Twenty-sixth report 1997 / Review Body on Doctors' and Dentists' Remuneration ; Chairman, C.B. Gough ; presented to Parliament by the Prime Minister by Command of Her Majesty, February 1997.

Review Body on Doctors' and Dentists' Remuneration

TWENTY-SIXTH REPORT 1997

Chairman: C B Gough, Esq

Cm 3535

£11.70

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971 to advise the Prime Minister on the remuneration of doctors and dentists taking any part in the National Health Service.

The members[1] of the Review Body are :

Brandon Gough, Esq *(Chairman)*
Mrs Beryl Brewer
Miss Carol Hui
Michael Innes, Esq
Roderick Jackson, Esq
Christopher King, Esq CBE
Dr Elizabeth Nelson
David Penton, Esq

The Secretariat is provided by the Office of Manpower Economics.

[1]Miss Hui, Mr Jackson and Mr King were appointed to the Review Body by the Prime Minister from February 1996.

Contents

Summary of Recommendations and Conclusions

Chapter 1 – Economic and general considerations

- Consultants' concerns about manpower shortages in particular specialties, as well as their concerns about their expanding non-clinical workload, should be addressed in the Departments' forecasting of future manpower needs (paragraph 1.25).
- The parties should have due regard to the development of flexible working arrangements in their future considerations of manpower planning in the NHS (paragraph 1.27).
- From our appraisal of pay comparisons we have concluded that the remuneration of our remit groups remains broadly in line with their comparators in other professions (paragraph 1.37).
- Our proposed pay increases should be enhanced by a further 0.7 per cent on account of the relative deterioration of pension benefits for members of our remit groups. The enhancement should be implemented over two years with 0.35 per cent applying from 1 April 1997 and the balance of a further 0.35 per cent from 1 April 1998 (paragraph 1.47).
- We continue to support the principle of pay parity between clinical academic staff and NHS clinicians (paragraph 1.53).

Chapter 2 – Career grade hospital doctors and dentists

- Trusts' managers should consider how consultants' job plans might be better structured to deal with doctors' individual workloads and agree appropriate remuneration arrangements with consultants (paragraph 2.13).
- The Departments should offer more positive guidance to Trusts on the more flexible use of extra sessional payments (paragraph 2.13).
- There should be 103 new distinction awards for consultants (paragraph 2.19).
- The values of distinction awards should be maintained at the current percentages of the consultants' national scale maximum (excluding discretionary increments) (paragraph 2.20).
- We see no need for an exceptional increase in lecture fees (paragraph 2.31).
- Pay scales for consultants, associate specialists, staff grade practitioners, hospital practitioners and clinical assistants should be increased by 3.4 per cent with a further addition of 0.35 per cent for pensions (paragraph 2.33).
- Trusts adopting transitional local pay, as recommended in our Twenty-Fourth Report, should negotiate locally on the level of increase appropriate for 1997-98 (paragraph 2.34).

Chapter 3 – Doctors and dentists in training

- There should be no change in the remuneration structure for the specialist registrar grade (SpR) which was introduced provisionally for 1996–97 (paragraph 3.11).
- Remuneration for Locum Appointments—Service should be based on the mid-point of the nine-point SpR scale. Remuneration for Locum Appointments—Training should be the appropriate rate of pay applicable on entry to the substantive SpR grade (paragraph 3.15).

- Priority should be given to eliminating any on-call post which involves doctors having to work at full shift intensity (paragraph 3.22).
- There should be no change in the remuneration structure for additional duty hours (paragraph 3.23).
- The Departments and employers should take appropriate action to ensure that non-pay elements of the New Deal are in place (paragraph 3.23).
- The remuneration structure for flexible trainees should remain unchanged (paragraph 3.28).
- Imaginative and flexible solutions are required to address the nature of part-time contracts and training arrangements (paragraph 3.28).
- The salary scales for all grades of junior doctors should be increased by 3.4 per cent with a further addition of 0.35 per cent for pensions (paragraph 3.29).

Chapter 4 – Doctors in public health medicine and community health

- The nine point scale for specialist registrars in the hospital service should apply to specialist registrars in public health medicine. The conditions prescribed for the award of the top two increments are designed to protect doctors whose training has not been completed and who have performed satisfactorily (paragraph 4.15).
- The public health trainees' out-of-hours supplement should continue at its present level of 15 per cent (paragraph 4.22).
- Sessional fees for 1997–98 should be set nationally. Our recommended levels take into account "shortfalls" in remuneration arising from previous years (paragraph 4.30).
- Salaries for doctors in public health medicine and community health should increase by 3.4 per cent with a further addition of 0.35 per cent for pensions (paragraph 4.31).

Chapter 5 – Ophthalmic medical practitioners

- The gross fee for OMPs' sight tests should be £14.10 (paragraph 5.7).
- Fees for OMPs' domiciliary visits should be increased by 3.4 per cent (paragraph 5.9).

Chapter 6 – General medical practitioners

- The notional value for GMPs' out-of-hours work and responsibility should be £7,000 (paragraph 6.33).
- The level of IANR for GMPs, taking account of the enhancement regarding pensions, should be increased by 3.75 per cent to £46,450. The whole-time equivalent figure would be £49,005 based on the Departments' suggested methodology. GMPs will earn on average a further £3,300 from higher target payments making a total of around £52,300 (paragraph 6.46).
- The provision for GMPs' expenses should be £23,200 (paragraph 6.49).
- The balancing mechanism for GMPs should operate under normal rules for 1997–98 and should recover £615 in that year (paragraph 6.52).
- The gross amount to be delivered by the fee scale in 1997–98 should be £69,035 (paragraph 6.53).

- Our recommendation on the fee scale distributes our recommended increase in IAGR evenly across all items (paragraph 6.55).
- The GMP registrars' supplement should be increased to 22.5 per cent of basic salary (paragraph 6.59).
- The transitional deprivation payments scheme for GMPs should end on 31 March 1997 (paragraph 6.63).
- The associate's allowance should be linked to points 2 to 5 of the senior registrar scale (paragraph 6.68).

Chapter 7 – General dental practitioners

- The parties should carry out an exercise with a view to adjusting individual fee items from 1 April 1997, where appropriate (paragraph 7.22).
- Gross fees for items of service and capitation payments should be increased by 3.55 per cent. This includes an enhancement for pensions which has been adjusted to allow for gross fees containing an element for expenses as well as net income (paragraph 7.23).
- Compensation should be payable to dentists in cases where the fee scale applicable to a course of treatment is more than one financial year out-of-date (paragraph 7.25).
- Sums exceeding £10 million could be needed for schemes to make a significant impact on access to NHS dentistry once the piloting phase is complete. Finance initiatives should be "ring fenced" to dentists to ensure that resources are targeted to meet their objectives (paragraph 7.35).
- There should be no change to the structure of the salaried GDP pay scale (paragraph 7.38).
- The remuneration of salaried general dental practitioners should be increased by 3.4 per cent with a further addition of 0.35 per cent for pensions (paragraph 7.39).
- Sessional fees for emergency dental services should be increased by 3.4 per cent with a further addition of 0.35 per cent for pensions (paragraph 7.40).

Chapter 8 – Dental public health and the community dental service

- There should be an additional increment at the top of the assistant district dental officer salary scale (paragraph 8.8).
- The salary scales for all grades of dentist in dental public health and the Community Dental Service should be increased by 3.4 per cent with a further addition of 0.35 per cent for pensions (paragraph 8.10).

Our main recommendations on pay levels are:

Grade	*Point on scale*[1]	*Recommended basic scales 1 April 1997* £
Hospital doctors and dentists — main grades (whole-time salaries):		
House officer	minimum	15,440
	maximum	17,430
Senior house officer	minimum	19,260
	maximum	24,440
Registrar	minimum	21,530
	maximum	26,120
Senior registrar	minimum	24,800
	maximum	31,400
Specialist registrar	minimum	21,530
	maximum[2]	31,400
Staff grade practitioner	minimum	23,390
	maximum	34,880
Associate specialist	minimum	25,945
	maximum (normal)	45,120
	maximum (discretionary)	51,885
Consultant	minimum	43,750
	maximum (normal)	56,470
	maximum (discretionary)	67,765
	distinction award 'A plus'	53,645
	distinction award 'A'	39,530
	distinction award 'B'	22,590
Community health and community dental staff — selected grades (whole-time salaries):		
Clinical medical officer	minimum	22,370
	maximum	31,120
Senior clinical medical officer	minimum	31,925
	maximum	45,820
Dental officer	minimum	21,635
	maximum	31,505
Senior dental officer	minimum	31,505
	maximum	45,120

[1]Salary scales exclude additional earnings, such as additional duty hours for doctors in training.
[2]Subject to conditions.

Grade		*Recommended basic scales 1 April 1997* £
General medical practitioners — intended average net remuneration[1]:	From 1 April 1997	46,450
General dental practitioners	The gross fee for each item of service and capitation payment should be increased by 3.55 per cent from 1 April 1997.	
Salaried dental practitioners	minimum	21,655
	maximum	31,505

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OFFICE OF MANPOWER ECONOMICS

8 January 1997

[1]GMPs receive payments for reaching higher targets which are outside IANR. It is estimated that GMPs will receive, on average, approximately £3,300 from these payments in 1997–98.

Chapter 1

Economic and General Considerations

The 1996–97 settlement

1.1. In our Twenty-Fifth Report we put forward recommendations on the levels of remuneration that we considered appropriate for doctors and dentists in the NHS as at 1 April 1996. Our main recommendations were: an increase of 3.8 per cent for career grade hospital doctors and dentists and in the level of intended average net remuneration for general medical practitioners (GMPs); an increase of 5.3 per cent for senior registrars and registrars; an increase of 6.8 per cent in the salary scales for senior house officers and house officers (the level of that increase providing compensation for a reduction in the level of out-of-hours payments); and an increase of 4.3 per cent in gross fees for general dental practitioners (GDPs). The Government accepted our recommendations but decided to stage the increases so that one per cent was held back until 1 December 1996.

1.2. In its evidence the British Medical Association (BMA) observed that the Government's decision on staging would cost the average doctor practising in the NHS £280 during 1996–97. The British Dental Association (BDA) said that interference with our recommendations undermined the confidence of the dental profession in the Review Body system. In joint evidence the National Association of Health Authorities and Trusts (NAHAT) and the NHS Trust Federation[1] observed that, although staging our awards cushioned to some extent the in-year effect, the cost of those awards still had to be met the following year and would cause further pressure on resources.

Comment

1.3. We were very concerned at the Government's action in staging our recommended increases. As an independent body, our recommendations are made in the light of a number of factors which include the Government's own economic evidence. Our objective is to be fair to both taxpayers and members of the medical and dental professions alike by recommending levels of remuneration appropriate, in our judgement, to recruit, retain and motivate doctors and dentists. In our view the achievement of that objective is put at risk if our recommendations are not met in full on the due dates. As usual our recommendations for 1997–98 take into consideration all relevant circumstances and evidence received from the parties concerned.

Conduct of the 1997–98 Review

1.4. We received written and oral evidence for this review from the British Medical Association; the British Dental Association; the General Dental Practitioners Association (GDPA); the Health Departments, whose representatives were led by the Minister for Health; the NHS Trust Federation and the National Association of Health Authorities and Trusts—these two bodies provided joint evidence; the Advisory Committee on Distinction Awards (ACDA); and the Universities and Colleges Employers Association (UCEA). We received written evidence from the Hospital Consultants and Specialists Association; the Association of GPs in Urban Deprived Areas; the Federation of Medical Services; the Medical Protection Society; and the Overseas Doctors'

[1] referred to in this report as the 'employers'.

Association in the UK Ltd. We also received letters from a small number of individual members of our remit groups.

1.5. Following discussions with the Health Departments and the BMA's General Medical Services Committee (GMSC), we commissioned management consultants—Ernst and Young—to conduct a wide-ranging review of general medical practitioners' out-of-hours work and responsibility. We report on this in Chapter 6. The BMA itself commissioned a review of pay comparability for hospital consultants and general medical practitioners from Hay Management Consultants whose report provided part of the profession's evidence to us. We comment on this in paragraphs 1.30 to 1.37 below. The BMA also commissioned William M Mercer to prepare a paper on the evaluation of pension arrangements for doctors and dentists which we published in our report last year. This raised a number of technical points which required us to liaise with the Government Actuary's Department and Bacon and Woodrow who carried out last year's evaluation.

1.6. As part of our preparation for the review we continued our programme of visits to NHS Trusts, health authorities, and medical, ophthalmic and dental practices throughout the country. We also held a series of discussions with groups of medical and dental practitioners at local level. We found these visits and meetings helpful and informative and we would like to thank all those who arranged and participated in the programme for their time and their contributions.

Economic evidence from the Government

1.7. On 17 September 1996, the Government published its economic evidence to the Pay Review Bodies for the 1997–98 pay round. In a statement to accompany the evidence, the Chancellor of the Exchequer told us that, over the past few years, the Government had established an approach to public sector pay that had helped to deliver improved efficiency in government departments and throughout the public sector, maintained firm control of public spending, and provided for pay settlements at realistic and affordable levels. He said that such an approach would continue and suggested to us that our pay recommendations for 1997–98 should be set at lower levels than for the previous year to reflect the changed economic context; we were asked to note that inflation had fallen since last year and was expected to fall further; there were no pressures on pay in the economy generally; and the Government remained determined to contain public expenditure.

1.8. In its evidence, the Government informed us that its approach to public sector pay meant that in public expenditure terms, the cost of running government and the public services should not increase as the result of pay settlements and might fall to the extent that greater efficiencies were possible or additional savings were made in support of the overall public expenditure objectives. It meant also that any increases in pay should at least be offset by improvements in efficiency or productivity; that pay should reflect the needs of staff recruitment, retention and motivation in a way which reflected local circumstances, without assuming any automatic entitlement to annual increases or comparability with other groups; and that, although there was no guideline or going rate for the size of settlements, all pay settlements must be affordable and reflect the finance available and the other pressures on the budget from which the paybill would be met. The Government's evidence observed that there would be no access to the Reserve to fund settlements in the coming year.

1.9. We were asked to take account of the full year costs of the doctors' and dentists' 1996 settlement and to recognise the need for public sector settlements in 1997 to adjust to the lower levels of inflation that now prevailed and would continue, and the importance of containing pay costs within the Government's overall responsibility to maintain healthy public finances and economic performance.

Affordability

1.10. The Departments suggested to us that, in formulating our recommendations, we should have regard to their affordability within the total amount identified by the Government for expenditure on the NHS in 1997–98. They said that there was no simple arithmetic link between increased cash funding for the NHS nationally and the amount which could be afforded for a paybill increase. They observed that the resources available to the NHS combined a cash uplift for 1997–98 over 1996–97 and efficiency savings which would be used together for service improvements, pay increases and price rises. The equation of resources and costs would be different in each Trust, as the sums available depended on Trusts' contract incomes, local scope for efficiency savings and non-pay cost pressures. They said that no single figure in the unified Budget—neither the overall Hospital and Community Health Services (HCHS) funding increase, nor the efficiency target, nor the gross domestic product deflator forecast for inflation—should be taken as a benchmark for NHS pay.

1.11. The employers pointed out to us that the recommendations in our Twenty-Fifth Report had created particular pressure on those Trusts employing large numbers of doctors and that, owing to the relative size of the awards to our remit groups, Trusts could only afford to offer a very limited local pay element to other staff groups.

1.12. The BDA observed that key economic indicators showed a strengthening economy with steady growth, low inflation, falling unemployment, and average earnings increasing at a faster rate than inflation. It said that the NHS and NHS dentistry were increasing their efficiency and productivity, seeing more patients and treating them more quickly. It believed that the profession should share in this increased national prosperity and NHS productivity through similar improvements in remuneration.

The Government's plans for National Health Service expenditure 1997–98

1.13. On 26 November 1996, the Departments submitted to us supplementary evidence on the Government's plans for NHS expenditure in 1997–98. The key points in relation to England were an increase in NHS current spending of £1.6 billion over expenditure in 1996–97, or 2.9 per cent in real terms; a real terms increase for the HCHS current expenditure of 3 per cent; a further 2.7 per cent or £525 million for HCHS services from efficiency savings; and a real terms increase for the demand led Family Health Services of 3.2 per cent over the original plans for 1996–97, a large component being the increase in the cost of drugs prescribed by GMPs. We were informed that the Health Departments in Scotland and Wales were still some way off making announcements about their respective settlements.

1.14. The Departments reminded us of the Government's commitment to accept Review Body recommendations unless there were clear and compelling reasons not to. They said that the Government would consider our recommendations in relation to the expenditure allocations. The Departments said that no options could be ruled out now, including the possibility of staging all or some recommendations for the second year running to balance pay costs and the provision of services.

1.15. The BMA commented to us that the expenditure plans provided for a cash increase in revenue spending of 4.95 per cent and a requirement for efficiency savings of some 2.7 per cent. It said that theoretically a total increase of nearly 8 per cent was available to meet NHS cost and volume increases next year.

Comment

1.16. We have noted the Government's expenditure plans for the NHS and the parties' comments on the implications for doctors' and dentists' remuneration. We have already made observations on the likely adverse effects of staging our recommended awards in paragraph 1.3. We were surprised and disappointed that the Departments have told us, before we had even finalised our review and report, that our recommendations might again be staged.

Manpower, recruitment and retention

1.17. The Departments told us that entry to the medical and dental professions remained over-subscribed with the number of applicants to medical and dental schools 11 per cent and 33 per cent respectively above 1986 levels. They said that in 1995 there was an average of 2.2 applicants for every medical school place and 3.4 for every dental school place and that medicine and dentistry continued to attract university entrants with the highest 'A' level scores.

1.18. The Departments said that between 1985 and 1995 the number of doctors and dentists working in the NHS in Great Britain had risen by 17 per cent and would continue to rise. This, they said, was a clear indication of the Government's commitment to provide high quality care for patients and of the employment opportunities available to the professions.

1.19. The Departments said that there was no evidence to suggest that a poor retention rate was creating unfilled vacancies, and that it was clear that the great majority of doctors and dentists remained committed to the NHS throughout their careers and provided long years of service. The position was, they said, being kept under review. They said that more flexible working arrangements would be required in the future—both to ensure women were able to re-enter the workforce easily after career breaks and to enable older doctors to adjust their working patterns without feeling the need to leave the workforce entirely.

1.20. The employers observed in their joint evidence to us that the move to local determination of pay and terms and conditions would place the NHS in a better position to respond to recruitment and retention issues. The employers believed, however, that such problems were not simply pay issues. Other factors, they said, played a part, including workforce planning and the supply of doctors; the extent of training opportunities; the wastage and turnover rates during training; inappropriate limitations on some grades; and inflexibility in granting work permits for overseas doctors.

1.21. The British Medical Association acknowledged there to be a sufficient number of highly qualified applicants to fill medical school places. It told us, however, that there were signs that the new generation of doctors would not tolerate the exploitation of their vocational commitment that had taken place in the past. The Association referred to studies which it had carried out, indicating young doctors'views that medicine would have to provide the flexibility and time necessary for family and social life. The BMA said that this, taken with the increasing proportion of women entering the profession, would result in a substantially lower supply of doctors than a simple head count would suggest. The BMA also told us that general practice was experiencing an unprecedented crisis in recruitment and it implored the Review Body to act decisively to prevent what it described as a further haemorrhage of doctors from the specialty.

1.22. The BDA expressed concern at the numbers who qualified but did not subsequently remain in the NHS. It said that the increase in the number of dentists registered had not been matched by a similar increase in the number of dentists working in the NHS. It said that in September 1990 there were 26,320 dentists on the Register and that the number had risen to 27,957 in September 1995, a rise of 6.2 per cent. By contrast, for the same period, there had been an increase of only 4.1 per cent in the number of dentists in the NHS in Great Britain, from 18,011 to 18,743.

Comment

1.23. It has been a feature of evidence to this and previous recent reviews that the parties have markedly differing views on whether recruitment and retention into and among the medical and dental professions is satisfactory. The sole area of common agreement is that the quality of students entering medical and dental schools is first rate with entrants achieving high 'A' level scores. This year, the Departments have acknowledged there to be difficulties in filling vacancies in some specialties in the hospital service. They have also expressed their concern about sustaining the number of trainees in general medical practice to avoid longer term problems and on 17 December 1996 they published a White Paper

containing a range of measures aimed at making general medical practice a more attractive working environment. They have also initiated action in the General Dental Service (GDS) to help improve the availability of NHS dental treatment. We report on these initiatives in Chapters 6 and 7 respectively. From the evidence available to us, we do not accept the BMA's view that there is an "unprecedented crisis" in recruiting doctors to general practice. That said, we have noted the fall in the numbers of GMP trainees in recent years and we have come to the view that if the trend in GMP recruitment were to continue, there are likely to be manpower shortages in future years. Moreover, figures from cohort studies of graduates show that the proportion of medical graduates wishing to enter general practice decreased significantly between 1983 and 1993. In 1983, 45 per cent of doctors who qualified stated their first preference was for a career in general practice[1]. This reduced to 26 per cent of doctors qualifying in 1993. We have noted that the cohort studies have revealed that financial prospects were the lowest ranking consideration and were not widely regarded as an important influence on career choice. However, despite the Departments' actions to counter the growing difficulty of GMP recruitment, we believe that some action is needed by us to enhance GMP registrars' remuneration. We comment on this in Chapter 6.

1.24. We find the position on retention to be less clear cut. The available data suggest to us that wastage rates are low, particularly among GMPs. Evidence provided by the Health Departments shows that wastage rates among GMPs aged under 55 are relatively low, typically being below 3 per cent per year. We have also noted a growing trend among NHS consultants to opt for early retirement. In our Twenty-Fifth Report, we asked for evidence on the reasons for members of our remit groups leaving the NHS. We are disappointed that little information has so far been forthcoming and we again ask for this issue to be addressed by the parties.

1.25. The evidence submitted to us this year has commented, often critically, on central manpower planning mechanisms. It is apparent to us that these have fallen well short of what is needed to bring about a satisfactory balance between the supply of and the demand for medical and dental manpower. The Departments assure us that the planning mechanisms now in place will allow them to be more responsive to changes in demand. We consider that to be most important as, to date, we have been given insufficient data on manpower planning generally. Current shortages in some hospital specialties increase the work pressures on those in the service, with implications for morale. Moreover we believe that past shortcomings in manpower planning have had a significant impact on the professions' perception of recruitment and retention. We have also been made aware that female doctors and dentists are playing an increasing role in the delivery of services to patients. We consider this development to be important in the context of manpower planning, as women's preferred working patterns, particularly in regard to hours of work, can be markedly different from those of men. In addition we consider it important that consultants' concerns about manpower shortages in particular specialties, as well as their concerns about their expanding non-clinical workload, should be addressed in the Departments' forecasting of future manpower needs.

1.26. In the following chapters we report further, where appropriate, on recruitment and retention in relation to specific 'craft' groups.

Flexible working

Comment

1.27. We have noted from the parties' evidence that flexible working arrangements have been developed for many doctors and dentists in our remit group. We have commented on some specific issues relating to flexible working, as it applies to various craft groups, in the following individual chapters. We believe, however, that the continued development of these arrangements will be an important feature of working patterns in the NHS generally and will also play

[1]Career preferences of doctors who qualified in the United Kingdom; British Medical Journal volume 313, 6.7.96.

a major part in the effective delivery of health care services to patients. Flexible working arrangements will be particularly important to accommodate the growth of part-time working and the increasing number of female entrants to the professions. We therefore urge the parties to have due regard to the development of flexible working arrangements in their future considerations of manpower planning in the NHS.

Pay comparability

1.28. In our review last year we carried out a study into how the remuneration of members of our remit groups compared with that of other comparable professions both within and outside the public sector. Our Twenty-Fifth Report detailed our methodology and described the results of our study. We observed that we intended repeating the exercise in future years and we have accordingly looked at the latest relevant data on earnings, including fringe benefits, to inform our considerations for the current review.

1.29. The BMA in its evidence commented that in 1995 doctors' earnings on average had fallen 46 per cent behind those of comparator groups since 1980, and that pay increases averaging 53 per cent would be needed to restore doctors to their position in 1980 relative to other professions. We think, however, that such comparisons need to be treated with extreme caution as vastly different conclusions can be drawn according to the base year chosen and the choice and composition of the comparator groups. Moreover, previous Review Body reports have commented that it would be wrong for doctors and dentists to occupy a fixed position in the general pay hierarchy or for their remuneration to be determined by an automatic formula. Our view on that is unchanged.

1.30. As part of its evidence this year, the BMA submitted to us a report by Hay Management Consultants on a Review of Pay Comparability for Hospital Consultants and General Medical Practitioners which the profession had commissioned. The management consultants were asked to provide comparative remuneration data for both groups to be used as a benchmark for the BMA's evidence. Hay were asked by the BMA to conduct a review of whole-time consultants and general medical practitioners. To ensure the objectivity of the review, Hay made an assessment of the 'job weight' of these two posts, and used them to select appropriate comparators for the pay comparability exercise. The scope of the exercise included base pay, variable pay and key benefits, and, as a separate exercise, an analysis of the comparability of pensions. Doctors' private practice earnings were not included in the analysis.

1.31. The BMA suggested to us that whilst, according to the Hay Report, GMPs' and consultants' remuneration was broadly competitive with public sector comparators (a key conclusion in our view) the extent to which public sector pay had been depressed generally in recent years made the process of comparisons within the sector both circular and largely irrelevant. In oral evidence, the BMA also argued that the profession saw itself as primarily serving patients rather than working in the public sector as such. It thought therefore that different considerations should apply to doctors' remuneration over and above those applicable to public sector employees. Although the study was constrained in its scope by timing pressures, the findings, it said, showed a wide range of job weights for consultants and GMPs. Drawing its conclusions from the study, the BMA said that GMPs and consultants were disadvantaged in comparison with the private sector when looking at levels of remuneration. In oral evidence the BMA observed that a substantial pay increase was necessary.

Comment

1.32. In the past we have made clear to the parties the need for more detailed and authoritative evidence on the issues under review. We have therefore received the BMA's evidence on the Hay Report with particular interest and we have given the management consultants' report very careful appraisal. There was a subsequent exchange of correspondence with the BMA about the consultants' report and we held a meeting with the profession's representatives to discuss it in detail. We also considered the Departments' observations on the study.

1.33. We do not accept the profession's argument that pay comparisons with the public sector are both circular and largely irrelevant to our considerations. Employment in the public sector represents around one fifth of the national working population and we can see no valid case for excluding appropriate data for such a large group. Moreover, medical staff for all the purposes which we address are paid from taxpayers' money and we do not believe they should be excluded from considerations applying to other professions where incomes are met from public funds. Our practice is to consider our remit group in relation to both private and public sectors. That remains our position.

1.34. In examining the comparators, we felt the study to be weakened through its disregard of comparable professionals such as solicitors and accountants in public sector employment and in small private practices. We were also disappointed that the comparisons with the private sector were based on only four comparator professions, despite the comment in our Twenty-Fifth Report that comparability studies should be based on a wider range of comparator professions.

1.35. We noted that the results of the study showed a wide range of 'job sizes' among both NHS consultants and general medical practitioners, but significantly no detail was produced about the distribution of consultants and GMPs over the various levels identified by the job evaluation. We found it difficult to reconcile such a range of job weights with the concepts of a single salary scale for all consultants and a single figure of intended average net remuneration for all general medical practitioners—concepts which the profession has argued forcibly to us that it wishes to maintain. The BMA has also consistently argued against differentiation in consultants' remuneration according to specialty.

1.36. We do not feel that the study showed GMPs and consultants were, on average, disadvantaged compared with the private sector. The range of job weights for GMPs and consultants is very large, and although the evidence suggested consultants' and GMPs' remuneration to be below that of the private sector comparators at the upper end of the job size range, the situation was reversed at the lower end of the job size range. We consider that pay comparisons need to be based on total earnings arising from NHS activity and should have included consultants' distinction awards and notional half days. In the case of GMPs, we think the data should have been based on whole-time equivalent earnings, not simply on the remuneration of an average practitioner.

1.37. With the above considerations in mind, we have compared the findings of the Hay Report (which used assessments of 'job weightings') with those of our own exercise which was more broadly based. Taking account of the wider range of comparators in both the public and private sectors and the fact that there is already scope for those with heavier weighted jobs to earn more, we find there to be no significant discrepancy between the findings of the two studies. We have concluded that the remuneration of our remit groups remains broadly in line with their comparators in other professions. We note that the recent White Paper 'Choice and Opportunity' has outlined some suggested measures which, if implemented, might provide scope for GMPs in larger sized jobs to earn more, and we invite evidence from the parties on this for our next review. We also invite the parties to consider whether they would wish to see any further developments, for example, an expansion of the discretionary points scheme or more use of notional half-day payments, to increase the scope for greater reward to those in larger sized posts in hospital service.

Local pay

1.38. In our recent reports we have encouraged the development of local pay initiatives for our remit groups. We have some concern though about delays in procedures to facilitate their implementation at local level. However, there have also been positive signs: the move to discretionary scale points for consultants and associate specialists, implemented last year, has allowed Trusts' managements to determine a substantial part of the pay of these groups within

the framework of national terms and conditions of service. The Departments have described this as a radical step forward on local flexibilities for doctors and dentists, and we are pleased to note (see Chapter 2) the employers' observation that the new arrangements are so far working well. That view is not disputed by the medical profession. For the coming year, we have noted the Departments' aim to introduce more flexibility into the remuneration structure for the staff grades, although as we go to press no agreement has been reached with the BMA.

1.39. In our Twenty-Fifth Report, we endorsed a proposal from the Departments that sessional fees should be determined locally, but as we report in Chapter 4, the majority of Trusts have been very slow to respond. We find that disappointing. It is apparent to us that the medical profession continues to have reservations on extending local pay flexibilities and it is important, if Trusts are to gain the confidence of the profession, that they should implement appropriate policies. In the meantime our recommendation on sessional fees in Chapter 4 has been framed so as to ensure the doctors concerned receive fair reward over the coming year.

1.40. Turning to the contractor professions, we have noted the publication of the Departments' recent White Paper 'Choice and Opportunity' and, in particular, that the Government intends bringing forward legislation to enable wider contractual choices for general medical practitioners to be tested and made available. Positive results might well allow for greater local flexibility in regard to practitioners' contracts. For general dental practitioners, the White Paper has announced the Government's intention to introduce legislation to meet its long standing aim of piloting local flexibility in primary care dentistry; and, as we report in Chapter 7, an access fund for NHS dentistry has now been established in England to enable health authorities to target cash resources to local needs. We welcome these developments.

Pensions and other benefits

1.41. In our review last year, we carried out a detailed examination of the value of doctors' and dentists' pensions and other benefits in comparison with those of other professions. We commissioned the Government Actuary to carry out the evaluation of pension benefits, with further advice from Bacon and Woodrow. We reproduced the Government Actuary's findings as an appendix to our Twenty-Fifth Report.

1.42. In its evidence to this review, the BMA provided for us a paper by William M Mercer which commented on our findings. In turn we asked both the Government Actuary and Bacon and Woodrow for their further observations. The issue was further pursued through a consequent exchange of correspondence between our Secretariat and the BMA.

1.43. In our Twenty-Fifth Report, we noted the Government Actuary's conclusion that improvements in the average private sector comparator scheme since 1990 had been 'rather greater than in the NHS pension scheme, to the extent of rather more than one per cent of pay'. We commented on the full inflation protection enjoyed by doctors and dentists which, we said, represented a considerable comfort factor against times of high inflation. We accepted that since our previous examination there had been some small shift in the balance of advantage away from doctors and dentists, but we did not regard that as large enough to require any specific monetary recognition through the current remuneration system at that time. We observed that over recent years the overall improvements to private sector schemes at senior levels had outpaced developments in those for members of our remit groups. We concluded, however, that the matter was best addressed in the context of an appraisal by the Government of the doctors' and dentists' pension scheme.

1.44. In its evidence to this review, the BMA observed that our suggestion regarding the NHS pension scheme (NHSPS) was impractical because: the Government had insisted that changes to the scheme should be cost neutral; the NHSPS had been reviewed in 1995 and a wide-ranging (and cost-neutral)

package of changes had been agreed; and doctors and dentists were in a minority in the NHSPS and any changes would need to take into account the position and views of other staff groups as well as other review bodies.

1.45. In his oral evidence, the Health Minister informed us that the Health Departments were not planning any further review of the NHSPS.

Comment and recommendation

1.46. We have considered the profession's observations in the light of the Minister's comment. We have concluded that the level of our recommended pay increases for 1997–98 should take into account the shift in the balance of advantage, paragraph 1.43 above. We do not, however, intend to apply an enhancement of 'rather more than one per cent' as the Government Actuary's findings might appear to suggest. This is because we have taken into account that an increase in pay would automatically feed through to the value of pensions. Our recommendation is set at a level which avoids such double-counting.

1.47. We **recommend** that our proposed pay increases should be enhanced by a further **0.7 per cent** on account of the relative deterioration of pension benefits for members of our remit group. As pension benefits accrue over a period of years **we are recommending** that the enhancement is implemented over two years with **0.35 per cent** applying **from 1 April 1997** and the balance of a further **0.35 per cent from 1 April 1998**. For general dental practitioners the extra enhancement to gross fees which we are recommending will be lower than 0.35 per cent in both 1997–98 and 1998–99 because this increase should only apply to their net income and not expenses (see Chapter 7, paragraph 7.23).

1.48. We have also looked carefully at the non-pension benefits for doctors and dentists and their comparators. There has been an increase in recent years in the number of profit related pay schemes for private sector employees but the Government has announced its intention to phase out the tax relief on these schemes. Overall we have concluded that changes in the non-pension benefits do not have implications for our recommendations for this year.

Clinical academics

1.49. In our recent reports, we have drawn attention to the delays in 'translating' our recommended awards to clinical academics. In September 1996, the BMA wrote to us requesting that we make a specific recommendation on clinical academics' remuneration for 1997–98.

1.50. During his oral evidence on 25 October 1996, the Health Minister made clear that all parties with an interest in clinical academic pay believed that pay parity with NHS clinicians was important.

1.51. We invited both written and oral evidence from the BMA and the Universities and Colleges Employers Association. Following receipt of that evidence, we held separate meetings with representatives from each of these bodies to discuss the issue. The parties were in agreement that parity of pay between NHS medical grades and clinical academics should be maintained. They informed us that a shortfall in clinical academics' salaries relative to their NHS colleagues would result in serious recruitment difficulties which would impact on training, research and the treatment of patients. The UCEA told us that university employers had been unable to translate the full 1996–97 NHS doctors' award to clinical academic pay scales as they had insufficient cash resources available to do so.

1.52. On 26 November 1996, the Departments informed us that the Government's expenditure plans for 1997–98 had made provision for a resolution of the difficulty concerning the funding of clinical academic pay awards. We were told that the Secretary of State for Education and Employment had decided to place a condition of grant on the Higher Education Funding Council from 1997–98 that should enable universities and colleges to meet any additional costs from medical schools arising from any pay increase awarded by the Government to the NHS clinicians. We were told that the condition of grant would similarly extend to Scotland. We were subsequently informed that the funding problem for 1996–97 had also been resolved.

Comment

1.53. We continue to support the principle of pay parity between clinical academic staff and NHS clinicians and we welcome the new mechanism which we hope will ensure that problems will not arise in future in 'translating' our awards to clinical academics.

Increases in remuneration for 1997–98

1.54. In recommending pay increases which we think appropriate for 1997–98, we have, as usual, taken into account a variety of factors. These include: recruitment and retention; nature and volume of workloads; morale; job security; our findings on pay comparability, pensions and other benefits; affordability; and economic indicators such as price inflation and the level of pay settlements in the wider economy. We emphasise that our approach is not mechanistic. We have balanced all relevant factors and arrived at our judgement in an independent and objective manner on the basis of the evidence received.

1.55. The detail of our recommended increases is set out in the following chapters, each relating to specific groups of doctors and dentists. The effective date for our recommendations is 1 April 1997, with a further enhancement for pensions (see Chapter 1, paragraph 1.47) applying from 1 April 1998. Our recommendation on sessional fees (see Chapter 4, paragraph 4.30) is effective from 1 July 1997.

Chapter 2

Career Grade Hospital Doctors and Dentists

Manpower, recruitment and retention

2.1. The Departments' statistics showed that, at 30 September 1995, there were 66,080 hospital medical staff in Great Britain. These included 21,920 consultants; 2,190 staff grade; and 1,280 associate specialists. The Departments informed us that, over the last 10 years, from 1985 to 1995, the number of hospital doctors had risen by 27 per cent in England. They said that in the last 5 years the increase in hospital doctors had been slightly higher, equivalent to 2.6 per cent a year compared with 2.4 per cent for the decade.

2.2. The Departments commented that there had been some difficulties in filling vacancies with appropriately trained doctors in some specialties and disciplines and in some places. They did not accept, however, that national pay levels were a significant factor in difficult-to-fill posts, nor that there was a poor retention rate which was leading to difficulties in filling vacancies. They said that, where there were particular local circumstances or a specialty imbalance in supply or demand, Trusts already held the option of offering higher pay for a particular post or to an exceptional candidate on Trust contract terms. They said that a large, across-the-board increase in pay would be counter-productive in that it would reduce Trusts' ability to respond flexibly to local recruitment and retention difficulties.

2.3. The Departments said that it was increase in demand which had altered the balance between supply and demand and that changes in demand might be rapid and not easy to predict. They said that there were inevitably long lead-in times to the planning process which did not help them to bring supply and demand into balance. The Departments told us that the range of planning mechanisms now in place would enable them to be more responsive to changes in demand to ensure a better match between supply and demand than in the past.

2.4. The Departments observed that there was no indication of a high or increasing wastage rate among doctors but they accepted the need to take effective action to address potential problems in future years. They said that there were no signs that the level of early retirements among consultants was significant or that it differed from trends in the general population. They commented that it was clear that the great majority of doctors remained committed to the NHS throughout their careers and provided long years of service.

2.5. The employers informed us that, in 1995, NAHAT had undertaken a survey of HCHS medical recruitment difficulties. It had explored Trusts' concerns in some detail and the action that was being taken. The vast majority of Trusts had identified recruitment difficulties both at consultant and training level. The employers told us, however, that pay had not usually been mentioned in the survey as a significant factor.

2.6. The BMA also drew our attention to the medical recruitment survey by NAHAT which, it said, had revealed that 79 per cent of Trusts had experienced recruitment problems among consultants and other non-training grades, with

difficulties occurring in virtually all specialties. The BMA observed that, whilst many Trusts had highlighted problems of manpower planning as a contributory factor, one of the main reasons given for difficulties was a high fall out rate among trainees. The BMA commented that retention was a serious concern.

2.7. The BMA said that current levels of consultant expansion were intended only to maintain current levels of service provision. It referred to the Calman Report's recognition that an increased rate of consultant expansion would be required if the proposals on the future of specialist medical training were to be implemented successfully. It said that such expansion would need to be sustained for at least five years at the rate of 7.5 per cent per annum. It pointed out to us that the latest Health Departments' statistics[1] showed expansion averaging only 3.5 per cent per annum for the period 1990–95. It observed that the underlying figures hid substantial variations by specialty.

2.8. During his oral evidence, the Health Minister told us that the number of consultants needed in the NHS was under constant review. He said that the effect of the introduction of the specialist registrar grade had been accounted for in projections of consultant numbers.

Comment

2.9. We have noted the parties' differing views. We have already commented in Chapter 1 about the importance of improved manpower planning as past shortcomings in such systems can affect the professions' perception of recruitment and retention.

Workload

2.10. Our Twenty-Fifth Report highlighted the profession's concern that consultants' non-clinical activities were not being appropriately rewarded. Our report suggested that the current remuneration system already contained sufficient flexibility to address at local level the issue of consultants' expanding non-clinical workload. In its evidence to our present review, the BMA repeated its concerns and argued that temporary additional notional half days were awarded where the practitioner had taken on significant responsibilities which were not part of his or her normal contractual responsibilities. It said that such duties would undoubtedly include management in many situations and that some consultants were properly awarded temporary additional notional half days for such work. It observed, however, that activities such as unit administration and other non-clinical work were unlikely to attract temporary additional notional half days. It said that the increasing time spent on administration was permanent and should be reflected in a national pay increase.

2.11. The BMA also drew our attention to an increasing number of instances where consultants were being asked to cover juniors' duties. It described this as a particular problem in relation to on-call work and said that, during the past year, a number of examples of consultants being asked to undertake resident on-call cover had come to light.

Comment

2.12. In view of the profession's concern, we sought clarification from the Health Departments of the circumstances under which temporary notional half days could be awarded. The Departments informed us that there was nothing in the national terms and conditions of service[2] or other guidance which prevented the use of temporary additional notional half days to reward non-clinical work of the types referred to by the BMA. The Departments commented that current arrangements provided flexibility to reward particularly onerous and additional work, both clinical and non-clinical, and to review job plans where contractual requirements were unreasonable. They said that they would be willing to enter into discussions with the BMA on this issue.

[1] Department of Health statistical bulletin—Hospital, Public Health Medicine and Community Health Service Medical and Dental Staff in England 1985 to 1995, July 1996.

[2] The Hospital Medical and Dental Staff Terms and Conditions of Service sets out the criteria for the payment of temporary additional notional half days.

2.13. We welcome the Departments' positive response and their suggestion that the parties should meet to discuss the profession's concerns. In the meantime it is clear to us that suitable pay mechanisms are available locally to reward consultants over and above their basic salaries. There is, however, a clear need for Trusts' managers to address the issue of doctors' perceptions of their increasing workload. These are having a marked effect on doctors' morale and the difficulties are exacerbated by perceived pressures generated as a result of the introduction of the new specialist registrar training regime. We urge Trusts' managers to consider how consultants' job plans might be better structured to deal with their individual workloads and to agree appropriate remuneration arrangements with consultants. Trusts might also consider the scope for reducing consultants' non-clinical workload through devolving appropriate tasks to non-medical administrative grades. We also suggest that the Departments offer more positive guidance to Trusts on how extra sessional payments might be used flexibly including to reward, where appropriate, non-clinical activity. In addition, we invite the Departments to examine thoroughly the shorter-term implications of introducing the new training grade.

Distinction awards

2.14. We were told by the Chairman of the Advisory Committee on Distinction Awards (ACDA) that the changes to the distinction awards scheme, agreed between the Departments and the profession, had been successfully introduced and that the new scheme had worked well in its first year.

2.15. ACDA observed that the actual outturn for consultants employed in the NHS on 30 September 1995 was 23,241 and that, on the basis of the returns so far received as part of the 1996 data verification exercise, it was likely that the total number would increase by approximately 5 per cent to some 24,400 NHS consultants at 30 September 1996.

2.16. ACDA told us that it had carried out an analysis of distinction award holders. This had shown that, although it could take a consultant anything between three and twenty-six years to receive a 'B' award, on average most consultants would take fifteen years to reach 'B' award status. Further analysis had shown that in 1995 the average age of consultants who received 'B' awards was 49 years, with the corresponding age for 'A' and 'A+' award holders being 52 and 55 respectively. ACDA observed that, on that basis, an increase in the consultant population at the rate referred to in paragraph 2.15 above would not have immediate effect on the numbers of consultants that might be regarded as eligible for higher awards. It said that evidence also suggested that, although consultants in general were now retiring from the NHS sooner, this was not the case among consultants who held distinction awards. It observed that, although the average age of consultants was falling due to the increase in younger, newly appointed consultants, the average age of consultant award holders might be falling less fast. During oral evidence ACDA informed us that the five-yearly review process for award holders had been vigorously pursued but that, to date, no awards had been withdrawn.

2.17. ACDA observed that the age range of consultants holding distinction awards was currently 39 to 70 and that, for the purposes of the Review Body's exercise, it had taken this age range as representing the ACDA cohort i.e. the pool eligible for awards. ACDA said that on 30 September 1995 there were 16,044 consultants in the ACDA cohort group and that the provisional figures for the 1996 outturn suggested that the cohort group would increase by approximately 2.8 per cent to an estimated 16,501 consultants at 30 September 1996.

2.18. In proposing a specific number of additional awards for the coming year, ACDA told us that it would recommend that additional awards should be made available with the specific aim of ensuring that younger consultants who had worked to a meritorious level for a number of years were not overlooked and to continue the progress made in reducing the average age of consultants receiving awards. ACDA proposed new awards for 1997–98 which would

translate an estimated 2.8 per cent increase in the cohort group for 1996 with a further 0.5 per cent to help meet claims of the younger consultants into a 3.3 per cent increase.

Comment and recommendations

2.19. We welcome the more analytical and targeted approach this year by ACDA to its proposed number of awards for 1997–98. We are content with these proposals and **recommend** the creation of 103 new awards at the following levels: 9 'A+'; 29 'A'; and 65 'B'.

2.20. We **recommend** that the values of awards are maintained at the current percentages of the consultants' national scale maximum (excluding the new discretionary increments) as set out in Appendix A.

Discretionary points and local pay

2.21. In our Twenty-Fifth Report, we priced the new discretionary points on both the consultants' and associate specialists' pay scales following structural changes agreed by the parties. Our report welcomed the increased local pay flexibility generated.

2.22. In their evidence to this review, the Departments told us that detailed feedback on the progress of implementing the discretionary points system for consultants was still awaited. However, a survey of 114 Trusts undertaken by the NHS Trust Federation earlier in the year had found that 90 per cent of Trusts had either developed, or were in the process of developing, a consultants' discretionary points procedure. During oral evidence the employers said that not all Trusts would need to implement a system because they did not all have any eligible consultants.

2.23. The employers told us that, according to early indications, the new arrangements were working well and had enabled Trusts to give recognition to the various contributions being made by eligible consultants and associate specialists. They observed, however, that because of the limits placed on the scheme, it would take a number of years before all those contributions could be appropriately recognised through pay. They said that, in the longer term, pay flexibility for these staff groups could be further extended by establishing the relationship between reward levels and doctors' duties. Reward strategies, they said, should reflect the range of duties including patient care, management, teaching, research, audit and publishing.

2.24. The BMA said, that whilst it had no firm evidence yet as to how the new schemes had bedded down, there was anecdotal evidence indicating that they were developing satisfactorily.

Comment

2.25. The evidence to date on how the new schemes are settling down is encouraging, as are the positive and constructive attitudes of all the parties involved. We welcome the statement from the employers about their longer term strategies regarding local pay flexibilities. We commented in our Twenty-Fifth Report that the process of developing and implementing effective local pay systems can only be brought about over a period of time involving several years of transition. It is clear to us that the parties are moving towards realistic local pay flexibilities at a sensible pace. We invite further evidence to our future reviews on the implementation and evaluation of the discretionary points schemes and how pay flexibilities might be introduced for other salaried grades.

Associate specialists

2.26. The BMA told us that associate specialists had been employed under new terms of service since December 1991. It was particularly concerned about anecdotal reports of exploitation of the professional nature of the associate specialist contract, particularly in relation to out-of-hours working. It said that this included restrictions on the number of temporary additional notional half days with no correlation to expected workload.

2.27. In their oral evidence to us, the Departments observed that on-call work was part of the associate specialist professional contract and therefore those

concerned worked the same on-call rota patterns as other grades. They added that Trusts had freedom to reward hard pressed specialties.

Comment

2.28. We have noted the parties' comments. It is evident to us that pay mechanisms are in place which allow for particularly onerous duties to be recognised through additional remuneration and associate specialists are eligible for the discretionary points over and above the normal maximum of their pay scale. We have seen no detailed evidence to support the BMA's concerns that the grade is being exploited, but we will re-address this issue if such evidence emerges.

Lecture fees

2.29. The BMA observed that practitioners were entitled to receive a fee for a post-graduate lecture on a professional subject to a group of doctors. It said that it regarded the fee as unacceptably low for the amount of work involved. It commented that consultants and other senior hospital doctors spent a considerable amount of time in preparing for such lectures and that in most cases the preparation took place outside normal working time. The BMA said that if the level of fee was not increased in line with the amount of work involved, it could lead to problems in the continued delivery of high quality post-graduate education.

2.30. The Departments informed us they had considered the BMA's request for an increase in lecture fees but they had found the profession's case unconvincing. They said that it was usual for lectures to be given in normal working hours and that the amount of preparation time needed was variable. They said that some lectures might need to be devised, updated or revised but that most would be re-used in their entirety with little preparation done. They also observed that many consultants were allocated time for teaching in their job plans and that giving lectures was part of the post-graduate medical education responsibilities of consultants.

Comment

2.31. Lecture fees are increased annually in line with the percentage increases in pay. From 1 December 1996, the level of the fee has been £50.45. Fees for lectures are paid in addition to basic remuneration and we see no need for an exceptional increase.

Staff grade

2.32. The parties told us that discussions were taking place between them on service conditions and more flexible remuneration arrangements for doctors in the staff grade. As we go to press, there has been no agreement and we have been asked to base our recommendations on current terms and conditions.

Level of remuneration increase

2.33. We **recommend** an increase of **3.4 per cent**, with a further addition of **0.35 per cent** for pensions[1], on the national pay and salary scales of consultants, associate specialists, staff grade practitioners, hospital practitioners and clinical assistants. The recommended pay scales are in Appendix A.

2.34. For those Trusts which adopted our suggestion for a form of transitional local pay, as described in our Twenty-Fourth Report, we recommend the parties negotiate locally on the level of increase appropriate for 1997–98, taking into account our recommendations for the coming year.

Other salaries, sessional rates and allowances

2.35. We **recommend** all other salaries, rates and allowances be increased by **3.4 per cent**, with a further addition of **0.35 per cent** for pensions.

[1] See Chapter 1, paragraph 1.47.

Chapter 3

Doctors and Dentists in Training

Manpower, recruitment and retention

3.1. The Departments reiterated their evidence to our review last year: that Health Ministers had accepted a recommendation from the Medical Workforce Standing Advisory Committee for a further increase in the number of medical students for five years, from 1996, to arrive at a maximum annual target intake of 4,970 by the year 2000. They said this represented an increase of 500 over five years (11 per cent—making a 15 per cent increase for the decade as a whole). They commented that medical schools had already made good progress in implementing this measure which would increase the supply of doctors in the future. They observed that the number of medical students was now at an all time high.

3.2. The BMA said that there continued to be problems in recruiting junior doctors to certain specialties and that the 'crisis' in staffing accident and emergency departments had not been resolved. It said that a surplus in senior house officer (SHO) posts had given the opportunity to those in the grade to pick and choose between jobs, leaving shortages in less popular specialties and locations. In February 1996, 25 per cent of accident and emergency departments had junior doctor vacancies and 57 per cent had experienced problems filling junior doctor posts. The BMA observed that the high number of doctors not practising medicine was disturbing. It referred to the results of a questionnaire study[1] carried out in 1994 which had estimated that of the 1983 cohort of qualifiers to the medical profession, 16.5 per cent were not in medical practice eleven years after qualification. The BMA observed that efforts needed to be focused on retaining staff by making medicine a more attractive career and increasing the opportunities available to those who wished to work more flexibly.

Specialist registrar grade

3.3. The Departments told us that implementation of the new specialist registrar (SpR) grade began in December 1995 and that transition was taking place in four quarterly phases. They said that such an arrangement would ensure an efficiently managed process. At the time of their evidence (September 1996), the Departments said there were 15 specialties (covering over 1,700 doctors) in transition and two further tranches were planned for October 1996 and January 1997 covering a further 3,700 doctors.

3.4. The Departments said that they were developing monitoring arrangements designed to provide headline information on the progress of implementation and any particular problem areas. To complement that process they had commissioned a full evaluation of the reforms in two stages. Stage one (to be completed in 12 months) would be an evaluation of the implementation process and management of the transition arrangements from the viewpoint of key stakeholders. Stage two, they said, would involve a fuller assessment, including questions relating to the assessment of competence, work patterns,

[1] Career destinations in 1994 of United Kingdom medical graduates of 1983: results of a questionnaire study. J. Parkhouse *et al. British Medical Journal* 6.4.96

changes in the mix of trainees, career paths and morale among trainees, consultants and other members of the clinical team. That stage would be completed within three years.

3.5. The employers said that they welcomed the development of the SpR grade. They anticipated that the role of the doctor in training would bring changes to working practices and career structures which would require sound and responsive local management. They told us that the full implications of the new system would shortly be the subject of a NAHAT survey of Trusts. They referred to anecdotal evidence suggesting that there might be a major issue in relation to the funding of the posts.

3.6. The BMA observed that for the most part there had been a smooth transition to the SpR grade but it was concerned about a number of issues which had affected individual doctors in training. It was especially concerned about the delay in providing contracts of employment and training arrangements for each specialist registrar.

Remuneration structure for SpR grade

3.7. In our Twenty-Fifth Report, we recommended, on a provisional basis, a nine point salary scale for the new SpR grade. In evidence to our present review, the BMA told us that it was disappointed with our recommendation. It observed that specialist registrars would face a major change in their working practices and career structure and that shorter, more structured training would mean that they would develop expertise earlier and would therefore be able to make a contribution to higher level service work at an earlier stage than at present. The BMA also commented that it was concerned about the discretionary nature of the top two points on the SpR scale. It said that it was particularly disturbing to see an element of local pay being applied to the SpR grade and linked in some way to performance. It said that local pay was inappropriate for junior doctors. It proposed to us that the salary scale for the grade should be based on the full range of registrar and senior registrar pay, but with only seven incremental points.

3.8. The BMA said that it was already becoming clear that some junior doctors were being disadvantaged in pay terms relative to their former position. It said that the introduction of a single grade, where previously there had been two, was resulting in many doctors losing out financially because they were no longer eligible for the promotion increase in pay that applied when doctors were promoted into the higher grade.

3.9. The Departments said that the provisional arrangements we had recommended last year provided appropriate reward for specialist registrars. They said that the first seven automatic incremental points of the salary scales catered adequately for the vast majority of trainees following programmes of the durations stipulated in college curricula. They observed that access to the top two points was available where training necessarily took longer, or a trainee reached the top of the scale early because of provisions for previous experience to be taken into account when calculating starting salaries and protection of previous salaries. The Departments acknowledged that under the new SpR pay structure some doctors might be disadvantaged through the loss of a promotion increase. However, they said that the advantage of having a promotion increase between registrar and senior registrar grades had been traded for the advantage of receiving better training and the prospect of becoming a consultant earlier. Moreover, SpRs now had uninterrupted progression through their pay scale without any delay in obtaining a senior registrar's post, as might have occurred under the previous arrangements. They commented that they would welcome a continuation of the provisional structure until the implementation programme had been evaluated in three years' time.

Comment and recommendations

3.10. We were surprised by the profession's reaction to our recommendation last year. Our Twenty-Fifth Report was quite specific about the conditions governing payment of the top two increments of the SpR pay scale. We said they were to apply in cases where (i) on the due date, a doctor's training had not been

completed and the continuation of training was necessary and not due to less than satisfactory performance and (ii) in other circumstances at the discretion of Trusts' managements locally. In practice, these conditions allow Trusts no discretion to withhold incremental progression during the training programme except on grounds of unsatisfactory performance. Moreover, the arrangements even allow Trusts, should they so wish, to award the final two increments in cases where doctors have fallen behind the normal rate of training progression or when the training programme has been completed.

3.11. In our Twenty-Fifth Report, we invited the parties to provide detailed evidence on how the more intensive training arrangements for the SpR grade impacted upon doctors' work and responsibility at each year of the new specialist training programme. The parties have been unable to supply that information as the new arrangements have yet to settle down. We have noted that the Departments have commissioned a full evaluation of all aspects of the SpR grade. Our intention is to review the remuneration structure of the grade in three years' time following the completion of that evaluation process. In the meantime, on the basis of the evidence presented by the parties, we recommend no change in the structure which was introduced for 1996–97.

Locum appointments in the specialist registrar grade

3.12. The Departments told us that operational guidance for the new SpR grade provided for two types of locum appointments: Locum Appointments Service (LAS) and Locum Appointments Training (LAT). They said that a LAS appointment was designed to cover the service element of a SpR placement for a few days or a few weeks only. It was implicit in the title of the appointment that it was short term and service based. They said that there was little structured training or training benefit to be derived from such appointments and that they were limited to a maximum of three months. They observed that these were 'traditional' locum appointments which might attract a locum pay rate.

3.13. The Departments said that the Locum Appointments Training posts had a different role. In assessing the nature and length of an SpR vacancy, the employers and the dean might decide that they could offer suitable training experience which could count towards the completion of a CCST[1] training programme. In those cases the relevant Royal College might give prospective training recognition to individual applicants. Such places would generally be open to SHOs and other candidates for CCST training. The Departments said that such posts would not last longer than one year unless there were exceptional circumstances. A series of LATs could not be linked together to enable a trainee to achieve the CCST without entering the SpR grade substantively. They observed that entry to a LAT post was on a competitive basis and was subject to the same standard of entry as that applying to substantive appointments. They said that LATs held SpR contracts although they did not form a separate grade. These contracts did not provide trainees with priority entry into the substantive SpR grade and the LAT holder would need to compete for a substantive place along side other candidates. The Departments said that the LAT posts were more long term and an integral part of the grade in both training and service terms. They considered therefore that the posts should attract the usual pay to which the trainee would be entitled on entry to the substantive grade.

3.14. The BMA informed us that it had no objections to the Departments' proposals regarding the remuneration for both types of locum appointments.

Recommendations

3.15. For LAS appointments, we **recommend** that remuneration be based on the mid-point of the nine point SpR pay scale. The resulting weekly and hourly rates are set out in Appendix A, Part 2. For LAT appointments, we **recommend** that trainees should receive the appropriate rate of pay applicable on entry to the substantive SpR grade.

Out-of-hours work

3.16. The Departments said that the prime aim of the New Deal was to improve the quality of both patient care and the working conditions of hospital

[1]Certificate of Completion of Specialist Training

junior doctors by reducing both contracted hours and hours of work. They informed us that at 31 March 1996, more than 95 per cent of junior doctors were working within the New Deal contracted hours targets set for the end of 1996 when all on-call posts, whether defined as hard-pressed or non hard-pressed, were subject to a maximum average of 72 hours per week. They said that further significant progress was expected before the end of the year although a very small number of difficult posts might still need to be addressed in 1997.

3.17. The Departments said that the same rate of progress had not been achieved in reducing actual hours of work. While there had been good progress in that area, about 25 per cent of junior doctors in England (about 6,600) did not yet comply in full with the New Deal limits. It was estimated that the major reason for non compliance was that hours of work exceeded on average the 56 hour limit required by the New Deal. The Departments observed that the position, while representing a significant improvement over the position 12 months ago, remained unsatisfactory. They said they would continue with action to achieve the New Deal targets in full and that there was no intention to reduce activity once the final target date was reached at the end of 1996. Action was in hand to develop a further stage of the New Deal which would aim to eliminate the remaining problems and to ensure the sustainability of what had been achieved.

3.18. The employers told us that Trusts continued to make efforts to address the issue of hard-pressed posts among doctors in training in keeping with the New Deal targets. They said that it was appropriate to reduce unacceptable work intensity rather than to increase pay as compensation for long work intensive hours. It said that such matters were best addressed by local management.

3.19. The BMA proposed that we should re-examine pay arrangements for additional duty hours (ADH) in view of the manifest failure of the New Deal to be implemented as a whole. It said that the ADH rates currently in force did not remunerate fairly the work of junior doctors, on which the NHS depended absolutely. It submitted that those rates should be increased substantially for 1997–98 and suggested that we recommend a figure in excess of the standard rate for class one ADHs and that classes two and three ADHs should be increased by a proportionate amount. It observed that: the rates were set at an inequitably low level; they were structurally unfair; junior doctors in countries with comparable training and working structures were paid far more for their out-of-hours work than was the case in Britain; and today's junior doctors' out-of-hours work was not a continuing professional responsibility but more akin to the overtime or extra work for which any other professional was paid above the standard rates. The BMA said it was not proposing that the three ADH classes be abolished, but that the rates of remuneration applying to those classes be increased. It commented that it was unfair to pay rates below the standard rate for additional duty hours, and that even the class one rate for a full shift did not reflect the intensity of work performed in unsocial hours. It observed that junior doctors actually worked hard during their rest periods and that class two and class three rates should be increased to recognise that.

3.20. The BMA also proposed that doctors working at full shift intensity on on-call rotas, or partial shifts should be paid at class one (full shift) ADH rates. Commenting on that proposal during his oral evidence, the Health Minister said that his emphasis was on eliminating hard-pressed posts, not introducing higher permanent rates.

Comment and recommendation

3.21. Since implementation of the New Deal in 1990, considerable progress has been made in reducing junior doctors' hours of work to tolerable levels. Despite that, as at 31 March 1996, some 7,000 doctors in Great Britain did not comply with the New Deal limits and the Departments have recognised that the present situation is unsatisfactory. We have noted their intention to continue with action to achieve the New Deal targets in full, but it is obvious to us that the rate of progress has slowed significantly and there is now reason to doubt

whether much more is likely to be achieved in the immediate future, at least in relation to actual hours worked on-call, if not hours contracted for.

3.22. We are concerned about the length of time being taken to eliminate on-call posts of high intensity. There has even been much delay in identifying which posts fall into that category and we would consider it regrettable if progress were being impeded by financial constraints. We find it difficult to understand why more has not yet been achieved and we urge all concerned to give the matter priority. We consider that priority should be given to eliminating any on-call post which involves doctors having to work at full shift intensity.

3.23. In our Twenty-Fifth Report, we commented on low morale among some junior doctors and recommended an increase in their basic remuneration which was significantly higher than that for most other members of our remit groups. We also endorsed a proposal that high intensity on-call posts should be remunerated at the partial shift rate. This year, we have considered very carefully the profession's case for an increase in all three classes of ADH levels. We have seen no evidence to suggest that the existing rates are inconsistent with average levels of out-of-hours work intensity and we have concluded that such across the board enhancements would not be justifiable. **We are therefore recommending no change**. We do, however, urge that full use be made of the facility to pay partial shift rates for high intensity on-call posts. Moreover, we consider that much more could be done by the Departments and the employers to improve the conditions under which junior doctors, particularly those working long hours on on-call rotas, have to work. We are aware that the New Deal was not simply about reducing hours and structuring rates of remuneration to particular patterns of working. It was also concerned with standards relating to service conditions and facilities such as accommodation, catering arrangements, car parking, and opportunities for recreation. We regard it as important that employers, as well as seeking to achieve full implementation of the hours reduction targets, should ensure that these other elements of the New Deal are in place. We urge the Departments and employers to take appropriate action, where needed.

3.24. In our Twenty-First Report, we recorded that the New Deal measures included: the introduction of shift and partial shift systems; the reorganisation of working patterns including a greater use of part-time doctors; the maximum use of cross-cover; and the targeting of additional non-training grade appointments to areas with particular difficulties. The agreement referred to a number of other ways in which long hours of work could be tackled. These were to be the subject of negotiations between the parties. The New Deal is now more than six years old. We do not wish to devalue its considerable achievements, but by general recognition its success has only been partial. We feel the time is now ripe for the Departments, in consultation with the employers and the profession, to conduct a full appraisal of whether existing working patterns, including the shift and on-call systems as they are presently structured, provide the best means of achieving service objectives.

Flexible training and working

3.25. The Departments informed us that an increasing number of women were entering the medical profession. They said that some 50 per cent of medical students were now female and would, over the years, increase the proportion of women doctors at all levels. The Departments said that it was their responsibility to produce policies which would recognise this and to ensure that skills of women doctors were not lost by failing to offer them patterns which fitted in with their needs. They commented that flexible working was not restricted to women and that any doctor who could demonstrate well founded individual reasons for requiring part-time training could apply. The Departments said that the introduction of the specialist registrar grade gave them the opportunity to consider new arrangements for flexible training. These provided for part-time trainees to be treated on the same basis as full-time trainees in terms of entry requirement and training standards, with post-graduate deans having direct responsibility for funding flexible training.

3.26. The employers said that there was much that could be done to make training posts for particular shortage specialties more attractive through the provision of flexible training opportunities. They asked us to guard against proposals in our report that would make part-time posts much more expensive than full-time posts as this could act as a significant disincentive to Trusts.

3.27. The BMA told us that it was disappointed with our conclusions in our previous two reports that the remuneration structure for flexible training should remain unchanged. It said that most flexible trainees were not earning a decent wage although the majority were working what would be regarded as 'full-time' in other professions. Observing that over 50 per cent of those entering medical school were women, the BMA said that it was evident that there needed to be reasonably attractive options open to those, both men and women, who wished to work in other ways from the traditional patterns and who wished to work part-time at some point in their careers. The BMA indicated its concern that because of poor flexible training opportunities, many doctors were opting for part-time non consultant career grade posts. The BMA observed also that there was an unmet need for more flexible training and that there were over 300 doctors awaiting flexible training posts for which there was no funding. It said that demand was increasing by approximately 15 per cent per year and that there were many more doctors who wished to work flexibly, but who could not afford to do so. The BMA said they remained deeply concerned that flexible trainees were not being fairly paid as they received standard rates for only the first 20 hours and the lower out-of-hours rate thereafter. The profession concluded that the changes in the medical workforce underlined the need to increase the opportunities available to those who wished to work more flexibly. At present, it said, flexible training was not an attractive option and pay rates for flexible trainees needed to be improved.

Comment and recommendation

3.28. We have addressed this issue in each of our previous three reports. Again we have given careful consideration to the views expressed by the parties respectively. It remains the case that the structure of remuneration for flexible trainees is fully consistent with that for full-time junior doctors: the system provides for them to be rewarded during their out-of-hours work on the same percentage ADH rates as those applicable to their full-time colleagues. Moreover, part-time doctors, like their full-time colleagues, are eligible to receive enhanced out-of-hours rates for posts of exceptionally high intensity and we urge Trusts to ensure that they receive appropriate reward in such cases. It seems to us, however, that the system of flexible training is not meeting the needs of individual trainees, a situation which is having an adverse effect on junior doctors' perceptions of their workload and their morale. Despite the Departments' good intentions in matching working patterns and service requirements to the needs of individual part-time doctors, it seems that in many instances these flexibilities are not being applied. We would like to see even more encouragement given to Trusts for flexible working arrangements especially in the light of recognised medical staff shortages in some locations and some specialties. Our view is that imaginative and more flexible solutions are required to address the nature of part-time contracts and the training arrangements themselves. We invite the Departments to examine this issue in consultation with the employers and the profession. We would welcome evidence from them to our next review on progress made. In the meantime, we **recommend** no change in the present remuneration structure for flexible trainees.

Level of remuneration increase

3.29. We **recommend** that the salary scales for all grades of junior doctors be increased by **3.4 per cent** with a further addition of 0.35 per cent for pensions[1].

3.30. The proposed scales are set out in Appendix A.

[1]See Chapter 1, paragraph 1.47.

Chapter 4

Doctors in Public Health Medicine and Community Health

Public Health Medicine

Organisation and manpower

4.1. The Departments told us that in the year to 30 September 1995, the number of career grade doctors in public health medicine in Great Britain increased from 660 to 728. For training grades, the number of staff in post increased from 420 to 439.

4.2. The Departments informed us that from 1 April 1996, Regional Health Authorities had been abolished and regional offices of the NHS Executive had been established. They commented that medical and dental staff who had transferred to these regional offices had been offered Senior Civil Service terms and conditions but could opt to retain their NHS terms and conditions which were protected under the Transfer of Undertakings (Protection of Employment) Regulations 1981. The Departments said that all of them had taken that option. They asked us to continue to recommend pay rates for regional consultants in public health who retained NHS terms and conditions; and to continue to recommend Band A of the chief officers' supplement which is payable to the Regional Directors, who have opted not to transfer to Civil Service terms.

Directors of Public Health

4.3. The profession reminded us that the chief officer supplements (see paragraph 4.2 above) were paid to District Directors of Public Health on a population-banded basis to reflect their additional responsibilities as executive members of health authority boards. It said that these supplements were payable in addition to their consultant salaries and that they were also eligible to receive distinction awards or discretionary increments. It observed that the top band was reserved for Regional Directors of Public Health.

4.4. The BMA provided a table which showed the numbers of districts within the population bandings for the years 1991 and 1996.

Health authorities in England by population 1991 and 1996

Population banding	Number of districts 1996	Number of districts 1991
50,000 to 249,000	7	104
250,000 to 449,000	44	69
450,000 to 649,000	39	11
650,000 to 849,000	10	1
Over 849,000	4	1
All populations	104	186

The BMA asked us to revise the scheme of supplements to take account of the major changes in the number and size of health authorities since the scheme was last reviewed. We were especially asked to bear in mind the decrease in the number of districts and the increases in their average population.

4.5. The Health Departments argued that there was no need to change the supplements payable to District Directors of Public Health simply because health authority populations had grown and a greater proportion of health authorities now fell into the upper population bands. They said that the current supplements provided for a range of payments from £2,345 to £9,100, providing scope for fair rewards for the responsibilities for widely varying population sizes. They said that the current system also provided very considerable flexibility for health authorities to reward varying job weights within population bands. They observed that population size was an important but by no means the sole determining factor in assessing the job weight of District Directors of Public Health and hence appropriate reward. They said that the current system allowed for supplements to be paid up to an exceptional maximum of each population band where duties were particularly complex or onerous and that anecdotal evidence from health authorities had suggested that such payments were being made to those District Directors responsible for exceptionally large populations.

4.6. The employers said that District Directors' responsibilities varied according to the organisational arrangements of each health authority with, for example, some having responsibility for contracting whilst others did not.

Comment

4.7. In our Twenty-Fifth Report, we commented that the banding structure for the supplements was sufficiently flexible to provide an adequate reward for the District Directors' work and responsibilities. We still believe that to be the case, particularly as the cash values of the payments span a wide range. We have noted the Departments' evidence that flexibility exists within population bands according to the relative job weights of particular posts. In evidence to our next review, we would like to receive the parties' views on whether the size of a district's population should be the sole determinant in placing a post within a particular job band and whether health authorities should adopt an even more flexible approach through applying a criterion of overall job size, irrespective of the level of population covered. We would be particularly interested to receive evidence on the specific correlation between size of populations and the weight of the District Director posts. In the meantime, we are proposing no change to the existing banding structure.

Consultants in public health medicine

4.8. The BMA told us that it had suggested to the Health Departments a new form of supplement available to a wider group of consultants in public health medicine. It referred to the effect of the shortage of consultant posts on the career prospects of trainees and observed that this also had a disruptive effect on existing consultants who had no alternative to taking on the responsibilities of vacant posts in addition to their own. It said that the additional burden of a large vacancy level was more than that involved when providing temporary cover for absent colleagues and, with no prospect of relief, consultants had to do two or more jobs at once. The BMA said that in the relative isolation of a health authority, without the degree of peer support that larger units allowed, the stress on the individual consultant was increased and another pressure to encourage early retirement was created. It observed that in 1988, the Government had accepted the Acheson Report[1] and had provided additional central funding for the recruitment of extra trainees in public health medicine with the object of bringing the number of consultants up to a level of 15.8 per million population. The profession asked us to recommend an additional supplement payable to consultants in authorities where the complement of consultants fell below that level. It said that in 1995, the number of consultants in public health medicine in post in England was only 12.3 per million population.

4.9. The Health Departments argued that appropriate staffing levels were a matter for local decision and management action rather than for pay. They observed that recruitment to public health consultant posts in the health

[1]Public Health in England: Report of the Committee of Inquiry into the Future of the Public Health Function in England (the Acheson Report); Cm289, January 1988.

authorities remained good and did not therefore support the profession's case for a pay lead for this group.

Comment

4.10. The profession has provided no detailed evidence to suggest that the job weight of consultant posts is significantly affected in authorities where the ratio of consultants to population size is below the Government's target. We are not therefore persuaded of the need for an additional supplement.

Specialist registrars in public health medicine

4.11. The Departments informed us that public health medicine would begin its transition to the new structure of higher specialist training from 1 January 1997. They said that they had been involved in protracted discussions with the profession on terms and conditions of service but they had been unable to reach agreement. Since transition was about to begin, they had told the profession that new terms and conditions would be promulgated for any new public health trainees entering the specialist registrar (SpR) grade from 1 January 1997. They said that existing registrars and senior registrars on 1 January 1997 would retain their current terms and conditions of service. They would be advising post-graduate deans to offer any new public health trainees short term contracts to cover the period 1 January 1997 to 31 March 1997 pending the Review Body's consideration of this issue.

4.12. The Departments observed that the introduction of the new grade and the new structured training programme would result in a significant reduction in the duration of training. They said it would reduce the minimum duration of higher specialist training in public health medicine to five years. They commented that once the supply of and demand for public health consultants was balanced, trainees would reach the consultant pay scale much earlier than under the present arrangement. They said that the effect would be a major opportunity for enhanced career progression and career earnings.

4.13. The Departments asked us to recommend a nine point basic salary scale identical to that currently in place for hospital SpRs.

4.14. The BMA said that the Departments' proposals would disadvantage specialist registrars in public health medicine as, unlike other specialties, there was already a single salary scale for registrars and senior registrars through which, subject to the achievement of educational goals, doctors proceeded automatically to the top of the scale by annual increment. It added that such disadvantage was more likely to arise in public health medicine than in other specialties because trainees were appointed at a much later stage in their careers and on a higher point in the salary scale. The BMA asked us to recommend the same salary scale as for other specialties but with the proviso that SpRs should proceed through the salary scale automatically including the top two points.

Comment and recommendation

4.15. On the basis of the evidence presented to us we can see no good reason why either the structure or the level of basic remuneration for this specialty should be at variance with those for SpRs in the hospital service. We **recommend** the same nine point scale that applies to other specialties. The conditions we have prescribed for the award of the top two increments are designed to protect doctors whose training has not been completed and who have performed satisfactorily. The recommended scale is at Appendix A, Part 1.

Trainees' out-of-hours supplement

4.16. The Departments told us that they had been seeking to negotiate a revised out-of-hours payments package with the profession, subject to our endorsement, but that they had failed to reach agreement with the profession. They said that their proposed package had now been withdrawn.

4.17. The Departments observed that the out-of-hours commitments of individual trainees varied widely and bore no relation to the commitments of the vast majority of hospital based trainees. They said therefore that it would be inappropriate to contract for public health trainees' out-of-hours commitments on the same basis as was applied to their hospital counterparts. They said that call-outs under environmental health and communicable disease rotas might

require very occasional intense work commitments during a communicable disease outbreak but on the whole would be virtually non-existent. They said that attendance at evening meetings might not occur on a regular basis and averaged around one and a half hours per week. They said that other out-of-hours activity was consistent with the training of other professional groups where generally no additional remuneration was made available for such activities. They told us that some trainees, during their academic placement, had no service commitments at all but continued to receive the out-of-hours supplement. They said that, taking all these factors into consideration, they believed the supplement at its current level of 15 per cent (representing a sum equivalent to pay for approximately six hours of work) was more than fair. They asked us to recommend that the supplement be continued at its present level.

4.18. The BMA said that our refusal last year to recommend an increase in the out-of-hours supplement, combined with growing uncertainty about their career prospects, had resulted in a further serious loss of morale among trainees in the specialty. It observed that the out-of-hours work of trainees consisted of participation in duty rotas for environmental health and the control of communicable disease and that they were also expected to perform other activities, often in the evening, such as attending health authority and public consultation meetings, and preparing documents. It observed that the last out-of-hours workload survey, conducted in 1982, had shown that the trainees worked, on average, 14 hours or 40 per cent beyond the standard working week. The BMA said there was no evidence to suggest that the out-of-hours workload had diminished in any way since that date and it argued that, in common with all measures of medical workload, it had increased. The BMA commented that it was important for the future of healthcare to retain the attractiveness of the public health medicine specialty for doctors and that the most effective way of so doing was to retain the linkage of its overall remuneration with trainees in other specialties. The BMA asked us to note that the 'drop out' rate of public health doctors during their training was now 25 per cent, and rising higher, it believed, than any other specialty.

4.19. The BMA asked us to recommend a substantial increase in the out-of-hours supplement and in late supplementary evidence it asked us to recommend that SpRs in public health medicine be paid through the additional duty hours system applicable to junior hospital doctors.

Comment and recommendation

4.20. In our recent reports we have suggested to the parties that they might usefully provide us with an appraisal of recruitment and retention for public health trainees together with information on the amount of time actually worked by trainees additional to their normal hours, with any significant changes measured over a period of time. The parties have again failed to provide us with any meaningful detailed data on which we can make a judgement as to whether a change in the supplement's level can be merited. We invite relevant evidence to our next review. We would also like information so as to enable us to have a more comprehensive understanding of the nature of the training programme for doctors in this specialty and how it varies from that for other specialties. In addition we would also like information on whether public health trainees are disadvantaged in obtaining consultant status in comparison with other trainees. In the light of the Departments' evidence we would also welcome the parties' views on how the out-of-hours supplement can be justified in cases where trainees on an academic placement have no service commitments.

4.21. We were surprised by the BMA's very late proposal that we should recommend additional duty hours payments for trainees in this specialty. On this we were provided with no argument or other evidence to inform our consideration of such a change.

4.22. We **recommend** that the supplement should continue at its present level of 15 per cent.

Community Health

4.23. The BMA informed us that, in 1994, as a result of the Joint Working Party on Medical Services for Children, agreement had been reached on mechanisms for the assimilation of clinical medical officers (CMO) and senior clinical medical officers (SCMO) in community child health to hospital grades and hospital terms and conditions of service. It said that the number of doctors transferring had been limited and that the majority of CMOs and SCMOs in community child health had chosen to retain their existing posts and terms and conditions of service. It said that the timescale for this process had now concluded in England and Wales. It observed that in specialties other than child health even less had been achieved: there had been a marked increase in new appointments of CMOs and SCMOs but often not in community health specialties as employers realised that these grades could be used as cheap and simple alternatives to consultant appointments. The profession said that there remained a large group of doctors employed as CMOs and SCMOs in all the community health specialties with no clear proposals for change in the near future. It asked us to maintain their existing relativities with the rest of the profession.

Sessional fees for doctors in the community health services

4.24. In our Twenty-Fifth Report, we recommended that sessional fees should be subject to local negotiation between the parties and we drew attention to the fact that these fees had not been increased nationally in 1994–95. In its evidence to this review the BMA told us that local sessional fee negotiations were likely to be frustrated by health authorities' and Trusts' inability to identify the sums needed to reach agreement with the profession, or even to acknowledge their responsibility to do so. The BMA observed that in most cases doctors were still being paid at the rates which applied until 31 March 1996. The BMA said that the imposition of local negotiations was both unnecessary and unfair to a particularly vulnerable group of doctors. These were mainly women running local authority family planning clinics. They had no other source of professional income and little connection with the local representatives structures that the Health Departments insisted must negotiate for them. It urged us to recommend national fees for sessional work in the community health service.

4.25. At our request, the Departments wrote to all Community Trusts asking about the local determination of sessional fees for all doctors in the community health service. On 21 November 1996, they told us that they had received 75 responses and that the emerging picture was mixed. A quarter of the Trusts replying had increased fees in line with the staging of our recommendations for 1996–97. The Departments reported that most of these Trusts had felt that our recommendations were 'somewhat over generous' and considered therefore that no further action was needed by them in regard to 1994–95. The Departments reported also that over 30 Trusts had not yet increased fees because negotiations were continuing, in many instances, as part of Trust-wide local pay negotiations for all staff groups.

4.26. The Departments also reported examples of Trusts paying sessional fees to doctors with whom they also had a main contract but who wished to top-up their main source of income with payments for additional sessions. They said that these doctors were receiving the Review Body's recommended increase on their main source of income, but would not be receiving any increase to their sessional fees. Again, the reason reported was that our main award for 1996–97 was considered 'over generous' by the Trusts concerned which had felt strongly that it was more appropriate to concentrate the resources available to them on local pay for other staff groups.

4.27. The Departments commented that local arrangements needed to be given sufficient time to become established and they asked us not to make a national recommendation for sessional fees in 1997. They suggested that it might be more helpful for us to encourage Trusts to demonstrate their ability to handle

their responsibility for local pay determination of these fees. They offered to monitor Trusts' decisions in 1997 as part of their evidence to our next review.

Comment and recommendation

4.28. In recommending in our Twenty-Fifth Report that sessional fees should be determined locally from 1 April 1996, we emphasised that these payments remained within our remit (as is the case for the remuneration of doctors and dentists taking any part in the NHS). We also asked Trusts' managements to have in mind during their local negotiations with the professions that no uplift had been applied to these fees in 1994 through no fault of the individual doctors concerned. We commented that, if Trusts were to gain the confidence and the subsequent necessary backing from the profession towards further moves towards devolved pay determination, it was important that they sent out appropriate signals to the profession generally during these early stages of transition.

4.29. It is apparent that many Trusts have not responded positively to our previous comment. We have noted that the monitoring information supplied by the Departments presents an incomplete picture of Trusts' progress. Some Trusts had implemented the staged pay recommendations for 1996–97, but were not intending to implement anything further in respect of the outstanding increase for 1994–95. It was apparent also that a very large number of doctors have yet to receive an enhancement of their fee levels in 1996, some eight months or so after the settlement date of 1 April 1996. We have observed in Chapter 1 that our recommendations are based on a number of relevant factors after careful consideration of all the evidence. The levels of the recommended increases are sensitively balanced with the intention of being fair to both the professions and the taxpayer. We are especially concerned that the doctors disadvantaged by the Trusts' approach to local pay are those who are unlikely to wield influence in local negotiations.

4.30. The Departments have asked us to give further encouragement to Trusts to demonstrate their ability to handle their local pay responsibilities. In view of the Trusts' reported comments we do not feel confident that doctors are likely to receive awards at a fair level for either 1994–95 or 1996–97 were we to take such action. We have decided therefore to **recommend** national levels of sessional fees from 1 July 1997 which take into account 'shortfalls' in remuneration arising from previous years. The recommended levels are in Appendix A, Part 2.

Level of Remuneration Increases

Recommendation

4.31. We **recommend** increases of **3.4 per cent**, with a further **0.35 per cent** for pensions[1], for doctors working in public health medicine and community health[2]. The proposed scales are set out in Appendix A.

[1]See Chapter 1, paragraph 1.47.

[2]This recommendation excludes sessional fees which are covered in paragraph 4.30.

Chapter 5

Ophthalmic Medical Practitioners

Manpower and workload

5.1. The Departments informed us that the decline in the numbers of ophthalmic medical practitioners (OMPs) had reversed during 1995. Between 31 December 1994 and 1995, the number of OMPs practising in Great Britain had increased from 735 to 752. They said that the General Ophthalmic Services (GOS) continued to attract adequate numbers of practitioners of good calibre and appropriate training and qualifications.

5.2. The Departments observed that the demand for NHS sight tests had continued to increase, albeit at a lower rate than in recent years. They said that 7.5 million NHS sight tests were paid for by health authorities and health boards in Great Britain in 1995–96, an increase of 2 per cent on 1994–95 and within that figure the proportion of sight tests carried out by OMPs had continued to fall, from 6.9 per cent in 1994–95 to 6.4 per cent in 1995–96. They said that there were no reports of patients having difficulty in obtaining sight tests.

5.3. The Departments said that although OMPs were medically qualified, the tasks they were required to perform under the GOS regulations entailed no wider responsibilities and skills than those required of optometrists, who were not so qualified. There was no evidence, they said, that outcomes from the eye examinations conducted as part of the sight test varied depending upon whether the examinations were conducted by OMPs or optometrists. They commented also that they had no evidence to suggest that patients preferred sight tests to be undertaken by OMPs rather than optometrists. They observed that their surveys had shown that the majority of OMPs practised optometry on a part-time basis.

5.4. The BMA commented that OMPs were highly skilled specialist doctors with a high level of specialist ophthalmic training and qualifications. It said that the high level of skill and expertise of OMPs—and the value of the contribution they made to a primary care-led NHS—had for many years, been unrecognised by the Health Departments. It said that, while Government policies sought to secure the treatment of patients in the community and to avoid expensive referrals for hospital treatment, the Health Departments had sought to keep the OMPs' sight test fee below that for optometrists, with the result that the number of OMPs was declining, along with the proportion of sight tests that they conducted.

The sight test fee

5.5. The Departments said that most OMPs undertook NHS sight tests whilst working on a sessional basis in establishments which might, for example, be owned or managed by dispensing opticians. They commented that OMPs did not have to meet the overheads associated with running business premises and employing ancillary staff which most optometrists incurred. The Departments said that they believed the differential between the OMPs' and the optometrists' sight test fees, prior to the 1996–97 increase, more accurately reflected those cost differences and, more significantly, provided appropriate incentive for the recruitment, retention and motivation of the staff required to provide good

quality service. The Departments did not consider that there should be any increase in the remuneration of OMPs for sight tests carried out in 1997–98.

5.6. The BMA argued that, in the continued absence of comparative data, there could be no justification for the remaining differential between the fee payable to OMPs and that payable to optometrists. During oral evidence the BMA said that OMPs incurred expenses, such as rent and provision of equipment, when carrying out sight tests on dispensing opticians' premises and that as half of all sight tests were carried out in chains of opticians, employed optometrists were not incurring high expenses anyway.

Level of gross sight test fee

Comment and recommendation

5.7. In our Twenty-Fifth Report, we decided to move away from our previous practice of recommending separately on the level of the net sight test fee and an element for expenses. Instead, we recommended on a level of gross fee. We altered our approach in the light of the Departments' failure to supply us with relevant and up to date information on OMPs' expenses. As the Departments remain unwilling to initiate a survey of the respective costs and overheads of both OMPs and optometrists, we continue our approach this year of recommending only on a level of gross fee. The Departments have failed to provide evidence to support their argument that OMPs' overheads are lower and we have seen no objective reason why overheads properly attributable to sight tests should vary between OMPs and optometrists. We do not accept therefore that the fee level for OMPs should be at significant variance with that for optometrists. For 1997–98 we **recommend a gross fee of £14.10[1] for OMPs**.

Fee for domiciliary visits

5.8. The Departments made reference to the restructuring of the domiciliary visit fee from 1 October 1995, which they had reported to us last year. They said that they were satisfied that the scheme now better reflected the costs incurred in undertaking multiple sight tests at a single location.

Recommendation

5.9. For OMPs, we **recommend** an increase of **3.4 per cent** in the domiciliary visits fees for 1997–98.

[1]This figure takes account of our recommended enhancement for pensions.

Chapter 6

General Medical Practitioners

Introduction

6.1. In the following paragraphs, we record the essential thrust of the parties' respective evidence to us on manpower, recruitment and retention; workload and morale; and doctors' out-of-hours work and responsibility. We also record recent policy initiatives from the Government relating to the future of primary care: these, following on from consultation with the profession and other interested parties, are likely to have a significant longer term impact on the way General Medical Services are organised and administered. We have already reported in Chapter 1 on the comparability study which the medical profession commissioned from Hay Management Consultants to inform our review and we have examined its results alongside those from an update of our own comparability exercise conducted last year. We also report on a wide ranging review of out-of-hours work and responsibility which we commissioned from Ernst and Young. We have weighed the parties' evidence, together with our conclusions from the Hay and Ernst and Young studies, in framing our recommendations on remuneration for 1997–98.

Manpower, recruitment and retention

6.2. The Departments told us that the number of unrestricted principals at 1 October 1995 was 31,950. That, they said, was an increase of 0.6 per cent over the previous year. They observed that the trend towards more part-time working continued. In whole-time equivalent terms, they estimated that the increase had been just 0.2 per cent. They said that the marginal growth in GMP principal numbers had been supported by larger increases in assistant GMPs (up 8 per cent on 1994) and practice nurses (up by an average of 1.5 per cent per annum since 1993). The Departments said that they were satisfied that the manpower position was reasonable overall but that further action was required to make general practice a more attractive working environment. In the event, the Departments published a White Paper 'Primary Care: Delivering the Future' on 17 December 1996.

6.3. The Departments also provided data which showed a classification by the Medical Practices Committee (MPC) of the adequacy of GMP principals by areas. The MPC observed that in October 1995 only 1.7 per cent of areas were classified as open (i.e. under-doctored). The Departments commented that this was the lowest proportion ever and was an improvement from 2.1 per cent last year. The details are shown in the following table.

Numbers of areas designated open (less than adequately doctored) by the Medical Practices Committee as at 1 October each year since 1986

1986	103
1987	71
1988	57
1989	42
1990	49
1991	55
1992	47
1993	39
1994	30
1995	25

6.4. The Departments made reference to the MPC's third annual survey of GMP recruitment; they said that, although the survey had recorded a drop in the number of applicants per vacancy, there were still, on average, over 9 applicants for each post. They said that 80 per cent of practices did not feel that they had to compromise on the quality of the candidate chosen. The Departments observed that although it was taking longer to recruit, around 80 per cent of vacancies were filled in less than a year. They said that the reported increase in time taken to fill vacancies might to some extent have been due to very long standing vacancies being filled in 1996 and also to some lack of clarity in the survey on when a vacancy was deemed to begin. They said that the MPC Report showed an overall vacancy rate of 3.3 per cent and that the findings suggested that there were sufficient numbers of good quality applicants to meet vacancies. The Departments said that, while the current size of the workforce was meeting service needs at present, they were not complacent about prospects for the future.

6.5. The Departments told us that the number of trainees had fallen from 2,100 at 1 October 1991 to 1,790 at 1 October 1995. They said that, although the rate of decrease had slowed, it was too early to confirm that the numbers were bottoming out. Early indications were that the April 1996 census figures for England and Wales would not show further decline. They said that some 1,700 doctors were needed to enter general practice each year to sustain the existing growth trend. They maintained that it was clear that the pool of trained GMPs, together with the number of trainees, was more than adequate to meet this need, at least in the short term.

6.6. Commenting on retention of general medical practitioners, the Departments said that the option to retire at age 55 with reduced pension, which had become available in March 1995, had led to an increase in the number of leavers in the 55–60 age range. There were also increases in leavers in younger age groups, particularly 30–39. They expected that this showed that more doctors were taking career breaks, reflecting the increasing proportion of women entering general practice. They said that the figures underlined an increasingly flexible workforce and did not necessarily represent a retention problem as long as doctors could be attracted back to work after career breaks. They told us that more flexible working arrangements would be required in future, both to ensure doctors were able to return to work easily after career breaks, and to enable older doctors to adjust their working patterns without feeling the need to leave the workforce entirely.

6.7. The employers told us that health authorities had expressed considerable concern at the fall in the number of trainees. The employers regarded it as important that the present downward trend in numbers was reversed and appropriate remedial action taken. They said that would include trainee registrars receiving comparable remuneration packages to the equivalent posts in hospitals.

6.8. The BMA observed that general medical practice was experiencing an unprecedented crisis in recruitment, morale and workload. It implored us to act decisively to prevent a further haemorrhage of doctors from this specialty by radically improving the overall remuneration of GMPs. It made reference to a report by its General Medical Services Committee in February 1996: 'Medical Workforce Task Group Report'. That report, it said, had identified a deepening crisis in general practice. The BMA said that it was clear that there were now insufficient doctors to cope with the ever increasing demands placed on NHS general practice by changes in service delivery. It said that the crisis would undoubtedly be compounded by the growing number of GMPs opting to take early retirement because of factors such as the pressure of general practice as a career, the lack of value placed on their clinical skills and the Review Body's failure over many years to ensure that doctors' earnings remained broadly in line with those of comparable professions. The BMA said that the report had demonstrated that, of those doctors retiring in the next ten years, more than a third would be overseas graduates from outside the European Union. It noted that the law did not allow replacement from that source. It said that general practice recruitment difficulties would be most severe in areas where these doctors who qualified overseas were currently in practice, i.e. large towns and cities. It observed that many urban areas already had significant difficulty in recruiting sufficient numbers of GMPs to work in areas where patients' needs were generally higher due to factors such as deprivation, high unemployment, and increased incidence of illnesses such as depression. It said that these factors were compounded by rapid population turnover.

6.9. The BMA said that a further cause of workforce difficulties was the inability of the NHS to encourage EU doctors who came to the United Kingdom for training to stay in UK general practice. It said that, while the total number of GMP registrars included EU doctors, the majority of these returned to their home countries after completing their training. The BMA said that the overall crisis in the number of GMP registrars was therefore even more serious than the Health Departments' statistics suggested, as their numbers were falsely inflated.

6.10. The BMA said that the last year had seen a further dramatic fall in the number of qualified doctors who chose to enter general practice. It said that research undertaken by the University of Oxford's Medical Careers Research Group showed that in a recent survey of a cohort of 3,657 doctors, 70.5 per cent had stated that their first preference was for a career in hospital medicine, with only 25.8 per cent expressing an interest in general practice. The BMA observed that this compared to the 1983 cohort where, by marked contrast, 44.7 per cent of doctors had specified that their first preference was general practice, as opposed to 51.7 per cent for hospital medicine. The BMA said that it found the evidence from the Oxford study depressing: the choice of general practice as a career preference had almost halved in 1993 compared with 1983. Fewer than one in five men and only one in three women gave general practice as their first choice.

6.11. In its written evidence the BMA asked us to recommend an increase in GMPs' pay of at least 53 per cent for 1997–98, and in addition to compensate for the relative deterioration in GMPs' superannuation benefits by increasing GMPs' pay by a further 5.3 per cent. In oral evidence, and in the light of the Hay Report, the BMA qualified this by saying that it wanted a substantial increase.

Comment

6.12. We have had regard to the parties' evidence in framing our recommendations on intended average net remuneration (IANR) (see paragraph 6.46) and the level of the GMP registrars' supplement (see paragraphs 6.58 and 6.59).

Workload and morale

6.13. The Departments told us that they had taken steps to make general practice a more attractive working environment. They said that, in addition to having implemented all elements of the out-of-hours agreement, they had introduced measures aimed at reducing the burden of GMPs' paperwork. They

said that they were publishing guidance on how good organisational development could help practices to cope more effectively with essential administration. Agreement had also been reached with the profession on new health promotion arrangements. They said that these reflected feedback from the profession and health authorities for more professionally led, locally based activities with minimum bureaucracy. The intention was both to reduce time spent on administration and to enhance professional satisfaction. The Departments said that they were continuing to support GMPs with cash limited direct reimbursement for staff, premises and computers. They observed that, despite these improvements, further action was required and they intended therefore to detail a range of proposals in the form of a White Paper[1].

6.14. The BMA said that the range of services provided by GMPs was continually expanding as they became more skilled in the provision of treatment that was once only available in hospitals. It said that increases in complex disease management, care of the elderly, increases in psychiatric consultations, day care surgery and other labour intensive activities had led to a considerable increase, not only in volume, but also in the intensity of GMPs' work without a corresponding financial reward. Many GMPs, it said, were now finding that they were unable to cope to their satisfaction with the huge demands being made on them to provide the necessary care to patients under current contractual arrangements. It said that the prospect of even more unresourced services being delivered in general practice was leading many doctors to question whether they wished to remain in practice.

6.15. The BMA said that morale among GMPs was at one of its lowest ebbs since the inception of the National Health Service. It said that GMPs, in all stages of their careers, felt undervalued in terms of remuneration and standing with comparable professionals such as solicitors and accountants. It said that they felt overworked and under extreme pressure to provide labour intensive clinical services to patients with an ever higher level of expectation. It observed that an increasing number of GMPs felt unable to control their workload as the demands being made of them were too high. It said that GMPs dealt with ninety per cent of all patient contacts within the NHS and commented that, whilst this was a tremendous testament to the abilities of the doctors concerned, it provided an insight into why many doctors, both newly qualified and experienced, were suffering from intolerable levels of stress and anxiety. It said that, understandably in a profession where workload and stress were serious problems, morale was, for many, so low that they would not remain in general practice for financial, personal and health reasons.

Workload survey

6.16. In our Twenty-Fifth Report, we asked the parties to re-appraise how their evidence on workload might more usefully be presented to enable us to evaluate changes over time in both GMPs' work volume and responsibility. In its evidence to this review, the BMA told us that it had declined the Health Departments' invitation for a new workload survey. It said that it saw little merit in lending its co-operation to such an exercise as the results of previous surveys had appeared to have little influence over our considerations. The BMA also made reference to the Health Secretary's willingness to look at new contractual options for GMPs and the work being undertaken by the GMSC in defining those services which are core and non-core within general practice. It said that the results of a workload survey would be of little value to the Review Body or to either of the parties at the present time.

6.17. The Health Departments said that they were disappointed that the profession was continuing to oppose a new joint workload survey as they believed such exercises were an important point of reference both for the Review Body in considering GMPs' pay and for the parties when considering the impact of service development. The Departments believed, however, that the measures they had taken to improve general medical practitioners' working conditions

[1] The White Paper was published on 17 December 1996.

were making a difference, both in the out-of-hours period and, during surgery hours, through the elimination of bureaucracy and health promotion changes.

Comment

6.18. We understand the reasons for the profession's rejection of a new workload survey, but we believe its view to be misguided. We observed in our Twenty-Fifth Report that the previous survey was in a form agreed by the parties, but that the consequent evidence did not fully address the profession's concerns and therefore did not equip us to respond as the BMA might have wished. The evidence concentrated on hours worked and did not illuminate changes in the professional and other demands on doctors, which we understand to be at the heart of the BMA's concerns. We accept that the impact of changes in the nature of GMPs' work and responsibility arising from the Government's White Papers 'Choice and Opportunity' and 'Primary Care: Delivering the Future' are unlikely to be measurable in the short-term but we would expect the Government's policy to have a significant impact on the extent of GMPs' contractual obligations and the way they are remunerated. With these developments in prospect we believe that the parties should aim to consider possible modifications to the structure of GMP remuneration from the basis of an agreed evaluation of the present workload position.

6.19. Our recommendation on IANR is made in the light of all available evidence presented to us but we recognise, as we did last year, that we have seen no detailed evidence relating to qualitative aspects of GMPs' whole workload. The study we commissioned from Ernst and Young, which we describe below, included a full appraisal of GMPs' out-of-hours work and responsibility, and for example, examined work under a number of broad criteria which included: knowledge required, complexity, communication skills, and physical demands. It related only, however, to out-of-hours workload. We believe that the parties themselves are in the best position to address how both quantitative and qualitative evidence might helpfully be presented, but we consider that the type of approach used by Ernst and Young could well serve as a useful starting point for their deliberations. We have noted the Departments' willingness to engage upon a new survey and we urge the profession to give that further consideration in the light of our comment above.

The future of primary care

6.20. In October 1996, the Government published a White Paper 'Choice and Opportunity' which set out details of legislative proposals to be contained in the Government's Primary Care Bill. The White Paper observed that over the last year there had been a wide debate about the future development of primary care. A number of ideas had been suggested offering ways forward and opening new possibilities and opportunities for addressing service issues. These included: a salaried option for GMPs, either within partnerships or with other bodies, such as NHS Trusts; practice based contracts which could more easily reflect the nature of practice in many areas, embrace non-medical professionals, and open new possibilities for the development of skill mix and careers; and a single budget for general medical services. The Paper observed that while there was considerable interest among those consulted in trying out these ideas, there was no enthusiasm for moving directly to any, or all, of the options without careful exploration first and no enthusiasm for forced change. The Paper announced the Government's intention to bring forward legislation to enable wider contractual choices to be tested and made available. The legislation would enable the piloting of different types of contract to test their practical implications and the benefits they could bring. Existing contractual arrangements are to continue alongside any new approaches.

6.21. During his oral evidence to us, the Health Minister said that the proposed flexible arrangements for general medical practitioners in the White Paper could include voluntary local contracts for GMPs. He observed that such initiatives in primary care would help recruitment and retention for GMPs.

Out-of-hours work and responsibility

6.22. In their evidence to our review last year, the parties provided for us the results from a survey of GMP co-operatives and deputising services which they

had carried out to identify the average price of out-of-hours work and, where possible, clinical responsibility. In our report last year, we concluded that doctors generally would be prepared to pay within a range of £2,000 to £8,000 for transferring their out-of-hours work to deputising/co-operative organisations, the exact price being dependant upon local factors. Following publication of our report, we agreed with the parties that the survey should be repeated to inform our considerations for the coming year.

6.23. In May 1996, we received a letter from the Chairman of the BMA's General Medical Services Committee which indicated that general practitioners were extremely disappointed that we had failed to identify the appropriate proportion of the remuneration applicable to their out-of-hours periods. We were asked if we would reconsider attaching a specific notional value to GMPs' out-of-hours work and responsibility as a matter of urgency. Following a meeting with the BMA, we agreed that, as part of the 1997–98 pay round, we should carry out a broad ranging appraisal of out-of-hours work from which we would assess the implications for the level of GMPs' remuneration and take appropriate action. We said that, as part of this process, we would determine whether it was possible, based on the information provided by the appraisal, and further evidence from the parties, to put a notional price on GMPs' out-of-hours work and responsibility. We commissioned management consultants, Ernst and Young, to carry out an appropriate study on our behalf.

6.24. Prior to the study's commencement, discussions took place between the management consultants and our Secretariat to determine a suitable methodology and to agree detailed points. In turn, our Secretariat consulted the Health Departments and the BMA who both provided useful input to guide the consultants' approach. In the event, the study included a diary based survey of work volumes (for which the response rate was 38 per cent) and a qualitative research exercise to assess whether there had been a 'sea change' in the nature of out-of-hours work since pre the 1990 GMPs' contract.

6.25. Ernst and Young concluded that there had not been a 'sea change' since the introduction of the new contract in 1990 in the fundamental nature and responsibilities of out-of-hours work. They commented that while there was evidence that the nature of out-of-hours work had been subject to change, the changes that had occurred mainly represented an evolutionary shift and were not inconsistent with what was happening in other service industries. The management consultants reported some contradiction regarding workload during out-of-hours. The qualitative research provided a fairly consistent message that demand had increased yet the quantitative diary based survey did not support that. It was noted that the quantitative survey focussed on out-of-hours work delivered personally by the participating GMPs and therefore workload covered by deputising services was excluded. Those doctors who perceived that demand had increased tended to interpret it as an increase in responsibility rather than recognising that it represented a higher volume of broadly similar work.

6.26. Ernst and Young's report drew our attention to a gradual shift to 24 hour availability of consumer services within society to such an extent that patients' expectations had risen. That had led to mixed views among the GMP population as to whether 24 hour medical cover by the GMP, i.e. the traditional approach, was still realistic. Ernst and Young observed that arrangements used by GMPs might in many cases have changed during the period under review, for example a shift to a co-operative arrangement. Typically, where the change had reduced the burden on a GMP, it represented the most significant change that had impacted on doctors' perceptions of out-of-hours work. The management consultants observed that their research provided evidence positively supporting initiatives arising from the Government's Development Fund expenditure.

6.27. Ernst and Young also concluded that, although there had been no 'sea-change' in GMPs' out-of-hours work, GMPs felt that the daytime workload had

increased to an extent that GMPs were less willing or were physically unable to incorporate out-of-hours work into the service they provided.

6.28. We allowed the parties sight of the quantitative and qualitative reports from Ernst and Young and invited relevant supplementary evidence. The Health Departments drew a comparison with the 1992–93 workload survey and highlighted that the average number of hours worked by GMPs per week during out-of-hours had decreased since 1992–93, from 6.93 to 5.52 per week. They made reference to the reported impact of the new out-of-hours arrangements, and welcomed the evidence of the reducing burden for GMPs, and the part the new arrangements were playing. They expressed surprise at the report's assertion that the burden of day-time working had increased, commenting that there was no supporting evidence for that, other than the reported perception of some GMPs taking part in the qualitative survey.

6.29. The BMA drew our attention to what they described as the disappointingly low response rate for the quantitative study and the retrospective nature of the qualitative exercise. It described these factors as obvious drawbacks which must colour its view of the findings. It observed that the evidence that work volume during out-of-hours had decreased slightly would be affected by the survey's response rate and by the exclusion from the survey of the work of deputising services. The BMA highlighted that the complexity, stress and physical demands associated with meeting the 24 hour responsibility for patients all remained a significant burden on GMPs. It said that the changing nature of doctors' in-hours work would have an adverse impact upon GMPs' willingness and physical ability to deliver out-of-hours care. The BMA emphasised the importance the profession attached to our establishing a notional value for GMPs' out-of-hours work and responsibility.

Comment

6.30. We have considered the results of the studies by Ernst and Young, along with the parties' comments, as part of our deliberation on the level of IANR for 1997–98. We have particularly noted Ernst and Young's observation that recent changes in the way doctors' out-of-hours work is organised have impacted significantly on their perceptions of out-of-hours work. We welcome innovations that have helped a growing number of doctors to reduce their individual burden of out-of-hours work. We believe that the data and the full findings from the quantitative and qualitative studies should be given a wide audience and we have therefore decided to publish them in full as an appendix to our report.

Pricing of out-of-hours work

6.31. We considered the parties' evidence on the results of their further survey of prices charged to doctors by co-operatives and deputising services. The results for co-operatives showed that the median cost to a GMP for transferring all his/her out-of-hours work was almost £7,300[1]. The range was £1,300 to £14,000. The cost of deputising services was dominated by one company which charged £6,850 for a typical GMP to be relieved of all his/her out-of-hours work.

6.32. We said last year that the parties had not told us for what specific purpose they required out-of-hours work to be priced. We would like, again, to emphasise that the notional price has no direct relevance to our determination of the level of GMPs' intended average net remuneration. We commented on this in our Twenty-Fifth Report. We do not believe that there is one correct price for out-of-hours work since workload varies between practices and service delivery costs vary according to location and organisation of service.

Comment and recommendation

6.33. In the light of the parties' evidence and other approaches for calculating a notional price for GMPs' out-of-hours, we have concluded that a notional value for GMPs' out-of-hours work and responsibility should be £7,000. This value assumes commitment to an average list size; clearly in reality there is a wide spread of practice character, list size and patient need. In our deliberations,

[1] The figures show the costs of a co-operative or deputising service and include the costs of any recurrent expenditure which are met by development funds.

we considered various approaches to calculating a notional price, none of which was clearly preferable. We have exercised a degree of judgement in arriving at this figure and emphasize that it should be used with a great deal of caution to avoid a notional value being misinterpreted or mis-applied in the context of remuneration discussions.

IANR on a whole-time equivalent basis

6.34. In our Twenty-Fifth Report, we examined the parties' separate evidence on the feasibility of recommending IANR on a whole-time equivalent (WTE) basis instead of for an average GMP. We decided to continue recommending on a 'head count basis' pending further information from the parties on the role, responsibilities and working patterns of part-time GMPs.

6.35. In their evidence this year, the Departments said that the growing number of part-time GMPs made it increasingly important to differentiate between the average GMP and the average full-time GMP when considering both pay and workload. They said that they therefore welcomed our decision last year to publish in our report an estimate showing what our recommended level of IANR represented, in terms of net earnings, for an average full-time GMP (based on the Departments' methodology).

6.36. The Departments told us that the roles and responsibilities of general medical practitioners were matters for individual practices, and that they had no comprehensive data for comparing the positions of part and full-time doctors. They had, however, commissioned an analysis of the 1992–93 workload survey data to provide information on the distribution of hours worked within each contractual commitment. They said that the analysis helped quantify how many part-timers worked longer hours than full-timers.

6.37. The Departments concluded that the great majority of full-time GMPs worked longer than the great majority of part-time GMPs. They said that the fact that some part-time GMPs worked longer than some full-time GMPs was already reflected in the average hours worked by each category. They argued that these considerations should not invalidate using those hours as a weighting to determine a whole-time equivalent for recommending IANR. They observed that there were activities (e.g. professional reading, attendance of education courses and practice administration) which were under General Medical Services but which fell outside the definition of 'availability to patients' on which the contractual commitment was based.

6.38. The BMA argued that we already had the means to adjust IANR to reflect the shift to flexible working should we think that necessary. It said that, as doctors' hours of work were not related to contractual availability, it would be wholly unjust to determine the size of the GMP remuneration pool on the basis of contractual availability, given that some part-time GMPs worked as many hours as full-time and most GMPs, whether part or whole time, worked substantially more than the amount the public would regard as a normal working week.

6.39. Commenting on the Departments' analysis of doctors' working patterns (see paragraph 6.37 above), the BMA said that the data did not support the conclusion reached by the Health Departments nor did they offer any rational argument for the whole-time equivalent concept. It commented that the analysis showed there to be a considerable overlap between the working hours of full and part-timers. In any other field, argued the BMA, some of the part-timers would be counted as full-time. It said that in workforce planning in relation to employee doctors, part-time working was related to the fixed working week of a full-timer as set by contractual commitment. It said that a part-time employee contracted for a specified proportion of the hours contracted for by a full-timer and for such a commitment to be related to the average hours worked would be both unworkable and contractually unsustainable. It further argued that moving to a WTE basis, and thereby reducing the size of the remuneration pool, would further erode the morale of an undervalued profession.

Comment

6.40. We have commented in previous reports that we are attracted by the principle of recommending IANR on a whole-time equivalent basis. We regard such a change to be sensible, given the growth in the number of GMPs with less than full-time commitments. We have, however, stressed the importance of ensuring that the change should be soundly based and presented in a way that enables GMPs and their financial advisers to understand the background and the reasons for it. The profession has forcefully presented evidence against moving to a WTE basis, but we find much of its argumentation obscure. In particular, we fail to understand why any change should automatically reduce the size of the remuneration pool when we could compensate for that in our recommended level of IANR, should we think that appropriate. We have, however, carefully considered the BMA's views that any change at the present time would have an adverse effect on the morale of GMPs at a time when there may be significant changes in the way their services are delivered to patients. We have noted also that the Departments welcomed the approach that we adopted last year. For these reasons, our approach for 1997–98 is unchanged.

6.41. We recall that general medical practice is a contractor activity. IANR, whether determined according to average work contribution or on a whole-time equivalent basis, is a mechanism for determining the pool of income available to GMPs, and is not in any sense a GMP 'salary'. Actual GMP earnings are influenced by a variety of factors outside our immediate considerations, including patient list size, practice business considerations and agreements within a partnership for the sharing of net profits from practice.

Level of IANR

6.42. In recommending the level of IANR for 1997–98, we have had regard to the parties' evidence as described in the previous paragraphs of this chapter. We have looked carefully at the recruitment and retention situation and we have commented on this in Chapter 1. We have noted the Departments' and the employers' concerns, which we share, that action is now required to reverse the present downward trend in the number of GMP trainees. We comment further on that in paragraph 6.58 below. On 17 December 1996 the Government announced new measures aimed at making general medical practice more attractive and in our review next year we would like to receive evidence from the parties concerning the impact of these measures on recruitment, retention and doctors' morale.

6.43. We have taken due note of the profession's evidence concerning the changing nature of medical practice, and the expansion of services provided by GMPs. At the same time, we are disappointed at the profession's refusal to co-operate with the Departments in a new workload survey. We have made observations on that in paragraphs 6.18 and 6.19. We are greatly impressed with doctors' dedicated approach to their out-of-hours activity and our report last year welcomed the innovative approaches by individuals or groups of doctors to providing systems for patient cover. It is evident to us that these innovations are reducing the out-of-hours work burden for a large number of doctors.

6.44. In our deliberations we have also had regard to the likely impact of the White Paper 'Choice and Opportunity'. It is evident to us that the proposed new contractual arrangements (the detail still to be determined) may provide scope for GMPs to enhance their remuneration. We shall pay particular attention to relevant developments in our future reviews.

6.45. We have weighed the factors described in paragraphs 6.42 to 6.44 above, alongside others as detailed in Chapter 1, paragraph 1.54, in arriving at our recommendation for IANR.

6.46. We **recommend** an increase to IANR of **3.75 per cent**. This brings IANR for 1997–98 to a level of £46,450. This recommendation takes account of the enhancement regarding pensions which we have recommended for 1997–98 (see Chapter 1, paragraph 1.47). Based on the Departments' methodology (which we described in our Twenty-Fifth Report), IANR for the average full-time GMP would be £49,005. The rate of increase for a full-time equivalent

GMP is higher than that for the average GMP because of a further fall within the GMP population of the proportion of full-time contracted GMPs. We expect that GMPs will earn on average a further £3,300 in 1997–98 from higher target payments, so that the aggregate earnings of a full-time equivalent GMP are expected to be approximately £52,300.

Expenses provision for 1997–98

6.47. The Departments told us that the estimated level of indirect expenses for 1994–95 from the 1996 Inland Revenue Enquiry was £21,142 with a sampling error of plus or minus £547. They said this estimate pointed to a further slowing in the rate of increase of indirect expenses since the surge around the time of the new contract in 1990–91. They suggested two approaches for forecasting indirect expenses and concluded that the underlying level of indirect expenses for 1997–98 was likely to be around £22,300.

6.48. The BMA told us that it had used its forecasting model up to and including 1988–89 to forecast through the following three years to derive the underlying trend in the absence of the impact of the contract changes. It had assumed that 1992–93 saw the underlying trend re-assert itself. Its forecast for 1997–98 was £23,375 assuming no change in IANR. The forecast would increase by £136 for every one per cent increase in total net income.

Comment and recommendation

6.49. We are aware that the introduction of the new contract caused a discontinuity in the trend of indirect expenses in 1990–91 which has made it hard to forecast the level of expenses in the future. Taking account of our recommendation on IANR for 1997–98, we have concluded that the expenses provision for 1997–98 should be £23,200.

Balancing mechanism

6.50. The Departments suggested that we should apply the balancing mechanism in the usual way, but we would need to consider the effect of any offsetting corrections forecast for future years. They concluded, on the basis of the most recent data available, that there had been a significant over-provision for expenses in 1996–97.

6.51. The BMA said the normal limitations on the size of the correction to be made in 1997–98 should apply.

Recommendation

6.52. We **recommend** that the balancing mechanism should operate under normal rules again for 1997–98 and we have decided to recover £615 in that year.

Amount to be delivered through the fee scale

6.53. The gross amount to be delivered through the fee scale is £46,450 (IANR) + £23,200 (expenses) — £615 (balancing item) or £69,035.

Evidence on the fee scale

6.54. Both the Departments and the BMA told us that they did not want to change any of the fee scale relativities this year.

Recommendation

6.55. In the light of the views of both parties our recommendation on the fee scale distributes our recommended increase broadly evenly across all items.

GMP registrars' supplement

6.56. The BMA observed that the pay of GMP registrars continued to fall well behind that of their hospital colleagues. It said that it was unacceptable that doctors who wished to enter training in general practice should be obliged to take a drop in remuneration. It said that the low pay of registrars was a major factor in the significant fall in their overall numbers. The BMA asked us to recommend a meaningful increase to the supplement payable.

6.57. The employers told us that health authorities had expressed considerable concern at the fall in the number of trainees. They said it was important that the present downward trend in numbers was reversed and that appropriate action was taken to achieve this. They said that trainee registrars should receive comparable remuneration packages to the equivalent posts in hospitals.

Comment and recommendation

6.58. There is some evidence of difficulties in recruiting adequate numbers of doctors into general medical practice (see paragraphs 6.2 to 6.10) and we have already reported on the measures announced by the Government to help alleviate the present adverse trend. Whilst we hope these measures will prove effective, we believe further action is needed in regard to GMP registrars' remuneration. We therefore intend to complement the Government's measures through increasing the level of the supplement payable to this group. Such action will also serve to reduce the earnings differential between hospital and general practice training. We can see no reason, however, why the remuneration level of GMP registrars should be completely in line with that for hospital trainees. The latter work relatively long hours, often at high intensity levels, and we have seen no evidence to suggest that GMP registrars are working to similar pressures.

6.59. We **recommend** an increase in the level of the supplement from 17.5 per cent to **22.5 per cent** of basic salary.

Deprivation payments—transitional scheme

6.60. In the supplement to our Twenty-Fourth Report, we recommended a deprivation payments transition scheme to protect those GMPs who lost income as a result of the introduction of 1991 Census data. Last year, following separate evidence from the parties, we recommended that the transitional scheme should continue for one further year, at reduced levels of compensation, and end on the 31 March 1997.

6.61. In its evidence this year the BMA said that the scheme had been widely welcomed by the profession. It added that, by its very nature, the transitional scheme was intended to address short-term difficulties. It observed, however, that the financial consequences of implementing the 1991 Census data was severely disadvantaging doctors who were practising in some of the country's most deprived communities. It asked us to extend the scheme for a further year at the current level of payments, in order to allow doctors more time to reorganise their practices to adjust to the new level of deprivation payments.

6.62. During their oral evidence the Departments said that two years of the transitional scheme was sufficient to cover the effect on practice income following changes to the new 1991 Census data. They told us that health authorities could, if they thought it appropriate, make sums available through cash limited budgets to help doctors in deprived areas through, for example, the provision of extra practice staff.

Comment and recommendation

6.63. We gave this issue careful consideration last year when we recommended an extension to the transitional scheme for one final year. We have noted the parties' evidence this year and we see no reason to change our view. We **recommend** that the scheme should end on 31 March 1997.

Associate's allowance

6.64. As part of our visits programme for 1996, we visited the Western Isles Health Board and had discussions with a number of doctors from local practices on the Isle of Lewis. Following that visit we requested evidence from the parties on the associate's allowance.

6.65. The BMA told us that the purpose of the allowance was to provide financial support for single handed, isolated GMPs to allow them to employ associate doctors, in conjunction with other isolated practitioners, so as to give them the opportunity for time off and training in situations where continuous duty would otherwise be an inescapable feature of the provision of General Medical Services. Referring to the development of co-operatives and the introduction of other arrangements to help doctors with their out-of-hours commitments, the BMA told us that it would now like to see the benefits of such shared methods of working extended to the most isolated areas of the country through improvements in the associate's allowance scheme. It told us that it had already put proposals to the Health Departments that, in geographically isolated areas where co-operatives or deputising arrangements were not feasible, the associate's scheme should be enhanced. It had asked for measures that would facilitate an increase in the number of doctors serving in these isolated areas. The

BMA asked us to consider enhancing the level of the associate's allowance payable.

6.66. The Departments observed that this was largely a Scottish issue and that there was no evidence of any particular problems over associate doctors. They said that their number had increased from 29 in 1992 to 44 in 1996 and that health boards had reported no difficulties in recruitment. The Departments informed us that, in addition to the basic allowance, associates were also eligible to receive other allowances (including those for a car and post-graduate education).

Comment and recommendation

6.67. We have already drawn attention to the growth in the number of co-operatives and deputising services which have been perceived by doctors generally as having a significant impact on their handling of out-of-hours work. Doctors in isolated areas of the country, often working single handed, have no access to such services and it is apparent to us that a successful associate's scheme is an essential feature of such areas, if GMPs' commitments to their patients are to be satisfactorily realised. Unlike GMP registrars, who assist in these isolated locations, associate doctors (who are fully trained) receive no supplement, as a matter of course, to their basic remuneration. We have observed that associates make an important contribution to the out-of-hours work of practices where they are employed and we hope that contribution is reflected in their contractual arrangements. The associate's allowance is currently linked to the second, third and fourth points of the senior registrar scale. In order to encourage the development of the associate's scheme, we are proposing this year to introduce a further increment in the level of the allowance as an incentive to doctors wishing to extend their period of service as an associate.

6.68. We **recommend** the associate's allowance is linked to points 2 to 5 of the senior registrar scale. The recommended scale is in Appendix A, Part 2 item 34.

Chapter 7

General Dental Practitioners

Manpower, recruitment and retention

7.1. The Departments told us that the number of dentists in the General Dental Service (GDS) in Great Britain had risen from 18,472 at 31 March 1995 to 18,728 at 31 March 1996. They said that this was only 30 below the all time quarterly peak at 31 March 1994. They observed that lengthening the degree course to five years had altered the seasonal pattern for graduate recruitment to the GDS and a further increase in the total number of dentists was therefore expected in September 1996. They said that the underlying trend was upward.

7.2. The Departments said that health authorities had been encouraged to apply for the Secretary of State's approval to appoint a salaried dentist where local circumstances so required. In August 1996, there were 149 salaried dentists working full or part-time in England. At the same date, there were 32 salaried dentists in Scotland and 6 in Wales.

7.3. The Departments observed that the number of students entering UK Dental Schools in the 1995–96 session again exceeded the Higher Education Funding Council's quota for home and overseas students. They said that there were 4,066 students in training on 1 January 1996 of whom 91 per cent were from the UK. They said that the ratio of applications to places continued to rise—from 2.9 in 1994 to 3.4 in 1995. The Departments commented that the recruitment and retention position continued to be encouraging with no difficulties experienced nationally.

7.4. The BDA told us that it was concerned at the numbers of dentists who qualified but did not subsequently remain in the National Health Service. It observed that the increase in the number of dentists registered had not been matched by a similar increase in the number of dentists working in the NHS. For example, it said, there were 26,320 dentists on the Register in September 1990 and this had risen to 27,957 in September 1995, a rise of 6.2 per cent; by contrast, for the same period there was an increase of only 4.1 per cent in the number of dentists in the NHS in Great Britain (from 18,011 to 18,743).

7.5. The BDA said that there was strong evidence of patients being unable to find a NHS dentist and of practice owners having difficulty in finding associate dentists. It said that the Central Committee for Community Dental Services had also reported difficulties in filling posts in the Community Dental Service. The BDA commented that the non-availability of NHS dentistry in many parts of the country needed to be addressed through the remuneration system but that any additional payments to dentists would not address the problem of general under-funding which lay at the heart of the problem of availability. The BDA observed that there appeared to be a shortage of dentists in the UK and asked us to support the need for a manpower review by the Departments.

Comment

7.6. In our Twenty-Fifth Report, we considered the need for action on our part to address the shift to private practice. We commented that we did not believe that such a shift could be halted simply through large increases in NHS dentists' fees. In paragraphs 7.26 to 7.35 below we describe and comment on a

recent Government initiative aimed at widening patients' access to NHS dentistry. Such an approach is consistent with what we consider is needed, both to improve access to the NHS and to reward dentists' commitment. We believe that its success in targeting resources to meet local needs depends on sufficient funds being made available for that purpose.

7.7. We have noted that it is the Government's policy that NHS dentistry should be accessible to all who want to make use of it. We have observed that, whilst the number of dentists in the GDS has risen over the last year, data on the total earnings of dentists show that the shift to private practice is continuing. We have been made aware that 55 per cent of the population of Great Britain is registered with a dentist (65 per cent of children and 52 per cent of adults[1]). It is not for the Review Body to make a judgment as to whether the number of dentists in the GDS is sufficient to meet the Government's objectives regarding oral health. However, the BDA asked us to support its suggestion for a manpower review of NHS dentistry and accordingly we invite the Departments to give that serious consideration.

Reform of NHS dentistry

7.8. Our Twenty-Fifth Report made reference to the Government's plans for the reform of NHS dentistry. In evidence to this review, the Departments informed us that constructive progress had been made this year in a number of key areas. Agreement had been reached with the profession on the reforms package announced in April 1995 and in view of that, the Government had announced a waiver of the remaining overpayments to general dental practitioners. These amounted to some £16,500 per GDP for the period ending 1993–94. This major step, they said, had removed a particular source of concern among dentists including many who were not in practice when the overpayments arose. The Departments said that the profession had responded by ending its dispute with the Government. They observed that these were significant and encouraging developments which had resolved a number of key points of contention and had brought to an end a lengthy period of uncertainty for the dental profession. The Departments said that they would continue to pursue the aim of achieving fundamental reform of the remuneration system through local purchasing.

7.9. Commenting on the reforms themselves, the Departments said that, from 1 September 1996, a range of item of service payments for children would be paid in addition to the capitation payments for each child registered. The registration period for both adults and children would be reduced to 15 months following each course of treatment. The first element of more rigorous prior approval for certain types of advanced treatments, to ensure that all treatments were clinically essential and were secured in the most cost-effective way, would be introduced from 1 December 1996. They said that the aim of the reforms was not to generate savings, but rather to target funding more effectively and ensure that the right incentives for oral health were given within the remuneration system. They said that the impact on GDPs' overall remuneration was intended to be neutral and that the impact of the reforms would be monitored jointly by the parties.

7.10. The BDA told us that dentists' reaction to the announcement of the reforms had been muted and that it was difficult to assess the effect on work patterns, income or morale. It said that the reforms of children's dentistry were first called for by the General Dental Services Committee (GDSC) in 1991 and had been generally welcomed. On the other hand, it said, nothing had been done to address the problems of under-funding so that adult dentistry would have to pay the price for the improvements for children.

Workload survey

7.11. In our Twenty-Fifth Report we invited the parties to carry out a new survey of GDPs' workload to inform our future deliberations. The BDA told us that the recent reforms package would create some disturbance to dentists'

[1]Department of Health statistics at 13 September 1996.

working patterns and it had agreed with the Health Departments that a workload survey would be premature at the present time and open to different interpretations.

Comment

7.12. We accept the parties' observations and we invite evidence on a new workload survey once dentists' new working patterns have stabilised.

Work volume, earnings and expenses

7.13. The Departments told us that at 30 April 1996, there were 22.9 million adult patients registered with a GDP in Great Britain. They said that the peak of 24.8 million had been reached in December 1993, but that much of the difference between the two figures stemmed from operational factors such as the removal of duplicate registrations. They said that at 30 April 1996, the number of child patients registered was 7.9 million, slightly more than at 30 April 1995. They commented that child registrations were less likely to be affected by operational factors because on average the registration period was shorter.

7.14. Commenting on dentists' NHS earnings, the Departments said that since 1993–94, these had been much more stable than in the preceding years. They said that in 1993–94, the last year for which there had been a target average net income, the Inland Revenue results had indicated a small underpayment of net fee earnings of £110 per Dental Rates Study Group (DRSG) Principal. The provisional results for 1994–95 suggested that average net earnings totalled £38,742, an increase of 6.8 per cent over 1993–94; higher than the fee scale increases of 2.9 per cent in January 1994, and 3 per cent in April 1994 (in line with the Review Body's recommendation for 1994–95). They said that gross earnings per GDP had increased by about 0.5 per cent between 1994–95 and 1995–96, somewhat less than the effect of fee increases. The underlying volume of payments was estimated to have reduced by about 2 per cent over the year including the effect of operational influences. The Departments also made reference to the volume of NHS treatments in 1996–97: they said that comparisons were not straightforward because of seasonal and operational factors. Gross fees in Great Britain in the quarter ending June 1996 had shown an increase of 2.1 per cent over the same quarter in 1995. They said that taking account of fee scale changes this suggested a reduction of about 0.8 per cent in underlying volume.

7.15. Our approach to GDPs' remuneration over the last three years has been to recommend increases in gross fees. The BDA expressed its concern that this mechanism did not necessarily produce an equivalent increase in actual payments to dentists. It said that as the General Dental Services were funded through such payments, a shortfall in payments meant under-funding for the service generally. It quoted an example for 1995–96, observing that the Review Body had recommended increases in fees of 2.5 per cent but in the event fee payments for GDS dentistry, in Great Britain, had risen from £1,419 million in 1994–95 to £1,429 million in 1995–96, a rise of £10 million or 0.7 per cent. The BDA made reference to a quarterly report from the Dental Practice Board for England and Wales which had pointed out that payments for children were 5.0 per cent higher, whereas those for adults had decreased by 0.6 per cent between 1994–95 and 1995–96. The BDA said that the number of adults registered in England and Wales had dropped from 22.3 million to 21.4 million but the number of adult courses of treatment had fallen by only 0.2 million. The average cost of a course of treatment was £33.21 compared with £33.12 the previous year. The BDA concluded from these figures that dentists were doing approximately the same volume of work, but were switching from adult to child treatment. It said that such a trend would accelerate when the recent reforms came on stream in 1997–98 and observed that percentage increases in fees did not automatically result in similar increases in funding for NHS dentistry.

7.16. The BDA commented that it was now five years since a full fee setting exercise had taken place and that many fees no longer reflected the time taken for the dental procedures involved or accurately reimbursed the laboratory and materials costs incurred. It said that the Departments had proposed a small scale

exercise to investigate these problems. During oral evidence, the Departments told us that they were content to discuss with the profession a realignment of selected fees on a cost-neutral basis. The GDPA told us in oral evidence that it also supported a review of fee scale relativities.

7.17. The parties produced joint supplementary evidence on dentists' NHS earnings and expenses. The key data are shown in the following table:

GDS earnings and expenses of DRSG principals

Year	Actual Gross Earnings £ per DRSG principal	Expenses £ per DRSG principal	Net Income £ per DRSG principal	Expenses Ratio Per cent
1992–93	87,916	47,331	40,585	53.9
1993–94	81,873	45,609	36,264	55.7
1994–95	84,556	45,814	38,742	54.2

Note: the 1994–95 expenses data are provisional. Income includes fee and non-fee earnings and direct reimbursements. Net income includes net notional rent.

7.18. The Departments suggested that we should take into account a number of factors in our consideration of GDPs' expenses: that dental consumables, a significant part of GDPs' expenses, fluctuated considerably in price; that the reduction in the level of complex advanced treatments would already be exerting downward pressure on expenses; that the introduction of more rigorous prior approval from December 1996 should add to that effect; and that dental fees provided indirect reimbursement of GDPs' practice expenses as well as net income. They commented that our recommendation in 1996–97 would have boosted expenses by a margin significantly in excess of the general rate of inflation. The Departments said there was no evidence to suggest that the overall movement of expenses would be other than consistent with the very low level of general wage settlements, interest rates and inflation.

7.19. The BDA made reference to a survey of business trends which it had conducted among its members in June 1996. The survey had looked into the extent of private practice, profitability of practices and pressures on practice owners. The BDA observed that there was an on-going move towards private practice, which should be seen as an adjunct to practice in the NHS, with the majority of dentists relying solely or largely on the NHS for their income. The BDA said that the profession remained committed to the NHS and believed that the current level of funding for the GDS should be enhanced. It said there was widespread pessimism about the future of general dental practice with just over half of BDA members feeling less confident about the future than they did two years ago. They said among practice owners that figure rose to two-thirds. Dentists, they said, were rather more confident about their own practices, but professional job satisfaction had also declined in the last two years with just under a half being less satisfied than they were two years ago.

Comment

7.20. There is a wide variation in the income of individual GDPs and also in the number of hours they work within the GDS. Any changes in dentists' income over a period of time have to be considered against changes in their commitment to the NHS. The parties' joint evidence shows that, after allowing for changes in the fee scale, the level of gross fee payments paid in the quarter ending June 1996 showed a reduction of about 0.8 per cent on the payments made in the same quarter the previous year. The parties' joint supplementary evidence to our review last year had indicated a reduction of 2 per cent in the underlying level of gross fees for the quarter ending 30 June 1995 compared with the same quarter in 1994. It is apparent that there has been a reduction in the underlying level of payments made through the General Dental Service. It is not possible to be entirely clear about the reasons for this reduction although we believe that a

major part of the reason is that dentists are performing less work on the NHS. We note it is not possible to quantify the precise level of decrease due to seasonal and operational factors.

Nature and level of recommendation for 1997–98

7.21. The Departments said that the overall picture was one of stability in levels of NHS dentistry. Their longer term plan was to move towards more locally sensitive provision of services through local contracting. They said that stability in pay arrangements would best enable the future agenda to be taken forward. They therefore supported a recommendation for 1997–98 based on gross fees. The BDA said that increasing gross fees remained, for the time being, the most appropriate way of making a general uprating of GDPs' remuneration. It argued, however, that the annual increase should be nearer the rate of increase in the Average Earnings Index to enable GDPs to keep up with the general national improvement in living standards.

Comment and recommendations

7.22. In our Twenty-Third Report, we recommended an increase in gross fees with the aim of relating dentists' income directly to the amount of work they did and at least maintaining the value against inflation of items of service and capitation payments during the coming year. We have continued that practice over the two subsequent years. In the light of the data now available to us, we have concluded that our aim has been broadly successful, but we have noted the profession's evidence that some individual fee levels are now in need of re-appraisal (see paragraph 7.16 above). We therefore **recommend** that the parties carry out such an exercise with a view to adjusting individual fee items from 1 April 1997, where appropriate. We have given advance notice of this recommendation to the parties to enable them to engage upon the necessary preparatory work.

7.23. We intend to continue our practice of recommending on gross fees for 1997–98. Neither party dissents from this approach. We **recommend** that the gross fees for items of service and capitation payments should be increased by an average of **3.55 per cent**[1] in 1997–98.

Time-lag

7.24. In our Twenty-Fifth Report, we recommended that the Departments enter into discussion with the profession on initiating a compensation scheme for dentists covering the time-lag effect of long treatments. In their evidence to this review, the parties told us that they were in agreement that a mechanism for providing compensation should be introduced and that they had agreed on a methodology to calculate the amount due to dentists. They informed us, however, that they had been unable to agree on how far back the compensation should be pitched.

Comment and recommendation

7.25. Time-lag occurs because increases in the fee scale do not mean immediate increases in payments to dentists as dental treatment is paid for according to the date on which a contract is entered into with the patient. We have commented previously that dentists can be severely disadvantaged through the application of fee scales that are considerably out-of-date. In the absence of complete agreement between the parties, we **recommend** that compensation should be payable to dentists in cases where the fee scale applicable to a course of treatment is more than one financial year out-of-date. Our intention is that once dentists have started receiving compensation, they should receive additional increases so that they are never more than one fee scale in arrears. We have noted that the parties have agreed a methodology for compensation and we invite them now to give priority to finalising the necessary detail of the scheme.

Additional payments to dentists

7.26. In our Twenty-Fifth Report we commented on patients' difficulty in obtaining access to NHS dentistry. We said that the issue needed to be addressed through the remuneration system and proposed, for consideration by the parties,

[1]This includes an enhancement of 0.15 per cent for pensions during 1997–98 (see Chapter 1, paragraph 1.47). The percentage enhancement has been adjusted to allow for gross fees containing an element for expenses as well as net income.

ways in which dentists' commitment to the NHS might be rewarded. Alternatively, we suggested that the parties might wish to devise and agree a suitable scheme of their own and we invited joint evidence to our next review on the progress made. Against that background the parties provided relevant evidence to our current review.

7.27. The parties informed us that they had been unable to agree joint evidence. The Departments said that they were considering the need for additional measures to secure full availability of GDS treatment, taking account of the proposals we had made in our Twenty-Fifth Report. They said that they had established an access fund in England to enable health authorities to target problem areas. Bids in the region of £40,000 had been invited from health authorities for schemes to increase the number of patients registered and treated through the GDS in local areas where there was inadequate availability of services. In Wales a comprehensive £3 million initiative had been launched in September 1995 and in Scotland innovative projects targeted at improving oral health had also received pump-priming funding from the Scottish Office.

7.28. The Departments told us that, on 31 October 1996, the Health Minister had announced that twenty-two different schemes had been selected for grants totalling nearly £800,000 from the access fund. He had said that although the schemes differed widely in content they were all chosen because of their quality and innovation. The Departments said that they were now planning to make sums available to the health authorities for selective schemes to improve the provision of dentistry in certain areas. They said that experience gained with existing initiatives would enable the health authorities to devise appropriate schemes tailored to local circumstances, avoiding the risk of creating perverse incentives which rewarded some but inadvertently acted as a disincentive to others. That, they said, would avoid the inflexibility of nationally determined arrangements. The Departments said that they would expect health authorities to demonstrate that there was significant need for registration and/or treatment within their areas. They would give priority to schemes which would be most likely to have a direct impact on the availability of NHS dentistry and which offered the best value for money. They said that they would require schemes to be monitored and evaluated to give them clear evidence about which measures were successful and which ones were less so.

7.29. The Departments said that they intended to build up these schemes over a period of time, drawing on examples of best practice derived from existing initiatives. Such an approach would enable them to test the effectiveness and value for money of a number of possible models for improving availability. It would allow them to learn from experience and ensure that schemes did not succeed at the expense of other parts of the country, or by targeting certain patient groups at the expense of others. It would also help them to ensure the success of any more widespread initiatives which might follow.

7.30. The BDA said that it regarded the level of the access fund as totally inadequate. It commented that the concept of additional payments could be further developed as a means of delivering resources to dentistry where they were most needed. It said that in addition to the problem of availability there were many other occasions on which special payments would be appropriate, for example, where levels of registration were low or where tooth decay levels were high. It said that another problem previously identified had been the level of dentists' expenses in high cost areas.

7.31. The BDA said that its General Dental Services Committee was in favour of both a nationally and a locally based scheme. It believed that additional payments should be designed to encourage dentists both to maintain their existing levels of commitment and in some cases to encourage greater commitment.

7.32. In its oral evidence to us, the BDA made reference to a range of incentive and support payments which it considered could be used to tackle the

problem of poor access to NHS dentistry in many parts of the country. The measures suggested included: loyalty and skill bonuses to dentists; local incentives such as cash grants towards the cost of equipment; soft loans for the setting up of new practices; help towards staff training costs; and an enhanced capitation payment. Subsequent to that, the Departments said that some of the BDA's suggestions might be reflected in the local solutions proposed by the health authorities but that they did not believe they should be implemented on a national level as they contained drawbacks, not the least of which would be the level of expenditure involved in their implementation.

7.33. The GDPA told us that dentists' expenses varied considerably and it was important to achieve fairness of financial reward for all GDPs. The GDPA suggested that the direct reimbursement of fixed costs and the introduction of payments which were workload sensitive would provide more scope for dentists to invest in their practices and maintain a quality service. The GDPA told us that it would favour the direct reimbursement of rent and the introduction of deprivation payments. It also advocated a system of seniority payments similar to that for GMPs to counter the retention problem in NHS dentistry.

Comment

7.34. We are encouraged by the parties' positive responses to our suggestion for additional payments to dentists. In particular, the access fund (referred to in paragraph 7.27 above) has had some success and has highlighted a number of problems throughout England, where patients have had difficulty in obtaining access to NHS dentistry. We have noted successful bids for cash from health authorities to help resolve local difficulties which have included: large numbers of adult de-registrations; practices only accepting child patients for NHS treatments; patients having to travel distances of up to 50 miles in the round to obtain treatment; large numbers of patients attending emergency dental centres; and a great number of enquiries from patients to dental help lines.

7.35. We have noted the Departments' evidence that they intend building on the schemes so far introduced. We urge them, as part of their considerations, to address the need to attract adequate numbers of young dentists into the profession and to retain them in the NHS. It is by no means apparent to us that the scale of the Departments' proposed initiatives is likely to resolve fully the difficulties of access to NHS dentistry. In our Twenty-Fifth Report, we made reference to a sum of £45 million being made available to encourage workforce flexibility for general medical practitioners in the London Initiative Zone and in its evidence to us this year, the BDA has called for a sum of £14 million which it says is needed for capital investment in practices. We are surprised at the difference between the small sums so far made available to help dentists and the much larger sums allocated to help doctors. We have noted that a sum of £800,000 was allocated by the Departments to pilot 'access' schemes, and we would envisage that sums exceeding £10 million could be needed to make a significant impact on the current problem once the piloting phase is complete. It is, we feel, important that solving problems of access to NHS dentistry should not be constrained through insufficient funding being allocated. We also think it desirable to 'ring fence' finance initiatives to dentists to ensure that resources are targeted to meet their objectives. We intend monitoring the situation throughout the coming year and would like to receive evidence to our next review on the progress and effectiveness of the schemes.

Salaried general dental practitioners

7.36. The BDA said that salaried general dental practitioners were employed where there were problems for patients in accessing a NHS dentist. It regarded it as anomalous that this 'safety net' function was divided between salaried GDPs who were employed by health authorities and Community Dental Service (CDS) dentists who were employed by NHS Trusts. It observed that pay scales of salaried GDPs and dental officers in the CDS were the same from points 3 to 7 inclusive. It said there was some evidence that health authorities had problems in recruiting salaried GDPs at such pay levels. The BDA asked us to recommend an extension to the salaried GDP pay scale with two additional incremental points, of about £2,000 each, which would bring the scale maximum to a level about

90 per cent of a GDP's average net earnings. The BDA also observed that salaried GDPs would have completed their vocational training and have had experience of working on their own. It proposed to us that the first two points of their salary scale be abolished.

7.37. The Departments said that it was inappropriate to compare salaried general dental practitioners with dentists in the Community Dental Service. They said the appropriate comparison was with general dental practitioners as both groups worked under the same regulations and had similar duties and the same responsibility towards patients. They pointed out to us in oral evidence that salaried dentists did not carry the cost or the risk of practice investment which was associated with contractor GDPs. They also said that health authorities could appoint salaried GDPs to higher points on the pay scale than the normal entry point if they considered that appropriate. They also commented that there was nothing to prevent a health authority employing a dentist without extensive practice experience or somebody who had just completed his/her vocational training. The Departments said that salaried dentists were appointed to meet a shortfall in local GDS provision and that demand for their services frequently centred on emergency one-off treatment, rather than the normal mix of continuing care.

Comment and recommendations

7.38. We have seen no data to suggest that there are any difficulties in recruiting salaried general dental practitioners and the profession has provided no other information in support of its proposal that the first two points of the salaried GDPs' scale should be abolished. It is clear to us that there is flexibility for health authorities to place salaried GDPs on the appropriate point of the scale on entry. We **recommend** therefore no change to the structure of the salaried GDP pay scale but we intend keeping the position under review.

7.39. We **recommend** a **3.4 per cent** increase, with a further addition of **0.35 per cent** for pensions[1], in the remuneration for salaried general dental practitioners.

Emergency dental services

7.40. We **recommend** that sessional fees for taking part in emergency dental services be increased by **3.4 per cent** with a further addition of **0.35 per cent** for pensions[1].

[1]See Chapter 1, paragraph 1.47.

Chapter 8

Dental Public Health and the Community Dental Service

Manpower

8.1. The Departments told us that in the year to 30 September 1995 there were 40 consultants in dental public health. In the same period there were 1,380 dentists in the Community Dental Service (CDS), of whom 410 were employed directly by health authorities and 970 by NHS Trusts, with which health authorities had contracted for the provision of those services.

Community Dental Services

Role of the Community Dental Services

8.2. In its evidence the profession outlined the responsibilities of the CDS and drew attention to the increased 'safety net' function of the CDS, that is, the responsibility of the service to provide dental care to those individuals unable to access the General Dental Service. The BDA also said that, despite the intention to increase the 'safety net' role of the CDS, some health authorities had already indicated their intention to reduce their spend on Community Dental Services.

Recruitment and retention

8.3. The BDA told us that it had repeated its survey on recruitment to the Community Dental Services and had approached Clinical Directors of Community Dental Services who had advertised in the British Dental Journal during the first three months following the new 1 April 1996 salary scales. That had shown that 20 dental officer posts had been advertised but only 14 had been filled. At least 3 of those were posts specifically for vocational trainees and so had attracted considerable interest from new graduates. The BDA said that 9 senior dental officer (SDO) posts had been advertised but only 5 had been filled. It commented that, according to the Clinical Directors, the filling of these posts had often been the result of placing more than one advertisement and/or they had been able to offer the incentive of study opportunities for a post-graduate qualification. In some cases there had only been one applicant for a particular post and many had felt that the low numbers of applicants reflected the lack of confidence in the future of the CDS.

8.4. The BDA made reference to an informal survey that it had conducted. That had concluded that 20 per cent of dental officers either had, or were working towards, a further registerable qualification and that many had provided the funding for that themselves. It commented that lack of funding for post-graduate study, and for continuing education generally, was a source of concern among dental officers.

Assistant district dental officers and senior dental officers

8.5. In our Twenty-Fifth Report we recommended an additional incremental point to the top of the SDO salary scale, following the job evaluation exercise carried out jointly by the parties. In evidence to our current review, the BDA observed that one consequence of that additional award was that the top point of the SDO scale was now £330 higher than the top point of the assistant district dental officer (ADDO) scale. The differential previously had been some £2,200 in

favour of the latter. The BDA said that the ADDO grade was the next step up the career ladder for SDOs and that a number of SDOs who had recently been promoted to ADDO had found themselves facing a pay cut as a consequence of our action. It also observed that recruitment to the ADDO grade had been difficult during the current year. The BDA said that the responsibilities of ADDOs were significantly greater than those of SDOs, as they had responsibility for clinical leadership of both the service and of staff as well as the responsibility for professional liaison and giving advice to others involved in the delivery of primary care, social and educational services. Additionally their role would require them to have a complete overview of the service and to pursue its development in accordance with local dental health needs. The BDA told us that Directors of Community Dental Services were normally employed on either assistant district dental officer or district dental officer (DDO) pay scales and that each provider unit would usually employ one or other of the two grades but not both. Observing that movement from ADDO to DDO did not represent a promotion, the BDA said that its proposed improvement to the ADDO scale would not therefore have a consequence for any other grade.

8.6. The Departments said that during the course of discussions with the profession it had been recognised by both parties that the new SDO scale could now result in a situation where a SDO might be managed by an ADDO, who was earning less than the SDO he was managing. The Departments said they had made it clear that this differential in pay would not, of itself, justify an increase in the pay scale of the ADDO. However, during oral evidence the Departments observed that it might now be necessary to review the top point of the ADDO scale. They also told us that the move of the CDS into Trusts had changed the coverage of the service and could have altered the job weights of individual DDOs with some functions now transferred to consultants in dental public health. They suggested a need for a review of population bandings for DDOs in the light of their changed responsibilities.

8.7. The employers commented that the differential between the salary scales of SDOs and ADDOs was anomalous and needed addressing. They commented that while SDOs were mainly involved in clinical work, ADDOs had both managerial responsibilities and clinical responsibilities and that the former should be appropriately recognised in their salaries.

Comment and recommendation

8.8. We invite evidence from the parties to our next review on how the incorporation of the CDS into Trusts has impacted on the population bandings structure for DDOs. We would like the parties to provide specific proposals for our consideration. In the light of the parties' evidence, we **recommend** an additional increment on the ADDO scale. The revised scale is in Appendix A, Part 1.

Dental Public Health

8.9. The profession referred to the role of those in dental public health and their important contribution to the commissioning of oral health care for the resident population of a health authority or health board area. They said that that role would become crucial in the event of local contracting of General Dental Services being introduced. It observed that in some cases consultant posts were being extended to cover a larger population, which often meant having responsibility to more than one health authority or health board.

Level of Remuneration Increases

Recommendation

8.10. We **recommend** increases of **3.4 per cent**, with a further addition of **0.35 per cent** for pensions[1], for dentists of all grades in dental public health and the Community Dental Service. The proposed scales are set out in Appendix A.

[1]See Chapter 1, paragraph 1.47.

Appendix A

Detailed recommendations on remuneration

PART I: RECOMMENDED SALARY SCALES

The salary scales that we recommend for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be increased *pro rata*.

A. Hospital medical and dental staff

	Current scales	*Recommended scales payable from 1 April 1997*
	(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)	
	£	£
House officer	14,880	15,440
	15,840	16,435
	16,800	17,430
Senior house officer	18,560	19,260
	19,810	20,555
	21,060	21,850
	22,310	23,145
	23,560	24,440
Registrar	20,745	21,530
	21,800	22,620
	22,855	23,710
	23,910	24,800
	25,180	26,120
Senior registrar	23,910	24,800
	25,180	26,120
	26,450	27,440
	27,720	28,760
	28,990	30,080
	30,260	31,400
Specialist registrar	20,745	21,530
	21,800	22,620
	22,855	23,710
	23,910	24,800
	25,180	26,120
	26,450	27,440
	27,720	28,760
	28,990[1]	30,080[1]
	30,260[1]	31,400[1]

[1]These two points are subject to certain conditions being fulfilled, see Chapter 3 paragraph 3.10.

	Current scales	*Recommended scales payable from 1 April 1997*
	£	£
Consultant	42,170	43,750
	45,235	46,930
	48,300	50,110
	51,365	53,290
	54,430	56,470
Discretionary points	*Notional scale*	
	56,615	58,725
	58,790	60,985
	60,965	63,245
	63,140	65,505
	65,315	67,765
Associate specialist	25,000	25,945
	27,720	28,765
	30,440	31,585
	33,160	34,405
	35,880	37,225
	38,600	40,045
	42,210	43,795
	43,490	45,120
Discretionary points	*Notional scale*	
	45,120	46,815
	46,750	48,505
	48,380	50,195
	50,010	51,885
Staff grade practitioner	22,545	23,390
	24,390	25,305
	26,235	27,220
	28,080	29,135
	29,925	31,050
	31,770	32,965
	33,615	34,880

	Current scales	*Recommended scales payable from 1 April 1997*
	annual rates on the basis of a notional half day per week	
	£	£
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 107 of the Terms and Conditions of Service)	3,080	3,195
Hospital practitioner (limited to a maximum of 5 half day weekly sessions)	3,005	3,120
	3,175	3,295
	3,345	3,470
	3,515	3,645
	3,685	3,820
	3,855	3,995
	4,025	4,170

B. Public health medicine staff

	Current scales	*Recommended scales payable from 1 April 1997*
	(excluding earnings from out-of-hours payments for training grades)	
	£	£
Trainee in public health medicine	20,745	21,530
	21,800	22,620
	22,855	23,710
	23,910	24,800
	25,180	26,120
	26,450	27,440
	27,720	28,760
	28,990	30,080
	30,260	31,400
Specialist registrar in public health medicine		21,530
		22,620
		23,710
		24,800
		26,120
		27,440
		28,760
		30,080[1]
		31,400[1]
Consultant in public health medicine	42,170	43,750
	45,235	46,930
	48,300	50,110
	51,365	53,290
	54,430	56,470
Discretionary points	*Notional scale*	
	56,615	58,725
	58,790	60,985
	60,965	63,245
	63,140	65,505
	65,315	67,765

Details of the supplements payable to public health medicine staff are set out in Part II of this Appendix.

[1]These points are subject to certain conditions being fulfilled, see Chapter 4 paragraph 4.15.

C. Community health staff

	Current scales	*Recommended scales payable from 1 April 1997*
	(excluding earnings from out-of-hours supplements)	
	£	£
Clinical medical officer	21,560	22,370
	22,765	23,620
	23,970	24,870
	25,175	26,120
	26,380	27,370
	27,585	28,620
	28,790	29,870
	29,995	31,120
Senior clinical medical officer	30,765	31,925
	32,680	33,910
	34,595	35,895
	36,510	37,880
	38,425	39,865
	40,340	41,850
	42,255	43,835
	44,170	45,820

D. Community dental staff

	Current scales	*Recommended scales payable from 1 April 1997*
	(excluding earnings from out-of-hours supplements)	
	£	£
Trainee in dental public health	20,745	21,530
	21,800	22,620
	22,855	23,710
	23,910	24,800
	25,180	26,120
	26,450	27,440
	27,720	28,760
	28,990	30,080
	30,260	31,400
Consultant in dental public health (formerly known as community dental health specialist) ...	42,170	43,750
	45,235	46,930
	48,300	50,110
	51,365	53,290
	54,430	56,470
Discretionary points	*Notional scale*	
	56,615	58,725
	58,790	60,985
	60,965	63,245
	63,140	65,505
	65,315	67,765
Assistant district dental officer (assistant chief administrative dental officer in Scotland and Wales)	33,420	34,675
	35,855	37,200
	38,290	39,725
	40,725	42,250
	43,160	44,775
		47,300

	Current scales	*Recommended scales payable from 1 April 1997*
	£	£
District dental officer (chief administrative dental officer in Scotland and Wales) Band F (District of 50,000-149,999 population)	43,275	44,895
	43,910	45,555
	44,545	46,215
	45,180	46,875
	45,815	47,535
District dental officer (chief administrative dental officer in Scotland and Wales) Band E (District of 150,000-449,999 population)	43,465	45,095
	44,115	45,770
	44,765	46,445
	45,415	47,120
	46,065	47,795
District dental officer (chief administrative dental officer in Scotland and Wales) Band D (District of 450,000-800,000 population)	44,955	46,640
	45,610	47,320
	46,265	48,000
	46,920	48,680
	47,575	49,360
District dental officer (chief administrative dental officer in Scotland and Wales) Band C (District with population over 800,000)	46,140	47,870
	46,795	48,550
	47,450	49,230
	48,105	49,910
	48,760	50,590
Regional dental officer Band B (Region with population under 3.5 million)	48,680	50,505
	49,335	51,185
	49,990	51,865
	50,645	52,545
Regional dental officer Band A (Region with population of 3.5 million and over)	49,695	51,560
	50,350	52,240
	51,005	52,920
	51,660	53,600
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	38,475	39,920
	40,910	42,445
	43,345	44,970

	Current scales	*Recommended scales payable from 1 April 1997*
	£	£
Dental officer	20,855	21,635
	21,925	22,745
	24,670	25,595
	26,570	27,565
	28,470	29,535
	30,370	31,505
Senior dental officer	30,370	31,505
	32,870	34,100
	35,525	36,855
	38,180	39,610
	40,835	42,365
	43,490	45,120

	Current rates	*Recommended rates payable from 1 April 1997*
	£	£
Part-time dental surgeon: *Sessional fee (per hour)*		
Dental surgeon	18.85	19.55
Dental surgeon holding higher registrable qualifications	24.95	25.90
Dental surgeon employed as a consultant	31.20	32.35

Details of the supplements payable to community dental staff are set out in Part II of this Appendix.

E. Salaried dental practitioners

	Current scales	*Recommended scales payable from 1 April 1997*
	£	£
Salaried dental practitioners	20,870	21,655
	22,770	23,625
	24,670	25,595
	26,570	27,565
	28,470	29,535
	30,370	31,505

PART II: DETAILED RECOMMENDATIONS ON FEES AND ALLOWANCES

Operative date

1. The new levels of remuneration set out below should operate from 1 April 1997 (excluding item 42). The previous levels quoted are those currently in force.

Hospital medical and dental staff

2. The annual values of distinction awards for consultants should be increased as follows. The percentage of the maximum of the consultant scale is shown in brackets.

A plus awards (95 per cent)	from £51,710 to £53,645
A awards (70 per cent)	from £38,100 to £39,530
B awards (40 per cent)	from £21,770 to £22,590

The number of A plus awards should be increased from 258 to 267, the number of A awards from 891 to 920, and the number of B awards from 1,977 to 2,042.

3. The supplements payable to doctors and dentists in training grades for duties outside basic hours are reckoned in additional duty hours. These hours should be paid at the following percentages of the equivalent rates of the basic salary for full-time staff, depending on the type of contract.

full shift	100 per cent
partial shift and those in high intensity on-call posts...	70 per cent
on-call rota	50 per cent

4. The fee for domiciliary consultations should be increased from £55.00 to £56.85 a visit. Additional fees should be increased *pro rata.*

5. Weekly and sessional rates for locum appointments in the hospital service should be increased as follows:

Consultant appointment[1]	from £952.60 to £988.35 a week; from £86.60 to £89.85 a notional half day
Associate specialist, senior hospital medical or dental officer appointment ...	from £661.65 to £686.40 a week; from £60.15 to £62.40 a notional half day
Specialist registrar LAS appointment ...	the weekly rate should be £502.40; the sessional rate should be £12.56 per standard hour
Senior registrar appointment	from £521.20 to £540.80 a week; from £13.03 to £13.52 per standard hour
Registrar appointment	from £437.60 to £454.00 a week; from £10.94 to £11.35 per standard hour
Senior house officer appointment	from £404.00 to £419.20 a week; from £10.10 to £10.48 per standard hour
House officer appointment	from £306.00 to £317.60 a week; from £7.65 to £7.94 per standard hour

[1]Where a consultant takes a locum appointment after retirement, and provided the consultant was remunerated at the scale maximum, the rates applicable instead should be increased as follows:
from £1,046.10 to £1,085.15 a week;
from £95.10 to £98.65 a notional half day.

Hospital practitioner appointment ...	from £67.25 to £69.75 a notional half day
Staff grade practitioner appointment ...	from £538.00 to £558.00 a week; from £53.80 to £55.80 a session
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 107 of the Terms and Conditions of Service)	from £59.60 to £61.85 a notional half day

6. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

Ophthalmic medical practitioners

7. The ophthalmic medical practitioners' gross fee for sight testing should be £14.10.

General medical practitioners

8. The Intended Average Net Remuneration for general medical practitioners should be increased from £44,770 to £46,450 from 1 April 1997.

9. Basic practice allowance for full-time practitioners should be increased as follows:

First 400 patients	from £3,000 to £3,120
Each successive patient from 401 to 600	from £7.50 to £7.80
Each successive patient from 601 to 800	from £6.00 to £6.24
Each successive patient from 801 to 1,000... ...	from £4.50 to £4.68
Each successive patient from 1,001 to 1,200 ...	from £3.00 to £3.12
Maximum rate for 1,200 patients	from £7,200 to £7,488

10. The additions (full rate) to the basic practice allowance should be increased as follows:

Designated area allowance:	
Type 1	from £3,490 to £3,645 a year
Type 2	from £5,325 to £5,560 a year
Seniority:	
First stage	from £445 to £465 a year
Second stage	from £2,325 to £2,425 a year
Third stage...	from £5,015 to £5,235 a year
Allowance for the employment of a full-time assistant:	
Ordinary level	from £6,240 to £6,515 a year
Where the principal receives the designated area allowance	from £8,735 to £9,120 a year

11. Deprivation payments for each patient resident in a deprived area should be increased as follows:

Patients in a high level deprived area	from £10.75 to £11.20 a year
Patients in a medium level deprived area	from £8.05 to £8.40 a year
Patients in a low level deprived area	from £6.20 to £6.45 a year

12. The standard capitation fees should be increased as follows:

Patients aged under 65	from £15.35 to £16.05 a year
Patients aged 65 to 74	from £20.30 to £21.20 a year
Patients aged 75 and over	from £39.25 to £41.00 a year

13. The capitation addition for out-of-hours cover should be increased from £3.05 to £3.20 a year.

14. The child health surveillance fee should be increased from £11.15 to £11.65 a year.

15. The registration fee should be increased from £6.80 to £7.10.

16. Night visit payments should be increased as follows:

Annual allowance	from £2,078 to £2,165
Fee	from £20.80 to £21.65

17. Target payments[1] for childhood immunisations should be increased as follows:

higher rate	from £2,235 to £2,340 a year
lower rate	from £745 to £780 a year

18. Target payments[1] for pre-school boosters should be increased as follows:

higher rate	from £660 to £690 a year
lower rate	from £220 to £230 a year

19. Target payments[1] for cervical cytology should be increased as follows:

higher rate	from £2,505 to £2,610 a year
lower rate	from £835 to £870 a year

20. The fees for items of service carried out for reasons of public policy should be increased as follows:

Vaccination and immunisation

higher rate	from £5.45 to £5.65
lower rate	from £3.75 to £3.90

21. The fees for the provision of contraceptive services should be increased as follows:

Ordinary fee...	from £14.25 to £14.90
Intra-uterine device fee...	from £47.70 to £49.80

22. The annual payments for health promotion programmes for a practitioner with an average list size for Great Britain (adjusted *pro rata* for other list sizes) should be increased as follows:

Band 3	from £2,165 to £2,260

The annual payments per GMP for chronic disease management programmes should be increased as follows:

Diabetes allowance...	from £380 to £395
Asthma allowance	from £380 to £395

23. The fee for doctors on the obstetrics list providing complete maternity services should be increased from £178.00 to £186.00. Other maternity medical service fees should be increased *pro rata*. In addition, night visit fees should be payable for certain maternity service work undertaken during the qualifying times.

[1]The rates shown for target payments are the maxima which can be paid to GMPs with the average number of eligible patients on their list. The difference between the higher rate and the lower rate is excluded from average remuneration.

24. The temporary resident fees should be increased as follows:

Patients expecting to remain in the district for:	
not more than 15 days	from £9.05 to £9.45
more than 15 days	from £13.60 to £14.20

25. The fees for emergency treatment given by a practitioner to a patient not on his or her list should be increased as follows:

Involving a night visit	from £20.80 to £21.65
Emergency consultation	from £22.60 to £23.60
Minor surgical operation involving local or general anaesthetic	from £22.60 to £23.60
Treatment of a fracture...	from £22.60 to £23.60
Reduction of a dislocation	from £22.60 to £23.60
Administration of a general anaesthetic ...	from £37.70 to £39.35

26. The fees for the provision of an anaesthetist for administration of a general anaesthetic should be increased from £37.70 to £39.35.

27. The fees for arrest of dental haemorrhage should be increased as follows:

higher rate	from £22.60 to £23.60
lower rate	from £15.40 to £16.10

28. The full rate of the postgraduate education allowance should be increased from £2,260 to £2,360 a year. The reduced allowances should be increased as follows:

level 1	from £450 to £470 a year
level 2	from £900 to £940 a year
level 3	from £1,350 to £1,410 a year
level 4	from £1,800 to £1,880 a year

29. The training grant under the trainee practitioner scheme should be increased from £4,925 to £5,140 a year.

30. The initial practice allowance should be increased as follows:

Type 1	Maximum allowance
First year	from £22,170 to £23,010
Second year	from £14,780 to £15,340
Third year	from £7,390 to £7,670
Fourth year	from £3,695 to £3,835
Type 2	Guaranteed net income (for up to 5 years from date of appointment of first doctor)
First doctor	from £58,200 to £60,385 a year
Second doctor	from £44,770 to £46,450 a year

The Health Departments should negotiate the amount to be compared with total reckonable income for the calculation of the Type 1 initial practice allowance.

31. The fee for doctors on the minor surgery list providing a minor surgery session should be increased from £111.90 to £116.80.

32. Rural practice funds should be increased by 4.4 per cent.

33. Average remuneration from on-cost and professional fees per unrestricted principal in respect of dispensing and supply of drugs and appliances should be increased by 4.2 per cent, assuming no change in workload.

34. The associates allowance[1] should be increased as follows:

First year	from £25,180 to £26,120 a year
Second year	from £26,450 to £27,440 a year
Third year	from £27,720 to £28,760 a year
Fourth and subsequent years	this should be £30,080 a year

35. The maximum weekly rate of the locum allowance[1] should be increased from £437.60 to £454.00.

36. The supplement payable to trainee general medical practitioners for out-of-hours duties should be increased from 17.5 per cent to 22.5 per cent of basic salary.

General dental practitioners

37. The gross fee for each item of service and capitation payment should be increased by 3.55 per cent from 1 April 1997.

38. The sessional fee for practitioners working a 3-hour session under emergency general dental service schemes should be increased from £79.30 to £82.25.

39. The sessional fee for part-time salaried dentists working six 3-hour sessions a week or less in a health centre should be increased from £56.10 to £58.20.

Doctors in public health medicine and community health and community dental staff

40. The supplements payable to district directors of public health (directors of public health in Scotland and Wales) and for regional directors of public health should be increased as follows:

	Current range of supplements	*Recommended range of supplements payable from 1 April 1997*
	£	£
Island Health Boards		
Band E (under 50,000 population)	1,175–2,345	1,220–2,435
District director of public health (director of public health in Scotland/Wales) (formerly known as district medical officer)		
Band D	2,345–4,695	2,435–4,870
(District of 50,000–249,999 population)	(Bar); 5,870	(Bar); 6,090
Band C	2,940–5,870	3,050–6,090
(District of 250,000–449,999 population)	(Bar); 7,045	(Bar); 7,310
Band B	3,520–7,045	3,650–7,310
(District of 450,000 and over population)	(Bar); 9,100	(Bar); 9,440
Regional director of public health (formerly known as regional medical officer)		
Band A	...9,100–13,205	9,440–13,700

41. The supplement payable to trainees in public health medicine for out-of-hours commitments should be 15 per cent of basic salary.

[1] These allowances are directly reimbursed and are excluded from average remuneration.

42. The fees payable to medical practitioners undertaking part-time work on the community health service or for local authorities under the collaborative arrangements should be as follows from 1 July 1997:

	Recommended fees payable from 1 July 1997 £
Sessional fees	
a. Consultant or specialist work	
i. Full session	87.60
ii. Short session	56.80
iii. School ophthalmic work (session of not less than 3 hours)	95.50
iv. Vasectomy session (full session)	145.00
b. Clinical refraction work (full session)	64.30
c. Dental anaesthetic work, where the practitioner has a recognised qualification in anaesthetics (full session)	64.30
d. Other medical work	
i. Full session	55.80
ii. Short session	36.00
iii. Family planning session concerned with patients with marital difficulties or instructing other doctors in family planning (full session)	68.70
iv. Family planning session concerned with patients with marital difficulties or instructing other doctors in family planning (short session)	56.40
v. Vasectomy session (full session)	89.10
Examination of blind or partially-sighted persons for the completion of Form BD8	
a. Examination in consulting room	53.60
b. Re-examination in consulting room	36.00
c. Examination in patient's home	71.50
d. Re-examination in patient's home	53.60
Psychiatric examination under Section 105 of the NHS Act 1977 or for the purposes of the Mental Health Act 1983	
a. Consultant or specialist work, including work carried out by a practitioner approved under Section 12(2) of the Mental Health Act 1983	53.60
b. Other medical work	40.80
Children in care, adoption and fostering	
a. Examination and reports on children committed or about to be committed to the care of the local authority, or received or about to be received into care by a local authority, or about to be fostered (unless b. below applies)	
i. Initial examination	29.70
ii. Subsequent examination by the same doctor, or his partner, assistant or locum tenens	19.00
iii. Freedom of Infection Certificate only	19.00

b. Examination and reports in a form recommended by the British Agencies for Adoption and Fostering (BAAF)
   i. Forms C, D, YP, or AME (detailed medical examinations to report on child) 76.60
   ii. Form Adult 1 (medical examination to report on prospective parent) 29.70
   iii. Form Adult 2 (supplementary to Adult 1, where necessitated by the period of time between initial application and placement) 19.00
   iv. Form R (preliminary examination of child) 29.70
   v. Form B3 (retrospective paediatric report on child over 5) 28.40
   vi. Forms B1 and B2 (obstetric/neonatal reports on child under 5) 19.00
   vii. Forms MH (medical history of child) 19.00

Other examinations and reports

a. Examinations and reports required by local authorities under the collaborative arrangements for purposes not specified above
   i. From consultants 56.80
   ii. From other doctors (full medical examination including report and opinion) 29.70
   iii. From other doctors (report and opinion only) 19.00
   iv. Emergency attendance by consultants 87.60
   v. Emergency attendance by other doctors 55.80
b. Medical examinations of prospective NHS employees
   i. Full medical examination including report and opinion 29.70
   ii. Report and opinion only... ... ... 19.00

Visiting Medical Officers to establishments maintained by Local Authorities

a. Payment on a salary basis
   i. 1 hour per week 1,445.00
   ii. 2 hours per week 2,619.00
   iii. Each additional hour over 2 ... ... 1,120.00
b. Emergency visits
   i. Between 9am and 8pm 19.50
   ii. Between 8pm and 9am 39.50

Miscellaneous fees

a. Domiciliary visits for family planning purposes
   i. Fee per visit 18.60
   ii. Fee per unproductive visit 7.00
b. Fee for the notification of infectious diseases or food poisoning 2.50
c. Fee for lecture to the public 44.40

43. The teaching supplement for assistant district dental officers (assistant chief administrative dental officers in Scotland and Wales) should be increased from £1,615 to £1,675 a year.

44. The teaching supplement payable to district dental officers (chief administrative dental officers in Scotland and Wales) should be increased from £1,825 to £1,895 a year.

45. The supplement for district dental officers (chief administrative dental officers in Scotland and Wales) covering two districts should be increased from £1,175 to £1,220 a year and the supplement for those covering three or more districts should be increased from £1,885 to £1,955 a year.

46. The allowance for dental officers acting as trainers should be increased from £1,285 to £1,335 a year.

47. The supplement payable to trainees in dental public health for out-of-hours commitments should be 15 per cent of basic salary.

48. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

Appendix B

Number of doctors and dentists in the National Health Service [1,2]

Great Britain

	1994		1995		Change	
	number		number		per cent	
	medical	dental	medical	dental	medical	dental
Hospital medical and dental staff[3]						
Consultants	20,450	660	21,920	680	7	2
Associate specialists	1,160	80	1,280	90	10	6
Staff grade	1,620	50	2,190	70	35	51
Senior registrars	4,630	140	4,920	140	6	–1
Registrars	7,590	220	7,590	220	0	0
Senior house officers	15,050	410	15,790	460	5	14
House officers	3,790	110	4,010	90	6	–10
Hospital practitioners	770	100	820	80	7	–17
Clinical assistants	7,420	770	7,550	780	2	1
Other	20	0	10	0	–13	–75
Total	62,490	2,540	66,080	2,620	6	3
Public health and community medical staff[3]						
Regional and district directors	120		130		8	
Consultants	540		590		10	
Special salary scale staff	0		0		33	
Trainees in public health medicine	420		440		4	
Senior clinical medical officers	1,140		1,110		–3	
Clinical medical officers	1,530		1,370		–11	
Other medical staff	1,170		1,140		–2	
Total	4,930		4,790		–3	
Community dental staff[3]						
Regional and district dental officers	80		70		–12	
Assistant district dental officers	60		60		2	
Consultants	40		50		29	
Senior dental officers	420		450		8	
Dental officers	1,090		1,040		–4	
Other dental staff	20		50		165	
Total	1,700		1,720		1	
General practitioners						
General medical practitioners:[4]						
unrestricted principals	31,770		31,950		1	
restricted principals	160		140		–12	
assistants	630		680		9	
trainees	1,840		1,790		–3	
associates	30		40		29	
General dental practitioners:[3]						
principals	17,640		17,670		0	
assistants and vocational trainees	960		1,070		11	
salaried dentists[5]	130		150		18	
Ophthalmic medical practitioners[6]	740		750		2	
Total	53,880		54,230		1	
Total—NHS doctors and dentists	125,530		129,430		3	

[1]The table contains the number of medical and dental posts. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.
[2]All figures have been rounded independently and percentage changes have been calculated from unrounded figures.
[3]At 30 September.
[4]At 1 October.
[5]Figures for July 1994 and July 1995.
[6]At 31 December.

Appendix C

Intended and actual average net remuneration of GMPs: 1979–80 to 1996–97

1. The actual average net remuneration received by GMPs can in any year be higher or lower than the Intended Average Net Remuneration that we recommend. In the past this has been mainly due to the difficulties in estimating precisely in advance the practice expenses that will, on average, be incurred by GMPs in any one year. Since 1983, we have operated a formal balancing mechanism to correct any underpayment or overpayment in net remuneration. Final figures of actual practice expenses are only available in the second year after the expenses are incurred. This means that a full correction cannot be made until the following year. This correction may in turn be offset to the extent that forecasts for later years indicate an opposite correction, and also to take account of any offset brought forward from the previous year.

2. The latest year for which final estimates of practice expenses based on Inland Revenue returns are available is 1994–95. In 1994–95 there was a net overpayment of £147. This brings the total sum outstanding, after the recovery of £485 in 1996–97, to £1,380. As explained in paragraph 6.52 we have decided to recommend a recovery of £615 in 1997–98, and this sum has been deducted from Intended Average Gross Remuneration for GMPs to derive the gross amount to be delivered through the fee scale. The following table shows the operation of the balancing mechanism since 1979–80.

	INTENDED			ACTUAL		
Year	Intended average net remuneration	Corrections for earlier periods etc.	Adjusted intended net remuneration	Net remuneration	Over (+)/ under (–) payment	Outstanding amount carried forward
	£	£	£	£	£	£
1979–80	12,327	—	12,327	11,902	– 425	—
1980–81	16,290	—	16,290	15,608	– 682	—
1981–82	17,970	+ 440	18,410	17,793	– 617	—
1982–83	18,990	+ 640	19,630	19,440	– 190	—
1983–84	20,288	+ 27	20,315	20,404	+ 89	—
1984–85	21,615	+ 617	22,232	22,687	+ 455	—
1985–86	23,212	+ 190	23,402	23,849	+ 447	—
1986–87	24,670	– 89	24,581	24,601	+ 20	+ 386
1987–88	26,840	– 455	26,385	26,508	+ 123	+ 406
1988–89	28,800	– 61	28,739	28,979	+ 240	—
1989–90	31,105	0	31,105	31,388	+ 283	– 250
1990–91	33,630	– 529	33,101	36,455	+1,254*	—
1991–92	37,512	– 490	37,022	37,972	+ 950	+ 757
1992–93	40,010	– 33	39,977	40,165	+ 188	+1,354
1993–94	40,610	– 497	40,113	40,506	+ 393	+1,325
1994–95	41,890	– 353	41,537	41,684	+ 147	+1,233
1995–96	43,165	– 217	42,948			
1996–97	44,483	– 485	43,998			

Note: Intended average net remuneration has been adjusted where appropriate to take account of delayed implementation of awards.
* After allowance for £2,100 waived by the Secretary of State.

Appendix D

REVIEW OF GMPs' OUT-OF-HOURS WORK: REPORT BY ERNST AND YOUNG

PART I: QUALITATIVE REPORT

EXECUTIVE SUMMARY

Ernst and Young were commissioned by the Office of Manpower Economics to assist in a broad ranging review of out-of-hours work. This report summarises the findings and conclusions of the qualitative research, to assess whether there has been a sea-change in the nature of out-of-hours work since pre the 1990 contract.

The main focus of the research involved face-to-face discussions with GMPs to ascertain their understanding of the main changes. In total, 24 interviews and seven workshops were conducted. Some of the basic principles underpinning job evaluation processes were adopted to assist with the assessment of the findings.

Four key characteristics of out-of-hours work, communication, knowledge, complexity and physical demands were considered and individually rated using one of three evaluations. A (+) denotes a perception that there has been a significant increase in demands, an (=) where demands were perceived to be similar and a (–) where there was a perceived decrease in demands.

The results of the research provide overwhelming evidence that overall both the responsibilities and nature of out-of-hours work have remained the same. Amongst the interview population at least 75 per cent of GMPs felt that demands were broadly the same for each of the four job characteristics. There was a more varied response within the workshops where the overall result was a fairly even split between a similar level and significantly increased. The nature of the workshop discussions often promoted and reinforced some of the more negative aspects of out-of-hours work than was observed within the interview environments. Much of the dissension associated with out-of-hours work was related to factors other than the responsibilities of the job.

In our view, the overall responsibilities delivered during out-of-hours have remained constant since pre 1990. The changes that were repeatedly mentioned, eg, more demanding patients, increased evidence of trivia calls, higher workload level and the shift of work from secondary to primary care, are reflective of general changes in the delivery of the responsibilities rather than a fundamental change in the nature of the responsibilities themselves.

In understanding the pressures associated with the delivery of out-of-hours work it is important to recognise some of the changes that have impacted on GMPs' ability to effectively deliver out-of-hours work. The main factors are the increase in daytime activity levels, a perception of an increased demand during the out-of-hours period, general changes within society and the arrangement(s) used to deliver the out-of-hours service. It became apparent that where these changes were observed there was a tendency to misinterpret the change as a shift in out-of-hours responsibilities.

The main conclusions are as follows:

- there has not been a change since 1990 in the fundamental nature and responsibilities of out-of-hours work;
- there has not been a sea change in the responsibilities of out-of-hours work, the research indicates that they are broadly similar, the changes that have occurred represent, in the main, an evolutionary change and are not inconsistent with changes evidenced in other service industries;
- there appears to have been an increase in daytime activities (attributed to the 1990 contract) such that 'slack' time that was previously available has

now disappeared and has resulted in the GMP being less able physically to deliver the out-of-hours work;

- there is some contradiction regarding workload during out-of-hours. The qualitative research provided a fairly consistent message that demand had increased yet the quantitative diary based survey does not support this. It should be noted that the quantitative survey focused on out-of-hours work delivered personally by the participating GMP and therefore workload covered by deputising services was excluded. Those GMPs who perceived that demand had increased tended to interpret it as an increase in responsibility rather than recognising that it represents a higher volume of broadly similar work;
- there has been a gradual shift to 24 hour availability of consumer services within society to such an extent that patient expectations have risen. This has led to mixed views amongst the GMP population as to whether 24 hour medical cover by the GMP ie, the traditional approach, is still realistic; and
- the arrangement(s) used by GMPs may have changed during the period under review eg. a shift to a co-operative arrangement. Typically, where the change has reduced the burden on a GMP, it represents the most significant change that has impacted on the perceptions of out-of-hours work. The research provided evidence positively supporting initiatives coming out of Development Fund expenditure.

SECTION 1— INTRODUCTION

1.1 The Doctors and Dentists Review Body (DDRB) sets a fee scale that should deliver an amount of Intended Average Gross Remuneration (Intended Average Net Remuneration plus average expenses) to General Medical Practitioners (GMPs). Part of the fee scale relates to the work completed during out-of-hours periods which is currently divided into an annual allowance of £2,078, a night consultation fee of £20.80 for visits between 10pm and 8am plus a percentage of the capitation fee.

1.2 The Review Body agreed, that in preparation for the 1997 pay round, a broad ranging appraisal of out-of-hours should be conducted. The results of the appraisal would enable the DDRB to assess the implications for GMPs' remuneration.

1.3 The Office of Manpower Economics (OME) commissioned Ernst and Young to assist in the research and evaluation of the out-of-hours broad ranging review. The terms of reference were as follows:

(i) to plan, design and conduct a diary based survey to determine information on current out-of-hours workload and how GMPs' organise the delivery of their out-of-hours responsibilities; and

(ii) to conduct a qualitative research exercise to assess the changes in workload and the nature of out-of-hours work since immediately prior to the 1990 contract.

1.4 This report summarises the findings and conclusions relating to (ii) above.

1.5 The report is divided into four sections encompassing methodology, findings, additional relevant comments and conclusions.

Context

1.6 In 1990, the then Minister for Health, Kenneth Clark issued a new contract for GMPs. Although the contract had been fully discussed with the BMA, the respective parties failed to reach agreement before the contract was imposed. The content of the new contract impinged upon the self-regulated nature of the medical profession and elements such as remuneration incentives

were questioned as they represent a shift, in balance, towards a managed profession.

1.7 Out-of-hours work was a point of dissension during the discussions as GMPs perceived that demand for their services during out-of-hours would increase due to the content of the new contract.

1.8 In 1994 GMP representatives floated the idea of splitting the GMPs' contract to separate the out-of-hours work and so reduce the overall burden upon individual GMPs. In response to this, the Government established the Development Fund (£45 million) to help GMPs adopt different arrangements for the delivery of the out-of-hours service. In Autumn 1995 the split contract was rejected at the LMC Conference.

1.9 Out-of-hours work is often perceived as a major 'downside' of GMPs' work. In an attempt to partially alleviate this burden, reforms have been introduced to increase flexibility such that the choice of how the service is delivered now rests with the individual GMP. The various ways in which out-of-hours can be delivered include a GMP performing their own, a practice developing a partners' on-call rota, a collaborative arrangement between a number of practices, participation in a co-operative and/or an out-sourced or deputising arrangement.

SECTION 2 — METHODOLOGY

Process

2.1 The focus of the qualitative research was to identify and assess change since pre the 1990 contract. To effectively measure change it is necessary to obtain a clear picture of the situation immediately prior to 1990 in terms of the level of demand during out-of-hours, the nature of the work completed and the processes used to deliver the workload. This information was not at hand in a readily available format.

2.2 It was agreed that the most appropriate process would be one that enabled GMPs who had been in practice for the period under review to describe their personal experience and observations.

2.3 After consultation with the OME it was decided that a series of interviews and workshops with GMPs would be appropriate to obtain the face-to-face contact required to elicit the personal experience data.

2.4 The interviews delivered a set of clear and unsolicited views from a number of GMPs. In total, 24 GMPs were interviewed on a one-to-one basis.

2.5 The workshops enabled face-to-face access to a larger number of GMPs than would have been possible if only the interviews had been conducted. The workshop discussions complemented the interviews to the extent that they enabled an assessment of consensus amongst the GMPs in attendance and benefited from the results of their joint discussions. Seven workshops were held with an average of eight attendees at each.

2.6 The diary based quantitative research was completed simultaneously and a section dedicated to qualitative questions on subjects such as complexity, workload and personal safety was designed and included in the process. The responses were based on the perceptions of the participating GMP and provided feedback on key aspects of out-of-hours work from a large population. The results were used to support the interview and workshop research and provide a barometer of general views. The questionnaire was mailed to 4,300 GMPs, of these, 1,626 responded.

2.7 The interviews and workshops were organised such that face-to-face contact was provided with a representative number of GMPs in terms of factors such as geography, practice location, practice size, sex and out-of-hours arrangement.

2.8 The OME provided Ernst & Young with a list of 75 GMPs within England and Wales and 25 GMPs within Scotland to use as a basis for selecting GMPs for interview. Some GMPs on the list were unable to participate, predominantly due to holiday commitment or pressure of work. We therefore progressed systematically through the lists encouraging participation until both the target number was achieved and a representative sample secured.

2.9 Each interview lasted approximately one hour and the workshops between two and three hours.

2.10 The project had to be completed during August and September 1996 and required therefore the workshops to be organised within a short timescale. To achieve this, the recommendations of the BMA to use the regional LMC network to co-ordinate the organisation of the workshops and to recruit participants was followed. This approach proved highly successful. The workshops comprised GMPs who use a range of out-of-hours arrangements and were representative, as far as possible, of the local area.

2.11 Seven workshops were conducted in the following locations:

Workshop	Location Date
Ipswich	28th August
Winchester	29th August
Cardiff	2nd September
Ayrshire	5th September
Warwick	9th September
London	11th September
Glasgow	17th September

2.12 The research concentrated on out-of-hours work specifically and for the purposes of the exercise, out-of-hours were defined as from 7pm to 8am weekdays and 1pm Saturday to 8am Monday. Although this did not match with out-of-hours periods in some areas (eg, Glasgow), the definition was consistent with previous research.

2.13 The interviews and workshops covered the same subject matter and a structured questionnaire (produced in consultation with the OME) was used to ensure both consistency in approach and comprehensive coverage of all areas. The main subject areas addressed were:

- out-of-hours arrangements;
- change in the nature of on-call out-of-hours work;
- administration workload (during out-of-hours); and
- financial aspects of using support services to deliver on-call services out-of-hours, and views on pricing.

2.14 In order to derive a realistic assessment of the extent to which there had been a sea-change in the demands and responsibilities of out-of-hours work, an analytical tool drawing on **job evaluation** principles was developed to assist with the process. Job evaluation identifies the content of a job and provides an assessment of JOB SIZE, based on the dominant responsibilities and on contextual factors such as professional, legal and financial accountability, which influence the level of expertise, knowledge, management skills and so on required to successfully undertake the job. This specifically excludes workload factors such as hours worked and inconvenience, and usually excludes duties which are ancillary to the primary purpose of the job and are less demanding in job size terms. The techniques involve assessing the demand of the job according to key factors. We concentrated on changes that had occurred within four key characteristics of the work: communication, knowledge, complexity and physical demands.

2.15 *Communication* relates to the importance of oral and written communication, and the quality demanded, in conducting out-of-hours work. In

investigating this element the focus was placed on the interaction with patients, liaison with other GMPs and staff and the impact of changes in telecommunications. The skill set required to communicate effectively was explored to ensure that the full range of requirements in this area was fully understood.

2.16 *Knowledge* focused on the level required in terms of both clinical and non-clinical knowledge. It is accepted that the knowledge base required by the individual GMP will be constantly changing due to the nature of progress in medicine – the discussions therefore concentrated on the rate of change as well as the type of knowledge required.

2.17 *Complexity* assessed the processes and procedures undertaken in the delivery of out-of-hours work. Discussions were structured around the specific steps followed for each task associated with out-of-hours work, the extent to which these had changed and the degree to which such procedures are precedented.

2.18 *Physical demands* examined the impact that out-of-hours work has on GMPs' personal well-being as well as out-of-hours work related aspects such as personal safety.

2.19 Each of the four characteristics were independently assessed in the context of what was heard at the interviews and workshops. The extent to which there had been a significant change since pre 1990 was considered and each characteristic was awarded one of three ratings dependent on the overall evaluation. For each job characteristic a (+) rating represents a significant increase in demands, a (=) rating represents a similar requirement in demands and a (–) rating represents a significant decrease in demands. It was possible during the interviews to complete the evaluation exercise with the GMP whereas the workshop environment did not easily lend itself to evaluation due to varying opinions amongst participants. The evaluations for the workshops were therefore completed subsequent to the event.

2.20 The combined results from the workshops and interviews were reviewed and considered and the main findings and conclusions are presented in Sections 3, 4 and 5 of this report.

SECTION 3 — FINDINGS — THE NATURE OF OUT-OF-HOURS WORK

Introduction

3.1 This section provides a summary of the findings based upon the four job characteristics, communication, knowledge, complexity and physical demands, which were identified as relevant in the overall assessment of whether a sea-change had occurred in out-of-hours work.

3.2 Our research revealed several factors which had affected out-of-hours work, but which did not influence Job Size. **Section 4** deals with these factors which are important to an understanding of GMPs' perceptions of out-of-hours work and their ability and willingness to undertake it.

Communication

3.3 The ability to communicate effectively is perceived to be a key requirement in the delivery of out-of-hours work. In many of the workshops and interviews it was this characteristic that attracted most discussion and focus. It is also one of the characteristics for which GMPs provided a fairly consistent message regarding the areas of change. The main comments can be categorised under three headings, namely, patient interaction, media impact and telecommunications.

3.4 **Patient Interaction.** GMPs reported that patients are more demanding generally in terms of the service they expect during the out-of-hours periods. Out-of-hours is no longer seen by some patients as an emergency service. Such

patients are a small minority but they are responsible for generating much of the demand and GMPs' views of out-of-hours work were heavily influenced by the characteristics of this group. Within this group there tended to be problem cases such as single parent families or drug users who sought social as well as clinical support. Many of their calls were trivial, if not inappropriate, but they were demanding; often with strong views on the service they expected. They therefore made great demands of the persuasive skills of GMPs and because they could be highly critical tended to call for extreme rigour in handling their cases to protect the GMP in the event of comeback. Aggressive behaviour by some patients was mentioned as an increasing problem. A separate feature of this group was a tendency to regard GMP services as available at will like other 24 hour services. This was identified with the impact of the Patients' Charter and with an attitude encouraged by the consumer society that patients' demands should be met at any time of day without query.

3.5 The proportion of trivia based calls during out-of-hours has increased significantly. Trivia calls range from minor clinical problems that could have waited until the morning surgery through to non-clinical issues that should not be within the remit and responsibility of the GMP. The management of such trivia calls can be demanding as the patient perceives it to be perfectly acceptable to make contact with the GMP, whereas the GMP may be irritated by such interruptions during the out-of-hours period. In many instances trivia calls can be managed with telephone advice instead of visiting the patient. The results of the quantitative survey indicate that 36 per cent of all telephone calls are not appropriate and 64 per cent of all calls are not an emergency.

3.6 GMPs acknowledged that they can refuse a visit but the predominant view was that requests for a visit are complied with. It is more appropriate to 'visit and educate' patients regarding the out-of-hours service, although there were mixed views as to whether education is realistically possible. Personal preference and beliefs of the GMP are important in determining how a GMP responds during the initial interaction with the patient.

3.7 The demands on a GMP in terms of communication skills will vary dependant upon the demographic make-up of the patient list. For example, on repeated occasions there were comments relating to the knowledgeable patients who request a full explanation of the nature of their illness and any implications. This factor can be seen as advantageous in that a knowledgeable patient can help the GMP operate more effectively. However, providing detailed explanations can significantly lengthen consultation time and requires the GMP to be able to articulate the nature of the illness and treatment in a reassuring and understandable way to the patient.

3.8 Comments were made relating to the fact that GMPs are being used to 'plug some of the gaps' generated by societal change. For example, it is not unusual for a GMP to be required to provide basic reassurance that would traditionally have been provided by the extended family. This requirement is particularly noticeable amongst young single mothers and the elderly. In some areas it is particularly noticeable that a concentration of calls are evidenced on a Saturday or Sunday afternoon when the family are visiting an elderly relative and want the GMP's opinion on an ailment during their visit. Again such behaviours reinforce the tendency for patients to call the GMP at their convenience rather than on an emergency basis.

3.9 There were relatively few comments relating to written communication requirements during out-of-hours. Most of the notes generated as part of out-of-hours work are handwritten with multiple copies being distributed to the relevant parties. However, GMPs are increasingly thorough with and give higher priority to case notes in case they need to defend their diagnoses and actions. The consequence is partly greater workload and partly a greater demand for relevant skills in writing reports that will stand up to formal investigation in pursuit of a patient's complaint.

3.10 **Media Impact.** Medical information is presented regularly by the media and is perceived to be an attractive subject area to increase readership or viewing numbers. Whilst such attention can be beneficial from an education perspective there have been a number of instances where the media have sensationalised a medical story and injected fear into the population. Most recent examples include scares associated with baby milk, meningitis and the contraceptive pill. Such situations impact on GMPs' out-of-hours work in that they are inundated with calls from worried patients. The GMP is required to provide reassurance and, if necessary, to provide correcting information to allay any fears. A further consequence of heightened media attention is its contribution to patient knowledge such that they ask for a more extensive explanation of their condition.

3.11 **Telecommunication.** There have been significant advances in telecommunications over recent years with the advent of mobile phones, pagers and fax machines. These advances are perceived to be both an advantage and disadvantage in terms of assistance to the GMP during the out-of-hours period. For example, the ability to use the mobile phone has made communication more convenient and enables the GMP to manage the demanding workload more easily. In some instances having a mobile phone has removed the need for the spouse to be on call at home when the GMP is on an out-of-hours visit. Some of the disadvantages include the perception that GMPs are constantly available and instantly accessible. The corresponding service levels that patients attach to such accessibility can also be a problem.

Conclusions

3.12 In analysing the overall response to communication as a characteristic of GMPs' out-of-hours responsibilities, the over-riding message was that communication had changed in nature since pre 1990, but on balance the changes had resulted in demands of a broadly similar level. In the interviews, 18 GMPs responded that demands were the same, whilst six felt there had been a significant increase in demands. The pattern within the workshops was consistent with the interview evaluations and four workshops reported demands of a similar level with three reporting that demands had significantly increased.

3.13 The responses to the survey questionnaire showed that 69 per cent of respondents perceived a greater proportion of out-of-hours calls requiring socially driven, non-clinical advice. More detailed analysis found that this perception is generally upheld by all GMPs, the only significant variance being a lower number of GMPs in rural (58 per cent) and inner city (59 per cent) locations felt that the proportion had increased.

Knowledge

3.14 To operate effectively as a GMP it is necessary constantly to update one's knowledge base and absorb new developments of both a clinical and non-clinical nature. It is difficult to differentiate the knowledge requirements for the daytime activities from the out-of-hours period. Indeed there was no evidence to suggest that the knowledge base required for the out-of-hours period was significantly different from that required during the daytime.

3.15 The advances that have taken place in drug treatments were highlighted as one of the knowledge areas that had most significantly changed. Changes are twofold and include an increase in a number of ailments that can be treated effectively with drugs as well as an increase in the range of drugs that are available to the GMP for use.

3.16 GMPs are generally more aware of their exposure to a patient complaint. This requires them to have an understanding of the legal implications of the care that they provide. Specific actions are taken during out-of-hours consultations to ensure that the GMP is appropriately protected should a patient submit a complaint. For example, when relevant, a GMP would now include 'negative' comments during a consultation on a child, such as, no evidence of meningitis.

3.17 Referral of patients to secondary care is increasingly a significant management task made more complex because of problems of supply which puts extra demand on GMPs to be able to use procedures and contacts to circumvent problems of placement.

3.18 The extent to which GMPs felt that the knowledge required during out-of-hours had changed since 1990 depended partly upon the personal philosophy of each individual GMP in terms of what he or she should be delivering as part of the service. For example, one GMP stated that the knowledge requirements are significantly lower than daytime requirements given that the out-of-hours service is predominantly a 'patch-up process' to enable the patient to receive a full consultation during the daytime surgery. At the other extreme, there were comments that the knowledge base required is equivalent to the daytime activities, as a full consultation would take place during the out-of-hours period and as such this reduces the daytime demand.

3.19 GMPs commented that they use the out-of-hours time to complete the reading needed to maintain their knowledge base. Prior to 1990 there was sufficient slack within the system to enable a GMP to complete some or all of the necessary reading within the daytime periods. Post the 1990 contract this slack time has been removed and daytime activities consume the full time allotted, such that reading associated with expanding the knowledge base is completed, for many GMPs, during the out-of-hours period.

Conclusions

3.20 In terms of analysis from the interviews, 20 GMPs felt that the changes that had occurred, although relevant, were not significantly different and classified the knowledge demands as somewhat similar to pre 1990. Four GMPs felt that the knowledge demands post 1990 have increased significantly and attributed this change to the requirement to absorb more information at an ever increasing rate. Within the workshops, four suggested that the knowledge demands had remained similar, whilst three indicated an increase in knowledge demands.

Complexity

3.21 In assessing the complexity of the out-of-hours demands, discussions were focused around the procedures and processes followed pre 1990 comparative with those of today. In the main, most GMPs confirmed that the process steps are broadly the same and that the range of ailments within society were of a similar nature. Repeatedly there were comments that the population are no more ill today than they were pre 1990. The quantitative research indicated that of those consultations that were given a classification, 89 per cent were categorised as straightforward.

3.22 However, there are three significant changes in the make up of the patient population that impact on what a GMP may be required to deal with during the out-of-hours period. These changes relate to early discharge from secondary care, nursing homes and drug addiction. The extent to which a GMP is exposed to any or all of the above is dependent on their patient list and to a wider number of patients when participating in a local arrangement or co-operative.

3.23 The impact of early discharge from secondary care was the area referred to most consistently by GMPs. The main issue in dealing with such patients is not so much the complexity involved in treating the individuals but the concern that they have been discharged ahead of time and are likely to have to be re-admitted to hospital in some instances. There is also a widespread feeling that GMPs have been 'dumped on' by the NHS and have to provide care that they were not previously accountable for. This additional care is provided for no additional fees.

3.24 Staff within nursing homes and elderly peoples' homes will call a GMP whenever one of the occupants has had a fall or appears to have a medical

problem. These calls are made irrespective of whether they are absolutely necessary. Such actions are taken by staff within the homes to protect themselves should a complaint be filed by the occupant or the occupant's family. Dealing with these calls is often not difficult for the GMP from a technical perspective, but is a source of concern during the out-of-hours period.

3.25 GMPs who are servicing high drug user areas reported that this population had had an impact on their out-of-hours work. The GMP is seen as a potential source of drugs, although most GMPs reported they had managed to implement procedures and processes that had educated the drug user population that this was not the case. Drug related issues were not widely reported and tend to be concentrated within inner city populations.

Conclusions

3.26 In completing the analysis, 20 of the GMPs interviewed felt that the complexity in terms of how out-of-hours work is delivered had not changed significantly since pre 1990. Four of those interviewed felt that the complexity had increased significantly. Within the workshop environment the majority of workshops suggested that the demands in terms of complexity were similar to those pre 1990—four were evaluated at this level. The conclusion for two of the workshops was that there had been an increase in demands relative to pre 1990. During one workshop there was insufficient discussion relating to this area to be able to complete an evaluation.

3.27 One of the questions in the quantitative survey asked GMPs to indicate whether the out-of-hours work had become more or less complex. The results represent an even split of opinion—51 per cent stated that complexity was the same or less, whilst the remaining 49 per cent reported that they perceived the out-of-hours work to be more complex. The survey found this result to be general across all types of doctor and practice.

Physical Demands

3.28 The physical demands of out-of-hours work were assessed from two perspectives, firstly personal safety of the GMP and secondly, the extent to which the work is physically demanding on the GMP. Interestingly, this job characteristic generated the widest divergence of views of the four characteristics discussed. This difference in view was not associated with significant change in the overall physical demands but is influenced most significantly by the arrangement used by the GMP to deliver the out-of-hours work. For example, those GMPs who have recently joined a co-operative or deputising arrangement reported significant enhancements in personal quality of life.

3.29 The personal safety of the GMP is an issue for most practices in the delivery of both daytime and out-of-hours service and care. Most practices have established some form of policy or procedure to assist and protect the GMP should an incident arise. There are very few actual cases of assault during the out-of-hours period, the emphasis was on the perception of increased danger. This issue appears to be of greater concern to female GMPs than male GMPs and it was commented by some female GMPs interviewed that they had chosen not to do out-of-hours cover because of personal safety issues.

3.30 The demands associated with the delivery of out-of-hours cover do not appear too demanding when the actual number of hours spent providing a consultation either by telephone or a visit are assessed. However, a consistent message was that the disruption caused through constant interruption and the pressure of a possible call causes the cover to be demanding. Should a GMP not receive a call during the out-of-hours period, the waiting and expectation of a call is highly disruptive to home life.

3.31 The over-riding view from both the workshops and interviews was that the demand during the out-of-hours period had increased such that the delivery of these services was more physically draining than previously. Given that the perceived increase in demand is attributed to trivia calls rather than serious

clinical cases then there was felt to be some correlation between the 1990 contract and the nature of the workload.

3.32 The overall picture relating to physical demands is not straightforward. Where GMPs have changed the method for delivering out-of-hours work, this has impacted on the physical demands placed on them personally. For example, those GMPs who are now part of a co-operative reported significant enhancements to their personal well-being as a result of the effective operation of the co-operative. In general they would work several sessions per month on behalf of the co-operative. Whilst these sessions are intensive and require constant work for anything up to six/seven hours, for most GMPs this is preferable than the option of covering their own out-of-hours through some other arrangement. Section 4 of the report explores fully both the workload demand issue and the change in arrangements for delivery of out-of-hours work.

Conclusions

3.33 The analysis of physical demands varied considerably dependant upon the personal situation of the GMP. Within the interviews the majority of GMPs (13) felt that the overall position in respect of physical demands was the same, seven felt that the physical demands had reduced, whilst four felt that they had increased. The analysis associated with the workshops show a different distribution. Within these, four of the workshops felt that the physical demands had increased significantly, two felt that they had stayed somewhat similar and one reported a reduction in physical demands since pre 1990.

3.34 Personal safety was felt to be the same or improved by 63 per cent of the survey respondents, only 37 per cent felt less safe. The statistics for female GMPs were not significantly different. However some differences were evidenced amongst the GMP population. For example, GMPs under 30 years of age feel less safe, 46 per cent reported that they felt relatively less safe now than pre 1990. GMPs in inner city areas feel significantly less safe (56 per cent) and those using deputising services also feel less safe (47 per cent) possibly contributing to their decision to use a deputising arrangement. However, of those based in a rural practice 78 per cent felt personal safety was the same or safer and those in urban/rural areas also feel more safe than the total population, with 68 per cent reporting that they perceived personal safety to be the same or safer.

3.35 Survey respondents were also asked to indicate the extent to which stress associated with out-of-hours work had changed. 71 per cent reported that the work was more stressful. The population as a whole provided a consistent response to this question although the corresponding figure for younger GMPs was 61 per cent and 66 per cent for GMPs who participate in a co-operative arrangement.

Summary

3.36 The following tables summarise the requirements during out-of-hours for each job characteristic and provide an evaluation of the situation pre and post 1990.

3.37 COMMUNICATION

Requirements in providing out-of-hours service:

- respond to patient calls providing advice and reassurance as necessary;
- to conduct face-to-face consultations with patients;
- respond to a range of clinical, social and psychological demands;
- to explain often complex medical details to patients;
- to make detailed notes of each interaction; seek new and innovative ways of improving the interaction with the patient;
- to educate patients in terms of proper use of the service.

Pre/Post 1990

Each of the above responsibilities have featured as part of the out-of-hours service pre and post 1990. The changes during this period relate to the nature of the interaction with the patient rather than a change in the fundamental responsibilities.

Overall, therefore, in terms of job size the communication demands are broadly similar.

3.38 KNOWLEDGE

Requirements in providing out-of-hours service:

- maintain clinical knowledge base on the full range of ailments a GMP may be required to deal with;
- ensure understanding of how associated services operate to enable a patient to be referred;
- understand legal implications of services provided and how to ensure personal protection.

Pre/Post 1990

The first two responsibilities above have been a constant feature of the out-of-hours service. The final responsibility has been somewhat heightened since the 1990 contract.

Given that the maintenance of the knowledge base dominates as the critical requirement under this job characteristic, the overall evaluation is that knowledge demands are somewhat similar to pre 1990.

3.39 COMPLEXITY

Requirements in providing out-of-hours service:

- to clarify through questioning the facts relating to the problem to make an evaluation;
- where necessary, to consult on a face-to-face basis, to conduct an examination and to provide advice/treatment;
- to make decisions based on available facts and information;
- to follow procedures and processes as determined by the practice and other relevant bodies eg, FHSA, BMA;
- to operate within the scope and boundaries for the GMP population, knowing when to refer;

- to ensure out-of-hours rotas are in place and when cover is to be provided personally.

Pre/Post 1990
Processes followed are almost exactly the same although the method used to deliver out-of-hours cover may have resulted in some of the procedures being streamlined.

The fundamental method of delivering the service remains the same today as in pre 1990 and would, in job sizing terms be deemed the same.

3.40 PHYSICAL DEMANDS

Requirements in providing out-of-hours service:

- to ensure sufficient precautions are in place to protect the GMP whilst travelling to a patient and during consultation;
- ensure that the GMP is physically able to deliver the service.

Pre/Post 1990
Whilst the responsibilities are relevant to both periods there is some evidence that personal safety has become a more significant element of the job. Also, where an increase in demand is evidenced this would represent an additional physical pressure on the GMP.

Drawing one conclusion on this job characteristic is difficult as it will depend upon the workload of the individual GMP and the method used to deliver out-of-hours work. Three scenarios exist:

(i) Significant increase in job size where:

— personal safety is a real risk;

— demand has increased significantly ie, 50 per cent plus, such that the delivery is physically more draining; and

— there has been no change in the method of delivering the service such that the burden on the GMP has not reduced.

(ii) Similar job size:

— safety issues and demand are broadly the same as pre 1990; and/or

— there has been a change in the method used to deliver out-of-hours service such that issues associated with safety and/or demand have been alleviated.

(iii) Reduced job size:

— a new method for the delivery of out-of-hours has been adopted such that safety and demand pressures have been positively impacted.

3.41 The above shows that although there have been changes to the four key characteristics of GMPs' out-of-hours work, these are not significant when assessing whether there has been a 'sea-change'. The only factor which shows any sign of a significant increase in job size is physical demands. Assessing the conclusions on this job characteristic is difficult as the assessment is dependent upon the workload of the individual GMP and the method used to deliver out-of-hours work. There has been an increase in job size where personal safety is a real risk, and where demand has increased significantly without a change in the method of delivering the service. The three other factors are more important in job-sizing terms. As these show no significant changes in job-sizing terms, the

overall conclusion is that there has been no 'sea-change' in GMPs' out-of-hours work since pre 1990.

SECTION 4 — FINDINGS — ADDITIONAL COMMENTS

Introduction

4.1 The objective of the qualitative research exercise was to assess the extent to which the work and responsibilities of GMPs during out-of-hours have changed since pre 1990. The previous section focused on the detail of work performed during out-of-hours and used a job sizing framework to perform an assessment. However, the report would be incomplete unless some of the key factors, other than job responsibilities, are considered. Indeed, the research indicates that factors other than the nature of out-of-hours work have had a greater impact on out-of-hours work and GMPs' attitudes.

4.2 For the purposes of this report five factors are of particular relevance to the exercise. These are:

- daytime workload;
- the volume of work during out-of-hours;
- GMPs' own perceptions;
- societal change; and
- the arrangements used to provide the out-of-hours cover.

4.3 **Daytime Workload**. GMPs' comments identified an important link between the demands of the day-time job, and perceptions and attitudes about out-of-hours on-call duties. There was a widely held view that increases in daytime activity (mainly but not entirely additional administration and management), which had taken up all the slack time, had adversely affected both the ability of GMPs physically to cope with on-call commitments and their attitudes towards this work. The current levels of remuneration were of particular concern to some as inadequate compensation for the disruption to their leisure and the physical demand of long hours; willingness of many to pay others to cover their on-call duties was another indication that GMPs are generally less willing to deliver personally on-call services. In the co-operative in Glasgow, which was widely welcomed by those participating (all but a small number of GMPs in the area) approaching half of the GMPs left their on-call work entirely to other GMPs.

4.4 **Volume of work during out-of-hours.** It was repeatedly mentioned that demand during out-of-hours had increased significantly since pre 1990. The perceived increase in demand was attributed partially to the Patients' Charter which has fuelled patients' expectations such that they believe a GMP should be available at their convenience 24 hours a day. Whilst some GMPs felt that they had been successful in educating their patients the majority felt that general education programmes were unsuccessful in controlling demand. The estimated increase in workload suggested by the GMPs was in the order of 30 per cent to 60 per cent. There was general consensus that the perceived increase could be attributed to non urgent, often trivia cases.

4.5 The quantitative survey results show that the average hours worked during the out-of-hours period for all GMPs is five and a half hours per week which represents just over 5 per cent of the total hours classified as out-of-hours. This figure increases to six and a half hours when GMPs who actually conducted some activity are considered as a distinct population. Both of these figures are lower than those reported in the 1992-93 survey. These results contrasted both with the views on the demands of out-of-hours work and the results from the interviews and workshops. GMPs' responses in the postal questionnaire indicated on the whole an increase in demand. The size of the majority who felt there was an increase comprised 58 per cent in respect of Weekday nights, 67 per cent in respect of Weekday evenings and 70 per cent in respect of Weekends.

4.6 The quantitative results contradict the findings of the qualitative research suggesting that reality differs from perception. However, interpretation of this element requires careful consideration as many factors could impact on the overall situation.

4.7 The differences may be explained by a number of factors. Firstly, the demand for out-of-hours consultations is partly met by deputising services, and in the case of some GMPs, by allowing other GMPs in co-operative arrangements to undertake most or all of the work. The diary results also indicate a shift in the balance between time-consuming visits, and other consultations, so that the effects of an increase in the number of consultations are more than offset by a reduction in the average time required for a consultation. A third and more complex factor is that the measurement of perceptions may reflect a tendency to show the strongest held views rather than a fully representative balance of views.

4.8 Of the total number of consultations that have been classified, 58 per cent of the total were categorised as non-emergency and 32 per cent of the total as inappropriate. The high proportion of trivial calls and the apparent generation of most calls by a difficult minority of patients, may be another factor affecting GMPs' views about the out-of-hours demand.

4.9 The increased use of deputising services and co-operatives may have resulted in some GMPs being personally on call for less time than previously. However, these GMPs may continue to complete as many consultations in total as previously, producing a perception that overall demand has increased.

4.10 The survey did not capture out-of-hours work completed by deputising services yet those GMPs who use such an arrangement will receive data on their practice demand levels. Comments relating to increased demand therefore may relate to the overall level not just the demand serviced by the individual GMP.

4.11 If the daytime activity level has increased, as suggested, GMPs are likely to be physically more tired and therefore delivering similar levels of out-of-hours work may feel more demanding.

4.12 Those GMPs who participate in a co-operative will tend to work sessions where there is a constant flow of patients and the comments relating to demand could be based on an extrapolation of their particular sessions.

4.13 The method of delivering out-of-hours cover is in transition. Over 80 per cent of those GMPs who have adopted either a co-operative or deputising arrangement quoted workload as the predominant reason. Given that some GMPs have only recently adopted new arrangements their most vivid perception of demand will be under the previous delivery arrangement when the demand may well have been increasing and had to be delivered, in part or whole, by themselves.

4.14 **GMPs' own perceptions.** In conducting the research it became clear that there is a wide divergence of views amongst the GMP population as to whether out-of-hours work should or should not be part of the contract and also the extent to which the commitment is demanding for each GMP. For example, a number of GMPs believe that the 'traditional approach' to GMP services is appropriate. The traditional viewpoint is that the out-of-hours service should be provided by the GMP's own practice and that such an approach ensures a quality service due to familiarity with the patients. The GMPs who hold this viewpoint expressed grave concerns regarding the overall general direction of the structuring of the out-of-hours service. The opposite view is that the traditional approach to providing out-of-hours cover is no longer appropriate given the expectations that a GMP will be constantly available. For the GMPs who are comfortable with this change, the option of covering some or all of the out-of-hours service, with either a deputising or co-operative arrangement, is fairly attractive. GMPs who participate in such arrangements, for example, the co-operative GEMS in Glasgow, feel that it provides a better quality of service for the patient, is efficient and has released GMPs from one of the most unattractive

elements of the job. There is not one factor that dictates which viewpoint an individual GMP will adopt. However, as a general trend, it appears that older GMPs have a natural preference for the more traditional approach to providing the out-of-hours service whilst younger GMPs are objecting to the commitment to out-of-hours work and have a preference for using alternative arrangements.

4.15 **Societal change.** There were, within the various workshops and interviews, GMPs who had been in service for much longer than the six year period under discussion. It became apparent that the role of the GMP in general and specifically in the delivery of the out-of-hours service, has been subject to change associated with societal shifts as well as specific incidents such as the 1990 contract. It was recognised that the 1990 contract represents only one event in a constantly changing process.

4.16 By far the most important general change in society has been the shift in many service industries to 24 hour availability. The services offered by the GMP have been swept along with such general changes and it is difficult for the patient to adopt a different set of principles when using the medical service than they would use, for example, whilst shopping or banking. The consequence of such change is that GMPs feel that there has been an increase in demand for their services during the out-of-hours period. A secondary reaction is that as patients expect the service to be available constantly there is little evidence of gratitude for consultations during out-of-hours or tolerance of the GMP should he/she question the motive for the call. This general shift within society has caused several concerns within the GMP population. For example, the psychological contract of providing 24 hour service was on the basis that out-of-hours work would be geared to emergency cases only. Given that this is not necessarily the situation today there is a tendency for GMPs to feel 'abused' given that they are expected to deliver a different definition of 24 hour care for no additional recognition or fees.

4.17 A further implication of the changes in society is the feeling that the GMP's total work burden has increased significantly. This comment relates to the daytime activity level combined with the out-of-hours responsibility and there is a perception that the total contribution is far greater than would be typically expected of a peer group in other industries. Interestingly, such comments are typical of management and professional groups across a wide range of sectors who would also comment that relative to previous years their workload demands are now such that they have to work considerably more hours to deliver their job effectively. The issue for the GMP is whether the demands are such that the commitment to provide 24 hour cover is unrealistic.

4.18 **Arrangements used to provide the out-of-hours cover**. Where GMPs have shifted the responsibility for out-of-hours work to a co-operative during the period under review, this has represented the most significant change in terms of the demands involved in delivering the out-of-hours work. Whilst co-operatives appear to have had the most significant impact, where there has been any change in arrangements such that the GMP's personal time commitment is reduced, these have been reported as positive.

4.19 There is evidence that the money allocated to the Development Fund for the purposes of establishing collective arrangements to deliver out-of-hour services has been successful and has acted as a catalyst to generate real alternatives for GMPs. Although some GMPs express concern about the quality of care provided by such arrangements, those who have joined co-operatives reported an enhanced service level.

4.20 Significant disparities between rural and non-rural areas are apparent. It is recognised that having the free choice to use alternative arrangements is not available to some GMPs and this disadvantages them relative to GMP colleagues who do have options. This is a potential issue in terms of developing all embracing comments relating to GMPs and is particularly pertinent in context of the pricing of out-of-hours.

SECTION 5 — CONCLUSIONS

5.1 The objective of the research based on an evaluation of both the qualitative and quantitative research was to assess the extent of change in out-of-hours work since before the new contract in 1990. There are eight main conclusions:

5.2 The objective of the exercise was to assess the changes in the responsibilities and nature of out-of-hours work since immediately prior to the 1990 contract. Whilst the 1990 contract has had an impact and contributed to some of the changes that have taken place, it is not the most significant factor.

5.3 There is evidence that the nature of out-of-hours work has been subject to some change in all aspects of the job we assessed i.e. communication, knowledge, complexity and physical demands. However, the overall evaluation is that there has not been a sea-change in terms of the level of responsibility associated with out-of-hours relative to responsibility levels pre 1990. The changes represent an evolutionary change in some of the aspects associated with the execution of those responsibilities, the demands are basically similar.

5.4 Where GMP populations have perceived there to be an increase in demand, it has been misinterpreted as an increase in job responsibility and a fundamental change in the nature of out-of-hours work. In reality, where a higher demand was perceived it represents a requirement for the GMP population to complete a higher volume of broadly similar work.

5.5 The daytime workload appears to have increased to an extent that GMPs are less willing or physically able to incorporate out-of-hours work into the service they provide. More work is displaced into the out-of-hours periods, increasing the demand on GMP time out-of-hours, while on-call duties are seen as more onerous given the increased demands on them for the daytime job.

5.6 GMPs perceive a change in attitude amongst some patients (who generate most calls) about out-of-hours care which is increasingly regarded as a 24 hour care service, rather than an emergency service. They also point to the high proportion of trivial and inappropriate calls, which make unnecessary demands on them. From this emerges an attitude that their professional services are misused, and that the rewards in the form of professional satisfaction they expect to gain from helping patients in need of clinical care during out-of-hours, is diminished both by patients' attitudes and the low-grade work they are called on to perform. This gives rise to questions about the role of on-call duties within the contract to provide 24-hour care.

5.7 The main changes identified were concerned with workload. Developments in the delivery of care by the primary, secondary and tertiary services had tended to increase out-of-hours work, partly by extending the range of circumstances in which GMPs would be called on to provide clinical care and partly because of increasing complexity in working with other services.

5.8 There was evidence that the use of co-operative arrangements had improved the workload for some GMPs. Co-operatives could bring major benefits in a number of ways. GMPs had greater scope and flexibility to manage the burden of out-of-hours responsibilities. There were also opportunities to organise the service to patients using lower qualified staff to reduce the burden of trivial or inappropriate calls. Deputising services could also be used more efficiently. By giving more control over the range and volume of consultations and the ability to have breaks from providing out-of-hours services, this could considerably improve GMPs' attitudes to the provision of out-of-hours care.

5.9 The Development Fund appeared to have an important pump-priming role in enabling new arrangements to emerge, although it was unclear from this limited research whether new arrangements would be financially attractive without the continued support. GMPs' views on the benefits of different arrangements for covering out-of-hours care varied widely, from those who felt that there was no substitute for their personal attention to the needs of their

patients, to those GMPs who appeared willing to pay considerable sums in order to have out-of-hours care provided entirely by other services.

PART II: QUANTITATIVE REPORT

SECTION 1— INTRODUCTION

1.1 This report contains the results of a postal questionnaire and diary survey of GMPs' out-of-hours work commissioned by the Office of Manpower Economics (OME) on behalf of the Doctors' and Dentists' Review Body.

1.2 The objective of the survey was to provide up-to-date information on the volume of out-of-hours work (which could be compared with the results of a survey carried out in 1992–93) and to provide information not previously collected on the nature and quality of this work.

1.3 The survey was designed to estimate the out-of-hours work carried out by GMPs, under the GMS contract, distinguishing between on-call duties and other work in the out-of-hours period. It did not cover services provided by deputising services and therefore the results under-represent the total demand from patients. The diary survey provided information on a seven-day period in September 1996.

Sample and Response

1.4 A statistically random sample of 4,300 GMPs, drawn by the NHS Executive, was obtained. A valid response was obtained from 1,442 GMPs (allowing for ineligible responses this represents a response of approximately 38 per cent). Diary information was obtained from a lower number of 1,154 GMPs. It was not possible, in the time available, for the survey to investigate whether the relatively low response would give rise to bias in the results, for example, GMPs with a lower than average workload may have been more likely to respond. However, we have no evidence to suggest the results are biased—a comparison of the general characteristics of GMPs who responded indicates that they are reasonably representative of all GMPs.

SECTION 2 — METHODOLOGY

2.1 The survey collected information on the characteristics of GMPs and their practices, together with information on their arrangements for dealing with out-of-hours work. A number of attitudinal questions were included to collect GMPs' views on changes in aspects of the work. The diary collected information on GMS activities during the out-of-hours period. The survey covered the period Thursday 5 September to Thursday 12 September 1996. For the purposes of this research, out-of-hours were defined as from 19.00 to 08.00 weekdays and from 13.00 Saturday to 08.00 the following Monday.

2.2 The survey had to be completed over a relatively short timescale in order to be incorporated effectively within the Review Body system. Advice was therefore sought from the BMA regarding factors such as the best day of the week to commence the diary exercise and the most appropriate week to use given time constraints. The survey commenced on a Thursday to avoid adding to GMPs' burden at the start of the week. Early September was chosen given that August is traditionally a month during which a significant proportion of people opt to take holiday and this would influence response rates.

2.3 The survey was sent to 4,300 GMPs which represents 14 per cent of the total GMP population. The sample was provided to Ernst and Young by the OME. The response rate was 38 per cent. This is somewhat disappointing given that a response rate greater than 40 per cent was hoped for.

2.4 Before completing any analysis the response rates were cross checked against the 12 stratification groups for GMPs provided by the OME. The spread

of responses by these groups was good. In addition the demographic profile of the respondent population was checked against the profile of the total GMP population, and it was agreed that the profiles were similar. Therefore, as the responses were deemed sufficiently representative this enabled the analysis to proceed.

The strata descriptions were as follows:–

Strata Number	Description
1	Dispensing doctors, with dispensing list size 0–799
2	Dispensing doctors, with dispensing list size 800–1399
3	Dispensing doctors, with dispensing list size 1400 and over
4	Non-dispensing doctors, without help, list size 0–1499
5	Non-dispensing doctors, without help, list size 1500–1749
6	Non-dispensing doctors, without help, list size 1750–1999
7	Non-dispensing doctors, without help, list size 2000–2249
8	Non-dispensing doctors, without help, list size 2250 and over
9	Non-dispensing doctors, with help, list size 0–1749
10	Non-dispensing doctors, with help, list size 1750–1999
11	Non-dispensing doctors, with help, list size 2000–2249
12	Non-dispensing doctors, with help, list size 2250 and over

Questionnaire Design and Administration

2.5 A key aim in designing the questionnaire was to simplify some aspects to enhance user friendliness. The main changes (compared with the survey carried out in 1992-93) were as follows:

- the layout was redrafted to remove the requirement to read horizontal and vertical information on one page;
- the information was presented such that the form appeared less cluttered;
- those elements that were requested previously but were deemed unhelpful or inconclusive in the final analysis because the information was not valid were removed;
- a set of pre-dated sheets were provided to eliminate the need for the GMPs to complete date and day details; and
- five blank diary sheets were provided as spares in case of error or to be used as continuation sheets.

2.6 The final questionnaire had significantly more questions relating to out-of-hours than previous surveys. This was partly due to the focus of this study but also because of the changes that have occurred regarding arrangements used to deliver out-of-hours work such that additional 'new' information is now required.

2.7 The draft questionnaire was piloted with five GMPs, selected by the OME, to obtain feedback on the clarity and practicality of completing the exercise. All five GMPs participated and provided useful feedback that enabled the questionnaire design to be enhanced.

2.8 Achieving an acceptable response rate was regarded as difficult given that the survey had to be completed over a short time period and based on the response levels observed from previous workload surveys. The following initiatives were followed in an attempt to maximise response rates:

- inclusion of a business reply envelope with the questionnaire;
- a telephone exercise prior to the start of the survey week to ascertain whether the GMPs had received the questionnaire, to answer any immediate queries and to encourage interest;

- provision of a helpline service from 07.00 to 22.00 on Thursday 5 to Friday 20 September; and
- a guarantee that all responses would be handled confidentially.

2.9 It was anticipated that GMPs would return the questionnaire by Friday 20 September 1996 and the database was to be closed at this stage. However, questionnaires were arriving in reasonable numbers subsequent to this date and it was therefore agreed to close the database on 27 September 1996, the latest possible date to enable the analysis to be completed for the DDRB.

Data Validation/Analysis

2.10 All data was input to a statistics software database (SPSS). To maximise the accuracy during the data input process an extensive list of 'logic checks' were incorporated, (for example, ensuring that mutually exclusive responses had only one answer). After the data had been processed a series of data validation tests were run (for example, identification of any GMPs who had been on-call personally for more than 72 hours continuously). Any apparent irregularities were investigated and, if necessary, clarified with the relevant GMPs by telephone. The data was checked to ensure that only activities during the specific out-of-hours periods being surveyed were incorporated into the analysis. Data items that could not be 'cleaned' using this process were excluded for reporting purposes.

2.11 Although the sample was found to be broadly representative it was decided to re-weight the responses by strata to conform to the national distribution—this included allowing for the percentage of GMPs on annual leave during the survey week. The telephone exercise (paragraph 2.8) showed that approximately 5 per cent of GMPs were on annual leave during the survey week. The data were grossed up to the national total for GMPs in each strata in order to provide national estimates in terms of numbers of GMPs as well as their distribution.

SECTION 3 — MAIN RESULTS OF GMPs' OUT-OF-HOURS DIARY SURVEY CARRIED OUT IN SEPTEMBER 1996

Characteristics of sample results compared with population estimates

Table 1 : Sex of GMP (unrestricted principals)

	Sample results*		Population estimates (1994)	
Sex	Number of GMPs	Percentage	Number of GMPs	Percentage
Male	23,079	73.8	22,940	72.2
Female	8,143	26.0	8,830	27.8
Unknown	70	0.2	—	—
Total	31,293	100.0	31,770	100.0

* The sample was drawn from the GMP population as at October 1994.

Table 2 : Age of GMP

	Sample results		Population estimates (1994)	
Age	Number of GMPs	Percentage	Number of GMPs	Percentage
39 and under	11,910	38.1	12,140	38.2
40–49	12,060	38.5	10,900	34.3
50–59	6,039	19.3	6,800	21.4
60–69	1,049	3.4	1,910	6.0
70 and over	0	0.0	0	0
Not known	235	0.8	—	—
Total	31,293	100.0	31,770	100.0

Table 3 : Number of GMPs by contractual commitment

	Sample results		Population estimates (1994)	
Contractual commitment	Number of GMPs	Percentage	Number of GMPs	Percentage
Full time	28,077	89.7	28,240	88.9
¾ time	1,580	5.1	1,700	5.4
½ time	1,039	3.3	1,130	3.6
Job share	458	1.5	690	2.2
Not known	138	0.4	—	—
Total	31,293	100.0	31,770	100.0

Key points

- The respondents to the survey are representative of the GMP population of unrestricted principals at the time the sample was drawn in terms of age, sex and contractual commitments.
- The sample slightly over-represents males and under-represents females but the differences between the sample and GMP population are small in percentage terms.
- The sample slightly over-represents the percentage of GMPs aged between 40 and 49, and slightly under-represents those aged between 50 and 59 but again the differences are small.
- In terms of contractual commitments, the survey respondents and population estimates are very similar.

Table 4 : Location of GMPs' practice (sample results only)

Location of practice*	Number of GMPs	Percentage
Rural	3,822	12.2
Mixed urban/rural	10,674	34.1
Suburban	5,419	17.3
Urban	8,133	26.0
Inner city	3,066	9.8
Not known	179	0.6
Total	31,293	100.0

* As assessed by respondents.

Table 5a : Frequency of on-call sessions typically worked by GMPs during out-of-hours

Frequency of sessions	Number of GMPs	Percentage
Never	1,492	4.8
Less than once a month	504	1.6
Once a month	1,199	3.8
Once every 3 weeks	725	2.3
Once every 2 weeks	4,023	12.9
Once a week	11,064	35.4
2 to 3 times a week	7,051	22.5
4 to 5 times a week	1,289	4.1
6 to 7 times a week	700	2.2
Other	2,552	8.2
Not known	693	2.2
Total	31,293	100.0

Table 5b : Number of hours typically spent on-call per week

Out-of-hours arrangement (for GMPs exclusively using one arrangement)	Number of GMPs	Number of hours per GMP		
		Mean	Median	Interquartile range
Own	3,402	26.8	24.0	12.0 to 37.5
Local arrangement	1,657	18.9	15.0	7.0 to 32.5
Co-operative	6,595	5.5	5.0	2.0 to 7.0

Key points

- There are wide variations in the number of hours GMPs typically spend on-call in a week: 5 per cent of GMPs are never personally on-call during the out-of-hours period; just over 5 per cent typically work once a month or less; over a third are typically on-call once a week and 6 per cent are typically on call at least 4 times a week
- The number of hours spent on-call varies significantly according to the arrangement used. A GMP conducting his/her own out-of-hours work as part of a practice rota (every day if a single-handed practice) can typically expect to be on-call for about 25 hours per week, while a GMP solely using a co-operative can typically expect to spend 5 hours on-call per week.

Table 6 : GMPs' out-of-hours arrangements - Number of GMPs using arrangement to some extent

Type of out-of-hours arrangement	Number of GMPs using arrangement (for at least some of the out-of-hours period)	Percentage of all GMPs*
Own	17,252	57.0
Local arrangement	5,217	17.2
Co-operative	15,490	51.2
Deputising service	9,050	29.9

* The number of GMPs responding to this question was 30,245 (out of a total of 31,293). The figures will sum to more than 100 per cent as some GMPs use more than one arrangement to cover their out-of-hours work.

Key points

- GMPs typically use more than one arrangement for covering the out-of-hours period.

- Over half of all GMPs use a co-operative at least part of the time, and 30 per cent use a deputising service at least part of the time.

Table 7 : Alternative methods available for GMPs conducting at least some of their own out-of-hours work (by practice location)

Practice Location	Number of GMPs with alternative methods	Per cent	Number of GMPs without alternative methods	Per cent
Rural	778	31.3	1,704	68.7
Mixed rural/urban	2,996	52.9	2,667	47.1
Suburban	1,937	59.3	1,331	40.7
Urban	2,937	63.0	1,722	37.0
Inner city	1,045	61.6	652	38.4
Total	9,693	54.5	8,076	45.4

Note: The above table analyses those GMPs who responded to questions concerning (i) practice location and (ii) for those GMPs covering, at least some, of their own out-of-hours work; whether there were any alternative methods a GMP could choose to use.

Key points

- In rural areas, a lower proportion of GMPs who are conducting their own out-of-hours have access to alternative methods.
- Overall, just over half of GMPs who are covering at least part of their on-call work have access to alternative methods.

Table 8 : Number of hours worked per week per GMP during out-of-hours period

Type of activity	All GMPs	
	Number of hours (mean)	Per cent of out-of-hours time*
Patient contact	2.14	1.98
Admin (patient)	1.00	0.93
Sub-total	**3.14**	**2.91**
Admin/management (practice)	1.23	1.14
Other GMS	1.15	1.06
All activities	**5.52**	**5.11**

* Out-of-hours has been defined as being 19.00 to 08.00 weekdays and from 13.00 on Saturday to 08.00 the following Monday.

Key points

- During the survey week, 84 per cent of GMPs performed some GMS work between 7 pm to 8 am on weekdays and 1 pm on Saturday to 8 am the following Monday morning.
- Across all GMPs (including those on annual leave), the time spent working during out-of-hours was 5½ hours per week, of which just over 3 hours was related to patient contact (either direct contact or subsequent administration).
- Further analyses show GMPs working in suburban areas work longer hours than those in other areas (Note: The above table excludes time spent working for deputising services).

Table 9a : GMPs who now use a co-operative; reasons for joining

Reason	Percentage of GMPs
Workload	85.3
Personal reasons	49.2
Cost effectiveness	29.9
Better service for patients	37.8
Already in existence when joined practice	3.7

Table 9b : GMPs who now use a deputising service; reasons for doing so

Reason	Percentage of GMPs
Workload	85.4
Personal reasons	51.9
Cost effectiveness	14.5
Better service for patients	12.9
Already in existence when joined practice	32.3

Table 9c : GMPs who perform their own out-of-hours work; reasons for doing so

Reason	Percentage of GMPs
Workload not sufficient to warrant alternative arrangements	13.1
Alternative arrangements would be too costly	56.6
Concern over quality of alternative arrangements	43.2
Do not want to disrupt close relationship with patients	34.6
Not yet considered alternatives	5.9
Prefer to provide own service	38.1
No agreement among partnership	12.0

Key points

- Over 95 per cent of those GMPs now using a co-operative and over 85 per cent of those GMPs using a deputising service thought the move from providing their own out-of-hours cover had been positive.
- Over 85 per cent of those GMPs using a co-operative thought the service provided offered value for money. The corresponding figure for those using deputising services was almost 75 per cent.
- 85 per cent of GMPs using a co-operative or deputising service say one of their reasons for joining was workload.
- Of those GMPs performing their own out-of-hours cover, 57 per cent say that alternative arrangements would be too costly.

Table 10 : Distribution of hours worked per week during out-of-hours period

Number of hours worked per week	All GMS activity		Patient contact and related administration		Patient contact only	
	Number of GMPs	Per cent of GMPs	Number of GMPs	Per cent of GMPs	Number of GMPs	Per cent of GMPs
0	5,006	16.00	6,325	20.21	8,652	27.65
greater than 0, up to 2	6,129	19.59	9,029	28.85	11,064	35.36
greater than 2, up to 4	5,217	16.67	6,864	21.93	5,981	19.11
greater than 4, up to 6	3,874	12.38	4,194	13.40	2,876	9.19
greater than 6, up to 8	3,625	11.58	1,975	6.31	1,497	4.78
greater than 8, up to 10	2,289	7.31	1,397	4.46	567	1.81
greater than 10, up to 15	2,782	8.89	1,023	3.27	512	1.64
greater than 15, up to 20	1,582	5.06	402	1.28	89	0.28
20 or more	789	2.52	84	0.27	55	0.18
Total	31,293	100	31,293	100	31,293	100

Key point

- During the survey week, there was a wide variation in the number of hours worked in the on-call period. This variation is, in part, influenced by the rotas for working for co-operatives and a lower degree of variation would be expected when looking across the year as a whole.

Table 11 : Number of patient consultations per week during out-of-hours

Type of consultation	Total number of consultations in week	Percentage of consultations	Mean number of consultations per GMP per week
Phone call	133,386	48.3	4.3
Visit	77,793	28.2	2.5
Surgery/premises	50,275	18.2	1.6
Clinic	6,085	2.2	0.2
Not known	8,611	3.1	0.3
Total	276,150	100	8.8

Key point

- Across all GMPs (including those on annual leave during the survey week), there was an average of 8.8 consultations with patients per week. Almost half of these were phone calls.

Table 12 : Nature of patient consultations per week during out-of-hours

Type of consultation	Number of consultations	Nature of patient contact								
		Emergency			Appropriate			Straightforward		
		Yes	No	Not known	Yes	No	Not known	Yes	No	Not known
Phone call	133,386	41,242	72,359	19,786	74,247	41,582	17,557	102,198	10,944	20,244
Visit	77,793	37,538	34,855	5,401	54,108	19,835	3,850	62,652	10,557	4,585
Surgery/premises	50,275	18,192	28,732	3,351	32,692	14,787	2,796	43,652	3,728	2,894
Clinic	6,085	3,289	1,358	1,438	4,158	887	1,041	4,375	611	1,100
Not known	8,611	1,157	2,044	5,409	2,446	1,340	4,824	2,992	268	5,350
Total	276,150	101,418	139,348	35,384	167,651	78,431	30,068	215,869	26,108	34,172

Key point

- The above table shows that almost 90 per cent of consultations during out-of-hours are regarded by GMPs as being straightforward (excluding the not known category). In almost 70 per cent of cases the GMP thought the consultation was appropriate. Only just over 40 per cent of contacts with patients during out-of-hours were classified as emergencies.

Table 13 : Nature of patient consultations

Percentage of all patient contacts which resulted in the following actions:

Clinical advice	Social advice	Examination	Treatment	Prescription	Referral
69.5	8.1	48.8	23.7	27.4	10.9

Patients condition : Reason for consulting a GMP (percentage of all patient contacts)

Physical	Psychological	Social
90.4	11.2	8.6

Note: The above two tables do not sum to 100 per cent as patients may have more than one reason for contacting a GMP and the treatment may require more than one action.

Key points

- Of all patient contacts, 70 per cent required clinical advice and almost 50 per cent an examination.
- GMPs administered treatment in almost a quarter of all patient contacts.
- Just over a quarter of all patient contacts necessitated a prescription and just over 10 per cent of patients were referred to another medical institution or medical profession.
- Of all patient contacts, 90 per cent involved an ailment of a physical nature. Almost 10 per cent of all contacts had no apparent medical reason (classified as social in the above table).

Table 14 : Duration of patient consultations during out-of-hours

Type of consultation	Number of GMPs carrying out activity	Average time of consultation (minutes)
Phone call	18,893	5.43
Visit (including travel time)	17,910	31.37
Surgery/premises	8,630	10.95
Clinic	1,101	14.05

Key point

- The results show that a visit takes almost 6 times longer than a telephone call, 3 times longer than a consultation performed at a surgery and twice as long as a consultation carried out during a clinic.

Table 15 : Out-of-hours patient consultations by time of consultation (000's)

(The following percentages are based on those observations where the start time and nature of the consultation are both known)

	Start time of patients consultation- Number and percentage of patient contacts (000's)									
Type of event	1900–2200	%	2200–0800	%	0800–1300	%	1300–1900	%	Not known	Total
Phone call	49,439	37	42,828	32	14,904	11	26,196	20	20	133,386
Visit	28,006	36	25,804	33	8,119	10	15,836	20	28	77,793
Surgery/premises	17,613	35	11,040	22	8,223	16	13,399	27	—	50,275
Clinic	2,579	42	1,471	24	583	10	1,452	24	—	6,085
Not known	2,216	—	3,391	—	585	—	852	—	1,566	8,610
Total	99,853	36	84,534	31	32,415	12	57,735	21	1,614	276,150

Key points

- During the survey week, almost one-third of all out-of-hours consultations took place between 8 am and 7 pm (these were at the weekend), almost 40 per cent occurred between 7 pm and 10 pm with the remaining 30 per cent between 10 pm and 8 am.
- In addition to the above table, analysis of the data shows that about half of all patient contacts took place during the weekend.

Table 16 : Net income* of providing cover for out-of-hours periods for those GMPs exclusively using one arrangement

Type of arrangement	Number of GMPs	Net Income(+ve)/Cost*(-ve) (£) Mean	Median	Interquartile range
Own	3,914	3,876	2,132	1,000 to 4,558
Local arrangement	1,785	2,826	2,000	1,080 to 3,845
Co-operative	6,808	-637	-241	-2,000 to 1,400
Deputising service	1,173	-7,475	-5,969	-10,000 to -3,720

* Net income/cost has been defined as fee income from the NHS (relating to night consultations with patients) plus income from work in a co-operative/local arrangement less payments made to co-operatives/deputising services/local arrangements. It therefore excludes the annual allowance of £2,078 for out-of-hours work and any subsidy from the development fund.

Key point

- The table shows that there is a wide variation in the costs of providing out-of-hours care to patients. Although the type of arrangement used by a GMP for providing out-of-hours care affects the cost, there is also a wide variation caused by factors such as the list size of patients and the frequency an individual GMP works.

Comparison with 1992–93 survey

The following points provide a comparison with the previous workload survey carried out in 1992–93. However, before making comparisons the following should be noted. Both surveys excluded work covered by deputising services so the conclusions relate to GMS work only. The extent to which deputising services are used will have changed between 1992–93 and September 1996. The results shown from the 1996 survey have not been adjusted for seasonality—analyses of previous workload surveys carried out in 1989–90 and 1992–93 show that although there are significant seasonal factors affecting GMPs' workloads, September is not considerably different from the average across the year.

- The average number of hours worked during out-of-hours has decreased since 1992–93, falling from 6.93 hours to 5.52 hours per week.
- The total number of patient contacts in September 1996 (an average of 8.8 per GMP per week) was similar to the number made during 1992–93 (an average of 8.9).
- GMPs are now receiving more telephone calls during out-of-hours than they did during 1992–93 (an average of 4.3 per week compared with 3.2 per week in 1992–93).
- The total number of patients seen during out-of-hours (either through home visits or consultations at a surgery/clinic) has reduced since 1992–93 (from 5.7 per GMP per week to 4.3). The number of visits has dropped from an average of 4.4 per GMP per week to 2.5. Note: this does not necessarily imply that the number of visits made between 10 pm and 8 am has decreased because of a change in the use of deputising services and a possible change in the times at which GMPs carry out their visits.

Appendix E

Previous reports by the Review Body on Doctors' and Dentists' Remuneration

1971	Cmnd. 4825, December 1971
1972	Cmnd. 5010, June 1972
Third Report (1973)	Cmnd. 5353, July 1973
Supplement to Third Report (1973)	Cmnd. 5377, July 1973
Second Supplement to Third Report (1973)	Cmnd. 5517, December 1973
Fourth Report (1974)	Cmnd. 5644, June 1974
Supplement to Fourth Report (1974)	Cmnd. 5849, December 1974
Fifth Report (1975)	Cmnd. 6032, April 1975
Supplement to Fifth Report (1975)	Cmnd. 6243, September 1975
Second Supplement to Fifth Report (1975)	Cmnd. 6306, January 1976
Third Supplement to Fifth Report (1975)	Cmnd. 6406, February 1976
Sixth Report (1976)	Cmnd. 6473, May 1976
Seventh Report (1977)	Cmnd. 6800, May 1977
Eighth Report (1978)	Cmnd. 7176, May 1978
Ninth Report (1979)	Cmnd. 7574, June 1979
Supplement to Ninth Report (1979)	Cmnd. 7723, October 1979
Second Supplement to Ninth Report (1979)	Cmnd. 7790, December 1979
Tenth Report (1980)	Cmnd. 7903, May 1980
Eleventh Report (1981)	Cmnd. 8239, May 1981
Twelfth Report (1982)...	Cmnd. 8550, May 1982
Thirteenth Report (1983)	Cmnd. 8878, May 1983
Fourteenth Report (1984)	Cmnd. 9256, June 1984
Fifteenth Report (1985)	Cmnd. 9527, June 1985
Sixteenth Report (1986)	Cmnd. 9788, May 1986
Seventeenth Report (1987)	Cm 127, April 1987
Supplement to Seventeenth Report (1987)	Cm 309, February 1988
Eighteenth Report (1988)	Cm 358, April 1988
Nineteenth Report (1989)	Cm 580, February 1989
Twentieth Report (1990)	Cm 937, February 1990
Twenty-First Report (1991)	Cm 1412, January 1991
Supplement to Twenty-First Report (1991)	Cm 1632, September 1991
Second Supplement to Twenty-First Report (1991) ...	Cm 1759, December 1991
Twenty-Second Report (1992)	Cm 1813, February 1992
Twenty-Third Report (1994)	Cm 2460, February 1994
Twenty-Fourth Report (1995)	Cm 2760, February 1995
Supplement to Twenty-Fourth Report (1995)	Cm 2831, April 1995
Twenty-Fifth Report (1996)	Cm 3090, February 1996

Printed in the UK for the Stationery Office Limited on behalf of the
Controller of Her Majesty's Stationery Office
Dd 5065623 2/97 48003 3401/9 Ord. 365269

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