

British Medical Association: Memorandum of Evidence to the Review Body on Doctors' and Dentists' Remuneration

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Overarching BMA Position

At its June 2022 Annual Representatives Meeting (ARM), the British Medical Association (BMA) passed a motion that mandates the BMA to achieve full pay restoration for its members back to the 2008 value. We have chosen to look at pay erosion since 2008 to coincide with the changes in government pay policy brought about by the financial crisis and subsequent economic recession. This encompasses the period over which austerity has frequently meant below inflation pay uplifts, including pay freezes in some years.

The BMA is, therefore, asking the DDRB to recommend the required pay increase so that pay restoration is either achieved for 2023/2024, or else, incrementally over the next five years.

The Doctors and Dental Review Board should disregard economic and affordability constraints and, instead, present their truly independent recommendations for government to then consider economic and affordability constraints. We are particularly concerned around the issue of a remit letter in Northern Ireland where, due to the lack of functioning of the Northern Ireland Assembly, the letter has had to be issued by the permanent secretary, rather than a minister, which would be preferable. Also, we are concerned at the published remit letter in Wales, where the letter implies that their government has taken a political choice that doctors' pay in Wales is effectively determined by the UK Government's affordability constraints, by stating they will in effect be bound by UK Government funding despite their devolved tax and borrowing powers.

In addition, we are concerned around governments' statements relating to SAS doctors who have not transferred to the new contract, which essentially encourage the DDRB to cap its recommendations for those on the old contracts so as not to undermine the new contracts. We ask that the DDRB is not constrained in making a recommendation for all SAS grades and contracts, as well as for other doctors on multiple year pay deals, to reflect the pay erosion that all doctors have suffered.

Scope of the BMA evidence

For a second year, two major branches of practice within the BMA's representational structures – the UK consultants committee (UKCC) and the UK junior doctors committee (UKJDC) – will not be engaging with the DDRB process this year on behalf of the doctors they represent in England. The DDRB's report and recommendations for the previous pay round did not address their longstanding concerns about the Review Body's independence and has, therefore, taken no steps to restore their faith in the pay review process.

For the first time this year, the Welsh consultants committee (WCC) and Welsh junior doctors committee (WJDC) have also decided they do not wish to engage with the DDRB for this round due to the reasons provided above for their England counterparts. Both WCC and WJDC found no evidence that the information provided to the DDRB was influencing the outcome of its report. Furthermore, they raised concerns that, by continuing to formally engage with the process, they would be complicit in the negative outcome for the medical profession.

In addition, WCC has consistently expressed disappointment with the DDRB's decision not to recommend an uplift to the value of National Clinical Impact Awards and commitment awards in Wales since 2020. Whilst members in Northern Ireland share the concerns of our colleagues in Wales and England, they have reluctantly decided to submit evidence and would urge the DDRB to return to its remit and remain truly independent.

In addition, for this year, BMA Scotland will be submitting its own separate evidence for our members working in that country. This submission therefore relates to all doctors in Northern

Ireland, and to Specialty, Associate Specialist, and Specialist (SAS) grades, medical academics, GP trainees and salaried GPs in England and Wales, with the addition of contractor GPs in Wales. For GP contractors' pay in England this year, in the same way as for SAS doctors, we ask the DDRB to not be constrained in making recommendations for doctors on multi-year pay deals. We also ask the review body to 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.

The BMA has produced a 'Critical Report' about the doctors' and dentists' pay review process which it has now shared with civil servants at the national health departments. The report formalises the concerns about remit and process that we have previously expressed, both to the DDRB and to health ministers, and sets out the ways in which we believe the pay review process urgently requires reform if it is to regain the trust of the profession and meaningfully address the long-term erosion of doctors' pay.

Response to 50th DDRB Recommendations

The BMA does welcome the DDRB's continued recognition of the impact of the pandemic on the ability of the health service to respond to demand, and the resultant impact on backlogs in care and workload pressure for staff. We also appreciate and agree with the DDRB's view that workforce shortages and overreliance on temporary staff makes the clear economic case for a pay recommendation in excess of the constraints that governments attempted to place upon it. Indeed, the DDRB clearly expressed the position that the BMA has long argued: that 'government pay policies or affordability figures [are not] an absolute limit on what our recommendations should be'.

Despite this welcome restatement of the Review Body's intended independence from government constraint, the DDRB has nevertheless resolutely failed once again in its critical task of ensuring that, at an absolute minimum, doctors' pay does not continue to be subject to a real-terms reduction in value. While we recognise the exceptional economic context in which the DDRB's recommendations were made, yet another year's pay award that is drastically below the level of inflation simply compounds the appalling erosion of doctors' pay that has taken place on the DDRB's watch over the last 15+ years.

This approach is all the more concerning, and indeed confusing, when the Review Body itself recognises and has clearly stated that 'pay does serve as an important signifier of value and, perhaps more importantly, if it is sensed to be deficient, can exacerbate a feeling amongst the medical and dental workforce that they are neglected and undervalued [which] can in turn make staff feel they no longer wish to put in the additional discretionary effort on which the NHS/HSC depends, or that they no longer want to work full-time, or that it is no longer worth staying in the NHS/HSC at all'. Likewise, it emphasised the need to 'ensure that doctors and dentists feel that their vital role in our society is properly respected and that they are treated fairly, relative to earnings growth among similar professionals'.

Despite this, the Review Body's continued assertion that it is not within their remit to 'undo past decision making' – a position with which we profoundly disagree – means that any recommendation for an increase below the level of inflation amounts to a casual acceptance that doctors' pay can continue to be reduced, and that there will necessarily be no opportunity to restore this loss in the future. For this to be the position of a body that, from its inception, was intended to keep doctors' pay in line with the 'cost of living, the movement of earnings in other professions and the quality and quantity of recruitment in all professions,' it further underlines the BMA's concerns, which we have expressed on numerous occasions, about the way in which the DDRB is constrained, whether directly or indirectly, from meaningfully addressing the issues that persist with doctors' pay.

We are further sorry to have to report that, yet again, the application of the pay uplift has been hugely delayed in Northern Ireland, with this only finally being announced on 22 December 2022. This is a consequence of the fundamental dysfunction of the pay review system as currently operating in Northern Ireland, as well as the lack of a functioning Northern Ireland Assembly. This is not an abstract matter: the faith of doctors and dentists in the pay review system hinges upon them receiving their pay awards in a timely manner and as transparently as possible. During a developing cost of living crisis, the lack of any pay uplift for many months has been an acute and practical concern for many.

Multiple year pay deals

Despite noting the BMA's clear request last year that groups on multi-year pay deals be included in the DDRB's deliberations, the review body evidently felt once again constrained from making a formal recommendation in relation to groups not included in governmental remit letters.

We were grateful for the DDRB's comments that recruitment, retention and motivation arguments applied equally to these groups, as well as noting that the current multiple year deals were agreed prior to the full extent of the current economic context being known, as well as its recognition that the headline increases set as part of the pay deals were 'likely not sufficient' to address those issues. We also appreciated its arguments that the exceptional economic context provided a clear justification for revisiting agreed multiple year pay deals, as well as echoing the BMA's warning that failure to flexibly address exceptional circumstances 'would make entering a [multiple year pay deal] less attractive to staff, which would affect the governments' ability to agree contract reforms in future'.

Nevertheless, despite 'strongly urg[ing] the governments to consider the unique economic and workforce context [and] the need to protect the relative pay position of staff on [multiple year pay deals]', we once again view the DDRB's decision not to make a formal recommendation in relation to these groups to be a missed opportunity – and a direct reason for our UK junior doctors committee again choosing to not submit specific evidence this year.

We do not believe the Review Body's terms of reference prevent it from making a recommendation for groups that are subject to existing pay deals where it thinks it appropriate and necessary, which in this case the DDRB evidently did, and especially where some of the parties to the pay review process have explicitly requested this. Instead, by failing to make an active recommendation, it simply allows the governments of the UK to conspicuously ignore such 'encouragement' or 'urging', while still stating that it has agreed to implement all recommendations.

In addition to the concerns outlined above, we would like to highlight some specific concerns surrounding the Welsh Government's continued application of the multi-year pay deal for SAS doctors on the 2021 contract and their decisions related to this for those who are on the top of the 2008 contract pay scale. These are discussed fully in the section on SAS doctors, but we would like to express concern at the precedent that has been set by the Welsh Government in renegeing on a contract framework agreement and in using a new contract's multi-year pay arrangement to stagnate the pay of those who did not choose to transfer.

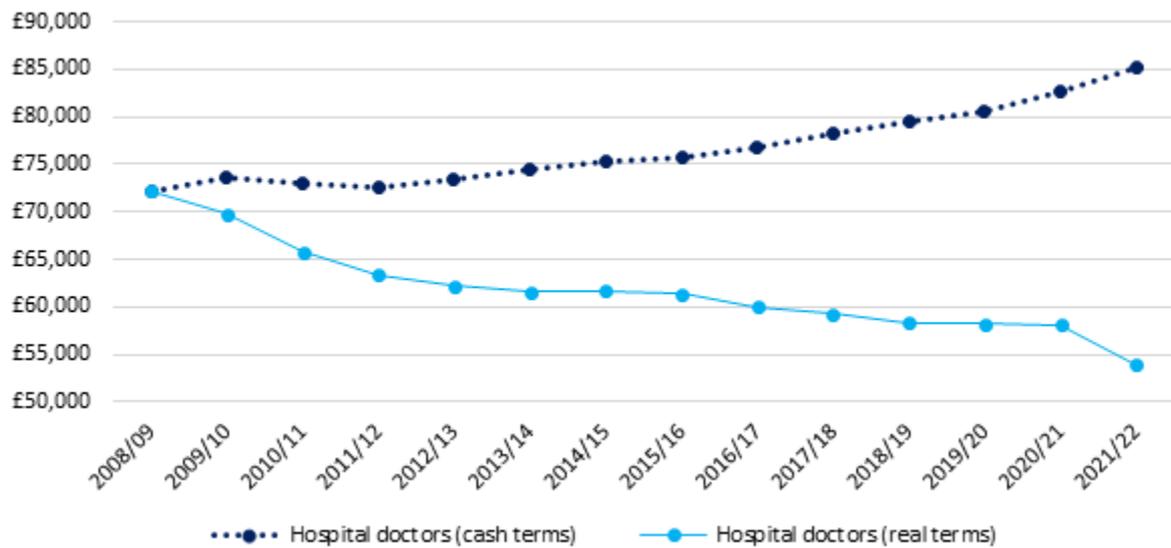
Pay erosion

As different groups of doctors have experienced different levels of pay erosion in the period since 2008, it is not possible to provide a specific single figure that will be applicable to all our members. As well as erosion due to pay awards falling short of inflation leading to a substantial fall in real earnings over the last 15 years (for example, by around 26% for junior doctors in England), changes

to taxation and pension arrangements have meant some groups of doctors have had an even greater decline in their real take-home pay (for example, up to 35% for consultants in England).

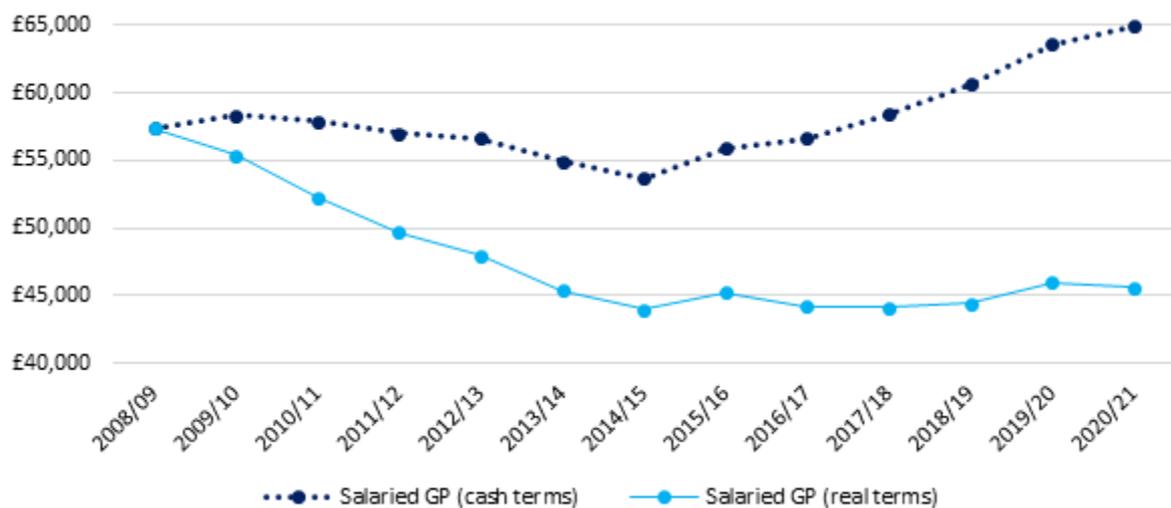
We have included some illustrative graphs below to demonstrate the fact that doctors have faced an unprecedented cut in their average real terms income, which we have charted below in both nominal cash and real terms since 2008-09 (Figures 1-3). These should be viewed as indicative, and do not form a specific ask.

Figure 1: Real decline in value of gross pay for the average hospital doctor (England)



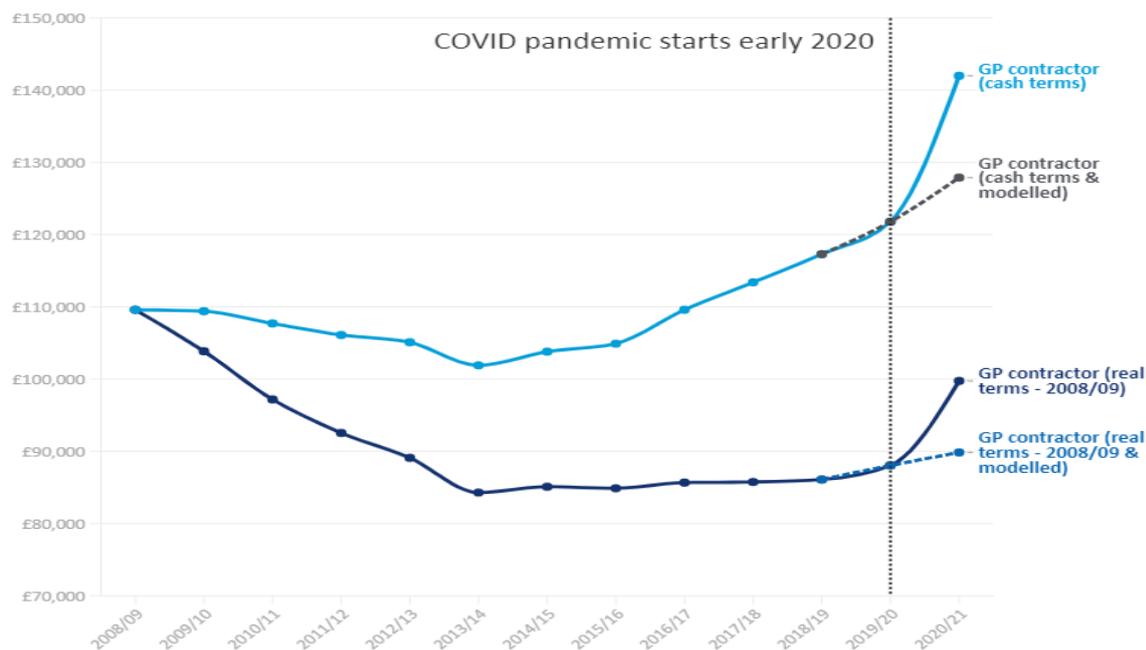
Source: BMA analysis of NHS Digital's NHS Staff Earnings Estimates for HCHS doctors (England); real terms analysis in April 2009 (RPI) value

Figure 2: Real decline in value of income before tax for the average salaried GP (England)



Source: BMA analysis of NHS Digital's GP Earnings and Expenses Estimates (England); real terms analysis in April 2009 (RPI) value

Figure 3: Real decline in value of income before tax for the average GP contractor (England)²



Source: BMA analysis of NHS Digital's GP Earnings and Expenses Estimates (England); real terms analysis in April 2009 (RPI) value. The modelled 2020/21 figures adjusts the earnings to remove one-off payments directly relating to the Covid pandemic services

Economic outlook

It is not the role of the BMA to provide detailed information on the state of the economy. However, what is very clear is that doctors are facing what for many if not most is an unprecedented cost of living crisis, with the current and immediate future levels of inflation conspiring with more than a decade of declining real terms pay to create an environment where for many it is no longer attractive to continue to work as a doctor.

Current inflation (as measured by our preferred measure of RPI, which we feel best reflects the cost pressure facing doctors) is running at 14.0% (November 2022, source ONS¹) and is therefore considerably higher than last year's pay award. While forecasts suggest some reduction in this headline rate in 2023, this is only to the level of 10.7% (OBR Economic and fiscal outlook, November 22²) or a range up to 11.0% (HM Treasury, Forecasts for the UK economy, November 22³) from various independent forecasts. It is not until 2024 that inflation is forecast to reduce significantly.

While wages and average earnings in other professions and sectors have also struggled to keep pace with current inflation, forecasts are predicting a rising trend. The OBR estimates an average increase in wages of 4.3% for 2023, and the independent pay benchmarking company IDR⁴ identifies that more than half of the organisations it surveyed expect to make an award greater than 5%. Similarly,

¹ <https://www.ons.gov.uk/economy/inflationandpriceindices>

² <https://obr.uk/efo/economic-and-fiscal-outlook-november-2022/>

³ <https://www.gov.uk/government/collections/data-forecasts#2022>

⁴ <https://www.incomesdataresearch.co.uk/pay-climate> (subscription only)

XpertHR's provisional headline measure of basic pay awards⁵ has risen sharply to 5% over the three months to the end of November 2022. Official data from ONS show a 6.1% increase in average weekly earnings (up to October 2022, source Labour Market Overview, December 2022). Looking at an example of specific professions, accountants have shown an 8.6% average increase, according to the latest ASHE data.

However, to reiterate, it is not just the current financial situation that needs addressing, but the longer-term erosion of earnings. Using 2008/9 as the starting point, some relevant comparators might be:

- RPI: a 58.2% increase in general inflation (up to 2021/22), compared with average weekly earnings⁶
- (AWE whole economy total pay including bonuses) up 38.1% (which therefore equates to a real terms decline of 12.7% which is considerably less than doctors have experienced)
- private sector AWE of 39.0% (a 12.1% real terms decline), and
- the finance and business service sector AWE of 45.5% (a real terms cut of 8.1%).

Looking at some individual professions using the latest 2022 ASHE⁷ data, we can also see for instance that head teachers and principals received a 49.9% real terms increase over that period (since 2008), solicitors and lawyers a 23.6% increase, chartered and certified accountants a 97.3% increase, and management consultants a 25.6% increase. While we have some concerns around the ASHE figures, they do clearly point to a diverging picture, where doctors' real pay continues to decline but other professions (that both we and the DDRB itself have recognised as appropriate comparators) have shown real increases (or at least much slower declines). The implication of this is that the "value" of doctors has declined, both in absolute and relative terms, so there is a "fairness" argument, that reinforces the cost of living and recruitment & retention arguments, to reinstate the historic value of doctors in relation to these comparators.

The BMA notes that non-NHS- employed doctors working in the UK have not been included as comparators with NHS-employed doctors, nor is there a comparison between NHS doctors' pay and that of doctors employed in other English-speaking countries, where doctors could easily transfer to work. The BMA, therefore, suggests that market forces are not considered in the DDRB report, which risks missing early trends which can explain the increasing migration of doctors from the NHS to other healthcare systems. BMA survey research has also identified that many doctors compare themselves against doctors working in other countries, especially the English-speaking world (including notably, Ireland for our members working in Northern Ireland, and Australia / New Zealand for junior doctors). While we have not yet been able to source a robust source of data on earnings in other countries, anecdotal evidence from, for example, job adverts, has suggested pay is higher in many of these countries, whilst working conditions are also significantly more attractive.

While governments will no doubt present their own views, we do not believe there is compelling evidence that a higher than inflation pay award will necessarily create a wage-price spiral. Indeed, the Bank of England's governor stated that 80% of the current inflationary pressures are due to global prices hikes for energy and other goods and not wage pressures, and international research

⁵ <https://www.xperthr.co.uk/survey-analysis/pay-trends-december-2022-median-award-hits-5-/166710/> (subscription only)

⁶ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours>

⁷ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/2022>

from the IMF⁸ and from Nobel-prizewinner Joseph Stiglitz⁹ has also questioned the existence of spirals in practice. Similarly, company profits appear to have been growing at the expense of wages: a study by Unite¹⁰ found that profits were responsible for 58.7% of inflation compared with only 8.3% due to labour costs. The argument that public sector pay increases somehow drive private sector awards is also not borne out by evidence, as public sector earnings lag behind private.

Moreover, increasing doctor wages can actually benefit the economy in two key ways. The first is through the direct, indirect, and induced multiplier effects of additional demand injected into the economy. London Economics analysis of pay uplifts for Agenda for Change staff shows that a large portion of the Exchequer cost would be offset through the economic multiplier effect¹¹, and there would likely be a similar offset affect for doctors. The second is through improving recruitment and retention within the NHS, therefore leading to more staff who are able to work productively, which in turn leads to improved health outcomes, a healthier and more productive workforce / population, and therefore economic growth. The cost of pay uplifts is therefore mitigated, and a large portion of the cost will be offset directly through additional tax receipts as well as indirectly and induced through tax receipts generated by increased economic activity. This cost should be compared to the opportunity cost of not increasing wages and losing doctors as a consequence at a time when the service is under extreme pressure.

The theoretical macroeconomic arguments against a substantial public sector pay award are therefore weak. As we have noted in previous evidence submissions, affordability is predominantly a political decision around the level and how spending is financed, but we would argue that any additional net cost of an acceptable pay award will be both relatively small and crucially easily outweighed by the benefit from improved retention and greater morale.

Workforce, workload and morale

Health service capacity and the backlog of care

Doctors are working in understaffed and under-resourced health systems which are facing record demand while working through enormous backlogs of care made worse by the pandemic. These pressures, underpinned by a workforce crisis with no end in sight, are leading to declining morale, wellbeing and leading many doctors to consider leaving.

There are record numbers of patients waiting for care and treatment across the UK, while winter and a high burden of respiratory diseases are adding to existing pressure on health services.¹² In England, as of September 2022, a record high of 7.1 million patients were waiting for treatment, in Wales, there were 754,677 patients waiting for treatment¹³, and in Northern Ireland, the outpatient waiting list grew to 376,833 people.¹⁴

⁸ <https://www.imf.org/en/Publications/WP/Issues/2022/11/11/Wage-Price-Spirals-What-is-the-Historical-Evidence-525073>

⁹ <https://rooseveltinstitute.org/publications/the-causes-of-and-responses-to-todays-inflation/>

¹⁰ <https://www.unitetheunion.org/media/4757/unite-investigates-corporate-profiteering-and-the-col-crisis.pdf>

¹¹ <https://londoneconomics.co.uk/wp-content/uploads/2021/01/LE-NHS-Trade-Unions-Net-Exchequer-impact-of-increasing-AfC-pay-18-01-2021-STC.pdf>

¹² Office for National Statistics, '[Coronavirus \(Covid-19\) Infection Survey, UK](#)', 25 November 2022

¹³ Stats Wales, '[Patient pathways waiting to start treatment by month, grouped weeks and stage of pathway](#)', 22 December 2022.

¹⁴ Department of Health, '[Outpatient waiting times](#)', 24 November 2022. ; '[Inpatient and day case activity](#)', 24 November 2022.

A ‘hidden backlog’ and the complexity of conditions when patients are finally seen is also growing¹⁵ across the four UK nations but is more difficult to quantify. This is storing up greater problems for the future, leading to a greater demand on health services – and greater pressure on staff.

The combination of ongoing pressure on services, backlogs of care and chronic workforce shortages means waiting times for emergency care have increased to record highs. In England, the number of patients waiting over 12 hours from decision to admission has increased by 34%, bringing the total number to a record high of 43,800 in October 2022. It is now over 60 times, as high as it was in October 2019. In November 2022, the President of the Royal College of Emergency Medicine, Dr Adrian Boyle, said that issues in emergency care contributed to the deaths of 200 people who died in England over the past week¹⁶. This data illustrates how imperative it is that we do not lose any more doctors.

In Wales, performance against the same standard dropped to 67% in October 2022.¹⁷ The number of patients waiting more than 12 hours to be admitted, transferred, or discharged at NHS emergency departments is now the highest on record, with 11,030 patients waiting 12 hours or more.¹⁸ These figures also represent an underestimate of actual waiting times, as patients will have been waiting for additional time before a ‘decision to admit’ was made. Keeping the workforce we have and ensuring the NHS is an attractive place to work is crucial in order for these figures to be reduced. Ambulance waiting times are also at an all-time high in Wales with an average response time for life-threatening calls now at 8 minutes 18 seconds.¹⁹

In Northern Ireland, waiting time targets have similarly been massively breached. For example, in June 2022, only 38.9% of patients urgently referred with a suspected cancer in Northern Ireland began treatment within 62 days against a target of 95%.²⁰ In September 2022 no type 1 or type 2 emergency department met the 4 hour target, with the average for type 1 facilities at 45% seen in this time. Inpatient waiting times also paint a bleak picture in Northern Ireland. Against a March 2023 target of 50% of patients waiting no longer than 13 weeks for inpatient/day case treatment and no patients waiting over 52 weeks, in September 2022 these figures stood at 80.1% and 55.4% respectively. The picture is just as difficult for outpatient treatment. Against a March 2023 target of 50% of patients waiting no longer than 9 weeks and no patients waiting longer than 52 weeks, as of September 2022, the figures stood at 82.0% and 50.3% respectively.

These failures to achieve targets is partly due to a lack of beds capacity, but particularly due to the fact that there are simply not enough staff to manage demand. The UK has a relatively low number of hospital beds: latest available data shows it has 2.4 beds per 1,000 inhabitants, compared to the EU25 average of 5.²¹ This results in high occupancy rates: in 2020, the acute care bed occupancy rate in the UK averaged 76.6%, which is above the EU21 average of 63.8%.²² Since 2010, average bed occupancy in England has consistently surpassed 85%, the level generally considered to be the point beyond which safety and efficiency are at risk, with many trusts regularly exceeding 95% capacity in the winter months. This problem is also compounded further by delays in discharges, meaning that

¹⁵ <https://www.nao.org.uk/reports/managing-nhs-backlogs-and-waiting-times-in-england/>

¹⁶ <https://www.theguardian.com/society/2022/dec/01/emergency-care-england-death-waits-ambulances>

¹⁷ StatsWales, [Performance against 4 hour waiting times target by hospital](#), accessed 1 December 2022.

¹⁸ NHS activity and performance summary: September and October 2022. <https://www.gov.wales/nhs-activity-and-performance-summary-september-and-october-2022-html>

¹⁹ NHS activity and performance summary: September and October 2022. <https://www.gov.wales/nhs-activity-and-performance-summary-september-and-october-2022-html>

²⁰ <https://datavis.nisra.gov.uk/health/ni-cancer-waiting-times-apr-jun-22.html>

²¹ OECD, [Health at a Glance, Europe 2022](#), 2022.

²² OECD, [Health at a Glance: Europe 2022](#), 2022.

beds are occupied by patients who are medically fit to be discharged as there is no space for them in social care.²³

Chronic workforce shortages

Addressing the growing backlogs of care would represent a significant challenge even without the present workforce crisis. Yet the reality is that the health services across the four UK nations are facing ‘the greatest workforce crisis in their history’²⁴. The lack of official, publicly available workforce planning makes it difficult to quantify the full extent of medical shortages. In comparison to other nations, the UK has a very low proportion of doctors relative to the population. The average number of doctors per 1,000 people in OECD EU nations is 3.7 - while the UK has 3. Germany, by comparison, has 4.3, and Austria has 5.3. England would need the equivalent of an additional 46,300 full time doctors simply to put us on an equivalent standard with today’s OECD EU average of 3.7 doctors per 1,000 people. Almost nine in 10 BMA members think that the Government’s aim to tackle the Covid backlog is either “totally or mostly” unachievable with the existing workforce²⁵.

The BMA acknowledges the DDRB's repeated requests for workforce data, in order to enable a greater understanding of workforce trends. While the data remains incomplete, the reported increases in agency staff reflects a rising vacancy rate, be it temporary or permanent.

The BMA also notes that no calculations have been made in relation to the relationship between NHS staff reducing hours or leaving due to less competitive NHS pay and the budgetary impact on temporary staff pay as a consequence. While government remits cite affordability in relation to ceilings of pay award increases, there is no calculation which demonstrates how insufficient pay awards result in the false economic consequence of increased spending on expensive temporary staff. You previously reported the estimated £1 billion UK spend on temporary staff in your 2022 report. Sickness absence also fails to be considered in the overall workforce calculations, despite rising sickness rates. This is an invisible absence of the workforce. The main reason for staff sickness is mental health illness.²⁶

We also note that Wales has failed to submit both recruitment and retirement figures to the DDRB every year from 2018 onwards, making staff turnover more difficult to quantify as a result. The BMA has directly emphasised the lack of this data at ministerial level.

The BMA also recognises that whole time equivalent numbers of doctors do not reflect the amount of direct clinical care provided, therefore, the relationship between doctors numbers and productivity is not a direct relationship.

The BMA has repeatedly called for data regarding workforce numbers. When doctors are counted in full time equivalents, the assumption is that doctors work no more than ten sessions a week i.e. between 37.5 (Wales) and 40 hours (England, Scotland, N Ireland) a week. In reality, most hospital consultants work a greater number of sessions. When consultants reduce their working hours, therefore, the hours may reduce to 10 sessions a week, but the data does not capture this loss of productivity, since the consultants are still formally working full time.

²³ The Guardian, [Up to one in three English hospital beds occupied by patients fit for discharge](#), November 2022; Welsh Parliament, [Delayed transfer of patients causing widespread failings across NHS and social care](#), June 2022; Public Health Scotland, [Delayed discharges in NHSScotland monthly](#), October 2022; Department of Health, [Public support urgently required for hospital discharges](#), July 2022.

²⁴ <https://committees.parliament.uk/publications/23246/documents/171671/default/>

²⁵ British Medical Association, ‘[Viewpoint surveys](#)’, 31 May 2022

²⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/january-2022-provisional-statistics>

The DDRB has defined a session of Programmed Activity as being four hours, yet, in Wales, a session equates to 3.75 hours. The overall consultant workforce for Wales, as measured by WTE, therefore, should be reduced by 6.67% if the DDRB definition of WTE is used for the entire UK workforce.

It is not just that we have fewer doctors than other nations. Existing staffing is further impacted by stubbornly high vacancies. Health services in all four UK nations have long carried a high number of unfilled vacancies, a problem that far predates the pandemic. These vacancies create a vicious cycle: shortages produce environments of chronic stress, which increases pressure on existing staff, and in turn encourages higher turnover and absence. As of September 2022, 133,446 posts in secondary care are vacant in England - the largest number of unfilled vacancies since June 2018. 9,053 (6.2%) of these unfilled vacancies are medical posts – this is a slight decrease from the 10,639 (7.4%) medical vacancies in the previous quarter.

In Northern Ireland, in the same month, there were 8,048 vacancies in health and social care, of which 11.3% were nursing and midwifery vacancies, and 5.4% were medical vacancies.²⁷ Care is delivered by multi-disciplinary teams, so nursing shortages directly impact the medical workforce who must take on a greater burden of work as a result. The concerns we raised regarding secondary care vacancy figures, using Freedom of Information requests, in our published report²⁸ of November 2021, *Consultant vacancies in Northern Ireland: an analysis*, remain valid.

DoHNI only measure vacancies that are actively being recruited to; therefore, if it has not been possible to fill a post then 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 in Northern Ireland. We further note that the BSO does not collect data on less-than-full-time working in the GP cohort. It is important that this gap in the data is filled as soon as possible to allow a more informed understanding of trends in working amongst GPs.

Notwithstanding this, and a slight drop from the reported vacancy rate high of 6.7% last year, the current reported vacancy rate continues to confirm a longer-term trend towards higher levels of medical vacancies in Northern Ireland. It is notable that consultant vacancies are at the highest reported level and have remained steady at that level from January to September 2022, suggesting an emerging consultant recruitment crisis. We are also hearing increasing anecdotal evidence that consultants in particular are choosing to work part time or full time in Ireland for significantly higher levels of pay, which will further increase that rate. It is important therefore that, in considering appropriate pay uplifts in Northern Ireland, the DDRB also examines pay levels within Ireland as it is clear this is an increasingly relevant dynamic within the regional labour market.

In a landmark report by the recently constituted Northern Ireland Fiscal Council, the financial sustainability of the Northern Ireland health and social care service was examined.²⁹ The NIFC notes that ‘demand and cost pressures in health will continue to grow in NI, just as they will throughout the developed world. For NI, the major additional concern is that the overall Block Grant will not grow at the same rate as spending in England’, even though Northern Ireland has a ‘higher health spend need’. A key element of combatting this, the report argues, will be the ‘funding of transformation and work-

²⁷ Department of Health, [Northern Ireland health and social care \(HSC\) workforce vacancies September 2022](#), 23 November 2022

²⁸ <https://www.bma.org.uk/media/4821/bma-ni-consultants-shortages-and-vacancies-nov21.pdf>

²⁹ <https://www.nifiscouncil.org/files/nifiscouncil/documents/2022-10/NIFC%20Sustainability%20report%202022%20special%20focus%20-%20Health%20-%20web%20version%20with%20correction%20.10.22.pdf>

force planning'. Workforce planning, therefore, is not just of benefit to our members – who desperately need proper, rigorous assessment of social need in decisions about staffing levels – but also the health service itself and its continued survival.

In Wales, despite the importance of improved workforce planning being highlighted as part of the 50th DDRB report, once again, we would like to express our frustration at the continued lack of official, central data collected and published on medical vacancy rates. As was reported in our last submission of evidence, we are currently only able to acquire vacancy data within secondary care by submitting Freedom of Information requests to Welsh health boards and trusts. This data is often incomplete and, due to differing definitions of what constitutes a vacancy, it is not possible to make meaningful comparisons between health boards.

The lack of accurate data means it is not possible to determine the scale of problems caused by vacancies, to plan or address workforce needs. This absence of accurate data also makes measuring the effects of new models of care and national workforce policies aimed at increasing preventative care within primary and community care settings highly problematic. We understand that the Welsh Government is developing a workforce implementation plan and has therefore come to realise the importance of identifying vacancies across the NHS in Wales. However, we note that these figures will not be available to be considered as part of this year's recommendation.

Despite rising demand, the total GP workforce in England has seen little growth since 2015, with the fully qualified GP workforce shrinking over that time. As of October 2022, there are now the equivalent of 1,896 fewer fully qualified full-time GPs than there were in 2015. There are now only 0.44 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 322 – nearly 17% - 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. 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.

In Wales, analysis by the Nuffield Trust³⁰ on behalf of BBC Wales demonstrates that the number of GPs in Wales has remained broadly static on a headcount basis compared to the size of population when compared to a decade ago. This ratio at 63 per 100,000 people is significantly lower than in Scotland (77 per 100k) and Northern Ireland but slightly higher than in England. However, this comparison does not take into account working patterns, the trend toward part-time and portfolio working, or the evidence on the higher age and morbidity of the Welsh population.

The Welsh National Workforce Reporting System (NWRS) captures practice level workforce data including FTE info; completion of the tool now being mandatory for practices as of the recent 22/23 contract agreement. Due to concerns over data quality and validation, FTE data has only been published relatively recently. From December 2021 to December 2022, there was a decline from 1480.4 to 1447.5 FTE GP practitioners³¹ working in Wales, a change of -2.2% in an extremely short timescale. Additionally, this workforce is on average older than other UK nations. According to GMC register data³², Wales has the highest proportion of GPs over the age of 60 with 18.6%, with England on 17.1% as a comparator.

³⁰ <https://www.nuffieldtrust.org.uk/news-item/how-well-is-the-nhs-in-wales-performing>

³¹ Data from StatsWales <https://statswales.gov.wales/v/MiHO>. GP practitioners defined as partners/providers and salaried GPs.

³² Statistics from the [GMC Data Explorer](#) – based on doctors on GP register with a registered address in Wales not place of work.

This stagnation, or real-terms decline, in terms of numbers of available GPs in Wales is coupled with a gradual reduction in the overall number of GP partnerships in Wales over the last decade, with an approximate decline of 21% since 2009 to 2022. Whilst some of this may result from voluntary practice mergers or integrations, many will stem from partners handing back their contract to their contracting health board. Health Boards have the option to close the practice and disperse the patient list or seek to manage the practice directly. Our research³³, via FOI requests, demonstrates that Health Boards are required to spend significantly more to operate these surgeries than the usual budget allocation: approximately 30% more expensive per registered patient. This suggests the greater efficiency of the independent contractor model and the need to adequately reward those providing the services and hence increase retention.

The House of Commons Health and Social Care Committee have found that almost every branch of practice in England is facing chronic shortages³⁴. Despite this, the Government has previously rejected out of hand the longstanding recommendation from the BMA and over 100 other expert health and care organisations to improve the supply of new staff with an independent analysis of the shortage in every specialty, voting it down three times during the passage of the recent Health and Care Act. It is therefore vital that the Chancellor's very recent commitment in November 2022 to producing a workforce plan in 2023 with independently verified modelling covering the next 5, 10 and 15 years is made a reality. The plan must be transparent, backed up with the necessary funding, engagement and resourcing to make its implementation a success.

There are also for the first time in many years some very worrying signs that it is possible fewer people may want to pursue a career in medicine because working in the publicly funded health services are less attractive due to the immense workload doctors face and the poor pay and conditions they must endure, which needs to be incorporated into the workforce plan. UCAS (University and Colleges Admissions Service) reported a 9.7% drop in applications from those wanting to study medicine (as of the 15 October 2022 deadline)³⁵. Albeit this could also be for other reasons including the high tuition fees and other costs that medical students incur over the course of their study which again make a considerable pay rise imperative this year.

Impact on wellbeing

The workforce crisis both causes and worsens rising stress, fatigue, and burnout among NHS staff, as well as poor wellbeing and mental health. When doctors are compelled to cover chronic staffing gaps purely to provide a safe service, they become overworked and eventually can experience burnout. Such strain on mental health and wellbeing has long impacted workforce morale by placing increased and often entirely preventable burdens on doctors.

The COVID-19 pandemic has exacerbated existing challenges around workforce shortages and staff burnout, but these issues are pre-existing, systemic, and deep-rooted. A recent BMA survey (December 2022) found that 56% of doctors were suffering from stress and work-related anxiety.³⁶ Mental health issues are consistently the highest single category of sickness absence in secondary care staff, so reducing these figures by adequately staffing the service by offering attractive terms and conditions is imperative. NHS Digital statistics on sickness absence reinforce these findings: the

³³ BMA Cymru Wales *Freedom of information requests on managed practices in Welsh health boards* (May 2022) - unpublished

³⁴ <https://committees.parliament.uk/publications/23246/documents/171671/default/>

³⁵ <https://www.ucas.com/data-and-analysis/undergraduate-statistics-and-reports/ucas-undergraduate-releases/2023-cycle-applicant-figures-15-october-deadline?hash=VV39-0YVL6Bnlari9AVKhxYZw1YXoldsdYJJP-FueFeU>

³⁶ <https://www.bma.org.uk/what-we-do/viewpoint-surveys> December 2022

latest data show that sickness absence rates range between 27% (Other/locally employed doctors) and 107% (FY2 trainee doctors) which is higher than a year earlier (July 2022 compared with July 2021) depending on the medical staff group.

When doctors do experience poor mental health or wellbeing, there is not yet a culture within the UK's health services in which doctors feel able to take time off. When surveyed in November 2021³⁷, seven in 10 respondents said they would feel less comfortable applying for sick leave for reasons of mental health compared to physical health. That doctors feel unable to take time off generally because of feelings of overwork and guilt shows a general sense that doctors' wellbeing, and ability to tend to their wellbeing, is poor. Furthermore, recent unpublished BMA research has revealed that well-being provisions in NHS Trusts in England are in some cases far from adequate, perpetuating a culture where doctors are unable to prioritise their wellbeing.

The economic crisis facing the UK is also having a negative impact on the mental health and wellbeing of doctors. Aside from the stresses that doctors are facing along with the rest of the population about inflation rises and increased energy costs – making it even more imperative for them to receive a proper pay rise this year, doctors have told us they feel powerless to help their most vulnerable patients in the face of the economic crisis. They have reported feeling unable to cope with the existing pressures let alone what is being stored up because of the Government's continued failure to protect our health.³⁸

Doctors' views

The BMA undertakes a regular "Viewpoint" survey of its membership. The latest version (December 2022) asked a number of questions relevant to workforce (e.g. vacancies), workload, and wellbeing; while the response numbers are not large (2,945 in this latest run), they are a very helpful update to other national datasets (which are often out of date by the time they are published, for example the NHS staff survey results reported below) and provide a leading indicator as to likely developments in the coming year.

The survey asked about level of morale, physical and mental wellbeing, and desire to continue working in the NHS in the next 12 months. Nearly 1 in 5 respondents described their morale as very low, and a similar proportion expressed a very strong desire to leave the NHS next year. Around 1 in 10 stated their mental wellbeing was very negative, and 6% their physical wellbeing.

A similar survey carried out by BMA Cymru Wales³⁹ undertaken following last year's pay award showed a low level of morale, and with 79% of respondents saying the pay award further decreased their morale. As part of that survey, BMA Cymru Wales gauged how morale following this pay award might affect the Welsh NHS with 52% of respondents saying they were more likely to leave the Welsh NHS as a result of the pay award.

The Viewpoint survey reflected on current pressures to undertake additional working hours (with the implication this was due to staffing shortages and pressures to address the waiting list backlog), with nearly a quarter stating they had faced significant pressure from their employer within the last month, and 3 in 10 saying they pressured themselves into feeling they had to do so in order that patients received as good quality of care as possible. A follow-up question confirmed that 6 in 10

³⁷ <https://www.bma.org.uk/what-we-do/viewpoint-surveys> November 2021

³⁸ <https://www.bma.org.uk/media/6527/bma-the-country-is-getting-sicker-report-december-2022.pdf>

³⁹ <https://www.bma.org.uk/bma-media-centre/bma-cymru-wales-pr-doctors-struggle-to-justify-remaining-in-the-nhs>

respondents had actually worked unpaid additional hours, and over 1 in 4 worked paid additional hours.

The Viewpoint survey also asked about unfilled vacancies. Just under half of survey respondents reported their place of work had junior doctor posts vacant, with a similar number (44%) reporting consultant vacancies. Other types and grade of doctor showed lower, but still very significant, existence of vacant posts. While these data are not comparable with official national statistics, they do suggest the staffing situation is worse and worsening. Worryingly, our members reported that staffing shortages in their place of work have impacted on the quality and timeliness of care they can provide.

We specifically asked about the impact of the cost of living crisis on doctors. 43% survey respondents said they were very worried about the impact of the rising cost of living on their personal situation, with a significant proportion stating they had had difficulties for paying for essentials within the last year (rent/mortgage 15%, commuting 17%, childcare 9%, utilities 25%).

Retention

The Viewpoint survey also asked some questions of doctors who had left the NHS, and around the career intentions of current working doctors. While the number of survey respondents who have left is small, insufficient pay was given as a high reason for leaving by 18% of those respondents, and the financial impact of pension taxation by 26%; the main reasons related to workload and personal health and wellbeing.

A similar pattern of responses applied to the forward-looking question as to what factors might influence thoughts of doctors who are currently working about leaving the NHS. While survey responses do not necessarily translate into firm actions, insufficient pay was given as a high reason by 58% respondents, pension taxation by 63%; again workload, personal wellbeing, and additional workforce shortages were also given as high drivers to leaving.

Our own research is backed up by a recent data and research from the GMC⁴⁰. They state that the number of doctors wanting to leave their role or organisation is rising, with the GMC estimating that in 2021 7% of doctors had taken hard steps to leave the profession, up from 4% in 2020. Nearly 3 in 10 of those who graduated in the UK are moving abroad. The GMC estimates around 4% doctors (which equated to just under 5,000 doctors) permanently leave the NHS every year. The European average is 3.2%. Furthermore, many others will seek new opportunities abroad⁴¹. According to a recent GMC survey,⁴² 1 in every 3 doctors (33%) from the group surveyed who graduated in the UK moved abroad, the majority to Anglophone countries.

In Northern Ireland, where clear alternative employment is available in Ireland, medical students are increasingly thinking of turning away from working in Northern Ireland. In a recent survey we conducted, only 7% of medical student respondents said they would stay in Northern Ireland for their training.⁴³ This is in addition to the anecdotal evidence we have around working in Ireland.

⁴⁰ https://www.gmc-uk.org/-/media/documents/completing-the-picture-survey_pdf-87815271.pdf

⁴¹ <https://www.bmj.com/content/374/bmj.n1998/rr>

⁴² <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/completing-the-picture-report>

⁴³ BMA NI survey, 2022.

Further data is available from the NHS staff survey⁴⁴, and from NHS Digital reports⁴⁵ for England on reasons for leaving the NHS. While the staff survey relates to 2021, we believe from our own surveys that the situation has not improved and has probably worsened since.

The NHS staff survey in England allows questions to be broken down by occupational groups, of which the most relevant are Medical & Dental – consultants, M&D – in training (i.e. junior doctors), and M&D – other (which we interpret as mainly SAS grades). Regardless of the breakdown, the findings are unequivocal, and show an alarming and worsening picture across relevant questions.

Staff survey question	Consultants 2021 (2020)	Trainees 2021 (2020)	Other M&D 2021 (2020)
Q2a I look forward to going to work (Often/Always)	59.4% (67.2%)	43.4% (62.6%)	60.8% (65.7%)
Q4c My level of pay (Satisfied / Very satisfied)	59.6% (65.3%)	34.5% (47.1%)	38.4% (43.3%)
Q5a I have unrealistic time pressures (Never/Rarely)	13.5% (15.6%)	17.8% (21.5%)	23.9% (27.5%)
Q10c On average, how many UNPAID hours do you work per week over and above your contracted hours? (% staff working these)	83.5% (81.2%)	76.9% (72.4)	62.5% (60.0%)
Q12b How often if at all do you feel burnt out because of your work? (Often/Always)	31.4%	39.2%	29.9%
Q22a I often think of leaving this organisation (Agree/Strongly agree)	26.1% (22.4%)	23.9% (18.7%)	25.9% (22.9%)
Q22c As soon as I can find another job, I will leave this organisation (Agree/Strongly agree)	9.1% (7.9%)	16.9% (13.1%)	15.8% (12.8%)

Data from NHS Digital shows that from April 2011 to March 2022, 1,146 doctors have left for better pay and reward – that is an average of 104 hospital and community health doctors (headcount) voluntarily resigned per year for the primary reason of pursuing a better rewards package. The number of hospital and community health doctors leaving the NHS for this reason has been accelerating since March 2019, for example between April 2018 and April 2019, 59 doctors (all grades) voluntarily resigned for a better reward package, but between April 2021 to March 2022, 130 doctors (all

⁴⁴ <https://www.nhsstaffsurveys.com/results/national-results/>

⁴⁵ [NHS Digital, Reason for Leaving by quarter, 2021-22](#)

grades) voluntarily resigned for a better reward package. While these numbers may not appear especially large, the figures represent only those doctors who gave reward as the primary reason for leaving, with the majority of leavers either not giving a reason, or as we know from our own research leaving for workload / worklife balance reasons where that work pressure is not adequately compensated for by pay.

Competition for Medical School Places

We note that you use the high competition for medical school places as soft evidence to support that sub-inflationary annual pay awards have not disincentivised school children to consider a career in medicine. While this data may accurately reflect the number of medical school places taken by school children in the UK (rather than the number of medical school places taken by overseas students who pay significantly higher tuition fees to the institutions), a qualified doctor has the choice to work in any healthcare setting in the world. For this reason, the BMA disagrees that competition for medical school places reflects a healthy NHS working environment with healthy salaries for NHS doctors.

Equalities issues

The DDRB asked for further information around equalities issues. Monitoring pay gaps on the basis of protected characteristics is important to highlight areas of discrimination which must be addressed and support actions that must be taken to improve the working lives of doctors and ensure doctors are retained in the workforce. We have evidence of disparities in pay across a number of areas.

In Northern Ireland, it remains the case that, despite primary legislation setting out gender and other equalities pay gap reporting, the lack of a functioning Assembly has meant that the subsequent regulations have not been issued, resulting in organisations in Northern Ireland still not being required to publish this data. This hinders our efforts – and every other organisation committed to fair pay – from examining equalities issues and pay.

The cost of childcare impacts greater on the career progression of women. The findings from the [Mend the GAP: The Independent Review](#) into the Gender Pay Gaps in England⁴⁶ show that 35.4% of women noted that a lack of affordable childcare was a barrier to career progression. The unsociable and unpredictable hours some doctors work makes childcare even more costly. The review identified the role this plays in the gender pay gap and recommended increasing the provision of NHS nurseries (following a significant closure over the past decade); the BMA asked for this recommendation to be prioritised, but this has not taken place and doctors continue to cover the increasing costs of childcare. [Analysis from the IFS](#)⁴⁷ has shown that government spending on free childcare entitlements has fallen in 8% in real-terms based on inflation resulting in higher-costs for parents in the UK, who already face amongst the most expensive childcare costs in the world. Rises in salaries not reflecting the rising costs of childcare leads to more women leaving the workplace. Furthermore, the BMA's [Sexism in Medicine report](#)⁴⁸ found that doctors with caring responsibilities were more likely to state that they were actively discouraged from senior positions.

The findings from the [Mend the GAP: The Independent Review](#) also demonstrate that salaried GPs had a gender pay gap that was 22.3% in favour of men; three times the size of the gender pay gap

⁴⁶ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf

⁴⁷ <https://ifs.org.uk/publications/early-years-spending-update-impact-inflation>

⁴⁸ <https://www.bma.org.uk/media/4487/sexism-in-medicine-bma-report.pdf>

for GP partners. This is despite 68% of salaried GPs being women (NHS Digital, 2022). That data is relatively old now (relating to 2016/17), and a recent BMA survey (see later section on salaried GPs) has suggested the situation has improved; however, the underlying reasons for the gap such as the differential ability of male and female GPs to negotiate salaries still applies to an extent, so further work is required to fully understand what the best solutions are to ensure this improvement continues. DHSC should also urgently update the gender pay gap data to the latest year to confirm this.

Women who work in the field of medical academia are more likely to have additional requirements of academic training, such as going out of programme to undertake research. This exacerbates gender pay gaps of female academics who are additionally more likely to work less than full time and will progress through pay scales at a slower rate – having an impact on career earnings and pensions values. The structure of additional pay awards, for example Clinical Excellence Awards, should have equality impact assessments in all stages of development and review to ensure that they do not exacerbate gender, ethnicity of other pay gaps. The previous England national scheme has now been reformed (as has the scheme in Wales), but the local schemes in England are still open to pay gaps in how they are implemented.

Our [Racism in Medicine survey report](#)⁴⁹ showed that that doctors from ethnic minority backgrounds are less likely to agree that they are supported, 60% of respondents from Asian backgrounds, 57% from Black backgrounds, 45% from Mixed backgrounds, 36% from White non-British backgrounds, and 58% from all other backgrounds said they felt racism had been a barrier to their career progression, compared to 4% of White British respondents. Overseas qualified respondents were almost twice as likely as UK qualified respondents to feel that they had less support to access opportunities as a result of their ethnicity.

We support ethnicity pay gap analysis, more granular data and analysis on ethnicity is needed to establish experiences and working patterns of staff from different ethnicities. In our [Delivering Racial Equality in Medicine report](#)⁵⁰ and [BMA's commentary on the Gender Pay Gap](#)⁵¹, we noted that there is little information available about the ethnicity pay gap for doctors in the UK and highlighted that more work must be done to understand the differences in the gender pay gap at the intersection of different protected characteristics, including race and disability. All data analysis by protected characteristic should where possible look at the intersections between different characteristic to understand the barriers that must be tackled. Additionally, our commissioned research⁵² [‘Why are we still here? The factors still affecting the progression of ethnic minority doctors in the UK’ Specified](#) that after acknowledging there is bias in the pay systems, ‘one place to start in examining how bias may be built into the system is to conduct an audit of pay gaps by ethnic group.’

In our [response](#)⁵³ to the UK government’s consultation on disability workforce reporting, we highlighted that mandatory disability workforce reporting would provide an important baseline for employers to assess the impact of their current practices on the recruitment and retention of disabled people and prompt them to take steps to proactively tackle existing disability employment gaps. It would also assist in understanding the resources necessary to meet their statutory obligations to make reasonable adjustments to support disabled people in their workforce. The BMA survey and report on [Disability in the Medical Profession](#)⁵⁴ found that there was considerable concern among

⁴⁹ <https://www.bma.org.uk/media/5746/bma-racism-in-medicine-survey-report-15-june-2022.pdf>

⁵⁰ <https://www.bma.org.uk/media/5745/bma-delivering-racial-equality-in-medicine-report-15-june-2022.pdf>

⁵¹ <https://www.bma.org.uk/media/3617/bma-commentary-on-medicine-gender-pay-gap-dec-2020.pdf>

⁵² <https://www.bma.org.uk/media/5753/bma-bme-inequalities-report-external-june-2022.pdf>

⁵³ <https://www.bma.org.uk/media/6485/bma-disability-workforce-monitoring-may-2022.pdf>

⁵⁴ <https://www.bma.org.uk/media/2923/bma-disability-in-the-medical-profession.pdf>

disabled doctors about the potential consequences of disclosing their disability status to their employer. 77% of respondents said they were worried about being treated unfavourably if they disclosed a disability or long-term health condition at work or medical school.

In addition, only around one third (36%) of respondents felt comfortable telling people about their disability or health condition because they believed the organisation was disability friendly. This hinders how much we can analyse disability pay gaps but our evidence still shows that better efforts must be made to retain the workforce by providing more flexible structures of training, and employment and easier reasonable adjustment processes. The gender pension gap is also still a significant issue. We would welcome more research and analysis into this particular area to understand how changes in the schemes in 1995/2008 and 2015, have impacted on doctors who work less than full time.

Pensions

Pensions are an incredibly important part of the overall remuneration for doctors and once again we express our significant disappointment at the DDRB's continued lack of recognition of the problem and its failure to correct for this loss of remuneration or make recommendations to Government to resolve this. This is particularly important given the large increase in the numbers of doctors who are retiring with repeated surveys demonstrating that the fundamental driving force behind this remains the pension taxation system, which continues to unfairly penalise doctors for continuing to contribute to the NHS. Indeed, just last year, the Health and Social Care Select Committee described the pensions situation in the NHS as a "national scandal".

The cause of the problem is complex, and is related to a number of factors, including the impact of pay restraint, pension taxation and inflation. Whilst the DDRB has in the past argued that some of these issues such as pension tax rules is outside of its remit, given the severity of the issue, and the devastating impact it has had not only on overall remuneration but recruitment and retention, we firmly believe that it is critical that the DDRB gives its full consideration to the impact of pension taxation and other pension changes when making its recommendations.

We also believe that the DDRB can make recommendations and observations to Government about how it can resolve the situation and indeed that, through recognising their wider role in raising this issue, other Review Body's have been much stronger in highlighting these vital issues to Government. 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.

As part of this submission, we will look to demonstrate a number of points:

1. The impact of pay restraint and contribution changes on pensions and the overall fall in the remuneration package.
2. The issues around what is pensionable being changed in terms of the value accrued within the pension.
3. The pension taxation system
4. The impact of inflation on pensions

The impact of pay restraint and contribution changes

As highlighted in our previous evidence, the current pension system is inappropriately designed and in effect penalises doctors and other higher earners in the NHS. Since 2008, there has been an increase in employee contribution rates from 6% to 14.5% (recently reduced to 13.5%) for higher earners such as doctors in the NHS. Given that all pension scheme members 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 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. Under these defined benefit arrangements, this increase in contribution does not result in an increased pension, and yet the DDRB have never taken this reduction in take home pay into account when making its recommendations.

The loss in pension is significantly increased by the impact of pay awards that have repeatedly fallen well below the rate of inflation. are far below the rate of inflation for more than a decade. The cumulative impact of these sub-inflationary pay awards has resulted in pensionable pay falling markedly since 2008. However, the impact of this lost pay also has a devastating impact on the value of pension particularly for those with legacy final salary pension benefits. The impact of pay restraint that resulted from the DDRB complying with the government imposed pay freezes and caps during the period of austerity, has resulted in huge losses to the lifetime remuneration of doctors. It is essential that the DDRB recognise these losses and take corrective action in order to resolve the issues around recruitment and retention.

This is demonstrated by the modelling we have produced on the lifetime loss of gross earnings for a “model” consultant and how they are impacted by years of pay restraint⁵⁵. In our example, Alice, a consultant in England, has reached the top of the pay scale in 2011-12 at age 50. She was working 10 programmed activities - namely, as a full time doctor. She also had a 5% on-call availability supplement (a medium frequency of 1 in 5 to 1 in 8, category A), which is pensionable, and she held a level 6 local clinical excellence award, which is also pensionable. She is a 1995 NHS pension scheme member who retired in 2021-22 at age 60, having accrued 38 years of pensionable service.

As a result of consultants’ pay falling behind RPI inflation since 2008-09 and increases to pension contribution rates, she stands to have lost about £1 529 238 in gross earnings and future pension payments. This figure includes a loss of:

- £268 715 from basic pay
- £13 588 from on-call availability supplement pay
- £53 610 from level 6 local clinical excellence award pay
- £70 820 in additional employee pension contributions withheld
- £77 293 from her tax-free pension lump sum, and
- £1 045 212 in lost future pension payments, assuming that she lives to age 90

⁵⁵ We will share the full modelling for this separately.

This demonstrates how the losses caused by consultants' pay falling behind retail price index (RPI) inflation since 2008-09 and increases in contribution rates to the NHS pension scheme are compounded over time, and thereby demonstrates the significance of this lost income and its impact on doctor's pensions. It also therefore emphasises the need for immediate action and mitigation of this issue by Government through addressing both the reduction in the value of doctors' pay relative to RPI, and the unfair contribution tiering system if there is to be any hope of improving the retention of doctors within the workforce.

The issues around what is pensionable being changed in terms of the value accrued within the pension.

The impact of pay falling relative to inflation is heightened as a consequence of changes to what are considered pensionable earnings. For example, both local and national clinical excellence awards are now non-pensionable, and this results in a very significant reduction in the amount of pension that eligible doctors can receive. Furthermore, DHSC in England are proposing that, under the new National Clinical Impact Award arrangements, existing National Clinical Excellence Award (NCEA) holders who successfully apply for an NCIA will only receive pensionable pay protection for a period of 5 years. After such a point, even if they are successful, they will lose the pensionable value of their award.

The BMA strongly dispute the Government interpretation of these protection arrangements. Not only does this approach result in existing NCEA holders being treated more harshly than existing LCEA holders who retain the option (subject to successful renewal) of holding local pensionable awards until retirement, we believe it results in unlawful age discrimination, as in effect older NCEA holders will still be able to retire whilst in receipt of their pensionable national award (and thereby have the value incorporated in their final salary pension), younger NCEA holders will be prevented from doing so and will potentially lose the value of their award in their pension despite having paid contribution and potentially annual allowance tax charges as a result of receiving the award. Whilst the possibility exists to apply for the pension to be based on the higher pensionable pay value, it is not guaranteed that this will be accepted, and younger award holders would expect their basic pay to increase as a result of moving to higher pay increments.

Furthermore, under the government's proposals, they have created a perverse incentive that if an existing NCEA holder fails to gain a new NCIA, and reverts to a pensionable local award, they will be better off financially than an existing NCEA holder who successfully applies for an award. This is a non-sensical situation, and the BMA have outlined cost neutral solution to Government and ACCIA but they have been unwilling to engage. We urge the DDRB to recommend to government that they address this anomaly, but also to consider the loss of pension from the overall remuneration of doctors from these changes when making its recommendations on pay uplifts, as this enforced reduction in the overall remuneration package can only be a negative in both the recruitment and retention of doctors.

The pension taxation system

One of the rationales repeatedly used to try and justify a tiered contribution structure was a need to adjust for the benefits of higher rate tax relief. Indeed, the current tiered contribution structure, with the highest employee contribution of 13.5% (compared to the lowest contribution tier of 5%), removes tax relief from employee contributions in its entirety.

However, despite it being unclear why higher earners in the NHS should for some reason be denied the tax relief all other employees receive on their pension contributions, this has been the end result of the steep tiering. Despite effectively not receiving this 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 a significant 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.

We have repeatedly and consistently argued that a solution similar to the one implemented for judges should be introduced for doctors and other higher earners in the NHS. Under these tax unregistered arrangements, there is no tax relief available on employee pension contributions, and therefore there is no requirement to claw back tax relief through the annual and lifetime allowance. Given that doctors don't benefit from such tax relief in the first place, the rationale for such a solution is even more compelling. However, as there are a wide range of earnings within the NHS, we propose that the tax unregistered scheme is a separate, opt in scheme that members can choose to move across to once it is clear that the pension taxation rules are having a negative impact on their ability to work more or pushing them towards early retirement. Such a solution would significantly aid retention, with a BMA survey suggesting that 77% of respondents would delay their retirement if this was implemented.

The impact of inflation on pensions

Ahead of the proposed changes by the UK and Devolved Governments, there are at present potentially three major impacts of inflation. Firstly, for hospital doctors nearing retirement age with final salary schemes, the DHSC in England have suggested that, despite CPI being over 10% in September 2022, the likely pay award for doctors in 2023 will be limited to 2%, as the NHS budget is already set. We strongly dispute these arbitrary DHSC limits on pay, especially given that this unprecedented gap between the level of inflation and likely pay award risks significantly devaluing the legacy final salary pensions as well as impacting the overall value of CARE pensions.

This is compounded by the fact that there are no late retirement factors in the 1995 NHS pension scheme (the scheme that the vast majority of those staff approaching the age of 60 are in). This means that, for every year spent working beyond the age of 60, the level of annual pension that could have been received had they retired at the age of 60 is effectively lost. In response to inaccurate information published by NHSEI that claimed that NHS staff would receive a higher pension if they delayed retirement, the [BMA has produced a tool](#) enabling hospital doctors aged 59 or above to model the impact on their own situation if they worked for an extra year. This has demonstrated that a doctor may be well over £100,000 worse off if they retire at the age of 61 rather than age 60. Although the Government is currently consulting on the option of partial retirement, it is understood that, if accepted, the proposals will not be implemented until October 2023.

Furthermore, these consultations will not introduce late retirement factors. We urge the DDRB to consider the impacts of lost pension resulting from this and recurrent sub-inflationary pay awards when it makes its recommendations.

The second pressing issue in relation to the current rates of CPI, is the fact that two different measures of inflation are used in the NHS pension scheme. This particularly impacts those on Career Averaged Revalued Earnings (CARE) Pension Schemes. As GPs have been wholly within a CARE scheme for far longer than those in secondary care, it has the biggest impact on this group of doctors. The current rules use a different CPI value for "opening" value (which is based on the rate of CPI measured in September LAST year), versus the revaluation/dynamisation of earnings built in the NHS pension scheme (based on the rate of CPI measured in September this year).

When inflation was stable, and last year/this year CPI are similar, this does not present a major problem. When though inflation changes rapidly, like it is now, it becomes a very significant problem for many. For example, CPI in September 2022 was 10.1% and under the scheme rules, the pension will therefore be revalued by "inflation"+1.5%, i.e. 11.6%. However, the opening value of a doctor's pension will only increase by 3.1% (September 2021 CPI). Therefore, even though the AA is only supposed to test pension growth above inflation, the discrepancy caused by using two different measures of inflation will result in this purely inflationary growth being tested against the AA and for many this will use a significant proportion of the available AA or in some cases exceed it entirely, resulting in an additional tax charge simply as a result of inflation. This impact is compounded by the fact that the opposite scenario will occur next year if as predicted inflation returns to more "normal levels".

Due to the fact that, despite receiving a single pension, the 2015 scheme and the 1995/2008 schemes are considered under the Finance Act to be technically different schemes, negative growth in one scheme cannot be offset against positive growth in another as negative growth is simply considered to be "zero". In addition, negative growth in the 1995/2008 scheme cannot be offset against either previous or future years. Consequently, even though if inflation falls again next year, the value of the 1995/2008 pension will fall in real terms, this fall is completely ignored. This effectively means that GPs in particular will face additional AA tax bills of tens of thousands of pounds this year for "pseudogrowth", the majority of which will be lost next year but with no refund/reduction of the tax paid.

An example in a recent [BMJ article](#) outlined a GP with median partner earnings of £115k (significantly below the £200k taper limit) receiving an AA charge of over £32k due to this flaw. Although the government is consulting about a change in the date of revaluation to mitigate this, they have not addressed the root cause, which is the anomaly in the Finance Act. Consequently, even if the changes proposed in the consultation are enacted, this won't necessarily resolve the issue for all doctors, particularly those in membership of non-NHS pension schemes.

Thirdly, the high levels of inflation have exacerbated the impact of the decision to freeze the Lifetime Allowance (LTA). This is likely to see over £100k real terms value removed from the LTA this year alone. We have previously engaged with the DDRB on this issue, but would reemphasise the potentially catastrophic impact this will have on the retention of senior clinicians. This creates a dual negative impact on a doctor's pension, both in it falling significantly behind inflation, whilst also not moving the cap at which these earnings will be taxed. This will lead to doctor's being forced to retire, thereby significantly impacting the NHS workforce. We would therefore strongly encourage the DDRB to address this in their response to Government and to support our calls for this cap to be lifted.

Issues with current proposed solutions from UK Government

The DDRB will no doubt be aware of the proposals from UK Government to address some of these issues (mainly the CPI disconnect). The BMA have responded fully and extensively to these consultations but feel it important to highlight some of the main issues with the proposals that mean they will not adequately address the problem.

Fixing the CPI disconnect through the NHS Scheme regulations

The UK Government has proposed, in order to address the CPI disconnect for this year, to amend the NHS Scheme regulations and move the valuation dates (devolved Governments are at present considering different options). This would allow for the inflationary figures to be taken from the same year for both measurements described above.

This would though only partially mitigate this issue rather than solve it, and would not apply to those doctors outside of the NHS Pension Scheme, thereby doing nothing to support these practitioners. It does nothing to fix the issue around 'negative growth' in one scheme being in effect zeroed off, and therefore represents at best partial support to doctors and, in stark reality, nowhere near enough to safeguard doctors from pseudogrowth now and in the future.

Introduction of partial retirement and the extension of abatement rules

The BMA believes that the introduction of partial retirement represents a welcome development, and will provide greater flexibility to those doctors close to retirement who may wish to continue to work within the NHS. However, it is essential that employers support staff wishing to pursue this option and we await further details in the consultation. However, we understand that even if accepted, this change won't be enacted until October 2023. This is far too late and risks large numbers of NHS staff retiring in April 2023 to prevent their pension falling in value due to the rate of inflation and the lack of late retirement factors.

Further to this, we would emphasise that this again only represents a partial mitigation for doctors. Partial retirement inevitably means you are losing some form of contributions from these doctors, which will only further pressure the NHS in terms of workload. More substantive and immediate fixes are required.

As for the extension to the suspension of abatement rules, the BMA has repeatedly stated that it is not only illogical, but extremely unfair to reduce the pension of staff who have retired when they return to work for the NHS. In reality, this policy only affects a small number of doctors seeking to return to work post-retirement, namely psychiatrists with 'mental health officer' status. It does nothing to prevent the exodus of senior consultants and GPs who are retiring from the NHS due to absurd punitive pensions tax charges. The BMA is clear that abatement rules should be scrapped entirely.

'Encouragement of recycling'

We would note that, whilst we are pleased to see the Westminster Government, in line with other politicians and senior groups, have sought to facilitate recycling policies being undertaken by trusts in England, 'encouragement' of these goes nowhere near far enough. In order for this policy to be successful and for it to achieve its aim of retaining senior clinicians, whilst avoiding the 'postcode lottery' of trusts enacting different policies, recycling of the full employer contribution must be

mandated as a next immediate step by Government. In comparison, in Wales, this option is available nationally. It is hoped there will be a similar national offering in Northern Ireland and Scotland although these have not yet been confirmed.

As currently applied in Wales, however, the full employer contribution has not been made available for recycling as additional salary to those who have opted out of the pensions scheme. The full employer contribution is 20.68%, but only 14.38% is currently offered for recycling by Welsh health boards and trusts. We are unclear if the remaining 6.3% contribution is still being paid directly onto the pension scheme by the UK Government or if the funding of it is now passing through the Welsh Government, but we would nonetheless repeat our call for this portion of the contribution to also be made available for pension recycling.

The BMA has long campaigned to ensure that staff who are adversely impacted by pension taxation and are left with little option but to opt out of the scheme can access the employer's pension contributions. It is encouraging that the Government have committed to ensure that this is made available, but it is essential that this is available in every employing organisation and that it represents the full value of the employer's contributions. Although the recycling of employer contributions is not a solution to the issues caused by pensions taxation, it can be an important mitigation until the wider issues are addressed. However, given the importance of pensions as part of the overall remuneration package for doctors, for it to be useful, the Government take a more definitive stance in mandating the use of recycling policies.

Flexibilities

Whilst there have not been further announcements recently on the introduction of flexibilities, following previous Government indications on this issue, we remain clear that taking an approach of introducing flexibilities, or 'tinkering' with the existing system, while ignoring its fundamental flaws will not resolve the situation, and the result is that senior NHS workers will leave the NHS in unprecedented numbers.

The government has conducted two prior consultations on pension flexibility over the last 4 years. The first "50:50" consultation was pulled, and the second "decile flexibility" consultation was rejected by both members and the government. A third attempt to push flexibility as the solution will fail to delay and will not solve the problem, leading to thousands more doctors retiring over the next year.

The option to "flexibly" contribute towards an NHS pension does not work for several reasons. Firstly, it adds another layer of incredible complexity to an already extremely complicated pension scheme and pension tax system. Secondly, scheme members will not know their own pension growth position during a given tax year. Once a tax year has ended, there is no ability to retrospectively adjust your pension inputs, so any flexible options are not available. The complexity is such that a member cannot predict their pension growth in advance, even with specialist advice and if trying to "guess" the level of accrual, it is very likely that the majority will over or under contribute. The penalties for guessing wrong are so severe, and the complexity, so high that most members simply will not be able to use this option. To pretend that introducing such flexibilities would in some way mirror the very straightforward in the private sector is quite misleading.

We are aware that the Government have been discussing the option of exchanging a portion of the NHS pension and receiving a portion of the employers pension contribution and that the proposals were discussed in the House of Lords by Lord Markham on the 11th Jan 2023). No firm details of

these proposals are yet available, but the BMA is clear that for the reasons outlined above, this is not a solution to the issues caused by pension taxation. Any such option is extremely complicated, and the information required to determine how much pension to “exchange” is not available until after the tax year has ended - by which time it is too late. Furthermore, there are potential circular interactions with the tapered annual allowance such that if a scheme member who was utilising this option to try and mitigate their pension tax liability, could find themselves significantly worse off if the pension exchange resulted in them breaching their threshold income.

This option has also been suggested as a way to “increase” pay for lower paid staff, particularly those like junior doctors and agenda for change workers who are currently in a pay dispute with government. However, this proposal is not a pay increase and is simply taking money from one part of the remuneration package and transferring it to another. Indeed, the DDRB have in the past have tried to justify sub-inflationary pay awards by citing the “generosity” of the remuneration within the pension scheme. This is despite the NHS pension scheme becoming much less generous because of increased contribution costs, pay restraint and pension taxation. It is therefore disingenuous of Government to suggest that pension exchange is a “pay rise”.

Additionally, provisional modelling suggests that with all these pension exchange options, the amount lost in pension far exceeds any short-term increase in take home pay and hence pension exchange represents a large cut to overall remuneration. We urge the DDRB to be clear when making its recommendations that pay and pensions are part of the overall remuneration package and that any such proposals must not be allowed to be used as an argument to restrain pay even further. Furthermore, without recycling being mandated, flexibility (i.e. reducing how much you contribute towards your pension) is likely to simply represent an overall pay cut.

Movement of the tax year dates

We appreciate that Government have made some steps with regard to addressing our second concern around inflation. We would however emphasise that they propose to do so not via what would be the objectively right and full proof solution that the BMA propose, but instead by moving the dates of the revaluation.

We would emphasise that, whilst this fixes some of the problems, it does not address the fundamental issues in anywhere near as progressive a fashion as made out by Government. The Government have noted their modelling which takes the tax charge this year, as a result of moving the revaluation dates, from over £8,000 to under £700. However, this takes into account the substantive effect of the 2015 benefits. These 2015 benefits, as a result of the McCloud remedy, will be lost, as the proposed changes will move everyone back on to the legacy scheme. When the calculation is done, there will not therefore be the bulk of 2015 benefits available to the doctor. It therefore leads to the charge only going down £3,000 rather than the promised £7,000 by Government.

Further to this, they have not dealt with the issue of negative pension growth. This is not only the fair way to resolve this issue but, in not fixing this issue, the Government are, in effect, charging members of the scheme for non-existent pension growth. Were you to take this into account, our modelling shows that, using the example provided by the Health Secretary, that consultant goes from a tax charge of over £39,000 goes to nothing.

Even worse, the detriment to those who undertake extra work exacerbates the issues identified. Were a consultant to undertake extra work to help with the 7.2m waiting list - doing 12 PAs, and

only one 8 hour list per month at the BMA consultant rates, this would, using the Health Secretary's exemplar consultant, push the pension tax charge to £76,000, without being able to accrue any pension growth.

If we were take an average mid-career consultant, the results are still significant. Over 10 years, their pension tax charge would be £68,498. Had though they had the opportunity to count negative pension growth, thereby measuring real growth above inflation, this figure falls to £19,763 - some £48,735 lower, highlighting the clear impact of Government not addressing this issue.

What we therefore have in these issues not being addressed is a clearly overwhelmingly negative impact on the ability of doctors to not only undertake further hours within the NHS, but in merely maintaining their hours. Without addressing this, the NHS will be unable to address the waiting list and, therefore, it is imperative that this is resolved immediately.

Our asks of the DDRB

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 has ignored 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.

Given the devastating impact of this, the DDRB simply cannot ignore the dual 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.

[Branch of Practice specific evidence](#)

Specialty, Associate Specialist, and Specialist (SAS) doctors

Last year, the BMA highlighted the negative impact of the refusal to award anything beyond that agreed as part of the multi-year pay deal on SAS doctors in England. Data from NHS Employers in England shows that transfer numbers to the new contracts remain well-below projections, with only a minority of doctors transferring onto the new contracts since their introduction in 2021. In Northern Ireland, only 90 specialty doctors have been transferred to the new contract, with the vast majority of offer letters rejected. A BMA survey undertaken in March 2022 showed that the three main reasons individuals gave for not transferring onto the new SAS contracts were: 'I believe that my long-term financial position will be better on my old contract'; 'I am concerned about a drop in pay'; and 'I do not want to work under the new definition of plain time (7am to 9pm weekdays)'.

The subsequent decision to not award the new contracts further remuneration beyond the multi-year pay deal for a second year in a row – despite skyrocketing inflation and in the context of the greatest cost of living crisis faced in a generation – will have only exacerbated these reasons. Many more SAS doctors will now see a drop in their pay if they choose to transfer onto the new contracts than was

previously projected, and we are hearing more doctors on the new contracts regretting their decision to transfer. Further to this, the government's decision has now created an anomaly whereby many senior specialty doctors will see their pay drop if they choose to become specialists. This is because the decision not to uplift the new contracts appropriately has meant the starting salary for specialists now falls behind the top pay point for specialty doctors on the 2008 contract. We already know this is having a negative effect on recruitment, with many Trusts consequently being unable to recruit specialists.

Last year, the DDRB accepted the governments' position that doctors on multi-year pay deals are outside of the review body's remit, despite recognising that the 2021 SAS contracts were agreed at a time of low inflation and in a completely different economic climate. We note that, in its remit letter this year, the UK and Welsh governments have repeated their request that the DDRB does not make recommendations for SAS doctors on multi-year pay deals. We also note that the government has asked the DDRB to give careful consideration to the impact of its recommendations on the 2021 SAS contracts.

We strongly oppose this attempt to once again exclude SAS doctors on the new contracts from any pay award recommendation this year. We would also be extremely concerned with any attempt or suggestion that the issue caused by the governments' refusal to uplift the new contracts in line with the old contracts may be addressed by taking funding away from the 2008 contracts and redirecting it to the 2021 contracts, or awarding SAS doctors on the 2008 contracts a lower uplift as a result. All SAS doctors have worked tirelessly in a chronically under-staffed and under-funded health service with little to no recognition, and all are facing the same cost of living challenges. All SAS doctors, therefore, deserve a proper uplift regardless of which contract they are on.

We have undertaken a more recent survey of our SAS members in England. This shows that 82% of SAS doctors feel this year's pay award for SAS doctors on old /closed contracts is "inadequate" or "completely unacceptable.". 84% of SAS doctors feel the continued exclusion of SAS doctors on the new/open 2021 contracts from any additional uplift to the MYD in 22/23 has "decreased/significantly decreased morale."

In our last evidence submission, we highlighted the importance of the SAS advocate role, which was introduced as part of the 2021 contract negotiations and which was intended to promote and improve support for SAS doctors' health and wellbeing. Whilst we welcomed both NHS Employers' support for the role and the DDRB's recognition of the increased rates of bullying and harassment amongst SAS doctors, appointment of SAS advocates by Trusts remains disappointingly low.

Our recent survey of the SAS workforce, undertaken in March 2022 and covering SAS doctors in England, Wales, and Northern Ireland showed unacceptably high rates of bullying of SAS doctors. 43% of respondents stated that they had experienced bullying, harassment or victimisation in the past year. 61% of those respondents stated they did not report this incident, and the main reasons given were because they did not think the authorities would do anything about it, because they were afraid of future discrimination or harassment from authorities, and because they were afraid of reprisal from the perpetrator. Even more worryingly, of those who did report it, only 11.5% stated that positive/satisfactory action was taken in response. 75% of those who experienced bullying, harassment, or victimisation said that this was linked to their grade as SAS doctors. These figures highlight the persistently high and unacceptable discrimination SAS doctors face and underline the importance of having SAS advocates in place to promote the wellbeing of SAS doctors. We would reiterate that we would welcome the DDRB's stronger support for these roles and that the review body highlights the importance of all employers creating and funding these roles across the UK.

The same survey showed that 52% of respondents had mutually agreed job plans, and 70% have had to give up their Supporting Professional Activities time to fulfil other clinical duties in the last year. 39% had worked additional unpaid hours in the past year. 27% of respondents stated they would not recommend the SAS grade to others, and South Asian doctors were also twice as likely as white British doctors to not recommend the SAS grade (at 38%). 44% of survey respondents stated they were suffering from a mental health condition relating to or made worse by their work, including depression and burnout. 11% of respondents stated they hoped to leave the NHS to work overseas in the next 5 years, 9% hoped to leave medicine entirely, and 21% intended to retire.

The 2022 GMC workforce report data which includes SAS and Locally Employed doctors together suggests that although these two groups of doctors have grown exponentially – by 40% between 2017 to 2021 – most of this is due to overseas recruitment, and in fact SAS doctors and LEDs were disproportionately more likely to leave the workforce than the average doctor.⁵⁶ The report also highlights that these doctors face substantial challenges including difficulties in continuous professional development, unsupportive work environments and bullying.

As part of the 2021 SAS contracts, the parties also jointly agreed to spend part of the monies on a SAS development fund in England, aimed at supporting the professional development of SAS doctors. Unfortunately, despite confirmation from NHS England that this money has been allocated to all Trusts in England, many Trusts are informing us that they are either unable to find the money or have already allocated it elsewhere.

In addition to these issues, we have particular concerns regarding the viability of the SAS contracts in Northern Ireland. As we noted last year, each year of funding for the 3-year reform deal required separate approval of funding by the Department of Health. With no funding allocated by the department in April 2022, all trusts eventually undertook to pay the uplift from their existing funding. Only very recently has the Department paid this back to the trusts. We can only presume that the same issue will arise for the funding for the pay scales of year three of the deal. It did not have to be this way: the Department of Health could have chosen to guarantee funding for the three years of the deal as the other two governments did. This contract reform increasingly represents a missed opportunity in Northern Ireland to strengthen the role and standing of SAS doctors and demonstrate their value. With few doctors having transferred over, little in the way of ongoing good reason to do so given the uncertainty of the funding, and still no SAS advocates in post, there seems little to celebrate of what was originally a promising and mutually agreed deal.

In Wales, it was clear from the Welsh Government's decision to award a non-consolidated payment of £1,400 to those on the 2021 SAS contract that they appreciated the concerns raised by the DDRB around these deals. However, it is extremely concerning that this, albeit inadequate amount, was awarded as a one-off non-consolidated payment. Furthermore, the continued application of multiple year pay deals for doctors on the 2021 contract led to the Welsh Government decision to ignore the DDRB recommendation to uplift pay for all individuals on the 2008 contract by 4.5%. The Welsh Government instead announced a freeze in pay for those on the top of the 2008 pay scale, awarding only a 4.5% non-consolidated payment that will not therefore be carried forward to 2023-24.

The Welsh Minister for Health and Social Services has now confirmed that this decision was made to ensure that doctors were not discouraged from transferring to the 2021 contract from the 2008 contract on grounds of pay. This decision goes squarely against section 5 of the *framework agreement for SAS contract reform in Wales*, co-signed by Welsh Government and NHS Employers, that states "SAS doctors on national TCS will be given the opportunity to transfer to the new contracts or opt to

⁵⁶ https://www.gmc-uk.org/-/media/documents/workforce-report-2022---full-report_pdf-94540077.pdf

remain on their existing contract and TCS without detriment.” We continue to challenge this, and have already responded to the minister directly regarding her request to discuss this in social partnership on a cost neutral basis. We have explained that a cost neutral approach cannot resolve this situation without being detrimental to either those on either the old or the new SAS contract.

We have also repeatedly raised concerns with the Welsh Government that this decision has a disproportionate impact on female and BAME doctors as SAS grades feature a greater proportion of these groups. We would ask DDRB to support our concern at the precedent that has been set by the Welsh Government in reneging on a contract framework agreement in this way and in using a new contract’s multi-year pay arrangement to stagnate the pay of those who did not choose to transfer. We would therefore, request that a recommendation for a pay uplift (supplemental to the multi-year deal) is made to both groups of doctors, taking into account these points, as a fairer approach to preventing the 2008 contract from becoming comparatively more attractive. We also ask that any recommendation for this group incorporates the consolidation of last year’s 4.5% pay rise, as was recommended by the DDRB last year, to those at the top of the 2008 pay scale to avoid any further detriment to them.

The number of full-time equivalent Speciality doctors continues to increase in Wales. As noted in our last submission we were also pleased to see the introduction of the new specialist role. As anticipated, where posts have been created these have primarily been used to replace associate specialists when they have moved, resigned, or retired. This is evident because, as of October 2022, there were 14.3 full-time equivalent specialist roles in Wales⁵⁷ compared with a decrease of 9.1 full-time equivalent associate specialist post holders between December 2021 and June 2022⁵⁸. However, we would once again like to reiterate that the service need for associate specialists is unlikely to have decreased since the grade was closed to new entrants. We, therefore, continue to request an increase in the number of specialist posts, and that these are not simply used mainly to replace outgoing associate specialist post holders as we have seen thus far. We continue to work with NHS employers on tools to highlight how and when health boards could make use of the new specialist grade.

Locally Employed Doctors

‘Locally Employed Doctors’ (LEDs) is a term used to describe those employed on contracts/terms and conditions which are produced by and specific to a particular employer, rather than being automatically aligned with the national terms and conditions of service for specific grade contracts (though there will often be similarities with one or other grade of national contract). We understand this is the group referred to by the DDRB as ‘doctors on locally determined contracts.’

It remains the case that the specific number of LEDs is not reliably known to either the GMC or NHS Employers. This problem is compounded the multiplicity of names attached to such roles, such as Trust grade, clinical fellow, senior clinical fellow and FY3. However, we believe that there are over 20,000 LEDs in England alone.

In 2022, the BMA has continued its project to better support LEDs, which has included auditing the numbers and use of LEDs in England and seeking to improve the contracts available to them, including by encouraging employers to move such doctors from temporary to permanent contracts and, where appropriate, to the national 2021 Specialty Doctor contract. The BMA’s audit has

⁵⁷ Data provided by NHS Wales employers to BMA Cymru Wales.

⁵⁸ Data from Stats Wales: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Medical-and-Dental-Staff/hospitalmedicalanddentalstaff-by-specialty-year> *Medical and dental staff by specialty and year*

involved Local Negotiating Committees (LNCs) seeking information from the ~209 Trusts in England, but this has encountered a patchy response hindered by pandemic pressures, medical HR capacity, lack of reliable locally held data, and prioritisation of SAS contract implementation and junior doctor rotations. Many Trusts have indicated that they do not hold and monitor standard information on this group of doctors, making it difficult to secure usable data.

For reasons we have outlined previously, we believe it is critical that as much information can be gathered about this cohort as possible, given their increased vulnerability to poor employment and job planning practices, so that their roles and contractual provisions can be better understood and supported.

While the BMA is able to undertake large scale surveys, there are clear limitations in the case of this group, given that they are harder to identify and contact. We also know from our engagement with members that there is a limited understanding of individuals' own contractual arrangements, or what relation they bear to national contracts, meaning that any response we received to a survey aiming to identify the contractual provisions or terms and conditions to which these doctors are subject is likely to be incomplete or unreliable.

In the interests of gaining a more complete understanding of this cohort and their contractual arrangements, we would ask the Review Body to exert greater pressure on the health departments and NHS bodies to encourage cooperation from employers with any efforts to gather this data, or indeed for such NHS bodies to undertake their own comprehensive audit of the numbers and contractual arrangements of doctors in this cohort. Separate to this, we believe that it would be beneficial for the GMC to take necessary steps to better identify LEDs within their own data; at present, there is no distinction in current GMC data between those in this cohort and those in nationally agreed SAS grades. Collecting very basic information on employment status and contract type would be enormously beneficial to all stakeholders, including the DDRB.

Numbers

As of October 2022, we identified 13,062 LEDs working in the 133 Trusts that we already have data for (out of approximately 209). Based on the figures those 133 Trusts have provided, this equates to around 10% of their total medical workforce. From the data we have been able to gather from the audit, which functions as a rolling snapshot, we have identified a pattern of fewer LEDs in community and mental health Trusts, whereas major acute or specialist centres tend to employ greater numbers of LEDs. At some large Trusts, LEDs can make up as much as 46% of their medical staff (Great Ormond Street Hospital, 252 LEDs). The highest number of LEDs employed at a single employer is Barts Health NHS Trust, with 646 LEDs (23.64% of their medical workforce). Other major employers include East Lancashire Hospitals (233 LEDs; 38% of medical workforce), Manchester University (638 LEDs; 24.4% of medical workforce) and King's College Hospital (557 LEDs; 23% of medical workforce). Outside of major urban centres, we have also identified a marked regional variation in numbers, indicating that greater numbers of LEDs are employed in geographies that are generally difficult to recruit to.

Demographics

Given that the employment conditions of doctors employed under these local contracts are often less favourable than the nationally agreed terms – not just in terms of pay, but also in reduced training and career development opportunities – we remain concerned about the equalities implications of the widespread use of these contracts. LEDs are disproportionately doctors from

BAME backgrounds, with BAME doctors making up a majority of LEDs. From the information gathered, ethnicity data was available for just under half (47.7% of the total). While incomplete, this data confirms our expectations of the demographics of this group, with just over 60% identified as BAME (with 29% identified as White and 10% as 'Not stated'). From the data available, the gender split was approximately 55% male to 45% female. We also know that a disproportionate number of these doctors are International Medical Graduates (IMGs), and are often offered only local contracts on recruitment, despite doing the same work as doctors on national contracts.

Length of service and contract type

We have also gathered data about length of service, which can be useful for identifying poor contract management. Individuals accrue certain employment rights after 2 years of continuous service and have a legal right to a permanent contract after 4 years of continuous service. The majority of doctors in our data (4884 LEDs) were between 1 – 2 years' service, with 840 between 2 – 4 years' service, 451 between 4 – 10 years' service, and 111 with greater than 10 years' service. The widespread use of temporary contracts in inappropriate circumstances remains a problem that needs to be resolved.

Crucially, however, we have been unable to identify from the data provided by Trusts which types of contracts these LEDs are employed on, both in terms of whether they are permanent or temporary contracts and of which national contracts their terms may be most closely analogous to (whether 2002 junior doctor, 2016 junior doctor, or SAS grade contracts, if at all). We continue to work locally to properly identify the contracts currently in use, the length of service of individuals, and to seek their transfer to national contracts where appropriate.

At present, the route available to LEDs for moving to national contracts is almost entirely reliant on the BMA's member relations staff entering into negotiations on behalf of these doctors individually to try to secure employers' agreement to transfer them to national terms and conditions. We believe there needs to be a fairer and more consistent process for facilitating transfer from these roles, which we consider to be effectively 'hidden' SAS doctor jobs in many cases, to national contracts.

Application of pay award

We note that the DDRB stated in its 50th report that LEDs are included in their overall remit and that it 'would expect that employers would uplift their pay in line with our overall recommendations' (11.29).

Based on our engagement with Trusts, we have no evidence that the 4.5% pay award recommendation for LEDs in the last pay round has been implemented in any widespread or systematic way. The view of NHS Trusts appears to be that local employers are not legally or contractually obliged to apply any pay award to those on local terms, regardless of the DDRB's recommendations, unless there are explicit provisions in their local contracts to require this.

As a result, many Trusts report to us that unless they are directed to take a different approach, they will not apply the 4.5%. This has not been helped by the NHS Employers pay circular (MD 3 2022) not addressing LED pay. The nature of LED contracts means that NHS Employers consider it is not their role to issue instructions or guidance about LED pay, or any increase that might be applied to it, in their pay circulars. Trusts look to these circulars to explain what changes have been implemented to pay in any given pay round. If it is correct that the DDRB's recommendations for LEDs should not be

implemented through the M&D pay circular, we would invite the DDRB to clarify through what mechanism they expect this uplift will be implemented. DDRB recommendations pertaining to LEDs which are not implemented will have no impact upon the recruitment, retention or morale of this already under-supported segment of the medical workforce.

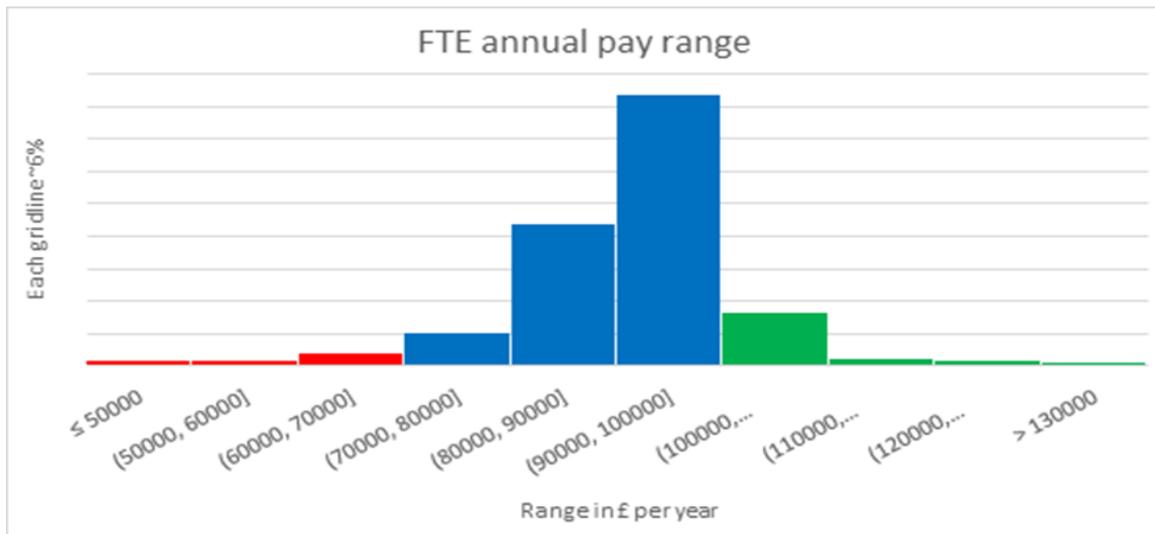
If the pay award is to be properly applied to this group, we believe the DDRB will need to recommend that the health departments actively direct employers to uplift pay appropriately, otherwise we believe that many will simply ignore this group and make no adjustment to their pay.

Salaried GPs

In our evidence to DDRB last year, we indicated that we had undertaken some initial research relating to the salaried GP pay range in 2020 which underlined the extent to which the pay range bears little relation to actual levels of pay. Building upon that evidence base, we took the opportunity to run a second survey in Autumn 2022 which also collected a wider range of information around how salaries are set in practice. The survey was open to GPs in England, Scotland and Northern Ireland, and received 1,870 valid responses (of which 73% were from female GPs). Based on the responses from England, the average number of hours worked by salaried GPs per week was around 20, with over 4 additional hours unpaid overtime. Interestingly, the survey showed no relationships between pay and years worked (in current role or career as a whole). The range of pay showed a median of £90,000 per FTE (mean of £90,688). When compared to the DDRB salaried GP pay range, just 4% respondents earned below the DDRB range, but 21% earned above the range in FTE terms.

In the BMA's evidence to the DDRB last year, an 80% confidence interval range was used to propose a new range. The basis for this was threefold: to maintain broadly the same length range as the current one, that there appeared a step-change around the proposed bottom and top points, and that this interval reflected what the pay range would now look like if it had been uplifted by inflation since its introduction (not by DDRB pay range recommendations).

The data from this survey is sufficiently normally distributed (bell curve shaped), i.e. it is not skewed, for this to be a sensible approach, so the 80% range using this survey data would be approximately £74,200 to £107,200. This compares to last year's evidence which proposed a range of £77,250 to £103,870 on that basis, so broadly similar. Both the 2020 and the 2022 surveys confirm that there is a consistent discrepancy between the DDRB recommended range and reality and that the bottom and top ends need to be uplifted by at least £9000 (before applying the pay recommendation for this pay round) if it is to fulfil its purpose and ensure a level of consistency across all salaried GPs regardless of their gender, work patterns and ability to negotiate locally.



The survey provided some rich data around how salaried GPs and contractor partner GPs who employ them believe salaries are set and increased, which identified some differing views around the extent of negotiation, which was proposed by the [Mend the GAP: The Independent Review](#) as one reason for the gender pay gap with female salaried GPs feeling less able to negotiate a higher salary. For example, in our survey, male salaried GPs were more likely to report they negotiated their starting salaries in a new job or indeed proposed a salary that was accepted (44.0% male GPs compared with 34.5% female); conversely female GPs were more likely to say they were not able to negotiate where the starting salary was lower than hoped (21.3% female, 14.0% male). This again highlights the importance of revising the pay range to bring it more in line with market forces. Our contention is that a reliable, evidence-driven basis for pay ranges for sessionals would go some way to challenging the pay "ask gap" and thereby drive a reduction in this disparity. (The "ask gap" measures the extent to which women ask for lower salaries than comparable men. This is one component of a complex set of issues contributing to gender pay inequality and discrimination.)

The survey continued to show that the average annual pay increase was below the DDRB recommendation (e.g. 3.1% for those salaried GPs who have received a pay rise since April 2022), despite the review body's emphasis that it is 'important that pay uplifts are passed on to salaried GPs, in line with the BMA model contract'. Around 12% respondents stated they had not received any pay rises. A pay range that does not reflect the current market forces will exacerbate this situation, as salaried GPs outside the range may find themselves excluded from any increase to that range and hence any pay increase. There was also some evidence that male salaried GPs were more likely than female GPs to negotiate their uplifts personally.

What was clear from our survey is that there is a continuing demand for a salaried GP pay range, and for DDRB to continue to make recommendations for an annual pay increase for salaried GPs – but crucially that the range has to be realistic which currently is not the case. As a minimum, we would ask that DDRB increases the bottom and top of the pay range by a minimum of £9,000 before any further pay recommendation for this group. As a minimum, this would bring the DDRB pay range to £74,070 to £107,194 before applying any pay uplift for this year.

GP Appraisers and Trainers

We have no new evidence this year to draw upon with regard to appraisers and the GP trainers grant. We would request that DDRB ensures, as a minimum, the appraisers' fee and the trainers' grant is uplifted by a minimum of 4.5% for 2022/23 and that the recommendations for 2023/24 likewise uplift in line with the GP pay recommendations as a minimum.

Health Education England (HEE) is currently seeking a new formal mechanism to fund GP trainers appropriately, so that presents an opportunity to evaluate the funding going to training practices to ensure it is sufficient. They are also keen to increase the annual GP specialty training cohort to 5,000 – 6,000 a year, in order to plug the thousands of gaps in the workforce, which with the opportunity for any practice to be a training practice, means this all needs to be properly resourced. This is critical as GP numbers have been falling leading to a GP shortfall in England estimated at 4,200 full-time equivalents by the Health Foundation⁵⁹, which has meant that GP trainers find it increasingly more difficult to dedicate time to the level of supervision GP trainees need, given their clinical commitments to patients. This will certainly be the case in areas of poor health equality and deprivation because, when there is a shortage of supply, less desirable places to live and work almost certainly experience recruitment difficulties the most. It is therefore vital that as many practices and GPs as possible are incentivised to become GP trainers because we cannot overcome the GP workforce crisis without additional trainers and trainees.

We hope to undertake some more specific research in this area, so will update DDRB in next year's evidence, or sooner if available for this round.

GP trainees

For the past 4 years, GP Trainees (alongside other junior doctors) in England have been part of a 4 year pay deal. Due to that deal, the government has not asked the DDRB to make any recommendations on GP Trainee pay. This includes not making any recommendations on the GP Flexible Pay Premia (GP FPP). However, the submission from DHSC for the 21/22 pay round noted that "... following the conclusion of the four-year deal, it will be appropriate to ensure that the GP FPP remains at the level which is appropriate in aiding wider priorities around GP recruitment."⁶⁰

The BMA has consistently advocated, throughout the long term pay deal, that with regards to the FPPs already in place in England, it is important that the DDRB continues to recommend that any percentage uplift to pay applies to these cash sums so that they are not degraded by inflation.

However, in the case of the GP FPP the cash sum has not only failed to keep up with inflation, but has also failed to fulfil its original purpose which was to ensure pay parity between GP trainees and their hospital counterparts as its value was originally set too low. This was something that both the BMA and NHS Employers acknowledged during the 2018 contract review but were unable to resolve at the time due to the tight timeframe of the negotiations. It was agreed that this pay discrepancy would be addressed through one of the thematic groups that would be taken forward by the joint negotiating committee on juniors but, however, due to the unwillingness of NHS Employers this has yet to progress.

We believe that it is now high time for this to be addressed not least because it is fundamentally unfair, but also because it likely has a significant impact on the ability of general practice to retain GP trainees

⁵⁹ <https://www.health.org.uk/news-and-comment/charts-and-infographics/the-gp-shortfall-in-numbers>

⁶⁰ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/966692/DHSC-written-evidence-to-the-DDRB-for-2021-to-2022.pdf#page107

at a time they are needed the most. As a recent BMA survey of junior doctors⁶¹ showed that more than half of GP trainees who responded to that survey strongly agreed that they often think about leaving the NHS, with around a quarter stating they will leave the NHS as soon as they can find another job. Over three-quarters gave the level of current pay as a reason for these answers.

The BMA has carried out an analysis of this gap and identified that non-basic pay added approximately 37.9% to basic pay in the average earnings of Specialty Registrar doctors in 21/22, the latest full year available. The GP FPP however is currently 22.7% of basic pay, significantly below the previous contract's 45% supplement, and critically below the 37.9% addition to basic pay in the average earnings of Specialty Registrar doctors in 21/22. This equates to £6,117 so we therefore call on the DDRB to recommend an uplift to the GP FPP by at least that amount to correct the historic discrepancy.

Medical academics

Medical academics play vital roles in the education of undergraduate medical students and other healthcare students, in research and innovation and in the provision and leadership of clinical services. Their invaluable role was particularly highlighted during the height of the COVID pandemic. However, despite the planned and unplanned increases in the number of medical students in recent years the number of medical academics has fallen, both in absolute terms but more significantly as a proportion of the medical workforce. It is crucial, therefore, that the recruitment and retention of medical academics is prioritised so that we have a cadre of doctors that can lead both the teaching of medical students and the UK's medical research efforts. This requires the governments of the UK to commit to providing the funding necessary to secure and build the academic workforce of the future. Without offering full pay parity between medical academics and their NHS colleagues, the UK will struggle to recruit and retain this group of doctors and will not be able to improve quality in NHS care or compete internationally.

Maintaining pay parity with NHS colleagues is a vital principle underpinning academic medicine and we remain concerned about the impact of inadequate funding on this. We would therefore urge the DDRB to recognise and highlight the importance of pay deals in the NHS being funded by the government in the academic sector. This principle applies to areas such as clinical excellence and clinical impact awards, as well as access to pay related proposals such as pensions recycling.

The academic pay premium was established in England to compensate academic trainees and other junior doctors that stepped out of training to undertake a PhD or other medical research activity and who, as a consequence of this, had their pay progression delayed. Hence, the pay premium is a mechanism for assuring pay parity between NHS and academic trainees.

However, it is a rather blunt instrument which is not based on a detailed calculation of the impact of the delay in progression on career earnings. In addition, under the terms and conditions of service it is supposed to be fixed at the point when the trainee first received it. Hence, its effect in ensuring pay parity is diminished during the course of training.

As set out in last year's evidence submission, academic medicine and academic trainees would do better under a system in which the flexible pay premium is set as a fixed percentage of the full-time equivalent basic pay. This means its value would increase in line with basic pay. Our starting position is that 15% of basic pay might be an appropriate value of this premium for academic trainees. In this way clinical academic trainees and trainees that have completed a PhD would be appropriately rewarded for their invaluable contributions to the medical research and academic medicine.

⁶¹ Life as Junior Doctor, unpublished. November 2022

We would also reiterate our position that this must be funded by the UK Government, rather than by expecting universities to absorb this cost. Failure to do so would risk reducing the number of available academic training posts and will have a negative knock-on effect on the training of future clinicians. Teaching staff in particular are vulnerable to fluctuations in the income of universities in the UK, whether this is a result of tuition fees not rising at all in each successive year or a reduction in overseas students, and there is a risk that this will negatively impact the number of clinical academics needed to train the next generation of medical students and undertake the medical research needed to improve patient care.

Northern Ireland Consultants

Consultant members in Northern Ireland continue to describe the dual challenges of requiring pay uplifts which recognise their value, rectify historic pay erosion and address ongoing recruitment and vacancy issues, whilst also managing the problems that arise from any further pay uplifts regarding their pension allowances. Over 80% of consultant respondents to our survey were dissatisfied with the 2022/23 pay award. 56% of consultants reported that the pay award would make them more likely to leave the HSC in Northern Ireland.⁶²

Consultant members are increasingly reporting colleagues taking up work in the Republic of Ireland, often for significantly higher pay with significantly lower workloads. Many consultants live sufficiently close to the land border that undertaking this work requires little or no adjustment to other elements of their lives but provides clear benefits for their careers and working lives. This was confirmed in a 2022 GMC workforce report which detailed that Ireland is the second most popular destination for doctors who left the UK workforce and wanted to practise and live abroad between May 2021 and May 2022.⁶³

The recently agreed Sláintecare Contract for public sector work for consultants in Ireland, with pay scales ranging from €209,915 to €252,150 for a 37-hour week,⁶⁴ represents a development that could have a significant effect on the supply of consultants in Northern Ireland. We ask that the DDRB investigates this issue in particular this year and considers these labour market dynamics, which are unique to Northern Ireland within a UK context, when providing their recommendation. We believe there is a clear case for a significant pay uplift for consultants to address the recruitment and retention issues this will cause.

The BMA and the Department of Health in Northern Ireland are working together through a mediated settlement process to create and agree a framework for a new CEA Scheme. The BMA is committed to this process and hopes for a successful outcome, and will update DDRB in next year's evidence. If this is not possible, we will consider whether the adjourned trial should be re-listed.

Northern Ireland Junior doctors

In Northern Ireland, junior doctors continue to work under outdated terms and conditions that provide little reassurance of fair pay for work done, nor the safe working practices that are enjoyed in other parts of the UK. We have some anecdotal evidence that there is widespread practice of not honouring key elements of the terms and conditions, particularly regarding rota monitoring. Little progress has been made on fatigue and facilities issues in Northern Ireland and increased work

⁶² BMA NI survey, 2022

⁶³ https://www.gmc-uk.org/-/media/documents/workforce-report-2022---full-report_pdf-94540077.pdf, pg. 65.

⁶⁴ <https://www.gov.ie/en/press-release/33536-minister-for-health-announces-government-approval-of-new-slaintecare-consultant-contract/#:~:text=The%20new%20SI%3%A1intecare%20contract%20will,du-ties%20and%20overtime%20as%20applicable>

pressures as a result of the continuing deterioration of the health service overall will hit junior doctors particularly hard.

We are beginning to see the effects of this. In August 2022, 11% of training posts across Northern Ireland sat vacant, up from 8% in August 2021.⁶⁵ To us, this is not surprising: 88% of junior doctors that responded to our survey this year were dissatisfied with the pay uplift of 4.5% for 2022/23. 73% of respondents felt their morale would decrease as a result of the pay uplift and 72% said it would make them more likely to cease working for the HSC in Northern Ireland.⁶⁶ In the context of eroding pay, increasing working pressures and poor working conditions, it is no wonder we are beginning to see a greater number of vacant training posts.

We continue to call for a dialogue with DoHNI regarding contract reform that will improve trainee safety, work-life balance, and recognition. It is unlikely this will be possible until an executive is formed. Therefore, until this work is underway, the importance of pay as part of the total reward package only increases and so too do expectations upon the DDRB to provide a fair uplift that works towards restoring junior doctor pay to previous levels. All options remain open to us, including escalation of a trade dispute, in order to achieve this aim. We urge the DDRB to provide a significant pay uplift for junior doctors in Northern Ireland that makes steps to address historic pay erosion and ensure that Northern Ireland remains an attractive location for medical training.

Wales and Northern Ireland GP

For general practitioners in Northern Ireland, we are once again obliged to raise the issue of indemnity. GPs in Northern Ireland remain the only doctors in the UK who are responsible for their own indemnity costs. We remain deeply frustrated with the DoHNI who continually promise that this will happen, but yet nothing is brought forwards. We would like the DDRB to take this into account and support our calls for a reimbursement scheme for GP indemnity.

GPs in Northern Ireland have also seen no uplift to the out of hours payments since 2013 and GPs with special interest rate may also be in a similar position. The department of health specifically mandated the exclusion of OOH GPs from the pay increase as GP OOH were not included in the pay circular. This remains the case. This cohort of GP's had received the pay increase up until this point. We understand that a business case was supposed to be taken forwards but again this remains outstanding from 2013 and there are no plans to progress. We are aware that the development of Urgent Care centres is a major departmental policy approach and that the pay rates of OOH doctors will be taken forwards during this development and this is welcome. But BMA NI will be seeking retrospective payments for this cohort of doctors. It is therefore crucial that GP OOH and GPs with special interests are specifically included within the remit of the DDRB report and that these rates are uplifted as soon as possible.

In the wake of Welsh Government's pay award announcement⁶⁷ in 2022, BMA Cymru Wales undertook a survey of the profession in Wales during July 2022. We included GPs in this survey, despite the fact that pending GMS contract negotiations would determine the method of application of the pay award to contractor GPs, and salaried GPs who work at practices. Overall, 86% of GP respondents said they were either 'angry' (30%) or 'disappointed' (57%) with the pay award. When asked if the announcement would affect their future likelihood of remaining in the NHS, 48% or

⁶⁵ NIMDTA vacancies figures, August 2022 and 2021.

⁶⁶ BMA NI survey, 2022

⁶⁷ <https://www.gov.wales/health-minister-announces-pay-rise-nhs-wales-staff>

respondents said that it would⁶⁸. These statistics demonstrate the level of morale amongst the GP profession and the precarious nature of this workforce in the near future.

This last year has seen an unavoidable and extraordinary increase in the cost of living. In many parts of Wales this has called into question the sustainability and indeed viability of many practices. When seeking to apply any pay awards to a practice-based contract, it is imperative that practices also receive sufficient financial investment to the expenses portion of the contract. Without this, any GP contractor uplift cannot be realised after the respective pay uplifts are passed on to employed staff (including salaried GPs) and other expenses are accounted for. We have in the past welcomed DDRB's endorsement of an uplift for wider practice staff through our agreement of an expenses investment through our negotiations, alongside a contribution toward mounting energy costs. However, this does not mitigate against the full cost of doing business and urgent action is needed.

Following extensive tripartite negotiations, GPC Wales agreed the GMS contract deal with Welsh Government in October 2022. Certain elements of that agreement lay the groundwork for the development of a new streamlined and simplified GMS contract. Emphasis has been placed on clinical judgement with a focus on those things which only GMS can and should do at an individual practice level. It is proposed that the new 'Unified contract' takes effect from October 2023 subject to Ministerial approval and Senedd legislative procedures. We will update DDRB with progress on this in next year's evidence.

Conclusion

The current cost of living crisis on top of 15 or more years of real terms pay decline, coupled with punitive pension taxation and ever increasing workload from an under-resourced service, has meant many doctors feel they now have no alternative but to leave the health service, which will further exacerbate this situation.

While pay is of course only one element in doctors' career decisions, our evidence has shown that it is very, and in many cases the most, important factor. Therefore the BMA is asking DDRB to recommend a substantial pay increase to all doctors which will deliver full pay restoration, which will help turn round the retention issues and restore the value of doctors before it is too late. We further ask that DDRB makes its recommendation as a fully independent body which is not constrained by the governments' remit letters or affordability constraints.

⁶⁸ BMA Cymru Wales Pay Announcement Survey, July 2022. 39.1% answered 'Yes' and 8.4% answered mentioning 'retirement' or 'resignation'