Department of Health & Social Care

The Department of Health and Social Care's written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for the 2021/22 Pay Round

Published 4 March 2021

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Executive Summary

We recognise that this year has posed unprecedented challenges to our NHS. Under the most difficult conditions, the NHS has been at the forefront of the COVID-19 pandemic response.

In these most challenging times, patients, and their experience of care, must be at the heart of everything the system does. We want to help ensure that the NHS can continue to deliver world-class patient care whilst being equipped to deal with the COVID-19 pandemic and its aftermath.

The longstanding aims of the Government remain the same. Within the challenging economic context, we must ensure that we can continue to recruit, retain and motivate the compassionate and dedicated workforce the NHS needs in order to deliver world-class care, whilst also guaranteeing the best value for the taxpayer. Carefully balancing these aims is a complex matter of judgement that reflects the overall impact of the NHS employment offer, including pay and non-pay terms and conditions.

The COVID-19 pandemic has posed an unparalleled challenge to the UK economy and NHS finances. Funding the response to COVID-19 has been, and continues to be, a priority. In the Spending Review 2020 (SR20) the Chancellor provided a further £3 billion to support the NHS recovery on top of the Long Term Plan (LTP) settlement. It is vitally important that the financial pressures that have resulted from the COVID-19 pandemic, both within the NHS and wider public finances, are considered to ensure that staff are retained and recruited, while enabling the ongoing response to COVID-19 and the provision of care to patients to be affordable.

This written evidence therefore seeks to enable the Review Body to make independent recommendations, weighing all the evidence, including the importance of affordability within the current challenging economic and fiscal context, along with recruitment and retention trends and staff motivation.

This evidence is split into four sections. Section 1 details the wider context for the Government’s evidence, the current strategic context for NHS pay and the position of the medical workforce within it. Section 2 presents information on NHS finances and the Department’s approach to pay, total reward and workforce strategy across the whole medical and dental workforce. Section 3 looks specifically at medical and dental Hospital and Community Health Staff within the NHS. While, Section 4 focusses on General Medical Practitioners and section 5 on General Dental Practitioners.

Section 1: NHS Strategy and Introduction

1.1 This chapter sets out the current strategic context for NHS pay and where the medical workforce sits within this. The chapter also provides wider context for the Government's 2021-22 evidence.

1.2 COVID-19 has had a wide-ranging impact across the whole of society, with those working in the health and social care sector playing a crucial role on the frontline of the response. In the most challenging of times the commitment of NHS staff has never been clearer.

1.3 As part of SR20 the Chancellor announced that, *"to protect jobs, pay rises in the rest of the public sector will be paused next year"*. However, given the unique impact of COVID-19 on the health service, the government will continue to provide pay rises for NHS workers. The Chancellor highlighted that, in setting the level for these rises, the government will need to take into account the challenging fiscal and economic context.

1.4 The government, as always, needs to consider how to get the best value from a limited funding envelope. As the funding envelope is fixed, increased spending in one area will inevitably lead to knock on impacts elsewhere. Funding the response to COVID-19 has been, and continues to be, a priority. It is important to stress that the financial impact of COVID-19 will be felt across the health and social care system in the 2021-22 financial year and beyond.

1.5 Chapter 2 sets out in more detail the impact COVID-19 has had on NHS finances and re-iterates the importance of pay awards in 2021/22 being affordable to support the government's objective of delivering long-term financial sustainability in the NHS.

1.6 The SR20 settlement maintains the government's commitment to the long-term settlement for the NHS which provides a cash increase of £33.9 billion a year by 2023-24. This takes the NHS England budget from £114.6 billion in 2018-19 to £148.5 billion in 2023-24, with an increase of £6.3 billion in 2021-22. It also confirms the commitment to deliver 50,000 more nurses and to create an additional 50 million appointments in general practice a year.

1.7 The SR20 settlement included four priority outcomes for the Department, one being to "improve healthcare outcomes through a supported workforce fit for the future". The settlement provided investment in the NHS workforce via funding for Health Education England (HEE) to train more new nurses and doctors, deliver some of the biggest undergraduate intakes ever and deliver training to NHS staff.

1.8 However, demand for NHS and social care services continues to rise. The COVID-19 pandemic has posed an unprecedented challenge to the UK economy and NHS finances including that of the LTP. The LTP sets out the NHS's 10-year strategy to improve the quality of patient care and health outcomes, ensuring that patients will be supported with world-class care at every stage of their life. The Plan rightly sets out that putting the NHS back onto a sustainable financial path is a key priority and is essential to delivering further improvements in care, and so, within the plan, the Government set the NHS five financial tests that show how it will put the service onto a more sustainable footing.

1.9 The NHS has faced unique pressures due to COVID-19 along with pre-existing trends such as an ageing population with multiple and complex care needs. Responding to COVID-19 and meeting the continuing demand whilst maintaining and improving quality and care is a significant challenge. The additional £3 billion of funding set out in SR20 will help the NHS to get back on track to delivering the LTP, but the Government recognises that recovering previous efficiency plans will be challenging.

1.10 As the long-term NHS funding settlement is held by NHS England and Improvement (NHSEI), they will set out the affordability constraints and financial pressures within the system. Spend on pay awards is one of the biggest financial pressures on NHS funding, a pressure which is recurrent. NHSEI will set out in their evidence the interaction between pay uplifts and their ability to deliver their wide-ranging priorities.

Workforce

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

1.12 Recruitment and retention are not only driven by satisfaction with pay, but by a culture and environment where staff want to work, where staff feel safe to raise concerns and to learn from mistakes; where employers listen to and empower staff, work hard to keep them safe and ensure bullying and harassment is not tolerated. There is strong evidence that staff who feel well supported and engaged with their employer will deliver better care, with improved patient safety and patient satisfaction.

1.13 Following the Interim NHS People Plan published on 3 June 2019, 'We are the NHS: People Plan 2020/21 - action for us all' was published in July 2020. This plan sets out actions that NHSEI and HEE will take to support transformation across the whole NHS, acknowledging the impact of the COVID-19 pandemic. It focuses on how the NHS will foster a culture of inclusion and belonging, as well as action it will take to grow the workforce, train people, and work together differently to deliver patient care.

1.14 Published alongside 'We are the NHS: People Plan 2020/21 - action for us all' was 'Our NHS People Promise'. This sets out the vision and immediate actions to make the NHS the best place to work. One of the most important elements of the plan is to improve the day to day experience of front-line staff and make the NHS an employer of excellence, where people are valued, supported, developed and empowered. This investment in our workforce is a key strand in our actions to reward and retain NHS staff.

1.15 The challenge of COVID-19 has compelled the NHS to make the best use of our people's skills and experience to provide the best possible patient care. It will be important to capitalise on this momentum to transform the ways teams, organisations and systems work together, and how care is delivered for patients.

1.16 Staff engagement is crucial to securing and retaining the workforce the NHS needs, as is making the best use of the entire employment reward offer, which includes both pay and non-pay benefits. For staff within the remit group the wider employment package includes a range of benefits exceeding those offered in many other sectors including a generous holiday allowance and sickness absence arrangements well beyond the statutory minimum, as well as access to a much-valued pension scheme and support for learning, development and career progression.

1.17 Where possible, the Department has focused on pay and contract reform across the NHS workforce as part of our ambition to make the NHS a world class employer, providing high quality and safe care. Pay and contract reforms we have made are not only about headline pay uplifts. The changes we have agreed will help to increase productivity and improve recruitment and retention by enhancing the working lives of staff and supporting them to maintain their physical and mental health and wellbeing.

2020/21 Pay Awards

1.18 In 2020/21, after giving full consideration to recruitment, retention and motivation as well as the financial and budgetary constraints and any impact on the priorities

for the health service and its staff, the Government responded to the DDRB's recommendations via a Written Ministerial Statement.

1.19 The decision was taken to accept the DDRB's recommendations in full. This gave a 2.8% uplift in pay across the whole remit group, with the exception of those already in multi-year agreements. This included uplifting the value of the Genera; Medical Practitioner (GMP) trainers' grant, the GMP appraisers' grant and the minimum and maximum pay range for salaried GMPs. As recommended by the DDRB, the value of National and Local Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points was frozen.

1.20 At the time it was recognised that accepting the DDRB's recommendations would require difficult trade-offs and reprioritisation within the wider context of the original financial plans set out in the LTP. Whilst the government deemed accepting the DDRB's recommendations as important to reward and retain valued staff during the midst of the first wave of COVID-19, this placed recurrent financial pressure on the remaining years of the funding settlement.

COVID-19

1.21 Significant additional funding has been provided to support the NHS response to the COVID-19 pandemic, including provisions to ensure staff who need to self-isolate or are sick through COVID-19 are financially supported.

1.22 The NHS Terms and Conditions of Service have been supplemented by temporary non-contractual guidance introduced by DHSC in March 2020. The intention of the guidance is to ensure that where staff are told to self-isolate, they receive full pay based on what they would have received at work, and in addition to ensure that where staff are off sick with the COVID-19 virus, they receive full pay whilst they are infectious to make sure there is no incentive to attend work.

Government Pay Policy and our approach for the NHS

1.23 As has been briefly set out above and will further be detailed within the rest of our evidence, COVID-19 has placed a huge strain on both public and NHS finances. The economic outlook for 2021/22 remains uncertain and pay awards must be both fair and affordable.

1.24 The government announced a pause in public sector pay rises for all workforces, with an exception for employees with basic full-time equivalent salaries of £24,000 or under and for the NHS. In settling the DHSC and NHS budget, the government

assumed a headline pay award of 1% for NHS staff. Anything higher would require re-prioritisation.

1.25 As set out within the Secretary of State remit letter in December, the DDRB are not asked to make pay recommendations for those already within existing multi-year deals where pay for these staff has already been agreed. For SAS doctors a multi-year agreement has been agreed in principle with the British Medical Association (BMA) to begin from 1 April 2021, subject to the outcome of a referendum of BMA members. The deal seeks to modernise terms and conditions and provides certainty on pay increases for the lifetime of the deal for all SAS doctors who choose to transfer. All SAS doctors will have a choice over whether to transfer to the new contracts and therefore, we expect the DDRB to make recommendations for those SAS doctors who choose not to transfer.

1.26 CPI inflation has been consistently low in 2020. The latest figure available (December 2020) shows CPI inflation at 0.6%. Whilst inflation is an important consideration of the DDRB it is also important to view inflation within the wider economic context set out by HMT.

Figure 1.1- CPI inflation by month, April 2020 - December 2020

Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
CPI inflation	0.8%	0.5%	0.6%	1.0%	0.2%	0.5%	0.7%	0.3%	0.6%

Source: ONS Inflation and price indices

2021/22 Recommendations

1.27 We are asking for recommendations on uplifts for consultants and on the pay element of dentists employed by, or providing services to, the NHS.

1.28 As set out in Chapter 9 a multi-year pay and contract reform agreement for SAS doctors has been agreed in principle. All current SAS doctors would have a choice over whether to transfer to the new contracts, with pay uplifts agreed for the next three years. We are asking for recommendations on uplifts for those SAS doctors who choose to remain on their current contracts. .

1.29 As you are aware, we reached a multi-year pay and contract reform agreement for doctors and dentists in training (2019/20 - 2022/23). We are not seeking a pay recommendation for this group but, as usual, welcome your comments and observations on the evidence you receive.

1.30 Similarly, independent contractor GMP are subject to a five-year pay agreement between NHSEI and the British Medical Association and therefore no pay recommendation is being sought for this group. We are seeking a recommendation on uplifts to the minimum and maximum of the salaried GMP pay scales.

Section 2: All workforces

This section provides information on NHS finances and the Department's approach to pay, total reward, and workforce strategy across the whole medical and dental workforce. In parts, this will be more relevant to the employed Hospital and Community Health Staff (HCHS) workforce but is here to provide an overarching view for the entire remit group. This section in particular should be read in conjunction with evidence provided by NHS England and Improvement (NHSEI).

Chapter 2 provides information on NHS finances including funding growth and pressures. Chapter 3 sets out the workforce strategy including an update on the NHS People Plan. Chapter 4 provides information on the total reward package, including the NHS Pension Scheme and additional elements that make up the total reward package.

2. NHS Finances

2.1 This chapter describes the financial context for the NHS.

Funding Growth

2.2 The NHS LTP (January 2019) sets out the NHS's 10-year strategy to improve the quality of patient care and health outcomes, ensuring that patients will be supported with world-class care at every stage of their life. The Plan rightly sets out that putting the NHS back onto a sustainable financial path is a key priority and is essential to delivering further improvements in care. The Government signalled its clear support for this plan in the 2019 Spending Round, where it confirmed the five-year settlement for the NHS which provides an additional £33.9 billion cash terms annual increase by 2023-24 compared to 2018-19 budgets.

2.3 At Budget 20 DHSC received over £5 billion to meet the Government's manifesto commitments of 50,000 more nurses, 50 million additional appointments in primary care, more funding for hospital car parking and establishing a Learning Disability and Autism Community Discharge Grant to support discharges into the community.

2.4 The SR20 also provided a further £3 billion to support NHS recovery from the impacts of COVID-19 in 2021-22, on top of the LTP settlement. This includes around £1 billion to begin tackling the elective backlog; and around £500m for mental health services and investment in the NHS workforce.

2.5 The SR20 settled non-NHS revenue budgets for 2021-22. This includes £260 million for HEE to continue to support the education and training of the NHS's workforce and deliver on the commitments of the LTP. Included within this is funding for training more new nurses and doctors, delivering some of the biggest undergraduate intakes ever.

2.6 The SR settlement delivers a 3.5% real terms a year increase on DHSC's overall core resource budget (excluding COVID-19 funding) since 2019-20. Increasing these vital budgets will further enable the NHS to deliver a better service and health outcomes for patients. Despite the settlement, COVID-19 has placed strain on NHS finances as described below.

Figure 2.1- Opening mandate for NHS England

NHS England (NHSE)	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £bn*	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £bn
2013-14	93.676	0.200
2014-15	97.017	0.270
2015-16	100.200	0.300
2016-17	105.702	0.260
2017-18	109.536	0.247
2018-19	114.603	0.254
2019-20	123.377	0.260
2020-21	129.681	0.305
2021-22	136.134	-
2022-23	142.841	-
2023-24	151.318	-

Source: 2020-21 Financial Directions to NHS England

2.7 Figure 2.1 above shows the opening mandate for NHS England (NHSE) in 2020-21, and indicative amounts for future years, as per NHSE's Financial Directions. These figures include an increase for pensions revaluation which was provided alongside the LTP settlement. Figures exclude depreciation, AME and technical budget.

2.8 The LTP commitment gives the NHS the financial security to address challenges in a sustainable manner. There will be multiple calls on available funding, including pay, and these will need careful prioritisation in order stay within available funding. More funding put towards pay will mean less funding for other priorities, including the size of the workforce that is affordable, as well as wider investments required to deliver the NHS LTP.

2.9 It is essential this money is spent wisely, which is why the Government set five financial tests alongside the LTP settlement to ensure the service is put on a more sustainable footing for the future. The five tests are:

(a) The NHS (including providers) will return to financial balance;

(b) The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care;

(c) The NHS will reduce the growth in demand for care through better integration and prevention;

(d) The NHS will reduce variation across the health system, improving providers' financial and operational performance.

(e) The NHS will make better use of capital investment and its existing assets to drive transformation.

2.10 While the five tests remain important to the delivery of the LTP, the onset of the global pandemic has meant reporting against the tests has rightly been temporarily put on hold to allow the system to focus on managing and responding to the developing pandemic.

Financial Position

2.11 The Government's 2020-21 Mandate to the NHS provides clarity on headline objectives for the NHS. The financial directions to NHSE published alongside the Mandate partially reflect further funding to deliver manifesto commitments agreed at Budget 2020 and do not fully reflect emergency COVID-19 funding. Given the nature of COVID-19, the Mandate reinforces the importance of public money being spent with care on targeted, timely and time-limited interventions.

2.12 Although recovering finances in the NHS continues to be a major focus, in these exceptional circumstances funding the response to COVID-19 has been, and continues to be, a priority. In 2015-16 disciplined financial management was reintroduced to stabilise finances and secure the immediate future of our health service. NHS leaders devised a plan of action, in operation since July 2016, involving a series of controls and levers designed to exert tighter control over local organisations.

2.13 This approach has been broadly successful in doing what it set out to achieve – notably we have seen a stabilising of finances across NHS providers, with the majority of trusts demonstrating strong, effective and sustainable financial management.

2.14 In the 2019-20 financial year the NHS balanced its financial budget based on opening accounts of NHS planned spend, excluding COVID-19 spend. Through continuing focus on financial rigour and efficiency, most Trusts have once again met their control totals.

2.15 This financial rigour and efficiency will need to continue in future years to help recover from COVID-19. The impact will be felt across the health and social care system in the 2020-21 financial year and beyond.

2.16 2019-20 was the first year of the LTP period and represented a step towards these longer- term ambitions; where both commissioner and provider sectors move towards aggregate financial balance and fewer organisations end the year in deficit. Significant progress was made pre COVID-19, with the NHS once again delivering overall financial balance, with the number of trusts in deficit reduced by half and finances in most trusts and commissioners in a much healthier position than seen in previous years. A minority of trusts remain with significant deficit levels, but a number of those have hit their agreed financial targets and were on track to recovery.

2.17 While the majority of COVID-19 related spend will occur in future financial years, spending impacts have been felt in February and March of 2019-20. Those trusts affected and the NHS overall have been fully supported with funding and financing at the right time, and all spending pressures have been met.

Figure 2.2- NHS Providers RDEL Breakdown

NHS Providers RDEL Breakdown	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Total Resource DEL (£m)	2,548	935	1,038	826	1,008
Provisions Adjustment (£m)	-74	-43	-39	23	50
Other Adjustments (£m)	-27	-101	-8	-22	-159
Aggregate Net Deficit (£m)	2,448	791	991	827	899
Unallocated Sustainability Funding (£m)	0	0	-25	0	-144
Adjust Net COVID-19 Impact (£m)	0	0	0	0	-85
Reported Net Deficit (£m)	2,448	791	966	827	669

Share of Resources Going to Pay

2.18 Figure 2.3 shows the proportion of funding consumed by NHS provider permanent staff spend over the last five years. Note that NHS provider permanent staff spend only covers staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

Figure 2.3- Increases in Revenue Expenditure and the Proportion Consumed by Pay bill

Year	NHSE RDEL (£bn)	NHS Provider Permanent and Bank Staff Spend (£bn)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2013/14	93.7	42.9	45.8%	n/a	n/a
2014/15	97.0	43.9	45.3%	3.57%	2.37%
2015/16	100.2	45.2	45.1%	3.28%	2.80%
2016/17	105.7	47.7	45.1%	5.49%	5.58%
2017/18	109.5	49.9	45.6%	3.63%	4.64%
2018/19	114.4	52.6	45.9%	4.46%	5.35%
2019/20	120.5	56.1	46.6%	5.34%	6.76%

Notes: 2018/19 - retrospective adjustment to RDEL total (2018-19 Revised Financial Directions) 2019/20 - excludes £2.8 billion for revaluation of NHS pensions

2.19 Up until the financial year 2017-18, under the public sector pay cap, pay rises across the health service remained largely around 1%. However, in 2018 the NHS Staff Council (a partnership of NHS Employers and NHS trades unions) reached an agreement with the NHS on the multi-year Agenda for Change (AfC) pay and contract reform deal (2018/19 – 2020/21) resulting in several pay and non-pay reforms to support recruitment and retention, improve productivity and increase capacity

2.20 In 2019, the Government also reached agreement with the BMA on a multi-year deal for junior doctors (2019/20 – 22/23) providing certainty over pay and supporting recruitment, training and retention, which guaranteed annual pay uplift of 2 per cent each year.

2.21 The Government has been in negotiations with BMA on new contractual arrangements for SAS doctors and has made a financial envelope broadly commensurate with other recent multi-year pay and contract reform agreements.

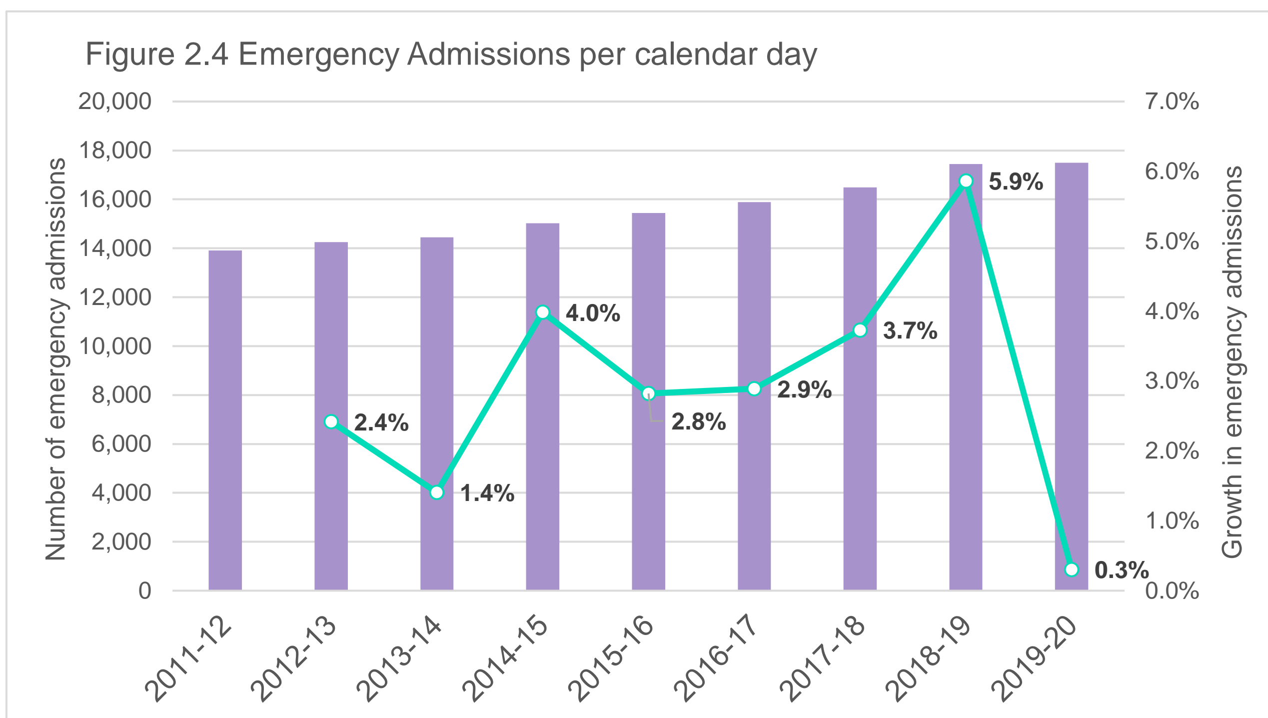
2.22 Pay over the three-year period of the AfC deal and the two years of the junior doctor deal has increased beyond the level of inflation and together with the increase in staffing numbers this has meant a greater proportion of spend going to pay and being spent on staff. This trend is important to bear in mind when considering the affordability of pay recommendations particularly considering the challenging fiscal and economic context, along with other pre-existing pressures such as an ageing population.

2.23 DHSC has embarked on pay and contract reform right across the NHS workforce as part of our ambition to make the NHS the best employer in the world providing the very best and safest care. As these reforms have illustrated this is not just about headline pay but delivering changes that will help improve the working lives and the physical and mental health and wellbeing of all our dedicated NHS staff.

Demand Pressures

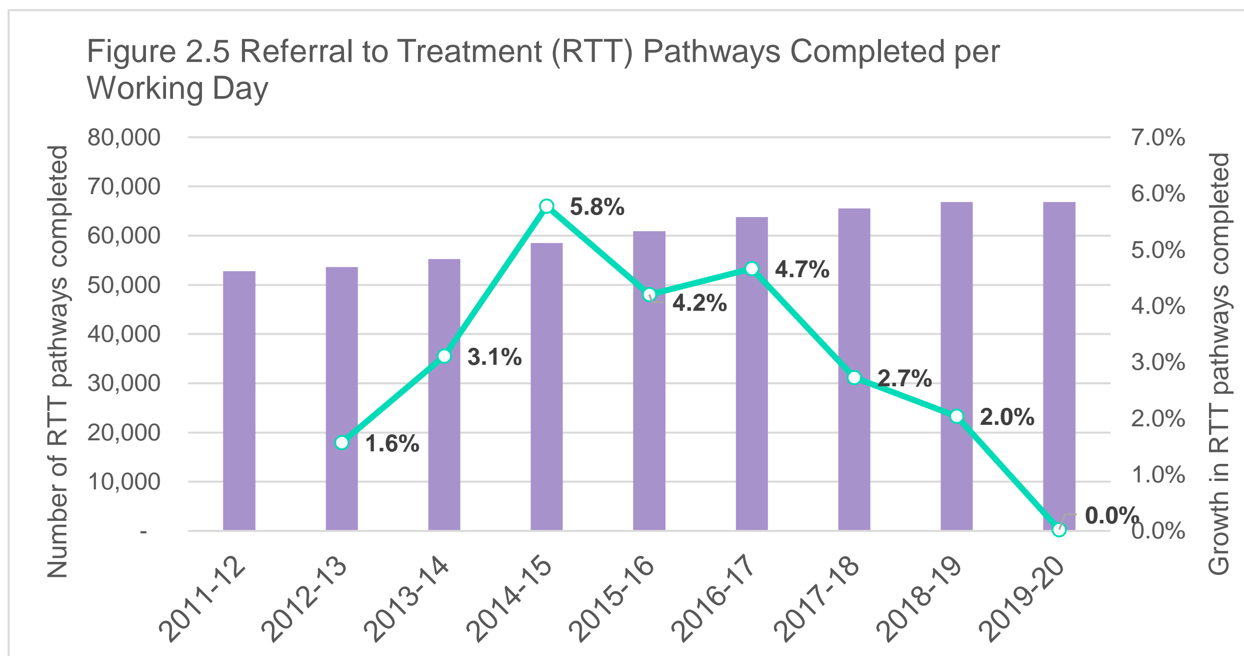
2.24 We had been seeing a rise in demand for services provided in the health system during 2019-20. However, due to the onset of COVID-19 at the end of the financial year, there was a reduction in elective and emergency activity as numbers of self-presenting patients reduced and the NHS freed-up capacity to manage COVID-19 demand. This included suspending all non-urgent elective operations. As a result, full-year growth has ultimately remained flat compared to 2018-19.

Figure 2.4- Emergency Admissions – per calendar day



Source: A&E attendances & Emergency Admission Statistics

Figure 2.5- Referral to Treatment (RTT) Pathways Completed per Working Day



Source: NHSE Consultant Led Referral to Treatment Statistics. Data adjusted for non-submitting Trusts and exclusion of sexual health services from 2013.

2.25 Compared to the year before, in 2019-20 there were 53 (0.3%) more emergency admissions per day. There were also only 15 more elective care pathways completed per working day, as shown in figures 2.4 and 2.5.

2.26 Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2019-20, largely due to the increasing demand pressures placed on frontline services throughout the year, including prior to COVID-19. These included A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards.

2.27 The Government is committed to supporting NHS capacity during surges in COVID-19 cases alongside the increased pressures on the system during winter. This is whilst also working hard to deliver the maximum elective activity possible.

2.28 £3bn of additional funding was announced in July to support the NHS this winter. This ensures Nightingale hospital surge capacity is available when needed, that the NHS has ongoing access to additional independent sector bed capacity, and funding to support the safe discharge of patients from NHS hospitals which can help ease pressure on hospital beds. In addition, £450m of capital funding is being provided to hospitals across the country to upgrade A&E's this winter to increase capacity, reduce overcrowding and improve infection control

2.29 Longer term, the SR funding includes £1billion to address backlogs and tackle long waits, by facilitating up to 1 million extra checks, scans and additional operations for the 2021-22 financial year.

Productivity and Efficiency in the NHS

2.30 Putting the NHS onto a sustainable financial path will be key to its recovery from the COVID-19 pandemic. Making productivity improvements will be a central part of this path.

2.31 Through the five financial tests, the Government set the NHS a stretching but realistic goal of making productivity growth of at least 1.1% per year, with all savings reinvested in front line care. The impact of COVID-19 has caused major disruption to this goal, as the system has not had capacity to plan for and deliver efficiencies. The additional £3 billion of funding set out in SR20 will help the NHS to get back on track to delivering the LTP, but the Government recognises that recovering previous efficiency plans in the short term will be challenging.

2.32 COVID-19 has made improving productivity more important than ever. Improved efficiency will be needed to deal with increased waiting lists caused by cancellations during the epidemic and ensure that patients can be treated effectively while Infection Control Procedures are still in place. During COVID, the NHS has also found more effective ways to work and has accelerated some efficiency programmes, such as virtual appointments.

2.33 NHSEI has several priorities for improving productivity and efficiency across the NHS:

(a) Workforce productivity:

- Using the right staff in the right place at the right time: this includes using workforce deployment and planning tools (including e-rostering and e-job planning) to use the most effective staff, match workforce to need, and reduce agency spend and absence. It is supported by improved skill mix models to tackle staff shortages by staffing teams by capability instead of job title.

- Clinical productivity: NHSEI and GIRFT are collaboratively redesigning elective care pathways to reduce variation and improve performance across surgery, diagnostics and outpatients. Standardising high volume, low acuity procedures and driving to top decile performance will boost throughout and ease capacity. This is linked to improving theatre productivity by ensuring lists are full and cancellations and gaps between cases are minimised.

- Digitisation: Using digital tools such as single sign-on, improved communication tools, and shared care records to save clinical staff time that can be better spent caring for patients.

- In addition to workforce productivity programmes, the wider productivity improvements support workforce productivity improvements in specific areas:

  (b) Diagnostics improvement – This includes improvements through consolidation of imaging and pathology networks and upgrading digital infrastructure. This will enable improved skill mix and will allow diagnostics teams to work more flexibly, e.g. by allowing for home reporting.

  (c) Hospital medicines and pharmacy improvement – This includes aseptic pharmacy transformation that will free up time equivalent to 4000 WTE nurses through development of hub and spoke networks and use of robotics, continued roll-out of electronic prescribing to save time on routine medicines administration, and making better use of clinical pharmacists to release medical staff.

  (d) Outpatients transformation – Reducing the number of face-to-face appointments by a third by 2023/24 through improved clinical pathways, use of virtual consultations, and a greater role for patient decision making.

  (e) Mental health improvement, Ambulances, and Community Health – This includes a range of tools to improve productivity, including a no wrong door approach in mental health to cut the cost of repeat assessments and admin, make ready hubs so that ambulance crews can start shifts immediately, and greater use of digital in community healthcare.

  (f) Primary Care – This includes continuing the Time for Care programme that uses similar approaches to general workforce productivity programmes to free up GP time.

2.34 Planned improvements to workforce productivity are linked to the ambitions of the 2020/21 NHS People Plan to deliver new ways of working and delivering care while supporting staff. The People Plan supports more flexible and remote working, as supported by e-rostering software and digitisation in diagnostics and outpatients. The Plan states the NHS will make the best use of skills within its teams, as supported by NHSEI's new skill mix models and multi-professional workforce planning teams. Further information on the NHS People Plan is set out in Chapter 4.

2.35 The programmes to deliver the required productivity improvements build on the recommendations of the 2016 Carter Review and the Operational Productivity

programme that aimed to reduce unwarranted variation across NHS acute, mental health, ambulance, and community Trusts. Lord Carter's review identified £5.8bn in potential savings from improving productivity across workforce, diagnostics, medicines and pharmacy, corporate services, estates, procurement, ambulances, and mental and community health. In 2018/19, these programmes delivered £1.45bn in savings and had delivered £801.7m in recurrent Cost Improvement Plans through to January 2020 (collection of data was paused due to COVID-19). In total, the Carter Programme had delivered £3.57bn in savings by January 2020.

2.36 The productivity programmes are also closely linked to NHSEI's Clinical Improvement programmes, Getting It Right First Time and Right Care. These programmes aim primarily to improve patient outcomes and patient safety by reducing unwarranted variation in surgical and clinical practice, with the secondary benefits of improving productivity and saving money.

2.37 Alongside this, progress has been made in reducing the reliance on the use of expensive agency staff within the NHS, reducing spending on agency workers to £2.38 billion in 2019/20 compared to £3.6bn in 2015/16. Agency spend in 19/20 accounted for 4.0% of the overall NHS Pay bill, down from 7.8% at its peak in 2015/16. The overall average price per agency shift decreased by 1.3% from 2018/19, resulting in an overall saving of £19m (0.8%).

2.38 The Department and NHSEI have created a Flexible Staffing strategy that aims to reduce agency spend by developing and promoting alternative flexible working arrangements (see chapter 4 for NHS People Plan commitments on flexible working). We aim to:

- Grow and develop the NHS substantive flexible offer.
- Continue our work on the development of Trust level bank capability, including the development of collaborative banks across several NHS Trusts.
- Support NHSEI and the Department to capture the returners and volunteers from the COVID-19 response and create a model that can be used to ease pressure in the NHS in the future.
- Continue the monitoring of compliance with Agency rules as well as continuing our work with NHSEI on reducing agency spend.

Calculating Productivity in the NHS

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

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

2.41 Labour productivity is an important component of efficiency, but labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, e.g. including drugs as an input. This is called total factor productivity and is also measured by York University (CHE). Their figures show that between 2005/06 and 2015/16 the NHS's average annual total factor productivity growth was 1.2%.

2.42 Although the average total factor productivity growth between 2005-06 and 2015-16 reflects the progress made by the NHS workforce's committed efforts to improving productivity where possible, there still remains areas for improvement which must be targeted if the objectives set out in the LTP are to be achieved.

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

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

2.45 The input factor of productivity can be more easily broken down by staff group. The labour input in York CHE's productivity measure is a weighted combination of different staff groups; the growths for each staff group is summarised in Chapter 4 of this evidence.

Figure 2.6- York CHE Total Factor Productivity

Year	Quality Adjusted Output	Total Input	Total Factor productivity
2005/06	7.1%	7.2%	-0.1%
2006/07	6.5%	1.9%	4.5%
2007/08	3.7%	3.9%	-0.2%
2008/09	5.7%	4.2%	1.4%
2009/10	4.1%	5.4%	-1.3%
2010/11	4.6%	1.3%	3.2%
2011/12	3.2%	1.0%	2.1%
2012/13	2.3%	2.0%	0.4%
2013/14	2.6%	0.4%	2.2%
2014/15	2.5%	1.9%	0.5%
2015/16	2.6%	2.7%	-0.2%
2016/17	3.5%	0.6%	2.9%
2017/18	1.7%	0.5%	1.3%

Note: Figures are all quality adjusted so take into account changes in quality of care (e.g. waiting times)

Figure 2.7- York CHE Labour Productivity

Year	Quality Adjusted Output	Labour Input	Labour Productivity
2005/06	7.1%	3.4%	3.6%
2006/07	6.5%	0.6%	5.9%
2007/08	3.7%	0.7%	2.9%
2008/09	5.7%	4.1%	1.5%
2009/10	4.1%	4.5%	-0.4%
2010/11	4.6%	1.4%	3.1%
2011/12	3.2%	0.1%	3.1%
2012/13	2.3%	-2.0%	4.4%
2013/14	2.6%	0.4%	2.3%
2014/15	2.5%	2.8%	-0.3%
2015/16	2.6%	1.3%	1.3%
2016/17	3.5%	2.4%	1.1%
2017/18	1.7%	2.4%	-0.6%

Note: Figures are all quality adjusted so take into account changes in quality of care (e.g. waiting times)

2.46 If the NHS is 1% more productive than last year it will produce 1% more output (e.g. treatments) per input (e.g. per doctor/nurse). Hence, with fixed inputs it will deliver 1% more output (e.g. treatments). This means within a fixed funding

envelope the NHS can increase treatments by 1% (to meet increased demand) or increase input prices by 1% (e.g. increase wages) or a mixture of the two.

2.47 The 2019 Report from the DDRB included a request for an update on progress with regards to a common understanding of NHS productivity. A working group has been formed between DHSC and NHSEI which has begun to examine early outputs; we will provide a further update when these are mature enough to report on.

Conclusion

2.48 The additional funding provided to handle COVID-19 has further reinforced the Government's continued financial commitment to the NHS. The SR20 provided a further £3 billion to support NHS recovery from the impacts of COVID-19 in 2021-22, on top of the LTP settlement. This includes around £1 billion to begin tackling the elective backlog; and around £500m for mental health services and investment in the NHS workforce.

2.49 To help control the spread of infection, employers have been supported financially to ensure that staff are given full pay where they are told to self-isolate and where they are off sick because they are infectious with the COVID-19 virus. Funding has not only been given to recognise the increased cost of sickness absence during the pandemic, but also to cover the unprecedented backfill costs which have arisen through staff having to self-isolate.

2.50 This support is also evident in the agreed multi-year funding deal for junior doctors and staff on AfC contracts. The agreed 2018 AfC multi-year deal provided a new pay structure that reinforced public sector pay policy of increased pay flexibility in return for reforms that improve recruitment and retention while boosting productivity. Over a million NHS staff received pay rises in April 2020 from existing multi-year deals and in July we accepted the independent pay review body's recommendations of a 2.8% pay rise for SAS doctors, dentists, consultants and salaried GPs.

2.51 Additionally, the Government accepted most of the recommendations made by the DDRB for 2020-21, rewarding staff dedication and productivity improvements, as well as encouraging recruitment and retention.

2.52 The NHS employment and reward offer is not just about headline pay but includes a much broader reward package. This includes a range of benefits exceeding those offered in many other sectors such as annual leave and sickness absence arrangements well beyond the statutory minimum, as well as access to a much-

valued pension scheme and support for learning, development and career progression. Total reward is discussed in greater detail in Chapter 4.

2.53 COVID-19 has resulted in additional financial pressures. These are not only the direct costs of dealing with the pandemic, but also indirect costs into future years from the consequences of lost efficiency opportunities during the course of 20/21. These indirect costs include potential productivity gains foregone. Indirect costs have been recognised in the SR settlement, but there is still an expectation that the NHS can catch-up on some of the lost efficiency and make greater productivity savings in 21/22 than the LTP originally expected. This is so that the NHS can get back towards the longer-term ambition of returning all organisations within the NHS to financial balance.

2.54 It is consequently important that the 2021/22 pay awards support the Government's objective to deliver long-term financial sustainability in the NHS, as well as aligning with the full range of investment priorities in the NHS LTP, in light of COVID-19.

3. Workforce Strategy

3.1 This chapter discusses the current strategy for the NHS workforce and provides further information on the NHS People Plan 20/21.

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

3.3 The Department works through its Arms-Length Bodies (ALBs) on the delivery and implementation of workforce policy. NHSEI is responsible for setting the priorities and direction of the NHS and encouraging and informing the national debate to improve health and care. NHSEI is responsible for delivering the NHS People Plan. The NHS People Plan is a key route for setting out policy and actions to expand the NHS workforce, strengthening recruitment and retention through improving staff health and wellbeing, equality diversity and inclusion and the NHS leadership culture. Education and training of the workforce is the core function of HEE. Information on General Medical Practitioners and General Dental Practitioners can be found in section 12 and 13.

3.4 The NHS LTP Plan published in 2019 sets out how new models of care will be transformed over the next 5 years to allow patients to have more options, better support and properly joined-up care at the right time in the optimal care setting.

3.5 The LTP highlights the following objectives as most important for the workforce:

- Ensuring we have enough people, with the right skills and experience so staff have the time they need to care for patients well;
- Ensuring NHS staff have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment and have the support to manage the complex and often stressful nature of delivering healthcare;
- Strengthening and supporting good, compassionate diverse leadership at all levels - managerial and clinical - to meet the complex practical, financial and cultural challenges a successful workforce plan and Long-Term Plan will demand.

The NHS People Plan

3.6 'We are the NHS: People Plan 2020/21 – action for us all' was published in July 2020. This plan sets out actions that NHSEI and HEE will take to support transformation across the whole NHS acknowledging the impact of the COVID-19 pandemic.

3.7 COVID-19 has placed greater focus on these issues and highlighted just how important work on staff wellbeing is. The People Plan puts health and wellbeing at its core with a new support package. Since April 2020 - NHS staff have been able to access:

- A dedicated and confidential staff support line, operated by the Samaritans and a 24/7 text support line operated by Frontline;
- Specialist bereavement support through a helpline provided by Hospice UK, manned by a team of fully qualified and trained bereavement specialists;
- Free access to mental health and wellbeing apps;
- Virtual staff common rooms, in partnership with NHS Practitioner Health, which have given staff the opportunity to reflect, share experiences and find ways to cope with how COVID-19 is affecting their life at home and at work.

3.8 Through the NHS People Plan a range of further measures are also being introduced to support staff wellbeing including:

- A new wellbeing guardian role which will ensure board level scrutiny of health and wellbeing support for staff;
- Continued support for staff to get to work and free car parking;
- A focus on healthy working environments and safe spaces for staff to rest and recuperate;
- Support to switch off from work, take breaks and annual leave;
- An extra £15m has been invested to strengthen mental health support for NHS staff. This funding is being used to set up a first wave of mental health hubs that will provide outreach and assessment services to help frontline staff receive rapid access to evidence based mental health services. It will also create a national support service for critical care staff, and support the development of wellbeing and psychological training; and

- Improved occupational health support.

3.9 The People Plan is ensuring flexible working is being made a priority, actions include:

- From January 2021, all clinical and non-clinical permanent roles will offer flexible working patterns;

- Flexible working will be covered in standard induction conversations and the right to request flexible working will not require a justification and will be available from day one;

- Board members should give flexible working their focus and support, with the NHS oversight and performance frameworks now including a key performance indicator on the percentage of posts advertised as flexible; and

- Organisations being supported to implement and make effective use of e-rostering systems.

Belonging in the NHS

3.10 It has never been more urgent for leaders to take action and create an organisational culture where everyone feels they belong – in particular to improve the experience of NHS people from Black, Asian and minority backgrounds (BAME).

3.11 Respect, equality and diversity is central to improving the culture in the NHS and is at the heart of the NHS People Plan. Actions include:

- The appointment of a named equalities champion in every NHS organisation.

- Ensuring all trusts have a thriving BAME network.

- A five-year plan to ensure organisations reflect the communities they serve.

- Overhauling recruitment and promotion practices to ensure that staffing reflects the diversity of communities and labour markets.

- Resources training and guidance to support line managers to discuss equality and diversity.

- Stretching targets to reduce the likelihood of entry into disciplinary processes.

- Competency frameworks for every board level position that will reinforce the responsibility for leading and making progress on equality diversity and inclusion.

- The CQC placing emphasis on whether organisations have made real and measurable progress on equality diversity and inclusion.

- Joint training for Freedom to Speak Up Guardians and Workforce Race Equality Standard (WRES) leads with more BAME staff recruited to Freedom to Speak Up Guardian roles.

3.12 The following actions are being taken to support leaders to build compassionate and inclusive cultures:

- Refreshed support for leaders in response to the current operating environment including expert-led seminars on health inequalities and racial injustice.

- Expansion of the number of placements for talented clinical leaders each year.

- An updated talent management process to make sure there is greater prioritisation and consistency of diversity of talent being considered for director, executive senior manager, chair and board roles.

- All central NHS leadership programmes will be available in digital form and accessible to all, updated by the principle of inclusion.

- NHS England and Improvement have completed the engagement exercise commissioned by government in response to Tom Kark QC's review of the Fit and Proper Persons Test and are working with the Department of Health and Social Care to finalise a response to the review's recommendations.

- NHSEI will launch a new leadership observatory which will highlight areas of best practice globally, commission research and translate learning into advice and support for leaders.

Growing for the Future

3.13 The People Plan sets out plans to build on the increased interest in NHS careers, strengthen retention and reverse the trend of early retirement.

3.14 HEE will make progress through 2020/21 in addressing the most pressing workforce shortages in those service areas with the highest demand and those professions that require urgent focus including mental health, cancer, advanced

clinical practice, expanding shortage specialities, expanding undergraduate places and developing clinical pharmacists.

3.15 A greater focus will also be placed on recruitment locally. Employers should offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.

3.16 Internationally, the People Plan details commitments to increase ethical recruitment; pilot new English language training programmes for international nurses and launch a new health and care visa which will make it easier and cheaper for registered health staff to come from overseas to work.

3.17 Employers will also encourage staff to return to practice building on interest to support the NHS through the pandemic. HEE is exploring the development of a return to practice scheme.

3.18 The People Plan also encourages employers to:

- Do more to retain staff aged 55 years and over - who comprise over 19% of our workforce - by ensuring that staff who are mid-careers and approaching retirement have a career conversation with their line manager, HR and occupational health;
- Make sure future potential returners, or those who plan to retire are aware of the ongoing pension flexibilities under the current emergency rules.

NHS Staff Survey 2019

3.19 The NHS Staff Survey is a key source of evidence that has informed the NHS People Plan. It is one of the largest workforce surveys in the world and has been conducted every year since 2003. It asks NHS staff in England about their experiences of working for their respective NHS organisations and provides essential information to employers and national stakeholders about staff experience across the NHS.

3.20 The most recent survey was published in February 2020. The survey went out to over 1.1 million staff across 300 NHS organisations in England of which 569,440 responded - a 48% response rate.

Key Findings

3.21 Broadly, the 2019 NHS Staff Survey results show an improvement in responses regarding immediate managers, quality of appraisals and safety culture.

3.22 There was a decrease in the percentage of NHS staff that were looking to leave the NHS. This is a strong and positive step, but more work needs to be done.

3.23 No theme scores have worsened over the last four years of the survey. However, Ambulance Trust staff continue to perform poorly across a range of staff experience metrics, although have made improvements in most metrics since 2015.

3.24 A full list of theme and questions for the NHS Staff survey, and further breakdowns are available online at: www.nhsstaffsurveys.com.

NHS People Pulse and Morale Tracker

3.25 Alongside the annual staff survey NHSEI launched the NHS People Pulse Survey on 1 July. This gives staff the chance to have a say on issues such as the level of support they're receiving at work during the COVID-19 pandemic, what support would make the biggest difference to them and secure feedback on staff morale. The main purpose of the tool is to support organisations with listening, engaging and supporting decision making to improve working experiences for our NHS People. Employees who feel listened to are more likely to feel connected and engaged with the NHS, which results in improved performance. There are currently over 100 organisations using the People Pulse which reports monthly.

3.26 The People Plan also commits to a new quarterly staff survey to track people's morale in the first quarter of 2021/22. In the interim there has been an effort to use the NHSEI Staff Feedback Hub to get a more frequent temperature check. This hub provides confidential access to approximately 1200 members of the NHS workforce, across a variety of professions and geographical regions.

Gender and Ethnicity Pay Gaps

3.27 To support the wider equality, diversity and inclusion work of the NHS People Plan the Department has been focussing on pay gap issues.

3.28 Specific information on pay gaps in the HCHS workforce and the GP workforce can be found in Chapter 5 and 11 respectively.

3.29 Pay gaps are defined as differences in the average pay for one group of staff compared to those from a different demographic group. This is different to pay discrimination, paying different people different amounts for the same job, which is illegal.

3.30 Key factors which contribute to the development of a pay gap include:

- A "grade mix effect" may occur if staff from one demographic group are more likely to be in a more senior grade. This is particularly the case if one group of staff, e.g. males, are more likely to be Consultants given the large wage disparity between Consultant and Junior grades.

- A "point mix effect" occurs if staff from one demographic group are more likely to be at a higher pay step within the pay scale. For example, male consultants may be more likely to be at the top of the consultant pay scale compared to female consultants due to the very long time to reach the top of the scale.

- On the total earnings measure a gap may also develop, or be exacerbated, if staff from one group are more likely to receive additional earnings. For example, male staff are more likely to undertake additional shifts or be in receipt of Clinical Excellence Awards.

The Gender Pay Gap in Medicine Review

3.31 In April 2018, DHSC commissioned an independent review into the GPG in medicine. The review was chaired by Professor Dame Jane Dacre and the review itself was undertaken by Professor Carol Woodhams from the University of Surrey. The aim of the review was to help identify the causes of the GPG.

3.32 Some of the key findings of the review were:

- The review identified pay gaps throughout the medical profession, with the mean full-time equivalent pay gap for hospital doctors at 18.9%, 15.3% for GPs and 11.5% for clinical academics.

- The review details the causes of the pay gap, citing an unsympathetic career and pay structure in medicine which creates barriers, especially for women with caring commitments. This leads to penalties for lower levels of experiences and less favourable career paths.

- Men are more likely to be older, have more experience and hold more senior positions. Women are more likely to work part-time which can have long-term implications on women's career trajectories as they reduce experience and slow down progression to more senior roles.

- The gap is larger for total earnings than for basic pay. This suggests that men are more likely to access additional pay elements including APAs, CEAs or on-call work.

3.33 The review has made a series of recommendations to help reduce, and ultimately eliminate, the Gender Pay Gap including:

- Reviewing the process used to set pay (e.g. having shorter pay scales).

- Strive for greater balance of additional work and extra payments including Clinical Excellence Awards.

- Promote flexible working for example ensuring that all jobs are available for Part-Time staff and placing a greater emphasis on competency rather than just time served.

3.34 The final report sets out 47 recommendations themed into seven “calls for action” that include contractual and structural changes alongside recommendations calling for the importance of better flexible working opportunities to both men and women, without penalties to pay. The recommendations also address issues around good practice on recruitment and standardisation of additional pay. The full report can be found https://www.gov.uk/government/publications/independent-review-into-gender-pay-gaps-in-medicine-in-england

3.35 Following publication, the Minister of State for Care announced her intention to create an Implementation Panel that will be responsible for driving forward work on tackling the gender pay gap.

3.36 Membership of the Panel will be made up of those instrumental in the review itself and those who will be integral to delivery, including NHSEI and NHS Employers.

The Ethnicity Pay Gap Review

3.37 A recommendation in the 'The Gender Pay Gap in Medicine Review' relates to extending pay gap research to other protected characteristics.

3.38 The Minister for Care will be chairing a roundtable in 2021 that brings together stakeholders from across the health system to understand the causes of the Ethnicity Pay Gap.

3.39 The Department will also be exploring ways to capture the employee experience on the barriers and causes of the Ethnicity Pay Gap across the NHS workforce.

3.40 This will complement the ongoing work of the WRES to close the gaps in experience between BAME and white staff throughout the NHS.

4. Total Reward

Introduction to Total Reward

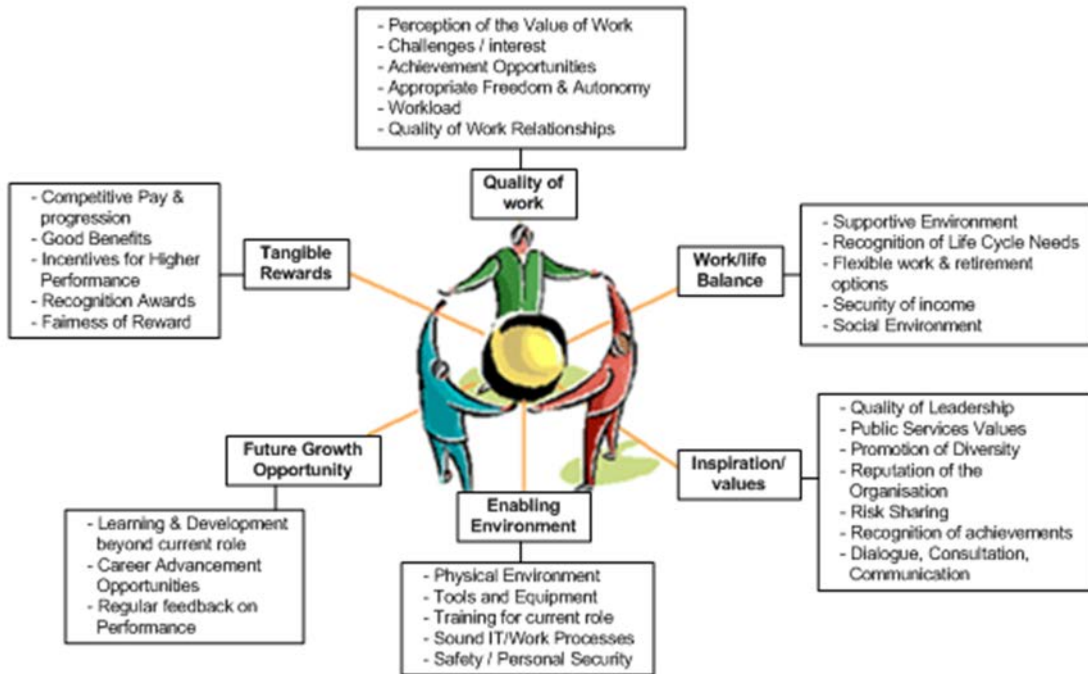
4.1 Total reward is the tangible and intangible benefits that an employer offers an employee, and it remains central to recruiting and retaining staff in the NHS. The value of the NHS total reward package remains high, as has been noted in previous rounds of DDRB evidence.

4.2 The Department's ambition for the NHS reward strategy remains that employers should develop their capacity and capability to:

- Utilise the NHS employment package to recruit, retain and motivate the staff they need to deliver excellent services to patients;
- Develop and implement local reward strategies that meet organisational objectives and workforce needs;
- Improve staff understanding of their reward package and what options they have to change aspects of it;
- Improve staff experience of working for the NHS;
- Contribute to improvements in workforce productivity and efficiencies in use of the NHS workforce pay bill; and
- Continue to be at the leading edge of innovation in public sector reward to help improve NHS staff satisfaction with pay.

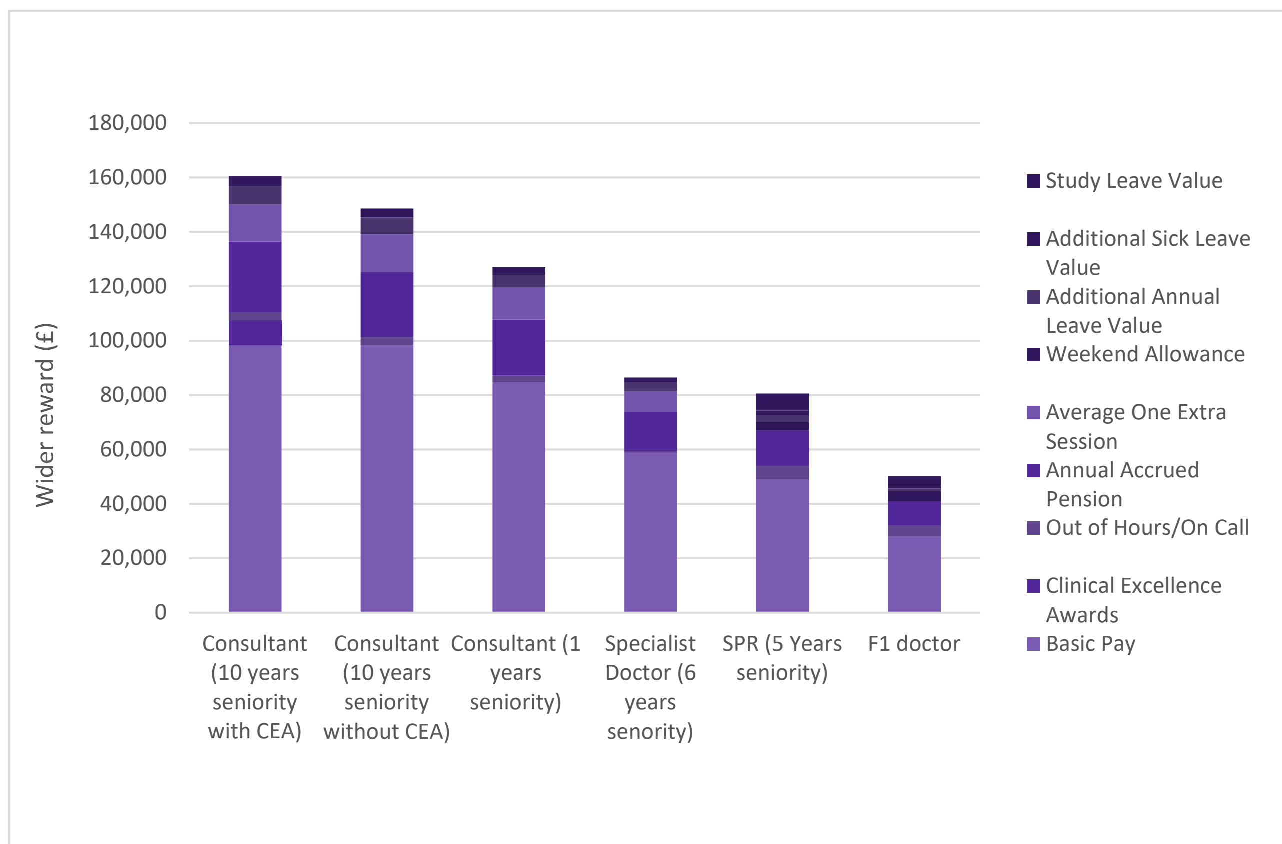
4.3 The Department commissions NHS Employers to provide advice, guidance and good practice to the NHS on developing a strategic approach to reward based on the Hay Model (Figure 4.1).

Figure 4.1- The Hay Model



4.4 The value of the reward package for doctors is shown in Figure 4.2 below, which has been produced for the Department by the Government Actuary's Department (GAD). It includes basic pay, other pay such as clinical excellence awards (CEAs) for consultants (including dental consultants), out of hours/on call payments, annual accrued pension, extra sessions worked and weekend allowances. It also includes additional leave over the statutory minimum, additional sick leave over statutory sick pay and study leave for doctors and dentists in training. It does not include self-employed practitioners in primary care, please refer to chapters on GMPs and GDPs.

Figure 4.2- Value of wider reward package 2020/21 (£)



Trend Analysis

4.5 The Department also commissioned GAD to carry out trend analysis for different NHS staff, based on the previous total reward analysis at 2017/18, 2018/19 and 2019/20.

4.6 The roles considered are Foundation Year 2 (F2) doctors, Speciality Registrars (SPR) with 5 years' seniority, consultants with 14 years' seniority and average consultants. The chart below compares average rewards at 30 September 2018, 30 September 2019 and 30 June 2020 with pay bands at 2018/19, 2019/20 and 2020/21. It is believed that this will only cause a negligible difference for the purpose of comparison.

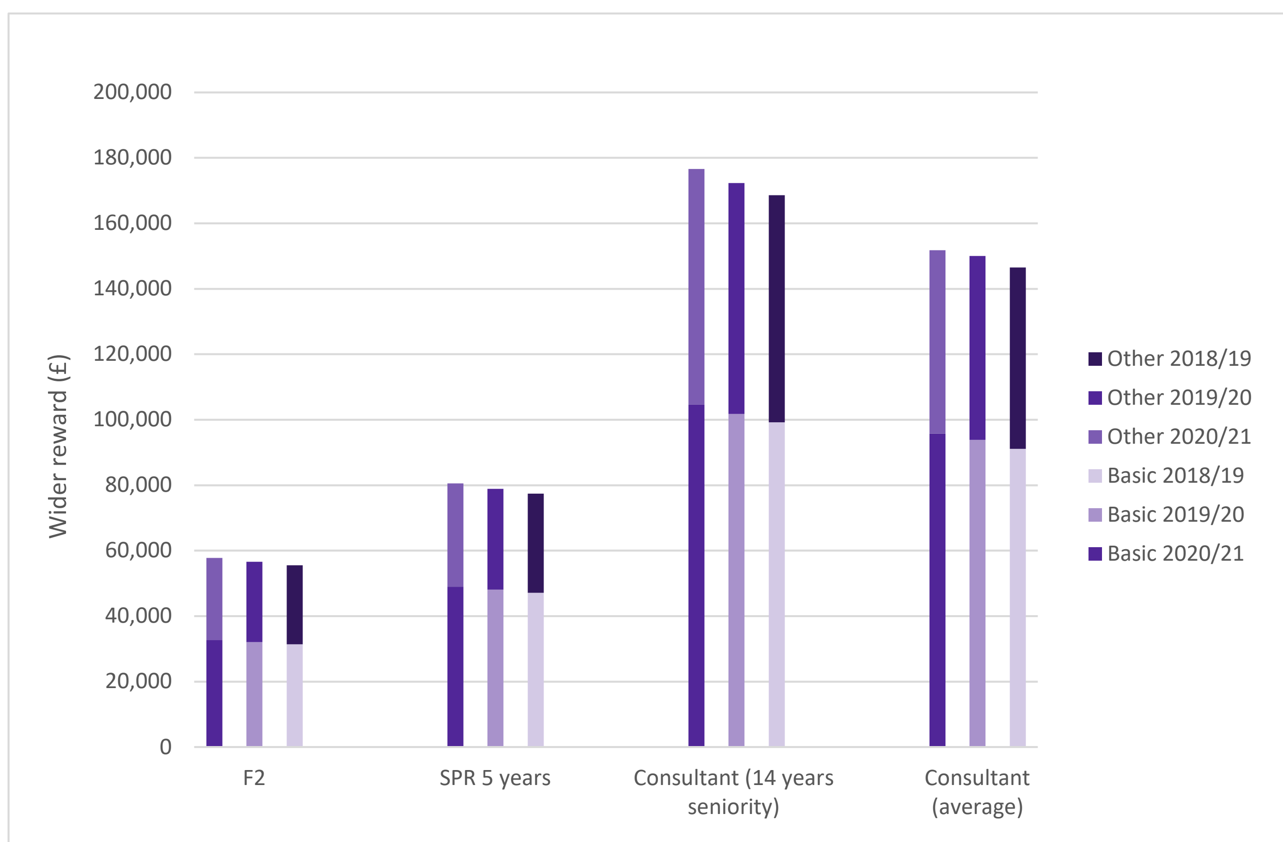
4.7 Figure 4.3 shows that all doctor roles considered as part of the analysis have experienced an increase in total wider reward over the period 2018/19 to 2020/21. F2 doctors and SPR doctors experienced broadly consistent increases of around 2% in each year over the period, meaning the total reward package for this role increased by around 4% between 2018/19 and 2020/21. Consultants with 14 years seniority experienced a similar 2% increase over the period between 2018/19 and 2019/20, but a slightly higher increase between 2019/20 and 2020/21 of 2.5%, bringing the total wider reward package increase to around 4.5% over the period.

The value of reward package for average consultants increased by around 4% over the period 2018/19 to 2020/21. All doctor roles considered have at least 35% of the total reward made up of non-basic pay.

4.8 GAD also analysed total reward across various private sector occupations, based on Office for National Statistics (ONS) data for salary and pension benefits, and compared them against pay rewards for NHS doctors based on their previous analysis from 2012 to 2019.

4.9 This analysis of reward is intended to give an approximate indication on how wider reward between roles and occupations change over time; it is not intended to provide a direct comparison between any direct NHS role and other occupation. The roles included in this analysis are F2 doctors, SPRs with 5 years' seniority, and average consultants. The private sector occupations considered are managers, directors & senior officials and professional occupations.

Figure 4.3- Total Reward Trends



4.10 Figure 4.4 below shows that all roles considered as part of this analysis experienced an increase in reward between 2012 and 2019. The new 2016 Doctors in Training contract was introduced over this period and so the impact of

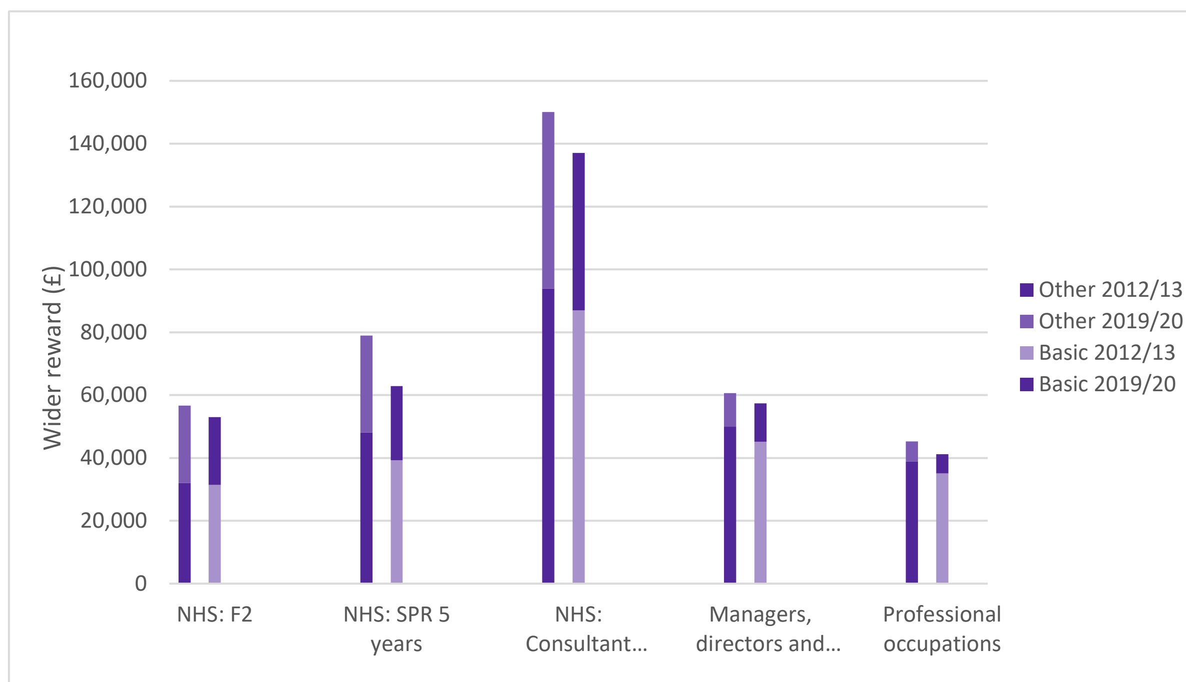
this will be reflected in value of reward over the period from 2012 to 2019. SPR experienced an increase of around 26% over the period from 2012 to 2019. This may be driven by an increase to basic pay following the new 2016 Doctors in Training contract. The value of reward packages for F2 doctors increased by around 7% over this period. The value of reward packages for average consultants increased by around 9% over the period.

4.11 Private sector occupations experienced lower increases compared to the public sector. Professional occupations experienced a larger increase than Managers, Directors and Senior Officials with increases of around 10% and 6% respectively in total wider reward over the period.

4.12 Non-basic pay makes up a larger proportion of NHS total rewards across all roles analysed relative to private sector occupations, with this making about 37% of consultant rewards. One driver for this might be the value of public sector pension benefits available to NHS staff and additional pay elements and awards available, relative to the private sector.

4.13 Although they are not included in the chart, the additional non-basic pay elements of the total reward package available to NHS staff should be considered as they usually exceed that available in other sectors. These include benefits available to members of the NHS Pension Scheme (other than the value of pension benefits accrued each year), maternity leave and other flexible benefits.

Figure 4.4- Total Reward Trends



Introduction to the NHS Pension Scheme

4.14 Doctors and dentists working in the NHS have access to the NHS Pension Scheme ('the Scheme'), which remains a valuable part of the total reward package available to them and one of the best pension schemes available.

4.15 Membership of the Scheme is high, with around 9 in 10 NHS staff actively participating. Employers now contribute more towards the cost of the scheme than members, with a current contribution rate of 20.6%, and an additional administration charge of 0.08%. Employee contributions are tiered according to income, with the rate paid by the lowest earners being 5% and the highest 14.5%, for those earning over £111,377.

4.16 Eligible doctors and dentists will now belong to one of the two existing Schemes. The final salary defined Scheme, or legacy scheme, is made up of the 1995 and 2008 Sections and is now closed to new members. All new staff will join the 2015 Scheme, a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career. Benefits in the 1995/2008 Sections for self-employed doctors and dentists (practitioner members) are also calculated on a CARE equivalent basis.

4.17 The key differences between the two Schemes, other than the way benefits are calculated, are different normal pension ages (1995 Section – 60, 2008 Section 65, and 2015 Scheme – State Pension Age) and accrual rates (1995 Section – 1/80th, 2008 Section – 1/60th, 2015 Scheme – 1/54th). Under the new CARE

scheme, most low and middle earners working a full career will continue to receive pension benefits that are as good, if not better, than those they would receive under the former final salary schemes.

4.18 A judgement by the Court of Appeal in the cases of McCloud and Sargeant found that the transitional protection arrangements that were awarded to members of the final salary schemes gave rise to unlawful discrimination. These arrangements allowed members closer to retirement age to remain in their legacy scheme and not move to the 2015 Scheme. Whilst the judgement was found against the Judges' and Firefighters' pension schemes, the Government announced on 15th July 2019 that it accepts the judgement applies to other public service schemes, including the NHS, and will remedy the discrimination in all schemes.

4.19 In light of the judgment, work to remedy the discrimination is currently underway. This will unwind the transitional protections which allowed some members to remain in the legacy schemes. Between 16 July and 11 October 2020, the Government consulted on two possible options to remove this discrimination. The Government published its response to the consultation on 4 February 2021[i]. After the remedy period ends, all those who continue in service will do so as members of their respective reformed scheme. For NHS staff, this is the 2015 Scheme.

4.20 The 2015 Scheme provides a generous pension for doctors and dentists and is one of the best pension schemes available. GAD calculates that Scheme members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. The Scheme is backed by the Exchequer and is revalued in line with price inflation, providing a guaranteed income in retirement.

4.21 A junior doctor commencing employment and membership of the 2015 Scheme from August 2019 (retiring at 68) can expect a pension of around £62,800 p/a if they progress to be a full-time consultant. A similar junior doctor progressing to be a part-time consultant can expect a pension of around £53,800 p/a. Junior doctors progressing to be GPs can expect a pension of around £64,300 p/a.

NHS Pension Scheme Contributions

4.22 Member contributions are set in tiers based on earnings, with higher earners contributing proportionately more, factoring the beneficial effect of higher tax relief.

Figure 4.5- Pensionable Pay

Tier	Pensionable Pay (whole-time equivalent)	Contribution Rate
1	Up to £15,431.99	5.0 per cent
2	£15,432.00 to £21,477.99	5.6 per cent
3	£21,478.00 to £26,823.99	7.1 per cent
4	£26,824.00 to £47,845.99	9.3 per cent
5	£47,846.00 to £70,630.99	12.5 per cent
6	£70,631.00 to £111,376.99	13.5 per cent
7	£111,377.00 and over	14.5 per cent

4.23 Member contribution rates and earnings tiers have been frozen since 1st April 2015. It is expected that around 12% of members will be in a higher contribution rate band (increases are between 0.6% and 3.2% of pensionable pay, depending where they are in the pay range) in 2021 compared to 2018. A proportion of members are expected to progress to higher contribution tiers year to year through pay progression.

4.24 DHSC keeps member pension contributions under review, in dialogue with NHS trade unions and employers through the NHS Pension Scheme's Scheme Advisory Board (SAB). The NHS Pay Review Body previously concluded that annual pay awards should not have the unintended consequence of reducing take-home pay where a pay award means members must pay higher pension contributions. The Department commissioned the SAB to review the approach to member contributions and provide recommendations by the end of March 2020 on an appropriate structure to implement from 1 April 2022, as the point which all members will join the 2015 NHS Pension Scheme for future accrual in line with the measures to remedy McCloud as announced by HMT. This builds on previous work by the SAB to explore several design elements, including whether the rate payable should be determined using whole-time equivalent or actual earnings, the range and number of tiers, and whether tier boundaries should be revalorised to avoid pay awards placing individuals in higher contribution tiers.

4.25 In their review work to date, the SAB concluded that a move to assessing contributions based on actual earnings was appropriate and recognised that further discussion was needed with regards to the approach to avoiding cliff edges. Cliff edges refer to areas of the current contribution structure where a pension scheme member receives a pay award which causes them to move to a higher contribution band. Although this increases the overall value of a member's total reward package, it has the potential to reduce their take-home pay. However, it is common for doctors and dentists to earn supplementary payments for on-call

or out-of-hours work, which may increase their pensionable pay. This means that not all members of the NHS Pension Scheme have pensionable pay which matches nationally agreed pay scales, and it is therefore difficult to design a contribution structure which avoids cliff edges.

NHS Pension Scheme Membership

4.26 The Department continues to monitor scheme membership rates through the Electronic Staff Record (ESR), which records staff working in hospitals. Figure 4.6 shows the total number of NHS Pension Scheme members by staff group at July 2020. It also compares the change in membership rates from October 2011 to July 2020, July 2019 to July 2020 and April 2020 to July 2020.

Figure 4.6- Pension Scheme Membership Rates by Staff Group

Staff Group	FTE July 20	NHS Digital Headcount July 20	% With pension contributions July 2020	% Points change Apr 2020 and Jul 2020	% Points change Jul 2019 and Jul 2020	% Points change Oct 2011 and Jul 2020
All	1,169,045		89%	0.0%	-0.6%	4.8%
Doctor	120,607	128,307	88%	-0.1%	-1.1%	-3.4%
Qualified nursing, midwifery & health visiting staff	323,885	26,718	90%	-0.2%	-1.1%	2.5%
Qualified Scientific, therapeutic and technical staff	148,319	169,674	92%	-0.1%	-0.5%	1.8%
Qualified Ambulance Staff	17,019	18,103	92%	0.0%	-1.5%	-2.9%
Support to Clinical Staff	372,987	429,301	89%	0.3%	-0.1%	9.8%
Central Functions	151,590	175,710	86%	0.1%	-0.4%	9.0%

& Hotel, Property & Estates						
Managers	21,588	22,534	89%	-0.1%	-0.5%	-2.7%
All Non-Medical	1,048,438	1,191,625	90%	0.0%	-0.6%	5.6%

4.27 Membership of the scheme amongst doctors is high, at 88%. This is a reduction of 0.1% compared to April 2020 (the end of the previous quarter), a reduction of 1.1% compared to July 2019 (the same point in the previous year), and a reduction of 3.4% compared to October 2011.

4.28 Further investigation is necessary to explain the decline in scheme membership rates for doctors since October 2011. However, the Department recognises that experience of the lifetime allowance (LTA) and annual allowance (AA) may be a factor. Tax charges from breaching these allowances do not have to be paid in cash and can instead be deducted from a member's pension pot at retirement. The tax charge means that the member gets less value from the contributions that purchase pension benefits in excess of the tax-free allowances - effectively less pension is bought for the same amount of contributions.

4.29 Affected members are therefore likely to consider if they are getting sufficient value from their contributions by continuing to build up pension beyond their allowances. Accruing pension benefits in excess of the LTA or AA can still be in the member's financial interest net of tax, as they will benefit from a larger retirement pension that is a secure Exchequer-backed investment. However, the value proposition may be more finely balanced for some members if further pension growth would attract both AA and LTA charges, which may lead them to opt out of the pension scheme.

4.30 Further to this, the Department is supportive of employers who engage with high-earning clinicians to discuss how best to maximise the value of the reward package and encourages them to consider the guidance published by NHS Employers[ii]. This presents approaches that employers can take locally to address the impact of pension tax on their workforce. This includes the potential for recycling unused employer contribution into extra pay.

4.31 Pension taxation is discussed in more detail in the Pension Flexibilities section below.

4.32 However, membership rates for the NHS Pension Scheme compare favourably with private sector pension scheme participation. The Department for Work and Pensions published a report in June 2019 comparing the participation rates and savings trends between public and private sector pension schemes[iii]. The report

studied pension scheme data between 2008 and 2018. Although private sector pension scheme participation has risen since the introduction of auto-enrolment, participation in private sector schemes (85%) is still lower than the public sector (93%). The report also shows that scheme participation for lower earners in public sector schemes is higher than that of lower earners in private sector schemes.

4.33 Figures 4.7, 4.8 and 4.9 show the number of consultants, GMPs and GDPs claiming their NHS pension earlier than their normal pension age, taking Voluntary Early Retirement (VER).

Figure 4.7- The number of consultants claiming their NHS Pension on a voluntary early retirement (VER) basis (1995 pension scheme only). Source- NHS Business Services Authority

Consultants	VER	% of all retirements
Y/E 2008	178	13.9
Y/E 2009	146	11.6
Y/E 2010	183	12.5
Y/E 2011	286	16.5
Y/E 2012	315	17.9
Y/E 2013	388	24.4
Y/E 2014	405	25.5
Y/E 2015	453	28.5
Y/E 2016	496	31.0
Y/E 2017	495	30.1
Y/E 2018	445	29.2
Y/E 2019	416	27.8
Y/E 2020	524	30.6

Figure 4.8- The number of GPs claiming their NHS Pension on a voluntary early retirement (VER) basis (1995 pension scheme only). Source- NHS Business Services Authority

GPs	VER	% of all retirements
Y/E 2008	198	17.2
Y/E 2009	264	20.2
Y/E 2010	322	22.6
Y/E 2011	443	28.5
Y/E 2012	513	33.2
Y/E 2013	591	41.9
Y/E 2014	746	49.6
Y/E 2015	739	51.4
Y/E 2016	696	52.4
Y/E 2017	723	61.0

Y/E 2018	588	56.8
Y/E 2019	607	55.6
Y/E 2020	591	54.7

Figure 4.9- The number of dental practitioners claiming their NHS Pension on a voluntary early retirement (VER) basis (1995 pension scheme only). Source- NHS Business Services Authority

Dental practitioners	VER	% of all retirements
Y/E 2008	103	27.6
Y/E 2009	148	36.0
Y/E 2010	126	33.3
Y/E 2011	154	32.6
Y/E 2012	183	36.0
Y/E 2013	185	36.2
Y/E 2014	164	38.1
Y/E 2015	185	38.9
Y/E 2016	188	43.4
Y/E 2017	170	42.0
Y/E 2018	164	39.6
Y/E 2019	205	40.8
Y/E 2020	198	39.8

4.34 The data shows that GPs take early retirement at a higher rate than other clinicians. The decision to retire is a personal one and the scheme administrator, the NHSBSA, does not request this when staff choose to retire. Further work is required to determine why this is the case.

4.35 However, it is important to note when examining the VER data that it does not necessarily mean that staff have left NHS service altogether. For members of the 1995 Section, there is the option to 'retire and return', by which they can leave service and return to work, providing they meet certain conditions. Under this arrangement members are not permitted to re-join the NHS Pension Scheme, which explains why they may be absent from data, yet remain part of the workforce.

4.36 Trade unions have previously noted that the fear of breaching the LTA is causing many doctors to retire early. Although breaching the LTA may be a contributory factor in doctors deciding to claim VER, it is also important to note that clinicians have well remunerated careers, and many make the choice to retire early as they have built up a substantial level of financial security.

Pension Flexibilities

4.37 To encourage individuals to plan for their retirement, the Government provides tax incentives by allowing pension scheme contributions to be made tax-free. However, the cost of providing this tax incentive is very substantial, at over £50bn a year. To ensure sustainability, since 2010 there have been progressive restrictions on the amount that individuals can save into their pension tax-free.

4.38 As previous DDRB reports have noted, in previous years there has been evidence of high-earning clinicians opting out of the NHS Pension Scheme or retiring early because of issues with the LTA and AA, which limit the total amount of tax-free pension savings that an individual can make over their career and each year. Before 6th April 2020, the allowances were as follows:

- £1.055m for the LTA; and
- £40,000 for the AA, tapering down to £10,000 at a rate of £1 less allowance per £2 of relevant earnings above £150,000. HMRC calculates relevant earnings to include the value of pension growth over the year.

4.39 The Government is committed to increasing the LTA in line with the Consumer Price Index (CPI). From 6th April 2020 the LTA has increased to £1.073m.

4.40 The Government's manifesto committed to addressing the taper problem in doctors' pensions. This followed a review of the tapered AA commissioned by the Prime Minister before the General Election.

4.41 In response to evidence of senior clinicians reducing their working patterns due to the impact of the taper, the Department also consulted on a package of pension flexibilities between September and December 2019[iv]. Responses to the consultation were shared with HMT, who led the review of the taper.

4.42 However, following the review the Government decided that a tax solution was the simplest way to address the issue. At Budget in March 2020, the Chancellor increased the tapered annual allowance thresholds by £90,000 from 6th April 2020. The net income and adjusted income thresholds were increased to £200,000 and £240,000 respectively. Following these changes, the pension flexibility proposal consulted on in 2019 will not be implemented.

4.43 The incentive to take on additional work is now restored, and all NHSPS members can earn an additional £90,000 before they are affected by the taper. We estimate that this will take up to 96% of GPs and up to 98% of NHS consultants outside the scope of the taper based on their NHS income, so they can perform the work that the NHS needs without worrying about tax bills. A small number of GPs and

consultants will still experience tapering based on their NHS earnings. These are the very highest earners in the NHS.

4.44 The Scheme Pays facility allows members to meet the cost of a tax bill from the value of their pension benefits, without needing to find funds upfront. Where a member uses Scheme Pays, the scheme applies an interest rate that will reduce the value of pension benefits at retirement.

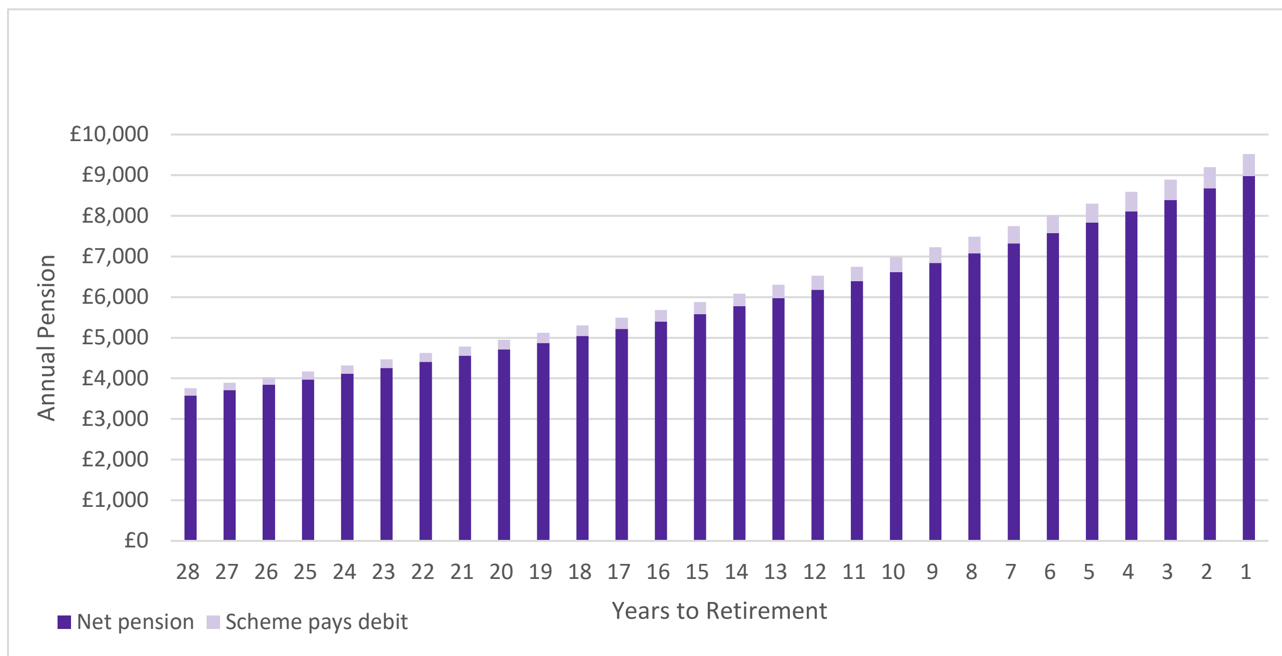
4.45 The Department is aware of concerns raised by the BMA that the system is too complex, and the interest rate charged is too high. The headline compound rate of Scheme Pays interest is 2.4% plus CPI, which is the current discount rate used by public service pension schemes. However, the value of the pension accrual that led to the AA charge will also increase over time. When the rate by which accrued 2015 pension increases is offset against the rate by which the Scheme Pays deduction increases, the effective rate of the Scheme Pays charge is 0.9% for pension under the 2015 Scheme and for doctors facing standard annual allowance breaches the claw back of tax relief via scheme pays is relatively modest.

4.46 Analysis from GAD demonstrates that Scheme Pays is a proportionate means of dealing with an AA charge, and at retirement will have a relatively small impact on the pension accrued that year. The analysis shows that it may be a sound financial decision to incur an AA charge and use Scheme Pays to deal with it. Although Scheme Pays will reduce the value of the pension accrued, the growth in benefits represents a good return on the contributions made.

4.47 For example, a 40-year old 2015 Scheme member earning £125,000 with £20,000 additional non-pensionable income would build in the 2020-21 scheme year an annual pension worth £9,521pa at retirement. This would be reduced by 6% to £8,974pa once the Scheme Pays debit is applied. Figure 4.10 illustrates the progression up to retirement of pension benefits accrued and the annual allowance charges incurred over a single year following the post-April 2020 annual allowance regime for this example member.

4.48 The Department is also committed to improving the availability of high-quality information on the NHS Pension Scheme for members. As part of this, the Department has commissioned NHS Employers to provide a ‘ready reckoner’ to help members assess their potential tax liability. The tool was launched in September 2020 and allows members to input their pay and pension details to get a view on whether their prospective NHS commitments may lead to an AA tax charge.

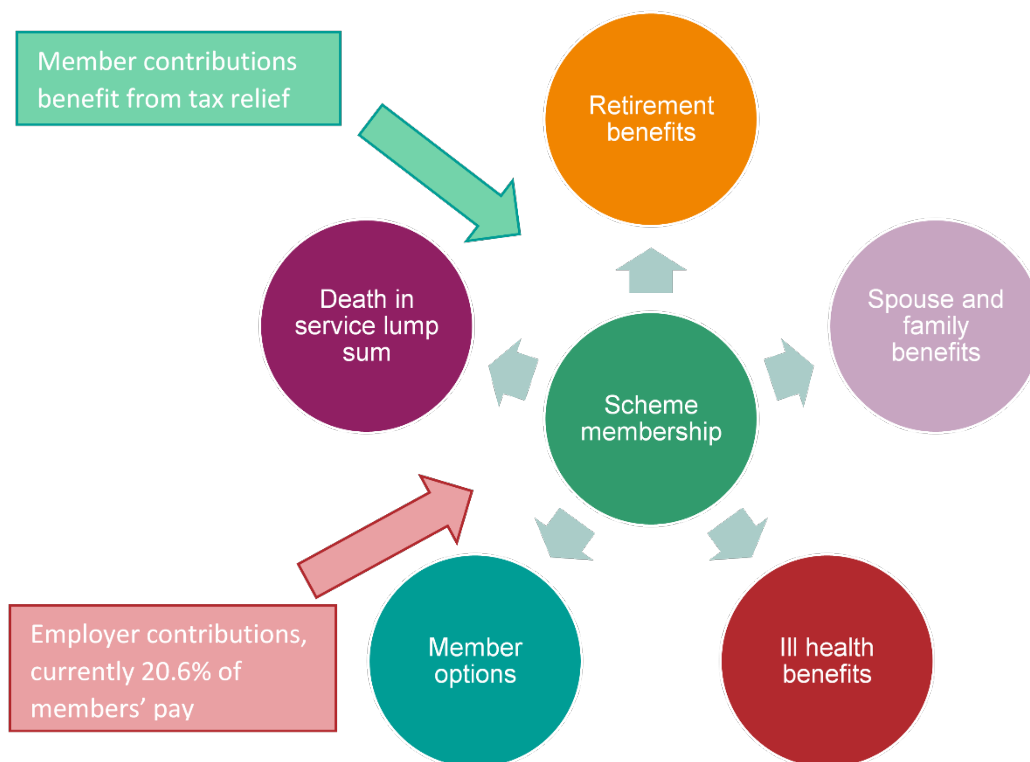
Figure 4.10- Example growth in pension earned over year 2020/21 Member with 2015 Scheme benefits, Pensionable pay £125,000



4.49 The Department also welcomes local solutions proposed by employers where pension scheme membership can be improved to encourage recruitment and retention and continues to work with NHS Employers to facilitate this.

NHS Pension Scheme Benefits

Figure 4.11- Illustrative analysis of the wider Scheme benefits



4.50 Figure 4.11 above presents an illustrative analysis of the wider scheme benefits for a member of the 2015 Scheme at 1 April 2021, beyond the pension which is payable for life following retirement.

4.51 Members of the NHS Pension schemes are also entitled to protection benefits. In particular, if a member dies while working, their dependants are entitled to a death in service lump sum equivalent to 2 x salary. Therefore, if a scheme member earning £55,000 dies in active service, their dependants would be entitled to a lump sum payment of £110,000.

4.52 Pensions are also paid to a spouse following the death of pensioner members. The level of benefits paid to a spouse varies across the NHS schemes. For a retired member of the 2015 scheme with a pension of £60,000, following their death in retirement, their spouse is entitled to a pension for life of £20,250, increasing annually each year. Children's pensions are also available in some cases.

4.53 Members are also entitled to ill health retirement benefits. Under ill health Tier 1, members are entitled to full retirement benefits accrued without reduction. Under ill health Tier 2, members are entitled to enhanced benefits for prospective service up to normal retirement age.

4.54 Members have the option to exchange pension for a tax-free cash lump sum (subject to limits). There are a range of options available to members including early and late retirement options (subject to limits) and the option to purchase additional pension.

4.55 Members of the NHS Pension scheme are also entitled to tax relief on their contributions to the scheme, which reduces the cost of the scheme to members. The Employer contribution meets the balance of the cost of the scheme.

Maternity Leave

4.56 Employees with 12 months continuous service with one or more NHS Employers are entitled to maternity benefits above the statutory entitlement. A doctor earning £55,000 would be entitled to earn maternity pay of around £7,200 more than they would be entitled to under the statutory maternity leave allowance.

4.57 This calculation is provided for illustrative purposes only. Maternity pay depends on the member's contractual entitlements and is calculated relative to the current statutory maternity pay[v] entitlements.

4.58 Salaried GMPs are expected to be employed on terms and conditions no less favourable than those set out in the model salaried GP contract[vi]. This includes maternity benefits above the statutory entitlement and as set out in the General Whitley Council Handbook. Salaried GPs can negotiate with their employer for terms and conditions more favourable than the model contract.

Flexible Benefits

4.59 Other than the reward elements included in the above analysis, many employers also offer a range of flexible benefits, discounts and support offered to staff that may support recruitment and retention of staff and improve employee engagement. Although the range of flexible benefits offered varies across employers, some popular flexible benefits can include salary sacrifice schemes, options to buy and sell leave and a range of discount vouchers. Employers may offer travel benefits such as season ticket loan and cycle to work scheme, as well as health and wellbeing benefits including discounted gym memberships.

4.60 Many trusts have also partnered with third party providers offering staff up to 20% discount on shopping, insurance and travel. NHS employees may also be entitled to cashback on purchases at specified retailers of up to 12% using prepaid cards. Therefore, NHS employees spending around £3,000 per year at a participating supermarket could offset spending by up to £360 (around 1% of basic pay on average). The overall value to staff can vary depending on the specific benefits options offered across employers and the level of benefits taken up but we estimate these additional flexible benefits could be valued up to 1% - 3% of basic pay on average across NHS employees.

Total Reward Statements

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

- Recommend a friend scheme;
- Affordable accommodation
- Childcare and carer support;
- Counselling and support;
- Various salary sacrifice schemes;
- Retail Discounts;
- Education and learning support;
- Financial wellbeing;
- Physical and mental health and wellbeing;
- Signposting to pensions advice services.

Annual Benefit Statements

4.62 NHS Pension Scheme members also receive an annual benefit statement (ABS), which shows the current value of their NHS Pension benefits.

4.63 Data obtained from the BSA, who issue these statements, shows that from August 2019 to August 2020, the number of combined statements (which includes where there is an ABS available or where there is just employer benefits) available increased by 70,665. The calculation success rate, which represents the percentage of members for whom it is possible to calculate an ABS, increased from 90.08% in 2019 to 91.56% in 2020.

4.64 On 10th October 2020, the number of statements viewed by staff was 375,457, an increase from the 314,916 that had been viewed at the same point in 2019. This may indicate that more people are viewing their updated statements earlier.

4.65 Since 2016, the BSA have held stakeholder engagement events across the country for a range of different NHS organisations to help employers better understand their role in promoting TRS. The workshops also explain the difference between a TRS and an ABS.

Section 3: HCHS Medical and Dental Staff workforce

This section provides evidence for all employed medical and dental HCHS within the NHS. This includes all those employed on the three main national contracts: doctors and dentists in training (commonly referred to as 'junior doctors'), SAS doctors, and consultants.

Chapters 5 provides the Department's evidence on HCHS medical and dental earnings with Chapter 6 providing information on the recruitment, retention and motivation trends along with wider workforce planning. Chapters 8, 9 and 10 then provide specific narrative for each separate contract group within the HCHS workforce.

5. HCHS Medical and Dental Staff Earnings

Introduction and Summary

5.1 Average earnings have increased across the medical workforce over the past year reflecting the impact of annual pay awards and existing pay agreements. Assessments of longer-term HCHS earnings should consider the impact of the pandemic on the wider labour market which are not yet fully apparent. It should also be noted that individuals in the HCHS workforce may also receive earnings growth through promotion and pay progression on top of basic pay awards. This is especially the case for doctors who also have a reasonable expectation of having earnings at the top end of the UK salary distribution.

5.2 This chapter contains the latest information on pay and earnings for the medical and dental workforce working in the HCHS in England. This covers those working under the three national Medical contracts which cover Doctors and Dentists in Training, SAS doctors and Consultants. In 2020-21 basic pay spans from £28,243 for those in Foundation Year 1 through to £110,683 at the top of the consultant grade. Doctors can also receive additional earnings, for example linked to either increased activity, the time activity takes place, for consultants for excellence in performance, and for doctors in training for choosing to train in certain specialties.

5.3 We have also set out how pay for this group compares to the wider economy. We also look at how individual members of staff experience pay growth under the system. On a broader scale the goals of pay policy include supporting recruitment & retention (Chapter 6), the delivery of manifesto commitments (Chapter 2) while also meeting affordability requirements (Chapter 2) and taking account of the general economic situation (separate HMT evidence).

5.4 Average earnings for the remit group increased by 1.3% in 2019-20. Growth in earnings was highest for SAS Doctors and lowest for doctors and dentists in training, though this may be impacted by how data is recorded during the annual rotation period. Data is not yet available for 2020-21 but we know that basic pay rates increased by 2% for Junior Doctors, 2.8% for SAS Doctors and 2.8% for Consultants with no change to the value of CEAs.

5.5 In 2021-22 Junior Doctors will enter the 3rd year of a multi-year pay agreement and negotiations have recently concluded with the SAS workforce on a multi-year agreement to commence in 2021-22.

5.6 Medical earnings remain highly competitive when compared to the wider economy with median average earnings in the top 3% of occupations. The medical profession is perhaps unusual in that most new doctors on completion of their specialty training have the realistic opportunity to reach the most senior positions, with the highest earning potential, within the profession. Over the last 5 years the number of Consultants employed in the HCHS sector has increased by 20%.

5.7 Chapter 3 summarised the results of the Gender Pay Gap in Medicine Review. The latest data shows some progress in closing the gender pay gap in medicine as the proportion of female consultants increases.

5.8 The remainder of this chapter provides information on the latest levels of pay and earnings for the medical workforce and outlines some of the key factors that have been driving change. We then highlight information on how individual members of staff experience the pay system and how doctors progress through different career stages. The final section provides some comparisons with the wider economy and key priorities for the Department including equalities data.

Pay & Earnings for HCHS Doctors and Dentists

5.9 This chapter contains information on the latest levels of pay and earnings for medical and dental staff working in the HCHS in England. While we focus on levels of pay and earnings it should be noted that the total reward package available also includes a range of benefits exceeding those offered in many other sectors, including sick pay and access to the NHS Pension Scheme. Further information on total reward can be found at Chapter 4.

5.10 Doctors are generally high earners. A new doctor in Foundation Year 1, will start with basic pay of £28,243, while a Consultant with 19 years' experience can earn as much as £110,683, as well as having access to additional earnings through, for example, Additional Programmed Activities (APAs) or Local Clinical Excellence Awards (LCEAs) or CEAs. Our data do not capture any earnings from non HCHS employment, for example through private work.

5.11 NHS Digital publishes three different measures of earnings which are:

- Basic Pay per full time equivalent (FTE) - Average basic pay with scaling applied for those who work Part-Time.
- Basic Pay per Person - The total amount of basic pay per person with no scaling for Part-Time employees. Effectively this divides the total amount of basic pay by the total headcount.

- Total Earnings per Person - The average paid to each individual employee inclusive of all additional payments and allowances without scaling for Part-Time employees. Effectively the total amount paid divided by the total number of people who worked as doctors during the year.

5.12 Figure 5.1 shows the average pay for the 12 months to the end of the March 2020. It is partitioned by medical grade and shows the growth compared to the period to the end of March 2019. Average total earnings per person ranged from £34,000 for Foundation Year 1 doctors to over £114,000 for Consultants.

5.13 These data suggest that earnings for Foundation Year 1 and Foundation Year 2 Doctors fell in the past 12 months. We believe that this relates to how data is recorded in ESR during the annual rotations period. Allowing for this we believe that the increase in basic pay per FTE for these doctors was broadly in line with the 2% expected under the terms of the 2019 multi-year pay agreement which included overall investment of 3% across those on the junior doctor contract.

Figure 5.1- Medical Earnings by Grade - 12 Months to March 2020

Medical Grade	**Basic Pay per FTE**	**Basic Pay per Person**	**Total Earnings Per Person**	**Basic Pay per FTE Growth**	**Basic Pay per Person Growth**	**Total Earnings Growth**
HCHS Doctors	£67,408	£61,478	£80,536	2.7%	2.8%	1.3%
Consultants	£95,205	£88,501	£114,489	3.5%	3.2%	1.5%
Associate Specialist	£87,338	£77,783	£94,325	4.1%	3.6%	2.9%
Specialty Doctor	£64,911	£55,102	£68,158	4.0%	4.4%	3.0%
Staff Grade	£59,066	£49,066	£64,796	2.7%	6.5%	6.8%
Specialty Registrar	£44,454	£41,841	£58,865	3.3%	3.0%	1.3%*
Core Training	£39,669	£38,136	£51,549	3.1%	2.3%	0.9%*
Foundation Doctor Year 2	£31,593	£30,409	£40,900	1.6%	-1.1%	-0.9%*
Foundation Doctor Year 1	£27,239	£26,617	£34,288	0.8%	0.5%	-0.9%*

Hospital Practitioner / Clinical Assistant	£117,208	£33,175	£35,739	3.0%	6.0%	6.2%
Other & Local Grades	£87,937	£50,688	£53,019	5.4%	1.9%	0.7%

Source: NHS Digital Earnings Statistics

Note: Data for junior doctors, and in particular F1 & F2 doctors are impacted by the annual rotation process in August. Around this time more staff than normal will spend a portion of the month in the grade, but total pay and workforce capacity remain constant. This leads to lower average earnings per person in the month as the numerator (pay) is unchanged while the headcount denominator increases. The size of this effect changes year to year depending on the day which rotations occur.

5.14 NHS Digital do not publish a figure for total earnings per FTE as total earnings are not scalable in the same way as basic pay.

5.15 In addition to basic pay medical staff can access additional earnings dependent on factors such as individuals working patterns, location or if they are in receipt of a CEA. In the major grades the proportion of earnings which come through these elements' ranges from 18% (Associate Specialist) to 29% (Specialty Registrar).

5.16 Junior Doctors were the most likely to receive pay for working unsocial hours, while for those who received them, CEAs are a major element of earnings for Consultants.

5.17 More detail on the proportion / value of additional earnings is available from NHS Digital Earnings data - https://digital.nhs.uk/data-and-information/publications/statistical/nhs-staff-earnings-estimates/march-2020-provisional-statistics.

5.18 The Review Bodies have sought evidence on the effectiveness of using Recruitment & Retention Premia (RRPs) to support recruitment and retention. RRPs are pay supplements which can be applied to individual jobs, or groups of jobs, where labour market pressures make it difficult for employers to recruit and retain staff in enough numbers at the normal salary rate. These can either be short or long term depending on whether retention problems are likely to be resolved in the near term or if the labour market conditions are more deep-rooted and will take more time to resolve.

5.19 There have been only small changes in the number, and value, of RRP payments over the last year. Only 0.3% of doctors receive these payments and the average

value of payments is largely unchanged over the past two years. More information on RRP payments, including links to recruitment and retention, are outlined in Chapter 6.

Earnings Distribution

5.20 Earnings vary within medical grades as well as between them, as shown in Figure 5.2. This can be due to seniority, hours worked, working patterns, and other additional earnings. Figure 5.2 below shows how earnings vary within career grades in the 12 months to the end of March 2020. Only those working in the same grade for the full financial year are included, meaning data is not available for F1 & F2 doctors as annual training cycles (Aug - Aug) do not align with financial years (Apr - Mar).

5.21 Data are provided based on earnings per person. A distribution of earnings per FTE is not possible as earnings do not scale in the same way as basic pay.

Figure 5.2- Distribution of Total Earnings by career grade - 12 months to March 2020

Career Grade	25% Earn Less Than	Median	25% Earn More Than	Mean Average
HCHS Doctors	£48,5,00	£84,000	£117,000	£80,500
Consultant	£94,500	£113,000	£134,000	£114,500
Associate Specialists	£76,000	£95,000	£113,000	£94,300
Specialty Doctors	£51,000	£71,500	£87,500	£68,200
Specialty Registrars	£30,500	£43,500	£62,000	£58,900
Core Training	£31,000	£48,000	£54,000	£51,500
Foundation Doctor Year 2	-	-	-	£40,900
Foundation Doctor Year 1	-	-	-	£34,300

Source: NHS Digital Earning Statistics

Pay Drivers - Explaining the growth in Medical Pay

5.22 Figure 5.3 presents trends in medical average earnings growth and its component drivers. This comes from DHSC Headline Paybill Metrics which includes a Paybill Drivers Analysis which can help explain the factors behind growth in Paybill.

Figure 5.3- Breakdown of Average Earnings Growth for Medical Staff

Pay Growth Element	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Basic Pay per FTE Growth	0.8%	0.8%	2.0%	2.8%	2.3%	3.3%
Additional Earnings per FTE Growth	2.5%	0.6%	1.2%	-1.5%	-2.4%	-2.9%
Total Earnings per FTE Growth	1.2%	0.7%	1.8%	1.7%	1.1%	1.8%
Of Which	-	-	-	-	-	-
Headline Pay Awards	0.1%	0.1%	1.0%	1.0%	1.0%	3.4%
Total Earnings Drift	1.1%	0.6%	0.8%	0.7%	0.0%	-1.6%
Of Which	-	-	-	-	-	-
Basic Pay Drift	0.3%	0.2%	0.3%	1.6%	1.2%	0.3%
Additional Earnings Drift	0.4%	-0.1%	-0.2%	-1.1%	-1.3%	-1.7%
Grade Mix Effect	0.4%	0.6%	0.6%	0.2%	0.2%	-0.2%

Source: DHSC HCHS Paybill Metrics

5.23 Several factors drive changes in average earnings. Some relate to changes in the composition of the workforce, some relate more specifically to pay rates.

5.24 The impact of headline pay awards on average earnings for medics in 2019-20 compared to 2018-19 was 3.4%. This reflects the combined effect of 2019-20 pay awards applied to earnings at the end of 2018-19 (averaging 2.4%), and the impact of staged 2018-19 pay awards on earnings at the end of 2018-19 compared to earnings for 2018-19 (averaging 1.0%). 2018-19 awards were staged from 1 October 2018, so earnings for the whole year include six months before the pay awards were applied and hence are lower than earnings at the end of the year. The average 2.4% impact of 2019-20 pay awards is based on:

- 2.35% impact for Consultants (average of 2.5% increase to basic pay scales and no change in the value of CEAs, existing LCEAs granted prior to 1 April 2018, discretionary points and distinction awards).
- 2.3% impact for Junior Doctors (2% increase to basic pay scales plus changes to additional earnings streams as part of the multi-year deal agreed in 2019).
- 2.5% impact for Staff Grade and Associate Specialist Doctors.

5.25 Average total earnings grew by less in 2019-20 than the pay awards impact (1.8% vs 3.4%), implying negative Earnings Drift. Drift levels are driven by several factors:

- A grade mix effect of -0.2% reflecting a shift in the workforce towards lower earning staff groups i.e. Junior Doctors.

- Basic Pay Drift of 0.3%, positive but similar to the lower levels observed prior to 2017-18 and 2018-19 and reflecting wider workforce mix effects such as a shift in the distribution of staff towards higher pay points. Higher Basic Pay Drift in 2017-18 and 2018-19 reflected the phased implementation of the Junior Doctor contract reforms introduced in 2016, which deliberately moved earnings from additional to basic pay through shifting former band supplements towards basic pay, but Basic Pay Drift does not show a strong continuing effect from Junior Doctors in 2019-20.

- Negative Additional Earnings drift of -1.7%, which might suggest the proportion of additional earnings has reduced. Additional Earnings per FTE fell by 2.9% in 2019-20, continuing a recent trend. The reduction in the use of banding supplements due to Junior Doctor contract reform contributed to the negative Additional Earnings drift in 2017-18 and 2018-19 - this continued in 2019-20, but with a smaller negative effect. A reduction in additional earnings per FTE for Consultants, including payments for additional activities, also contributed to negative drift in 2019.

- Although data are not yet available for 2020-21, we know the value of the 2020-21 pay settlement to different groups.

- Basic pay to Consultants and SAS doctors increased by 2.8%.

- There was no change to the value of CEA / LCEA payments.

- Basic pay to Junior Doctors increased by 2.0% as part of a multi-year pay agreement.

Employee Experience of the Pay System

Pay Advancement under existing medical contracts

5.26 Doctors can expect substantial pay advancement over their careers as they progress through their current grade and are promoted to more senior positions. As shown in Figure 5.4, starting basic pay for Junior Doctors (FY1) is £28,243 with a new Consultant receiving basic pay of £79,860. In year 6 Junior Doctors might

have progressed to ST4 which has a Basic pay of £48,075 (an increase of 73.6%) and Consultants will have reached the 5th pay step worth £89,856 (an increase of 12.5%).

5.27 The overall increase in salary between the bottom of the Junior Doctors grades (£28,243) and the top of the Consultant Pay Scales (£110,683) represents an increase of 291% which would be an annualised increase of 5.6% per year over a 25-year period.

Figure 5.4- Pay Progression & Advancement for Medical Staff

Pay Journey	**Starting Basic Pay**	**Basic Pay in 6th Year**	**Increase**
Junior Doctors	£28,243	£49,036	73.6%
Consultants	£82,096	£92,372	12.5%
Pay Route	Starting Basic Pay	Maximum Basic Pay	Increase
F1 - Consultant Maximum	£28,243	£110,683	291.9%

Source: NHS Employers Pay Circulars

5.28 Figure 5.5 provides additional information on pay progression that HCHS Doctors are eligible to receive at different points in their careers. Note that:

(a) Pay progression is linked to either the stage of training for Junior Doctors or the amount of time served in the Consultant or SAS grades.

(b) Junior Doctors are eligible to receive pay progression after the completion of F1, F2 and after the second year of either Specialty or Core Training. In October 2020 an additional point was added for doctors in ST6 and above. Doctors who train on a Less Than Full Time (LTFT) basis will take longer to progress as pay scales are linked to the stage of training which reflect skills and competence.

(c) Consultants are eligible to receive progression in each of the first 4 years after attaining Consultant level and then at 5 yearly intervals until they have reached 19 years in post and are not dependent on FTE.

Figure 5.5- Example pay progression journey of Doctors in Training

Stage of Training	Basic Pay	Increase over Previous Point	Per Year - Annualised
F1	£28,243	N/A	N/A
F2	£32,691	15.7%	N/A
CT1/ST1 - CT2/ST2	£38,694	18.4%	N/A
ST3 - ST5	£49,036	26.7%	N/A
ST6 - ST8	£52,036	6.1%	N/A
F1 - ST8	N/A	84.2%	7.0%

Source: NHS Employers Pay Circulars

Figure 5.6- Example pay progression journey of Consultant Doctor

Years Completed as Consultant	Basic Pay	Increase over Previous Point	Per Year - Annualised
0 (Entry)	£82,096	N/A	N/A
1	£84,667	3.1%	N/A
2	£87,238	3.0%	N/A
3	£89,809	2.9%	N/A
4 - 8	£92,372	2.9%	N/A
9 - 13	£98,477	6.6%	N/A
14 - 18	£104,584	6.2%	N/A
19 +	£110,683	5.8%	N/A
Entry - Top of Scale	N/A	34.8%	1.6%

Source: NHS Employers Pay Circulars

5.29 The system of national contracts for medical staff mean that staff can access both pay progression and promotion. Progression occurs when somebody accesses a higher pay step within the same grade while promotion occurs when somebody reaches a more senior grade (e.g. attaining Consultant level).

Longitudinal Analysis

5.30 Using data from the ESR Data Warehouse, a monthly snapshot of the HR & Payroll system, we can conduct analysis of individual members of the workforce, or cohorts of people, over time to chart common career pathways for doctors and calculate increases in earnings at the individual level.

Career Pathways

5.31 It can be helpful to analyse how members of staff move between different grades over time to learn more about common development pathways and if there are any points at which people may be more likely to exit the workforce entirely. Chapter 6 goes into more detail on retention in the HCHS workforce including some of the reasons why people may leave at different stages.

5.32 Analysis is based on identifying doctors who were employed in March 2010 and then seeing where they were employed in March 2020. Figure 5.7 shows how individuals moved between grades over the period - for example of those who were identified as Consultants in 2010, 62% were still employed as Consultants in 2020, with most of the rest no-longer employed in the HCHS sector. This attrition from the workforce will include people who have retired from service.

5.33 Of those who were Doctors in Training in 2010 around one third were Consultants by 2020, over 10% were still Junior Doctors with a small proportion in either the SAS or other grades.

5.34 Just under half of people who were in junior grades in 2010 were not in the HCHS sector in 2020. This is to be expected as our data does not cover those working in Primary Care and around half of each cohort of junior doctors pursue careers in General Practice.

Figure 5.7- Career Journeys - Medical Grades in 2010 and 2020

Grade in 2010	Consultant	SAS Doctor	Doctor in Training	Others & Unknown	Not in HCHS
Consultant	62%	0%	0%	0%	37%
SAS Doctor	11%	35%	1%	2%	52%
Doctor in Training	37%	3%	12%	1%	47%
Others & Unknown	5%	3%	1%	22%	68%

Source: DHSC Analysis of Electronic Staff Record

5.35 The most common career path for a Junior Doctor is to progress into specialty (or core) training after completing the Foundation Programme and then reach Consultant level once they have obtained a CCT. A small proportion will choose to join the SAS grades with some doing this for a short period of time while they seek a suitable training or consultant post.

Pay Tracking Analysis

5.36 Changes in pay for individual members of the workforce can differ from national averages due to pay progression or promotion. Using ESR data it is possible to look at how earnings have changed for individual members of the workforce over time and includes the impact of progression / promotion.

5.37 Analysis is based on around 50,000 Doctors who were employed in the Hospital and Community Health Sector in both March 2010 and March 2020 and present the average changes in basic pay per FTE over that period. Where someone has progressed to a more senior grade the 2020 grade is shown.

5.38 The median level of growth over the period was over 34% which highlights the importance of pay advancement for doctors as this is in excess of changes to headline pay rates. The mean rate of growth is higher (71.4%) which suggests a skewed distribution and that some staff received much higher increases following promotion. The highest rates of growth will have been for those who were Junior Doctors in 2010 and had reached Consultant level by 2020.

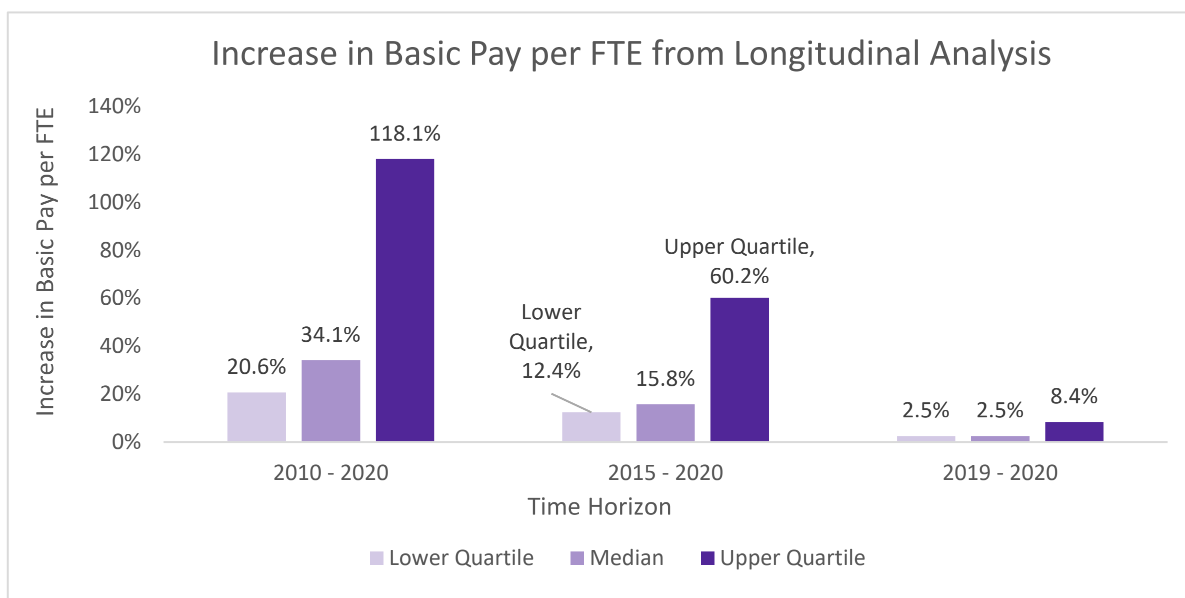
Figure 5.8- Change in Basic Pay per FTE for Medics March 2010 - March 2020

Career Grade in March 2020	Count	Mean	Median	Lower Quartile	Upper Quartile
Consultant	38,600	73.0%	27.6%	20.5%	128.9%
Associate Specialist	1,200	34.3%	25.5%	17.4%	38.3%
Specialty Doctor	2,700	61.3%	53.5%	35.2%	82.9%
Staff Grade	100	14.4%	9.9%	9.9%	12.3%
Core Training	300	59.0%	54.0%	30.8%	74.7%
Specialty Registrar	4,700	72.1%	70.2%	54.0%	104.0%
Hospital Practitioners / Clinical Assistants	200	13.0%	9.8%	9.8%	9.9%
Other and Local Grades	500	31.2%	16.8%	8.8%	30.2%
Unallocated	1,200	112.7%	49.3%	9.9%	181.8%
Total	49,500	71.4%	34.1%	20.6%	118.1%

Source: DHSC Analysis of Electronic Staff Record. F1 & F2 are not shown as it would be highly unusual for a doctor who was F1/F2 in 2010 to still be in that grade in 2020.

5.39 Figure 5.9 presents similar analysis conducted over alternative time periods. Between 2019 and 2020 the median increase was 2.5% (IQR = 2.5% - 8.4%) which is consistent with changes to pay rates. The largest increases are for those who progressed to a more senior career grade.

Figure 5.9- Longitudinal Analysis over alternative time horizons



Source: DHSC Analysis of Electronic Staff Record

5.40 The experience for some staff, especially those operating at the top of the pay scales, may differ from these averages. For example, a Consultant who has been at the top of the pay scale for the past 10 years will have seen an increase of around 10%, as no further pay progression was possible, although they may have been able to access other parts of the reward package such as CEAs.

Comparison with the Wider Economy

5.41 Medical staff have high potential earnings, with ONS data placing them in the top 3% of occupations in the UK. This section contains information on how earnings for HCHS doctors compare to those of other high-earnings groups. More information on general economic conditions has been submitted in HMT evidence.

5.42 There is a considerable level of uncertainty in the UK and global economy due to the ongoing pandemic. At this stage the full effect of the pandemic on either the

NHS or wider economy may not be seen in ASHE data which is taken as of April 2020.

High Earning Profession Comparison

5.43 Medical professionals can expect to earn a high wage compared to the broader economy. In 2020, median gross annual pay for medical practitioners was over £54,000, which is more than double median earnings for the UK and makes it the occupation with the 11th highest average earnings in the UK.

5.44 Figure 5.10 compares ASHE data for medical practitioners with all other occupations with median earnings of over £55,000 who might expect to have a similar level of education and qualifications. Medical practitioners have the 11th highest earnings across all occupation groups which is down from 4th in 2015 but the median of over £54,000 still places them in the top 3% of all occupation groups.

5.45 This data suggests that the median annual pay for medical practitioners has fallen over the past five years. This is out of step with other comparator groups, who have mostly seen rises in median pay. Most groups have seen a rise, and no groups have fallen by even half as much as medical practitioners.

5.46 This finding does not fit with earnings data published by NHS Digital which shows total earnings per person has grown by 6.9% in the previous 5 years (Apr 2015 - Apr 2020). There are several reasons why the ASHE figure should not match exactly with these measures: compositional effects and a shift towards more salaried (lower paid) GPs and fewer GP practice partners who are not included in HCHS data. The number of medical practitioners has risen from 170 thousand to 202 thousand and may now comprise a higher proportion at less senior levels. ASHE data uses a different definition of medical practitioners than NHS Digital Statistics and should be used as a supplementary data source to the existing statistics provided elsewhere.

Figure 5.10- Median Annual Pay for High Earnings Occupations in 2015 and 2020

Occupation	SOC Code	Median Gross Annual Pay (2015)	Median Gross Annual Pay (2020)	% Increase	Rank 2015	Rank 2020	Number of jobs (000s, 2020)
Aircraft pilots and flight engineers	3512	84,597	92,330	9.1%	1	1	N/A

Chief executives and senior officials	1115	80,827	78,457	-2.9%	2	2	88
Marketing and sales directors	1132	68,395	74,122	8.4%	3	3	190
Medical practitioners	2211	65,588	54,539	-16.8%	4	11	202
Senior police officers	1172	61,747	56,665	-8.2%	5	8	11
Information technology and telecommunications directors	1136	60,982	68,732	12.7%	6	5	31
Advertising and public relations directors	1134	60,219	58,353	-3.1%	7	7	13
Financial managers and directors	1131	56,506	59,468	5.2%	8	6	343
Senior professionals of educational establishments	2317	50,643	56,340	11.2%	9	9	101
Train and tram drivers	8231	49,838	55,662	11.7%	10	10	29
Legal professionals n.e.c	2419	N/A	71,366	N/A	11	4	46

Source: Annual Survey of Hours and Earnings

Note: 'N/A' indicates figures not included in ASHE tables. This is because estimates were considered unreliable due to sampling error. Included data may still be subject to variation due to sampling error. Air traffic controllers are ranking above medical professionals based on 2015 median annual pay but are not included because their 2020 median pay is not published. ASHE data is not adjusted for hours worked, and includes medics not covered by ESR data, such as GPs. It may also be affected by composition effects, such as the proportion of salaried GPs or Part Time workers. ASHE data for doctors differs from NHS Digital data. The former is a sample based on around 1% of PAYE records from HMRC. NHS Digital data is based on data extracted from ESR and should provide a more complete picture.

5.47 Doctors can have the unusual but realistic expectation of reliably transitioning from junior positions into the most senior positions, and that this growth in earnings is not so frequent in all comparator groups. This pay advancement has been discussed above.

5.48 HMT's evidence will provide more information on wider economic conditions.

Equalities

Gender Balance in the HCHS Workforce

5.49 Figure 5.11 shows the current gender balance of the medical workforce split by career grade. Overall just under 55% of Doctors are male but there are some differences by career grade with over 62% of Consultants being male and over half of Doctors in Training being female. The DDRB has previously raised the question of gender balance in the SAS grades - we see that most of these doctors are male, but the proportion is slightly lower than for Consultants. Gender balance is important because if there are more staff from a single demographic group in a high paying grade then it can contribute to a pay gap developing.

Figure 5.11- Gender Balance by Medical Grade - Headcount - March 2020

Grade	Male	Female
HCHS Doctors	54.5%	45.5%
Consultant	62.5%	37.5%
Associate Specialist	60.6%	39.4%
Specialty Doctor	52.9%	47.1%
Staff Grade	58.5%	41.5%
Specialty Registrar	47.8%	52.2%
Core Training	50.5%	49.5%
Foundation Doctor Year 2	45.7%	54.3%
Foundation Doctor Year 1	44.6%	55.4%
Hospital Practitioner / Clinical Assistant	50.2%	49.8%
Other and Local HCHS Doctor Grades	32.9%	67.1%

Source: NHS Digital Workforce Statistics - NHS Trusts & CCGs - March 2020

5.50 The proportion of female Consultants continues to increase. Since 2006 the proportion of Consultants (headcount basis) that are female has increased from 27% to 37% and in recent years has increased by around 0.5% per year. The increase in the proportion of female consultants is one reason behind the reduction in the medical gender pay gap.

5.51 The DDRB has sought additional evidence on equalities issues for SAS doctors. Like Consultants most SAS doctors are male although the proportion is slightly lower than in the Consultant grade. The proportion of SAS doctors with BAME backgrounds is also higher than in other medical grades - for example over 57% of

SAS doctors have BAME ethnicity compared to 38% of Consultants and 43% of doctors in training.

Gender & Ethnicity Pay Gaps

5.52 As discussed in Chapter 3 the Gender Pay Gap in Medicine Review explored some of the factors that contribute to the existence of a pay gap in medicine with women having lower average wages than their male counterparts.

5.53 The latest data published by NHS Digital, which also includes analysis of the Ethnicity Pay Gap, considers data as of May 2020 and shows that:

- The gender gap has reduced since 2016. Across medical grades the gap is 12% for white females (meaning average pay for white females is 12% lower than for white males) and 14% for BAME females. In both cases this is down by around 4 percentage points from 2016 as the proportion of female consultants has increased.

- As found by the Gender Pay Gap in Medicine Review gaps reduce after controlling for employee characteristics – Gaps for individual career grades are smaller than those for the whole workforce.

- The Ethnicity Pay gap, for example comparing average earnings for BAME females to white females, has slightly increased for both genders by around 1 percentage point. Female BAME staff have basic pay around 11% lower than their white colleagues and male BAME staff have basic pay around 9% lower. This may be related to an increase in the proportion of BAME staff in the junior grades.

Figure 5.12- Basic Pay per FTE by Gender, Ethnicity & Medical Grade - May 2020

Staff Group	**GPG – White**	**GPG - BAME**	**EPG - Female**	**EPG – Male**
Description	Comparison of White Female & White Male	Comparison of BAME Female & BAME Male	Comparison of BAME Female & White Female	Comparison of BAME Male & White Male
Doctors	-12%	-14%	-11%	-9%
Consultants	-3%	-2%	-3%	-3%
SAS Doctors	-1%	-6%	-5%	1%
Doctors in Training	-0%	-4%	-1%	3%

Source: DHSC Analysis of Electronic Staff Record

Conclusion

5.54 The evidence in this chapter shows that average earnings have increased across the medical workforce over the past year reflecting the impact of annual pay awards and existing pay agreements. Assessments of longer-term HCHS earnings should consider the impact of the pandemic on the wider labour market which are not yet fully apparent. It should also be noted that individuals in the HCHS workforce may also receive earnings growth through promotion and pay progression on top of basic pay award. This is especially the case for Doctors who also have a reasonable expectation of having earnings at the top end of the UK salary distribution.

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

6.1 This chapter discusses and describes the existing size of the workforce, how it has changed with regards to patterns of recruitment, retention and motivation amongst the HCHS workforce. The remainder of the chapter reflects on and updates on aspects of workforce planning and key topics of interest as requested.

Summary and Background

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

6.3 There is a record and growing number of doctors in the NHS. HCHS doctors have increased by 16% in the period between January 2014 and January 2020. Ensuring that the NHS is well staffed, with colleagues well looked after, to prevent pressures becoming too great, is an absolute top priority for this government.

6.4 The Department continues to take action to increase the supply of trained Medical and Dental staff available to work in the NHS and wider health and care system by supporting a world class health education and training system. In conjunction with HEE and NHS England and Improvement NHSEI, the Department has taken a range of actions to boost the supply of domestically trained staff.

6.5 However, NHS staff have been under increasing pressure since the response to COVID-19 began, and there will be further challenges ahead. Workload remains a pressing challenge and recruitment and retention indications are mixed.

6.6 Working with partners including HEE and NHSEI, DHSC continues to take a range of actions to increase the supply of domestically trained medical and dental staff available to work in the NHS and wider health and care system, by supporting a world class health education and training system.

6.7 Over the last three years we have expanded undergraduate medical school places by 1,500 (25%). There are now 7,500 medical students entering training each year.

6.8 In addition, the Government recognises that COVID-19 has had an adverse impact on higher education and lifted the cap on medical and dental school places for students who completed A-Levels in 2020 and who had an offer from a university in England to study medicine and dentistry, subject to their grades. This ensured a place this year or next for every eligible student. Consequently, around 700 medical and dental students entered training in 2020/21 academic year.

6.9 During the COVID-19 response, NHS people have shown energy, creativity and drive in finding innovative solutions to new problems. The NHS needs to build on this to meet the complex and evolving staffing needs of NHS services. We are the NHS: People Plan for 2020/21 – action for us all provides a plan on the national and local steps that need to be taken for the rest of 2020/21 to support NHS people and help manage the pressures and uncertainty that will continue to be felt.

6.10 Getting the skills mix right is critical in addressing workload pressures and delivering appropriate patient care. To meet the needs of an ageing population, there will be an increasing focus on enhancing doctors' generalist skills to complement existing specialism, alongside further increases in Medical Associate Professional roles, specifically Physician Associates.

Numbers in Work

6.11 NHS HCHS doctors have increased by 15,861 FTEs (16%) in the period between January 2014 and January 2020 (used to ensure no impact of the coronavirus on workforce numbers), including by 7,982 (6.7%) over the last two year of that period. Between 2014 and 2020, consultants, increased by 9,135 (23%), from 40,292 to 49,427. There have been large, proportionate changes, such as for Junior Doctors in Core Training which have seen the largest increase (56%). The SAS group, have decreased but this is expected as they have not been open to new entrants since the introduction of the Speciality Doctor contract in 2008.

Figure 6.1- HCHS doctors FTEs January 2014 to January 2020

Staff Group	Jan-14	Jan-16	Jan-18	Jan-20	Change in FTE 2014-2020	% Change 2014-2020
Consultant	40,292	43,355	46,297	49,427	9,135	23%
Associate Specialist	2,765	2,359	2,041	1,906	-859	-31%
Speciality Doctor	5,758	6,116	6,709	7,457	1,699	30%
Staff Grade	385	393	347	316	-68	-18%

Speciality Registrar	29,414	28,866	29,894	31,296	1,882	6%
Core Training	8,670	8,885	10,155	13,564	4,894	56%
Foundation Doctor Year 2	6,480	6,627	6,560	5,667	-813	-13%
Foundation Doctor Year 1	6,326	6,334	6,142	6,434	108	2%
Hospital Practitioner / Clinical Assistant	525	499	502	505	-20	-4%
Other and Local HCHS Doctor Grades	928	901	862	830	-98	-11%
Grand Total	101,541	104,335	109,509	117,402	15,861	16%

Source: NHS Digital HCHS monthly workforce statistics

Analysis of Joiners and Leavers

6.12 Analysing changes in the number of joiners and leavers across different staff groups, and the reasons behind them, is an important step in identifying potential risks in recruitment and retention of Medical and Dental (M&D) staff.

6.13 Doctors are a highly skilled workforce, as part of their professional development and the scope of their work, it is common to take career breaks from the NHS or move between employers. The joiner and leaver data reflects this, for example doctors have a higher annual turnover rate than nurses. Junior doctors are increasingly taking career breaks, although we continue to see the vast majority return to the UK to work in the NHS. Despite the high degree of movement within the workforce, longitudinal studies show low rates of loss over the long term and the workforce is inherently stable.

Joiners

6.14 The number of joiners in the HCHS doctors' workforce has grown by 36% in the last 5 years. Joiners from education / training have remained the largest source of joiners from outside the NHS and have remained fairly level since 2014. The majority of these join Foundation Training as newly qualified doctors.

6.15 The number of entrants coming from non-EU countries has grown rapidly. The number of joiners from EU countries has declined slightly, and there are around 15% fewer joiners from EU countries than in 2015-16.

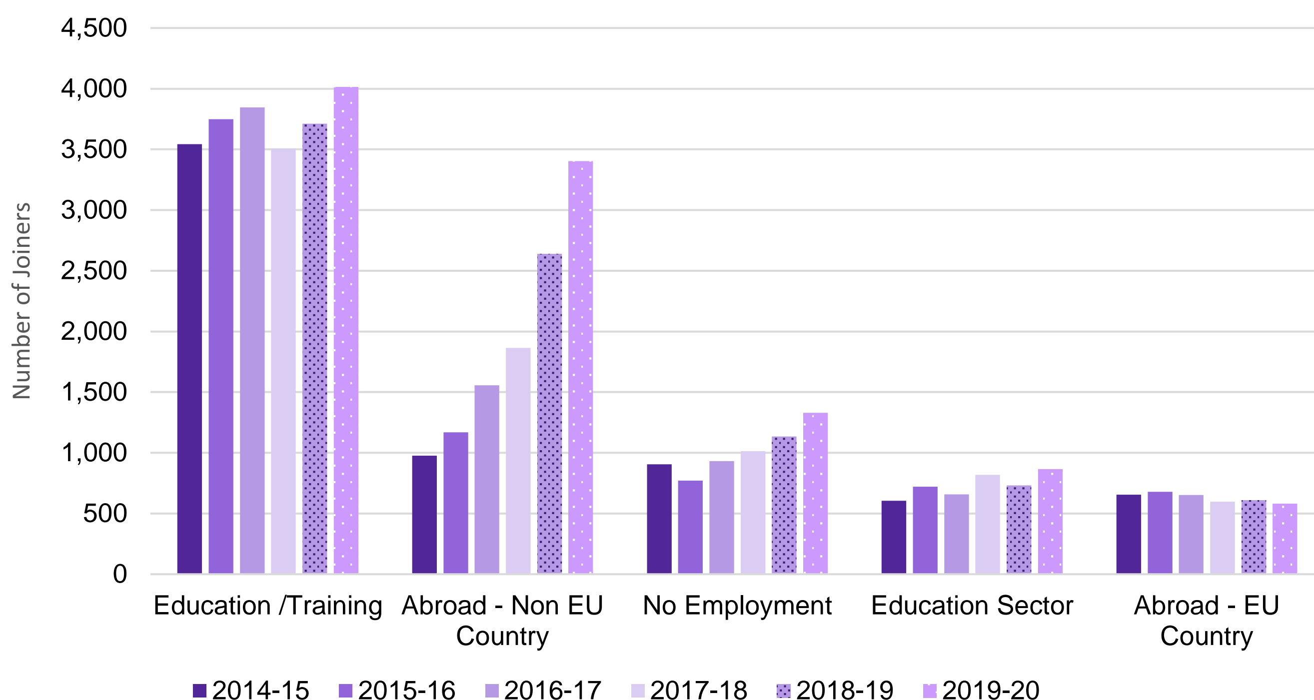
Figure 6.2- Source of HCHS Doctors

Absolute Numbers	2015-16	2016-17	2017-18	2018-19	2019-20
Abroad - Non EU Country	1,169	1,556	1,866	2,639	3,404
No Employment	771	932	1014	1,136	1,331
Abroad - EU Country	680	653	596	611	582

Source: NHS Digital HCHS workforce statistics

6.16 New entrants from non-EU countries have continued to grow year on year and has almost tripled in the past five years, up by 2,235 (191%) between 2015-16 and 2019-20.

Figure 6.3- HCHS Doctors Joining NHS from the Five Largest Sources (excluding internal NHS movement): Time Series



Source: NHS Digital HCHS workforce statistics

6.17 The data collected by NHS Digital provide a general picture of joiner rates in regions across England (the joiner rate is the percentage of the workforce in the HCHS joining their staff group in a year). For HCHS doctors, joiner rates vary little between regions, and there are no clear trends. The joiner rates between all

regions vary between 15% and 21% throughout the time series as shown in Figure 6.4. These rates represent new joiners and re-joiners.

Figure 6.4- 12-months joiner rates by region, HCHS Doctors

NHSEI name	Mar 14 - Mar 15	Mar 15 - Mar 16	Mar 16 - Mar 17	Mar 17 - Mar 18	Mar18 - Mar 19	Mar19 - Mar 20
All NHSEI regions	16.3%	16.2%	16.8%	17.1%	18.4%	19.7%
London	17.1%	16.3%	17.1%	17.3%	18.8%	18.7%
South West	16.0%	16.3%	15.8%	18.2%	18.4%	19.3%
South East	16.4%	17.3%	16.6%	17.5%	18.0%	19.7%
Midlands	15.8%	15.7%	16.8%	16.9%	18.8%	20.2%
East of England	16.9%	15.3%	19.4%	18.7%	19.3%	20.5%
North West	15.8%	16.1%	16.0%	15.7%	18.1%	21.3%
North East and Yorkshire	15.7%	16.0%	16.3%	16.1%	17.3%	18.7%

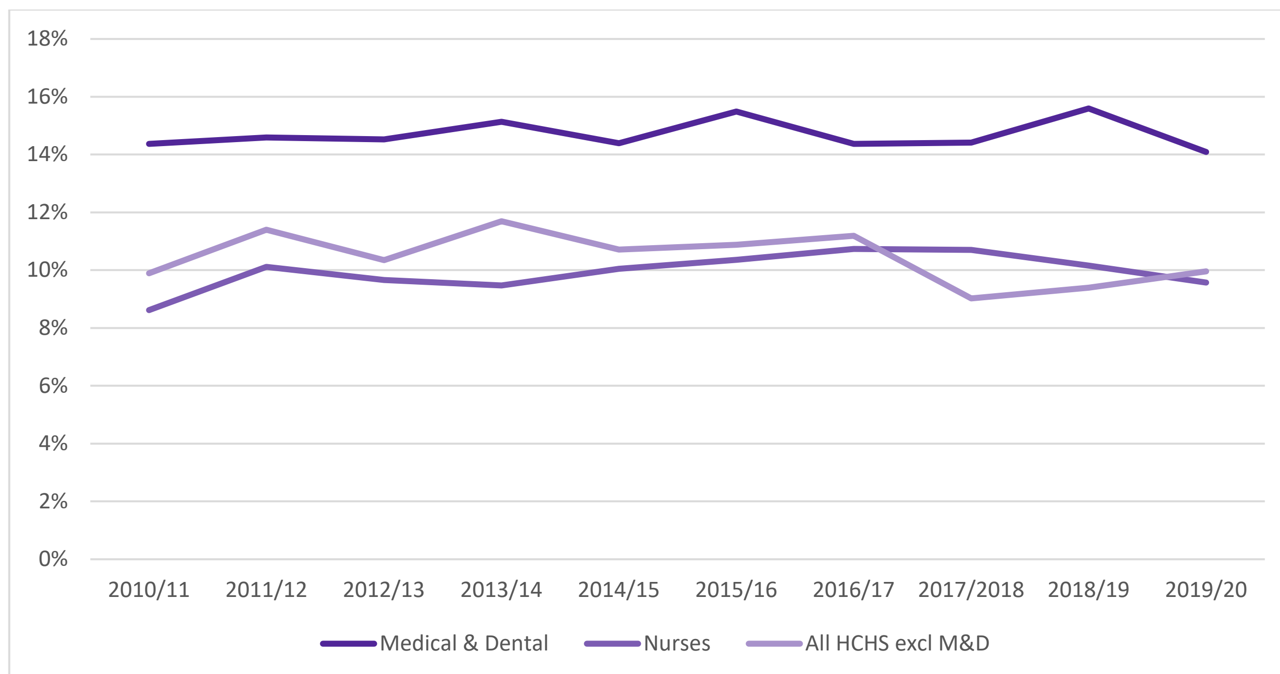
Source: NHS Digital Workforce Statistics

Leavers

6.18 The leaver rate for HCHS Medical and Dental staff has fluctuated but held relatively steady over recent years as shown in Figure 6.5. The leaver rate is the percentage of the workforce leaving their staff group in the NHS Trusts and CCGs in a year. It excludes staff moving between Trusts, but includes people moving from the Trusts to for example a GP Practice. NHS Digital produces turnover statistics based on information in the NHS ESR.

6.19 The leaver rate for HCHS Medical & Dental staff was around 14.5% per year in 2010/11 to 2012/13. There was a one-off temporary increase in 2013/14 during transformation of the health system, including the transfer of some jobs out of the HCHS into Public Health England. The rate increased to 15.5% between 2014/15 and 2015/16, however decreased in 2016/17 to a similar rate of 14.4% in 2016/17. A rise in 2018/19, appears to have been offset by the rate in 2019-20 falling to its lowest level of the period at 14.1%. For context a thousand additional/fewer doctors leaving the NHS equates to about a 0.8% change in the leaver rate.

Figure 6.5- HCHS Staff Leaver Rates by Staff Group: Time Series



Source: NHS Digital Workforce Statistics

6.20 Leaver rates vary between 12% to 19% across regions and time series, but there are no clear trends.

Figure 6.6- Medical Leaver Rates by Region

NHSEI name	Mar 14 - Mar 15	Mar 15 - Mar 16	Mar 16 - Mar 17	Mar 17 - Mar 18	Mar18 - Mar 19	Mar19 - Mar 20
All NHSEI regions	14.4%	15.5%	14.4%	14.4%	15.6%	14.1%
London	15.1%	16.8%	15.0%	15.0%	14.9%	14.0%
South West	17.3%	14.4%	14.7%	14.1%	15.9%	14.4%
South East	14.4%	14.4%	15.2%	14.5%	16.8%	14.3%
Midlands	14.0%	14.6%	14.1%	14.4%	14.9%	14.6%
East of England	11.8%	19.4%	13.0%	14.4%	15.5%	14.0%
North West	13.7%	13.8%	13.7%	14.2%	16.3%	14.2%
North East and Yorkshire	14.2%	15.2%	14.3%	13.9%	15.4%	13.2%

Source: NHS Digital Workforce Statistics

6.21 Leaver rates vary between the different specialties, however, they appear to be broadly consistent over a number of years within a speciality area. Figure 6.7 shows the leaver rates for HCHS doctors by specialty. This is calculated by

dividing the number of leavers by the difference between the staff in post at the start of the year and the number of staff in post at the end of the year.

Figure 6.7- Leaver Rates by Specialty

Leaver rates	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Anaesthetics	9%	9%	9%	9%	10%	10%	8%
Clinical oncology	12%	13%	14%	13%	12%	14%	11%
Dental group	19%	18%	17%	17%	18%	17%	16%
Emergency Medicine	21%	21%	22%	22%	21%	22%	20%
General medicine group	17%	17%	19%	17%	17%	19%	16%
Obstetrics & gynaecology	18%	18%	19%	17%	17%	19%	16%
Paediatric group	17%	16%	18%	15%	16%	17%	15%
Pathology group	11%	11%	11%	11%	10%	10%	10%
PHM & CHS group	35%	17%	22%	17%	19%	16%	20%
Psychiatry group	14%	14%	16%	14%	14%	15%	14%
Radiology group	7%	8%	7%	8%	8%	8%	6%
Surgical group	12%	12%	13%	12%	12%	14%	13%

Source: NHS Digital Workforce Statistics

6.22 On average of the larger specialities, the Emergency Medicine groups has the highest leaver rate every year, while the Pathology, Anaesthetics and Radiology groups have the lowest. Most speciality groups have stayed relatively similar from the period 2013-14 to 2019-20.

Retention

6.23 Another way to express outflows from the workforce is the stability index. This has also held relatively steady over recent years as shown in Figure 6.8 alongside other staff groups. The stability index captures how successful the NHS is in retaining its staff. The index is computed by NHS Digital on data for England.

6.24 The overall stability index for all HCHS doctors is brought down by the lower stability index of Junior Doctors. Doctors below Consultant level often move and work abroad during their careers and may well move between sectors, such as into General Practice. A larger share of doctors taking career breaks may also be a factor.

Figure 6.8- Stability Index of M&D staff and for non-medical staff in the last six years

Staff groups	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Doctors	84.6%	85.2%	84.2%	85.4%	85.4%	84.1%	85.5%
Nurses &Health Visitors	90.3%	89.7%	89.5%	89.1%	89.3%	89.8%	90.2%
Midwives	91.0%	90.2%	89.7%	89.2%	89.4%	89.6%	89.8%
Ambulance	93.2%	92.6%	92.4%	92.7%	91.9%	92.2%	93.0%
STT	89.4%	88.5%	88.3%	88.6%	89.0%	89.3%	89.8%
Support to Clinical	89.1%	88.4%	88.4%	87.6%	88.2%	88.9%	89.5%
Infrastructure Support	81.1%	87.9%	88.3%	88.4%	88.4%	89.8%	90.3%

Source: NHS Digital Workforce Statistics

Note: The Stability Index is the percentage of staff there at the start of the period that do not leave the specified group (e.g. organisation, staff group or the NHS in England) during period in question.

Reasons for Leaving

6.25 Reasons for leaving are collected within ESR and provide a useful insight for some aspects of staffing motivation but any conclusions drawn need to be mindful of an ever-increasing rate of ‘unknown reason’ being recorded, up to over 40% of leavers by 2019-20.

6.26 The most common specified reason for leaving is staff reaching the end of a Fixed Term Contract (19.9%) however this is linked to Junior Doctors moving training posts. The number, and proportion, of voluntary resignations has reduced until the current year, though what effect the level of unknowns has on this figure is unclear. Among those leaving voluntarily the most common reasons are relocation, promotion and work life balance.

Figure 6.9- Reasons for leaving among HCHS doctors

Reason for leaving	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Dismissal	102	88	69	65	71	53	0.6%	0.4%	0.4%	0.4%	0.4%	0.3%
Employee Transfer	364	298	169	164	673	195	2.0%	1.5%	1.0%	1.0%	3.7%	1.1%
End of FTC	5,645	5,986	4,026	3,855	4,148	3,439	30.6%	29.9%	25.0%	23.2%	22.6%	19.9%
End of FRC - Completion of Training	1,337	1,526	985	875	993	851	7.2%	7.6%	6.1%	5.3%	5.4%	4.9%
End of FTC-End of Work Requirement	264	306	216	198	218	197	1.4%	1.5%	1.3%	1.2%	1.2%	1.1%
End of FTC - External Rotation	2,406	2,592	1,685	1,503	1,259	1,182	13.0%	12.9%	10.4%	9.1%	6.8%	6.8%
End of Fixed Term Contract - Other	519	678	413	398	324	353	2.8%	3.4%	2.6%	2.4%	1.8%	2.0%
Mutually Agreed Resignation	23	19	9	6	3	3	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
Others	76	89	62	47	36	66	0.4%	0.4%	0.4%	0.3%	0.2%	0.4%
Redundancy	58	35	31	25	34	26	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%
Retirement	1,060	1,059	908	925	891	917	5.7%	5.3%	5.6%	5.6%	4.8%	5.3%
Voluntary Resignation	3,608	3,883	2,817	2,870	2,686	2,750	19.6%	19.4%	17.5%	17.3%	14.6%	15.9%
Unknown	2,993	3,481	4,746	5,668	7,052	7,283	16.2%	17.4%	29.4%	34.1%	38.4%	42.1%
All Reasons for Leaving	18,455	20,040	16,136	16,599	18,388	17,315	100%	100%	100%	100%	100%	100%

Source: NHS Digital

Recruitment & Retention Premia

6.27 RRP can either be short or long term depending on whether retention problems are likely to be resolved in the near term or if the labour market conditions are more deep-rooted and will take more time to resolve.

6.28 Currently a small proportion of Doctors are in receipt of an RRP payment as shown in the figure below. Only around 0.3% of Doctors are in receipt of an RRP and while this has been increasing slowly in recent years, the average value of RRP payments has been stable for the past three years.

Figure 6.10- Proportion and Average Value of RRP Payments for HCHS Doctors

Year	Proportion in Receipt of RRP	Average Value of RRP
2013-14	0.1%	£19,015
2014-15	0.1%	£17,632
2015-16	0.1%	£18,634
2016-17	0.2%	£15,687
2017-18	0.2%	£19,267
2018-19	0.2%	£20,481
2019-20	0.3%	£19,889

Source: NHS Digital Earnings Statistics

Flexible Pay Premia

6.29 Flexible Pay Premia (FPPs) are a form of RRP designed to support recruitment to certain "hard to fill" specialties and training programmes. The 2016 Junior Doctor Contract introduced FPPs in several specialties including General Practice, Psychiatry, Emergency Medicine, and Academia, and subsequently Oral and Maxillofacial Surgery and Histopathology. Full details on the value of these payments and who is eligible to receive them are available via NHS Employers - https://www.nhsemployers.org/case-studies-and-resources/2020/08/pay-and-conditions-circular

6.30 Further detail on FPP is contained in Chapter 7 on doctors and dentists in training.

Vacancies

6.31 There are multiple measures for vacancies which NHS Digital collate as an experimental statistics. As part of that series, NHSEI undertake a monthly

workforce data collection from NHS Trusts, which includes data on staff in post (including bank and agency) and vacancies. This is the considered the best available measure presently and helpful as represents the variance between the reported whole-time equivalent (WTE) substantive staff in post and planned workforce levels. Tables are published by NHS Digital[vii].

6.32 The overall vacancy rate has shown large variation over the last two years, ranging from 5.9% to 9.6%, which is equivalent to vacancies of over 7,000 to over 12,000 as shown in Figure 6.11.

6.33 Vacancies should reflect the headroom for sickness absence, maternity leave and temporary staffing which a trust is expecting to require. Bank and agency staff are used to cover some vacancies, in addition to covering sickness absence and long-term leave.

6.34 Some further information on geographic and specialty specific recruitment for doctors and dentists in training is covered in Chapter 7.

Figure 6.11- Medical Vacancies (FTE and Rate) – 2017/18 Q1 to 2019/20 Q1

Medical Staff	**Vacancy Rate**	**WTE Vacancies**
17/18 Q1	9.1%	10,848
17/18 Q2	8.3%	10,096
17/18 Q3	7.9%	9,738
17/18 Q4	7.8%	9,635
18/19 Q1	9.6%	12,025
18/19 Q2	7.7%	9,743
18/19 Q3	7.1%	8,989
18/19 Q4	7.2%	9,183
19/20 Q1	9.0%	11,630
19/20 Q2	7.0%	9,247
19/20 Q3	6.7%	8,876
19/20 Q4	6.3%	8,338
20/21 Q1	5.9%	7,294

Source: NHSEI monthly workforce data collection for foundation trusts and NHS trusts.

Note: Data on SAS doctor vacancy rates is unavailable as it is not covered in the scope of data collection by NHS Improvement.

The International Workforce

6.35 The Government is committed to ensuring that the NHS and social care system have the nurses, midwives, doctors, carers and other health and care professionals that it needs: international recruitment is fundamental to delivering this commitment. There are two current Government policies in place to support internationally trained health and care staff in the UK:

- The Home Office EU Settlement Scheme is a simple registration process for EU nationals who arrive in the UK to live before the end of 2020, allowing them to remain living in the UK with broadly the same rights as they currently enjoy. Any EU Citizens living in the UK by 31 December 2020 have until 30 June 2021 to apply for the scheme.

- From October 2020 all health and social care staff, including EEA staff who come to work in the UK from January 2021 will be exempt from paying the Immigration Health Surcharge (IHS). A reimbursement is available for those staff that have been working from 31 March 2020.

6.36 The Government is clear that international recruitment of health and care staff must be managed in accordance with high ethical standards. We have a long list of countries that UK health and care employers should not actively recruit from: this is currently under review, with engagement from other Government Departments and the World Health Organisation (WHO). Government-to-government agreements are in place where we proactively recruit from countries that receive aid. This is the case in the Philippines and several states in India.

6.37 The COVID-19 pandemic and resultant border closures saw a significant fall in the numbers of doctors able to travel to the UK to take up NHS posts in the first half of 2020. As restrictions have eased, we have seen a steady increase in joiners. While future restrictions remain a possibility, we expect a to return to pre-COVID-19 levels once the pandemic impact decreases. (see Fig 6.1)

6.38 The General Medical Council (GMC) suspended its Professional and Linguistics Assessment Board 2 testing during lockdown, leading to a backlog of applicants. Subsequent restrictions on places due to social distancing guidance has compounded delays in registration for internationally trained doctors seeking GMC registration. We continue to engage with the GMC to assess what steps can be taken to mitigate and minimise the backlog.

6.39 As at March 2020 across 29% of doctors have a non-UK nationality (a further 3% have an unknown nationality). Doctors in the Specialty Doctor (48%) and Core Training (44%) grades are the most likely to hold a non-UK nationality while F1s (16%) and Consultants (20%) had lower than average rates of non-UK nationality.

6.40 Figure 6.12 is taken from NHS Digital Workforce statistics and shows the proportion of staff from different nationality groups are split between the different medical grades. Data are presented on a headcount basis. Data on Nationality is collected via the "Nationality" field on ESR. Nationality is self-declared and may differ from immigration or citizenship status.

Figure 6.12- HCHS Doctors by Nationality Group and Career Grade March 2020

Staff group	All	UK	EU	EEA	Rest of World	Unknown
HCHS Doctors	126,523	69%	9%	0%	20%	3%
Consultant	53,280	76%	9%	0%	11%	3%
Associate Specialist	2167	64%	7%	0%	22%	6%
Specialty Doctor	8,709	48%	11%	0%	37%	4%
Staff Grade	366	47%	16%	1%	31%	6%
Specialty Registrar	32,837	65%	9%	0%	25%	1%
Core Training	14,005	53%	9%	0%	35%	2%
Foundation Doctor Year 2	5,827	73%	7%	0%	19%	2%
Foundation Doctor Year 1	6,679	81%	6%	0%	10%	2%
Hospital Practitioner / Clinical Assistant	1,666	88%	4%	0%	3%	4%
Other and Local HCHS Grades	1,369	86%	5%	0%	5%	4%

6.41 Over time the proportion of non-UK doctors has increased from 24% in 2016 to 29% in 2020 as shown in Figure 6.13. The "Core Training" grade has seen the largest increase with an increase of 15 percentage points since 2016.

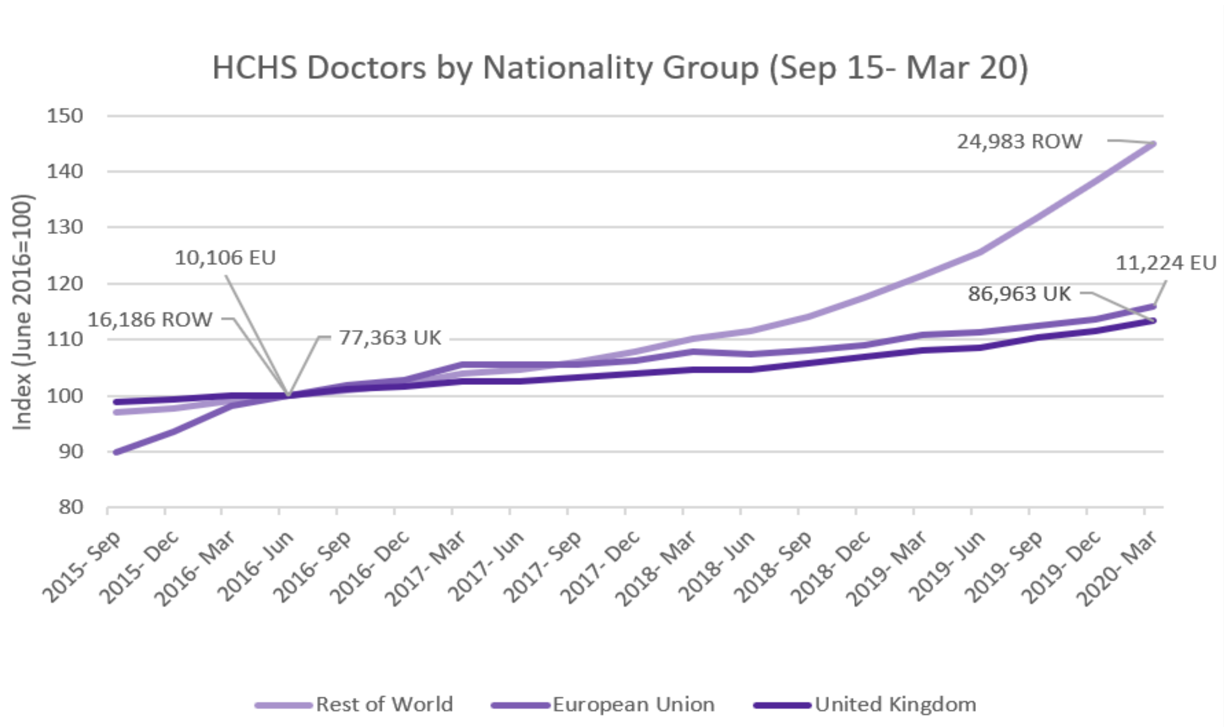
Figure 6.13- non-UK Doctors March 2020

Proportion Non-UK	2016-MAR	2017-MAR	2018-MAR	2019-MAR	2020-MAR
HCHS Doctors	24%	25%	26%	27%	29%
Consultant	20%	20%	20%	20%	21%
Associate Specialist	28%	28%	28%	28%	30%
Specialty Doctor	45%	46%	46%	47%	48%
Staff Grade	44%	48%	44%	41%	48%
Specialty Registrar	30%	30%	30%	32%	34%
Core Training	29%	31%	35%	40%	45%

Foundation Doctor Year 2	17%	18%	20%	23%	25%
Foundation Doctor Year 1	14%	16%	16%	16%	17%
Hospital Practitioner / Clinical Assistant	9%	8%	7%	7%	8%
Other and Local HCHS Doctor Grades	11%	11%	12%	11%	10%

6.42 The number of overseas staff from both the EU and Rest of the World has increased over the past 4 years, however growth from the Rest of the World has increased at a faster pace than from both the UK and EU regions. As shown in Figure 6.14 the number of staff from the rest of the world has increased by over 40% over the past 4 years and now represent about 20% of the total medical workforce. The number of medical only staff with EU Nationality has increased by 16% which is at a slightly faster pace to those from the UK (13%). The recent increase in Rest of World doctor numbers is likely due to a combination of factors, including the removal of the cap on Tier 2 visas and addition to the Shortage Occupation List of all medical roles.

Figure 6.14- Medical Workforce and Growth by Nationality Group- Sep 15- Jun 19



Source: NHS Digital Workforce Statistics

EU Exit

6.43 Since the referendum in 2016 DHSC has been clear that EU staff working in the NHS prior to 1 January 20201 are able to stay and welcomed and encouraged to do so. The Department and its ALBs will continue to support the health and care system to ensure they are able to deliver the services on which patients rely.

6.44 The Home Office EU Settlement Scheme allows EU nationals who arrived in the UK to live before exit day to remain living in the UK, with broadly the same rights as before the UK left the EU.

6.45 In the years since the referendum until 2019 there were no significant changes to the recruitment patterns for doctors from the EU. The number of doctors from the Rest of the World increased in the same timeframe. More Overseas doctors registered with the GMC in 2019 than those who trained in the UK. There has been a dip in EU/EEA and rest of world numbers joining in 2020, which is likely to be attributable to the COVID-19 crisis and restrictions on movement.

Figures 6.15, 6.16 and 6.17 NHS Hospital and Community Health Services-Proportion of all Medical Joiners by Staff Grade to NHS Trusts and CCGs in England, by nationality, annual to 30th June (headcount)

UK	Jun-17	Jun-18	Jun-19	Jun-20
HCHS Doctors - All Grades	64.5%	63.1%	59.4%	64.3%
Consultant	67.0%	68.0%	65.6%	69.7%
Associate Specialist	54.8%	62.5%	51.2%	48.1%
Specialty Doctor	40.7%	34.8%	30.8%	34.5%
Staff Grade	23.7%	31.3%	15.8%	12.7%
Specialty Registrar	56.6%	59.5%	55.4%	58.6%
Core Training	55.5%	48.3%	41.8%	46.6%
Foundation Doctor Year 2	45.5%	34.8%	29.4%	28.2%
Foundation Doctor Year 1	80.0%	79.0%	81.0%	83.0%
Hospital Practitioner / Clinical Assistant	88.1%	82.7%	85.6%	88.7%
Other and Local HCHS Doctor Grades	82.6%	64.8%	82.7%	86.4%

Figure 6.16

EU+EEA	Jun-17	Jun-18	Jun-19	Jun-20
HCHS Doctors - All Grades	11.8%	10.4%	9.8%	8.2%
Consultant	17.3%	15.2%	15.6%	13.7%

Associate Specialist	7.1%	17.5%	12.2%	9.3%
Specialty Doctor	15.9%	12.4%	12.3%	9.2%
Staff Grade	23.7%	18.8%	10.5%	25.5%
Specialty Registrar	14.5%	11.4%	10.6%	9.3%
Core Training	10.2%	12.3%	9.8%	8.2%
Foundation Doctor Year 2	16.3%	16.7%	11.0%	9.2%
Foundation Doctor Year 1	6.9%	6.4%	6.6%	5.9%
Hospital Practitioner / Clinical Assistant	3.9%	1.9%	4.0%	3.0%
Other and Local HCHS Doctor Grades	4.8%	3.9%	4.6%	3.1%

Figure 6.17

Rest of World	Jun-17	Jun-18	Jun-19	Jun-20
HCHS Doctors - All Grades	19.9%	21.4%	27.7%	25.3%
Consultant	11.4%	12.3%	15.8%	14.1%
Associate Specialist	28.6%	15.0%	19.5%	37.0%
Specialty Doctor	39.5%	46.1%	51.8%	52.3%
Staff Grade	44.7%	50.0%	73.7%	52.7%
Specialty Registrar	25.5%	25.7%	32.1%	31.1%
Core Training	30.3%	33.9%	44.6%	42.6%
Foundation Doctor Year 2	37.2%	42.2%	56.4%	60.3%
Foundation Doctor Year 1	8.8%	8.9%	9.2%	8.7%
Hospital Practitioner / Clinical Assistant	2.7%	3.2%	4.0%	4.9%
Other and Local HCHS Doctor Grades	6.6%	9.5%	6.4%	4.3%

6.46 DHSC does not expect the UK's exit from the EU to have a significant short-term impact on availability of doctors in the NHS. In the longer term there may be a reduction in the in-flow of staff from the EEA, due to new immigrations requirements and economic uncertainty. The Department has taken steps to mitigate against this, for instance by passing legislation that allows regulators to unilaterally accept qualifications from the EU after exit day.

6.47 We continue to monitor and analyse overall staffing levels across the NHS and Adult Social Care, and we’re working across Government to ensure there will continue to be sufficient staff to deliver the high-quality services on which patients rely.

6.48 From January 2021 the UK introduced a new points-based immigration system to replace free movement from the EU. This system is global, meaning overseas recruits face the same immigration control whether they come from the EU or further afield. The new system has several significant changes, including a

reduction to the salary threshold, from £30,000 to £25,600 (or the appropriate national NHS pay scale for the job) and a reduction in the skill threshold from RQF-6 (a degree-level role) to RQF-3 (an A-Level equivalent role).

Agency Staff

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

6.50 NHSEI and DHSC are supporting Trusts to make greater use of bank staff as an alternative to using agency staff for flexible staffing. An early focus of this work included a pilot programme aimed at improving Trusts' bank offers by providing bank staff with the ability to self-book shifts; allowing them to see those shifts alongside their normal rota using integrated technology; and providing prompter payment and pension flexibility for those shifts. This programme was paused due to COVID-19 but is currently being picked up by colleagues in the Department together with NHSEI. A new launch date is pending.

6.51 NHSEI have committed in the Interim People Plan, to increase flexible working opportunities to make the NHS a better place to work. We see the development of better staff banks as a key element of improving flexible working in the NHS.

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

6.53 Trusts also recognise the importance of attracting staff to work on cost effective banks, in addition to developing the substantive offer, and have introduced many other initiatives including:

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

6.54 NHS Trust spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6bn to £3.6bn). Following the introduction of agency spend controls, expenditure on agency staffing has reduced to £2.38bn in 2019/2020.

6.55 Since April 2017 agency costs have consistently been below 5% of overall pay costs and have now fallen to 4.0%. The continued reduction in the proportion of agency staff costs to total pay bill is a significant achievement in view of the record levels of demand and the extreme pressure on the acute sector.

6.56 Agency shifts have increased by 0.5% from 2018/19 to 2019/20, however, the overall average price per shift decreased by 1.3% from 2018/19, resulting in an overall saving compared to 2018/19 of £19m (0.8%). We also saw a reduction in agency shifts during the first wave of COVID-19.

6.57 According to our anecdotal evidence, doctors who work through agencies cite flexibility, relatively higher pay, and a smaller admin burden as the main reasons for doing so. This is opposed to those who choose to work substantive shifts, who tend to cite involvement in teaching and research; learning and development; and predictable pay and hours.

Staff Engagement and Wellbeing

6.58 The NHS Staff Survey gives useful information about many aspects of staff experience at work. The following sections highlight some headlines. Published NHS staff survey results for 2015-2019 is available at: http://www.nhsstaffsurveyresults.com/

Engagement

6.59 The "Staff Engagement" score in the Staff Survey is based on responses to three sections of the survey covering staff motivation & satisfaction, involvement and willingness to be an advocate for the service. This score can then be used to compare between different organisations.

6.60 The staff engagement index amongst medical staff has remained the same since 2015.

Satisfaction with Pay

6.61 Medical staff satisfaction with level of pay remains positive on balance. From 2016 to 2018 satisfaction fell slightly, however satisfaction with pay has risen 4.4 percentage points on last year to 55% in 2019. Satisfaction with pay has increased since last year amongst Consultants, Junior Doctors, and Other

Doctors, however the highest level of satisfaction as well as the largest increase is seen with Consultants.

Flexible Working & Additional Hours

6.62 Overall, medical staff working any number of additional paid hours (in the average week) has remained fairly steady since 2015, although the percentage working additional paid hours has been increasing since 2016.

Proportion experiencing Bullying or Harassment

6.63 Staff experiencing bullying & harassment in the workplace remains consistent with last year after having fallen slightly since 2017. There is no significant variation amongst the medical grades.

Recommending as a Place of Work

6.64 Staff who recommend their organisation as a place of work has remained fairly consistent since 2015, showing minor increases year on year. This year, the percentage of Consultants and Other Doctors who would recommend their organisation as a place of work has slightly increased, however recommendation amongst Junior Doctors remains level with last year.

6.65 Additionally, as part of 'friends and family test' all staff are asked two questions: would they recommend the care at the organisation to friends and family, and would they recommend the organisation to friends and family as a place to work. Results are published monthly by NHSEI.

6.66 Q1 2019-2020 (1st April – 30th June) results demonstrate that staff remain favourable about their organisation as a place of both work and care, with results remaining in line with Q1 2018-2019 and having stayed fairly consistent since 2015. When asked if they would recommend the care at the organisation, 81% of staff would recommend the care whilst 6% would not recommend it. When asked if they would recommend the organisation as a place to work, 66% would recommend it whilst 16% would not recommend it.

6.67 Published Staff Friends and Family Test data is available at: https://www.england.nhs.uk/fft/staff-fft/data/

Staff Health and Wellbeing

6.68 The staff survey score for health and wellbeing for all medical staff has remained level with last year, after having shown a decrease since 2016. Consultants score highest, while Doctors in Training score lowest.

Sickness Absence

6.69 For the 12-months to the end of March 2020 the absence rate for medical staff was 1.49% which compares to 4.21% across all staff groups. Their rate of sickness absence has been very stable over the past decade. Rates have always been between 1.16% and 1.49%. While the rate has increased in recent years this may reflect improved data quality.

6.70 Data on Sickness Absence for Doctors comes from the ESR and is published by NHS Digital. It is presented below.

Figure 6.18- Annual Sickness Rate for Medical Staff (2009 – 2020)

Year	Sickness Absence Rate
2009-10	1.21%
2010-11	1.16%
2011-12	1.19%
2012-13	1.25%
2013-14	1.22%
2014-15	1.21%
2015-16	1.23%
2016-17	1.25%
2017-18	1.29%
2018-19	1.29%
2019-20	1.49%

Source: NHS Digital Workforce Statistics

6.71 For the last three years data are also available by career grade. In general, there have been only small changes in rates over that time. Where changes have been larger (e.g. the Hospital Practitioner grade) these tend to be the staff groups with the smallest staff numbers.

Figure 6.19- Average Sickness Absence Rate by Staff Group (2016 - 2020)

Career Grade	2016-17	2017-18	2018-19	2019-20
HCHS doctors	1.25%	1.29%	1.29%	1.49%
Consultant	1.18%	1.24%	1.24%	1.40%
Associate Specialist	2.38%	2.88%	2.50%	2.79%
Specialty Doctor	2.08%	2.11%	2.05%	2.37%
Staff Grade	4.44%	3.37%	3.47%	1.97%
Specialty Registrar	1.15%	1.19%	1.20%	1.44%
Core Training	1.14%	1.09%	1.10%	1.38%
Foundation Doctor Year 2	0.98%	0.99%	1.12%	1.22%
Foundation Doctor Year 1	0.95%	0.97%	1.02%	1.25%
Hospital Practitioner / Clinical Assistant	1.52%	1.38%	2.65%	2.69%
Other and Local HCHS Doctor Grades	1.99%	2.20%	2.05%	2.25%

Source: NHS Digital Workforce Statistics

Figure 6.20- Medical Sickness Absence by Region 2018-19 to 2019-20

Region	2018-19	2019-20
England	1.3%	1.5%
London	0.9%	1.1%
South West of England	1.4%	1.6%
South East of England	1.2%	1.4%
Midlands	1.5%	1.6%
East of England	1.3%	1.5%
North West	1.5%	1.7%
North East and Yorkshire	1.5%	1.6%
Special Health Authorities and other statutory bodies	1.5%	1.5%

Source: NHS Digital Sickness Absence Statistics

6.72 The DDRB has previously requested more granular information on sickness absence for Medical Staff - including the length and reasons for absence. After consultation with NHS Digital these data are not currently available as after examining the data the quality and completeness of the data is not sufficiently robust to provide reliable insight to the Review Bodies. In addition, data on "length of absence" is not reliable as ESR only measures the time between the start and end of penniform lost.

COVID-19 related sickness absence

6.73 NHS Digital data is available to describe trends in sickness absence during the initial response period to the pandemic. During this period, additional coding was made available on ESR for organisations to record against. However, organisations were not mandated as to how the codes should be used so there are likely to be different patterns of use.

6.74 NHS Digital as part of their publication NHS Sickness Absence Rates August 2020 that:

- "Over 60,800 full time equivalent days (from a total of 1,488,000 FTE days lost) were lost due to COVID-19 related sickness absence in August 2020, equating to 4.1% of all absences recorded, compared to 5.7% in July 2020.

- During the March to July 2020 period, overall sickness absence rates peaked nationally at 6.2% in April. However, the equivalent rate for COVID-19 reported absences was 1.9%."

Figure 6.21a- Monthly Total Sickness Absence Rates by Staff Group

Staff Group	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
All staff	5.3%	6.2%	4.7%	4.0%	3.9%	3.9%
Of which…. HCHS doctors	2.7%	3.0%	1.7%	1.4%	1.3%	1.1%
Of which…. Nurses & health visitors	5.7%	7.4%	5.6%	4.5%	4.3%	4.3%
Of which…. Midwives	5.9%	5.8%	4.4%	4.1%	4.2%	4.6%
Of which…. Ambulance staff	6.0%	7.0%	4.9%	4.3%	4.4%	4.8%
Of which…. Scientific, therapeutic & technical staff	4.1%	4.1%	3.1%	2.8%	2.7%	2.6%
Of which…. Support to clinical staff	6.9%	8.1%	6.4%	5.5%	5.2%	5.4%
Of which…. NHS infrastructure support	4.5%	4.4%	3.5%	3.2%	3.1%	3.1%
Of which…. Other staff or those with unknown classification	4.0%	4.0%	3.2%	2.7%	2.9%	2.7%

Figure 6.21b- Monthly COVID-19 Related Sickness Absence Rates by Staff Group

Staff Group	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
All staff	0.8%	1.9%	0.9%	0.4%	0.2%	0.2%
Of which…. HCHS doctors	1.0%	1.5%	0.5%	0.2%	0.1%	0.1%

Of which…. Nurses & health visitors	1.0%	2.7%	1.3%	0.5%	0.3%	0.2%
Of which…. Midwives	1.0%	1.6%	0.6%	0.3%	0.2%	0.2%
Of which…. Ambulance staff	0.7%	1.7%	1.1%	0.6%	0.3%	0.3%
Of which…. Scientific, therapeutic & technical staff	0.8%	1.3%	0.6%	0.3%	0.2%	0.1%
Of which…. Support to clinical staff	0.9%	2.2%	1.1%	0.5%	0.3%	0.2%
Of which…. NHS infrastructure support	0.5%	0.9%	0.4%	0.2%	0.1%	0.1%
Of which…. Other staff or those with unknown classification	0.6%	1.2%	0.5%	0.1%	0.1%	0.1%

Source: NHS Digital Monthly Sickness Absence Statistics Publication

6.75 NHS Digital publish further tables and information at the following link https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/august-2020

Workforce Planning Response

6.76 In July 2020, HEE published the Future Doctor report. This sets out the reforms needed in education and training to equip doctors with the skills that the future NHS needs and which have been much in demand during the COVID-19 response so far. Enhanced generalist skills for doctors are central to these reforms. Over 2020/21 HEE has been developing the educational offer for generalist training and working with local systems to develop the leadership and infrastructure required to deliver it.

6.77 There is wide recognition of the need for a nationally recognised critical care qualification which is open to different professions. HEE will work with professional and regulatory bodies to provide this to offer continuing professional development opportunities for people wishing to specialise in this area. HEE is also working with the medical Royal Colleges and regulators to ensure that competencies gained by medical trainees while working in other roles during COVID-19 can be recognised and count towards training.

6.78 To tackle shortages in specialties, in 2020/21 HEE is investing in an extra 250 foundation year 2 posts, to enable the doctors filling them to grow the pipeline into psychiatry, general practice and other priority areas – notably cancer, including clinical radiology, oncology and histopathology.

6.79 In March 201, HEE established the Enhancing Junior Doctors Working Lives (EJDWL) programme in partnership with the BMA Junior Doctors' Committee,

NHS Employers, the GMC, the Academy of Medical Royal Colleges. Initiatives include:

- Increasing flexibility in training
- Managing deployment concerns
- Enabling trainees with special circumstances (e.g. caring responsibilities) to be pre-allocated to placements near to where they live
- Supported return for doctors who have taken out of training for caring, illness or parental leave.

6.80 HEE have already delivered much of the programme, including an investment of £10m pa to support doctors return to training, improving the quality of educational, clinical and workplace supervision (working with NHSE/I and CQC). HEE now need to ensure ongoing delivery and monitor the impact. The programme of work will lead to improvements in recruitment and retention; well-being; morale and experience; productivity and efficiency.

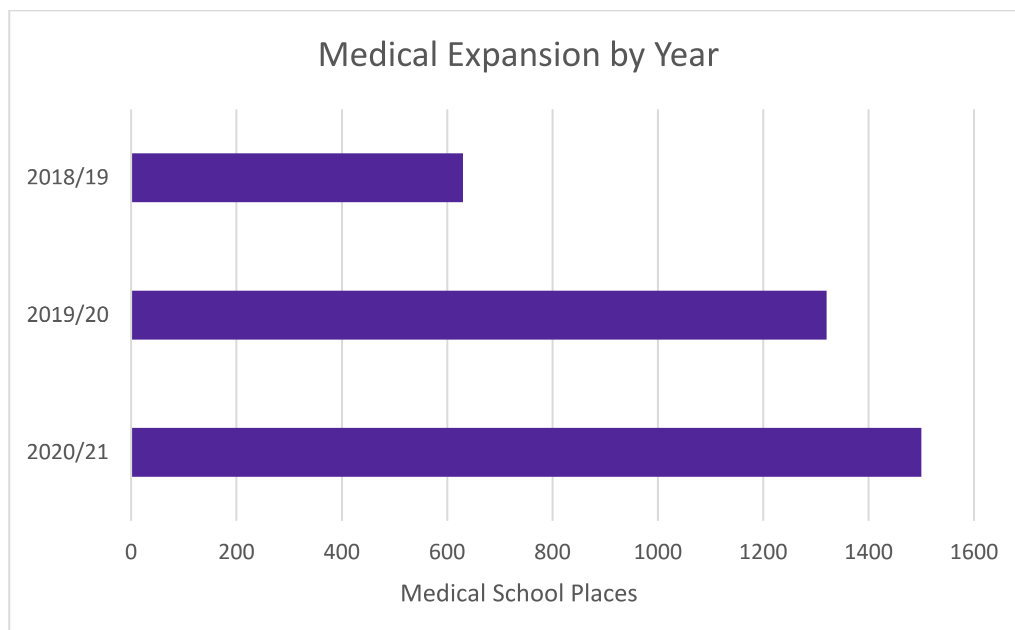
6.81 During the rest of 2020/21, HEE will continue to increase the flexibility of training for junior doctors, such as less than full-time training, out-of-programme pauses and opportunities to develop portfolio careers. Full roll-out will happen by 2022/23, so that all junior doctors will be able to apply for flexibility in their chosen training programme.

6.82 The Department and partners are undertaking a range of actions to increase and support the GP workforce – this is covered in more detail in Chapter 10.

6.83 The Government has increased the number of funded medical school places in England by 1,500 over the last 3 years – a 25% increase. As part of this record expansion, five new medical schools were opened, in Lincoln, Canterbury, Sunderland, Lancashire and Chelmsford. This will ensure an increase in the supply of doctors in coming years.

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

Figure 6.22- Number of new Medical Training places by Academic Year



Source: Medical Schools Council

Note: Due to COVID-19 situation and the subsequent changes in A-level grading, we expect a higher intake of medical students in the academic year 2020/21 than originally planned.

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

6.86 It will mean that more of our doctors will be UK trained, reduce reliance on expensive medical agency staff, and ensure the money is better spent on treating more patients.

Skill Mix

6.87 The Department continues to work with NHSEI and HEE to consider how skill mix changes can help address workforce shortages.

6.88 The Department is working with its ALBs to address areas of workforce shortage and to consider where appropriate skill mix interventions may be needed.

6.89 As set out above, we will need to enhance generalist skills in the medical workforce to complement existing specialism, to meet the complex and evolving

needs of our population. There will also be further work to enable trainees to switch specialities without re-starting training, as well work to accelerate the development of credentialing.

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

- Physician Associate (PA)
- Anaesthesia Associate (AA)
- Surgical care Practitioner (SCP)
- Advanced Critical Care Practitioner (ACCP)

6.91 The increased use of MAP roles could contribute to an improved skill mix and facilitate high quality patient care in both Primary and Secondary Care settings.

6.92 The further growth of this profession is a key part of the Government's policy to develop a more effective, strong and expanding General Practice to meet future need. Secretary of State announced in October 2018 the intention to introduce statutory regulation for PAs and AAs. On 29 July 2019 the GMC confirmed that they were content to take on the regulation of these roles and work is currently underway to take this forward.

6.93 PAs and AAs train and work to a medical or surgical model and work closely with and/or are supervised by medical practitioners. Regulation by the GMC will give the regulator responsibility and oversight of all three professions, allowing it to take a holistic approach to the education, training and standards of the roles. Regulation is a significant step towards embedding PAs and AAs in the multi-disciplinary healthcare workforce.

6.94 The further growth of the PA profession is a key part of the Government's policy to develop a more effective, strong and expanding General Practice to meet future need.

6.95 Since 2014, the PA workforce has grown considerably. At present, there are 36 institutions across the UK running courses leading to the award of a PA qualification. As of May 2020, around 1,700 qualified PAs are registered on the Faculty of Physician Associates (FPA) voluntary register, representing around

between 80-90% of all qualified PAs. The number of PAs is projected to grow to around 6,000 by the end of 2023 (as set out in the Interim NHS People Plan).

7. Doctors and Dentists in Training

7.1 This chapter covers doctors and dentists in training in England. Since February 2020, all doctors and dentists in training in England in approved postgraduate training programmes under the auspices of HEE are covered by the 2016 Contract for Doctors and Dentists in Training. The 2016 contract, following agreement with the British Medical Association Junior Doctor Committee (BMA JDC) in 2019, is currently subject to a four year pay and contract reform deal.

7.2 The junior doctor workforce, consisting of the foundation programme and core and specialty training, makes up the largest proportion of the medical workforce in England (approximately 48%), with January 2020 workforce numbers showing just under 57,000 FTEs, although many within this group will be “trust grade” doctors on local contracts outside of an approved HEE postgraduate training programme. Between January 2014 and January 2020, the number of junior doctors (all grades) has increased by approximately 10.7%. Medical graduates becoming doctors and dentists in training make up the largest numbers of new joiners to the medical workforce.

7.3 Latest NHS Staff Survey results show junior doctor satisfaction with pay has increased on the previous year.

Working arrangements through COVID-19

7.4 In the face of the challenges presented by COVID-19, doctors and dentists in training have shown flexibility to deliver care in uncertain and rapidly changing circumstances.

7.5 Working arrangements through the pandemic have been largely managed through the provisions within the 2016 contract which pays for every hour worked (should additional hours be worked) and pays an additional supplement on top of basic salary for weekends worked, increasing as weekend frequency increases. We are aware some employers have also come to local agreements with their junior doctor workforce (for example around further premium rates of pay) where this has been agreed as necessary to provide the services required during the pandemic. Further detail of provisions is set out in Chapter 1.

Background to the 2016 contract

7.6 In our 2020/21 evidence to the DDRB we provided the in-depth background to the 2016 contract. This background can be found here.

7.7 Within last year's evidence we noted that the first junior doctors became employed on the 2016 arrangements in October 2016, and the Department estimated that approximately 4 in every 5 doctors and dentists in training in England were employed on the 2016 contract. Since then, following collective agreement with the BMA, all doctors on approved postgraduate training programmes have moved on to the 2016 arrangements. The previous national contractual arrangements for doctors in training in England, otherwise known as the Terms and Conditions of Service - NHS Medical and Dental Staff (England) 2002, are now closed for doctors and dentists in training in England. The previous 2002 arrangements may still be being used locally by employers for "trust grade" roles, i.e. local posts not on a nationally agreed contract. It is also important to note that doctors and dentists in training in the devolved administrations of Scotland, Wales, and Northern Ireland are still employed under the 2002 arrangements.

Review of the 2016 contract and collective agreement

7.8 The 2021/22 pay year will be the third year of the four-year agreement reached with the BMA JDC in 2019, covering 2019/20, 2020/21, 2021/22, and 2022/23.

7.9 Our 2020/21 evidence highlighted that the ACAS agreement reached in 2016 had committed to a review of the 2016 terms and conditions of service, and that the contract review began in 2018 and was completed in 2019. This in turn resulted in the five partnership sub-groups set up by the review each producing a final report for consideration by the Joint Negotiating Committee for Juniors (JNC(J)), the partnership forum between the BMA JDC and NHS Employers.

7.10 We also noted that the recommendations contained within these final reports provided the basis for formal negotiations to commence between the BMA JDC and NHS Employers, and that these negotiations culminated in the framework agreement which was published in June 2019.

7.11 Part of the framework agreement was the four year pay and contract reform deal for doctors and dentists in training. The full details of which can be found in the framework agreement document. A brief overview was provided in our 2020/21 evidence to the DDRB.

7.12 This framework agreement officially ended the dispute with the JDC that had been ongoing since 2016 and made the 2016 contract a national collective agreement, subject to collective bargaining. Placing the 2016 contract on an equal footing with other national employment contracts in the NHS, where the contract is maintained through partnership working between the relevant employer side and staff side organisations (in this case through the JNC(J)).

7.13 Our 2020/21 evidence to the Review Body also set out non-contractual issues that were separate to the four-year deal, these included a £10 million provision to NHS Trusts to be spent locally by the Guardian of Safe Working in each Trust in agreement with junior doctors.

Implementation of the four-year deal

7.14 Our evidence last year noted that since the framework agreement was concluded, NHS Employers have been working with the BMA JDC to translate the provisions agreed in the framework agreement into the terms and conditions of service. This gives the provisions contractual force and is still ongoing.

7.15 As pay awards were agreed for all four years of the agreement, increases to pay points were able to take place in April 2020, and salaries will again increase in April 2021. Pay increases are set at 2% per annum, meaning as a result of the deal all existing nodal point values will have increased by a cumulative 8.2% by the deals completion.

7.16 In October 2020, nodal point 5 was also introduced in line with the terms agreed in the framework agreement.

7.17 All doctors and dentists in training in England are now employed under the 2016 arrangements, as a result of the collective agreement reached with the BMA JDC. We are aware that there may still be local grades, commonly referred to as trust grade doctors, employed under the previous 2002 arrangements in England. Trusts are of course free to employ staff outside of national arrangements on local contracts if they wish to do so should this serve the needs of their services and patients, and so long as they are compliant with employment law.

Approach to the review body round 2021/22

7.18 As a result of the four-year agreement, our remit letter to the review body set out that we are not looking for a pay recommendation for doctors and dentists in training for the 2021/22 round, but as usual we would welcome comments and observations on the evidence you receive from DHSC and other parties on this group.

7.19 Pay uplifts for doctors and dentists in training have been agreed at 2% per annum for the years 2019/20, 2020/21, 2021/22, and 2022/23. Figure 7.1 below shows the basic pay values for the 2016 contract over the course of the four-year agreement.

Figure 7.1- 2016 terms and conditions of service - basic salaries 2018/19 - 2022/23

Nodal point / grade	2018/19 (£)	2019/20 (£)	2020/21 (£)	2021/22 (£)	2022/23 (£)
Nodal point 1 / FY1	27,146	27,689	28,243	28,808	29,384
Nodal point 2 / FY2	31,442	32,050	32,691	33,345	34,012
Nodal point 3 / ST/CT 1-2	37,191	37,935	38,694	39,467	40,257
Nodal point 4 / CT3/ST3-5	47,132	£48,075	49,036	50,017	51,017
Nodal point 5 / ST6-8	N/A	N/A	From October 2020: £52,036	From October 2021: £56,077	58,398

7.20 It is important to note that the 2% headline uplift to salaries does not represent the total investment over the four-year period. As set out in Chapter 7 of last years' evidence to the Review Body, a number of other pay and non-pay improvements were agreed for the 2016 contract.

7.21 One such example, is the introduction of Nodal point 5, which, as detailed above, was implemented in October 2020.

7.22 These improvements represent an investment of approximately £90 million on top of the investment into basic pay awards. Profiled over the course of the deal, the total investment in the contract was equivalent to approximately 2.3% in 2019/20, and approximately 3% in 2020/21, and will be approximately 3% in 2021/22 and 2022/23.

7.23 This deal was not just about pay awards. Important contract reforms were made, both in 2016 and 2019, such as changes to safety and rest limits and improved support for those training LTFT, to modernise and ensure the national contract is fit for the future.

Exception Reporting

7.24 The review body has previously asked for any further information or insight on the exception reporting system introduced as part of the 2016 contract. The exception reporting system is unique to doctors in training in the NHS and provides them with a bespoke system to raise concerns either about their working hours or training, paired with a formal system to review, escalate, and resolve issues where

they are raised. The exception reporting system is unique to doctors in training in the NHS and provides them with a bespoke system to raise concerns either about their working hours or training, paired with a formal system to review, escalate, and resolve issues where they are raised.

7.25 The system is also supported by an independent guardian of safe working, a post created specifically for the 2016 contract, to oversee safe working hours and act as arbiter in difficult cases.

7.26 The issues that were reported in evidence to the review body for the 2019/20 round did not on the face of it appear to find any issues with the exception reporting system in itself, i.e. the content of the terms and conditions document, but did appear to point to cultural issues. We look forward to NHS Employers observations in this area.

Geographic and Specialty Specific Recruitment and Retention, and Flexible Pay Premia (FPP)

7.27 The Review Body has previously asked the Department for more information on geographic and specialty specific shortages for doctors and dentists in training. Clearly this is an important area, as shortages in regions and specialties of doctors in training invariably lead through to shortages in career grade doctors in these areas, such as consultants and general practitioners. The Review Body has also asked for any insight into the efficacy of FPP in the 2016 contract for doctors and dentists in training.

7.28 It is important the Department's evidence in this area is read in conjunction with the evidence from HEE who retain responsibility for recruitment to training posts. Some of the general themes around recruitment and retention are also described in Chapter 6.

7.29 Shortages and vacancies in the doctor workforce are varied. They vary by a combination of geographical region, speciality, and doctor grade (level of training/skill/contract type). We present a range of data as evidence of the current shortfalls.

7.30 As referenced in Chapter 6 in many cases the current workforce demand is met by international recruitment (IR). There are uncertainties in the reliability of IR as a source of future supply as the international labour market may change. Medical school numbers have been increased by 25% over 2018-20 in order to boost domestic supply. The boost will impact the workforce from the mid to late 2020s due to the long lag of doctor education and training.

7.31 Core/specialty training (CT/ST) is the main route to specialisation after doctors complete the Foundation Programme. There are unfilled training posts in some specialties. There are significantly more training posts available in England than doctors from the domestic pipeline, there were 7,682 available posts at July 2020 (source HEE online, Specialty recruitment: round 1 - acceptance and fill rate for august 2020 start). The number of available posts varies by year, it is primarily dependent on the number of trainees completing training in the past year.

7.32 Most domestic trainees enter core/specialty training within three years of completing Foundation Training. Approximately 10% of the available posts are filled by existing trainees who repeat a training level, or switch specialties. Around a quarter of new trainees are doctors with non-UK primary medical qualifications.

7.33 FPPs are a form of recruitment and retention payment unique to the 2016 contract, designed to support recruitment to certain "hard to fill" specialties and training programmes, as well as to ensure certain career pathways, such as academia and dual qualification in oral and maxillofacial surgery, are not disincentivised due to their earnings potential or training requirements.

7.34 The 2016 contract introduced FPPs in several specialties including General Practice, Psychiatry, Emergency Medicine, and additionally for academia. Subsequently FPPs were introduced in Oral and Maxillofacial Surgery and Histopathology. FPPs are worth between £2,700 and £8,800 per year under specific conditions. Full details on the value of these payments and who is eligible to receive them are available via the latest medical and dental pay circulars available from NHS Employers.

7.35 The GP specialty training FPP under the 2016 arrangements was designed to ensure there was not a pay disincentive to enter GP specialty training when compared to other training programmes in a similar way to the "GP Supplement" under the 2002 contract. This financial disincentive would occur as the previous banding system placed a significant emphasis on hours worked and out of hours working patterns, which occur less frequently in general practice placements when compared to hospital settings.

7.36 In addition to the FPP payment GP trainees may also be able to access the Targeted Enhanced Recruitment Scheme (TERS)[viii] which offers GP trainees a one-off payment of £20k to commit to working in areas that have been hard to recruit in for the past three years. This scheme is led by HEE and is separate to the 2016 contract.

Training Fill Rates

7.37 The latest available training post fill rate data for a complete recruitment year is for trainees starting in 2019/20 which shows a 95% fill rate across all specialties for posts across all years of training.

7.38 While the total fill rate was 95% across all training posts there were some differences at specialty level including Psychiatry, Paediatrics and Geriatric Medicine achieving fill rates of below 90% while also having at least 50 unfilled training places. General Practice achieved an “overfill” with more recruits than training posts.

7.39 The data includes posts available at all levels of training. Typically, only core/specialty level 1 (CT/ST1) data is considered to give a view of training vacancies because if the level 1 posts are filled, we would expect the higher levels to have a robust supply in later years. However, this risks masking current shortages at higher training grades where posts may also become increasingly important in providing service.

7.40 The trend is for improvements in fill rates by region. The North East and Yorkshire remain underfilled (94%) compared to other regions. Some regions are reported as over-filled. This all-specialty view likely masks more pronounced regional issues at a specialty level.

7.41 Recruitment data for all trainees starting in 2020/21 is not yet available. HEE have published a comparison of the 2020 recruitment at the same stage in previous years. Total fill rates in 2019 and 2020 are much improved on 2018 at this stage of the recruitment year. Core psychiatry training has 99.3% fill in 2020 compared to 79% in 2018.

FPP Efficacy & Future Planning

7.42 As we have previously noted in our Review Body evidence, pay is not the only factor in influencing choice of specialty. A whole system perspective is required in order to ensure appropriate recruitment and supply to all specialties, as part of the workforce strategy.

7.43 Pay and non-pay related factors attract trainees to specialties and regions. These are very important to consider when assessing the use of financial incentives. Doctors are historically attracted to working in areas with high population density and wider case mix (even though cost of living may be higher).We understand that doctors are more likely to move to areas they have lived before, therefore medical school places have been better distributed to meet the future needs for doctors by region.

7.44 There are still regions and specialties with unfilled posts. The apparent over-fill in some areas may have masked the scale of underfill in others. In achieving 100% fill rates it is right to examine the cost effectiveness of FPPs as well as schemes like TERS to ensure they are appropriate for use in each area.

7.45 Some historically attractive specialties that filled their training posts have recently seen lower fill rates, such as paediatrics or genitourinary medicine. We need to understand more about the reasons for this.

7.46 The areas assisted by TERS GP training recruitment have achieved 99.6% recruitment. It would appear the scheme was a strong success in increasing recruitment. It is hard to give details of the success of the scheme without understanding the driving factors for the trainees who accepted these posts and their career choices had the scheme not been available.

7.47 HEE have recently led an analysis of geographical distribution of speciality training posts to better align with the needs of the population and reduce health inequalities.

7.48 If training posts are re-distributed and more are in areas that are hard to recruit to, there is the potential for greater need for pay incentives or alternates to pay incentives to ensure vacancies are filled.

7.49 HEE data shows improvement in fill rates of specialties that have an FPP between 2018 and 2020, although there may be other drivers that are contributing to the improvement in fill rates other than the FPP's.

7.50 It is likely the influence on fill rates would be achieved lower down the training pipeline. The 25% expansion in medical school intake over 2018-20 prioritised the allocation of places to areas with a shortage of doctors, or in certain specialties. In the longer term this should improve fill rates across all geographies and specialities.

7.51 The geographical mobility of Doctors is more likely in the earlier grades where the age of Doctors is younger. Therefore, any interventions, pay or non-pay, would likely be best targeted in this area. HEE's distribution of speciality training programme is considering methods to guide the distribution of training posts into alignment with population health requirements. The redistribution will be a medium to long term process with a focus on service stability, patient safety and educational excellence; initially focused on specialties aligned to the Long-Term Plan priorities.

7.52 Currently there is no formal method or review set up to assess the effectiveness of these RRP's or potential to create unexpected consequences such as shortages in places where supply is responsive to changes in pay in neighbouring locations.

GP specialty trainee FPP

7.53 Under previous arrangements, GP trainees were paid a 45% supplement to their salary whilst in the general practice part of their training placement. This roughly mirrored the average pay banding for hospital-based training posts.

7.54 Upon introducing the 2016 contract there was a desire to ensure that the rationale behind the GP supplement, to maintain earnings levels for general practice placements and therefore not create a recruitment disincentive, was to continue. In setting the GP FPP consideration was given to the overall increase in salaries (and therefore the increase in fixed pay as opposed to variable pay) in the new contract, as well as the new system of pay for out of hours, weekends, and on-call.

7.55 As covered further up in this chapter, HEE have also introduced recruitment incentives for general practice.

7.56 The increase in the value of FPPs was agreed as part of the four year pay and contract reform deal for doctors and dentists in training, meaning FPP values increase at the same rate as basic pay, at a 2% level. However, following the conclusion of the four-year deal, it will be appropriate to ensure that the GP FPP remains at the level which is appropriate in aiding wider priorities around GP recruitment.

8. Consultants

8.1 As senior leaders of multidisciplinary health-care teams, consultants provide clinical leadership and hold overall responsibility for the patients under their care. Consultants are responsible for taking forward changes needed to deliver system priorities. Retaining and maximising the contribution of our highly skilled clinical workforce is imperative to the delivery of high-quality care.

8.2 Between January 2014 and January 2020 the number of consultants has increased by 23%, with just under 49,500 consultants in January 2020. Less than 38% of consultants are female, compared to 45.5% of the hospital medical workforce as a whole. Around 20% of consultants hold a non-UK nationality, which is lower than other staff groups (29% for Associate Specialists and 48% for Specialty Doctors). The proportion of consultants with a non-UK nationality has remained stable over the last four years.

8.3 In 2020 the government accepted the DDRB's recommendations and uplifted pay for consultants by 2.8%. The award was worth between £2200 and £3000 for consultants. As recommended by the DDRB, the government did not uplift the value of local and national CEAs.

8.4 As the 2003 consultant contract retains incremental pay progression, consultants benefit from both incremental and cost of living increases to pay. So, for example, an individual who started their consultant career in 2010/11 on a starting salary of £74,504 would be earning a basic salary of £98,477 in 2020/21. This represents an increase in basic pay of 32% over 10 years. This does not include additional earnings consultant have access to, such as Additional Programmed Activities, CEAs and management allowances which make up a significant proportion of earnings for consultants.

8.5 The results of the 2019 NHS Staff Survey, published in February 2020 showed that consultants were more satisfied with pay than any other staff group, with the rate showing an increase for the first time in two years.

8.6 In 2019/20 one of the key concerns for consultants was around the impact of pension tax. To address this, the Chancellor announced changes to the annual allowance taper thresholds in the March 2020 budget. We estimate that this will take up to 98% of NHS consultants outside the scope of the taper based on their NHS income. This issue is covered in more detail in Chapter 4.

Working arrangements through COVID-19

8.7 For consultants, working arrangements through the pandemic have been largely managed through the provisions within the 2003 contract which allows for appropriate local arrangements to be agreed, for example, for those working a significant proportion of hours in premium time or excessive unpredictable emergency work, doctors who are required to be resident on-call. This has enabled employers to maintain a comprehensive service provision focused on meeting their most pressing needs, whilst ensuring that doctors are paid for additional hours at appropriate rates. Further detail of these provisions is set out in Chapter 1.

Contract reform

8.8 Whilst there remains a strong case for reform of the consultant contract to bring about modernised terms and conditions which attract and retain staff and support service requirements, this year has not afforded to opportunity to focus on this due to the priorities of responding to the pandemic.

8.9 The priorities for reform of the consultant contract largely remain as have been set out in our previous evidence to the DDRB. The pandemic has shone a light on some other contractual elements which may benefit from reform in the future, such as regular out of hours and on-call working.

8.10 Previously, plans to reform the contract did not progress due to concerns from the BMA about the level of funding offered to support this. The realities of the current fiscal climate may limit any potential for investment into contract reform in the short term. In this fiscal context, we may wish to jointly explore with employers and trade unions whether there are any improvements to the contract which could be agreed, including to support some recommendations from the Gender Pay Gap in Medicine Review (see Chapter 3). We continue to engage positively with the trade unions and welcome open discussions on what we may be able to achieve.

Local Clinical Excellence Awards

8.11 In April 2020 NHS Employers, the BMA and HCSA jointly approached the government to request approval to cancel the LCEA round in 2020/21 to focus on the priority of responding to the pandemic. It was agreed that, rather than run a competitive round, as a one-off response to exceptional circumstance the funds should be distributed equally amongst eligible consultants, in order to relieve the burden on doctors and employers.

8.12 The parties had also been planning to engage in negotiations to reform the LCEA scheme, with successor arrangements to be introduced from April 2021. However, it was suggested that as the capacity to engage in negotiations would likely be reduced on all sides, it would be pragmatic to extend the interim arrangements for a further year to the end of March 2022. This extension was approved.

8.13 Towards the end of 2020 the negotiating parties have begun to make some initial progress to negotiate a successor to the current LCEA scheme. The talks are at a relatively early stage and have focused largely on the principles the parties wish to pursue. The key priorities for the Department will be to diversify the distribution of awards and ensure they motivate consultants to achieve the highest levels of performance.

8.14 The DDRB highlighted in the 2020 report concerns about the equity and effectiveness of CEAs in general. The DDRB expressed concerns that CEAs do not necessarily reward all those who are currently contributing the most towards the delivery of high-quality services and patient care and that they are potentially a factor exacerbating pay inequalities. We take these concerns seriously and must ensure that our plans for reform effectively tackle these issues.

8.15 The Department's planned consultation on reform of the national CEA scheme was also delayed due to the coronavirus pandemic. The intention is now to launch the consultation in early 2021 and we will update the DDRB on the outcomes in due course.

8.16 The Advisory Committee on Clinical Excellence Awards (ACCEA) have provided evidence on the review of national CEAs which is found at Annex 3.

9. Specialty Doctors and Associate Specialist contracts

9.1 SAS doctors are a diverse group of staff comprising of specialty doctors, and doctors from the closed grades of associate specialist, staff grade, hospital practitioner and senior clinical medical officer. All SAS doctors are expected to have at least four years' postgraduate training, with two of those years in a relevant specialty.

9.2 There are currently approximately 10,000 SAS doctors, up approximately 30% since 2014, a higher rate of growth than seen for consultants over the corresponding period (23%). The number of Associate Specialists has declined by 30% over the same period. A decline in this group would be expected, given that the grade is closed to new entrants. The Specialty Doctor grade is made up of around 47% women and women make up almost 40% of the Associate Specialist grade, this compares to 37.5% for consultants. SAS doctors are more likely to hold a non-UK nationality (29% of Associate Specialists and 48% of Specialty Doctors), compared to consultants (20%). Significant proportions of Specialty Doctors (37%) and Associate Specialists (22%) are from outside of the EU (see Chapter 6 for information on international recruitment).

9.3 The starting salary for a Specialty Doctor, the only SAS grade currently open, is £41,158. SAS doctors currently benefit from incremental pay progression. A Specialty Doctor will reach the top of the pay scale (£76,751 in 2020/21) after 18 years in the grade

9.4 The results from the most recent NHS Staff Survey in 2019 showed a small increase in the rate of satisfaction with pay amongst SAS doctors, although the satisfaction rate remained lower than for consultants, who earn between £82,096 and £110,683, and junior doctors who earn between £28,243 and £52,036 but benefit from much faster progression to the top pay point.

9.5 Overall questions in the 2019 NHS Staff Survey relating to staff engagement generated a similar rate of satisfaction to the previous year amongst SAS doctors. However, the percentage of SAS doctors reporting that they had experienced bullying and harassment had increased. Chapter 3 provides further detail on the NHS Staff Survey.

9.6 In 2020 the government accepted the DDRB's recommendation to uplift pay for SAS doctors by 2.8%. This award was between £1100 and £2100 for speciality doctors and £1500 and £2600 for associate specialists.

Working arrangements through COVID-19

9.7 The standard national contractual provisions for specialty doctors and associate specialists set out the rates of pay for additional Programmed Activities, out of hours work and on-call rotas. This has supported employers and SAS doctors to effectively manage the changes to working patterns needed to respond to the pandemic. Further detail of these provisions is set out in Chapter 1.

Contract reform

9.8 As noted in the DDRB's 48th Report, negotiations on a multi-year pay and contract reform agreement for SAS doctors began in March 2020. The negotiations have taken place on a three-country basis covering England, Wales and Northern Ireland and reached a conclusion at the end of December 2020 resulting in a proposed multi year pay and contract reform agreement. The Framework Agreement can be located at the following link Framework Agreement SAS contract reform 2021 The negotiating parties have remained highly committed to driving forward the talks, despite the pressures of responding to the coronavirus pandemic. This is an indicator of how important it is to all parties to improve the working experiences of SAS doctors.

9.9 It is the intention for the new contractual arrangements, should they be approved by the required parties and successfully pass through a referendum process, to be introduced from April 2021. As the agreement offers current SAS doctors a choice as to whether to transfer to the new terms and conditions, it is the expectation that the DDRB will make recommendations for those SAS doctors who choose not to transfer.

9.10 The overarching aim of the reforms is to raise the profile and status of SAS roles to attract and retain SAS doctors and support a valued and engaged workforce to be productive and effective in delivering quality care to patients.

9.11 The joint proposals for collective agreement should help facilitate the recruitment, retention, motivation and engagement of SAS doctors and the provision of high-quality care. The reformed SAS contracts should offer an additional pathway for a career in medicine which supports flexible career options and continued development for doctors at all stages of their career.

9.12 The negotiated proposals include a separate reformed senior SAS grade, to replace the closed Associate Specialist grade. Opening a role which requires advanced clinical skills and experience will enable SAS doctors to operate at the top of their skill set. This should help to recruit, motivate and retain doctors and contribute to SAS grades being a positive and fulfilling career choice, offering

opportunities for career progression for senior, experienced doctors. The new role should also help employers to meet their local workforce demands.

9.13 It is the expectation that the proposals for modernised terms and conditions will support the safety and well-being of staff, with arrangements for work schedules which balance the need for flexibility with the need to maintain the capacity levels necessary to meet service requirements.

9.14 The negotiated proposals also deliver a new pay scale with a reduced number of pay points and faster progression to the top. Automatic incremental progression will be removed and replaced by a system which aligns pay progression more closely with the development of skills, competency and experience. It is intended that these combined changes will improve overall satisfaction with rates of pay for SAS doctors and will contribute towards addressing the gender and ethnicity pay gaps (see Chapter 3 for further information on the Gender Pay Gap in Medicine Review). The agreement sets the pay increases for each of the three years covered by the deal.

9.15 The equality implications of proposals have been carefully considered as they have developed, to ensure the most positive possible outcomes are achieved.

Section 4: General Medical Practitioners

The material in this section is intended to provide a background to ongoing developments in general practice. It sets out the context of the five-year GP contract, as the framework for the financial envelope and priorities for general practice, and the changes brought in to help general practice deal with the COVID-19 pandemic. Evidence and data are presented on the trends in General Medical Practitioner (GP) workforce and earnings and, finally, the actions government is taking to improve retention rates for GPs. Further evidence on general practitioners will be provided separately by NHSEI.

GPs are subject to a five-year investment agreement to 2024/25 between NHSEI and the BMA and therefore no pay recommendation is being sought for GP Contractors.

Salaried GP pay was agreed for 2019/20 only as part of this five-year agreement. You are invited to make recommendations on uplifts to the minimum and maximum of the salaried GP pay scales.

10. GP Fiscal and Workforce Context

Affordability

10.1 In January 2019, NHSEI and the BMA's General Practitioners Committee (GPC) agreed a five-year GP (General Medical Services) contract framework from 2019/20. Funding for the core practice contract is agreed and fixed for the next five years, providing funding clarity and certainty to practices. This settlement covers all aspects of publicly funded practice income and expenses including salaried GP pay.

10.2 The full package of GP contract reform seeks to expand the general practice workforce and secure two national workforce targets, transform the system to address workload and retention issues and better meet patient needs. As the GP contract has been set for five years, there is direct trade-off between pay and staff numbers which will inform decisions on the pay of salaried GPs by practices.

10.3 These factors, as well as the state-backed scheme for GP indemnity, which started in April 2019, provide important context to uplifts to the salaried GP pay range. Evidence detailing the challenging economic and fiscal context has been provided separately by HM Treasury. Recommendations should be made in line with resources available to practices under the multi-year contract deal and should take account of affordability in the wider economic context.

Investment and spend on general practice

10.4 In January 2019, the Government agreed to the most ambitious GP contract in recent years. The resulting five-year framework for GP contract reform seeks to implement the shared ambition of the Government and NHSEI, set out in the NHS LTP, to transform General Practice between 2019/20 and 2023/24. The framework is underpinned by a record level of additional investment in Primary and Community Care (an extra £4.5 billion by 2023/24). This commitment is a 'floor' level of nationally guaranteed investment, which local Clinical Commissioning Groups (CCGs) and Integrated Care Systems (ICSs) may supplement further. This investment guarantee is set to fund demand pressures, workforce expansion, and new services to meet relevant goals set out across the Plan.

10.5 Until 2018/19, NHS Digital provided a rolling five-year time series publication of Investment in General Practice for the whole of the UK. As shown in figure 10.1 compared to 2014/15, total spend on general practice services in England in

2018/19 (including reimbursement of drugs), increased by 22.4% in cash terms and 14.3% in real terms. NHS Digital advised that recent changes to contractual arrangements across the countries mean the payment categories and spending practices are no longer comparable. From 2020, each country will produce and publish its own report. NHSEI will publish these data for England for the period 2019/20 in due course.

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

Year	Including Reimbursement of Drugs (cash terms)	Including Reimbursement of Drugs (real terms)	Excluding Reimbursement of Drugs (cash terms)	Excluding Reimbursement of Drugs (real terms)
2014/15	9,173.04	9,824.68	8,570.50	9,179.34
2015/16	9,696.56	10,303.05	9,088.46	9,656.92
2016/17	10,193.71	10,590.03	9,603.67	9,977.05
2017/18	10,879.99	11,079.55	10,197.97	10,385.02
2018/19	11,228.12	11,228.12	10,526.33	10,526.33

Source: NHS Digital, Investment in General Practice, 2014/15 to 2018/19, England, Wales, Northern Ireland and Scotland, September 2019, Table 1 and 2. Real terms figures have been based on unrounded figures.

Developments in general practice and implementation of the multi-year deal

10.6 The five-year GP contract framework sets the financial framework and priorities for general practice and is subject to annual negotiations between NHSEI and the BMA's GPC. The update to the GP contract agreement 2020/21 - 2023/24 reflects the outcomes of the 2020/21 negotiations and included measures to address workforce and workload pressures, improve access for patients, ensure general practice is sustainable and deliver improved services. The agreed settlement covers all aspects of core practice income and expenses, providing funding clarity and certainty to practices. Expansion of the workforce and uplifts to pay for practice staff need to be achieved within the fixed envelope.

10.7 The 2020/21 agreement included enhancements to improve access to general practice and create an extra 50 million appointments in general practice a year and secure the two national workforce targets: 26,000 extra staff under *the Additional Roles Reimbursement Scheme* (ARRS), and 6,000 extra doctors

working in general practice. Funding was committed for 6,000 extra staff under the ARRS, in addition to the pre-existing commitment of 20,000, and reimbursement for the 26,000 roles increased from 70% to 100%. More roles were added to the Scheme from April 2020 in addition to those previously agreed, including pharmacy technicians, dieticians, personal care coordinators, podiatrists and occupational therapists, with others, including mental health professionals, being added from April 2021. New measures to aid GP training recruitment and retention were also introduced (see paragraph 12.9).

10.8 Attainment of these two general practice workforce commitments will help secure the headline commitment to 50 million more appointments, supporting the delivery of the NHS LTP and further sustaining the future of general practice. The new *GP Access Improvement Programme* was introduced to help improve access and will initially seek to cut the longest waits for routine appointments. An improved appointments dataset will be introduced by March 2021, alongside a new, as close to real-time as possible, measure of patient experience.

10.9 Building on the five-year framework and the review of the Quality and Outcomes Framework (QOF) in 2018, further improvements have been made to the QOF (a voluntary annual reward and incentive programme for all GP surgeries in England). Significant reforms were made in 2020/21 to the asthma, COPD and heart failure QOF domains, plus a new indicator on non-diabetic hyperglycaemia was introduced. The new 2020/21 QOF quality improvement modules were designed to focus on improving care for people with learning disabilities and supporting early cancer diagnosis. QOF delivery was disrupted due to the pandemic and these quality improvement modules were recast during the second phase of the general practice response to the pandemic, to focus on restoring care delivery in these two areas.

10.10 The 2020/21 contract brought in reforms for routine vaccination and immunisation payments and established a more effective set of incentives to increase vaccination coverage and improve population outcomes. Maternity medical services are now an essential service, with a universal 6-8 week post-natal check introduced for new mothers, backed by £12m of additional funding.

10.11 The 2019 five-year GP contract framework incentivised GP practices to form Primary Care Networks (PCNs), covering 30-50k population footprints. As at September 2020, there were currently 1,256 PCNs, with 99% of all GP practices participating in a network.

10.12 The five-year GP contract framework also introduced PCN service specifications, enabling general practice to focus on core areas of risk. Three service specifications were introduced during the 2020/21 financial year: *The Structured Medication Review and Medicines Optimisation, Enhanced Health in Care Homes,*

and *Supporting Early Cancer Diagnosis*, all coming into effect from 1 October 2020 (postponed from the original date of 1 April, due to the pandemic).

10.13 The deal also included improvements to the Network Contract Directed Enhanced Service (DES) registration process and updates to the Network Agreement including provisions to auto-enrol practices into subsequent iterations of the DES, reducing the bureaucracy associated with signing up to the DES and becoming a PCN.

10.14 *The Impact and Investment Fund* was introduced at PCN level as part of the amended 2020/21 Network Contract DES from 1 October 2020, to help PCNs make faster progress towards meeting the service specifications and deliver the priority objectives articulated in the NHS LTP. Due to the pandemic, the introduction of the fund was postponed by six months and £16.25m of funding was redirected to support PCNs' response to COVID-19. The fund will be worth £24.25 million in 2020/21, rising to £300m by 2023/24.

10.15 In recognition of the rising costs of purchasing professional indemnity and the impact this was having on the profession, a key component of the GP contract for 2019/20 was the introduction of a state backed indemnity scheme to provide more stable, affordable cover for GPs and patients. The Department launched the Clinical Negligence Scheme for General Practice (CNSGP) on 1 April 2019, which aims to contribute to the recruitment and retention of GPs in the future, as well as protecting current GPs from the rising costs of clinical negligence indemnity. From 6 April 2020, the Department also launched the Existing Liabilities Scheme for General Practice (ELSGP). The ELSGP provides cover for NHS work carried out before 1 April 2019 for existing and former general practice members of the Medical and Dental Defence Union of Scotland (MDDUS). The scheme will apply to general practice members of the Medical Protection Society from 1 April 2021.

GP Contractors

10.16 Update to the GP Contract Agreement 2020/21-2023/24 confirmed the introduction of measures to increase pay transparency in general practice, aimed at safeguarding public trust in the partnership model.

10.17 As GP contractors are subject to a five-year investment agreement between NHSEI and the BMA, no pay recommendation is being sought for this group.

Salaried GPs

10.18 Following the 2020 DDRB recommendations, the minimum and maximum pay range for salaried GPs were uplifted by 2.8% in 2020/21. However, as long as pay

is above the minimum rate, actual rates of pay are negotiated between the salaried GP and their employer.

Impact of COVID-19 and support provided to general practice

10.19 General practice has played a vital role in the response to the COVID-19 pandemic, including identifying and offering proactive care to shielded and high-risk patients while continuing to be there for patients when they have health concerns. Throughout the pandemic, practices have been encouraged to deliver as much routine and preventative work as can be provided safely, including vaccinations, immunisations and screening, as well as supporting their more high-risk patients with ongoing care needs. Due to COVID-19 the primary care sector has significantly increased digital delivery of appointments at unprecedented pace (see paragraphs 10.31-1.33), has provided a strong foundation for the delivery of enhanced health care in care homes and delivery of an expanded winter flu programme. PCNs have also provided resilience as a natural footprint for organisation of coronavirus ‘hot hubs’.

10.20 To ensure that practices did not lose significant income as a result of the outbreak, and to support deployment of general practice staff to activities of the highest clinical priority, income protection arrangements were put in place by NHSEI. On 4 August 2020, details of the COVID-19 support fund for general practice were also confirmed. The purpose of this fund was to assist with the legitimate additional costs of the response borne by GP practices to the pandemic, including costs for COVID-19 related absence cover, bank holiday opening and the additional costs of PPE and other consumables. This ensured practices could continue to operate and deliver patient services whilst supporting their staff.

10.21 In November, the Government announced a £150 million General Practice Covid Capacity Expansion Fund, which has been made available to support expanding GP capacity up to the end of March 2021. Priorities include identifying and supporting patients with long term COVID-19, continuing to support clinically extremely vulnerable patients and increasing GP numbers and capacity, for example through the creation of additional salaried GP roles that are attractive to practices and locums, employment of staff returning to help with COVID-19, or to increase the time commitment of existing salaried staff.

10.22 General practice is expected to take a leading role in administering the COVID-19 vaccine to patients across England. In late 2020, NHSEI agreed arrangements with the BMA for general practice's involvement in the delivery of COVID-19 vaccines, to be commissioned as an enhanced service. The Enhanced Service Specification: COVID-19 vaccination programme 20/21 was published in early December with practices expected to co-ordinate and deliver COVID-19

vaccinations at scale in PCN groupings, working in collaboration with commissioners, regional operations and other local providers to develop and implement a local delivery plan. Participation is voluntary, with practices opting into the Enhanced Service. The first PCN groupings were asked to start vaccinating from the week commencing the 14 December. This was the beginning of the general mobilisation of general practice from their designated sites and over 1,000 PCN led sites are now live.

10.23 To help general practices meet demand safely, the government enabled the suspension of enforcement for some contractual requirements and lessened bureaucratic burdens to reduce pressures on GPs, considering how these requirements impact on the workload and work life balance of general practice staff. These included scaling down CQC inspections, appraisals and revalidation, simplifying requirements for medical evidence and seeking more effective ways to gather information required for services, such as medical assessments of fitness to drive. The Isolation Note was also introduced in March for the duration of the pandemic as an alternative to the Fit Note, to enable individuals to digitally self-certify sickness absence relating to COVID-19.

10.24 To further relieve pressure on GPs and to free up more time for staff in general practice to care for their patients, three easements were introduced in March 2020 through the GP Contract Pandemic Regulations. These easements, which have been extended until March 2021, are:

- Suspension of the requirement for individual patient consent for transfer onto the electronic repeat dispensing (eRD) system;
- Maintenance of the requirement that practices make available a minimum of 1 appointment per 500 patients for NHS 111 direct booking, reducing the amount of triaging practices have to do;
- Suspension across the NHS of the requirement for practices to report to commissioners about the Friends and Family Test.

10.25 We announced further easements on 7 January to free up capacity in general practice and support the delivery of the COVID-19 vaccine. Several aspects of GP work would will be income protected from 1 January 2021 to March 31 2021, including the minor surgeries DES and the quality improvement domain within QOF.

10.26 Many of these changes are expected to continue until April 2021 and beyond, and our experience of COVID-19 has encouraged Government to look at new and innovative ways to reduce the burdens from bureaucracy for good (see paragraph 12.11 for details).

10.27 To provide wellbeing support for general practice staff during the pandemic, NSHEI launched the *#LookingAfterYouToo: Coaching Support for Primary Care Staff* service, developed in collaboration with the Royal College of General Practitioners. The service provides access to individual coaching sessions to support the mental health and wellbeing of all clinical and non-clinical primary care workers employed or contracted to deliver work on behalf of the NHS. We are the NHS: People Plan 2020/21 – action for us all has additionally set out local and national steps needed to look after the workforce, with a focus on support during the pandemic.

Access to General Practice

10.28 The government is committed to improving general practice access for patients, by growing the workforce and creating 50 million more appointments in general practice.

10.29 The 2020/21 update to the GP contract included measures to improve access to general practice through expanding availability of appointments and increasing the range of healthcare professionals in PCNs.

10.30 The NHS LTP committed that every patient will have the right to be offered digital-first primary care by 2023/24. The vision is that, at the choice of the individual patient, patients should be able to safely and easily access advice, support and treatment from primary care using digital and online tools.

Access to general practice services during COVID-19

10.31 The COVID-19 pandemic has changed the way in which people access general practice and how practices manage their services, to ensure as many patients as possible could be seen, while protecting staff and patients from avoidable risk of infection. General practice adapted at an unprecedented rate and transformed the way primary care services operate. As part of the response, practices introduced triage for all patient contacts and offered more telephone and online consultations. This enabled patients to access services remotely and staff to work from home while remaining open for face-to-face appointments where clinically appropriate. In support of this, 40,000 laptops and over 21,000 headsets were delivered to local IT service providers for deployment to general practices for remote working and NHSEI estimate that as of 20 November 2020, 90% of practices have online consultation capability and 99% have video consultation capability.

10.32 The Government has heard some positive feedback from practice staff on the increased ability to work remotely and more flexibly during the pandemic, however the changes have not been without challenge. There is now an opportunity to build

on the huge progress that has been made in improving digital provision across primary care as part of the emergency response to COVID-19. The Government, NHS, and professional representatives are working to ensure that these innovations can be adapted into a sustainable model for the future that provides the best quality of care and ease of access for patients.

10.33 We will continue working towards the ambitions set out in the LTP to drive digital transformation, with the aim of providing the best quality of care and ease of access for patients, via a service that is most appropriate to their needs and preferences.

GP appointments dataset

10.34 NHS Digital collect and publish data from general practice appointment systems on a monthly basis, collated by CCG area. The data reflects only the planned and scheduled activity recorded within general practice appointment systems, including:

- The mode/setting of an appointment e.g. face to face, home visits, telephone or online;
- Type of healthcare professional carrying out the appointment;
- The number of appointments where a patient did not attend; and
- The time between the appointment being booking and taking place.

10.35 NHS Digital regard the GP appointments dataset as experimental statistics, which means they are still in the testing phase and not yet fully developed for reasons such as poor coverage, poor data quality or the data is undergoing evaluation.

10.36 The outbreak of COVID-19 has led to unprecedented changes in the work and behaviour of General Practices and this has impacted on reporting and appointment numbers. General practice offers triage with referral to remote consultations and face-to-face consultations where required. This is a significant change in how general practice services are provided and has impacted on the appointment data quality. For example, most video consultations start off as telephone calls and will be recorded as telephone appointments.

10.37 The total estimated number of appointments recorded in GP practice systems declined to a low point of 16.6 million in April 2020 and steadily rose to 24.0 million in December 2020. An estimated 280.1 million appointments were booked across all GP practices in England in the twelve months up to December 2020. Compared

to the previous twelve months up to December 2019 (312.1 million) this is down 10.3%.

10.38 It is important to note that the decline in appointment numbers during the first wave of the pandemic does not necessarily imply a reduction in activity in general practice. The data do not allow us to make inferences about, for example, workload including proactive care, activity taking place outside of core hours, demand and capacity.

10.39 Prior to the COVID-19 lockdown over 80% of appointments were face-to-face, dropping to 47% in April 2020, with 50% of appointments in April, May and June taking place over the telephone. Face-to-face appointment numbers are now increasing but remain relatively low at 56.4% in December 2020.

10.40 The Department is committed to ensuring all patients can access the services they need as safely as possible, whether they have COVID-19 symptoms or other physical and mental health needs. In September 2020, NHSEI wrote to practices and commissioners reiterating the importance of providing face-to-face appointments for those who need them and sharing an Access to general practice communications toolkit, to help practices explain to patients how they can safely access general practice. Further guidance for practices was included in the December update to the Standard Operating Procedure for general practice in the context of COVID-19.

11. GP workforce and earnings

GP earnings

11.1 GP practices are self-employed contractors to the NHS and it is for practices to determine pay for their staff. GP Contractors are responsible for meeting the requirements set out in the contract for their practice and they take an income after expenses. Salaried GPs should be on a salary no less favourable than the minimum pay range in the model terms and conditions, as set out by NHS Employers and the model salaried GP contract, although employers have the flexibility to offer enhanced terms and conditions, for example, to aid recruitment and retention. In responding to the DDRB's recommendations, Government will adjust the minimum and maximum pay threshold accordingly. It is up to practices to determine the pay uplift for their staff following this uplift.

11.2 The latest available data from NHS Digital on GP earnings and expenses is for the financial year 2018/19 and is based on a sample from HM Revenue and Customs' (HMRC's) tax self-assessment database. As the data are based on samples with weighting applied, rather than the whole population, they are subject to sampling error and uncertainty. The dataset is divided by contractor and salaried GPs working under both General Medical Services (GMS) and Personal Medical Services (PMS) contracts, and it does not include GPs who work solely as locums.

11.3 The self-assessment tax returns contain information on GP's total earnings, and it is not possible to distinguish between full and part time workers, nor is it possible to calculate the split between private and NHS work. As a guide to NHS/private earning proportions, the average NHS superannuable income for contractor GPs working in either a GMS or PMS practice in the UK as a whole was 96.2% of income before tax in 2016/17, which is the latest year for which pensions data are available. Chapter 2 of the NHS pension scheme guidance sets out what comprises NHS pensionable income.

11.4 Figure 11.1, below, sets out the average percentage increase in actual annual earnings for salaried and contractor GPs over recent years, against the uplifts recommended by the DDRB and agreed by Government for the same year. The latest available earnings data is prior to the five-year GP contract deal which started in April 2019. GP earnings and expenses data for 2019/20 will be available in September 2021.

Figure 11.1- Average percentage increase in actual annual earnings for salaried and contractor GPs and the recommended/agreed uplifts for the same year

Year	DDRB recommendation	Government response	Average % earnings increase for salaried GPs	Average % earnings increase for GP contractors
2015/16	1%	1%	-1.4%	1.1%
2016/17	1%	1%	1.3%	4.5%
2017/18	1%	1%	3.2%	3.5%
2018/19	4%	2%	3.8%	3.4%
2019/20	*	2% agreed as part of the 2019/20 contract for salaried GPs	Data to be published Sept 2021	Data to be published Sept 2021
2020/21	2.8% (salaried GPs only)*	2.8% (salaried GPs only)*	Data to be published Sept 2022	Data to be published Sept 2022

Sources: NHS Digital, GP Earnings and Expenses Estimates 2018/19, September 2020, Tables 1a and 8a.

* Contractor GPs were stood down from the remit of the DDRB for the duration of the five-year contract, 2019/20-2023/24, salaried GPs were stood down for one year in 2019/20.

GP contractor earnings

11.5 In England, the average pre-tax income for a contractor GPs working in either a GMS or PMS practice in the UK increased from £113,400 in 2017/18 to £117,300 in 2018/19, a rise of 3.4 per cent. UK Income distribution figures published by HMRC, based on total income subject to tax for the year 2017/18 (which do not account for hours worked), show that contractor GPs were in the 97th – 98th percentile group (£98,600 - £121,000) in that year.

11.6 Figure 11.2 shows the change in contractor GP income in England since 2003/4 in both nominal and real terms (2018/19 prices). The data in this figure represent average earnings for GP contractors in both GMS and PMS practices. The GMS contract is the national standard GP contract and in 2018/19, around 70% of GP practices operated under it. Expenses are split into categories including office and general business, premises, employee, car and travel, interest, net capital allowance and other (e.g. cost of drugs for dispensing GPs). It is worth noting that

these data are for the financial year preceding introduction of the CNSGP indemnity scheme for GPs, so it is yet to be seen what impact the scheme has had on contractor or salaried GP expenses and take-home pay.

11.7 The income data are based on a sample of GPs' total actual earnings by headcount and not rates of pay by FTE. NHS Digital have previously provided experimental analysis of GP earnings estimates by FTE. However, due to concerns about the validity and quality of the data, this was not sufficiently robust to be published for 2018/19. In September 2020, the average participation rate for contractor GPs in England was 84.1%.

Figure 11.2 - Earnings and expenses for GP contractors in England - GMS and PMS, all practice types

Year	Report Population	Estimated Gross Earnings in Cash Terms	Total Expenses	Income Before Tax	Estimated Gross Earnings in real terms (2018/19 prices)	Total Expenses	Income Before Tax
2002/03	25,928	£191,777	£116,671	£75,106	£265,000	£161,200	£103,800
2003/04	26,147	£212,467	£127,672	£84,795	£287,800	£172,900	£114,900
2004/05	27,334	£241,795	£138,231	£103,564	£318,500	£182,100	£136,400
2005/06	27,436	£257,563	£143,950	£113,614	£331,200	£185,100	£146,100
2006/07	27,279	£260,764	£149,198	£111,566	£326,100	£186,600	£139,500
2007/08	27,121	£266,110	£155,971	£110,139	£324,100	£190,00	£134,200
2008/09	26,712	£274,100	£164,500	£109,600	£325,600	£195,400	£130,200
2009/10	26,400	£278,100	£168,700	£109,400	£324,900	£197,100	£127,900
2010/11	26,300	£283,000	£175,300	£107,700	£325,100	£201,300	£123,800
2011/12	26,350	£284,300	£178,200	£106,100	£321,700	£201,700	£123,800
2012/13	26,200	£289,300	£184,200	£105,100	£320,700	£204,200	£120,000
2013/14	25,700	£290,900	£189,000	£101,900	£316,400	£205,600	£116,500
2014/	25,500	£302,600	£198,800	£103,800	£324,600	£213,300	£111,300

15							
2015/16	18,300	£315,600	£210,800	£104,900	£335,700	£224,200	£111,500
2016/17	19,850	£338,300	£228,700	£109,600	£351,500	£237,600	£113,900
2017/18	20,350	£357,300	£243,900	£113,400	£364,900	£249,100	£115,800
2018/19	20,300	£380,900	£263,600	£117,300	£380,900	£263,600	£117,300

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2018/19, September 2020, Tables 1a and 1b. The conversion has been carried out using Gross Domestic Product (GDP) deflators as at June 2020 available from HMT. The dataset shows total earnings, expenses and income (pre-tax). 'Earnings' is the total that GPs receive; however, expenses come out of this sum, meaning that 'income' is total earnings minus expenses.

11.8 The data for 2018/19 for contractor GPs by contract type are shown in Figure 11.3 below.

Figure 11.3 - Earnings and expenses for GP contractors in England by contract type - 2018/19, all practice types

Contract type	Gross Earnings	Total Expenses	Income Before Tax
GMS	£371,800	£255,700	£116,100
PMS	£406,100	£285,600	£120,500

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2018/19, September 2020, Table 1a. The conversion has been carried out using Gross Domestic Product (GDP) deflators as at June 2020 available from HMT. The dataset shows total earnings, expenses and income (pre-tax). 'Earnings' is the total that GPs receive; however, expenses come out of this sum, meaning that 'income' is total earnings minus expenses.

Salaried GP earnings

11.9 The corresponding data for salaried GPs in England is shown in Figure 11.4 below. The real average pre-tax income of salaried GPs in 2018/19 was £60,600, compared to £58,400 in 2017/18, an increase of 3.8 per cent in cash terms. When compared with the UK Income distribution figures from 2017/18, salaried GPs were in the 91st – 92nd percentile group (£57,700 - £61,000) for that year. As above, these data are for the financial year preceding introduction of the CNSGP

indemnity scheme for GPs, so the impact of the scheme on salaried GP expenses and take-home pay is not yet understood.

11.10 Information on systematic data for salaried GPs was requested by the DDRB committee, however, as described above, this information is not available, so these figures are based on headcount data and will not take account of part time working. Note that in September 2020, the participation rate for salaried GPs in England was 64.0%.

Figure 11.4 - Earnings and expenses for salaried GPs England - GMS and PMS, all practice types

Year	Report Population	Gross Employment Earnings	Gross Self Employment Earnings	Total Gross Earnings	Total Gross Earnings in Real Terms (2018/19 prices)	Total Expenses	Total Income Before Tax
2006/07	4,704	£47,354	£12,891	£60,245	£75,300	£6,139	£54,106
2007/08	4,665	£49,854	£12,337	£62,191	£75,800	£6,260	£55,931
2008/09	5,991	£50,300	£13,800	£64,200	£76,200	£6,800	£57,400
2009/10	6,650	£50,800	£14,700	£65,500	£76,500	£7,100	£58,300
2010/11	7,000	£50,000	£15,100	£65,100	£74,800	£7,300	£57,900
2011/12	7,050	£49,600	£14,800	£64,400	£72,800	£7,300	£57,000
2012/13	7,550	£49,200	£15,500	£64,700	£71,800	£8,100	£56,600
2013/14	8,000	£48,200	£15,800	£64,100	£69,700	£9,200	£54,900
2014/15	8,750	£47,800	£14,700	£62,500	£67,000	£8,700	£53,700
2014/15*	8,750	£50,800 r	£14,700	£65,500 r	£70,200	£8,700	£56,700 r
2015/16	7,250	£51,500	£12,300	£63,900	£67,900	£7,900	£55,900
2016/17	8,550	£51,700	£13,700	£65,300	£67,900	£8,700	£56,600
2017/18	9,400	£52,400	£15,800	£68,200	£69,700	£9,800	£58,400

2018/19	10,500	£53,700	£16,400	£70,100	£70,100	£9,400	£60,600

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2018/19, September 2020, Table 8a and 8b. There are breaks in the time series (each year between 2011/12 and 2014/15) due to the use of unrevised pension contribution rates when calculating adjustments to income before tax.

* (r) 2014/15 Income Before Tax and Gross Earnings figures have been recalculated since the GP Earnings and Expenses Estimates 2014/15 publication using updated adjustments for superannuation contributions.

11.11 The data for 2018/19 for salaried GPs by contract type are shown in Figure 11.5 below.

Figure 11.5 - Earnings and expenses for salaried GPs in England by contract type - 2018/19, all practice types

Contract type	Gross Earnings	Total Expenses	Income Before Tax
GMS	£69,500	£9,500	£60,000
PMS	£71,100	£9,400	£61,700

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2018/19, September 2020, Table 8a. The conversion has been carried out using Gross Domestic Product (GDP) deflators as at June 2020 available from HMT. The dataset shows total earnings, expenses and income (pre-tax). 'Earnings' is the total that GPs receive; however, expenses come out of this sum, meaning that 'income' is total earnings minus expenses.

GP earnings by age, gender and working hours

11.12 Mean earnings, expenses and income by age group, gender and grouped working hours (divided into 0 to <22.5, 22.5 to <37.5 and 37.5+ hours) for salaried and contractor GPs in the UK are set out in Figure 11.6. As would be expected, GPs who work longer hours earn more. When split into working hours, age band and gender, male GPs earned more than female GPs in all but one of the groups (women over 60, working between 0 and 22.5 hours as contractors).

11.13 However, there are known data quality issues with these experimental statistics, so care should be taken when interpreting data that show differences in earnings according to gender, age band or working hours bands. The factors that affect the

quality of these data are listed below and may differentially impact male and female workers. However, it is not possible to assess the extent to which they may or may not explain the observed earnings gap:

- Earnings are total income figures based on anonymised tax data from HMRC Self-Assessment tax records, whereas the weekly hours bands have been calculated using contracted hours or average weekly hours taken from the Workforce Minimum Data Set (wMDS), collected by NHS Digital, but do not capture the actual number of hours worked.

- Working hours are a snapshot as at 30 September 2018 and could have changed over the course of the year.

- GPs may work longer than their contracted hours or may work outside their practice, in an alternative setting such as a hospital or extended access hub, or they may undertake additional locum work. Income for these hours would be included in these data but not the hours worked.

- The working hours bandings were chosen to provide large enough sample sizes to analyse the figures by characteristics such as age and gender. However, NHS Digital's analysis of working hours using smaller bands shows a greater proportion of female GPs working shorter hours. Within the 22.5 to <37.5 band in particular, females tend to be distributed towards the lower end of the band. This distribution of gender could have the effect of pulling down the average income for female GPs compared to male GPs in the same band.

- As a higher proportion of male GPs are older, age and years of service could also influence these results. It is not unreasonable that GPs who have greater experience receive higher earnings than their less experienced colleagues. Female GPs may also be more likely to take a career break and therefore have fewer years of reckonable service than male GPs of the same age. As discussed above, average earnings will depend on the distribution of hours worked in each band, which may change with age.

- Contractor GPs' earnings may be affected by the terms of any partnership agreements in effect for their practices.

- It is not possible to calculate the split between private and NHS work and therefore the data presented is a combination of both. This may vary between male and female GPs.

Figure 11.6 - Average GP earnings and expenses in England by weekly contracted working hours, age and gender - 2018/19, GMS and PMS, all practice types

Contractor GP, England

Age	Working hours	Gender	Report population	Average total gross earnings	Average total expenses	Average total income before tax
Under 40	0-22.5	Male	100	£297,800	£199,500	£98,300
Under 40	0-22.5	Female	250	£234,600	£160,600	£74,000
Under 40	22.5-37.5	Male	850	£372,400	£252,400	£119,900
Under 40	22.5-37.5	Female	1,000	£313,300	£219,200	£94,200
Under 40	37.5+	Male	800	£405,800	£274,100	£131,700
Under 40	37.5+	Female	350	£353,300	£245,400	£107,900
40-49	0-22.5	Male	200	£360,900	£256,500	£104,400
40-49	0-22.5	Female	850	£264,900	£186,400	£78,400
40-49	22.5-37.5	Male	1,550	£424,500	£296,700	£127,800
40-49	22.5-37.5	Female	2,100	£352,500	£248,600	£103,900
40-49	37.5+	Male	1,950	£453,300	£312,000	£141,300
40-49	37.5+	Female	700	£407,400	£282,500	£124,900
50-59	0-22.5	Male	250	£293,100	£205,200	£87,900
50-59	0-22.5	Female	750	£254,800	£177,300	£77,500
50-59	22.5-37.5	Male	1,750	£409,100	£285,000	£124,200
50-59	22.5-37.5	Female	1,650	£343,100	£239,800	£103,300
50-59	37.5+	Male	2,200	£463,500	£318,200	£145,300
50-59	37.5+	Female	700	£434,000	£304,800	£129,200
Over 60	0-22.5	Male	350	£238,700	£157,800	£80,800
Over 60	0-22.5	Female	150	£288,100	£199,000	£89,200
Over 60	22.5-37.5	Male	550	£380,100	£258,100	£122,000
Over 60	22.5-37.5	Female	200	£306,800	£210,100	£96,700
Over 60	37.5+	Male	750	£428,700	£290,100	£138,600
Over 60	37.5+	Female	200	£385,900	£258,700	£127,200

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2018/19, September 2020, Tables 6a and 6b. Earnings and expenses estimates are only available for England GPs and were calculated for the first time for 2016/17

Salaried GP, England

Age	Working hours	Gender	Report population	Average total gross earnings	Average total expenses	Average total income before tax
Under 40	0-22.5	Male	400	£77,800	£6,500	£71,300
Under 40	0-22.5	Female	1,650	£54,800	£6,000	£48,700
Under 40	22.5-37.5	Male	700	£88,800	£14,100	£74,700
Under 40	22.5-37.5	Female	2,200	£62,300	£6,600	£55,800
Under 40	37.5+	Male	200	£132,100	£42,900	£89,200
Under 40	37.5+	Female	300	£70,000	£8,200	£61,900
40-49	0-22.5	Male	250	£85,300	£13,100	£72,200
40-49	0-22.5	Female	1,400	£58,400	£7,700	£50,700
40-49	22.5-37.5	Male	350	£93,300	£14,700	£78,600
40-49	22.5-37.5	Female	900	£75,000	£12,700	£62,200
40-49	37.5+	Male	150	£95,900	£8,400	£87,500
40-49	37.5+	Female	100	£81,600	£6,700	£74,900
50-59	0-22.5	Male	200	£93,000	£8,400	£84,600
50-59	0-22.5	Female	650	£59,500	£6,000	£53,500
50-59	22.5-37.5	Male	150	£95,600	£16,500	£79,100
50-59	22.5-37.5	Female	350	£76,400	£11,000	£65,400
50-59	37.5+	Male	100	£113,900	£20,200	£93,700
50-59	37.5+	Female	50	£94,000	£8,300	£85,700
Over 60	0-22.5	Male	150	£60,800	£5,200	£55,500
Over 60	0-22.5	Female	100	£62,300	£14,100	£48,200
Over 60	22.5-37.5	Male	50	£74,000	£9,900	£64,200
Over 60	22.5-37.5	Female	50	£57,300	£3,300	£54,000
Over 60	37.5+	Male	50	£98,300	£22,800	£75,500
Over 60	37.5+	Female	50	£63,700	£3,900	£59,800

Source: NHS Digital, GP Earnings and Expenses Estimate Time Series 2018/19, September 2020, Table 13. Earnings and expenses estimates are only available for England GPs and were calculated for the first time for 2016/17

The gender pay gap in general practice

11.14 The Gender Pay Gap in Medicine Review found that the mean gender pay gap in overall annual pay (by headcount) among GPs in England was found to be 33.5% in 2019. This compares to 24.4% among HCHS doctors, 21.4% for clinical academics and 16.9% in HCHS consultants. However, these figures do not account for working hours. Adjusting for contracted hours, the gender pay gap for GPs drops to 15.3%.

11.15 One reason for the large gender pay gap for GPs is that women GPs are less likely to be contractor GPs: the report states that 48% of women GPs are contractor GPs, whereas the corresponding figure for men is 83%. This uneven representation across GP types may explain some of the overall gender pay gap, however, substantial gender pay gaps remain within GP types. The mean gender pay gap for gross annual earnings is 22.6% among contractor GPs and 31.1% among salaried GPs. The FTE-corrected mean gender pay gap is substantially lower for contractor GPs at 7.7%, but remains high for salaried GPs at 22.3%.

11.16 Given that the gender pay gap in general practice is calculated using data from the NHS Digital/HMRC source described above (2016/17 tax year), there are some known quality issues with the FTE adjusted earnings figures, so caveats, as outlined in paragraph 11.13, apply. The limitations of using contracted hours are particularly relevant, as could understate actual working hours, and any hours worked outside of a general practice setting would not be accounted for, whereas the income from such work would be included in total income figures.

11.17 Further information on the gender analysis of the wider workforce, with a specific focus on the gender pay gap can be found in Chapter 3 and 5.

GP Trainer grants

11.18 The GP trainer grant, which was previously published in an annex of the Directions to Health Education England, was published as part of the document containing GP Educator pay scales and from 1 April 2020 is £8,584.

11.19 The Department continues to work with stakeholders to promote a fair and equitable approach to the funding of clinical placements in GP practices, irrespective of geography and historical arrangements. The 2020/21 annual Education and Training tariff guidance document introduced a new national minimum rate for undergraduate medical placements in general practice of £28,000. This means that although prices continue to be agreed under local arrangements, no price will be lower than this amount.

General Medical Practitioner Appraisers' rates

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

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

GP Workforce numbers

11.22 Data on the general practice workforce has been published by NHS Digital since 2016. The latest figures, for September 2020, showed a total of 35,434 GPs (all types) working in England by FTE (46,821 headcount). Figures 11.7a and 11.7b present a summary of doctors working in general practice by full-time equivalent and headcount from the General Practice Workforce publication.

11.23 General practice workforce data is best compared on a year-on-year basis (i.e. September-September) due to seasonal fluctuations in the data, so the figures below are presented on this basis. NHS Digital advised that completeness and coverage of general practice workforce data extracted in March and June 2020 may have been adversely affected by the COVID-19 pandemic. However, NHS Digital believe that levels of data quality and completion had returned to normal for the data extract from September 2020.

Figure 11.7a - Doctors in general practice by FTE

Full-Time Equivalents	**September 2015**	**September 2016**	**September 2017**	**September 2018**	**September 2019**	**September 2020**
All GPs	34,429	35,229	34,653	34,534	34,862	35,434
GP Contractors	21,688	21,143	20,205	19,262	18,303	17,352
Salaried GPs	6,867	7,375	7,635	8,065	8,469	9,126
GP Registrars	5,026	5,731	5,509	5,880	6,547	7,454
GP Retainers	76	74	88	121	186	228
GP Locums	772	906	1,216	1,208	1,357	1,275

Source: NHS Digital, General Practice Workforce 30 September 2020, November 2020, Table 1a. Figures include estimates for the practices that did not provide fully valid data.

Figure 11.7b - Doctors in general practice by Headcount

Headcount	**September 2015**	**September 2016**	**September 2017**	**September 2018**	**September 2019**	**September 2020**
All GPs*	comparable data not available	comparable data not available	comparable data not available	44,378	45,625	46,821

GP Contractors	24,521	23,605	22,791	21,857	21,161	20,627
Salaried GPs	10,283	11,029	11,465	12,236	13,076	14,257
GP registrars	5,141	5,805	5,646	5,986	6,686	7,558
GP retainers	173	175	213	314	483	576
GP locums*	comparable data not available	comparable data not available	comparable data not available	5,082	5,272	4,824

Source: NHS Digital, General Practice Workforce 30 September 2020, November 2020, Table 1b. Figures include estimates for the practices that did not provide fully valid data.

* Headcount figures are not comparable across the time series due to changes in locum recording prior to March 2017 and December 2017.

11.24 Overall, the General Practice Workforce data show the number of "All GPs" increased by 2.9% from 34,429 to 35,434 between September 2015 and September 2020. The number of GP contractors in England has been on a decreasing trend. Between September 2015 and September 2020, the GP contractor FTE decreased by 20% from 21,688 to 17,352. Conversely, the salaried GP FTE increased over the same period by 32.9%, from 6,867 to 9,126 FTEs. GP registrar FTE also increased over the same period by 48.3%, from 5,026 to 7,454.

11.25 As the most recent figures demonstrate, there continue to be issues around retention of fully qualified GPs. A number of policy programmes are being undertaken to boost retention and increase participation to grow the FTE GP number. Information on these policies are provided in paragraph 12.9.

11.26 When comparing the September 2019 and September 2020 figures, the GP headcount numbers have increased (by 1,196), and FTE count has increased (by 573 FTE), this may in part be due to changes in the workforce demographics. The demographic makeup of the workforce is shown in Figure 11.8 by job role and gender and in Figure 11.9 by age and gender. Note that age and gender disaggregation of GP headcounts are only published bi-annually. There are more female GPs (all types) by headcount (26,152) than male GPs (20,045) (unknown 660) in September 2020; however, the younger workforce is predominately female whilst the older workforce is predominantly male. Differences in working patterns (see participation rates and part time working in Figures 11.10 and 11.11) between male and female workers is likely to impact trends in the GP workforce by FTE. There are also differences in the proportion of male and female GPs by role type.

Figure 11.8 - Doctors in general practice FTE by job role and gender, September 2020

FTE	All	% of All GPs by type	Male	% of all Male GPs by type	Female	% of all Female GPs by type	Unknown	% of all unknown GPs by type
GP Contractors	17,352	49.0%	10,280	61.0%	6,940	37.9%	132	46.1%
Salaried/ Other GPs	9,126	25.8%	2,783	16.5%	6,262	34.2%	80	27.8%
GP Registrars	7,454	21.0%	3,072	18.2%	4,353	23.8%	29	10.0%
GP Retainers	228	0.6%	40	0.2%	186	1.0%	2	0.7%
GP Locums	1,275	3.6%	666	4.0%	565	3.1%	44	15.4%
Total	35,434	100%	16,841	100%	18,306	100%	287	100%

Source: NHS Digital, General Practice Workforce 30 September 2020, November 2020, Table 1a. Figures include estimates for the practices that did not provide fully valid data.

11.27 The demographic makeup of the workforce is shown in Figure 11.9 by age and gender. The younger workforce is predominately female whilst the older workforce is predominantly male. Note that age and gender disaggregation of GP FTE are published bi-annually.

Figure 11.9 - General Practitioner FTE (excluding registrars & locums) by age and gender, September 2020

FTE	All	%	Male	%	Female	%
Under 30	194	0.7%	58	0.4%	135	1.0%
30-34	2,867	10.7%	1,015	7.7%	1,849	13.8%
35-39	4,305	16.1%	1,610	12.3%	2,689	20.1%
40-44	4,597	17.2%	2,189	16.7%	2,406	18.0%
45-49	4,381	16.4%	2,092	16.0%	2,287	17.1%
50-54	3,851	14.4%	2,023	16.0%	1,827	13.6%
55-59	3,672	13.7%	2,177	16.6%	1,494	11.2%
60-64	1,533	5.7%	1,094	8.4%	438	3.3%
65 and over	1,041	3.9%	806	6.2%	235	1.8%
Unknown	264	1.0%	38	0.3%	29	0.2%
Total	26,705	100%	13,103	100%	13,389	100%

Source: NHS Digital, General Practice Workforce 30 September 2020, November 2020, Table 2a. Figures include estimates for the practices that did not provide fully valid data.

For further information on the methodology used by NHS Digital, please refer to the publication General Practice Workforce 30 September 2020.

11.28 NHS Digital publishes ethnicity data for general practice. Of those recorded, as of March 2020, 16% of practice staff (36% of GPs) identified themselves as from a BAME background. As more was learnt about the impact of COVID-19, NHS employers were advised to risk assess all staff at a potentially greater risk, including those from BAME backgrounds. NHSEI have committed to taking the lessons learned during the first COVID-19 peak into account, including targeted work to support workforce and patients from BAME communities.

Part-time working and participation rates

11.29 Participation rates are used to measure the extent of part-time working in the GP workforce. They are defined as the ratio of full-time equivalents to headcount, and vary by job type, age and gender. Participation rates by age and gender for the whole GP workforce in September 2019 are shown in Figure 11.10 and by job role and gender in September 2019 are shown in Figure 11.11. A full-time working week is considered to be 37.5 hours.

11.30 Participation rates are lower for female GPs in each job role and in every age band except those under 30. The average participation rate for male GPs increases with age to a peak in the 50-54 and 55-59 age brackets, before declining again, whereas participation rates by age for female GPs are more varied. Contractor GPs and registrars have the highest participation rates regardless of gender.

Figure 11.10 - General Practitioner participation rate (excluding locums and registrars) by age and gender, September 2020

Age Band*	Male	Female	All (Including unknown)
Under 30	68.5%	70.9%	70.3%
30-34	75.7%	68.2%	70.7%
35-39	81.0%	65.1%	70.3%
40-44	88.6%	64.3%	74.0%
45-49	88.9%	68.5%	77.0%
50-54	90.4%	69.8%	79.3%
55-59	90.7%	71.2%	81.6%
60-64	83.3%	67.8%	78.2%
65 and over	81.8%	73.1%	79.7%
Unknown	82.1%	67.9%	74.1%
All practitioners	86.1%	67.5%	75.6%

Source: NHS Digital, General Practice Workforce 30 September 2020, November 2020, Tables 1a and 1b. Figures include estimates for the practices that did not provide fully valid data.

Figure 11.11 - General Practitioner participation rate by gender and job role, September 2020

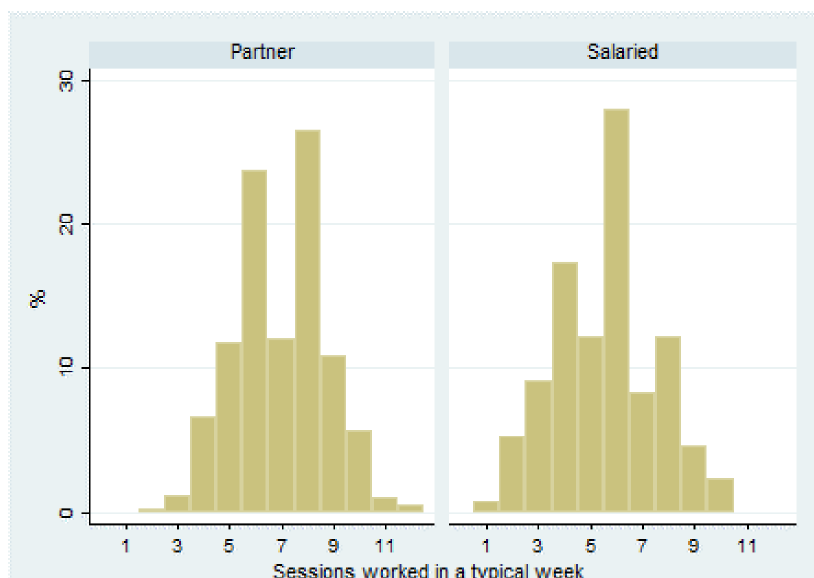
Practitioner type	Male	Female	All (including unknown)
GP Contractors	91.4%	75.3%	84.0%
Salaried GPs/Other GPs	70.9%	61.3%	64.0%
GP Registrars	103.9%	95.1%	98.6%
GP Retainers	40.2%	39.4%	39.6%
GP Locums	29.3%	25.5%	26.4%
All practitioners	84.0%	70.0%	75.7%

Source: NHS Digital, General Practice Workforce 30 September 2020, November 2020, Tables 1a and 1b. Figures include estimates for the practices that did not provide fully valid data. GP registrar participation rates appear to be higher as a registrar's full-time contract is 40 hours, compared to the standard full time salaried/contractor GP contract which is 37.5 hours.

11.31 The Tenth GP Work life survey also provides insight into GP working hours and participation rates. As the report has not yet been published, the findings below are classed as 'interim' and caution is advised while interpreting these results (see paragraphs 12.1-12.2 for further detail on the findings of the survey).

11.32 The GP Worklife Survey asks respondents "how many sessions do you work per week" (including out of hours work). For salaried GPs, respondents most frequently reported working 6 sessions per week. For Contractor GPs, respondents most frequently reported working 8 sessions per week, followed by a high proportion of respondents who worked 6 sessions per week (Figure 10.13). Across all GPs surveyed, the median number of sessions worked in a typical week in 2019 was 6.25 (inter-quartile range 5 to 8). The mean number of sessions worked per week in 2019 was 6.6, slightly lower than that observed in the last survey in 2017, which was 6.7 sessions per week. Figure 11.12 shows how the distribution of sessions worked in a typical week in 2019 differs for contractors and salaried GPs.

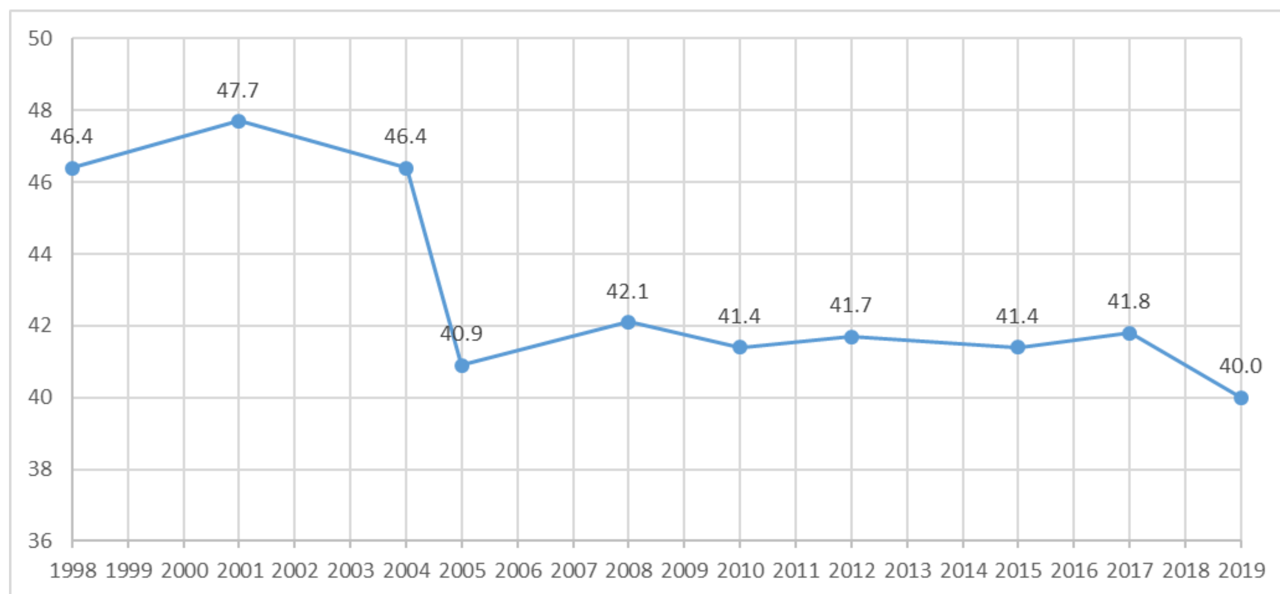
Figure 11.12- Sessions worked per week for contractor and salaried GPs, 2019



Source: 10th GP Worklife Survey. The survey has not yet been published therefore these results are badged as 'interim', therefore we would advise caution when using these figures. The survey targeted two samples of GPs: 5,000 randomly sampled GPs (cross sectional sample) and 1,612 GPs who had replied to the 2017 survey (longitudinal sample).

11.33 The GP Worklife Survey also asks respondents “How many hours do you spend, on average, per week, doing NHS GP-related work?" (including all clinical and non-clinical NHS work but excluding out of hours work). The mean number of weekly hours worked was 40 hours (standard deviation 15.2) and the median was 40 (inter-quartile range 31.3 to 50). This represents a decrease in mean working hours since 2017, when the mean working hours was 41.8, with little variation observed since 2015. Figure 11.13 shows trends in average GP working hours since 1998.

Figure 11.13- Average GP Working hours 1998- 2019



Source: 10th GP Worklife Survey. The survey has not yet been published therefore these results are badged as 'interim', therefore we would advise caution when using these figures. The survey targeted two samples of GPs: 5,000 randomly sampled GPs (cross sectional sample) and 1,612 GPs who had replied to the 2017 survey (longitudinal sample).

Note: The step-change observed between 2004 and 2005 is explained by the introduction of the new GMS contract in March 2004, which allowed practices greater flexibility to opt out of providing some additional and out of hours services.

Staff movement

11.34 We have previously included GP workforce vacancy rates by job role; however, data quality is poor, due to low completion rates. As result, the most up-to-date figures published by NHS Digital are from September 2019, and as such we have not provided GP vacancy rates in our evidence submission for this year.

11.35 NHS Digital publish experimental data on the number of joiners and leavers in general practice. For the period 30 September 2019 to 30 September 2020, headcounts for joiners and leavers (excluding locums and registrars) were 3,573 and 2,732 respectively, implying a net increase of 841. The actual change in the headcount workforce between those two dates was an increase of 728 GPs, based on the difference in the number of fully qualified permanent GPs (excluding registrars and locums). One reason for this discrepancy may be that joiners and leavers data do not include estimates for practices that do not provide fully valid records, whereas the headline general practice workforce statistics do.

11.36 We have also included data on staff movement by reason for leaving in our previous evidence submissions. However, NHS Digital have advised that they do not believe the reason for leaving data is of sufficient quality to be used, due to adverse effects of the COVID-19 pandemic on completeness and coverage of the March 2020 data extract. As such, we have not included these data in our evidence submission for this year.

GP Locums

11.37 The general practice workforce data includes FTE data for locums that are consistent and comparable over the period September 2017 to September 2020. The data shows that for the 2,457 (of 6,650) practices that reported locum use, the number of FTE locums has decreased by 6% (1,357 to 1,275) between September 2019 and September 2020. The September 2020 FTE figures for locum GPs make up around 3.6% of all GP FTE (a small reduction from 3.9% in September 2019). However, NHS Digital advise that locum figures are likely to be an underestimate due to poor data-reporting.

11.38 Locums are generally younger than salaried and contractor GPs (52% of headcount locums aged less than 45, compared to 48% of substantive, fully qualified GPs). GP locum data showed a higher proportion of men working as GP locums than women by headcount in September 2020 (although 7% of locums are of unknown gender), compared to more women than men working as substantive fully qualified GPs. This is a change in trend compared to September 2019, which showed a higher proportion of women working as locums.

11.39 The average participation rate for male locums is 29%, compared to 86% for male substantive GPs, whereas female locums have an average participation rate of 26%, compared to 68% for female substantive GPs. Although GP locum participation rates are relatively low compared to substantive GPs, this may be driven, in part, by contractor or salaried GPs doing additional locum sessions to supplement their substantive work. Additionally, the NHS Digital data may not capture all locum work if practices have not supplied data or if the locum is also working in settings outside of traditional general practice.

11.40 Data for the March and June 2020 extracts show a decline in locum use, which supports anecdotal reports of decreased locum use during the COVID-19 pandemic. A number of changes were introduced in general practice to enable practices to meet the challenges of dealing with the COVID-19 pandemic, including digital enablers for more flexible working, meaning that some practices may not have needed to rely on locum GPs to manage staff shortages and deliver patient care in the same way as before the pandemic. We understand practices also relied on substantive staff members increasing their hours and cancelling

annual leave during the first wave. A number of locums were recruited into the NHS 111 COVID-19 clinical assessment service to provide remote triage and clinical assessment of COVID-19 patients. As described in paragraph 11.23, NHS Digital advise caution when interpreting the findings of general practice workforce data extracts during the pandemic period.

12. GP Recruitment and Retention

GP Worklife Survey

12.1 The GP Worklife Survey provides an important source of information on GPs and is independent research commissioned by DHSC and carried out by Manchester University on behalf of the Policy Research Unit in Health and Social Care Systems and Commissioning (PRUComm). The tenth survey will be published later this year after it was paused due to COVID-19. The results are based on surveys completed by a sample (approx. 1,332) of GPs between November 2019 and January 2020. The Tenth GP Worklife survey is currently undergoing peer review so these statistics have been badged as 'interim' until this is completed, therefore, we would advise caution while considering these figures.

12.2 The review explores the views and motivations of GPs on issues including:

- Job Satisfaction: Respondents were asked about 9 individual aspects of their job. Figure 12.1 shows the top 5 sources of most satisfaction with respondents reporting the most satisfaction with their colleagues and fellow workers (85.90%) and the amount of variety in their job (75.80%). Figure 12.2 shows the top 5 sources of dissatisfaction with respondents reporting to be most dissatisfied with hours of work (45.90%) and remuneration (26.20%).

Figure 12.1- Sources of most satisfaction for GPs

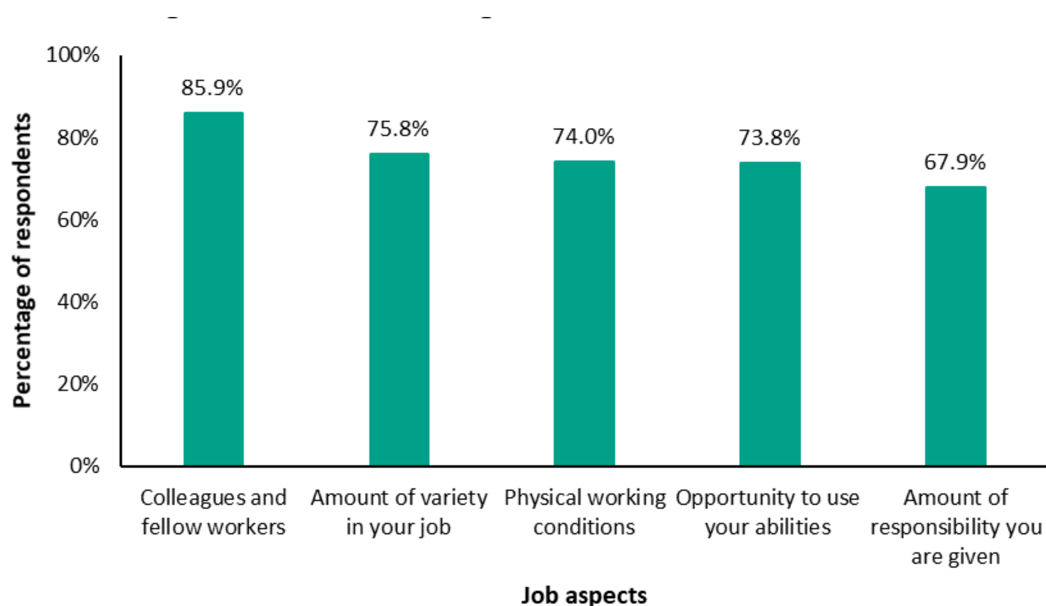
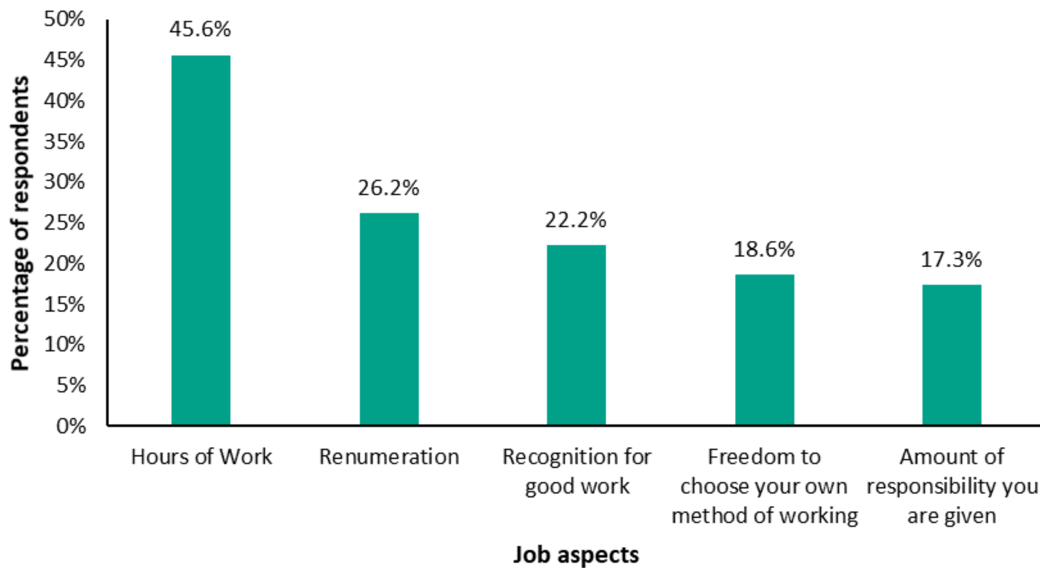


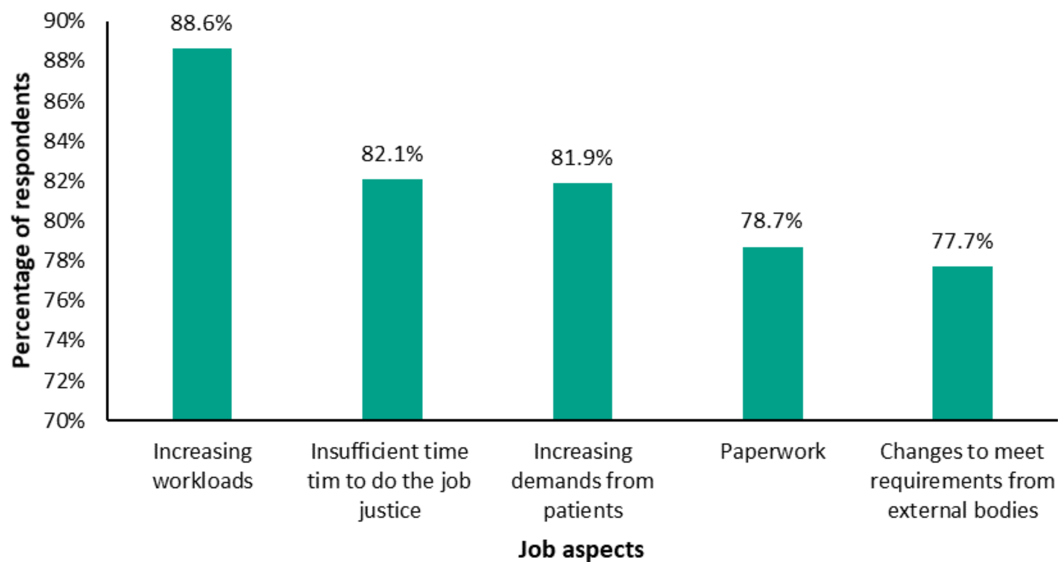
Figure 12.2- Sources of most dissatisfaction for GPs



Source: 10th GP Worklife Survey. The survey has not yet been published therefore these results are badged as 'interim', therefore we would advise caution when using these figures. The survey targeted two samples of GPs: 5,000 randomly sampled GPs (cross sectional sample) and 1,612 GPs who had replied to the 2017 survey (longitudinal sample).

- Job Pressures: Respondents were asked to rate 14 factors according to how much pressure they experienced from each in their job, on a five-point scale from ‘no pressure’ (1) to ‘high pressure’ (5). Although all average reported pressures have decreased by varying amounts between 2017 and 2019, they remain at a relatively high level compared with previous surveys. Figure 12.3 shows the top 5 sources of stress in their job with ‘increasing workloads’ (88.60%) and ‘insufficient time to do the job justice’ (82.10%) being the highest reported sources of stress.

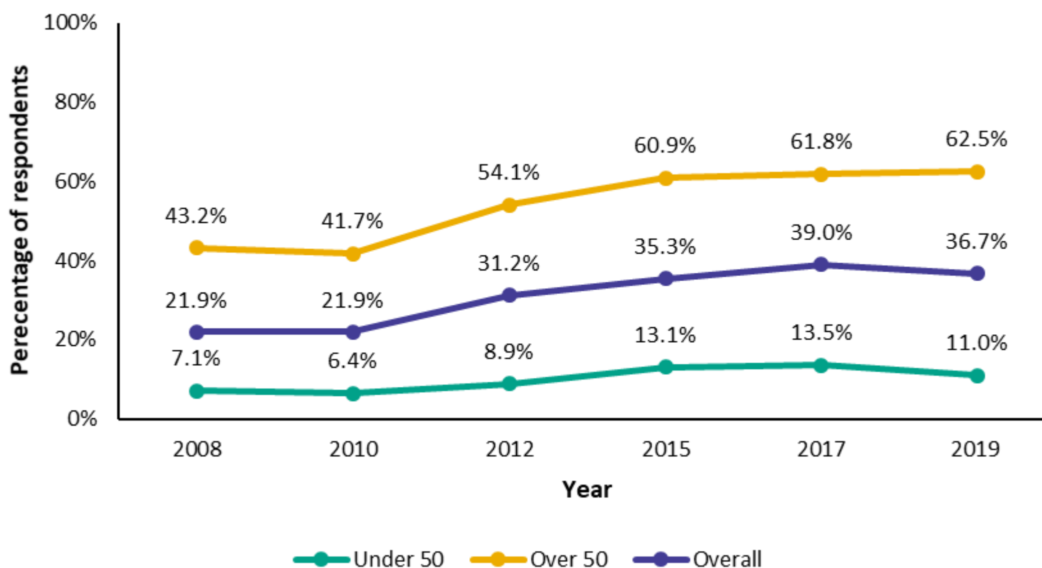
Figure 12.3- Sources of the most stress for GPs



Source: 10th GP Worklife Survey. The survey has not yet been published therefore these results are badged as 'interim', therefore we would advise caution when using these figures. The survey targeted two samples of GPs: 5,000 randomly sampled GPs (cross sectional sample) and 1,612 GPs who had replied to the 2017 survey (longitudinal sample).

- Intentions to quit: 36.7% of respondents (all ages) indicated that there was a considerable or high likelihood that they would quit direct patient care within five years. This is -2.3 percentage points less compared to 2017 (39.0%) and +14.8 percentage points more compared to 2008 (21.9%). As can be expected, intentions to quit within five years were significantly more common among GPs over the age of 50 (62.5% in 2019, compared with 61.8% in 2017 and 43.2% in 2008). Comparisons of intentions to quit going back to 2008 can be found in Figure 12.4.

Figure 12.4- GPs' intentions to quit direct patient care in the next five years, considerable or moderate likelihood, 2008-2019



Source: 10th GP Worklife Survey. The survey has not yet been published therefore these results are badged as 'interim', therefore we would advise caution when using these figures. The survey targeted two samples of GPs: 5,000 randomly sampled GPs (cross sectional sample) and 1,612 GPs who had replied to the 2017 survey (longitudinal sample).

Older GPs leaving the profession

12.3 According to analysis of NHS pensions scheme membership, of the GPs taking their pension for the first time (all reasons), the proportion doing so on a VER basis increased from 17.2% in 2007/08 to a peak of 61.0% in 2016/17(see Figure 12.5 for further detail). The proportion taking VER has dropped slightly since but has remained high at 54.7% in 2019/20 (591 VERs of 1,081 of all those taking their pension for the first time).

12.4 However, this is not a measure of retirement, but a measure of GPs taking their pension and anecdotally, we know some GPs will take their pension and return to the workforce (retire and return). We do not have robust data on the number of GPs that take their pension and remain in the workforce, and if they do stay in the workforce, in what capacity this is, including job role. NHSEI have a number of schemes in place aimed at enhancing retention, which may benefit the older age group (see paragraph 12.9, below).

Figure 12.5 - The number of GPs taking their pension (NHS Business Services Authority analysis of 1995 pensions scheme membership)

Pension year (1 April to 31 March)	Total number of GPs* claiming VER pensions	Number of GPs in total claiming NHS pensions**	% taking VER
2007/08	198	1,154	17.2
2008/09	264	1,304	20.2
2009/10	322	1,427	22.6
2010/11	443	1,555	28.5
2011/12	513	1,545	33.2
2012/13	591	1,411	41.9
2013/14	746	1,504	49.6
2014/15	739	1,438	51.4
2015/16	696	1,328	52.4
2016/17	723	1,186	61.0
2017/18	588	1,036	56.8
2018/19	607	1,092	55.6
2019/20	591	1,081	54.7

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

Actions to enhance GP recruitment and retention

12.5 DHSC is working with NHSEI and HEE, together with the profession, to increase the general practice workforce. This includes measures, as described below, to boost recruitment into general practice, encourage GPs to return to practice, and address the reasons why experienced GPs are considering leaving the profession.

12.6 The manifesto commits to creating an extra 50 million appointments in general practice a year by growing the workforce by 6,000 more doctors in general practice and 26,000 more primary care professionals, such as physiotherapists and pharmacists.

Recruitment

12.7 The 2020 updated GP contract announced that from 2021, the Government has committed to increasing the number of GP training places to 4,000 a year. The highest ever number of doctors accepted a place on GP training in 2020/21, with a total of 3,793 acceptances against HEE's target of 3,500. This compares to a total of 3,540 acceptances in 2019, surpassing the 3,250 target set for that year. Figure 12.6 shows fill rates for GP training places since 2014.

12.8 From 2021/22, the GP training model will undergo significant reform to support better training for GPs and a more balanced distribution of trainee capacity across the NHS. GP registrars currently spend around half of their three-year training working in general practice, but this proportion is set to increase to 2 out of the 3 years from next year. HEE and NHSEI have a number of schemes in place to attract more doctors to GP speciality training including the “Choose GP” advertising campaign, the Targeted Enhanced Recruitment scheme (TERs) and the Targeted GP Training Scheme.

Figure 12.6 - GP speciality training places available, accepted and fill rate

GP speciality training	2014	2015	2016	2017	2018	2019	2020
Places available	3,067	3,117	3,250	3,250	3,250	3,250	3,500
Acceptances	2,671	2,769	3,019	3,157	3,473	3,540	3,793
Fill rate	87%	89%	93%	97%	107%	108%	110%

Source: Health Education England, Recruitment Figures

GP Retention schemes

12.9 As outlined in Chapter 10, the 2020 update to the multi-year GP contract framework included new measures to aid GP training recruitment and retention and support the general practice workforce targets, so that practices and patients have access to the workforce they need. An overview of the available schemes are outlined below:

- The General Practice Fellowship programme is a national scheme announced in the NHS LTP and restated in the 2020 update to the contract agreement. This two-year programme is available to all newly qualified substantive GPs and nurses in general practice with a focus on working within and across PCNs. Participants receive mentorship, funded CPD opportunities and rotational placements to develop experience and support transition into the workforce in a local area.

- A new Supporting Mentor Scheme was launched by NHSEI in August 2020, offers highly experienced GPs the opportunity to mentor newly qualified GPs entering the workforce through the Fellowship Programme. This offer, of funded training for a recognised mentoring qualification and opportunities for portfolio working, is expected to be attractive to GPs nearing the end of their career. Once trained, GP mentors will be reimbursed to conduct one session of mentoring every week.

- The New to Partnership Payment Scheme is a new scheme from the 2020/21 contract update, aimed at growing the number of contractors (and individuals with equivalent status) working in primary care, stabilising the partnership model and helping to increase clinicians' participation levels. Eligible participants (including GPs who have not been contractors before and other professional groups such as nurses and pharmacists) will benefit from £3,000 of business training allowance to develop non-clinical partnership skills and a guaranteed one-off payment of £20,000 to support their establishment as a new contractor.

- The GP Retention Scheme provides a package of financial and educational support and acts as a safety net to help GPs remain in clinical practice where they cannot undertake a regular part-time role and might otherwise leave the profession.

- The National GP Induction and Refresher Scheme provides a safe, supported and direct route for qualified GPs who have left practice (for example to take extended maternity leave or a career break) to return to NHS general practice in England. This package of educational and financial support was enhanced in July 2020 with the addition of funding for childcare support.

Workload

12.10 Workload is reported as the key factor affecting GP recruitment and retention, and addressing workload includes increasing GP workforce supply through the range of actions described above. Information on the schemes in place to specifically target workload are included in NHSEI's evidence.

12.11 To help maximise the time available for clinical/patient-facing tasks, DHSC, in partnership with NHSEI, is reviewing the impact of bureaucracy on general practice. This review was a government commitment in the 2020/21 GP contract agreement document. It focusses on improvements that can be made to bureaucratic and administrative requirements including appraisals, revalidation, reporting, the interface with secondary care, certification, and requests for medical evidence. The review aims to simplify processes, remove duplication, make better

use of digital technology, and ensure the best-suited professional is completing tasks. Changes will begin to be made by the end of 2020 and work will continue across government and the NHS to implement the solutions that emerge. We anticipate that this workstream will impact general practice workforce targets through improving workload pressures and staff retention.

Multidisciplinary team working in general practice

12.12 The five-year contract seeks to address workload pressures and provide full reimbursement of additional staff in PCNs via the ARRS. Growing the general practice workforce with 26,000 more primary care professionals, including clinical pharmacists, social prescribers, physiotherapists and dieticians, will mean bigger teams of staff providing a wider range of care options for patients, including multi-disciplinary teams (MDTs) to deal with complex cases out of hospital.

12.13 As of September 2020, there were 1,091 additional full-time equivalent clinical staff working in general practice, excluding GPs, compared to September 2019. This consisted of 154 more nurses and 937 more other direct patient care staff (see Figure 12.7a).

Figure 12.7a- All staff working in general practice by FTE

FTE	September 2015	September 2016	September 2017	September 2018	September 2019	September 2020
All Staff	123,621	127,999	127,135	129,494	132,951	135,309
All Staff excluding GPs	89,193	92,770	92,482	94,960	98,090	99,875
GPs	34,429	35,229	34,653	34,534	34,862	35,434
Nurses	15,241	15,793	16,030	16,276	16,573	16,727
Other Direct Patient Care	10,883	11,636	11,901	12,555	13,565	14,502
Admin / non-clinical	63,069	65,341	64,551	66,129	67,952	68,645

Source: NHS Digital, General Practice Workforce 30 September 2020, November 2020, Table 1a. Figures include estimates for the practices that did not provide fully valid data.

Figure 12.7b - All staff working in general practice by Headcount

Headcount	September 2015	September 2016	September 2017	September 2018	September 2019	September 2020
All Staff	-	-	-	180,386	185,272	187,813
All Staff excluding GPs	131,498	135,159	133,844	136,037	139,674	141,031
GPs	-	-	-	44,378	45,625	46,821
Nurses	22,758	23,126	23,136	23,406	23,834	23,941
Other Direct Patient Care	17,150	17,931	18,210	18,788	19,973	20,971

Source: NHS Digital, General Practice Workforce 30 September 2020, November 2020, Table 1b. Figures include estimates for the practices that did not provide fully valid data. GP headcount figures are not comparable prior to 2017 due to changes in locum recording from March 2017.

12.14 Since March 2020, NHS Digital have also published quarterly statistics on the workforce in PCNs, to complement the above practice level data. The PCN data are published separately to the main NWRS workforce publication and labelled as "experimental". NHS Digital have advised that data coverage is lower than needed to give a full picture of the PCN workforce, which we believe is because this is a new data collection and there is an added pressure on PCNs due to COVID-19. For the workforce data extract on 30 September, only 50% of PCNs (617) provided data (an increase from 40% in June 2020). As such, we advise caution when using these data.

12.15 The PCNs that submitted data reported 1,880 FTE (2070 headcount) Direct Patient Care staff (primarily Pharmacists, Physiotherapists and Social Prescribers), 86 FTE Clinical Directors (391 headcount) and 249 FTE admin staff (455 headcount).

12.16 Up to the 31 March 2020 funding was only available for each PCN for social prescribers (100% reimbursement) and pharmacists (70% reimbursement). Further funding has been made available via the PCN contract from 1 April 2020 for more staff in a greater variety of roles with 100% reimbursement. By 2023/24, the PCN contract will include funding for around 20,000 more health professionals. Bigger teams of health professionals will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.

The NHS People Plan

12.17 Detail on the NHS People Plan can be found in Chapter 3. General practice staff are not currently included within the NHS staff survey and the 2020/21 NHS People Plan committed to exploring options to implement this survey in primary care.

Section 5: General Dental Practitioners

This section provides an update on GDPs providing NHS primary care services.

Evidence and data are presented on the trends in GDP workforce and earnings, recruitment and retention, motivation and morale as well as the impact of COVID-19 and support provided through the pandemic to the sector. Further evidence on dentistry will be provided separately by NHSEI.

You are invited to make a recommendation on the pay element of remuneration for dentists holding contracts with the NHS.

13. General Dental Practitioners

Workforce Numbers and Recruitment and Retention

13.1 NHSEI is responsible for commissioning NHS primary care dental services from providers to meet local dental needs in England. Providers are individuals or corporate bodies who hold a contract with the NHS.

13.2 NHS dentists can be either performer only (also known as associates), who subcontract with or are employed by dental contract holders to deliver NHS dentistry or provider-performers (contract holders who perform NHS dentistry). Dentists can also offer private care alongside NHS services.

13.3 NHS Digital publishes data on the number of dentists who have delivered NHS dentistry in any given financial year. This is based on data from NHS Business Service Authority who process dental payments and forms. Figures are shown in Figure 13.1.

13.4 Due to a change in methodology used to determine dental type for dentists in England and Wales, figures in this publication are not comparable to previously published results prior to 18/19. The results below refer to England only.

Figure 13.1- Number of dentists with NHS activity by dentist type, 2007/08 to 2019/20

Year	Total	Providing-Performer	Performer only/associates
2007/08	20,815	7,286	13,529
2010/11	22,799	5,858	16,941
2011/12	22,920	5,099	17,821
2012/13	23,201	4,649	18,552
2013/14	23,723	4,413	19,310
2014/15	23,947	4,038	19,909
2015/16	24,089	3,449	20,640
2016/17	24,007	2,925	21,082
2017/18	24,308	2,555	21,753
2018/19*	24,545	4,954	19,550
2019/20*	24,684	4,863	19,781

Source: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report

*Methodology changed in these years, figures are not comparable to earlier years. They refer to ENGLAND ONLY. There was a small number of dentists in these years where it was unknown whether they were a providing-performer or associate

13.5 From 2018/19 to 2019/20 the total number of dentists actively delivering NHS services increased from 24,545 to 24,684 (0.57% increase). During this period, the number of providing-performers fell and the number of performer only dentists rose. Last year data was not available on the split between providing-performer and performer only due to technical issues with NHSBSA data. These have now been resolved and recalculated. This split has been included for 2018/19 and 2019/20, however, with a slightly different methodology, hence the change in figures. The new methodology for determining dentist type implemented for 2018/19 onward, has resulted in many dentists being reclassified as Providing-Performer.

13.6 The percentage of dentists actively delivering NHS services who are female has increased from 40.1% in 2007/08 to 51.3% in 2019/20). There are more female dentists than male dentists in the under 35 group (59.3%). However, male dentists disproportionately represent those aged 55 and above, making up 71.5% of dentists in this age group.

13.7 The age band that has shown the greatest decline – in proportion – from 2009/10 to 2019/20 is 45-54 (23.6% to 20.2%), while the age group that has increased most is 35-44(26.6% to 28.7% over the same period).

13.8 The relationship between age group and motivation/morale is confounded by the correlation between age of performers and other factors such as weekly hours, amount of annual leave and proportion of NHS work. It is difficult to determine any conclusive impact from these demographics.

Earnings and Expenses

13.9 The average taxable income for all dentists in 2018/19 was £68,600, down from £68,500 in 2017/18. This reflects an increase in the average gross income to £147,100 in 2018/19 from £146,700. The level of expenses to gross income ("the expenses ratio") has increased very slightly to 53.4%. See Figure 13.2.

Figure 13.2- Gross income, expenses and taxable income for all dentists from 2004/05 to 2018/19

Year	Average Gross Earnings	Average Expenses	Average Taxable Income	Expenses ratio
2004/05	£193,215	£113,187	£80,032	58.6%
2005/06	£205,368	£115,450	£89,919	56.2%
2006/07	£206,255	£110,120	£96,135	53.4%
2007/08	£193,436	£104,373	£89,062	54.0%
2008/09	£194,700	£105,100	£89,600	54.0%
2009/10	£184,900	£100,000	£84,900	54.1%
2010/11	£172,000	£94,100	£77,900	54.7%
2011/12	£161,000	£86,600	£74,400	53.8%
2012/13	£156,100	£83,500	£72,600	53.5%
2013/14	£155,100	£83,400	£71,700	53.8%
2014/15 2015/16	£152,500 £148,000	£82,000 £78,900	£70,500 £69,200	53.8% 53.3%
2016/17	£145,700	£77,000	£68,700	52.9%
2017/18*	£146,700	£78,100	£68,500	53.3%
2018/19*	£147,100	£78,500	£68,600	53.4%

13.10 In England, the earnings of a dentist are dependent on whether they are a Providing-Performer dentist or a performer only dentist. Generally, Provider-Performers tend to earn more (higher gross earnings and taxable income). This is true for the 2018/19 figures and is consistent with previous years. However, the changing ratio of Providing-Performers to performer only dentists has moved the average figure closer to the lower-earning Performer only dentists. In 2018/19 Providing-Performer dentists had an average taxable income £113,100 a slight drop from £113,200 in 2017/18. In contrast, an associate dentist saw their average taxable income increase to £57,600 in 2018/19 compared to 2017/18 when it was £57,000.

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

nature of practice business models, the new methodology used to collect data and the rise of incorporation.

Motivation and Morale

13.12 The Dental Working Patterns: Motivation and Morale 2018/19 & 2019/20 report was last published by NHS Digital in August 2020. Motivation is regarded as the internal drive of an individual, e.g. inspiration or enthusiasm. Dentists were asked six motivation questions. For those who answered ‘agree’ or ‘strongly agree’, the difference in average motivation between 2018/19 and 2019/20 for Provider-Performers is -2.6%, compared to 0.6% for Performer only. They were asked ‘How would you rate your morale as a dentist?’ For those that answered ‘high’ or ‘very high’, the difference in average morale between 2018/19 and 2019/20 for Provider-Performers is 0.3%, for Performer only the difference is 0.4%. Due to the methodological changes, these results cannot be compared to previous years beyond 17/18 and refer to England only. This is shown in Figure 13.3 below:

Figure 13.3- Average motivation results; Average morale results 2012/13-2019/20

Year	Average motivation (%) Provider-Performer	Average motivation (%) Performer only	Average Morale (%) Provider-Performer	Average Morale (%) Performer only
2012/13	48.6	48.1	27.8	42.3
2013/14	45.9	48.9	27.5	42.8
2014/15	48.2	44.2	23.0	32.8
2015/16	45.8	45.2	22.6	33.3
2016/17	45.0	39.4	21.0	24.7
2017/18	42.5	38.9	20.2	24.9
2018/19	43.5	39.8	20.4	25.2
2019/20	40.9	40.4	20.7	25.6

Note: Average of ‘strongly agree’ or ‘agree’ responses to the motivation questions

Note: Percentage of dentists who recorded their morale as ‘very high’ or ‘high’

13.13 Morale generally relates to comfort and satisfaction. Performer only dentists appear to have higher morale than Provider- Performer dentists (4.9% difference in morale between the two groups).

13.14 The Dental Working Group (DWG) is a technical group with a UK wide remit and membership. Its primary role is to carry out agreed programmes of work to meet

the requirements of dentists' remuneration (including the associated Review Body on Doctors' and Dentists' Remuneration (DDRB)). The DWG survey covered individuals undertaking more NHS work and working longer hours.

Impact of COVID-19 and support provided to general dental practices

13.15 Dentistry has been particularly affected by the COVID-19 pandemic. So called aerosol generating procedures (AGPs), which create a fine spray of saliva, present a high risk of infection to those in direct contact with patients and for up to an hour after treatment concludes. Full PPE is therefore required, as is room resting for up to an hour after such treatments.

13.16 Initially, for the period 25th March- 7th June, NHSEI asked all NHS dentists to suspend all face to face routine care and, except through designated urgent dental centres (UDCs), all urgent care. Dentists were asked to provide remote advice, triage, antibiotics and analgesics from their practices and also to volunteer for more direct COVID-19 facing roles.

13.17 NHSEI continued to remunerate dentists in full through this period for their NHS contracted activity less a planned abatement of 16.75% (reflecting consumables not needed due to the absence of face to face care).

13.18 Dentist were asked to reopen their practices for NHS care from 8th June onwards as far as safety and availability of PPE allowed. During the restart period NHSEI continued to remunerate in full whatever the level of actual delivery of contracted activity.

13.19 For Q4 2020/21 NHSEI intend to require dentists to deliver at least 45% of their contracted activity in order to receive their full remuneration for the period 1 January- 31 March. This takes into account clinical advice on the safe level of care that can be expected and is pending further work to establish safe levels and approaches for 2021/22.

13.20 NHS income has therefore been largely protected despite the fact that dentistry has been necessarily limited to ensure practices remain stable through the pandemic period.

13.21 To provide wellbeing support for general practice staff during the pandemic, NSHEI launched the #LookingAfterYouToo: Coaching Support for Primary Care Staff service, developed in collaboration with the Royal College of General Practitioners. The service provides access to individual coaching sessions to support the mental health and wellbeing of all clinical and non-clinical primary care

workers employed or contracted to deliver work on behalf of the NHS. We are the NHS: People Plan 2020/21 – action for us all has additionally set out local and national steps needed to look after the workforce, with a focus on support during the pandemic, see Chapter 3 for more information.

Supply of Dentists and status of NHS Contracts

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

Targeting

13.23 Targeting is unlikely to be effective because for General Dental Service and Personal Dental Service agreements commissioners already have the ability to target and commission new services where there is need. They have the flexibility to commission services at an appropriate contract value to reflect local circumstances including the cost of service provision, potential service availability and the level of need. Pay recommendations for GDS and PDS apply at contract level so there is no guarantee that any recommendation is taken forward by contract holders and applied to any performer only dentists who work on that contract.

Dental contract reform

13.24 A new way of delivering NHS dentistry and paying dentists is continuing to be tested in over 100 high street dental practices (prototypes). At the heart of the new approach is a prevention-focussed clinical pathway which includes offering all patients an Oral Health Assessment and advice on diet and good oral hygiene, with follow up appointments where necessary to support patients' self-care and provide any further preventative treatments. The prototype practices are testing the pathway alongside a new remuneration system which is a blend of capitation and non-capitated activity. Under the prototype scheme two remuneration variants are being tested (Blend A and Blend B); in one capitation makes up 80% of payment and in the other around 55%, with the remainder being payments for treatments delivered.

13.25 The regulations permitting the variation from the GDS and PDS standard arrangement expire on 31 March 2022. We are continuing to evaluate this approach and an evaluation covering the three years of prototyping is expected to

be available in the new year. The underlying principles of the contract reform programme is to find an approach that can improve oral health, maintain or increase dental access, offer sustainability for dental practices and value for money for the NHS. NHSEI with DHSC will be carefully considering the findings of the evaluation together with the wider dental context in planning next steps.

Community Dental Services

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

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

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

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

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

Ophthalmic Practitioners

13.31 DHSC remains firmly of the view that there should be a common sight test fee for optometrists and Ophthalmic Medical Practitioners (OMPs), which is consistent with previous DDRB recommendations for joint negotiation of the fee. Optometrists carry out over 99.9 per cent of NHS sight tests. Commissioning of the NHS sight testing service in England is the responsibility of NHSEI.

13.32 Between 2018/19 and 2019/20, the number of OMPs who were authorised by the NHSEI in England to carry out NHS sight tests decreased from 218 to 193, -11%, and the number of optometrists increased from 13,468 to 14,087 an increase of 5.0 per cent. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications. In 2019/20, there were 13.4 million NHS sight tests. This was 1%

more than in 2018/19 and is consistent with the year-on-year rise seen in previous years[ix].

Annex 1 - Hours Worked for High Cost Medics by Specialty

Table 6.19 Hours worked for high cost medics – medical acute

Specialty	Total Hours 2018/19	Total Hours 2019/20	Change
General Medicine	234,073	113,189	-52%
Adult Mental Illness	191,188	101,667	-47%
Accident & Emergency	177,612	88,059	-50%
Psychiatry Services	173,612	89,990	-48%
Geriatric Medicine	146,307	76,297	-48%
Not Specified	98,147	65,486	-33%
Child And Adolescent Psychiatry	94,207	58,917	-37%
Radiology	93,069	42,225	-55%
Paediatrics	84,451	45,413	-46%
Gastroenterology	84,835	40,977	-52%
Ophthalmology	82,344	39,041	-53%
Acute Internal Medicine	81,545	38,592	-53%
Other Community	62,021	41,269	-33%
Trauma & Orthopaedics	64,515	30,534	-53%
Cardiology	59,676	29,306	-51%
Dermatology	56,983	29,466	-48%
Old Age Psychiatry	53,190	32,983	-38%
Respiratory Medicine	50,302	32,041	-36%
General Surgery	52,093	28,054	-46%
Stroke Medicine	52,272	27,307	-48%
Anaesthetics	50,559	24,298	-52%
Urology	50,670	22,112	-56%
Other Mental Health	49,292	21,003	-57%
Rheumatology	39,753	19,419	-51%
Diagnostic Pathology	34,364	19,533	-43%
Neurology	29,796	17,413	-42%
Obstetrics	32,357	13,565	-58%
Ent	29,197	16,381	-44%
Medical Oncology	27,006	17,317	-36%
Haematology	27,649	16,236	-41%
Gynaecology	19,930	9,941	-50%
Chemical Pathology	17,116	12,626	-26%
Learning Disability	18,083	10,672	-41%
Diabetic Medicine	16,681	10,731	-36%
Clinical Haematology	15,682	10,220	-35%
Clinical Oncology	17,919	6,815	-62%
Pathology	12,696	8,402	-34%

Community Care Services	13,203	4,146	-69%
Cardiothoracic Surgery	12,705	4,070	-68%
Breast Surgery	9,036	5,925	-34%
Endocrinology	9,295	5,207	-44%
Forensic Psychiatry	7,101	7,148	1%
Plastic Surgery	7,039	6,178	-12%
Neurosurgery	8,964	2,220	-75%
Rehabilitation	5,592	2,513	-55%
Community Nursing	5,227	2,176	-58%
Oral & Maxillo Facial Surgery	4,468	2,207	-51%
Neonatology	3,621	3,011	-17%
Critical Care Medicine	3,356	2,247	-33%
Nephrology	3,538	1,371	-61%
Intermediate Care	1,371	2,729	99%
Infectious Diseases	3,278	395	-88%
Imaging	2,679	885	-67%
Paediatric Surgery	2,627	883	-66%
Spinal Injuries	2,321	1,009	-57%
Orthodontics	2,108	783	-63%
Palliative Medicine	1,603	794	-50%
Oral Surgery	1,371	756	-45%
Other	1,269	777	-39%
Midwife Led Care	1,707		-100%
Dental Medicine Specialties	1,593		-100%
Occupational Medicine	1,052	390	-63%
Public Health Medicine	472	700	48%
Genitourinary Medicine	194	723	273%
Medical Ophthalmology	722	164	-77%
Therapy Services	577	63	-89%
Theatres	189	40	-79%
Clinical Neuro-Physiology	193	36	-81%
Psychiatric Intensive Care Unit		142	
Paediatric Neurology	76	43	-43%
Clinical Physiology	63	40	-37%
Orthotics and Prosthetics	100		-100%
Paediatric Dentistry	60		-100%
Paediatric Cardiology	10	40	300%
Restorative Dentistry	40		-100%
Clinical Immunology and Allergy		39	
Clinical Pharmacology	26		-100%
Sexual Health Services	24		-100%
Clinical Support - Physio		0	
Total	2,600,059	1,367,340	-47%

Source: NHSEI Temporary Staffing Team. This data does not reflect the entire locum workforce but refers to shifts worked at “high cost” meaning these shifts were procured either at 50% above the Agency rules price cap, or without use of an NHS approved procurement framework.

Annex 2 - Medical Expansion by University

Table 6.20 - Expansion table – Medical degree places before (6,071) and after the expansion (7,571)

University	2017/18	2020/21	Increase
Lancaster University	54	129	139%
University of Plymouth	86	156	81%
University of Exeter	130	218	68%
Universities of Hull and York	141	231	64%
Universities of Brighton and Sussex	138	203	47%
University of Sheffield	237	306	29%
Keele University	129	164	27%
University of East Anglia	167	208	25%
University of Leicester	241	290	20%
Queen Mary, University of London	316	371	17%
University of Nottingham	327	371	13%
University of Warwick	177	193	9%
University of Oxford	184	200	9%
University of Liverpool	307	332	8%
University of Southampton	242	261	8%
University of Leeds	258	278	8%
St George’s Hospital Medical School	259	279	8%
University of Bristol	251	270	8%
University of Cambridge	292	313	7%
Imperial College	322	345	7%
University of Manchester	371	397	7%
University of Newcastle	343	367	7%
University of Birmingham	374	400	7%
King’s College London	403	430	7%
University College London	322	334	4%
Total	6,071	7,571	25%

Source - Office For Students

Annex 3 - ACCEA evidence to DDRB

REVIEW OF NATIONAL CLINICAL EXCELLENCE AWARDS SCHEME

Introduction

1. In 2011, the United Kingdom's health ministers asked the Doctors and Dentists Pay Review Body (DDRB) to review compensation levels and incentive systems and the various Clinical Excellence and Distinction Awards schemes for NHS consultants at national and local levels (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226727/DDRB_CEA_Cm_8518.pdf).

2. DDRB recommendations have not been taken forward up to this point due to NHS changes and other priorities. We are now in a position to take forward reform of the national CEA scheme to meet the aims set out in paragraphs 4 and 5.

3. A stronger distinction between national CEAs and local awards is planned, although this is subject to the outcome of negotiations on reforming local CEAs.

Consultation

4. Subject to ministers' approval, we will use the DDRB recommendations as a framework for our consultation exercise which will seek views on:

    - Changes to the domains for assessing national CEA applications.
    - Improving the application process for and widening access to the CEA competition.
    - Maintaining excellence during the period covered by a national CEA.
    - Changing the number and value of new national CEAs.

5. The consultation also aims to complement some of the DDRB recommendations in that:

    - They will be non-consolidated and non-pensionable;
    - National CEA holders will also be able to hold a local performance award concurrently.

- They will not be renewable – eligible clinicians will have to make a new application at the end of their CEA period or relinquish the award they hold at the end of 5 years.

- The progression element of the current scheme will be removed – eligible clinicians will make a single application, competing against peers who have also applied for a national CEA. Scoring and ranking being the determinant of the level of award achieved. This should encourage more applicants from under-represented backgrounds attaining national CEAs at all levels improving diversity.

- The national bronze awards and their funding will be devolved to become part of employers' annual performance awards, replacing local CEAs, so trusts can have a greater say in recognising local and regional achievement. This will give a better delineation between local/regional clinically excellent performance and the national scheme where recognition will be required nationally and/or internationally.

- Eligibility criteria for applying for a national CEA will remain the same.

- There will be more national CEAs, albeit at a lower remuneration. Given the ability to hold local and national awards simultaneously, this will provide a similar level of reward opportunity for those holding national CEAs. We anticipate a higher number of national CEAs will act as a prompt for more applicants from a wider range of backgrounds, with a stronger tie to annual appraisal performance, whereby those recognised as delivering clinical excellence locally, are more actively encouraged and supported in applying for a national CEA.

- In addition, we intend to capture the recommendations outlined in the Gender pay Gap in Medicine Review. These include addressing the issues faced by those working LTFT, encouragement from employers to increase the diversity of those who should be applying for awards, and to broaden applications from across all medical specialties;

- Whether they should continue to be fixed for a five-year period or reduced to a four-year period.

- Informal discussions in the form of focus groups took place over the the Summer, with suggestions and comments on the proposals to reform the scheme. Discussion papers can be found at: https://www.gov.uk/government/publications/national-clinical-excellence-awards-scheme-reforms-submit-your-view

Timescales

6. Discussions have continued with both the Chair and Medical Director of ACCEA to determine, aside from the 2012 recommendations, what else should be addressed in the consultation.

7. Work is underway on the consultation document, to obtain ministerial approval to run the consultation, with the aim of publishing in February 2021. The consultation itself will last for 12 weeks, and once ministerial approval has been granted, then work will commence on implementing a new national CEA scheme to commence from 2022. We anticipate that there will be a 5-year transition period as the current scheme closes down and takes the new scheme to its steady state.

8. Both the ACCEA Chair and Medical Director met with the DDRB in late 2020 and updated them on progress.

Endnotes

[i] The consultation document and consultation response can be found at: https://www.gov.uk/government/consultations/public-service-pension-schemes-consultation-changes-to-the-transitional-arrangements-to-the-2015-schemes

[ii] Available from: https://www.nhsemployers.org/pay-pensions-and-reward/pensions/nhs-pension-tax/local-flexibilities-for-affected-staff

[iii] Workplace Pension Participation and Savings Trends of Eligible Employees Official Statistics: 2008 to 2018, available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806513/workplace-pension-participation-and-saving-trends-2008-2018.pdf

[iv] A copy of the consultation document is available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/830862/NHSPS_flexibility_consultation_document.pdf

[v] See https://www.gov.uk/maternity-pay-leave/pay

[vi] See https://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/TCS-GP-GMS%20150409.pdf

[vii] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2020

[viii] https://gprecruitment.hee.nhs.uk/Recruitment/TERS/England

[ix] https://digital.nhs.uk/data-and-information/publications/statistical/general-ophthalmic-services-activity-statistics/england-year-ending-31-march-2020

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