Memorandum of Evidence to the Review Body on Doctors’ and Dentists’ Remuneration

30 September 2016
### Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of key points of BMA Evidence</td>
<td>3</td>
</tr>
<tr>
<td>Response to 2016 Recommendations and Overarching BMA Position</td>
<td>5</td>
</tr>
<tr>
<td>Contract negotiations</td>
<td>7</td>
</tr>
<tr>
<td>Recruit, retain and motivate: Vacancies</td>
<td>8</td>
</tr>
<tr>
<td>Recruit, retain and motivate: Workload and Motivation</td>
<td>13</td>
</tr>
<tr>
<td>Economic background: Affordability</td>
<td>16</td>
</tr>
<tr>
<td>Economic background: Pay comparability</td>
<td>18</td>
</tr>
<tr>
<td>Patients at the Heart: NHS performance</td>
<td>23</td>
</tr>
<tr>
<td>Additional specific issues</td>
<td>25</td>
</tr>
<tr>
<td>Conclusions</td>
<td>28</td>
</tr>
<tr>
<td>References</td>
<td>29</td>
</tr>
<tr>
<td>Appendix: BMA briefings</td>
<td>30</td>
</tr>
</tbody>
</table>
Summary of key points of BMA Evidence

- The British Medical Association (BMA) is submitting evidence for the whole of the UK, and is seeking a common recommendation for all doctors, though we note an increasing divergence between the four constituent UK nations. We ask that DDRB continues to assert its independence to make a full set of recommendations, irrespective of any remit that a constituent health department might seek to impose.

- We are disappointed that the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) again chose not to make recommendations around GP gross earnings. While we managed to negotiate an uplift for England last year and will apply the same broad methodology this year, this was not the case for the devolved nations. In the case of Wales, this led to average GP earnings again falling in cash and real terms last year. We hope our approach will form the basis for DDRB to feel able to resume this role from next year.

- We are similarly disappointed that DDRB again only felt able to recommend an uplift in line with the public sector pay policy as set out in the Chief Secretary to the Treasury’s remit letter, which is well below comparable wage inflation in the wider economy. We have significant concerns that the continuation of this policy will mean that future DDRB recommendations will follow a similar pattern, lending credence to the impression that DDRB is no longer acting independently.

- We are not proposing a specific figure for the 2017/18 pay award, but we argue that doctors should be treated in line with the wider economy, where pay settlements continue to run at higher than the public sector pay policy cap, at around 2% currently.

- We do not support targeted recommendations to address location or specialty recruitment issues, and we do not wish DDRB to pursue its suggestion of applying funds to different approaches than pay to alleviating pressures – unless there was a substantial increase to the overall funding availability. We do however note that previous DDRB recommendations around distinction awards in Scotland, GP earnings in Wales, and clinical excellence awards in Northern Ireland, have not been implemented by the respective governments.

- It is not possible to know when, where and in what exact form a new contract for consultants (in England and potentially Northern Ireland) might be put in place, but this will not be before October 2017 at the earliest, so we request that DDRB should make its recommendations on the basis of the current contracts in each respective nation of the UK.

- There is ongoing dispute around the imposition of a new junior doctors contract in England, but should the phased introduction and implementation in England proceed, there will be significant numbers of junior doctors on the existing contract for some years. Moreover, the other UK nations are not threatened by imposition as in England, so we are asking DDRB to make recommendations across the UK on the basis of the existing contracts.

- In light of the ongoing contractual issues for consultants and junior doctors in England, increasing contract divergence for GPs across the UK, and the overarching issue of health being a devolved matter, we request that DDRB schedules a separate oral evidence session for the parts of our submission relating to devolved national evidence.
• We were disappointed at the failure to follow a fair and transparent process last year, with national governments seemingly able to submit their evidence and remit letters well beyond DDRB deadlines, with no consequences to them but creating difficulties for those parties like the BMA who did adhere to the timetable, and whose evidence was therefore visible to governments before they submitted theirs.

• We appreciate DDRB’s helpful steer on data requirements, but we note that the Review Body has now requested much of this information in several of its previous reports, so we question whether parties are actually able to provide the requested information, and whether DDRB could therefore commission its own research to fill key gaps. We have tried to identify data gaps that would be helpful to the BMA and DDRB if these could be filled.

• In particular, we note a lack of consistent and comprehensive data around vacancies and rota gaps for all staff groups across the whole of the UK, and linked to this the use of locums to fill these shortages. We note continuing shortages in the specialties of emergency medicine, psychiatry, radiology, and general practice.

• The financial distress of the NHS, and the lack of credible plans to increase capacity will further worsen recruitment and retention issues, and create real concerns around the health and wellbeing of the remaining doctors as a result of their increased yet unrecognised workload, and their lack of time and empowerment to be able to contribute to sustainable solutions.

• We note the remit letter from England asks DDRB for observations around salaried GPs. We believe there is a significant lack of data currently available around sessional GPs (salaried and locum) on which to base any firm recommendations, for example around pay ranges, and how GPs choose to take a partnership, salaried or locums post. We request that DDRB considers who is able to provide what data with a view to a more in-depth analysis in next year’s pay round.

• In general, we note there is a lack of data around how doctors choose their career paths, both in terms of specialty and location, but also in terms of choice between a permanent role or locum position. We hypothesise that the increased attractiveness of a locum role reflects the seeming low value and ever-increasing unrecognised workload of permanent positions. The recent moves to advertise Staff, Associate Specialist and Specialty doctor (SAS) roles at the closed Associate Specialist (AS) grade are also a reflection of this recruitment and retention issue.
Response to 2016 Recommendations and Overarching BMA Position

1. We are profoundly disappointed that DDRB in its 44th report again only felt able to recommend an uplift in line with the public sector pay policy as set out in the Chief Secretary to the Treasury’s remit letter, which is well below comparable wage inflation in the wider economy. We have significant concerns that the continuation of this pay policy will mean that future DDRB recommendations will follow a similar pattern, eroding any sense of the Review Body’s independence and further worsening the morale, recruitment and retention of medical staff.

2. We are pleased to see the mention of “fairness” but do not agree that the recommendations reflected this, with pay settlements in the wider economy continuing to run at higher than the public sector pay cap.

3. We are similarly disappointed that DDRB again chose not to make recommendations around GP expenses, but we have put in place alternative arrangements for this year in England, and are having discussions with the devolved administrations, to agree a methodology that will allow DDRB to resume this role from next year.

4. We do not wish DDRB to pursue its suggestions of targeted recommendations to address location or specialty recruitment issues, and of applying funds to different approaches than pay to alleviating pressures or to multi-year recommendations – unless there was a substantial increase to the overall funding availability.

5. It is not possible to know when, where and in what exact form a new contract for consultants (in England and potentially Northern Ireland) might be put in place, so our request is that DDRB should make its recommendations on the basis of the current contracts. It seems probable that a new contract would not be introduced before October 2017 at the earliest.

6. There is ongoing dispute around the imposition of a new junior doctors contract in England, but even should the phased introduction and implementation in England proceed, there will be significant numbers of junior doctors on the existing contract for some years. Moreover, the other UK nations are not threatened by imposition as in England, so we are asking DDRB to make recommendations across the UK on the basis of the existing contracts.

7. We are extremely unhappy at the process last year, with national governments seemingly able to submit their evidence and remit letters well beyond the DDRB deadlines, with no consequences to them but creating difficulties for those parties like the BMA who did adhere to the timetable. We appreciate DDRB’s willingness last year to offer an additional oral evidence session relating to issues in the devolved nations; in light of the ongoing contractual issues for consultants and junior doctors in England, and increasing contract divergence for GPs across the UK, and the overarching issue of health as a devolved matter, we would ask that DDRB again offers a separate oral evidence session for the devolved nation evidence.

8. At time of writing, we have seen remit letters from the Chief Secretary to the Treasury, and from the England, Northern Ireland and Wales ministers. We have concerns, that we have expressed previously, around the ability of national governments to effectively over-ride the DDRB’s standing remit through the remit letters, so we would welcome a clear statement from DDRB on the purpose of these letters. We would also reiterate that the Treasury remit does not extend directly to the devolved national governments.
9. We similarly remain concerned that governments are able to reject DDRB’s recommendations, which significantly weakens the value of an independent pay review body. For instance, the Scottish Government chose not to accept DDRB’s recommendation to increase the value of consultant discretionary points and distinction awards by 1%, and there have been no new clinical excellence awards (CEAs) in Northern Ireland since 2010. For GPs in Wales, the uplift for expenses was insufficient, as it has been in a number of previous years, to deliver DDRB’s net GP pay recommendation. We would ask that DDRB formally expresses its disappointment where its recommendations were not accepted or implemented, and considers for instance whether there could be an award on CEAs in Northern Ireland and distinction awards and discretionary points in Scotland that reinstates their value and thus delivers DDRB’s recommendations.

10. We appreciate DDRB’s helpful steer on data requirements, but we note that the Review Body has now requested much of this information in several of its previous reports, so we question whether parties are actually able to provide the requested information, and whether DDRB could therefore commission its own research to fill key gaps. We have suggested where there are clear data gaps throughout our submission, and we would be pleased to work with DDRB on what information would be most useful and how this might be collected.
Contract negotiations

11. We would remind DDRB that contract negotiations relate to consultants in England and Northern Ireland, and junior doctors in England, and the other devolved national governments have not requested to enter into negotiations covering these doctors in their countries. We would therefore request that DDRB makes its recommendations on the basis of existing contracts.

12. We continue to negotiate with the Department of Health in England, with Northern Ireland representation, around a new consultant contract, most likely for partial implementation from October 2017. The ongoing contract discussions cover seven day working, and a new pay and performance pay system which is linked to competency not time. We identified some fundamental issues around equality with regard to the junior doctor contract, so these are also being considered for the consultant contract.

13. The junior doctor contract in England was rejected by ballot, with issues around pay rates for less than full time and weekend frequency working – and the equality impact of these – being of particular concern. There were also concerns around whistleblowing and confidence in the guardian role. BMA Council has authorised further industrial action, but this has currently been suspended following feedback from doctors, patients and the public, and discussions with NHS England about the ability of the NHS to maintain a safe service if the industrial action planned for October, November and December were to go ahead. We shall update DDRB on this in our supplementary and oral evidence.

14. As noted previously, SAS doctors are not engaged in contract negotiations anywhere in the UK, and we believe will not be asked to enter negotiations until there has been resolution of the junior doctors’ dispute, and completion of the consultants’ contract negotiations.

15. The General Practitioners committee (GPC) of the BMA has just begun its usual annual negotiations with NHS Employers on contract changes in England for 2017, again later than some years because of a delay in NHS Employers being given their mandate. Scottish GPC has started to discuss a potential new or revised contract with the Scottish Government, but it is currently likely that introduction of this will be gradual. In Wales similarly there is an ongoing two year deal, with a further shift from quality targets into core funding and a focus on development of GP cluster networks, as there is in Northern Ireland. We would also note that the latest data shows that average GP earnings in Wales have fallen again. However, while GMS contracts do differ across the nations, the underlying principles do remain broadly the same, so we are not seeking any differential uplift for the devolved nations this year.
Recruit, retain and motivate: Vacancies

16. We have appended as a separate document a member briefing for our May 2016 Special Representative Meeting. This includes an overview of the BMA’s position on workforce, recruitment, retention and morale issues, and includes additional background and evidence (some of which has been previously reported to DDRB but which is still valid) to that which is included in the main body of this evidence submission.

17. We have had discussions with all the national governments around the availability of consistent – which is important for looking at cross-border flows - and robust data on vacancies for both hospital doctors and general practice. While there has been some progress, it remains impossible to provide evidence on the precise problems with recruitment and retention of doctors, and for some groups such as SAS doctors where there is no data source in any UK nation.

18. Vacancy numbers have a substantial impact on the workload of the remaining doctors: the NHS in all four nations is suffering from a severe staffing shortage, and this has led to doctors being forced to take on additional workload, at the expense of their own health and wellbeing, and without additional remuneration. This cannot be sustainable, and while there are some initiatives to address some of the recruitment difficulties these are necessarily longer-term solutions, or in the case of physician associates have implication for fairness where these new staff groups take on roles that previously doctors with more years training would have undertaken at a lower rate of pay.

19. As well as advertised/reported vacancies, we consider that rota gaps and use of locums are key indicators of staffing difficulties. The attractiveness of a career as a locum could be seen as a response to the unattractiveness of a permanent position in the NHS, including excessive workload, lack of flexibility, or other constraints on doctors’ power to deliver the highest quality patient care.

Scotland

20. With regard to official government statistics, we would draw DDRB’s attention to the increase in long term (greater than six months) consultant vacancies in Scotland with an increase of 17.4 WTE over a year to a total of 166.1 WTE in March 2016, which is considerably higher than the rate prior to 2015. We consider that the long term vacancy rate is a good indicator of systematic staffing shortages, but the overall consultant vacancy rate at 6.5% is also considerably higher than rates seen prior to 2015. The Scotland data identifies clinical radiology, emergency medicine, psychiatry and general acute medicine as particular shortages, as well as specific problem geographies such as paediatrics in West Lothian. We have in previous submissions noted that we believe these official statistics underestimate the true rate, for example vacant posts not approved for advertisement are excluded, but we have still not seen any substantive changes to the methodology.

21. Audit Scotland has not reported on the NHS yet for 2016, but we expect it will again show increases in vacancies, staff sickness, and locum spending; we shall update DDRB in our supplementary evidence. In last year’s evidence we also referenced the high number of consultant recruitment panels that had been cancelled in Scotland; the updated figures are not yet available but we understand the same position still applies. We similarly referenced the continuing use of 9:1 job plans, with only very low numbers being appointed to the standard 7.5:2.5; we strongly believe this to be a deterrent to working in Scotland, and detrimental to not only the individuals concerned but also to the NHS more generally as the scope for
clinically led innovation is severely diminished. Retention is increasingly an issue in some specialties; almost half of the orthopaedic consultants appointed in Scotland in the last five years have subsequently left to work elsewhere, mostly outside Scotland. Across all specialties, there are significant issues around recruitment to remote and rural geographies that require internationally competitive remuneration packages. The Royal College of Radiologists in Scotland has reported a survey that shows that demand for MRI and CT scans has increased by 55% between 2010 and 2015, but that consultant radiologist numbers only increased by 3% over the same period, with this lack of capacity leading to Scottish health boards having to outsource £5.2 million radiology work.

22. With regard to training, Scotland data shows low fill rates for core psychiatry and general practice, and in higher specialty training for emergency medicine, acute medicine, psychiatry, general surgery, and clinical oncology. DDRB previously raised the question as to how unfilled posts at the end of the national recruitment process were subsequently filled, with the response from Scottish Government that these were passed back to NHS Scotland health boards to fill through local recruitment. However, no data are available on whether, when and how these posts were finally filled, by trainees, locums or other service posts.

Wales

23. Welsh vacancy rates have not been published officially since 2011, so have had to be obtained as a freedom of information (FOI) request, for example an FOI by the BBC showed a rate of 7.8% for doctors in Welsh health boards in December 2015, having risen sharply over the preceding year, and with significant variation across the boards. While this provides an indication of recruitment difficulties, the lack of an agreed and consistent definition makes comparisons within Wales and across the UK difficult. The BMA has additionally collected data on locum consultant usage, which equates to 7.5% WTE consultant posts; while there are issues around when and for how long locum use is the most cost-effective solution, this does suggest the true vacancy rate will be higher than the headline figures. The BBC also discovered a 61% over three years increase of cost of overtime payments for consultants in Welsh hospitals, which reflects existing staff having to undertake additional work to cover for vacancies and rota gaps. The NHS Wales Workforce Review also confirmed this increase in locum use, with an increase in agency and locum spend (not just consultant) of 62% in 2014/15 to a figure of £88 million. Moreover, there appears to have been a fall in the numbers of doctors per head in Wales from 2.8 per thousand population from 3.1 last year.

24. We also hold some snapshot data that shows 281 unfilled trainee vacancies in Wales, not including GP posts in training practices, which equates to a rate of roughly 10% - though we do not have any official published data on this.

Northern Ireland

25. Northern Ireland vacancy rates are running at a 5.2% rate for medical and dental WTE staff as at March 2015, compared with 4.4% a year earlier, though this data is not available at a more granular level, for example consultant or SAS rates. The long-term rate has also increased from 2.4% in March 2014 to 3.2% in March 2015. A recent BMA survey of Northern Ireland local negotiating committees (LNCs) indicated around 250 consultant vacancies across various specialties at August 2016, with 8% of these posts vacant for longer than a year, and particular shortages in radiology, anaesthetics, emergency medicine, psychiatry and laboratory medicine. There has been an increase in locum use, with the Department of Health Northern Ireland quoting an overall 30% increase between 2010 and 2015, although again there is a lack of broken down data on numbers, grades, specialties and workplaces of locums. A new e-recruitment system will be used to track job adverts, similar to England, but no information on exact content or timing is available, and work is ongoing as to whether the HR system in Northern Ireland could also be used to extract vacancy data. The Department of Health in Northern Ireland has also recently undertaken overseas medical recruitment exercises to try to
fill gaps; BMA Northern Ireland’s view is however that this reflects ineffective medical workforce planning.

26. In Northern Ireland, figures from the Medical and Dental Training Agency at April 2016 show low fill rates for core medical training (49% posts unfilled), emergency medicine specialist LAT posts (30%), and an overall 17% of unfilled posts.

27. BMA Northern Ireland has also sought current information on rota gaps from each trust. This has indicated 158 rota vacancies overall, with anecdotal evidence from our members that consultants are being asked to fill gaps that would previously have been filled by specialty trainees.

England

28. The England data from NHS Digital based on NHS Jobs website adverts shows a step-change increase from last year of around 6,000 medical and dental vacancies advertised in a quarter to a figure in 2015 of considerably over 8,000 WTE vacancies. We do have concerns around these data as the figures are a proxy for true vacancies in that they measure job adverts, which will underestimate the true level as jobs may either not be advertised through that route, one advert may reflect several posts, or jobs may have been previously advertised but then remain unfilled. However, as a guide to staffing problems, the data already seems to be exhibiting a substantial growth in vacancies over time. The Health Foundation has also analysed Office for National Statistics (ONS) unemployment data between 2013 and 2015 to show a 60% increase in doctor vacancies over that period.

29. With regard to specific specialties, Health Education England (HEE) has identified emergency medicine, general practice and mental health as areas where further expansion is desirable in England. While final fill rates are not yet available, interim figures show that psychiatry (core training, child and adolescent, and old age in particular) and general practice training are again proving increasingly hard to fill, with round one rates in the low 80%s, and with some geographical concerns with GP training seeming less attractive in the North of England.

Public health: England

30. In the specialty of public health, there is no longer an official reporting of Director of Public Health (DPH) vacancies in England. The latest list of DPHs in England shows that 110 of the 132 posts are filled substantively, with interim arrangements in place for the remainder, which is roughly the same position as last year. There is a GMC and Faculty of Public Health working group to look at this area. There are also significant concerns around recruitment, retention and promotion being hampered by the fragmentation of the system and the difficulties that the various parts of the system (NHS, local government, Public Health England [PHE]) have in recognising previous and/or continuous service when an employee moves from one employer to another or to a different contract. The Health Select Committee expressed its concern that this issue had still not been resolved three years after the transfer of responsibility of public health to local authorities. Related to this, we have heard anecdotal evidence that there is a small group of public doctors in local authorities who have received neither NHS nor local government pay uplifts due to being in a “grey area” between organisations; we would ask DDRB to seek further information on this group from the health department in England.

UK wide

31. Both Scotland and England carry out an FY2 career destination survey. The UKFPO report shows a decline in the proportion of FY2 trainees continuing straight into specialty training from 67% in 2012, to 58.5% in 2014 and just 52% in 2015. There appears to be a trend increase in trainees taking a career break, and a step change increase in taking a service
appointment both within and outside the UK. Although the contract dispute for junior doctors in England is likely to affect the relative attractiveness of training in England in future, there does currently appear to be an issue in the devolved nations with medical school graduates and foundation year trainees in the devolved nations choosing to complete their specialty training outside those countries (for example, only 54% of juniors who started training in Scotland are still there 30 months post FY2). We understand that researchers at Edinburgh University are investigating this issue, and the BMA itself is undertaking a small study around career choice, so we may be able to update DDRB in next year’s evidence submission. This is however where systematic data collection of doctors’, particularly junior doctors’, career paths would be helpful, as we do expect to see a change in cross-border flows in future years.

32. The BMA carried out a small survey with around 1,800 responses from across the UK and all branches of practice to support our evidence to DDRB this year. This showed that around 6 in 10 departments or practices currently had one or more vacancies, with an alarming report that around two-thirds of these vacancies had been for six months or longer, and worse for GP practices than for hospitals. We also asked about rota gaps for hospital doctors, with 3 in 10 reporting regular and unfilled rota gaps. Vacancies and rota gaps were more common in England, though the time to fill was longer in Scotland. The vast majority of departments and practices use locums, with 30% stating for most of the time, though interestingly it appears difficult to recruit locums quickly (on average well over a month) which further evidences an overall staffing shortage.

33. A small scale independent study of junior doctors on rota gaps also identified concerns around the constant pressure to take on additional shifts when tired and stressed, with 16% rota gaps not being covered in any capacity. Various Royal Colleges have also surveyed doctors around rota gaps and vacancies: while not current year data in some cases, they are symptomatic of the widespread problem. For instance, the Royal College of Paediatrics and Child Health 2016 survey showed an overall rota gap rate of 14.9% in January 2016, up from 12.1% the year before. The Royal College of Anaesthetists 2015 survey reported that 89% of departments in England covered rota gaps more frequently than once a week, with higher figures still in Northern Ireland (100%) and Wales (92%). The 2015 Royal College of Physicians workforce survey similarly reported 21% of respondents identifying frequent rota gaps, and 40% of UK advertised consultant posts being unfilled.

Medical academics

34. The Medical Schools Council (MSC) reports on vacancy rates for medical clinical academics. The latest MSC report shows that in 2015 that the vacancy rate was 4.8% overall, or 11.4% at lecturer grade, with particular concerns around radiology and oncology. There has been a trend decline in the number of medical academics since 2010, and an increasing age profile, compared with the wider medical workforce. Medical academics have significant concerns around the impact of the new junior doctor and consultant (particularly arrangements around clinical excellence awards [CEAs]) contracts in England on the relative attractiveness of academia as a career path, which will need to be monitored closely as and when any new contracts are implemented.

General practice: England

35. There is relatively little current information around GP vacancies. A BMA survey in December 2015 showed that only 1 in 10 practices in England did not require locum cover, with 46% of respondents stating that they frequently had trouble finding locum cover within an acceptable time period.
36. The bursary scheme for GP trainees in England is being evaluated currently, and while early feedback has been positive, it has been suggested that the scheme has not increased supply but has instead altered the distribution of trainees, taking trainees from the surrounding areas. The bursary scheme was only ever intended to attract doctors to parts of the country where there have been consistent shortages of trainees, but it is not particularly helpful if it is only going to succeed in tempting existing trainees away from their original location, with other initiatives needed to address the fundamental problem of there being too few GP trainees overall.

General practice: Scotland
37. The Scottish Government primary care workforce survey for 2015 shows a significant increase in the use of locum GPs (with 9 out of 10 practices employing at least one locum, despite difficulty in recruiting) and in GP vacancies (with 1 in 5 practices reporting at least one vacancy, and half of those for more than six months), and in part-time working (from 51% working eight or more sessions in 2013 to 43% in 2015). These official figures are supported by Scottish GPC’s vacancy survey which shows a trend rise in vacancies, with a vacancy rate of 28.6% in June 2016, up from 24% one year earlier.

38. There have been some initiatives to address the relative unattractiveness of general practice. A proportion of 100 new GP training places in Scotland, advertised in August 2016, will receive a £20,000 incentive for trainees who choose to work in remote areas.

General practice: Northern Ireland
39. Northern Ireland already has the lowest number of GPs per head compared with the other nations. In June 2016, Northern Ireland GPC published the results of a survey of all practices, with a 64% response rate. This showed a vacancy rate of 14%, with an average duration of just under a year, but an alarming rate of 27% for practices in the “danger of collapse” (self-reported financial unviability) category. Around 3 in 5 GPs reported increasing need for locum cover, with a slightly lower proportion having difficulty taking annual leave through being unable to obtain cover.

General practice: Wales
40. In Wales, a number of initiatives have been agreed as part of the Welsh Government’s workforce plan for primary care, including a national recruitment campaign, introducing an occupational health service for GPs, streamlining the existing GP returners scheme and providing additional support for the retainer scheme, introducing a voluntary bonding scheme to encourage recently-qualified GPs to practice in difficult to recruit areas, and reimbursing student fees linked to service commitment to general practice. It is too early to know the effect of these various initiatives, which need to be fully evaluated to ensure there are no unintended consequences in the longer-term, and they need to be placed in the wider context of where trainees then choose to practise in their post-qualification roles.
Recruit, retain and motivate: Workload and Motivation

41. The consequence of staffing shortages impacts on doctors by increasing their workload, and consequently by affecting their work-life balance and wellbeing, which in turn affects morale and ultimately motivation. While all doctors want to do the best job they can for patients, continuing shortages are unsustainable. This situation is substantially exacerbated by the lack of compensating remuneration for much of the additional workload, but also by the seeming lack of recognition and unwillingness or inability of government and employers to empower doctors to make changes to service delivery that are clinically sustainable. In terms of headlines, the Kings Fund report 54,000 additional A&E attendances, and 14,200 more emergency hospital admissions compared to a year ago. A paper in the Lancet similarly showed severe pressures on general practice, with an overall workload increase of 16% for GPs in England since 2007/8, which is backed up by our recent survey that showed over 90% of GPs faced greater demand than a year ago leading to more than 60% describing their workload as unmanageable for a large part of all the time.

42. We asked in our latest survey for DDRB about working patterns and workload. With regard to “unsocial” hours, we have confirmed previous findings that a substantial proportion of doctors taken across all branches of practice frequently work in evenings (53%) and nights (31%), and at weekends (Saturdays 39%, Sundays 36%), with a further substantial number doing so occasionally. The sample was not large enough to breakdown by grade and specialty, but we know from previously reported surveys and rota data that virtually all junior doctors work some nights and weekends, and 90% of consultants undertake at least some weekend working. More crucially, just over one-third of the survey respondents stated that the proportion of unsocial hours they work has increased over the last year.

43. On workload more generally, the survey supports the argument that shortages have created work for existing staff with 27% reporting a significant increase in the total number of hours worked, and a further 36% a slight increase. Respondents report this workload as unmanageable (18%, higher for GPs – which is a further increase in the six months since we last surveyed that group), or too high at times (59%), which reinforces the unsustainability argument and is likely to have a negative effect on patient care. Furthermore, 77% of respondents did not receive additional remuneration for the additional work. This repeats findings from our regular Omnibus survey that show that at least 7 in 10 doctors often work outside their regular hours.

44. Our survey is supported by other research. The GMC training survey preliminary results from 2016 show that almost half of trainees thought their workload was intense, and that one in seven senior doctors who deliver training considered there were not enough staff to make sure patients are treated by someone with appropriate level of clinical expertise.

Morale and wellbeing

45. The Nuffield Trust Health leaders’ panel April/May 2016 poll asked about staff engagement and morale in England. A clear majority of respondents reported that morale in their organisation had fallen in the last six months, and that the main reason for this was workload. The majority of leaders also noted that the government’s dispute with junior doctors will damage the future supply of the workforce. The cap on agency spending was viewed by around 30% as having a negative impact on their organisations, presumably further worsening the workload concerns.
46. The NHS Staff survey in England identified lack of time (41% of consultants were not able to meet all the conflicting demands on time at work) and lack of staff (48% of all doctors reporting not enough staff to do their job properly) as significant concerns to doctors. The Scottish NHS survey showed a worse position, with only 34% of medical staff able to meet all conflicting demands, and only 25% stating there are enough staff.

47. As part of both our specific survey and our regular Omnibus survey of our membership, we ask about work-life balance, morale and wellbeing. Of particular concern to us is the finding that around half of doctors have felt unwell as a result of work-related stress at some point over the last year, with 1 in 10 taking time off work sick as a result of this. The reasons given were the demand on their job, particularly in shortage specialties, with the amount of organisational change (particularly in England) offered as a secondary reason. We have proposed an all-Wales comprehensive occupational health service as one response to this, and a more formal process for analysing and actioning exit interviews. This stress has in turn led to around 1 in 4 deciding to retire early, and 1 in 8 to work overseas (we did not distinguish whether permanently). The finding that 55% of respondents (England/Wales at a higher rate than Scotland/Northern Ireland) would no longer recommend a career in medicine gives significant concern that future generations will be deterred from training as doctors, as will returners from re-entering the profession. We are already seeing a clear decline in university applicants, with a fall of 9% since 2012 in England for example and one medical school actually having places in the clearing process, which we suggest reflects both the cost of training and the impact of a demoralised and disempowered profession. We also ask a tracker question around morale, which consistently shows a reported range of very low or low morale for around half of respondents, which seems unsustainable in the longer-term.

48. The effect of excessive workload has been made worse by a perceived feeling of disempowerment and disengagement. For instance, three-quarters of survey respondents do not feel able to positively influence the fortunes of the NHS. Nearly half do not feel that their contribution is valued by managers, and a staggering 85% do not feel valued by government and politicians (and even higher for junior doctors in England, for obvious reasons), with a worsening in relationships over the last 12 months. The Scottish NHS survey also identifies lack of consultation with staff about changes at work, and a lack of confidence from staff that ideas or suggestions would be listened to.

General practice: England

49. With regard to GPs in England, NHS England has now launched the GP development programme, which is the three year £30 million national development programme designed to support practices to manage their workload differently and free up GP time, though it is a very small amount when divided by the number of practices and years. In addition, initial discussions have been held about unresourced workload shifting between secondary and primary care. These initiatives are welcome, but need to be evaluated against alternative uses for the funding to ensure the maximum benefits.

50. The BMA GPC has undertaken a significant amount of work with NHS England on changes to the retainer scheme in England. From 1 July 2016, both the money for practices employing a Retained GP (RGP) and the annual payment towards professional expenses for GPs on the scheme will be significantly increased, with the current sessional rate increased from £59.18 to £76.92, and the bursary that has been available to the RGP will now increase to £1,000 per session. These payments will be available to current GPs on the scheme as well as for new GPs and the increased funding is available up until 30 June 2019. We shall report back next year on the success of these and other initiatives.

SAS doctors
51. DDRB specifically asked for more detail around SAS doctors. We reported last year initial findings from our workplace experience survey that indicated increasing workload pressures (with 74% working more hours than in their job plan) and an emerging retention problem for these grades, with 53% planning to leave (to become a consultant, apply for CESR, retire or leave medicine) within the next five (now four) years. The survey has now been published; key findings were the inability of SAS doctors to progress their personal development plan (PDP) with workload pressures leading to supporting professional activity (SPA) time being used for direct patient contact and a lack of support to protect this time, and the lack of preparation time for appraisal even though there has been progress in the proportion of SAS doctors now receiving annual appraisal (93%).

52. Beyond the survey, SAS doctors in Wales remain concerned about ineffective job planning, and in England SAS doctors have concerns around the new junior doctor contract as it removes pay protection upon return for SAS doctors leaving the grades to take up training posts (except specific hard-pressed specialties such as A&E). This is a strong disincentive for SAS doctors to consider re-entering mainstream training. The lack of access to CEAs and access to private practice, together with the length of the pay scale (17 years), means SAS doctors feel their pay does not reflect their experience and autonomy. The closure of the Associate Specialist (AS) grade further contributes to this, although we are now seeing that AS posts are being widely advertised in England to improve recruitment and retention, and we have heard reports of local proposals being put forward in Northern Ireland and Scotland, with support from management and clinicians in a number of health boards for such a move. We would ask DDRB to raise the issue of recruitment and vacancy data for SAS doctors with the administrations in all four nations, in order to obtain a fuller picture of the recruitment problems.

53. Following those in England and Scotland, a new charter for SAS doctors has been launched in Wales, jointly developed by BMA Cymru Wales, NHS Employers, Welsh Government and the Welsh Deanery. The Charter sets out the rights and responsibilities of SAS doctors and their employers. We were particularly pleased to see a zero tolerance approach to harassment and bullying; as we reported in last year’s evidence, this has been a particular concern for SAS doctors across the UK, with a worrying 35% of SAS doctors taking part in the survey saying they have been victims of bullying or harassment in the workplace in the previous year. However, we are concerned that Wales does not follow the example of England, where SAS development funding is diminishing despite the existence of the charter, which anecdotally appears to not have fully bedded in. Northern Ireland launched its SAS charter in December 2015, but SAS doctors do not have a dedicated SAS development fund, which BMA Northern Ireland has lobbied for parity with the other nations. We shall report further in future evidence on the implementation of the charters.
Economic background: Affordability

54. The NHS continues to show increasing signs of financial distress across the whole system and the whole of the UK. We have appended under separate cover a recent BMA briefing on NHS funding and efficiency savings that provides further useful background on this. We believe that the financial situation is unsustainable. The consequence of insufficient budgets is that doctors are being asked to work increasingly longer hours and more intensely, not only without any recognition or compensatory reward, but also against the backdrop of continuing real term pay cuts. Clinician involvement is widely recognised as vital to achieving successful and sustainable change in the NHS, which is impossible under these conditions.

55. As we noted last year, we accept that the overall health service budgets are outside DDRB’s direct control, but we ask the Review Body to consider the impact of further years’ pay controls on the ability of the NHS to deliver safe care and to recruit, retain and motivate sufficient staff to deliver the current service let alone any aspirations to innovate to save, and to extend access.

General practice

56. Within NHS funding, the share of total funding going to primary care continues to fall (from 10.5% in 2005/6 to 7.5% in 2015/16 in England; data on current total spending is not yet available for the rest of the UK). It is becoming increasingly unviable to run a GP practice in some areas, which in turn reduces the quality of service to patients and increases the pressures on those existing doctors who have to try to manage an increasing workload with decreasing resources, as well as reducing the capacity of general practice to help deliver the public health agenda. The increase in secondary care referrals, and consequently in waiting lists and times, could be seen as one inevitable response to lack of primary care and public health investment and staffing (though causes are of course multi-factorial).

England

57. The Department of Health in England annual accounts for 2015/16 show an overspend on the revenue DEL measure of £207 million, which crucially was only achieved through a series of one-off accounting measures to avoid breaching the parliamentary limit, and despite a 3.4% growth in health spending in real terms. Future spending is also front-loaded with NHS England’s budget for 2016/17 to increase by £5.4 billion (3.6%). However, beyond 2017 total health spending is planned to increase only at 0.7% per year in real terms. With the majority of NHS providers in England (65% at the end of 2015/16) in deficit, and an overspend of £0.55 billion estimated for 2016/17, it seems impossible that the financial situation can improve without further new investment.

58. There is still no credible plan for the majority of the £22 billion efficiency savings that the Five Year Forward View identified as needed. Even with the optimistic assumption that government and the NHS achieve all planned measures, this only results in around £6.5 billion savings. The lack of investment in social care in England – with a likely funding gap of £2.8 billion - £3.5 billion by the end of the parliament – will further add to NHS financial pressures. Future plans show health service real terms annual growth at only 1% over this decade, compared with the 4% historic long-term average. NHS trusts in England are already behind on their cost improvement programmes by £45 million overall, which suggests that the headline figures of a small improvement in the first quarter of 2016/17 has only been achieved by a deterioration in the financial position of clinical commissioning groups, with 23% of CCGs forecasting end of year deficits.
59. It is unclear how the planned “reset” for NHS financial performance through the Sustainability and Transformation Fund, whereby NHS trusts receive no growth money unless they live within a control total, will allow organisations to improve performance and efficiency without impacting on quality of care; the Kings Fund’s most recent survey of finance directors shows that for 92% of providers, their forecast end-of-year position is dependent on getting significant financial support, which therefore risks a vicious circle of failing to hit control totals leading to even worse financial positions and negative impact on quality. Around 2 in 5 NHS providers are concerned or very concerned they will not hit their 2016/17 financial targets, and NHS Improvement has acknowledged an end of year provider deficit between €250 million and €644 million. As the Health Foundation argues, we need to focus on engaging and supporting clinical staff to lead and make improvements at a local level, but this is very difficult when real terms pay cuts and ever increasing workload does not motivate and facilitate staff to contribute to these improvements.

60. Public health budgets in England have been cut in the 2015 Spending Review following an earlier cut in July 2015 to a share of 4.1% of total health spending. The evidence around public health and preventative interventions shows that these are relatively cost-effective, with a positive return on investment that typically reduces pressures on secondary care services, leading the Health Select Committee to conclude that cuts to public health are a false economy.

Scotland, Wales, Northern Ireland

61. The financial situation in the devolved nations is also difficult. There is surprisingly little official data or commentary on NHS finances in Scotland, Wales and Northern Ireland. Audit Scotland report that NHS Boards ended the 2014/15 year with a small underspend of 0.09%, against a health budget that has decreased in real terms by 0.7% from 2008/9. They have not yet published their NHS in Scotland 2016 report to give a more current position. The Scottish Government’s draft budget for 2016/17 does increase the real terms funding for health from £12.29 billion in 2015/16 to £12.98 billion in 2016/17, a 5.6% increase (or 3.84% in real terms). However, this headline does not reflect the increasing burden of integration of health and social care on the budget nor the heroic efficiency year on year savings assumptions underpinning it.

62. The Welsh Government shows a 4.1% increase in total NHS delivery spending from £6.018 billion in 2015/16 to £6.262 billion in 2016/17. The Northern Ireland budget shows a 3.97% increase from £4.627 billion in 2015/16 to £4.811 billion in 2016/17. All the devolved nations are therefore planning for limited real growth in their health spending, but have prioritised health in their overall government budgets, within the confines of their respective settlements from the UK government. However, as in England, the demands on the NHS are growing at a faster rate, so the same issues around need for additional investment and sustainable innovation apply across the UK.
Economic background: Pay comparability

63. In our survey for this year’s evidence, we did ask whether respondents had changed employer within the last year, and if so whether their terms and conditions had changed. As we suggested last year, it is still too soon for there to have been a significant shift to working under new organisational structures and contractual arrangements, though roughly 1 in 6 (higher for GPs as expected) indicated that they did expect to be working differently next year. We propose therefore that we test whether and what precisely has happened as part of next year’s evidence.

64. We are also undertaking a small research project over the next year around the factors that drive doctors’ career choices at different stages of their lives, in the absence of any routine national data from say exit interviews around doctors’ (of all grades) reasons for leaving posts and their destinations, be that within or outside the NHS, overseas, or retirement. As part of this programme of research, we included an initial few questions in our survey for DDRB around the incentive effect of pay on recruitment and retention. While this was a very crude exercise, and will be followed up with greater robustness in 2017, the findings seem to suggest that only a very significant pay increase in isolation of more than 10% would incentivise a doctor to move location or retrain. We would not want DDRB to place much weight on this, not least as the response rate was relatively low, but it does reinforce our argument against pay targeting within any restricted pay envelope.

65. To demonstrate the continuing decline on real (inflation adjusted) earnings, we have charted the level of earnings in both nominal cash and real terms, using 2008/9 as the most recently available base year. The current rate of Consumer Price Inflation (CPI) inflation is currently 0.6% (August 2016). The Retail Price Index (RPI) which we believe better reflects the costs facing doctors is currently 1.8% (August 2016). NHS Digital uses the GDP deflator to produce its series of real terms of GP earnings, which is currently at 0.1%, though we disagree with the application of this inflation indicator to income statistics, as it is designed for national expenditure; for the sake of consistency with national publications we have however still used the GDP deflator for the GP charts, and CPI for the hospital doctor charts.

66. Figures 1-4 show that all groups of doctors have faced a significant fall in real income over the last five years (eg consultants 14%, juniors 17%, SAS 5%, GPs 13%). The smaller fall in SAS doctor earnings is unexplained, but we hypothesise that this may reflect a changing profile of SAS doctors within the payscale, or that the data category that NHS Digital uses is being skewed by non-SAS doctors within its “Other medical and dental” heading; we do not have access to sufficient data on SAS and other doctors’ age and career paths to be able to test these explanations.

67. GPs actually show a small cash terms increase in 2014/15 over one year in England, Scotland and Northern Ireland, but a fall in average earnings in Wales. However, the cumulative effect over the full period is still an actual fall in GPs’ average pay in cash terms (of just under 4% since 2008/9), as well as in the inflation-adjusted figures (of just under 13%).
Source: HSCIC. Figures are England only for hospital doctors; data is not available on a consistent basis for all UK nations. HSCIC definitions do not exactly match with descriptions in chart, for example the SAS doctors category includes a small number of other medical and dental staff. HSCIC no longer routinely publish median FTE figures, which have been used in previous evidence submissions as a better measure, so the mean has been used instead. We ask that DDRB request HSCIC to reinstate routine publication of median data.
Figure 3

UK GP income before tax

Figure 4

Real terms average GPMS contractor income

Note: GP figures are contractor earnings, which include an element of income that does not relate to their NHS contract. This will include, for example, private practice, which the HSCIC estimates at around 5% of total income. It is not possible therefore to make direct comparisons of GP income with employed hospital doctors. Earnings for salaried GPs are not available for Northern Ireland, so the UK figure excludes that nation.
Scotland, Wales, Northern Ireland

We ask DDRB to note and raise with the national governments the lack of comparable earnings data for the devolved nations; while we believe that the nations will show similar falls in income, with the increasing divergence in contracts and government pay policies across the UK, it is imperative that detailed earnings (basic pay and non-basic by category) and workload (eg split between direct clinical care, management and supporting professional activities, and overtime and total hours worked) data is collected for each country, for all hospital doctors. This is illustrated very clearly by the continuing failure in Northern Ireland to pay new consultant clinical excellence awards (CEAs) since 2010; while rounds were opened in 2014, applicants were not processed and this decision confirmed following a consultation in 2015. The impact is that the percentage of Northern Ireland consultants with CEAs has fallen to 32%, creating a growing gap with the rest of the UK, and a significant recruitment and retention risk. The Scottish Government’s ongoing freeze on distinction awards (though discretionary points are still being awarded) will have a similar effect in Scotland.

Related groups

It should be noted that for medical academics, the longer training programmes and the requirement to compete and deliver on excellence in research and training whilst retaining and developing high quality clinical skills and competencies to achieve service objectives, mean that academic doctors are often further disadvantaged across their lifetime against hospital doctors, This will ultimately lead to recruitment and retention problems. Similarly, although public health consultants in England are no longer primarily employees of the NHS, whilst obviously part of the health care system, their pay is still determined by NHS consultant pay scales. For both academic and public health doctors, we continue to hear of doctors being excluded from out of hours rotas, which undermines pay alignment with the NHS and makes these career pathways relatively less attractive.

Comparator data

We have further looked at other earnings data, which are currently showing recent pay settlements averaging (median) 2% according to Incomes Data Research. The official average weekly earnings whole economy total pay indicator at the latest available date of the three months to June 2016 shows a comparison of 2.4% over the previous year, or for just the public sector of 1.9%. Depending on exactly which indicator is chosen (weekly, hourly, annual), ASHE data shows a 1.6-1.9% increase over the previous year (April). In all cases, this is significantly above the 1% public sector pay policy figure. Additionally, while international comparisons are fraught with technical difficulties in comparing contracts and adjusting for exchange rates, DDRB’s own research has shown that NHS consultants appear to be increasingly underpaid compared with their peers in various Commonwealth and European countries; the market for doctors is a global one, and while we have no specific robust data on increasing emigration of consultants, the combination of this divergence together with nugatory pay increases and an imposed contract for doctors in training means that we consider there is a significant and severe risk of a substantial outflow of doctors over the next few years, exacerbating the workload situation for those who remain. The BMA’s tracker survey showed that 32% of respondents had considered leaving the NHS to work abroad at December 2015, and while this is not the same as actually leaving the UK in practice, it does represent an increasing trend.
71. If the wider economy is such that employers feel able to offer pay increases in the region of 2%, even with any “Brexit effect”, then it is unclear why the public sector should not be able to offer similar uplifts, from a fairness perspective as well as the likely impact on recruitment and retention, as private sector jobs become relatively more attractive. As the NHS Wales Workforce Review stated: “the long term strategic direction for pay in the NHS must be to keep pace with wage growth in the wider economy if the NHS is to avoid serious recruitment and retention difficulties, a worsening of staff morale, and a decline in levels of competency.” Inflation projections for 2017/18 are also estimated at over 2% for CPI, which implies any recommendation below that level will lead to yet another real terms pay cut for doctors, while the wider economy achieves at least a real terms pay freeze, thus further increasing the unfairness.

London weighting

72. As the London weighting has formed part of the junior doctor contract negotiations, we are not making a specific argument for an increase this year, though we note it has not been updated since 2005 and as a cash sum is therefore worth considerably less now in real terms. We reiterate that we believe the London allowance is primarily designed to address the disproportionate costs of living in the capital, more so than as a recruitment tool.
Patients at the Heart: NHS performance

73. Although the public generally remain satisfied with the NHS – the British Social Attitudes Survey showed 77% were satisfied in 2015, and the Scottish Inpatient Experience Survey showed that 90% were satisfied with their care – almost everyone agrees the NHS has a funding problem, though there is no consensus on how to address this, with around a quarter of respondents stating the NHS needs to live within its current budget.

74. Interestingly, there is virtually no support from the public for making patients wait longer as a strategy for staying within budget; while we have concerns around the use of waiting list and times as a measure of quality and performance because of the incentives these create against clinical prioritization, it is clear that the public and their advocates (eg Patients Association) still consider them as important indicators of NHS performance, and the Sustainability and Transformation Fund (STF) in England for instance requires providers to plan improvement trajectories for cancer, emergency and elective treatment (18 week target) in order to receive STF money, despite the perverse incentives this may create and the likely need for upfront investment to actually be able to address the problems.

75. The worsening performance across the UK reflects the lack of funding, including a chronic shortage of staffing, which increases pressures on those providing the service. Moreover, the narrow focus on performance measures such as waiting times, potentially diverts resources away from areas, such as primary care and public health, which is not cost-effective in the longer-term. Most important though is the lack of any detailed plans to address the funding gap that do not rely on further cuts, which will lead to even worse performance in both the short- and longer-term. There is an urgent need for clinical involvement in finding ways to improve the services. In effect, we need to invest in new staff to fill vacancies and rota gaps and meet demand and reduce waiting times, and value existing staff through fair remuneration, and providing time and empowerment to contribute to sustainable service redesign and innovation.

76. The King’s Fund Quarterly Monitoring Report and Health Foundation / Nuffield Trust QualityWatch research programme have undertaken studies reviewing the performance of the NHS both historically and against international comparators. QualityWatch reports that care services are improving in a few areas, notably sustained improvements in prevention of harm to children and reductions in unplanned admissions for children with chronic conditions. However, access to care (eg four hour A&E waits, and 18 week referral to treatment times) has deteriorated to levels last seen in the late 2000s, and the ambulance service is under significant strain with falling performance on its targets and high staff turnover. QualityWatch notes the problems being stored up around childhood obesity and access to mental health crisis services as areas where funding cuts now, will create severe problems in future.

77. The Kings Fund (September 2016) reports that 58% of finance directors felt that patient care in their local area has worsened in the past year, with around 3.8 million patients waiting for hospital treatment in England – the highest number since 2007 – and 1.85 million patients spending longer than four hours in A&E – the highest number since 2003. The proportion of patients on the waiting list for more than 18 weeks in England increased to 8.5% at March 2016, above the target of 8%, and the targets for diagnostic test waiting, and the 62 day urgent referral to treatment for cancer has been missed for the past two years. Delayed transfers of care is an increasing problem; lack of social care and step-down facilities has meant that there has been a 22% increase in delayed discharges between June 2015 and June 2016.
78. Recent media reports have suggested local health economies are considering radical reconfiguration plans as part of their Sustainability and Transformation Plans (STP), which could include hospital closures and centralisation of services, as well as innovative approaches to cost-saving such as greater use of “virtual consultations”. There may be strong clinical reasons and evidence to support these plans, but it is imperative that clinical staff are involved in their design in order to ensure patient safety and quality care, not cost-cutting to balance budgets, and to help explain the plans to public and patients in any consultation periods.

79. Similarly, we would note that the public needs to be properly informed about the government’s “seven day service” policy in England, with the recent revelations around the risks identified by civil servants around “workforce overload” with a lack of staff “meaning the full service cannot be delivered”. The BMA has consistently stated our support for better patient care across every day of the week, but continues to challenge the lack of detailed plans for how increases in staffing will be funded, and the government’s use of misleading statistics.

80. Other areas of public concern are around the so-called “postcode lottery” with variation in performance across the country (and indeed across all four UK nations) in services such as dementia care, diabetes care, and learning disabilities. Information on these services is available in England on the MyNHS website, and shows for instance that 120 of England’s 209 CCGs needs to improve their performance on diagnosis and annual review of patients with dementia, and 149 CCGs needing to improve on the number of people getting diabetes checks or attending education courses. While the use of any specific measures can create perverse incentives as to how resources are allocated, benchmarking can be a powerful tool to improve quality, where for instance clinicians are involved in its interpretation and in identifying innovative and best practice ways to improve services.

Wales
81. In Wales, there have been some minor improvements for cancer waiting times, but the NHS is still failing to achieve the 62 day target. The referral to treatment waiting times have been breached since 2011, despite the target being 26 weeks compared with 18 weeks in England (March 2016 86.8% achieved against a target of 95% within 26 weeks). The situation is the same for A&E, with 83.3% waiting less than four hours against the 95% target.

Scotland
82. In Scotland, the A&E performance has been better than elsewhere in the UK, with 94.5% of patients meeting the four hour standard at May 2016. The cancer targets have been breached with 90.8% achieved against the 95% 62 day target for example. The 18 week target was also breached at March 2016 with 86.6% against the 90% local delivery plan (LDP) referral to treatment 18 week standard. Delayed transfer of care was also recognised in the Scottish Inpatient survey, with 17% of respondents stating they were delayed longer than expected while support was being organised.

Northern Ireland
83. In Northern Ireland, there has been a worsening of performance on A&E waiting times, with the four hours standard achievement dropping from 78.2% in June 2015 to 75.6% in June 2016. Cancer waits against the 62 day ministerial target of 95% show a poor achievement of 71.6% at March 2016. For referral to treatment, where as in Wales the standard is against 26 weeks, a figure of 27.8% were waiting longer than that standard in February 2016, against a ministerial target of zero per cent.
**Additional specific issues**

84. There are some additional issues that do not relate directly to recruitment, retention and motivation, or the economic background, or to the patient at the heart remit.

**GP expenses**

85. For GP contractors, the share of expenses in total practice income continues to rise, particularly in England and Wales (Table 1). We have no clear explanation for the differences between the nations; there is a lack of data for instance on locum rates, which as a major element of expenses and is likely to be a key driver. Similarly, the economies of scale from networking practices may be more limited in areas where local access is difficult and practices need to maintain multiple small sites.

<table>
<thead>
<tr>
<th>Year</th>
<th>UK %</th>
<th>England %</th>
<th>Scotland %</th>
<th>Wales %</th>
<th>Northern Ireland %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>60.9</td>
<td>61.9</td>
<td>53.9</td>
<td>59.6</td>
<td>52.6</td>
</tr>
<tr>
<td>2011/12</td>
<td>61.6</td>
<td>62.7</td>
<td>53.6</td>
<td>60.1</td>
<td>51.8</td>
</tr>
<tr>
<td>2012/13</td>
<td>62.5</td>
<td>63.7</td>
<td>53.6</td>
<td>61.1</td>
<td>51.8</td>
</tr>
<tr>
<td>2013/14</td>
<td>63.5</td>
<td>65.0</td>
<td>53.0</td>
<td>61.9</td>
<td>51.7</td>
</tr>
<tr>
<td>2014/15</td>
<td>64.2</td>
<td>65.7</td>
<td>53.0</td>
<td>62.9</td>
<td>50.9</td>
</tr>
</tbody>
</table>

86. The BMA does believe it is part of DDRB’s remit to make a recommendation around gross GP practice income, but we accept we can offer no substantial new detail on expenses this year. As a result of DDRB not making a recommendation last year, we managed to negotiate an expenses uplift in England, which the Welsh Government followed (less specific England elements such as CQC fees). While the Scottish Government considered a similar approach to that used in England, they ultimately imposed a non-negotiated figure. We have requested a commitment to cover expenses in full in Wales for this year’s contract negotiations, with a greater than 2% contract uplift, in order in part to reduce the differential in earnings with England GPs across the border.

87. NHS England has obtained some expenses data as part of its review of the Carr-Hill resource allocation formula, which should allow some useful analysis; for instance, it seems to challenge the case for significant economies of scale for larger or networked practices.

88. We have established a working group with NHS Employers and NHS England to identify any possible data sources, perhaps including practice accounts, at a sufficiently granular level and with a time series of historic data available. This will hopefully both identify the most significant areas of expenses, and the most unavoidable, with a view to comparing these against official measures of inflation, such as CPI or RPI. It may also help to quantify their impact, with the aim of estimating an expenses uplift that should be added to the DDRB net GP income recommendation in order to produce the gross uplift figure.

89. The working group has not yet reported, so will not be available to DDRB for this round. However, the BMA’s aim is that the methodology and data sources we agree upon should then form part of the information provided as part of parties’ evidence to the review body, for DDRB to then make the gross as well as net uplift recommendations as it previously used to do.
90. Broadly, we are proposing a two-stage methodology, where an underlying inflation uplift (which may relate to either official measures or simply to past expenses totals on the basis that practices operate in a competitive environment so have incentive to minimise their costs) is adjusted for known cost pressures relating to the year in question. Thus for instance medical indemnity costs and employer National Insurance (NI) contributions formed part of the negotiations for last year.

91. We would expect indemnity costs to remain an issue this year across the UK, and agreement has been made with NHS England around an approach to these, with a new GP indemnity support scheme. This is however a short-term solution, and a long-term solution to support all GPs across the UK is still required, for example full direct reimbursement. It is also likely the national minimum wage will impact junior practice staff, so will be a cost pressure for many practices.

**GP trainers grant**

92. We do ask that the Review Body continue to make recommendations around increases to the GP trainers’ grant, which we believe should increase at least in line with the overall contract recommendation. A greater increase might attract new trainers, which would then enable growth in trainee numbers and foundation year placements.

**New models of care**

93. It is still too early to provide evidence on new models of care under the Five Year Forward View in England, as these are typically not yet legally constituted and operational. We are starting to see some examples of new models in Wales, such as in Prestatyn, where Betsi Cadwaladr University Health Board is running a multidisciplinary service with GPs as a response to the previous contractor owned practice being unable to recruit new partners upon their retirement. We do however have some concerns as to how the new model has been made financially viable, and what standards it needs to adhere to compared with a full GMS practice, so we await evaluation and further detail. As a number of GP members have indicated that they expect to be working under new organisation and potentially contractual arrangements within the next year or two, then we shall return to this topic in our next evidence. We believe it is however too early for DDRB to make any recommendations in this area.

**Salaried GPs**

94. The England remit letter asked DDRB to make observations around salaried GPs. As with new models, we believe there is insufficient data currently available around sessional GPs, including how GPs choose whether to take a salaried or locum position, and if so, for how long (eg younger sessional GPs have told us that they envisage at looking for a partnership at some point), as well as how the different employers (practices, locum agencies, independent sector organisations) set pay rates for the different types of sessional GP.

95. It is clear that the proportion of salaried GPs is increasing with the majority of GPs now entering the workforce on a salaried or locum basis, and that the gender split is more weighted towards female doctors than for contractor GPs (roughly 60:40 female: male for salaried versus 37:63 for contractors). While we have some anecdotal explanation for this in terms of greater opportunities to work less than full time – with improved work-life balance and flexibility to those with family responsibilities – and less administrative workload – which has implications for who should then undertake that administration and how that should be remunerated - we do not have a systematic understanding of career choice for GPs, and crucially how GP trainees will view the options open to them in terms of new models of
provision, and salaried versus locum versus contractor status. The increasing divergence between the four national GP contracts will further influence this choice.

96. NHS Digital’s new workforce minimum data set now collects some data on type of GP. The dataset is experimental and we need to understand better the definition of full-time equivalent GPs, as well as what appears to be a low number of only 1,330 identified locum GPs. Data collection is improving over time, so we expect some useful comparative information for next year. The question of how to define FTE GPs is also under consideration by Welsh Government; many, if not most GPs, work more hours than their nominal contracted time, such that a part-time GP may for instance be considered as working full-time. There is a data gap around sessions worked for all types of GP, and indeed wider healthcare professionals. The data availability around sessional GPs is similarly virtually non-existent in Scotland and Northern Ireland.

97. We would make two observations specifically with regard to salaried GPs. Firstly, we believe that the national model contract for salaried GPs is operating well, and protects salaried GPs as well as providing consistency for when they choose to change jobs. Secondly, we believe that the pay range for salaried GPs included in DDRB’s report no longer reflects the actual pay rates needed to recruit and retain salaried GPs. The pay range was introduced in response to the PCTMS model of provision, but is in need of fundamental review once data on actual pay rates can be sourced. However, it should be noted that GP contractors are able to recruit practice staff at any rate, and while there are certainly norms in what a practice nurse or salaried GP will be paid for which a pay range is helpful, we do not accept that GP contractors should be forced to recruit against a national payscale, given their independent contractor status.

98. The BMA would be very interested to work with DDRB and other parties to scope what data and evidence would be helpful to collect around sessional GPs. However, we believe this is a complex area so for this year’s pay round, we ask that DDRB makes a recommendation for salaried GP pay uplifts in line with all other doctors.
Conclusions

99. We believe that doctors are being unfairly punished by government with continuing real loss of earnings and increasing cost pressures, when pay rises above 1% are still regularly being seen across the economy, and at a time when doctors are working harder than ever to deliver a safe and quality service to patients, often at the expense of their own health.

100. We believe that DDRB should make its recommendations based on the value of doctors, not within any constraints imposed by governments.

101. We believe the NHS is facing a significant recruitment and retention crisis across the UK, which will only be worsened by a low or zero pay increase.

102. We believe it is within DDRB’s remit to make a gross earnings recommendation for GPs, but with the Review Body’s explicit statements that it will not do so for this round, we shall work with other parties to develop a process for future years that will allow DDRB to resume its role.

103. We believe there is a lack of credible plans to address the health and social care funding shortfalls, and without greater valuing and engagement of staff this cannot be solved on a sustainable basis.

104. We believe there is currently insufficient data for DDRB to make recommendations around staff working under new models of care, or as sessional GPs. The BMA would be keen to work with other parties to help scope what will be useful in these respects.

105. Consequently, this year the BMA is again seeking a fair and common recommendation across all doctors, whoever and wherever they are.

106. We ask that DDRB formally expresses its disappointment that its recommendations last year on distinction awards and discretionary points were not accepted by the Scottish Government, that no new clinical excellence awards have been paid since 2010 in Northern Ireland, and that the increase in expenses payments to GPs in Wales, as it has been in a number of previous years, has been insufficient to deliver DDRB’s recommendation of a net pay increase. We ask DDRB to consider how these examples of recommendations that are not accepted or implemented by governments could be reflected in the Review Body’s recommendations this year.
References

A full set of references will be available upon request.
Appendix: BMA briefings

We have appended under separate cover two recent BMA member briefings:

- Workload, recruitment, retention and morale.
- NHS funding and efficiency savings.