PREM 19/3856

NEW FILE COVER

MT

PART 4

CONFIDENTIAL FILING

DOCTORS' AND DENTISTS' PAY

NHS CONSULTANTS CONTRACTS

NATIONAL HEALTH

Part 1: May 1979

Part 4: November 1986

Attached folder: Government evidence to the DDRB 22nd Report on D+D Pay

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
new file cover							
~~17.1.92~~							
~~3.2.92~~							
~~7.2.92~~							
~~10.2.92~~							
20.5.92							
29.5.92							

PREM 19/3856

PART 4 ends:-

AA to Pm 29.5.92

PART 5 begins:-

D. Health to BP 1.6.92

Published Papers

The following published paper(s) enclosed on this file have been removed and destroyed. Copies may be found elsewhere in The National Archives.

Review Body on Doctors' and Dentists' Remuneration.
Twenty-Second Report, 1992
Presented to Parliament by the Prime Minister by Command of Her Majesty, 1992.
Published by HMSO

Signed J. Gray Date 7/9/2017

PREM Records Team

Barry

Good!

PRIME MINISTER

DENTISTS

Just to bring you up to date on salaried dentists. I have spoken to Mrs. Bottomley's office and she does intend to refer to more salaried dentists next week. The Treasury have been difficult about switching between non-cash limited and cash-limited spending but I have told them this is an essential part of the package.

AA

ALEX ALLAN

29 May 1992

a:\pps\dentists.vlb

cst.ps/dr/5mp22.5

CONFIDENTIAL

File

Prime Minister

The agreed settlement.

BHP 22/5.

Treasury Chambers, Parliament Street SW1P 3AG
071-270 3000
Fax 071-270 5456

Colin Phillips Esq
Principal Private Secretary
Department of Health
Richmond House
79 Whitehall
London
SW1

22 May 1992

Dear Colin,

DENTISTS' REMUNERATION

I am writing to record the agreement which the Chief Secretary and Mrs Bottomley reached last night on this issue and which officials confirmed the terms of this morning.

2. Your Secretary of State has agreed:

a) to announce a proposed cut of 7 per cent in dentists' fees;

b) to surrender £11½ million from cash-limited budgets;

c) to tighten up the prior approval rules under which dentists operate before they can provide expensive or complex treatment. Your Secretary of State believed this would save £20 million in the current year.

3. The Chief Secretary will look to the department to orchestrate the appropriate territorial split of the surrender at (b).

4. Provided the fee cut becomes operational on or before 8 July, such a package is consistent with the Chief Secretary's offer to concede a claim on the Reserve of £51 million. The Chief Secretary and your Secretary of State also discussed, however, the position should that not prove possible, notwithstanding the department's most strenuous efforts. They agreed that the additional cost of any delay between 8 and 15 July should be borne equally between the Reserve and the department's cash-limited

budgets. Neither your Secretary of State nor the Chief Secretary gave any undertakings in relation to financing any further delay beyond 15 July.

5. It is clearly crucially important to do everything possible to secure operation of the fee cut before 8 July. 15 July must be regarded only as an option in extremis.

Yours,

Peter

PETER WANLESS
Private Secretary

PRIME MINISTER

DENTISTS

Can I add a postscript to Sarah's note - attached. (Sarah has done all the negotiations.)

Late this evening I took several phone calls from both the Department of Health and Chief Secretary's Private Offices.

Just as Sarah indicates, Department of Health officials are telling their new Secretary of State that she has gone too far already and cannot go further. The Permanent Secretary had clearly been involved.

There is a £10 million gap between the two sides. There are only three means now of bridging that gap:

- a transfer of funds from within the Health Service programme to dentists; or

- a further hit on the Reserve; or

- a start date for the new contract later than 15 July.

(This assumes that the maximum permissable fee cut is 9% and that the extra £20 million through limitations of expensive treatment is agreed.)

I suspect Department of Health will prove reluctantly willing to find £5 million from elsewhere in their budget. Similarly I think Treasury will accept another £5 million hit on the Reserve if they must. A Private Secretary's note to that effect is being handed to the Chief Secretary later tonight.

Treasury's last hope is an earlier start than 15 July for the new contract. My understanding from Department of Health is that an earlier start risks judicial review. But they will check.

Given the advice in their Boxes, a final stage for an overall deal comprising a £5 million hit on the Reserve for a £5 million transfer from elsewhere within the Health Service budget looks achievable.

Content on that basis?

BHP

BARRY H. POTTER

20 May 1992
c:\wpdocs\economic\dentists.dca

Prime Minister (2)
See also attached note
BHP 20/5

CONFIDENTIAL

PRIME MINISTER 20th May 1992

DENTISTS

I spoke today to both Virginia Bottomley and Michael Portillo.

I intimated to Mrs Bottomley privately your view.

You fully understood that:

- A cut is unprecedented;

- There will be a great deal of political stink;

- There is a danger that a proportion of dentists, concentrated in the south east, will withdraw from NHS practice, thus giving rise to "privatisation" accusations.

- She personally thinks it is wrong to make any cut at all, and we should content ourselves with announcing a review of the system.

However, I told her that you were not prepared to resist the Treasury's demand that there must be a cut; they could not take the full £114m on the reserve.

I also spoke to Michael Portillo.

You fully understood that:

- The reserve was overspent;

- A cut would be a very important signal;

- It would also mean lower charges for patients, which was good news.

However, I told him you did not want as deep a cut as the 13.8 per cent on which negotiations were broken off before the election, still less the 20 per cent-plus which would be needed to recoup the same amount of money, given the cut is being delayed until July. Mr Portillo had started asking for this, but had then scaled his demand down to a 13.8 per cent cut from July (costing roughly £40m on the reserve). I intimated that you wanted the cut to be in single figures.

On that basis, they met again and made some progress.

Mrs Bottomley offered to find some money by reintroducing limits on expensive treatment above which dentists would have to seek prior approval (this has the effect of slowing work down a bit). The Treasury did not quarrel with her calculation that this would save £20m, which is equivalent to 4 per cent on fees.

Mr Portillo meanwhile argued that dentists' incomes had risen yet further than forecast; to achieve the equivalent of the 13.8 per cent cut he had asked for, he would now need 15 per cent. Allowing for the benefit of the limit on expensive treatment, he would need 11 per cent. He was prepared to lower that to 10 per cent. He said that Mrs Bottomley had offered to find £10m from other Department of Health resources; this would reduce the cut to 8 per cent- comfortably within single figures.

Mrs Bottomley denies this. She says she only offered to consider whether she could find a bit more; and she doesn't think she can.

The final wrinkle is that delay has meant the cut cannot be put in place before the middle of July. Mrs Bottomley is not ready to give the negotiating panel a paper by this Friday; parliamentary business managers are not keen on this (which will inevitably leak) happening during the recess, when MPs are most vulnerable to dentist pressure and least susceptible to departmental/whips' briefing. The delay probably costs another £5m. Mr Portillo argues that if this is necessary, there must be an 11 per cent cut, not a 10 per cent cut; he argues that if she can find £10m, that would still allow the final cut to be only 9 per cent, ie within single figures.

Although the gap is now very small, they seem to have reached an impasse again, which is tedious.

Mrs Bottomley feels she has already gone too far in offering Mr Portillo help. The reintroduction of limits will be painful; even if it is not as stark as a direct hit on fees, dentists will clearly see it as a cut in income. She cannot find more money in the health budget. And a cut in fees of any size is going to be very hard to bear.

Mr Portillo, however, argues that he is offering £46m out of the reserve, which is a painfully big figure. The health settlement is very generous, and it is a good principle that departments should find some of the money to finance what they have to do.

To sum up:

The gap is effectively £10m, amounting to the difference between an 11 per cent cut in fees and a 9 per cent cut.

Michael Portillo was told you thought the cut should be below 10 per cent. He has not delivered that. On the other hand, he is now being asked for something more - which is to finance two extra weeks. Mind you, the fault for delay lies as much with the Treasury as on DH!

They ought to be able to close that gap between themselves. But that will need another nudge at Mr Portillo. If he won't move, Mrs Bottomley will certainly ask to see you.

Mr Portillo can reasonably be asked to find at least another £5m. For if you see Mrs Bottomley, you will certainly give her that much. And he has not delivered a cut in single figures which you asked for.

As for Mrs Bottomley, she has found a £20m contribution to the problem already.

The question is whether Mrs Bottomley can be persuaded to find another £5m. She clearly is at the end of her tether, and hassled by officials who all think she's gone far too far already.

My advice would be to say to Michael that he should try to secure Mrs Bottomley's agreement by offering a bit more; that he's nearly there and that you won't thank him for dumping the problem in his lap when the gap is so small. You are bound to give her something if you have to see her. Likewise, I could urge Mrs Bottomley to have another chat with Mr

Portillo and see if they can close the gap. I can warn her that if it comes to you, you will feel obliged to lean the Treasury way.

I have to confess that while I know the financial problems, my sympathy is with Mrs Bottomley. It is a signal victory for the Treasury to secure a cut in fees. I know it is still costing them a lot of money; but to spoil the victory by quibbling over so small a residual sum seems foolish.

Could we have an early word on Thursday?

Sarah

SARAH HOGG

022.sh

MRS. HOGG

DENTISTS' REMUNERATION

This is to summarise what we discussed earlier.

Treasury and Department of Health are holding off minuting the Prime Minister on dentists pay at our request.

Treasury have proposed a 21.4 per cent cut in dentists' fees - Mrs. Bottomley, no cut at all. In an attempt to break the impasse, the Chief Secretary offered privately a reduction of 13.7 per cent as from 1 July. But Mrs. Bottomley would not hear of it.

We are agreed that Treasury must win this case - though not necessarily even at their compromise level. If not, the Prime Minister's statement of yesterday will look pretty meaningless.

Yet the politics are very difficult - just like the problem itself. It is clear that the biggest difficulties arise in the south east. That is where the pressure on dentists to leave the NHS seems greatest.

I have loosely floated across the Treasury the idea that, as a condition for getting agreement from DH to a cut in dentists' fees from 1 July, they may have to concede a wider review of the present system.

Clearly that system does not work. Specifically I suspect it fails to take account of differences in costs. But there may also be significant regional differences in demand, eg. for fancier type dentist work in the south east; and differential gaps between costs and standard payments under the NHS. It needs a thorough review.

Good luck in your negotations with Virginia Bottomley. I attach a further brief note, purloined from the Treasury.

BHP

BARRY H. POTTER 15 May 1992 c:\e\vb (slh)

Copy to Alex Allan at No 10.
Alex I think the PM should see this. He raised it with me. Rachel.

POLICY IN CONFIDENCE

DEPARTMENT OF HEALTH

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

The Rt Hon Michael Portillo MP
Chief Secretary
HM Treasury
Treasury Chambers
Parliament Street
LONDON
SW1P 3AG

13 May 1992

Dear Michael,

DENTISTS REMUNERATION

We are to meet tomorrow to discuss this.

The attached note by my officials which has been agreed with yours explains the background.

The note rightly seeks to be factual. One of our biggest problems however is being sure what the facts are. There are at least three areas where we can do no more than make best judgements:

> First, we cannot be certain why the cost of the new dental contract is so much higher than forecast. It is possible for example that the impact of the new contract will rapidly diminish. In that case, a different approach might be needed.
>
> Second, dentists are very insistent that proper and full account is not being taken of their expenses, even though officials believe fair provision for this is being made.
>
> Third, and most important, we cannot be certain what the effect of any fee cut would be. There has been no fee cut for 40 years. David Ennals did not manage to carry through fee cuts that were considered by the Labour Government in the 1970s. Whatever the logic of the Government's position, dentists will be outraged. They will say, and the public will agree, that they have worked harder yet are being penalised for doing so although we as a Government are publicly committed to performance pay. So even though it might not be in their best financial interest, any fee cut might

produce a brush fire effect - with many dentists leaving the NHS, particularly in the South East where expenses are higher and premises more costly. The Chief Dental Officer's personal view is that even the lowest option of a 7% cut could mean 25% of dentists in the South and 5% elsewhere leaving the NHS.

Alongside these uncertainties are the political and policy implications of making any fee cuts. As a Government we have worked extremely hard in recent years to reassure people, both the general public and everyone working for the NHS, that we are totally committed to a comprehensive NHS to which everyone has ready access. We have been very successful in these efforts. I have to say we should run a grave risk of undermining all that hard work if we imposed a fee cut which could be seen as - and certainly would be presented by dentists as being - a move that would seriously damage the NHS dental service. Indeed dentists would portray it as backstairs privatisation.

While I entirely recognise the importance we all attach to keeping public expenditure under control, as Health Secretary I would have to advise colleagues that while I wholly accepted we must address urgently the serious issue of overpayments to dentists, it would be wrong to do so by imposing a fee cut. We should instead look to an urgent and fundamental review of dentists remuneration as the way forward.

I am copying this to John Wakeham, Tony Newton, William Waldegrave and Richard Ryder and to the other three Health Secretaries Ian Lang, David Hunt and Patrick Mayhew.

yours ever
Virginia

VIRGINIA BOTTOMLEY

CONFIDENTIAL

THE PROBLEM OF DENTAL REMUNERATION

NOTE BY DH OFFICIALS

The system of dental remuneration

Dental remuneration is determined as follows. The Doctors' and Dentists' Review Body (DDRB) recommends what the average net income of dentists should be: let us say for illustration £35,000 per annum. Assuming that the Government accepts this recommendation, its implementation is passed to the Dental Rates Study Group (DRSG) - a negotiating forum composed of representatives of the dentists and Health Departments' officials under an independent chairman. The DRSG has two tasks. First it forecasts the expenses - such things as the cost of practice premises and the expense of fillings amalgam - which will be incurred to enable dentists to receive the net £35,000 income. Let us say that expenses will be £40,000 so that to deliver the net £35,000 a gross income of £75,000 is required. Arranging for delivery of the £75,000 is the DRSG's second task. To do this it sets the 300 or so fees for individual items of dental treatment so that, taking into account its forecasts of the likely incidence of treatment items, £75,000 gross will be paid to the average dentist.

2. The system deals in averages. Individually the greater the caseload a dentist has, the more he or she can earn: in 1990-91 13 per cent of dentists received less than £30,000 gross and 18 per cent received more than £100,000 (see Table 3 and the histogram labelled Table 4). Overall the dentists are playing in a zero sum game, because the intention is to deliver £x million in total. Obviously the system never in fact delivers exactly what was intended; but under- or over- payments are carried forward under the so-called balancing mechanism. In the third year after any under- or over- payment (it is only then that the Inland Revenue can provide figures for the expenses dentists have actually incurred) it is brought into account in settling the year's remuneration. The system worked well, including for the purposes of public expenditure control, for many years. During that time the differences between what it was intended to pay and what was paid were not large.

The current problem

3. A new dental contract was introduced in October 1990. Since then dentists have done much more work than the DRSG anticipated. The constituent parts of this overpayment are shown in Table 2. Most of the increased work was on adult item-of-service payments, that is payments for treatment. There were many contributory factors involved but the main ones are as follows. Dentists went to a great deal of trouble to recruit adults into continuing care ("capitation"), and not surprisingly found that many people who had not seen them, or any other dentist, for a long time needed treatment. Secondly, the rules on mixing private and NHS

treatment were modified by the new contract, and the result seems to be that some of the work dentists previously persuaded patients to have done privately is now done on the NHS. Thirdly, before October 1990 dentists had to secure the prior approval of the Dental Practice Board to more treatments than now. Fourthly, there may have been some element of dentists working harder because they believed they needed to do so to compensate for what they perceived to be low fee levels.

4. So, in 1991-92, the dentists were paid about £195 million in gross fees more than was planned; although this reduces to £190 million when payments on allowances less than forecast are taken into account. The true overpayment, that is of net income, could reduce further, to around £160 million, if the current forecast of dentists' expenses is correct. In 1992-93, even after the DDRB's (accepted by Government) recommendation of an 8.5 per cent increase in net income, the dentists are being overpaid by about £14 million a month. The diagram labelled Table 1 gives more precise figures for net and gross remuneration in 1991-92 and estimates for 1992-93 corresponding to the illustrative figures in paragraph 1 above.

5. In order to avoid "overpaying" dentists, it will be necessary to reduce the fees paid to them. These fees are received partly from the charge the non-exempt patients pay the dentist, and partly from NHS remittances, roughly in the ratio 1:2. Thus an overpayment to dentists involves both most dental patients and the taxpayer paying more than they should - in 1992-93 the sums involved are currently estimated at £55 and £115 million respectively.

6. Three points about using the word "overpayment". First, for 1992-93 the reference to an overpayment is as stated after taking into account the 8.5 per cent increase in net remuneration recommended by the DDRB, and accepted by the Government earlier this year. A fee cut is needed to deliver the level of net income thought right for dentists by the DDRB. Secondly, we know with certainty only about the recent gross overpayments to dentists. When the full data on expenses are available, the net overpayments may be less. Dentists must be expected to make much of this. They will argue that the new contract has involved a secular increase in their expenses - for example that their increased number of patients has in many cases tipped them over into needing an additional receptionist. There is unlikely to be much substance in this point. The Government's calculations about the level of fees needed to deliver the DDRB recommendation make an adequate, even generous, allowance for expected expenses, and the projections are thoroughly defensible. Nevertheless, it is a complication that has to be borne in mind.

7. Thirdly - and a very important facet of the problem - is the attitude of the dentist in the High Street. DH officials advise that he does not see this as an overpayment. There further advice on how dentists see the matter follows in this paragraph. The dentist considers he was given a fee scale, and encouraged to

go out and make a success of the new dental contract. He did the work and did it quite properly: there is no suggestion of excessive treatment here. The dentist regards himself in this context as a piece-worker. Hence a reduction in fees seems to him to be changing the rate on which he has founded his work plans, including decisions on the employment of ancillary staff, surgery equipment and so on. Appreciation of the overall zero sum game did not, prior to this February, extend much beyond those who negotiate on the dentists' behalf. The dentists have two further complaints. Having been awarded 8.5 per cent by the DDRB, they want to see an 8.5 per cent increase in their fees: "Dentists were awarded 8.5 per cent by the Review Body; they want an 8.5 per cent rise in fees it is as simple as that," as the newspaper of the British Dental Association put it on 14 March. Secondly, they regard any suggestion that what was overpaid in 1991-92 should be clawed back as wholly unreasonable. Although dentists are aware of the balancing mechanism explained in paragraph 2 above, the effect of the mechanism on fees has, in any previous year, been small. In any case fees, and that is what the High Street dentist bothers about, have continually increased over the years.

The past overpayment

8. The 1991-92 overpayment together with earlier overpayments constitute an overhang of money - some £260 million in total - that under the present rules stands to be recovered over future years. This is a great deal of money by any standards, and about two-thirds of it was provided from the Exchequer. To recover such a sum under the present balancing mechanism rules would require reductions in dentists' income each year well into the next century. Accelerating recovery would require even larger fee reductions than those considered in this paper.

9. It should be noted that the costings shown later in this paper do not assume any offset through the operation of the balancing mechanism, that is for the overhang of money described in the previous paragraph.

The National Health Dental Service

10. Dentists have recruited far more patients into adult continuing care and child capitation - 30 million and still rising by 0.75 million a month - than anyone expected. Similarly, much more treatment than expected has been provided. But the public, or at any rate the Press, perception is of increasing difficulty in securing NHS dental care. Partly this is the result of dentists' shroud-waving; but very significantly it is because pockets have emerged in places like Bromley and Barnet where people find difficulty in securing NHS treatment. It is planned to deal with this by employing salaried dentists.

11. While we must maintain the NHS dental service, we must also control its costs and ensure that we have mechanisms in place such that we pay dentists no more than we intended to pay them.

Secondly, we have to take account of what was said in the Citizens' Charter about performance pay. Thirdly, the dentists do have what the DDRB thought were legitimate complaints about the reimbursement of their expenses. All these matters will be dealt with in the fundamental review of dental remuneration which we have promised to get started at the same time as we settle 1992-93 fees.

Developments this year

12. In February this year, the Department opened negotiations with the General Dental Services Committee (GDSC) to secure, from 1 April, a fees reduction of 13.8 per cent. On 20 February Ministers decided that the proposed reduction should be suspended. This was in return for a period of quiet from the dentists, plus the promise of a radical review of dental remuneration. We also agreed to a joint enquiry into what happened in 1991-92. But the principle of the fee cut was not abandoned and at present the GDSC is expecting negotiations in May to settle fees for the 1992-93 year. The Press Release which is the text of the agreement was as follows.

> "The Health Departments and the General Dental Services Committee have agreed that
> - The cut in fees for 1 April will be suspended
> - They will undertake a joint inquiry into the reasons why the level of payments to dentists in 1991-92 has exceeded the level anticipated by the Dental Rates Study Group (DRSG) last year and the extent to which this may carry forward into 1992-93, this inquiry to be completed in time for the DRSG to consider it in May. Simultaneously they will begin a more fundamental review of the dental remuneration system, as recommended by the Doctors' and Dentists' Review Body, one of the aims of which will be to prevent a repetition of the current problem.
>
> The Chairman of the GDSC is writing to all general dental practitioners today informing them of this agreement and asking them to suspend their actions in support of his earlier appeal.
>
> William Waldegrave, Secretary of State for Health, said: "I am pleased that the Department and the General Dental Services Committee have agreed on a practical way forward to examine this sensitive and complex issue." "

It should be noted that on 20 February the dentists did not make what one might have expected would be their response to the Department's negotiators: a demand that the threat of a fee cut should be lifted for the 1992-93 year.

13. The 13.8 per cent which would have balanced the books from 1 April equates to roughly 20 per cent from 1 July, and the GDSC is well aware of this. The GDSC contend that it is doubtful whether a revised fee scale can be implemented by this date. It can be just - providing decisions are taken very quickly. Any delay would of course increase the fee cut required to balance the books.

The immediate problem: options for action

14. The options for dealing with the 1992/93 problem, and estimates of their costs which are based on many assumptions and subject to margins of error (see paragraphs 23 and 25 below) may be tabulated as follows

Fee Cut (per cent)	Overpayment Per Dentists (£s)	Overpayment Aggregate (£million)	Borne by: Exchequer (£million)	Borne by: Patients (£million)
0	10,200	171	114	57
7	6,900	116	77	39
10	5,400	91	61	30
13.8	3,600	61	41	20
21.4	-	-	-	-

Cutting fees by less than 21.4 per cent would mean making an overpayment. We would have to be publicly explicit that we were deliberately acquiescing in an overpayment - because of the special circumstances - and that we would intend to recover it in later years. Without such an explicit statement, our legal advice is that we would be precluded from later recovery. There could also be difficulties if the DDRB were to conclude that they should make their recommendations from a permanently higher base.

Discussion of options: (a) general considerations

15. Row with dentists. Any fee cut will provoke a huge row with the dentists, and Mr Rich, the Chairman of the GDSC, has said he would never lend his countenance to a fee cut. So the best to be hoped for from negotiations with the GDSC is reluctant acquiescence to something they privately thought not unreasonable: there can be no serious hope of the GDSC's public agreement to a fee cut.

16. Effect of fee cut on dentists' commitment to the NHS. Any fee cut will provoke resignations. The word is used here to denote any of the following.

(a) A mass resignation by the Profession.

(b) Individual resignation from all NHS work.

(c) Refusal by dentists to add new patients to their list.

(d) The dropping by dentists of categories of NHS work, for example, adult paying patients, or refusal to add new categories to their list.

It is important to recognise that dentists - and public commentators - use the term resignation very loosely as indicated above. This is one of the two reasons why it is so difficult to make an assessment of the effect of a fee cut, or of the relative effect of possible fee cuts. The second reason is that what dentists say they will do may well be different from what they actually will do. The one obvious general point is that the larger the fee cut, the less the expected overpayment per dentist. By the same token, however, the bigger the cut the more strongly dentists will feel the effects and react accordingly.

17. Effect on patients and charge income. As noted earlier not all of any overpayment would be borne by the Exchequer. Dental charges to patients are determined by the level of dentists' fees. Failure to cut fees by the full amount needed to prevent an overpayment would mean that dental charges to patients were higher than otherwise they would be. In this way, patients could expect to bear roughly one-third of the cost of any overpayment and the Exchequer the remaining two-thirds.

18. Effect on 1993-94 fee levels. One important consideration in setting the level of fees from 1 July is the likely impact of the DDRB award for 1993-94. For example, it is likely that a DDRB award for average net income for 1993-94 of the order of 20 per cent would be needed to allow the current (July 1991) fee scale to stand through 1992-93 and 1993-94. Alternatively, and on the same assumptions, a fee cut from 1 July of 7 per cent to 10 per cent, combined with a DDRB aware of 5 per cent for 1993-94 would probably balance that year's books.

Discussion of options: (b) salient features of each option

19. The salient features of each option are as follows.

Option 1: No fee cut from 1 July

(a) This would produce an overpayment per dentist in excess of £10,000 at an expected cost to the Exchequer of £114 million and to patients of £57 million.

(b) Moreover on any plausible assumption about the DDRB's pay recommendation for 1993-94, a fee cut from April 1993 in the region of 7 per cent to 10 per cent would still be needed to deliver it. Not doing so would mean yet another overpayment.

Option 2: 7 per cent fee cut from 1 July

(a) This would still produce a very large overpayment

(b) It might, however, be just enough to preclude the need for a further fee cut in April 1993

(c) DH officials judge that the great majority of NHS dentists would continue to offer services at such fee levels.

Option 3: 10 per cent fee cut from 1 July

As for Option 2 except that the current year overpayment would be a little lower and the chances of avoiding an April 1993 fee cut would be increased.

Option 4: 13.8 per cent fee cut from 1 July

(a) This is the fee cut which the Government announced in February was necessary to deliver the DDRB's pay recommendations for 1992-93. It thus represents the level of fees which would have applied throughout 1992-93 if the Government had not agreed on 20 February to suspend the cut.

(b) It would still generate a sizeable overpayment to dentists in 1992-93.

Option 5: 21.4 per cent fee cut from 1 July

(a) Such a fee cut could be expected to prevent an overpayment. It is therefore the action needed to deliver the DDRB's recommendation of an 8.5 per cent increase in dentists' target pay.

(b) DH officials are quite sure that a fee cut of this size would lead to a reaction from dentists generally which would result in considerable erosion of the NHS dental service.

Difficulties and uncertainties: (a) legal

20. We have consulted Counsel extensively about the legality of our actions and proposed actions. The last paragraph of his Opinion said

"Many of the proposals which I address above raise legal issues of some difficulty. Given the amounts of money involved, those responsible should carefully consider

amending the legislation to clarify the position and to confer express powers to implement such proposals."

Nevertheless, Counsel does advise that if a fee cut of 20 per cent is imposed from 1 July, "this will not be perverse or otherwise an abuse of power". Counsel was specifically addressing a cut of 20 per cent derived from the earlier 13.8 per cent figure, but we have confirmed that a figure of up to 20 per cent would be similarly acceptable.

21. More generally, Counsel's advice places considerable constraints on Government action which in practice hem in the scope for considering variants to the options set out above. "The longer we go into the financial year, the greater the degree of reduction required, and the greater the risk that a Court would say it is perverse," is one theme. Counsel advises that we could not make subsequent adjustments to a fee scale once it was set for a year (though he also qualifies this and we are seeking further clarification). Neither could we operate the balancing mechanism on gross rather than net remuneration. As we do not know the accurate net remuneration figure until three years after the year of payment, this is another severe constraint.

Difficulties and uncertainties: (b) statistical forecasting

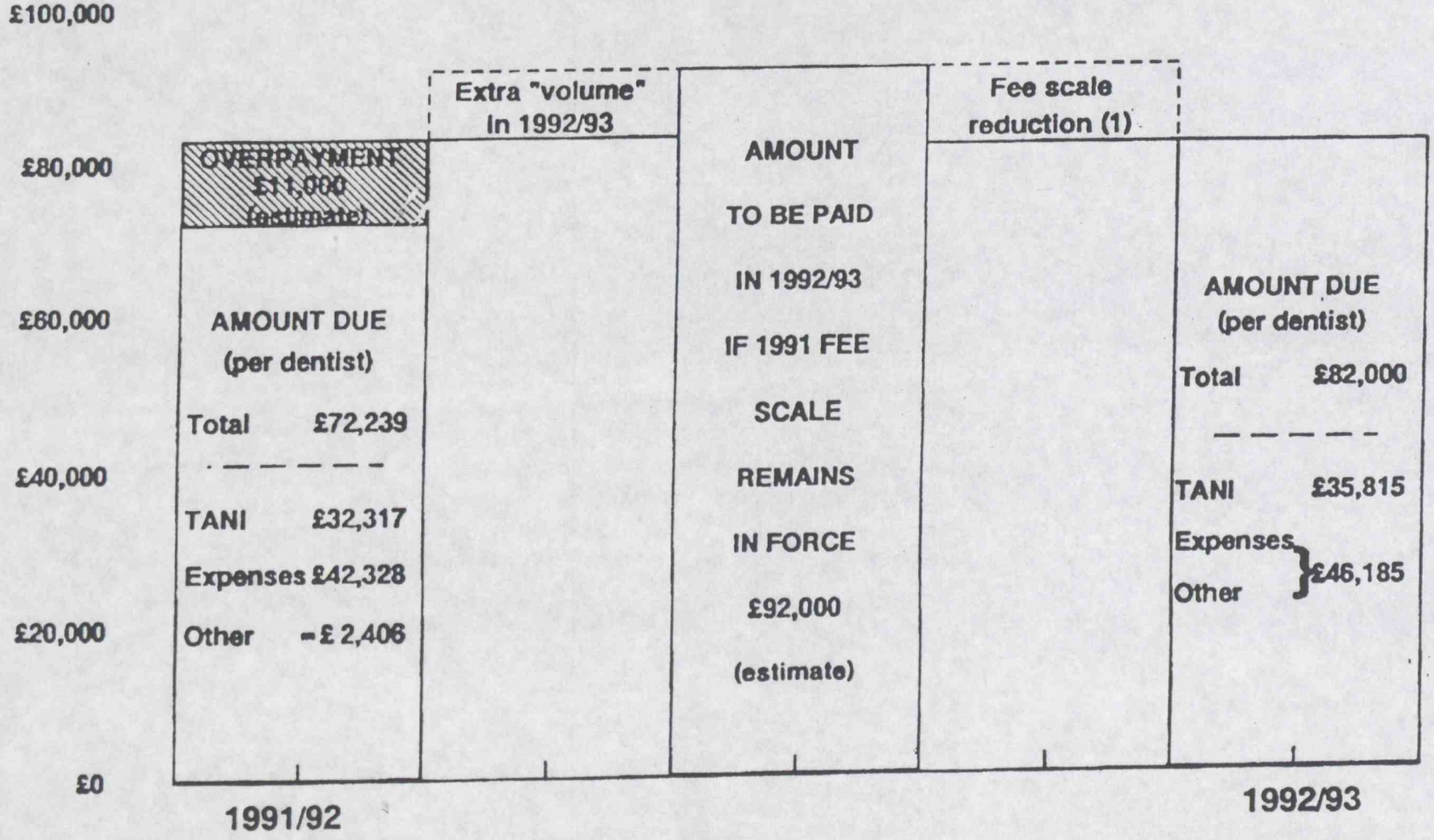
22. The dental remuneration system is based on forecasts of the volume of work dentists will do and of the expenses they will incur in carrying out this work. The costings of the various options set out in the paper have all been made on the assumption that the volume of work done by dentists will be unaffected by the level of the fees they are paid. Such an assumption is unlikely to be true, but it is impossible to predict with any certainty what dentists' reactions to a cut in fees will be. They might seek to do more NHS work to maintain their gross income - thereby reducing the impact of the cut in fees on public expenditure. Alternatively, they might cut back NHS treatment (with or without a corresponding increase in private treatment) thus exaggerating the impact of the cut in fees on public expenditure.

23. This sort of uncertainty does underline the need for measures to improve public expenditure control of dental remuneration.

24. Such uncertainty is most marked in relation to 1993-94. It is impossible to make a categorical statement about the fee reduction which would be large enough to avoid the need for another fee cut in 1993-94. For one thing we do not know what recommendation the DDRB will make about dentists' remuneration. It is also the case that if (say) there were to be a 7 per cent cut in fees and a 7 per cent increase in output, we would face an equally difficult problem next year. All we can say is that a fee cut of the order of 7 per cent to 10 per cent now will make the need for a further fee cut in 1993-94 much less likely.

TABLE 1

DENTISTS' PAY - ILLUSTRATION OF THE 1992/93 PROBLEM



(1) Introduce new feescale from 1.7.92 to ensure that amount to be paid in 1992/93 equals Amount Due

Dir:w:\DRSGSTATS\MINUTE\Dpayscal

TABLE 2

1991 DRSG Settlement and 1991/92 Outturn

GB

Fee	1991 DRSG Settlement	Estimated Error £ per DRSG Principal	Percentage Error	Error GDS (2) £m	Percentage Distribution of errors
Adult I of S	53,131	7,536	14.2%	126.2	66.5%
Child I of S	3,222	832	25.8%	13.9	7.3%
Cont Care	5,192	998	19.2%	16.7	8.8%
Capitation	8,700	624	7.2%	10.4	5.5%
Entry	1,994	1,787	89.6%	29.9	15.8%
Allowances (1)	1,769	-440	-24.9%	-7.4	-3.9%
Total	74,008	11,338	15.2%	189.9	100.0

(1) Seniority, maternity, sickness, postgraduate education, vocational training payments and direct reimbusement of business rates.

(2) Converted using 1.0913 factor and 15,390 principals.

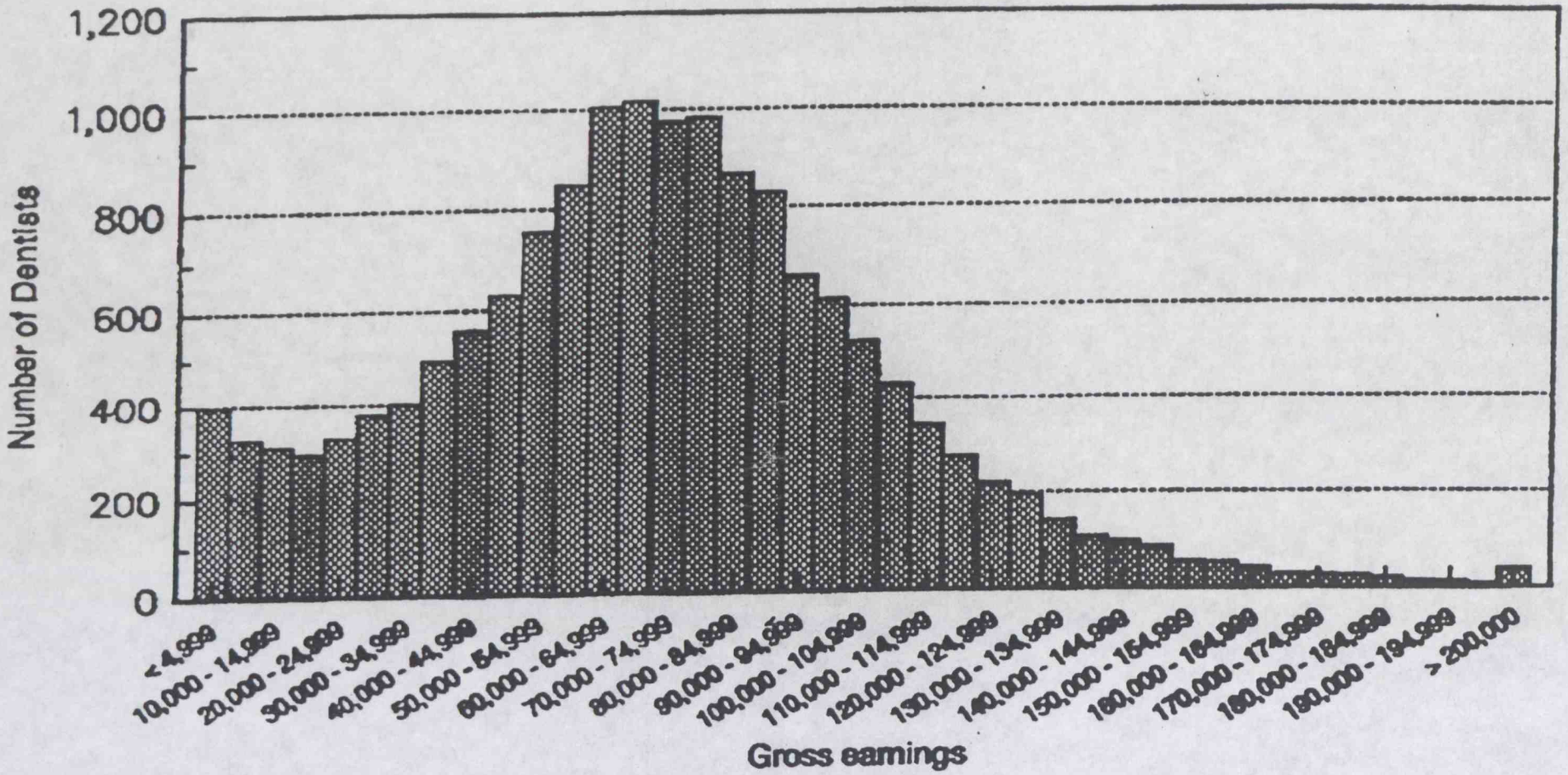
TABLE 3

Distribution of Gross Earnings of dentists
Great Britain 1990/91
'(DR5Q principals only)

Gross Earnings	Total	%	Cumulative %
< 4,999	393	2.5	2.5
5,000 - 9,999	327	2.1	4.7
10,000 - 14,999	310	2.0	6.7
15,000 - 19,999	295	1.9	8.6
20,000 - 24,999	330	2.1	10.7
25,000 - 29,999	379	2.5	13.2
30,000 - 34,999	402	2.6	15.8
35,000 - 39,999	495	3.2	19.0
40,000 - 44,999	559	3.6	22.6
45,000 - 49,999	630	4.1	26.7
50,000 - 54,999	756	4.9	31.6
55,000 - 59,999	846	5.5	37.1
60,000 - 64,999	1,005	6.5	43.6
65,000 - 69,999	1,016	6.6	50.2
70,000 - 74,999	973	6.3	56.5
75,000 - 79,999	982	6.4	62.8
80,000 - 84,999	865	5.6	68.4
85,000 - 89,999	829	5.4	73.8
90,000 - 94,999	665	4.3	78.1
95,000 - 99,999	616	4.0	82.1
100,000 - 104,999	526	3.4	85.5
105,000 - 109,999	434	2.8	88.3
110,000 - 114,999	345	2.2	90.6
115,000 - 119,999	277	1.8	92.4
120,000 - 124,999	221	1.4	93.8
125,000 - 129,999	195	1.3	95.1
130,000 - 134,999	142	0.9	96.0
135,000 - 139,999	107	0.7	96.7
140,000 - 144,999	97	0.6	97.3
145,000 - 149,999	85	0.6	97.9
150,000 - 154,999	55	0.4	98.2
155,000 - 159,999	53	0.3	98.6
160,000 - 164,999	42	0.3	98.8
165,000 - 169,999	30	0.2	99.0
170,000 - 174,999	29	0.2	99.2
175,000 - 179,999	26	0.2	99.4
180,000 - 184,999	22	0.1	99.5
185,000 - 189,999	14	0.1	99.6
190,000 - 194,999	13	0.1	99.7
195,000 - 199,999	7	0.0	99.7
> 200,000	40	0.3	100.0
Total	15,433	100	

TABLE 4

Distribution of Gross Earnings of Dentists Great Britain 1990/91



Average gross earnings per dentist = £70,679

DRSG principals

TABLE 5

TAGI AND TANI 1979/80 TO 1991/92

YEAR	TANI	TAGI
1979/80	11,128	27,495
1980/81	14,675	34,270
1981/82	15,555	36,827
1982/83	16,435	39,744
1983/84	17,556	42,650
1984/85	18,707	45,896
1985/86	20,083	48,415
1986/87	21,345	50,814
1987/88	23,220	56,340
1988/89	24,920	61,165
1989/90	26,915	65,038
1990/91	29,035	67,235
1991/92	32,317	72,239
1992/93	35,815	

SUBJECT
MASTER
Filed on:

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

21 February 1992

Dear Colin,

DENTISTS' FEES

In the margins of Cabinet yesterday, your Secretary of State met the Prime Minister, the Chief Secretary and the Chancellor of the Duchy of Lancaster to consider whether the reduction in dentists' fees proposed from 1 April should go ahead as planned.

Following a brief discussion, it was agreed that the proposed interim reduction in dentists' fees should not apply as from 1 April. Instead, officials should meet dentists' representatives later in the afternoon as planned and secure agreement to a review of dentists' expenses in running their practices. This review would be relevant to the further discussion on dentists' fees which would take place at the usual time in May. Following that meeting, Ministers would decide on the level of dentists' fees for the forthcoming financial year.

No understandings or agreements were reached on the level of fees that would be appropriate in the next financial year - or on the future handling of current and past over-payment of fees to dentists.

I am copying this letter to Nicholas Holgate (Chief Secretary's Office), Robert Canniff (Chancellor of the Duchy of Lancaster's Office) and to Sonia Phippard (Cabinet Office).

Yours

Barry

BARRY H. POTTER

Colin Phillips, Esq.,
Department of Health.

10 DOWNING STREET

Prime Minister

Mr Waldegrave wants to raise the subject of Aberporth. I have persuaded him not to raise it in open session but to have a word after Cab with you and CST.

AT
20/2

what is the loss to average dentist of claw back!

PRIME MINISTER

DENTISTS

what is cost of W. package?

William Waldegrave's Private Secretary telephoned this morning to indicate that his Secretary of State was becoming increasingly concerned about dentists' fees.

You will recall the background (see attached note). Following the announcement that there would be an interim cut in dentists' fees, the various dentists' representatives are embarking on a hostile campaign.

In essence, Mr. Waldegrave is putting out feelers to see whether you might support a less tough deal for the dentists. What he has in mind is two possibilities:

- first, the Government would write off past over-payment rather than seeking to claw it back in future years;

- second, the fall in dentists' fees might be moderated.

Department of Health officials are meeting the dentists' representatives tomorrow; Mr. Waldegrave meets them on Monday.

Assessment

I have spoken to Carolyn Sinclair. We both consider that it would be wrong for the Government to backtrack now. The essence of Mr. Waldegrave's argument is that the dentists are a well organised group, and are going to give him trouble. That is not a case for giving way to them.

The basics are unchanged.

(i) Dentists have been overpaid in the past: in small part, only because they are doing more work. In short, they have gained more income than their own Pay Review Body suggested was appropriate.

(ii) The Government has implemented the Pay Review Body recommendations for dentists for next year in full. That award was the highest of all the PRB recommendations. It is nearly twice the level of private sector wage settlements. The Government can do no more than it has.

(iii) Lower dental fees for dentists feed into lower dental charges for patients. Moderating the reduction in dental fees means fewer benefits for dental patients.

But there is a difficulty. The only stick available to the dentists is to threaten that they will leave the NHS. Carolyn's view is that some may do so: but the scope for increasing private practice in the short term is relatively limited. Most know that, and would be quickly driven back into the arms of the NHS.

That said, stories persist of people finding difficulty in getting an NHS dentist. The problem is localised - in the south, in affluent areas. The dentists will nonetheless use the threat. And it is not being well handled by DH. We have asked DH for a brief on the facts and their line to take.

So far as fees are concerned, it may be that Mr. Waldegrave was badly advised by his officials who failed to appreciate the strength of the dentists' reaction. But backtracking at this stage is poor politics and not justified. The Government has a good case and should stick to it.

Content?

BHP

Barry H. Potter
19 February 1992
a:\economic\dentists.dsg

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

10 February 1992

Dear Sir Trevor,

Thank you for your letter of 16 January enclosing the Twenty-second Report of the Review Body on Doctors and Dentists Remuneration. I am most grateful to you and your colleagues for all the hard work which has clearly gone into preparing this report. Please pass on my thanks to the other members.

As you will know, I announced today that the Government has accepted all the recommendations of the Review Body and will implement them in full from 1 April.

Yours sincerely,
John Major

Sir Trevor Holdsworth

(2)

No choice. f.

PRIME MINISTER

PAY REVIEW BODY REPORTS: DENTISTS

After yesterday's decisions on the Pay Review Body reports, the difficult issue of dentists' fees was to be resolved bilaterally between the Health Secretary and the Chief Secretary.

Following bilateral discussions today, they have reached an agreement. However, that agreement involves indicating, when the Pay Review Body recommendations are announced on Monday, that dental fees will need to be reduced in the next financial year. This will not go down well with the dentists: yet no action risks a claim on the Reserve of up to £150 million.

On balance, I think DOH should go ahead with their proposed announcement. The public line is clear:

- the Government has accepted the DDRB recommendations for dentists in full;

- dentists are already being paid more than was intended;

- the reduction in dental fees proposed is fully consistent with the DDRB recommendations; and

- in due course, lower dental fees, associated with greater efficiency by dentists, will lead to lower dental charges to the public.

In view of the politics, however, you should be aware of Mr. Waldegrave's proposals. I attach his draft speaking note for his meeting with dentists' representatives on Monday morning.

BHP

BARRY H. POTTER

7 February 1992

c:\ECONOMIC\DENTISTS

POLICY IN CONFIDENCE

SPEAKING NOTE FOR SECRETARY OF STATE'S MEETING WITH MR RICH

1. The DDRB have recommended that the salaries of salaried dentists (hospital and community dentists, and salaried general dental practitioners) should be increased by 5.5%. For the bulk of GDPs, ie those who are not salaried, they have recommended an increase of 8.5% over the level of TANI they recommended last year. The Government has decided to accept the Review Body's recommendations.

2. There is, however, a problem in relation to GDPs which we shall need to discuss with you in detail. The information which we have points to a very substantial overpayment in the current financial year. So much so, that it looks as though, if the current fee levels remained unchanged, there would be a further substantial overpayment in 1992-93, despite the increase in TANI I have just mentioned. In other words, it is very likely that a fee cut will be needed - quite possibly in double figures.

3. Clearly, the extent of any cut will depend on a number of factors, notably the expenses which dentists are forecasted as likely to incur in 1992-93 and the extent to which their output is forecasted to increase or decrease. I do not think we are in a position at this time to come to final conclusions on those matters. Officials will therefore be consulting you, at Wednesday's meeting of the Dental Rates Study Group (DRSG), on the proposal that the normal business of the DRSG should be deferred until later in the year - probably May - with a view to introducing a new fee scale from 1 July. They will also be putting forward our ideas as to how we might, in the meantime, obtain information which would help us reach a better informed judgement.

4. However, in my view it would be highly undesirable to allow the overpayments inherent in the current fee scale to continue. I therefore propose to consult you on the possibility of an interim fee reduction from 1 April, based on the best information now available to us. Officials will spell out this proposal in more detail at Wednesday's DRSG meeting, but it is our firm intention to let you have a draft revised fee scale by the end of the week, so that you will have a reasonable time to comment on it, and I will have a reasonable time to consider your comments before reaching a final conclusion.

5. Clearly, the situation we are now in is highly unsatisfactory and we must jointly make every effort to ensure that it does not occur again. I therefore propose that we should take a fundamental look at the remuneration system - as, indeed, the Review Body has recommended - with a view to giving agreed evidence to the DDRB for the 1993 pay round. As part of these discussions, we must clearly cover how to deal with this year's overpayment. I would not rule out further waivers of the kind we made in respect of 1988-89 if progress overall was satisfactory.

MR POTTER

6th February 1992

cc Mrs Hogg

DENTISTS' PAY

Dentists' NHS pay, like doctors', is made up of a number of fees. Each year the DDRB sets a target average net income (TANI) for dentists. The Dental Rates Study Group (which includes dentists' representatives) then work out the level of fees which will produce these figures. This depends on the assumptions made about expenses and volume of work. If these assumptions prove wrong, dentists will be over - or-under-paid.

- Last year the DDRB recommended a TANI of £33,000 pa for 1991-2. But the DRSG under-estimated the amount of work dentists would do.

- Actual average net income is running at £44,000 pa.

Therefore the DDRB's recommended TANI of £35,815 for 1992-3 will involve a drop of over £8,000 on average. Fees would have to be cut by $18^1/_2$ per cent from 1st April to achieve this.

This is pretty ghastly. On the other hand:

- dentists have been overpaid around £17,000 on average since 1988-9. This has not yet been clawed back (cumulative total around £230m);

- just keeping fees where they are would cost £150m from the Reserve in 1992-3;

- an $18^1/_2$ per cent cut in fees benefits NHS patients, many of whom pay three quarters of the fee themselves.

A system which produces these results is lunatic. The aim is to agree a new system with the dentists for 1st April 1993. Meanwhile how do we solve today's problem?

William Waldegrave has no ideas and suggests putting a decision off until after the Election. it is quite usual for the negotiations on fee levels to drag on for months - last year the new fees were not fixed until 1st July. But the shorter the period of 1992-3 covered by new fees, the bigger the cut will have to be. The $18^{1}/_{2}$ per cent cut needed to achieve this year's TANI from 1st April becomes a 26 per cent cut if delayed until 1st July. And the dentists who negotiate the fee rates may well realise that they have more bargaining power before an Election and may force the pace of the negotiations.

Conclusion

£150 million from the Reserve to buy off trouble from the dentists is simply too much. It is true that cutting fees will produce a row - and it will exacerbate the problem of dentists in the South East withdrawing from the NHS (but there are solutions in that e.g. a South East allowance of some kind, or direct employment of dentists by FHSAs).

There seem to be two options:

- try to play things long and have the row after the Election (but it may not be possible to achieve this);

- go for the $18/_{2}$ per cent cut from 1st April, but offer to write off the accumulated over-payments of £230m which would otherwise have to be clawed back in 1993-4, 1994-5 etc.

CAROLYN SINCLAIR 267.cs

SECRET

cc B/up
1.5PM 6(a-b)
- have told DES they must resolve with HMT in first instance.
BttP
3/2

SECRETARY OF STATE FOR EDUCATION AND SCIENCE

SANCTUARY BUILDINGS GREAT SMITH STREET
WESTMINSTER LONDON SW1P 3BT
TELEPHONE 071-925 5000

The Rt Hon KENNETH CLARKE QC MP

The Rt Hon John Major
Prime Minister
10 Downing Street
LONDON

Dear Prime Minister.

-3 FEB 1992

CLINICAL ACADEMIC PAY

We are meeting on Tuesday to consider our response to the reports of the Review Bodies. You have already seen my letter of 22 January to David Mellor on this topic.

If we agree on Tuesday to accept the recommendation of the DDRB to raise doctors' pay by 5.5% and if the Department of Health is compensated for the cost of this in excess of current provision, I shall seek an additional sum of £1.2m to put the universities, who employ the clinical academics, on an equal footing with the National Health Service in the funding of this award. We are publicly pledged to give the universities no less favourable treatment than the Hospital and Community Health Service in any decisions to provide additional funds to meet the cost of DDRB awards.

At present we give effect to that pledge through a formula which, provided the NHS is also compensated, compensates the universities for any excess in cost of a settlement for clinical academics based on the Government's response to the DDRB, relative to the settlement which they negotiate for non-clinical academics. In recent years the non-clinical settlement has come several months after our award to NHS doctors, and the Vice-Chancellors have declined to put the full clinical award into payment straight away, on the grounds that their compensation will depend on the non-clinical settlement still outstanding, and that hence they have to look at the clinicals along with the much larger outlay on non-clinical academic pay. This has led to enormous resentment among clinical academics working in the NHS, who cannot understand why it takes so long to give effect to the principle of parity when everyone agrees to it. In the end of course they do get parity, and this self-inflicted wound saves us nothing.

Accordingly I propose that we break the link with the non-clinical pay settlement, and compensate the universities for the

DES

SECRET

difference between the forecast increase in the GDP deflator and the increase in pay decided by Government in the light of the DDRB report. With a 4.5% GDP deflator forecast, £1.2m would make up the 1% difference to a 5.5% settlement. This would put the universities on all fours with the NHS in accordance with our pledge. I should make clear to the Vice-Chancellors that this £1m was on offer only if they agree immediately to translate to clinical academics the award we make to NHS doctors. I have reason to think that they will accept that. For the future, we could separate the clinical academic pay bill in our planning for university expenditure, and make the same allowance for the following year's increase as we make for the NHS doctors.

I have sent copies of this letter to Norman Lamont, David Mellor and William Waldegrave; also to Sir Robin Butler.

KENNETH CLARKE

cst.ps/dr/11dm31.1

CONFIDENTIAL

Treasury Chambers, Parliament Street SW1P 3AG
071-270 3000
Fax 071-270 5456

The Rt Hon Kenneth Clarke QC MP
Secretary of State for Education and Science
Department of Education and Science
Sanctuary Buildings
Great Smith Street
Westminster
London
SW1P 3BT

3 February 1992

CLINICAL ACADEMIC PAY

Thank you for your letter of 22 January.

2. I was disappointed to learn that you are not willing to accept my proposal, or the modification of it that our officials discussed. I believe that it would have directly tackled the timing difficulties which are your - and the BMA's - concern.

3. For my part, I have already made clear that I cannot accept the change you propose. As you acknowledge, it would involve an additional claim on the Reserve. And since the settlement of grant for universities is not specifically based on particular pay assumptions - given the responsibility we give higher education institutions to assess their own spending priorities - it would not be possible to avoid higher total public spending in the way you suggest. I am not prepared to agree to an arrangement that will cut across our policies towards public sector pay and higher education institutions in this way, simply because of irresponsible behaviour from the Vice Chancellors.

4. I also think it would be inappropriate to raise this matter when we consider the Review Body reports: not least because I do not accept that the DDRB's recommendations on NHS doctors take any account of the position of clinical academics.

5. I am copying this letter to the Prime Minister and to William Waldegrave.

DAVID MELLOR

NAT HEATH : Doctors and Donors - PTL

SECRETARY OF STATE FOR EDUCATION AND SCIENCE

SANCTUARY BUILDINGS GREAT SMITH STREET
WESTMINSTER LONDON SW1P 3BT
TELEPHONE 071-925 5000

The Rt Hon KENNETH CLARKE QC MP

CONFIDENTIAL

The Rt Hon David Mellor QC MP
Chief Secretary
HM Treasury
Parliament Street
LONDON
SW1P 3AG

22 January 1992

Dear David,

CLINICAL ACADEMIC PAY

Thank you for your letter of 23 December. I think that this may have crossed with a letter from my officials to yours dealing with the further information to which you referred in paragraph 5 of your letter.

Our officials have now discussed in detail your own proposal for funding what I had in mind. It is certainly ingenious. However it impinges on the funding of initiatives in education generally in a way which I cannot accept. I continue to believe that the way forward lies in the much more straight forward arrangement whereby annual PES settlements for universities explicitly include provision for clinical academic pay increases at the level of the relevant GDP deflator. That would avoid any additional total public spending; and any additional claim on the reserve would be insignificant as compared with claims arising from the Review Bodies as a whole.

While I can reassure the CVCP about the operation of our present formula and encourage them to consider an early settlement, I think it is very unlikely that this will have any more impact than in recent years. The Vice-Chancellors will say quite properly that the link which the formula provides with the pay of other staff means that they must look at the two settlements together.

So I think I only have two options left. I can either leave matters on that basis and wait and see whether the potential problems become a matter of real concern in the NHS in February

DES

and March following the Government's decision on the DDRB recommendations. I doubt whether our colleagues will thank us if I proceed in that way and if things go wrong. The statement from the BMA on 6 January (copy attached) reveals a continuing high degree of concern about the problem. Or I can raise the problem when we meet with the Prime Minister to discuss the Review Body reports. That is, I think, what I shall have to do.

I am sending a copy of this letter to the Prime Minister and to William Waldegrave.

KENNETH CLARKE

FILE

MJ

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

17 January 1992

Dear Sir Trevor

Thank you for your letter of 16 January to the Prime Minister covering the Twenty-Second Report of the Review Body on Doctors' and Dentists' Remuneration.

The Report is now being carefully considered by the Prime Minister in consultation with colleagues. As soon as a decision has been reached on its recommendations the Prime Minister will write to you setting out the Government's conclusions.

Yours sincerely

Barry H. Potter

Barry H Potter

Sir Trevor Holdsworth

WB

copy

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 071-405 5944
Fax 071-405 5148

The Rt Hon John Major MP
Prime Minister
10 Downing Street
LONDON SW1

16 January 1992

Dear Prime Minister

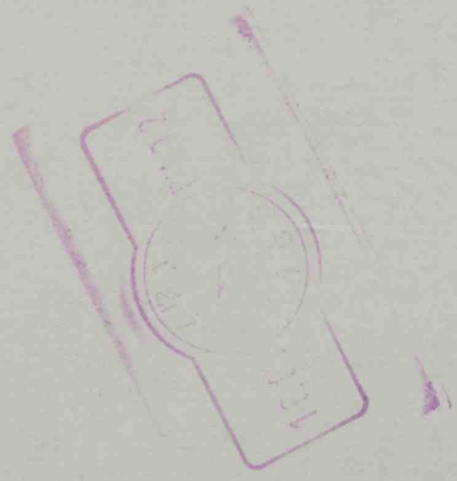
REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

I enclose the Twenty-Second Report of the Review Body on Doctors' and Dentists' Remuneration. This contains our recommendations on the levels of remuneration we consider to be appropriate as at 1 April 1992 and sets out the factors we considered were of particular importance when reaching our conclusions.

Yours sincerely

Trevor Holdsworth

SIR TREVOR HOLDSWORTH
CHAIRMAN



FAH/3777p+/3

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cc DH

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

FAX DOCUMENT LEADER

For the attention of: Barry Potter

From: Colin Phillips
Room 407
WILLIAM WALDEGRAVE'S OFFICE

Total No of Pages: 4 (inc cover

Any queries: 210 5319

DRAFT DRAFT DRAFT

91-743 16 December 1991

GOVERNMENT ANNOUNCES PAY RISES FOR JUNIOR DOCTORS

250 more doctors to be appointed in drive to reduce hours

The Government is to give junior hospital doctors and dentists pay increases for out of hours work worth £44 million a year.

It is also making £11.5 million available next year to enable the Health Service in England to recruit 150 more consultants and 100 more staff grade doctors to help reduce juniors' hours.

The new pay rates recommended by the Doctors and Dentists Review Body follow the agreement reached in June between the Government and doctors' representatives to restructure the working arrangements of junior doctors and reduce their hours of duty.

The award will add an estimated 5.8 per cent to the paybill for junior doctors. For the first time, junior doctors and dentists will be paid at different rates according to the type of working pattern for which they are contracted.

The new posts are in addition to the 200 consultants and 50 staff grade posts funded this year and are part of a rolling programme aimed at implementing the joint agreement on juniors' hours. In all, some £24.5 m will be available in England next year to help reduce hours by recruiting extra doctors.

William Waldegrave, Secretary of State for Health, said:

"These decisions demonstrate once again our commitment to reducing the unacceptably long hours worked by junior doctors. It remains one of our top priorities.

"I know that much work has been going on to take forward the hours reduction, but inevitably junior doctors have been reluctant to move towards new working arrangements until they had a clear idea of the new pay rates. Once these are implemented I am sure we shall see further progress.

"We have always recognised that it is not possible to reduce working hours for all juniors overnight and that additional posts would need to be established in some places to enable change to happen.

(MORE)

I look to Regional Task Forces to ensure that the extra posts are targeted to the units where they are most needed. Funding for additional posts in future years will be considered in the light both of progress in reducing hours and of future public expenditure rounds."

NOTES FOR EDITORS

1. Acceptance of the recommendations of the Review Body was announced by the Prime Minister today in a parliamentary written reply to ( ).

2. The reduction in junior doctors hours is a UK initiative. Announcements on plans in Scotland, Wales and Northern Ireland will be made shortly.

3. The Review Body has recommended that junior doctors and dentists should be paid at different rates according to the type of working pattern for which they are contracted.

Full shift working

Those who work full shifts are be expected to work effectively all the time they are on duty and will be paid at basic rates for out of hours working.

Partial shift working

Those who work partial shifts will be working for a substantial proportion of their contracted hours. They will be paid at 70 per cent of the basic rates.

On-call rota working

Those working the traditional on-call rota will be paid at 50 per cent of the basic rates.

4. The full year cost of the award is estimated at £44 million in the United Kingdom, £36 m in England.

5. The DDRB is chaired by Sir Trevor Holdsworth and was established in 1971 to advise the Prime Minister on the remuneration of doctors and dentists taking any part in the National Health Service. It was invited to make recommendations on the rates of pay for out of hours working earlier this year following the joint agreement on new working arrangements for junior hospital doctors and dentists.

6. Full details of the new working arrangements, including full shift, partial shift and on-call working are contained in "Junior Doctors: The New Deal", published by the NHS Management Executive in June this year.

7. Maximum average contracted hours for doctors in training in hard-pressed posts - generally the busiest jobs - will be reduced to 72 per week by 31 December 1994. Regional Task Forces will report by the end of 1993 on the practical implications of reducing hours in posts which are not hard-pressed to 72 a week by 31 December 1996.

(ENDS)

PLEASE FAX TO BARRY POTTER, NO 10

DRAFT QUESTION

To ask the Prime Minister if he has yet received the supplementary report from the Doctors and Dentists Review Body on Pay for Out of Hours Work by Junior Doctors.

SUGGESTED ANSWER

This report has been published today and copies are in the Vote Office. I am grateful to the Review Body for the work they have put into preparing it.

The report recommends new rates of pay for out of hours working by hospital doctors and dentists in training following the agreement reached earlier this year which introduced new working arrangements and set limits on contracted hours of duty for such staff.

The recommended rates of pay are:-

100% of the basic rate for full shift working

70% of the basic rate for partial shift working

50% of the basic rate for on call rota working

The recommendations, which arise from a major restructuring of working arrangements, are estimated to increase the paybill for hospital doctors and dentists in training by 5.8% given certain assumptions about the proportion of staff who will be contracted under each working pattern.

The Government has decided to accept these recommendations and we shall seek to implement them as soon as possible in order to help to deliver our objective of reducing the hours of work of hospital doctors and dentists in training. The costs of the award will be met by Health Authorities and Boards from the resources which we have made available to them this year and which we shall be making available to them in future years, ~~as announced by my Rt. Hon. Friend the Chancellor on 6 November.~~

MA\183-7

File

DIS

cc: DoH
CO
HMT
Questions
Policy Unit

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

16 December 1991

Dear Sir Trevor,

You wrote to me on 4 October enclosing your supplementary report on pay for out of hours work by hospital doctors and dentists in training. I am most grateful to you and your colleagues for the work which has gone into preparing it.

I am announcing today that the Government has decided to accept the recommendations. We shall now be seeking to implement them as quickly as possible in order to help deliver the goal of reducing the hours worked by hospital doctors and dentists in training.

Yours sincerely,

John Major

Sir Trevor Holdsworth

DFS

cst.ps/dr/10dm12.12

CONFIDENTIAL

Treasury Chambers, Parliament Street SW1P 3AG
071-270 3000
Fax 071-270 5456

The Rt Hon William Waldegrave MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

12 December 1991

Dear Secretary of State,

DOCTORS' AND DENTISTS' REVIEW BODY: REPORT ON REMUNERATION RATES FOR OUT OF HOURS WORKING BY JUNIOR HOSPITAL DOCTORS

Thank you for your letter of 19 November.

2. I have to say that I see very little justification in combining a 5.8% pay increase for junior doctors with what I understand to be an average 12% reduction in working hours. Taken together with the DDRB's main recommendations, junior doctors would then have received an increase of over 16% in their pay, before taking account of the proposed reduction in hours. This is hardly a helpful signal to offer in the context of current Review Body considerations. In pay policy terms it is completely unjustified.

3. Against that, I recognise we have to set the political sensitivity of a group of doctors who attract considerable public sympathy for their current terms and conditions of service. There is also an argument for avoiding further public disagreement with the BMA. We also have to ask ourselves whether it is worth provoking industrial action by a relatively small number of staff over an issue where we would in any case propose to give them much of what they want. There are gains for the Government from the proposals and in particular the reduction in hours recommended by the DDRB is less than we might have expected.

4. Under the circumstances therefore I am prepared to agree that you should recommend acceptance of the DDRB recommendations. I am sure you will want to give any announcement a positive spin. It may be helpful if we present the increases in pay as justified by

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a fundamental restructuring of junior doctors conditions of service, and avoid creating a precedent whereby every reduction in hours is expected to be accompanied by further pay increases. I am sure that you will also wish to make the point to the Review Body in submitting evidence in future that pay increases are not necessarily appropriate when recommendations are accompanied by reductions in hours of service or other easing of conditions.

5. I am copying this letter to the Prime Minister, Chris Patten, Ian Lang, Peter Brooke and Sir Robin Butler.

Yours sincerely

Justin Wray

DAVID MELLOR

[Approved by the Chief Secretary and signed in his absence]

CC Q

Note

Explained proposal to PM
I'll see yesterday. P.M. content.

BTP
13/12

CONFIDENTIAL

PRIME MINISTER

DDRB SUPPLEMENTARY REPORT ON RATES OF PAY FOR OUT OF HOURS WORKING BY JUNIOR HOSPITAL DOCTORS AND DENTISTS

In October the DDRB submitted to you their supplementary report recommending the rates of pay for the working arrangements introduced under our "New Deal" for junior hospital doctors and dentists. Their recommendations were that out of hours work should be remunerated at the following rate:-

- 100% of basic rates for full shift working
- 70% of basic rates for partial shift working
- 50% of basic rates for work on 'on-call' rotas

They estimated, and we agree, that their recommendations would add 5.8% to the junior doctors paybill given the assumptions we have made about the movement by junior doctors on to different working patterns. The additional costs stem primarily from their proposal that the 'on-call' rate should be 50% for all junior doctors. Our evidence to the Review Body had proposed rates of 35% for registrars and senior registrars and 40% for house officers and senior house officers which would have resulted in a broadly cost neutral outcome.

I have considered the recommendations carefully and I have discussed them with the Review Body chairman, Sir Trevor Holdsworth. I have also consulted Norman Lamont. I recognise the very real difficulties which flow from accepting the recommendations as they stand. In particular they give a further substantial pay increase to many (though not all) junior doctors

on top of the 9.5% increase recommended by the Review Body earlier this year. Furthermore the recommendations give an unwelcome increase in the rates of pay for those junior doctors who will in future be working least intensively. However, there are, in my view, two overwhelming arguments in favour of acceptance.

Firstly, the 'New Deal' which we launched this June is still viewed with some scepticism by many junior doctors who are only too ready to accuse us of not being willing to resource the changes we wish to see. Their new, and more radical, committee is committed to fighting for higher pay rates. They are holding a meeting on 13 December which will discuss strike action. If we reject the Review Body report, and propose lower rates for those working 'on-call' rotas, we shall give them a stick with which to beat us. Furthermore, the general public is sympathetic to the junior doctors cause and is unlikely to understand it if we interfere with the Review Body recommendations. Finally, of course, the opposition will make play of any unwillingness to accept the Review Body's proposals on purely financial grounds.

Secondly, accepting the Review Body's recommendations will send them a clear signal that we continue to value their work at a time when, despite our continued statements that we do not intend to wind them up, they remain uneasy about their future role.

In short, despite the disappointing nature of the Review Body's recommendations, I recommend that we accept them and that we publish the report and announce our decision, as quickly as possible. You are meeting the Chairman of the BMA on Monday and

it would be very helpful if you could tell them of our acceptance then. I attach a draft PQ, a letter to Sir Trevor Holdsworth and a Press Release for your and colleagues approval.

So far as funding is concerned, I have agreed that the overall addition to my programme obtained in the recent Survey would cover any additional costs stemming from accepting the Review Body's Report. I shall make this clear to the health Service when we announce our decision.

I am copying this minute to Norman Lamont, Ian Lang, David Hunt, Peter Brooke and Sir Robin Butler.

W.A.W.
12 December 1991

DRAFT LETTER TO SIR TREVOR HOLDSWORTH

You wrote to me on 4 October enclosing your supplementary report on pay for out of hours work by hospital doctors and dentists in training, and I am most grateful to you and your colleagues for the work which has gone into preparing it. I am announcing today that the Government has decided to accept the recommendations and we shall now be seeking to implement them as quickly as possible in order to help us to deliver the goal of reducing the hours worked by hospital doctors and dentists in training.

CAP36

DRAFT QUESTION

To ask the Prime Minister if he has yet received the supplementary report from the Doctors and Dentists Review Body on Pay for Out of Hours Work for Junior Doctors.

SUGGESTED ANSWER

This report has been published today and copies are in the Vote Office. I am grateful to the Review Body for the work they have put into preparing it. The report recommends that hospital doctors and dentists in training should receive payment at the following rates for out of hours working:-

- For full shift working at 100% of the basic rate
- For partial shift working at 70% of the basic rate
- For on call rota working at 50% of the basic rate

It is estimated that the recommendations will increase the paybill for junior hospital doctors by 5.8% given certain assumptions about the proportion of hospital doctors and dentists in training who will be contracted under each working pattern.

The Government has decided to accept these recommendations and we shall seek to implement them as soon as possible in order to help to deliver our objective of reducing the hours of work of hospital doctors and dentists in training. The costs of the award will be met by Health Authorities and boards from the resources which we have made available to them this year and which we shall be making available to them in future years, as announced by my Rt. Hon. Friend the Chancellor on 6 November.

CAP36

10 DOWNING STREET

Spoke → HMT. They will try to accelerate. NFA – thanks. RHP 9/12

Boyfry.

I spoke to Chris Padwick.

He says they are waiting for HMT clearance and have been chasing Treasury hard but to no luck. They are anxious to see this one dealt with but feel they are getting nowhere with HMT. Chris even suggested that a call from you to Treasury might make the difference if you tell them that you want a reply by X date. Worth a try?

Robert.
9/12

10 DOWNING STREET

Robert,
PO. ask DH when we will be able to reply. Tais has gone on rather long.

Barry,

See Chris's note & PTP 9/12 on at top of file about DI Health's letter at A.

Did Health ring you about this? When should we chase Health for the reply?

Robert
9/12.

10 DOWNING STREET

Bobby. Thanks
Don't press them.
BHP 2/12

We are still awaiting a substantive reply to Sir Trevor Holdsworth. Chris Padwick wrote to you with a holding reply (at A). I've just spoken to him and he says that this is very tricky. He is going to get Paul to ring you and discuss - ~~you~~ may may care to see the papers first.

Christopher
2/12

cst.ps/dr/10dm25.11

CONFIDENTIAL

Treasury Chambers, Parliament Street SW1P 3AG
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Fax 071-270 5456

The Rt Hon William Waldegrave MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

29 November 1991

Dear William,

DENTISTS' OVERPAYMENTS

Thank you for your letter of 19 November.

2. Like you, I regard it as very important that we adopt a principled approach to this. Our officials have continued their discussion and I am persuaded that it would be right to waive some £1529 of the dentists overpayment, at a cost of around £23 million.

3. There are, however, conditions which I must attach to this. First, what is said in public about the waiver will be as important as the figure itself if we are to avoid adverse repercussions or setting unwelcome precedents. Our officials have agreed a public presentation to avoid these changes which would have to be adhered to strictly.

4. Second, one of the factors which has influenced me is what your officials have described as a near certainty that without some kind of gesture of this kind we are likely to find the DDRB taking matters into their own hands and recommending a larger increase than they would otherwise do next January. There is clearly a risk that they might still do so for some or all of the balance of the overpayment. It will be very important that you should use whatever means are available to you to try to prevent this.

5. Third, we are agreed that we must take whatever steps are necessary to prevent anything like this happening again in the future. As a minimum that must mean your Department taking steps

3 PM
BHP
19/4

CYPD.

DEPARTMENT OF HEALTH

POLICY IN CONFIDENCE

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

The Rt Hon David Mellor QC MP
Chief Secretary
HM Treasury
Treasury Chambers
Parliament Street
LONDON
SW1P 3AG

19 November 1991

Dear David,

DENTISTS' OVERPAYMENTS

You wrote to me on 5 November recording that we had agreed to write off some part of the outstanding overpayment to dentists. You suggested it should be related to the change in the time taken by the Dental Practice Board to process claims for payment from dentists. I was and am happy to agree with that.

Our officials have been working hard to turn this general principle into an agreed figure. They have not managed to do so simply because there is no one "right" statistical answer. At least five statistical approaches have been considered. And even the statistical approach favoured by your officials can provide a wide range of different outcomes depending on the time period chosen.

My conclusion is that it is not possible to reach agreement simply on a statistical basis. Instead, you and I need to reach a political decision. And we need to do so very quickly, I hope by Friday, so that we can get the most positive and helpful response from the dentists and their leaders. An early and reasonable offer is by far our best chance of an agreement that both is welcomed and supported by dentists and much less than the complete write off they would really like.

I have looked at the various options. I am not going to press for the highest figures but we do need a figure which looks reasonable besides the amount of the GP settlement and which can be sensibly explained. A write-off of £1778 meets these

to ensure that the Dental Payments Board does not in future speed up (or slow down) payments significantly without a deliberate decision to do so, and in full knowledge of all the consequences. It might also mean changing the basis on which the balancing mechanism operates so as to put it on accruals rather than a cash basis. How quickly the DPB operated would then cease to be significant in this context (though it would still affect the timing of public expenditure). Your officials have helpfully promised mine a note on both points when they have though through the implications. But it would be worth putting down a marker now with the profession and with the DDRB.

6. I am copying this letter to the Prime Minister, Chris Patten, Ian Lang, Peter Brooke and Sir Robin Butler.

DAVID MELLOR

CYPJ.

3PM
BHP
19/4

DEPARTMENT OF HEALTH

POLICY IN CONFIDENCE

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

The Rt Hon David Mellor QC MP
Chief Secretary
HM Treasury
Treasury Chambers
Parliament Street
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SW1P 3AG

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I have looked at the various options. I am not going to press for the highest figures but we do need a figure which looks reasonable besides the amount of the GP settlement and which can be sensibly explained. A write-off of £1778 meets these

criteria. It is less than some of the figures being considered but more than your officials have recommended. I suggest you and I agree on this.
The cost is £28 million over the next few years. I shall then seek public backing from the dentists leaders.

It is important to us all to settle these overpayment issues as soon as possible, and, of course, to examine carefully how they arose.

I am copying this letter to the Prime Minister, Chris Patten, Ian Lang, Peter Brooke and Sir Robin Butler.

WILLIAM WALDEGRAVE

NAT HEALTH: DOCTORS + DENTISTS Pay Pt 4

Mr Potter

We spoke about this letter, which you kindly agreed to show to the Post but not to others.

N Hayes

12/11

SECRET

PERSONAL AND CONFIDENTIAL

CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street SW1P 3AG
071-270 3000
Fax 071-270 5456

The Rt Hon William Waldegrave MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

12 November 1991

Dear William.

DOCTORS AND DENTISTS OVERPAYMENTS

I have sent you formal replies on GPs and on dentists. But I thought that I should add this personal note underlining my concern about the way this issue has developed.

2. Even allowing for difficulties with the contract and the advantage of hindsight, cumulative overpayments of as much as £10,000 a GP and £6000 a dentist simply should not have happened. Moreover some of the explanations offered - the fifth target payment for GPs and the apparent failure to recognise the implications of speeding up payments to dentists - look pretty culpable.

3. Though I have been constructive in my response, I am sure you appreciate that it goes very much against the grain to agree to write offs on the scale we have discussed. These are not groups on whom I would have chosen to spend over £390 million of public money and then write a large proportion of that off. Such a sum exceeds the entire additions to the Survey baseline for 1992-93 which I agreed with Kenneth Baker or with Ken Clarke.

4. I was also annoyed by the way the issue surfaced. With minimal notice of the full size of the problem, I was expected to respond to your letter of 31 October almost instantaneously. Even then some of the figures justifying your proposition on dentists appear not to have been available. I fear that one factor in the handling of all this has been the presumption that, because the doctors and dentists are sensitive groups, it does not matter all that much if mistakes are made as the Exchequer will foot the bill. We cannot accept that and have got to do better than that.

PERSONAL AND CONFIDENTIAL

5. We clearly have to find out exactly how this all happened and plainly it must never happen again. My officials have already asked yours a large number of questions. I have already suggested a full and searching inquiry I would want this to cover the role of the Treasury as well as that of your department and OME. I hope you will take this very seriously and that we will have the opportunity to discuss the results soon.

DAVID MELLOR

cst.ps/dr/4dm6.11

COPY

CONFIDENTIAL

Treasury Chambers, Parliament Street SW1P 3AG
071-270 3000
Fax 071-270 5456

The Rt Hon William Waldegrave MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

12 November 1991

Dear William.

FAMILY DOCTORS' PAY: OVERPAYMENTS

Thank you for your letter of ~~31 October~~ 1 Aug, which we discussed yesterday morning following intensive discussions between our officials. This letter is to record what we agreed in respect of the GP overpayments: I have written to you separately about the dentists.

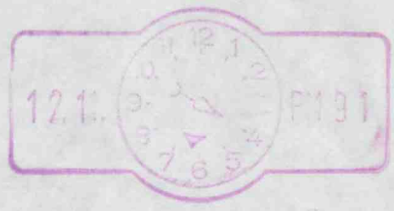
2. I accept that we have no option other than to write off that element of the GP overpayment which Ian Bogle describes as due to the "target payments fiasco". Accordingly, I am content that you should waive some £2,100 of the cumulative overpayment of around £10,000. But that would need to be part of a package to include consultation with the profession about the handling of the remaining overpayment. That must include the possibility of accelerated repayment, though I do not rule out further waivers if making overall progress should make that appropriate. Furthermore, the consultations must cover the proper incorporation of incentives and performance pay within the overall remuneration system. As you said to me, there is a need for a fundamental review of the GPs' pay system. I should be more than happy for our officials to take this forward together, though it is clearly a major undertaking; and to report back to us.

3. It is clearly most unsatisfactory to be in the position that we now find ourselves. The cumulative overpayment to GPs alone is worth well over £300 million, effectively an interest free loan to doctors from taxpayers' money. The dentists' overpayments adds a few score of extra millions to that. Waiving the £2,100 for GPs amounts to writing off over £60 million. I am sure you are no less disturbed by all this than I am. I trust, therefore, that you will be instituting a full internal inquiry as to the circumstances in which these excess payments arose, not least to determine why the

problem came to light so late, causing us to need to take decisions together at extremely short notice. In due course, I would welcome sight of the inquiry's finding. We must ensure the lessons from this experience do not go unheeded.

4. Copies of this letter go to the Prime Minister, Chris Patten, David Hunt, Ian Lang and Sir Robin Butler.

DAVID MELLOR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CONFIDENTIAL

CC/PO

13 pm

7/4

Treasury Chambers, Parliament Street SW1P 3AG
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Fax 071-270 5456

The Rt Hon William Waldegrave MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

5 November 1991

Dear Secretary of State,

DENTISTS' OVERPAYMENTS

We reached agreement this morning on how to treat the overpayments to GPs discussed in your letter of 31 October. I will be writing to you separately about that.

2. I also agreed this morning that you should write off some part of the analogous but entirely unrelated overpayment to dentists in 1988-89, subject to further clarification of the figures and on the basis that it was thought important to reach an early decision. My officials have now reported to me on the discussions they have had with yours today, which show matters in a different light.

3. The proposition which I had understood you to put to me was that it would be appropriate to write off that part of the overpayment which was believed to be due to a once and for all step change in the average length of time it took to process and pay dentists' claims for payment. It is possible to see how the dentists might feel aggrieved that the fact that the Government was now paying its bills to them more quickly, for reasons which had nothing to do with them, should result in a reduction in their level of fees. There is in my view a perfectly respectable answer to that. But it is not one which it is easy to get across.

4. I had supposed that it would be possible to justify this contention by demonstrating that the average period of payment actually had fallen in the year in question from a higher level before to an unambiguously lower level since. I was surprised to discover that these figures were not immediately available, and I

NHS HEALTH: Doctors + Dentists

understand that it may take a few days yet before they are. From the limited evidence that is available, it is far from clear that there was an exceptional and unambiguous movement in that year alone.

5. As I hope I showed in my response to your proposals about GPs, I am prepared to be constructive. But I do not see how I can reasonably agree to any write off for dentists before these figures become available and in advance of seeing what, if any, waiver they justify. Nor, I imagine, would you really want to find yourself in the position of announcing a write off without being certain that the facts are such as to justify it.

6. I recognise that this has implications for what you can say about dentists in the statement which you want make tomorrow. The best course is probably to say nothing.

7. I am copying this letter to the Prime Minister, Chris Patten, David Hunt, Ian Lang and Sir Robin Butler.

Yours sincerely,

Nicholas Hogarth

DAVID MELLOR

(approved by the Chief Secretary and signed in his absence)

Prime Minister
To see. HMT & DH have effectively resolved this. Loose ends will be tied up tomorrow. DH will provide a brief for P. Qs tomorrow morning — I will endorse DH minutes & your PM PQ tonight.
BHP 4/11

(2)

MR POTTER

4 November 1991

GP AND DENTISTS' PAY

The Treasury and the Department of Health are very close to agreeing a statement on "overpayments" to GPs which could be made by William Waldegrave on Wednesday. (Ian Bogle of the BMA should be told about it first, for diplomatic reasons).

Agreement has been reached:

- on the amount of the "overpayment" which is to be written off - £2,400;

- what is to be said about dealing with the rest of the problem and the system of determining pay more generally (the total "overpayment" is actually £10,000 per GP, though the BMA do not yet know this. They soon will).

The one outstanding point between Health and the Treasury is whether or not £250 which is due to be paid to GPs in December under the staging arrangements for this year's pay award should be paid in the face of the "overpayments". The Chief Secretary feels that it should not. But William Waldegrave thinks that holding back the £250 (which would after all have been paid to doctors had we not decided to stage the DDRB award) could lose us all the goodwill bought by writing off some of the "overpayment". I agree.

Must be right

Dentists

It has emerged that dentists too have been "overpaid" to the tune of £4,874 per dentist. The overpayment occurred in 1988/89, so clawback is due to start in 1992/93.

The circumstances are not exactly similar. But the Chief Secretary has told Treasury officials that if we write off some of the overpayment for doctors we will have to do something for dentists. Efforts are being made to wrap all this up in time to make a joint announcement, on Wednesday about GPs and dentists.

Conclusion

I see no need for the Prime Minister to adjudicate on the £250. I believe that if William Waldegrave digs in, the Chief Secretary will cave in.

I understand that William Waldegrave may try to talk to the Prime Minister. He wants to point out that while the proposal agreed with the Treasury should buy off an immediate fuss with the BMA, there still could be difficulties in the longer run about what should be done about the remaining "overpayments".

I suggest that you fend this off until we know that an agreement is in the bag.

CAROLYN SINCLAIR

012.CS

POLICY IN CONFIDENCE

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

The Rt Hon David Mellor QC MP
Chief Secretary
HM Treasury
Treasury Chambers
Parliament Street
LONDON
SW1P 3AG

31st October 1991

Dear David,

FAMILY DOCTORS' PAY

I am writing to let you know how I propose to deal with the over-delivery of pay to family doctors following the introduction of their new contract in April 1990. Developments since then are facing us with a series of problems, brought to a head by Ian Bogle's decision on 17 October to write to all family doctors informing them about the over-delivery during 1990-91. I enclose a copy of that letter (Annex A). Your officials will have briefed you about the questions at issue. And you will know of the Prime Minister's direct interest in their solution.

First of all the facts. In 1990-91, the first year of the contract, family doctors in Britain were paid in aggregate £182m more than intended (some £6,000 per doctor, gross of a figure for the expenses for running their practices which will not be known until December 1992). For 1991-92, on Government's advice, DDRB adjusted the levels of fee income which doctors could get for their work in order to bring these into line with intended income for that year. However, the latest figures show that the adjustment has not had the planned effect. Half year data point to a possible further overpayment for 1991-92 of £107m (£3,500 per doctor, gross of expenses).

Taking account of a small additional net overpayment of £600 per doctor inherited from the last year of their old contract, we therefore face the 1992-93 pay round with a probable overpayment to family doctors of £307m in aggregate (£10,000 per doctor before adjustment). The 1991-92 figure is not known to DDRB, nor the GMSC negotiators; but they will all learn about it by mid November when technical work begins on the final evidence for the 1992-93 pay round.

It would be wrong to underestimate the significance of an overpayment of this magnitude. It is going to place strain on the established DDRB arrangements for balancing the interests of the tax payer with the needs of family doctors for a predictable pay system.

But, equally, the first year of the new GP contract has seen major achievements for which we have taken great credit. Indeed, the benefits to patients from the contract changes have been a centrepiece in our accounts of the Government's record on health. And GPs are both the most politically influential members of the profession and the group in whom we have seen the most marked shift over the past year towards greater sympathy with the Government's reforms. We need to build on this, not to put it at risk. Any radical change of direction in response to the (undoubted) problem of the overpayment could only undermine the high profile claims we have made - with good reason - for the new contract. We should also face a <u>certain</u> row with the doctors themselves.

At such a cost it would be too early in the coming months to signal a change of course. DDRB, Government and the doctors themselves need at least a further year in operating the current arrangements before we could say that pricing decisions were being taken on the basis of informed judgement about the operation of the new contract. At any event we already know the route to take for the future on family doctor remuneration. We shall be negotiating with the profession from 1992 onwards to obtain the introduction of an improved performance pay element in the contract, based on stronger local management influence over GP remuneration.

I do not rule out the need to reconsider whether we are proceeding along the right lines. But it would be important to get the timing of any such review right, and to get the presentation of a possible change off on a positive footing. My immediate intentions are therefore two fold: we must first "nip in the bud" any pay campaign being developed within the profession following Ian Bogle's letter; then we must manage the coming pay round in order to limit possible damage. I deal with each below.

<u>The 1990-91 Overpayment to Family Doctors</u>

My detailed proposals for what can be done immediately to defuse issues which may come to us in direct consequence of Ian Bogle's letter are set out in the attached note (Annex B). You will see Dr Bogle himself gives us a way forward by directing attention to two specific issues which the GMSC see as candidates for special treatment. The issues are unique to the particular circumstances of 1990-91, and can be addressed without bringing into question the basic principles of the DDRB system for setting out remuneration arrangements, and for balancing resultant over

and under-payments. You will also note that there is more to the GMSC's "accounting procedures" point than the specific issue raised by Dr Bogle. My proposals result in Government writing-off £3290 per doctor (for Britain as a whole £100m in aggregate) of the 1990-91 overpayment. I believe this will be seen generally as appropriate Government recognition of the unprecedented circumstances of 1990-91, and can be presented to family doctors as a substantial concession which recognises their legitimate concerns.

I do not propose to negotiate with the GMSC on this, or on the other matters raised in Dr Bogle's letter - these are addressed appropriately to DDRB in the first instance. I think that we get maximum benefit from the concession by presenting it as a recognition, without precedent, that the changes introduced in 1990 have had unforeseen consequences which require remedy. To realise the benefit we need to act <u>now</u> - certainly before the 1991-92 overpayment further complicates the issue. I should be grateful for a quick response to these immediate proposals, therefore.

I have considered carefully how far, in return for a very substantial concession of this sort, we can secure the profession's commitment to strenuous measures to recover the sum likely to be left outstanding. Even for 1990-91 there is missing information which complicates the issue, and for that year we shall not know for sure the exact sum that falls to be recovered until Autumn 1992. At any event, the continued over delivery of the fee scales this year will dominate our concerns for the coming pay round.

With overall increases set to be very modest I, therefore, see no room to do more in 1992-93 than apply the balancing mechanisms in the usual way. Any attempt to force the pace by special measures would be likely to provoke the sort of row we want to avoid.

<u>Pay for Dentists</u>

The other contractor profession dealt with through the DDRB arrangements is also facing over-delivery of pay, again in consequence of one-off technical factors. Here, too, the sum is substantial and carries the same issues for the balancing arrangements and delivery of an important new contract.

It is clear from their questions to Virginia Bottomley when she gave oral evidence to them on 23 October that DDRB will want to be convinced that the Government is treating the dentists as even-handedly as the doctors. DDRB could adopt their own line on this if they suspect unfair treatment. In any case, Government would expect to have to answer public questions from the profession, and others, if we are less than even-handed.

On the sums, the balancing mechanism itself will bite substantially harder on the dentists in 1992-93 than on the doctors. On dentists' perceptions, we face a row every bit as damaging as with the doctors. We do not yet have all dentists fully on side on the new contract. We are currently contending with significant disturbance for them, and their patients, which has extended into public questions about the availability of NHS dentistry. Our position with the profession is therefore delicate. The political stakes are considerable.

On timing, the DDRB sets the same general framework as for doctors, and again mid-November is a critical period. Officials and the profession are due to give further oral evidence to the DDRB on dental matters and we expect DDRB to raise the overpayment issue again then. In their current restive state, there is a strong risk that the profession will follow the doctors and go public on the issue. With the current political sensitivities attached to NHS dentistry, I should like to be able to settle this matter and tell the profession as soon as possible.

I have concluded, therefore, that we must not avoid conflict with the family doctors over pay at the price of trouble with the dentists: and that we must recognise their claims also. A note on what is involved is attached to this letter (Annex C). The unprecedented consequence is that we would write off £2008 per dentist (£34m for Great Britain) from the dentists' outstanding need to pay back income in excess of intended earnings.

The 1992-93 Pay Round

Finally there is work to be done to manage the 1992-93 pay round. I cannot pretend in the circumstances that this will be other than damage limitation. Our officials will need to work closely together as will you and I; and in January there will need to be collective decisions on the DDRB's proposed award.

The first step is to assure everybody that we do not intend to accelerate the arrangements for recovering overpayments in the coming round. As I have said, I see no merit in getting into confrontation on this until we know the final size of the problem, and the strength of the measures that we shall need to deal with it. So I propose making it clear to both the profession and the DDRB as necessary that the right time to address these issues will be Autumn 1992. At that stage, the Government would wish to handle the issue in the light of the sums involved, the profession's concerns about a manageable pace of repayment and, above all, the interests of the tax payer on whose behalf Government had already waived a substantial sum. If need be, Government might then wish to ask the DDRB to make changes in the operation of the balancing mechanisms, in order to increase the rate at which outstanding overpayments were repaid.

Presented positively, I believe that this could set the tone for discussion and decision on the most urgent problem facing the DDRB this round - namely, how to re-balance the fee scales for family doctors within intended average income. It has to be said that on a most pessimistic view there would be no pay rise for doctors in 1992-93. But there is some way to go yet before the final calculations can be done.

Our officials have yet to discuss what evidence to put to the Review Body on the 1992-93 allowance for the indirect expenses GPs have to meet in running their practices. In addition, my officials will be working with GMSC to decide which adjustments to the fee scales are likely to be least damaging, and in the circumstances, I would expect the GMSC negotiators to work with us constructively on this.

To summarise my proposals, therefore, I should like to get maximum benefit from an early concession - defusing a potential row, and setting the terms for a constructive approach to the coming pay round. The pay round itself is critical. We may face difficult choices in Cabinet in the new year. I am instructing officials here to work with DDRB and GMSC so that an optimum balance is struck between getting the fee scales in balance with intended income, and giving the family doctors a defensible level of income for 1992-93. After that we shall have a platform for the longer term work which will undoubtedly be necessary.

Copies of this letter to go to the Prime Minister, Chris Patten, David Hunt, Ian Lang and Sir Robin Butler.

WILLIAM WALDEGRAVE

ANNEX A

BRITISH MEDICAL ASSOCIATION

BMA House Tavistock Square London WC1H 9JP

Secretary: Ian T Field MB BS FFPHM

GMSC
GENERAL
MEDICAL
SERVICES
COMMITTEE

CSD/IGB/JC
17 October 1991

Dear Colleague

YOUR PAY

As you know, in the financial year 1990/91 there was a projected 'overpayment' of about £3000 per GP. I am writing to you now because I have just received further information which indicates that this figure has increased to £5951. It may be reduced as a result of evidence about GPs' expenses; a special enquiry will report on these to the Review Body later this year. Whatever the final amount, under present arrangements it is due to be clawed back, over a period of several years, from future pay awards starting in April 1993.

For the financial year 1990/91, the Review Body recommended a general pay increase of 9.5% with 11.5% for GPs. This was intended to give GPs average pay of £34,680. In addition, the Review Body said that any GP who achieved the higher targets should receive the extra payment as a premium over and above average pay. However, the Government's interference in the 1990/91 award included bringing these premium payments inside average net pay for the nine month period April to December 1990. This unilateral decision by the Government accounts for £1400 of the £5951 so called 'overpayment'. To add insult to injury, Government accounting procedures require all payments resulting from activities carried out within any financial year to be regarded as having been earned in that year. Because double target payments were made in September 1990 to start the system off, GPs are thus deemed to have received target payments equivalent to the value of five quarters during 1990/91 causing a further £700 of the 'overpayment'.

Other major factors contributing to the 'overpayment' include the impact of GPs' considerable efforts to meet the demands of the new contract, notably in the areas of health promotion clinics, minor surgery, immunisations and vaccinations, and cervical cytology.

When I presented this information to the General Medical Services Committee at today's meeting they were as outraged as you will be, particularly as Kenneth Clarke, when Secretary of State, had told GPs that he would have no problems in rewarding extra effort. The challenge to the present Secretary of State is to ensure that the promises of his predecessor are honoured. He can do this by not seeking to claw back that part of the overpayment resulting from the target payment fiasco. At the same time we are calling upon the Review Body to correct their original underpricing of the new contract.

We are making the profession's anger known to both the Government and the Review Body.

Yours sincerely

DR I G BOGLE
Chairman
General Medical Services Committee

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Listed as a Trade Union under the Trade Union and Labour Relations Act 1974

ANNEX B

1990-91 OVERPAYMENT: GMSC PROPOSALS

1. The GMSC's 17 October letter to the profession argues that two elements of the overpayment, both relating to target payments, were caused by special circumstances, unique to 1990-91, and should not be subject to the normal claw-back arrangements. In both cases, the Department recognises that there are technical arguments which would support the profession's case. Indeed the "fifth target payment" is one element of a larger one-off accounting effect caused by the shift to a more performance-related contract, which in itself deserves consideration as an exception to the normal rules.

Higher Target Payments

2. The largest single element of the 1990-91 overpayment is the effect of the Government's decision to bring higher target payments within IANI for 9 months - contrary to the DDRB's recommendation - as part of the staging of the award. This decision, interacting with the DDRB's underestimate of the number of GPs who would achieve higher targets, added a sum of £1800 per GP (not the GMSC's estimated £1400) to the "overpayment". Had it not been for the Government's staging decision, the payments would have been outside IANI, and the question of recovery would not have arisen.

3. The Health Departments have continued to argue in evidence to the DDRB - most recently, when giving oral evidence on 23 October - that it is right in principle to bring all target payments within IANI. But that is an issue of principle for the future. It is a matter of fact that the Government's intervention in 1990-91 compounded the problem of predicting uptake of payments in the first year of the contract. There are good grounds for treating this as an exceptional circumstance; this element of the overpayment could legitimately be waived without putting at risk the principles behind the balancing mechanism.

The Fifth Target Payment and the change to a more performance-related contract

4. The profession's complaints about the clawback of the "fifth target payment" in fact relate to one element of a larger transitional effect. In the case of target payments, the difficulty arises because the interval required to verify the data on practice achievements means that payments have to be made six months in arrears. Thus the first target payments were not made until October 1990. In order to maintain the flow of cash payments it was agreed that this first target payment should be doubled, so that the equivalent of four cash payments would be made in the course of 1990-91. For accounting purposes, however, a fifth payment, made in June 1991 in respect of achievements at January 1991, also falls to be brought to account. The interaction of this "fifth payment", with the decision to bring higher targets within IANI for 9 months, increases the total overpayment attributable to what GMSC describe as the "target payments fiasco" to £2043.

5. However, making target payments six months in arrears is just one example of a general shift in the timing of payments to GPs which resulted from the new contract. A consequence of having greater emphasis on payment by performance is that there is now a longer interval between when money is earned and when it is paid. The GP remuneration system operates on an accruals basis - that is, taking into account money earned in a year irrespective of when it was paid. We therefore have to make an adjustment each year to move from the cash basis on which payments are usually reported to an accruals basis. In an established pay system the adjustment is small but this was not the case in the first year of the contract. The longer delays in payment meant there was a large overhang of payments made in 1991-92 but earned in 1990-91 which far exceeded the overhang of payments made in 1990-91 but earned in 1989-90. In the first year of the contract the cash to accruals adjustment was equivalent to some £1250 per GP (excluding target payments which were dealt with in the preceding paragraph). This technical "accounting" effect is a direct consequence of the move to a more performance related pay structure and consequent re-timing of payments. In the Department's view it too could be waived without prejudice to the application of the balancing mechanism and without creating a difficult precedent as this change is unique to the first year of the new pay system.

Conclusion

6. Waiver of these two sums would reduce the overpayment by some £3290, bringing the outstanding overpayment down to less than £3000. It is relevant that the profession have been aware since the DDRB's last report that a gross overpayment of the order of some £3000 was in prospect. The year-end figure of almost £6000 has caused evident shockwaves, and bringing the problem back within the bounds GPs have been contemplating for some time would have clear benefits.

7. A further consideration is that in recognising and waiving elements of the overpayment which relate especially closely to the success of the performance-related elements of the contract, the Government would clear the path for further progress on performance pay. Without such a concession, any new proposals would be met by accusations that the Government had penalised the profession for its past successes. There is work to be done to find ways of further developing performance pay without the turbulence of 1990-91, but there will be a much better prospect of constructive dialogue with the profession if the particular grievances of 1990-91 can be resolved.

HCD-SD
October 1991

OVERPAYMENT TO GENERAL DENTAL PRACTITIONERS 1988-89

Background

General Dental Practitioners' target average net income (TANI) is recommended by the DDRB, but its translation into a fee scale is carried out by the Dental Rates Study Group (DRSG) on behalf of the DDRB. The DRSG has an independent chairman, but its membership is joint between the Department and the British Dental Association (BDA), and there is a joint Department/BDA secretariat. There is a similar balancing mechanism for dentists' pay to that for doctors'.

In 1988/89, dentists were overpaid £4,874 per dentist, some £82 million in Great Britain. The over-payment arose from two sources:

1) An over-forecast of dentists' practice expenses; (£1,650 per dentist; £28 million in GB)

2) An under-forecast of dentists' output, that is the volume of treatment undertaken (£3,224 per dentist; £54 million in GB).

The details are as follows:

Over-forecast of expenses

DRSG was much concerned in 1988 about the extra expenditure that dentists would have to incur to improve their cross infection control procedures, with the advent of HIV and Hepatitis B. The size of this extra expenditure, and the extent to which dentists would reduce other purchases to accommodate it, was very difficult to forecast. The forecasting of practice expenses in the 1988 DRSG was further complicated by technical factors arising from the practice expenses of associate dentists. In all, these special factors led to an over-forecast of practice expenses of £1,650 per dentist.

Under-forecast of dentists' output

The 1988 DRSG forecast that dentists' output would fall by 1.25% in 1988/89. In fact, it rose by 2.9%. Two major reasons for this under-forecast are:

The rate at which the Dental Practice Board (DPB), which pays all dentists in England and Wales, processed dentists' claims for payment. The 1988 DRSG met in July 1988, at which time the DPB was experiencing severe difficulties with its processing arrangements. Consequently, the amount of money being paid to dentists was reduced in the first quarter of 1988/89. The 1988 DRSG took account of these difficulties, and the other factors that affect dentists' output, in reaching its forecast of output. In fact the improvement by the DPB was rapid and dramatic, and some 1.1 million extra estimates were scheduled in the next six months. In the 1991 DRSG, the dentists argued strongly that this money was simply a late payment for work they had already done (an "interest free" loan to the NHS) and thus outside the balancing mechanism. We suspect that the DDRB shares this view.

The Government announced in November 1988, after the 1988 DRSG had set the dentists' fee scale, the introduction of a charge for dental examinations with effect from 1 January 1989. The introduction of this charge led large numbers of patients to bring forward their next visit to the dentist, which had the effect of increasing dentists' output in 1988/89. The DPB coped well with this extra surge of estimates in late 1988 and early 1989, and most were processed and paid to dentists within 1988/89.

The Department has considered carefully the factors surrounding the speed-up by the DPB. We have considered also what happened in 1987/88 and 1989/90; in each of these two years scheduling difficulties led to under-payments to dentists, although on a much smaller scale (£334 per dentist in 1987/88 and £882 in 1989/90). We take the view that, in calculating the impact of the DPB speed-up in 1988/89, we should first discount the impact of their slow downs in the other two years. Thus £1,216 (£334 plus £882) should be offset against the £3,224 overpayment in 1988/89, with the remaining £2,008 being regarded as adventitious and thus discounted when operating the balancing mechanism.

BH CF
I wrote on
8 October. DH
letter is too late
anyway - unless nothing
to exclude letter.
B.

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

21 October 1991

22/10

Dear Sir Trevor,

The Prime Minister has asked me to thank you for your letter of 4 October enclosing your report on pay for out of hours work for doctors in training. He is grateful for the valuable work that you and your colleagues have done in this very important area.

Your report and its recommendations are being closely examined, and the Prime Minister will reply to you as soon as the Government has reached its decision.

Yours sincerely,

Barry H. Potter

BARRY H. POTTER

Sir Trevor Holdsworth

R 21/10

(7)

DEPARTMENT OF HEALTH

CONFIDENTIAL

Barry Potter Esq
Private Secretary
10 Downing St

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of
State for Health

Dear Barry

As discussed, I attach a draft holding reply to Sir Trevor Holdsworth. I have spoken to our officials who are quite pessimistic about some of the supplements's recommendations. We will certainly have to approach this one with a great deal of care. I shall send you the full advice and reply as quickly as possible.

Yours ever

Chris

CHRIS PADWICK

Sir Trevor Holdsworth
Chairman
Review Body on Doctors' and Dentists' Remuneration

The Prime Minister has asked me to thank you for your letter of 4 October enclosing your report on pay for out of hours work for doctors in training. He is grateful for the important work that you and your colleagues have done in this very important area.

Your report and its recommendations are being closely examined, and the Prime Minister will reply to you as soon as the Government has reached its decision.

BARRY POTTER

NATIONAL HEALTH : Doctors & Dentists Pay Pt 4

ale BH
cpy
c/econ/doctors

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

8 October 1991

REVIEW BODY ON DOCTORS AND DENTISTS REMUNERATION: SECOND SUPPLEMENT TO 21ST REPORT

I enclose the covering letter which Sir Trevor Holdsworth sent to the Prime Minister on 4 October when he submitted the Review Body's Report on pay for out of hours work for doctors in training.

I should be grateful if you could let me have your advice and a draft reply by no later than Friday 18 October.

I am copying this letter and enclosure to Peter Owen (Cabinet Office) and Owen Barder (H M Treasury).

BARRY H. POTTER

Stephen Alcock, Esq.,
Department of Health

SH

RCa

c/ Holdsworth

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

8 October 1991

Thank you for your letter of 4 October to the Prime Minister covering the Doctors and Dentists Review Body's supplement to its 21st Report on pay for out of hours work for doctors in training.

The Report is now being carefully considered by the Prime Minister in consultation with colleagues. As soon as a decision has been reached on its recommendations the Prime Minister will write to you setting out the Government's conclusions.

BARRY H. POTTER

Sir Trevor Holdsworth

R

cc PM +1 bar

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 071-405 5944
Fax 071-405 5148

CONFIDENTIAL

The Rt Hon John Major MP
Prime Minister
10 Downing Street
LONDON
SW1

4 October 1991

Dear Prime Minister

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION: SECOND SUPPLEMENT TO TWENTY-FIRST REPORT

I enclose our second Supplement to the Twenty-First Report of the Review Body on Doctors' and Dentists' Remuneration, on pay for out-of-hours work of doctors in training.

Yours sincerely

TREVOR

SIR TREVOR HOLDSWORTH
Chairman

CONFIDENTIAL

MR POTTER

3 October 1991

cc Mrs Hogg

GP's PAY

The problem flagged up by William Waldegrave last night is not quite as bad as it sounded. There is no question of asking GPs to pay money back. Nor is it a question of making £150 million available this year, or in 1992-93.

The issue is what we do about doctors' pay in future years to take account of the fact that GPs on average are receiving £5-6,000 more than provided for in the DDRB's recommended average intended income for 1991-92.

This is not a new problem. The complicated system of payments to doctors frequently under - or over-shoots the sum of average intended income ie the total cake for doctors' pay. There is a mechanism for taking account of this in future years, adjusting awards upwards or downwards to compensate. Usually the figure by which pay is adrift is of the order of £600-£700 per doctor. Downward adjustments of this order, following over-payment, are not really noticed amid all the complexities.

You will see that it is the size of this year's "over payment" which is the problem. Logically the answer must lie in the speed with which you phase in "clawback".

What is not clear is how all this is going to become explicit, and when. We will need to see what William Waldegrave's note says (the senior officials involved are all out today). The Treasury are broadly aware of the issue. While not happy, they do not immediately see why it should be a political problem this winter (which is not to say that it won't be!)

CAROLYN SINCLAIR (481.CS)

FILE KW

CDSH

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

27 September 1991

Dear Trevor,

I am grateful to you and to your colleagues on the Review Body for the work which you have undertaken to produce your report on the supplement for Associate Specialists.

The Government have decided to accept the Review Body's recommendation that the performance supplement should be 7.5 per cent of the maximum of the Associate Specialist scale. The publication of your report can, therefore, go ahead. As the salaries of Associate Specialists are increased on 1 December, the Government plan to coincide the introduction of the new arrangements with that increase. This should allow health authorities and trusts time to prepare for the reform of the pay of this grade.

Yours sincerely,
John Major

Sir Trevor Holdsworth

SJ

PRIME MINISTER

DOCTORS AND DENTISTS REVIEW BODY: SUPPLEMENTARY REPORT

Both Mr Waldegrave and the Chancellor endorsed the DDRB recommendation for a new performance supplement for the Associate Specialist grade. The cost is small and can be absorbed within the Department of Health's existing provision. The only change proposed to the Review Body's recommendation is that the new arrangement should take effect from 1 December rather than, as they had assumed, 1 October. The 1 December date is when other medical staff salaries increase take effect.

If you are content, I attach a draft letter for you to send to the Review Body's Chairman, Sir Trevor Holdsworth. This letter will go out early next week when the Supplementary Report is laid in the House (this can be done during the recess). There will be a low key accompanying press release.

DOMINIC MORRIS
25 September 1991
c\ddrb (kw)

PPs pl to DM

P/A

C/R

Pl Type attached letter for PM sig.

10 DOWNING STREET

Dominic

The PM's approval to make an announcement needs to be sought, (I would recommend either Friday 27/9 or Monday 30/9). The PM also needs to sign the draft letter to the chairman of the review body, which will be despatched on the morning the paper is presented to Parliament by us.

CONFIDENTIAL

Dominic Morris Esq
Private Secretary
10 Downing St

Roy.
Advice pl. on
all the next steps
DR

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

24 SEP 1991

Dear Dominic

REVIEW BODY ON DOCTORS AND DENTISTS REMUNERATION: SUPPLEMENT TO 21ST REPORT

As you know, the Chancellor of the Exchequer has agreed with my Secretary of State's proposal to the Prime Minister in his minute of 10 September, to accept the Review Body's recommendation. I attach a draft letter to Sir Trevor Holdsworth from the Prime Minister.

Yours

Chris

Chris Padwick
Assistant Private Secretary

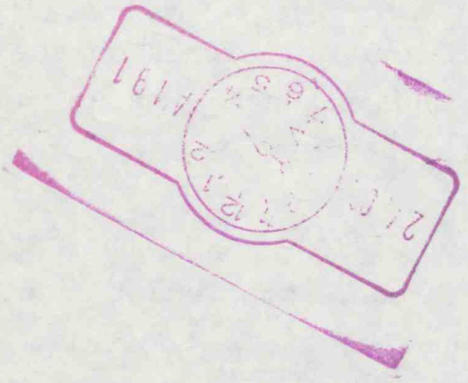
DRAFT LETTER TO SIR TREVOR HOLDSWORTH

I am grateful to you and to your colleagues on the Review Body for the work which you have undertaken to produce your report on the supplement for Associate Specialists.

The Government have decided to accept the Review Body's recommendation that the performance supplement should be 7.5 per cent of the maximum of the Associate Specialist scale. The publication of your report can, therefore, go ahead. As the salaries of Associate Specialists are increased on 1 December, the Government plan to coincide the introduction of the new arrangements with that increase. This shall allow health authorities and trusts time to prepare for the reform of the pay of this grade.

JOHN MAJOR

NAT HEALTH: DOCS
+ Dentists Pt4



chex.kf/ob/71 **CONFIDENTIAL**

CCPS

BL when draft reply rec'd or in 7 days!

Treasury Chambers, Parliament Street, SW1P 3AG
071-270 3000

PRIME MINISTER

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION: SUPPLEMENT TO TWENTY-FIRST REPORT

I have seen William Waldegrave's minute to you of 10 September, in which he recommends acceptance of the DDRB report on a new performance pay system for Associate Specialists.

2. I agree that the Review Body's recommendation should be accepted as proposed by William, with effect from 1 December 1991, and that the Department of Health should prepare a letter to Sir Trevor Holdsworth and a suitable press release.

3. My agreement is subject to two provisos:

(i) that an adequate system of evaluating the new scheme is put in place. My officials are currently corresponding with William's about this; and

(ii) that the cost of the scheme, as currently promulgated, will be absorbed within existing provision in both this and future years.

4. I am copying this to William Waldegrave, Ian Lang, David Hunt, Peter Brooke and Sir Robin Butler.

N.

[N.L.]

20 **September 1991**

NAT HEALTH: Docs + Dentists' Bill pt 4

Awaits Tsy
Comments
B/f when they arrive
or in 1 week

DMy
11/9

CONFIDENTIAL

D Morris Esq
Private Secretary
10 Downing St

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of
State for Health

11 SEP 1991

Dear Dominic

I attach a minute to the Prime Minister from my Secretary of State about the DDRB report on Associate Specialists. Treasury have been consulted at official level on the DDRB recommendation. They have advised that their Minister's views will need to be sought before a final response is sent to Sir Trevor Holdsworth.

Yours

Chris

CHRIS PADWICK

NAT HEALTH : Doctors + Dentists pay PTL

CONFIDENTIAL

Prime Minister

REVIEW BODY ON DOCTORS AND DENTISTS REMUNERATION (DDRB): SUPPLEMENT TO TWENTY FIRST REPORT

The Chairman of the DDRB, Sir Trevor Holdsworth, wrote to you on 7 August enclosing their report on Associate Specialists.

The DDRB have recommended that the performance supplement for Associate Specialists should be set at 7.5% of the maximum of the scale for the grade. This would be £2,780 per annum at 1 December 1991. The performance supplement is an element in a set of changes to the terms and conditions of the Associate Specialist grade which has been the subject of discussions with the professions representatives over the past two years. The package of changes will put the remuneration of this group on a more professional basis, and the introduction of performance supplements, although not a full performance-related pay system, will provide a reward for those Associate Specialists judged to be making particularly strong contributions to the service.

The net cost of the changes in Associate Specialists' terms, including the DDRB's recommendation, is estimated at £77,000 in 1991-2 and £181,000 in 1992-3 for Great Britain as a whole. The Health Departments would absorb the cost of this recommendation of the DDRB within existing provision.

I recommend acceptance of the DDRB's report, as it would replace the extra-duty allowance system, costing £2.0 million per annum, by more flexible arrangements.

If you and colleagues are content and accept the report, we will prepare a letter to Sir Trevor Holdsworth and a press release to be issued on publication of the report.

The DDRB report assumed implementation of its recommendations from 1 October. In view of the time taken so far and the fact that medical staff salaries increase on 1 December, it would be more appropriate if the new arrangements also took effect from that date.

I am copying this letter to Norman Lamont, Ian Lang, David Hunt, Peter Brooke and Sir Robin Butler.

W.A.W

10 September 1991

NAT HEALTH : Doctors + Dentists pay 1Td

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

22 August 1991

The Prime Minister has asked me to thank you for your letter of 7 August enclosing your Report on Associate Specialists. He is grateful for the close examination that you and your colleagues have given to the issues relating to Associate Specialists' pay.

Your recommendations are being carefully considered, and the Prime Minister will reply to you as soon as the Government has reached its decision.

DOMINIC MORRIS

Sir Trevor Holdsworth

Dominic Morris Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

22 August 1991

Dear Dominic

REVIEW BODY ON DOCTORS AND DENTISTS REMUNERATION: SUPPLEMENT TO 21ST REPORT

Thank you for your letter of 14 August, enclosing the letter of 7 August from Sir Trevor Holdsworth on the DDRB's report on Associate Specialists.

We are consulting Treasury at official level on the Review Body's recommendation for the level of the performance supplement. They had still not seen (20 August) a copy of the Report. We will provide advice on the report as soon as we can. I attach a suggested holding reply, and I am returning your original supplement as requested.

I am copying this letter to Peter Owen (Cabinet Office) and Kate Gaseltine (HM Treasury).

Chris Kelsall

STEPHEN ALCOCK
Principal Private Secretary

NATIONAL HEALTH : Doctors & Dentists Pt 4

DRAFT LETTER TO SIR TREVOR HOLDSWORTH

'REVIEW BODY ON DOCTORS AND DENTISTS REMUNERATION; SUPPLEMENT TO 21st REPORT

The Prime Minister has asked me to thank you for your letter of 7 august, enclosing your report on Associate Specialists. He is grateful for the close examination that you and your colleagues have given to the issues relating to Associate Specialists' pay.

Your recommendations are being carefully considered, and the Prime Minister will reply to you as soon as the Government has reached its decision.'

File to Pay/Review

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

14 August 1991

REVIEW BODY ON DOCTORS AND DENTISTS REMUNERATION:
SUPPLEMENT TO 21ST REPORT

I enclose the covering letter which Sir Trevor Holdsworth sent to the Prime Minister, when he submitted the Review Body's Report on the Associate Specialists' Performance Supplement.

I should be grateful if you could let me have your advice and a draft reply by not later than 1800 on Thursday, 22 August.

I am copying this letter and enclosure to Peter Owen (Cabinet Office) and Kate Gaseltine (HM Treasury).

DOMINIC MORRIS

Stephen Alcock, Esq.,
Department of Health.

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 071-405 5944
Fax 071-405 5148

CONFIDENTIAL

The Rt Hon John Major MP
Prime Minister
10 Downing Street
LONDON
SW1

7 August 1991

Dear Prime Minister

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION : SUPPLEMENT TO TWENTY-FIRST REPORT

I enclose our Supplement to the Twenty-First Report of the Review Body on Doctors' and Dentists' Remuneration, on the Associate Specialists' Performance Supplement.

Yours sincerely

Trevor Holdsworth

SIR TREVOR HOLDSWORTH
Chairman

Review Body on Doctors' and Dentists' Remuneration: Supplement to Twenty-First Report

1. Letter to Department of Health, copied to Cabinet Office and the Treasury for advice and draft reply to the Chairman of the Review Body's letter. — Has this gone yet? No - below

2. Subject to advice, seek Prime Minister's approval to make announcement* and submit reply to Chairman's letter for signature.

3. On day of announcement, letter must be sent to the Chairman 2-3 hours before the document is presented formally by No 10 to both Houses of Parliament.

* If departments respond on time I would recommend announcement on 29 August or 3 September.

10 DOWNING STREET

Dominic

Doctors + Dentists.

Health advice to proceed as normal - (even though we're in recess.)

Lenden
1418.

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

20 June 1991

Dear Dr. Lee-Potter,

Thank you for your letter of 7 June concerning comments made by the Secretary of State for Education and Science, Kenneth Clarke, on the "Today" programme on 6 June.

Kenneth Clarke did not wish to imply that the BMA's advertising campaign played any part in the Government's decision to reject the DDRB's recommendation of an increase in the value of the A+ awards for consultants. On the contrary, his remarks reflected his view that BMA reactions to that decision "had a lot to do with" fuelling the campaign.

As was made clear at the time, the Government's decision was based on its belief that the three-year programme to create a further 100 permanent consultant posts offered a better way of maintaining and improving the attractiveness of a career in hospital medicine than increasing the rewards available to those already at the top of the consultant scale.

Yours sincerely,

John Major

Dr J P Lee-Potter

SECRETARY OF STATE FOR EDUCATION AND SCIENCE

ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH
TELEPHONE 071-934 9000

The Rt Hon KENNETH CLARKE QC MP

Andrew Turnbull Esq
Principal Private Secretary
10 Downing Street
LONDON
SW1A 2AA

14 June 1991

Dear Andrew,

Thank you for your letter of 10 June with which you enclosed a copy of a letter from the Chairman of Council of the British Medical Association, taking issue with recent remarks by my Secretary of State concerning the past operation of the Doctors' and Dentists' Review Body.

I attach a draft reply for the Prime Minister, which draws on the observations of my Secretary of State and a letter sent to the BMA in 1990 by the then Prime Minister (copy enclosed for information). I believe it is self-explanatory.

I am copying this letter to Stephen Alcock (Department of Health) and Sonia Phippard (Cabinet Office).

Yours ever

CHRISTINA BIENKOWSKA
Principal Private Secretary

DES

SCANNED

DRAFT REPLY FOR THE PRIME MINISTER TO SEND TO DR J P LEE-POTTER, BMA

Thank you for your letter of 7 June concerning comments made by the Secretary of State for Education and Science, Kenneth Clarke, on the "Today" programme on 6 June.

Kenneth Clarke ~~was certainly not suggesting~~ did not wish to imply that the BMA's advertising campaign played any part in the Government's decision to reject the DDRB's recommendation of an increase in the value of the A+ awards for consultants. On the contrary, his remarks reflected his view that BMA reactions to that decision "had a lot to do with" fuelling the campaign.

As the Prime Minister made clear at the time, the Government's decision was based on its belief that the three-year programme to create a further 100 permanent consultant posts offered a better way of maintaining and improving the attractiveness of a career in hospital medicine than increasing the rewards available to those already at the top of the consultant scale.

Mrs Rutan
Mr Shaw
Mr Walden

10 DOWNING STREET
LONDON SW1A 2AA

Mr Moylan S/M
To see and return.
DLW
14/3

THE PRIME MINISTER

12 March 1990

Thanks for this.
Mr Gadhian might like to see it — & please return it to Mr Walden
S/M
15/3

Dear Sir Graham,

Thank you for your letter of 21 February about the Government's decisions on the Review Body's Twentieth Report. I am grateful to you and your colleagues for your recognition of the reasons why the Government decided to stage the payment of the recommendations of all the Review Bodies.

As for our decision not to accept the Review Body's restated recommendations for increases at the top of the consultants' scale and in the size of A+ distinction awards, perhaps I could reiterate what I said in my letter of 13 March 1989. The Government's decision does not reflect any fundamental change in attitude towards either the Review Body system or the important work undertaken by your Review Body. Indeed, as last year, we have accepted all the remaining recommendations in your latest Report. And, as you would expect, we gave particularly careful thought to your recommendations on consultants, precisely because they were rejected last year and restated in the current report.

Nevertheless, we do maintain our right to reject Review Body recommendations if there are clear and compelling reasons for so doing. We do of course all share the objective of maintaining and improving the attractiveness of a career in hospital medicine. But it remains our view that the three-year programme to create a further 100 permanent consultant posts is a better way of achieving that objective than increasing the

13 JUN '91 17:47

rewards available to those already at the top of the consultant scale. Those additional consultant posts do represent a major investment of resources over and above the considerable expansion of consultant numbers which we have seen over recent years and to which we remain committed for the future.

Yours sincerely

Margaret Thatcher

Sir Graham Wilkins

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

13 March 1989

Dear Sir Graham,

Thank you for your letter of 22 February about the Government's decision not to accept the Review Body's recommendations for the increase at the top of the consultants' scale and in the size of the A+ distinction awards.

May I first assure you that the Government's decision does not reflect any fundamental change in attitude to the Review Body system and the important work undertaken by the Review Bodies. Indeed, we have accepted all the remaining recommendations in your Nineteenth Report. We have always maintained our right to accept Review Body recommendations or to reject them if there are clear and compelling reasons for so doing. Whilst I understand the reasons you advance in your letter, I believe - as I made clear in my letter of 16 February - that the creation of the 100 additional permanent consultant posts over the next three years will achieve what I know is our joint objective of improving the long-term career structure for hospital doctors.

Yours sincerely

Margaret Thatcher

Sir Graham Wilkins

P.3/3

CONFIDENTIAL

10 DOWNING STREET

LONDON SW1A 2AA

From the Principal Private Secretary

10 June 1991

Dear Christina,

REVIEW BODIES

The Chairman of the BMA has taken issue with some remarks your Secretary of State made on the Today programme when considering the implications for teachers of the way in which the Review Body for Doctors and Dentists has worked. I would be grateful for advice and for a draft reply for the Prime Minister to send to Dr. Lee-Potter. Could this reach me by Friday 14 June.

I am copying this letter to Stephen Alcock (Department of Health) and Sonia Phippard (Cabinet Office).

Yours sincerely

Andrew Turnbull

ANDREW TURNBULL

Miss Christina Bienkowska,
Department of Education and Science

CONFIDENTIAL

10 DOWNING STREET

LONDON SW1A 2AA

From the Principal Private Secretary 10 June 1991

This is to acknowledge your letter of 7 June to the Prime Minister which is receiving attention. A reply will be sent to you as soon as possible.

ANDREW TURNBULL

Dr. J. P. Lee-Potter

BMA

BRITISH MEDICAL ASSOCIATION

BMA HOUSE
TAVISTOCK SQUARE LONDON WC1H 9JP

From the CHAIRMAN OF COUNCIL **Telephone: 071-387 4499**

PRIVATE & CONFIDENTIAL

Ref JPL-P/DRW Direct Line: 071-383 6100

7 June 1991

8/6

The Rt Hon John Major MP
Prime Minister
10 Downing Street
London
SW1A 2AA

Dear Prime Minister

In an interview yesterday with Mr McAvoy of the NUT on the 'Today' radio programme the Secretary of State for Education, Mr Kenneth Clarke, made several disturbing statements which I feel obliged to raise with you privately. To be certain we have not misheard the Secretary of State we have obtained a written transcript of the interview (enclosed).

Responding to Mr McAvoy's expressed belief that the Government will interfere with the recommendations of the proposed Review Body for teachers, as it had with the recommendations of other Review Bodies, Mr Clarke said, "We did once decline to implement a recommendation that would have given well over a 10% increase to consultants ..... and that had a lot to do with the BMA's campaign, and a lot to do with the BMA spending all that money on advertising".

The implication of this observation by Mr Clarke is that the "clear and compelling reason" of the Government for interfering with a Doctors' and Dentists' Review Body recommendation was that the prospective recipients had criticised Government policy. This is the first time that there has been an admission by a Minister that criticism of Government policy gives rise to the withholding of income increases recommended by an independent Review Body. This admission has potentially serious consequences for the Review Body system. I would be grateful to learn whether this was, in fact, the underlying reason for the Government's modification at that time.

Quite apart from his other gratuitous jibes at this Association, Mr Clarke also repeated the canard about the level of our spending on the publicity programme eighteen months ago. He greatly exaggerated the figure as is amply demonstrated by our now published audited accounts for that year.

Yours sincerely

Jeremy Lee-Potter

DR J P LEE-POTTER

Enc

BBC RADIO FOUR

TODAY

JUNE 6, 1991

08.10

PRESENTER:

Do you remember the posters that the BMA, the British Medical Association, put up which said 'what do you call a man who ignores medical advice? Mr Clarke'.

Well now the National Union of Teachers is running advertisements in the papers that say 'the future of teaching will now be determined

on a one-man, one-vote system - this is the man', and there's a picture of Mr Clarke.

Well Mr Clarke is with me. If you were running for party leadership this might be quite useful; but it's probably an embarrassment.

KENNETH CLARKE MP:
Well it's quite a nice photograph actually; the BMA were not always so kind. It's got, the standards of accuracy of the BMA, I have to say, as I don't think a word of the text that's underneath is actually correct...

PRESENTER:
NUT.

KENNETH CLARKE MP:
...well that's right. It's got the low level of accuracy of the BMA. This time it's the NUT.

We're going to debate today the teachers pay

review body for teachers. I'm going to refute all this. I think it's a pity the NUT have imitated the BMA but I don't think they'll pursue it. Firstly, they're not so nasty as the BMA really; secondly, they don't have the money. It cost the BMA £6 million to put out their nonsense about 12 months ago. I should think the NUT have spent about a million so far but I don't think they've got a lot more.

PRESENTER:
Well now in our York studio is the General Secretary of the NUT, Doug McAvoy. Good morning.

DOUG McAVOY: (phonetic)
Good morning.

PRESENTER:
Now you haven't got enough money to insult him roundly...

DOUG McAVOY:
Well all we want to do is tell the truth. And

I reject the suggestion of the Secretary of State that he can refute the statement we make through the press.

The review body that he's going to set up as a result of today's debate in Parliament will do the things and have the power to do those things that we claim, and that's made clear in the Bill itself. And really for the Secretary of State this morning to suggest there's something wrong with our accuracy is trying to distort the picture.

I'd like the Secretary of State to tell me whether or not the review body can consider only matters referred to it by the Secretary of State; I invite him to tell the public whether or not the recommendations of the review body can be overruled by Kenneth Clarke, the Secretary of States; and whether he can by-pass the review body and impose his own recommendations even though the review body may recommend other solutions. And I know from my reading of the Bill that what we've said is absolutely accurate.

PRESENTER:

Right, Mr Clarke.

KENNETH CLARKE MP:

The answers to those questions are no, the first assertion is untrue. No, the second assertion is untrue. The third is partially true in very minute circumstances, but not circumstances described in the advertisement saying that we can impose bigger classes and other things, which I have no powers to do whatever.

The actual situation, as Doug knows, is that the Prime Minister will appoint an independent review body which will report back to him and to me, and whose recommendations on pay terms and conditions will be accepted, unless there are clear and compelling reasons for the contrary.

If the Government decides that there are clear and compelling reasons to the contrary they will have to go to Parliament and put to Parliament the reasons for varying from the

recommendations. The review body can consider anything put to it by the parties who'll give evidence to it, including the National Union of Teachers. I am not given any of the draconian powers that the advertisement describes, even in the rather unlikely event that I want to use them.

And honestly Doug, despite what the BMA told you 12 months ago, I actually made this proposal to enhance the status of teachers, to take their pay out of the area of industrial conflict which some of your more extreme members want to see back in I know - but I doubt whether you do really - and in order to give them the advantages of review body status which doctors, dentists, judges, senior civil servants, nurses and midwives all know they enjoy.

PRESENTER:

Mr McAvoy, but is it not true that doctors, dentists and nurses have all received less than their review bodies recommended? It says so in your advert.

DOUG McAVOY:

Well certainly they have. I don't say they always have, but they have on many occasions - and we don't say they always have in the advert. What we say is that doctors, nurses and dentists have not received the recommendations made by the review body. And indeed if the Secretary of State was to refer to one of the review body reports for doctors and dentists in 1987, the review body itself is critical of the way in which the Government doesn't implement the recommendations.

Now I can't believe that this Government suddenly is going to be more generously disposed towards teachers than it has been towards doctors and dentists and nurses in the years past.

So I believe the Government will interfere with the recommendations of review bodies, just as it has with those other review bodies for those other employees.

PRESENTER:

Mr Clarke.

KENNETH CLARKE MP:

Let me concede to you, Doug, one thing to be fair: we did once decline to implement a recommendation that would have given well over a 10% increase to consultants earning £85,000 a year. And that had a lot to do with the BMA's campaign, and a lot to do with the BMA spending all that money on advertising.

In every other case so far as the clinical professions are concerned, we implemented the review body recommendations before the next year...

DOUG McAVOY:

Not true, that is not true...

KENNETH CLARKE MP:

...we phased them, it is true. Well don't let us say it is, it isn't...

PRESENTER:

Whoa, don't just shout each other down...

KENNETH CLARKE MP:

...we phased them, we phased them. We've done it with the teachers this year under the much, following the much weaker independent body we've got at the moment. We've only given you 7½% now, 9½%, the full increase for this year, will come before the end of the year. We've done that with nurses and with doctors this year, we've done that before.

But we've always implemented the recommendations and for some of your teachers, will be getting over 14% this year by the time the year's over because of the extra flexibility the IAC advised. The doctors, the nurses have always got it in full before the next year with the result, that as you know, doctors' and nurses' earnings have gone up faster in the period of this Government than any other group of public servants.

Now I think teachers are going to do quite well under what we propose, and an independent review body does put compelling pressure on a Government and a Prime Minister to accept outside advice. You've actually got a Prime Minister who wants to enhance the status of teachers, wants to put teachers in the same position as the doctors, the dentists and the nurses have been for some years.

PRESENTER:

A final word, Doug McAvoy?

DOUG McAVOY:

Well I just want to use the words not of the BMA and not of the NUT, but of the doctors' and dentists' review body. And this is what they said in 1987: 'when the Government decides to delay the implementation of review body recommendations, we do not believe it right to state that our recommendations have been fully implemented'.

And that's the con about review bodies, the

Government can pick and choose when they make them payable; and in the one that will apply to teachers the Secretary of State has even greater powers, as are clearly set out in the teachers pay and conditions Bill.

PRESENTER:

But Mr Clarke, you will be generous?

KENNETH CLARKE MP:

I think the review body will probably advise us to be generous, I hope they advise us to be generous to the really high performing classroom teachers, and those whom we need to attract and keep in the profession.

DOUG McAVOY:

Well time will tell.

END

Prime Minister
BTP 22/2

(4)

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 071-405 5944
Fax 071-405 5148

The Rt Hon John Major MP
Prime Minister
10 Downing Street
LONDON SW1A 2AA

21 February 1990

R22

Dear Prime Minister

DOCTORS' AND DENTISTS' PAY REVIEW BODY

Thank you for your letter of 31 January telling me the Government's decisions on the recommendations of the Twenty-First Report of the Doctors' and Dentists' Review Body. I am very pleased that you were able to accept all our recommendations, even though, for reasons which I quite understand, their implementation is to be staged.

It is kind of you to give your personal recognition to the work which Review Body members put into the review and I am delighted to be able to pass your message to my colleagues.

Yours sincerely

Trevor Holdsworth

SIR TREVOR HOLDSWORTH

NHS: Docs & Dent fam pt 4

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

31 January 1991

Dear Sir Trevor,

Thank you for your letter of 14 January and for the Twenty-First Report of the Review Body on Doctors and Dentists Remuneration. I am most grateful to you and your colleagues for all the hard work which has clearly gone into preparing this report. Please pass on my thanks to the other members.

As you will know I announced today that the Government has accepted all the recommendations of the Review Body. In view of the wider economic considerations which the Government must take into account we have decided to implement them in two stages. Accordingly all groups covered by the Review Body will receive a basic increase of 7.5 per cent from 1 April with the balance payable from 1 December. This means that all the recommendations will be in full payment well before the end of the calendar year.

Yours sincerely,

John Major

Sir Trevor Holdsworth

JJ/1982p+

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of
State for Health

R1/2

31 JAN 1991

Dear Colleague,

PAY FOR DOCTORS, DENTISTS, NURSES AND MIDWIVES AND THE PROFESSIONS ALLIED TO MEDICINE

I am writing to give you details of the pay rises to doctors, dentists, nurses and midwives and the professions allied for medicine which the Prime Minister announced today.

Briefly, we have accepted in full the recommendations of the independent Pay Review Bodies. We are implementing the awards in two stages, so that they will be fully in payment by the end of the calendar year. All the staff concerned will receive an increase of at least 7.5 per cent from 1 April and at least a further 2 per cent from 1 December 1991 when the recommendations have been fully implemented, average pay levels for nurses and midwives will have increased by 9.7 per cent; for doctors and dentists by 10.2 per cent; and for the professions allied to medicine by 10.8 per cent. Examples of what those increases mean for those at different grades are attached.

The general recommendation for nurses is a 9.5 per cent increase, which will be paid as 7.5 per cent from April and 2 per cent from December. But the Nurses' Review Body has recommended higher increases for lower-paid staff - chiefly students and nursing auxiliaries - and this group will receive increases of up to 9 per cent from 1 April, again with a further 2 per cent from December. The December increase will take the average real terms increase for nurses since the Government came to power to 43.5 per cent.

The Doctors and Dentists Review Body has recommended basic increases of 11 per cent for general dental practitioners; 10.5 per cent for consultants, and 9.5 per cent for other hospital doctors and general medical practitioners.

For the professions allied to medicine, the Nurses' and PAMs' Review Body has recommended basic increases of 10.4 per cent to 14.2 per cent for professional staff, and 10 per cent to 11 per cent for helpers and technical instructors. All these groups will receive an increase of 7.5 per cent from 1 April, with the balance in December.

Over the year, the two-stage award means that the average pay increase will be 8.4 per cent for doctors and dentists and for nurses, and 8.6 per cent for the professions allied to medicine.

The Government is providing an extra £250 million to the NHS in the UK in order to meet the bulk of the costs of the award, over and above the existing provision. This brings the gross total additional resources available to the NHS in 1991/92 to £3.4 billion, a real terms increase of 5.6 per cent, compared with 1990/91. We are asking health authorities to find £44 million towards the full cost of the awards from their cost improvement programmes. This has been budgeted for and can be met without diverting money from patient care.

William

WILLIAM WALDEGRAVE

DDRB 1990: BACKGROUND EFFECT OF OFFER

		Current £	Recommendation 1991 £	Offer 1991 £	Notes
					All payments other than GMP expenses will be staged as follows: 7.5% from 1/4/91, with the balance from 1/12/91.
1.	GMPs: average+ net intended income	34,680	37,975	37,280 - 1/4/91 37,975 - 1/12/91	+9.5% by stage 2
	Expenses provision	15,893	18,000	18,000 - 1/4/91	+13.3% from 1 April
2.	GDPs: target average net income	29,740	33,010	31,970 - 1/4/91 33,010 - 1/12/91	+ 11.0% by stage 2
3.	HCHS staff				
	Consultant maximum	41,980	46,390	45,130 - 1/4/91 46,390 - 1/12/91	+10.5% by stage 2
	Consultant + C award	49,380	55,670	53,085 - 1/4/91 55,670 - 1/12/91	+12.7% by stage 2
	Consultant + A+ award	81,860	90,460	88,000 - 1/4/91 90,460 - 1/12/91	+10.5% by stage 2
	Associate Specialist max.	33,850	37,065	36,390 - 1/4/91 37,065 - 1/12/91	+9.5% by stage 2
	Senior Registrar*	30,320	33,217	32,595 - 1/4/91 33,217 - 1/12/91	"
	Registrar*	25,875	28,334	27,818 - 1/4/91 28,334 - 1/12/91	"
	Senior House Officer*	24,930	27,302	26,798 - 1/4/91 27,302 - 1/12/91	"
	House Officer*	18,016	19,731	19,370 - 1/4/91 19,731 - 1/12/91	"

NOTES:

1. All other HCHS grades receive +7.5% from 1 April 1991 and the balance, making a total award of +9.5%, from 1 December 1991.

2. +Figures exclude payments for meeting higher targets for childhood immunisation and cervical cytology

3. * Maximum of scale with average on-call supplements based on average contracted hours per week at 30.9.89 for House Officers 84, SHOs 82, Registrars 80, and Senior Registrars 81.

NAP

OUTSIDE LONDON

NURSES' AND MIDWIVES' BASIC PAY

The Clinical Grades

Grade		1.1.91 Rates	1.4.91 Rates	1.12.91 Rates	TOTAL % INCREASE IN BASIC PAY OVER 1990/91 RATES
Student	1st yr	5,800	6,325	6,440	11.0
	3rd yr	6,750	7,315	7,450	10.4
GRADE A	MIN	5,950	6,485	6,605	11.0
	MAX	7,355	7,955	8,100	10.1
GRADE B	MIN	7,115	7,705	7,845	10.3
	MAX	8,115	8,770	8,930	10.0
GRADE C	MIN	8,115	8,770	8,930	10.0
	MAX	9,650	10,375	10,570	9.5
GRADE D	MIN	9,335	10,045	10,230	9.6
	MAX	10,700	11,505	11,720	
GRADE E	MIN	10,700	11,505	11,720	
	MAX	12,390	13,320	13,570	
GRADE F	MIN	11,865	12,755	12,995	
	MAX	14,545	15,635	15,920	
GRADE G	MIN	13,995	15,045	15,320	9.5
	MAX	16,195	17,410	17,735	
GRADE H	MIN	15,645	16,820	17,130	
	MAX	17,860	19,200	19,565	
GRADE I	MIN	17,305	18,605	18,955	
	MAX	19,600	21,070	21,470	

Notes

Increase from 1.4.91 is in all cases 2% less than the total increase (last column)

Increase from 1.12.91 is a further 2% for all grades

Grades A and B are for nursing auxiliary posts

Grade C is the minimum grade for enrolled nurses, but the majority are on Grade D or above.

Grade D is the minimum grade for staff nurses on qualification, but 3 out of 4 staff nurses are on Grade E or above.

Grade F is the minimum grade for sister, though 3 out of 4 sisters are on Grade G or above.

Grades H and I are for sisters responsible for more than one ward and for clinical specialist nurses and midwives.

NAP

INNER LONDON

NURSES AND MIDWIVES BASIC PAY
(INCLUDING LONDON ALLOWANCE)

		Pay at 1.1.91 £	Pay from 1.4.91 £	Pay from 1.12.91 £	Total Increase %
Student	1st yr	7,390	8,041	8,187	10.0
	3rd yr	8,388	9,081	9,248	10.3
GRADE A	MIN	7,540	8,209	8,360	10.9
	MAX	9,023	9,753	9,930	10.1
GRADE B	MIN	8,771	9,490	9,662	10.2
	MAX	9,821	10,609	10,802	10.0
GRADE C	MIN	10,071	10,875	11,077	10.0
	MAX	11,683	12,560	12,799	9.6
GRADE D	MIN	11,352	12,212	12,442	9.6
	MAX	12,785	13,745	14,006	9.6
GRADE E	MIN	12,785	13,745	14,006	9.6
	MAX	14,560	15,561	15,949	9.5
GRADE F	MIN	14,008	15,058	15,345	9.5
	MAX	16,715	17,966	18,300	9.5
GRADE G	MIN	16,165	17,376	17,700	9.5
	MAX	18,365	19,741	20,115	9.5
GRADE H	MIN	17,815	19,151	19,510	9.5
	MAX	20,030	21,531	21,945	9.6
GRADE I	MIN	19,475	20,936	21,335	9.6
	MAX	21,770	23,401	23,850	9.6

NAP

OUTSIDE LONDON

NURSES' AND MIDWIVES' BASIC PAY

The Clinical Grades

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	MAX	7,355	7,955	8,100	10.1
GRADE B	MIN	7,115	7,705	7,845	10.3
	MAX	8,115	8,770	8,930	10.0
GRADE C	MIN	8,115	8,770	8,930	10.0
	MAX	9,650	10,375	10,570	9.5
GRADE D	MIN	9,335	10,045	10,230	9.6
	MAX	10,700	11,505	11,720	
GRADE E	MIN	10,700	11,505	11,720	
	MAX	12,390	13,320	13,570	
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	MAX	14,545	15,635	15,920	
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Notes

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Grades A and B are for nursing auxiliary posts

Grade C is the minimum grade for enrolled nurses, but the majority are on Grade D or above.

Grade D is the minimum grade for staff nurses on qualification, but 3 out of 4 staff nurses are on Grade E or above.

Grade F is the minimum grade for sister, though 3 out of 4 sisters are on Grade G or above.

Grades H and I are for sisters responsible for more than one ward and for clinical specialist nurses and midwives.

NAP

INNER LONDON

NURSES AND MIDWIVES BASIC PAY
(INCLUDING LONDON ALLOWANCE)

		Pay at 1.1.91 £	Pay from 1.4.91 £	Pay from 1.12.91 £	Total Increase %
Student	1st yr	7,390	8,041	8,187	10.0
	3rd yr	8,388	9,081	9,248	10.3
GRADE A	MIN	7,540	8,209	8,360	10.9
	MAX	9,023	9,753	9,930	10.1
GRADE B	MIN	8,771	9,490	9,662	10.2
	MAX	9,821	10,609	10,802	10.0
GRADE C	MIN	10,071	10,875	11,077	10.0
	MAX	11,683	12,560	12,799	9.6
GRADE D	MIN	11,352	12,212	12,442	9.6
	MAX	12,785	13,745	14,006	9.6
GRADE E	MIN	12,785	13,745	14,006	9.6
	MAX	14,560	15,561	15,949	9.5
GRADE F	MIN	14,008	15,058	15,345	9.5
	MAX	16,715	17,966	18,300	9.5
GRADE G	MIN	16,165	17,376	17,700	9.5
	MAX	18,365	19,741	20,115	9.5
GRADE H	MIN	17,815	19,151	19,510	9.5
	MAX	20,030	21,531	21,945	9.6
GRADE I	MIN	19,475	20,936	21,335	9.6
	MAX	21,770	23,401	23,850	9.6

PROFESSIONS ALLIED TO MEDICINE : 1991 REVIEW BODY REPORT

TYPICAL INCREASES (ON MAXIMUM OF SCALE)

	Current Pay	1.4.91 Rates	1.12.91 Rates	Total % Increase in Basic Pay over 1990/91 rates
Unqualified Staff				
Helper	7,475	8,035	8,230	10.1
Technical Instructor Grade II	10,200	10,965	11,220	10.0
Qualified Staff				
Basic grade	11,250	12,095	12,500	11.1
Senior I	15,385	16,540	17,000	10.5
Head/ Superintendent I	20,365	21,890	22,500	10.5

Barry H Potter
Private Secretary
10 Downing Street
London
SW1A 2AA

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

30 January 1991

Dear Barry

REVIEW BODY ON DOCTORS AND DENTISTS PAY

Your letter of 29 January asked for a draft reply to the letter Sir Trevor Holdsworth, Chairman of the DDRB, sent when he submitted the Review Body's report. A draft is attached.

Yours

Paul Ahearn
Private Secretary

DRAFT LETTER FROM THE PRIME MINISTER TO SIR TREVOR HOLDSWORTH

Thank you for your letter of 14 January and for the Twenty-First Report of the Review Body on Doctors and Dentists Remuneration. I am most grateful to you and your colleagues for all the hard work which has clearly gone into preparing this report. Please pass on my thanks to the other members.

As you will know I announced today that the Government has accepted all the recommendations of the Review Body. In view of the wider economic considerations which the Government must take into account we have decided to implement them in two stages. Accordingly all groups covered by the Review Body will receive a basic increase of 7.5% from 1 April with the balance payable from 1 December. This means that all the recommendations will be in full payment well before the end of the calendar year.

JOHN MAJOR

NAT HEALTH : DD Pay PL4

DRAFT LETTER FROM THE PRIME MINISTER TO SIR TREVOR HOLDSWORTH

Thank you for your letter of 14 January and for the Twenty-First Report of the Review Body on Doctors and Dentists Remuneration. I am most grateful to you and your colleagues for all the hard work which has clearly gone into preparing this report. Please pass on my thanks to the other members.

As you will know I announced today that the Government has accepted all the recommendations of the Review Body. In view of the wider economic considerations which the Government must take into account we have decided to implement them in two stages. Accordingly all groups covered by the Review Body will receive a basic increase of 7.5% from 1 April with the balance payable from 1 December. This means that all the recommendations will be in full payment well before the end of the calendar year.

JOHN MAJOR

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

29 January 1991

REVIEW BODY ON DOCTORS AND DENTISTS PAY

I enclose the covering letter which Sir Trevor Holdsworth sent to the Prime Minister, when he submitted the Review Body's 1991 Reports.

I should be grateful if you could let me have a draft reply by not later than 1800 on Wednesday 30 January.

I am copying this letter and enclosure to Peter Owen (Cabinet Office).

BARRY H. POTTER

Stephen Alcock, Esq,
Department of Health.

BF of the Cabinet ce'd
Committee secretary (letter only)

OFFICE OF MANPOWER ECONOMICS

22 KINGSWAY
LONDON WC2B 6JY

Telephone 071-405 5944
Fax 071-405 5148

The Rt Hon John Major MP
Prime Minister
10 Downing Street
LONDON SW1

14 January 1991

Dear Prime Minister

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

I enclose the Twenty First Report of the Review Body on Doctors' and Dentists' Remuneration. This contains our recommendations on the levels of remuneration we consider to be appropriate as at 1 April 1991 and sets out the factors we considered were of particular importance when reaching our conclusions.

Yours sincerely

Trevor Holdsworth

SIR TREVOR HOLDSWORTH
CHAIRMAN

CONFIDENTIAL

Ale M
c: lewin/griffiths

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

10 September 1990

NHS CONSULTANTS' CONTRACTS

The Prime Minister has asked me to thank you for your letter of 6 September on NHS consultants' contracts. The Prime Minister was grateful for the work you have undertaken to assess the impact of the new consultants' contracts. She has noted carefully your view that the negotiations have not resulted in constraints on the best NHS authorities and have greatly enhanced the management position in others.

BARRY H. POTTER

Sir Roy Griffiths

CONFIDENTIAL

DI

Prime Minister ①

Sir Roy's response to the concerns about the new consultants contracts which you expressed at the recent discussion. Sir Roy is satisfied that the contracts do put more pressure on consultants, yet give more power to local NHS managers - particularly in NHS Trust hospitals.

Content for me to acknowledge letter, without further comment?

PHP 7/9

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1 2NS

Telephone 01-210 5166/7/8

From Sir Roy Griffiths

CONFIDENTIAL

6th September 1990

The Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street
LONDON SW1A

Yes

Dear Prime Minister,

NHS - CONSULTANTS' CONTRACTS

In our discussion on the 31st July concern was expressed that the new consultants' contracts appear to reduce managerial authority, and further that the detailed arrangements would allow too many of the consultants sessions to be marked down to training or administration.

I have talked these points through with the members of the Department and the Regional General Manager who were involved in the negotiations with the BMA; also with the management at local level particularly with Chris West of Portsmouth who had expressed some initial reservations about the results of the negotiations.

A tactical decision, generally agreed to be correct, was taken at an early stage in the negotiations to build on existing agreements and not to go for an entirely new contract. I am satisfied that the ensuing negotiations with the BMA have not resulted in constraints on the best NHS authorities, and at the same time have greatly enhanced the management position in the other authorities.

By April 1991 all hospital consultants (including clinical academics) must have a detailed and annually reviewable job plan agreed with local managers.

This requirement has been incorporated in those doctors' terms and conditions of service. Job plans will provide NHS managers on the ground with a much better means:

i. of arranging consultants' duties so as to mesh more effectively with the overall service pattern of the hospital; and

ii. to detect and take effective action against abuse where it is suspected.

A key feature of the job plan is that it must identify each consultant's "fixed commitments" to the NHS, ie the times and places where certain functions, such as operating lists and out-patient clinics, must be performed. These should normally account for a substantial proportion of the working week. Some of these fixed commitments may be marked down to training or administration but this would be quite exceptional and have to be agreed locally. It is for local management to ensure that they get a good deal from the new arrangements and I believe that the central agreement which has been reached with the profession should enable them to do so.

The particular reservations expressed by some districts have centred round the concern

1) that the terms and conditions of service set a minimum of 10 notional half-days in a contract for a maximum part-time consultant whereas in some districts, the practice and indeed the clinical commitment is agreed as being 11 notional half-days.

2) the number of notional half-days specified as fixed commitment as defined above is set at 5-7 depending on specialty, whereas again at local level in some districts 8 are agreed.

To achieve the higher figures in negotiation centrally with the BMA is laudable as an objective but the stuff of pipe dreams in reality. The higher figures could have been imposed with all the consequent disadvantages. As it is the outcome is very satisfactory for the NHS and the BMA clearly understand that these are minimum specifications and that local agreements may improve on

them. In general consultants are well aware, and have accepted increasingly over the past few years, that their work is coming under closer control; the skill for NHS management is to achieve this without demotivating the many consultants who are giving good value in commitment to their NHS work. This control should be enhanced from the centre by continuing to promote and indeed expect that in practice the agreements should be improved on at local level. Nothing I have found in my discussions supports the view that even in the best authorities the announced arrangements will be restrictive or other than beneficial.

There are two other points.

1) The NHS Trusts will allow separate negotiations at local level and totally new contracts outside the national agreements can be made.

2) The main thrust of your review and the recent legislation is to ensure that there are new forms of motivation for consultants ie if their hospital or specialty performs well it will attract increased work and funding and so they have an incentive to see that the contracts are met.

I have discussed the above with the people mentioned from the management side both in the Department and locally and they are satisfied that it represents a correct assessment. I will continue to keep the matter under review.

Roy Griffiths.

SIR ROY GRIFFITHS

Cole DCA

cc DH

10 DOWNING STREET

LONDON SW1A 2AA

THE PRIME MINISTER

12 March 1990

Dear Sir Graham,

Thank you for your letter of 21 February about the Government's decisions on the Review Body's Twentieth Report. I am grateful to you and your colleagues for your recognition of the reasons why the Government decided to stage the payment of the recommendations of all the Review Bodies.

As for our decision not to accept the Review Body's restated recommendations for increases at the top of the consultants' scale and in the size of A+ distinction awards, perhaps I could reiterate what I said in my letter of 13 March 1989. The Government's decision does not reflect any fundamental change in attitude towards either the Review Body system or the important work undertaken by your Review Body. Indeed, as last year, we have accepted all the remaining recommendations in your latest Report. And, as you would expect, we gave particularly careful thought to your recommendations on consultants, precisely because they were rejected last year and restated in the current report.

Nevertheless, we do maintain our right to reject Review Body recommendations if there are clear and compelling reasons for so doing. We do of course all share the objective of maintaining and improving the attractiveness of a career in hospital medicine. But it remains our view that the three-year programme to create a further 100 permanent consultant posts is a better way of achieving that objective than increasing the

rewards available to those already at the top of the consultant scale. Those additional consultant posts do represent a major investment of resources over and above the considerable expansion of consultant numbers which we have seen over recent years and to which we remain committed for the future.

Yours sincerely

Margaret Thatcher

Sir Graham Wilkins

MG1 1530

D P Walden
Pc 421
PPS 1A

POH(1)1694/2727

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 01 210 3000
From the Secretary of State for Health

08 MAR 1990

Dear Paul

Thank you for your letter of ~~21~~ 21st February enclosing one received from Sir Graham Wilkins of the Office of Manpower Economics.

In many ways the letter from Sir Graham Wilkins is rather ritualistic. It has clear echoes of the letter which he wrote last year when the Government first rejected the two recommendations on consultants.

I do not think there is anything to be gained at this stage by introducing new arguments, for example, on comparability which was one of the original grounds adduced by the Review Body for putting forward the recommendations on consultants. Instead, I suggest we once again base the reply on the fact that:

i. the Government reserves the right to reject recommendations where there are "clear and compelling reasons for doing so". This answers the charge in paragraph 5 of Sir Graham's letter; and

ii. additional consultant posts are a better means of improving the long-term career structure than enhanced pay for those already on the top of the scale.

Attached is a draft for the Prime Minister's signature.

I hope this is helpful.

Yours sincerely,

Helen

MRS HELEN SHIRLEY-QUIRK
Private Secretary

8 MAR '90 18:26 01 210 5814 PAGE.002

Attached is covering letter from Private Secretary and draft reply.

If there are any queries, please contact -

Michelle McGlynn
226 RY
Tel 210 5075

Thanks

8 MAR '90 18:26 01 210 5814 .AGE.001

MG11530/2

Sir Graham Wilkins
Office of Manpower Economics
22 Kingsway
LONDON
WC2B 6JY

Thank you for your letter of 21 February about the Government's decisions on the Review Body's Twentieth Report. I note that you and your colleagues appreciate the reasons why the Government decided to stage the payment of the recommendations of all the Review Bodies.

As for our decision not to accept the Review Body's restated recommendations for increases at the top of the consultants' scale and in the size of A+ distinction awards, may I reiterate what I said in my letter of 13 March 1989. The Government's decision does not reflect any fundamental change in attitude either to the Review Body system or to the important work undertaken by the Review Body. Indeed, we have accepted all the remaining recommendations in your Twentieth Report, as we did last year. Nevertheless, we do maintain our right to reject Review Body recommendations if they are clear and compelling reasons for so doing. As always, we gave very careful consideration to all the recommendations put forward by the Review Body. We gave particularly careful thought to the recommendations on consultants, precisely because they were rejected last year and restated in the current report.

We all share the objective of maintaining and improving the attractiveness of a career in hospital medicine. In our view, it is preferable to concentrate NHS resources on manpower solutions and particularly on expanding the number of consultant opportunities, rather than on pay. We therefore continue to believe that the three-year programme to create a further 100 permanent consltant posts is a better way of achieving the objective than increasing the rewards available to those already at the top of the consultant scale. Those additional consultant posts do represent a major investment of resources over and above the considerable expansion of consultant numbers which we have seen over recent years and to which we remain committed for the future.

8 MAR '90 18:27 01 210 5814 PAGE.003

NATHGATH : DOCTOS Pan
PTH.

MG11530

DEPARTMENT OF HEALTH

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 01 210 3000
From the Secretary of State for Health

POH(1)1694/2727

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

08 MAR 1990

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i. the Government reserves the right to reject recommendations where there are "clear and compelling reasons for doing so". This answers the charge in paragraph 5 of Sir Graham's letter; and

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Attached is a draft for the Prime Minister's signature.

I hope this is helpful.

Yours sincerely,

Helen.

MRS HELEN SHIRLEY-QUIRK
Private Secretary

MG11530/2

Sir Graham Wilkins
Office of Manpower Economics
22 Kingsway
LONDON
WC2B 6JY

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As for our decision not to accept the Review Body's restated recommendations for increases at the top of the consultants' scale and in the size of A+ distinction awards, may I reiterate what I said in my letter of 13 March 1989. The Government's decision does not reflect any fundamental change in attitude either to the Review Body system or to the important work undertaken by the Review Body. Indeed, we have accepted all the remaining recommendations in your Twentieth Report, as we did last year. Nevertheless, we do maintain our right to reject Review Body recommendations if they are clear and compelling reasons for so doing. As always, we gave very careful consideration to all the recommendations put forward by the Review Body. We gave particularly careful thought to the recommendations on consultants, precisely because they were rejected last year and restated in the current report.

We all share the objective of maintaining and improving the attractiveness of a career in hospital medicine. In our view, it is preferable to concentrate NHS resources on manpower solutions and particularly on expanding the number of consultant opportunities, rather than on pay. We therefore continue to believe that the three-year programme to create a further 100 permanent consltant posts is a better way of achieving the objective than increasing the rewards available to those already at the top of the consultant scale. Those additional consultant posts do represent a major investment of resources over and above the considerable expansion of consultant numbers which we have seen over recent years and to which we remain committed for the future.

10 DOWNING STREET

Paul

Please see your letter at flag. Health advice that the draft is going into Mr. Blanke's box tonight — we should get it first thing tomorrow morning.

DC

RACG 7/3

Patricia

7 March 1990.

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

21 February 1990

I enclose a copy of a letter the Prime Minister has received from Sir Graham Wilkins.

I should be grateful if you would provide advice together with a draft reply, for the Prime Minister's signature, to reach this office by Wednesday 7 March.

I am copying this correspondence to Tancred Tarkowski (HM Treasury) and Sonia Phippard (Cabinet Office).

PAUL GRAY

Mrs. Helen Shirley-Quirk,
Department of Health

CCPV

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 01-405 5944

The Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street
LONDON SW1A 2AA

21 February 1990

Dear Prime Minister,

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION: TWENTIETH REPORT

Thank you for your letter of 1 February. I much appreciate your message of thanks, which has been conveyed to my colleagues.

Whilst my colleagues and I are disappointed that the Government has decided to stage the payment of our recommendations, we do appreciate the reasons, which are of course common to the recommendations of all the Review Bodies.

We are however deeply concerned that the Government has again rejected our two specific recommendations for additional increases at the top of the consultants' scale and in the size of their distinction awards, particularly in the light of the reasons given.

Since this Review Body was set up, successive Governments have affirmed that its recommendations would be accepted by the Government unless there were clear and compelling reasons for not doing so; and the Minister for Health reaffirmed that position to us during the course of the latest review. There is of course room for debate about the precise effects which our recommendations would have achieved, just as there is room for debate about the likely effects of the Government's programme for expanding the number of additional consultant posts. But we did consider this matter very carefully in our last review before re-stating these recommendations and this is, after all, very much the sort of judgement that the Review Body has been set up to exercise.

We note that the Government has not sought to say that their reasons for rejecting our specific recommendations were "clear and compelling", and it is hard for us to see how they could be so regarded. (This is in contrast to the Government's decision to stage the awards.) The Government's position in this matter, therefore, seems to us to undermine the purpose of the Review Body and to contradict the Government's stated position on the normal acceptance of our our recommendations.

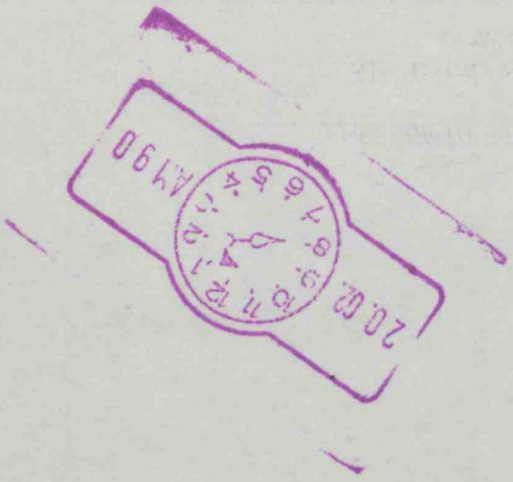
The terms of this letter have been discussed with my colleagues on the Review Body and they wish to be associated with it. I am also sending a copy of it to Sir Trevor Holdsworth.

Yours sincerely

SIR GRAHAM WILKINS

NAT HEALTH: Doctors and Dentists' Pay

B.4.



C: WILKINS (MJ)

CC HMT
FCO H
CO.

10 DOWNING STREET

LONDON SW1A 2AA

THE PRIME MINISTER

1 February 1990

Dear Sir Graham,

Thank you for your letter of 12 January and for the twentieth report of the Review Body on Doctors and Dentists Remuneration. Once again I am most grateful to you and your colleagues for the energy and time which has clearly gone into this important work, particularly in a very busy year when new contracts for both general medical and general dental practitioners had to be considered; please pass on my thanks to the other members.

I am announcing today that we have accepted all of the Review Body's recommendations, with the exception of those we rejected last year and which you have put forward again. However the Government considers that, if the recommendations being accepted were implemented in full from 1 April, the overall pay costs in 1990-91 would be too high. The Government has therefore decided, in line with the approach being adopted for the other Review Body groups and for teachers, to stage the payment of the recommendations. Accordingly a 7 per cent increase in pay will be made from 1 April, with the balance of the recommendations taking effect from 1 January 1991.

After most careful consideration we have decided not to accept your restated recommendations for additional increases at the top of the consultants' scale and in the size of consultants' distinction awards. The Government remains of the view that the three-year programme to expand the number of

permanent consultant posts, as set out in "Working for Patients", is the best means of achieving the objectives of improving both the long-term career structure and the morale of hospital doctors. Nor are we convinced that those two recommendations would significantly improve the attractiveness of hospital medicine as a career.

Yours sincerely

Margaret Thatcher

Sir Graham Wilkins

AM218

CONFIDENTIAL

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON SW1

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 01 210 5155
From the Secretary of State for Health

30 January 1990

Dear Paul

REVIEW BODY REPORTS

As we agreed I attach a draft letter for the Prime Minister to send to Sir Graham Wilkins thanking him for the DDRB's work in producing its Twentieth Report and informing him of the Government's decision.

You should know that the draft has not been seen by my Secretary of State and I will let you have any comments he may have tomorrow. Nevertheless, this will provide you with a reasonable working draft.

I hope to be able to let you have the letter for Sir James Cleminson shortly.

I am sending a copy of this letter to John Gieve (Treasury) and Sonia Phippard (Sir Robin Butler's Office).

Yours
Andy

A J McKEON
Private Secretary

The Government has carefully considered

CONFIDENTIAL

DRAFT LETTER FROM THE PRIME MINISTER TO SIR GRAHAM WILKINS

Thank you for your letter of 23 January and for the Twentieth Report of the Review Body on Doctors' and Dentists' Remuneration. Once again I am most grateful to you and your colleagues for ~~all~~ the energy and time which has clearly gone into this important work, particularly in a ~~very~~ busy year when new contracts for both general medical and general dental practitioners had to be [priced.] considered.

[Insert general paragraph on reasons for staging - for No.10]

Accordingly, as you will know, I announced today that the Government has accepted all but two of the recommendations of the Review Body but that it has decided to stage their payment. Accordingly, all groups covered by the Review Body will receive a basic increase of seven per cent from 1 April, with the balance payable from 1 January 1991.

After most careful consideration we have ~~also~~ decided not to accept your restated recommendations for additional increases at the top of the consultants' scale and in the size of consultants' distinction awards. The Government remains of the view that the three-year programme to expand the number of permanent consultant posts, as set out in "Working for Patients", is the best means of achieving the objectives of improving both the long-term career structure and the morale of hospital doctors. Nor are we convinced that those two recommendations would significantly improve the attractiveness of hospital medicine as a career. ~~[Subject to this, all of the accepted recommendations will be in full payment well before the end of the financial year to which they relate.]~~

W\35-4

SECRET

FLAG B

5a. Copied to NH: Nurses Pay Pt 4.

NOTE FOR MEETING WITH MR CLARKE 29/1/90

Latest Position

Mr Clarke will not be sending in a further note for the meeting.

You agreed with him last night that:

- He would drop demands for special treatment for any of the doctors or dentists.

- But that he could consider a small package bringing forward some of the add-ons for nurses to 1 April as long as this kept the 1990-91 pay bill costs at 7.9 per cent.

My intelligence is that:

- Mr Clarke will say he continues to be disturbed by the difficulties of handling GPs. But I am not sure whether he will seek to reopen that issue.

- He will not come forward with a precise 7.9 per cent package for nurses. He may say he continues to want all three add-ons brought forward to 1 April, ie:

  a. student nurses - £13.65 million cost in advancing from 1 January to 1 April;

  b. low paid auxilliaries - extra £6.3 million costs;

  c. London Allowance - extra £11.6 million costs.

  This produces a total nurses package of 8.24 per cent. To get it to marginally 8 per cent (but probably still rounding up to that figure) means trimming £16 million of the package. That means that only one of the three elements could be paid in full.

- I suspect Mr Clark will argue such trimming back is difficult and press for the full 8.24 per cent.

SECRET

- He may also suggest that consideration be given to bringing forward some of the add-ons for Professions Allied to Medicine. If so, he could quote your comments last night which were supportive of some of the PAMs.

- Again, he may also resist a possible Treasury attempt to stage the expenses element of the DDRB. The expenses side of the equation has never been staged before, and, as I understand it, is not usually scored in the percentage "pay" increase.

Line To Take

Subject to the outcome of your talk on Saturday with Mr King, the best approach could be to argue that the only add-on to be advanced for the nurses is that for students. That would bring the package back below 8 per cent. It is students and the Community Charge issue that Mr Clarke argued was the political problem. And you might urge him to use his ingenuity to come up with the best rationalisation for granting just this one special case. That would also dispose of any knock-ons to PAMs, for which there are no "students".

file
Economic/Doctors.

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

26 January 1990

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

I enclose a covering letter from Sir Graham Wilkins to the Prime Minister sent when he submitted the Review Body's 1990 Report. The Prime Minister will need to send a reply to Sir Graham on the day of publication of the Report and I should be grateful if you could let me have a draft reply by 1600 on Tuesday 30 January please.

I am copying this letter and enclosure to John Gieve (H.M. Treasury) and Sir Robin Butler.

Paul Gray

Andy McKeon, Esq.,
Department of Health.

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 01-405 5944

CONFIDENTIAL

The Rt Hon. Margaret Thatcher MP
Prime Minister
10 Downing Street
London
SW1

17th January 1990

Dear Prime Minister,

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

I enclose the Twentieth Report of the Review Body on Doctors' and Dentists' Remuneration. This contains our recommendations on the levels of remuneration we consider to be appropriate at 1 April 1990 and sets out the factors we considered were of particular importance when reaching our conclusions.

Yours Sincerely

GRAHAM WILKINS
CHAIRMAN, REVIEW BODY
ON DOCTORS' AND DENTISTS'
REMUNERATION

Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Swits fwrdd)
01-270 (Llinell Union)

Oddi wrth yr Is-Ysgrifennydd Seneddol

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switchboard)
01-270 (Direct Line)

From The Parliamentary Under-Secretary

10 August 1989

Dear Paul

GP CONTRACT

file attached.

With reference to other correspondence on the GPs contract, I enclose, for your information, a copy of a letter which Mr Ian Grist has sent to all GPs in Wales together with copies of the same booklet issued by the Department of Health in England.

A copy of this letter goes to the Private Secretaries to the Chancellor of the Duchy of Lancaster and the Secretary of State for Health, Scotland and Northern Ireland.

Yours sincerely,
Howell.

HOWELL REES
Private Secretary

NBPM (who has seen English & Scottish letters)
CAB 14/8

Paul Gray Esq
10 Downing Street
London SW1

Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switsfwrdd)
01-270 (Llinell Union)

Oddi wrth yr Is-Ysgrifennydd Seneddol

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switchboard)
01-270 (Direct Line)

From The Parliamentary Under-Secretary

IAN GRIST MP

3 August 1989

Dear Doctor,

GENERAL PRACTICE: THE NEW CONTRACT

On 23 February I sent you a document entitled "A New Contract" setting out the Government's then position on the reform of the family doctors' remuneration system. That document set out the state of play from the Government's point of view after the first hundred hours of detailed discussions spread over twelve months with your representatives, the General Medical Services Committee. I am writing now to bring you up to date on the steps that the Government is now taking.

The proposals set out in "A New Contract", were later modified in a number of important respects as a result of more lengthy discussions with the General Medical Services Committee negotiators, on 4 May. The modified package was commended to the profession by the Chairman of the GMSC and his negotiating team. I regret the subsequent decision of a majority of GPs not to support their leaders, especially as a number of important concessions had been made in order to secure a fair deal.

Since I wrote to you in February Health Ministers have conceded:

- the retention of seniority payments but at a reduced level with the opportunity to increase them to present levels through the new post graduate education allowance;

- the introduction of a second and lower threshold for target payments for childhood immunisation and screening for cancer of the cervix;

- the retention of the present rural practice payments scheme until the Central Advisory Committee on Rural Practice Payments has considered how to revise it;

- the continuation of entitlement to BPA based on partnership average list size instead of personal lists as originally proposed and lowering the new threshold for full BPA from 1,500 to 1,200.

/...

Ministers have decided not to withdraw any of those concessions that were made on 4 May although the basis of the agreement with the GMSC negotiators was quite clear that Ministers would be free to consider doing so if the profession did not accept the agreement reached with the negotiators.

The main features of the new payment systems to doctors from 1st April 1990 will therefore be:

- more money paid through capitation fees as a result of abolishing supplementary basic practice allowance, supplementary capitation fees and group practice allowance and reducing seniority payments;

- new capitation payments for newly registered patients;

- higher capitation payments for patients aged 75 and over;

- new two-tier payments for reaching targets for childhood immunisation and cervical cytology to replace item of service payments;

- new payments for gps who provide child health surveillance services;

- a new postgraduate education allowance available to all gps for continuing medical education to replace the vocational and postgraduate training allowances;

- reduced overall payments through basic practice allowance but weighted to help small list practices;

- a new basic practice allowance supplement for gps practising in areas of deprivation;

- a new allowance for gps who teach medical students;

- new payments for gps who provide minor surgery services;

- a new sessional fee for running health promotion clinics;

- a higher level night visit fee where the patient is visited by a doctor from the patient's own practice or from a small non-commercial local rota.

The precise figures to be placed on each and every component part of this contract can only be settled finally after the Government have received the Doctors and Dentists Review Body's report next year.

I believe therefore that the Government has responded to most of the serious points put to it by the profession after I sent my last document to all GPs. I am still receiving some letters from GPs who are concerned that the increase in capitation from 48% to 60% of the contract will mean a return to the "bad old days before the GPs' Charter in the 1960s", longer lists and less time for patients. I am convinced that that will not happen. There are a lot of important differences between then and now. Two in particular stand out.

/...

In the early 1960s there was concern amongst GPs that recruitment to the profession was declining while the population was rising. The situation is totally different now. The population is virtually static and the number of doctors in general practice is increasing at the rate of over 500 a year. General practice is clearly a popular option and average list size seems likely to decline still further.

The other main difference between the early 1960s and now concerns the way practice expenses are reimbursed, particularly expenditure on staff and premises. Before the changes to the GPs' contract in 1966 all the cost of staff and premises had to be paid out of fees and allowances. In other words a GP who recruited staff and provided good surgery premises was worse off financially than one who did not. To deal with that situation we now have a system of direct reimbursement for practice team staff and for premises development. That system is to be retained and improved. The Government intends to invest more in expansion of practice teams and in improvements to premises. In future FPCs will target additional funds where they are most needed. For example, there will be more help with the recruitment of extra staff to provide a wider range of services.

Everything in the field of primary health care has been moving in the right direction: more doctors, more practice team staff and better premises. But general practice needs a new patient-oriented impetus.

The Government's aim is to improve the family doctor services with this new and fairer contract which will reward those who work hardest and provide the good quality services which we all want. It will not reduce the average net income of doctors at all but it will mean that some gain and some lose. Of course many practices will find that their incomes increase based on the workload and performance they already achieve.

The GMSC is still being consulted on the detailed amendments to Regulations and the Statement of Fees and Allowances which will be required to implement the new contract. Once the consultation process has ended Regulations in their final form will be placed before Parliament with a view to implementation on 1 April 1990.

It is clearly of the utmost importance that GPs should be kept fully informed of the changes to their contract so that they can prepare for the new arrangements. I am enclosing with this letter a revised version of the document sent to you under cover of my letter of 23 February. This document - "The 1990 Contract" - includes all the changes agreed on 4 May. As soon as the detailed changes to the Statement of Fees and Allowances and terms of service have been settled, copies of those documents will be sent to you.

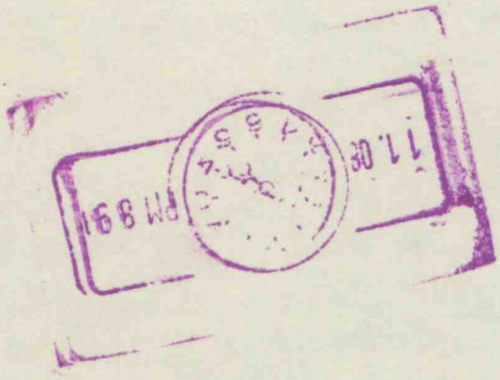
I hope you find "The 1990 Contract" helpful in providing you with a comprehensive picture of the changes to be made to your remuneration system and terms of service.

Yours sincerely,

Ian G.

Nat Health.

Doctors & Dentists Pay P-4



From THE MINISTER FOR EDUCATION AND HEALTH

cc PM.

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

Prime Minister 2
Follows the Ken Clarke
letter which you
cleared.
RLG 4/8

Paul Gray Esq
10 Downing Street
LONDON
SW1

3 August 1989

Dear Mr Gray, MS

GP CONTRACT — with PG?

Andy McKeon has sent you a copy of the letter which the Secretary of State for Health intends to send to all GPs today giving them details of the contract which will be implemented from 1 April 1990.

I enclose a copy of a letter which Mr Michael Forsyth is sending to all GPs in Scotland today together with copies of the same explanatory booklet which is to be issued in England.

A copy of this letter goes to the Private Secretaries to the Chancellor of the Duchy of Lancaster and the Secretary of State for Health, Wales and Northern Ireland.

Yours Sincerely
Craig Clifford.

PP DAVID BINNIE
Private Secretary

MCO215L3

FROM THE MINISTER FOR EDUCATION AND HEALTH

SCOTTISH OFFICE
NEW ST. ANDREW'S HOUSE
ST. JAMES CENTRE
EDINBURGH EH1 3SX

To All GPs in Scotland

3 August 1989

Dear Doctor

THE NEW CONTRACT FOR GENERAL MEDICAL PRACTITIONERS

The Government have decided to proceed with the new GPs contract derived from the proposals which I sent to you on 12 April. These proposals took account of the views I had received from the Scottish General Medical Services Committee, and the many comments sent to me by Scottish GPs. They subsequently formed the basis of an agreement reached on 4 May with the GMSC Negotiators.

I am anxious that GPs should be kept fully informed of the changes to the contract so that you can prepare for the new arrangements. I am, therefore, enclosing with this letter a revised version of the document which I sent to you on 12 April. This document - "The New Contract" - includes all the changes agreed on 4 May.

As you will see, the main points which we were able to import into the GB contract and which were agreed on 4 May are:

Basic Practice Allowance

* Entitlement to BPA will be based on average list size within the partnership.

* BPA will be paid in respect of patient list sizes from 400-1,200. The level of payment will vary in such a way that GPs with smaller lists will receive proportionately more BPA for their patients than those with larger lists.

Safeguarding of Rural Doctors

* The Scottish Rural Practices Fund Committee will continue to have overall supervision of the Scottish Rural Practices Fund which the Government consider is well-targeted to meet needs.

* To assist the position of single-handed GPs practising in very isolated areas a new allowance will be introduced to enable them to employ a shared associate GP so that they can have time off; these associate doctors will be eligible for the new postgraduate education allowances.

* The arrangements for Inducement Practitioners will continue.

* The GPs' terms of service will be amended to require GPs to be available for 26 hours on average over 5 days each week. This will include availability in surgery, health promotion clinics and home visits. In recognition of the work that some GPs do elsewhere in health-related activities in the public service, this commitment can be reduced to 4 days subject to agreement with the Health Board.

* So that patients will benefit fully from the new arrangements for more minor surgery in the GPs' premises, individual operations up to a total of 5 will be allowed to count towards entitlement to a monthly sessional payment.

Doctors in Deprived Areas

* In determining the deprived areas where GPs will receive a BPA supplement, the index to be used will be weighted to take account of specifically Scottish housing and standard mortality ratio factors.

Prevention targets

* Payments will be made for 2 levels of achievement:

  - for childhood immunisation a higher level of payment will be made to GPs who achieve 90% coverage. A lower payment will be made for reaching 70% cover. The differential will be 3:1;

  - for screening for cervical cancer the upper level will be 80% and the lower level will be 50%; the same differentials will apply.

Seniority Payments

* Seniority payments will be retained but will be reduced by the value of the new postgraduate education allowance. This change will reflect the fact that under the new arrangements all GPs who are entitled to seniority payments will be entitled to the new PGEA (provided they meet the necessary training requirements).

* Commitments entered into under the existing arrangements for the direct reimbursement of staff, premises, and premises improvements will be honoured.

Capitation Payments

It was also agreed on 4 May to submit joint evidence to the Doctors and Dentists Review Body about pricing the new contract which would demonstrate the profession's acceptance of the Government's intention to raise the proportion of the remuneration of GPs arising from capitation based payments to 60% from 1 April 1990. That will not necessarily lead to longer lists and less time for patients. With a smaller population in Scotland than we had 25 years ago and 30% more GPs there can be no question of a return to the situation before the present contract. Our

proposals will not oblige GPs to take on more patients but those who provide wide-ranging, high quality services which attract more patients will rightly be rewarded for doing so.

Women Doctors

I know that many women doctors in particular were worried about some of the original proposals for a New Contract and again I think we have taken account of their views. "The New Contract" explains how arrangements for flexible working - such as half time or 3/4 time working - will be particularly helpful to women doctors as will the abolition of the list size restriction for employing a locum during confinement.

What Now?

The Government therefore believe that the package agreed with the GPs' negotiators on 4 May represents the best arrangements for patients and for GPs. They will

- make services more responsive to the needs of the consumer
- raise standards of care
- promote health and prevent illness
- give patients the widest range of choice in obtaining high quality primary care services
- improve value for money
- enable clearer priorities to be set for the family practitioner services in relation to the rest of the NHS
- reward those doctors who do most for their patients by providing the good quality services which we all want.

The period of consultation for these and other changes in primary health care started over three years ago with the aim of improving the family doctor services with this new and fairer contract. There is no sensible basis for reopening the negotiations concluded with the profession's leaders on 4 May. The Government intend, therefore, to honour the agreement reached on that occasion.

The GMSC is being consulted on the detailed amendments to Regulations and the Statement of Fees and Allowances which will be required to implement the new contract. Once that consultation process is ended, the Regulations will be placed before Parliament with a view to implementation on 1 April 1990. As soon as the detailed changes to the Statement of Fees and Allowances and terms of service have been settled, copies of those documents will also be sent to you.

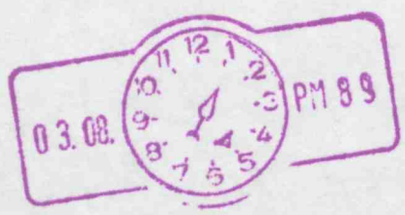
I hope you will read "The New Contract" carefully because I think there has been a great deal of misunderstanding about it within the profession over the last few months. The discussions in Scotland leading up to the Contract amply demonstrated the Government's willingness to listen to those who have a constructive contribution to make to the process of bringing the whole of the NHS up to the standard of the very best. I

would very much like to continue those discussions so I hope you will take the opportunity of talking to me about "The New Contract" when I am travelling extensively in Scotland during the Summer Recess; I hope to visit every Health Board area.

Yours sincerely

MICHAEL B FORSYTH

MCO212L4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PM 89

10 DOWNING STREET
LONDON SW1A 2AA

From the Principal Private Secretary

3 August 1989

Dear Andy,

GP CONTRACT

The Prime Minister has seen the letter which your Secretary of State is sending to all GPs giving details of the Contract. She commented that it was an excellent letter and should clear up a lot of misunderstanding.

I am copying this letter to the Private Secretaries to the Chancellor of the Duchy of Lancaster and the Secretaries of State for Wales, Scotland and Northern Ireland.

Yours sincerely

Andrew Turnbull

(ANDREW TURNBULL)

Andy McKeon, Esq.,
Department of Health.

SC37490

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

Paul Gray Esq
10 Downing Street
London SW1

2 August 1989

Prime Minister 2

Dear Paul

GP CONTRACT

An excellent letter — it should clear up a lot of misunderstandings. Also a very good interview.

I attach a copy of a letter which my Secretary of State intends to send to all GPs on Thursday giving them details of the Contract which will be implemented from 1 April 1990. The letter will be accompanied by an explanatory booklet. (to follow)

File A

The Secretary of State thought that the Prime Minister might also be interested to see the article which appeared last week in the Independent based on an interview he gave Nick Timmins, the paper's health correspondent. He believes it sums up well where we now stand on the implementation of the Review and the GP Contract.

A copy of this letter goes to the private secretaries to the Chancellor of the Duchy of Lancaster and the Secretaries of State for Wales, Scotland and Northern Ireland.

Yours
Andy

A J McKEON

1823A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

TO ALL GPs

3 August 1989

Dear Doctor,

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E.R.

I have decided not to withdraw any of those concessions that I made on 4 May although the basis of my agreement with the GMSC negotiators was quite clear that I would be free to consider doing so if the profession did not accept the agreement I had reached with the negotiators.

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I hope you find "The 1990 Contract" helpful in providing you with a comprehensive picture of the changes to be made to your remuneration system and terms of service.

KENNETH CLARKE

cc Mr Davey
Mrs Baldock
Ms Kirk
Mrs Hosmich
Man Sugrm
Dr. McInnes
Mr Carpente
Mr Rayne.
Dr. Abrams.
Mr. Shaw

1338A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

Prime Minister
This answers your query. It still means the clock watchers can do a lot less than best but then they are likely to attract fewer patients and less capitation.
AT 5/5

Andrew Turnbull Esq
10 Downing Street
LONDON SW1

5 May 1989

Dear Andrew

GPs CONTRACT

I attach a note as requested on the 26 hours commitment agreed yesterday as part of the contract settlement.

Yours

Andy

A J McKEON

1339A

NOTES FOR No 10 ON "26 HOURS A WEEK" FOR GPs

Present position

The most recent survey (1985/86) of GP workload showed that the average GP spends 38 hours a week on family doctor services, plus a further 30 hours on call. At present there is no terms of service requirement on GPs to work a minimum number of hours; but in order to qualify for full basic practice allowance (currently £9,250 but due to be reduced) he or she must provide at least 20 hours a week of services in the surgery or on home visits at times which are reasonably spread over the normal working week.

Weakness of the present system

Commitment to patient care is weak. "Twenty hours reasonably spread over ... the week" is difficult to monitor and enforce because it is not specific. Some GPs draw full pay for a four day week. Some are often not available at their surgeries at times convenient to their patients or only for the minimum number of hours they can get away with.

New arrangements

Under the new contract proposals, GPs will be required under their terms of service to be available for at least 26 hours over five days per week in the surgery and for home visits. This change defines formally for the first time the minimum commitment required of GPs. It also raises the number of hours from the level currently set for full BPA (20) to the new higher figure of 26. GPs will be expected to be in their surgeries for five days a week unless they have other health care duties approved by the Family Practitioner Committee, in which case 26 hours over 4 days will be approved.

Why 26 hours?

26 is chosen as it broadly reflects the time spent by the average GP on direct contact with patients as shown by the survey referred to above. The rest of the GPs' working week is spent on activities such as training staff including new GPs, patient case discussion, arranging for patients to be referred to hospital and practice administration.

GM3872p

RA Health

I am glad to be able to tell the House that, late last night after prolonged discussions, I reached agreement with Dr Michael Wilson the Chairman of the General Medical Services Committee of the BMA and his negotiating colleagues on all the major outstanding issues involved in the new contract proposed for family doctors. I now expect a contract on the lines agreed to be introduced for family doctors throughout Great Britain with effect from 1 April 1990. My Department is now preparing a new Statement of Fees and Allowances and Regulations for consultation on minor details with representatives of the profession and I will lay the Regulations in their final form before the House in due course.

The new contract will introduce new performance bonus payments for those doctors who reach the Government's targets of 90 per cent coverage for childhood immunisation and 80 per cent coverage for screening for cervical cancer. I have also agreed to introduce new lower rate bonus payments of one third of the full rate for those doctors who attain 70 per cent cover for immunisation and 50 per cent cover for cervical cancer screening.

The negotiators have agreed my proposal that the fee paid where a right visit is made by a doctor from the patient's own practice should be three times the fee paid when the visit is made by a deputy.

To meet representation's put to me on behalf of doctors in small practices, I have agreed that the higher fee for night visits should also be paid when the visit is made by a doctor from a small rota of local GP's so long as the rota does not include more than ten practitioners.

I had originally proposed that the new contract should require GPs to be available to patients for 20 hours each week in surgery. To meet representations put to me by rural doctors in particular, I have now agreed that the terms of service will require GPs to be available for 26 hours on average over 5 days each week and that this will include availability in surgery, health promotion clinics and for home visits. In recognition of the work that some GP's do elsewhere on health related activities in the public service, for example in community hospitals, this commitment can be reduced to four days in individual cases subject to agreement with the Family Practitioner Committee.

The GMSC and I have always agreed that additional payments should be made to rural practitioners and that the present system of rural practice payments needed to be up-dated. We have not yet agreed on the fairest method but we are confident that we will be able to do so. We agreed last night that work on revising the scheme would be taken out of the present negotiatins and considered by the Central Advisory Committee on Rural Practice Payments.

We also reached mutually satisfactory agreements on minor surgery, seniority payments, the basic practice allowance, funds for practice terms and premises and new higher capitation payments for GP's serving deprived areas.

We also agreed to submit joint evidence to the Doctors and Dentists Review Body about pricing the new contract in such a way as to meet the Government's policy objective for the General Medical Services in that the joint evidence would refer to the profession's acceptance of the Government's intention that the porportion of the remuneration of GP's arising from capitatin based payments will reach 60 per cent from 1 April 1990.

There were large areas of the new contract upon which we had always been in agreement with the profession. I am glad to say therefore that, for example, the proposed new payments for surveillance of young children and the new higher capitation payments for patients over the age of 75 with whom doctors retained close contact were never at my time the subject of controversy between us.

The Negotiator undertook to commend last nights agreement to the profession for implementation with effect from 1 April 1990.

Mr Speaker, this agreement is a very significant step in the development of the family doctor service in our NHS. the new contract will be very different to the old one. It will ensure that the highest rewards go to the most hard-working doctors and thatl incentives and rewards are given to those who introduce new services and hit high standards of performance. The negotiators and I are quite agreed that it provides the foundation for further improvements in raising the quality of primary health care for all our NHS patients.

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PRIME MINISTER

DOCTORS' CONTRACT

Attached is a copy of the agreement reached between Mr Clarke and the doctors. The Government have made a number of concessions e.g.

- rather than simply one target for higher immunisation/screening levels there will be a lower target qualifying for small payments

- the figures for the basic practice allowance have been reduced as Mr Clarke indicated when you saw him yesterday.

- doctors in a practice will be allowed to average out their list sizes.

The most significant feature is the retention of the principle that capitation based payments should form 60 per cent of doctors' income. It has been agreed that the DDRB should take this as its starting point for the next review. I asked whether the footnote on page 3 represented a watering down by defining within capitation a number of new elements. DOH see its significance as the opposite, excluding certain major payments.

Mr Clarke proposes to make an oral statement to the House this morning.

AT

Andrew Turnbull

5 May 1989

MJ2DON

cc JA
cc Press

DEPARTMENT OF HEALTH
Richmond House
79 Whitehall
London SW1A 2NS
Tel: 01-210 5319

FAX DOCUMENT LEADER

For the attention of: DUTY CLERK
No 10

From: ANDY McKEON
Room 407
Kenneth Clarke's Office

Total No of pages: 4

Any queries: 210 5319

1335A

Kenneth Clarke, Secretary of State for Health, and David Mellor, Minister for Health met Dr Wilson, Chairman of the GMSC and his Negotiating colleagues on 4 May. The purpose of the meeting was to discuss the new contract for family doctors.

Agreement was reached on all the major outstanding issues. These were:

1. Prevention Targets. Payments will be made for two levels of achievement:

   - for childhood immunisation a higher level of payment will be made to GPs who achieve 90% coverage. A lower payment will be made for reaching 70% cover. The differential will be 3:1;

   - for screening for cervical cancer the upper level will be 80% and the lower level will be 50%; the same differential applying.

2. Night visits. It was agreed that a two level fee will be introduced for night visits on the ratio of 3:1. The higher level will be paid where the visit is made by a doctor from the patient's own practice or from a small rota of local GPs (up to a maximum of ten practitioners).

3. Minor surgery. So that patients will benefit fully from the new arrangements for more minor surgery in the GP's premises, individual operations up to a total of five will be allowed to count towards entitlement to a monthly sessional payment:

4. Availability to patients. To optimise the time that GPs are available to patients, the GPs' terms of service will be amended to require GPs to be available for 26 hours on average over 5 days each week. This will include availability in surgery, health promotion clinics and for home visits. In recognition of the work that some GPs do elsewhere on health related activities in the public service, this commitment can be reduced to four days subject to agreement with the Family Practitioner Committee.

1335A/2

5. Rural Practice. It was agreed that the present system of rural practice payments needed to be updated. Work on revising the scheme will be taken out of the present negotiation and considered by the Central Advisory Committee on Rural Practice Payments.

6. Seniority Payments. This allowance will be retained but will be reduced by the value of the new postgraduate education allowance. This change will reflect the fact that under the new arrangements all GPs who are entitled to seniority payments will be entitled to this new allowance (provided they meet the necessary training requirements).

7. Basic Practice Allowance. This allowance will be reduced as a proportion of GPs' income. The payment will be made on a proportionate basis for all patients up to 1200. GPs with fewer than 400 patients will not be entitled to BPA. This is a change from the original proposal that the limits should be 500-1500 and will be consistent with proposals in Scotland.

Another change to the original proposals for BPA will be that one of the main criteria for assessing entitlement will be retained, namely that entitlement to BPA will be based on average list size within the partnership.

8. Funds for practice teams and premises. The Secretary of State confirmed that commitments entered into under the existing arrangements for the direct reimbursement of staff, premises, and premises improvements will be honoured.

9. Areas of Deprivation. The Health Departments will consult the GPs' representatives about the detailed arrangements for distributing the new capitation payments to GPs serving deprived areas.

10. The Secretary of State and the Negotiators also agreed to submit joint evidence to the Doctors and Dentists Review Body about pricing the new contract in such a way as to meet the Government's policy objective for the General Medical Services in that the joint

1335A/3

evidence would refer to the profession's acceptance of the Government's intention that the proportion of the remuneration of GPs arising from capitation* based payments will reach 60% from 1 April 1990.

11. Finally, the Negotiators undertook to commend this agreement to the profession for implementation with effect from 1 April 1990; and that (i) evidence be prepared for the DDRB to price the new proposals and (ii) draft amendments to the Statement of Fees and Allowances and Regulations be prepared for consultation with representatives of the profession.

KENNETH CLARKE
Secretary of State for Health

DR MICHAEL WILSON
Chairman, General Medical Services Committee

* Under the new contract capitation will include: standard capitation fees (as currently understood) together with the new capitation fees for registrations, child health surveillance and the deprivation supplement but exclude Basic Practice Allowance and [illegible]otive payments.

PRIVY COUNCIL OFFICE
WHITEHALL. LONDON SW1A 2AT

14 March 1989

Dear Andrew

PRIVATE MEMBER'S (LORDS) BILL:
JUNIOR HOSPITAL DOCTORS (REGULATION OF HOURS) BILL

Thank you for your letter of 9 March to Steve Catling conveying your Secretary of State's recommendation that Lord Rea's Junior Hospital Doctors (Regulation of Hours) Bill should be blocked at Second Reading in the Commons.

The Lord President understands that the Prime Minister is content with this approach. No member of L Committee has commented and the Lord President has accordingly asked me to confirm that your Secretary of State may take it that the Committee is content that the Bill should continue to be blocked.

I am sending copies of this letter to Paul Gray (No 10), to the Private Secretaries to members of L Committee and to Trevor Woolley (Sir Robin Butler's office) and First Parliamentary Counsel.

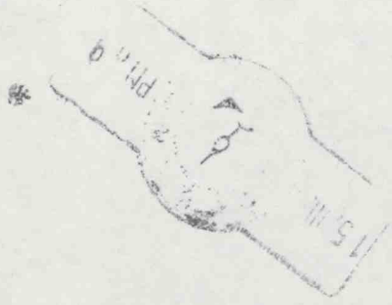
Yours sincerely,

Nicholas.

N D J DENTON
Private Secretary

A J McKeon Esq
PS/Secretary of State
Department of Health

NAT HEALTH : Doctors Pay PT4



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cc DgH

10 DOWNING STREET

LONDON SW1A 2AA

THE PRIME MINISTER

13 March 1989

Dear Sir Graham,

Thank you for your letter of 22 February about the Government's decision not to accept the Review Body's recommendations for the increase at the top of the consultants' scale and in the size of the A+ distinction awards.

May I first assure you that the Government's decision does not reflect any fundamental change in attitude to the Review Body system and the important work undertaken by the Review Bodies. Indeed, we have accepted all the remaining recommendations in your Nineteenth Report. We have always maintained our right to accept Review Body recommendations or to reject them if there are clear and compelling reasons for so doing. Whilst I understand the reasons you advance in your letter, I believe - as I made clear in my letter of 16 February - that the creation of the 100 additional permanent consultant posts over the next three years will achieve what I know is our joint objective of improving the long-term career structure for hospital doctors.

Yours sincerely

Margaret Thatcher

Sir Graham Wilkins

KK

PRIME MINISTER

PRIVATE MEMBERS (LORDS) BILL: JUNIOR HOSPITAL DOCTORS (REGULATION HOURS)

The Secretary of State for Health minuted on 5 January proposing that when Lord Rea's Bill reached the Commons, the Government should ensure that it was blocked at second reading. You took the view that there was no need to take a decision at that time and commented that the Bill might be very charged when it got to the Commons.

Mr Clarke feels that statutory regulation of doctors' hours is unacceptable in principle amd that, in any case, much of the heat has gone out of the protest by junior doctors. This reflects the fact that some progress has been made in discussions with the BMA.

Agree that the Bill should be blocked when it is taken tomorrow?

ANDREW TURNBULL
9 March 1989

RG 02820/4

PPS AH

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for Health

PO(9H)1694/1933

Ms Janice Richards
10 Downing Street
LONDON
SW1A 2AA

9 MARCH 1989

Dear Janice

Thank you for the letter of 24 February from Paul Gray I enclose a draft reply.

Yours sincerely

P Harriman

PHILIP HARRIMAN
Private Office

KL3DJL. GR Pl type for PM signature. PRCG 15/3

DRAFT LETTER: PRIME MINISTER TO SIR GRAHAM WILKINS

Thank you for your letter of 22 February about the Government's decision not to accept the Review Body's recommendations for the increase at the top of the consultants' scale and in the size of the A+ distinction awards.

May I first assure you that the Government's decision does not reflect any fundamental change in attitude to the Review Body system and the important work undertaken by the Review Bodies. Indeed, we have accepted all the remaining recommendations in your Nineteenth Report. We have always maintained our right to accept Review Body recommendations or to reject them if there are clear and compelling reasons for so doing. Whilst I understand the reasons you advance in your letter, I believe - as I made clear in my letter of 16 February - that the creation of the 100 additional permanent consultant posts over the next three years will achieve what I know is our joint objective ~~in~~ of improving the long-term career structure for hospital doctors. ~~In my judgement, that is sufficient reason for rejecting the recommendations to which you refer.~~

1043A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

NBPR

RESTRICTED

Note for Record
PM agreed that Bill should now be blocked
AF 10/3

Steve Catling Esq
Private Secretary to the
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

9 March 1989

Dear Mr. Catling

PRIVATE MEMBERS (LORDS) BILL - JUNIOR HOSPITAL DOCTORS (REGULATION OF HOURS) BILL

We spoke about Lord Rea's Bill which received its Third Reading in the House of Lords on 2 March and unexpectedly is due to receive its Second Reading in the House of Commons tomorrow, 10 March. As I explained, my Secretary of State is very firmly of the view that the Bill should be blocked and should not receive a Second Reading.

The arguments against the Bill have changed little since my Secretary of State wrote to the Lord President on 5 January. Indeed, Ministers have had further meetings with the BMA following which both parties are taking further steps to achieve reductions in junior doctors hours of work.

I am sending copies of this letter to Andrew Turnbull and the Private Secretaries of members of L Committee.

FOR

A J McKEON
Private Secretary

NHS - DrD Pay Pt 4

FILE MM

Sir G. WILKINS
6/3

1)7/3

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

ACK 24 February 1989

Dear Flora,

The Prime Minister has received the attached letter from Sir Graham Wilkins protesting at the Government's rejection of two of the recommendations of the Doctors' and Dentists' Review Body.

I should be grateful if you could let me have a draft reply for the Prime Minister's signature by 6 March.

I am copying this letter and enclosure to Alex Allan (HM Treasury) and to Trevor Woolley (Cabinet Office).

Yours,
Paul

PAUL GRAY

Mrs. Flora Goldhill,
Department of Health

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 01-405 5944

The Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street
LONDON SW1A 2AA

22 February 1989

Dear Prime Minister,

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION: NINETEENTH REPORT

Thank you for your letter of 16 February. I have arranged for your message of thanks to be conveyed to my colleagues on the Review Body.

We were pleased to learn that the Government had accepted our main recommendations, but disappointed that you were unable to adopt our proposal for the increases at the top of the consultants' scale and in the size of the A+ distinction award. We regarded these particular recommendations as an important part of the package which we believed necessary to encourage more doctors to opt for a hospital career.

The terms of your announcement imply that we might not have made these recommendations if we had known of the Government's plan to create 100 additional consultant posts. I am confident, however, that we would still have put forward the recommendations, since we saw the increased incentives for senior consultants as complementary to the expansion of consultant posts in achieving the objective of improving the long-term career structure for hospital doctors.

In the course of the Government's evidence, we were assured by the Minister for Health, as we have been in previous years, that the Government would continue to implement our recommendations unless there were clear and compelling reasons to the contrary. My colleagues and I have noted with concern the fact that, despite this assurance, the Government have for the first time felt it necessary to reject recommendations of this Review Body relating to the remuneration of a specific group in the medical and dental professions. We believe that the credibility of the Review Body system is damaged if our recommendations are to be rejected in this way.

Yours Sincerely

SIR GRAHAM WILKINS

23.11.
PM 9

10 DOWNING STREET
LONDON SW1A 2AA

16 February 1989

THE PRIME MINISTER

Dear Sir Graham,

Thank you for your letter of 11 January and for the Nineteenth Report of the Review Body on Doctors' and Dentists' Remuneration. I am grateful to you and your colleagues for the time and effort you have put into this important work and for completing it within the new timetable.

As you will know, I announced today the Government's acceptance of the recommendation of the Review Body for a basic increase of eight per cent for all the groups covered. In the Government's view the creation of 100 additional permanent consultant posts over the next three years, as proposed in the White Paper, "Working for Patients", will best achieve the objective of improving the long-term career structure for hospital doctors. The creation of these posts will therefore take the place of the increase recommended, in addition to the eight per cent basic increase, at the top of the consultants' scale and in the size of consultants' distinction awards. Subject to this, the Government accepts the Review Body's recommendations.

Yours sincerely

Margaret Thatcher

Sir Graham Wilkins

MS1650p Covering Confidential

RT

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

Paul Gray Esq
Private Secretary
10 Downing Street
London
SW1

15 February 1989

Dear Paul

I attach a draft letter for the Prime Minister to send to Sir Graham Wilkins, Chairman of the DDRB. The last paragraph is drafted intentionally in a fairly low key.

Yours

Andy

A J McKEON
Private Secretary

CONFIDENTIAL

DRAFT LETTER: PRIME MINISTER TO SIR GRAHAM WILKINS

Thank you for your letter of 11 January and for the Nineteenth Report of the Review Body on Doctors' and Dentists' Remuneration.

I announced [today] [on 16 February] that the Government decided to accept the recommendation of the Review Body for a basic increase of 8% for all the groups covered. In the Government's view the creation of 100 additional permanent consultant posts over the next 3 years, as proposed in the White Paper, "Working for Patients", will best achieve the objective of improving the long-term career structure for hospital doctors. The creation of these posts will therefore take the place of the increase recommended, in addition to the 8% basic increase, at the top of the consultants' scale and in the size of consultants' distinction awards. Subject to this, the Government accepts the Review Body's recommendations.

NP I am grateful to you and your colleagues for the time and effort you have put into this important work and for completing it within the new timetable.

SECRET 4

PRIME MINISTER

PAY REVIEW BODIES

You had a quick glance last weekend at the Doctors' and Dentists' Report. This week we have had in the Reports on Armed Forces, Nurses and Professions Allied to Medicine. These are certainly not required reading, but I am attaching them in case you wanted to glance at them over the weekend.

Paul Gray
20 January 1989

SECRET

SECRET

PM 3

PRIME MINISTER 2

DOCTORS' AND DENTISTS' REVIEW BODY REPORT (DDRB)

I have put separately in the box a minute from Robin Butler reporting his discussion with Permanent Secretaries on the Review Body Reports.

But, if time permits, you may also want to glance over the weekend at the ~~4th~~ full DDRB Report which we have now received (attached).

We are now promised the reports on nurses, professions allied to medicine and the armed forces on Monday. As you know, the TSRB report will not be available for another fortnight.

Recd.

PAUL GRAY
13 January 1989

DASATG

SECRET

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 01-405 5944

CONFIDENTIAL

The Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street
LONDON SW1

11 January 1989

Dear Prime Minister

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

I enclose the Nineteenth Report of the Review Body on Doctors' and Dentists' Remuneration. This contains our recommendations on the levels of remuneration we consider to be appropriate at 1 April 1989 and sets out the factors we considered were of particular importance when reaching our conclusions.

Yours Sincerely

GRAHAM WILKINS
CHAIRMAN, REVIEW BODY ON DOCTORS'
AND DENTISTS' REMUNERATION

DDRB 19th REVIEW

SECTION A: GENERAL

18th REPORT

A.1. Following receipt of the Review Body's 18th Report, the Government implemented all the recommended rates and allowances in full from 1 April 1988; and the recommendation that from 1 January 1988, there should be reimbursement, in certain circumstances, of ⅔ of Defence Body subscriptions.

19th REVIEW

A.2. The 18th Report emphasised the DDRB's strength of feeling on the independent nature of their recommendations. The Government accepts this completely but the Government also has a duty, in line with its responsibility for the funding of the NHS and its services, to put forward a view about an appropriate level of pay for the professions. The Departments' evidence does, however, seek to persuade the Review Body that a further award of last year's order is neither necessary nor affordable.

A.3. The Departments believe that in recommending levels of pay for the professions, the Review Body should take account of:-

- the real terms increases the profession have enjoyed over a sustained period;
- the effects of continuing low inflation, nothwitstanding the projected but temporary rise in the RPI;
- reduced taxation which applies especially to high earning groups, including doctors and dentists;
- the increased resources the Government has made available to the NHS; and
- the success of the NHS in recruiting and retaining medical and dental practitioners.

The Health Departments' general approach is consistent with previous years, namely that within the limit of what can be afforded, pay should be set according to what is needed to recruit and motivate staff. In the Government's view, there is no need for any further increase in real terms remuneration levels.

THE ECONOMY

A.4. The Government's plans for public spending form a central part of its economic policy. Within the framework of the

Medium Term Financial Strategy, the Government's objective is to hold the rate of growth of public spending below the growth of the economy as a whole, and thus to reduce public spending as a proportion of national income. This will enable a prudent fiscal stance to be combined with reductions in the burden of taxation, so encouraging enterprise and efficiency, and thus the growth of output and employment.

A.5. The Medium Term Financial Strategy is intended to reduce inflation progressively over a number of years with the ultimate goal of achieving price stability. The growth in money GDP has fallen from 17% p.a in 1980 to just under 10% in 1987. Simultaneously, inflation has fallen from over 20% p.a to about 4% p.a in 1987. In real terms the economy has grown at an average rate of over 3.% for the last 7 years. The Budget forecast is that it will continue to grow at 3% in 1988 (although it is now likely to be exceeded) with assumed growth of about 2.5% in 1989/90.

A.6. Unemployment has fallen throughout the country. In the year to August adult unemployment fell by over half a million to its lowest level since May 1981. It has now fallen for 25 months in succession - the longest period of falling unemployment since the war. In the year to July the number of long-term unemployed fell by over a quarter of a million. Since 1983, the economy has put on 2 million more jobs.

A.7. Inflation has averaged below 5 per cent for the last 5 years; but in August it rose to 5.7%. With increases in the mortgage interest rate, it is likely to edge up further in the next few months before coming down in 1989. The Government will take whatever action is required to keep inflation under control.

A.8. The Tax and Price Index (TPI) - which measures the pay rise required by the average employee to compensate for price increases after taking account of tax changes - only rose by 3.7 per cent in the year to August.

A.9. Given the background outlined in paragraphs A7-A8, the Government believes that modest increases sufficient to take account of changes in the cost of living are all that are required.

A.10. Between the beginning of 1983, and the last quarter of 1987, the underlying increase in average earnings in the economy as a whole was generally between 7½ and 7¾ per cent. Since October 1987 it has been running at between 8 and 8½ per cent, and in the year to July it rose to 9%. This is much too high. It is about double the rate of increase in the earnings of our main competitors, and jeopardises our international competitiveness and further reductions in unemployment. It is estimated that every percentage point reduction in the rate of growth of real wages would boost employment by between 110,000 and 220,000 jobs.

A.11. In 1987 high pay increases were partly offset by very rapid productivity growth in manufacturing, and labour costs per unit of output only rose slightly - (although on average they fell in our major competitors). In the year to the first quarter of 1988, productivity in the economy as a whole rose by 3.0%. In the manufacturing sector the increase was 7.2% . Although the outlook for manufacturing is good, we cannot rely on manufacturing productivity continuing to compensate for the service sector where measured productivity growth is rather less than half that in manufacturing. The public sector accounts for 20 per cent of service sector employment and it must play its part in improving productivity and in controlling unit costs.

A.12. The most important component of the increase in average earnings is the average level of pay increase agreed between employers and employees - ie settlements. Confederation of British Industry data shows that in the second quarter of 1988 manufacturing settlements averaged 5.9 per cent (with just under half being under 5½ per cent) and settlements in private sector services in the first half of 1988 have averaged 6.8 per cent.

A.13. For the economy as a whole, the Office of Manpower Economics conducted a survey of settlements on behalf of the Official Side of the Police Negotiating Board. The Survey shows that in the year to June 1988 half the settlements for basic pay were below 6% and the average was 6.8%. In the private sector as a whole, the average was 6.1% (6.7% for non-manual workers) but in the public sector it was 8.6%.

A.14. The increase in earnings is greater than settlements because of "drift". In the past year this has added about 1¾ per cent to earnings, which is in line with experience in earlier years. Drift reflects changes in overtime, bonus payments (including performance pay), and in some cases movement up incremental scales. Every occupation benefits from earnings drift to a greater or lesser extent, and the Government does not consider that any settlement for a Review Body group should reflect earnings drift elsewhere in the economy: otherwise they would benefit from drift twice over, their own, and that of other groups as well.

A.15. The economic evidence will be up-dated when the Autumn Statement becomes available.

NHS SPENDING PLANS

A.16. Planning provision for the NHS takes broad account of the expected levels of general inflation but makes no explicit assumptions about the levels of pay and price increase within the service. From within the cash provision made, the NHS will need to meet the cost of developments in order to keep pace with the increasing number of elderly people, to meet specific policy objectives for priority groups and to take advantage of medical advances.

A.17. To the extent that pay increases exceed the level of general inflation, the excess cost is, therefore, a call on the same pool of resources as service developments. Although health authorities have been able to generate increased cash in recent years from their cost improvement programmes, their room for manoeuvre is inevitably restricted. The Government's decisions on levels of spending in the NHS in 1989-90 and the two following years will form part of the Autumn Statement and will subsequently be outlined in greater detail by the Secretaryof State for Health. A summary of these announcements will be provided by the Health Departments in the form of supplementary evidence. Details of the contribution the continuing programme of cost improvements and the income generation initiative will make to the pool of resources available to health authorities will similarly be given later.

FUNDING OF PAY AWARDS

A.18. Despite the Government's commitment to the development of the NHS, the taxpayer cannot be expected to provide a blank cheque annually to underwrite the additional cost of National Health Service pay rises beyond that which can be reasonably afforded and which do not, of themselves contribute to improvements to service. Those responsible for managing the NHS cannot expect to be insulated by the taxpayer from the pressures and demands faced by any employer in seeking to improve services and contain costs whilst at the same time remaining sufficiently competitive in the recruitment and retention of staff. In 1988/89, the Government has made available an additional £161m specifically to provide for the costs over and above baseline funding of the 1988/89 award for doctors and dentists. This will not however constitute a precedent for the future. As stated in paragraph A.17 the Autumn Statement will set out the resources to be made available to health authorities in 1989-90 and there are also again expected to be cash savings as a result of improved efficiency. There can therefore be no presumption of additional funding at a later date and no such presumption should underlie any recommendation.

THE PROFESSION'S POSITION

A.19. The profession's concept of fairness is still wedded to comparisons with the highest earners. The Government believes that there are no logical or economic reasons why relative positions of individual groups in a historic earnings league should be perpetuated indefinitely. The profession's perceived "shortfall" relative to their chosen comparators since 1980 is something which has happened across the public sector if that year is chosen at random. The profession's evidence to the 18th Review (paragraph 1.12 and Table 1.2) compared medical settlements with those in the top decile of the private sector. These private sector figures, are based on NES data. The top earners are not a constant group for comparison purposes, and

tend to work in areas where job security cannot be guaranteed. The professions have little reason to feel aggrieved. They have done better over the lifetime of this Government than any other NHS group (see Table A3) , academics, teachers and most civil servants. The professions have bettered the average earnings over the period. The picture since 1980 - removing the effect of "catching-up" awards - is still favourable. Averaged out, the professions annual settlements have run at about 7.2% compared with average settlements of about 6.2% in both the public and private sectors, and have kept pace with average earnings increases. But the real issue is not the relevance of historical levels of pay; it is whether the professions are attracting sufficient high quality recruits at current levels - and they are; and whether the exceptional degree of job security with an expanding service continues to offer them a significant advantage - and it does.

A.20 The Government recognises that co-operation and good relations with the profession are crucial to the smooth functioning of the NHS. It is a successful and expanding service, and the Government is determined that it should be a satisfying one in which to work. The Government agrees with the profession that many factors other than pay can influence this. The record levels of resources the government has put into the National Health Service and the savings it has generated for itself have helped to improve facilities and frontline staffing in ways that clinicians themselves would wish. National Health Service spending for a family of four is now £1,650 per annum. The Government is bound to look for ways of ensuring maximum value for money from that and to plan for growth at a pace the country can afford. As the Review Body will know, the Government is undertaking a review of the National Health Service and will bring forward proposals soon.

MANPOWER, RECRUITMENT AND RETENTION

A.21. We have always argued that, within the limits of affordability, the main determinant of pay levels for the professions should be what is sufficient to recruit, retain and motivate staff of the right quality for the job to be done. Pay, however, is not the only element in an effective recruitment and retention strategy. Indeed, pay-related solutions, based wholly or principally on successive real-terms increases in remuneration levels are likely to prove both costly and ineffective. They will result in unproductive leap-frogging in settlement levels between competing employers. This will be damaging not only to the NHS but to the economy more generally.

A.22. We accept that minor recruitment difficulties have been experienced in the junior training grades in some, but not all, specialties and Districts. We believe that the main cause of these lies in the imbalance in the hospital medical staffing structure, which the measures published in "Achieving a Balance: Plan for Action" are intended to resolve. The Department is collecting information from health authorities on

SHO posts currently vacant; this should provide information on the Districts and the specialties where the problems are occurring. A copy of the letter and questionnaire is at Annex A. Viewed overall, however, the recruitment position is one of increasing competition for posts.

A.23. Manpower targets were introduced in England to promote effective and efficient staffing. There was an overall increase in the proportion of staff providing direct patient care (i.e medical and dental, nursing and midwifery and professional and technical staff) from 66% of the total in March 1987 to 66.3% in March 1988. Manpower targets were set for all Regional Health Authorities for March 1988 based on their Short Term Programmes. In total the overall manpower target was set 8,230 lower than in 1987; but as at March 1988 13 of the 14 Regions were below their targets (one Region being 0.9% above). Between March 1987 and March 1988 the total number of directly employed staff, excluding locum and agency staff, fell by 4,700 WTEs or 0.6% (see Table A.2) but direct care staff increased - medical and dental by 700 WTEs or 1.8%. Manpower targets for March 1989 are to be based on Regional Health Authorities own estimates of the manpower they require. Formal approval will be given shortly. Overall the targets are likely to be approximately 767,408. This is lower than those agreed for March 1988, but are still above the actual staff in post total at March 1988.

A.24. It has been the Government's policy to encourage the service to concentrate manpower resources on direct patient care, thus favouring employment opportunities for the professions. From 1978 to 1987, the number of practitioners working in the NHS increased by 14,000 whole-time equivalents (WTEs). Numbers of gmp unrestricted principals and gdp principals rose by 18 per cent and 25 per cent respectively. With the spread of vocational schemes, the increase in trainee numbers was much greater - 69 per cent. In the HCHS, there were increases of 13 per cent (5810) in medical and dental WTEs and 18 per cent in direct patient care staff, whereas support staff WTEs fell by 12 per cent (see Table A.1). More of the workforce is more highly trained; the growth in consultant manpower over the period, at 2,899 WTEs or 22%, was well ahead of that for medical and dental staff generally. The proportion of qualified nursing and midwifery staff, excluding agency, also improved, from 54 per cent (in 1978) to 60 per cent.

Entry and Prospects

A.25. Recruitment performance is an important indicator of the adequacy of pay levels . In 1987/88 the average A-level score of students accepted to study medicine was 13.2 (better than one "A" grade and two "Bs"), the same as in 1986/87. There were more than 2 UK-based candidates per available place, but this understates the potential demand for places. Those who are not expecting good results tend not to apply for medicine; of the unsuccessful applicants only one in five got two

A-levels or fewer, compared with half of all unplaced university applicants. In 1987/88 the average score of dental school entrants was 11.4, compared with 10.2 in 1980/81, and there was more than twice as many applicants as places. The level of quality and competition suggests that the attractiveness of medical and dental careers remains high relative to other professions and occupations.

WORKLOAD AND PRODUCTIVITY

A.26. Whilst it is true that the conventional hospital activity figures submitted to the Review Body (Table HMS 13) clearly show substantial increases in some areas between 1980 and 1986, the Health Departments' evidence to the 18th Review (paragraphs A.25 to A.28) fully explained the problems which arise in attempting to compare the productivity of staff in the private sector with some notion of output per head among HCHS staff in aggregate or by individual grade. Any measure of HCHS productivity based upon a broad index of activity cannot be an accurate measure of final medical output since the available indices are measures merely of intermediate medical outputs (eg number of cases treated) and are insensitive to changes in case-mix, quality of care and policy. Comparisons of such indicators with private sector productivity measures which are based on the monetary value of final output do not compare like with like. The contribution of individual disciplines to (even the intermediate measures of) aggregate HCHS productivity cannot be identified separately.

CONCLUSION

A.27. The important issues the Government have been addressing with the professions - notably the reform of hospital medical staffing, the Primary Care White Paper and the public health functions - are not fundamentally about pay, but about improving the quality of services for consumers and thereby increasing the job satisfaction of a career in the NHS. The Government recognises the importance of rewarding the professions adequately to reflect their responsibilities and career expectations; but in the light of the evidence we have submitted, we believe that only modest increases can be justified and that there is no need for any further increase in real terms in remuneration levels.

TABLE A1

NATIONAL HEALTH SERVICE DIRECTLY EMPLOYED STAFF BY MAIN STAFF GROUP
GREAT BRITAIN AT 30 SEPTEMBER - WHOLE TIME EQUIVALENT

Directly Employed Staff (1)	1978	1987	% change 1978-87
Nursing and Midwifery (2),(3)	428,000	495,400	+ 15.7
Medical and Dental (4)	46,200	52,000	+ 12.5
Professional and technical (5),(6)	68,700	92,600	+ 34.9
Ancillary (5)	211,700	148,000	- 30.1
Administrative and clerical	119,100	135,500	+ 13.8
Maintenance	24,100	23,000	- 4.9
Works	6,700	7,000	+ 4.3
Ambulance (including officers)	20,500	22,500	+ 9.7
All staff (directly employed)	925,100	976,100	+ 5.5

Source: Department of Health (SR7) Annual Censuses of NHS Medical & Non-Medical Manpower; Welsh Office; Scottish Health Service Common Services Agency.

(1) Includes staff at the Dental Estimates Board and Prescription Pricing Authority and equivalent bodies in Wales and Scotland. Figures are independently rounded to the nearest one hundred (100) whole-time equivalents. Percentages calculated on unrounded figures.

(2) Not adjusted for reduction in working hours during 1980/81 (from 40 to 37.5 hours per week).

(3) Includes agency staff and health visitor students.

(4) Includes permanent paid, honorary and locum staff in hospitals and community health services.

(5) From 1 April 1984 Operating Department Assistants (ODAs) - some 3,100 (wtes) at 30 September 1984 - were transferred from Ancillary Staffs Council to Professional and Technical Council. The figures for 1978 and 1987 are therefore not directly comparable.

(6) Includes Professions Allied to Medicine and Scientific and Professional staff.

TABLE A.2.

NHS DIRECTLY EMPLOYED STAFF

ENGLAND (1)

(All figures rounded and expressed as whole-time equivalents) (2)

	STAFF IN POST			CHANGE MARCH 87-MARCH 88		CHANGE DEC 87 - MARCH 88	
	31 MARCH 1987	31 DEC 1987	31 MARCH 1988	+/-	%	+/-	%
NURSING & MIDWIFERY (EXCL. AGENCY)	396,100	396,000	399,200	1,100	0.3	3,200	0.8
PROFESSIONAL & TECHNICAL (EXCL. WORKS) (3)	32,100	31,800	31,500	-600	-1.9	-300	-1.0
PROFESSIONS ALLIED TO MEDICINE	33,800	35,100	35,000	1,200	3.5	-100	-0.4
SCIENTIFIC & PROFESSIONAL	10,400	10,800	10,300	-100	-1.0	-500	-4.6
WORKS	5,700	5,600	5,500	-200	-3.5	-100	-2.0
MAINTENANCE	18,800	18,100	17,800	-1,000	-5.3	-300	-1.7
ADMINISTRATIVE & CLERICAL	111,800	114,700	114,200	2,400	2.1	-500	-0.4
AMBULANCE (INCL. OFFICERS)	19,100	19,000	18,900	-200	-1.0	-100	-0.5
ANCILLARY	119,000	112,700	110,900	-8,100	-6.8	-1,800	-1.6
TOTAL NON-MEDICAL (EXCL. AGENCY)	748,900	743,800	743,400	-5,500	-0.7	-400	-0.1
AGENCY N&M	6,000	5,000	5,500	-500	-8.3	500	10.0
NURSING & MIDWIFERY (INCL. AGENCY)	404,100	401,000	404,700	600	0.1	3700	0.9
TOTAL NON-MEDICAL (INCL. AGENCY)	754,900	748,800	748,900	-6,000	-0.8	100	0.01
MEDICAL & DENTAL (6) (INCL. LOCUMS)	41,400	N/A (4)	(7) 42,000	600	1.4	N/A (4)	N/A (4)
MEDICAL & DENTAL LOCUMS	1,500	N/A (4)	(7) 1,400	-100	-6.7	N/A (4)	N/A (4)
TOTAL NHS STAFF (EXCL. AGENCY & LOCUMS)	788,700	N/A (4)	784,000	-4,700	-0.6	N/A (4)	N/A (4)

1. Includes staff in Special Health Authorities for London Postgraduate Teaching Hospitals, London Ambulance Service, Family Practitioner Committees, Dental Estimates Board and Prescription Pricing Authority.

2. Because of rounding the sum of the component figures may not be equal to the separately rounded totals.

3. This group comprises MLSOs, Technicians and other P&T staff covered by the P&T 'B' Whitley Council. PAMs and S&P staff formerly included within the P&T (Excl. Works) group are now shown separately. The P&T (Excl. Works) figures are, therefore, not directly comparable with those quoted in earlier circulations.

4. Figures for Medical & Dental staff are not collected at June or December.

5. Some returns for Agency N&M, Bank N&M and/or Sessional Chiropodists had not been received when these figures were compiled. The latest available figures have been substituted in these instances.

6. Figures exclude Hospital Practitioners and Clinical Assistants.

7. March 1988 figures were not available for Trent and South East Thames Regional Health Authorities and the Royal Marsden Hospital. In these cases September 1987 figures were used.

SR7B
DH88

TABLE A3

PAY SETTLEMENTS FOR SELECTED NHS GROUPS AND RPI, AEI and TPI MOVEMENTS WITHIN PAY-BOUND YEARS; PLUS REAL TERMS CHANGE
(Percentages with Backdated cumulative percentages)

Pay Round Year 1 August - 31 July	@ RPI (July - July)		@ AEI (July - July)		@ TPI (July - July)		NHS											
							Doctors and Dentists		Nurses and Midwives		PAM's		ASC		A & C		AMB		Mainten. (CGS)	
1978/79	15.6	112.5	16.5	170.0	13.2	101.8	25.7	189.8	10.0	186.9	9.0	177.8	9.0	108.8	25.8	116.3	9.0	138.0	16.5	97.5
1979/80	16.9	83.7	19.0	131.9	18.5	78.2	18.7 10.7	130.6	21.0+ 14.0	160.8	21.0+ 14.0	154.9	10.6+ 13.0	91.5	14.0	72.0	23.0+ 13.0	118.3	14.0	69.5
1980/81	10.9	57.1	12.0	95.4	14.3	50.3	6.0	75.5	6.0	89.1	6.0	84.8	7.8	53.3	6.0	50.8	7.3	57.1	6.0	48.7
1981/82	8.7	41.7	10.9	74.5	9.6	31.5	6.2	65.5	-	78.4	7.5	74.4	6.0	42.2	6.0	42.3	6.0	46.4	6.0	40.3
1982/83	4.2	30.3	7.8	57.3	3.1	20.0	9.7	55.9	12.3‡	78.4	4.5	62.2	4.5	34.1	4.5	34.3	4.5	38.1	6.07	32.3
1983/84	4.5	25.1	5.2	45.9	3.3	16.4	6.9	42.1	7.5	58.9	7.8	55.2	4.5	28.4	4.5	28.5	4.5	32.2	6.15$	24.8
1984/85	6.9	19.7	8.8	38.7	6.3	12.7	6.3	32.9	8.6	47.8	12.1	44.0	4.7	22.8	4.7	22.9	7.8‡‡	26.5	0.0	17.5
1985/86	2.4	12.0	8.2	27.4	0.4	6.0	7.6	25.0	7.8	36.1	8.2	28.4	6.0	17.3	6.0	17.4	6.0	17.3	5.4	17.5
1986/87	4.4	9.4	8.1	17.8	2.8	5.6	7.7	16.2	9.5	26.3	9.1	18.7	5.0	10.7	5.0	10.8	5.0	10.7	6.2++	11.5
1987/88	4.8	4.8	9.0	9.0	2.7	2.7	7.9	7.9	15.3	15.3	8.8	8.8	5.4$$	5.4	5.5	5.5	5.4$$	5.4	5.0	5.0

Whole Period 1978/9 to 1987/88							
Pay settlements - % ahead (+) or behind (-) REAL TERMS:	RPI	+ 36.4	+ 35.0	+ 30.7	-1.7	+ 1.8	+ 12.0	-7.1
	AEI	+ 7.3	+ 6.3	+ 2.9	-22.7	-19.9	-11.9	-26.9
	TPI	+ 43.6	+ 42.2	+ 37.7	+ 3.5	+ 7.2	+ 17.9	-2.1

Notes:

@ The % change in the RPI, AEI and TPI is that from July of the base year to July of the latest year - not the yearly cumulative increase. The AEI for 1987/88 is based on the provisional July 1988 annual increase.

\+ Staged Clegg award paid 1/8/79 & 1/4/80.

‡ Two-year award paid wholly in 1982-83 pay round.

$ 16 month settlement.

‡‡ Assumes all projected efficiency savings are achieved.

++ Assumes all long-term assumptions on manpower changes are realised.

$$ In addition the standard working week was reduced by 1 hour.

PAY INFORMATION UNIT
September 1988

TABLE A4

PAY SETTLEMENTS FOR SELECTED PUBLIC SECTOR GROUPS AND RPI, AEI and TPI MOVEMENTS WITHIN PAY-ROUND YEARS; PLUS REAL TERMS CHANGE

(Percentages with Backdated cumulative percentages)

Pay Round Year 1 August - 31 July	@ RPI (July - July)		@ AEI (July - July)		@ TPI (July - July)		PUBLIC SECTOR GROUPS: Police (Federated Ranks)		Civil (1) Service (Grade 3)		Civil (2) Service (Grade 5)		Head (3) Teachers (E & W)		(4) Professors		Local Government (Manual)		Local Government (Admin)	
1978/79	15.6	112.5	16.5	170.0	13.2	101.8	+ 20.0 15.5	238.1	12.5	140.3	38.5	139.1	9.6	164.8	15.7	176.6	26.0	140.3	26.0	117.9
1979/80	16.9	83.7	19.0	131.9	18.5	78.2	13.5	143.9	13.9	113.6	14.7	72.6	24.4	141.6	28.0	139.1	13.0	90.7	15.0	73.0
1980/81	10.9	57.1	12.0	95.4	14.3	50.3	21.3	114.9	7.0	87.5	7.2	50.5	19.3	94.2	19.8	86.8	7.5	68.7	7.5	50.4
1981/82	8.7	41.7	10.9	74.5	9.6	31.5	13.2	77.2	14.0	75.3	6.3	40.4	6.0	62.8	5.0	55.9	6.9	57.0	5.7	39.9
1982/83	4.2	30.3	7.8	57.3	3.1	20.0	10.3	56.5	0.0	53.8	4.3	32.1	5.0	53.6	4.6	48.5	4.9	46.8	4.9	32.4
1983/84	4.6	25.1	5.2	45.9	3.3	16.4	8.4	41.9	14.3	53.8	4.2	26.6	5.1	46.2	4.6	41.9	4.5	40.0	4.9	26.2
1984/85	6.9	19.7	8.8	38.7	6.3	12.7	5.13	30.9	11.1	34.5	5.8	21.5	6.9	39.1	5.2	35.7	5.1	34.0	5.6	20.3
1985/86	2.4	12.8	8.2	27.4	0.4	6.0	7.5	24.5	11.3	21.1	6.0	14.9	1.5	30.2	0.0	29.0	8.0	27.5	5.96	13.9
1986/87	4.4	9.4	8.1	17.8	2.8	5.6	7.5	15.8	4.2	8.8	4.2	8.4	14.3	28.2	19.0	29.0	6.7	18.0	7.5	7.5
1987/88	4.8	4.8	9.0	9.0	2.7	2.7	7.75	7.75	4.4	4.4	4.0	4.0	12.2	12.2	8.4	8.4	10.6 ‡	10.6		
Whole Period 1978/79 to 1987/88																				
Pay settlements - % ahead (+) or behind (-) REAL TERMS: RPI							+ 59.1		+ 13.1		+ 12.5		+ 24.6		+ 30.2		+ 13.1			
AEI							+ 25.2		-11.0		-11.4		-1.9		+ 2.4		-11.0			
TPI							+ 67.5		+ 19.1		+ 18.5		+ 31.2		+ 37.1		+ 19.1			

Notes:

@ The % change in the RPI, AEI and TPI is that from July of the base year to July of the latest year - not the yearly cumulative increase. For 1987/88 the AEI assumes a 8.3% increase in Average Earnings in the year to July 1988 (based on the provisional June 1988 annual increase).

(1) Based on scale maximum increases. A further 1.35% w.e.f. 1.10.88 (1988/89 pay-round) will be paid.

(2) Based on scale maximum increases. One 'performance point' was introduced from 1.9.87; a further 3.55% wef 1.10.88 (1988/89 pay-round) will be paid.

(3) Based on Grade 7 scale maximum increases.

(4) Based on increases to 'average' prescribed level.

\+ 1st and 2nd part of Edmund-Davies award paid 1/9/78 and 1/5/79.

‡ 14 month settlement paid two months earlier than usual - from 1/7/87.

PAY INFORMATION UNIT

September 1988

TABLE A.5

Median pay settlements: weighted by number of employees

Twelve months ending	All Sectors	Public Sector	Private Industries	Private Companies
		(percentages)		
July 1985	5.6	5.6	5.6	6.4
July 1986	5.9	6.0	5.7	6.0
July 1987	6.0	7.2	5.0	5.7
June 1988 (latest available)	6.0	6.3	5.7	6.0

Source: Industrial Relations Services

ANNEX A

Department of Health and Social Security
Eileen House 80-94 Newington Causeway London SE1 6EF
Telex 883669 Telephone 01-703 6380 ext Enquiries Ext 3056

Your reference

To: Regional General Managers
Copies to District General Mangers

Our reference
EL(88)P/122

Date
21 July 1988

Dear General Manager

SHO posts without a permanent holder

The Department is seeking information on the difficulties which health authorities are having in filling some SHO posts. The DDRB in its 1988 Report has been critical of our lack of data on SHO/registrar level. In particular, we want to know:-

(1) in which districts posts have proved difficult to fill,

(2) in which specialties, and

(3) what action has been taken to fill the posts.

The Department does not at present collect any information on SHO vacant posts. The Hospital Consultants and Specialists Association (HCSA) carried out a survey of the recruitment of locums in 1986 and again in 1987, but these lacked precision. The present survey is intended to provide a comprehensive picture of where there are SHO shortages. We envisage that some limited information along these lines will in future be incorporated into the annual hospital medical staffing census.

The Department is considering collecting from 1989 onwards regular information on vacant Registrar posts. Nationally, this is not as great a problem as SHO shortages, but if your District has a problem we would be interested to have details, and the attached questionnaire allows for this.

We are anxious to collect the data on SHO vacancies in the near future in order to present evidence to the DDRB whose timetable has now been advanced.

May I ask for replies from each district by 25 August?

Yours sincerely

J C Dobson

J C DOBSON
Medical Manpower and
Education
Division

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This letter will be cancelled and deleted from the Communications Index on 30 November 1988.

0742S/EMC/4

SHO POSTS WITHOUT A PERMANENT HOLDER
FOR FOUR WEEKS OR MORE

.....HEALTH AUTHORITY

1. Please state the number of SHO posts in each specialty which were without a permanent holder on 30 June 1988 (or a date close to this - please specify) and which had been without a permenent holder for at least 4 weeks.

If recruitment of Registrars is also difficult in some specialties, please indicate the number of those posts without a permanent holder in column 3. You may also complete a copy suitably amended for each registrar post in col 3.

Line	Specialty (1)	Vacant SHO Posts (2)	Vacant Registrar posts (3)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
Total All Specialities		_____	_____

2. Number of SHO posts in the District:_____.

3. The District is a Teaching/not a Teaching District.

4. For each SHO post without a permanent holder please complete a copy of the attached sheet. You may also complete it for Registrar posts, but please specify which are Registrar posts.

Name and post held of the officer making the return.

ANALYSIS OF SHO POSTS WITHOUT A PERMANENT HOLDER FOR FOUR WEEKS OR MORE ON 30 JUNE 1988

.....HEALTH AUTHORITY

1. Post: specialty

2. Number of months the post has been without a permanent holder?

3. What steps have been taken to try to fill the post?

   (a) Number of times advertised

   (b) Other - please specify

   (c) What has been the response?

4. When the post has been filled on a temporary basis the locum doctor was recruited:

   (a) through advertisement

   (b) through a locum agency

   (c) through an NHS locum bank

   (d) in other ways - please specify

5. Does the post form part of a planned rotation?

   If not, are there any plans to include it in a rotation?

SECTION B: GENERAL NHS DEVELOPMENTS

GRIFFITHS REPORT

B.1. Sir Roy Griffiths' report "Community Care: Agenda for Action" was published on 16 March 1988. He had been asked in December 1986 by the then Secretary of State for Social Services, to undertake a review of the way in which public funds were used to support community care policies and to advise on how their use might be made more effective. In his last report, Sir Roy outlines a programme of action aimed at improving the management of community care services and resources. A key recommendation is that responsibility for assessing the need for community services and for meeting their costs should be brought together within one agency. In the case of the non-health elements of community care, Sir Roy recommended that this role should be given to the local social services authority.

B.2. The Government is now giving careful consideration to Sir Roy's recommendations and has indicated its intention to bring forward its own proposals in due course, in the light of further work now underway. They are unlikely to have major implications for the medical profession, but any implications will become clearer as the Government's thinking advances over the course of the coming year.

RESOURCE MANAGEMENT

B.3. A new resource management initative was launched in November 1986. The key objective is to improve patient care by ensuring that resources are used more efficiently, notably through the involvement of clinicians in the management process and the development of new information systems. Six acute sites are currently involved in piloting and work on establishing organsational structures and information systems is now well under way. Twelve sites have been nominated for community projects to take forward work already done at Worcester and Bromley. These will implement computerised data collection, and encourage the interest and involvement of gps. HM(86)34 gives further details (Annex B1). The acute projects are being subjected to an interim evaluation in October 1988. It is hoped the evaluation exercise will point the way to a phased extension of this initiative and plans are being formulated to this effect. In Wales, clinicians have been closely involved in the resource management project being piloted in West Glamorgan. Projects in Scotland are firmly linked with the development of wider management information systems, and work is proceeding at two pilot sites.

BETTER COMMUNICATION

B.4. The Review Body is aware that the NHS Management Board have endeavoured to develop better communications in the HCHS;

the key element of this initiative being to encourage better employee communications because, in such a labour intensive service as the NHS, staff are a crucial resource. A better informed workforce will improve morale within the health service, and encourage greater commitment in the interests of patients. An initial pilot project in South West Thames Region on management communication, including communication with staff, patients and local interests, was completed on 1 October 1987. The second stage of this work in Mersey, Northern and North Western Region is now well underway. As a third stage the NHS Management Board will extend work to additional regions. This is a matter currently under consideration.

MANAGEMENT COMMUNICATION AND CONSULTATION

B.5. The need to improve the means of communication between the Departments and the NHS has been addressed on two broad fronts:

a. the issue of formal management communications;

b. informal discussions and consultation.

Formal management communications

B.6. A more ordered and standardised system for the issue and circulation of letters to Health Authorities collectively was introduced in October 1987. The aims of these new arrangements are to ensure that:

a. the Department exercises greater self-discipline in assessing the need for each written communication;

b. communications adopt a clear, management orientated format;

c. communications are cancelled automatically once they have outlived their purpose and are subject to regular reviews.

B.7. The Department has also been looking at ways of speeding up communications with the service - a need identified at the time of the Chernobyl incident. An electronic mailing system has been introduced to enable the Department to send urgent messages almost instantly and simultaneously to all RHAs/DHAs and SHAs. The system also allows Health Authorities to send electronic messages to the Department and to other NHS users.

Consultation

B.8. The Department recognises that it is essential for all health authorities to be fully involved in debates on policy before final decisions have been reached. There is provision for full and timely discussion of issues at Secretary of State's meetings with RHA Chairmen or at NHS Management Board meetings with Regional General Managers or with the individual "lead" RGMs. The management bulletin is a further development

in consulting with the service to explain the thinking underlying policy decisions.

HEALTH SERVICES INFORMATION

B.9. The Review Body will be aware of the widespread changes in management information recommended by the Steering Group on Health Services Information (the Korner Group). The bulk of the recommendations, covering hospital activity, manpower, finance and patient transport, were implemented on 1 April 1987. Other recommendations, covering particularly community and paramedical services were implemented on 1 April 1988. These measures will give districts a much firmer basis for informed management. A number of changes to statistics will flow from the introduction of more sensitive measures; for example, information on the number of deaths and discharges will be replaced by information on the total period of care within a district (District spell) and the number of separate episodes of consultant care within a District spell (consultant episodes).

B.10. The information requirements not covered by Korner have also received consideration. These include dental services, on which a report by the Dental Services Statistics Group was published in 1987 (the Review Body has received a copy). Its recommendations for hospital services were implemented from 1 April 1988 and those relating to community services are currently scheduled for implementation by April 1990.
We remain committed to creating a managerial climate in which active use of information and information technology leads to improved patient services. The national strategic framework for information management launched in October 1986, and described in paragraph B.19 of our last submission, set a number of tasks towards this goal both for the centre and for authorities. The majority of tasks for the centre have been completed ; other work will be taken forward by authorities as information is more widely used to support better defined objectives.

PROFESSIONAL DEFENCE ORGANISATIONS

B.11. The Government accepted the recommendation in the Review Body's 18th Report (paragraph 35) and implemented it with effect from 1 January 1988. It also agrees with the Review Body that the changes made should be an interim measure. Present and projected costs to health authorities are substantial and deflect resources which could otherwise be devoted to further improvements in patient care. The Government is, therefore, undertaking a thorough examination of the system, the outcome of which will be discussed with the relevant parties. The Review Body will be kept fully informed of developments.

GENERAL MANAGEMENT

General managers' pay

B.12. As the Review Body will be aware, guidance on the appointment of medical and dental general managers is still of an interim nature. The Health Departments hope to be in a position to discuss permanent arrangements with the professions later in the year. The Health Departments' evidence to the 18th Review (paragraph B.7) remains current.

Senior managers' pay

B.13. The arrangements for paying senior managers were set out in paragraph B.8 of the Health Departments' evidence to the 18th Review. The Department is considering how best to extend the senior managers' pay and grading arrangements to senior managers in units and to posts in regions and districts not included in the first tranche. It is unlikely that these proposals will extend to clinicians who take on resource management functions while continuing to occupy a full-time clinical post. Any developments in this field over the coming weeks will be reported to the Review Body at the oral stage.

CLINICAL ACADEMIC STAFF SALARIES

B.14. It is the function of the Clinical Academic Staff Salaries Committee (CASSC) of the Committee of Vice-Chancellors and Principals to translate the Review Body's recommendations into comparable pay levels for clinical academic staff. The 1988 award was implemented without delay; on 22 April, the Secretary of State for Education and Science announced the increase of £3.1M in the Universities' cash limit for the financial year 1988-89.

Annex B1

HEALTH NOTICE

HN(86)34

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities)
District Health Authorities)
Special Health Authorities for the) for action
London Postgraduate Teaching Hospitals)

Family Practitioner Committees) for information
Community Health Councils)

November 1986

HEALTH SERVICES MANAGEMENT

RESOURCE MANAGEMENT (MANAGEMENT BUDGETING) IN HEALTH AUTHORITIES

The guidance in this Notice ceases to be valid in October 1990 unless notified separately.

SUMMARY

This Notice

a. assesses progress in developing management budgeting in health authorities since the issue of HN(85)3 (January 1985);

b. gives details of a new approach to management budgeting (resource management) to be piloted at selected hospitals as a joint venture between the NHS Management Board, the Joint Consultants Committee and local management;

c. for community health services, puts forward a strategy for extending to other districts the approach to management budgeting piloted at Bromley and Worcester;

d. sets out arrangements, reflecting these initiatives, for co-ordinating the further development of resource management within and between Regions.

BACKGROUND

1. The broad aims and principles of management budgeting in health authorities were defined in the Department's report, prepared on the advice of the Steering Committee on Management Budgets, which was circulated under cover of HN(85)3. The report gave an assessment of progress up to that date (January 1985) at the four "first generation" hospital sites, and suggested the lines of a strategy for further development in the light of their experience.

2. As an immediate sequel to HN(85)3, fourteen districts throughout the country were identified as "second generation" sites for management budgeting with RHA (and limited Departmental) support, and in parallel the Department funded the development of the first management budgets for DHA-managed community health services, at Bromley and Worcester. Subsequently, the Director of Financial Management, NHS Management Board, undertook a comprehensive review on behalf of the Board of progress in both the first and second generation sites and of regional plans for the wider development of management budgets. At an early stage in this review the Department arranged for short-term additional support, financed from central funds, to be provided for three of the four first generation districts to help in overcoming specific problems which were being encountered (at the fourth district, Ealing, it was agreed to suspend the development of management budgets after a series of difficulties with the computer system developed for the project). Following the review Ministers have approved plans put forward by the Management Board for a new phase of development of management budgets. The approach has also been agreed with Regional Health Authority Chairmen and the key points are set out below.

3. The basic principles stated in the earlier report still stand and are reflected in the new approach. In particular, the over-riding aim of introducing management budgeting is, as paragraph 2 of the earlier report stated, to enable the National Health Service "to give a better service to its patients, by helping clinicians and other managers to make better informed judgements about how the resources they control can be used to the maximum effect". But the experience of the first and second generation sites demonstrates very clearly the difficulty of creating the conditions in which these principles can be applied. It is this above all which the new approach seeks to overcome.

4. The earlier report concluded that while the work at the first generation sites had established a good technical foundation for management budgeting in health authorities, there was still some way to go before it became fully effective as a management system. While both the first and second generation sites have made significant further progress on both fronts, some fundamental problems (particularly affecting the management dimension) have still not been overcome. The main lessons of this experience can be summed up as follows:

a. while HN(85)3 underlined the importance of active medical and nursing involvement, it is questionable how far this can be achieved through a management budgeting system in isolation. Experience suggests that management arrangements which centrally involve doctors and nurses are a necessary precondition for effective management budgets;

b. if medical and nursing managers, and other professionals, are to welcome better financial information and use it positively, the information must be perceived by them as relevant to their work and must illuminate the key choices about how resources might best be deployed. Thus doctors and nurses must be centrally involved in specifying the information requirements of the new systems;

c. effective financial management support is vital (to both the management and technical dimensions) and the present pressures on health authorities mean that it will often be difficult to provide the level and quality of support needed;

d. to reflect all these factors, the pace at which management budgets are introduced will need to be carefully judged.

ELEMENTS OF THE NEW STRATEGY

5. To reflect the wider aims already mentioned, the term "resource management" is used in preference to "management budgeting" to describe the strategy as a whole. The three main elements of the strategy now agreed are, in summary:

a. The establishment of a new series of resource management experiments at 6 hospital sites. These sites have been deliberately selected as hospitals where doctors and nurses are already centrally involved in the management process. They will be geared to the introduction of patient case-mix planning and costing and will be supported from the outset by management development and training programmes. The new sites are being jointly sponsored and monitored by the NHS Management Board, the Joint Consultants Committee and local management. They will be fully evaluated, once the initial development and implementation period is over, before any final decisions are taken on national implementation;

b. Setting up a limited number of second generation resource management development sites for community health services to consolidate and extend the experience built up in this field at Bromley and Worcester;

c. Promoting a regular exchange of experience between development work at the new sites and all existing sites, so as to maximise the chances of achieving solutions which are workable and cost-effective, and which fully reflect both the new approach and the valuable experience of the last few years. A series of "user groups" - between them covering all regions in the country - is being created to assist this process.

6. The broad intention is to establish reference or pilot sites where information and planning processes have the committed support of the local doctors and nurses and then use them to convince other districts and units nationally of the benefit of adopting similar processes.

NEW MODEL ACUTE UNITS

7. Objectives for the approach to be piloted in the selected acute units have been drawn up in discussion with the representatives of hospital doctors on the Joint Consultants Committee, and the new approach has the JCC's full support. A copy of the agreed joint statement by the Management Board and the JCC is attached to this Notice as Appendix 1. The JCC have also agreed with the Management Board, and local and regional management, on the choice of six pilot sites. They are:

Freeman Hospital, Newcastle-upon-Tyne
Clatterbridge Hospital, Wirral
Arrowe Park Hospital, Wirral
Royal Hampshire County Hospital, Winchester
The Royal Infirmary, Huddersfield
Guy's Hospital, Lewisham and North Southwark (where the initial emphasis of the joint programme will be on supporting the new organisation structures which have been introduced at the hospital).

As well as satisfying the basic requirement that doctors and nurses should be fully involved in management, the six sites represent a balanced mix of teaching and non-teaching hospitals and a wide geographical spread. In addition they are at different stages in developing the information systems needed to support better resource management processes. As a group, therefore, they provide a cross-section with which most acute units in the country will be able to identify at some level. Four of the six (Freeman Hospital, Clatterbridge Hospital, Arrowe Park Hospital and the Huddersfield Royal Infirmary) are in designated second generation districts and will be building on the experience of that stage.

8. The initial cost of developing the new approach will be met mainly from central funds, with the balance being provided by the regions,districts and units concerned (costs and benefits are discussed in paragraphs 17-19). Outline project plans have now been agreed for three of the six units and work is in progress on completing these and developing project plans for the other three. The key aims in developing the approach relate to:

a. medical and nursing "ownership" of the system. This needs to cover both the management process and its supporting information systems;

b. patient case-mix planning and costing. There is wide agreement in the medical profession on the need to identify costs to defined groups of patients so that the actual and expected use of resources in their treatment can be compared. This is important both in monitoring clinical performance and in enabling informed choices to be made about the deployment of resources within specialties and for the unit as a whole;

c. accuracy of basic patient activity data. This must command medical confidence, and the existing information systems will need to have substantial work done on them if this is to be achieved.

The detailed work programme will reflect the varying needs of the individual units but will include strengthening the existing specialty costing and planning systems, experimenting with the use of diagnostic related groups (DRGs) and other approaches to case-mix planning, developing advanced nursing dependency and management systems, and linking the financial and activity systems together into a key-item planning and reporting system.

9. The overall aim (through the 6 individual project plans) is to have achieved sufficient progress by 1988 to make possible a provisional evaluation of likely, eventual, success. Assuming that the 6 initial sites are successful in demonstrating the value of the approach, the aim would be that implementation in other acute units should follow over the 4 years 1988-92.

COMMUNITY HEALTH SITES

10. Work on the pilot projects at Bromley and Worcester started on site in February 1985. Both have achieved encouraging progress. The picture is one of high commitment from community medical and nursing staff, the increasing involvement of GPs and, despite delays in making some of the sub-systems fully operational, the emergence of important benefits. In particular, the process of identifying activity down to the level of individual patient contacts is having direct operational value in planning the day-to-day work of services and the discipline of developing better information flows has led to agreeing much clearer divisions of responsibility and accountability between the consultants, the GPs and the field teams of district nurses, midwives, health visitors and paramedical staff.

11. A more detailed summary of the approaches adopted at Bromley and Worcester is attached to this Notice as Appendix 2. Given this encouraging start, the strategy for community health services is geared to extending the approach first to a limited number of second generation community sites, and then to the remaining community health services units. Selection of the second generation sites is currently being discussed with regional and district managements. The intention is to establish a close link between each of the second generation sites and either Bromley or Worcester, so that the development officers appointed at the new sites can inform themselves fully about the working of the approach and then lead implementation in their own districts. The approach will then be extended in the same way from the second generation sites to the remainder. The broad timetable suggested is:

a. Bromley & Worcester — full implementation during remainder of 1986/early 1987

b. 2nd generation community units

- o system design — during 1987
- o system implementation — 1988

c. remaining community units

- o systems design and implementation — 1987/1991

CONTINUITY AND CO-ORDINATION

12. The introduction of the new approach to resource management in acute units is not intended to put a stop to worthwhile development at existing first and second generation acute sites. But in some districts where fundamental difficulties have been encountered, or medical or nursing staff have been seriously antagonised, there may be a case for suspending management budgeting development for the time being. The Management Board's Financial Management Directorate will be discussing with regions the approach to be adopted for individual sites.

13. One of the main roles of RHAs at this stage should be to encourage a much greater exchange of experience within and between regions. To support the exchange of experience between new and existing sites the Management Board is leading the formation of four user groups covering, respectively:

- Northern, Yorkshire and Trent
- Mersey, North Western and West Midlands
- The four Thames regions
- East Anglian, Oxford, Wessex and South Western

Each of these user groups will be made the responsibility of, and led by, one or more of the six new pilot units, and will also include a second generation community unit.

14. RHAs also have a significant role to play in:

a. promoting a regionally co-ordinated approach to the development of all the basic supporting activity and finance systems;

b. developing regional training programmes designed both to prepare districts for resource management and to support existing sites;

c. forming a nucleus of experienced staff who can then take the lead in extending successfully established community and acute systems throughout the region.

15. Existing regional strategies which were framed on the basis of HN(85)3 will need to be reviewed in the light of the developments recorded above. In particular it is important that timetables for regional implementation do not prejudice the eventual introduction of systems based on the new approach for acute hospitals. As stated in paragraph 9, the programme for the new model acute sites will be geared to enabling implementation in other acute units to start from 1988, but both this and the subsequent pace of development will clearly depend on the results actually achieved at the pilot sites.

16. It should be noted, finally, that the Joint Consultants Committee is giving its support at this stage only to the piloting of the new approach for acute hospital services at the six selected sites. Both RHAs and DHAs have an important part to play in involving the profession's local representatives in their plans and ensuring that they have the fullest possible support from doctors, nurses and paramedical staff.

COSTS AND BENEFITS

17. For the new model acute sites, the best estimate that can be made at present is that the initial development will cost between £400,000 and £600,000 for each one. About 70 per cent of these costs are being met from central funds, and the balance by the RHAs and DHAs concerned. Part of the initial cost will reflect the development of the basic approach and it should cost less to introduce it in other units. Establishing realistic costings will be one of the key aims of the pilot work and its evaluation.

18. An overall target for the new model units will be to release at least 1 per cent of annual expenditure for redeployment on patient services through the operation of the new resource management approach. Achievement of this target will be a key criterion for judging whether and when the approach should be extended more widely.

19. For community health services, the Department proposes to contribute from central funds to the initial cost of employing development officers in the new districts as described in paragraph 11 above. The cost of this support is estimated at some £1 1/2 million over the period. RHAs may need to provide further support for districts which have difficulty in meeting other development costs in the short term. The broad target of a 1 per cent improvement in the use of resources will apply equally in this field.

ACTION

20. Regional health authorities are asked to ensure that all authorities review their existing plans for introducing better financial planning and control systems at unit level, and ensure that they are compatible with the overall strategy described in this Notice. RHAs are particularly asked to see that regional strategies reflect the objectives set out in paragraphs 12-16.

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JOINT STATEMENT BY THE JCC AND NHS MANAGEMENT BOARD ON MANAGEMENT BUDGETING IN ACUTE UNITS

BACKGROUND

1. Since October 1983 the NHS has been attempting to design and implement management budgeting as recommended by the NHS Management Inquiry team (the Griffiths report) and endorsed by the Secretary of State. As part of the Government's initiative to encourage this development, four acute hospital and two community demonstration sites were set up and these were later supplemented by fourteen second generation acute hospital sites. In addition, some districts have developed schemes on their own initiative.

2. The first review of management budgeting undertaken on behalf of the Steering Group in January 1985 (HN(85)3) set out the following important principles:

a. management budgeting should not be seen as an accounting exercise, or as a device for containing costs. The key purpose is to improve services through more effective management at local level;

b. clinicians, nurse managers and other budget holders need to be actively involved, and to gain an understanding of their own management role, if the system is to succeed;

c. budget setting and review involve judgements about priorities which need to be integrated with the district priorities through the planning system;

d. although the principles are straightforward, preparing and maintaining budgets involves manipulating a great deal of detailed information. It is essential that the systems established for this purpose are equal to the task, and that the data generated is reliable.

3. It went on (in paragraph 32) to state that, before deciding to move to full management budgets, DHAs need to ensure that two conditions are met. The first is the commitment and enthusiasm of clinicians and other budget holders, and of local management generally. The second is the adequacy of the information systems, and their ability to deliver information accurately and on time.

EXPERIENCE TO DATE

4. Since October 1983 worthwhile gains have been achieved in developing software systems for attributing costs to "end users" and collecting historical costs as a basis for forward budgeting. However, only in the case of the two community sites has the broader management budgeting story been an entirely happy one. In the case of the four acute sites, the specialty and consultant costing and budgeting developments to date have:

a. coincided with a period of considerable organisational uncertainty which has inhibited their full integration with the management process;

b. so far, not generally been seen as making any worthwhile contribution to the planning and costing of patient care.

The net result is that (despite the Department's declared position recorded at 2a above) many doctors, both at the demonstration sites and elsewhere, have still to be convinced that management budgeting is more than an accounting exercise which simply increases overheads for no commensurate benefit.

DESIRABLE ENVIRONMENT

5. In recognising the need for a fresh start to be made to experimentation regarding the development of management budgeting, we would like to emphasise four environmental characteristics which everybody in the HCHS should be seeking to achieve at every level and every location in the ultimate interests of better patient care. These characteristics are:

a. Firstly, general managers who set as their most important and declared objective, building on the dedication and level of commitment felt for the NHS by doctors and nurses;

b. Secondly, organisation structures which, under the leadership of general managers, consist of management teams in which there is significant medical and nursing involvement and which have appropriate professional advice available to them;

c. Thirdly, regardless of what individuals may or may not think is the right level of funding for the NHS (a vitally important but political issue): a clear recognition of the need for professional leadership, the opportunities for making more effective use of limited resources and the scope for eliminating avoidable waste all in the interests of better patient care;

AND

d. Fourthly, general and medical managers who are supported rather than led by financial and personnel management of the highest quality.

6. We believe that a significant involvement on the part of doctors in the management process is a sine qua non of an effective and responsible health service. Put another way, we consider it crucial that doctors feel properly and fully involved in the decision-making processes which determine how the service is run and thereby have a genuine feeling of ownership regarding those processes and the information tools (of which management budgeting forms a potentially important part) necessary to support it. We put this view with some emphasis because, despite the volume of words spoken and literature generated over the last few years, its importance is by no means a totally absorbed or accepted part of the current NHS culture.

NEW APPROACH

7. Given a greater sense of medical ownership, the potential benefits of management systems which genuinely inform and have the ability favourably to influence clinical as well as non-clinical behaviour must be very substantial indeed. Thus, with the help of doctors, nurses and non-medical staff throughout the service, we are determined to establish once and for all, as objectively as possible, the practicality or otherwise of developing cost-effective information services for clinicians in our acute units. Like the previous approach we plan to do this through a number of pilot sites; unlike that approach the new sites:

a. will be co-sponsored by local management, the Management Board and the JCC;

b. will be limited to acute units at which local doctors and nurses play a major senior management role;

c. will include two units where the effort will be directed, from the outset, to the development and implementation of patient costing;

d. will be monitored jointly by local management, the Management Board and the JCC;

AND once the initial development and implementation period is complete:

e. will be objectively evaluated before any final decisions are taken about what is right or appropriate for the NHS as a whole.

8. The six sites to be co-sponsored by local management, the Management Board and the JCC will be:

a. The Freeman Hospital, Newcastle-upon-Tyne;

b. The Royal Hampshire County Hospital, Winchester;

c. Arrowe Park Hospital, Wirral;

d. Clatterbridge Hospital, Wirral;

e. The Royal Infirmary, Huddersfield;

AND

f. Guy's Hospital, London

9. The local managers, clinicians and nurses at these sites have agreed to their units being used to establish the practicality or otherwise of developing better cost-effective information systems and all six units have the active support of their respective districts and regions. (The agreed objectives for the pilot sites, and criteria for evaluating them, are set out in the annex to this statement.)

10. The JCC's support and commitment is limited to developments and experiments at the above six sites and does not include other existing first and second generation sites which the Management Board, acting independently of the JCC, will want to continue to encourage because the local management environment is right and further, fruitful, progress is possible. The Management Board will be making arrangements to ensure that the experience which continues to be built up at such "un-sponsored" sites and the experience about to be gained at the six co-sponsored sites is freely exchanged to the mutual benefit of all sites. It will also be making arrangements:

a. to persuade any existing sites where local antagonisms and anxieties make further useful progress unlikely to slow down or halt all developments;

AND

b. to encourage all other units and districts to take cognisance of the lessons of the past 2 1/2 years at the first generation sites and consult the Management Board before embarking on their own developments and experiments.

"MANAGEMENT BUDGETING"

11. This joint statement addresses itself to the question of "management budgeting" because that is the title coined by the Griffiths report and used to cover all developments since 1983 relating to better information for clinicians and nurses. Bearing in mind the rather narrow, financially exclusive, meaning associated with this term by large numbers of doctors, both the Management Board and the JCC consider it would be sensible in future to refer to the search for better information systems for clinicians and nurses as 'resource management'. In consequence, the title "Resource Management" will be applied to all six new projects and will be increasingly used by the Management Board when referring to all similar initiatives and developments taking place elsewhere.

OBJECTIVES FOR THE NEW MODEL "RESOURCE MANAGEMENT" EXPERIMENTS

PRINCIPAL OBJECTIVE

1. Introduction of a new approach to resource management and to demonstrating whether or not this results in measurable improvements in patient care.

SUBSIDIARY OBJECTIVE

2. Provision, for clinicians, of information which enables them to:

   a. identify areas of waste and inefficiency;

   b. benefit from clinical group discussion and review;

   c. highlight areas which could most benefit from more resources;

   d. identify and expose the health care consequences of given financial policies and constraints;

   e. understand the comparative costs of future health care options and hold informed debates about such options.

EVALUATION

3. The initial process of project set-up should include agreeing the above objectives with local management (and through them local clinicians), the Management Board and the JCC and the subsequent process of evaluation should involve identifying and publicising the investment and running costs of the new arrangements and obtaining the (subjective) views of local doctors, nurses and other managers as to whether the objectives have or have not been achieved.

4. At the end of the day local management, doctors and nurses need to be able to answer confidently, in the affirmative, the following questions:

   a. has the management scheme involved fully the clinicians?

   b. has this enabled the clinicians to have a positive influence on the management of resources of the unit?

   c. have the information systems provided data relevant to patient care and has the information been of value to clinicians in providing that care?

   d. what have been the direct and indirect costs of implementing the scheme and have these costs been justified by the resulting benefits of the scheme?

   e. has the time-input required by clinicians to implement the scheme been considered by the clinicians themselves to be beneficial to patient care?

MANAGEMENT BUDGETING DEVELOPMENTS IN THE COMMUNITY UNITS AT WORCESTER AND BROMLEY

1. Work on the pilot management budgeting projects for community health services at Bromley and Worcester started on site in February 1985. An important factor in both projects has been the fact that the organisation and role of community health services are much less well documented than for hospital services. This meant that the management consultants engaged for the two projects had to spend a good deal of time in the initial stages on mapping the structure and sources of patient referral. The following is a brief summary of the stage now reached at each project.

WORCESTER

2. At Worcester the budget reporting structure is now established and corresponds to the management structure agreed for the unit. Budgets are held by:

- 7 sector nursing officers, covering 3 geographical sectors for district nursing, the same 3 sectors for health visiting and one specialising in mental handicap, covering the whole district;
- the community paediatrician, covering medical staff working in child health;
- the doctor managing family planning services;
- the heads of individual paramedical professions.

All budget holders report direct to the Unit General Manager. Sector administrative officers have been appointed to provide administrative support for each of the geographical sectors.

3. After considering the alternatives of using the FIP or MIPP community systems, the district decided in favour of developing an ad hoc information system though the option of changing to FIP or MIPP has not been ruled out for the longer term. The system has been written by a software house to the District's specification. It operates at present on two linked IBM PCs, but is to be transferred to a multi-user system and is easily transferable to a wide range of other hardware. The information collected has been agreed with line management to reflect operational needs. It fully meets the requirements of the Fifth Korner Report. The standard records completed by staff categorise the different activities undertaken and the age group of the patient. Activity reports show both the split between age groups and the category of staff doing the work, to enable "task mix analysis" to be undertaken. Following initial fieldwork standard times have been assigned to activities. This has allowed the time spent on each activity to be established and enabled managers to measure staff performance.

4. The Arthur Young Management Budgeting System is used to prepare budgets and budget reports, bringing data from the activity system together with finance and manpower data from the Standard Accounting System.

5. For 1986-87, workload related budgets were set on the basis of activity data for the six months to 31 March 1986, together with service changes projected for the year. Seminars have been held with all staff to discuss the use of the information and budget holders are now receiving monthly activity and budget reports.

BROMLEY

6. The basic unit for budget reports is the individual profession in each of the three geographical sectors. Management structures for the community unit have yet to be fully agreed, but the budget reporting structure is being introduced on the basis of geographical sectors with two additional divisions covering headquarters and district-wide services which are not devolved to sectors. In addition, functional managers will continue to receive reports for each function. Individual members of the Unit Management Board will act as "sector co-ordinators" alongside their existing functional responsibilities.

7. The FIP community system is being used for activity information. The system was originally piloted in one of the geographical sectors and has now been extended throughout the unit. Data is input at 16 remote terminals. District nurses now input their own data direct. Other staff groups have the option of direct data input and about half of them do this with data for the rest being input by clerical staff.

8. The system creates a file for each patient seen by the community services, functioning in effect as a community patient administration system. Both individual patient contacts and the time spent on non-patient related activity are recorded. Weightings have been assigned to different face-to-face contacts and the weighted face-to-face contact serves as the basic unit of activity for budgets. Contacts are recorded both on the individual patient file and that of the individual staff member. As well as giving an age group classification, and other data required by the Fifth Korner Report, the system summarises activity by client group and by sector. For individual contacts, the location and the content of the contact are recorded.

9. The budget preparation and reporting system has been developed by local Bromley staff, using a proprietary financial modelling package running on General Automation Zebra equipment. This brings together the monthly financial reports and the summarised activity information from FIP.

10. The process of producing 1986-87 shadow budgets is under way at the time of writing. It involves translating the functional budgets which have already been set into the new format. Activity recording for all sectors and functions is now fully operational and the initial budgets are being based on extrapolation from the available data. For 1987-88, the intention is that the new system will be used to set budgets from the outset.

CONCLUSION

11. In both districts, considerable time and effort have been required to establish the system and to develop the first management budgets for 1986-87. This largely reflects the substantial work which the information systems have required, but also the process of defining management structures for the units. A shorter timescale should be achievable in other districts which can profit from the work done in Bromley and Worcester. But experience at both shows that staff training is a crucial factor and the time required for it should not be underestimated.

12. The information systems are the main point of difference between the two approaches. The FIP system in use at Bromley has the advantage of greater capacity and more flexibility in recording and presenting information to reflect management needs. It is also more expensive in computer hardware and has taken longer to implement with the result that Bromley has taken longer than Worcester to develop the initial 1986-87 budgets.

13. Despite these delays in making budgets fully operational there is already evidence of important benefits in both districts. In particular, the process of identifying activity down to the level of individual patient contacts is seen as having a direct operational value in planning the day-to-day work of service. The emphasis on building up the overall profile of the units from this basic level is probably the main strength of the approach in the community projects. Management and staff commitment is generally high and much greater benefits are anticipated when it becomes possible to use budgets in planning the overall deployment of the units' resources and in gearing effort to high priority areas.

SECTION C: HOSPITAL DOCTORS AND DENTISTS

MANPOWER

C.1. The increase in medical consultants in England and Wales during the year to 30 September 1987 was 216 or 1.5% compared with 2.4% the previous year. The growth in consultant numbers is a little below recent trends although we do not consider too much should be read into a single year's figures. Despite this drop the average annual increase over the last five years remains at about 2.2%. Juniors numbers increased in the registrar grades but fell in all other grades. As a result the consultant: junior ratio continues to improve. (See Tables C 1-2).

HOSPITAL MEDICAL STAFFING STRUCTURE - "ACHIEVING A BALANCE: PLAN FOR ACTION"

C.2. Last year we reported the introduction of this initiative to resolve some of the problems in the hospital medical staffing structure. Implementation of the "Plan for Action" is now under way and arrangements are in hand to monitor the various measures as they are introduced. During this, the first year of implementation, monitoring is concentrated on ensuring that machinery is in place to cope with the new arrangements as they are introduced although more detailed information about consultant expansion has also been requested from health authorities. Details of the implementation of some of the main measures are given below.

Consultant expansion

C.2.1. In the "Plan for Action" authorities are asked to maintain their planned rate of consultant expansion of some 2% p.a. The census data mentioned in C1 show that this level has not been reached for the 1986/87 census year. This is disappointing as it is below recent trends but we do not consider that too much should be read into a single year's figures particularly as the package of measures was only announced last year and extends over a ten year period. We are monitoring consultant expansion closely and have asked Regions for an interim progress report covering the financial year 1987/88. Consultant expansion should also result in future from the conversion of surplus training posts into consultant posts. This has not so far occurred but machinery for reviewing posts on consultant retirement is being established.

Pump-Priming Scheme

C.2.2. Allocations have now been made for both tranches of these 100 centrally funded consultant posts. Progress in filling them is being monitored closely and appears to be on schedule.

Early Retirement Scheme

C.2.3. This has now been introduced. Over 100 bids were received and 86 have been given manpower approval. Regions will report how many have been taken up in October.

Registrar Posts

C.2.4. Indicative quotas have been issued and the JPAC began its review of individual specialties in September and quotas for reductions of posts will be issued to Regions

Staff Grade

C.2.5. The basis of allocation of staff grade posts has been decided. Health authorities will be informed once the negotiations on terms and conditions of the grade are concluded. (Paragraphs 11-13 discuss in more detail the problems associated with the introduction of the staff grade).

"Safety-Net" to provide 24 hours emergency cover in acute specialties

C.2.6. Guidance has been issued to health authorities about the procedure for carrying out this review which is due to be completed by 30 September 1989. This review is being linked with a review of junior doctors hours aimed at eliminating onerous rotas. (See paragraphs C.8 - C.10 for further details).

SHO Recruitment

C.2.7. First indications from the responses to the Department's request (referred to in A21) are that SHO vacancies are concentrated geographically and in just a few specialties. The non-Teaching Districts in the North Western Region have a particularly high number of SHO posts in relation to population. The vacant posts are most numerous in Traumatic and Orthopaedic Surgery, Anaesthetics, Accident and Emergency and ENT Surgery; these four specialties account for over half of the vacant SHO posts recorded.

The Plan for Action : Scotland

C.3. Although the "Plan for Action" principles applied also in Scotland, the detailed proposals needed to be "translated" in terms of Scottish hospital staffing. Accordingly, a Scottish Working Group under the Chairmanship of the Deputy Chief Medical Officer at the Scottish Home and Health Department (SHHD) with members drawn from that Department, the medical profession, Health Boards, universities and the Scottish Council for Post-Graduate Medical Education has agreed a package of measures designed to make the "Plan for Action" work in Scotland.

C.4. In para C8 of our submission last year, we drew The Review Body's attention to the report, "Staffing the Service - The Next Decade" by a Steering Group under the chairmanship of

Dr Gavin Shaw presented to the Department on 14 December 1987, and copied to the Review Body.

C.5. The Department consulted Health Boards, Universities, the Scottish Council for Postgraduate Medical Education, the Scottish Joint Consultants Committee (SJCC) and the medical profession on the recommendations of the Shaw report. Responses were mixed. There was a general welcome for the report's efforts to improve hospital medical staffing structures but concern about the effect the reduction in registrars would have on the quality of service to patients (despite increases in consultant numbers and the introduction of a new staff grade) and teaching and research in medical schools; the cost and disruption of expensive programmes of rotation for registrars; and that the health service would be dependent on visiting registrars whose quality and numbers could not be ensured. There was also criticism of the report's recommendations for individual specialties and the working group's methodology.

C.6. SHHD discussed the Shaw Report with the representatives of SJCC who too had received the same level of mixed reaction to the report. They accepted that the report could not be implemented in its entirety and that it had to be considered in the context of Scottish implementation of the "Plan for Action" Report since the two were inexorably linked.

C.7. SHHD is very pleased with progress in implementing the Plan for Action in Scotland and welcomes the co-operation from the profession. The last meeting of the working Group was held on 15 July and the Scottish Home and Health Department is now finalising a draft circular on hospital medical manpower planning which will set out, inter-alia, the Government's response to the Shaw proposals and introduce a re-structuring of the hospital medical staffing based on service and training needs. Key features of the new staffing regime will be a more consultant-based service, improved post-graduate medical training, quicker progress of doctors in training towards consultant status and movement of less able but still competent junior doctors into the staff grade.

JUNIOR HOSPITAL MEDICAL AND DENTAL STAFF : HOURS OF WORK AND "ACHIEVING A BALANCE"SAFETY NET REVIEW

C.8. The Health Departments' evidence to the 18th Review (paragraph C.31) reported on discussions about the scope for further progress towards minimising excessive rota commitments for junior hospital doctors.

C.9. Following discussions with NHS management and representatives of the profession, agreement was reached on the terms of an Executive Letter to health authorities asking them to re-convene District Working Parties to:

C.9.1. achieve further reductions in the rota commitments of junior doctors and dentists; and to

C.9.2. provide a district input into the review of "safety net" levels of staffing required in "Achieving a Balance - Plan for Action".

C.10. A copy of the Executive Letter is at Annex C1. The Review Body will note from the Annex to the letter the timetable for action and, whilst it is too early to give the Review Body any substantial progress report in this evidence, the Health Departments will keep the Review Body informed of developments on this important initiative.

Introduction of the Staff Grade Doctor

C.11. The Review Body will recall the joint evidence on pay levels for the staff grade doctor submitted by the Health Departments and the profession in October 1987. The Review Body subsequently produced a supplement to the 17th Report (Cmd 309) recommending pay scales which the Government accepted.

C.12. In subsequent discussions with the profession about detailed arrangements for introducing the staff grade, an unexpected snag emerged. The Review Body will recall that the pay scales they recommended were based on a basic working week of 40 hours (ten sessions) but with the expectation that many staff grade doctors would be required to work up to thirteen sessions. The profession have represented that all sessions worked above ten should be superannuable; and it is this issue which has led to a delay in reaching final agreement.

C.13. The Health Departments understand that the professions may invite the Review Body to consider this issue and press for higher sessional rates of pay to compensate the doctors concerned for the fact that superannuation benefits cannot accrue from the eleventh to thirteenth sessions. If that is the case, the Health Departments would urge the Review Body not to accede to the profession's request. There have been lengthy discussions between the parties aimed at resolving this problem; but no solution acceptable to both parties has emerged. The Health Departments accept that sessions worked beyond ten are not "overtime" in the accepted sense; but to regard those sessions as being superannuable would run counter to existing Superannuation Regulations; and to give a higher rate of pay for those sessions by way of compensation would almost certainly have serious knock-on effects for other NHS (and other public sector staff).

Locum Staff

C.14. The number of hospital medical locum staff in each grade in the years 1982-87 are given in Table C3. The number of locums occupying vacant SHO posts (or temporary posts) fell from 157 in 1986 to 146 in 1987. The figures represent a small proportion of the total of some 10,000 SHOs in England and Wales, and the slight drop from 1986 to 1987 of course occurred before the implementation of the Review Body's 1988 Award. For

these reasons one year's figures should be treated with caution. For 1987 the Health Departments have for the first time a breakdown of the hospital medical locum staff between those on NHS terms and those employed through agencies. This should facilitate the provision of better information for future years.

C.15. Paragraph 46 of the Review Body's 18th Report discussed the shortage of internal locum cover and "an apparent extensive use of agency locums". As a proportion of total spending on medical and dental staff, spending on agencies trebled between 1984/85 and 1986/87 from 0.8% to 2.29% i.e £26.3 million in England. All the indications are that this trend is continuing and the Government is presently considering what action, if any, should be taken to control this expenditure. The Review Body will be kept informed of developments.

Associate Specialists

C.16. The survey by the OME of the pattern of work and responsibilities of the Associate Specialist (AS) grade has now been completed although the Departments have asked the OME to carry out some further analysis of the results. The parties have agreed to re-open discussions on the terms of service for the grade. A preliminary meeting between the parties has been held and further meetings are planned.

"DOCTORS AND THEIR CAREERS" RESEARCH BY ISOBEL ALLEN

C.17. This research report was published in June 1988: copies were sent to the Review Body. The research, which was initiated and funded by the Department, set out to compare the career progress of male and female doctors and to study the factors which could help or hinder doctors in their efforts to climb the career ladder. The study consists of an analysis of some 600 structured interviews, 100 each of male and female doctors who graduated in each of the years 1966, 1976 and 1981. Fieldwork was carried out in 1986. The study therefore gives a snap-shot of doctors respectively 5, 10 and 20 years into their careers. It highlights not only the problems found by women in reaching the top of the career structure in medicine but also areas of difficulty experienced by men eg the need for geographical mobility, long hours and rigidity of career structures in hospital medicine.

C.18. Following publication of the report the Department together with the Policy Studies Institute has arranged two joint seminars to examine the implications of the research findings. The first, held in July, was mainly for representatives of the Royal Colleges and Faculties, the BMA and its craft committees, the JCC and Health Authorities. The second November will look particularly at careers advice and guidance.

C.19. The Joint Consultants' Committee has considered a report of the research and as a result a working group with members

from the JCC, NHS and the Department is being set up to consider the implications of the findings.

C.20. The main areas identified for follow-up work are given below. Work has already begun in some cases.

Part-time training and greater opportunities for part-time career posts

C.21.1. The system for part-time training of senior registrars has already been reviewed by the Department, the JCC and the NHS. A similar review of part-time training at registrar level has started.

C.21.2. The Department is looking at the Doctors' Retainer Scheme which aims to help doctors with domestic commitments to keep in touch with medicine and proposes that opportunities for retraining after a career break should be considered at the same time. It also recognises the demand for part-time career posts and proposes to enter into discussions with representatives of the medical profession and the NHS about the possibility of increasing these.

The Career Structure

C.21.3. Some of the uncertainty about the career structure expressed by doctors in the survey may be due to the career blockages which are already being tackled through the "Achieving a Balance" package. The general question of rigidity of training requirements, which affects men as well as women, will be brought to the attention of the Royal Colleges and Faculties.

C.21.4. The stresses due to the need for junior doctors to be mobile geographically and to work long hours are already recognised. The review of junior doctors' hours which has recently begun may help improve at least the second of these.

Career guidance and advice

C.21.5. There is a need to consider the improvement of careers guidance and advice at all stages - from careers advice at school through to postgraduate training. One of the seminars will look specifically at this issue. Proposals for improvements in careers advice and counselling are outlined in Achieving a Balance and the Technical Sub-Group is monitoring work currently being undertaken in these areas.

Appointments

C.21.6. The Department intends to discuss with those involved ways of eliminating discriminatory questioning by Appointments Committees and whether women candidates need guidance on how to deal with such questions. Some preliminary work has started on the possibility of issuing some more detailed guidance to appointments committees on the whole area of equal opportunities.

C.21.7. The Department also intends to consult the Royal Colleges and Faculties about the perceived importance of patronage for career advancement.

MANPOWER POLICIES

Manpower Planning Advisory Group MPAG) Working Group on Medical Manpower

C.22. The DHSS/NHS Manpower Planning Advisory Group (MPAG) has set up a working group to consider how health authorities assess their medical staffing needs and to advise on how their planning might be improved. The Working Group has reviewed how health authorities carry out their medical manpower planning and have visited health authorities. The Group is concerned that medical manpower planning should be better integrated with authorities' strategic planning. A suggested framework for strategic planning has been drawn up and is being piloted with Districts. For short-term programmes the group has proposed a checklist of questions which a District could use in assessing the medical manpower part of the programme; this is to be issued in the Department's guidance to health authorities. The Working Group plans to report to MPAG in October.

Second Advisory Committee for Medical Manpower Planning (ACCMP II)

C.23. The Health Departments written evidence to the 18th Review (Annex B5) summarised the Departments' objectives in carrying out medical manpower planning, and reported on the work of the Second Advisory Committee for Medical Manpower Planning (ACMMP II).

C.24. ACMMP II has now agreed its report. The Committee adopted the broad method of previous reviews of medical manpower needs, projecting separately the demand for and the supply of medical manpower. On its main projection a small shortfall of doctors was forecast (in contrast to ACMMP I, which projected a small surplus). The projected shortfall was of some 1,600 doctors - about 1.5% of medical manpower in the year 2005. This result was naturally sensitive to the assumptions made; for instance, if the number of GMPs were to grow at 0.5% rather than 1% per year of the period, there would be a slight surplus. If growth in the demand for doctors in

the hospital service were only 0.5% per year rather than 1.0% the surplus would be approximately 3,000 doctors. In view of the margin of uncertainty they recommended that no measures be taken to alter the supply of medical manpower, but that the future balance should be kept under review.

Clinicians in general management

C.25. The interim arrangements for clinicians appointed as general managers (GMs) are set out in HC(85)9, at Annex C of our submission for the 16th Review, and continue to operate. Further guidance will be issued on all GMs appointed on a part-time basis. The maximum combined fee payable to unit GMs serving as unit medical representatives (umrs) under paragraph 16 of that circular was increased on 1 April 1988 from £4,255 to £4,378.

Category 2 arrangements

C.26. In the Departments' evidence last year (Para C.25) we said that a report on the Departmental scrutiny of Category 2 arrangements had been issued for consultation to the NHS, the professions and other interested organisations. The consultation period has ended, and we are now considering the results.

Disciplinary procedures and Professional Review Machinery

C.27. The Working Party which was established by the then Secretary of State in March 1987 to review hospital and community doctors' and dentists' disciplinary procedures has now completed its work and has submitted a report to Ministers. The proposals which the profession submitted for "Professional Review Machinery" (described at C28 of our submission last year) have been linked with the package of measures which the Working Party has recommended to Ministers. Once Ministers have considered the recommendations and decided whether they should be implemented, they will be subject to negotiation between the parties in the normal way.

Distinction awards

C.28. In its eighteenth Report, Last year the Review Body made a number of recommendations for changes to the distinction awards system and urged the parties to consider "whether the scheme can be improved in these or other ways" (Paragraph 55). The Government welcomes the Review Body's initiative and believes that reform of the system is long overdue. The professions have indicated their willingness to discuss the Review Body's recommendations and the Departments expect to be in a position very soon to open the discussions.

Table C1

TABLE (1) : Consultant expansion by specialty group

Specialty/ specialty group	Consultant expansion (% pa) 1981-86	1986-87
General medicine and related specialties (incl. Geriatric Med) (2)	2.2	1.0
Paediatrics (incl. Paed. Neurology)	4.2	4.7
Other internal medicine (3)	6.7	28.8
General surgery	0.1	0.2
Traumatic and orthopaedic surgery	1.5	0.4
Otolaryngology	0.1	1.1
Ophthalmology	1.5	1.1
Other surgery	2.7	0.7
Accident and emergency	6.2	9.2
Obstetrics and gynaecology	2.0	0.6
Anaesthetics	3.4	2.7
Radiology Group	3.8	3.0
Radiotherapy	1.5	1.9
Pathology Group	1.6	-0.4
Mental illness	1.9	3.6
Other psychiatry	4.8	-3.6
All medical specialties	2.3	1.5

(1) Prior to 1987 figures for Consultants have included Senior Hospital Medical Officers with allowance

(2) Including all General Medical Specialties except Other, Paediatrics and Paediatric Neurology Specialties

(3) General Hospital duties to which no Specialty is appropriate

Table C2

JUNIOR MEDICAL STAFF CHANGES (1) BY SPECIALTY GROUP

AT 30 SEPTEMBER EACH YEAR

ENGLAND AND WALES

Specialty Group	Change in Junior doctors numbers 1981 - 86	(% pa) 1986 - 87
All Specialties	0.9	-1.2
General Medicine and related specialties	1.3	2.8
Accident and Emergency	2.0	0.2
Surgical specialties	-0.1	-2.4
Obstetrics and Gynaecology	0.7	-1.4
Anaesthetics	0.3	-4.1
Radiology and related specialties	2.3	-5.3
Radiotherapy	2.2	-2.6
Pathology specialties	1.7	-7.4
Psychiatry specialties	1.2	-3.1

(1) Includes Senior Registrars, Registrars and Senior House Officers.

Table 3C

HOSPITAL MEDICAL LOCUM STAFF: ANALYSIS BY GRADE AND TYPE OF APPOINTMENT
AT 30 SEPTEMBER EACH YEAR

ENGLAND AND WALES

GRADE		Locum occupying Post without Permanent Holder or Temporary Post						Locum occupying Post in Temporary Absence of Holder					
		1982	1983	1984	1985	1986	1987	1982	1983	1984	1985	1986	1987
Consultant													
	No	340	357	275	276	214	339	226	213	147	250	257	342
	WTE	229.5	245.1	194.9	195.6	151.7	227.9	136.5	164.2	115.5	183.6	182.8	223.4
Associate Specialist													
	No	46	39	23	23	28	39	6	12	21	34	28	25
	WTE	41.6	33.5	20.1	18.8	25.0	29.7	5.1	10.4	19.7	20.7	16.6	19.3
Senior Registrar													
	No	45	51	68	61	41	98	42	69	68	98	98	97
	WTE	42.2	50.2	66.5	60.0	40.9	95.4	40.5	67.6	67.8	97.2	95.5	93.9
Registrar													
	No	197	187	176	190	187	156	202	218	203	196	161	139
	WTE	196.6	187.0	175.2	188.0	186.5	151.9	201.6	215.6	202.2	194.8	158.5	130.3
Senior House Officer													
	No	131	153	141	163	157	99	443	417	382	326	278	200
	WTE	129.8	153.0	140.9	163.0	157.0	98.1	440.0	413.4	380.5	322.1	273.8	182.9
House Officer													
	No	2	6	4	6	11	8	11	15	11	12	9	4
	WTE	2.0	6.0	4.0	6.0	11.0	8.0	11.0	14.6	11.0	11.2	7.6	4.0
Other (includes SHMOs with & without allowance)													
	No	2	1	2	1	-	1	1	-	-	13	5	1
	WTE	0.7	0.1	0.6	1.0	-	1	0.1	-	-	2.4	2.1	0.2
Hospital Practitioner													
	No	1	-	1	1	-	-	1	1	1	-	1	-
	WTE	0.2	-	0.1	0.3	-	-	0.1	0.5	0.1	-	0.2	-
Paragraph 94													
	No	119	101	152	122	93	193	40	37	66	128	115	184
	WTE	28.6	32.2	43.8	37.7	31.1	51.7	12.6	15.0	24.2	33.6	28.1	51.3

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Our ref MDC/1/17

To: General Manager of:
Regional health authorities) for action
District health authorities)
Special health authorities)
Regional Medical officers) for information
Regional Specialists in Community medicine (Medical Staffing))
Chairman of Regional Medical Manpower Committees)

6 June 1988

Dear Manager

JUNIOR HOSPITAL MEDICAL AND DENTAL STAFF:
HOURS OF WORK AND "ACHIEVING A BALANCE" SAFETY NET REVIEW

Summary

1. This letter asks health authorities to re-convene District Working Parties, under the direction of a Regional Steering Group, to:

1.1. achieve further reductions in the rota commitments of junior doctors and dentists; and to

1.2. provide a district input into the review of "safety net" levels of staffing required in "Achieving a Balance - Plan for Action".

Objectives

2. In November 1982, Ministers announced a programme of action for health authorities to work towards the elimination of regular rota commitments requiring junior staff to be on duty on average more than 1 night and 1 weekend in 3, where resources and the needs of patients permit. Detailed procedures were set out in PM (82) 37, AL (MD) 3/83 and PM (85) 1. The Department and the profession remain firmly committed to the objective of the programme, and in particular to the elimination of rotas more onerous than 1 in 3 for practitioners first on call in the hard-pressed specialties. Having reviewed the position with advice from a panel of senior NHS officers, they consider that further progress is most likely to be achieved by combining the examination of rota requirements with the "safety net" review. HC (87) 25 asked RHAs to begin a review in all districts in order to establish what support staff are needed to provide 24-hour cover in the acute specialties. The review is to be completed by 30 September 1989.

Model proposals

3. Model proposals for combining these tasks are set out in the Annex to this letter. Since many RHAs will already have set up machinery for the safety net review, any local variations which would achieve the fundamental objectives of this

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ANNEX

1. JUNIOR HOSPITAL MEDICAL AND DENTAL STAFF: HOURS OF WORK

2. "ACHIEVING A BALANCE - PLAN FOR ACTION" : SAFETY NET REVIEW

Model proposals

1. RHAs/Regional Manpower Committees (RMCs) to agree on the composition of a Regional Steering Group (RSG) - which could be the RMC itself or a smaller sub-group including representation of the Hospital Junior Staff Committee - which would oversee the development of a consistent regional approach to the determination of "safety net" levels and junior doctors' and dentists' hours of work. In particular, the RSG would, with the advice of the specialty sub-committees, issue guidance for each district or regional acute specialty on:

1.1. a uniform regional policy to reduce the hours of work of junior practitioners and to eliminate regular rotas more onerous than 1 in 3, particularly those in hard-pressed posts, as defined in paragraph 6 of PM (85) 1;

1.2. the staffing levels likely to be available in the region in the support grades (SHO, R, SR and SG) up to 1998;

1.3. factors likely to be taken into account in determining their allocation to district (split-site working, workload, teaching commitments);

1.4. acceptable cross-cover arrangements (on which further guidance is likely to be issued in the light of advice from the Conference of Royal Colleges);

1.5. statistical information which will be required from districts in support of their safety net proposals.

"Acute specialties" should include those listed in paragraph C.58 of the "Plan for Action", and any other specialties to which in the view of the RSG the principle of the safety net is relevant.

2. District Working Parties (DWPs) to be re-established, in consultation with representatives of the profession locally. Each DWP to consist of equal numbers of representatives of staff in the training and career grades, and one or two NHS management representatives, and to be kept small (perhaps no more than six or seven in all). DWPs to have a dual remit:'

2.1. to consider the scope for the further reductions in rotas. This might be carried out in two phases:

2.1.1. the first priority would be to look for rota reductions which could be achieved in the short term (ie., before the redeployment of staff under the safety net review - see below - comes into effect), in particular those which would benefit practitioners in hard-pressed posts, as defined in paragraph 6 of PM (85) 1. In any case in which the DWP agrees to recommend the continuation of a regular rota more onerous than 1 in 3, it should specifically justify this to the RSG, and should where appropriate produce proposals for change in the longer and shorter term;

Local variations

7. Since many RHAs will already have set up machinery for the safety net review by the time they receive this advice, any local variations on the machinery or the timetable which would achieve the fundamental objectives of this circular would be acceptable, provided that they have been agreed with the RMC. RHAs and SHAs should report back to the Department by 31 July 1988 on how they propose to take forward this exercise.

Timetable

8. The suggested timetable is:

1988	July	Establish DWPs and RSGs. DWPs start work on task 2.1.1.
	September	DWPs give interim report on immediately achievable rota reductions to district management, who will seek early implementation.
	October	RSGs issue guidance (task 1).
	December	DWPs submit initial proposals on rota reductions to RSGs (task 2.1.1).
1989	January	DWPs submit inital proposals on rota reductions to district management for implementation.
	March	DWPs submit proposals on staffing to RSGs (task 2.2).
	April/ June	RSGs and DWPs discuss/revise staffing proposals.
	July/ September	RSGs' proposals on staffing to RHAs for decision
	October	RHAs/SHAs report to Department.
	October/ onwards	DWPs consider any further rota reductions following from redeployment of staff.

SECTION D: GENERAL MEDICAL PRACTITIONERS

"PROMOTING BETTER HEALTH"

D1. The White Paper 'Promoting Better Health' proposes a number of changes to the contracts of General Medical Practitioners. Discussions on implementing these changes are being held with the General Medical Services Committee and, where appropriate, with FPC interests as well as the Medical Practices Committee over the proposed changes in the distribution of General Medical Practitioners. To inform its discussions with the GMSC the Health Departments have also sought advice from the Royal College of General Practitioners. These discussions will all take time and it is not likely that any changes arising from the White Paper will be agreed with the profession during the Review Body's current review.

MANPOWER AND RECRUITMENT

D2. Recruitment into general practice continues to be buoyant. The number of unrestricted principals grew by some 500, or 1.8% in the year to 1 October 1987. This continues to be slightly below the peak growth rate of the early 1980s, but in line with the average rate of growth over the past decade. As indicated in last year's evidence, the number of gp trainees increased by 3% in 1987. Even though overseas doctors will no longer be undertaking GP training and entering general practice, the number of GP trainees (2182) remains greater than the annual number of first admissions as an unrestricted principal. The available evidence, for instance on applicants for GP vacancies, does not suggest that growth is constrained by any shortage of supply.

D3. The increasing popularity of general practice as a career choice has been confirmed in the study "Doctors and their Careers" by Isobel Allen, referred to in paragraph C.17. The percentages of doctors who qualified in different years choosing general practice were as follows (at the time of registration):

	General Practice as Career Choice		
Year of qualification	1966	1976	1981
Percentage of doctor	22	30	41

10% of the 1981 qualifiers gave "no clear idea" of career choice at registration. In their subsequent careers to the time of being interviewed in the Spring of 1986, 25% of those who had given a hospital specialty as their first choice had switched to general practice, while only 11% (8% of the men and 14% of the women) had changed from general practice to a hospital specialty. The main reasons given for changing were

the need for work to fit in with family life, and increased interest in their present specialty/career.

WORKLOAD ENQUIRY

D4. In paragraph 84 of their 18th Report the Review Body urged the parties to put in hand preparations for a further joint survey of gmps' workload to be started in 1989. The profession and the Departments have now agreed to a further survey to commence in 1989 the results of which will be available to the Review Body in time for their 21st Report. It is proposed that the forthcoming survey should follow, broadly, the format of the 1985/86 survey, so that changes over time may be identified. Discussions between the parties on the arrangements for the survey will begin shortly. We hope it will be possible to provide the Review Body with a further report on progress prior to the publication of the 19th Report.

D5. The Health Departments would like to use the forthcoming survey to collect information about workload in those areas of activity on which the White Paper "Promoting Better Health" is likely to have an impact. We believe it is essential for the 1989 survey to provide a baseline against which aspects of the work of gmps after the introduction of White Paper changes at some future date can be compared.

General Workload Data

D6. In producing evidence on indicators of gmps' workload and on trends this year, we have again relied on traditional sources of data, including the General Household Survey. These show that over the last 10 years the population of Great Britain has increased by less than 2% (Table D4) whereas the number of unrestricted principals has increased by nearly 20% from 24,939 in 1977 to 29,808 in 1987 (Table D6). As a result the average list size continues to fall (Table D3). From 1977 the average list has reduced by 13% and over the last year by 1.2%; from 1,991 in 1986 to 1,969 in 1987 (from 1,876 to 1,848 after account has been taken of list inflation).

D7. The overall population in Great Britain has not changed significantly over the last ~~ten~~ 10 years. Only the 75 and over age group shows any significant increase over the past 10 years. In 1981 patients 75 years and over accounted for 6% of the average list rising to 7% in 1987. This trend is, however, offset by the overall decrease in list sizes so that in 1987 the average gmp's list included only 4 more patients aged 75 and over than it did in 1981 and only one more than it did in 1986. The other age group to show some increase has been children under the age of 5 but the reduction in list sizes has more than kept pace with this increase.

Consultations

D8. On the basis of estimates from the General Household Survey patients' contacts with their gmps was greater in 1987

than in 1986, reaching 5 consultations per patient per annum (Table D2). Although the increase is reflected across all age bands the most noticeable increase has been in children's consultations; in particular the consultation rate for the under 5s has increased from 6.6 per person per annum in 1986 to 7.8 in 1987. By contrast consultations by the 75 and over age group has barely increased. As a result the number of consultations per gmp in 1987 showed an increase over the previous year which is not representative of the past trend of small annual increases. The General Household Survey relies upon small samples and it is possible that the latest one may have been less representative than others. But FPC payments to gmps indicate a significant increase in vaccinations and immunisations (nearly 20% above expectation). This might account to some extent for both the increased consultation rate amongst children and the increase in prescriptions (see D9). The majority of consultations, including most of the increases, were conducted at the surgery or over the telephone.

Prescriptions and Certificates

D9. The total number of prescriptions dispensed, which because of the statistical data base includes some prescriptions issued by others than gmps, increased by nearly 18 million in 1987 compared with 1986 (Table D1) - an increase of about 4%
Although this reflects the highest number of prescriptions per patient over the past ten years the number issued per gmp per annum has remained fairly constant, to some extent reflecting lower list sizes. Two aspects are interesting. First, the total number of prescriptions (including personally administered items) dispensed by dispensing doctors increased by 5.9% between 1986 and 1987 compared with an increase of 4.2% in the number dispensed by chemists and personally administered by non-dispensing doctors. The increase of 6.6% in the issue of prescriptions per dispensing patient is noticeably higher than the increase of 3.5% for non-dispensing patients. Second, the number of prescriptions personally administered by non-dispensing doctors showed the most significant increase for many years with a rise of 1 million in 1987, an increase of nearly 40% over last year's total. The increase in vaccination and immunisation of children, the prescribing of tetanus and influenza vaccines and media publicity given to the financial benefit to individual gmps of personal administration may have been contributory factors.

D10. The number of new claims to sickness and invalidity benefit continue to decrease from 1.1 million in 1986 to just under 1 million in 1987. The Statutory Sick Pay scheme means that doctors now deal with far fewer claims than they did in the late 1970s.

Ancillary Staff

D11. The number of whole time equivalent (WTE) ancillary staff for whom gmps are eligible for direct reimbursement under the Ancillary Staff Scheme rose from 33,981 to 36,041 (6%) between

1986 and 1987. This is a slightly smaller percentage increase than last year, but it is in line with increases in previous years. However, between 1979 and 1987 numbers of WTE ancillary staff rose by over 50% (53.4). Over the same period the number of gmps increased by 16% (25,614 to 29,808). Within the overall increase in staff, the number of practice nurses rose dramatically again, by over 17% (the largest annual percentage increase since 1979) from 2803 WTEs in 1986 to 3280 WTEs in 1987. Practice nurses now account for over 9% of ancillary staff compared to less than 5% in 1979. Overall, gmps were employing under the Ancillary Staff Scheme 121 WTE ancillary staff per 100 doctors in 1987, as against 116 per 100 in 1986 and 92 per 100 in 1979. In addition in some cases gmps employ relatives and other staff outside the terms of the Ancillary Staff Scheme and in many places have the benefit of the services of attached health authority staff such as nurses and health visitors.

D12. The Government recently announced that £150,000 is being made available in the financial year 1988-89 for practice nurse training. This expenditure will provide at least 500 training opportunities in England on courses for practice nurses based on the curriculum approved by the four UK National Boards for Nursing, Midwifery and Health Visiting. It has been agreed with medical and nursing professional bodies that those entering practice nursing since 1 January 1987 for the first time should be given priority in the selection of applicants for those courses. The provision of these courses should further improve the quality of gmps' ancillary staff.

Average Workload

D13. It is not clear to what extent gmps themselves may have been involved in the increased number of consultations suggested by the latest General Household Survey data nor to what extent they may have reduced other activities to accommodate any increased consultations. The continuing increase in the numbers of ancillary staff is likely to have helped gmps cope with any increase. In particular, the high increase in practice nurses in 1987 is likely to have allowed gmps to delegate more clinical functions. If consultations did increase significantly as a result of increased activity in vaccinating and immunising children it is possible that a good deal of that work might have been carried out by practice nurses or health authority attached nurses.

Deputising Services

D14. In the Departments' evidence last year (Annex D7 page 12) we reported the findings of its latest survey on the use of deputising services which it carried out in November 1987. This found a continued increase (of 3.3%) in the number of doctors with consent to use deputising services in Great Britain between 1985 and 1987. Also, the number of night visit claims increased by 5.3% in the same period. Those involving deputising services increased by 4.6% and the remainder by

5.8%. In accordance with past practice to conduct the survey at two-yearly intervals, the Department plans to carry out a further survey in 1989.

D15. In July, the Department issued a Health Circular (HC(FP)(88)23) (Annex D1), authorising payments to Deputising Services Liaison Officers employed by FPCs in accordance with a model contract and job description. Liaison officers are to be paid a sessional rate equivalent to the second increment of the Hospital Practitioner scale per notional half day with effect from 1 April 1988. Payments are funded from FPC Administration Budgets, not from general medical services. An important function of liaison officers is to ensure the accuracy of data on usage of deputising services and the next survey should reflect the greater involvement of liaison officers in monitoring usage.

Trainer's Grant/Course Organisers

D16. In paragraphs 86 and 87 of their 18th Report, the Review Body expressed their belief that there should be a different arrangement for reimbursing course organisers and that the trainer's grant is not an adequate substitute. The Review Body urged the parties to resume the negotiations on the matter so that joint evidence could be presented at this review to enable the Review Body to price a separate fee for course organisers. In the light of the Review Body's recommendation, the Health Departments and the profession have resumed discussions about a possible way forward. At this stage it is not possible to say whether negotiations will be completed in time for the current Review Body round but even if that does not prove possible we shall provide the Review Body with a progress report, if possible agreed with the profession, in time for it to be taken into account in the forthcoming Report. There are no course organisers in Scotland where equivalent duties are carried out in conjunction with post-graduate medical education. Funding is therefore provided from the Health and Community Health Service Vote and not from the General Medical Services Vote as in England and Wales.

MEDICAL DEFENCE SUBSCRIPTIONS

D17. In paragraphs 30-39 of their 18th report the DDRB recommended that, as an interim measure, ⅔ of the medical rate of defence body subscriptions should be reimbursed as an expense for all whole or part-time employed practitioners working wholly for the NHS (paying the medical rate), with effect from 1 January 1988. In response the Health Departments agreed (following consultation with the profession) that in order to maintain equal treatment with junior hospital doctors a similar provision should apply to GP trainees. Accordingly, with effect from 1 January 1988, where a Trainer requires that a Trainee becomes, or continues to be, a member of a recognised Professional Defence Body, ⅔ of the annual subscription or premium costs will be reimbursed to the Trainer by equal monthly instalments. This is provided the Trainer has paid the

subscription, that the Trainer has received an application from the Trainee for reimbursement, and the Trainer has reimbursed the Trainee. Otherwise, the cost will not be reimbursed. Part months of service count as complete months but a Trainee who leaves the service of one employer (Health Authority or Trainer) and joins the service of another during the same calendar month receives one instalment for that month, payable by the former employer.

Assistants' Allowance

D.18. When the assistants' allowance was introduced in 1966 it was set at one half of the basic practice allowance. In succeeding years the relativity reduced and in 1982 the Review Body recommended a small relative increase (Twelfth Report, Cmd 8550, paragraph 84) to about 46%. Since then the relativity has remained at about the same level. Whilst it is recognised that the assistants' allowance is not intended to cover all the cost of employing an assistant the allowance at its present level represents less of the cost of employing an assistant than it did in earlier years. The Health Departments would be sympathetic to a further modest relative increase in the level of the assistants' allowance to be accommodated within the total gmps' fees and allowances, as it was in 1982.

GENERAL MEDICAL PRACTITIONERS: INDICATORS OF WORKLOAD - GREAT BRITAIN 1977-1987

		1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
PHARMACEUTICAL SERVICES												
Total Number of prescriptions	Millions	370.8	386.2	383.6	382.8	379.2	393.5	399.7	407.1	405.8	411.3	429.0
Prescriptions per GMP(1)	Thousands	14.9	15.3	15.0	14.6	14.2	14.4	14.4	14.4	14.1	14.0	14.4
Chemist dispensed prescriptions												
Number of prescriptions(2)	Millions	351.3	365.5	362.5	361.3	357.3	370.3	375.6	381.9	379.8	384.3	399.7
Number of people on NHS lists(3)	Millions	53.7	53.8	53.9	54.1	54.1	54.1	54.2	54.3	54.6	54.9	55.3
Prescriptions per person(3)	number	6.5	6.8	6.7	6.7	6.6	6.8	6.9	7.0	7.0	7.0	7.2
Prescriptions per GMP(1)	thousands	14.1	14.5	14.2	13.8	13.4	13.6	13.5	13.5	13.2	13.1	13.4
Dispensing doctors												
Number of prescriptions (4)	Millions	19.3	20.4	20.6	21.0	21.2	22.1	22.7	23.5	24.0	24.7	26.1
Number of people on dispensing lists	Millions	3.2	3.2	3.3	3.3	3.4	3.4	3.4	3.5	3.5	3.5	3.5
Prescriptions per person on dispensing list	Number	6.0	6.3	6.3	6.3	6.3	6.6	6.7	6.8	6.9	7.1	7.6
Prescriptions per dispensing doctor	Thousands	6.5	6.7	6.7	6.7	6.6	6.8	6.8	6.9	6.8	6.9	7.1
Personal administration												
Number of prescriptions(5)	Millions	0.2	0.3	0.5	0.5	0.7	1.0	1.4	1.8	2.0	2.3	3.3
NATIONAL INSURANCE CERTIFICATION												
New claims to sickness and invalidity benefit(6)	Millions	10.2	11.2	10.8	9.3	7.6	6.9	3.1	1.4	1.4	1.1	1.0
Average new claims per GMP(1)	Number	433	467	446	377	301	269	118	50	50	39	33
RMS references - sickness	Millions	0.7	0.7	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
RMS references - injury	Millions	0.05	0.04	0.03	0.03	0.02	0.02	0.01	-	-	-	-

(1) Unrestricted principals only.

(2) Includes prescriptions by hospitals, clinics, dentists, ship and service doctors dispensed under the NHS in retail pharmacies. These collectively account for about 1 1/2 per cent of the total volume.

(3) Excludes those patients on the lists of dispensing doctors for whom the doctor dispenses.

(4) Includes personally administered prescriptions of dispensing doctors. Figures prior to 1984 exclude prescriptions covered by the capitation fees paid to certain dispensing doctors. Capitation fee dispensing doctors were abolished 1 July 1984.

(5) Excludes personally administered prescriptions of dispensing doctors.

(6) From 6 April 1983 Statutory Sick Pay was introduced.

0303Q/NDP

TABLE 11

GENERAL MEDICAL PRACTITIONER WORKLOAD
LIST SIZE, CONSULTATIONS AND NUMBER OF HOURS CONSULTING
GREAT BRITAIN

	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
1. Average number of patients per unrestricted principal	2,275	2,253	2,229	2,192	2,150	2,107	2,068	2,039	2,017	1,991	1,969
2. Average number of persons per unrestricted principal (1)	2,168	2,141	2,111	2,071	2,043	2,000	1,961	1,931	1,903	1,876	1,848
3. Average number of consultations per person per year	3.7	4.0	3.9	4.3	3.8	4.3	4.3	4.2	4.3	4.4	5.0
4. Number of consultations per unrestricted principal per year	8,020	8,560	8,230	8,910	7,800	8,580	8,350	8,020	8,120	8,330	9,200
5. Percentage of consultations at patients' homes	16	17	16	15	14	16	15	15	14	14	15
6. Number of consultations at the surgery or by telephone per unrestricted principal per year	6,740	7,100	6,910	7,570	6,740	7,250	7,120	6,780	7,000	7,150	7,830
7. Number of consultations at patients' homes per unrestricted principal per year	1,280	1,460	1,320	1,340	1,060	1,330	1,230	1,240	1,120	1,180	1,360
8. Number of hours "consulting" per unrestricted principal per year (2)	990	1,080	1,020	1,090	940	1,060	1,020	990	980	1,010	1,120
9. Number of hours "consulting" per unrestricted principal per year (3)	1,160	1,250	1,190	1,280	1,110	1,240	1,200	1,160	1,160	1,190	1,320
10. Number of hours "consulting" per unrestricted principal per year (4)									1,420	1,460	1,630

4072Q/NDP/1

Table D2

Notes The figures in rows 3 to 10 are based on information from the General Household Survey.
The figures in rows 4, 6, 7, 8, 9 and 10 are rounded to the nearest ten.
The figures in rows 6 and 7 may not add in the total in row 4 due to rounding.

(1) Based on estimates of civilian population at 30 June each year.
(2) The estimates are derived by taking the figures in rows 6 and 7 and assuming 6 minutes for a surgery visit and 15 minutes for a home visit.
(3) As row 8 but assuming $7^{1}/2$ minutes per surgery consultation and 15 minutes for a home visit.
(4) As row 8 but assuming $8^{1}/4$ minutes per surgery consultation and $24^{1}/2$ for a home visit as reported in the GMP Workload Survey 1985/86.

29

Table D3

GENERAL MEDICAL SERVICE

AVERAGE LIST SIZE - GMPs (UNRESTRICTED PRINCIPALS)

GREAT BRITAIN

	ALL PATIENTS	0-64 YEARS	65 YEARS AND OVER	65-75 YEARS	75 YEARS AND OVER
1.10.77	2275	1946	329	N/A	N/A
1.10.78	2253	1923	330	N/A	N/A
1.10.79	2229	1898	331	203	128
1.10.80	2192	1864	328	199	129
1.10.81	2150	1825	325	194	131
1.10.82	2107	1790	316(1)	186	131
1.10.83	2068	1759	309	178	131
1.10.84	2039	1733	306	174	132
1.10.85	2017	1708	309(1)	175	133
1.10.86	1991	1682	309	175	134
1.10.87	1969	1661	308	173	135

(1) Figures do not add up because of rounding.

0564Q/NRE/1

Table D4

CIVILIAN POPULATION

GREAT BRITAIN

Thousands

Years	Total Persons	Age in (years)					
		0 - 4		65 - 74		75 and over	
		Number	Percent of total	Number	Percent of total	Number	Percent of total
1977	54056.8	3408.6	6.3	4997.4	9.2	2852.5	5.3
1978	54047.7	3281.7	6.1	5026.8	9.3	2926.6	5.4
1979	54088.7	3258.6	6.0	5050.4	9.3	2997.0	5.5
1980	54140.2	3281.9	6.1	5070.0	9.4	3076.9	5.7
1981	54553.1	3323.4	6.1	5078.7	9.3	3209.5	5.9
1982	54519.6	3387.1	6.2	4995.1	9.2	3289.1	6.0
1983	54558.3	3447.5	6.3	4853.3	8.9	3376.4	6.2
1984	54635.0	3455.8	6.3	4732.6	8.7	3465.8	6.3
1985	54784.6	3475.5	6.3	4827.7	8.8	3543.0	6.5
1986	54923.5	3506.1	6.4	4891.8	8.9	3602.3	6.6
1987	55079.8	3548.9	6.4	4924.6	8.9	3698.6	6.7

(1) Figures from 1981 onwards are based on 1981 Census.

4026Q/RD/1

Table D5

HOSPITAL PRACTITIONERS, GPs WITH PARAGRAPH 94 APPOINTMENTS AND DOCTORS PARTICIPATING IN HOSPITAL STAFF FUNDS SHOWING NUMBER AND WTE

ENGLAND AND WALES AT 30 SEPTEMBER/1 OCTOBER EACH YEAR

Year	Hospital Practitioners (30 September)		GPs with para 94 Appointments (1) (1 October)		GPs participating in Hospital Staff funds (30 September)
	No	WTE	No	WTE	No
1977	160	42.9	4688	938.6	1944
1978	466	117.2	4515	897.1	1876
1979	601	150.7	4550	895.0	1900
1980	732	186.8	4412	845.9	2325
1981	864	216.1	4352	814.6	2450
1982(2)	871	221.1	4434	847.1	2605
1983(3)	908	228.2	4420	826.3	-
1984	929	235.4	4523	839.7	-
1985	905	224.1	4663	878.6	-
1986	917	231.2	4603	852.0	-
1987	921	219.8	4793	885.6	-

(1) Including staff who also hold appointments under both paragraphs 88-93.

(2) From 1982 staff in special hospitals (which were returned for the first time in 1982) have been excluded to achieve comparability with earlier years.

(3) From 1983 data on GPs participating in Hospital Staff funds is not available

4073Q/NDP/1

DOCTORS IN GENERAL PRACTICE: ANYALYSIS BY TYPE OF PRACTITIONER
GREAT BRITAIN

Year(1)	All doctors		Unrestricted principals		Restricted principals		Assistants		Trainees	
	Number	Net Change	Number	Net Change	Number	Net Change	Number	Net Change	Number	Net Change
1971	24,668		23,252		455		657		304	
		+ 515		+ 470		- 32		- 24		+ 101
1972	25,183		23,722		423		633		405	
		+ 400		+ 243		- 49		+ 7		+ 199
1973	25,583		23,965		374		640		604	
		+ 261		+ 290		- 36		- 114		+ 121
1974	25,844		24,255		338		526		725	
		+ 284		+ 209		+ 2		- 84		+ 157
1975	26,128		24,464		340		442		882	
		+ 290		+ 193		- 17		+ 8		+ 106
1976	26,418		24,657		323		450		988	
		+ 392		+ 282		- 8		- 15		+ 133
1977	26,810		24,939		315		435		1,121	
		+ 417		+ 306		- 19		- 44		+ 174
1978	27,227		25,245		296		391		1,295	
		+ 469		+ 369		- 20		- 46		+ 166
1979	27,696		25,614		276		345		1,461	
		+ 718		+ 527		- 19		- 33		+ 243
1980	28,414		26,141		257		312		1,704	
		+ 838		+ 561		- 19		+ 3		+ 293
1981	29,252		26,702		238		315		1,997	
		+ 554		+ 554		- 11		- 14		+ 25
1982	29,806		27,256		227		301		2,022	
		+ 616		+ 569		- 23		+ 16		+ 54
1983	30,422		27,825		204		317		2,076	
		+ 554		+ 474		- 9		- 17		+ 106
1984	30,976		28,299		195		300		2,182	
		+ 489		+ 484		- 11		- 42		+ 58
1985	31,465		28,783		184		258		2,240	
		+ 389		+ 496		- 9		+ 25		- 123
1986	31,854		29,279		175		283		2,117	
		+ 568		+ 529		- 3		- 23		+ 65
1987	32,422		29,808		172		260		2,182	

(1) At 1 October

4070Q/NDP/1

12

Table D6

ANNEX D1

HEALTH CIRCULAR

HC(FP)(88)23
HN(88)21

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Family Practitioner Committees) for action

Regional Health Authorities)
District Health Authorities) for information
Community Health Coucils)

July 1988

FAMILY PRACTITIONER SERVICES - MANAGEMENT

PAYMENT OF DEPUTISING SERVICES LIAISON OFFICERS

SUMMARY

This Circular:

a) Provides for Family Practitioner Committees to make payments to Deputising Services Liaison Officers with effect from 1 April 1988.

b) Gives further guidance to FPCs on the appointment and accountability of liaison officers, including a model job description in Annex A.

INTRODUCTION

1. Circular HC (FP)(84) 2 sets out arrangements for the appointment of liaison officers by Deputising Services Sub-Committees (DSSCs) or where a single deputising service covers more than one FPC, by a Joint Deputising Services Committee (JDSC) including members appointed by each FPC. Annex A of the Circular provided for reimbursement of normal expenses of liaison officers on the same basis as for FPC members but made no provision for any other payments.

2. The Department is concerned to ensure the highest possible standard of deputising services. It recognises the essential role of liaison officers in achieving this and is making available additional resources to permit FPCs to remunerate liaison officers accordingly. Subject to agreement on a written contract to ensure proper accountability to the FPC and also a comprehensive range of duties as set out in the enclosed model job description, FPCs have authority to make payments to liaison officers in accordance with the terms of this Circular with effect from 1 April 1988.

PAYMENT DETAILS

3. Following discussion with representatives of the profession and FPCs it has been decided that payment of liaison officers should be by a flat-rate payment per notional half day (nhd) equivalent to the second increment on the Hospital Practitioner scale. The minimum commitment for which payment will be made is one nhd weekly. No increments will be paid but payments may be uprated in line with Government decisions following on from DDRB reports.

ANNEX A

HC(FP)(88)23
HN(88)21

DRAFT JOB DESCRIPTION FOR DEPUTISING SERVICES LIAISON OFFICERS

Appointment

The liaison officer is to be nominated by a Deputising Services Sub-Committee (DSSC) or by a Joint Deputising Services Committee (JDSC) including representatives of more than one FPC. He is to be appointed by the FPC or, in the case of a JDSC, by the responsible FPC. Only a medically qualified person may be appointed, normally a principal on an FPC medical list (not necessarily the medical list of the appointing FPC) or a recently retired principal. He need not be a member of the DSSC or JDSC, although he will normally attend meetings except when matters relating to his post are discussed.

Accountability

The liaison officer should be accountable to the appointing FPC through the Administrator, with a direct reporting and advisory responsibility to the DSSC and/or JDSC in respect of professional matters. The Administrator of the FPC (in the case of a JDSC, normally the Administrator of the FPC in whose area the main control centre of the deputising service is located) is responsible for paying the liaison officer and for other administrative matters relating to his employment.

Role

The liaison officer's role is to monitor deputising services and to provide the day-to-day link between the DSSC or JDSC and one or more deputising services on whose adequacy the DSSC or JDSC is required to advise the FPC(s). In the case of a JDSC, the liaison officer may also provide a link between the JDSC and any DSSCs established by individual FPCs within the area served by the joint committee. The liaison officer will be responsible for monitoring patients' rights to the confidentiality of any information disclosed to a deputising service or made available to the liaison officer during the course of his duties. Where appropriate, FPCs shall provide the liaison officer with secretarial and other support facilities to carry out his role.

Tasks

The tasks of the liaison officer include:

a. attending regular meetings with the management of the deputising service in order to monitor the matters covered in Annex B to HC(FP)(84)2;

b. making visits (including some random, unscheduled visits) to the main control centre of the service during operational hours to monitor the quality of service, in particular the efficiency of handling calls, arrangements to ensure confidentiality, setting of priorities for visiting patients, levels of equipment, and security of drugs;

c. to assess and report on the quality of the work of the doctors employed by the deputising service;

d. monitoring complaints made about the service from all sources whether made to the service itself or to the FPC, and presenting information for consideration by the DSSC and/or JDSC;

INCOME TAX, NATIONAL INSURANCE AND SUPERANNUATION

10. Payments to liaison officers will be subject to Income Tax and National Insurance deductions, and will normally be superannuable. Retired doctors who are no longer on an FPC's medical list and any other doctors who are not included on an FPC's medical list cannot qualify for NHS superannuation. For those not on an FPC list who cannot be superannuable in the NHS scheme, an FPC may pay a minimum contribution to a personal pension as part of their National Insurance contributions. This contribution should be equal to the difference between the full and contracted out rate of National Insurance contributions.

ACTION

11. FPCs are asked:

i. to apply the arrangements set out in this Circular to pay Deputising Services Liaison Officers;

ii. to draw up and agree written job descriptions (as in the model job description at Annex A) and contracts of employment for these officers.

From: Family Practitioner Services Division 1B
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SECTION E

GENERAL DENTAL PRACTITIONERS

"Promoting Better Health"

E.1. In Paragraph E.1 of last year's evidence we summarised the main decisions concerning dental practitioners in the White Paper "Promoting Better Health". There has been significant progress on a number of these matters, as indicated separately below. Those requiring legislation were included in the Health and Medicines Bill introduced in the House of Commons on 25 November 1987. By the Summer recess the Bill had completed its Commons stages, and was awaiting Report and Third Reading in the House of Lords. A number of the proposals in the White Paper require the agreement of the profession, and discussions are continuing.

New Contractual Arrangements

E.2. Paragraph E.16 of the Departments' evidence last year, referred to the proposals in the White Paper for new contractual arrangements. It was contemplated that these would include an enhanced commitment to NHS practice, changes to the remuneration system with a view to encouraging both efficiency and quality, and an expanded and more clearly defined requirement to give advice on prevention. We also referred to proposals for allowances to help offset income lost as a result of attendance at postgraduate courses. Discussions on the technical and statistical aspects of new contractual arrangements, and on related matters such as introduction of a maternity pay scheme, have begun together with collection of necessary background information and preparation and evaluation of options. It is hoped to begin formal negotiations later in the year. The Departments do not consider that these matters have progressed sufficiently for the Review Body to take them into account in its consideration of Target Average Net Income in 1989/90.

Retirement

E.3. In paragraph E.1.2 of last year's evidence we indicated that the Government proposed to take powers to prescribe a retirement age for general dental practitioners. The necessary powers are contained in the Health and Medicines Bill. The intention is to introduce retirement provisions from April 1990 which it is considered will give practitioners time enough to make whatever adjustments might be necessary to their financial plans. It has also been made clear that there will be no compensation paid in respect of these provisions other than in respect of the earlier than anticipated sale of dental practices. Unlike doctors, dentists' practice goodwill was not bought out at the inception of the NHS. Dentists will still be

able to practice privately should they wish to do so. Discussions between the Departments and the profession on the level of compensation payable are proceeding. Preliminary discussions are also being held on a system of voluntary early retirement from age 55 based on an annual quote reviewed in the light of prevailing manpower considerations. Provision is also contained in the Health and Medicines Bill to end the option (available only to doctors or dentists providing general medical, ophthalmic or dental services) whereby a medical or dental practitioner who delays retirement until the age of 65 can then retire for a day and return to practice without abatement of pension. This provision will not attract any compensation.

Dental Practice Advisers

E.4. Paragraph E.13 of last year's evidence indicated that consultations were in progress on the proposal to implement the recommendation of a Joint Working Party of the Departments, the Dental Estimates Board and the profession that Dental Practice Advisers (DPAs) should be introduced, on a trial basis, in some areas. Consultations are still in progress on some aspects of the scheme, but it is intended to introduce about 50 DPAs into 15-20 Family Practitioner Committee (FPC) areas in England early in 1989. DPAs will be contracted to work for two half-day sessions per week. Their duties will include examination of patients at the request of dentists or the Dental Estimates Board, practice inspections, counselling and "pastoral" visits. It will be a condition of DPAs' contracts with the FPCs that they attend a three day, centrally-organised training course before taking up their duties. FPCs in Wales are expected to join the scheme in 1989/90. The question of whether to introduce DPAs in Scotland is still under consideration.

E.5. The Departments have discussed remuneration for DPAs with the profession and the following agreement has been reached. It is proposed that DPAs should be paid a fee for their services linked to that paid to regional advisers in general dental practice (that is, pro rata to the top of the consultant scale). On the basis of current scales this amounts to £68.27 per half-day session. In addition an allowance will be paid to reimburse DPAs for on-going expenses incurred in their own dental practices while undertaking DPA duties. The allowance will be linked to the expenses element in Target Average Gross Income, less the appropriate percentages in respect of laboratory charges, dental consumables and car expenses. On the basis of this year's DSRG settlement this works out at £42.80 per half-day session. Travel and subsistence allowances will be paid in accordance with the usual NHS arrangements. The Review Body is asked to note and endorse these arrangements for DPA remuneration.

Financial Incentives to Improve Distribution of Dentists

E.6. In the White Paper the Government indicated that it would

be discussing with the profession measures to reinforce the effect of market forces on the distribution of general dental practitioners, including financial assistance towards the cost of establishing and equipping practices in designated areas. Agreement has now been reached on the outline of a pilot scheme whereby funds would be made available to selected FPCs for the payment of grants to practitioners setting up or expanding dental practices in areas where there is a serious shortage of such facilities. The participating FPCs would designate target zones within their areas where in their view it is particularly important to increase the number of dentists. Dentists wishing to take advantage of the scheme would apply to the FPC for a grant, submitting detailed plans and costs relating to the proposed investment. There would need to be a substantial commitment to NHS practice at the premises concerned.

E.7. Agreement has also been reached on the level of grants payable. This will be 15% of the relevant investment, payable over three years subject to a minimum level of investment of £10,000 and a maximum of £50,000. To aid cash flow the payments would be tapered so that higher amounts would be paid in the first year, reducing over the next two.

E.8. Discussions are continuing with the profession on detailed aspects of the scheme. Four FPCs selected according to criteria of dentist shortage relative to population and the level of service provided have been invited to express an interest in principle in taking part in the scheme and to take part in discussions about its implementation. Subject to satisfactory progress in these discussions it is hoped to introduce the scheme from the beginning of 1989. It is intended that other FPCs, selected according to similar criteria, will be invited to participate as the scheme proceeds.

Dental Estimates Boards

E.9. The Health and Medicines Bill contains a number of proposals for changes concerning the Dental Estimates Boards, most of which reflect recommendations of the Committee of Enquiry into Unnecessary Dental Treatment. First, the name of the Boards is to be changed to "Dental Practice Boards", so as more accurately to reflect the breadth of their functions. Secondly the Boards will have the power to direct a dentist to provide information such as radiographs, models or records. Thirdly, the Boards will have power, subject to a right of appeal, to direct a dentist for a limited period to submit for prior approval all estimates required to undertake other activities concerned with the provision of general dental services, including conducting or commissioning surveys or other research.

Charges for Dental Services

E.10. With effect from 1 April 1988, the system of charges for dental services was substantially revised and simplified.

Prior to that date charges for dental treatment were 100% of cost up to £17 plus 40% of the cost in excess of that sum, subject to a maximum of £115. Charges for dentures and bridges were on a fixed scale ranging from 25% of cost to over 90%. Treatment (excluding dentures and bridges) is now charged at a uniform 75% of cost, subject to an increased maximum of £150. Because of defective legal powers, which would be put right by the Health and Medicines Bill, charges for dentures and bridges cannot be specified as proportions of cost. Fixed charges have however been introduced as close as possible to 75% of cost. Children under 16, full-time students under 19, pregnant women and nursing mothers, and people on low incomes remain exempt from charges for dental treatment and for dentures and bridges. Young people aged 16 and 17 are exempt from charges for treatment but not from those for dentures and bridges. Once the powers in the Bill become law, all charges for treatmemt and dentures and bridges will be brought onto a fully proportional basis. The representatives of the dental profession have warmly welcomed these moves to proportional charging as a considerable simplification in their adminstrative procedures, as well as an encouragement to regular attenders. The Bill also contains a provision inserted during the proceedings in the House of Commons to exempt 16 and 17 year olds from denture and bridges charges as well as treatment charges. This move has likewise been warmly welcomed by the profession.

E.11. The White Paper contained proposals to bring the dental examination within the scope of these charging arrangements, subject to the same exemptions as for other treatment, as part of its strategy to generate more resources for improvements in primary care. In the dental field these improvements include initiatives described elsewhere in this evidence, such as dental practice advisers (paragraph E.4), financial incentives to improve distribution (paragraph E.6), allowances for attendance at postgraduate courses (paragraph E.2) and an expansion of the vocational training scheme (paragraph E.26). The Government remains of the view that it is right that those who can afford to should contribute towards the cost of dental examinations and thereby help generate the resources for these improvements.

Treatment Requiring Prior Approval of the Dental Estimates Board

E.12. About 20% of the individual items of treatment in the scale of NHS fees for general dental services require prior approval from the Dental Estimates Boards for either the whole or part of the treatment before treatment can commence. This means that each such estimate must be sent to the appropriate Board at least twice. In October 1987 significant easements from these requirements were introduced in respect of radiographic examinations and orthodontic treatment. From October 1988, following a comprehensive review of all outstanding items, the requirements will be removed in whole or in part from over thirty items, including most crowns.

extractions, dentures and bridges. Items have only been retained on prior approval where there is good reason for doing so, for example, for the protection of patients' health. The profession have welcomed these relaxations which should lead to a substantial reduction in paperwork and in delays in providing treatment.

MANPOWER

E.13. By 1 January 1988, the number of dentists on the Dentists Register had risen to 25,286, an increase of 436 over the previous year. The growth over the last three years of 876 has been much lower than that of the previous five, during which the Register had increased by some 3,200 dentists. The number of students admitted to their first professional year at dental schools in the UK was 914 (provisional figure) in 1987/1988 compared with 909 in 1986/87. As indicated in paragraph E.5 of last year's evidence, Health Ministers have endorsed a 10% reduction in the dental school intake. It is a matter for the University Grants Committee (UGC) and the Department of Education and Science to decide how this reduction is to be implemented, and this is still under consideration.

E.14. Data about the number of dentists practising in the general dental service (gds) will be included in Volume II of the Departments' evidence. The latest figures show a continuation of the upward trend. The increase over the past two years has been an average of 1.8%, marginally higher than the last two years but one. The total increase over the past 10 years has been slightly over 25%.

E.15. In 1987 the national (English) average population to dentist ratio was 3212:1 but within this there was wide variation, as in previous years, from 2265:1 in North West Thames to 4101:1 in Trent. While there was an increase in the number of dentists relative to population in both Regions the increase was higher in the Region with the lower provision. Market forces are therefore continuing to have a slow but discernible effect on the distribution of dentists. It should also be borne in mind that courses of treatment per dentist have historically been higher in regions such as Trent offsetting to some extent the relatively unfavourable dentist:population ratio. It is hoped that the initiative referred to in Paragraphs E.6 to E.8 above to provide grants for new practices in designated areas will accelerate the process of market forces in areas where the ratios of dentists and courses of treatment to population are both unfavourable.

Workload

E.16. In 1986/87 there were 36.8 million completed courses of dental treatment and cases of occasional treatment in Great Britain. In 1987/88 there were 37.2 million, and in 1988/89 we estimate there will be 37.6 million. Patient charges were revised from 1 April 1988 as indicated in paragraph E.10 above.

The following table shows on a quarterly basis the percentage changes in numbers of treatment courses since the previous year.

Quarter ended	% change in course of treatment per quarter since the previous year
March 1987	- 2.4%
June 1987	- 1.0%
September 1987	+ 6.2%
December 1987	- 4.6%
March 1988	+ 4.0%
June 1988	- 2.1%

The last figure may well have been affected by recent delays in scheduling at the Dental Estimates Board for England and Wales and figures for a subsequent quarter are likely to show a compensating increase as the backlog is cleared. The long term trend continues to be upward, with the number of courses of dental treatment increasing by an average of 1.9% over the past ten years. The growth in the 12 months to 30 June 1988 was 0.7%.

E.17. Information on the overall number of courses of treatment is not a measure of dentists' output, since it does not take account of the increase in the number of gdps, nor of alterations in the content of courses of treatment. In previous years we have produced as a measure of output a chained index of dentists' earnings attributed solely to time spent providing treatment, calculated for each year both on that year's fee scale and that of the previous year. The index is constructed by weighting individual treatments according to the time cost portion of the scale of fees. The results are therefore based on the premise that the average times taken by dentists to carry out each item of treatment are directly related to their time cost allocations in the scale. The data for the construction of the index are derived directly from the total claims made by all gdps for fees for work they claim to have undertaken, and the Departments have therefore every confidence in their reliability as a basis for measure of practitioners' workload. However, as indicated in their evidence to the Review Body last year this view is not shared by the BDA. In their view the index is seriously flawed in that it does not adequately reflect changes in recent years in methods of payment for periodontal treatment. More generally they feel that it does not take sufficient account of work not directly related to the item of fee scale. In its eighteenth Report the Review Body indicated that it was for the Departments and the profession to determine the accuracy and appropriateness of the index as a workload measure. Despite considerable effort agreement has not so far been reached.

E.18. The Departments have therefore re-calculated the index on the same basis as in previous years. The updated index is shown below:

Index of Dentists' Earnings attributed to time

1979/80	100.00
1980/81	101.1
1981/82	101.8
1982/83	102.9
1983/84	103.2
1984/85	95.5
1985/86	91.1
1986/87	91.3
1987/88	88.9

There has been a decline in dentists' output of 13.9% since 1983/84 and of 11.1% since the baseline year of 1979/80. We are of the view that the Review Body should take this decline into account in its recommendations for Target Average Net Income for 1989/90.

The Balancing Arrangement

E.19. In its 11th Report, the Review Body recommended that the Dental Rates Study Group (DRSG) introduce a balancing arrangement to correct retrospectively for differences between dentists' actual and intended incomes and asked to be kept informed of the operation of the arrangement. When setting fees for 1988/89, the DRSG increased Target Average Gross Income by £131 on this account. The overall error for 1985/86 represented an underpayment of £927 per dentist. The provisional overall error for 1986/87 represented an overpayment of £796 per dentist. The provisional error for 1986/87 had the opposite sign and was a lower amount than the previous year's final error. As there was a zero balance carried over from 1984/85, the final correction for 1985/86 was made by an addition to the pool of £131 per dentist with a balance of £796 carried over to 1989/90.

Inclusion of Associates in the DRSG Population

E.20. In Paragraph E.9 of last year's evidence we indicated that we hoped by means of a statutory return from a sample of dentists under the Statistics of Trade Act 1947 to obtain sufficient data in respect of associates' expenses for 1985/86 for consideration by the DRSG in the 1988 round. From a sample of 780 for inclusion in the final analysis. The data obtained were sufficient to establish reliably that associate practices do not show the same economies of scale as partnerships, and therefore that deductions made in earlier years provisional on the identification of such economies were inappropriate. The DRSG parties have agreed that repayment of these deductions will be made over a period of three years, commencing in 1988/89. Further surveys will be needed before the level of associates' expenses can be reliably estimated, and it is proposed to continue the return under the Statistics of Trade Act in future years.

Under-declaration of Income

E.21. In Paragraph E.10 of last year's evidence we indicated that we were expecting the results of a survey to estimate the size of undeclared income in 1986/87. We also indicated that a further survey would be carried out for 1987/88. In the light of the results of the first of these two surveys, the DRSG decided it would be appropriate to make an adjustment this year in respect of 1985/86 outside the normal balancing arrangement. Appropriate adjustments for 1986/87 and 1987/88 will be made in 1989 and 1990 respectively. The DRSG has agreed that with the introduction of proportional charging from 1 April 1988 adjustments for 1988/89 and subsequent years would not be justified.

Interim Fee Reviews

E.22. This year as in the previous two years gdps have received interim fee adjustments pending completion of the DRSG deliberations. The interim adjustment this year was 3%. On each occasion the Departments were of the view that there was a reasonable case for such an adjustment, and in their eighteenth Report the Review Body endorsed this approach. The Departments have now agreed with the representatives of the profession's long term arrangements for future interim increases. An interim increase will normally be paid with effect from 1 April in each year or the first day of the earliest month for which it is possible for the Dental Estimates Board to include the payment in schedules following the Government's decision on the Review Body's recommendation for Target Average Net Income. The Departments will determine the size of the increase after consultation with the representatives of the profession. Only in exceptional circumstances would an interim increase not be agreed. Such circumstances might include any year in which the Government defers the date of implementation of the increase in Target Average Net Income or in which there is evidence that dentists' earnings in the immediately preceding year have substantially exceeded the Target Average Gross Income agreed by the DRSG.

Notional Rent Enquiry

E.23. An amount of £95 per dentist was added to the 1988/89 DRSG pool in respect of the net notional rent addition. As indicated in Paragraph E.11 of last year's evidence the DRSG is reviewing its procedures for estimating this addition. It expects to complete the review during 1988/89.

Capitation Payments to General Dental Practitioners

E.24. In Paragraph E.15. of last year's evidence we informed the Review Body of the progress of the three-year study to establish the costs and benefits of a capitation system for children's dentistry. At 1 July 1988 409 dentists were in capitation arrangements in Great Britain with 127,419 children

registered as patients. The Dental Health Research Unit at the University of Manchester Dental School, who are carrying out the study, are currently running tests to establish the level of satisfaction of parents, dentists and administrators with the scheme. In paragraph E.15 of last year's evidence we referred to some concern among dentists about the amount of paperwork involved. Consultations are currently under way about the design and practicality of a single new form which would replace the five currently in use.

Minimal Intervention Techniques in the Fee Scale

E.25. In Paragraph E.16 of last year's evidence we referred to the introduction of fissure sealing into the gds fee scale as a preventive measure for children with special needs, and also as a therapeutic measure in conjunction with minimal restoration without restriction as to type of patient. From 1 October 1988 the range of therapeutic procedures involving fissure sealants in the fee scale has been extended to cover fissure sealing on its own and in conjunction with a range of small restorations.

Vocational training

E.26. In paragraph E.18 of last year's evidence we indicated that arrangements were in hand to provide some 178 vocational training places in England and Wales from 1 January 1988, with further places becoming available later in the year. With only one or two exceptions all available places have been taken up. On 1 July 1988 there were 189 trainees in the scheme. As indicated in the White Paper, the Departments are providing funds additional to those previously planned to allow for more rapid expansion of the scheme to 308 places by 1 January 1989.

E.27. A Committee on Continuing Education and Training was established in May 1988 under the chairmanship of the Chief Dental Officer for England, with representatives of the dental profession, teaching interests had observers from the other UK Health Departments, to oversee arrangements for postgraduate education in the general and community dental services. A sub-committee has been established specifically to monitor the gds vocational training scheme. The sub-committee has recently instituted a system of visits to ensure that standards of training are as far as possible uniform across the country.

E.28. In Scotland a committee on vocational training for general dental practice was established by the Scottish Health Department within the framework of the Scottish Council for Postgraduate Medical Education to make arrangements for the introduction of a vocational training scheme. Four schemes providing 46 places are planned to be in operation by 1 January 1990. The first two schemes, providing 26 places, were introduced on 1 August 1988. 11 available places have been taken up. A Third scheme will commence on 1 January 1989 providing ten places and a fourth on 1 January 1990 providing a further ten places.

Emergency Dental Services

E.29. During the 1987/88 financial year, 4226 sessions were provided at weekends and bank holidays compared with 3844 during the year ending 31 August 1987. 28,597 were seen, an average of 6.8 patients per three hour session, of whom 19,619 (69%) received some form of treatment and 6825 (24%) received prescriptions only. A total of 50 FPCs in England and Wales provided sessions during the year, of which 48 were continuing to do so at the end of the year. The remaining two also had alternative arrangements. Of the remainder 9 were covered by neighbouring FPCs and 32 solely by their own alternative arrangements. In7 FPCs there was no emergency cover.

E.30. In Scotland during the year ended 31 March 1988 a total of 707 sessions were provided at weekends and bank holidays in four Health Board Areas. 9113 patients were seen, an average of 12.9 patients per three hour session, of whom 90.45% received treatment and 9.55% prescriptions only.

E.31. A number of FPCs have reported that they have arranged sessions for emergency dental treatment which last for less than the standard three hours; others have reported that some three hour sessions have over-run and that it has been appropriate to make additional payments to the dentists involved. The Departments propose to make it clear to FPCs that dentists may be reimbursed pro rata to the three hour sessional rate if sessions are shorter or longer than three hours and is discussing this with the profession.

Salaried General Dental Practitioners

E.32. At 30 June 1988, there were 53 salaried practitioners directly employed by FPCs in England and Wales and providing general dental services from health centre premises. Of these 38 were working part-time. In Scotland there were 20 salaried practitioners, and 12 practitioners remunerated on a salary plus bonus basis, all of whom worked full-time.

SECTION F : OPHTHALMIC MEDICAL PRACTITIONERS

F1. Tables OMP1 and 2 (Tables F1 and F2) in our statistical evidence give the number of OMPs and the numbers and proportion of GOS sight tests carried out by them for the last 10 years. The numbers of OMPs and their sight tests have varied little but there has been a marked decline in the proportion of GOS tests undertaken by them (Annexes F1, F2 and F3).

Health and Medicines Bill

F2. In our evidence last year we outlined the Government's proposals to confine the GOS sight test to particular groups. [It remains the Government's view that it is right for those who can afford it to pay for their sight test and to retain the GOS for those who cannot.]

F3. The Health Departments will be discussing with the profession what remuneration arrangements would be appropriate to a situation where the GOS is replaced by the private market as the source of sight tests for the majority of people. However, we will wish to assess the impact of such a development and would bring forward any proposals for change in the next round. We would hope that such proposals might be agreed with the profession.

Appropriate level of remuneration

F4. For the current round we consider that the OMPs' net remuneration should be increased in line with whatever general increase in remuneration is agreed. In its Eighteenth Report (Chapter 3 paragraph 73) the Review Body accepted that there was no case for aligning the OMPs' net remuneration with that of the ophthalmic opticians in view of the differences in the composition of those fees. The Departments also re-affirm the view that the wider skills and responsibilities which OMPs may exercise outside the GOS should not be reflected in the GOS fee. Nor are there reasons of recruitment or retention which warrant a premium rate of payment to the OMPs. Indeed under the Government's proposals demand on the GOS for sight tests will fall to approximately one third of its present level.

Domiciliary visits

F5. The Departments will be discussing with the profession the question of a fee for domiciliary visits under the GOS. We will be putting evidence to the Review Body later in this round once these discussions have been completed.

Expenses

F6. The expenses enquiry has been completed and the report is under consideration. The results will be discussed with the profession and, hopefully, it will be possible to submit joint evidence to the Review Body later in this round.

TABLE OMP1

OPHTHALMIC MEDICAL PRACTITIONERS

NUMBER ON THE LIST OF FAMILY PRACTITIONER COMMITTEES BY APPOINTMENT HELD AND AGE GROUP

AT 31 DECEMBER 1987

ENGLAND AND WALES

Appointments	Total Number	Age group						
		Under 30	30-39	40-49	50-59	60-64	65-69	70 + Over
All OMPs[1]	885	4	190	244	223	66	48	110
OMPs Known to Hold Other Appointments	597	2	148	197	194	42	7	7
OMPs Holding Hospital Appointments [2]	556	2	143	184	179	38	5	5
Consultant	205	-	27	71	85	18	3	1
Associate Specialist	67	-	1	14	41	9	1	1
Senior House Medical Officer	11	-	1	-	5	3	-	2
Senior Registrar	31	-	31	-	-	-	-	-
Registrar	37	2	27	8	-	-	-	-
Senior House Officer	11	-	7	3	1	-	-	-
Hospital Practitioner	16	-	2	4	8	2	-	-
Clinical Assistant [3]	178	-	47	84	39	6	1	1
OMPs Not Holding Hospital Appointments [4]	41	-	5	13	15	4	2	2
General Practice	22	-	3	9	7	2	1	-
Community Medicine	19	-	2	4	8	2	1	2
OMPs Not Known to Hold Any Other Appointments	288	2	42	47	29	24	41	103

Notes (1) Includes 23 OMPs who are also in contract with Scottish Health Boards.

(2) House Officer Appointments: None

(3) Since the Korner Report staff appointed under Paragraph 89,94 and Paragraph 89 and 94 of the Terms and Conditions of Service have now been regraded as Clinical Assistants.

(4) University Appointments: None

NB In the above analysis, an OMP with more than one appointment has been counted once only and has been included at that appointment which appears earlier in the list. The analysis of Hospital Appointments is at 30 September 1987.

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Table F1

TABLE OMP 2

OPHTHALMIC MEDICAL PRACTITIONERS

NUMBER OF OMPS, OMP SIGHT TESTS AND TOTAL SIGHT TESTS

ENGLAND AND WALES

CALENDAR YEAR	NO OF OMPS	OMP SIGHT TESTS		TOTAL SIGHT TESTS
		NUMBER	AS PERCENTAGE OF TOTAL SIGHT TESTS	
1977	876	1,342,079	17.1	7,856,441
1978	844	1,325,925	16.0	8,308,060
1979	852	1,354,552	15.8	8,592,871
1980	865	1,330,722	15.1	8,794,615
1981	880	1,300,712	14.6	8,931,763
1982	878	1,360,413	14.8	9,191,599
1983	862	1,310,742	13.7	9,558,199
1984	865	1,355,842	13.2	10,308,229
1985	881	1,354,245	12.5	10,843,527
1986	909	1,300,134	11.7	11,124,691
1987	885	1,275,862	10.9	11,742,293

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Table F2

ANNEX F1

FIGURE 1

JMPs BY APPOINTMENT (31 DECEMBER 1987) GREAT BRITAIN

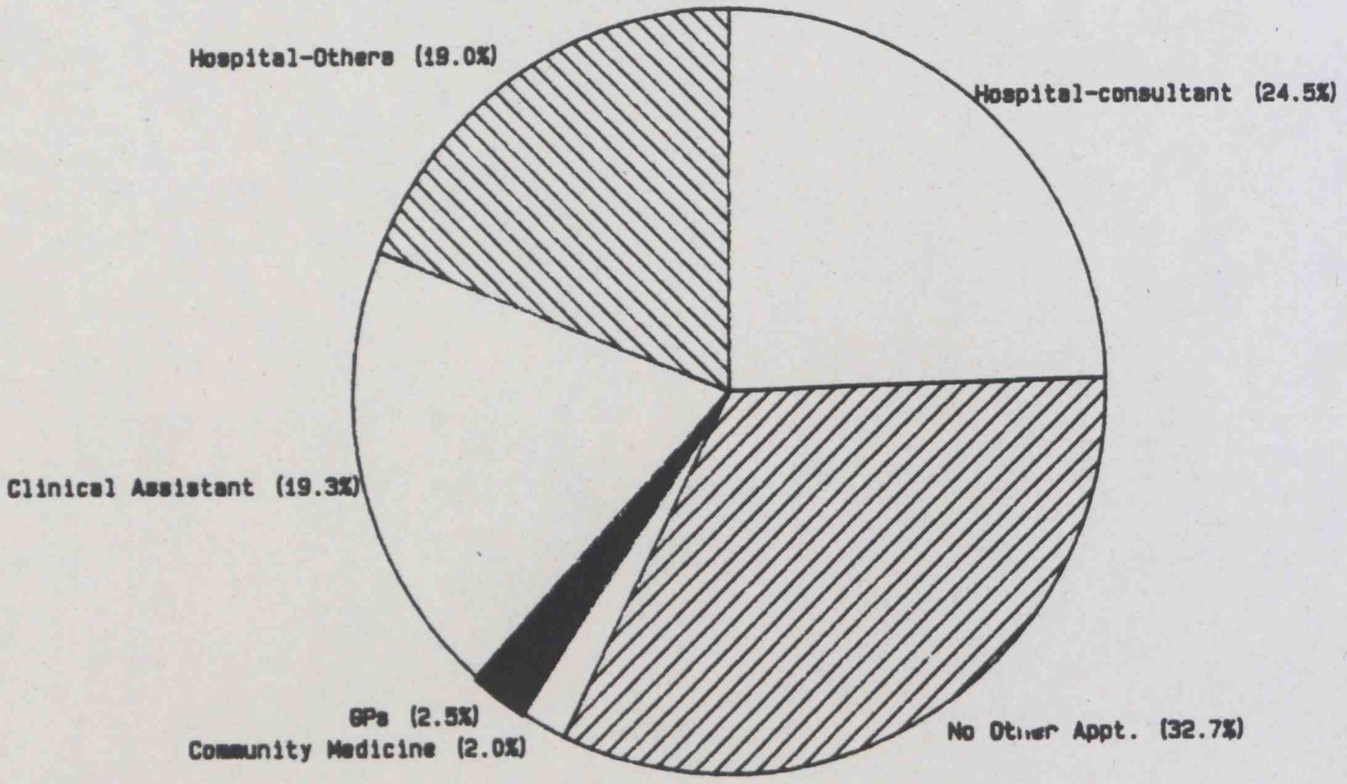
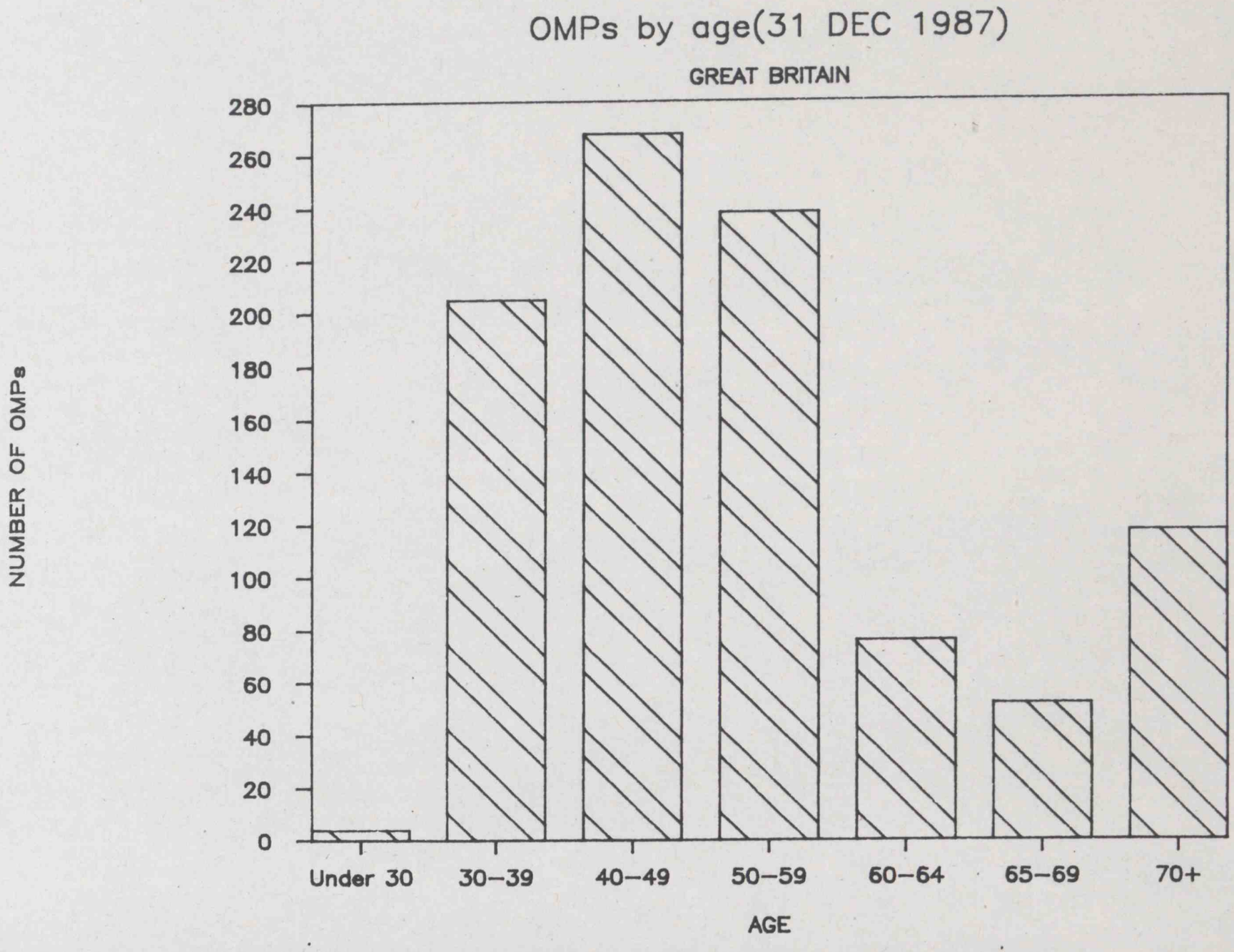


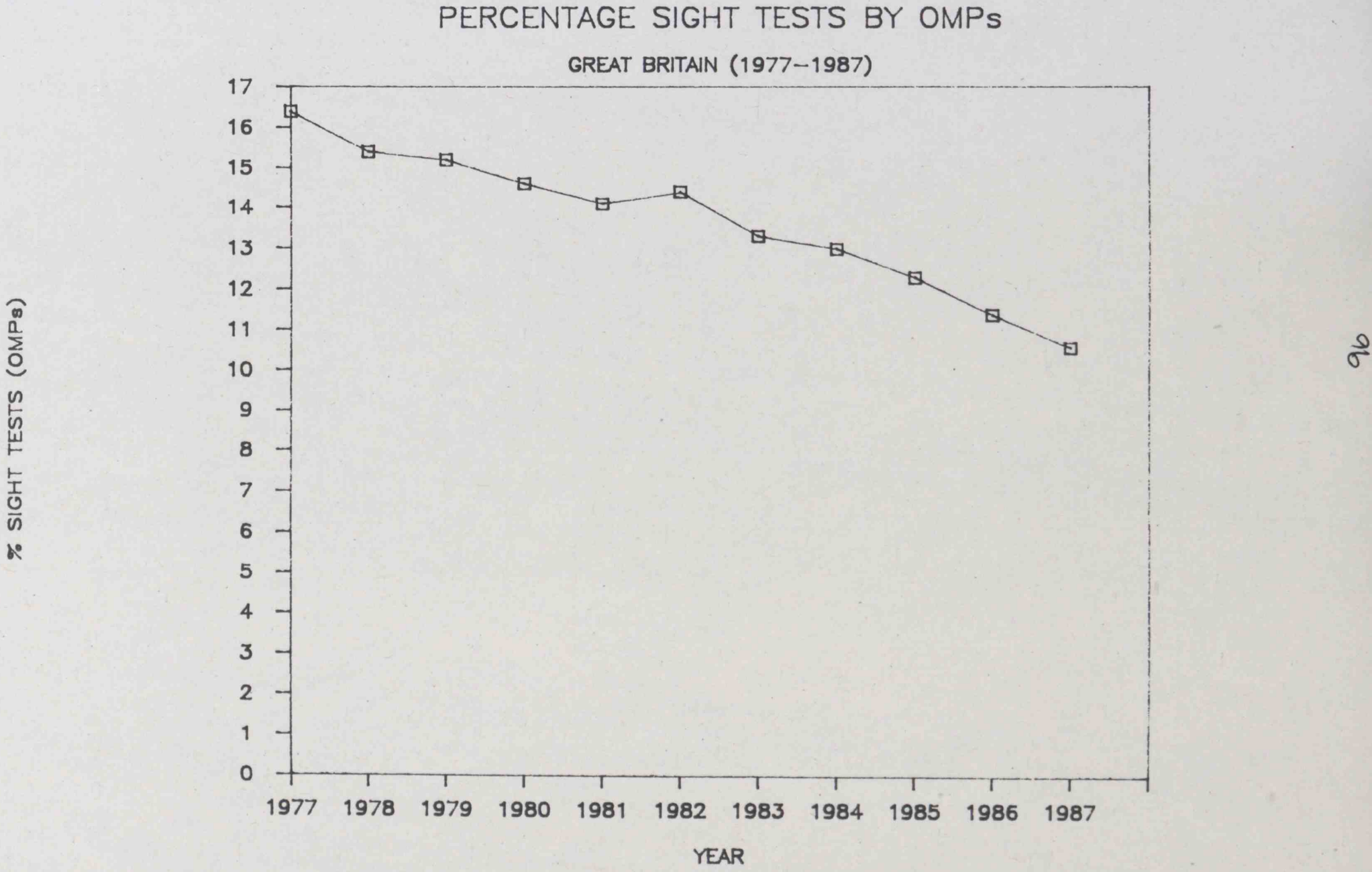
FIGURE 2

ANNEX F2



ANNEX F3

FIGURE 3



SECTION G: COMMUNITY DOCTORS

DOCTORS IN COMMUNITY MEDICINE

Manpower

G.1. In a reversal of the trend in recent years, in the year to 30 September 1987 the establishment of career posts for community physicians in England and Wales rose by 6.9% to 587 but the number in post fell by 3.7% to 494 as a result of which vacancies rose from 6.6% to 15.8%. At the same time the steady rise apparent in recent years in the training grades (SR and registrar), which are still not subject to manpower control in England and Wales, continued with an increase in establishment of 7.8% to 278 but because of an increase in vacancies from 1.9% to 10.1% the number in post remained steady (250 compared to 253 in 1986). Nevertheless, these figures need to be interpreted with caution. Figures presented by the Faculty of Community Medicine to the Public Health Enquiry indicated that there was an extremely high drop-out rate from the training grades. This was variable across Regions and seemed to reflect the quality of training a Region was able to offer and the calibre of trainees they appointed. This is clearly not a problem which can simply be remedied by altering the remuneration of Community Physicians.

Public Health Inquiry

G.2. On 22 July Ministers announced that they accepted the principle advanced in the Report "Public Health in England" of a greater commitment to improving the public health and that they were taking the following steps to carry forward its recommendations:-

G.2.1. Guidance would be issued to health authorities based on the Report's conclusions about their responsibilities to improve the health of the population including the prevention, surveillance and control of communicable disease; and would also ask authorities to arrange for the publication of an annual report on the health of the public to be prepared by their Director of Public Health. A draft circular on these lines has been sent to various professional and NHS groups for comment and it is expected it will be issued formally in the autumn.

G.2.2. The capacity of the Public Health Laboratory Service and the Communicable Disease Surveillance Centre to provide specialist help to health authorities was being strengthened. The Department was also taking forward the Report's recommendations to review the present system, for the notification of communicable diseases and the scope for bringing public health legislation up

to date.

G.2.3. A small multi-discipinary unit within the Department of Health was being set up to monitor and analyse information about the health of the population and to provide an improved epidemiological input at the centre.

G.2.4. Ministers also stated that in the longer term the implementation of this strategy would depend on an adequate supply of appropriate trained manpower. The main professional bodies concerned were therefore being asked to consider and act on those of the Report's recommendations which related to education and training in the public health field.

G.3. The application of the Report outside England is being separately considered by the Health Departments in Scotland, Wales and Northern Ireland. The Scottish Home and Health Department have already issued a circular on Community Medicine (April 1988) (Annex G1).

Community physicians in general management

G.4. The interim arrangements for community physicians appointed as general managers are set out in HC(85)30, at Annex G.1 of our submission of the 16th Review, and continue to operate. Further guidance will be issued on all GMs appointed on a part-time basis, and on those appointed from among community physicians. Meanwhile, community physicians appointed as full-time GMs may opt for the terms established in PM(86)7, at Annex B.3 of our submisson for the 17th Review.

Chief Officer supplements

G.5. As reported to the Review Body in paragraph G.4 of the Departments' 18th Report, the parties reached agreement on the abolition of offsetting Regional Medical Officer supplements against distinction awards. The change was implemented with effect from 1 April 1988.

G.6. The parties were unable to reach agreement on the profession's proposals for replacing the population-banded supplements for DMOs with a flat rate supplement payable to all DMOs.

Trainees in community medicine

G.7. It remains our view that the level of supplement for out-of-hours work is generous in relation to the commitments trainees are expected to undertake, and that it should not be increased.

DOCTORS IN COMMUNITY HEALTH

G.8. The Departments remain of the view previously advanced that the levels of pay for the CMO and SCMO grades are generous in comparison with other non-consultant grades and with gmps. However, we agree with the approach suggested by the Review Body's 18th Report (paragraph 124) that this issue should be considered in the light of the outcome of any changes arising from the White Paper "Promoting Better Health" and discussions following the Public Health Inquiry Report.

ANNEX G

SCOTTISH HOME AND HEALTH DEPARTMENT
St Andrew's House Edinburgh EH1 3DE
Telephone 031-556 8400 ext 244 2264

28 April 1988

Sir Donald Acheson
Chief Medical Officer
Department of Health and
Social Security
Richmond House
79 Whitehall
London

Dear Donald

COMMUNITY MEDICINE IN SCOTLAND

I am now able to enclose a copy of the final version of the above circular which was issued to health boards in Scotland yesterday. It is essentially the same as the draft which I sent to you recently. There have been few very minor improvements in wording here and there but the substance has not been changed.

On paragraph 11, action has already been started informally by the Secretary of the Scottish Council for Postgraduate Medical Education to review postgraduate education and training and I am hopeful that something interesting will emerge from that.

On paragraph 12, we are now taking the first steps to set up a committee to review the establishment in community medicine.

On paragraph 13, we have begun to look within the Department about the implications of setting up a unit on environmental hazards.

Yours sincerely

(I S MACDONALD)
Chief Medical Officer

copy Dr G Crompton, Chief Medical Officer, Welsh Office
Dr J F McKenna, Chief Medical Officer, DHSS (NI)

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NHS Circular No 1988(GEN)15

Your ref

Our ref NJD/1/18

Date 27 April 1988

General Managers of Health Boards
General Manager, Common Services Agency

Dear Sir

COMMUNITY MEDICINE IN SCOTLAND

SUMMARY

1. This circular gives guidance to Health Boards on the role and organisation of the specialty of community medicine in Scotland. It sets out the main areas of work with which community medicine specialists should be concerned and invites Boards to establish a Department of Community Medicine headed by the Chief Administrative Medical Officer. It takes into account comments received on the Discussion Paper on the Future Development of Community Medicine in Scotland issued on 17 July 1986 and the Consultation Paper on the same subject issued on 30 June 1987.

INTRODUCTION

2. An important long-term aim of these proposals is to maintain an effective source of relevant medical knowledge which can be brought to bear in a systematic way upon a range of issues affecting the health of the public. An immediate problem arises from the present age structure in the specialty of community medicine which will lead during the next decade to a diminution in the number of community medicine specialists available to the service. It is therefore important to ensure that essential skills relevant to the role of community medicine specialists are maintained and effectively deployed.

3. The contribution which the medical profession can and should make to public health, using that term in a broad sense, will complement the work of others and enhance the total effort within the present statutory framework. The responsibilities of other professions in safeguarding and improving the health of the public are acknowledged and developments which have taken place in these professions are recognised.

THE RESPONSIBILITIES OF THE SPECIALTY OF COMMUNITY MEDICINE

4. The effective practice of community medicine as a specialty requires, in addition to broad general medical experience, a knowledge of epidemiology, the principles of health promotion and an understanding of how they may be applied to meet the responsibilities of health and other public authorities in discharging their health and health service responsibilities. Community medicine specialists should therefore be equipped to carry a major responsibility for the following functions -

1. Determining and interpreting the health status of the population and the factors which have a bearing upon it.

2. Identifying the requirement for health care as a basis for promoting and planning health service provision; monitoring and improving the efficiency and effectiveness of the service. Liaison with the medical advisory structure and with individual clinical colleagues will be relevant to these functions.

3. Developing information services to provide medical information to assist in determining the health status of the population, and in supporting the planning and management of the service. In Scotland this has implications for Health Boards and for the Common Services Agency.

4. Promoting health by means of health education, vaccination and immunisation, screening services, and preventive measures generally.

5. Identifying outbreaks of communicable diseases and controlling such outbreaks in co-operation with others who have statutory and professional responsibilities in relation to communicable diseases.

6. Identifying the effects on the population of adverse environmental factors and initiating action to control such hazards in co-operation with others who have statutory and professional responsibilities for environmental health.

7. Identifying the needs of special groups in the population such as children, the physically handicapped, the chronic sick, the mentally handicapped, the mentally ill, and the elderly. Liaison with appropriate professional colleagues in statutory and voluntary agencies is important in undertaking this function.

8. In addition to the above, community medicine specialists may be particularly suited to providing advice on medical manpower planning, postgraduate medical education, and the physical planning of health service buildings.

ACTION BY HEALTH BOARDS

5. Each Health Board should establish a Department of Community Medicine, headed by the Chief Administrative Medical Officer who should have authority to ensure that an appropriate range of community medicine skills are developed, maintained and deployed effectively. All community medicine specialists employed by the Board, together with those holding honorary contracts, should be part of the Department of Community Medicine.

6. The position and relationships of medical members of unit management teams, who may or may not be community medicine specialists, remain as described in paragraph 22 of NHS Circular 1986(GEN)20. Those medical members of unit management teams who are community medicine specialists should also be members of the Board's Department of Community Medicine to maintain their identification with their specialty and to enable the Chief Administrative Medical Officer to fulfil his responsibility to ensure that an appropriate range of community medicine skills are developed and deployed effectively.

7. Departments of Community Medicine must have adequate access to epidemiological and other information required to carry out their functions. In larger Boards the employment within Departments of Community Medicine of non-medical staff with expertise in statistics and other relevant subjects should be considered in order to enhance the competence of these departments. Adequate and suitable administrative and clerical support and access to computer resources must be provided.

8. Boards should assign to Departments of Community Medicine responsibilities which take into account the functions of the specialty of community medicine as described in paragraph 4 above. In particular, Departments of Community Medicine will provide medical advice and support to the Board and the General Manager in determining the health care needs of the population and in the planning, provision and management of the health services in the area.

9. The Chief Administrative Medical Officers and Community Medicine Specialists with relevant experience will also provide medical advice on public health matters to district, regional and island authorities. Boards should now consult with local authorities on the medical advice and support from community medicine which it would be appropriate to provide, bearing in mind the requirement in section 13 of the National Health Service (Scotland) Act 1978 for Health Boards, local authorities and education authorities to co-operate with one another to secure and advance the health of the people of Scotland, as well as the specific provision made in section 14 of that Act to make the services of medical officers from Health Boards available to local authorities. A medical officer designated in accordance with section 14 does not, however, have a responsibility to provide a clinical service for local authorities; this is a matter for joint discussion and arrangement between Health Boards and local authorities. Copies of this circular have been sent to the Chief Executives of Regional, District and Islands Councils.

10. The Chief Administrative Medical Officer should be required by the Health Board to provide, normally on an annual basis, regular reports upon the health of the population of the area. Such report should be commentaries on the health of the population drawing attention to changes which are taking place, to factors influencing these changes and to the implications for public services. The Chief Administrative Medical Officer should present his report to the Health Board and should send copies to the local authorities in the area of the Health Board and to the Scottish Home and Health Department. Health Boards are asked to arrange for the preparation of a report for the calendar year 1989 and annually thereafter. The report should be available as soon as possible after the end of each year and not later than 30 June in the following year. The Department believe that there will be advantages in having certain common elements in the report and propose to discuss this with CAMOs.

ACTION BY SCOTTISH COUNCIL FOR POSTGRADUATE MEDICAL EDUCATION

11. The Scottish Council for Postgraduate Medical Education has been asked to undertake, in co-operation with the heads of the University Departments of Community Medicine in Scotland and of the Faculty of Community Medicine, a review of the content of postgraduate education and training in community medicine and of the facilities available. This review will take account not only of the needs for postgraduate medical education in order to obtain specialty qualifications but also the continuing need for postgraduate medical education for specialists in community medicine at later stages in their careers. The Council has been asked to report and to make recommendations within 6 months.

CTION BY SCOTTISH HOME AND HEALTH DEPARTMENT

12. The Scottish Home and Health Department will make arrangements for an early review of the manpower requirements in community medicine with a view to making recommendations on the numbers required in each area and in the CSA and on the consequential training requirement.

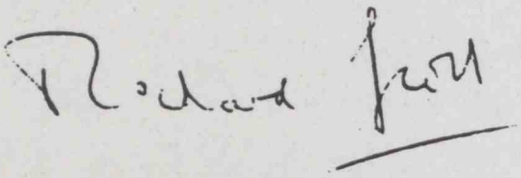
13. The Department will give further consideration, in consultation with appropriate interests, to the proposal in paragraph 10.7 of the consultation paper entitled "The Future Development of Community Medicine in Scotland", circulated on 30 June 1987, that a central unit should be established to build up and make available a high level of expertise in the medical aspects of environmental hazards.

REPORTING BY HEALTH BOARDS ON ACTION TAKEN

14. Health Boards are asked to submit reports to the Scottish Home and Health Department by 30 April 1989 on action taken to implement paragraphs 5 to 10 of this circular.

15. Any enquiries regarding this circular should be directed either to Mr L C Cunning, Room 158, St Andrew's House, Telephone 031-244 2504 or Dr A D McIntyre, Room 20, St Andrew's House, Telephone 031-244 2293.

Yours faithfully



RICHARD SCOTT

SECTION H : COMMUNITY DENTAL SERVICES

H1. This section deals with the remuneration of administrative dental officers, dental staff employed in the community dental service and with trainees in community dental health.

The Health and Medicines Bill

H2. Our last submission outlined the intention to redirect the resources of the community dental service away from the routine examination and provision of treatment for schoolchildren in favour of increased screening, group preventive programmes and providing treatment for children and other groups who experience difficulty in obtaining treatment from general dental practitioners. The Health and Medicines Bill, currently before Parliament, will facilitate these changes. Consultation with the profession on guidance to be issued to Health Authorities about the future role of the service has already taken place. The Health Departments issued draft guidance to HAs on 1 August 1988 (Annex H1) for comment; subject to HAs agreement together with other interested parties, the formal issue of the guidance will be promulgated, once the Bill has been enacted.

Manpower

H3. The overall figures for Great Britain, together with details of the numbers of staff in each grade for England, Wales and Scotland at 30 September 1988 will be presented in Volume II of our evidence.

H4. In England and Wales 128 District Dental Officers (DDOs) and Chief Administrative Dental Officers (CADOs) have been appointed to provide services for 163 Districts (provisional). In Scotland 14 of the 15 Health Boards have a CADO in post.

H5. Of the 166 Districts in England who had the services of a DDO, 85 had made arrangements to share management responsibilities. Similar arrangements applied to 4 of the 9 Districts in Wales. Thus 41 DDOs/CADOs now manage services in more than one district.

Supplement for multi-district responsibility

H6. In its 18th Report, (paragraph 50 Appendix 2) the Review Body recommended that the annual rate of supplement for multi-district responsibilities should be £775 for those officers responsible for 2 districts, and £1,240 for those responsible for 3 or more districts. There has been no change in the duties undertaken by these officers since our last submission. We therefore request that this allowance be up-rated in line with the overall increase in recommended

remuneration.

Specialists in Community Dental Health

H7. 22 posts in England and Wales have been re-designated as specialist posts, and all but two Regions now have manpower approval for a specialist post. Several posts have also been established in Scotland and Wales. Some progress has been made towards the establishment of trainee posts in England. 6 posts have received manpower approval. We understand that only one has to date been filled and there remains scope for further progress in a number of Regions.

H8. Discussions with the profession on the specialty took place at a meeting earlier this year when it was agreed that the interim phase should be brought to a close. We now propose to end the interim arrangements and to delegate to Health Authorities the power to determine their own needs for specialist posts subject to the approval of candidates by the Royal College of Surgeons.

H9. The Health Departments intend to issue a circular of guidance on the future of the specialty to Health Authorities later in the year, following further discussions with the profession. (It may be possible to elaborate further on this in our oral evidence.) Until these discussions have been completed and guidance has been issued, we do not believe that the specialty can be considered comparable with the specialty in community medicine. We therefore consider that the allowance payable to specialists in community dental health should continue unchanged for the time being and that an increase in line with the overall increase in earnings would be appropriate this year.

Community Clinical Dental Service - Payment of Trainers

H10. In its 18th Report (paragraph 52, Appendix 2) the Review Body indicated that the allowance payable to dental officer trainers should be increased to £325. The responsibilities of trainers have remained unchanged while, as in previous years, there have been no apparent difficulties in obtaining dental officers to undertake these duties. We therefore consider that the current allowance is sufficient and do not believe that an increase would be justified this year. The Review Body may, however, wish to note that the Department has established a Sub-Committee of the Committee on Continuing Education and Training for Dental Practice (COCET). The proposed terms of reference are:

> "To make arrangements for the introduction of a national scheme for the post-registration vocational training of new entrant dental officers into the Community Dental Service in England and Wales, to include a part-time off-the job course of training."

This may lead to a review of the role of trainers.

Community Dentists as General Managers

H11. Guidance on the terms and conditions of service of part-time general managers (GMs) remains under consideration. The terms and conditions of full-time GMs drawn from the community dental service will be promulgated at the same time as those for community physicians. In the meantime, community dentists appointed as full-time general managers may continue to opt for the terms established in PM(86)7 (Annex H2).

Job Security

H12. Although four redundancies have occurred in one district health authority the profession continues to enjoy good job security. In their last submission the profession again expressed concern about the threat of widespread redundancies in the community dental service. This has not, however, proved to be the case. Much concern has also been voiced that the changes to the role of the community dental services, outlined in paragraph H2 would be taken as an opportunity by some Health Authorities to make reductions in the level of the service. While we have agreed with the profession that these changes will lead to some overall reduction in the numbers of dental staff in future years, we would expect such reductions to occur primarily through natural wastage. We believe that the service will continue to offer good prospects for well-trained staff.

H13. The increased role of the community dental service in prevention and health education and care for special needs groups will require a greater variety of skills from staff to provide care for a broader range of people. The positive emphasis now being placed on the service, extending its areas of responsibility, will require a new career and salary structure. We hope to begin discussions with the profession on these matters in the near future.

Annex H1

Department of Health and Social Security
Hannibal House Elephant and Castle London SE1 6TE

Telex 883669 Telephone 01-703 6380 ext
GTN (2916)

Your reference

Our reference

Date 1 August 1988

Regional General Managers

Dear Regional General Manager

GUIDANCE ON THE COMMUNITY DENTAL SERVICE

The White Paper on Primary Health Care which was issued towards the end of last year emphasised the Government's commitment to a new role for the Community Dental Service which, at present, focusses mainly on carrying out the Secretary of State's duty to inspect and treat schoolchildren, far greater numbers of whom now receive regular dental care from general dental practitioners compared with when the service was established in 1948. The Health and Medicines Bill, currently before Parliament, will amend Section 5 of the 1977 National Health Service Act so that the resources presently deployed by health authorities in carrying out their duty to schoolchildren - and duplicated by the general dental service - can be switched to other groups and used for other specific functions, such as dental health education.

You may be aware that during the Committee Stage of the Bill in the House of Lords, the Government announced its intention to reconsider its position on replacing the statutory duty to inspect and treat schoolchildren with a power and to bring forward an amendment to the Bill at the Report Stage in the Lords in October that would retain the Secretary of State's duty in this respect, but which would explicitly qualify the circumstances in which it will need to be exercised. The guidance reflects the Government's intentions about the exercise of that duty.

The profession is already aware of the contents of the circular and has agreed its general direction. As it seems unlikely that any amendments made during the Bill's passage through Parliament would seriously alter the thrust of the circular, the Department feels that it would be useful to issue the guidance for consultation now so that it can be issued in its final form as soon as the legislation comes into effect. Indeed, it is written as if the Bill had already been passed.

I hope that this will help to remove the uncertainty which has hung over parts of the service for some time now. The only part of the guidance that is as yet unclear is paragraph 4 which will describe the final form of the legislative changes. You will appreciate that it would be somewhat improper to cover this aspect before the Government has had an opportunity to put down its amendment to the Bill.

I would be grateful to receive the views of your corporate management in the Region down to district level on these proposals by 1 November at the latest. As Family Practitioner Committees will also have an interest in these, they, too, will be consulted over the coming months.

Yours faithfully

P ALLEN

GUIDANCE TO HEALTH AUTHORITIES ON FUTURE DEVELOPMENT OF COMMUNITY DENTAL SERVICES

1. This circular cancels HC(78)14, which extended the remit of the community dental service to the care of people with handicaps.

Summary

2. This circular gives guidance to District Health Authorities on the future development of the community dental services, and outlines the amendments made to the statutory basis of the services in the Health and Medicines Act 1988, and requires health authorities to review their provision of community dental services in line with the proposals set out in the White Paper "Promoting Better Health". These described the continuing valuable role of the community dental service, and pointed to the need to adjust its role to provide services more suited to current needs.

Introduction

3. The White Paper "Promoting Better Health" described how the influences of improvements in childrens' dental health, the fall in the school population, and the increased availability of dental treatment for children through the general dental services have combined to make it necessary to re-examine the objectives of the community dental service. In 1978 district health authorities were given discretion to extend the provision of treatment to the elderly and people with handicaps, two groups which still experience considerable unmet need for treatment. While some health authorities have made positive progress in this respect the continued existence of the statutory duty to inspect and provide treatment for schoolchildren has restricted the ability of many authorities to extend care to these groups, and to re-deploy the resources necessary to meet their needs. The White Paper also set out other functions in the community dental service which needed to be developed, such as the monitoring of levels of dental health and the care of special groups who may have difficulty in receiving treatment in the general dental services.

4. Section 10 of the Health and Medicines Act 1988 amends existing legislation .....

5. The Government believes that each district health authority should in future provide a community dental service with adequate resources to undertake the following tasks:

- planning and monitoring of the dental health of all age groups in the population, jointly with Family Practitioner Committees

- provide dental health education and preventive programmes,

- provide facilities for a full range of treatment to patients who have experienced difficulty in obtaining treatment in the general dental service, or for whom there is evidence that they would not otherwise seek treatment from the general dental service,

- screen the teeth of children in state funded schools at least three times in each child's school life (in areas of poor dental health and where availability of general dental services is poor, such screening may need to be more frequent).

6. Annex A of this circular describes in greater detail the specific aspects which health authorities should examine in order to ensure that their community dental service is capable of fulfilling these objectives. It stresses the need for the community dental service to monitor levels of dental health throughout the population, to identify special needs, to encourage the use of the general dental service, and to provide a safety net service of treatment for those whose needs cannot be met in the general dental service.

7. A key factor in developing and monitoring these strategies, both for screening and for treatment, will be the use of the management information system outlined in the report of the Dental Services Statistics Group*, which sets out the means of setting objectives, defining the target group and the level of coverage of that group, the degree to which the objective is achieved, and the costs of doing so. Implementation of the report has been delayed pending the passing of the legislation on the community dental service. Guidance on the development of the new information system will be issued in time for implementation on 1 April 1990.

Collaboration between the DHA and the FPC

8 Family Practitioner Committees are responsible for the planning and provision of general dental services in their area, but there is a statutory duty for District Health Authorities and FPCs to co-operate with one another. The planning of dental services is an area where the two authorities will need to work in close collaboration in order to develop and maintain effective complementary services

9. The role of the District Dental Officer includes a duty to work with the Family Practitioner Committee and the Local Dental Committee to assist them in promoting adequate and effective general dental services. District Health Authorities and Family Practitioner Committees should ensure that a formal structure is created in each area to develop and keep under regular review the adequacy of the provision of dental care by the two services. This will vary locally, but may make use of existing structures, such as the Local Dental Committee or the Dental Advisory Committee. The two authorities will need to exchange their information on matters such as distribution of manpower, treatment provision, attendance patterns and levels of dental health. The two bodies will also need to undertake consultation on any changes in policy likely to affect the other service. In developing such a structure, health authorities should consider the benefits of consultation with Family Practitioner Committees on the

* "Dental Services Information Requirements" Report of the Dental Services Statistics Group, HMSO, 1987

appointment of district dental officers, who will be responsible to a great extent for ensuring that effective complementary services are developed.

Conclusion

10. Health authorities will need to undertake a thorough review of the objectives and management of the community dental services in their area, in collaboration with the local family practitioner committees to ensure that their service meets the objectives described in Annex A. The Regional review system will include the need to report on progress in this subject.

11. Queries on this circular should be addressed to .....

116

ANNEX A

THE FUTURE ROLE OF THE COMMUNITY DENTAL SERVICE

Dental health education

1. The provision of dental health education aimed at encouraging self care and regular attendance at the dentist should be increased, particularly in those areas where dental attendance is poor. Health authorities should establish policies setting out the target groups for such health education programmes - schoolchildren will be a primary target, but other groups for consideration would include expectant and nursing mothers, pre-school groups, and the elderly, who are often reluctant to seek dental care. The recommendations of the Dental Services Statistics Group will enable health authorities to monitor the effectiveness of these initiatives.

2. The means of conducting health education programmes will need to be considered fully - professional dental staff should be involved in the stage of planning programmes, co-ordinating and training those who will carry out the programmes and monitoring outcomes. They will be less involved in the direct delivery of programmes, where the co-operation of local teachers and professional health educators will be of value. Where resources allow, other programmes may also be instituted - for example in workplaces, which may involve liaison with occupational health services, including, where available, dentists. Such campaigns would require close co-operation with the Local Dental Committee, to ensure that practices are prepared for any increase in demand for their services.

Preventive programmes

3. The need for these programmes must be determined locally, in the light of local levels of dental health. Possible programmes may include initiatives to promote good oral hygiene, or toothbrushing techniques, as well as schemes for fluoride tablets or rinses.

4. The role of the district dental officer in advising the health authority will continue to include a responsibility for considering the benefits and practicability of water fluoridation for the area, and promoting the health authority policy on this matter where appropriate.

Epidemiological surveys

5. Many district health authorities already carry out local surveys of child dental health, which are an important tool in planning dental services. As the need to provide a direct treatment service diminishes, the community dental service will be able to expand its activities in monitoring levels of dental health by such surveys, not only for children, but also for other groups, enabling authorities to target their services more accurately at those in greatest need. Standardisation of such surveys will assist planning at both national and Regional level, and the Department will be discussing with representatives of the community dental service mechanisms for achieving greater consistency in the methodology employed.

6. District health authorities will need to liaise with the family practitioner committees to ensure general dental practitioners are kept informed of their programmes, and appreciate the role of the district dental officer in planning services.

Dental screening

7. Epidemiological surveys as described above will provide an accurate profile of levels of dental health in the district. They are not intended to screen individuals to identify those in need of referral for dental care.

8. District health authorities should review their policy on the dental screening of different client groups. For schoolchildren, their policy should state those ages at which all children should be screened, for example when starting primary and secondary school, and in the year before leaving school. The screening of 8-9 year olds may also be appropriate in

assessing the development of occlusion. The policy should allow for more frequent screening in localities where levels of dental health and attendance are poor, as a means of promoting better dental health. The community dental service does retain the statutory right of access to schools to carry out its activities. In most areas annual screening will no longer be necessary. It would nevertheless be helpful to stimulate demand for treatment by sending an annual reminder to parents about the benefits of regular dental examinations for their children.

9. Health authorities will need to agree, after consultation with Family Practitioner Committees, systems for screening special needs groups, such as people with handicaps, the elderly and children with special educational needs. Local authorities too may assist in identifying groups in need and providing access to residential homes. For the elderly in particular, improved levels of dental care can produce considerable benefits in the quality of life, and screening programmes may assist in informing this group of the services that are available. Screening programmes aimed at for example pre-school children and expectant and nursing mothers may also identify unmet need, and enable the establishment of regular dental attendance patterns.

10. As set out in the Dental Services Statistics Group Report, it will be necessary to define closely the objectives and target groups for screening programmes, in order to be able to evaluate their usefulness at regular intervals.

Referral to the general dental service

11. It is desirable that wherever possible the general dental services should provide care for the whole family, developing a pattern of dental attendance in children that can continue into adult life. If this aim is to be achieved, it can no longer be appropriate that the community dental service should carry out dental screening of all schoolchildren and then offer as a matter of routine to provide treatment for those who are found to have dental disease. This system can mean that some children who could otherwise become regular attenders in general practice instead rely on the

community dental service. There is then the risk that they may fail to attend their dentist on leaving school.

12. Where a patient is found to be in need of dental treatment the aim generally should be to refer the case to a general dental practitioner. The system of referral should be agreed locally by the district dental officer and the local dental committee. Where the patient's family does not already have regular contact with a general dental practitioner, and the case is identified as being suitable for the general dental service, it should be possible to provide the patient, or the parents of the patient, with a manageable shortlist of general dental practitioners willing to provide NHS treatment within reasonable range of the school or home, as appropriate. Such a list would need to be updated regularly, and the FPC's close collaboration would be essential. It is unlikely that the address of the FPC, or a copy of their entire list of practitioners would be sufficient to meet the needs of families unused to attending the dentist.

13. It is essential that arrangements for monitoring the effectiveness of the referral system are agreed before the system comes into being. For example, if a child is in need of treatment and the family does not already attend a dentist, the parents could be asked to identify the practitioner of their choice from a shortlist provided, and the community dental service could then collaborate with the practitioners to find out whether or not treatment is then sought. Alternatively surveys of parents could be carried out to discover the take-up rates of treatment after screening. The district health authority and the family practitioner committee should keep the system under regular review, to ensure that it is effective, and to assess the prospects for increasing the number of children suitable for transfer to general dental practice.

<u>Provision of treatment in the community dental service</u>

14. It is desirable that the general dental practitioner should be the lynch-pin of dental care, as recommended in the report of the Dental Strategy Review Group in 1981*.

* "Towards Better Dental Health - guidelines for the future", Report of the Dental Strategy Review Group, DHSS, 1981

There will however be instances where the community dental service needs to provide a safety-net service of treatment because this prospect is not feasible - for example, adults and children with special needs. This will also be true in some localities where there may be no readily available general dental practitioner, or in some instances the child may not have been taken for treatment despite a referral. In these cases the community dental service should continue to provide a treatment service.

15. Since 1978 the community dental service has made progress in extending the dental care available to adults with handicaps, many of whom have had difficulty in gaining access to a general dental practitioner in the past The district health authority and the family practitioner committee should agree a policy for identifying those groups which have special dental needs, and determining how these needs should be met. For example, it may be necessary to provide domiciliary care for medically compromised patients. Practical problems, such as access to the surgery, may often require that the community dental service become involved in direct provision of treatment. The development of appropriate services may be assisted by collaborating with other organisations responsible for the welfare of the elderly and the disabled. Other members of the health care team will also be able to identify dental need and to notify the community dental service of individuals in need of advice or treatment, or in encouraging the individual to seek dental care. The health authority will also need to consider in its operational plans the dental needs of those in long-stay hospitals, determining as appropriate whether care should be provided by the hospital or the community dental service. This will be particularly relevant where the community dental service at present provides little or no care to hospital patients. In all cases, the appropriate level and source of service for long-term patients would need to be determined locally.

Training of community dental staff

16. When planning the switch of resources from the treatment of children to the screening and treatment of adults with special needs, health authorities will need to assess the training needs of their staff, and develop specific programmes of continuing post-graduate education. It is expected that many officers may need further training. Accordingly health authorities will need to assess the level of resources needed for this purpose.

ANNEX H2

PM(86)7

PERSONNEL MEMORANDUM

DHSS

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities, District Health Authorities, Special Health Authorities for the London Postgraduate Teaching Hospitals — for action

Family Practitioner Committees, Community Health Councils — for information

May 1986

PAY AND CONDITIONS OF SERVICE

GENERAL MANAGERS: ARRANGEMENTS FOR REMUNERATION AND CONDITIONS OF SERVICE

SUMMARY

This Personnel Memorandum (PM) encloses a Direction by the Secretary of State on new arrangements for the remuneration and conditions of service of persons appointed as general managers (GMs) in England and gives guidance on its application.

INTRODUCTION

1. The arrangements in this PM apply to all full-time GMs at region (RGM), district (DGM) and unit (UGM), and to GMs in the Special Health Authorities for the London postgraduate teaching hospitals. Further guidance will be issued on those GMs appointed on a part-time basis and on those appointed from among community physicians and community dentists.

2. GMs have a totally new role in the National Health Service and can be recruited from any discipline within the NHS and outside it. Their pay and conditions of service have not been the subject of negotiation in a Whitley Council nor of consideration by a pay review body.

3. Paragraphs 5 to 11 set out the main features of the new arrangements. Guidance on their implementation is given in paragraphs 12 to 36.

4. The Direction authorising the implementation of remuneration and conditions of service for GMs is contained in Annex 1.

PART 1: ESSENTIALS OF THE NEW ARRANGEMENTS

ROLLING CONTRACTS

5. The Secretary of State re-affirms the guidance given in HC(84)13 that all GMs should be appointed on the basis of short-term contracts. Such contracts may be rolled forward one year at a time where performance is judged satisfactory. It is a condition of application of the new rates of pay notified in this PM that no other NHS contract may be held concurrently.

GRADING

6. A grading structure for GMs has been devised which provides for one grade at region, three at district and five at unit. The district and unit grades are based on revenue and on the presence or absence of teaching responsibilities.

7. GMs will be paid flat-rate salaries. It is considered that the use of incremental scales is not appropriate at this most senior level.

8. Total pay for GMs will consist of:

- *a basic salary* for each post comprising the *grade rate* and, where appropriate, a *discretionary amount* to reflect special local factors, and

- from as early a date as possible, *performance-related pay*, if awarded.

BASIC SALARY

9. On top of the grade rates for RGM, DGM and UGM posts a discretionary amount may be added of up to 5%, 10% and 15% respectively. This enables the rates of pay for individual posts to reflect special local factors not fully reflected in the grade rates.

PERFORMANCE-RELATED PAY

10. A scheme for performance-related pay for GMs will be developed and published as soon as possible. This will be quite separate from and independent of any discretionary addition. Whereas a discretionary addition reflects an assessment of the *weight of the post*, a performance-related element will reflect an assessment of the *performance of the postholder*. The aim is to publish the scheme during 1986, with payments earned becoming due in 1987.

11. The purpose is to reward that performance which is above normal expectations. It will be earned by those GMs whose performance reaches a high standard based on clear, pre-determined and (as far as possible) measurable criteria. The maximum amount of performance-related pay which could be earned has not yet been set, but will be a substantial proportion of the grade rate.

PART 2: IMPLEMENTATION

PAY AND GRADINGS

12. The new pay and grading structure is set out in the Schedule to the Direction at Annex 1. The new rates are effective from 1 February 1986 and should be applied to all GM *posts*, irrespective of the remuneration of the present occupant. (Arrangements for protection are set out in paragraph 18). The pay rates will be reviewed later this year in the light of general movements in NHS pay. Arrangements for adjustments thereafter will be considered following decisions on the introduction of performance-related pay.

ESTABLISHMENT OF BASIC SALARIES

13. A discretionary amount may be added to the grade rate to reflect the different weights attaching to individual posts, as follows:

RGM posts	–	up to 5% of the grade rate
DGM posts	–	up to 10% of the grade rate
UGM posts	–	up to 15% of the grade rate

Discretionary amounts awarded will also be payable from 1 February 1986. For RGM posts the discretionary addition will be determined centrally following consultation with Regional Chairmen. For DGM and UGM posts DHAs should make the initial assessment under the procedure outlined in paragraphs 15–17 below. In doing so, they should take two kinds of factor into account. These are set out at a) and b) below. The illustrations given are not intended to be exhaustive and others may be adduced if they are judged to have a comparable significance:–

a) Factors relating to the extent of change that the GM is expected to achieve in the services provided. For example:

- substantial movements from hospital-based to community-based provision

- substantial capital developments

- substantial closure programmes

- substantial re-locations.

All GMs are expected to achieve change, much of it in the areas listed above. In order to justify any discretionary addition, a post would have to carry an obligation to achieve change to exceptional degree.

b) Factors relating to the inherent difficulty and complexity of the management task to be performed, for example organisational and environmental problems which are not necessarily fully reflected in revenue. Examples of organisational problems at district level are management of an unusually large number of units or the need to operate planning and other links with an unusually large number of local authorities. At unit level they may include an exceptional number of clinical specialties or locations. An example of an environmental problem could be a very high incidence of social problems in the community served by the district or unit.

RENEWAL OF CONTRACTS

24. Decisions on whether or not to renew a DGM's or UGM's contract are matters for the DHA subject to such procedural arrangements as may be laid down by the RHA for use in the region. These arrangements should in any case include the following points:

- no decision to renew a contract may be taken until 24 months before its expiry date
- no contract may be renewed for more than one year at a time
- RHAs should look rigorously at any proposal to renew a DGM's or UGM's contract beyond his or her sixtieth birthday.

25. It is the Department's expectation that a GM's performance will be formally appraised at intervals of not more than one year and that notice of non-renewal will normally be given through this process, but in no case less than 6 months before expiry of the contract.

26. The Department should be consulted when an RHA is proposing to renew an RGM's contract, or to give notice of its non-renewal.

27. All contracts should contain an agreement to exclude claims under Section 54 of the Employment Protection (Consolidation) Act 1978. At no stage should the contract be allowed to run beyond the due date, since this may be held to have created a new contract without limit of time.

CONDITIONS OF SERVICE

28. All contracts entered into as a result of the implementation of the PM should provide that a GM shall be subject to the conditions of service of the Administrative and Clerical Staffs and General Whitley Councils, subject to the following exceptions:—

GWC Handbook	*A & C Handbook*
Sections 45—47 and 74	Section 9: Paragraphs 4312 and 4315 — 4318

29. It is the Department's intention that GMs shall eventually be subject to conditions of service specially designed for senior NHS management. Further guidance on this will be issued in due course.

30. It should be noted that the NHS Superannuation Scheme is not a condition of service for this purpose and is governed by statutory provisions which cannot be modified in individual cases. All GMs are subject to these provisions.

GENERAL PRACTITIONERS

31. In any case of a general practitioner being appointed as a full-time GM, the Department should be consulted before any contract is agreed.

COMMUNITY PHYSICIANS AND COMMUNITY DENTISTS

32. Further guidance will be issued on GMs appointed from among community physicians and community dentists. In advance of this guidance, community physicians and community dentists appointed as full-time GMs may nevertheless choose to accept the arrangements set out in this PM.

LONDON POSTGRADUATE TEACHING HOSPITALS

33. The grade rates of GM posts in the Special Health Authorities for London postgraduate teaching hospitals are also set out in the Schedule to the Direction at Annex 1. These have been determined by reference not only to revenue allocations and teaching responsibilities but with regard to the whole range of SHA responsibilities as compared with those of other health authorities. All responsibilities and duties placed on RHAs by this PM will be exercised, as regards these SHAs, by the Department, which will also determine the amount of any discretionary addition for GMs in these SHAs.

COSTS

34. The cost of the introduction of the general management function, including the salary costs, is to be met within the existing overall provision for management.

INFORMATION ON UGM APPOINTMENTS

35. Until the first round of UGM appointments has been completed, RHAs should continue to send to the Department the same details of appointments as before.

14. The factors at (a) above are considered to be more significant than those at (b) and should therefore account for two-thirds of any discretionary element awarded. In this respect, it is the Secretary of State's firm intention that the full range of the discretionary addition should be used in the districts and units in each region. He would expect, for example, that some districts and units in each grade will be awarded no discretionary addition, and that, for the remainder, the full range up to the permitted maximum will be used.

15. It is the responsibility of the RHA to give guidance within the region on how the discretionary addition should be assessed. The Department will not wish to suggest in what way any individual post should be assessed but will wish to be informed, in advance of any commitment to pay, of the precise addition recommended for each district and for each unit. The Department's function in this respect will be to monitor the use to which this discretion is put in the country as a whole. Since the addition relates to the post and not to the postholder there is no reason why the assessment should not be made immediately for all GM posts, whether or not filled.

16. The size of the discretionary addition for a particular post is not immutable. The factors on which it is assessed will change over time. The amount of the addition should therefore be reviewed whenever there is a change of GM; whenever there are significant changes in responsibilities as a result of organisational changes (eg amalgamation of units); or, if there is no such change during that period, every 5 years. However, a reduction in the discretionary addition should take place only on a change of GM.

17. The DHA should submit to the RHA proposals for the discretionary addition for its DGM and UGM posts. Once the RHA has endorsed them it should send a return showing the proposed discretionary addition for every DGM and UGM post in the region to the Department (HAP 2, Room 10, Hannibal House) on the proforma attached at Annex 2. The Department will either agree to these proposals, or comment on them, within a week of receipt. The RHA should approach the Department if in the future it wishes to make any change in the percentage addition for any DGM or UGM post.

PROTECTION OF EXISTING REMUNERATION

18. A GM should receive protection of existing remuneration where:

- he or she has been appointed under the interim arrangements with a level of remuneration higher than the basic salary (see paragraph 8), or

- he or she is appointed from within the NHS after the date of this PM, and has a level of remuneration which immediately prior to appointment as GM was higher than the basic salary (as in paragraph 8). A GM moving from one GM post to another GM post will not be eligible for protection of salary, unless his first appointment as GM was itself on a protected salary.

Protection should extend only to actual remuneration paid at the date of this PM (or, if later, date of appointment) and not to a scale of remuneration. The amounts protected will be reviewed by the Secretary of State from time to time. In the case of a full-time GM who was a consultant with a distinction award, this award should be disregarded in applying the provisions of this PM. (Paragraphs A6 and B6 of the model contract at Annex 3 set out how this calculation should be made).

19. Any proposal to pay rates other than those allowed in this PM should be referred to the Department in the usual way.

SHORT-TERM ROLLING CONTRACTS

20. All GMs should be employed on short-term rolling contracts, initially of between 3 and 5 years. A model of a suitable contract is set out in Annex 3. No other NHS contract may be held concurrently with a full-time GM contract, other than as described in paragraph 21.

21. A GM already in post may, if he wishes, retain a contract pre-dating his first appointment as GM. If he so chooses, he will not be entitled to receive the pay authorised in this PM nor will he be eligible for performance-related pay when this is introduced. In those circumstances he will continue to be paid on the basis authorised on behalf of the Secretary of State under the interim arrangements and his existing GM contract shall not be renewed after expiry.

22. Any other full-time GM will be required to resign from any other NHS contract before the rates of pay in this PM may apply. He may do this at any time from now until 28 days after publication of the results of the 1986 pay review referred to in paragraph 12, in which case the rates of pay set out in this PM (including any discretionary addition) will apply from 1 February 1986, or date of appointment as GM if this is later. If the option is exercised at a date beyond that time limit, the new rates of pay shall apply from that date.

23. If it is necessary to draw up an entirely new contract to reflect the provisions of this PM, then the expiry date should be the same as that in the interim contract which it replaces, subject to the possibility of rolling on (see paragraph 24).

NOTIFICATION TO GMs

36. RHAs should ensure that the contents of this PM are drawn to the attention of all full-time GMs and that the contractual options are fully explained.

ENQUIRIES

37. Written enquiries on the implementation of these arrangements should be addressed, via the RHA, to the Assistant Secretary, HAP 2, Hannibal House. Urgent enquiries relating to the process of recruitment may be made on extensions 3933 and 3934.

FURTHER GUIDANCE

38. Further guidance will be issued on:

- part-time GMs (paragraph 1)
- community physicians and community dentists appointed as full-time GMs (paragraphs 1 and 32)
- arrangements for performance-related pay (paragraph 10).

From:

Health Authority Personnel Division 2
Hannibal House
Elephant and Castle
LONDON
SE1 6TE

Tel. 01-703 6380

GMA/16

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DIRECTION

The Secretary of State for Social Services, in exercise of powers conferred on him by paragraph 10(1) of Schedule 5 to the National Health Service Act 1977, hereby gives the following Direction:—

1. This Direction is addressed to Regional Health Authorities, District Health Authorities, and Special Health Authorities listed in Table B in the Schedule to this Direction.

2. Any person appointed as full-time General Manager, on or after the date of this Direction shall, subject to paragraphs 3 to 6 below, be remunerated in accordance with the tables ("the Tables") set out in the Schedule to this Direction.

3. Where a General Manager is remunerated in accordance with the Tables a discretionary amount, as provided for in the relevant Notes in the Tables, may be added to the grade rate to reflect special local factors.

4. (1) Where —

(a) a person is appointed as full-time General Manager on or after the date of this Direction, and

(b) the employment immediately preceding that appointment was by a health authority and satisfies the conditions specified in sub-paragraph (2) below, and

(c) the annual rate of remuneration, exclusive of any distinction award, being paid to him immediately preceding that appointment as General Manager ("the old rate") was greater than that payable under paragraphs 2 and 3 of this Direction for that appointment,

he may continue to be paid at the old rate.

(2) The conditions referred to in sub-paragraph (1)(b) above are that

(a) the immediately preceding employment was an employment otherwise than as a General Manager under this Direction, or

(b) the General Manager's first appointment as a General Manager under this Direction was one to which this paragraph applied.

5. (1) A General Manager who —

(a) has been employed by a health authority under any employment which commenced before the date of this Direction, and

(b) resigns that employment at any time within the period from the date of this Direction until 28 days after the date in 1986 on which the Secretary of State publishes the results of his review of the remuneration payable under this Direction, in order to be employed in the same post in accordance with the provisions of this Direction,

shall, if his net remuneration, exclusive of any distinction award, during the relevant period was less than that which he would have received during that period under paragraphs 2 and 3 of this Direction, be paid an amount representing the difference.

(2) In sub-paragraph (1) above "the relevant period" means the period beginning —

(a) in the case of a General Manager appointed on or before 1 February 1986, on 1 February 1986;

(b) in the case of a General Manager appointed after 1 February 1986, on the date of his initial appointment as General Manager;

and ending with the date of the resignation referred to in sub-paragraph (1)(b) above.

6. Any person appointed as full-time General Manager on or after the date of this Direction shall in addition to the remuneration payable to him under paragraphs 2 and 3 or 4 (as the case may be) above, be paid an annual amount equivalent to the annual amount of any distinction award being paid to him under any immediately preceding employment with a health authority.

7. The following conditions of service shall be applied to any person appointed as full-time General Manager on or after the date of this Direction.

The Conditions of Service of the Administrative and Clerical Staffs and General Whitley Councils, subject to these exceptions:

(i) in section 9 of the Administrative and Clerical Staffs Council Conditions of Service, paragraphs 4312 and 4315-4318;

(ii) in the General Whitley Council Conditions of Service, sections 45, 46, 47 and 74.

Signed by authority of
the Secretary of State
for Social Services

29 May 1986

B A R SMITH
Assistant Secretary

EXPLANATORY NOTE

(This Note is not part of the Direction)

This Direction authorises new arrangements for the salary and conditions of service of full-time General Managers employed in the National Health Service in England. It applies to persons in post at the date of the Direction provided that they hold no other National Health Service contract and to persons subsequently appointed to such a post.

PM(86)7
ANNEX 2

IN CONFIDENCE

REGION: _____

All districts and all units should be included on this form

Name of District	Designation of Unit	Revenue	Teaching/Non-Teaching	Grade (e.g. DGM2, UGM4 etc)	Proposed Discretionary Addition	
					£	%

MODEL CONTRACT (Full-time posts)

Post of Regional/District/Unit General Manager, ... Health Authority

With effect on . . . . . you resigned your contract dated . . . . . as . . . . . with the . . . . . Health Authority.

TENURE

1. The appointment is for a period of [3/4/5] years beginning on . . . . . and terminating on . . . . . .

2. Your performance will be reviewed at intervals of not more than one year. This assessment will also be used in connection with any scheme of performance-related pay which is introduced at a future date.

3. The contract will be reviewed 24 months before its expiry and may be renewed then and at subsequent annual reviews on the basis of yearly fixed-term contracts. If the contract is not to be renewed, you will be so notified in writing at least 6 months prior to the expiry of the then existing contract.

UNFAIR DISMISSAL

4. You are required to agree in writing to exclude any right, under Section 54 of the Employment Protection (Consolidation) Act 1978, to claim unfair dismissal in respect of a termination which consists only of the expiry of your fixed-term contract without its being renewed.

REMUNERATION

5. Your post will be graded [ ] within the grading structure for General Managers, set out in the schedule to the Secretary of State's Direction dated . . . . . 1986.

EITHER

A6. Your remuneration will be £ . . . . . , paid monthly in arrears at 1/12th of the annual rate by bank credit. [This includes [a discretionary addition of . . . . . per cent of the basic grade rate] [a sum of £ . . . . . being the equivalent of the value of the distinction award which you previously held].] [No discretionary addition will be payable]. The remuneration is subject to variation from time to time in accordance with Directions given by the Secretary of State.

OR

B6. The annual rate of remuneration attaching to it is currently £ . . . . . [including a discretionary addition of . . . . per cent of the basic grade rate]. This rate is subject to variation from time to time in accordance with Directions given by the Secretary of State. However the annual rate of remuneration which you received under your contract with . . . . . Health Authority immediately preceding this contract was £ . . . . . [excluding distinction award] [and excluding London Weighting]. You will continue to be paid at that rate on a mark time basis until the annual rate of remuneration, as varied from time to time in accordance with Directions given by the Secretary of State, for this post exceeds it. [You will also be paid a sum of £ . . . . . being the equivalent of the value of the distinction award which you previously held]. You will be paid monthly in arrears at 1/12th of the annual rate by bank credit.

7. The post is superannuable and your remuneration will be subject to deduction of superannuation contributions in accordance with the National Health Service Superannuation Scheme.

CONDITIONS OF SERVICE

8. The conditions of service other than remuneration applicable to this post are those of the General Whitley Council and the Administrative and Clerical Staffs Whitley Council, as varied from time to time, but excluding:–

> Sections 45, 46, 47 and 74 of the General Whitley Council Conditions of Service, and Section 9, paragraphs 4312 and 4315 to 4318 of the Administrative and Clerical Staffs Whitley Council Conditions of Service.

These conditions of service are set out in the handbooks, copies of which are available for inspection at . . . . . .

OUTSIDE EMPLOYMENT AND FINANCIAL INTERESTS

9. You may not, without the consent of the Authority, engage in any outside employment, and you must declare to the Authority any financial interest or relationship you may have which may affect the Authority's policies or decisions.

LOCAL CONDITIONS OF SERVICE

10. The post is also subject to locally agreed conditions of service [and health authority policies] dealing with:—

disciplinary procedures and rules

grievance procedures

retirement age

. . . . . .

. . . . . .

Copies of these conditions [and policies] are available for inspection at . . . . . .

LOCATION

11. Your headquarters will be . . . . . but you may be required by the HA to work anywhere determined by the duties of the post.

CONTINUOUS EMPLOYMENT

12. For the purposes of the Whitley Council conditions of service applying to this post, continuous employment dates from . . . . . .

13. For the purposes of the Employment Protection (Consolidation) Act 1978, continuous employment dates from . . . . . .

NOTICE TO TERMINATE EMPLOYMENT

14. The period of notice required from either party to terminate this contract before the expiry of the fixed term is . . . . . but this is not taken to prevent either party waiving the right to notice, or from accepting payment in lieu of notice. Nor does it affect the right of either party to terminate the contract without notice by reason of the conduct of the other party.

15. A copy of the job description of your post is attached.

Signed

Chairman

Dated

I, ... , hereby accept the terms of the contract set out above. I agree to exclude my right to any claim under Section 54 of the Employment Protection (Consolidation) Act 1978 in respect of the termination of this contract which consists only of the expiry of the fixed term without its being renewed.

I accept that this contract replaces any existing contract I may have with a health authority.

Signed

Dated

SCHEDULE

TABLES OF REMUNERATION

TABLE A: REGIONAL AND DISTRICT HEALTH AUTHORITIES

	GRADING CRITERIA		*GRADE*	*GRADE RATE* [3]
	Teaching or Non-teaching [1]	Revenue [2]		
REGION	–	–	RGM	£33,200
DISTRICT	Teaching Non-teaching	£45mn or more £60mn or more	DGM 1	£31,600
	Teaching Non-teaching	£45mn or less £30mn to £60mn	DGM 2	£30,200
	Non-teaching	£30mn or less	DGM 3	£28,800
UNIT	Teaching	£20mn or more	UGM 1	£26,400
	Teaching Non-teaching	£10mn to £20mn £15mn or more	UGM 2	£24,100
	Teaching Non-teaching	£5mn to £10mn £10mn to £15mn	UGM 3	£21,700
	Teaching Non-teaching	£5mn or less £3mn to £10mn	UGM 4	£18,900
	Non-teaching	£3mn or less	UGM 5	£15,600

NOTES:

1. "Teaching district" means one currently designated as such for the purposes of negotiations in Whitley Councils. "Teaching unit" means a unit in which a university clinical department is based.

2. "Revenue" means the annual revenue budget for the financial year 1985/86 or, in the case of a new unit, an estimate of the annual revenue budget for that financial year.

3. For any RGM, DGM or UGM grade post, a discretionary amount of up to 5%, 10% and 15% respectively of the grade rate may be added to reflect special local factors.

TABLE B: SPECIAL HEALTH AUTHORITIES

SPECIAL HEALTH AUTHORITY	*GRADE RATE*
Hammersmith and Queen Charlotte's SHA	£30,200
B of G of the Hospitals for Sick Children B of G of the National Hospitals for Nervous Diseases B of G of Moorfields Eye Hospital Bethlem Royal Hospital and Maudsley Hospital HA B of G of the National Heart and Chest Hospitals B of G of the Royal Marsden Hospital	£28,800
B of G of the Eastman Dental Hospital	£24,100

NOTES:

1. A discretionary amount of up to 10% of the grade rate may be added to the above grade rates.

2. Where a unit general manager (UGM) is appointed, his grade rate shall be determined in accordance with Part A of this Schedule as though he were employed by a District Health Authority; and a discretionary amount of up to 15% may be added to his grade rate to reflect special local factors.

SECRET AND PERSONAL 2a-b

FILE DA

10 DOWNING STREET

LONDON SW1A 2AA

Copy also filed on ~~NEB~~ ECON POL: TSRB pt 10

From the Private Secretary

SIR ROBIN BUTLER

1989 PAY REVIEW BODY REPORTS

The Prime Minister had a brief discussion with the Chancellor of the Exchequer this afternoon about the main recommendations of the Pay Review Bodies as reported to you by Mr. Covington.

On the substance, both the Prime Minister and the Chancellor expressed serious concern about the recommendations on doctors and dentists. They would like serious consideration to be given to options for scaling down the award. Possibilities they discussed were:

(i) awarding doctors and dentists no more than nurses;

(ii) agreeing the additional £1,000 to the top of the consultants scale only if this was contained within an overall 8% settlement;

(iii) not agreeing to the proposed £1,000 on the top of the consultants scale, on the basis that in the NHS Review White Paper extra resources were being signalled for adding to the numbers of consultants posts.

Although the Prime Minister and Chancellor were initially minded to favour the last of these options, I think it would be sensible if the Cabinet Office could prepare a range of options for Ministers' consideration.

There was no discussion of possible amendments to the size of the settlement proposed by the other pay review bodies.

There was also discussion of the handling of the reports. The Prime Minister and Chancellor noted that one possibility, subject to the TSRB Report being delivered by 27 January at the latest, would be to aim for publication of the five review body reports on Thursday 2 February. But they recognised that this would involve publication - and the announcement of the Government's decisions on the review body reports - before the Government was in a position to respond to the Chilver Report on Teachers' Pay; and indeed possibly before Lord Chilver had delivered his report to the Government. Considerable attraction was therefore seen in the alternative approach of delaying publication of the review body reports until the Government was in a position also to announce its conclusions

b

on the Chilver Report. It was noted that this was likely to mean delaying publication and announcement until Thursday 16 February. Such an approach was also likely to require pressure to be exerted on Lord Chilver to deliver his report to Government at the latest by the end of the first week of February.

The Prime Minister would be grateful if you could take these thoughts about handling into account in your meeting with Permanent Secretaries later this week.

I am also attaching to this minute a copy of the full DDRB Report, which has just arrived.

I am copying this minute and the DDRB Report to Richard Wilson (Cabinet Office). Perhaps your office could let me know when you would like to circulate copies to other departments.

PAUL G.

(PAUL GRAY)

11 January 1989

CONFIDENTIAL

FWE
DA

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

11 January 1989

Dear Andy,

PRIVATE MEMBER'S (LORDS) BILL: JUNIOR HOSPITAL DOCTORS (REGULATION OF HOURS) BILL

The Prime Minister has seen your Secretary of State's letter of 5 January to the Lord President. She has commented that there is no need to take a decision yet on whether the Bill should be opposed if it reaches the Second Reading Debate in the Commons. She thinks that the Bill may be very charged if it gets to the Commons.

I am copying this letter to the Private Secretaries to members of (L) Committee and to Trevor Woolley (Cabinet Office).

Composition

Lord President of the Council (Chairman)
Lord Chancellor
Secretary of State for Wales
Secretary of State for Scotland
Lord Privy Seal
Attorney General
Lord Advocate
Parliamentary Secretary, Treasury
Minister of State, Foreign and Commonwealth Office (Mrs Lynda Chalker)
Financial Secretary, Treasury
Minister of State, Home Office (Mr John Patten)
Captain of the Gentlemen-at-Arms

Andy McKeon, Esq.,
Department of Health.

CONFIDENTIAL

CONFIDENTIAL

FWE
DA

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

11 January 1989

Dear Andy,

PRIVATE MEMBER'S (LORDS) BILL: JUNIOR HOSPITAL DOCTORS (REGULATION OF HOURS) BILL

The Prime Minister has seen your Secretary of State's letter of 5 January to the Lord President. She has commented that there is no need to take a decision yet on whether the Bill should be opposed if it reaches the Second Reading Debate in the Commons. She thinks that the Bill may be very charged if it gets to the Commons.

I am copying this letter to the Private Secretaries to members of (L) Committee and to Trevor Woolley (Cabinet Office).

Yours,
Paul

(PAUL GRAY)

Andy McKeon, Esq.,
Department of Health.

CONFIDENTIAL

0423A

RESTRICTED

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ XXXXXXXXXX Health

Prime Minister
Cabinet for the Bill to be blocked at Second Reading in the Commons?

The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

5 January 1989

No need to take a decision on this yet. The Bill may be very changed when it gets to our House

Dear John.

PRIVATE MEMBER'S (LORDS) BILL: JUNIOR HOSPITAL DOCTORS (REGULATION OF HOURS) BILL

Introduction

The attached Bill was introduced by Lord Rea on 15 December. It seeks to limit with effect from 1 January 1992 the hours a junior hospital doctor should work or be available for work to no more than 72 hours in any one working week, averaged over a one-month period. The Bill also provides that the Secretary of State may by order reduce the working hours in stages from 72 hours to 60 hours. I understand the Bill may receive its Second Reading on 25 January.

Background

Junior hospital doctors contract for a basic working week of 40 hours, or 10 basic units of medical time (UMTs). Hours over 40 are contracted at UMT rates which vary between 30 and 38% of the basic rate depending upon the grade of doctor. Average weekly contracted hours for all grades are approximately 85. Not all this time is spent working, as opposed to being available in hospital or at home should the need arise. Average hours spent actually working are 57, ranging from 46.4 in psychiatry to 66.9 in general surgery. The Doctors' and Dentists' Review Body has priced basic and additional UMT's so as to deliver what it judges to be a fair total salary having regard to average hours of work and duty.

Junior Doctors' hours of duty fell from an average 91.3 in 1976 to 87.7 in 1982. A Government initiative in 1982 was a major factor in a further reduction of hours to an average of 85.7 in 1986. Despite this progress, a survey carried out by the Department of Health in 1987 identified a significant number of junior doctors whose commitments were undesirably heavy and, in June 1988, the Government in agreement with the medical profession announced a new scheme

E.B.

whereby local professional working parties would be set up in each District Health Authority to advise on the elimination, wherever possible, of regular rota commitments which require a junior doctor to be on duty, on average, more than 1 night and weekend in 3. This initiative is being carried forward in conjunction with a systematic review to assess the number of medical staff required in each Region to provide essential support for consultants in the acute specialties. Regional Health Authorities have been asked for full reports by October 1989. We are committed to the objectives of this initiative and are determined that further progress should be made in reducing excessive hours of duty. Accordingly we have asked for progress reports from authorities before the Bill's Second Reading in the Lords and, if necessary, will press for further action in the light of these.

There is every chance that the Bill will receive a sympathetic hearing in the Lords. Despite the reductions in average hours of work, occasional concern is expressed both in Parliament and in the media about long hours of work and associated stress and fatigue. If progress on the Bill is not blocked during its passage through the Lords, I believe that we should seek to do so when it reaches Second Readng in the Commons and for the following reasons:

a. The Government's initiative announced last June must be given an opportunity to work.

b. The hours of work of junior hospital doctors cannot - and should not - be determined centrally. Hours of work and rota commitments can only sensibly be worked out locally. They are influenced by a number of factors: specialty, training needs, the organisation of hospital services locally, the needs of individual consultants and, last but certainly not least, the need to ensure satisfactory medical cover for patients throughout the year.

c. Using unconventional staffing arrangements, it might be possible to reduce weekly hours to 72 hours without many additional staff; but this would not be acceptable clinically to the vast majority of consultants and we believe many junior doctors themselves. On the alternative assumption of conventional medical staffing arrangements, we estimate that, to meet the proposed statutory requirements by 1 January 1992, a further 3000 Senior House Officers would be required at an approximate gross cost of £60 million per annum in salaries alone. (It is also likely that junior doctors would press to retain existing salary levels even after a significant reduction in hours). But it would not be possible, of course, to produce extra junior medical staff overnight and something in the order of 1000 additional medical students would be required to "fill the gap". Because neither solution is practicable in the short-term, a theoretical alternative might be to freeze all new consultant appointments for a period of, say, 4 years to ensure that a higher proportion of junior medical staff remained in those grades. That would not be acceptable to the profession at large, including the junior doctors.

F.R.

d. The main thrust of "Achieving a Balance" published in 1987 in agreement with professional and health authority interests, was to improve the present hospital medical staffing structure. At present, there are in order of 10,000 Senior House Officers and 6500 Registrars. To increase the number of Senior House Officers by 3000 would affect severely the career structure and career prospects of junior doctors. It would completely undermine everything the Government has agreed with the profession to improve the career structure.

e. It is most unlikely that such a significant reduction in hours as proposed by Lord Rea would be received sympathetically by either the hospital consultants or, perhaps, the Royal Colleges. The ability of juniors to gain the necessary experience in all types of situations could be affected adversely.

CONCLUSIONS

Clearly, the Government would not wish to appear to be unsympathetic to hard-working junior doctors and the stresses associated with their duties. But, for the reasons I have given above, I propose, subject to your and colleagues' agreement, that the Bill is opposed as and when it reaches a Second Reading debate in the Commons.

I am sending a copy of this letter to the Prime Minister and members of "L" Committee.

KENNETH CLARKE

A

B I L L

INTITULED

An Act to regulate the hours worked by Junior Hospital Doctors. A.D. 1988.

BE IT ENACTED by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

Hours worked by junior hospital doctors.

1. Subject to sections 2 and 3 below, a junior hospital doctor shall not be required after 1st January 1992 to work or be available for work for more than 72 hours in any one working week, averaged over a one-month period.

Progressive reduction to 60 hours.

2. The Secretary of State may by order reduce the working hours specified in section 1 above in stages to 60 hours.

Exceptions to ss. 1 and 2.

3. Sections 1 and 2 above shall not apply in the event of—

(a) a state of emergency proclaimed by Her Majesty under section 1(1) of the Emergency Powers Act 1920; or 1920 c. 55.

(b) a major accident procedure or its equivalent being put into operation.

Modifications etc.

4. On the application of a Health Authority or a Health Board, the Secretary of State may by order make modifications or adaptations of sections 1 and 2 above for individual cases in exceptional circumstances.

Reports.

5. The Secretary of State shall monitor the implementation of sections 1 to 4 above and shall submit a report to Parliament before 1st February in each year.

Orders.

6. The power to make an order under sections 2 and 4 above shall be exercisable by statutory instrument which shall be subject to annulment in pursuance of a resolution of either House of Parliament.

Interpretation.

7. In this Act—

"hospital" has the meaning assigned to it by section 128 of the National Health Service Act 1977; 1977 c. 49.

"junior hospital doctor" means a registered medical practitioner who is employed in a hospital as a house officer or a senior house officer or a registrar;

"working week" means seven consecutive days beginning with a Sunday.

Short title and commencement.

8.—(1) This Act may be cited as the Junior Hospital Doctors (Regulation of Hours) Act 1989.

(2) This Act shall come into force on 1st January 1990.

Junior Hospital Doctors (Regulation of Hours) Bill [H.L.]

A

B I L L

INTITULED

An Act to regulate the hours worked by Junior Hospital Doctors.

The Lord Rea

Ordered to be Printed, 15th December 1988

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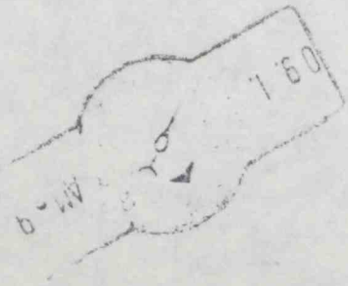

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bc: Policy Unit

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

10 October 1988

Dear Geoffrey,

CONSULTANTS' CONTRACTS

Thank you for your letter of 5 October, which the Prime Minister has now seen. She has commented that the two alternatives to consider are either to abolish paragraph 190 of the Terms and Conditions in return for a longer automatic period of notice, or to speed up the paragraph 190 process.

I am sending a copy of this letter, and yours, to Richard Wilson (Cabinet Office).

Yours,

Paul

PAUL GRAY

D.D. 2y

Geoffrey Podger, Esq.
Department of Health

DD

RG 7139p

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

Prime Minister

No immediate action, but you may want to come back to this at the next NHS review meeting.

5 October 1988

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON SW1

Dear Paul, The answer would be to abolish 190 in return for a longer automatic period of notice. RRG

I understand that at the meeting before last of the Ministerial Group, the Prime Minister expressed some surprise that consultants' contracts were terminable on only three months' notice as she would have expected six months in line with the Law of Master and Servant. My Secretary of State has now had a chance to look into this and has asked me to write to you.

Or to speed up the 190 process

The minimum period of notice for NHS consultants is set at three months by the Terms and Conditions of Service of Hospital Medical and Dental Staff; these Terms and Conditions are the result of negotiations between the Department and the profession. In practice, Health Authorities have some latitude in the terms of employment which are agreed with consultants. However, the recommended form of contract which health authorities are expected to follow provides for three months notice and as far as we know, health authorities use this contract in every case. There is no pressure from the profession for NHS consultants' contracts to provide for a longer period although provision for a period of six months might well be generally regarded as reasonable in the private sector.

The main justification for keeping the period of notice to three months in the case of NHS consultants is the very considerable additional protection against losing their jobs which is conferred on them by paragraph 190 of the Terms and Conditions. This paragraph entitles an NHS consultant who is facing dismissal to apply to the Secretary of State for a decision (to confirm the dismissal or order reinstatement), which cannot be given until a very high-powered professional committee has looked into the case and made its recommendations: the paragraph 190 procedure inevitably takes many months (sometimes over a year) to complete, during which time the NHS consultants' contract continues.

So long as paragraph 190 protection exists, the Secretary of State would be very reluctant to see the minimum period of notice for NHS consultants lengthened beyond the three months which the profession has accepted and still accepts as reasonable.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

05. X.
PM 8 6

JH/A2/63

SECRETARY OF STATE FOR EMPLOYMENT

Caxton House Tothill Street London SW1H 9NF

5803

Telephone Direct Line 01-273 .....
Switchboard 01-273 3000 Telex 915564
GTN Code 273 Facsimile 01-273 5124

The Rt Hon Kenneth Clarke QC MP
Department of Health
Richmond House
79 Whitehall
LONDON
SW1A 2NS

October 3

Dear Ken,

GOVERNMENT EVIDENCE TO REVIEW BODIES: NURSES AND DOCTORS AND DENTISTS

I have seen the evidence to these Review Bodies which you and David Mellor circulated with your letters of 27 September and the responses from John Major and the Prime Minister.

In the current situation of rapidly rising earnings it is more than ever important that we should argue for real moderation in pay, especially in those cases where Government itself has a direct input. The awards of the Review Bodies will be significant both in themselves and also in their influence on the whole climate of expectations affecting negoitators generally. The fact that we are bringing forward the reporting and announcement dates of the awards this year will of course strengthen that effect.

I hope the case can be expressed unambiguously in the terms of the evidence and during the oral evidence stage.

I am copying this letter to the Prime Minister, John Major, David Mellor, Wyn Roberts, Michael Forsyth, Richard Needham, and to Sir Robin Butler.

Yours ever,

NORMAN FOWLER

CONFIDENTIAL

Cite SRW
CCBS

Copy filed in
NAT HEALTH
Nurses Pay pt 4

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

3 October 1988

Dear Geoffrey,

GOVERNMENT EVIDENCE TO THE NPRB AND THE DDRB

Thank you for your letter of 30 September.

The Prime Minister is content for the revised formulation proposed by your Secretary of State to be used in relation to the NPRB. She has commented however that in further discussions - particularly when oral evidence is given to the Review Body - it will be important to stress that "maintenance" of remuneration levels should be judged by reference to the average position over the last year, not the year on year RPI figure in the last few months of 1988.

I am copying this letter to the recipients of yours.

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health.

CONFIDENTIAL

CONFIDENTIAL

TF/0429t

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

CEPO

Copy filed on NAT HEALTH. Nurses Pay pt 4

Prime Minister
This is the response to your talk with Mr. Clarke (earlier paper below). 30 September 1985
Content with this word blender
Formulation for the key phrase?

PRCG
3/9

Yes NR

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON SW1

Dear Paul,

GOVERNMENT EVIDENCE TO THE NPRB AND THE DDRB

file with PG

Thank you for your letter of 29 September.

X1

My Secretary of State now proposes that the formulation referred to in paragraph 2 of your letter in relation to the NPRB should read 'the Health Departments conclude that the existing remuneration levels should be maintained'. I understand that this has the agreement of the Chancellor of the Exchequer.

I should be grateful to know if the Prime Minister is content with this formulation.

I am copying this letter to Carys Evans (Chief Secretary's Office), Clive Norris (Department of Employment), Ceri Thomas (Minister of State's Office, Welsh Office), David Binnie (Parliamentary Under-Secretary of State's Office, Scottish Office), Catrione Garrett (Parliamentary Under-Secretary of State's Office, Northern Ireland Office) and to Trevor Woolley (Cabinet Office).

Yours sincerely,

Geoffrey Podger

N.B. Whether the RPI figure is maintained? The average increase over the year as a whole?

NR

G J F PODGER
Private Secretary

cst.ps/1jm30.9./let

CONFIDENTIAL

cc PK.

MBPM
RREC
30/9

Treasury Chambers, Parliament Street, SW1P 3AG

David Mellor Esq
Minister for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

30 September 1988

Dear Minister,

GOVERNMENT EVIDENCE TO THE DOCTORS AND DENTISTS' REVIEW BODY

at flap.

Thank you for your letter of 27 September and the Draft Evidence to the Doctors and Dentists Review Body attached to it.

I am of course content with the line that there should be no real increase in remuneration levels. This must be right. But in the conclusion in paragraph A27 it is undermined by saying that the profession's rewards should reflect their responsibilities and career expectations. This could be used to justify hefty increases despite the absence of any recruitment and retention problems - indeed, arguably we already have too many doctors. The last sentence of the paragraph should therefore be amended to read "The Government recognises the importance of rewarding the professions adequately but in the light of the evidence we have submitted, particularly on the very satisfactory state of recruitment and retention, we believe that there is no need for any increase in remuneration in real terms." I also consider that given the brevity of Section A the general economic evidence has too much prominence. It would be appropriate to delete paragraphs A5, A6, A10, and A11 in order to highlight our main message. Finally, I would be grateful if, as in previous years, our officials could discuss the briefing for the oral evidence beforehand.

I am copying this letter to the Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham and to Sir Robin Butler.

Yours sincerely,

P. Walker

pp **JOHN MAJOR**

[Approved by the Chief Secretary and signed on his behalf.]

NAT HEALTH: Doctors pay pt 4.

CONFIDENTIAL

Me MJ

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

COPIED TO:

NAT HEALTH: Nurses Pay PT4

29 September 1988

Dear Geoffrey,

GOVERNMENT EVIDENCE TO THE NURSES' PAY REVIEW BODY AND THE DOCTORS' AND DENTISTS' REVIEW BODY

The Prime Minister has seen your Secretary of State's letter to the Chief Secretary of 27 September and the enclosed draft evidence on nurses' pay together with the Minister for Health's letter of the same date enclosing draft evidence on doctors' and dentists' pay. The Prime Minister had a brief discussion with your Secretary of State about this correspondence earlier today.

The Prime Minister said that she was content with the proposal for the Government evidence on nurses' pay to be published. But she was most concerned about the line taken in the draft. It was essential to emphasise the need to exert downward pressure on pay settlements, and make clear that the future prosperity of nurses as well as other groups depended critically on this. Against this background the Prime Minister did not accept it would be appropriate to use the formulation "there is no need this year for any further substantial increase in real- terms for remuneration levels"; this would give much too loose a signal.

Your Secretary of State agreed to consider the matter further and to propose an alternative formulation.

I am copying this letter to Carys Evans (Chief Secretary's Office), Clive Norris (Department of Employment), Ceri Thomas (Minister of State's Office, Welsh Office), David Binnie (Parliamentary Under-Secretary of State's Office, Scottish Office), Catrione Garrett (Parliamentary Under-Secretary of State's Office, Northern Ireland Office) and to Trevor Woolley (Cabinet Office).

Yours,
Paul.

Paul Gray

Geoffrey Podger Esq
Department of Health

CONFIDENTIAL

PRIME MINISTER 1

COPIED TO:
NAT HEALTH: Nurses Pay PTH

GOVERNMENT EVIDENCE TO THE NURSES' AND THE DOCTORS' AND DENTISTS' REVIEW BODIES

You will recall the decision earlier this year to speed up the timetable for the reports of the Pay Review Bodies, so that decisions can be taken and announced comfortably before the beginning of the financial year. A necessary consequence is that the Government's evidence to the Review Bodies has to be submitted much earlier. Department of Health Ministers have now prepared their proposals:

(1) At flag A Mr. Clarke has circulated draft evidence to the Nurses' Review Body.

(2) At flag B Mr. Mellor has circulated draft evidence to the Doctors' and Dentists' Review Body.

They are seeking comments on an extremely tight timetable - by tomorrow - so that they are in a position to submit evidence at the end of this week.

There are, however, some important points on this you will want to consider carefully.

Level of general pay increases

Mr. Clarke proposes that, for the nurses, the crucial phrase should be "there is no need this year for any further substantial increase in real-terms remuneration levels" (see paragraph 1.6 of the draft evidence). But in the case of doctors and dentists Mr. Mellor proposes as the key phrase "there is no need for any further increase in real-terms remuneration levels" (see paragraph A-3).

The difference is the proposed inclusion of "substantial" in the case of the nurses. The background to this is that DOH officials, having consulted the Treasury, advised Mr. Clarke not to include the word "substantial". But he has declined to accept that advice, and he seeks to justify his proposed approach in the covering letter.

You will want to consider his arguments. Frankly, I find them most unconvincing - and all the more surprising, given Mr. Clarke's commendably robust line on pay in his last job. We must bear in mind that the year on year rate of increase in the RPI when the Review Bodies are considering their recommendations is likely to be well over 6 per cent - and possibly as much as 7 per cent. So giving the message that the Government is prepared to contemplate some degree of further real increase in pay is an open invitation to the Nurses' Review Body to propose, say, 8-9 per cent. Since they are also inclined to add something to what they think the Government would readily accept, this would almost certainly pave the way for another recommendation in double figures.

There is also the question whether it makes sense for the Government to be making different recommendations about general pay levels for nurses and for doctors and dentists.

You will want to consider whether to press for Government evidence urging general pay increases below the RPI. Possible arguments would be the lower level of TPI and the distorting effect of mortgage payments on the RPI. But this could be pushing things too far. Perhaps it is best for you to insist that, both for nurses and for doctors and dentists, the general line should be "no need for any increase in real-terms". I gather this is the line the Treasury will take.

Mr. Clarke may have a point about the presentational difficulties of the past use of the word "modest". But it is bizarre that, despite his comments in his covering letter, in paragraph 2.4 of the draft nurses' evidence the phrase "modest

pay increases" is once again used! Paragraph 2.4 is clearly inconsistent with paragraph 1.6. In any event, this problem is easily got round simply by omitting the word "modest" from the words in paragraph A.9 of the doctors' and dentists' document; and then using the same formula for nurses.

Publication of evidence

In the past, evidence to both these Review Bodies has not been published. But you will recall the tendency for the evidence on nurses to leak. So Mr. Clarke proposes this year that the evidence on nurses should be published, while Mr. Mellor proposes sticking to the established practice of non-publication in the case of doctors and dentists.

This inconsistency is a bit odd, but arguably could be defended. You will want to consider whether, as long as it is properly drafted, there are the presentational advantages in publishing the nurses' document that Mr. Clarke puts forward in his letter. I gather the Treasury support this idea.

Further restructuring in pay arrangements

Paragraphs 4.1-4.4 and 5.1-5.2 of the nurses' document report the state of play on negotiations for rationalising the payment of supplements for staff in London, and for reviewing the structure of senior nursing grades not included in this year's clinical grading restructuring. In both these areas the progress achieved by DOH is disappointing. It is probably now too late to do much more before the Review Body starts work. But you may want to stress to DOH the importance of early progress - and the need to ensure we have no replay next year on this year's presentational muddle and disaster over the costing of the restructuring proposals.

You may also want to ask about the timetable for submitting evidence on the professions allied to medicine, which Mr. Clarke says (second sentence of covering letter) is limited to the continuing negotiations on restructuring.

Detailed points

There are two further areas where the nurses' and doctors' and dentists' documents are inconsistent.

(1) Paragraph A.10 of the doctors and dentists and 2.11 of the nurses. The last sentence of the latter carries the unfortunate implication that the Government would be happy if earnings' growth was only one per cent lower than it is. It would be much better to substitute the wording in the doctors and dentists paragraph referring to "every" percentage point reduction.

(2) Paragraphs A.4 of the doctors and dentists and 2.1 of the nurses. The last sentence of the latter refers to "the objective of a balanced budget". It would be much better to standardise on the words "prudent fiscal stance" in the doctors and dentists paragraph.

Conclusion

Content:

(1) To insist that the word "substantial" should be removed from the nurses' evidence; and to suggest that any problem with "modest" can be overcome simply by omitting that word from the relevant sentences?

(2) For the nurses' evidence, as amended, to be published?

(3) To urge DOH to make rapid progress on the London supplement and senior nursing grades restructuring exercises; and to avoid further muddles both here and in the restructuring exercise for professions allied to medicine?

(4) To make the detailed comments on the two minor points above?

PAUL GRAY

28 September 1988

PM3ACA

SD/6847p

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Minister for Health

Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
London SW1P 3AG

27 SEP 1988

Dear John

GOVERNMENT EVIDENCE TO THE DOCTORS' AND DENTISTS' REVIEW BODY

I enclose a draft of the Government's evidence on Doctors' and Dentists' pay for this year's Review Body round. I am afraid we are already later than we or the Review Body would have wished in submitting this evidence to them and it would be helpful to have your agreement by 29 September so that the evidence can go forward.

As you know, for the first time we intend to publish the evidence to the Nurses' and PAMs' Pay Review Body. Evidence to the Doctors' and Dentists' Review Body has not, by convention been made public until after the Review Body has reported. We have not previously experienced any difficulty in keeping the evidence confidential even after the two parties have exchanged evidence and we do not, therefore, wish to change the arrangements.

A copy of this letter and of the draft evidence goes to the Prime Minister, Normal Fowler, Wyn Roberts, Michael Forsyth, Richard Needham and Sir Robin Butler.

DAVID MELLOR

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

21 April 1988

Dear Sir Graham

Thank you for your letter of 6 April and for the Eighteenth Report of the Review Body on Doctors' and Dentists' Remuneration.

As you know, I announced today the Government's full acceptance of the recommendations, which will be implemented from 1 April 1988.

I am grateful to you and your colleagues for the time and effort which you have put into this important work. I should be glad if you would pass on my thanks to the other members of the Review Body.

Yours sincerely

Margaret Thatcher

Sir Graham Wilkins

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 01-405 5944

CONFIDENTIAL

The Rt Hon Margaret Thatcher MP
10 Downing Street
London SW1

6 April 1988

Dear Prime Minister,

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

I enclose the Eighteenth Report of the Review Body on Doctors' and Dentists' Remuneration. This contains our recommendations on the levels of remuneration we consider to be appropriate at 1 April 1988 and sets out the factors we considered were of particular importance when reaching our conclusions.

Yours Sincerely

GRAHAM WILKINS, CHAIRMAN
REVIEW BODY ON DOCTORS'
AND DENTISTS' REMUNERATION

Nat Health - D + D Pay
Pre

PRIME MINISTER

NEW HOSPITAL STAFF GRADE

You agreed last month the Review Body's recommendations on the proposed new hospital staff grade and the arrangements for a PQ and publication of the report. The report has now been printed and DHSS propose making the announcement next week. Could you please sign the letter to Sir Graham Wilkins for despatch on Monday and approved the PQ for Tuesday.

PAUL GRAY

5 February 1988

10 DOWNING STREET

Mr. Addison

See Widdys' minute of this. MEA 4/2

NEW HOSPITAL STAFF GRADE

1. See Dodge's letter of 14 December.

2. He now proposes the arranged PQ announcement on 9 February, with the letter to Williams on 8 February. Can Parliamentary please make the arrangements for the PQ please, in conjunction with DHSS? I will happily sort out the letter if you like.

RRCG
4/2

FILE
DA

bc BG
MEA

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

11 January 1988

Dear Geoffrey,

You wrote to David Norgrove on 14 December concerning the DDRB's report on the new Hospital Staff Grade. The Prime Minister is content with the recommended salary scale and for an arranged PQ in her name. She thinks however it would be preferable for the DDRB document to be published rather than simply placed in the library.

In the light of this the second sentence of the PQ Answer should perhaps be changed to "The report has been published." and the draft letter for the Prime Minister to send to Sir Graham Wilkins should be amended by deleting the last paragraph and adding to the first paragraph "The report is being published tomorrow.".

I should be grateful if you could advise me of the date on which the DDRB report will be published so that we can make the necessary arrangements for writing to Sir Graham Wilkins and arrange the PQ.

I am copying this letter to Alex Allan (HM Treasury), Jon Shortridge (Welsh Office), Nick Wilson (Department of Employment), David Crawley (Scottish Office) and Trevor Woolley (Cabinet Office).

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

Prime Minister

Are you content:

(1) With the scale? Yes

(2) With the PQ in your name? Yes

(3) With the publicity arrangements? Yes

(4) With the draft letter to Sir Graham Wilkins?

PRC6 Yes MR

8/1

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

David Norgrove Esq
Private Secretary
10 Downing Street
LONDON
SW1A 5AA

14 December 1987

Dear David,

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION (DDRB)

Thank you for your letter of 20 November covering the DDRB's report on the new Hospital Staff Grade.

On the substance, the grade is a key element in the package of reforms of the hospital medical staffing structure - "Achieving a Balance" - which our Ministers announced on 27 October. We are keen to press ahead with its introduction so that the first appointees can be in place by next April if possible. The salary scale recommended by the DDRB (£13,720 to £20,470) so closely matches our prior informal understanding with the profession as to an appropriate rate (£14,000 - £20,000) that we see no real difficulty on our side or theirs in accepting it. (1)

On handling, we suggest an inspired PQ - draft enclosed. Any press inquiries could be directed here, and we would produce our own notice and briefing. The annex to Sir Graham's letter could properly be regarded as a supplement to the 1987 Report, and published as such now. You may however feel that in view of its limited scope, it will suffice to make copies available in the Library. (2) (3) Yes No — NB I gather there are no precedents for handling supplementary mid-year reports. PRC6.

The profession have not seen the report and, unless I hear from you to the contrary, we would propose to notify them of the recommendations shortly before the announcement is made. I am also enclosing a draft acknowledgement to Sir Graham Wilkins. (4) The DDRB have done well. They received a substnatial volume of evidence on 16 October, cross-examined us and the BMA about it on 19 November and produced a report the next day.

Yours ever

I am copying this letter and enclosures to Trevor Woolley (Cabinet Office), Alex Allan (Chancellor's Office), Jon Shortridge (Welsh Office), David Crawley (Scottish Office) and Nick Wilson (Department of Employment).

Yours sincerely,

Geoffrey Podger

G J F Podger
Private Secretary

DRAFT PQ AND ANSWER

Q. To ask the Prime Minister if she will make a statement on the latest report by the Review Body on Doctors' and Dentists' remuneration.

A. I have received the Review Body's report on the proposed new Hospital Staff Grade. Copies are available from the Library. The Government is grateful to the Chairman and members for the speed and thoroughness of their deliberations. The salary scale they have recommended is from £13,720 progressing by 6 equal increments to £20,470. The Government proposes to accept the Review Body's recommendation. There will be further discussions with the profession's representatives to finalise detailed arrangements with the aim of introducing the new grade in the Spring ~~next year~~.

~~The report~~ Just now has been published.

which is being published this ~~afternoon~~. Copies will be available in the Vote Office.

DRAFT : PRIME MINISTER TO SIR GRAHAM WILKINS (CHAIRMAN DDRB)

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

Many thanks for your letter of 20 November covering the Review Body's recommendations on the proposed new Hospital Staff Grade. I am most grateful to you and your members for considering and reporting on a substantial volume of evidence in such a brief period. I am pleased to tell you ~~and I have announced today~~, that the Government ~~proposes to accept~~ your recommendations, subject to further discussions with the profession s' representatives on detailed arrangements for the introduction of the grade.

I note your intention to append your recommendations to your next report. I have meanwhile, decided to make copies of the annex to your letter available to the Press and public, via the Health Departments.

NAT HEALTH: Doc + Dentist pay pt 4

PRCG Can we spk pl. MEA 5/1

MB Rodgers to … the pl … PM.

10 DOWNING STREET

MEA

DDRB

Could you arrange for the question to be laid and for the letter to go after the recess please?

DGW.
18/12

CF.

PL of on 5/1

Mark
File as requested.
Keith 5/1

Covering CONFIDENTIAL

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

20 November 1987

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

I enclose a letter to the Prime Minister from the Chairman of the Review Body on Doctors' and Dentists' Remuneration. Could you please provide a draft reply for the Prime Minister's signature, cleared with the Treasury, and other Departments as necessary. I should also be grateful for advice on the manner and timing of announcement.

I am copying this letter and enclosure to Jill Rutter (Chief Secretary's Office).

DAVID NORGROVE

Geoffrey Podger, Esq.,
Department of Health and Social Security

Covering CONFIDENTIAL

CONFIDENTIAL

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 01-405 5944

The Rt Hon Margaret Thatcher MP
10 Downing Street
London SW1

20 November 1987

Dear Prime Minister

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

We have considered evidence from the professions and the health departments on the new hospital staff grade. The attached annex summarises the evidence put to us, and contains our recommendations on the levels of remuneration we consider appropriate for the grade from 1 April 1987.

I am transmitting our recommendations under cover of a letter, rather than in a formal report, in the interests of speed. It is our intention to append these recommendations to our next full report.

Yours sincerely

Graham Wilkins

GRAHAM WILKINS
Chairman
Review Body on Doctors' and
Dentists' Remuneration

CONFIDENTIAL

DDRB(87)66

20 November 1987

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

RECOMMENDATIONS ON THE NEW STAFF GRADE

1. Attached is a copy of the Chairman's letter sent to the Prime Minister today and containing the Review Body's recommendations on the staff grade.

2. The letter will remain confidential until the Government publishes its contents. If members are approached by the media they should, as for the main reports, decline to be drawn into any comment about it. They may wish to refer enquirers to Pat Carty, on 405 5944 ext 370, or Barry Mercer on ext 378.

3. We will inform members as soon as we learn of any Government action on the letter.

OFFICE OF MANPOWER ECONOMICS

CONFIDENTIAL

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 01-405 5944

The Rt Hon Margaret Thatcher MP
10 Downing Street
London SW1

20 November 1987

Dear Prime Minister

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

We have considered evidence from the professions and the health departments on the new hospital staff grade. The attached annex summarises the evidence put to us, and contains our recommendations on the levels of remuneration we consider appropriate for the grade from 1 April 1987.

I am transmitting our recommendations under cover of a letter, rather than in a formal report, in the interests of speed. It is our intention to append these recommendations to our next full report.

Yours sincerely

Graham Wilkins

GRAHAM WILKINS
Chairman
Review Body on Doctors' and
Dentists' Remuneration

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ANNEX

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

THE NEW HOSPITAL STAFF GRADE

1. We have recently received joint written evidence from the Health Departments and the professions on a new grade - to be called the "Staff" grade - and have taken oral evidence from both parties separately. The proposal to introduce a new hospital intermediate grade was included in the consultative document, "Hospital Medical Staffing - Achieving a Balance", which was issued by the DHSS in July 1986 on behalf of the Health Departments, Joint Consultants Committee and Chairmen of Regional Health Authorities*. We are now in a position to recommend an appropriate salary structure for the staff grade, at rates effective from 1 April 1987.

2. The parties have described the main purpose of the grade as contributing to the support available to consultants at an intermediate level of experience so as to offset, in part, expected reductions in Registrar posts and to reduce reliance on unplanned clinical assistant appointments. The grade is intended to provide a satisfactory hospital career for those practitioners unable or unwilling to complete higher specialist training. The posts will be offered in any specialty, but particularly in specialties with recruitment difficulties, or where reductions in the training grades are expected, or where reliance on multi-session clinical assistants is high. It is intended that practitioners in the grade will spend substantially the whole of their contracted time working, on-call duties being minimal.

3. The parties have agreed that staff grade contracts should be for 4 hour sessions and that basic salary should relate to a minimum average commitment of 10 such sessions, with a liability to deputise for certain absences and undertake additional duties in exceptional circumstances. Contracts may specify 3 regular additional sessions and, exceptionally, one temporary additional session. Time off in lieu, or where this is impracticable, the

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*The proposal was referred to in our Seventeenth Report (Cm 127), paragraph 42.

CONFIDENTIAL

equivalent of one session at locum rates, will be granted for cover outside normal contracted hours. The maximum possible remuneration would therefore relate to an exceptional commitment of 60 hours, equivalent to 15 sessions.

4. The parties state that the minimum entry requirement to the staff grade will be 3 years' service in the Senior House Officer grade with training in the relevant specialty. Practitioners on appointment will be expected to be capable of tasks carried out by experienced Senior House Officers or first-year Registrars. More experienced entrants will be paid higher up the incremental scale. It is intended that continuing education will be available to enable practitioners in the grade to update and improve their skills with a reasonable prospect, for those suitably qualified, of being regraded to Associate Specialist. Exceptionally, where a practitioner wishes to compete to re-enter a training grade, he or she will be entitled to salary protection if successful.

5. We have been asked to recommend a basic annual salary relating to a 10 session commitment, together with locum rates per session and per week related to the mid-point of the basic scale. The parties suggest that a scale comprising a minimum and 6 incremental points should reward the varying levels of experience encompassed by the grade. They suggest that the minimum point of the scale might be the second incremental point of the Registrar scale and the maximum point approximately the mid-point of the Associate Specialist scale.

6. The parties' suggestions are made on the grounds that a scale minimum higher than the pay that a Senior House Officer with 3 years' service would receive in basic salary on promotion to Registrar is justified because the staff grade is different from a training grade in terms of tenure, career expectations and duties; and that a scale maximum around the mid-point of the Associate Specialist scale is justified because the Associate Specialist will generally undertake more specialised procedures and work with less supervision from a consultant. They wish the staff grade scale to be sufficient to retain the commitment of those in the grade until retirement and to provide a reasonable reward for the practitioners whose other commitments limit them to the basic salary. At the same time, they do not want the maximum possible earnings for the grade to distort seriously current internal relativities between hospital doctors.

7. We have considered all the evidence presented to us and have noted the intentions and expectations of the parties. The evidence suggests that there can be no certainty in predicting the impact of the new staff grade on the profession, particularly on those in the other intermediate grades. We therefore attach importance to the need to monitor the situation closely to ensure that introduction of the new grade has no unforeseen consequences on intake, morale and career prospects.

8. We are particularly concerned about the relativities between the staff grade and the Associate Specialist grade where 13 sessions or more are worked by the staff grade practitioner. At this level of commitment, the staff grade practitioner's level of remuneration compared with that of the Associate Specialist might give rise to potential detrimental effects on morale and promotion incentives. The limited scheme agreed by the parties to allow the Associate Specialist to re-grade to a staff grade practitioner where it is financially advantageous, might not, in our view, solve all the problems. However, we note that the parties have agreed to further talks on the terms of service of the Associate Specialist grade in the near future.

9. Accordingly we recommend a salary scale which in our judgement and on the basis of the available information represents an appropriate level of remuneration for the staff grade. Our recommended scale, which is to be effective from 1 April 1987, is as follows:-

£
20,470
19,345
18,220
17,095
15,970
14,845
13,720

10. We recommend that locum rates per session and per week are related to the mid point of the basic scale. Thus the recommended rates are £32.85 per session and £328.50 per week.

20 November 1987

PM87

CONFIDENTIAL

Review Body -

file CL3Bw2

cc DHSS

10 DOWNING STREET

LONDON SW1A 2AA

THE PRIME MINISTER

27 April 1987

Dear Sir Graham

I am writing to thank you and your colleagues for the seventeenth Report of the Review Body for Doctors and Dentists. I am most grateful for the hard work and careful consideration which clearly went into their preparation.

As you know, I announced on 23 April the Government's acceptance of your recommendations and our decision to implement them in full with effect from 1 April.

Yours sincerely

Margaret Thatcher

Sir Graham Wilkins

DTS.

Seen by DRM

OFFICE OF MANPOWER ECONOMICS
22 KINGSWAY
LONDON WC2B 6JY

Telephone 01-405 5944

CONFIDENTIAL

The Rt Hon Margaret Thatcher MP
10 Downing Street
London SW1

10 April 1987

Dear Prime Minister

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

I enclose the Seventeenth Report of the Review Body on Doctors' and Dentists' Remuneration. This contains our recommendations on the levels of remuneration we consider to be appropriate at 1 April 1987 and sets out the factors we considered were of particular importance when reaching our conclusions.

Yours Sincerely

Graham Wilkins

GRAHAM WILKINS, CHAIRMAN
REVIEW BODY ON DOCTORS'
AND DENTISTS' REMUNERATION

PERSONAL AND CONFIDENTIAL

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

10 April 1987

DOCTORS' AND DENTISTS' REVIEW BODY

I enclose a copy of the 1987 report of the Doctors' and Dentists' Review Body. I should be grateful if you could confine sight of this to your Secretary of State, the Permanent Secretary and the Principal Finance Officer and if Alex Allan and Trevor Woolley, to whom I am also sending copies of the report, could give it a similarly restricted circulation.

(David Norgrove)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

PERSONAL AND CONFIDENTIAL

010
copied to other subject files.

Prime Minister
I shall arrange a meeting for 22 April.
DLS 9/4.

Ref. A087/1058

MR NORGROVE

Difficult ms

Review Body Recommendations

The recommendations of the Review Bodies, all to take effect from 1 April 1987, are or will be as follows:

Top Salaries

Increase of 4.8 per cent on existing paybill.

Armed Forces

Increase of 5.96 per cent on existing paybill: increases varying from 4.0 to 7.0 per cent for individual ranks.

Doctors and Dentists

Increase of 7.7 per cent on existing paybill:

General medical practitioners	7.0 per cent
General dental practitioners	7.0 per cent
Hospital and community doctors	8.25 per cent

Nurses and Midwives

Increase of 9.5 per cent on existing paybill:
based explicitly and strictly on arguments of recruitment and retention;
ranging from 5 per cent for first and second year learners to 11.0 to 12.7 per cent for staff nurses.

Professions Allied to Medicine

Increase of 9.1 per cent on existing paybill:
ranging from 6 per cent to 12.6 per cent for individual groups.

2. I shall be discussing these recommendations with the Permanent Secretaries concerned in the next twenty four hours, with a view to the preparation of a note which could be circulated to Ministers

directly concerned for a meeting on Wednesday 22 April and thereafter consideration by Cabinet and announcement on Thursday 23 April.

3. I understand that you will be responsible for arranging printing. We have two of the reports; the DDRB Report should reach us tomorrow or Monday; the Nurses and Midwives and PAM Reports on Wednesday or Thursday of next week.

RA

ROBERT ARMSTRONG

9 April 1987

PRIME MINISTER

John Sparrow has refused to be a member of the DDRB. Cabinet Office will have to find another name.

I attach a short letter for you to send to John Sparrow.

NIGEL WICKS

7 November 1986

original with Appts.

46 NEW BROAD STREET
LONDON EC2M 1NB
01-256 7500

From: Sir JOHN SPARROW

6th November 1986

R7/11

Rt.Hon. Mrs Margaret Thatcher, MP
10 Downing Street
London SW1A 2AA

Dear Margaret,

Your letter of 4th November, inviting me to serve as a member of the new body on Doctors' and Dentists' Remuneration, puts me in some difficulty.

I am very willing indeed to help in any way in which I can be of real use. I do however think that it would be a mistake to accept an invitation to do something which I am not convinced that I would do particularly well, a difficulty that is compounded by my feeling that remuneration is very much a matter for management rather than for external adjudicators. Time is obviously a factor, but it would be dishonest of me to pretend that that was in the forefront of my thinking, because I am quite sure that I could find time to do things to which I am more obviously suited. But, feeling as I do, I hope that you will accept that I would prefer not to be a party to this review body, as indeed was my feeling when Robert Armstrong approached me with a somewhat similar proposition a year or so ago.

Although I have been silent for some considerable time, I have continued to follow public affairs with very considerable interest and I am delighted that you are still set firmly on the broad course that you have set yourself. I am sure that that will be rewarded in due course.

It was very good to hear from you again.

Yours sincerely,

John.

DCA

cc CO CCAPPTS

10 DOWNING STREET

LONDON SW1A 2AA

THE PRIME MINISTER

4 November 1986

Dear John,

I am writing to ask whether you would be willing to serve as a member of the Review Body on Doctors' and Dentists' Remuneration.

As you will probably be aware, this Body is one of the three original pay review bodies set up in 1971 to advise the Government on the remuneration of various groups. The other two are the Top Salaries Review Body and the Armed Forces Review Body, to which the Nurses', Midwives' and Professions Allied to Medicine Review Body was added in 1983. The Review Body on Doctors' and Dentists' Remuneration has the task of advising the Prime Minister on the remuneration of doctors and dentists taking any part in the National Health Service. The present Chairman is Sir Graham Wilkins.

The appointment is unpaid, although members are able to claim travelling and similar expenses, and would be for a period of three reviews. It has been the practice for the Review Body to undertake annual reviews, which are usually conducted between December and March, with a report submitted to the Prime Minister by 1 April. It is, however, open to the professions or the Government to approach the Review Body at any time and, exceptionally, a supplementary report may be required. Meetings are normally infrequent except during the period when a report is being produced,

SH

when they average about one or two a week. Every effort is made to fit in with the competing demands on members' time.

Sir Graham Wilkins has suggested that if you are prepared to consider taking on this task you might like to have a word with him first to find out what is involved. He can be reached via Mr. Nick Covington, the Director of the Office of Manpower Economics, which provides the Secretariat to the Review Bodies (telephone number: 01-405-5944).

I realise that there are many heavy calls upon your time, but I hope very much that you will feel able to accept the appointment. Considerable importance is attached to the work of the Review Body and I am sure that you would be able to make a valuable contribution to the success of its operation.

It would be helpful to have your reply as early as possible.

Yours ever

Margaret

Sir John Sparrow

3

ORIGINAL WITH APPTS

Prime Minister

letter attached for signature to go to Sir John Sparrow.

N.L.W.

Ref. A086/3117

PRIME MINISTER

Review Body on Doctors' and Dentists' Remuneration: Appointment of Member

This submission seeks your agreement to the appointment of a new member of this Review Body, whose terms of reference are:

3.11

"To advise the Prime Minister on the remuneration of doctors and dentists taking any part in the NHS."

The new member would replace Sir Graham Wilkins, who has been appointed the Chairman. Annex A shows the current membership.

2. I should like to recommend the appointment of Sir John Sparrow. You will remember that he was among the names considered for the chairmanship, and you felt that, before he was considered for the chairmanship, he should be tried out as a member. We now have the opportunity to do this. It is proposed that he should be appointed for the usual term of three years in the first instance. Health Ministers endorse this recommendation, and Sir Graham Wilkins and the medical and dental associations would support it.

Flag A

3. Draft letters of invitation and confirmation are at Annexes B and C respectively.

RA

ROBERT ARMSTRONG

3 November 1986

PART 3 ends:-

PM to SIR R. CLARK 29/5/86.

PART 4 begins:-

RTB to PM (A0816/3117) 3/11/86

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