

**The Review Body on Doctors' & Dentists'  
Remuneration  
Review for 2015  
General Medical Practitioners and  
General Dental Practitioners**

**Supplementary Evidence**

# **The Review Body on Doctors' and Dentists' Remuneration**

## **NHS England's Supplementary Evidence for the 2015 Review**

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## **Contents**

EXECUTIVE SUMMARY	3
Overarching question raised by DDRB	3
CHAPTER 1: GENERAL MEDICAL PRACTITIONERS (GMPs)	5
Introduction	5
Contractual negotiations	5
Questions raised by DDRB	5
Issues raised by the BMA in their evidence	7
CHAPTER 2 – GENERAL DENTAL PRACTITIONERS	8
Introduction	8
Contractual negotiations	8
Questions raised by DDRB	8
Next steps	8

## EXECUTIVE SUMMARY

- 0.1 Pay uplifts for doctors and dentists, who work for the NHS, are determined by the Government in light of recommendations made by the independent review body on doctors and dentists remuneration (DDRB). This body takes evidence from the four UK governments and other bodies / organisations, including NHS England, as well as trade unions and NHS Employers before making its recommendations.
- 0.2 The original pack of evidence from NHS England was published on 30 September, 2014 and is available on NHS England's website:  
<http://www.england.nhs.uk/wp-content/uploads/2014/09/ddrb-evidence-1516-140914.pdf>
- 0.3 This further evidence follows on from the above publication, and contains NHS England's evidence to DDRB on General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs) in response to the supplementary questions raised by the Review Body's members.

### Overarching question raised by DDRB

- 0.4 DDRB have asked a number of questions. The section below deals with their question that applies to both GMPs and GDPs, as follows.
- 0.5 **DDRB question:** *The BMA says it does not wish DDRB to continue using the formula approach for the GMS uplift. The BDA (para 5.55) supports the continued use of the formula. What is NHS England's position?*
- 0.6 **NHS England response:** Our view is that it seems anomalous that DDRB is a pay review body, yet it makes recommendations for independent contractors which involves considering the level of their expenses.
- 0.7 In many ways this is not a logical position. Independent contractors, by their very nature, are able to influence the level of income and expenditure which their businesses experience.
- 0.8 Focussing on GMPs:
  - (a) additional income could also be gained from NHS and other public sector work. For example, in providing enhanced services such as extended opening hours and receiving payments under the Extended Hours Directed Enhanced Service. In addition, practices providing high quality services that respond to patient need can attract more patients and therefore funding; and
  - (b) expenses could be reduced through seeking greater efficiencies, for example, through:
    - (i) the introduction of federated approaches and sharing of back office functions and staff across practices;

- (ii) appropriate increased delegation to other members of the practice team; and
  - (iii) partnership working with local pharmacies.
- 0.9 If the BMA, and DDRB, feel it is no longer appropriate to use a formula to calculate the gross contract uplift, we would suggest a better alternative would be for NHS England and the negotiating parties to discuss and consider an appropriate uplift for expenses within future contract negotiations. In addition, while we note that the BDA supports the use of a formula approach, we would suggest that independent contractors are treated in a uniform way.
- 0.10 We note that in their evidence to DDRB, the BMA have commented at paragraph 74 that they believe that GPs have delivered substantial efficiency savings already, and on that basis, “*...it is unnecessary and inappropriate to apply efficiency savings to the Review Body’s recommendations on gross contract uplift for GMPs*”.
- 0.11 We believe that the best way to test that point, and to take into account and credit any relevant efficiencies that have been delivered by the professions, is by discussing these in the annual contract negotiations where we would also discuss an appropriate uplift to expenses, after efficiency gains are taken into account.
- 0.12 This is the same approach that is taken for setting national prices within the NHS National Tariff Payment System, where an efficiency factor is taken into account within those calculations.
- 0.13 To conclude, given the real concerns from the BMA and others that a formula approach is no longer appropriate, we would suggest that in future:
- (a) DDRB make recommendations on the pay uplift for independent contractors, which fits more with their role as a pay review body; and
  - (b) NHS England and the negotiating parties (BMA and BDA) discuss what uplift may be appropriate for expenses, after taking account of efficiencies, within the annual contract negotiations.

# CHAPTER 1: GENERAL MEDICAL PRACTITIONERS (GMPs)

## Introduction

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

## Contractual negotiations

- 1.2 NHS Employers has completed negotiations with the General Practitioners' Committee (GPC) of the BMA over potential improvements to the General Medical Services (GMS) contract for 2015/16. The letter of agreement has already been forwarded to the DDRB secretariat.

## Questions raised by DDRB

- 1.3 **DDRB question:** *Please respond to the request from last year's report to consider the seniority payment schemes for both GMPs and GDPs to assess their compliance with age legislation and to make changes where necessary, and to report back.*

- 1.4 **NHS England response:** Alongside the Equality Act 2010, there is an additional "Public Sector Equality Duty" on NHS England to:

- a. "eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act" and
- b. "advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it (e.g. age and sex)"

- 1.5 NHS England therefore reviewed the seniority awards system and, in the 2014/15 contract negotiations, NHS Employers agreed with GPC that seniority payments under the GMS contract would be eliminated by March 2020 – and the savings reinvested in global sum payments for all contractors. That process began in 2014/15 with stopping new entrants to the seniority scheme. A methodology for the remaining reduction and elimination of seniority payments has been established within the 2015/16 agreement, based on actual payments driving the required reductions.

- 1.6 New seniority payments to GDS and PDS dentists ceased before NHS England was created, the remaining aspects of the scheme are residual and relate only to dentists who already received these payments when the Department of Health stopped new entries to the scheme in March 2011.

- 1.7 **DDRB question:** *We have seen the joint letter on the GMS contract changes for 2015-16, including detail on the agreement to publish GMPs' net earnings. Will this only apply to GMS contract practices? We would welcome your thoughts on how the publication of this data might assist DDRB in its annual*

*recommendations for GMPs.*

- 1.8 **NHS England response:** The GMS contract changes are normally mirrored across all contracts, in order to ensure all contractor groups are treated equitably. The primary purpose of this is to provide further information about the cost of GMP services and GMP pay under the government's transparency agenda. The first element of that is the publication of gross practice income during 2014/15, moving to average GP pay in each practice in 2015/16 and, ultimately, individual GP pay.
- 1.9 The joint letter sets out that:

*“...it will be a contractual requirement for practices to publish on their practice websites by 31 March 2016 mean net earnings that relate to the GMS contract for GPs in their practice (to include contractor and salaried GPs) relating to 2014/15.”*
- 1.10 Given that it will be a combined average (mean) total across both the contractor and salaried GPs within a practice, it is unlikely that this will assist DDRB in its annual recommendations for GMPs, at this stage.
- 1.11 **DDRB question:** *The BMA has called for a public debate on health service funding, focussing on how to reconcile increasing demand with universal and comprehensive care, without targeting the terms and conditions of NHS staff. It comments (para 22) 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. How do you respond to these points?*
- 1.12 **NHS England response:** We agree on the usefulness of a debate, which is why we published the “*Call to Action*” document<sup>1</sup> in July 2013. It called on the public, NHS staff and politicians to have an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of its patients. That was followed up in August 2013 by a sector-specific *GP Call to Action* document<sup>2</sup>. We published our emerging findings in March this year in our Phase One Report<sup>3</sup>, and this has directly informed NHS Five Year Forward View<sup>4</sup> – which we published on 23 October.
- 1.13 It recognises that the NHS has to change in the coming years, setting out a new commitment to preventing ill health, and illustrating new care models that could deliver a better and fundamentally more productive health service. The Forward View also outlines the investment that will be required by the next government, partly because we do not believe that pay freezes can be repeated

<sup>1</sup> Available at: <http://www.england.nhs.uk/2013/07/11/call-to-action/>

<sup>2</sup> Available at: <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/>

<sup>3</sup> Available at: <http://www.england.nhs.uk/2014/03/11/cta-emerging-findings/>

<sup>4</sup> Available at: <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

indefinitely. The NHS must stay broadly in line with private sector wages in order to recruit and retain frontline staff.

- 1.14 However, as the changes framed by the Forward View will not be immediate, it is likely that wage restraint will need to be assumed for 2015/16 at least. Also, we believe that simultaneous action will be needed to reduce demand, increase efficiency and to secure the right funding. Less impact on any one of them will require compensating action on the other two. There are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government.
- 1.15 **DDRB question:** *We look forward to receiving your update on the 2015-16 GMS contract negotiations.*
- 1.16 **NHS England response:** As set out in paragraph 1.2 above, NHS Employers have already written to DDRB to provide an update on the 2015/16 negotiation outcomes.

### **Issues raised by the BMA in their evidence**

- 1.17 We have seen the other comments made by the BMA in their evidence, concerning efficiencies, the value of a QOF point and MPIG and we believe these are matters that are best discussed and taken account of in the annual contract negotiations.

## CHAPTER 2 – GENERAL DENTAL PRACTITIONERS

### Introduction

- 2.1 This chapter provides an update on general dental practitioners (GDPs) providing NHS primary care services and those salaried GDPs on terms and conditions set by NHS organisations in England.
- 2.2 NHS England has met the General Dental Practice Committee of the BDA to discuss practice expenses and possible quality and efficiency improvements for 2015/16.

### Contractual negotiations

- 2.3 NHS England and the Department of Health met with the BDA on 15 October to open discussion on the efficiencies for 2015/16. This was a preliminary meeting to identify possible areas of efficiency and a further meeting to advance negotiations is scheduled for November.

### Questions raised by DDRB

- 2.4 **DDRB question:** *We would welcome an update on the outcome of the GDS negotiations for 2015-16 when known.*
- 2.5 **NHS England response:** We will be pleased to provide an update once negotiations are concluded.
- 2.6 **DDRB question:** *Para 5.58 – are you able to provide us with a comprehensive list of reimbursements?*
- 2.7 **NHS England response:** The contract between NHS England and dental providers is normally set at a rate per Unit of Dental Activity or Unit of Orthodontic Activity. As these are local contracts and agreements they can be, and often are, varied locally to include specific local payments. Broadly, the value of the UDA/UOA is intended to cover all costs of providing the services. The only national reimbursement of expenditure that NHS England makes to dental contractors above the UDA/UOA value is for non-domestic rates. Other payments are made in line with the Statement of Financial Entitlement and include domiciliary services, though they are not expenses reimbursements.

### Next steps

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