Review Body on Doctors' and Dentists' Remuneration

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Fifty-First Report 2023

Chair: Christopher Pilgrim

CP 861

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

Presented to the Scottish Parliament by the First Minister
and the Cabinet Secretary for NHS Recovery, Health and Social Care

Presented to the Senedd by the First Minister
and the Minister for Health and Social Services

Presented to the Permanent Secretary of the
Northern Ireland Department of Health

by Command of His Majesty

July 2023

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Review Body on Doctors' and Dentists' Remuneration

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

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

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

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

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

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

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

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

The members of the Review Body are:

Christopher Pilgrim *(Chair)*
Helen Jackson
Professor Melanie Jones
John Matheson CBE
Ann McConnell
Nora Nanayakkara
Dr Raj Patel MBE
Peter Ward

The Secretariat is provided by the Office of Manpower Economics.

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Introduction

1. The Review Body on Doctors' and Dentists' Remuneration (DDRB) provides advice to ministers in the governments of the UK on the remuneration of doctors and dentists employed by, or providing services to, public health services across the UK. Our terms of reference are reproduced in full on page iii.

2. For this pay round we received remit letters from all four UK governments. The remits differed slightly, reflecting the different priorities of each government, as well as the multi-year pay deals that are in place for some groups within our overall remit. The UK Government did not seek recommendations from us for contractor GMPs or SAS doctors and dentists on reformed terms and conditions in England, while the Welsh Government and Northern Ireland Executive similarly did not ask us to make recommendations for SAS doctors and dentists on reformed terms and conditions in Wales and Northern Ireland respectively. We were asked by the governments for recommendations for all other groups of doctors and dentists across the UK.

Pay Proposals from the Parties

3. In their written evidence, DHSC said that within the current financial settlement provided to them by HM Treasury, and reprioritisation decisions that had subsequently been made, funding was available for pay awards up to 3.5 per cent for the relevant staff groups within the DDRB remit for 2023-24.

4. In their written evidence, the Scottish Government said that they would publish a public sector pay policy for 2023-24. Their Public Sector Pay Strategy was published in March 2023, and said that efficiencies and workforce changes would be required for public bodies to go beyond the 2 per cent pay assumption set in the Resource Spending Review. The Pay Strategy also included setting a pay award floor of 2 per cent, and recommended a central metric of 3.5 per cent and an award ceiling and pay envelope maximum of 5 per cent[1].

5. The Welsh Government did not present us with a pay proposal or an affordability figure but stressed to us that NHS organisations in Wales were already facing significant financial pressures in 2023-24, and that many health boards were already expecting to overspend significantly, to the extent that this may affect their ability to deliver services.

[1] https://www.gov.scot/publications/public-sector-pay-strategy-2023-2024/pages/5/

6. The Department of Health (Northern Ireland, DoH) said that at the time of writing, no Budget had been agreed for 2023-24, but that there would need to be departmental budgetary reductions even before taking account of inflationary pressures. They said that there was no capacity to afford a pay uplift for 2023-24 without implementing corresponding cuts to expenditure on services or additional funding being made available. The 2023-24 budget[2] was published in April 2023 and saw Northern Ireland departments allocated a combined resource budget of £14.2 billion, of which £7.30 billion was allocated to DoH, compared to £7.28 billion for 2022-23.

7. The BMA said that they were "asking DDRB to recommend a substantial pay increase to all doctors which will deliver full pay restoration". They also said that our recommendations should not be "constrained by the governments' remit letters or affordability constraints". BMA Scotland said that they were "seeking a significantly above inflation pay uplift that convincingly front loads the necessary reversal of junior doctors' real terms pay cut of 23.5% on average since 2008." They also said that they were "seeking an uplift that prevents any further real terms pay cut by matching RPI inflation (12-month RPI inflation to April 2023) and provides a further 5% uplift to make some progress in addressing long term pay erosion."

8. The BDA asked that we recommend a pay increase of RPI plus 5 per cent for GDPs and employed dentists.

9. HCSA did not provide us with a pay proposal.

Our Views on the Pay Proposals and Affordability

10. We note what the BMA said about our recommendations not being constrained by remit letters or affordability evidence. Our position on these issues remains the same as in previous years, and as we outline elsewhere in the report. Our view is that if we are asked to consider or make observations on a specific issue in our remit letter, as was the case for Scotland and Wales this year, we will do so. However, our role is to consider all the evidence that is provided to us based on our terms of reference, and relating to all of our remit group, regardless of whether an issue is or is not raised in remit letters. We do not view the remit letters as having a role in limiting the scope of our considerations in a given year. We would also wish to reiterate that our view is that we are able to make recommendations for any part of our remit group as we consider appropriate, though we also believe that it is important that we generally operate with the consensual agreement of all of the parties.

[2] https://www.finance-ni.gov.uk/news/department-finance-statement-202324-northern-ireland-budget#:~:text=Department%20of%20Finance%20statement%20on%202023%2F24%20Northern%20Ireland%20Budget,-Date%20published%3A%2027&text=The%20Secretary%20of%20State%20today,bn%20capital%20in%202022%2F23.

11. We remain of the view that affordability is one of the key factors that we must consider when making recommendations, but it sits alongside the other considerations included in our terms of reference, including recruitment, retention and motivation. The affordability evidence provided to us by the governments therefore represents crucial contextual information for our recommendations but does not serve as a constraint on what they can be. Our report and recommendations for this year are made in keeping with these positions, as has been the case in recent years. We discuss affordability in more detail in Chapter 2.

12. Since written evidence was submitted by the governments and health departments, three of them (DHSC and the Scottish and Welsh Governments) have made significantly enhanced pay offers for NHS staff for 2022-23, 2023-24 or both. We discuss these in detail in Chapter 2. In England and Scotland, this comprised staff on the Agenda for Change contract only, but in Wales this also included some groups within our remit. All three also included consolidated elements that would be carried into pay bills going forward. None of the three governments explained how these pay offers, all of which represent substantial increases to NHS pay bills during a time of pressure on services, will be funded, or how they will affect the affordability context for our recommendations this year. In particular, we note that DHSC's offer to Agenda for Change (AfC) staff included a consolidated pay uplift for 2023-24 of 5 per cent, despite them having submitted evidence to NHSPRB that said that 3.5 per cent was available in current budgets to fund pay increases for 2023-24 just a few weeks earlier. This suggests either that the UK, Scottish and Welsh Governments are expecting to provide more funding to their health systems than was previously outlined, or that existing funding has been redirected towards increasing AfC staff pay and less funding would then be available to spend on services or service development, or some combination of these. Whichever of these is the case, these pay offers call into question the integrity of the affordability evidence that they have previously provided to us and make it difficult for us to know what the true affordability picture is.

13. Our remit group has faced many similar challenges in the past year to those facing AfC staff, while also receiving a broadly similar pay award in overall percentage terms through the review body process for 2022-23. We are therefore concerned that governments taking action to supplement pay for AfC staff or, in the case of Wales, for some parts of our remit group and not others, risks creating a sense that the contribution of our remit group, or parts of it, are recognised less than other health service staff.

14. We note with concern what the DoH said about the affordability situation in Northern Ireland, and we note that the recently announced Budget for 2023-24 includes only a very small cash increase compared to 2022-23. DoH also discussed particularly severe challenges to recruitment and retention that were being faced by HSC, including the increasing attractiveness of working and practising in the Republic of Ireland. At the same time, workforce growth in Northern Ireland seems to be slower than the rest of the UK.

15. We note the BMA's request relating to what they describe as pay restoration. As we discuss in Chapter 6, we do not believe that it is our role to ensure that pay for our remit group retrospectively tracks, or avoids tracking, inflation or any other measure, though we are cognisant of long-term developments in our remit group's position within the overall earnings distribution, their real-terms pay, and how their pay compares to comparator professions.

16. As we said last year, we believe that our role is to examine current and long-term trends in pay for doctors and dentists as they relate to recruitment, retention and motivation, in line with our terms of reference. Therefore, in this report we do not seek to answer the broader question of where doctors' and dentists' pay should be positioned in wider society and the economy as a whole. Parties may wish to consider how such a broad consideration should play a part in ongoing long-term workforce planning efforts, and the extent to which the DDRB could make a contribution to this, if requested to do so.

Our Views on the Pay Context

17. We discuss the key economic and labour market indicators in Chapter 2. Inflation remains significantly higher than target levels with 12-month CPI and CPIH rates having fallen from their October 2022 peak levels of 11.1 per cent and 9.6 per cent to 10.1 per cent and 8.9 per cent respectively for March 2023, the latest month for which we have data at the time of writing. ONS average pay growth measures are also at elevated levels compared to recent years, but remain some way below inflation. Median pay settlements across both public and private sectors, which HM Treasury say are the most relevant direct comparators for review body recommendations, are similarly at elevated levels compared to recent years, with the most recent data from XpertHR and IDR at 6.0 and 5.0 per cent respectively, but remain below inflation. This suggests that the current period of higher inflation is leading to a negative impact on real incomes across the economy as a whole.

18. Our view is that doctors and dentists should not be treated as an exception to these trends, either through having their incomes exceptionally protected against inflation when this is not taking place for other groups, nor through having their pay increases held down when pay settlements and growth is elevated for others. Instead, our recommendations are informed by recruitment, retention and motivation, taking into account the affordability context. However, we remain cognisant of this challenging wider economic context.

Our Views on Recruitment, Retention and Motivation

19. We recognise the considerable challenges and pressures being put on health budgets, though as we discuss elsewhere in the report, we are concerned that a pay award that is too low would have negative budgetary implications related to poor motivation and increases to temporary staffing spend, amongst other things. We are also concerned that it would affect the UK's competitiveness in the international labour market for doctors and dentists.

20. We note that health services remain under considerable strain, as a result of long waiting lists and demand growth. Addressing this requires a workforce that is sufficient to meet demand. It is therefore increasingly important that staff are retained and motivated to perform. In this context we note with concern the GMC's observation that the number who left the medical register in 2021-22 was higher than previous years, though they said that it was not yet clear whether this represented decisions to leave that were not taken during the pandemic or an increase that would be sustained into future years.

21. In this context of high demand and constrained workforce supply, we welcome that there has been strong growth in the full-time equivalent (FTE) size of the Hospital and Community Health Services (HCHS) workforce in England, Scotland and Wales, though we are concerned that this growth seems not to have been replicated in Northern Ireland. However, a long-term context of workforce shortages and high demand remains, and vacancy rates remain high across the UK. As yet, there is also no clear picture of how these issues will be addressed for the long-term through workforce planning.

22. In general medical practice, despite welcome increases in the size of training intakes, the effective size of the GMP workforce is stagnant, once falling participation rates are taken into account. Despite positive trends in the use of non-medical clinical staff, evidence suggests that practices and their GMPs are struggling to meet demand, and access is severely challenged.

23. Inadequate access to NHS/HSC dental services is widely reported across the UK. Parties have said that the cause of this relates to issues of recruitment and retention, as well as contract structures that are no longer fit for purpose. We saw evidence that an important factor was the relative unattractiveness of NHS/HSC dentistry compared to private work. In England this may be related to some extent to the significant increase in clawback that took place in 2022-23, to a level that is potentially unsustainable. This situation may also be exacerbated by the process through which the expenses component of dental contract values is uplifted, which we discuss below.

24. There are ongoing long-term trends in workforce behaviour, including an increase in flexible and less-than-full-time working, that will affect workforce capacity across our remit group regardless of trends in the numbers leaving the NHS/HSC or retiring. These trends may be driven by a combination of shifting demographics, workloads or working conditions. However, regardless of the cause, a decrease in average working hours necessitates a higher absolute number of staff to deliver the same quantity of services, providing a significant additional challenge to recruitment and retention, and warranting a further re-examination of workforce demand. Alongside this, across the remit group, the proportion of individuals that aspire to take on senior, leadership and contractor roles seems to be waning. It remains to be seen the extent to which the changes to pensions taxation announced in the 2023 Budget will help to improve this situation by enhancing the incentive placed on the most senior, and therefore highest-paid, members of our remit group to maximise their contribution to the NHS/HSC.

25. At the same time, the staff survey results that are available to us suggest severe and urgent challenges to motivation in general, with NHS Staff Survey results in England for 2022 poorer still than the results for 2021, which themselves showed substantial declines on every measure compared to 2020, including particularly significant falls in pay satisfaction.

26. Many of the issues driving the challenges to recruitment, retention and motivation are not directly solvable with higher pay awards. We would therefore continue to stress the need for these issues to be addressed outside the pay setting process through workforce planning and other actions. We discuss this, including our frustration over the lack of progress in agreeing detailed, funded workforce plans, in Chapter 2.

27. However, pay does serve as an important signifier of value and, perhaps more importantly, if it is sensed to be deficient, can exacerbate a feeling amongst the medical and dental workforce that they are neglected and undervalued. This can in turn make staff feel they no longer wish to put in the additional discretionary effort on which the NHS/HSC depends, or that they no longer want to work full-time, or that it is no longer worth staying in the NHS/HSC at all. In order to address this, a pay award is required that is significantly in excess of the 3.5 per cent proposed to us by DHSC and which was used as the central metric of the Scottish Public Sector Pay Strategy. However, this must be balanced against the financial challenges being faced by health services, and our perspective on the pay context, as described above.

Our Recommendations

28. As we say in Chapter 2, our position has generally been to consider the affordability situation as being broadly similar across the UK, in the absence of compelling evidence to the contrary. The challenges to recruitment, retention and motivation, including high workloads, are also felt broadly consistently across the UK.

29. This year, evidence from DoH suggests that there are additional affordability challenges in Northern Ireland. However, offsetting this, we are also concerned that recruitment, retention and motivation are particularly challenged in Northern Ireland compared to the rest of the UK, including that growth in the FTE size of the hospital medical and dental (ie the HCHS) workforce in the rest of the UK has not been replicated in Northern Ireland. Therefore, we again came to the conclusion that this year it would not be appropriate for us to make differentiated recommendations for different parts of the UK.

30. Our first recommendation relates to the following groups within our remit:

- Consultants
- SAS doctors and dentists on old contracts, and those on reformed contracts in Scotland
- Salaried dentists, including those working in Community Dental Services/ the Public Dental Service
- Contractor GMPs in Scotland, Wales and Northern Ireland
- Salaried GMP pay ranges
- The pay element of dental contracts

There are other groups, discussed below, for whom we make further recommendations. Our recommendations are summarised in Table 1, below.

31. **Our first recommendation is for there to be a 6 per cent increase to national salary scales, pay ranges or the pay element of contracts for the groups outlined in paragraph 30 this year. Uplifts should be consolidated and backdated to 1 April as necessary so that they would be paid in full for the 2023-24 financial year.** We set out our recommendations in full in Appendix B.

32. This first recommendation, as well as all of the others that follow, are made considering the evidence we received, reflecting the need to recruit, retain and motivate staff, while also considering affordability, in line with our terms of reference. Decisions about how to fund pay awards across our remit group, whether through increases to departmental budgets, or to fund them from existing budgets, remain a political choice that sits with the governments.

Doctors and dentists in training

33. We have a number of specific concerns relating to doctors and dentists in training this year, following the conclusion of the multi-year deal (MYD) for doctors and dentists in training in England, and in response to the request by the Scottish Government that we make a separate and specific recommendation for them. We are also aware that BMA, BDA and HCSA members who are doctors and dentists in training in England have undertaken industrial action during the early part of 2023, and the BMA Scotland Junior Doctor Committee has now voted to do so. We make our recommendations cognisant of this, but also of the wider factors that have driven industrial relations issues, which are felt across the UK.

34. There remain many significant benefits to medical and dental careers, including guaranteed employment, generous pensions, and strong pay progression both during training and following its completion. Doctors and dentists in training also have varied routes for career progression. However, we remain concerned that these benefits are being undermined by issues of retention and motivation for those at the start of their careers. Addressing these issues would be of particular benefit to recruitment and retention in the long-term, and therefore to health services and ultimately patients.

35. We are particularly concerned about a number of issues of retention and motivation that affect the trainee workforce. During our visits programme, and in the evidence we received from the parties, we heard more frequently than in previous years about doctors and dentists in training considering leaving the UK to practise abroad. In an increasingly competitive international labour market for doctors and dentists, it is very important that those at the start of their careers, who are the most internationally mobile members of our remit group, are incentivised to remain in the UK. As well as this, given that doctors and dentists in training comprise the pipeline of future consultants, SAS doctors and dentists and GMPs, incentivising them to remain in training, rather than taking on non-training work or working as a locum or bank staff member, is important for safeguarding the future of all parts of our remit group.

36. We are also concerned that worsening issues of motivation, workload and working conditions amongst our remit group are felt particularly severely amongst doctors and dentists in training, whose staff survey results in England have seen a more precipitous decline between 2020 and 2022 than the HCHS medical and dental workforce as a whole. For example, pay satisfaction amongst doctors and dentists in training fell by 30.0 percentage points compared to 20.3 percentage points for the medical and dental workforce as a whole, and the proportion of doctors and dentists in training who reported looking forward to going to work fell by 14.0 percentage points compared to 10.8 percentage points for the medical and dental workforce as a whole.

37. Trainees must show a greater degree of flexibility around where they work than other parts of the remit group, potentially having to relocate several times throughout their time as a trainee. They must also manage the competing pressures of training and delivering clinical care in a context of increased pressure on health services. During our visits we heard from trainees about their frustration at having to fund a significant proportion of the costs of their own training, including having to pay for their own exams. This is a pressure that is potentially felt most severely by those who are the lowest paid within their profession and therefore have the least disposable income.

38. Given all of these factors, we believe it necessary for our recommendations to be higher for doctors and dentists in training than for the other groups within our overall remit.

39. **Therefore, our second recommendation is that pay points for doctors and dentists in training should be uplifted by 6 per cent plus £1,250. This increase should be consolidated and backdated to 1 April 2023 as necessary so that it would be paid in full for the 2023-24 financial year.** We set out our recommendations in full in Appendix B.

SAS doctors and dentists

40. In Scotland, we were asked to make recommendations for SAS doctors and dentists employed on old and new contracts, and we do so this year. Similarly, in England, Wales and Northern Ireland, we make recommendations for SAS doctors and dentists on older contracts as usual. As we set out in paragraphs 30 and 31, for each of these groups, we recommend that their pay is uplifted in line with our first recommendation.

41. In England, Wales and Northern Ireland, we share the concerns expressed by multiple parties that the benefits of contract reform will not be realised as a result of poor uptake of the new contracts. We note that many parties said that this was driven, at least in part, by the financial disincentive of working on the new contracts relative to the old, with this situation having been negatively affected by our recommendations for 2021-22 and 2022-23 being higher than the parties expected at the time the MYD was agreed in 2021, and also by the governments not taking action to ensure that this situation could be avoided.

42. We were asked by the governments not to make recommendations for the new contracts in England, Wales and Northern Ireland, as pay uplifts for this group have already been determined under the MYD, which concludes after 2023-24. However, we are gravely concerned that a further relative deterioration of the new pay scales, compared to the old, will lead to the new scale being permanently disadvantaged. This could lead to a large number of specialty doctors and dentists electing to remain on the older contract indefinitely, which could, in turn, lead to individuals being paid significantly different amounts for the same job. A sense that pay for those on the new contract was unfairly low could also lead to issues of motivation for those that are working on them. We remain particularly concerned that the benefits to recruitment, retention and motivation of the new contracts would not be fully realised. We note the suggestion from NHS Employers that we consider the case that pay uplifts for those on the old contract should be made lower to restore the pay incentive to move onto the new. However, we believe that doing this would foster a sense that specialty doctors and dentists are being treated less favourably than their colleagues in other grades as a result of having agreed contract reforms that are intended to benefit both them and services, and so would severely impact morale and motivation.

43. Multiple parties also expressed concern to us in written evidence that the uplifts applied to the old Specialty Doctor pay scale in England, Wales and Northern Ireland, compared to those made for the new Specialist scale had created a situation where some on the old Specialty Doctor pay scale would experience a pay cut on getting promoted to the new Specialist grade, though we note that due to the freezing of the top of the old pay scale in Wales this issue is not felt as severely there.

44. As discussed in last year's report, we believe that it is important that we generally operate with the consensual agreement of all parties, and we are therefore reluctant to make recommendations for SAS doctors and dentists on the reformed contracts. However, given the lack of action last year to address this situation and restore the financial incentive to move over to the new contracts, we do not have confidence that such action will be taken without us making a recommendation to that effect. We expect to revisit the issues described above in future years, once pay structures have reached their final form and the multi-year deal has come to an end. However, we have concluded that allowing this situation to further worsen, as a result of SAS doctors and dentists on the new contracts receiving a 3 per cent average pay uplift, compared to the 6 per cent recommendation that we are making for other groups including SAS doctors and dentists on old contracts, would not be appropriate this year. Therefore, we have decided to make a recommendation that would have the effect of achieving the same average uplift for 2023-24 for those on the new contracts as for those on the old, once the uplifts included in the multi-year deal have been taken into account.

45. **Therefore, our third recommendation is that the new Specialty Doctor and Specialist pay scales in England, Wales and Northern Ireland be increased by 3 per cent. This uplift is in addition to the uplifts included in the MYD and should be consolidated and backdated to 1 April as necessary so that it would be paid in full for the 2023-24 financial year.** We set out our recommendations in full in Appendix B.

General practice and dental expenses

46. As we discuss in Chapters 4 and 5, the BMA and BDA raised issues relating to how expenses uplifts for GMPs and GDPs were determined last year. The BDA, BMA Scotland and BMA Cymru Wales each asked us to return to making recommendations on expenses this year.

47. As with recent years, we make our recommendations this year net of expenses. We were not provided with evidence that could support us to make a recommendation on what represents an appropriate expenses uplift this year, nor do we believe that we are necessarily best-placed to do so. However, we would wish to stress, for the avoidance of doubt, that our pay recommendation is not a recommendation on an expenses uplift, nor should it be taken as such. **Instead, we expect that expenses uplifts for GMPs and dentists should be sufficient for the full value of our recommendations to be reflected in earnings for contractor and salaried GMPs at typical general practices, and for earnings for NHS/HSC work done by providing performer and associate dentists at typical dental practices**. The rationales provided by the governments for the dental expenses uplifts applied for 2022-23 suggested that none of them had made an effort to determine an expenses uplift that would achieve this. Similarly, those explanations provided to us for the expenses uplifts applied to GMP contracts were not comprehensive.

Consultant reward

48. As we outline in Chapter 3, we continue to have concerns about the equity and effectiveness of the consultant reward schemes. For the new National Clinical Impact Award scheme, it remains to be seen whether welcome increases in the proportion of applicants from previously under-represented groups will translate into increased numbers actually receiving awards; evidence which we would be very keen to see as soon as possible. For the other schemes in operation across the UK, we have yet to hear of evidence of improvements that could lead to the schemes operating more effectively and fairly going forward, or to the equalities issues with the schemes which we have discussed in previous reports being addressed. We also remain cognisant of the budgetary pressures on health services, and the need to ensure that our recommendations represent the most effective possible use of funds in improving recruitment, retention and motivation.

49. **Therefore, we have decided not to make a recommendation for the consultant reward schemes this year. However, we remain supportive of their reform, and would expect to hear of progress made towards improving the schemes in evidence next year.**

Summary of our recommendations

50. Our recommendations, for the various groups within our overall remit, are outlined in the below table. Recommendations are for the whole of the UK unless otherwise stated.

Table 1: Summary of our recommendations

Workforce Group	Recommended increase
Consultants	6%
Consultant Reward Schemes	No recommendation
SAS doctors and dentists (old contracts, and new contracts in Scotland)	6%
New Specialty Doctor and Specialist contract pay scales (England, Wales and Northern Ireland)	3%, in addition to the uplifts included in the multi-year deal
Doctors and dentists in training	6% plus £1,250 consolidated increase for all pay points
Salaried dentists including CDS and PDS	6%
Locally-employed doctors and dentists	The same as the national contract that their employment arrangement mirrors, otherwise 6%
Contractor GMPs (Scotland, Wales and Northern Ireland)	6%
Salaried GMP pay range	6%
Pay element of dental contracts	6%
Expenses uplifts for GMPs and dentists	Sufficient for the full value of our recommendations to be reflected in earnings for contractor and salaried GMPs at typical general practices, and for earnings for NHS/HSC work done by providing performer and associate dentists at typical dental practices

51. We estimate that implementing these recommendations would add £1.1 billion to the substantive HCHS pay bill in England, against a total DHSC Resource Departmental Expenditure Limit in 2023-24 of £176.2 billion. We estimate that it would add £125 million to the pay bill in Scotland, £80 million to the pay bill in Wales, and £40 million to the pay bill in Northern Ireland.

CHAPTER 1: INTRODUCTION

Introduction

1.1 The Review Body on Doctors' and Dentists' Remuneration (DDRB) provides advice to ministers in the governments of the UK on the remuneration of all doctors and dentists employed by, or providing services to, the NHS in England, Scotland and Wales and HSC in Northern Ireland. In this report, we make our recommendations and observations for the 2023 pay round, covering the 2023-24 financial year.

The Pay Review Body Process

1.2 We are governed by our standing terms of reference, which are reproduced at the start of this report. Our annual pay review process begins with a programme of visits, where we meet local health service leaders and members of our remit group in a variety of different locations and care settings across the UK. We also take written and oral evidence from a range of different organisations, including governments and trade unions, before making our recommendations. Following receipt of our recommendations it is then up to the governments to decide how to respond, and it is them, and the leaders of the health services they oversee, who ultimately implement annual pay uplifts for doctors and dentists.

The breadth of the DDRB's work and remit

1.3 Our primary focus is on pay, and its impact on recruitment, retention and motivation, in the context of patient care. We also consider the budgets available to the four Health Departments, in line with our terms of reference. However, pay can rarely be considered in isolation from other factors which influence recruitment, retention and motivation, and issues of workforce supply and demand. To understand the role of pay in addressing these questions, it is often necessary to consider this broader context. In our reports, we make a pragmatic judgement about pay informed by due consideration of these wider questions, based on the evidence provided to us.

The independence of the DDRB

1.4 The question of the independence of the DDRB has been raised by the trade unions in evidence this year. We would reiterate that our recommendations are based on our independent assessment of all of the evidence provided to us by the parties. We have in recent years made recommendations that run contrary to some or all of the parties' positions, including both governments and trade unions, and we do so again this year.

1.5 We also note that the BMA and BDA jointly published the paper *Report into the Failings of the Pay Review Process for Doctors and Dentists*[1], which called for a number of changes to how the DDRB process operates. We believe it is important that we reflect and consider how our process can be improved, as we do each year, and we would welcome the opportunity to work constructively with them and other parties, including the governments, to discuss practical steps for how the process can be improved.

This Report

1.6 In this report, we make recommendations based on our standing terms of reference and the remit letters that we received from the four governments, that are supported by the evidence that we received from the parties. In it, we set out the evidence that we received and the conclusions and recommendations that we reached based on it.

Remit Letters for this Report

1.7 The text from the remit letters from each of the four governments is included in full at Appendix A.

Department of Health and Social Care (England)

1.8 The Secretary of State sent his remit letter on 16 November 2022. It asked us to make recommendations for consultants, SAS doctors and dentists who chose not to transfer onto the new contracts, doctors and dentists in training, the minimum and the maximum of the pay range for salaried general medical practitioners (GMPs), and the pay element of remuneration for NHS dentists in England. It asked us not to make recommendations for independent contractor GMPs and SAS doctors and dentists who chose to move onto reformed contracts, since both are currently subject to multi-year pay deals.

1.9 The letter noted that the NHS budget had been set until 2024-25, and that pay awards must strike a careful balance between recognising the vital importance of public sector workers while delivering value for the taxpayer, considering private sector pay levels, not increasing the country's debt further and being careful not to drive prices even higher. It also asked that we give very careful consideration to the impact that our recommendations might have on the integrity of the agreed reforms to the SAS contracts, and the delivery of the new contracts' intended benefits.

Department of Health (Northern Ireland)

1.10 In the absence of a Minister of Health, the Permanent Secretary wrote to us on 8 December 2022, asking us for recommendations on pay for all doctors and dentists working in Health and Social Care (HSC) in Northern Ireland not otherwise subject to a negotiated settlement. This included SAS doctors and dentists who chose not to move onto reformed contracts, though he asked that we give very careful consideration to the impact our recommendations for this group would have on the integrity of the agreed reforms to the contract.

[1] https://www.bma.org.uk/media/6720/bma-report-into-the-failings-of-the-pay-review-process-for-doctors-and-dentists-2023-v2.pdf

Welsh Government

1.11 The Minister for Health and Social Services wrote to us on 19 December 2022. She asked for our advice on what would be a fair and affordable pay rise for staff to recognise their dedication and continued hard work. The remit letter noted that any changes to NHS staff's terms and conditions would need to come from existing budgets that were already struggling with inflationary costs.

1.12 As with England and Northern Ireland, recommendations were not sought for SAS doctors and dentists on reformed contracts in Wales. However, the remit letter asked us to offer observations on how the top pay points of the old and new contracts can be aligned, and also noted that DHSC had asked us to give careful consideration to the impact our recommendations for SAS doctors and dentists on the old contract would have on the integrity of the agreed reforms to the contract.

Scottish Government

1.13 The then Cabinet Secretary for Health and Social Care sent us his remit letter on 20 December 2022. It asked us for recommendations for all groups of medical and dental staff in Scotland, though it asked us to make a separate and specific recommendation for junior doctors.

1.14 On 5 April 2023, the newly-appointed Cabinet Secretary for NHS Recovery, Health and Social Care wrote to us asking for us to provide them with details of any specific recommendation we would be able to make for junior doctors in Scotland, in advance of the publication of our report. In accordance with our usual practice, we have submitted this report to the governments and it is their decision when and how to respond to it and make our recommendations public.

Parties Giving Evidence

1.15 We received evidence from the parties listed below. These were the same as last year, though NHS England had in prior years submitted its evidence under its previous name of NHS England and Improvement. This is also the final year that we will receive separate evidence from Health Education England, following the completion of its merger with NHS England in April 2023. The organisations were as follows:

Government departments and agencies

- Department of Health and Social Care (England, DHSC)
- Scottish Government
- Welsh Government
- Department of Health (Northern Ireland, DoH)
- NHS England (NHSE)
- Health Education England (HEE)

Employers' bodies

- NHS Employers
- NHS Providers

Bodies representing doctors and dentists

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

1.16 We also considered evidence from a number of other sources, including HM Treasury's submission to the Pay Review Bodies and NHS staff data and economic and other data prepared by the Office of Manpower Economics (OME). We undertook a comprehensive programme of visits, where we discussed issues relevant to our process with local health service leaders and members of our remit group, across all grades and across the UK.

1.17 For the second year in a row, parts of the BMA declined to participate in the DDRB process. As a result of this, the BMA's written evidence submissions did not cover consultants or doctors in training in England and Wales in detail. Following the submission of their written evidence, the BMA Chair of Council then wrote to the DDRB Chair explaining that the BMA UK Council had voted to withdraw from the DDRB process with immediate effect. Subsequent to this, the Chairs of BMA Scotland and BMA Northern Ireland wrote to the DDRB Chair to confirm that they would be participating in the DDRB process going forwards. Therefore, for this round, we received written evidence submissions from the BMA covering all of the UK, though not the groups mentioned above. BMA Scotland and BMA Northern Ireland also attended oral evidence sessions with us, but the parts of the BMA that represent doctors in England and Wales did not.

1.18 HCSA's written evidence did not discuss the current state of recruitment and retention in detail, instead discussing only their views about how the DDRB process can be improved from their perspective. They also declined the opportunity to attend an oral evidence session with us.

Our Comments on the Remit Letters and the Submission of Evidence

1.19 We are aware that some of the trade unions have discussed the role of the remit letter in limiting the scope of what we cover in a given year. Our view is that if we are asked to consider or make observations on a specific issue in our remit letter, as was the case for Scotland and Wales this year, we will do so. However, our role is to consider all the evidence that is provided to us based on our terms of reference, and relating to all of our remit group, regardless of whether an issue is or is not raised in remit letters, and we do not view the remit letters as having a role in limiting the scope of our considerations in a given year.

1.20 We reiterate our view that we are able to make recommendations for any part of our remit group as we consider appropriate, though we also believe that it is important that we generally operate with the consensual agreement of all of the parties. We also discuss doctors and dentists employed in the NHS/HSC on locally-determined contracts, who were not explicitly mentioned in the remit letters but are a part of our remit group, in Chapter 3, and we discuss their inclusion in the scope of our recommendations in Chapter 6.

1.21 We note the specific asks made of us by the Scottish Government in respect of doctors and dentists in training, and the Welsh Government in respect of SAS doctors and dentists. We discuss these in more detail in Chapters 3 and 6.

1.22 We also note that the remit letters for England and Wales asked us to submit our report earlier than in previous years. As we have said in previous reports, we share this aim, and would wish that our process could conclude prior to the start of the financial year, as was standard practice previously. In support of this aim, the DDRB secretariat communicated a deadline for written evidence of 11 January 2023 to all parties. We welcome that most parties met or came close to meeting this deadline, including some parties that last year submitted their evidence several weeks late. However, we did not receive written evidence from DHSC until 21 February. The Chair wrote to the Secretary of State for Health and Social Care on 1 February to convey the DDRB's concerns[2], but it took a further three weeks before evidence was submitted. We would wish to stress again that further progress towards the process concluding earlier in the year will not be possible without adherence to evidence deadlines.

1.23 These delays ultimately result in hard-working members of our remit group receiving their pay uplift later than they should, which sends an unhelpful signal about the way that the pay setting process for doctors and dentists is viewed by the UK Government.

1.24 While timely submission of written evidence is necessary for progress to be made towards this aim, we would also welcome receiving remit letters from the governments earlier than was done for this year, as this would also help us return to a timetable that supports pay awards being implemented ahead of the start of the financial year. Given this, we also note with concern that the Welsh Government told us that they might announce pay uplifts ahead of our process concluding, as they were in negotiations with health trade unions in the context of ongoing pay disputes. If the Welsh Government would wish that we submit our recommendations to them sooner, they should work with us to look to facilitate this.

1.25 We are thankful to all the parties that submitted evidence to us; doing so ensures that their views are recognised in our considerations. Active participation by all parties is important to the integrity of the pay-setting process. We are particularly appreciative of the parties that responded to the requests we made of them in last year's report, including in particular DHSC. We requested and received more detail on a number of key issues from parties in evidence for this year, including in particular on locally employed doctors and dentists, dental expenses and trends in average working hours.

[2] https://www.gov.uk/government/publications/letter-from-ddrb-chair-to-the-secretary-of-state-for-health-and-social-care

1.26 The decision by HCSA and parts of the BMA to decline the opportunity to provide evidence to our process means that the views of their members are not represented in our considerations, and therefore cannot shape our recommendations. We believe this cannot be in the interests of HCSA and BMA members or the remit group more generally and would again urge all concerned to reconsider this position.

1.27 We note that the UK, Scottish and Welsh Governments made offers to groups of NHS staff following their submission of written evidence to us. As we discuss in Chapters 2 and 6, this called into question the credibility of their affordability evidence.

Last Year's Recommendations

1.28 In our 50th Report 2022, our basic recommendation was for a 4.5 per cent increase to the national salary scales or the pay element of contracts for all groups for which we were asked by the governments to make recommendations. This comprised the following:

- Consultants
- Staff grade, associate specialist, specialist and specialty (SAS) doctors and dentists in Scotland, and those in England, Wales and Northern Ireland who did not elect to move onto reformed contracts
- Doctors and dentists in training in Scotland, Wales and Northern Ireland
- Independent contractor GMPs in Scotland, Wales and Northern Ireland
- The GMP trainers' grant and GMP appraisers fee
- The pay range for salaried GMPs
- Providing-performer and associate GDPs
- Salaried GDPs including Community Dental Service/Public Dental Service practitioners

1.29 We were asked not to make recommendations for doctors and dentists in training and independent contractor GMPs in England, or for SAS doctors and dentists in England, Wales and Northern Ireland employed on reformed contracts, as all were subject to multi-year pay deals (MYDs). However, we said that we were extremely concerned that the uplifts contained within the MYDs were likely not sufficient to address the issues of recruitment, retention and motivation that we discussed elsewhere in the report. While we concluded that our terms of reference enabled us to make recommendations for any part of our remit group that we saw fit, we also said that it was important that we operate with the consensual agreement of all parties. We therefore did not make a formal recommendation that these groups receive a pay uplift. However, we urged the governments to consider the unique economic and workforce context, the need to protect the relative pay position of staff on MYDs, and the challenges to recruitment, retention and motivation, and work with the trade unions to take action to address these issues. We also stressed the harm that may be caused by the governments not acting.

1.30 We also did not make a recommendation that Clinical Excellence Awards, Distinction Awards, Discretionary Points and Commitment Awards for consultants should be uplifted.

Responses to our Recommendations

1.31 Following the submission of our report in June 2022, the four governments implemented the annual pay uplifts for our remit group as detailed in Table 1.1 below. DHSC, the Scottish Government and the Welsh Government announced that they would implement our recommendations in July 2022, whilst in Northern Ireland they were implemented in March 2023.

Table 1.1 Implementation of 2022 DDRB recommendations.

Group	DDRB 2022 recommendations	England	Wales	Scotland	Northern Ireland
Consultants (pay scales)	4.5%	4.5%	4.5%*	4.5%	4.5%
Consultants (Clinical Excellence and Impact Awards, Commitment Awards, Discretionary Points, Distinction Awards)	No recommendation	Value frozen	Value frozen	Value frozen	Value frozen
SAS doctors and dentists	4.5% (in England, Wales and Northern Ireland, those on the old contracts only)	4.5% (those on new contracts received an average uplift of 3% under the MYD)	4.5%* (non-consolidated for those on the top pay point of the 2008 Specialty Doctor contract pay scale. Those on new contracts received an average uplift of 3% under the MYD)	4.5%	4.5% (those on new contracts received an average uplift of 3% under the MYD)
Doctors and dentists in training	4.5% (Scotland, Wales and Northern Ireland only)	n/a (basic pay uplifted by 2% and a further 1% invested in contractual changes under 2019 multi-year deal)	4.5%*	4.5%	4.5%
Independent contractor GMPs	4.5% (Scotland, Wales and Northern Ireland only)	n/a (MYD has no explicit pay uplift figure)	4.5%	4.5%	4.5%
Salaried GMPs range	4.5%	4.5%	4.5%*	4.5%	4.5%
Providing-performer and associate GDPs	4.5%	4.5%	4.5%	4.5%	4.5%
Salaried GDPs	4.5%	4.5%	4.5%*	4.5%	4.5%
GMP trainers' grant and GMP appraisers	4.5%	4.5%	4.5%	4.5%	4.5%

*See paragraph 1.32, below.

1.32 In February 2023, the Welsh Government announced that they had made an offer to unions representing NHS staff including the BMA that would see an additional 3 per cent added to pay in 2022-23, half of which would be consolidated. This offer applied only to salaried employees of Health Boards, and so included consultants, SAS doctors and dentists, doctors and dentists in training and salaried dentists, though the pay range for salaried GMPs in Wales was also uplifted by 1.5 per cent. Contractor GMPs and providing-performer and associate GDPs were not included. While not all of the BMA Cymru Wales committees accepted this offer, it was implemented ahead of the end of the 2022-23 financial year[3].

Our Comments on the Responses to our Recommendations

1.33 Our recommendations last year were made against a challenging economic backdrop, with high and increasing levels of inflation, that were affecting real-terms pay for all parts of the economy, including our remit group. Our recommendations were some way above the affordability figures provided to us, and therefore we welcome that all of our formal recommendations were implemented in England, Scotland and Northern Ireland, and that most of our formal recommendations were implemented in Wales. We note that the Welsh Government decided not to implement our 4.5 per cent recommendation with respect to the top of the Specialty Doctor pay scale, instead freezing it and making a non-consolidated payment of 4.5 per cent instead.

1.34 We are, however, particularly concerned and disappointed that action to address the concerns about recruitment, retention and motivation amongst those under MYDs was not taken in England, Wales and Northern Ireland, though we note that in Wales a non-consolidated payment of £1,400 was paid to those on the new Specialty Doctor and Specialist contracts. We discuss this issue as it relates to our recommendations this year in Chapter 6.

1.35 As we said last year, the delays to the pay award process in Northern Ireland continue to be unacceptable. Doctors and dentists in Northern Ireland had to wait eight months longer than their counterparts in England, Scotland and Wales to receive their pay award. During our visits programme, members of the remit group in Northern Ireland told us that they felt less valued by government as a result of these delays.

1.36 We expect pay awards to be made in a timely fashion following the submission of our reports. We have repeatedly urged the Executive in Northern Ireland to respond to our reports soon after they are submitted, and once again this has not happened. These delays undermine the credibility of the pay determination process amongst the remit group and is likely to have had a negative impact on morale.

1.37 We welcome that the Scottish Government again showed flexibility in applying its public sector pay policy for 2022-23, which proposed lower pay uplifts for higher paid staff, to our remit group. We would welcome them doing so again this year with their Public Sector Pay Strategy.

[3] https://www.nhs.wales/search-results/?searchFilter=&Keywords=pay+circular&strippedKeywords=pay+circular&display=search&newSearch=true&noCache=1&csrf_token=F20FC0A36E3F2ECD7B0B8E3A4643E1CF&csrf_token_expires=230404192119276 , M&D(W) 02_2023 Pay Circular, 04_2023 – M&D Circular

1.38 We also note the actions taken by the Welsh Government to increase pay for some groups within our overall remit outside the usual pay-setting process. As it also included a consolidated element, this unusual action will have affected affordability baselines for 2023-24 and the pay position of the groups affected by it both relative to the rest of our remit group and relative to their counterparts in the rest of the UK. The Welsh Government did not explain to us how affordability for 2023-24 was affected by this action, which we believe sets a difficult precedent about the integrity of our process. We discuss this further in Chapters 2 and 6.

1.39 We note that for GMPs and GDPs, our recommendations are combined with an expenses uplift by the governments in order to determine the overall annual GMP and dental contract uplifts. We discuss this in more detail in Chapters 4, 5, 6 and 7.

1.40 Finally, we note that, since our last report was submitted, significant changes have been made to the pensions taxation system, that address some of the concerns that we and others raised about the way that the annual and lifetime allowances affect retention of the most senior members of our remit group. We discuss this in more detail in Chapter 6.

CHAPTER 2: WIDER CONTEXT AND EQUALITIES

Introduction

2.1 In this chapter we discuss wider factors that provide important context for our considerations of recruitment, retention and motivation, which follow in later chapters. This includes a discussion of the latest economic and labour market indicators, as well as details of public sector pay policies and finances, at the time of this report. We also discuss a number of key contextual factors relating to the planning and management of health services, including workforce planning and long-term changes to health workforces. We also discuss equalities issues here, including in the context of long-term demographic shifts in the make-up of the medical and dental workforces.

The Economy and the Labour Market

HMT Economic Evidence

2.2 In January 2023, HM Treasury sent economic evidence to the Pay Review Bodies[1], which sets out their perspective on the economic and fiscal position.

2.3 In their submission, they said that the UK economy grew in the first half of 2022, but had been exposed to an inflationary shock from the war in Ukraine, and contracted by 0.2 per cent in the third quarter of 2022, with the Office for Budget Responsibility (OBR) forecasting a recession that will end in quarter 4 2023 with a peak to trough fall of 2.1 per cent. They said that while inflation had been driven primarily by energy prices, price pressures had become more widespread. They said that the OBR expects inflation to peak at 11.1 per cent and then begin to fall sharply, averaging 5.5 percent over 2023-24 and turning negative in 2024-25. They also note that the Bank of England has assessed that risks around inflation are skewed to the upside, including inflation expectations becoming embedded due to greater persistence in wage and price setting, as well as further developments in the war in Ukraine.

2.4 In describing the state of the labour market, HM Treasury said that median pay remained 11 per cent greater in the public sector than the private sector in 2022. They also said that median private sector pay settlements were 3.5 per cent in the last quarter of 2021-22 and 4 per cent in the first quarter of 2022-23, broadly in line with or lower than the 2022-23 awards implemented for the public sector workforces that have a pay review body process. They said that pensions in the public sector are substantially more generous than those in the private sector.

[1] https://www.gov.uk/government/publications/economic-evidence-to-the-pay-review-bodies-january-2023

2.5 Their submission also said that median private sector pay settlements provide the best comparator to public sector pay settlements in 2022-23. They said that data from XpertHR showed median private sector pay settlements were 4.0 percent in quarter 2 and 3 of 2022. They also said average earnings growth (whole economy, regular pay) was 6.1 per cent in the latest data for the three months to October, and private sector regular pay growth increased to 6.9 per cent over the same period compared to 2.7 per cent in the public sector (though this value does not fully capture pay settlements agreed for 2022-23 which were backdated, with many not reaching pay packets until after October 2022). They also said that public sector pay awards significantly above the private sector could risk higher and more persistent inflation, requiring further interest rate rises. They said that OBR forecasted that unemployment will rise from 3.7 per cent, for the three months to October 2022 to 4.3 per cent in 2022-23 and 4.9 per cent in 2023-24 and HM Treasury said that in this context the public sector is likely to continue to provide greater job security.

2.6 HM Treasury said that in response to the high levels of inflation the Bank of England has raised interest rates from 0.1 per cent in December 2021 to 3.5 per cent in December 2022 and to support the Bank of England the Government must demonstrate fiscal discipline. They cited OBR forecasts that said that borrowing was to remain high in 2023-24 at £140.0 billion with public debt increasing across the forecast and falling marginally from 2026-27, with debt interest costs expected to reach £120.4 billion in 2022-23. HM Treasury also said that departments have already undertaken significant reprioritisation to make funding available for pay awards in 2023-24 and pay rises above affordability would require further reprioritisation. They said that there is a direct trade-off between more staff, investing in public services, and giving higher pay rises.

Economic growth

2.7 In 2022 as a whole UK gross domestic product was estimated to have grown by 4.0 per cent[2]. In March 2023 the OBR said that they expected there to be a 0.2 per cent contraction in 2023, and a growth of 1.8 per cent in 2024[3].

Inflation

2.8 The latest inflation figures from ONS, for March 2023 showed CPI inflation at 10.1 per cent, CPIH inflation at 8.9 per cent, and RPI inflation at 13.5 per cent, each over 12 months[4]. The OBR said in March 2023 that they expected CPI inflation to fall sharply to 2.9 per cent by the end of 2023[5].

[2] https://www.ons.gov.uk/economy/grossdomesticproductgdp/timeseries/ihyp/pn2
[3] https://obr.uk/efo/economic-and-fiscal-outlook-march-2023/, 2.38 and 2.39
[4] https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation Table 1
[5] https://obr.uk/efo/economic-and-fiscal-outlook-march-2023/ 1.3

Employment and the labour market

2.9 The latest official statistics in the labour market showed that employment grew by 384,000 over the year to February 2023, and rose by 169,000 over the three months to February 2023, to reach 32.95 million. The employment rate was at 75.8 per cent in the three months to February 2023, up 0.3 percentage points over a year previously[6].

2.10 The level of unemployment (those looking for and available for work), fell by 5,000 over the year to February 2023, and increased by 49,000 in the three months to February 2023, to 1.29 million. This gave an unemployment rate of 3.8 per cent in February 2023, the same as a year previously[7].

2.11 The number of job vacancies from January to March 2023 was 1.105 million. This was a decrease of 188,000 compared to 12 months previous, and an increase of 304,000 from the pre-pandemic level[8].

Earnings growth

2.12 In the three months to February 2023, average weekly earnings growth was stronger in the private sector than the public sector. Year-on-year average weekly earnings growth in February 2023 was 5.9 per cent across the whole economy, 6.1 per cent in the private sector and 5.3 per cent in the public sector[9].

2.13 According to IDR, the median pay award across the economy in the three months to March 2023 was 5.0 per cent, with around two-fifths of awards worth 6.0 per cent or higher[10]. XpertHR said that the median pay settlement for the three months ending 31 March 2023 was 6.0 per cent[11].

2.14 We pay particular attention to the movements of earnings at the upper end of the wage distribution, which includes the more highly paid members of our remit group. According to the Annual Survey of Hours and Earnings (ASHE), growth in annual earnings at the top end of the distribution was weaker than for those in the middle in the 12 months up to April 2022, in both the private and public sectors. Growth in annual earnings, between 2021 and 2022, for full-time employees in the private sector as a whole was 6.4 per cent at the median, 3.5 per cent at the 90th percentile, 2.4 per cent at the 95th percentile, 3.0 per cent at the 97th percentile and 3.4 per cent at the 98th percentile. Growth in annual earnings for full-time employees in the public sector, over the same period, was 3.9 per cent at the median, 2.2 per cent at the 90th percentile, 1.3 per cent at the 95th percentile, 1.4 per cent at the 97th percentile (there was no data available at the 98th percentile for the public sector in 2022 to make a comparison against).

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[6] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes MGRZ and LF24

[7] https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment MGSC and MGSX

[8] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/jobsandvacanciesintheuk/april2023 AP2Y. The pre-pandemic level is taken to be the figure for January-March 2020.

[9] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/latest KAC3, KAC6 and KAC9

[10] https://www.incomesdataresearch.co.uk/resources/viewpoint/median-steady-in-march-but-likely-to-rise-further-in-april

[11] https://www.xperthr.co.uk/indicators/pay-awards/16100/

Affordability, Public Sector Pay Policies and Finances

England

2.15 DHSC said in their written evidence that funding is available for pay awards up to 3.5 per cent for the relevant staff groups within the DDRB remit this year. They said that pay awards above this level would require trade-offs for public service delivery or further Government borrowing at a time when headroom against fiscal rules is historically low and sustainable public finances are vital in the fight against inflation. They also said recommendations on salaried GP pay should be informed by affordability and the fixed contract resources available under the 5-year GP contract, which were sufficient for a 2.1 per cent pay increase.

2.16 We also note that, following negotiations with the unions representing NHS staff outside our remit group in early 2023, a pay award of 5 per cent will be implemented for staff on the Agenda for Change contract for 2023-24, alongside two additional non-consolidated payments for 2022-23, one of 2 per cent, and the other a 'COVID recovery bonus' for 2022-23 worth between £1,250 and £1,600[12], with the overall non-consolidated package equalling 6 per cent of the pay bill. Prior to this, NHSPRB was also told that 3.5 per cent was available under current NHS budgets for the 2023-24 pay award for Agenda for Change staff[13].

2.17 NHS England said that they funded the pay award for 2022-23 in full for that year but it created a recurrent pay inflation pressure for future years as it was above what had been accounted for in the NHS financial settlement. They also said that pay awards higher than what is affordable, and which are not supported by additional investment, will put further pressure on the NHS budget. They said that this could impact on staffing numbers and the ability to deliver activity or service improvements, and that these decisions would have a longer-term impact on the NHS's ability to restore services and make progress in tackling elective care backlogs.

2.18 NHS Providers said that community and mental health providers have a higher percentage of their costs taken up by pay when compared to acute Trusts and this means the assumptions in the national tariff uplift are not actually representative of all provider organisations, so community and mental health providers face a proportionally higher cost pressure for pay. They also said that while the difference between the pay award for 2022-23 and what was available in budgets was funded from existing budgets, they do not believe that this would be an appropriate approach for DHSC and HM Treasury to take for 2023-24 given the impact this has on NHS finances and patients.

2.19 The BMA said that the DDRB should disregard economic and affordability constraints.

2.20 The HCSA said that the DDRB should not be required to assess the funds available to the health department or consider the government inflation target.

[12] https://www.gov.uk/government/news/government-and-health-unions-agree-pay-deal-paving-way-for-an-end-to-strike-action

[13] https://www.gov.uk/government/publications/dhsc-evidence-for-the-nhsprb-pay-round-2023-to-2024, p.17

Scotland

2.21 The Scottish Government said that health and social care services would receive £19 billion for 2023-24, their highest ever budget settlement. They said that NHS Boards would receive an uplift of almost 6 per cent for 2023-24, including a baseline budget uplift of 2 per cent along with further support for the enhanced 2022-23 pay deals and to cover recurring allocations brought forward from 2021-22.

2.22 They said that the Scottish Budget for 2023-24, which was published in December 2022, stressed that pay and workforce must be explicitly linked to both fiscal sustainability and to reform. While at the time they submitted their written evidence submission, the Scottish Government had not published a public sector pay policy, they subsequently published a Public Sector Pay Strategy in March 2023. It said that business efficiencies and workforce changes would be required for public bodies to go beyond the 2 per cent pay assumption set in the Resource Spending Review. It also said that the key features of the Pay Strategy were[14]:

- The implementation of the real Living Wage rate of £10.90 per hour, including it being applied for internships and Modern Apprentices;
- A suggested cash underpin of £1,500 for public sector workers who earn £25,000 or less;
- Pay uplift for Chief Executives is capped at the same cash amount as the lowest paid;
- Setting a pay award floor of 2 per cent; and
- Recommending a central metric of 3.5 per cent and setting both an award ceiling and pay envelope maximum of 5 per cent on business efficiencies and/or pay bill savings.

2.23 They also said that they had asked Health Boards to make plans for 2023-24 on the basis of 2 per cent pay awards for doctors and dentists, and that awards higher than this which were not supported by consequentials under the Barnett Formula would require difficult choices. We note the Scottish Government's pay offer to Agenda for Change staff, which was accepted by the unions, included uplifts of at least 6.5 per cent for 2023-24 for all but the most senior staff[15].

2.24 BMA Scotland said that the Scottish Government had the ability to reprioritise spending or increase taxes, and asked that the DDRB recommendation was not constrained by the government's remit letter or affordability constraints.

[14] https://www.gov.scot/publications/public-sector-pay-strategy-2023-2024/pages/5/
[15] https://www.gov.scot/publications/nhs-staff-pay-offer/#:~:text=Over%20the%20two%20years%20of,between%205.4%25%20and%2019.26%25.

Wales

2.25 The Welsh Government said in their draft budget from December 2022 Health and Social Services would receive £10.97 billion in 2023-24 and £11.28 billion in 2024-25. They said that the UK spending on health is less than many other western countries, especially Germany. They also said that Health Boards had a significant overspend for 2022-23 and that the pay uplift recommendation for 2023-24 needed to take a balanced approach, as it could cause additional overspend by Health Boards, while also needing to address the impact of the cost of living crisis on doctors and dentists.

2.26 As discussed in chapter 1, we note that the Welsh Government implemented an enhanced pay award for 2022-23 for NHS staff This included some members of our remit group but excluded contractor GMPs and practice-based dentists. This amounted to a pay increase of 3 per cent, of which 1.5 per cent was consolidated and 1.5 per cent non-consolidated, on top of DDRB and NHSPRB recommendations which had already been implemented[16]. The pay range for salaried GMPs was also uplifted by 1.5 per cent.

Northern Ireland

2.27 The Department of Health (DoH) said that at the time of their submitting written evidence no Budget has been agreed for 2023-24. They also said that budget outcomes for 2023-24 would require departmental budgetary reductions even before taking account of inflationary pressures. They said that there was no capacity to afford a pay uplift in 2023-24 without implementing corresponding cuts to expenditure on services or additional funding being made available in year. The 2023-24 budget[17] was published in April 2023 and saw Northern Ireland departments allocated a combined resource budget of £14.2 billion, of which £7.3 billion was allocated to DoH, compared to £7.28 billion for 2022-23.

Health Service Demand and Workforce Planning

2.28 We remain conscious that while the restrictions and support for the coronavirus (COVID-19) pandemic have either stopped, or are coming to an end, there is a continuing impact on the NHS/HSC, and our remit group, from it. Waiting times and waiting lists for elective treatments have increased, and our remit group was at the forefront of responding to the pandemic at the same time as developing safe operating practices. Through the pandemic and since, our remit group has worked in difficult conditions and under a great deal of pressure, and continues to do so.

[16] https://www.gov.wales/written-statement-nhs-pay-award-enhancement-20222023-0

[17] https://www.finance-ni.gov.uk/news/department-finance-statement-202324-northern-ireland-budget#:~:text=Department%20of%20Finance%20statement%20on%202023%2F24%20Northern%20Ireland%20Budget,-Date%20published%3A%2027&text=The%20Secretary%20of%20State%20today,bn%20capital%20in%202022%2F23.

2.29 Alongside addressing these issues, governments and health service leaders must also respond to long-term issues of access and demand in planning health services and their workforces in the long-term. This is related to the ageing population, increased demand for care for chronic conditions, and increased levels of comorbidity. These changes will impact both the overall demand for services, as well as how demand is distributed across different parts of the NHS/HSC. The way that some conditions are treated also continues to evolve, necessitating further change in how services are delivered. Alongside this, long-term service and workforce transformation will change how many doctors and dentists are required to meet that demand, and also what kinds of doctors and dentists are needed.

England

2.30 DHSC said that the waiting list has grown to over 7 million, from 4.4 million at the start of the pandemic, and that activity has been recovering to pre-pandemic levels and is currently just below normal levels. They also said that it is estimated that healthcare-specific output excluding Test and Trace and vaccination had recovered to pre-COVID-19 levels. They said that additional workload to recover from the pandemic will impact on doctors and dentists who are themselves still recovering from their experiences during the pandemic.

2.31 No new workforce plan or strategy has been published for the NHS in England since *We are the NHS: People Plan for 2020/21 – action for us all* was published in July 2020. DHSC said that the Secretary of State had commissioned NHS England and Health Education England to develop a long-term comprehensive workforce plan for the NHS in February 2022. NHS England said that it would be published in Spring 2023.

2.32 In April 2023 Health Education England (HEE), NHSX and NHS Digital merged with NHS England, which DHSC said would put 'long-term planning and strategy for healthcare staff recruitment and retention at the forefront of the national NHS agenda'.

2.33 DHSC said that HEE had previously been commissioned to review long-term strategic trends for the health and regulated social care workforce and update the existing long term strategic framework for the health workforce. They also said this will help underpin actions which will ensure the system has the right numbers, skills, values and behaviours to deliver world leading clinical services and continued high standards of patient care.

2.34 NHS Employers said that the workforce plan is a vital component in reassuring an over-stretched service, that the government is willing to seriously engage in planning for the workforce required to meet the needs of the population. NHS Providers said that workforce shortages are the key limiting factor in bringing down waiting lists and delivering high quality patient care, and they said that they believe a robust long-term workforce plan and increased longer term investment in workforce expansion, education and training is the key lever to addressing these shortages. They also said that it is important that HEE's expertise is retained during their transition into NHS England, and funding for its work is protected.

Scotland

2.35 In March 2022, the Scottish Government published their National Workforce Strategy, which set out a framework to shape the health and social care workforce in Scotland over the next decade, and which outlined changes to workforce demand, and vision, values and outcomes for health and social care. The Scottish Government also said that NHS Boards and Health and Social Care Partnerships (HSCPs) were required to develop three-year workforce plans, which would align with the key policy commitments set out in the NHS Recovery plan, and were required to publish the plans on their websites by October 2022.

2.36 The Scottish Government committed to publishing projections of required workforce growth across health and social care in early 2023. They said the experience of COVID-19 has highlighted the need for a paradigm shift in the way they plan for the future health and social care needs of the population of Scotland and the workforce that delivers the services needed.

Wales

2.37 In October 2020, Health Education and Improvement Wales (HEIW) and Social Care Wales launched A Healthier Wales: A Workforce Strategy for Health and Social Care. The document is intended to support the delivery of the more seamless models of health and care proposed in A Healthier Wales: Our Plan for Health and Social Care, which was published in 2018. Included in the Strategy is a commitment to develop workforce plans for key professional and occupational groups, including medicine. The Welsh Government said that in March 2021, the 40 actions in A Healthier Wales were critically reviewed to ensure they reflected the work required to support the stabilisation and recovery of services following Covid-19 and the priorities that have been brought to the forefront by the pandemic. They also said that HEIW were due to prepare a workforce plan for dentistry this year and are working with the current cadre of undergraduates to understand their ambitions and motivations for their career.

Northern Ireland

2.38 The Department of Health said that the Workforce Strategy Second Action Plan was published in June 2022 and identifies a range of strategic actions over the period 2022-23 to 2024-25 for pre and post-registration training, attraction, recruitment and retention across all healthcare professions including doctors and dentists.

Future workforce planning context

2.39 Through our visits to Trusts and Health Boards and from evidence that we have received, we heard that more and more doctors and dentists wish to work flexibly and/or less-than-full-time (LTFT). The Scottish Government said working LTFT is becoming increasingly popular because of the flexibility it offers trainees, regardless of their grade or specialty. They also said basing training establishments on WTE (Whole time Equivalent) data rather than headcount is therefore imperative, especially in specialties with a high proportion of trainees working LTFT such as GMP. This shift may be driven to some extent by the demographic changes discussed below.

2.40 NHS England said that an older population, with different health needs, and more empowered patients, means the size and shape of the workforce, and the skills NHS staff have, will need to alter.

2.41 The Scottish Government also said that they use a participation reduction factor when performing workforce planning exercises, of 1.4, to reflect a number of factors including increased LTFT working. They said that this represents that 1.4 trainees would be required to produce one consultant or GMP.

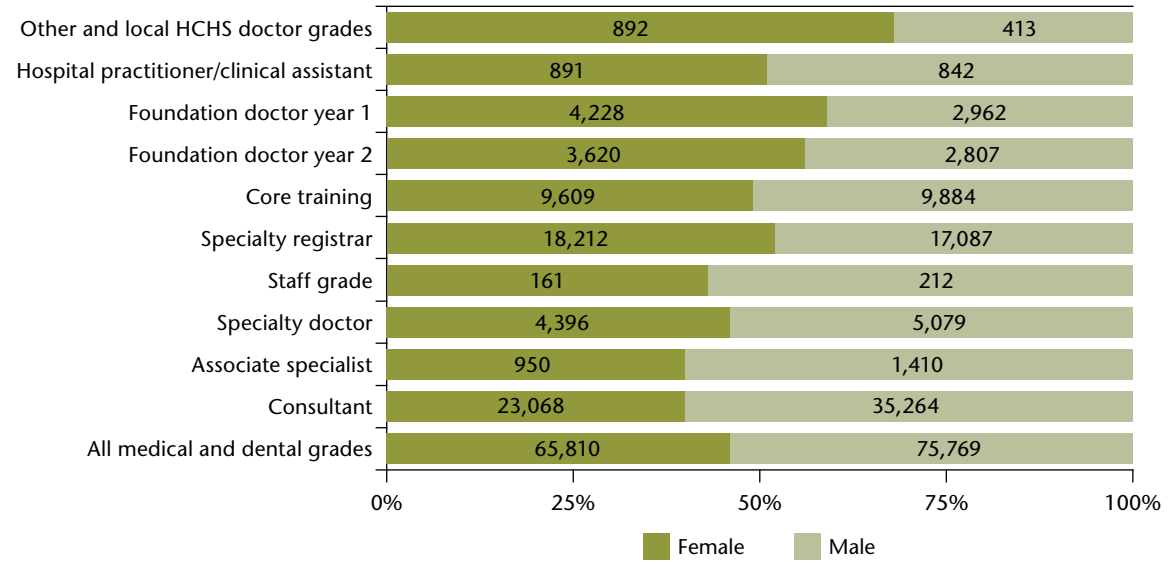
Equalities

2.42 In this section, we discuss the evolving demographic makeup of the medical and dental workforce, as well as the actions being taken by governments and health service leaders to respond to equalities issues being experienced by members of our remit group. Given the shifting demographics of our remit group, understanding and responding to these trends and issues is crucial for ensuring that the long-term challenges for workforce demand and supply are met.

Composition of the Medical and Dental Workforces

2.43 Figure 2.1 shows that in December 2022, 46 per cent of hospital and community health service (HCHS) doctors and dentists in England were female. Although 40 per cent of consultants were female, 45 per cent of SAS doctors were female, and over half of doctors and dentists in training were female. Since September 2019, prior to the onset of COVID-19, the percentage of HCHS doctors and dentists that were female has increased from 45 per cent to 46 per cent, while the percentage of consultants that were female has increased from 37 per cent to 40 per cent.

Figure 2.1: HCHS doctors and dentists, England, gender, by staff group, December 2022, headcount

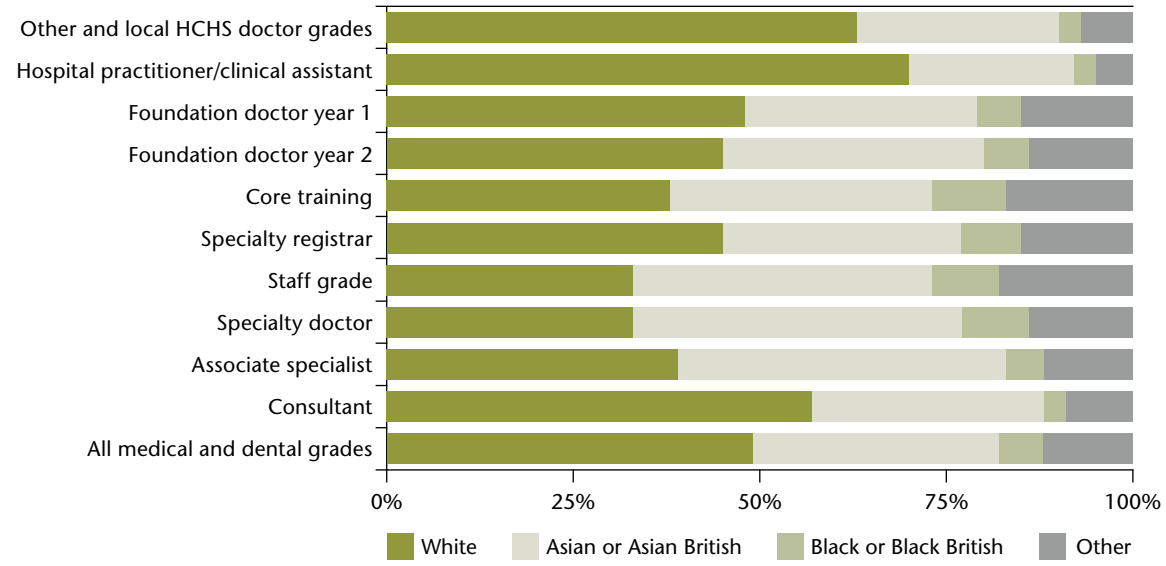


Source: NHS Digital.

2.44 Figure 2.2 shows that in December 2022, 49 per cent of HCHS doctors and dentists in England were White, 33 per cent were Asian/Asian British, 6 per cent Black, and 12 per cent were from other ethnic groups. 57 per cent of consultants were White, while doctors and dentists in the SAS grades were more likely to be Asian/Asian British than any other ethnic group. Of those in training, 43 per cent were White, 33 per cent were Asian/Asian British, 8 per cent were Black and 15 per cent from other ethnic groups.

2.45 Since September 2019, prior to the onset of COVID-19, the percentage of HCHS doctors and dentists that were: White has declined from 55 per cent to 49 per cent; Asian/Asian British has increased from 30 per cent to 33 per cent; Black has increased from 5 per cent to 6 per cent; from any other ethnic group has increased from 10 per cent to 12 per cent.

Figure 2.2: HCHS doctors and dentists, England, ethnic group, by staff group, December 2022, headcount



Source: NHS Digital.

Pay gaps

2.46 The report Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England (GPG Review) was published in December 2020[18]. DHSC said that NHSE are conducting a research project examining the Ethnicity Pay Gap (EPG) across the NHS, with aims to analyse pay-related data in a manner that gives a clearer and more accurate picture of where there are potential ethnicity-based inequalities in pay and presenting recommendations aimed at reducing inequalities where they exist.

2.47 DHSC said that the Government was committed to eliminating gender and ethnicity pay gaps. For the HCHS workforce they said that overall, male and white doctors are paid more than female and ethnic minority doctors. They also said the average earnings for white females are around 11 per cent lower than for white males, and for ethnic minority females they were around 13 per cent lower than for white females. They said these results are very similar when compared to last year.

2.48 They also said that GMP earnings data does not take account of part time working, and average participation rates are lower for female GMPs than male. They said it was therefore difficult to assess the extent to which differences in working patterns may explain the observed earnings differences between male and female GMPs of different ages.

2.49 They also said that the Gender Pay Gap Implementation Panel had agreed its second-year work programme, informed by the recommendations from the GPG Review and the progress from the first year, and the work plan is soon to be submitted to the Minister of State for Health.

[18] Department of Health and Social Care (2020) *Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England* https://www.gov.uk/government/publications/independent-review-into-gender-pay-gaps-in-medicine-in-england

2.50 NHS England said that there are accuracy and quality limitations for female and male GMP earnings and expenses data and comparing pay per FTE would facilitate a more robust investigation into the gender pay gap for salaried GMPs. They also said that on average male dentists have higher gross earnings, total expenses and taxable income than their female colleagues. They also said this could be partly explained by the data including a higher proportion of male providing-performer dentists and that male dentists tend to work more hours per week than their female colleagues.

2.51 The BMA said that increases in the provision of NHS nurseries should be prioritised. They also said that DHSC should urgently update the gender pay gap data, and that the structure of additional pay awards should have equality impact assessments in all stages of development and review to ensure that they do not exacerbate gender, ethnicity and other pay gaps.

2.52 The BDA said that there is a clear and discernible gap in pay between male and female dentists. They also said that the self-employed nature of much of the dental workforce means that determining the extent and causes of the gender pay gap is made more complex.

Wider equalities issues

2.53 NHS England said that the NHS Long Term Plan set the ambition to increase minority ethnic representation at senior levels across the NHS, and each NHS organisation is now required to set its own targets to contribute to this. They also said that they want to improve equality, diversity and inclusion (EDI) by embedding Freedom To Speak Up across primary care to give the workforce a safe place to speak up.

2.54 HEE said that the inaugural HEE EDI learner assembly helped to inform a national EDI Quality Improvement plan, that will be delivered through the HEE Quality Framework.

2.55 NHS Employers said that they believe it is particularly important to gather more information about locally employed doctors in order to promote equitable employment practices and access to support and development.

2.56 NHS Providers said that Medical Workforce Race Equality Standard (WRES) data showed that minority ethnic staff are underrepresented at consultant level, and also experience higher levels of discrimination at work, during recruitment, and in increased referral rates to disciplinary procedures. They also said the experience of staff at work, particularly for minoritised groups, shows there is much work to be done to tackle inequalities in the workplace and in wider society, including on both gender and ethnicity pay gaps.

2.57 The Scottish Government said that they will analyse responses to their iMatter Health and Social Care Staff Experience Continuous Improvement Model questionnaire survey by demographics to better understand the experience of staff from the view of protected characteristics and will be completed in 2023 for the 2021 and 2022 data. They also said the National NHS Ethnic Minority Forum was created in 2021 to amplify the voices of ethnic minority staff across the health service and tackle issues on systemic racism, and that an EDI objective has been drafted for Board Chairs.

2.58 The BMA said that their Racism in Medicine report found significantly more respondents from other ethnicities and backgrounds, compared to white British respondents, felt racism had been a barrier to their career progression. They also said they support ethnicity pay gap analysis and that more granular data and analysis is needed.

Our Comments

The economy and the labour market

2.59 We are thankful to HM Treasury for providing us with a clear account of their perspective on the state of the economy and the labour market. We would note that their analysis is principally focused on the median earners within the public and private sectors. We would therefore welcome hearing more about how their analysis of pay and reward in the public and private sectors varies across the earnings distribution.

2.60 As well as comprising almost exclusively higher earners, our remit group is also relatively unusual in a number of other ways. It is highly skilled, and has a very limited workforce supply. The vast majority of our remit group is also employed in the public sector. Therefore, there is potentially less scope for pay awards for doctors and dentists to spill over into pay demands in the wider economy than is the case for other public sector workforces.

2.61 We also note the latest economic data, as outlined above. We would in particular note that the latest data on median pay settlements across the public and private sectors, which HM Treasury said was the best comparator to public sector pay awards, from XpertHR and IDR for March 2023 were 6.0 per cent and 5.0 per cent respectively. This is significantly above the figure that DHSC said was available to fund pay awards for our remit group within current budgets and without further reprioritisation.

Affordability, public sector pay policies and finances

2.62 We acknowledge what we heard in evidence from multiple parties about the challenges being faced by health services, and their view that pay awards must be fully funded by HM Treasury in order to avoid a negative impact on services. As we have said in previous years, decisions on the resourcing of the NHS/HSC remain a political choice. In this context, we note the affordability positions that were described to us by the four governments in written evidence. In particular, we note with concern the situation in Northern Ireland, which seems to be more restrictive than for the rest of the UK.

2.63 We are also concerned that developments external to our process have called into question the integrity of the affordability evidence provided to us, and affected the wider context within which we make recommendations for pay awards for our remit group. NHS staff in England, Scotland and Wales, including some members of our remit group in Wales, received or were offered significantly enhanced pay uplifts for 2022-23, 2023-24, or both, since written evidence was submitted to us. In England, this included an offer to Agenda for Change staff for 2023-24 that was significantly in excess of the affordability figure provided to NHSPRB, which was the same 3.5 per cent figure that was provided to us. In Scotland, this included awards for 2022-23 and 2023-24 for Agenda for Change staff that were significantly in excess of what they said that they currently had available in budgets for doctors and dentists, and in Wales, this included a supplementary offer for 2022-23 that included some parts of our remit group, and part of which was consolidated. While this may be understandable given the fast-moving nature of high-profile industrial disputes, none of these governments provided to us an explanation of how these actions affected the affordability context within which we make our recommendations this year, nor how budgets for service delivery might be affected by this action. They also did not include an explanation as to whether the action being taken for Agenda for Change staff in England will lead to the devolved governments receiving consequentials under the Barnett formula, that could alter the affordability situation for them.

2.64 Our position has historically been that, in the absence of compelling evidence to the contrary, the affordability situation should be considered broadly similar across the UK, especially given the nature of the Barnett Formula. We discuss this in relation to our making recommendations in Chapter 6.

2.65 We also note what DHSC said about there being a trade-off between pay and staff numbers. However, we would stress that given the potential downsides of pay awards that are too low, this trade-off is not straightforward in practice; lower pay awards can negatively affect morale and motivation and potentially lead to worse retention and therefore lower-quality, more expensive services delivered through temporary staffing. We therefore view the affordability figures being provided by the parties to us as one of a number of key considerations that we take account of when we make recommendations, without viewing them as a formal constraint on what our recommendations can be.

Health service and workforce planning

2.66 We heard in evidence that a new workforce planning exercise for England is well-advanced. It is of critical importance that it is published soon, and we also expect that it will include fully costed and funded plans to meet long-term trends in workforce demand. It would be disappointing if, like other recent workforce planning exercises for England, this was not included, as this is central to the addressing of issues of recruitment and retention for our remit group and the rest of the NHS workforce. In the absence of such a plan, it is difficult to know whether medical and dental staffing can be considered to be sustainable in the medium- and long-term, nor how current issues with workload, and recruitment and retention, including those discussed elsewhere in this report, will be addressed.

2.67 We welcome that the Scottish Government committed to publishing projections of required workforce growth across health and social care in Scotland in early 2023, and would welcome the Welsh Government and DoH performing similar exercises for Wales and Northern Ireland, as well as outlining how they would plan to meet their long-term workforce demand.

2.68 At the same time, we acknowledge that these workforce planning exercises will be challenging. They will need to account for the long-term service transformation trajectory. There is a clear need to react to how long-term trends, including increased comorbidity and the ageing population, will place changing demands on health services. This includes the need to deliver a higher proportion of health services in community and primary care, whilst reacting to long-term shifts in which parts of health services are accessed, by who, and how. It will also be important to respond to trends in the demand for all parts of our remit group from the private healthcare sector, as growth in medical and dental workforce demand from the private sector has the potential both to necessitate increased workforce supply in the long-term, but also to affect what represents a level of pay sufficient to maintain recruitment, retention and motivation.

2.69 Alongside this, the long-term transformation of the workforce itself must be taken into account. In particular, there seems to be a shift towards falling working hours, which is happening especially quickly in general medical practice, and may be linked to some extent to the shifting demographics of the medical and dental workforces. Clearly, the overall context of falling working hours means providing the same volume of care requires a higher absolute number of staff than would otherwise be the case.

2.70 At the same time, proper consideration must also be given to the balance between domestic and international workforce supply. Long-term shifts in the competitiveness of the international labour market for doctors and dentists, potentially driven to some extent by shifts in the global and regional economy and the UK's competitiveness within it, may mean that it becomes more difficult for the UK to attract doctors and dentists from overseas to the same extent that it can do now. These shifts are also likely to provide further opportunities for doctors and dentists who are towards the beginning of their careers to work abroad, providing a further and important new challenge to retention, as this could constrain the pipeline of doctors and dentists moving towards more senior grades in future. A sustainable long-term balance must therefore be struck between domestic and international workforce supply, informed by this evolving context.

2.71 Governments may also want to consider other benefits of maintaining or increasing domestic supply, including providing more opportunities for young people in the UK to enter the medical and dental workforces, especially as demand for medical school places remains strong. Widening access to the medical profession could also help to improve social mobility. In this context we welcome progress towards introducing a medical apprenticeship, though we note that some parties have said that questions remain about the role that medical degree apprenticeships can or should play in addressing issues of workforce supply.

Equalities

2.72 The demographics of our remit group continue to shift in a variety of ways. Shifts are also not uniform across our remit group. For example, there remains significant variation in the gender makeup of different medical specialties, and the increase in the ethnic diversity of our remit group, which is affected to some extent by international recruitment, is happening at different speeds across parts of the medical and dental workforces. Therefore, we would continue to stress the need for a detailed, granular and intersectional understanding of the equalities issues faced by our remit group, and for the issues that are identified to be addressed. Such an analysis should be wide-ranging, including all protected characteristics and should also be cognisant of the social backgrounds of those in the medical and dental workforces. This is crucially important both in its own right but also for maximising recruitment and retention in the long-term. We would therefore welcome any additional data or insights that parties can provide to us in evidence in future years.

2.73 We would also welcome hearing more from all parties across the UK on the work they are doing to build on the Gender Pay Gap in Medicine Review, both in implementing its recommendations swiftly and in using it as a springboard to understanding other pay equalities issues. Doing so is increasingly critical given the shifting demographics of our remit group. We would therefore welcome hearing in detail what the current work programme of the Implementation Panel is, and how much progress it is making. While the Review covered doctors in England only, its findings are likely to be applicable to the rest of the UK, given the strong similarities between health systems. We were disappointed that we did not hear more about this in evidence this year. The findings of the Gender Pay Gap Review, as well as lessons learned from implementing its recommendations should also prove informative for understanding other pay equalities issues affecting our remit group, including for dentists, who share similarities with GMPs in particular, as well as pay equalities issues relating to other protected characteristics, including ethnicity and disability.

CHAPTER 3: THE HOSPITAL AND COMMUNITY HEALTH SERVICE (HCHS) WORKFORCE

Introduction

3.1 In this chapter, we discuss the Hospital and Community Health Service (HCHS) workforce. HCHS doctors and dentists are those directly employed by NHS Trusts and Foundation Trusts in England, NHS Boards in Scotland, Health Boards in Wales, and HSC Trusts in Northern Ireland. Key groups within this workforce include doctors and dentists in training, specialty and specialist (SAS) doctors and dentists[1] and consultants, though the HCHS workforce also includes doctors and dentists employed on local contracts. We discuss salaried dentists working in the Community Dental Services (CDS), most of whom are also part of the HCHS workforce, in Chapter 5.

Workforce Numbers

3.2 In England, the total full-time equivalent (FTE) size of the HCHS medical and dental workforce in September 2022 was 131,305. This represented a 3.1 per cent increase on September 2021. Between September 2021 and September 2022, the FTE size of the HCHS medical and dental workforce grew by 3.4 per cent to 15,348 in Scotland, by 4.4 per cent to 7,836 in Wales, and fell by 0.8 per cent to 4,892 in Northern Ireland. Equivalent figures for doctors and dentists in training, SAS doctors and dentists and consultants are included in Table 3.1.

Table 3.1 HCHS doctors and dentists, by staff group, September 2022, FTE

Group	England	Scotland	Wales	Northern Ireland (March 2022[2])
Total	**131,305**	**15,348**	**7,836**	**4,608**
% growth	+3.1%	+3.4%	+4.4%	-0.6%
Doctors and dentists in training	**65,584**	**6,632**	**3,976**	**2,063**
% growth	+3.5%	+3.9%	+5.7%	-1.5%
SAS doctors and dentists	**10,517**	**1,205**	**922**	**553**
% growth	+3.6%	+0.8%	+6.5%	+2.1%
Consultants	**53,811**	**6,032**	**2,873**	**1,929**
% growth	+2.7%	+2.2%	+2.1%	+2.3%

Source: NHS Digital. Percentage growth is compared to September 2021 (March 2021 for Northern Ireland)

[1] This diverse group comprises doctors and dentists on national contracts in non-consultant roles, who are also not actively undertaking postgraduate training. In this report they are referred to as specialty and specialist (SAS) doctors and dentists, reflecting the two contracts for this group that are open to new entrants, but when the SAS grades are mentioned collectively, doctors and dentists in a number of closed grades are also included. These are associate specialists, staff grade doctors and dentists and senior clinical medical officers.

[2] The total figure here is for March 2022, unlike the one mentioned in paragraph 3.2 so as to use data from the same month as the figures for doctors and dentists in training, SAS doctors and dentists and consultants elsewhere in the table.

Recruitment and Retention

Turnover

England

3.3 In the year to December 2022, the joining rate (on a FTE basis), which excludes staff moving between Trusts, for all hospital medical and dental staff in England, was 19.1 per cent, an increase from 17.9 per cent in the previous year. In the year to December 2022 the leaving rate, which also excludes staff moving between Trusts, was 15.0 per cent, an increase from 14.2 per cent in the previous year. The stability index, which measures the percentage of staff there at the start of the year who do not leave during the year, was 84.8 per cent in the year to December 2022, down from 85.6 per cent in the previous year.

3.4 In the year to December 2022, the leaving rates, for consultants and associate specialists, in England were 5.3 per cent and 8.2 per cent respectively. These rates represent increases from the same period a year earlier – from 5.0 per cent for consultants and from 6.8 per cent for associate specialists.

Scotland

3.5 In 2021-22, the numbers joining the service decreased from 2020-21, while the number of leavers increased over the same period. In 2021-22 the turnover rate was 11.7 per cent, as 970 HCHS medical and dental staff left the service, an increase from 594, or 7.8 per cent, in 2020-21. In 2021-22 1,240 HCHS medical and dental staff joined the service, a decrease from 1,276 in 2020-21.

Northern Ireland

3.6 In 2021-22, the joining rate for hospital medical and dental staff in Northern Ireland was lower than the leaving rate. The joining rate was 5.3 per cent, down from 5.8 per cent in 2020-21. The leaving rate was 5.9 per cent, up from 4.5 per cent in 2020-21.

The international workforce

3.7 Data from NHS Digital (Table 3.2) show that in 2022-23 32.2 per cent of HCHS doctors had a non-UK nationality, comprising 7.8 per cent from within the EU and 24.4 per cent from outside the EU.

3.8 Since 2016-17, the share of HCHS doctors with EU nationalities has fallen each year, from 9.2 per cent, to 7.8 per cent in 2022-23. The share of HCHS doctors with non-EU nationalities has increased each year since 2015-16 from 15.1 per cent to 24.4 per cent.

Table 3.2: HCHS doctors, England, by nationality, between 2012-13 and 2022-23, %, headcount

	EU (exc. UK) (%)	Non-EU (%)	EU (exc. UK) and Non-EU (%)
2012-13	7.3	16.9	24.2
2013-14	7.9	15.8	23.7
2014-15	8.4	15.1	23.5
2015-16	8.9	15.1	23.9
2016-17	9.2	15.2	24.4
2017-18	9.1	15.6	24.8
2018-19	9.1	16.6	25.7
2019-20	8.9	18.7	27.6
2020-21	8.6	19.8	28.4
2021-22	8.1	21.8	29.9
2022-23	7.8	24.4	32.2

Source: NHS Digital

3.9 Table 3.3 shows the nationalities of HCHS doctors, in September 2022, by grade. Non-UK nationals making up over 50 per cent of staff grades (58 per cent), specialty doctors (52 per cent) and core trainees (51 per cent).

Table 3.3: Medical and dental staff by nationality, September 2022, headcount, England

	EU (exc. UK)	Non-EU	EU (exc. UK) and Non-EU
Consultants	4,998 (9%)	7,099 (12%)	12,097 (21%)
Associate specialists	177 (8%)	635 (28%)	812 (35%)
Specialty doctors	803 (9%)	3,993 (43%)	4,796 (52%)
Staff grade	49 (14%)	158 (44%)	207 (58%)
Registrar	2,704 (8%)	11,249 (32%)	13,953 (40%)
Core training	1,271 (7%)	8,146 (44%)	9,417 (51%)
Foundation year 2	380 (6%)	1,542 (24%)	1,922 (30%)
Foundation year 1	444 (6%)	1,191 (16%)	1,635 (22%)
Hospital practitioner/clinical assistant	65 (4%)	91 (6%)	156 (9%)
Other and local HCHS doctor grades	62 (5%)	74 (6%)	136 (11%)
Total	10,927 (8%)	34,107 (24%)	45,034 (32%)

Source: NHS Digital

3.10 DHSC said that the ethical recruitment of health and care staff from overseas was vital, and that they had updated their code of practice for international recruitment on 2 August 2022 in line with latest advice from the World Health Organisation.

3.11 They also provided data that showed that of the 44.6 per cent of medical joiners to NHS trusts and other core organisations in England with a known non-British nationality, just under half (approximately 20 per cent of the overall number of joiners) were Indian, Pakistani, Nigerian or Egyptian.

Retirement trends

3.12 NHS England (NHSE) said that retention of doctors in later stage careers was a key concern. They said that doctors choose to leave the NHS for various reasons, including workplace pressures, lack of opportunities to work flexibly and issues relating to pensions taxation, which we discuss in more detail in Chapter 6. They said that they were piloting a programme where senior consultants would have structured 'late stage career conversations', which would cover their motivations at work, career and retirement plans, issues that would push them to leave and changes that would encourage them to stay. The conversations would then enable team-centred discussions around what changes are possible and better succession planning. They also said that anxiety about the impact of pensions tax issues was influencing senior doctors' retirement plans.

3.13 The Northern Ireland Department of Health (DoH) said that a number of consultants in Northern Ireland had retired as a result of pensions tax issues, with more considering retiring. They said senior consultants were also concerned about taking on additional sessions and were seeking more flexibility in their working patterns and opt outs from on-call work in order to stay on when later in their careers.

3.14 The Scottish Government said that pensions taxation charges were having an impact on the consultant workforce, with many senior clinicians reducing their commitment to NHS Scotland or retiring altogether as a result.

3.15 NHS Employers said doctors experiencing burnout were more likely to consider taking early retirement.

3.16 BMA Scotland said that the main factors that could improve retention for consultants in later career were actions to address issues with clinical leadership, pension taxation and career planning and development. They also said that workforce shortages and excessive workloads were considerable challenges.

England

3.17 DHSC provided data on the numbers of hospital doctors and dentists who claimed their pension in the 1995 section of the NHS Pension Scheme between 2007-08 and 2021-22, and the proportion who did so on a voluntary early retirement (VER) basis. They said that this data was not comparable to data provided in previous years, though it should be more accurate as scheme members can no longer be counted multiple times to include revised and cancelled awards, which may have led to an inflation of figures. The data show that the proportion of retirements under the 1995 section of the NHS pension scheme that were VERs increased in the early years of the 2010s, before levelling off after 2013, and falling slightly since 2017-18.

Table 3.4: NHS Pension awards (1995 section), all awards, and voluntary early retirement (VER) awards, hospital doctors and dentists, England

Year End	Hospital doctors			Hospital dentists		
	All pension awards	VER pension awards	% VER	All pension awards	VER pension awards	% VER
2008	1,400	138	10	61	9	15
2009	1,499	147	10	44	10	23
2010	1,687	190	11	69	12	17
2011	1,898	248	13	53	20	38
2012	1,828	272	15	65	16	25
2013	1,559	319	20	76	24	32
2014	1,858	334	18	55	12	22
2015	1,776	359	20	77	19	25
2016	1,854	381	21	72	27	38
2017	1,954	393	20	50	15	30
2018	1,886	339	18	78	28	36
2019	2,144	345	16	75	20	27
2020	2,285	405	18	72	16	22
2021	2,292	392	17	71	12	17
2022	2,352	354	15	51	15	29

Source: DHSC Evidence (tables 7.5 and 7.6)

3.18 NHS Digital statistics show that, between April 2021 and March 2022, of those doctors and dentists who reported their reasons for leaving, retirement was the third most likely reason (1,099 people), behind end of fixed term contract (6,216), and voluntary resignations (3,226).

Wales

3.19 Once again, we did not receive data from the Welsh Government on medical and dental retirements for this year. We would welcome information on the number of retirements, especially voluntary early retirements, from the Welsh Government for the next report.

Northern Ireland

3.20 DoH said that retirement was the second-most common given reason for leaving HSC given by medical and dental staff, after resignations. They also said that the combined effects of pensions tax issues were leading to some senior consultants and SAS doctors and dentists retiring from HSC early.

Vacancy rates

England

3.21 DHSC said that the vacancy rate for medical staff in England had shown large variation over the last four years, ranging from 4.8 to 9.0 per cent, but while the rate had increased since the height of the pandemic, it had not yet reached the same levels seen in other staffing groups. They said that vacancy rates should reflect the expected headroom for sickness absence, maternity leave and temporary staffing. They also said that stakeholders had expressed concerns that recent growth in the consultant workforce would stall due to the after-effects of the pandemic and concerns about pensions tax. They said that it was important that actions were targeted at retaining highly experienced individuals and ensuring that the total reward package for consultants remained attractive and was supported by positive working experiences.

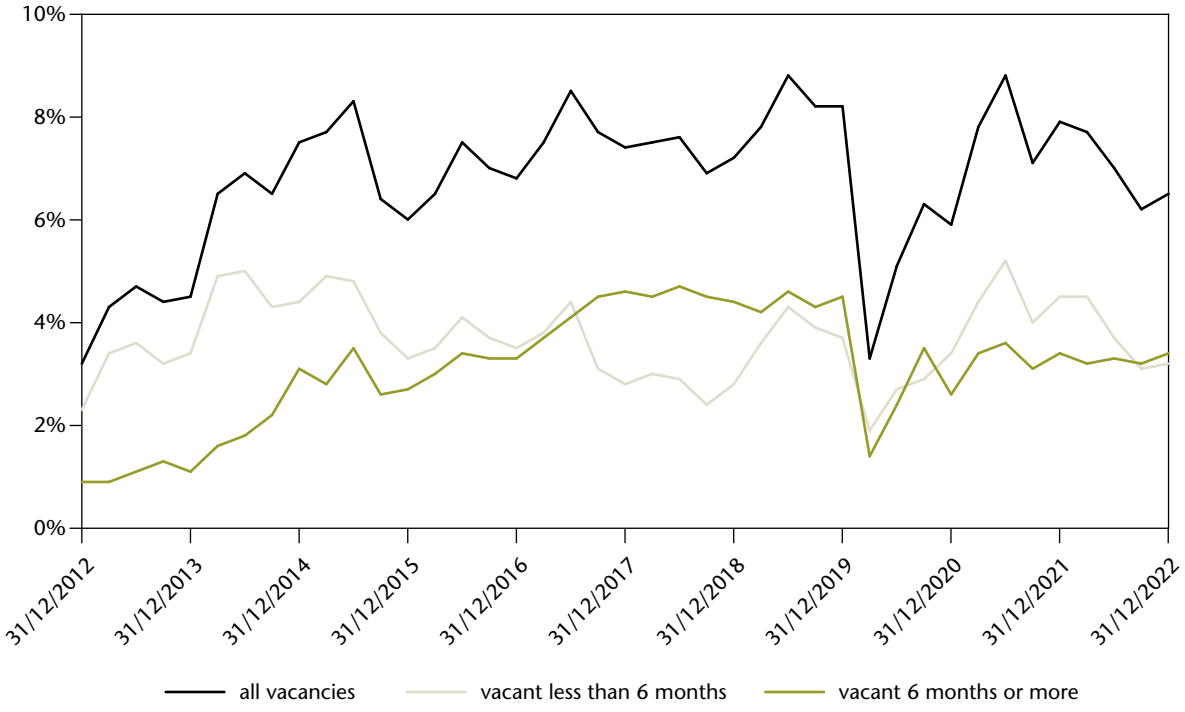
3.22 NHSE said that consultants were an essential component of the medical workforce, and that their skill set was not replaceable by workforce redesign, meaning that the consultant workforce would remain an essential component of delivering high-quality care across NHS services. They added that they were essential to providing clinical leadership, training the future generation of doctors and contributing to essential research, and that they would be important as the NHS strives to recover from the pandemic.

3.23 They said that consultant vacancies fell marginally between July and September 2022, but remained above the medium-term trend. They said that some geographies and specialties had particular difficulties.

Scotland

3.24 Data from NHS Education for Scotland showed that at the end of December 2022 there were 413 FTE vacant posts for medical consultants, a vacancy rate of 6.5 per cent (Figure 3.1). Of these vacancies, 201 had been vacant for less than 6 months and 212 vacant for 6 months or more. Compared with a year earlier the vacancy rate had fallen from 7.9 per cent, with all of the fall accounted for by a reduction in the number of posts vacant for less than 6 months.

Figure 3.1: Consultant vacancy rates, medical and dental, in Scotland, total, 2012 to 2022



Source: NHS Education for Scotland.

3.25 BMA Scotland said that according to data they had obtained through Freedom of Information requests, the true consultant vacancy rate in Scotland in September 2022 was 14.3 per cent, more than double the official rate of 6.2 per cent. They said that 48 per cent of consultant respondents to a Royal College of Physicians census reported adverse effects from consultant vacancies within their department on their work-life balance, and that 73 per cent of consultants said they wanted to work fewer Programmed Activities in future.

Wales

3.26 The BMA said that they continued to be frustrated at the continued lack of official, central data collected on medical vacancy rates in Wales. They said that they were only able to obtain data on vacancy rates through Freedom of Information requests, which were often incomplete, and made making comparisons difficult, as health boards used differing definitions of what constitutes a vacancy.

Northern Ireland

3.27 DoH said that workforce shortages within HSC were significant, with high vacancies and a consequent high reliance on locum agencies. They said that there were shortages across a range of specialties, mostly at both junior and consultant levels. They said that this was in part due to insufficient numbers in training grades coming through the education system which, coupled with younger doctors' increased desire for flexible working arrangements including reduced hours, created significant challenges for services. They also said that competition for staff from the Republic of Ireland, including new consultant contracts, was a concern, though they did not provide us with any specific details.

3.28 The BMA said that their consultant members in Northern Ireland were increasingly reporting colleagues taking up work in the Republic of Ireland, often for significantly higher pay and lower workloads. They said that the new Sláintecare consultant contracts there had placed HSC in a difficult situation.

Contract and Workforce Reform

Doctors and Dentists in Training

England

3.29 The four-year pay and contract reform deal that was agreed between the BMA, DHSC and NHS Employers concluded at the end of the 2022-23 financial year.

Scotland

3.30 The Scottish Government told us they did not currently have plans to reform their junior doctor contract. They also said that they were on target to implement a restriction to four on the number of shifts over 10 hours that a junior doctor can take during a seven-day period, by February 2023, and were working with the BMA and employers to facilitate broader improvements to rota design.

Wales

3.31 The Welsh Government said that they had worked in social partnership with NHS Wales Employers and BMA Cymru Wales to develop a new contract for doctors and dentists in training, which was based to some extent on the contract that is in place in England. However, 64 per cent of BMA members voted to reject the proposed contract. The Welsh Government said that they, employers and the BMA would reflect on the outcome of the referendum and have agreed not to abandon contract reform in its entirety, and would work together in 2023 to agree reforms, given the potential benefits to services and to doctors and dentists in training.

Northern Ireland

3.32 DoH said that a lead employer model for doctors and dentists in training had been fully implemented in Northern Ireland. They said that they and the BMA were informally discussing the potential for contract negotiations for doctors and dentists in training in Northern Ireland.

3.33 DoH also said that they were concerned that differences in pay and contracts between Northern Ireland and the rest of the UK were leading to those entering training in Northern Ireland potentially facing a significant drop in pay, which was making training there less attractive.

SAS Doctors and Dentists

England, Wales and Northern Ireland

3.34 Two new SAS contracts were introduced in England, Wales and Northern Ireland from the start of the 2021-22 financial year, a reformed Specialty Doctor contract and an entirely new Specialist grade and contract. The new Specialist grade was introduced to serve as a more senior grade within the overall SAS workforce, replacing the Associate Specialist grade that was closed to new entrants in 2008. Under the terms of the framework agreements between the three governments, NHS Employers and the BMA, new, shorter pay scales would be introduced over the three years to 2023-24, with 3 per cent overall investment into the pay scales made annually.

3.35 The contracts in England, Wales and Northern Ireland apply to all new staff entering the SAS grades from 1 April 2021. Existing SAS doctors and dentists employed on national terms and conditions of service have had the opportunity to choose to transfer to the new Specialty contract or remain on their current contract. Similarly, doctors and dentists on national terms and conditions in the closed Associate Specialist grade were able to choose to move onto the new Specialist contract. Under the framework agreement, recommendations would still be sought from us for doctors and dentists who choose to stay on the old contracts.

3.36 DHSC said that the contract deal includes improvements to pay progression, with those on the new Specialty Doctor contract now progressing to the top of the pay scale five years faster. They also said that the contract deal includes new safeguards, the introduction of the SAS advocate role, an additional day of annual leave after seven years' service, increases to on-call availability supplements to create parity with consultants and modernised terms and conditions. The contract extends the definition of plain time, from 7am to 7pm to 7am to 9pm on weekdays.

3.37 DHSC said that uptake had been driven by joiners from other grades or new joiners to the NHS, as the uplifts awarded to those on the closed contracts had been higher. They said that if the 2008 contracts (the older contracts that most existing SAS doctors and dentists were employed on prior to the introduction of the new contracts in 2021) were uplifted by an amount higher than the average investment in the 2021 contracts, this will lead to further divergence between the two pay scales. They said that it was important that the DDRB consider the future position of the SAS workforce when making recommendations this year, and that it was important to protect the long-term appeal of the new contract in comparison to both the closed SAS contracts and the rest of the medical and dental workforce.

3.38 They also said that the growth in the number of specialists was more than making up for attrition in the associate specialist grade, and they anticipated that the number of specialist posts would continue to increase as employers become more familiar with it and the benefits it can bring.

3.39 NHSE said that, as a result of the uplifts applied to the old SAS contracts during the last two pay rounds, it was not attractive financially in the short-term for some SAS doctors to move to the new grades, and that they would wish to see a coherent set of national grades for this group of doctors.

3.40 NHS Employers said that SAS contract reform aimed to support employers to attract, motivate and retain SAS doctors and dentists, but fewer transferred to the 2021 Speciality Doctor contract than originally forecast, with the main contributing factor being the uplifts that were applied for those on the old contracts, as the uplifts for those on the new contracts had been determined on the assumption that pay awards would be lower. They said that in specific pay terms the incentive to transfer was diminished, and that remedial action would be necessary to reset the pay differentials between the open and closed contracts to encourage transition onto the new contracts as an attractive career option. They said that employers would welcome seeing the pay points for the old contracts being frozen in value in 2023-24.

3.41 They also said that the creation of specialist posts was to be driven by employer need with funding secured locally, and they were aware that some employers were experiencing difficulties with this, which had contributed to slow uptake. However, they said they were confident that this issue would diminish over time. They also said that the 2022-23 pay awards meant that the top of the old specialty doctor pay scale was now above the bottom of the specialist pay scale, which was not intended when the new grades were introduced.

3.42 NHS Employers also told us that as of September 2022, there were 522 specialist doctors in England, representing 22 per cent of the senior SAS workforce[3], and there were 3,462 specialty doctors on the new contract, representing 37 per cent of the overall specialty doctor workforce.

3.43 In response to our recommendations last year, the Welsh Government did not uplift the top of the pay scale for the old Specialty Doctor contract in line with our recommendations, instead giving those affected a non-consolidated payment of 4.5 per cent. In a letter to the DDRB Chair, the Minister for Health and Social Services said that she would freeze the top pay point for the old contract until it was aligned with that of the new, in order to preserve the integrity of the new contract's pay scales.

3.44 The Welsh Government also provided data on how many doctors and dentists were employed on the old and new Specialty Doctor contracts, the new Specialist contract and the old Associate Specialist contract, included as Table 3.5, below. Those on the new contract represent both those that have moved over from the old contract and those that are new to the grade since the contracts were introduced in 2021.

[3] The senior SAS workforce is defined here as comprising specialists and associate specialists.

Table 3.5: Total SAS doctors and dentists in NHS Wales by contract type, as of 18 October 2022

Contract type	Headcount	FTE
Specialist (2021)	16	14.3
Specialty Doctor (2021)	422	383.3
Associate Specialist (closed)	171	149.9
Specialty Doctor (2008)	441	379.1

Source: Welsh Government written evidence (Table 25)

3.45 DoH said that only a small number of SAS doctors and dentists had moved over to the new contract, and it was not anticipated that many more would do so, given the size of DDRB recommendations in 2021 and 2022.

3.46 The BMA said that many more SAS doctors and dentists would see a drop in their pay if they chose to transfer onto the new contracts than was previously projected, and they were hearing of more doctors on the new contract regretting their decision to transfer. They said that they opposed the governments' request that we do not make recommendations for this group this year. They also said that the decision by the Welsh Government not to uplift the top pay point of the old Specialty Doctor contract was concerning, and said it went against the framework agreement that had been co-signed by the Welsh Government and NHS Employers.

3.47 The BMA said the refusal to award anything beyond what was agreed as part of the multi-year deal had led to the numbers transferring to the new contract being well below projections. They said that most respondents to a BMA survey about this issue said that this was driven by pay issues, and the new definition of plain time included in the contract, a message that was also reflected during our visits programme. They also said that there was now an anomaly whereby those at the top of the old Specialty Doctor pay scale would see their pay drop on being promoted to the Specialist grade.

England

3.48 NHS Employers said that they encouraged trusts to allocate adequate resources to SAS advocates, but it was not a contractual requirement. They also said that they were working with a newly established network of SAS advocates to promote the creation of the role, share best practice and promote the health and wellbeing of SAS doctors and dentists. They also said that they had worked with the BMA on SAS Week in October 2022, which aimed to provide a platform for the work and value of SAS doctors and dentists to be highlighted and promoted.

3.49 The BMA said that the number of Trusts that had appointed SAS advocates remained disappointingly low.

Northern Ireland

3.50 DoH said that there were a number of initiatives in place to value and develop SAS doctors and dentists, including an Interdisciplinary Training Forum, and a national SAS week that included daily meetings discussing and promoting aspects of the SAS contracts and opportunities for professional development. They also said that they had provided regional funding for the development of SAS doctors and dentists, including offering bespoke training courses.

3.51 The BMA said that they were concerned about ongoing uncertainties over how the SAS contract deal would be funded.

Scotland

3.52 A reformed Specialty Doctor contract and a new Specialist contract, similar to the rest of the UK though without the new definition of plain time, was introduced in Scotland on 1 December 2022 following a ballot of BMA members. As in the rest of the UK, existing specialty doctors and dentists can choose to move onto the new contract. The Scottish Government also said that specialists in Scotland will be able to act as an autonomous decision maker. The contracts were introduced without a multi-year pay deal and recommendations have been sought from us for both new and old contracts. They said that over 90 per cent of existing specialty doctors and dentists had expressed an interest in moving onto the new contracts, significantly more than they were expecting.

Consultants

Contract Reform

England

3.53 DHSC said that while they had ambitions to press forward with consultant contract reform, given the current fiscal climate it was unlikely that they would be able initiate a full programme of contract reform in the near future. However, they said that they would also wish to make progress towards addressing the recommendations of the Gender Pay Gap in Medicine Review, even in the absence of substantive reform. In particular, they said that there may be some opportunity in future to use annual pay uplifts to make incremental changes to start the move towards merging pay points and reducing the overall time taken to reach the top of the pay scale. They said that, if done gradually over a number of years, this could be achieved within the affordability envelope for pay by differentially distributing funds and targeting larger and smaller uplifts at certain pay points.

3.54 NHS Employers said that in 2018 the government had offered the BMA and HCSA a multi-year deal for consultants based on the funding that was available at the time, but they decided not to enter into meaningful negotiations, unless the proposals were combined with pensions tax flexibilities, and so contract reform discussions were paused. They added that consultant contract reform was not one of the immediate priorities set out in the NHS Long Term Plan. However, they also said that employers would still welcome the opportunity to modernise the consultant contract and reform the pay structure, including promoting greater flexibility about deployment and addressing the recommendations of the Gender Pay Gap in Medicine Review. They said that employer priorities would include shortening the pay scale, modernising terms and conditions and removing the clause under which consultants have the right to refuse non-emergency work between 7pm and 7am to enable better deployment. They said that there was some support among employers for targeting pay awards to help address the gender pay gap, but this position was not held universally. They added that an alternative could be to create a contract for new starters, with those on the current contract being able to optionally transfer over.

Northern Ireland

3.55 DoH said that no real progress had been made towards consultant contract reform in Northern Ireland.

Clinical Excellence Awards (CEAs), Clinical Impact Awards (CIAs), Commitment Awards, Distinction Awards and Discretionary Points

National CIAs (England and Wales)

3.56 DHSC said that the 2022 National CIA round was underway, and they anticipated confirming outcomes to applicants in early 2023. They said that, while it was still too early to fully assess the impact of the reforms, they had seen positive signs in provisional application data that more female and ethnic minority consultants are engaging with the scheme. Through the implementation of a new application portal, the Advisory Committee on Clinical Impact Awards (ACCIA[4]) hopes to report more accurately on the diversity of the scheme in future years; current data available reflected applications, with success rates to be confirmed once the 2022 outcomes had been publicised.

3.57 DHSC said that the overall budget for the National CIA scheme would grow by approximately 1 per cent per year, to reflect projected growth in the size of the consultant workforce. They said that the award values would remain subject to DDRB recommendations, and therefore any uplift in their value would require reprioritisation, and they asked that the DDRB allow the reforms to be fully implemented prior to making uplift recommendations.

[4] ACCIA was previously the Advisory Committee on Clinical Excellence Awards but was renamed to reflect the new name for the scheme.

Local CEAs (England)

3.58 DHSC said that following the failure to reach collective agreement on a new local CEA scheme, new arrangements had come into effect which allow employers a significant degree of local flexibility to run their schemes to suit their own priorities. They said that unfortunately, it had not been possible to reach agreement with the trade unions on joint guidance to support employers to run their new schemes. They said that the arrangements in place required employers to spend £7,900 annually per eligible FTE consultant, covering both consolidated awards that were made before 2018 and new awards, and that they would expect the amount spent on consolidated awards to reduce over time as staff retire, leave the service or accept a National CIA award, which would leave a greater proportion of funding available for new awards. They said their ambition remained for local employers to increase and diversify the distribution of awards, effectively tackle issues of inequity, and ensure engagement and participation is encouraged.

3.59 DHSC also said that they understood that in the first year of the new arrangements most employers had agreed not to run an awards round, instead distributing the funding equally amongst eligible staff members after existing awards had been paid out.

3.60 NHS Employers said that concerns had been raised about the amount of time and resources necessary to process reviews of pre-2018 awards. They said that employers planned to return to a full competitive award round for the 2023-24 award year. They also said that employers felt that local CEAs should end, and available funds should be redirected to support wider contract and/or pay structure reform. They said that this was influenced by concerns over the administrative burden of running the rounds, and whether the process can be considered truly fair and equitable.

Distinction Awards and Discretionary Points (Scotland)

3.61 The Scottish Government said that there was no evidence to suggest that an adverse impact had resulted from the freezing in value of Distinction Awards (DAs) and Discretionary Points (DPs) since 2010, and that while DAs are closed to new entrants, the number of DPs awarded continue to grow in line with growth in the size of the consultant workforce. They said they were not seeking recommendations from us for DAs and DPs.

3.62 The BMA said that the closure of the DA scheme to new entrants had led to significant savings for the Scottish Government that had not been reinvested elsewhere into the overall pay offer for consultants in Scotland.

Commitment Awards (Wales)

3.63 The Welsh Government said that no progress had been made towards reforming Commitment Awards in 2022-23.

CEAs (Northern Ireland)

3.64 DoH said that they were working with the BMA to co-design a new, revised CEA scheme. They said that the underlying principle of the scheme is to reward excellence over and above the standard normally expected of a consultant. They also said the draft objectives of the proposed new scheme include encouraging consultants to develop and deliver high-quality services, encouraging excellence, innovation and leadership, and attracting and retaining staff, as well as being a fair and transparent scheme for all those eligible. They said that they aimed to have developed an outline scheme with the BMA by April 2023, though implementing it would be a matter for an incoming Minister.

3.65 The BMA said that they were committed to the process of creating and agreeing a framework for a new CEA scheme in Northern Ireland, and they were hopeful for a successful outcome.

The Training System

Doctors and dentists in training

3.66 After completing medical school, which normally takes around five years, doctors in the UK begin their hospital training in the Foundation Programme, normally a two-year, general post-graduate medical training programme, where they are known as foundation doctors (F1 and F2). Following this training, doctors can enter specialty training which, depending on the specialty, may include two or three years' core training, or enter general practice training. Dentists undertake a training programme of around five years' undergraduate study at dental school, after which there is a dental postgraduate training system that includes a one-year foundation programme which all dentists who wish to practice NHS/HSC dentistry must complete. After this foundation programme dentists choose whether to work in primary care dentistry or train to work in a hospital setting.

3.67 Doctors in training, often referred to as junior doctors, comprise doctors undertaking the foundation programme or core, specialty, or general practice training. General practice training takes at least three years, and core and specialty training together at least six. On completion of specialty training, doctors receive the Certificate of Completion of Training from the General Medical Council (GMC) and become eligible for consultant roles. Doctors may also, if they wish, leave training prior to completion, entering the SAS grades.

Undergraduate medical and dental training

3.68 Table 3.6 shows the time series from 2019 to 2022 for the numbers of applicants[5] and acceptances[6] to study medicine courses. The equivalent figures to study dentistry are shown in table 3.7[7].

[5] Number of unique applicants: defined as the number of applicants making at least one choice through the main UCAS scheme.

[6] Acceptance: defined as an applicant who has been placed for entry into higher education.

[7] Using the Common Aggregation Hierarchy (CAH) of subjects, medicine (CAH01-01-02), dentistry (CAH01-01-04). Differs from the data in previous reports which was based on the Joint Academic Coding (JACS) system of classifying academic subjects.

3.69 In 2022 there were 24,155 applicants to study medicine, of which 10,155 were accepted on a course. Compared with 2021, this represents a reduction of 10.1 per cent in students accepted on to courses and an increase of 0.7 per cent in the number of applicants.

3.70 In 2022 there were also 4,280 applicants to study dentistry in the UK of which 1,310 were accepted on a course. Compared with 2021, this represents a reduction of 15.2 per cent in students accepted on to courses and an increase of 8.9 per cent in the number of applicants.

Table 3.6: Numbers of applicants and acceptances to study medicine, UK, 2019-2022

	Number of Applicants	Number of Acceptances	Applicants per Acceptance
2019	18,780	9,890	1.90
2020	19,485	10,860	1.79
2021	23,995	11,295	2.12
2022	24,155	10,155	2.38

Source: OME estimates using UCAS data

Table 3.7: Numbers of applicants and acceptances to study dentistry, UK, 2019-2022

	Number of Applicants	Number of Acceptances	Applicants per Acceptance
2019	3,330	1,380	2.41
2020	3,580	1,605	2.23
2021	3,930	1,545	2.54
2022	4,280	1,310	3.27

Source: OME estimates using UCAS data

3.71 The gender and ethnic composition of those accepted to study for medical and dental degrees has changed between 2019 and 2022. Over that period the share of students accepted onto medical degree courses that were female had increased from 62 per cent to 63 per cent. For dentistry, the proportion increased from 68 per cent to 72 per cent.

3.72 Table 3.8 shows the ratio of applicants to acceptances in 2022. Medicine and dentistry has a greater ratio of applicants to acceptances than other subject areas.

Table 3.8: Undergraduate subjects, ratio of applicants to acceptances, United Kingdom, 2022

Subject area	Ratio of applicants to acceptances
Medicine and dentistry	2.41
Veterinary sciences	1.77
Subjects allied to medicine	1.55
Social sciences	1.37
Education and teaching	1.36
Mathematical sciences	1.35
Design, and creative and performing arts	1.34
Engineering and technology	1.34
Computing	1.31
Combined and general studies	1.29
Business and management	1.29
Biological and sport sciences	1.26
Media, journalism and communications	1.26
Psychology	1.26
Law	1.25
Agriculture, food and related studies	1.23
Architecture, building and planning	1.23
Historical, philosophical and religious studies	1.23
Physical sciences	1.19
Language and area studies	1.19
Geography, earth and environmental studies	1.18

Source: OME calculations using UCAS data

3.73 DHSC said that they expected the pandemic-related increase in the size of medical school intakes in 2020 and 2021 would lead to there being an increase in the number of new doctors joining the NHS workforce in 2025, and this would help the build the resilience of the medical workforce. They also provided data that suggested that the medical school intake in England had returned to approximately its normal level of 7,500 in 2022.

3.74 DHSC said that Health Education England (HEE) was working with a range of partners to develop a medical apprenticeship, and that funding for 200 medical doctor degree apprenticeships had been confirmed as part of a pilot scheme. They said that medical apprentices would be trained to the same high standard as traditional education routes and would meet all GMC requirements. They said the apprenticeship had been introduced to make the profession more representative of local communities, and it aimed to recruit students from varying backgrounds, including those who may have struggled to pursue a traditional medical education.

3.75 The Scottish Government said that for 2022-23, they had approved a medical undergraduate intake of 1,317, which represented a 55 per cent increase compared to 2015-16. They said that their 2021-22 Programme for Government committed to increasing medical school places by 500 over the lifetime of the Scottish Parliament, and the first 100 places of this commitment was delivered in 2021-22.

3.76 The Welsh Government said that they were establishing a new independent medical school in North Wales so that more medical students could be trained in Wales and so that training opportunities could be better distributed across Wales. They said that it would create another 140 undergraduate training places annually over the forthcoming years.

Recruitment and training choices

England

3.77 HEE said that recruitment into specialty training remained competitive, with over 45,000 applicants across UK training programmes in 2022-23, compared to 40,000 in 2021-22. They said that fill rates at the CT1/ST1 level were 99.75 per cent, including the target of 4,000 acceptances into general practice training being met. They added that fill rates for higher specialty training remained generally strong at 87 per cent, but there were some specialties that required remedial action due to low fill in recent year, including palliative medicine and paediatric and perinatal pathology. They said that action could include financial incentives.

3.78 HEE said that they had worked with NHSE to develop a robust model for guiding the geographic distribution of training posts, and it was being piloted in three relatively large specialties (haematology, cardiology and obstetrics and gynaecology), as part of efforts to tackle health inequalities. They said that this was based on evidence that they had seen that upon completion of training, most doctors settle to practise permanently throughout their careers, and there was also evidence that there was a misalignment between staffing levels and patient need. They said that the first tranche of training posts in their new locations commenced in August 2022, and following further discussions, they aimed to reallocate training places for the remaining medical specialties over the next 10-15 years.

Flexible Pay Premia

3.79 The contract for doctors and dentists in training in England includes flexible pay premia (FPPs) for general practice training, hard-to-fill training programmes including emergency medicine, psychiatry, histopathology and oral-maxillofacial surgery and for clinical academic trainees.

3.80 HEE said that FPPs had helped improve recruitment for hard-to-fill specialties, as it made it clear to potential applicants that working in those specialties was valued. They also said that the potential to award FPPs based on geography could complement their work to redistribute training places geographically.

3.81 DHSC said it was hard to evaluate the success of FPP-type payments without fully understanding the reasons that trainees chose their specialties, and the choices they would have made had the FPP not been available. They also said that pay was not the only factor that influenced choice of specialty.

Targeted Enhanced Recruitment Scheme (TERS)

3.82 TERS is an initiative that offers a one-off payment of £20,000 to general practice trainees committed to working in particular locations where recruitment had previously been challenging. The scheme is currently active in England, Scotland and Wales. The sum is repayable if the trainees leave the programme during the training period. The sub-regional areas covered by TERS in England saw over 96 per cent fill rates in 2021-22. HEE said that TERS had proved successful in attracting GMP trainees to hard-to-recruit areas, but as a relatively new scheme, evidence did not yet exist that the scheme improves long-term retention post-qualifying. They said that longitudinal tracking was needed to ascertain if TERS trainees remain in area post-CCT, and they were working with NHSE to support a review of TERS ahead of negotiations for the next iteration of the GMP contract.

Flexible Training

3.83 HEE said that they had further developed the options available for trainees to undertake training flexibly, as part of their Enhancing Junior Doctors' Working Lives (EJDWL) programme. They said that in 2021-22, this included expanding the availability of category 3 (personal choice) less-than-full-time (LTFT) training to all specialties, extending the Out of Programme Pause offer, embedding the Supported Return to Training programmes, and continuing to develop the Flexible Portfolio Training scheme.

Scotland

3.84 The Scottish Government said that their postgraduate training places in 2022 had a 93 per cent fill rate, including a 96 per cent fill rate for foundation training, a 99 per cent fill rate at CT1/ST1, a 98 per cent fill rate for general practice training and an 80 per cent fill rate for higher specialty training. They said that while fill rates were slightly down on 2021, the total number of places that had been filled was the highest they had ever recorded.

3.85 The Scottish Government said that they were adding a further 152 training places in 2023, on top of the 139 additional places that were created in 2022. They said that this would include 35 more general practice training places in 2023, and their annual foundation training intake had increased by 105 over the course of 2021 and 2022. They said that the number of training places they maintained was informed by modelling assumptions that were agreed between 2010 and 2013, and included a 'participation reduction factor' of 1.4 to reflect LTFT working. They said that it was important that trainee numbers and training establishments reflected the need for consultants in future.

3.86 They also said that they were making progress towards basing training establishments on FTE, rather than headcount, to reflect increased LTFT working.

Progression through training

3.87 DHSC said that the pandemic had had a significant cumulative impact on the postgraduate medical and dental training pipeline, as doctors were redeployed to COVID-19-facing settings or had elective learning opportunities cancelled. They said that the necessary interventions they and system partners had made to ensure that trainees could continue to progress through training had been effective, and that by the start of the 2022-23 academic year, they estimated that 3 per cent of trainees were at risk of COVID-19-related delays to their progression through training. They also said that they, the BMA and NHS Employers had agreed guidance on measures to address the career earnings impact of pandemic-related delays to progression through training.

3.88 HEE said investment and support would continue to be required to enable progression for the 3 per cent of trainees who continue to require additional training time or carry a future extension risk. They said that they invested £26 million in supporting postgraduate trainees in 2021-22 and £25 million in 2022-23. Actions included ensuring every trainee in England was able to have an individualised, one-to-one conversation with an education supervisor or training programme director, to identify their training and wellbeing needs. They also said that they were continuing to monitor trainee progression regularly, including whether placements ensured access to learning and curriculum opportunities, identifying risks to experiential learning and progression, and on the number of extensions to training made.

3.89 The Scottish Government said that in Annual Reviews of Competence Progression (ARCPs), 2.6 per cent of outcomes recorded in the 2021-22 academic year reflected the impact of the pandemic, down from 14 per cent in the 2019-20 academic year.

3.90 DoH said that similar funding to that provided by DHSC in England to enhance training following the disruption through the pandemic was not available in Northern Ireland.

Trainee experience

3.91 HEE said that results of the most recent National Education and Training Survey were positive, with 87 per cent of respondents saying that their educational supervision was satisfactory or better, and 92 per cent of respondents saying their overall supervision was satisfactory or better. They also said that they had discussed with the Royal Colleges the costs to trainees of training and exams, an issue that is frequently raised with us during our visits programme, and were encouraging them to be more transparent about the costs of exams. They also said they were working with the GMC on an evaluation of the costs and benefits of postgraduate exams more generally.

3.92 HEE also said they were working with postgraduate deans to help to minimise the strains that movement between placements can cause for trainees. They said that deans had asked their teams to minimise rotational distance where possible, and to review their training programmes in order to achieve progress towards this aim. They also said they worked closely with the BMA and other stakeholders on providing a consistent approach to supporting trainees with the financial costs of moving.

3.93 DHSC said that the EJDWL programme, which was a cross-system collaboration led by HEE, would include initiatives including reforming study budgets and study leave, and delivering greater flexibility in medical training.

3.94 The Scottish Government said that most trainees in Scotland continued to be satisfied with the quality of their training, consistent with the rest of the UK. They also said that they were working with NHS Education for Scotland to streamline selection and recruitment processes, improve flexibilities within training programmes and offer Out of Programme opportunities.

3.95 DoH said that they had reactivated the Strategic Group to Enhance the Quality of Medical Education in Northern Ireland (SGEQMENI), which aimed to enhance the quality of undergraduate and postgraduate training in Northern Ireland. They said that SGEQMENI had made a number of recommendations that would make a difference to the lives of trainees, increase morale and reduce the risk of burnout. These included facilitating dedicated time for education and personal development, appointing dedicated rota organisers so that trainees can be made aware of their rotas six weeks in advance, adopting the BMA's Fatigue and Facilities charter, appointing leads for junior doctor engagement and inclusion, ensuring trainees work in teams and appointing senior pastoral care leads with responsibility for junior doctor wellbeing.

Motivation, Morale and Wellbeing

England

3.96 Since our 2022 Report, the 2022 survey of NHS Staff in England was published. It was conducted between September and December 2022, and over 44,000 medical and dental staff responded.

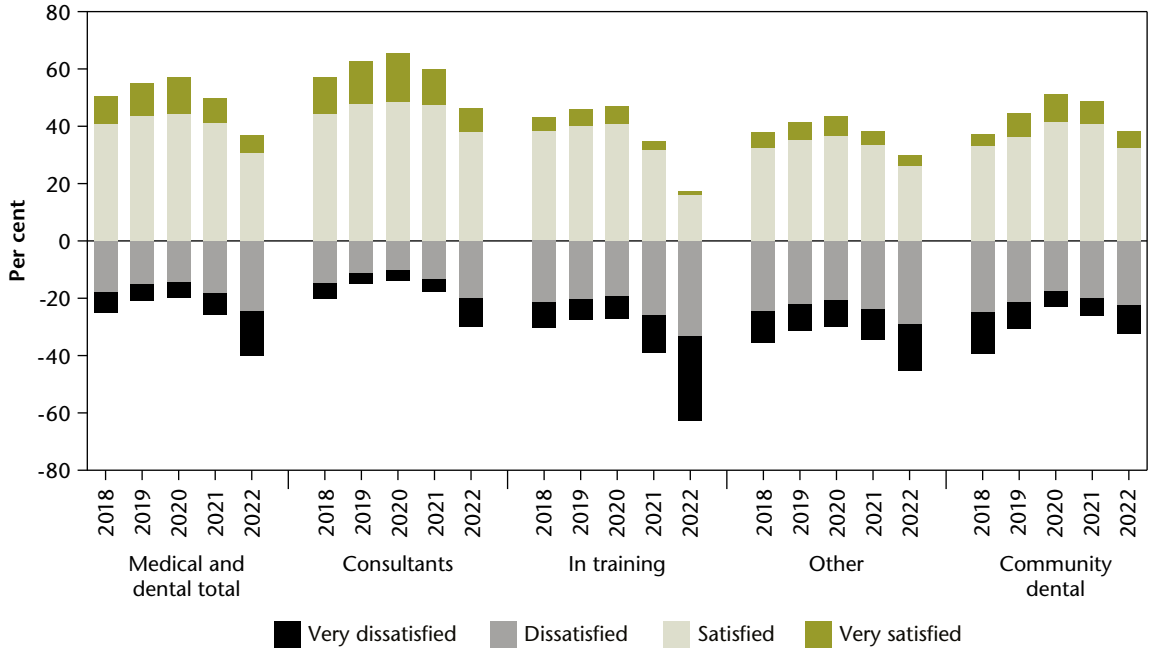
3.97 In 2022, 37 per cent of medical and dental staff responding said they were satisfied[8] with their pay, a decrease of 13 percentage points, from 50 per cent in 2021 (Figure 3.2), and the lowest recorded since at least 2018. There was a decrease in satisfaction with pay for consultants, specialty doctors and associate specialists, doctors and dentists in training, and community dentists.

- A larger proportion of consultants said they were satisfied with their pay than other groups. In 2022, 46 per cent said they were satisfied, a decrease of 14 percentage points from 2021.
- For doctors and dentists in training, in 2022, 17 per cent said they were satisfied with pay, a decrease of 17 percentage points compared to 2021.

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

- For the 'other' group (comprising mainly SAS doctors and dentists), 30 per cent said they were satisfied with pay, a decrease of 9 percentage points from 2021.
- For community dentists, 38 per cent said they were satisfied with their pay, a decrease of 10 percentage points from 2021.

Figure 3.2: HCHS doctors and dentists satisfaction with level of pay, England, 2018 to 2022

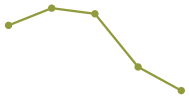
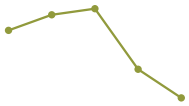
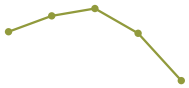
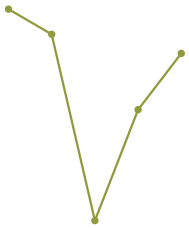


Source: NHS Staff Survey.
Note: The percentage saying "neither satisfied nor dissatisfied" omitted throughout this chart.

3.98 Looking across a range of measures related to job satisfaction, the results for medical and dental staff as a whole in 2022, were generally worse than in each of the previous four years (Table 3.9).

- The percentage of staff saying that: they looked forward to going to work; were enthusiastic about their job; that time passed quickly at work; they were satisfied with the recognition they got for good work; their line manager valued their work; they would recommend their organisation as a place to work; their organisation values their work; they were satisfied with their pay, was at the lowest level since at least 2018.
- Over one third of respondents said that they experienced harassment, bullying or abuse from patients, relatives or the public, an increase from 2021.
- Almost a quarter of respondents said that they were considering leaving the NHS, an increase from 20 per cent in 2021.

Table 3.9: Selected results from the National Staff Survey, medical and dental staff, England, 2018 to 2022

Measure	Question number in 2022 survey	2018	2019	2020	2021	2022	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	2a	66.8	67.1	65.6	58.1	54.7	
I am enthusiastic about my job	2b	77.4	77.4	75.2	68.2	64.9	
Time passes quickly when I am working	2c	82.8	82.2	80.5	77.1	74.8	
The recognition I get for good work	4a	57.7	60.0	59.0	51.8	48.5	
My immediate manager values my work	9e	69.7	71.1	70.6	66.6	65.0	
Considering leaving the NHS[2]	24d	19.6	18.4	16.2	20.2	24.4	
Recommend my organisation as a place to work	23c	66.0	67.2	69.7	62.0	58.0	
The extent to which my organisation values my work	4b	48.3	50.4	51.1	42.9	39.2	
My level of pay	4c	50.6	55.0	56.9	49.8	36.6	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]	14a	36.2	35.8	32.8	34.6	35.5	

Source: National NHS Staff Survey

Notes: Data rounded to 1 decimal place

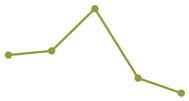
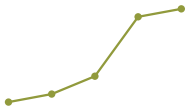
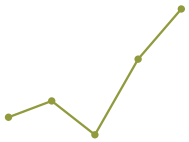
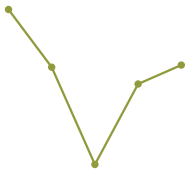
(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure

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

3.99 In 2022 workload pressures generally remained high and worsened since 2021 (Table 3.10). In 2022:

- The percentage of staff saying that: they were able to meet all the conflicting demands on their time; they had adequate materials, supplies and equipment to do their work; there were enough staff at their organisation for them to do their job properly was at the highest level since at least 2018;
- The percentage of staff saying that they had felt unwell as a result of work related stress, 45.7 per cent, was at the highest level since at least 2018;
- Compared with 2021, there was an increase in the percentage of staff saying they worked paid hours over and above their contracted hours and an increase in the percentage saying that they were working unpaid hours over and above their contracted hours.
- New questions were added to the survey in 2021, covering work-life balance and burnout. In 2022, the results had worsened from 2021; 40 per cent of respondents said that they were able to achieve a good balance between work and home life, while 35 per cent said that were feeling burnt out because of work.

Table 3.10: Selected results from the National Staff Survey, medical and dental staff, England, 2018 to 2022

Measure	Question number in 2022 survey	2018	2019	2020	2021	2022	Trend[1]
Workload							
I am able to meet all the conflicting demands on my time at work	3g	36.5	38.3	41.1	35.3	32.8	
I have adequate materials, supplies and equipment to do my work	3h	50.4	51.4	56.5	50.1	45.0	
There are enough staff at this organisation for me to do my job properly	3i	29.4	30.3	39.0	24.6	21.5	
During the last 12 months have you felt unwell as a result of work related stress?[2]	11c	37.3	38.0	39.8	45.0	45.7	
Achieve good balance between work and home life	6c				41.5	39.9	
Feeling burnt out because of work[2]	12b				33.1	35.3	
Percentage of staff working PAID hours over and above their contracted hours?[2]	10b	42.7	43.6	41.8	45.6	48.1	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]	10c	80.8	78.8	75.2	78.1	78.8	

Source: National NHS Staff Survey

Notes: Data rounded to 1 decimal place

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

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

3.100 DHSC said that the staff survey results for 2021, which were the latest available at the time they submitted written evidence, suggested a picture of a system under sustained pressure, which was impacting on staff's experience working in the NHS. They said that considerable work through the NHS People Promise had been undertaken to support staff wellbeing, create a compassionate and inclusive culture and leadership, and promote flexible working opportunities. They said that in addition to national investment in specialist mental health and wellbeing support, NHS organisations had wellbeing guardians, and line managers had been given training to support them to facilitate wellbeing conversations with staff.

3.101 NHSE said that there was no quick fix to improving staff wellbeing and addressing its determining factors, which included adequate staffing levels to meet demand. They said it would require long-term investment, culture change, service improvement and, above all, a focus on what drives workforce wellbeing, some of which lies outside the workplace. They said that a number of interventions were being made under the national Health and Wellbeing Programme, including health and wellbeing conversation training for line managers, wellbeing guardians and champions, introducing a wellbeing dashboard for providers and ICSs and a new national strategy for occupational health, amongst other things.

3.102 The BMA said that the ongoing workforce crisis worsens rising stress, fatigue and burnout amongst NHS staff, as well as poor wellbeing and mental health.

Scotland

3.103 The Staff Experience Survey for health and social care staff for 2022 was conducted between 16 May 2022 and 8 August 2022 and had over 110,000 responses from health and social care staff, a response rate of 55 per cent. Key results, with comparisons to 2021:

- 67 per cent of medical and dental staff said that their organisation cares about their health and wellbeing, unchanged from 2021;
- 84 per cent of medical and dental staff said that their direct line manager cares about their health and wellbeing, up 1 percentage point from 2021;
- 81 per cent of medical and dental staff, said that their work gave them a sense of achievement, up 2 percentage points from 2021;
- 74 per cent of medical and dental staff said that they felt appreciated for the work they do, up 2 percentage point from 2021;
- 83 per cent of medical and dental staff said that they were treated with dignity and respect as an individual at work, up 1 percentage point from 2021;
- 81 per cent of medical and dental staff said that they were treated fairly and consistently at work, up 1 percentage point from 2021;
- 68 per cent of medical and dental staff said that they got the help and support they needed from other teams and services, unchanged from 2021.
- 71 per cent of medical and dental staff said that they would recommend their organisation as a good place to work, unchanged from 2021.

3.104 The Scottish Government said that they had provided a range of resources to complement the wellbeing support being provided to staff at a local level. They said that this included the National Wellbeing Hub, a 24/7 National Wellbeing Helpline, confidential mental health treatment through the Workforce Specialist Service, and funding for additional local psychological support.

Wales

3.105 The Welsh Government said that Health Education and Improvement Wales (HEIW) was leading the implementation of the new NHS Wales Staff Survey, which was due to launch in March 2023. They said that in implementing the survey, they would consider lessons learnt from the NHS England Staff Survey.

3.106 They also said that staff health and wellbeing should be at the core of organisational planning and governance. They said that they had made a very significant investment in workforce health and wellbeing during the pandemic, and they continued to work with system partners including trade unions to further inform proposals to improve staff wellbeing. They described a number of programmes that they were undertaking to improve staff wellbeing, including a Workforce Wellbeing Conversation Guide to support managers and staff to have wellbeing conversations, the Canopi staff mental health support service, a new All-Wales Centre for Occupational Health Excellence, and the development of new resources to support healthier working relationships.

Northern Ireland

3.107 The last survey of Health and Social Care staff was for 2019, which we discussed in our 2020 report.

3.108 DoH also described the initiatives that Trusts were putting in place to support staff both through the pandemic period and going forward. These include dedicated staff helplines, psychological support sessions, increased communication of the wellbeing offer, incorporating staff health and wellbeing material into induction programmes and training for medical and dental staff to hold improved wellbeing conversations.

Locally-Employed Doctors and Dentists (LEDs)

3.109 We again asked parties to provide us with evidence relating to doctors and dentists employed on locally-determined contracts, after discussing this group in detail in our report for the first time last year. LEDs include those sometimes referred to as trust grade doctors and dentists or clinical fellows. It is clear that, in England at least, there are a significant number of doctors and dentists working under such arrangements.

3.110 DHSC said that they do not determine the pay, terms and conditions of LEDs, but they recognise and share our interest in understanding more about this group. They said that they understood that most LEDs are in arrangements where their pay is uplifted annually in line with comparable workforces on national contracts, while for a small number of others it was ultimately up to local employers to determine their pay uplifts.

3.111 They said that there was a variety of different reasons that doctors were employed on local contracts, including junior doctors who have stepped out of training, and international doctors in their first post prior to taking on a long-term role. They also said that analysis of the NHS Electronic Staff Record identified around 10 per cent of HCHS doctors as being under arrangements labelled 'trust grade' or 'other' contracts, who would be considered to be LEDs. They said that the majority of this group (around 6 per cent of the overall HCHS workforce), which were marked as 'trust grade' doctors, were employed on contracts that mirrored pay scales linked to national contracts, and so would have seen their pay uplifted in line with those national contracts in 2022-23, whose uplifts were determined either through the DDRB process or the multi-year deals in place. However, they said that they did not have information about how pay was uplifted for the remaining group of 5,736 doctors, who amounted to around 4 per cent of the overall total, and just over a third of the LED workforce.

3.112 DHSC also said that it was for employers to determine employment arrangements for LEDs, and a degree of flexibility had value in certain circumstances, but that they expected all doctors, regardless of how they were employed, to be treated as part of a team, appropriately rewarded, and respected for the contribution they delivered.

3.113 NHSE said that many LEDs' pay and terms and conditions mirror those of national contracts, including closed contracts such as the old associate specialist contract, that was closed to new entrants in 2008. They added that the specialty grade required at least four years of postgraduate experience, so doctors who are between foundation and specialty training would not be eligible for employment on the Specialty Doctor contract, should they wish to spend a period of time outside training during this stage of their careers. They said that doctors on bespoke contracts comprised around 4 per cent of the HCHS medical workforce.

3.114 NHSE and NHS Employers both said that many LEDs were on pay codes for the national contract that their contract shadowed. They said that this meant that they would receive the same pay uplift as those on the national contract, but also that collecting data on them was difficult.

3.115 NHS Employers also said that there were many reasons that employers used local contracts. These included ensuring that LEDs that were on the same rota as doctors and dentists in training had access to exception reporting and educational opportunities; because the LEDs themselves may not meet the eligibility requirements for the SAS contracts; to reflect bespoke working arrangements; and to appoint clinical fellows who can support undergraduate medical education at the same time as contributing to junior doctor rotas. They said that the number of LEDs had increased as employers looked to fill gaps in junior doctor rotas, and as some doctors in training wished to remain in LED posts as they waited to achieve a training place in their desired specialty. They said that more information was needed about how LED contracts were designed and utilised to ensure LEDs were properly supported and treated equitably.

3.116 The BMA said that they believed there were over 20,000 LEDs in England alone, and that they had identified at least 13,062 LEDs working in the 133 Trusts that they had data for as of October 2022. They said that major acute or specialist centres tended to employ greater numbers of LEDs than other trusts, and that greater numbers of LEDs were employed in geographies that were generally difficult to recruit to. They said that the data that they had available to them suggested that most LEDs were from minority ethnic backgrounds, and most were men. They also said that a disproportionate number were international medical graduates.

3.117 They said that the availability of routes for LEDs to move onto national contracts was reliant on BMA staff entering into negotiations on their behalf to try to secure their employer's agreement to do so, and there should be a fairer and more consistent process for facilitating transfer from these roles to national contracts. They said that LED roles were often 'hidden' SAS doctor jobs.

3.118 They also said that there was no evidence that last year's pay award for LEDs was implemented in a widespread or systematic way, and that trusts seemed to be of the view that local employers are not obliged to apply pay awards for those on local terms, regardless of our recommendations.

Productivity

3.119 Discussions on NHS/HSC finances often make reference to productivity and efficiency. However, given the complexity of health services, productivity is not straightforward to quantify or determine. Within NHS/HSC, services are limited by politically determined budgets and the costs of inputs as well as by productivity. Within a given budget, technologies, efficiencies, and staff mix, there is then a trade-off between real pay and overall employment: higher pay is affordable with lower staff numbers and higher output-per-head productivity. However, this can be an oversimplification. Pay can impact staff numbers as a result of its impact on recruitment and retention, and both pay and staffing can also have consequences for the quality and safety of services. Therefore, this trade-off is not straightforward in practice.

3.120 Pay policies intended to lower costs can also result in a less effective or efficient staff mix. For example, if recruitment and retention is worsened as a result of lower pay and employers become more reliant on more expensive agency work as a result, the budgetary and productivity benefit of lower pay can be undermined.

3.121 DHSC said that public service productivity had been mostly steady since the second quarter of 2021 but was still 6.5 per cent below the pre-pandemic level. They said that reductions in productivity result in reductions in outputs in the NHS, which means less of the elective backlog can be tackled. They also said that as part of the £8 billion of additional funding for the NHS announced during the most recent spending review, the Government had invested in programmes to help the NHS achieve its ambitious productivity trajectory while delivering on the elective recovery challenge. They said that programmes prioritised by NHSE included improving patient pathways, surgical hubs, community diagnostic centres, and making outpatient care more personalised.

3.122 NHSE said that their current financial settlement was predicated on stretching efficiency targets of at least 2.2 per cent each year, which was significantly higher than the roughly 1 per cent per year the NHS had historically delivered.

3.123 The Scottish Government said that as a result of continuing cost pressures, including those related to COVID-19 and energy prices, they would need to achieve efficiency improvements of roughly double the usual target of 3 per cent, that Health Boards had historically struggled with.

Spending on Temporary Staffing

The BMA Rate Cards

3.124 During the second half of 2022, the BMA published a number of 'rate cards', that outlined their view as to what the minimum rates of pay should be for different groups of doctors and dentists for work beyond standard contractual hours. They also said they felt doctors should consider declining additional work unless the rates on the rate card were paid.

3.125 DHSC said that there had been no national level discussion with employers prior to issuing the cards, and no attempt to agree mutually acceptable rates. They said that it remained to be seen whether there would be a resulting impact on the amount of extra-contractual work undertaken or the cost of such work. NHS Employers said that employers felt that the rates suggested by the BMA were unaffordable, they were disappointed with how this had been introduced, and they would continue to register their strong concern. NHS Providers said that Trust leaders had reported that the situation was proving difficult to manage, and, where BMA members had co-ordinated locally, some Trusts were finding themselves unable to staff backlog recovery initiatives. They said that NHSE should manage the response to the rate cards locally.

3.126 DoH said that the rates for the consultant rate card in Northern Ireland had been established by the BMA with no consultation or input from DoH and were not supported by them.

England

3.127 DHSC said that the NHS was experiencing unprecedented demand, and so providers may need to use temporary staff. They said that they and NHSE were working to reduce agency staff bills and encourage workers into substantive and bank roles. They said that they were doing this by helping providers to reduce off-framework spending, improve price cap compliance, offer increased flexibility to bank staff and working towards introducing a system agency expenditure limit. They said that doctors and dentists who choose to work through agencies do so for the increased flexibility, higher pay, improved support systems and culture and lower administrative burden, while those in substantive roles choose them for the teaching and research, learning and development and predictable pay and hours. They said that agency spending had fallen as a percentage of the overall NHS pay bill, from 7.8 per cent in 2015-16 to 4.0 per cent in 2020-21, though during this period bank spending increased. They said that as a result of high demand and workforce pressures, agency and bank spending increased in 2021-22, and demand would remain high in 2022-23.

3.128 DHSC also said that price cap compliance is poorer in the medical and dental staff group as a result of staff shortages, with shortages particularly acute in certain specialties, and higher temporary staffing costs were driven by both demand and supply pressures.

3.129 NHSE said that reductions in agency spend from 2015-16 were achieved by reducing the proportion of overall temporary staffing spend that was taken up by agency shifts, with an increase in the proportion procured through a bank. They also provided data for 2021-22 that showed that medical and dental agency spend was just under 6 per cent of the total medical and dental wage bill in NHS trusts in England, while bank spend was just over 7 per cent. The overall temporary medical and dental staffing spend, as a proportion of overall the overall wage bill, had grown gradually from just under 12 per cent in 2017-18 to around 13 per cent in 2021-22.

Scotland

3.130 The Scottish Government said that medical agency spend increased by 17 per cent, from £87.6m in 2020-21 to £102.4m in 2021-22.

Wales

3.131 Medical and dental locum expenditure in Wales was £63.2 million in 2021-22, an increase from £58.6 million in 2020-21. Overall medical and dental locum spending has been relatively steady at between £50 million and £65 million in recent years.

Northern Ireland

3.132 Data from DoH showed that agency spend in 2021-22 on medical and dental staff was £103 million. This was an increase, of 4 per cent, from £99 million in 2020-21. They said that employers feel that the services provided by locums do not provide the same level of stability and consistency and are more expensive. They also said that they had a limited pool of locums due to the physical separation of Northern Ireland from the rest of the UK and locums drove doctors away from rotational training schemes. They said that rising locum spend was a consequence of the current configuration of services in Northern Ireland, was not sustainable, and changing the model of care was the only solution.

3.133 DoH also said that they aimed to eliminate the use of off-contract agency spending, and this drive would run parallel with ongoing initiatives to build the HSC workforce, including additional investment to expand the number of undergraduate and postgraduate training places.

Our Comments

Recruitment, Retention and Motivation

3.134 While there remain a number of key challenges to recruitment and retention for the HCHS workforce, there are also aspects that remain robust. Demand for medical school places remains very strong, and fill rates into specialty and general practice training remain on a positive trajectory. At the same time, there has been strong growth in the FTE size of the HCHS workforce in England, Scotland and Wales, though it is concerning that this trend has not been replicated in Northern Ireland.

3.135 Official vacancy rates remain at historically relatively high levels, and we note that the BMA have said that these vacancy rates tend to understate the true vacancy picture. High vacancy rates, coupled with continued growth in demand for services, are likely to have a negative impact on working conditions. We would therefore welcome more information, including more granularity, about trends in vacancy rates.

3.136 This overall picture, at least in England, Scotland and Wales, of strong workforce growth at the same time as high vacancy rates, is somewhat contradictory. Understanding this, as well as how workforce demand trends will evolve in the medium- and long-term, should be at the heart of ongoing workforce planning efforts.

3.137 As we discuss in Chapter 2, a proper consideration of the balance between domestic and international workforce supply is critically important to ongoing workforce planning efforts. Given the current high dependency on international recruitment in the HCHS, future shifts in the international labour market for doctors and dentists could present challenges to recruitment and retention.

3.138 We note the GMC's observation that the number who left the medical register in 2021-22 was higher than previous years, though they said that it was not yet clear whether this represented decisions to leave that were not taken during the pandemic or an increase that would be sustained into future years[9]. We are also concerned about issues of 'hidden' retention relating to falling working hours; while on an individual level, doctors and dentists working LTFT or reducing their hours might mean that they are more likely to stay in the NHS/HSC for longer, at a system-wide level, this can present challenges to adequately staffing services. We note that DHSC provided data that suggested any changes to participation rates are gradual in England, but even a small fall in participation rates will lead to increased demand on a headcount level. This is also critical context for ongoing workforce planning efforts.

3.139 These shifts are taking place at the same time as other shifts in the way that doctors at the start of their careers work and train. Increasing numbers seem to be taking breaks in training, in particular following the completion of the foundation programme. While the overwhelming majority of doctors return to postgraduate training programmes in the NHS/HSC, this represents a significant challenge to retention, and also affects the speed at which trainees can expect to reach more senior grades and also therefore the pipeline of doctors and dentists into more senior roles in the long-term.

3.140 We are also concerned about what appear to be increasingly severe challenges to motivation amongst the HCHS workforce. The NHS Staff Survey results in England for 2022 were in general worse than those of 2021, which had in turn declined substantially compared to 2020. These issues are likely to be related to ongoing challenges to service delivery, care backlogs and fatigue and burnout following doctors' critical contribution to the pandemic response. This has been accompanied by particularly large falls in pay satisfaction.

3.141 In evidence and on visits, issues of pensions and pensions taxation were frequently mentioned to us as a crucial factor in the retention of the most senior consultants, and their willingness to perform additional duties. We discuss this, and the changes to pensions taxation that were made in the 2023 Budget, in Chapter 6.

[9] https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report-2022, see, for example, p.14.

Consultants

3.142 We welcome that the parties remain supportive of contract reform in principle, given that the current contract has been in place for two decades. It is frustrating that no progress has been made in the last year. We note the suggestion made by DHSC in written evidence that progress can be made towards addressing pay equalities issues through the carefully differentiated application of pay awards to the consultant pay spine. We are supportive of efforts to address pay equalities issues. However, we are also concerned that awards of this sort could have consequences for retention, particularly as there are some issues of retention that are most specifically felt amongst the most senior members of the consultant workforce. We also believe that any such changes should take place in an open and transparent manner, with all parties able to express their concerns and present proposals for solutions. Therefore, we would welcome all parties including in evidence for next year's report proposals for how this sort of change could be achieved, should they wish, and also for them to outline any considerations they feel should be taken into account when making recommendations of this kind.

3.143 We welcome that the new national CIA scheme in England and Wales seems to have made some progress towards improving the diversity of the consultants rewarded by it, though it remains to be seen whether this will translate into increased numbers of those in previously under-represented groups actually receiving awards. We will of course welcome hearing more about this in evidence next year. We also welcome that progress seems to be being made towards reopening the CEA scheme in Northern Ireland. We remain concerned that issues with the other schemes remain unaddressed.

SAS doctors and dentists

3.144 We welcome that contract reform negotiations were successful in Scotland. We also note the situation with respect to contract reform in England, Wales and Northern Ireland, and discuss it in relation to our making recommendations this year in Chapter 6.

Doctors and dentists in training

3.145 We note that a reformed contract was rejected by BMA members in Wales, and that the multi-year deal for doctors and dentists in training in England has now concluded.

3.146 We are aware that BMA, BDA and HCSA members who are doctors and dentists in training in England have undertaken industrial action during the early part of 2023, and the BMA Scotland Junior Doctor Committee has now voted to do so. We discuss this situation, and how it informs our recommendations this year, in Chapter 6.

3.147 We would also welcome hearing more about the benefits of the single employer model that was introduced for doctors and dentists in training in Northern Ireland.

Locally-Employed Doctors and Dentists

3.148 We welcome that parties told us more about LEDs. At least in England, it is clear that LEDs represent a significant and growing part of the overall HCHS workforce. From what the parties have told us, LEDs are a diverse group in a number of ways. They seem to be employed on a wide variety of different contracts, some based on national contracts and others on bespoke arrangements. They are also used by employers in a variety of different ways. However, the evidence that we received seems to suggest two particular uses of local contracts that stand out; bespoke arrangements for doctors that are not in training but are used to fill junior doctor rotas, and as an initial and potentially temporary contractual arrangement for newly-arrived international doctors and dentists. These two groups are also likely to overlap to some extent.

3.149 Our view remains that there is a clear need for all parties to better understand this group. They should work together to understand what can be done to maximise the contribution that LEDs can make to services and to ensure equitable and consistent treatment of LEDs. Better understanding of LEDs should then lead to action being taken that can improve recruitment, retention and motivation and therefore ultimately improve services and patient care. This is an important opportunity that health service leaders should embrace.

3.150 While in the absence of a more detailed understanding of the group it is not clear specifically what this action could look like, it could include developing open, transparent and attractive routes for LEDs to enter training at the appropriate level or to move onto SAS contracts, enhanced development opportunities for LEDs, including potentially support for undertaking the CESR process, and national minimum standards for terms and conditions.

3.151 We discuss pay for LEDs, and the applicability of our recommendations to them, in Chapter 6.

Productivity and Temporary Staffing

3.152 We note with concern what DHSC said about public service productivity. Clearly, during a period where health services are struggling to meet demand, improving productivity is important to ensuring that demand can be met. It is critically important that health services return to the productivity growth trajectory that existed before the pandemic. Improving motivation could also be helpful in improving productivity.

3.153 Multiple parties discussed the relationship between vacancy rates and staff shortages on the one hand, and the demand for temporary staff on the other. Permanent staff will typically offer better and more cohesive care than temporary staff. Reducing the dependency on temporary staff is therefore one way that improving recruitment and retention can ultimately benefit patients. The use of temporary staffing also has significant cost implications, and so reducing this dependency can make services more cost-effective. In a similar vein, we once again welcome the increased use of bank staff, relative to the amount spent on agency staff, given that bank staffing is generally more cost effective than agency.

3.154 Since permanent staffing provides better, safer and cheaper care, we remain concerned that the overall use of temporary staffing remains at a high level across the UK and in particular in Northern Ireland. Given the challenges that health services face to meet demand, addressing this is even more important. In order for this to be addressed in the long-term, it is essential that workforce demand is understood and met, as we discuss earlier in this chapter.

CHAPTER 4: GENERAL MEDICAL PRACTITIONERS

Introduction

4.1 In this chapter we consider issues relating to General Medical Practitioners (GMPs). The traditional role for GMPs has been as the family doctor, and they work at the heart of local primary care services. There are several contracting arrangements in place under which primary care medical services are provided, the most common of which is referred to as the General Medical Services (GMS) contract. General practice services are typically delivered by partnerships of GMPs that own their practices, which can also employ salaried GMPs, though some practices are owned and operated by other NHS/HSC organisations, and GMPs also work in other parts of the NHS/HSC, including Out of Hours services. Doctors become GMPs after five years of postgraduate medical training, comprising the two-year foundation programme and three years' general practice training. Doctors in general practice training are doctors in training, and they are covered in Chapter 3.

Workforce Numbers

4.2 For England, in March 2023, the headcount estimate for regular GMPs (excludes locums, but includes GMP trainees) was 44,383, an increase of 1.4 per cent from March 2022. The full-time equivalent (FTE)[1] estimate for regular GMPs in March 2023, was 35,788, an increase of 1.5 per cent from March 2022. Excluding GMP contractors, there were 25,392 salaried GMPs, GMPs in training grades and GMP Retainers on a headcount basis and 19,189 on an FTE basis.

4.3 In September 2022, the latest date for which data is available, Scotland had 5,209 GMPs, an increase of 0.6 per cent from September 2021. Within that total the number of performers fell by 2.1 per cent, the number of salaried GMPs increased by 5.2 per cent, and the number of registrars increased by 8.6 per cent.

4.4 The most recent data measuring the number of GMPs in Wales is from 30 September 2022. The data showed 2,498 GMPs, of which 1,974 were practitioners, 498 registrars and 26 were retainers[2]. Compared with 30 September 2021, the overall number of GMPs increased by six (0.2 per cent), as the number of practitioners fell by 64 (3.1 per cent), the number of registrars increased by 72 (16.9 per cent), and the number of retainers fell by two.

4.5 The latest data for Northern Ireland, from March 2022, was for 1,419 GMPs, an increase of 9 from a year earlier. Within that total there were 1,180 partner GMPs (down 1 from 2021), 225 salaried GMPs (up by 20 in 2021) and 14 retainers (down by 10 from 2021).

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

[2] GMP retainers in Wales are practitioners on the GP retainer scheme, who are only able to practice a maximum of 4 clinical sessions a week.

4.6 The composition of the GMP workforce has changed over recent years, with the share of contractor GMPs having fallen and that of salaried GMPs having increased. In England, between September 2015 and March 2023, the proportion of the regular GMP workforce headcount made up of contractors had fallen from 61 per cent to 44 per cent, while that of salaried GMPs increased from 26 per cent to 35 per cent. In Scotland, between 2012 and 2022, the proportion of the GMP workforce made up of contractors fell from 77 per cent to 62 per cent, while that of salaried GMPs increased from 11 per cent to 24 per cent.

4.7 The proportion of GMPs who are women has also been increasing. Between 2012 and 2022, the proportion of the general practice medical workforce who are women in Scotland increased from 53 per cent to 62 per cent. In 1985, in Northern Ireland, women made up 19 per cent of the GMP population, but by 2022 that had increased to 59 per cent. Over a shorter period, between September 2015 and March 2023, in England, the share of the GMP workforce who are women increased from 51 per cent to 57 per cent.

Contract Reform

England

4.8 In 2019 a five-year pay and contract reform agreement for England was finalised between the Department for Health and Social Care (DHSC), NHS England/Improvement (NHSE/I), and the General Practitioners Committee of the British Medical Association (BMA). The parties said that the contract would give clarity and certainty for practices. NHSE/I and the BMA agreed that there would be no further expectation of additional national funding for practice or contract entitlements until 2024-25.

4.9 The parties to the new contract agreed to ask the DDRB not to make recommendations relating to independent contractor GMP pay in England over the period of the agreement. However, the agreement said that the UK Government would continue to include recommendations on the pay of salaried GMPs in DDRB remit letters from 2020 onwards, and our remit letter for England asked us to only make recommendations for salaried GMPs again this year.

Scotland

4.10 The Scottish Government said that initial changes to their GMS contract were made in 2018, including reducing GMPs' workloads through the expansion of the primary care multidisciplinary team and increasing transparency on general practice funding, activities and workforce to assist strategic planning, commissioning and delivery of primary care services.

4.11 They also said that Phase 1 of the new contract would include a new workload formula to better match resource to demand and, from April 2021, a GP partner's whole-time-equivalent earnings expectation that would mean that no GP Partner will receive less than £89,784, and that this would be uplifted in line with DDRB recommendations. They said that this would be followed by a second phase of reforms, dependent on a further vote from the profession, which would comprise a number of changes, including introducing an income range for partner GMPs that is comparable to consultants and directly reimbursing practice expenses.

4.12 The BMA said that the implementation of Phase 1 of the GMS reforms was precarious, as funding for a number of priority areas for reform had been frozen. They also said that Phase 2 had been paused due to insufficient funding.

Wales

4.13 The Welsh Government and the BMA both said that they had worked together to develop a streamlined and simplified GMS contract for Wales, with an emphasis on clinical judgement, and a focus on the things that only GMP practices can do. They said that a consultation was planned for April 2023, with the aim that the new Unified Contract is brought into force in October 2023.

Northern Ireland

4.14 The BMA said that GMPs in Northern Ireland, unlike those in England and Wales, had to pay for their own indemnity cover. The Department of Health (DoH) said that work was ongoing to review arrangements for the provision of indemnity cover for GMPs in Northern Ireland, and a range of options were under consideration, including a state-backed scheme.

Access to GMP Services

England

4.15 Results of the 2022 GP patient survey with respect to general practice showed significant deterioration compared to 2021. Selected headline findings are included in Table 4.1.

Table 4.1: Selected headline findings from the GP Patient Survey

Question	2022	2021	Change
Reported a good overall experience of their GP practice	72.4%	83.0%	-10.6%
Said they were satisfied with the appointment they were offered the last time they tried to book one	71.9%	81.7%	-9.8%
Got an appointment at a time they wanted or sooner	51.2%	58.9%	-7.7%
Reported a good overall experience of making an appointment	56.2%	70.6%	-14.5%

Source: GP Patient Survey[3]

[3] https://www.gp-patient.co.uk/surveysandreports. Data point for 'Got an appointment at a time they wanted or sooner' taken from National Report, slide 44.

4.16 DHSC said that they remained committed to creating an extra 50 million appointments in general practice each year by 2024. They said that to achieve this they were taking steps to grow the number of doctors in general practice and diversify the workforce. In service of the former aim, they said that record-breaking numbers of doctors were accepting places on GP training, and in service of the latter, they were looking to have 26,000 more primary care professionals, which will help reduce GMP workload and deliver more appointments. They said that between March 2019 and September 2022, over 21,000 professionals had been recruited into general practice through the additional roles reimbursement scheme.

Scotland

4.17 The Scottish Government said that 75 per cent of respondents to the 2021-22 Scottish Health and Social Care Experience Survey found it easy to contact their GMP practice in the way they want, compared to 85 per cent in the 2019-20 Survey. They said they had set up the General Practice Access Group to work to understand the challenges and issues accessing appointments with GMPs, and that they were transforming primary care, including developing multidisciplinary teams, to put in place long-term, sustainable change within GMP services so that they can better meet changing needs and demands, to ensure that patients can access the right person at the right time.

Wales

4.18 The Welsh Government said that improving access to general practices continued to be a key area of focus, and the contract agreement they had reached builds on the significant progress that had already been seen over the previous three years. They said that access standards would be mandated through the contract from April 2023, and practices would take account of patient experiences and feedback to develop action plans for improvement by 31 March 2023.

Northern Ireland

4.19 DoH said that the number of GMP practices in Northern Ireland was falling, with those in rural areas having particular difficulties, but at the same time, the total number of patients registered with a practice continued to increase, growing by 0.75 per cent in the year to 31 March 2022. They said that practices were facing sustained levels of high demand even before the pandemic, and the pandemic had accelerated the implementation of new ways of working, including making better use of technology, but demand for telephone appointments was not being met. They said they were working to better understand the nature of demand on GMP practices, and how to improve patient experience and manage demand.

4.20 In response to these challenges, they said they were continuing to work towards the full roll-out of the multidisciplinary teams model in Northern Ireland, but this was dependent on there being a Budget in place. They also said that in September 2022, they had announced £5.5 million of funding for additional support measures for practices.

Recruitment, Retention and Wellbeing

General practice training

4.21 Recruitment into general practice training again reached a record high in 2022, with the new, higher target of 4,000 doctors entering training in England being met for the second year. Recruitment into general practice training in Scotland, Wales and Northern Ireland in 2022 was also successful, achieving fill rates of 98 per cent, 109 per cent and 97 per cent respectively, despite an increase in the number of places in Northern Ireland. We cover specific initiatives undertaken in each of the nations to attract trainees into general practice training, as well as the pay and conditions of general practice trainees, in Chapter 3.

England

4.22 DHSC said that they were increasing the proportion of the three-year general practice training programme that trainees spent in practice from 18 months to two years, to better prepare trainees for a role in general practice. They also said that 2,464 doctors received their Certificate of Completion of Training (CCT) as a GMP during the 2021-22 academic year, despite 3,473 doctors entering training in 2018-19, and that this highlights the importance of ensuring that trainees are supported to achieve their CCT.

4.23 They also said that under the updated GP Contract Framework they had announced a number of new retention schemes for GMPs, including the GP Fellowship Programme, the Supporting Mentors Scheme and the New to Partnership Payment, which had supported 2,000 GMPs to take up partnership positions by September 2022.

4.24 DHSC said that the 2021 GP work-life survey found that increasing workloads were the most considerable job stressor amongst GMPs surveyed, and they were continuing to work to understand how to help GMPs and improve their working environment. They added that they were aware that pensions tax issues can trigger GMP retirement decisions, and that they would encourage GMPs to seek independent financial advice as it could remain in their interest to stay in the profession even when faced with pensions tax issues. They also said that the measures included in their December 2022 consultation, which we discuss in Chapter 6, would help to retain senior NHS staff including GMPs, and that as independent contractors, GMP partnerships were able to set up their own contribution recycling arrangement for their partner and salaried GPs should they wish.

4.25 NHSE said that their GP International Induction Programme and their Return to Practice Programme were supporting overseas qualified GMPs and GMPs who left practice respectively. They also mentioned a number of initiatives to help retain GMPs, including the General Practice Fellowship Programme, support for international GMP trainees to find practices with visa sponsorship licences and the Supporting GP Mentors Scheme.

4.26 They also said that according to National GP Worklife Surveys, overall job satisfaction for GMPs fell between 2019 and 2021. They said that more than eight in ten GMPs reported experiencing considerable or high pressures from increasing workloads and demands from patients. They said that supporting health and wellbeing for GMPs was more important than ever, and they had introduced coaching and practitioner health services that were open to staff in primary care.

4.27 The BMA said that the GMP workforce in England had seen little growth since 2015, with 1,896 fewer fully qualified FTE GMPs in October 2022 compared to 2015. They said that meant that the GMPs that remained had to take care of more patients. They also said that political criticism of how GMPs worked had arguably increased the likelihood of GMPs experiencing physical and verbal attacks.

4.28 DHSC provided us with time series data for the participation rate (defined as the ratio of FTEs to headcounts, expressed as a percentage) of different groups within the overall GMP workforce between September 2017 and September 2022, included in table 4.2. They show that for GMP partners and salaried GMPs there had been a relatively slight but consistent downward trend in average working hours, though this was not clearly reflected in the trends for all doctors in general practice, likely as a result of compositional effects and the increase in the number of GMPs in training in the dataset.

Table 4.2: Doctors in general practice in England, participation rates, by role, September 2017 to September 2022 (%)

Staff Group	2017	2018	2019	2020	2021	2022
All	81.8	81.2	79.9	79.3	79.4	80.0
GMP partners	88.7	88.3	87.5	86.6	85.8	85.7
Salaried GMPs	66.6	65.9	64.8	64.1	63.9	63.9
GMPs in training	97.6	98.2	97.9	98.6	99.0	98.4
GMP retainers	41.4	38.3	38.4	39.6	39.7	40.8
GMP regular locums	40.2	38.9	41.0	40.8	40.4	41.3

Source: NHS Digital via DHSC written evidence (Table 4.9). All data as at September of the given year

4.29 DHSC provided data on the numbers of GMPs who claimed their pension in the 1995 section of the NHS Pension Scheme between 2007-08 and 2021-22, and the proportion who did so on a voluntary early retirement (VER) basis. They said that this data was not comparable to data provided in previous years, though it should be more accurate as scheme members can no longer be counted multiple times to include revised and cancelled awards, which may have led to an inflation of figures. The data show significant growth in the proportion of retirements that were VER between 2010 and 2014, before levelling off and falling slightly since then. The proportions are also consistently higher than those of hospital doctors.

Table 4.3: NHS Pension awards (1995 section), all awards, and voluntary early retirement (VER) awards, GMPs, England

Year End	All pension awards	VER pension Awards	% VER
2008	1,126	224	20
2009	1,235	245	20
2010	1,412	301	21
2011	1,238	363	29
2012	1,231	464	38
2013	1,105	425	38
2014	1,451	714	49
2015	1,142	529	46
2016	865	397	46
2017	1,192	614	52
2018	1,011	450	45
2019	1,044	473	45
2020	1,017	433	43
2021	943	387	41
2022	683	274	40

Source: DHSC Evidence (table 7.4)

Scotland

4.30 The Scottish Government said that according to the Primary Care Workforce Survey Scotland 2022, there were 8.7 vacant GMP sessions for every 100 total GMP sessions, though this rate varied by NHS Board and outside the Island boards, which are particularly volatile due to small numbers, varied between 5.6 for every 100 sessions in Greater Glasgow and Clyde to 13.7 in Lanarkshire. They said that to support recruitment and retention, they were introducing a range of measures including Fellowships, the GP Returners Programme, and specialist support measures. They also said that they had launched a new recruitment campaign in June 2022, which seeks to encourage GMPs from the rest of the UK to move to Scotland.

4.31 They also said that seniority payments were available in Scotland to reward years of service, as were Golden Hello payments for remote, rural and deprived areas, and areas where recruitment had proved difficult in the past.

4.32 The BMA said that FTE GMP numbers in Scotland were falling, despite practices providing services to an increasing number of patients with greater health needs. They said that without considerable intervention, recruitment and retention for GMPs in Scotland would be on a downward spiral, which would have a profound impact on the wellbeing of GMPs and their patients. They said that despite falling FTE numbers, the amount of consultations practices were providing per week was growing.

4.33 The Scottish Government provided data from the Scottish Public Pensions Agency on the retirements of GMPs in Scotland. 81 GMPs were identified as retiring early in 2021-22, up from 70 in 2020-21 and from 63 in 2019-20. They said that the number of retirements in 2022-23 at the time of writing was similar to 2021-22.

Wales

4.34 The Welsh Government said that quarterly Wales National Workforce Reporting System data showed that the FTE:headcount ratio of the practitioner workforce, which includes partner and salaried GMPs but not trainees or locums, was 0.73.

4.35 They also said they introduced the Partnership Premium scheme in 2019 to incentivise GMPs to take up partner roles, with payments based on the number of clinical sessions undertaken.

4.36 The BMA said research from the Nuffield Trust demonstrated that the number of GMPs in Wales had remained broadly static on a headcount basis compared to the size of the population over the last decade. They said that while FTE data had only been made available recently, it was showing that the FTE size of the GMP workforce in Wales was falling. They also said that the GMP workforce in Wales was on average older than in the rest of the UK.

Northern Ireland

4.37 DoH said that the headcount number of GMPs in Northern Ireland as at March 2022 had grown by 0.6 per cent since 2021 and 20.3 per cent since 2014. These figures took no account of hours worked, though data from the Northern Ireland Medical and Dental Training Agency suggested that the total number of GMS sessions provided had decreased compared to 2014.

4.38 DoH also said that they were looking to continue the rollout of the multidisciplinary teams model, which was already in place in seven of the 17 GP Federation areas in Northern Ireland, but this was subject to the availability of appropriate funding. They also highlighted a number of actions they were taking to improve recruitment and retention of GMPs including additional funding being made available to practices in hard-to-recruit areas and a new GP Crisis Response Team. BMA Northern Ireland said that demand for services was unsustainable and was leading to increased numbers of practices handing back their contracts. They said that this could be particularly challenging on a localised level, where services could be more dependent on individual practices.

GMP Trainers' Grant and Appraiser Fee

4.39 DHSC said that they worked with stakeholders to promote a fair and equitable approach to the funding of clinical placements in GMP practices, irrespective of geography and historical arrangements.

4.40 NHSE said that the fee for GP appraisers, of £584, meant that time spent on appraisals earned considerably in excess of what could be earned delivering clinical work, and that it should not remain within the DDRB remit.

Earnings and Expenses

Contractor GMPs

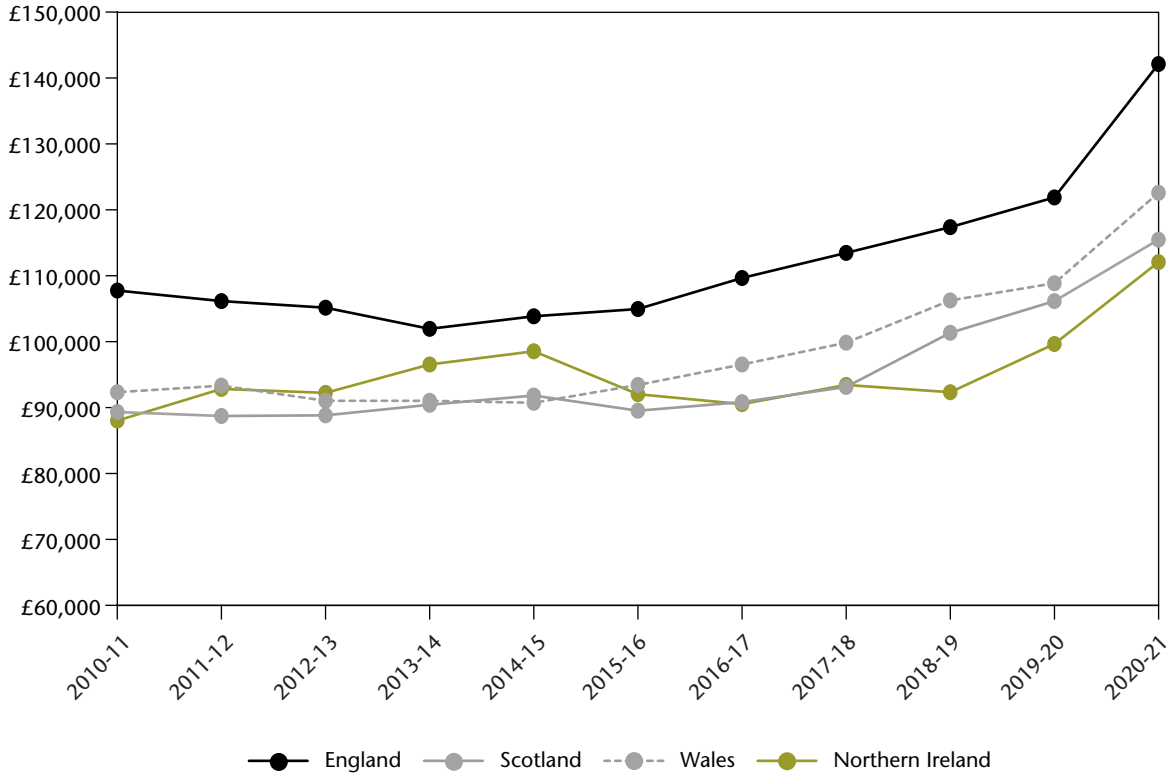
4.41 In 2020-21, the latest year for which data were available, average taxable income for contractor GMPs in each of the four countries was:

- England – £142,000 (**up by 16.6%**, from 2019-20 (£121,800))
- Scotland – £115,400 (**up by 8.8%**, (£106,100))
- Wales – £122,500 (**up by 12.6%**, (£108,800))
- Northern Ireland – £112,000 (**up by 12.4%**, (£99,600)).

4.42 The average earnings estimates are produced on a headcount basis and take no account of hours worked. NHS Digital produce estimates of the numbers of contractor GMPs for England, on both a headcount basis and a FTE basis. This shows that the number of FTE contractor GMPs in September 2020 was 0.866 of the headcount number of contractor GMPs. If the relationship for average earnings, on a FTE basis were calculated in a similar way, this would give an approximate FTE average earnings estimate for 2020-21 of £163,900 rather than £142,000 on a headcount basis, and a 17.7 per cent increase from 2019-20. Multiple parties said that the increases to contractor GMP pay in 2020-21 related to actions taken through the pandemic, including for example payments made to practices for delivering the vaccine programme. They said that they anticipated that these increases will be maintained only to some extent into 2021-22 and beyond.

4.43 Figure 4.1 shows GMP contractors' nominal average income before tax for each country within the UK, since 2010-11. Between 2010-11 and 2013-14 average incomes in England, Scotland and Wales were flat or falling, but have since grown in each of the last: seven years in England; six years in Wales; and five years in Scotland. In Northern Ireland average incomes increased between 2010-11 and 2014-15, before falling back to 2018-19, and then increasing in both 2019-20 and 2020-21.

Figure 4.1: GMP contractors' average headcount income before tax, by United Kingdom country, 2010-11 to 2020-21



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

Salaried GMPs

4.44 As with dentists, there is an inherent tension for contractor GMPs in deciding to pass on pay uplifts to the salaried GMPs that work at their practice; doing so can potentially affect the sustainability of their practice. In this context it is important that overall contractual uplifts are sufficient to ensure that practices can afford to uplift pay for contractors and salaried GMPs. This includes expenses uplifts, which we discuss below. Across the UK, our recommendations for salaried GMPs are formally applied to a published pay range. Additionally, the BMA's model contract for salaried GMPs says that salaries for salaried GMPs will be uplifted 'in accordance with the Government's decision on pay of general practitioners following the recommendations of the Doctors' and Dentists' Review Body',

4.45 NHSE said that our recommendations for salaried GMPs needed to be informed by affordability to practices, and that the practice global sum increase in 2023-24 will reflect sufficient funding for 2.1 per cent for salaried staff, agreed as part of the fixed five-year deal with the sector.

4.46 In 2020-21, average headcount taxable income for salaried GMPs in each of the four countries was:

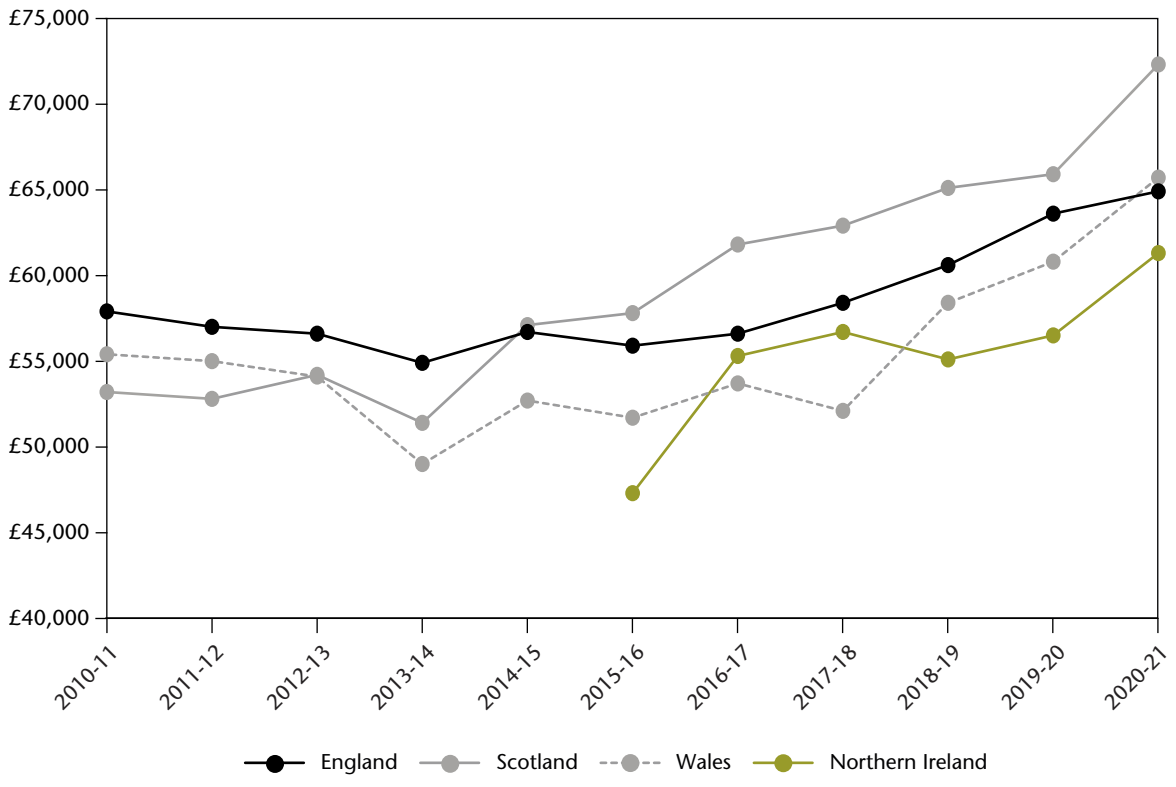
- Scotland – £72,300 (**up by 9.7%**, from 2019-20 (£65,900))
- Wales – £65,700 (**up by 8.1%**, (£60,800))

- England – £64,900 (**up by 2.0%**, (£63,600))
- Northern Ireland – £61,300 (**up by 8.5%**, (£56,500)).

4.47 The average earnings estimates are produced on a headcount basis, and take no account of hours worked. NHS Digital produce estimates of the numbers of salaried GMPs for England, on both a headcount basis and a FTE basis. This shows that the number of FTE salaried GMPs in September 2020 was 0.641 of the headcount number of contractor GMPs. If the relationship for average earnings, on a FTE basis were calculated in a similar way, this would give an approximate FTE average earnings estimate for 2020-21 of £101,300 rather than £64,900 on a headcount basis, and a 3.2 per cent increase from 2019-20.

4.48 Figure 4.2 shows salaried GMPs' nominal average income before tax for each country within the UK, since 2010-11 (for Northern Ireland since 2015-16). Average incomes fell between 2010-11 and 2013-14. However, more recently, average incomes have grown: in each of the last seven years in Scotland; in each of the last five years in England; in the last three years in Wales. In Northern Ireland average incomes grew each year between 2015-16 and 2020-21, except for 2018-19.

Figure 4.2: Salaried GMPs' average headcount income before tax, by United Kingdom country, 2010-11 to 2020-21



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

Gender pay gaps and other pay equalities issues

4.49 Last year, we noted again that the Gender Pay Gap Review found that there was a particularly large gender pay gap in general practice, which was driven to some extent by both the composition of the workforce, with a higher proportion of contractor GMPs being men and a higher proportion of salaried GMPs women, but also by the unstructured way that pay is determined for salaried GMPs.

4.50 The BMA said that in a survey they had conducted male salaried GMPs were more likely to report they negotiated their starting salaries in a new job or indeed proposed a salary that was accepted (44.0 per cent for male GMPs compared with 34.5 per cent for female GMPs); conversely, female GMPs were more likely to say they were not able to negotiate where the starting salary was lower than hoped (21.3 per cent female, 14.0 per cent male). They said that in this context it was important that pay ranges were revised to bring them in line with market forces.

Expenses

4.51 In 2015, the DDRB took a decision to make pay recommendations for GMPs net of expenses. Taking this approach required the parties to work together to agree on an expenses uplift, and we continue to expect that expenses uplifts are sufficient for contractor and salaried GMPs to receive the full value of pay awards, and for practices to be able to meet their other costs, including non-medical staff costs. The Scottish Government told us that last year, they uplifted the GP contract by a total of £44.2 million, based on implementing the 4.5 per cent DDRB pay recommendation, and providing 5 per cent to uplift practice staff expenses and 4.5 per cent for wider expenses. The Welsh Government said that they provided funding for practices to ensure that all practice staff received a 4.5 per cent uplift, and an expenses uplift of £2.718 million was applied to the remaining expenses element of the contract. The BMA this year asked us to return to making expenses uplifts for GMPs in Scotland and Wales.

Our Comments

4.52 We note that DHSC asked us not to make recommendations for contractor GMPs in England who remain subject to the multi-year deal that began in 2019. We discuss this in Chapter 6.

4.53 We note that there remain issues of access to general practice services, as illustrated by the significant deterioration in the results of the 2022 GP Patient Survey in England. This may have been driven to some extent by the increase in hospital waiting lists and a growing elderly population. Issues may also have been driven in the long-term by an increase in patients with complex, or multiple, conditions that are managed in general practice. These demand pressures are likely to have led to higher aggregate demand on practices, as well as changes to the nature of patient demand. There is also a growing dissatisfaction amongst the public about access to a GMP or practice.

4.54 We note that against the higher demand for GMPs in England there has been a general fall in the average participation rates for qualified GMPs since 2017, especially by partner and salaried GMPs who form the core of the GMP workforce. We would expect the trends in Scotland, Wales and Northern Ireland to be broadly similar. This trend has meant that the effective size of the GMP workforce has failed to grow sufficiently to meet the growing levels of demand.

4.55 We also note that the composition of the GMP workforce is shifting, with a higher proportion of the workforce made up of salaried GMPs, with a smaller proportion practicing as contractors. This trend may be related to the anecdotal evidence we have heard about an increase in the number of practices that are 'handing back' their contracts. We are concerned that this indicates that, in this context, some practices' financial viability is being diminished. We would welcome hearing more about this in evidence from the parties next year.

4.56 These trends have the potential to undermine the extent to which the welcome increase to the number of doctors who are entering GMP training will help address workforce issues in the long-term. We also remain concerned that, given the increases to GMP training intakes have been driven to some extent by international medical graduates[4], it may prove more difficult to retain newly-qualified GMPs in the context of an increasingly competitive international labour market for doctors. At the same time, we welcome the progress towards greater use of multidisciplinary teams, as this has the potential to make it easier for general practice to meet demand, and we expect this trend to continue.

4.57 It is noted that early retirement can be a significant factor for retention. While the percentage of retirements that were VER has changed little, or even fallen, over recent years, it is unclear if there will be an increase following the pandemic. As well as this, we would welcome hearing from parties in evidence next year whether there has been growth in demand for GMPs in the private sector, and whether this has affected recruitment and retention.

4.58 It remains important that the gender pay gaps for GMPs are understood and addressed, and we were disappointed not to have heard more about this in evidence for this year's report. With the increasing proportion of women and ethnic minorities training to become GMPs it is vital pay equalities issues are understood and addressed, and action is taken to ensure that they do not impact on retention or motivation. We also note the BMA's ask with respect to the salaried GMP pay ranges and would welcome hearing more about this in evidence from all parties next year. We would also note that, similar to the gender pay gap, ethnicity pay gaps in general practice are also likely to be exacerbated by relatively fewer ethnic minority GMPs achieving contractor status, and potentially as a result of the unstructured way that pay is determined for salaried GMPs. We would also welcome hearing more about this in evidence next year.

[4] See, for example, https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report-2022, figure 38

4.59 We note that earnings data for contractor and salaried GMPs in 2020-21, when compared to 2019-20, showed growth significantly in excess of the DDRB's 2.8 per cent recommendation for that year, except for salaried GMPs in England. Multiple parties said that these changes could be due to changes to how practices were run during the pandemic, as well as pandemic-related activity, and we would welcome hearing more from parties about how they expect the earnings picture to evolve in the coming years.

4.60 Given that participation rates have been gradually declining in recent years, we would expect that earnings for salaried and contractor GMPs would have grown by slightly less than the pay uplifts that have been applied, as average working hours have fallen, and the earnings data we receive is collected on a headcount basis. However, the data appears to show that this has not been happening, with earnings instead growing more quickly, though the data is unclear and does not reflect our most recent recommendations, as there is a significant time lag in when we receive it. We would welcome hearing more about this from parties in evidence next year.

4.61 We note the request by the BMA that we return to making recommendations on uplifts for the expenses component of contract values in Scotland and Wales. As with the issue of dental expenses uplifts, which we discuss in Chapter 5, we are concerned that this process is negatively affecting GMPs' pay and GMP services. We also discuss this issue in Chapters 6 and 7.

CHAPTER 5: DENTISTS

Introduction

5.1 Our remit covers all General Dental Practitioners (GDPs) and salaried dentists providing NHS/HSC services in England, Scotland, Wales, and Northern Ireland. This includes dentists working in the Community Dental Services (CDS) in England, Wales and Northern Ireland and the Public Dental Service (PDS) in Scotland.

University Admissions

5.2 We discuss the numbers of those applying for and being accepted into dental schools in Chapter 3.

General Dental Practitioners

5.3 While terminology differs between the nations of the UK, general dental practitioners delivering practice-based NHS/HSC services are generally split into two categories. Dentists that hold a contract with the NHS/HSC to provide services, and who generally own or run their practices, often in partnerships, are referred to as 'providing-performer' or 'principal' dentists. Practice owners, whether they are providing-performers, limited companies or another kind of organisation, who carry the responsibility of procuring, equipping, resourcing and staffing the practice, receive gross fees from the commissioners in respect of services provided. Dentists that deliver NHS/HSC services under a contract held by another body are referred to as 'performer-only' or 'associate' dentists. Associate dentists usually practise as subcontractors, whose income is determined as a proportion of the gross fees received on their behalf by the contract holder. They also typically receive a proportion of the income generated by the private work that they do at their practice, where applicable. In this report we will generally refer to the former group as providing-performers and the latter as associates.

5.4 The remit of the DDRB includes making recommendations on the pay of practice-based GDPs for the NHS/HSC work that they do. Associate dentists will be paid by the contract holder concerned. Providing-performer dentists will be paid out of the value of their contract. In either case their income for NHS/HSC work will ultimately be funded by the contracts they hold with the NHS/HSC, often supplemented by additional revenues generated by private work.

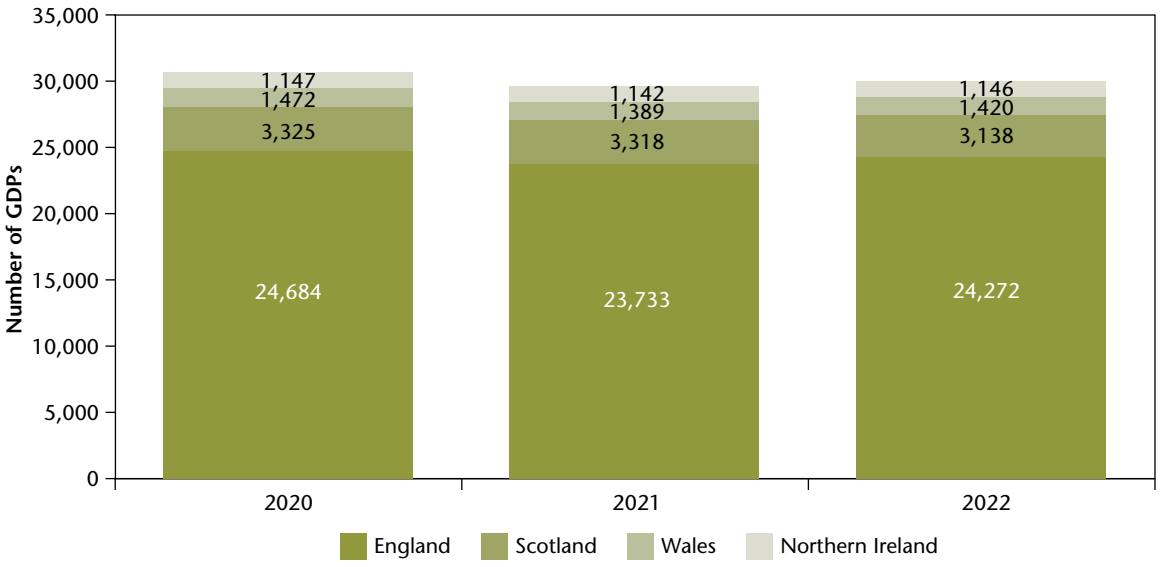
5.5 Dental contracts in different parts of the UK are structured differently. In England, contracts are structured around the Unit of Dental Activity (UDA). Different courses of dental treatment are worth different numbers of UDAs. Those that hold contracts to deliver NHS dentistry are expected to perform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

5.6 Earnings can vary based on career choices, the balance of NHS/HSC and private work, the number of hours worked and the location of the practice. Calculated on a headcount basis, and including both NHS/HSC and private income, on average in 2020-21 providing-performer dentists in England earned £132,200, while associates earned £58,700. The equivalent figures for Scotland were £136,400 and £59,800; Wales £100,200 and £60,100; and Northern Ireland, £122,000 and £59,500.

5.7 In 2022[1] there were 29,976 dentists providing NHS/HSC services in the UK, an increase of 394 (1.3 per cent) from a year earlier. There were increases of: 539 (2.3 per cent) in England; 31 (2.2 per cent) in Wales; and four (0.4 per cent) in Northern Ireland; but a decrease of 180 (5.4 per cent) in Scotland. Despite the overall increase across the UK between 2021 and 2022, there were still 2.1 per cent fewer dentists in the UK than in 2020, with falls recorded in each country, albeit a fall of only one in Northern Ireland.

[1] Data for each country are as at 31 March.

Figure 5.1: Number of General Dental Practitioners, United Kingdom, 2020 to 2022



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

Access to Dental Services and Contract Reform

England

Support measures and access to dentistry

5.8 Dental results from the 2022 GP Patient survey for England included that 52 per cent of respondents had tried to get an NHS dental appointment in the last two years, a reduction of 4 percentage points on 2021. Of these, 77 per cent were successful, compared to 94 per cent pre-pandemic.

5.9 DHSC said that as a result of the impact of the pandemic on access to dentistry, the Government provided unprecedented financial support to the sector during this time to ensure that practices remained viable and able to offer treatment during the COVID-19 pandemic and beyond. They said that, as a result of practices operating below capacity, many people have not been able to access a dental professional, and they were taking action to address this in a way that was fair for patients, dentists and the taxpayer.

5.10 NHSE said that the proportion of UDAs delivered in 2022-23 remained below pre-pandemic levels, despite the relaxation of infection prevention and control measures.

5.11 The BDA said that dentists were expected to return to delivering 100 per cent of their contractual targets from the start of the second quarter of 2022-23 (1 July 2022), despite a number of factors acting as a brake on activity, including unfunded cost increases and recruitment and retention issues. They said that unrealistic UDA delivery targets would destabilise the dental sector.

Clawback

5.12 While clawback figures for 2022-23 were not included in written evidence, as it was submitted before the end of the financial year, the BDA said that their analysis of UDA delivery in the first nine months of 2023 suggested that practices could lose as much as an aggregate £400 million, equivalent to well over 10 per cent of overall contracted activity[2].

Contract reform

5.13 DHSC said that they, along with NHSE, had worked with the sector on a package of improvements to the dental contract. They said that they announced details of the improvements in July 2022, and that they included:

- Introducing a new minimum indicative UDA value of £23[3]
- Changing the way that dentists are remunerated for treatments currently covered in band 2[4]
- Providing support for practices to adhere more closely to clinical guidance on recall intervals
- Promoting more effective use of dental professionals including nurses, hygienists and therapists
- Maximising patient access, including by enabling practices that wish to deliver more than 100 per cent of contracted activity, and enabling rebasing of contracts where activity is not being delivered

5.14 DHSC also said that they continued to work with NHSE and the sector on further improvements to the dental contract, with a focus on urgent care and further workforce and payment reform, with an announcement expected in 2023. They said that this work would build on previous analysis on payment models, and while there was no perfect system, consideration would be given to changes to the model so that they deliver a system that was better for patients and the profession.

5.15 The BDA said that their preference would have been for substantive discussion on fundamental reform of the GDS contract, but they felt that incremental improvements were better than no improvements, and that they had communicated clearly with NHSE that tweaks to a broken contract could not replace the fundamental reform required. They said that they had taken a neutral stance on what they described as the marginal changes that were offered by NHSE.

5.16 They also said that the new minimum UDA value was set too low to have more than a small impact on approximately 200 practices. They also said that given the difficulties faced by practices in recruiting members of the wider dental team, the changes associated with better use of dental hygienists, therapists and nurses would likely not have a material impact on activity.

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[2] https://bda.org/news-centre/latest-news-articles/Pages/Clawback-set-to-break-records-and-push-NHS-practices-to-the-wall.aspx

[3] The indicative UDA value of a NHS dental contract in England is equal to the overall value of the contract, divided by the total number of UDAs to be delivered under it in a year. For example, a contract for 20,000 UDAs, worth £550,000 per year would have an indicative UDA value of £27.50.

[4] A number of treatments, including where patients require three or more teeth to be filled or extracted, would now attract five or seven UDAs, instead of three, as was the case previously.

Scotland

5.17 The Scottish Government said that since April 2022, emergency financial support had been withdrawn from practices. They said they had also made changes to a small number of fees to provide an improved incentive to bring patients into their practices. They also said that to continue to support practices during 2022-23, a multiplier was applied to IoS payments to increase them by 70 per cent during the first quarter, 30 per cent for the second, 20 per cent for the third and 10 per cent for the fourth. They said that across key treatment items, NHS dental services in Scotland were at levels of activity comparable to levels seen before pandemic restrictions were introduced.

5.18 The Scottish Government also said that they were carefully developing significant payment system reform, delivering a simplified system with around 35-40 payment codes, compared to the current 700. They maintained that they felt that the current blended payment model provides the most effective use of public spending on NHS dental services. They also said that they intended to undertake an 'open books' exercise to better understand the nature of NHS dental expenses in Scotland and help to inform future pay awards.

5.19 The BDA said that there was widespread recognition that the current fee-per-item model for NHS dentistry is not sustainable, and that there needs to be a payment model that prioritises prevention, is patient-centred and reflects modern dentistry. They said that they were also having fee reform discussions with the Scottish Government, with the ambition to have an agreement on fees finalised by April 2023, and implemented in 2023-24.

Wales

5.20 The Welsh Government said that contract reform had been fully restarted in April 2022. They said that practices in Wales can now opt in to a variation of their contract that significantly reduces the reliance on the UDA as the principal measure of dental activity. They said practices on the reformed contract will also be required to see a given number of new NHS patients, in order to improve access. They said that the reformed contract has 25 per cent of activity allocated to existing metrics based on the UDA, but 75 per cent of activity was allocated to new metrics. The BDA said that it remains to be seen whether the new targets in place in Wales would prove workable.

Northern Ireland

5.21 The Department of Health (DoH) said that while the impact of the pandemic was reduced in 2021-22 and 2022-23 compared to 2020-21, financial support continued. They said that IoS payments were enhanced by 25 per cent during the first two quarters of 2022-23, and by 10 per cent during the last two quarters. They said that the pandemic had created new issues of access to dentistry, and overall GDS capacity had not yet increased back to pre-pandemic levels. However, they also said that the proportion of patients who were registered with a practice continued to grow.

5.22 DoH also said that prior to the pandemic, it was focused on changing the GDS contract in Northern Ireland to a model focused more on prevention. However, they said their focus was currently on rebuilding the dental sector so that the public's immediate oral health needs are met, but that the GDS Contract Reform Group was meeting to explore options to ensure that HSC dentistry is sustainable and delivers for patients and the profession. They also said that they had amended regulations to enable them to amend the Prior Approval Limit without further regulatory changes, which would help to facilitate timely treatment and improve administrative efficiency.

5.23 The BDA said that they had called on DoH to commission and independent Cost of Service investigation to help inform the appropriate level for fees, as current fee levels do not correlate with the costs incurred to deliver treatments. They also said that political dysfunction had made it harder for DoH to address the challenges being faced by the dental sector.

5.24 They also said that practices were disincentivised from providing HSC care, and this was a factor in the widespread access issues now being seen in Northern Ireland.

Recruitment and Retention

5.25 DHSC said that they were working with the General Dental Council (GDC) to support flexibility to ensure that international recruitment processes were proportionate and streamlined, improve its processes about its Overseas Registration Exam, and allow it to explore alternative pathways to international registration.

5.26 They also said that they thought that the fall in the number of dentists practicing in the NHS in England in 2020-21, compared with 2019-20, was as a result of pandemic-related falls in activity levels, with that fall being mostly reversed in 2021-22.

5.27 NHSE said that current trends in the dental workforce were difficult to assess, as available data does not detail whole-time or part-time working, though they were aware of some geographical shortfalls limiting service provision, including in rural and coastal areas. They said that while the numbers of dentists who were delivering NHS care had increased in 2021-22, they were concerned that they were delivering less NHS care than a similar number would have before the pandemic.

5.28 They also said that during their engagement with the sector, they had heard that very low indicative UDA values were having an impact on care delivery, which was why they introduced a minimum indicative UDA value from 1 October 2022. They also said they were working with the GDC and others to spread good practice in the use of skill mix.

5.29 The Welsh Government said that recruitment and retention difficulties were being encountered by all Health Boards, with particular issues in rural and remote areas of Wales. They said that challenges had been exacerbated by the pandemic, but that Health Boards had successfully awarded several new contracts in 2022, reflecting an appetite amongst some dentists to become providing-performers or expand their practices. They also said that, on average, dentists worked 36.0 hours per week, of which 26.8 hours was devoted to NHS services.

5.30 The BDA said that a survey of practice owners that they had conducted found that 90 per cent of practice owners who sought to recruit an associate during 2020-21 had difficulty doing so, up from 80 per cent on a year previously. They also said that recruitment difficulties were more acute for practices with higher NHS/HSC commitment. They also said that amongst both practice owners and associates alike, higher NHS/HSC commitment was correlated with being more likely to want to leave dentistry. They also said that an increasing proportion of associates wanted to take on more private work.

5.31 DHSC also provided data on the numbers of dentists who claimed their pension in the 1995 section of the NHS Pension Scheme between 2007-08 and 2021-22, and the proportion who did so on a voluntary early retirement (VER) basis. They said that this data was not comparable to data provided in previous years, though it should be more accurate as scheme members can no longer be counted multiple times to include revised and cancelled awards, which may have led to an inflation of figures. The data shows that the proportion of retirements under the 1995 section of the NHS pension scheme that were VERs increased in the early years of the 2010s, before levelling off after 2013, and falling slightly since 2017-18. Unlike the data for hospital doctors and dentists and GMPs, there are no clear trends.

Table 5.1: NHS Pension awards (1995 section), all awards, and voluntary early retirement (VER) awards, GDPs, England

Year End	All pension awards	VER pension awards	% VER
2008	533	193	36
2009	423	116	27
2010	503	177	35
2011	460	124	27
2012	464	151	33
2013	469	148	32
2014	450	139	31
2015	532	153	29
2016	413	120	29
2017	540	151	28
2018	475	108	23
2019	600	167	28
2020	594	156	26
2021	560	174	31
2022	525	117	22

Source: DHSC Evidence (table 7.3)

5.32 The Scottish Government also provided data from the Scottish Public Pensions Agency on the retirements of GDPs in Scotland. 21 GDPs were identified as retiring early in 2021-22, up from 14 in 2020-21 and 19 in 2019-20. They said that the number of retirements in 2022-23 at the time of writing was similar to 2021-22.

Earnings and Expenses for Providing-Performer GDPs

5.33 NHS Digital, using HMRC data, publishes statistics on the earnings and expenses of primary care dentists who carried out NHS/HSC work in each part of the UK. The overall picture on earnings is unclear as it is not known how many hours' work the statistics were based on, and some dentists choose to take incorporated status, affecting how their income appears in the statistics. The earnings figures that we have also combine earnings attributable to NHS/HSC work with earnings arising from private work, as do the expenses figures. Due to a change in the methodology used to determine dental type, for dentists in England and Wales, there is now a break in the timeseries. The figures published in 2018-19 are not comparable to those of previously published reports. HMRC have recalculated the 2017-18 figures using the new dental type methodology, allowing comparisons to be made from 2017-18 and establishing a new timeseries.

5.34 DHSC and the BDA both said that the significant increases in the earnings for providing-performers in England, Scotland and Northern Ireland in 2020-21 were associated with short-term pandemic-related changes to the funding and delivery of dentistry, including that practices were supplied with free personal protective equipment in some places.

England

5.35 Table 5.2 shows that in 2020-21, providing-performer dentists in England had average taxable income of £132,200, an increase of 17.4 per cent from 2019-20, and average expenses of £258,500 (Expenses to Earnings Ratio (EER) of 66.2 per cent).

Table 5.2: Providing-performer GDPs' average gross earnings, income and expenses, England, NHS and private, headcount, 2017-18 to 2020-21

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	4,200	365.1	251.9	113.2	69.0
2018-19	4,100	383.4	270.3	113.1	70.5
2019-20	3,950	386.3	273.7	112.6	70.8
2020-21	3,750	390.7	258.5	132.2	66.2
Latest change (%)		*+1.1%*	*-5.6%*	*+17.4%*	*-4.6pp*

Source: NHS Digital using His Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Wales

5.36 Table 5.3 shows that in 2020-21, providing-performer dentists in Wales had average taxable income of £100,200, an increase of 1.3 per cent from 2019-20, and average expenses of £185,700 (Expenses to Earnings Ratio (EER) of 65.0 per cent).

Table 5.3: Providing-performer GDPs' average gross earnings, income and expenses, Wales, NHS and private, headcount, 2017-18 to 2020-21

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	200	274.5	189.2	85.3	68.9
2018-19	200	294.6	206.1	88.4	70.0
2019-20	200	322.5	223.6	98.9	69.3
2020-21	200	285.8	185.7	100.2	65.0
Latest change (%)		*-11.4%*	*-16.9%*	*+1.3%*	*-4.3pp*

Source: NHS Digital using His Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Scotland

5.37 Table 5.4 shows that in 2020-21 providing-performer dentists in Scotland had average taxable income of £136,400, an increase of 31.5 per cent from 2019-20, and average expenses of £229,700 (EER 62.7 per cent).

Table 5.4: Providing-performer GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2009-10 to 2020-21

Year	Estimated population	Gross earnings (£000s)	Expenses (£000s)	Income (£000s)	EER (%)
2009-10	650	337.0	223.2	113.8	66.2
2010-11	700	334.7	233.6	101.1	69.8
2011-12	700	332.9	230.0	102.9	69.1
2012-13	650	319.6	222.3	97.4	69.5
2013-14	650	330.3	231.9	98.4	70.2
2014-15	600	347.2	244.3	102.9	70.4
2015-16	500	377.8	267.0	110.8	70.7
2016-17	500	377.3	268.3	109.0	71.1
2017-18	500	367.7	260.0	107.6	70.7
2018-19	500	370.9	258.6	112.2	69.7
2019-20	500	344.1	240.4	103.7	69.9
2020-21	450	366.1	229.7	136.4	62.7
Latest change		*+6.4%*	*-4.5%*	*+31.5%*	*-7.2pp*

Source: NHS Digital using His Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Northern Ireland

5.38 Table 5.5 shows that in 2020-21, providing-performer dentists had average taxable income of £122,000, an increase of 23.0 per cent, and average expenses of £197,900 (EER 61.9 per cent). Variations in average incomes, suggest that there is a degree of volatility in these statistics associated with the small sample size.

Table 5.5: Providing-performer GDPs' average gross earnings, income and expenses, Northern Ireland, Health Service and private, headcount, 2009-10 to 2020-21

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2009-10	350	344.6	221.7	122.9	64.3
2010-11	300	331.0	216.8	114.2	65.5
2011-12	350	318.6	206.1	112.5	64.7
2012-13	300	316.0	205.2	110.9	64.9
2013-14	300	335.6	223.1	112.5	66.5
2014-15	250	328.7	217.0	111.7	66.0
2015-16	250	336.0	218.4	117.6	65.0
2016-17	200	314.7	215.5	99.1	68.5
2017-18	250	347.1	231.1	116.0	66.6
2018-19	200	334.2	229.7	104.4	68.8
2019-20	200	312.9	213.7	99.2	68.3
2020-21	250	319.9	197.9	122.0	61.9
Latest change		*+2.2%*	*-7.4%*	*+23.0%*	*-6.4pp*

Source: NHS Digital using His Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Earnings and Expenses for Associate GDPs

England

5.39 Table 5.6 shows that in 2020-21, associate dentists in England had average taxable income of £58,700, an increase of 1.0 per cent from 2019-20, and average expenses of £25,100 (EER of 29.9 per cent).

Table 5.6: Associate GDPs' average gross earnings, income and expenses, England, NHS and private, headcount, 2017-18 to 2020-21

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	16,300	90.3	33.3	57.0	36.9
2018-19	16,600	89.0	31.4	57.6	35.3
2019-20	16,750	87.5	29.4	58.1	33.6
2020-21	16,200	83.8	25.1	58.7	29.9
Latest change		*-4.2%*	*-14.6%*	*+1.0%*	*-3.7pp*

Source: NHS Digital using His Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Wales

5.40 Table 5.7 shows that in 2020-21, associate dentists in Wales had average taxable income of £60,100, a decrease of 2.9 per cent from 2019-20, and average expenses of £35,500 (EER of 37.1 per cent).

Table 5.7: Associate GDPs' average gross earnings, income and expenses, Wales, NHS and private, headcount, 2017-18 to 2020-21

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2017-18	850	104.6	46.4	58.3	44.3
2018-19	950	105.3	46.5	58.8	44.2
2019-20	950	110.0	48.1	61.9	43.7
2020-21	900	95.6	35.5	60.1	37.1
Latest change		*-13.1%*	*-26.2%*	*-2.9%*	*-6.6pp*

Source: NHS Digital using His Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Scotland

5.41 Table 5.8 shows that in 2020-21, associate dentists in Scotland had average taxable income of £59,800, an increase of 2.6 per cent from 2019-20, and average expenses of £27,700 (EER of 31.7 per cent).

Table 5.8: Associate GDPs' average gross earnings, income and expenses, Scotland, NHS and private, headcount, 2009-10 to 2020-21

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2009-10	1,450	91.9	28.8	63.1	31.3
2010-11	1,450	87.9	27.8	60.1	31.6
2011-12	1,550	85.0	27.5	57.6	32.3
2012-13	1,650	84.9	27.7	57.2	32.6
2013-14	1,650	84.9	28.7	56.2	33.8
2014-15	1,750	84.7	29.7	55.0	35.1
2015-16	1,700	86.0	30.7	55.2	35.7
2016-17	1,750	88.6	32.1	56.4	36.3
2017-18	1,800	85.2	29.9	55.4	35.0
2018-19	1,850	90.1	32.7	57.4	36.3
2019-20	1,900	89.8	31.5	58.3	35.0
2020-21	1,900	87.6	27.7	59.8	31.7
Latest change		*-2.4%*	*-12.1%*	*+2.6%*	*-3.3pp*

Source: NHS Digital using His Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Northern Ireland

5.42 Table 5.9 shows that in 2020-21, associate dentists in Northern Ireland had average taxable income of £59,500, an increase of 4.0 per cent from 2019-20, and average expenses of £31,300 (EER of 34.5 per cent).

Table 5.9: Associate GDPs' average gross earnings, income and expenses, Northern Ireland, Health Service and private, headcount, 2009-10 to 2020-21

Year	Estimated population	Gross earnings (£000)	Expenses (£000)	Income (£000)	EER (%)
2009-10	500	97.9	35.2	62.7	36.0
2010-11	550	96.2	36.9	59.4	38.3
2011-12	600	91.6	35.8	55.7	39.1
2012-13	650	86.7	33.7	53.0	38.9
2013-14	700	89.7	35.5	54.2	39.6
2014-15	700	90.2	36.1	54.0	40.1
2015-16	750	98.9	44.7	54.2	45.2
2016-17	850	104.8	45.7	59.1	43.6
2017-18	850	85.9	33.6	52.3	39.1
2018-19	850	98.1	39.4	58.7	40.2
2019-20	900	96.2	39.0	57.2	40.5
2020-21	900	90.8	31.3	59.5	34.5
Latest change		*-5.6%*	*-19.7%*	*+4.0%*	*-6.0pp*

Source: NHS Digital using His Majesty's Revenue and Customs data.
pp: percentage point change.
EER: expenses to earnings ratio

Expenses and Contractual Uplifts

5.43 Since 2015 the DDRB has made recommendations on uplifts in pay net of expenses. The 2015 DDRB Report explained that this decision was taken on the basis that the parties were unable to provide them with evidence on income and expenses to the required level of robustness and detail, and recommended that the parties should determine how to deliver the recommended uplift through the annual contract negotiation process. Taking this approach required the parties to discuss expenses to agree a gross increase to overall contract values.

5.44 In England, on 23 January 2023, NHS Business Services Authority announced that an overall contractual uplift of 4.75 per cent would be applied to GDS contract values for 2022-23, incorporating implementing our 4.5 per cent recommendation from last year's report and an expenses uplift worth 5.3 per cent, based on a modified gross domestic product deflator. The Scottish and Welsh Governments both applied an overall contractual uplift of 4.5 per cent. The Welsh Government said that applying an overall contractual uplift equal to our recommendations was a more straightforward approach. DoH said that before leaving his post, the previous Health Minister accepted and approved a 4.5 per cent net increase to fees and allowances, incorporating a 4.5 per cent expenses uplift alongside implementing our recommendations.

5.45 The BDA said that they had written to the governments in July 2022 setting out evidence that they had gathered on the increasing costs being faced by practices. They said that this evidence made the case that dental inflation stood at 11.15 per cent and staff costs inflation was 15 per cent. They also said that no justification was provided by governments in Scotland, Wales and Northern Ireland for their 4.5 per cent expenses uplifts. They added that the expenses uplift for England, which amounted to 5.3 per cent based on a modified gross domestic product deflator, was subject to consultation not negotiation, and no evidence was provided that such a deflator was an appropriate proxy for practice expense inflation.

5.46 In remit letters for this year's pay round, DHSC asked us to make recommendations on the pay element of dental contracts, and the Scottish Government asked us to make a recommendation on pay for dentists, without specifying whether this might include expenses. The remit letters for Wales and Northern Ireland were silent on this matter. The BDA asked us to return to making separate recommendations on expenses uplifts.

Community Dental Services/Public Dental Service

5.47 The Community Dental Services (CDS) in England, Wales and Northern Ireland and the Public Dental Service (PDS) in Scotland, provide general dental care to people who cannot access care through practice-based GDPs. This includes those with particular dental needs, including vulnerable groups. CDS dentists are salaried and are usually managed as NHS Trust employees, and salaried primary care dentists have their own nationally agreed pay, terms and conditions though where applicable, CDS dentists may also have their pay, terms and conditions aligned to other employed medical and dental staff such as consultants, dependent on their post, grade or seniority. CDS are commissioned by NHSE in England. In Scotland, Wales and Northern Ireland, PDS/CDS are provided by Health Boards/Trusts.

England

5.48 NHSE said that 84 per cent of CDS contracts in England were held with NHS trusts, with the other 16 per cent with Community Interest Companies (CICs). They said that staff working in CICs may be subject to different rates of pay and wider terms and conditions, but Trust-employed CDS dentists were paid based on nationally agreed pay scales. They said that workforce gaps in the CDS would compound backlog issues for the management of oral health in vulnerable groups, and they were setting up a waiting list reporting mechanism for the CDS.

5.49 NHS Employers said that they had surveyed a small group of CDS employers on issues concerning recruitment, retention and morale. They said that the sample size limited the extent to which broad conclusions may be drawn but did provide a snapshot. They said that pay and annual leave arrangements for salaried dentists was generally less favourable in comparison with practice-based posts.

5.50 The BDA said that headcounts in the CDS in England were falling, and they also said that a high proportion of staff were aged over 55. They also said that BDA surveys of CDS dentists in England had shown a significant decline in a number of job satisfaction measures, including pay satisfaction. They said that 30 per cent felt their pay was fair in 2022, compared to 50 per cent in 2021. They said that increased stress amongst the CDS workforce was caused by workload increases, demand shifting from other parts of the dental system to the CDS, poor staffing and poor leadership.

5.51 NHS Staff Survey data for England for salaried primary care dentists has been available from 2018 onwards. In 2022, 38.4 per cent of dentists were satisfied with their pay, a decrease from 48.5 per cent in 2021. The results for 2022 were less positive than for consultants, but more positive than those for SAS doctors and doctors and dentists in training.

Scotland

5.52 The BDA said that surveys of PDS dentists in Scotland identified challenges to job satisfaction, morale, workload and stress and career plans. They said that only four in ten PDS dentists surveyed planned to continue practicing as a community dentist, and over one third of PDS dentists were aged over 55.

Wales

5.53 The Welsh Government told us that their latest data, from March 2020, indicated that the FTE size of the CDS workforce in Wales fell by 4.8 to 99.3 during the previous year. They said that they encourage the expansion of the CDS, especially where there are gaps in independent contractor provision, and that they hoped the recent downward trend in the size of the CDS workforce in Wales would be reversed.

5.54 The BDA said that surveys of CDS dentists in Wales identified challenges relating to waiting lists, underinvestment, workload and mental health. They said that the introduction of e-referrals to the CDS in Wales had led to the CDS treating double the number of children with no additional funding or resources, and this had led to other groups of CDS patients being disadvantaged as a result.

Northern Ireland

5.55 DoH said that there were few opportunities for career progression in the CDS in Northern Ireland, which accounted for higher staff turnover, due to a lack of senior posts and training pathways. They also said that an increase in referrals had led to increased waiting lists, and increased personal protective equipment requirements had made practicing in the CDS more challenging, having a detrimental impact on staff wellbeing and retention. They also said that they were looking to negotiate a new out of hours pay system for CDS dentists in Northern Ireland.

5.56 The BDA said that surveys of CDS dentists in Northern Ireland identified challenges to job satisfaction, morale, workload and stress.

Our comments

5.57 We are increasingly concerned about the continuing severe difficulties in access to NHS/HSC dentistry across the UK and the consequences for the oral and overall health of patients. In particular, the results of the GP Patient Survey with respect to dentistry in England are concerning, with significant falls in both the proportion of the public who are trying to get an NHS dental appointment and in the proportion of those who are successful. Poor access to NHS dental services will negatively affect oral health, and can also exacerbate other health issues as, for example, dental appointments play a crucial role in the detection of oral cancers. It is likely that these trends are replicated across the UK. We note with interest the ongoing Health and Social Care Select Committee inquiry into access to NHS dentistry, which will also examine dental contract reform[5].

5.58 We are very concerned that delivery against UDA targets in England in 2022-23 was so low, which suggests that the contractual model is not functioning effectively. DHSC and NHSE did not say how the clawed back funds will be used, and, therefore, there is no guarantee that they will not be lost to dentistry. This means that there is, in effect, a significant deficiency in the amount of NHS dentistry that has been funded in England, relative to the amount contracted, and so it seems unlikely that this lesser amount will be sufficient to meet demand, further exacerbating issues with the accessibility of dental services.

5.59 We note that the BDA identified an increasing difficulty for practices to recruit associates as a major factor in being unable to meet their activity targets, leading to clawback. They also said that there was a correlation between difficulties recruiting associates and the proportion of NHS/HSC activity done by a practice.

5.60 While there are always likely to be ways in which doing private dental work is more attractive than doing NHS/HSC dentistry, for access to NHS/HSC dentistry to improve there either need to be more dentists trained, or practices need to be incentivised to take on more NHS/HSC work. This clearly relates to the need for a robust assessment of workforce demand to inform workforce planning efforts, including relating to the number of dental school places, as we discuss in Chapter 2. At the same time, ensuring that the relative profitability of NHS/HSC dentistry, compared to private work, is at a sustainable level is crucial for the viability of NHS/HSC services.

[5] https://committees.parliament.uk/work/7140/nhs-dentistry/news/175008/mps-to-examine-struggle-to-access-nhs-dentistry-services/

5.61 In previous reports, we have not taken a specific position on what represents an appropriate direction of travel for contract reform. However, we are severely and increasingly concerned that contractual models everywhere across the UK are no longer capable of providing a stable and sustainable basis for the delivery of widely accessible NHS/HSC dental services. Trends in access may be driven to some extent by other issues, including that of expenses, which we discuss below, and the relative attractiveness of private work. However, it seems to be that the case for fundamental contract reform, to move to a model that can better support dentists to deliver good-quality clinical practice to the general public, is becoming increasingly clear. It would be disappointing if the governments spent another year failing to address this issue, and while we have some sympathy with DHSC's view that no contractual model is perfect, this should not be taken as an excuse not to reform contractual models that are not working, or to delay ongoing attempts to reform contracts.

5.62 We note the significant increase in earnings for providing-performer dentists in England, Scotland and Northern Ireland in 2020-21, which was not replicated for associate dentists or in Wales. Clearly, the changes to the way that the dental sector functioned that year due to the pandemic will have been a major factor in this change, and we note that clawback fell to almost zero in England in 2020-21. The separate arrangements across the four nations will also have impacted earnings levels differently, which will likely have led to the different percentage changes that were seen in each nation. It is important that all parties look to understand the impact of pandemic measures on earnings especially when comparing them to values pre- and post-pandemic. It remains important to understand how the long-term earnings position has been affected through the pandemic years, including how changes in the proportion of dentists' workloads that relate to NHS/HSC and private work, and trends in working hours, affect this situation. At the same time, we acknowledge that the earnings data that is provided to us is an imperfect measure of how much dentists are earning for NHS/HSC work, given it is prepared on a headcount basis and includes all income, including for private dental work and non-dental income.

5.63 Last year we made our recommendation for GDPs net of expenses. We also said that we 'expect that an expenses uplift will be agreed between the BDA and the governments as part of annual contract negotiations. Expenses uplifts must address issues such as increased operating and practice staff costs, which fall under practice expenses.' We also noted that DHSC said that they would typically use CPI as a starting point for determining an expenses uplift. We note that across the UK, the expenses uplifts that have been implemented are considerably below CPI inflation, and that the BDA have said that detailed negotiations over an expenses uplift did not take place anywhere in the UK. They said that expenses uplifts were instead subject to consultation in England, and were imposed in Scotland, Wales and Northern Ireland.

5.64 In last year's report, we also asked the parties to provide us with 'detailed rationales for expenses uplifts and efficiencies applied' in evidence for this year's round. None of the governments provided us with this; NHSE told us that they used an adjusted gross domestic product deflator without explaining any of the specifics of the process they followed, while governments in Wales and Northern Ireland said that they had simply used our pay recommendation to uplift expenses, despite us being clear that our recommendation was for pay, not overall contract values. The Scottish Government did not explain to us why they made a 4.5 per cent expenses uplift.

5.65 None of these approaches suggest a detailed and evidence-based consideration of how the costs faced by practices evolve in a given year. Therefore, it is difficult for us to have confidence that the expenses uplifts applied to dental contracts across the UK will accurately and fairly reflect annual growth in the costs being faced by practice, and therefore for us to have confidence that our pay recommendations will ultimately be reflected in the take-home pay of dentists working at a typical practice, as we have repeatedly said they should. We discuss this alongside the similar issue of GMP expenses in Chapters 6 and 7.

5.66 We are also increasingly concerned about the CDS/PDS workforce. Whether as a result of wider pressures on NHS/HSC dentistry, or a deliberate strategy to treat more patients in the CDS/PDS, this important group of dentists are reporting greater demand pressure, longer waiting lists and higher workloads across the UK. Regardless of the reasons why these pressures are increasing, this situation means it is ever more crucial that health services do more to understand and address issues of recruitment and retention, establish whether their CDS/PDS workforces are sufficiently large to meet demand, and act to ensure that they can fill vacancies. Important to addressing issues of recruitment and retention is ensuring that pay is sufficient to attract dentists to the CDS/PDS. Ultimately, ensuring that the CDS and PDS are sufficiently staffed is necessary for this relatively small but important part of health services to be able to treat some of the UK's most vulnerable people, and neglecting them is likely to lead to greater demand on other parts of the NHS/HSC. We therefore note with concern that NHS Employers said the relative size of the starting salary for salaried dentists, compared to practice-based posts, was affecting recruitment and retention. This message was also reflected in our conversations with CDS and PDS dentists during our visits programme. We would welcome hearing in detail from all relevant parties about whether they agree with this characterisation of the situation, as well as what role reform and restructuring of the CDS and PDS pay scales could play in addressing it.

CHAPTER 6: PAY OBSERVATIONS & RECOMMENDATIONS

Introduction

6.1 In this chapter, we first set out and discuss long-term trends in pay and discuss the latest developments for pensions. Following this, we outline our recommendations for 2023-24.

Long-term Pay Trends

6.2 We examine trends in pay for doctors and dentists in three main ways. We consider how earnings have evolved relative to the pay distribution across the UK economy (using the Office for National Statistics' (ONS's) Annual Survey of Hours and Earnings (ASHE) dataset), which we refer to as the 'pay position', how real terms pay has evolved over the last decade, and how pay compares to comparator professions. Our pay comparability methodology was last reviewed by the Institute for Employment Studies in 2017[1].

The pay position

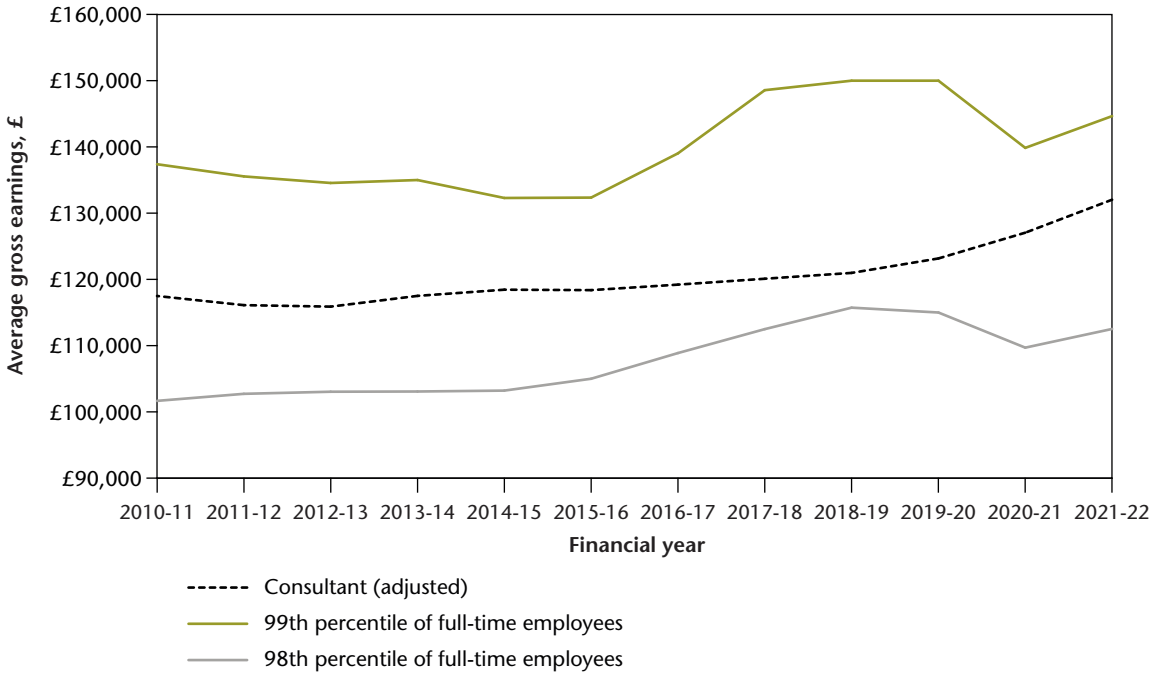
6.3 Since our 2019 report, the calculations for Hospital and Community Health Service staff in England, which are represented below, have been based on the NHS Digital mean annual basic pay per FTE, added to non-basic pay per head data adjusted by a factor that reflected the ratio between FTE and headcount estimates of basic pay. In our 2019 report we said that we believed this estimate was a more appropriate comparator to the ASHE data, which is based on the total earnings of full-time employees. A new earnings estimate for GMPs was also introduced from 2019, which adjusted the data published by NHS Digital on a headcount basis by a factor that reflected the ratio of the number of GMPs on a headcount basis to the number of GMPs on an FTE basis. The calculations in this section are based on the adjusted earnings estimates introduced in 2019, unless stated otherwise.

6.4 In 2021, we also introduced a new earnings estimate for GDPs, which adjusted the headcount data published by NHS Digital for each of the four UK countries, by factors that reflect the average weekly number of hours worked, as reported in the survey of Dentists' Working Patterns, Motivation and Morale published by NHS Digital. However, the Working Patterns survey was not conducted in 2020-21, and given that working patterns of GDPs in 2020-21 were heavily distorted by COVID-19 we do not think it appropriate to adjust the earnings estimate for 2020-21 by hours worked in a previous year. Therefore, our comparisons of earnings for GDPs are based on the unadjusted earnings data, with no adjustments made for estimates of hours worked. As we discuss in Chapter 5, earnings data for GDPs continues to be based on HMRC data, and therefore includes all income, including for private dental work and non-dental income, as well as income from NHS/HSC dentistry.

[1] https://www.gov.uk/government/publications/review-of-ddrb-pay-comparability-methodology-2017

6.5 Figure 6.1 shows that for consultants, since 2010-11, estimated average total earnings per FTE have been consistently between the 98th and 99th percentiles of FTE earnings in the wider economy. Between 2015-16 and 2018-19 consultant average earnings fell back from the 99th percentile and down towards the 98th percentile, although in both 2019-20 and 2020-21 this was reversed as average consultant earnings increased while earnings at the 98th and 99th percentiles were either flat or falling, and in 2021-22 consultant earnings grew more quickly than earnings at the 98th and 99th percentiles.

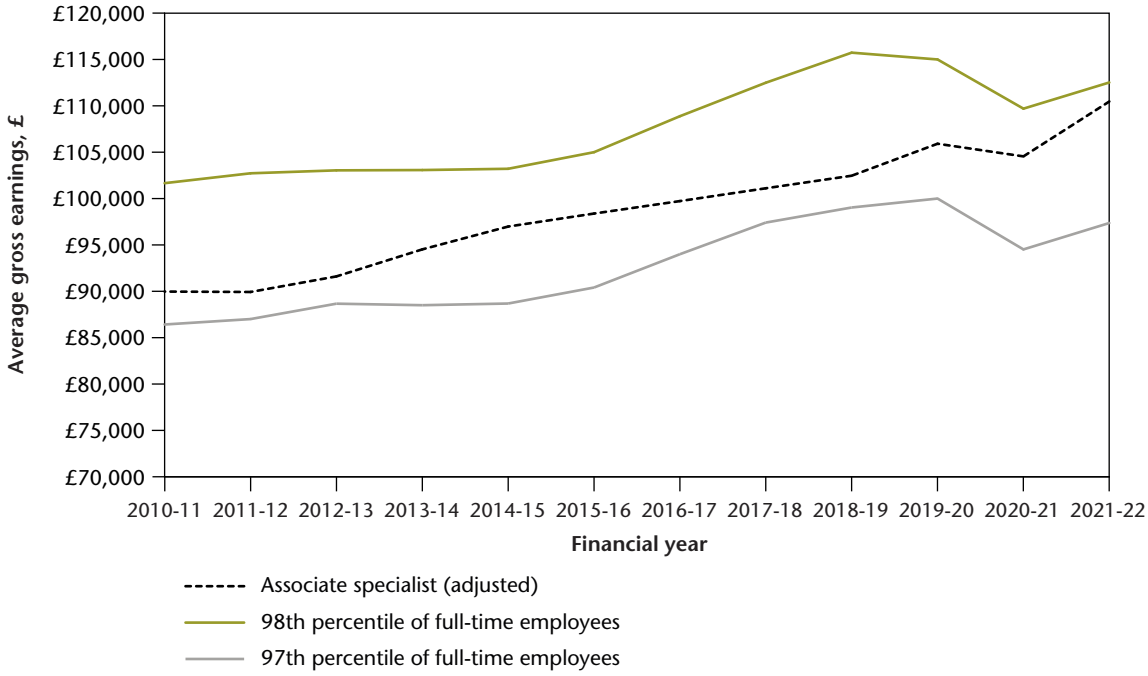
Figure 6.1: Estimated average total earnings per FTE of consultants in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



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

6.6 Figure 6.2 shows that associate specialists' estimated average total earnings per FTE have been consistently between the 97th and 98th percentile in the wider economy. After falling back towards the 97th percentile between 2015-16 and 2018-19 associate specialists' average earnings moved closer to the 98th percentile in each year since 2019-20.

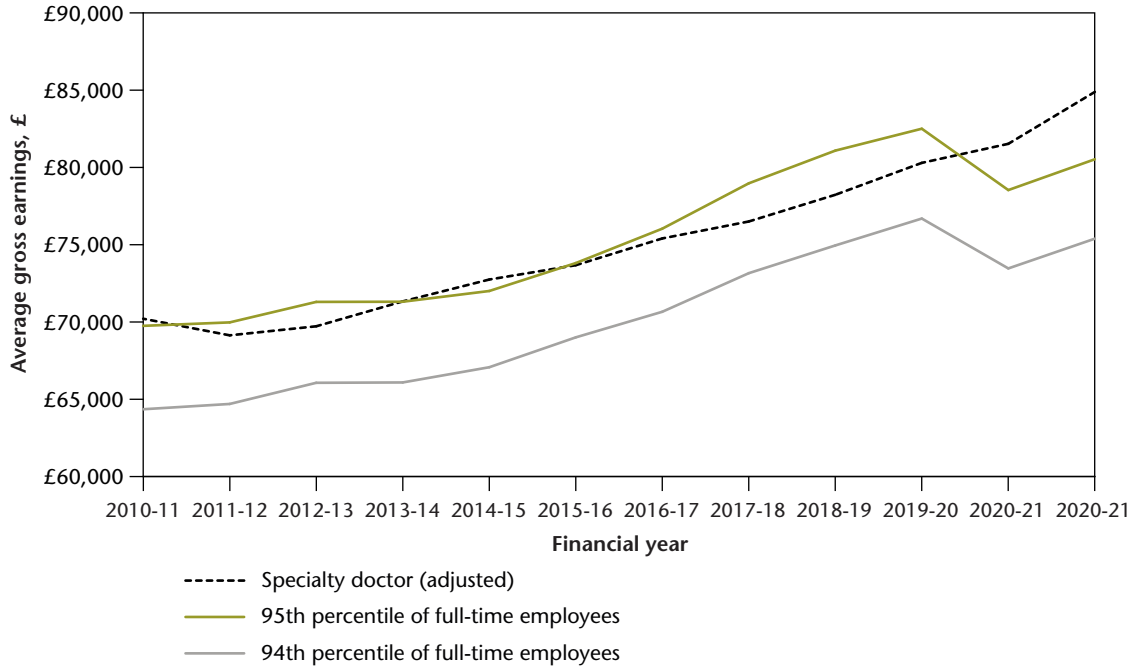
Figure 6.2: Estimated average total earnings per FTE of associate specialists in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



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

6.7 Figure 6.3 shows that estimated average total earnings per FTE for specialty doctors were broadly in line with earnings at the 95th percentile between 2010-11 and 2015-16. Average total earnings for specialty doctors fell below earnings at the 95th percentile between 2016-17 and 2019-20, before moving back above that benchmark in 2020-21 and 2021-22.

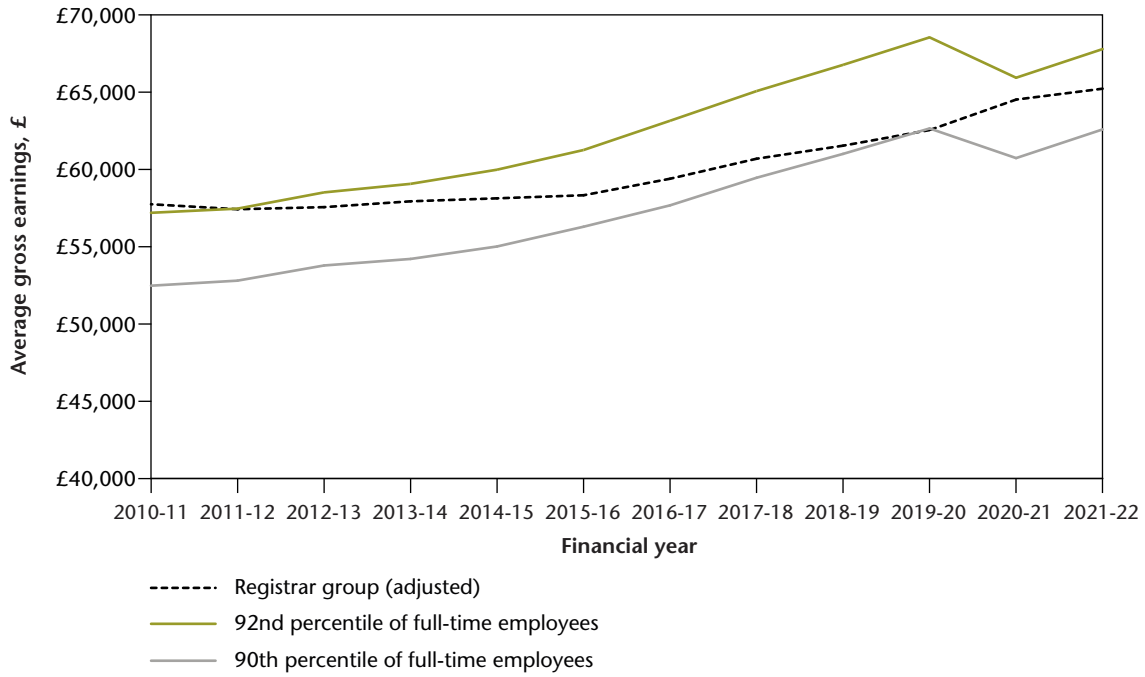
Figure 6.3: Estimated average total earnings per FTE of specialty doctors in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



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

6.8 Figure 6.4 shows that estimated average total earnings per FTE of the registrar group were just above the 92nd percentile in 2010-11. However, by 2019-20 average earnings of the registrar group had fallen back in line with those of the 90th percentile, before moving back towards the 92nd percentile across 2020-21 and 2021-22.

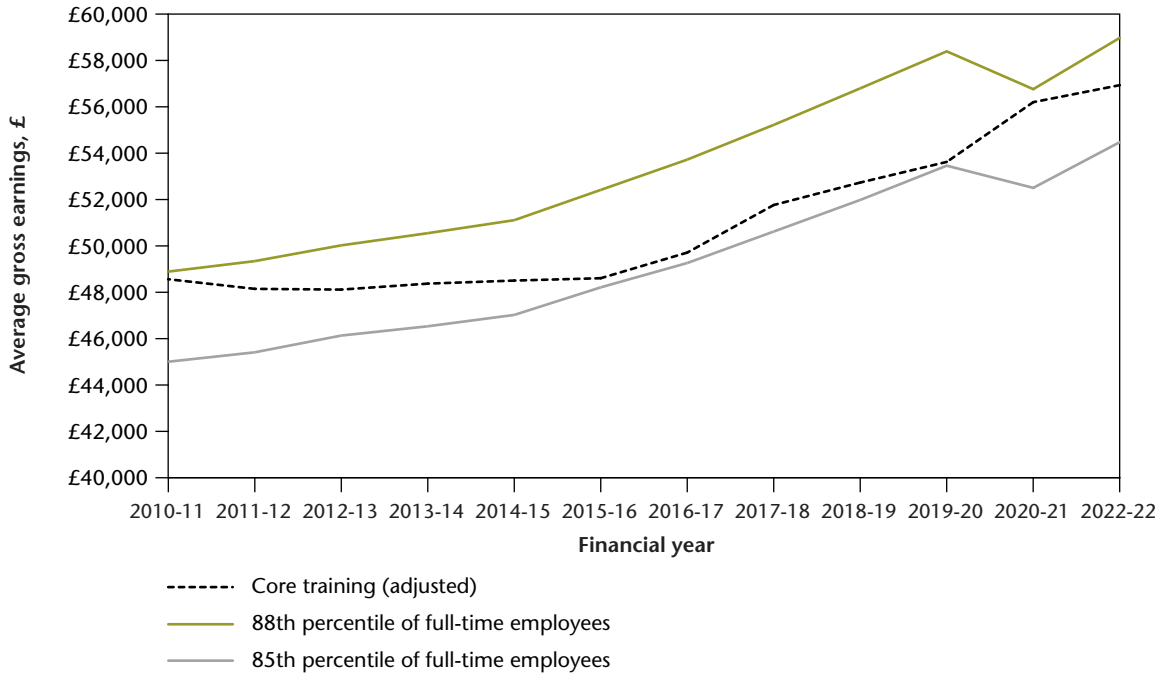
Figure 6.4: Estimated average total earnings per FTE of the registrar group in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



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

6.9 Figure 6.5 shows that estimated average total earnings per FTE of those in core training fell back from the 88th percentile in 2010-11 to the 85th percentile in 2015-16, maintained that relative position to 2019-20, before moving back towards to the 88th percentile.

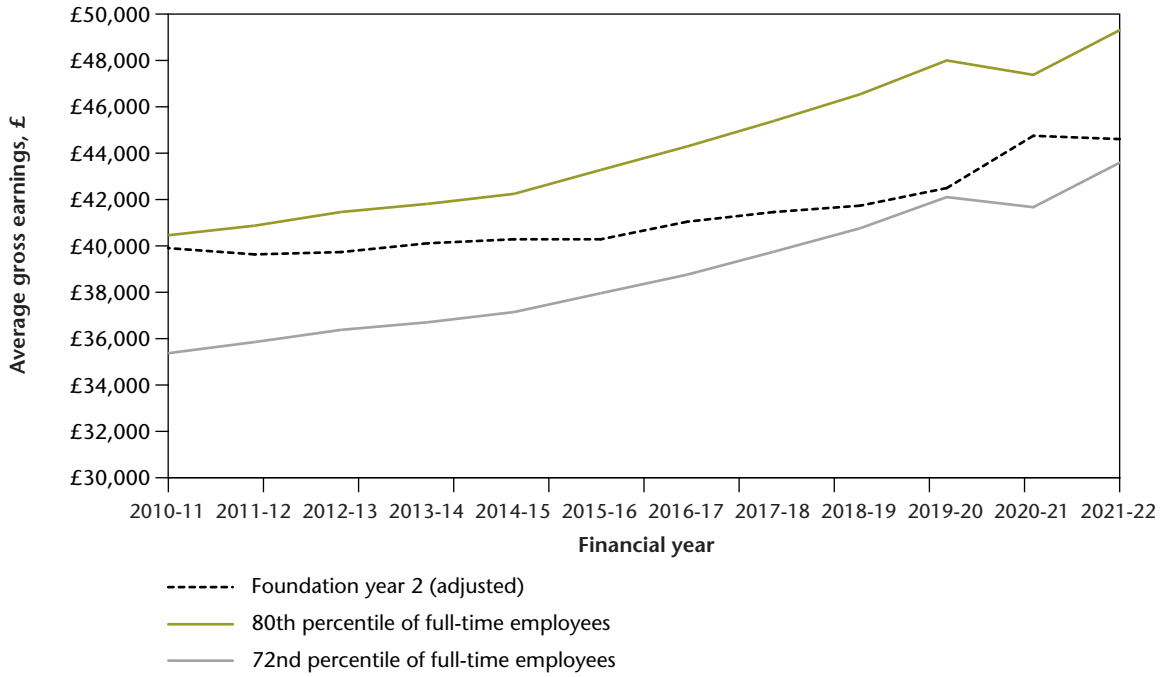
Figure 6.5: Estimated average total earnings per FTE of those in core training in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



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

6.10 Figure 6.6 shows that estimated average total earnings per FTE for those in the second year of foundation training fell back from just below the 80th percentile in 2010-11 to just ahead of the 72nd percentile by 2019-20, moved back up towards the 80th percentile in 2020-21, but fell back again closer to the 72nd percentile in 2021-22.

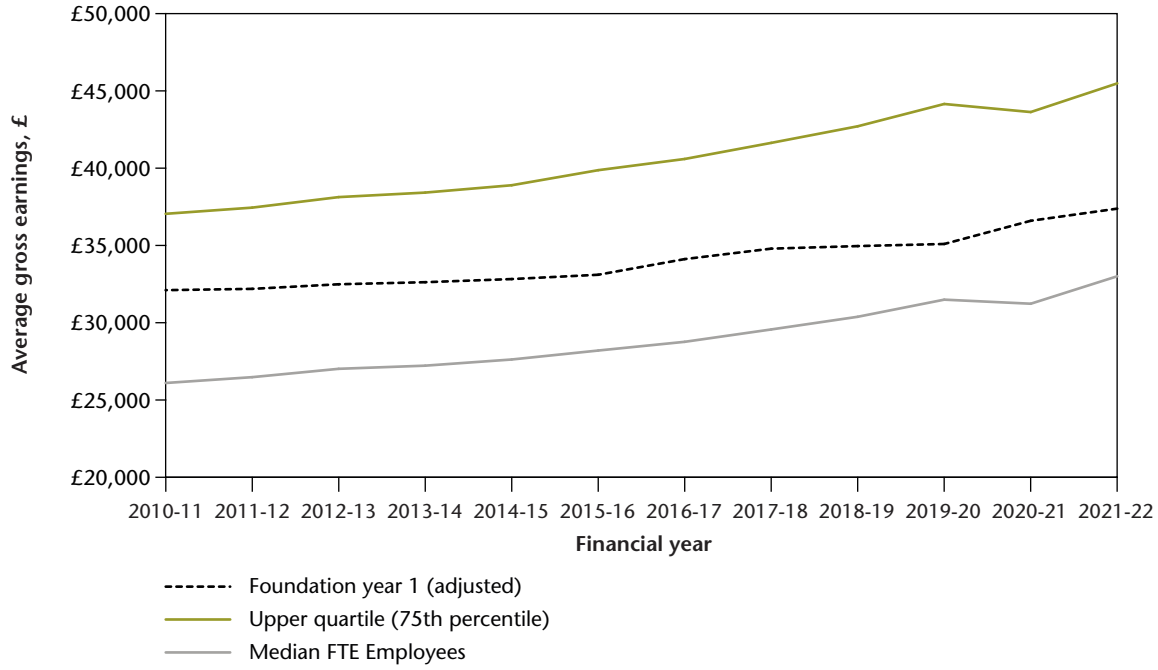
Figure 6.6: Estimated average total earnings per FTE of foundation year 2 trainees in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



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

6.11 Figure 6.7 shows that, for those in the first year of foundation training, between 2010-11 and 2021-22, estimated average total earnings per FTE remained between the median and the upper quartile of earnings across the economy as a whole, although falling away from the upper quartile and towards the median until 2019-20, before moving back towards the upper quartile in 2020-21, then falling back towards the median in 2021-22.

Figure 6.7: Estimated average total earnings per FTE of foundation year 1 trainees in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22

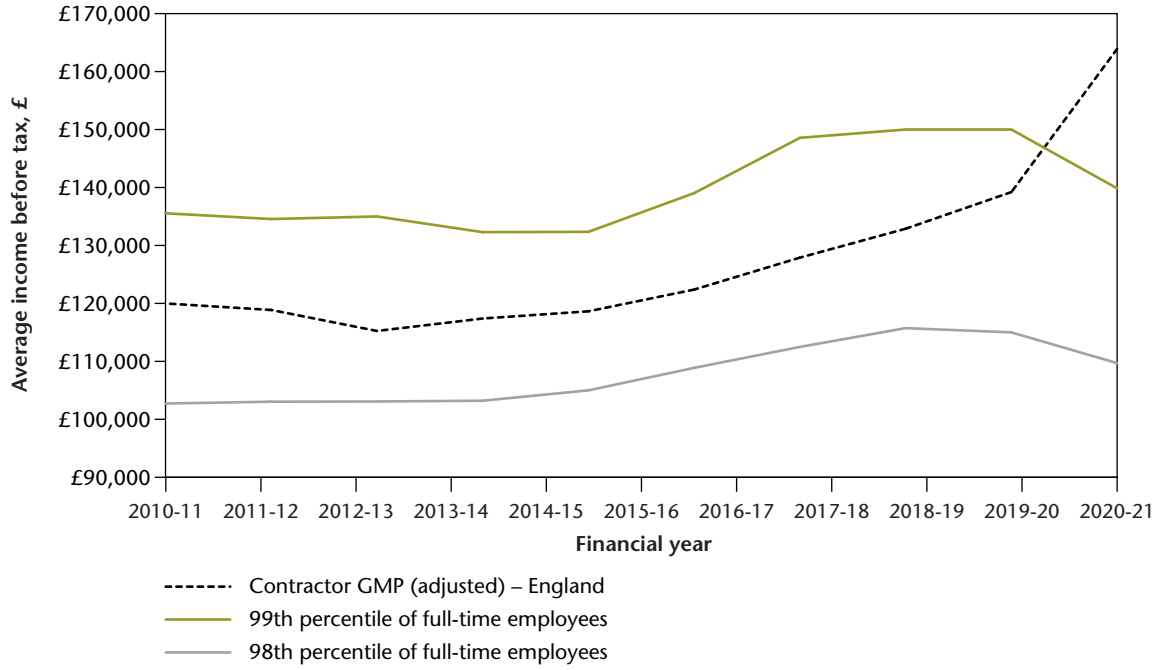


Source: OME estimates, based on data from NHS Digital, ONS.

6.12 Figure 6.8 shows contractor GMP income before tax consistently between the 98th and 99th percentiles of earnings for the economy as a whole. Contractor GMP income before tax fell back towards the 98th percentile between 2010-11 and 2013-14, but regained some ground against the 98th percentile since that date, and in 2020-21 moved above the 99th percentile of earnings for the economy as a whole.

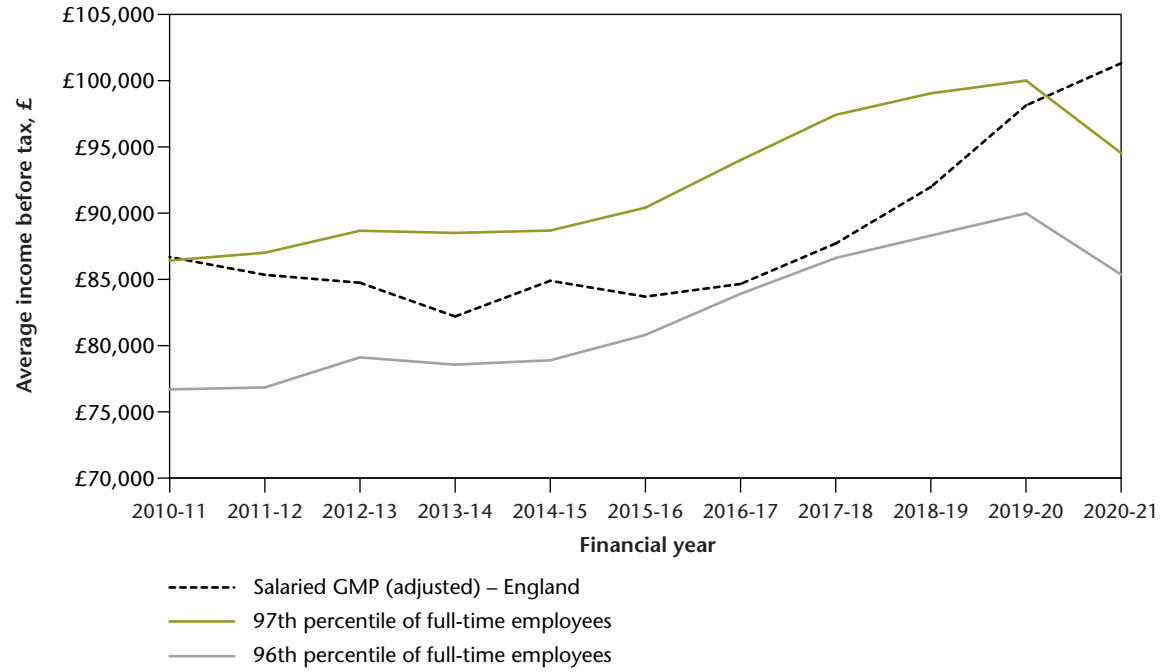
6.13 Figure 6.9 shows in 2010-11 salaried GMPs income before tax on average were in line with those of the 97th percentile, but had fallen back to the 96th percentile by 2016-17, before regaining some ground on the 97th percentile in both 2018-19 and 2019-20, and exceeding the 97th percentile in 2020-21.

Figure 6.8: Average income before tax of contractor GMPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



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

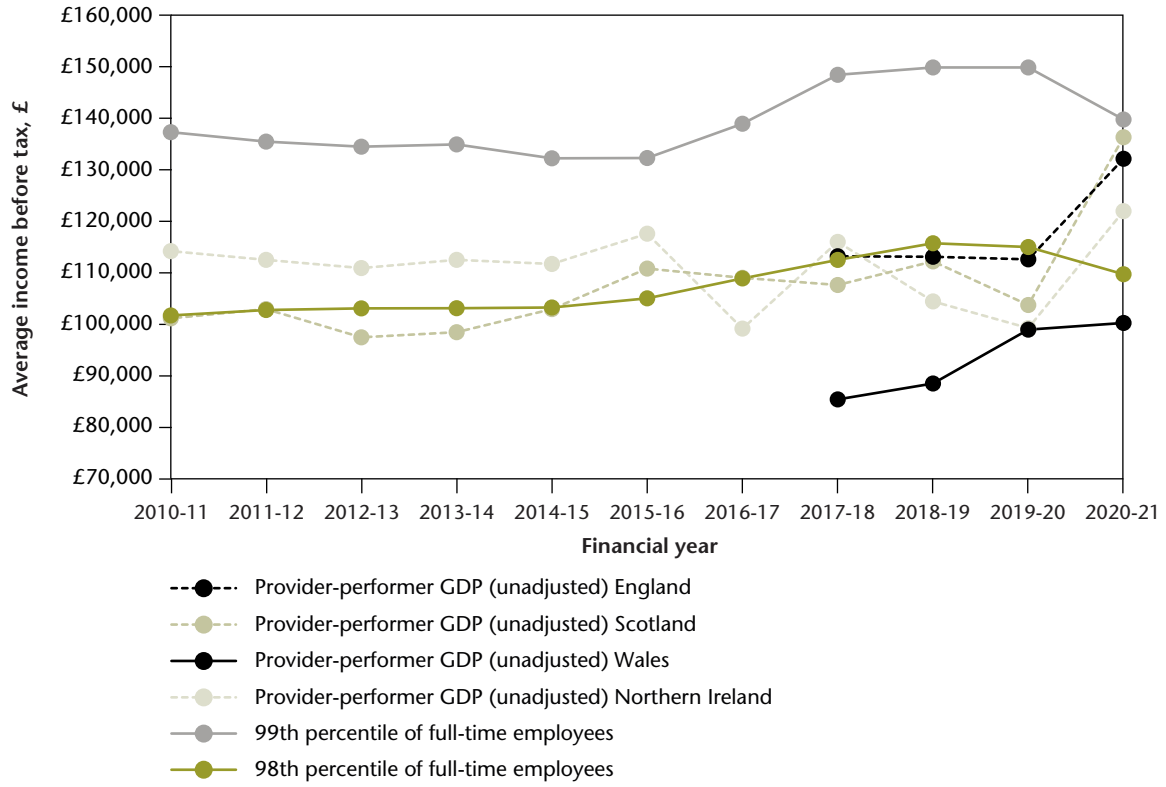
Figure 6.9: Average income before tax of salaried GMPs in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



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

6.14 Figure 6.10 shows in 2010-11 unadjusted providing-performer GDP earnings (including non-NHS/HSC income) in Scotland were in line with the 98th percentile in the wider economy and Northern Ireland were between the 98th and 99th percentiles. In 2020-21, unadjusted providing-performer GDP earnings were between the 98th and 99th percentiles in England, Scotland, and Northern Ireland, and below the 98th percentile in Wales. In 2020-21, the levels of activity and the income and expenses of dental contractors will have been affected by COVID-19.

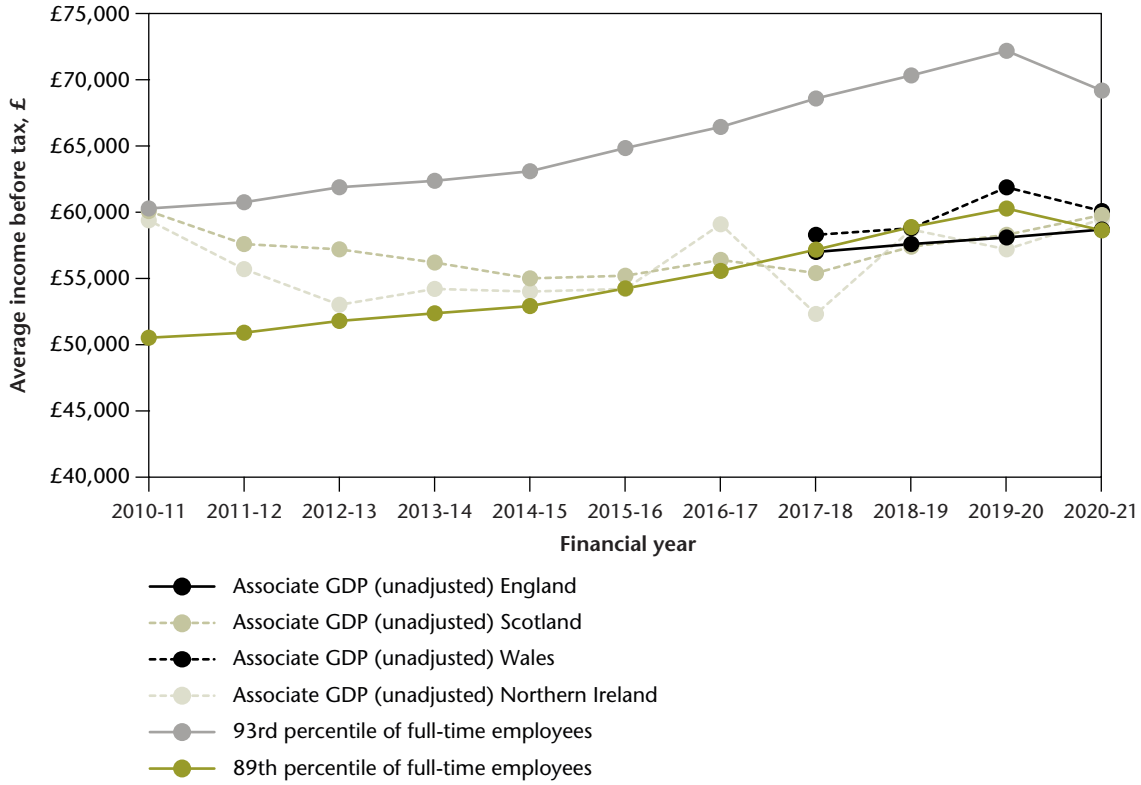
Figure 6.10: Average headcount income before tax of providing-performer GDPs in England, Scotland, Wales, Northern Ireland, unadjusted for average weekly hours worked, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



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

6.15 Figure 6.11 shows in 2010-11 unadjusted associate GDP earnings (including non-NHS/HSC income) in Scotland and Northern Ireland were just below the 93rd percentile in the wider economy. In 2020-21, unadjusted associate GDP earnings were just above the 89th percentile in Scotland, Northern Ireland, Wales and England.

Figure 6.11: Average headcount income before tax of associate GDPs in England, Scotland, Wales, Northern Ireland, unadjusted for average weekly hours worked, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2020-21



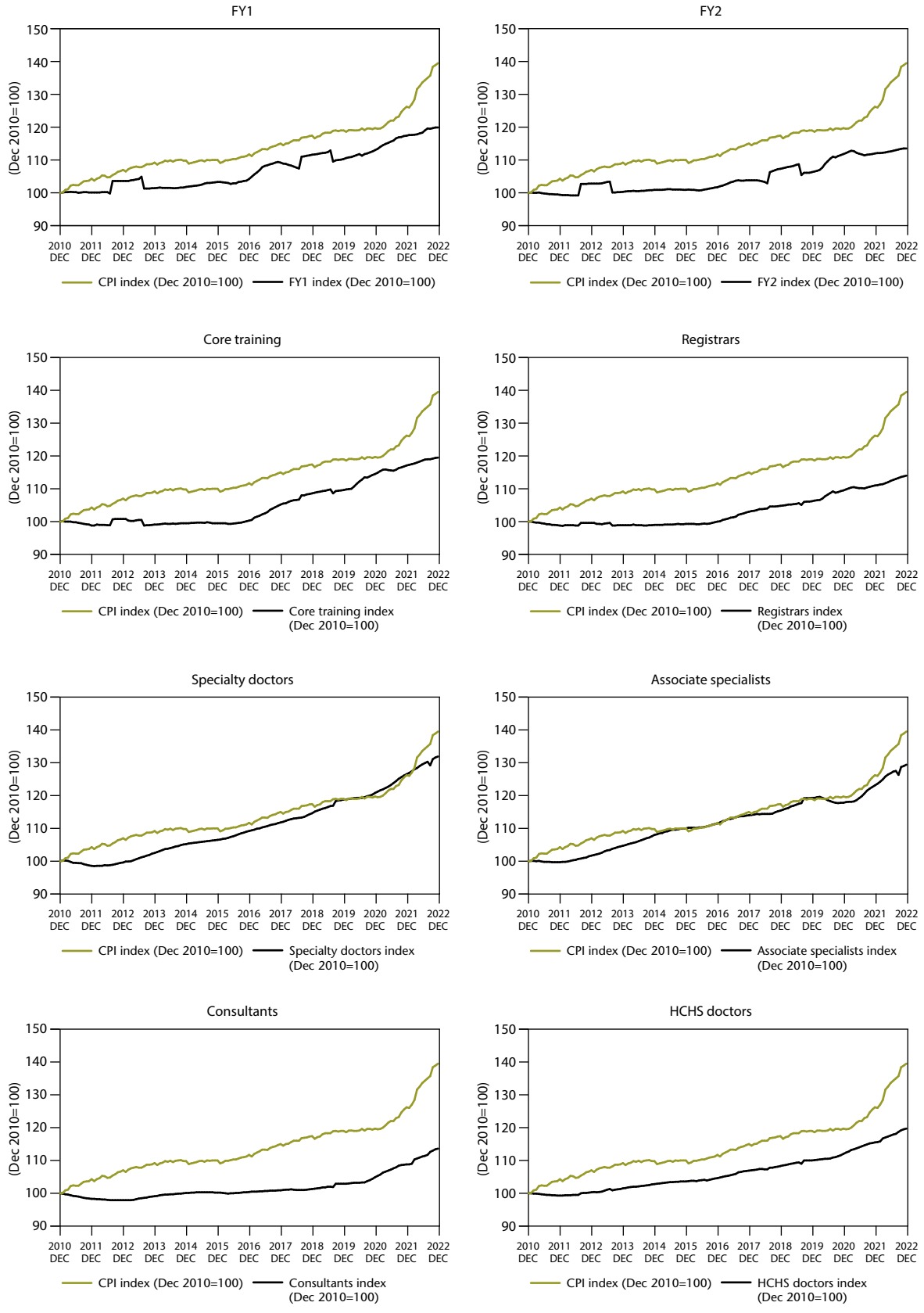
Source: OME estimates, based on data from NHS Digital, ONS.

Long-term trends in real terms pay

6.16 As we have said in previous reports, we do not believe that it is our role to ensure that pay tracks or avoids tracking historical economic measures, retrospectively or otherwise. However, long-term trends in real pay do have the potential to impact on our wider considerations, which is why we examine them in our report.

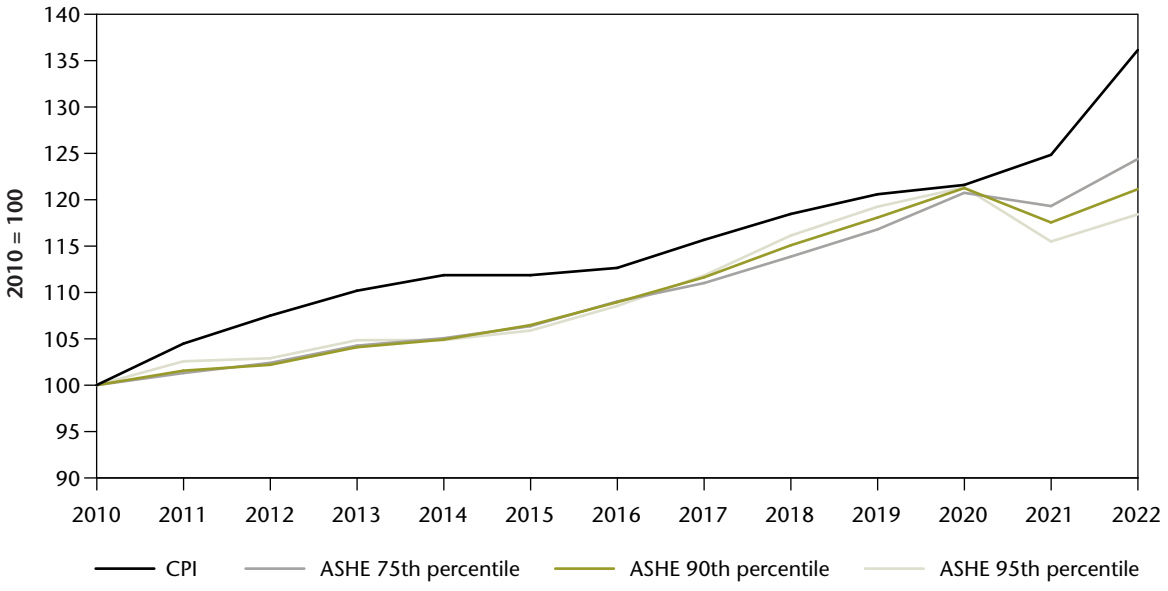
6.17 The graphs below show the change between 2010 and 2022 of mean average earnings for different grades within our remit group, compared to CPI. It shows that there have been falls amongst most groups relative to CPI, but much of this has occurred since the spring of 2021 and the period of higher rates of inflation.

Figure 6.12: Hospital and Community Health Services (HCHS) doctors, England, change in mean average earnings per person and CPI, between December 2010 and December 2022



6.18 Over a similar period, figure 6.13 shows that CPI has grown more quickly than the Annual Survey of Hours and Earnings (ASHE) estimates of full-time earnings at the 75th, 90th and 95th percentiles of the earnings distribution, particularly since 2021.

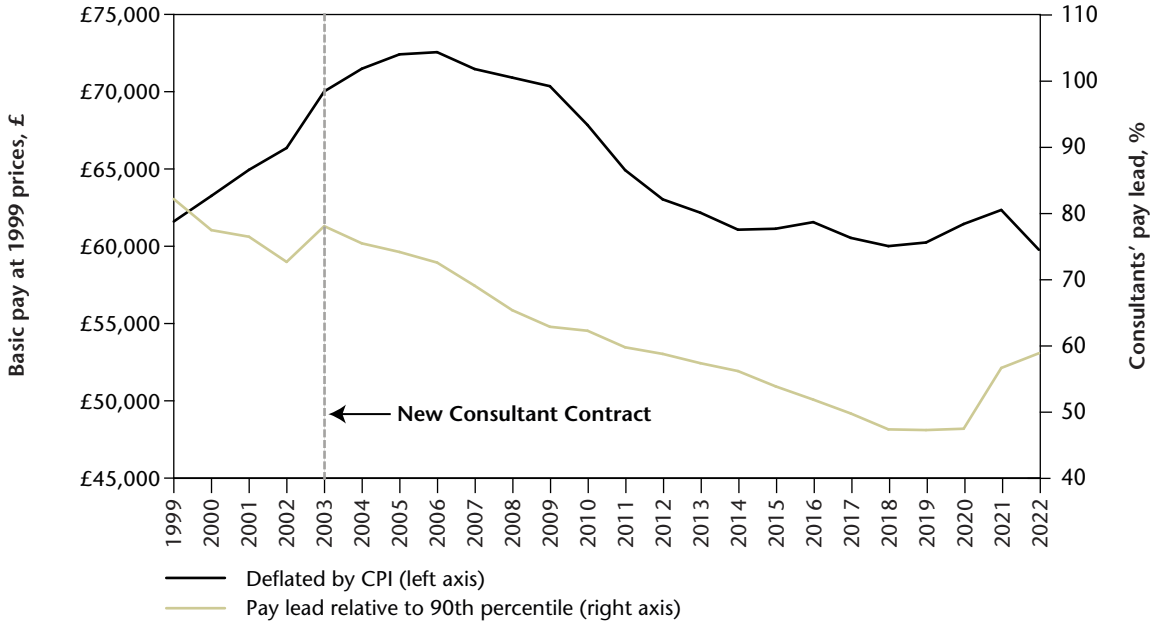
Figure 6.13: ASHE 75th, 90th and 95th percentiles and CPI index, from 2010



Source: NHS Digital.

6.19 Looking at the value of a single point on one of the pay scales, in this case the fifth pay point on the consultants' pay scale is a different way of assessing long-term trends in real pay, as it is not affected by the changing composition of the workforce. Compared with CPI inflation, the value of this pay point decreased between 2006 and 2018, then increased between 2018 and 2021, before falling back in 2022 (Figure 6.14). Compared with average earnings at the 90th percentile, the value of the 5th point on the consultants' pay scale lost value between 2003 and 2018, but retained its value between 2018 and 2020 and increased its value in both 2021 and 2022.

Figure 6.14: Change in the value of the 5th point on the consultants' pay scale, in real terms and as compared to 90th percentile earnings, England, 1999 to 2022



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

6.20 The BMA said that doctors had faced an unprecedented cut in their average real-terms income over the last 15 years. They said that while it was not possible to provide a specific single figure that would be applicable to all their members, but that it amounted to around 26 per cent for junior doctors in England and, when changes to taxation and pension arrangements were taken into account, consultants had seen a decline of up to 35 per cent in their real take-home pay.

Pay comparability

6.21 Figure 6.15 compares the pay distributions for doctors and dentists of different grades to those for comparator professions. It is important to note that, in this section, the pay for other professions is on a full-time equivalent (FTE) basis, whereas that for doctors and dentists this data is on a headcount basis, and so is lower than it would be on an FTE basis. Groups with lower average working hours, such as salaried GMPs are likely to be particularly affected by this. Generally speaking, doctors and dentists earn more than their veterinary and academic comparators, but less than their other professional comparators. The scale of the differences vary somewhat by group.

Figure 6.15: Total earnings inter-quartile ranges of DDRB grades, (England), compared with professional comparator groups, full-time rates, 2022

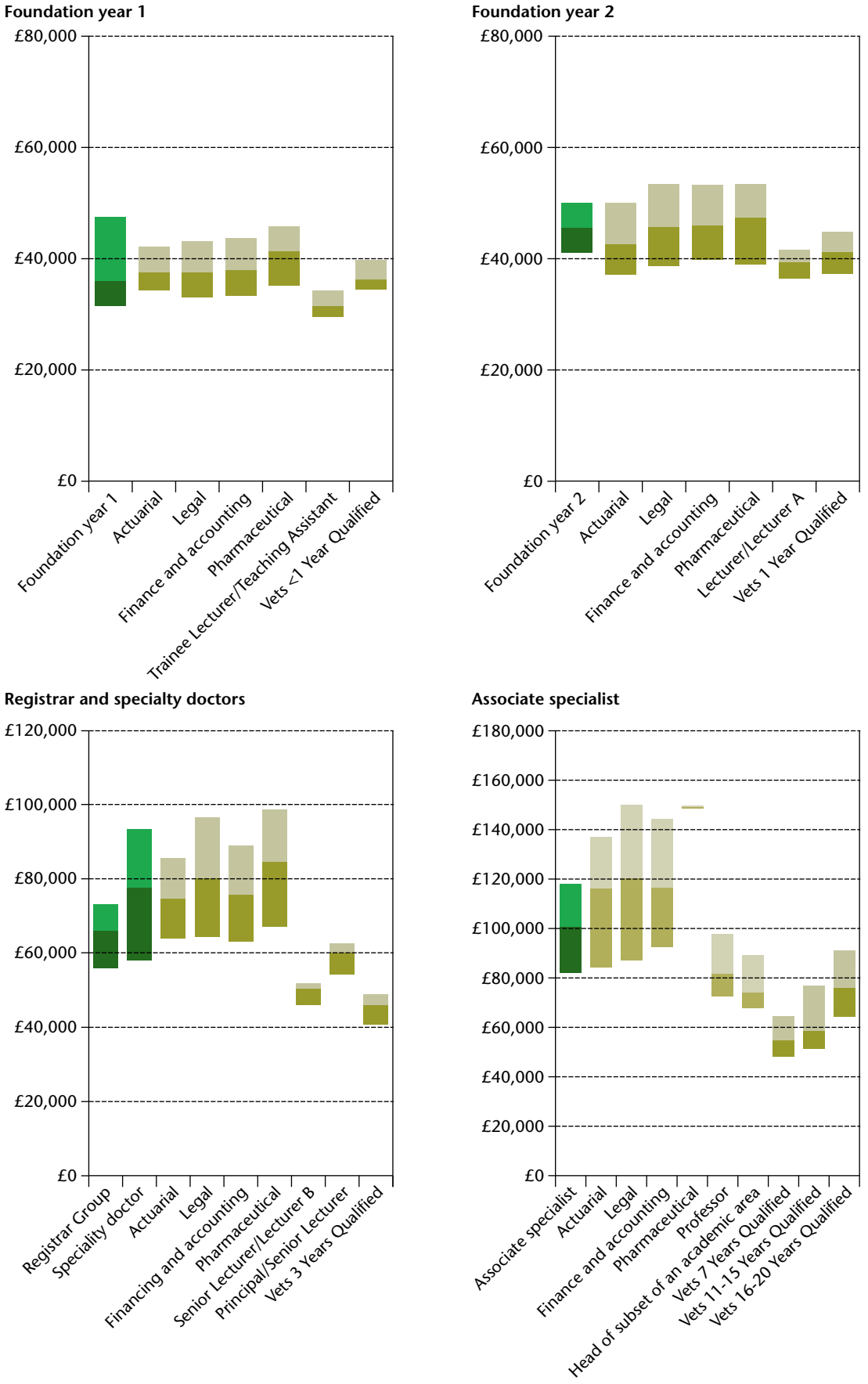
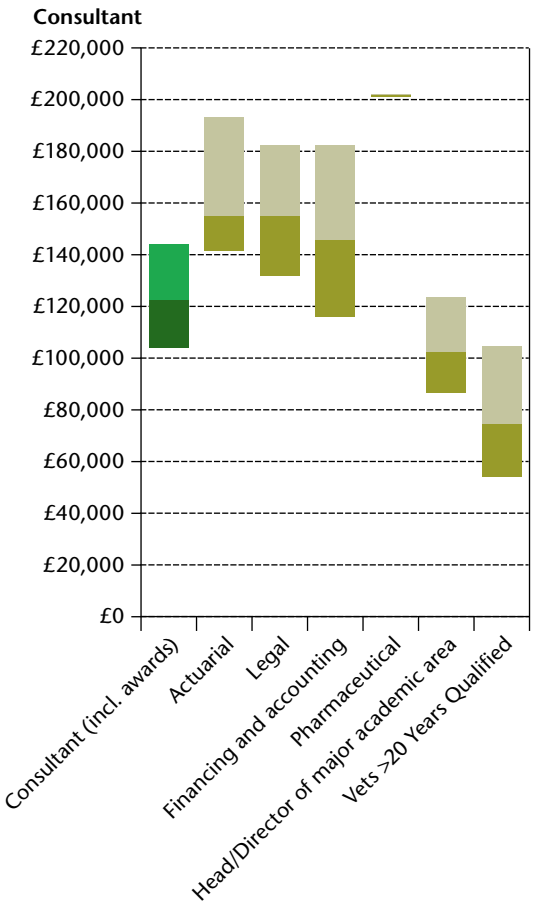
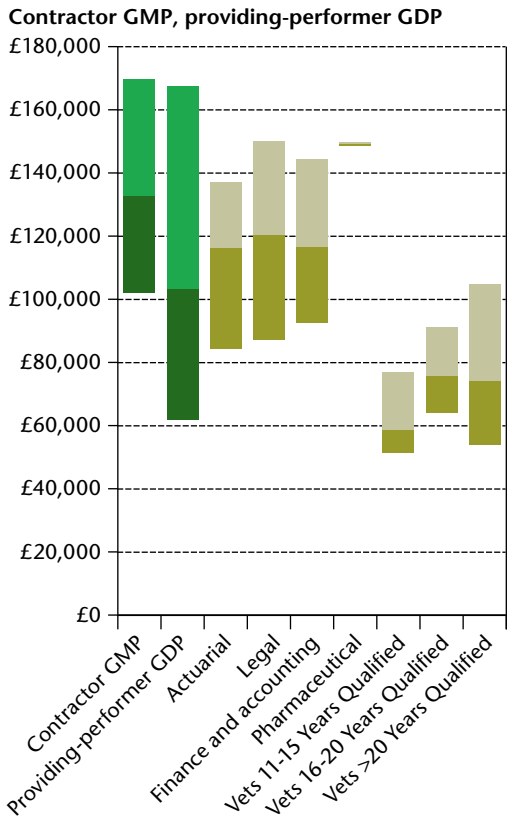
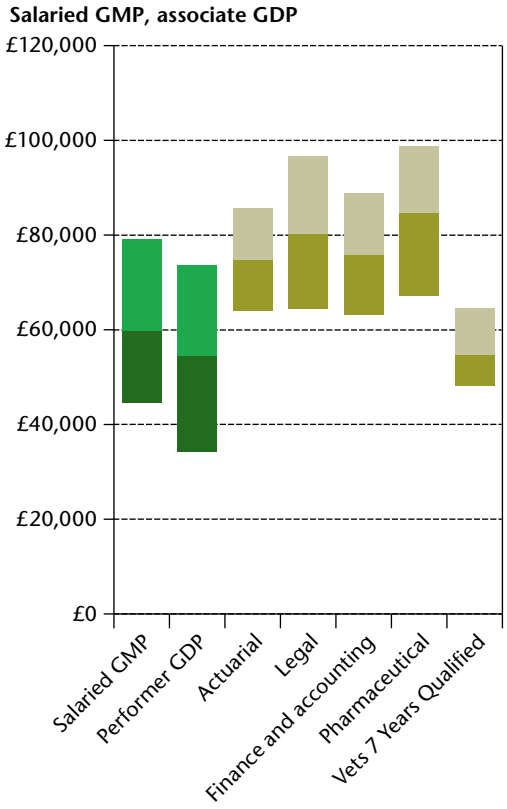


Figure 6.15 (continued): Total earnings inter-quartile ranges of DDRB grades, compared with professional comparator groups, 2022







Pensions and Pensions Taxation

6.22 While pensions and pensions taxation are outside the formal remit of the review body, as a prominent part of total reward they can have a significant impact on recruitment, retention and motivation. We therefore discuss pensions and pensions taxation in some detail in this report, and it featured prominently in the evidence provided to us by the parties.

Changes to NHS/HSC pension schemes

6.23 In December 2022, DHSC published the consultation paper *NHS Pension Scheme: proposed amendments to scheme regulations*. This paper proposed four sets of changes to the NHS Pension Scheme's regulations, which would apply for scheme members in England and Wales. These were:

- New retirement flexibilities
- Aligning the timing of Consumer Price Index (CPI) inflation rates used for revaluing pension benefits and the CPI used in annual allowance tax calculations
- Ensuring scheme access for staff employed by primary care networks (PCNs)
- Technical updates to member contributions provisions

6.24 In March 2023, DHSC published a consultation response that said that the changes were well received and so they intended to proceed with the proposals.

6.25 The first of these sets of proposals would see a number of changes made to regulations to provide scheme members with a greater degree of flexibility about how they take their pension benefits. This included:

- Removing the 16-hour rule, which limits how much an individual can work in their first month back without impacting their pension
- Enabling those who have taken their pension in the 1995 Scheme to join the 2015 Scheme upon re-employment
- Introducing a new partial retirement scheme

6.26 Proposed changes to the employee contribution structure in England and Wales were implemented from 1 October 2022. These changes saw the overall contribution structure partially flattened, and also saw rules change so that contributions would be based on actual, rather than FTE earnings.

6.27 In December 2022, the Scottish Public Pensions Agency (SPPA) published a consultation paper on changes to the NHS Pension Scheme (Scotland) regulations. The proposed changes were similar to those relating to retirement flexibilities and aligning the timing of CPI rates used that were consulted on for England and Wales. SPPA also published a consultation paper in early 2022 on changing the employee contribution structure in Scotland. Changes would have been similar to those that were implemented in England and Wales from 1 October 2022. However, the Scottish Government said that, after examining the consultation responses, SPPA had decided to consider the proposals further and that they would consult again in early 2023. At the time of writing, this consultation has not been published.

6.28 In November 2022, a new employee contribution structure was introduced in HSC Pension Scheme regulations in Northern Ireland, similar to the changes that were implemented from October 2022 for England and Wales; the contribution structure was partially flattened and contribution tiers would from then on be determined by actual rather than FTE pay. In January 2023, DoH published a consultation paper on changes to scheme regulations, with proposals that were similar to those proposed in the December 2022 consultations for England and Wales and Scotland. The consultation also proposed changes to scheme regulations so that, going forward, contribution tier thresholds would also be uprated by the Agenda for Change pay uplift each year. In their consultation response, which was published in March 2023, DoH said that they intended to implement these changes from 1 April 2023.

Parties' views on changes to NHS/HSC pension schemes

6.29 DHSC said that the new employee contribution structure was likely to benefit doctors and dentists, who are generally higher earners within the overall NHS workforce. They also said that the shift to basing contribution tiers on actual, rather than FTE earnings, would benefit many part-time doctors and dentists. DHSC noted that the proposals for increased retirement flexibilities reflected that retirement was now often a gradual process over many years, and staff valued the ability to retire flexibly in a way that suits their work-life balance. They also said that they had commissioned a programme of communications about the new flexibilities from NHSE and NHS Employers. They added that they believed the new flexibilities could also support senior doctors and dentists impacted by pension tax to continue to deliver their NHS work whilst reducing their pension tax exposure.

6.30 NHS Employers said that a wider range of retirement flexibilities would further support employers to retain parts of the NHS workforce. They said that they welcomed the proposals included in the DHSC consultation and would support their introduction in their consultation response, and would look to promote and raise awareness of all retirement flexibilities to help educate and prepare employers ahead of changes being introduced in 2023.

6.31 NHS Providers, who provided us with a copy of their response to the DHSC consultation, said that the proposals would go some way to mitigate retention issues for the highest earners, but the proposals would not address the core issue of annual allowance taxation for higher earners (which is discussed below). They said that they welcomed the headline proposals on new retirement flexibilities, but had some specific concerns, and they welcomed the proposal to realign CPI rates.

6.32 The Scottish Government said the proposed new retirement flexibilities would offer staff more options at the end of their careers and that NHS Scotland would then be able to benefit from their skills and experience, providing an important boost to NHS capacity at a crucial time. They also said that the changes around CPI inflation could mean there was less of a likelihood that some scheme members would face annual allowance tax charges.

6.33 The BMA said that the action to align CPI dates would only partially mitigate issues, rather than solving them. They also said that they welcomed the development of partial retirement options, but that it was essential that employers supported staff wishing to pursue this option. They added that abatement rules should be scrapped entirely. BMA Scotland also said that the non-implementation of changes to the employee contribution structure there meant that those who work less-than-full-time (LTFT) or are towards the top of the employee contribution structure have been paying significantly higher contribution rates than the rest of the UK.

Pensions taxation

6.34 In evidence submissions from all parties and on visits, a key topic of discussion was the impact that issues relating to pensions taxation were having on retention of the most senior doctors and dentists. All parties agreed that the situation led to senior doctors and dentists being disincentivised from taking on additional work or responsibilities, or from continuing to work in NHS/HSC at all.

6.35 Across the UK, governments made further progress towards enabling access to schemes under which unused employer contribution would be paid as salary to those who have opted out of pensions schemes, a practice known as 'recycling'. DHSC said that they were working with NHSE to ensure that NHS employers were able to offer recycling for staff who opt out of the pension scheme because they have exceeded their pension tax allowances. They also said that GMP partnerships were able to set up their own contribution recycling arrangement for their partner and salaried GMPs should they wish.

6.36 The Scottish Government said that they had delegated the powers to NHS Boards to offer recycling, and employers had worked with BMA Scotland to develop a scheme that was now in operation. They also said that offering recycling in the long-term was not a sustainable solution. BMA Scotland said that they welcomed this, and it was one of the most effective initiatives at the Scottish Government's disposal, but that it was disappointing that only a portion (12.4 per cent instead of 18.4 per cent) of the employer contribution was made available.

6.37 The Welsh Government said that their recycling scheme had helped address the situation, but it was not a perfect solution.

6.38 DoH said that they were working to introduce guidance to allow HSC employers to offer flexibilities including recycling for those affected by pensions taxation issues.

6.39 The BMA said that recycling of the full employer contribution needed to be mandated nationally across the UK, which they said was at the time of writing only the case in Wales. They said that whilst recycling was not a solution to the issues caused by pensions taxation, it could be an important mitigation until wider issues were addressed.

6.40 In the March Budget, the Chancellor announced that the pensions tax Annual Allowance would be increased from £40,000 to £60,000 and the Lifetime Allowance would be abolished. This took place following the submission of written evidence to us by all parties, and so it was not discussed in detail in the evidence provided to us. However, on their website, the BMA said that 'Senior doctors in the BMA have welcomed the end to the NHS 'pension trap' for the majority of doctors, following a pledge to increase the annual allowance announced in today's Budget[2].' They added that 'the changes, which have come following years of campaigning by the BMA, mean that a significant number of senior doctors will no longer be subjected to punitive tax rules regarding how much they accrue within their pensions[3].'

NHS pension scheme membership

6.41 DHSC provided us with data about the HCHS workforce in England. This showed that there had been a long-term fall in the proportion of the HCHS workforce who are members of the pension scheme, including in particular those in the consultant, associate specialist and core training groupings. For the first two of these groups in particular, it is possible that this fall is related to pensions taxation issues.

Table 6.1: NHS Pension Scheme membership for the HCHS workforce, England, June 2022

Group	Headcount	Membership	1-year change	5-year change	10-year change
Consultant	57,000	91%	0%	-2%	-4%
Associate specialist	2,000	90%	-1%	-3%	-3%
Specialty doctor	9,000	86%	0%	-2%	0%
Staff grade	<1,000	90%	-1%	5%	0%
Core training	34,000	86%	0%	-6%	-5%
Speciality registrar	18,000	92%	+2%	-2%	-1%
Foundation year 1	6,000	93%	-1%	-2%	-1%
Foundation year 2	7,000	92%	0%	-3%	-2%
Hospital practitioner/clinical assistant	2,000	70%	0%	-5%	-10%
Other and local HCHS doctor grades	1,000	82%	+1%	-1%	-7%
All HCHS doctors	137,000	90%	0%	-3%	-3%

[2] https://www.bma.org.uk/news-and-opinion/government-raises-annual-allowance-for-pensions, captured on 20 April 2023
[3] ibid

Our Comments on Long-Term Pay Trends and Pensions and Pensions Taxation

6.42 The three main ways that we examine long-term trends in pay for our remit group discussed above each present a different picture. Long-term trends relative to inflation generally show a fall that accelerated after inflation started to increase in 2021, though the scale of the loss differs slightly between different groups. However, depending on the starting year and the inflation measure used, the loss varies in size. The unions' choice of RPI and a starting year of 2008 maximises the scale of falls, and we note that ONS have previously expressed concerns about the use of RPI, saying that it represents 'a very poor measure of general inflation, at times greatly overestimating and at other times underestimating changes in prices and how these changes are experienced.'[4] This is the reason that CPI and CPIH are our preferred inflation measures. The BMA said to us that they believe that RPI better represents the costs faced by doctors, but did not provide us with any justification for this. We would also note that long-term trends in real pay for the upper part of earnings distribution as a whole suggest that doctors and dentists are not exceptional in having experienced this shift in real-terms pay.

6.43 On the other hand, long-term trends in the pay position, relative to the earnings distribution, generally show a small and gradual fall during much of the 2010s, somewhat smaller than any falls relative to inflation during the same period. This fall was slightly larger for doctors and dentists in training. This was reversed slightly and gradually after the DDRB returned to making recommendations more freely after 2018, and then much more quickly during the early part of the pandemic, before falling back again slightly in 2021-22, but with the fall representing a relatively small proportion of the gain made in 2020-21. It is not clear how this will continue to evolve going forward and as the volatility associated with the pandemic stabilises.

6.44 Long-term trends in pay comparability with other professions are also mixed. Doctors and dentists remain ahead of some comparator groups and behind others. We also note what DHSC said about the total reward package being significantly more valuable for doctors and dentists relative to basic pay than for comparator groups mostly employed in the private sector, though we would also note that as well as not capturing total pay, the comparability data also do not capture differing working conditions. Groups in the private sector may also receive more additional or bonus pay relative to their basic pay than doctors and dentists.

[4] https://www.ons.gov.uk/economy/inflationandpriceindices/articles/shortcomingsoftheretailpricesindexasameasureofinflation/2018-03-08#:~:text=Overall%2C%20RPI%20is%20a%20very,how%20these%20changes%20are%20experienced.

6.45 As we discuss earlier in this chapter, we do not believe that it is our role to ensure that pay for our remit group retrospectively tracks, or avoids tracking, inflation or any other measure. And as we discuss later in this chapter, we also do not believe that our remit group should be treated as an exception to trends that affect the economy as a whole. Therefore, even notwithstanding issues of affordability, we do not believe it would be appropriate for us to make a recommendation that pay for doctors and dentists be restored to the real level that it was purported to be at some point in the past, justified purely for its own sake.

6.46 As we said last year, we believe that our role is to examine current and long-term trends in pay for doctors and dentists as they relate to recruitment, retention and motivation, in line with our terms of reference. Therefore, in this report we do not seek to answer the broader question of where doctors' and dentists' pay should be positioned in wider society and the economy as a whole. Parties may wish to consider how such a broad consideration should play a part in ongoing long-term workforce planning efforts, and the extent to which the DDRB could make a contribution to this, if requested to do so.

6.47 For several years, we have warned of the potential impact of the pensions taxation system on retention for the most senior members of our remit group. The issues have been a product of how senior doctors' and dentists' pay, which is high relative to the economy as a whole, and pensions, which maintain a level of security and generosity that has largely disappeared from the private sector, have interacted with the pensions taxation system.

6.48 We have urged employers and health service leaders to take swift action to ensure that the most senior doctors and dentists are not disincentivised from staying in the NHS/HSC or taking on extra work or leadership roles, in order to maximise recruitment and retention and ultimately improve services. Therefore, we welcome the changes to the pensions taxation system made in the 2023 Budget, as well as the other actions taken in the last year intended to improve retention for the most senior doctors and dentists, including progress towards introducing recycling of employer contribution and new flexibilities around retirement. It is clear that under the new pensions taxation regime, doctors and dentists will be able to earn more and accrue more pension before needing to be concerned about the impact of pensions tax on their finances. The progress towards the introduction of recycling schemes and new retirement flexibilities will provide those that are affected with more options to manage pensions tax issues. We would expect that this will significantly increase the financial incentives placed on the most senior and qualified doctors and dentists to maximise their contribution to NHS/HSC. However, it is unlikely that issues of pensions tax and retention will be resolved entirely. It therefore remains important that the impact of these changes is monitored in the coming years to ensure that any remaining issues are appropriately addressed, and to ensure that retention for this important group is maximised for the long-term. We would also welcome hearing more about how these changes affect the numbers that retire early, or change their working patterns or hours.

Our Recommendations

Pay proposals from the parties

6.49 In their written evidence, DHSC said that within the current financial settlement provided to them by HM Treasury, and reprioritisation decisions that had been made, funding was available for pay awards up to 3.5 per cent for the relevant staff groups within the DDRB remit for 2023-24. They said that pay awards above this level would require trade-offs for public service delivery or further government borrowing at a time when headroom against fiscal rules is historically low and sustainable public finances are vital in the fight against inflation. They also said that recommendations on salaried GMP pay should be informed by affordability and the fixed contract resources available to practices under the 5-year GP contract deal. NHSE said that the general practice global sum, which they said was the main way that practice staff pay including for salaried GMPs was funded, reflected sufficient funding for a 2.1 per cent uplift.

6.50 In their written evidence, the Scottish Government said that they would publish a public sector pay policy for 2023-24. Their Public Sector Pay Strategy was published in March 2023, and said that efficiencies and workforce changes would be required for public bodies to go beyond the 2 per cent pay assumption set in the Resource Spending Review. The Pay Strategy also included setting a pay award floor of 2 per cent, and recommended a central metric of 3.5 per cent and an award ceiling and pay envelope maximum of 5 per cent[5].

6.51 The Welsh Government did not present us with a pay proposal or an affordability figure but stressed to us that NHS organisations in Wales were already facing significant financial pressures in 2023-24, and that many health boards were already expecting to overspend significantly, to the extent that this may affect their ability to deliver services.

6.52 The Department of Health (Northern Ireland, DoH) said that at the time of writing, no Budget had been agreed for 2023-24, but that there would need to be departmental budgetary reductions even before taking account of inflationary pressures. They said that there was no capacity to afford a pay uplift for 2023-24 without implementing corresponding cuts to expenditure on services or additional funding being made available. The 2023-24 budget[6] was published in April 2023 and saw Northern Ireland departments allocated a combined resource budget of £14.2 billion, of which £7.30 billion was allocated to DoH, compared to £7.28 billion for 2022-23.

[5] https://www.gov.scot/publications/public-sector-pay-strategy-2023-2024/pages/5/

[6] https://www.finance-ni.gov.uk/news/department-finance-statement-202324-northern-ireland-budget#:~:text=Department%20of%20Finance%20statement%20on%202023%2F24%20Northern%20Ireland%20Budget,-Date%20published%3A%2027&text=The%20Secretary%20of%20State%20today,bn%20capital%20in%202022%2F23.

6.53 The BMA said that they were "asking DDRB to recommend a substantial pay increase to all doctors which will deliver full pay restoration". They also said that our recommendations should not be "constrained by the governments' remit letters or affordability constraints". BMA Scotland also said that they were "seeking a significantly above inflation pay uplift that convincingly front loads the necessary reversal of junior doctors' real terms pay cut of 23.5% on average since 2008." They also said that they were "seeking an uplift that prevents any further real terms pay cut by matching RPI inflation (12-month RPI inflation to April 2023) and provides a further 5% uplift to make some progress in addressing long term pay erosion."

6.54 The BDA asked that we recommend a pay increase of RPI plus 5 per cent for GDPs and employed dentists.

6.55 HCSA did not provide us with a pay proposal.

Our views on the pay proposals

6.56 We note what the BMA said about our recommendations not being constrained by remit letters or affordability evidence. Our position on these issues remains the same as in previous years, and as we outline elsewhere in the report. Our view is that if we are asked to consider or make observations on a specific issue in our remit letter, as was the case for Scotland and Wales this year, we will do so. However, our role is to consider all the evidence that is provided to us based on our terms of reference, and relating to all of our remit group, regardless of whether an issue is or is not raised in remit letters. We do not view the remit letters as having a role in limiting the scope of our considerations in a given year. We would also wish to reiterate that our view is that we are able to make recommendations for any part of our remit group as we consider appropriate, though we also believe that it is important that we generally operate with the consensual agreement of all of the parties.

6.57 We remain of the view that affordability is one of the key factors that we must consider when making recommendations, but it sits alongside the other considerations included in our terms of reference, including recruitment, retention and motivation. The affordability evidence provided to us by the governments therefore represents crucial contextual information for our recommendations but does not serve as a constraint on what they can be. Our report and recommendations for this year are made in keeping with these positions, as has been the case in recent years. We discuss affordability in more detail in Chapter 2.

6.58 Since written evidence was submitted by the governments and health departments, three of them (DHSC and the Scottish and Welsh Governments) have made significantly enhanced pay offers for NHS staff for 2022-23, 2023-24 or both. We discuss these in detail in Chapter 2. In England and Scotland, this comprised staff on the Agenda for Change contract only, but in Wales this also included some groups within our remit. All three also included consolidated elements that would be carried into pay bills going forward. None of the three governments explained how these pay offers, all of which represent substantial increases to NHS pay bills during a time of pressure on services, will be funded or how they will affect the affordability context for our recommendations this year. In particular, we note that DHSC's offer to Agenda for Change (AfC) staff included a consolidated pay uplift for 2023-24 of 5 per cent, despite them having submitted evidence to NHSPRB that 3.5 per cent was available in current budgets to fund pay increases for 2023-24 just a few weeks earlier. This suggests either that the UK, Scottish and Welsh Governments are expecting to provide more funding to their health systems than was previously outlined, or that existing funding has been redirected towards increasing AfC staff pay and less funding would then be available to spend on services or service development, or some combination of these. Whichever of these is the case, these pay offers call into question the integrity of the affordability evidence that they have previously provided to us and make it difficult for us to know what the true affordability picture is.

6.59 Our remit group has faced many similar challenges in the past year to those facing AfC staff, while also receiving a broadly similar pay award in overall percentage terms through the review body process for 2022-23. We are therefore concerned that governments taking action to supplement pay for Agenda for Change staff or, in the case of Wales, for some parts of our remit group and not others, risks creating a sense that the contribution of our remit group, or parts of it, are recognised less than other health service staff.

6.60 We note with concern what DoH said about the affordability situation in Northern Ireland, and we note that the recently announced Budget for 2023-24 includes only a very small cash increase compared to 2022-23. DoH also discussed particularly severe challenges to recruitment and retention that were being faced by HSC, including the increasing attractiveness of working and practising in the Republic of Ireland. At the same time, workforce growth in Northern Ireland seems to be particularly challenged, compared to the rest of the UK.

Our views on the pay context

6.61 We discuss the key economic and labour market indicators in Chapter 2. Inflation remains significantly higher than target levels with 12-month CPI and CPIH rates having fallen from their October 2022 peak levels of 11.1 per cent and 9.6 per cent to 10.1 per cent and 8.9 per cent respectively for March 2023, the latest month for which we have data at the time of writing. ONS average pay growth measures are also at elevated levels compared to recent years, but remain some way below inflation. Median pay settlements across both public and private sectors, which HM Treasury say are the most relevant direct comparators for review body recommendations, are similarly at elevated levels compared to recent years, with the most recent data from XpertHR and IDR at 6.0 and 5.0 per cent respectively, but remain below inflation. This suggests that the current period of higher inflation is leading to a negative impact on real incomes across the economy as a whole.

6.62 Our view is that doctors and dentists should not be treated as an exception to these trends, either through having their incomes exceptionally protected against inflation when this is not taking place for other groups, nor through having their pay increases held down when pay settlements and growth is elevated for others. Instead, our recommendations are informed by recruitment, retention and motivation, taking into account the affordability context. However, we remain cognisant of this challenging wider economic context.

Our views on recruitment, retention and motivation

6.63 We recognise the considerable challenges and pressures being put on health budgets, though as we discuss elsewhere in the report, we are concerned that a pay award that is too low would have negative budgetary implications related to poor motivation and increases to temporary staffing spend, amongst other things. We are also concerned that they would affect the UK's competitiveness in the international labour market for doctors and dentists.

6.64 We note that health services remain under considerable strain, as a result of long waiting lists and demand growth. Addressing this requires a workforce that is sufficient to meet demand. It is therefore increasingly important that staff are retained and motivated to perform. In this context we note with concern the GMC's observation that the number who left the medical register in 2021-22 was higher than previous years, though they said that it was not yet clear whether this represented decisions to leave that were not taken during the pandemic or an increase that would be sustained into future years.

6.65 In this context of high demand and constrained workforce supply, we welcome that there has been strong growth in the FTE size of the HCHS workforce in England, Scotland and Wales, though we are concerned that this growth seems not to have been replicated in Northern Ireland. However, a long-term context of workforce shortages and high demand remains, and vacancy rates remain high across the UK. As yet, there is also no clear picture of how these issues will be addressed for the long-term through workforce planning.

6.66 In general medical practice, despite welcome increases in the size of training intakes, the effective size of the GMP workforce is stagnant, once falling participation rates are taken into account. Despite positive trends in the use of non-medical clinical staff, evidence suggests that practices and their GMPs are struggling to meet demand, and access is severely challenged.

6.67 Inadequate access to NHS/HSC dental services is widely reported across the UK. Parties have said that the cause of this relates to issues of recruitment and retention, as well as contract structures that are no longer fit for purpose. We also saw evidence that an important factor was the relative unattractiveness of NHS/HSC dentistry compared to private work. In England this situation may be related to some extent to the significant increase in clawback that took place in 2022-23, to a level that is potentially unsustainable. This situation may also be exacerbated by the process through which the expenses component of dental contract values is uplifted, which we discuss below.

6.68 There are ongoing long-term trends in workforce behaviour, including an increase in flexible and LTFT working, that will affect workforce capacity across our remit group regardless of trends in the numbers leaving the NHS/HSC or retiring. These trends may be driven by a combination of shifting demographics, workloads or working conditions. However, regardless of the cause of these trends, a decrease in average working hours necessitates a higher absolute number of staff to deliver the same quantity of services, providing a significant additional challenge to recruitment and retention, and warranting a further re-examination of workforce demand. Alongside this, across the remit group, the proportion of individuals that aspire to take on senior, leadership and contractor roles seems to be waning. It remains to be seen the extent to which the changes to pensions taxation announced in the 2023 Budget will help to improve this situation by enhancing the incentive placed on the most senior, and therefore highest-paid, members of our remit group to maximise their contribution to the NHS/HSC.

6.69 At the same time, the staff survey results that are available to us suggest severe and urgent challenges to motivation in general, with NHS Staff Survey results in England for 2022 poorer still than the results for 2021, which themselves showed substantial declines on every measure compared to 2020, including particularly significant falls in pay satisfaction.

6.70 Many of the issues driving the challenges to recruitment, retention and motivation are not directly solvable with higher pay awards. We would therefore continue to stress the need for these issues to be addressed outside the pay setting process through workforce planning and other actions. We discuss this, including our frustration over the lack of progress in agreeing detailed, funded workforce plans, in Chapter 2.

6.71 However, pay does serve as an important signifier of value and, perhaps more importantly, if it is sensed to be deficient, can exacerbate a feeling amongst the medical and dental workforce that they are neglected and undervalued. This can in turn make staff feel they no longer wish to put in the additional discretionary effort on which the NHS/HSC depends, or that they no longer want to work full-time, or that it is no longer worth staying in the NHS/HSC at all. In order to address this, a pay award is required that is significantly in excess of the 3.5 per cent proposed to us by DHSC and which was used as the central metric of the Scottish Public Sector Pay Strategy. However, this must also be balanced against the financial challenges being faced by health services, and our perspective on the pay context, as described above.

Our recommendations

6.72 As we say in Chapter 2, our position has generally been to consider the affordability situation as being broadly similar across the UK, in the absence of compelling evidence to the contrary. The challenges to recruitment, retention and motivation, including high workloads, are also felt broadly consistently across the UK.

6.73 This year, evidence from DoH suggests that there are additional affordability challenges in Northern Ireland. However, offsetting this, we are also concerned that recruitment, retention and motivation are particularly challenged in Northern Ireland compared to the rest of the UK, including that growth in the FTE size of the hospital medical and dental (ie the HCHS) workforce in the rest of the UK has not been replicated in Northern Ireland. Therefore, we again came to the conclusion that this year it would not be appropriate for us to make differentiated recommendations for different parts of the UK.

6.74 Our first recommendation relates to the following groups within our remit:

- Consultants
- SAS doctors and dentists on old contracts, and those on reformed contracts in Scotland
- Salaried dentists, including those working in Community Dental Services/ the Public Dental Service
- Contractor GMPs in Scotland, Wales and Northern Ireland
- Salaried GMP pay ranges
- The pay element of dental contracts

There are other groups, discussed below, for whom we make further recommendations. All of our recommendations are summarised in Table 6.2, below.

6.75 **Our first recommendation is for there to be a 6 per cent increase to national salary scales, pay ranges or the pay element of contracts for the groups outlined in paragraph 6.74 this year. Uplifts should be consolidated and backdated to 1 April as necessary so that they would be paid in full for the 2023-24 financial year.** We set out our recommendations in full in Appendix B.

6.76 This first recommendation, as well as all of the others that follow, are made considering the evidence we received, reflecting the need to recruit, retain and motivate staff, while also considering affordability, in line with our terms of reference. Decisions about how to fund pay awards across our remit group, whether through increases to departmental budgets, or to fund them from existing budgets, remain a political choice that sits with the governments.

Doctors and dentists in training

6.77 We have a number of specific concerns relating to doctors and dentists in training this year, following the conclusion of the multi-year deal (MYD) for doctors and dentists in training in England, and in response to the request by the Scottish Government that we make a separate and specific recommendation for them. We are also aware that BMA, BDA and HCSA members who are doctors and dentists in training in England have undertaken industrial action during the early part of 2023, and the BMA Scotland Junior Doctor Committee has now voted to do so. We make our recommendations cognisant of this, but also of the wider factors that have driven industrial relations issues, which are felt across the UK.

6.78 There remain many significant benefits to medical and dental careers, including guaranteed employment, generous pensions, and strong pay progression both during training and following its completion. Doctors and dentists in training also have varied routes for career progression. However, we remain concerned that these benefits are being undermined by issues of retention and motivation for those at the start of their careers. Addressing these issues would be of particular benefit to recruitment and retention in the long-term, and therefore to health services and ultimately patients.

6.79 We are particularly concerned about a number of issues of retention and motivation that affect the trainee workforce. During our visits programme, and in the evidence we received from the parties, we heard more frequently than in previous years about doctors and dentists in training considering leaving the UK to practise abroad. In an increasingly competitive international labour market for doctors and dentists, it is very important that those at the start of their careers, who are the most internationally mobile members of our remit group, are incentivised to remain in the UK. As well as this, given that doctors and dentists in training comprise the pipeline of future consultants, SAS doctors and dentists and GMPs, incentivising them to remain in training, rather than taking on non-training work or working as a locum or bank staff member, is important for safeguarding the future of all parts of our remit group.

6.80 We are also concerned that worsening issues of motivation, workload and working conditions amongst our remit group are felt particularly severely amongst doctors and dentists in training, whose staff survey results in England have seen a more precipitous decline between 2020 and 2022 than the HCHS medical and dental workforce as a whole. For example, pay satisfaction amongst doctors and dentists in training fell by 30.0 percentage points compared to 20.3 percentage points for the medical and dental workforce as a whole, and the proportion of doctors and dentists in training who reported looking forward to going to work fell by 14.0 percentage points compared to 10.8 percentage points for the medical and dental workforce as a whole.

6.81 Trainees must show a greater degree of flexibility around where they work than other parts of the remit group, potentially having to relocate several times throughout their time as a trainee. They must also manage the competing pressures of training and delivering clinical care in a context of increased pressure on health services. During our visits we heard from trainees about their frustration at having to fund a significant proportion of the costs of their own training, including having to pay for their own exams. This is a pressure that is potentially felt most severely by those who are the lowest paid within their profession and therefore have the least disposable income.

6.82 Given all of these factors, we believe it necessary for our recommendations to be higher for doctors and dentists in training than for the other groups within our overall remit.

6.83 **Therefore, our second recommendation is that pay points for doctors and dentists in training should be uplifted by 6 per cent plus £1,250. This increase should be consolidated and backdated to 1 April 2023 as necessary so that it would be paid in full for the 2023-24 financial year**. We set out our recommendations in full in Appendix B.

SAS doctors and dentists

6.84 In Scotland, we were asked to make recommendations for SAS doctors and dentists employed on old and new contracts, and we do so this year. Similarly, in England, Wales and Northern Ireland, we make recommendations for SAS doctors and dentists on older contracts as usual. As we set out in paragraph 6.74 and 6.75, for each of these groups we recommend that their pay is uplifted in line with our first recommendation.

6.85 In England, Wales and Northern Ireland, we share the concerns expressed by multiple parties that the benefits of contract reform will not be realised as a result of poor uptake of the new contracts. We note that many parties said that this was driven, at least in part, by the financial disincentive of working on the new contracts relative to the old, with this situation having been negatively affected by our recommendations for 2021-22 and 2022-23 being higher than the parties expected at the time the MYD was agreed in 2021, and also by the governments not taking action to ensure that this situation could be avoided.

6.86 We were asked by the governments not to make recommendations for the new contracts in England, Wales and Northern Ireland, as pay uplifts for this group have already been determined under the MYD, which concludes after 2023-24. However, we are gravely concerned that a further relative deterioration of the new pay scales, compared to the old, will lead to the new scale being permanently disadvantaged. This could lead to a large number of specialty doctors and dentists electing to remain on the older contract indefinitely, which could, in turn, lead to individuals being paid significantly different amounts for the same job. A sense that pay for those on the new contract was unfairly low could also lead to issues of motivation for those that are working on them. We remain particularly concerned that the benefits to recruitment, retention and motivation of the new contracts would not be fully realised. We note the suggestion from NHS Employers that we consider the case that pay uplifts for those on the old contract should be made lower to restore the pay incentive to move onto the new. However, we believe that doing this would foster a sense that specialty doctors and dentists are being treated less favourably than their colleagues in other grades as a result of having agreed contract reforms that are intended to benefit both them and services, and so would severely impact morale and motivation.

6.87 Multiple parties also expressed concern to us in written evidence that the uplifts applied to the old Specialty Doctor pay scale in England, Wales and Northern Ireland, compared to those made for the new Specialist scale had created a situation where some on the old Specialty Doctor pay scale would experience a pay cut on getting promoted to the new Specialist grade, though we note that due to the freezing of the top of the old pay scale in Wales this issue is not felt as severely there.

6.88 As discussed in last year's report, we believe that it is important that we generally operate with the consensual agreement of all parties, and we are therefore reluctant to make recommendations for SAS doctors and dentists on the reformed contracts. However, given the lack of action last year to address this situation and restore the financial incentive to move over to the new contracts, we do not have confidence that such action will be taken without us making a recommendation to that effect. We expect to revisit the issues described above in future years, once pay structures have reached their final form and the multi-year deal has come to an end. However, we have concluded that allowing this situation to further worsen, as a result of SAS doctors and dentists on the new contracts receiving a 3 per cent average pay uplift, compared to the 6 per cent recommendation that we are making for other groups including SAS doctors and dentists on old contracts, would not be appropriate this year. Therefore, we have decided to make a recommendation that would have the effect of achieving the same average uplift for 2023-24 for those on the new contracts as for those on the old, once the uplifts included in the multi-year deal have been taken into account.

6.89 **Therefore, our third recommendation is that the new Specialty Doctor and Specialist pay scales in England, Wales and Northern Ireland be increased by 3 per cent. This uplift is in addition to the uplifts included in the MYD and should be consolidated and backdated to 1 April as necessary so that it would be paid in full for the 2023-24 financial year.** We set out our recommendations in full in Appendix B.

Locally-employed doctors and dentists (LEDs)

6.90 As we said last year, we would stress that under our terms of reference LEDs are included within our overall remit. Terms and conditions for LEDs are naturally at the discretion of employers and individuals, in a similar way to the situation for salaried GMPs and associate dentists. However, as we discuss in more detail in Chapter 3, it is important for the retention and motivation of this large and growing part of the medical and dental workforce that they are treated fairly and consistently.

6.91 **We would expect our recommendations to be implemented consistently and fairly for LEDs. For those LEDs whose pay and terms and conditions mirror a national contract, we would expect them to receive the same uplift as those on the national contract that their arrangements mirror. For others, we would expect them to receive a pay uplift equal to our first pay recommendation.**

General practice and dental expenses

6.92 As we discuss in Chapters 4 and 5, the BMA and BDA raised issues relating to how expenses uplifts for GMPs and GDPs were determined last year. The BDA, BMA Scotland and BMA Cymru Wales each asked us to return to making recommendations on expenses this year.

6.93 As with recent years, we make our recommendations this year net of expenses. We were not provided with evidence that could support us to make a recommendation on what represents an appropriate expenses uplift this year, nor do we believe that we are necessarily best-placed to do so. However, we would wish to stress, for the avoidance of doubt, that our pay recommendation is not a recommendation on an expenses uplift, nor should it be taken as such. **Instead, we expect that expenses uplifts for GMPs and dentists should be sufficient for the full value of our recommendations to be reflected in earnings for contractor and salaried GMPs at typical general practices, and for earnings for NHS/HSC work done by providing performer and associate dentists at typical dental practices.** The rationales provided by the governments for the dental expenses uplifts applied for 2022-23 suggested that none of them had made an effort to determine an expenses uplift that would achieve this. Similarly, the explanations provided to us for the expenses uplifts applied to GMP contracts were not comprehensive.

6.94 Therefore, we remain deeply concerned that the process by which expenses uplifts are determined for GMPs and dentists is not functioning effectively. This has the potential to lead to practice underfunding, which would then affect either: how GMPs and dentists are paid, thereby undermining our recommendations; how other practice staff are paid, affecting their ability to recruit and retain staff; or how able a practice is to meet its non-pay overheads; or some combination thereof.

6.95 We would expect to receive further information about expenses and expenses uplifts in evidence for next year's round, to help us to navigate this issue. We discuss this in more detail Chapter 7.

Contractor GMPs in England

6.96 As with SAS doctors and dentists on reformed contracts in England, Wales and Northern Ireland, we were again not asked to make recommendations for contractor GMPs in England this year. 2023-24 represents the fifth and final year of the MYD that was agreed in 2019. As we said last year, we remain concerned that the MYDs agreed before the pandemic and the economic changes of recent years will not prove sufficient to maintain recruitment, retention and motivation. We also continue to have concerns about the lack of growth in the effective size of the GMP workforce, which we discuss in more detail in Chapter 4.

6.97 However, in the absence of a figure that represents the percentage value of the MYD for contractor GMPs themselves, and also of a comprehensive and up-to-date explanation for recent trends in earnings for contractor GMPs, it is difficult for us to determine what might represent an appropriate recommendation this year. However, we continue to stress the need for parties to work together to determine what action might be appropriate and necessary in this context to address critically important issues of recruitment, retention and motivation.

Consultant reward

6.98 As we outline in Chapter 3, we continue to have concerns about the equity and effectiveness of the consultant reward schemes. For the new National Clinical Impact Award scheme, it remains to be seen whether welcome increases in the proportion of applicants from previously under-represented groups will translate into increased numbers actually receiving awards; evidence which we would be very keen to see as soon as possible. For the other schemes in operation across the UK, we have yet to hear of evidence of improvements that could lead to the schemes operating more effectively and fairly going forward, or to the equalities issues with the schemes which we have discussed in previous reports being addressed. We also remain cognisant of the budgetary pressures on health services, and the need to ensure that our recommendations represent the most effective possible use of funds in improving recruitment, retention and motivation.

6.99 **Therefore, we have decided not to make a recommendation for the consultant reward schemes this year. However, we remain supportive of their reform, and would expect to hear of progress made towards improving the schemes in evidence next year.**

Differences between the nations of the UK

6.100 Our recommendations this year are forward looking, and do not seek to reverse decisions previously taken by the governments. However, we are concerned that the action taken by the Welsh Government earlier in 2022-23, to enhance pay for parts of our remit group and not others, may cause lasting issues for recruitment, retention and motivation. We are particularly concerned as no comprehensive justification was provided to us for why contractor GMPs and practice-based dentists were excluded, and we would welcome hearing in evidence next year why the Welsh Government took this decision, and about how this may impact recruitment, retention and motivation. We would also welcome hearing about whether this additional pay enhancement has affected recruitment and retention in border areas.

6.101 The Wales pay enhancement represented a new, additional way that pay, terms and conditions have diverged between the nations of the UK. Differences in pay, terms and conditions between the nations of the UK, for groups within our remit, have grown wider in recent years, and we would expect that this might start to have an effect on national recruitment, retention and motivation, and potentially the mobility of our remit group across the UK. We would welcome hearing more about this issue in future years.

Summary of our recommendations

6.102 Our recommendations, for the various groups within our overall remit, are outlined in the below table. Recommendations are for the whole of the UK unless otherwise stated.

Table 6.2: Summary of our recommendations

Workforce Group	Recommended increase
Consultants	6%
Consultant Reward Schemes	No recommendation
SAS doctors and dentists (old contracts, and new contracts in Scotland)	6%
New Specialty Doctor and Specialist contract pay scales (England, Wales and Northern Ireland)	3%, in addition to the uplifts included in the multi-year deal
Doctors and dentists in training	6% plus £1,250 consolidated increase for all pay points
Salaried dentists including CDS and PDS	6%
Locally-employed doctors and dentists	The same as the national contract that their employment arrangement mirrors, otherwise 6%
Contractor GMPs (Scotland, Wales and Northern Ireland)	6%
Salaried GMP pay range	6%
Pay element of dental contracts	6%
Expenses uplifts for GMPs and dentists	Sufficient for the full value of our recommendations to be reflected in earnings for contractor and salaried GMPs at typical GMP practices, and for earnings for NHS/HSC work done by providing performer and associate dentists at typical dental practices

6.103 We estimate that implementing these recommendations would add £1.1 billion to the substantive HCHS pay bill in England, against a total DHSC Resource Departmental Expenditure Limit in 2023-24 of £176.2 billion. We estimate that it would add £125 million to the pay bill in Scotland, £80 million to the pay bill in Wales, and £40 million to the pay bill in Northern Ireland.

CHAPTER 7: LOOKING FORWARD

Introduction

7.1 In this final chapter we look ahead to some of the challenges facing our remit group, as well as some of the key developments that are likely to be important to our consideration of recruitment, retention and motivation in the coming years. We also discuss some of the things we would wish to see covered in the parties' evidence submissions for next year's report.

Our 52nd report 2024

7.2 As we discuss in Chapter 1, we expect that following the receipt of remit letters and the setting of evidence deadlines, all the parties will provide us with written evidence in a timely manner, which would enable our report to be prepared and submitted at an earlier point in the year than has been the case in the last few years.

7.3 We would also welcome a more general shift towards our process being completed prior to the start of the financial year, though this is dependent on us receiving remit letters significantly earlier than has been the case in recent years, and also on the parties submitting evidence in line with earlier deadlines than the one set this year.

7.4 We expect all parties to return to participating fully in our process. In particular, we would expect the BMA and HCSA to represent the views of their members to our process next year, in order that they can influence our recommendations.

The Coming Year

Wider context

7.5 During the coming months, we would expect to see further developments related to ongoing pressures on services, including actions taken to address long waiting lists. In particular, we would expect to see and hear more about how backlogs caused by pandemic-related disruption to care will be tackled, as well as progress towards reducing them.

7.6 We would also expect there to be continued economic uncertainty, influenced by the changing geopolitical situation. This is likely to lead to lower, but potentially volatile, inflation and energy prices. This could hamper economic growth. It is not clear to what extent inflation will follow the trajectory forecast by the OBR and fall back towards the Government's 2 per cent target in the coming 12 months, but this will clearly be a crucial factor in the pay context for our remit group, as well as funding and managing health services. We would also expect there to be less uncertainty in pay settlements, pay growth and the labour market.

Workforce planning and equalities

7.7 It is critically important that the new workforce plan for the NHS in England is published soon, in line with the timescales outlined by NHS England. We expect that it will include fully costed and funded plans to meet long-term trends in workforce demand. This plan is key to ensure that the NHS in England is appropriately staffed in the long-term, that doctors and dentists are supported, as well as reducing the reliance on expensive locum or agency staff. We would also expect to hear of more progress being made in understanding long-term workforce demand in Scotland, Wales and Northern Ireland, and appropriate, properly funded efforts to ensure that it is met. This should include considering appropriate expansion to medical and dental schools. Alongside this, we look forward to hearing about more progress being made in implementing the recommendations of the Gender Pay Gap in Medicine Review, including more detail about what the current work programme of the Implementation Panel, and how much progress it is making. We expect to hear more about efforts to address wider equalities issues including in dentistry and in our remit group in Scotland, Wales and Northern Ireland, and some exploration of equalities issues relating to other protected characteristics.

The Hospital and Community Health Services (HCHS) workforce

Recruitment, retention and motivation

7.8 We would welcome more information about trends in participation rates for the HCHS workforce across the UK to be included in evidence for next year's report, including how these trends affect workforce demand and supply. We would also welcome hearing more about trends in progression through training and the retention of doctors and dentists in training in particular.

7.9 We would expect to hear from all parties about how diverging contractual structures affect recruitment and retention between different parts of the UK.

7.10 We would welcome evidence from the parties about trends in international recruitment, and whether they believe that the UK will continue to be able to attract the numbers of doctors from abroad that they are currently able to. This should inform ongoing workforce planning efforts, which depend on a sustainable balance between domestic and international workforce supply. We also heard from the Department of Health and BMA Northern Ireland about the impact that new Sláintecare contracts were having on recruitment and retention. We would welcome hearing more about this issue from both parties.

7.11 We would expect to hear from parties in Wales about whether and how the additional pay enhancement made in early 2023 has affected recruitment, retention and motivation.

Doctors and dentists in training

7.12 At the time of submitting this report doctors and dentists in training in England are in dispute with the UK Government and have taken strike action. The BMA Scotland Junior Doctor Committee has also voted to take part in strike action. With the recent vote against the proposed reforms to the doctors and dentists in training contract in Wales we would expect that all parties will return to negotiations to progress these reforms as soon as possible. We would also expect governments in Scotland and Northern Ireland to consider the case for contract reform for doctors and dentists in training.

SAS doctors and dentists

7.13 The multi-year deal currently in place in England, Wales and Northern Ireland ends after the 2023-24 financial year. We would also like to hear more about the number of SAS doctors and dentists who have moved over to the new contracts across the UK, and what action is being taken to ensure that the benefits of contract reform are being realised.

Consultants

7.14 While the most recent round of negotiations over reforms to local CEAs in England did not lead to a proposal that will be implemented, we expect that progress will be made towards improving the equity and effectiveness of the scheme at a local level, supported by national NHS bodies including NHS Employers. New National Clinical Impact Awards have begun to be awarded in England and Wales, and we would expect to hear more about the extent to which the new scheme is achieving its aims, including in particular how much progress has been made in addressing equalities concerns. We also expect to hear more about progress towards reforming the other consultant reward schemes in Scotland, Wales and Northern Ireland. We also hope to hear of progress being made towards wider consultant contract reform.

Locally-employed doctors and dentists

7.15 In Chapter 3, we stressed the need for all parties to improve their understanding of who is working on locally-determined contracts, how, and why. We also said that action should then be take that can improve recruitment, retention and motivation and therefore ultimately improve services and patient care. We would expect to hear about more progress made towards these aims next year.

7.16 We would also welcome more evidence about the extent to which locally-determined contracts may be being used in Scotland, Wales and Northern Ireland, including for 'clinical fellow' roles or similar.

General Medical Practitioners

7.17 We expect that the larger cohorts that have entered general practice training in recent years will start to have an impact on workforce shortages and access issues, though if average working hours continue to fall, this benefit may be undermined. We would therefore expect to hear more from all relevant parties about trends in participation rates for GMPs, and how this will affect workforce demand and access in future.

7.18 We have heard from some parties that there has been an increase in the handing back of contracts and would welcome more evidence about this from all relevant parties next year. Given that the multi-year deal currently in place for contractor GMPs in England ends after the 2023-24 financial year, we would expect to return to making recommendations for contractor and salaried GMPs across the UK as usual next year.

7.19 As we discuss in Chapter 4, we would expect the parties to provide us with a comprehensive explanation for trends in GMPs' earnings.

General Dental Practitioners

7.20 Given that all four governments have expressed their desire to continue the reform of dental contracts, we would expect significant progress to be made in dental contract reform across the UK, and we would be disappointed if further progress was not made in the coming year. We also look forward to seeing the findings of the ongoing Health and Social Care Select Committee inquiry into NHS dentistry in England, which will examine issues of access and contract structures. Parties should also tell us more about how the expenses uplifts applied in 2022-23 impacted on practices and access to NHS/HCS dental services.

7.21 As we discuss in Chapter 5, we would expect the parties to provide us with a comprehensive explanation for trends in dentists' earnings, including in particular how the proportion of providing-performer and associate dentists' earnings that are from NHS/HSC work has changed in recent years. We would also welcome parties' views on how dental earnings have been affected by expenses uplifts, as discussed below.

7.22 In Chapter 5, we also discussed what NHS Employers said to us, that the relative size of the starting salary for salaried dentists, compared to practice-based posts was affecting recruitment and retention. This message was also reflected in our conversations with CDS and PDS dentists during our visits programme. We would welcome detailed evidence from all relevant parties about whether they agree with this characterisation of the situation, as well as what role reform and restructuring of the CDS and PDS pay scales could play in addressing it.

General practice and dental expenses

7.23 In Chapters 4, 5 and 6, we discuss the issue of dental and GMP expenses uplifts for 2023-24. As we say in Chapter 6, we would expect that for 2023-24, expenses uplifts for GMPs and dentists should be sufficient for the full value of our recommendations to be reflected in earnings for contractor and salaried GMPs at typical general practices, and for earnings for NHS/HSC work done by providing performer and associate dentists at typical dental practices. However, we are concerned that the process by which expenses uplifts are determined for GMPs and dentists is not functioning effectively.

7.24 We would therefore expect to be provided with detailed rationales for the expenses uplifts applied for GMP and dental practices alike by all four governments, as well as a clear account for how the views of GMPs and dentists themselves were represented in this process. We would also encourage parties to offer views on how improvements can be made to the process through which expenses uplifts are determined.

7.25 We also note that governments in Scotland and Northern Ireland said that they were planning to undertake exercises to properly determine the costs of running an NHS/HSC dental practice. We welcome this development, and would urge DHSC and the Welsh Government also to consider undertaking such exercises. We would also urge all governments to undertake this work as soon as possible, given the increasingly pressing need to do so, and would urge them to expand the scope of this work to include GMP practices. We would expect to see progress made towards this aim in evidence next year. As part of this exercise, it may be determined that there was a case for developing new formulae that could be used to determine year-on-year expenses uplifts, as was done before 2015, in between more substantial reviews into the costs faced by practices. Such an undertaking would be challenging and would require the commissioning of detailed research, and should involve all parties. If this was a consideration made by the parties, we would particularly welcome hearing about this in evidence next year.

Pensions and total reward

7.26 We would welcome hearing more from all parties about how they expect recent developments in pensions and pensions taxation, including in particular the changes to the pensions tax regime made during the 2023 Budget, have affected or will affect recruitment and retention. This includes how they expect the numbers that choose to retire early will be affected.

The DDRB process

7.27 In Chapter 1 we discussed that the BMA and BDA jointly published the paper *Report into the Failings of the Pay Review Process for Doctors and Dentists*. We would expect that there will be an open and constructive discussion between all parties on practical steps for how the process can be improved.

Future Data and Evidence Requirements

7.28 There are also a number of areas where we would welcome additional data or evidence from the parties. This is in addition to what we would expect to receive from them in the coming year or have received from them in previous years, such as the results of annual or periodic surveys. We would generally appreciate receiving data in time series form where applicable and possible.

Chapter	Data and Evidence Requests
2	• Data that can help us quantify the extent to which our recommendations impact inflation in the wider economy • More information about ongoing medical and dental workforce planning, in particular assessments of future workforce demand, including what may underpin assessments of potential medical and dental school expansion • Delivery dates for full, costed medical and dental workforce plans • More information about future workforce supply challenges, including assessments of future levels of international recruitment and how workforce supply is affected by trends in average working hours • Updates on the progress of the Gender Pay Gap Review Implementation Panel, including details of its work programme • More granular and intersectional data on equalities, and data on other protected characteristics including disability • Progress towards ethnicity pay gap research in England, and efforts to improve understanding of other pay equality issues across the medical and dental workforces, across all protected characteristics, and across the UK
3	*Recruitment, retention and motivation:* • Results of the renewed NHS Wales Staff Survey • Data on reasons for leaving in Scotland, Wales and Northern Ireland, and more detailed and accurate data on reasons for leaving in England • Medical and dental retirement data for Wales • Trends in average working hours for all groups of HCHS doctors and dentists, and parties' views on what is driving these trends • Explanation of the methodology used for official vacancy rates across the UK (and ideally a standardised methodology to be used), as well as breakdowns by specialty and geography • Staff survey results in Scotland, Wales and Northern Ireland that include sufficient detail to identify doctors and dentists separately • Information about specific recruitment and retention challenges associated with land borders and widening contractual differences between different parts of the UK, and between Northern Ireland and the Republic of Ireland • Parties views on trends in international recruitment • Information and data about the impact of Sláintecare on recruitment and retention of doctors and dentists, especially in Northern Ireland *Doctors and dentists in training:* • Trends in the retention of trainees and the numbers progressing through various stages of training, and whether getting to various stages of training is taking longer than previously • Postgraduate training fill rates • Evaluations of the various financial initiatives in place, including flexible pay premia in England, TERS in England, Scotland and Wales and Foundation Priority Programmes in England • Details of actions to improve trainee experience *SAS doctors and dentists:* • Detailed data on the trends in uptake of the new SAS contracts, separately for England, Scotland, Wales and Northern Ireland, as well as of action being taken to ensure that the benefits of contract reform are realised • Trends in the number of Specialist posts created • Trends in average working hours for SAS doctors and dentists *Consultants:* • Trends in the average number of Programmed Activities and Supporting Professional Activities worked (ideally disaggregated by age) • Update on reforms to local CEAs in England, Distinction Awards and Discretionary Points in Scotland, Commitment Awards in Wales and CEAs in Northern Ireland • Detailed equalities data for the existing consultant reward schemes *Locally-employed doctors and dentists:* • Detailed account from the parties as to how many are on local contracts, what roles they play in hospitals, why they are on local contracts, and how their terms and conditions differ from those on national contracts *Productivity and temporary staffing:* • Productivity growth estimates and information about delivery against efficiency targets • Details of actions taken to reduce temporary staffing spend, particularly in Northern Ireland

Chapter	Data and Evidence Requests
4	• Numbers completing training and joining the GMP register • Trends in numbers taking on contractor roles, and evaluation of the effectiveness of schemes to encourage GMPs into contractor status • Trends in participation rates, by contractor status • Trends in the number of contracts being handed back across the UK, and parties' views on what is driving these trends • Average retirement ages • Details of the passing on of pay awards from contractors to salaried GMPs, as well as details about whether the salaried GMP pay range continues to reflect what salaried GMPs are earning in practice • Further information about the ethnicity pay gap amongst GMPs • A comprehensive explanation of earnings trends for GMPs, including how the pandemic has impacted them • Detailed breakdown of contractual uplifts, including detailed rationales for expenses uplifts and efficiencies applied, as well as anticipated impact on contractor and salaried GMP earnings • Information about whether there has been growth in demand for GMPs in the private sector, and whether this has affected recruitment and retention.
5	• The latest version of the Working Hours Survey next year, if it is performed. Otherwise other details about trends in working hours, including trends in the proportion of working hours dedicated to NHS/HSC care • Detailed breakdown of contractual uplifts, including detailed rationales for expenses uplifts and efficiencies applied, as well as anticipated impact on providing-performer and associate earnings • A comprehensive explanation of earnings trends for dentists, including how the pandemic has impacted them, as well as enhanced understanding of trends in earnings specifically for NHS/HSC work • An explanation of the bidding process in place in England and Wales may affect remuneration, and identification of any checks and balances in place to ensure that bidders for dental contracts do not undermine their viability by bidding below a sustainable level • Analysis of clawback and any trends that relate to socio-economic or disease profiles of relevant patient bases, case studies of the impact of clawback on practice sustainability and account of how clawed back funds are used by the NHS • Explanation of interaction between pandemic-related practice financial support and clawback, and time series trends for clawback • Explanation for fall in numbers working as providing-performers • Analysis of the origin, scale and severity of issues of access to dentistry, including how localised issues may or may not correlate with deprivation • Explanations of trends in recruitment and retention in the CDS/PDS, including whether the size of starting salaries, relative to earnings for associates, are having an impact on recruitment
6	• How parties expect recent developments in pensions and pensions taxation, including in particular the changes to the pensions tax regime made during the 2023 Budget, have affected or will affect recruitment and retention. This includes how they expect the numbers that choose to retire early will be affected

7.29 We expect the parties to work closely with the DDRB secretariat to help them respond to these requests and improve the evidence submissions they send to us in future years.

APPENDIX A: REMIT LETTERS

Department of Health & Social Care

From the Rt Hon Steve Barclay MP
Secretary of State for Health and Social Care
39 Victoria Street
London
SW1H 0EU
020 7210 4850

Mr Christopher Pilgrim
Chair, Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Level 3, Windsor House
50 Victoria Street
London
SW1H 0TL

16 November 2022

Dear Mr Pilgrim,

I would firstly like to offer my thanks for the Review Body for Doctors' and Dentists' Remuneration's work over the past year on the 2022 report. The Government appreciates the independent, expert advice and valuable contribution that the DDRB makes.

I write to you now to formally commence the 2023-2024 pay round.

As described during last year's pay round, the NHS budget has already been set until 2024-2025. Pay awards must strike a careful balance – recognising the vital importance of public sector workers, whilst delivering value for the taxpayer, considering private sector pay levels, not increasing the country's debt further, and being careful not to drive prices even higher in the future.

In the current economic context, it is particularly important that you also have regard to the Government's inflation target when forming recommendations.

The evidence that my department, HM Treasury and NHS England will provide in the coming months, will support you in your consideration of these factors, for example via the provision of details on recruitment and retention.

We invite you to make recommendations on an annual pay award for all doctors and dentists not in multi-year deals.

This includes Consultants, junior doctors, Specialty Doctors and Associate Specialists (SAS) doctors not on new 2021 contracts, salaried General Medical Practitioners and the pay element of remuneration for dentists employed by, or providing services to, the NHS.

For SAS, you will be aware of the multi-year pay and contract reform deal agreed with the British Medical Association (BMA) in 2020. In making your recommendations for SAS doctors who have not transferred to the new contract, we ask that you give very careful consideration to the impact any such recommendations might have on the integrity of the agreed reforms to the contract and on the delivery of their intended benefits.

Independent contractor General Medical Practitioners remain subject to a five-year pay agreement between NHS England and Improvement and the BMA and therefore, the Government is not seeking recommendations for this group.

We do, however, invite you to make recommendations on uplifts to the maximum and minimum of the salaried General Medical Practitioner pay scales. As ever, recommendations will need to be informed by affordability and the fixed contract resources available to practices under the five-year GP contract.

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.

It is important that we make progress towards bringing the timetable of the pay review body round back to normal. We are hoping to expediate the process as much as possible this year and would welcome your report in April 2023, subject to ongoing conversations with the Office of Manpower Economics.

I would like to thank you again for your and the Review Body's invaluable contribution to the pay round and look forward to receiving your 2023 report in due course.

Yours ever,

RT HON STEVE BARCLAY MP

FROM THE PERMANENT SECRETARY AND HSC CHIEF EXECUTIVE

Mr Christopher Pilgrim
Chair of the Review Body for
Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

By email

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
BELFAST BT4, 3SQ
Sub-0496-2022

Date: 8 December 2022

Dear Mr Pilgrim

I am writing to formally commence the 2023/24 pay round for doctors and dentists in Northern Ireland. I wish to begin by thanking the Review Body for Doctors' and Dentists Remuneration (DDRB) for its invaluable work on the 2022/23 pay round. Robin Swann, the previous Minister of Health, accepted the recommendations of the Review Body in full.

With the lack of an Executive to agree a Departmental budget, and the resulting inability for the Department of Finance to set a Public Sector Pay Policy, implementation of the recommended pay award has been delayed. Please be assured, however, that this Department will seek to implement at the earliest possible opportunity now that the Secretary of State for Northern Ireland has determined relevant budgets and that our Department of Finance has issued public sector pay guidance.

I would therefore welcome, for consideration, your recommendations on pay for all doctors and dentists working within health and social care in Northern Ireland not otherwise subject to a negotiated settlement. Officials have commenced the evidence gathering process to inform your considerations.

For doctors on SAS terms and conditions, this should include those who choose not to transfer to the new contractual arrangements. I also ask that you give very careful consideration to the impact any such recommendations might have on the integrity of the agreed reforms to the contract and on the delivery of their intended benefits.

Yours sincerely

Peter May

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Mr Christopher Pilgrim
Review Body on Doctors and Dentists Remuneration
Level 3
Windsor House
50 Victoria Street
London
SW1H 0TL
United Kingdom

19 December 2022

Dear Mr Christopher Pilgrim

Thank you for the DDRBs hard work and independent report and observations which have been invaluable.

I would like to take this opportunity to say I truly value the hard work and commitment of all of our dedicated healthcare workers in Wales, at all times but particularly during this challenging time.

I am now writing to formally commence the 2023-24 pay round for medical and dental staff in Wales including general medical practitioners and general dental practitioners. In this pay round I would like your advice on what would be a fair and affordable pay rise for staff to recognise their dedication and continued hard work whilst the NHS is supporting the recover efforts. The pay award should address motivation, recruitment and retention to ensure the NHS delivers service needs. I am also very conscious of the continued inflationary pressures felt by us all and the impact on take home pay from energy, mortgage and food costs.

I urge you to make a pay rise recommendation that truly recognises the pressures on pay, the commitment and hard work of our NHS staff. However, affordability is a key issue for Welsh Government, in the absence of increased UK Government funding, any changes to NHS staff's terms and conditions will need to come from existing budgets that are already struggling with the inflationary costs, energy, and the cost-of-living crisis. Therefore, any consideration of NHS staff's pay and conditions will need to remain affordable.

For SAS Doctors I am not remitting for those on multiyear deals. However, for Specialty Doctors you will be aware that I took the decision to freeze the top of the 2008 Specialty Doctor Contract until it is aligned to the top of the 2021 contract, as explained this was on the grounds to preserve the integrity of the new contract pay scales. Also my overriding objective for making this decision was to not undermine the transition and implementation of the reformed 2021 contract by discouraging doctors from transferring to the 2021 contract from the 2008 contract on grounds of pay. Welsh Government's policy is to ensure the 2021 contract benefits can be fully realised i.e. improved terms and conditions for doctors, leading to better services and patient experience along with addressing long standing safety and wellbeing concerns for this group of doctors.

However, given the strength of feeling towards this decision from the Welsh SAS Committee, I have asked the committee to work in social partnership with my officials and employers to look again if there are other options not considered to align the top pay points of the two contracts (2008 and 2021), however I stressed any proposals needs to be on a cost neutral basis and should not undermine our policy objective of encouraging movement to the 2021 contract.

I would also welcome any observations from the pay review body in relation to this. I have also noted that DHSC have asked that you give very careful consideration to the impact any such recommendations might have on the integrity of the agreed reforms to the contract and on the delivery of their intended benefits as these would equally apply in Wales.

In order to support your work, I will provide written evidence to the Pay Review Body and I will also plan to attend the oral evidence session when arranged.

I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed past April 2022.

I look forward to receiving your advice and recommendations.

Yours sincerely,

Eluned Morgan AS/MS

Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Cabinet Secretary for Health and Social Care
Humza Yousaf MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

Mr Christopher Pilgrim (Chair)
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
3rd floor, Windsor House
42-50 Victoria Street
London SW1H 0TL

20 December 2022

Dear Mr Pilgrim

Further to my letter of 9th December 2022, I am now writing to formally set out our remit for the Doctors' and Dentists' Review Body (DDRB) for 2023-24.

You will be aware that the Scottish Draft budget was announced in the Scottish Parliament on 15th December. A copy of the draft Budget, which is subject to parliamentary approval, is available here.

You will also be aware that the Scottish Government has been unable to publish our Public Sector Pay Policy this year, given the uncertain and challenging economic outlook in Scotland and the rest of the UK, and our need to conclude the pay deals for this year

Although we are seeking Recommendations from the DDRB on a pay uplift for one year only (2023-24), it will be necessary to consider these in the context of our longer term vision on:

- retention and recruitment of medical and dental staff in NHS Scotland
- increasing staff morale and ensuring staff in our health service feeling valued as employees
- ensuring all medical and dental staff receive appropriate support to carry out their roles and responsibilities
- ensuring improved productivity and efficiency of our health service

For Junior Doctors in Scotland, we would ask you to consider making a separate and specific recommendation for the 2023-24 pay round.

I am aware of and sympathetic to the challenges faced by junior doctors in the early stages of their careers, and the impact of the cost of living crisis on them. While the BMAs ask for an above RPI pay uplift in the next financial year, alongside pay restoration of 23.5% over a five year period, is unaffordable, it is clear the pay differential between Junior Doctors and their senior colleagues is not insignificant. I would therefore ask if DDRB consider it appropriate to make a separate and specific recommendation for this group for the 23/24 pay round.

For General Medical Practitioners (GMPs) we are only seeking a recommendation on the pay element.

For General Dental Practitioners (GDPs) we are also requesting a recommendation on pay. The dental sector moved out of emergency financial support arrangements in April 2022, and has since been supported by financial arrangements that enhance activity in the sector. Levels of activity are presently close to pre-pandemic levels. The 2022/23 pay award was implemented from 1 November 2022 and applied to gross item of services fees, and capitation and continuing care payments.

Copies of this letter will be sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the Staff Side and NHS Employers.

HUMZA YOUSAF

APPENDIX B: DETAILED RECOMMENDATIONS ON REMUNERATION

Appendix B1: Detailed recommendations on remuneration in England

The salary scales that we recommend should apply from 1 April 2023 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be pro rata to those of equivalent full-time staff.

Unless stated otherwise, the 2022 salary scales reflect those that were implemented from 1 April 2022.

Basic pay scales and awards

	2022 (£)	2023 (£)
Doctors and dentists in training (2016 contract)		
Foundation doctors – year 1	29,384	32,397
Foundation doctors – year 2	34,012	37,303
Core/Run-through training – years 1-2	40,257	43,922
Core/Run-through/Higher training – years 3-5	51,017	55,328
Core/Run-through/Higher training – years 6 +	58,398	63,152
Flexible pay premia (2016 contract)		
General practice	9,144	9,693
Psychiatry core training	3,718	3,941
Psychiatry higher training (3 year)	3,718	3,941
Psychiatry higher training (4 year)	2,789	2,956
Academia	4,461	4,729
Histopathology	4,461	4,729
Emergency medicine/Oral & maxillofacial surgery:		
3 years	7,435	7,881
4 years	5,577	5,912
5 years	4,461	4,729
6 years	3,718	3,941
7 years	3,187	3,378
8 years	2,789	2,956
Consultant (2003 contract)	88,364	93,666
	91,131	96,599
	93,898	99,532
	96,665	102,465
	99,425	105,391
	105,996	112,356
	112,569	119,323
	119,133	126,281

	2022 (£)	2023 (£)
National Clinical Impact Awards		
Level 1	20,000	20,000
Level 2	30,000	30,000
Level 3	40,000	40,000
Salaried General Medical Practitioner range		
Minimum	65,070	68,974
Maximum	98,194	104,086
Dental foundation training	36,288	38,465
Salaried primary care dental staff (2008 contract):		
Band A: Salaried dentist	44,955	47,652
	49,950	52,947
	57,443	60,890
	61,189	64,860
	64,935	68,831
	67,433	71,479
Band B: Salaried dentist[1]	69,930	74,126
	72,428	76,774
	76,174	80,744
	78,047	82,730
	79,920	84,715
	81,793	86,701
Band C: Salaried dentist[1, 2, 3]	83,666	88,686
	86,164	91,334
	88,661	93,981
	91,159	96,629
	93,656	99,275
	96,154	101,923

[1] The first salary point of Band B is also the extended competency point at the top of Band A.
[2] The first salary point of Band C is also the extended competency point at the top of Band B.
[3] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

	2022 (£)	2023 (£)
Specialty doctor (2008 contract)		
MC46-01	44,300	46,958
MC46-02	48,088	50,973
MC46-03	53,012	56,193
MC46-04	55,652	58,991
MC46-05	59,454	63,021
MC46-06	63,242	67,037
MC46-07	63,242	67,037
MC46-08	67,115	71,142
MC46-09	67,115	71,142
MC46-10	70,990	75,249
MC46-11	70,990	75,249
MC46-12	74,864	79,356
MC46-13	74,864	79,356
MC46-14	74,864	79,356
MC46-15	78,737	83,461
MC46-16	78,737	83,461
MC46-17	78,737	83,461
MC46-18	82,611	87,568
Associate specialist (2008 contract)		
MC41-01	62,111	65,838
MC41-02	67,104	71,130
MC41-03	72,095	76,421
MC41-04	78,687	83,408
MC41-05	84,401	89,465
MC41-06	86,772	91,978
MC41-07	86,772	91,978
MC41-08	89,865	95,257
MC41-09	89,865	95,257
MC41-10	92,958	98,535
MC41-11	92,958	98,535
MC41-12	96,051	101,814
MC41-13	96,051	101,814
MC41-14	96,051	101,814
MC41-15	99,145	105,094
MC41-16	99,145	105,094
MC41-17	99,145	105,094
MC41-18	102,240	108,374

	2022 (£)	2023 (£)
Staff grade practitioner	41,042	43,505
(1997 contract, MH03/5)	44,300	46,958
	47,557	50,410
	50,816	53,865
	54,074	57,318
	57,910	61,385
Discretionary points	*Notional scale*	
	60,590	64,225
	63,847	67,678
	67,105	71,131
	70,364	74,586
	73,621	78,038
	76,880	81,493

	2022 (£)	2023 (£) already implemented	2023 (£) DDRB recommendation
Specialty doctor (2021 contract)			
MC75-01	50,373	51,000	52,530
MC75-02	50,373	51,000	52,530
MC75-03	50,373	51,000	52,530
MC75-04	56,906	58,756	60,519
MC75-05	56,906	58,756	60,519
MC75-06	58,756	58,756	60,519
MC75-07	64,237	65,500	67,465
MC75-08	64,237	65,500	67,465
MC75-09	64,237	65,500	67,465
MC75-10	71,654	72,500	74,675
MC75-11	71,654	72,500	74,675
MC75-12	71,654	72,500	74,675
MC75-13	75,361	80,000	82,400
MC75-14	75,361	80,000	82,400
MC75-15	75,361	80,000	82,400
MC75-16	75,361	80,000	82,400
MC75-17	75,361	80,000	82,400
MC75-18	78,759	80,000	82,400

	2022 (£)	2023 (£) already implemented	2023 (£) DDRB recommendation
Specialist (2021 contract)			
MC70-01	80,693	81,500	83,945
MC70-02	80,693	81,500	83,945
MC70-03	80,693	81,500	83,945
MC70-04	86,139	87,000	89,610
MC70-05	86,139	87,000	89,610
MC70-06	86,139	87,000	89,610
MC70-07	91,584	92,500	95,275

Appendix B2: Detailed recommendations on remuneration in Scotland

The salary scales that we recommend apply from 1 April 2023 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2022 (£)	2023 (£)
Foundation house officer 1	27,653	30,562
	29,380	32,393
	31,106	34,222
Foundation house officer 2	34,299	37,607
	36,543	39,986
	38,787	42,364
Specialty registrar (full)	36,472	39,910
	38,704	42,276
	41,821	45,580
	43,706	47,578
	45,978	49,987
	48,251	52,396
	50,527	54,809
	52,800	57,218
	55,073	59,627
	57,349	62,040
Specialty doctor (2022 contract)	54,903	58,197
	65,497	69,427
	69,507	73,677
	77,532	82,184
	85,554	90,687
Specialty doctor (2008 contract)	45,193	47,905
	49,057	52,000
	54,080	57,325
	56,772	60,178
	60,651	64,290
	64,516	68,387
	68,466	72,574
	72,418	76,763
	76,370	80,952
	80,321	85,140
	84,272	89,328

	2022 (£)	2023 (£)
Specialist (2022 contract)	83,130	88,118
	88,740	94,064
	94,350	100,011
Associate specialist (2008 contract)	63,361	67,163
	68,454	72,561
	73,546	77,959
	80,271	85,087
	86,099	91,265
	88,517	93,828
	91,673	97,173
	93,880	99,513
	96,945	102,762
	100,008	106,008
	103,074	109,258
Staff grade practitioner	41,868	44,380
(1997 contract)	45,193	47,905
	48,515	51,426
	51,838	54,948
	55,162	58,472
	59,075	62,620
Discretionary points	*Notional scale*	
	61,809	65,518
	65,132	69,040
	68,455	72,562
	71,779	76,086
	75,103	79,609
	78,427	83,133
Consultant (2004 contract)	91,474	96,962
	93,406	99,010
	96,185	101,956
	98,967	104,905
	101,741	107,845
	108,345	114,846
	114,949	121,846
	121,548	128,841
Salaried General Medical Practitioner range:		
Minimum	66,031	69,993
Maximum	98,555	104,468

	2022 (£)	2023 (£)
Dental core training[4]	40,509	44,190
Dental senior house officer/Senior house officer	34,299	37,607
	36,543	39,986
	38,787	42,364
	41,029	44,741
	43,272	47,118
	45,514	49,495
	47,757	51,872
Salaried primary care dental staff (2008 contract):		
Band A: Dental officer	46,310	49,089
	51,457	54,544
	59,175	62,726
	63,033	66,815
	66,892	70,906
	69,465	73,633
Band B: Senior dental officer	72,037	76,359
	74,609	79,086
	78,469	83,177
	80,399	85,223
	82,329	87,269
	84,258	89,313
Band C: Assistant clinical director	86,187	91,358
	88,760	94,086
	91,332	96,812
Band C: Specialist dental officer	86,187	91,358
	88,760	94,086
	91,332	96,812
	92,985	98,564
Band C: Clinical director/Chief administrative	86,187	91,358
dental officers	88,760	94,086
	91,332	96,812
	92,985	98,564
	95,483	101,212
	97,981	103,860

[4] On completion of Core training employees will move to the nearest point on or above their existing salary on the Dental senior house officer scale.

Appendix B3: Detailed recommendations on remuneration in Wales

The salary scales that we recommend should apply from 1 April 2023 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Basic pay scales and awards

	2022[5] (£)	2023 (£)
Foundation house officer 1 (2015 contract)	27,115	29,992
MN13	28,808	31,786
	30,502	33,582
Foundation house officer 2 (2015 contract)	33,633	36,901
MN15	35,833	39,233
	38,031	41,563
Specialty registrar (full)	35,940	39,346
MN37	38,137	41,675
	41,209	44,932
	43,068	46,902
	45,305	49,273
	47,547	51,650
	49,787	54,024
	52,028	56,400
	54,267	58,773
	56,510	61,151
Specialty doctor (2008 contract)	45,187	47,898
MC46	49,049	51,992
	54,074	57,318
	56,764	60,170
	60,641	64,279
	64,506	68,376
	68,455	72,562
	72,407	76,751
	76,360	80,942
	80,310	85,129
	80,632	85,470
Associate specialist (2008 contract)	63,352	67,153
MC41	68,444	72,551
	73,535	77,947
	80,258	85,073
	86,087	91,252
	88,502	93,812
	91,659	97,159

[5] 2022 scales include the supplementary award for 2022-23 implemented by the Welsh Government in February 2023

	2022 (£)	2023 (£)
	94,815	100,504
	97,968	103,846
	101,125	107,193
	104,282	110,539
Staff grade practitioner	41,864	44,376
(1997 contract, MH03/5)	45,187	47,898
	48,510	51,421
	51,831	54,941
	55,156	58,465
	58,476	61,985
Discretionary points	*Notional scale*	
	61,801	65,509
	65,123	69,030
	68,446	72,553
	71,769	76,075
	75,090	79,595
	78,414	83,119
Consultant (2003 contract)	87,354	92,595
ZM81	90,137	95,545
	94,789	100,476
	100,191	106,202
	106,363	112,745
	109,882	116,475
	113,408	120,212
National Clinical Impact Awards		
Level 0	10,000	10,000
Level 1	20,000	20,000
Level 2	30,000	30,000
Level 3	40,000	40,000
Commitment awards[6]	3,334	3,334
	6,668	6,668
	10,002	10,002
	13,336	13,336
	16,670	16,670
	20,004	20,004
	23,338	23,338
	26,672	26,672

[6] Awarded every three years once the basic scale maximum is reached.

	2022 (£)	2023 (£)
Salaried General Medical Practitioner range:		
Minimum	67,677	71,738
Maximum	102,122	108,249
Dental foundation training	35,927	38,083
Dental core training	33,798	37,076
MN21	36,009	39,420
	38,218	41,761
	40,429	44,105
	42,638	46,446
	44,849	48,790
	47,059	51,133
Salaried primary care dental staff (2008 contract):		
Band A: Salaried dentist	45,632	48,370
	50,704	53,746
	58,308	61,806
	62,110	65,837
	65,913	69,868
	68,448	72,555
Band B: Salaried dentist[7]	70,981	75,240
	73,517	77,928
	77,319	81,958
	79,220	83,973
	81,122	85,989
	83,023	88,004
Band C: Salaried dentist[7, 8, 9]	84,927	90,023
	87,460	92,708
	89,994	95,394
	92,530	98,082
	95,064	100,768
	97,599	103,455

[7] The first salary point of Band B is also the extended competency point at the top of Band A.
[8] The first salary point of Band C is also the extended competency point at the top of Band B.
[9] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

	2022 (£)	2023 (£) already implemented	2023 (£) DDRB recommendation
Specialty doctor (2021 contract)			
MC75-01	51,379	51,765	53,318
MC75-02	51,379	51,765	53,318
MC75-03	51,379	51,765	53,318
MC75-04	58,040	59,637	61,426
MC75-05	58,040	59,637	61,426
MC75-06	59,637	59,637	61,426
MC75-07	65,518	66,482	68,476
MC75-08	65,518	66,482	68,476
MC75-09	65,518	66,482	68,476
MC75-10	73,083	73,587	75,795
MC75-11	73,083	73,587	75,795
MC75-12	73,083	73,587	75,795
MC75-13	76,866	81,200	83,636
MC75-14	76,866	81,200	83,636
MC75-15	76,866	81,200	83,636
MC75-16	76,866	81,200	83,636
MC75-17	76,866	81,200	83,636
MC75-18	80,331	81,200	83,636
Specialist (2021 contract)			
MC70-01	81,903	82,722	85,204
MC70-02	81,903	82,722	85,204
MC70-03	81,903	82,722	85,204
MC70-04	87,431	88,305	90,954
MC70-05	87,431	88,305	90,954
MC70-06	87,431	88,305	90,954
MC70-07	92,958	93,887	96,704

Appendix B4: Detailed recommendations on remuneration in Northern Ireland

The salary scales that we recommend apply from 1 April 2023 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be pro rata to those of equivalent full-time staff.

Basic pay scales and awards

	2022 (£)	2023 (£)
Foundation house officer 1	26,713	29,566
M220	28,381	31,334
	30,046	33,099
Foundation house officer 2	33,133	36,371
M230	35,298	38,666
	37,466	40,964
Specialty registrar (full)	35,405	38,779
M241	37,753	41,268
	40,597	44,283
	42,428	46,224
	44,634	48,562
	46,842	50,903
	49,050	53,243
	51,256	55,581
	53,463	57,921
	55,670	60,260
Specialty doctor (2008 contract)		
M215	44,515	47,186
	48,323	51,222
	53,270	56,466
	55,922	59,277
	59,744	63,329
	63,551	67,364
	67,442	71,489
	71,335	75,615
	75,227	79,741
	79,120	83,867
	83,013	87,994

	2022 (£)	2023 (£)
Associate specialist (2008 contract)	62,413	66,158
M090	67,431	71,477
	72,446	76,793
	79,070	83,814
	84,810	89,899
	87,193	92,425
	90,302	95,720
	93,410	99,015
	96,518	102,309
	99,625	105,603
	102,738	108,902
Staff grade practitioner	41,242	43,717
(1997 contract)	44,514	47,185
M211/12	47,788	50,655
	51,064	54,128
	54,337	57,597
	58,192	61,684
Discretionary points	*Notional scale*	
	60,884	64,537
	64,157	68,006
	67,432	71,478
	70,705	74,947
	73,979	78,418
	77,255	81,890
Consultant (2004 contract)	88,799	94,127
M400	91,581	97,076
	94,362	100,024
	97,141	102,969
	99,913	105,908
	106,520	112,911
	113,124	119,911
	119,723	126,906
Salaried General Medical Practitioner range:		
Minimum	66,013	69,974
Maximum	99,615	105,592

	2022 (£)	2023 (£)
Salaried primary care dental staff:		
Band 1: Salaried dentist	41,262	43,738
	44,600	47,276
	47,936	50,812
	51,276	54,353
	54,614	57,891
	57,950	61,427
	61,290	64,967
	64,628	68,506
Band 2: Senior salaried dentist	58,962	62,500
	63,629	67,447
	68,294	72,392
	72,959	77,337
	77,626	82,284
	78,656	83,375
	79,683	84,464
Band 3: Assistant clinical director salaried dentist	78,350	83,051
	79,562	84,336
	80,772	85,618
	81,987	86,906
	83,198	88,190
	84,411	89,476
Band 4: Clinical director salaried dentist	78,350	83,051
	79,562	84,336
	80,772	85,618
	81,987	86,906
	83,198	88,190
	84,411	89,476
	85,624	90,761
	86,858	92,069
	88,071	93,355
	89,283	94,640

	2022 (£)	2023 (£) as per Framework Agreement	2023 (£) DDRB recommendation
Specialty doctor (2021 contract)			
MC75-01	50,373	51,000	52,530
MC75-02	50,373	51,000	52,530
MC75-03	50,373	51,000	52,530
MC75-04	56,906	58,756	60,519
MC75-05	56,906	58,756	60,519
MC75-06	58,756	58,756	60,519
MC75-07	64,237	65,500	67,465
MC75-08	64,237	65,500	67,465
MC75-09	64,237	65,500	67,465
MC75-10	71,654	72,500	74,675
MC75-11	71,654	72,500	74,675
MC75-12	71,654	72,500	74,675
MC75-13	75,361	80,000	82,400
MC75-14	75,361	80,000	82,400
MC75-15	75,361	80,000	82,400
MC75-16	75,361	80,000	82,400
MC75-17	75,361	80,000	82,400
MC75-18	78,759	80,000	82,400
Specialist (2021 contract)			
MC70-01	80,693	81,500	83,945
MC70-02	80,693	81,500	83,945
MC70-03	80,693	81,500	83,945
MC70-04	86,139	87,000	89,610
MC70-05	86,139	87,000	89,610
MC70-06	86,139	87,000	89,610
MC70-07	91,584	92,500	95,275

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN THE NHS/HSC IN THE UK[1]

ENGLAND[2]	2021		2022		Percentage change 2021-2022	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff						
Consultants	52,381	55,946	53,811	57,747	*2.7%*	*3.2%*
Associate specialists	1,927	2,154	2,053	2,299	*6.6%*	*6.7%*
Specialty doctors	7,907	9,045	8,140	9,259	*2.9%*	*2.4%*
Staff grades	322	358	324	360	*0.8%*	*0.6%*
Specialty registrar	33,660	35,142	33,775	35,300	*0.3%*	*0.4%*
Core Training	16,834	17,153	18,277	18,640	*8.6%*	*8.7%*
Foundation doctor year 2	6,247	6,292	6,270	6,323	*0.4%*	*0.5%*
Foundation doctor year 1	6,624	6,658	7,263	7,298	*9.6%*	*9.6%*
Hospital practitioners/Clinical assistants	588	1,698	588	1,644	*0.1%*	*-3.2%*
Other staff	830	1,346	804	1,279	*-3.1%*	*-5.0%*
Total	**127,319**	**135,341**	**131,305**	**139,683**	***3.1%***	***3.2%***
General Medical Practitioners[3]	**35,641**	**44,170**	**36,338**	**44,874**	**2.0%**	**1.6%**
GMP partners	17,059	19,876	16,750	19,537	-1.8%	-1.7%
GMPs in training	8,576	8,664	9,470	9,628	10.4%	11.1%
GMP retainers	254	640	252	618	-0.8%	-3.4%
Salaried GMPs	9,752	15,267	9,865	15,433	1.2%	1.1%
General Dental Practitioners[4, 5]		**23,733**		**24,272**		**2.3%**
Providing performers		4,682		4,752		1.5%
Associates		19,026		19,485		2.4%
Unknown		25		35		40.0%
Total general practitioners		**67,903**		**69,146**		**1.8%**
Total – NHS doctors and dentists		**203,244**		**208,829**		**2.7%**

[1] An Employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.
[2] Data as 30 September unless otherwise indicated.
[3] Data excludes locums.
[4] This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms.
[5] Data as at 31 March of that year.

SCOTLAND[6]	2021		2022		Percentage change 2021-2022	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff						
Consultants	5,902	6,435	6,032	6,593	2.2%	2.5%
Staff and associate specialist grades	1,195	1,536	1,205	1,532	0.8%	-0.3%
Doctors in training	6,383	6,659	6,632	6,904	3.9%	3.7%
Other staff	1,357	2,030	1,480	2,162	9.1%	6.5%
Total	**14,837**	**16,495**	**15,348**	**17,020**	**3.4%**	**3.2%**
General medical practitioners		**5,177**		**5,209**		**0.6%**
Performers (partners)		3,304		3,236		-2.1%
Registrar/Specialist trainee		639		694		8.6%
Retainers[7]		63		56		-11.1%
Salaried		1,192		1,254		5.2%
General dental practitioners (non-hospital)[8]		**3,207**		**3,063**		**-4.5%**
General Dental Service		2,945		2,791		-5.2%
Public Dental Service		375		365		-2.7%
Total general practitioners		**8,384**		**8,272**		**-1.3%**
Total – NHS doctors and dentists		**24,879**		**25,292**		**1.7%**

[6] Data as 30 September of that year.
[7] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.
[8] Includes salaried, community and public dental service dentists.

WALES[9]	2021		2022		Percentage change 2021-2022	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff[10]						
Consultants	2,813	3,033	2,873	3,100	2.1%	2.2%
Associate specialists	170	194	151	171	-11.6%	-11.9%
Specialty doctors	692	781	768	866	11.0%	10.9%
Staff grades	3	3	3	3	0.0%	0.0%
Specialist registrars	2,648	2,881	2,853	3,043	7.7%	5.6%
Foundation house officers 2	609	632	617	638	1.2%	0.9%
Foundation house officers 1	505	536	506	574	0.2%	7.1%
Other staff	64	166	65	170	1.8%	2.4%
Total	**7,505**	**8,226**	**7,836**	**8,565**	**4.4%**	**4.1%**
General Medical Practitioners		**2,492**		**2,498**		**0.2%**
GMP providers		2,038		1,974		-3.1%
General practice specialty registrars		426		498		16.9%
GMP retainers		28		26		-7.1%
General Dental Practitioners[11]		**1,389**		**1,420**		**2.2%**
General Dental Services only		1,129		1,114		-1.3%
Personal Dental Services only		60		74		23.3%
Trust-led Dental Services contracts		48		48		0.0%
Mixed		152		184		21.1%
Total general practitioners		**3,881**		**3,918**		**1.0%**
Total – NHS doctors and dentists		**12,107**		**12,483**		**3.1%**

[9] Data as at 30 September unless otherwise specified.
[10] Some hospital practitioners and clinical assistants also appear as General Medical Practitioners, General Dental Practitioners or ophthalmic practitioners.
[11] Data as of 31st March that year.

NORTHERN IRELAND[12]	2021		2022		Percentage change 2021-2022	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[13, 14]						
Consultant	1,885	2,006	1,929	2,062	2.3%	2.8%
Associate Specialist/Specialty Doctor/ Staff Grade	541	627	553	638	2.1%	1.8%
Specialty/Specialist Registrar	1,547	1,615	1,542	1,620	-0.4%	0.3%
Foundation doctor	547	552	521	526	-4.7%	-4.7%
Other[15]	209	364	223	369	6.7%	1.4%
Total	**4,638**	**4,985**	**4,608**	**4,961**	**-0.6%**	**-0.5%**
General Medical Practitioners[16]		**1,410**		**1,419**		**0.6%**
GMP principal		1,181		1,180		-0.1%
GMP salaried		205		225		9.8%
GMP retainers		24		14		-41.7%
General Dental Practitioners[17]		**1,142**		**1,146**		**0.4%**
Total general practitioners		**2,552**		**2,565**		**0.5%**
Total – NHS doctors and dentists		**7,537**		**7,526**		**-0.1%**

[12] As at 30 September unless otherwise specified.
[13] Some hospital practitioners and clinical assistants also appear as General Medical Practitioners, general dental practitioners or ophthalmic practitioners.
[14] As at March that year.
[15] Due to changes the collection of staff groups, the 'other' category is not consistent across year groups and should not be compared with previous years.
[16] Date as at 31 March that year.
[17] Date as at 31 March that year.

APPENDIX D: GLOSSARY OF TERMS

ADVISORY NON-DEPARTMENTAL PUBLIC BODY – a body whose function is to provide advice to government and which has a role in the processes of national government but is not a government department or part of one, and which accordingly operates to a greater or lesser extent at arm's length from ministers.

AGENDA FOR CHANGE – the pay system used for all NHS/HSC staff except for doctors, dentists and senior managers.

ASSOCIATE DENTISTS – self-employed dentists who enter into a contractual arrangement, that is neither partnership nor employment, with principal dentists. Associates pay a fee for the use of facilities, the amount generally being based on a proportion of the fees earned; the practice owner provides services, including surgery facilities and staff to the associate. They are sometimes referred to in England and Wales as performer-only dentists. See also *performer-only dentists.*

BANK – an entity managed by a trust, or through a third-party organisation who contract healthcare professionals to take on temporary shifts at trust hospitals.

BARNETT FORMULA – a formula used by HM Treasury to allocate funding to the devolved governments in Scotland, Wales and Northern Ireland, based on the funding allocated to public services in England, England and Wales or Great Britain, as appropriate.

BASIC PAY – the annual salary without any allowances or additional payments.

BMA RATE CARD – A card with minimum hourly rates for extracontractual work for doctors produced by the BMA.

BRITISH DENTAL ASSOCIATION (BDA) – A trade union that represents all groups of dentists across the UK.

BRITISH MEDICAL ASSOCIATION (BMA) – A trade union that represents all groups of doctors across the UK.

CAPITATION – the technical term used in the NHS/HSC dental contract system regulations in Scotland and Northern Ireland to describe payment per patient registered.

CERTIFICATE OF COMPLETION OF TRAINING (CCT) – A CCT confirms a doctor has completed an approved UK training programme and is eligible for entry onto the Specialist Register or GP Register, thereby becoming eligible for consultant or GMP roles. CCTs are issued by the GMC.

CERTIFICATE OF ELIGIBILITY FOR SPECIALIST REGISTRATION (CESR) – An alternative to the CCT for doctors who have not completed a GMC-approved programme of training but who can show they have knowledge, skills and experience equivalent to the approved curriculum for their specialty.

CLINICAL EXCELLENCE AWARDS (CEAs) – payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. National CEAs in England and Wales have been replaced with National Clinical Impact Awards, but the local scheme is still in operation. The CEA scheme in Northern Ireland is currently closed to new entrants. See also *Local CEAs, National CEAs.*

CLINICAL IMPACT AWARDS (CIAs) – payments that provide consultants with financial reward for exceptional achievements and contributions to patient care and have replaced National CEAs in England and Wales.

COMMITMENT AWARDS – a reward scheme for consultants in Wales, Commitment Awards are awarded every three years after reaching the maximum of the pay scale. There are eight levels of Commitment Awards. Commitment Awards replaced Discretionary Points in October 2003. See also *Discretionary Points.*

COMMUNITY DENTAL SERVICES (CDS) – See *Salaried GDP*

COMPARATOR PROFESSIONS – groups identified as comparator professions to those in the DDRB remit groups are: legal, tax and accounting, actuarial, higher education, pharmaceutical and veterinary.

CONSULTANTS – senior hospital doctors and dentists that are working in roles that require the holder to have completed postgraduate training in a specialised area of medicine or dentistry and are listed on the GMC's or the GDC's specialist register.

CONTRACTOR GMP/PARTNER GMP – A GMP who hold a contract with the NHS/HSC to provide GP services to the public. Contractor GMPs are typically partners in a practice owned by multiple GMPs.

COVID/COVID-19 (Coronavirus) – an infectious disease that can affect the lungs and airways. This is caused by a newly discovered coronavirus (a family of viruses) which is referred to as COVID-19 and was discovered in 2019. This virus that causes the disease is referred to as SARS-CoV-2. The outbreak of COVID-19 was declared a pandemic by the World Health Organisation in March 2020, and in this report, the term **PANDEMIC** is generally used to refer to the COVID-19 pandemic.

DDRB – See *Review Body on Doctors' and Dentists' Remuneration*

DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC) – the department of the UK Government responsible for funding and overseeing the NHS in England.

DEPARTMENT OF HEALTH (NORTHERN IRELAND) (DoH) – the department of the Northern Ireland Executive responsible for funding and overseeing Health and Social Care (HSC) services in Northern Ireland.

DISCRETIONARY POINTS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by local Clinical Excellence Awards in England and Northern Ireland, and Commitment Awards in Wales, but remain in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Discretionary Points are pensionable. See also *Clinical Excellence Awards, Commitment Awards, Distinction Awards.*

DISTINCTION AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by national Clinical Excellence or Impact Awards in England, Wales and Northern Ireland, but remain in Scotland, though the scheme is closed to new entrants. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable. See also *Clinical Excellence Awards, Discretionary Points.*

DOCTORS AND DENTISTS IN TRAINING – doctors and dentists who are employed in a medical post or training programme which has been approved by the Postgraduate Medical Education and Training Board, or employed in a postgraduate training programme in hospital dentistry. Dentists participating in Dental Foundation Training are not generally included in this group. Doctors in training are often referred to as **JUNIOR DOCTORS**.

ETHNICITY PAY GAP – the difference in average pay rates for doctors and dentists from different ethnic backgrounds, as a percentage of earnings of those from a white background.

EXPENSES TO EARNINGS RATIO (EER) – the percentage of earnings spent on expenses rather than income by a general medical practitioner or a general dental practitioner.

FLEXIBLE PAY PREMIUM – Additional payments made to doctors and dentists in GP practice placements and recognised hard-to-fill training programmes.

FOUNDATION DOCTOR/FOUNDATION HOUSE OFFICER – a trainee doctor undertaking the **FOUNDATION PROGRAMME**, a (normally) two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. 'F1' refers to a trainee doctor in the first year or the programme; 'F2' refers to a doctor in the second year.

FOUNDATION PROGRAMME – See *Foundation Doctor/Foundation House Officer*

FREEDOM OF INFORMATION ACT – is an Act of the Parliament of the United Kingdom that creates a public "right of access" to information held by public authorities.

GENDER PAY GAP – the difference in average pay rates for men and women, as a percentage of men's earnings.

GENDER PAY GAP IN MEDICINE REVIEW – the independent review, led by Professor Dame Jane Dacre, was commissioned by the Department of Health and Social Care in April 2018 to advise on action to improve gender equality in the NHS. Its report, *Mend the Gap,* was published in November 2020.

GENERAL DENTAL COUNCIL – maintains an up-to-date register of all qualified dentists and other dental care professionals, as well as lists of fully-qualified specialists.

GENERAL DENTAL PRACTITIONER (GDP) – a qualified dental practitioner, registered with the General Dental Council and on the dental list of an NHS England Region (Geography) for the provision of general dental services. *See also Providing-Performer Dentist, Principal Dentists, Performer-only Dentist, Associate Dentist and Salaried Dentists.*

GENERAL DENTAL SERVICES CONTRACT (GDS) – the standard national contract under which dental services are commissioned and delivered. Different versions of the GDS are used in England, Scotland, Wales and Northern Ireland.

GENERAL MEDICAL COUNCIL (GMC) – A public body that maintains the medical register – the list of doctors who are registered to practice in the UK, as well as lists of fully-qualified specialists.

GENERAL MEDICAL PRACTITIONER (GMP) – more commonly known as a GP, a GMP works in primary care and specialises in family medicine. See also *Contractor GMP/Partner GMP* and *Salaried GMP*

GENERAL MEDICAL SERVICES (GMS) CONTRACT – one of the types of contracts primary care organisations can have with primary care providers. It is a mechanism for providing funding to individual general medical practices, which includes a basic payment for every practice, and further payments for specified quality measures and outcomes.

GENERAL PRACTITIONER (GP) – *See General Medical Practitioner*

GMP RETAINER – a general medical practitioner, who provides service sessions in general practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

GMP TRAINER – a general medical practitioner, other than a general practice specialty registrar, who is approved by the General Medical Council for the purposes of providing training a general practice specialty registrar.

HEALTH AND SOCIAL CARE (HSC) – the publicly funded health and social care system in Northern Ireland

HEALTH AND SOCIAL CARE PARTNERSHIPS – organisations formed to integrate services provided by Health Boards and Councils in Scotland.

HEALTH BOARD – an NHS organisation in Scotland and Wales with a geographical remit.

HEALTH EDUCATION ENGLAND – a former Arm's Length Body of DHSC that funded and managed the NHS's workforce training systems, including the medical and dental training systems. It has now merged with NHS England.

HEALTH EDUCATION AND IMPROVEMENT WALES (HEIW) – has a leading role in providing the healthcare workforce in Wales with education, training and development.

HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS) WORKFORCE – A collective term for the groups within medical and dental workforce that are employed by NHS/HSC Trusts or Health Boards. The HCHS workforce comprises consultants, doctors and dentists in training, SAS doctors and dentists, salaried dentists and others (including those on locally-determined contracts). General medical practitioners, general dental practitioners and ophthalmic medical practitioners that practice in primary care are excluded from this category.

HOSPITAL CONSULTANTS AND SPECIALISTS ASSOCIATION (HCSA) – A trade union that represents hospital doctors across the UK.

ITEM OF SERVICE (IOS) – the technical term used in the NHS/HSC dental contract system regulations in Scotland and Northern Ireland to describe weighted courses of treatment.

JUNIOR DOCTORS – see *doctors and dentists in training*.

LOCAL CEAs – A reward scheme for NHS consultants and academic GMPs in England. Administered locally by employers, payments are temporary and non-pensionable, under arrangements that will expire in 2022. Some consultants continue to receive pensionable, consolidated payments under the former Local CEA scheme, that was replaced in 2018.

LOCALLY-EMPLOYED DOCTORS AND DENTISTS – Doctors and dentists directly employed by NHS/HSC Trusts or Health Boards, but not on the national contracts for consultants, SAS doctors and dentists or doctors and dentists in training. Instead, they are employed on locally-determined contracts that are generally agreed on an individual basis.

LOCUM – a doctor or dentists who works, and is paid, as a temporary member of staff.

LONG TERM WORKFORCE PLAN – a document to be published by NHS England in Spring 2023, which sets out its priorities for healthcare in England.

NATIONAL CEAs – A closed reward scheme for NHS consultants and academic GMPs in England and Wales, that has been replaced by the National Clinical Impact Awards Scheme – See *National Clinical Impact Awards*

NATIONAL CLINICAL IMPACT AWARDS (NCIAs) – A reward scheme for NHS consultants and academic GMPs in England and Wales. Administered by the ACCIA, there are three levels of award in England, currently worth £20,000, £30,000 and £40,000 per year, with a fourth level, currently worth £10,000 per year, in place in Wales. Awards are temporary, non-consolidated and non-pensionable.

NATIONAL HEALTH SERVICE (NHS) – the publicly funded healthcare systems in England, Scotland and Wales.

NHS DIGITAL – the former national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care in England. It has now merged with NHS England.

NHS Education for Scotland – an education and training body and a special health board within NHS Scotland.

NHS EMPLOYERS – a national employers' body that represents NHS Trusts in England.

NHS ENGLAND – an Arm's Length Body of DHSC responsible for funding and commissioning NHS services, and overseeing NHS Trusts in England. It now also has responsibility for administering the NHS's workforce training systems, following its merger with Health Education England – see *Health Education England*

NHS ENGLAND AND IMPROVEMENT (NHSE/I) – *now called NHS England.*

NHS LONG TERM PLAN – a document published by NHS England and Improvement, which sets out its priorities for healthcare in England over the next 10 years and shows how the NHS funding settlement will be used. The plan builds on the policy platform laid out in the NHS Five Year Forward View, which articulated the need to integrate care to meet the needs of a changing population.

NHS PAY REVIEW BODY (NHSPRB) – an advisory non-departmental public body, sponsored by the Department of Health and Social Care that advices on the pay of Agenda for Change staff.

NHS PROVIDERS – a membership organisation for NHS acute, ambulance, community and mental health Trusts in England.

OFFICE OF MANPOWER ECONOMICS (OME) – The Office of Manpower Economics is a part of the Department for Business and Trade, whose sole function is to provide an independent secretariat to the eight Pay Review Bodies, including the DDRB.

OUT OF HOURS SERVICES – the arrangements to provide access to primary care at times when General Practitioner surgeries are closed.

OUT OF PROGRAMME PAUSE – a system that allows trainees to step out of formal for a period of time – currently up to one year – and have any competencies gained whilst out of training assessed upon their return.

PANDEMIC – see *COVID-19*

PARTNER GMP – see *Contractor GMP*

PERFORMER-ONLY DENTISTS (ENGLAND AND WALES) – performer-only dentists deliver NHS dental services but do hold a contract with the NHS in their own right. They are typically subcontracted to deliver dental services to the public by a providing-performer or by a corporate dental provider. The equivalent in Scotland and Northern Ireland is associate dentist. See also *associate dentists.*

PRIMARY CARE NETWORKS – groups of practices working together to focus local patient care in England

PRINCIPAL DENTISTS (SCOTLAND AND NORTHERN IRELAND) – dental practitioners who are practice owners, practice directors or practice partners, have an arrangement with an NHS board, and provide General Dental Services. The equivalent in England and Wales is providing-performer dentists. See also *providing-performer dentists.*

PROGRAMMED ACTIVITIES (PAs) – under the 2003 contract, consultants have to agree the numbers of programmed activities they will work to carry out direct clinical care; a similar arrangement exists for specialty doctors and associate specialists on the 2008 contracts. Each programmed activity is four hours, or three hours in 'premium time', which is defined as between 7 pm and 7 am during the week, or any time at weekends. A full-time consultant typically does 10 PAs, but some do more. A number of PAs are dedicated to **SUPPORTING PROFESSIONAL ACTIVITIES**, during which time consultants carry out training, continuing professional development, job planning, appraisal and research.

PROVIDING-PERFORMER DENTISTS (ENGLAND AND WALES) – dentists who hold a contract with a primary care organisation and also perform NHS dentistry on this or another contract. The equivalent in Scotland and Northern Ireland is principal dentists. See also *principal dentists.*

PUBLIC DENTAL SERVICE (PDS) – see *Salaried GDPs*

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION (DDRB) – an advisory non-departmental public body, sponsored by the Department of Health and Social Care, that advises government on the rates of pay for doctors and dentists.

ROYAL COLLEGES – Organisations that set standards for the way that doctors are educated, trained and monitored. They are typically arranged around specialties. See *specialty.*

SALARIED GMPs – general medical practitioners who are employed by either a primary care organisation or a practice under a nationally agreed model contract. See also *independent contractor status.*

SALARIED DENTISTS – provide generalist and specialist care, largely for vulnerable groups. They often provide specialist care outside the hospital setting to many who might not otherwise receive NHS dental care as part of the Community Dental Services in England, Wales and Northern Ireland, and the Public Dental Service in Scotland.

SAS ADVOCATE – a strategic role to promote and improve support for SAS doctor's health and wellbeing.

SAS GRADES – see *staff grade, associate specialists, specialist and specialty doctors and dentists.*

SPECIALTY – Specialties are divisions of clinical work which may be defined by body systems (dermatology), age (paediatrics), clinical technology (nuclear medicine), clinical function (rheumatology), group of diseases (oncology) or combinations of these factors. Hospital doctors and dentists typically choose one specialty to train and work in.

SPECIALTY AND SPECIALIST GRADES/SAS GRADES – This group of hospital doctors and dentists comprises specialty doctors and dentists, associate specialists, staff grades, clinical assistants, hospital practitioners and specialists. All of these grades are filled by doctors and dentists who have not completed training but are also not actively undertaking it. All but the specialty grade and, in England, Wales and Northern Ireland, the specialist grade, are closed to new entrants.

SUPPORTING PROFESSIONAL ACTIVITIES – see *programmed activities.*

SOCIAL CARE WALES – statutory body with regulatory powers to protect, promote and maintain the safety and well-being of the public in Wales.

TARGETED ENHANCED RECRUITMENT SCHEME (TERS) – A scheme under which GMP trainees in certain hard-to-fill locations receive a payment of £20,000 that is refundable under certain circumstances.

TRUST – an organisation NHS or HSC service in England or Northern Ireland.

UNIT OF DENTAL ACTIVITY (UDA) – the technical term used in the NHS dental contract system regulations in England and Wales to describe weighted courses of treatment. The UOA is an equivalent figure used for orthodontic treatments.

UNIT OF ORTHODONTIC ACTIVITY (UOA) – see *Unit of Dental Activity.*

UNIVERSITIES AND COLLEGES ADMISSIONS SERVICE (UCAS) – operates the application process for UK universities and colleges.

VOLUNTARY EARLY RETIREMENT (VER) – Refers to clinicians who elect to receive their pension ahead of the normal retirement age defined by their pension scheme.

WE ARE THE NHS: PEOPLE PLAN FOR 2020-21 – a document published by NHSE/I which sets out actions that will be taken by NHSE/I and HEE over 2020-21 to address workforce challenges.

WORKFORCE RACE EQUALITY STANDARD (WRES) – a requirement for NHS commissioners and healthcare providers under the NHS standard contract, under which NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

APPENDIX E: THE DATA HISTORICALLY USED IN OUR FORMULAE-BASED DECISIONS FOR INDEPENDENT CONTRACTOR GMPS AND GDPS

E.1 This appendix gives the latest data that would have populated the formulae for both GMPs and GDPs, had we used the previous formulae-based approach (Table E.1).

E.2 Whilst we are not making formula-based recommendations for independent contractor GMPs and GDPs, we set out below in Table E.1 the data that would have populated the formulae as they existed in 2015. Given our ongoing concerns with the reliability of the formula, we do not consider it appropriate this year to adjust the weightings of the coefficients in the formula. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work: as noted in our 2012 report, average earnings and expenses for dentists reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound. The parties may wish to consider this point as part of their discussion of expenses and the uplift.

Table E.1: Data historically used in our formulae-based decisions for independent contractor GMPs and GDPs

Coefficient	Value
Income (Contractor GMPs in Scotland, Wales and Northern Ireland, Salaried GMPs across the UK) *DDRB recommendation*	6.0%
Staff costs (GMPs) *Annual Survey of Hours and Earnings (ASHE) 2022 (general medical practice activities)*	7.0%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2022*	13.4%
Income (GDPs) *DDRB recommendation*	6.0%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2022 (dental practice activities)*	4.1%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2022*	13.4%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2022*	13.4%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2022*	13.9%
Other costs (GDPs) Scotland *RPIX for Q4 2022*	13.4%

Sources: Annual Survey of Hours and Earnings (Table 16.5a, all, median), Consumer Price Inflation (CDKQ, CZBH)

APPENDIX F: ABBREVIATIONS AND ACRONYMS

ACCIA	Advisory Committee on Clinical Impact Awards
AfC	Agenda for Change
ARCP	Annual Reviews of Competence Progression
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CCT	Certificate of Completion of Training
CDS	Community Dental Services
CEA	Clinical Excellence Award
CESR	Certificate of Eligibility for Specialist Registration
CIA	Clinical Impact Award
CIC	Community Interest Company
CPI	Consumer Prices Index
CPIH	Consumer Prices Index including owner occupiers' housing costs
COVID/COVID-19	Coronavirus disease 2019
CT 1-3	Core training, years 1-3
DA	Distinction Award
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSC	Department of Health and Social Care (England)
DoH	Department of Health (Northern Ireland)
DP	Discretionary Point
EDI	Equality, Diversity, and Inclusion
EEA	European Economic Area
EER	Expenses to earnings ratio
EJDWL	Enhancing Junior Doctors' Working Lives
EPG	Ethnicity Pay Gap
EU	European Union
F1-2	Foundation, years 1-2
FPP	Flexible Pay Premium
FTE	Full-Time Equivalent
GDC	General Dental Council
GDP	General Dental Practitioner

GDS	General Dental Services contract
GMC	General Medical Council
GMP	General Medical Practitioner
GMS	General Medical Services
GP	General Practitioner
GPG	Gender Pay Gap
HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association
HEE	Health Education England
HEIW	Health Education and Improvement Wales
HMRC	His Majesty's Revenue and Customs
HMT/HM Treasury	His Majesty's Treasury
HSC	Health and Social Care (Northern Ireland)
HSCP	Health and Social Care Partnerships
ICS	Integrated Care Systems
IDR	Incomes Data Research
IoS	Item of Service
LED	Locally Employed Doctor or Dentist
LTFT	Less-Than-Full-Time
MYD	Multi-Year pay Deal
NI	Northern Ireland
NHS	National Health Service
NHSE	NHS England
NHSE/I	NHS England and Improvement
NHSPRB	NHS Pay Review Body
OBR	Office for Budget Responsibility
OME	Office of Manpower Economics
ONS	Office for National Statistics
PCN	Primary Care Networks
PDS	Public Dental Service
RPI	Retail Prices Index
SAS	Specialty and Specialist
SGEQMENI	Strategic Group to Enhance the Quality of Medical Education in Northern Ireland
SPPA	Scottish Public Pensions Agency

ST1-9	Specialist Training, years 1-9
TERS	Targeted Enhanced Recruitment Scheme
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity
UOA	Units of Orthodontic Activity
UK	United Kingdom
VER	Voluntary Early Retirement
WRES	Workforce Race Equality Standard
WTE	Whole-Time Equivalent/Working-Time Equivalent

APPENDIX G: PREVIOUS DDRB RECOMMENDATIONS AND THE GOVERNMENTS' RESPONSES

The main DDRB recommendations since 1990 for the general pay uplift are shown in the table below, together with the November or Quarter 4 RPI and CPI inflation figures which were usually the latest figures available at the time of publishing the Review Body's report and the Governments' responses to the recommendations as a whole.

Report year	Main Uplift	RPI %[1]	CPI %[2]	Response to report
1990	9.5%	7.3	5.5	Not accepted. Rejected increases at top of consultants' scale and in the size of the A+ distinction award; staged implementation
1991	9.5% to 11%	10.9	7.8	Accepted, but staged implementation
1992	5.5% to 8.5%	3.7	7.1	Accepted
1993		3.6	2.6	No report following Government's decision to impose a 1.5% pay limit on the public sector
1994	3%	1.4	2.3	Accepted
1995	2.5% to 3%	2.4	1.8	Accepted
1996	3.8% to 6.8%	3.2	2.8	Accepted, but staged implementation
1997	3.7% to 4.1%	2.7	2.6	Accepted, but staged implementation
1998	4.2% to 5.2%	3.7	1.9	Accepted, but staged implementation
1999	3.5%	3.1	1.4	Accepted
2000	3.3%	1.2	1.2	Accepted
2001	3.9%	3.1	1.1	Accepted, but Government suspended the operation of the balancing mechanism (which recovers GMPs 'debt')
2002	3.6% to 4.6%	0.9	0.8	Accepted
2003	3.225%	2.6*	1.5	Accepted
2004	2.5% to 2.9%	2.5	1.3	Accepted
2005	3.0% to 3.4%	3.4**	1.5	Accepted
2006	2.2% to 3.0%	2.2**	2.1	Accepted, although consultants' pay award of 2.2 per cent was staged – 1.0 per cent paid from 1 April 2006 and the remaining 1.2 per cent paid from 1 November 2006
2007	£1,000 on all pay points***	3.9	2.7	Accepted, although Scottish Executive did not implement one of the smaller recommendations relating to the pot of money for distinction awards to cover newly eligible senior academic GMPs. England and Wales chose to stage awards in excess of 1.5 per cent – 1.5 per cent from 1 April 2007, the balance from 1 November 2007
2008	2.2% to 3.4%	4.3	2.1	Accepted
2009	1.5%	3.0****	4.1	Accepted
2010	0% to 1.5%	0.3	1.9	Mostly accepted: DDRB recommended: 0% for consultants and independent contractor GMPs and GDPs; 1% for registrars, SAS grades, salaried GMPs and salaried dentists; and 1.5% for FHOs. England and Northern Ireland both restricted the FHO recommendation to 1%.
2011	No recommendation due to public sector pay freeze	4.7	3.3	
2012	No recommendation due to public sector pay freeze	5.2	4.8	

[1] At November in the previous year unless otherwise indicated, series CZBH
[2] At November in the previous year unless otherwise indicated, series D7G7

Report year	Main Uplift	RPI %[1]	CPI %[2]	Response to report
2013	1%	3	2.7	Accepted
2014	1%	2.6 (Q4 figure)	2.1 Q4	Accepted in Scotland. Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales. Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales.
2015	1%	1.9 Q4	0.9 Q4	Recommendation only applied to independent contractor GMPs and GDPs in the UK and for salaried hospital staff in Scotland Accepted
2016	1%	1.0 Q4	0.1 Q4	Accepted
2017	1%	2.2 Q4	1.2 Q4	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland
2018	2%	3.7 Q1	2.7 Q1	Staged and abated in England. Accepted in Wales and Northern Ireland. Accepted in Scotland, except for staff earning at least £80,000 who received £1,600.
2019	2.5%	2.5 Q1	1.9 Q1	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards. Additional 1% for SAS not implemented anywhere.
2020	2.8%	2.6 Q1	1.7 Q1	Accepted
2021	3%	1.4 Q1	0.6 Q1	Accepted
2022	4.5%	8.4 Q1	6.2 Q1	Accepted with the exception of SAS doctors and dentists at the top of the 2008 Specialty Doctor pay scale in Wales, where a 4.5% non-consolidated payment was made instead. Subsequent to implementing most of the recommendations, the Welsh Government also implemented an additional 1.5% consolidated uplift and made a 1.5% non-consolidated payment to HCHS doctors and dentists and uplifted the salaried GMP pay range by 1.5%.
2023	6% (6%+£1,250 consolidated uplift for doctors and dentists in training)	13.6 Q1	10.2 Q1	

* Due to the late running of the round, DDRB was also able to take account of the March figures for RPI (3.1%)

** Due to a later round, November to February, DDRB was also able to take into account the December RPI figure

*** £650 on the pay points for doctors and dentists in training. The average banding multiplier for juniors meant that this would also deliver approximately £1,000

**** DDRB also took into account the December RPI figure (0.9%)

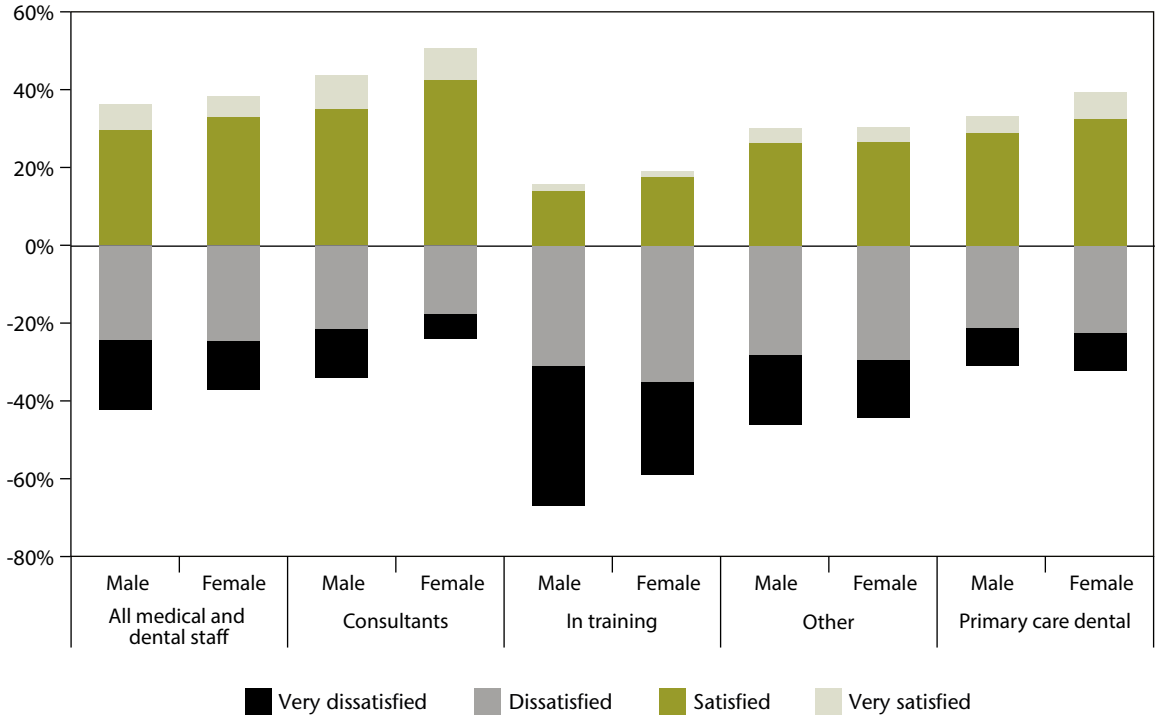
APPENDIX H: STAFF SURVEY GENDER AND ETHNICITY DATA

H.1 In this appendix, we include NHS Staff Staff Survey Data for England broken down by gender and ethnicity. In the 2022 NHS Staff Survey, data broken down by gender was collected separately for those that identify themselves as non-binary or prefer to self-describe their gender identity. This data has been included alongside male and female data, but we would note that the sample size is relatively small, and so it may be difficult to draw firm conclusions from it.

Cross-HCHS Data

H.2 Figure H1 shows satisfaction with pay broken down by staff group and gender in 2022. When looking across all medical and dental staff, there was a 2.1 percentage point difference between female and male staff. 38.3 per cent of female staff and 36.2 per cent of male staff expressed satisfaction with pay. Female consultants, doctors and dentists in training, SAS doctors and primary care dental staff were all more likely than their male counterparts to express satisfaction with pay.

Figure H1: Hospital and Community Health Services (HCHS) staff satisfaction with level of pay by grade and gender, England, 2022

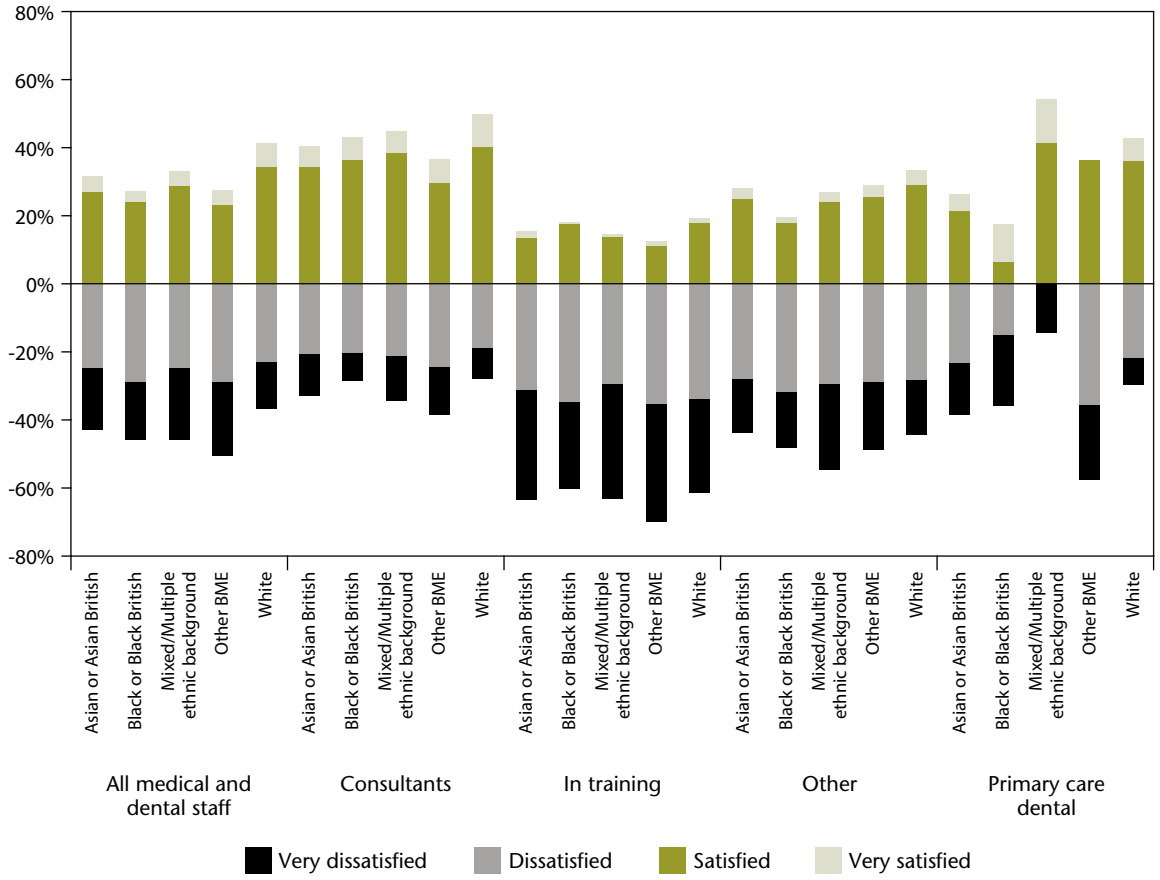


Source: NHS Staff Survey data, Picker Institute Europe.
Note: Those answering 'neither satisfied nor dissatisfied' have been excluded from this chart
Those answering 'prefer to self-identify' or 'prefer not to say' are not shown.

H.3 Figure H2 shows satisfaction with pay broken down by staff group and ethnic group in 2022. When looking across all medical and dental staff, 41.5 per cent of White staff expressed satisfaction with their pay, compared with 33.1 per cent of staff from a mixed/multiple ethnic background, 31.6 per cent of Asian or Asian British staff, 27.6 per cent of staff from other ethnic groups and 27.2 per cent of Black or Black British staff.

- White consultants (49.7 per cent) were more likely to express satisfaction with their pay than consultants from a mixed/multiple ethnic background (44.9 per cent), Black or Black British consultants (43.2 per cent), Asian or Asian British consultants (40.5 per cent), and consultants from other ethnic groups (36.6 per cent).
- White doctors and dentists in training (19.4 per cent) were more likely to express satisfaction with their pay than colleagues from a mixed/multiple ethnic background (14.5 per cent), Asian or Asian British staff (15.4 per cent), Black or Black British staff (18.0 per cent) and staff from other ethnic groups (12.5 per cent).
- White SAS doctors and dentists (33.2 per cent) were more likely to express satisfaction with their pay than Asian or Asian British staff (28.0 per cent), Black or Black British staff (19.5 per cent), colleagues from a mixed/multiple ethnic background (26.8 per cent), and staff from other ethnic groups (29.0 per cent).
- Salaried primary care dentists from a mixed/multiple ethnic background (54.1 per cent) were more likely to express satisfaction with their pay than White colleagues (42.7 per cent), Asian or Asian British staff (24.4 per cent), those from other ethnic groups (36.3 per cent), and Black or Black British staff (17.6 per cent).

Figure H2: HCHS staff satisfaction with level of pay by grade and ethnic group, England, 2022

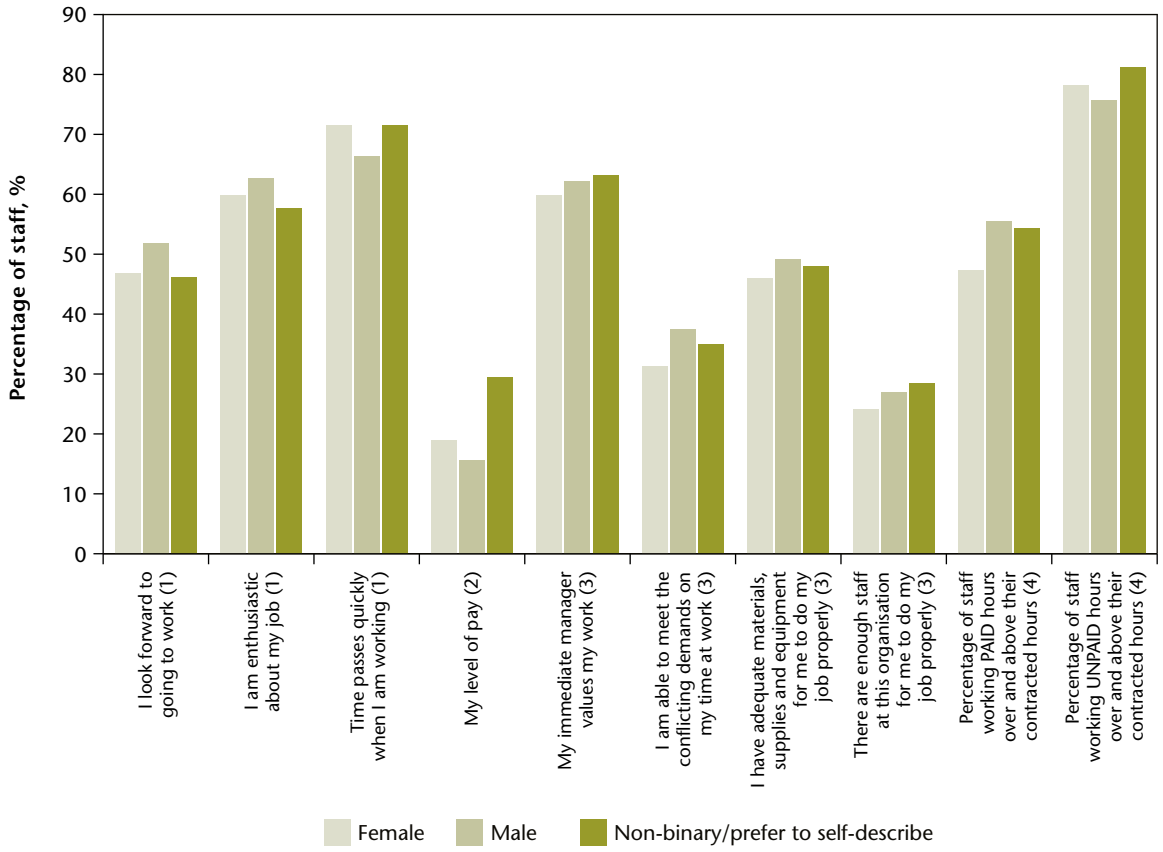


Source: NHS Staff Survey data, Picker Institute Europe.
Note: Those answering 'neither satisfied nor dissatisfied' have been excluded from this chart. Those answering 'prefer to self-identify' or 'prefer not to say' are not shown.

Doctors and Dentists in Training

H.4 Figure H3 shows that in 2022 female doctors and dentists in training were more satisfied with their pay than their male colleagues but less positive than non-binary/prefer to self-describe colleagues. However, compared with both female and non-binary/prefer to self-describe colleagues, male doctors and dentists in training were more likely to say that they looked forward to going to work, were enthusiastic about their job, were able to meet the conflicting demands on their time, and had adequate materials to do their job. Male doctors and dentists in training were most likely to work paid hours over and above their contracted hours, and least likely to work extra unpaid hours.

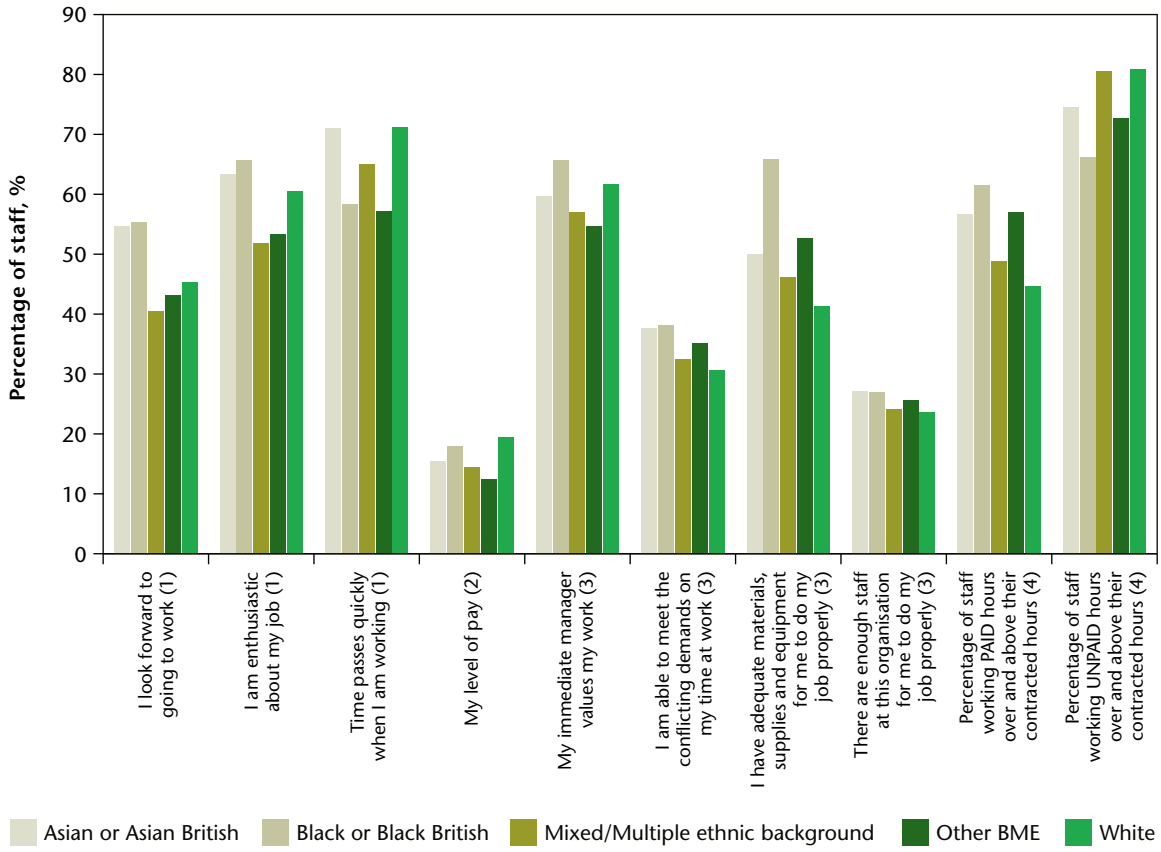
Figure H3: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by gender, England, 2022



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

H.5 Figure H4 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian or Asian British and Black or Black British doctors and dentists in training were more likely to say that they looked forward to going to work, were enthusiastic about their job and were able to meet the conflicting demands on their time than those from other ethnic groups. White and Black or Black British doctors and dentists in training were more satisfied with their pay than colleagues from other ethnic groups. White doctors and dentists in training were less likely to say that they worked paid hours in addition to their contracted hours than colleagues from other ethnic groups, while White doctors and dentists in training were more likely to say that they worked unpaid hours in addition to their contracted hours.

Figure H4: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by ethnic group, England, 2022

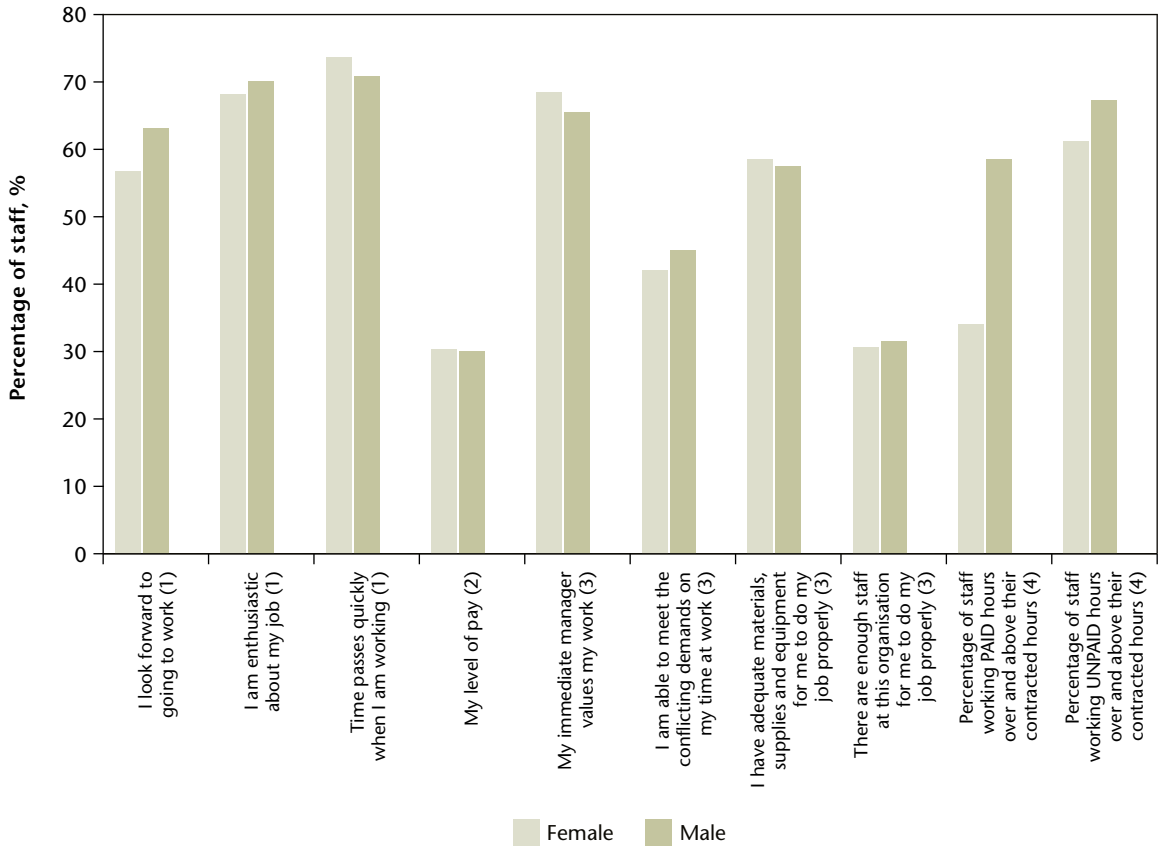


Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours

SAS Doctors and Dentists

H.6 Figure H5 shows that 30 per cent of male and female SAS doctors and dentists were satisfied with pay. Compared with female SAS doctors and dentists, male SAS doctors were more likely to say that they looked forward to going to work, were enthusiastic about their job, and were able to meet the conflicting demands on their time. Female SAS doctors and dentists were less likely to work hours over and above their contracted hours, both paid and unpaid hours, than their male colleagues. Results for non-binary/prefer to self describe SAS doctors and dentists are not included due to the small sample size.

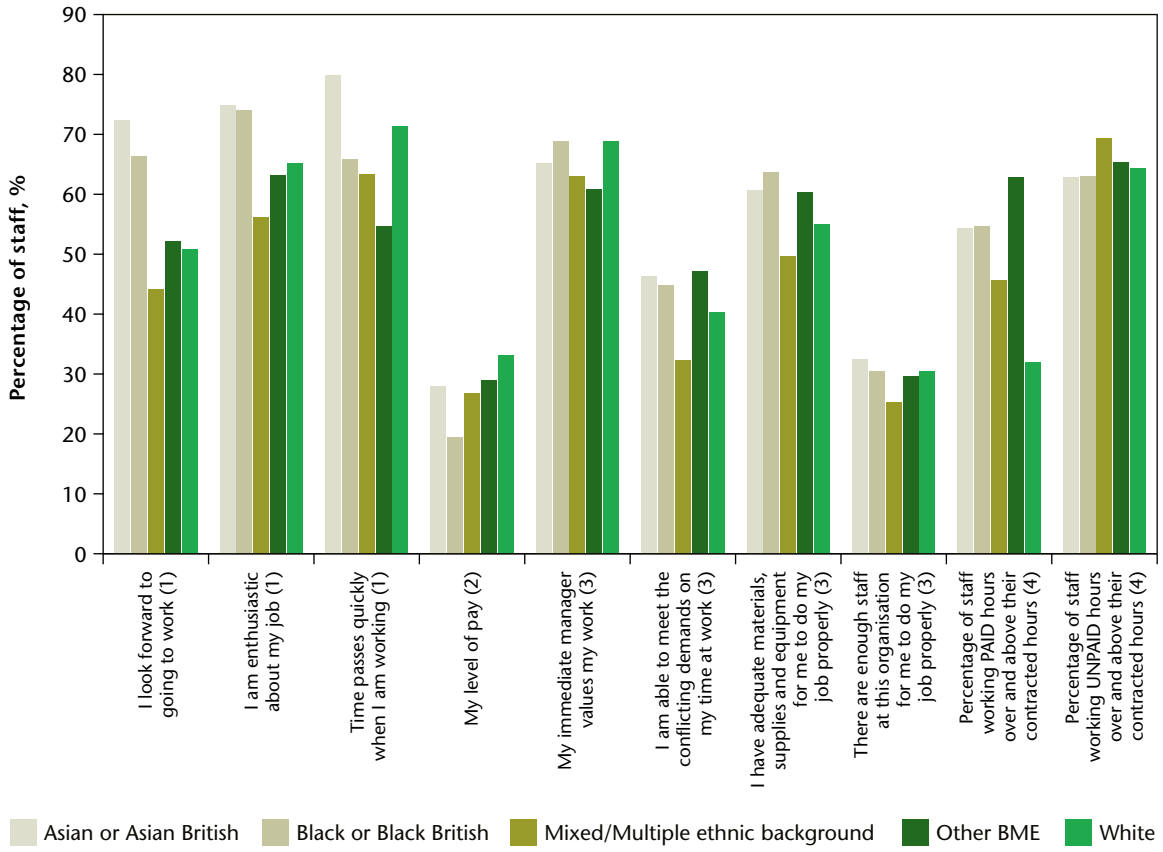
Figure H5: HCHS SAS (other) doctors, satisfaction with aspects of the job and work pressures by gender, England, 2022



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

H.7 Figure H6 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian or Asian British SAS doctors, compared with those from other ethnic groups, were more likely to say that they looked forward to going to work, were enthusiastic about their job, and said that time passed quickly when they were working. White SAS doctors were less likely to work extra paid hours than colleagues from other ethnic groups.

Figure H6: SAS (other) HCHS doctors training, satisfaction with aspects of the job and work pressures by ethnic group, England, 2022

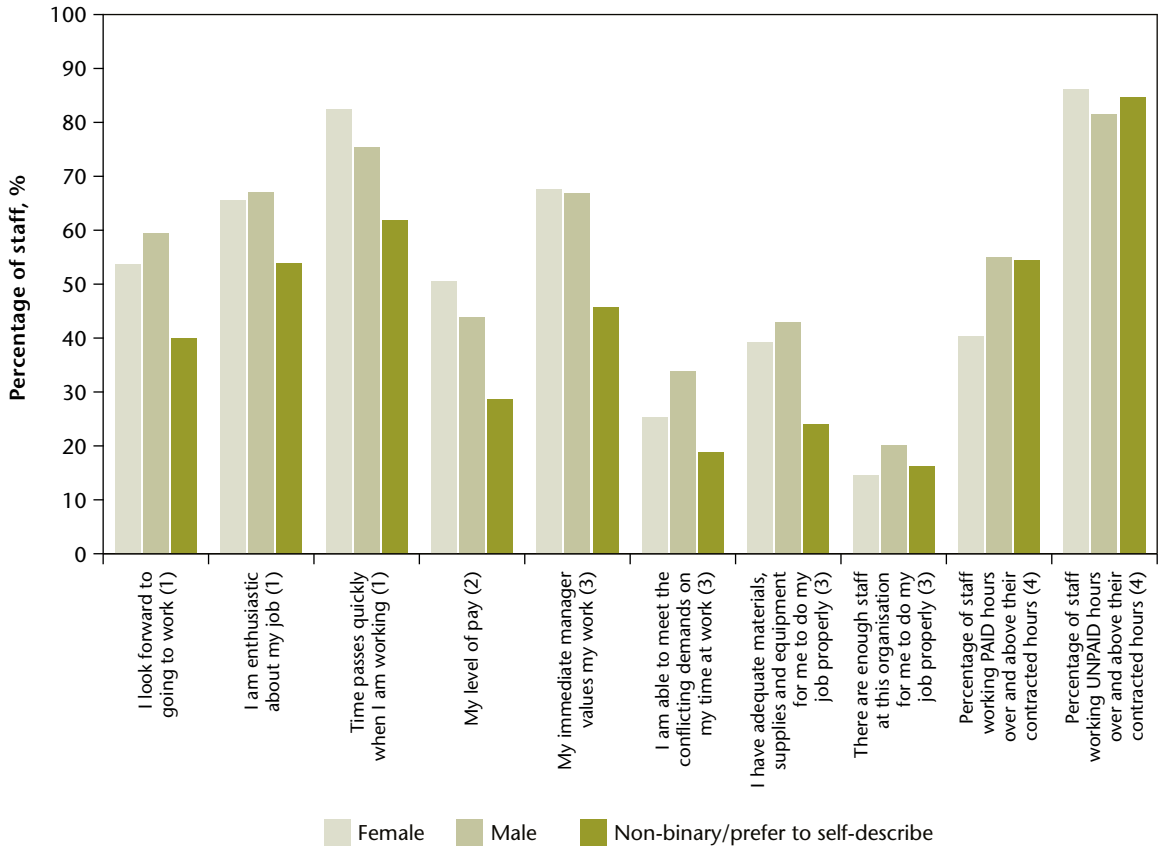


Source: NHS Staff Survey data, Picker Institute Europe.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours

Consultants

H.8 In 2022, female consultants were more likely to say they were satisfied with their pay than male or non-binary/prefer to self-describe colleagues (Figure H7) and were more likely to say that time passed quickly when they worked. However, compared with female consultants and non-binary/prefer to self-describe colleagues, male consultants were more likely to say that they looked forward to going to work, were enthusiastic about their job, were able to meet competing demands on their time, had adequate materials, and that there were sufficient staff at the organisation. Male consultants were most likely to work extra paid hours, while female consultants were most likely to work extra unpaid hours.

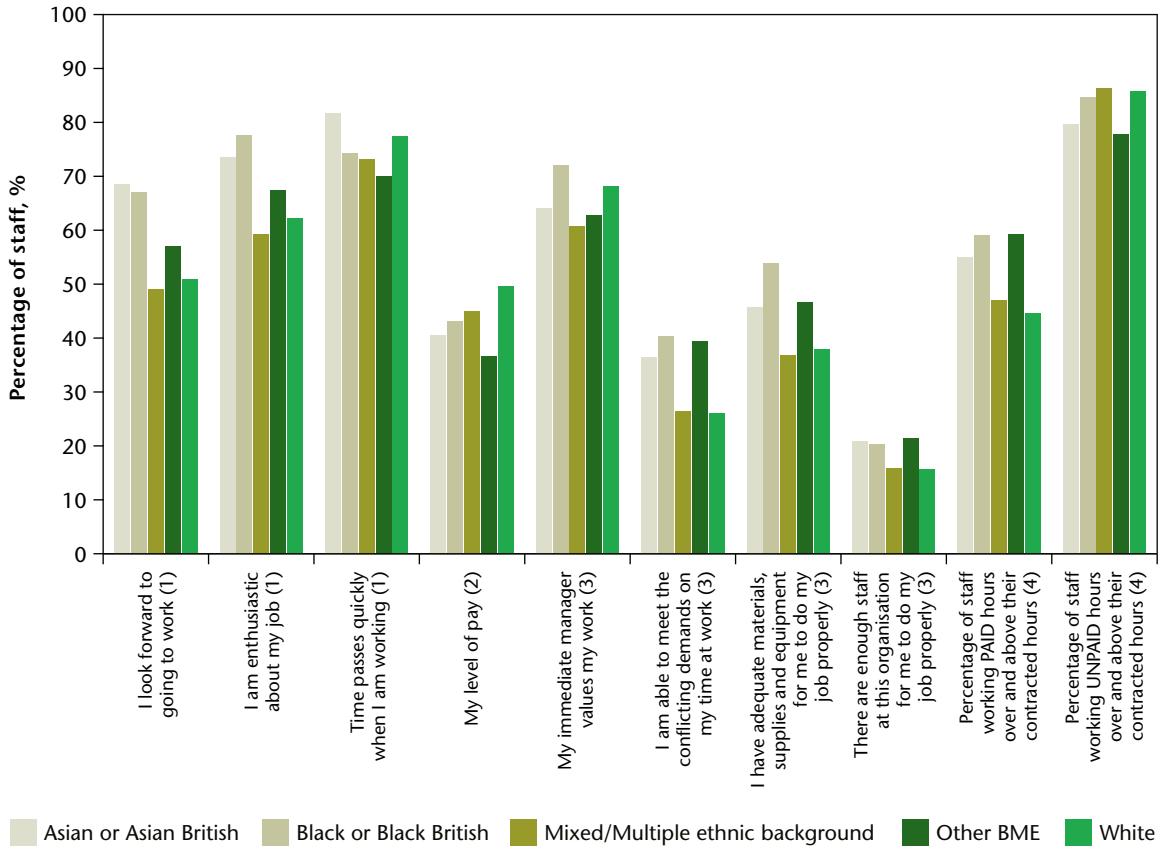
Figure H7: HCHS consultant satisfaction with aspects of the job and work pressures by gender, England, 2022



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

H.9 Figure H8 shows satisfaction with aspects of the job and work pressures, by ethnic group. For most of the variables, Asian or Asian British and Black or Black British consultants were more satisfied than their White colleagues or those from other ethnic groups, although White consultants were more satisfied with their pay than consultants from other ethnic groups. White consultants were less likely to say that they worked paid hours in addition to their contracted hours than colleagues from other ethnic groups.

Figure H8: HCHS consultant satisfaction with aspects of the job and work pressures by ethnic group, England, 2022



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

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