Twenty-fourth report 1995 / Review Body on Doctors' and Dentists' Remuneration ; Chairman, C.B. Gough ; presented to Parliament by the Prime Minister by Command of Her Majesty, February 1995.

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TWENTY-FOURTH REPORT 1995

Chairman: C B Gough, Esq

Cm 2760 HMSO £8.10 net

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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 :

C B Gough, Esq *(Chairman)*
Douglas T Boyd, Esq
Ms Tina Boyden
Ms Sally Field
Dennis Fredjohn, Esq MBE
Dr Elizabeth Nelson
David Penton, Esq
Professor G F Thomason, CBE[2]

The Secretariat is provided by the Office of Manpower Economics.

[1]Mr Penton was appointed to the Review Body by the Prime Minister from May 1994.
[2]Also a member of the Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine.

Contents

Chapter 1

Economic and General Considerations

The 1994–95 settlement

1. The Government decided to implement the recommendations in our Twenty-Third Report in full on the due date of 1 April 1994. These recommendations provided for increases in remuneration approximating to 3 per cent for all members of our remit groups, excluding general dental practitioners (GDPs). For the latter group, we recommended an increase of 3 per cent in gross fees.

Conduct of the 1995–96 Review

2. We have received written and oral evidence for this review from the British Medical Association (BMA); the British Dental Association (BDA); the General Dental Practitioners Association (GDPA); the Health Departments, whose representatives were led by the Minister for Health; the NHS Trust Federation; the National Association of Health Authorities and Trusts (NAHAT); and the Central Advisory Committee on Distinction and Meritorious Service Awards. We also received written evidence from the Hospital Consultants and Specialists Association; the Association of GPs in Urban Deprived Areas; the Medical Protection Society; the Federation of Medical Services; the Chartered Institute of Public Finance and Accounting; the Association of Healthcare Human Resource Management; and the Senior Medical Staff Committee of the Western Isles Hospital.

3. As part of our preparation for the review we continued our programme of visits to NHS Trust hospitals, Health Authorities, Family Health Services Authorities (FHSAs) and general medical and dental practices throughout the country. This year we also held, for the first time, 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.

Economic evidence from the Government

4. On 14 September 1994, the Government published its economic evidence to the Pay Review Bodies for their current reviews. In a statement to accompany the evidence, the Chancellor of the Exchequer said that a realistic approach to pay was a key element in achieving firm control of public spending in order to reduce public borrowing. That, he said, was essential to achieving sustained economic growth with low inflation, leading to improved living standards and more jobs. He referred to the Government's intention that pay should be set at levels to recruit, retain and motivate staff in the public sector within available cash levels. It would be up to employers and employees to negotiate settlements to reflect local circumstances and performance. The Chancellor commented that, as for 1994–95, there would be no set limit laid down centrally and no need to abandon agreed procedures for pay bargaining and pay setting.

5. The Government's evidence drew our attention to the low levels of inflation currently prevailing and forecast for the end of 1994 and 1995. It further commented on the level of recent pay settlements, which were described as low by historical standards. Referring to the Government's approach for 1995, the evidence

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emphasised that a tight regime on pay would continue to play an important part in overall expenditure control. In the current public expenditure survey, the running costs of central government departments and the provision for the rest of the public sector would be set on the basis that pay and price increases should be offset, or more than offset, by efficiencies and other economies. It was pointed out to us that the approach to public sector pay allowed the flexibility to apply different arrangements to different groups, so that each could be addressed on its own merits and circumstances, and pay could be linked to the needs of staff recruitment, retention and motivation without assuming any automatic entitlement or comparability. The evidence emphasised that it was essential that decisions on pay settlements took full account of affordability considerations in respect of the resources available. There would be no access to the Reserve to fund settlements in the coming year.

6. The Government told us that it was important that settlements arising from recommendations from the Pay Review Bodies should be reconcilable with developments in the public sector generally. It expressed concern that cumulatively over the years Review Body settlements had more than matched most other public sector groups. It said that our recommendations for the coming year should be framed to reflect its approach to public sector pay, taking account of the circumstances of our particular remit groups, the need for settlements to be affordable within the available provision and the need within that framework to promote the development of pay flexibility. Higher pay costs could lead to reductions in service levels or reductions in employment if they could not be covered within provision by the necessary efficiency savings and other economies.

Affordability

7. On 29 November 1994, the Departments submitted to us supplementary evidence on the Government's plans for NHS expenditure in 1995–96. The key points were: an increase in total NHS funding of £1.3 billion over this year's spending or 1 per cent in real terms; a real terms increase for the Hospital and Community Health Services (HCHS) current expenditure of 1.3 per cent; a further 3 per cent or £600 million for HCHS services from efficiency savings; and a real terms increase for the family health services of 2.5 per cent over the original plans for 1994–95.

8. Commenting on the implications for NHS pay, the Departments said that HCHS purchasers would be required to secure at least 3 per cent in efficiency savings, including savings resulting from streamlining NHS management, to be deployed for patient care. We were told that, provided pay rises (taking into account both locally agreed increases and any national increase) were earned by increases in efficiency, the funding settlement for the HCHS would secure an increase in activity of around 4 per cent. An increase in activity of that order was essential if the NHS was to achieve the new Patient's Charter standards as well as meeting other pressures. The Departments said that NHS purchasers would receive further guidance on the implications of the efficiency target, which would emphasise that the funding secured through the public expenditure survey allowed for reasonable pay increases covered by efficiency gains.

9. We were told that local pay flexibility did not extend to the contractor professions, but that we should assume, in determining remuneration centrally for these groups, that efficiency in the General Medical Services (GMS) should rise broadly in line with the efficiency target set for the HCHS. The Departments observed that general dental practitioners already had a system which related their income directly to the amount of work they undertook, and options for changes to the remuneration of GDPs allowed for local contracts for the efficient provision of a specifically targeted local service. These options were set out in the Green Paper 'Improving NHS Dentistry' (see Chapter 7).

10. The BMA commented that the substantial improvements in efficiency and productivity in the National Health Service in recent years could not have been made without the active co-operation and support of doctors and other health service workers. It said that, with a cash increase of 4.5 per cent and the expectation of productivity improvements on top of that, the service would be well able to support fully funded reasonable improvements in pay. It observed that increased

activity was not possible without an additional contribution from the NHS workforce.

Recruitment, retention and morale

11. The Departments said that from 1983 to 1993 the whole-time equivalent number of practitioners working in the NHS increased by 16.0 per cent in Great Britain. Numbers of general medical practitioners[1] (GMPs) and general dental practitioners[2] had risen by 11.5 per cent and 13.1 per cent respectively. In the HCHS, there had been increases of 18.6 per cent in medical and dental whole-time equivalents over the same period. The Departments said that there had been significant increases in the number of applicants to medical and dental schools in 1992 and 1993 to over 10 per cent more than 1985 levels. In 1993, there had been an average of 2.4 applicants for every medical and dental school place and average 'A' level scores for students accepted to study medicine and dentistry remained higher than for any other discipline. We were told by the Departments that recruitment and retention at national level was very good. They believed that a move towards an increasing level of local pay determination would encourage employers to use pay flexibility to tackle any isolated problems of recruitment and retention.

12. The BMA told us that any general problems of recruitment and retention were unlikely to arise because the numbers of posts available were calculated nationally based on medical school output. In addition, it said, it was very difficult for doctors to change direction in mid-career, the NHS being a near-monopoly employer for junior doctors. The BMA made particular reference to the low morale of junior medical staff, saying that it continued to be a major problem. It said that the reasons for this were complex and, whilst not entirely linked to pay, were linked to perceived levels of worth.

13. The BDA expressed concern about the lack of recruits to dentistry. Its evidence recorded that during the 1970s and 1980s there had been fierce competition for dental school places. It said that recruitment had fallen sharply until 1988, since when the number of home applicants had changed little.

Comment

14. We commented in our Twenty-Third Report that morale and motivation are not primarily a matter of earnings or earnings comparisons. We also thought it important that doctors and dentists should not feel undervalued by the community. This year we have recognised the particular concerns of the profession about junior doctors. These are discussed in Chapter 3. Data from the Universities and Colleges Admissions Service (UCAS) support the Departments' evidence on recruitment and we conclude that there is still no shortage of good quality applicants coming forward for both the medical and dental professions. There is, however, evidence to suggest that there might be an emerging problem concerning recruitment into the General Medical Services. We discuss this in Chapter 6. We will continue to monitor recruitment trends generally.

Pay comparability, pensions and fringe benefits

15. The professions said that they regarded fair comparisons as the most important factor in assessing proper pay levels for doctors and dentists. The BMA suggested that our recommendations last year had led to a probable further deterioration in doctors' position of some 2 per cent against comparable earners. The BDA drew our attention to the Employment Department's New Earnings Survey, saying that earnings had again risen more at the top of the pay distribution than at the middle or lower end. Both professions commented on pensions and fringe benefits. The BMA observed that a recent report from the Government Actuary showed that there had been substantial improvements to occupational pension schemes during the period 1987 to 1991. The BDA said that a recent independent survey had shown a continuing trend towards more generous fringe benefits outside the NHS.

16. The Departments said that in recent years the pay of doctors and dentists had increased more rapidly than that of most other NHS staff groups as well as those of both the public and private sectors as a whole. Doctors' and dentists' pay, they said, had also increased significantly more than prices, with settlements rising on

[1]unrestricted principals
[2]principals

average in real terms by 34.6 per cent between 1979–80 and 1993–94. The Departments commented that excessive pay increases for doctors and dentists would remove the scope at local level for arrangements reflecting the reality of local conditions, and would fuel undue expectations in other parts of the NHS.

Comment

17. We have noted the parties' comments. We do not find the Departments' reference to the year 1979–80 as a base line for comparing relative pay movements to be particularly enlightening, as that year fell in the middle of a period of staged 'catching-up' awards for many public sector groups including doctors and dentists. As in previous years we have looked at a range of comparable professions and of self-employed people. We do not believe that the comparative remuneration of our remit groups has so deteriorated in recent years as to make this a particularly significant issue in determining pay for 1995–96.

18. We do, however, accept the professions' argument that any comparison of rewards for posts in different sections of employment must deal with the total remuneration package available, including the value of pension arrangements and non-cash benefits, and not merely with basic rates of pay. We keep these factors under continuous review and we do not believe that any specific action on them is needed in this pay round. However, we last carried out a detailed examination in our Twenty-First Review and we intend to do so again in our Twenty-Sixth Review next year.

Local pay

19. In our Twenty-Third Report, we noted the Departments' intentions to move away from centrally determined pay for employed medical and dental staff. We supported the general principle of devolution but commented that arrangements were not sufficiently advanced for us to recommend an element of local pay for 1994–95. We expressed disappointment that more progress had not been made and suggested that the Departments intensify their efforts.

20. In their evidence to this year's review the Departments have urged us not to recommend an across the board increase for employed staff but instead to facilitate the continued development and implementation of local arrangements by leaving employers with maximum scope for local action. The Departments stressed the freedom of Trusts increasingly to determine the pay and conditions of their own staff to be an important part of making services more responsive to local needs. We were told that an *ad hoc* forum of interested parties had produced a draft enabling clause to allow locally agreed schemes to be introduced through local negotiations. Such schemes would be based on the performance of the organisations in relation to their objectives for the provision of high quality patient care. They would allow for contributions by teams as well as by individuals to be rewarded. The Departments said that their intention was to enable Trusts and other units to implement schemes for all staff whether they were on locally determined employment contracts or were continuing on nationally determined terms and conditions.

21. We were told by the Departments that the NHS Chief Executive had written to all provider units in England (different arrangements were made for Scotland and Wales) in June 1994 requiring the preparation of action plans by October 1994 and local pay machinery to be set up by February 1995. This action was taken in response to the Prime Minister's acceptance of our Twenty-Third Report and our comments suggesting that the parties should give high priority to establishing arrangements in time for our next review.

22. The Departments acknowledged that, to enable us to advise the Prime Minister on remuneration of doctors and dentists in future years, information on pay levels throughout the service was essential. They reaffirmed during oral evidence that, despite their high degree of autonomy, Trusts were not fully independent and remained part of the NHS. The Departments intended a system to be set in place to accommodate the requirement for information on pay levels in the Trusts and other units. Specifically, they intended in Autumn 1995 to provide us with a report on the extent, coverage and proposed payment levels in local pay schemes which had been introduced in 1995. That information, they said, would

allow us to take stock of the position on local pay and inform our consideration of recommendations for 1996–97.

23. The BMA told us that it seemed unlikely that significant progress would be made towards reaching an agreement on the proposed enabling provision, as they strongly disagreed with the Departments on a number of fundamental points of principle. The BMA said, however, that it was not opposed to rewarding high quality professional performance and that it would be feasible to devise acceptable national schemes for local implementation. Such schemes would have to be fair and equitable, be fully funded, appropriately monitored and contain safeguards against abuse in their implementation. The BMA commented further that a system of local pay determination was compatible with a Review Body system if all local employers provided the Review Body with the information it needed to make its recommendation and if the Review Body continued to make recommendations (e.g. to indicate ranges or expected averages and to comment on systems, distribution etc) applicable to those employers.

Comment and recommendations

24. We have no wish to prevent the parties from moving to local determination of pay generally but our view is that this needs to be brought in after careful analysis of potential benefits and costs. The Departments have not given any clear indication of how local systems for determining doctors' pay might be developed in a way that would enable us to carry out our remit. In the absence of any such indication **we propose a mechanism by which a modest development of local pay for hospital consultants may be made in 1995–96 where the local parties are willing and able to take advantage of the opportunity. Where no local pay arrangements are agreed by the parties, we have recommended that the national pay scale should continue to apply.** Our proposals are set out in Chapter 2. It may be the case that some Trusts and other provider units have already set up arrangements for other grades in accordance with the directive from the NHS Chief Executive but we have been given no detailed evidence of how the relevant mechanisms would work in practice. Where units are in a position to establish and implement arrangements for other grades they are, of course, free to do so.

25. We have noted that consultants are concerned that local pay systems should recognise the quality of patient care and we suggest that, in their development of schemes, Trusts and Directly Managed Units (DMUs) should provide opportunities for consultants locally to be closely involved in the decision making process. We regard the implementation of the proposed new arrangements as experimental—the first stage in a period of transition which we intend to monitor. Before we consider the extension of our recommendations to other grades, we wish to be confident that the necessary mechanisms are working satisfactorily for consultants and have produced no significant disadvantages. We will therefore consider the results achieved in respect of consultants and of other grades in our next and subsequent reviews.

26. For consultants and other staff in community and public health services, it is not yet clear to us how their duties are apportioned between 'purchaser' and 'provider' functions or how local pay mechanisms would work in their particular circumstances. We look to the parties to supply the relevant detail in evidence to our next review.

27. We are also particularly concerned about the position of junior doctors and how they might be affected by local pay. It was only at a relatively late stage in this year's review that the Departments made it clear for us that they intended their proposals on local pay to apply to juniors. Previously, we had been led to believe that they would not. Indeed, the NHS Trust Federation told us in its evidence that it was not requesting the introduction of performance related pay for juniors and that it regarded the continuation of national terms and conditions of pay determination for this group as beneficial. The BMA has suggested to us in evidence that juniors are in a special position stemming from their short term contracts and the way the training system currently shifts them from post to post. For our next review, we invite evidence from the parties as to how local pay might be developed and applied to juniors, taking due account of any new training arrangements to be initiated through implementation of the Calman Report. We would also like the evidence to consider what benefits might accrue from such a change. It would be a

point of obvious concern to us if the views of the Departments directly contradicted those of the NHS Trust managers, as is currently the case.

28. General medical practitioners and general dental practitioners are not affected by our recommendations on local pay, as their remuneration systems are framed on an entirely different basis.

29. In our previous reports, we have commented that the remuneration system for general medical practitioners should be made more sensitive to local circumstances and requirements, and we have noted the lack of enthusiasm from the parties for such an approach. We have noted with interest that the Departments' long term strategy on the remuneration of general dental practitioners is likely to recognise the desirability for local factors to be taken into account. We are unclear why the Departments are pursuing an apparently inconsistent policy on local pay determination across different sections of the medical and dental professions.

Clinical academics

30. Those with responsibility for determining the remuneration of clinical academics with NHS responsibilities customarily take note of what we have recommended for doctors and dentists in the NHS. The professions have expressed their concern to us about how developments on local pay determination would bear on clinical academics, commenting that some of those concerned have two contracts to fulfil (one with a university and one with the NHS). Clinical academics have an important role to play within the NHS and we have commented in previous reports that delays in 'translating' pay awards to them have caused considerable grievance. We urge the employers to ensure that their clinical academic staff suffer no disadvantage in relation to their medical colleagues during either the transition to or the full implementation of local pay arrangements.

Chapter 2

Career Grade Hospital Doctors and Dentists

Manpower

31. The Departments told us that whole-time equivalent hospital medical and dental staffing had increased by 23 per cent in Great Britain during the ten years to September 1993. They said that consultant and staff grade expansion was continuing. For the year ending September 1993, the whole-time equivalent rate of consultant expansion was 2.2 per cent in England and Wales and 1.2 per cent in Scotland. In England and Wales an additional £2 million funding had been made available to encourage the employment of part-time consultants. The rate of release of staff grade posts had been accelerated to help reduce junior doctors' hours of work. The Departments observed that the release of staff grade posts up to the overall national ceiling of 10 per cent of consultant posts had now been reached.

Workload

32. The BMA referred to the 1989 survey on consultant workload conducted by the Office of Manpower Economics (OME). That showed that whole-time and maximum part-time consultants spent an average of 49.2 hours per week on all NHS activities, some 14.2 hours in excess of their minimum contracted requirement of 10 notional half days (NHDs). The BMA said that, since the survey had been undertaken, consultants had taken on a range of additional management and educational responsibilities, which included the provision of advice on clinical aspects of purchaser-provider contracts.

33. The BMA said that implementation of the report of the Working Group on Specialist Medical Training would have significant implications for consultant workload. It would result in a reduced proportion of junior doctors to consultants; doctors would spend less time in the training grades; juniors would devote less time to service commitments; and there would be an increase in the time and effort required of consultants in which to teach their junior staff.

Comment

34. We think it appropriate and in accordance with the autonomy granted to NHS Trusts that the profession's concerns should be addressed at local level and not through centrally determined remuneration arrangements. Trusts which provide for a measure of pay flexibility will be able to address the profession's concerns through local agreement.

Job security

35. The profession told us that job security was no longer guaranteed for senior hospital doctors and that the reorganisation of the health services in the major cities, particularly London at present, was a grave threat to jobs. The BMA estimated that between 150 and 200 redundancies of senior hospital doctors had occurred over the last year.

Comment

36. We recognise that relative job security is declining among many public service professions and in those parts of the private sector which have traditionally enjoyed high levels of job security. Redundancies are now occurring in significant numbers in both the Civil Service and in the banking profession.

37. We commented in our Twenty-Third Report that consultants' current concerns about job security arose more from the pressure of *mobility* rather than

from the risk of becoming *unemployed*. We do not believe such pressures, which affect morale, can be relieved through remuneration. We again urge the Departments to take account of the profession's concerns and to explore whether the package of measures already agreed for London might be applied to other areas where redundancies are occurring.

Local pay
Comment

38. We have commented generally on local pay in Chapter 1. We have also noted that detailed guidance on local schemes has not been issued centrally, the preference being to leave decisions to the local managements. For 1995–96, we propose to facilitate moves towards local pay determination for hospital consultants employed in NHS Trusts and other provider units where there is a desire and an ability to move in such a direction. We propose that this should be done in a measured way which will allow the NHS Executive to monitor outcomes as they have undertaken to do.

39. Trusts, and now DMUs[1], have a large degree of autonomy and have a developing role within the NHS internal market to provide effective and efficient services to meet patients' needs. To fulfil their objectives it is evident that ultimately Trusts need to have control over their pay bill costs which comprise around 70 per cent of their overall expenditure. The pay of hospital doctors is a significant element within this. Despite the comment in our last report that the parties should give high priority to establishing local pay arrangements in time for our next review, we have noted with some surprise that it was not until 6 June 1994 (some four months after publication of our report) that the NHS Chief Executive wrote to provider units, asking them to take action. We find this delay disappointing, in so far as it reduces the time available to units to plan an effective response.

40. We have observed that the few Trusts which have reached the point where comprehensive local pay systems can be introduced have usually spent a long time in preparing the ground. The Departments' evidence acknowledged that the design and introduction of local pay are complex, and the Health Secretary declared on 15 June 1994 that devolved pay arrangements should be introduced constructively and that a period of transition would command the confidence of the staff concerned. We strongly support this statement and have framed our recommendations for 1995–96 to be consistent with it.

41. We are of the view that moving to local pay should be seen as part of a process which is likely to continue for at least another two or three years. We believe that, over such a period, there should be parallel running of different forms of pay determination with effective control and monitoring from the centre, so that lessons can be learnt and confidence in the new approach built up. We do not believe that the necessary confidence of doctors and dentists can be obtained through coercing them into accepting rapidly devolved arrangements. We have noted that the Departments' proposed enabling provision for local pay schemes makes the "provision of high quality patient care" a principal objective. We believe that such an objective should be reconcilable with the professions' own aspirations. This will require the definition of quality criteria and the setting of targets supported by the appropriate management system.

42. It is evident to us that local pay is likely to impact on the distribution of consultant resources and possibly on the overall funding requirement. Therefore, during the transition from central to local pay determination, we consider it essential that the process be subject to central monitoring so that costs remain under control and health provision is safeguarded. Also, without central monitoring, we do not believe we would be able to continue to discharge our terms of reference. As local pay develops we would wish in future reviews to receive in evidence clear details, not only on how local pay has impacted on doctors' salaries, but also on the ability of NHS Trusts to recruit, retain and motivate the doctors required to meet patients' needs. We have asked our Secretariat to liaise with the parties concerned to determine a framework for the provision of such information.

[1]Our comment and recommendations in this chapter make frequent reference to 'Trusts'. These should be taken to refer also to units which continue to be directly managed.

43. It is quite clear to us that the great majority of Trusts will not have concluded agreements with the professions' representatives to enable local pay to operate from 1 April 1995. Our recommendations, as set out below, are designed both to accommodate Trusts that do not feel themselves ready yet to introduce local arrangements, and to help those that are now ready to make the transition through the provision of appropriate incentives likely to be attractive to the professions.

44. In anticipating a move towards local pay for hospital consultants it is necessary to have regard to current pay arrangements. While the pay of most consultants is based on the national pay scale, Trusts are already free to negotiate variable contractual terms with individual doctors and dentists. Furthermore, there is a long established practice whereby units can enhance the scale by paying for notional half days, either to reward additional responsibilities or to provide an additional incentive for individual doctors and dentists. We do not have any information on the extent and value of additional payments made by granting notional half days for specific purposes. However, we note that Trusts already have some flexibility to vary salaries upwards from the national scale, according to perceived local needs and that the Departments' proposed enabling clause would increase the scope for such flexibility, allowing some consultants to receive either more or less than their colleagues, if Trusts' managements so wished.

Recommendations

45. We **recommend**: (i) the continued freedom of Trusts to negotiate variable contractual terms with individual doctors and dentists which in practice are likely at first to involve additions to, rather than reductions from, national pay rates; (ii) the continuation for the time being of national pay scales for use in those Trusts which are not yet in a position to introduce local pay, although during the period of transition to local pay we would expect the numbers of doctors and dentists on these scales to reduce gradually; and (iii) the introduction of a system of *transitional local pay* that combines local flexibility within a centrally constrained pay framework. Consistent with the draft enabling provision it would be incumbent upon Trusts to persuade their consultants that the benefits outweighed the possible risks. The system of *transitional local pay* is described below.

Transitional local pay

46. For the purposes of *transitional local pay* we intend to recommend only on (i) a *minimum* remuneration level for hospital consultants and (ii) a *maximum percentage* increase in the average salary per head (excluding distinction and merit awards) for consultants in a Trust. We do not intend either to set a maximum salary level or that the individual scale points above the minimum should necessarily apply where a local scheme is introduced. Our intention is that salary progression by individuals would be at the discretion of each Trust in accordance with its objectives and remuneration strategy. We believe that it is necessary, at least for a transitional period, to maintain the concept of a national minimum salary for consultants. We also believe that the inflationary effect on the pay bill cost would be limited through our recommended cap on the increase in average remuneration. However, to provide reasonable flexibility locally and to give an incentive to hospital consultants to accept a divergence from the nationally determined scale, the recommended maximum percentage increase in the average salary in individual Trusts for 1995–96 over the previous year is at a higher level than that recommended for the national scale. We suggest that, for the first year, the percentage increase is determined through a comparison of consultants' salaries both immediately before and after the pay award is made. It is essential that there should be central monitoring by the Health Departments both, for their own purposes and on our behalf, as to how Trusts have implemented the new arrangements, and we reserve the right to revert exclusively to old style 'national recommendations' in the next two years if the monitoring of settlements provides us with cause for concern.

47. Within the *transitional local pay* scheme we **recommend** that consultants' minimum salary should increase by **2.5 per cent** to £40,620. We **recommend** that the maximum increase in the consultants' average salary in each Trust should be **5 per cent**. We emphasise that this is a *maximum* which individual Trusts should not exceed and we would expect the average increase for all Trusts adopting this scheme to be less. For those Trusts unable to implement local arrangements in 1995–96, we

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recommend an increase of **2.5 per cent** on existing salaries. Our recommendations are effective for the year commencing 1 April 1995.

48. The above measures are recommended in the expectation that the professions will be willing to endorse the concept of local pay arrangements in accordance with the Departments' proposed enabling provision. In our review next year we intend to monitor closely the reaction of the professions to our recommendations on *transitional local pay* and to take what further action we consider necessary, if we think our suggested transitional measures are not fulfilling our objective.

Linking local pay to distinction and merit awards and notional half day payments

49. In paragraphs 52–53 we comment on the Report of the Working Party on the Review of the Consultants' Distinction Awards Scheme which is currently under consideration by the Government. The report was published in October 1994. We believe that the future of the awards scheme cannot be assessed in isolation from considerations of local pay. If the report's recommendations are implemented the higher awards would be funded centrally and the responsibility for determining and funding 'C' awards devolved to local level. Under present arrangements and those recommended in this report, the elements of a consultant's remuneration might be unnecessarily complex comprising: (i) basic salary, including an element of local pay; (ii) cash value of one or more notional half days, if agreed under present flexible local arrangements; and (iii) value of a 'C' award—or a higher award funded centrally.

50. With the introduction of flexible pay we would see an argument in favour of simplification through combining these elements into either one locally determined basic sum or a basic rate plus variable bonus. This would involve the abolition of the present rigid system of notional half day payments. It would be for each Trust to devise and agree with the professions appropriate local arrangements. We invite evidence from the parties to our next review as to how 'C' awards and notional half day payments could be incorporated into locally determined salaries. This assumes the parties' acceptance of the Working Party's Report over the coming year.

Distinction and meritorious service awards

51. In October 1994, the Government published the Report of the Working Party on the Review of the Consultants' Distinction Awards Scheme. The Health Minister told us that he had decided to retain the scheme one more year, but only on the basis that 1995 would be the last year in which those arrangements would apply. We were informed that no decision had yet been taken on implementing the report's recommendations.

Comment

52. We have noted with interest some of the key points emerging from the Working Party's initial conclusions, in particular that: national awards should be centrally identified and funded; and local awards should continue to be funded by employers locally and should be for outstanding contributions to local services. We welcome the Working Party's recommendation that a joint professional/employer local awards committee should be established to assess nominations for local awards made by NHS employers. We have also noted that the Departments intend to carry forward discussions on the Working Party's Report with the BMA in the light of those already taking place on local pay.

53. We welcome these developments and hope that brisk progress will be made in the discussions between the parties. We support the recommendation of the Working Party for central funding of the higher awards, as Trusts employing consultants with these awards have at present no control over the relevant costs. We also support the recommendation that the lower awards should continue to be determined and funded locally. We welcome the discussions on the awards scheme being related to those on local pay development. We have commented on the possible ramifications for local pay in paragraphs 49–50 above.

Awards for 1995

54. We now turn to our recommendations for 1995. The Chairman of the Central Advisory Committee requested that, while awaiting Ministerial decisions on the Working Party's Report, we should again do no more than mark time on the proportion of award holders in the consultant population and maintain the existing ratios between the awards.

Recommendations

55. We agree that for 1995 the number of awards should be calculated on the basis as suggested in the preceding paragraph. We **recommend** the creation of 175 new awards at the following levels: 7 A+; 23 A; 45 B; and 100 C. This maintains the proportion of consultants holding awards in line with the existing totals.

56. We **recommend** that the values of awards are maintained at the current percentages of the consultants' national *scale* maximum, as set out in Appendix A. This recommendation applies to *all* consultants, including those who agree to be remunerated on the basis of our *transitional local pay* arrangements as set out in paragraphs 46–48.

Age limits

57. The BMA asked us to recommend the removal of age limits on the receipt of distinction and meritorious service awards. It said that, prior to the introduction of limits, very few awards were made to consultants over the age of 60, and it was important that such awards should be made if justified on merit.

Comment and recommendation

58. We reiterate the comments made in our Eighteenth Report that giving awards to those approaching retirement, with the additional pensions benefit entailed, can hardly be said to be in the best interests of the service. One of the original purposes of these awards was to encourage consultants to remain within the National Health Service. We **recommend** the retention of the existing age limits.

59. Given the development of the NHS Trusts and the autonomy of these organisations we believe it appropriate, however, that local managements should have the necessary flexibility to confer some smaller reward on consultants outside the age limits should they think that justified. Our proposed local pay scheme would allow for such flexibility.

Associate specialists

60. The BMA again asked us to increase the level of the performance supplement payable to associate specialists, emphasising that the criteria for such awards were particularly stringent.

61. The BMA expressed its concern to us that there had been no effective monitoring of these supplements or notional half days. The profession told us that the Departments had taken the view that, although employers had been asked to monitor the arrangements, there was no need for any central feedback of results.

Comment and recommendations

62. The cash value of these supplements is now £3,145 on the basis of our recommendations for 1995–96. We think that provides reasonable reward over and above basic salary. Where Trusts and DMUs are already able through their own local agreements to introduce or extend local pay to the associate specialist grade the profession's concerns might reasonably be addressed through local negotiation. In our next review we intend to consider, in the light of our monitoring of local pay for the consultant grade, whether similar arrangements might apply to associate specialists and other grades. Wherever the local parties have not been able to develop schemes of their own, we would also wish to consider whether the value of the performance supplement should be incorporated into a basic salary. For our next review, we invite the parties to give us their views on this issue. In the meantime, we **recommend** the supplement continues to be set at 7.5 per cent of the associate specialist national scale maximum.

63. The profession's concern over monitoring could be alleviated if the Departments were to include such information as part of the monitoring arrangements to be introduced on local pay (see paragraph 46). We **recommend** accordingly.

Level of remuneration increase

64. We **recommend** a remuneration increase of **2.5 per cent** 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.

65. We **recommend** that an alternative system of *transitional local pay* (as described in paragraphs 46-48) should apply to the hospital consultant grade, for those Trusts which are able to implement local pay from 1995–96.

66. We **recommend** that Trusts able to conclude local pay agreements with the profession outside the arrangements we have proposed above should proceed accordingly.

Other salaries, sessional rates and allowances

67. We **recommend** all other salaries, rates and allowances be increased by **2.5 per cent**.

Chapter 3

Doctors and Dentists in Training

Terms and conditions

68. The Health Departments reaffirmed that national terms and conditions of service continue to apply to all doctors and dentists in training, whether they are employed in Directly Managed Units or in NHS Trusts. The Departments told us, however, that they intended junior doctors to be included in local pay schemes. We have commented on the application of local pay to juniors in Chapter 1.

Hospital doctors: training for the future

69. The Departments told us that further work was in progress to carry forward the implementation of the Calman Report. One of the main recommendations of the report was the introduction of a new unified training grade in which higher specialist medical training was to take place. This would not be a direct replacement for the registrar and senior registrar grades but rather a completely new arrangement to reflect generally shorter and more highly structured training programmes. We were told that a working party was considering the educational principles on which the operation of the new grade was to be based and that, once principles had been agreed, discussions with the profession would begin on the terms and conditions of service for the grade.

Comment

70. We look forward to receiving joint evidence to our next review on remuneration issues relevant to the introduction of the proposed unified training grade.

Out-of-hours work

71. The Departments said that only a very small minority of junior doctors remained contracted for more than 83 hours per week at 1 April 1994. The current phase in the programme of hours' reductions provided for the maximum contracted hours for hard-pressed on-call posts to be reduced to 72 a week, for partial shifts to 64 a week and for full shifts to 56 a week. The deadline for these reductions was 31 December 1994. The priority target for the year is that relating to hard-pressed posts. The Departments indicated to us that, whilst some progress on that had been made, further significant reductions would be necessary to achieve the objective. They said there was no evidence to justify any change in current rates for out-of-hours work.

72. In December 1994, the Departments updated their evidence. They told us that since March 1994, task forces had authorised 228 extra staff grade and 617 extra senior house officer posts to help reduce juniors' hours of work in England, with at least 500 of these posts in the process of being established. Task forces had also exceeded the target for establishing new consultant posts to support the New Deal and by September 1994 some 680 extra posts had been created, 80 over the minimum requirement. Funding had also been used to create additional nurse and support posts. Similar measures were being adopted in Wales and Scotland. The Departments told us, however, that the Ministerial Group on Junior Doctors' Hours had accepted in November that the targets for the end of 1994 would not be achieved for all junior doctors. They said that in England between 31 March and

30 September 1994, the number of hard-pressed on-call posts contracted for more than an average of 72 hours per week had fallen from 6,524 to 3,870. In Scotland there was a reduction from 985 to 513, and in Wales a reduction from 480 to 165.

73. The BMA argued that junior doctors should not be paid at less than their standard rate of pay for overtime work. It said it did not favour the payment of differential out-of-hours rates according to grade and/or specialty, and that junior doctors' pay should increase as hours came down to ensure that juniors did not lose out financially as a result of the New Deal. The profession also claimed that additional work was increasingly being performed unpaid as junior doctors worked beyond their contracts to maintain patient care.

Comment

74. We have noted the parties' comments. The information provided by the Departments showed that in England and Wales around 10 per cent of juniors were contracted to work full or partial shifts on 31 March 1994. The expected move to shifts, however, has not materialised (in 1991 when we first set the out-of-hours work rates in the second supplement to our Twenty-First Report we reported that the Departments regarded partial shifts to be appropriate for a great deal of medical work). We are concerned that a large number of hard-pressed on-call posts remain contracted for over 72 hours per week on average.

75. From our own observations we are aware of low morale among junior doctors, particularly those in the lower grades, and this continues to be of concern. There is a perception among this group that they are under-valued, in terms of both their pay and conditions and also the type of work, often administrative, clerical and menial, which they are asked to perform. We do not consider the level of remuneration to be the only factor affecting their morale which, as other independent studies have concluded, could be significantly alleviated through suitable management action. At our request, the Health Departments submitted a report to us on a survey of measures taken in support of hours reductions. These included consideration of making better use of the skills and support services of other professions such as nurses and midwives, and technical, administrative and clerical staff. We welcome these initiatives but we have seen little evidence that these basically sound ideas are being implemented to any significant extent. We have concluded that, in our consideration of appropriate remuneration levels for 1995–96, junior doctors justify preferential treatment. Having regard to the prospect of new terms and conditions for the new unified training grade, we have decided to place the emphasis this year on enhancement of on-call rates for the more junior grades of house officer and senior house officer. Generally, the more junior staff are likely to be resident more often and first on-call and as a result work for a higher proportion of their time on-call.

76. We do not accept the profession's repeated argument that juniors' pay should increase as hours of work reduce. The object of the New Deal was to improve the position of juniors by reducing their duty hours but not necessarily to preserve pay levels which were designed to compensate for the excess hours on duty. The pay rates implemented under the New Deal were intended to recognise the relative work intensity of shift and on-call working patterns. As hours reduce, juniors are compensated by the improvement of working conditions. We do not regard protection of income in such circumstances to be appropriate.

Recommendation

77. We **recommend** that the out-of-hours on-call rate for house officers and senior house officers be increased from 50 per cent to **52.5 per cent** from 1 April 1995.

Part-time training

78. In our previous two reports we have urged the parties to address the issue of part-time training and provide joint evidence on remuneration for such posts. In our Twenty-Third Report we asked for a clear and unambiguous statement of the Departments' policy towards part-time working.

79. The parties have been unable to reach agreement on how remuneration for this group should be structured. The Departments regard the present structure as still appropriate. Its key feature is that the standard hours contracted for are paid at the standard rate and the additional duty hours at the rate appropriate to the working pattern on which a doctor is rostered. The BMA's view is that the term 'part-time'

is a misnomer for doctors whose working week approximates to a full-time contract of employment for most people. The profession told us that, in effect, those doctors who were in flexible training were in full-time employment without compulsory overtime. It said it was inappropriate that only the first 20 hours of such employment should be paid at the standard rates. The BMA also said that 25 per cent of graduates left the profession in the first five years after qualification and that a survey it had conducted showed that 40 per cent of juniors questioned would like to work part-time given the opportunity. Only 3 per cent did so.

80. The Departments said that there was no evidence to suggest that current rates of pay were a disincentive to change from full-time working. They thought the best way to encourage part-time working was to create opportunities for more posts, both in the career and training grades.

81. The Departments said that the entry of female medical students to medical schools in the UK had been around 50 per cent of the total for the last two years, emphasising the importance of policies which ensured that women doctors were able to contribute fully to the service. They commented also that opportunities for flexible training would need to be considered within the unified training grade, which would take account of the level of demand.

Comment

82. We have noted the views of the parties. Junior doctors, whether working full-time or part-time, contract for a specified number of standard hours and additional duty hours. We have seen no evidence to suggest that the work intensity of part-timers is markedly different from that of their full-time colleagues during their out-of-hours duties. Part-time senior house officers and house officers will, of course, benefit from our recommendations to increase on-call rates for these grades generally. We conclude that the remuneration structure for part-time working should remain unchanged.

83. The demand for flexible work opportunities is likely to increase, not only because of the level of female recruitment into the profession, but also because a minority of male junior doctors would also like to work part-time. We concur with the Departments' observation that more opportunities for part-time employment should be created. We hope they will do more to encourage this as a matter of priority to meet the continuing demand for flexibility. We have noted also that opportunities would need to be considered in the light of the pending introduction of the unified training grade. That development, in itself, should provide a focus for discussion with the profession on the most appropriate ways of encouraging Trusts to place more emphasis on part-time working patterns. We will continue to monitor the situation in our future reviews.

Level of remuneration increase

84. We **recommend** that the salary scales for doctors and dentists in training be increased by **2.5 per cent**. The proposed scales are set out in Appendix A.

Chapter 4

Doctors in Public Health Medicine and Community Health

Public Health Medicine

Manpower

85. In the year to 30 September 1993, the number of career grade doctors in public health medicine in Great Britain declined from 630 to 610. For training grades (senior registrar, registrar and senior house officer), the number of staff in post increased from 440 to 460. The table in Appendix B shows the changes by staff groups between 1992 and 1993.

Developments in the service

86. The BMA told us that the Departments had published a report which had clarified the position of public health medicine in the reformed NHS. The report dealt with the future of the regional public health function following the Government's decision to transform RHAs into outposts of the NHS Executive. It welcomed the renewed emphasis on public health and health promotion, but was concerned that the reduction in the number of regional public health directors and their eventual absorption into the civil service meant the loss of some of the most experienced high profile voices advocating the public health message.

87. The Departments said that changes to the Department of Health and NHS in England meant that work in public health was facing reorganisation. They said that it was too early to say exactly what the implications would be for the workloads and job security of doctors in public health medicine but their position would be kept under review.

Local pay arrangements

88. We have commented on the proposed introduction of local pay arrangements for these groups in Chapter 1.

Recruitment, retention and morale

89. The BMA said that training in public health medicine had until this year been funded centrally in response to the recognition of the considerably expanding need for public health physicians occasioned by the NHS reforms and *Health of the Nation*. It told us, however, that the relatively slow progress on expected links between public health and primary care and the 'inevitable blight' on development resulting from reorganisation and merger had delayed this process. The BMA was extremely concerned that there would not be sufficient consultant posts immediately for many of the current trainees in public health medicine. It said that this, combined with the disparity between out-of-hours remuneration for trainees in public health medicine and hospital medicine, had produced a serious loss of morale and that there was a serious danger that large numbers would leave the specialty.

90. The Departments told us that there had been a steady increase in public health trainee appointments in recent years and that they had no evidence of recruitment problems.

Comment

91. We have seen no evidence of any recruitment and retention difficulty, or any other factors, which would justify consideration of a special pay increase for doctors in this group.

Directors of Public Health

92. The BMA said that the dwindling number of health authorities as a result of mergers had reduced the number of public health physicians who were eligible to receive chief officer supplements and thereby diminished the total sums available to the profession from that source. It asked for increases in the chief officer supplement to compensate for the increased workload that followed from a merger, and the increasing general complexity of the work of Directors of Public Health. It asked for an increase in the top of the band of the chief officer's supplement based on job weight.

Comment

93. We consider that the current banding arrangements for the chief officer's supplement provide adequate compensation for the additional duties involved.

Trainees in public health medicine

94. The BMA told us that our decision last year not to recommend an increase in the out-of-hours supplement payable to trainees in public health medicine, combined with growing uncertainty about career prospects, resulted in a serious loss of morale. It claimed that trainees were now doing more evening work, writing reports or attending meetings, in addition to their on-call rotas. The BMA said that it was important to retain the attractiveness of this specialty and that the most effective way of so doing was to retain the linkage of its overall remuneration with that of trainees in other specialties. It said that since the New Deal the hours of work of hospital trainees had reduced and the rates of pay had increased, whereas no corresponding changes had been made for public health medicine trainees.

95. The Departments argued that the steady increase in public health medicine trainee appointments was continuing and that there was no evidence of recruitment problems which merited a reappraisal of the level of the out-of-hours supplement for trainees.

Comment

96. We reject the profession's argument that out-of-hours remuneration for trainees in public health medicine should in some way be automatically linked with that for junior hospital doctors. We repeat the comment made in our Twenty-Third Report that any case for altering the value of the supplement should be assessed on its own merits. We have suggested that any appraisal should take account of recruitment and retention problems and look carefully at the amount of time actually worked by trainees additional to their normal hours and measure any significant changes over time. We have noted the continuing increase in public health medicine trainee appointments and we consider the present percentage value of the trainees' supplement to be adequate compensation for their out-of-hours duties.

Community Health

97. The number of community health staff in Great Britain at 30 September 1993 was 4,470, a reduction of approximately 6 per cent over the previous year.

98. The Departments told us that arrangements to create a unified medical career structure for child health through assimilation of the senior clinical and clinical medical officers into the hospital medical career structure were agreed with the profession and put into effect from 4 March 1994 in England and from 23 May 1994 in Wales. Guidance relating to Scotland had also been issued.

99. The BMA said that the detailed mechanisms for transfer and protection arrangements for community health doctors who chose to retain their existing appointments had been agreed with the Departments. However, it said that the Departments were not willing to protect the salary of senior clinical medical officers (SCMOs) who took associate specialist appointments and it had advised SCMOs not to accept the transfer. The BMA said that it was not aware that large numbers of child health doctors were accepting transfers to hospital terms and conditions of service. It also told us that Trusts were not taking into account time spent in SCMO and clinical medical officer (CMO) posts in applications for associate

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specialist and staff grade posts. The Departments told us that sufficient salary protection was offered to those SCMOs who transferred into the unified medical career structure. They said that, although the transfer was complex, SCMOs were set on the appropriate point of the associate specialists' scale.

Comment

100. In view of the continuing difficulty over the implementation of assimilation arrangements, we are continuing to recommend pay scales for CMO and SCMO posts.

Level of Remuneration Increase

101. We **recommend** that the pay of doctors in public health medicine and community health be increased by approximately **2.5 per cent**, as for other doctors and dentists in the HCHS. The proposed scales are set out in Appendix A.

Other Fees and Allowances

102. We **recommend** that other fees and allowances in this area of work be increased by **2.5 per cent**.

Chapter 5

Ophthalmic Medical Practitioners

Manpower and workload

103. The number of ophthalmic medical practitioners (OMPs) in the General Ophthalmic Services (GOS) in Great Britain was 789 at 31 December 1993, a reduction of 48 over the previous year. The Departments told us that they believed the actual number to be smaller because of the number of OMPs who were no longer practising but were still on FHSA lists. The total number of sight tests in 1993–94 paid for by the NHS was 6.9 million, an increase of 7.4 per cent on 1992–93. The proportion of NHS sight tests carried out by OMPs fell from 8.6 per cent to 7.6 per cent over the period 1991–92 to 1993–94.

104. The Departments said that following a recommendation in our Twenty-Second Report they had agreed a methodology with the optometric professions for conducting an annual survey of the overall volume of sight tests. The first survey produced an estimate that 13.184 million sight tests would be performed in Great Britain in the year to 31 March 1994. Of these, 6.594 million were estimated to be NHS and 6.589 million private sight tests. It was estimated that 6.9 per cent of all sight tests would be carried out by OMPs. The Departments said that the majority of OMPs practised on a part-time basis, with 85 per cent working 20 hours or less as an OMP.

105. The BMA said that the survey results indicated that OMPs conducted on average 17 NHS sight tests per week and 14 private tests per week. In comparison, optometrists were performing on average 26 NHS sight tests and 25 private sight tests per week. The BMA said that the number of sight tests being performed by OMPs impacted upon their level of remuneration. Optometrists, it said, not only received a higher sight test fee for conducting the same test, but also had a far greater share of the market and therefore received greater remuneration.

Level of the sight test fee

106. The Departments told us that the NHS sight test fee should reflect the work OMPs undertake for GOS, not the other skills which they exercise in other capacities. They considered that the increase in the overall remuneration paid to OMPs in respect of sight tests should be the same as the increase in the remuneration of optometrists for identical work. In view of the fact that the Review Body recommended an effective increase of 3 per cent for 1994–95 when the sight fee for optometrists had been increased by 1.78 per cent, the Departments felt that there should be no increase in the remuneration of OMPs for sight tests carried out in 1995–96.

107. The BMA remained concerned that parity had not been achieved with optometrists who conduct essentially the same test but receive a higher payment for it. It acknowledged that some but not all optometrists might incur higher overheads than OMPs but said that this consideration should have no bearing on the net sight test fee paid to OMPs. It also said that a large proportion of optometrists were employees of individual or chains of opticians and therefore had no expenses to pay themselves. The BMA commented on the role of OMPs both in the early

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diagnosis and treatment of eye disease and in ensuring that costly referrals to the NHS were undertaken only where necessary. It said this should be recognised by a commensurate level of remuneration.

Comment and recommendation

108. We are unable to set the net fee of OMPs at an equivalent level to that for optometrists, as we have no information on the latter's expenses. As we have commented previously, we believe that in general OMPs operate with lower overheads than optometrists and we do not accept that the respective gross fees should be the same. We would find it helpful in our deliberations to have access to data on the expenses of optometrists in order to calculate the net sight test fee and to compare it with that of OMPs.

109. We **recommend** that the net sight test fee be increased by **2.5 per cent** in 1995–96 to £7.95.

Practice expenses

110. Using what they described as 'traditional methodology', the BMA suggested that expenses per sight test should be £2.85 in 1995–96. It also estimated the effect of a reduction in the numbers of sight tests per OMP on the overheads component of expenses. The workload enquiry showed that, after allowance for a fall in the numbers of OMPs, total sight tests were running at around 66.5 per cent of their 1988–89 level. After allowing for the impact of spreading overheads over a smaller number of sight tests, the BMA estimated that the £2.85 expenses element would rise to £3.14.

111. The BMA suggested that, as there was no current data on OMPs' practice expenses, an expenses survey similar to that carried out in 1987–88 should be conducted.

112. The Departments said that because most of their work was undertaken in medical eye centres and optometric practices, the overheads of OMPs were low and the continuing fall in inflation should mean that they were not increasing rapidly.

Comment and recommendations

113. We are grateful to the parties for supplying us with the information we requested on numbers of sight tests performed each year by OMPs and optometrists. We have noted these conclusions in framing our recommendations this year but, in the absence of up-to-date information on expenses, we do not feel confident that the current expenses element of the fee properly reflects the true position. We agree with the BMA that an expenses enquiry would be helpful to our future deliberations and we **recommend** this be set up. We hope the study will also reflect the expenses of optometrists, so that a true comparison between the expenses of the two groups can be made (see paragraph 108 above). We look forward to seeing the results of the enquiry, together with comments from the parties, in evidence to our Twenty-Sixth Review.

114. We **recommend** that the expenses element of OMPs' remuneration be increased to £2.77.

Fee for domiciliary visits

115. The Departments told us that OMPs carried out 4.2 per cent of domiciliary visits paid for by the NHS in 1993–94. The Departments said that as OMPs and optometrists provided the same domiciliary service they should receive the same domiciliary fee. They told us that the Review Body's recommendation to increase the fee by 3 per cent in its Twenty-Third Report had endangered this parity, although they subsequently informed us that optometrists had also been awarded the 3 per cent increase. For 1995–96, we were asked not to increase the fee.

116. We were informed that the Health Departments and the profession were now discussing a restructuring of the domiciliary visit fee for optometrists but that the BMA did not support an extension of the restructuring proposals to OMPs.

Comment and recommendation

117. In our Twenty-First Report we commented that OMPs should not necessarily be equated with optometrists for the purpose of domiciliary visit fees. Optometrists and OMPs do not necessarily share the same working patterns or practices for their domiciliary visits, with the former, for example, placing some emphasis on bulk testing in residential homes. Optometrists are not part of our remit group, and the

question of fee parity for domiciliary visits is a matter for the Departments and the professions to determine. For OMPs, we **recommend** an increase of **2.5 per cent** in the fee for domiciliary visits.

Chapter 6

General Medical Practitioners

The remuneration system

118. The Departments told us that the remuneration system was coping well and had now settled down following the introduction of the 1990 contract. Against that background, the present year had focused on service developments, particularly aimed at allowing GMPs to make better use of their time and at addressing concerns expressed by the profession.

Manpower

119. The Departments said that the number of GMP unrestricted principals had increased by 1.2 per cent in the year to 1 October 1993, whilst the average number of patients per GMP had declined. The proportion of GMPs who did not work full-time had continued to increase. The Departments said there was no problem with recruitment to GMP principal posts.

120. The BMA told us that it remained concerned that the current levels of recruitment were insufficient to ensure that general practice could fulfil its pivotal role in the reformed NHS. The BMA further commented that recent net increases in the number of GMP principals had been caused by fewer doctors leaving general practice rather than more doctors joining.

Comment

121. We have seen no evidence of recruitment and retention difficulties which would justify special treatment for GMPs this year in regard to our recommendations on remuneration. The position regarding GMP trainees gives us cause for concern, however, and we address this problem in paragraphs 161–165 below.

Workload

122. In our Twenty-Third Report, we commented on the interim results from the 1992–93 GMPs' workload survey, the first undertaken since the introduction of the 1990 contract. The interim data showed that the average number of weekly GMS hours had increased by 3.5 hours or 9.4 per cent from the previous survey in 1989–90. We have now received the final results of the survey, which show that workload has risen by a lower amount: by 1.8 hours or 4.9 per cent. GMPs work an average 38.8 hours per week on GMS activity or 58.0 hours per week, including time spent being personally on-call but not actually providing GMS services. In 1989–90, the comparable figures were 37.0 and 60.5.

123. The Departments observed that two-thirds of the increase was accounted for by the change in categorisation of educational courses between the 1989–90 survey and the 1992–93 survey. They said that, comparing like with like, the actual increase in workload was 2 per cent. They also noted that by 1993–94 there had been a real terms increase in remuneration since 1989–90 of over 14 per cent, made up of the increase of 6 per cent in Intended Average Net Remuneration (IANR), and the payments outside IANR.

124. The BMA said that target payments were not intended to recognise the workload involved in reaching target levels of coverage but were instead a performance related bonus to recognise high achievement. Therefore, it said, it would be quite wrong to offset target payment income against the results of the workload survey. The BMA also argued that an adjustment to the survey results

for post-graduate education courses was not needed as these had now been incorporated into General Medical Services and therefore represented a genuine increase in GMS activity since 1990.

Comment

125. There is no specific relationship between changes in workload and the amount we recommend for an increase in GMPs' remuneration. We balance the results of workload surveys against many other factors, including recruitment and retention, morale, pay levels of other professions and the various economic indicators. This year we have looked carefully at the final results of the 1992–93 workload survey. Whilst we acknowledge the BMA's case that the volume of work for GMPs has increased since the previous survey in 1989–90, we have noted that the final results have indicated a lower workload than that suggested by the interim findings which we took into account last year.

126. We do not find the profession's arguments concerning target payments and post-graduate education courses at all persuasive. First, an increase in IANR for the extra workload for meeting target payments would reward most GMPs (the vast majority are now meeting the higher targets) twice for the same work; and second, hours spent on post-graduate education do not represent additional work but have simply been redefined as part of GMS, and there has been no loss of pay in that process.

Morale

127. Following our comments on GMPs' morale in our Twenty-Third Report, the Departments informed us that they had identified a number of contributory factors. Prominent among those were: out-of-hours arrangements; violence against GMPs; bureaucracy; and patient expectations. The Departments said that, over the last year, they had taken steps to address each of these concerns.

Comment

128. We welcome the Departments' initiatives, although we have seen little during the course of our visits programme to suggest that the general level of GMPs' morale has improved to any significant degree. We have noted the Departments' comment that it is too early to gauge the success of the steps taken.

129. In our Twenty-Third Report, we commented that among the factors contributing to GMPs' low morale was the way some elements of their remuneration were structured and we drew attention to the differentiation in out-of-hours fees and the criteria for deprivation payments. For our present review the parties have submitted evidence to us on these issues, which are discussed in the following paragraphs.

Out-of-hours arrangements

130. The BMA informed us that, throughout the past year, out-of-hours work had been the main subject of negotiations between the General Medical Services Committee (GMSC) and the Health Departments. Contractual changes had been agreed including an amendment to GMPs' terms of service, making it clear that a home visit was neither the most appropriate nor the required response to every out-of-hours contact. Instead the new emphasis was on providing a clinically appropriate response for patients, with doctors deciding whether a patient's medical condition required a consultation and, if so, when and where this should take place. For the first time it was to be made explicit that options included seeing a patient at the surgery or a primary care emergency centre rather than at the patient's home. Terms of service had also been amended to make all GMP principals acting as deputies directly responsible for the care they give to patients.

131. The BMA said that the agreed changes needed to be supported by changes in the way out-of-hours services were remunerated. It said the present system of fees and allowances was unsatisfactory on two counts. First, there was no identifiable sum of money attributable to out-of-hours work other than night visit fees; and second, the present night visit fee structure (with the higher fee payable only for home visits by a patient's own GMP or member of small rota) provided a perverse incentive and militated against the introduction of a more flexible, clinically appropriate method of providing out-of-hours care.

132. In October 1994, the Departments told us during oral evidence that they were hoping to submit to us joint supplementary evidence on a revised structure for fees for services provided at night and the cost parameters within which the revised arrangements would operate. On 21 November 1994, the BMA informed us, however, that the Departments' package of proposals had been rejected outright by its General Medical Services Committee. On 12 December, the BMA wrote to us saying that there was no prospect of reaching agreement with the Departments unless new money was brought into the existing pool of remuneration. It asked us to price separately the out-of-hours part of the GMP's contract.

Comment

133. In our Twenty-Third Report, we commented that present out-of-hours arrangements had built up to a serious grievance for a large number of GMPs. We are disappointed that there has so far been no agreement between the parties on a revised fee structure for out-of-hours services, the more so since they had both told us during their respective oral evidence that such agreement seemed likely.

134. We have noted the Departments' intention to continue discussions with the profession. Pending the results of these talks, we have decided to defer the setting of the 1995–96 fee scale for GMPs. We intend to meet in March 1995 to appraise developments, with a view to producing a supplement to our Twenty-Fourth Report.

Deprivation payments

135. The Departments told us in very late supplementary evidence that Ministers had decided to implement 1991 Census data within the deprivation payments scheme in 1995–96. The Departments commented that deprivation payments were designed to recognise additional workload associated with under-privileged areas, and to provide an incentive within the pay system to ensure that GMPs in those areas are adequately compensated. They said that the increase in the proportion of the population living in 'under-privileged' areas simply indicated a change in the relative distribution of GMPs' workload, as any absolute increase had already been counted in workload surveys and compensated for in levels of IANR. They commented that the existing proportion of Intended Average Gross Remuneration (IAGR) taken up by deprivation payments was sufficient to recognise the workload effects and to secure recruitment and retention of GMPs in under-privileged areas.

136. The Departments suggested that, in order to help those doctors who would suffer variations in income because of the new fee structure, the new data could be introduced so that doctors bore only half of the financial effect of the change in the first year. They suggested the new fees for deprivation should operate from 1 October 1995.

137. The BMA observed that the 1991 Census data had shown an increase in the numbers of the population living in areas which attracted deprivation payments, as compared with the 1981 Census data. It argued that the new data provided grounds for additional remuneration for deprivation payments funded from an appropriately higher IAGR. The BMA commented that it would be inappropriate for those general practitioners working in other areas to fund increased deprivation payments since there has been no suggestion that their workload had decreased. It told us that it thought the revised contractual arrangements introduced in 1990–91 had been underpriced, due to the lack of up to date information on which to base deprivation payments. It referred also to a qualitative dimension to the work of doctors in areas of deprivation, exacerbated by the increase in patient numbers.

Comment and recommendations

138. The main effect of the implementation of the 1991 Census data is to increase the number of patients for whom deprivation payments are made. Under the Departments' proposals, the increase would be funded by *reductions* to the fees currently payable to doctors in areas of deprivation. We do not regard such a measure to be appropriate. Our recommendations are intended to ensure that, rather than being reduced as proposed by the Departments, the present scale of deprivation payments should be modestly increased in line with the rises in other fees. The aggregate cost of deprivation payments will, however, be increased as a consequence of the decision of the Departments to bring the new Census data into the scheme. We propose to deal with this through two measures for 1995–96: first, **through an appropriate increase in the level of IANR**, part of which will be specifically

targeted to deprivation payments in our recommendations on the fee scale (see paragraph 134); and second, **through recommending no increases to the levels of target payments in the coming year**.

Payments outside IANR

Comment

139. Target payments to GMPs were introduced in our Twentieth Report (1990) which anticipated the introduction of the GMP's new contract from 1 April 1990. In that report, we commented that once the target payments schemes had been in operation for some time, it would be possible to determine the take up of the higher payments and to review whether or not they should remain outside average remuneration[1].

140. We now know that nearly 90 per cent of GMPs achieve the higher targets, although we have observed that some (such as those in deprived areas) do so with significantly more difficulty than others. We now wish to consider whether the scheme requires modification in the light of present circumstances. In our Twenty-Sixth Review, we intend to review both the level and the nature of these payments and whether they should be consolidated into IANR. We invite evidence on this issue from the parties.

IANR on a whole-time equivalent basis

141. The Departments have suggested to us that IANR should, from 1996–97, be based on average GMP whole-time equivalents (WTE), instead of an average GMP as at present. They have asked us to agree that the 1995-96 award should form the baseline for converting future awards to a WTE basis. They said the proposed new approach would have several advantages: first, it would reflect the changing nature of the workforce and the increase in part-time GMPs (in 1993–94, nearly 10 per cent of GMPs were contracted for less than full-time); second, it would give a clearer basis for comparison with full-time hospital doctors; and third, comparisons over time would not be distorted by changes in the make-up of the workforce, particularly for measures of workload.

142. The BMA argued that the Technical Sub-Committee had agreed in 1990 that the best way to deal with increases in part-time GMPs was to rely on workload studies to determine the workload of an average GMP. The BMA also observed that: (i) flexible working was not an innovation; and (ii) WTE was not a suitable concept for GMPs who are not salaried and do not work a fixed number of hours. There was no definition of a whole-time equivalent GMP and no obvious number of hours which could be said to equate to full-time.

Comment

143. We are attracted by the Departments' proposal. With a significant proportion of GMPs contracted for less than full-time and with women now comprising around 50 per cent of the intake to medical schools, it seems to us realistic to base our recommendation on a WTE. From 1996–97, we intend to recommend on the level of IANR appropriate to whole-time equivalent GMPs. We will base that recommendation on practitioners working **full-time** for the NHS and we wish to receive relevant joint evidence from the parties to our next review.

Payments to course organisers for GMP training

144. The parties told us that they had agreed to remove a restriction which prohibited the payment of the trainer's grant to general practice trainers who are also course organisers. The parties also agreed that there were no consequences for GMPs' workload or practice expenses and funding of the new arrangement should be from within the existing remuneration pool.

Comment

145. The new arrangement has ramifications for the GMPs' fee scale in 1995–96. The parties have estimated that the change will increase the number of claims for the trainer's grant by 55 above current levels. Our recommendation on the fee scale in the supplement to this report will make due allowance.

Dispensing doctors' discount rate

146. The Departments told us in supplementary evidence that a discount enquiry, conducted on behalf of the parties, had found that, on average, dispensing doctors were able to obtain a discount on their purchase of drugs and appliances of just over 8 per cent. This discount compared with a rate of just under 5 per cent which

[1]The difference between the higher rate and the lower rate is excluded from average remuneration.

had been assumed during the past decade and which the present discount scale had been designed to reflect. We were told that the Prescription Pricing Authority data for England had indicated that in 1993–94 the average discount per prescription item that was applied was, in fact, 7.1 per cent. The evidence of the enquiry did not support any change to the scale rates applied to Scotland.

147. The Departments said that they intended to revise the discount scale rates from 1 April 1995 to reflect more closely the evidence of the joint enquiry. They said that the new scale rates would be applied in England and Wales only.

148. The Departments said that they estimated that implementation of the new discount rates released around £6 million from directly reimbursed expenses. They said that while the new discount scale affected only the direct reimbursements paid to GMPs it did, however, have implications for our work in pricing fees and allowances. The profession's total GMS expenses, they said, were reimbursed either through direct reimbursements, or through the indirect expenses element of IAGR which fees and allowances delivered. If £6 million of total expenses was no longer to be delivered through the direct reimbursements for drugs and appliances, then other reimbursements would need to be increased by that amount to ensure reimbursement to the profession of their expenses in full.

149. The Departments said that, as part of the package on out-of-hours cover, Ministers were proposing to make available some £6 million in Great Britain in 1995–96 through GMS cash-limited funds to support the costs of GMP co-operatives. The GMSC had not been able to accept the proposed package in its existing form. The Departments said that discussions between the parties were continuing, and in the meantime they suggested that we should make no adjustment to the forecast for expenses to include the £6 million from the dispensing doctors' discount.

150. The BMA said that the impact of the existing arrangements for drug discounts had been to deprive practitioners generally of the correct level of indirect expenses. This was due to over-reimbursement of direct expenses elsewhere in the system.

Comment

151. We have noted the parties' views. The changes intended by the Departments to the drug discount scale from 1 April 1995 will provide a more appropriate level of direct reimbursement to the dispensing doctors concerned, following the results of the discount enquiry. It is clear to us that, under the present arrangement, GMPs generally have been subsidising those of their colleagues who receive direct reimbursement for dispensing. In our recommendations for the fee scale in 1995–96, we intend distributing the available £6 million through our estimate of indirect expenses.

Local flexibility

152. The Departments told us that they were building on substantial performance related elements already within the GMP contract so that pay reflected the standard of care being provided by the GMP. This included both the capitation payments, where GMPs who were able to attract more patients received higher income, and target payments linked to achieving specific targets for service delivery to patients. They also told us that those performance elements in the contract were backed up by the flexibility FHSAs had to provide support to GMPs, according to practice needs, through use of cash-limited funds.

153. The BMA said that, given the pool system of remuneration, it would be inappropriate to adjust national criteria for payment to reflect local circumstances. They felt that this would simply open the way for individual FHSAs to draw in higher remuneration for some GMPs at the expense of colleagues elsewhere.

Comment

154. In our recent reports, we commented that the parties should make progress on making the remuneration system for GMPs more sensitive to local circumstances and requirements. In Chapter 1, we questioned why the Departments were not pursuing a consistent policy on local pay determination for all doctors and dentists. Working patterns and conditions vary considerably among practices and we again urge that FHSAs be given discretion for setting local criteria and payment levels for items such as immunisation, cervical cytology, health promotion and deprivation.

Dispensing in rural areas

Comment

155. It has come to our attention that some GMPs in rural areas have lost their licences to dispense drugs as a result of the requirements under present regulations for FHSAs to allow new pharmacies to be set up in the same locality. We are concerned that such a loss of dispensing rights by a rural practice, especially after a long period of time, leads to an abrupt and significant loss of income to the practice, a deterioration in the accustomed service to patients and an increase in the dispensing cost to the NHS.

156. We understand there are other anomalies in the present dispensing regulations which are currently the subject of discussions between the GMSC and the Departments. With the introduction of budget holding practices, the greater emphasis on patient choice and the encouragement being given to doctors to adopt a more commercial approach in the management of their practices, it would be sensible for a thorough review of dispensing regulations to be undertaken.

Fundholding

157. During the course of this review, we decided to question whether the development of fundholding among GMP practices had affected average remuneration and we requested joint evidence from the parties. We were told that GMPs' work on fundholding did not attract a specific allowance, but that associated expenses were recognised in two types of reimbursement specifically for fundholding purposes. These took the form of (i) a management allowance to reimburse the practice for the extra costs incurred in managing a fund and to provide for the cost of locum care for the time GMPs spent on fundholding duties and (ii) computer reimbursement to meet part of the costs of installing the obligatory fundholding computer systems.

158. The parties informed us that the system allowed for the transfer of money from fundholders' budgets into practice accounts, but that the joint Technical Sub-Committee (TSC), in considering the effects of fundholding for the GMS remuneration system in 1990–91 and 1991–92, had concluded that fundholding had made no significant impact for those years. We were told that the TSC was currently studying the potential effects of GMP fundholding on GMS remuneration in 1992–93 and, in particular, of the impact of the accounting treatment of capital purchases reimbursed through the management allowance or from savings. The parties have made us aware, however, that there are three routes by which money from fundholders' budgets may transfer into practice accounts: (i) the staff element is paid from the fundholding account into the practice account to reimburse staff costs. Additional staff under the GMS practice staff scheme must be approved by the FHSA exactly as for non-fundholders, but fundholders may additionally vire in-year from other elements of the fund, or use year-end audited savings to reimburse the costs of employing additional staff to provide non-GMS services; (ii) savings may be used to fund approved investments in primary care, for example to purchase additional services, buy equipment for the surgery or to improve the premises for the benefit of patients; and (iii) fundholders, from April 1993, are permitted to be reimbursed from the fund for providing a limited list of non-GMS services for their patients. This is similar to the freedoms all GMPs have to be in contract with a District Health Authority to provide some non-GMS services, and will generate extra income for the practice.

159. The parties said that Ministers were currently considering options for expanding and extending the fundholding scheme. The NHS Executive was also conducting a review of the existing system of management and computer allowances for fundholders.

Comment

160. We have noted the parties' comments. There is no firm evidence to suggest that fundholding has as yet had significant direct impact on GMPs' remuneration although it is evident to us that fundholding practices benefit from the arrangements described above. Fundholding is continuing to expand among the GMP population and we welcome the further appraisal by the Technical Sub-Committee referred to in paragraph 158. We would like to be informed of the conclusions of that appraisal and intend to monitor the impact of fundholding on GMPs' remuneration in our future reviews.

GMP trainees

161. The BMA again asked us to increase the out-of-hours supplement payable to GMP trainees in order to restore their pay relativity with junior hospital doctors. The BMA said that hours worked by GMP trainees were not relevant to its case and that it had therefore declined the Departments' invitation to join in a workload survey of trainees' hours (as we had suggested in our Twenty-Third Report). The BMA observed that the issue was one of the propriety of maintaining steady earnings during a period when, in the interests of the NHS as a whole, young doctors moved between training posts in the hospital service and general practice. It was pointed out to us that the fall in income experienced in the trainee's general practice year was over £5,000. The BMA said that it had received worrying reports of difficulties in recruiting sufficient trainees for vocational schemes.

162. The Departments acknowledged a reduction of 5 per cent in the number of trainees on attachment to general practices since 1992, but commented to us that past fluctuations in trainee numbers had not prevented a continuing increase over the years in the number of GMP principals. The Departments provided for us the results of a survey of GMP training places, which they concluded were consistent with their view that the current supply of trainees was sufficient to maintain GMP recruitment at a satisfactory level. They observed that regional advisers were still able to fill places on vocational training schemes with good quality candidates, notwithstanding a reported fall in the number of applicants.

163. The BMA said that the survey data were not comprehensive and provided little evidence of trends over recent years. It observed that one in eight places on vocational training schemes remained unfilled and that the comments from regional advisers showed that both the quantity and quality of applicants for vocational training had fallen.

Comment

164. We consider the survey results to be inconclusive, as only 13 substantive responses were received from 21 regional advisers and very few of these were complete. From our own appraisal of the comments from regional advisers we do, however, share the profession's concerns about the quantity and quality of applicants even allowing for the fact that the related evidence was anecdotal. We do not, however, accept the BMA's argument concerning pay relativity between GMP trainees and junior hospital doctors. We repeat the comments made in our Twenty-Third Report that the case for any increase in the trainee's supplement should be assessed on its own merits and not as an automatic consequence of changes to junior hospital doctors' out-of-hours arrangements. Nevertheless, we have found it difficult to discount entirely the BMA's observation about the large drop in pay for trainees when they embark upon their period of training in general practice, particularly as this year we have recommended an increase in the on-call rate for senior house officers and house officers (see Chapter 3). That consideration, taken alongside our concern over recruitment, has weighed heavily in our recommendation on the level of the GMP trainees' supplement.

Recommendation

165. We **recommend** an increase in the supplement to **17.5 per cent** of basic salary.

Intended Average Net Remuneration in 1995–96

166. This year we **recommend** an increase in Intended Average Net Remuneration of **3.0 per cent** to a level of £43,165 per annum.

Expenses provision for 1995–96

167. The Departments said that forecasting the underlying trend in GMPs' expenses since the very large increase in 1990–91 had been unusually difficult. The trends, they said, were even more difficult to interpret this year since the most recent estimated actual total (derived from the Inland Revenue survey of GMPs' accounts for 1992–93) was nearly £1,000 per GMP lower than previously forecast. They commented that the under-estimate might have resulted from sampling error in the Inland Revenue survey or through problems with the statistical forecasting model used by the Departments.

168. For their forecast of indirect expenses in 1995-96, the Departments told us that they had used a variety of formal and less formal methods. They had examined the 'step change' in expenses following on from the new contract and had concluded that the upward trend would probably revert to a lower level than that seen in the 1980s before the introduction of the new contract.

169. The Departments told us that the value of expenses in 1995–96 would probably fall within the range £21,200 to £22,000 per GMP and suggested that a forecast in the middle of the range would be reasonable.

170. The BMA told us that it had used its econometric model to forecast practice expenses and had assumed that the underlying trend (upwards) had re-occurred following the introduction of the new contract. The BMA had concluded that expenses in 1993–94 and 1994–95 were likely to be £20,636 and £21,373 respectively. It said that, assuming no increase in net incomes for 1995–96, expenses would be £21,709.

171. The BMA argued that the £6m released from the application of the dispensing doctors' discount scale should not be used to fund the cost of mechanisms for out-of-hours cover, as the Departments were suggesting. The BMA said that the use of the new discount scale implied total indirect expenses in 1995–96 of around £22,000. Each 1 per cent addition to net income would add a further £125 to the 1995–96 forecast. Bearing in mind the continued uncertainty about the full impact of the 1990 contract changes on expenses, the BMA considered that the provision to be made for practice expenses in 1995–96 should remain at £22,500.

Comment

172. We have previously commented that it is very difficult for either of the parties to forecast the future level of practice expenses. It is evident that the rate of increase in indirect expenses has slowed and that the level has been lower than expected. Moreover it is apparent that the expenses provisions in 1993–94 and 1994–95 are likely to have been too high and therefore will result in overpayments to GMPs.

173. The parties have been unable to agree on how the £6 million released from the application of the new drugs discount scale from April 1995 should be distributed among members of the profession. As we have already commented in paragraph 151 we consider it appropriate that the sum should now be included in our estimate of indirect expenses. Our recommended expenses provision for 1995–96 allows for that.

174. We have concluded that the expenses provision for 1995–96 should be £21,700.

Balancing adjustment

175. The Departments told us that overpayments from 1993–94 and 1994–95 might total some £2,120 per GMP, about £64 million overall. They predicted that, at current and forecast levels of inflation, the current rates of the balancing mechanism would take ten years to clear the amount outstanding. They said that the mechanism had been formalised in 1983 after a period of high inflation, with the expectation that IAGR was likely to provide a sizeable pool of 'new money' each year from which corrections could be made. They suggested to us that, with the current low levels of inflation, the rules of the balancing mechanism were no longer appropriate and its operation should be reviewed during the course of the coming year.

Comment and recommendation

176. Our recommendation for IANR makes allowances for changes to the deprivation payments scheme resulting from the incorporation of the 1991 Census data. We have, however, decided not to 'claw back' in 1995–96 that part of the increase in IANR that relates to increased expenditure on deprivation arising from the introduction of the new scheme (see paragraph 138).

177. We **recommend** that the balancing mechanism should operate under current rules for 1995–96 and we have decided to recover **£217** in that year.

178. We have noted the Departments' concerns about the current rules of operating the system, and invite evidence from the parties to our next review on any proposed changes for 1996–97.

Amount to be delivered through fee scale

179. The gross amount to be delivered through the fee scale is £43,165 (IANR) + £21,700 (expenses) including the £6m discount adjustment – £217 (balancing item) or £64,648.

The fee scale 180. As we have indicated in paragraph 134 above, we will report on the fee scale in a supplement to this report.

Chapter 7

General Dental Practitioners

Recommendation for 1994–95

181. Last year, we departed from our normal practice of recommending a level of Target Average Net Income (TANI) for general dental practitioners. Instead, we recommended an increase of 3 per cent in the gross fee for each item of service and capitation payment. Our recommendation was accepted by the Government and implemented accordingly.

The remuneration system

182. In our Twenty-Third Report, we commented at length on the flaws inherent in the GDPs' remuneration system and urged the parties to give the utmost priority to the development and implementation of a new scheme.

183. In July 1994, the Government published a Green Paper 'Improving NHS Dentistry', in which it set out its proposals on payments to dentists in the future. Its aims were to ensure that the system worked simply, fairly and effectively for both dentists and their patients. In the short and medium terms, the Green Paper proposed either a new sessional fee system based on payment for time spent on treating NHS patients or a reform of the present system for dental remuneration under which dentists are paid a fee for each item of service. In the longer term, the paper suggested a system of local purchasing which would allow FHSAs, or newly merged local health authorities, to decide locally about the level and type of treatments. The Green Paper indicated that the Government would consult widely, including with the dental profession, on establishing pilot studies to evaluate such a system. It observed that the running of pilot studies and a sessional fee system would require legislation. The Health Minister wrote to us on 14 July 1994, inviting our views on the issues raised in the Green Paper.

Comment

184. In our response to the Health Minister we commented that, until a credible remuneration system was in place for GDPs, our recommendation on net incomes could only offer a degree of 'rough justice' both to the profession and to the taxpayer and we would not wish these temporary arrangements to continue for any longer than was absolutely necessary without our having a clear and agreed basis for determining dentists' pay. We are concerned at the absence of any resolution of this important issue. The longer the present situation is allowed to continue, the greater the risk that dentists' pay will be at an inappropriate level, increasing the difficulties involved in moving to whatever long term remuneration system is adopted.

185. In our response we also noted the proposed pilot studies and the need for their evaluation and confined further comment to the Paper's proposed interim changes. We thought it a matter for the Government, rather than the Review Body, to weigh up the pros and cons of the two options outlined in the Paper, following consultation with the parties concerned. However, we thought it helpful to set out basic design features which should be inherent in any new system in order for it to operate effectively and to enable us to carry out our task of recommending on dentists' net remuneration. We listed those features as: (i) the system should be seen to operate fairly, and the complexities (and sometimes perverse results) of the existing pay system based on TANI should be eliminated; (ii) net recommended

income should be capable of being delivered to the average dentist within a reasonable margin of tolerance (if fee scale option is chosen); (iii) any new system should incorporate improved forecasting of dentists' output and expenses; (iv) the need for retrospective 'balancing' should be minimised; (v) the new system should be based on a dentist working full-time for the NHS; (vi) unnecessary change in the short term should be avoided; (vii) the system should make allowance for differing local circumstances; (viii) the issue of dentists' capital investment in their practices needed to be addressed; (ix) the individual dentist should be able to make reasonable predictions of his or her annual income according to their contribution to the NHS; (x) the chosen system must be capable of recognising the intermingling of expenses incurred in dentists' private and NHS work and its effect on their remuneration; and (xi) the option selected should be consistent with maintaining dentists' current self-employed status. We also suggested that the Government should publish the criteria by which it would judge the performance of the specific option adopted.

Manpower, recruitment and retention

186. The Departments informed us that the number of dentists in the General Dental Service in Great Britain at 31 March 1994 was at an all time high of 18,758. They said there was an upward trend in the number of dentists coming forward to provide NHS work compared to those leaving the NHS.

187. The Departments said that the number of both adult patients and children registered was close to an all time peak. Some dentists were still limiting their commitment to NHS dentistry, but the Government's monitoring had shown that whilst General Dental Services were maintained in most areas, there were local pockets where there were shortages of dentists offering NHS services. They said that there was no overall availability problem for NHS dental services which could not be resolved by FHSAs locally.

188. The BDA said that figures from the Universities and Colleges Admissions Service continued to show that school leavers did not see dentistry as an attractive profession to enter. The BDA commented that a ratio of about two applicants per place was not enough to give the dental schools the choice of applicants that they felt they needed.

Comment

189. As we have commented in Chapter 1 we have seen no evidence, either from UCAS or from other sources, to suggest that there is a shortage of quality applicants coming forward for the dental profession. We have noted the Departments' view that local difficulties regarding NHS dental provision could be resolved through action by FHSAs. We think that sensible and do not regard such problems as justifying preferential treatment for GDPs generally this year. We will continue to monitor the position in our future reviews.

Morale and motivation

190. The BDA drew our attention to poor morale among members of the dental profession, arising from the delay in the Government's response to the Bloomfield Report[1] and the continuing uncertainty about how dentists should be remunerated, both in the long and short term. The BDA asked us to recognise low morale in our recommendations for 1995–96.

Comment

191. We have sympathy for the profession's concerns. As we comment below, we believe our recommendations last year succeeded in bringing a greater degree of stability into the present dental remuneration system, at least in the short term. We understand dentists' feelings of uncertainty about how that system will evolve, following the publication of the Green Paper, but we do not think their low morale would be resolved through any preferential treatment this year on their levels of remuneration. We believe dentists' concerns should best be addressed through the early implementation of a new system of remuneration which would include the characteristics we have outlined in paragraph 185 above.

Expenses and earnings

192. The parties provided joint evidence showing data on GDS earnings and expenses of dentists over recent years up to 1992–93. We were also provided with monthly figures of gross fee payments, up to October 1994.

[1]'Fundamental Review of Dental Remuneration'—Report of Sir Kenneth Bloomfield, December 1992.

193. The parties gave us their separate views on expenses for the years since 1992–93. The Departments suggested that expenses would be low for several reasons. They cited first, the low levels of inflation across the economy as a whole; second, the low level of wage inflation, for example the pay of British dental surgery assistants; and third, the evidence of discounting by the dental laboratories and dental supply houses. The Departments said that dental consumables fluctuated considerably in price, for example, due to changes in the price for precious metals and to changes in exchange rates. They said, however, that exchange rates had been steady over a recent period and there was no reason to expect significant change in that factor.

194. The BDA argued that the ratio of expenses to gross income in 1993–94 and 1994–95 would be higher than in 1991–92 and 1992–93, and could be expected to fall within the long term normal range of 58–59 per cent. The BDA also told us that increased health and safety precautions, such as sterilisation measures to prevent cross-infection, had led to increased expenditure on laboratory costs and therefore higher expenses.

195. The Departments told us that, since 1 April 1994, volumes of treatments had begun to increase steadily and they anticipated that volume could grow by up to 2.5 per cent this year. They said that the combined effect of such a volume growth on top of the fee scale change would be to generate a significant increase in dentists' gross earnings, thus tending to destabilise the system once more.

196. The BDA argued that the volume of treatment being produced by GDPs had been stable since mid 1993. From its forecasts of gross payments and expense levels, it suggested to us that dentists' net incomes would have fallen short of TANI in 1993–94 and would probably fall below the level of what they described as 'implied TANI' in 1994–95.

Time-lag

197. The profession made reference to our recommendation last year to increase the GDPs' fee scale by 3 per cent from 1 April 1994. It told us that our recommendation did not mean that there were immediate increases in payments to dentists, as dental treatment was paid for according to the date on which a contract was entered into with the patient. The parties agreed that about 25 per cent of payments made in 1994–95 would be on the pre 1 April 1994 fee scale. The BDA asked us to take this time-lag, inherent in the dentist payments system, into account in making our recommendation for 1995–96. It suggested that we should recommend increasing *all* payments in 1995–96 (rather than fees for courses of treatment started on or after 1 April) and set the increase without taking account of the tail of payments from 1994–95 which would still be feeding through in 1995–96.

198. The Departments argued that there were time-lags each year which meant that each year's earnings were boosted by the lag effect of the year before. They said that if we were to ignore this fact in any one year the system would be distorted. They pointed out to us that alternative methods to eliminate time-lags had implications for patients' charges and public expenditure. They said that patient charges were calculated with reference to the fees in operation when treatments started and to uprate the dentists' fee for that treatment subsequently would result in extra cost to the Government.

Level of remuneration for 1995–96

Comment

199. We have noted the parties' comments and we have studied carefully their joint evidence on expenses and earnings. In recommending on gross fees last year, our purpose was to relate the remuneration of GDPs directly to the amount of work they carried out and to protect its value against inflation. Firm data on dentists' expenses in 1994–95 are not available to us and the parties' forecasts are necessarily speculative, but we have seen nothing in the evidence presented to us, including that on the time-lag effect, to suggest that dentists' average net income for that year will fall short by any significant amount from what was appropriate in the circumstances.

200. In the absence still of a new remuneration system being in place for 1995–96 the parties have suggested to us that, as an interim measure, our recommendations should be made on the same basis as last year. We do so, but with the strong reservation expressed in paragraph 184 above. In our recommendation, we have considered the evidence from the parties on the time-lag and we do not propose any change in the timing arrangements for the introduction of the new fees.

Recommendation

201. For the coming year we are continuing to recommend on the gross fee scale. Our intention, like that for last year, is to relate GDPs' income directly to the amount of work they do, and to protect its value against inflation over the coming year. We believe that the present fee scale, which we recommended from 1 April 1994, has provided a fair basis for dentists' remuneration and has brought some much needed stability into the system. **We recommend that the gross fee for each item of service and capitation payment is increased by 2.5 per cent in 1995–96.**

Emergency dental services

202. We **recommend** that the sessional fee for taking part in emergency dental services be increased by **2.5 per cent**.

Salaried dental practitioners

203. We **recommend** a **2.5 per cent** increase for salaried dental practitioners.

Chapter 8

Dental Public Health and the Community Dental Service

Manpower

204. The total number of community dental staff in Great Britain decreased from 1,820 to 1,780 in the year to 30 September 1993, according to the latest figures. The table in Appendix B shows the changes in individual grades between 1992 and 1993.

General developments in the service

205. The Health Departments told us that the Green Paper 'Improving NHS Dentistry' envisaged that the Community Dental Service (CDS) 'safety net' role would continue to be a vital part of the provision of dental services. The BDA welcomed the Government's commitment to a strengthening of the safety net role for the CDS and it hoped that the proposals in the Green Paper would go some way to alleviating uncertainties about job security.

206. The BDA described to us the changes which had recently taken place in the Community Dental Service. It said that the service had developed significantly and had retained responsibility for: monitoring the dental health of the population; the provision of dental health education and preventative programmes; the provision of treatment for special categories of patients; and the screening of children's teeth in state funded schools. The BDA said that the provision of Community Dental Services was now firmly established within NHS Trusts, which provided services, including community dentistry, to local populations.

Local pay arrangements

207. We have commented on the proposed introduction of local pay arrangements for these groups in Chapter 1.

Dental public health

208. The BDA told us that there were at least 40 consultants in dental public health posts. Dental public health staff had responsibility for assessing dental health needs, advising on the procurement of services to meet those needs, monitoring the delivery of services and giving dental advice to the purchasing authority. It said that the setting of national targets for oral health within the recently published 'Oral Health Strategy' would need to be reflected locally, and the responsibility for this would fall on those dentists working for purchasing authorities.

Management of the Community Dental Service

209. The BDA told us that the responsibilities of those who managed the delivery of Community Dental Services included staffing, budgetary control and health and safety. In addition they needed to be skilled in business planning, in negotiation with purchasers and in the provision of dental advice to the NHS Trust in which they worked. Managers of Community Dental Services had also been extensively involved in preparing and presenting bids to win the contracts for dental services.

Senior dental officers

210. In our Twenty-Third Report we suggested that the parties agree appropriate terms of reference for a comparative evaluation of the work of both senior dental officers and associate specialists, conduct such a study and provide joint evidence for this review. The parties told us that progress had been made in setting up the study and that they hoped to submit joint evidence to our next review.

Comment

211. We are pleased to note that at least some progress has been made on this long standing issue. It is of some concern to us that yet another year will have passed, however, without the matter being finally resolved. We look forward to receiving joint evidence to our next review.

Training allowance for supervision of undergraduate dental students

212. In our Twenty-Third Report, we commented on the profession's claim for an allowance to be paid to dental officers who supervise undergraduate dental students. An allowance is already payable to those in the grade who supervise vocational trainees. We suggested that the parties carried out an appraisal of the relative work and responsibilities of those dental officers involved in both types of training.

213. The BDA commented on a survey, conducted by the parties, of the duties and responsibilities of community dental officers with training responsibilities. The BDA said that the survey had indicated that the additional responsibilities of community dental officers acting as supervisors of undergraduate dental students were equivalent to those of officers supervising vocational trainees.

214. The Departments observed that the majority of dental officers did not have to work additional hours as a result of the supervision of undergraduate students, but otherwise confirmed that the BDA had provided a fair and accurate summary.

Comment and recommendation

215. The allowance currently paid to dental officers recognises their additional responsibilities over those normally required for the basic grade. **We recommend the allowance be extended to dental officers supervising undergraduate dental students from 1 April 1995**. The allowance is only payable to those in the basic dental officer grade.

Level of remuneration increase

216. We **recommend** the pay of dentists in dental public health and the Community Dental Service be increased by **2.5 per cent**. The recommended salary scales are set out in Appendix A.

Chapter 9

Summary of Main Recommendations

217. The factors we have taken into account in reaching our recommendations on the levels of remuneration we consider appropriate for doctors and dentists in the NHS as at 1 April 1995 have been set out in the previous chapters.

218. As we have explained in Chapter 2, our recommendations for consultants allow for both the parallel running of a national pay scale and for local pay arrangements to be determined at local level. We have made it clear that, during the transition from central to local pay determination, there must be central monitoring of pay settlements so that costs remain under control and health provision is safeguarded. We consider it essential that local pay determination should take into account the quality of patient care and we have suggested that consultants locally should be closely involved in the decision making process.

219. Our proposed introduction of a system of *transitional local pay* (where Trusts and other units are unable to agree other local arrangements with the professions) incorporates recommendations on a *minimum* salary level of £40,620 and a *maximum* percentage increase of *5 per cent* in the *average* salary level for hospital consultants. These are effective from 1 April 1995. The system does not extend to consultants in public health medicine and community health or to those in dental public health or the Community Dental Service. It does not apply to grades other than consultants.

220. In the absence of a workable system for setting GDPs' remuneration, we have again recommended on their fee scale. We have done so with the considerable reservation that we would not wish these temporary arrangements to continue for any longer than was absolutely necessary without our having a clear and agreed basis for determining dentists' pay.

221. Our main recommendations are as follows:

Grade	*Point on scale*[1]	*Recommended basic scales 1 April 1995* £
Hospital doctors and dentists — main grades (whole-time salaries):		
House officer	minimum	13,930
	maximum	15,730
Senior house officer	minimum	17,380
	maximum	22,060
Registrar	minimum	19,705
	maximum	23,910
Senior registrar	minimum	22,705
	maximum	28,730
Staff grade practitioner	minimum	21,725
	maximum	32,375
Associate specialist	minimum	24,085
	maximum	41,900
Consultant	minimum	40,620[2]
	maximum	52,440[2]
Community health and community dental staff — selected grades (whole-time salaries):		
Clinical medical officer	minimum	20,775
	maximum	28,895
Senior clinical medical officer	minimum	29,640
	maximum	42,555
Dental officer	minimum	19,805
	maximum	29,100
Senior dental officer	minimum	29,100
	maximum	39,340
General medical practitioners — intended average net remuneration[3]	From 1 April 1995	43,165
General dental practitioners	The gross fee for each item of service and capitation payment should be increased by 2.5 per cent from 1 April 1995.	

[1] Salary scales exclude additional earnings, such as Additional Duty Hours for doctors in training.

[2] Applicable to consultants remaining on national pay scales.

[3] GMPs receive payments for reaching higher targets which are outside IANR. It is estimated that GMPs will receive, on average, approximately £3,150 from these payments in 1994–95.

222. We **recommend** an increase in the out-of-hours on-call rate for house officers and senior house officers from 50 per cent to 52.5 per cent.

223. For general medical practitioners we **recommend** *no increase* in the level of target payments for 1995–96.

224. We **recommend** an increase in the supplement payable to GMP trainees from 15 per cent to 17.5 per cent.

225. We **recommend** an allowance of £1,240 per year payable to community dental officers responsible for training undergraduate trainees. This is an extension of the allowance already payable to dental officers supervising vocational graduate training.

226. We **recommend** increases in the numbers of the distinction and meritorious service awards. Full details of these and all other recommendations on remuneration are in Appendix A.

BRANDON GOUGH (*Chairman*)
DOUGLAS T BOYD
TINA BOYDEN
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OFFICE OF MANPOWER ECONOMICS

10 January 1995

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 1995*
	(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades and the performance supplement for associate specialists)	
	£	£
House officer	13,590	13,930
	14,470	14,830
	15,350	15,730
Senior house officer	16,960	17,380
	18,100	18,550
	19,240	19,720
	20,380	20,890
	21,520	22,060
Registrar	19,225	19,705
	20,200	20,705
	21,175	21,705
	22,150	22,705
	23,325	23,910
Senior registrar	22,150	22,705
	23,325	23,910
	24,500	25,115
	25,675	26,320
	26,850	27,525
	28,025	28,730
Consultant[1]	39,625	40,620
	42,510	43,575
	45,395	46,530
	48,280	49,485
	51,165	52,440
Associate specialist	23,500	24,085
	26,055	26,705
	28,610	29,325
	31,165	31,945
	33,720	34,565
	36,275	37,185
	39,675	40,665
	40,880	41,900

[1]For details of our *transitional local pay* scheme, see Chapter 9, paragraph 219.

	Current scales	*Recommended scales payable from 1 April 1995*
	£	£
Staff grade practitioner	21,200	21,725
	22,930	23,500
	24,660	25,275
	26,390	27,050
	28,120	28,825
	29,850	30,600
	31,580	32,375
	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)	2,895	2,965
Hospital practitioner (limited to a maximum of 5 half day weekly sessions)	2,820	2,890
	2,980	3,055
	3,140	3,220
	3,300	3,385
	3,460	3,550
	3,620	3,715
	3,780	3,880

B. Public health medicine staff

	Current scales	*Recommended scales payable from 1 April 1995*
	(excluding earnings from out-of-hours supplements for trainees)	
	£	£
Trainee in public health medicine	19,225	19,705
	20,200	20,705
	21,175	21,705
	22,150	22,705
	23,325	23,910
	24,500	25,115
	25,675	26,320
	26,850	27,525
	28,025	28,730
Consultant in public health medicine	39,625	40,620
	42,510	43,575
	45,395	46,530
	48,280	49,485
	51,165	52,440

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

C. Community health staff

	Current scales	*Recommended scales payable from 1 April 1995*
	(excluding earnings from out-of-hours supplements)	
	£	£
Clinical medical officer	20,275	20,775
	21,405	21,935
	22,535	23,095
	23,665	24,255
	24,795	25,415
	25,925	26,575
	27,055	27,735
	28,185	28,895
Senior clinical medical officer	28,915	29,640
	30,715	31,485
	32,515	33,330
	34,315	35,175
	36,115	37,020
	37,915	38,865
	39,715	40,710
	41,515	42,555

D. Community dental staff

	Current scales	*Recommended scales payable from 1 April 1995*
	£	£
Trainee in dental public health	19,225	19,705
	20,200	20,705
	21,175	21,705
	22,150	22,705
	23,325	23,910
	24,500	25,115
	25,675	26,320
	26,850	27,525
	28,025	28,730
Consultant in dental public health (formerly known as community dental health specialist)	39,625	40,620
	42,510	43,575
	45,395	46,530
	48,280	49,485
	51,165	52,440
Assistant district dental officer (assistant chief administrative dental officer in Scotland and Wales)	31,410	32,200
	33,700	34,545
	35,990	36,890
	38,280	39,235
	40,570	41,580
District dental officer (chief administrative dental officer in Scotland and Wales) Band F (District of 50,000-149,999 population)	40,680	41,695
	41,275	42,305
	41,870	42,915
	42,465	43,525
	43,060	44,135
District dental officer (chief administrative dental officer in Scotland and Wales) Band E (District of 150,000-449,999 population)	40,855	41,875
	41,465	42,500
	42,075	43,125
	42,685	43,750
	43,295	44,375
District dental officer (chief administrative dental officer in Scotland and Wales) Band D (District of 450,000-800,000 population)	42,255	43,310
	42,870	43,940
	43,485	44,570
	44,100	45,200
	44,715	45,830

	Current scales	*Recommended scales payable from 1 April 1995*
	£	£
District dental officer (chief administrative dental officer in Scotland and Wales) Band C (District with population over 800,000)	43,370	44,455
	43,985	45,085
	44,600	45,715
	45,215	46,345
	45,830	46,975
Regional dental officer Band B (Region with population under 3.5 million)	45,755	46,900
	46,370	47,530
	46,985	48,160
	47,600	48,790
Regional dental officer Band A (Region with population of 3.5 million and over)	46,705	47,875
	47,320	48,505
	47,935	49,135
	48,550	49,765
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	36,160	37,065
	38,450	39,410
	40,740	41,755
Dental officer	19,320	19,805
	20,310	20,820
	22,330	22,890
	24,350	24,960
	26,370	27,030
	28,390	29,100
Senior dental officer	28,390	29,100
	30,890	31,660
	33,390	34,220
	35,890	36,780
	38,390	39,340

	Current rates	*Recommended rates payable from 1 April 1995*
	£	£
Part-time dental surgeon: *Sessional fee (per hour)*		
Dental surgeon	17.70	18.15
Dental surgeon holding higher registrable qualifications	23.45	24.05
Dental surgeon employed as a consultant	29.30	30.05

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

PART II: DETAILED RECOMMENDATIONS ON FEES AND ALLOWANCES

Operative date

1. The new levels of remuneration set out below should operate from 1 April 1995. The previous levels quoted are those currently in force. Where no previous level is shown, no change is being recommended.

Hospital medical and dental staff

2. The annual values of distinction and meritorious service 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 £48,605 to £49,820
A awards (70 per cent)	from £35,815 to £36,710
B awards (40 per cent)	from £20,465 to £20,975
C awards (20 per cent)	from £10,235 to £10,490

The number of A plus awards should be increased from 243 to 250, the number of A awards from 838 to 861, the number of B awards from 1,865 to 1,910 and the number of C awards from 4,277 to 4,377.

3. The annual value of performance supplement for associate specialists should be increased from £3,065 to £3,145 a year (7.5 per cent of the maximum of the associate specialist scale).

4. 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	70 per cent
on-call rota (registrars and senior registrars)	50 per cent
on-call rota (house officers and senior house officers)	52.5 per cent (increased from 50 per cent)

5. The fee for domiciliary consultations should be increased from £51.70 to £53.00 a visit. Additional fees should be increased *pro rata*.

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

Consultant appointment[1]	from £895.40 to £917.95 a week; from £81.40 to £83.45 a notional half day
Associate specialist, senior hospital medical or dental officer appointment ...	from £622.05 to £637.45 a week; from £56.55 to £57.95 a notional half day
Senior registrar appointment	from £482.80 to £494.80 a week; from £12.07 to £12.37 per standard hour
Registrar appointment	from £405.60 to £415.60 a week; from £10.14 to £10.39 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 £982.85 to £1,007.60 a week;
from £89.35 to £91.60 a notional half day.

Senior house officer appointment ...	from £369.20 to £378.40 a week; from £9.23 to £9.46 per standard hour
House officer appointment	from £279.60 to £286.40 a week; from £6.99 to £7.16 per standard hour
Hospital practitioner appointment ...	from £63.20 to £64.80 a notional half day
Staff grade practitioner appointment	from £506.00 to £518.50 a week; from £50.60 to £51.85 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 £55.98 to £57.40 a notional half day

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

Ophthalmic medical practitioners

8. The net remuneration element in the ophthalmic medical practitioners' fee for sight testing should be increased from £7.76 to £7.95, and the practice expenses element should be increased from £2.70 to £2.77.

250
861
1910

General medical practitioners

9. The Intended Average Net Remuneration for general medical practitioners should be increased from £41,910 to £43,165 from 1 April 1995.

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

First year	from £23,325 to £23,910 a year
Second year	from £24,500 to £25,115 a year
Third and subsequent years	from £25,675 to £26,320 a year

11. The maximum weekly rate of the locum allowance[1] should be increased from £405.60 to £415.60.

12. The supplement[1] payable to trainee general medical practitioners for out-of-hours duties should be increased from 15 per cent to 17.5 per cent of basic salary.

General dental practitioners

13. The gross fee for each item of service and capitation payment should be increased by 2.5 per cent from 1 April 1995.

14. The sessional fee for practitioners working a 3-hour session under emergency general dental service schemes should be increased from £74.55 to £76.40.

15. The salaries of salaried dental practitioners should be increased as follows:

Current scale	*Recommended scale payable from 1 April 1995*
£	£
19,615	20,105
21,400	21,935
23,185	23,765
24,970	25,595
26,755	27,425
28,540	29,255

The sessional fee for part-time practitioners working six 3-hour sessions a week or less in a health centre should be increased from £52.75 to £54.05.

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

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

16. 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 1995*
	£	£
Island Health Boards		
Band E (under 50,000 population)	1,100–2,205	1,130–2,260
District director of public health (director of public health in Scotland/Wales) (formerly known as district medical officer)		
Band D	2,205–4,415	2,260–4,525
(District of 50,000–249,999 population) ...	(Bar); 5,515	(Bar); 5,655
Band C	2,760–5,515	2,830–5,655
(District of 250,000–449,999 population)	(Bar); 6,620	(Bar); 6,785
Band B	3,305–6,620	3,390–6,785
(District of 450,000 and over population)	(Bar); 8,550	(Bar); 8,765
Regional director of public health (formerly known as regional medical officer)		
Band A	8,550–12,410	8,765–12,720

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

18. The teaching supplement for assistant district dental officers (assistant chief administrative dental officers in Scotland and Wales) should be increased from £1,515 to £1,555 a year.

19. The teaching supplement payable to district dental officers (chief administrative dental officers in Scotland and Wales) should be increased from £1,715 to £1,760 a year.

20. The supplement for district dental officers (chief administrative dental officers in Scotland and Wales) covering two districts should be increased from £1,100 to £1,130 a year and the supplement for those covering three or more districts should be increased from £1,770 to £1,815 a year.

21. The allowance for dental officers acting as trainers should be increased from £1,210 to £1,240 a year.

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

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

Appendix B

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

Great Britain

	1992		1993		Change	
	number		number		per cent	
	medical	dental	medical	dental	medical	dental
Hospital medical and dental staff[3]						
Consultants	19,440	670	19,830	650	2	–2
Associate specialists	1,110	90	1,190	90	7	1
Staff grade	860	20	1,300	30	51	100
Senior registrars	4,350	150	4,530	160	4	11
Registrars	7,470	230	7,440	220	0	–4
Senior house officers	14,010	320	14,710	370	5	17
House officers	3,800	140	3,800	130	0	–12
Hospital practitioners	760	80	790	90	3	10
Clinical assistants	8,410	860	7,940	790	–6	–8
Other	20	10	10	10	–35	40
Total	60,230	2,550	61,530	2,530	2	–1
Public health and community medical staff[3]						
Regional and district directors	160		140		–14	
Consultants	470		480		2	
Special salary scale staff	10		10		–17	
Trainees in public health medicine	440		460		4	
Senior clinical medical officers	1,310		1,240		–6	
Clinical medical officers	1,790		1,680		–6	
Other medical staff	1,640		1,550		–6	
Total	5,810		5,540		–5	
Community dental staff[3]						
Regional and district dental officers		100		90		–17
Assistant district dental officers		60		70		3
Consultants[4]		10		20		57
Senior dental officers		450		420		–6
Dental officers		1,180		1,160		–1
Other dental staff		10		20		100
Total		1,820		1,780		–2
General practitioners						
General medical practitioners:[5]						
unrestricted principals	31,070		31,450		1	
restricted principals	150		160		6	
assistants	520		540		3	
trainees	2,070		1,960		–5	
associates	30		30		7	
General dental practitioners:[3]						
principals		17,380		17,700		2
assistants		640		770		21
salaried health centre dentists		90		130		34
Ophthalmic medical practitioners[6]	840		790		–6	
Total	52,790		53,520		1	
Total—NHS doctors and dentists	123,190		124,900		1	

[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] Some consultants in dental public health have been misclassified and appear in other areas of this table. The BDA estimate that in December 1994 the number of consultants in dental public health was 43.

[5] At 1 October.

[6] At 31 December.

Appendix C

Intended and actual average net remuneration of GMPs: 1979–80 to 1994–95

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 1992–93. In 1992–93 there was a net overpayment of £188. This brings the total sum outstanding, after the recovery of £353 in 1994–95, to £1,542. As explained in paragraphs 176–177 we have decided to recommend a recovery of £217 in 1995–96, and this sum has been deducted from Intended Average Gross Remuneration for GMPs to derive the gross amount to be delivered through the freescale. The following table shows the operation of the balancing mechanism since 1979–80.

Year	INTENDED			ACTUAL		Outstanding amount carried forward
	Intended average net income	Corrections for earlier periods etc.	Adjusted intended net income	Net income	Over (+)/ under (–) payment	
	£	£	£	£	£	£
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			
1994–95	41,890	– 353	41,537			

Note: Intended average net income 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

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
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