

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

January 2021

Response to 48th DDRB Report and Overarching Position

- The BMA acknowledges that the context in which the DDRB submitted its 48th report to the UK and devolved governments was unprecedented. We appreciate that the situation with COVID-19 rapidly escalated shortly after the DDRB completed its submission of evidence process, and therefore, the DDRB was unable to take into account the demands of COVID-19 on the NHS and doctors as part of its report. Nevertheless, we were disappointed that the UK and devolved governments failed to recognise the contributions made by doctors in fighting COVID-19, especially in light of the widespread public support shown for the NHS and our letter to DDRB in May 2020 which highlighted the herculean efforts of doctors.
- We therefore expect that this pay-round must fully consider and recognise the extraordinary work of our members in responding to the exceptionally difficult circumstances of the pandemic, in which they are truly going above and beyond to care for their patients.
- While the 2020/21 pay award as recommended by the DDRB was greater than inflation, the 2.8% fails to address the real terms pay cut for doctors that has been created over the past decade. Meaningful steps to reverse the downwards trend in doctors pay must be taken as a matter of priority. The pandemic has shone a light on how important our doctors are to society and the unparalleled work they do. This has always been the case, but the repeated below inflation recommendations have not recognised this.

We would also like to challenge a comment made in your last report, which states that your *'recommendations and observations are not explicitly intended to undo past decision making'*. We strongly believe that this is part of your role, given the original purpose of the formation of the DDRB was to keep doctors pay in line with the 'cost of living, the movement of earnings in other professions and the quality and quantity of recruitment in all professions.'

- The BMA's representative body passed a motion in September, asking the BMA to withdraw from the DDRB. This was the result of our members feeling repeatedly let down by the review body process, with a decade of derisory pay uplifts and a lack of confidence in its independence. Nonetheless, the BMA decided that this year, more than ever, is a time in which we must submit evidence to ensure the extraordinary efforts of our members do not go underappreciated.
- The recommendation to not increase the value of Clinical Excellence Awards (CEAs), Discretionary Points and Distinction Awards effectively resulted in consultants not receiving the full pay award. Whilst we recognise that these awards contribute to the gender pay gap, using this as a rationale to not uplift them is in our view inappropriate. The reasons for these awards contributing to the gender pay gap are complex and a large component relates to the tiered nature of these awards and lower than expected number of applications from women. However, at this very moment meaningful reforms are being made to the CEA scheme, particularly in England to ensure that these issues are addressed, it is therefore illogical to in effect reduce the value of these awards. Indeed, such an action will only result in disadvantaging women who it is hoped will be more likely to apply and receive awards as a result of these reforms.

In Wales, the Commitment Awards were similarly not increased also resulting in an erosion in pay. Despite their name, we do not view these as an award scheme as such, as all

consultants in Wales with an appropriate length of service are entitled to obtain them. We therefore consider these should be increased in line with the basic pay uplift.

The issue is more problematic in Scotland and Northern Ireland. In Scotland, the Government have been ignoring the DDRB's recommendations to increase the value of their awards and have not allocated any new distinction awards in Scotland. In Northern Ireland, the government suspended CEAs in 2009/10 and these have not been restored and the value of the existing awards have not been increased.

- As the Review Body will know, both GP Principals and junior doctors in England were subject to existing pay awards which increased salaries by a lower percentage than the government's pay award last year. Whilst this was a result of previously agreed multi-year pay deals, these arrangements were agreed during normal times, before the unprecedented demands of the COVID-19 pandemic. The BMA therefore feels that it was incredibly unfair and damaging to the morale of these doctors not to be awarded an additional uplift to take into account their vital contributions during these extremely challenging times.
- There have been significant delays to the public acceptance of DDRB recommendations by the Minister of Health in Northern Ireland and the actual award of the recommended uplift. This has impacted morale and contributed to a lack of pay parity between doctors pay in Northern Ireland and the rest of the UK, particularly during the months of the delays. The 2019/20 pay award for Health and Social Care-employed doctors in Northern Ireland was paid in July 2020, a year later than the rest of the UK. This is unacceptable and the DDRB must insist that the NI Department of Health implement pay uplifts in a timelier fashion. The 2020/21 pay uplift was only committed to in January in Northern Ireland, with no date on which this will be paid. We would be grateful if the DDRB could ascertain the reasons behind these delays.
- This year, the BMA is calling for a significant pay uplift for all doctors across the UK, which not only goes well beyond the retail price index (RPI) inflation but also goes some way towards addressing the real terms pay cuts since 2008. This must be paid at the earliest point to our members. We will be submitting further information on this in the coming weeks.
- It is also vitally important that the DDRB makes a recommendation that recognises the sacrifices of all doctors fighting the pandemic and the huge debt the nation owes healthcare workers at this time. This includes those doctors who had previously agreed multi-year pay deals.
- Whilst we note that the DDRB has previously stated that pensions and the system of pensions taxation is outside their remit, the impact of the changes has been so devastating that we do not believe that the DDRB can ignore the impact when making its recommendations. Indeed, we note in the past that the DDRB have used the 'generosity' of the NHS pension scheme as a reason to justify below inflationary pay awards for doctors. However, the NHS pension scheme is no longer generous for doctors, which we explain in further detail below. The BMA calls on the DDRB, to take into account the impact of these pension changes when making its pay recommendation and support the BMA in its call to remove annual allowance in the NHS pension scheme.

Our key asks

In our submission of evidence to the DDRB for 2021/22 we are asking for:

- A significant and early pay award, that is much higher than RPI and will go some way to addressing the real terms pay erosion doctors have faced over the past decade.
- Recognition that all doctors, including those doctors who had previously agreed multi-year pay deals have gone to extreme lengths to tackle the pandemic and that they should be rewarded accordingly.
- The DDRB to take into account the devastating impact of the current pensions system, including the unfair system of tiering of contribution rates and the impacts of pension taxation on doctors take home pay. The BMA request that this is not only taken into account when making its recommendation but that the DDRB support the BMA in calling for the annual allowance to be scrapped in the NHS pension scheme.

Remit letter

The BMA has well documented concerns with governments attempting to restrict DDRB's remit and we ask that DDRB continues to assert its independence to make a full set of recommendations, irrespective of any remit that a constituent health department might seek to impose.

We are particularly disappointed to note that the 2021 Department of Health and Social Care's remit letter to the DDRB¹ includes selective reading of data around pay and the economy that neither directly nor specifically relate to this particular remit group of doctors and dentists. Notwithstanding the fact that it is inappropriate to include evidence in the remit letter, the figures are misleading.

The letter refers to an Office of National Statistics (ONS) report² that compares public and private sector earnings. However, the specific figures extracted from the report average for the public and private sectors as a whole. The same ONS report, when read in its entirety, very clearly shows that for highly skilled workers such as doctors, there is actually a significantly higher level of gross pay for workers in the private sector (excluding the very smallest organisations which would not apply to the NHS). Nevertheless, the report does not include a specific comparison for doctors, and it is inappropriate to apply pan-sector averages to specific groups.

The remit letter also references another data source, which uses average weekly earnings (AWE) rather than the Annual Survey of Hours and Earnings (ASHE) data. As above, there is no specific comparison for doctors, so the relevance of this to the remit group is questionable. While it is not clear how the figures were calculated, it appears to be an average of the six months change in annual average earnings. This is also a misleading comparison to make, as looking at the actual earnings latest figures (currently October 2020) and comparing these with where they were at in April 2020 and indeed April 2019,³ average earnings have actually increased slightly for both the public and private sectors over those periods, and in fact the private sector has shown a marginally higher increase. However, the remit letter implies that private sector salaries have been cut. The AWE figures are not a measure of the outcomes for employees under annual pay reviews, and the use of averages masks a wide variation in pay deals. Also, the private sector median pay review is currently showing an increase,⁴ rather than a decrease that the letter seems to imply.

¹ <https://www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-remit-letter-2021-to-2022/review-body-on-doctors-and-dentists-remuneration-remit-letter-2021-to-2022>

² <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/publicandprivatesectorearnings/2019>

³ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/averageweeklyearningsingreatbritain/december2020>

⁴ IDR Pay Climate December 2020

Mention is also made to differential employment changes in the public and private sector. Again, although we are unclear what the relevance of overall private sector employment levels are, we feel it helpful to provide commentary on this point. Jobs are created where they are needed, which in the pandemic has been substantially within the public sector. The figures in the remit letter are not referenced and we have been unable to confirm them. However, the ONS dataset⁵ shows that between March 2020 and September 2020, private sector employment fell by 414,000, and public sector employment rose by 96,000. This does not explicitly identify doctors (though using another data source from NHS Digital⁶ we can see that there has been a slight increase over that period by around 4,000, which we have provided more detail on below).

The implication of the content of this remit letter is that pay has no motivational impact. Where there is a clear need for additional staff, a zero or low pay increase will only make the situation worse by disincentivising recruitment and retention, which will make it impossible to provide enough staff to cover the extraordinary requirements during the pandemic and the consequential impact of backlogged care resulting from it. Moreover, a low pay uplift may also prove counter-productive, as recipients will reduce unnecessary spending, so reducing overall levels of economic demand, and potentially creating a vicious circle whereby private sector employers also then reduce their pay deals for employed workers which in turn reduces tax income to support unemployed workers as well as facilitate needed expansion.

Contract updates and recent developments

Welsh GP Contract

In Wales, the BMA GP Committee (GPC Wales) negotiated an update to the Welsh GP contract for 2020/21, successfully concluding an agreement with the Welsh Government and NHS Wales. The contract allowed for contractor and salaried GPs in Wales to receive a 2.8% pay uplift as recommended by the DDRB. It also enabled Welsh GPs to pass on a 2.8% uplift to their staff budgets.⁷ As part of the contractual discussions, GPC Wales and Welsh Government agreed to establish a task and finish group to evaluate data sources on GP practice expenses in time for the next contractual round. However, due to the pressures associated with COVID-19, this has not yet been possible.

Scottish GP contract

GPs received last years' award from Scottish Government as recommended by the DDRB and the BMA Scottish GP committee encouraged practices to pass on the staff uplift. Contractually we have agreed with Scottish Government a time extension to the 2018 contract for development of the attached multidisciplinary teams to reduce inappropriate GP workload and free up more GP time for their role as expert medical generalists. We are currently awaiting the analysis of data on Workforce and Earnings and Expenses collected in January 2020.

SAS contract negotiations – England, Wales and Northern Ireland

In December 2020, the BMA and NHS Employers concluded negotiations on two contracts – a new Specialty Doctor contract and a Specialist grade contract – for SAS doctors in England, Wales and

⁵<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/publicandprivatesectoremploymenttemp02>

⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2020>

⁷ A full summary of the agreement can be found here - <https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/gp-contract-wales-202021>

Northern Ireland. The contract package is currently with relevant stakeholders, including ministers and the BMA's representative structures, for further consideration. If approved, the contract package will subsequently be put to a referendum of BMA members in the SAS grades.

As part of these negotiations, a level of investment to facilitate this contract reform was identified. This funding will be distributed over three years from 2021-2024. It is the shared intention of the parties to write to the DDRB to set out the contract offer in further detail and highlight specific issues for its consideration.

SAS contract discussions - Scotland

Separate discussions between BMA Scotland and Scottish Government on SAS contract reform were ongoing until early 2020, with an agreed Heads of Terms document covering contract negotiations that was awaiting sign off by the Cabinet Secretary. However, in March the Scottish Government paused all work it deemed non-essential to focus on its COVID-19 response. This has remained the Scottish Government's position, and it has been unable to give us a projected start date for the resumption of formal contract discussions. Noting the DDRB's previous concern to raise the profile and attractiveness of the SAS grades, and that its previous recommendations on SAS pay have not been fully implemented, we would ask the DDRB to take this ongoing delay in achieving contractual reform in Scotland into account when determining its pay uplift recommendations for 2021.

GP contract agreement in England

Last year the DDRB recommendation for salaried GPs in England (2.8%) was higher than the amount of funding NHS England and Improvement/government provided to GP practices toward salaried GP pay (1.8%). This therefore led to individual practices having to find the additional 1% to pay their staff, which has put significant pressure on practice finances, and GP principals themselves. Not only were these GP Principals not rewarded with the same uplift as their own staff, but they also had to use much of the funding provided for their own uplift to increase their staff's pay to the level the government decided. The difference between what the government decides and the amount of funding they provided to practices must be reconciled by the government with additional funding, and the same situation cannot be allowed to happen again.

Similarly, the rise in the national living wage has also meant some practices have had to pay significantly more than the 2.8% rise to staff members, without any additional income to cover this, meaning this additional funding can only come from practice accounts and ultimately from GP principals themselves.

On a separate note, the Sessional GP committee undertook a survey of salaried GPs in England in the Autumn and they found that 19% of respondents on the BMA model contract reported that they did not receive last year's pay award and were not expecting to receive any uplift, this is compared to 32% not on the model contract. We would welcome the DDRB, in making its recommendations, make it explicitly clear that their recommendations are made to all salaried GPs regardless of their contractual status. We would also ask the DDRB to express its disappointment when its recommendation is not implemented for salaried GPs on the model contract.

Scotland COVID-19 payment

A £500 payment was paid to all full-time NHS staff and social care workers in Scotland in acknowledgement of their "extraordinary service" during the coronavirus pandemic. This was a welcome gesture to recognise the professionalism and value doctors have clearly demonstrated in their response to COVID-19. However, the BMA hopes that this is merely the first step towards truly

valuing the work that doctors continuously do. Furthermore, a non-consolidated one-off award should not be made to supplement a poor pay uplift. We would therefore hope that the DDRB in its recommendations to the UK and devolved governments commit to successive pay uplifts that properly address the long-term decline in real terms pay.

Response to COVID-19⁸

Throughout the COVID-19 pandemic, all doctors across the UK have demonstrated extraordinary levels of commitment and a willingness to exceed expectations by taking on additional work and clinical duties outside of their workplans at short notice, often to their personal detriment and without adequate protection. We have also seen unequivocally the importance of public health medicine in ensuring the health and safety of the UK. Doctors have shown significant flexibility, with many agreeing to change their working patterns, rotas, out-of-hours work and SPA time in order to respond to the increased pressures on the NHS.

Developing innovative ways of working

Prior to the emergence of COVID-19, the NHS was already under strain. In January 2020, NHS England reported its worst performance figures against all major metrics since such records began. The pandemic has exacerbated this situation by putting unprecedented demands on the system. This has acted as a catalyst for rapid innovation in the NHS, predominately led by doctors on the frontline, in order to cope with such demands.

Across the UK, doctors developed innovative, well-organised systems and new delivery models to continue providing high-quality care to patients. This required expertise, leadership and flexibility from doctors to respond to such demands, as well as significant changes to their working patterns, conditions and environments. The BMA Northern Ireland survey found that:⁹

- 98% of GPs moved to telephone/online triage followed by comprehensive remote consulting with risk assessed face to face work continuing where needed
- 66% of secondary care doctors increased the amount of work they do remotely
- 56% of consultants and SAS doctors have used more technology to carry out patient consultations

The provision for IT has historically been poor in the NHS, with many hospitals relying on old technology. This has led to many having to use personal devices and what is more, we have received reports that many secondary care doctors have had to purchase or upgrade their own equipment in order to work remotely. Yet the costs associated with this has frequently not been reimbursed by their secondary care employer. If the NHS is to retain some of the more innovative ways of working, which can bring with them both cost savings and patient benefits, it is important that doctors are reimbursed for the use of equipment. Indeed, we note the increase allowances recommended by the Independent Parliamentary Standards Authority to support remote working and suggest that the DDRB explore similar arrangements.

⁸ During the COVID-19 pandemic, the BMA has conducted a regular COVID tracker survey to better understand doctors' experience and the impact of COVID-19 on their working conditions. The analysis has been referenced throughout the BMA's submission of evidence and the analysis of these findings can be found here -

<https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-bma-actions-and-policy/covid-19-analysing-the-impact-of-coronavirus-on-doctors>

⁹ <https://www.bma.org.uk/bma-media-centre/over-two-thirds-of-ni-doctors-say-they-have-been-unable-to-provide-a-full-range-of-services-to-non-covid-patients-as-we-approach-christmas-latest-bma-survey-finds>

More generally, beyond COVID-19, the BMA believes that upgrading IT infrastructure would vastly improve patient care, reduce individual staff workload burden, and help patients better manage their own wellbeing long into old age. In our NHS infrastructure, technology and data report,¹⁰ we highlighted the impact of poor IT infrastructure on doctors, estimating that 8.15 million medical hours per week¹¹ could be freed up by investing in better IT alone. If the NHS is to capitalise on the changes mandated by the pandemic, it is vital that the IT infrastructure available to doctors is improved.

Redeployment

Doctors were readily willing and able to adapt to sometimes unfamiliar settings or to a much more intense pace throughout the pandemic, and in some cases with limited training available, in order to support their colleagues in delivering the highest level of care for patients. BMA surveys found that:

- As early as August in the pandemic, over 53% of respondents in England and Wales had been redeployed or had their rotas changed.¹²
- In Northern Ireland, one in five consultants or SAS doctors were redeployed to a different site or service to that at which they usually worked.¹³

Many have continued to work with no guarantee of when they might return to their prior role and in some cases doctors have been pressed to continue in those roles by their employers despite their objections. As of December, nearly 35% of respondents to a BMA survey of English, Welsh and Northern Irish doctors currently redeployed noted they had no agreed end point for their temporary role¹⁴. This uncertainty risks undermining the motivation of doctors and may in turn result in further attrition of the workforce.

Even though redeployment (unless the employment contracts states otherwise) should legally be voluntary, we have received concerning reports of employers forcing doctors to be redeployed, with no notice and with no prior consultation or agreement. This can be especially detrimental to doctors with caring responsibilities and can compromise doctors training progression or adversely impact the ability to train medical students, diminishing the supply of doctors in the future. Additionally, it is of paramount of importance that when doctors are redeployed in rotas or work patterns of higher intensity they are remunerated accordingly.

As noted above, the pandemic has had a significant impact on doctors in training grades or academic roles who have been redeployed. Many foundation, core and higher trainees have spent long periods of time on intense and often constantly changing COVID-19 rotas, which is likely to delay their progression and have a detrimental impact on their wellbeing. In the COVID-19 tracker survey, over a third of all trainees, and slightly fewer academic consultants/GPs report that this had worsened during the pandemic.¹⁵ Yet in some cases no local pay arrangements have been reached for them despite the service provision they have delivered. Therefore, it is important that this is recognised in any pay award made for this group in recognition of their work during the pandemic, and including junior doctors working in England. If they are not included by virtue of the multi-year agreement, which was agreed in normal times, this will have a significant impact on morale and in turn have an

¹⁰ BMA report, *NHS infrastructure, technology and data*, 2019: <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/technology/nhs-technology-infrastructure-and-data-report>

¹¹ Equating to 4,870 full-time equivalent doctors working 37.5 hours a week over the calendar year.

¹² Ibid, August 2020 survey results

¹³ Ibid

¹⁴ Ibid, December 2020 survey results

¹⁵ Ibid

impact on recruitment and retention with them feeling overlooked and underappreciated for the efforts they have made over the past months. Additionally, the framework agreement of the junior doctor contract agreement, on the pay deal, specifically states that *'there will be an annual pay uplift of 2% over the next four years. The DDRB terms of reference allow them to make further pay recommendations or observations should one of the parties request it, or indeed where they consider it appropriate'*.¹⁶ This clearly demonstrates that the DDRB has the ability to make a recommendation in light of the pandemic and therefore, we feel it is crucial for them to do so.

Furthermore, many consultants have also been redeployed during the pandemic. While many of them have willingly been redeployed to aid patient care, this has for many meant the re-familiarisation with clinical roles and skills that have not been needed for many years. Alongside that they have reported experiencing increased levels of anxiety as a result of working in areas with high risk of exposure to COVID-19 infection.

Medical students stepping up and retired members returning to the health service

During the first peak of the COVID-19 pandemic, 28,000 doctors made themselves available to return to work, but only a small proportion were eventually deployed. Many doctors that applied reported encountering largely administrative difficulties when trying to return. While many staff were restored to the temporary medical register, it has not been possible to provide all of them with productive work. This is a serious shortcoming at a time when there is great need for medical personnel.

The NHS must find better ways to harness the skills of a willing and available workforce at a time when they are so obviously needed to ease the pressure on the existing workforce. As a minimum requirement, returners should receive an induction, have access to a mentor and be able to have open conversations about how they are able to contribute, including within medical education. There also needs to be adequate funding in place to employ returning doctors.

England

In England, during the first wave the BMA and NHS Employers published two joint statements; one relevant to consultants, consultant clinical academics and SAS doctors¹⁷ and the other relevant to junior doctors.¹⁸ The statements recognised that depending on local circumstances and on a temporary basis many working patterns, rotas, work schedules, out-of-hours work or SPA time may change. For junior doctors, the statement specifically provided employers the flexibility when absolutely necessary to suspend relevant working hours restrictions and rest requirements in the terms and conditions, resulting in many junior doctors working more than one in two weekends; this was in place until withdrawn in July 2020.

These statements demonstrated the commitment of doctors to go above and beyond and highlighted the importance that staff work did not work in a manner that compromised their own or their patients' health or safety.

Alongside these statements, the BMA approached the Department of Health and Social Care (DHSC) and NHS Employer's (NHSE) in order to try and agree national rates for COVID-19 related additional

¹⁶ <https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/Framework-Agreement.pdf>

¹⁷ <https://www.bma.org.uk/media/2425/bma-joint-statement-for-consultants-and-sas-during-covid-may-2020.pdf>

¹⁸ <https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/Joint-statement-on-managing-rotas-NHS-Employers-and-BMA.pdf>

or extracontractual work. Our view was that this would be helpful in terms of providing both employers and doctors with clarity on how this work should be scheduled and remunerated. Unfortunately, however, despite our best efforts, NHSE and DHSE were not given a mandate by government to agree rates for extra-contractual work and instead suggested that this was left to local agreements. This led to a variety of different rates being agreed, on occasion for doctors working at the same trust. Even worse, in some areas, no additional pay was provided, which meant that doctors worked significantly surpassing their contractual duties and arrangements with no recognition or reward. Clearly this is not equitable and consumed unnecessary amounts of discussion time that could have been better utilised caring for patients. What is more, it had an extremely detrimental impact on morale among doctors in England, as many believe that their willingness and extraordinary efforts have not been fairly or consistently recognised by their employers.

As the second wave of the pandemic progressed alongside the backlog of the elective work and winter pressures the BMA issued unilateral guidance for juniors doctors¹⁹, SAS doctors²⁰ and consultant and consultant medical academics²¹ on developing new working patterns, incorporating many of the lessons learned from the first wave.

GPs have seen a significant increase in practice expenses over the pandemic period – much of which has not been covered by funding provided by the government/NHS England and Improvement. This has negatively impacted the earnings of GP Principals, who have worked tirelessly to ensure their practices remained open for business during the pandemic, running the largest flu campaign in recent history while managing the massive and complex COVID-19 vaccination programme.

Scotland

In response to the first and second wave, BMA Scotland agreed with the Management Steering Group²² statements on the application of contractual provisions for junior doctors and dentists in Scotland during the COVID-19 pandemic.²³ These statement outlined the temporary working arrangements which allowed junior doctors to excel in their response to the pandemic – including rota changes, redeployment, and annual leave policies, amongst others. As elsewhere, the first wave caused widespread disruption to junior doctor training with the suspension of planned rotations, widespread deployment etc. Rota monitoring was also suspended in March and only reinstated from August.

We also published a joint statement in September with the Scottish Government and NHS Scotland Employers, which covered COVID-19 working arrangements for consultants and SAS doctors. It reinforced that any changes to working patterns needed to be agreed through the established job planning process.

Of key importance in the discussions leading up to this joint statement was the BMA proposal to the Scottish Government of a temporary national solution, where substantial disruption to normal consultant and SAS doctors working patterns would be adequately remunerated. The intention

¹⁹ <https://www.bma.org.uk/news-and-opinion/statement-on-junior-doctor-rostering-and-workforce-management-during-the-second-wave>

²⁰ <https://www.bma.org.uk/advice-and-support/covid-19/your-contract/covid-19-terms-and-conditions-sas-doctors-and-consultants/changes-to-working-patterns-and-pay-rates-for-sas-doctors-in-england>

²¹ <https://www.bma.org.uk/advice-and-support/covid-19/your-contract/covid-19-terms-and-conditions-sas-doctors-and-consultants/changes-to-working-patterns-and-pay-rates-for-consultants-in-england>

²² Representing the Scottish Government and NHS Scotland Employers

²³ <https://www.bma.org.uk/media/2431/bma-joint-statement-junior-doctors-COVID-19-may-2020.pdf> and <https://www.bma.org.uk/media/3487/bma-msg-joint-junior-doctors-rota-guidance-nov-2020.pdf>

behind this was to reflect the intensity of the work and the level of disruption to the work-life balance of doctors caused by such working patterns.

It also reflected the local arrangements in place pre-COVID-19 across numerous specialties in several NHS boards across Scotland, where shift working had already been introduced. Despite our best efforts to reach an agreement, our proposal was rejected in the summer. Instead, the Scottish government indicated that local agreements should be reached. To date only one NHS board in Scotland has implemented such an agreement.

Wales

BMA Cymru Wales agreed a joint statement with NHS Wales Employers and the Welsh government on the application of the 2002 terms and conditions of service for junior doctors during COVID-19. With one or two exceptions, the BMA did not agree any changes to the terms and conditions of service. Instead, we have worked with stakeholders to come up with solutions that protect the safety, wellbeing and pay of doctors whilst ensuring the effective running of the NHS in Wales. This includes rotation freezes, with the agreement stipulating that any agreed temporary rotas must remain under constant review and be both proportionate to demand and sustainable for doctors. This joint statement was initially published during the first wave of the COVID-19 pandemic, with an updated agreement having also been reached for the second wave.

Although they may have been deemed necessary, rotation freezes were not necessarily seen as positive by junior doctors and in many cases had an adverse impact on their wellbeing. Another negative impact upon junior doctors came from the cancellation of study leave and annual leave, including last minute requests to cancel leave just prior to Christmas. Despite an adverse impact on their welfare and finances, junior doctors also tolerated cancelled, delayed and adjusted examination and recruitment processes.

Unfortunately, not all aspects of the joint statement were fully adhered to with some junior doctors finding rota changes were imposed on them with less than a day's notice. In addition this, one of the exceptions to maintaining terms and conditions of service that was included at the request of employers was the suspension of rota monitoring, which led to reduced assurance on both safety and contractual compliance for junior doctors (with many finding their rotas were changing on a weekly or monthly basis).

During both the first and second waves, consultants and SAS doctors have been asked at short notice to take on considerable extra or new clinical duties not in line with their agreed pre-COVID-19 job plans. Many have had to radically change their normal working pattern and job plan to ensure there is senior clinical input available 24 hours a day, seven days a week. This has resulted in increased out of hours working and loss of time spent supporting activities such as governance, safety and training. The loss of routine and urgent clinics and theatres has led to increased waiting lists and additional stress and strain on doctors who remain clinically responsible for their patients with no hope of treating them in the foreseeable future.

We therefore agreed an advisory notice with the Welsh Government and NHS Wales Employers that if a doctor's hours have changed because of COVID-19, they should be paid an enhanced rate. This advisory note was initially in place for the first wave and was subsequently reinstated for the second wave. For the second wave, the enhanced rates are being backdated from 1 November 2020 and will apply until 31 March 2021.

Northern Ireland

Throughout the pandemic doctors in Northern Ireland have worked above and beyond their existing terms and conditions.

Across all branches of practice, doctors in Northern Ireland faced significant upheaval and changes to their normal working patterns. Surge rotas were implemented in all trusts and across many specialities resulting in additional responsibilities and disruption to many of our members. These pressures included but were not limited to additional on call responsibilities, both resident and non-resident, multi-site working, working a different specialty, working at a different site and the cancellation of annual leave.

During the first wave of the pandemic BMA Northern Ireland agreed the suspension of the monitoring process with the Department of Health (NI) and health and social care trusts. This removed a significant administrative burden from the trust and increased the amount of time junior doctors could dedicate to patient care. The removal of monitoring removed a safety net, rendering rotas unchecked in terms of their contract. Additionally, BMA Northern Ireland provided guidance to junior doctors on key principles that should be adhered to regarding any changes to their rotas in response to the COVID-19 emergency. During the second wave BMA Northern Ireland produced a statement on junior doctor monitoring and workforce management, outlining the potential impact of COVID-19 on terms and conditions. The statement was designed to ensure that staff safety and wellbeing remained paramount throughout this difficult period, whilst recognising the need for a degree of flexibility. This included guidance on rota changes, redeployment, annual leave policies, etc. It was particularly disappointing that the Department of Health and trusts were unable to agree to this statement.

BMA Northern Ireland took a proposal to the Department of Health (NI) for a national solution to adequately remunerate doctors who faced substantial disruption to their normal working patterns. Two solutions were put forward, one for consultants/SAS doctors and one for junior doctors. Despite the efforts of BMA Northern Ireland to negotiate these agreements, and the intensity of the work undertaken by doctors, the Department of Health (NI) did not agree to either proposal, instead preferring that local solutions be agreed.

Separate to the pandemic, two issues we highlighted in last year's DDRB evidence continue unaddressed in Northern Ireland:

- Dental trainees continue to be placed on pay points much lower than those elsewhere in the UK. This is despite all dental trainees being recruited nationally, inevitably this creates a recruitment issue when a trainee in Northern Ireland is underpaid compared to their colleagues elsewhere in the UK.
- GPs in Northern Ireland are the only doctors in the UK who now must pay their own expensive indemnity costs. These indemnity costs may be a block for those who wish to increase the number of sessions they work to facilitate the rollout of the COVID-19 vaccination programme, as an increase in sessions will lead to an increase in indemnity costs.

Impact of COVID-19

High levels of burnout

Pre-COVID-19, NHS staff sickness absence rates were already double the national average,²⁴ placing major burdens on the NHS in terms of cost and continuity of care. While we are aware that a significant proportion of staff will also come to work when they are unwell, we consider that this absence rate demonstrates an at-risk workforce, who are more likely to be exposed to transmissible diseases, and who are also more likely to be subject to intense pressure and overwork that will negatively impact their overall health and wellbeing.

In the most recent NHS Staff Survey²⁵ 56.6% of staff reported attending work despite feeling unwell because they felt pressure from their manager, colleagues or themselves. Work-related stress is also a significant contributor to NHS workers feeling unwell, affecting over 40% of staff.²⁶

This situation was clearly unsustainable prior to the arrival of COVID-19. The pandemic has laid these workforce shortages bare and drastically compounded the health, wellbeing and morale problems encountered by doctors, many of whom have lost colleagues and patients to COVID-19 as well as risking their lives on the frontline and have seen work patterns significantly altered.

The pandemic has intensified the range of wellbeing issues that NHS staff face:

- Over 45% of respondents to the most recent tracker survey (December 2020) of doctors in England, Wales and Northern Ireland reported that they are currently suffering from depression, anxiety, stress, burnout, emotional distress or other mental health condition that both relate to or are made worse by their work, and which have worsened since the start of the pandemic.²⁷
- Over 62% of respondents to this survey reported their current level of fatigue or exhaustion from working or studying during the pandemic to be higher than normal.²⁸
- The BMA's own mental health and wellbeing support services saw a 40% increase in use over March, April and May 2020, including from those feeling anxious about going to work and facing unknown and unprecedented situations.
- NHS Digital data shows that depression, anxiety or other psychological illnesses are consistently the highest reported category of sickness absence for NHS staff, accounting for the loss of 472,715 full-time equivalent days and one third of all recorded sickness absence in August 2020 across all staff groups²⁹. This remains at a higher level than previous years, and we anticipate that data for subsequent months will show this rising again as staff weather the impact of the second and now third waves alongside the winter crisis.

²⁴ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/april-2020-provisional-statistics>

²⁵ https://www.nhsstaffsurveys.com/Caches/Files/ST19_National%20briefing_FINAL%20V2.pdf

²⁶ <https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/>

²⁷ Ibid, December 2020 survey results

²⁸ Ibid, December 2020 survey results

²⁹ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/august-2020>

In May 2020, the BMA asked members to discuss and provide examples of pressures they were under. We received over 2000 testimonials from UK doctors across the NHS detailing how they had been impacted by the pandemic.³⁰ Here are some of the comments we received include:³¹

"I signed up to be a doctor. But my family didn't choose this career path, I feel like I've forced the risk on them, and I can't get away from the guilt."

"At times it felt completely relentless without an end in sight. The most traumatic part was the stress on patients, and even more so, their relatives."

"The fatigue after wearing PPE all day cannot be underestimated. It impacts on what I physically and mentally could do after a shift of work."

The situation has been made much worse as the impact of the pandemic has meant that many doctors have had annual leave cancelled or have not been able to book annual leave due to the needs of the service. Annual leave is an important factor in supporting staff health and wellbeing and therefore we were pleased at the government's introduction of temporary statutory rules that mean that employees who are unable to take their annual leave entitlement due to COVID-19, can carry over up to 20 days (pro-rated for part-time staff) of annual leave over a two year period. For contractual annual leave, NHS Employers have issued guidance for England stating where employees cannot use their full entitlement of annual leave because of the pandemic, employers should consider revising their local policies to exercise maximum flexibilities in relation to carrying over leave to the next leave year. Despite this clear steer centrally, we are aware that some employers locally have ignored or misinterpreted this clear guidance and denied doctors the opportunity to carry over leave that was not able to be taken, which means that some doctors have completely lost this key contractual requirement without any recompense. In addition, we must also recognise the impact COVID-19 has had on those in education and training. Junior doctors have had their rotations frozen while medical students have had to step up out of the education system to support the efforts to tackle the pandemic. It is important that any missed learning opportunities are restored, and completion of training is achieved when the health service is capable of doing so.

However, junior doctors, many of whom are juggling caring responsibilities alongside studies and their clinical work, now have more intense rotas as a result of the pandemic which equates to reduced opportunities to revise for exams. Therefore, we must recognise that there is a real risk that this increase in stress and decrease in opportunities to study for vital career-defining examinations may increase the likelihood that junior doctors experience burnout and need to take time out of their clinical work.

It is also true to say that consultants have experienced an extremely hard pandemic. As noted above, they have contributed significantly to redesign services and redeployment of all grades of medical staff as the crisis unfolded. This is whilst they have continued to oversee and deliver patient care of the most in need, sometimes requiring them to make extremely difficult decisions. Yet in this context, it is also worth remembering that the demographics of the consultant workforce in respect to age mean that for many, COVID-19 carries very substantial personal risk. Despite that, consultants have been completely committed to providing the best quality of patient care. It is, therefore, vital that this year's pay uplift recognises the pressures doctors have been under and the level of service they continue to provide during this extraordinary time.

³⁰ Ibid, June 2020 survey results

³¹ More full list of the testimonials can be found here - <https://www.bma.org.uk/media/2525/01062020-free-text-answers.pdf>

Vacancies and the future supply of doctors

Consistent workforce shortages across the medical profession over many years have contributed to doctors being overworked, which has long impacted morale through placing increased and unnecessary pressure on doctors. Over time, this has led to more and more staff leaving the NHS, whilst medical vacancies still persist across the NHS: as of September 2020, there were 7,502 medical vacancies in England.³²

Despite the UK government's plea to former clinical staff who had previously retired or left the NHS to return and help with the pandemic response, secondary care medical FTE vacancies only decreased by 422.³³ This slight decrease in vacancy numbers does not begin to address the scale of growth needed, nor does it address the exponential rise in patient demand and complex multiple morbidities in recent years. More must be done to overcome inadequate staffing levels across the NHS.

It should also be noted that there is presently 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 are not currently being advertised, are not included. The number of vacancies is therefore likely to be far higher than reported figures. The quality of data collected and reported must be improved to develop a picture of staffing requirement.

COVID-19 has compounded existing GP retention issues. Full-time equivalent GP numbers continue to fall. As it is clear that workload is a factor in GPs choosing to leave the profession or reducing their working commitment, any increases in workload due to a backlog of work following COVID-19 could significantly worsen the retention crisis. This situation is exacerbated in Northern Ireland, where GPs are still required to pay for their own indemnity.

Prior to the COVID-19 pandemic, the NHS workforce faced a perfect storm of consultants choosing to retire earlier and a significant proportion approaching retirement age. As noted above, COVID-19 added significant additional pressure on the workforce, with doctors working long hours, in new settings, sometimes whilst risking their own lives. Now the NHS is facing a growing backlog of unmet patient needs, on top of the existing staff and resource shortages. Every consultant has become more valuable than ever before; retention is crucial to the success of any plans for continuing to deliver safe patient care and catching up with existing and developing backlogs.

Furthermore, over the next 20 years, the UK population aged over 65 is expected to grow significantly, alongside a general growth in population numbers. ONS data suggests that this age cohort will increase by 50% over that period, in some parts of the country rising from one in 10 of the population to one in three or four. Since more healthcare is consumed at either end of the age range – under five and over 65 – this increase will drive a need for a growing medical workforce if population needs are to continue to be met by the NHS in the future. An appropriately sized consultant workforce is both essential to look after this growing and ageing population and unlikely to be delivered by current workforce policy as it applies to consultants. It can take up to 15 years to train a doctor to consultant level.

³² <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2020>

³³ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2020>

A recent estimate, from data supplied by Health Education England to the DDRB in 2017 suggested that 6.8-7.7% or 3,400 – 3,756 FTE consultants were needed.³⁴ Despite the recent increase in numbers in some specialties,³⁵ overall growth within the consultant workforce has evidently not been keeping pace with the increased demand for their services. Royal college census data indicates current and anticipated consultant workforce deficits across a range of specialty areas.³⁶

As part of this survey in October, 26.7% of respondents said they were now more likely to take early retirement within the next year. We understand many are choosing to stay within the NHS based upon their moral duty to support the national crisis. However, this goodwill cannot be assumed for the future. It is therefore vital that the UK and devolved governments and arms-length bodies take urgent action to guarantee safe levels of consultant provision now and in the future.

Health and wellbeing

Healthcare and social care workers are at the forefront of fighting the COVID-19 pandemic. Doctors have clearly demonstrated their irreplaceable value to society through their work during the crisis. The crisis has weighed heavily on doctors, and throughout the pandemic, significant numbers of healthcare workers became seriously ill as a consequence of their work, and many lost their lives to the virus.

The BMA has consistently raised concerns regarding the disproportionate impact of COVID-19 on people from Black and Asian Minority Ethnic (BAME) backgrounds. As of April 2020, 61% of 200 healthcare workers who died from COVID-19 come from BAME backgrounds.³⁷ Among doctors, over 90% of those who have died from COVID-19 have been from a BAME background, more than double the proportion in the medical workforce as a whole.³⁸ The BMA is concerned that differences in access to PPE, exposure to high-risk environments, and fear of raising concerns around the health and safety of their workplace could have contributed to this disproportionate mortality. We have repeatedly called for data about healthcare worker deaths to be published, disaggregated by protected characteristic.

Furthermore, shortages of PPE and, in some cases, limited access to basic infection prevention and control measures, was a serious issue during the first wave of the pandemic. The COVID-19 tracker survey also monitored this situation. Whilst its findings suggest that the situation improved throughout the pandemic, shortages were still prevalent of key PPE items even by December, particularly of eye protection³⁹. Nonetheless, these figures demonstrate the willingness of doctors to care for patients despite not being adequately protected within a safe working environment.

COVID-19 testing was also delayed and not available at certain times. In the April edition of the BMA COVID-19 tracker survey, nearly 40% of respondents within the UK who had used or had a member

³⁴https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/819453/DDRB_2019_report_Web_Accessible.pdf p. 78-80 (2019)

³⁵ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/may-2020>

³⁶ [RCEM Workforce Recommendations 2018](#) , [In Depth Review of the UK's Anaesthetic and Intensive Care Medicine Workforce 2015](#), [The UK's Anaesthetic Workforce 2019](#) , [RCPsych's Workforce Strategy 2020-23](#), [O&G Workforce Report 2018](#), [RCPC Workforce Briefing 2018](#), [Clinical Radiology Workforce Census Report 2019](#), <https://www.rcplondon.ac.uk/projects/outputs/focus-physicians-2018-19-census-uk-consultants-and-higher-specialty-trainees>

³⁷ Health Service Journal [Deaths of NHS staff from COVID-19 analysed](#) (April 2020)

³⁸ This is based on information the BMA has been collecting based on media reports and our records.

³⁹ Ibid, December 2020 survey results

of their household use the COVID-19 testing facilities reported that the process was either not accessible, timely or convenient⁴⁰. Again, this improved in the following months.

Mental health of the workforce is also of concern, with over 53% of doctors in Northern Ireland responding to a survey in December reporting that they were suffering with a mental health condition, which was worse than before the start of the pandemic.⁴¹ It is also important to consider that doctors who work remotely are at risk of burnout and mental health consequences. In a BMA tracker survey in October, over 60% of respondents from England, Wales and Northern Ireland who used remote consultations noted an increase in their tiredness, whilst 48% noted an increase in the length of their working day as a result of using remote consultations.⁴² Remote workers may be shielding, facing isolation, coping with family and caring responsibilities, and operating without usual support networks.

Moral injury

Moral injury occurs where doctors are forced to make decisions that contradict their deeply held professional and moral commitments, particularly where systems frustrate their ability to act directly to benefit their patients. For doctors, this can stem from being forced to make or act on decisions that they know are not ideal for their patients, and then doing so repeatedly due to the dysfunctional system they work in. The risk of moral injury has been increasing in the NHS but has been particularly intensified by COVID-19.

In hospitals, a lack of critical resources, such as Intensive Care Units, ventilators or essential medicines, has meant that doctors have had to fight – and at times have failed – to secure adequate treatment for all patients. From a GP perspective, COVID-19 has lengthened waiting lists to the point where the provision of timely care for even serious conditions is imperilled. Under-staffing adds strain to the system, which can also lead to moral injury. This makes it difficult to retain doctors and is therefore linked to early retirement as well as severe psychological and mental health problems.

The NHS Long Term plan for England⁴³ called for properly funded services that ensure doctors work in a system that allows them to care for their patients properly. To meet the aims of this strategy, this issue must be addressed. In the short term, there must be further open dialogue about doctors having to take responsibility for patients care without having the autonomy or tools to effectively deliver the standard of care they would otherwise aim to, and employers must stop putting unrealistic demands on the workforce.

Increased system pressure

COVID-19 has brought a massive increase in workload for doctors across the NHS. This was not only as a result of dealing with COVID-19 patients but also due to the huge backlog of non-COVID-19 care that has built up. A survey of consultants and SAS doctors in Northern Ireland found that 59% of respondents were not confident that the health service will be able to manage patient demand when 'normal' service eventually resumes.⁴⁴

From March 2020 onwards, steps were taken to ensure that the NHS would be able to cope with a large influx of COVID-19 patients. This included cancelling planned treatments and operations. Whilst

⁴⁰ Ibid, 30 April 2020 survey results

⁴¹ Ibid

⁴² Ibid, October 2020 survey results

⁴³ <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

⁴⁴ Ibid

these changes meant that intensive care did not have to be rationed to COVID-19 patients, data published by the NHS has indicated that the shutdown of most non-COVID services, combined with drastic changes in patient behaviour, has resulted in the NHS facing a large backlog of non-COVID care in addition to the pre-existing substantial waiting lists. This is demonstrated by figures in August 2020 highlighting that more than 110,000 patients in England had waited more than a year for routine hospital treatment.⁴⁵ These backlogs and delays will have the effect of storing up greater problems for the NHS in the future and significantly increasing doctors' workload.

BMA data analysis highlights the size of the backlog in England, estimating that between April and October 2020 there were 2.4 million less elective treatments and 16.5 million less outpatients in England appointments than in the previous year.⁴⁶

Infection control measures and the ongoing diversion of healthcare resources towards COVID-19-related services in many parts of the country during the second and ongoing third waves of the pandemic has ensured that this backlog of care will take even longer to work through as it continues to accumulate. Combined with the seasonal onset of winter pressures, the NHS is set for its hardest winter yet.

Waiting lists for specialist treatment have already begun to soar. In October, the number of patients waiting more than one year for treatment in England increased 123-fold compared to 2019, and of September 2020 the number of patients in Wales waiting more than 36 weeks to start hospital treatment grew by 518% and is only likely to have increased.⁴⁷ 4.44 million patients are now waiting for specialist treatment.⁴⁸ However, there is likely to be a number of patients still waiting to be referred onto the waiting list. This total therefore probably skims the surface of the actual volume of unmet care. This demonstrates the unprecedented workloads doctors have faced this year, which will only continue to increase into the winter period and beyond.

The 2019 NHS Staff survey in England found that, 56% of respondents in England said that on average across England they would work up to five or more unpaid hours over and above their contracted hours per week. 9% of all respondents worked six to ten additional unpaid hours per week, whilst 3.5% of respondents worked 11 or more additional unpaid hours per week.⁴⁹

Staff must be paid for the hours they work and not relied upon to work for free. This only serves to paper over cracks caused by underfunding, since the lack of funding discourages recruitment in order to limit spending thereby leading to unsafe staffing levels and shortages of available staff within the overall workforce. Good will quickly dissipates when staff are treated poorly, are left overworked, exhausted and, often, unwell, and their contractual terms are regularly flouted.

The increased pressure within the NHS that has been massively compounded by the COVID-19 pandemic makes it more important than ever that the DDRB and government do everything they can to recruit and retain doctors. Conversely, a failure to recognise the value of doctors who have been working under such pressure will be hugely damaging for morale and may well result in many doctors leaving the profession or working outside the NHS.

⁴⁵ <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2020-21/>

⁴⁶ Calculated by comparing 2019 and 2020 activity levels using NHS Digital Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data April 2020 - October 2020 (<https://digital.nhs.uk/data-and-information/publications/statistical/hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data>)

⁴⁷ <https://www.bbc.co.uk/news/uk-wales-54989021>

⁴⁸ <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2020-21/>

⁴⁹ <https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/>

Rising cost of childcare so that staff can go to work

The UK was already reported to have the highest costs of childcare in the world. On average, 28% of a typical household income is spent on childcare⁵⁰, three times the average across the European Union.⁵¹ This is acting as a barrier to career progression, with the findings from the *Mend the GAP: The Independent Review into the Gender Pay Gaps in England* showing that 35.4% of women noted that a lack of affordable childcare was a barrier to career progression⁵².

As set out in the BMA's letter to the Secretary of State for Education in England,⁵³ the costs of childcare have increased for doctors who have worked during the pandemic following the sudden temporary and then permanent closures of early-years nursery providers. Particularly at the start of the first lockdown, doctors frequently did not have access to informal childcare provided by family and friends and, as a result, had to resort to paying for more expensive forms of childcare.

This need for often expensive childcare was amplified due to the unsocial and increased hours doctors have worked before and throughout the pandemic. As this was clearly unsustainable for many doctors, some have had little choice but to resort to significantly reducing their hours or taking unpaid leave, both of which have lowered their income.

Moreover, there is a significant concern that the additional costs of childcare incurred by doctors will extend beyond the pandemic because of the insufficient financial support offered by the UK and devolved governments to childcare providers, which is likely to result in them no longer being financially viable.⁵⁴

The reduced availability of childcare places will lead to increased costs for doctors. If the rising costs of care do not come with a rising income, it is likely that more doctors, particularly female doctors, will be forced to reduce their hours to avoid incurring these increased costs. This will significantly widen the gender pay gap.

Higher education

Through a long-standing commitment to pay parity by the university employers of doctors in senior clinical academic roles (that is those combining teaching and research activities with clinical work in the NHS), the pay awards by the DDRB have an impact on the higher education sector. It is already clear that the COVID-19 crisis is significantly damaging the finances of the UK's universities. The loss of overseas students and the expected deferral by a number of UK students is leading to the universities sector incurring hundreds of millions of pounds of debt.⁵⁵

On the background of a 52% real terms reduction of senior clinical academics after adjustment for rising students places,⁵⁶ and a noticeable movement of senior research academics to more lucrative roles in the pharmaceutical sector, the current threat to senior clinical academics is two-fold: a significant reduction in posts, just at the point when the healthcare workforce is due to be increased and/or the commitment to pay parity is broken. Neither of these would be acceptable to the BMA

⁵⁰ <https://data.oecd.org/benwage/net-childcare-costs.htm>

⁵¹ Ibid

⁵² https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf

⁵³ <https://www.bma.org.uk/media/2450/bma-letter-to-gavin-williamson-re-covid-19-and-childcare.pdf>

⁵⁴ <https://www.gov.uk/government/publications/covid-19-series-briefing-on-early-years-november-2020>

⁵⁵ <https://www.ifs.org.uk/uploads/BN300-Will-universities-need-bailout-survive-COVID-19-crisis.pdf>

⁵⁶ <https://www.medschools.ac.uk/media/2491/msc-clinical-academic-survey-report-2018.pdf>

and those we represent. It would also place the burden of teaching medical students increasingly on others, namely consultants, SAS doctors and senior trainees.

This means that any pay award for clinical academics would need to be separately funded by the UK and devolved governments in the current and future years.

It is also worth noting the impact of the proposed significant increase in medical student places and the opening of new medical schools on the current workforce. This will require a significant increase in the number of medical academics to design and quality assure the curricula and to teach the medical and other healthcare students. It is, therefore, important that this career pathway remains an attractive option for doctors. It is also essential that any rise in medical student places is matched by a rise in speciality training places. Additionally, clinical academics, consultants, SAS doctors, junior doctors and GPs must also be given sufficient time to deliver vital teaching to medical students. This is particularly an issue for consultants and SAS doctors who have repeatedly seen their time for supporting professional activities (SPA) time progressively reduced by employers, leaving many doctors to deliver this activity in their own time.

An additional issue we would like to highlight is that, unlike medical students elsewhere in the UK, Northern Ireland medical school graduates are ineligible for the NHS student bursary and the NHS loan. This is inequitable and will no doubt influence medical students' decision to read medicine in Northern Ireland. GP appraisers and trainers

In response to the pandemic, NHSEI, HEIW and the HSCB (NI) relaxed the appraisal process to allow GPs to spend more time on clinical care. As such, the number of appraisals has dramatically dropped and therefore this income stream has been significantly reduced.

GP trainers have seen an increase in their workload and responsibility in order to support their trainees through significant changes to MRCGP examinations and recording evidence for this with remote consultations.

Public health doctors

The vital role of public health doctors has been firmly underlined during the pandemic. They have compiled essential data about the virus, its spread and its impact on the population. They have also advised ministers on policy, spoken directly to the public at daily government media briefings and managed outbreaks of local infection and contact tracing. However, a recent survey carried out by the BMA, found that as a result of their work battling COVID-19 many are now suffering from dangerously high levels of mental and physical fatigue. We also heard from respondents that they felt that they continue to be overlooked as a branch of practice by decision makers.⁵⁷ We are therefore, asking the DDRB to support the principle that there must be pay parity for doctors working in the NHS and for public health. This principle will help to ensure that public health remains an attractive place to work and that there are sufficient numbers of doctors to call on in the event of a future pandemic.

In Wales, increasing numbers of non-medically qualified public health consultants are being employed by Public Health Wales. This staff group is paid according to Agenda for Change (AfC) pay scales at Band 9,⁵⁸ which has a basic rate of pay that is higher than new medically qualified public

⁵⁷ <https://www.bma.org.uk/news-and-opinion/public-health-doctors-completely-shattered>

⁵⁸ <https://www.nhsconfed.org/-/media/Confederation/Files/Wales-Confed/Wales-Employers/Annex-2-Wales.pdf>

health consultants.⁵⁹ Additionally, pay progression occurs within a shorter period for those on AfC scales: it takes 13 years for a consultant to eventually overtake AfC, and in the early years there is an enormous gulf for effectively doing the same job. Given the efforts of our public health members throughout the pandemic we feel that this should be addressed.

Consultants

Economic outlook

In our previous submissions we have provided extensive evidence of the real terms pay erosion that doctors have experienced since 2008. For consultants this has been exacerbated by the erosion of the value of CEAs, commitment awards and distinction awards, as well as the impact the pensions taxation has on their overall reward.

Since the start of the last recession in 2008, doctors have experienced a pay freeze followed by a cap on pay awards. During this period, measures of inflation have consistently been significantly higher, resulting in some consultants experiencing a near 30% fall in real terms take-home pay, as reported in the BMA’s January 2020 DDRB submission. In addition, doctors during this period have been subject to punitive pension taxation, which essentially results in consultants and other senior doctors paying significantly more per pound of pension than other NHS workers (detailed information on this below in the pension section later in our submission of evidence). The impact of this real terms pay erosion and additional employee pension contributions is stark.

Figure 1: Actual basic pay compared against Consumer (CPI) and Retail Prices Index (RPI) for consultants in England

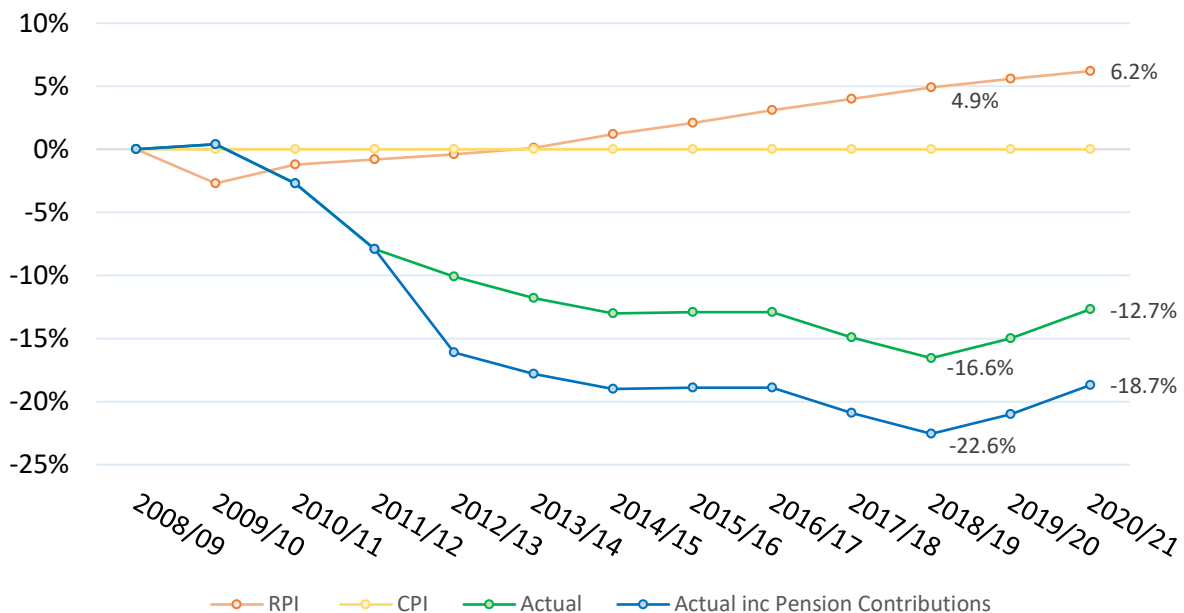


Figure 1 demonstrates the extent to which changes to the consultant pay scale in England since 2008/09 have cumulatively fallen behind CPI, and even further behind RPI, shown by the “Actual” line above. It is worth noting that although this graph is based on the English payscale, a similar drop

⁵⁹ <http://www.wales.nhs.uk/documents/MD%28W%29%205-20-%20MD%20Pay%20Circular%20Final%20Draft%20v%202%20PDF.pdf>

in real-terms pay has been experienced by consultants across the UK. There has been a further detrimental impact from the additional 6% employee pension contributions that became payable by top tier earners from April 1, 2012, shown by the “Actual inc Pension Contributions” line above. Tax relief has not been taken into account on this additional 6% as this tax relief is more than clawed back via annual allowance and the lifetime allowance.

It also demonstrates that when using RPI⁶⁰ consultant basic pay, accounting for the increase to employee pension contributions, fell behind by 27.5% in 2018/19. Whilst RPI is a less commonly used measure of inflation, the BMA believes that assessment against this measure remains important as many of the costs faced by consultants, including travel and essential items, typically increase by a level above RPI. Whilst the pay awards of the last couple of years have been above inflation, they have done virtually nothing to rectify the years of pay restraint. Indeed, when including the effect of increased pension contributions, the shortfall against RPI remains at 24.9% for basic pay alone. This shortfall will be further increased when the pay restraint applied to clinical excellence awards, discretionary points and distinction awards are included.

The impact of this pay restraint is not confined to a consultant’s working career. The majority of consultants have retained their final salary link for their pensions and the years of pay restraint have significantly reduced the final salary on which their pension is based. This is demonstrated in the example below.

Case Example: Alice, Consultant (60 years old in 2020)

Alice works full-time in England and reached the top of the consultant pay scale in 2010. She had celebrated her 50th birthday prior to April 1, 2012, which meant that she remained a fully protected member of the 1995 final salary pension scheme. Her final salary pay is 79% of what it would have been, had the top of the consultant pay scale kept track with RPI since 2008/09. Put another way, her final pensionable salary is 21% lower than what it would have been, had the consultant pay scale kept up with inflation, which has a considerable detrimental impact on her cumulative lifetime earnings. Over the 10-year period from 2010, her cumulative actual pay before tax was more than £214,000 lower than it would have been if it had kept up with inflation as described. Alice was also required to pay an additional 6% in employer contributions from 2012. This has cost Alice an additional £56,000 in employee pension contributions (income tax relief has been ignored as this has been claimed back via the AA and LTA). Alice had 38 years’ service in the NHS pension scheme and as a result, has lost nearly £43,000 in her pension lump sum. If she lived until 80, she will experience a further loss of nearly £345,000 in pension over her retirement. Overall, the negative impact of pay restraint on her cumulative earnings and pension, coupled with the increase in employee pension contributions, has cost Alice approaching £658,000 over the course of her lifetime.

Consultant Payscale

Consultants have an 8-point pay-scale that typically takes 19 years to reach the top pay point. This essentially results in a system where older consultants are more highly paid than younger consultants, even when they are doing the same job. A further problem is that there is a higher proportion of women and those from ethnic minority groups in the younger consultant workforce, whereas older consultants are more likely to be white and male. This is an important component of

⁶⁰ Figure 1 uses the 12-month inflation percentage changes to September of each year (mid-year) for RPI and CPI, to enable inclusion of the 2020/21 pay rise on a consistent basis in the time series.

the gender pay gap and results in unequal rates of pay even when consultants are doing the same job.

The BMA engaged with NHS Employers and the Department of Health and Social Care (DHSC) in negotiations to rectify this in England by moving to a 2-point payscale. However, despite the DDRB previously making it clear that the costs of any transition to a new contract should be met from outside the pay envelope, this was not agreed to by DHSC, who insisted that the cost of pay uplifts to younger consultants must be met by pay freezes by older consultants. The BMA believes that this is entirely unacceptable, and we ask the DDRB to once again make it clear that these payscales need to be addressed and that the cost of doing so needs to be met from outside of the current consultant pay envelope. This will go a long way to reducing the gender pay and indeed the gender pensions gap.

Clinical Excellence Awards, discretionary points and distinction awards

Last year's pay uplift of 2.8% did little to address the real terms pay cut that consultants experienced over the past decade, which for some consultants has been over 30%. In England, the government's decision to not increase the value of Clinical Excellence Awards meant that a significant portion of the consultant pay envelope was in effect frozen. The rationale given regarding the gender pay gap does not hold up to scrutiny, as this year the parties agreed to distribute Local Clinical Excellence Awards (LCEAs) equally amongst eligible consultants, meaning that all eligible consultants would receive an equal share, irrespective of gender or any other protected characteristic. The Advisory Committee on Clinical Excellence Award (ACCEA) normally grant 300 awards in England and 10 awards in Wales each year. The decision not to run an awards round for National Clinical Excellence Awards (NCEAs) in 2020 has resulted in a substantial portion of the consultant paybill not being spent on consultants this year. It is essential that ACCEA carry forward these awards to the 2021 round by committing to award 600 new awards in England and 20 new awards in Wales, which will be cost neutral and prevent further funding being lost from the consultant paybill.

The BMA are also extremely concerned by the suggestions to make future NCEAs non-pensionable. This will significantly reduce the overall value of these awards and result in problems for existing award holders who potentially will not receive pension benefits on which they have paid contributions and annual allowance taxation on. Even if some protection of pensionable pay is offered this will be extremely problematic as younger members who may expect to see their basic pay rise through incremental pay progression will not be afforded the same level of protection as older members who have reached the top of the payscale. In addition, such protection will disadvantage women who make up a higher proportion of the younger consultant workforce as they will no longer be able to access pensionable awards whilst their older male colleagues may have their pension protected. This will further exacerbate the gender pay gap. Indeed, changing the local CEAs to non-pensionable awards had a significant impact on the perceived value of the scheme with applications significantly reducing in number, leading to difficulty in making awards in some trusts.

Investment previously announced by the Secretary of State for Health and Social Care on 24 July 2018 and technically implemented by the Pay and Conditions Circular (medical and dental) 2/2019 R2 on 10 January 2019 has yet to translate into the funding 'pot' for LCEAs from 2019/20 onwards in a cumulative fashion at local level. This equates to a further 0.5% of the total NHS Consultant pay which has not been distributed for two years now.

Additionally, the DHSC has yet to confirm the funding ratio following the extension of Schedule 30 for a further year, due to the constraints placed upon the negotiation process due to COVID-19. This

uncertainty further compounds our concerns regarding value being stripped from the LCEAs, and a subsequent downwards pressure on consultant pay.

In Wales, the Commitment Awards were similarly not increased in value in 2020/21 for the second year running, meaning a further element of the consultant pay envelope has been frozen in Wales. This is particularly an issue given that all consultants in Wales with an appropriate length of service are entitled to these awards. Whilst we appreciate that money held back by the Welsh Government from the DDRB-recommended uplift to both the Clinical Excellence Awards and the Commitment Awards for 2019/20 has been re-purposed and therefore retained within the consultant pay envelope, with discussions currently ongoing about how this funding may be allocated going forward, we are concerned that these funds have not been allocated in a consolidated manner, leading to their value being diminished year-on-year compared to the situation that would have arisen had they been allocated in accordance with the DDRB's recommendation.

The situation in Scotland is more problematic. The Scottish Government has consistently ignored any DDRB recommendations to increase the value of distinction awards or discretionary points. The value of a discretionary point has remained frozen at £3,204 since April 2009; if it had kept pace with RPI, it would now be valued at £4,477.⁶¹ The Scottish Government has also refused to allow any new distinction awards to be made in Scotland for the last 10 years. In September 2009, there were 578 distinction award holders in Scotland, comprising 12% of all consultants.⁶² By September 2019, the latest data for which figures are available, that had fallen to 209 award holders, representing only 3.6% of the total number of consultants. This huge and continuing fall in the number of award holders has generated significant savings for the Scottish Government that have not been recycled elsewhere into the overall pay offer for consultants in Scotland.

Northern Ireland consultants also have not been awarded new Clinical Excellence Awards (CEAs) since 2010. As a result, many consultants who would have received an award over the past decade are significantly losing out. In 2009/10, about half of the consultant workforce in Northern Ireland held either local or national CEAs,⁶³ on which employers spent nearly £14 million. The BMA NI has collected data from all HSC trusts in NI to estimate the number of CEA award-holders remaining in 2019/20.⁶⁴ This suggests that there were only 300 CEA award-holders remaining, which represented just 16% of the consultant workforce. 50% of the consultant workforce held a CEA in 2009/10; had this proportion been maintained in 2019/20, there would have been 960 award-holders in 2019/20. That is 660 more award-holders than the BMA NI data collection suggests actually remained. This suggests that consultants in Northern Ireland missed out collectively on nearly £24 million in gross CEA pay in 2019/20,⁶⁵ as a result of the CEA award stoppage and relative to a counterfactual where the CEA awards kept up with RPI inflation in each year. This loss would accrue individually to consultants who did not hold a CEA in 2019/20 but would have without the award stoppage.

⁶¹https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/229506/Cm_8301_1.pdf

⁶² <https://www.shsc.scot/media/62162/sacda-2019-annual-report-1.pdf>

⁶³ BMA analysis of NI Health and Social Care Workforce Census data and the Nominal roll of consultants

⁶⁴ BMA NI-collected data from HSC trusts in NI

⁶⁵ NI Assembly question on CEA spending, includes employer costs -

<http://aims.niassembly.gov.uk/questions/printquestionssummary.aspx?docid=248705>. Assuming value of awards kept up with RPI inflation since 2009/10 and equal distribution across award steps; gross earnings cost only, excludes employer costs.

National Clinical Excellence Awards

The decision not to run an awards round for National Clinical Excellence Awards (NCEAs) in 2020, has meant that another substantial portion of the consultant paybill has not been spent on consultants, approximating to saving of some £25 million over the five year duration of a national award, further reducing the overall value of the uplift.

Whilst the Advisory Committee on Clinical Excellence Awards (ACCEA) and ministers have acknowledged that there will be an increased number of awards available in 2021, it is disappointing to hear that there is still no clear commitment to carry forward in full the 300 awards in England and 10 awards in Wales from 2020, that would otherwise have been allocated if the 2020 award round had not been suspended.

The BMA is clear that there must be 600 awards made available in England and 20 awards available in Wales in 2021, to ensure that consultants are not disadvantaged and that the funding for NCEAs, which are an important part of the consultant paybill, is not reduced as a result of the suspension of the 2020 round. We are concerned that ACCEA have stated that any recommendation to increase the number of awards by ACCEA is subject to '*financial scrutiny and approval by ministers*'. Had the 2020 awards round taken place as planned, the 310 awards would be paid for a further four years, including in 2021 and consequently awarding 620 awards in 2021 is entirely cost neutral. The additional costs resulting from the one-year extension for those due to renew in 2020 is addressed by the decision to renew those awards only for a further four years. A failure to award 620 awards in the 2021 round, not only limits the opportunity to recognise the substantial effort made by consultants in these exceptional times but it is completely unacceptable for the government to seek to profit from the suspension of the 2020 round due to the COVID-19 pandemic. We would urge the DDRB to recommend that all awards from 2020 are carried over to 2021, to ensure consultants do not face detriment as a result of the decision to suspend applications this year.

Salaried GPs working outside practice settings

There is a growing cohort of GPs who are remunerated outside of GP practice contracts and have no access to any central pay uplifts. This includes GPs working in out of hours, prisons, federations and commissioning among a growing list, reflecting the diversity of general practice. These roles contribute significantly to the delivery of important patient care in the NHS. Therefore, pay for those on these contracts should not remain stagnant by virtue of them not being on the model salaried GP contract. We ask the DDRB to support our view that, such doctors pay should be uplifted at least in line with that which their colleagues working in GP practices receive.

Similarly, the payscale for senior GP educators (i.e. deans, HEE directors etc.) has not been uplifted for several years. If we are to retain those currently in post and attract future GP educators in primary care, the DDRB must recommend that the payscale is reviewed regularly to ensure that their work is appropriately remunerated.

Pensions

Pension taxation contribution structure

- Although the BMA accepts that taxation policy lies outside of the DDRB's remit, we do not believe that the DDRB can ignore the devastating effects this ill-conceived system of taxes has had both on the overall level of doctor's remuneration and the impact it has had on retention of doctors. Indeed, repeated surveys have demonstrated that pensions taxation is one of the major factors in causing doctors to either to retire early or reduce their hours: a

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.⁶⁶

- A survey from the Royal College of Physicians and Surgeons of Glasgow revealed that 45% of those surveyed decided to retire at a younger age than previously planned, with 86% of them citing pension concerns as one of their reasons for this decision.⁶⁷
- 53% of surgeons in Wales have been advised (e.g. by an accountant or financial adviser) to work fewer hours in the NHS.⁶⁸

The current pension taxation system is unfair and punitive to doctors working in the NHS. Annual allowance (AA) is fundamentally inappropriate in a defined benefit scheme such as the NHS. However, this anomaly is further compounded by the fact that doctors are taxed multiple times on the same earnings, through tiered contribution rates, AA, the lifetime allowance (LTA) and through income tax on pension when it is received. These additional layers of taxes all serve to remove tax relief that has already been removed in its entirety via the tiered contribution rates. The pension taxation system must be urgently reformed to avoid the NHS further feeling the consequences. As noted above, even before the COVID-19 pandemic hit, the healthcare system was already under pressure. It is, therefore, vital that doctors no longer feel forced into reducing their work and, in many cases, stopping working within the NHS entirely in order to avoid huge and disproportionate tax bills on their pensions.

Whilst the changes announced in the March 2020 budget⁶⁹ have offered some mitigation with respect to the tapered AA for most doctors, the fundamental problems remain. Almost all consultants and GPs as well as many SAS doctors will still incur significant additional tax bills as a result of exceeding the standard AA, which remains at £40,000. Particularly for secondary care doctors in the officer scheme who retain a final salary link, a modest increase in pensionable pay can result in breaching the standard AA. These pay rises are typically out of the control of the doctor and may be as a result of incremental pay progression. Indeed, some doctors even saw their take home pay fall as a result of the government's failure to fully backdate the 2018/19 pay award as this resulted in their deemed pension growth being above inflation and incurring additional AA charges.

Further problems arise with the issue of 'pseudo-growth'. Pseudo-growth occurs when there is a temporary rise in pensionable pay and is a particular issue for those with a final salary link in the 1995/2008 pension schemes. The issue arises where a doctor receives a temporary rise in their pensionable pay, e.g. through taking on a fixed term management position that attracts a pensionable responsibility payment or receiving a national clinical excellence award that is subsequently not renewed, they may incur a significant AA tax charge. However, if the pensionable pay falls before retirement, the pension may be calculated on the lower level of pensionable pay and the doctor may not receive the increased benefit on which they have paid AA tax charge.

A further problem occurs with salary sacrifice schemes, where the level of pensionable pay falls as a result of entering such a scheme but, when the scheme ends, the level of pensionable pay rises potentially triggering an AA tax bill. This happens even if the total amount of pensionable pay does not exceed that earned before entering into the salary sacrifice scheme. A large number of doctors

⁶⁶ <https://questionnaires.bma.org.uk/news/payingtowork/index.html>

⁶⁷ <https://www.rcplondon.ac.uk/news/pension-tax-driving-half-doctors-retire-early>

⁶⁸ [RCS Survey on the NHS Pension Scheme, Royal College of Surgeons](#)

⁶⁹ https://www.bma.org.uk/news-and-opinion/annual-allowance-what-does-the-2020-budget-announcement-mean?utm_source=The%20British%20Medical%20Association&utm_medium=email&utm_campaign=11909257_FIS21Z1%20Financial%20services%3A%20Pension%20update%20All%20BoPs%20%28Members%29&utm_content=March%20budget&dm_t=0,0,0,0,0

are members of both the legacy (1995/2008) and reformed (2015) schemes. Due to an anomaly in the calculations whereby negative growth in one scheme is not offset against positive growth in the other, doctors in both schemes pay significantly more in AA tax charges than those members who were solely in the 1995 scheme despite receiving a lower pension. The DDRB needs to acknowledge these difficulties and the effect they have on reducing the overall level of doctors' remuneration when making its recommendation as well as calling on the government to scrap the AA in defined benefit schemes such as the NHS.

A further problem is caused by the LTA. This is another tax designed to limit tax relief despite this being removed entirely via tiered contribution rates and once again via the AA. The LTA is a potent driver of early retirement across both primary and secondary care. In general practice, many GP principals reach the lifetime allowance in their early 50s, resulting in them opting out of the scheme and considering early retirement at the age of 55. A similar problem exists in secondary care, but consultants, sessional GPs and SAS doctors affected by this are generally unable to retain the value of the employer's pension contributions if they opt out. This significantly affects their overall level of 'total reward' and makes it less likely for them to remain in the workforce.

There is no justification for applying both an AA and LTA to pension growth, something that the Office of Tax Simplification (OTS) has also noted. The OTS stated that 'given the policy aim of limiting the overall amount of pensions savings tax relief available to any one individual, applying both the AA and LTA charges to pensions may be unnecessary. One possibility would be for the AA to apply in relation to DC [defined contribution] schemes and the LTA in relation to DB [defined benefit] schemes.'⁷⁰

As noted above, in the NHS pension scheme, there are tiered contribution rates, with higher earners paying 14.5% compared to lower earners paying 5%.⁷¹ These rates were brought in to specifically offset the benefit of higher rate tax relief and as explained above more than offsets the benefit of higher rate tax relief. These represent the highest employee contribution rates in the public sector.

In a career averaged revalued earnings (CARE) scheme, there is no justification for such steeply tiered contribution rates as we believe each member should in effect pay the same amount per £1 of pension. Nevertheless, the justification for such tiered contribution rates is said to be to offset the benefit of higher rate tax relief. However, at the current rates in the 2015 CARE scheme, this tiering more than offsets the benefit of higher rate tax relief, to the extent that those paying 14.5% employee pension contribution in effect receive less than basic rate tax relief. This is the result of the higher rate tax relief being more than entirely removed by the tiered contribution rates. Yet, on top of this the AA and LTA both attempt to remove this tax relief again, resulting in doctors paying many times more per £1 of pension than other NHS workers.

A further problem with the system of contribution rates in the officer scheme is that those working less than full time have their level of contribution based on their full-time equivalent pay rather than their actual pensionable pay. This is despite the pension they accrue being based on their actual pensionable pay. This in effect means that someone working less than full time pays more per £1 of pension in the 2015 CARE scheme than a full-time colleague with the same level of overall earnings. The situation is even more stark for locum GPs within the practitioner scheme, as their contribution

⁷⁰https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/838130/Taxation_and_life_events_Oct_2019.pdf

⁷¹ <https://www.nhsbsa.nhs.uk/sites/default/files/2019-04/Tiered%20employee%20contributions%20from%202015-2016%20-%20employer%20factsheet-20190329-%28V6%29%20.pdf>

tier is based on their annualised pay and the calculation assumes that they will be working for 365 days a year. For many this means that they are required to pay the top contribution tier of 14.5% even if they have a modest level of overall earnings. This is demonstrated in table 1.

Table 1. Relative costs for three different NHS workers purchasing approximately the same amount of pension.

	Laura, GP Locum (working 1 day a week for 42 weeks a year)	Fran, FY2, (LTFT 60%)	Peter, Porter (full-time) Band 3
Actual Pensionable salary	£21,000	£20,620	£21,142.00
income used for calculation	£182,500 (annualised)	£34,368 (FTE)	£21,142.00
Tiered rate	14.5%	9.3%	5.6%
Employee contributions	£3,045	£1,918.	£1,184

As can be seen from Table 1, the annualised GP pays significantly more in employee contributions despite accruing the same amount of pension in the 2015 CARE scheme compared to a full time lower paid NHS worker with a similar level of actual pensionable pay.

The BMA has recently commissioned an actuary to consider the impact of the annual allowance and lifetime allowance on member contributions and benefit outcomes in relation to the 2015 NHS pension scheme, as well as the contribution tax rate structure. The modelling of this can be found in the appendix.⁷²

The modelling very clearly demonstrates that doctors pay more for the same level of pension even when the higher rate tax relief is factored in, further reducing the justification for the annual allowance. This is the result of the same pensions savings in effect being taxed multiple times.

BMA asks of the DDRB on pensions

The BMA recognises that the above issues are caused by the current pension taxation and pension scheme rules. However, we believe that the DDRB cannot ignore the impacts of the pension taxation on the overall remuneration on doctors. In addition, there are number of direct recommendations that the DDRB can take:

1. Acknowledging the significant increase in employee pension contributions has significantly reduced the level of take-home pay and increased pension contributions does not necessarily translate to an increase in an individual’s pension, including within its recommendations a pay uplift that takes into account the increase in pension contributions.
2. Acknowledging the unfair way in which those working part time across primary and secondary care are treated with respect to paying more for their pension in a CARE scheme and ensuring this disparity in take home pay is addressed.
3. Acknowledging the major problems of recruitment and retention the current system of pension taxation creates regarding doctors and the resultant impact this has on the NHS. The DDRB should encourage the UK government to undertake a review of pension

⁷² This appendix is to be treated as confidential and not shared outside of the BMA’s submission to the DDRB.

taxation and to reconsider the appropriateness of tiered pension contributions in a CARE pension scheme. In particular, the BMA believes that the AA should be scrapped in defined benefit schemes such as the NHS. Other options that the BMA has explored to provide members some control over their pension growth, include alternative methods of savings once tax limits have been reached. This includes unregistered pension arrangements or receiving pension contributions currently being paid into the scheme as salary for use in other pensions or saving vehicles. However, all of these retain significant complexity within the scheme, requiring doctors to take detailed financial advice which is incredibly time consuming – time which could be better spent delivering much needed patient care.

Finally, there is irrefutable evidence that the current system of pension taxation is having a severe impact on capacity within the NHS. With the NHS struggling under the pressure of the pandemic, we cannot afford to see any further deterioration in its capacity. This, therefore, must finally be resolved at the earliest opportunity so that the NHS can better retain doctors in the workforce and ensure that they can take on additional work and leadership roles without being financially penalised as a result.

Annual allowance charges 2019/20 in Northern Ireland

Last year NHS England and NHS Wales introduced the 2019/20 Annual Allowance Charge Compensation Scheme. The scheme guarantees that any AA tax charge for eligible clinicians will be compensated for at the time of retirement. The Scottish Government instead introduced a REC (Recycling Employers Contributions) Scheme part way through the 2019/20 tax year, which allowed for payment of the employer pension contributions as additional basic salary at a rate of 18.365%, in addition to employee contributions, which could be saved by opting out of the pension scheme (typically 13.7-14.7%) – both these amounts are subject to income tax and national insurance deductions in the usual way.

As explained above, these do not solve the taxation problems, though they at least attempt to somewhat alleviate them. There have been no plans to mitigate the impact of pension tax charges on doctors for the 2019/20 tax year in Northern Ireland. This is inequitable, and we therefore ask the DDRB to support our ask that there be a fair repayment scheme for AA charges across all four nations.

Universities Superannuation Scheme (USS)

Following the changes made to the USS in recent years, BMA members who have USS pensions are now significantly disadvantaged compared to those in the NHSPS. For example, the current highest contribution rate to the NHS pension scheme (England and Wales) is 14.5%, whereas current highest contribution rate to the USS is 8%. In addition, they are now trapped in USS because USS is no longer part of the public sector 'family' of pension schemes and cannot transfer out. It should also be noted that some clinical academics were forced to join the USS, either because of the policy of the scheme (as in Scotland) or because they were advised that they had to join USS when they began university employment.

This issue is in the context of the DDRB regarding pensions as deferred pay and considering it when determining pay parity with the reference groups outside medicine. We also believe that the DDRB must share the commitment of all stakeholders in medicine and academic medicine to pay parity between clinical academics employed in the HE sectors, and their clinical colleagues employed in the

NHS. The differences in the USS and NHS pension schemes, therefore, represent a deviation from this principle.

We ask that the DDRB supports our position that USS members, who are eligible to be members of one of the NHS pension schemes, should be allowed to transfer to one of those schemes if they wish.

Conclusion

Since 2008, doctors have experienced a prolonged period of pay freezes, caps on increases and sub-inflationary increases. As a result, the medical profession has seen the biggest drop in pay compared to all other pay review body professions. Even though some of our members have suffered cumulative, real terms drop in pay of more than 30%, the government has yet to take effective positive steps to address the years of underpayment and low pay awards. The 2.8% uplift this year for some doctors goes nowhere near addressing the long-term decline. At the same time, the unfair and punitive pensions taxation system, has had a further diminishing impact on doctors overall total reward package

Against this backdrop, doctors have had to work in a system which is under immense pressure due to chronic underfunding, workforce shortages, and rising patient demand. The resultant impact on doctors' mental and physical wellbeing is well documented. Intense workloads, understaffed rotas, and long hours are leaving doctors at risk of illness and burnout, forcing many of our members out of the profession altogether.

Fair remuneration and terms and conditions for all doctors will save money in the long-run and provide staffing solutions that will improve recruitment and retention, reduce absence and lead to happier, more productive staff.

We also call for meaningful funding to be made available to support the principle of pay parity for doctors working in the NHS and for public health, whether their substantive employer is a university, a body such as Public Health England, or a local authority. Similarly, we call for pay parity between medical and non-medical public health consultants in Wales. The principle and the funding to support this is essential to ensure that academic medicine and public health remain attractive places for doctors to work, that staff can move easily round the system and that the workforce can respond to the changing demands placed upon it. The benefits of both medical academics and public health doctors have been firmly underlined during the pandemic.

The already overstretched service has been put to the test by the COVID-19 pandemic, which rapidly exacerbated ongoing problems resulting in a challenging and complex environment. To cope with the unprecedented demands posed by the pandemic, many doctors had to go above and beyond to support the national effort to tackle the virus. Doctors have shown their resilience, dedication and professionalism, working very long hours, frequently in unfamiliar healthcare settings, sometimes risking their lives and the lives of their loved ones in the process.

The unprecedented demands on doctors are unlikely to be eased anytime soon because doctors will have to deal with the massive backlog of non-emergency work which has accumulated since the pandemic started.

Whilst we know doctors will continue to demonstrate their commitment to provide safe and effective care, we are concerned about the long-term impact of the lack of recognition for their work will have on attrition rates amongst doctors. This will in turn inevitably have further adverse effects on the NHS for many years to come. The pandemic has exposed something long suspected: that the NHS is inadequately sized to continue to fulfil its obligations. Compared to western healthcare

comparators it has too few beds, too little equipment and most importantly, too few staff including too few medical staff in both primary and secondary care. All of these already critically important issues are set to increase in their impact as a consequence of population growth, particularly in respect of those over 65, over the next twenty years. The NHS is, at present, set to fail.

If when we emerge from the pandemic we are to retain the doctors who have guided us through this period and recruit a workforce that is capable of responding to the future healthcare needs of the UK, we must ensure that doctors are appropriately rewarded; effort must be made to address the real terms pay erosion; and the governments across the UK and allied bodies must endeavour to make the career of a doctor attractive again.