BRITISH MEDICAL ASSOCIATION

MEMORANDUM OF EVIDENCE TO THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

SEPTEMBER 2013

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Background

1. The Chief Secretary to the Treasury wrote to the Chair of the Review Body on Doctors' and Dentists' Remuneration (DDRB) on 23 July 2013 setting out the high level context for the public sector 2013/14 pay round, and specifically for England that the Government will continue with its policy that pay awards should average 1 per cent applied to basic salary.[1]

2. The Department of Health in England has subsequently written to the DDRB Chair on 3 September 2013 to set out its remit on doctors' remuneration for 2014/15.[2] The Scottish Government has also just written to the Review Body Chair on 24 September 2013,[3] though this does reflect the previously issued Public Sector pay policy.[4] The other UK nations have not at time of submission set out their remit for doctors' remuneration.

Overarching BMA view

3. The BMA continues to disagree with the instructions from the Government to the Review Body in relation to a continuing cap on pay, and wishes to put on record yet again that it is inappropriate to restrict the Review Body in this way. The Review Body's remit obliges it to take account of the economic climate, thus it is unnecessary to impose restrictions, which limit consideration of any structural changes surrounding the pay and conditions of doctors.

4. While the Scottish public sector pay policy does not directly apply to the NHS, the Scottish Government's remit letter does state that it is intended to inform considerations around pay for NHS Scotland staff. The BMA is pleased to see the removal of the pay freeze in Scotland on those earning over £80,000, but is disappointed that it has not been possible to move beyond the current 1 per cent cap on annual increases in pay bill costs.

5. We also disagree with the English Department of Health's additional consideration around incremental pay in its remit letter. This does not form part of DDRB's existing core Terms of Reference, and we maintain that pay progression is an issue for contractual negotiations. Further, as we noted in our supplementary evidence to DDRB last year, we do not accept that a majority of doctors receive incremental pay in practice.

6. The BMA is especially concerned about the Department of Health's decision not to accept the DDRB's recommendation on GP gross earnings last year, and the similar decision by the Scottish Government to uplift these by the lowest amount of all the UK nations. This will again, in the BMA's analysis, lead to GPs facing another year of pay cuts in their personal net income. We do note that for this year, DDRB has been invited to make a recommendation on gross earnings for practices, which we welcome.

7. While we understand the economic context, we are extremely concerned that the erosion in the real value of contracts for doctors due to relatively high levels of inflation but low or zero awards and changes to NHS pensions over the last few years, as well as widening differentials with comparator professions, has now reached a critical point.

8. Further, we believe that the performance of the NHS, and in particular patient outcomes and satisfaction with the NHS, has not declined and in many cases has improved since last year, despite the cuts in funding – though there are a number of warning signs that this is not sustainable. The BMA considers therefore that doctors should not face a further cut in real income this year, in recognition of their part in maintaining a quality health service despite the upheaval from re-organisation and continually rising demand. **The BMA therefore is seeking an increase in line with inflation on this occasion.**

9. The current rate of inflation on the Government's preferred measure Consumer Price Inflation (CPI) is currently 2.7 per cent. The Retail Price Index (RPI) is currently 3.3 per cent (August 2013).[5]

10. DDRB did ask parties to consider whether there should be a differential uplift, for instance to address recruitment difficulties in emergency medicine, general practice and psychiatry. In the absence of clear research that differential pay will significantly improve recruitment and retention for particular groups, as well as the continuing lack of comprehensive vacancies data, **the BMA is again seeking that any increase be applied equally to the net incomes of all doctors.**

11. We would also confirm that the BMA considers it imperative that the DDRB to make recommendations for both individual GP income, and also for practice gross earnings, such that GP expenses are fully funded to deliver the same net income increase as for other doctors.

12. For the sake of avoidance of doubt, the Chief Secretary made clear in his letter to the Review Body that there should be no new centrally determined local pay rates or zones. The BMA strongly rejects attempts to introduce local market facing-pay for doctors, and continues to believe that a national contract with independent pay recommendations represents the most efficient, effective and beneficial approach for the NHS, for patients and for the profession. We believe the disbanding of the South West Pay Consortium in March 2013 reinforces the national nature of the market for doctors, and the need for national contracts.

13. The 2013 Spending Review has created concerns for the BMA as the 2014 baseline NHS budget for England appears to be £1.4 billion lower than previous Government statements have suggested, with no clear explanation from the Treasury for this discrepancy. This may reflect return of anticipated overspends to the Treasury, or form part of the planned shift of funding to local Government, but regardless the BMA is concerned that this will lead to even greater pressures on staff with a consequent demotivating impact. With regard to the planned shift of funding to social care, we note that £3.8 billion pooled budget represents in effect a real terms cut to the NHS allocated budget, with as yet no clear evidence to support the cost-effectiveness of this shift nor an impact assessment of the removal of funding from NHS organisations. Scotland similarly plans a shift of funding of £100 million towards prevention services.

14. Further, while the overall increase in the NHS budget for England will be 1.9 per cent with an expectation of 1.8 per cent inflation (based on the GDP deflator which typically is lower than other inflation indicators such as CPI or RPI), recent history has shown that inflation has frequently exceeded expectations, so there is a considerable risk that the English NHS may actually face a real terms cut. Moreover the choice of inflationary indicator is of key importance here: different staff groups face different patterns of expenditure (e.g. lower income groups typically spend a higher proportion of their earnings on fuel), so even if the overall NHS budget does increase at a macro level, for an individual doctor they may face a disproportionately high pay cut.

15. The Scottish draft budget shows a growth in the health DEL of around 1 per cent for the next two years, which is significantly below inflation, so the Scottish NHS will face a further real-terms cut in funding.[6] The position in Wales will be worse still, as the overall Welsh Government budget for the same period has been cut by 2 per cent in real terms, so the NHS will inevitably face a real terms cut also.[7]

16. The NHS continues to struggle to achieve efficiency savings, for instance the Kings Fund Quarterly Monitoring Report suggests that only 14 per cent trust finance directors are confident about achieving their savings plans for 2013/14.[8] The Francis Inquiry and the Keogh Report however suggest that staffing levels should not be traded off against quality, and that a culture of self-interest has put financial balance above patient care. Clearly the BMA does not condone poor care, but we believe the solution to the NHS' problems lies with an engaged and supported workforce which is empowered to provide a quality service to patients. We agree with the NAO's recent conclusion that "sustaining the savings made through pay restraint may….have a detrimental effect on staff morale and productivity".[9]

Scope of evidence

17. The BMA's evidence for this round is more limited in scope than previous years. This is for two main reasons:

- The need for more in-depth research, for instance in areas proposed in DDRB's last (Forty-first) report and subsequent correspondence from the Secretariat, than can be delivered within the usual timetable for submission of evidence, or through simple surveys as previous years' BMA evidence have employed.
- The context of national contract negotiations for UK Junior doctors and Consultants (in England and NI), whereby a new contract or contractual variation may obviate DDRB's request for evidence in a number of areas (and evidence submitted may theoretically cut across negotiating positions).

18. Our evidence will not therefore cover the following issues which were raised by the DDRB as items of interest, as these will all potentially form part of formal contract negotiations over the coming year:

- Clinical Excellence Awards, including diversity monitoring.
- Age and gender equality issues around different elements of contracts (e.g. pay progression).
- Banding supplements for juniors doctors.
- Recruitment premia.
- GP specialist registrar supplement.

19. The BMA does however strongly support the DDRB's desire for more research in a number of areas, and proposes that immediately following the publication of the report in early 2014, if not before, we agree a programme of research of mutual interest which will inform future years' submissions. This is additional to existing planned or potential BMA in-house research, which notably will include:

- A study on GP practice workload (Winter 2013/Spring 2014), to update the last research done in this area from 2006-2008.[10]
- A survey of Consultants workload (Autumn/Winter 2013).

20. The implications of any significant divergence between the four nations in the UK, that may result from differential Government policy and contract negotiations - albeit still within a national contract structure - will be included as part of our evidence for next year.

21. Additionally, but without making any commitment, the following topics may be of interest to the BMA for further longer-term research:

- The link between motivation, performance and different forms and levels of reward, particularly building on the evidence included here around outcomes (clinical and patient experience) and considering the asymmetric effect of a pay rise against a cut. This research might also usefully consider recruitment and retention issues in certain specialties and remote geographical areas, and would link to the second bullet below.
- The "value added" of non-direct patient contact time, both for hospital doctors (e.g. consultant and SAS doctor SPAs and CPD time) and GPs (contractor/provider and sessional), in terms of innovation, research activity, professional development, quality and outcomes. This might also consider whether and how this can be related to productivity, again looking at the asymmetry of reducing this time against maintaining it.

- The scope to make and measure efficiency and productivity gains in the context of ever increasing patient demand and need but within a fixed NHS budget, again for both hospital and general practice (but noting the different nature of primary and secondary care contracts).
- Specifically for GPs, a more systematic review of expenses out of the direct control of practices with a view to identifying practice specific inflation indicators, and reviewing the DDRB's formula for making its gross earnings recommendation.

22. These topics largely concur with the previous DDRB report and subsequent correspondence from the Secretariat, but we do not believe it is possible to produce a robust piece of research on the original timescale proposed by the Review Body.

Contract erosion

23. As we argued last year, the value of doctors' remuneration continues to fall in real terms, due to Government imposed below inflation settlements, as shown in the following figures 1 and 2[11] which are in 2008/9 prices.

Figure 1 – Inflation-adjusted mean annual basic pay

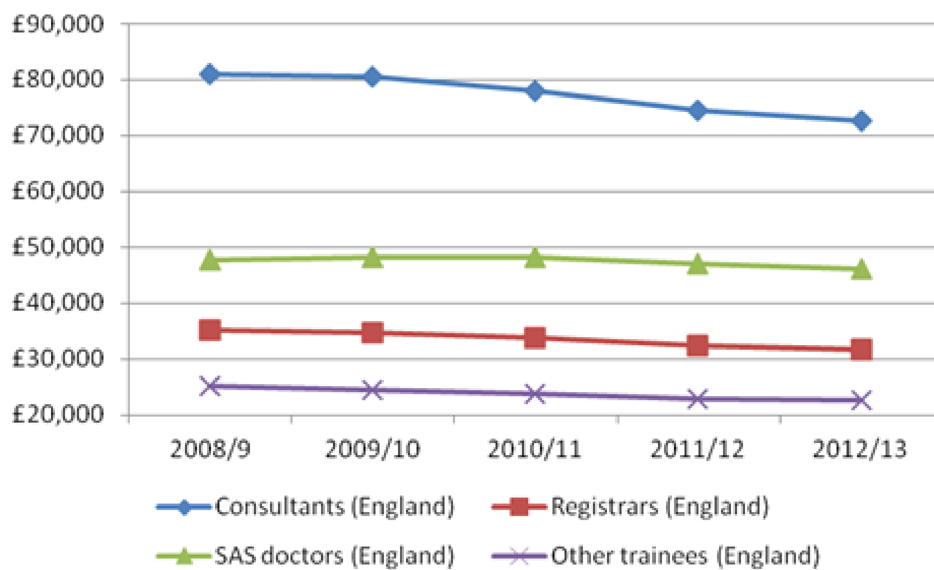
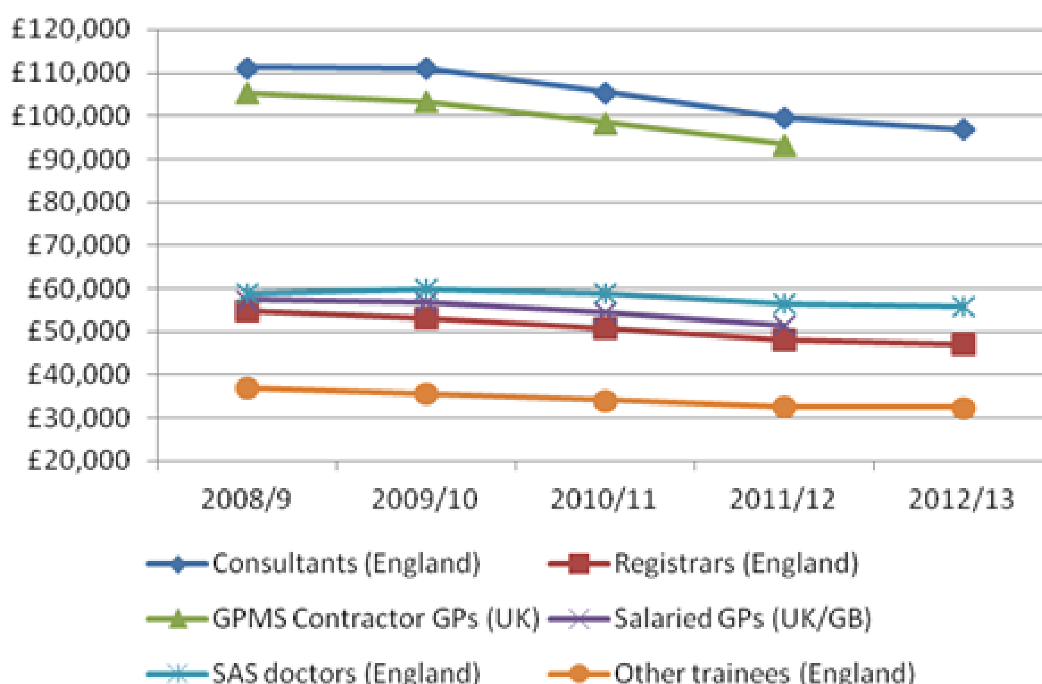


Figure 2 – Inflation-adjusted Mean annual earnings / GP income before tax



Source: HSCIC

24. The charts show a fall in average income adjusted for inflation of around 13 per cent for consultants between 2008 and 2013, 13 per cent for doctors in training, 5 per cent for SAS grade doctors, and 11 per cent for GPs (to 2012). For junior doctors, the decline in the proportion of earnings coming from banding supplements continues to fall, reinforcing the decision to enter contract negotiations for this group. Similarly for consultants, their real earnings are now below the level they were in the first year of the new contract a decade ago.

25. We believe a similar pattern of continuing pay erosion applies to other groups, including medical academics and public health doctors, where the nature of their contracts and career paths means that these doctors are often further disadvantaged across their lifetime against trust employed doctors, which will ultimately lead to recruitment and retention problems.

26. We have further looked at other earnings data, which are currently showing recent pay settlements centred on 2.5 per cent (May-July 2013, source IDS August 2013), or 2.1 per cent on the official average weekly earnings total pay indicator (April-June 2013, source ONS Labour Market Statistics August 2013). We note too DDRB's own analysis that doctors continue to fall behind the legal and actuarial comparator professions. We would further note that last year's recommendation was set in a climate of inflationary expectations of 1.9 per cent CPI, which has clearly been exceeded over the year. Taking all this together, we consider an increase in line with CPI (currently at 2.7 per cent at August 2013) as the minimum for this year.

27. Again, further increases to pension contribution rates and a reduction in the annual allowance in April 2014 will reduce doctors' take home pay and potential lifetime remuneration still further. There are big disparities in the proportion of the overall scheme benefits that members fund in the different public service pension schemes. For example, after April 2015, NHS staff will overall fund almost double the proportion of their scheme's future benefits compared with civil servants. Contribution rate tiers are higher and steeper for NHS Pension Scheme members. The BMA continues to lobby Government on this unfairness and will update the DDRB with any progress, but we would ask that any recommendation takes into consideration planned pension changes.

28. As illustration of this, a junior doctor aged 25 (with an expectation of gaining a consultant post) can expect to receive a pension of about 16.5 per cent less under the new 2015 section of the NHS pension scheme, than if they had been allowed to remain in the 1995 section. Further, their pensionable age would rise to 68, so they would draw their pension for 8 fewer years. On top of this, their career contributions would increase by 2.25 times from the rates that were in place prior to 1 April 2012.

29. It should also be noted that for those grades which are not engaging in negotiations, including Staff, Associate Specialists and Specialty doctors, there may be limited opportunities outside of standard pay progression. Thus, while recent and ongoing pension reforms will have a detrimental impact on lifetime earnings and take-home pay (exacerbated as higher earners pay tiered higher contribution rates) for all doctors, with no contract negotiations on the horizon the importance of an inflationary uplift is even more necessary for these groups.

30. As of 1 April 2013, GP practices in England and Wales have additionally become responsible for the employer's pension contributions of the locums they engage. These payments had, until then, been made by Primary Care Organisations (PCOs). While some funding has been transferred from PCO budgets into the GMS Global Sum Equivalent part of the practice budget, this takes no account of the actual use of locums by a practice. As such, small and single-hander practices are likely to be unfairly affected, as they have limited scope to reduce their use of locums. Furthermore, PMS practices have not yet received the money, so this reflects a real pay cut to them. The DDRB is asked to note this unfairness, which the BMA continues to monitor and lobby Government about, as it may impact significantly on practice expenses and hence GP income in future years.

31. We would draw the DDRB's attention to the continuing suspension of distinction awards in Scotland, which we believe will reduce the ability to recruit and retain consultants, as well as breaking parity with the rest of the UK. In Northern Ireland, secondary care doctors face two issues of relevance to DDRB: the 1 per cent pay rise for last year has not yet been applied to secondary care doctors, so even with backdating this means NI hospital doctors will have taken a greater real terms pay cut than the rest of the UK; furthermore, while CEAs have now been unfrozen in Northern Ireland, there is in effect now a two year funding gap which places NI at a significant disadvantage against England consultants if this is not funded. We would ask the DDRB to consider this imbalance, and we will update the Review Body on this, alongside contract negotiations progress reports.

32. We would therefore ask that the Review Body considers the record of previous years' implementation of their recommendations, and whether a higher recommendation this year is justified in light of both Government rejection of the Review Body's recommended uplifts, and whether the recommended increases were actually achieved in practice. While we would argue that the implicit "value" of a doctor has declined as a consequence of this inflationary contract erosion over the life of the various contracts, in seeking an at least inflationary uplift (2.7 per cent for CPI or 3.3 per cent for RPI) this year, we are asking DDRB to recognise that the value of a doctor as understood by them has not diminished since the Review Body's last report.

Contract negotiations

33. NHS Employers and the BMA have held exploratory talks about a new contract (or contract variation) for junior doctors (for the UK) and Consultants (for England and Northern Ireland; Scotland and Wales are not currently engaged in talks). These talks have led to jointly agreed "Heads of Terms" which would form the basis of any formal negotiations.[12]

34. The Junior Doctors Committee (JDC) of the BMA agreed in July 2013 to enter formal negotiations with NHS Employers and employer representatives in the devolved nations to develop a new contract for doctors in training. The move follows analysis of feedback from junior doctors and final

year medical students on key employment issues. JDC has given its negotiating team a mandate to enter negotiations based on the heads of terms document. Negotiations will start in the Autumn, and the BMA will update DDRB as these negotiations progress, where possible.

35. The Consultants Committee (CC) of the BMA also agreed in September 2013 to enter formal negotiations, covering England and Northern Ireland. There was strong support for maintaining a nationally negotiated contract, and important messages around the value of SPAs and the need to preserve or enhance this time. Negotiations are likely to start once NHS Employers has secured a mandate to negotiate from the Government. As with doctors in training, the BMA will update DDRB where possible on progress with negotiations.

36. As noted, Staff, Associate Specialists and Specialty doctors are not engaged in contract negotiations. The General Practitioners Committee (GPC) of the BMA is engaged in the usual annual negotiations with NHS Employers on contract changes for 2014, following the imposition by Government of significant changes to the GP contract in 2013. These negotiations will cover England and extend in part (clinical QOF changes) to Wales.

37. It is not currently possible to confirm whether negotiations, will reach a satisfactory conclusion, nor the exact timescale. As such, we have assumed no changes to contracts for the purpose of this evidence and review round, and trust the Review Body is willing and able to make their recommendations on that basis.

Recruitment and retention

38. Due to continuing lack of data around vacancies and recruitment and retention in England more generally, we are unable to provide other than anecdotal evidence around these issues this year. There is some data available for Scotland[13] that shows a trend increase in total vacancy rates for consultants, and particular shortages in emergency and acute medicine. However, the BMA is aware of an increasing difficulty in recruitment in rural and remote areas across the whole of the UK, but particularly in the devolved nations, and particularly for General Practice. Similarly, we have limited evidence from the Medical Schools Council that recruitment and retention into an academic career is becoming increasingly difficult, both for doctors employed in the universities and in the NHS, but also academic trainees.

39. The shortage of emergency medicine consultants is well recognised;[14] while additional Government funding is welcome,[15] this needs to be in the context of wider system change, and the capacity of doctors to contribute to this given their current and increasing workloads. There is no short-term solution to the A&E shortages, as at training level the competition ratio for A&E medicine is well below one (i.e. more training places than applicants), and only at 1.4 for intensive care,[16] which means there will not be an expansion in trained doctor numbers in the near future.

40. Similar future problems are likely in other specialties, particularly psychiatry (and within that, old age psychiatry which is particularly concerning with an ageing population,[17] rehab medicine, and general practice. While 2013 fill rates are not yet publicly available, we understand from Health Education England that there are significant shortages across the training specialties of psychiatry, emergency medicine (Round 1 fill rate of 39%), and small specialties such as nuclear medicine.

41. BMA Cymru Wales has undertaken in June 2013 a small survey (currently unpublished) around GP recruitment. This does provide clear anecdotal evidence that around one quarter to one third of practices receive zero applicants to advertised posts, and the number of applicants to posts has fallen considerably compared with even five years ago. The survey also indicated that recruitment difficulties were perceived as more acute in the more rural areas of Wales. Alongside these headlines, further anecdotal evidence suggests that there is a fixed pool of locum cover, such that practice vacancies cannot be filled through temporary cover, and the competition ratio for places in

GP training are the third lowest for any specialty[18] so problems will continue to worsen as more GPs retire or quit.

42. We have specific examples of recruitment problems across all the nations. In Scotland, we are aware of practices that will become unviable as a result of being unable to recruit GPs, with remuneration and antisocial hours commitment being offered as explanations for this. In Wales, we understand that around half of the GP partnerships in the Llyn Peninsula are unfilled, some for as long as two years. In Northern Ireland, it has now become impossible to get locum cover without three months notice, which is having significant impact on small practices.

43. The Seventh National GP Worklife Survey[19] has found that more than half of GPs aged 50 or over now expect to quit direct patient care within five years, driven by the lowest level of job satisfaction since 2001 and highest reported levels of stress since 1998. That survey predates the contract imposition, so the BMA undertook a survey of GPs (over 3600 responses,[20] specifically around the imposition, that showed when compared to a year ago, GPs report worsened morale and having to work harder to deliver quality patient care. A similar survey (750 responses) showed that 77 per cent GPs say working in general practice has become more stressful in the past year.[21]

44. Clearly the relationship between recruitment and retention, workload, and remuneration is complex, but we believe even this anecdotal evidence reinforces our view that the NHS has now reached a critical point in some specialties and some rural locations, and we expect this to continue to worsen.

Patients at the heart

45. In addition to the contract erosion argument, we have tried this year to support our claim with a wider range of NHS performance and outcomes measures, particularly those which relate to the patient experience and safety, and where there is a link with doctors' interventions, including greater consultant involvement and direct clinical supervision of trainees.

46. We do believe however that this needs to be a longer-term research project, so while the measures included do support a position of improving (or at worst static) outcomes and quality, and in turn therefore support an increase in line with inflation, we make no claim that these should be seen as definitive or with a quantifiable causal relationship with the work of NHS doctors.

47. As well as difficulties in attributing outcomes to direct interventions by doctors (and teams they lead) specifically, much data is only available with a significant lag, so it hard to conclude this is fully reflective of current performance. For instance, while even a frequently quoted outcome measure like mortality rates appears to be falling, there is no national comprehensive data beyond 2010 currently available. This is true for most of the indicators in the NHS Outcomes framework, where latest data is mostly for 2011/12 if not before.[22]

48. Similarly, the most recent productivity data from ONS relates to 2010, which is outside the period of relevance here, as well as not distinguishing the contribution of the medical profession from the wider healthcare system.[23]

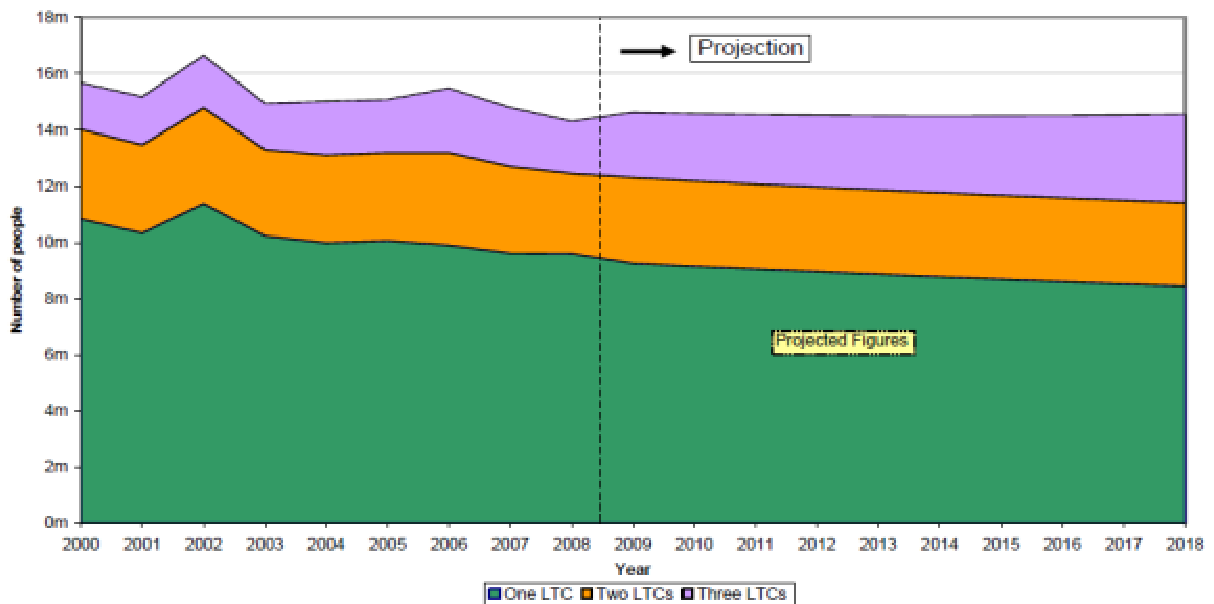
49. The NAO similarly use out of date figures,[24] as well as a crude non-quality adjusted measure, for consultant productivity. For information, the data to 2010 shows a very slight decline in productivity (0.2 per cent per annum) which when quality adjusted would suggest no change or a slight improvement, but without more recent years' data it is difficult to conclude further. We would additionally note that a focus on these relatively crude measures of "productivity" may be counter-productive in improving quality as they create a perverse incentive to increase certain types of activity (inpatient and outpatient FCEs, and A&E attendances) at the expense of increasing quality through for instance being seen by multiple consultants at a "one stop shop" visit or A&E

attendance, or being treated at home (e.g. IV antibiotics) which reduces length of stay and attendance but appears to lower productivity.

50. There is however the start of some evidence around growing demand for healthcare, as a result of increasing patient expectations and patients presenting with multiple morbidities. This has both increased the number of contacts, but also the complexity and intensity of these. As noted, the BMA is undertaking a longer-term research project around this in primary care (early feedback from focus groups has confirmed these trends anecdotally), but there are some independent studies of patient demand, which when coupled with evidence on outcomes can be used to show that doctors are continuing to add the same or greater value but for less money.

51. The Department of Health shows that 53 per cent of people report that they have a long-standing health condition, and that the number of people with multiple long-term conditions (LTCs) has risen and will continue to rise (Figure 3).[25] People with LTCs are the most intensive service users, so will require more and longer contacts with all parts of the healthcare system.

Figure 3 – Actual/projected numbers with one or more long-term conditions by year and number of conditions



Source: Department of Health projections (2008 based)

52. Looking at hospital activity, HES data for England shows a small increase in total inpatient finished consultant episodes (FCEs) of 1.5 per cent between 2011/12 and 2012/13.[26] For outpatients, the growth was 2.7 per cent over the same period, and for A&E attendances 4.1 per cent.

53. This growth in activity, complexity and intensity, has not been achieved at the expense of patient satisfaction or outcomes, which therefore supports our argument for an inflationary increase this year. As stated, a fuller research project would provide a more robust justification for choice of indicators, but the selection below are typically considered as a good benchmark of health service performance or attitude towards doctors.

54. Public satisfaction with the NHS shows a static or slightly improving position, though there are difficulties with interpreting much of this kind of data as it often conflates several dimensions, such as clinical quality with hotel services with cleanliness. The British Social Attitudes Survey for 2013[27] shows an overall level of satisfaction with the NHS of 61 per cent - the third highest on record and

a slight rise from the previous year - and below that headline, satisfaction levels of the relatively high figure of 74 per cent for general practice, 64 per cent for outpatients, and a significant rise to 59 per cent for A&E. Only inpatients showed a small decline to 52 per cent. The survey also supports continued spending on the NHS, with over 70 per cent respondents placing health as first or second priority for extra Government spending.

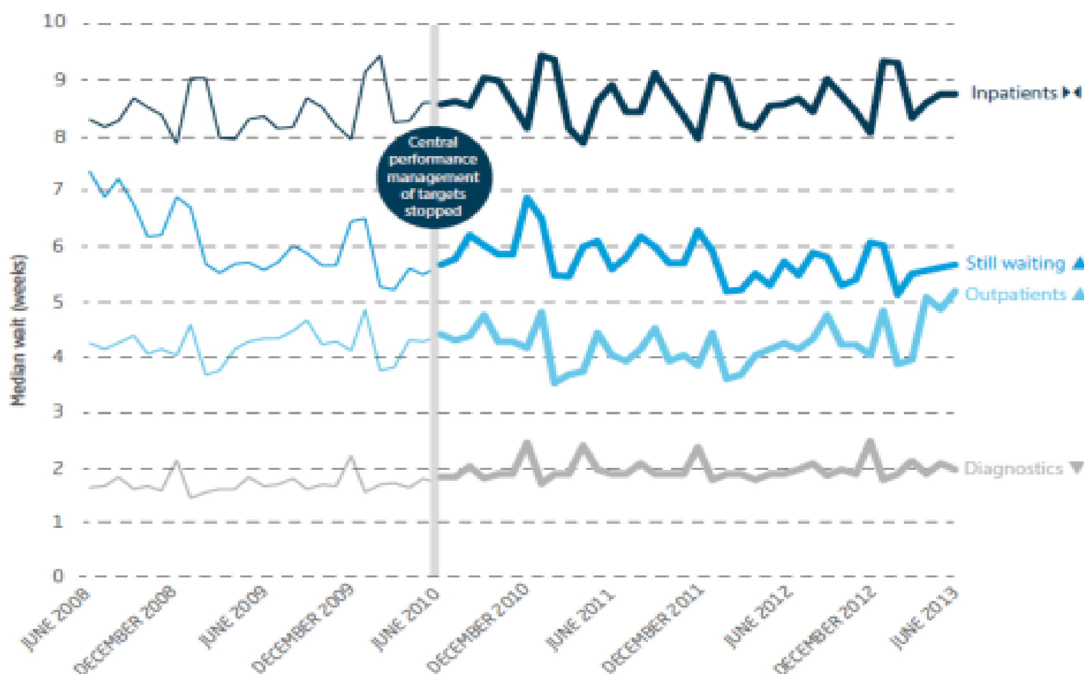
55. Ipsos MORI undertakes a regular poll of public trust in various professions.[28] The most recent results from February 2013 show that doctors remain the most trusted profession (89 per cent up one percentage point from the previous survey in 2011). The BMA has also commissioned (currently unpublished) research from ICM, that shows a majority of the public believe doctors have their best interests at heart, with satisfaction in GPs and local hospitals running at 68 per cent and 57 per cent respectively, but considerably higher for those respondents who actually have had direct experience of using the NHS within the last year.

56. The NHS Inpatient survey administered by Picker is similarly a year old[29] but shows an improvement between 2011 and 2012, with the majority of respondents saying that doctors: "always" answered their questions in a way they could understand (68 per cent, up from 67 per cent in 2011); did not talk in front of them as if they were not there (75 per cent, up from 73 per cent in 2011); "always" had confidence and trust in the doctors that were treating them (80 per cent a statistically significant increase of less than one percent from 2011).

57. The latest GP survey (Ipsos MORI for DH March 2013,[30] confirms this level of satisfaction with 93 per cent patients having trust and confidence in the GP they saw and 87 per cent describing their overall experience of GP surgery as good, largely unchanged from the year before.

58. With regard to access, although this is less directly under the control of doctors, trends in waiting times have remained generally constant despite seasonal fluctuations (Figure 4,[31] although A&E waits have shown a recent breach in the target – though the explanation for this does not lie with a failure of General Practice as the Government has attempted to argue.[32] In Scotland, doctors have delivered the 12 week legally-binding target for treatment.

Figure 4 – Waiting times: Median wait (weeks)



Source: Kings Fund (from NHS England data)

59. With regard to outcome measures, it is extremely difficult to separate out the contribution of doctors, not least as many reflect patients' wider environment so factors such as housing and lifestyle are arguably more important than direct medical interventions.

60. Examples of outcomes include patient reported measures (PROMS),[33] survival rates (not available post 2010, though they do show an improving trend), and healthcare associated infection rates. The PROMS data in table 1 shows a stable position since 2011.

Table 1

% improved (using EQ-5D index)	2011/12	2012/13
Groin hernia	49.8%	49.7%
Hip replacement	87.3%	87.3%
Knee replacement	78.4%	79.4%
Varicose vein	52.7%	53.2%

61. For healthcare acquired infections (Figures 5 and 6), there is a trend decline in counts.[34 35] These are a good measure of the quality of patient care, and are sensitive to financial pressures, so imply strong clinical input in their reduction.

Figure 5 – Mortality rates for deaths mentioning Clostridium difficile, England and Wales

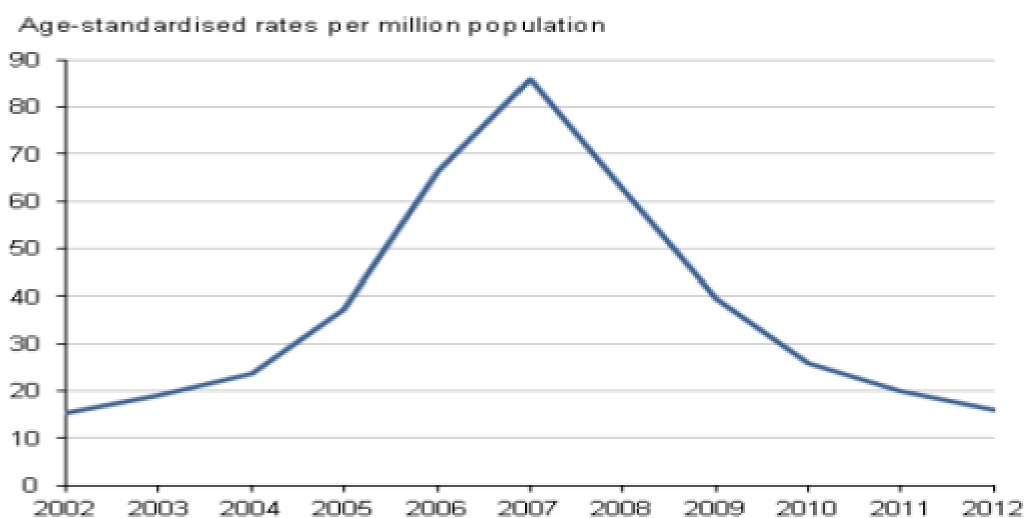
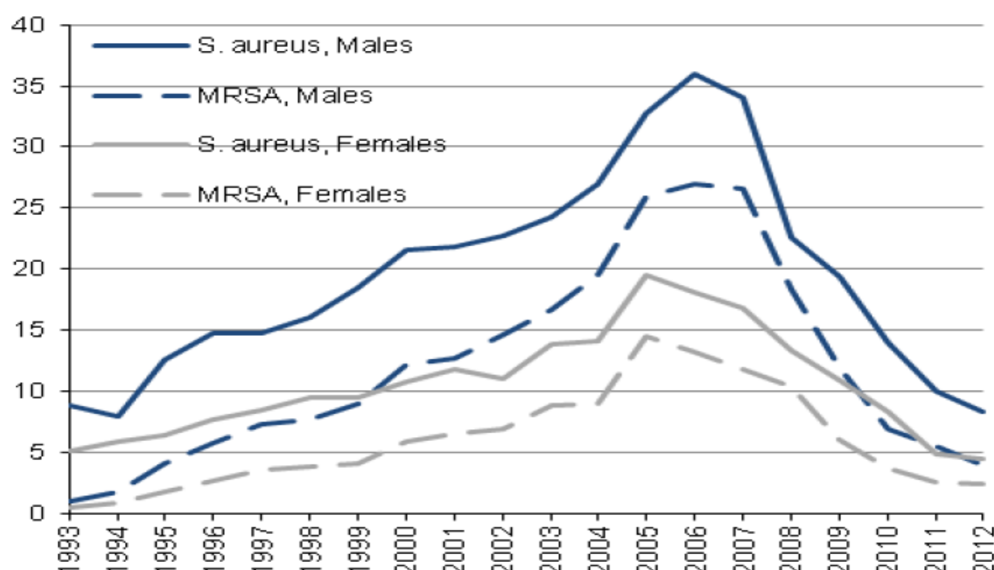


Figure 6 – Age standardised mortality rates for deaths mentioning staphylococcus aureus and MRSA, England and Wales



Source: ONS

GP contractors

62. As in previous years, we wish to place on record our strong agreement with the Review Body that it is unnecessary and inappropriate to apply efficiency savings to the Review Body's formula for the contract uplift for GMPs. We believe that GPs have delivered substantial efficiency savings already in addition to actual cuts in take home pay. The trend increase in the Expenses:Earnings Ratio (EER) in table 2 that demonstrates that efficiency savings have indeed taken place has continued, as practice expenses have increased disproportionately to income.[36]

Table 2

Year	Ratio
2008/9	0.593
2009/10	0.597
2010/11	0.609
2011/12	0.616

63. This trend has been supported by a recent (September 2013) BMA survey of GPs around last year's contract imposition.[37] The survey received 3,629 responses, and showed that nearly 90 per cent expected their practice funding to decline as a result of the imposition, and a similar number expected their practice expenses to increase, which together will mean that GPs will be unable to earn the DDRB's recommended uplift in their personal net incomes.

64. On the subject of the Review Body's gross earnings formula, we provided some initial thoughts on possible revisions to the formula as part of additional evidence to the Review Body in the last round. We would reiterate here our absolute belief that the DDRB continues to make a recommendation for practice gross earnings, and note our disappointment that the Government chose to not accept the Review Body's recommendation from last year, but imposed a settlement that we believe will prove insufficient for GPs to be able to achieve the individual net income recommendation (of 1 per cent). The BMA would like to work with the DDRB over the next year on a research project that will identify the most accurate measures of expenses inflation to include within a revised formula.

65. We would for this year wish the DDRB to continue with the formula, but using the most recent data from the Information Centre on Investment in General Practice and GP Earnings & Expenses reports to calculate the co-efficients (not least as the current EER now exceeds the "norm" of 0.6 in the original formula). We believe other parties should be amenable to this.

66. In the absence of any detailed source of information on staff expenses inflation, we agree with DDRB that a publicly available indicator such as Annual Survey of Hours and Earnings (ASHE) or Average Weekly Earnings (AWE) is a more appropriate measure than the previous version of the formula that used the Agenda for Change (AfC) Pay Review Body recommendation, when only a small proportion of practice staff are on AfC terms. The BMA does not currently have access to a large enough sample of time-series practice data to suggest whether an alternative indicator might more closely match actual staff expenses growth, so for this round we would ask the Review Body to use the ASHE measure as per last year's recommendation.

67. We remain concerned that the use of RPIX as the inflator for non-staff expenses underestimates the actual cost increase. We are not able to propose a single measure that would provide a figure more closely related to the level of inflation we believe practices currently face, so are willing to retain the use of RPIX for this round.

68. We would however like to propose to DDRB that we work together to consider whether a more bespoke measure that takes into account more accurately those costs which are largely outside the control of GPs (at least in the short to medium term). In particular, members have indicated that utilities costs (gas, electricity), stationery and postage, and professional subscriptions and insurance, are areas that are difficult if not impossible to reduce and which face cost rises above general inflation, as well as an increasing volume of activity.

69. There are additionally some new areas of expenses that are adding to practice cost pressures. Locum employer superannuation was mentioned earlier as a particular issue for small practices. Trade waste is an area of contention: the BMA believes that this should be a directly reimbursable expense as it was formerly rolled into the heading of "business rates" which were met by PCOs, but this was not the position consistently across the country, and NHS England has now decided it should not be reimbursed, even though disposal of confidential waste is something practices are obligated to do by the terms of their contract.

70. The 2013 Premises Directions have also created a potential cost pressure, as non-GP tenants using practice premises now need to pay full market rent under a formal full repairing and insuring lease, not just the licence to occupy service charge many previously paid. This has made GPs now liable for stamp duty land tax, even though the facility is primarily for their NHS use.

71. To support the anecdotal and practice accounts based indicators, we have looked at the breakdown of the Consumer Price Index, as this is calculated from a basket of goods and services.[38] It is therefore possible to quantify at a national level those areas of expenditure that practice accountants have indicated higher than general inflation, which are largely outside of practice control, as in table 3 overleaf. Without further research it would not be possible to create a bespoke index that reflects a typical pattern of practice expenditure, but certainly the utilities growth of over double general inflation does argue for a higher than CPI uplift for expenses.

Table 3

CPI component	Inflation rate 2013 (July)
Electricity / Gas	8.0%
Water	5.5%
Maintenance & Repair	2.5%
Postage	18.4%
Overall CPI	2.8%

72. GP medical indemnity costs have also risen by over four times the rate of inflation in 2013, with an average annual premium of nearly £7,000 for the average GP partner.[39] Medical Defence bodies have provided figures showing current average annual indemnity costs had risen by 13 per cent for partners and 12 per cent for salaried GPs, even though the current rate of inflation is 2.7 per cent. This is higher still for those GPs who undertake special interest including out of hours work, as this is perceived as more risky. Medical defence bodies defended the indemnity costs rise, pointing to the rapid rise in the number of legal claims, which according to the Medical Protection Society was up by 40 per cent in 2012.

73. The DDRB Secretariat additionally asked for some detailed information around GP earnings and expenses. Much of the requested data is available from other parties or published sources.[40] We were unclear as to the purpose for some of the requests (for instance references to the previous GMS contract), and some information is not available from any source, for instance time spent on private practice - though anecdotally we believe this to be extremely low. We would be pleased to discuss practice funding with the Review Body further, but we do not believe it is necessary to provide this detail in our evidence submission.

74. While we have no new evidence around GP trainers' workload, we would re-iterate our previous concerns around recruitment, and the need to ensure a sufficient number of trainers to facilitate an expansion in GP numbers. While the BMA is represented on a Department of Health group looking at a tariff based education and training system for primary care, we do not expect firm proposals in the immediate future, so would ask the Review Body to recommend at least an inflationary uplift in this grant for this year.

75. The Review Body asked for information on skill-mix. There is limited data available from the Information Centre on this and only at a high level of aggregation,[41] but there appears to be no clear picture on skill-mix changes in recent years. Table 4 overleaf is based on England only Full-Time Equivalents as many practice staff work on a part-time basis, though we do have some concerns around the accuracy of this data. As there are no clear trends other than the well-known shift in the balance between GP contractor partners and salaried GPs, we have not reworked the analysis for the other countries.

Table 4

FTE	2010	2011	2012
GP Providers	24,394	24,415	24,095
Other GPs	6,962	6,976	7,483
GP Registrars	3,718	3,784	4,138
Practice Nurses	14,644	14,797	14,695
Other practice staff	68,158	69,812	70,851
Nurses per GP	0.42	0.42	0.41
Other staff per GP	1.93	1.98	1.98
Other GPs per Provider	0.29	0.29	0.31
Registrars per Provider	0.15	0.15	0.17

76. We would however like to inform DDRB of the data quality sub-group of the Technical Steering Committee (TSC) that has been established recently to examine the sources of data on funding streams into general practice, in order to inform the Information Centre's publications (GP Earnings & Expenses, Investment in General Practice). This will include consideration of whether and how GP income from CCGs should be monitored, as well as looking at how the Enhanced Services funding streams will flow (a concern as more practices may now have to compete for LES contracts) so we will update DDRB on this as the work of the group proceeds.

Conclusions

77. The BMA continues to value the independence of the Review Body and submits this evidence in a fully open and co-operative manner. We believe strongly that the Review Body should not be constrained by a Government's imposed pay cap, and would ask that DDRB considers how their previous recommendations have been actually implemented, when making its recommendations this round.

78. A combination of continuing contract erosion from general and expenses-specific inflation and against comparators, yet still managing to improve quality in a financially-constrained climate, means that doctors continue to add value to the NHS, and on that basis t**he BMA therefore seeks as a minimum an increase in line with inflation, and asks that any uplift is applied equally to the net incomes of all doctors.**

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