activity is four hours, or three hours in 'premium time', which is defined as between 7pm and 7am during the week, or any time at weekends. A number of **SUPPORTING PROFESSIONAL ACTIVITIES** are also agreed within the job planning process to carry out training, continuing professional development, job planning, appraisal and research.

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

SALARIED CONTRACTORS (including salaried GMPs) – general medical practitioners or general dental practitioners who are employed by either a primary care organisation or a practice under a nationally agreed model contract. See also *independent contractor status.*

SALARIED DENTISTS – provide generalist and specialist care, largely for vulnerable groups. They often provide specialist care outside the hospital setting to many who might not otherwise receive NHS dental care.

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

STAFF GRADE, ASSOCIATE SPECIALISTS AND SPECIALTY DOCTORS AND DENTISTS/ SAS GRADES – doctors and dentists in the SAS grades work at the senior career-grade level in hospital and community specialties. The group comprises specialty doctors, associate specialists, staff grades, clinical assistants, hospital practitioners and other non-standard, non-training 'trust' grades. The associate specialist grade is closed to new entrants.

SUPPORTING PROFESSIONAL ACTIVITIES – see *programmed activities.*

UNIT OF DENTAL ACTIVITY (UDA) – the technical term used in the NHS dental contract system regulations in England and Wales to describe weighted courses of treatment.

VOLUNTARY EARLY RETIREMENT (VER) – the term for when a doctor voluntarily retires before their NHS pension scheme's normal pension age.

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

E35. This appendix supports Chapters 8 and 9 and gives the latest data that would have populated the formulae for both GMPs and GDPs, had we used the formulae-based approach (Table E.1).

E36. Whilst we are not making formula-based recommendations for independent contractor GMPs and GDPs, we set out below in Table E.1 the data that would have populated the formulae. Given our ongoing concerns with the reliability of the formula, we do not consider it appropriate this year to adjust the weightings of the coefficients in the formula. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work: as noted in our 2012 report, average earnings and expenses for dentists reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound. The parties may wish to consider this point as part of their discussion of expenses and the uplift.

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

Coefficient	Value
Income (GMPs) *DDRB recommendation*	2.8%
Staff costs (GMPs) *Annual Survey of Hours and Earnings (ASHE) 2019 (general medical practice activities)*	3.1%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2019*	2.2%
Income (GDPs) *DDRB recommendation*	2.8%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2019 (dental practice activities)*	0.8%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2019*	2.2%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2019*	2.2%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2019*	2.2%
Other costs (GDPs) Scotland *RPIX for Q4 2019*	2.2%

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

APPENDIX F: ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
A&E	Accident and Emergency
ASHE	Annual Survey of Hours and Earnings
BAME	Black, Asian and Minority Ethnic
BDA	British Dental Association
BMA	British Medical Association
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CDS	Community Dental Services
CEA	Clinical Excellence Award
CPD	Continuing Professional Development
CPI	Consumer Prices Index
CPIH	Consumer Prices Index including owner occupiers' housing costs
COVID-19	Coronavirus disease 2019
CT1-3	Core Training, Years 1-3
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSC	Department of Health and Social Care (England)
EER	Expenses to Earnings Ratio
F1	Foundation Year 1
F2	Foundation Year 2
FHO	Foundation House Officer
FPP	Flexible Pay Premium
FTE	Full-Time Equivalent
GDC	General Dental Council
GDP	General Dental Practitioner
GDS	General Dental Services
GMC	General Medical Council
GMP	General Medical Practitioner
GMS	General Medical Services
GP	General Practitioner
HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association
HEE	Health Education England
HMRC	Her Majesty's Revenue and Customs
HSCNI	Health and Social Care Northern Ireland

LTP	NHS Long Term Plan
MPIG	Minimum Practice Income Guarantee
MSP	Member of the Scottish Parliament
NAO	National Audit Office
NHS	National Health Service
NHSE/I	NHS England/Improvement
NI	Northern Ireland
OBR	Office for Budget Responsibility
OME	Office of Manpower Economics
ONS	Office for National Statistics
PA	Programmed Activity
PDS	Public Dental Service
PMS	Personal Medical Services
RPI	Retail Prices Index
RRP	Recruitment and Retention Premium
SAS	Staff grade, associate specialist and specialty doctors and dentists
SPA	Supporting Professional Activity
ST	Specialty Training
TERS	Targeted Enhanced Recruitment Scheme
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity
UOA	Unit of Orthodontic Activity
UK	United Kingdom
UKFPO	UK Foundation Programme Office

APPENDIX G: PREVIOUS DDRB RECOMMENDATIONS AND THE GOVERNMENTS' RESPONSES

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

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

[1] At November in the previous year, series CZBH.
[2] At November in the previous year, series D7G7.

Report year	Main Uplift	RPI % (Nov)[1]	CPI % (Nov)[2]	Response to report
2010	0% to 1.5%	0.3	1.9	Mostly accepted: DDRB recommended: 0% for consultants and independent contractor GMPs and GDPs; 1% for registrars, SAS grades, salaried GMPs and salaried dentists; and 1.5% for FHOs. England and Northern Ireland both restricted the FHO recommendation to 1%.
2011	No recommendation due to public sector pay freeze.	4.7	3.3	
2012	No recommendation due to public sector pay freeze.	5.2	4.8	
2013	1%	3	2.7	Accepted
2014	1%	2.6 (Q4 figure)	2.1 Q4	Accepted in Scotland. Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales. Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales.
2015	1%	1.9 Q4	0.9 Q4	Recommendation only applied to independent contractor GMPs and GDPs in the UK and for salaried hospital staff in Scotland. Accepted
2016	1%	1.0 Q4	0.1 Q4	Accepted
2017	1%	2.2 Q4	1.2 Q4	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland.
2018	2%	3.7 Q1#	2.7 Q1#	Staged and abated in England. Accepted in Wales and Northern Ireland. Accepted in Scotland, except for staff earning at least £80,000 who received £1,600.
2019	2.5%	2.5 Q1#	1.9 Q1#	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards. Additional 1% for SAS not implemented anywhere. Northern Ireland yet to respond.
2020	2.8%	2.6 Q1#	1.7 Q1#	

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

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

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

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

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

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