

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

January 2020



Response to 47th DDRB Report and Overarching Position

- The 2019/20 recommendations and subsequent pay awards in Wales, Scotland and England signalled a slight departure from previous years in which doctors had been singled out to receive some of the worst uplifts in the public and private sectors alike. Nonetheless, we have still seen a failure to address years of underpayment and low pay awards. There is no recognition of the huge additional tax bills generated by the Annual Allowance and the high rate of pension contributions.

The combination of sub-inflationary awards across the UK, with the punitive pensions tax rules imposed by the UK Government means that many doctors have in effect seen a pay reduction. We believe this flies in the face of the DDRB's original purpose which was to keep doctors pay in line with '*cost of living, the movement of earnings in other professions and the quality and quantity of recruitment in all professions.*'¹ This is undeniably having an adverse impact on the morale of a depleted and over-stretched workforce that do not feel their contributions are being recognised. Consequentially having a damaging impact on the NHS at a time of unprecedented demand.

- Once again, we were frustrated that governments did not fully implement the DDRB's recommendations. This includes the recommendation for SAS doctors to receive an extra 1 per cent in addition to the 2.5 per cent general increase. Also, the recommendation to increase the value of Clinical Excellence Awards, Commitment Awards, Discretionary Points and Distinction Awards in line with the recommendation for the basic consultant pay scales, which were ignored in England, Wales and Scotland (although in Wales the money was retained in the pay uplift envelope). We believe that all recommendations that were ignored last year must be fully implemented now and back-dated and be treated as entirely separate to this year's pay award.
- The situation in Northern Ireland is unacceptable. The 2018/19 recommendations of the DDRB for hospital doctors² (which was adopted by Department of Health NI) was paid in November 2019. This is compounded by the fact that a decision still has not been made about the pay uplift for 2019/20, with no indication on when doctors will receive this. It has been decided on and paid across the other nations, creating a bigger time lag and effective pay gap between Northern Ireland and the other nations.

It is also important to note that Northern Ireland is dependent on the recommendations of the DDRB for doctors across all branches of practice as there has not been a functioning government or executive since January 2017.

- We know that doctors are angry that the DDRB did not include in its recommendations a mechanism to address the real terms pay cut that doctors have experienced since 2008. We recognise that other public and private sectors have also seen a real-terms cut in pay but the fact that doctors have seen the steepest pay erosion compared to all other pay review body occupations and the wider working population, makes a more compelling case to consider ways in which to deal with the real terms reduction in pay for our members.
- We continue to be concerned about the delays to the announcements of the pay award. Therefore, we repeat our call to return the process back to the previous calendar cycle so that awards can be made at the beginning of the financial year or as close to the start as possible, so that doctors can project their income for the financial year. This is especially important given the complexities of the current pension taxation rules as small rises in pay can trigger large additional tax bills.

¹ Royal Commission on Doctors' and Dentists' Remuneration 1957-1960 report, para 431

² Note that Public Health doctors are also part of the same hospital doctors' contract in N. Ireland.

- We were pleased that the DDRB listened to our concerns and avoided making any recommendations on targeting pay by specialty or geography, as we believe the remit of the DDRB is to make fair recommendations for all doctors across the UK.
- This year, the BMA is calling for an uplift for all doctors across the UK³ of at least retail price index (RPI) inflation, with an additional mechanism to counter the real-terms pay cuts since 2008. We also would look to work with the DDRB on the methodology for addressing the real-terms pay cuts.
- We also ask the DDRB to support our position that Annual Allowance should be removed in defined benefit schemes such as the NHS Pension Scheme, that the DDRB recognise that the lifetime allowance is a potent driver for early retirement and make recommendations as to how we can better retain our most experienced doctors within the NHS beyond the age of 60. We also ask the DDRB to make observations on how national pay scales could be amended to smooth out large incremental pay rises in order to spread out pension growth and minimise annual allowance tax charges.

Our key asks

In our submission of evidence to the DDRB for 2020/21 we are:

1. Calling for all doctors across the UK to be awarded at least retail price index (RPI) inflation and a mechanism to counter the real-terms pay cuts since 2008;
2. Asking the DDRB to support our calls to the UK Government to overhaul pension taxation policies;
3. Support our calls for NHS pay policies to promote equal opportunities for all genders.

Economic outlook

Pay erosion

As noted in previous years' evidence, since the start of the last recession in 2008, doctors have experienced a prolonged pay freeze followed by a cap on pay awards through a period when inflation has often run much higher. According to the Office for National Statistics (ONS), the rate of consumer prices index (CPI) inflation is currently 1.5 per cent (October 2019),⁴ whereas retail prices index (RPI) currently sits at 2.1 per cent (October 2019).⁵

We have included graphs below to demonstrate the fact that doctors have faced an unprecedented cut in their average real terms income after tax and pensions deductions (22.0 per cent for hospital-based doctors in England with some individuals seeing up to 30 per cent real terms pay reduction, 26.8 per cent for contractor GPs and 24.5 per cent for salaried GPs in the UK), which we have charted below in both nominal cash and real terms since 2008-9 (Figures 1-3).

Figure 1: Hospital doctor pay erosion 2008/9 – 2018/19

³ Independent contractors and Junior Doctors in England have secured a 2 per cent pay uplift through their respective contract negotiations. However, both groups have experienced significant erosion in their pay and therefore should be included in any recommendations that aim to undo the effects of the period of pay restraint.

⁴ [Consumer price inflation, UK: October 2019, Office of National Statistics](#)

⁵ [Inflation and price indices, Office of National Statistics](#)

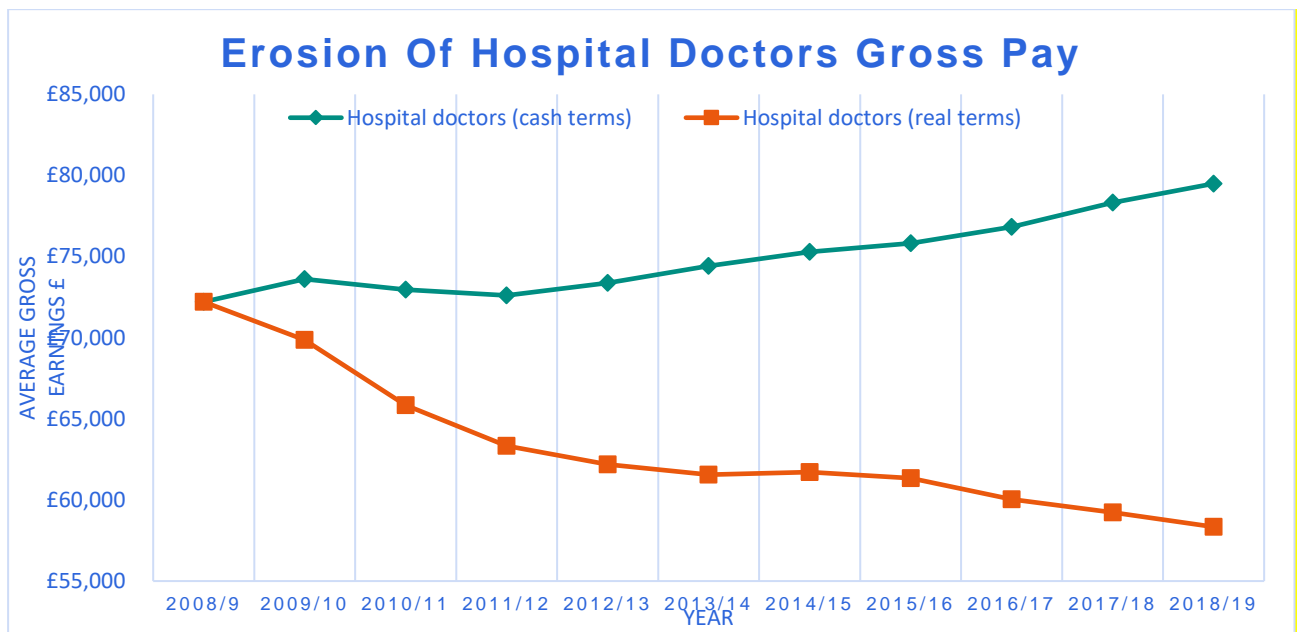
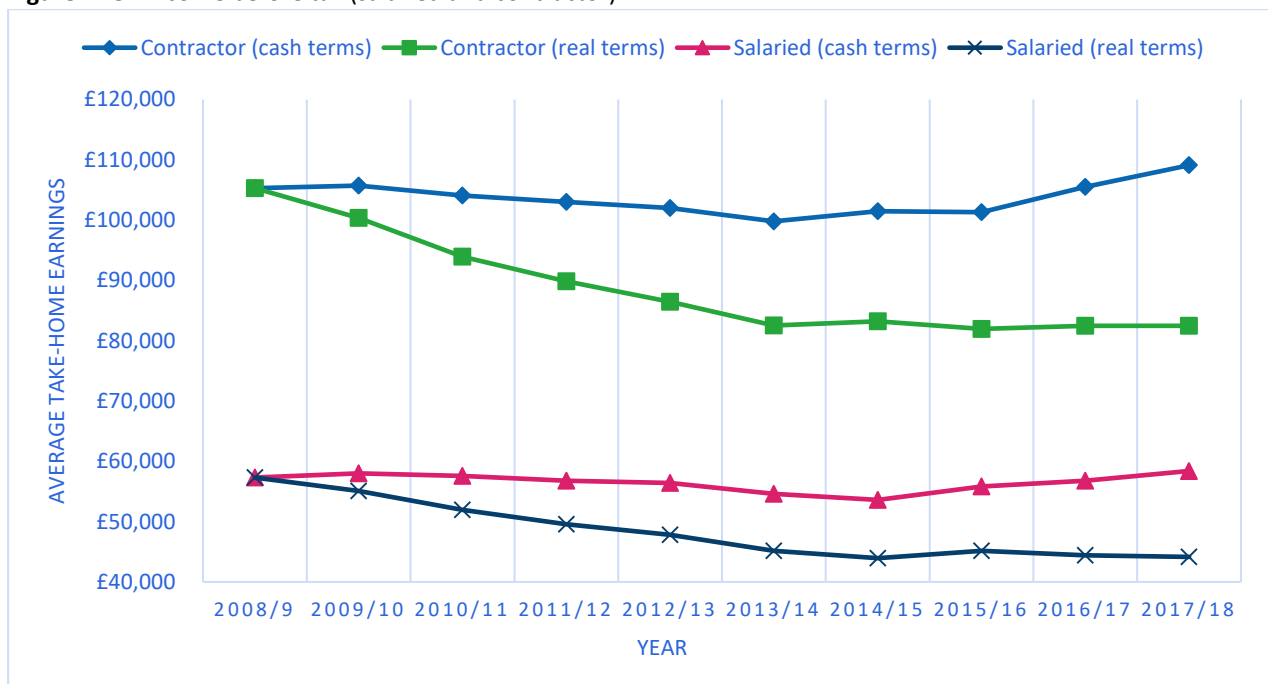


Figure 2: GP income before tax (salaried and contractor)⁶



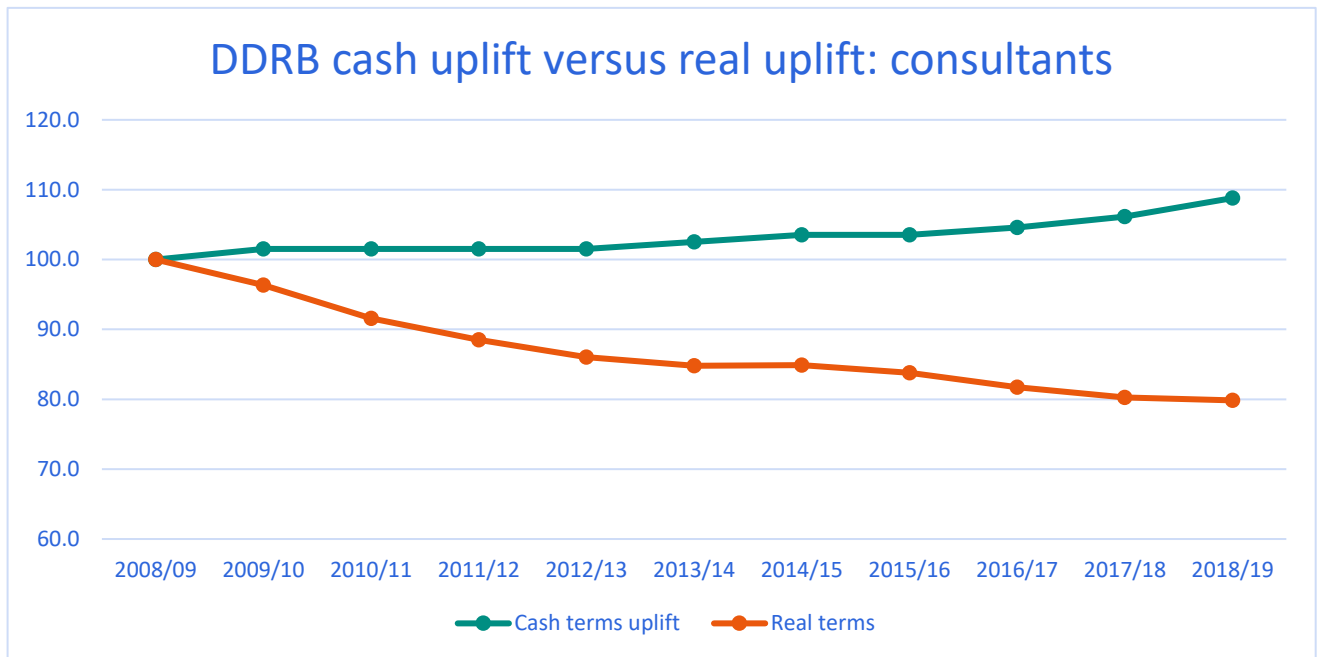
Over the same period of time, the DDRB, through its recommendations and by conforming with government pay policies, has failed to fulfil its original purpose as outlined in the findings of the Royal Commission on Doctors’ and Dentists’ Remuneration in 1960. The Royal Commission recommended that a Review Body was necessary in order to provide the medical profession with some assurances against arbitrary government action and that the process will ‘give the profession a valuable safeguard’.⁷ However, as shown in figure 3, the DDRB’s pay recommendations consistently fell below inflation which means that even if the recommendations were implemented in full, consultants for example would still have seen a significant decrease in real income. In cash terms over the 11 years, the Review Body’s recommendations would have totalled an 8.8 per cent pay

⁶ The only reason GP income appears increased in 2016-17 is the ongoing GP workforce crisis and the falling GP numbers which mean that GPs must work unpaid overtime just to cope with demand.

⁷ Ibid

increase; when inflation is taken in account, the pay recommendations equate to a 20.3 per cent cut to consultants' real pay.

Figure 3: DDRB uplift recommendations against inflation



When the years of sub-inflation pay awards are combined with the increased pension contributions and the wider reforms that have reduced the value of public pensions, the stark nature of the reduction in doctors' total remuneration package becomes all too apparent.

Economic context

Pay in the wider economy rose on average by 2.9 per cent in the year to April 2019 according to the UK government's Annual Survey of Hours and Earnings (ASHE).⁸ Over the period since the peak in UK average in earnings in 2008, the economy has performed poorly on pay. According to the ONS, based on ASHE data, median earnings as of April 2019 are still 2.9 per cent below their peak in real terms. This figure is however relatively small compared to the double digit decreases in real earnings faced by all doctor groups, with some hospital doctors seeing up to a 30 per cent real terms reduction and virtually all doctors having seen their real terms pay cut by double figures over the past decade. Although pay growth has been weak across the economy, pay for doctors has clearly been hit much harder than the average worker.

The Office for Budget Responsibility's latest inflationary forecasts has RPI inflation staying close to 3 per cent over the coming years and CPI at about 2 per cent.⁹ Following the result of the general election and the uncertainty surrounding a possible hard Brexit, there is still the possibility for negative economic impacts such as higher inflation or a fall in the value of the pound. Any pay award would need to take account of the forecasted inflationary pressures, the risks of higher inflation and the loss of income since 2008/09.

Over several years from 2010, the DDRB accepted the UK government's view that pay restraint in the public sector was necessary to fulfil its ambition to eliminate the budget deficit by 2015. The DDRB recommendations in many of the years that followed matched the UK government's pay policies exactly. Pay restraint and real terms pay reduction in the public sector has not meant that the deficit has been brought under control. In fact, a decade later, the UK's debt to GDP ratio has remained high and stands at 84 per cent,¹⁰ compared to 69

⁸ [Employee earnings in the UK: 2019, Office of National Statistics](#)
⁹ [The economy forecast, Inflation, Office of Budget Responsibility](#)
¹⁰ [UK government debt and deficit: June 2019, Office of National Statistics](#)

percent in 2009/10. Although the annual deficit has slowly reduced, the recovery has been weak resulting in consistent high levels of borrowing.

Higher pay can have positive impacts on the rest of the economy through the multiplier effect and can ultimately lead to higher tax revenue. Lower pay in the public sector was also coupled with lower tax for others, therefore displaying a transfer of resources rather than a pure resource constraint in government finances. Although the UK government is likely to claim further resource constraints in its evidence trying to justify further income reduction for doctors, the DDRB should see this for what it is – a political philosophy – and reassert its objective independence. The pay uplift should be based on real cost of living changes, previous reductions to pay and the positive goal of raising standards of living. The pay uplift should not be based on a resource constraint narrative that has been shown to be ineffective at its most basic goals around the deficit.

Workforce and workload: working in a system under pressure

Doctors are working in a system which is under immense pressure due to chronic underfunding, workforce shortages, and rising patient demand.¹¹ This is affecting their mental and physical wellbeing. Intense workloads, understaffed rotas, and long hours are leaving doctors at risk of illness and burnout and putting patient safety at risk. This was demonstrated in a recent Guardian article, where doctors were asked, in view of the pressure the hospital was under, to make clinical decisions in respect of patients that caused the least patient harm.¹²

Medical vacancies persist across the UK

Ensuring a safe working environment for doctors and patients must be a top priority for government. This means having adequate staff to meet service requirements. The BMA is calling for legislation in all four nations to ensure system-level accountability for safe staffing.

'8 out of 18 registrar posts unfilled. Vacancies staffed by locums, Senior House Officers or just left empty. Our managers are trying to impose additional evenings on the current registrars to increase staffing levels – making it less likely they will retain the staff they already have and harder to recruit'
Consultant¹³

There are a significant number of medical vacancies across the UK¹⁴, with a worrying number of posts being left unfilled for six months or more. A multitude of sources report worrying patterns, some key findings are:

- 91 per cent said that staffing levels are inadequate to deliver quality patient care.¹⁵
- 47 per cent of GPs taking part report a doctor vacancy in their practice. Of these, 73 per cent said that at least one vacancy had gone unfilled for six months or more.¹⁶
- Two-thirds of hospital-based doctors have been asked to act up into more senior roles or cover for more junior colleagues, while eight in ten said that individuals at their hospital were encouraged to take on the workload of multiple staff.¹⁷

¹¹ [The state of medical education and practice in the UK](#)

¹² [Doctors told to use 'least unsafe' option in Norwich hospital, The Guardian](#)

¹³ BMA Safe staffing project, a doctor's personal account

¹⁴ In 2019/20 Q2 there were 9,319 medical vacancies in England. Full stats [here](#).

¹⁵ [Future vision for the NHS: all member survey, BMA](#)

¹⁶ [BMA Quarterly Survey](#)

¹⁷ [Medical rota gaps in England, BMA](#)

- Three quarters of SAS doctors reported that they had worked more hours than in their job plan in the past year, according to a BMA survey.¹⁸
- 65 per cent said medical trainees are pressurised to take on extra shifts. More than a third (35 per cent) reported that their employers had re-designed rotas to include fewer doctors, thereby obscuring the rota gap problem.
- A report from the Nuffield Trust, Health Foundation and King's Fund project estimated that by 2030 the gap between supply of and demand for staff employed in England, by NHS trusts could reach 250,000 FTE posts.¹⁹

'Unsafe staffing leads to delays in seeing patients, ordering tests and making management plans. I often need to stay well beyond my working hours to ensure everybody is seen and their needs are met'

Junior doctor

It should also be note that there is no official definition of 'vacancy'. This means that a significant number of 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 being advertising is not included. Additionally, the use of locums to maintain services is not captured. Our ask therefore would be for the DDRB to support our calls to Government to improve the quality of the data collected across all four nations.

Brexit adds another layer of uncertainty and complexity when planning for the future workforce in the health and social care sector. 9 per cent of all licensed doctors (over 22,000) in the UK are graduates from the rest of the European Economic Area (EEA).²⁰ The acute sector of the NHS is particularly reliant on EEA doctors and they make up 14 per cent of hospital consultants²¹ – certain specialties such as surgery (18 per cent) are even more reliant on this group.²² Approximately 5 per cent of GPs are EEA graduates – since 2012 there has been a 10 per cent decline in EEA GPs.²³ BMA survey of EU doctors working in the NHS in 2018, found 35 per cent are considering leaving the UK and moving to another country, with Brexit being an overriding factor.²⁴ We also expect this to have a significant impact on Northern Ireland as they have the highest percentage of doctors who gained their primary medical qualification in another EU country.

Vacancies are directly linked to increased workloads and consequently negatively affect doctors' wellbeing, morale and motivation. The BMA's recent survey²⁵ found that relatively few doctors in the UK work only the hours they are contracted for. Conversely, more than half of doctors work significantly beyond their contracted hours (exceeding their contracted hours by more than an additional 10 per cent).

'One weekend a consultant did a 36-hour resident shift. Staff are working long hours leading to insufficient rest, diminishing morale and poor staff wellbeing. Our work-life balance is greatly reduced too'

Consultant

Service pressures are increasing doctors' workload

Doctors from all branches of practice report that their workload is increasing in complexity. Health and social care services are caring for an increasing number of older people with long-term conditions, whose more

¹⁸ [SAS doctor survey, BMA](#)

¹⁹ [The health care workforce in England: make or break?, Nuffield Trust](#)

²⁰ [The state of medical education and practice in the UK, GMC](#)

²¹ Ibid

²² Ibid

²³ Ibid

²⁴ [EU survey 2018, BMA](#)

²⁵ Ibid

complex and long-term health care needs are placing new demands on the NHS. As a result, patient demand continues to rise across the NHS, for example in England, there were an estimated 26.4m appointments in general practice in September 2019, a 9.7 per cent rise on the previous September²⁶ and 63,288 more patients at GP surgeries as of 1 December 2019, compared to 1 November 2019.²⁷

'Routinely having to handle 120 new calls a day in the practice... [as we are] unable to afford locums... [and it is] very difficult to recruit partners as the pay is so much lower than it used to be... working at much higher intensity than is judged to be "safe". Partners have taken impossibly low drawings for years to make sure that the surgery is staffed even when the practice income is cut again and again'
GP partner

Understaffed and under-resourced hospitals and primary care services are having to cope in increasingly pressurised environments:

- Report by Audit Scotland warned that the NHS is 'running too hot' - referring to staff being under intense pressure.²⁸
- In Scotland, more than 3.5 million working hours have been lost in the NHS through stress or mental health problems, according to figures obtained by Scottish Labour through an FOI.²⁹
- In October 2019 in England, there were 80,092 trolley waits of over four hours, an increase of over 30,000 compared to the same month last year.³⁰
- In September 2019 in England, the waiting list for treatment grew to its highest level since records began, reaching 4.57 million people (including estimates for missing data). Compared to last September, there are an additional 245,024 people waiting for treatment, a rise of nearly 6 per cent.
- In Northern Ireland, 120,000 people are currently waiting for more than a year for treatment.³¹
- During September 2019, 3,465 patients waited over twelve hours in Type 1 EDs in Northern Ireland, 1,754 more than September 2018 (1,711).³²
- Nuffield Trust analysis found that 'a person in Northern Ireland is at least 48 times as likely as a person in Wales to wait more than a year for care.'³³
- The target for 95 per cent of patients to spend four hours or less in emergency departments has never been met in Wales since the benchmark was introduced in 2012.³⁴

Chronic staff shortages and medical rota gaps persist across the NHS which add to an already pressurised working environment for staff. Heavy workloads are increasingly affecting doctors' physical and mental health:

- Our recent mental health survey completed by over 4,300 medical students and doctors found that the vast majority of respondents (80 per cent) were at high risk of burnout – the risk of burnout among respondents was largely driven by exhaustion.³⁵

²⁶ [Appointments in General Practice September 2019, NHS Digital](#)

²⁷ [Patients Registered at a GP Practice December 2019](#)

²⁸ [NHS is 'running hot' and needs to refocus priorities](#)

²⁹ [Call for action on NHS 'crisis' as stress and anxiety-related absences among staff soar, The Scotsman](#)

³⁰ [Combined Performance Summary: September–October 2019](#)

³¹ [Change or collapse: Lessons from the drive to reform health and social care in Northern Ireland, Nuffield Trust](#)

³² [Emergency Care Waiting Time Statistics for Northern Ireland, Department of Health \(NI\)](#)

³³ [Change or collapse: Lessons from the drive to reform health and social care in Northern Ireland](#)

³⁴ [NHS Activity & Performance Summary: September/October 2019, NHS Wales](#)

³⁵ [Mental health and wellbeing in the medical profession, BMA](#)

- A recent GMC survey found that over a quarter of SAS doctors and nearly a third of Locally Employed (LE) doctors feel burnt out because of their work.³⁶
- 40 per cent of respondents reported currently suffering from a broader range of psychological and emotional conditions. Doctors working the longest weekly hours (51 or more hours per week) were most likely to say they were currently suffering.³⁷

‘Shortage of trained staff and employer unable to recruit. We recently recruited a consultant, but they left after 9 months due to stress in the workplace’

Consultant

As a result, doctors are considering leaving or retiring early:

- Concerns about health and wellbeing (including risk of burn-out) is now a major driver in breaks in training according to BMA research.³⁸
- A GMC report has found that a third of doctors are considering leaving clinical practice in the next three years.³⁹
- A 2019 BMA survey found that 6 out of 10 consultants intend to retire before or at the age of 60; for 70 per cent the most important factor influencing retirement age was work-life balance.⁴⁰
- A recent GMC survey found that nearly a quarter of doctors in training and just over a fifth of trainers are burnt out because of their work. As a result, around a third of the current training population has taken a break in the past five years.⁴¹

‘It is unsafe on-call. There are long waits for patients to be reviewed in the acute medical unit and on the on-call wards. The ward nursing team is chronically short staffed too. It’s difficult to retain staff on account of poor working conditions and lack of clear or workable plans out of hours’

Junior doctor

We are also very disappointed that the additional pressures and challenges that specialty and associate specialist (SAS) and locally employed (LE) doctors experience persist. Half of SAS and LE doctors are BME and an increasing number are women. In a recent GMC survey, over a third of SAS doctors and one in four of LE doctors said they have experienced bullying in the past year. In addition, approximately a sixth of SAS and LE doctors who had experienced bullying described it as threatening or insulting comments or behaviours. Of the nine protected characteristics, bullying related to race was most commonly selected by both groups. The independent Caring for doctors Caring for patients report by Professor Michael West and Dame Denise Coia, reveals that bullying and undermining can affect doctors across all career stages and roles. The GMC survey findings suggest that this could be a particular challenge for this group. What is more, over a third of SAS doctors and almost 52 per cent of LE doctors disagreed with the statement that they are always treated fairly.⁴²

The survey also found that even though awareness of the SAS charters and implementation by employers seem to be improving recently across the UK, less than one in three SAS doctors reported that their employer had taken steps to implement the charter and almost a third have not heard of their charter at all. These results were consistent across the four nations with no major difference in indicators between England, Northern Ireland, Scotland and Wales.

³⁶ [General Medical Council \(GMC\): Specialty, associate specialist and locally employed doctors survey – initial findings report](#)

³⁷ Ibid

³⁸ [Junior doctors career trends survey, BMA](#)

³⁹ Ibid 7

⁴⁰ [Consultants pension survey, BMA](#)

⁴¹ [Training environments 2018: Key findings from the national training surveys, GMC](#)

⁴² Ibid

More must be done immediately to retain existing staff

More doctors, nurses and other health care professionals are urgently needed to ensure a safe service for patients. The BMA has called for additional medical school places but given the time it takes to train a doctor to consultant level and the diminished medical academic workforce, a renewed focus on retaining existing staff must be a key priority of NHS leaders to ensure a safe and sustainable health service that values and looks after its workforce.

The BMA believes this is particularly important at the key interface where research meets service. Medical research is a vital activity which underpins all that happens in healthcare. In addition, research done by doctors contributes significantly to the UK economy. A key message from the recent report by the Academy of Medical Sciences⁴³ is that the Government needs to ensure all NHS employers support and encourage the education and training, research and innovation that is undertaken by doctors and other healthcare professionals. We believe that this is the only way forward to protect and enhance the NHS of the future and the quality of healthcare it can offer to patients and ask that the DDRB support these objectives.

Other initiatives which will also improve retention and therefore, we call on the DDRB to support fully and encourage implementation are:

- The BMA's [mental wellbeing charter](#) provides practical steps that employers can take to create healthy working environments for doctors and staff and should be implemented in full.
- The GMC's recent report [Caring for Doctors, Caring for Patients](#) notes that "the wellbeing of doctors is vital because it is linked to a significant problem with retaining doctors".⁴⁴ The recommendations from this report should be implemented in full.
- The [SAS Charters](#) to be promoted and implemented by employers across all four UK nations.
- Opportunities for wider professional activities, such as dedicated time for teaching and research, which it has been demonstrated assist with both recruitment and retention.⁴⁵

We were encouraged that the workforce plans which have been published to date, highlight the importance of valuing and supporting the workforce and improving NHS culture. However, change will only come if the plans are fully resourced and their recommendations are practical and achievable, which we would welcome your encouragement to this regard.

The progressive reduction in the value of the lifetime allowance is also a potent driver of early retirement. In a recent BMA survey⁴⁶ half of doctors suggested they intend to retire before the age of 60, with over half of these citing the current pension taxation as the reason behind this. The DDRB should make recommendations on how to best mitigate this issue and ensure that we can retain our most experienced doctors within the NHS.

Pensions

Introduction

Given the severity of the issue, and the interlinked impact of pay awards, pension growth and additional taxation, it is essential that the DDRB consider the issue of pensions taxation.

The DDRB has previously justified giving doctors either zero percent or sub-inflationary pay awards on the basis that they had high levels of pension growth. However, the current annual allowance rules and the separate

⁴³ [Transforming health through innovation: Integrating the NHS and academia, Academy of Medical Sciences](#)

⁴⁴ [Caring for doctors, Caring for patients, GMC](#)

⁴⁵ [Academic factors in medical recruitment: evidence to support improvements in medical recruitment and retention by improving the academic content in medical posts](#)

⁴⁶ [Paying to Work, BMA](#)

changes introduced in the 2015 scheme have significantly impacted doctors overall total reward package, with some doctors having lower levels of take-home pay despite doing more work for the NHS.

Additionally, punitive annual allowance tax charges are forcing doctors to reduce their working hours or retire early, even though they want to work, and the health service desperately needs them, to avoid unexpected charges on their pension growth.⁴⁷ A recent BMA survey indicated that two-thirds of doctors over 55, and one in eight aged between 35 and 54 are considering retiring within three years.⁴⁸ If working lives were extended by a year this could over time represent a supply boost of between 3 per cent and 5 per cent (assuming average service of 20-30 years with breaks) with perhaps £30 million saved in agency costs over five years.

Other factors impacting doctors' pensions

The introduction of the annual allowance and tapered annual allowance coupled with doctors working patterns made this a significant problem for doctors and the NHS. The key issues causing this are:

- The NHS Pension scheme is a defined benefit which means doctors have no control over their pension growth.
- For consultants there are nationally determined pay increments with pensionable pay rises;
- There is a multiplication factor applied to any in year pension growth which means that even a small rise in pensionable pay can trigger large pension growth.
- The average pay for consultants and GPs is around the 'threshold income' of £110,000 which when combined with pension growth creates a cliff edge, becoming subject to tapering.
- Doctors have a large component of non-pensionable pay, which means doctors can be financially disadvantaged by doing additional shifts or overtime.
- The introduction of the 2015 CARE pension scheme and the way pension growth is calculated separately across each scheme. The BMA has calculated that a consultant with the same earnings profile who was able to remain within the 1995 pension scheme, would have a scheme pays loan that was 10 times less than if they had been forced to transition to the 2015 pension scheme, even if the annual allowance and tapered annual allowance remained in place. They would pay significantly less in tax despite receiving a higher pension with a tax-free lump sum. This effect is driven in part by the fact that it is not possible to build up 'carry forward' of annual allowance if you are in the 2015 scheme as this generates constant background growth. In addition, negative growth in the 1995 scheme occurs when there have been sub-inflationary pay awards, is rounded up to £0 growth and not deducted from positive growth in the 2015 scheme. This is fundamentally unfair.

Inequalities within the pension scheme

Furthermore, there specific issues with the overall pension scheme which disproportionately affect certain groups of doctors. The DDRB should be mindful of this when making overall pay recommendations. These issues include:

- **Annualisation of earnings for sessional GPs** - following changes introduced as part of the 2015 NHS pension scheme, there has been a move to base the level of pension contributions for practitioners on their whole-time equivalent earnings rather than their actual earnings. For sessional GPs and those who take a career break within the NHS pension scheme year may have to tier their pension contributions at a higher rate based on their annualised earnings, rather than their actual earnings. This disproportionately affects low earners and contributes to the gender pay gap as women with caring responsibilities who work less are being hit the hardest, paying more for the same pension benefit as colleagues who are contracted to work throughout the year, despite having significantly lower levels of actual pay.
- **Tiered contributions for less than full-time workers** - a similar issue arises for employed doctors who work part time, the majority of whom are women, doctors with caring responsibilities and those with health issues or disabilities. The pension contribution rates they pay are based on their

⁴⁷ Ibid 10

⁴⁸ Ibid

whole-time equivalent earnings rather than their actual pay. There is no justification for this under a career averaged pension scheme. Particularly, as many face childcare costs, other caring costs or additional costs because they are disabled. Many junior doctors working part-time are also struggling with high levels of student debt. These additional costs and the high contributions relative to earnings can force them to opt out of the pension scheme altogether, thereby giving up vital benefits.

- **Tiered contributions resulting in cliff edges** – a particular issue that arose last year was that as a result of the pay award, many junior doctors in England found that the DDRB pay award meant that they moved into the next tier of pension contributions, with an increase in contribution rate between 9.3 - 12.5 per cent, which offset the effect of the 2019 pay rise. Furthermore, the award was given when many juniors had moved employers, which resulted in their previous employer contacting them asking them to pay extra to make up the pension shortfall. We believe that no doctor should be financially disadvantaged in a year as a result of a pay award. In addition, the tiering of contribution rates more than offsets the benefits of higher rate tax relief on employee pension contributions, meaning that doctors pay more for the same amount of pension even when the higher rate tax relief is factored in, which further reduces the justification for the annual allowance. The DDRB should consider the appropriateness of tiered pension contributions in a CARE pension scheme.
- **Gender Pension Gap** - The gender pension gap is a significant issue and is even wider than the gender pay gap. It goes without saying that the gender pay gap itself has a significant impact on the gender pension gap (further detail on this below). The presence of an annual allowance is problematic. The reason for this is that as women are far more likely to work part time during their career and/or have taken career breaks, they are more likely to have late but career progression. This can result in significant problems with the annual allowance and as a result many people choosing not to take on additional roles.

Additionally, individuals who choose to work part time, will accrue less years of service. Previously this could be offset by the purchase of added years, but this was closed in 2008. Whilst it remains possible to purchase additional pension under the 2015 scheme, the terms offered are significantly inferior and this is an important factor in the gender pension gap. The DDRB should consider reviewing whether the system of added years purchase should be re-opened particularly for those working part time.

- **GPs accessing their pension statement** - following a decision to outsource primary care services England to Capita (PCSE), GPs have experienced significant delays in receiving their pension statements. This has resulted in GPs data being several years out of date and as such it is impossible to predict pension growth, therefore being unable to make an informed decision on their working commitments. It should also be noted that GPs in the devolved nations have difficulties getting access to their up to date pension record due to the overly complicated pension scheme process. The DDRB should recommend that GPs are able to access their pension information in a timely manner, preferably in an electronic format to enable them to ensure that their remuneration is appropriate.

Solutions

The BMA firmly believes that the only long-term solution is to remove the annual allowance (and thereby the tapered annual allowance) completely in defined benefit schemes such as the NHS Pension Scheme. We believe that the annual allowance is completely unsuited to defined benefit schemes. This view is shared by the Office for Tax Simplification (OTS), who have acknowledged that the 'rules are complex and widely misunderstood'. They went on to suggest that annual allowance should only apply in relation to the defined contribution schemes and the lifetime allowance in relation to defined benefit schemes.

Due to the way pension growth is calculated and the interaction between the two schemes, all other suggestions will still lead to instances in which an annual allowance charge is incurred by doctors. In addition, removing the annual allowance but retaining a lifetime allowance in defined benefit schemes and retaining an

annual allowance but removing the lifetime allowance in defined contribution schemes is not only a fair and simple solution but it is likely to be the least costly for HM treasury.

The interim proposal announced by NHS England to pay off annual allowance bills for doctors who breach the annual allowance limit on pension growth in 2019/20, unfortunately does not solve the taxation problems. We have received some legal guarantees to underpin this policy which go a long way to ensuring that even if a doctor's current employer or even NHS England were to not exist in their current form at such a time this commitment would still stand at the point of drawing down their pension.

A similar scheme has been announced in Wales and the BMA is continuing to lobby the Scottish Government to do the same. However, there are also no plans or discussions taking place in Northern Ireland to mitigate the impact of pension tax charges on doctors.

Any interim policies should be made available in all four nations as these issues are causing a workforce crisis across the UK as demonstrated in a survey in Wales:⁴⁹

- 94 per cent of surgeons in Wales are concerned about the current tapered annual allowance and pension taxation rules.
- 55 per cent of surgeons in Wales reduced the amount of time they spent working in the NHS this year, compared to last year, as a direct result of changes to pension taxation rules.
- 53 per cent of surgeons in Wales have been advised (e.g. by an accountant or financial adviser) to work fewer hours in the NHS.

Consultants

Pay cuts have had a damaging impact not only on doctors' living standards but also on their morale, recruitment and retention. Chronic shortages and rota gaps across the NHS, force consultants to work longer hours and more intensely than ever and to act down to cover their junior colleagues. As a result, the consultant workforce feels deprofessionalised, disengaged and demoralised.

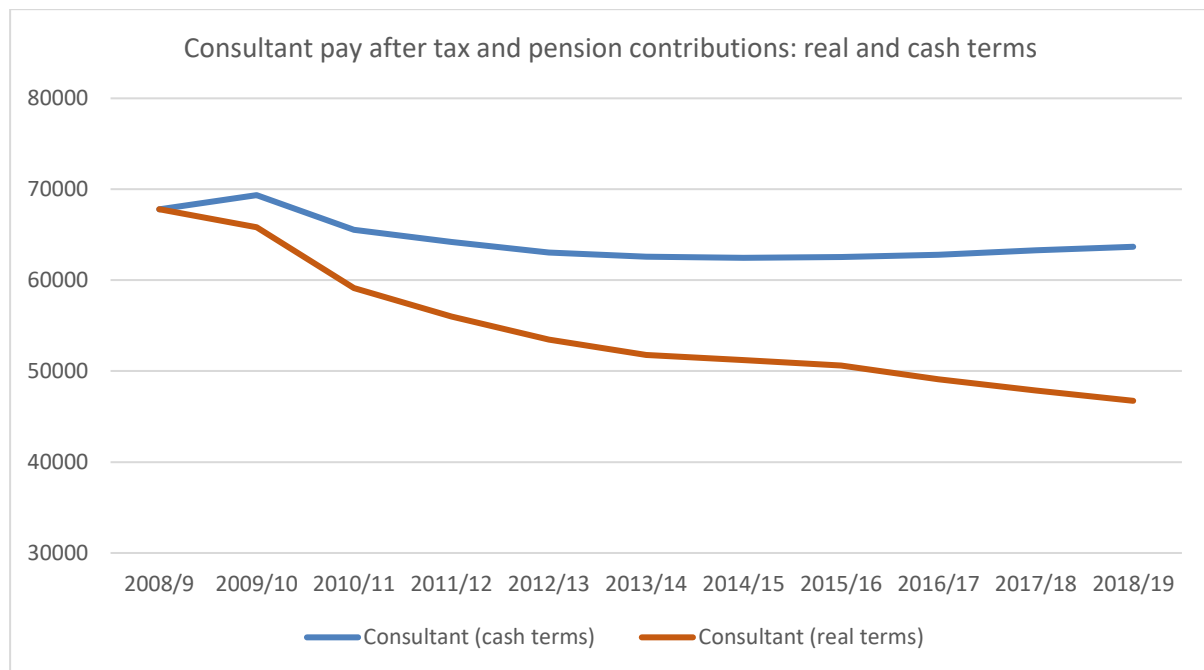
Pay

As outlined above, consultants have faced an unprecedented cut in their average real terms income after tax and pensions deductions as a result of inadequate pay awards. We have calculated that in cash terms over the past 11 years, the Review Body's recommendations would have totalled an 8.8 per cent pay increase, however when inflation is taken in account, the pay recommendations equate to a 20.3 per cent cut to consultants' real pay and in some cases, up to 30 per cent real terms reduction.

At the same time, pay settlements in the wider economy run at 60 per cent higher than doctors' awards and consultants in the UK are paid significantly less compared to their international counterparts, both in the EU and internationally.

Figure 4: Consultant pay after tax and pension contributions: real and cash terms (England)

⁴⁹ [RCS Survey on the NHS Pension Scheme, Royal College of Surgeons](#)



The situation reached a critical point in 2018/19 when some governments across the UK chose to opt for sub-inflationary award of 1.5 per cent. To make things worse, the UK Government's decision to not backdate pay in England meant that consultants received less than a 0.75 per cent uplift in average pay over that year, the lowest of any group within the public sector and less than the 1 per cent consultants had received in previous years. This means that the real terms pay cut that consultants in England suffered that year was even greater than when the pay cap was in place. It has also had a detrimental impact on their pensions which is detailed below.

Another issue of concern for consultants is the fact that the four governments did not accept the recommendation from last year's DDRB report to apply a 2.5 per cent uplift to the national CEA, discretionary points, distinction and commitment awards. This was particularly problematic in Scotland and Northern Ireland where the Scottish Government and the Northern Ireland Executive have been ignoring the DDRB's recommendations to increase the value of distinction awards, discretionary points and CEAs for a number of years, with no new distinction awards being allocated in Scotland and no CEAs at all in Northern Ireland.

Workforce pressures

The retention of consultants has been a neglected issue for many years now. This is in large part due to attention being focused on increased levels of recruitment and a general belief that this means there cannot be any problems with this cohort of doctors. However, there is a paucity of data on the number of consultants we are lacking in terms of current vacancies, unfilled specialty training posts and required future supply. The combination of insufficient staffing levels per head of population, punitive changes to the NHS pension scheme and other workforce issues are collectively having a detrimental impact on consultant workforce.

These recruitment and retention influences are resulting in low levels of consultant staffing in hospitals around the UK, and more needs to be done to collaboratively explore, understand and resolve these multi-faceted issues. Poor working conditions, including unsafe levels of staffing, are damaging to consultants' emotional and physical wellbeing, as well as their morale and rates of retention.

- According to the BMA Quarterly Survey, 67 per cent of the consultants responding to the survey reported working outside their regular hours 'often' or 'very often'.⁵⁰
- A June 2017 survey of Northern Ireland consultants:

⁵⁰ Ibid 6

- 26 per cent of respondents described their workload as ‘consistently unmanageable’
- 72 per cent of respondents describe their morale as either ‘low or very low’
- In Scotland, the Information Services Division (ISD) figures show the official vacancy rate at 7.87 per cent (some 448 vacancies) and approximately 242 vacancies have not been filled after 6 months, demonstrating that many jobs remain extremely challenging to recruit to.⁵¹
- A recent BMA survey of 4000 consultants (58 per cent over 50, 10 per cent over 60 and 83 per cent working full time) highlighted that 60 per cent intended to retire before the age of 60.

‘We opened a brand-new emergency department and immediately closed nine beds as we could not staff them. We cannot fill the numerous rota gaps at all levels. We are several consultants short too’
Consultant

These surveys show that unmanageable workloads impact not only doctors’ morale, motivation and wellbeing but will also inevitably impact the quality of care they deliver. This is further exacerbated by other factors, such as consultants often being forced to act down to cover their junior colleagues, to work increasingly longer hours and more intensely to fill the gaps, otherwise services may be reduced. The BMA believes this can be mitigated by good job planning so that resources can be organised effectively and efficiently in a way which brings mutual benefits to organisations, patients and doctors in the planning and delivery of high-quality patient care. However, in a BMA survey carried out in 2017, more than half of consultants have had a negative experience in their last job planning meeting, and almost a quarter have experienced job planning related bullying.⁵² We are committed to raising awareness of all forms of bullying and harassment and the consequences for doctors’ wellbeing and patient care.

‘We were aware for several weeks that we would have gaps in our trainee cover, since we had too few trainees to fill all of the trainee posts in our department. We had asked the trust to find locums to cover their overnight on calls but were told none could be found. The consultants who were on call overnight when there was a rota gap were asked at short notice simply to be resident on-call to cover the absent trainee. If they objected to working in this way, sometimes because of their age some colleagues felt that they would struggle to work safely if resident overnight or working with a depleted staff complement, they were told that they were not offering an appropriate level of patient care and that cover was their responsibility’
Consultant

Furthermore, the burden of responsibility for patient care ultimately falls on consultants. Although it is often the case that many people are involved in the care of a patient, the responsibility for diagnosis, decisions and treatment within hospitals falls to the consultant. If a patient is tested or treated by a nurse or trainee and something goes wrong, the consultant is responsible. For the most complex cases, which consultants will be likely to carry out themselves, they remain responsible: there is nobody else they can turn to. This can be extremely stressful for consultants and impact on their personal lives and wellbeing. It is important that the DDRB considers this as part of its considerations.

The example used above about an East Anglian Trust which was reported in the Guardian, demonstrates that consultants are the final point of responsibility for care, with initial circulation of the guidance to use the ‘least unsafe’ option being sent to consultants within the trust as they take the responsibility for clinical decisions for the whole hospital system.⁵³ We have also included a number of brief personal accounts of the impact this is having on consultants:

⁵¹ Please note that the actual rate is likely to be running substantially higher than official statistics. The BMA collated FOI data last year which indicated vacancies are around double the level recorded by official statistics.

⁵² [Quarter of consultants experience bullying when job planning, BMA](#)

⁵³ Ibid 6

- *“When we are very short of beds consultants get asked to urgently review all of their current in-patients with a view to discharging them; we get told how many we need to discharge in order to accommodate the people who are waiting for admission. I have felt that sometimes we have to discharge people earlier than I would have liked but we don’t have a choice really. Consultants carry the final responsibility for those decisions.”*
- *“Our on-calls are really busy, and all of our team has to work incredibly hard to meet demand. We have excellent juniors and they are very hard-working, but the plain truth is that we all have simply too much to do for me to be able to supervise them properly when we’re on-call. As the consultant on-call I retain responsibility for them and other members of the team too and what they do but, I can’t know what they’re doing.”*
- *“Whenever there’s a problem in our trust consultants get asked to fix it. Of course, we expect to critique our work and try to improve our performance, that’s part of our job, but it’s everything else. If there’s a problem, any problem it sometimes seems, with patient care we must sort it out. If there are problems in our team, I must resolve it. If there are loads of admissions, consultants get pressured into turning people away at the front door or discharging patients, and some of those decisions can be very marginal. If you have a huge waiting list, even though there is more demand than I can meet and despite the fact that hospital beds are so short I can’t get my patients in to operate on them, the Trust still insists it’s my problem to sort out. I wouldn’t mind sorting some of these things out, but we don’t get any additional time for it, we don’t get any extra resource and particularly we don’t get any recognition either.”*
- An anonymous [blog](#) written by a Consultant working in an emergency department.

It would be fair to report that more of our consultant members feel that the daily stress of their work, the long hours, and personal sacrifices that they make are not being recognised, as year after year their pay is diminishing. This is resulting in retention issues with greater pressures being felt by the workforce, resulting in loss of skilled and experienced staff which will not be easy to repair in the current system. We ask the DDRB to take these pressures into account when recommending this year’s pay uplift as well as support our position on improved terms and conditions, in order to mitigate the current issues with retention.

Pensions

Large, unexpected and unpredictable pension tax bills are hitting senior doctors across the UK. We have seen that this is having a real and significant impact on the NHS, with a recent survey revealing that:⁵⁴

- 30 per cent of consultant respondents have already reduced their work commitments over pension tax charges, and of those who haven’t already, 40 per cent plan to.
- On average, consultants plan to reduce their workload by 2.2 PAs. This is equivalent to about 8.8 hours per week for consultants.
- 47 per cent of consultant respondents plan to retire early over pension tax charges

We firmly believe that unless there are urgent changes to the current regulations, these tax issues will result in exacerbating the current workforce crisis in the NHS. As detailed above, the BMA calls on the DDRB to recommend that the UK Government takes quick and decisive action on this issue to prevent doctors reducing the work they do for the NHS on a large scale.

‘We’re reliant on outsourcing as substantive consultants will no longer take on additional paid sessions [due to] workload plus pension/tax implications... The impact is resignations and retirements.’

Consultant

Furthermore, as stated above last year’s sub inflationary award of 1.5 per cent which was not backdated to April, meant that consultants in England received less than a 0.75 per cent uplift in average pay over that year.

⁵⁴ Ibid 10

As this figure was a sub-inflationary pay rise, doctors were not able to maximise the use of uprating of the opening value of their pension by CPI. In addition, when coupled with the pay rise in April 2019, this has led to supra-CPI pay growth in 2019-20, which for many doctors will effectively receive a pay cut in 2019-20.

Table 1: Demonstrates the effect of the delayed pay rise in England for consultants for 18/19 (with half paid in 19/20) combined with the pay rise for 19/20 which was backdated to April.⁵⁵

Consultant with 1995 service (yrs.)	15	20	25	30
2018/19 April – Sept (2017/18 pay scale)	£86,369.00	£92,078.00	£97,787.00	£103,490.00
2018/19 October – March (delayed pay rise of 1.5%)	£87,665.00	£93,459.00	£99,254.00	£105,042.00
2018/19 Average pensionable pay (0.75%)	£87,017.00	£92,768.50	£98,520.50	£104,266.00
2019/20 pensionable pay (remaining 0.75% + 2.55%)	£89,856.63	£95,795.48	£101,735.35	£107,668.05
2019/20 gross pay rise	£2,839.62	£3,026.97	£3,214.85	£3,402.05
2019/20 net pay rise (after 47% income tax/NI)	£1,505.00	£1,604.30	£1,703.87	£1,803.09
Allowable pay rise (CPI) for AA (2.4%)	£2,088.41	£2,226.44	£2,364.49	£2,502.38
Pay rise over CPI	£751.22	£800.53	£850.36	£899.67
Pensionable rise in 1995 section (80ths) 1995 over CPI	£140.85	£200.13	£265.74	£337.37
Pension rise in 2015 section (1/54 pay rise over CPI)	£13.91	£14.82	£15.75	£16.66
Taxable pension growth for AA (19x)	£2,898.79	£4,039.72	£5,300.96	£6,676.69
AA Tax assuming 45%/taper zone/no CF arising ONLY from pay rise	£1,304.46	£1,817.87	£2,385.43	£3,004.51
Net pay change after income tax, NI and AA tax (arising SOLELY from pay rise)	£200.54	-£213.58	-£681.56	-£1,201.42
Equivalent gross pay change	£378.39	-£402.97	-£1,285.96	-£2,266.84
Equivalent Gross Pay changes (% age)	0.3%	-0.43%	-1.31%	-2.17%

The situation in Northern Ireland is unacceptable. The 2018/19 recommendations of the DDRB for hospital doctors (which was adopted by Department of Health NI) was not paid until November 2019. The BMA requested flexibility around the payment of the uplift, but it was denied resulting in a pay cut and massive pension tax bill for many doctors. This means that there was in effect no pay rise. This is further compounded by the fact that a decision still has not been made about the pay uplift for 2019/20, with no indication on when doctors will receive this. This has already been decided on and paid across the other nations, creating a bigger time lag and growing pay gap between Northern Ireland and the other nations as demonstrated.

Targeted pay, flexible pay premia and productivity

Targeted pay (by speciality and geography)

We recognise that targeted pay has a reputation for addressing recruitment and retention pressures in the public sector and can be used to encourage individuals to work in less affluent areas but given the extent of the workforce crisis in the NHS, it is our view that such incentives would not be able to address the pressing issues the NHS is facing. Targeting pay by speciality or geography would simply move the problem around rather than address the need to recruit more doctors and such an approach is likely to cause more harm to the morale of our members resulting in further motivation problems.

Therefore, we strongly believe that the best way to increase recruitment and improve the working lives of our doctors to safeguard their future in the NHS would be to develop a comprehensive workforce strategy in all four nations, to address shortcomings relating to inadequate workforce planning. At least part of that solution would be through better pay and conditions.

Flexible pay premia (England)

⁵⁵ NB assumes no available carry forward and marginal tax rate of 45 per cent.

With regards to the FPPs already in place in England, 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. With regard to any new pay premia we believe that these are contractual matters for negotiation between the BMA and NHS Employers and out with the remit of the Review Body.

Productivity

The DDRB has been interested in recent years in the notion of targeting pay to support increases in productivity. The BMA has repeatedly argued against this as the performance and efficiency of the NHS relies on multiple factors beyond the performance of individual doctors. For example, productivity of wider teams, activities performed, infrastructure, technology, management, working environment, demand and so on. It is, therefore, the system, not the individuals, that has the biggest impact on performance variance. Doctors have effectively little control over all the variables that affect the productivity of the system they operate within and therefore linking pay to productivity improvements they would not be able to affect would be unfair and demoralising.

Further issues

Enhanced shared parental leave and child bereavement provisions

Earlier this year, the BMA welcomed the introduction of the enhanced rates of pay for shared parental leave (SPL) and child bereavement leave (CBL) to the junior doctors' contract in England and which has now also been agreed in Scotland for all NHS-employed doctors, and by the university employers. We believe all doctors should benefit from this agreement as it would mean that parents are not financially disincentivised from sharing their care responsibilities more equally if they choose to do so. As such, SPL is an important equalities-related employment benefit, which is key to addressing the gender pay gap in medicine and will be another mechanism in which will improve the recruitment and retention of the people working for the NHS.

We ask the DDRB to support our calls to the Governments for the new SPL and CBL provisions to be made available to all doctors across the UK and that these provisions should not be tied to other conditions being accepted.

Gender pay gap

The BMA has been represented on the steering group of the UK Government's Department of Health and Social Care commissioned review of the gender pay gap in medicine in England. We have commented on the draft research findings. However, we have not yet been involved in drafting the final recommendations from the review. It is our understanding that the final full report will be published in February 2020.

The interim findings revealed a gender pay gap of 17 per cent for hospital doctors⁵⁶ and we understand, when comparing full-time equivalent pay, the gender pay gap for GPs is similar. A key factor explaining these pay gaps is seniority and the under-representation of women among consultant, leadership and GP partner roles. However, even after adjusting for seniority and other objective factors, there is still a small gender pay gap.

We hope that the review recommendations will focus on the need to minimise the career costs of caring which still fall disproportionately on women, for example, by ensuring greater access to flexible working and fairer treatment of those who work less than full time (e.g. in pension contributions and CEAs). We also believe that enabling more men to take time off in the early childcare years through policies like enhanced Shared Parental Leave (SPL) will help change expectations, challenge stereotypes and lead to more gender balance in caring responsibilities. The Government Equalities Office guidance to employers on actions to narrow the gender pay gap notes that the gap widens dramatically after having children and employers should encourage men to take Shared Parental Leave and 'Offer enhanced Shared Parental Pay at the same level as enhanced maternity

⁵⁶ [Gender pay gap review finds female doctors earn 17 per cent less, University College London](#)

pay'.⁵⁷ As already stated, enhanced SPL should be available to all doctors across the UK and given the stated Government priority of eliminating the gender pay gap in medicine this should happen as a matter of urgency and not be tied to other unrelated contractual conditions being accepted.

The gender pay gap in total pay is larger than in basic pay. For hospital doctors, this is partly due to the fact that women are less likely than men to receive CEAs because they are less likely to apply for them. The BMA, DHSC and NHS Employers have recently agreed steps in England, to address the gender gap in applications for CEAs and to ensure greater transparency in local CEA decisions and information-sharing with LNCs. We will continue to review the effectiveness of these steps and what more needs to be done to reduce the gender gap in additional payments like CEAs. Negotiations are likely on a new CEA scheme in 2020 and reducing the gender pay gap will be a central feature of considerations.

The review also appears to be showing that the gender pay gap tends to be wider where market forces play more of a role in determining pay. The current shortage of GPs is likely to be exacerbating the gender pay gap among salaried GPs. Practices are struggling to fill vacancies and men tend to be more mobile and able to move or commute longer distances to gain higher pay than women who are more likely to be acting as primary carers. This is supported by recent analysis from the ONS which shows significant gender differences in commuting distances emerging around childbearing age. The shortage of GPs must be addressed, and steps taken to encourage more equal parenting.

GP trainers' grants

The BMA has widely advocated that adequate resourcing is essential in the NHS to ensure the highest quality of patient care. However, GPs who host registrars on placements are not being sufficiently funded to do so.⁵⁸ There is therefore a real risk that the government plans to increase the number of GPs will not be achieved if the underfunding of registrar placements is not addressed to attract and secure the future GP workforce. It is vital that government urgently provides the necessary funds to attract and retain practices to train the next generation of GPs, as we know that workforce challenges in the NHS present a huge threat to health services. It should also be noted that the government committed to extend the time it takes to train in general practice which will inevitably require more GP trainer capacity and thus the need for an increase in the grant to attract more trainers.

GP Appraisers scheme

As previously stated, we welcome the Review Body's recommendation in its latest reports to uplift the rate for GP appraisers and we ask that the fee is adjusted annually in line with DDRB's recommendations.

Medical academic and public health doctors

The BMA calls on the Review Body to support the principle of pay parity for consultants working for the NHS and for public health whether their substantive employer is a university, body such as Public Health England, or a local authority. This principle is vital to ensuring that academic medicine and public health remain attractive places to work and to ensuring that staff can move easily round the system and the workforce can respond to the changing demands placed upon it. Academic medicine also plays a vital role in educating and training the next generation of medical students and doctors and, as noted earlier in this submission, there are already plans to increase the number of medical students.

Since the implementation of the Health and Social Care Act, there has been no formal local clinical excellence awards scheme in England, for Senior Academic GPs (SAGPs) which in turn restricts their access to the national scheme. For consultant clinical academics, the NHS employer is the local Trust, for SAGPs it has been NHS England. Despite lengthy discussions, NHS England has refused to run a local CEA scheme for its medical staff. This has meant that SAGPs have lost awards that they were previously entitled to or have failed to enter and

⁵⁷ [Reducing the gender pay gap and improving gender equality in organisations: Evidence-based actions for employers](#)

⁵⁸ ['Undergraduate teaching in general practice remains severely underfunded', RCGP](#)

make progress through the scheme. This diminishes the attractiveness of an academic career for GPs and risks losing senior GPs to medicine altogether. We believe that enhancing the academic opportunities for GPs is one way of improving recruitment to primary care.

In public health, consultants in local government are being forced off medical and dental terms in a bid to save money. This has the compounding effect of removing their right of access to local and national clinical excellence awards. We believe that in such circumstances and where doctors remain licensed to practice, retain eligibility to medical and dental terms of service and are employed by a qualifying employer, they should retain the right of access to the awards. More broadly, we believe that the contractual right to local clinical excellence awards also belongs to consultant clinical academics with honorary NHS contracts and would welcome the Review Body's support for this position which we contend goes back to the establishment of the scheme back in 1948.

The national living wage and the impact of general practice

The government recently announced that the national living wage in England would rise by 6.2%. This will have a cost pressure on GP practices, as they will not only have to find the resources to uplift the salaries of those entitled to the pay uplift but also those higher on the pay scale as it will inevitably have a knock-on effect up the pay structure. We acknowledge that the BMA and NHS England successfully agreed a 5 year pay deal last year, but as this is a new development which will have a huge impact on GP practice finances, we ask the DDRB to consider this in their recommendation.

General practice in Northern Ireland

The potential agreement in terms of a pay uplift as a result of the industrial action for the agenda for change (AfC) unions will impact on GP practices in terms of their ability to remain competitive and attract key staff into general practice. Additionally, GP's in Northern Ireland are also still liable to pay their own indemnity costs. Therefore, the DDRB must acknowledge this in their deliberations for GPs in Northern Ireland through an uplift in core GMS.

Dental trainee pay disparity in Northern Ireland

Dental trainees in Northern Ireland are placed on pay points much lower than elsewhere in the UK, resulting in not only significantly reduced pay, but a feeling that Northern Ireland dental trainees are undervalued in comparison to trainees of the equivalent experience level elsewhere in the UK. The Department of Health in Northern Ireland has explained this disparity by advising that dental trainees in England are paid on the Core Dental Trainee pay scale, however, in Northern Ireland, the competencies of dentists were reviewed against competencies of junior doctors and the decision made that they were delivering competencies at an Foundation 2 (F2) level and not at core level, so they were put on the F2 pay scale. All dental trainees are recruited nationally through the same process and there should therefore be no difference between the competencies of trainees in Northern Ireland and the other nations. Therefore, we ask the DDRB to support our ask that there be pay parity across the all four nations.

Conclusion

Doctors' pay must stop being cut in real terms and the losses experienced over the past decade need to be reversed now. As we have seen with the drop in worked hours due to the pensions crisis, once too many mistakes are made by governments, it is difficult to reverse the trend. Therefore, we urge the DDRB to recommend a pay uplift this year which will properly recognise and reward this group of public servants.

The confidence of our members in the DDRB process is at an all-time low due to the inadequate pay uplifts our members have received over the last 10 years which has meant up to 30 per cent real terms pay cuts. This is further compounded by the clear lack of independence from government.

There are significant workforce issues resulting in patients facing severe delays in receiving routine and emergency care and staff are working under ever increasing pressure. Therefore, there is a pressing need to

improve recruitment and retention which is not helped by punitive tax bills, underfunded services and lack of proper recognition for the work our members do.

This year we are calling for an uplift in line with RPI for 2020, plus a mechanism to address the pay depreciation that doctors have experienced since 2008. We believe this will go some way towards addressing the worsening morale and wellbeing of our members, which will in turn improve the negative workplace culture of the NHS. We also ask for the DDRB to support our position and insist that the Government urgently reforms the punitive pension taxation policies by removing the annual allowance in defined benefit pensions schemes, such as the NHS pension schemes.

Conclusively, we are asking for a fair and proper system of pay and reward that will reinvigorate confidence in the process and better reflect the challenges and pressures faced by doctors, improves recruitment and retention, and begins to restore pay to appropriate levels after a decade of real terms decline.