BRITISH MEDICAL ASSOCIATION

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

SEPTEMBER 2014

BMA

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- The BMA strongly rejects the restrictions placed upon the DDRB's role and remit. While the Scottish Government implemented the Review Body's recommendation from its last report in full, the explicit constraints imposed by the Government in England, and probable restrictions in Wales and Northern Ireland, are both unacceptable and unnecessary.

- The BMA has therefore submitted evidence covering the whole of the UK, and is seeking a common recommendation for all doctors wherever they work.

- Contract negotiations are ongoing for Consultants in England and Northern Ireland, and Doctors in Training across the UK. This means that our evidence will not cover issues directly relating to these negotiations.

- We do have some concerns that previous DDRB recommendations appear to have placed greater weight on affordability arguments, being largely in line with public sector pay policy, and would ask that the Review Body considers how its recommendations have been implemented when making this year's recommendations.

- We are concerned that the timescale for submission of evidence has been brought forward this year. This has necessitated other vital publications to also be advanced, and has limited our ability to substantiate some points. We ask that the deadline for next year is not before the end of September.

- The BMA believes that doctors deserve an award in excess of inflation this year. We do not accept the Government in England's pre-announced figure of 1 per cent. We are not however including a specific figure we are seeking by way of a pay increase.

- We are again asking the DDRB to make a recommendation for GP gross earnings as well as for net income. However, the formula previously used has been shown to be not fit for purpose, so we are asking for this recommendation to be made outside the use of this formula.

- We have included some evidence around London weighting this year. This has not been reviewed nor increased for many years, and the London property market and travel costs have risen at a significantly higher rate than elsewhere.

- We have included some case study "vignettes" to illustrate what it is like to work as a doctor in a climate of sub-inflationary pay awards and largely static health service funding.

Content of Evidence

- We warned last year that health services were reaching a turning point, with doctors being asked to work increasingly long hours and more intensely, but without financial and other recognition. We believe that this point has now been reached, with capacity constraints in a number of areas, leading to worsening health services performance, recruitment difficulties, and a short-term focus on activity at the expense of finding sustainable solutions to an overall funding shortfall.

- Contract erosion has continued, with doctors regressing to the financial position they were in 2008 (and earlier in many cases).

- Pay differentials with comparable professions continue to widen, with recent pay settlements exceeding two per cent, and changes to the NHS pension scheme also worsening this differential.

- The BMA shares DDRB's concerns around the availability of data, particularly around vacancies. We have included some limited evidence where this has been possible, but we believe there are increasing signs of recruitment and retention difficulties.

- We believe lack of capacity and lack of recognition have led many doctors to feel demotivated and disempowered. The BMA considers that the only way to ensure a long-term sustainable health service is to engage and involve clinicians in developing solutions that are both clinically- and cost-effective. Cost-cutting and restrictions on, for instance, SPA time, have dissuaded doctors from taking on additional responsibilities, as well as making certain employers, locations and specialties unattractive career choices.

- While the Commonwealth Fund declared the NHS the best international healthcare system overall - which the BMA believes is due to a very significant contribution from doctors – examples of poor performance within the NHS are beginning to emerge, illustrated by the worsening picture around waiting times across the UK.

- For GPs, we note that an increased workload, some contractual changes in England that have reduced funding for many practices, and an inability to avoid certain expenses such as utilities and medical indemnity cover, have meant that GPs have not received the DDRB's recommended increase, even where Governments chose to implement that recommendation.

- We have attempted to revise the formula used by DDRB to translate its net income recommendation into a gross earnings uplift. However, we were unable to identify alternative indicators that produce better results, so this year we are asking to make a recommendation for gross earnings without the use of the formula.

Background and Overarching BMA view

1. The Doctors' and Dentists' Review Body (DDRB) recommendation in its last review[1] of an increase of one per cent for all doctors was accepted in full by the Scottish Government, but rejected by the Governments in England and Wales (with no official confirmation from Northern Ireland on how it will be implemented). This failure to accept the Review Body's recommendations outside Scotland has led to payscales in England, Wales, and Northern Ireland falling behind, which could worsen recruitment difficulties should this be repeated.

2. It appears that the DDRB has again had its remit restricted this year in England. The Chief Secretary to the Treasury wrote to the members of the DDRB on 31 July 2014 setting out the context for the public sector pay in 2015/16[2]. This states that the Government does not intend to invite DDRB to make recommendations on a pay award for employed doctors in England in the 2015 pay round.

3. On 26 August 2014, the Department of Health (DH) in England subsequently wrote to the DDRB Chair setting out its remit on doctors' remuneration for 2015/16.[3] This remit letter goes beyond, the Treasury letter by stating that DDRB is neither required to report or make recommendations or observations for hospital doctors on remuneration, nor on recruitment and retention, and regional and local variations in labour markets.

4. The British Medical Association (BMA) strongly rejects this restriction on the Review Body's ability to undertake the role it was established to take. It is not clear how to reconcile these explicit constraints with statements in both the Treasury and DH letters about how the value they place on the contribution of the pay review bodies. As the Review Body's remit already obliges it to take account of the economic climate, it is unnecessary to impose further restrictions.

5. Consequently, the BMA wrote to the Chief Secretary on 21 August 2014 to remind the Government on the DDRB's role in giving the medical profession "some assurance that their standards of living will not be depressed by arbitrary Government action", as well as achieving "the settlement of remuneration without public dispute".[4] [5]

6. This letter follows previous correspondence with the Health Departments around the implementation of last year's report. The BMA wrote to the Secretary of State for Health in England on 21 March 2014[6] setting out the "deep sense of outrage" felt by doctors at the decision not to implement the DDRB's recommendations in full, not least as the recommended one per cent is still a real terms pay cut.

7. The BMA is particularly incensed by the deliberate conflation of pay progression and cost-of-living uplift – which is repeated in the remit letters – and we strongly agree with DDRB's statements[1] that "it is inappropriate for us [DDRB] to take account of such [incremental] increases when considering our general uplift on the basis of the current contracts… We believe…this issue should be addressed through contract negotiations". With such contract negotiations ongoing for a number of remit groups, we believe it is equally vital this year that this deliberate blurring is not accepted.

8. The BMA also wrote to the Welsh Government on 11 August 2014[7] following the Government's rejection of the DDRB recommendations, re-iterating our commitment to a fully independent DDRB process across the whole of the UK. We have written to the Northern Ireland Health Minister on two occasions and in the latest response of 26 August 2014,[8] he advised that he is considering all options available before issuing his response to both the DDRB report and the NHS Pay Review Body report recommendations. He referred to the considerable gap between requirements in relation to health and social care services in the current year and the extent of the

budget available. The situation is further exacerbated by the recently announced £140m shortfall in the DHSSPS budget, and the Minister has publically stated that he would find it difficult to implement a one per cent pay rise or incremental pay progression if the proposed budget cuts go ahead.

9. The Scottish Government did accept last round's DDRB's recommendations in full, but as yet has not published its Pay Policy for 2015/16, nor its remit letter to DDRB.

10. **This year, the BMA is submitting evidence for the whole of the UK, and is seeking a common recommendation for all doctors. We believe strongly that the DDRB should continue to make recommendations for all grades in all nations, but if it is not able to make recommendations for hospital doctors in England, it is imperative that this does not influence its recommendations for other groups.**

11. The BMA does have concerns around the timetable for this year's DDRB round. For example, the evidence submission date of 22 September 2014 necessitated bringing forward a key evidence publication from the HSCIC on GP earnings and expenses; the Technical Steering Committee (TSC) of which BMA is a member wrote to the DDRB about this on 21 August.[9] In addition, a number of other key documents have not been published in time for submission of this evidence, for example the Scottish draft budget and English specialty fill rates, which has limited our and other parties' ability to substantiate some of our points. **We would ask that the DDRB timetable is revisited next year, so that evidence is not required until the end of September at the earliest and preferably not until the necessary information has been published.**

Scope of Evidence

12. As in last year's submission, the BMA's evidence is more limited in scope than it has been historically. This is for reasons of:
    - The continuing context of national contract negotiations for UK Doctors in Training and for Consultants in England and NI, whereby a new contract or contractual variation may obviate DDRB's request for evidence relating to those particular groups of doctors.
    - Consequently, a lack of progress in comprehensive in-depth research, as previously discussed with DDRB and in our previous submissions.
    - Increasing concern around the weight DDRB appears to place on the affordability element of its remit (where this has been given) through making sub-inflationary recommendations, largely in line with the public sector pay policy, since at least 2008/9, with little consideration of how shortfalls against previous year's recommendations can and should be incorporated into this year's recommendations.

13. Again, our evidence will not cover issues directly relating to the contract negotiations, but does include evidence around those groups not in negotiations, for instance around Scottish consultant vacancies. We have attempted to include a wider range of references to all the UK nations this year, which is particularly important given the constraints around employed doctors in England.

14. We continue to share DDRB's concerns around the lack of data in particular areas, notably recruitment and retention and workload. The BMA is unable to provide evidence for most of the specific future evidence requirements identified in the DDRB's last report (section 2.98). This evidence either does not exist, or is only available from the various Health

Departments. As in recent years, we have also 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. We have included some specific comments on the Review Body's General Practice data requests in the GP section of this evidence.

15. We have also chosen this year to include some case-study "vignettes" in our evidence that illustrate what it is like working as a doctor in today's health service. While these have been anonymised, they are semi-structured interview responses from BMA members, which we hope will provide some qualitative evidence (and reinforce DDRB's own visits to NHS organisations), and will allow the Review Body to see the impact that the continuation of below inflation pay settlements and wider health service budgetary restrictions are having on typical doctors.

16. Our study on GP practice workload is underway, as is a study of Scottish consultants' perceptions of their role in the health service and the implications for patient care. There are as yet no results ready from either of these projects; we would of course be pleased to share these with DDRB when they do become available. Longer-term projects around productivity, motivation, and outcomes attributable to doctors' direct interventions, have all been put on hold pending resolution of the contract negotiations. Although we have not commissioned any specific new research evidence around motivation this year, we have identified relevant points from our case-studies and other qualitative research the BMA has undertaken. While we remain keen to work with DDRB on some of these more fundamental questions, we consider that this is best left until contract negotiations are concluded.

17. **This year, the BMA believes that doctors merit an award in excess of inflation. We believe that the English Government's pre-announced figure of one per cent (which in practice is actually lower because employed doctors not at the top of the scale will not receive this) is unacceptable, and that any award should be made by independent adjudication. We are not however including a specific figure that we are seeking by way of a pay increase.**

18. **We are again asking DDRB to make a recommendation for GP gross earnings as well as for net income, but in light of review of the formula used to convert net to gross, we are asking that this year the gross recommendation is made outside of that formula. We have included more details on this in the GP section of this evidence.**

19. **We have included some evidence around London weighting this year, as this has not been reviewed in detail by the Review Body since 2007. We have again not specified a precise figure for any increase that DDRB might recommend.**

Economic and Productivity Context

20. Since our last evidence, we have seen the start of a decline in the performance of the NHS across the UK, reflecting an exhausted staff, working at capacity, to deliver ever more with ever less resources. The section in this submission on "Patients at the Heart" includes some comparisons of health service performance (waiting times), but 2014/15 feels like a turning point, where doctors have contributed as much as they can to sustaining and improving NHS performance, without additional investment in the service. This is supported by a number of influential commentators like the Nuffield Trust,[10] [11] who argue that the health service budget is now becoming insufficient to deliver a consistently quality service for a growing and ageing population, and increasing demands upon the system, making it very hard, if not impossible, to continue to deliver the same quality of service without additional resources.

21. The BMA has therefore, with others, called for a public debate on health service funding, focussing on how to reconcile increasing demand with universal and comprehensive care, and without targeting the terms and conditions of the very NHS staff needed to deliver this.

22. The consequence of insufficient budget is that doctors are being asked to work increasingly longer hours and more intensely, but without any recognition or compensatory reward, and further on top of continuing real terms pay cuts. We warned in our evidence last year that this situation was not sustainable, and we are now starting to see real problems of recruitment and retention, personal issues arising from a deteriorating work-life balance, and detrimental effects on the future of the NHS itself, due to a short-sighted focus on immediate activity demands but without investment into finding innovative structural solutions to this funding crisis.

Case Study: Associate Specialist, Southern England

Dr A is an Associate Specialist General Surgeon working in a general hospital in southern England. He has worked there for the last fourteen years. When he began working in this unit referrals were initially steady, typically around 400 per year. However, in the last two to three months, there has been a marked change in patient demand for this specialist service. Referrals to the unit are increasing, on an almost monthly basis – 55 patients were referred in July 2014 alone. Annual referrals look set to increase to approximately 600 per year, on average.

Dr A is deeply concerned about the importance of maintaining quality of care and a good patient experience. Only providing 10 minutes per patient consultation is often not adequate for either patient or clinician. Given the increasing number of patients referred to the unit, it is typical for an outpatient clinic that is scheduled to finish at 12.30pm continuing into the middle of the afternoon.

Set against this rise in patient demand is less stable staffing within the department. Two experienced consultants that worked closely with the unit have retired in the last year. A locum consultant was appointed but left after just two months. A staff grade colleague working at the department for over 12 years, left the UK last year for due to lack of recognition or progression. He was replaced by a specialty doctor, who is also now planning to leave for a locum consultant job.

Dr A feels he has become undervalued. He is doing more each month but is being paid less in real terms for his work. He says his morale has become worse in the last two years. This feeling of being undervalued is compounded by a lack of recognition for his contribution. He is currently considering a move to practice medicine in the Middle East where he can increase his income and gain more recognition for his contribution.

23. Of course, the overall health service budgets are outside DDRB's direct remit and influence. However, it appears to us that in recent years the Review Body has placed considerably greater weight upon affordability arguments, including the specific argument that pay restraint is required to deliver against this, and conversely insufficient weight upon the impact that real pay cuts is

having upon doctors' motivation and ability to deliver ever more care at the expense of their wellbeing and the goodwill upon which the NHS has always relied.

24. With regard to the overall economic climate, the BBC has reported[12] that the NHS in England faces a funding gap of up to £2 billion for the 2015/16 financial year. Commentators such as the Nuffield Trust and Kings Fund, as well as NHS England[13] have suggested that as well as population growth, this may relate to the transfer of NHS budgets into the Better Care Fund to help local councils deliver better integrated care with the NHS. The Department of Health has already reported a 2.6 per cent increase in spending (TDEL measure), which the Kings Fund suggests means that there can now be no 'rainy day underspend' for any future demands that may arise.[14]

25. This funding gap is underlined by estimates from Monitor, the NHS regulator in England, which identifies a deficit of £1.6 billion even assuming planned efficiency savings are achieved – and with considerable doubts about the ability of the health service to make continuing productivity gains as previously mentioned. 41 of the 147 Foundation Trusts recorded a deficit at the end of 2013/14, which is 20 more than the previous year. Already in this year, 86 FTs have reported a deficit in Quarter 1 2014/15.[15] The Audit Commission's end of year report said that 19 English NHS Trusts and 24 CCGs were referred to the Secretary of State during 2013/14, mainly on financial grounds, and in Wales the Auditor General qualified three health board accounts because of overspends.

26. The HSJ[16] has recently produced analysis of the whole acute sector in England that suggests a net deficit of £750 million for 2014/15, with nearly half the sector planning or forecasting a deficit. This is a significant worsening of the £421 million net deficit in 2013/14. As efficiencies need to continue to exceed 4 per cent per annum, this is likely to be an underestimate, as history has shown that the easy efficiencies are achieved first.

27. The Kings Fund Quarterly Monitoring Report[17] surveys NHS finance directors in England and the latest June figure show 85 per cent are now fairly or very pessimistic about the state of local finance health economies over the next year. There are concerns too about how the Better Care Fund in England is being used, with the Association of Directors of Adult Social Services (ADASS) finding that nearly half of the money transferred to local authorities from the NHS budget this year is being used to protect existing services rather than to expand provision.

28. The situation is at least as difficult across the other nations that make up the UK. The Nuffield Trust[18] suggests that the NHS in Wales will face a £2.5 billion funding gap over the next decade, driven by population growth and an increase in patients with chronic conditions. Of particular concern is the decision by the Welsh Government to continue cutting its health budget.[19] The Institute for Fiscal Studies calculates an 8.6 per cent cut in real terms since 2010/11; this compares with a 0.4 per cent real terms increase over the same period in Scotland. In both Scotland and Wales the draft budgets for 2015/16 are not yet available, but are unlikely to be better than zero real-terms growth. The BBC has reported that the NHS in Scotland may indeed face a £400m funding gap.[20]

29. The scale of the financial challenge in Northern Ireland is equally daunting: the DHSSPS requires additional funding of £420 million to meet all identified costs of existing policies, but the planned increase to budget is only £90 million (in real terms actually a -0.2 per cent cut) with identified – but no guaranteed - savings of £170-190 million. There is thus a gap of at least £140 million, and the Department is looking at a further pay constraint as one way to plug this, with a figure of £15 million suggested as well as cuts in the use of locums to save a further £9 million.[21] As noted, the Northern Ireland Minister is yet to issue a response to the last DDRB report,[8] despite earlier requests from the BMA seeking clarity on this.[22] As we noted last year, while CEAs have now been unfrozen in Northern Ireland, the two year funding gap has not been made up, which places consultants in NI at a significant disadvantage against their consultant and senior clinical academic counterparts in England.

Case Study: Consultant, Northern Ireland.

Dr B is a Consultant in Northern Ireland, where he works across two hospitals. He has recently taken on a Clinical Director role.

Across Northern Ireland there is a major recruitment problem with 111 unfilled Consultant vacancies. Dr B has approached this problem by deliberately holding back consultant jobs until he knows they will be filled with a high quality candidate. This does however require a good working dialogue with the commissioners to manage overall demand, and does mean that waiting list initiative money has to be used to create extra capacity with existing resources.

A consequence is that around up to half of all elective activity in some specialties now goes to the independent sector. Dr B made a personal career choice to work in the NHS because of its public service ethos, and feels he is now too old to try to establish a private practice. He is therefore demoralised by the freeze of CEAs in Northern Ireland, which has worsened the differential between his earnings and other parts of the UK, and has led him and colleagues to choose not to take on additional roles and responsibilities. This in turn makes it harder to deliver innovative and radical change.

On a personal level, Dr B has struggled to find time for everyday activities such as dentist appointments for him or his family. He has not been able to take his full entitlement of annual leave. With the pension contribution increases, and below inflation pay increases, he is now concerned how he will be able to help his children through university in a couple of years' time. He does appreciate that doctors are still relatively well off, but made the point that you entered medicine with certain expectations which were now being attacked one by one.

30. In Wales the BMA is opposing Welsh Government moves[23] to cut the pay of many Welsh trainees by 0.5 per cent as part of attempts to align doctors' terms and conditions more closely with those in England. This discrepancy has arisen as a result of Welsh Government fully implementing a DDRB recommendation in 2010 to increase pay for FY1 and FY2 junior doctors by 1.5 per cent when this increase was limited to just 1 per cent in England by the UK Government. The BMA is concerned that this present unilateral decision by the Welsh Government cuts across the current junior doctor contract negotiations which are being conducted under the premise that the existing pay envelope should be maintained, and leads to risks around recruitment and retention in a country that is already showing signs of difficulties. We are also concerned at the decline in the Welsh Clinical Academic Track (WCAT); this programme has fallen from 10 posts in 2009 to just three in 2014 when Welsh Government funding was no longer available, which creates further risks around recruitment and therefore the future of academic medicine in Wales.

31. While one partial solution to the health service funding position is to increase productivity, we believe that there is both a limit to what genuine gains there can be in the short-term without major system-wide reconfiguration, and that the very narrow focus on activity (e.g. as measured by FCEs or GP consultations) rather than clinical and patient outcomes is potentially dangerous in diverting resources away from their most cost-effective and sustainable longer-term use. The NHS has delivered some productivity gains over recent years, as recent updating of research by Centre for Health Economics at York University[24] has identified a 2.1 per cent rise in total NHS (England) productivity from 2010/11 to 2011/12. While this figure is now out of date, the methodology used does make some adjustment for quality of service not just volume, so supports our case that doctors and other NHS staff are working harder to keep the health service afloat, but achieving this through goodwill is not an appropriate reward.

32. The limits to productivity argument is also supported by academic literature associated particularly with Baumol,[25] who argues that productivity gains are necessarily limited in service industries where standardisation and automation are hard to achieve, and where personalisation is desirable if not essential. While healthcare is amenable to technological innovation, the lack of increase in budgets has restricted investment and the attempts to limit for instance Consultant SPA time will further reduce the scope for sustainable cost-savings. It is important in this context to note that

UK expenditure on health has slipped down the international league table, behind France, Germany, Denmark, Austria and Canada for example[26] [27]

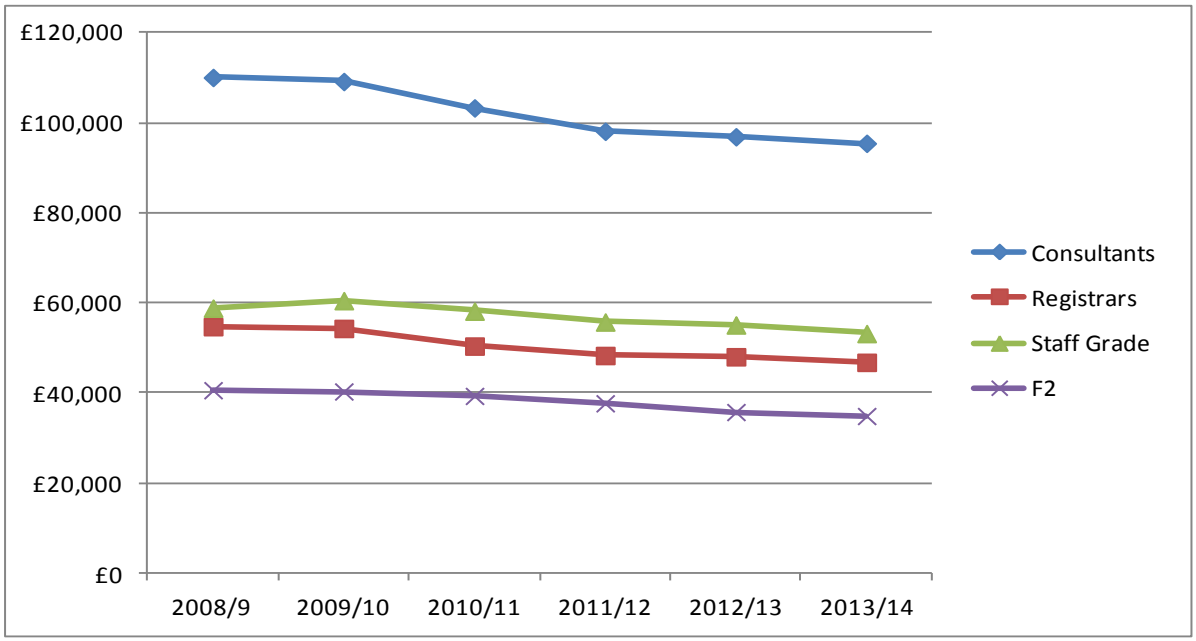
33. While the BMA celebrates the commitment of many of its members who work substantially above their contracted hours and in unsocial times to support safe patient care (an internal survey we undertook last year that showed around seven in 10 UK Consultants worked at least one weekend in the previous month and around 55 per cent worked at least one night in the previous week[28]) we have significant concerns that the NHS is currently struggling to deliver services across the working week. We are concerned therefore by, for instance, the remit from the DH to the NHS Pay Review Body[29] which implies that sustainable seven day services can be achieved without increasing the existing spend, which we do not believe will be possible.

34. We are receiving anecdotal evidence around employers pressuring Consultants to give up their SPA time to deliver additional direct clinical contact sessions, and in Scotland that employers continue to offer consultant contracts with a "9:1" split between Direct Clinical care and SPA time. We believe that in the medium to longer term these moves will be self-defeating as we know from the Keogh Mortality review[30] "that the best treatment is delivered by those clinicians who are engaged in research and innovation."

Pay Erosion and Comparison

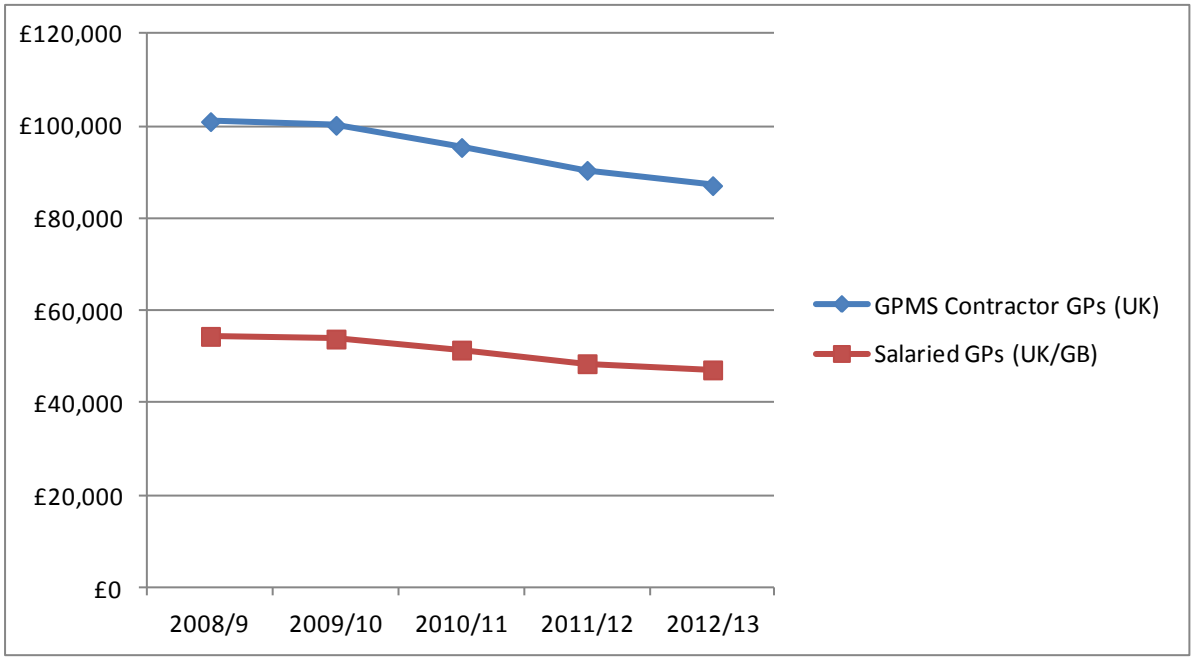
35. As in previous years, we have updated the chart of the real-terms cut in earnings (in 2008/9 prices) over recent years.[31] [32] This reports Median earnings in 2008/9 prices, using the Westminster Government's preferred measure Consumer Price Inflation (CPI) deflator. The current rate of CPI inflation is currently 1.6 per cent (July 2014). The Retail Price Index (RPI) which we believe better reflects the costs facing doctors is currently 2.5 per cent (July 2013).

Median Earnings for Hospital Doctors



Source: HSCIC. Figures are England only. HSCIC no longer publish median FTE figures, so these have been estimated for the latest two years.

Median Income for General Practitioners



Source: HSCIC. Figures are UK/GB.
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 4% of total income. It is not possible therefore to make direct comparisons of GP income with employed hospital doctors.

36. The chart shows a fall in average (median) income adjusted for inflation of around 13 to 14 per cent for most staff groups between 2008 and 2014. In effect, doctors are now back approximately at the position they were in 2008, with some groups such as GP contractors and some doctors in training showing an actual fall in their average pay in cash terms, not just the inflation-adjusted figures. For junior doctors, the decline in the proportion of earnings coming from banding supplements continues to fall.

37. Although for SAS doctors the fall in average earnings was relatively lower than other crafts, this group of doctors is unique in that the vast majority of SAS doctors work exclusively in the NHS and are likely to remain at that grade and payscale range until they retire, a situation further compromised by the recent hike in pension contributions with concomitant reduced pensions from the imposed CARE Scheme.

38. A similar pattern of continuing pay erosion applies to other groups, including medical academics and public health doctors. In addition, the longer training programmes and often more complex career paths means 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 health care services, their pay is still determined by NHS consultant pay scales. Earlier this year Public Health England[33] committed to implement for PHE consultants the government's settlement following the DDRB recommendation and agreed that consultants in NHS-facing roles will remain on NHS equivalent terms and conditions as part of the 2013 transfer arrangements. Local authorities are also recognising that PH consultants should be appointed on pay scales that reflect "NHS market" salaries. Public Health contracts in the devolved nations, and for trainees, remain unchanged. For both academic and public health doctors, we also 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.

Case Study: Junior Doctor (ST4), South Wales

Dr C is a ST4 junior doctor in training, in the dual specialties of Anaesthetics and ITU intensive care medicine. He aspires to a Consultant position when he completes his training in around 3 years' time, but is increasingly concerned on what future opportunities there might be with the continuing health service austerity, made worse by lack of support for doctors in the media.

On his current ITU rota, there is one rota gap that is being filled with locum cover. However, it is becoming difficult to find locums, from either junior doctors or indeed consultants.

The hospital management attempts to cut costs have led to a general loss of morale that Dr C noticed when he started this rotation, having come back to the hospital from a placement elsewhere. Cuts include not paying overtime so all lists have to finish on time, which adds to waiting lists as fewer patients can be scheduled, to avoid over-runs.

On a personal level, Dr C has noticed that travel costs have gone up significantly, and most noticeably that examination fees have increased (next set over £1,100) and study budgets cut (from £800 a couple of years' ago to £600 now), which means a substantial increase in out of pocket expenses without compensating increase in pay.

39. We have further looked at other earnings data, which are currently showing recent pay settlements averaging over 2 per cent according to Xpert HR,[34] but with a significant proportion (1 in 6) of awards at 3 per cent (July 2014). Similar data from IDS[35] shows a median pay settlement of 2.5 per cent, with the majority (3 in 4) awards being in the range 2 to 3 per cent. The official[36] average weekly earnings total pay indicator is not yet available at the same date, but the latest available date of May 2014 shows a private sector comparison of 1.8 per cent.

40. From 1 April 2015 a new NHS Pension Scheme will be introduced and will apply to 75 per cent of existing doctors and all new joiners after that date. The new scheme will differ considerably from the existing 1995 and 2008 sections of the NHS Pension Scheme as benefits will accrue on a Career Average Revalued Earnings (CARE) basis. The normal pension age of the scheme will be linked to State Pension Age (which currently extends to age 68, depending on year of birth).

41. As the BMA noted in its evidence to the DDRB last year, pension benefits payable to doctors will be markedly lower than under the existing schemes in future and at the same time contributions have increased by 58 per cent since 2008.

42. The Department of Health in England, and the Scottish Government, have recently confirmed that the same tiered contribution structure that is in place for 2014/15 will continue beyond 2015. As acknowledged in Lord Hutton's Final Report, once a scheme design changes from final salary to CARE, the original justification for tiered contributions becomes less valid. This is because the removal of the final salary link ends the discrepancy between the benefits for higher and lower earners. Defined benefit schemes are collective vehicles for pension provision, with significant cross subsidies operating between members. The continuation of tiered contributions in a CARE undermines the principle of collective provision.

43. From 2015 doctors will therefore have to work longer to receive lower pension benefits, and due to the tiered contribution system will pay proportionately more than other NHS Pension Scheme members. It should also be noted that for those grades not engaged 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 for all doctors, with no contract negotiations on the horizon the importance of an above inflationary uplift is even more necessary for these groups.

London Weighting

44. 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 may be included in the contract negotiations, and a discrepancy with Agenda for Change contracts for other NHS staff who receive a proportion (20 per cent for inner London, up to £6,279) of salary rather than a fixed amount.

45. Although there are strong arguments that other areas in the UK face similarly high costs of living (for example Cambridge, Edinburgh), this year we are asking the DDRB to consider uplifting the 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.

46. General inflation (CPI) has risen over 26 per cent since 2005. More relevantly, property rental prices in London have risen by around 24 per cent since 2010 or over 3 per cent in the last year, compared with 13 per cent and 1.3 per cent for England and Wales overall[37]. London travel costs have risen by around 4 per cent per annum on average over the same period.[38]

47. **We are therefore asking DDRB to consider uplifting London weighting, either in line with the Agenda for Change arrangements, or by some other cost of living type inflator.** We shall update the Review Body if this issue is considered as part of the contract negotiations, and will return to the wider issue of cost of living differentials in future evidence submissions.

Contract Negotiations

48. NHS Employers and the BMA are in formal negotiations about a new contract (or contract variation) for doctors in training (for the UK) and Consultants (for England and Northern Ireland); Scotland and Wales are not currently engaged in negotiations. We note that the Welsh Government has recently asked to join the England and Northern Ireland Consultant contract negotiations, but this has not been agreed by the parties involved. The Scottish Government has not approached the BMA to engage in consultant contract talks in Scotland. The negotiations will have an impact on public health doctors, and also on medical academics where any changes will be implemented in higher education sector through separate negotiations between the BMA and the university employers.

49. As noted above, 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 2015. 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.[39] As we do not expect significant changes to the GMS contract in England or Wales this year, the GMS contract remains broadly the same across the four nations, so we are again not seeking any differential uplift for the devolved nations.

50. It is not currently possible to indicate 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 as in last year. The negotiating parties are required to update the Secretary of State for Health in England on progress in October, so we may be able to update the Review Body after that date.

Recruitment and Retention

51. Despite DDRB's best efforts, there is a continuing lack of data around vacancies and recruitment and retention in England and Wales, other than anecdotal. In Northern Ireland, the HSC Workforce Vacancies survey showed 114 Consultant vacancies at March 31 this year.[40] The Telegraph undertook a Freedom of Information request across 62 English Trusts[41] that showed average vacancy rates for doctors of 4.5 per cent, but with rates of up to 17 per cent for Consultant shortages in some respondents. It also reported an increase in the number of doctors planning to work in Australia and Canada.[42]

52. The BMA sent a Freedom of Information request to 260 NHS organisations in England to ask about SAS grade vacancies and received 149 responses; this showed a current average vacancy rate of 4.6 SAS doctors per organisation, with a particular problem in emergency medicine and A&E, and psychiatry, in common with recruitment trends across all career grades. Taken over the last 24 months, the average number of SAS vacancies was over 15 per organisation.

53. There is some official data available for Scotland[43] that shows a trend increase in total vacancy rates for consultants, with a substantial worsening over the last year (June 2013 rate 4.7 per cent, June 2014 rate 6.9 per cent, with a similar worsening in length of vacancy over the same time period, from 1.1 per cent to 1.8 per cent for vacancies of six months and over). The BMA believes the official figures may also understate the true position, for instance because of the delay in waiting for a post to be cleared for advertisement; the BMA has therefore pressed the Scottish Government to agree consistent definitions for measuring vacancies, but regardless of the definition there appears to be a worsening position.

- In May, the Chief Executive of NHS Dumfries & Galloway reported its consultant vacancies were at their highest level for more than a decade, reaching over 22.[44]
- In June, A & E consultants in NHS Grampian publicly raised concerns that, due to staff shortages, they would be unable to continue to provide safe care for patients, e.g. resuscitation of those with life and limb-threatening conditions.[45]
- In June, NHS Fife confirmed that close to a quarter of its 170 acute division consultant posts had not been permanently filled due to difficulties in recruitment.[46]

54. The Medical Schools Council reports on vacancy rates for medical clinical academics.[47] The latest report shows that at July 2013 a total of 23 of the 35 medical schools reported vacancies, with rates of up to 8 per cent. A key reason given was the pressure of increasing clinical activity acting as a deterrent and detrimental to academic work. Similarly, in the specialty of Public Health, the current level of vacancies reported by Public Health England[48] for Director of Public Health posts is 25 out of 131.

55. While 2014 specialty 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, and general practice – with a particular regional issue for GPs for everywhere other than London and the South. We will update DDRB with any specific concerns once we have seen the full data.

Case Study: GP Partner, North Wales

Dr D has been a general practice partner since the 1980s. He is currently planning for his approaching retirement. The practice has always managed a large number of patients. The practice list size has remained at over18,000 patients over the last decade. However, unlike 10 years ago, the number of partners in the practice has reduced from 8.5 FTE to just five currently.

Although skill mix has changed – there is greater use of nurse practitioners, locums and the practice has employed a salaried GP – workload has continued to rise at a time when Dr D and three of his colleagues would prefer to reduce their commitments over the next three years.

The practice has undertaken four separate recruitment rounds for new partners in the past two years, placing adverts locally and by using the BMJ to advertise nationally. None have resulted in long term partners being recruited to the practice. Unusually, due to the current financial position of the partnership, a new partner would not be required to personally buy into the practice, thereby removing an immediate financial impediment. Despite that, the practice has been unable to attract a long term partner, strongly suggesting that locality and concerns for work-life balance are deterrent to interest in a partnership. While the practice has managed to recruit a salaried GP, ensuring that sessional commitment was tightly defined formed a key factor during those contractual discussions.

It was necessary recently for the practice to rescind its role in the training of undergraduate medical students from Liverpool and Cardiff Universities in order to focus on delivery of core services to its patients. Dr D said this was regrettable, given the role of practices in developing the GPs of tomorrow, but necessary too, as the practice was no longer able to devote the amount of time and tutelage they would like to give to students.

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

Motivation

57. The BMA supports DDRB in its desire to be able to better define and measure what we mean by motivation. We have this year undertaken a number of deliberative events with members with some interesting findings relevant to the topic, and some case study interviews with a small number of doctors specifically for this evidence. We have not however been able to progress a larger scale research project around motivation, performance and reward.

58. A recurring theme from these interactions has been a growing sense of "de-professionalisation" and "disempowerment". Related to this is an increasing focus by management on measuring performance, interpreted very narrowly as direct patient contact activity. This severely restricts consultants' ability to maintain their own professional development, teach, train and supervise the next generation of doctors, promote and ensure quality through audit and other clinical governance activities, engage in research or contribute to service development through medical leadership - all of which are strong motivating forces.

Case Study: Associate Specialist, Northern Ireland

Dr E is an associate specialist in a specialised centre in Northern Ireland. Throughout the year the unit is nominally staffed by four staff doctors: three consultants, and one associate specialist; a registrar and a junior ST rotate through the unit. However, the work of the unit is impacted by the poor availability of staff of all grades. The unit is currently short of one consultant – a shortage recognised by hospital management for several years. There has been difficulty in recruiting for this position in part as there is often a need to recruit from outside Northern Ireland.

The patient case mix the unit receives is changing significantly each year. The unit is providing an increasing number of the most complex treatments, and cares for patients returning from other specialist units. Combined with changes in the population demographics of Northern Ireland, previously unseen or rare conditions have created a need to develop the expertise of medical staff in the unit. The unit has increasingly adopted a multidisciplinary approach to case work, exchanging knowledge and learning on the job whilst enhancing the care of the patient. All referrals to the centre have the potential to require urgent care yet this is a workflow that the unit must try to carefully manage down to ensure it is not overwhelmed and is able to continue to function as a highly specialist unit with the capacity to provide the most complex care. To this end the staff must try to redirect some referrals elsewhere whilst ensuring patient safety.

Going the 'extra mile' for patients is an important part of the ethos within the unit, where inevitably work can be emotionally demanding. A typical working day for Dr E is from 8.30am in the morning to 7pm in the evening.

Dr E and her colleagues believe there is a gradual erosion of goodwill and morale as a consequence of the decline in their real pay. While she retains a high level of motivation for the patients she cares for, she feels strongly there is a growing sense of being undervalued by the wider political system.

59. Doctors feel that they are not being used most effectively, to bring their clinical skills into developing longer-term sustainable solutions to ensure the future of the NHS. There is increasing concern that the lessons of the Francis Report around the inappropriate dominance of finance over quality of patient care do not seem able to be addressed, and that clinical involvement in finding innovative solutions has not been sought and indeed actively deterred by demanding increased activity at the expense of time to develop professionally and personally.

60. One consequence of this perceived or actual disempowerment has been that a number of clinicians have been unable or unwilling to take on additional responsibilities (with their hospital or for a CCG say), which will further limit the scope for clinical involvement in management and leadership.

61. In Scotland, NHS employers have been severely restricting SPA time for consultants, routinely appointing new consultants with only 1 SPA in their job plan, in contrast to the nationally agreed norm of 2.5 SPAs. This restriction is strongly demotivating, and is a significant factor in the growing difficulties in recruitment and retention north of the border, with Scotland developing a reputation for unattractive consultant jobs.

62. 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, which makes it now the only one of the four nations to have no higher awards system in operation. When taken together with Scottish NHS employers "9:1" approach to consultant job plans, 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.

Case Study: Consultant, Scotland

Dr F is a surgeon based in Scotland. He works in a team of 6 consultants, with around 800 cases a year.

Dr F noted that comparative professions, such as lawyers, did seem to be diverging from consultants in terms of pay, but suggested that while additional pay would address some recruitment problems and compensate for additional workload, many of the problems of the NHS are as much cultural around failure to engage clinical staff in the management of the hospital.

The absence of feeling valued has led Dr F to scale back his NHS commitments to take on more medico-legal work, as this is both more appreciated and less time consuming than taking on additional operating list with follow-up ward rounds. Waiting lists have increased in his hospital, but "goodwill fatigue" from lack of recognition has made many consultants in his hospital unwilling to take on extra work.

This failure to engage is exemplified by anecdote about supplies purchasing. The hospital management decided to switch supplier for surgical gloves, but the cheaper brand split, so had to be replaced again, thus making no savings. There was no clinical involvement in this purchasing decision, and it is this finance-driven culture that has led Dr F to restrict his NHS contribution.

There have been a number of junior doctor vacancies which have been filled with locums. Their relative lack of experience and local knowledge means Dr F feels he needs to undertake tasks that he would have previously expected a junior or specialty doctor to undertake without supervision, such as blood tests and X-rays, which would not be the case with a fully resourced team.

63. We also undertake some more regular surveys of members, of which our Omnibus survey[49] and Consultant survey[27] include some relevant, if self-reported or anecdotal, evidence.

Consultant Survey Results

- Workload: Respondents reported working an average 36.5 hours in direct clinical care (DCC) per week compared to average contracted hours of 33 per week.
- Appraisal: Only 88 per cent of respondents reported having an appraisal in the last 12 months. 2 per cent had never had an appraisal.
- Job planning: Only 87 per cent of respondents were working to an agreed job plan.
- Management: one-third of clinicians who are not currently managers would not consider such a role under any circumstances.
- Study leave: Respondents reported being able to access only around 17 days of Study Leave in the last three years, compared to their entitlement of 30 days with pay and expenses. Just over one-quarter that were able to take study leave received full funding.

64. Our survey confirms earlier research by the NAO,[50] which showed that consultants are working 1.46 DCC PAs unpaid in a typical week. With other unpaid PA time (for example, external duties) the NAO estimates a total of 3.34 PAs, or over 13 hours per week, is unpaid. If this is multiplied by the number of consultants in the UK (roughly 40,000), then well over half a million unpaid hours of consultant time per week is being contributed by Consultants, before even considering the other staff groups.

Omnibus Survey Results

- GPs are most likely to report their workload as unmanageable/unsustainable (67 per cent)
- GPs most likely to report 'always' working outside their regular hours in the last month (62 per cent)
- Doctors most frequently reported working outside their regular hours due to too much work (79 per cent); hospital doctors were most likely to report this was due to vacancies/staff shortages (31 per cent) or pressure from an employer (12 per cent).
- More than one-third of respondents (35 per cent) had voiced a concern about the standard of patient care in their workplace in the last month, including almost half of all consultants. Worryingly, more than four in 10 reported that to the best of their knowledge no action was taken as a result (42 per cent). Almost a further one-fifth (18.3 per cent) felt action taken was not satisfactory and almost one-fifth (18.9 per cent) thought positive action was taken.
- Barriers to improving patient care: half of all respondents said that a lack of capacity/time was a barrier to improving patient care (51 per cent), combined with too much bureaucracy (46 per cent), organisational financial constraints (38 per cent) and a lack of managerial/organisational support (35 per cent).

65. Our case studies have also unearthed some concerning findings about the desirability of medicine as a career, as a consequence of pay constraint, work-life balance, but especially what might be best described as a sustained attack on the public service ethos and the "social contract" that doctors enter into with their employers. While the interviews were with working members, this raises significant issues around how the next generation of junior doctors and medical students will view a long-term NHS career.

Case Study: Junior Doctor (CT), North of England

Dr G has just completed his fourth year as a core trainee in an NHS community psychiatry team in the North of England. He trained there previously as a CT1.

That department is nominally staffed by at least five doctors: a consultant, registrar, two core trainees and a GP trainee. This relatively skeletal staffing has afforded little if any flexibility in working arrangements across the team and impacted on the overall capacity of the unit. The unit has seen a shortfall of at least one FTE doctor across the year. This represented a change to Dr G's previous experience in the same department when there was a greater availability of senior doctors.

Demand for psychiatric services in the locality has gradually increased waiting times, inevitably not helped by medical understaffing. Patients must wait up to five months for a first appointment since being referred from their GP. Three years ago, an equivalent wait was in the region of two months, at times even shorter. Waiting times for some conditions, such as ADHD assessments, had waiting lists as long as 18 months. Dr G explained this inevitably impacts on staff within the unit, both in terms of workload but also morale, as staff would like to provide the best service possible and they have struggled to do that.

Dr G believes the competing factors of declining real pay and the increased drive from his hospital to provide services with fewer real resources when demand is rising is fragmenting attitudes of junior doctors. Some juniors will pursue as much work as possible in order to maximise their earnings, to save for a deposit, fund a mortgage or start a family. Another group are increasingly feeling less goodwill to their hospital. He recalled that previously, junior colleagues would quickly take up acute locum shifts, not exclusively for pay, but in recognition of a collective solidarity to their junior colleagues, to share the burden. Feeling undervalued, both in terms of pay and access to educationally productive training, has led some juniors to re-evaluate their own work-life balance. Personally, Dr G was close to leaving the UK to work in New Zealand before the offer of his current position came through, and he will continue to evaluate if his future lies in the UK over the next year.

Case Study: Junior doctor (ST6), Southern England

Dr H is an ST6 trainee who will complete his training in Forensic Psychiatry and take up a Consultant post in autumn 2014. Throughout the early years of his training, Dr H was wary of taking a post in the independent sector, but over the last year or two has completely changed his view as a result of the continuous erosion of benefits from working in the NHS, so will be starting his first Consultant post in the independent sector working for a large charity.

Specifically, Dr H felt that he and other young doctors entered medicine with certain expectations around the future careers in terms of job satisfaction, job security, a sense of public service of being valued, a salary that progresses with time and skills, and a good pension scheme. Dr H feels that there have been continuing erosion and attacks on all these expectations over the last few years, which have led to a significant drop in morale and loss of goodwill. This has led Dr H to changing his views around the relative attractiveness of the NHS against the independent sector, and hence his imminent move to a non-NHS Consultant post. When looking for consultant posts, Dr H did not even consider an NHS Consultant post.

As more specific examples, Dr H identified two of his forensic psychiatry consultant colleagues who felt undermined when the prisons they served were contracted to another provider, with the uncertainty over what would happen to half their jobs, and the potential loss of their experience and knowledge Similarly, he has colleagues who have gone to Australia, initially on a temporary basis, but then deciding to stay permanently due to their improved quality of life and job satisfaction.

More generally in forensic psychiatry, the UK has insufficient NHS beds when compared to patient need. Patients therefore have to be sent away to different parts of the country where there is capacity, or to the private sector. This means that there are limited longer-term career opportunities in the NHS, combined with an expanding independent sector which offers substantially improved salary packages compared to the NHS. This creates a vicious circle of the most talented psychiatrists leaving the NHS, further damaging the NHS service.

Patients at the Heart

66. We included in last year's submission some evidence around a wider range of health service performance and outcomes measures. We noted at that time that this needed to be a longer-term research project, as these measures ideally need to be able to show a quantifiable causal relationship with the work of NHS doctors and the teams they lead. Additionally, as much of the data we previously reported has not been updated, we have predominantly limited our evidence this year to one main area of waiting times.

67. This year, the Commonwealth Fund[51] declared the NHS the best healthcare system overall, scoring highest on access and efficiency. However, much of the data now dates back to 2010 or earlier, which supports the argument we used in last year's evidence that doctors have contributed significantly to maintaining and improving the performance of the NHS, despite the almost static budgets and personal pay cuts.

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

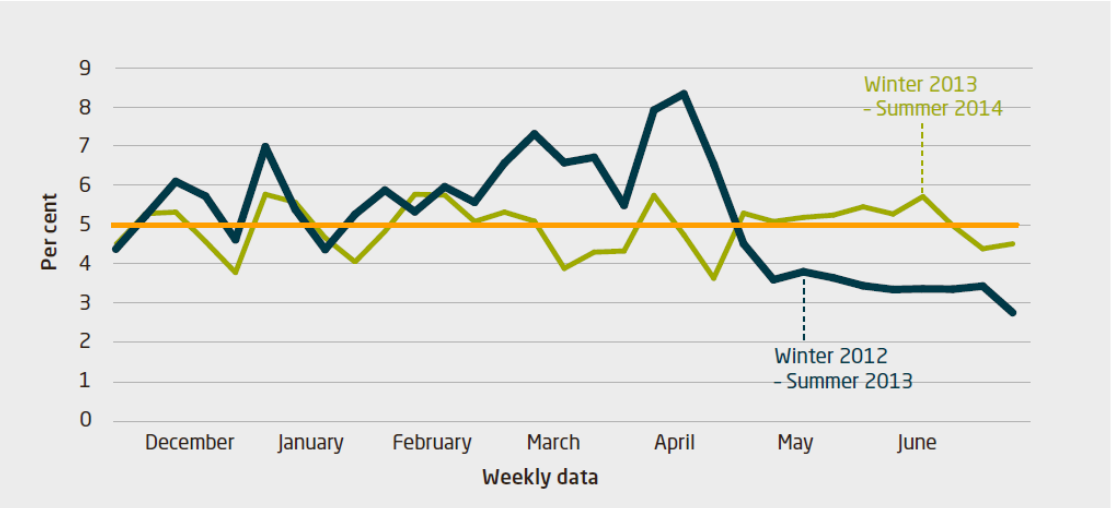
Source: Commonwealth Fund

68. There has been some good news around improving mortality rates, and improved quality of life for older persons.[26] However, recent performance has begun to show signs of unsustainability, and we have focussed on waiting times in this submission as an indicator of systematic underlying problems. While the BMA does not condone the use of specific waiting time targets as these do not necessarily reflect clinical priorities and may lead to ineffective and inappropriate diversion of resources and patients, they are a key measure for politicians and the public, and they have significant staffing implications with greater workload and intensity of work for doctors, which have not been rewarded.

69. Even with additional 'system resilience' funding being released by the DH and NHS England to reduce A&E and 18 week Referral to Treatment (RTT) waiting times, there appears to be a worsening trend in waiting times. The proportion of inpatients waiting more than 18 weeks from referral to treatment breached the 10 per cent target for the first time in almost three years in February and March 2014. The proportion of patients waiting more than six weeks for a diagnostic test missed its 1 per cent target for the past six months in a row. The target that 85 per cent of patients should wait no longer than 62 days from an urgent GP referral to first definitive treatment for cancer was missed for the first time in quarter four of 2013/14. The total waiting list in England exceeded 3 million patients for the first time in six years in April and May 2014; the reported size of the waiting list is now 3,090,000, more than 5 per cent of the population of England.[16]

70. The weekly A&E waiting times data for England (week ending 6 July 2014) shows that across all types of departments 4.8 per cent of patients waited more than four hours. However, for major A&E departments which treat roughly two-thirds of patients, the target of 95% has been missed for the past 51 weeks. Perhaps most worryingly, the A&E target was breached during May and June, which is extremely unusual for that time of year, and suggests a significant systematic problem.

Proportion of A&E patients waiting longer than four hours from arrival to admission, transfer or discharge: comparison of winter and summer 2013 and 2014



Source: Kings Fund, NHS England

71. In the rest of the UK, the situation is similar. In Northern Ireland, at the end of June 2014 the country as a whole did not meet the first element of the target that at least 80 per cent patients should wait no longer than 13 weeks for inpatient or day case treatment.[52] Overall the second element of the target that there should be no patients waiting longer than 26 weeks was also breached. Although over the longer-term, waiting times have improved, 2014 seems to be showing a reversal of this trend.

72. In Scotland,[53] while the 18 week RTT target has been met, the four hour A&E target has been breached (94 per cent against 98 per cent target), and the 12 week outpatient target has deteriorated from 2.9 per cent in June 2013 to 4.5 per cent a year later.

73. Finally, in Wales,[54] the RTT target is 26 weeks, and this has been breached with only 79 per cent of patients treated within this time against a target of 95 per cent. The secondary target that all patients should be treated within 36 weeks was also breached by over 7 per cent of patients.

GP Contractors and Salaried GPs

74. 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 recommendation on gross 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 to Earnings Ratio (EER) demonstrates that efficiency savings have continued, as practice expenses have increased disproportionately to income.[30]

Expenses to Earnings Ratio

Year	Ratio
2008/9	0.593
2009/10	0.597
2010/11	0.609
2011/12	0.616
2012/13	0.625

Source: HSCIC

75. Additionally, as a result of an ageing population, the number of consultations is increasing, but due to the effect of "normalising" the Global Sum payment back to the national population, GPs are not fully remunerated for this additional workload. This is on top of the increase in patients presenting with multiple morbidities, and a trend increase in general practice activity more generally.

Case Study: GP partner in Scotland

Dr I has been working in general practice as a partner in a GMS practice in Scotland for 12 years. The practice has repeatedly struggled to recruit new GPs, either on a partnership or salaried basis. As the practice list size has grown by over 80% during the last decade, so has the need to attract and retain new GPs to cope with the increase in the complexity of health problems in the local population and demand for GP appointments.

Approximately 18 months ago, the practice attempted to recruit a new partner using the BMJ nationally, and related networks locally. Only four applications were received, of whom two candidates ultimately withdrew their application, and a local GP trainee was not considered suitable for appointment after interview.

Over the last three years the partners have managed to maintain their individual income, but only as a consequence of minimal use of locums and at the expense of ever increasing working hours and poorer overall quality of life. With the introduction of remote access to the clinical system, all audit and QoF work is now through necessity undertaken at home outside of practice hours. Now days are longer, starting at 7am and often not finishing until 7pm with work continuing at home after an evening meal.
Dr I has recently had to give up voluntary work, after ten years of volunteering, due to a lack of time and energy.

Despite attempts within the practice to manage rising patient demand, with no prospect of another partner and succession planning not foreseen, Dr I was concerned for her own health having already recovered from a serious illness some years previously. Aware of the potential harmful effects of fatigue and poor work–life balance on her long term health, she notified her partner last year that she would like to exit the partnership and become a GP locum so she can regain control of her work-life balance.

For the practice, this led to another unsuccessful round of recruitment – a national advert in the BMJ attracted a single application. After interview, it was felt they were not ready for partnership. Only recently has a GP locum agreed to become a partner on a part time basis.

76. The face value of a QOF point has not increased: most QOF indicators have thresholds for payment which are expressed as a percentage of the relevant population; so if population grows then to achieve the same percentage achievement level with a greater population means that the practice needs to see more patients. This increases workload but is not remunerated.

77. The impact of the phased removal of the Minimum Practice Income Guarantee (MPIG) in England is creating financial difficulties for a number of practices, with the criteria for financial support being a "cliff edge" £3 per patient, with no graduation.[55] We have received details of a number of practices who appear to be financially unviable as a result of this funding removal, including practices where the only way to continue would be to cut services and to take a personal cut in income.

78. These issues have been raised as part of the annual GP contract negotiations, and we shall update DDRB with any progress, but without additional funding there will undoubtedly be a significant proportion of GPs who can only continue to deliver a full range of quality services by taking a very substantial cut in their personal income, regardless of any Review Body recommendation.

79. We are unable at time of submission of this evidence to provide an update on our project to measure primary care activity, which is aiming to collect data on both volume and intensity of GP consultations and other activities. Clearly, this increased workload relates to all GPs, both contractors and salaried. There have been other estimates of growth in consultations. NHS England[56] extrapolated previous trends to suggest there are currently around 340 million consultations per year up from 30 million in 2008; the RCGP[57] estimates that this will rise by another 69 million by 2017/18. In Northern Ireland, the Department is working with the BMA NI GPC to look at pressures on GP workload, including extracting data from GP IT systems; the analysis of this work is underway, but initial results show that there have been very substantial increases in workload across most types of activity, including consultations, prescribing, incoming mail and administration, lab test received, and so on. Scotland did provide some official data around practice contacts up to 2012/13, but this is currently under review. The last publication[58] showed a 0.5 per cent increase in combined GP and practice nurse contact from 2011/12 to 2012/13, or nearly 10 per cent when considered since 2004/5.

80. In the last DDRB report and subsequent discussions with the Review Body members and secretariat, the DDRB requested a large amount of data and evidence around General Practice expenses, with a view to reformulating the way in which a GP net income recommendation is translated into a gross practice earnings recommendation. We have undertaken some further investigation into what may be possible in this respect, but the BMA has significant concerns about the ability of any party to provide this level of detail. We are particularly concerned about the bureaucratic burden this may place on practices, and the considerable costs it may impose – for instance to collect and analyse practice accounts – especially where it is unclear what the benefit will be. We do not believe the Health Departments are able to request, let alone demand, this evidence directly from practices either.

81. **We strongly urge the DDRB therefore to work with the TSC at the HSCIC to request what it believes the minimum essential additional data collection might be, which can then be considered in depth by all the national Governments, NHS Employers and the BMA, as to the feasibility, timescale and costs of a new data collection exercise.**

82. We have, as indicated to DDRB, undertaken a review and discussed with specialist medical accountants the possibility of using practice accounts to provide greater granularity around practice expenses. Putting aside the practical issues of collecting a sufficient sample, this work has confirmed that practice accounts are unlikely in their present format to be a helpful source of data with which to inform a formula. This is mainly because the level of detail in published accounts is typically too aggregated to identify specific expenses that are largely outside the ability of a GP to control, and that there is too much variability across practices in how expenses are presented.

83. With regard to staff expenses, the review has also revealed that there is a great deal of variability year on year, which makes it very difficult to find an appropriate proxy coefficient (like ASHE used in the current formula). This is because for instance of the use of locums to fill a retired or long-term sickness partner post in one year (an expense), which is then recruited or returned to permanently by a contractor the following year (earnings).

Case Study: GP Partner, Northern England

Dr J has been working for two years in the same practice in the North of England in which he also trained. In this time the practice, and the workload it has to manage, has changed enormously. The practice currently has three full time partners, two full time salaried GPs and a locum to fill occasional sessions. Through departures of GPs and unavoidable changes in the overall staff composition, the practice has lost an equivalent of 1.5 FTE GPs in the last two years. In addition, the surgery has also lost a practice nurse and 1.5 FTE administrative staff. It has been considered unaffordable to recruit and employ in those positions again.

Attempts to recruit new GPs to the practice, partners especially, have been made but have proven unsuccessful. Both of the salaried GPs to be recruited to the practice in the last two years were offered, but declined, partnerships. With a rising workload within the practice, salaried positions with greater protection around hours of work and assurance of income were more attractive. In order to attract salaried GPs to the practice, it has been necessary to raise the salary in the region of 13 per cent and pay medical indemnity costs.

Dr J and his colleagues work hard to maintain their core service provision. However, some enhanced services are increasingly seen as a source of added pressure, reducing the time available to provide core appointments and are likely to be relinquished in the next year or two. Examples included Prostate Cancer Follow Up (LES) and Risk Profiling (DES) of the practice population. Inevitably this will reduce income, but this is seen as necessary to avoid a worsening of core services, ensuring enough acute and non-urgent appointments can be made available to the widest range of patients and the practice can cope with rising demand locally. Partner income is shared equally within the practice and has already declined considerably in recent years. Dr J says his monthly net income is lower now than when he was a GP trainee in the practice.

84. We have also considered alternative indicators to the measures of inflation currently included within the formula (ASHE for staff expenses, RPIX for non-staff), but none of the official statistics (for example, CPI, AWE) offer better predictive power on expenses. We have also considered the possibility of a bespoke inflation index; in theory this may be beneficial if the main drivers of expenses inflation are the same each year, but in the same way as staff expenses, an initial trawl of accounts suggests that there is variability in many areas of expenses, so this would probably need to be re-specified each year.

85. **While our preference would still be for some kind of national formula, the failure of the current formula to reflect expenses growth over the last few years as DDRB acknowledged in its last report, means that this year the BMA does not wish the Review Body to continue with the formula. We do however believe it is important the DDRB makes a gross earnings recommendation as well as net income one if this is possible.**

86. It is our view that without the "straitjacket" of a formula it may actually be easier to make such a recommendation that will minimise the risk of a perverse result such as last year's recommendation, which forced significant cuts on practices by recommending a lower gross uplift (0.28 per cent) than the net income increase (1 per cent). If other parties or DDRB itself have suggestions for how to rework a formula, we would of course be very pleased to assist with this, but do not believe this will now be possible for this round.

87. We took advice from the specialist accountants and some members around which areas of expenses show the greatest increases this year, and which are difficult to control, at least in the short-medium term. In particular, members have indicated that utilities costs (gas, electricity), stationery and postage, bank charges 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. Many of these expenses do of course apply equally to salaried GPs as well as to contractor partners. Contractor GPs are also responsible for employer pension contributions, and face an increased rate in these in April 2015 followed by further cost increases in 2016 from the loss of the contracted out rebate.

88. As examples of why these costs are difficult to control, some CCGs provide a particular brand of printer for the practice but the GP then has to buy the toner cartridges themselves, even though they would have chosen a different brand with a lower whole life cost themselves. CQC requirements for cleaning standards have also imposed a level of cleanliness that is not necessary in certain areas of a practice but for which there is no flexibility. Because of the increased demand for consultations, many practices have attempted telephone consultations and triage, but initial anecdotal evidence suggests that this does not necessarily generate savings from reduced physical consultations.[59] Postage is still required for sending confidential information to patients, in case their email or text can be accessed by other people.

89. GP medical indemnity costs have also 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 Pulse magazine reports instances of increases of over one-third, and one Medical Defence Union said its fees had increased by 10 per cent.[60]

Case Study: Single handed GP, Midlands

Dr K has been running a popular single-handed practice in the Midlands since 1988. At his practice it is not uncommon for him to see generations of the same family. For Dr K, managing a practice on his own increases the degree of personal and professional pride in the service he is able to provide to patients. When workload becomes severe, as it can do at times throughout a year, continuing to provide the same level of service is difficult. Employing suitable locums is problematic due to a lack of availability. Even if they are available, arranging for locum cover can require a 6-8 week lead time.

Dr K's income has declined by approximately 22 per cent in the last three years. In his practice, he thinks that a combination of fixed or unavoidable costs is an increasing problem to practice funding. The cost of disposing of clinical waste and essential utilities like electricity has risen in recent years. Despite a decline in his own income, Dr K has remained committed to awarding annual pay rises to his staff working within the practice, from the Practice Manager to the practice Health Care Assistant.

90. To support the anecdotal and practice accounts based indicators, we have again looked at the breakdown of the Consumer Price Index, as this is calculated from a basket of goods and services. It is therefore possible to compare at a national level those areas of expenditure that practice accountants have indicated higher than general inflation, which are largely outside of practice control.

Breakdown of the Consumer Price Index

CPI component	Inflation rate 2014 (July)
Electricity / Gas	**4.7 per cent**
Water & Sewerage	**2.4 per cent**
Postal Services	**3.7 per cent**
Domestic Services	**3.0 per cent**
Medical products	**2.6 per cent**
Telephone	**0.5 per cent**
Newspapers & Periodicals	**7.5 per cent**
Overall CPI	**1.6 per cent**
Overall RPIX	**2.6 per cent**

91. Finally, we are unable again to offer any new evidence around GP trainers' workload, but 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. The Centre for Workforce Intelligence[61] recommended for instance a substantial increase in the number of GP training numbers to avoid a major workforce imbalance by 2020. In the continued absence of firm proposals for reviewing the GP trainers' grant, we would ask the Review Body to recommend an increase in line with its overall recommendations for all doctors this year.

Conclusions

92. The BMA has become increasingly concerned about the ability of the DDRB to exercise its independence, with recent recommendations seeming to us to reflect the Westminster Government's pay policy and affordability constraints. We believe strongly that the Review Body should not be constrained in this way, and would ask that DDRB considers how their previous recommendations have been actually implemented, when making its recommendations this round.

93. The BMA remains committed to providing evidence in areas where we feel we can add value, especially as the devolved nations have not (at time of submission) restricted the DDRB's remit. However, much of the evidence sought is outside our control, or would place an unacceptable cost on our members. Our evidence this year has also been less comprehensive than some previous years due to uncertainties around continuing contract negotiations for many of our members.

94. As we warned in recent years, we believe that the health services have now reached a critical juncture. Doctors have been working harder and harder to deliver the quality services that patients deserve, with year on year real pay cuts, but this reliance on goodwill is not sustainable and doctors cannot offer much greater contribution without a significant input of resources. Our case-studies present a powerful illustration of the impact of under-funding on real doctors' working and personal lives.

95. While the overall health spending by Governments is outside the DDRB's remit, we would ask that the Review Body considers the contribution that doctors have made and continue to make in "keeping the NHS afloat", and that their recommendation reflects this.

96. The BMA believes that doctors merit an award in excess of inflation this year. We are not however including a specific figure that we are seeking by way of a pay increase.

97. In light of the performance of the formula that DDRB has used to translate the net income recommendations for GPs into the gross earnings recommendation, we are asking the Review Body to make their recommendation without use of the formula. We remain committed to working with relevant parties to develop an alternative approach, but our attempts this year have been unsuccessful.

98. 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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