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 2020/21 Pay Round

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Executive Summary

We recognise that the NHS continues to face significant challenges with increasing demand for health services due to an ageing and growing population.

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, putting patients first and keeping them safe whilst providing the high-quality care we all expect and the pay review bodies for the NHS are asked, as part of their standing remits, to give regard to that.

The Government's longstanding aim remains the same. It is to ensure that we can recruit, retain, and motivate sufficient high calibre NHS staff to deliver government policy, ensure best value for the taxpayer and continue to deliver world-class patient care. It is a complex matter of judgement which includes the overall impact of the NHS employment offer, pay and non-pay terms on attracting and keeping the staff the NHS needs.

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

The key context for evidence for the 2020/21 pay round is NHS England's Long Term Plan. As in the remit letter from the Secretary of State for Health and Social Care (Annex 5), this written evidence asks the Review Body to:

- consider its recommendations within the context of workforce growth assumptions and the importance of making planned workforce growth affordable, as well as wider financial risks facing the NHS;

- make recommendations for targeting funding to support productivity and recruitment and retention; and

- set out, in its report to government, how its recommendations take account of affordability and need for workforce growth and improved productivity

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

- high-level evidence from the Department, including the strategic policy objectives and the economic and financial (NHS funding) context;

- evidence from NHS England and NHS Improvement on its Long Term Plan and the implications of that for workforce growth and affordability; as well as evidence on provider issues including provider affordability, and recruitment and retention;

- evidence from Health Education England on doctors and dentists in training, including specialty and geographical issues and fill rates, in order to examine recruitment and retention issues; and

- evidence from NHS Employers providing views from provider organisations which employ doctors in the review bodies remit group.

1. NHS Strategy and Introduction

1.1 As set out in our 2018/19 evidence, the 2015 Spending Review saw the Government commit to an additional £8 billion in real terms by 2020/21, and an additional £2.8 billion of revenue funding in the Autumn 2017 budget.

1.2 In June 2018 the Prime Minister set out a new funding settlement for the NHS, growth in spending in return for the NHS agreeing a Long Term Plan, setting the course for the NHS for future years and allowing the NHS to plan with funding certainty.

1.3 The NHS Long Term Plan (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.

1.4 Demand for NHS and social care services continues to rise, due to amongst other things, an increasingly aging population with multiple and complex care needs. Meeting this demand whilst maintaining and improving quality, and maintaining affordability, is one of the systems significant challenges.

1.5 The Long Term Plan stated that NHS England would publish a Workforce Implementation Plan, and in June 2019 NHS England and NHS Improvement published their Interim People Plan, with a full People Plan set to be published in the near future. NHS England and Improvement will set out more detail on the People Plan in their evidence.

1.6 As a result of the NHS settlement being held by NHS England, it is of course in their interest to set out affordability constraints and financial risks to the system, taking in to account all of the competing demands on the fixed financial settlement. Spending on pay awards is one of the biggest cost pressures placed on the fixed funding settlement, and of course has a recurrent impact in future years. NHS England and Improvement will set out the financial position of the service in their evidence, highlighting the demands placed on the limited funding available.

1.7 The Department values the independent recommendations of the review body, but it is important that we highlight in our evidence what we believe the impact of unaffordable pay recommendations would be. NHS England would have to commit to additional funding above their planned assumptions, meaning a re-prioritisation

of existing plans. 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.

1.8 The government, in its election manifesto, set out an ambition to substantially grow the nursing workforce. While nurses are of course not a part of the DDRB's remit, the NHS funding settlement covers all staff groups. The consultant workforce has grown considerably over the last decade but there is a need to ensure that investment can be made in workforce growth across multidisciplinary teams, to secure the best outcomes for patients.

Workforce

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

1.10 The Department has embarked on pay and contract reform right across the NHS workforce, including workforces not covered by the DDRBs remit, as part of our ambition to make the NHS the best employer in the world providing the very best and safest care.

1.11 Pay and contract reforms we have made are not just about headline pay uplifts. The changes we have made will help to increase productivity and improve recruitment and retention by improving the working lives of staff and helping them maintain their physical and mental health and wellbeing.

1.12 As detailed further in Chapter 6, in 2019 we agreed a pay and contract reform deal for doctors and dentists in training. In Chapter 8, we discuss our planned work on reform of the Specialty and Associate Specialist (SAS) grade contracts.

Staff engagement

1.13 Staff engagement is crucial to securing and retaining the workforce that the NHS needs, as is making the most effective use of the entire NHS employment offer - pay and non-pay benefits.

1.14 We strongly believe that recruitment and retention is not just about pay, it is about creating a culture and environment in the NHS where staff want to work, where

staff feel safe to raise concerns and to learn from mistakes; where employers listen to and empower staff, work hard to keep them safe and ensure bullying and harassment is not tolerated. The Department continues to work in partnership with its arms-length bodies and other organisations to support trusts in their responsibility for improving staff experience.

Pensions taxation

1.15 The review body commented in its 47th report on the issue regarding pension taxation and will be aware of the interim solution put in place by NHS England and NHS Improvement. We hope that the review body will recognise that this is a significant measure, that will benefit the consultant workforce in 2019/20. As per the governments manifesto commitment, further work is ongoing to ensure a permanent solution will be in place going forwards.

Government Pay Policy, 2019/20 Awards and our Approach to Pay and Contract Reform

1.16 The Government aims to ensure that the overall remuneration package for public sector workers is fair to them and that we can deliver world class public services which are affordable within the public finances and fair to taxpayers as a whole.

1.17 We expect the DDRB to make recommendations within an envelope of £310m for substantive HCHS medical staff. Of this, around £120m covers the 2020/21 element of the pay and reform deal already agreed for doctors and dentists in training (see Chapter 6 for further detail on the deal).

1.18 This envelope is based on the forecast medical paybill for 2020/21 before the application of any pay awards. It is derived as:

(a) The 2018/19 substantive HCHS medical paybill (£11.7bn);

(b) Plus the remaining recurrent impact of the 2018/19 pay award (1.05%)

(c) Plus the assumed cost weighted impact of staffing growth in 2019/20 (4.1% based on in-year data)

(d) Plus the assumed paybill impact of the NHS pension scheme revaluation (3.8%)

(e) Plus the recurrent impact of the 2019/20 pay award (2.35%)

(f) Plus the assumed impact of pay drift in 2019/20 (0.1%)

(g) Resulting in a recurrent paybill going into 2020/21 of £13.1bn

(h) Plus the assumed cost weighted impact of staffing growth in 2020/21 (2.8%)

(i) Plus the assumed impact of pay drift in 2020/21 (0.1%)

(j) Resulting in a projected £13.5bn paybill before pay rises in 2020/21

1.19 Workforce growth is assumed to be 2.8% for 2020/21, which assumes growth levels continue at broadly the same level as recent trends.

1.20 Note that this is the cost to the substantive workforce only. Wider financial planning must allow for the knock-on impacts for temporary staffing and non-HCHS employers whose workforce terms and conditions of service (TCS) are linked to national HCHS TCS.

1.21 For General Dental Practitioners (GDPs) we expect the DDRB to make recommendations on income and staff costs within an envelope of £37m. The value of all NHS dental contracts in 2018/2019 was £2.8bn[i] and this envelope is based on the weighting of income and staff costs. The table below gives a breakdown of the weighting to each element of the NHS dental contract. Any uplifts on the other costs mentioned below would need to be considered separately.

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

Element of the NHS Dental contract	Weighting
Income	50.0%
Staff costs	16.2%
Laboratory Costs	6.1%
Materials Costs	6.6%
Premises Costs	0.0%
Other Non-staffing Costs	21.1%

1.22 For Salaried General Practitioners, the five-year deal agreed in 2019 sets the context for affordability. NHS England and NHS Improvement and the BMA General Practitioners Committee agreed a five-year GP (General Medical

Services) contract framework from 2019/20. Funding for the core practice contract (i.e. excluding the network Directed Enhanced Service (DES)) is now agreed and fixed for five years. The new contract provides five-year funding clarity and certainty to practices. This settlement covers all aspects of practice income and expenses including salaried GP pay. The uplift to the contract should be taken in the context of the full package for GP contract reform which included seeking to address workload by providing additional staff though the Additional Roles Reimbursement Scheme and the introduction of the new state-backed scheme for GP indemnity which started in April 2019. As the GP contract has now been set for five years, there is direct trade-off between pay and staff numbers which provides the context to the uplift to the salaried GP pay range and will inform decisions by GP partners on the pay of salaried GPs.

1.23 In the last pay round the review body recommended a general award of 2.5%, and an additional 1% for SAS doctors. CPI inflation was 2.2% in September-November 2018, falling to 2% in December and 1.8% in January-March 2019. The review body made an award of approximately half a percent above the general CPI inflation trend at the time.

Figure 1.2 - CPI inflation by month, September 2018 - March 2019

Month	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
CPI inflation	2.2%	2.2%	2.2%	2%	1.8%	1.8%	1.8%

1.24 CPI inflation has been consistently lower in 2019/20 than in the previous financial year and is showing a downward trend, falling from 2% in April 2019 to 1.5% in October and November 2019. The latest figure available (December 2019) shows CPI inflation at 1.3%.

1.25 The Department and NHS England and NHS Improvement believe that the cash figure available for pay awards in 2020/21 is sufficient to provide an appropriate real-terms pay award.

1.26 We do not believe that there is sufficient evidence to show that a pay award of similar value or higher than 2019/20 is necessary in 2020/21. We recognise that there were arguments for the 19/20 pay award to be higher as a response to the relatively restrained award in 18/19, but do not believe that this principle should be applied in 2020/21, given the 2.5% general pay award in 2019/20.

1.27 If the pay award value in 2020/21 was a similar level above current CPI inflation to the award in 2019/20, we think this would provide a balance between a fair pay

rise giving a real-terms increase, and affordability considerations in terms of other workforce spending in 2020/21.

1.28 Following the 2019 General Election, there is a renewed focus on workforce growth, meaning that it is now more important than ever to ensure that the correct affordability balance is achieved. Whilst additional funding has been committed within the Government's manifesto for recruitment and retention of the NHS workforce, there will be service costs that will need to be funded from the NHS five-year settlement

1.29 We would ask the review body to consider the changes set out in our evidence on recruitment, retention, and motivation, as well as the economic arguments. We believe, given the general improvements in these areas and metrics, combined with the reduction in inflation, and pay satisfaction remaining positive overall, means that the 2020/21 context is different to that in 2019/20, and the approach to the pay award should reflect this.

1.30 In terms of workforce groups:

(a) The consultant workforce continues to grow, and our evidence finds no overall recruitment and retention difficulties that would be solved by higher pay. The main financial concern for consultants are issues related to pensions taxation. The Government has accepted the overall case that pension taxation arrangements are a unique problem for NHS clinicians. In line with this the Government has consulted on the introduction of a range of pensions flexibilities. Alongside this, the Government has also accepted the need to consider whether further changes are required, and as per the Government's manifesto commitment, we have announced a review of the operation of the pensions taper which will report at the next fiscal event. We expect this will impact positively upon the morale and motivation of this workforce.

(b) For SAS doctors, the Department recognises the issues the review body has raised in previous reports, and we are committed to resolving these issues through contract reform. Plans to reform the SAS grades intend to bring about improvements in pay satisfaction, morale and motivation to this group. The focus of reforms will be on improving the status and attractiveness of these roles by enhancing opportunities for meaningful career development. There will be additional investment from the NHS Funding Settlement to fund reform, but as with other recent contract reform deals for junior doctors and AfC staff, it is expected that investment will be in return for improvements in productivity and engagement.

(c) For salaried GPs, we would ask that the review body consider the fixed practice funding GP partners will have available through the five year deal.

(d) For general dental practitioners, evidence shows that overall headcount has slightly increased but without whole time equivalent (WTE) data it is not possible to assess if this translates overall into more time spent on NHS dentistry. There have been some reports regarding increased difficulties with recruitment and retention in parts of the country. However, without WTE data it remains challenging to understand fully the extent of recruitment and retention issues. National plans to reform the current NHS dental contract to focus on a more preventative approach to treatment aims to make the NHS attractive to the dental profession.

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

1.32 To achieve this requires the right balance between pay and staff numbers through systems of reward that are affordable and fit for purpose. Staff tell us that they want to know they will have the right number of colleagues working alongside them in hospital or in the community. Our focus on balancing affordability with ensuring staff get the pay rises that help to recruit and retain them is key to this.

1.33 Since the Public Sector Pay Cap was lifted, the Department has not lost sight of the need for pay discipline to ensure affordability and sustainability, and where contracts have been reformed we have done this on a “something for something” basis, ensuring that investment in to pay and contracts sees contract improvements and productivity benefits, as well as helping to recruit and retain staff.

1.34 The recommendations in the DDRB’s 47th report - for a general uplift of 2.5% across all the review body's remit groups, plus an additional 1% for SAS doctors, were given very careful consideration by Government, in the context of:

- Affordability for pay and workforce growth in 2019/20 in the context of the long-term funding settlement;
- the importance of prioritising patient care within the available funding settlement and delivering on the objectives of the NHS Long Term Plan;
- the contract reform we have already undertaken, such as the recent four-year deal for doctors and dentists in training, the five year deal for General Medical Practitioners, and the three-year deal for Agenda for Change staff, and;
- the case for contract reform for Specialty and Associate Specialist doctors.

1.35 The Department will again advise ministers to consider the review body recommendations on this basis in 2020.

1.36 In 2019/20, after full consideration of the state of recruitment, retention and motivation as well as the necessary budgetary constraints and how that might impact the aims and priorities of the health service and its staff, the Government responded to the DDRB report via Written Ministerial Statement.

1.37 The decision was taken to accept the review bodies recommendation of a general uplift of 2.5%, to be implemented from April 2019.

1.38 It is important to note that the 2019/20 recommendation for a 2.5% general uplift was above what the Department and NHS England had calculated as an affordable uplift, and therefore placed financial strain on the 2019/20 position. The 2019/20 award will also place recurrent pressure on every remaining year of the five-year settlement.

1.39 We did not fully accept the recommendation to uplift SAS doctor pay by an additional 1% on top of the 2.5% general uplift, instead choosing to use this money for the important reforms we plan to undertake to the SAS contracts, which we discuss in more detail in Chapter 8. This additional 1% to be invested in reform of the SAS contacts is not included in the cash affordability figure for pay awards in 2020/21.

1.40 We did not uplift unreformed national or old style local Clinical Excellence Awards for Consultants, but we did uplift new reformed local Clinical Excellence Awards by the general 2.5% increase.

1.41 The review body did make a recommendation for doctors and dentists in training, but by the time the review body report was published, NHS Employers and the BMA had already collectively agreed a four year pay and contract reform deal. This is detailed further in Chapter 6.

1.42 Similarly, NHS England and the BMA General Practice Committee have agreed a five-year deal, which sets out funding uplifts to the GMS contract. An update on the multi-year deal can be found at Chapter 9.

1.43 A general uplift of 2.5% was applied to contractor and salaried dentists, to the salaried GP pay ranges, to the GP trainer grant and appraiser fees, and to the GP and dental educator pay scales.

1.44 As set out in the remit letter, the NHS Long Term Plan provides the context for the long-term funding of the NHS, and the affordability of pay recommendations will

have to be considered within the affordability assumptions underpinning the NHS Long Term Plan.

1.45 The NHS budget is set for 2019/20 to 2023/24 and this budget includes money for planned workforce growth. This is why, as set out in our remit, there are trade-offs if money above affordability assumptions is spent on pay.

1.46 As already set out above, NHS England and Improvement will set out in their evidence a more detailed financial picture, and we have asked in our remit that you take that in to account in your final report.

1.47 Once again, we are seeking your views on targeting available funding to ensure that the optimum balance is achieved between affordability and addressing recruitment and retention pressures.

1.48 The multi-year pay and contract reform agreement we have reached for doctors and dentists in training is covered at Chapter 6. We are not seeking a pay recommendation for this remit group, but as usual we would welcome your comments and observations on the evidence you receive from all parties.

1.49 Similarly, as Independent Contractor General Medical Practitioners are subject to a five-year pay agreement between NHS England and the British Medical Association, we are not seeking pay recommendations for this group. We are seeking a recommendation on uplifts to the minimum and maximum of the salaried General Medical Practitioner pay scales.

1.50 We are asking for recommendations on uplifts for consultants, and for General Dental Practitioners and Salaried Dentists (including community dentists).

1.51 As we detail in Chapter 8, we are embarking on exploratory talks with the BMA on Specialty and Associate Specialist (SAS) doctors, with a view to negotiating a multi-year pay and contract reform deal, and as such would expect your recommendations to be informed by these talks with the BMA as we update you on progress.

2. NHS Finances

2.1 This chapter describes the financial context for the NHS.

Funding Growth

2.2 The NHS Long Term Plan (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 The Spending Round 2019 also settled non-NHS revenue budgets for 2020-21 only. This confirmed a 3.4% real terms increase to the Health Education England (HEE) budget, including an additional £150 million for Continuing Professional Development (CPD) and wider education and training budgets will also get a £60 million funding boost to support delivery of the NHS Long Term Plan and the NHS People Plan. This is important in making a start towards the broader goal of addressing workforce shortages. A multi-year Spending Review is expected in 2020.

2.4 The settlement gave a 3.1% real-terms increase on 2019-20 for the overall DHSC group position. Increasing these vital budgets will further enable the NHS to deliver a better service and health outcomes for patients.

Figure 2.1 NHS England Total Departmental Expenditure Limit (TDEL) (£bn)

NHS England	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	123.562	0.305
2020-21	129.858	0.305
2021-22	136.134	-
2022-23	142.841	-
2023-24	151.318	-

Source: 2019-20 Financial Directions to NHS England

2.5 The table above shows the opening mandate for NHS England in 2019-20, and indicative amounts for future years, as per NHS England's Financial Directions. These figures include an increase for pensions revaluation which was not included as part of the original Long Term Plan settlement. Figures exclude depreciation, AME and technical budget.

2.6 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 Long Term Plan.

2.7 It is essential this money is spent wisely, which is why the Government has set five financial tests to ensure the service is being put on a more sustainable footing. 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.

Financial Position

2.8 The Government's Mandate to the NHS includes a clear objective for the NHS to balance its budget. From April 2019, NHSE and NHSI have been working from a joint operating model, with oversight for NHS finance conducted by a joint CEO and joint chief finance officer who both report to NHSE/I's joint board. Together they are both responsible for stabilising finances across the system and increasing financial sustainability through improved efficiency and productivity in the provision of healthcare.

2.9 Recovering finances in the NHS continues to be a major focus. A growing deficit in 2015-16 needed to be halted, and 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.

2.10 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.

2.11 In 2018-19, NHS England and NHS Improvement continued to work closely to build plans with individual providers and commissioners that aggregated to a balanced plan for the NHS. This plan built on the improvements made in previous years.

2.12 However, NHS providers were experiencing greater than planned for financial pressures. The main pressure for providers continued to be increasing staffing costs driven by growing emergency patient numbers. Equally, some clinical commissioning groups (CCGs) reported overspends as these increased patient volumes meant increased commissioning costs beyond those planned for.

2.13 The overspends in both providers and commissioners were identified early and, as a result, the NHS leadership intervened and covered the higher than planned deficit by delivering underspends in central commissioning budgets. As a result, and for the third consecutive year, the NHS has once again delivered financial balance. However, we recognised that continuing this approach was not sustainable. There are no quick fixes; new, long-term sustainable solutions will take time and effort, with those organisations facing the greatest challenges being assessed, supported and assisted by NHS Improvement and NHS England.

2.14 Building on the relative success of the last few years, we are now moving into the next phase; our plans to go further to achieve financial sustainability across the

NHS are set out in the NHS's Long Term Plan. A new financial framework that is better able to support and encourage the health system to develop in a more sustainable way with a rebalancing of its finances will form part of this. Ending 2018-19 in a stable financial position has been very important as the financial assumptions in the NHS Long Term Plan were dependent on this being the case.

Figure 2.2 Provider deficit time series

NHS Providers RDEL Breakdown	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Total Provider Deficit (£m)	(458)	(476)	(544)	107	842	2,448	791	991	827
Provisions Adjustment (£m)	(106)	(163)	(120)	53	121	74	43	39	(23)
Other Adjustments (£m)	(183)	3	68	(11)	(47)	27	101	8	22
Total Revenue DEL (£m)	(748)	(636)	(596)	149	916	2,548	935	1,038	826

Share of Resources Going to Pay

2.15 Figure 2.3 shows the proportion of funding consumed by NHS provider permanent staff spend over the last 5 years. Note that NHS provider permanent staff spend only covers staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

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

Year	NHS England RDEL (£bn)	Provider Permanent Staff Spend (£bn)	% of spend on staff	Increase in total spend	Increase in provider permanent staff spend
2013/14	93.7	43.0	45.8%	0	0
2014/15	97	43.9	45.3%	3.5%	2.26%
2015/16	100.2	45.2	45.1%	3.3%	2.80%
2016/17	105.7	47.7	45.1%	5.5%	5.58%

2017/18	109.5	49.9	45.6%	3.6%	4.64%
2018/19	114.6	52.6	45.9%	4.7%	5.35%

2.16 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.

2.17 2020/21 marks the third and final year of the AfC multi-year deal. The deal reflects the Government's continued support for the NHS workforce to deliver excellent care, while reinforcing a public sector pay policy that pay flexibility should be in return for reforms that improve recruitment and retention, and boost productivity.

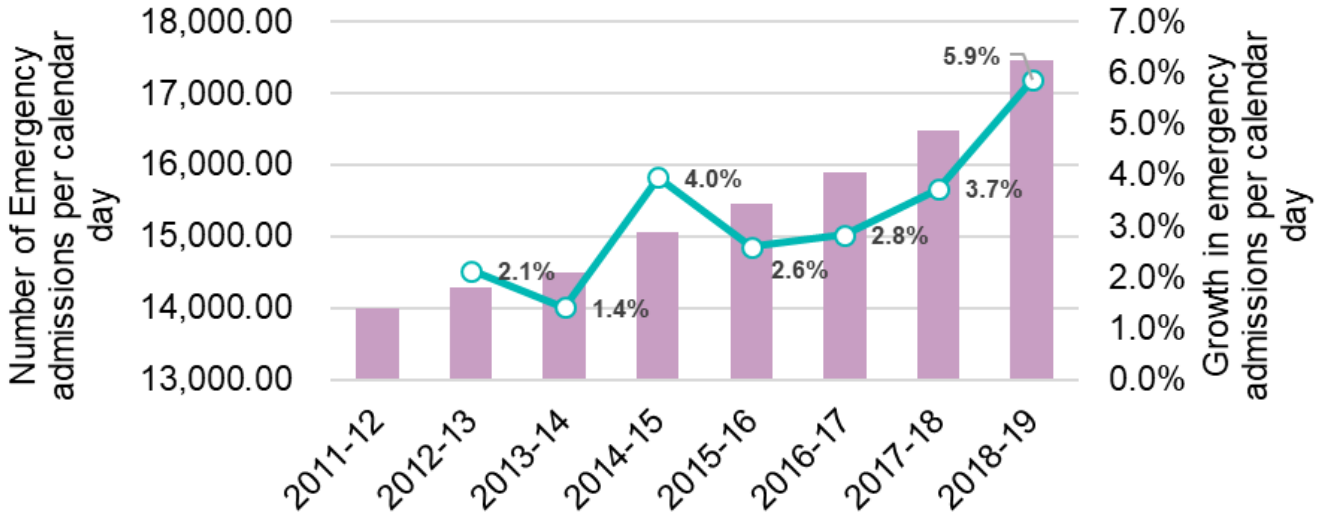
2.18 DHSC has embarked on contact reform right across the medical workforce, in addition to the multi-year AfC deal, as part of its continued ambition to make the NHS the Best Place to Work, as set out in the Interim NHS People Plan.

2.19 The Government accepted the majority of the recommendations made by the DDRB in their latest report. This resulted in pay awards higher than the 2% which was deemed affordable considering the context of the NHS Long Term Plan, placing a financial strain on the 2019/20 position and necessitating reprioritisation of expenditure and planned investments. Given the NHS budget is fixed for the next four years, the 2019/20 award also places recurrent pressure on the remaining years of the settlement.

Demand Pressures

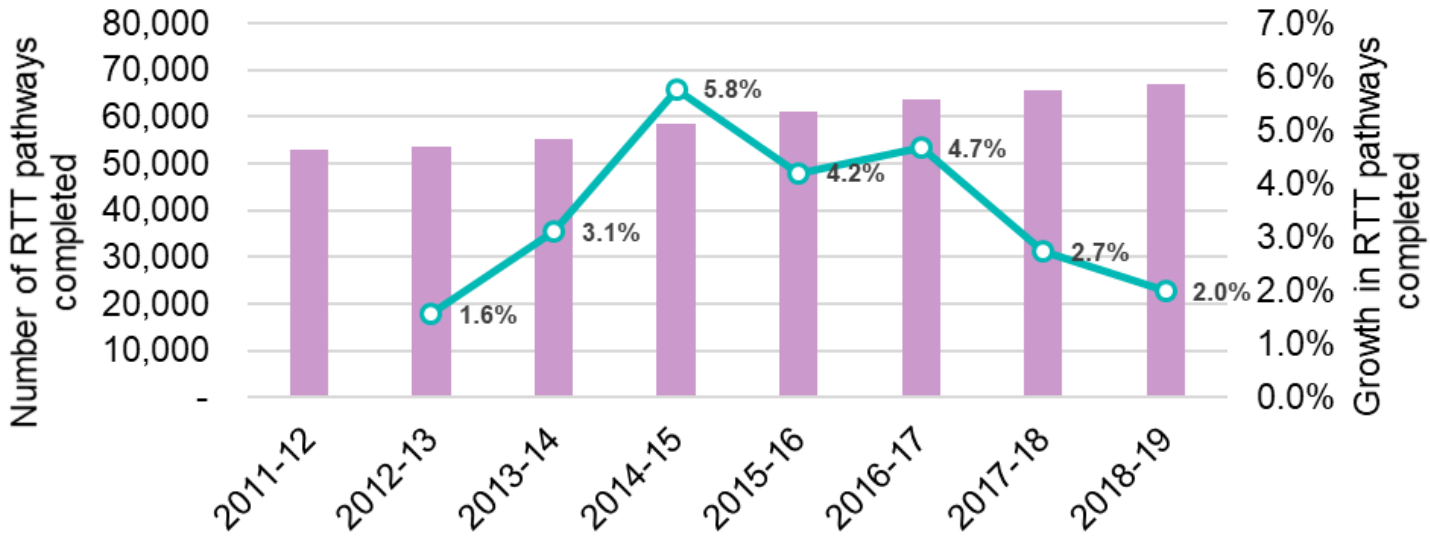
2.20 Demand for services provided in the health and care system continues to rise above what would typically be expected from population growth and demographics alone. To meet this demand the NHS continues to deliver more activity than ever before, as evidenced by the number and growth in emergency admissions and elective (i.e. non-emergency) treatments over the last 7 years.

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

2.21 Compared to the year before, in 2018-19 there were 966 (5.9%) more emergency admissions per day as well as 1,336 (2.0%) more elective care pathways completed per working day, as shown in figures 1.4 and 1.5.

2.22 Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2018-19, partly due to the increasing demand pressures placed on frontline services. These included A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards.

2.23 There is no evidence to suggest that trend in increasing demand will ease. Therefore, demand pressures represent a principal challenge faced by the NHS both now and in the future. The long-term funding settlement reflects the government's continued support to the NHS in mitigating this issue. Considering this, managing demand effectively is one of the five financial tests that the government has set as part of the settlement.

2.24 Managing demand, cutting down avoidable demand and using resources effectively therefore represent key target areas that must be improved to meet growing demand pressures and ensure the long-term sustainability of the system.

Productivity and Efficiency in the NHS

2.25 Putting the NHS back onto a sustainable financial path is a key priority in the Long Term Plan and is essential to allowing the NHS to deliver the service improvements in the plan.

2.26 The Long Term Plan commits to making re-investable productivity gains of at least 1.1% a year over the next five years. Thanks to the agreed revenue funding settlement, all these gains can be retained by the NHS and reinvested in more and better patient care.

2.27 The plan identifies ten priority areas in the first two years of implementation as part of a strengthened efficiency and productivity programme:

(a) Improving the availability and deployment of the clinical workforce.

(b) Making savings in procurement through aggregation of volume and standardisation of specifications.

(c) Delivering pathology and imaging networks to improve the accuracy and turnaround times on tests and scans.

(d) Improving efficiency in community health services, mental health and primary care.

(e) Delivering better value from the NHS medicine spend.

(f) Making further efficiencies in NHS administrative costs across providers and commissioners.

(g) Improving the way in which the NHS uses its land, buildings and equipment.

(h) Ensuring that the least effective interventions are not routinely performed, or only performed in more clearly defined circumstances.

(i) Reducing patient harm and the substantial costs associated with it.

(j) Continuing to tackle patient, contractor, payroll, and procurement fraud.

2.28 The programmes to deliver the required productivity improvements build upon the 10 Point Efficiency Plan devised as part of the NHS Next Steps on the Five Year Forward View (2017). This was an agreed plan of action as to how the NHS will deliver the necessary savings to ensure it lives within its means. Programmes from the plan key to delivering the required productivity improvements include;

(a) Operational Productivity Programme: reducing variation in clinical practice and improving management of resources in NHS acute, community, mental health, and ambulance providers, following the recommendations of the Carter Reviews of operational productivity in acute, mental health, community, and ambulance trusts.

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

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

2.29 Efficiency improvements are monitored through provider Cost Improvement Programmes (CIPs), and commissioner Quality, Innovation, Productivity and Prevention plans (QIPPs). During 2018/19, providers achieved savings through CIPs of £3.2 billion or 3.6%, almost identical to the level achieved in 2017/18 while Commissioners delivered QIPPs totalling £3.0billion.

2.30 The Carter reports identified a savings opportunity of £5.8 billion in the provider sector across specific work programmes over five years. These Operational Productivity work programmes include workforce productivity, procurement and back-office functions, clinical support functions and specific sectors (mental health, community health, ambulance). The NHS has developed and grown the Model Hospital, which helps trusts to understand how their performance compares with their peers and identify opportunities for further improvements.

2.31 In 2018/19, these programmes helped deliver £1.18 billion in recurrent CIPs. While this is encouraging progress, there remains a significant challenge in ensuring that learning and best practice is spread across the NHS.

2.32 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 £2.4 billion in 2018/19 compared to £3.6bn in 2015/16. Agency spend now accounts for 4.4% of the overall NHS Pay bill, down from 7.8% at its peak in 2015. The Department and NHS England and NHS Improvement are also supporting trusts to increase their use of bank staff, who are typically more committed to their trusts.

Calculating Productivity in the NHS

2.33 Productivity and economy savings are components of efficiency. While economy savings are realised through buying inputs at cheaper prices, productivity growth delivers more outputs for the same level of inputs.

2.34 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.

2.35 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%.

2.36 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%.

2.37 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 Long Term Plan are to be achieved.

2.38 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.

2.39 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.

2.40 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%

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%

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

2.41 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 NHSE/I which has begun to examine early outputs; we will provide a further update when these are mature enough to report on.

Conclusion

2.42 The Government reiterated its commitment to the NHS when it confirmed the five-year settlement for the NHS with an additional £33.9 billion cash terms annual increase by 2023-24 compared to 2018-19 budgets.

2.43 We have made great strides in tackling the NHS provider deficit and need to build on this success to deliver the Long Term Plan commitments with a new financial framework which will support the delivery of a financially sustainable health system. It is important that the 2020/21 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 Long Term Plan.

2.44 Government's continued support for the NHS workforce is reflected in agreed multi-year funding deals for junior doctors and staff on Agenda for change contracts. For example, the agreed AfC multi-year deal reinforced a public sector pay policy of increased pay flexibility in return for reforms that improve recruitment and retention while boosting productivity. Alongside this, the Government accepted the majority of the recommendations made by the DDRB for 2019-20, rewarding staff dedication and productivity improvements, as well as encouraging recruitment and retention.

2.45 Pay forms one part of a wider rewards package that includes pensions (discussed in greater detail in chapter 12), and as a whole is intended to recognise the hard work of the NHS workforce.

3. HCHS Medical and Dental Staff Earnings

Summary and Background

3.1 In 2018/19 doctors had Average Total Earnings per Person of £79,500. There is much variation across staff groups and experience. The equivalent figures for Foundation Year 1 Doctors and Consultants range from £34,600 to £112,800.

3.2 HCHS Doctors Average Earnings continue to grow - with 1.5% growth in 2018/19. This varies across staff groups, with particularly high growth for Foundation Doctors (at 3.2% 3.3% and 4.1% for years 1 and 2 respectively) and the lowest growth for Consultants at 0.5%.

3.3 Earnings growth was largely driven by pay awards. The 2018/19 award was staged to apply from October 2018 with an average in-year impact of 1%, although other factors are relevant too. The implementation profile for Junior Doctor contract reform introduced in 2016 is estimated to have added around 0.4%. Within this a greater proportion of Junior Doctor earnings are now Basic Pay rather than Additional Earnings.

3.4 Furthermore, workforce mix effects are important - shifts towards a more consultant heavy, and therefore high earning workforce are estimated to have added around 0.2%. Against this, ongoing growth within grades is likely decreasing average levels of experience and depressing overall Average Earnings growth.

3.5 Doctors earnings remain amongst the highest in the economy based on national earnings data from recent years, although recent earnings growth is slower than comparator high earnings professions. However, the medical profession is perhaps unusual in that all new doctors have the realistic expectation of reaching the most senior positions of their profession and becoming amongst the very highest earners in the economy through pay advancement.

3.6 The starting Basic Pay alone for Junior Doctors is £27,689 and the top of the Consultant Pay scales is currently worth £107,668. This means that Doctors are eligible for pay advancement of 289% over the course of their careers.

3.7 Gender pay issues remain at every staff-group. However, this is reflective of historical recruitment patterns in favour of men. The latest data shows that over 50% of Junior Doctors are women and the proportion of women consultants has

had sustained increases over time from 27% of the consultant workforce in 2006 to 37% in March 2019.

Average Earnings

3.8 Doctors are generally high earners, although there is much variation across staff groups and levels of experience. Earnings across all staff groups have continued to grow in recent years, with larger increases for Junior Doctors and relatively lower increases for Consultants. Further exploration of recent earnings growth is provided in a following section.

Basic Pay and Total Earnings

3.9 Earnings per Person varies according to level of seniority. The average ranges from £34,600 for Foundation Year 1 doctors to £112,800 for Consultants.

3.10 The latest NHS Digital data on Pay and Earnings for Doctors working in the Hospital and Community Health Sector (HCHS) in England (for the 12 months to the end of March 2019) is provided in figure 3.1. Growth rates are based on the difference over the past 12 months.

Figure 3.1 - Total Earnings per Person for 12 months to end of March 2019, and growth over the last year

Staff Group / Medical Grade	Basic Pay per FTE	Basic Pay per Person	Earnings per Person	Basic Pay per FTE Growth	Basic Pay per Person Growth	Earnings per Person Growth
HCHS doctors	£65,600	£59,800	£79,500	3.2%	2.7%	1.5%
Consultant	£92,000	£85,800	£112,800	1.2%	1.0%	0.5%
Associate Specialist	£83,900	£75,000	£91,700	1.9%	2.2%	1.6%
Specialty Doctor	£62,400	£52,800	£66,200	2.8%	3.3%	2.8%
Staff Grade	£57,500	£46,100	£60,700	7.6%	2.0%	0.4%
Specialty Registrar	£43,000	£40,600	£58,100	4.1%	4.3%	1.6%
Core Training	£38,500	£37,300	£51,100	6.1%	7.2%	2.9%

Foundation Doctor Year 2	£31,100	£30,800	£41,300	3.0%	6.4%	4.1%
Foundation Doctor Year 1	£27,000	£26,800	£34,600	1.7%	4.4%	3.2%
Hospital Prac/ Clinical Assistant	£113,800	£31,300	£33,700	10.1%	3.6%	3.0%
Other and Local Doctor Grades	£83,400	£49,700	£52,700	4.6%	1.5%	2.3%

Source - NHS Digital Earnings Statistics

- NHS Digital publish three measures around pay: Basic Per per FTE; Basic Pay per Person and Total Earnings per Person. Earnings per Person includes additional earnings such as Geographical Allowances or On-Call Payments.

- NHS Digital do not publish a measure of Earnings per FTE as not all types of Additional Earnings scale to FTE in the same way.

- The table suggests high growth in earnings for individuals in the Staff Grade & Hospital Practitioner categories. There are small numbers of staff in these grades that are closed to new entrants. High growth will reflect that no new staff are entering these grades at the bottom of payscales as well as a compositional effect for those remaining in the grade.

Take Home Pay

3.11 Previous review body reports have requested further information on the consequences for take-home pay of crossing pension, tax and National Insurance thresholds. This is discussed in more detail in chapter 7, ‘Pensions and Total Reward’.

Earnings Distribution

3.12 Earnings vary within all staff groups as shown in figure 3.2. This reflects: seniority, hours of work, working patterns, and the receipt of other allowances.

3.13 The NHS Digital data presented in figure 3.2 are based on Earnings per Person and are not adjusted for those who work on a less than full time basis. Also note that since last year, the NHS Digital methodology changed. Now the figures include only those who have been in the same grade over full 12-month period to

the end of March. This means that figures for Foundation Doctors are not available as these are likely to switch grade within this time period.

Figure 3.2 - Distribution of Total Earnings by career grade - 12 months to March 2019

Career grade	25% Earn Less Than	Median	25% Earn More Than	Mean Average
HCHS Doctors	£62,500	£91,500	£119,500	£79,500
Consultant	£94,000	£112,500	£134,000	£112,800
Associate Specialists	£76,000	£92,000	£109,000	£91,700
Specialty Doctors	£50,500	£70,500	£85,500	£66,200
Specialty Registrar	£52,000	£62,000	£68,000	£58,100
Core Training	£48,500	£51,000	£57,500	£51,100
Foundation Doctor Year 2	N/A	N/A	N/A	£41,300
Foundation Doctor Year 1	N/A	N/A	N/A	£34,600

Source - NHS Digital Earnings Statistics

Additional Earnings

3.14 Figures 3.4 and 3.5 give details on Additional Earnings per Person. They average around 25% of Total Earnings, and capture several different types of payment, but the patterns vary across staff groups.

3.15 Interpreting Additional Earnings data is complicated by the different contractual arrangements for the different staff groups. For example, Medical Award Payments are most important for Consultants, but that is because it largely captures Clinical Excellence Awards that only apply to Consultants. Similarly, some Junior Doctors are still paid according to terms and conditions established by their 2002 contract. This pays Banding Supplements for a combination of extra and unsocial hours, but these same activities would be rewarded through different payments for other medical staff groups (this particular issue will erode as full implementation of the 2016 Junior Doctor contract is reached in the future).

Recruitment and Retention Premia

3.16 Recruitment and Retention Premia (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 sufficient 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.

3.17 NHS Digital data (Figure 3.3) shows that only a small proportion (0.2%) of Doctors are in receipt of RRPs.

3.18 Over time the proportion of medics in receipt of RRPs has increased slightly as has the average value of those payments.

Figure 3.3 Proportion in receipt of RRP and average value of that RRP (18/19)

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

Source - NHS Digital Workforce Statistics

Figure 3.4 - Proportion in receipt of Additional Earnings by earnings category (12 months)

Staff Group / Medical Grade	Additional Activity	Band Supplement	Medical Awards	High Cost Area Allowances	Local Pay	On Call Payments	Overtime	RRP	Shift Work	Other
HCHS doctors	56.8%	15.0%	18.4%	25.8%	14.0%	34.2%	0.0%	0.2%	26.7%	7.1%
Consultant	61.2%	0.4%	43.3%	25.7%	19.2%	71.5%	0.0%	0.3%	0.6%	5.7%
Associate Specialist	49.4%	0.3%	0.5%	22.8%	16.7%	16.9%	0.0%	0.2%	0.3%	2.2%
Specialty Doctor	47.5%	1.2%	0.0%	21.6%	17.0%	14.1%	0.1%	0.7%	0.3%	2.4%
Staff Grade	29.4%	16.3%	0.7%	22.1%	18.5%	4.5%	0.0%	1.4%	0.1%	1.3%
Specialty Registrar	41.3%	47.8%	0.0%	29.6%	8.0%	7.1%	0.1%	0.0%	40.8%	9.6%
Core Training	71.5%	16.8%	0.0%	27.5%	8.4%	5.9%	0.0%	0.2%	71.7%	13.5%
Foundation Doctor Year 2	80.3%	6.2%	0.0%	23.0%	9.2%	2.3%	0.0%	0.0%	79.8%	7.9%
Foundation Doctor Year 1	88.1%	1.8%	0.0%	21.8%	14.4%	0.4%	0.0%	0.0%	87.3%	2.3%
Hospital Practitioner / Clinical Assistant	3.5%	0.4%	0.1%	3.9%	9.5%	0.3%	0.0%	0.1%	0.4%	2.8%
Other and Local Grades	6.3%	1.5%	0.5%	12.4%	7.0%	0.9%	0.0%	0.2%	1.5%	3.3%

Figure 3.5 Average value of Additional Earnings by category - those who received payment only (12 months to end of March 2019)

Staff Group / Medical Grade	Additional Activity	Band Supplement	Medical Awards	High Cost Area Allowances	Local Pay	On Call Payments	Overtime	RRP	Shift Work	Other
HCHS doctors	£14,423	£18,604	£13,746	£1,699	£18,534	£3,724	£12,957	£20,481	£5,305	£5,747
Consultant	£21,913	£13,624	£13,750	£1,681	£21,221	£3,696	£18,695	£22,641	£2,192	£6,960
Associate Specialist	£22,495	£23,317	£6,148	£1,437	£24,827	£5,307	£6,992	£11,780	£4,239	£832
Specialty Doctor	£17,674	£13,461	£4,034	£1,292	£23,044	£3,053	£7,447	£11,661	£2,841	£3,193
Staff Grade	£18,688	£18,325	£3,506	£1,528	£26,586	£10,015	-£254	£4,274	£104	£9,101
Specialty Registrar	£7,586	£19,240	£0	£1,785	£14,918	£4,172	£13,472	£35,606	£6,051	£6,390
Core Training	£6,593	£15,738	£0	£1,831	£11,448	£3,596	£867	£9,124	£5,864	£4,066
Foundation Doctor Year 2	£4,991	£13,900	£0	£1,641	£8,626	£3,821	£0	£10,556	£5,301	£1,772
Foundation Doctor Year 1	£4,493	£10,482	£0	£1,647	£4,755	£3,457	£115	£0	£2,948	£1,373
Hospital Practitioner / Clinical Assistant	£18,950	£8,003	£6,535	£466	£13,811	£21,827	£7,604	£2,350	£1,433	£9,642
Other and Local Grades	£16,327	£20,374	£20,789	£1,408	£14,171	£8,330	£1,638	£6,587	£4,269	£5,841

Source - NHS Digital Earnings Statistics

Earnings Growth

3.19 Total Earnings per FTE for medics increased by 1.5% in 2018/19. This exceeded the in-year effect of staged pay awards which average 1%. Two key drivers of this difference are shifts towards a more consultant heavy, and therefore high earning workforce, and the ongoing effects of Junior Doctor contract reform introduced in 2016. This continues the broad trends seen in previous years.

3.20 Figure 3.6 presents trends in medical earnings growth and its component drivers. This comes from DHSC Headline Paybill Metrics which includes a Paybill Drivers Analysis which breakdowns Paybill growth into its constituent parts

Figure 3.6: Breakdown of Average Earnings Growth for Medics

Breakdown	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Basic Pay Growth	1.2%	0.8%	0.8%	2.0%	3.0%	2.6%
Additional Earnings Growth	1.3%	2.6%	0.6%	1.2%	-1.5%	-1.9%
Total Earnings Growth Of Which	1.2%	1.3%	0.7%	1.8%	1.8%	1.5%
Headline Pay Awards	1.0%	0.0%	0.1%	1.0%	1.0%	1.0%
Total Earnings Drift Of Which	0.2%	1.3%	0.6%	0.8%	0.8%	0.4%
Basic Pay Drift	-0.2%	0.3%	0.1%	0.3%	1.9%	1.4%
Additional Earnings Drift	0.0%	0.5%	0.0%	-0.2%	-1.2%	-1.1%
Grade Mix Effect	0.4%	0.4%	0.6%	0.7%	0.2%	0.2 %

Source: DHSC HCHS Paybill Metrics

3.21 As presented in the table above, several factors drive changes in Average Earnings. Some relate to changes in the composition of the workforce (e.g. more senior staff), some relate more specifically to pay rates:

- Headline pay awards for 2018/19 were staged from 1st October 2018, with an in-year effect averaging 1% with:
    - 1% in-year impact for Consultants and Junior Doctors from a staged 2.0% award.
    - 1.5% in-year impact for Staff Grade and Associate Specialist Doctors from a staged 3.0% award.
- Average Total Earnings grew faster than the pay award in 2018/19 (1.5% vs 1%) implying positive Earnings Drift. Drift levels are driven by several factors:
    - A grade mix effect of 0.2% reflecting a shift in the workforce towards higher earning staff groups i.e. consultants.
    - The ongoing implementation of the Junior Doctor contract reforms introduced in 2016, but yet to fully impact Average Earnings due to its phased implementation starting with the newest Junior Doctor posts. This coupled with reforms to redistribute earnings towards the part of Junior Doctor pay scales created an immediate boost in Average Earnings and Earnings Drift. As full implementation is reached drift would return to normal levels. However, we estimate contract reform has added around 0.4% to Total Earnings Drift for the whole medical workforce in 2018/19.
- Wider workforce mix effects, not separately visible in the headline data table, where the distribution of staff across pay points alters. For example, growth in the consultant workforce suggests more relatively inexperienced consultants at the lower pay points.
- Additional Earnings effects – where changes in Basic Pay are not matched by changes in Additional Earnings. This can be suggestive of changing use of Geographical Allowances, Medical Awards, Recruitment and Retention Premia etc.

3.22 In 2018/19, Additional Earnings Drift was -1.1%. This continued a recent trend. However, this is expected as Junior Doctor contract reform introduced in 2016 is deliberately moving earnings from Additional to Basic pay through shifting former Banding Supplements towards Basic Pay.

Earnings growth for Foundation Doctors

3.23 The review body have asked for additional information on the earnings for Foundation Doctors. Over the past 5 years (since 2013/14) earnings for Foundation Year 1 Doctors have increased by over 10% and 7% for Foundation

Year 2 Doctors. In the previous year earnings increased by 3.2% and 6.9% for Foundation Year 1 & 2 Doctors respectively. Recent growth reflects both headline pay awards and the effects of Junior Doctor contract reform, introduced in 2016, which shifted earnings towards the earlier stages of Junior Doctor careers

Figure 3.7 Foundation Year 1 Earnings by Earnings category

Grade	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Foundation Y1 Total Earnings, of which:	£31,374	£31,546	£31,879	£32,830	£33,537	£34,606
Basic Pay	£21,951	£21,912	£21,885	£22,999	£25,630	£26,760
Non-Basic Pay	£9,423	£9,634	£9,995	£9,831	£7,907	£7,846
Earnings growth since 2013/14	N/A	0.5%	1.6%	4.6%	6.9%	10.3%

Source - NHS Digital Earnings Statistics

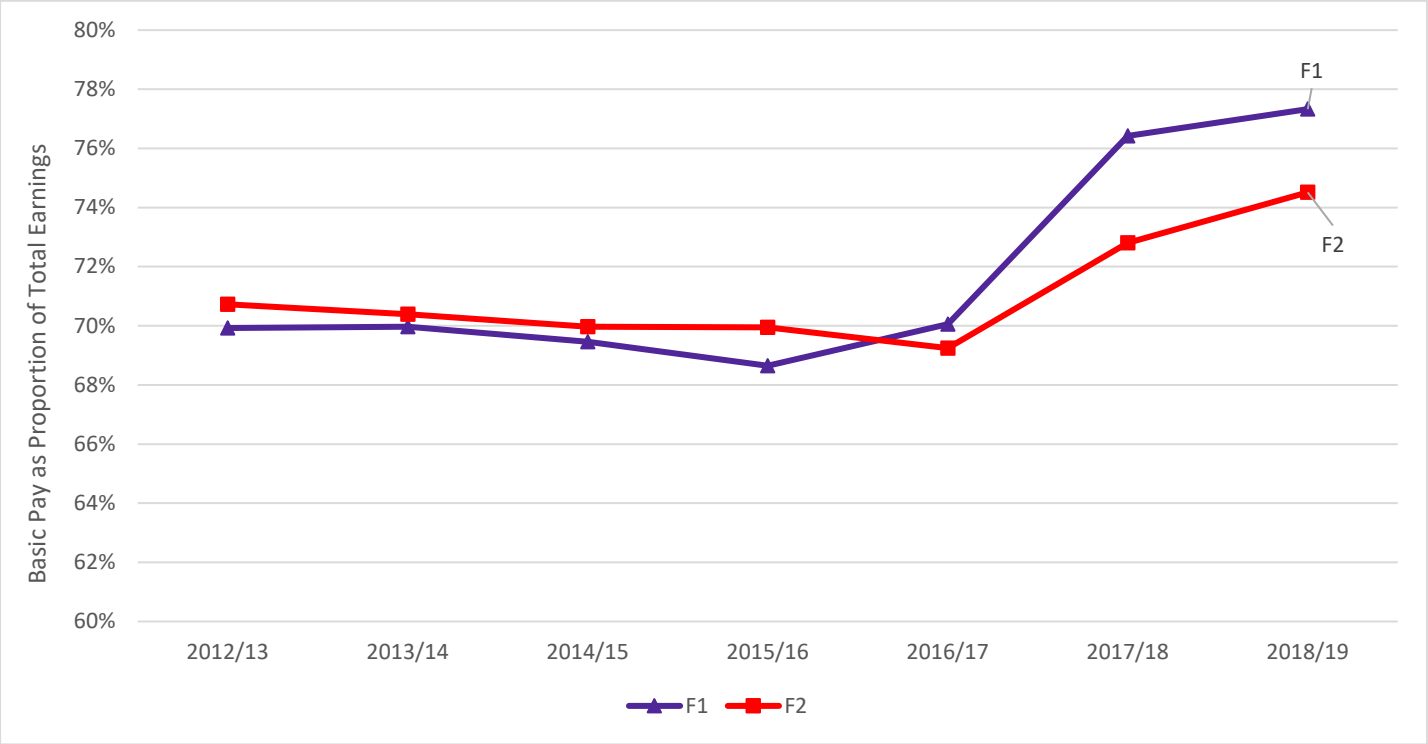
Figure 3.8 - Foundation Year 2 Earnings by Earnings category

Grade	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Foundation Y2 Total Earnings Of Which	£38,451	£38,603	£38,576	£39,191	£39,689	£41,274
Basic Pay	£27,067	£27,010	£26,984	£27,138	£28,895	£30,755
Non-Basic Pay	£11,385	£11,593	£11,592	£12,053	£10,793	£10,519
Earnings growth since 2013/14	N/A	0.4%	0.3%	1.9%	3.2%	7.3%

Source - NHS Digital Earnings Statistics

3.24 Alongside earnings growth, there has been a shift of earnings towards Basic Pay. Figure 3.9 shows how Basic Pay now accounts for an increased share of Total Earnings - with an increase of about 5 percentage points over the past two years. This is a deliberate effect of the contract reform introduced in 2016 which shifted former Banding Supplements towards Basic Pay

Figure 3.9 - Basic Pay as proportion of Total Earnings for Foundation Doctors.



Source - NHS Digital Earnings Statistics

Wider Economy Comparisons

3.25 The Median Gross Annual Pay for doctors is around 2.4 times the national average for all employees in the UK. Earnings growth for doctors has been lower than several other high earning occupations over recent years, and median annual pay for doctors was lower in 2019 than in 2015. However, doctors remain one of the highest paid professions in the UK.

3.26 This section considers earnings growth between 2015 and 2019 for doctors against other high earning occupations such as airline pilots, IT directors and senior police officers, using data from the Annual Survey of Hours and Earnings (ASHE). In this analysis, doctors equate to the ASHE 'Medical Practitioners' group, which includes all types of doctor, from Foundation Doctors to Consultants and GPs. Table 4.10 compares the Median Gross Annual Pay for occupations which had a median above £55,000 in 2015 (and a published median figure for 2019).

Figure 3.10 Median Annual Pay for High Earning Occupations in 2015 and 2019

Occupation	SOC CODE	Median Gross Annual Pay 2015	Median Gross Annual Pay 2019	Percentage Increase	Rank 2015	Rank 2019	Number of jobs (000s) 2019
Aircraft pilots and flight engineers	3512	£84,597	£75,922	-10%	1	3	x
Chief executives and senior officials	1115	£80,827	£91,701	13%	2	2	87
Air traffic controllers	3511	£73,548	£94,431	28%	3	1	x
Marketing and sales directors	1132	£68,395	£75,184	10%	4	4	175
Medical practitioners	2211	£65,588	£60,838	-7%	5	6	190
Senior police officers	1172	£61,747	£58,854	-5%	6	8	8
IT and telecommunications directors	1136	£60,982	£66,922	10%	7	5	30
Advertising and public relations directors	1134	£60,219	£57,856	-4%	8	9	10
Financial managers and directors	1131	£56,506	£60,186	7%	9	7	289
All employees	XXXX	£22,436	£24,897	11%	n/a	n/a	22,441

Source: Office for National Statistics (ONS), Annual Survey of Hours and Earnings (ASHE) for 2015 and 2019 – Gross Annual Pay by Occupation (4-digit SOC 2010)

- 'x' indicates figure not included in ASHE tables (because estimates considered unreliable for practical purposes due to sampling error). Included data may still be subject to year-on-year fluctuations due to sampling issues.

- Legal Professionals n.e.c. are ranked above Medical Professionals based on 2019 Median Annual Pay, but are not included because 2015 median pay is not published.

- Based on most recent available data, number of jobs is 7,000 for Aircraft Pilots (2017) and 6,000 for Air Traffic Controllers (2013).

- ASHE data is not adjusted for hours worked and includes medics not covered by Electronic Staff Record 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 the Electronic Staff Record and should provide a more complete picture.

3.27 Median Annual Pay for doctors decreased by 7% between 2015 and 2019, compared to an increase of 11% for the all employees average and increases for several of the other high earning occupations. However, the Median Annual Pay of doctors broadly maintained its rank position moving from 5th to 6th out of 9 (now below IT directors). The figures are subject to year-on-year fluctuations (for example, median pay for doctors increased by 2% between 2014 and 2018), and the decrease for doctors reflects sample composition effects such as a shift towards more salaried (lower paid) GPs and fewer GP practice partners.

3.28 It is important to note that the variation of doctors' earnings is high. The analysis considers doctors as a whole, including lower paid Junior Doctors. The data for all of the professions covers people at various stages of career progression. However, doctors are unusual in that ongoing rapid growth in the professions increases the share of relatively inexperienced and lower paid staff that drag down apparent Average Earnings.

3.29 Furthermore, they are unusual in that all new doctors have the realistic expectation of potential reaching the most senior positions of their profession and becoming amongst the very highest earnings in the economy. This point is emphasised in the pay advancement statistics in the following section.

Pay Advancement

3.30 Doctors can expect substantial pay advancement over their careers - either through pay progression with pay scales or promotion between. As shown in table 4.9, the starting Basic Pay alone for Junior Doctors is £27,689 with Consultants starting with 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 tier worth £89,856 (an increase of 12.5%).

3.31 The overall increase in salary between the bottom of the Junior Doctors grades (£27,689) and the top of the Consultant Pay Scales (£107,668) represents an increase of 289% over a period of at least 25 years

Figure 3.11 Pay Progression & Advancement for medical staff.

Pay Journey	Starting Basic Pay	Basic Pay in 6th Year	Increase
Junior Doctors	£27,689	£48,075	73.6%
Consultants	£79,860	£89,856	12.5%
Pay Route	Starting Basic Pay	Maximum Basic Pay	Increase
F1 - Consultant Maximum	£27,689	£107,668	289%

Source - NHS Employers Pay Circulars

3.32 Figure 3.11 provides additional information on pay progression that HCHS Doctors are eligible to receive at different points in their careers. Note that:

- 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.
- Junior Doctors are eligible to receive pay progression after the completion of F1, F2 and after the second year of Specialty Training. From October 2020 a 5th "Nodal Point" will be added for more senior Junior Doctors (ST5 & above). Doctors who train on a Less Than Full Time basis will take longer to progress as these payscales are linked to the stage of training based on skills and experience.
- Consultant Doctors 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 Full Time Equivalent.

Figure 3.12 - Example pay progression journey for Doctors in Training

Stage of Training	Basic Pay	Increase over Previous Point	Per Year - Annualised
F1	27,689	N/A	N/A
F2	32,050	15.7%	N/A
CT1/ST1 - CT2/ST2	37,935	18.4%	N/A
ST3 - ST8	48,075	26.7%	7%

Source - NHS Employers Pay Circulars

Figure 3.13 - Example pay progression journey for Consultant Doctors

Years Completed as Consultant	Basic Pay	Increase over Previous Point	Per Year - Annualised
0 (Entry)	79,860	N/A	N/A
1	82,361	3.1%	N/A
2	84,862	3.0%	N/A
3	87,362	2.9%	N/A
4 - 8	89,856	2.9%	N/A
9 - 13	95,795	6.6%	N/A
14 - 18	101,735	6.2%	N/A
19 +	107,668	5.8%	1.8%

Source - NHS Employers Pay Circulars

Gender Balance and Gender Pay Gap

3.33 The Gender Pay Gap (GPG) is the difference in Average Pay and Earnings between men and women within any unit of comparison (e.g. organisation or staff group). It is not the same as gender discrimination, which is illegal, where staff would be paid differently for the same job based on gender.

3.34 NHS Digital have provided data on Basic Pay per FTE split by gender and career level. Figure 3.11 shows the Average Basic Pay per FTE for a single month of March 2019. It shows that across all medical staff women had Basic Pay of 12.6% less than that of a man however within individual grades the gap was much smaller (e.g. 2.3% for Consultants)

3.35 Gaps across the whole staff group are caused by variation in the proportion of staff at different career levels including a higher proportion of consultants being men. Gaps within a career level are caused by having different proportion of staff at different pay grades- for example the gap for consultants suggest more men are toward the top of the consultant pay scales than women

Figure 3.14 Gender Pay Gap by Career Grade - Basic Pay Per FTE for March 2019

Career Grade	Women	Men	Gap
HCHS Doctors	£5,158	£5,904	-12.6%
Consultant	£7,615	£7,789	-2.3%
Associate Specialist	£7,048	£7,080	-0.5%
Specialty Doctor	£5,195	£5,365	-3.3%
Staff Grade	£4,520	£4,958	-9.7%
Core Training	£3,232	£3,273	-1.2%
Specialty Registrar	£3,602	£3,683	-2.3%
Foundation Doctor Year 1	£2,264	£2,266	-0.1%
Foundation Doctor Year 2	£2,613	£2,621	-0.3%
Hospital Practitioner / Clinical Assistant	£9,159	£9,545	-4.2%
Other and Local HCHS Doctor Grades	£6,644	£8,563	-28.9%

Source - NHS Digital Workforce Statistics

3.36 Because the overall pay gap is determined, to a large extent, by the composition of the workforce the pipeline of trainee doctors might provide an indication as to what might happen to the GPG in the future. As more women doctor's progress to Consultant level we would expect the gap to reduce (as the Average Earnings for women would increase). Figure 3.12 shows that over 50% of Junior Doctors are women and the proportion of women Consultants has been slowly increasing over time.

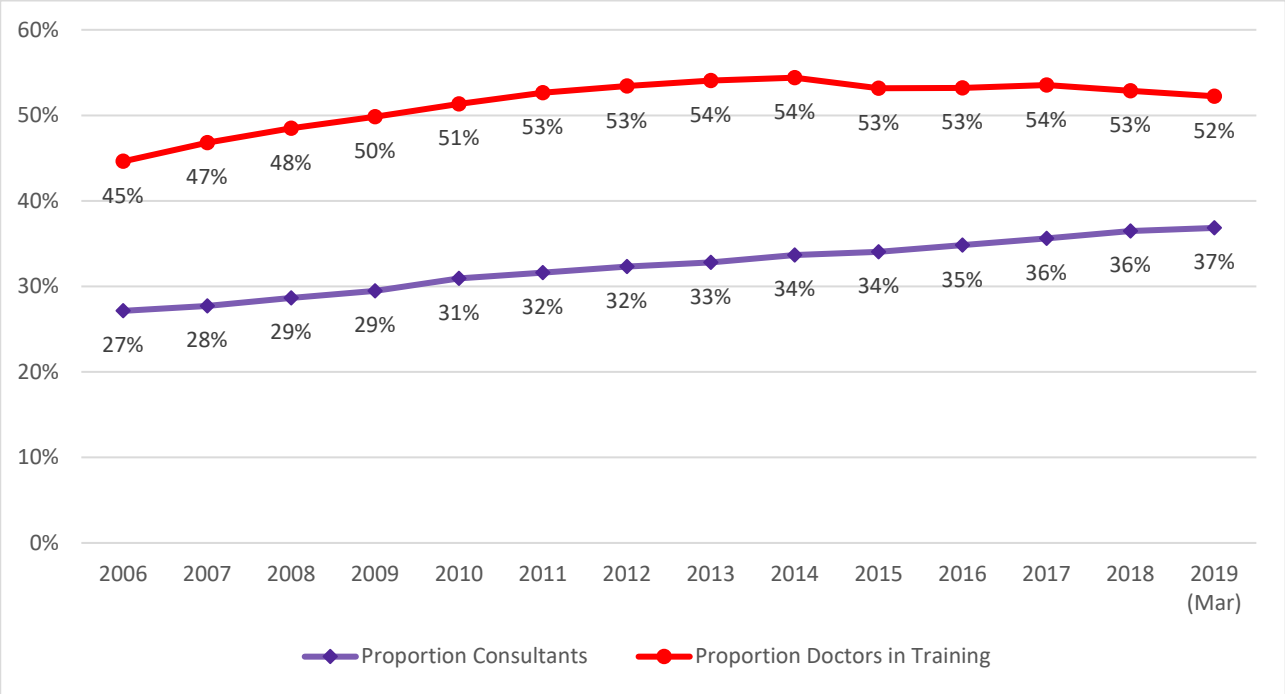
Figure 3.15 - Gender composition by medical career grade

Grade	Mar-16 (women)	Mar-17 (women)	Mar-18 (women)	Mar-19 (women)
Consultant	34.4%	35.2%	36.2%	36.8%
SAS Doctor	44.3%	45.1%	44.9%	45.1%
Doctor in Training	52.9%	53.3%	53.1%	52.2%
Other	54.1%	53.9%	54.9%	56.1%
Total	44.5%	45.0%	45.2%	45.2%

Source - NHS Digital Equality and Diversity Statistics

3.37 Figure 3.16 indicates how the proportion of Junior Doctors (Foundation Y1, Foundation Y2, Core Training and Specialty Registrar) and Consultant grades have changed since 2006. Since 2009 a plurality of Junior Doctors has been women and the proportion of Consultants has increased by 8 percentage points over the last decade.

Figure 3.16 - Proportion of women in Consultant and Junior Grades



Source - NHS Digital Equality and Diversity Statistics

3.38 In April 2018, DHSC commissioned an independent review into the GPG in medicine. The review is chaired by Professor Dame Jane Dacre and the review itself undertaken by Professor Carol Woodhams from the University of Surrey undertaking the qualitative and quantitative elements of the review. The aim of the review was to help identify the causes of the GPG. The GPG shows the difference in the average pay between all men and women in the workforce and is not an equal pay issue. The review team are working with our stakeholders develop a series of implementable and evidence-based recommendations. The review itself is on the verge of completion and its findings starting to emerge.

3.39 For Hospital and Community Doctors:

- The choice and access to medical specialties is another contributory factor to the GPG. Whereas women represent half of the medical workforce in Medicine, they remain under-represented in Surgery at 31% compared to over representation in specialties such as Obstetrics and Gynaecology and Public Health Medicine where their share is 66% and 73% respectively.

- There is an unequal distribution of genders across regions, where in London hospitals women doctors represent half of the total number of doctors. There are regions where women are under-represented including the North East and wider analysis suggests a North-South divide.

3.40 ESR data provided a wide range of information on individuals regarding their pay, working patterns, location, grade, specialty and demographic characteristics including gender, ethnicity, age etc. Quantitative data was obtained from several sources. Data relating to hospital and community doctors was derived from the ESR Payroll system and pay and employment data for GPs collected by HMRC.

3.41 Qualitative data:

- Possible negative influences on pay rates that produce and sustain gender pay gaps include pregnancy, maternity and adoption leave, marriage, caring and family responsibilities, and career breaks.

- More women make specialty choices based on family friendly work, social hours, and avoiding on-call work. Women and men doctors are broadly comparable regarding attitudes on the fairness of their pay and the extent to which they maximise earnings.

3.42 Qualitative evidence was gathered through an extensive self-reported survey (~5,500 responses) and 20 in depth interviews with doctors, both male and female and a variety of career stages and grades.

3.43 Workplace factors also have an impact on the GPG:

- Those with caring responsibilities and wishing to train on a less than full time basis encounter both structural and cultural resistance about their commitment to their career.

- Often results in women stepping off their training programmes which disadvantages consequent career progression.

- SAS grades, preferred by some women, provides no clear career pathway due to the difficulties in returning to training and limited progression grades within this role.

3.44 General Practitioners:

- The mean GPG in overall annual pay among GPs in England is 33.5% and the median GPG is 37.2% However, this data is a direct comparison between men and women’s pay but when FTE corrected the GPG is substantially smaller

and for all GPs is 15.3%. Contractor GPs experience a gender pay gap of 7.7% and is 22.3% for salaried GPs.

- Decomposition analysis of annual pay among GPs demonstrates that differences in working hours and GP type explain most of the GPG.

Recommendations

3.45 The review's recommendations have been themed into 7 key areas that looks at barriers to women's progression; how senior jobs can be made more accessible and attractive to women; increasing transparency around salary scales; mandating of good practice to address pay gaps in organisations, tackling bullying, harassment and micro-aggressions in the medical and wider workforce; address the issues preventing women from applying for CEAs and; other areas of work such as examination of other pay gaps in the medical workforce and potential creation of an oversight group.

3.46 The review will be published in February 2020.

4. Workforce Strategy

4.1 Effective workforce policy 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 the Department of Health and Social Care's overarching strategic programme for the health and care system.

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

4.3 The Department works through its Arms-Length Bodies (ALBs) on the delivery and implementation of workforce policy. NHS England/Improvement is responsible for setting the priorities and direction of the NHS and encouraging and informing the national debate to improve health and care. NHS England/Improvement is responsible for delivering the NHS People Plan. Education and training of the workforce is the core function of Health Education England (HEE).

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

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

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

4.6 The 2019 Spending Round, published on 4 September 2019, announced a 3.4 per cent real terms increase in the Health Education England (HEE) budget. This

includes an additional £150 million for Continuing Professional Development, as well as increased funding of up to £60m to support delivery of the NHS People Plan.

4.7 NHS England and NHS Improvement published the Interim NHS People Plan on 3 June 2019. The Interim NHS People Plan focusses on the action that will be taken now and over the long term to address workforce shortages, strengthen education and training, and improve culture and leadership in the NHS. These are necessary steps if the NHS is to deliver the Long Term Plan.

4.8 The Interim NHS People Plan is composed of the following six key themes: making the NHS the best place to work, improving leadership culture, addressing urgent workforce shortages in nursing, delivering 21st century care, a new operating model for workforce and the immediate next steps to develop the full NHS People Plan.

4.9 The full NHS People Plan will be published in the coming months. It will set out a clear framework for collective action on workforce priorities over the next five years and a fuller range of specific targeted actions to address our biggest shared challenges

Making the NHS the best place to work

4.10 The Interim NHS People Plan 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. By improving staff experience, we can improve retention of staff and drive continuous improvements in care.

4.11 There are cultural issues to address. The 2018 NHS Staff Survey indicates rates of reported bully and harassment are increasing; instances of bullying and harassment could have been exacerbated due to staff feeling under pressure because of staff shortages.

4.12 To improve the experiences of the people working in the NHS, a new core offer for NHS staff will be developed as set out by the Interim NHS People Plan. This will be set out in the full NHS People Plan and will be framed around the themes of creating a healthy, inclusive and compassionate culture; enabling great development and fulfilling careers; and ensuring everyone feels they have voice, control and influence.

4.13 This will be underpinned by a national action programme to help solve long standing practical issues with NHS employment, including flexible working, action to improve staff health and wellbeing, measures to tackle bullying and harassment, and steps to improve equality, diversity and inclusion.

NHS Staff Survey 2018

4.14 The NHS Staff Survey is a key source of evidence that will inform action taken in the NHS People Plan. The most recent survey was published in February 2019. Over 1.1 million NHS employees in England were invited to participate in the survey between September and December 2018; 497,117 responded – a 46% response rate.

4.15 The NHS Staff Survey 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 in England.

4.16 Data from the 2018 Staff Survey shows that in 2018, 68.7% of medical and dental staff reported 'always' or 'often' looking forward to going to work. This is an improvement from 2017, though not the highest that this response has been in recent years. Those in training report lower motivation scores, in this respect than the average medical or dental professional. The percentage of staff, broken down by year and job role, who look forward to going to work are detailed in Figure 4.1.

Figure 4.1 – NHS Staff Survey Question 2a, percentage of staff who look forward to going to work

Staff survey - looking forward to going to work	2014	2015	2016	2017	2018
Medical & Dental	64.4%	70.1%	70.4%	67.2%	68.7%
Medical / Dental – Consultant	64.3%	69.4%	69.6%	68.4%	70.0%
Medical / Dental - In Training	65.8%	74.0%	75.5%	64.4%	67.8%
Medical / Dental – Other	66.3%	66.5%	67.2%	67.2%	68.2%

4.17 Staff retention is a key metric used in the NHS Staff Survey to ensure appropriate, long-term staffing arrangements in the NHS. In the 2018 dataset, a question was

posed regarding how strongly the respondent agrees with the statement, “I often think about leaving the [NHS]”. 2018 was the first year that this question was asked, therefore time-series data is unavailable. Breakdown by Job Role is contained in Figure 4.2, overall 22.6% of Medical and Dental staff often think about leaving the NHS.

Figure 4.2 – NHS Staff Survey, Question 23a, percentage of staff who often think of leaving the NHS

Staff survey - often thinking of leaving the NHS	2018
Medical & Dental	22.6%
Medical / Dental – Consultant	23.3%
Medical / Dental - In Training	18.6%
Medical / Dental – Other	22.8%

4.18 The NHS Staff Survey also asked respondents if they have experienced harassment or abuse in the last year, in three separate questions. These questions are differentiated by the source of the abuse/harassment: from members of the public; from managers; and from other colleagues. If the respondent has not received abuse or harassment, the score for each question is recorded as a 10, otherwise 0 - therefore, a higher score indicates a preferred outcome. The theme score is the average over the three questions.

Figure 4.3 – NHS Staff Survey, Safe environment – bullying and harassment theme score

Staff survey - bullying & harassment	2015	2016	2017	2018
Medical & Dental	7.8	7.8	7.8	7.5
Medical / Dental - Consultant	7.7	7.8	7.7	7.5
Medical / Dental - In Training	7.9	7.9	7.8	7.6
Medical / Dental - Other	8	7.9	7.8	7.6

4.19 As highlighted in paragraph 4.11, the NHS Staff Survey 2018 indicates that overall bullying and harassment levels in the NHS are increasing. Figure 4.3 shows that,

compared to prior years, bullying and harassment levels are steadily increasing, as the theme score for bullying and harassment decreases.

4.20 Similarly to paragraph 4.18, the NHS Staff Survey generates a theme score for equality, diversity and inclusion. This metric is composed of 4 binary response questions; with each 'positive' response recorded as a 10, each 'negative' response recorded as 0. The theme score is the average across the four questions.

Figure 4.4 – NHS Staff Survey, Equality, diversity and inclusion theme score

Staff survey – Equality, diversity and inclusion	2014	2015	2016	2017	2018
Medical & Dental	9.2	9.2	9.1	9.1	8.9
Medical / Dental - Consultant	9.2	9.2	9.2	9.1	9
Medical / Dental - In Training	9.3	9.3	9.2	9.1	9
Medical / Dental - Other	8.9	8.9	8.9	8.8	8.6

4.21 Figure 4.4 shows a decrease in the equality, diversity and inclusion theme score in 2018, continuing the trend from previous survey results. This is due to more NHS staff experiencing instances of discrimination at their workplace, from both managers and members of the public. Also, more NHS staff are reporting discrimination regarding career progression.

4.22 The interim NHS People Plan states that leadership is the most effective route to making real change within the NHS. As shown in Figure 4.5, The 2018 NHS Staff Survey indicates that all staff, regardless of job role, are feeling more satisfied with the support from their immediate manager compared with previous years. This is an important first step, although more data points will be needed to establish a trend.

Figure 4.5 – NHS Staff Survey, Percentage staff satisfied with support from immediate (line) manager

Staff survey – satisfied with support from immediate manager	2015	2016	2017	2018
Medical & Dental	67.5%	69.2%	68.3%	71.3%
Medical / Dental - Consultant	64.6%	67.2%	65.6%	69.0%

Medical / Dental - In Training	79.3%	74.5%	75.4%	77.5%
Medical / Dental – Other	67.8%	70.2%	67.0%	70.1%

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

Improving the Leadership Culture

4.24 The interim NHS People Plan places an emphasis on supporting leaders, enabling them to create positive and inclusive cultures. It means supporting leaders to work together across whole systems – encompassing social care, community services and GPs – for the benefit of patients.

4.25 NHS England / Improvement are undertaking system-wide engagement on a new 'NHS Leadership Compact' that will establish the cultural values and leadership behaviours expected from NHS leaders, along with the support and development leaders should expect in return. This will be aligned with the NHS Oversight Framework and Well-Led Framework.

4.26 NHS England / Improvement are now responsible for the NHS Leadership Academy; the organisation having transferred from HEE in April 2019. This means that they are able to ensure our efforts to improve leadership culture are aligned with our wider objectives around sustainability, quality and improvement.

Delivering 21st Century Care

4.27 It is important that we free up health and care teams from duplicative, administrative and non-essential tasks that get in the way of providing care and support to patients and service users. This means designing pathways that explicitly match staff resources to activities and interventions that have the greatest impact on quality and outcomes; developing multidisciplinary teams with a stronger focus on care pathways, preventive interventions and community-based care; and removing non-productive tasks and making essential tasks more efficient, supported by a clear pipeline of digital and technological innovations.

4.28 The full People Plan will set out how we can redesign the workforce to better reflect changing patient needs and models of care, contribute to better outcomes, deliver more rewarding careers for those who work in the NHS, and more sustainable patterns of workforce growth.

4.29 As set out in Chapter 5, the interim NHS People Plan highlights the need to continue to grow the medical workforce to address gaps in certain specialties and regions and to deliver our vision for flexible working and training for doctors at all stages of their career.

4.30 Actions to expand the medical workforce include exploring the possibility of for further expansion of undergraduate medical school places and implementing post-foundation Internal Medicine Training to expand the number of doctors with generalist skills.

4.31 During 2019/20, through the next phase of the ‘Future Doctor’ programme, Health Education England will work with providers, commissioners and local health systems, as well as partners across the UK and experts in the fields of population health, leadership, quality improvement and technology, to establish for the first time a clear view of what the NHS, patients and the public require from future doctors.

4.32 This work will support the medical Royal Colleges and the medical schools in their ongoing review of how to educate and train undergraduate medical students and doctors in training and will also be used by the GMC to help support the shaping of curricular outcomes.

4.33 NHS England /Improvement, along with HEE will establish a national programme board to address geographical and specialty shortages in doctors, including staffing models for rural and coastal hospitals and general practice.

4.34 The Interim NHS People Plan acts to ensure that those providing care in the NHS, both now and over the coming years, are equipped with the knowledge and skills to keep up with scientific and technological advances and that we have the right specialist workforce to support the broader multi-professional team in applying these advances.

4.35 NHS England / Improvement and HEE will begin work to review current models of multidisciplinary working within and across primary and secondary care. They will also develop accredited multidisciplinary credentials for mental health, cardiovascular disease and older people’s services, with a focus on multidisciplinary training in primary care.

A new operating model for workforce

4.36 The NHS Long Term Plan is clear that integrated care systems (ICSs) should be the main organising unit for local health services and that we will support all local health systems in becoming ICSs by 2021.

4.37 The full People Plan will set out how we implement a new operating model for workforce, with greater clarity about respective roles of individual employers, local health systems and regional/national teams. This will include a greater role for integrated care systems (ICSs) to lead collaborative, system wide approaches on workforce and people priorities.

4.38 Health Education England, NHS England / Improvement will support local health systems (STPs/ICSs) to develop five-year workforce plans, as an integral part of service and financial plans, enabling us to understand better the number and mix of roles required to deliver the NHS Long Term Plan and inform national workforce planning.

4.39 Whilst the NHS People Plan is tasked to focus on NHS staff, there are substantial areas where the Plan impacts on social care and the wider health system. The People Plan team has agreed to work with the social care sector on these touch points to provide positive outcomes for the integrated health and care system and the populations they serve.

4.40 The Strategic Advisory Forum for the Adult Social Care workforce (SAF) states that there must be a specific national and funded social care workforce plan, to maximise opportunities for integration and to recognise the specific requirements and contributions of the social care workforce.

4.41 Workforce plans developed jointly and reflecting the needs of the whole health and care system must be advocated at the local (ICS) level and at the system levels. All stakeholders, including providers of all sizes and sectors and the workforce at every level, must be and feel that they are part of any local strategy for it to be successful.

5. Recruitment, Retention, Motivation and Medical Workforce Planning

Summary and Background

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

5.2 There is a record and growing number of doctors in the NHS. HCHS doctors have increased by 10% in the period between March 2014 and March 2019. Consultants, who represent the largest group in the HCHS doctors' workforce, increased by 18%

5.3 However, demand for NHS services continues to grow and recruitment and retention indications are mixed - the need to address supply issues remains:

- Vacancies still present a problem across the NHS. The Vacancy rate for doctors has shown large variation over the last year, ranging from 7.1% to 9.6% (which is equivalent to vacancies of 9,000 to 12,000 posts) although this is an improvement on the 8.0% to 9.3% reported to the last DDRB evidence round.

- NHS reliance on international doctors has increased. Around 27% of doctors have a non-UK nationality, up from 24% in 2016. This is increasing over time across most staff groups but has remained constant over time for Consultants. However, the Department is clear that our priority is to ensure those currently working in NHS are not only able to stay but feel welcomed and encouraged to do so.

- Bank and agency staff are also used to cover some vacancies, in addition to covering sickness absence and long-term leave, although agency spend has now fallen to 4.4% of pay costs.

- Leaving rates are stable and retention generally high, but leavers are increasingly citing work-life balance as a reason for leaving. This is up from 6.1% of voluntary resignations in 2014/15 to 8.9% in 18/19.

- Health and well-being scores, in the staff survey, have fallen from 6.3 to 6 in the past two years, although recorded sickness absence rates remain extremely low.

- Staff engagement indicators are holding firm and pay satisfaction remains positive overall (56% satisfied / very satisfied vs 22% dissatisfied / very dissatisfied) and remains higher than 5 years ago. However, pay satisfaction has slipped a couple of percentage points on average over the past two years although it has increased by around 5% for Junior Doctors in the past year.

5.4 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 Health Education England (HEE) and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff.

5.5 The Government's commitment to expanding undergraduate medical training places will not only increase our supply of doctors but will also provide more opportunities for students with the talent, drive and ambition to train as a doctor. Overall, by 2020 there will be an extra 1,500 medical students entering training each year.

5.6 As set out in the Long Term Plan, HEE and NHS England have established a national workforce group which is examining options for growing the medical workforce and the vision and actions set out in the Interim NHS People Plan. These options include the possibility of increasing part-time study, expanding the number of accelerated degree programmes and greater contestability in allocating the 7,500 medical training places to drive improvements in curricula. Depending on future plans made locally by Sustainability and Transformation Partnerships and integrated care systems, the number of medical school places could grow further and this will be addressed in the final NHS People Plan which is expected to be published in the next few months.

5.7 In particular the NHS is targeting supply increases for General Practice. This year, HEE recruited the highest number of GP trainees ever for the second year in a row, surpassing their target of 3,250, and there has been recruitment in geographical areas where there have been consistent shortages of GP trainees.

5.8 Getting the skills mix right is critical in addressing workload pressures and delivering appropriate patient care. As set out in the Long Term Plan, there will be an increasing focus on accelerating the shift from a dominance of highly specialised roles to a better balance with more generalist ones to meet the needs of an ageing population, including further increases in Medical Associate Professional roles, specifically Physician Associates.

Numbers in Work

5.9 NHS HCHS doctors have increased by 10,645 FTEs (10%) in the period between March 2014 and March 2019. Consultants, who represent the largest group in the HCHS doctors' workforce, increased by 7,381 (18%), from 40,637 to 48,018. There have been large, proportionate changes, such as for Junior Doctors in Core Training which have seen the largest increase (38%). The Associate Specialist and Staff Grade groups have decreased by 30% and 31%, but this is expected as they have not been open to new entrants since the introduction of the Speciality Doctor contract in 2008.

Figure 5.1: HCHS doctors FTEs March 2014 to March 2019

Staff Group	Mar-14	Mar-19	Change in FTE	% Change
Consultant	40,637	48,018	7,381	18%
Associate Specialist	2,750	1,927	-823	-30%
Speciality Doctor	5,798	7,092	1,294	22%
Staff Grade	374	258	-115	-31%
Speciality Registrar	29,076	29,788	711	2%
Core Training	8,475	11,732	3,258	38%
Foundation Doctor Year 2	6,459	5,487	-973	-15%
Foundation Doctor Year 1	6,354	6,268	-85	-1%
Hospital Practitioner / Clinical Assistant	530	526	-4	-1%
Other and Local HCHS Doctor Grades	934	934	1	0%
Grand Total	101,386	112,031	10,645	10%

Source: NHS Digital HCHS monthly workforce statistics

Analysis of Joiners and Leavers

5.10 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.

5.11 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 as doctors. 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

5.12 The number of joiners in the HCHS doctors' workforce has grown by 20% in the last 5 years. Joiners from abroad - non EU countries 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. 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 7% fewer joiners from EU countries than in 2014.

Figure 5.2: Source of HCHS Doctors

Absolute Numbers	2014-15	2015-16	2016-17	2017-18	2018-19
Abroad - Non EU Country	976	1,169	1,556	1,866	2,639
Not previously employed	906	771	932	1,014	1,136
Abroad - EU Country	655	680	653	596	611

Data quality notes:

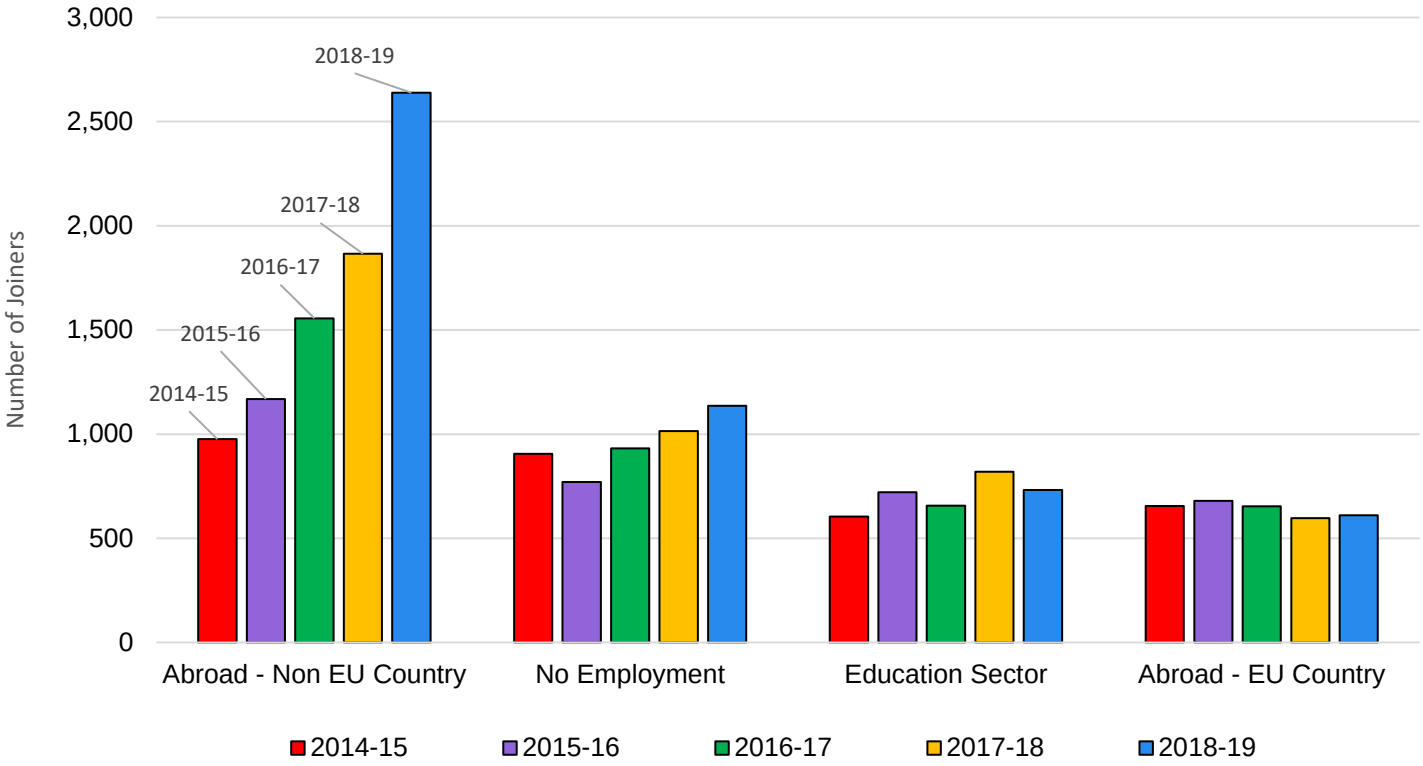
- NHS Digital seeks to minimise inaccuracies and the effect of missing and invalid data but responsibility for data accuracy lies with the organisations providing the data.

- Methods are continually being updated to improve data quality. Where changes impact on figures already published, this is assessed but unless it is significant at national level figures are not changed.

- Information relating to known issues that affect the NHS workforce can be found in the Data Quality Annex which accompanies the NHS Workforce Statistics publication series and is updated monthly.

5.13 New entrants from non-EU countries have continued to grow year on year and has more than doubled in the past five years, up by 1,663 (170%) between 2014/15 and 2018/19.

Figure 5.3: HCHS Doctors Joining NHS from the Four Largest Sources (excluding internal NHS movement): Time Series



Source: NHS Digital HCHS workforce statistics

5.14 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 20% throughout the time series as shown in figure 5.4. These rates represent new joiners and re-joiners.

Figure 5.4 12-months joiner rates by region, HCHS Doctors

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

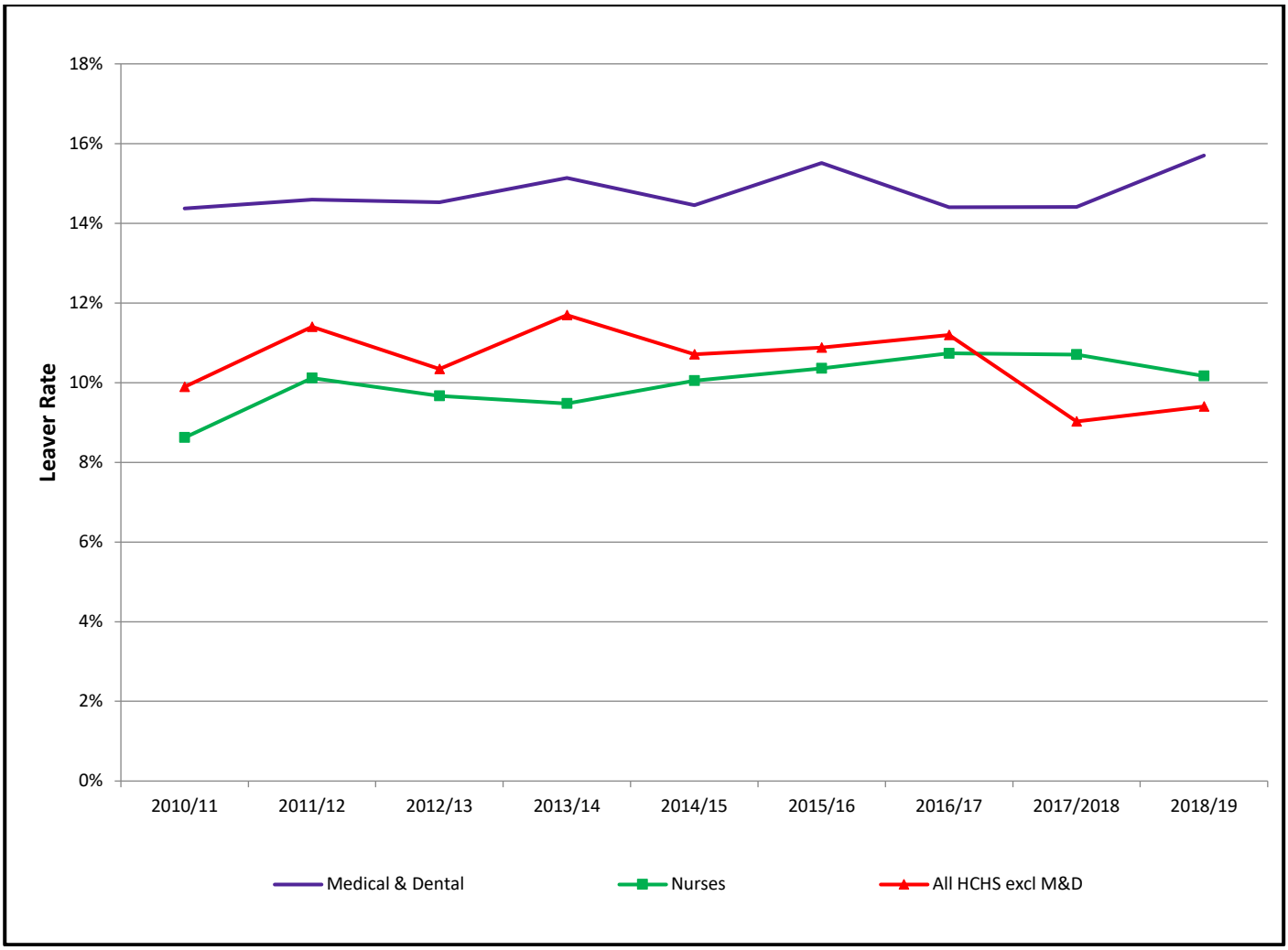
Source - NHS Digital Workforce Statistics

Leavers

5.15 The leaver rate for HCHS Medical and Dental staff has fluctuated but held relatively steady over recent years as shown in Figure 5.2. The leaver rate is the share of the workforce leaving their staff group in the NHS Trusts and CCGs in a year. It excludes staff moving between Trusts, but includes people moving from the Trusts to e.g. a GP Practice. NHS Digital produces turnover statistics based on NHS Electronic Staff Record data.

5.16 The leaver rate for HCHS Medical & Dental staff was around 14.5% per year in 2010/11 to 2012/13. There was a one-off temporary increase in 2013/14 during transformation of the health system, including the transfer of some jobs out of the HCHS into Public Health England. The rate increased to 15.5% between 2014/15 and 2015/16, however decreased in 2016/17 to a similar rate of 14.4% in 2014/15. However, in 2018/19, there has been a steady increase to 16% in 2018/19.

Figure 5.5: HCHS Staff Leaver Rates by Staff Group: Time Series



Source: NHS Digital Workforce Statistics

Table 5.6 Medical Leaver Rates by Region, HCHS Doctors

Region	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Health Education East Midlands	14.1%	14.3%	13.5%	15.7%	14.6%	15.6%	15.7%	13.9%	14.7%
Health Education East of England	14.1%	14.3%	14.6%	14.8%	11.7%	19.6%	13.0%	14.6%	15.5%
Health Education Yorkshire and the Humber	13.9%	13.6%	15.0%	15.3%	14.5%	15.9%	14.5%	13.9%	14.7%
Health Education Wessex	13.6%	14.4%	14.5%	15.3%	13.1%	13.4%	13.8%	13.5%	15.8%
Health Education Thames Valley	15.2%	14.4%	14.9%	16.5%	16.3%	14.9%	16.1%	15.5%	16.5%
Health Education North West London	15.9%	16.4%	15.8%	16.1%	16.1%	17.5%	15.0%	15.1%	14.5%
Health Education South London	15.8%	14.8%	15.2%	15.7%	14.1%	16.5%	14.4%	14.7%	15.3%
Health Education North Central and East London	14.7%	15.5%	15.0%	14.9%	15.6%	16.7%	15.6%	14.7%	15.4%
Health Education Kent, Surrey and Sussex	14.4%	15.0%	15.3%	13.7%	14.2%	14.8%	15.5%	14.3%	17.5%
Health Education North East	13.8%	13.5%	13.8%	12.8%	13.5%	14.2%	13.9%	13.9%	16.3%
Health Education North West	14.6%	14.5%	13.8%	17.0%	14.0%	13.9%	13.9%	14.3%	16.4%
Health Education West Midlands	13.1%	13.2%	13.3%	13.7%	13.6%	14.1%	13.0%	14.3%	15.1%
Health Education South West	14.6%	16.7%	15.2%	14.6%	18.4%	14.5%	14.8%	14.6%	15.9%
All Health Education England regions	14.4%	14.6%	14.5%	15.1%	14.5%	15.5%	14.4%	14.4%	15.7%

Source - NHS Digital Workforce Statistics

5.17 Leaver rates vary between 13% to 20% across regions and time series, but there are no clear trends. There are signs of possible small increases in the West Midlands as well as the East of England.

5.18 Leaver rates vary between the different specialties, however, within the specialty groups, there is little variation with no clear trends. Table 5.7 shows the leaver rates for HCHS doctors by speciality. 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.

Table 5.7 - Leaver Rates by Speciality

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

Source - NHS Digital Workforce Statistics

5.19 On average, the Emergency medicine group has the highest leaver rate every year, while the pathology and radiology groups have the lowest. Most speciality groups have stayed relatively similar from the period 2013-14 to 2017-18. The only group that has declined significantly is the population health management & clinical health specialists' group from a leaver rate of 35% in 2013-14 to a leaver rate of 19% in 2017-18.

Retention

5.20 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 5.8 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.

5.21 Consultants have the highest stability index within the medical workforce at 94%. 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 5.8 Stability Index of M&D staff in the last six years

Staff Grade	2014-15	2015-16	2016-17	2017-18	2018-19
All grades	85.5%	84.5%	85.5%	85.4%	84.1%
Consultant	94.0%	94.1%	94.1%	94.0%	94.2%
Associate Specialist	92.5%	93.2%	92.3%	93.7%	93.6%
Speciality Doctor	89.1%	88.7%	89.3%	89.9%	89.9%
Staff Grade	88.9%	88.1%	89.0%	88.1%	90.8%
Speciality Registrar	77.4%	75.3%	78.5%	78.2%	76.1%
Core Training	79.3%	78.6%	79.1%	80.3%	80.0%
Foundation Doctor Year 2	60.6%	52.8%	51.8%	50.2%	49.6%
Foundation Doctor Year 1	93.3%	94.0%	93.0%	92.6%	76.2%
Hospital Practitioner / Clinical Assistant	81.4%	80.7%	79.7%	82.6%	82.8%
Other and Local HCHS Doctor Grades	86.9%	85.0%	88.0%	81.7%	86.5%

Source - NHS Digital Workforce Statistics

Note: The definition of the stability index is provided by NHS Digital

Reasons for Leaving

5.22 The most common reason for leaving is end of Fixed Term Contract (22.6%) however this is linked to Junior Doctors moving training posts. The number, and proportion, of voluntary resignations has reduced over the past 4 years.

Figure 5.9: Reasons for leaving among HCHS doctors

Reason for leaving	2014/15	2015/16	2016/17	2017/18	2018/19	2014/15	2015/16	2016/17	2017/18	2018/19
Dismissal	102	88	69	65	71	0.6%	0.4%	0.4%	0.4%	0.4%
Employee Transfer	364	298	169	164	673	2.0%	1.5%	1.0%	1.0%	3.7%
End of FTC	5,645	5,986	4,026	3,855	4,148	30.6%	29.9%	25.0%	23.2%	22.6%
End of FRC - Completion of Training	1,337	1,526	985	875	993	7.2%	7.6%	6.1%	5.3%	5.4%
End of FTC - End of Work Requirement	264	306	216	198	218	1.4%	1.5%	1.3%	1.2%	1.2%
End of FTC - External Rotation	2,406	2,592	1,685	1,503	1,259	13.0%	12.9%	10.4%	9.1%	6.8%
End of Fixed Term Contract - Other	519	678	413	398	324	2.8%	3.4%	2.6%	2.4%	1.8%
Mutually Agreed Resignation	23	19	9	6	3	0.1%	0.1%	0.1%	0.0%	0.0%
Others	76	89	62	47	36	0.4%	0.4%	0.4%	0.3%	0.2%
Redundancy	58	35	31	25	34	0.3%	0.2%	0.2%	0.2%	0.2%
Retirement	1,060	1,059	908	925	891	5.7%	5.3%	5.6%	5.6%	4.8%
Voluntary Resignation	3,608	3,883	2,817	2,870	2,686	19.6%	19.4%	17.5%	17.3%	14.6%

Others	2,993	3,481	4,746	5,668	7,052	16.2%	17.4%	29.4%	34.1%	38.4%
All Reasons for Leaving	18,455	20,040	16,136	16,599	18,388	100.0%	100.0%	100.0%	100.0%	100.0%

Source: NHS Digital

5.23 Among those leaving voluntarily the most common reasons are Relocation, Promotion and Work Life Balance. The proportion of leavers in these categories has increased over time however there has also been a reduction in cases where no reason is provided.

Figure 5.10: Top 3 reasons for voluntary resignation (excluding Other / Not Known) among Doctors - Number and Percentage

Reason for voluntary resignation	2014/15	2015/16	2016/17	2017/18	2018/19	2014/15	2015/16	2016/17	2017/18	2018/19
Voluntary Resignation - Relocation	709	736	660	702	642	19.7%	19.0%	23.4%	24.5%	23.2%
Voluntary Resignation - Work Life Balance	221	292	237	256	247	6.1%	7.5%	8.4%	8.9%	8.9%
Voluntary Resignation - Promotion	237	221	149	147	160	6.6%	5.7%	5.3%	5.1%	5.8%

Source: NHS Digital

Vacancies

5.24 There is no one perfect measure of NHS vacancies available. NHS Improvement undertake a monthly workforce data collection from NHS Trusts, which includes data on staff in post (including bank and agency) and vacancies. The overall vacancy rate has shown large variation over the last year, ranging from 7.1% to 9.6%, which is equivalent to vacancies of 9k to 12k as shown in figure 5.11. Vacancies typically show seasonal variation with peaks occurring at the start of the financial year, and troughs occurring at the end.

5.25 Bank and agency staff are used to cover some vacancies, in addition to covering sickness absence and long-term leave.

Figure 5.11 - Medical Vacancies (FTE and Rate) - 2017 Q1 to 2019 Q1

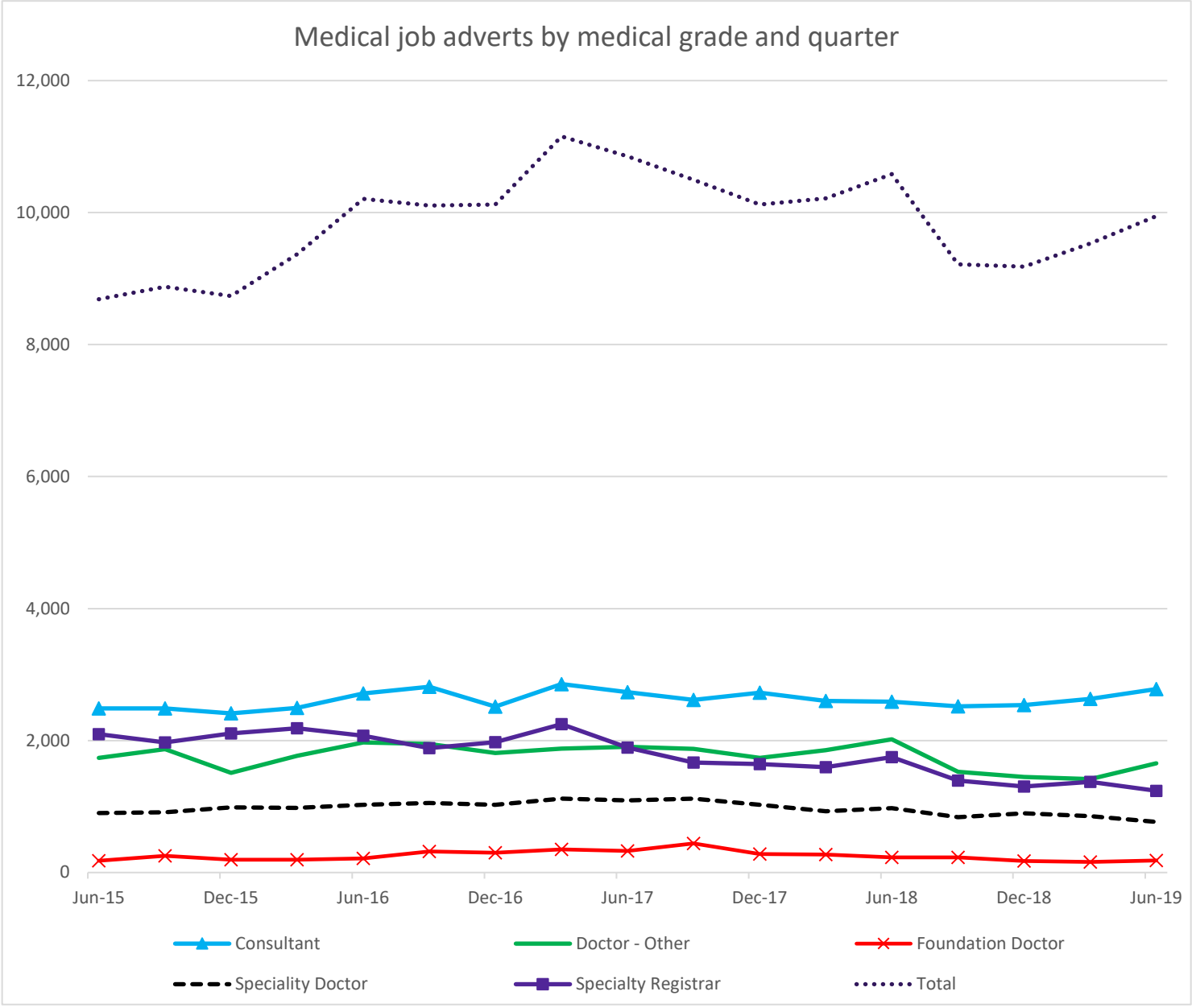
Medical vacancies (FTE & rate)	17/18 Q1	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1
Vacancies	10,848	12,025	9,743	8,989	9,183	11,304
Vacancy rate	9.10%	9.60%	7.70%	7.10%	7.20%	8.80%

Source: NHS Improvement monthly workforce data collection

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

5.26 In addition, NHS Digital publish data on the number of job advertisement placed on the NHS jobs website. This provides a proxy for vacancies, and an insight into recruitment practices across the HCHS sector. Since data collection began in 2015, there was an early increase, with variation from then onwards.

Figure 5.12 - Medical Job Adverts by Grade



Source: NHS Digital vacancy publication

Note: The total for medical job adverts is not equal to the sum of the medical grades. This is due to some medical job adverts not being advertised at a grade, as well as some being advertised on different terms.

The International Workforce

5.27 Across all doctors just around 27% of staff have a non-UK nationality with a further 4% where nationality is not known. Doctors in the Specialty Doctor (48%) and Core Training (40%) 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.

5.28 Figure 5.13 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 5.13 - Doctors by Nationality Group and Career Grade

Staff group	All	UK	EU	EEA	Rest of World	Unknown
HCHS Doctors	119,597	69%	9%	0%	18%	4%
Consultant	51,043	75%	9%	0%	11%	5%
Associate Specialist	2,148	62%	7%	0%	21%	10%
Specialty Doctor	8,203	48%	12%	0%	35%	5%
Staff Grade	313	52%	16%	0%	25%	7%
Specialty Registrar	31,162	66%	9%	0%	22%	2%
Core Training	11,975	57%	10%	0%	30%	3%
Foundation Doctor Year 2	5,541	74%	7%	0%	16%	2%
Foundation Doctor Year 1	6,299	81%	6%	0%	9%	3%
Hospital Practitioner / Clinical Assistant	1,774	86%	4%	0%	3%	8%
Other and Local HCHS Grades	1,440	82%	5%	0%	6%	7%

Source - NHS Digital Workforce Statistics

5.29 Over time the proportion of non-UK doctors has increased from 24% in 2016 to 27% in 2019 as shown in table 6.10. The "Core Training" grade has seen the largest increase with an increase of 10 percentage points since 2016.

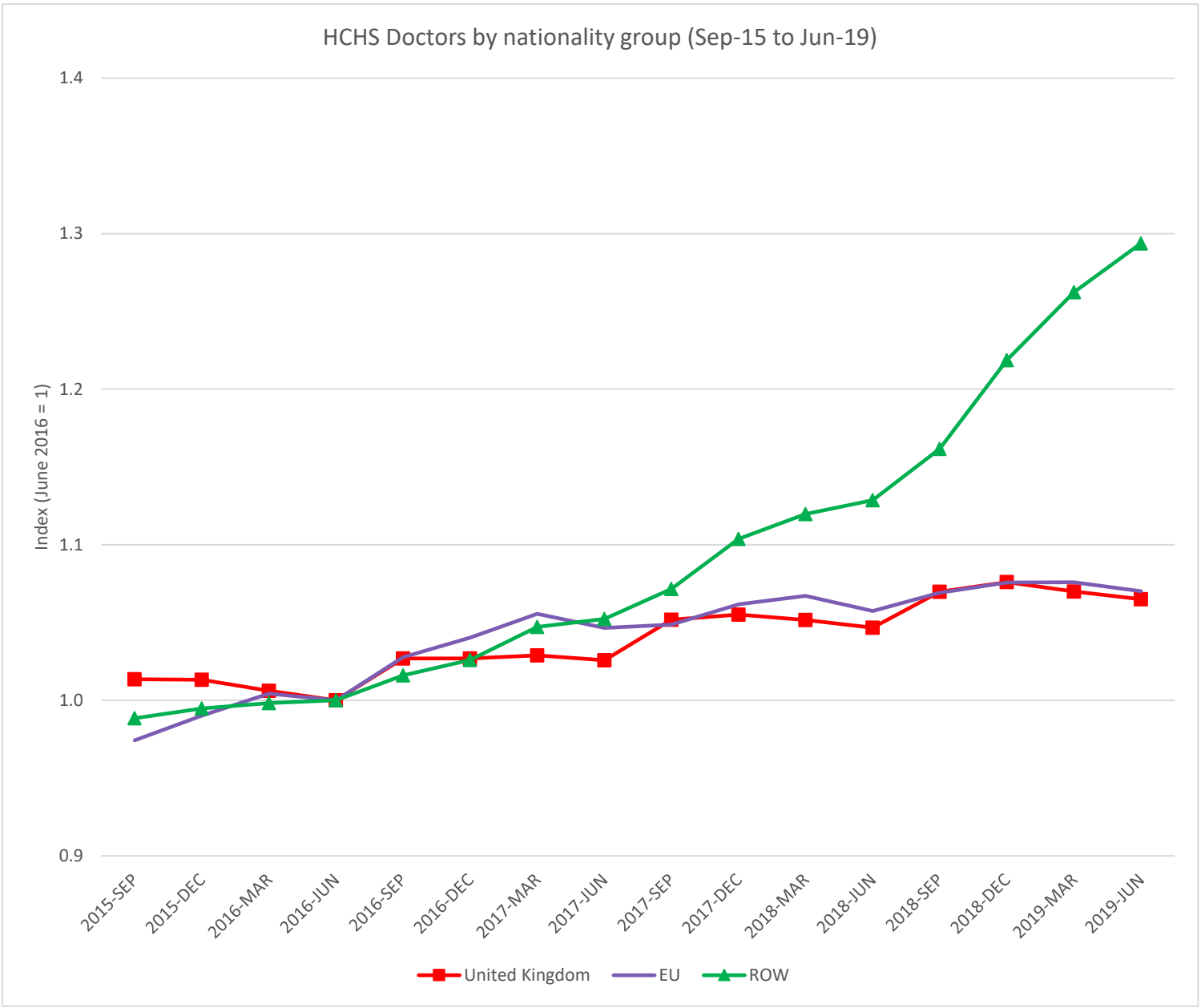
Figure 5.14 - Proportion of Doctors with Non-UK Nationality

Proportion Non-UK	2016-MAR	2017-MAR	2018-MAR	2019-MAR
HCHS Doctors	24%	25%	26%	27%
Consultant	20%	20%	20%	20%
Associate Specialist	28%	28%	28%	28%
Specialty Doctor	45%	46%	46%	47%
Staff Grade	44%	48%	44%	41%
Specialty Registrar	30%	30%	30%	32%
Core Training	29%	31%	35%	40%
Foundation Doctor Year 2	17%	18%	20%	23%
Foundation Doctor Year 1	14%	16%	16%	16%
Hospital Practitioner / Clinical Assistant	9%	8%	7%	7%
Other and Local HCHS Doctor Grades	11%	11%	12%	11%

Source - NHS Digital Workforce Statistics

5.30 To give more detail, the number of overseas staff from both the EU and Rest of the World has increased over the past 3 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 5.15 the number of staff from the rest of the world has increased by over 30% over the past 3 years and now represent about 18% of the total workforce. The number of staff with EU Nationality has increased by 6.7% which is a similar pace to those from the UK (5.8%). The recent increase in Rest of World doctor numbers is likely due to the removal of the cap on Tier 2 visas and to a lesser extent the expansion of the Medical Training Initiative (MTI). The MTI scheme gives international doctors an opportunity to experience training development in the NHS for up to two years before returning to their home country.

Figure 5.15 Medical Workforce and Growth by Nationality Group - Sept 15 - June 19



Source - NHS Digital Workforce Statistics

Exiting the European Union

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

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

5.33 Following a pilot process with the health and social care workforce, the scheme was launched in Spring 2019 and has now received over 2 million applications. We will continue to work with stakeholders across the system to encourage staff who are EU citizens to apply and we are aware of many employers offering more practical support.

5.34 There are over 6,600 more EU27 nationals since the referendum employed in NHS Trusts and CCGs. This includes over 700 more EU27 doctors.

5.35 DHSC does not expect EU Exit 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 as they currently do.

5.36 Since 2016 there are no signs of any significant changes to the recruitment patters for doctors from the EU. Since 2016 the number of EEA doctors joining the GMC register is stable and there are increasing numbers of EU doctors in the NHS workforce. The number of doctors from the Rest of the World is increasing with data from the GMC showing that in the last year more Overseas doctors registered with the GMC than those who trained in the UK.

5.37 We continue to monitor and analyse overall staffing levels across the NHS and Adult Social Care, and we're working across Government to ensure there will continue to be sufficient staff to deliver the high-quality services on which patients rely following the UK's exit from the EU.

5.38 From January 2021 the UK will introduce a new immigration system to replace free movement from the EU. This system will be global, meaning overseas recruits will face the same immigration control whether they come from the EU or further afield.

5.39 The Prime Minister has announced plans for a Points-Based Immigration System and the Home Secretary has commissioned the Migration Advisory Committee to give advice on how this could work in the UK. The Migration Advisory Committee will publish its report in January 2020. Following this the Government will take policy decisions on the shape of the immigration system post-2020.

Agency Staff

5.40 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.

5.41 NHS Improvement and DHSC are supporting Trusts to make greater use of bank staff as an alternative to using agency staff for temporary 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. The evaluation for the pilot will be published in late 2019.

5.42 Alongside this work, NHS England & NHS Improvement plan to launch a new suite of bank programmes, which will have central responsibility for guidance and national standards and will oversee targeted improvement processes in those Trusts with the least mature banks. The programme involves establishing an entirely new team and will be operational from April 2020. NHS England and NHS Improvement 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.

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

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

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

5.45 NHS Trust spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6bn to £3.7bn). Following the introduction of agency spend controls, expenditure on agency staffing has reduced to £2.4bn in 2018/2019.

5.46 Since April 2017 agency costs have consistently been below 5% of overall pay costs and have now fallen to 4.4%. 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.

5.47 Essentially the sector has spent the same on agency staff in 2018/19 as in 2017/18 but procured 5.3% more shifts and managed the cost pressures associated with the first year of the Agenda for Change agreement, which were higher than trusts originally anticipated.

5.48 NHS Improvement have provided data on the proportion of agency spend that can be attributed to different staff groups and by region. In 2018/19 a total of £938m (39%) was for Medical agency staff. In 2019/20 (M6 YTD) a total of £468m (39%) has been spent on Medical agency staff.

5.49 Figure 5.16 provides detail on hours worked for high cost medics. Annex 1 gives split by speciality.

Figure 5.16 Hours worked by High Cost Medics - Acute Sector

Grade	Total Agency Hours 2018/19
Medical - Consultant / GP	1,948,506
Medical - Registrar ST3(+)	241,292
Medical - Speciality / staff grade	191,625
Medical - Registrar ST1-2	68,337
Medical - Associate Specialist	56,815
Not Specified	46,334
Medical - Foundation Y2	27,690
Medical - Dental core training	1,017
Very Senior Managers	901
Medical - Foundation Y1	900
Total	2,583,415

Source: NHS England and NHS Improvement, Temporary Staffing Team

Note: 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

5.50 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.

5.51 Below is a summary for primary care:

- Experimental NHS Digital (NHSD) data shows that for the 2000 (of 6800) practices that reported locum use, FTE locums have increased by 4% (1264 to 1316) between June 2018 and 2019.

- The 4% increase in FTE locums is in contrast with a 2% decrease in all FTE GPs (~27,500 to ~27,000) between June 2018 and 2019. GP partner FTE specifically has reduced by 5% (~19,500 to ~18,500) between June 2018 and 2019.

- Whilst we currently do not have data that accurately reflects the true number of GP locums, NHSD estimates there to be ~5,000 GP locum headcount or ~1,300 locum FTE as of June 2019 – so locums are around 3.9% proportion of overall GP FTE (a small increase from 3.7% since June 2018). However, we believe NHSD figures are likely to be an underestimate due to poor data-reporting.

- 40% of practices which reported locums had an increase in locum numbers between June 2018 and 2019, suggesting that practices are increasingly needing locums.

- Locums are generally younger than salaried and partner GPs (60% of locums aged less than 45, compared to 50% of substantive GPs).

- GP locum data showed a higher proportion of women to men as GP locums compared to salaried/partner GPs.

- However, whilst there are more female than male GP locums by headcount, the male GP locum FTE is higher, suggesting that female GP locums may work fewer sessions than male counterparts.

- Data also showed that female GP locums tend to be younger (60% between 30 and 45) than their male counterparts (50% between 30 and 45).

- Only 20% of GP locums reported had ‘dual roles’ (also working as a salaried/partner GP), with the majority (68%) as salaried GPs.

Staff Engagement and Wellbeing

5.52 The NHS Staff Survey gives useful information about many aspects of staff experience at work. The following sections highlight some headlines.

5.53 The results displayed in the subsequent tables and graphs on staff survey data are all unweighted.

Engagement

5.54 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.

5.55 The staff engagement index has broadly remained much the same for the last five years for medical staff, with no changes in the last three years.

5.56 Female Doctors in training have a lower engagement score than male staff.

Figure 5.17: Staff survey score for the staff engagement index for medical staff

Staff survey score for engagement (/10)	2014	2015	2016	2017	2018
Medical & Dental	6.9	7.1	7.1	7.1	7.1
Medical / Dental - Consultant	6.9	7.1	7.1	7.1	7.1
Medical / Dental - In Training	6.9	7	6.9	6.9	6.9
Medical / Dental - Other	6.9	7	7	7	7

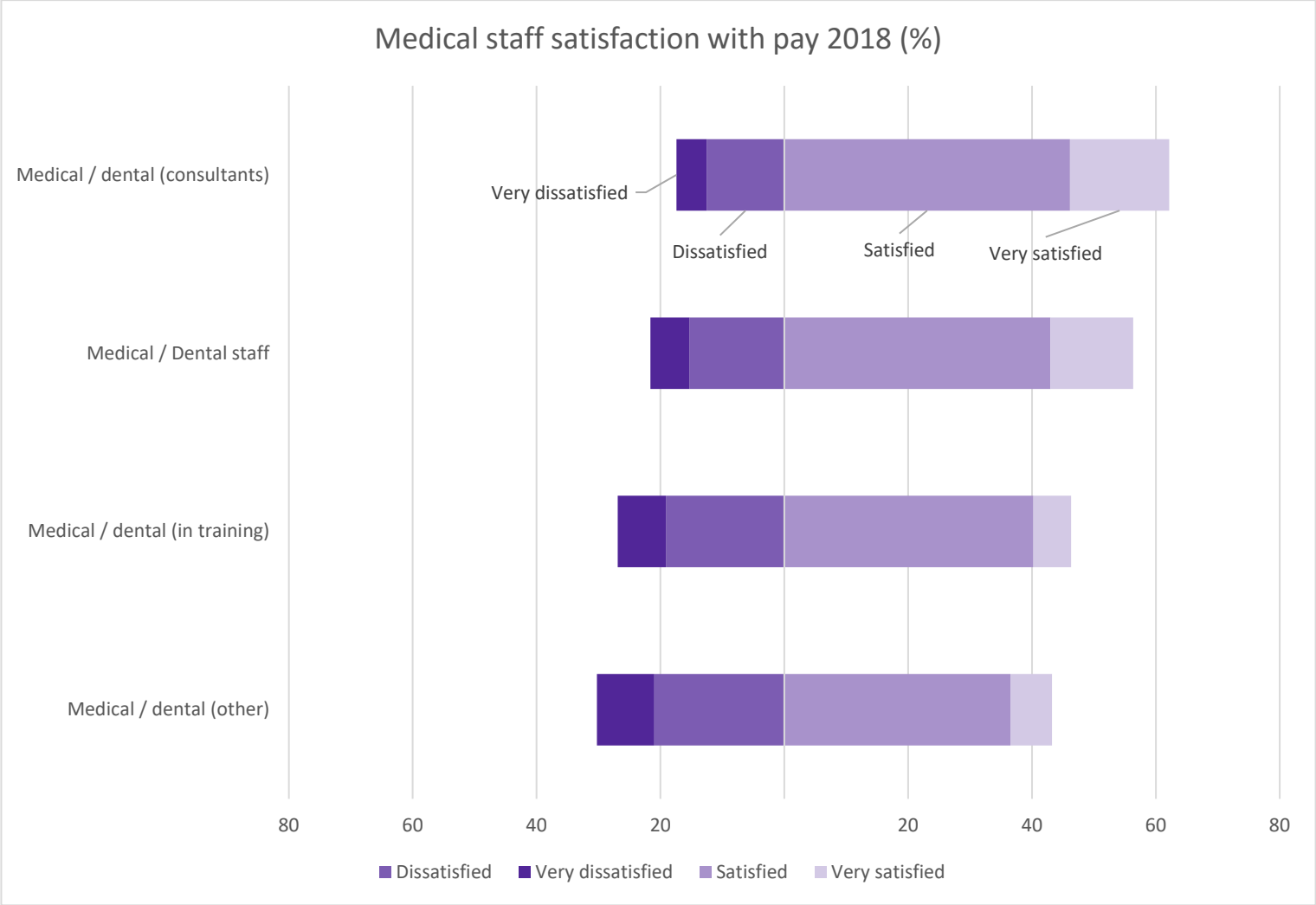
Source: NHS staff survey 2018

Satisfaction with Pay

5.57 Medical staff satisfaction with level of pay remains positive on balance. However, it has fallen slightly over the last two years, while leading up to 2016 it had risen - this pattern is the same for consultants also. Doctors in Training have shown some notable changes over the last five years - decreasing from the peak in 2014, it rose almost 5 percentage points on last year to 46.3%.

5.58 There is notable variation across gender within grades. Both male Doctors in training and consultants are more dissatisfied with their level of pay than female staff.

Figure 5.18: Medical staff satisfaction with pay in 2018



Source: NHS staff survey

Note: This excludes staff who selected 'neither satisfied nor dissatisfied' in response to the question

Figure 5.19: Medical staff who are satisfied with pay

Staff survey - satisfied or very satisfied with level of pay	2014	2015	2016	2017	2018
Medical & Dental	54.1%	55.4%	58.0%	57.1%	56.3%
Medical / Dental - Consultant	59.5%	61.6%	63.8%	63.2%	62.1%
Medical / Dental - In Training	51.0%	43.6%	45.2%	41.6%	46.3%
Medical / Dental - Other	41.4%	42.9%	46.2%	42.9%	43.2%

Source: NHS staff survey

Flexible Working & Additional Hours

5.59 Medical staff working any number of additional paid hours (in the average week) has fluctuated, but overall remained steady over the last four years. There has been some variation in the proportion of Junior Doctors doing so, with a notable increase in the last two years.

Table 5.20: Proportion of medical staff working additional paid hours

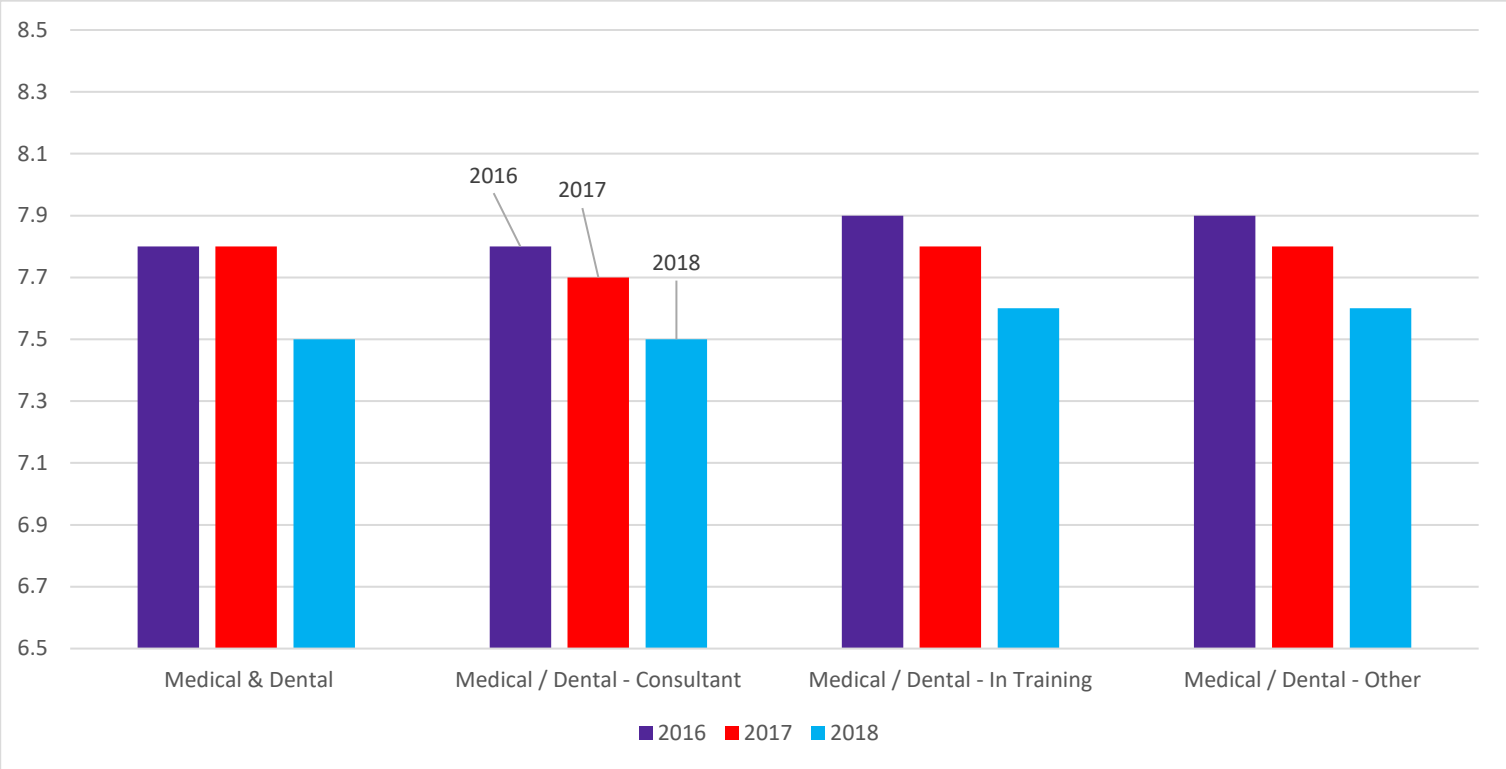
Staff survey - additional paid hours	2015	2016	2017	2018
Medical & Dental	37.4%	35.9%	36.3%	38.0%
Medical / Dental - Consultant	40.8%	39.3%	39.4%	40.6%
Medical / Dental - In Training	36.2%	34.1%	38.2%	41.0%
Medical / Dental - Other	32.0%	33.3%	33.7%	35.6%

Source: NHS staff survey

Proportion experiencing Bullying or Harassment

5.60 Staff experiencing bullying & harassment in the workplace has fallen slightly over the last couple of years. There is no significant variation amongst the medical grades, though a notable deterioration in the score for other medical staff is apparent.

Figure 5.21: Staff survey score for bullying and harassment index for medical staff



Source: NHS staff survey 2018

Recommending as a Place of Work

5.61 Staff who recommend their organisation as a place of work has shown minor changes over the last five years. Consultants generally score more positively, while Junior Doctors and Other Doctors score less positively.

Figure 5.22: Medical staff who would recommend organisation as a place to work

Staff survey - agree or strongly agree with recommending organisation	2014	2015	2016	2017	2018
Medical & Dental	66.1%	65.7%	68.4%	67.2%	68.4%
Medical / Dental - Consultant	64.7%	65.8%	68.1%	67.3%	68%
Medical / Dental - In Training	72%	71.5%	70.3%	67.7%	71.4%
Medical / Dental - Other	65%	61.9%	64.2%	64%	66.5%

Source: NHS staff survey 2018

5.62 Additionally, as part of 'friends and family test' 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 NHS England.

5.63 Staff remain favourable about their organisation as a place of both work and care, as shown in figure 5.23

Figure 5.23 - Friends and Family Test results by Test Type

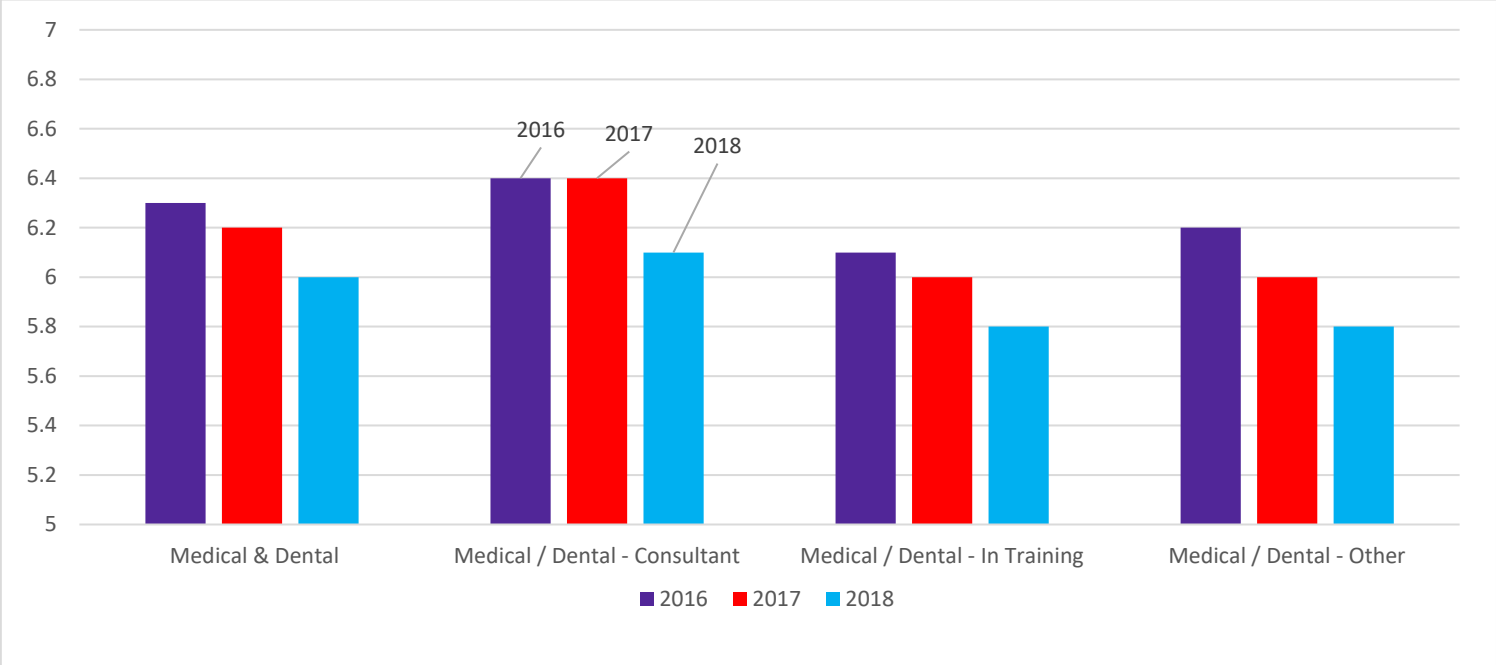
Staff friends and family test - Q1 18/19	% recommend	% would not recommend
Would Recommend as place to receive care	81%	6%
Would Recommend as place to Work	66%	16%

Source: NHS friends and family test

Staff Health and Wellbeing

5.64 The staff survey score for health and wellbeing has shown a decrease over the last couple of years across all medical grade groupings. Consultants score higher than the average medical staff score, while Doctors in Training score lower.

Figure 5.24: Staff survey score for health and wellbeing index for medical staff



Source: NHS staff survey

5.65 The DDRB requested information on engagement and wellbeing broken down by a combination of demographics, such as staff group, age and sex. We are currently in the process of obtaining and processing this data and are happy to provide it soon as part of supplementary evidence.

Sickness Absence

5.66 Doctors continue to have the low rates of recorded sickness absence. For the 12-months to the end of March 2019 the absence rate for medical staff was 1.29% 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 1.29%. While the rate has increased slightly in recent years this may reflect improved data quality.

5.67 Data on Sickness Absence for Doctors comes from the Electronic Staff Record and is published by NHS Digital. It is presented in figure 5.25.

Figure 5.25 Annual Sickness Rate for Medical Staff (2009 - 2019)

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%

Source - NHS Digital Workforce Statistics

5.68 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 5.26 - Average Sickness Absence Rate by Staff Group (2016 - 2019)

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

Source - NHS Digital Workforce Statistics

Figure 5.27 - Medical Sickness Absence by Region (2018-19)

Row Labels	SA Rate
Health Education East Midlands	1.7%
Health Education East of England	1.3%
Health Education Kent, Surrey and Sussex	1.2%
Health Education North Central and East London	0.9%
Health Education North East	1.4%
Health Education North West	1.5%
Health Education North West London	0.7%
Health Education South London	0.9%
Health Education South West	1.4%
Health Education Thames Valley	1.0%
Health Education Wessex	1.3%

Health Education West Midlands	1.4%
Health Education Yorkshire and the Humber	1.5%
Special Health Authorities and other statutory bodies	1.5%
Grand Total	1.3%

Source - NHS Digital Sickness Absence Statistics

5.69 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 absence and does not measure the number of work days that are lost.

Workforce Planning Response

5.70 The evidence suggests that whilst medical workforce growth remains strong overall, demand also continues to grow and there are still supply issues to address. The Department continues to act to increase the supply of trained Medical and Dental staff available to work in the NHS and wider health and care system by supporting a world class health education and training system. In conjunction with Health Education England (HEE) and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff.

5.71 As described further in the following section, the Government’s commitment to expanding undergraduate medical training places will not only increase our supply of doctors but will also provide more opportunities for students with the talent, drive and ambition to train as a doctor. Overall, by 2020 there will be an extra 1,500 medical students entering training each year.

5.72 As set out in the Long Term Plan, HEE and NHS England have established a national workforce group which is examining options for growing the medical workforce. These options include the possibility of increasing part-time study, expanding the number of accelerated degree programmes and greater contestability in allocating the 7,500 medical training places to drive improvements in curricula. Depending on future plans made locally by Sustainability and Transformation Partnerships and integrated care systems, the number of medical school places could grow further and this will be addressed in the final NHS People Plan which is expected to be published in the next few months.

Expansion of Undergraduate Medical Training Places

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

5.74 By 2020, five new medical schools will have opened in England, all of which are outside of London (in Sunderland, Lancashire, Chelmsford, Lincoln and Canterbury).

5.75 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.

5.76 Overall, by 2020 there will be an extra 1,500 medical students entering training each year. The first 630 additional places were taken up in September 2018, with a further 690 available in September 2019. The remaining additional 180 places will have been made available by universities by 2020/21.

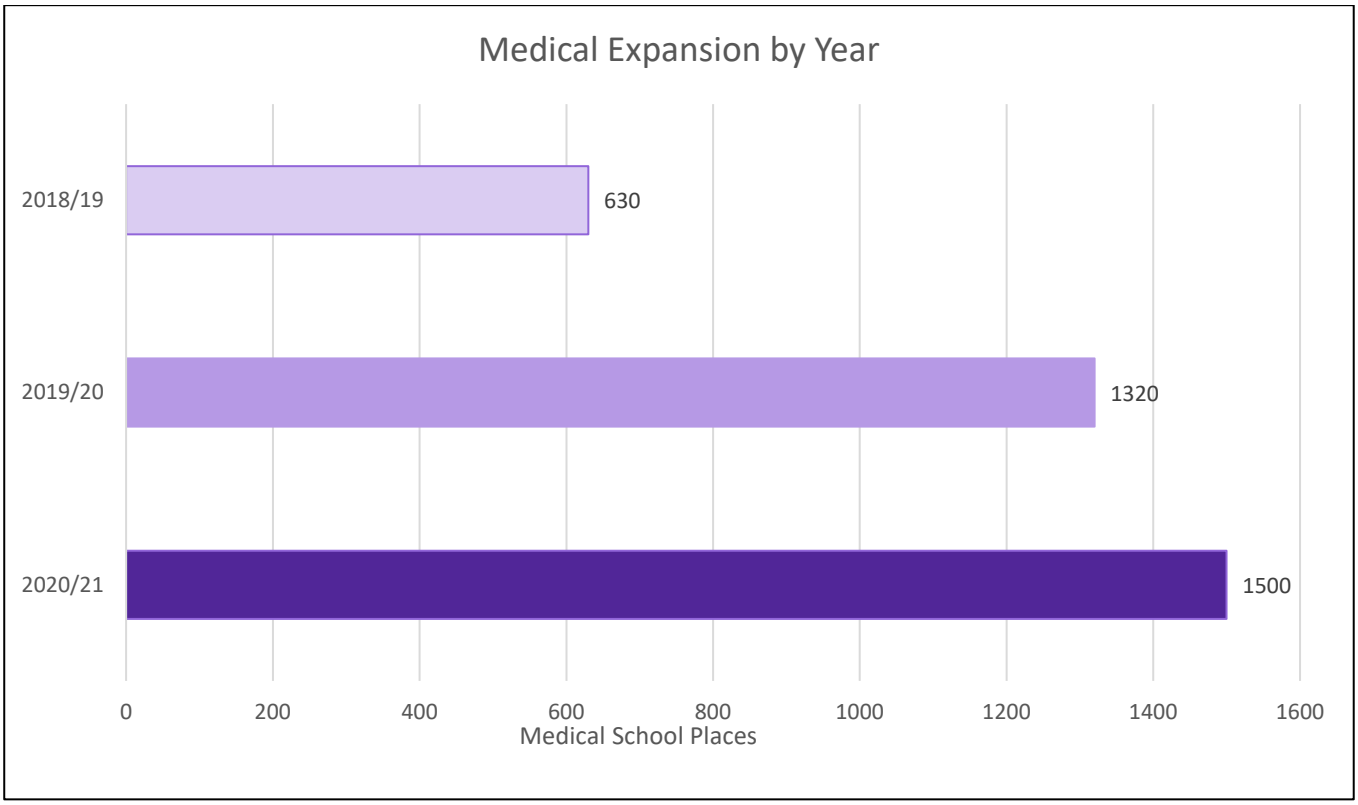
5.77 In terms of entry criteria to medical courses, these remain, as far as the department is aware, similar to previous years. Data showing average scores for those starting on Medical and Dental degrees is not published by UCAS.

5.78 The allocation of the additional places are shown, along with pre-existing places in Annex 2

5.79 The expansion began in 2018/19 and is spread over three years until 2020/21. The expansion phasing per year is shown in figure 5.28

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

Figure 5.28 - Number of new Medical Training places by Academic Year



Source - Medical Schools Council

5.80 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.

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

5.82 A review of postgraduate medical education and training was undertaken under the chairmanship of Professor Sir David Greenaway to ensure that doctors now and in the future, are able to meet the changing needs of patients, society and health services. The final report, The Shape of Training: Securing the future of excellent patient care was published in October 2013.

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

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

Skill Mix

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

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

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

5.88 General Practice is an area that has been a focus for the Department; in particular, targeting increased recruitment and retention. This year, HEE recruited the highest number of GP trainees ever for the second successive year, surpassing their target of 3,250. The Targeted Enhanced Recruitment Scheme (TERS) is attracting GP trainees to parts of the country where there have been consistent shortages of GP trainees. Over 500 trainees entered the scheme in 2016-2018 and a further 276 places are available in 2019.

5.89 Getting the skills mix right in general practice is critical in addressing workload pressures, as well as in delivering appropriate patient care. This will mean bigger teams of staff, providing a wider range of care options for patients and freeing up more time for GPs to focus on those with more complex needs. As of March 2019, there are over 2,500 more clinical staff (excluding GPs) working in general practice since 2016; consisting of over 850 more nurses and over 1,600 more other direct patient care workers.

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

5.91 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)

5.92 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.

5.93 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 General Medical Council confirmed that they were content to take on the regulation of these roles and work is currently underway to take this forward.

5.94 HEE has committed to train 1000 PAs and help secure increases in the number of PAs taking up new roles in Primary Care as part of the wider system commitment to make available 10,000 health care professionals in primary care within this timeframe.

5.95 Since 2014, the PA workforce has grown considerably. There are currently 1592 PAs in training across 35 training programmes across England and workforce demand increasing rapidly (compared with 2 course providers and 33 trainees in 2013/14). By 2020, it is predicted that annual output of PA graduates is likely to reach at least 900 and cumulative numbers of PAs to reach 2,500-3,000

6. Doctors and Dentists in Training

Background to the 2016 contract

6.1 As review body members will know, the DDRB commented on numerous occasions on the need for reform of the previous 2002 “New Deal” national contractual arrangements for doctors and dentists in training.

6.2 In June 2013, NHS Employers and the BMA Junior Doctor Committee (JDC) reached heads of terms for negotiations to achieve a new contract for doctors and dentists in training, to replace the 2002 “New Deal” arrangements. Formal negotiations commenced later in 2013 on a four-country basis.

6.3 After over a year of negotiations, the BMA Junior Doctor Committee walked away. The parties put evidence to the review body, detailing the progress of negotiations and proposed ways forward. The DDRB published a special report in July 2015 titled “Contract reform for consultants and doctors & dentists in training – supporting healthcare services seven days a week”.

6.4 The report contained observations on consultant contract reform, and recommendations on contract reform for doctors and dentists in training. These recommendations, in the Department’s view, provided the basis of a constructive way forward for contract reform for doctors and dentists in training.

6.5 Following further negotiations during 2015 and 2016, building on the recommendations of the review body, including with the involvement of ACAS, the employer and government sides made a significant number of concessions to the BMA Junior Doctor Committee, which resulted in an agreement being reached in early 2016. The JDC agreed to put this agreement to their members, however it fell just short of achieving the majority needed for the BMA JDC to be able to formally endorse it.

6.6 The Secretary of State for Health at the time made the decision to introduce the agreement, unamended (as agreed by the BMA negotiators), for use by employing organisations. This was met with ballots for industrial action by the JDC, and subsequent strike action.

6.7 The 2016 contract was introduced for use by NHS organisations in August 2016, and doctors became employed under the 2016 arrangements as and when they were offered the new arrangements by their employing organisations. This mostly followed a structured timetable based on when differing specialties moved to their next rotation and were therefore offered new contractual arrangements.

6.8 The first doctors became employed on the 2016 arrangements in October 2016, and the Department now estimates that approximately 4 in every 5 doctors and dentists in training in England are employed on the 2016 contract.

6.9 The doctors still employed on the old 2002 arrangements (in England) are mainly doctors who are employed in lead employer arrangements, where it is typical to offer doctors in training longer contracts of employment, as their employer does not change as they rotate. This means that for these doctors, there has not been a natural break in their employment contract where the 2016 arrangements could be offered. Note that doctors in the devolved administrations of Scotland, Wales, and Northern Ireland are still under the 2002 arrangements.

6.10 Doctors were offered transitional pay protection arrangements upon moving to the 2016 contract, to ensure that the transition to a different pay system did not mean they would be worse off. These arrangements took two forms:

- For those trainees in the latter stages of their training, they were allowed to continue on the existing pay arrangements (the 2002 incremental pay scale plus banding supplements), as this preserved their expectations of what their pay would be until they completed training.

- For those in the earlier stages of their training, a "cash floor", based on their previous earnings was calculated, which their pay could not fall below.

Review of the 2016 contract and collective agreement

6.11 The ACAS agreement reached in 2016 committed to a review of the 2016 contractual arrangements, and this commitment was mirrored in the 2016 terms and conditions of service. The contract review began in 2018 with the BMA JDC participating as equal partners. Our 2018/19 evidence to the review body described the ongoing review of the 2016 contract.

6.12 This review has now completed. The five partnership sub-groups set up by the review each produced a final report, for consideration by the Joint Negotiating Committee for Juniors (JNC(J)), the partnership forum between the BMA JDC and NHS Employers. The JNC(J) had not met since the 2016 dispute had begun.

6.13 The recommendations contained within the final reports formed the basis for formal negotiations to commence between the BMA JDC and NHS Employers. These negotiations took place from early 2019 and culminated in a framework agreement which was published on 10 June 2019.

6.14 The framework agreement included a four year pay deal, which will also introduce a new higher pay point above the current fourth nodal point. As well as basic pay, the agreement introduces new elements of pay, such as enhancing the existing weekend allowance provisions, and improving unsocial hours payments for those working ‘disco shifts’ – shifts which start in the afternoon/evening and continue late in to the night or early morning. A high number of 'non-pay' improvements were also agreed. The changes are detailed fully in the framework agreement document, and a brief overview is given below.

6.15 The JDC put the framework agreement to their members in a referendum, and announced at the end of June 2019 that the agreement was overwhelmingly supported.

6.16 This had the effect of officially ending the dispute with the JDC which has been ongoing since 2016, and making the 2016 contract a national collective agreement, subject to collective bargaining. This puts the 2016 contract on the same footing as all 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)).

6.17 Our evidence to the DDRB last year set out how we would ask the review body to consider, as the contract is implemented, how funding freed up during transition has been-invested within the pay structure and informed by the outcome of the 2018 Review. It is important to note that, upon detailed modelling and analysis it was discovered that the funding expected to be freed up during transition was significantly less than had originally been anticipated.

6.18 Modelling found that the funding expected to be released during transition had essentially already been spent within the existing 2016 contract, which meant that junior doctors already had the benefit of additional funding in their pay packets. This meant modest additional funding had to be found to reach the framework agreement position.

Overview of the four-year deal

6.19 The four-year agreement, covering 2019/20 - 2022/23, sets out increases to pay and amendments to the 2016 junior doctors contract. Investment is over 4 years and consists of 2% pay awards per year, and additional investment in the contract of £90m to fund the contractual changes agreed with the BMA.

6.20 In the Departments view the deal is a significant step in improving junior doctors’ working lives, supporting recruitment, training and retention and supporting the delivery of excellent and safe patient care through the NHS Long Term Plan.

6.21 Highlights from the deal include:

- A guaranteed 2% increase to salary scales each year, which taken cumulatively means the junior doctor pay scales will be increased by 8.2% over the course of the deal.

- Approximately 1 in 8 doctors in training will receive more pay as they reach a new higher pay point at nodal point 5, to reflect their level of responsibility and recognise that they are often taking decisions and delivering care at or near-consultant level.

- Those working the most frequently at weekends will be better rewarded through an increase to the weekend allowance.

- Night pay rates (time plus 37%) will apply for the whole of shifts that finish after midnight and by 4AM, so called ‘disco shifts’.

- More safety and rest limits will be introduced including a commitment to reduce the number of consecutive shifts, long-days or weekends a junior doctor has to work. The aim of these limits is both to ensure that doctors are safe to work, and additionally to improve their work life balance.

- A permanent allowance of £1,000 a year for junior doctors who work less than full time to recognise the additional costs they face when training less than full time and to make the NHS a more flexible and diverse employer.

6.22 The agreement provides pay certainty for doctors and employers for four years (inclusive of 2019/20), and importantly ensures that once doctors on the previous 2002 contract are transferred to the 2016 contract, there will once again be one nationally agreed contract for doctors and dentists in training.

Non-contractual issues

6.23 In addition, but separate to the four-year deal, in recognition of the importance of improving the working environment for junior doctors the Secretary of State for Health made an extra £10 million available to NHS trusts, to be spent locally by the Guardian of Safe Working in each Trust in agreement with junior doctors.

6.24 Health Education England have worked with the BMA, NHS Employers, NHS Improvement and the Academy of Medical Royal Colleges to agree the allocation of the £10m by trust. We understand that the money is now with employing organisations, who are using it to improve facilities locally.

6.25 Similarly, separate to the four year contract deal, Health Education England have continued to work with stakeholders, including the BMA, on non-contractual issues. HEE will set out these significant work programmes and initiatives in their evidence to the review body.

Implementation of the four-year deal

6.26 Since the agreement of the framework agreement, NHS Employers have been working with the BMA JDC to translate the provisions agreed in the framework agreement in to the terms and conditions of service. This gives the provisions contractual force.

6.27 An implementation timeline has been agreed between the parties reflecting the reality that employing organisations will need time to prepare to implement certain provisions before they can "go live" in the contract. An example of this is where the agreement changes established rota rules. In order for this kind of change to be enacted, the rota software employers use needs to be updated to reflect updated rules, so employers can then re-write existing rotas where necessary.

6.28 Doctors and dentists in training received their 2019/20 pay increase, plus backpay, in their September 2019 salaries. Pay scales will increase again in April 2020 to reflect the 2% increase agreed.

6.29 In addition to the provisions in the framework agreement, the parties have also agreed upon a transitional pay protection process to move the remaining doctors on the 2002 arrangements on to the 2016 arrangements. This is possible now the 2016 contract is a national collective agreement.

6.30 This transition is set to take place in February 2020 and will offer protection arrangements similar to those offered originally to doctors transferring to the 2016 contract. After this point, there should no longer be any doctors and dentists in training employed on the previous 2002 arrangements in England.

6.31 We are aware that a number of organisations have historically used the 2002 arrangements for their 'trust grade' posts, local appointments that are not on a national training programme. We are aware that in some cases organisations, sometimes working on a regional basis, have agreed new 'trust grade' arrangements, sometimes mirroring the 2016 arrangements.

6.32 We hope that the work we will be undertaking for SAS grade arrangements (see Chapter 8) may in the future, in some circumstances, provide an attractive alternative option to local arrangements for employers and doctors. It is important

that there are flexible options for doctors and dentists in training where they wish to ‘step off’ their training programme but continue to provide service to the NHS.

Approach to the review body round 2020/21

6.33 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 2020/21 round, but as usual we would welcome comments and observations on the evidence you receive from the Department of Health and Social Care and other parties on this group.

6.34 Basic 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. The table below shows the basic pay values for the 2016 contract over the course of the four-year agreement.

Figure 6.1 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

6.35 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 earlier in this chapter, a number of other pay and non-pay improvements have been agreed for the 2016 contract. One such change can clearly be seen in the table above, the introduction of a fifth nodal point to the pay structure from October 2020, which will gradually increase in value.

6.36 These improvements represent an investment of approximately £90 million on top of the investment in to basic pay awards.

6.37 Besides pay and contractual improvements, we understand that the review body is keen to understand the future model for postgraduate medical training and how this may change moving forwards.

6.38 The Department is aware of work to explore moves towards a more flexible system of training for doctors and dentists, that recognises the changing demographics and attitudes of modern trainees and medical students. Chapter 8 goes in to detail on SAS doctors and the proposed reform in this area, which we hope to ensure aligns closely to our other national arrangements for doctors, to create a comprehensive and attractive career structure throughout the different doctor grades to promote choice and flexibility.

6.39 We understand the review body is keen to understand the impact that different ways of working will have on the service and how this may change career pathways. It is certainly the case that any change in the way doctors in training are working and training is of interest, given there are potential impacts to the service.

6.40 For example, if it is the case doctors and dentists in training are increasingly stepping off their training programmes to do other things (either out of programme activities or stepping out of training altogether) it is certainly of interest what doctors are choosing to do, and whether they still providing any level of NHS service. It is also important to understand the proportion of these doctors that return to training following time away. We hope that Health Education England (HEE) will be able to provide more evidence on this point.

6.41 It is also of course the case that, should more doctors and dentists in training choose to train less than full time, there is also a potential service impact. LTFT training and stepping out of training clearly alter the time it takes for a doctor to achieve their Certificate of Completion of Training (CCT). As above, we are hopefully that HEE will provide evidence on LTFT training, and the length of time (on average) it takes doctors to reach their CCT, so the review body can comment on any long-term trend that may emerge.

Flexible pay premia (FPP)

6.42 Our evidence last year set out the background to the introduction of flexible pay premia, and an initial assessment of the effectiveness of these initial FPPs as well as proposals to use FPPs to further support specialty recruitment and retention.

6.43 It is important to ensure that FPPs are having the desired effect on specialty training recruitment, whether that is to ensure that there is not a financial disincentive to training in a particular specialty or, conversely, providing a financial incentive to train in a particular specialty. Clearly without this evidence, it is difficult to assess whether or not financial levers do make a difference to recruitment and retention in different specialties.

6.44 Given the purpose of FPPs is to aid recruitment and/or retention to certain specialties, trends in application rates and fill rates in to specialties should provide an interesting indicator of the success of FPPs. Longer term trends in vacancy rates could also be an interesting indicator.

6.45 HEE are the custodians of the data in this area, so we would expect them to provide the review body with sufficient evidence to assess trends in application and fill rates in relevant specialties.

6.46 NHS Employers will provide the review body with evidence on whether employing organisations believe flexible pay premia have helped to recruit and retain doctors in the specialties where they apply.

6.47 As we have previously noted, pay of course is not the only factor in influencing choice of specialty and the DDRB will need to be informed on the extent to which pay can be identified as a factor in specialty recruitment and retention. A whole system perspective of ensuring appropriate recruitment/supply to all specialties as part of the workforce strategy also needs to be considered.

Geographical flexible pay premia

6.48 As covered in our evidence last year, the introduction of FPPs was originally borne out of a proposal for recruitment and retention premia in NHS Employers evidence to the review body for their special report on contract reform. At the time it was thought by the management side that there would be potential in the future for recruitment and retention premia, or FPPs as they became known, to be used to incentivise recruitment in geographies as well as specialties. In previous reports the review body has stated they would be supportive of appropriately targeted geographic premia.

6.49 We understand that the review body is interested to hear what the methodology might be should such a system of FPPs be introduced in the future.

6.50 Clearly any system of incentives would need to be based on a sound evidence base. HEE will provide information on geographical fill rates in their evidence,

which will enable the review body to observe the challenges across different regions in England.

6.51 HEE undertake recruitment to specialty training, so it would be important that their views were taken into account, in terms of the regional areas that may attract an FPP should one be made available in the future.

6.52 Clearly any knock-on impacts on surrounding HEE regions would need to be considered, as would the evidence on if financial incentives do impact upon recruitment and retention on a geographical basis. The interaction between any geographical FPPs and existing specialty FPPs would also need to be considered.

6.53 It would be for the Department, in conjunction with NHS England and NHS Improvement, to determine if a geographical FPP would be of benefit to recruitment and retention in under-doctored areas of the country, based on all of the available evidence.

6.54 We would welcome comments from the review body on evidence received regarding improving recruitment and retention in certain geographies for doctors and dentists in training.

6.55 We note, as we did last year regarding specialty FPPs, the dilemma that whilst it is difficult to evidence a direct correlation between a pay intervention (separate from other efforts/initiatives) and application/fill rates, it is also the case that it is difficult to establish any evidence of pay interventions working until they have been tried.

GP specialty trainee FPP

6.56 Under the previous 2002 arrangements for doctors and dentists in training, doctors were paid a basic salary plus a banding supplement, designed to cover additional hours and any work done in unsocial hours, including weekends.

6.57 GP trainees, whilst in the GP practice part of the rotations, historically did not meet the requirements to receive a banding supplement. This meant that on average GP specialty trainees were paid less than their colleagues in hospital specialties whilst they were in a practice setting. It was thought that this provided a disincentive for some to choose general practice as a specialty.

6.58 Therefore, under the old 2002 arrangements, a GP supplement was introduced for GP trainees whilst they were working in a GP practice setting. This supplement was set at the average banding received by other doctors in training, to ensure there was not a pay disincentive in general practice. At the time of the introduction of the 2016 contract this "GP supplement" was 45% of basic pay.

6.59 The GP specialty training FPP under the 2016 arrangements was designed to mirror the intention of the GP supplement under the 2002 arrangements, i.e. to ensure there was not a pay disincentive to enter GP specialty training when compared to other training programmes.

6.60 However, the 2016 arrangements in practice work differently to the previous 2002 arrangements. Under the 2002 arrangements, the basic salary plus the GP supplement comprised the entirety of the doctors pay whilst in a GP practice, but under the 2016 arrangements this may not be the case.

6.61 Under the 2016 arrangements, GP trainees when in a GP practice are paid their basic salary plus the GP specialty trainee FPP, however they are also eligible for all of the pay elements under Schedule 2 of the terms and conditions, meaning they are paid in the same as hospital trainees, but additionally receive a FPP.

6.62 The GP supplement under the previous arrangements meant that when in a GP practice, doctors could theoretically be paid the same for working a 40-hour week in daytime hours, as they would be for working more than 40 hours and doing work in the evenings or weekends. A doctor under the 2016 contract should be paid according to the hours and times they work.

6.63 As the purpose of the GP FPP is to ensure that there is no pay disincentive to entering GP specialty training, we will wish to keep under review the total earnings of GP specialty trainees relative to other specialties on the 2016 contract, to ensure that the GP specialty trainee FPP continues to be fit for purpose in ensuring there is no pay disincentive to entry in to GP training.

7. Consultants

7.1 Consultants are relied on by the entire health-care team as system leaders, providing the direction necessary to ensure patient care is safe and of the highest quality.

7.2 Consultants represent the largest group in the medical workforce. Over recent years the rate of growth in the consultant workforce has been consistently high with 18% growth over the last 5 years. However, there continue to be shortfalls within certain specialities and in certain areas of the country.

7.3 At consultant level it is likely that a doctor is already set on their speciality and geographic location. Therefore, we do not consider that targeting pay for consultants at certain specialties or geographies would alleviate any shortages.

7.4 According to the most recent Staff Survey results, the proportion of consultants who are satisfied with their pay has dropped slightly from previous years but remains significantly higher than other medical staff groups.

7.5 In 2019 the Government accepted the DDRB's recommendation and uplifted the national salary scale for consultants by 2.5%. This pay award was worth between £1940 and £2630 for consultants.

7.6 In recent months concerns amongst the consultant workforce relating to the effects of pension taxation has led some consultants to consider reducing their workloads. Retaining and maximising the contribution of our highly skilled clinical workforce is imperative to the delivery of high-quality care and the Government is seeking a solution. This matter is covered in further detail in Chapter 12.

Contract reform

7.7 The case for reform of the 2003 consultant contract has been well documented by bodies such as the Public Accounts Committee and National Audit Office.

7.8 Reform of the consultant contract would provide consultants with refreshed terms and conditions which reflect modern working practices and support developing service requirements. Reformed terms and conditions would be developed with a view to attract, retain and motivate consultants, support them to be responsive to patient's needs, whilst being affordable to employers.

7.9 Negotiations have been ongoing for several years and agreement has been reached in principle on some of the key aspects, for example in relation to pay progression. However, progress has been slow.

7.10 At present the resource potentially made available to fund consultant contract reform remains unchanged from that presented by NHS England to the BMA in 2018 and rejected as insufficient to continue with negotiations.

Local Clinical Excellence Awards

7.11 Interim arrangements for Local Clinical Excellence Awards (LCEA) were introduced in April 2018, to run until March 2021, with the intention of opening up more opportunity for high performing consultants to apply for awards. Under these arrangements all employers are required to run an annual award round. New awards are time limited, bringing a closer link between reward and current excellent performance.

7.12 The requirement set out in the interim agreement was that employers must invest 0.3 CEA points per eligible consultant each year. By making the decision in 2018 to target a proportion of the 2019/20 pay bill on this new system of performance pay, the required investment ratio will see an increase from that set out in the agreement. Employers will be able to decide, in conjunction with their local consultant representative group, whether to use the increased investment to create more awards, or the same number of awards at a higher value.

7.13 In its response to the DDRB's 2019 report the Government again froze the value of 'old style' consolidated LCEAs as it sees that such awards reward those with historical excellent performance but do not necessarily incentivise excellent performance, increase productivity or reward those making the greatest contribution today. The value of a point under the interim arrangements was increased in line with the uplift to basic pay for consultants.

7.14 The interim arrangements for LCEAs are a means of beginning the transition to a new system whereby employers will have more flexibility to use performance pay in a way which supports the achievement of personal, team and organisational objectives. Successor arrangements to be introduced from 2021 must open up access even further and motivate consultants to achieve the highest levels of performance. Proposals for a new performance pay system will be broadly based on the recommendations set out by the DDRB in their report Review of the compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants published in December 2012. Initial discussions with trades unions on a potential framework for a successor scheme are planned

to begin in early 2020. It is the intention to reach a negotiated agreement on a new successor scheme to replace LCEAs from April 2021.

7.15 The Department plans to embark on a consultation in the coming months to review the national CEA scheme. The proposed changes will be in line with the recommendations set out in the DDRB's report cited in the paragraph above. We will update the DDRB on the outcomes of the consultation in due course. The intention would be to introduce new arrangements for national CEAs from April 2021, in line with the timeline for new arrangements for LCEAs.

7.16 The Advisory Committee on Clinical Excellence Awards (ACCEA) have provided evidence on the review of the national clinical excellence awards scheme. This is provided at Annex 3.

8. Specialty Doctors and Associate Specialists (SAS)

8.1 SAS doctors play a vital role in delivering high quality care within healthcare teams. Their roles are often focused on service delivery and they also provide an important contribution to addressing workforce pressures and gaps.

8.2 In recent reports the DDRB has highlighted the need for a review of the role, career structure and development available to SAS doctors in the interests of addressing motivation for this group.

8.3 In 2018 the Secretary of State made a commitment to work with the BMA SAS Committee to reform the SAS contract and an agreement in principle that this would include reopening a reformed Associate Specialist (AS) grade to extend career development for this group of doctors.

8.4 The preparatory work with stakeholders to re-open a reformed senior SAS grade identified a strong feeling that the newly reformed grade must be aligned with a strategy for reform to the whole SAS grades and some concern that piecemeal reform may not maximise the potential return in benefits to both staff and services.

8.5 Following from this, the government’s response to the recommendations of the DDRB's 47th report committed to negotiations on a multi-year pay agreement, incorporating contract reform for the entire SAS grades to begin in 2020/21.This included the potential for an additional 1% to be added to pay in 2020/21 conditional on contract reform, through a multi-year agreement. This presents the opportunity to reform and improve the whole SAS grades' contractual arrangements and offer these doctors an attractive and fulfilling career with greater flexibility for progression.

8.6 The overarching aim of reform 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 providing quality care to patients. Updated contracts will provide terms and conditions which support the priorities of a modern workforce and ongoing developments in service provision. The reform will be reflective of a shared vision and aligned commitment across system partners to enhance the experiences of SAS doctors. Reforms will support the objectives set out in the NHS Long Term Plan and People Plan. The programme to reform the SAS grade will run concurrently with ongoing work by NHS Employers, NHS England and NHS Improvement and HEE, together with the BMA and the profession, to develop SAS guidance and improve working lives and career opportunities for the whole SAS group.

8.7 The reformed SAS grades will offer an alternative pathway for a career in medicine which supports flexible career development and gives doctors more opportunity to develop a fulfilling career which meets their personal needs and aspirations. Doctors' expectations of a career in medicine are changing and not all doctors want to progress straight through a formal training programme to become a consultant. Introducing more flexibility into the medical career pathway will provide more opportunity for doctors to create a career which works for them.

8.8 The reformed grades should support 'step on and step off' by offering a fulfilling option for those who wish to pause their formal training while continuing to contribute to service delivery. They should offer a means of recognising skills and expertise gained while not in a formal training role.

8.9 In the absence of a national contract for senior SAS doctors, employers are currently seeking local solutions to aid recruitment and retention by creating local contracts. Opening a nationally agreed reformed senior SAS grade, in place of the closed Associate Specialist grade, should contribute to the SAS grades becoming a positive career choice, offering attractive opportunities for career development and progression for senior, experienced doctors. This senior SAS grade should help to recruit, motivate and retain senior doctors who want a fulfilling career but do not necessarily want to become a consultant.

8.10 A further aspect of the reform will be to consider changes to the pay scale to help enhance rates of satisfaction with pay and improve morale.

8.11 It is intended that the reforms will be applicable to doctors in England and Wales. The intention is that NHS Employers will begin negotiations with the BMA as soon as practicable. We would expect the DDRB's recommendations to be informed by these talks and will update the DDRB on the progress of negotiations.

9. General Medical Practitioners

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

9.2 General Medical Practitioners are subject to a five-year investment agreement between NHS England & Improvement and the British Medical Association and therefore no pay recommendation is being sought for GP Contractors.

9.3 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.

Affordability

9.4 In January 2019, NHS England and the British Medical Association's General Practitioners Committee agreed a five-year GP (General Medical Services) contract framework from 2019/20. Funding for the core practice contract (i.e. excluding the network DES) is now agreed and fixed for the next five years. The new contract provides five-year funding clarity and certainty to practices and the settlement covers all aspects of practice income and expenses including salaried GP pay. The uplift to the contract should be taken in the context of the full package for GP contract reform which included seeking to address workload by providing additional staff though the Additional Roles Reimbursement Scheme and the introduction of the new state-backed scheme for GP indemnity which started in April 2019. As the GP contract has now been set for five years, there is direct trade-off between pay and staff numbers which provides the context to the uplift to the salaried GP pay range and will inform decisions by GP partners on the pay of salaried GPs. We support NHS England's evidence on affordability in line with fixed contract resources.

Spend on General practice

9.5 The total spend on general practice services in England, including the reimbursement of drugs dispensed in general practices, was £11.2 billion (£10.5 billion excluding reimbursement of drugs) in 2018/19. This was an increase of 3.2% in cash terms, and 1.3% in real terms, relative to the spend of £11.1 billion in 2017/18. Compared to 2013/14, the 2018/19 total spend was an increase of 27.1% in cash terms and 19.8% in real terms (Figure 9.1).

Figure 9.1 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)
2013/14	8,830.54	9,374.21	8,234.01	8,740.95
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, Table 1.

9.6 In April 2016, NHS England published the General Practice (GP) Forward View, a package of support for general practice. This included a commitment to invest an extra £2.4 billion a year in general practice services by 2020/21 compared to 2015/16. From 2019/20 this commitment was superseded by the Long Term Plan commitment, see 1.6.

NHS Long Term Plan Investment

9.7 In June 2018, the government announced a multi-year funding plan for the NHS. The NHS budget will receive an extra £33.9 billion a year by 2023/24 (compared to 2018/19). This increased funding will support a new 10-year long-term plan developed by the NHS. The NHS Long Term Plan was published on 7 January 2019 and included a commitment to increase investment in primary medical and community health services as a share of the total national NHS revenue spend across the five years from 2019/20 to 2023/24. This commitment will mean spending on these services will be at least £4.5 billion higher by 2023/24 in real terms. This commitment is a 'floor' level of investment that is being nationally guaranteed, that local Clinical Commissioning Groups (CCGs) and Integrated Care Systems (ICSs) are likely to supplement further. This investment guarantee is set to fund demand pressures, workforce expansion, and new services to meet relevant goals set out across the Plan.

Current GP pay

9.8 NHS Employers (on behalf of NHS England) and the General Practitioners Committee (GPC) of the British Medical Association (BMA) negotiated an agreement on the GP contract for 2019/20 before the DDRB reported. Funding for the core practice contract was agreed and fixed for five years. From 1 April 2019, core general practice funding will increase by £109m, rising to an extra £978m per year by 2023/24. This takes into account other agreed changes. The settlement covers all aspects of practice income and expenses. This contract is the most ambitious in recent memory and has created a five-year framework for GPs that will support the delivery of the NHS Long Term Plan.

9.9 The National Health Service (General Medical Services Contracts and Personal Medical Services Agreements) (Amendment) Regulations 2019 No. 1137 were published on legislation.gov.uk in July 2019. It came into force in October 2019.

9.10 Specifically, this agreement:

- Includes a new network payment that incentivises GPs to form Primary Care Networks (PCNs). These are networks of GP practices covering 30-50k population foot prints. As of July 2019, 1,259 PCNs had been formed. 99.7% of all GP practices are now covered by a network. Up to £1.799 billion will flow nationally through the Network Contract Directed Enhanced Service (DES) by 2023/24. This will include funding for the new additional role reimbursement scheme, network support, access and new Investment and Impact Fund. Networks who make faster progress against the dashboard and Long Term Plan goals will benefit from additional funding from the Investment and Impact Fund, which NHSE expects to stand at £300m nationally by 2023/24.

- Seeks to address workload issues resulting from workforce shortfall. Through a new Additional Roles Reimbursement Scheme, Primary Care Networks (PCNs) will be guaranteed funding towards an up to estimated 20,000 additional staff by 2023/24.

- Delivers new services to achieve NHS Long Term Plan commitments. The scale of the investment in primary medical care under this agreement was secured for phased and full delivery of all relevant NHS Long Term Plan commitments. The funding for the additional staff is subject to PCNs delivering seven national Network Service Specifications by 2020/21. (These specifications cover structured medicines reviews, enhanced health in care homes, anticipatory care, personalized care, supporting early cancer diagnosis, cardio-vascular disease case finding and reducing inequalities).

- Helps join-up urgent care services. The NHS Long Term Plan envisages PCNs joining up the delivery of urgent care in the community. Funding and responsibility for providing the current CCG-commissioned enhanced access services transfers to the Network Contract DES by April 2021 at the latest.

- Delivers on our commitment to introduce a new state-backed scheme for GP indemnity. The new and centrally-funded Clinical Negligence Scheme for General Practice started in April 2019.

- Improves the Quality and Outcomes Framework (QOF). The findings of the QOF Review. 28 indicators, worth 175 points in total, were retired from April 2019.

- Enables practices and patients to benefit from digital technologies. NHS England will continue to ensure and fund IT infrastructure support including through the new GP IT Futures programme, which replaces the current GP Systems of Choice. All patients will have the right to digital-first primary care, including web and video consultations by April 2021. All patients will be able to have digital access to their full records from 2020 and have been able to order repeat prescriptions electronically as a default from April 2019.

- Gives five-year funding clarity and certainty for practices. Resources for primary medical and community services increase by over £4.5 billion by 2023/24. Spend will rise as a share of the overall NHS budget. This agreement now confirms how much of this will flow through intended national legal entitlements for general practice under the practice and network contracts.

- Protects investment by committing to create a balancing mechanism so that if there are windfall profits in future years these will be reinvested in extra staff for networks. This will also involve publishing details of GP partners earning more than £150k pa.

9.11 The creation of PCNs, the move towards patients having digital access to their health records, and the state-backed indemnity scheme are three key policy directions which the 19/20 contract supports.

9.12 2020/21 contract negotiations - whilst a five year overall framework was negotiated, there are elements of the contract that will continue to be negotiated every year (such as the new service specifications) and some elements where the details of the principals established need to be agreed. The GP contract is negotiated annually between NHSE England and the General Practitioner Committee of the British Medical Association (BMA). Negotiations typically run October - January. Work remains in progress to negotiate and confirm the details of the agreement and an update can be provided via supplementary evidence.

9.13 General Medical Practitioners are subject to a five-year pay agreement between NHS England & Improvement and the British medical Association and therefore no pay recommendation is being sought for GP Partners. You are invited to make recommendations on uplifts to the minimum and maximum of the salaried GP pay scales.

GP Contractors

9.14 To safeguard public trust in the partnership model, pay transparency will increase. Subject to agreement with the BMA, GP partners with a total NHS earnings of over £150,000 per annum will be listed by name and earnings in a national publication starting with 2019/20 income. From 2020/21 a balancing mechanism to adjust between practice level global sum and network level Additional Roles Reimbursement Sum depending on the levels of real terms partner NHS earnings will be introduced by NHS England and GPC England.

Salaried GPs

9.15 Under the contract agreement, the minimum and maximum pay range for salaried GPs were uplifted by 2% in 2019/20. Under this agreement, we assumed that practice staff, including salaried GPs, would receive at least a 2.0% increase in 2019/20, but the actual effect will depend on indemnity arrangements within practices.

GP Indemnity

9.16 In October 2017, the previous Secretary of State for Health and Social Care announced his intention to develop a state backed indemnity scheme for general practice in England. The rising cost of clinical negligence indemnity has been a great source of concern for GPs. The state-backed scheme was designed to provide more stable, affordable cover for GPs and patients.

9.17 The Department launched a clinical negligence scheme for general practice (CNSGP) on 1st April 2019, which will provide indemnity for NHS clinical negligence of all staff working in general practice for incidents occurring from that date. The clinical negligence costs of NHS practice under the scheme will be funded centrally, not met individually by practices. GPs and other professionals working in general practice will still need to purchase separate indemnity cover for services not covered by the scheme, e.g. medico-legal advice. The new scheme delivers a key component of the GP contract for 2019-20 and aims to contribute to the recruitment and retention of GPs in the future, in addition to protecting current

GPs from the rising costs of clinical negligence indemnity. The Department has agreed commercial terms with the Medical Protection Society (MPS) and the Medical and Dental Defence Union of Scotland (MDDUS) in respect of the arrangements for an existing liabilities scheme (ELS), covering claims for historical NHS clinical negligence incidents of their GP members occurring at any time before 1st April 2019.

GP earnings

9.18 The latest available data from NHS Digital on GP earnings and expenses is for the financial year 2017/18 and is based on a sample from HM Revenue and Customs' (HMRC's) tax self-assessment database. 2018/19 earnings and expenses will be available in September 2020. It is not possible to calculate the split between private and NHS work and therefore the data presented below is a combination of both. The most recent assessment (2014/15) showed the average NHS superannuable income for a GPMS contractor was 94 per cent before tax. The dataset is divided by contractor (GP partners) and salaried GPs working under both GMS and PMS contracts, and it does not include GPs who work solely as locums. In England, the average pre-tax income for a GP contractor (GPMS) increased from £109,600 in 2016/17 to £113,400 in 2017/18, a rise of 3.4 per cent. During the same period, the average pre-tax income for a salaried GP in England increased from £56,600 to £58,400, an increase of 3.2 per cent. When compared with the latest income distribution figures (2016/17), this puts contractor GPs in the 97th – 98th percentile group (£96,400 - £116,000).

9.19 Figure 9.2 shows the change in contractor GP income in England since 2003/4 in both nominal and real terms (2017/18 prices). The data in this figure represent average earnings for GP contractors in both GMS and PMS practices and are based on a survey of GPs' actual earnings by headcount and not by FTE.

Figure 9.2 - GMS and PMS contractors in England, Earnings and Expenses – GMS & PMS – all practice types

Year	Estimated gross earnings in cash terms	Total Expenses	Income Before Tax	Estimated gross earnings in real terms (2017/18 prices)	Total Expenses	Income Before Tax
2002/03	£191,777	£116,671	£75,106	£258,988	£157,560	£101,428
2003/04	£212,467	£127,672	£84,795	£281,094	£168,911	£112,183
2004/05	£241,795	£138,231	£103,564	£311,504	£178,083	£133,421
2005/06	£257,563	£143,950	£113,614	£323,341	£180,712	£142,629
2006/07	£260,764	£149,198	£111,566	£317,911	£181,894	£136,016
2007/08	£266,110	£155,971	£110,139	£316,585	£185,555	£131,030
2008/09	£274,100	£164,500	£109,600	£317,500	£190,600	£126,900
2009/10	£278,100	£168,700	£109,400	£317,600	£192,600	£125,000
2010/11	£283,000	£175,300	£107,700	£317,300	£196,500	£120,800
2011/12	£284,300	£178,200	£106,100	£314,600	£197,200	£117,400
2012/13	£289,300	£184,200	£105,100	£313,800	£199,800	£114,000
2013/14	£290,900	£189,000	£101,900	£309,800	£201,300	£108,500
2014/15	£302,600	£198,800	£103,800	£318,200	£209,100	£109,100
2015/16	£315,600	£210,800	£104,900	£329,300	£219,900	£109,400
2016/17	£338,300	£228,700	£109,600	£345,200	£233,300	£111,900
2017/18	£357,300	£243,900	£113,400	£357,300	£243,900	£113,400

Source: GP Earnings and Expenses Estimate Time Series 2017/18 (published August 2019), Tables 1a and 1b. The conversion has been carried out using Gross Domestic Product (GDP) deflators as at June 2018 available from HM Treasury.

9.20 The corresponding data for salaried GPs in England is shown in Figure 9.3 below. The real average pre-tax income of salaried GPs in 2017/18 was £58,400,

9.21 compared to £56,600 in 2016/17, an increase of 3.2 per cent in cash terms. When compared with the latest income distribution figures (2016/17), this puts salaried GPs in the top 91st – 92nd percentile group (£56,300 - £59,500). As before, these figures are based on headcount data so will not take account of part time working. Note that in June 2019, the participation rate for salaried GPs in England was 64.9%.

Figure 9.3 – GMS and PMS salaried GPs England –Earnings and Expenses – all practice types

Year	Gross Employment Earnings	Gross Self Employment Earnings	Total Gross Earnings	Total Expenses	Total Income Before Tax	Total Gross earnings (Real terms - 2017/18 prices)	Total Expenses in real terms (2017/18 prices)	Total Income Before Tax in real terms (2017/18 prices)
2006/07	£47,354	£12,891	£60,245	£6,139	£54,106	£73,448	£7,485	£65,964
2007/08	£49,854	£12,337	£62,191	£6,260	£55,931	£73,987	£7,447	£66,540
2008/09	£50,300	£13,800	£64,200	£6,800	£57,400	£74,300	£7,900	£66,400
2009/10	£50,800	£14,700	£65,500	£7,100	£58,300	£74,800	£8,200	£66,600
2010/11	£50,000	£15,100	£65,100	£7,300	£57,900	£73,000	£8,100	£64,900
2011/12	£49,600	£14,800	£64,400	£7,300	£57,000	£71,200	£8,100	£63,100
2012/13	£49,200	£15,500	£64,700	£8,100	£56,600	£70,200	£8,800	£61,400
2013/14	£48,200	£15,800	£64,100	£9,200	£54,900	£68,200	£9,800	£58,500
2014/15	£47,800	£14,700	£62,500	£8,700	£53,700	£65,700	£9,200	£56,500
2014/15	£50,800 r	£14,700	£65,500 r	£8,700	£56,700 r	£68,900	£9,200	£59,700
2015/16	£51,500	£12,300	£63,900	£7,900	£55,900	£66,600	£8,300	£58,400
2016/17	£51,700	£13,700	£65,300	£8,700	£56,600	£66,600	£8,900	£57,700
2017/18	£52,400	£15,800	£68,200	£9,800	£58,400	£68,200	£9,800	£58,400

Source: GP Earnings and Expenses Estimate Time Series 2017/18 (published August 2019), Table 11b. 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.

9.22 The data for 2017/18 for contractor (figure 9.4) and salaried GPs (figure 9.5) by contract type are shown in the figures below.

Figure 9.4 - GP Contractors' earnings and expenses by Contract Type, England, 2017/18 – all practice types

Contract type	Gross Earnings	Total Expenses	Income Before Tax
GMS	£348,600	£236,200	£112,400
PMS	£380,900	£264,700	£116,200

Source: GP Earnings and Expenses Estimate Time Series 2017/18 (published August 2019), Tables 1c and 1d.

Figure 9.5 - Salaried GPs earnings and expenses by Contract Type, England, 2017/18 – all practice types

Contract type	Gross Earnings	Total Expenses	Income Before Tax
GMS	£67,200	£9,700	£57,500
PMS	£69,900	£10,000	£59,900

Source: GP Earnings and Expenses Estimate Time Series 2017/18 (published August 2019), Table 11b.

9.23 Mean earnings, expenses and income by age group, gender and (grouped) working hours for GPMS contractors in the UK are set out in Figure 9.6. However, there are known data quality issues which are listed below. These factors may differentially impact male and female workers:

- Contractor GPs' earnings may be affected by the terms of any partnership agreements in effect for their practices.
- It is not possible to calculate the split between private and NHS work and therefore the data presented below is a combination of both.

- GPs may work longer than their contracted hours or may work outside their practice in an alternative setting such as a hospital or extended access hub (their income would be included in this data but not their hours).

- Salaried / partner GPs may undertake locum work outside of their contracted working hours, the pay for these hours would be captured but not the hours worked.

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

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

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

9.25 The mean Gender Pay Gap in overall annual pay (headcount) among GPs in England is 33.5%, while the median Gender Pay Gap is 37.2%. Further information on the gender analysis of GPs with a specific focus on the gender pay gap can be found in chapter 3.

Figure 9.6 – GMS and PMS GP average earnings and expenses by weekly working hours (contracted), age and gender, England, 2017/18

Contractor GPs

Weekly hours	Gender	Age	Sample Count	Gross Earnings	Total Expenses	Income Before Tax
0 to <22.5	Male	Under 40	100	£276,800	£185,400	£91,500
0 to <22.5	Male	40 to 49	200	£328,600	£231,400	£97,100
0 to <22.5	Male	50 to 59	300	£278,000	£189,800	£88,200
0 to <22.5	Male	over 60	350	£225,500	£151,100	£74,400
0 to <22.5	Female	Under 40	250	£221,100	£149,900	£71,300
0 to <22.5	Female	40 to 49	750	£242,200	£169,900	£72,300

0 to <22.5	Female	50 to 59	750	£237,200	£163,300	£73,900
0 to <22.5	Female	over 60	150	£266,300	£177,800	£88,400
22.5 to <37.5	Male	Under 40	900	£343,600	£231,000	£112,600
22.5 to <37.5	Male	40 to 49	1,500	£395,400	£274,600	£120,800
22.5 to <37.5	Male	50 to 59	1,750	£386,900	£265,300	£121,600
22.5 to <37.5	Male	over 60	550	£348,300	£233,500	£114,800
22.5 to <37.5	Female	Under 40	1,000	£284,300	£195,800	£88,500
22.5 to <37.5	Female	40 to 49	2,050	£326,100	£226,500	£99,500
22.5 to <37.5	Female	50 to 59	1,550	£326,200	£226,100	£100,100
22.5 to <37.5	Female	over 60	200	£293,700	£198,100	£95,600
37.5 and over	Male	Under 40	950	£377,800	£250,100	£127,700
37.5 and over	Male	40 to 49	1,950	£424,800	£288,200	£136,600
37.5 and over	Male	50 to 59	2,350	£440,400	£298,200	£142,200
37.5 and over	Male	over 60	750	£392,000	£257,400	£134,600
37.5 and over	Female	Under 40	450	£323,700	£217,900	£105,800
37.5 and over	Female	40 to 49	700	£384,300	£265,500	£118,800
37.5 and over	Female	50 to 59	700	£411,200	£283,900	£127,300
37.5 and over	Female	over 60	200	£377,800	£251,800	£126,000

Salaried GP, England

Weekly hours	Gender	Age	Sample Count	Average Total Gross Earnings	Average Total Expenses	Average Total Income Before Tax
0 to <22.5	Male	Under 40	250	£81,800	£11,300	£70,500
0 to <22.5	Male	40 to 49	200	£84,500	£14,800	£69,800
0 to <22.5	Male	50 to 59	200	£97,100	£12,900	£84,200
0 to <22.5	Male	over 60	100	£58,200	£7,500	£50,700

0 to <22.5	Female	Under 40	1,450	£52,200	£6,300	£45,900
0 to <22.5	Female	40 to 49	1,250	£55,300	£7,100	£48,200
0 to <22.5	Female	50 to 59	600	£58,000	£6,200	£51,800
0 to <22.5	Female	over 60	100	£45,600	£6,900	£38,700
22.5 to <37.5	Male	Under 40	650	£84,300	£12,400	£71,900
22.5 to <37.5	Male	40 to 49	300	£91,100	£15,700	£75,300
22.5 to <37.5	Male	50 to 59	150	£91,700	£13,800	£77,900
22.5 to <37.5	Male	over 60	50	£71,600	£6,400	£65,300
22.5 to <37.5	Female	Under 40	1,950	£61,900	£8,000	£53,900
22.5 to <37.5	Female	40 to 49	800	£69,400	£10,900	£58,500
22.5 to <37.5	Female	50 to 59	350	£68,500	£7,300	£61,100
22.5 to <37.5	Female	over 60	50	£59,000	£6,200	£52,800
37.5 and over	Male	Under 40	250	£118,400	£34,000	£84,500
37.5 and over	Male	40 to 49	150	£98,800	£13,200	£85,600
37.5 and over	Male	50 to 59	100	£111,900	£18,900	£93,000
37.5 and over	Male	over 60	50	£94,000	£27,300	£66,700
37.5 and over	Female	Under 40	350	£73,500	£10,300	£63,200
37.5 and over	Female	40 to 49	100	£90,300	£13,700	£76,600
37.5 and over	Female	50 to 59	50	£92,500	£15,500	£76,900

37.5 and over	Female	over 60	c	c	c	C

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

Source: GP Earnings and Expenses Estimates 2017/18–Experimental statistics

GP Trainers' grants

9.26 The GP trainer grant, which was previously published in an annex of the Directions to Health Education England, is now published as part of the document containing GP Educator pay scales and from 1 April 2019 is £8,350.

9.27 The Department is working with stakeholders to introduce a fair and equitable approach to the funding of clinical placements in GP practices, irrespective of geography and historical arrangements. Further information on any changes for the 2020/21 financial year will be communicated as part of the annual Education and Training tariff guidance document, due to be released in early 2020.

General Medical Practitioner (GMP) Appraisers' rates

9.28 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.

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

GP Workforce numbers

9.30 Data on the general practice workforce are published quarterly by NHS Digital. The latest figures, for September 2019, showed a total of 45,625 headcount GPs working in England (34,862 FTEs). See figure 9.7 for a summary of from the "General Practice Workforce" publication on doctors working in general practice by headcount and full-time equivalent. Statistical advice is to compare the workforce data only on a year-on-year basis (September-September) due to seasonality concerns, rather than across quarters, so the main numbers below are presented on this basis.

9.31 All practitioner figures are presented in 9.7 in a time series, however these headcount figures are not comparable across the time series due to changes in locum recording from March 2017.

Figure 9.7 – Doctors in general practice by headcount* and FTE

Headcount	Sept 2015	Sept 2016	Sept 2017	Sept 2018	Sept 2019
All GPs*	41,230	41,865	42,375	44,378	45,625
GP Contractors	24,521	23,605	22,791	21,857	21,161
Salaried GPs	10,283	11,029	11,465	12,236	13,076
GP registrars	5,141	5,805	5,646	5,986	6,686
GP retainers	173	175	213	314	483
GP locums*	1,433	1,677	3,025	5,082	5,272

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

Full-Time Equivalents	Sept 2015	Sept 2016	Sept 2017	Sept 2018	Sept 2019
All GPs	34,429	35,229	34,653	34,534	34,862
GP Contractors	21,688	21,143	20,205	19,262	18,303
Salaried GPs	6,867	7,375	7,635	8,065	8,469
GP registrars	5,026	5,731	5,509	5,880	6,547
GP retainers	76	74	88	121	186
GP locums	772	906	1,216	1,208	1,357

Source: NHS Digital General Practice Workforce 30 September 2019 [GP Tables – September 2019], Tables 1a and 1b. Figures include estimates for the practices that did not provide fully valid data. Headcount figures for Locums is not comparable across the time series due to changes in locum recording from March 2017.

9.32 Overall, the General Practice Workforce data show the number of "All GPs" increased by 1.3% from 34,429 to 34,862 between September 2015 and 2019. The number of GP contractors in England has been on a decreasing trend. Between September 2015 and September 2019, the GP contractor FTE decreased by 15.6% from 21,688 to 18,303. Conversely, the salaried GP FTE increased over the same period by 23.3%, from 6,867 to 8,469 FTEs. GP registrar FTE also increased over the same period by 30.3%, from 5,026 to 6,547;

signalling that policies to recruit additional GPs are beginning to have an impact. Note, that comparisons with workforce numbers prior to September 2015 are not possible.

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

9.34 When comparing the September 2019 and September 2018 figures (excluding locums), the GP headcount numbers have increased (by 1,013), however the FTE count has only increased (by 178 FTE), this may in part be due to changes in the workforce demographics. The demographic makeup of the workforce is shown in Figure 9.8 by job role and gender and in Figure 9.9 by age and gender. Note that age and gender disaggregation of GP headcounts are only published bi-annually. There are more female GPs by headcount (25,263) than male GPs (19,675) (including registrars, locums and retainers) (unknown 725) in September 2019; 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 9.8 and 9.9) between male and female workers is likely to impact workforce FTE rates. There are also differences in the proportion of male and female workers in individual job roles.

Figure 9.8 – GP workforce demographics, England (General Practitioner headcount FTE by job role and gender, March September 2019)

FTE	All	%	Male	%	Female	%	Unknown	%
GP Contractors	18,303	52.5%	10,888	64.9%	7,224	40.8%	191	54.3%
Salaried/Other GPs	8,469	24.3%	2,546	15.2%	5,825	32.9%	98	27.7%
GP Registrars	6,547	18.8%	2,604	15.5%	3,931	22.2%	12	3.3%
GP Retainers	186	0.5%	29	0.2%	154	0.9%	2	0.6%
GP Locums	1,357	3.9%	719	4.3%	589	3.3%	49	13.9%
Total	34,862	100%	16,787	100%	17.723	100%	352	100%

Source: NHS Digital General Practice Workforce 30 June September 2019 [GP Tables – June September 2019], Table 1ba. Figures include estimates for the practices that did not provide fully valid data. Headcount totals may vary slightly from the sum of the component values in the tables published by NHS Digital, for example if staff who work in more than one role or more than one practice have been counted twice. For further information on

the methodology used by NHS Digital, please refer to the publication General Practice Workforce 30 June September 2019.

9.35 The demographic makeup of the workforce is shown in Figure 9.9 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 9.9 - General Practitioners FTE (excluding Registrars & Locums) by age and gender, September 2019

FTE	All	%	Male	%	Female	%
Under 30	206	0.8%	75	0.6%	130	1.0%
30-34	2,914	10.8%	1,009	7.5%	1,902	14.4%
35-39	4,227	15.7%	1,654	12.3%	2,570	19.5%
40-44	4,591	17.0%	2,229	16.6%	2,359	17.9%
45-49	4,305	16.0%	2,081	15.5%	2,223	16.8%
50-54	4,085	15.2%	2,205	16.4%	1,878	14.2%
55-59	3,747	13.9%	2,294	17.0%	1,452	11.0%
60-64	1,471	5.5%	1,051	7.8%	420	3.2%
65 and over	1,050	3.9%	822	6.1%	228	1.7%
Unknown	361	1.3%	42	0.3%	40	0.3%
Total	26,958	100%	13,463	100%	13,204	100%

Source: NHS Digital General Practice Workforce 30 September 2019 [Bulletin Tables], Table 5b. 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 2019.

Part-time working and participation rates

9.36 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 9.10 and by job role and gender in September 2019 are shown in Figure 9.11. Participation rates are lower for female GPs in every age band and job role (except GP retainers). The

average participation rate for younger male GPs (under 35) is lower than other (male) age categories.

Figure 9.10 – All GPs participation rate by age and gender. Participation rate = ratio of FTEs to headcount (September 2019 participation rate by age excluding locums and registrars)

Age Band*	Male	Female	All (including unknown gender)
Under 30	78.8%	71.6%	74.3%
30-34	78.8%	69.3%	72.3%
35-39	85.6%	66.9%	73.2%
40-44	91.6%	66.4%	76.6%
45-49	91.9%	69.8%	79.0%
50-54	93.1%	72.1%	82.2%
55-59	92.0%	72.4%	83.2%
60-64	84.0%	71.1%	79.9%
65 and over	83.4%	74.6%	81.3%
Unknown	79.4%	66.5%	74.8%
All practitioners	88.9%	69.3%	77.9%

Source: Calculated from NHS Digital General Practice Workforce 30 September 2019, [Bulletin Tables], Tables 5a and 5b. Figures include estimates for the practices that did not provide fully valid data.

Figure 9.11 – All GPs participation rate by gender and job role. Participation rate = ratio of FTEs to headcount (September 2019 participation rate by age excluding locums and registrars)

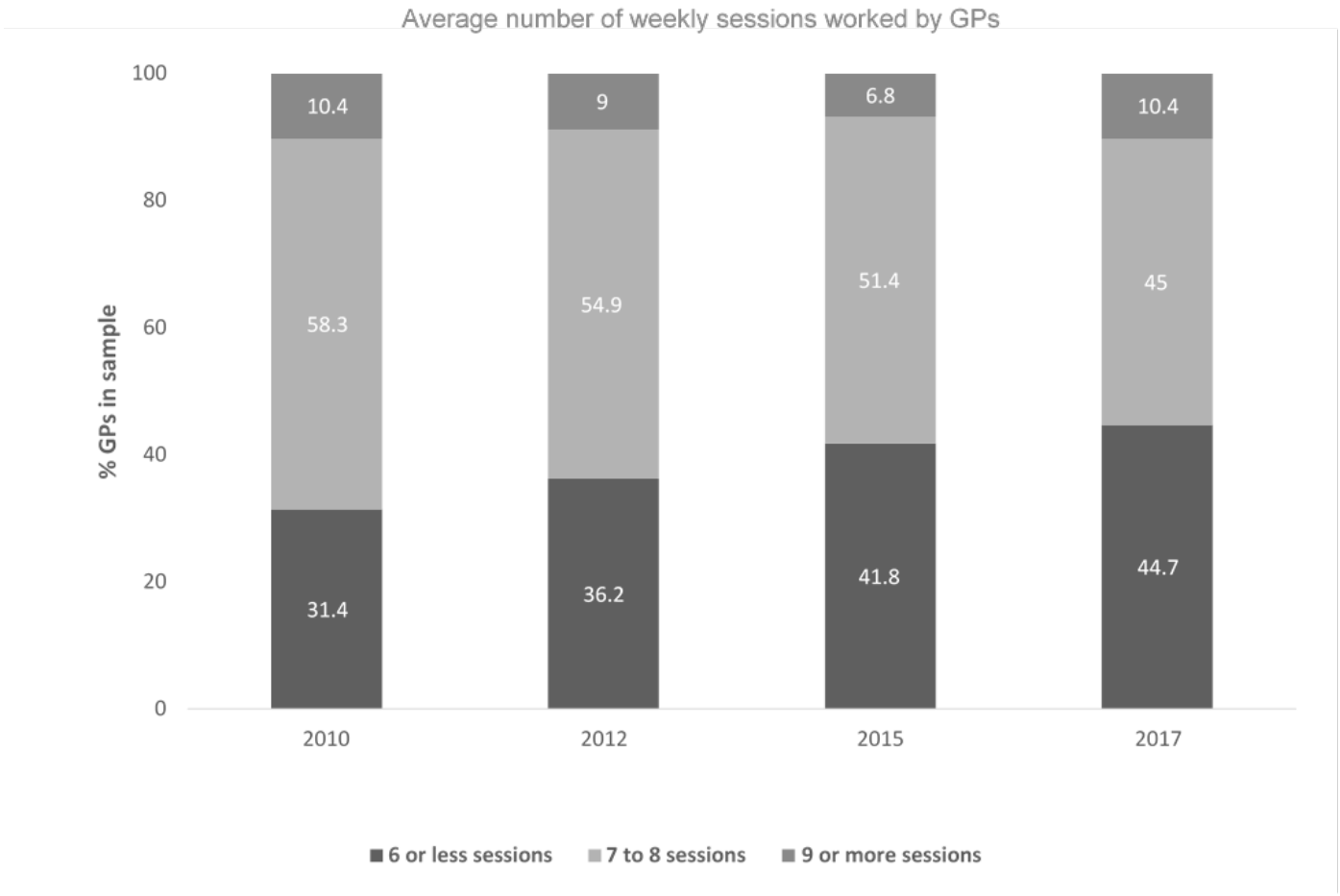
Type	Male	Female	All (including unknown gender)
GP Partners	93.9%	77.3%	86.5%
Salaried GPs/Other GPs	72.1%	62.0%	64.8%
GP Registrars	104.1%	94.2%	97.9%
GP Retainers	37.6%	38.6%	38.5%

GP Locums	29.6%	23.3%	25.7%
All practitioners	85.3%	70.2%	76.4%

Source: Calculated from NHS Digital General Practice Workforce 30 September 2019 [GP Tables – September 2019], 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/partner GP contract which is 37.5 hours.

9.37 The number of sessions GPs report conducting every week (according to the GP worklife survey) is shown in figure 9.12. The percentage of GPs doing 6 or fewer sessions per week increased between 2015 and 2017 and the percentage doing 9 or more sessions increased between 2015 and 2017.

Figure 9.12 - The average number of weekly sessions worked by a GP. The proportion of GPs working fewer than 6 sessions a week has continuously increased over time (GP Worklife Survey)



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

GP Locums

9.38 The quality of GP locum data has been improved. This latest publication provides FTE data that are consistent and comparable over the period September 2015 to September 2019. Previously, the data series had two breaks, in December 2016 and in September 2017, due to inconsistent recording of locum numbers. NHS Digital undertook a methodology review and consultation over the autumn and implemented a revised methodology for the locum data, which has removed the breaks in the time series.

9.39 Please note, headcount figures are not comparable across the time series due to changes in locum recording from March 2017.

Staff movement

9.40 GP workforce vacancy rates are published by job role (figure 9.13); however, the data quality is low for this dataset (less than 1,500 practices submitted data each year), no estimates are made for the practices that did not submit data as practices may not have recorded data if they did not have any vacancies in the given period.

Figure 9.13 Recorded GP vacancies by job role, headcount

Job Role	2015/2016	2016/2017	2017/2018	2018/2019
GP Contractors	125	168	123	125
Salaried/Other GPs	532	499	441	480
GP Registrars	1	-	9	9
GP Retainers	-	1	6	6
GP Locums	17	37	38	32
Number of Practices that submitted data	1,233	1,218	1,247	1,398
Total	675	705	617	652

Source: Calculated from NHS Digital General Practice Workforce 30 September 2019 [Supplementary Information Tables], Table 10. Figures do not include estimates for the practices that did not provide fully valid data.

9.41 Data on GP Joiners and Leavers has been improved through exclusion of staff movement between practices. However, there are still data quality issues, as this data only being based on around 60-70% of GP practices and GPs transferring between practices are excluded if identified by their GMC number, however, if a valid GMC number is not provided at both practices they would be incorrectly recorded as either a joiner or a leaver. For the period 30th September 2018 to 30th September 2019, the headcounts for joiners and leavers (excluding locums and registrars) were 3,902 and 3,437 respectively, implying a net increase of 465. The actual change in the headcount workforce between those two dates was an increase of 373 GPs (excluding registrars and locums).

Staff Motivation

9.42 Staff movement by reason for leaving is also recorded and published (figure 9.14) and this data does include GPs that have transferred between practices. In 2018/19 the most common known reasons for leaving a practice were: voluntary

resignation (other/ not known, relocation and work/life balance), retirement (age) and end of fixed term contract (other and end of work requirement).

Figure 9.14: GP movement (including movement between practices) by reason for leaving (headcount)

Reasons for Leaving	2015-16	2016-17	2017-18	2018-19
Bank staff not fulfilled minimum work requirement	13	3	4	1
Death in Service	9	2	4	1
Dismissal - Capability	2	2	-0	2
Dismissal - Conduct	4	2	4	3
Dismissal - Some Other Substantial Reason	2	0	1	1
Dismissal - Statutory Reason	3	1	0	0
End of Fixed Term Contract - Completion of Training Scheme	609	477	394	12
End of Fixed Term Contract - End of Work Requirement	79	152	179	118
End of Fixed Term Contract - External Rotation	229	178	193	3
End of Fixed Term Contract - Other	460	499	439	119
Initial Pension Ended	-	-	-	-
Mutually Agreed Resignation	55	45	43	44
Pregnancy	38	23	30	12
Redundancy - Compulsory	3	2	5	3
Redundancy - Voluntary	13	16	11	12
Retirement - Age	426	325	243	291
Retirement - Ill Health	56	23	17	25
Voluntary Early Retirement - No Actuarial Reduction	44	39	28	33
Voluntary Early Retirement - With Actuarial Reduction	24	19	22	19
Voluntary Resignation - Adult Dependants	6	8	1	6
Voluntary Resignation - Better Rewards Package	65	61	43	33

Voluntary Resignation - Child Dependants	22	41	18	34
Voluntary Resignation - Health	16	32	20	26
Voluntary Resignation - Incompatible Working Relationships	15	16	10	18
Voluntary Resignation - Lack of Opportunities	5	4	4	4
Voluntary Resignation - Other/Not Known	502	373	319	469
Voluntary Resignation - Promotion	162	160	113	42
Voluntary Resignation - Relocation	545	416	327	371
Voluntary Resignation - To undertake further education or training	34	31	31	15
Voluntary Resignation - Work/Life Balance	264	251	213	233
Unknown	1,900	1,958	1,646	541
Total	5,605	5,159	4,362	2,491

Source: NHS Digital General Practice Workforce 30 September 2019 [Supplementary Information Tables], Table 5a. The figures only include data on staff movement from practices which submitted staff movement data (2015/16 – 82%, 2016/17 – 84%, 2017/18 – 73%, 2018/19 – 70%). Figures from 2018-19 onwards are not directly comparable with earlier figures (see publication for further information).

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

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

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

GP recruitment and retention

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

9.45 In the Long Term Plan there is also a commitment to implement a new two-year Primary Care Fellowship Programme that offers newly qualified GPs and nurses entering primary care a secure contract of employment alongside a portfolio role tailored, where possible, to the aims of the individual and the needs of the local primary care system.

9.46 We have committed to growing the workforce by 6,000 more doctors in general practice and, by 2024/25, 6,000 more primary care professionals, such as physiotherapists and pharmacists to deliver 50 million extra general practice appointments a year. This is on top of the additional 20,000 primary care professionals NHS England are providing funding towards recruiting.

Recruitment

9.47 In total in 2018, there were 3,473 acceptances to specialty GP training posts. This was surpassed in 2019 as over 3,500 have accepted a place. This is the highest number of GP trainees Health Education England (HEE) has ever recorded. GP trainees are included in the workforce data (GP registrars) when working in a general practice and they usually spend 50% of their training working in a general practice. HEE and NHS England have a number of schemes in place to attract more doctors to GP speciality training including the “Choose GP” advertising campaign, the Targeted Enhanced Recruitment scheme (TERs) and the Targeted GP Training Scheme. Further detail will be provided in NHS England’s written evidence.

Figure 9.15 – Places available, places filled and fill rate of GP speciality training.

GP speciality training	2014	2015	2016	2017	2018	2019
Places available	3,067	3,117	3,250	3,250	3,250	3,250
Acceptances	2,671	2,769	3,019	3,157	3,473	3,540
Fill rate	87%	89%	93%	97%	107%	108%

Source: HEE's recruitment statistics

International Recruitment

9.48 The International GP Recruitment (IGPR) Programme was announced in August 2017 and recruitment began from April 2018. Prior to this, four pilot schemes were established between May 2016 and November 2017. The IGPR programme has now recruited doctors from overseas through the extended national programme and the pilots. These are part of the pipeline of doctors who are currently working through the Induction and Refresher scheme aimed at supporting both international GPs joining general practice in England and domestically trained doctors wishing to return to practice.

Retention and Return to practice

9.49 To improve retention, NHS England has launched a number of schemes which are included below. Details of these schemes will be provided in NHS England's evidence.

- GP Retention Fund - The Local GP Retention Fund supports GPs to stay in the workforce, by promoting new ways of working and offering additional support. It supported local systems to develop innovative local retention initiatives for GPs who are newly qualified or within their first five years of practice, who are seriously considering leaving general practice or are considering changing their role or working hours, and those who are no longer working for the NHS in England but remain on the National Performers List (Medical).

- GP Retention Scheme - The National GP Retention Scheme is a package of financial and educational support to help doctors, who are only able to work 4 or less sessions per week and who might otherwise leave the profession, remain in clinical general practice.

- GP Health Service - A free, confidential, self-referral service provided by health professionals specialising in mental health support to doctors. It is available to any GP or GP trainee who is registered on the National Performers List in England or looking to return to clinical practice after a period of absence.

- National Induction and Refresher Scheme - The GP induction and Refresher Scheme is designed to provide a safe, supported and direct route for qualified GPs to return to or join NHS general practice in England.

9.50 In addition, NHS England has developed Making general practice a better place to work - a practical toolkit that provides a step-by-step process for those involved in developing the primary care workforce to develop and implement a robust GP retention action plan.

Workload

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

9.52 Increasing the skills mix in general practice will also address workload pressures, as well as deliver appropriate patient care. This will mean larger teams of staff, providing a wider range of care options for patients which will free up more time for GPs to focus on those with more complex needs. The new contract for general practice will see funding towards up to 20,000 extra staff working in Primary Care Networks by 2023/24 to provide a wider range of care options for patients. As of June 2019, there were 818 additional full-time equivalent clinical staff working in general practice, excluding GPs, compared to June 2018. This consisted of 39 more nurses and 779 more other direct patient care staff. However, to provide a longer time series we have compared March 2016 to March 2019 in Figure 9.16.

Figure 9.16 All staff working in general practice (Headcount and FTE)

Headcount	Sept 2015	Sept 2016	Sept 2017	Sept 2018	Sept 2019
All Staff	173,070	177,396	176,616	180,801	185,619
All Staff excluding GPs	131,840	135,531	134,241	136,423	139,994

GPs	41,230	41,865	42,375	44,378	45,625
Nurses	22,758	23,126	23,136	23,406	23,834
Other Direct Patient Care	17,150	17,931	18,210	18,788	19,973
Admin / non-clinical	91,932	94,474	92,895	94,229	96,187

Source: NHS Digital General Practice Workforce 30 September 2019 [GP Tables – September 2019], Summary. Figures include estimates for the practices that did not provide fully valid data. GP headcount figures are not comparable across the time series due to changes in locum recording from March 2017.

FTE	September 2015	September 2016	September 2017	September 2018	September 2019
All Staff	123,621	127,999	127,135	129,494	132,952
All Staff excluding GPs	89,193	92,770	92,482	94,960	98,090
GPs	34,429	35,229	34,653	34,534	34,862
Nurses	15,241	15,793	16,030	16,276	16,573
Other Direct Patient Care	10,883	11,636	11,901	12,555	13,565
Admin / non-clinical	63,069	65,341	64,551	66,129	67,952

Source: NHS Digital General Practice Workforce 30 September 2019 [GP Tables – September 2019], Summary. Figures include estimates for the practices that did not provide fully valid data.

Older GPs leaving the profession

9.53 The proportion of GPs taking their pension for the first time on a Voluntary Early Retirement (VER) basis increased in the 9 years prior to 2016/17 according to analysis of NHS pensions scheme membership; see chapter 12 (and figure 9.17) for further detail. The proportion taking VER dropped slightly in 2018/19, but it still remained high at 57.1% (604 VERs of 1,058) of those taking their pension for the first time (all reasons). However, this is not a measure of retirement, but a measure of GPs taking their pension and anecdotally, we know some GPs will take their pension and return to the workforce (retire and return). We do not have robust data on the number of GPs that retire and return, and if they do return to the workforce, in what capacity this is, including job role. Reaching the pensions

lifetime allowance may be a factor in GPs retiring early and in recent years the lifetime allowance has been lowered.

9.54 NHS Digital report on staff movement by ‘reasons for leaving’ (figure 9.14 and figure 9.18) in the General Practice Workforce publications when a valid ‘Termination Date’ is inputted. The overall reported number of retirements is lower than is reported from the pension scheme membership analysis. This is perhaps owing to some practices not submitting data (70% submitted data in 2018/19) and because a high proportion of ‘reasons for leaving’ are recorded as unknown (see figure 9.14). According to the publication ‘reasons for leaving’ data, the proportion of GPs taking VER compared to all retirements figure in 2018/19 was 14.1%.

9.55 NHS England have a number of schemes in place aimed at enhancing retention, which may benefit the older age group.

9.56 Further detail on GP pensions have been outlined in chapter 12 on Pensions and Total Reward, including data on GP voluntary early retirements, numbers of opt-outs and those leaving the service.

Figure 9.17 The number of GPs taking their pension (NHS Business Authority analysis of 1995 pensions scheme membership)

Pension year (1 April to 31 March)	*Total number of GPs claiming the VER pensions	**Number of GPs in total claiming NHS pensions	% taking VER
2007/08	198	1,154	17.2
2008/09	265	1,307	20.3
2009/10	322	1,427	22.6
2010/11	443	1,555	28.5
2011/12	513	1,545	33.2
2012/13	591	1,409	41.9
2013/14	746	1,502	49.7
2014/15	739	1,436	51.5
2015/16	695	1,324	52.5
2016/17	721	1,171	61.6
2017/18	588	1,019	57.7
2018/19	604	1,058	57.1

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

Figure 9.18 The number of GPs reported as retiring in staff movement data (General Practice Workforce Publication)

Year (1st April – 31st march)	Number of GPs 'reasons for leaving' recorded as VER	Number of GP reason for leaving recorded as retirement	% taking VER
2015/16	68	550	12.4
2016/17	58	406	14.3
2017/18	50	310	16.1
2018/19	52	368	14.1

Source: NHS Digital General Practice Workforce 30 September 2019, [Supplementary Information Tables], Table 5a. Figures do not include estimates for the practices that did not provide fully valid data (2015/16 – 82%, 2016/17 – 84%, 2017/18 – 73% and 2018.19 – 70% of practices submitted staff movement data).

NHS Long Term Plan - primary care workforce

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

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

9.59 As part of measures to grow the medical workforce, the NHS Long Term Plan set out plans for a two-year fellowship programme for newly qualified doctors and nurses entering general practice. Further details can be found in NHS England's evidence.

Interim NHS People Plan

9.60 In June 2019, NHS England published the Interim NHS People Plan. This set out their vision for how people working in the NHS will be supported to deliver care and identifies the actions will be taken to help them. The plan reiterated commitments around GP recruitment and retention programmes and improving the workload of GPs. Further details will be provided in NHS England's evidence and in the final report of the People Plan.

GP Partnership Review

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

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

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

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

9.64 Many of the recommendations have been addressed in NHS England's Long Term Plan and the five-year framework for GP contract reform to implement The NHS Long Term Plan.

Access to General Practice

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

9.66 In April 2016, the GP Forward View, building on the learning from the GP Access Fund, committed to deliver extended access to primary care across the country. Additional funding has been provided to enable clinical commissioning groups (CCGs) to ensure that by 2020 everyone in England has access to GP services including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services.

9.67 Evening and weekend appointments are routinely available across the country now to ensure patients can find appointments at a time convenient to them, with millions of patients having already benefitted from this. This means that patients can see a doctor, nurse or other member of a general practice team at a time that is convenient to them, offering greater choice for patients. It also provides additional capacity to help to reduce some of the pressure on general practice and the wider system. Alongside these measures, the government is committed to reducing waiting times for general practice appointments. NHS England, working with stakeholders, is undertaking a national review of access to general practice services. The review's main objective is to improve patient access both in hours and at evenings and weekends and reduce unwarranted variation in experience.

GP appointments

9.68 Data on "appointments in general practice" was published for the first time in December 2018 by NHS Digital. The most recent publication covers the number of appointments delivered by GP practices in England in the twelve months from December 2018 to November 2019, inclusive. NHS Digital estimated that this was equivalent to a total of 310.5 million appointments across all GP practices in England in this twelve-month period. Note that these statistics are badged as

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

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

Integrated Care Providers (ICPs) and the ICP Contract

9.69 Integrated Care Providers (ICPs) will be one option for local areas wishing to integrate care. Doing so will help deliver more care in the community and patients' homes, reducing reliance on acute providers. NHS England has developed the ICP Contract to enable local areas to commission local health and care services, including primary medical services, through a single contract. The intention is to establish the right organisational and financial incentives for providers to collaborate in order to deliver preventative, proactive and coordinated care to their local population.

9.70 The ICP contract allows commissioners to create a single contract that includes primary care, community services, mental health services, acute hospital services and, in some cases, adult social care services. This will be a longer term contract (up to 10 years) and will create a single 'whole population' budget covering all the services in the contract.

9.71 NHS held a consultation on the contract in 2018 and published its response in March 2019. This confirmed that the ICP contract would be made available for use by commissioners in a controlled and incremental way.

9.72 NHSE and DHSC plan to make the final contract available in 2019 once regulations have been amended to ensure that existing rules apply to the ICP contract in the same way as they apply to the standard NHS contracts.

GP participation in Integrated Care Providers

9.73 As part of the changes for ICPs, two changes to regulations will allow GPs to suspend their contracts to join an ICP contract if they wish.

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

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

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

10. General Dental Practitioners

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

Workforce Numbers and Recruitment and Retention

10.2 In England, NHS England is responsible for commissioning NHS primary care dental services from providers to meet local dental needs. Providers are individuals or corporate bodies who hold a contract with the NHS.

10.3 NHS dentists can be either associate dentists (working for practice owners or corporate bodies) or provider-performers (practice owners who perform NHS dentistry). Dentists can also offer private care alongside NHS services.

10.4 Over the last few years there has been a greater change in the workforce, with a continued shift away from Providing- Performer to associate dentists[ii]

10.5 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 (NHS BSA) who process dental payments and forms. For 2018/19 data showing the split between providers and associate dentists is not available due to technical issues with the data. The NHS BSA have confirmed that the data will be available next year. Figures are shown in Figure 10.1.

Figure 10.1: Number and percentage of dentists with NHS activity by dentist type, 2007/08 to 2018/19iii

Type	2007/08	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	20,815	21,343	22,003	22,799	22,920	23,201	23,723	23,947	24,089	24,007	24,308	24,545
Providing-Performer	7,286	6,778	6,279	5,858	5,099	4,649	4,413	4,038	3,449	2,925	2,555	Data unavailable
Associate Dentist (previously performer only)	13,529	14,565	15,724	16,941	17,821	18,552	19,310	19,909	20,640	21,082	21,753	Data unavailable

10.6 From 2017/18 to 2018/19 the total number of dentists actively delivering NHS services increased from 24,308 to 24,545. This includes full-time and part-time practitioners, with variation in terms of working patterns and hours. As explained in paragraph 10.5 data showing the split between providing-performer and associate dentists is not available.

10.7 The percentage of dentists (undertaking NHS activity submitted by FP17[iv]) who are female has increased from 40.1% in 2007/08 to 50.4% in 2018/19).

10.8 In terms of age groups, the age band that has shown the greatest decline – in proportion – from 2008/09 to 2018/19 is 45-54 (23.5% to 20.2%), while the age group that has increased most is 35-44(26.9% to 28.7% over the same period)

Earnings and Expenses

10.9 The average taxable income for all dentists in 2017/18 was £68,100, down from £68,700 in 2016/17. This reflects a fall in the average gross income to £144,800 in 20117/18 from £145,700. The level of expenses to gross income ("the expenses ratio") has increased very slightly to 53.0%. However, the expenses ratio remains towards the lower end of the range seen during the last ten years. Table 10.2 has details for the last fourteen years.

Figure 10.2: Gross income, expenses and taxable income for all dentists from 2004/05 to 2017/18

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	£152,500	£82,000	£70,500	53.8%
2015/16	£148,000	£78,900	£69,200	53.3%
2016/17	£145,700	£77,000	£68,700	52.9%
2017/18	£144,800	£76,800	£68,100	53.0%

10.10 In England, the earnings of a dentist are dependent on whether they are a Providing-Performer dentist or an associate dentist. Generally, Provider-Performers tend to earn more However, the changing ratio of Providing-Performers to associate dentists has moved the average figure closer to the associate dentists. In 2017/18 Providing-Performer dentists had an average taxable income £116,700 a rise from £115,800 in 2016/17. In contrast, an

associate dentist saw their average taxable income decrease to £59,700 in 2017/18 compared to 2016/17 when it was £60,800

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

Motivation and Morale

10.12 The Dental Working Hours: Motivation and Morale 2016/17 & 2017/18 report was last published by NHS Digital in August 2018. The difference in average motivation between 2015/16 and 2017/18 for Provider-Performers is -3.0%, for associate dentists the difference is -6.0%. This is shown in the table below:

Figure 10.3: Average motivation results; Average morale results 2012/13-2017/18

Year	Average motivation (%) Provider-Performer	Average motivation (%) Performer only	Average Morale (%) Provider-Performer	Average Morale (%) Performer only
2012/13	48.3	48.2	27.3	42.1
2013/14	45.7	48.8	27.2	42.7
2014/15	47.5	44.3	22.8	32.9
2015/16	45.1	45.3	22.2	33.4
2016/17	44.6	39.7	21.3	24.6
2017/18	42.1	39.3	20.1	24.9

Average of ‘strongly agree’ or ‘agree’ responses to the motivation questions
Percentage of dentists who recorded their morale as ‘very high’ or ‘high’

10.13 In 2017/18, associate dentists responded less positively than Provider-Performer dentists with a 39.3% ‘strongly agree’ or ‘agree’ response compared to 42.1%.

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

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

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

Supply of Dentists and status of NHS Contracts

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

Targeting

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

Dental contract reform

10.19 The Government is committed to introducing a new prevention focussed NHS dental contract which increases access to NHS dental services, whilst preventing as well as treating dental disease.

10.20 We currently have 101 dental prototype practices, testing the new approach across the country.

10.21 Practices are testing a prevention based clinical pathway which includes offering patients advice on diet and good oral hygiene at an oral health assessment and follow-up appointments, where necessary, to reinforce preventative messages or to provide preventative treatments such as fluoride varnish.

10.22 The clinical approach has been tested for a number of years and is widely accepted by the profession as being the right approach. Evaluations of the clinical pathway, during testing of the prototype approach, have shown that a patient's oral health improves, and their risk of dental disease changes. With some patients moving from red to amber from amber to green over successive periods.

10.23 Practices are testing a new remuneration model, alongside the clinical pathway, which is a blend of capitation and activity. The introduction of capitation is to provide the financial drivers that align with the new clinical approach, to drive prevention as well as treatment.

10.24 The first formal evaluation report on the first year of data was published in 2018.

10.25 The findings from the second year of prototyping are being finalised ready for publication.

10.26 Ahead of decisions being taken regarding the possible wider roll out of this new approach, the DHSC is currently working, subject to consultation and legislative process, to extend the current prototype agreement scheme to allow prototype practices to continue post April 2020.

Community Dental Services

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

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

10.29 The 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.

10.30 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.

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

11. Ophthalmic Practitioners

11.1 The 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 nearly 99.9 per cent of NHS sight tests. Commissioning of the NHS sight testing service in England is the responsibility of NHS England. Discussions are to take place with representatives of the professions on fees for 2020/2021.

Background

11.2 Between 31 December 2017 and 31 December 2018, the number of OMPs who were authorised by the NHS in England to carry out NHS sight tests increased from 190 to 218. During this same period, the number of optometrists increased from 12,951 to 13,468, an increase of 4.0 per cent. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

11.3 In 2018/19, there were 13.2 million NHS sight tests. This was 1.5 per cent more than in 2017/18.

12. Pensions and Total Reward

Introduction

12.1 The NHS Pension Scheme remains a valuable part of the total reward package available to NHS doctors and dentists, and one of the best pension schemes available.

12.2 Eligible members of the NHS workforce will now belong to one of the two existing schemes. The final salary defined benefit scheme consisting of the 1995 and 2008 Sections is now closed to new membership, and new NHS staff will join the NHS Pension Scheme 2015. The 2015 Scheme is a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career. Self-employed doctors and dentists (practitioner members) also had their benefits in the 1995/2008 Sections calculated on a CARE equivalent basis. The key differences between the two schemes, other than the way benefits are calculated, are different normal pension ages (1995 Section – 60, 2008 Section 65, 2015 Scheme – State Pension Age) and accrual rates (1995 Section – 1/80th, 2008 Section – 1/60th, 2015 Scheme – 1/54th).

12.3 A recent judgement by the Court of Appeal in the cases of McCloud and Sargeant found that transitional arrangements gave rise to unlawful discrimination. 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. Transitional protections which allowed some members to remain in legacy schemes are to be unwound in light of the McCloud ruling.

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

12.5 A junior doctor commencing employment and membership of the 2015 Scheme from August 2019 (retiring at 68) can expect a pension of around £61,600 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 £52,600 p/a. Junior doctors progressing to be GPs can expect a pension of around £63,000 p/a.

Pension Scheme Contributions

12.6 The employer now contributes more than any member of the workforce toward the cost of the scheme. From the 2019/20 scheme year, the employer contribution rate has risen to 20.6% of pensionable pay. Employee contributions are tiered according to whole-time equivalent earnings, with the rate paid by the lowest earners being 5% and the highest is 14.5% for those earning £111,377 or above.

Figure 12.1 - Employee Contribution Rates

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

12.7 Member contribution rates and earnings tiers have been frozen since 1st April 2015, and will remain set until 31st March 2021. 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.

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

12.9 The SAB submitted their review conclusions in July 2018, and reached full agreement that;

- The principles underpinning the current contribution structure should be retained: include protection for the low paid, minimise the risk of opt-outs, and ensure the scheme remains a sustainable and valuable part of staff reward.

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

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

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

12.10 The SAB reached a majority recommendation that the existing contribution structure be retained for a further two years until 31st March 2021, and this recommendation was accepted by the Department in February 2019.

12.11 There was a recognition that further discussion as required on a number of areas, including the approach to avoiding ‘cliff edges’, and a desire by the majority of trade union representatives to seek formal mandate from their membership before recommending any move to actual pay as the basis for determining contribution rates.

12.12 During the transitional period to March 2021, the SAB will continue developing a recommended contribution structure based on the agreed elements outlined above. The timing of any change to the contribution structure would need to be considered in light of unwinding transitional provisions and returning staff to final salary accrual.

Pension Scheme Membership

12.13 The Department continues to monitor scheme participation rates using data from ESR. Annex 4 presents the position as of July 2019 and shows the percentage point change from the previous month, the previous 12 months and from October 2011.

12.14 Membership amongst employed doctors remains high. 89% of doctors are members of the scheme, a reduction of 0.4% compared to April 2019 (the end of the previous quarter). This is also a reduction of 1.5% compared to July 2018 (the same point in the previous year), and a reduction of 2.2% compared to October 2011.

12.15 The following table shows the number of employed doctors, GPs and dental practitioners claiming their NHS pension earlier than their normal pension age.

The figures are based on membership data from the 1995 NHS Pension Scheme. Data is not yet fully available for General Practitioners in Y/E 2019. NHS England, Primary Care Support England and the Local Health Boards (Wales) are not required to provide pension returns for GPs under scheme regulations until May 2020.

Figure 12.2 - Number claiming their NHS Pension on a voluntary early retirement (VER) basis

Hospital Doctors	VER	% of all retirements
Y/E 2009	142	11%
Y/E 2010	183	13%
Y/E 2011	286	16%
Y/E 2012	315	18%
Y/E 2013	387	24%
Y/E 2014	406	26%
Y/E 2015	453	28%
Y/E 2016	494	31%
Y/E 2017	490	30%
Y/E 2018	424	29%
Y/E 2019	416	28%

General Practitioners	VER	% of all retirements
Y/E 2009	265	20%
Y/E 2010	322	23%
Y/E 2011	433	28%
Y/E 2012	513	33%
Y/E 2013	591	42%
Y/E 2014	746	50%
Y/E 2015	739	51%
Y/E 2016	695	52%
Y/E 2017	721	62%

Y/E 2018	588	58%

Dental Practitioners	**VER**	**% of all retirements**
Y/E 2009	125	37%
Y/E 2010	118	36%
Y/E 2011	131	32%
Y/E 2012	161	37%
Y/E 2013	158	36%
Y/E 2014	149	40%
Y/E 2015	161	41%
Y/E 2016	145	41%
Y/E 2017	143	42%
Y/E 2018	115	37%
Y/E 2019	165	41.8%

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

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

Pension Flexibility for Senior Clinicians

12.18 There is evidence of high earning individuals opting-out of the scheme or leaving NHS employment through early retirement. Concerns have been raised in previous DDRB reports that this could be due to lower lifetime and annual allowance tax limits which potentially affect some higher earners. The lifetime and annual allowances are currently:

- £1.055m for the lifetime allowance

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

12.19 The Department recognises that annual allowance tax charges, particularly for individuals subject to a tapered annual allowance, reduce the incentive for higher earners to remain in the scheme or increase their pensionable earnings by taking on additional work or responsibilities. It is difficult to draw too much from GP and senior clinician opt-out figures, as such groups of staff may opt-in and out of the scheme frequently to manage their pension accrual.

12.20 Discussions with the medical profession and employers have highlighted the need for clinicians to have wide-ranging pension flexibility to control the amount of tax-free pension saving they build up in the NHS Pension Scheme, and so manage their annual allowance tax liability without reducing their workload.

12.21 On September 11th 2019 the Department launched a consultation proposing a new flexibility within the NHS Pension Scheme from April 2020. The proposed flexibility would be available to any clinician who has a reasonable prospect of an annual allowance charge, allowing them to choose a personal accrual level and pay correspondingly lower employee contributions. The accrual level chosen would be a percentage of the normal scheme accrual level in 10% increments, with members paying slightly more to meet the cost of ancillary benefits at full rate.

12.22 Under flexibility employers have discretion to recycle unused employer pension contributions into pay to maintain the value of the reward package.

12.23 The consultation also invited comments on the principle of allowing the pensionability of large pay increases for high earners to be ‘phased-in’ over several years to smooth the annual allowance impact.

12.24 The consultation closed on 1st November 2019 and the Department is currently considering responses with the intention of implementing flexibilities for 1st April 2020.

12.25 NHS Employers, on 2nd September 2019, published guidance on possible local approaches that employers can consider taking immediately to mitigate the impact of pension tax on their workforce in this tax year. This has allowed employers to take immediate action ahead of flexibilities being implemented in the next scheme year.

12.26 The Department has commissioned NHS Employers to provide a modeller to help individuals assess options for using flexibilities tailored to their personal circumstances. This modeller does not constitute financial advice. It will support affected clinicians and their employers to agree programmed activities and other contractual commitments equipped with a clear understanding of their pension tax liability and how the flexibilities can be best deployed to deliver the right balance of incentives.

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

12.28 In 2018, the Department closed a gap in the Scheme Pays coverage operated by the NHS Pension Scheme, which prevented those with charges arising from the tapered annual allowance or charges under £2,000 from utilising it. From tax year 2017-18 the scope of Scheme Pays was extended so it can be used to meet any pension tax charge of any amount.

12.29 The NHS has implemented a short-term measure to compensate NHS clinicians at retirement for the effect on their pensions of annual allowance tax charges incurred in 2019-20. In December 2019, NHS England and NHS Improvement wrote to trusts to confirm a commitment to provide an additional salary supplement in retirement to compensate affected clinical staff for any reduction in pension from a 2019/20 annual allowance charge. The commitment is supported by the Department.

12.30 The Government is committed to reviewing the impact of the tapered annual allowance on the NHS. This review is ongoing and will involve key stakeholders from across the NHS. The review will report at the next fiscal event.

Total Reward

12.31 Total reward, the tangible and tangible benefits that an employer offers an employee, remains central to recruiting and retaining staff in the NHS. There is

some evidence that more employers across the NHS are developing a strategic approach to reward which may be due to:

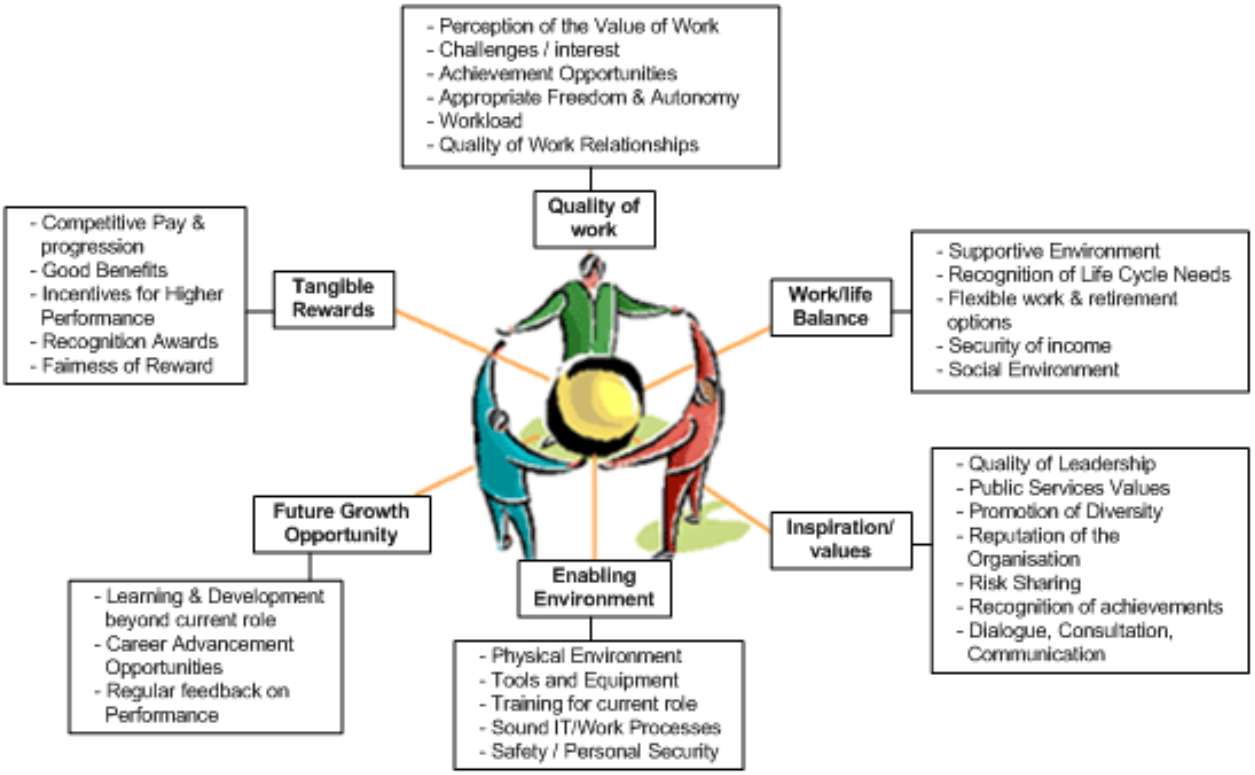
- Staff demand rising from total reward statements
- Trusts recognising that they need to do more to recruit and retain staff in an increasingly competitive employment market
- Employers working to reduce staff sickness and other absences by ensuring they are offering the support staff need for their physical, mental and financial wellbeing.

12.32 The Department's ambitions for the NHS reward strategy remains that employers should develop their capacity and capability to;

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

12.33 For consultant doctors and dentists, satisfaction with their level of pay is 57.1% (NHS staff survey 2018) a decrease from 58.6% in 2017. For doctors and dentists in training, satisfaction with pay has increased from 41.3% in 2017 to 43.1% in 2018. For 'other' doctors and dentists satisfaction with pay has increase slightly between 2017 and 2018, from 37.3% to 37.7%. The Department commissions NHS Employers to provide advice, guidance and good practice to the NHS on developing a strategic approach to reward based on the Hay Model (below).

Figure 12.3 - Hay Model

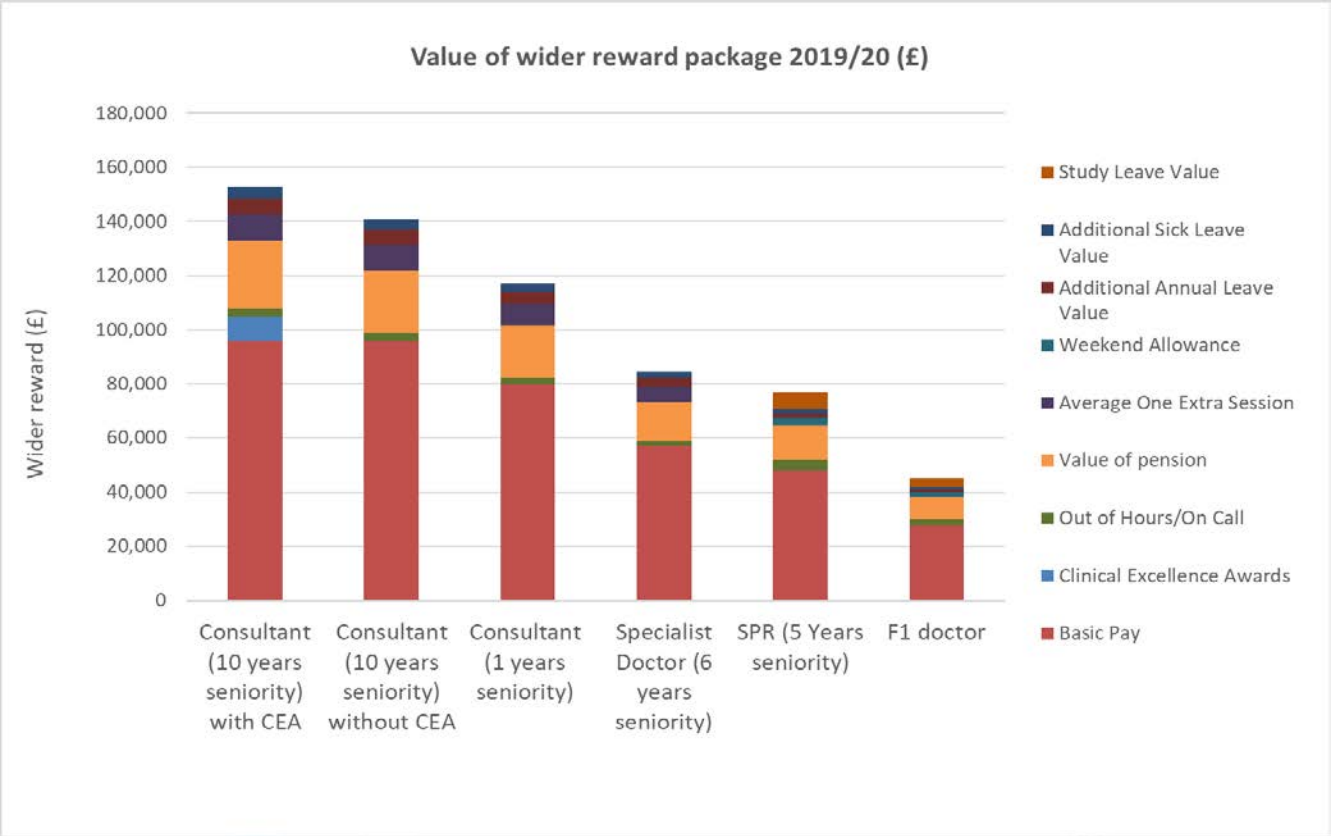


12.34 NHS Employers will update on;

- Ensuring the strategic context for total reward in the NHS remains ‘fit for purpose’ and aligned with their other programmes;
- How their engagement with employers is improving NHS understanding of total reward and why they should be developing their own local reward strategies;
- Their promotion of existing and new tools to support trusts in using strategic reward to deliver local workforce priorities;
- Their approach to gaining and sharing intelligence about the evolution of total reward across the NHS; and
- Their promotion of better uptake and understanding of total reward statements.

12.35 The value of reward packages for doctors is shown in the graph below and includes; basic pay, employer’s pension contribution, other pay such as clinical excellence awards for consultants, out of hours/on call payments, weekend allowances (for Specialist Registrars), and extra sessions worked. It also includes additional leave over the statutory minimum, additional sick leave over statutory sick pay and study leave for doctors in training.

Figure 12.4 - Value of Doctor's Total Reward Package



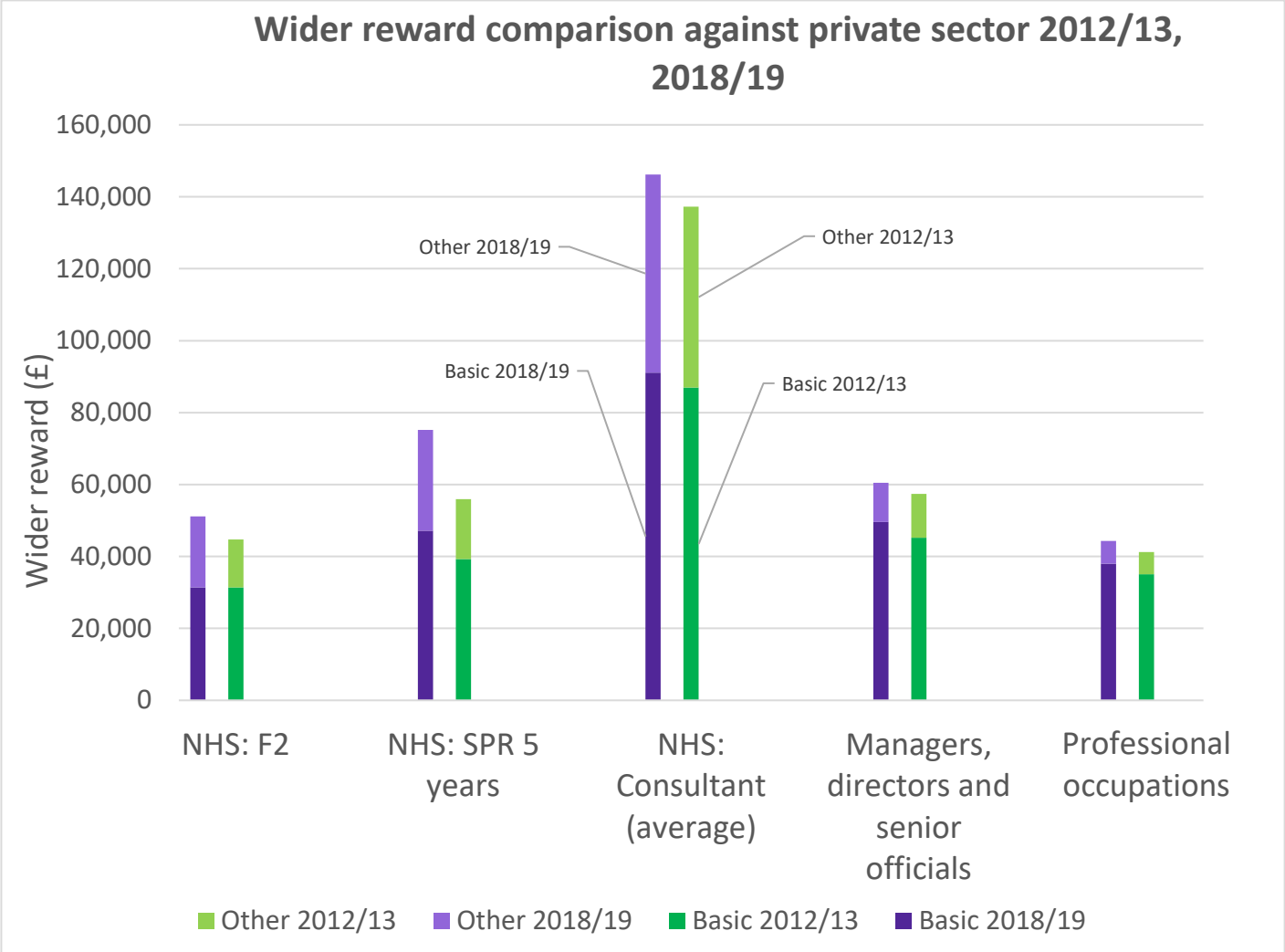
12.36 The Department commissioned the Government Actuary's Department (GAD) to analyse total reward across various private sector occupations, based on Office for National Statistics (ONS) data for salary and pension benefits, and compared them against pay rewards for various NHS staff based on previous GAD analysis from 2012 to 2018.

12.37 A total reward package considers basic pay plus "other" (non-basic pay), the latter including all other pay elements such as overtime, incentives, other elements of pay, and employer pension contributions. The graph below shows the relative change in total reward packages from 2012 to 2018 for each of the identified roles. Registrars, doctors in training and consultants in the NHS are compared to managers, directors and senior officials in the private sector, as well as other private sector professional occupations. This is mainly due to the availability of data and difficulty drawing appropriate comparisons with any one NHS role and other roles. The graph splits basic and "other" non-basic pay for each of the occupations, at 2012 and 2018, and is based on;

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

- 2018 basic + 2018 non-basic = 2018 pension/salary data (private sector occupations)
- 2018/19 NHS pay bands

Figure 12.5 - Comparison of total rewards for private sector occupations vs NHS roles as at 2012 and 2018



12.38 All roles considered as part of this analysis experienced an increase in reward between 2012 and 2018. 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 2012-2018. SPR experienced an increase of around 30% over the period 2012-2018. 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 14% over this period, which was largely down to changes in 'other' pay likely due to the introduction of the new Doctors in Training contract.

12.39 Private sector occupations experienced lower increases, with professional occupations experiencing a larger increase than Managers, Directors and Senior Officials with increases of 5% and 8% respectively in total wider reward over the period.

12.40 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 38% 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.

12.41 Although they are not included in the graph above, 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. NHS staff are entitled to redundancy up to a maximum of £160,000 which would be reached for those made redundant after 24 years' service and earning £80,000 pa, whereas statutory redundancy has a maximum cap of £15,240. NHS staff receive one month's pay for every year of service up to a maximum of 24 months, whilst statutory redundancy provides 0.5 weeks per each year of service below age 22, 1 week for service for each year worked up to age 41 and 1.5 weeks for each year worked in service beyond age 41.

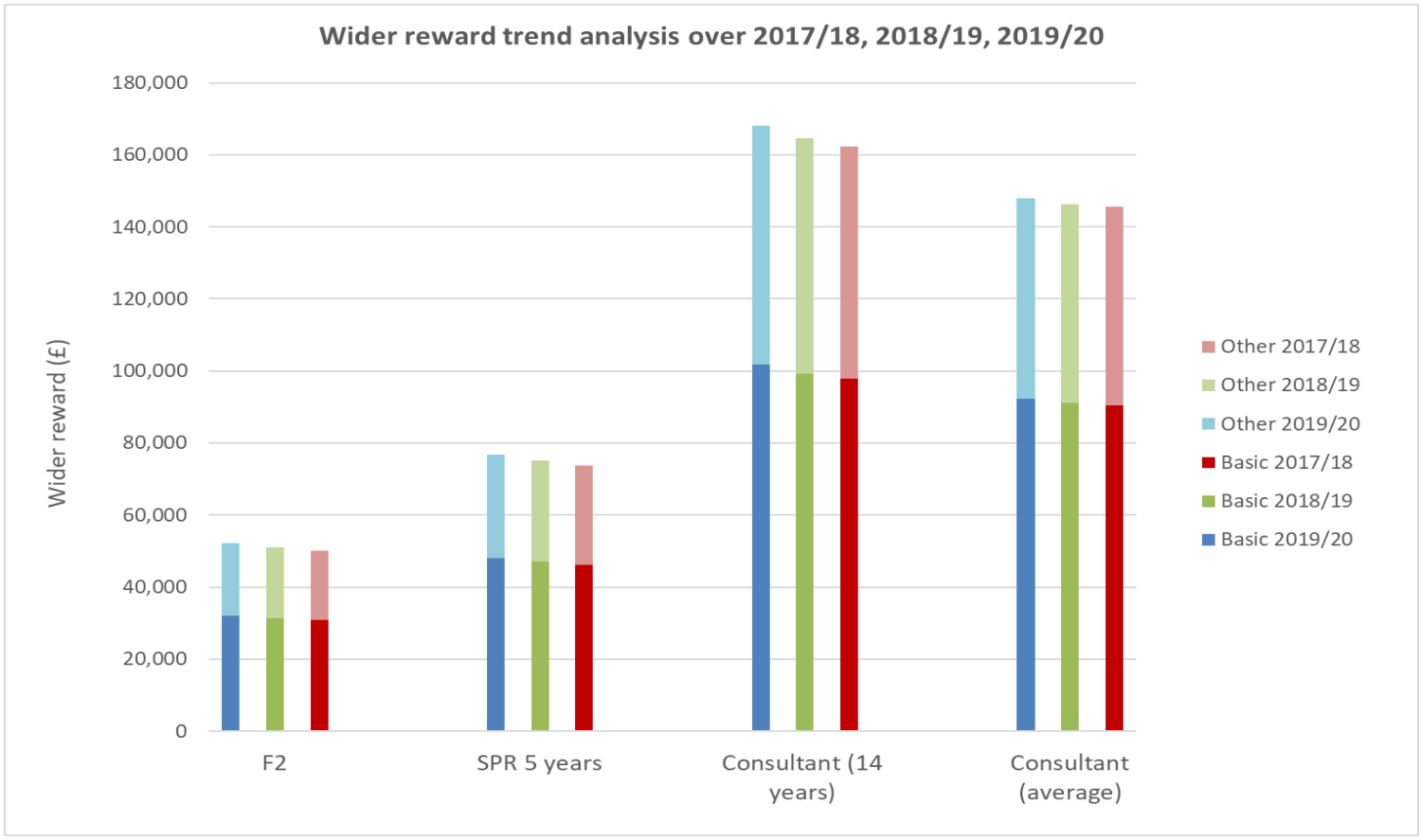
12.42 It is difficult to quantity the value of redundancy benefits given the sometimes-difficult circumstances when it would apply. The likelihood of redundancy in the NHS may be less in some NHS occupations than others and less than in some other sectors (NB could GAD get any evidence to support this statement? It would be helpful to include if they could but not if we can't back it up) and we would therefore need assumptions about the rate at which members leave under redundancy terms. Eversheds Sutherland conducted a survey of employers in 2016, which found that 1/3 of respondents offer statutory benefits only. 60% of respondents consider enhanced redundancy to be discretionary, unlike the NHS, suggesting the redundancy offer made by those included in the survey is less generous than that offered by the NHS.

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

NHS Trend Analysis

12.44 GAD also carried out trend analysis for different NHS staff, based on the previous total reward analysis at 2017/18, 2018/19 and 2019/20.

Figure 12.6 - Total rewards across different NHS roles on pay bands from 2017/18 and 2019/20



Source: NHS Digital NHS Staff Earnings Estimates: June 2019

12.45 All doctor roles considered as part of this analysis have experienced an increase in total wider reward over the period 2017/18 to 2019/20. F2 doctors and SPR experienced broadly consistent increases of around 2% in each year over the period, meaning the total reward package for these roles increased by around 4% between 2017/18 and 2019/20. Consultants with 14 years' seniority experienced a slightly lower increase of around 1% over 2017/18 to 2018/19 relative to the following year. Their total reward package increased by over 3% over the period 2017/18 and 2019/20.

12.46 The value of reward package for average consultants increased by the lowest level out of all roles considered, increasing by less than 2% over the period 2017/18 to 2019/20. The increase over the period was largely driven by basic pay. The level of non-basic pay fell between 2017/18 and 2018/19. Therefore, although the value of total wider rewards did increase over the whole period, this decrease in non-basic pay over the first year of the analysis will likely have dampened overall improved experience of consultants. All doctors considered have over 35% of their total rewards made up of non-basic pay.

Total Reward Statements

12.47 Total Reward Statements (TRS) provide NHS staff with 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 might include;

- Recommend a friend scheme
- Affordable accommodation
- Childcare and carer support
- Counselling and support
- Various salary sacrifice schemes
- Discounts
- Education and learning support
- Financial wellbeing
- Physical and mental health and wellbeing
- Signposting to pensions advice services
- Members of the NHS Pension Scheme are also provided with an annual benefit statement (ABS), which shows the current value of their NHS Pension benefit.

12.48 Since 2016, the NHS Business Services Authority (NHSBSA), which is responsible for issuing ABSs, has held stakeholder engagement events across the country which cater for different types of employers with a workshop on TRS, so employers can understand the role they play in promoting TRS in their organisations. The workshop also explains the difference between a TRS and an ABS, as local employers are responsible for issuing a TRS whilst the BSA issues an ABS.

12.49 Data on staff accessing TRS from August 2019 shows that 359,779 statements were accessed, compared to 366,527 at the same point in the previous year. There are 2,342,146 statements available for staff to access from August 2019.

12.50 TRS improvements include changes to the embedded links following the introduction of BSA’s new website and an update to branding in line with the rest of the NHS.

Annual Benefit Statements

12.51 Members of the NHS Pension Scheme also receive an annual benefit statement (ABS), which shows the current value of their NHS Pension benefits. An ABS is included as part of a staff member's TRS if they are a member of the NHS Pension Scheme.

12.52 Since 2016, the NHS Business Services Authority (NHSBSA), which is responsible for issuing ABSs, hold stakeholder engagement events across the country for a range of different NHS organisations, including workshops on TRS, to help employers better understand their role in promoting TRS within their organisations. The workshops also explain the difference between a TRS and an ABS.

Annex 1 - Hours Worked for High Cost Medics by Specialty

Hours worked for high cost medics – medical acute

Specialty	Total Agency Hours 2018/19
General Medicine	234,073
Adult Mental Illness	191,188
Accident & Emergency	177,612
Psychiatry Services	173,612
Geriatric Medicine	146,307
Not Specified	98,147
Child And Adolescent Psychiatry	94,207
Radiology	93,069
Paediatrics	84,451
Gastroenterology	84,835
Ophthalmology	82,344
Acute Internal Medicine	81,545
Other Community	62,021
Trauma & Orthopaedics	64,515
Cardiology	59,676
Dermatology	56,983
Old Age Psychiatry	53,190
Respiratory Medicine	50,302
General Surgery	52,093
Stroke Medicine	52,272
Anaesthetics	50,559
Urology	50,670
Other Mental Health	49,292
Rheumatology	39,753

Diagnostic Pathology	34,364
Neurology	29,796
Obstetrics	32,357
Ent	29,197
Medical Oncology	27,006
Haematology	27,649
Gynaecology	19,930
Chemical Pathology	17,116
Learning Disability	18,083
Diabetic Medicine	16,681
Clinical Haematology	15,682
Clinical Oncology	17,919
Pathology	12,696
Community Care Services	13,203
Cardiothoracic Surgery	12,705
Breast Surgery	9,036
Endocrinology	9,295
Forensic Psychiatry	7,101
Plastic Surgery	7,039
Neurosurgery	8,964
Rehabilitation	5,592
Community Nursing	5,227
Oral & Maxillo Facial Surgery	4,468
Neonatology	3,621
Critical Care Medicine	3,356
Nephrology	3,538
Intermediate Care	1,371
Infectious Diseases	3,278
Imaging	2,679
Paediatric Surgery	2,627

Spinal Injuries	2,321
Orthodontics	2,108
Palliative Medicine	1,603
Oral Surgery	1,371
Other	1,269
Midwife Led Care	1,707
Dental Medicine Specialties	1,593
Occupational Medicine	1,052
Public Health Medicine	472
Genitourinary Medicine	194
Medical Ophthalmology	722
Therapy Services	577
Theatres	189
Clinical Neuro-Physiology	193
Psychiatric Intensive Care Unit	n/a*
Paediatric Neurology	76
Clinical Physiology	63
Orthotics and Prosthetics	100
Paediatric Dentistry	60
Paediatric Cardiology	10
Restorative Dentistry	40
Clinical Immunology and Allergy	n/a*
Clinical Pharmacology	26
Sexual Health Services	24
Clinical Support - Physio	n/a*
Total	2,600,059

Source: NHS England and NHS Improvement, 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. n/a* describes where data is unavailable

Annex 2 - Medical Expansion by University

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%

Annex 3: ACCEA evidence to DDRB, review of national Clinical Excellence Awards Scheme

Introduction

In 2012, United Kingdom's health ministers asked 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'.

DDRB recommendations have not been taken forward up to this point due to NHS changes and other priorities but progress to implement a new scheme is required to ensure the national Scheme is able to meet the aims set out in paragraph 5 (below).

Consultation

Subject to ministers' approval, we plan to use the DDRB recommendations as a framework for our consultation exercise which will seek views on a range of issues, yet to be finalised but are expected to include:

- The Future of the national CEA scheme
- Changes to the domains for assessing national CEA applications
- Improving the national CEA application process
- Maintaining excellence during the period covered by a CEA
- Changing the number and value of CEAs
- Removing progression between CEA levels
- Improving diversity and spread in the distribution of national CEAs **Error! Bookmark not defined.**
- Using the national CEA scheme to support eligible clinicians undertaking national leadership roles
- Eligible clinicians with CEAs who take their pension benefits and return to work
- Whether to establish separate CEA schemes for any subsets of eligible clinicians

Our consultation aims to complement our plans to make the following changes to the national CEA scheme which align with some DDRB recommendations in that:

- they will not be pensionable;
- they will be for a fixed 5 year period;
- 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. If they make an application in the hope of achieving a higher award during the 5 year award period they will relinquish their existing award and be assessed as a completely new award within the annual applicant pool. As such a decision to apply early will have to be taken with the understanding that there is a risk of being unsuccessful in gaining any award;
- 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;
- funding per eligible clinician currently used for bronze awards will be included in trust tariffs to bolster amounts available for employers' annual performance awards 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

Timescales

With the General Election, it is not possible to outline timescales except that, once launched, the consultation will last for 12 weeks and, subject to ministers' approval, we are planning to implement a new national CEA scheme from April 2021. We are anticipating a 5 year transition period to close down the current national CEA scheme and take the new scheme to its "steady state".

We will keep DDRB informed of progress.

Annex 4: Pension Scheme Membership at July 2019

Staff Groups	FTE (Jun 2019)	% with pension contributions Jul 2019	% Change Apr 2019 and Jul 2019	% Change Jul 2018 and Jul 2019	% Change Oct 2011 and Jul 2019
All	1,095,189	90%	0.6%	0.7%	5.5%
Doctor	111,860	89%	-0.4%	-1.5%	-2.2%
Qualified nursing, midwifery & health visiting staff	310,278	91%	0.7%	0.8%	3.5%
Qualified Scientific, therapeutic and technical staff	133,701	93%	0.5%	0.3%	2.2%
Qualified Ambulance Staff	15,763	94%	1.4%	-0.2%	-1.7%
Support to Clinical Staff	336,504	90%	0.7%	1.5%	10.5%
Central Functions & Hotel, Property & Estates	142,154	87%	0.5%	1.3%	9.4%
Managers	31,773	90%	0.3%	-0.5%	-3.1%
All Non-Medical	983,329	90%	0.7%	1.0%	6.3%
AfC Band 1	24,439	81%	1.0%	0.5%	18.1%
AfC Band 2	151,875	89%	0.7%	1.7%	13.1%
AfC Band 3	125,342	90%	0.6%	1.4%	9.4%
AfC Band 4	84,175	90%	0.8%	1.1%	6.3%
AfC Band 5	197,367	89%	0.6%	1.0%	3.8%

AfC Band 6	180,409	92%	0.8%	0.3%	2.2%
AfC Band 7	102,500	93%	0.4%	0.0%	0.1%
AfC Band 8a	35,751	93%	0.3%	-0.2%	-1.3%
AfC Band 8b	14,342	93%	0.3%	-0.3%	-2.1%
AfC Band 8c	7,527	93%	0.2%	-0.1%	-1.9%
AfC Band 8d	3,703	92%	0.4%	-0.2%	-4.1%
AfC Band 9	1,419	92%	0.0%	-0.8%	-4.2%
Non AfC	166,339	88%	-0.2%	-1.2%	0.6%

Annex 5: Remit letter from the Secretary of State for Health and Social Care to the Chair of the Review Body on Doctors' and Dentists' Remuneration

Mr Christopher Pilgrim
Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

16 October 2019

Dear Mr Pilgrim,

I am writing firstly to express my thanks for the valuable work of the Review Body on Doctors' and Dentists' Remuneration (DDRB) on the 2019-20 pay round and to welcome you as the new Chair.

I write now to formally commence the 2020-21 pay round.

The NHS Long Term Plan and the 2019 Spending Review provide the context for the long-term funding of the NHS. The affordability of pay recommendations will have to be considered within the context of the affordability assumptions underpinning the NHS Long Term Plan, the importance of making planned workforce growth affordable and other financial risks facing the NHS. Given the NHS budget has been set for five years (2019/20 – 2023/24), there is a direct trade-off between pay and staff numbers and our evidence, and that from NHS England and NHS Improvement, will set out the balance.

The evidence that I will provide in the coming months will also support you in your consideration of affordability and I request that you describe in your final report what steps you have taken to take account of affordability and need for workforce growth and improved productivity. Pay awards will also be considered in the context of planned workforce reform and productivity improvements, which we will cover in our evidence.

I am also seeking your views on the targeting of available funds in pay in 2020-21 to ensure recruitment and retention pressures are properly addressed, and ask that you outline what consideration you have given to targeting in your final report.

As you are aware, we have reached a multi-year pay agreement (2019/20 – 2022/23) for doctors and dentists in training and so we are not asking the DDRB to make pay recommendations for this group. As is usual however, we would welcome your comments and observations on the evidence you receive from the Department of Health and Social Care and other parties on this group.

You are invited to make recommendations on an annual pay award for consultants.

For Specialty Doctors and Associate Specialists we are embarking on exploratory talks with the BMA with a view to negotiating a multi-year pay and contract reform deal. Any agreed deal would need to be one that gives valued staff a fair pay rise alongside improving recruitment and retention and developing reforms which better reflect modern working practices, service needs and fairness for employees. This does not prejudge the role of the DDRB in recommending the level of pay award that these staff should receive, but we would expect your recommendations to be informed by these talks with the BMA and we will update you on progress.

Independent Contractor General Medical Practitioners are subject to a five-year pay agreement between NHS England and the British Medical Association and therefore no pay recommendation is being sought for this group. You are invited to make recommendations on uplifts to the minimum and maximum of the salaried General Medical Practitioner pay scales, recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under the five year GP contract.

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

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year’s pay round and to communicate this to you directly.

Yours ever,

MATT HANCOCK

Endnotes

i This is a rounded figure so appears identical to previous figures provided, despite having increased.

ii Subcontractor dentists within England & Wales have previously been referred to as Performer Only dentists (dental earnings and expenses 2006/07 to 2015/16). Last year the terminology used to refer to these dentists was changed to Associate dentists, to match the terminology for dentists in Northern Ireland and Scotland.

iii Table 8a

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