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NHS England

The Review Body on Doctors' & Dentists' Remuneration

Review for 2014

General Medical Practitioners and General Dental Practitioners

THE NHS CONSTITUTION
the NHS belongs to us all

Contents

INTRODUCTION

Background

0.1 From April 2013, NHS England took over the responsibilities of Primary Care Trusts (PCTs) for commissioning primary care services, including primary medical care. NHS England has responsibility for developing primary medical care contracts and for the negotiations with the GPC on improvements to the GMS contract.

0.2 This document contains written evidence from NHS England to inform the Review Body on Doctors' and Dentists' Remuneration (DDRB) report on 2014/15 pay for their remit group.

0.3 In his letter[1] of 3rd September to the Chair of the DDRB, the Parliamentary Under Secretary of State for Health set out that detailed evidence would be provided to you from:

- NHS Employers – on recruitment, retention, motivation and morale for employed doctors and dentists;
- NHS England - on primary care contractors; and
- Health Education England – on education, training and workforce capacity.

0.4 In addition, the Department of Health and ourselves in NHS England would provide high level evidence on the context. For NHS England's part, we are therefore providing evidence on those matters where we feel it most appropriate for us to comment on, including affordabilty and funding constraints.

Affordability and funding constraints

0.5 NHS England is funded by the Department of Health to commission health services as required under the NHS Constitution and the NHS Mandate, with objectives to deliver improved health outcomes.

0.6 In 2013/14, NHS England was allocated £95,623m of funding.

0.7 For 2014/15, the Department of Health is expected to set the Mandate and associated funding during November 2013. Whilst the NHS has been protected from real term cuts in funding, the fiscal position and demand pressures mean the scale of funding growth will be considerably constrained by historic standards.

0.8 NHS England set out its analysis of what the constrained public finances might mean for the NHS in the period to 2020 in the *Call to Action*[2]. This analysis identified a £30bn gap between likely available funding and expected demand levels on NHS services by 2020. In addition, page 16 gave an indication showing how projected costs outstrip projected funding from 2014/15 onwards.

[1] Available from: http://www.ome.uk.com/Search/Default.aspx?q=remit+letter&page_num=1
[2] Available from: http://www.england.nhs.uk/2013/07/11/call-to-action/

0.9 In June 2010, the Government announced a public sector pay freeze, covering 2011/12 and 2012/13. During the 2011 Autumn Statement, the Government announced that, for 2013/14 and 2014/15, public sector pay increases would be capped at an average 1%. In March, the Government announced that the public sector pay cap would be extended by a further year to include 2015/16.

0.10 On the basis of the above, we would urge the DDRB to consider very carefully what, if any, uplift is appropriate for 2014/15.

Basis of the evidence

0.11 The evidence in Chapters 1 and 2 has been provided in discussion with NHS England's Regional Offices and Area Teams, and therefore represents views from across the organisation.

CHAPTER 1: GENERAL MEDICAL PRACTITIONERS

Introduction

1.1 This chapter relates to information on general medical practitioners (GMPs) providing NHS primary care services in England.

1.2 NHS Employers is currently in discussion with the General Practitioners Committee (GPC) of the BMA over potential improvements to the General Medical Services (GMS) contract for 2014/15. An update on the negotiations will be provided in NHS England's supplementary evidence, due with DDRB later in the year**.**

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

Background

1.4 Most doctors working in GMS are independent contractors, who are self-employed individuals or partnerships running their own practices as small businesses. According to the latest figures published by the Information Centre for Health and Social Care[3], as at 30 September 2012, there were 8,088 GP practices in England. Of these, around 55% of practices (accounting for 51% of GMPs) operated under the national GMS contract.

1.5 Contractors with Personal Medical Services (PMS) arrangements operate within locally agreed contracts, and any uplifts in investment for PMS contracts are a matter for NHS England to consider. NHS England is committed to ensuring an equitable funding approach for Primary Medical Care Contracts.

1.6 Part of this work involves a data collection exercise to collate a national picture of the payments made to PMS contractors, the findings of which we intend to publish later in the financial year. In addition, there are a small number of GMPs (969) who work under, or hold, contracts under a locally contracted Alternative Provider Medical Services (APMS) arrangement across some 260 practices.

Recruitment, retention and motivation of GMPs

1.7 As at September 2012[3], in headcount terms, there were 35,527 GMPs - an increase of 112 (0.3%) since 2011 and an estimated increase of 6,325 (22.6%) since 2002 (an annual average increase of 2.0%).

1.8 Of these, there were 26,886 GMP providers, a slight decrease of 332 (1.2%) since 2011, and an estimated decrease of 1,231 (4.3%) since 2002.

1.9 The number of 'other' GMPs (typically salaried practitioners) now stands at 8,898, an increase of 313 (3.6%) since 2011 and an estimated increase of 7,813 (720%) since 2002.

[3] Available at: http://www.hscic.gov.uk/article/2021/Website-Search?productid=10382&q=gp+staff&sort=Relevance&size=10&page=1&area=both#top

1.10 The average age of the workforce continues to grow, with 43.1% of practitioners in 2011 under the age of 45 compared with 47.5% in 2002 and 22.5% over the age of 55 in 2012 compared with 18% in 2002.

1.11 There are now 4,491 GMP registrars, compared with 1,980 in 2002, an increase of 2,511 - 127%.

1.12 The Seventh National GP Work Life Survey[4] conducted by Manchester University in Autumn 2012, on working conditions and job satisfaction of GMPs, is the most up to date comparable evidence in measuring GMP satisfaction based on the 1,189 responses from 3,000 GMPs (in England). This showed:

- on a seven-point scale, overall average job satisfaction had increased from 4.7 points in 2008 to 4.9 points in 2010 and then decreased slightly to 4.5 points in 2012.

- average working hours were 41.7 hours per week - a slight increase (by 0.3 hours – 0.7%) since the 2010 survey - which had remained unchanged since the 2008 survey. There was no change between 2010 and 2012 in the proportion of GPs reporting undertaking out-of-hours work: in 2012, 21% did so, for a median of 4 hours. However, that was significantly fewer than in 2008, when 32% reported undertaking out-of-hours work

- The proportion of GPs expecting to quit direct patient care in the next five years had increased from 6.4% in 2010 to 8.9% in 2012 amongst GPs under 50 years-old and from 41.7% in 2010 to 54.1% in 2012 amongst GPs aged 50 years and over. This reverses the trend in previous years when, in 2010 the proportion of GMPs expecting to quit direct patient care in the next five years fell from 7.1% in 2008 to 6.4% in 2010 amongst GMPs under 50 years old and from 43.2% to 41.7% amongst GMPs aged 50 and over.

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

1.14 It should also be noted that, as the DDRB recommendation affects the contract price, salaried GP pay may not be automatically amended (depending on the contract). This would lead to inequity between GMP and salaried GPs with resulting impacts on salaried GP recruitment. Salaried GP recruitment and retention is a problem for some areas of England, and would not necessarily be influenced or resolved through a contract uplift.

[4] Source: http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf

Workload of GMPs

1.15 The average number of patients per medical practitioner in England has fallen from 1,764 in 2002 to 1,569 (-11.1%) in 2012, partly because the number of GMPs continues to grow faster than the number of patients.

1.16 The number of patients per practice has risen from 5,833 in 2002 to 6,891 in 2012. Over the same period the number of practices has decreased from 8,833 to 8,088, reflecting a move towards larger practices employing more GMPs. This trend is also evident in the decline of single-handed GMPs from 2,283 in 2002 to 921 in 2012.

1.17 There remains a significant overall increase in headcount numbers of practice staff between 2002 and 2012, with total practice staff numbers increasing by 30,015 (28%) to 137,290.

1.18 Taken together, the total number of primary care staff (GMPs and practice staff) was 136,477 in 2002 which increased by 36,340 or 27% to 172,817 in 2012. Over the same period, the ratio of patients to primary care staff has decreased by 55 patients (-15%), from one for every 378 patients to one for every 323 patients.

Trends in the earnings and expenses of GMPs

1.19 In 2012/13, the NHS in England spent £8.5 billion on primary medical services compared to £5 billion in 2002/03, an overall real-terms increase of 34%.

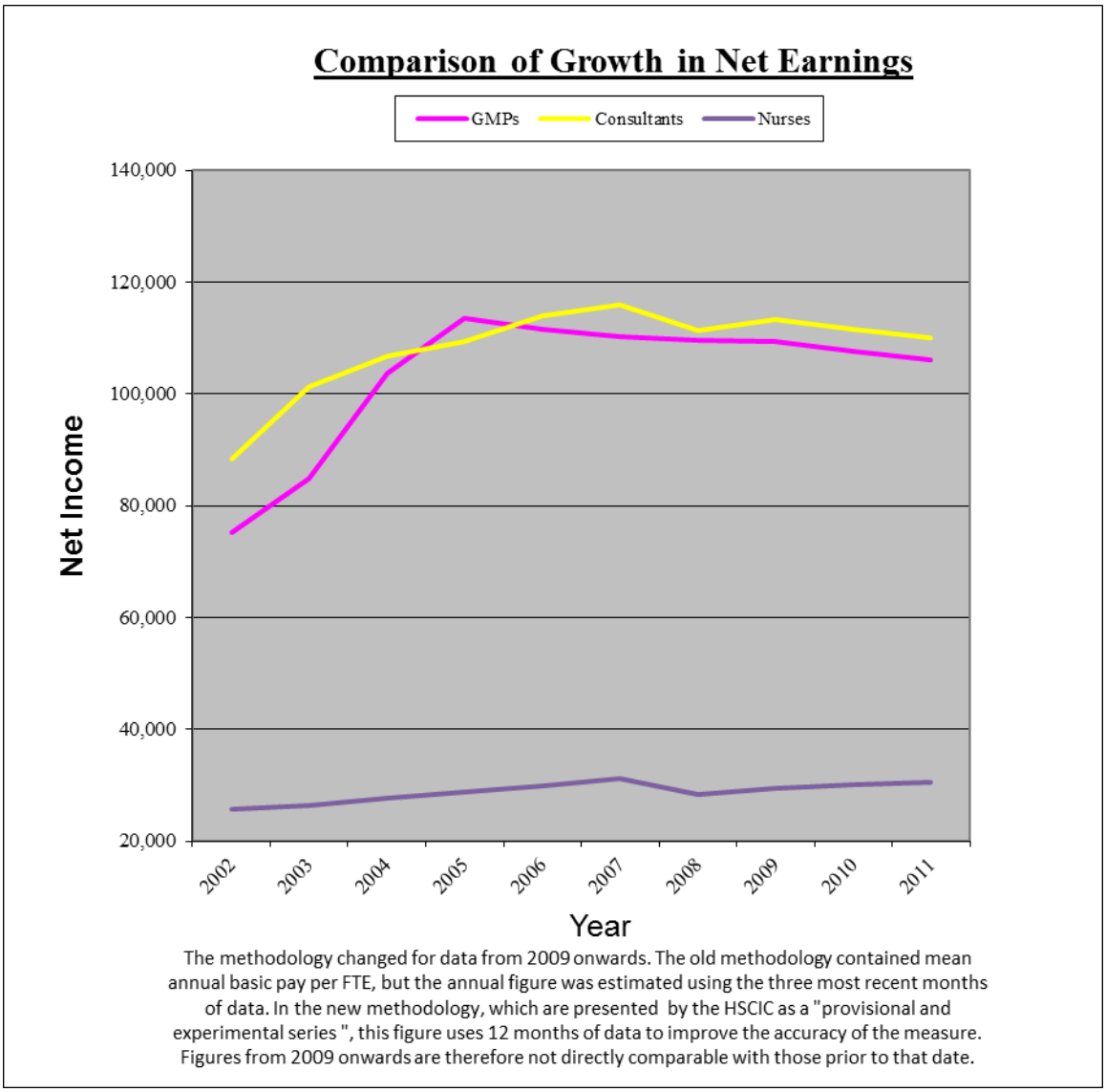
1.20 The following points set out the trends in GMP earnings and expenses in England since 2002/03:

- GMP pay has increased in cash and real terms relative to other NHS staff groups. Figure 1.1 shows the comparison of pay growth between GMPs, nurses and consultants. Please see the note on the change to the methodology at the bottom of the graph. On a cash basis, pay has increased by 41% over the period 2002/03 to 2011/12 (the latest year for which figures are available). This compares to an increase of 25% for consultants and 18% for nurses over the same period.

- In real terms pay has increased by more than 13% over the same period, compared to a reduction of 0.1% for consultants and a reduction of 5% for nurses.

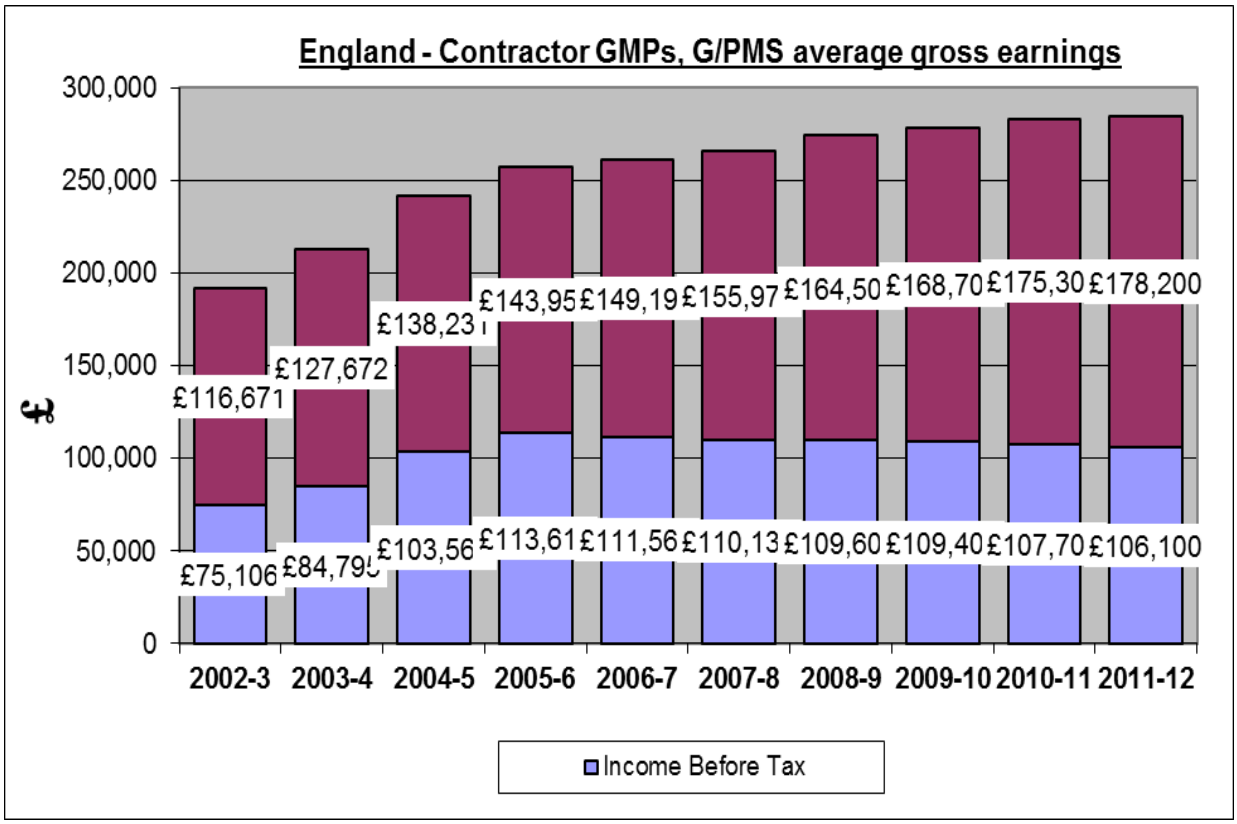
- Increases in GMPs' pay were concentrated in the three years from 2003/04 to 2005/06 following introduction of a new GMS contract. Since 2005/06, there have been small year-on-year falls in net income.

Figure 1.1



1.21 Figure 1.2 below, based on data provided by Her Majesty's Revenue & Customs (HMRC), shows increases in gross earnings and net income for the average GMP in England during the period 2002/03 to 2011/12 (the latest year for which data are available).

Figure 1.2



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

Table 1.3

Numbers of UK GPMS GMPs in different net income brackets (before tax)						
Financial Year	**Less than £50k**	**£50k - £100k**	**£100k - £150k**	**£150k - £200k**	**£200k - £250k**	**More than £250k**
2002/03	7,842	20,493	3,875	221	0	0
2003/04	5,138	19,883	6,469	904	222	0
2004/05	3,060	15,442	12,264	2,492	475	154
2005/06	2,001	12,342	14,534	3,876	816	307
2006/07	2,048	13,387	13,832	3,623	739	258
2007/08	2,320	13,610	13,220	3,560	650	260
2008/09	2,310	14,020	12,820	3,280	700	250
2009/10	2,280	13,410	13,180	3,280	680	210
2010/11	2,360	13,780	12,930	3,190	530	200
2011/12	2,390	14,180	12,690	3,020	510	160

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

1.24 Table 1.4 below sets out actual GMP average net income for 2002/03 to 2011/12.

Table 1.4

England GPMS GMPs				
Financial Year	**Average Net Earnings £**	**Year on Year Cash Change**	**Cumulative Cash Change**	**Cumulative Real Terms Change**
2002/03	75,106	-	-	-
2003/04	84,795	12.9%	12.9%	10.5%
2004/05	103,564	22.1%	37.9%	31.0%
2005/06	113,614	9.7%	51.3%	40.5%
2006/07	111,566	-1.8%	48.5%	34.4%
2007/08	110,139	-1.3%	46.6%	29.5%
2008/09	109,600	-0.5%	45.9%	25.4%
2009/10	109,400	-0.2%	45.7%	25.2%
2010/11	107,700	-1.6%	43.4%	23.2%
2011/12	106,100	-1.5%	41.3%	13.3%

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

Table 1.5

England GPMS GMPs			
Financial Year	**Gross Earnings £**	**Expenses £**	**Expenses as a % of Earnings**
2002/03	191,777	116,671	61%
2003/04	212,467	127,672	60%

2004/05	241,885	138,321	57%
2005/06	257,564	143,950	56%
2006/07	260,764	149,198	57%
2007/08	266,110	155,971	59%
2008/09	274,100	164,500	60%
2009/10	278,100	168,700	61%
2010/11	283,000	175,300	62%
2011/12	284,300	178,200	63%

1.26 Unlike many other staff groups, GMP contractors have scope to increase their net income. They can do this by attracting new income from a range of sources and / or looking to reduce their practice expenses. For example:

- additional income could be gained from a variety of professional activities outside their NHS work. The latest GMP earnings and expenses report by the NHS Information Centre states that it is not possible to provide an NHS/private split using HMRC earnings data. However, as a guide, NHS superannuable earnings for GPMS contractor GMPs in Great Britain were 94.8% of total earnings, suggesting 5.2% was private income;

- additional income could also be gained from NHS and other public sector work. For example, in providing enhanced services such as extended opening hours and receiving payments under the Extended Hours Directed Enhanced Service. In addition, practices that provide high quality services that respond to patient need can attract more patients and therefore funding; and

- expenses could be reduced through seeking greater efficiencies, for example, through:

    - the introduction of federated approaches and sharing of back office functions and staff;
    - appropriate increased delegation to other members of the practice team; and
    - partnership working with local pharmacies.

Clinical Commissioning Groups and GP income

1.27 Clinical commissioning groups (CCGs) have been responsible since April 2013 for commissioning most healthcare services for local populations. The BMA and NHS Employers agreed in 2011 that it will be a contractual duty for holders of primary medical services contracts (i.e. each GP practice) in England to be members of CCGs.

1.28 CCGs are statutory public bodies and are accountable to NHS England for how they use the resources allotted to them to commission high-quality services. CCGs have a

running costs allowance to meet the administration costs that they incur in commissioning services, whether by employing staff themselves or by buying in external commissioning support. With the exception of this running costs allowance, the annual budget allotted to CCGs has to be spent wholly on healthcare services for patients. It is distinct from the NHS income that GP practices receive under their primary medical services contracts.

1.29 NHS England makes payments to CCGs to reward them for the quality of the services they commission and the contribution that these services make to improving health outcomes and reducing inequalities. Regulations under the Health and Social Care Act make provision for how CCGs can use any quality payment awarded to them.

1.30 The NHS England guidance, "Clinical Commissioning Group governing body members: Role outlines, attributes and skills" [5] published in October 2012, sets out the requirements for CCGs to have in place governing bodies. Annex 2 of the guidance also sets out the principles relating to reimbursement and remuneration for members of the CCG governing body.

1.31 With respect to GPs serving on the governing body, the guidance states that:

*"**GPs on the governing body***

Remuneration should be either:

- *at a reasonable rate, in line with practice earnings;*
- *at a rate commensurate with allowing backfill, recognising that a locum cannot replace an experienced partner on a like for like basis, and that some additional locum time would be necessary;*
- *in line with any local sessional rate".*

1.32 It is clear that some GPs are receiving remuneration for serving on the governing bodies of CCGs. However, it is too early to say what effect this might have on GP income. This is because those GPs may be using some of their remuneration to engage locums to backfill at their practice, while the GPs themselves are serving on the CCG governing body. The overall effect on GP net income will depend on both the overall level of payments to GPs serving on CCG governing bodies and also any increased expenses where some or all of those GPs engage locums in order to backfill.

Contract agreements for 2011/12 to 2013/14

Investment levels

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

[5] Available at: http://www.england.nhs.uk/wp-content/uploads/2012/09/ccg-members-roles.pdf

in both years to cover expected increases in expenses, thereby aiming to ensure an overall freeze in net income.

1.34 In both years, this uplift was delivered through an increase in the value of QOF points (a 2.53 per cent increase in 2011/12 and a 2.49 per cent increase in 2012/13). In 2013/14, the overall uplift to the contract value of 1.32% was delivered through introducing four new enhanced services, further improvements to quality and productivity and agreeing equitable funding in the contractual arrangements from 2014/15.

GMS contract changes agreed 2011/12

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

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

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

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215691/dh_125039.pdf

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

GMS contract changes agreed in 2012/13

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

- Two indicators, worth in total 17 points, were retired and a further 26 points were released from existing indicators.
- Seventeen of the NICE recommendations for new or replacement indicators were implemented (covering 141 QOF points, funded by 40 of the points released above, and 101 points from existing indicators being replaced).

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

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

- A number of small changes to the thresholds for QOF clinical indicators:

    - Raising lower thresholds for those indicators currently 40-90% to 50-90%

    - Raising lower thresholds for indicators with an upper threshold of 70-85% to 45%

    - Raising upper threshold changes for 10 indicators

    - Raising lower and upper threshold for 3 indicators.

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

1.40 Full details of all 2012/13 contract changes are set out in the '2012/13 GMS Contract Negotiations' letter (Gateway reference 16837) available on the DH website:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130951.pdf

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

GMS contract changes in 2013/14

1.42 The 2013/14 contract changes announced on 18 March, 2013, included an increase to the Global sum equivalent by an overall 1.47%. That was the combined uplift as a result of a 1.32% uplift to the contract value and the transfer of locum superannuation funding into the global sum equivalent, representing a further 0.15%. This was achieved through;

- introducing equitable funding in GMS contractual arrangements from 2014/15 phased over a seven year period, along with the redistribution of correction factor payments between contractors;

- introducing changes to the Quality and Outcomes Framework (QOF), as follows.

- full implementation of all recommendations made by NICE, although two indicators will be implemented in 2014/15;
- raising upper thresholds for existing indicators to reflect the current achievement of top performing practices (in line with the 75th centile of achievement). This will be phased in over two years, with the increase being applied to 20 indicators in 2013/14 and the remaining indicators from 2014/15. From 2015/16, thresholds could change on an annual basis in relation to practice achievement;
- the introduction of a new public health domain;
- retaining the Quality and Productivity indicators (QP) until 31 March 2014;
- retiring all remaining organisational domain indicators not retained in QP or moved into the Public Health Domain;
- removing the current year end overlap for most indicators by changing the indicator timeframe (from 15 to 12 months or 27 to 24 months, including changing the time period for general exceptions); and
- reforming the list size weighting (Contractor Population Index – CPI).

- Introducing changes to accommodate recommendations made by the Joint Committee for Vaccination and Immunisation (JCVI). These include introducing a new item of service (IOS) fee of £7.63 for a completed course of rotavirus for infants from July 2013, removing one dose of meningitis C from the childhood vaccination scheme and introducing a new IOS fee of £7.63 for routine shingles vaccination for patients aged 70.

1.43 Alongside the above changes, NHS England has developed four new enhanced services to facilitate:

- the identification and management of patients identified as seriously ill or at risk of emergency hospital admission;
- a proactive approach to the timely assessment of patients who may be at risk of dementia;
- preparatory work to support the subsequent introduction of remote care monitoring for patients; and
- enabling patients to utilise electronic communications for appointment booking and obtaining repeat prescriptions.

1.44 Full details of all 2013/14 proposed contract changes are set out in the '2013/14 GMS Contract Negotiations' letter (Gateway reference 18276) available on the DH website:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213014/gms-contract-2013-2014.pdf

1.45 Taken together with the 1.32% increase in gross funding, the agreement reached with the GPC delivered an estimated efficiency gain of around 4.68%.

GMS contract changes proposed in 2014/15

1.46 NHS England has provided a detailed negotiating remit to NHS Employers, which they are currently discussing with the GPC. We will provide an update on the conclusion of these negotiations in NHS England's supplementary evidence, due to be provided to DDRB in November.

Conclusion

1.47 This chapter provides information on the latest position on recruitment and retention, earnings and expenses, and other relevant developments in general practice. In view of the on-going negotiations on possible changes to the GMS contract, NHS England is not yet in a position to provide evidence on the level of gross uplift it deems appropriate for 2014/15. Such an increase will need to be within the pay remit set by Ministers, of up to 1%, which applies to both GMP contractors and all of the staff they employ.

1.48 We will provide our view on this as part of our supplementary evidence, unless as part of a negotiated agreement there is a consensus amongst the parties over what this should be, in which case there would be no need for DDRB to make recommendations.

CHAPTER 2 – GENERAL DENTAL PRACTITIONERS

Introduction

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

2.2 This is the fourth year of the Government's public sector pay policy. The Government has announced that public sector pay increases will be capped at an average 1% increase for 2014/15.

2.3 NHS England will meet the General Dental Practice Committee of the BDA in early Autumn to discuss practice expenses and possible quality and efficiency improvements for 2013/14. We believe that overall levels of uplift for independent contractors are best considered as part of such discussions with the profession's representatives about on-going improvements in contractual arrangements and, provided that it is possible to secure appropriate improvements in quality and efficiency of services.

Background

2.4 In April 2013 NHS England became responsible for commissioning all NHS dental services, including primary, community and hospital dental services. NHS England are working towards a single operating model, which provides an opportunity for consistency and efficiency where it is required, but enables flexibility through Area Teams where it is necessary. The proposals for dental commissioning will build on the single operating model for primary care commissioning described in Securing excellence in commissioning primary care.[6]

2.5 NHS England is committed to designing a commissioning system for dental services that is capable of:

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

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

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

2.7 In 2011, in response to dentists continuing to say the current contract leaves them on an “activity treadmill” with no specific rewards for delivering high quality care or for delivering prevention, the Department of Health set up a new pilot scheme. The pilots look at elements of new contract based on capitation and quality, which will focus on the treatment patients need and avoid unnecessary treatments. The aim of the new contract will be to improve the quality of patient care and increase access to NHS dental services, with an additional focus on improving the oral health of children. The pilot scheme was expanded in spring 2013 to include an additional 28 practices bringing the total number of practices in the scheme to 98. NHS England supports the Department’s work on the pilots and will be involved in all future developments.

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

2.9 Although it is clear that changes to the current system are necessary, we are pleased to note that the current position on NHS dentistry continues to improve and there has been a further increase in the number of dentists working in the NHS in 2012/13. We want to see a continued improvement in access to NHS dental services. Questions included in the GP Patient Survey tell us about access to NHS dental services. This shows that 95% of people who tried to get an appointment with an NHS dentist in the past two years were successful. For those seeking an appointment in the last six months, the success rate is 96%.

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

	Success rate in last 24 months: % who succeeded, not including “Can’t remembers”	Success rate in last 6 months: % who succeeded, not including “Can’t remembers”
England	95	96
North East	97	98
North West	94	96
Yorkshire & the Humber	94	96
East Midlands	95	97
West Midlands	96	97

East of England	96	97
London	93	94
South East Coast	94	96
South Central	95	97
South West	96	97

2.10 In the last year:

- access to NHS dental services has risen 29.8 million patients were seen by an NHS dentist in the 24-month period ending June 2013, 56 % of the population. The number is 191,000 higher than twelve months earlier, and 2.8 million higher than the low point reached in June 2008;
- NHS dental activity has fallen slightly, from 88.2 million units of dental activity (UDAs) in 2011/12 to 88.1 million UDAs in 2012/13. This fall will be due in part to the phasing out of prescription only UDAs from November 2012. Area Team commissioning plans at June 2013 for the following twelve months are 31,000 UDAs higher than a year ago;
- the number of dentists providing NHS services rose by 281 to 23,201 dentists in 2012/13;
- the proportion of dentists' time spent on NHS work is rising. It rose from 74.4% in 2010/11 to 74.8% in 2011/12. By region, the NHS proportion ranges from 66.3% in the former South Central and South East Coast SHA regions, to 82.3% in the North East;
- the number of new dental graduates fell slightly in 2013 to 918 (taken from Dental School estimates), however this is a 36% increase since 2004; this will help to sustain the healthy workforce position; and
- there continues to be an increase in applications for Foundation Trainees and an increase in places in 2012/13.

2013/14 settlement

2.11 As part of the wider Government policy the DDRB was not asked to make recommendations on dentists' pay for 2011/12, 2012/13 and 2013/14. Instead, officials from DH discussed dental expenses with representatives of the profession. They continued to use the formula approach to expenses that had previously been used by DDRB. The Government indicated that it expected the primary care sector to deliver the same improvement in quality, efficiency and productivity that was required from the rest of the NHS and this was incorporated in the discussions.

2.12 DH had a series of useful and informative discussions and meetings with the BDA, which led to a determination which allowed for a 1% pay increase for dentists and dental practice staff in 2013/14, in line with wider public sector pay policy. The overall contract value was increased by 1.5% to allow for increases in non-staff expenses. The national uplift was applied to gross contract values for GDS contracts and PDS agreements.

2.13 As part of this package, dentists were expected to continue to work closely with the Department and NHS England to prepare for moves to a new national contract based on capitation, quality and registration; this included a further move to fully computerised practice systems and a nationally consistent approach to contract management.

2.14 The 2013/14 package also included: changes to the way the NHS managed dental contracts at the end of the financial year; measures to ensure more appropriate patterns of referral between dentists both within primary care and to acute services. There was also a freeze in Vocational Trainee salaries for 2013/14. As with other NHS efficiencies, every penny saved will be invested back into patient care, and thus will help to improve further the quality of patient services including primary dental care.

General Dental Practitioners: Earnings and Expenses

2.15 The averages cover dentists doing any NHS work in the year. A significant number of dentists come and go within a year. With 21,800 covered by GDS or PDS contracts in 2011/12, we have 1,300 leavers and 1,700 joiners in a year i.e. 3,000 or 14% working for only part of the year.

2.16 The numbers of dentists for the years 2006/07 to 2012/13 are set out on the facing page. (Table 7e from 'NHS Dental Statistics for England 2012/13').

Table 2.4: Number and percentage of dentists with NHS activity in the year ending 31 March, by dentist type, 2006/07 to 2012/13

	Number							Per cent						
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Total	20,160	20,815	21,343	22,003	22,799	22,920	23,201	100	100	100	100	100	100	100
Providing performer	7,585	7,286	6,778	6,279	5,858	5,099	4,649	37.6	35.0	31.8	28.5	25.7	22.2	20.0
Performer only	12,575	13,529	14,565	15,724	16,941	17,821	18,552	62.4	65.0	68.2	71.5	74.3	77.8	80.0

Notes:

1. Dentists are defined as performers with NHS activity recorded by FP17 forms.
2. Data consists of performers in General Dental Services (GDS), Personal Dental Services (PDS) and Trust-led Dental Services (TDS).

Net Earnings

2.17 The data from the HSCIC continues to be hard to compare with previous years' because of changes in the way dentists pay themselves, especially the move towards personal and practice incorporation, which takes profits out of the self employed tax system for the individual dentist and moves them into company accounts. This is a significant issue, which has a serious impact on our ability to access the data on key areas including the relative level of expenses and earnings and we wish to find a way to address it. However, it is clear that dentists continue to receive a good income. Although the average identifiable net profit after expenses for dentists in 2011/12 fell to £74,400 compared with £77,900 in the previous year this remains a well remunerated profession. For dentists holding a contract earnings were considerably higher at an average of £112,800, down 3.7% from the previous year's £117,200. The data also show some dentists earning considerably more; with 1% earning over £300,000. Dentists working for others still had an average net profit of £61,800, down 1.8% from the £62,900 of the previous year.

2.18 We do not have exact figures on how many dentists changed their business arrangements in this way, but we do know the changes in the number of self-employed dentists overall in 2012/13. Compared to 2011/12 there were 8.8% fewer dental contract holders and 4.1% more "dentists who work for others".

2.19 On expenses, the data showed that just over half (53.8%) of gross payments to dentists was to meet their expenses.

Table 2.2: Gross income and net profit of primary care dentists 2004/05 to 2011/12

	Population	Average gross income	Expenses	Net profit	Expenses ratio
2004/05 GDS only	13,309	£193,215	£113,187	£80,032	58.6
2005/06	18,796	£205,368	£115,450	£89,919	56.2
2006/07	19,547	£206,255	£110,120	£96,135	53.4
2007/08	19,598	£193,436	£104,373	£89,062	54.0
2008/09	19,636	£194,700	£105,100	£89,600	54.0
2009/10	20,300	£184,900	£100,000	£84,900	54.1
2010/11	20,800	£172,000	£94,100	£77,900	54.7
2011/12	21,300	£161,000	£86,600	£74,400	53.8

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

2.20 Information on dentists' income compiled by the National Association of Specialist Dental Accountants and Lawyers (NASDAL), which represents approximately a fifth of dentists in practice, reported a decrease in net profit for NHS practices in 2011/12 of nearly 3%, to an average profit of £130,000. Net profit on NHS practices of £130,000 exceeds average net profit of private practices of £117,000, a reversal of the situation before 2005/06.

Table 2.3: Net profit for the practice

Type of practice	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
NHS	£104,000	£118,000	£142,400	£149,500	£148,000	£161,300	£147,800	£133,020	£130,000
Mixed	£98,800	£100,400	£129,600	£147,100	£140,700	£138,600	£143,800	£127,045	-
Private	£113,000	£124,700	£131,400	£130,900	£136,500	£130,600	£126,400	£117,552	£117,000

Source: NASDA. NHS practices are those where NHS earnings are 80% or more. Private practices are those where private earnings are 80% or more. Data for mixed practices was not provided in 2011/12

2.21 NASDAL report that average net profit for associate dentists (those dentists with no share of ownership) reduced to £67,000 in 2011/12 from £68,000 in 2010/11.

Expenses

2.22 DDRB asked all parties to provide a view on the DDRB methodology for adjusting the expenses to earnings ratio to reflect multiple counting and suggest alternative approaches if available. NHS England have considered the methodology and find it provides an acceptable solution to double counting in the absence of more detailed data. We do not have an alternative approach but will continue to work with the Dental Working Group to develop other approaches to the problem.

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

HSCIC Report on dental earnings and expenses 2011/12, paragraphs 1.18 to 1.22.

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

The extent of this multiple counting is difficult to quantify, but may have increased since the introduction of the new dental contractual arrangements on 1 April 2006. Under the new system, payments for NHS dentistry are made to the Providing-Performer dentist (or in some cases to a corporate body) who holds the contract under which the dentistry is performed; if the Providing-Performer has sub-contracted this work, then some of the payment will be passed on to a Performer Only dentist. A single sum of money can be declared as gross earnings by both the Providing-Performer and Performer Only dentist, and also as an expense by the Providing-

Performer. Where a dentist is a sole-trader (i.e. the only dentist working in a practice), multiple counting will not occur, and where dentists operate in an Expenses Sharing Group, multiple counting is likely to be kept to a minimum.

This report only considers those primary care dentists who are self-employed (i.e. they have earnings from self-employment). Traditionally, the employment status of a vast majority of primary care dentists (both Providing-Performer and Performer Only) has been self-employment. As such, these dentists complete self assessment tax returns which, subject to certain exclusion criteria[7] have been used to inform the analyses presented in the dental earnings reports.

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

It is currently not known how many dentists have incorporated their business(es) and what the precise consequences of incorporation may be for the results presented in this report. HSCIC and Dental Working Group are working towards gaining greater understanding of this issue with a view to including further information in each subsequent edition of the report. Some potential arrangements and their likely effects are discussed in Dental Earnings and Expenses, England and Wales: Methodology."

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

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

2.26 The issue of multiple counted expenses is also important as noted by the HSCIC. For example, a dental performer pays the laboratory bills associated with treatment out of

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

their gross income. The performer pays the contract holder who in turn pays the laboratory. Both the contract holder and the dental performer show the cost as an expense, with the contract holder showing the payment from the performer as an income. The HSCIC paper (above) indicates that the extent of double counting may have increased since 2006. This is because gross payments are no longer paid directly to individual dentists.

2.27 Extracts from the NASDAL results are in the table below. They show that, with the exception of non-staffing costs in mainly private dentists which has increased by 1.1%, there has been only slight variations in expenses as a percentage of gross income in 2011/12. Laboratory costs have fallen for the second year in both mainly NHS and mainly private dentists.

Table 2.5 Categories of expenses as a percentage of gross income

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Non-clinical staff wages (NASDAL)							
NHS practices	18.2%	17.3%	17.9%	17.7%	18.8%	19.8%	19.9%
Private Practices	17.2%	17.4%	17.8%	17.6%	18.1%	19.4%	19.5%
Laboratory costs (NASDAL)							
NHS practices	6.4%	5.6%	6.1%	6.0%	6.5%	6.3%	6.1%
Private Practices	8.9%	7.8%	7.6%	7.1%	7.9%	7.6%	7.2%
Materials costs (NASDAL)							
NHS practices	5.6%	5.0%	5.6%	5.4%	5.6%	6.3%	6.6%
Private Practices	6.7%	7.0%	7.5%	7.1%	7.5%	7.9%	7.4%
Other Non-Staffing Costs (Morris & Co)							
NHS practices	16.4%	16.8%	15.7%	15.6%	15.1%	16.7%	16.6%
Private Practices	23.0%	23.2%	23.6%	21.4%	21.2%	21.7%	22.8%

Note: 2006/07 figures for NHS practices are affected by temporary increase in income from transition to the new contract. 2005/06 NHS figures include PDS.

General Dental Practitioners: Recruitment, Retention and Motivation

2.28 The numbers of dentists providing NHS services continues to be a relatively weak indicator of supply: it is the number of NHS patients and the amount of NHS service they receive that is more important and these continue to rise. However, the numbers of dentists has also continued to rise, up by 1.2% last year. Overall, the number of dentists providing NHS services rose by 281 to 23,201 dentists in 2012/13.

2.29 Dentists are still ready (and indeed enthusiastic) to bid for and undertake NHS contracts, especially in areas where dentists had previously chosen not to set up or provide NHS services and NHS access continues to rise.

2.30 Dentists have achieved a reduction in working hours, with evidence from the HSCIC dental working hours survey published in August 2012 showing that dentists are working an average of 37.5 hours per week in 2011/12 compared to 39.4 hours in 2000, almost a 5% reduction. (Source: Dental Working Hours England and Wales 2008/09 and 2011/12 published by The HSCIC)

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

Future workforce supply

2.32 The situation with respect to supply of dentists in the workforce has changed fundamentally over the last few years. The causes of this are complex, but the Department of Health and Health Education England recently commissioned the Centre for Workforce Intelligence to carry out analysis of workforce needs and supply up to 2040. Although there are many variables, and assumptions have to be made on basis of best evidence, all the scenarios suggested an excess of supply over demand/need. Recommendations will be made soon to allow intakes to dental schools to be adjusted to reflect this new situation.

2.33 Health Education England will also be looking to review training requirements for dental care professionals in the coming year to see that full use is made of the opportunities for skill mix and delegation within the dental team.

Foundation trainees and trainers

2.34 There appears to be an anomalous differential between the salary of a foundation trainee dentist (DFT) and the salary for a foundation year 2 (first year post registration) doctor. This causes problems when foundation dentists continue with post registration training with the ambition of appointment to a specialty registrar training post.

The current pay rates are:

	£
DFT (formerly Vocational Dental Practitioner)	30,132
Foundation House Officer 2 (medical) min	28,076
Foundation House Officer 2 (medical) 1st point	29,192
Foundation House Officer 2 (medical) 2nd point	31,748

This means that a DFT who progresses to a second year of training has to mark time on a DFT salary in a FH2 point 1 post. This could be a disincentive to an able dentist pursuing specialist training.

General Dental Practitioners: Conclusion

2.35 We are taking forward discussions with the BDA with a view to making appropriate improvements in the contract to secure on-going improvements in quality.

Other Dental Staff Groups

Community Dental Services

2.36 Community dental services were previously known as salaried dental services, there are over 1,000 salaried dentists (latest headcount: HSCIC data) in England, delivering a range of services, including specialist- led special care, and paediatric dental services for people with additional care needs. Prior to April 2011 the majority of these services were provided by PCTs but are now provided by a range of different organisations including Social Enterprises, Community Trusts and acute NHS Trusts.

2.37 These dentists are an important and valued part of the overall dental workforce. NHS England has a task group to lead work on a proposed operating model for commissioning specialist and community dental care as part of the work to standardise commissioning dental services across England. Dentists in this group will receive the same adjustment to pay as other dental groups.

Dental Public Health Staff

2.38 These staff transferred to Public Health England in April 2013, however we expect their remuneration to be in line with other dental practitioners.