

**The Review Body on Doctors' & Dentists'
Remuneration
Review for 2016
General Medical Practitioners and
General Dental Practitioners
Supplementary Evidence**

The Review Body on Doctors' and Dentists' Remuneration

NHS England's Supplementary Evidence for the 2016 Review

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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, 2015 and is available on NHS England's website:

<http://www.england.nhs.uk/wp-content/uploads/2015/10/ddrb-evidence-16-17.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:** *Para 0.12: what is NHS England's assessment of the necessary uplift to the pay of GMPs and GDPs? Your evidence on affordability (paras 0.8 to 0.11) suggests a low award, but the Five Year Forward View set out your belief that "as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff". Please clarify your position.*
- 0.6 **NHS England response:** The five year forward view acknowledges that NHS pay will need to be competitive in a buoyant economy, but also notes the strict efficiencies needed to meet the funding gap. In addition, NHS England will also need to live within the Government's public sector pay policy, of only funding uplifts of up to 1%, for the next four years. The 1% cap will deliver some of the required efficiencies, whilst the remainder will be delivered through contractual negotiations.
- 0.7 **DDRB question:** *Can you set out what you consider to be the main unavoidable non-reimbursed cost drivers that NHS practices face (both GMPs and GDPs), in order of magnitude. How have these costs changed in recent years?*
- 0.8 **NHS England response:** It is worth noting the context that inflation in the economy is at historically low levels as reported by the ONS¹ in their September press release "*Inflation remains negligible.*"

¹ Available at: <http://www.ons.gov.uk/ons/rel/cpi/consumer-price-indices/september-2015/sum-cpi-september-2015.html>

- 0.9 As GMPs and GDPs are independent contractors we do not have access to detailed accounts and expenses data.
- 0.10 However, in focussing on GMPs, the Health & Social Care Information Centre (HSCIC) publish a range of data on GP Earnings & Expenses² and also a separate Earnings & Expenses time series³ which shows how the various expenditure categories – such as employee cost, car & travel, general office and business expenses and other – have changed over time up to 2013/14. This data is aggregated from individual GP tax returns.
- 0.11 It is of course open to practices to reduce their costs by taking the opportunity to federate and achieve economies of scale, or to remain independent but to – for example – share back office functions or club together when purchasing.
- 0.12 It does not necessary follow that, just because a particular expenses category has increased in the past – or appears to be doing currently, as in the case of professional indemnity insurance - we should necessarily automatically fund any increase relating to that going forward.
- 0.13 Professional indemnity insurance cost increases are affecting practice expenses nationally – and NHS England is working closely with the BMA and others to investigate the issue. This includes what the cost drivers are and how it might be possible to help mitigate them.
- 0.14 As the NHS Five Year Forward View made clear, we need to start doing things differently as the previous model is unsustainable.
- 0.15 Focussing on GDPs, the HSCIC also publish a time series of dental expenses⁴ although the same logic applies to dental expenses as to GP expenses.

² Available at: <http://www.hscic.gov.uk/catalogue/PUB18375>

³ Available at: <http://www.hscic.gov.uk/catalogue/PUB12625>

⁴ Available at: <http://www.hscic.gov.uk/catalogue/PUB18376>

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 continues to negotiate with the General Practitioners' Committee (GPC) of the BMA over potential improvements to the General Medical Services (GMS) contract for 2016/17. An announcement will be made in due course, and details shared with DDRB.

Questions raised by DDRB

- 1.3 **DDRB question:** *We understand that you are responsible for meeting 1,000 of the 5,000 target increase in GMPs, to be delivered by retention and return initiatives. Can you give us some more information on how you are addressing this. Are you on target to hit the 1,000 GMPs by 2020? How are these initiatives being funded, and is this an area for which you would welcome DDRB recommendations for the targeting of this year's award?*
- 1.4 **NHS England response:** We are currently developing three main initiatives:
- improving the ability of people to return to practice by making it easier administratively, and by removing the cost barriers to doing so;
 - testing out the kind of factors that will help people to remain in practice, and reviewing the research base on this. Clearly, the overall state of general practice and the direction of travel has a bearing, as well as funding issues; and
 - stimulating initiatives to develop the wider workforce in general practice, e.g. through piloting the introduction at scale of clinical pharmacists, in order to manage workload better and improve outcomes.
- 1.5 We do not think it is practical for financial incentives to be targeted through the DDRB award as it is a national pay award. Instead, the GP Workforce 10 Point Plan, which is funded from the four year Primary Care Transformation Fund, will incentivise trainee recruitment into under-doctored areas, as well as a range of targeted measures to encourage the retention and return of more experienced GPs within the workforce. The latter are already beginning to contribute towards the target.
- 1.6 **DDRB question:** *Does NHS England have a view on the level of the GP specialty trainee supplement? Does it need adjusting?*

- 1.7 **NHS England response:** The GP specialty trainee supplement is the responsibility of Health Education England (HEE).
- 1.8 Regarding DDRB's recommendation on GP trainee payments, we are keen that any changes do not create a disincentive for junior doctors to train as GPs at a time when we are planning a significant GP recruitment drive, with the aim of recruiting an extra 5,000 doctors in general practices. We would like to be able to clearly state to GP trainees that nobody will be disadvantaged as a result of these changes.
- 1.9 **DDRB question:** *Para 1.15 says "salaried GP recruitment and retention is a problem for some areas of England". Can you give us more detail, please. Whilst you say that any such problems would not necessarily be influenced or resolved by a contract uplift, is there another way that additional funding (or a DDRB recommendation) could help address any recruitment and retention issues for salaried GMPs?*
- 1.10 **NHS England response:** NHS England is implementing the GP workforce 10 point plan (see paragraphs 1.4 and 1.5) and we are also working with HEE to increase the numbers of doctors in General Practice by 5,000. The 10 point plan is introducing a number of carefully targeted measures to address the geographical recruitment and retention challenges in some areas of England, which couldn't be addressed as effectively through either a contract uplift or DDRB recommendation.
- 1.11 **DDRB question:** *Para 1.38 – how are NHS indemnity costs paid at present: are they directly reimbursed, or do GMPs bear the cost?*
- 1.12 **NHS England response:** NHS indemnity costs are generally not directly reimbursed; GMPs are independent contractors responsible for their own operating costs, including appropriate indemnity cover. We know that the awards of damages in general have increased significantly above inflation in recent years, and this has had an impact on the charges that are now being incurred by GMPs.
- 1.13 During spring, 2015, NHS England piloted a scheme to reimburse some indemnity costs to GMPs. The article published in the NHS England CCG newsletter is copied below:

"Winter pressures: supporting GPs to work in unscheduled care settings"

NHS England is piloting a scheme with the main medical defence organisations (MDO) to reimburse indemnity costs to GPs committing to new Out Of Hours sessions between now [1 February] and 7 April 2015. GPs will need to pay their MDO but, by evidencing their payment to their employer, will get reimbursed the value of any additional premium they have had to pay. Providers recruiting GPs will need to cover this additional business expense but will be able to be reimbursed from their lead commissioner, who in turn will be reimbursed by NHS England. CCGs interested in learning more about the scheme should contact england.primarycareops@nhs.net"

This is provided as context for DDRB members to be aware of, rather than an issue that DDRB can directly help to address.

- 1.14 **DDRB question:** *The Prime Minister has announced a voluntary seven-day services contract for GMPs. How will the value of these contracts be decided and what are the funding streams that will make up the total income for such contracts? How will DDRB's recommendations be applied to such contracts?*
- 1.15 **NHS England response:** Subject to Ministers accepting DDRB recommendations, we would envisage they are applied to all GMS contractors, with GPs in other contract arrangements being treated equitably, as happens currently with PMS and APMS contractors.
- 1.16 **DDRB question:** *Para 1.2 Please let us know the outcome of the 2016/17 GMS contract negotiations when known.*
- 1.17 **NHS England response:** We will be pleased to provide an update once negotiations are concluded.

Issues raised by the BMA in their evidence

- 1.18 **DDRB question:** *Comments please on the BMA's evidence on GP vacancies (para 41 of their evidence).*
- 1.19 **NHS England response:** We acknowledge there is a lack of data on vacancy rates in General Practice. From September 2015, as part of the Workforce Minimum Dataset, the HSCIC has started to collect information on vacancies from practices. The data will be published in March 2016.
- 1.20 **DDRB question:** *BMA (para 50) refers to physician associates being employed on a salary of £50,000. How was this salary arrived at?*
- 1.21 **NHS England response:** We understand this is a recruitment exercise hosted by The Hillingdon Hospitals NHS Foundation Trust with which we have had no involvement. It appears from the published job advertisements, that these are fixed term contracts of one or two years' duration.
- 1.22 **DDRB question:** *Your evidence (0.6) says that GMPs will need to continue to deliver efficiency gains. But the BMA says (para 75) that GMPs have delivered virtually the maximum level of efficiency savings that is possible. How do you respond?*
- 1.23 **NHS England response:** Whilst we recognise that delivering efficiencies is challenging, the NHS is required to meet the funding gap identified in the Five Year Forward view. All areas of the NHS are required to contribute to these efficiencies. This includes contractors working for the NHS, such as GMPs and GDPs, as well as those directly employed.

- 1.24 As set out at paragraph 0.11, above, practices do have opportunities to reduce their costs, including through federating - or even simply clubbing together to purchase supplies and achieve economies of scale. To suggest there is no scope for improvement would not be accurate. The recent report published by the Primary Care Foundation and NHS Alliance identified a number of ways in which practices can secure greater efficiencies.
- 1.25 **DDRB question:** *Do you agree with the BMA (para 82) that the review of the Carr-Hill formula will provide an opportunity to review the question of expenses?*
- 1.26 **NHS England response:** No. The formula simply distributes a sum of funding across practices determined by the number of registered patients and the price per weighted patient. The formula does not determine the quantum of funding that might be required for expenses. However, NHS England remains open to discuss the issue of expenses with the GPC as we have flagged for the past two years.
- 1.27 **DDRB question:** *BMA (para 88) seeks an increase to the GP trainers' grant in line with the overall contract uplift. Views please.*
- 1.28 **NHS England response:** The GP trainer grant is the responsibility of HEE and not NHS England, we are therefore not in a position to comment on any changes to this payment. We would reiterate, though, that at a time when we are planning an increase of 5,000 doctors in general practice, there would need to be sufficient GP trainers available to deal with the increased number of trainees.
- 1.29 **DDRB question:** *BMA (para 88) seeks an increase to the GP appraiser contract. Views please. What are these contracts, how are the value of such contracts agreed, and what is your view on them being uplifted?*
- 1.30 **NHS England response:** Medical appraisal is appraisal of a doctor by a trained appraiser, in which the doctor demonstrates that they are practising in accordance with the GMC Good Medical Practice Framework for appraisal and revalidation. The appraiser fee is determined by NHS England as a payment for this service. The current fee was a consolidation of a range of fees prior to 2013/14 and is set at £500 per appraisal. The ease of recent recruitment indicates that the fee is sufficient remuneration for the service.

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 2016/17.

Contractual negotiations

- 2.3 NHS England continues discussions with the BDA and will make a recommendation to the Department of Health based on the outcome.

Questions raised by DDRB

- 2.4 **DDRB question:** *Para 2.2 Please let us know the outcome of the discussions with the BDA when known.*
- 2.5 **NHS England response:** We will be pleased to provide an update once negotiations are concluded.
- 2.6 **DDRB question:** Is there evidence to indicate that GDPs are actually “well remunerated” for their NHS work, not just their private work?
- 2.7 **NHS England response:** The HSCIC earnings and expenses report looks at the 2013/14 NHS and private dental earnings and expenses of self-employed primary care dentists by percentage of time spent on NHS dentistry as opposed to private dentistry. The report shows that when looking at all self-employed primary care dentists, those who spend 75% or more of their time on NHS dentistry have an average taxable income £71,400 and those who spend 25% or less of their time on NHS dentistry have an average taxable income of £82,100. Although it appears earnings are lower when there is more NHS work than private work, those performing mostly NHS work appear to be well remunerated.

Issues following the BDA evidence

- 2.8 **DDRB question:** *The BDA says (para 2.2) that it has approached NHS England with a view to submitting joint evidence on expenses but also notes concerns (para 4.6) with the way negotiations were conducted on efficiencies. Will NHS England work with the BDA on joint expenses evidence?*
- 2.9 **NHS England response:** NHS England has been discussing the handling of dental expenses with the Department of Health and the BDA. We intend to discuss this further with the BDA but, in the absence of a lead from DDRB, we are not inclined to try and develop a new methodology for determining expenses at this point.

- 2.10 The close interaction with the challenging, but essential, efficiency savings that dentistry – along with all other NHS commissioned services – are expected to achieve – would make this very difficult. There is no evidence that NHS dentistry is not sufficiently funded, as can be seen in the HSCIC report on earnings, dentists continue to be well remunerated from NHS dentistry - which implies that the balance between expenses and income is broadly right.
- 2.11 **DDRB question:** *For GDPs, how are NHS indemnity costs paid at present: are they directly reimbursed, or do GDPs bear the cost?*
- 2.12 **NHS England response:** NHS Indemnity costs are not reimbursed as part of the dental contract; GDPs are independent contractors responsible for their operating costs, including appropriate indemnity cover.
- 2.13 **DDRB question:** *The BDA (paras 4.7 to 4.9) discuss the possibility of 7-day services for primary care dentistry. What plans are there for such services?*
- 2.14 **NHS England response:** Primary care dentistry is a locally commissioned service planned in consultation with our local partner organisations and reflecting oral health needs assessments. The operating hours are determined as part of the tendering processes for each contract and will reflect local needs, including any expectation of access sessions outside the current normal working hours. We have no plans at present to change these arrangements.

Next steps

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