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

30 September 2015
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Executive Summary

Overarching BMA View

- The BMA is extremely disappointed by the Doctors’ and Dentists’ Review Body (DDRB) decision in its last review to only make recommendations for salaried doctors in Scotland, and net pay of GPs across the UK.
- The BMA is submitting evidence for the whole of the UK, and is seeking a common recommendation for all doctors. We ask that DDRB asserts its independence to make a full set of recommendations.
- We request that DDRB returns to making recommendations around GP gross earnings in this year’s review.
- We are not proposing a specific figure for the 2016/17 pay award, but we argue that doctors should be treated in line with the wider economy, where pay settlements are running at higher than the public sector pay policy cap.
- We are asking DDRB to look again at the rationale for increasing the existing London weighting, as this allowance has not been reviewed for nearly a decade.
- It is not possible to know whether, precisely when, where and in what exact form a new contract for consultants (in England / NI) or junior doctors in training (in England / NI) might be put in place, so our view is that DDRB should make its recommendations on the basis of the current contracts.
- We challenge the Review Body to think more broadly about the funding requirements of the health service from a more “bottom up” approach of what reward is needed to recruit, retain and motivate doctors, than from a “top down” recommendation driven by affordability constraints.

Content of Evidence

- There are significant cost pressures across the UK. The Five Year Forward View assessed that £30 billion of pressures will be faced over the next five years in England, but that only £8 billion has been committed as additional funding, and without any commitment to front-load this. The share of General Practice within the total NHS budget has also fallen further, despite the pledge to recruit 5,000 more GPs in England by 2020. Health spending in the UK accounts for a lower proportion of Gross Domestic Product than comparable countries.
- The consequence of insufficient budgets is that doctors are being asked to work increasingly longer and harder, without recognition or compensatory reward, and against the backdrop of continuing real terms (and for GPs cash terms) pay cuts. We believe that the Treasury’s pay policy in England will now tip the balance and we shall see further and significant problems of recruitment and retention.
- Pay comparisons show pay settlements averaging over 2%. A lower increase for doctors would further impact on recruitment and retention, as alternative jobs become relatively more attractive.
- Although still limited, data around recruitment and retention shows an increasing problem both with particular specialties (e.g., emergency medicine, general practice, and psychiatry) and locations, but generally across the board. Indications for fill rates for these specialties suggest that these problems will continue to worsen.
- Various surveys report low levels of morale, and increasing levels of unmanageable workload, leading to work-related stress and desire to leave the profession. Less than half of both SAS doctors and GPs would now recommend their career path.
• NHS performance continues to deteriorate, and doctors often feel excluded from strategic decision making, whilst still retaining their clinical accountability for patient care.
• A number of GP practices now face serious financial viability concerns as a result of funding changes, and the crisis in general practice recruitment. GP workload has increased substantially but limited ability to reduce expenses means that personal income continues to fall, thus completing the vicious circle. New models of provision and staffing initiatives will not have a significant impact in the short term.
Background and Overarching BMA View

1. The BMA is extremely disappointed by the Doctors’ and Dentists’ Review Body (DDRB) decision in its last review\(^1\) to only make recommendations for salaried doctors in Scotland, and net pay of GPs across the UK. We have serious concerns about the value of a process where an independent body can have its standing terms of reference seemingly overruled through a remit restricted at the unilateral request of one or more party. While we note the comments that DDRB does not consider their decision last year as setting a precedent, this decision has created a dilemma for the BMA in deciding whether to submit evidence where the conclusion might appear foregone and the very independence of the process thrown into doubt.

2. At time of submission, we have not seen any specific remit letters. However, the Chief Secretary to the Treasury has written to the Chair of the DDRB on 19 August 2015 setting out the context for the public sector pay in England in 2016/17\(^2\), which was announced in the Budget with a four year pay award of 1% a year from 2016/17. We do note that some workers could receive more than 1%, and we trust that DDRB will not therefore consider the 1% figure as a cap on their recommendations. The Treasury remit does not extend to the devolved nations, and pay policies for the devolved nations have not been published at time of submission. We understand that the Scottish budget is likely to be delayed this year\(^3\).

3. We also need to express our severe disappointment at the DDRB’s decision to only make recommendations for GP net pay. While we accept and agree that the formula previously used to determine a gross earnings uplift was not fit for purpose, we do strongly believe that a gross earnings recommendation does and should form part of DDRB’s remit, not least as a key element of practice expenses is salaried GPs’ pay. Furthermore, the timing of publication of DDRB’s review in February/March does not allow parties sufficient time to negotiate a gross uplift in time for the start of the financial year. We request therefore that DDRB returns to making recommendations around GP gross earnings in this year’s review.

4. While we are unable to source data on the impact on recruitment and retention across borders, we would stress that the BMA believes there is a UK-wide national – and indeed international - market for doctors (though not as DDRB appears to have suggested\(^4\) a single UK-wide consultant contract), and differential recommendations and implementation risk fragmenting this. As last year, the BMA is therefore submitting evidence for the whole of the UK, and is seeking a common recommendation for all doctors. We ask that DDRB asserts its independence to make a full set of recommendations, even should its remit be restricted.

5. We are again not proposing a specific figure for the 2016/17 pay award, but we argue that doctors should be treated in line with the wider economy, where pay settlements are running at higher than the public sector pay policy cap. We are also asking DDRB to look again at the rationale for increasing the existing London weighting, as this allowance has not been reviewed for nearly a decade.
Scope of Evidence

6. As in the last two years’ submissions, the BMA’s evidence is more limited in scope than it has been historically. This reflects the continuously developing situation around the consultant and doctors in training contracts, following the publication of the DDRB’s special remit report on contract reform for both consultants (in England and Northern Ireland) and doctors and dentists in training (across the UK), and subsequent discussions and decisions. The BMA submitted substantial amounts of evidence towards this report which we do not repeat in this submission, but which DDRB may wish to reference.

7. It is not possible at this juncture to know whether, precisely when, where and in what exact form a new contract for consultants or juniors might be put in place, so we strongly believe that DDRB should make its recommendations for these affected groups on the basis of the current contracts. DDRB will further be aware that the Scottish Government and Welsh Government have adopted a different approach to the doctors in training contract than the government in England, which reinforces the continuation of existing contracts. Even if a new contract is imposed in England, this could not be introduced until some way into the 2016/17 year, and it would be unacceptable for a group of doctors to have to forego a pay increase on this basis.

8. We continue to share DDRB’s concerns around the lack of data in particular areas, notably recruitment and retention and workload. We note that HSCIC has now produced some data around job advertisements as a proxy for vacancies in England, which is welcome and will act as a baseline to allow us to make more evidenced comments around recruitment in future years, though this is not a comprehensive vacancy measure. As in recent years, we have limited our evidence to data or information that has been published or specifically collected in the year since our previous submission; we have previously noted the risks around using older data (for instance, the NHS staff survey), where this may have become obsolete as a result of subsequent events.

9. Our focus over the time since the last submission has been on producing evidence for the contract negotiations and DDRB special remit (for consultants in England and NI, and UK wide for trainees), and we continue to work with other parties around data to support discussions on seven day services and career progression. We have not therefore commissioned any new research specifically for this pay evidence submission, for instance around productivity and motivation. We are able to update DDRB on research into GP practice workload, and the study we commissioned externally of Scottish consultants’ perceptions of their role in the health service. We report on new surveys of GPs and SAS grade doctors.
Economic Context

10. The NHS continues to show increasing signs of financial distress across the whole system. We have argued over recent years that DDRB has appeared to take as a given the government’s stated affordability constraints, but we would challenge the Review Body this year to think more broadly about the funding requirements of the health service from a more “bottom up” approach of what reward and remuneration is needed to recruit, retain and motivate doctors for them to be able to deliver highest quality care and contribute to sustainable service redesign – and not a “top down” recommendation driven by financial constraints.

11. The Five Year Forward View assessed that £30 billion of pressures will be faced over the next five years in England, but that only £8 billion has been committed as additional funding, and without any commitment to front-load this. The share of General Practice within the total NHS budget has also fallen further (to under 8.0% in England, down from 10.0% in 2004/5), despite the pledge to recruit 5,000 more GPs by 2020.

12. Commentators including CIPFA, Nuffield Trust, King’s Fund, and the Health Foundation, uniformly agree that both the quantification of the shortfall and the proposals to address it are extremely optimistic. This commentary is reinforced by surveys of providers and analysis of Board papers of NHS organisations that suggest the NHS in England is heading for a £2 billion deficit this year. A survey carried out by Dods found that four in five health professionals said their organisation had insufficient resources to meet its current needs, and that these financial constraints had impacted on their role.

13. In particular, the ability of the NHS to deliver productivity gains at double the historic rate, and when the “easy wins” have been exhausted with Foundation Trusts for example only achieving 3% efficiency savings against the 4% requirement, casts serious doubt (even acknowledged by the government itself, for instance in the Carter review on operational productivity) on the ability of the NHS to continue to deliver quality healthcare without further substantial upfront investment. Already we have seen raids in England on the NHS capital budgets, and the supposedly ring-fenced public health funding (a 7% reduction in 2016/17), which will simply store up future problems in limiting the options for radical service redesign across integrated pathways of care. The Health Service Journal reports the Department of Health in England as paying out £1.2 billion in bailouts in 2014/15, with three trusts receiving more than £50m apiece. CIPFA estimate that a 1% rise in interest rates could wipe out £8 billion – the most optimistic government estimate of the gap – simply by increasing the cost of servicing debt.

14. Health spending in the UK accounts for a lower proportion of Gross Domestic Product (GDP) than comparable countries (9.3% of GDP in 2012 against the EU average of 9.9%). It seems probable that last year’s trust overspend of £823m (in England) will more than double this year; the majority of providers are in deficit, including even the most prestigious hospitals now forecasting deficits. Of particular relevance is that many providers have taken on additional staff in response to safety concerns, and have relied on agency staff (e.g. spending on temporary staff in England rose from £3.6 billion in 2012/13 to £4.6 billion in 2013/14). As we have noted previously, the savings to date have been largely achieved through pay constraints, and reductions in tariff payments, but the progress on fundamental change has been much slower than required.

15. We warned last year that the financial situation was unsustainable and called for greater public debate. 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 against the backdrop of continuing real terms pay cuts. We believe that the Treasury’s pay policy in
England will now tip the balance and we shall see further and significant problems of recruitment and retention on top of those already experienced in many specialties and locations, growing personal issues arising from a deteriorating work-life balance, and detrimental effects on the future of the NHS itself, as a result of a short-sighted focus on immediate activity demands without investment into finding innovative structural solutions to this funding crisis. Clinician involvement is widely recognised as vital to achieving successful and sustainable change in the NHS, which is impossible under these conditions. We would therefore expect to report an increase in doctors choosing to work overseas or indeed leaving the NHS in our next submission.

16. While restrictions on the cost and use of temporary staff may have a short-term beneficial effect, this does not address the underlying issue of why staff are choosing to take on temporary roles, which we would hypothesise is one consequence of pay restraint on permanent staff and the deteriorating work-life balance. The BMA has lobbied the Migration Advisory Committee – so far unsuccessfully - to add GPs to the Occupation Shortage List, which has added to recruitment pressures by making it harder still to recruit non-EU doctors into shortage specialties.

17. We accept that the overall health service budgets are outside DDRB’s direct control, but we challenge the Review Body to consider the impact of four (in England) 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 extend access.
Pay Erosion and Comparison

18. As in previous years, we have updated the charts of the real-terms (adjusted for inflation) cut in earnings over recent years. This reports average (mean) earnings in 2008/9 prices, using the government’s preferred measure Consumer Price Inflation (CPI) deflator. The current rate of CPI inflation is currently 0.1% (July 2015). The Retail Price Index (RPI) which we believe better reflects the costs facing doctors is currently 1.0% (July 2015).

Source: HSCIC

Note: GP contractor earnings 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.
19. The chart shows that all groups of doctors have faced a significant fall in real income over the last five years (eg consultants 13%, juniors 17%, GPs 19%), with GPs showing an actual fall in their average pay in cash terms, not just the inflation-adjusted figures.

20. The Pensions Act 2014 introduced a new flat rate State Pension from 6 April 2016. A key element of this change will be the abolition of the State Second Pension (S2P). This means that contracting-out of the S2P will also end. After 6 April 2016 members of the NHS Pension Scheme will therefore also pay full NICs due to ending of “contracting out”, and as such will see an increase equivalent to 1.4% of relevant earnings. The maximum additional NICs for employees is estimated to be £480 a year.  

21. In addition, 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, which will ultimately lead to recruitment and retention problems. 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.

22. We have further looked at other earnings data, which are currently showing recent pay settlements averaging over 2% according to Incomes Data Research, and a similar figure from XpertHR who show a bimodal median settlement of 2.0% or 2.5%. The official average weekly earnings whole economy total pay indicator at the latest available date of July 2015 shows a comparison of 2.9%. ASHE gross hourly pay for 2014 for general medical practice activity showed a 2.5% increase, or 3.1% for medical and dental practice activities. We would also draw attention to the greater than 10% increase for members of parliament, in stark contrast to the 1% cap for public servants.

23. If the wider economy has recovered sufficiently from the recession such that employers feel able to offer pay increases in the region of 2%, 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 part of the contract negotiations for the consultant contract in England and NI, the BMA did commission some comparator pay research from IDS. This showed that consultants are typically underpaid by approximately 20% on basic pay (and greater still for total earnings) compared to other benchmark professions with similar levels of responsibility and risk.
**London Weighting**

24. The London weighting is a cash supplement of £2,162, which has not been updated since 2005 (and longer for fringe zone payments which have not been updated since 1981). There are additionally a number of issues relating to definition of boundaries within which the allowance is paid which do not match well with current administrative boundaries, and a discrepancy with other contracts for other NHS and public sector staff who receive a proportion (eg Agenda for Change 20% for inner London, up to £6342) of salary rather than a fixed amount.

25. Although there are strong arguments that other areas in the UK face similarly high costs of living (for example Cambridge, Edinburgh – which other industries sometimes recognise), this year we are again asking the DDRB to consider uplifting the existing London weighting to address the very significant house price / rental and travel cost inflation in London. This is important with around 13,000 doctors in training in the London region alone.

26. Property rental prices in London\(^\text{28}\) have risen by around 20% to 30% since 2010, or by 4.6% in the last year alone, with average London rentals now more than twice the national average. London travel costs have risen by around 2.5% in the last year, well above general inflation and NHS pay settlements.

27. We note - but do not agree with - DDRB’s statement in last year’s report that the London allowance is designed to address recruitment and retention. As we made clear, while pay may be one way to attract staff to particular areas or career paths, other factors such as work-life balance are likely to be as if not more important, and we argue that the London allowance is primarily designed to address the disproportionate costs of living in the capital. We are therefore asking DDRB to again consider uplifting London weighting.
Contract Negotiations

28. Following publication of the DDRB’s special remit report into the consultant contract in England and Northern Ireland (Welsh Government also gave a remit, but DDRB stated their observations applied to only England and NI), and the junior doctors in training contract across the UK, and the government response to that report, the BMA entered into discussion with NHS Employers and the Department of Health to see whether there were grounds to re-enter formal negotiations based on the DDRB recommendations.

29. We would remind DDRB that Scottish consultants did not form part of this process, and that the Scottish Government would not seek negotiations on a new consultant contract in Scotland until there was greater clarity on sustainability and seven days services. Furthermore, as stated, the Scottish Government gave assurances on 17 August 2015 that it will not be seeking to impose any new arrangements on trainees in Scotland, and that it will continue to service the current New Deal contract. Similarly, the Welsh Government has confirmed in September 2015 that it too will not impose a new contract on junior doctors in Wales.

30. On 13 August 2015, the BMA’s UK junior doctor committee voted not to re-enter contract negotiations with NHS Employers. This was on the grounds that the proposals would remove vital safeguards which discourage employers from making junior doctors work dangerously long hours, extend routine working hours such that a Wednesday morning would be viewed the same as a Saturday evening for instance, and see pay no longer linked to the experience junior doctors gain through their training. The government in England has indicated on 15 September that it will now impose a contract on junior doctors in training from August 2016. No formal response has been received from the government in Northern Ireland.

31. As a consequence of this threat to impose a new contract in England, the BMA junior doctors committee at its meeting on 26 September 2015 have found themselves forced to ballot for industrial action. We shall update DDRB on this ballot in our supplementary evidence. The Academy of Medical Royal Colleges, and various Royal Colleges and associations individually, have also raised their concerns around safety to the Secretary of State for Health in England. Their fears of an exodus of junior doctors appear very real, with a dramatic increase in the number of doctors in training applying for Certificates of Current Professional Status (CCPS) that would allow them to seek work abroad.

32. The consultants committee of the BMA has decided on 10 September to re-enter formal contract negotiations with NHS Employers and the Department of Health in England. The Northern Ireland consultants committee also has taken the decision to resume negotiations at its meeting on 17 September. Contract negotiations stalled in October 2014 because the proposed safeguards intended to guarantee patient safety and keep doctors from being over tired at work were not robust enough. There was also a lack of reliable data to base planning for any changes to doctors’ contracts. The government in England has now agreed to improved contractual safeguards and a data gathering exercise.

33. As a consequence of the timing and uncertainty of the final outcome of consultant contract negotiations, and the governments’ response to the juniors’ decision not to re-enter negotiations – together with the explicit continuance of existing contracts in Scotland and Wales – we request DDRB to assume that the current contractual arrangements will continue in 2016/17, even if not for the whole year, and make recommendations on that basis.
As noted previously, Staff, Associate Specialists and Specialty (SAS) doctors are not engaged in contract negotiations. The General Practitioners committee (GPC) of the BMA has just begun its usual annual negotiations with NHS Employers on contract changes for 2016, somewhat later than previous years because of a delay in NHS Employers being given their mandate. However, the Scottish GPC has agreed with the Scottish Government that there will be a period of stability to March 2017, with a commitment to address wider issues for a potential new or revised contract for implementation after April 2017. In Wales similarly there is a two-year deal, with a further shift from quality targets into core funding and a focus on development of GP cluster networks. While GMS contracts do differ across the nations, the underlying principles do remain broadly the same, so we are again not seeking any differential uplift for the devolved nations.
Recruitment and Retention

35. The quality and consistency of data on vacancies remains limited across the UK; however the message from the various sources that do exist is compelling, showing significant recruitment and retention problems, and increasingly long-term vacancies.

36. We are pleased to see that HSCIC has released some provisional experimental statistics around vacancies in England, although technically the figures are a proxy for true vacancies in that they measure job adverts on NHS jobs website, which will understated 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. As it is the first collection of this data it is hard to draw conclusions – although with over 6,000 medical and dental vacancies advertised in a quarter this feels to be an increasingly significant problem - and we would support continuing efforts for a formal collection of recruitment and vacancy data across all branches of practice, and consistent across the whole of the UK.

37. BMA Cymru Wales sent Freedom of Information requests to local health boards and trusts in March 2015 to ask about consultant vacancy rates. Results showed a high vacancy rate of 6.8%, with considerably higher rates in some health boards and trusts. In addition, the FOI showed high use of locum consultants, with an estimated 10.5% of consultant headcount in Wales being locums.

38. In Northern Ireland, the DHSSPS recorded an overall medical FTE vacancy rate of 5.3%, of which over 60% were long-term vacancies. The BMA has concerns about the definitions used, but believe the data does reflect a trend of increasing long-term vacancies.

39. In Scotland, a questionnaire sent to all 987 GP practices in Scotland received responses from 330 practices across all 14 health board areas. We do have some concerns around the accuracy of the data, but the survey did reveal 92 unfilled GP vacancies. There were also 68 salaried GP vacancies.

40. BMA Scotland also runs its own quarterly vacancy survey of GP practices. Of the 588 (61%) of practices that responded to the latest (June 2015) survey, nearly a quarter reported at least one vacancy, 43% had been unable to source locum cover on at least one occasion in May 2015, and some practices were unable to secure a locum for 14 or more days in that month.

41. GPs are finding it increasingly hard to recruit in England too, with almost one in ten GP partner positions currently vacant, according to a Pulse survey. The survey finds that 9% of full-time equivalent GP positions are currently unfilled, compared with a 6% vacancy rate last year. The figures also reveal that it is taking longer to recruit partners, with almost one in five roles taking more than a year to fill, compared with one in ten vacancies last year. Figures from the GP National Recruitment Office also show that 632 out of 3124 training posts in GP surgeries have not yet been filled.

42. In our latest Omnibus survey we asked about the factors that would make general practice more attractive to medical students. The staffing levels for general practice, and assurances of increased funding were the top ranked responses, with a majority opinion that financial incentives would help with recruitment.

43. There is some official data available for Scotland that shows a trend increase in total vacancy rates for consultants, with a substantial worsening over the last year (June 2014 rate 6.9%, June 2015 rate 8.3%). The number of vacancies that had been vacant for more than six months has also significantly increased to 188 WTE, an increase of 95.1 WTE on June 2014. The BMA believes the official figures...
understate the true position, for instance due to how NHS boards interpreted the vacancy definitions used in the current data collection. BMA Scotland has discussed these concerns with the Scottish Government who tell us that a short-life working group is being established to consider how further clarity and consistency can be applied to the recording and reporting of vacancy details by NHS Boards on a pan-workforce basis. To date however, we are not aware that this has resulted in any changes to the vacancy definitions.

44. The Scottish Government has also implied that high vacancy rates simply reflect the creation of new posts that have not yet been filled, so represents natural turnover. While there has been an expansion of consultant numbers, it is not clear why this should increase the vacancy rate (as opposed to the absolute number), and the increase in long-term (over 6 months) vacancies confirms that this is a genuine recruitment and retention problem. While core training fill rates are reasonable at around 98%, there is a serious recruitment problem at higher training level, so we expect the vacancy rate to continue to rise.

45. A small scale survey in England from the Smith Institute\textsuperscript{44} showed that 63% of NHS Trust HR directors were “unsure” that they had enough staff to meet demand, with 85% finding recruitment “very or fairly difficult”, particularly for skilled and experienced staff, which includes consultants and mid-grade doctors. Around two-thirds of respondents felt that the NHS pay squeeze had “some or significant impact” on recruitment and retention, that this is bad for morale, and will increasingly impact on future ability to recruit and retain staff.

46. The Medical Schools Council (MSC) reports on vacancy rates for medical clinical academics, the group of doctors that DDRB itself describes as a “vital group of staff... given their role in teaching future generations of doctors” such that there is a need to “ensure that [clinical] academic careers remain attractive”. The latest MSC report\textsuperscript{45} shows that in 2014 that the vacancy rate was 6% overall, or 11% at lecturer grade. Twenty-three medical schools cited specific difficulties in recruitment, including a shortage of high quality applicants particularly for some specialties such as cancer and cardiology, reduction in NHS funding for joint appointments.

47. In the specialty of Public Health, there is no longer an official reporting of Director of Public Health vacancies in England. The latest list of DPHs shows that 112 of the 131 posts are filled substantively, with interim arrangements in place for the remainder. An FOI request of Local Authorities in June 2015 showed a slightly higher figure of 32 vacancies for public health specialists (based on a response rate of 69%)\textsuperscript{46}

48. The previous DDRB report stated that data on final fill rates was a priority. At time of submission however, 2015 specialty fill rates are not yet publicly available in England. We understand from Health Education England that there are significant shortages across the training specialties of core psychiatry and general practice – with general practice showing a significant drop from last year as well and higher unfilled posts in the North and Midlands than in the South and London. At specialty training level, general and old age, and child and adolescent psychiatry and paediatrics are a particular concern, but also some of the smaller specialties like GUM, rehabilitation medicine and chemical pathology.

49. Similarly, we understand from NHS Education for Scotland (NES) that there are significant issues with fill rates for higher specialty training. The data reflects serious shortages for instance in emergency medicine, acute medicine, clinical oncology, geriatric medicine, and psychiatry – with significant geographical differences, for example the very low rates for emergency and geriatric medicine in the East NES region. In addition, GP fill rates are at their lowest for five years. It is unclear that initiatives
such as the International Medical Training Fellowship and the NHS Lothian Clinical Development Fellows scheme have made a significant impact upon rota and workforce gaps, and BMA Scotland has not seen an update of the Scottish Government’s strategy and targets to address these challenges.

50. The NHS plan to recruit 200 physician associates from the US to GP practices and hospitals in England on an annual salary of £50,000 is of significant concern to the BMA. These physician associates are not doctors, and do not have the same level of training or carry the same level of risk and responsibility as SAS, junior doctors, or salaried GPs. While they will not have a career progression like some doctors, to achieve the same level of salary and terms and conditions would take a UK trained doctor 10 or so years. As a short-term solution to the recruitment problem, physician associates are one solution, but they are not doctor substitutes, so we would ask DDRB to consider the impact in terms of motivation and retention of longer-term use of physician associates for different groups of fully trained doctors.
Motivation

51. A report published by the Academy of Medical Royal Colleges in Scotland warns of a loss of leadership, poor staff morale, a ‘defective culture’, disconnected clinical staff and management, and inappropriate targets and poor accountability mechanisms. The report echoes concerns raised in a major piece of research commissioned by the BMA Scotland consultants committee from Dundee and Glasgow Universities, which revealed that the consultant workforce was feeling deprofessionalised, disengaged and demoralised.

52. That report identified that many consultants perceive they no longer have the opportunity to participate fully in decision-making that affects the services for which they are and remain clinically responsible. There is also an overriding sense of frustration at the focus on financial priorities in the decision-making process; and strategic decisions being made without clinician involvement but where the consequences of these still leaves the clinical accountability with the consultants, who have not been compensated for carrying this risk whilst being denied the means to manage it.

53. Further contributing to this, we would like to draw the Review Body’s attention to the Scottish Government’s ongoing freeze on distinction awards in Scotland. When taken together with the “9:1” approach to consultant job plans still being adopted by several Scottish employers, this can only make Scotland even more uncompetitive and unattractive, not only in the UK market for consultants and clinical academics, but also internationally. It also potentially creates a vicious circle as the workforce gaps caused by recruitment problems put more stress on the system, and increased workload pressures on the remaining medical staff make it harder for them to provide a good level of care to their patients.

54. In Northern Ireland, CEAs have not been paid to consultants since 2010, and despite applications invited for 2012/13 no awards were made, compared to 318 awards in England & Wales (ACCEA). This means only 34% of consultants received CEAs in 2013 compared with 50% in 2009. This devalues consultants in NI and BMA NI has heard anecdotal evidence that this is impacting on recruitment and retention in some specialties such as radiology.

55. We also undertake some more regular surveys of members, of which our Omnibus survey includes some relevant, if self-reported or anecdotal, evidence. In our latest survey, 46% of respondents reported their level of morale as low or very low, with GP showing a lower level than other branches of practice. 48% of respondents also perceived their level of workload as unmanageable or unsustainable. Around three in ten are now in the process of making changes to their career, which includes taking early retirement, working overseas, and indeed leaving the profession.

56. We explicitly asked about the likely impact of the announcement on continuing pay restraint on doctors’ career intentions. While around half had not changed their intentions, around two in ten doctors were reconsidering their career intentions, potentially leaving the NHS.

57. While the BMA has some concerns about the national NHS staff surveys in terms of timeliness, as well as reconciliation with our internal surveys, there are a number of findings in the England 2014 survey that are of concern. We report the continuing relatively low levels of appraisal for SAS grades in particular, and a cross-branch of practice 44% response to the question of whether appraisals are well-structured more generally. We are also concerned that around one-third of doctors have suffered from work-related stress in the last twelve months, and a similar proportion have suffered harassment from patients and their families. Of most concern from a service redesign perspective is that only around 70% felt able to contribute towards service improvement in their
place of work; without this it seems difficult to see how sustainable improvements to the NHS can be made with clinicians able to contribute to the financial and clinical viability of their organisations.

58. In Scotland, the staff survey also identified problems with appraisal, with only 49% medical and dental staff agreeing that appraisal helped them do their job better. Other worrying findings reflected our research on consultant disempowerment, with just 32% medical staff being clear on how changes would affect their work in practice. The survey also confirmed the recruitment situation with only 26% medical staff believing there are enough staff for them to be able to do their job effectively, and consequently 32% not being able to meet the conflicting demands on their role.

59. The Hospital Consultants and Specialists Association (HCSA) undertook a small-scale survey\textsuperscript{13} that showed that 81% of its 817 members who responded to the survey had thought about retiring early as a direct result of work pressures, and 83% said work-related stress had taken a toll on their family life, with a third of respondents facing unreasonable levels of stress across the whole working week.

60. The BMA has also undertaken two large-scale surveys of its members this year. Our survey of GPs in early 2015\textsuperscript{54} received a response of over 15,000 GPs, around 45% of the profession. Our survey of SAS grades\textsuperscript{55} in July 2015 received over 1,500 responses.

61. The results of the SAS survey are still under analysis, but early headlines show that a significant minority of SAS doctors do not have a current job plan (38%). This group of doctors also report a lack of opportunity to take on additional roles and responsibilities, for instance only 24% report being an appraiser, but 34% report not being offered appraiser training which suggests a significant untapped resource as well as being personally motivating and developmental.

62. The majority of SAS doctors have been asked to give up their SPA time to fulfil other clinical duties, and a similar proportion (three-quarters) report they work more hours than in their job plan. This shows the crucial role SAS doctors play in the NHS and the reliance placed on them by employers. Worryingly, around 45% of SAS doctors would not now recommend that career path to other doctors, which as we highlighted last year supports our argument of a future recruitment crisis.

63. The GP survey shows a picture of workload verging on the unmanageable, and insufficient funding to be able to address this. Around 1 in 3 GPs intend to retire within the next five years, and less than half of GPs would now recommend general practice as a career path.

64. More than nine in ten GPs (93%) say that their workload has negatively impacted on quality of care given to patients; this is comprised of seven in ten (71%) saying that their workload has, at times, had a negative impact of the quality of care, and just under a quarter (23%) who say that their workload has a significantly negative impact on the quality of care their patients receive. The majority of GPs (68%) state that they experience a significant but manageable amount of work-related stress, but a further 16% report experiencing a significant and unmanageable amount of work-related stress.

65. The Eight National GP Worklife Survey\textsuperscript{56} reinforces the findings from our BMA survey. It shows that the level of overall job satisfaction reported by GPs was lower than in all the surveys undertaken since 2001. From the previous 2012 to this latest 2015 survey, average satisfaction declined from 4.5 to 4.1 points, with the largest decreases in the domains relating to remuneration and hours of work. Reported levels of stress also increased over the last three years and are now at their highest level since 1998, with most stress due to increasing workloads, changes to meet requirements of external bodies, and paperwork. The proportion of GPs expecting to quit direct patient care in the next five years increased from 8.9% in 2012 to 13.1% in 2015 in GPs under 50 years old, and from 54.1% to 60.9% for those over 50.
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 the UK performs worse on 14 of its 27 indicators than most countries, and that performance is deteriorating on two (volume of antibiotics prescribed in primary care, and cervical cancer screening). The UK continues to lag behind other countries, despite some historic improvements, in areas such as stroke and acute myocardial infarction, and in cancer survival rates.

While the UK appears to perform well in relation to access to care, there are some difficulties in making comparisons at an aggregate level. For instance, for waits of less than one month, the UK performs well internationally, but when considered over a four month horizon, the UK’s performance is amongst the weakest.

The international comparator data moreover typically dates from 2013 or before. The Quarterly Monitoring Report from the King’s Fund provides a helpful summary of current performance, and demonstrates very clearly the decline over the last couple of years. While in times of austerity all health systems are likely to have suffered some decline in performance in some areas, it does seem reasonable to infer that the UK’s position relative to comparator countries will have declined, as well as against its own long-term trend historic performance.

For instance, respondents to the King’s Fund survey of finance directors in England reported that from September 2014 onwards more than 30% believed the NHS had got worse in terms of patient care, with more than 20% citing staff morale as giving the major concern for providers, and waiting times the major concern for commissioners of services. Around six in ten believed the government new controls on agency staff in England would have no significant impact on their agency spend, with the issue being an overall shortage of staff, not a lack of controls.

With regard to performance more generally, while healthcare acquired infections do appear to be largely static, as we reported last year the position around waiting times continues to be poor, and symptomatic of general unsustainability of the system. The BMA has significant concerns around the use of waiting times as a crude quality indicator, as they potentially skew clinical priorities, but governments, the media and the general public do still recognise these as a key indicator, so we include some data here in that context.

The latest England figures at May 2015 show continued inpatient wait breaches, though with marginal improvements in the 18 week referral to treatment measure. Cancer waiting times are below target (82.3% against 85% in Q4 2014/15). A&E targets continue to be a problem, with 5.9% patients waiting more than four hours from arrival to discharge or admission in Q1 2015/16 – the highest figure recorded for this quarter, with 32% providers missing the target. This reflects the severe recruitment problems in that speciality.

In Scotland, a new regime of Local Delivery Plan standards has replaced the former HEAT targets. Most of the waiting time standards have been breached, for instance the 12 week treatment time guarantee (94.9% vs 100% standard), and the four hour A&E standard was marginally missed.

Northern Ireland and Wales also continue to miss their A&E targets, reflecting the severe recruitment difficulties in emergency medicine. NHS Wales also has a longer 26 week referral to treatment target than elsewhere in the UK, but has failed to achieve this.
74. While the additional reallocation of funding (in England) does seem to have prevented a significant deterioration in NHS performance, we reiterate our position that we set out in last year’s evidence that the situation is unsustainable without new investment and recruitment, and without compensating staff for their continuing efforts to maintain quality at the personal expense of unmanageable workloads and worsening worklife balance.
GP Contractors

75. The net income of GP contractors continues to fall in both cash- and real-terms. GPs have a direct incentive to manage their expenses, so have delivered virtually the maximum level of efficiency savings that is possible. The trend increase in the Expenses to Earnings Ratio (EER) demonstrates this clearly, as the inability of practices to limit many of their expenses has led to practice expenses increasing disproportionately to income, with the consequence of take-home pay cuts. We believe that the EER has reached a “tipping point”, and while there may be some scope for larger practices in some areas to reap the small remaining efficiency gains, this will be at the expense of patient access and confidence in a local service, which is what our research tells us is desirable.

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/9</td>
<td>0.593</td>
</tr>
<tr>
<td>2009/10</td>
<td>0.597</td>
</tr>
<tr>
<td>2010/11</td>
<td>0.609</td>
</tr>
<tr>
<td>2011/12</td>
<td>0.616</td>
</tr>
<tr>
<td>2012/13</td>
<td>0.625</td>
</tr>
<tr>
<td>2013/14</td>
<td>0.635</td>
</tr>
</tbody>
</table>

Source: HSCIC

76. The impact of the phased removal of the Minimum Practice Income Guarantee (MPIG) and PMS Reviews in England continues to create financial difficulties for a number of practices, with the criteria for financial support being a “cliff edge” £3 per patient, with no graduation. While the BMA welcomes the commitment to helping struggling practices, the Secretary of State’s “New Deal” speech referred to a £10m programme but this simply re-allocated funding from infrastructure investment, thus creating problems in the other key areas of general practice of premises redevelopment. In Wales, BMA Cymru Wales and Welsh Government have agreed a GP sustainability assessment framework to review vulnerable practices viability, particularly in rural and deprived areas. While the BMA has worked with affected practices to obtain some funding support, we have continued to receive details of a number of practices who appear to be financially unviable as a result of funding removal. NHS figures show that over 650 practices have already closed since 2010, and while there are some benefits from larger practices in terms of ability to offer extended access and services, this is at the cost of patients’ travel times and of a direct link to the local community. A Guardian poll suggested that 10% of practices in London could close in the next three years.

77. The Roland Commission report confirms the crisis in general practice, noting that between 2003 and 2013 the number of hospital doctors increased by 48%, while GP numbers only went up by 14%. The number of GPs per head of population has declined since 2009. This is accompanied by a nursing shortage, with the number of community nurses falling by 38% in the decade to 2011. The
Commission makes a number of recommendations around reducing the administrative burden, better use of technology, making greater use of clinical and community pharmacists, but with a strong focus on evaluating alternative models, for instance the use of allied health professionals and relatively clinically unskilled out of hours triage. Importantly, the report stresses the need for continuity of care for patients with multiple long-term conditions and polypharmacy requirements, and the likely need for longer consultations for these complex patients. The declining ability of people to see their GP of choice was a key finding of the report.

78. The BMA’s own national survey of the future of General Practice – with a huge response from over 15,000 GPs - identifies many of the same themes. GPs rank continuity of care as the top factor essential to general practice, with increased core funding, longer consultation times, and reduction in bureaucracy as the top factors that would allow GPs to deliver a high quality service better. The survey also finds that GPs are already joining with networks and federations, but around three-quarters still supported the continuance of the national GMS contract.

79. In our evidence last year, we indicated that the BMA was undertaking some research around GP workload. The GP survey asked about workload, with 37% of GPs reporting that their workload is unmanageable, and more than nine in ten stating that their workload has negatively impacted on quality of patient care, with insufficient time with each patient an issue for 43% respondents. In Northern Ireland, the Department has worked with the BMA NI GPC65 to look at pressures on GP workload, including extracting data from GP IT systems; initial results show that there have been very substantial increases in workload across most types of activity, including consultations, prescribing, and administration. These findings reinforce the DHSSPSNI conclusions that there need to be 46 more GPs trained per year in order to meet gaps in workforce.

- The number of acute prescriptions increased by 28% from 2003/04 to 2013/14
- The number of repeat prescriptions issued increased by 42% from 2003/04 to 2013/14
- The number of test results dealt with by practices increased by 217% from 2003/04 to 2013/14
- Administrative tasks per patient rose by 115% from 2003/04 to 2013/14
- Total consultations rose from 7.2 million in 2003/04 to 12.7 million in 2013/1411. This works out at 6.6 consultations per patient per year, or an increase in overall consultations per patient of 63% from 2003/04 to 2013/14

80. Our research on GP workload that tested the ability to extract workload data from GP IT systems has been overtaken by developments at NHS England and the Scottish Government who are both reviewing the resource allocation formula for general practice (“Carr-Hill” in England, Scottish Allocation Formula in Scotland). This work requires updated measures of activity, so to avoid reinventing the wheel we have passed on details of our research to date to inform these reviews, which are both considering the use of GP systems data as a way of quantifying consultations and other activities in general practice.

81. The government commitment to increasing the workforce by 5,000 GPs is clearly welcome, and GPs are already working to introduce new models of provision. However, as illustrated on the BMA’s recent vision report into a new future for general practice66, it is simply not possible for many of these changes to happen in the immediate term, many will require evaluation before wider rollout, and there will always be some practices that due to their nature and location will require special arrangements. The consequence of this is that over the next few years, GPs will continue to suffer severe workload pressures that some practices and individuals will find unsustainable.
82. In the last DDRB report the Review Body reiterated its request for a large amount of data and evidence around General Practice expenses. In discussions with the national government and the HSCIC through the TSC, the DDRB Secretariat has been provided with more detail on why this level of detail is not possible in the short-term or without potentially significant cost of collection implications (for instance, if this required reviews of practice accounts). It may be possible to review the question of expenses as part of the reviews of the allocation formulae mentioned above, but we are unable this year to provide any further comprehensive detail to assist DDRB around GP expenses.

83. The BMA does however believe it is part of DDRB’s remit, and possible even without this level of granular data, to make recommendations for gross GP practice earnings. As we stated last year, while our preference would still be for some kind of national formula, we reiterate that the previous formula has not worked, but we do believe a crude “rule of thumb”, coupled with consideration of any one-off cost pressures, makes it possible to recommend a gross earnings increase. The table below shows the “shortfall” of DDRB’s previous recommendations against outturn gross and net earnings. Using the Expenses to Earnings Ratio (EER), it also estimates how much a gross earnings recommendation would have needed to be to deliver the net income uplift. This is clearly a very crude estimate, so the figures are for illustrative purposes only and do not constitute a proposed methodology.

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual increase in gross earnings from previous year</th>
<th>DDRB recommendation on gross earnings</th>
<th>Actual increase in net income from previous year</th>
<th>DDRB recommendation on net income</th>
<th>Estimated gross uplift to deliver net income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/9</td>
<td>2.6%</td>
<td>2.7%</td>
<td>-0.7%</td>
<td>2.2%</td>
<td>5.7%</td>
</tr>
<tr>
<td>2009/10</td>
<td>1.6%</td>
<td>2.29%</td>
<td>0.4%</td>
<td>1.5%</td>
<td>2.8%</td>
</tr>
<tr>
<td>2010/11</td>
<td>1.4%</td>
<td>1.34%</td>
<td>-1.5%</td>
<td>0%</td>
<td>2.9%</td>
</tr>
<tr>
<td>2011/12</td>
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<td>-1.1%</td>
<td>No recommendation</td>
<td>No recommendation</td>
</tr>
<tr>
<td>2012/13</td>
<td>1.5%</td>
<td>No recommendation</td>
<td>-0.9%</td>
<td>No recommendation</td>
<td>No recommendation</td>
</tr>
<tr>
<td>2013/14</td>
<td>0.7%</td>
<td>2.29%</td>
<td>-2.2%</td>
<td>1%</td>
<td>3.8%</td>
</tr>
<tr>
<td>2014/15</td>
<td>Data not available</td>
<td>0.28%</td>
<td>Data not available</td>
<td>1%</td>
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</tr>
<tr>
<td>2015/16</td>
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<td>No recommendation</td>
<td>Data not available</td>
<td>1%</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

Source HSCIC. Estimates are calculated by uplifting net income by the DDRB recommendation then scaling up by the EER to calculate the required gross earnings increase.

84. In this respect, we would also draw attention to a couple of cost pressures in 2015/16 and 2016/17. From April 2015 employer superannuation contributions for GP contractors have increased to 14.3% (previously 14%). From April 2016, for GPs who employ practice staff the removal of the contracting-
out rebate will further mean an increase in NICs paid for each employee who is a member of the NHS pension scheme of 3.4% of relevant earnings, as well as increased deductions in their personal income. The new national living wage may also impact on some practices from next April; we are unable to quantify this impact as we do not hold data on practice staff pay rates.

85. GP medical indemnity costs have continued to rise for all GPs, and it is difficult to switch provider without losing some extent of coverage. We do not have a current estimate, but GP Online magazine reports instances of increases of 150%67, and the Family Doctor Association68 reports a small survey showing cost increases around 25% (equating to several hundred pounds per GP) in one year. The Medical Defence Organisations (MDOs) indicate that claims inflation has been rising at more than 10% a year69, which has an inevitable impact on premia.

86. Although the general level of inflation is low, some elements of GP expenses continue to outstrip this, for example the postal component of the CPI shows a rate of 1.3% (to July 2015), and the medical products and equipment component of 2.5%. These are cost pressures as it is not possible to avoid these expenses, for instance confidential patient clinical information can only be sent through the post. The RPIX measure, previously used in the DDRB’s formula, is running at 1.1%.

87. We propose as an alternative to a revised formula a simple approach of looking at the most recently available increase in expenses (from the HSCIC), and the current cost pressures identified here. This is on the basis that general practice has now virtually exhausted its efficiency gains through the additional workload which we have now evidenced (eg in Northern Ireland) and that GPs operate in a competitive environment and thus are incentivised to be as efficient as possible, thus DDRB’s previous concern around the need for an efficiency adjustment is not now relevant.

88. We also ask that the Review Body continues to make recommendations around increases to the GP trainers’ grant, which currently stands at £7751, which we believe should increase at least in line with the overall contract recommendation. In addition, NHS England now holds all the GP appraiser contracts in England70; the amount has not been increased in many areas since appraisal was introduced in 2004, so we ask DDRB to make recommendations for increases to this amount going forward.
Conclusions

89. The BMA has become increasingly concerned about the ability of the DDRB to exercise its independence. We ask that DDRB is not constrained by any remits it may receive this year when making its recommendations, and we ask additionally that the Review Body challenges the affordability part of its standing remit.

90. We believe that doctors are being unfairly punished by government when pay rises above 1% are 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.

91. We believe the NHS is facing a significant recruitment and retention crisis across the UK, which will only be worsened by low or zero pay increase. We continue to believe that there is a national (and international) market for doctors so we are seeking a common recommendation for all branches of practice and all nations.

92. We believe it is within the DDRB’s remit to make a gross earnings recommendation for GPs, and we suggest using the latest available expenses data from HSCIC and current cost pressures as a guide to setting this.

93. Finally, we ask that DDRB reviews the London weighting again this year, as it has not kept pace with inflation and specifically the excess costs of living and working in London.
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