Memorandum of Evidence to the Review Body on Doctors’ and Dentists’ Remuneration

December 2017
Response to 2017 Recommendations and Overarching Position

- For many years, the BMA has participated in the annual process run by the DDRB and has signed up to the principle of review being carried out by an independent body. Furthermore, the BMA highly values the expertise of the DDRB and believes this combination of expertise and independence is essential if a fair assessment of doctors’ and dentists’ remuneration is to take place. However, relatively recent government interference in the process has put undue pressure on the DDRB to accept government policies on pay caps in the public sector and this has eroded the confidence of the profession in the independence of the DDRB. It is vital that the stakeholders in this process understand that maintenance of an independent review is key to the longevity of the arrangement.

- We were extremely disappointed by the DDRB’s decision in its 45th report to recommend again an uplift in line with the public sector pay policies, even though the report recognised that there was a ‘diminishing case’ for limiting pay awards at 1 per cent and linked this to issues of fairness. The capped pay awards of 1 per cent that doctors have been receiving were about 60 per cent less than in the wider economy.

- At the same time, doctors are being asked to work increasingly longer and harder, without the recognition or increased compensatory reward, which ultimately contributes towards a negative impact on their wellbeing, morale and motivation. Increased tiredness can also have a detrimental impact on patient care, and can, along with other factors, cause doctors to retire early or leave the profession altogether. A further sub-inflation uplift will mean further degradation of the perceived value of doctors’ work and it will worsen the current recruitment and retention issues.

- As the report of the OME confirms, out of the ten pay review body occupations doctors have seen the biggest fall (-22.5 per cent) in median real gross hourly earnings. This confirms that government policies over the past decade have unfairly punished doctors by reducing significantly their real terms pay. We therefore ask for the DDRB to explore a mechanism to address the real terms cuts in doctors pay over the long term. Unless meaningful steps are taken towards this direction the resultant negative implications on doctors’ morale, recruitment and retention will only exacerbate.

- Doctors’ capped pay awards of 1 per cent were about 60 per cent less than in the wider economy. We believe that doctors should be treated in line with the wider economy and we therefore ask for a recommendation to uplift the pay of all doctors across the UK in line with the Retail Price Index (RPI), plus £800 or 2 per cent (whichever is greater).

- We urge the DDRB to reinstate its independence and return to its original purpose by insisting that pay policies should simply form part of government evidence and not be given any special status in the process. It is important to stress that another recommendation constrained by government policies would clearly fail to address inflation and would serve as another blow to the confidence of our membership in the process and the value of the review body.

- Similarly, we are disappointed that the DDRB did not criticise strongly enough the Scottish Government and the Northern Ireland Executive for ignoring again the DDRB’s recommendation to increase the value of distinction awards, discretionary points and CEAs (clinical excellence awards) for consultants. The DDRB should have reminded the Scottish Government and the Northern Ireland Executive that this is part of the consultants’ pay package.

- We do not support targeted recommendations to address location or specialty recruitment issues and we do not want the DDRB to consider developing a new mechanism for enabling targeted pay

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2 Royal Commission on Doctors’ and Dentists’ Remuneration (1960) Royal Commission on Doctors’ and Dentists’ Remuneration 1957–1960 Report. We also note that even though paragraph 43 of the report states that “The members of the Review Body should be appointed by the Government after consultation with representatives of the medical and dental professions”, the profession has not been consulted on appointments to the Review Body in recent years.
solutions. There are already recruitment and retention premia available to employers to use, if they deem it necessary. Instead, we ask the DDRB to support our call for a long-term comprehensive workforce strategy in order to address issues relating to workforce planning. In times of generally declining morale, it is important that all doctors are valued equally in order to avoid the negative consequences that selecting a few would have on the morale and motivation of the wider workforce.

– We are concerned that the DDRB didn’t manage to address the timetable problems from the previous year, leading to the Scottish Government again having access to our evidence long before they submitted their own. It is essential that the DDRB agrees a timetable with all parties that everyone is committed to. If any party signals at any point that it cannot make the agreed timescale, then steps should be taken to either revise the timescale or at the very least ensure that no evidence is shared by the DDRB until all parties have submitted their evidence.

– In light of the increasing contract divergence across the UK, and the overarching issue of the devolution of health policy, we request that the DDRB schedules should reflect this in its process.

– We ask the DDRB to note and raise with national governments the lack of comparable earnings data for the devolved nations and we express our dissatisfaction with the lack of reliable and comprehensive evidence on rota gaps and vacancies across four nations.

– We are pleased to see the focus on the gender pay gap, equality and work-life balance issues and we welcome the government’s announcement in July 2016 of an independent review of the gender pay gap in medicine in England. It is vital that the profession continues to attract and retain women and offers them a rewarding and equitable career structure, however, it is disappointing that the review has taken more than a year to establish, which potentially means further delay in dealing with the gender pay gap in medicine.

– We reiterate that it is very challenging to measure productivity in the NHS and any attempt to do so should take into account quality of care, equity of resources, and patient care outcomes.

– We ask the DDRB to make a recommendation on GP expenses in England as outlined in the GP expenses in England section. We do not ask for a recommendation on GP expenses in the devolved nations; these will be negotiated directly with the devolved governments.

– We welcome that the DDRB expressed concern with regards to Northern Ireland and urged the Northern Ireland Executive to take steps to ensure primary care delivery is not irrevocably damaged.

– We challenge the DDRB on its ‘Generation Y’ generalisations which we believe are diverting attention away from long standing concerns about gender equality and the unequal distribution of caring responsibilities. Generational theory must not be used to hide the fallout of undervaluing junior doctors, the impacts of Modernising Medical Careers, and the legacy of the imposition of the 2016 Terms and Conditions of Service in England.
Contract negotiations

Junior Doctors

**England**

1. The 2016 junior doctor contract in England is being introduced without BMA agreement for the majority of trainees as their existing contracts expire, with a staggered approach which started in October 2016. The last group of junior doctors expected to transition will be moved onto the contract in October 2017. The BMA has not accepted this contract because many of our members’ outstanding concerns, as highlighted in last year’s submission, remain.

2. The 2016 contract includes various flexible pay premia targeted at those training in shortage specialties or who would disproportionately lose out financially as a result of the new contract. Now that these are in place, it is important that the DDRB continues to recommend that any percentage uplift to pay applies to these cash sums so that they are not degraded by inflation. However, we do not support further targeted recommendations to address location or specialty recruitment issues, and we re-iterate our request to the DDRB to support our call for a long-term comprehensive workforce strategy in order to address shortcomings relating to inadequate workforce planning.

**Scotland, Wales and Northern Ireland**

3. As junior doctors in England are gradually moving across to the English 2016 contract, their colleagues in Scotland, Wales and Northern Ireland remain on the 2002 contract, after their governments agreed not to impose the new contract. We therefore request that DDRB makes its recommendations on both contracts.

Consultants

4. We ask that the DDRB makes its recommendations on the existing consultant contracts, as the new consultant contract negotiations in England and Northern Ireland are ongoing and the other devolved national governments have not requested to enter negotiations in their countries.

**England**

5. The parties are broadly aligned on changes to the structure of consultant pay over the course of their career. This includes movement from the current eight-point scale over 19 years to a two-point scale, with a starting salary no lower than at present, and progression to the top of the pay scale at an earlier stage, subject to the meeting of specific agreed criteria (this is likely to be set at five years).

6. The parties have been considering the potential for various pension flexibilities, including allowing consultants who choose to opt-out of the NHS pension scheme, and who would in any case cease to contribute to it, to choose to be paid a proportion of the employers’ pension contribution. It is worth noting that such provisions are made available to other staff groups at the discretion of employers in England as part of individual remunerations packages. Representatives of the Department of Health (DH) have continued to explore these options with HM Treasury.

7. The BMA’s position is that the existing CEA scheme, including its local award component, is a legal contractual entitlement for consultants on the 2003 contract. Therefore, we have been exploring a deal in which existing CEA holders would be able to retain the awards they have already earned and local awards rounds would continue to be run.

8. Alongside this, we are working with our negotiating partners to develop a successor awards scheme which continues to encourage and fairly reward excellence across a number of domains. Further discussions are needed for the parties to agree details which will ensure that the scheme is equitable, consistently applied, transparent, and is not administratively burdensome. The transition between the two schemes is likely to be long and potentially complex, particularly given issues identified by DH with disparity in current levels of awards funding between Trusts. However, we believe that a new scheme which is appropriately funded in its early years is more likely to be successful.
9. While we have been clear that the current contract does not present any obstacle to the delivery of urgent and emergency care, we have sought to ensure that the new contract will facilitate the safe provision of expanded hospital services while, crucially, providing individual consultants with protections against excessive working at nights and on weekends. However, the BMA retains concerns that insufficient progress has been made in securing protections for evening work, particularly for those who routinely undertake a greater proportion of their clinical work out of hours, such as those in emergency medicine. We note that while the intensity of consultants’ work has increased across the board, the protections they are afforded should be improved commensurately.

SAS

UK Wide

10. As mentioned last year, SAS doctors are not engaged in new contract negotiations anywhere in the UK, and we believe they will not be asked to enter negotiations until the completion of the consultants’ contract negotiations in England and Northern Ireland, so we request that the DDRB makes its recommendations on the basis of existing contracts.

General Practitioners

Scotland

11. The BMA and Scottish Government have published a proposed contract offer for a new GMS contract for General Practitioners in Scotland for introduction from 1 April 2018. If accepted by the profession the contract will introduce a revised role for general practitioners and reduce GP practices’ role as service providers. The framework proposes a two-phase introduction. Phase one will replace the existing formula with a workload based formula, will introduce protection to ensure no practices receive reduced funding, and will expand multidisciplinary teams in practices. The detail of phase two remains to be agreed. The proposed contract offer explicitly does not address GP pay uplifts. We therefore request the DDRB to make a pay uplift recommendation. The BMA and Scottish Government have agreed that the UK negotiated model salaried contract, in its current form, should be embedded in any new Scottish GMS contract.

Wales

12. In Wales, as a result of the agreed changes to the GP contract for 2017/18, investment in general medical services will increase by approximately £27m which includes an uplift of 2.7 per cent for GP pay and expenses for 2017/18. There is also provision for GP practices to provide new enhanced services covering care homes, warfarin management, diabetes, and the delivery of secondary care initiated phlebotomy tests which will improve significantly the quality and safety of patient care. We have also agreed parity with the English agreement for maternity and sickness locum reimbursement.

13. As part of the changes to the GP contract for 2017/18 in Wales, approximately 40 per cent of the available clinical QOF (quality and outcomes framework) points have been designated as ‘inactive’ where practices will be paid the value of these points without demonstrating achievement. These arrangements are unique to Wales and build on the 2016/17 decision to relax QOF. It is considered that the clinical aspects of these indicators have little value in managing a patient’s condition or will be monitored at a cluster level through enhanced services such as diabetes or linked to wider national clinical audits such as Chronic Obstructive Pulmonary Disease. The impact of the agreed changes to QOF for 2017/18 will free up GPs to spend more time with the frail elderly and chronically sick, and strengthen cluster network activity planning and patient care. The clinical QOF indicators designated as ‘inactive’ will be subject to peer review during 2017/18 to provide assurance on the quality of care.

14. Alongside Welsh Government and NHS Wales, GPC Wales has commenced the review of the future of the Welsh GMS contract. The review oversight group has had two initial meetings, with six task & finish groups set to begin shortly focusing on areas such as funding and risk minimisation. This work is anticipated to take until April 2019.
**England**

15. In England, the 2017/18 GMS contract changes provided a level of stability to GMS and PMS contracts, and provided much needed funding to address (in part) GP practice expenses. The contract also tackled some of the unnecessary bureaucratic workload which takes vital time away from clinical care of patients.

16. The 2017 deal included a number of issues, such as ending the bureaucratic Avoiding Unplanned Admission Directed Enhanced Service. Instead, we agreed a contractual requirement for practices to focus on management of patients with severe frailty and the funding for the DES has been transferred into the global sum to cover any additional workload associated with this new contractual clause.

17. Finally, an expense increase was agreed which should deliver a pay uplift of 1 per cent through global sum as well as uplifts to recognise increased superannuation costs, increased workload due to changes to Primary Care Support England (Capita), and population growth.

18. The General Practitioners committee (GPC) of the BMA has just begun its usual annual negotiations with NHS Employers on contract changes in England for 2018/19.

**Northern Ireland**

19. There is no new GMS contract for 2017/18 in Norther Ireland as the 2016/17 contract has been rolled over.
Economic outlook: pay comparability

20. The 1 per cent pay awards granted over the past number of years have equated to real terms cuts in doctors’ pay, with inflation generally running above 1 per cent. The decrease in the value of sterling in the aftermath of the UK’s referendum decision to leave the European Union has increased these inflationary pressures, accelerating the decline in doctors’ living standards. To demonstrate the continuing decline on real (inflation adjusted) earnings, we have charted (below) the level of earnings in both nominal cash and real terms, using 2008/9 as the most recently available base year. The rate of CPI (Consumer Price Inflation) inflation is currently 3 per cent (October 2017). The RPI which we believe better reflects the costs facing doctors is currently 4 per cent (October 2017). According to the ONS (Office of National Statistics), RPI is predicted to rise and stay high over the coming years. Falling real income comes at a time when, as described in the next section, cuts to health and social care budgets have meant higher workloads for doctors. Doctors are therefore working more, without commensurate reward, with negative implications for morale, recruitment and retention in the health system.

21. Figures 2-5 show that all groups of doctors have faced a significant fall in real income, since the start of the last recession in 2008 (e.g. consultants 19 per cent, juniors over 21 per cent, and approximately 20 per cent for GPs). Due to changes to NHS Digital’s categorisations, we do not include a graph of the decline in the real income of SAS doctors, as we only have data from the last five years.

Figure 2: Consultant pay erosion 2008/9 – 2016/17

22. It should be noted that the above graph represents the pay erosion in consultant average earnings, including pay for unsocial hours, availability supplements, etc. The basic rate of pay for consultants is at a much lower level across the UK. The decline in the average earnings of consultants is happening at

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a time in which consultant workloads are becoming unmanageable and are obliged to take on greater amounts of out-of-hours work to cope with demand, effectively without any remuneration.

**Figure 3:** Junior doctor pay erosion 2008/9 – 2016/17

**Figure 4:** UK GP income before tax 2008/9 – 2015/16


**Figure 5:** Real terms average GPMS income 2008/9-2015/16

![Real terms average GPMS income graph](image)

Source: HSCIC. Figures are England only for hospital doctors; data is not available on a consistent basis for all UK nations. HSCIC definitions have changed this year, so that the data for the first three years on the chart is slightly different to the later years, this is why SAS doctor numbers have been excluded pre 2011/12. HSCIC no longer routinely publish median FTE figures, which have been used in previous evidence submissions as a better measure, so the mean has been used instead. We ask that DDRB request HSCIC to reinstate routine publication of median data.

**Junior Doctors**

23. Against the backdrop of the significant cuts to their real terms pay, junior doctors face significant increases in their cost of living. For example, due to the rise in tuition fees of up to £9,000 per year, current junior doctors come out of university with very high levels of student debt. At the same time, house price increases over the past two decades have outstripped earnings growth and general inflation to a point where the ratio between the average salary and house prices has more than doubled. These changes, combined with the heavier student debt burdens, have a significantly negative impact on junior doctors’ standards of living, effectively locking them out of the property market.

24. In addition, junior doctors have to cope with the ever increasing, mandatory costs of training involved in College enrolment fees, examination costs and GMC (General Medical Council) fees. These are outlined in a recently published paper by the Academy of Medical Royal Colleges. Even though we argue that the paper underestimates the actual costs, it still provides a rough estimation of the mandatory expenses of training. For example, the following tables outline the GMC Annual fees and the Advanced Life Support (ALS) for all trainee doctors.

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Table 1. General Medical Council Annual Fees

<table>
<thead>
<tr>
<th>Application for full registration with a licence to practice for doctors who hold, or have previously held, provisional registration</th>
<th>Annual retention fee for registration with a licence to practice</th>
<th>Certificates of Completion of Training (CCT)</th>
<th>Certificate of Eligibility for Specialist Registration (CESR/CEGPR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>£200.00</td>
<td>£425.00</td>
<td>£420.00</td>
<td>£1,600.00</td>
</tr>
</tbody>
</table>

Table 2. Advanced Life Support (ALS)

<table>
<thead>
<tr>
<th>Course fees</th>
<th>Resuscitation Council (UK) – course centre per candidate registration fee</th>
<th>ALS Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varying fees depending on the Trust</td>
<td>£26.00</td>
<td>£28.00</td>
</tr>
</tbody>
</table>

25. What is more, despite the below inflation rises to junior doctors pay since 2007, the costs associated with training have been steadily rising above inflation. Table 3 provides as an example the percentage increase in the costs of examinations for paediatric trainees, as provided by the Royal College of Paediatrics and Child Health.

Table 3. Exam fees for paediatric trainees

<table>
<thead>
<tr>
<th>Exam</th>
<th>2010</th>
<th>2018</th>
<th>Percentage increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRCPCH Foundation of Practice Examination and MRCPCH Theory &amp; Science Examination</td>
<td>£355.00</td>
<td>£525.00</td>
<td>47.8%</td>
</tr>
<tr>
<td>MRCHPCH Clinical Examinations</td>
<td>£542.00</td>
<td>£750.00</td>
<td>38.7%</td>
</tr>
</tbody>
</table>

26. It is also recommended that doctors in training pay an annual indemnity fee, which will vary depending on the provider, specialty, and the level of training. According to the Academy, fees may vary from £50 to £500 per year. The below inflation increases combined with the increasing costs of training exam fees, means that the junior doctors’ income has decreased even more than the figures on pay suggest.

General Practice

27. We have used the RPI from the ONS to calculate real income changes as, we believe, it most accurately represents the cost pressures faced by doctors, especially as RPI includes housing costs,
which the CPI does not. NHS Digital\textsuperscript{11} uses the GDP deflator to produce its series of real terms GP earnings. This measure is more commonly used for commercial earnings. However, since GP income better resembles a salary rather than the income of a large company, we have decided to use RPI.

28. Overall, GP earnings (combined contractor and salaried) declined in both cash and real terms this year. As can be seen in figures four and five above, this decline has been ongoing since 2008/9. The average income before tax for combined GPs (contractor and salaried) in the UK in 2015/16 was £90,100 for those GPs working in either a GMS or PMS (GPMS) practice compared to £91,200 in 2014/15, a decrease of 1.2 per cent. The average income before tax for salaried GPs in the UK in 2015/16 was £55,800, for those working in either a GMS or PMS (GPMS) practice compared to £56,600 in 2014/15, a decrease of 1.5 per cent. In real terms, salaried GPs suffered a 2.5 per cent decrease in their pre-tax pay.

29. GP contractor pre-tax income continued on its real terms downward trend in 2015/16, with static cash terms income after expenses for contractors, according to this year’s GP Earnings and Expenses report. Cash terms pay has stayed the same, despite gross earnings increasing, which means that the increase in expenses outstripped the 1 per cent pay increase intended for GPs. GP incomes are therefore suffering as a result of inadequate compensation for increasing GP practice expenses.

30. GP contractor expenses continued their long run increasing trend in the latest figures, with expenses now accounting for over two thirds of total practice income on average. The result has been declining income for GPs as funding has failed to keep pace with increased expenses, many of which are not amenable to efficiency savings, such as indemnity insurance. The average gross earnings for GPMS contractor GPs in the UK in 2015/16 was £288,200, compared to £283,100 in 2014/15, an increase of 1.8 per cent. This earnings growth was wiped out by average expenses growth of 2.8 per cent, leading to a real terms reduction in GP income.

31. It is important to note that the above figures do not yet include the latest round of higher inflation, as there is a time lag before we get the latest pay information. Given that over the past year pay has been capped at 1 per cent again, we would expect the decline in real incomes to have accelerated with continued negative impact on living standards, morale and recruitment and retention. The current downward trajectory of sterling, and likely time lag between currency devaluation and price increases, makes it likely that these inflationary pressures will continue in the medium term, with the OBR (Office for Budgetary Responsibility) predicting RPI inflation at 3.7 per cent for 2017.\textsuperscript{12} The OBR’s inflation prediction for 2017 and 2018 is that CPI inflation will run at over twice the level of the pay cap level of 1 per cent and that RPI inflation will remain above 3 per cent into 2022.

Scotland, Wales, Northern Ireland

32. We ask DDRB to note and raise with the national governments the lack of comparable earnings data for the devolved nations. While we believe that it is highly likely that the nations will show similar falls in income (excluding the greater detriment on consultants’ income from the suspension of CEAs in Northern Ireland and distinction awards in Scotland), with the increasing divergence in contracts and government pay policies across the UK, it is imperative that detailed earnings (basic pay and non-basic by category) and workload (e.g. split between direct clinical care, management and supporting professional activities, and overtime and total hours worked) data is collected for each country, for all hospital doctors. This is illustrated very clearly by the continuing failure in Northern Ireland to pay new consultant CEAs since 2010.\textsuperscript{13} Northern Ireland Assembly written questions show that the total spending on CEAs fell by 39 per cent between 2010/11 and 2014/15.\textsuperscript{14}

\begin{footnotesize}
\textsuperscript{14} Northern Ireland Assembly Question AQW50481/11-16
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Comparisons to the wider economy

33. Looking at comparator pay increases over the last number of years, the pay cap on doctors' wages has meant that increases for doctors have been significantly lower than in the wider economy. According to the ONS, pay increases in the wider economy were just below 2.5 per cent in 2016/17 and just above that level in 2015/16. This means that doctors' capped pay awards of 1 per cent were about 60 per cent less than in the wider economy. The most recent figures on the three months to the end of July 2017 show pay continuing to increase at around 2.4 per cent on an annualised basis. This continues a concerning trend over 2014/15 and 2013/14 when pay increases in the wider economy also outstripped those awarded to doctors.

34. The above findings are supported by the UCL Wage Growth in Pay Review Body Occupations, which was published in July of this year. The report was an independent multi-year review of pay growth for employees in occupations covered by the pay review bodies and how this compared to the earnings growth of employees in other comparable occupations. The report finds a 5.8 per cent decline in the median real gross hourly occupational earnings between 2005-2015 in the pay review body occupations. Out of the 10 pay review body occupations, doctors have seen the biggest fall (-22.5 per cent) in median real gross hourly earnings, confirming that the pay awards recommended by the DDRB over the past decade have led to significant real terms reductions in doctors' earnings, with the resultant negative implications on morale and living standards.

35. Research from the Institute of Fiscal Studies confirms that the pay differential between the public and private sector is not the same across the whole public sector. On average, pay at the top end in the public sector is not as high as it is in the private sector, and it should be expected that if this trend continues it would become increasingly more difficult for the public sector to recruit or retain highly skilled and highly educated professionals, such as doctors. What is more, the research found that the increases to employee pension contributions in the public sector have again affected workers in the most highly educated professions of the public sector. For example, for NHS workers earning £50,000 per annum, employee pension contributions have increased from 7.5 per cent in 2010/11 to 12.5 per cent 2016/17. Combining this with reforms that have reduced the value of public pensions, these increases in the contributions signify that doctors' remuneration has suffered a steeper decrease than the headline earnings figures would suggest.

36. Most importantly, the report highlights that another year of below-inflation increases would lead to growth in public pay (especially for high earners) falling significantly behind that of the private sector, which will have a detrimental effect on the already significant recruitment, retention and motivation problems in the public sector. It is only by increasing public sector pay, at least in line with the wider economy, that these problems will be mitigated.

37. However, significant disparities in the remuneration do not exist just between private and public sector, but within the public sector as well. For example, there are significant differences in the proportion of the overall scheme benefits that members fund in the various public service pension schemes. Since April 2015, NHS staff have funded almost double the proportion of their scheme's future benefits compared to civil servants. The reason for this is that contribution rate tiers are higher and steeper for NHS Pension Scheme members. Specifically, the NHS scheme has seven tiers of contributions, with a top rate of 14.5 per cent, while the indicative contribution rates for Principal Civil Service Scheme have just four tiers, with a top rate of 9 per cent.

38. As a result, most doctors will pay significantly more for their pensions than other public sector employees earning similar salaries. At the top of pay scales, doctors will be paying almost twice as

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18 Institute for Fiscal Studies (2017) Public sector pay: still time for restraint? Available at: https://drive.google.com/file/d/0B59chPQfmt1aUp1b33yUnh2ZQU5mIGMGQyM05sOXSmeHBj/view
much a year in contributions for a similar pension as civil servants or high court judges. The NHS Pension Scheme also compares unfavourably with schemes for teachers, local authority staff, police and parliamentarians.

39. Similarly, since 2015, there has been an even greater variation in the proportionate cost of accruing benefits between NHS staff on different salaries. Taking tax relief into account, the proportion of their salaries that top earners in the NHS Pension Scheme will pay into their pensions will be 2.2 times that of the lowest earners; before the latest reforms, the contribution rate (post tax relief) for the highest earners was 1.3 times that of the lowest. At the same time, even though staff on all career pathways will receive the same CARE (career average revalued earnings) accrual rate, steep tiering of contribution rates means that lower paid NHS staff will receive better value for each £1 of contributions over the whole of their careers than higher earners. The vast majority of NHS staff are now in the CARE scheme and as such there is no justification for the steep level of tiering.

International comparisons

40. Comparisons with wages of doctors in other countries are often difficult, as wage structures and responsibility levels differ, even in countries with relatively similar health systems to the UK. Despite these difficulties, it is still worth contextualising UK pay levels with international equivalents as, with the NHS being a near monopoly provider within the UK, it is useful to see what other employers pay.

41. Ireland has a relatively similar system to the UK when it comes to doctor roles and responsibilities in hospitals. Pay for consultants in the Irish public healthcare system compares favourably to that in the UK. Looking at the consultant pay scale in Ireland, salaries tend to start at €150,000 and go up to about €200,000. Although it is difficult to draw a direct comparison, these salary rates indicate significantly higher pay for consultants in Ireland compared to the UK average earnings.

42. Similarly, data from the Australian tax office show significantly higher pay rates at consultant level for doctors in Australia. Based on 2014/15 figures, surgeons in Australia earn an average of over $377,000 ( £216,00). This indicates that surgeons in Australia are compensated at almost twice the level of consultants in the UK, which is one of the reasons Australia has become a popular choice for medics leaving the UK health system.

The fiscal and economic impact of lifting the cap

43. During the period of the government’s pay cap, the primary justification for maintaining the cap has been affordability. However, as noted in a recent report from the Institute for Public Policy Research, the net costs of maintaining pay rates in line with inflation are much lower than the headline costs. Lifting the pay cap and increasing pay would not only directly lead to higher receipts from income tax, it would also have a wider positive economic impact as it would generate additional GDP. Higher earnings will lead to higher spending, which would also increase indirect tax receipts, such as VAT. Thinking of affordability in terms of the net impact figures, further weakens the case for continued below-inflation pay awards.
Economic outlook: NHS finances

44. Over recent years, the DDRB seems to accept the governments’ policies to deprioritise NHS spending, however we ask the Review Body to consider affordability in terms of what funding is needed to ensure the health service is able to recruit and retain adequate levels of staff to deliver safe and quality patient care. The BMA has consistently highlighted the shortfall in NHS funding across all four nations of the UK which has come at the expense of patient care and doctors’ wellbeing, with sustained cuts over the best part of a decade exhausting genuine efficiencies. At present the NHS is barely coping with unprecedented rising patient demand set against an environment of severe financial restraint. What is more, austerity over NHS finances widens inequality in health, directly impacting on the health of the population and adding further to the strain on a service already struggling.

45. As a result of the insufficient funding, doctors are working increasingly longer hours and more intensely, not only without any recognition or compensatory reward, but also, as was discussed in the previous section, against the backdrop of continuing real terms pay cuts, which impacts adversely on morale and motivation and affects negatively on recruitment and retention. Clinician involvement, which is widely recognised as vital to achieving successful and sustainable change in the NHS, is very difficult under these conditions.

46. The case for increasing investment in the NHS becomes stronger as the public’s appetite for austerity is running low. The most recent British Social Attitudes survey showed that for the first time since the financial crash of 2007/8 more people want more tax and spending, than want it to stay the same, with 48 per cent of the respondents saying they want higher taxes to pay for more funding on health, education and social benefits.

47. This does not come as a surprise, as due to years of underinvestment in the NHS and despite the extraordinary dedication of its staff, research shows that more than four in five (82 per cent) of the public are worried about the future of the NHS and almost seven in ten (69 per cent) believe the NHS is heading in the ‘wrong direction’. It is indicative that for the first time in our polling, a higher proportion of the public in England say that they are dissatisfied (43 per cent) with the NHS than satisfied (33 per cent).

England

48. The Department of Health in England annual accounts for 2016/17 show a headline deficit of £791 million. This figure masks the true magnitude of the precarious financial position in England, as it has been reduced using short term and one-off measures, rather than through long term improvements in financial sustainability. The figure is low because of billions of pounds’ worth of one-off savings, temporary extra funding and accountancy changes that did nothing to improve the real state of NHS provider finances. When these measures are removed, the underlying deficit for 2016/17 is about £3.7 billion. This deficit is still an improvement on the 2015/16 figure of £4.3 billion, but when we include the impact of inflation, this actually represents £2.3 billion in permanent savings compared to a year earlier.

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Scotland

49. Similarly, the NHS in Scotland faces significant financial difficulties. Although health spending in Scotland has previously been protected in real terms, this equated to an increase in revenue spending of just 0.6 per cent in 2016/17. Moreover, as Audit Scotland has pointed out, the 2016/17 NHS budget included £250 million ring-fenced for social care.26 If this non-health spending is excluded from calculations, the 2016/17 health revenue budget in Scotland decreased by 1 per cent in real terms from the previous year. The health budget for revenue spending for the current year has increased by 0.8 per cent in real terms on 2016/17.27 At the same time, the NHS has increasing costs each year. For example, NHS drug costs increased by 10 per cent. The Scottish Government anticipates that NHS drug costs in both primary and secondary care will continue to rise by 5 to 10 per cent each year.28 Services across the NHS are also experiencing increasing demand, for example between 2013 and 2030 it is predicted that there will be a 12 per cent increase in GP consultations and a 9 per cent increase in new outpatient appointments.29 This means the gap between NHS resources and demand is rapidly increasing, creating an urgent challenge that is causing services across Scotland to deteriorate.

50. As a result, our members consistently report unsustainable workloads. A recent BMA GP survey found that 55 per cent of respondents in Scotland said workload had the most negative impact on their commitment to being a GP and 21 per cent cited un-resourced work being moved to general practice as the biggest negative.30

51. At the same time, the Scottish Government has set out ambitious plans to shift the focus of care from hospital to community settings, and to individual homes where it is appropriate.31 This vision, which involves the greater integration of health and social care services, has been set out in a number of wide-ranging strategies, including the National Clinical Strategy. However, as Audit Scotland have highlighted32 community health services need to be in place before resources can be shifted from acute services, and such double-running requires additional funding. Serious concerns have been raised, not just by the BMA, but other sources such as the Nuffield Trust33 about how the Scottish Government’s ambitious plans for health and social care fit with the uncertainty, financial challenges, and increasing demand faced by the NHS in Scotland. As the most recent Audit Scotland report34 highlights there is yet no financial framework to show how the Scottish Government plans to fund moving healthcare into the community. While the Scottish Government has announced additional funding of £250 million recurrent annually by 2021 “in direct support” of General Practice (£500 million total to primary care) as part of its joint vision with BMA Scotland for the future of primary care, the Audit Scotland report35 notes the distinct lack of clarity over how much of this will be new investment or reallocated funding from other areas.

Wales

52. The total health, wellbeing and sport budget for Wales in 2017/18 is £7.3 billion.36 This is almost half of the Welsh Government’s annual budget and represents a 2.3 per cent year-on-year real terms increase. The increase, however, is notably below the annual estimate needed according to the recent

27 Audit Scotland (2017), NHS in Scotland 2017 Auditor General
parliamentary review into health and social care. The interim report stated that to keep pace with demand an average 3.2 per cent increase a year in real terms would be needed until 2030/31.37

53. As a result, resources are not keeping up with demand and financial pressures are apparent across the NHS. Between 2014/15 and 2016/17, Welsh health boards overspent by £253 million, with only three local health boards meeting the statutory requirement of operating within their revenue spending limit over the three-year period.38 A BMA Cymru Wales survey of general practitioners found an overwhelming number of respondents (82 per cent) reported they were worried about the sustainability of their practice.39 Evidence from BMA Cymru Wales’s GP ‘heatmap’ demonstrates that this concern is very real; nearly one in five GP practices are at risk of closure, been taken over by a health board, or have already closed within the past two years.40 Financial instability was also a central theme in the findings of a recent survey we conducted with doctors across Wales in response to the Parliamentary review into health and social care.41

54. There are also concerns of delays in funds reaching front line care. Our members, for example, have reported significant delays in the release of the £10 million for primary care clusters announced in April 2016 and concerns that in some cases health boards are using cluster under-spend to prop up other services outside of the budget.42 These concerns about funding clusters were picked up by the National Assembly for Wales Health, Social Care and Sport Committee43 as part of an inquiry into primary care clusters. The committee recommended that the Welsh Government provide funding to clusters on a three-year rather than a one-year basis and to commence a wider review of the primary care funding to provide greater transparency and accountability.

**Northern Ireland**

55. As with the rest of the UK, the HSC (health and social care) system in Northern Ireland is under significant financial pressure. The Department of Health budget in 2017/18 is just over £5 billion (total non-ring fenced departmental limit).44 In Northern Ireland this budget includes social care, therefore direct comparisons with spending in other UK nations are difficult. Although it has been estimated that at least an annual 6 per cent budget increase is needed to maintain the current care services, the 2017/18 budget contained just 2.6 per cent real terms increase from the prior year.17 Department of Health Northern Ireland officials have estimated that an additional £1.1 billion will be needed between 2018/19 and 2019/20 to maintain services at current levels.45

56. Financial pressures are having an immediate and direct impact across care services. Northern Ireland currently has the worst performing health service in the UK with none of the waiting targets being met and there has been no funding for a general practice rescue package. In Northern Ireland, the proportion of total spending on health and social care allocated to general medical services has decreased from 11 per cent in 2003 to approximately 5.4 per cent in 2015/16.46 Similarly, recent trust savings plans focused on secondary care to find £70 million in savings. Reductions in elective care

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41 BMA Cymru Wales (2017) Supplementary response from BMA Cymru Wales – Findings from survey of members BMA.
42 BMA Cymru Wales (2017) Primary care clusters, inquiry by the National Assembly for Wales Health, Social Care and Sports Committee.
46 NHS Digital (2016) *Investment in General Practice 2011/12 to 2015/16 England, Wales, Northern Ireland and Scotland*
were planned despite Northern Ireland having 64,000 people waiting over a year for their first outpatient appointment. 47

57. Reviews of the HSC system in Northern Ireland, most recently the Bengoa review, have called for fundamental changes to the care system. The implementation of these recommendations has not been completed due to the lack of a health minister and functioning Executive since March 2017. 48 Adequate additional and dedicated funding is essential to implement a transformation programme, without which the situation will undoubtedly deteriorate.

**BMA’s position on health spend**

58. We are calling on the UK and devolved governments to match or exceed the average spend of other comparable European countries on health and social care. This is an area where the UK has been falling short and has been spending less on health as a proportion of GDP than the average of the 10 leading European countries. 49

59. In 2015, the average health spend as a proportion of GDP for these 10 leading EU countries was 10.4 per cent (compared to 9.8 per cent spent by the UK). If the UK matched this percentage, its total spend on health in 2015 would have been £193.8 billion. This would mean that the UK’s health spending would have been £10.3 billion higher in 2015 than it was.

60. If the UK matched the average health spend of these leading economies and continued to spend 10.4 per cent GDP on health, it is predicted that total UK health spending would reach £227.2 billion by 2022/23 - £22.9 billion more than current spending plans suggest will be spent.

61. The difference between the proportion of the national income that the UK and the devolved governments have committed to spending on health compared to other leading economies, demonstrates that the sharp decline in the doctors’ pay and in the resources available to the NHS is not a necessity based on the size of the economy, but a political choice.

**Figure 1: Predicted UK health spend 2017/18 – 2022/23**

![Graph showing predicted UK health spend 2017/18 – 2022/23](image)

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49 Comparable European countries have been defined as the top 10 leading EU economies, based on their level of economic development. GDP per capita was used as a proxy for the level of economic development.
62. The continued underfunding of health has and will increase the workload of NHS staff, including doctors. For the past number of years’ doctors have suffered real terms pay decreases, with increased workloads.
Vacancies, workforce planning and future supply

63. Year after year of real-term pay cuts have had a damaging impact on the morale of frontline NHS staff at a time when understaffed and under-resourced hospitals and primary care services are having to manage unprecedented levels of patient demand. There are currently chronic shortages and rota gaps across the NHS and the difficulties with recruiting and retaining staff are a major challenge. The critically low levels of staffing in the NHS are well documented. Increasing rota gaps and vacancies are a key driver of dissatisfaction for doctors, impacting on their wellbeing, patient care and the sustainability of the NHS.

64. As a result, consultants are forced to act down to cover their junior colleagues, while junior staff are asked to act up and take on the responsibilities of more experienced doctors. Staff are asked to work increasingly longer hours and more intensely to fill the gaps, or services may be reduced. Staff are asked to act across specialties or look after inappropriate numbers of patients. This is not sustainable. It is therefore important that the NHS improves the monitoring of rota gaps and vacancies alongside a system-wide commitment to tackling the underlying causes that exacerbate the recruitment and retention issues that drive doctors to retire early or leave the NHS.

65. We are concerned by the lack of robust data relating to the medical workforce across the UK. Adequate data is necessary for the effective delivery of patient care, for sustainable planning and for understanding the requirements for medical training provision. It is therefore important to improve the availability, quality and accuracy of NHS data collection across the four nations of the UK, particularly around rota gaps, vacancies, and the use of locums, which are not routinely collected.

66. A report from the Royal College of Physicians shows that the UK has one doctor for every 360 people, compared with an EU average of one doctor for every 288 people.\(^5\) This has led hospitals in a situation in which they are chronically understaffed. Between 2013 and 2015, the number of doctor vacancies increased by 60 per cent. 70 per cent of doctors in training report working on a rota with a permanent gap and eight in ten consultants report gaps in the rotas of doctors in training; more than one in four report gaps so serious and frequent that they cause significant problems for patient safety.\(^1\)

67. In a recent BMA survey,\(^6\) 71 per cent of SAS doctors reported SAS doctor vacancies where they work. Of those reporting vacancies, 90 per cent said that there was at least one long-term vacancy (a post unfilled for more than 6 months) in their department. The prevalence of long-term vacancies among SAS doctors highlights the additional workload pressures that they face.

68. Vacancy and recruitment issues also extend to medical academics. Figures from 2014 showed a vacancy rate of 6 per cent overall for medical academics, with 11 per cent at lecturer grade. Medical schools cited difficulties in recruiting due to a shortage of high quality applicants particularly for some specialties including cancer and cardiology.

69. Furthermore, the Medical Schools Council noted in their Survey of Medical Clinical Academic Staffing Levels 2017\(^7\) that medical academics vacancies had risen by 17 per cent between 2015 and 2016. As with other areas of the medical workforce, the Medical Schools Council note the limitations of the vacancy data available and therefore the potentially inaccurate or limited picture presented. Despite these limitations it does appear certain there is a growing recruitment problem among medical academics, and it is only the scale of the problem which can be questioned.

70. Public health doctors are also concerned that the available workforce is being spread too thinly.\(^5\)\(^4\) Evidence of workforce pressures within public health are apparent in the BMA’s 2017 Public Health

\(^7\) British Medical Association (2017) Survey of SAS doctors.
\(^5\) British Medical Association (2016) Workload, recruitment, retention and morale: a BMA member briefing for the 3 May 2016 Special Representative Meeting
Survey in which 61 per cent of the respondents reported having at least one non-trainee public health vacancy in the last 12 months.

71. Additionally, 28 per cent of the respondents stated they planned on leaving their public health roles within the next 12 months. If this figure is realised across public health doctors, then the workforce pressures within public health will increase dramatically within the next year.

**England**

72. In England, vacancy data compiled by NHS Digital using NHS Jobs show there were 7872 FTE (full time equivalent) advertised vacancies in the first quarter of 2017, an increase of around 500 on the same period in 2016.\(^55\) This is likely to be an underestimate of the true level of vacancies, as jobs may not be advertised through this route, one advert may reflect several posts, or jobs may have been previously advertised but remain unfilled. It also does not give an indication of how long positions have been vacant.

73. In general practice, a total of 430 GP vacancies were reported in England from April to September 2016 by 866 GP practices that returned data, equating to roughly one vacancy for every two practices.\(^56\) More worryingly, 60 per cent of these remained unfilled for more than three months. Again, the true picture of this recruitment problem is likely to be even more serious, as these figures are based on information from a relatively small number of practices. Indeed, a BMA survey found that nearly a third of GP partners in England had been unable to fill staff vacancies in the past 12 months and only one in eight respondents said they had no staff gaps to fill.\(^57\)

74. From March 2016 to March 2017, excluding GP registrars, which are supernumerary, the total number of FTE GPs fell by 678 (-2.3 per cent).\(^58\) This reduction occurred despite the various national workforce initiatives introduced following the publication of the GP workforce 10-point plan in January 2015 and the GP Forward View in April 2016. The latter promised an additional 5,000 GPs by 2020/21, but the reality remains that general practice is experiencing one of the most protracted recruitment and retention crises in decades. The total GP headcount further decreased by 240 between June and September 2017.\(^59\)

75. In response to rising workload, too few doctors are choosing general practice as a career and many GPs are reducing their time commitment or leaving the workforce altogether. The NHS pay cap, which has led to a real terms decrease of more than £31,000 (23 per cent)\(^60\) in GP’s pay in England since 2005/06 has exacerbated matters further.

76. Patients are waiting longer for appointments to see a GP and practices are unable to recruit enough GPs or nurses. With many carrying long term staff vacancies, growing numbers of practices are either closing their lists to new patients, so they can manage their existing population safely, or closing altogether, leaving some communities at risk of being without local GP services.

77. This crisis will only worsen in the future, as a recent survey of GP trainees\(^61\) shows that the majority (62 per cent) intend to work five to seven sessions as a GP, whilst only one in six of the respondents are prepared to work more than 7 sessions, which is effectively a full-time contract. A survey of GP

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trainees,\textsuperscript{62} conducted by Pulse, the online GP magazine, showed similar intentions, with only one in ten of the respondents stating they would be willing to work eight sessions; the average GP trainee wanted to work 5.5 sessions a week. One-third of the trainees that participated in the survey cited work-life balance as the main reason they entered the profession, with a further third citing the ability to pursue portfolio career and having flexibility over working hours.

78. While both surveys had small sample numbers, their findings correspond with the anecdotal evidence that we receive from trainees about their future career intentions. Unless these are considered and addressed through comprehensive workforce planning, they will put further pressures on general practice and will affect its ability to recruit and retain.

79. Even though we note the lack of adequate data on consultant vacancies in England, it is evident that in secondary care hospitals are facing similar difficulties in recruiting across numerous specialties. For example, a survey by the RCPCH (Royal College of Paediatrics and Child Health) in 2017 showed that one in five of paediatric trainee positions and 25 per cent of the more senior trainee posts are vacant.\textsuperscript{63}

80. Similarly, a recently published report by the Royal College of Physicians found that 84 per cent of its members was experiencing staffing shortages across the team, when at the same time 78 per cent cited rising demand for their service in the past 12 months.\textsuperscript{64}

81. Analysis from NAO (National Audit Office) predicts that poor workforce planning will lead to significant undersupply over the next five to ten years in a number of medical specialties, including a 30 per cent undersupply of old age psychiatric consultants.\textsuperscript{65}

82. Too few newly qualified doctors are choosing to train in psychiatry, and one-third of consultant psychiatrists are working outside the NHS within five years of completing specialist training. Mental health services are also highly reliant on non-UK doctors.\textsuperscript{66}

\textit{Scotland}

83. ISD (Information Services Division) Scotland reported on 5 September that medical consultant vacancies rose by 15 per cent in the year to June 2017, and there are now more than 470 WTE vacant posts, almost half of which have been open for six months or more.\textsuperscript{67} This rise appears to be under-recognised in the Scottish Government’s \textit{National Health and Social Care Workforce Plan} in June 2017, with the number of vacancies only considered to have “increased slightly”. As figure 6 shows this rise meant there was a reported vacancy rate of 8.5 per cent for all consultant posts in June 2017, up from 7.5 per cent in June 2016.

\textsuperscript{62} Pulse (2017) GP trainees want to work 5.5 sessions a week in general practice, available at http://www.pulsetoday.co.uk/trainee-pulse/gp-trainees-want-to-work-55-sessions-a-week-in-general-practice/20034912.article
\textsuperscript{63} Royal College of Paediatrics and Child Health (2017), Rota compliance and vacancies, available at https://www.rcpch.ac.uk/rotas
\textsuperscript{64} Royal College of Physicians (2017), NHS reality check – Delivering care under pressure, available at https://www.rcplondon.ac.uk/projects/outputs/nhs-reality-check-delivering-care-under-pressure
84. Even though these data go a long way in exemplifying the systematic staffing shortages, they still underrepresent the true extent of the problems around recruitment and retention, as the official definition of a vacancy does not include posts where someone has left but the advert for their replacement has not been authorised, or vacant posts which an employer has tried and failed to fill and is not currently re-advertising. Additionally, it does not capture the use of locums to maintain services.

85. The Scottish Academy’s Annual Report[^68] provides further evidence of the pressures within the Scottish consultant workforce, and an indication that the number of consultant vacancies will continue to grow, as it reported that 34 per cent of all consultant appointment panels, between January – December 2016, were cancelled. This marked a 3 per cent increase from 2015. Of these cancellations, half were due to there being no applicants, with another 24 per cent being due to candidate(s) withdrawing or there being no suitable candidates. These cancellations clearly indicate there is an insufficient supply of consultant grade doctors in Scotland and proves that without a viable solution the current level of vacancies will persist and continue to grow.

86. The Scotland data identifies child & adolescent psychiatry (67 per cent), general medicine (58 per cent), and general psychiatry (48 per cent) as specialties with markedly high cancellation rates. Additionally, the cancellation of appointment panels is particularly prevalent in Health Boards in remote or rural geographies. The pressures these unfilled posts are generating within their specialties and local areas are unsustainable and are leading to increasingly unmanageable workloads.

87. The Scottish Academy’s report also demonstrates the continuing predominance of 9:1 job plans, which constituted 58 per cent of all advertised consultant posts. This is of particular concern as the prevalence of 9:1 jobs is acting as a deterrent to working in Scotland and is detrimental to the NHS.

88. Vacancy rates for other types of secondary care doctors are currently not collected. However, we welcome the acknowledgement within the Scottish Government’s Workforce Plan of the need to bring together all existing sources of workforce data. In addition, we welcome the calls by the Auditor General, in their NHS Workforce Planning report in July 2017, for the Scottish Government to improve its “understanding of future demand to inform workforce decisions”. We hope these efforts by the Government, and pressure from the Auditor General, will enable a truly comprehensive picture of the Scottish medical workforce to emerge which will highlight all the pressures to the system.

89. A BMA survey has highlighted the worrying scale of the recruitment problems facing general practice in Scotland, with more than one in four practices reporting at least one vacancy. Three quarters of the vacancies reported had been vacant for six months or more. Every unfilled vacancy puts more and more strain on remaining GPs who must struggle to cover the gaps in their practice while also coping with increasing demands on GP services. The BMA and Scottish Government have published a new contract offer for 2018/19, which seeks to address recruitment and retention issues. However, the

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contract offer still needs to be agreed by the profession and we need to ensure that practices are being supported to deal with the problems they are currently facing.

Northern Ireland

90. Information on vacancy rates in Northern Ireland has not been published since March 2015, with vacancy levels worsening up to this point. Data showed that the consultant vacancy rate increased from 6.2 per cent WTE to 9.3 per cent between March 2013 and March 2015, the SAS vacancy rate grew from 10.1 per cent WTE to 14.5 per cent in the same period. BMA Northern Ireland surveys have indicated a real terms consultant vacancy rate of 13 per cent. A further indicator of worsening vacancy rates within secondary care in Northern Ireland is the doubling of expenditure on medical locums between 2011 and 2016. Across trusts in Northern Ireland there is no common definition of a vacancy, and there is no Northern Ireland wide system through which vacancy rates can be monitored to assess if they have become critically high.

91. Attempts to fill these vacancies through an initial international medical recruitment project have not yielded the number of recruits initially planned, as only 15 appointments were made, with some of these being unable to initially take up posts. Our position is that the ongoing recruitment crisis can only be addressed through comprehensive workforce planning and appropriate remuneration across the board, however it should be noted that that Northern Ireland trusts do not adequately utilise the existing recruitment and retention premia currently available to them to help fill vacancies or retain existing staff. Our recent survey of consultants in Northern Ireland showed that 62 percent of respondents felt that, in their opinion, it was now more difficult to recruit to their specialty than it was five years ago, or since they became a consultant.

92. We have advocated for a new mechanism to be introduced by the Department of Health to effectively collect data on rota gaps and vacancies in Northern Ireland, arguing that the current definition of a vacancy leads to an undercount. The Department of Health currently considers only those posts actively under recruitment as vacant. This should be viewed as an index of current recruitment activity, not of total vacancies within the service. An LNC survey in November 2015 showed that 8.2 per cent of vacancies in Northern Ireland were long term and had not been occupied by a permanent post holder since September 2014. Further to the high number of vacancies it should be noted that 13 per cent of doctors (excluding doctors in training on rotation) in Northern Ireland are currently employed on temporary contracts, compared with just 2 per cent of nurses.

93. BMA Northern Ireland continues to advocate for a single lead employer for doctors in training, which we believe would assist with recruitment and retention. Junior doctors in Northern Ireland have stated that the absence of a single lead employer leads to significant duplication of work and affects the ability to plan and take study or other leave. In a health economy the size of Northern Ireland, a single lead employer for doctors in training appears to be a feasible way of reducing bureaucracy and making Northern Ireland a more attractive place to train and work.

94. The risks of Brexit and its effects on the medical workforce across the UK, which are discussed in detail in the following section, have the potential to be particularly pointed in Northern Ireland given the unique situation of sharing a land border with the Republic of Ireland. Almost 9 per cent of Northern Ireland’s doctors are EEA graduates, of which two thirds trained in the Republic of Ireland. There is a genuine risk that when the UK leaves the EU, workforce issues in the health system in Northern Ireland will become much worse. Uncertainty around Brexit, changes in the relative valuation of the sterling versus the euro, and application of public sector pay policy may further worsen recruitment and retention of medical staff in Northern Ireland.

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Wales

95. According to figures provided to us by the Wales Deanery, the overall fill rate for core and specialty training posts in Wales fell from 83 per cent in 2016 to 81 per cent in 2017. This represents an increase in unfilled posts from 87 to 94.

96. In evidence to an inquiry by the National Assembly for Wales Health, Social Care and Sport Committee72 into medical recruitment, the Welsh NHS Confederation reported that as at July 2016, all local health boards across Wales (excluding Powys) had significant medical vacancies: 154 consultant, 253 Specialty, Associate Specialist and Higher Grade Training doctors and 132 junior doctors. The committee was told that there remain trainee vacancies in every acute hospital rota in Wales. The RCP (Royal College of Physicians) told the committee that, in 2016, NHS Wales was unable to fill 39.8 per cent of the consultant physician posts it advertised and that Wales struggles to recruit enough trainees to fill hospital rotas. It was also noted that 33 per cent of core medical trainee places were unfilled in 2016.

97. Similarly, although we welcome the increase to 92 in the fill rate for GP specialty training in Wales, this figure masks the ongoing issue of GP specialty recruitment in Wales. The Wales Deanery has voiced this issue, highlighting that in order to meet increased demand for GP services, the number of GP training places has increased from 2,400 to 3,250 (35 per cent increase) in England over the last ten years, and in Scotland it has increased to 400, whilst in Wales the number of places has remained at 136.

98. The product of this recruitment crisis can be seen in the number of GP practices closing or becoming Health Board managed. From October 2015 to April 2017, BMA research73 has shown that 5 practices have closed, with 18 becoming Health Board managed, and in addition a further 58 practices are at risk of having to become health board managed.

99. As the sustainability of GP practices across Wales is under threat, it is clear that the number of GP specialty places needs to be increased dramatically if the situation is to be improved in the near future. There are fewer GP training places in Wales per head of population than in both England and Scotland. As already noted above, there are 136 GP specialty places in Wales compared to 3,250 in England and 400 in Scotland. Based on the 2016 mid-year population estimates,74 this means we have 4.37 GP training places per 100,000 of population in Wales, compared to 5.88 in England and 7.40 in Scotland. In light of this, we are supportive of the recruitment campaign launched by Welsh Government. We welcome steps to solve the current recruitment and retention problems, particularly the incentive based schemes which we’ve been calling for, for a number of years. Our recent survey clearly proves that GPs across Wales love the work they do but cannot continue working within the current environment, with 82.1 per cent of respondents worried about the sustainability of their practice. Solutions need to be put in place for GPs currently working in Wales, so that patients receive the care they require.

Pre and post-graduate medical recruitment

100. At a time when specialties are critically short of new recruits and the NHS is struggling with shortages of key medical personnel, data on the current state of recruitment into pre and post graduate medical education and training show a further worsening of an ongoing, established trend. Increasing workload, low morale, stress and burnout are unfortunately characteristic of the life for too many doctors working in the NHS today. For many junior doctors, the imposition of the new contract in England has had a demoralising effect which compounds the pressures already faced at work.

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101. Against this backdrop, fewer people are choosing medicine as a career with many more choosing to leave the health service at a time when they are needed the most. Although medicine remains highly competitive, with only 8,000 places available annually across the UK, figures from UCAS (University and Colleges Admissions Service) show that the number of people applying to UK medical schools has decreased for the third year in a row and by more than 13 per cent since 2013. This year, the number of EU applicants dropped to its lowest since 2013 as did applicants from non-EU countries. The 16 per cent decrease in EU applicants from last year is notable and could reflect the uncertainties surrounding Brexit.

Table 1. Applicants for medicine courses with 15 October deadline (2017 cycle)\(^75\)

<table>
<thead>
<tr>
<th>Domicile of applicant</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>% change from prior year (2016-2017)</th>
<th>% change over five years</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>14,520</td>
<td>14,670</td>
<td>12,930</td>
<td>12,620</td>
<td>12,320</td>
<td>-2.4%</td>
<td>-15.2%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>660</td>
<td>590</td>
<td>570</td>
<td>580</td>
<td>540</td>
<td>-6.9%</td>
<td>-18.2%</td>
</tr>
<tr>
<td>Scotland</td>
<td>1,160</td>
<td>1,170</td>
<td>1,060</td>
<td>1,050</td>
<td>1,030</td>
<td>-1.9%</td>
<td>-11.2%</td>
</tr>
<tr>
<td>Wales</td>
<td>670</td>
<td>710</td>
<td>660</td>
<td>570</td>
<td>570</td>
<td>0%</td>
<td>-14.9%</td>
</tr>
<tr>
<td>UK</td>
<td>17,000</td>
<td>17,140</td>
<td>15,220</td>
<td>14,820</td>
<td>14,450</td>
<td>-2.5%</td>
<td>-15.0%</td>
</tr>
<tr>
<td>EU (excluding UK)</td>
<td>1,990</td>
<td>2,110</td>
<td>1,940</td>
<td>2,050</td>
<td>1,720</td>
<td>-16.0%</td>
<td>-13.6%</td>
</tr>
<tr>
<td>Non-EU</td>
<td>3,130</td>
<td>3,490</td>
<td>3,230</td>
<td>3,240</td>
<td>3,040</td>
<td>-6.2%</td>
<td>-2.9%</td>
</tr>
<tr>
<td>All</td>
<td>22,130</td>
<td>22,740</td>
<td>20,390</td>
<td>20,100</td>
<td>19,210</td>
<td>-4.4%</td>
<td>-13.2%</td>
</tr>
</tbody>
</table>

102. As noted by the National Assembly for Wales Health, Social Care and Sport Committee\(^76\) in its inquiry into medical recruitment, the fall in Welsh-domiciled applicants to UK medical schools during the past two years has been particularly steep. There was a decline of around 14 per cent between 2015 and 2017 in the number of Welsh – domiciled students applying to study medicine. This compares to a fall of 5 per cent across the UK during the same period. The committee also noted evidence from RCP that in 2016 only 30 per cent of Welsh medical school undergraduates were Welsh domiciled, compared with 85 per cent in Norther Ireland, 80 per cent in England and 55 per cent in Scotland.

103. Doctors are now working harder than ever to deliver a safe and quality service to patients, when at the same time are being unfairly punished by government with continuing real loss of earnings and increasing cost pressures. The decrease in the number of applications to medical courses shows that the current realities of the medical workforce are acting as a deterrent to a medical career. More than three-quarters of medical students said that they were now less likely to recommend studying medicine to friends and family, according to a recent BMA survey.\(^77\)

104. Similarly, preliminary figures from the 2017 recruitment cycle indicate a significant drop in the number of applicants to F1 posts via the national allocation process.\(^78\) The number of newly qualified doctors recruited to the AFP (Academic Foundation Programme) has also fallen slightly, whereas the number of LTFT foundation doctors recruited was less than half of what it was in 2013.

105. In 2016, the number of foundation doctors beginning the second year of their two-year foundation training was higher than in the previous year and higher than in 2013. However, total recruitment to F2 has fallen by almost 3 per cent since 2013. In 2016, those recruited to the second year of AFP also fell from previous years and those appointed to one-year F2 posts decreased from the previous year.


\(^{77}\) British Medical Association (2016) Medical students’ survey.

\(^{78}\) UKFPO (2017) Recruitment stats and facts, Interim Report
The number of foundation doctors repeating their F2 year, however, was significantly lower in 2016 than in the previous three years.

106. In addition to the current vacancy issues, the 2016 UKFPO career destination survey indicates that the steep decline in the number of foundation doctors progressing directly into specialty training has continued, with only half (50.4 per cent) of F2 doctors reporting that they would progress directly into specialty training following completion of their Foundation Programme training. This is down from 52 per cent in 2015, and 71.3 per cent in 2011, as figure 7 shows. With the percentage of trainees progressing directly into specialty training being perilously close to dropping below 50 per cent, it is clear that the reasons why trainees choose not to progress immediately must be addressed. As such, we welcome the UKFPO’s call for a study to be undertaken into why more doctors are choosing a career break after their foundation programme. Future BMA research will seek to shed more light on this growing trend and the implications it has for training programmes, the nature of doctors’ jobs and workload.

Figure 7: Progression into specialty training following F2 year

![Graph showing progression into specialty training](image)

**Impact of Brexit**

107. The political uncertainty generated by Brexit, poses further risks to the NHS. If a large number of EEA and non-EEA doctors leave the UK, the existing workforce shortages will be exacerbated and adversely impact both the existing workforce and patient safety. Data collated by the OECD (Organisation for Economic Co-operation and Development) demonstrates that in 2014 the UK had 2.8 doctors per 1000 population— which is below the OECD average of 3.2 doctors per 1000 population.\(^80\) Evidence shows that the UK does not have the medical workforce it requires to serve its ageing population.

108. Doctors from within the EU/EEA (European Economic Area) and outside the EEA make up a substantial proportion of the NHS workforce. In 2015, data from the GMC (General Medical Council) shows that almost 30 per cent of NHS doctors were from overseas, with more than 45,000 doctors receiving their primary medical qualification from outside the UK. Of these, around 10,000 are from the EEA (6.6 per cent of the NHS workforce), and 35,000 are from outside the EEA (22.3 per cent of the NHS workforce).\(^81\) These individuals have enhanced the UK healthcare system over the years, improving the diversity of the profession to reflect a changing population, bringing great skills and expertise to the NHS, and filling shortages in specialities in order to continue to provide a high-quality, reliable and safe service to patients.

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109. A BMA survey of EEA doctors working in the UK, found that more than four in ten are considering leaving following the EU referendum result.\textsuperscript{82} Findings also showed:

\begin{enumerate}
\item Four out of ten European doctors stated they feel substantially less appreciated by the UK Government in light of the EU referendum result.
\item Six out of ten European doctors stated they feel significantly less committed to working in the UK.
\end{enumerate}

110. A recent GMC survey of EEA doctors complemented these findings as 60 per cent of respondents currently working in the UK indicated an intention to leave as a direct result of the Brexit vote.\textsuperscript{83} While figures of inflow and outflow of EU NHS doctors are not showing reduction as yet the above findings, which highlight the emotional impact regarding their right to stay, are alarming. It is indicative that figures published by the NMC (nursing and midwifery council) show an increase in the numbers of nurses and midwives leaving the NMC’s register, which coincides with a large fall in the number of nurses and midwives coming to work in Britain from Europe, since the UK voted to leave the EU.\textsuperscript{84}

111. In addition, existing challenges within the immigration rules for non-EU nationals create further difficulties in being able to recruit highly skilled workers, and have serious impact on the medical workforce. Such challenges include increases within the Tier 2 minimum salary threshold for experienced workers,\textsuperscript{85} and the introduction of the immigration skills charge (the aim of which is to reduce the reliance on employing migrant workers and to invest in training UK workers).\textsuperscript{86}

112. A paper focusing on doctors with a European primary medical qualification in 2017, which was recently published by the GMC, showed that since 2013, the number of licensed EEA graduates has gone down, both in absolute number and as a percentage of the workforce.\textsuperscript{87} What is more, from 2012 to 2014, the number of EEA graduates joining the profession increased, but that trend stopped in 2015. Since then fewer doctors than in 2012 have joined each year. Between 2012 and 2016, the number of EEA graduates leaving has almost doubled, which has been a steady increase over time.\textsuperscript{88}

113. In light of the ongoing staff shortages across the UK, it is essential that the necessary flexibilities within the immigration system are maintained in order to ensure that the system is able to recruit and retain doctors where necessary to fill gaps in the UK trained workforce and protect patient safety.

\textbf{Gender pay, equality and work-life balance}

114. The BMA welcomes the 2017 DDB’s focus on the gender pay gap, equality and work-life balance issues. As discussed, understanding and addressing these factors are key to the profession’s ability to recruit and retain the future workforce.

115. As the latest findings from the BMA’s cohort study demonstrate,\textsuperscript{89} junior doctors are increasingly making changes to their careers, including switching specialty, opting for a career break and leaving the NHS. Ensuring the NHS is able to retain its medical workforce increasingly requires a long-term system of rewards and benefits, that addresses the need for more men and women to train on a flexible basis, to work part time or take time out of their careers at certain stages in their lives, without being unfairly penalised for doing so.

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\textsuperscript{85} Available at https://www.gov.uk/guidance/immigration-rules/immigration-rules-appendix-j-codes-of-practice-for-skilled-work
\textsuperscript{86} Available at https://www.gov.uk/uk-visa-sponsorship-employers/immigration-skills-charge
\textsuperscript{87} General Medical Council (2017) Our data about doctors with a European primary medical qualification in 2017.
\textsuperscript{88} General Medical Council (2017) Our data about doctors with a European primary medical qualification in 2017.
116. In looking at generational trends and preferences around working hours, it is important to avoid making a simplistic evaluation of more long-term developments in society more widely, namely the increase in women’s participation in the workforce. The historic gender disparity in the medical profession has been re-balanced, with women now making up 57 per cent of junior doctors. This development has pushed long overdue consideration of how traditionally intensive medical training patterns can be made more flexible to allow trainees to combine work with caring responsibilities. The BMA’s latest cohort study findings show that women trainee doctors are far more likely than their male peers to work and train on a less than full-time basis because of children or other caring responsibilities. Women are also more likely to switch into the specialties which are most amenable to flexible and part-time working. Our evidence show that for many women, this switch is directly linked to having children. Men on the other hand, are far less likely to switch specialty after they have children.

**Gender pay gap review**

117. Similarly, the BMA welcomes the government’s announcement in July 2016 of an independent review of the gender pay gap in medicine in England. It is vital that the profession continues to attract and retain women and offers them a rewarding and equitable career structure.

118. The gender pay gap currently stands at 30 per cent among doctors, based on the standard measure of comparing median hourly earnings (excluding overtime) for all male and female employees.91 This is significantly higher than the gender pay gap for the whole economy which stood at 18 per cent in 2016.

119. The planned independent review should provide a major opportunity to thoroughly consider the underlying causes of the gender pay gap in medicine and what action is needed to close it. However, it is disappointing that the review has taken more than a year to establish, which potentially means further delay in dealing with gender pay issues.

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Workload and motivation

120. Vacancies are directly linked to increased workloads and consequently negatively affect doctors’ wellbeing, morale and motivation. Even though all doctors want to do the best job they can for patients, continuing shortages are unsustainable. This situation is substantially exacerbated by the significant decline in their pay, the lack of compensating remuneration for much of the additional workload, but also by the seeming lack of recognition and unwillingness of government and employers to empower doctors to make changes to service delivery that are clinically sustainable.

121. At the same time, there have been significant increases in all NHS activity across the UK in recent years. In England, from March 2016 to February 2017, there were 19.6 million ‘finished consultant episodes’, up from 19.2 million in 2015/16. There were 92.5 million outpatient attendances, compared to 89.4 million in the previous year. Over the same period, A&E attendances rose from 20.3 million to 20.9 million.92

122. In Scotland, there were over one million outpatient attendances in the quarter ending March 2017, which signals a 9 per cent increase in the last five years. During April 2017, there were 136,077 attendances at A&E services across Scotland, compared to 131,755 the previous April.93

123. In Northern Ireland, the number of outpatient and inpatient appointments increased in 2015/16 compared to the previous year. The number of admissions to hospital has risen by 1.6 per cent since 2011/12.94 One in seven adults in Northern Ireland is on a waiting list for outpatient treatment. These statistics are indicative of a mismatch between the size of the workforce and workload.

124. There have been consistent increases in average consultation rates and the overall duration of consultations in general practice across the UK. Between 2007 and 2014 overall consultation rates for GPs in England rose by 13.6 per cent.95 In Scotland GP consultations rose by 3.9 per cent, from 15.6 million to 16.2 million between 2003 and 2013 (the last date for which information was collected).96 In Wales, in 2008/09, 10.2 million consultations were undertaken by GP practices. In 2012/13, that had risen to 12.4 million. What is more, data provided to the BMA by the SAIL (Secure Anonymised Information Linking) Databank show a significant increase in the average number of GP activity days in Wales between 2000 and 2014, which can be seen as a clear proxy measure for increased GP workload over that period.97 In Northern Ireland, total general practice consultations rose from 7.2 million in 2003/04 to 12.7 million in 2013/14.98

125. Some of these annual increases may seem relatively small, but the NHS had been dealing with similar year-on-year increases for the past decade. For example, A&E attendance in England has increase by around 23 per cent since 2005.99

126. Doctors from all branches of practice also report that their workload is increasing in intensity and complexity. When the NHS was created in 1948 only 10 per cent of the UK population was aged 65 or over – the current figure is 18 per cent. The number of people aged 80 or over is set to more than double to 6.1 million by 2037.100 Health and social care services are dealing with more older people

93 Information Services Division (2016) Emergency Department Activity and Waiting Times data comparison.
97 Presentation to BMA Cymru/GPC Wales on SAIL (2017) available upon request.
100 The Guardian (2013) UK population: how will it change over the next few decades? available at
than ever before, but it is the increase in numbers of the very elderly, and of older people with long-term conditions that is having the greatest impact on services.

127. The more complex and long-term health care needs of a rapidly ageing population are placing new demands on the NHS and will require further changes in the approach to workforce planning. Doctors have to work longer and harder to meet the requirements of their elderly patients, with no recognition. For instance, the normalisation in the GP contract provides more funding for increased population, but does not compensate for changes to the age profile of the population which is skewed towards the elderly, especially in Wales.

128. The increased intensity and complexity of workloads is reflected in the findings of a recent BMA survey of sesional GPs, in which the majority of respondents were of the view that the volume (56.2 per cent), intensity (68 per cent) and complexity (73.2 per cent) of their workload had increased in the last year – among sesional GPs this was most notable for practice-employed salaried GPs.

129. Heavy workloads have contributed to general feelings of low morale and motivation among doctors, sometimes leading to a desire to leave the profession. In the 2017 Q1 edition of the BMA’s tracker survey 45 per cent of the respondents reported their morale as being low or very low. This figure has remained consistent for the past year indicating a persistent trend of a demoralised workforce. This is a real challenge, as evidence shows that staff who are happy in their work and feel well-treated themselves will be better motivated to treat patients well.

130. GPs have consistently been reporting low feelings of morale. A 2015 UK-wide survey found that 68 per cent experience a significant but manageable level of work-related stress but a further 16 per cent report experiencing an unmanageable amount of work-related stress. As a result, less than half would recommend general practice as a career path.

131. Similarly, in secondary care, research from 2015 found that the consultant workforce felt de-professionalised, disengaged and demoralised, and less than half of SAS doctors would recommend their career path. Our survey on the working lives of consultants in Northern Ireland showed that one quarter of the respondents stated that their workload was “consistently unmanageable”. Consequently, when respondents were asked to describe their current level of morale, 72.5 per cent stated their morale was either ‘low’ or ‘very low’.

132. In a BMA survey of consultants conducted earlier this year in England, almost half of the respondents (46 per cent) reported consultant rota gaps in their department and 71 per cent reported junior doctor rota gaps in their department. Consultants said that, outside their contracted time, they work on average an extra 4.5 unpaid hours per week. A quarter of the respondents described their current workload as ‘consistently unmanageable and nearly half (49 per cent) had felt unwell over the last 12 months as a result of work related stress. Therefore, unsurprisingly, 61 per cent of the respondents described their morale as low or very low. The survey showed that doctors unmanageable workloads impacts not only doctors’ morale, motivation and well-being but also on the quality of care they deliver, as half of the respondents said that their current workload has a negative or a significantly negative impact on the quality of care that their patients received.

https://www.theguardian.com/news/datablog/2013/nov/06/uk-population-increase-births-migration
133. These findings are consistent with the results of the BMA survey of public health doctors according to which less than 60 per cent of respondents intend to remain with their current employer and almost 20 per cent intend either to retire or to stop working in public health.\textsuperscript{107}

134. The effect that staffing shortages and increased workloads are having on doctors' wellbeing is evident in the findings of the 2017 BMA survey of sessional GPs in which over half of the respondents reported having felt unwell due to work-related stress in the last 12 months. Such symptoms were most likely to be among those working full time or in a salaried role in findings that compare closely with those of GP contractor/partners in a 2016 BMA survey.\textsuperscript{108}

135. The ever-increasing workloads and the push to work more antisocial hours to manage with demand has an additional impact on women, single parents and working couples, as they have, at the same time, to deal with spiralling costs of childcare and the limited access to out-of-hours childcare. More and more of our members feel that the daily stress of their work, the long hours, and the considerable financial and personal sacrifices that they make during their training are not recognised, as year after year their pay is diminishing. This wide range of factors could magnify the current gaps in the clinical workforce, in particular, the pressures on the workforce created by the current productivity challenge. The falling morale in many staff groups and subsequent loss of skilled and experienced staff will not be easy to repair.\textsuperscript{109}

\textsuperscript{108} British Medical Association (2017) Survey of sessional general practice.
Additional specific issues

New Models of Care

136. As the development of new models of care is at an early stage in all nations, we believe it is too soon for the DDRB to make any recommendations in this area. Instead further information is required from each government on the plans and their impact upon services. Below are the BMA’s views on the progress in each nation.

England

137. The new models of care announced in the Five Year Forward View are continuing to develop through NHS England’s vanguard programme. For the MCP (Multispecialty Community Provider) and PACS (Primary and Acute Care Systems) model, NHS England have developed three voluntary contractual options, which are now described as ACO (accountable care organisation) models. However, the BMA is clear that structural and contractual integration should not become the main focus of any new model of care, as this alone does not guarantee more joined up services or quality of care for patients. Indeed, there are examples of care models already in operation that facilitate integrated services, which build on current contractual models.

138. We have strong concerns about the fully integrated, and even partially integrated, models that have been proposed, not least because it requires practices to relinquish their national core contract. At this stage, we also have concerns over the potential implications of signing up to integration of alliance agreements as part of the partially integrated model. We believe the key aims of the MCP/ACO contract can be met within the existing framework and protections of the national contract.

139. In addition, we have concerns about whether the new models of care will be financially viable once the additional funding from the vanguard is discontinued at the end of this financial year. Overall, there has been a complete lack of investment in transforming care, with the focus continually on plugging deficits rather than investing in transformation. It is unrealistic to expect radical new models of care to bed in whilst the NHS is under such huge financial pressures.

140. Furthermore, where services are reconfigured to facilitate vanguard programmes and the delivery of integrated care, there has been a lack of clinical engagement with the secondary care medical workforce as to the impact the transformation programme will have on working patterns, current funding for hospital based services and training and development opportunities. We are particularly concerned that without meaningful clinical engagement, ACOs may implement a redesign of services where the clinical evidence base is vague and opaque; and while well intentioned may result in recruitment and retention problems locally increasing pressures on the remaining workforce with adverse impacts on patient care.

Scotland

141. Like elsewhere in the UK, we have concerns about how new models of care, as set out in the Scottish Government’s Health and Social Care Delivery Plan, will be made financially viable.\footnote{Scottish Government (2016) \textit{Health and Social Care Delivery Plan} Scottish Government.} Audit Scotland have raised concerns about new models of care not progressing fast enough and the need for the Scottish Government to provide leadership in evaluating generally small-scale models and to share evidence of what works.\footnote{Audit Scotland (2014) \textit{Changing models of health and social care} Audit Scotland.} We have similar concerns and await evaluation and further detail on the new models of care.\footnote{BMA Scotland press release (20.12.17), available at https://www.bma.org.uk/news/2016/december/bma-demands-healthcare-plan-detail}
Northern Ireland

142. The recent Bengoa report echoed previous HSC (Health and Social Care) system reviews in Northern Ireland, highlighting the importance of new models of care in transforming the HSC system. The reason and benefits of new models of care need to be clear for both patients and the population as a whole. The review reiterated the important role the workforce would have in designing new models of care, and subsequently that the workforce would need to be empowered and engaged in this. Progress on developing new models of care has been very slow and hampered by the current absence of a health minister in Northern Ireland.

Wales

143. There is a broad consensus in Wales for the need of new models of care to address the challenges faced by the NHS. The current Parliamentary review on health and social care has highlighted the importance of the role new models of care will have in addressing these challenges, the interim report also emphasised the urgency for Wales to create practical solutions.

144. However, we have concerns about how new models of care will work in practice, including questions on funding and standards, as well as how new models will be evaluated and good practice shared. This is why we have called for further detail on the Prestatyn new model of care, where Betsi Cadwaladr University Health Board is running a multidisciplinary service with GPs as a response to the previous contractor owned practice being unable to recruit new partners upon retirement. At the same time, we have welcomed the Parliamentary review interim report’s recommendation that immediate work on new models of care should be started in close collaboration with healthcare professionals and we have been represented on the stakeholder forum set up by the review panel to look at this area of work in more depth.

145. The Health, Social Care and Sport Committee’s report on primary care clusters was reflective of our evidence submission and the longstanding calls of our members. It recommended that Welsh Government publish a refreshed model for clusters with a clearly defined vision, to enhance guidance on governance and decision making and to explore whether to establish clusters of a legal footing. Cluster development, encompassing working at scale and new models of care, is one of the defined task and finish groups within the Welsh GMS contract review which is now underway.

Salaried GPs

146. Following the remit letter from the Secretary of State for Health, the DDRB made a number of observations around salaried GPs in England. Given that the proportion of salaried GPs is increasing, with the majority of GPs now entering the workforce on a salaried or locum basis, we welcome the DDRB’s focus on examining matters relating to this group. However, we fundamentally disagree with the DDRB’s observation regarding the salaried GP model contract and the potential need to be revisited.

147. The BMA’s general practitioners committee (GPC) and the Department of Health agreed as part of the new GMS contract negotiations a model offer letter and a set of minimum terms and conditions, which together are known as the model contract. It was introduced in 2003 and became obligatory for GMS practices and PCOs (Primary Care Organisations) to use when employing a new salaried GP from 1 April 2004. The NHS England Standard Personal Medical Services Agreement 2015/16 set out that PMS practices shall also offer salaried GPs terms and conditions which are no less favourable than those in the model contract.

148. We do not agree that there is confusion about the status of the existing model contract for salaried GPs and there is no evidence that new models of care are encountering difficulties in contract arrangements for salaried GPs. The majority of GP practices that are entering into some kind of collaborative arrangement with other practices or primary care networks retain their GMS/PMS

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113 Health, Social Care and Sport Committee (2017) Inquiry into Primary Care: Clusters. National Assembly for Wales
contracts and therefore the minimal terms and conditions of service under which salaried GPs should be employed remain the same.

149. Similarly, the recently published ACO (Accountable Care Organisation) Contract and supporting documents which have been revised for use by local commissioners to inform the early stages of their procurement processes and can be used for accountable care models generally, including MCP and integrated PACS models, include the requirement that “where GPs are employed by MCPs they will be offered terms at least as favourable as the BMA model salaried GP contract.”

150. Apart from employers and commissioners, salaried GPs also seem to believe the model contract is fit for purpose and offers the appropriate levels of flexibility and protection in various settings. The findings of our 2017 survey of sessional general practitioners confirmed that the majority (68 per cent) of salaried GPs think that the current model salaried GP contract should continue to be used.

151. The BMA believes that the model contract represents good employment practice and is designed to ensure a minimum common standard for GPs delivering primary care services. It is possible for employers to offer improved terms and conditions, as long as these are no less favourable to the model contract, for example in order to aid recruitment and retention. What is more, both parties can agree a variation to the contract, thereby ensuring that the employment offer remains attractive, whilst maintaining value for money in the changing primary care landscape.

152. Under the model contract, full-time is defined as 37.5 hour per week. The contract breaks this amount down to nine notional sessions of 4 hours and 10 minutes, although the time of a session can be altered to suit the parties. Working should be carefully defined in a job plan, which is a condition of the model. A typical six session salaried GP working within typical core hours on the model contract is shown in appendix A.

153. A GP working within a new model of care, may be asked to undertake different tasks within their contracted sessions, but the principles of the contract can and should still apply. There are already many salaried GPs working in a variety of new models on the current contract, with job plans such as the one provided in appendix A. There is no evidence a change to this would provide any additional advantages.

SAS doctors

154. Specialist and Associate Specialist doctors, as a group, face some unique challenges, and we therefore welcome the DDRB’s call to all parties to better reflect these in our evidence. In order to improve our understanding of the working conditions of SAS doctors, the BMA carried out a comprehensive survey in September 2017.

155. Our research identified substantial issues regarding morale and motivation for SAS doctors, with almost one in two describing their current level of morale as being low or very low. More worryingly, it seems that the situation is deteriorating, as 46 per cent of the respondents stated that their morale has worsened over the past year. This is exacerbated by the unacceptably high level of bullying and harassment experienced by SAS doctors. 27 per cent of the SAS doctors that took part in the survey said that they have been victims of bullying, harassment or victimisation in the workplace. The low levels of morale and increased workloads have an impact on SAS doctors’ wellbeing, as half of the respondents reported having felt unwell due to work related stress.

156. On top of this, the SAS charters, which were designed to improve the working lives of SAS doctors, seem to have a low implementation rate with only 22 per cent of the respondents stating that the SAS charter has been introduced where they work (either in full or part). Similarly, over 27 per cent of the

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respondents reported that there were no SAS tutors where they work.\textsuperscript{116} SAS tutors and leads are appointed as contacts for SAS doctors to offer support and guidance on career related issues, education and development, as well as on the use of SAS CPD funding at local level. The lack of support for SAS doctors likely contributing to the morale issues mentioned above.

At the same time, similarly to the rest of the workforce, SAS doctors have been experiencing a steady decline in their real income, which is worsened by the lack of professional development and the reduced access to progression pay. When asked if they had appropriate opportunities to apply for management posts, 41 per cent of the respondents of our survey said that they did not. Similarly, over half of the respondents said that they did not have enough time for professional development.\textsuperscript{117} 70 per cent of the respondents said that SAS development funding has been cut where they worked in the past year, further exacerbating issues with professional development.

As the DDRB acknowledged in its 45\textsuperscript{th} report, SAS doctors play a leading role in health care delivery and it is therefore important that their knowledge and expertise is appropriately remunerated and valued by being given adequate access to training and development.

\textbf{NHS staff survey}

The BMA believes that the NHS staff survey paints an overly-optimistic view of doctors’ experience working in the NHS, as it fails to ask some key questions about the reality of doctors’ working lives and the results of our own surveys have shown significant morale issues for the profession. We are pleased that a large number of doctors do feel able to report that they are enthusiastic about their job. We would, however, suggest that focusing on one headline is misleading, and the NHS staff survey should not be seen as positive overall. A substantial number of responses to other of the survey questions raise serious cause for concern. In our main evidence, we mentioned the issues of lack of time, and lack of staff. We would further direct the DDRB’s attention to the unacceptable levels of stress (one-third of medical staff suffering from work-related stress), violence (15 per cent experiencing physical violence), and harassment and bullying (28 per cent from patients, relatives and public).

\textbf{National dashboard in Wales}

In their submission to the DDRB last year the Welsh Government stated they were “developing a comprehensive national dashboard which is due to go live towards the end of this year, this will then give consistent robust national data to respond to some of the issues raised in the Review Body’s call for evidence”. The BMA is unaware of any developments in relation to this, and would welcome an update from the Welsh Government in relation to this.

The call for systematic publication of more information on medical vacancies in Wales was picked up by the Health, Social Care and Sport Committee in its recent report on medical recruitment.\textsuperscript{118} The report said that: “We are concerned that there is no national system for recording and reporting the number and level of medical vacancies within Wales. We believe effective reporting is central in being able to measure and evaluate the extent of vacancies and the impact and outcome of local and national recruitment campaigns, enable effective targeting of such local and national recruitment campaigns and better inform workforce planning for healthcare in Wales.” A recommendation in the report that the Welsh Government collate and publish the number of medical vacancies in Wales was subsequently accepted by the Welsh Government.\textsuperscript{119}

\textsuperscript{116} British Medical Association (2017) BMA survey of SAS doctors.
\textsuperscript{117} British Medical Association (2017) BMA survey of SAS doctors.
\textsuperscript{118} Health, Social Care and Sport Committee (2017) Medical recruitment. National Assembly for Wales
Scottish Government evidence submission 2017

162. We were pleased to see the recognition by the Scottish Government in its written evidence\(^\text{120}\) that higher earners have been particularly affected by the combined changes to the NHS pensions scheme and the lifetime allowance and its recommendation on paragraph 47 that it should “consider whether the employer’s pension contribution could be used to fund a salary supplement in the event that a member of a pension scheme hits the lifetime allowance”. However, we are disappointed that no progress has been made against this commitment by the Scottish Government to date.

GP appraiser fee

163. GP appraiser fees have not increased in line with costs, as measured by inflation, for a number of years. The GP appraiser fee was standardised at £500 in April 2014 in England, with this being the amount that many PCTs had paid since the introduction of GP appraisal in 2004, and has remained at the same rate since then. This has led to a decline in the real income of GPs engaging in GP appraisal work and has lowered the attractiveness of this activity. At the same time, the workload associated with GP appraisal work has been increasing, particularly with the introduction of revalidation and increased requirement of responsible officers. In a recent BMA survey of GPs, over 60 per cent of those who are appraisers said that their workload per appraisal had increased in the past year and there were no respondents saying that the workload had decreased.\(^\text{121}\) Mirroring this, of those who had previously been appraisers and given up, 87 per cent listed increased bureaucratic workload as a major reason for stopping to work as appraisers.\(^\text{122}\) The appraiser fee forms a significant part of overall GP earnings and therefore needs to be adjusted annually, as has been the case for the GP trainers’ grant, otherwise the combination of increased costs and stagnant fees produce further downward pressure on the already compressed GP real earnings.

GP trainers’ grant

164. Over the past decade, the DDRB has made recommendations on the amount that the GP trainers’ grant should be uplifted by. On several occasions, the DDRB’s recommendation was not implemented in full and, in general, uplifts have not kept up with inflationary pressures over time. As GP educators and trainers spend a significant amount of time on these duties, the real terms cut in the trainers’ grant has a significant impact on their total earnings. Against this backdrop, the workload associated with GP training has increased. A recent BMA survey found that 70 per cent of GPs think that the workload of a GP trainer had increased over the past year.\(^\text{123}\) Similarly, overall workload was the most cited reason for no longer training, followed by the ‘amount of work associated with training compared to the size of the trainer grant.’ This is indicative of the possible recruitment issues that can emerge in the future, if the grant continues to diminish in real terms and relative to the workload of a GP trainer.

GP Expenses in England

165. We ask the DDRB to make a recommendation on GP expenses in England as outlined in this section.

166. GP expenses in England increased by an average of over 21 per cent in real terms from 2005/6 to 2015/16\(^\text{124}\) and have continued to increase since then. Over the same timeframe, investment in general practice to pay for those expenses has been limited. In practice, expenses have been vastly underfunded over a long period and this must be rectified.

167. Over the last two years, the annual GMS contract negotiation in England has included uplifts specifically for general expenses.

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\(^{121}\) British Medical Association (2017) BMA survey of GP appraisers and trainers.

\(^{122}\) British Medical Association (2017) BMA survey of GP appraisers and trainers.

\(^{123}\) British Medical Association (2017) BMA survey of GP appraisers and trainers.

168. For 2016/17: overall 0.84 per cent uplift (£58 million), in addition to £33 million for indemnity increases, comprised of:
   - 42.3 per cent GP pay (£24.5m for a 1 per cent uplift)
   - 40 per cent staff related expenses (£23.2m for a 1 per cent uplift)
   - 17.7 per cent other expenses (£10.25m for 0.1 per cent RPIX uplift).

169. For 2017/18: overall a 1.07 per cent uplift (£76.6m), in addition to £30 million for indemnity increases, comprised of:
   - 39.9 per cent GP pay (£30.5m for a 1 per cent uplift)
   - 43.3 per cent staff related expenses (£33.1m for a 1 per cent uplift)
   - 17.5 per cent other expenses (£13.4m for a 1.4 per cent CPI uplift).

170. Other investments through previous negotiations that have represented specific cost pressures (e.g. CQC fees increase) are not being sought separately and should form part of the general expenses uplift.

171. This shows that the overall percentage uplift for expenses is dependent on all three indices, and therefore all should be uplifted by the same amount to achieve an overall uplift. The proportion of total practice expenses going to GPs is decreasing, which demonstrates the cash terms loss to GPs’ incomes resulting from the underfunding of staff and other expenses.

172. GPs and practices in England must see a realistic increase in funding for expenses this year to reflect the real terms increase in expenses. We would expect an increase to general express of RPI, plus an amount (at least 2 per cent) to represent the historic underinvestment in GP expenses. The Secretary of State has publicly committed £30 million for indemnity increases for 2018/19 as a one-off cost pressure and based on the contractual agreement for 2017/18, therefore this will not need to be factored into any calculation of expenses increase.

173. We would therefore believe the following would represent an appropriate uplift for general expenses:
   - RPI plus 2 per cent for GP pay (39.9 per cent of total expenses)
   - RPI plus 2 per cent uplift for staff related expenses (43.3 per cent of total expenses)
   - RPI plus 2 per cent for other expenses (17.5 per cent of total expenses)
   - RPI plus 2 per cent total.

174. Some expenses, for example locum cover for maternity, sickness and suspended doctors, prolonged study leave, the retainer, and the retention and flexible careers schemes, are reimbursed under the SFE (Statement of Financial Entitlements).\(^{125}\) We expect the recommendation for an increase in general expenses of RPI plus 2 per cent, to be applied also to the amounts reimbursed through the SFE, to reflect the real terms increased expenses these have for practices.

175. Additionally, new expenses have been recognised which must be accounted for. For example, extra expenses related to GP practices using the new junior doctors contract (e.g. the cost of guardians of safe working) which we estimate to cost six sessions per trainee. This equates to approximately £3,000 per trainee and totals approximately to £15 million investment for England.

176. There are also increased costs for practices related to cyber security (following the WannaCry cyberattack); we have estimated approximately £500 per practice would be required to ensure appropriate systems are maintained, representing approximately £3.73 million investment for England. This expense is borne by the practice but is fundamental to the delivery of NHS services (as shown by the recent WannaCry attack) and therefore must be accounted for through further investment in practices’ general expenses.

177. Additional expenses will be incurred by GP practices due to the introduction of the GDPR (general data protection regulations). The fee currently associated with access requests (standard fee of £50) will be removed, but the workload associated with this will remain. The £50 cost of providing access request

reports should be included with GP expenses, although this cost does not take into account the clinical time associated with such requests or staff related on-costs. In addition to the expenses associated with access requests, the GDPR imposes more stringent rules on practices. At present NHS England and the Information Commissioners Office have not yet released their GDPR guidance specifically for primary care, but we anticipate a significant workload increase and financial cost in order to implement and maintain these new regulations. These costs should not be borne by individual practices and must be considered in addition to the previously mentioned expenses uplift.

178. We also expect any increase to apply equally to specific reimbursements for dispensing doctors, who have seen an erosion in their reimbursements over the last decade.
Conclusions

179. The BMA is very concerned about the ability of the DDRB to serve its original purpose. We urge the DDRB to reassert its independence and not be constrained by the Government’s continuing reluctance to properly fund the NHS. It is vital that the DDRB’s recommendations are made on the basis of the evidence considered, otherwise the confidence of the profession in the process may be irrevocably broken.

180. Year after year of below inflation increases have equated to significant real terms cuts in doctors’ pay and the decrease in the value of sterling in the aftermath of the UK’s referendum decision to leave the European Union has increased these inflationary pressures, accelerating the decline in doctors’ living standards. When taken together with multiple other financial changes such as reduction in CEA spending, tax on pensions which has disproportionately hit consultants, GP expenses not rising with inflation and increased pension contributions for all doctors, the stark nature of the reduction in doctors’ income is all too apparent. This cannot continue without an impact on recruitment and retention and we are already starting to see strong evidence of that. We therefore ask the DDRB to explore a mechanism to address the real terms cuts in doctors pay over the long term. Unless meaningful steps are taken towards this direction the resultant negative implications on doctors’ morale, recruitment and retentions will only exacerbate.

181. Insufficient budgeting and a growing, ageing population is leading to doctors being asked to work longer hours and more intensely than ever. This would be a stern test under ordinary circumstances but is not sustainable when coupled with large real terms pay cuts.

182. We are concerned that, as a result, more and more doctors are driven out of the profession and fewer people are applying to medical schools and higher training in the UK, contributing to the wider workforce crisis. This problem is getting worse, not better. The political uncertainty generated by Brexit poses the risk that the ongoing workforce shortages will be further exacerbated, adversely impacting both the existing workforce and patient safety.

183. We believe that a low or zero real terms pay increase, at a time when pay rises in the wider economy run well above inflation, will further impede the ability of the NHS to recruit and retain staff to deliver safe patient care. We therefore ask for a recommendation to uplift the pay of all doctors across the UK in line with the Retail Price Index (RPI), plus £800 or 2 per cent (whichever is greater).
Appendix A

Sample job plan under the model contract for salaried GPs

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<tr>
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<th>Morning</th>
<th>Afternoon</th>
<th>Extended hours (early morning or late evening)</th>
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<tbody>
<tr>
<td><strong>Monday</strong></td>
<td>Surgery and visits</td>
<td>Surgery</td>
<td></td>
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<tr>
<td><strong>Tuesday</strong></td>
<td>Surgery and visits</td>
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<tr>
<td><strong>Wednesday</strong></td>
<td></td>
<td>Surgery</td>
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<td><strong>Friday</strong></td>
<td>Surgery and visits</td>
<td>Surgery</td>
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<tr>
<td><strong>Saturday</strong></td>
<td>Surgery and visits</td>
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<td><strong>Sunday</strong></td>
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