

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

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1. BMA Response to 49th DDRB Report

The BMA welcomes the DDRB's focus, in its 49th report to the UK and devolved governments, on the exceptional contributions of medical staff in response to the challenges posed by successive waves of the Covid-19 pandemic. However, we do not believe that the 3% pay award recommended for some groups of doctors was in any way appropriate or proportionate to the effort and dedication demonstrated by doctors during an unprecedented crisis in public health.

Indeed, even at the time at which the recommendation was made, it had become clear that inflation was going to exceed 3%, and this disparity has only increased since then, with inflation now reaching 7.5% (RPI), which reflects the year-on-year rise to December 2021. On that basis, doctors are once again faced with a sub-inflationary pay award; one which, even though it has ostensibly rewarded their crucial role in responding to a national emergency, has seen their pay fall in real terms.

This state of affairs cannot be allowed to continue and we call upon the DDRB to ensure that this year's pay award actively benefits doctors, rather than simply mitigates the extent to which their pay is detrimentally affected by inflation. While we recognise the challenging economic context in which this pay award is being made, we note that the role that doctors have played in the successful navigation of the pandemic is a critical reason why the nation's finances haven't emerged in an even worse state.

We wish to reiterate our dissatisfaction with the DDRB's response in relation to the BMA's repeated arguments about the long-term pay erosion of doctors, which for some has now nearly reached an astonishing and unjustifiable 30% real decline in take-home pay since 2008/09 (see BMA submissions *passim*). The DDRB's position – that it is not within their remit to 'undo past decision making' – simply underscores the concerns that the BMA continues to convey about the extent to which the Review Body's remit constrains them from making meaningfully independent recommendations on pay.

We have written to you on several occasions to explain these concerns, which begin with the overall limitations created by the Review Body's narrow focus, the further restrictions imposed by the remit letters sent by the UK and national governments at the outset of each year's process, through to the ability of those governments to delay the release of the reports until a time of their choosing and, ultimately, the fact that they are in no way obliged to honour the recommendations that are made.

Disengagement from the pay review process

As you will be aware, the concerns among our membership about the perceived lack of independence are so severe that, for the first time this year, two major branches of practice within the BMA's representational structures – the UK consultants committee and the UK junior doctors committee – will not be engaging with the DDRB process this year on behalf of the doctors they represent in England.

As outlined in our previous correspondence, consultants in England no longer have faith in the pay review process and believe that it is subject to undue government interference. This has been underscored by the Westminster Government's remit letter for the 2022/23 pay round that once again seeks to constrain the DDRB through its repeated reference to affordability. Consequently, consultants in England will not be engaging in this year's DDRB process. The UK consultants

committee has written to the Secretary of State for Health and Social Care to reiterate its concerns, and we are calling for reform of the pay review process. It is essential to restore the faith of our members that the DDRB returns to its founding principles – a truly independent body, not one constrained by remit letters or government interference. Consultants in England have provided extensive evidence in previous submissions demonstrating the impact of pay restraint and pension tax not only on recruitment and retention but on the total reward package of consultants. They refer the DDRB to our previous submissions outlining the need for a significantly above inflation (RPI) pay award.

The UK junior doctors committee has also decided not to submit evidence and instead wishes to express its members' ongoing concerns about the independence of the Review Body and the extent to which it evidently continues to feel constrained by arbitrary political direction. We are concerned that, once again, the remit that has been set effectively precludes the DDRB from meaningfully recommending an award to junior doctors on the 2016 contract for the 2021/22 pay round.

Of particular concern is the way in which the DDRB's views in relation to contracts subject to multiple year pay deals have been disregarded. Despite the Review Body's efforts to 'encourage' the UK and national governments to offer additional recognition to those employed on contracts that are subject to multiple-year pay deals, this has been conspicuously ignored by the UK government. This is especially egregious given that, as we noted in last year's evidence, the Framework Agreement for the 2018 contract negotiations specifically states that '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' (8.1).¹ On this basis, far from being obliged to exclude those on the 2016 contract from its considerations, the Review Body should have felt empowered to make a recommendation on their behalf and should have rejected any remit that sought to limit their ability to do so. This has again demonstrated the extent to which the pay review mechanism for doctors is in urgent need of reform.

Multiple-year pay deals

While junior doctors in England have chosen not to engage with this process, they are not the only group of doctors who have been impacted by this approach. GPs – who are reflected under the remit of the DDRB in the form of appraisers, trainers and educators – and SAS doctors have also been affected by this oversight in different ways. Indeed, this short-sighted approach by governments has created particular complexities for SAS doctors in England, Northern Ireland and Wales, about which we will provide further detail in their respective sections of our submission.

In the case of GPs and SAS doctors, we recognise that these difficulties do not originate from the Review Body itself; however, we would from now on encourage the DDRB to make active recommendations on behalf of all groups of doctors, on the basis that simple 'encouragement' was summarily disregarded by governments. This resulted in many doctors not receiving any additional recognition in the context of a pay award round intended, in part, to recognise and reward the contributions of all doctors to the pandemic response – something about which we know the DDRB is likewise concerned.

Pensions

In our previous submission, we provided detailed information on the impact that pension taxation is

¹ https://www.nhsemployers.org/sites/default/files/media/Framework-Agreement-doctors-in-training_0.pdf

having not only recruitment and retention but also the direct impact it is having on overall remuneration of doctors. We are disappointed that whilst the DDRB highlighted that pensions are indeed an issue of significant concern to doctors, it once again failed to engage sufficiently with the problem. It has repeatedly argued that its remit prevents it from providing a meaningful intervention in this area. The critical importance of this issue means that it is not something the DDRB can afford to overlook. If its focus is intended to effectively address pay, recruitment, retention and motivation, there are few more salient issues than pensions. As will be made clear in the relevant section this evidence, if the DDRB are to make any headway in addressing recruitment and retention issues amongst senior clinicians, they must, as a matter of urgency, actively and vocally support measures to rectify the current punitive pension system; one that in effect penalises doctors for further contributing to the NHS.

2. Key asks

- The DDRB to recommend a pay award of RPI + 2%, as an initial step towards closing the real terms pay erosion that doctors have faced over the past decade.
- The DDRB to give recognition that all doctors, including doctors who had previously agreed multi-year pay deals, have gone to extreme lengths to tackle the pandemic and that they should be rewarded as such.
- The DDRB to take into account the devastating impact of the current pensions system, including the unfair system of tiering contribution rates within the NHS Pension Scheme, and the impact of different forms of pension taxation on doctors' take home pay. The BMA requests that this is not only taken into account when making its recommendation, but that the DDRB support the BMA in calling for tangible measures to address this issue.
- The DDRB to publish its report at the point at which it is sent to the Governments. As noted above, we do not believe it is reasonable for the national governments to be able to delay the release of the report until it becomes politically convenient to do so. Last year, this took place very shortly before the UK Parliament's summer recess, limiting our ability to respond and engage with relevant ministers. Moreover, in the context of a time of increased economic volatility, and in which rates of inflation play such a prominent role in considerations, we are also concerned that the governments may seek to delay release until the rate of inflation is expected to fall and implement an uplift that fails to take account of the effects of inflation over the preceding six months. Publishing its evidence in a timely way, rather than allowing it to be withheld by the governments, would be another crucial indicator that the DDRB process is meaningfully independent.

3. Pensions (UK)

Given the severity of the issue, and the interlinked impact of pay awards, pension growth and additional taxation, it is essential that the DDRB give full consideration to pensions taxation. As previously stated, to ignore this issue is to fail to grasp a key component of the crisis in recruitment and retention of medical staff.

In the past the DDRB has justified giving doctors either zero percent or sub-inflationary pay awards due to the relative "generosity" of the NHS pension scheme. However, this ignores the impact of not

only the drastic changes to the NHS pension scheme itself, but the complete change in the pensions taxation system. The combination of these two factors means that doctors and other higher earners in the NHS are paying almost 10 times the amount per £1 of pension than lower paid NHS workers. Furthermore, despite paying significantly more for their pension than was historically the case, doctors retiring now and, in the future, will receive a pension that is significantly lower than their already retired colleagues.

At a time of unprecedented pressure within the NHS, we can ill afford to have pension taxation system that in many cases results in penalties for doing additional work or for it to become financially detrimental to continue working rather than to take early retirement. The changes in the level of threshold and adjusted income that came into effect from the 2020-21 tax year, did mitigate the impact of the tapered annual allowance but have not solved the problem entirely. Due to the vast amounts of additional work that has been undertaken during the pandemic and the volume of work required to address the backlog in elective care, the fact that the tapered annual allowance remains will still result in a limit in the amount of extra work that doctors can do without incurring a severe financial penalty. Furthermore, all the difficulties with the standard annual allowance remains and as outlined below, even small changes in pensionable pay or even how inflationary uplifts are applied can result in doctors facing an unexpected additional tax bill. The consequence of this is that many doctors are choosing to work part time, even if they were able and willing to work full time to stay within the standard annual allowance.

The lifetime allowance is a powerful driver in pushing doctors to consider early retirement. This situation has been made worse by the freezing of the lifetime allowance until 2026. This decision coupled with the extremely high level of inflation means that the impact of this will be significant and dramatically reduce the real terms value of pension that a doctor can take without facing additional taxes. A survey undertaken by the BMA suggested that 72% of doctors will retire even earlier because of the decision to freeze the lifetime allowance and 61% of respondents stated that they would reduce the amount of work that they do for the NHS.

Given the devastating impact of this, the DDRB simply cannot ignore the impact of changes in the pension scheme and pension taxation. Whilst we accept the DDRB cannot change the scheme design or pension taxation directly, we call for the DDRB to clearly support the BMA's recommendations to resolve this issue in order to minimise their impact on recruitment and retention. In addition, the DDRB must consider the impact of these external factors on the total remuneration of doctors and address this when making its pay award as this too will mitigate the impending recruitment and retention crisis.

Other factors impacting doctors' pensions

Pension scheme design and contribution structure

As highlighted in prior evidence, the current pension system is inappropriately designed and in effect penalises doctors and other higher earners in the NHS. Given that all pension scheme members will be moved to a career averaged revalued earnings (CARE) scheme from 1 April 2022, this eradicates any justification for tiered employee pension contributions, let alone the steep tiering for doctors within the current and proposed future models. This is because every member is accruing pension at the same rate and tiering simply results in higher earners paying more per £1 of pension than lower earners in a CARE scheme. One of the rationales put forward for a tiered contribution structure was to adjust for the benefits of higher rate tax relief. Indeed, the current tiered contribution structure

(with the highest employee contribution of 14.5%, compared to the lowest contribution tier of 5%) removes tax relief from employee contributions in its entirety.

However, despite not receiving tax relief on employee contributions in the first place, doctors and other higher earners are still subjected to both the Annual Allowance (AA) and Lifetime Allowance (LTA). Both the AA and the LTA are designed to “claw back” tax relief and it is this compound impact of the tiered contribution structure, the AA and the LTA all trying to remove tax relief that results in the current complex and unfair system with its perverse incentives that leave doctors with little option but to limit the amount of work they do.

It is simply not fair to ignore annual and lifetime allowances, and instead base contribution structures solely on income tax relief, given such a high proportion of scheme members are affected by these taxes. As you will no doubt be aware, NHS pension scheme members are the largest group of workers affected by the annual allowance across all pension schemes. We would highlight that pension taxation is having a major impact on retention, and the failure to properly address the inappropriate tiering and a failure to address pension taxation reform represent missed opportunities to make the pension scheme fairer.

McCloud Remedy and impact of the pandemic on retirement plans

In addition to the pension taxation driving early retirements, it is clear that the strain of working through the pandemic has left many doctors considering their future and changing their retirement plans. The BMA’s recent survey showed that 32% of respondents were now considering early retirement, compared to just 14% of respondents when surveyed a year ago.² The BMA believes that over the next 18 months, the NHS will be faced with an unprecedented level of retirements unless the UK Government takes immediate action to keep people in the profession.

This was clearly demonstrated by a significant fall in the number of doctors taking voluntary early retirement in 2020, a figure that until then had increased nearly 4-fold since changes to the pension scheme and subsequent changes to pension taxation were introduced. These doctors, who are exhausted by nearly 2 years of working through the pandemic will likely retire this year. A further factor that will result in doctors retiring early in large numbers of the next 12-18 months is the impact of the McCloud remedy. This remedy effectively means that tens of thousands of doctors will receive up to an additional 7 years of legacy scheme membership, which for the vast majority will mean that their entire pension scheme membership will be subject to a normal pension age of 60 rather than part of their membership having a normal pension age of 67.

The impact of this is that these members will be able to retire earlier than planned with much less significant actuarial reduction of their pension. Data from NHS digital, suggests that in 2018, around 13% of the consultant workforce was between the ages of 55 and 60 and the number of GPs in this age range is likely to be similar. Unless reforms are introduced to address pensions taxation, it is highly likely that many of these doctors will retire in the next 18 months as the McCloud remedy is implemented.

This will also place even more pressure on doctors who remain in the NHS, potentially impacting their own mental health as workloads increase even further. This means urgent action is needed now to halt a potential workforce crisis at a time when the NHS is least equipped to weather it. If the

² <https://www.bma.org.uk/bma-media-centre/thousands-of-overworked-doctors-plan-to-leave-the-nhs-bma-finds>

UK Government waits until these doctors have retired and left the profession completely or retired and returned on reduced hours, it will be too late as a policy change at this point is unlikely to encourage people back to full time working. It is essential that the UK Government acts now before it is too late.

Additional taxation as a result of values inflation

We note that, as a result of the pandemic, there is a particular issue for the current tax year (21/22) that will result in doctors being adversely impacted by the annual allowance. The problem arises because of the fact that the opening values of the members pension benefits are assessed against the previous year's Consumer Price Index (CPI). Due to the impact of the pandemic, the value of CPI last year was 0.5%. This in effect means that the allowable increase in pension before being assessed against the annual allowance is only 0.5%. In addition, the revaluation of the 2015 pension is based on which for this year is an allowable increase of only 0.5%. Conversely, the revaluation of pension benefits is based on 1.5% plus the current year's CPI (3.1%), i.e. a total of 4.6%. Furthermore, despite once again being sub-inflationary, the 2021-22 pay award of 3% will result in legacy scheme pension benefit again increasing significantly above the "allowable increase" of 0.5%. This once again demonstrates the unsuitability of applying the annual allowance to defined benefit schemes.

Both of these factors will utilise a significant proportion of the available AA and in some cases may result in a significant AA tax liability even before a member has considered taking on additional work. Not only will this result in a disincentive in taking on additional work but those doctors who had little option but to increase their on-call frequency, take on new roles, or take on additional work may have incurred significant AA tax charges, simply as a result of doing their best to help patients and support their colleagues.

The cost of NHS pension scheme membership compared to other public sector schemes

We would also highlight that the current model for the pension scheme is unfair relative to other pension models. At the top end of the pay scales, doctors pay almost twice as much a year in contributions for a similar pension as civil servants or high court judges. The NHSPS target yield of 9.8% also compares unfavourably with a number of other public sector schemes, with the Local Authority scheme 6.5%, and the Civil Service scheme 5.6%. Indeed, no account was taken of the agreed changes in 2008 and, consequently, the 3.2% increase on top of the 2008 changes has resulted in the average yield of the NHSPS being set too high. We do not agree that the 9.8% average yield needs to be maintained post 2022. We would therefore urge the DDRB to recommend to the UK Government that they lower this yield to allow for a fair reflection of the amount of contribution needed from members to ensure the sustainability of the scheme.

Lack of option of partial retirement and no late retirement factors in the 1995 scheme

The majority of doctors approaching retirement age will have the majority of their pension benefits in the 1995 pension scheme, with a retirement age of 60. However, beyond April 2022, all new accrued pension benefit will be in the 2015 pension scheme with a retirement age linked to state pension age. There are a number of anomalies within the 1995 scheme that in effect mean that unless you retire at the age of 60, you lose value in pension.

The first of these is the lack of late retirement factors. If a member works beyond the age of 60, the pension they receive when they retire is not increased to take into account the fact that the pension was drawn during the period worked beyond the normal pension age. For example, if the pension available to a doctor was £45,000 at the age of 60, if they did not draw that pension and worked

until the age of 61, the £45,000 of pension they could have drawn is effectively lost. However, if they retire at the age of 60 and access their pension, under current rules, they are prohibited from re-joining the 2015 pension scheme. Not only does this provide further disincentive in terms of these doctors continuing to work beyond 60, but it essentially limits the amount of pension they are able to accrue in a cost-effective way. This is likely to become an even bigger problem in the future once an increasing number of people have mixed legacy (1995) and reformed scheme membership at the age of 60.

To resolve this, it is essential that the UK Government look to introduce the option of partial retirement, whereby you can flexibly access the 1995 pension without the need to fully retire as well having the option to re-join the 2015 scheme. In addition, this problem is resolved by the application of late retirement factors to 1995 pension, something that already exists in the 2008 and 2015 schemes.

We note the UK Government announcement for the reformed pension scheme for the judiciary, in response to similar issues with recruitment and retention to those found within the NHS. Early indications are that this has already started to reverse the recruitment and retention difficulties in the judiciary. This demonstrates that the UK Government has a willingness to explore such solutions in the public sector, and we strongly believe that the introduction of a similar tax unregistered defined benefit pension scheme across the UK for those affected in the NHS, to mitigate the current punitive pension taxation system, would ensure that the scheme remains sustainable.

However, if the UK Government failed to act until the NHS reached crisis point before taking action, it would be too late to rectify the situation, as senior doctors will have been left with little option but to retire. It would at this stage be substantially harder to persuade them to return to the NHS with a change in policy. We would therefore ask the DDRB to support the BMA in their calls for a tax unregistered top-up scheme to urgently be made available to members of the NHS Pension Scheme.

Further inequalities within the pension scheme

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

- **Annualisation of earnings for sessional GPs** - Following changes introduced as part of the 2015 NHS pension scheme, there has been a move to base the level of pension contributions for general practitioners on their annualised earnings rather than their actual earnings. For sessional GPs and those who take a career break within the NHS pension scheme year, they are likely to have to tier their pension contributions at a higher rate based on their annualised earnings, rather than their actual earnings. This disproportionately affects low earners and contributes to the gender pay gap, as women with caring responsibilities who work less are being hit the hardest, paying more for the same pension benefit as colleagues who are contracted to work throughout the year, despite having the same or significantly lower levels of actual pay. The other group that are discriminated against by this policy are those with ill health who are unable to work throughout the year. We note that the UK Government has not sought to address this in their recent consultation on member contributions, and we would encourage the DDRB to make recommendations that this issue is addressed by removing Annualisation to ensure the disparity in pensionable earnings for this group of sessional GPs is addressed.

- **Gender Pension Gap** - The gender pension gap is a significant issue and is even wider than the gender pay gap. It goes without saying that the gender pay gap itself has a significant impact on the gender pension gap. The presence of the AA is problematic. The reason for this is that, as women are far more likely to work part-time during their career and/or have taken career breaks, they are more likely to have late career progression. This can result in significant problems with the AA and as a result, many doctors being in effect forced to choose not to take on additional roles to avoid any AA charges. Additionally, individuals who choose to work part-time will accrue less years of service. Previously, this could be offset by the purchase of added years, but this was closed in 2008. Whilst it remains possible to purchase additional pension under the 2015 scheme, the terms offered are significantly inferior, and this is an important factor in the gender pension gap. The DDRB should consider reviewing whether the system of added years purchase should be re-opened, particularly for those working part-time.
- **GPs accessing their pension statement** - following a decision to outsource primary care pension support services England to Capita (PCSE), GPs have experienced significant delays in receiving their pension statements. This service has been found to be wholly inadequate by members, with our survey indicating widespread dissatisfaction in this process. This has resulted in GPs data being several years out of date and, as such, it is impossible to predict pension growth. GPs therefore are unable to make an informed decision on their working commitments. It should also be noted that GPs in the devolved nations have difficulties getting access to their up-to-date pension record due to the overly complicated pension scheme process. The DDRB should recommend that GPs are able to access their pension information in a timely manner, preferably in an electronic format to enable them to ensure that their remuneration is appropriate.

BMA asks from the DDRB with respect to pensions

Whilst we acknowledge that some aspects of pension scheme design and pension taxation are outside the remit of the DDRB, we believe that the DDRB is obligated to address the impact of these factors when making its recommendations and to support reform to mitigate and ultimately end the impact of these issues on recruitment and retention. Indeed, we note that the SRB were instrumental in securing a long-term solution for judges. Our key asks of the DDRB are:

- Support the BMA call for a tax unregistered top up scheme, similar to the solution offered to judges or higher earners in the NHS. This is a fundamentally fair solution as under such a scheme, there is no tax relief on employee contributions and hence there is no requirement to try and claw back this tax relief via the annual or lifetime allowance. Therefore, under such a scheme, there would be no requirement to test pension growth against the AA and LTA and this would immediately break the link between working more for the NHS and facing punitively high additional taxes as a result. Given that doctors and other higher earners in the NHS already do not benefit from tax relief on contributions due to the tiered structure, this would be a fair solution for scheme members and for the taxpayer as it ensures the correct amount of tax is paid on pension earnings. It is essential that such a scheme is available for all doctors, including those who may be members of other pension schemes such as the local government pension scheme, the armed forces pension scheme or the USS scheme
- Immediately introduce recycling schemes across the UK to ensure that those members who have been left with little option but to opt out of the scheme. Despite, this being “encouraged” by DHSC and by the DDRB in the last report, access to this is still patchy.

WE note a national recommendation to implement this in Wales has recently been agreed which is welcome but this needs to be available across the UK and the full 20.6% of employers' contributions need to be available for recycling.

- Support the BMA call for partial retirement and late retirement factors to be available in the 1995 legacy scheme. As outlined above, the lack of these options result in affected members losing the value of pension if they work beyond the age of 60
- Support the call for the introduction of a flat employee contribution rate given that all members will be in a career averaged revalued earnings scheme post April 2022.
- To take into account both the increasing costs of pensions and the reduced pension benefit when making your recommendation of pay. Pensions are deferred pay and it is certainly within the gift of the DDRB to not only address the recruitment and retention issues that have resulted from pension taxation but to restore the total reward of doctors when making its pay award.

4. England

4.1 BMA response to UK Government remit letter

As in previous years, we have significant concerns about the way in which the UK Government has used its remit letter for the 2022-23 pay review process to place unreasonable constraints on the DDRB. It attempts to narrow the focus of the DDRB from the outset by emphasising budgetary considerations that are simply not the Review Body's concern. The measure of 'affordability' should not be a primary consideration of the DDRB, which should instead feel empowered to make recommendations premised on appropriate remuneration and financial fairness for medical and dental staff. The wider costs of the NHS workforce should play no part in its considerations – the value society places on doctors should not be contingent on the relative numbers of nurses or other NHS staff.

Likewise, there is not, as the remit letter states, 'a direct relationship between pay and staff numbers'. This is a matter of political policy rather than an immutable law. While these may be considerations for a government, they are not legitimate grounds to restrict an independent pay review body. The positions outlined in the remit letter reflect the UK Government's own views – ones that the BMA would, of course, challenge – and they should be rightly confined to its own evidence submission, rather than straying into the remit letter. Despite the BMA having made its concerns about this clear on numerous occasions, the UK Government has wasted the opportunity to provide an open and neutral remit letter. We urge the DDRB to demonstrate its independence by rejecting the constraints placed upon it by the remit letter and to clearly state the UK Government's approach is incompatible with an independent pay review process.

4.2 Impact of pandemic on health and well-being

We would emphasise that, while the exceptional contributions of doctors during the pandemic are entirely deserving of recognition, this should not be a necessary condition for them receiving an appropriate pay award. The pandemic has nevertheless highlighted doctors' expertise, dedication and effort, and the impact of the pandemic on health and wellbeing is worth noting, given the concomitant effect this is likely to have on crucial matters of motivation and retention.

Doctors have been at the forefront of the response to COVID-19. Their work has been of indispensable value to society throughout the pandemic, but it has come at a high cost to their overall health and well-being. According to an April 2021 BMA survey, one in two doctors said they were suffering from depression, anxiety, stress, burnout, emotional distress or another mental health condition, with 38% reporting that this had become worse since the pandemic.³ A BMA survey of public health doctors towards the end of 2020 showed that this impact was particularly high for that specialty, reporting that 54% of respondents said they were suffering from depression, anxiety, stress, burnout, emotional distress or other mental health condition relating to or made worse by work. In the BMA's November Viewpoint survey, eight in 10 respondents (78%) reported that they felt extremely or quite anxious at the prospect of work in the forthcoming winter.⁴

Doctors have had to make incredibly difficult decisions in choosing between allocating beds to patients with COVID-19 or other urgent needs. The BMA has been concerned about the moral burden that doctors in the UK were facing, even before the COVID-19 pandemic. From March to April 2021, the BMA surveyed doctors throughout the UK on the issues of moral distress and moral injury – concepts we elaborate on in our report on this issue.⁵ 78.4% of doctors said that moral distress resonated with their experiences at work, whilst 51.1% said the same about moral injury. Of the respondents who stated that moral distress resonated with their experiences at work, 96.4% outlined that the pandemic had exacerbated the risk of moral distress. Despite already being at an unacceptably high rate, the substantial rise in doctors experiencing moral distress during the pandemic is concerning.

NHS Digital data on sickness absence rates is a tangible demonstration of these difficulties, with anxiety, stress, and depression being the most reported reason for staff absence, accounting for more than 566,000 full-time equivalent days lost and 27.8% of all sickness absence according to August 2021 data.⁶ Rates of reported burnout have also increased, from one quarter of trainees feeling burnout to a high/very high degree pre-COVID-19, to one third of trainees reporting high/very high of burnout in 2021, according to a GMC Survey.⁷ 67% of the trainees that responded to the BMA's public health survey reported that they felt worse than at the start of the pandemic. To add to this, 92% of Trusts told NHS Providers they had concerns about staff wellbeing, stress and burnout following the pandemic, demonstrating how pervasive the issue is.⁸

A burnt-out workforce has devastating consequences for morale, as well as the safety of patients and populations. The evidence suggests that the mental health and well-being of doctors has been at best strained, and at worst sacrificed, throughout the COVID-19 pandemic. In order to better show that their well-being is a priority, it is vital that doctors' work is appropriately recognised and rewarded.

³ <https://www.bma.org.uk/bma-media-centre/thousands-of-overworked-doctors-plan-to-leave-the-nhs-bma-finds>

⁴ <https://www.bma.org.uk/what-we-do/viewpoint-surveys>

⁵ <https://www.bma.org.uk/media/4209/bma-moral-distress-injury-survey-report-june-2021.pdf>

⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/august-2021-provisional-statistics>

⁷ https://www.gmc-uk.org/-/media/documents/national-training-survey-results-2021---summary-report_pdf-87050829.pdf

⁸ <https://nhsproviders.org/recovery-position-what-next-for-the-nhs/the-impact-of-the-pandemic-on-the-workforce>

Furthermore, we would highlight significant concerns for the health of doctors, which stem from insufficient protections. 64% of doctors said they feel only 'partly' protected from COVID-19 at work.⁹ We know that many staff dealing with Covid positive patients are doing so equipped only with fluid resistant surgical masks (FRSM). This stands in stark contrast to FFP2 masks being used as standard elsewhere in Europe, even in non-clinical settings. Despite this, doctors continue to demonstrate a willingness to care for patients despite not feeling adequately protected within a safe working environment. Concerns about their own health and well-being have manifested in a 105% increase in doctors presenting to receive professional therapy in March 2021 compared to March 2020, according to an NHS report.¹⁰

The House of Commons Health and Social Care Committee have welcomed additional support for health and care staff during the pandemic, yet have stressed that this support will need to be maintained during the recovery period and beyond to stop further staff from leaving.¹¹ To effectively navigate the challenges of the next few years, as the system tries to adapt to the ongoing impacts of Covid, and further prove that the health and well-being of doctors is a key priority, the BMA considers a fair pay award to be the bare minimum required to acknowledge the sacrifices that doctors have made to their own health and well-being throughout the pandemic.

4.3 Health service capacity and workforce shortages

Health service capacity and the backlog in care

The NHS is in the midst of the worst winter in its history. There are record numbers of patients waiting for care and treatment. Winter and the high burden of Covid cases across the UK is adding to existing pressure on health services. In England, the average waiting time for treatment has increased yet again to 11.5 weeks, as has the total number of patients waiting over 18 weeks for treatment, now standing at 2.06 million.¹² The number of patients waiting over a year for treatment is now 220 times greater than the number of people waiting over a year for treatment in pre-pandemic October 2019. The total waiting list currently sits at an alarming, record high 6.0 million and continues to grow.

Since 2010, average bed occupancy has consistently surpassed 85%, the level generally considered to be the point beyond which safety and efficiency are at risk.¹³ Coming into the pandemic, England had an average occupancy of 90.2% in 2019/20. However, local variation in supply and demand have seen many trusts regularly exceeding 95% capacity in the winter months.¹⁴ Data for the first two quarters of 2021/22 indicates that bed occupancy levels are on the rise again in England and are now past the recommended safe threshold, at 87.6%. These occupancy levels are likely to increase further as DHSC implements recommendations to ease some infection control measures in hospitals in order to see more patients.

⁹ <https://www.bma.org.uk/media/3810/bma-covid-tracker-survey-february-2021.pdf>

¹⁰ <https://www.practitionerhealth.nhs.uk/media/content/files/PHP-covid-report-web%20version%20FINAL.pdf>

¹¹ <https://committees.parliament.uk/publications/6158/documents/68766/default/>

¹² <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22/>

¹³ <https://nhsproviders.org/news-blogs/news/bed-occupancy-levels-highlight-scale-of-pressure-across-the-nhs>

¹⁴ <https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-day-only/>

More people are waiting for care and are waiting longer.¹⁵ Despite the best efforts of staff, there are now almost six million people on a waiting list in October 2021 in England, with over 310,000 of those waiting for more than a year. Based on analysis of NHS England data, since the start of the pandemic until October 2021, there have been more than 4.1 million fewer elective procedures and over 28.6 million fewer outpatient attendances than would have occurred in pre-pandemic times. Although some of these will be reflected in the higher waiting lists, many of these patients will not yet have sought care, showing that the waiting lists themselves do not present the total backlog of care. Some of it remains hidden in the community, presenting a large unknown for the NHS.

Workforce shortages

Addressing this backlog would represent a significant challenge even without the present workforce crisis. The present lack of official, publicly available workforce planning or national strategy makes it difficult to quantify the full extent of staffing gaps, but chronic workforce shortages across the medical profession have existed for many years. Previous BMA research has used the number of doctors per 1,000 people in OECD EU nations as a baseline to estimate the size of today's medical shortage. Given that we only have 2.9 doctors per 1,000 people, England would need nearly 50,000 additional full-time equivalent (FTE) doctors simply to put us on equal standing with today's OECD EU average of 3.7 doctors per 1,000 people.

The BMA has estimated that these shortages currently mean each FTE doctor in the English NHS is doing an average of 1.3 FTE roles, which is one to two more hours per week than the 48-hour per week average cap in the Working Time Regulations.¹⁶ This highlights the extent to which the health service is dependent on the effort and dedication of its existing doctors, requiring them to undertake additional work to function.

When doctors are compelled to cover chronic staffing gaps purely to deliver a safe service, this leads to doctors being overworked and eventually to burnout, and has long impacted on morale through placing increased and often unjustifiable burdens on doctors. The COVID-19 pandemic has certainly exacerbated existing challenges around workforce shortages and staff burnout, but these issues are pre-existing, systemic and deep-rooted.

Despite patient numbers rising, the total GP workforce has seen little growth since 2015, with the fully qualified GP workforce actually shrinking in that time. As of November 2021, there are now the equivalent of 1,756 *fewer* fully qualified full-time GPs than there were in 2015.¹⁷ There are now only 0.46 fully qualified GPs per 1,000 patients in England, down from 0.52 in 2015. For the GPs that remain, this means increasing numbers of patients to take care of, as the average number of patients each GP is responsible for has increased by around 300 – or 16% – since 2015. This is in stark contrast to the broken UK Government election campaign promises to increase the number of GPs in England by 6,000 by 2025.¹⁸ The UK Government have since admitted that they are likely to break this promise. This comes against the backdrop of political criticisms of how GPs work, which has arguably increased the likelihood of GPs experiencing verbal and physical attacks.

¹⁵ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs>

¹⁶ <https://www.bma.org.uk/media/4316/bma-medical-staffing-report-in-england-july-2021.pdf>

¹⁷ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice>

¹⁸ <https://www.theguardian.com/society/2021/nov/02/no-10-set-to-break-promise-of-6000-more-gps-in-england-sajid-javid-says>

The secondary care medical workforce is also experiencing insufficient levels of growth to cope with current and anticipated future need, carrying a large number of vacancies, with the total number of vacant posts rising since March 2021. As of September 2021, there are 99,460 total vacant posts in secondary care, 8,333 of which are medical posts.¹⁹ COVID-19 added significant additional pressure on the workforce, with doctors working long hours, in new settings, while accepting a greater degree of personal risk. Now the NHS is facing a growing backlog of unmet patient needs, on top of the existing staff and resource shortages.²⁰ The Chief Executive of NHS Providers, Chris Hopson, has predicted that ‘core’ workers will leave the NHS because “the whole concept of trying to close the [workforce] gap by asking our staff to work harder and harder is creating an impossible and unsustainable workload.”²¹

Impact on staff

Doctors responding to the BMA’s November 2021 Viewpoint survey indicated that they are working harder and longer to fill these gaps. Respondents were asked whether, in the past month, they had worked additional hours over and above their contractual or agreement requirement (including as part of the response to Covid). More than 3 in 4 respondents (about 77%) indicated that they had worked overtime; and more than half (about 55%) had done so unpaid.²²

They were also asked how, if at all, their career plans had changed for the next year.²³ 43% stated that they were more likely to leave the NHS for another career, and 45% were more likely to take a career break. In a separate report, the BMA found that the number of doctors now considering early retirement had more than doubled, with 32% considering early retirement in April 2021, compared to only 14% in June 2020.²⁴ These figures do not provide a definitive indication of who will leave the NHS, but they serve to underline the current crisis in morale, and foreshadow a substantial impact on retention. In addition to this, 72% of doctors conveyed that they are now more likely to work fewer hours. Again, this will have a considerable effect on the efforts of the health service to address the significant increase in waiting lists that have accumulated during the pandemic.

Members who indicated that they were more likely to change their career plans for next year were then asked a follow up question, where they had the opportunity to select the best explanation(s) for their changing career plans.²⁵ A striking 80% of responses report that an ‘increased workload (or less ability to take breaks/leave)’ accounted for their reasons for changing their career plans. A further 59% cited ‘workforce supply shortages’ and 58% reported ‘worsening personal wellbeing’. Crucially, 56% of doctors surveyed indicated that below inflation pay increases motivated their new intention to take early retirement, leave the NHS for another career, take a career break, work outside the UK, or work fewer hours.

¹⁹ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2021-experimental-statistics>

²⁰ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs>

²¹ <https://committees.parliament.uk/publications/6158/documents/68766/default/> [Oral Evidence by Chris Hopson for NHS Providers]

²² 2,102 responses received.

²³ 2,247 responses were received.

²⁴ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/medical-staffing-in-england-report>

²⁵ This question received 1,884 responses. Percentages tally above 100%, as respondents could all explanations that applied to them.

Beyond stated intentions to retire following the COVID-19 pandemic, actual early retirement rates have trebled since 2008.²⁶ In 2020-21, 1,358 GPs and hospital doctors in England and Wales took voluntary early retirement or retired because of ill health, up from 401 in 2007-08. A BMA report from May 2021 revealed that almost one in three may retire early while a quarter are considering taking a career break and a fifth are weighing up quitting the health service to do something else.²⁷ Doctors have cited that years of pay erosion have left them feeling undervalued and underappreciated.²⁸ Many doctors due to retire previously chose to stay within the NHS based upon their moral duty to support it through the current national crisis. However, relying on the goodwill of doctors to remain in the workforce is an inadequate short-term solution.

Action must be taken to ensure that the NHS remains an attractive place to work, and to provide an incentive for doctors who are actively considering changing their career plans to instead remain working in the NHS. While this would not solve the chronic workforce shortages outright, it could provide the health service with more breathing time until a long-term comprehensive workforce plan is introduced, which must happen as quickly as possible.

4.4 Feeling valued

In late November 2021, we surveyed doctors in England, Northern Ireland and Wales on the extent to which they felt valued, intentions around career plans, and their views on past and future pay awards. Members were also asked their views on how well they felt that they and their colleagues had been valued by politicians/government and the media for their enormous contribution during the COVID-19 pandemic.²⁹

Against the backdrop of declining pay, 47% of respondents felt that they were valued less than before the pandemic by politicians/government, with 31% stating that they felt not significantly or not at all valued, and 13% felt valued to an extent but no more than before the pandemic. In a similar vein, 48% of respondents felt less valued than before the pandemic by the media, and 19% felt not significantly or not at all valued by the media.

These findings shed significant light on the effects of a lack of support from government, unfavourable portrayals of doctors in some sections of the media, as well as the chronic failure to take decisive action in addressing longstanding erosion of pay, even when taking into account their enormous sacrifices. The UK Government should prioritise repairing this dynamic and shift the narrative that they do not appropriately value the work of doctors. A powerful message would be sent to not only doctors, but also the public and the media, by awarding a pay uplift that is viewed as fair and seeks to redress the long-term reduction in doctors' pay.

Those surveyed were also shown possible reasons as to why doctors might deserve a pay rise.³⁰ They

²⁶ <https://www.bmj.com/content/373/bmj.n1594.full>

²⁷ <https://www.bma.org.uk/bma-media-centre/thousands-of-overworked-doctors-plan-to-leave-the-nhs-bma-finds>

²⁸ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/medical-staffing-in-england-report>

²⁹ There were 2,244 responses for politicians/government, 2,234 for media. Percentages will not tally quite to 100%, due a small proportion of respondents indicating "don't know."

³⁰ 2,219 responses were received.

consistently identified the most compelling arguments as being the need to ‘ensure that the NHS/HSCNI can recruit and retain staff, and to minimise workforce supply shortages’ (rated an 8-10 by 80% of doctors surveyed), and to ‘address long-term pay erosion arising from successive below inflationary pay rises’ (rated an 8-10 by 77% of doctors surveyed). Ensuring that doctors’ pay keeps pace with comparable professions was also rated as a highly convincing argument, with 70% of doctors surveyed rating this an 8-10. Finally, 60% of doctors surveyed also gave an 8-10 rating to the argument that ‘doctors should get a pay rise because of the extraordinary pressures we have been placed under during the COVID pandemic.’

Doctors have been subject to extraordinary pressures and stressors throughout the pandemic, regardless of what contract they are employed under. While this is worthy of recognition, we would reiterate that this is not the sole and most significant justification for appropriate uplifting of pay, but is instead a vivid example of the value that the profession has for society; value that has not been adequately appreciated for many years pre-dating the pandemic.

We would emphasise, though, that this undervaluation has come from the UK Government, rather than wider society. There is broad public support for a higher pay settlement for doctors, following public sentiment in the wake of the DDRB’s 2021/22 recommendations. Polling by the New Statesman found that 47% of the public felt that the 3% pay rise announced by the government was too little.³¹ We would also note that the BMA does not believe that a pay uplift for doctors, on its own, will be sufficient to address the many substantial issues that doctors face within the NHS, and pay is certainly not the only way in which doctors can be valued. The Nuffield Trust highlights that wellbeing support, flexible working, annual leave entitlement, progression opportunities and manageable workloads are all also important.³² However, they restate that pay is an overwhelmingly important factor. It is also the most immediate way of ameliorating this perceived lack of recognition.

4.5 Rising costs of childcare

The expensive and inflexible childcare options that many doctors face can lead to them reducing their hours to make childcare manageable. These career changes are disproportionately likely to be undertaken by women who continue to take on more caring responsibilities than men. The UK was already reported to have the highest costs of childcare in the world.³³ On average, 28% of a typical household income is spent on childcare, three times the average across the European Union. 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 progression.³⁴ As well as this, the BMA’s *Sexism in Medicine* report found that doctors with caring responsibilities were more likely to state that they were actively discouraged from senior positions.³⁵

³¹ <https://www.newstatesman.com/politics/2021/08/exclusive-polling-majority-say-nhs-nurses-and-doctors-are-paid-too-little>

³² <https://www.nuffieldtrust.org.uk/news-item/after-the-dust-settles-some-overlooked-and-underappreciated-aspects-of-the-nhs-pay-settlement>

³³ <https://data.oecd.org/benwage/net-childcare-costs.htm>

³⁴ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf

³⁵ <https://www.bma.org.uk/media/4487/sexism-in-medicine-bma-report.pdf>

The reduced availability of childcare places has led to increased costs for doctors. In addition to this, providers of childcare struggled to remain sustainable during the pandemic, which has led to added stress. Childcare costs rose by 4% for children under two, and 5% for children over two, compared to statistics from 2020.³⁶ The 2021 Childcare Survey found that 39% of local authorities reported that providers in their areas raised fees, while 32% have seen fewer providers offering funded places, and 35% of local authorities reported an increase in the number of providers permanently closing in the last year. The nature of the pandemic, where doctors worked unsocial and increased hours, has meant that some doctors have had little choice but to resort to significantly reducing their hours or taking unpaid leave, in order to support childcare arrangements.

It is evident that institutional and structural factors such as this have and will continue to significantly disadvantage doctors who work flexibly. If the rising costs of childcare are not matched by 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 has the potential to further widen the gender pay gap.

4.6 Impact on education and training

The ratio of medical academics to medical students has worsened over the last decade and is set to deteriorate further. Clinical academics also make up a far smaller proportion of the consultant workforce than they did at the start of the implementation of the NHS Plan and the number of academic GPs remains low and flat. As medical school places have risen, the number of medical academics has fallen. With the largest cohort of the medical academic workforce remaining in the 46–55-year-old category, a further decline can be expected as these individuals reach the natural retirement age.³⁷ Workforce issues are likely to be compounded by the effects of COVID-19 and Brexit.

With the association agreement between the UK and Horizon Europe yet to be formalised, uncertainty around the UK's access to Horizon Europe funding, along with unclear guidance on new immigration rules and the UK's general attitude to immigrants and overseas doctors, is likely to worsen workforce issues.

A survey conducted by the Association of Medical Research Charities (AMRC) found that of 500 early career researchers, 40% were considering leaving research since the COVID-19 pandemic.³⁸ Uncertainty around funding, especially for non-COVID-19 related research projects, combined with pressures to remain in clinical work to deal with the post-pandemic backlog of care, could mean a drop in numbers of early-career researchers. The COVID-19 pandemic has emphasised the central role that the UK plays in global medical research stage and the value of medical academics in driving forward ground-breaking research and high-quality education. Medical academics are also crucial to ensuring we are able to train the next generation of staff.

³⁶ <https://www.familyandchildcaretrust.org/childcare-2021-press-release>

³⁷ <https://www.medschools.ac.uk/clinical-academic-survey>

³⁸ <https://www.amrc.org.uk/news/pandemic-threatens-future-of-research-as-early-career-scientists-look-to-leave>

4.7 Salaried/sessional GPs

We have highlighted in previous submissions the extent to which the current pay range for salaried GPs has ceased to meaningfully reflect reality, in terms of actual pay, and therefore that this pay range is no longer fit for purpose. We will undertake research in 2022 to understand what an appropriate pay range might look like for salaried GPs. In the meantime, we have tried to make sense of the current limited data available on salaried GP's earnings. We looked at the impact of inflation, explored the findings from our 2020 survey, and used the DDRB's own methodology to understand what mean earnings might look like in 2021/22. These all demonstrate just how out of date the current pay range is.

The current pay range has not kept pace with inflation. If the pay range in 2004³⁹ had risen in line with inflation, we would expect to have a pay range in the region of £77,000 to £118,000⁴⁰ in 2021/22, instead of a pay range of £62,268 to £93,965 – 25% below the level it should otherwise have reached.

As we have previously noted, our own survey of salaried GPs in 2020 underlines the extent to which the pay range bears little relation to actual levels of pay, with around 80% of respondent's salaries falling between £75,000 and £101,000 in 2020/21, and less than 2% of respondents reporting a salary below the 2020/21 pay range minimum of £60,455, but nearly a quarter reporting a salary⁴¹ above the pay range maximum of £91,229. If this was adjusted to take account of the DDRB recommended 3% increase in 2021/22, it would be around £77,000 and £104,000.

While evidence suggests that earnings are not always normally distributed (bell shaped curve), and that earnings data can be highly skewed, to enable us to adjust for working hours using NHS digital data and DDRB's own methodology, we needed to use the mean value for employment income – which we recognise is not an ideal measure. The unadjusted figure in 2019/20 for salaried GPs employment data was £54,200. Adjusting this figure for working hours⁴² gave us a mean estimate of £83,683. This was a 6.7% increase compared to 2018/19. If, in addition, we applied the DDRB recommended uplifts of 2.8% (2020/21) and 3% (2021/22), this would give us a mean estimate of £88,607. This is in line with the mean of the salaried GPs survey we ran in 2020 (£90,234 with the 3% increase applied for 2021/22⁴³).

The consequence of this drift is that significant numbers of salaried GPs see no benefit from the DDRB's recommended increases to the pay range, which does not encompass their actual pay. Continuing to make recommended increases to an outdated pay range, rather than actual pay, only makes the range more irrelevant. Combined with the lack of additional funding provided by Government to practices to enable them to apply pay awards, the pay of many salaried GPs has remained static for a number of years.

The DDRB itself, in its 49th report, emphasised that it is 'important that pay uplifts are passed on to salaried GPs, in line with the BMA model contract'. At present, this is simply not happening across

³⁹ Our understanding is that 2004 was when the pay range was first introduced for salaried GPs.

⁴⁰ Adjusted for inflation (RPI), exact figures are: £77,359 to £117,518.

⁴¹ Respondents provided their actual earnings, and these were adjusted to FTE.

⁴² Using the DDRB methodology of adjusting the earnings data using a ratio of FTE to headcount figures to estimate the average number of working hours for salaried GPs.

⁴³ The mean earnings figure for the salaried GPs survey in 2020 was £87,606.

the board. In a recent BMA survey of GPs⁴⁴, over a quarter of salaried GPs reported they had not received a pay increase for several years or had never had one. We also asked specifically about the 2021/22 DDRB recommended uplift, and just under 32% of salaried GPs expected to receive (or already had received it) the recommended DDRB uplift of 3%, with nearly 29% expecting to receive no pay rise at all, just under 19% expecting a lower pay rise, and 20% not being sure.

These issues have also served to exacerbate the gender pay gap, as we have previously highlighted. Salaried GPs have a significant gender pay gap that is 22.3% in favour of men; three times the size of the gender pay gap for GP partners. This is despite 73% of salaried GPs being women. The BMA's Sexism in Medicine survey found that GPs were more likely to share examples of institutional and structural factors when asked around incidents of sexism they had experienced, rather than individual behaviour.⁴⁵

The BMA's November Viewpoint survey has yielded very concerning responses that indicate the level of demotivation and extent to which salaried GPs feel undervalued. A troubling 92%⁴⁶ indicated that they felt either 'not significantly or not at all valued' or 'now less valued than before the pandemic' by the media, sections of which have engaged in a protracted campaign of vilification against those working in primary care.⁴⁷ It is therefore unsurprising that these worrying results are replicated in their perceptions of the extent to which they are valued by politicians (with nearly 90% responding to the same categories above) and even to some extent by the public (64%).

These perceptions are borne out by responses from General Practitioners more widely, two-thirds of which have reported that their experience of abuse, threatening behaviour or violence had got worse in the last year, with half (51%) saying they had been personally verbally abused, and 67% witnessing violence or abuse against other staff.⁴⁸ The attendant effect on morale is reflected in the Viewpoint survey when respondents were asked to rate their morale, with 62% describing it as either negative or very negative.

In such a toxic context, it is entirely unsurprising that salaried GPs are, like other medical colleagues, seriously considering making significant alternative career plans. 44% of salaried GP respondents to the BMA's November Viewpoint survey indicated that they were more likely to leave the NHS for another career, 43% were more likely to take a career break, and 42% were more likely to take early retirement. This echoes official data indicating that 23% of GPs in England are 55 or over and are expecting to quit within the next few years.⁴⁹ The implications of this require urgent action, as these are not simply longer-term career plans: 46% of salaried GP Viewpoint respondents described their desire to remaining working in the NHS during the next year as either negative or very negative.

Beyond those that are simply considering leaving the medical workforce altogether or for a protracted period of time, 65% reported that they were more likely to seek to work fewer hours.

⁴⁴ We ran a survey of GPs in September 2021, with 2357 GPs in England responding and 674 of them were GPs working as a salaried GP. We asked salaried GPs about their pay.

⁴⁵ <https://www.bma.org.uk/media/4487/sexism-in-medicine-bma-report.pdf>

⁴⁶ Of 259 respondents

⁴⁷ <https://www.bma.org.uk/bma-media-centre/anti-gp-media-rhetoric-risks-fuelling-climate-of-abuse-says-bma>

⁴⁸ <https://www.bma.org.uk/bma-media-centre/bma-urges-public-to-be-kind-as-survey-reveals-worrying-levels-of-abuse-against-doctors-and-colleagues>

⁴⁹ <https://www.theguardian.com/society/2021/oct/29/nhs-facing-mass-exodus-gps-doctors-england-experts-warn>

These drastic changes to career plans are being driven by a perfect storm of overlapping issues, including increased workload (91%), worsening personal wellbeing (59%), deteriorating working conditions (59%) and workforce supply shortages (58%). More than half (53%) identified below inflation pay increases as a motivator for their plans to curtail their career or reduce their commitments, indicating the limits to which financial solutions alone can remedy the situation.

As mentioned earlier, the BMA is seeking to undertake a larger piece of research to analyse salaried GP pay and place it properly within the context of motivation, recruitment and retention issues in general practice more widely. We anticipate being able to share the outcomes of this project with the DDRB in the evidence submission for the 2023/24 pay award round, and would value further engagement with the Review Body on this specific issue.

Despite this, we would emphasise that the issues faced by salaried GPs, and the ongoing problems created by a pay range that is not fit for purpose, are not challenges that can be deferred. In the short term, the DDRB must recommend an appropriate award that is based on the actual pay of existing salaried GPs, rather than simply uplifting a range that has long since ceased to provide an accurate and meaningful indication of pay. It must also urge the Government to ensure that funding is made available for practices to deliver on that pay award, otherwise it will only serve to exacerbate pressures on practice finances; last year, practice partners had to carefully consider what adaptation and service cuts could be made solely to deliver the uplift. It is obvious from our own recent survey of GPs that this meant many felt they could simply not deliver such a pay rise for their staff.

Salaried/sessional 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 settings, 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.

GP trainers' grants

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

GP Appraisers scheme

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

recommendations.

4.8 Staff, Associate Specialist, Specialty, and Specialist (SAS) doctors

2021 contracts

At the start of 2021, the BMA and its negotiating partner NHS Employers, with oversight from the Department of Health & Social Care and NHS England/Improvement, concluded negotiations on two new contracts – a new Specialty Doctor contract⁵⁰ and a Specialist grade contract⁵¹ – which were approved by BMA SAS members in a referendum. These contracts took effect from 1 April 2021, meaning that new starters to the grade would be employed under these terms and conditions of service. 1 April also represented the starting point of the six-month ‘window of opportunity’, during which existing SAS doctors employed on the previous national contracts would be able to express an interest to their employer in transferring to the new contracts, in line with the processes set out in Schedule 20 of both contracts.

The specialist grade is a new contract, and applicants must meet a set of generic capabilities criteria to be eligible for this grade.⁵² Save for any existing associate specialists who chose to transfer, all specialist posts in the future will be created at the discretion of the employer, where they have identified a specific workforce need. This means that specialty doctors on the 2021 and 2008 contracts will not have any automatic right to progress or be regraded from their current grade into the new specialist grade. Instead, they will have to apply for such a role when it becomes available.

The BMA has continued to express its concerns about the numbers of highly experienced and dedicated specialty doctors working at a senior level of responsibility and competence without appropriate recognition and remuneration. Where they are already undertaking such senior levels of work, their employers have little incentive to create a senior grade post for which they could apply. This issue has become more pronounced since the associate specialist grade was closed on a national basis in 2008/09, allowing the boundaries in roles and responsibilities between specialty doctors and more senior SAS doctors to become blurred. This is an area in which we have sought to support members; many feel that they have a case to make to their employer that there is an identifiable workforce need for a specialist grade doctor, but it is currently being papered over because this senior work is being done by doctors who are not being appropriately recognised and remunerated.

We continue to monitor the creation of specialist posts to ensure that they are being used as intended and represent a viable career pathway for SAS doctors in England. Given that prior to the creation of the specialist grade, many employers (as many as 37 based on the BMA’s figures) were either planning to or were already reopening the associate specialist grade on a local basis to fill existing workforce gaps, we know that senior SAS roles are an effective means of addressing recruitment and retention issues. As such, the creation and proliferation of specialist grade posts must be encouraged.

⁵⁰ <https://www.nhsemployers.org/publications/terms-and-conditions-service-specialty-doctors-england-2021>

⁵¹ https://www.nhsemployers.org/sites/default/files/media/TCS-for-specialist-grade-england-2021_0.pdf

⁵² <https://www.nhsemployers.org/sites/default/files/2021-06/sas-paper-2-specialist-grade-generic-capabilities-framework-2021.pdf>

One important feature of the 2021 contract negotiations was the design and creation of the SAS Advocate role, about which the parties have produced guidance which explains how the role could work.⁵³ However, due to disagreement about how these roles should be funded, they remain non-contractual, with employers under no obligation to create these posts. Given that they were intended to be a means of addressing ongoing reports of widespread bullying and harassment against SAS doctors⁵⁴, the BMA did not think it was appropriate that these roles be effectively funded by SAS doctors themselves. Rather, it should be incumbent upon employers to resource roles that are intended to redress negative workplace cultures.

We are anecdotally aware of small numbers of employers in England who have already created such roles, or indicated a willingness to do so. Our concern with this laissez-faire approach is that those employers who are least likely to identify the value that such a role would bring are also likely to be those whose staff would benefit most from its creation. We would welcome the DDRB's support in arguing that these roles are a benefit in and of themselves, and should be created and funded by all employers as a means to improve SAS doctors' motivation and their sense that they are a valued and supported member of staff.

Impacts of the 2021 pay award

As we noted at the start of this submission, the approach of the UK government in relation to the application of last year's pay award to all national SAS contracts in England, Northern Ireland and Wales, except the 2021 contracts subject to multiple year pay deals, has created significant complexities. These have, at this moment in time, had a clear detrimental impact on the attractiveness of the new contract and therefore the numbers who have sought to move to the new contracts. While the multiple year pay deal to which the 2021 contracts are subject is set at a headline of 3% per year over three years, only some of that funding in each year is targeted towards basic pay; the rest is used to fund other changes, such as provision of new safeguards and amended on-call availability supplements.

It is naturally the case that the 3% uplift to the older contracts means that, in the first year of transition, moving to the new contract will be comparatively less favourable, particularly when the entirety of the 3% uplift is focused on basic pay, rather than other elements of a contractual package. However, it remains the case that, for many, transferring to the new contracts will still represent a benefit in terms of their basic pay over time. The exceptions to this are specialty doctors on the top four points of the 2008 pay scale where, based on a counterfactual of an estimated 1% increase in each year, we anticipate that the top of the 2008 specialty doctor pay scale will increase beyond the top of the 2021 specialty doctor scale (as set out in the BMA's specialty doctor pay explainer document⁵⁵).

Those on the 2008 associate specialist contract would, even before the additional 3%, have seen no benefit to their basic pay by transferring to the 2021 specialist contract. Indeed, because the pay protection offered to them is based on the salary they would have been earning before the pay award was added, it is very clear that they would be better off remaining on the associate specialist contract in terms of basic pay (as set out in the BMA's associate specialist pay explainer

⁵³ <https://www.nhsemployers.org/sites/default/files/2021-06/SAS-reform-SAS-advocate-role-guidance.pdf>

⁵⁴ <https://www.bmj.com/content/368/bmj.m84>

⁵⁵ <https://www.bma.org.uk/media/4480/bma-specialty-doctor-in-england-pay-basic-pay-comparision-aug-2021.pdf>

document⁵⁶).

There is one particularly significant problem created by the 3% increases being applied to the 2008 specialty doctor contract but with no commensurate increases applied to the 2021 specialty doctor contract: the negative impact it has in the first year for the majority of pay points. When the scale was being designed, it was intended that no one would see their pay decrease by virtue of transferring to the new contract – their pay remained either the same in the first year or would increase by varying amounts. However, the 3% increase applied to the 2008 contract has meant that, in the first year, a far greater number of individuals would be immediately encountering a nominal reduction in their basic pay by transferring to the new contract. As this table, taken from the specialty doctor pay explainer, makes clear, only three of the existing pay points would be better off under the new contract. The rest all see an immediate reduction in salary.

Table 1 – Specialty doctor pay at point of transfer to 2021 contract

Starting year of experience	Basic salary 2008 contract (1 April 2021)	Basic salary 2021 contract (1 April 2021)	Difference on transfer to 2021 contract
0	£42,393	£45,124	+£2,731
1	£46,017	£45,124	-£894
2	£50,730	£49,745	-£985
3	£53,255	£55,790	+£2,534
4	£56,894	£55,790	-£1,104
5	£60,519	£58,756	-£1,763
6	£60,519	£62,978	+£2,459
7	£64,226	£62,978	-£1,248
8	£64,226	£62,978	-£1,248
9	£67,933	£66,614	-£1,319
10	£67,933	£66,614	-£1,319
11	£71,640	£70,249	-£1,391
12	£71,640	£70,249	-£1,391
13	£71,640	£70,249	-£1,391
14	£75,347	£73,883	-£1,464
15	£75,347	£73,883	-£1,464
16	£75,347	£73,883	-£1,464
17+	£79,054	£77,519	-£1,535

A further complication has been created by this differential uplift is that, with the 3% award for the older contracts being backdated to 1 April 2021, for the period between 1 April and the point at which they transfer to the new contract, those on the majority of pay points will be in receipt of an overpayment. While some employers have already sensibly indicated that they would not seek to recoup the effective overpayment made in the period that elapses between 1 April and the date on which the individual finally transfers, not all employers have agreed to this, despite the fact that doing so represents no additional cost to them on the basis that, if the individual chooses not to transfer, this is the level of pay they would in any case need to provide. The only effect that this has is to further discourage transition to the new contract, when considered in conjunction with the

⁵⁶ <https://www.bma.org.uk/media/4483/bma-as-doctor-in-england-pay-basic-pay-comparison-aug-2021.pdf>

initial reduction in pay on transfer.

While the negotiating parties have continued to meet and discuss the issue via the Joint Negotiating Committee for SAS (JNC(SAS)), and despite a joint statement⁵⁷ acknowledging the issue and stating the parties intentions to address it, there has been no progress in agreeing solutions to mitigate the issues that this pay award differential has created. While BMA Wales and the Welsh government have found a pay continuity solution, which removes the significant disincentives to transferring to the new contracts, no similar approach has been supported by DHSC or NHS England/Improvement.

The BMA has sought, initially, an extension of the window of opportunity and, more importantly, an agreement to remove the provision of the new contracts (Schedule 20, paragraph 6) which makes transfer after the window of opportunity closed on 30 September a matter of employer discretion. Without clarifying the arrangements for transfer after this period, such that individuals can choose to transfer to the new contracts when doing so becomes financially viable for them. The alternative is that we have a contract with very limited uptake on which only new starters are being placed, obviating many of the benefits of contract reform that all parties claim as a shared aim.

Based on ESR data shared via the Joint Negotiating Committee for SAS doctors (JNC(SAS)), as of August 2021, only 704 doctors were employed on the two new contracts, and of those only 473 had chosen to move to the new contracts from their existing contracts. As a consequence, a vanishingly small number of SAS doctors have benefitted from the headline investment of 3% per year over three years that was originally set aside to deliver contract reform.

Motivation and pay

It should be emphasised that while the issue has been created by the pay award applied to the older SAS contracts without a commensurate increase being awarded to the 2021 contracts, the solution is not to simply reduce or remove any pay award that might be made to those earlier contracts. Indeed, the contributions of all SAS doctors, and the risks that they have been subject to during the pandemic, mean that they are every bit as deserving of appropriate recognition and reward as any other group.

There are significant risks of demotivation among this group. Of the SAS grade respondents to the BMA's Viewpoint survey, 72% reported feeling that they were either valued 'not significantly or not at all' or 'now less valued than before the pandemic by the Government'. Perhaps unsurprisingly, in the same survey, 47% of SAS respondents indicated that their intention of taking early retirement has become more likely for the next year, with 39% saying the same about their intention of leaving the NHS for another career, and more than half (56%) saying that they intend to reduce their working hours.

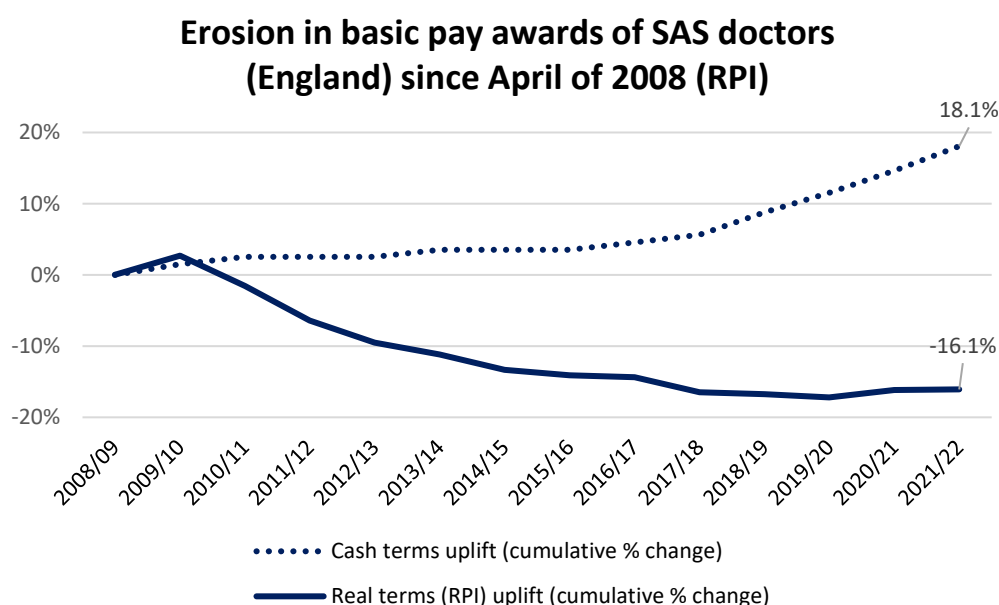
These drastic changes to career plans have been driven by factors specifically related to their working lives – the intensity of their workload (71%), a worsening workplace culture (57%), and a worsening of their personal wellbeing (54%) – but also the broader context of feeling that their work has been consistently undervalued, with more than half of SAS respondents citing below inflation pay increases (52%). Consequently, nearly three quarters (74%) of SAS respondents described their morale as either neutral or worse. The significant impact on morale, and the attendant impact on expected retention of staff, underlines the urgent need to ensure that SAS doctors are appropriately

⁵⁷ <https://www.nhsemployers.org/sites/default/files/2021-09/SAS-Reform-JNCsAS-joint-statement-Sept-moves-to-new-contract.pdf>

recognised and rewarded for their ongoing work.

The sense among SAS doctors that they are, like other medical colleagues, undervalued is borne out by the significant erosion of their pay in the recent past. With inflation currently at historic highs, this problem is even more keenly felt. According to the ONS (as of December 2021), the year-on-year rate of CPI (consumer prices index) inflation is currently 5.4 per cent, whereas RPI (retail prices index), which we believe better reflects the costs facing doctors, currently sits at 7.5 per cent. From April 2008 - April 2021, cumulative sub-inflationary pay awards for SAS doctors (England) have actually generated a real-terms (RPI) pay decline of 16.1%. This graph excludes SAS doctors under multi-year deals.

Table 2 – Erosion in basic pay awards of SAS doctors (England) since April 2008 (RPI):



In light of this, any recommendations for a pay award that are applied to the closed national SAS grade contracts should likewise be applied to the 2021 SAS contracts. We note and welcome the DDRB's efforts to encourage Ministers to offer additional recognition to those employed on contracts subject to multiple year pay deals, even though such encouragement was ultimately ignored. We understand that entering into multiple year pay deals as part of contract negotiations has usually meant that no consideration or recommendations are made for the duration of those agreements. However, the original pay deal was entered into at a time of relatively low inflation, and the expectations of all parties on which this agreement was reached have been significantly exceeded. As such, the potential benefit of that pay deal has been rapidly diminished.

The practical implications are that failure to review and increase the multiple year pay deal will continue to render transition to the new contracts – something that is still identified by all parties as the preferred outcome – a significantly less attractive option than remaining on previous national contracts. Ultimately, if such multiple year pay deals cannot be reviewed, and are rigid and inflexible in the face of economic volatility, then they will simply not be viewed as providing a viable basis for future contractual agreements.

In any case, we do not believe that the DDRB, as an independent pay review body, should feel

constrained from recommending an additional uplift to the 2021 contracts where this is justified.

4.9 Locally Employed Doctors (LEDs)

The BMA has begun a project to try to identify and better support doctors employed on local terms and conditions (i.e. contracts produced by and specific to a particular employer, rather than being tied to the national terms and conditions of service for specific grade contracts). At present, this audit has identified around 7,500 LEDs (from data received from 78/127 NHS Trusts), and we expect the final total to be significantly higher. There tend to be greater numbers of these doctors in major centres and difficult to recruit geographies, and they can represent anywhere up to 46% of an organisation's medical staff. In the region of London as a whole, they constitute 16% of the medical workforce (3372 LEDs in total).

These groups are also known as 'Trust Grade' doctors, and include many different job titles, such as 'clinical fellow', 'senior clinical fellow' and 'FY3'. LEDs, as an umbrella term, captures a wide range of different roles. For example, some doctors in training will make an active choice in their career to seek temporary employment on these contracts, such as if they wish to take a career break, focus on a particular area of practice, or simply await the advertising of a particular consultant post. However, we are aware that many LEDs are International Medical Graduates (IMGs) who are often not offered any other type of contract that might be more appropriate to their training and skills. Sometimes this will place them on working patterns and arrangements similar to those of doctors in training; others will effectively fulfil the same role as SAS grade doctors but on less generous pay and contractual arrangements.

For this reason, we have significant concerns about these localised contracts and how they are used. Doctors employed on LED contracts are at significantly greater risk of being employed on less favourable pay and terms and conditions than their colleagues on national contracts, such as those on the SAS grade contracts. They may also be pressured into undertaking the most onerous working patterns because they have fewer contractual protections than their colleagues on national terms and conditions. Crucially, by virtue of not being on national contracts, they will not be automatically subject to any pay awards applied to the national contracts, meaning that unless there is local agreement to implement the pay award granted to other grades, their pay will stagnate and they will receive less than colleagues with whom they share duties. Appropriate consideration needs to be given for this significant cohort of doctors who, by virtue of their non-standard contractual arrangements, do not stand to directly benefit from the pay review process.

We would ask that the DDRB consider the appropriateness of the proliferation of local, non-standard contracts where national contracts might appropriately be used, and recommend that, if there are specific circumstances in which a different type of contract is required, the BMA and NHS Employers enter into discussions to agree a national contract incorporating nationally bargained pay awards for this purpose. Even where there are local agreements to give LEDs pay awards matching those granted to other grades, this is often because individual employers are recognising the difficulty discussed above and feeling obliged to address it by duplicating unofficially the nationally negotiated terms agreed for other grades – despite official national guidance that they should not use national terms for LED contracts. We would ask that the DDRB question this disconnect between national advice and local practice, and recommend that it should encourage action regarding the recommendation above.

4.10 Medical Academics

In its 2021 Report the Review Body stated that “a robust and sufficiently large clinical academic workforce is essential to maintain the quality of new doctors and dentists, and we would expect those that are responsible for medical and dental training to ensure that this workforce is maintained. This is pivotal to both teaching and clinical research.” Clinical academics contribute significantly to the UK’s medical research effort. A report in the BMJ in 2018 stated that for every £1 invested in UK public medical research, a benefit equivalent to 15-18 pence per year in interest is received by the UK economy. Including health gains, this meant that for every £1 spent on medical research in the UK, we get back benefits, in GDP gains and health gains, equivalent to 25 pence per year.⁵⁸

The contractual mechanism that is used to help achieve the required academic workforce is through the long-standing commitment to pay parity for clinical academics with their counterparts in the NHS. This commitment is shared by the university employers of doctors in senior clinical academic roles, NHS employers and the BMA and BDA. Hence, the pay awards by the DDRB have an impact on the higher education sector and on clinical academics. It was clear at the time of the 2021 evidence that COVID-19 was having a significant negative effect on the finances of the UK’s universities. The loss of overseas students and the expected deferral by a number of UK students led to the university sector incurring hundreds of millions of pounds of debt. In academic medicine, this has been compounded by the loss of income from the medical research charities, which fund many training posts and research activities.

The DDRB’s 2021 report recognised the 52% real terms reduction in the number of senior clinical academics after adjustment for rising student places, and the need for a clinical academic workforce of sufficient size to meet the UK’s medical education and medical research needs. This requires a fully-funded commitment to pay parity across academic medicine, including in particular for academic trainees, who all too often lose out in overall pay terms by having to move in and out of the academic sector. We would welcome means of addressing this problem whilst maintaining the general commitment to parity. We also suggest that this means that any pay award for clinical academics needs to be separately funded by the UK and devolved governments in the current and future years rather than universities being expected to absorb the costs. Failure to do so risks maintaining pay parity at the cost of jobs.

MASC would also like to highlight the impact of the recent increases in medical student places (some of which was unplanned and was a result of the problems with A Level marking in 2020) and of the opening of new medical schools on the current workforce. To be of sufficient quality, these developments will require a parallel 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. If there are insufficient clinical academics available then the burden would fall on GPs, consultants and SAS doctors (who have repeatedly seen their time for supporting professional activities (SPAs) reduced by employers). This leaves many doctors delivering educational activities in their own time.

⁵⁸ <https://bmjopen.bmj.com/content/8/9/e022131>

We also note that the pay-scale for senior GP educators (including postgraduate deans, HEE directors and the like) 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 pay-scale is reviewed annually to ensure that their work is appropriately remunerated. We suggest that such doctors should also be able to have access to honorary and substantive academic posts on clinical academic contracts and to an appropriate pay-scale in the HE sector.

COVID-19

Throughout the COVID-19 pandemic, all doctors across the UK, including clinical academics, 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 from the virus. Clinical academics 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.

Even though redeployment should legally be voluntary and despite MASC being party to the agreement with NHS Employers near the start of the pandemic, we received reports of employers effectively forcing clinical academics to be redeployed. This took place at times with no notice and with no prior consultation or agreement. In part this was because in many areas academic activity ceased during the early stages of the pandemic and has not returned to pre-pandemic levels across the board.

Whilst we understand the reason for such redeployments, it was of particular concern that around half of clinical academics redeployed reported a lack of proper induction for their new areas of work and locations.⁵⁹ This will only add to the stress of an already high-pressure situation. In the medium term, such redeployments can be especially detrimental to doctors with caring responsibilities, compromise the progression of academic trainees or adversely impact on the education of medical students. All of these issues risks diminishing the future supply of doctors through rendering the profession as unattractive to potential clinical academics.

We agree with our NHS colleagues that the pandemic has had a significant impact on doctors in training. In acknowledging that, we also welcome the decision by NIHR and the other funders of academic training to guarantee from the second wave of COVID-19 that any future re-deployment of academic trainees would be on a voluntary basis. Unfortunately, however, this was too late for a cohort of academic foundation trainees who missed out on their academic rotation because of COVID. We have been assured that this will be taken into account when assessing future applications for academic posts, but we would ask that the situation is monitored as part of the Review Body's interest in the maintenance and development of the medical academic workforce.

Most other academic trainees will have been able to undertake the academic components of their training but will have been delayed or completed the component late because of the impact of the pandemic. This in turn will have delayed access to higher pay nodes, to the academic pay premium (both of which we cover in more detail below) and to consultant, GP and SAS posts and pay. We ask that the academic trainees affected be compensated for these losses of income arising from their contribution to the emergency effort in response to COVID-19.

⁵⁹ Brief review of the BMA Wave 3 Covid19 Tracker Survey, with particular reference to Academics and trainees, Mary Jane Platt, May 2020, a paper for the Medical Academic Staff Committee.

MASC, therefore, shared the disappointment of NHS colleagues that the UK and devolved governments have 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 the herculean efforts of doctors. MASC believes that it is vitally important that the DDRB makes a recommendation that recognises the sacrifices of clinical academics alongside their NHS colleagues in combatting the impact of the pandemic and in providing effective vaccines, treatments and anti-virals.

MASC notes that 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 gesture recognised the professionalism and value doctors have clearly demonstrated in their response to COVID-19 and by lobbying through BMA Scotland MASC had it confirmed that clinical academics were also eligible for this payment. Whilst a non-consolidated one-off award would not diminish the impact of years of poor pay uplifts, such a payment made by the NHS would be a first step in valuing the work that clinical academics and their NHS colleagues have done and continue to do in response to the pandemic. Such a payment would also take some of the pressure off already financially hard-pressed universities.

During the first peak of the COVID-19 pandemic some effort was made to encourage recently retired doctors to return to work and some 28,000 doctors made themselves available. MASC was disappointed that these efforts almost entirely focused on doctors who could provide clinical care, whereas efforts to encourage doctors to return as educators or to support research activities could have both ensured that these activities continued and that the burden of them fell less heavily on over-worked colleagues providing clinical care. Those doctors that did seek to return to provide educational support reported encountering a slow-moving bureaucratic process which led many of them to decide to give up making the attempt.

MASC believes that more effort needs to be made to tap into recently retired doctors as an educational resource, especially given the recent and ongoing increases in medical student numbers and has put some initial proposals to the Medical Schools Council for consideration. We would obviously expect such doctors to be paid appropriately for their work. We would welcome the Review Body’s support for this initiative.

Academic Trainees

The clinical academic training pathway is an essential pipeline to producing the senior medical academics of the future. Without clinical academic training now, there will not be senior academics of the future. Doctors are far more likely to carry an academic component through their career from the beginning than move into academia later, and hence the whole clinical academic pathway must be protected to ensure we recruit, train, and retain the clinical academics of the future.

Clinical academic trainees are those doctors in training that, in addition to their clinical training, will undertake training in academic activities, ranging from research methods to scholarship and teaching. This training is often done in parallel with clinical training, out of programme, or in separate blocks integrated with clinical training from specific days of the week to a period of months.

There are multiple stages to the clinical academic pathway and therefore it is crucial to ensure that academic training remains appealing throughout the pathway to keep these clinical academics

engaged and retain their growing skills. Academic training through to CCT will, for those in secondary care and public health, require the completion of a higher degree such as a PhD which is almost invariably done 'out of programme'. That means ceasing to be an NHS trainee and stepping off the NHS junior doctor pay-scale and thus delaying their progression up it. Academic trainees also contribute significantly to the wider UK medical research effort noted above.

During the COVID-19 pandemic, many academic trainees were redeployed away from their academic work to support clinical service pressures to return to their research later. This carried with it multiple impacts due to direct delays to their academic training, indirect delays due to time spent winding down and restarting sections of their academic work, and impacts to their research funding.

MASC is concerned that, despite their importance, both to the current research effort and as the research leaders and medical educators of the future, the principle of pay parity is less adhered to for academic trainees than it is for consultant clinical academics. The 2016 pay arrangements for junior doctors in the NHS were translated into the academic sector following negotiations between the BMA and Universities and Colleges Employers Association (UCEA). This means that, as for all doctors in training in England, pay progression is now linked to obtaining a job in a higher pay node.

2. Pay for clinical academic doctors in training (2016 contract / pay system [updated 2018])

Pay for doctors in training			
Nodal point	Stage of NHS training	2020	2021
1	FY1	28,243	28,808
2	FY2	32,691	33,345
3	CT1 or ST1/SpR1 CT2 or ST2/SpR2	38,694	39,467
4	CT3 or ST3 / SpR3 ST4 / SpR4 ST5 / SpR5	49,036	50,017
5	ST6 / SpR6 ST7 / SpR7 ST8 / SpR8	52,036	53,077

However, the additional requirements of academic training mean that training takes longer, and the need to go out of programme to undertake research and complete an MD(Res) or PhD delays progression between nodal points in the pay scale by 2-4 years. This impacts career earnings and pension value, and exacerbates the gender pay gap due to more female academics working less than full-time and thus progressing through the pay scale slower and reaching the post-CCT pay scales later.

The delay to pay progression is supposed to be compensated for by the academic pay premium, in recognition of the additional contribution to the NHS and healthcare, so that clinical academic trainees are not at a financial detriment, and do not feel disadvantaged by pursuing research, which in turn benefits society. However, the pay premium is a blunt instrument. It is of fixed value, which is not based on the actual income lost by the trainee and which does not necessarily increase with the annual pay uplifts. Furthermore, unlike the pay that has been lost, the pay premium is not pensionable.

Academic medicine and academic trainees would be better served with the pay premium being a percentage value of the full-time equivalent basic pay. We suggest 15% of full-time basic pay is appropriate remuneration for academic trainees. The pay premium should be awarded at the point of committing to either a higher degree or to the academic pathway, so that it increases in line with future increases to basic pay and ensuring that all clinical academic trainees are appropriately rewarded for their contributions and protecting against financial detriments.

We would however reiterate that where any increase to the pay premium is recommended, this would need separate additional funding from the UK Government. Universities should not be expected to absorb any additional costs and failure to provide the necessary funding risks an attendant reduction in the number of available academic training posts.

Due to the impact of the pandemic in delaying progress along the clinical academic training pathway, we call for additional financial recognition for those clinical academic trainees who have delayed or foregone parts of their academic work in order to ameliorate this greater impact than was envisaged by the blunt instrument of the existing academic pay premia.

A particularly concerning issue is that NHS employers do not recognise the higher pay points on the pre-2016 clinical lecturer pay scale in the HE sector.

6. Clinical academics below the level of consultant (post 2009 scale) and Senior Lecturer / Reader Scale

Post-2009 Clinical Lecturer Scale†		
	01.04.20	01.04.21
1	34,466	35,155
2	37,241	37,986
3	38,920	39,698
4	40,944	41,763
5	42,969	43,828
6	44,994	45,894
7	47,018	47,959
8	49,044	50,025
9	51,069	52,090
§10	56,423	57,551
§11	60,960	62,179
§*12	65,493	66,803

† This salary scale is retained for use for clinical academic trainees who are in 'Category 2' transitional protection during the transition period to the new pay system. It may also be used for any other clinical academic posts, who are not doctors or dentists in training- such use is a matter for local determination.

§ These points are HE specific pay scales that have no NHS equivalent. A 2% increase has been applied in line with the latest NHS Pay Circular.

* This point was introduced on 1 April 2002 and relates only to dentists.

This means that trainees returning to the NHS to complete clinical training can suffer a significant pay cut, especially if it is linked to a reduction in out of hours commitments. Such losses are demoralising for the individual concerned and damage the reputation of academic careers more generally. We would welcome the Review Body's support for greater flexibility on the part of NHS employers on this matter as a means of demonstrating their commitment to pay parity for academic trainees.

Clinical Excellence Awards

Clinical excellence awards and the merit awards that preceded them are, in MASC's view, a key and cost-effective mechanism of encouraging and rewarding academic activity in teaching, research and innovation. Indeed, MASC would argue that encouraging such activity was a major reason for establishing the awards in the first place and that the UK's leading roles in global life sciences and medical education is an indication of their success.

We know from our colleagues in Scotland that closing the scheme creates workforce and recruitment challenges, and we know from the lack of applicants for the UK Government's Global Talent visa of the difficulties that we face in recruiting the most able clinical academics from across the world. It has been argued that universities may offer higher rates of pay if they wish, but we believe that such processes lack transparency and the external oversight that is a feature of the CEA scheme. In addition, we would suggest that such *ad hoc* arrangements agreed on request are likely to disadvantage women academics and widen the gender pay gap further.

Nonetheless, we recognise that these awards contribute to the gender pay gap, but the reasons for this are complex and are in part due to the lower-than-expected number of applications from women. Reforms are proposed to the CEA scheme, particularly in England, to ensure that these issues are addressed. We would urge the Review Body to help ensure that in the first instance, all roles undertaken by clinical academics are remunerated at the point that they are undertaken and that it is genuine excellence in a role that is rewarded through the CEA scheme.

Senior Academic GPs

Since the abolition of Primary Care Trusts under the Health and Social Care Act 2012, the honorary contracts of most senior academic GPs (SAGPs) in England have been held by NHS England/Improvement. Some honorary contracts have been held by CCGs or even local NHS trusts and foundation trusts. Furthermore, some academic GPs have substantive contracts with NHSE/I. As the main contract holder for senior academic GPs, MASC has argued, alongside the Society for Academic Primary Care, that NHSE/I should run a local clinical excellence awards scheme for this group of senior academics. Access to CEAs was agreed as part of the SAGP contract package in 2004 to ensure pay parity across primary and secondary care and to provide a pay package broadly comparably to that of a GP Principal. Discussions have been held with NHSE/I almost continuously since 2013 with whatever limited progress that is made being subsequently eroded.

There is also evidence from ACCEA that lack of a local CEA scheme is disadvantaging SAGPs in the national scheme.⁶⁰ It is not clear from ACCEA's 2020 Annual Report how many academic GPs applied for awards. The last year in which it is clear, 2018, there were 12 applications from senior academic GPs, 3 of whom were successful. This represents a halving of the number of applications compared to the previous year, which had been in line with the three years before that. In addition, ACCEA's 2020 Annual Report⁶¹ stated that:

On [awards not renewed] the Committee noted that five academic GPs would lose their awards, not having access to a local CEA scheme. They would thus move from having a national award to having no award. Main Committee asked the Secretariat to raise their concerns about access to local CEAs for Academic GPs with NHS England. Main Committee

⁶⁰ 2019 ACCEA Annual Report: [ACCEA annual report 2019 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664444/2019-ACCEA-Annual-Report.pdf)

⁶¹ 2020 ACCEA Annual Report: [2020 ACCEA Annual Report \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664444/2020-ACCEA-Annual-Report.pdf)

separately agreed that applications from academic GPs with NHS England-held contracts should, in future, be scored by the national Arm's Length Body sub-committee' so that they could be better benchmarked against each other, in the same way as are Public Health Consultants employed by Public Health England

As is clear from ACCEA's statement above, SAGPs would also be particularly disadvantaged if the national scheme is amended as proposed by the Review Body back in 2012, and the total award is made up of an aggregate of a local award and a smaller national award. As part of the commitment to pay parity, we therefore ask the DDRB to support our call for a local CEA scheme to be established for eligible employees of NHSE/I.

Pensions

MASC notes that the DDRB has previously stated that pensions and the system of pensions taxation is outside their remit and has argued that the 'generosity' of the NHS pension scheme justifies below inflationary pay awards for doctors.

With regard to clinical academics, we reiterate the point made by our clinical colleagues that the NHS pension scheme is no longer generous for doctors and add that many clinical academics (especially those working in Scotland) are not in an NHS Pension scheme but in the Universities Superannuation Scheme which is now notably less generous than the schemes in the NHS. MASC would argue that this should be taken into account in the Review Body's deliberations on pay. We ask that the DDRB recognise these differences and supports the right of clinical academics to remain within the relevant NHS scheme even if employed by a university.

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. The USS has put forward further proposals that increase the contribution rates and significantly reduce the benefits offered to members of the scheme, especially for higher earners. This is on top of already reduced benefits to members of this scheme, that remove in totality any benefit accrued for a lower contribution rate for the scheme than for the NHSPS.

Furthermore, these clinical academics are now trapped in USS because it 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 incorrectly advised that they had to join USS when they began university employment.

The significant differences between the two pension schemes are relevant in the context of the DDRB regarding pensions as deferred pay. As such, the pension is part of what should be considered by all stakeholders in medicine and academic medicine when seeking to achieve pay parity between clinical academics employed in the HE sector and their clinical colleagues in the NHS. The differences between the USS and NHS pension schemes in our view represent a deviation from this principle. We, therefore, 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 as a means of ensuring pay parity and the recruitment and retention of clinical academics in the long-term.

4.11 Public Health Medicine

As might be expected the impact of the pandemic on public health was earlier and more consistently intense than almost any other part of medicine. Consequently, the data on morale, health and wellbeing and future intentions are certainly not better than those for clinical colleagues and are often worse. The BMA's survey of public health doctors in November 2020 reported that 43% of all respondents described their morale as either low/very low rising to 46% of PHE staff and 61% in the devolved nations. This was reflected in higher levels of fatigue than normal among 75% of respondents with 48% reporting that their health and wellbeing was worse than during the first phase of the pandemic and 54% saying they were suffering from depression, anxiety, stress, burnout, emotional distress or other mental health condition relating to or made worse by work. The Faculty of Public Health undertook a further survey in the early summer of 2021, and we are awaiting a report of its findings.

In public health in England, these issues – shared with colleagues in the NHS – were compounded by a sense of being undervalued and ignored. One respondent said that they 'felt invisible, and undervalued despite working on COVID since day 1, providing crucial part of response especially to outbreaks which has been relentless.' Conversely, they lacked confidence in the skills and knowledge of those in the new organisations (such as Test and Trace) and in the national leadership. The pace of the pandemic was always greater than the pace of response with system mobilisation slow. Respondents expressed frustration at the lack of inclusion of frontline expertise in development of guidance. This meant that guidance was unpredictable, not always rational, unscientific and damaging to relationships.

All this was then further exacerbated by the apparent scapegoating of Public Health England and its staff with one respondent reporting that the 'endless criticism of PHE by politicians and re-organisation of PHE are very damaging to morale'. Respondents generally felt that the re-organisation would weaken the country's response to the current and future pandemics, and few had any confidence in their ability to influence the proposed changes.

Unsurprisingly, in response to all this 27% of public health doctors said that they had a low or very low desire to continue working in public health, more than double the figure the BMA reported in 2017 (12%). Regarding their future intentions 25% said it was more likely they would leave public health for another sector and 44% said they were more likely to want to work fewer hours. These figures were worse for public health registrars with 40% saying that they wanted a career break.

As with medical academics mentioned above, a key concern and principle for the BMA is to maintain pay parity between public health doctors in England working outside the NHS and their clinical colleagues in the NHS. Furthermore, the need to ensure that public health specialists can move round the public health system requires pay parity between the different organisations that employ public health doctors and specialists. This has been eroded, especially in local government, since the reorganisation in 2013.

As the Review Body is no doubt aware, the House of Commons Health and Social Care Select Committee has repeatedly highlighted the barriers to moving round the public health system established by the Health and Social Care Act 2012 as an issue that needs to be tackled. Furthermore, we are unclear how this situation will be improved by creating three new public health organisations out of one. We would, therefore, welcome the Review Body's support for pay parity

and for the recognition of previous service between the NHS and the public health system and across the public health system as being fundamental to the recruitment and retention of doctors to public health.

A particular concern regarding pay has been the lack of remuneration for much of the additional work that public health doctors have undertaken during the course of pandemic. 32% of all eligible respondents to our 2020 survey reported not receiving any pay/time for additional hours worked. This rose to 56% of respondents working in local authorities. In some cases, doctors have been offered time off in lieu, but for many it has not been practically possible to take additional time off. Indeed, 45% of respondents to our survey reported that they had not been able to take of all the time they wanted, and for public health trainees taking such time off risks further delays to their training progression. We, therefore, ask for the Review Body's support for the fair remuneration of public health doctors, especially trainees, for the additional work they have had to undertake as part of the UK's pandemic response.

5. Northern Ireland

5.1 BMA Northern Ireland response to 49th DDRB report

BMA Northern Ireland write their evidence submission to the DDRB following the 2020/21 award where our members received yet another sub-inflationary pay increase. In addition to that, they are, once again, the last doctors in the United Kingdom to receive their pay uplift.

Doctors in Northern Ireland will not receive their pay uplift in the calendar year it was awarded, with the TC8 issued in December 2021 it will be January 2022 at the earliest before doctors receive their uplift, with some indication that it may be paid as late as March 2022.

Last year we welcomed the DDRB's condemnation of the Department of Health Northern Ireland (DOH) for repeatedly delaying the application of the uplift. It is disappointing to once again be in a position in which we are highlighting the same issue.

The impact on the morale of doctors continually experiencing a delay in receiving their pay uplift cannot be overstated. This is true in any year, but particularly this year given the amount of work doctors have undertaken leading the response to the coronavirus pandemic. In a July 2021 survey of consultants in Northern Ireland respondents were asked about the impact of the delay to their pay award this year, 88% reported that this delay had decreased or significantly decreased their morale.⁶²

To put this delay in context, doctors in Northern Ireland are the only employees paid using government funds who have received their pay uplift in a different tax year. No other staff group paid from the public purse has experienced similar delays to their pay uplift. It is an essential part of the moral contract that you receive your annual uplift in a timely manner out of respect and decency.

⁶² BMA 2021 Consultant pay survey - Northern Ireland results

It is essential for the morale of doctors that the 2022/3 uplift is paid in a timely fashion. We have significant concerns that the timing of the 2022 Northern Ireland Assembly election will lead to yet another delay in the application of the pay uplift as civil servants await direction from a minister.

Whilst a timely pay uplift is important. It is essential that any uplift reflects the spiralling cost of living, current inflation rates and addresses the years of sub inflationary pay awards.

We share the thoughts of other devolved nations that it is essential that doctors receive annual pay uplifts which are above inflation both this year and in subsequent years. This will go some way to eradicate years of below inflation pay rises and subsequent pay erosion.

5.2 Key asks

- BMA Northern Ireland is joining the rest of the BMA in calling for a significant pay uplift of RPI + 2% for the entire medical workforce in Northern Ireland this year.
- In addition to the pay erosion information detailed further in this evidence, and as we continually report to the DDRB, this pay erosion is exacerbated for consultants in Northern Ireland who have not received CEA uplifts, nor has a new award round been undertaken since 2010. This significantly impacts upon their pay parity with colleagues in other nations and on the ability of the HSC to recruit and retain consultants.
- Unlike their counterparts in the rest of the United Kingdom doctors in Northern Ireland still have no mitigations to deal with the pensions issues that we have previously raised with the DDRB.

5.3 Issues across the HSC in Northern Ireland

5.3.1 Current state of the health service in Northern Ireland and COVID-19

The coronavirus pandemic undoubtedly continues to impact heavily on the medical workforce in Northern Ireland. Every general practice surgery, trust and hospital site in Northern Ireland continues to work at more than 100% capacity and has done for much of this year. This is against a backdrop of:

- 1) many paused services – which has meant deployment and changed working patterns for many doctors
- 2) waiting lists – which were the worst in the United Kingdom prior to the pandemic, continuing to grow.

These waiting lists present many problems for both doctors and the health and social care system (HSC). Patients waiting longer for treatment will in many cases become sicker, presenting more difficult treatment options for doctors and costing more to the HSC in the long run. More demands will be made from primary care in the interim as patients understandably seek support from their GP. Attendances at accident and emergency, which were already untenably high continue to grow, with the addition of inevitable increased waiting times and missed waiting time targets. In Northern Ireland currently:

- There are 358,346 patients waiting for their first outpatient appointment, an increase of 2.7% on the previous quarter and an increase of 9.5% on the same quarter last year.⁶³
- Of that over 80% (83.8%) are waiting over nine weeks for their first appointment.
- Additionally, over half (52.5%) of patients are waiting over 52 weeks for their first appointment.
- Just 54.2% of patients begin their first cancer treatment within 62 days of their referral. This ministerial target has not been met in any trust in any of the last three years.⁶⁴
- There were 192,037 attendances at accident and emergency in the quarter ending September 2021 – an 8% increase on the same quarter in the previous year.
- Between September 2020 and September 2021, the number of patients waiting over 12 hours in A&E increased from 4,210 to 7,396⁶⁵

These statistics go some way to highlighting the pressure doctors in Northern Ireland are currently working under.

Additionally, the November 2021 survey of BMA members highlighted that many doctors are still working above and beyond their contract, just 14% of respondents had not worked additional hours in the last month. Sixty percent had worked additional hours that were unpaid. This survey also told us that doctors are finding it difficult to take breaks: whilst working in the two weeks prior to the survey 21% of respondents were never able to take the breaks they were entitled to; and a further 30% were only 'rarely' able to take their breaks.

In response to another question in the same survey 14% of respondents were unable to take annual leave due to workload pressures, an additional 7% had had annual leave cancelled.⁶⁶

This survey also outlined how the working day has changed for doctors compared to pre-pandemic with:

- 60% reporting an increase in the overall number of contacts in a day
- 86% stating they are now more tired at the end of the working day
- 70% stating the length of a working day had increased
- 64% responded that the amount of paperwork generated had increased
- 83% responded that the stress of meeting patient expectations has also increased.⁶⁷

The pandemic has undoubtedly intensified the pressure under which doctors are working. However, prior to this the HSC was already facing significant pressure. The 2016 Bengoa Report recognised this and 'Health and Wellbeing 2026; Delivering Together' set out a roadmap for the essential transformation of the HSC. Unlike many of the previous reviews this had support across the political spectrum and progress was being made on its implementation.

⁶³ DOHNI 'Northern Ireland Waiting Time Statistics: Outpatient Waiting Times Quarter Ending September 2021' <https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-ni-wts-outpatient-waiting-times-q2-21-22.pdf>

⁶⁴ DOHNI 'Northern Ireland Waiting Time Statistics: Cancer Waiting Times (April – June 2021)' <https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-ni-wts-cancer-waiting-times-q1-21-22.pdf>

⁶⁵ DOH 2021 'Emergency care waiting times July – September 2021' <https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-emergency-care-waiting-times-july-september-2021>

⁶⁶ BMA viewpoint survey November 2021 – Northern Ireland responses

⁶⁷ BMA viewpoint survey November 2021 – Northern Ireland responses

Unfortunately, the pandemic has paused much of this work. However, it is essential that we do not return to the old failing system of the past. Lessons must be learnt from the delivery of healthcare during the pandemic and applied as we emerge from the pandemic, whenever that may be. The response to the pandemic has shown how decisions can be taken and implemented quickly, a return to the old ways of delayed decision making will not serve either doctors or patients well.

What is clear is doing more of the same is not an option. If current waiting time statistics did not prove this our members spoke clearly in a recent BMA viewpoint survey. When asked “overall, do you think the NHS in your country is heading in the right direction or wrong direction?” 0% of respondents stated they thought the NHS in Northern Ireland was headed in the right direction, 88% felt it was headed in the wrong direction, with the remaining 12% not sure.⁶⁸

5.3.2 Pensions and taxation mitigations

The DDRB noted last year that issues relating to pensions taxation due to the impact of the annual allowance (AA) and lifetime allowance (LTA) will adversely impact on the ability to retain doctors. Therefore, it is disappointing that we are again reiterating that doctors in Northern Ireland continue to be at a significant disadvantage to the counterparts in the rest of the United Kingdom as, unlike in other UK nations, no mitigations for the issues caused by current pension taxation policy have been put in place.

Mitigations utilised elsewhere include the annual allowance compensation scheme adopted in England and Wales for the 19/20 tax year. A recycling employers’ contributions (REC) scheme was temporarily adopted in Scotland, and subsequently promoted to employers in Wales. While these mitigations in our view don’t go far enough to address the scale and scope of the issues faced across the UK, doctors in Northern Ireland have had no relief whatsoever during this period, leaving them at a significant disadvantage.

If immediate action is not taken in Northern Ireland, we believe substantial and long-lasting damage will be done, significantly impacting on retention of the medical workforce, particularly amongst consultants and senior doctors. Already, many consultants and SAS doctors have reached or are close to reaching their lifetime and/or annual allowance. This has made many consider either reducing their hours worked or retiring early. The HSC can ill afford doctors to take either option.

This unfairness exists within a pension scheme already inherently inequitable to many senior doctors. The unnecessarily high target yield (9.8%) within the HSC scheme puts a significant burden on healthcare workers when compared with those in other public sector pension schemes. The tiered contribution rates, which see many senior doctors currently paying contributions of up to 14.5% only adds to this burden.

Heightening concerns about the impact of the pension scheme, particularly on retention of consultants in the workforce is the McCloud judgement. It is a requirement for government to correct the unlawful age discrimination that occurred in 2015 when they introduced the new 2015 HSC pension scheme. Affected members will see their pensionable service between 2015 and 2022 revert to their legacy scheme. For most affected consultants this will see these 7 years of 2015 membership (pension age of 67) revert to 7 years of 1995 scheme membership (pension age of 60).

The net impact is that many can retire earlier without incurring such severe actuarial reduction of their pension and, given the Department of Health HSC Workforce Census (March 2021) states that

⁶⁸ BMA viewpoint survey November 2021 – Northern Ireland responses

38% of consultants in Northern Ireland are aged over 50 years, this will be a powerful lever for those consultants to consider early retirement.

The loss of senior staff will also lead to a significant training and mentoring gap, impacting not least on the education of medical students and junior doctors at the start of their medical careers, making replacing the consultant workforce even more challenging.

The Northern Ireland Executive must seriously consider the available options that could address and avoid a further workforce crisis. Alongside addressing the unfairness within the HSC pension scheme itself, we believe the immediate introduction of a recycling of employer contributions scheme to address punitive pension taxation is one such option. This mitigation has been deployed successfully in other areas of the United Kingdom.

Pension issues are also affected by the continued delay in pay uplifts, which we have highlighted previously. In 2020/21 doctors received two pay uplifts in one year leading to issues with annual allowances, through no fault of the doctors affected.

These issues are exacerbated further by delays in uplifts, which we have previously raised. We note that the 49th DDRB report called these delays ‘unacceptable’, adding:

“We expect pay awards to be made in a timely fashion following the submission of our reports, and we have noted previously that this has not been happening in Northern Ireland for some time, and again this unfortunately remains the case. These delays undermine the credibility of the pay determination process amongst the remit group and are likely to have a negative impact on morale.”

We welcome this recognition and agree that continual delays are having a hugely detrimental impact. This is perhaps best evidenced by the fact that in the 2020/21 tax year, a delay meant that the agreed 2019/20 uplift was paid in the same year as the 2020/21 uplift. Having two uplifts in one year caused many consultants and other senior doctors to receive large tax charges, which could have been avoided but for the unnecessary delay in implementing the uplift in the correct year. This issue could be remedied by the Department for Health by allocating the uplift to the tax year for which it was intended but action to address this has not been forthcoming.

The impact of this on morale cannot be understated. But more than this, many doctors are consequently forced to work less or give up management roles to ensure they aren’t levied with further charges. This has a far wider impact on the health service and could easily be avoided with timely pay uplifts that truly recognise and reward the work of consultants in Northern Ireland.

5.3.3 Pay erosion

Since the financial crisis in 2008, doctors have experienced repeated pay freezes, pay caps and sub inflation pay uplifts, all at a time when inflation has run much higher. According to the ONS (as of December 2021), the year-on-year rate of CPI (consumer prices index) inflation is currently 5.4 per cent, whereas RPI (retail prices index), which we believe better reflects the costs facing doctors, currently sits at 7.5 per cent.

We wish to emphasise to the DDRB that doctors in Northern Ireland, and across the UK, have faced an unprecedented decline in their real terms pay. The representative examples below, covering the period between 2008/9 and 2021/22, highlight the significant extent of the real decline in pay for doctors.

	Pay in 2008/9 (cash terms)	Pay in 2021/2022 if kept pace with inflation (real terms)	Actual pay in 2021/2022 (cash terms)	Pay shortfall in 2021/22 due to pay failing to keep up with inflation	Real pay erosion
Consultant (pay point 6)	£88,049	£123,886 (using RPI)	£101,933	£21,953	17.7%
Specialty registrar on pay point 2	£30,749	£43,264 (using RPI)	£35,955	£7,309	16.9%
FY2 doctor on minimum point	£27,116	£38,152 (using RPI)	£31,706	£6,446	16.9%

Figure 1 Pay decline of doctors in Northern Ireland across branches of practice – period 2008/9 and 2020/21.

5.3.4 Morale/wellbeing/burnout

Anecdotally our members tell us they cannot remember a time in which levels of burnout are so high and morale so low. Given the pressures of the pandemic, the impact of working as part of a system facing such difficulties, the prospect of facing an incredibly difficult winter and continually having pay uplifts significantly delayed, these feelings are hardly unexpected. BMA Northern Ireland recently surveyed members on the need for the introduction of a wellbeing service for doctors in Northern Ireland, 97.5% of respondents stated that such a service was needed.⁶⁹

The recent BMA viewpoint survey found that 41% of respondents were “currently suffering from any of depression, anxiety, stress, burnout, emotional distress or other mental health condition relating to or made worse by your work or study” that was worse in the last month. An additional 30% were suffering from the same list but at a level that was no worse in the last month.⁷⁰

The morale of doctors in Northern Ireland is also impacted by the continued potential introduction of criminal sanctions linked to a separate individual duty of candour as recommended by the DOH on the back of the IHRD programme. We believe should an individual duty of candour with criminal sanctions be legislated for in Northern Ireland we will face significant challenges recruiting doctors to work here and retaining many of those who currently do.

A BMA survey on the duty of candour from May 2021 showed that doctors are extremely concerned about the potential impact of the introduction. Almost 9% of respondents stated they would leave the HSC if criminal sanctions were introduced, an additional 33% stated they would retire early and a further 14% would reduce the number of hours they work – these numbers are incredibly concerning for a system already under pressure and under doctored.⁷¹

⁶⁹ BMA NI 2021 Wellbeing support for NI doctors

⁷⁰ BMA Viewpoint survey November 2021 – Northern Ireland results

⁷¹ BMA NI survey June 2021 - ‘Survey on the introduction of an individual duty of candour with criminal sanctions’

Concerningly, when we asked medical students about the impact of an individual duty of candour with criminal sanction on their future career plans 75% stated they would be worried about their future medical career and would make them reluctant to go into certain specialties.⁷²

5.3.5 The silent withdrawal - candour

BMA Northern Ireland is deeply concerned that the working conditions of doctors, exasperated by the pandemic, but by no means the sole cause, are so distorted that we will witness the silent withdrawal of senior clinicians. These are the mentors, the experts who not only train the next generation, but are often at the forefront of change and innovation. The level of individual clinical risk due to the unsustainable structures, limited resource allocation and the lack of professional support is now so extreme that it undermines these professional values.

Fundamental professional values of treating people and treating on the basis of need have been replaced by 'battlefield triage.' What is clear is that working at the pace required to maintain care standards is becoming impossible and unsustainable:

*"Eighteen unbroken months of responding to a pandemic have taken a brutal toll. Experiences of inadequate personal protective equipment (PPE), moral distress, challenging ethical decisions, colleagues debilitated and dying, all while striving to provide the best patient care, have left many disillusioned and wounded."*⁷³

5.3.6 Workforce planning

We are pleased that the DOH are now preparing safe staffing legislation that should enable a bill to be introduced to the Assembly early in the next mandate. The inclusive and deliberately considered way this has been progressed thus far is particularly welcome. For BMA it is essential that this legislation includes clear lines of accountability for workforce planning, with regular reporting to see needs, progress and outcomes. This is clearly does not currently happen within the Department or HSC.

Time and again BMA Northern Ireland have actively contributed to workforce reviews, unfortunately on each occasion the recommendations have not been fully implemented. Recommendation 16 of 'Health and Wellbeing 2026: Delivering Together' committed to producing a workforce strategy by spring 2017. BMA were involved in the development of this broad-based, high-level strategy. We welcomed the publication of the workforce strategy, which was to be accompanied by three consecutive action plans which would allow for 'flexibility in the delivery of the strategy.'⁷⁴ The first action plan covered the period 2018-2020, the development of the second action plan has been delayed by the pandemic.

Whilst we understand the pressures the pandemic has placed on the department, we would argue that given its impact on medical staff a responsive, up to date and retention focused workforce plan/strategy is now more important than ever.

The Department must urgently prioritise medical workforce planning, taking into consideration:

⁷² BMA NI survey June 2021 - 'Survey on the introduction of an individual duty of candour with criminal sanctions'

⁷³ <https://blogs.bmj.com/bmj/2021/09/21/the-great-resignation-how-do-we-support-and-retain-staff-already-stretched-to-their-limit/>

⁷⁴ AQO 2764/17-22

- Recruitment and retention – we will provide more detail on this throughout this submission
- Workload – the current working day for doctors is unsustainable and this will inevitably impact on recruitment and retention. Survey responses on a doctors working day compared to pre-pandemic have been included above.
- Data and definitions - effective medical workforce planning can only be achieved if it is underpinned by evidence and robust statistics. Adequate data on the medical workforce, including workforce numbers and vacancy rates is needed for both effective delivery of care and sustainable workforce planning.
- Medical school/training numbers – we have welcomed the increase in GP training numbers, and the opening of the graduate entry medical school at Ulster University. The Department must urgently consider if these are enough medical student places for the needs of the future, given the time it takes to train a doctor. The impact of an increase in medical student places on training places also needs to be urgently considered. There is little point educating enough future doctors in Northern Ireland if we do not have enough training places for them after medical school.
- Locum costs – a consequence of an inability to recruit and retain staff is over-reliance on the use of locum and agency staff. The use of such staff is associated with high costs, and in some instances, a lack of stability in a particular work area. An over-reliance on locums is a very clear consequence of the failures of workforce planning and implementation to date.

5.4 Primary care

Similarly, to their primary care colleagues across the UK, GPs in Northern Ireland are working under extreme pressure. They are faced with maintaining regular services, assisting those patients on long waiting lists, staffing COVID centres and playing a significant part in the vaccine/booster roll out. All whilst impacted by a reduction in the capacity of practices due to social distancing requirements and the need for GPs and staff to isolate following positive COVID tests and contacts.

Whilst the pausing of the GP contract has been welcome, this only removes some of the work from general practice. We know from HSCB data that the numbers of patient contacts with their practice continues to increase. In the week ending 10th December GPs in Northern Ireland undertook over 202,000 consultations either face to face, or via telephone/video.⁷⁵

As of 17th December, GPs in Northern Ireland have administered over 1.25million vaccines as part of the vaccine rollout.⁷⁶ This activity takes place against a backdrop of difficult national media coverage which regularly paints general practice as closed and unresponsive.

As of June 2021, there are currently 1,932 GPs on the performers list in Northern Ireland. This consists of:

- 523 Locum (Sessional) doctors.
- 26 Retainer doctors.
- 1169 GP Principals (partners).

⁷⁵ HSCB data

⁷⁶ HSC data

- 214 Salaried GPs.⁷⁷

This is an increase in the total number of GPs in Northern Ireland since 2014. However, the number of whole-time equivalent GPs has fallen 8% in the same period.⁷⁸ To counteract this fall and the number of GPs expected to retire in the coming years, it essential steps are taken to protect the existing GP workforce. We have welcomed the increase in GP training places but would like to see these increase further.

Additionally, whilst we welcome the commitment from the Department to the continued roll out of multi-disciplinary teams it is essential each general practice in Northern Ireland has access to an MDT as soon as possible.

Once again, we are raising the issue of indemnity. As we stated last year, general practitioners in Northern Ireland are the only doctors in the UK who are responsible for their own indemnity costs. These costs have been of particular concern as the Damages (Return on Investment) Bill passed through the Assembly and the introduction of a temporary discount rate until the Bill is enacted, it is expected to receive Royal Assent shortly. The temporary discount rate saw medical defence organisations alter the method they use to calculate the cost of indemnity insurance. This change stopped the dramatic rises in indemnity costs we initially feared; however, the Bill will still reduce the discount rate in Northern Ireland. As a result, indemnity fees are likely to rise in the future, further adding to the cost of being a GP. We would like the DDRB to take this into account and support our calls for a reimbursement scheme for GP indemnity.

Of additional concern, particularly given the need to roll out booster vaccines in the face of the omicron variant, is that these indemnity costs may well be a block for those who wish to increase the number of sessions worked to facilitate the rollout of the COVID-19 vaccination programme. An increase in sessions will lead to an increase in indemnity costs. They are also a block to recruitment of GPs to Northern Ireland and a reason junior doctors may not opt to enter general practice or will chose to work elsewhere.

General practitioners in Northern Ireland are impacted by the lack of pensions mitigations in the same way as their secondary care colleagues which we have outlined in greater detail above.

As employers GPs also face additional costs due to the national insurance rise. If GP contract income is not increased to cover these costs practices face large bills – in addition to higher contributions for individual practice staff, salaried GPs and partners.

5.5 Secondary care

The pressure faced by secondary care doctors in Northern Ireland cannot be understated. We have clearly set out the situation with COVID, workload, morale and waiting lists in the HSC in Northern Ireland.

To put this in context, as of 16th December the Northern Ireland COVID-19 dashboard states that hospital capacity is Northern Ireland is currently 106%, this is the equivalent of being 192 beds over

⁷⁷ HSCB 'Facts and figures on General Practitioners (GPs) and Practices' <http://www.hscboard.hscni.net/our-work/integrated-care/gps/gps-current-facts-and-figures/>

⁷⁸ AQO 2611/17-22

capacity.⁷⁹ ICUs across NI currently have two available beds. This is before the omicron wave hits Northern Ireland in the way it has in England.

It is fair to say that secondary care doctors in Northern Ireland have prepared themselves for the worst winter many will have faced. They additionally prepared for a period of significant upheaval over the holiday period. Indeed, for the first time some HSC trusts wrote to doctors asking them to work additional hours during the Christmas holiday period to help alleviate the expected increases and pressures over this period.

In some trusts junior doctors locally agreed to give up their 27th December holiday and receive a day in lieu later in the year in recognition of the pressures the system is currently facing. This demonstrates the commitment our members are giving to ensuring that the health service continues to operate, and patients are treated. A mutual recognition of this commitment by the DDRB would be a pay uplift that is above the current rate of inflation.

5.5.1 Consultants

As of March 2021, there are 1,885 WTE consultants in Northern Ireland, a 16% increase in the five years since March 2016.⁸⁰ Whilst this increase in WTE numbers is welcome, the age profile of the consultant workforce in Northern Ireland is concerning. Over 35% of the consultant workforce is over 50. We are aware from our membership that the lack of pensions mitigations, as discussed previously, will impact on these doctors with many seeing retirement as the only way to avoid large tax bills.

We are once again raising with the DDRB that consultants in Northern Ireland are at a significant detriment to their colleagues across the UK due to the refusal of the DOH to uplift existing clinical excellence awards (CEAs) or run an award round since 2010.

In 2009/10, approximately 50% of the consultant workforce here held either local or national CEAs, on which employers spent nearly £14 million. BMA Northern Ireland has collected data from all HSC trusts to estimate the number of CEA award-holders remaining in 2019/20. This suggests that just 16% of the consultant workforce currently hold an award. This means that many consultants are not being recognised or rewarded for demonstrating excellence in their field of medicine and ultimately benefitting patient care.⁸¹ Consultants in Northern Ireland have now missed out collectively on nearly £24 million in gross CEA pay in 2019/20.⁸²

We continue to be concerned by the high level of vacancies within the consultant workforce in Northern Ireland. These vacancies contribute to the pressure on the system and on those working within it who are forced to work above and beyond capacity to plug gaps.

Additionally, we continue to be concerned by the method used by the Department and trusts measure vacancies. The Department only measure vacancies that are actively being recruited to, therefore if it has not been possible to fill a post, that post is no longer counted as vacant, nor is a recently vacated post where recruitment has yet to begin. We believe that this results in a significant undercounting of the vacancies in the HSC.

⁷⁹ NI COVID-19 dashboard <https://www.health-ni.gov.uk/articles/covid-19-daily-dashboard-updates>

⁸⁰ DOH 'Northern Ireland Health and Social Care Workforce Census March 2016' <https://www.health-ni.gov.uk/sites/default/files/publications/health/hscwc-march-2016.pdf>

⁸¹ BMA NI 2021 'FAQs about consultant pay in Northern Ireland'

⁸² NI Assembly question on CEA spending, includes employer costs – <http://aims.niassembly.gov.uk/questions/printquestionsummary.aspx?docid=248705>

Departmental data points to a vacancy rate of around 6.7%, given what we have stated previously we expect this rate to be much higher in reality.⁸³ Data collected through freedom of information requests in 2021 sought to uncover a clearer picture of consultant vacancies and the true number of vacancies by capturing consultant posts not currently included in the existing DoH definition. These FOIs found that 14.9% of consultant posts across HSC trusts in Northern Ireland were not filled by a permanent consultant.⁸⁴

BMA surveyed consultant members in July 2021 on their pay. When asked about the 3% uplift for 2021/22 82% of respondents replied feeling that the recommendation is inadequate or completely unacceptable. Additionally, 91% of consultants felt that the recommendation valued their work either a little or not all. When asked about an award for 2022/23 about 72% of consultants in NI stated they felt they should be offered an award of 5% or above.⁸⁵

5.5.2 Staff, Associate Specialist, Specialty, and Specialist (SAS) doctors

Similarly, to consultants the last five years has seen an increase in the number of SAS doctors employed in the HSC, from 430 WTE in March 2016⁸⁶ to 541 WTE in March 2021. However, currently over 20% of the SAS workforce are aged over 50. This year many of our SAS members are reporting receiving communication from their employers regarding their pension, with many reconsidering the number of hours they work because of taxation.

As we have already stated doctors in Northern Ireland are significantly impacted by not having any of the pension mitigations that are afforded to their colleagues in the rest of the UK. Similarly, to the concerns we have raised relating to consultants, we are worried that unless mitigations are introduced immediately in Northern Ireland some SAS doctors will face no option but to retire early or reduce the number of PAs that they work.

As already noted, the HSC system in Northern Ireland is struggling to cope with demand with the number of doctors they currently have. The DOH must take all steps they can to allow for the retention of the existing workforce, introducing pensions mitigations will be a key part of this.

We have already highlighted the difficulties with vacancy data in Northern Ireland and how the collection method undercounts the true level. The current official SAS vacancy rate stands at 8.1%, we expect the true figure to be much higher.⁸⁷

The DDRB will be aware SAS doctors in Northern Ireland have been engaged in negotiations on a new contract alongside colleagues in England and Wales. These were put to the membership and were overwhelmingly backed in the referendum in 2021, prior to the DDRB uplift announcement. We are very pleased to see the first advertisement placed for a specialist doctor post in Northern Ireland. Having clear career development and progression for specialty doctors will be helpful for SAS recruitment and retention.

⁸³ DOHNI 'HSC staff vacancies' <https://www.health-ni.gov.uk/articles/staff-vacancies>

⁸⁴ BMA 'Consultant vacancies in Northern Ireland: an analysis' <https://www.bma.org.uk/media/4821/bma-ni-connsultants-shortages-and-vacancies-nov21.pdf>

⁸⁵ BMA 2021 Consultant pay survey – Northern Ireland results.

⁸⁶ DOH 'Northern Ireland Health and Social Care Workforce Census March 2016' <https://www.health-ni.gov.uk/sites/default/files/publications/health/hscwc-march-2016.pdf>

⁸⁷ DOH 'NI HSC workforce vacancies September 2021' <https://www.health-ni.gov.uk/publications/northern-ireland-health-and-social-care-hsc-workforce-vacancies-september-2021>

The 3% recommended uplift for 2021/22 has adversely impacted on uptake of the new contract in Northern Ireland. This is particularly because the DOH refused to consider any mitigations such as committing to not recoup overpayments or no detriment to those transferring, unlike in Wales where concessions such as these were granted.

When deciding whether they would move to the new contract SAS doctors in Northern Ireland had an additional difficult consideration as the DOH have been unable to commit to funding of the contract in year two and year three. This uncertainty has undoubtedly contributed to the low numbers of SAS doctors transferring to the new contract.

We firmly believe that any uplift recommended by the DDRB that is higher than that offered in the multi-year pay deal in the SAS contract must also be applied to the 2021 Specialty and Specialist contracts. Additionally, given the small numbers transferring in Northern Ireland it is essential the DDRB recommends an uplift for those SAS doctors who have not transferred to the 2021 contracts.

Implementation of the new contract in Northern Ireland has been particularly difficult, in no small part due to the refusal of the DOH to consider ways in which the impact of the 3% uplift could be mitigated to ensure the 2021 contracts remained an attractive option. This is obviously disappointing but perhaps unsurprising. The first meeting of the contract implementation group will finally take place in January 2021 where we hope to hear updates on a range of issues relating to the implementation of the contract, not least the fact that HR and payroll systems will not be updated to reflect the terms of the new contract until February 2021 at the earliest.

SAS doctors in Northern Ireland are awaiting progress from DOH on several key issues, such as;

- the appointment of an Associate Dean; the DOH first received funding for this role in 2018. The Associate Dean would develop and deliver quality management and enhancement for CPD for SAS doctors on a regional level.
- The completion of the review of the SAS charter; the charter review began in 2017 to monitor how the SAS charter had been implemented within HSC trusts. The SAS charter sets out both the rights and responsibilities of SAS doctors and their employers with a commitment to support and enable SAS doctors to realise their full potential to deliver the patient care and contribute fully to health services more widely.

5.5.3 Junior doctors

Doctors in training in Northern Ireland also, obviously, continue to be impacted by the pandemic. The impact on their education and training has been severe.

Increased admissions to hospitals as Northern Ireland moved out of two phases of lockdown have had a dramatic effect on training. This meant many doctors found it difficult or impossible to attend "mandatory" regional teaching. Those who were able to attend were remaining on HSC sites as sessions are currently being run virtually. This meant doctors experienced constant interruptions during the session due to the demands from wards. We have received specific complaints from F1s who report being unable to leave wards to attend mandatory core teaching due to the workload pressures they are facing.

There has been additional pressure on junior doctors to work additional locum shifts just to keep services running. Obviously, this means they have reduced time for research, management experience and for completing the necessary preparations for interviews.

Trainees in Northern Ireland are also reporting difficulties in attending courses that are required for certain specialty training posts as many are unavailable in Northern Ireland. Difficulties with travel and approval have meant many trainees are simply unable to attend and therefore cannot progress their training. NIMDTA must consider this issue urgently so we do not face a shortage of trainees in many specialties in years to come. In the rare instance that a trainee is able to attend a training course in Great Britain they also face additional travel costs and time pressures compared to their counterparts training in the rest of the United Kingdom.

For a third year, we are again highlighting the continuing issue with dental trainee pay scales in Northern Ireland. Despite continued lobbying and engagement with the DOH there continues to be no progress on this issue. This means dental trainees in Northern Ireland continue to be significantly underpaid compared to their counterparts in the rest of the United Kingdom. We believe this presents a serious issue for recruitment and retention to a key part of the HSC.

The DDRB will be aware that junior doctors in Northern Ireland continue to work under the terms of the 2002 junior doctor contract which has been replaced in England. Social partnership discussions are currently taking place in Wales with a view to the introduction of a new contract. We believe it is time for the DOH to consider opening discussions on a new junior doctor contract in Northern Ireland.

5.5.4 Academics

There have been significant delays to the public acceptance of DDRB recommendations by the Minister of Health in Northern Ireland and to the actual award of the recommended uplift. This also has an impact on clinical academic staff in Northern Ireland as their pay rates cannot be agreed until the Northern Ireland Government publishes the pay schedule for NHS doctors and dentists. We agree with our clinical colleagues that DDRB must insist that the NI Department of Health implement pay uplifts in a timelier fashion.

5.6 Concluding remarks

It is disappointing to again raise so many issues that we have already highlighted to the DDRB. It is even more disappointing to be in a situation where we are writing our submission to the DDRB when our members are still awaiting their 2021 pay uplift. We believe, however, that this highlights the difficulties of working with the DOH.

Key decisions, whether relating to pay uplifts, service transformation, contract reform or workforce planning take too long to be made. Leaving doctors in increasingly more difficult positions with levels of morale incredibly low. While these delays may be explained away in 2021 because of an overwhelmed civil service dealing with a pandemic, we know this has been the case prior to coronavirus.

To recognise the low levels of morale, and commitment to the HSC, despite the issues we have outlined, we believe it is essential the DDRB recommend an above inflationary pay rise, and couple this with a call to DOH for the uplift to be implemented in a timely fashion.

Clearly more work is needed to improve workloads and conditions, we firmly believe that appropriate remuneration via a significant pay uplift will help ensure that doctors feel valued for the essential work they do.

6. Scotland

6.1 BMA Scotland Response to 49th DDRB Report

BMA Scotland's evidence to the DDRB for last year's pay round called for a significant pay uplift along with the need to address long term pay decline. The DDRB report, published in July, recommended a 3% uplift, which the Scottish Government accepted in full. This pay uplift occurred as RPI inflation then went above 3%, and has increased to now currently sit at 7.5% - yet again doctors face seeing their pay fall in real terms. As we have continued to emphasise, and in our evidence to the DDRB last year, it is crucial that there is repeated year on year uplifts in pay which are significantly above inflation, if doctors' pay is to be restored to a reasonable level.

Dissatisfaction with pay

Following the disappointing 3% uplift announcement, BMA Scotland undertook a cross branch of practice survey of BMA members' views on their response to the pay uplift.⁸⁸ The survey provides evidence that the view of the profession in Scotland is that the pay award demonstrated that doctors do not feel valued. Of 1,429 responses, 59.64% said that the pay uplift of 3% was unacceptable and disappointing – that it should have been higher. Furthermore, in the context of the 3% uplift, 65% said that they were dissatisfied or very dissatisfied (31%) when asked if the Scottish Government values doctors and recognises their contribution to the NHS. Of concern are reports of the impact of the pay award on doctors' future plans for working in the NHS in Scotland. From the same survey, just under a third said that the pay award made them actively consider or had reinforced their plans for reducing their NHS clinical commitments. Just under a third said that the pay award had made them decide to consider or had confirmed already considered plans to go ahead with leaving Scotland to work elsewhere.

6.2 Key asks

BMA Scotland is calling for a significant pay uplift for 2022/23 for all doctors across Scotland, which not only addresses the severe risk to real terms pay posed by high inflation, but also begins to address the real terms pay cuts since 2008.

We are seeking an uplift that both prevents a further immediate real terms pay cut by matching RPI inflation (at April 2022) and provides a further 2% uplift to help make some progress in addressing long term pay erosion.

A significantly above inflation uplift is required not just for 2022/23 but will also need to be followed by further successive years of above inflation uplifts in pay to fully address past real terms pay erosion and to prevent further decline in pay in future years.

Previously the BMA has provided evidence of the real terms pay erosion doctors have experienced since 2008. For consultants this has been exacerbated by the erosion of the value of discretionary points and the loss of 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

⁸⁸ <https://bmascotland.home.blog/2021/09/16/chairs-update-arm-pay-and-supporting-doctors/>

followed by a cap on pay awards. During this period, inflation measures have consistently been significantly higher.

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. The impact of this real terms pay erosion and additional employee pension contributions is significant and needs to be addressed as a matter of urgency. We are aware of the Scottish Government's Public sector pay policy (PSPP) for 2022-23 recently published and expect that this will be referenced, as usual, in the Scottish Government's evidence to the DDRB. We urge the DDRB to give no credence to such an unrealistic and unsustainable approach to pay that would, if taken literally, deliver a basic pay uplift to doctors of as little as 0.44% at a time when the Bank of England is predicting CPI inflation to be at 6% by April 2022. Such a substantial real terms pay cut for doctors, following on from over a decade of real terms pay cuts would be a disaster for what is already a retention crisis in NHS Scotland, and would be the largest real term pay cut in the history of the DDRB.

6.3 Pay erosion

Since the financial crisis in 2008, doctors have experienced repeated pay freezes, pay caps and sub inflation pay uplifts, all at a time when inflation has run much higher. According to the ONS⁸⁹ (as of December 2021), the year-on-year rate of CPI (consumer prices index) inflation is currently 5.4%, whereas RPI (retail prices index), which we believe better reflects the costs facing doctors, currently sits at 7.5%.

We wish to emphasise to the DDRB that doctors in Scotland across all branches of practice have faced an unprecedented decline in their real terms pay, which we have detailed below (Figure 1). The representative examples below, covering the period between 2008/9 and 2021/22, highlight the significant extent of the real decline in pay for doctors.

	Pay in 2008/9 (cash terms)	Pay in 2021/2022 if kept pace with inflation (real terms)	Actual pay in 2021/2022 (cash terms)	Pay shortfall in 2021/22 due to pay failing to keep up with inflation	Real pay erosion
Consultant (pay point 6) and holding 3 discretionary points	£97,517 ⁹⁰	£137,207 (using RPI)	£113,291 ⁹¹	£23,916	-17.4%
Specialty registrar on pay point 2 with a typical banding supplement of 40% (1B)	£46,517 ⁹²	£65,450 (using RPI)	£56,028 ⁹³	£9,422	-14.4%
Specialty doctor with 10 years seniority (pay point 7)	£57,535 ⁹⁴	£80,952 (using RPI)	£69,299 ⁹⁵	£11,653	-14.4%

Figure 1 Pay decline of doctors in Scotland across all branches of practice – period 2008/9 and 2020/21.

⁸⁹ <https://www.ons.gov.uk/economy/inflationandpriceindices#timeseries>

⁹⁰ [https://www.scot.nhs.uk/sehd/pcs/PCS2008\(DD\)03.pdf](https://www.scot.nhs.uk/sehd/pcs/PCS2008(DD)03.pdf)

⁹¹ [https://www.sehd.scot.nhs.uk/pcs/PCS2021\(DD\)02.pdf](https://www.sehd.scot.nhs.uk/pcs/PCS2021(DD)02.pdf)

⁹² [https://www.scot.nhs.uk/sehd/pcs/PCS2008\(DD\)02.pdf](https://www.scot.nhs.uk/sehd/pcs/PCS2008(DD)02.pdf)

⁹³ [https://www.sehd.scot.nhs.uk/pcs/PCS2021\(DD\)02addendum.pdf](https://www.sehd.scot.nhs.uk/pcs/PCS2021(DD)02addendum.pdf)

⁹⁴ [https://www.scot.nhs.uk/sehd/pcs/PCS2008\(DD\)07.pdf](https://www.scot.nhs.uk/sehd/pcs/PCS2008(DD)07.pdf)

⁹⁵ [https://www.sehd.scot.nhs.uk/pcs/PCS2020\(DD\)02.pdf](https://www.sehd.scot.nhs.uk/pcs/PCS2020(DD)02.pdf)

6.4 Contract updates and recent developments

6.4.1 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. Work continues to put in place the multidisciplinary teams committed to in the 2018 GMS contract, despite the intended deadline for many of these services transferring to health board responsibility having passed in April 2021.

In late 2020, the BMA and Scottish Government agreed to put in place transitional arrangements from April 2022, to provide support to practices still required to deliver services that should no longer be their responsibility and ensure no gap in service provision to patients. It has been agreed that practices will receive £15m in December 2021 and a further £15m in April 2022 combining payments for these transitional arrangements and sustainability support to assist practices amid ongoing pandemic pressures. These will be distributed via the Scottish Workload Formula and Income and Expenses Guarantee. Work on analysing income and expenses data collected in late 2019 which has to date been delayed by the pandemic has now commenced. This is a critical precursor to substantive discussions on 'phase 2' of the 2018 GMS contract, which aims to reform GP earnings and expenses to move to a system of direct reimbursement of expenses and guaranteed income for GPs at a level that is similar to consultant earnings.

6.4.2 Scottish SAS contract discussions

Heads of terms for negotiations on a new SAS contract in Scotland were agreed in early 2020 but in March 2020 the Scottish Government paused all "non-essential" work to focus on the pandemic response. It was not until March 2021 that discussions with Scottish Government resumed and officials approached the Cabinet Secretary for Health & Social Care for a formal mandate to allow them to enter contract negotiations. However, the timing of the Scottish Parliament elections in May meant this was not progressed until a new Cabinet Secretary was appointed. Once the mandate was given to Scottish Government and Management Steering Group (MSG), negotiating meetings commenced in August 2021.

The delays have meant that in Scotland we are over a year behind in introducing a new contract for SAS doctors compared to the rest of the UK, and so continue to await the additional investment in the SAS grade that the DDRB considered was necessary in chapter 6 (paragraph 6.27) of its 47th report in 2019.⁹⁶

Although all parties agreed to a shared ambition to conclude negotiations by December 2021 this will not be achieved, and additional meetings have been scheduled until Spring 2022. Additional pressures due to the Omicron variant in December 2021 have impacted further on the schedule of negotiating meetings, with both meetings in January 2022 cancelled. The original intention was to have an implementation date of April 2021 and if necessary, backdate to this date. However, given that the negotiations will be continuing well into 2022, the implementation date and any backdating will form a part of the negotiations. The effect of this, and if experience in the rest of the UK is

⁹⁶ <https://www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-47th-report-2019>

anything to go by, could mean that there will be few, if any, SAS doctors who transfer to a new contract during 2022.

The negotiating meetings so far have been productive and conducted in a constructive manner. However, we remain concerned that in a final deal there might be insufficient incentive for current Specialty Doctors to move to the new contract. The majority of the current cohort of Specialty Doctors in Scotland are already at or near the top of the pay scale and until negotiations conclude it remains unclear whether there would be enough in the proposed deal to encourage them to move to the new 2021/22 contract.

Experience in the first year of the new contract in the rest of the UK shows that employers have so far been very slow to create the new Specialist posts. From a BMA perspective, the primary purpose of the establishment of the Specialist grade was to serve as a destination grade for skilled and experienced Specialty Doctors. There is now considerable disappointment from Specialty Doctors in the rest of the UK that those working at the top of the grade, and who are able to demonstrate they are working at a Specialist level, have been unable to access Specialist posts as there is no option for personal regrading and very few Specialist posts have so far been advertised for recruitment. SAS doctors in Scotland are very aware of this and whilst the ambition of all parties in the negotiations is to make the SAS grades an attractive option with good career prospects, any perception of very limited opportunities for further progression from Specialty Doctor to Specialist would make it a much less attractive proposition.

6.5 Impact of COVID-19

There is no doubt that the Covid 19 pandemic continues to have a major impact on the medical workforce and the services they deliver. Many of the changes made during the first wave in 2020 to hospital services, pausing non-urgent elective procedures and screening and prioritising essential services, either continued or resumed during the subsequent waves in 2021. The changes meant that many hospital doctors were redeployed to different areas of activity or had significant changes to their daily work activity.

General Practice was put under strong pressure to see an increasing proportion of patients in-person in the latter half of 2021, despite the ongoing challenges posed by infection control requirements and unprecedented levels of demand as patients who might otherwise have been treated in secondary care need to be maintained in the community. Meanwhile, in many parts of Scotland, the Covid community pathway has been scaled back or stood down entirely in response to staffing challenges, increasing demands on General Practice to safely manage patients with Covid or suspected Covid which did not exist to the same extent in the first phase of the pandemic. While reliable information on activity in general practice in Scotland to allow comparison is limited, a snapshot survey by BMA Scotland in October 2021 estimated that in the week of 4th October there were 514,930 consultations across practices in Scotland based on the responses of the 40% of practices who took part in the survey.

In response to pandemic related workforce pressures, in January 2021 and September 2021, health boards were again authorised to offer less than full-time HCSW positions to medical students, reflecting the severe lack of capacity across the NHS in Scotland.

Whilst there is no doubting there are now far fewer hospitalisations than before due to the

vaccination programme, the number of cases in Scotland has remained relatively high although stable (between 2,000 and 3,000 cases per day in November 2021).⁹⁷ However, from the end of November there was a marked increase in cases due to the effects of the new Omicron variant with a peak of 20,160 on 28 December 2021. Positive PCR tests fell during the first half of January but due to a change in requirements for a PCR test following a positive LFD test, new combined figures are reported; the trend is a fall in cases overall. As in previous waves, there was a corresponding rise in hospital admissions, ICU admissions or deaths following the trend for an increase in positive cases. Additional pressure also came from staff having to self-isolate due to their own illness or that of a family member or other close contact.

Recent BMA survey (January 2022) shows the ongoing impact of pandemic, and current wave of the Omicron variant on the health service, workforce pressures and delivery of patient care.^{98 99} The ongoing worsening impact on doctor wellbeing and morale is also evident. The BMA survey, which had nearly 700 responses, showed that 22% of doctors who responded had to self-isolate and remove themselves from work due to COVID within two weeks of the survey – that is nearly a quarter of those responding had to do that emphasises the scale of the impact. 1 in 4 docs reported they had clinical colleagues in their department/team/practice on sick leave or self-isolating within the last two weeks – and that it has had a significant impact on patient care and doctor health and wellbeing. Furthermore, 32% of doctors said delays to elective or non-urgent medical care, investigations, procedures and treatments have increased significantly since the emergence of Omicron, with 82% of docs say they are very or extremely concerned that Omicron may negatively impact staffing levels in their place of work. The impact on wellbeing and moral of doctors is evident and this is detailed further in this submission.

Prior to the pandemic Scotland's NHS carried out approximately 270,000 inpatient/day cases per year, and approximately 1.4 million outpatient appointments. The impact of addressing the pandemic resulted in the suspension or reduction of many health and care services across the entire NHS system. There were under one million (933,434) outpatient attendances between 1 April to 30 June 2021. Of these, 31% (290,267 attendances) were new cases. The remaining 69% (643,167 attendances) were patients returning for follow up appointments.¹⁰⁰ The next quarterly data are due to be published in February 2022.

The latest report from Public Health Scotland (November 2021) shows the NHS in Scotland unable to meet increasing demand. At 30 September 2021, 425,242 patients were waiting to be seen. This represents an increase of 7.4% (+29,150) from 30 June 2021 and is 33% (+106,148) higher than the same date in 2020.¹⁰¹

Figure 2 shows that at 31 March 2021 there were 105,630 people waiting for one of the eight key

⁹⁷ <https://www.gov.scot/publications/coronavirus-covid-19-daily-data-for-scotland/>

⁹⁸ <https://www.bma.org.uk/bma-media-centre/nhs-in-perilous-state-as-omicron-hits-workforce-and-delays-care-for-millions-of-patients-bma-survey-finds>

⁹⁹ <https://bmascotland.home.blog/2022/01/14/the-impact-of-omicron-on-doctors-ppe-testing-and-mental-exhaustion/>

¹⁰⁰ <https://publichealthscotland.scot/publications/acute-hospital-activity-and-nhs-beds-information-quarterly/acute-hospital-activity-and-nhs-beds-information-quarterly-quarter-ending-30-june-2021/data-summary/>

¹⁰¹ <https://publichealthscotland.scot/media/10560/2021-11-31-wt-ipdcop-report.pdf>

diagnostic tests. This is 24.9% higher than the same time in 2020. Of those people waiting, 38.6% had been waiting more than six weeks compared to 24.9% at 31 March 2020.¹⁰²

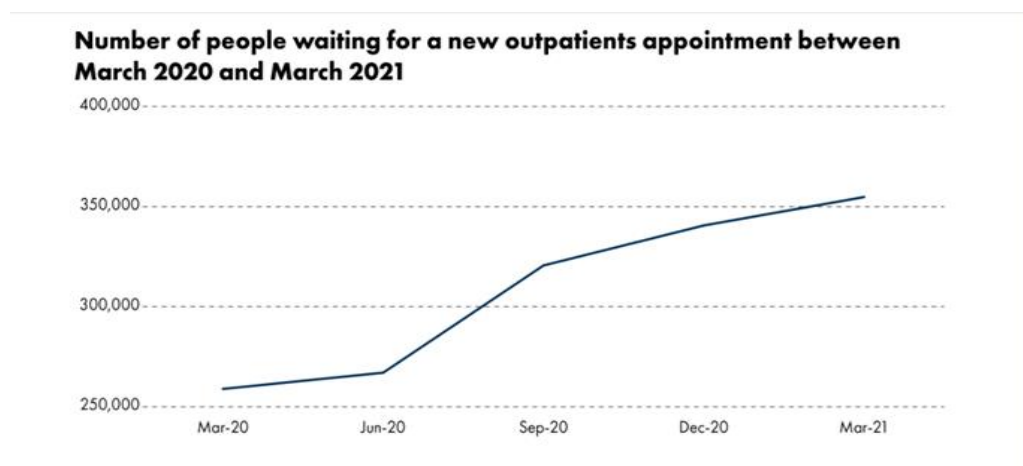


Figure 2 Number of people waiting for a new outpatient appointment between March and March 2021

Due to the Covid restrictions placed on the country, the number of people attending A&E declined significantly during 2020 as the public followed the health advice and restrictions and stayed at home.¹⁰³ However, with restrictions lifted gradually during 2021, attendances and admissions to A&E departments returned to pre-pandemic levels which were already historically high. This increase in attendances - combined with factors such as the reduced capacity resulting from infection control measures, and staff absences as a result of self-isolation - has contributed to the current pressures being experienced in A&E and unscheduled services. New Public Health Department records show that performance against A&E waiting times standards have hit a record low, with only 70.9% of those who visited A&E seen within four hours, whilst the last time the set target of 95% was met was July 2020.¹⁰⁴

Even in the summer of 2021 there were reports of ambulances queuing outside A&E departments, staff seeing patients in corridors due to a lack of beds and waiting lists rising.¹⁰⁵ The lack of beds delays movement into and through A&E departments. Out of the 131,491 A&E attendances in Scotland [Sept], 1,946 spent more than 12 hours waiting. Pre-pandemic, bed occupancy rates in Scotland were already above safe levels, at 86.7 percent.¹⁰⁶ The situation has not improved during 2021 and is predicted to get worse over the winter months (even without the impact of the new Omicron variant). The NHS cannot protect the fragile recovery of elective services and ensure patient safety during the winter months without a well-supported and healthy workforce.

The backlog of secondary care appointments and procedures ultimately also puts additional pressure on primary care as patients seek support and relief while they wait for the elective care they have been diagnosed as requiring. Growing numbers of health and care staff are being

¹⁰² <https://spice-spotlight.scot/2021/06/17/indirect-health-impacts-of-covid-19-nhs-performance-and-waiting-times/>

¹⁰³ <https://publichealthscotland.scot/publications/ae-activity-and-waiting-times/ae-activity-and-waiting-times-month-ending-31-july-2021/>

¹⁰⁴ <https://www.nationalhealthexecutive.com/articles/scotland-ae-wait-time>

¹⁰⁵ <https://www.bbc.co.uk/news/uk-scotland-57903066>

¹⁰⁶ <https://publichealthscotland.scot/publications/acute-hospital-activity-and-nhs-beds-information-annual/acute-hospital-activity-and-nhs-beds-information-annual-annual-year-ending-31-march-2021/>

subjected to violent verbal and even physical attacks in their places of work, due in part to anger and frustration over delayed care and overstretched services.¹⁰⁷

The NHS in Scotland is overwhelmed by unprecedented pressure, and doctors are faced with a surge in workloads and the most challenging period yet ahead with this winter already predicted as “the most challenging in the history of the NHS” by the Cabinet secretary for Health and Social Care. In NHS Scotland, the patterns of increased waiting times and target standards failing to be met are expected to continue.¹⁰⁸

This presents a worrying picture of the NHS in Scotland as a system under immense and unprecedented pressures, unable to meet the demands placed on it. Addressing the backlog of care, while continuing to meet the ongoing urgent health and care needs and the enduring expectations on the profession working within the NHS Scotland is having a critically detrimental effect on the health and wellbeing of the profession. During 2020 and 2021 staff had the option to carry over any leave which they had not been able to take because of service pressures from the 2020-21 leave year into the 2021-22 leave year. They also had an option to offer up to 10 days’ leave as “buy back” if they were unable to use all accumulated leave.¹⁰⁹ Although the “buy back” option is voluntary and it is being stressed that staff should take their leave, the fact these are given as options is another indicator of the pressure staff are under, and all the more ironic as taking leave is a critical part of health and wellbeing.

We have seen the introduction by the Scottish Government of the National Wellbeing Hub and Helpline¹¹⁰ in May 2020 for all NHS staff. In addition, a new Workforce Specialist Service¹¹¹ has been launched to offer tailored, confidential mental health support to regulated staff in NHS and social care.

But despite all these steps, the impact on the profession remains considerable and damaging. Whilst we welcome the introduction of these services, they do not in themselves address the stress the medical workforce is under in trying to cope with the physical and emotional demands the pandemic has placed on them and the ongoing pressure as normal services are repeatedly stepped up and then stepped down again with each wave of infection. The BMA’s “Rest, Recover, Restore: Getting UK health service back on track” report (March 2021)¹¹² outlines specific short-, medium- and long-term strategies to enable health service recovery – stressing the need to give overworked doctors and other health and care staff the time and support they need.

The Scottish Government’s NHS Recovery Plan¹¹³ set an aim to increase NHS capacity by 10% to address the backlog in care. This was also re-stated in their Programme for Government in September 2021. However simultaneously the NHS in Scotland is to remain on an emergency footing until March 2022.

How the 10% increase in capacity is to be achieved is not clear – whilst the ambition may be to

¹⁰⁷ <https://www.bma.org.uk/news-and-opinion/on-the-receiving-end-violence-aimed-at-doctors>

¹⁰⁸ <https://healthandcare.scot/default.asp?page=story&story=2934>

¹⁰⁹ [https://www.sehd.scot.nhs.uk/dl/DL\(2021\)35.pdf](https://www.sehd.scot.nhs.uk/dl/DL(2021)35.pdf)

¹¹⁰ <https://wellbeinghub.scot/>

¹¹¹ <https://wellbeinghub.scot/the-workforce-specialist-service-wss/>

¹¹² <https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf>

¹¹³ <https://www.gov.scot/publications/nhs-recovery-plan/pages/2/>

deliver this by service redesign, it is an increase in medical staff that is required to not only cope with the backlog of care but to continue to meet new and ongoing healthcare needs. The existing medical workforce is severely fatigued from almost 2 years of dealing with the pandemic and to expect them to be able to deliver increased capacity without additional staff is unrealistic. The pressure to not only return to “normal” activity but also increase capacity could lead to a further squeeze on the workforce with higher staff absence rates and staff reducing their working hours or leaving the profession altogether. This would make it harder for the NHS to recover and provide timely and safe care to patients who need it. It would also put even more pressure on those staff who remain working in the NHS.

8.5.1 Impact on education and training

Disruption to education and training has continued in 2020-21, with trainees entering a second year experiencing the significant and continued impact of the pandemic on medical education and training and their careers. The accumulative impact this has had on doctors in training and trainers cannot be overstated, as important training continues to be missed.^{114 115} Although junior doctors haven’t seen a significant return to trainee redeployment, with smaller number of doctors redeployed in some hard-pressed Health Boards, the recovery of clinical services fundamental for training has been variable across Scotland. This reflecting the ongoing waves of the pandemic and the resultant and building pressure on services. Trainees, their trainers, and other staff have continued to be affected by the requirement for absence due to self-isolation and illness.

The immediate impact has been significant in specialties such as obstetrics and gynaecology and some surgical and diagnostic programmes, particularly pathology, due to the reduction in training opportunities. Reporting from the GMC State of Medical Education report 2021¹¹⁶ stresses that trainees, and in particular those trainees in medicine, surgery and obstetrics and gynaecology programmes, are finding it difficult to gain required competencies, worsened by the need to catch up and find opportunities to backfill missed training, whilst working in the wider context of the ongoing pandemic and NHS recovery. Even in physician specialties, some opportunities have been hard hit – with traditional outpatient clinic opportunity and mitigations and derogations that are in place.

While data provided by Annual Review of Competency Progression (ARCP) Outcomes reported to the NHS Education for Scotland (NES) Specialty training boards (STBs) gives some reassurance that training progression has been sustained¹¹⁷, with about 87% of trainees found to be progressing normally, with around 13% facing problems, it must be recognised that this may mask considerable accrual of unmet competences for trainees who have not yet reached a critical progression point. GMC approved derogations remain in place and have facilitated progression however the full range of competences will be required for trainees to gain CCT, and we agree it is important that standards are maintained in those who CCT. At the current time the full picture of the effect of the pandemic on postgraduate medical educational progression is incomplete. We remain concerned that the slowing of the flow through the training pipeline will be impacted for at least the next five years with

¹¹⁴ <https://www.gmc-uk.org/news/news-archive/covid-disruption-hits-training-for-eight-in-ten-doctors-gmc-surveys-shows>

¹¹⁵ https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf?la=en&hash=058EBC55D983925E454F144AB74DEE6495ED7C98

¹¹⁶ https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf?la=en&hash=058EBC55D983925E454F144AB74DEE6495ED7C98

¹¹⁷ <https://www.scotlanddeanery.nhs.scot/covid-19/training-update-from-nes-and-dmes-december-2021/>

the full effect of the Covid-19 pandemic on the outturn of doctors not being seen until future years. We know there is a significant recruitment and retention issue for consultants, and the ongoing pandemic will exacerbate this position and impact on future consultant and GP workforce supply.

6.6 Primary care

General practice in Scotland is currently in a phase of extreme pressure, driven by inadequate numbers of GPs compared to the growing needs of the population, a sharp increase in workload driven by the pandemic, dwindling morale, growing expenses and pay that has not yet been reformed to increase the attractiveness of a career in general practice. The 2018 GMS contract, which included commitments to reduce workload pressure by greatly expanding the multidisciplinary team that supports work in general practice, has not yet been delivered in full despite its target date of April 2021, leaving general practice in Scotland to continue providing services that should no longer be their responsibility.

6.6.1 Workforce and workload

The most recently published GP workforce figures from the 2019 GP workforce survey found that between 2013 and 2019, the GP headcount (excluding trainees) in Scotland grew by just 6 from 4,394 in 2013 to 4,400.¹¹⁸ Over the same period however, WTE GP numbers fell from 3,675.1 in 2013 to 3,612.8 in 2019, a fall of 1.7%. While the National Primary Care Clinicians Database (which includes trainees) suggests there has since been a small increase in GP numbers based on the number of those on the performers list between 2019 and 2020, it will not be clear whether that will translate into an increase in WTE numbers for some time.¹¹⁹

The balance between the proportion of partners and salaried GPs during this period has changed over time. While in 2013 there were 3,755 partners representing 84% of GPs¹²⁰, in the 2019 GP workforce survey this had fallen to 3,347 partners making up 76.1% of the GP workforce. In WTE terms, there were an estimated 3,270 partners, representing 87.6% of WTE GPs in 2013, but by 2019 this had declined to 2,875 WTE partners representing 79.6% of WTE GPs. In 2013 there were 570 salaried GPs representing 12.8% of GPs while by 2019 this had increased to 998 representing 22.7% of GPs. In WTE terms this had grown from 400 WTE salaried GPs representing 10.7% of WTE GPs to 669 WTE salaried GPs in 2019, representing 18.5% of WTE GPs.

Over the same period, the number of patients registered with practices in Scotland grew from 5,568,304 in 2013 to 5,769,985 in 2019 and 5,784,870 in 2020, a rise of 3.6% and 3.9% on 2013 figures respectively.¹²¹ There are therefore fewer WTE GPs managing the health needs of a larger population than there were in 2013, which consequently has resulted in greater workload for those working in general practice.

These increasingly inadequate numbers of GPs are reflected in the level of practice vacancies that have been reported in successive GP workforce surveys. While the 2013 survey reported that 8.9%

¹¹⁸ <https://www.publichealthscotland.scot/publications/general-practice-workforce-survey/general-practice-workforce-survey-2019/>

¹¹⁹ <https://www.publichealthscotland.scot/publications/general-practice-gp-workforce-and-practice-list-sizes/general-practice-gp-workforce-and-practice-list-sizes-2010-2020/>

¹²⁰ <https://www.isdscotland.org/Health-Topics/General-Practice/GPs-and-Other-Practice-Workforce/primary-care-workforce-survey-2013.asp>

¹²¹ <https://www.publichealthscotland.scot/publications/general-practice-gp-workforce-and-practice-list-sizes/general-practice-gp-workforce-and-practice-list-sizes-2010-2020/>

of practices had at least one GP vacancy¹²², that figure has risen to 32.3% of practices in the 2019 survey. A BMA Scotland survey carried out in October 2021 found little change to this position, with 28% of practices reporting at least one GP vacancy.

Demographic change has also increased the workload demands on GPs as those with the greatest health needs which need managed by general practice falling disproportionately in the oldest age groups. Since 2013, the number of people in Scotland aged 85 or over has increased by 11.7% from 535,324 to 598,128, an increase of 62,804.¹²³

A survey by BMA Scotland in October 2021 asked practices to consider the extent to which current patient demand matches their available capacity. Amongst the 368 practices who responded to this question, 41% reported that capacity was slightly lower than demand while/ 42% reported that capacity was substantially lower than demand.

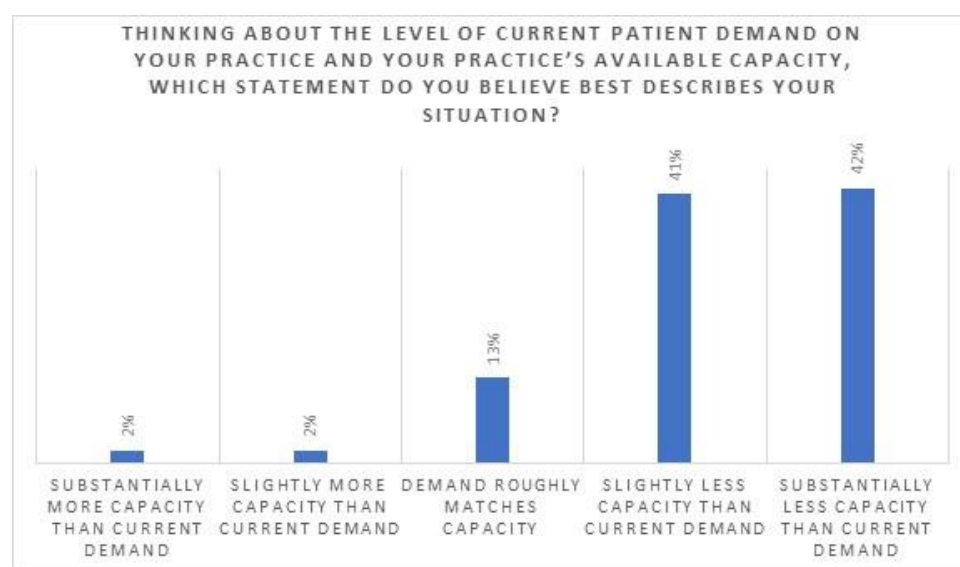


Figure 3 BMA Scotland survey of GP practices, October 2021

Practice capacity has been significantly impacted by the pandemic, in particular the requirements around self-isolation when GPs, staff or their families develop Covid symptoms or test positive for Covid; social distancing requirements; and the need for enhanced infection control. Meanwhile, Covid has also created increased demands on general practice, whether directly with Covid related issues such as increased mental health presentations and vaccination activity or indirectly through the impact of waiting times in other parts of the health system. The size of the secondary care waiting list for those waiting to be seen has increased by 37.7% since 2019 while the waiting list for those waiting for treatment has increased by 38.1%.¹²⁴ In many cases these patients will require ongoing care from General Practice before their secondary care treatment commences, further increasing General Practice workload.

¹²² <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/population-estimates-time-series-data>

¹²³ <https://www.publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-31-august-2021/>

¹²⁴ <https://www.publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-30-november-2021/>

Unmanageable workload acts as a barrier to attracting new doctors into General Practice and particularly into partnership where it is harder to limit workload. This leads to existing GPs seeking to reduce their sessional commitment or leave entirely and contributes to practice instability, with major knock-on effects on patient care. While the 2018 GMS contract sought to partially address this through expanding the multi-disciplinary team to support GPs, it is ultimately a significant expansion to the GP workforce which is required to return workload to sustainable levels.

6.6.2 Morale

The wellbeing and morale of GPs is a source of real concern as the profession increasingly shows signs that many are struggling to cope with the pressures of unsustainable workload, unrealistic expectations and increasingly abusive behaviour by patients.

A BMA Scotland survey of GPs in May 2021 asked about the impact of current workload pressures on the wellbeing of GPs. Amongst respondents, 57.2% said that they were struggling to cope and that their work was having a negative impact on their physical and mental wellbeing and had been made worse by the pandemic, while a further 16.1% also said that their work was having a negative impact on their physical and mental wellbeing, but that it was no worse than before the pandemic.

The same survey also asked about the future career intentions of respondents. Worryingly, 70.2% of respondents said that their experience of the preceding year of working during the pandemic was more likely to lead to them taking early retirement or leaving the profession, while 66.3% of respondents said it made them more likely to cut the number of sessions that they work.

Cases of verbal or physical abuse against practice staff also appears to have significantly increased, further damaging the morale of GPs and staff who are trying their best to cope with what remain extremely challenging circumstances. In BMA Scotland's survey in May 2021, 87.7% of responding GPs reported that they or staff at their practice had been subject to physical or verbal abuse from the public within the previous month. In BMA Scotland's subsequent survey in October 2021, 88% of respondents said that there had been an incident of physical or verbal abuse in the previous month when asked the same question. In that survey, practices were also asked to gauge whether instances of abusive behaviour had improved, remained the same or worsened since May 2021's survey, with 78% reporting that the situation had worsened while 19% reported it had remained the same.

6.6.3 Expenses

Last year the Scottish Government's uplift was calculated on the basis of awarding 3% for GPs in line with the DDRB's recommendation, a 4% uplift for GP staff to partially mirror Agenda for Change staff and a 1.9% uplift for non-staff expenses based on CPI.

While the Scottish Government elected to award Agenda for Change staff in Scotland a 4% pay increase backdated to December 2020 in 2021/22, the pay uplift to General Practice was applied only to the beginning of the 2021/22 financial year. While General Practice staff are not employed on Agenda for Change terms and conditions, this decision put practices in the challenging position of either awarding staff a less generous pay uplift than Agenda for Change staff, relatively weakening the attractiveness of careers in practices, or of providing a similar backdating to December 2020 and funding it out of practice profits, reducing partner drawings.

The NHS Digital GP Earnings and Expenses estimates for 2019/20 identified a significant increase of

13.2% in self-employment allowable expenses from £119,300 in 2018/19 to £135,000 in 2019/20.¹²⁵ This increase appears to have been primarily driven by employee costs in particular, which rose from £79,800 to £92,400 in 2019/20, an increase of 15.8%, while other expenses types fluctuated.

The 2018 GMS contract includes a yet to be implemented second phase which would introduce amongst other elements a process of direct reimbursement of practice expenses. The impact of the pandemic continues to delay negotiation and implementation of this.

The prevailing rate of inflation has increased significantly since the announcement of the 2021/22 pay award, with the effect of reducing partner profits from what would otherwise have been intended at the time of the pay award being made.

6.6.4 GP earnings

We continue to rely heavily on NHS Digital Earning and Expenses estimates of GP earnings in Scotland, which has notable limitations, particularly that it does not adjust earnings based on hours worked and includes private income.

In 2019, GP practices were asked to provide the Scottish Government with detailed earnings and expenses information. The purpose of collecting this information was to inform phase 2 of the 2018 contract which is to focus on GP earnings and expenses reform. The overarching policy for phase 2 is outlined in the [contract framework](#) and includes the introduction of an income range comparable to consultants and to directly reimburse practices expenses. Unfortunately, this work has been significantly delayed by the pandemic, but work to analyse this information has now commenced. This information is linked to workforce information collected at the same time and will provide greater insight into many elements of practice finances including GP contractor and salaried GP earnings adjusted for hours worked. We expect that this information will feature in our submissions to the DDRB in future years.

6.6.5 Independent contractors

NHS Digital states that in 2019/20 the average taxable income of GP contractors in Scotland was **£106,100**, which is an increase of 4.74% compared to 2018/19. However, a portion of the increase in earnings will be due to decreasing numbers of GP contractors (partners) working in Scotland:

- The NHS Digital report GP contractor population has decreased from 3,700 in 2014/15 to 3,300 in 2019/20.
- The Scottish GP workforce surveys show a headcount decline in GP contractors from 3,611 in 2017 to 3,347 in 2019.

GP contractor earnings are determined by practice profit – where there are fewer numbers of GP contractors this is expected to increase their average pay. Due to a lack of available information, it is not possible to directly assess whether GP contractor pay per unit of work is increasing as intended by annual pay awards. As GP contractor numbers reduce and vacancies increase (as they are now) the risk and workload of GP partnership is being carried by a smaller number of GP contractors. This

¹²⁵ <https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates>

is contrary to the central aim of the 2018 contract which was to make GP partnership more attractive and grow the numbers of GP partners.

The 2018 contract sought to improve several factors to make partnership more attractive – this included reducing workload to a manageable level, increasing the leadership role of GPs, allowing GPs to focus on expert medical generalism,¹²⁶ reduction of contractual risk, improving infrastructure (namely GP premises), and reform of GP contractor pay and expenses. While implementation of the 2018 contract proceeds and is starting to deliver some of the intended benefits, the work on reform of pay and expense has not yet proceeded.

We know that GP contractors are not content with recent pay awards. In response to a BMA pay survey in October 2021 – 57.7% of GP contractors that responded believed last year’s annual uplift was disappointing or unacceptable. And 71.9% of respondents GP contractors believed last year’s uplift didn’t sufficiently recognise their contribution to the NHS. More than half of the GP contractors responding to the survey indicated that last year’s pay uplift would influence them to reduce their NHS clinical commitments.

We are in a difficult place in Scotland – GP contractors are essential to the model of service provision but there are not enough GP contractors and dissatisfaction with pay and pay awards we expect is contributing in part to these recruitment and retention difficulties. At present, we do not appear to be on course to deliver the government target of an additional 800 GPs by 2027 and too few GPs are choosing partnership, contributing to the declining proportion of partners as a share of GPs in both headcount and WTE terms seen in the GP workforce surveys. There is an overwhelming need to urgently progress the 2018 contract to improve the attractiveness of GP partnership. Part of the solution to recruiting and retaining enough GP partners to cover the current vacancies and see meaningful expansion of GP partners (agreed by Scottish Government and the BMA) is to ensure they are satisfied with their earnings and the annual pay award. Above inflation pay awards in this and subsequent years will help to begin this process.

8.6.6 Salaried GPs

In 2019/20 NHS Digital reported that the average earnings of salaried GPs in Scotland was **£65,900** an increase of 1.23% compared to 2018/19. This annual increase in salaried GP earnings (average taxable income) is tracking below standard measures of inflation.

The report does also identify gross employment and self-employment earnings of salaried GPs. In 2019/20 the average gross employment earnings of salaried GPs in Scotland was **£57,300** a decrease of 2.4% compared to 2018/19.

We are particularly concerned that both the average salaried GP earnings and employment earnings of salaried GPs are tracking below standard measures of inflation.

We ask the DDRB to consider the importance of employment earnings for salaried GPs when making recommendations on pay. Annual pay awards should be directly applied to the employment

¹²⁶ The contract framework proposes a refocusing of the GP role as expert medical generalists. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership. All aspects are equally important. The aim is to enable GPs to do the job they train to do and enable patients to have better care.

earnings of salaried GPs. The self-employment earnings may not be directly impacted by annual pay awards since often rates are dependent on the market.

We know that salaried GPs are dissatisfied with previous annual awards. In response to a BMA pay survey in October 2021 – 52.9% of salaried GPs that responded believed last year's annual uplift was disappointing or unacceptable. While 56.7% of respondents believed last year's uplift didn't recognise their contribution to the NHS. Just over 42% of the salaried GPs responding indicated that last year's pay uplift would influence them to reduce their NHS clinical commitments.

The NHS Digital report also shows that female salaried GPs earn less than their male colleagues (£58,600 compared to £85,400 average annual taxable income). It is important to emphasise that these figures are not WTE incomes and the extent to which this reflects different average working hours between female and male GPs is unclear. This is an area which requires further investigation, including any effect for different types of employers of salaried GPs, the gender distribution between different salaried GP roles, and clarity on salaried GP WTE earnings. Better data is urgently required to more fully understand whether female salaried GPs are being disadvantaged.

We are increasingly concerned that the pay range for salaried GPs in Scotland does not reflect the reality of their pay and might be suppressing the expectations of both salaried GPs and their employers in terms of what is an appropriate level of pay. The current pay range for salaried GPs in Scotland is £61,346 to £91,564. Given that the GP workforce survey in Scotland estimates 0.67 WTE per headcount for salaried GPs – this would suggest (in combination with the average taxable income from the NHS Digital report) that the average WTE income for a salaried GP in Scotland is £98,358 which is above the top of the pay range. Alternatively, adjusting gross employment earnings in the same way results in a WTE income of £85,522 which is well above the midpoint of the pay range.

6.7 Secondary care

6.7.1 Recruitment and retention

The challenges of both workforce shortages and excessive workload are not new in Scotland. They existed long before the pandemic and have intensified with its impact. Doctors' jobs are increasingly more intense and demanding with evidence of excessive workloads and spiralling demand, while covering for growing and often under-reported medical vacancies. The COVID-19 pandemic has exacerbated existing challenges around workforce shortages and staff burnout, but these issues are not a result of the pandemic. The medical workforce in Scotland is in crisis and the urgent need to address this cannot be overstated. There are rising medical vacancies across the NHS in Scotland, with shortages in every major specialty. There is no single solution to this impending workforce crisis, given the length of time that it takes to train new doctors, and the potential for changed international labour market dynamics as a result of EU Exit, COVID-19 and other factors. It is crucial that the Scottish Government and NHS Scotland take a long-term view on Scotland's workforce needs and at the same time focus not just on recruitment but also make every effort to retain those doctors currently in the workforce. The backlog of care is at its highest in the history of the NHS. The system is at capacity – there are few beds available, staff are stretched to the limit and we are having to rely on help from the military and drafting in students to help us cope. It must be an absolute priority for Scottish Government to do everything in its power to retain existing doctors.

6.7.2 Vacancy data

BMA Scotland earlier this year published its report into consultant retention in Scotland¹²⁷, outlining the worsening crisis in the Scottish consultant workforce, of huge secondary care waiting lists and consultant vacancies which are now well more than double official reporting.

The way in which Scottish Government continues to collect and record its vacancy figures fails to capture the true extent of consultant vacancies across country. This means that a significant number of posts are not included and the real number of vacancies is therefore far higher than reported figures, which significantly underestimate the scale of the problem and therefore reduce the urgency to mitigate the true impact on the service. The equivalent of a whole, large hospital could be staffed from vacancies left out of the official figures. For SAS doctors, as the DDRB itself has previously noted, this data isn't collected at all, despite repeated BMA lobbying. The medical workforce is stretched more thinly than it has ever been before, while at the same time it is facing greater challenges than ever before.

For the last six years, BMA Scotland has submitted a Freedom of Information request to all NHS boards in Scotland asking for a breakdown of their consultant figures on 30 September. In 2018, the Scottish consultant vacancy rate was 13.9%, more than double the official rate. Using identical questions and methodology again in September 2020, the overall consultant vacancy rate for Scotland had increased to 15.2%. Yet the official Scottish Government figures for consultant vacancies for the same date put the vacancy rate at just 6.3%. We have repeated our FOI on vacancy figures for September 2021, and for the first time we have included SAS doctors. We anticipate we will share our findings with the DDRB as supplementary evidence. It is absolutely vital that Scottish Government improve the accuracy of data to understand more effectively the scale of the problem and be able to work towards ensuring the sustainability of the medical workforce. Vacancies are directly linked to increased workloads and negatively affect doctors' wellbeing, morale and motivation

These findings are reinforced by the most recent Scottish Academy report¹²⁸ which shows that 193 planned interview panels were cancelled in 2020, just under a third of all appointment panels held that year. Of the 193 cancelled panels, more than 80% of these were cancelled due to applicant related reasons (no applicants, no suitable applicants or candidates withdrew). This is not a temporary problem – since 2015 over 80% of all cancelled panels has consistently been due to either no applicants or no suitable applicants putting themselves forward for these consultant posts.

The impact of vacancies on staff is profound: in the most recent census from the Royal College of Physicians, more than half of consultants reported adverse effects from consultant vacancies within their department, most commonly adequate work-life balance (39%), audit/ quality improvement (25%), inpatient work (24%), educational supervision or assessments (24%) and elective clinical work (22%).¹²⁹

At a time when vacancies are rising and recruitment is getting increasingly difficult, signs are pointing to an ever-growing number of doctors who are considering leaving the profession or reducing their hours of work. The RCP census showed that 53% of consultants said that they wanted

¹²⁷ <https://www.bma.org.uk/media/3840/bma-scotland-consultants-retention-report-feb-2021.pdf>

¹²⁸ <http://www.scottishacademy.org.uk/external-advisers/annual-reports>

¹²⁹ <https://www.rcplondon.ac.uk/projects/outputs/life-time-covid-19-2020-uk-consultant-census>

to work fewer PAs in future and only 7% said that they wanted to work more PAs. It did not vary by gender, ethnicity or nation.¹³⁰

The DDRB report last year pointed to the worrying trend of senior hospital doctors being a persistently high proportion of voluntary early retirements across the UK, with a sharp increase choosing voluntary early retirement from 2007 onwards. Already more than one in five consultants are leaving NHS roles in Scotland in their mid-to-late 50s.¹³¹ A recent BMA Scotland survey¹³² showed that more than 45 percent of respondents are considering retiring in the next five years. Of those, more than half report that is earlier than their normal pension age. When those too young to take voluntary early retirement are filtered out, the figures become even starker - some 70% of consultants said they were planning to take voluntary early retirement. The RCP census reinforces this; without decisive action more than 10% of the consultant workforce will retire within the next 18 months.¹³³ Disillusionment with the job, struggles with work/life balance and impact on personal health and well-being have all been stated as reasons for early retirement.

This will have a major impact on Scotland's ability to deliver safe and effective clinical care and the training of the senior doctors of the future. All options to mitigate this should be on the table.

Retaining doctors is not just focusing on those doctors retiring from the profession early. The recent GMC report Completing the Picture¹³⁴ found that that large numbers of working age doctors are making the decision to stop practising in this country, many of whom are now working clinically abroad instead. For those who have retired, rather than just moved abroad, leaving the profession feels permanent and very few who have made this decision demonstrate a wish or likelihood of returning. The GMC survey revealed that dissatisfaction and burnout were among the main reasons given for leaving their jobs.

Calls are growing across Scotland to urgently address Scotland's medical workforce challenges. In November 2021, the Royal College of Physicians and Surgeons and Glasgow published the Scottish Medical Workforce Solutions Paper, providing similar warnings and recommendations to address the ongoing workforce challenges within NHS Scotland.¹³⁵ Despite this, we are concerned that the Scottish Government does not seem to be acknowledging the scale of the problem ahead.

The problem of consultant vacancies is exacerbated by the fact that junior doctors, who would normally replace the retiring consultants, are also under increasing pressure. Rising vacancies mean junior staff are asked to act up and take on the responsibilities of more experienced doctors. Staff are asked to work increasingly longer hours and more intensely to fill the gaps, or services may be reduced.

We are concerned that the Scottish Government does not appear to be addressing these issues. Last year the DDRB asked to hear in evidence for this round what measures are being taken to encourage retention among the most senior consultants and how they are working. The Scottish Government published its NHS recovery plan in August 2021, setting out its key ambitions and actions to be developed and delivered now and over the next 5 years in order to address the backlog in care and

¹³⁰ Ibid

¹³¹ <https://www.bma.org.uk/media/3840/bma-scotland-consultants-retention-report-feb-2021.pdf>

¹³² <https://bmascotlandhome.files.wordpress.com/2021/09/pay-survey-sept-2021.pdf>

¹³³ <https://www.rcplondon.ac.uk/projects/outputs/life-time-covid-19-2020-uk-consultant-census>

¹³⁴ https://www.gmc-uk.org/-/media/documents/completing-the-picture-survey_pdf-87815271.pdf

¹³⁵ <https://rcpsg.ac.uk/college/speaking-up-for-the-profession/news-and-statements/college-publishes-workforce-solutions-paper/>

meet ongoing healthcare needs for people across Scotland.¹³⁶ Although the plan talked of an ambition programme of recruitment, this plan seems to be based on recruiting from overseas to staff initiatives like the National Treatment Centres, or simply redesigning patient pathways to make them more efficient. While the plan acknowledged that the NHS is struggling and it is important to “put wellbeing of staff first”, the report does not feature any plan to retain its current staff or build the workforce needed for the future. This omission from the approach by the Scottish Government means the health service will not be able to deliver what is currently demanded – let alone the promised extra 10 per cent capacity. Scottish Government has had to delay again the launch of its National Workforce Strategy for Health and Social Care as a result of the pandemic to early 2022.

While increased training places announced within the report are positive, they will not mean additional consultants or SAS doctors in place for some considerable time. We need to hear much more from the Scottish Government on how it plans to retain the staff we currently have – by improving their work life balance, rewarding them with pay rises above inflation, and doing what it can to address pension rules that penalise doctors for doing more hours. With increasing reports of doctors wishing to work more flexibly, and particularly trainees who are increasingly wanting to work on a less than full-time basis,¹³⁷ this presents implications for consultant workforce pipeline and needs to be considered as part of future workforce planning. GMC report that a greater proportion of doctors in the later stages of their training work less than full-time, and this may provide some indication of the intentions of the future consultant workforce and the way they wish to work.

To address some of the uncertainties around workforce intentions, BMA Scotland is currently working with MSG (Management Steering Group – a joint Scottish Government / NHS employer body) and the Scottish Academy of Medical Royal Colleges on commissioning a joint survey of career grade doctors in Scotland around workforce intentions. This will be an externally run joint survey focusing on doctors’ intentions towards retirement, clinical commitment and the workforce pressures they are facing, and what could be put in place to mitigate this. We hope that the results of a neutral third party survey will be able to provide the data that is lacking at present. A Scottish survey commissioned by employers, the BMA and the Scottish Academy would have a powerful impact in having the best possible reach in getting doctors in Scotland to participate and provide us with much needed data.

Scottish Government needs to improve and protect the wellbeing of its medical workforce by providing suitable working conditions, contracts, flexibility and support. If we want to retain our doctors then we must change the way we do things, focusing on safe environments to work, train and innovate. This will require increased flexibility and putting an emphasis on allowing people to have the work life balance they need. Doctors must feel valued, and a fair pay award presents an opportunity to improve retention by providing greater incentives for NHS staff. A sustainable workforce relies on retention as well as recruitment.

6.7.3 Reward schemes

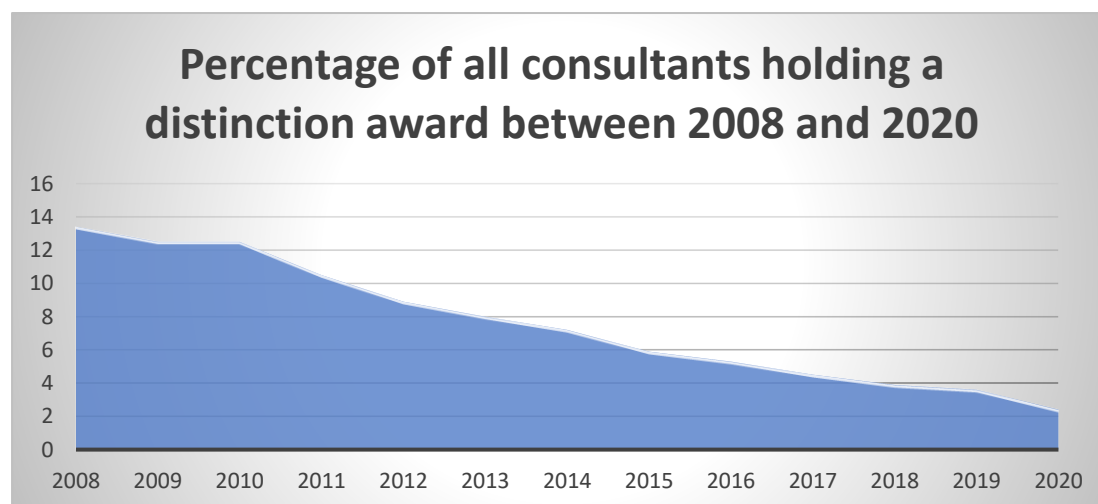
The Scottish Government has consistently ignored any DDRB recommendations to increase the value of consultant distinction awards or discretionary points. The value of a discretionary point has remained frozen at £3,204 since April 2009; if it had kept pace with RPI, it would now be valued at £4,477.61. The Scottish Government has also refused to allow any new distinction awards to be

¹³⁶ <https://www.gov.scot/publications/nhs-recovery-plan/>

¹³⁷ https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf?la=en&hash=058EBC55D983925E454F144AB74DEE6495ED7C98

made in Scotland for the last 11 years, in contrast to England where higher awards are still available. In September 2009, there were 578 distinction award holders in Scotland, comprising 12% of all consultants. It should also be noted that in 2009, 38% of consultants were in receipt of a distinction award at the point of retirement, which needs to be factored in when considering lifetime earnings. By April 2021, the latest data for which figures are available, this had fallen to 166 distinction award holders, representing only 2.4% of the total number of consultants.¹³⁸ This huge and continuing drop in the number of award holders has generated significant savings for the Scottish Government that have not been reinvested elsewhere into the overall pay offer for consultants in Scotland.

It should also be noted that closing the higher awards scheme is a significant contributory factor that has entrenched a historical gender pay gap by removing the opportunity of a higher award to the increasing proportion of female consultants. We now have a Scottish consultant workforce where 42.8% are female, yet 83.7% of distinction award holders are male. 94.6% of all distinction award holders are also aged 55 or older, yet the median consultant age is 47. Without progress on reform of the higher awards scheme in Scotland, this situation will never change so it is disappointing that the Scottish Government has refused to discuss the issue further.



6.7.4 Workload

Reports of burnout rates at an all-time high are of real concern for the profession and the NHS,¹³⁹ with the impact of burnout felt not only on the workforce itself and but also raising worrying implications for patient care.¹⁴¹ The GMC reports that a quarter (25%) of secondary care trainees and 33% of trainees said they feel burnt out to a high/very high degree because of their work. For trainees, across all specialties, data shows an increase in doctors at high risk.

Chronic excessive workloads remain a critical issue and are the primary reason for high levels of workforce burnout and fatigue.¹⁴² Excessive workload is a concern for the NHS Scotland workforce,

¹³⁸ <https://www.sehd.scot.nhs.uk/publications/DC20211112SACDA.pdf>

¹³⁹ https://www.gmc-uk.org/-/media/documents/national-training-survey-results-2021---summary-report_pdf-87050829.pdf

¹⁴⁰ https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf?la=en&hash=058EBC55D983925E454F144AB74DEE6495ED7C98

¹⁴¹ https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

¹⁴² https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf?la=en&hash=058EBC55D983925E454F144AB74DEE6495ED7C98

and they are worried about current and future patient care.¹⁴³ This is reinforced in the latest report from the GMC¹⁴⁴ which shows that workload pressures as the factor most often contributed to compromised patient care and safety. Of that same report over two-thirds of doctors have said workload pressure was a barrier to patient care, and in the face of current healthcare pressures – 30% of doctors said they often feel unable to cope with their workload, up from 19% in 2020. A BMA Scotland survey from August 2021 revealed that around half said excessive workload was a priority issue. Staff shortages are a key important factor in determining chronic excessive workload.¹⁴⁵ Persistent workforce shortages across the medical profession impact negatively on morale, with increasing unmanageable workloads putting more and more pressure on doctors. Whilst medical locum agency spend has been seen to fall, this masks a concerning picture across those NHS Boards in Scotland struggling with vacancies. Within NHS Borders alone, medical agency spend has more than doubled, £592,395 (March 2020) to £1,333,065.34 (March 2021).¹⁴⁶

Furthermore, consideration must be given to question as to how willing NHS Boards are to engage with locums and how often they leave a gap, which in turn has a negative impact on staff and workloads. Of concern are reports of long and intense working hours amongst doctors. Almost half of trainees (42.6%) have reported working beyond their rostered hours daily or weekly. 33.95% have said their work intensity by day as “heavy” or “very heavy”. 19.03% of trainees have said that at least weekly their working pattern left them short of sleep when at work. The BMA supporting junior doctor wellbeing report October 2021¹⁴⁷ has stressed the need to address fatigue and burnout as reports of junior doctors feeling exhausted, with concerns for their personal safety or that of their colleagues when working long shifts (a shift lasting 10 hours or longer). 74% said they felt concerned for their personal safety, or that of their colleagues, whilst working long shifts “often” or “sometimes” – with only 6% saying never. This is worrying with 50% of junior doctors reporting their current rota contained four consecutive long shifts and 18% having more than four consecutive long shifts in their current rota. The Scottish Government’s own Expert Working Group¹⁴⁸ made a number of recommendations (e.g., a maximum number of long shifts in a week) aimed at addressing junior doctor fatigue in its report submitted to Scottish ministers at the end of 2019. However, the Scottish Government delayed publication of the report until October 2021, and at the time of writing (December 2021) has yet to commit to any timescales for the implementation of the report’s recommendations.

It is important to stress again here that burnout and fatigue were prevalent and widespread before the pandemic; this however has been exacerbated by the effects of continuing and significant vacancies, unprecedented demand and waiting lists, and the pandemic response and backlog of care.¹⁴⁹ Audit Scotland 2020¹⁵⁰ noted that the pandemic led to a substantial backlog of patients, and

¹⁴³ <https://www.imatter.scot/media/1947/everyone-matters-pulse-survey-national-report-2020-final-version.pdf>

¹⁴⁴ https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf?la=en&hash=058EBC55D983925E454F144AB74DEE6495ED7C98

¹⁴⁵ <https://committees.parliament.uk/publications/6158/documents/68766/default/>

¹⁴⁶ <https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/07-december-2021-workforce/dashboards/nhsscotland-workforce/?pageid=5982>

¹⁴⁷ https://www.bma.org.uk/media/4670/bma-supporting-junior-doctor-wellbeing_final-publication-october-2021.pdf

¹⁴⁸ <https://www.gov.scot/publications/export-working-group-report-48-hour-maximum-working-week-without-averaging-junior-doctors-scotland/>

¹⁴⁹ <https://rcpsg.ac.uk/college/speaking-up-for-the-profession/news-and-statements/college-publishes-workforce-solutions-paper/>

¹⁵⁰ https://www.audit-scotland.gov.uk/uploads/docs/report/2021/nr_210117_nhs_overview.pdf

as has been reported for a long period, NHS Boards in Scotland have found meeting national waiting times targets very challenging. We are aware of current reports that NHS Boards in Scotland, in response to unprecedented pressures and the ongoing impact of Covid, referred to as the “greatest in living memory”¹⁵¹ are waiving such targets as they are unachievable due to demands and pressures.¹⁵² As we have stressed earlier in this submission on the compounding impact of Covid, the enduring expectations on the profession working under unprecedented pressure and surging high-intensity workloads. This is all having a critically detrimental effect on the health and wellbeing of the profession, and ultimately for patient care.

There are increasing reports which show that the current medical workforce values flexibility at all stages of their careers - in their scheduling and working arrangements, as well as their training.¹⁵³ The DDRB have highlighted that the extra-demands of working through the pandemic may result in doctors re-evaluating their priorities and to make different career choices, including the number of hours they work, and the time taken to progress through training. BMA Scotland has reported that doctors are concerned about workload and lack of work life balance, combined with inflexible working arrangements that lead to stress and burnout.¹⁵⁴ The BMA Scotland reports that of a short snap survey of junior doctors, 80% said that more flexible working patterns would have a positive impact on their health and wellbeing, whilst only 11% agreed there were opportunities to work more flexibly, including less-than-full-time (LTFT). This reflects findings from a Royal College of Physicians (RCP) survey (June 2021) which reports that doctors do want to work more flexibly, however 36% of doctors said that it would be difficult, very difficult or impossible to do so. Within the same survey, the key barriers identified were workforce shortages (79%) and excessive workload (58%).¹⁵⁵ To recruit and retain the medical workforce in the NHS the need to respond by allowing more flexible working arrangements to achieve work life balance and wellbeing is critical. As pointed to earlier, we know that lack of LTFT and flexible working arrangements is a significant factor in those leaving the profession in the UK, in addition to burnout and work-related stress.¹⁵⁶

At a time when the need to recruit more senior doctors has never been more critical, evidence outlined earlier in this submission, we are also facing a crisis in the recruitment and retention of training grade doctors in Scotland. Over the last decade, the number of foundation-level doctors who progress directly into specialty training has dropped dramatically from close to 90 per cent in 2010 to just 35 per cent.^{157 158 159} Research indicates that this choice is driven by a perceived lack of flexibility, alongside a belief that non-training posts offer a better work-life balance. However, the increasing number of early career doctors not proceeding directly into core or specialty training is a major issue for the healthcare system where such trainees are integral to service delivery at more senior level.¹⁶⁰ Unfilled training posts mean a shortage in the flow of doctors trained to specialist

¹⁵¹ <https://www.bbc.co.uk/news/uk-scotland-south-scotland-59506741>

¹⁵² <https://healthandcare.scot/default.asp?page=story&story=2934>

¹⁵³ <https://www.rcplondon.ac.uk/news/doctors-want-work-more-flexibly-and-we-need-make-it-reality>

¹⁵⁴ https://www.bma.org.uk/media/4670/bma-supporting-junior-doctor-wellbeing_final-publication-october-2021.pdf

¹⁵⁵ <https://www.rcplondon.ac.uk/news/doctors-want-work-more-flexibly-and-we-need-make-it-reality>

¹⁵⁶ https://www.gmc-uk.org/-/media/documents/completing-the-picture-survey_pdf-87815271.pdf

¹⁵⁷ <https://rcpsg.ac.uk/college/speaking-up-for-the-profession/news-and-statements/college-publishes-workforce-solutions-paper/>

¹⁵⁸ <https://foundationprogramme.nhs.uk/resources/reports/>

¹⁵⁹ <https://news.rcpsg.ac.uk/wp-content/uploads/2021/11/The-Scottish-Medical-Workforce-Planning-Supply-and-Retention-Solutions.pdf>

¹⁶⁰ <https://bmjopen.bmj.com/content/9/11/e032021>

registration to replace doctors who are retiring. This will have worsening effect on future consultant workforce supply, given we know of the significant recruitment and retention crisis for Scottish consultants, and critically for the sustainability of the NHS.

6.7.5 Morale

The Scottish Government NHS Recovery Plan 2021-26¹⁶¹ acknowledges that the NHS is struggling, and that recovery, remobilisation, and long-term sustainability of the NHS in Scotland can only happen by putting the wellbeing of staff first and enabling them to recover.¹⁶² Wellbeing of the workforce is key to improving retention of doctors and quality of patient care.

There is abundant evidence which shows that patient safety, patient quality of care and outcomes, financial performance and the sustainability of the health service are all critically dependant on the wellbeing of the workforce. It also points to the negative impact that workplace stress in healthcare organisations has on the quality of care for patients, as well as the health and wellbeing of doctors.¹⁶³

It must be recognised that the NHS was in a challenging period before the pandemic, and the pressure on the medical workforce has been widely reported for a long time, by the British Medical Association, General Medical Council, Royal Colleges and others.¹⁶⁴ Even prior to the pandemic with evident dominant workloads in the NHS, there were clear warning signs of risks to doctors' wellbeing and patient safety.¹⁶⁵ Doctors face more demand than ever before, and the impact of escalating workforce and workplace pressures, compounded by unprecedented and ongoing pandemic pressures, has exacerbated existing concerns about wellbeing, stress, and burnout that were widespread amongst the profession. Junior doctors, used as a vital resource in the NHS response to the pandemic, have experienced considerable disruption to their education and training, future plans and careers, and the GMC State of Medical Education report 2020 stressed the impact this has had on doctors' wellbeing cannot be overstated.¹⁶⁶

As already indicated earlier in our evidence, a BMA Scotland survey conducted in July 2021,¹⁶⁷ confirmed that doctors continue to not feel valued. Feeling valued is an important determinant of morale and motivation in the workplace. Low levels of morale are evident amongst the profession. 65% of doctors reported being dissatisfied (31% very dissatisfied) when asked to consider whether the Scottish Government values doctors and that their contribution to the NHS was recognised. Furthermore, a BMA Scotland snapshot survey of Junior doctors taken in July 2021 revealed that almost three quarters said they did not feel supported by their employer in relation to their wellbeing.¹⁶⁸ A recent BMA survey (January 2022) shows the severe and worsening impact the enduring pandemic, and this current wave of the Omicron variant, continues to have on doctor's

¹⁶¹ <https://www.gov.scot/publications/nhs-recovery-plan/>

¹⁶² https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf?la=en&hash=058EBC55D983925E454F144AB74DEE6495ED7C98

¹⁶³ https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

¹⁶⁴ https://www.audit-scotland.gov.uk/uploads/docs/report/2021/nr_210117_nhs_overview.pdf

¹⁶⁵ https://www.gmc-uk.org/-/media/documents/somep-2020_pdf-84684244.pdf

¹⁶⁶ https://www.gmc-uk.org/-/media/documents/somep-2020_pdf-84684244.pdf

¹⁶⁷ <https://bmascotland.home.blog/2021/09/16/chairs-update-arm-pay-and-supporting-doctors/>

¹⁶⁸ https://www.bma.org.uk/media/4670/bma-supporting-junior-doctor-wellbeing_final-publication-october-2021.pdf

workload, their wellbeing and morale. Scottish level data from that survey shows that 1 in 3 (34.5%) of doctors have said their morale has got quite a lot or far worse since the emergence of Omicron. 17.9% of docs say their morale is very low – 53.7% put their morale on the bottom two possible scores on a scale of 1-5 – where 1 is the most negative. Furthermore, the implications of low levels of morale on retention are evident with 17.5% of doctors reporting their desire to remain working in the NHS during the next year is very low/negative.^{169 170}

6.8 Pensions and Scotland

Pension taxation is a key issue in relation to the reward package for doctors. As the DDRB itself noted last year, the complexity of pensions for the most senior clinicians, alongside issues around pension taxation, have the potential to exacerbate existing issues of retention. Last year's DDRB report recommended that governments “... should also consider all options available to them to safeguard retention in the context of the changes to pensions taxation rules. This includes the practice of ‘recycling’ – paying unused employer contribution as salary to those who opt out of the NHS Pension Scheme as a result of having reached the annual or lifetime allowance”

Although pensions taxation is a reserved matter it is important to emphasise there are still ways of mitigating its impact that are within the Scottish Government's control. As the DDRB report stated, it is vitally important to look at all steps the Scottish Government could take right now to address the workforce crisis. One of the most effective initiatives at Scottish Government's disposal is to reintroduce and expand a recycling of employer contributions (REC) scheme with immediate effect and maintain this on an ongoing basis. The Welsh Government has written to NHS boards in Wales highlighting ‘pension recycling’ as a solution which should be usefully explored, and we know that a number of English NHS Trusts are currently offering a REC scheme to their staff.

We were extremely disappointed that the Cabinet Secretary's response has been that the Scottish Government does not see this as a priority and instead conflated with recent discussions around pension scheme contribution rates. Indeed, he suggested that the ability to access recycling would “send the wrong message” to other healthcare staff employed under Agenda for Change. We believe the reverse is true - Scotland must remain competitive within the UK recruitment marketplace and reintroducing a REC scheme in Scotland would send out a strong and unequivocal message that the Scottish Government wants its senior doctors to remain in the workforce for as long as they can. This alone will not be a fix-all, however offering NHS staff the ability to recycle employer contributions offers a powerful incentive to delay retirement and continue working for longer in the NHS – helping re-mobilisation and recovery of the NHS post-COVID. Introducing an ongoing REC scheme would acknowledge the challenges and pressures faced by senior Scottish doctors and provide a readily available solution to improve morale.

A recent BMA survey of doctors in Scotland again shows that pensions taxation is one of the major factors causing doctors to either retire early or reduce their hours, and that the current taxation system is unfair and punitive to doctors working in the NHS. Alongside workload, the impact of

¹⁶⁹ <https://www.bma.org.uk/bma-media-centre/nhs-in-perilous-state-as-omicron-hits-workforce-and-delays-care-for-millions-of-patients-bma-survey-finds>

¹⁷⁰ <https://bmascotland.home.blog/2022/01/14/the-impact-of-omicron-on-doctors-ppe-testing-and-mental-exhaustion/>

pension taxation is one of the biggest drivers of GPs opting to reduce their sessional commitment or to no longer undertake work in Out of Hours services, exacerbating the particularly difficult recruitment challenges they face.

We have stressed to the Scottish Government that we are keen to work with them to establish an open-ended REC scheme which is attractive to the full range of doctors and other senior NHS staff who might otherwise need to retire early or reduce their NHS commitments.

The consultation on proposed changes to member contributions to the NHS Scotland pension scheme from 1 April 2022 has still not been published in Scotland. The parallel consultation taking place for the England and Wales scheme has already closed, and the consultation on the HSC pension scheme in Northern Ireland is due to close on 31 January. We are concerned about the delay to publishing the consultation in Scotland, particularly if the final proposals result in higher pension contributions for doctors in Scotland compared to the rest of the UK

6.9 Equality, Diversity, and Inclusion

We recognise the Gender Pay Gap in Medicine Review in England¹⁷¹ and publication of its report and recommendations in 2020, and now look to progress of the Implementation panel. The DDRB report 2021 stressed the need to address the Review's observations and recommendations was critical for protecting the future of the medical workforce not only in England, but in Scotland and the other devolved nations. Furthermore, in parallel to that the need for action to address other issues of diversity and inclusion. We welcome the DDRB's reporting¹⁷² of the Scottish Government working to address gender pay gaps in all sectors and that it was considering the Review's findings and applicability to NHS Scotland. We would like to hear further on the Scottish Government's progress in this area, given the lack of reporting of progress on this to date.

We want to draw attention to key findings from a BMA report on 'Sexism in Medicine'¹⁷³ which shows that there are concerning levels of sexism and gender-based discrimination in NHS Scotland. Over 70% of Scottish respondents reported that they think there is an issue of sexism in NHS Scotland, with more than half of respondents reporting that the main drivers of that were due to the structural and institutional factors that disadvantage women. Over 65% said that they believe that sexism has acted as a barrier to career progression.

As we highlighted earlier in this submission, there is a clear need for better data on the link between gender and income across the NHS, such as to understand the extent to which the substantial difference between male and female salaried GP average earnings is simply a reflection of a difference in hours worked or an indication that female salaried GPs are being disadvantaged.

Last year's DDRB report welcomed the work that is underway to address race inequalities in the NHS in England and asked for that similar progress to be made in Scotland, Wales and Northern Ireland. This would mean that increased rates of bullying and harassment and differences in staff experiences are addressed and steps taken to improve the health and wellbeing of staff, including

¹⁷¹https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/94424/6/Gender_pay_gap_in_medicine_review.pdf

¹⁷²https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/100503/DDRB_2021_Web_Accessible_v2.pdf

¹⁷³<https://www.bma.org.uk/media/4492/sexism-in-medicine-bma-report-august-2021.pdf>

through providing additional support for ethnic minority doctors. We know that doctors from Black and Ethnic Minority (BME) backgrounds are less likely to agree that they are supported, often treated as ‘outsiders’ in the workplace.¹⁷⁴ As noted above, we support ethnicity pay gap analysis as well as pay reporting based on gender and income. More granular data and analysis on ethnicity is needed to establish experiences and working patterns of staff from different ethnicities.

7. Wales

BMA Cymru Wales submits its evidence to the 50th DDRB report following another highly disruptive year for the Welsh NHS due to the continuation of the coronavirus pandemic. The vaccination programme in Wales – testament to the dedicated hard work of all NHS staff, not least those in general practice who were instrumental to the programme’s success – allowed for a return to some degree of normality. Elective work has resumed and the BMA has worked with Welsh Government, NHS organisations and other trade unions to begin to introduce mechanisms to help with tackling the backlog of procedures.

That said, it would be a mistake to consider the 2021/22 pay year a ‘return to normality’. Indeed, rates of burnout and work-related stress are high and doctors increasingly report their intentions to leave medicine entirely as a result. The extreme pressures the NHS in Wales faces has been revealed in the widely reported pressures in urgent care and conditions reported at the Grange University Hospital in Aneurin Bevan University Health Board.

As noted in other sections of our submission, the cost of living is increasing rapidly, which must be taken into account in the DDRB’s recommendations. In Wales, this is particularly driven by the rapid increase in house prices. Between September 2020 and September 2021, house prices in Wales increased by 15.4%.¹⁷⁵ This is the highest increase of any area of the UK, with significant increases seen in the coastal and rural areas that are already hard to recruit to. For the first time ever, the average house price in Wales is now above the affordability criteria for the majority of foundation doctors, or even those at higher training grades.¹⁷⁶ This will have a further impact on the ability to recruit to these areas if doctors, particularly junior doctors choosing where to train, face challenges affording housing.

The problems facing the NHS in Wales make it absolutely clear that the safety of patients is underpinned by the wellbeing of staff. Now more than ever, it is vital that the DDRB recognises the need for an adequate pay award for doctors in Wales that recognises the challenges faced by the NHS, the unprecedented increases in living costs that our members face, and the pressing need to ensure adequate recruitment and retention of doctors given the vital role they will play in the

¹⁷⁴ https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf?la=en&hash=058EBC55D983925E454F144AB74DEE6495ED7C98

¹⁷⁵ UK House Price Index summary, September 2021. <https://www.gov.uk/government/statistics/uk-house-price-index-summary-september-2021/uk-house-price-index-summary-september-2021>

¹⁷⁶ Calculated based on FY2 doctor working full-time, earning £31,708 with a 50% banding supplement, i.e. band 1a or 2b. Excluding banding, which many mortgage companies will not accept as evidence of income, a junior doctor would require an income equal to basic pay under the 5th spinal point of the specialty registrar scale.

recovery following the pandemic – in 2022/23 and beyond.

7.1 BMA Wales response to 49th DDRB report

BMA Cymru Wales provides its submission to the DDRB following another year of sub-inflation pay awards provided in 2021/22. In advance of the 49th DDRB report, the Welsh Government stated that it would follow the report's recommendations. The report recommended a 3% uplift to all grades. With inflation reaching as high as 7% this year, the reward did not reflect ongoing increases to the cost of living, nor the significant erosion in pay that has been caused by multiple years of sub-inflationary pay rises.

Welsh Government confirmed upon publication that it accepted the recommendations of the DDRB report in full. However, we were disappointed that this did not prove to be the case. Whereas the DDRB recommended that 'recognising the contribution [doctors on multi-year pay awards] have made to the pandemic response is extremely important, and we would urge ministers to consider this',¹⁷⁷ in its initial response to the DDRB the Welsh Government chose not to recognise the contributions of SAS doctors who wished to move to the new specialty doctor or specialist contracts. This led to a difficult scenario where specialty doctors were in fact paid more to remain on their old contract than if they moved to one of the new ones. This was only solved after protracted discussions, detailed below.

Additionally, Welsh Government linked the pay award for partner GPs and salaried GPs (and by extension, practice staff) to contractual changes around prevention and GP access within the Welsh GMS contract negotiations. The process this year was rather protracted due to intense negotiations around these elements, ultimately resulting in a significant delay to the pay award to general practice. Whilst we fully appreciate the nature of the GMS funding envelope meaning that pay and expenses originate from the same budgets, this conflation is entirely unacceptable to us. We have made it clear to Welsh Government that the pay award and contractual change should be decoupled in future negotiations and would welcome the DDRB's support in this matter.

As in our response to the 2020/21 report, we are deeply unhappy that both the DDRB and the Welsh Government continue to freeze commitment award payments alongside clinical excellence awards for consultants. Whilst we recognise the need to address gender pay gap concerns and have welcomed discussions on innovative ways to do this, including through pay reform, we again reiterate that the commitment award is a manifestly different element of pay which is comparable to an extended pay scale and, to all intents and purposes, an element of basic pay rather than performance-related pay. We do not accept the argument that this award contributes substantially to the gender pay gap and it should not be regarded in the same light as clinical excellence awards.

7.2 NHS Wales in 2021

The crisis in unscheduled care, which was already under sustained pressure before the Covid-19 pandemic and has since deteriorated significantly, continues to develop. Ambulance waiting times have hit the highest levels since records began this year, with demand continuing to rise. In October

¹⁷⁷ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005003/DDRB_2021_Web_Accessible_v2.pdf

2021, average response times for life-threatening calls rose above 8 minutes.¹⁷⁸ In a recent BMA member survey, 95% of respondents in Wales described a delay in an urgent ambulance callout to them or their GP practice, by far the highest of UK nations surveyed.¹⁷⁹

In A&E departments, a record low number of patients were seen within the 4-hour target or discharged within the 12-hour target. Average stays in emergency care are at their highest levels since comparable records began.¹⁸⁰ These issues have been heavily publicised in the Welsh press.

In elective care, as is the case across the UK, the appointment backlog is severe. The number of patients waiting for diagnostic tests remains very high, and the number of patients waiting for therapies has increased throughout 2021 and is at its highest level since 2017. By September 2021, almost 670,000 patients were waiting to start treatment – the highest in comparable data. Although some improvements in closed patient pathways and treatment target times has been seen in recent months, this recovery is at its very early stages and the situation remains severe.

At the same time, the pressure on beds in secondary care remains very high. Bed occupancy rates hover around 90%¹⁸¹ and 85% of BMA members in Wales report increased delays in discharging patients in the last year, the highest level of UK nations surveyed.¹⁸² As a result, Welsh hospitals increasingly lack capacity to cope with surges in demand at times of high pressure. 85% of members report higher concerns regarding delays causing avoidable harm for patients than a year ago.

In primary care, our members report similar pressures. In a recent survey, GP members in Wales reported significant increases in patient contacts and increased pressure partly as a result of virtual working.¹⁸³ 82% of respondents said that remote consultations have increased their overall number daily contacts. Only 6% of GP respondents say that their workload is manageable and allows them to provide quality and safe care to patients. Worryingly, 30% say their workload is excessive and that they feel it significantly prevents them from providing quality and safe care to patients.

7.3 Staff morale

The extreme pressures under which doctors are working has had a direct impact upon their morale and wellbeing. 72% of members described themselves as feeling extremely or quite anxious about the approaching winter months.¹⁸⁴

Members report significant increases in the intensity and length of their working days. 54% reported an increase in overall daily patient contacts, 75% reported an increase in the number of complex patients and 63% reported an increase in the length of the working day. This is having a clear knock-on effect on wellbeing, with 76% reporting an increase in stress of meeting patient expectations and

¹⁷⁸ NHS activity and performance summary, September and October 2021. <https://gov.wales/nhs-activity-and-performance-summary-september-and-october-2021-html>

¹⁷⁹ Excluding those who reported 'Don't know'. BMA member viewpoint survey, November 2021

¹⁸⁰ NHS activity and performance summary, September and October 2021. <https://gov.wales/nhs-activity-and-performance-summary-september-and-october-2021-html>

¹⁸¹ <https://stats.wales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/nhs-activity-and-capacity-during-the-coronavirus-pandemic/nhsbed-by-date-use>

¹⁸² Excluding those who reported 'Don't know/not relevant'. BMA member viewpoint survey, November 2021

¹⁸³ BMA UK GP survey, September 2021. Analysis is of Welsh respondents.

¹⁸⁴ BMA member viewpoint survey, November 2021. Analysis is of Welsh respondents.

80% reporting an increase in feelings of tiredness at the end of the day.

The demands on the health service have unsurprisingly led to an increase in worked hours by our members beyond those for which they are contracted. It is of particular concern to us that Welsh members reported the highest occurrence of any nation surveyed of pressure being exerted by their employer for them to work additional hours, with over half reporting this to a significant or slight extent.

It is also clear that a large proportion of the additional hours being performed to provide this care are unpaid, with 48% of respondents reporting this. This is despite us negotiating a series of national agreements on pay for overtime work during the pandemic and recovery period, covering junior doctors, SAS doctors and consultants. It has long been our assertion that junior doctors in particular lack an effective method to track and report their overtime work and to receive fair remuneration for this.

All the pressure described above has impacted the mental health of the medical workforce in Wales. Well over 50% of members reported that they were suffering from depression, anxiety, stress, burnout or another mental health condition made worse by their work, with 38% reporting this having worsened in the previous month.

Two things must occur to improve the dire state of medical staff morale in Wales. Doctors must receive a considerable and sustained increase in pay to adequately reward the innate pressure and responsibility of their roles, which will remain heightened for years to come as we recover from the coronavirus pandemic. Secondly, Welsh Government must significantly increase the number of doctors in Wales and properly record and address the vacancies which exist across the workforce.

7.4 Staffing levels

We have been clear for a number of years that at the heart of the crises facing the NHS in Wales lies the dire need for more staff. The colossal backlog facing the medical workforce in the wake of the coronavirus pandemic only exacerbates this issue. With morale already weak and burnout high, the health service could soon face acute staffing issues if measures are not taken.

Recently published figures have demonstrated the critical state of staffing levels in Welsh A&E departments. According to the figures, every single one failed to meet safe staffing levels set by the Royal College of Emergency Medicine for the number of WTE consultants. Indeed, currently none of the hospitals is even close to meeting this baseline.¹⁸⁵

Over 75% of respondents to a recent BMA survey of consultant members in Wales believed that medical vacancies in their department have a detrimental impact on patient care to some extent.¹⁸⁶ Two-thirds (67%) report that medical vacancies in their department have a detrimental impact on their own well-being. Over one-third (36%) disagree to some extent that efforts are made to recruit to vacant posts quickly in their department. Over two in five disagree that additional measures to address the shortage are taken where there are difficulties recruiting to a vacant medical post.

¹⁸⁵ <https://www.walesonline.co.uk/news/wales-news/hospital-consultants-wales-nhs-22521669>

¹⁸⁶ BMA Cymru Wales consultants workforce survey, May 2021

Where we were successful in obtaining information on consultant vacancies from health boards, it became clear that the health service is increasingly relying on locum appointments to fulfil service needs. This information was acquired through Freedom of Information requests to each health board and is incomplete. However, in health boards that reported even partially reliable data, vacancy rates in consultant posts varied between 12% and 48%.¹⁸⁷

7.5 Workforce data availability

Of significant concern is the continued lack of official, central data collected and published in Wales on medical vacancy rates. For a number of years, we have repeatedly called on the Welsh Government to return to routinely publishing vacancy data across secondary care. We see the creation of a reliable and standardised workforce dataset as a necessary priority and remain deeply disappointed this has still not been addressed. The Welsh Government should build on the workforce reporting system for primary care by making secondary care workforce vacancy data available in the public domain.

Currently, we find that we are only able to acquire vacancy data within secondary care by submitting Freedom of Information requests to Welsh health boards and trusts. Often the data we received in response is incomplete, notwithstanding the fact that different organisations use different definitions to determine what counts as a vacancy, making comparisons between different NHS employers across Wales practically meaningless. No definition provided by any health board suggested a comprehensive workforce planning strategy behind the definition and identification of vacancies.

For doctors in training, vacancies should more clearly identifiable, being the difference between the identified and funded training posts advertised by HEIW and the doctors enrolled to a training programme who fill those posts. However, from a workforce perspective, rota gaps are arguably a more relevant measure, being the difference between the number of identified slots on junior doctor rotas (some, although not all, of which are also allocated as training posts) and the employed workforce on that rota. Although there is substantial anecdotal evidence of the widespread use of locum labour and local appointments to plug gaps in service need in the absence of full recruitment to training posts, again, without accurate and up-to-date publicly available data provided by the Welsh Government, it is difficult to hold an informed discussion about this issue.

Without accurate data, it is impossible to determine the scale of the problems caused by vacancies or to plan for workforce needs in the medium to long term. It is difficult to measure the effects of new models of care and national workforce policies aimed at increasing preventative care within primary and community care settings without accurate data. We continue to urge the Welsh Government to begin accurate recording of medical vacancies to allow proper analysis of staff shortages to inform workforce planning.

7.6 Pension mitigations

We welcomed Welsh Government's decision in 2019/20 to enable health boards and trusts to offer flexibilities that can, to an extent, mitigate punitive tax charges impacting senior doctors in recent

¹⁸⁷ Information requests on consultant vacancies in Welsh health boards, June 2021.

years for breaching annual allowance or lifetime allowance limits imposed by the UK Treasury, including by allowing employers to pay employer contributions as additional salary for those who have opted out of the pension scheme. This means employees who opt out of the scheme to avoid these significant tax charges don't then miss out to the full extent on contributions their employers would have otherwise made to their pensions, noting that these contributions constitute a clear part of their overall reward package. We therefore welcomed Dr Andrew Goodall's communication to NHS chief executives and workforce and OD directors in October 2021 making it clear they are again able to offer these flexibilities.

We previously made clear that these issues continue to impact on many of the more senior and more experienced doctors we wish to retain within the NHS in Wales, leading in many cases to them considering retiring earlier or reducing their willingness to undertake additional work such as taking part in much-needed activity under waiting list initiatives. In our survey of consultants, of those who wished to work fewer hours, 35% wanted to reduce pension-related tax liabilities. When asked what would encourage them to stay in the workforce longer or retire later than planned, an overwhelming 60% of respondents responded that changes to the annual or lifetime allowance would be necessary.

It is obvious that continued decisive action by Welsh Government and health boards to support retire and return principles and allow pension mitigations is essential to maintaining a stable senior workforce. We also call for further expansion of the pension recycling scheme to include the 6.3% of employer contributions that are paid directly into the England and Wales NHS Pension Scheme by the UK Government, as this also forms part of the total reward package. This portion of the employer contributions is currently not accessible by the Welsh Government or NHS employers in Wales, so is not able to be offered by them as additional pay for those who have opted out of the pension scheme. They are currently only able to offer the 14.38% contribution which is paid by the Welsh Government.

7.7 Pay erosion

Since the financial crisis in 2008, doctors have experienced repeated pay freezes, pay caps and sub-inflationary pay uplifts, all at a time when inflation has run much higher. According to the ONS, as of December 2021, the year-on-year rate of CPI (consumer prices index) inflation is currently 5.4 per cent, whereas RPI (retail prices index), which we believe better reflects the costs facing doctors, currently sits at 7.5 per cent.¹⁸⁸

We wish to emphasise to the DDRB that doctors in Wales, and across the UK, have faced an unprecedented decline in their real terms pay. The representative examples below, covering the period between 2008/9 and 2021/22, highlight the significant extent of the real decline in pay for doctors.

¹⁸⁸ <https://www.ons.gov.uk/economy/inflationandpriceindices>

	Pay in 2008/09 (cash terms)	Pay in 2021/22 if kept pace with RPI (real terms)	Actual pay in 2021/2022 (cash terms)	Pay shortfall in 2021/22	Real pay erosion
Consultant (pay point 6)	£92,357	£129,947	£106,920	£23,027	17.7%
Specialty registrar (pay point 2)	£33,226	£46,749	£38,851	£7,898	16.9%
FY2 doctor (minimum point)	£27,116	£38,152	£31,708	£6,444	16.9%

Figure 1. Pay decline of doctors in Wales across branches of practice between 2008/09 and 2021/22.

This situation clearly cannot continue. Alongside unprecedented workforce pressures, failure to address years of pay erosion represents one of the greatest risks to the NHS in Wales in maintaining the medical workforce it needs. We therefore are calling for a significant pay award that, as well as addressing high inflation, also begins to address the real terms pay erosion outlined above.

7.8 Key asks

In light of the economic context that we have outlined elsewhere in our evidence and the conditions in which our members are working in Wales which we have summarised above, BMA Cymru Wales are joining the rest of the BMA in calling for a substantial uplift to pay of RPI + 2% for the entire medical workforce in Wales this year.

We call for the pay award for 2022/23 to cover all pay elements and awards doctors receive, not simply basic pay, and in particular call for the DDRB to recognise the difference between the commitment award and CEAs and to explicitly recommend an uplift to the commitment award accordingly. Continued freezing of the commitment award is direct and deliberate erosion to consultant pay in Wales and will do nothing to address the equalities concerns that Welsh Government and the DDRB purport to hold. Given progress made this year in Wales in reforming the CEA scheme, we also request the DDRB recommend an uplift to this award.

Whilst we recognise that specialty doctors on the 2021 contract and specialist doctors are subject to a multi-year pay deal, we call upon the DDRB to consider this in the context of its wider recommendations on pay and to again urge the Welsh Government to consider further pay uplifts to these doctors if required to ensure they maintain parity with their peers.

In the sections that follow, we provide further detailed information on our specific requests for each grade, as well as other information we ask the DDRB to consider in its recommendations.

7.9 General practice

7.9.1 Workforce

99.5% of GP practices in Wales input data into the National Workforce Reporting Service (NWRS), a system operated by NHS Digital. Headline data from this system is reported periodically via Welsh Government's data release process; however, there has been no detailed trend analysis in the public

domain since the statistical release of July 2020.

The number of GPs working as sessional locums has steadily increased over the last several years, with 635 GPs declaring their primary work as a locum in 2015 and 828 locums registered on the All-Wales Locum Register in September 2020. However, this headcount data fails to take into account the changing working patterns amongst GPs. The WNWRS report from July 2020 notes that data on GP work patterns has not been reported, even though information on GP Whole Time Equivalent (WTE) is gathered, due to the need for data validation.¹⁸⁹

We suggest that this data will further evidence the increasing trend toward portfolio working amongst GP practitioners of all ages, with many GPs opting to reduce their number of sessions in practice in favour of other roles. Our own research reveals that when asked where they see themselves professionally in three years' time, just one-third (34%) of GP respondents said they would be working as a GP partner, while a further one in three (34%) said they will no longer be working as a GP at all.¹⁹⁰ It is clear that the stresses and pressures of the job right now are so high that many GPs are considering their futures. Not doing so will lead many to burn out completely.

This trend needs to be considered alongside the fact that Wales has the oldest GP workforce compared to other UK nations. According to data from the General Medical Council register, 23.9% of GPs in Wales are 60 years old and over, compared to an average of 19.5% elsewhere.¹⁹¹ This presents a clear sustainability challenge for independent contractor practices in Wales and emphasises the need for a sustained increase in GP trainee numbers, as well as contractual measures to reduce workload pressures in order to retain the most experienced. The retention of the seniority scheme for existing members in Wales assists to this end, much in the same way as the introduction of partnership premium scheme in 2019 aids in recruitment.

All this demonstrates that there is significant work to be done to increase the attractiveness of general practice medicine to ensure its sustainable future in Wales. A key component of this has to be recognising the vital work done by general practitioners and correctly rewarding this through a substantial pay rise.

7.9.2 Access and demand

General practice has rapidly, and rightly, changed its working patterns in order to cope with the national emergency caused by the COVID-19 pandemic, and demand on general practice for routine care has changed. Practices are expected to continue to provide routine care arrangements, while retaining the telephone first triage model which was brought in at the beginning of the pandemic according to Welsh Government regulations and guidance.

82% of respondents to our recent survey of GP members in Wales said that remote consultations have increased their overall number daily contacts, with over half (54%) saying that remote consultations have enabled longer lengths of patient contact.¹⁹² With 99% of GPs having personally undertaken remote consultations, the responses suggest that doctors are engaging with more patients and for longer periods of time than was the case in the past.

¹⁸⁹ <http://gov.wales/sites/default/files/statistics-and-research/2020-07/general-medical-practitioners31-march-2020-716.pdf>

¹⁹⁰ BMA UK GP survey, September 2021. Analysis of Welsh respondents only.

¹⁹¹ GMC data explorer, <https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report>

¹⁹² BMA UK GP survey, September 2021. Analysis of Welsh respondents only.

However, despite this, 61% of respondents rated their personal and professional wellbeing as poor, with responses revealing a worrying level of abuse directed at doctors and their colleagues as they deal with the greatest health crisis in a generation. 70% said they had experienced verbal abuse at work and 85% said they had witnessed verbal abuse directed at staff in the workplace. Worryingly, 8% said they had witnessed physical abuse directed at staff in the workplace.

Only 6% of GP respondents said that their workload is manageable and allows them to provide quality and safe care to patients. 30% said their workload is excessive and significantly prevents them from providing quality and safe care to patients. 41% of GP partners reported that the roles and responsibilities of being a partner are excessively onerous, with an additional 34% saying that the role is too onerous such that they wish to explore alternative working options.

Similarly, increased waiting lists for secondary care treatment are also having a severe impact, with 74% of respondents citing it as a reason for the increase in their workload. This includes patients often calling their GP in an attempt to find out about or prioritise their expected treatment. 62% of respondents also say an increase in requests from secondary care services for them to do tests has led to an increase in workload. This contravenes the All-Wales Primary-Secondary Care Communication Standards.

Reducing the increased workload GPs in Wales are facing must be a priority if we are to effectively navigate the challenges posed by the effects of the pandemic. GPs themselves are best placed to identify measures to achieve this as a means to ensure that more GPs remain in the profession for longer due to a more manageable and sustainable workload.

7.9.3 Contract

After protracted negotiations, the Welsh GMS contract agreement for 2021/22 was concluded in November 2021.¹⁹³ The contract implementation group is currently working through relevant contractual guidance with a view to issuing this early in 2022. The financial agreements, to be implemented in the next pay run and backdated to April 2021, were:

- An uplift of 3% to the GP pay element of the contract, fully meeting the DDRB recommendation but unfortunately tied by Welsh Government to wider contractual change, resulting in a delay in the payment of the increase.
- Investment of £4.8m to fund a 3% uplift to pay for all practice staff including salaried GPs. This will be a contractual requirement for this year and will see all existing GMS staff receiving a 3% uplift to their gross pay, in recognition of the vital role they play in the delivery of GMS.
- Continuation of the incentivised Access Standards QAIF system, with a new phase beginning 1 April 2022 alongside a tripartite *Access Commitment*.
- Outside of the direct practice allocation, a further £2m capacity fund over the coming winter accessible to practices via health board. This will increase to £4m from 1 April 2022 and will be recurrent for three years.

Further workforce measures were agreed, namely securing funded protected learning time sessions for all practice staff, allowing reimbursement for independent prescriber cover under the SFE, and enabling enhanced shared parental leave for salaried GPs.

¹⁹³ <https://gov.wales/written-statement-general-medical-services-gms-contract-reform-2021-22>

Additionally, a new phase of the Partnership Premium scheme will be open for non-GP partners, recognising the vital role these individuals play in the sustainability of independent contractor GP practices. This investment in the partnership model is to be welcomed; our recent FOI requests into the costs of directly Health Board managed practices between 2018 and 2021 demonstrated that they are far more costly to operate in comparison.¹⁹⁴ When calculated on an all-Wales basis, £31.98 of additional funding was spent per patient registered at managed practices compared to what the global sum funding allocation would be, underlining the incredibly good value GMS represents to the Welsh public compared to alternative models.

We have agreed on a wide ranging and ambitious contract reform programme alongside Welsh Government and NHS Wales, recognising that the 2004 GMS contract may not adequately represent what general practice is in 2021. Under this programme, several task and finish groups have been established to determine the nature of essential services provided by all practices versus more specialist services, and the assurance measures required from any new contract. Subject to negotiation of proposals and subsequent approval by the profession and government, any new contract would begin from 1 April 2023. However, we anticipate discussions for the 2022/23 year will be required whilst this work proceeds, particularly around the financial elements of the contract.

7.9.4 Request

We would welcome a recommendation from the DDRB in relation to pay for contractor GPs, and salaried GPs which addresses the significant workload and morale pressures facing primary care in 2022. Whilst the DDRB ceased officially making recommendations with regard to the expenses element of the GP contract as of 2016, in recent years it has partially strayed into this area by endorsing the agreed GP staff pay uplift from the 2020 Welsh GMS contract negotiations. Staff pay is of course considered part of expenses by practices. This arrangement was repeated in the 2021 negotiations with a 3% uplift to staff gross pay successfully agreed. As such, we would not oppose DDRB's further consideration of this area.

As an association we see the linkage of contractual change to the pay award within Welsh GMS contract negotiations by Welsh Government as inappropriate. We have made our view clear to Welsh Government that these should be decoupled in future negotiations and would welcome DDRB's support.

7.10 Public health medicine

Public health consultants have been at the forefront of the national response to the pandemic. These professionals should be rightly rewarded for their work. However, medical and non-medically qualified public health consultants current receive different pay as a result of being on different contracts (the 2003 consultant contract and the Agenda for Change contract respectively). This puts early career medical public health consultants at a disadvantage to those who are non-medically qualified, with significant pay differentials until the fourth year of employment and continued disparities in the fifth and sixth years. Indeed, excluding commitment award payments, the top of

¹⁹⁴ BMA Cymru Wales analysis of Freedom of Information requests to Health Boards on managed practices, 2018-2021

the scale is higher for those on the Agenda for Change pay scale than those on the consultant pay scale.

Years of experience	Agenda for Change (band 9)	2003 consultant contract
Min	£93,735	£82,356
1	£93,735	£84,979
2	£93,735	£89,366
3	£93,735	£94,459
4	£93,735	£100,278
5	£108,075	£103,596
6	£108,075	£106,920

Figure 2. Comparison of pay progression of public health consultants on non-medical and medical TCS.

This is a concern to us on the basis of equal pay and recruitment at a consultant and junior doctor level. Therefore, we request that the DDRB provide a specific pay recommendation around medical public health consultant pay that addresses this disparity.

7.11 Junior doctors

7.11.1 Workforce and training

2021 was another year where the ongoing coronavirus pandemic caused significant disruptions to training. Although the impact was perhaps less than last year, ongoing service pressures has resulted in further missed training opportunities, delays and inconveniences for doctors in training. Previously negotiated arrangements for management of emergency rotas, annual leave rollover and study leave rollover remained in effect where necessary, ensuring consistent standards for trainees across Wales.

Publicly available statistics reveal junior doctor workforce number to be at an all-time high both in terms of headcount and FTE.¹⁹⁵ We note also that HEIW report near 100% fill rates for training posts in many specialties and in foundation school. However, workforce data also reveal that the FTE per headcount shows a slight, although sustained downward trend for all groups except FY2. This reflects the increasing number of trainees who choose to train less-than-full-time (LTFT), often in order to balance caring and other commitments alongside work, or, increasingly, to manage burnout and work-related stress.

We have welcomed recent progress in this area from HEIW, who have made efforts to support flexible training requests from trainees, including by introducing the category 3 LTFT definition, significantly expanding access to LTFT training. However, HEIW, health boards and Welsh Government need to take this trend into account in workforce planning and service delivery considerations, as well as in the contractual provisions and remuneration of junior doctors.

¹⁹⁵ <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Medical-and-Dental-Staff/hospitalmedicalanddentalstaff-by-grade-year>

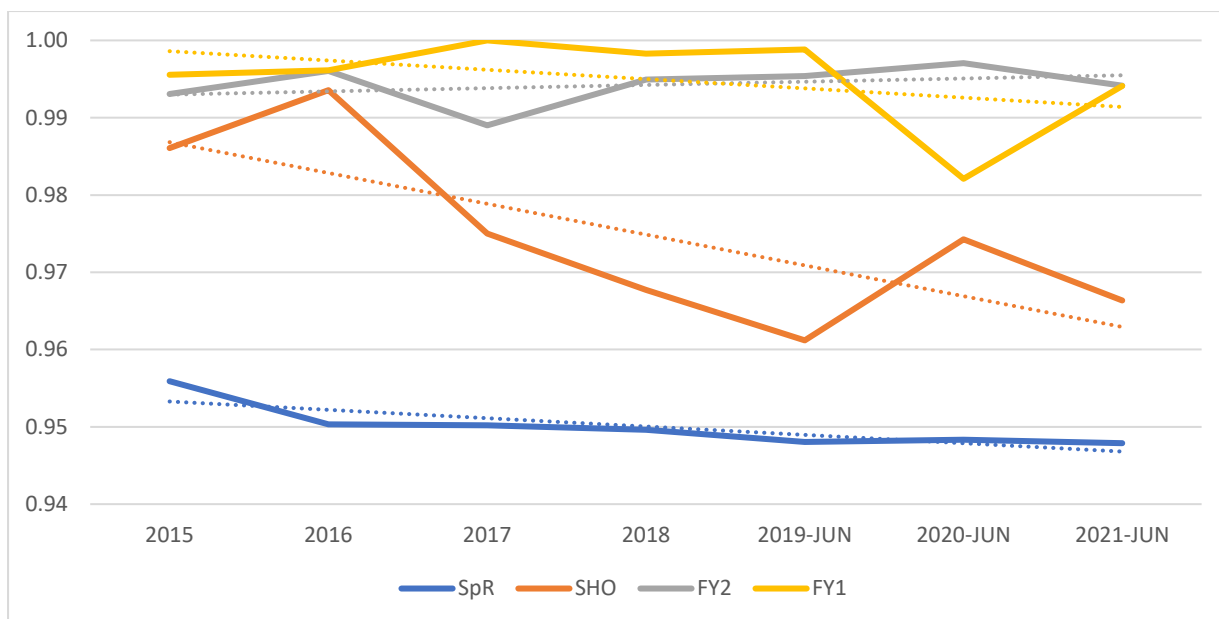


Figure 3. Average FTE per headcount of doctors in training in Wales between 2015 and 2021 (source: StatsWales).

7.11.2 Contract reform

BMA Cymru Wales has been in discussions with NHS Wales Employers and Welsh Government on reforming the junior doctor contract since March 2020. These discussions are well advanced. At the time of writing, we are awaiting a mandate from the Minister for Health and Social Services to enter formal negotiations on outstanding areas.

Although the contents of these discussions are confidential and beyond the purview of the DDRB, we would like to state our position as to what we believe are the necessary components of an attractive pay arrangement for doctors in training in Wales. With around one-third of training posts vacant, clearly the recruitment and retention of doctors in training needs to be a primary focus for all stakeholders in Wales.

Primarily, pay must be fair and attractive. It must recognise the actual work that trainees do and it must be flexible enough to recognise the unique experience that each trainee can bring to their job. All trainees are more than the specific role that they fill and their professional histories and training pathways should be taken into account in their remuneration.

This must include recognition of the value – both to the wellbeing of the trainee and to the vibrancy and diversity of the workforce – of flexible training, including out-of-programme experiences and other contributions to the Welsh NHS, as well as less-than-full-time training. We have welcomed many recent developments to welcome those who desire to train flexibly to Wales and it is absolutely vital that this is also recognised in the pay arrangements for doctors in training in the future.

9.11.3 Request

It is hoped that discussions on a new contract deal will conclude during 2022. However, it is certain that, for at least some (if not all) of the 2022/23 pay year, junior doctors in Wales will remain on

their existing terms and conditions and pay scales. Therefore, we request that the DDRB provides a recommendation on the pay award for doctors in training in Wales.

7.12 Staff, Associate Specialist, Specialty, and Specialist (SAS) doctors

7.12.1 Contract implementation

In February 2021, BMA members from the SAS grades in Wales voted to accept the new 2021 specialty doctor contract and specialist grade contract. These were consequently introduced in April 2021 and we have been working in partnership with Welsh Government and NHS Wales Employers to implement the new contracts since then. As part of this work, we have communicated regarding the choice exercise, where existing SAS doctors can choose to transfer to the equivalent new contract to their existing grade.

The 49th DDRB report noted that:

For those that we have not been asked to make recommendations for, we would stress that recognising their contribution during this period, as well as responding to the impact of the pandemic on them personally and on recruitment, retention and motivation, is as important as it is for other groups. Recognising the contribution they have made to the pandemic response is extremely important, and we would urge ministers to consider this.¹⁹⁶

We were sorely disappointed therefore that the Welsh Government chose not to heed this advice and offered no pay uplift to the new specialty doctor and specialist pay scales. This had the indirect effect of making the closed 2008 specialty doctor contract pay scale higher at almost every pay point than the new 2021 specialty doctor contract pay scale.

This had the effect of disincentivising existing specialty doctors from expressing interest in transferring to the new contract, despite significant long-term benefits for many in doing so. In order to mitigate this in Wales, we lobbied Welsh Government to provide a pay award for the new specialty doctor contract pay scale equivalent to that awarded to those on the 2008 contract.

This resulted in a pay continuity agreement, which ensures that any specialty doctor who transfers from the 2008 to the 2021 specialty doctor contract in Wales will benefit from either a higher salary on transfer or maintenance of their basic pay at the rate they were paid on their old contract. This will continue until 31 March 2022 for most pay points and until the doctor's 2022/23 pay progression date for a select few.

Although we consider this agreement to be a good result for specialty doctors in Wales, which ensures that these doctors are able to enjoy the benefits of the new contract without short-term financial penalty, it would have been unnecessary had the Welsh Government heeded the advice of the DDRB in the first place.

For 2022/23, we request therefore that the DDRB takes into account the effect of the general pay recommendation on the pay scales of the SAS contracts subject to a multi-year pay deal in Wales

¹⁹⁶ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005003/DDRB_2021_Web_Accessible_v2.pdf

and make a direct recommendation on a supplemental pay award for those on these contracts if appropriate to ensure parity of reward with other grades.

7.12.2 Specialist grade

The introduction of the new specialist grade represents, for the first time in over 10 years, the possibility for career development within the SAS grades. As such, we welcome its introduction wholeheartedly. We are pleased to have heard that the first specialists in Wales have been appointed.

We anticipate that where an associate specialist moves, resigns or retires they will be replaced by a specialist post. However, there has been a sustained decline in the number of associate specialists in Wales for many years, as illustrated below. In this time there has been a commensurate increase in the number of specialty doctors. It is unlikely that the service need for associate specialists reduced significantly in this time, and we therefore believe that there is a case for an immediate increase in the number of specialist posts to better support service provision as well as to provide further opportunities for recognition of talent for current specialty doctors. We urge Welsh Government and health boards to undertake this workforce planning to maximise the potential use of the new grade.

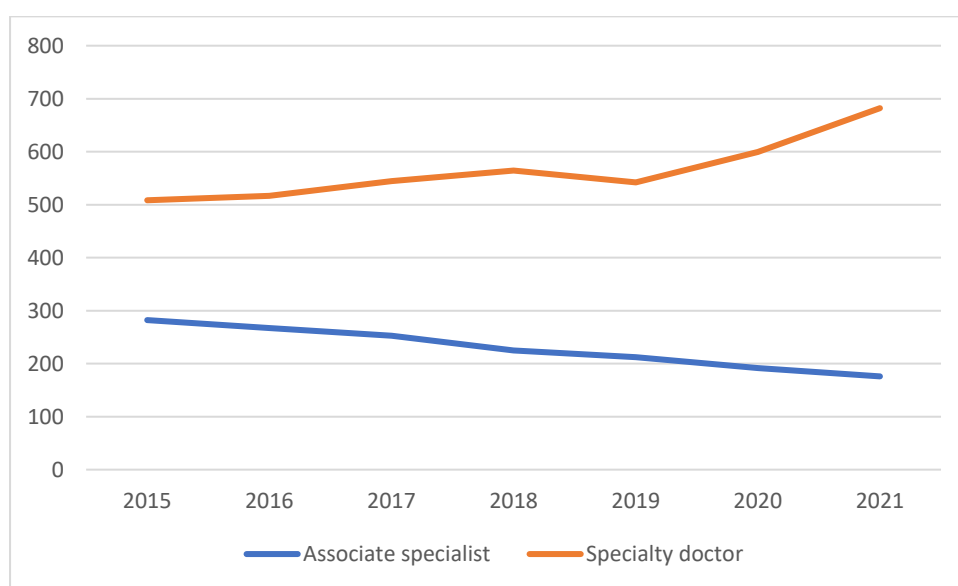


Figure 4. Headcount of Associate Specialist and Specialty Doctors between 2015 and 2021 (source: StatsWales).

We wish to highlight the issue currently presented for highly skilled specialty doctors who are at the top of the pay scale. Without any formal contractual means of regrading or progressing directly from the specialty doctor grade to the specialist grade, there is the risk that dedicated specialty doctors could be working at a senior level of responsibility and competence without appropriate recognition and remuneration. This also means employers have little incentive to create a specialist post for which they could apply.

This situation will not lead to the impact of retaining good, experienced doctors within the NHS in Wales. Nor will it ensure that Wales is competitive in attracting new, senior doctors where these are needed. Indeed, health boards need to recognise that the creation of specialist posts will act as a vital recruitment and retention incentive for SAS doctors from now on and they will experience

direct comparison in this regard with other NHS employers in other nations.

We are advising our members as to how they can demonstrate a workforce need for a specialist role in their team and are pleased to hear in many areas of associate specialists and consultants supporting speciality doctors in doing so. We believe the positive scope of the specialist role is considerable and that Welsh Government needs to work with employers to maximise its value as part of a wider workforce planning strategy.

7.12.3 Closed grades

We have stated above that it is important, regardless of the multi-year pay deal applicable to the new contracts, that the new SAS contracts remain competitive in pay in comparison with the closed SAS grades. This is a principle of equal pay for equal work and also in the interests of all parties that contributed to the negotiation of the new contracts.

That said, we want to make perfectly clear that this does not mean it is appropriate to withhold increased remuneration for those on the closed grades and call strongly upon the DDRB to recommend a pay increase for SAS doctors on the closed grades in line with recommendations for other grades. It is then very much in the government's interests to make the adjustments necessary to the new contract pay scales to maintain consistency and avoid the issues described above.

As part of contract negotiations, it was agreed that SAS doctors would have a choice whether to transfer to one of the new contracts. For many, remaining on their old contract made better sense, either due to their working pattern, their current pay or their future career intentions. Many would have been financially worse off by transferring but it is equally important to retain these doctors in order to maintain quality of service as it will be to attract doctors to the new contracts. We expect an uplift for those on the closed SAS grades to be included in the remit letter from Welsh Government.

7.12.4 Request

In light of the above, we request that the DDRB makes a recommendation for the pay award for doctors on the 2008 and pre-2008 associate specialist contracts, the 2008 specialty doctor contract, and all predecessor staff grade contracts. We also ask that the DDRB makes a recommendation for how the pay scales of the 2021 specialty doctor and specialist should be uplifted to maintain parity with equivalent closed grades where appropriate.

7.13 Consultants

7.13.1 Workforce

When we surveyed our consultant members on workforce issues, it was clear that vacancies were one of the major concerns. Vacancies are unevenly distributed geographically across Wales and, as noted above, are not consistently reported by health boards or by Welsh Government. Over three quarters (77%) surveyed believed that medical vacancies in their department have a detrimental impact on patient care to some extent.¹⁹⁷ Two thirds (67%) reported that medical vacancies in their department have a detrimental impact on their own well-being. That said, over one third

¹⁹⁷ BMA Welsh consultant workforce survey, May 2021.

(36%) disagree to some extent that efforts are made to recruit to vacant posts quickly in their department. Over two in five disagree that additional measures to address the shortage are taken where there are difficulties recruiting to a vacant medical post.

It is clear therefore that vacancies represent a significant challenge to the quality of service provision in Wales and have a further impact upon existing consultant workload and wellbeing. In light of the prominence of this issue it is therefore even more disappointing that we needed to issue FOI requests to each employer in order to ascertain the current vacancy levels per health board.¹⁹⁸ This data should be transparently and easily accessible.

Even when we had acquired this data, the information requests were incomplete, inconsistent and failed to provide a sufficient basis for Wales-wide collation and comparison. No two local health boards or trusts use the same definition of a 'vacancy' to measure their current workforce requirements.

For some local health boards and trusts, it was possible to determine the number of posts not filled by a permanent substantive consultant as a proportion of all posts. This provides an indicative vacancy rate, but comparison between health boards and other data collection exercises is hampered by incomplete data which is collected in different ways. Where it was possible to do this, vacancy rates varied from 12% to 48%. All health boards, to some extent, rely upon significant amounts of locum cover to meet service requirements.

7.13.2 Wellbeing and working hours

In common with all other staff groups, it is clear that the feelings of wellbeing of consultants have decreased as a result of working during the coronavirus pandemic as workload has increased. When surveyed, over three quarters (77%) said that their job changed due to COVID. Over three in five (61%) have felt pressure from their employer over the past 12 months to undertake additional sessions.

Many reported other pressures too, including from colleagues or from their own sense of duty and moral responsibility. Indeed, it is clear that the sense of motivation and duty that our consultant members feel is one of their prime motivators, rather than feelings of appreciation or adequate reward. Members cited 'guilt', 'patients need treatment, so moral reasons', 'own pressure to get work done as patients are having unacceptable waits' and 'personal responsibility' as reasons for increasing workload.

For many there is no end in sight: of those whose job had changed, four fifths (79%) said they hadn't returned to pre-COVID working arrangements. Over half (52%) said they didn't know when they would return to pre-COVID working arrangements and one in four (24%) said it would take longer than six months. Over two in five (43%) said that they had been asked to drop SPA sessions to assist with the pandemic. Over two in five were asked to not to take annual leave (41%) and to delay study leave (42%).

The impact of this is clear. Almost one in 10 (9%) have taken time off in the last 12 months as a result of work-related stress. Half of respondents (51%) aren't confident in seeking support for work related stress from their employer. Almost half (48%) think that Wales is a less attractive place for

¹⁹⁸ Information requests on consultant vacancies in Welsh health boards, June 2021.

consultants to work than five years ago.

Over one in four respondents (28%) planned to either reduce their working hours (15%) or leave the Welsh NHS altogether (13%) within the next twelve months. Of those wanting to work fewer hours, two thirds cited 'work pressures/seeking a better work life balance' as their main reason. Over two in five said they were 'winding down to retirement' and over one-third (35%) wanted to reduce pension-related tax liabilities. Of those looking to leave NHS Wales, two-thirds (62%) were planning to retire, while one third were planning to move outside of Wales.

It is neither acceptable nor sustainable that pressure, moral duty and guilt are the motivators behind significantly increased working hours for consultants. With consultants bearing a large degree of responsibility for the backlog of work following the pandemic, we are clear that proper compensation, and an adequately resourced workforce, are the only routes out of the current situation. Addressing the contractual needs of consultants, including continuing pension mitigations and resumption of pay increases for all elements of pay, are a vital part of this.

7.13.3 Contract

We are disappointed that last year once again the DDRB decided to not recommend any increase to the value of national clinical excellence awards or commitment awards. This is the third year running where these awards have been frozen (either by DDRB recommendation or Welsh Government's application of the award), which contributes directly and unacceptably to the erosion of consultant pay.

In particular, the freezing of commitment awards erodes what is ultimately an element of the basic pay scale. The word 'award' is misleading in the sense that there is no decision attached to the payment, it applies to all consultants as they progress through the pay scale in order to recognise their commitment to NHS Wales. All consultants in Wales with an appropriate length of service receive commitment awards. The continued freezing of the commitment awards does not place Welsh Government and us on a positive footing for any future pay and contract discussions and reduces the overall scope for determining a sustainable future for consultants in Wales by effectively eroding the consultant pay envelope.

The DDRB previously recommended CEAs should not be uplifted until the scheme has been reformed. We are now well advanced in agreeing a significant reform of the scheme in Wales so that a much greater number of consultants will be able to hold CEAs in future, thereby making the scheme considerably more equitable. In this context, we request that the DDRB provides a recommendation as to the uplift of CEAs in Wales.

On commitment awards, we maintain that these should not be seen as a performance-related award like CEAs. Rather, they are considerably more equitable as all consultants in Wales are in time eligible for them, like increases in basic pay. Commitment awards only contribute to the gender pay gap because a greater proportion of women than men who go on to be consultants have undertaken some of their medical training on an LTFT basis and consequently start on the consultant pay scale at a later stage in their life. This would better be addressed by allowing people who qualify as consultants in such circumstances to start at a higher point on the consultant pay scale. If that was done, then commitment awards would no longer contribute to the gender pay gap. Regardless of these wider reforms, we maintain therefore that commitment awards should be uplifted in line with basic pay and request that the DDRB provides a recommendation on this.

7.13.4 Request

Our request this year is that all elements of consultant pay – including commitment awards and national clinical excellence awards – receive an equitable pay uplift in line with recommendations for other grades.

7.14 Academics

We have been concerned to hear that some consultant clinical academics have not been paid the Commitment Awards to which they are entitled. Given that this is income previously funded by the NHS, it needs to be made clear which employer should pay for it, and for that employer to be funded appropriately.