BMA

BMA evidence submission to the DDRB 2025/26 pay round

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British Medical Association
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Table of Contents

Introduction 5

Response to the 52nd Report 2024 6

Comments on the updated terms of reference 7

Economic environment 8

- Pay Erosion 8
- Professional comparators 9
- International comparators 11
  - Australia 11
  - Canada 13
  - Republic of Ireland 15
- NHS Leavers Survey 16
  - All doctors 16
  - Reasons for leaving 17
  - Destinations 18
  - Welsh leavers' data 19

Workforce 20

England 23

- Consultants 23
  - National Clinical Excellence/Clinical Impact Awards (NCEAs/NCIAs) 25
  - Recommendations 27
- Specialist, Associate Specialist and Specialty (SAS) Doctors 27
  - The 2024 pay deal and contract transfer 27
  - Individual employers and contract transfer 28
  - Value and wellbeing 29
  - Pay ask 30
  - Specialist roles 31
  - Recommendations 33
- Locally Employed Doctors (LEDs) 33
  - Key issues facing LEDs 33
  - Retention 36
  - Continued data gap 36
  - Transferring contracts 36
  - Pay ask 37
  - Recommendations 37
- Resident doctors 37
  - Pay erosion 38
  - Physician associates and pay 39
  - Training 39
  - Recommendations 40
- Contractor GPs 40
  - Global Sum resource allocation payments 41
  - Training Fees 43
  - GP appraiser fee 44

Dispensing practices 44
Fellowships 44
Recommendations 45
Salaried GPs 45
Sessional GP unemployment and under-employment 46
Salaried GP pay range and uplifts 47
PCN payments for salaried GPs recruited via the ARRS 48
Workload and workforce 49
Pay erosion for salaried GPs 49
Recommendations 51
Public health doctors 51
Recommendations 52
Medical academics 53
Recommendations 54
Medical students 55
Recommendations 55
Northern Ireland 56
Consultants 57
Pay erosion for consultants in Northern Ireland 57
CEAs 58
Pay deal 58
Pension mitigations 58
Vacancy data 58
SAS 59
Pay erosion data for SAS doctors 59
Implementation of 2021 contract 60
Progress on creation of specialist roles 60
Vacancy data 61
SAS pay talks 61
Resident doctors 62
Pay dispute 62
Pay erosion 62
Training 64
Physician associate pay compared to resident doctors 64
Strike deductions 65
Contractor GPs 65
Number of GPs in Northern Ireland 66
Impact of increased National Insurance charges 66
GP Indemnity 66
NI issue for GPs with special interest and those working in out of hours (OOH) 67
Multi-disciplinary teams 67
Medical academics 67
Recommendations 68
Scotland 68
Wales 69

NHS Wales performance....69
Consultants....71
Workforce analysis....71
Pay campaigning....71
New pay scale....72
Pay erosion....72
Clinical impact awards....73
Expenses and allowances....74
Recognition of LTFT training and Covid disruption....74
SAS doctors....74
Workforce analysis....74
Pay campaign....75
Pay deal....75
Pay erosion....76
Locally employed doctors....76
Resident doctors....78
Workforce analysis....78
Data availability....79
Industrial action....79
Pay erosion....80
Contract reform....80
Study leave....81
Contractor GPs....81
Recent Welsh GMS contract settlements....81
General practice investment erosion in Wales....82
Workload....85
Education and Training issues....86
Recruitment and retention....87
Salaried GPs....88
Job opportunities and underemployment....88
Recommendations....89
Pensions (UK)....89
The impact of tiered employee pension contribution rates and pay erosion....89
Changes that limit accrual of pension benefits....91
The pension taxation system....92
The interaction between tiered employee pension contribution rates and income tax relief....92
Unresolved flaws in annual allowance (including the tapered annual allowance) design....94
Recommendations....96
Appendix 1....98
International comparators- cost of living....98
Appendix 2....99
Why does the BMA use RPI to calculate pay erosion?....99

Introduction

2024 has been an important year for the medical profession: secondary care doctors in all four nations were in ongoing pay disputes with their governments following over a decade of pay erosion and inaction by the Review Body on Doctors' and Dentists' Remuneration ('DDRB' or 'pay review body') to address this. Consultants in all four nations and resident doctors (formerly referred to as junior doctors) in England, Northern Ireland[1] have achieved pay deals following disputes with their respective governments. SAS doctors in England and Wales have agreed deals, while Northern Ireland SAS doctors have received a pay offer which will be put to members. SAS doctors in Scotland remain in talks with the Scottish Government to agree a pay deal.

While most disputes have been settled for secondary care doctors for 2023/24 and 2024/25, the same cannot be said for primary care doctors. Years of underfunding and insufficient contract investment have resulted in general practice being beyond breaking point in many places. GPC England is currently in dispute with the Government and have been undertaking a collective action campaign to establish a 'professional reset'[2] since August 2024. GPC Wales have recently rejected the GMS contract offer and will be holding a referendum of its members, recommending that they also reject the offer from Welsh Government[3]. Northern Ireland GPC are engaging in further talks regarding the implementation of their contract following issues with the outworkings of the 2024/25 contract which, if not resolved, will make 2025/26 contract negotiations difficult.

The new Government's pledge to 'build an NHS fit for the future'[4] cannot be realised without fixing general practice, and time has almost run out to do so. Even more GP partners are telling us that they are preparing to hand back their contracts; between 2013 and 2023, the number of independent GP practices in England fell by one fifth (20%)[5], with 29% of respondents to the GPC England Practice Finance survey having already stopped financially unviable services and a further 45% considering doing so.[6]

The pay awards agreed this year, and recommended by the DDRB, were a first step towards reducing pay erosion but have certainly not addressed the much wider issue of salary devaluation and the unfairness relating to this. The fight for pay restoration is by no means over: BMA member policy from 2022 makes clear that pay restoration needs to be achieved by 2027/28 and the BMA and its members will not hesitate to re-enter into disputes and, if necessary, undertake industrial action if the journey to pay restoration doesn't remain on course. It is high time for the DDRB to restore our confidence in the Review Body process and **recommend a significantly above inflation pay uplift, in RPI terms, to restore doctors pay to 2008/09 levels.**

[1] Resident doctors in Scotland were not in dispute in 2024, but were in direct negotiations with Scottish Government regarding pay following agreement on a pay deal in 2023.
[2] GPC England, August 2024
[3] GPC Wales, November 2024
[4] Labour Party Manifesto, June 2024
[5] BMJ, September 2024
[6] GPC England Practice Finance survey, September 2024

Response to the 52nd Report 2024

Despite the UK Government's attempt to curtail the DDRB's recommendation to another below inflation award of 2%,[7] the BMA acknowledges the DDRB's recommendation for 2024/25 of an above-inflation pay award for doctors across the UK.

The rampant inflation of late 2022, which persisted through much of 2023, had caused financial instability, low economic growth and unmanageable cost of living pressures. Inflation at the time of the DDRB's publication in July 2024 stood at 3.6%,[8] measured by RPI; a significant drop from 9% in July 2023.

Despite this year's above-inflation award, there is still a considerable amount of progress needed to realise pay restoration for both primary and secondary care doctors. The DDRB's recommendation, combined with in-year pay awards following pay disputes and periods of industrial actions, have begun to reduce the impacts of long-term pay erosion, but have by no means restored pay to 2008/09 levels.

Further disappointment was felt in the nations, with the devolved Governments delaying even more their acceptance of the DDRB recommendation. The Welsh Government only confirmed that it would accept the DDRB award in full in September 2024,[9] delaying the uplift and backpay reaching doctors by a further two months, while Welsh GP contract discussions for 24-25 only received ministerial sign-off to begin during that month. The Northern Irish administration has not yet confirmed that it will be honouring the DDRB recommendation, and to add insult to injury, it is expected that the full award of 6% for all doctors will not be acknowledged. Scottish Government's acceptance of the DDRB recommendations for GP contractors and salaried GPs was announced and implemented later than normal. Delays to, and indeed rejections of, the DDRB's recommendation undermine the faith doctors place in the Pay Review Body to authoritatively preside over their pay and further exacerbates their frustration at their Governments' inability to recognise their value.

We were disappointed to see the DDRB's repeated use of 2010 as the base year for measuring how doctor's earnings have tracked against inflation. The BMA has repeatedly asserted that pay erosion should be measured from 2008 because that was the onset of the financial crisis and subsequent austerity policies. Utilising later timepoints significantly underestimates the pay losses that doctors have experienced.

We have concerns with NHS England's presentation of salaried GP pre-tax income to the DDRB as wholly from employment, when this income includes from both employed and self-employed earnings. This approach by NHS England is disingenuous and artificially inflates the earnings of salaried GPs. This issue is covered in more detail in the salaried GPs in England section.

Further consideration must be given to international comparisons, to ensure that the competitor countries included in the DDRB's analysis are relevant to UK doctors. It is the BMA's view that being an OECD member should not be the benchmark for inclusion and many significant comparator countries (such as Australia, Canada and the United States) have been omitted from key data sets, decreasing the meaningfulness of this analysis. The key component of the new terms of reference are that they should be "relevant" international comparators, i.e. those competing for the current

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[7] DDRB, July 2024
[8] ONS, November 2024
[9] Welsh Government, 2024

and future UK medical workforce. We will explore in more detail the countries we consider attractive competitors for UK-trained doctors in the international comparators section of this evidence.

We were pleased that the DDRB have set a deadline for written evidence, which moves the implementation of the 2025/26 award closer to the intended timeline. We hope that this timeline will be achievable, and the publication of the report will be before or as close to 1 April 2025 as practically possible, so that the uplift and any backpay is in doctor's pay packets soon after. Ensuring that the award is implemented in a timely fashion at the beginning of the financial year will demonstrate to doctors that the DDRB is committed to independence and recognises the need for a relationship reset between the Pay Review Body and the profession within its remit.

Comments on the updated terms of reference

During the period of industrial action that took place throughout 2023, members from across branches of practise were clear that they felt meaningful DDRB reform was a key component in restoring their lost pay. Therefore, on behalf of all branches of practise, the United Kingdom Consultants Committee (UKCC) received a mandate to negotiate new terms of reference with Government, with the intention that these new terms would remove affordability constraints on the DDRB and enable the body to independently reach its recommendations. These agreed new terms of reference are:

> The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. Its terms of reference were introduced in 1998, and amended in 2003, 2007 and 2024 and are reproduced below.
>
> The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for NHS Recovery, Health and Social Care of the Scottish Government, the First Minister and the Minister for Health and Social Services of the Welsh Government and the First Minister, deputy First Minister and Minister of Health of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.
>
> In reaching its recommendations, the Review Body is to have regard to the following considerations, evaluating the weight of each independently, in parallel and non-contingently:
>
> - The need to attract, recruit, retain and motivate doctors and dentists, including consideration of local and regional labour market factors, in view of their contribution to the health of the nation;
> - Developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators;
> - Economic and other evidence submitted by the Government, and the funds available to the Government Health Departments;
> - Economic and other evidence submitted by staff and professional representatives, and others;
> - Wider macroeconomic factors;
> - The overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved; and
> - The legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.
>
> The Review Body may also be asked to consider other specific issues, where agreed by relevant unions and the Government. These Terms of Reference are intended to give all parties, including the remit groups, confidence that the Review Body's recommendations have been independently, properly and fairly determined. Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for NHS Recovery, Health and Social Care of the Scottish Government, the First Minister

and the Minister for Health and Social Services of the Welsh Government, and the First Minister, deputy First Minister and Minister of Health of the Northern Ireland Executive

Although the BMA is encouraged by the redrafting of these terms, and the Government's willingness to collaborate on this shared initiative, it is ultimately the proper implementation of these terms that is important, the results of which will not be made clear until the DDRB publishes its next recommendation. It is the perspective of the BMA that the DDRB should not ignore the historic circumstances that necessitated the revision of these terms. We expect that the DDRB will embrace the spirit of the reforms of its terms of reference for the 2025/26 pay round. In reaching this recommendation, the DDRB must do everything within its power to assert its independence and the independence of the recommendations that it makes.

The BMA was concerned earlier this Autumn, when the Government released the 2024 remit letter to the DDRB. Despite assurances that had been given by the Chancellor earlier in the year, the remit letter included several references to wider economic performance and inflation. This was in contravention of the deal that had been reached with the previous Conservative government, which agreed that "remit letters will not include information about inflation and wider economic performance, which will instead be addressed through Government evidence." Despite this, the 2024 remit letter included the following:

> *"…My department's evidence will … also set out the funds available to the Department of Health and Social Care for 2025 to 2026, which will be finalised through the Spending Review and announced at the Autumn Budget on 30 October 2024. That comes against the backdrop of the challenging financial position this government has inherited, including a £22 billion pressure against the spending plans set out for departments at Spring Budget 2024…"*

The inclusion of a narrative about "*funds available to the Department of Health and Social Care*" for the pay award; the mention of the Spending Review and Autumn Budget fiscal events; and the context of a "*backdrop of the challenging financial position… including a £22 billion pressure against the spending plans*" clearly and directly contradicts the agreement that remit letters will not include information about inflation and wider economic performance. Any such details should have been limited to the Government's own evidence to the DDRB and not mentioned directly, or indirectly (as a reference to the Government's own planned evidence or as a reference to an upcoming fiscal event), in the remit letter. It is extremely important that the DDRB, as clarified in subsequent correspondence from DHSC, does not consider these as constraints that should impact the review body's recommendations.

Therefore, whilst the BMA is hopeful that the new terms of reference will bring about meaningful changes to the way the DDRB works, we remain sceptical of the Government's commitment to respecting the spirit of the DDRB reforms.

Economic environment

Pay Erosion

Although the DDRB's 2024 recommendation was a step in the right direction, the uplift follows a long-term trend of real terms pay cuts and devaluation of doctors' roles over the past fifteen years. A sequence of below-inflation pay rises have significantly reduced the real value of doctors' earnings since 2008. As illustrated in Figure 1 the average hospital doctor earned £72,182 in 2008/09. However, in 2008/09 terms they earn only £51,319 in 2023/2024. This marks a clear failure of Government and the DDRB process to protect doctors' remuneration in real terms.

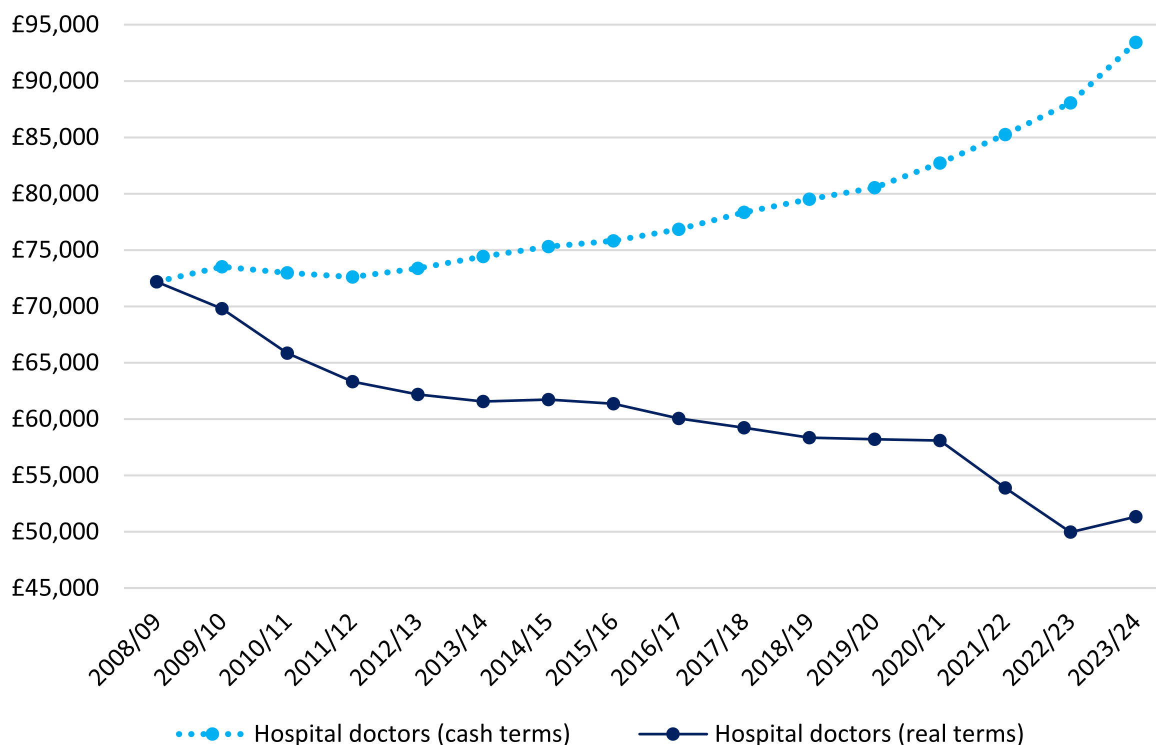

Figure 1: Real decline in value of gross pay for the average hospital doctor in England, using RPI

The starting point of 2008/09 was chosen as it marks the onset of the global financial crisis and significant changes in government pay policy. This period includes austerity measures and the point at which the government began actively constraining the DDRB, leading to successive pay freezes and below-inflation pay increases. Whilst earnings growth began to stagnate in early 2008, doctors' pay has eroded more significantly since then and has not recovered at the same pace as other professions, as shown in Figure 3.

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 within five years. Therefore, all calls to achieve pay restoration contained within this document are set according to this timeline, if not sooner. This means that our members expect their pay to be restored according to RPI by 2027.

Professional comparators

Despite the critical nature of healthcare, the average hospital doctor has seen a much greater decline in pay compared to professionals in Finance and Business services, sectors that have recovered more robustly post-2008. This discrepancy raises concerns about the government's valuation of healthcare professionals.

Figure 2 highlights that workers in the Finance and Business Services, Professional, Science & Technical and Private Sectors have seen their pay increase, adjusted for CPI, from March 2009 to levels unseen by the average hospital doctor at, 9%, 6% and 0.9% respectively. This clearly shows that the pay of average hospital doctors has not kept up with inflation or comparable professions.

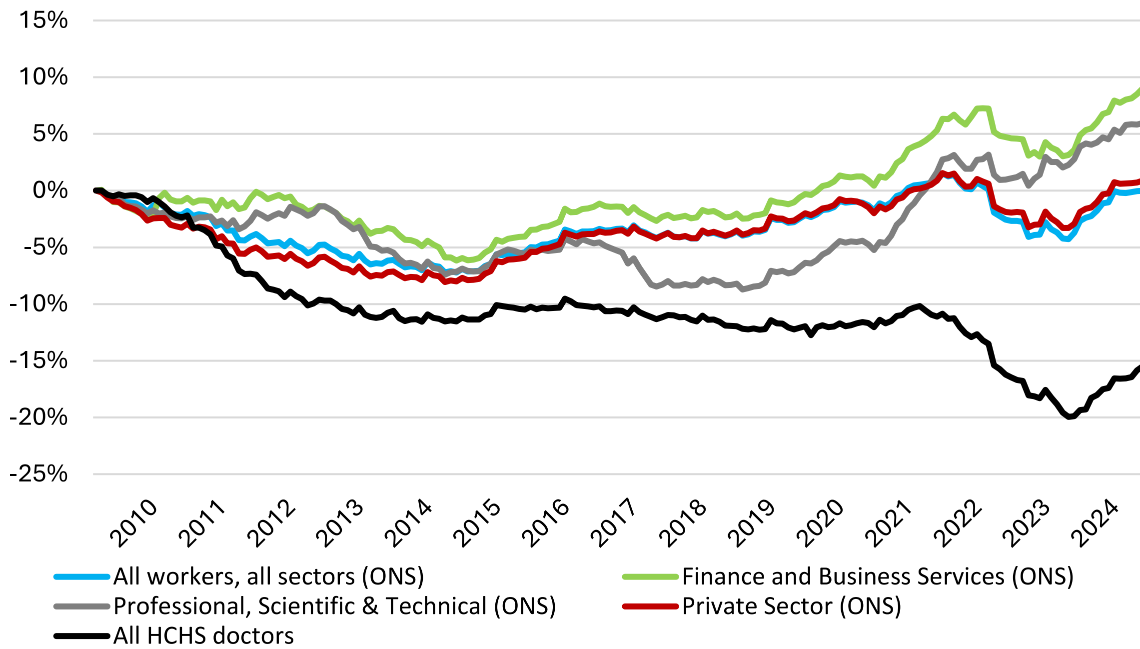

Figure 2: Real change (%) of mean earnings for all HCHS doctors in context, using CPI

Due to effective industrial action efforts from the profession, there has been a slight uptick in real terms pay for the first time since 2008/09. However, recommendations from the DDRB have been inadequate in facilitating this short-lived progress as additional negotiations with Government were necessary to additionally part-curb the negative impact of below inflationary pay uplifts recommended by the DDRB.

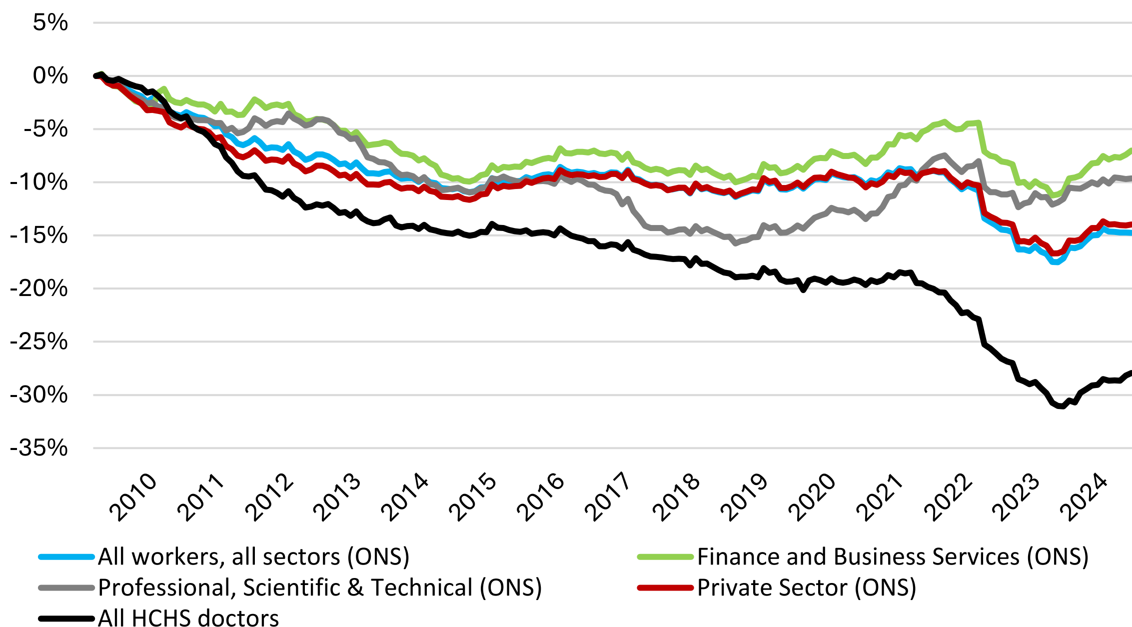

Figure 3: Real change (%) of mean earnings for all HCHS doctors in context, using RPI

Figure 3 above shows that against the RPI measure of inflation, there has been real terms decline in average earnings for all groups from March 2009 to June 2024. However, the average hospital doctor has seen their pay fall nearly twice as much as the average worker and exactly twice as much as

much as a private sector worker. When comparing the average hospital doctor to those in Finance & Business Services and Professional, Scientific & Technical, the average hospital doctor is 3.97 times worse off and 2.89 times worse off, respectively.

Although the DDRB has historically refused to address pay erosion through retrospective awards, the DDRB's new Terms of Reference explicitly state the need for analysis regarding the long-term trend of doctors pay. Therefore, the 2025/26 pay round brings the opportunity for significant awards that would begin the process of restoring fair pay to doctors. As mentioned in previous submissions and highlighted through this submission, there is a wider need for the DDRB to consider long-term labour market trends and comparator professions when considering uplifts to doctors pay.

Furthermore, ensuring that DDRB recommendations are produced based on the long-term socio-economic benefit brought by doctors and not contingent on the Government's assessment of what it believes it can afford in the short term is necessary to ensure the integrity of the DDRB process and contributes to the necessary reform required to ensure doctors pay is fairly evaluated.

The BMA would like to work with the DDRB to establish a list of specific roles which are appropriate professional comparators for the different types of doctors for future pay rounds. This was previously reviewed in 2017.[10] Currently, our comparison is against other relevant sectors as a whole, whereas it would be more meaningful to select other professional roles where individuals have the same level of qualification, experience and responsibility and compare pay year on year.

International comparators

That some doctors choose to leave the NHS and the UK to work in other countries is well documented by multiple organisations and in media,[11,12,13] including foreign media.[14] It has been researched directly[15,16] and noted in research with a wider scope than migration:

"More doctors than ever report taking steps to leave UK practice. In 2023, 16% of doctors said they had taken hard steps to leave UK practice, compared with 15% in 2022 and notably higher than 7% in 2021."[17]

We have attempted to compare take-home pay for doctors in the UK to doctors in Australia, Canada, and the Republic of Ireland for residents, GPs and consultants respectively using publicly available data.

Australia

Australia is a well-known destination for UK doctors, especially for doctors in training. In a BMA survey from December 2022 when asked "Which, if any, regions' or other countries' doctors do you compare yourself against?" 83.5% of resident doctors selected Australia as a comparator country,

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[10] UK Government, August 2017
[11] The Guardian, August 2015
[12] The Telegraph, April 2023
[13] Sky News, August 2024
[14] ABC News, May 2024
[15] GMC, April 2024
[16] GMC, October 2022
[17] GMC, August 2024

and when asked “If you are actively planning to work as a doctor in another country, please tick which country you plan to move to” 42% selected Australia.[18]

The Australian government is also seeking to increase the number of foreign doctors, and to that end are reducing the barriers to entry for doctors from the UK.[19]

“The Albanese Government has invested $90 million and is working with all state and territory governments to ensure overseas medical practitioners are not deterred from working in Australia by slow application processes and unnecessary red tape, as recommended by the independent Kruk Review given to National Cabinet last year.”[20]

We have therefore investigated the pay that resident doctors in England could expect to receive for equivalent work in Australia – our findings are shown in Table 1.

As Table 1 shows, there is a premium for doctors who choose to work in Australia, ranging from 16% to 34%

Table 1: Comparison of resident earnings to their equivalent post in Australia. The base salary values used here are averages for salaries across the Australian states.[21] The England working pattern assumptions are 46 hours per week, of which 10 are enhanced hours, and a weekend frequency allowance of 7.5%, equating to working between 1 in 4 and 1 in 3 weekends. An equivalent working pattern is assumed for a resident working in Australia, with remuneration based on the state of Victoria’s FWC trade agreement.[22] To calculate the equivalent earnings of an Australian resident, we modelled the doctor working 46 hours a week, of which, on average, 8 hours would attract an overtime rate of 150%, and 6.5 hours would be night shift rates of 125%, and 2 hours would be weekend shift rates of 150%. The values shown are after income tax[23,24] and exchange rate using HMRC’s 12-month average to March 2024.[25] Pension contributions have not been deducted from the England pay values, and the Australian superannuation scheme is a DC scheme and by default has no employee contributions.[26] Take-home pay for England would therefore be lower than shown below. Employer contributions have not been included here, but Australian doctors would benefit from employer-only contributions of 11.50% to 12.50% depending on the state.[21]

UK grade	Australian equivalent	England base + overtime after tax (£)	Australia base + overtime after tax (£)	Increase
FY1	Intern (PGY1)	38,972	47,530	22%
FY2	Resident (PGY2)	44,305	52,124	18%
ST1	Registrar - Y1	50,832	64,568	27%
ST2	Registrar - Y2	50,832	67,879	34%
ST3	Registrar - Y3	60,447	71,057	18%
ST4	Registrar - Y4	60,447	74,110	23%
ST5	Registrar - Y5	60,447	77,309	28%
ST6	Registrar - Y6	67,894	78,950	16%
ST7	Registrar - Y7	67,894	79,558	17%
ST8	Senior Registrar – Y1	67,894	83,532	23%

[18] BMA, December 2022
[19] ABC News, October 2024
[20] Australian Government, November 2024
[21] Australian Junior Doctor Pay Comparison, accessed November 2024
[22] Australia Fair Work commission, November 2022
[23] Australian Taxation Office, June 2024
[24] UK Government, accessed November 2024
[25] UK Government, March 2024
[26] Australian Taxation Office, August 2023

Canada

Figure 4 shows median GP earnings (after income tax) for GPs in different provinces in Canada (aggregated self-employed and salaried earnings) and nations in the UK for the combined contractor and salaried cohorts. Figure 4 shows median GP income (after income tax) for GPs in different provinces in Canada (aggregated self-employed and salaried) and nations in the UK for the combined contractor and salaried cohorts. GPs in Canada receive funding from government to provide services, with a fee-for-service payment model, whereas the UK is capitation-based payment model. Like the UK, the majority of GPs in Canada are self-employed, however we could not find any data for the proportions of self-employed vs salaried GPs.

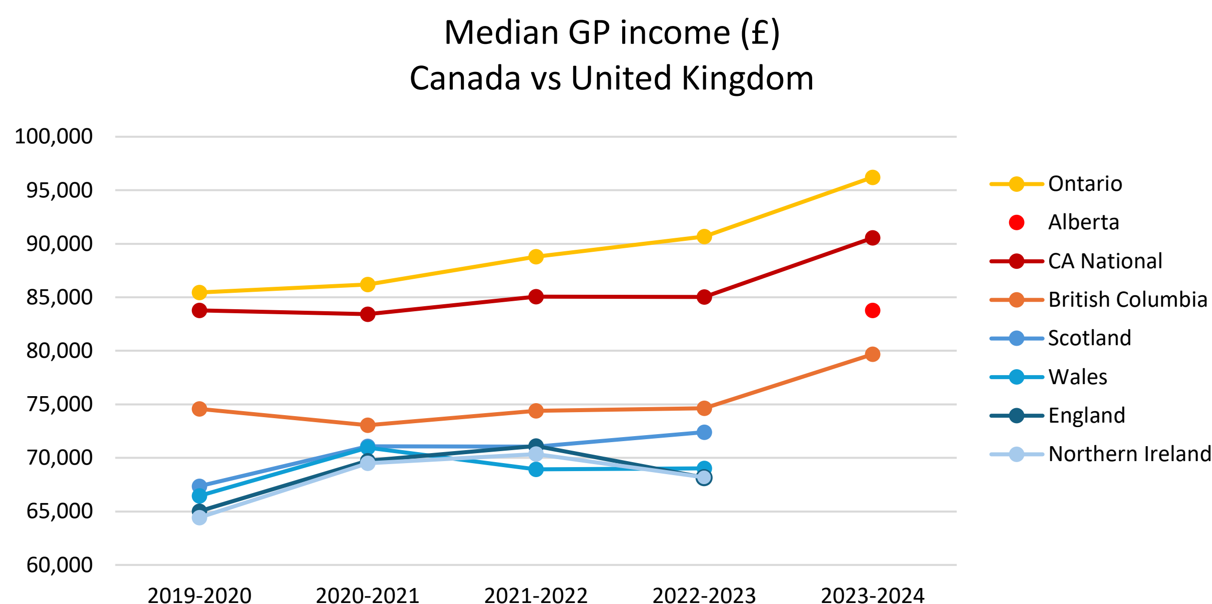

Figure 4: *GP income comparison, Canadian provinces vs UK nations. All data are taken from the Canadian government website[27], which collates data from other primary sources. Data from 2019-2024 come from the Canadian Institute for Health Information and the Canadian Medical Association. Canadian wage data are median salary and are not disaggregated between partner and salaried GPs. We have compared to the combined median wages in the UK from NHSE data[28] (for which 2023-2024 data are not yet available). We were not able to find data for hours worked, and therefore these are unadjusted for working patterns. These values are after income tax[29] (including federal and provincial tax rates for Canada[30]) and exchange rate using HMRC's 12-month average to March 2024.[31] Note also that non-recurring COVID payments in the UK affected the income for 2020-2021 to 2022-2023. We could not find evidence for equivalent COVID payments for Canadian GPs.*

Figure 5 shows median GP income (after income tax) for GPs in different provinces in Canada (aggregated self-employed and salaried) and nations in the UK for the contractor GPs only.

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[27] Government of Canada, September 2024
[28] NHS Digital, August 2024
[29] UK Government, accessed November 2024
[30] Government of Canada, January 2024
[31] UK Government, March 2024

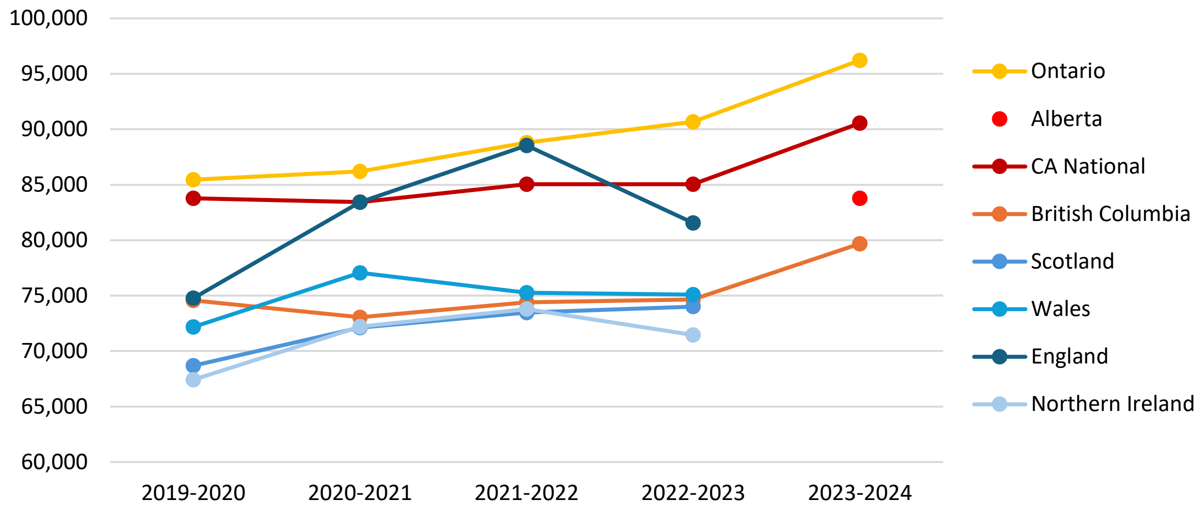

Figure 5: GP earnings comparison, Canadian provinces vs UK nations. All data are taken from the Canadian government website[32], which collates data from other primary sources. Data from 2019-2024 come from the Canadian Institute for Health Information and the Canadian Medical Association. The Canadian wage data are median salary, and are not disaggregated between partner and salaried GPs. Here we have compared them to median GP contractors' earnings in the UK from NHSE data[33] (for which 2023-2024 data are not yet available). We were not able to find data for hours worked, and therefore this is unadjusted for working patterns. These have been adjusted for income tax[34] (including federal and provincial tax rates for Canada[35]). Note also that non-recurring COVID payments in the UK affected the earnings for 2020-2021 to 2022-2023 - this is especially noticeable for England in 2021-2022. We could not find evidence for equivalent COVID payments for Canadian GPs.

Because we could not find disaggregated data for Canadian GPs, nor what proportion of Canadian GPs are self-employed vs salaried, the reality is likely to be somewhere between these two charts. Despite these data limitations, the charts show that GPs could significantly increase their income by moving to Canada. A GP in England on median income would have been able to increase their take-home pay from around £68,200 to around £85,000 for the Canadian national median in 2022-23, an increase of around 25%. If they had instead moved to Ontario (the largest province by population), this would be to £91,000, or an increase of 33%. Using the contractor-only median, a GP moving from England to Ontario could be increasing their take-home pay from around £82,000 to around £91,000, an increase of around 11%, and we note that the £82,000 figure is inflated by the circumstances surrounding COVID, including the COVID payments for vaccine delivery and the reduced costs at the time, as a result of the shift to total digital triage – to stop patients coming into close contact during social distancing measures – directed by the government / NHS England at the time, which is no longer the case.

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[32] Government of Canada, December 2024
[33] NHS Digital, August 2024
[34] UK Government, accessed November 2024
[35] Government of Canada, January 2024

Republic of Ireland

The Republic of Ireland is unique as an international comparator, as it shares a land border with the UK. For doctors already in Northern Ireland especially, the barrier for working south of the border is low. Despite the higher tax rates levied on income earned in the Republic of Ireland, there is a large disparity in take-home pay as shown in Table 2. Note that we have used the Northern Ireland consultant's pay scale for this analysis, which is marginally higher in the first few years than the England pay scale, but in either case falls far short of the Republic of Ireland's pay scale, and therefore there is a huge incentive to leave the NHS or HSC for the HSE in the Republic.

Table 2: A comparison of consultant's pay in Northern Ireland vs the Republic of Ireland using 2024 pay scales.[36] Take-home pay is net of pension contributions,[37] income taxes,[38] personal tax credits,[38] and PRSI,[39,40] and USC,[41] for the Republic of Ireland, and pension contributions, income taxes, and National Insurance for Northern Ireland. The UK and Ireland have a double taxation treaty,[42] and as the income tax payable in the Republic is greater than would be payable in Northern Ireland, no tax is due to HMRC for a consultant working cross-border in the Republic of Ireland. Both consultants are assumed to earn on-call allowances – 5% of pay for Northern Ireland (i.e. medium frequency on-call allowance of between 1 in 5 and 1 in 8 weekends, and a flat €10,586[43] (equivalent to £9,170.65) for the Republic of Ireland. Otherwise, neither work beyond the minimum contracted full-time hours (39 hours for the Republic of Ireland and 10 PAs for Northern Ireland). The Republic of Ireland values have been adjusted using HMRC's 12-month average exchange rate to March 2024.[44]

Years	Northern Ireland basic pay £	Republic of Ireland basic pay £	Increase	Northern Ireland take-home pay £	Republic of Ireland take-home pay £	Increase
0	106,424	192,505	80.9%	67,268	102,819	52.8%
1	106,424	202,909	90.7%	67,268	107,397	59.7%
2	106,424	213,895	101.0%	67,268	112,230	66.8%
3	111,724	219,675	96.6%	69,563	114,774	65.0%
4	114,904	225,455	96.2%	70,673	117,317	66.0%
5	114,904	231,237	101.2%	70,673	119,861	69.6%
6	114,904	231,237	101.2%	70,673	119,861	69.6%
7	114,904	231,237	101.2%	70,673	119,861	69.6%
8	126,034	231,237	83.5%	74,559	119,861	60.8%
9	126,034	231,237	83.5%	74,559	119,861	60.8%
10	126,034	231,237	83.5%	74,559	119,861	60.8%
11	126,034	231,237	83.5%	74,559	119,861	60.8%
12	126,034	231,237	83.5%	74,559	119,861	60.8%
13	126,034	231,237	83.5%	74,559	119,861	60.8%
14	139,920	231,237	65.3%	79,919	119,861	50.0%
15	139,920	231,237	65.3%	79,919	119,861	50.0%
16	139,920	231,237	65.3%	79,919	119,861	50.0%

[36] HSE, January 2024
[37] HSE, accessed November 2024
[38] Irish Tax and Customs, October 2024
[39] Irish Government, August 2024
[40] Irish Government, August 2024
[41] Irish Tax and Customs, January 2024
[42] UK Government, January 2019
[43] HSE, January 2024
[44] UK Government, March 2024

NHS Leavers Survey

All doctors

Understanding the reasons that doctor's leave can be challenging, in part because doctors who do leave typically do not maintain their BMA membership. However, we were able to contact ex-members of the BMA by email to invite them to respond to a survey regarding leaving the NHS. Some summary tables showing the survey respondent population are shown below.

Please note that this survey is still open, and further analysis will be conducted.

Table 3: Respondents to the Leavers survey: role in the UK

What was / is your most recent role as a doctor in the UK?	Number of respondents
Consultant	263
Resident	221
Blank (question skipped)	147
GP partner	141
Salaried or Locum GP	119
Locally employed / trust grade doctor	55
Specialist, Associate Specialist or Specialty	55
Medical academic	11
Other doctor	11
Medical student	5
Fellowship position	4
Public health doctor	2
Grand Total	**1034**

Table 4: Respondents to the Leavers survey: role after leaving the UK

What role are you taking / considering taking after leaving the NHS in the UK?	Number of respondents
Same / similar role as when working in NHS	370
Retirement	257
Blank (question skipped)	164
Different medical role than when working in NHS	69
Non-medical role	62
Not working	27
Formal study related to medicine	10
Other study	5
Locum GP	2
Other	66
Grand Total	**1034**

Reasons for leaving

To find out what reasons factor into doctors' decision to leave the NHS in the UK, we asked doctors "Which if any of these reasons influenced your decision to leave the NHS in the UK? Please tick all that apply". The results are tabulated in Table 5. The most chosen values were "Poor working conditions", "Don't feel my profession is valued in the UK", "To increase personal time away from work", "Burnout / work-related stress", "Pay is too low". These do seem to vary by cohort – for example "Don't feel my profession is valued in the UK" was selected by 69% of residents (152 out of 221) but only 33% of consultants (88 out of 263).

Table 5: Reasons selected by cohort for leaving the NHS.

Which if any of these reasons influenced your decision to leave the NHS in the UK?	**Resident**	**Consultant**	**Salaried or Locum GP**	**GP partner**	**LED**	**SAS**	**Total**
Burnout / work-related stress	130	92	65	57	33	17	**394**
Can't find a satisfactory role or job-location	59	13	5	18	17	10	**122**
Career development	67	13	2	7	20	14	**123**
Concerns with pension or pension tax	20	72	41	16	3	5	**157**
Decided medicine was not for me	9	1	2	2	2	2	**18**
Discrimination or bullying	26	39	4	7	8	8	**92**
Don't feel my profession is valued	152	88	62	61	28	19	**410**
Family or other dependants' circumstances	28	30	16	23	5	21	**123**
Health reasons	4	15	12	15	1	2	**49**
Insufficient annual pay increases	125	65	30	30	28	21	**299**
Insufficient research/teaching opportunities	39	8	1	1	10	3	**62**
Pay is too low	162	82	18	35	35	21	**353**
Poor working conditions	171	127	59	63	42	28	**490**
Retirement	0	39	25	14	1	8	**87**
To increase personal time away from work	130	111	61	46	35	27	**410**
Visa issues	6	3	1	2	3	2	**17**
Wanted to live or practise abroad	71	24	3	9	17	9	**133**

When asked to rank the reasons they had selected with the question "Of the reasons for leaving, what was the most important? Please order with 1 as the most important", the most common reasons in doctors' top 3 were "Poor working conditions", "Pay is too low", and "To increase personal time away from work". The importance of each reason is shown in Figure 6.

Figure 6: Chart showing the reasons and importance of those reasons. Doctors were asked "Of the reasons for leaving, what was the most important? Please order with 1 as the most important." Taking "Poor working conditions" as an example, this option was selected as a reason for leaving by 490 doctors (as shown in Table 5 and as the most important reason by 170 doctors, as the second most important reason by 159 doctors and as the third most important reason by 76 doctors. In total 405 doctors selected poor work conditions as one of their top three reasons for leaving – a further 85 selected this, but not in their top three.

Destinations

After excluding retirees, when asked "Where did you move to / are you planning to move to after leaving the NHS in the UK?", the most popular country picked was Australia. This preference was strongest amongst resident doctors, who made up the majority of doctors picking Australia (94). Amongst GPs the most popular destination was Canada (17), followed by Australia (16). For consultants the most popular choice was Australia (21), followed by the Middle East (19) and Republic of Ireland (10). Anecdotally, our resident, GP, and consultant members frequently mention Australia, Canada, and Ireland respectively, and these trends do seem to be borne out in Figure 7.

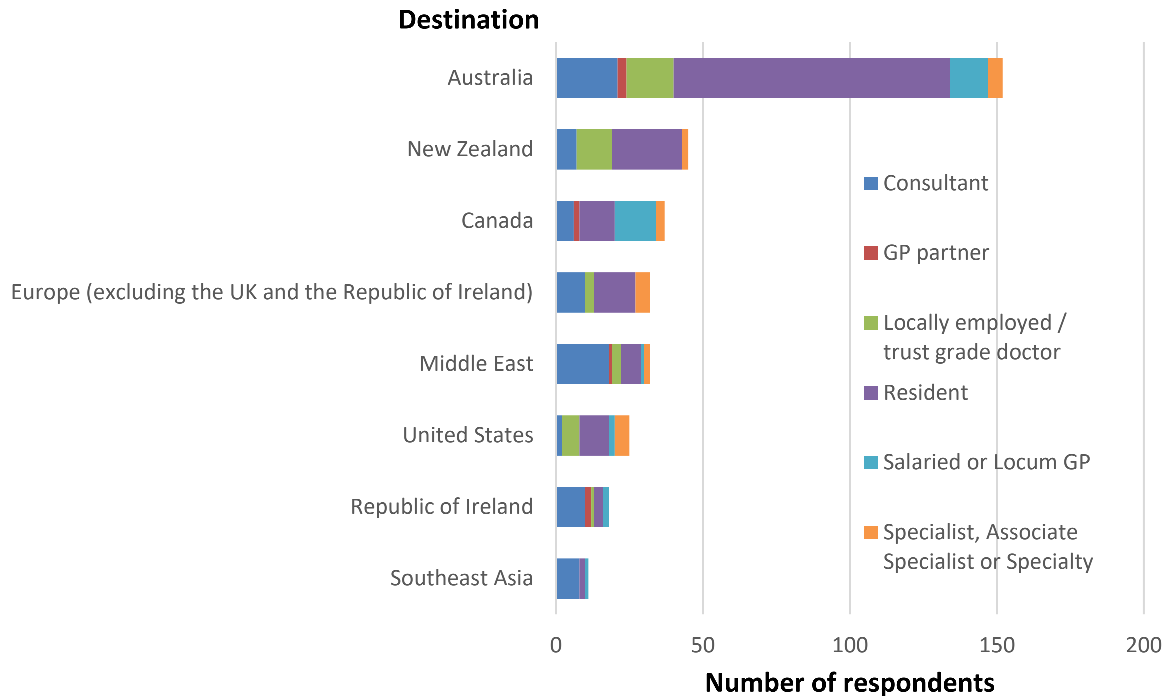

Figure 7: Chart showing the destinations chosen by doctors from different branches of practice. Doctors were asked "Where did you move to / are you planning to move to after leaving the NHS in the UK?"

Welsh leavers' data

BMA Cymru Wales requested data from the GMC on the numbers of Certificates of Good Standing (CGS) issued to doctors with a registered address in Wales.

Certificates of Good Standing, also known a Certificate of Current Professional Status, may be requested by a doctor to enable them to register and practice in another country. It represents what might be considered a 'hard step', signifying an intention to leave medical practice in one country and opt to work elsewhere. While there are many reasons a doctor may request a CGS, it is widely interpreted to indicate a desire to leave work as a doctor in the issuing country.

The number of doctors issued a CGS in Wales has risen from 184 in 2019 to 217 in 2023. Alarmingly, as of September 2024, that number has already been surpassed; 224 doctors had already been issued a CGS since January 2024. This rise corresponds with anecdotal evidence we are hearing from members who are increasingly exploring opportunities to work abroad for better pay and conditions.

The GMC advises that data on the numbers of CGSs issued should be read alongside the numbers of those to whom a CGS is issued but remain registered and licenced to practice in Wales. The table below shows the years in which full data was provided in Wales:

Table 6: Issued Certificates of Good Standing in Wales

Year of issue	Doctors issued CGS	Doctors issued a CGS and currently registered and licensed	Doctors issued a CGS and no longer registered and licensed
2019	184	165	115
2020	147	131	88
2021	188	171	124
2022	195	186	126
2023	217	214	133

It is reasonable to assume that the number of doctors who were issued a CGS and are now no longer registered and licensed represents a sound estimate of those who left the NHS in Wales to work elsewhere.

Workforce

On the backdrop of unprecedent pay erosion, increased demand for care, growing waiting lists and worsening public health, combined with persistent staff shortages and expanding medical student numbers, unmanageable workloads continue to be a major issue for doctors across the UK.

In England, secondary care logged a record high of approximately 6.5 million individual patients waiting for treatment in September 2023, and A&E attendances reached over 2.3 million in October 2024.[45] The number of patients per GP, meanwhile, has risen by over 17% since 2015.[46]

The supply of staff, however, is failing to keep up with demand. The EU members of the OECD (for which data are available) have an average of 3.9 doctors per 1,000 people. To reach this rate, the UK would require almost 49,000 additional doctors across the country.

In England, 6.9% (10,745) of all medical posts in secondary care were recorded as being vacant as of June 2024[47] and these figures have been skewed downward by the way a vacancy has been classified in some areas of health care e.g. being dropped from official figures when a post remans unfilled, or when a doctor post has been substituted by a non-doctor on a medical rota. The number of full-time equivalent, fully qualified GPs, meanwhile, has declined by almost 1,400 since 2015, with the number of full-time equivalent GP partners having fallen by almost 5,800 since 2015 – a huge drop of 27%. The Government's own workforce plan puts the shortage of NHS staff in England at 150,000 full time equivalents (FTE). Without action, this is predicted to grow to 260,000 – 360,000 FTE staff by 2036/37, including around 60,000 doctors.

The devolved nations face similar workforce and workload challenges. In Wales, waiting lists continue to reach record highs with over 800,000 patients awaiting treatment in August 2024.[48] Whilst the secondary care workforce has increased steadily over the past few years in Wales, vacancies for doctors remain high: Medical and dental staff (excluding resident doctors) consistently

[45] BMA, November 2024
[46] BMA, November 2024
[47] NHS England, August 2024
[48] Welsh Government, accessed November 2024

have the highest vacancy rate of all NHS staff groups (10.4%). This is almost double the average staff vacancy rate across all NHS Wales staff groups (5.4%).

Moreover, there is considerable variation in vacancy rates across Wales, suggesting significant inequality in access to health services for patients. The vacancy rate in Public Health Wales notwithstanding (34.28%), there is a nearly thirty percentage point difference between the rate in Powys (29.25%) and Cardiff and Vale health boards (0.46%). A vacancy rate of nearly a third anywhere in the country is not only far too high, but also clearly unsustainable.

Latest figures from the Audit Wales' NHS Workforce data briefing 2023 highlights specifically how a growing workforce does not equate to demand being met.

Table 7: Workforce vs. demand in Wales

	% change in numbers of referrals	**% Change in medical workforce**
General surgery	+28%	+12%
Ophthalmology	+56%	-2%
Ear, Nose and Throat	-1%	+21%
Gynaecology	+29%	+9%

Table 7 highlights the change in referrals and staffing between 2012-13 and 2022-23. For General surgery, whilst the workforce has grown 12%, this hasn't kept up with the increase in referrals, which are up 28%. Gynaecology presents a similar issue with just a 9% growth in workforce and a 29% increase in referrals. Some specialties, such as Ophthalmology, have seen an even bigger increase referrals (56%), whilst the medical workforce has decreased.

The GMC's 2022 report looked at the numbers of doctors leaving each UK country between 2017 and 2021. Whilst the number of doctors leaving England (5%), Scotland (10%) and Northern Ireland (15%) all decreased, Wales was the only nation to see an increase in the number of doctors leaving (3%).

The GMC's 2023 report highlights a further increase in the number of doctors leaving Wales, with almost 400 doctors in 2022 alone, up from 309 in 2021 and 224 in 2020, causing serious concern for the sustainability of the healthcare system and necessary long-term retention. Subsequently, Wales has fewer secondary care doctors per 1,000 people than the OECD average. To meet the OECD average of 2.7 secondary care doctors per 1,000 people, Wales would need an additional 647 doctors.

The number of fully qualified, permanent GPs (headcount) has seen little growth since 2016 in Wales. This means that the workload of GPs is rising, and individual GPs are responsible for more patients. In September 2024, the average full-time GP was responsible for 2,210 patients, compared to 1,676 in 2013. This represents an increase of 32% in the number of patients per full time GP – a significant workload increase for each individual practitioner.[49]

These vacancies and GP shortages are against a backdrop of an NHS Wales that is already understaffed. The population of Wales is growing and ageing, and health inequalities have been

[49] BMA, May 2024

exacerbated by the Covid-19 pandemic; factors which are increasing the pressures on the doctors working in Wales.

The quality and availability of vacancy data for Wales are poor, and the level of detail we can glean from the published vacancy data is very low. 'Medical and dental staff' is a very broad measure and gives us no information about the specific issues facing different staff groups in different parts of the country. For example, there is no detail on consultant vacancies (necessary to understand where teams are unable to function where there is no consultant), undersubscribed medical specialty vacancies, or regional vacancies.

Without accurate data, it is impossible to determine the scale of the problems caused by vacancies or to plan for workforce needs in the medium to long term.

In Northern Ireland, the situation with health and social care is beyond dire. Waiting lists continue to grow, transformation continues to stall and the pressure on doctors intensifies.

The four-hour waiting time target in emergency departments in Northern Ireland has not been met for over a decade; in September 2024 less than half (46.5%) of attendances were discharged or admitted within four hours, a three percent drop from September 2023.

Due to the introduction of a new computer system (Encompass) we can, frustratingly, no longer make comparisons across years for outpatient waiting times. The figures that do not include Northern Ireland's two largest HSC trusts by population, show 51 % of patients were waiting more than 52 weeks for a first consultant-led outpatient appointment on 30 June 2024, compared with 50% on 31 March 2024 and 48% on 30 June 2023.

At the end of 2023, 121,879 patients in Northern Ireland were waiting for inpatient or day case treatment. Over half (52.9%) had been waiting longer than 52 weeks, and nearly 77.4% had waited over 13 weeks. By September 2023, 188,850 patients were awaiting diagnostic tests, with 59.4% waiting over nine weeks, and 32.4% waiting longer than 26 weeks.[50] These figures represent an increase compared to previous periods, indicating growing delays.

Worsening waiting times can be seen in specific areas of medicine, particularly cancer care. With the caveat that the following figures do not included Belfast HSC Trust due to the introduction of the Encompass computer system,

The HSC target is 98% of patients starting their first definitive treatment within 31 days. In the quarter ending June 2024, 1,629 patients (91.4%) started their first definitive treatment, 7.7% (135) fewer than in the previous quarter (1,764), and 5.6% (96) fewer than in the same quarter last year (1,725). This data release marks yet another quarter in which the target has not been met; it has now been more than eight years since it was.

When cancer patients in Northern Ireland are urgently referred by their GP to start treatment, the HSC target is that at least 95% should start that treatment within 62 days. However, the latest data[51] shows that only 35.8% patients (894.5 patients) started their treatment within that 62-day window. This is 8.7% (85) fewer than in the previous quarter (979.5), and 14.8% (155) fewer than in the same quarter last year (1,049.5). We should view this as a distress signal from cancer care in Northern Ireland, and a clear sign that cancer patients are being failed.

[50] NISRA, August 2024
[51] Department of Health Northern Ireland, October 2024

Meanwhile, in breast cancer care, the data shows a similarly shocking story. The HSC target is that all breast cancer patients should be seen by a specialist within 14 days of an urgent referral. However, the latest data tells us only 30.7% (928) were seen within 14 days. That is no less than scandalous. Just five years ago, before the pandemic, in June 2019, the percentage of those patients able to see a specialist within that 14-day time window was double, at 76.1%. In June 2015, 100% patients were being seen within that time window. The collapse of this part of cancer care has been swift and brutal.

These figures also highlight substantial backlogs and delays across the healthcare system, exacerbating challenges for both patients and healthcare providers. The relentlessly persistent unmet targets underscore the need for urgent reforms and resource allocation.

Working in a system under such pressure is unsustainable. It is particularly so when your pay has been significantly eroded and uplifts continually delayed. BMA Northern Ireland's recent survey showed the impact of these delays to the pay uplift on the morale of doctors; 95.3% of respondents stated that they delay in implementing the 24/25 uplift has either "decreased" or "significantly decreased" their morale.

In the Chancellor's Autumn Budget, she stated that if the Pay Review Bodies recommend pay awards that exceed departmental budgets or are above inflation, productivity improvements would need to be made to unlock further Treasury funding.[52] While we agree that productivity needs to improve in the NHS, the already stretched and overworked workforce is not to blame. Antiquated IT systems, poor working conditions, systemically poor workplace cultures, the backlog of care, fragmented systems and managerial overcomplexities are all contributing to NHS inefficiencies. The BMA expects the DDRB to demonstrate its independence in this year's pay round and not link pay awards to unspecified 'productivity increases'. The Pay Review Body must consider the need to pay doctors fairly to recruit and retain the workforce necessary to increase capacity, reduce the necessity to employ more expensive models of care and meet the demands of the population it serves.

England

Consultants

Consultants' pay in England has been eroding steadily since 2008/09 when the Government escalated its interference with the independent pay review process by imposing a series of pay freezes and pay caps. This has exacerbated the effective devaluation of doctors' skills and expertise over a significant period. Although the most recent pay recommendation from the DDRB earlier this year was a step in the right direction, there is still significant ground to make up for the almost 15 years of sub-inflationary pay awards that the profession has experienced. Therefore, for all consultants (irrespective of pay point) to achieve pay restoration by 2027/28, the Government will need to award at least a 7.17% increase in basic pay per year on average for the next three years according to CPI, and a 14.23% increase in basic pay per year on average for the next three years according to RPI.[53]

[52] HM Treasury Autumn Budget, October 2024

[53] Based on the pay restoration values for those at pay threshold 3 (2 years completed as a consultant), who because of the pay deal are now the furthest from full pay restoration relative to 2008/09 real terms values.

As shown in Table 8 below, the consultant pay scale has lost anywhere from 3-27% of its real value between 2008/09 and 2024/25, depending on the pay point and the inflation measure used. Although the most recent DDRB recommendation and the deal secured with the Government last spring by consultants have made some iterative progress towards achieving pay restoration, much more still needs to be done.

Table 8: Consultant in England pay scale (2008/09 to 2024/25)

Years completed as consultant	2008/09	2024/25	2024/25 (if kept up with CPI)	Real Loss (CPI)		2024/25 (if kept up with RPI)	Real Loss (RPI)	
			Pay scale	£	%	Pay scale	£	%
0	£73,403	£105,504	£115,728	-£10,224	**-8.8%**	£136,393	-£30,889	**-22.6%**
1	£75,701	£105,504	£119,351	-£13,847	**-11.6%**	£140,663	-£35,159	**-25.0%**
2	£78,000	£105,504	£122,975	-£17,471	**-14.2%**	£144,935	-£39,431	**-27.2%**
3	£80,298	£111,714	£126,598	-£14,884	**-11.8%**	£149,205	-£37,491	**-25.1%**
4	£82,590	£114,894	£130,212	-£15,318	**-11.8%**	£153,464	-£38,570	**-25.1%**
5	£82,590	£114,894	£130,212	-£15,318	**-11.8%**	£153,464	-£38,570	**-25.1%**
6	£82,590	£114,894	£130,212	-£15,318	**-11.8%**	£153,464	-£38,570	**-25.1%**
7	£82,590	£114,894	£130,212	-£15,318	**-11.8%**	£153,464	-£38,570	**-25.1%**
8	£82,590	£126,018	£130,212	-£4,194	**-3.2%**	£153,464	-£27,446	**-17.9%**
9	£88,049	£126,018	£138,819	-£12,801	**-9.2%**	£163,607	-£37,589	**-23.0%**
10	£88,049	£126,018	£138,819	-£12,801	**-9.2%**	£163,607	-£37,589	**-23.0%**
11	£88,049	£126,018	£138,819	-£12,801	**-9.2%**	£163,607	-£37,589	**-23.0%**
12	£88,049	£126,018	£138,819	-£12,801	**-9.2%**	£163,607	-£37,589	**-23.0%**
13	£88,049	£126,018	£138,819	-£12,801	**-9.2%**	£163,607	-£37,589	**-23.0%**
14	£93,508	£139,882	£147,425	-£7,543	**-5.1%**	£173,751	-£33,869	**-19.5%**
15	£93,508	£139,882	£147,425	-£7,543	**-5.1%**	£173,751	-£33,869	**-19.5%**
16	£93,508	£139,882	£147,425	-£7,543	**-5.1%**	£173,751	-£33,869	**-19.5%**
17	£93,508	£139,882	£147,425	-£7,543	**-5.1%**	£173,751	-£33,869	**-19.5%**
18	£93,508	£139,882	£147,425	-£7,543	**-5.1%**	£173,751	-£33,869	**-19.5%**
19+	£98,962	£139,882	£156,024	-£16,142	**-10.3%**	£183,885	-£44,003	**-23.9%**

As a result of the deal that was accepted by consultant members in April, the pay scale currently has an anomaly at pay threshold 2, which is currently split between pay point 2a (3 years completed as a consultant) and 2b (4 years completed as a consultant). It is our view that this year's pay recommendation should correct for this, as this additional pay point was not intended to be permanent, and was a consequence of uplifting the pay point values for Years of Experience 4-7. As part of the agreement with government, the expectation was that this additional pay point would be temporary.

Our greatest priority, however, for pay uplifts is addressing the level of remuneration for the most senior consultants. Those in years nineteen and upwards (the former top of the pay scale) are amongst those who received the least from the deal that was reached with the Government last spring. Due to them being near the end of their careers and close to retirement, they won't receive any benefit from the faster pay progression as those earlier in their careers will. This also risks perpetuating the unfair erosion of this group of consultants pay into their retirement compared to both consultants retiring previously (before the significant pay erosion occurred) and those retiring in the future once pay recovers. Indeed, the top of the consultant pay scale (£139,882) still reflects double-digit real-terms erosion since 2008/09. This problem is further complicated for consultants in England specifically, whose top pay point is now the lowest in the country. A consultant in England at the top of the pay scale is now paid a significant 9.61% (£14,878) less than consultants in Wales, where the top pay point is now £154,760. This disparity in pay is exacerbated by the fact that Welsh consultants work 37.5 hours per week, whereas their English counterparts work 40 hours per week. It is therefore essential that the pay for the most senior consultants is addressed quickly, as the top of the pay scale is arguably the most important for the attraction, recruitment and retention of individuals to our field.

National Clinical Excellence/Clinical Impact Awards (NCEAs/NCIAs)

The UK Consultants Committee still has outstanding concerns about changes that the government enacted to the National CEA scheme. These concerns are primarily: the lower value of the national awards, their non-pensionability, and the inability of consultants to hold a national award concurrently with a local award. These changes negatively impact total compensation for many of our members, representing a significant decrease in the lifetime remuneration and pension accrual for the most talented and experienced consultants in the country. Overall, it is our view that these changes will impede the NHS from being able to attract and retain the best and brightest due to the meaningful impact on lifetime remuneration they have.

As shown in Table 9 below the combined earnings of a consultant in England on the top of the pay scale with a Level 4 Local Clinical Excellence Award (LCEA) has dropped by around 13-26%, depending on the inflation measure used.

Table 9: Combined earnings on top of consultant pay scale in England, with a Level 4 LCEA (2008/09 to 2024/25)

	Top pay scale (Consultants - England)	Level 4 LCEA (pensionable)	Combined Earnings (cash)	Combined Earnings (Real - CPI)	Combined Earnings (Real - RPI)
2008/09	£98,962	£11,652	£110,614	£174,395	£205,536
2024/25	£139,882	£12,064	£151,946	£151,946	£151,946
		CHANGE:	£41,332	-£22,449	-£53,589.95
			37%	**-12.9%**	**-26.1%**

Source: BMA analysis of NHS Employer Pay and conditions circulars for medical and dental staff (England), ONS inflation statistics and OBR inflation forecasts for 2025; real terms analysis adjusts the cash terms earnings values by price changes from April 2009 to April 2025.

As shown in Table 10, the combined earnings of a consultant in England on the top of the pay scale with a Level 9 Local Clinical Excellence Award or Bronze NCEA dropped by around 17-29%, depending on the inflation measure used.

Table 10: Combined earnings on top of consultant pay scale in England, with a Level 9 LCEA/Bronze NCEA (2008/09 to 2024/25)

	Top pay scale (Consultants - England)	Level 9 LCEA (pensionable)	Combined Earnings (cash)	Combined Earnings (Real - CPI)	Combined Earnings (Real - RPI)
2008/09	£98,962	£34,956	£133,918	£211,136	£248,838
2024/25	£139,882	£36,192	£176,074	£176,074	£176,074
	Change		£42,156	-£35,062	-£72,764
			31%	**-16.6%**	**-29.2%**

Source: BMA analysis of NHS Employer Pay and conditions circulars for medical and dental staff (England), ONS inflation statistics and OBR inflation forecasts for 2025; real terms analysis adjusts the cash terms earnings values by price changes from April 2009 to April 2025.

As shown in Table 11, the maximum in-year earnings potential of a consultant in England, accounting for the reduced value of the new National Clinical Impact Awards, has fallen. Adjusted for inflation since 2008/09, the maximum in-year earnings value has dropped by around 34-44% in real-terms, depending on inflation measure used and ignoring impact on lifetime pension income.

Table 11: Maximum earnings potential of a standard full-time consultant in England (2008/09 to 2024/25)

	Top pay scale (Consultants - England)	Max CEA Value		Combined Earnings (Real - CPI)	Combined Earnings (Real - RPI)
2008/09	£98,962.00	Platinum NCEA (pensionable)	£74,676	£273,759	£322,643
2024/25	£139,882.00	Level 3 NCIA (non-pensionable)	£40,000	£179,882	£179,882
		CHANGE:	£	-£93,877	-£142,761
			%	**-34.3%**	**-44.2%**

Source: BMA analysis of NHS Employer Pay and conditions circulars for medical and dental staff (England), ONS inflation statistics and OBR inflation forecasts for 2025; real terms analysis adjusts the cash terms earnings values by price changes from April 2009 to April 2025.

When the Advisory Committee on Clinical Impact Awards (ACCIA) consulted on reforms to the National Clinical Excellence Awards (NCEA) scheme in 2022, the British Medical Association (BMA) raised significant concerns about the proposals. At the time we highlighted that the proposed reforms would result in several anomalies and equity concerns. For example, the reforms would prevent younger applicants from ever holding a pensionable clinical excellence award. Based on current workforce data, older eligible consultants are proportionately more likely to be male and from a white background, whereas younger eligible consultants are proportionately more likely to be female and more ethnically diverse. Therefore, the loss of access to pensionable awards creates an inequity in the new national award scheme.

Despite the concerns that the BMA raised, ACCIA proceeded to implement these changes, and introduced a new criterion that meant that consultants must forfeit their local pensionable award if they successfully applied for a new non-pensionable National Clinical Impact Award (NCIA). This disincentive structure is contrary to how the DDRB previously suggested the system should run. The DDRB in its original review into CEAs proposed that if a new national system was introduced (with awards of a lower value) that consultants would be able to hold both a local and national award simultaneously. Indeed, this is what the DHSC initially consulted upon, and the contract was agreed in anticipation of that with the protection payment made via the LCEA of nearest equivalent value. The BMA maintains that there is no rationale for this arrangement because the funding for the local awards is held by employers locally and is not funded by ACCIA.

As a result of the deal that was struck between consultants and the Government last spring, there is no longer a contractual right to a local award round. Therefore, if ACCIA maintains its position of forcing holders of pre-2018 LCEAs to give up pensionable awards to apply for NCIAs, then up to 50% of the consultant workforce will no longer have an incentive to access an excellence award scheme as it would be financially disadvantageous to relinquish a consolidated, pensionable LCEA for a non-consolidated, non-pensionable NCIA. This disincentive to access new awards will have a negative impact on both consultant morale and motivation. Furthermore, DHSC in England are interpreting 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 pay protection (that would remain pensionable) for a period of 5 years. After such a point, even if they continue to successfully receive an NCIA, under the Government's proposals, they will lose the pensionable value of their award. There is then a perverse incentive that if an existing NCEA holder fails to gain a new NCIA and reverts to a pensionable local award that they will hold until retirement, they will be better off financially than an existing NCEA holder who successfully applies for an award.

The DHSC's proposed approach results in existing NCEA holders being treated more harshly than existing local Clinical Excellence Award (LCEA) holders who retain the option of holding local pensionable awards until they fully retire. This is especially unfair as NCEA holders will have

previously relinquished LCEAs when they were awarded an NCEA. These NCEA holders will have paid annual allowance tax and pension contributions on the value of their NCEA and yet may never receive the pensionable benefit of this in their final salary pension. The BMA strongly disputes the Government's interpretation of these protection arrangements that are outlined within the consultant contract. Not only is this grossly unfair, we believe that the DHSC approach results in indirect age discrimination, akin to the McCloud discrimination as older NCEA holders will in effect receive full protection (and therefore be able to incorporate this into their final salary pension) and yet younger NCEA holders will potentially lose almost the full value of the pensionable benefit on which they have paid AA tax charges and pension contributions in full.

In order to avoid this unfairness for NCEA holders and to correct the anomaly that NCEA holders may be better rewarded by being unsuccessful rather than successful, we have argued that there should be a reversion to the original intentions of the contract and for those that are successful, the protection payment should be made in the form of an LCEA, i.e. under the current system via a Local L9 LCEA. This would ensure equal treatment of both local and national CEA holders and remove the grounds of an age discrimination challenge.

We urge the DDRB to recommend to the Government not only that they address these anomalies within the DHSC interpretation of the current NCIA system but to also consider the loss of pension from the overall remuneration of doctors from these changes when making its recommendations on pay uplifts. As outlined, this represents a very significant reduction in the overall renumeration package for consultants and this significantly limits the ability of the UK to attract, recruit and retain the best doctors in an increasingly global healthcare market.

Recommendations

We recommend that the DDRB:

- recommend a pay award for consultants in England for 2025/26 of 14.23% to continue a path to achieve pay restoration according to RPI by 2027/28;
- uplift the highest pay point (Years 14+) so that the top of the pay scale in England is at least equal to that of Wales;
- uplift pay point 2a to bring it in line with pay point 2b;
- consider the impact that the removal of pensionable CEAs has on the overall lifetime remuneration of consultants when making recommendations on pay uplifts;
- payment protection for successful NCEA renewal applications after 5 years made in the form of a local level CEA to ensure they are not financially worse off than someone unsuccessful
- remove the restriction on holding both a local and national award concurrently, and open NCIAs to all consultants; and,
- The overall pot for NCIAs should be uplifted and award values uplifted so that the real-terms value of the awards do not erode over time.

Specialist, Associate Specialist and Specialty (SAS) Doctors

The 2024 pay deal and contract transfer

The BMA recognises that there has been progress since we last wrote to the DDRB regarding SAS doctors. The 2024 England SAS doctor pay deal – agreed after a successful ballot for industrial action and extensive negotiation – reformed the 2021 pay scales, and in doing so addressed some of our biggest concerns around closed and open contract pay disparities.

It is worth noting, however, that there remain disincentives for moving from the closed 2008 SAS terms and conditions to one of the open contracts. Namely:

- There are still several points on the old pay scales that are higher than the equivalent position on the new pay scales; and
- The old terms and conditions continue to have a preferable definition of plain time.

SAS doctors in England remain wary about the remunerative impact of moving to 2021 contracts, where premium time starts from 9pm on a weekday, rather than 7pm**.** This means that they would be paid at a standard rate for work completed between 7-9pm Monday-Friday, rather than time and a third.

In a recent BMA survey of SAS doctors in England, 19%[54] of respondents had neither expressed an interest in transferring contracts nor had plans to do so in the future; 12% were uncertain whether they would in the future; and 4% had initially expressed an interest but decided not to go ahead with the move.

Asked why they had decided not to transfer or express an interest in doing so, 47% cited concerns around plain time, 35% around a potential drop in basic rate of pay, and 40% were concerned about a drop to the overall remuneration package (including out of hours work and pensions).

The subject of plain time was also raised by members repeatedly during our periods of consultation on the two Government offers. It clearly remains a key issue, and it appears to have taken on a symbolic importance connecting to how SAS doctors are treated more widely.

Scotland never introduced the extension of plain time in its 2022 SAS doctor contracts, and Wales reversed this measure as part of its 2024 pay deal. We would urge England to take similar action to remove this obstacle to contract transfer. We believe the cost to the NHS would be fairly minimal but would provide a real benefit in sending a clear message to SAS doctors that they are valued.

Data shared by NHS Employers suggest that between August 2021 and August 2024, only 12% (1,056) of specialty doctors on the 2008 terms and conditions moved to the open 2021 contract. 40% (4,273) of current specialty doctors remain on the old terms and conditions. There is still work to be done to encourage further movement onto the new contract.

Individual employers and contract transfer

In the months following the deal, we have heard about individuals struggling to transfer contracts, due to Trusts' misguided belief that this was no longer an option for SAS doctors on old terms and conditions. We are concerned that there still seems to be a lack of understanding on this matter, and what this might say more broadly about certain Trusts' regard for SAS doctors.

Anecdotally, we have also heard of instances where individuals have waited a very long time to transfer to the new contracts, due to their employer's approach to the process. This has delayed their ability to access the new pay scales, through no fault of their own.

The BMA has worked with NHS Employers on producing renewed guidance on contract transfer, to better inform employers of this process. The guidance includes a new clause noting that:

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[54] Note figures quoted from our recent SAS doctor survey have been rounded to the nearest whole number throughout this evidence.

- Transfers should be completed within 35 working days of a doctor's expression of interest; and
- Should the process take longer than 35 working days (through no fault of the doctor in question), the new pay start date will be backdated to this point.

We hope that this guidance will help improve the transfer process for SAS doctors and enable more to move onto the new contracts.

Value and wellbeing

The arguments for pay restoration, of course, apply for all doctors who have seen their work devalued since 2008/09. SAS doctors, like their colleagues, have seen a real terms depreciation of pay. Like their colleagues, they too have options to leave the NHS, the country, or even the profession.

It is important to note, however, that there are specific issues facing the SAS cohort that can pose further risks to morale, recruitment and retention.

SAS doctors have repeatedly reported blocks to progression and poor treatment in the workplace, with specific concern having been raised around "gradeism". Over a third of UK SAS doctors responding to the 2019 GMC SAS and locally employed doctor survey disagreed with the statement that they are being treated fairly, with 30% of SAS respondents saying they had been bullied, undermined, or harassed in the last year.[55] Our own recent survey of SAS doctors in England showed that 37% of respondents experienced bullying and harassment in the last year. 74% of these doctors believed this was linked to their grade.

It is important to acknowledge the make-up of this cohort, when considering the way SAS doctors are treated. It is important to acknowledge the make-up of this cohort, when considering the way SAS doctors are treated. According to GMC's analysis of the SAS respondents to the 2022 Barometer survey, 66% of SAS doctor respondents were from Black, Asian or ethnic minority backgrounds, and 65% were international medical graduates (IMGs).[56] These demographics can mean that SAS doctors are more likely to be the recipients of not only gradeism, but also racist and xenophobic behaviour - or, indeed, that these different forms of ill treatment can intersect with and exacerbate one another as an equalities concern.

Even measures brought in to improve SAS wellbeing can too easily be ignored. The SAS advocate role, created as part of the 2021 pay negotiations, was intended to improve and promote the wellbeing of SAS doctors alongside their recruitment, retention and visibility. Despite the creation of the SAS advocate role, many doctors still have no access to this resource. Trusts have no contractual obligation to appoint advocates, and so can choose simply not to – 21% of respondents to our recent survey said they did not have access to a SAS advocate, with a further 31% being uncertain whether they had such access.

We have also had feedback that certain employers are ignoring the contractually mandated safeguards introduced to protect work-life balance.

Multiple Trusts failed to allocate the money ring-fenced for SAS development as part of these same contract negotiations, meaning these funds have effectively disappeared. The BMA has written to

[55] GMC, January 2020
[56] GMC, 2023

NHS England on multiple occasions, asking for redress to this situation, but has yet to receive a proper response.

In our recent survey, almost one in three SAS doctors reported that their morale was decreased or significantly decreased as a result of the last DDRB recommendation. Outside of this, almost half of the respondents stated that there has been no change in their morale meaning that the well documented feelings of demoralisation in the workforce have solidified.

Improved pay alone cannot address these various concerns, but it can help to demonstrate that this cohort is truly valued and avoid the risk of adding further insult to injury. This is evidenced by 68% of SAS doctors telling us that increased basic pay would make working as a SAS doctor more attractive, the most popular response to the survey question, followed by appointment to the specialist grade (62%).

We must also avoid the risk of pushing SAS doctors from the profession. NHS leavers data show that 7.3% of SAS doctors left the NHS in England between June 2023 and June 2024, with 7.8% leaving the year previous (June 2022-June 2023).[57],[58] NHS England data also showed that more than half of SAS doctors who left in 2021/22 did so because of voluntary resignation or early retirement.[59]

Pay ask

While the 2024 England SAS doctor pay deal raised basic pay for all SAS doctors, this uplift should not be seen as a panacea to this cohort's longstanding concerns. The consolidated £1400 increase for those on the old contracts represented only a 1.29% rise for those on the top of the associate specialty pay scale. While the revised Government offer was ultimately accepted, it is worth noting that the BMA received a fair amount of criticism from some quarters for presenting it at all.

The deal's uplift, combined with the implementation of DDRB's recommendations for the 2024/25 pay increase, did go some way towards addressing pay erosion. The BMA tentatively welcomed the above inflation increase at the time. We must underscore, however, that the association remains committed to the principle of pay restoration, and in our recent survey "pay restoration/improving pay" was the most popular answer in response to a question about what BMA's SAS committee priorities should be.

There is, of course, still some way to go before we see SAS doctors returned to the real-terms value they held before austerity. Accordingly, we ask the DDRB to commit to multiple pay awards that will restore SAS doctor pay to its real terms 2008/09 levels.

Based on current projections around inflation and the most recent available measurement of RPI, we believe that the average SAS doctor who received the lowest uplift in 2023/24 would require a pay increase of 12.8% for each of the next three years to reach 2008/09 levels in pay in real terms by 2027 (i.e. a 12.8% uplift in 2025, a 12.8% uplift in 2026, and a 12.8% uplift in 2027.)

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[57] NHS Digital, June 2024
[58] Data based on those listed under the associate specialist, specialty doctor, staff grade and hospital practitioner/clinical assistant grades. The figure cited in previous evidence underwent some change, due to NHS adjusting the figures after we submitted evidence.
[59] Data obtained directly from NHS England.

We would argue that the same uplift be applied to doctors on all pay points of all SAS contracts, in the interest of parity and to avoid undermining the gains made by the recent deal's pay scale reform.[60]

We appreciate the above figure is based on modelling, and that inflation could exceed current predictions. Accordingly, we would need to assess the situation next year and see whether the 12.8% figure needs to be amended.

Specialist roles

According to data recently shared with us by NHS Employers, there are 1,367 specialist doctors in England as of August 2024.

While this may seem like significant growth since the last DDRB report, this does not indicate that concerns around specialty doctor career progression have been resolved.

While the total number of specialist roles created between April 2021 and August 2024 is 1,686,[61] we can only say with certainty that less than half of this figure is made up of specialty doctors progressing to the more senior grade (29% of specialists transferred from the 2008 specialty contract, 14% from the 2021 specialty doctor contract).

Table 12: Specialist transfer breakdown April 2021 to August 2024; data provided by NHS Employers

	Headcount	%
Moved from trainee grade	158	9
Moved from consultant	213	13
Moved from specialty doctor (2008)	482	29
Moved from specialty doctor (2021)	234	14
Moved from staff grade	2	0
Moved from hospital practitioner	1	0
Moved from associate specialist	164	10
Moved from other career grade	9	1
Moved from other grade	39	2
No record in the previous month (do not know where they moved from)	384	23

Thousands of specialty doctors are still stuck at the top of their pay scales, unable to move to the next stage of their careers, due to the limited number of specialist posts.

[60] We note, however, that there is greater complexity in calculating pay erosion for those on new contracts, due to the restructuring that has occurred since 2008.
[61] We are aware of the discrepancy between current headcount and total figure. The difference between the two is made up of those who moved to another grade or role or have no current record (e.g. left the NHS).

When asked about barriers to applying for a specialist role, our survey respondents named the following as the top three obstacles:

1. Lack of specialist roles to apply to
2. Department/Trust seem unwilling to engage with the idea of a specialist grade on principle
3. Department/Trust prioritise funding for consultant roles over specialist roles

Following the 2024 England SAS doctor deal, representatives from the BMA, DHSC, NHS Employers and NHS England continue to meet as part of an "implementation group" focussing on the non-pay aspects of the deal. The group has produced work relating to specialists (including guidance on the establishment of the specialist role[62]), and plans are underway for a piece of research looking into the obstacles blocking Trusts from better utilising this grade.

However, it is important to note that there has been no major reform since we last wrote to the DDRB. While we hope the aforementioned guidance will raise awareness of the specialist grade, we are concerned that without active measures, many specialty doctors will remain unable to advance in their careers. We believe this represents a real missed opportunity for the health service, as expanding access to the specialist grade not only benefits specialty doctors but the NHS itself. Aside from benefits to SAS doctors' retention and morale, there is also the benefit of increasing the number of doctors who can act autonomously within defined and agreed scopes of practice. Considering the state of waiting lists, and ongoing workforce shortages, there is an obvious advantage of tapping into the skills and expertise of SAS doctors who, provided the appropriate grade and title, would be able to work at this senior level.

Concerns around SAS career progression are, of course, longstanding. A 2022 GMC SAS and locally employed doctor workforce report suggests that approximately one in five (22%) SAS doctors feel they are not provided with personal and professional development opportunities to advance their career[63]. The GMC report on the 2022 survey found that of all SAS doctors most likely to move to practice abroad, over half (52%) would do so because of a lack of career development or opportunities for progression.[64] When SAS doctors were asked about their future career intentions over the next five years in our recent BMA recent survey, 26% of respondents said they wanted to leave the NHS to work overseas or leave medicine completely for a different career. This shows that the NHS cannot rely on SAS doctors filling gaps in poor medical workforce planning and underscores the importance of valuing and retaining those we have.

There is a clear need to expand the number of specialists. The BMA stands by the argument that we need a process that better recognises the expertise of senior specialty doctors and reinforces the pathway to the specialist grade. We continue to believe this would best be achieved by a single pay spine that allows a doctor to progress to a more senior position by demonstrating their capacity for it, rather than forcing them to wait and hope for a role to open up. We accordingly call on the DDRB to support our ask for a single pay spine that will allow specialty doctors who meet the set criteria to progress to the specialist grade.

[62] NHS Employers, October 2024
[63] The state of medical education and practice in the UK: The workforce report 2022, p9
[64] Spotlight on SAS doctors and LE doctors: analysis of Barometer survey 2022 results, p33

Recommendations

We recommend that the DDRB:

- Supports BMA's call to reverse the extension of plain time in 2021 terms and conditions;
- Commits to a pay uplift of at least 12.81% in real-terms for SAS doctors for each of the next three pay rounds, to restore pay to real-terms 2008/09 levels by 2027; and,
- Supports the development of a process, ideally a single pay spine, to better strengthen the specialty doctor to specialist pathway.

Locally Employed Doctors (LEDs)

While LEDs are the fastest growing doctor group,[65] they continue to struggle with a series of issues unique to their employment status. In our previous evidence to the DDRB,[66] we outlined a list of issues facing this cohort. Unfortunately, these concerns remain pertinent.

The obstacles facing doctors on locally employed contracts have been ignored for too long. This status quo is untenable.

Below, we have listed several key issues facing LEDs and noted what could be done to resolve them. Please note this is not an exhaustive list. It will, however, give some idea of the problems this cohort faces. The limited amount of data on LEDs can make it difficult to assess how wide-spread certain issues are, but it is important to protect all doctors from possible ill treatment and exploitation, and to ensure that we are truly realising the potential of this part of the medical workforce – a cohort of skilled and knowledgeable individual doctors – rather than seeing them as faceless rota fodder.

Key issues facing LEDs

Unfavourable terms and limited training opportunities

There is a contractual "wild west" for LEDs, as they are not beholden to the standards set by national terms and conditions. This leaves doctors exposed to unfavourable terms (left without the protections of the national contracts) and even poses a risk to basic health and safety. LEDs tend to suffer from worse employment rights in general, which can span from an inability to access exception reporting to a lack of access to enhanced parental leave and pay.

For example: the national 2016 resident doctors' terms and conditions abolished hours monitoring, recognising that it was often subject to manipulation by departments (leading to an inaccurate picture of the real terms clinical hours doctors worked, posing a threat to doctors, employers and patients). Even though at times in practice ineffective, in principle, consultants and SAS doctors have job planning, and resident doctors have exception reporting. Many LEDs still do not have access to either measure, placing them in a precarious position.

International medical graduates who have moved to the UK, and are new to our national healthcare system, do not necessarily have the full context required to understand the shortfalls of non-standard contracts. This can lead to this group being particularly vulnerable to exploitation within certain departments or from employers.

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[65] GMC, August 2024
[66] BMA supplementary evidence to DDRB 2024/25: SAS doctors in England and locally employed doctors (LEDs)

While the DDRB has recommended that LEDs' pay be uplifted in line with nationally employed doctors', some LEDs employers could still choose to "opt out" of providing these doctors with pay uplifts – exacerbating issues around unfairness.

In addition to this, there is a clear risk of blocking LEDs' development and career progression. LEDs are often bottom of the pile when it comes to attending training opportunities, with no guaranteed minimum level of release to attend training. They may be covering the service to allow doctors in training to attend educational opportunities. This can cause frustration, especially if it is not what they were promised locally.

The clearest solution to unfavourable terms is to ensure that these doctors are on appropriate contracts, and to take the following steps:

- Cease the issue of non-standard contracts for doctors working at resident doctor level, including those based on 2002 resident doctors' terms and conditions.
- Follow the recommendation of NHS Employers and mandate the use of the 2016 resident doctors' terms and conditions for LEDs working at this level.[67] This will ensure minimum standards (including those benefitting health and safety), as well as lead to a reduction of errors when it comes to implementing standards across the workforce. For example, standardising doctors to the 2016 contract will mean that when departments review work done by doctors in departments these data are not skewed due to a mismatch in reporting mechanisms between the 2002 and 2016 contract. The introduction of the same exception reporting mechanism used by doctors on the 2016 contract will mean that there is one system for all resident doctors.
- At a minimum (until all are moved to the 2016 resident doctor terms and conditions), audit Trusts currently using 2002 terms and conditions, checking – amongst other things – that they are actively monitoring LED hours in line with the contract.
- Offer the appropriate SAS national contracts to those working at the level of a specialty doctor and above. (Note: At present, we are working with representatives from NHS Employers, NHS England and DHSC to develop a process that would enable this. This process will then need to be implemented.)
- Provide LEDs with access to study leave and study leave budget.
- Provide access to Guardian of Safe Working Hours and exception reporting to all LEDs.

Hampered progression

Anecdotal evidence shows Trusts with fewer SAS doctors often have more LEDs, which could indicate there are "hidden" SAS jobs with LED roles being used where SAS roles should be created. This can lead to doctors getting "stuck". Many LEDs (especially IMG LEDs) want to move into formal UK training, though we are uncertain how many of them are successful. Beyond this, not all LEDs have access to regular clinical supervision that enables them to develop professionally.

To address these issues, national research needs to be done to map the use of SAS and LED doctors. This could ascertain whether there are "hidden" SAS roles, and also explore the work journey of long-term LEDs within the NHS. It is also important that regular clinical supervision is provided to LEDs to ensure they are supported and enabled to progress.

[67] We acknowledge **some** wording within these terms and conditions may need to be amended for LEDs who are not in training (e.g. reference to being employed in a training post, references to placements and rotations, and the requirement to sit exams as per curriculum). This should be agreed, however, between the BMA and relevant organisations.

Isolation and lack of supervision

LEDs do not necessarily have access to regular clinical supervision, or standardised inductions. This can leave them unsupported in the workplace and at risk of isolation, as well as posing a possible risk of error. Trusts should ensure LEDs have access to a standardised induction as well as regular clinical supervision.

Job insecurity

LEDs are also vulnerable to job insecurity through the use of back-to-back fixed term contracts. Being subject to a series of short-term contracts creates a perceived sense of impermanence, both by the individual and employer, which can contribute to stress for the employee and also prove detrimental to one's prospects of applying for and accessing certain opportunities and benefits relative to those employed on permanent contracts (for example, maternity leave and pay). This issue would be resolved by the use of long-term, or permanent, contracts. (Note: At present, we are working on developing a process with representatives from NHS England, NHS Employers and DHSC that would provide LEDs with at least two years' continuous service the opportunity to move to a permanent contract. This process will then need to be implemented.)

Locum consultants

While locum consultants should be appropriately paid according to consultant pay scales, this is not always the case, and we remain concerned at the risk of exploitation of this subsection of locally employed doctors. They too are at risk of job insecurity (often unceremoniously sent back to previous jobs after several years), and sometimes have reduced access to study leave and Continuing Professional Development opportunities as well as issues with annual leave and expenses. Whilst entitled to a job plan, and review after three months in post as set out in in NHS Employer guidance, this frequently doesn't occur.

As the competition ratio deficit for substantive consultant posts continues to remain unaddressed, some specialty bottlenecks will continue to grow – and with it, the number of doctors who cannot move to consultant roles and instead become, or remain, LEDs. Other LEDs move to the UK to work for our health service, with a willingness to contribute to the NHS and see its patients. Many of these individuals are long term future colleagues.

The negative experiences do not solely apply to international medical graduates (IMGs) – data show that UK graduates also report a range of negative experiences. This being said, it is important to also consider how the demographics of this group - 70% of which are IMGs[68] – provides further, crucial context to their potential marginalisation in the workplace. There are concerns that doctors who are more likely to experience racist and xenophobic behaviour and treatment within the NHS are also being saddled with less favourable terms and conditions. Deprived of the protections of national contracts, these doctors can in fact be more vulnerable to unfair treatment. The equality concerns at play here need to be addressed.

It needs to be ensured that locum consultants are being paid appropriately, and have access to the same resources as consultants in substantive roles.

[68] GMC , August 2024

Retention

The NHS is increasingly reliant on LEDs (with the number of LEDs growing “much faster than other doctor groups”, and in 2021 “twice…the size of the SAS doctor group in England and Wales”,)[69] these doctors have clear reasons to leave the health service. Recruitment, as we have previously stated, is not the same as retention. The 2024 GMC workplace report notes that 20% of LEDs have taken “hard steps to leave” their roles, more than other groups of doctors.[70]

While some LEDs have simply taken time out of training and will return to this pathway, others may leave the NHS – and indeed the UK – altogether. A recent GMC survey[71] noted that 45% of LED respondents said they were “likely to leave” the UK profession (compared to 36% of all doctors), with 39% of LED respondents said they were likely to move to practice abroad (compared to 25% of all doctors).

Continued data gap

The BMA (alongside other bodies) has repeatedly raised concerns around the lack of data regarding LEDs. At a minimum, we need:

- To know the distribution of LEDs across the NHS
- To have a more holistic understanding of the terms and conditions these doctors are engaged on (e.g. what percentage are on mirrored SAS contracts, mirrored resident doctor contracts, non-mirrored terms and conditions, etc.)

This information is essential so we can better understand this cohort and, in turn, tackle the issues they face.

It was agreed through the 2024 England SAS pay deal that this gap would be addressed. As the deal’s wording states:

“DHSC, NHS England and NHS Employers will commit to undertaking a piece of work jointly with the BMA to determine how Locally Employed Doctors (LEDs) can be better supported to progress in their careers, building on NHS England’s LED Strategy

The shared objectives of this work are to:

- Better understand the makeup of the LED workforce including their contractual terms and needs.”

The BMA continues to meet with representatives from NHS England, NHS Employers and DHSC as part of an implementation group, focusing on the roll-out of non-pay aspects of the deal. At the time of writing, there has been discussion on the process of collecting data, though this has still not been completed.

Transferring contracts

The 2024 England SAS pay deal also included wording around developing a process to offer LEDs with at least 24 months’ continuous service the option to move to more favourable contracts – either a national SAS contract, or a permanent contract, depending on the circumstances of the individual (and whether they were fulfilling a role that is comparable to the “roles, duties and responsibilities of

[69] GMC , August 2024
[70] GMC , August 2024
[71] GMC, October 2023

a SAS doctor”). The hope is that this would provide longstanding LEDs with better security or, indeed, improved terms and conditions and therefore retain them within the NHS.

The implementation group (see above) are still in talks about this process.

We are conscious, however, that even the perfect implementation of such a process would only offer the protection of national terms and conditions to a small number of LEDs. We would remain concerned that others would be vulnerable to exploitation – for example, those on less than 24 months’ contracts, or who have been working at a resident doctor level. We urge further consideration of the protections that can be afforded to these individuals.

Pay ask

The BMA welcomes the DDRB’s continued recognition of LEDs in its recommendations, and specifically its application of the principle of parity when it comes to pay uplifts between LEDs and their nationally employed counterparts.

We ask that this principle be upheld for the 2025/26 pay round.

As previously, we recommend that:

- LEDs be provided with pay uplifts comparable to their national colleagues.
- The Government ensures there is funding provided to Trusts to enable this.

We remain concerned that employers might choose to “opt out” of providing LEDs pay uplifts in some circumstances and underscore that such instances must be and will be challenged.

As we still lack accurate data on LEDs as a cohort, the possibility of financial exploitation of these doctors – specifically the engagement of LEDs on less favourable rates of pay their nationally employed counterparts – also remains a concern. We ask that the DDRB continues to push for the timely production of the information required to investigate this possibility.

Should analysis of data demonstrate that this is indeed an issue, the DDRB needs to consider measures to ensure that LEDs receive the same pay as those performing similar work under national contracts.

Recommendations

We recommend that the DDRB:

- Promote resolutions to issues facing LEDs, as listed above;
- Continue to ask for LEDs to be awarded pay uplifts comparable to their national colleagues, and for the Government to ensure there is funding provided to Trusts to enable this; and,
- Continue to push for the provision of data regarding LEDs.

Resident doctors

Evidence suggests that medicine is no longer an attractive career path. The sharp drop to only 24,150 medical school applicants in 2024[72] represents the lowest number per year since 2020. In the face of increasing medical school throughput, the implication is of reduced selection at the point of entry, driven in part by increasingly uncompetitive professional remuneration.

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[72] UCAS, accessed November 2024

As a result, workforce shortages and increasing patient demand mean resident doctors have been faced with an unrelenting amount of work which has now become unsustainable.

Rota gaps are a persistent problem, and resident doctors in post often bear the brunt of this, being implicitly expected to work overtime and miss breaks to cover gaps. In 2018, more than 3 in every 4 respondents to a BMA survey undertaken for our Medical Rota Gaps in England report said that individuals (note this included not just residents) are encouraged to take on the workload of multiple staff; over 1/3 said yes their employer had at some stage redesigned a rota so it included fewer doctors and more than 7 in 10 of those said this had led to a decline in patient care as well as over 6 in 10 saying it has led to delayed patient admissions.

Since then, demand on staff has increased significantly as a result of the pandemic. Results from the 2022 GMC Training survey reported 10% of trainees saying they worked beyond their rostered hours daily (1% increase since 2021), a figure which was 16% for trainees in GP posts (2% increase 2021). 45% of trainees rated intensity of work as very heavy/heavy (6% increase since 2021); this varied for individual disciplines and was worst in emergency medicine and obstetrics and gynaecology.

The profession has had enough – they are burnt out, exhausted, suffering from poor mental health, relatively underpaid and demoralised. The BMA's regular tracker survey showed that in December 2022, 64% of resident doctors said they were currently suffering from depression, anxiety, stress, burnout, emotional distress, or another mental health condition, relating to or made worse by their work or study. From 1 Sept 2021 – 21 Aug 2022 resident doctors were the second highest branch of practice contacting the BMA counselling services after GPs.

In the GMC's National Training Survey 2024, while the results with regard to wellbeing saw some improvements, the overall picture remains extremely concerning. Over a fifth (21%), down 2 percentage points compared to 2023, of trainees measured to be at high risk of burnout and over half (52%), down 3 percentage points, described their work as emotionally exhausting to a very high or high degree.

Pay erosion

Resident doctors pay remains 20.8% lower in real terms than in 2008,[73] driving a persistent increase in pay dissatisfaction during the lead up to industrial action, with 67% of doctors in training dissatisfied or very dissatisfied with pay via NHS Staff Survey 2023, up from 62% 2022, 39.1% in 2021, and 27% in 2018.[74] Pending results from 2024 should be viewed in the light of the recently paused industrial dispute for resident doctors in England, a status resident doctors view as the first step of a *de facto* path to multi-year pay restoration.

The referendum on the pay offer demonstrated that a significant proportion of doctors remain unhappy with the progress towards full pay restoration (FPR), with one third of members voting to reject the offer and 83% of all balloted members willing at the time of survey either to continue or escalate strike action if necessary as required. Pay remains a central concern and driver for resident doctor satisfaction and remuneration must be the primary strategy to recruit and retain doctors in the NHS.

Pay erosion is not just a campaign call for resident doctors but a greatly troubling reality. In a BMA survey from 2022 it was reported that just under half (45%) of resident doctors had difficulty paying

[73] BMA, September 2024
[74] NHS Staff Survey, 2023

their rent or mortgage in the past year, whereas half (50.8%) of resident doctors had difficulty paying their utility bills (heating, lighting) in the past year. Nearly three in ten resident doctors (29%) had used their overdraft for consecutive months to pay their bills over the past year. A further 27% of resident doctors had not repaid the full amount of credit card borrowing for consecutive months over the past year and around half (49.5%) of resident doctors had borrowed money from family or friends over the past year due to the rising cost of living.

Physician associates and pay

Resident doctors continue to face myriad challenging problems related to poor pay and working conditions. Unfortunately, resident doctors' pay remains significantly below that of physician associates (PAs) for several years, and PAs' addition to the MDT has generated significantly more work, potential liability, and loss of training opportunities for resident doctors.[75] There is no other profession where the assistant is paid more than those they assist. Consideration of rectifying this anomalous pay differential should form part of the DDRB recommendations, alongside the wider thought that the medical profession is giving to the long-term safety of PA roles, and steps needed to ensure that resident doctors receive the training they need to become the consultants and GPs of the future.

Training

Further adding to pressures on the resident doctor to leave the NHS are the training bottlenecks occurring at multiple points along the training pathway. There is a clear stagnation in the career progression from graduation to CCT and beyond, as there are insufficient training posts and consultant jobs, despite a recognised need from rising demand, excessively long waiting lists and backlogs. In 2024, there were 59,698 applications for only 12,743 specialty training posts available at CT1, ST1, ST3 and ST4 training levels: an overall competition ratio of 4.7:1.[76] This marks an increase of 39.5% in the number of applications compared to 2023, with 42,794 applications. In contrast, the number of posts has increased by only 0.5% compared to 2023, when 12,680 posts were available.[77]

We would also emphasise that the current lack of available posts does not reflect the lack of actual need for these. For example, the Royal College of Anaesthetists has, in its November 2024 report, identified a shortfall of around 1,900 (15% of the workforce) consultant and SAS doctor anaesthetists short of what is needed. However, for the anaesthetists CT1 programme, there were 2,604 applications for Anaesthetics at CT1, with only 545 posts available, giving a competition ratio of 4.78[78]. This clearly demonstrates that factors other than actual need are at play in such decisions, and are depriving the NHS of the doctors they require.

The political decision to uncouple recruitment from training is magnified in impact by recent policy around student loan repayment. In April 2025, an underemployed recent UK medical graduate earning minimum wage would nonetheless be subject to a 37% marginal tax rate as a consequence of updated student loan debt thresholds.[79] It is within DDRB's remit to make the necessary adjustments to ensure recruitment into medicine does not come with severe financial detriment.

Such increased training ratios and poor pay contribute to the rising trend of resident doctors voting with their feet and moving overseas. More UK doctors were granted visas to work in Australia in the

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[75] BMA, February 2024
[76] NHS England, September 2024
[77] Specialty Applications, accessed November 2024
[78] HEE, accessed November 2024
[79] The Economist, November 2024

last year than for almost two decades.[80] In order to stop the mass exodus of medical talent, financial and workstyle incentives are required for them to remain. The promise of a higher wage at the completion of training is not a definitive incentive to stay, not with record GP unemployment,[81] and the road to becoming a consultant or GP no longer guaranteed and becoming more difficult to obtain each passing year. Pay recommendations must therefore take into account the current situation of poor financial remuneration and reducing prospects of career progression that resident doctors face, and to increase the total reward package.

Recommendations

We recommend that the DDRB:

- Takes into account the considerable pay erosion that resident doctors still face;
- Acknowledges the ever-increasing gap between graduating and securing a job post-CCT, and the need for appropriate pay as a resident doctor, not promises of future pay that may not eventuate; and,
- Restores resident doctor pay to 2008 levels.

Contractor GPs

For both 2023/24 and 2024/25, successive Governments have created an expectation that all practice employed staff will receive the DDRB-recommended pay award – GP contractors only received an uplift for 2024/25 (once the 2019-24 contract, and its fixed annual uplifts, had come to an end). The Government then applied the DDRB's pay recommendations of 6% in each of the two years through the standard mechanism of uplifting one or more of the three main elements – contractor income, other staff expenses and other expenses – of the national practice contract baseline fund – global sum. This of course is not the same as directly uplifting GP and practice staff pay by 6% due to the way global sum funding is allocated to practices via the Carr-Hill formula. That means many practices do not get enough guaranteed (core) recurrent funding to pass on the pay uplift to everyone / anyone.

This is an invidious position for practice employers and their staff to be in, not to mention terrible for staff pay erosion and morale. In 2023/24, contractors had to choose which of their staff members would get a full / partial pay uplift. In 2024/25, they have had to choose whether to give their staff a pay uplift, leaving nothing for themselves, or split the increase income amongst themselves and their staff. This must be urgently resolved by ensuring a sufficient funding uplift to guarantee all contractors and practice-employed staff get the intended annual pay uplift, to prevent further disruption and help end the national dispute in England. The DDRB has a vital role in making sure this happens sooner rather than later.

Given that practices are reliant on Global Sum to ensure they have enough funding to uplift staff pay, an adequate resourcing uplift for practices in 2025/26, which ensures staff pay awards and rising costs can be met in full, will help to stabilise them in the short/medium term. Not only will this help to restore expected resourcing, it would also have the secondary impact of helping to resolve issues such as GP under/unemployment, GP and practice-employed staff pay erosion, bringing back the family doctor and providing each patient on practices' registered lists with GP-led continuity of care, providing the foundations for agreeing a fully resourced new national GP contract, one GP per 1,000

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[80] Doctors, accessed November 2024
[81] RCGP, June 2024

patients by 2040, strong recruitment and retention of GPs and nurses, premises fit for the 21st century.[82]

Additional financial resources into global sum would clearly also help to stretch the financial envelope in preparation for negotiations on substantial GP contract reform.

Global Sum resource allocation payments

For delivering core GP contract services, practices receive the set Global Sum payment per weighted[83] patient. It should cover the cost of delivering essential (core) contractual services, including all staffing costs, but delivering these services is increasingly expensive, and Global Sum payments have not kept up. As noted by the DDRB in its 2024 report, UK governments have since failed to agree appropriate expenses uplift mechanisms with negotiating parties. Underfunded contract uplifts therefore mean that the DDRB recommendation for GP partner pay cannot be realised.

As of 2024/25, the Global Sum payment per weighted patient is £112.50 in England. Since the introduction of the current contract in 2004, these payments have generally kept up with inflation and are now 18.9% higher in real terms than they were in 2004/05 (see Figure 8 below). However, a period of comparatively high inflation has caused erosion between 2021/22 and 2023/24. The 2024/25 DDRB-recommended uplift has partially, but not fully, reversed this erosion (real-terms payments were 2.7% higher in 2020/21 than they are now).

At the same time, GP practices are expected to deliver more and more care per patient: the average number of practice visits per patient more than doubled, from an annual average of 11 to 25.[84] This is due to factors such as an ageing population and a rising prevalence of complex conditions and multimorbidity. A King's Fund report from 2016 noted that the increasing workload of GPs is further compounded by initiatives to transfer unresourced care from hospitals to the community.[85] As such, Global Sum payments per weighted patient need to see *real-terms growth every year*. Past real-terms increases have *not been enough* to meet rising need, and the erosion seen in recent years means real-terms growth has stagnated. The graph below demonstrates how practice registered patient and appointment numbers have increased in the past seven years whilst the fairly stagnant global sum payment per weighted patient subsequently eroded and did not fully recover between 2021/22 to 2024/25.

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[82] BMA , November 2024
[83] The amount of money a GP practice receives is not just based on how many patients they have on their list; it also depends on the demographic characteristics of those patients. Patient lists are 'weighted' to adjust for factors that are associated with a higher workload – including age, gender, chronic illness/additional needs, list turnover, staff market forces factors, i.e. the geographical variation in staff costs, and rurality.
[84] Kontopantelis et al. (2021). For consultations with GPs specifically, the annual average increased from 5 to 8 per person.
[85] The King's Fund, May 2016

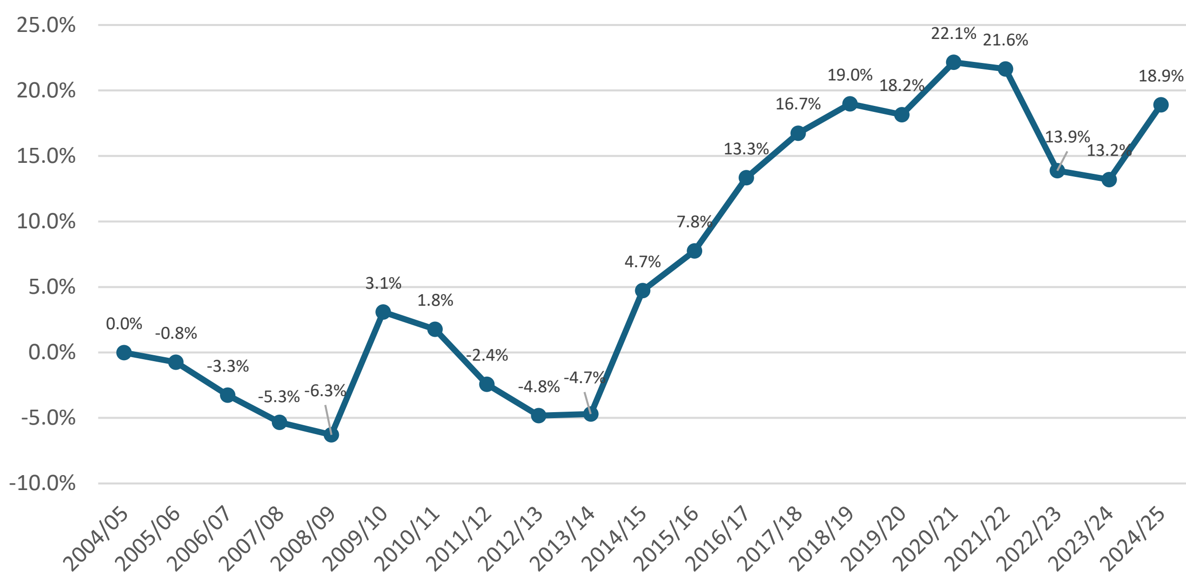

Figure 8: Real terms trend in Global Sum payments per weighted patient (CPI)

Source: BMA analysis of General Medical Services Statement of Financial Entitlements Directions (various years), OBR CPI financial year averages (October 2024).

Whilst Global Sum resource allocation payments are not the only source of income for practices, they are the most straightforward source of income, and this is what keeps their doors open and lights on. They are meant to fund delivery of essential services, including all staffing and other running costs and expenses. As such, real-terms funding increases for General Practice ideally happen through the Global Sum payment per weighted patient.

This is why the real terms decreases between 2020/21 and 2023/24 are problematic and are consequently negatively affecting average GP contractor income before tax with an almost 9% reduction in 2022/23 compared to 2021/22[86] from around £153,000 to around £140,000. According to NHS Digital's national data, this is the lowest it has been in real terms (RPI) since the current contract was introduced 20 years ago (in 2004/5).

We fully expect this average to have dropped further when the earnings and expenses data are published for 2023/24 in August 2025. Taking into account workforce trends for contractors in particular since 2015, this is one of the primary reasons why working patterns have shifted in the past decade or so. The clinical and financial risks, unlimited liability and rising costs that GP contractors take on is no longer sufficiently rewarded to make the role attractive. This is even more alarming when considering international comparator pay terms (please see the international comparators section). With this in mind, the BMA believes the independent contractor model is not broken, but is being broken; it is still well placed to deliver the most cost-effective patient continuity of care via the family doctor, but it has been under-resourced for too long.

[86] NHS Digital, August 2024

Where contractor income before tax is dropping so sharply, this affects practices' ability to pass on pay uplifts to other staff. GP practices are unable to run at a deficit, unlike the situation in secondary care. GPs' medical accountants seek to ensure practice financial planning takes place at least six months in advance of making service / staffing affordability changes. The graph below demonstrates how practice registered patient and appointment numbers have increased whilst the fairly stagnant global sum payment per weighted patient subsequently eroded and did not fully recover between 2021/22 to 2024/25.

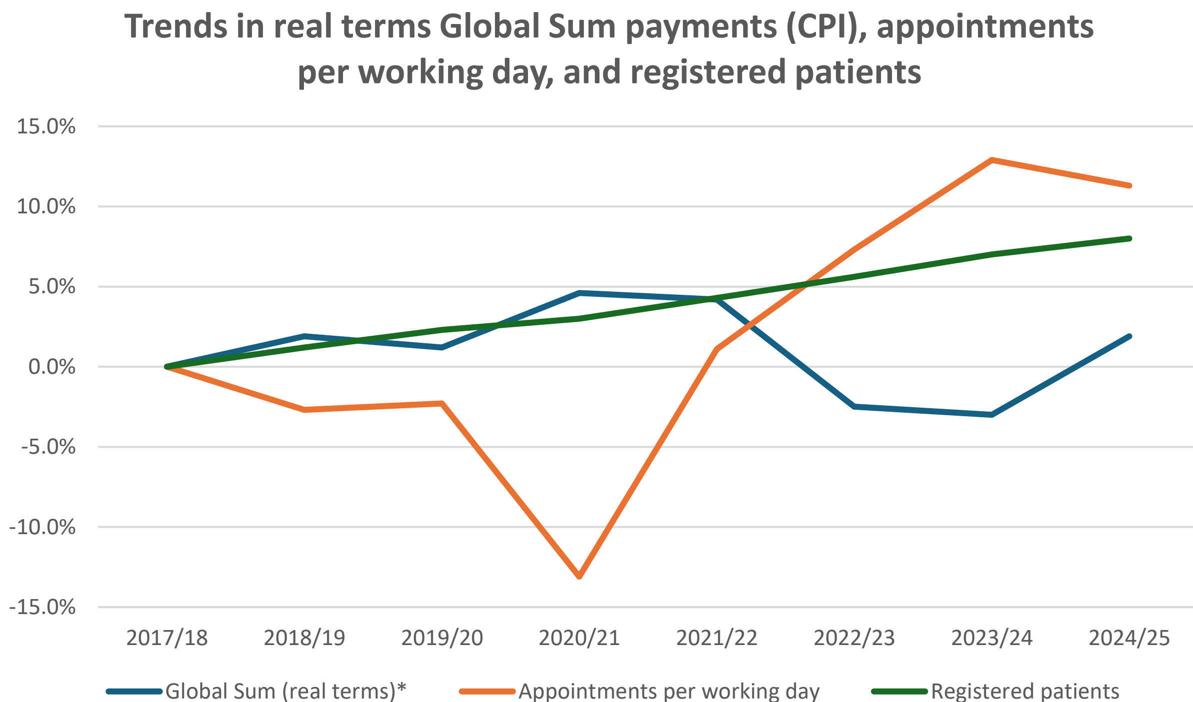

Figure 9: Trends in real terms Global Sum payments (CPI), appointments per working day, and registered patients

Source: BMA analysis of General Medical Services Statement of Financial Entitlements Directions (various years), GP Workforce data, GP appointments data, OBR CPI financial year averages (October 2024). The dip in the average number of appointments per working day seen in 2020/21 is due to the COVID-pandemic. Note that appointments averages do not include COVID-vaccination appointments.

The GP workforce is still below 2015-FTE levels. Although the annual cohort of new GP registrars has grown to record levels in the past five years and more, the workload that GP contractors have to take on, coupled with the financial risk and liability, is daunting for any newly qualified GP in their first five to 10 years of practice. However, there is no reason why properly resourced practices cannot have partnerships of contractors who are also able to work flexibility, alongside employed salaried and locum GPs, whilst making a long-term commitment and providing continuity of care to the patient communities they serve.

Training Fees

NHS England confirmed in writing to the BMA that the GP Educator Pay Scale would be uplifted for 2024/25 in line with the DDRB's 6% uplift recommendation. The annual GP Trainers' Grant amount is only published for the East of England and the Northwest and is stated to be £10,381.64 from April 2024[87]. It should therefore now be at least around £11,000 per year given the DDRB recommended

[87] NHS East of England, accessed November 2024

uplift was applied by PCSE (primary care support England) in October / November and back dated to 1st April 2024.

However, there are two outstanding issues with the grant, which, as an estimation, must now amount to around somewhere in the region of £865 - £917 per month:

- It has not been uplifted in line with inflation, so it does not go as far as it should, e.g. it was £7,485 in 2008[88], so should amount to around £13,775 if uprated by RPI inflation since then. That is 33% higher than the annual payment in April 2024.
- There is no published comprehensive evaluation of whether this grant is, or ever was, meeting the costs of GP registrar training in GP practices.

If our GP registrars get the highest quality support from senior GPs during their training, patients / the public will get the highest quality GPs upon completion of training. This will give the public the greatest return on their investment in these essential highly skilled public sector workers.

Furthermore, with the growth required to the GP workforce in England, it should really be possible for every single practice to become a training practice and host GP registrars.

GP appraiser fee

We note that both the DDRB and NHSE have said to the BMA in the past two years that the GP appraiser fee is no longer part of the DDRB's remit. However, this is the main source of income for some GP appraisers. In the same way as any other funding towards contractor or salaried GP income is treated, therefore, the GP appraiser fee must be uplifted in line with inflation. As far as we can glean, it has been fixed at £530 since 1st April 2020. Had it increased with RPI inflation, it would have been around £677 in April 2024.

Dispensing practices

Patient populations in rural and remote areas rely on dispensing practices for their healthcare needs. Without sufficient resources, there is a risk of health inequalities compared to areas of the country where patients have easy access to a pharmacy. We raise concern about the lack of uplift to the cost element of the fee scale, which covers dispensing practice staff salaries, every year, but this really does need urgently addressing.

The BMA and the DDA are prepared to work with the other parties to re-negotiate the fee scale as part of GP contract reform, to ensure *all* patients – urban, remote and rural – have a family doctor and continuity of care, and a DDRB recommendation on this would be extremely helpful in the context of dispensing practice sustainability for its patient communities.

Fellowships

NHSE confirmed to the BMA that payments for fellowships were uplifted by the DDRB's 6% recommendation for 2024/25. This must happen annually to ensure they continue to help with GP recruitment and retention and, ultimately, the GP workforce growth the nation so desperately needs. Fellowships will be a key contributing factor to the Government bringing back the family doctor and making GP an attractive career again to ensure sufficient nationwide supply.

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[88] 'Exclusive: DoH to scrap and replace GP training grant', GP Online (2008)

Recommendations

We recommend that the DDRB:

- Ensures its recommendation on pay means GP contractors *and* salaried GPs get the *full* pay uplift, i.e. not what is left over after other practice running costs have been covered, as the DDRB noted in its 2024 report;
- Uplifts GP and practice staff pay in tandem with increases to cover all other practice expenses / running costs to avoid variable or no pay uplifts each year;
- Uses CPI for its non-staffing expenses (running costs) uplift recommendation
    - non-staffing expenses uplifts cannot be based on the GDP deflators as they are not an appropriate measure for the GP contract's Global Sum uplifts (which have historically been based on CPI), as highlighted by the DDRB in its 2024 report;
- Recommends on staff pay *and* practice running expenses for 2025/26, as it did pre-2015, once again;
- Further adjusts the GP trainers' grant for 2025-26 to recognise the impact of significant inflation in recent years;
- Increases the GP appraiser fee at least in line with RPI inflation since April 2008;
- Considers the impact of rising dispensing practice expenses in the context of its 2025-26 award, and recommends a correction on the current discrepancy in the fee scale; and
- Annually reviews employment contracts, pay and protected learning time for fellowships to ensure fair remuneration in line with inflation.

Salaried GPs

The Sessional GPs Committee represents salaried, locum and retainer GPs across the UK. The DDRB recommendation is the only guaranteed means by which employed GPs can receive an annual uplift, and we were grateful for the DDRB's above inflation recommendation for 2024/25, which goes some of the way to restoring salaried GP pay.

However, in this year's DDRB report, salaried GP earnings were presented using the GP Earnings and Expenses Estimates NHS England data release, which is 'based upon anonymised tax data from HM Revenue and Customs' Self Assessment tax records and covers both NHS/Health Service and private income'.[89] The DDRB reported that the mean pre-tax income for salaried GPs in England was £68,000, in Scotland was £71,900, in Wales was £70,400 and in Northern Ireland was £58,600 for 2021/22. In reality, the mean employed gross earnings for salaried GPs in England were £58,500, in Scotland were £63,300, in Wales were £64,600 and in Northern Ireland were £51,400.[90] In reality, average *employed* income before tax for salaried GPs in England was £58,700, in Scotland £65,100, in Wales £65,300 and in Northern Ireland £55,800.

It is the Sessional GP Committee's position that, as the self-employed income of the salaried GPs in the NHS England data is earned from additional work, outside of salaried GPs' employed roles, it should be excluded from any assessment and recommendations made regarding salaried GP pay by the DDRB.

This additional self-employed income is likely to come from several different sources, including out of hours, locum, private and educational roles, which we understand fall outside of the remit of the

[89] NHS Digital, August 2023
[90] NHS Digital, August 2023

DDRB's recommendations on salaried GP pay. In addition, since the Earnings and Expenses Estimates do not include a breakdown of expenses, it is not possible to calculate income after expenses for employed income only with any precision. It remains misleading of NHS England to ignore this issue and present the mean average income of salaried GPs to the DDRB as earned entirely from employment. We would appreciate if, in this year's DDRB report, employed income before tax is presented separately.

Sessional GP unemployment and under-employment

In the Autumn of 2023, the BMA started hearing reports of locum GPs struggling to find work. At the start of 2024, these recruitment issues started to spread to salaried roles, with GPs looking for substantial employment informing us that opportunities were few and far between, and that competition for these roles meant that rates of pay were being driven down significantly. To find out more, the Sessional GP Committee conducted a survey of our members. The survey was sent to 8,887 sessional and locum GPs across the UK, was open between 28th May – 9th June 2024 and received 2,092 qualifying responses. While this survey focused on locum GPs, the results are indicative of wider market forces and the workforce crisis faced by all sessional GPs, including salaried GPs.

- Across the UK, 78% of respondents want to work more session, with 53% wanting to work more sessions but can't find additional suitable work and 25% being unable to find any suitable work at all.
- In England, 84% of respondents said they wanted to work more sessions, suggesting that the problem was more pronounced in England than the UK average.
- Of the 78% wanting to work more sessions, these respondents told us they currently work 2.8 sessions a week on average, and they would like to work an additional 3.5 sessions a week on average.
- 87% of respondents though that session availability has reduced since 2022. This perception was higher in England, with 91% believing that session availability had reduced since 2022.
- 79% of those who thought session availability has reduced in England believed that this was due to the Additional Roles and Reimbursement Scheme (ARRS) model only funding non-GP roles.
- Other reasons for session availability reducing were more non-GP roles being employed by practices (74%), practices actively trying to reduce locum costs (69%) and overall practice funding being insufficient (68%).
- 45% of respondents in England said that the locum fee rate had decreased since 2022.
- Respondents work 2.6 sessions less now than in 2022, decreasing from 5.7 sessions per week on average in 2022 to 3.1 sessions per week on average in 2024.
- 83% of respondents thought they don't have enough time in sessions to provide safe care.

The results of the sessional GP survey show that the GP workforce wants to work, but they cannot find suitable positions. Locum rates are being driven down by supply outstripping demand and this is having a knock-on effect on salaried GP positions. There have been reports of over 40 applicants to one part-time role.[91] and GPs having to travel hours cross border to find work. The employment crisis is particularly problematic for newly qualified GPs, who following CCT, are desperate to join the workforce and create a fulfilling career but find themselves unable to get locum or salaried GP work.

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[91] Pulse Live, May 2024

Many are considering their options abroad, such as in Canada, where salaries start at £166,000.[92] We are in the paradoxical situation where patients are desperate to see a GP, but sessional GPs cannot find appropriate roles in the UK.

GPC England conducted a Practice Finance Survey in August-September 2024. Due to cashflow problems, 76% of respondent practices said they had to reduce their locum usage, or intended to, and 27% of respondent practices said they were already hiring fewer salaried GPs than they required, with a further 25% considering doing so.[93]

Salaried GP pay range and uplifts

For a number of years, the Sessional GP Committee has felt the salaried GP pay range is unfit for purpose. Sub-inflationary pay uplifts have meant that the pay range has fallen behind what our members expect in terms of their remuneration. It has resulted in salaried GP pay being considerably behind hospital counterparts.

Due to the employment crisis highlighted in general practice, from October 1 2024, the ARRS scheme in England was expanded to include newly-qualified GPs, paid at the bottom of the salaried GP pay range. In light of the pay deals received by resident doctors in England, the bottom of the salaried GP range is £73,114, only £593 above more than GP registrars at the end of their training at ST3 (, at £72, 516).[94] In comparison, a secondary care resident can expect to earn up to £95,400 as a specialty doctor, £107,154 as a specialist and £139,882 at the top of the consultant pay scale.

In order to attract resident doctors into general practice when considering their career path, the salaried GP pay range needs to be revised to combat pay erosion and make general practice a desirable place to work.

As GP earnings data are only available up to 2022/23, we are unable to say for certain whether all salaried GPs have received the DDRB uplift for 2024/25. As contractors have historically struggled to pass on the uplift in full because the uplift is applied to the national GP practice baseline global sum, which is then distributed / allocated to practices via the Carr-Hill formula. This creates 'winners and losers', with many practices not provided with the appropriate funding for the number of salaried GPs they of necessity employ. In Wales last year the Welsh Government, following the 6% recommendation by the DDRB, said that it could only afford 5%. Therefore, many salaried GPs who were entitled to a 6% uplift as per their contracts only received 5% because that is what practices were funded for. The Sessional GPs Committee therefore echoes the calls made by GPC England and GPC Wales for sufficient funding to be provided for practices to enable them to pass on the uplift to salaried GPs in full.

It is imperative that all uplifts agreed by Government must be fully funded to ensure that, as per the DDRB's commentary in its 2024 report, GP contractors can afford to pass on the full amount to those intended to benefit.

In Wales, since 2021, the GMS contract has required practices to provide confirmation via a declaration letter, and more recently a Microsoft form, to their local health board that they have passed on the DDRB uplift for that financial year to their practice staff. If this is found to be untrue, the practices risk having the funding for the staff pay award within the global sum clawed back. The

[92] BMJ Jobs, October 2024
[93] GPC England Practice Finance Survey, 2024
[94] NHS Pay Circular, September 2024

intention of this mechanism is to ensure that the funding provided by the Welsh Government is being used as intended and that staff receive the pay uplift as agreed, rather than that funding being used elsewhere in the practice.

In theory, the costs of this mechanism in Wales are neutral. Practices are funded for the staff pay award on the specific proviso that the uplifts are passed on. The staff pay award money is ring fenced within the global sum. The declaration letters, although creating a minor additional piece of admin, also represent due diligence for employers. However, the mechanism relies upon a sufficient expense uplift that accounts for general expenses and all staff pay costs, e.g. including statutory wage and employer national insurance contribution increases and all other non-staffing costs. In practice, this has not been the case since the DDRB stopped recommending on expenses around 2014/15. In a December 2022 survey from GPC Wales, 92% of respondent practices said they were aware of the mechanism, indicating almost complete compliance with the requirement. Comparatively, in England, only 60% of practices who responded to the Practice Finance survey said they had been able to pass the full 6% DDRB uplift on to their salaried GP staff for 2024/25.[95] The mechanism used in Wales is an example of what more can be done to enable practices to pass on the DDRB uplift to salaried GPs.

PCN payments for salaried GPs recruited via the ARRS

Over summer 2024, the Secretary of State for Health and Social Care announced that, as an emergency measure to try to tackle the issue of GP un- or under employment, £82m would be made available to PCNs to recruit 1000 newly qualified GPs via the existing ARRS from October 2024.

The ARRS has been in place since April 2019. Until this year's announcement, this time-limited reimbursement scheme has been available to PCNs to recruit multiple AHPs (allied health professionals) and MAPs (medical associate professionals) but specifically excluded the employment of practice nurses and GPs, despite real-terms core general practice funding available to employ GPs eroding since 2019. This combination has directly led to the current absurdity of patients struggling to access GP appointments and the simultaneous under/unemployment of GPs, which we have no doubt is pushing some GPs into the private sector where terms and conditions are likely to be better and more flexible.

Whilst increased investment for the recruitment and retention of GPs is both essential and to be welcomed, directing this funding via PCNs and the ARRS raises concerns and questions about how these new GP roles will work in practice and what newly qualified GPs should expect from such jobs. This fails to provide the necessary longer-term solutions to the current GP under/unemployment crisis and does nothing to ensure the retention and recruitment of already established and experienced GPs. For the profession, it represents yet another temporary sticking plaster fix, attempting to partially treat the symptom of GP under/unemployment, without directly tackling the underlying causes.

The transition from being a GP registrar to a fully qualified GP can be a daunting time for even the most stoic of GPs. Going from the relative protection that a GP training post provides to dealing with an increased workload, working more autonomously and being suddenly responsible for much more clinical risk can come as a shock, especially in the current climate of escalating and unmanageable GP workload pressures.

[95] GPC England Practice Finance survey, September 2024

Alongside the increased clinical responsibilities, it will likely be the first time registrars have had to apply for jobs and negotiate the terms and conditions of their contracts, having previously been on very prescribed, standardised national training contracts which secure their pay and benefits of employment.

GPs employed via the ARRS are entitled to, as a minimum, the terms and conditions outlined in the BMA Salaried GP model contract. It is essential that these roles provide equitable terms to practice-employed salaried GPs and parity with other employed NHS doctors.

The salary for these roles must reflect the fact that this is likely to be a fixed-term position, which provides little in the way of long term security, whilst also recognising that the DDRB salaried GP pay range is outdated, is not representative of actual GP salaries (as outlined by the BMA indicative pay range) and that salaried GP pay has seen 32% real-terms erosion in England since 2008/09. The reimbursable full-time salary for these roles as outlined by NHS Employers currently sits at the very bottom of the DDRB salaried GP pay range at £73,114. This is derisory, uncompetitive, does not adequately value fully qualified GPs and risks failure to meet the intended aims of the scheme to temporarily alleviate the GP unemployment crisis and retain newly qualified GPs within NHS general practice. It is further problematic because, following the resident doctor pay deal agreed in September, GP registrars at the end of their training are being paid £72,516, meaning that they will barely see an increase in their pay if they take an ARRS role post qualification.

Workload and workforce

Salaried GPs consistently tell us of their unmanageable and often unsafe workloads. As of September 2024, the number of patients per FTE GP in England was 2,273, an increase of 335 since 2015. The British Journal of General Practice found that at the current average duration of sessions, six sessions per week aligns with the NHS definition of full-time hours[96] of 37.5 hours per week. These results support the findings of the committee's survey from 2022, which found that salaried GPs, on average, are working 25% above their contracted hours each week.[97] Our members have told us that the work of a GP has become more demanding: with patients presenting with more complex and multiple illnesses, increased administrative burden and some multidisciplinary teams needing supervision. Subsequently, many GPs are considering reducing their hours even further or leaving the profession all together. 40% of the GP workforce across the UK said it was unlikely that they would be working in practice in five years' time.[98]

Pay erosion for salaried GPs

With all of the above problems facing general practice, one key issue remains: salaried GPs are not being paid enough for the skills and expertise they bring to the work they are doing. Pay erosion for salaried GPs in England currently stands at 33% between 2008/09 and 2022/23, as illustrated in Figure 10.

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[96] British Journal of General Practice, October 2024
[97] Sessional GP Committee survey, 2022
[98] RCGP, October 2024

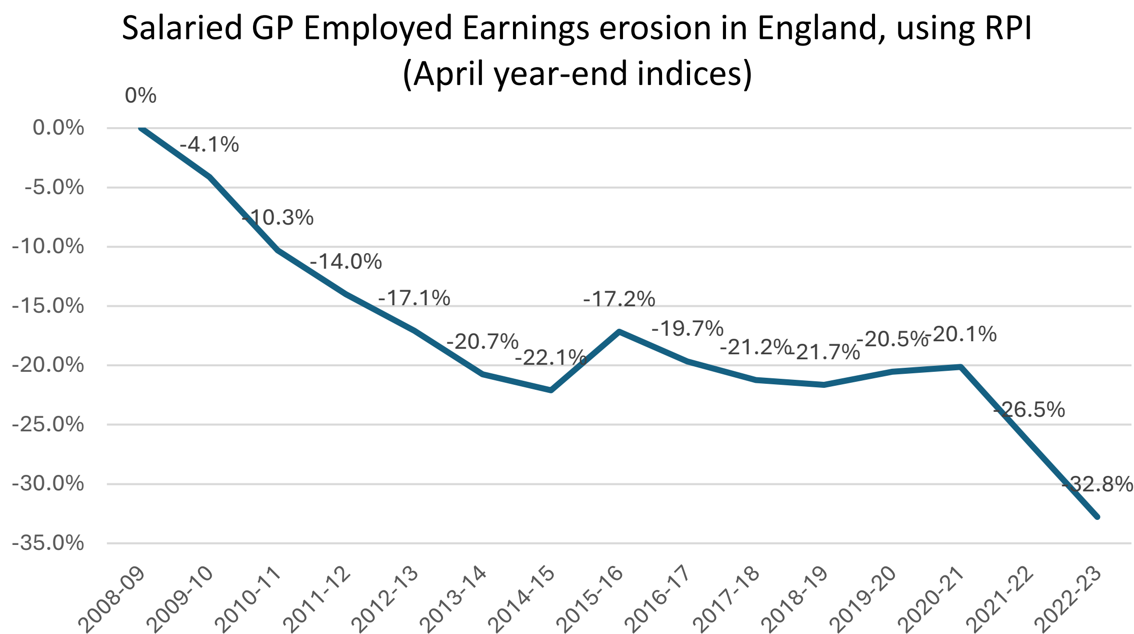

Figure 10: Salaried GP Employed Earnings erosion in England, using RPI (April year-end indices)

Salaried GPs are an integral part of the healthcare system in the UK, accounting for nearly half (48.3%) of all qualified permanent GPs in England as of September 2024. It is therefore imperative that progress is made towards pay restoration and a commitment made to future uplifts which ensure that does not erode any further. Consultants across the UK have entered disputes with their respective Governments, and all have received and accepted pay offers in 2024. Salaried GPs, have CCT'd like consultants, but have not received a pay award which comes close to the double figure award of 10.5% offered to consultants in Scotland or the between 6% and 19.6% pay uplift for 2023/24 accepted by consultants in England.

The argument has been made that salaried GPs have reduced their hours since 2015, and therefore are earning more for fewer hours. NHS Workforce data have shown that in 2015, on average salaried GPs were working the equivalent 66% of FTE. By 2023, on average salaried GPs working were working the equivalent 63% of FTE. This demonstrates that since workforce data started, there has only been a 3% reduction in FTE working.[99] Salaried GPs may be *contracted* for fewer hours, but on average are working full time hours.

The need to address pay erosion is urgent: funding to GP practices needs to be increased to enable them to hire the doctors they need and reduce the workload of the existing GPs who are facing burnout and leaving the profession all together. Pay needs to be enhanced and increased to attract resident doctors to train in general practice over the consultant pathway. Without reversing pay erosion, the salaried GPs already working in general practice will be looking elsewhere to other countries and private practice where they will find better salaries and an improved work/life balance. If salaried GPs leave the NHS, the Government's aim of improving continuity of care and bringing back the family doctor[100] cannot be achieved.

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[99] NHS Digital, October 2024
[100] Labour Party Manifesto, June 2024

Recommendations

We recommend that the DDRB:

- Recommend that the starting minimum salaried GP pay range is uplifted by 20%;
- Recommend a pay award for salaried GPs for 2025/26 of 20% + inflation, which is fully funded by the respective Governments of the UK;
- Commit to recommending a pay award of 8.1%[101] in 2026/27 and 2027/28 to reverse the effects of pay erosion; and
- Recommends the starting salary for GPs in the ARRS is uplifted in parallel to the salaried GP pay range.

Public health doctors

Public health doctors play a vital role in preserving and enhancing the health and wellbeing of the nation. This cohort makes a huge difference to patients at an individual, local, and national level and – if properly supported – can ease the burden on primary, secondary and community care. Recent history has only served to underscore the importance of public health, with continued threats from poverty to potential pandemics and the effects of climate change all underscoring the need to revitalise this precious resource.

The Faculty of Public Health estimates that the vacancy rate in the UK is between 8 and 25%. In 2022, the HEE census had an official figure that 11% of posts were infilled in England[102]. Furthermore, in England the proportion of medically qualified public health specialists in local authorities has significantly decreased: in 2017, 55% of the specialist workforce were registered with GMC[103], and in 2022 (when this was last measured this was only 21%[104].

Little has been done, however, since we last wrote to the DDRB to meaningfully change this situation. At roughly 10%, the attrition rate among medically qualified public health registrars in the UK is not only untenably high, but also worse than that for those from other professional backgrounds in the training scheme. The growing complexity of terms and conditions for this cohort in England, as well as continued pay disparities, remain major issues for this group.

Public health doctors can be employed by several different bodies, which in turn gives rise to contracts and pay disparities within the cohort (with local government typically paying less than NHSE, DHSC, UKHSA or OHID). These issues have arisen since the implementation of the Health and Social Care Act 2012, which moved Public Health out of the NHS. It was recognised at the time that, to ensure that doctors and other healthcare professionals continued to choose a public health career, NHS pay and terms and conditions needed to be retained. This meant that a dynamic clinical ring-fence was established for the doctors working for Public Health England (and subsequently UKHSA and OHID). However, the ring-fence was not extended to those working for public health in local government. This meant that medical and dental pay and conditions were retained and amended in line with NHS awards for those within the ring-fence, but not for those outside it.

Since 2013, local authorities have continued to erode pay. There are some local authorities advertising consultant posts at £20,000 below the NHS equivalent starting salary. In addition to this,

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[101] Contingent on the previous recommendation also being made by the DDRB.
[102] HEE, 2023
[103] HEE, 2018
[104] HEE, 2023

local authorities offer their own terms and conditions and are not bound to the minimum standards offered in NHS contracts.

The combination of different contractual arrangements, the lack of mutual recognition of those arrangements and pay disparities impedes movement around the public health system, making it harder at times of crisis to deploy staff where they are most needed. It also does little to retain skilled professionals or recruit new talent to this area.

The issue is further compounded when considering the 2024 England consultants' pay deal. First, this exacerbates the existing pay disparities between doctors in the national public health organisations and those working in local authorities. Second, while NHS employers were funded to cover the pay rise for their consultants, we have yet to receive an assurance from Government that the public health employers have been also. Whilst the national organisations have, so far, implemented the pay award we are concerned about whether this will continue to be possible in the future and that there is a risk of redundancies or posts being left vacant in order to maintain pay parity.

There are clearly alternative paths for public health doctors to pursue within the public sector, including other medical specialties, such as General Practice. Public health consultants are also incentivised to move to the Republic of Ireland, as outlined in the international comparators section, to join a consultant-led public health service and at rates of pay significantly above those offered in the UK. In addition, it is important to note there is also a growing demand for these specialists in the private sector, with management consultancy firms, amongst others, successfully attracting doctors to their employment.

Even public health doctors on NHS pay scales have concerns regarding their pay. Like their primary, secondary and community care colleagues, they have suffered significant pay erosion. The BMA has outlined the impact of the devaluing of the medical professional since 2008/09 in – especially the threat to morale, recruitment and retention – and these concerns, naturally, apply to this group.

To truly recognise the value of medical professionals working in a public health setting, they must be treated in line with their NHS colleagues. Ensuring proper pay, and proper pay parity, is a crucial step towards acknowledging the skills, expertise and insight that these professionals bring to this sphere. At a minimum, public health doctors should not be penalised for pursuing a specialty and a line of work that provides such health benefits for the nation.

Recommendations

We recommend that the DDRB:

- Calls for above-inflationary pay uplifts to address the long-standing erosion of doctors pay by 2026;
- Calls on the Government to ensure that the principle of pay parity is retained and provide the required funding to for the pay uplifts in the public health sector; and
- Calls on the Government to provide the funds necessary to ensure pay parity for all Public Health doctors and specialists working in the public sector and work with the BMA to achieve an improved ability for staff to move around the public health system without loss of employment rights.

Medical academics

We welcome the Secretary of State for Health's declaration that:

"We will make Britain a powerhouse for life sciences and medical technology. If we can combine the care of the NHS and the genius of our country's leading scientific minds, we can develop modern treatments for patients and help get Britain's economy booming."

Underpinning and embodying that ambition are the UK's medical academics. They are a cohort of doctors who hold the responsibilities of teaching medical students (and others) and of undertaking medical research *alongside* clinical roles. We need them to train the new generations of doctors; to make the kinds of discoveries that allow us to better treat patients; and to enable us to introduce evidence-based reforms that improve the delivery of our healthcare.

The UK, therefore, cannot afford to lose its medical academics. Yet there are clear threats to the future of medical academia. Workforce shortages – fuelled by multiple factors – need to be properly addressed. Insecurity, for example, poses a major issue: many lacking the job security of their NHS colleagues are constantly forced to decide between continuing to forge an uncertain path through a series of fixed term "gigs" or leaving their academic aspirations behind. This situation puts us at a particular risk of losing certain types of clinical academics. As the House of Lords Science and Technology Committee noted, there is a leaky pipeline for "clinical academics in their early 30s, particularly women and those from economically disadvantaged background, for whom the security of a full-time job as a consultant may be more necessary".[105]

We also need to ensure the right number of senior roles exists to provide long-term posts for fully trained clinical academics and to allow doctors to enter and reinforce the workforce pipeline mid-career.

We must also, however, consider concerns around pay – concerns that exacerbate anxieties around job security.

Since the founding of the NHS in 1948, it has been recognised that key to ensuring a cohort of doctors employed by universities is a commitment to pay parity between them and their NHS colleagues. In general terms, this had been adhered to by both sets of employers, though in recent years the NHS's commitment to this group of doctors seems to have diminished. Access to and funding of clinical excellence awards has been made harder for consultant clinical academics and academic trainees are disadvantaged by the nodal structure of the resident doctors' pay scale. Medical academics can also be engaged on comparatively unfavourable terms and conditions: for example, a medical academic employed by a university could have worse maternity leave and pay than their NHS counterparts.

These concerns have been compounded by anxieties around the funding of the recent pay awards in the academic sector, making the principle of pay parity between doctors working for academic institutions and the NHS increasingly difficult to protect, or risk have to do so at the cost of losing even more medical academic jobs.

Earlier this year, a deal was agreed between the BMA and the Government to reform NHS consultant pay scales. This deal was made without the Government agreeing specific funding for universities

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[105] While referring specifically to fully-qualified consultants, we believe a similar risk exists for those in primary care.

that employed consultant clinical academics and senior academic GPs (those academic GPs recognised as being equivalent to consultants and paid on that pay scale). Despite the BMA's multiple attempts to secure this funding since, the Government has still not made any provision for cash-strapped university employers (who, in this situation, are comparable to that for NHS employers). The Universities and Colleges Employers Association (UCEA) has issued pay circulars that match the pay uplifts agreed through the deal, but we remain concerned that these employers will not be able to absorb this cost without making cuts elsewhere. There is a threat that this could, in fact, lead to redundancies within an already diminished medical academic workforce.

Until the Government agrees to provide funding for pay parity – including basic pay, excellence and impact awards, and associated "parachute arrangements" – we will be constantly stuck in this difficult position. We certainly won't be able to expand the clinical academic workforce to meet either the Secretary of State's declaration above or the objectives in the NHS Long-Term Workforce Plan to expand medical student and doctor numbers. Ultimately, doctors are required to equip new doctors with the knowledge and skills required to perform their roles.

As we have noted in previous evidence, Medical School Council data have shown that medical academics are an ageing cohort.[106] Doctors aged over 55 made up 36% of the clinical academic workforce in 2023, compared to just 18% in 2005. 65% of professors in this cohort are over 55, which has more than doubled since 2004 (when it was just 31%).

There is an evident need to do more to encourage early career doctors into this field. We call – as we have done before – for the flexible pay premium for academic trainees (paid on completion of a higher degree) to be fixed at 15% of the basic salary of the trainee. This is important, as the premium seeks to compensate academic trainees for extending their training time (and delaying the acquisition of the next nodal point and their appointment to a consultant or equivalent post) by taking an academic route. The funding for this, too, would need to be provided directly from Government, for the reasons we outline above. We also need to do much more to retain clinical academics mid-career and at the completion of specialist training. This requires the funding of clinical senior lecturer posts for them to take up and re-enter clinical academia.

Outside concerns of parity within the UK healthcare system, it is important to note that all doctors in the public sector have suffered the effects of pay erosion. The arguments for above inflation pay uplifts are made elsewhere in this evidence – they apply to medical academics as much as to their colleagues. This workforce needs to see its pay restored, but again resource needs to be provided for this. Medical academics should not be forgotten simply because they are employed by higher education institutions. These doctors work in clinical settings, hold honorary NHS contracts, perform an unmistakable role in improving the nation's health and are an essential and integral part to the future of healthcare provision. They must be recognised and valued accordingly.

Recommendations

We recommend that the DDRB:

- Call for the protection of the principle of pay parity between medical academics and their NHS colleagues, including both basic pay and other areas of remuneration (e.g. national

[106] Medical Schools Council, April 2024

clinical impact awards and local clinical excellent awards and associated "parachute"[107] arrangements), and for the Government to provide the required funding for this;
- Fix the flexible pay premium for academic trainees (paid on completion of a higher degree) at 15% of the basic salary of the trainee and for access to the pay premium to be extended to all trainees that have completed a relevant PhD;
- Call for an expansion of clinical academic posts to ensure that there are sufficient clinical academics to teach and train the increased number of medical students and doctors envisaged by the NHS Long-Term Workforce Plan; and
- Call for any above-inflationary uplift awarded towards pay restoration in the NHS to be fully-funded in the Higher Education sector.

Medical students

The BMA has serious concerns about the stagnation of financial support for medical students. The next generation of potential doctors are being financially disincentivised from choosing to study medicine, and therefore pursuing it as a career, and the impact is particularly hard on those from disadvantaged backgrounds.

Both undergraduate and graduate medical students experience a significant drop in funding, once they transition to the NHS bursary funded years. This drop leaves the average student based in England £2,766 worse off in these years.[108]

For students on the highest means tested maintenance loan in England, the reduction in funding provided by Student Finance from year 5 onwards for undergraduate-entry and from year 2 onwards for graduate-entry,[109] results in an overall drop of £3,979 of available financial support in these years.[110]

Allowing students to retain their entitlement to full student finance maintenance funding would cost the treasury £24 million – this is just 0.12% of Student Finance England's annual lendings.

Recommendations

We recommend that the DDRB:

- Calls on the Government to review Student Finance arrangements to ensure that both undergraduate and graduate students are eligible for full SFE maintenance loan provision for all years of study;
- Support our calls for a meaningful uplift to the NHS bursary scheme; and,
- Calls on the Government to improve access to funding via the NHS Bursary, including improving the claims process, and exploring new sources of funding.

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[107] 'Parachute' arrangements are the arrangements that lessen the impact of losing national CEA or CIA awards by enabling those who have lost those awards to fall just to the top of the local awards scale rather than have no award at all. Consultant clinical academics should have the same access to those arrangements as NHS consultants.
[108] BMA, accessed November 2024
[109] The point at which medical students transition to the NHS bursary scheme.
[110] For Northern Ireland, the other nation in the UK where this drop takes place, the maximum drop is £3,056.

Northern Ireland

We cannot understate how frustrating it is to once again be in a position where BMA Northern Ireland are providing evidence to the DDRB for the upcoming year with no clarity on what our members can expect from the 2024/25 recommendation.

In previous years this has been explained away by the lack of a functioning Executive in Northern Ireland and therefore no Health Minister; that is not the case this year. We have had a Health Minister in post from February 2024 and we still do not have full clarity on the 2024/25 recommendations.

Whilst we acknowledge the recent update from the Minister that he would seek to pay the 2024/25 recommendations backdated to August 2024, rather than April 2024 as recommended by the DDRB, it is far from acceptable to our members.

Due to this ongoing delay, our members still sit behind their counterparts across the UK. If the Minister's proposal to pay some of the uplift now and some at a future date, is implemented, they will remain further behind whilst working in a system that is under greater pressure.

If implementation of the 2024/25 recommendation begins now it is unlikely our members will see it in pay until the next tax year thanks to the continued, frustrating, reality that it takes at least 12 weeks from the issuing of a pay circular to have it implemented into the pay system in Northern Ireland.

This should all sit in the context that our members only received their uplift for 2023/24 in June 2024, a full year later than they should have, with all the consequences that brings. We would like to say that these are unintended consequences, but we have spent many years when uplifts are delayed explaining these consequences to the Department of Health (DoH NI). It appears that the department is unwilling to act.

This year we are providing evidence despite the department not yet submitting a remit letter. Many of our members were questioning whether we should provide evidence at all until a remit letter was received, because we think the lack of engagement in the process is indicative of how our department currently views this process and our membership. We reserve the right to address the department's remit letter in any supplementary evidence.

BMA Northern Ireland are providing evidence this year while two of our branches of practice are still in direct dispute, one is in stalled contract negotiations and one more is still awaiting the implementation of their pay deal that was agreed in August.

Throughout each of our pay discussions with all branches of practice, the department has been at pains to tell us that they "put a lot of store in DDRB" and "have never not paid it." We believe it is simply not good enough to state that the DoH NI have "never not paid it" and then to disregard that it is routinely paid months, if not over a year late with all of the adverse financial consequences that brings for members.

In order to inform this response, BMA Northern Ireland undertook a survey of members to understand their thoughts on last year's recommendations and what they hope to see in this year's recommendation.

Almost 70% of our respondents told us that they felt either “dissatisfied” or “very dissatisfied” with the statement that the 24/25 recommendation recognised their contribution to the Health and Social Care (HSC).

The Minister subsequently has announced that he has 'found' money to fund the pay uplift from July and not August as previously announced. Either he has no regards for his staff as a valuable and important asset in the delivery of healthcare or he does not. This piecemeal, drip feed approach to staff pay shows that he does not.

Consultants

Pay erosion for consultants in Northern Ireland

Figure 11 below evidences the continuing pay erosion experienced by consultants in Northern Ireland. This equates to pay erosion of 28.8%. This figure will change when the consultant pay deal from Northern Ireland (agreed in August 2024) is implemented, but given the lag in time to pay this by DoH NI we could not include it in current figures. When it is paid, if this is before our oral evidence we will update the DDRB with revised figures.

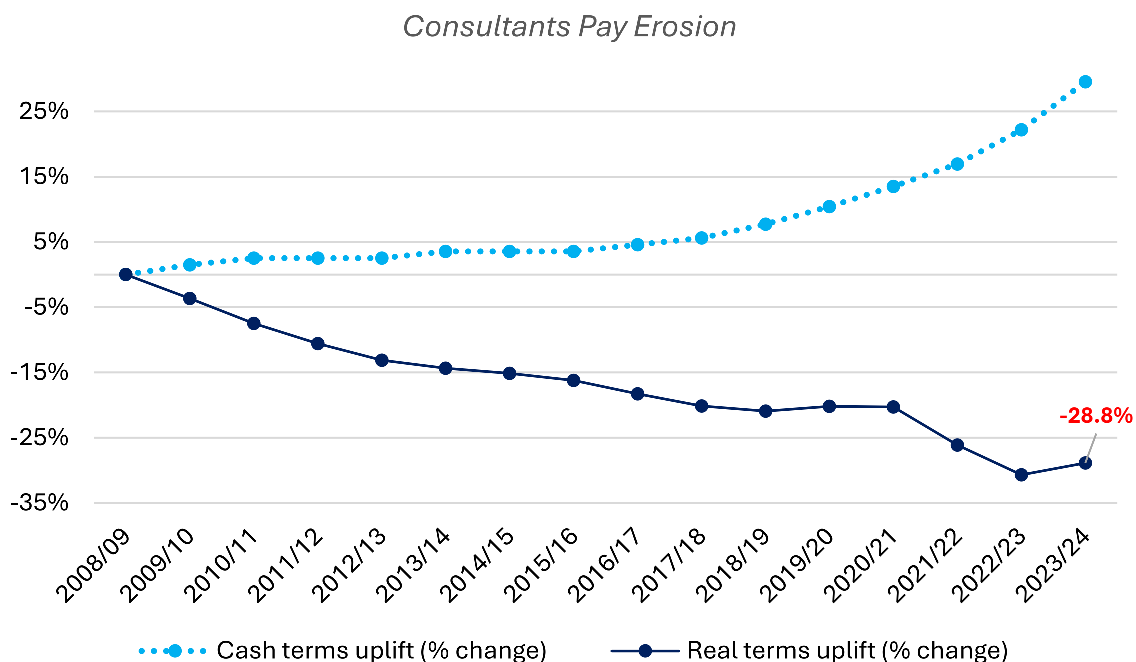

Figure 11: Pay erosion for consultants in Northern Ireland

Aside from pay erosion, the recent announcement from the Health Minister that he can only pay the DDRB for 2024/25 backdated to August 2024 is completely unacceptable to our members and will directly result in consultants in Northern Ireland being paid less than their counterparts across the UK.

Our DDRB survey, which was carried out prior to the announcement, found that the delay in paying the uplift altered career plans for 58% of respondents. Of that 58%, 27% stated that they were “actively planning to retire earlier than they otherwise would”. Nearly 1:5 (18%) stated they were “actively making plans to work outside Northern Ireland in the future,” the majority of these respondents were planning to work in the Republic of Ireland.

CEAs

BMA Northern Ireland have been lobbying for many years for the reintroduction of CEAs in Northern Ireland, including starting a legal case against DoH NI. This legal case resulted in mediated discussions with the DoH NI on the development of a new Clinical Excellence Awards Scheme throughout 2023, resulting in the launch of a consultation in November 2023. BMA Northern Ireland responded to this consultation before it closed in mid-February 2024.

We are still awaiting the DoH NI report on the consultation process.

Pay deal

Following announcement of strike dates in June of 2024 Northern Ireland Consultants Committee (NICC) was invited to take part in pay talks with DOH NI, as with other branch of practice colleagues this was to be largely based on the deal reached between UKCC and DHSC.

Following the conclusion of these talks the deal was overwhelmingly accepted by a majority of consultant members in Northern Ireland.

It is incredibly disappointing that the DoH NI have slipped on all the deadlines they included in the deal.

The additional monies will not be paid to consultants until January 2025. The constant delay in receiving uplifts, apparently due to the HRPTS pay system used, is incredibly frustrating for our members. We cannot understand why this process takes so long. Members across the rest of the UK never face the same 12-week delay.

Pension mitigations

NICC included pensions mitigations in their pay talks with DoH NI. The pensions mitigations, some of which should have been in place in April 2024, had a deadline to be in place of 1st October 2024. We have now heard it will be December 2024, though information our members would have expected to have received in advance of this date has not yet been forthcoming.

Coupled with the delay in receiving the additional monies, the delay in implementing pensions mitigations has caused considerable concern in the consultant community, who are frustrated to not see the DoH NI upholding their end of the deal.

Consultants in Northern Ireland also have significant concerns around the potential pension impact of the minister's plans for the DDRB uplift for 24/25 which may be received incrementally and almost certainly some, if not all, will be received in the next financial year.

Vacancy data

We consistently highlight the issues with official vacancy data collected by the HSC/DOH and as such put very little store in the official vacancy rate. Figures from June 2024 show there were 174 consultant vacancies currently being actively recruited to. With figures from the 2024 workforce census this would make a vacancy rate of 8%.

The workforce census for 2024 showed a total consultant workforce, by headcount, of 2150. This is an increase from 2023 of just over 2%.

In 2023 BMA carried out a piece of work on consultant vacancies through the use of FOIs. This showed a vacancy rate of 20.7%. If we look at the increase in the consultant workforce since then we can see no reason to think that the vacancy rate will be much lower than what we calculated via FOI.

SAS

Pay erosion data for SAS doctors

The chart below shows a similar pattern for SAS doctor pay erosion to that of their resident doctor colleagues. SAS doctors in Northern Ireland on the 2008 contract, who are the majority of SAS doctors here, are currently experiencing pay erosion at 28.8%, pay erosion for those on the 2021 contract is slightly higher at 29.8%

This could have been addressed more quickly through swift engagement from DoH NI on pay talks, but unfortunately these only began in earnest in late October and the Department had no interest in going further than the English deal. Any monies connected to this deal, if it is accepted by the SAS membership, are unlikely to be paid in this financial year.

It is important to note that the recent announcement from the health minister on the DDRB for 24/25 will have a potentially huge impact on SAS pay, relative to their colleagues across the UK, if the 24/25 DDRB is not paid in full.

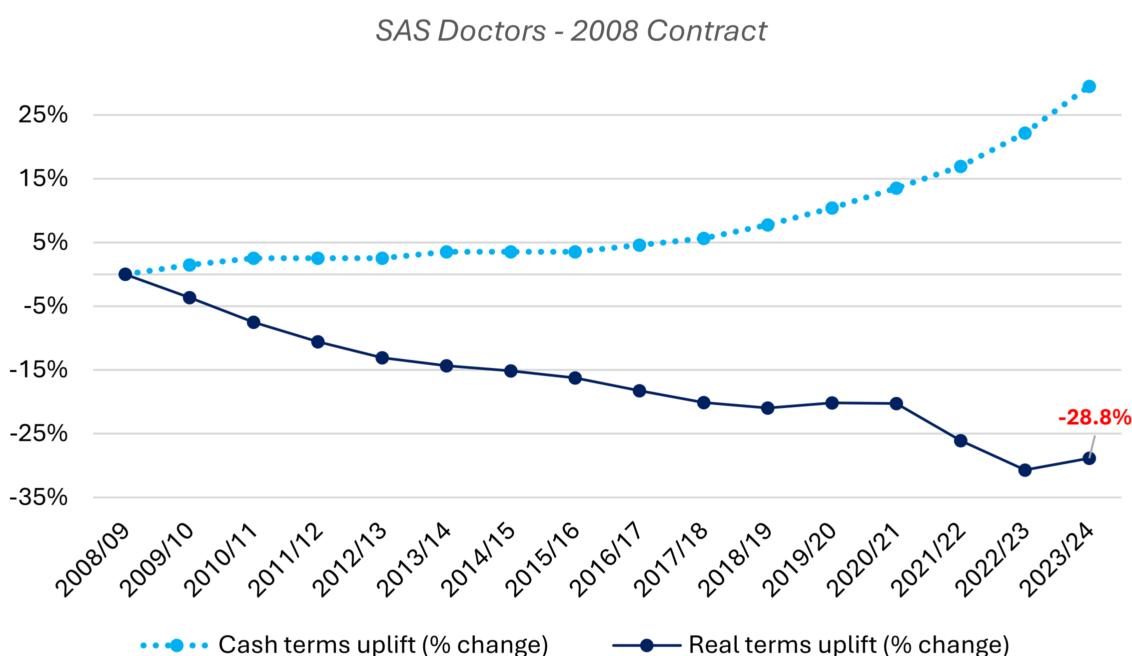

Figure 12: SAS doctors on the 2008 contract in Northern Ireland pay erosion in RPI

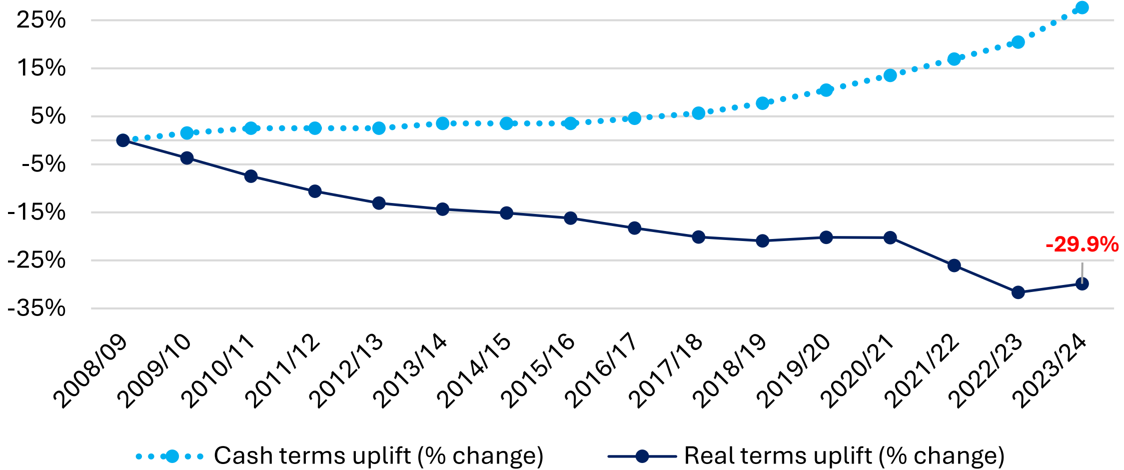

Figure 13: SAS doctors on the 2021 contract in Northern Ireland pay erosion in RPI

Implementation of 2021 contract

In previous years evidence to the DDRB we have raised issues with the implementation of the 2021 contract in Northern Ireland.

The majority of SAS doctors in Northern Ireland have stayed on the 2008 contracts despite the benefits of the new contracts in relation to protected SPA time and safeguarding around out of hours working for several reasons.

- Initially there was fear that the department of health would not honour the 3-year multi-year pay deal
- Followed by the exclusion of this group of doctors from DDRB awards, which meant that to transition from 2008 contract to a 2021 contract would mean a drop in pay for majority of pay points.
- Additionally, fear around employers misusing the change in plain time from 7pm to 9pm to the detriment of SAS personally and financially, has also been a deterrent to doctors moving to 2021 contracts.

To date only 32 doctors have transitioned to new contract, and all other 2021 SD Posts have been new posts created. Though the department of health have not confirmed how many 2021 specialty posts have been created.

It is also disappointing, and adds to our difficulties with HSC data collection, that DoH NI have thus far refused to add "specialists" to the workforce census.

Progress on creation of specialist roles

Over three years on from the introduction of the 2021 specialist contract progress on the creation of specialist roles is disappointing, to put it mildly.

A recent Assembly Question stated that since the introduction of the contract 39 specialist posts had been created, including 10 that were still being appointed to.[2] More recently during SAS pay talks the Department informed us there are currently 27 specialists doctors working in the HSC.

For a post introduced with much optimism any of 39, 29 or 27 new posts is poor progress in three years.

The disappointment felt by our SAS doctors is compounded by DoH NI's refusal to introduce a commitment, similar to that introduced in Wales, to allow specialty doctors to request a transfer to the specialist post. We believe the introduction of such a commitment would have shown a significant commitment to specialty doctors career progression and unlocked further potential amongst this staff group to assist with tackling the huge waiting lists in the HSC.

The Department has refused to answer an assembly question on the number of new specialty doctor posts created since in the introduction of the new contract.[3]

Vacancy data

We have made the point for many years now that vacancy data in Northern Ireland are unreliable to say the least. Official statistics only count vacancies that are being actively recruited to, therefore missing many posts.

Official data from June 2024 show 58 vacancies in the SAS workforce, or just over 8%. We reported last year that work from FOIs places this figure much higher. Our FOI work showed that as of September 2021, vacant SAS posts in Northern Ireland, as a proportion of the overall establishment (vacancy rate), was 25.4%. In September 2023, the vacancy rate was 31.8%.

Comparing HSC workforce data from 2023 and 2024 we can clearly see that the SAS workforce has only increased by 8%. If we removed the 39 specialist posts that are newly created and being recruited to that takes the growth of the SAS workforce down to just 3%. We see no reason why there would be any significant change to the vacancy rate we calculated via FOI in 2024.

SAS pay talks

NISASC entered into a dispute over pay with DoH NI in May of 2024. They were subsequently asked to take part in pay talks, based on the English SAS deal, in October 2024.

Throughout the talks it has been very disappointing to once again see DoH NI not want to do anything to go above and beyond the bare minimum for doctors in Northern Ireland. Our non-pay asks have been continually rejected or watered down, even where they are only asking for equivalencies to the other devolved nations.

A prime example of this is the extension to plain time, agreed as part of the 2021 contract. In Scotland this was not included in their new SAS contracts, in Wales they made the decision to reverse this. DoH NI would not countenance a reversal during the pay talks. This is despite one of their stated intentions being to encourage SAS doctors to move to the new contract. A survey of our English SAS colleague found that of those who hadn't transferred to the new contract 48% stated the reason why was because of the changes to plain time.

These talks have recently concluded and will be put to a ballot of the BMA SAS membership in due course. We can provide more detail on this at oral evidence or via supplementary evidence when there is a relevant update.

Resident doctors

As mentioned previously BMA Northern Ireland has undertaken a recent survey of members. One member summed up the feeling of resident doctors in Northern Ireland.

"Frankly besides pay we have the worst working conditions in the UK, we are the least popular region to apply to, and we need to accept the reality that a substantial change needs to happen for NI to be a popular place for people to train and work. Our contract lacks basic quality of life improvements the rest of the UK gets. Our pay is worse. Working conditions are worse. So yes, we need a substantial pay increase, well above inflation."

The results from the recent survey carried out by BMA Northern Ireland, were characterised by strong results from resident doctors in Northern Ireland both in terms of their disappointment on the progress on last year's pay offer and the impact on their future career plans.

Pay dispute

Resident doctors in Northern Ireland entered into a dispute with the department of health over pay restoration in September 2023. This was followed by a ballot for industrial action throughout January and February 2024 in which 97.6% responded in favour. Resident doctors subsequently have undertaken three rounds of industrial action.

Following the first round of industrial action resident doctors were invited to engage with DoH NI. This meeting was incredibly frustrating, with no willingness from the Department to discuss pay unless it was as part of a new contract negotiation. If resident doctors here wanted to make progress on pay restoration outside of contract negotiations, they had to wait for a deal in England. This is despite pay clearly being a devolved issue and pay talks underway in both Scotland and Wales in the absence of an English deal.

Following the deal in England, resident doctors here were finally invited to discuss a deal for doctors in Northern Ireland. It became immediately clear that the deal that was accepted by resident doctors in England was not on the table in Northern Ireland as the Department could not commit to paying the 24/25 DDRB recommendation in full. Having been told for over a year to wait for the English deal, residents here are now not being offered it. As a result, they face falling further and further behind colleagues across the UK and in the ROI.

Pay erosion

The 23/24 DDRB recommendation meant that pay erosion is now different depending on what point of the resident doctor pay scale you are on. If we calculate only to the end of 23/24 resident doctor pay erosion in Northern Ireland ranges between 25.7% or 27.3%.

This will inevitably be the highest number in the UK, because resident doctors in Northern Ireland are still awaiting an additional pay deal for 2023/24 and these figures do not take into account the fact that our resident doctor members have yet to receive their 24/25 uplift. Furthermore, nor do the figures take into account the current proposal from DoH NI that resident doctors in Northern Ireland will not receive the full uplift, or that, whatever uplift the DoH NI decides to apply it is very, very unlikely to reach pay packets until the next financial year.

Delayed uplifts impact resident doctors particularly hard. They are often trying to save to purchase their first home and will now have lost a years' worth of that ability and the related interest on any potential savings. Others will be seeking to pay down huge amounts of student debt and have lost a

years' worth of ability to that. On top of previous years of delayed pay uplifts, this is simply unacceptable.

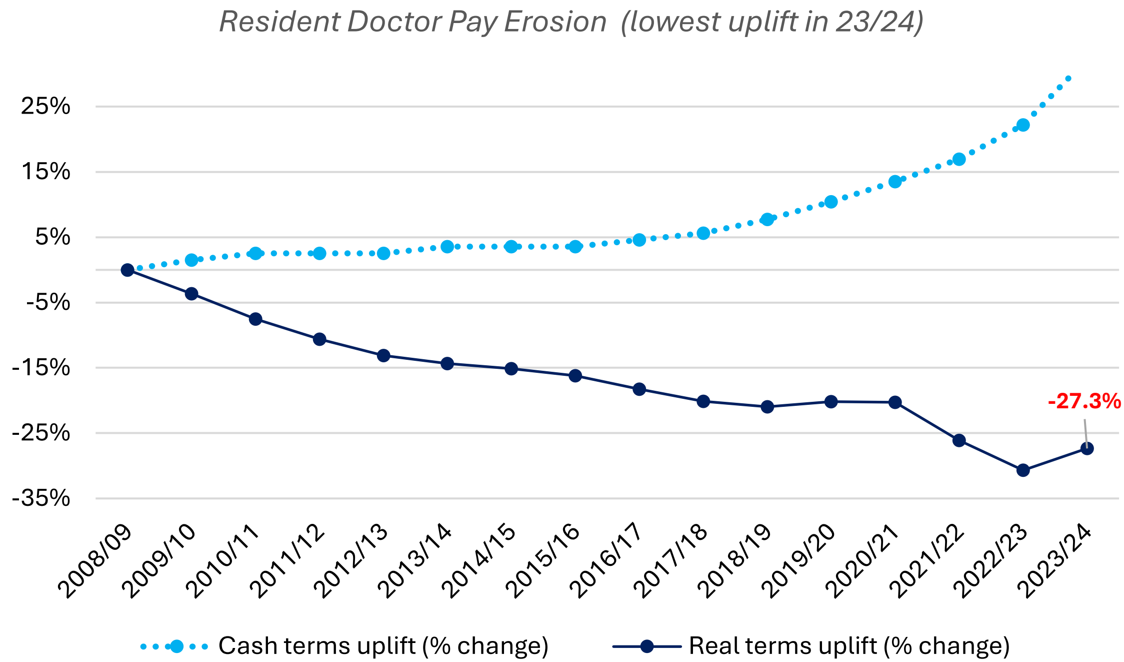

Figure 14: Resident doctor in Northern Ireland pay erosion (lowest uplift 23/24)

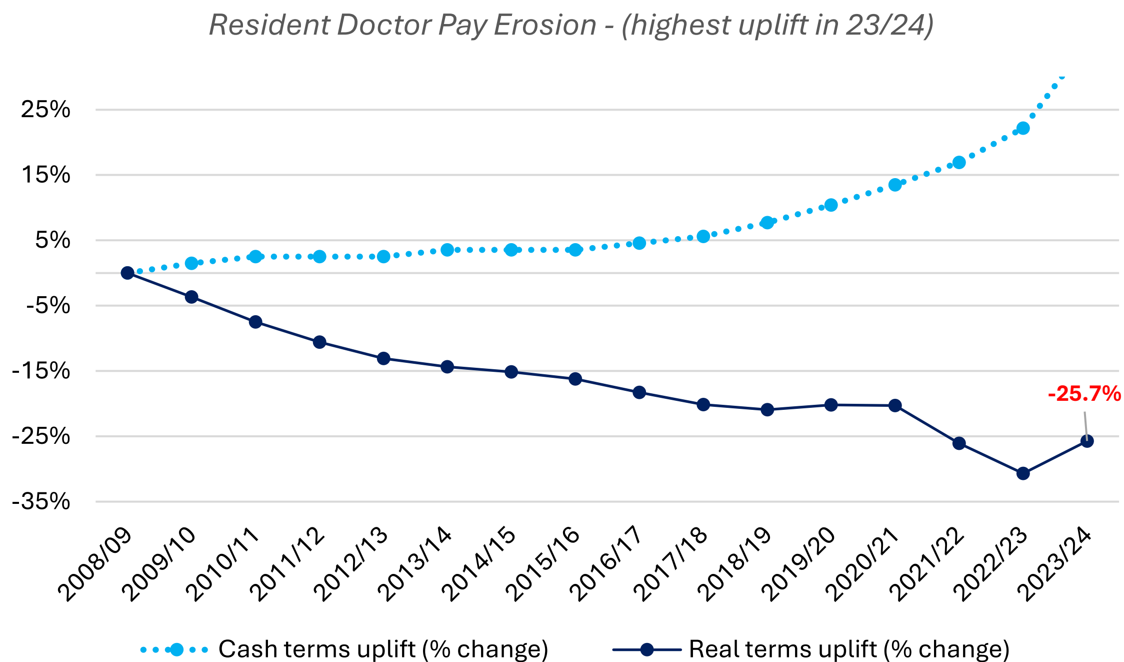

Figure 15: Resident doctor in Northern Ireland pay erosion (highest uplift 23/24)

Our survey showed the delay in applying last year's pay uplift has had a huge detrimental impact on the morale of resident doctors here in NI. Over 72% of resident doctor respondents stated that it “significantly decreased” their morale, an additional 25% stated that it has “decreased their morale.”

More worryingly 80% stated that the delay in paying the 24/25 DDRB recommendation had an impact on their future career plans. These impacts included 49% who were “actively making plans to work outside Northern Ireland in the future.”

Those respondents who said they were planning to work outside Northern Ireland were asked where they intended to go; one third of respondents stated they were considering the rest of the UK, an additional 20% stated the Republic of Ireland. We believe that this means DOHNI must seriously consider the impact of allowing terms and conditions and working conditions to fall far behind places that are geographically appealing to move to.

Training

Evidence suggests that taking up a training post in Northern Ireland is not currently an attractive career option. Many resident doctors are choosing to locum instead at a significant cost to the HSC[111]. The reasons they give for this is greater flexibility over their working lives and better pay. In previous BMA surveys we have heard from resident doctors who do not get their rotas until they are in post, making it almost impossible to plan daily life. Others report that they cannot get annual leave for their own wedding. Even taking annual leave is made more difficult by the necessity to swap any out of hours shifts, often losing the benefit of the break as you have many hours to cover on your return.

The most recent GMC national training survey shows that over a quarter of resident doctors in Northern Ireland said their training is adversely affected because rota gaps aren’t dealt with appropriately. This is further compounded by the late delivery of rotas which continues to happen year after year.

Data from NIMDTA shows us that recruitment to specialties such as general practice are regularly underfilled and additional recruitment rounds are required to fill the vacant posts. 106 new GP trainees started in August out of a potential 121 funded programmes.

A recent report from NIMDTA notes that due to budgetary constraints no funding was made available for specialty programme expansion despite identification of priorities for expansion in January 2024, with fill rates poor for Acute Medicine, Neurology, Clinical Oncology and Medical Oncology.

Physician associate pay compared to resident doctors

We echo the points made about physician associate pay compared to that of resident doctors across the UK in the resident doctors in England section. It is unfair that the responsibility carried by residents compared to their PA colleagues is not reflected in pay. It is disappointing even further that in Northern Ireland, should the DDRB not be paid in full, resident doctor pay will fail to make up ground on PAs.

This situation is compounded in Northern Ireland by the NI DOH paying fees for students on the PA course at Ulster University whilst medical students graduate with tens of thousands of pounds if not more of debt.

In Northern Ireland, students studying medicine as a second degree receive reduced financial support. They do not receive the maintenance grant, special support grant, or payment of final year tuition fees (which are paid for undergraduates). The Department of Health’s (DoH) bursary is also

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[111] HSCNI, accessed November 2024

not offered to Northern Ireland graduate medical students. Up until recently, all students studying medicine as a second degree were also unable to access a student loan for tuition fees. However, whilst we welcome the recent announcement from Department of Economy agreeing to the introduction of tuition fee loans for graduate entry medical students on GEM courses, ie Ulster University, we are disappointed that this is not applicable to graduates studying medicine at QUB.

Strike deductions

Whilst resident doctors in Northern Ireland have taken industrial action on three separate occasions in attempt to achieve pay restoration they have been adversely impacted by employers, in conjunction with DOHNI, insisting on using a method to calculate strike deductions which we believe is wildly unfair, and potentially actionable.

Their methodology means that residents in Northern Ireland are facing pay deductions for strike actions which are much more than their counterparts in either England or Wales. For example,

In Northern Ireland, a resident doctor will be deducted salary for the hours not worked due to strike action therefore, based on the deduction method used by the Single Lead Employer, if someone was on strike for 8 hours = £269.52 gross; if on strike for a 12 hour shift the deduction would be £404.28 gross.

In comparison, if the calculation methods applied in England and Wales (in line with their TCS) were used to work out deductions i.e. 1 day of strike action:

- England = £192.50
- Wales = £188.88

We have sought to address this inequity through our current pay talks; however, the Department has been reluctant to engage. It is incredibly frustrating to see our members hit with huge strike deductions compared to their English colleagues, when at the same time DoH NI insist on applying the same pay deal. Although NIRDC continues to hold a mandate for strike action in the push for full pay restoration in Northern Ireland, the success of any future action is questionable due to the current situation regarding the strike pay deductions which could be seen as an attempt to interfere with our members right to take industrial action. Therefore, we have been left with no alternative but to issue legal proceedings against the Single Lead Employer and DoH NI.

Contractor GPs

At the recent NILMC Conference Chair of NIGPC, Dr Frances O'Hagan stated that "the situation in general practice is dire, and likely to get worse." This statement can be evidenced by several statistics, Dr O'Hagan raised three.

- GMS funding has fallen by 6.6% in real terms since 2018/19.
- A recent departmental survey of the GP performers list found that 49% of respondents were likely to leave general practice in the next five years.
- A 2024 NI Audit Office report showed that the general practice share of the health budget was just 5.4%

That Audit Office figure is stark and the 2024 NILMC conference passed a motion that this should be at least 10%.

Number of GPs in Northern Ireland

The General Medical Services for Northern Ireland, Annual Statistics 2023/24 show us that there were 312 active GP practices in Northern Ireland at the end of March 2024. Five practices less than in 2023 a reduction of 38, or over 10%, since 2014.[4]

These statistics also show that the number of GP's has grown by around 23% since 2014. While this number sounds like huge growth, it appears that this growth is stalling, as the number has only grown 2% since March 2022.[5]

We have many frustrations with the lack of comparable health data in Northern Ireland and this is certainly true here, there are no centrally collected data that tell us if this increase in GPs actually represents an increase in GP hours. Self-reported data from GPs to NIMDTA suggests that there has actually been a reduction in WTE GPs between 2018/19 and 2021/22.[6] NIMDTA's data reports 136 fewer WTE GPs from 2014 at time when the population has grown by over 80,000.

The pressures facing remaining practices obviously increase, especially as the number of practices decrease and the number of registered patients increases. The average number of registered patients per practice has increased, by around one-fifth, from 5,500 to 6,586 since 2014.

Impact of increased National Insurance charges

GPs in Northern Ireland fear that the impact of increased National Insurance charges could be devastating on practices. GPs will have to find the money to pay the increased contributions, and it will cost practices tens of thousands of pounds.

A member of NIGPC provided us with their projected costs as a result of the increase, provided by their practice accountant. For their practice which serves 11,500 weighted patients with 5 partners, 3 salaried GPs and 25 other members of staff the accountant reports the additional cost will be around £40,000.

Practices are not like traditional businesses who can increases their charges when they experience increased expenses. GP partnerships have existed since the inception of the NHS and should be treated like all other parts of the NHS who will see these costs reimbursed. We have received confirmation that GP Federations will also not be funded for national insurance contributions, which could result in further redundancies and delays to the roll out of multidisciplinary teams being introduced to general practice in Northern Ireland.

We have absolutely no faith that a solution to this issue will be forthcoming from DOHNI unless a solution is found by the Westminster government or recommended by the DDRB.

GP Indemnity

It is incredibly frustrating to again have to be raising the issue of GP indemnity. BMA Northern Ireland have consistently raised this with the DDRB and the DOHNI since 2017, with no progress from the Department.

We were promised a paper on solutions to the indemnity issue by November 2022, this has not been forthcoming. The DDRB will understand that we are not reassured by a recent commitment from the Department to provide policy proposals by the end of this calendar year. If this paper does not meet this deadline there is no way a scheme can be in place by the beginning of the next financial year; even if the proposals paper is ready by the end of year it will take a huge effort to have it

implemented by the end of March 2025. Therefore, the DDRB recommendation for GP in Northern Ireland must take into account this additional financial burden on all GPs in NI.

We have said every year since 2017 about the chilling impact the cost of indemnity has on the ability to recruit to GP in Northern Ireland. We hear from GPs from Northern Ireland working in other parts of the UK who cannot return home because of the up-front cost of indemnity. We hear from retiring partners they cannot take on locum or salaried sessions because of the huge indemnity payments they will face. We hear from GPs who could and would do additional sessions but are priced out of them.

NI issue for GPs with special interest and those working in out of hours (OOH)

In Northern Ireland both GPs with a special interest (GPSIs) and those working in out of hours (OOH) settings are not included in the pay circular that sets pay and therefore do not get the DDRB uplift. The BMA has raised this on a number of occasions, our latest communications from the Department as of July 2024 is that the Department believe that HSC Trusts are best placed to identify the appropriate rate of pay for these staff. We do not accept this position or understand why this staff group would be treated differently to other staff groups. We believe that they require a significant uplift to make up for years of underpayment.

We have heard anecdotal data that GPs are choosing to resign their posts due to lack of uplifts particularly GPSIs where the rate has not increased in 15+ years. We believe that GPs working for Trusts are the only group of doctors in the NHS or HSC, who do not have DDRB recommendations applied to their pay.

It would be helpful for the DDRB to explicitly confirm whether the uplift they recommend applies to salaried GPs in OOH settings, and other non-practice settings, in all nations.

Multi-disciplinary teams

We were strong advocates for the introduction of multi-disciplinary teams (MDTs) in primary care and welcomed the start of their roll out in 2018. It is incredibly disappointing that their roll out has largely stalled since then. This stalling creates inequity for patients and means that some practices are more attractive to work in than others.

Primary care needs urgent progress on the rollout of funding for recruitment and premises necessary for this important development. Establishing MDTs will broaden primary care teams, increase the repertoire of staff available to deal with problems at source and enable GPs to focus on the most urgent care whilst giving patients improved access to services they need without the involvement of a GP. They also help build a strong and sustainable foundation in primary care for the wider transformation agenda that is so critical to the entire health service. With partial rollout, government has created an unacceptable inequity in service that needs to be urgently addressed.

Medical academics

We welcome the commitment by DOHNI to discuss the funding of the pay awards in the academic sector with both university employers. As in the rest of the UK the lack of such additional funds to university employers for the clinical academic pay uplifts risks a loss of posts at a time when more are required

Recommendations

We recommend that the DDRB:

- Recommends an uplift significantly above inflation, with the average figure stated by members in our survey 10.7%.

Scotland

Pay for doctors in Scotland is not fully settled for 2024/25, as negotiations for SAS doctors are ongoing, though the BMA hopes that this will be resolved as soon as possible. Direct pay negotiations with the Scottish Government over consultant and resident doctor pay also started later than expected, though were undertaken in good faith and delivered two pay deals which were recommended to members and accepted.

The Scottish Government was also late in accepting and implementing the uplift to contractor GP and salaried GP pay as recommended by the DDRB.

Due to the incomplete pay negotiations and the Scottish budget not being expected until 4 December 2024, the BMA will be unable to submit evidence on the situation in Scotland until after this date. BMA Scotland expects to submit its written evidence in mid-December when there is a Scottish Government remit letter, a Scottish Budget, and when pay for 2024/25 is concluded. We believe that Scottish Government may be aligning to a similar timescale for submission.

The Scottish Consultants Committee and Scottish GPC committee intends to participate in the DDRB process for this year, but both reserve the right to negotiate directly with Scottish Government if the outcome of the DDRB is deemed unsatisfactory.

Until Scottish SASC have concluded their pay negotiations with Scottish Government, they are unable to confirm whether they will participate in the DDRB process this year.

The Scottish Resident Doctor Committee will not be included in the DDRB's recommendations for 2025/26 or 2026/27 because the framework agreement used during their pay negotiations with Scottish Government removed them from process for that period.

Wales

We were glad to see Welsh Government commit, as part of the secondary care pay deal earlier this year, to a new approach to the DDRB process that addresses a number of our concerns. These included ensuring that remit letters are neutral and do not reference affordability of pay awards, agreeing that DDRB recommendations should only be rejected rarely and due to a compelling reason, that Welsh Government participation in the review process is in accordance with timelines set out by the review body, and to promptly implement recommendations upon publication of the report.

With these reforms agreed, alongside wider reforms to the terms of reference of the DDRB, all branch of practice committees in Wales have decided to provide evidence to the DDRB this year.

Within secondary care, our ask of the DDRB is simple: Welsh Government has committed to pay restoration and the historic erosion of pay now stands clearly within scope of the DDRB's considerations. Therefore, we ask that you provide recommendations for a pay award that takes into account inflation for the 2025/26 pay year, and additionally restores at least one-third of pay for each group to 2008/09 levels. We provide further information below on how we calculate the appropriate figures.

For GPs, it is disappointing to report that, at time of writing, the DDRB's recommendations for the 2024/25 financial year have yet to be implemented. Welsh Government's inadequate contract proposal has been rejected by the GPC Wales committee and will be put to a referendum of the Welsh GP profession from 25 November to 16 December 2024. We would ask that you provide recommendations for a pay award that takes into account inflation and the recent challenging financial circumstances for all GPs. Crucially, the pay award must be enabled and protected by a sufficient expense uplift. This has not been the case in recent years as recognised in the 2024 DDRB report.

BMA Cymru Wales remains concerned about the progress of the Welsh Government's National Workforce Implementation Plan building on *A Healthier Wales* to address the immediate challenges and pressures facing the NHS Wales workforce.

We accepted a seat on the Strategic Implementation Board, which has enabled regular monitoring of progress in the delivery of the Plan. To date, we estimate that around 50% of actions are not on track to be completed on time.

Particularly concerning is that work on a long-term workforce plan for health and social care, an approach to which was due to be outlined in September 2023, has not yet been started. This is a crucial and fundamental piece of work, needed to address the long-term challenges and ensure sustainability of the medical workforce in Wales.

NHS Wales performance

Vacancies at medical staff level within Welsh health boards and NHS trusts undoubtedly impact on the performance within NHS Wales and are therefore a clear contributory factor to the current high level of NHS waiting times which have well been documented within the NHS in Wales.

The most recent quarterly monitoring report[112] produced by the Senedd Research service in the Welsh Parliament shows that none of the six planned care recovery targets set by the Welsh Government in April 2022 are being met. The report's overview states that in April 2024:

- The number of patient pathways increased from just under 768,900 to just over 775,000. This is the highest figure on record.
- Patient pathways waiting longer than one year for their first outpatient appointment increased to 65,100. This means the planned care recovery target to eliminate these waits by the end of 2022 was not met.
- Just under 21,300 patient pathways were waiting more than two years for treatment (the first increase from the previous month after falling for twenty-four consecutive months). The target was for this to be achieved by March 2023, but this still hasn't been met. About 148,200 patient pathways were waiting more than one year for treatment.
- For diagnostic services, patient pathways waiting increased to just over 108,100. The number waiting longer than 8 weeks (the target for maximum wait) increased to just under 40,100. This means the planned care recovery target to eliminate waits of more than 8 weeks for diagnostic tests by March 2024 was also not met.
- For therapies, there were just over 56,300 patient pathways waiting. The number waiting longer than 14 weeks (the target maximum wait) was just under 5,300. This means the planned care recovery target to eliminate waits of more than 14 weeks for therapies by March 2024 was not met.
- Performance against the 62-day single cancer pathway target decreased to 53.8%. The target is for at least 75% of patients to start treatment within 62 days of first being suspected of cancer. The planned care recovery plan established a new target of 80% to be reached by 2026.

Many of the indicators presented in that report demonstrated a worsening position from previous reports. This paints a bleak picture of performance within NHS Wales and clearly underlines the importance of addressing vacancies amongst medical staff. Addressing recruitment and retention challenges for medical staff is undoubtedly a vital factor in achieving that.

[112] Welsh Parliament, July 2024

Consultants

Workforce analysis

We hear anecdotally about consultants reducing their sessional commitment in order to deal with unsustainable workload and burnout. An analysis of consultant headcount per FTE position in the Welsh NHS bears this out.

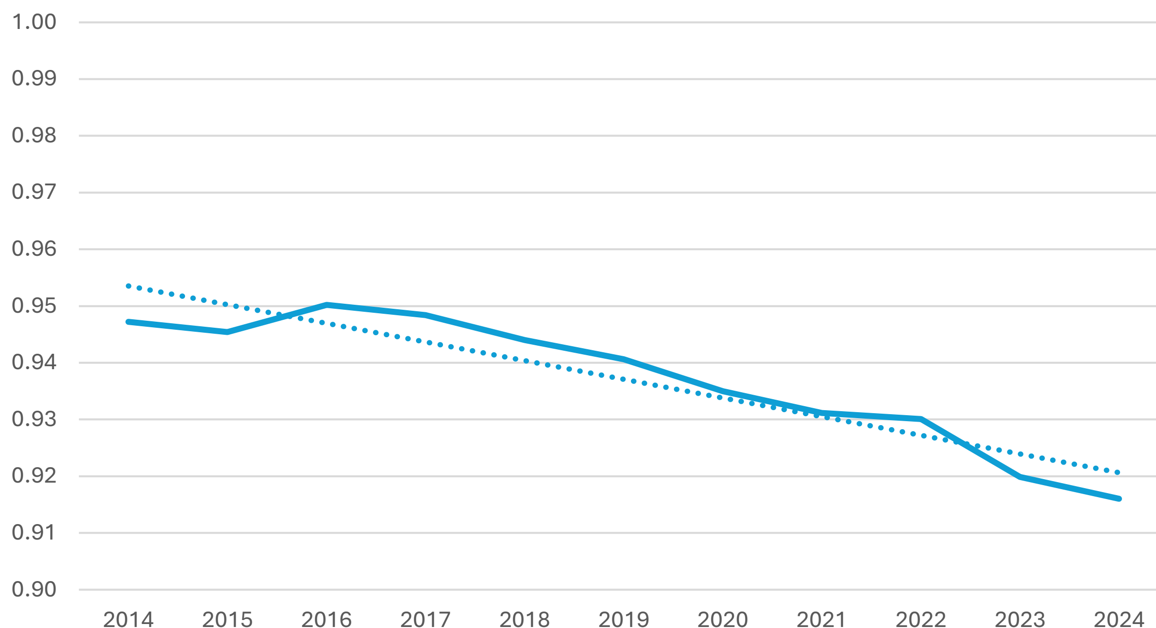

Figure 16: Headcount per FTE position for consultants in NHS Wales, and trendline. N.b. figures represent Q3 for all years except 2024, which uses Q2. Source: StatsWales.

As Figure 16 shows, there are fewer FTE positions per consultant now than a decade ago. The trend is one of continuous decline, with a sharper decline since 2022. We now have 0.92 FTE positions per consultant; a decade ago that figure was above 0.95, representing an average loss of several hours of NHS service per week per consultant. Although overall FTE has risen significantly in this time from 2,316 to 2,979, we can see that on average each consultant is dedicating slightly less time to work. With 3,252 consultants in post, this represents a loss of over 975 sessions per year to the NHS as a result of reduced sessional commitment per consultant. A significant factor in this trend is the work pressures experienced, from which the only escape is to work fewer sessions overall.

Pay campaigning

The pay campaign for consultants in Wales has been focused on restoring pay to 2008/09 levels. Pay talks on the 2023/24 award for doctors and dentists working in secondary care broke down in early August 2023. Despite a commitment by the Welsh Government to the principle of pay restoration, the first and final offer for consultants in Wales was to uplift pay by 5%; this was the lowest pay offer for consultants in the UK and was below this body's recommendation of 6%.

With consultants having seen real terms (RPI) pay cut of 30.3% to their basic pay at the outset of the 2023/24 pay year, our Welsh consultants committee rejected this pay offer and instead moved to ballot members for strike action in January 2024. As was the case in the resident doctor ballot, there was very strong sentiment for strike action amongst consultants with 86% voting in favour of taking action and over 70% of members returning ballots.

Shortly after announcing the ballot result, we called on consultants in Wales to participate in a 48-hour round of strike action alongside SAS doctors in mid-April 2024. Having provided over six weeks of notice to employers of the strike dates, we worked closely with NHS Wales employers to ensure that 'Christmas day cover' would be provided on strike days to ensure patient safety was maintained.

Due to the imminent strike action by consultants and SAS doctors and the impact of resident doctor strikes, Welsh Government invited us invited to re-enter negotiations for the 2023/24 pay award in April 2024. To enable productive negotiations to take place, we called off the planned strike action by consultants and SAS doctors. After negotiations, we agreed a consultant pay package worth approximately 5.25% on top of the existing consultant pay bill which we describe in more detail below.

New pay scale

Instead of an equal pay rise across all pay points, we agreed a new pay scale for consultants that addressed longstanding concerns shared by ourselves, employers and Welsh Government. The newly agreed pay scale for consultants in Wales results has fewer pay points (14 points down to 8), higher starting and final pay, faster progression in early years and a reduction from 31 to 23 years to reach the highest pay point.

The new pay scale responds to the DDRB's feedback regarding commitment awards by creating one, continuous pay scale with fewer points and faster progression. Whilst we have long rejected concerns that commitment awards inherently contribute to the gender pay gap and have previously expressed our displeasure at repeated refusals to uplift them alongside basic pay, we nevertheless also welcome a pay scale which results in faster progression to the maximum rate and a simple, single scale for all consultants.

We see the pay deal as an important step in realigning and modernising consultant pay; however, it does not fully resolve our concerns regarding pay erosion.

Pay erosion

At the start of the 2023/24 pay year, due to years of sub-inflationary pay uplifts, the basic pay of consultants in Wales had seen a real-terms decrease (RPI) of 30.3%. When also considering that commitment awards, representing a large amount of many consultants' pay, had been frozen for several years on the recommendations of the DDRB, the real terms pay decrease for consultants in Wales was as much as 32.4% by this time, as shown in the table below.

As outlined earlier in this submission, the threat of industrial action by consultants brought the Welsh Government back into negotiations for the 2023/24 pay year and resulted in a pay deal which brought about pay scale reform for consultants in Wales. Although we recognise the trend of real terms pay cuts has begun to be reversed for consultants in Wales, if RPI forecasts are correct, when taking into account the pay award for 2024/25, those starting as consultants in Wales will still have experienced a 21.2% real terms pay cut compared to 2008/09. This figure increases when considering those who have completed a greater number of years as a consultant, with those having been a consultant for 30 years or more experiencing a 30.5% in real terms pay decrease.

Table 13: Consultant pay erosion in Wales

	2008/09	2022/23			2024/25		
Years completed as consultant	Pay (inc. CAs)	Actual pay (inc. CAs)	Pay (inc. CAs) if kept in line with RPI	Erosion since 2008/09	Actual pay (new scale)	Pay if kept in line with RPI	Forecast erosion since 2008/09
0	£71,138	£87,354	£125,391	-30.3%	£106,000	£134,646	-21.2%
15	£101,825	£123,410	£179,482	-31.2%	£137,800	£192,729	-28.5%
30	£117,605	£140,080	£207,296	-32.4%	£154,760	£222,597	-30.5%

Clinical impact awards

Reforms were agreed to the higher award scheme for consultants in Wales in 2021 with the new Clinical Impact Awards (CIAs) coming into place in 2022, replacing the old system of Clinical Excellence Awards (CEA). A key aim of these reforms was to increase applicant and recipient diversity.

According to figures provided to us by the Welsh Government, a total of 86 applications were received for CIAs in the application round for 2023, 37 of which were ultimately successful in securing an award. This means that 43.0% of total applications were successful.

30 of the 86 applications were from consultants who identified themselves as female on their applications, representing 34.9% of applications. However, of the 37 applicants who were successful, only 10 of those were from female applicants. Thus, whilst 34.9% of the applicants were female, only 27.0% of successful applicants were female. This indicates that female applicants were less likely to be successful than non-female applicants in this application round.

At the same time, 31 of the 86 applicants identified as being from a non-white background and this represents 36.0% of applicants. However, of the 37 applicants who were successful, only 10 of those identified as being from a non-white background. Thus, whilst 36.0% of applicants identified as being from a non-white background, only 27.0% of successful applicants identified as being from a non-white background. This indicates that applicants who identified as being from a non-white background were also less likely to be successful than those who did not identify as being from a non-white background in this application round.

We have only to date been provided by the Welsh Government with data for the 2023 application round, but on the basis of this data it would seem that applicants who are female or applicants who identify as being from a non-white background may be less likely to be successful in securing a CIA than other applicants.

We perhaps need to be cautious in drawing too much of a conclusion using data from just one application year, but this would nonetheless suggest that the reforms have not so far been fully successful in improving diversity amongst recipients. Comparisons undoubtedly also need to be made, however, with outcomes from the former CEA scheme to show how the new scheme compares with the previous scheme. This should include looking at whether there has been any significant change in the percentages of those who are applying for these higher awards from amongst those consultants in Wales who are female or from a non-white background.

Expenses and allowances

Allowances for study leave, travel and subsistence expenses have not increased in some instances in Wales for decades. We ask the DDRB to provide recommendations to Welsh Government on appropriate levels of allowance for these expenses to ensure that barriers don't exist to the undertaking of professional development activities by consultants.

Recognition of LTFT training and Covid disruption

Changes were agreed at the end of 2023 to the terms and conditions of service for Welsh consultants in relation to those who have started as consultants followed lengthened training – either because they have trained LTFT for some or all of their time as a resident doctor, or because their training progression was delayed due to being disrupted as a result of COVID-19.

These changes ensured that the terms and conditions of service for consultants in Wales were brought into line with changes that had previously been agreed for consultants in both England and Scotland.

In relation to those who have trained LTFT, it was recognised that the lengthened training which may result from this can disproportionately affect female doctors who may, in some cases, be choosing to train LTFT as a result of caring responsibilities, including for dependent children. As such, failing to compensate for this can contribute to delaying a doctor's advancement on the consultant pay scale and therefore contribute adversely to the gender pay gap for consultants.

The change agreed means that those who have had lengthened training because they have trained LTFT, or have undertaken a dual qualification, will now be credited with additional seniority when appointed as consultants in Wales. This will be in line with the pay threshold they would have attained had they instead trained full time or on a single qualification basis. This removes any disadvantage they might have faced in terms of pay from taking longer to have completed their training. So far, 20 doctors in Wales have benefitted from this change.

A similar clause was also agreed for those who had taken additional time to undertake their training due to COVID-19 disruption, such as being awarded an ARCP outcome 10.2. This similarly grants additional seniority when they are appointed as consultants to compensate them for the additional time it has taken them to train as consultants.

SAS doctors

Workforce analysis

Overall, we are seeing the number of SAS doctors in Wales increase. However, the vast majority of that increase is in senior SAS grades. Taking associate specialists and specialists together, we have seen a 22.9% growth in FTE positions between June 2022 and June 2024. Naturally, given that the associate specialist grade closed in 2009, this growth is attributable to new specialist positions. We welcome this somewhat delayed uptake of the new grade. We would welcome further data from NHS Wales on whether these new posts are occupied by previous specialty doctors working for the same employer, which would demonstrate the career progression that has long been the ambition for the role.

However, we note with concern the significant slowdown in growth in 2023 and 2024. Between July 2023 and August 2024 (the most recent month we have data for), we see an 8.9% increase in senior SAS FTE roles (again, driven by growth in specialists outstripping loss of associate specialists) but a

1.56% drop in specialty doctor FTE roles (taking 2008 and 2021 contract holders in aggregate). Due to the respective size of these groups, during this time we have therefore only seen a growth of just under 4 FTE in the SAS workforce.

Without information on churn (i.e. transfer between grades and employers), it is hard to understand the underlying dynamics of this steady state in workforce numbers. However, given growth in SAS numbers observed in other nations, this is worthy of further scrutiny. At a time of significant workforce pressures, it may be that this vital part of the workforce is being underutilised in Wales.

Pay campaign

The pay campaign for SAS doctors in Wales has also been focused on the restoration of pay to 2008/09 levels by 2027. Pay talks on the 2023/24 pay award broke down after Welsh Government offered a 5% pay uplift for SAS doctors on the 2008 contracts and a 1.5% uplift for those on the 2021 contracts. With SAS pay erosion in Wales sitting at over -28% at the outset of the 2023/24, our Welsh SAS committee rejected this pay offer and instead sought to ballot all groups of SAS doctors on whether to take industrial action to secure an increased uplift for 2023/24. In this industrial action ballot, 94% of members voted in favour of taking strike action with a turnout of 58%.

We called on SAS doctors to take part in a 48-hour walkout alongside consultants in mid-April as detailed above. However, the threat of joint action from SAS doctors and consultants, alongside the impact of ongoing resident doctor strike action, led the Welsh Government to invite us to re-enter pay negotiations. As noted elsewhere in this submission, strike action by SAS doctors was then paused to allow talks to progress.

Pay deal

The SAS pay deal agreed with Welsh Government provided an overall uplift for associate specialists for 2023/24 of 9% and sufficient increases to the 2021 specialty doctor and specialist contracts to ensure higher pay across almost all points other than for those on the 2008 specialty doctor contract, and a higher starting salary in the senior role than the final salary on the 2008 specialty doctor pay scale.

Although we are disappointed that it required such efforts to secure changes to the 2021 contract pay scales in order to make them realistic career prospects once more, we are glad to be in a position whereby these contracts once again provide higher pay than the closed contracts they were designed to replace. As a result, we can now recommend these contracts to members. In particular, bringing forward the end of plain time hours from 9pm to 7pm on weekdays – in order to align with the older SAS contracts – is a positive change that will improve the pay of those undertaking shifts. We never believed that 7–9pm should constitute normal hours of working for a medical professional and do not intend to allow other contracts to be redefined in this way in the future.

As part of the pay deal, we also agreed the development of a regrading policy for specialty doctors to become specialist doctors. Although we have seen specialist recruitment improve in the past 12 months, access to the grade, its scope of practice and level of recognition, remains below our expectations. The SAS Career Progression Policy, shortly to be implemented at time of writing, will outline steps employers and managers should be taking to develop specialist doctors as they reach the most senior pay points of their scale, as well as the regrading process itself. This will automatically allow regrading to the specialist role where a specialty doctor has evidenced the required competencies and where there is an identified workforce need.

Pay erosion

As across the medical profession, due to repeated sub-inflationary pay uplifts SAS doctors in Wales had seen a substantial erosion in their real terms pay against RPI since 2008/09.

Associate specialists

At the outset of the 2023/24 pay year, when considering the percentage difference between actual pay and the value of pay had it tracked RPI increase since 2008/09, associate specialist pay in Wales had seen a real terms decrease of 28.6%. The final negotiated settlement for associate specialists for 2023/24 did begin to turn this trend, with the real terms pay decrease since 2008/09 decreasing to the 24.6%. Looking at the current 2024/25 pay year, if the current forecast of inflation is accurate, the decision by Welsh Government to implement a 6% uplift for associate specialists in Wales will continue to have a restorative impact on associate specialist pay. However, real terms pay will still have decreased by 23.2% since 2008/09.

Specialty doctors

As the improved pay offer for specialty doctors in Wales for 2023/24 removed the main barriers for transfer from the 2008 contract to the 2021 contract and ensured a pay uplift in either individuals' current or next incremental point, the pay erosion figures outlined here refer to the 2021 specialty doctor contract. To calculate the pay erosion figures, the average of the percentage difference between the value of the 2008 pay scale had it tracked RPI since 2008/09 and the equivalent pay point on the 2021 pay scale has been used.

At the outset of the 2023/24 pay year, the real terms pay of specialty doctors had decreased between 24.8% and 29.6%. The final pay deal for 2023/24 improved this situation and began to address pay erosion, taking erosion since 2008/09 to between 20.8% and 25.8%. As the pay award focused particularly on ensuring the top of the 2021 specialty doctor contract pay scale was higher than the top of the 2008 specialty doctor contract pay scale, there was a substantial restoration of pay in year for those on scale point 5 from an average erosion rate of -27.1% at the outset of the pay year to -21.8% at the end of the pay year.

The decision by Welsh Government to implement a 6% uplift for 2024/25 for specialty doctors will be, if forecasts are correct, above RPI inflation for the 2024/25. This is forecast to put the real terms pay decrease of specialty doctors at between -19.2% and -24.3% by April 2025.

Locally employed doctors

The GMC's 2023 report highlights a 46% increase in SAS and locally employed doctors (LEDs) between 2018 and 2022.

We followed this up by asking the GMC for further information on what was driving this increase in Wales, including asking for more information around the extent to which this was being driven by a growth in those on SAS contracts and/or a growth in those on non-standard contracts within the LED group of doctors. The GMC advised us they weren't always able to distinguish between those categories of doctors due to the way that NHS organisations in Wales code them on the Electronic Staff Record (ESR) system used within NHS Wales, from which the GMC derives data.

We subsequently raised this as a concern via the Medical and Dental Business Group. This was picked up by NHS Wales Employers who have now developed a standard coding framework aimed at unifying the classification of LEDs across Wales to enable better data accuracy and improved

workforce planning. They have committed to fully implement this new coding framework by February 2025.

Some LEDs are doctors who have come to work in Wales from overseas but who lack the necessary experience of working in a particular specialty in order to be offered SAS contracts. We believe it is important that such doctors are offered the opportunity to transfer onto appropriate SAS contracts, and benefit from being on nationally agreed terms and conditions of service, as soon as they have acquired the relevant level of experience.

Indeed, the SAS Charter for Wales which was agreed between us, the Welsh Government and NHS Wales Employers (and most recently revised and updated in 2023[113]) states that: 'Where a doctor working on a non-standard contract, whose role mirrors that of a Specialty Doctor and who meets the eligibility criteria considered for the Specialty Doctor contract (as set out in the 2021 contract), they should be considered for substantive appointment once they meet the eligibility criteria contained in the national contract.'

To take this forward, NHS Wales Employers have committed to undertaking a stocktake of LEDs' terms and conditions of service and then exploring the feasibility of transitioning those LEDs who would be eligible to appropriate nationally agreed contracts.

Another group of doctors who may be working as LEDs are resident doctors who have taken time out of training but who may wish to return to training at a later date. We believe it is also important to understand the workforce trends amongst this group of LEDs. Some may be choosing to take time out of training to obtain balance in their working lives, such as those who may choose to undertake an "F3" year after foundation training before progressing to core or specialty training.

Others may however choose to take a year out of training because they have failed to secure a training place within the specialty in which they are seeking to progress and are spending a year as an LED with the hope of securing their desired training post in a future year. It is important to fully understand this so we can know where such training bottlenecks may be halting the progression of resident doctors and delaying them from completing their training. Without fully understanding the extent to which this may be happening, it is not then possible to know where additional training posts may need to be created.

Clearly there is much more to be done in understanding what is driving the growth in the group of doctors that are either SAS doctors or LEDs in Wales. We are pleased that steps are now being taken which could help this to be achieved so it can better inform workforce planning and provide more doctors with the opportunity to be offered standard contracts and protections which have been achieved with the benefit of national negotiations. This is an area of work which we will be keen to monitor going forward.

[113] Welsh Government/NHS Wales Employers/BMA Cymru Wales, November 2023

Resident doctors

Workforce analysis

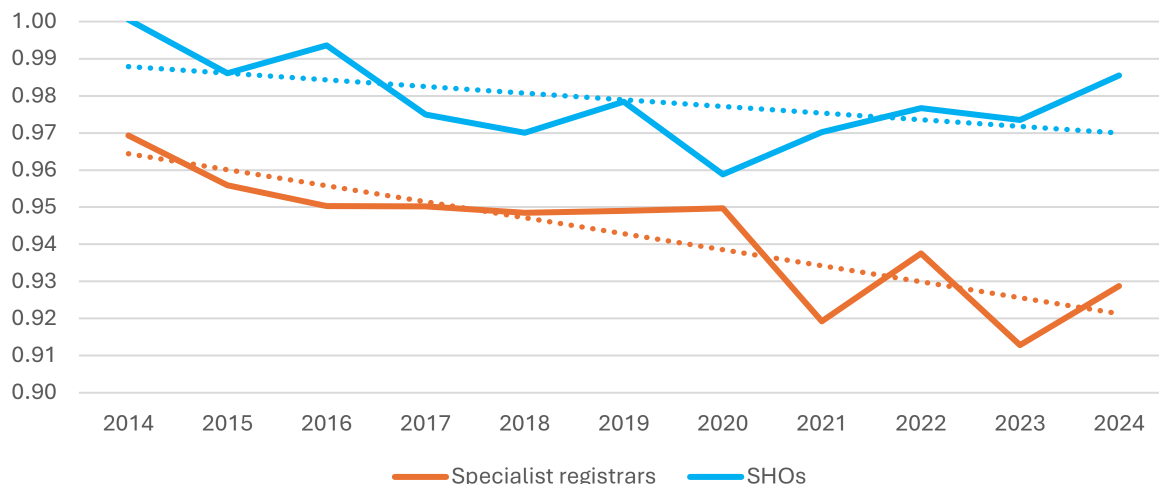

Figure 17: Headcount per FTE position for specialist registrar and SHO roles in NHS Wales and trendlines for each group. N.b. figures represent Q3 for all years except 2024, which uses Q2. Source: StatsWales.

As Figure 17 shows, there are fewer FTE positions per resident doctor now than a decade ago, representing a decline in the overall working time commitment of resident doctors in these grades. The trend is one of relatively consistent decline, albeit with a recent recovery in SHO roles. This may represent doctors engaged in clinical fellowship or full-time locum positions which typically have much less onerous night working requirements. The trend is particularly stark in specialist registrars: whereas on average there was just over 0.96 FTE positions per registrar a decade ago, that figure has now declined to 0.92 FTE. A significant factor in this trend is the work pressures experienced, from which the only escape is to enter less than full time training.

Indeed, the results from this year's GMC National Trainee Survey give us cause for concern about how resident doctors are managing at work. 19.5% of trainees in Wales are recorded as being at high risk of burnout, with 42% at a moderate risk. The rate of those at high risk of burnout has almost doubled since before the pandemic. In 2019, trainees in Wales recorded a 10.4% high risk of burnout. Whilst the moderate risk rate was slightly lower (39.5%), the sharp increase in high risk suggests the pandemic exacerbated existing burnout. Burnout is a long-standing issue, which is getting worse; meaningful and systematic change is necessary.

Meanwhile, the survey showed that 22.5% of resident doctors in Wales are on LTFT contracts, the highest proportion in the UK. The highest proportion of those stating their reasons for being LTFT was stated as 'to have a better work life balance'. These data points, taken with the burnout data, suggests that burnout is affecting not only resident doctors' mental health, morale, and willingness to stay in their job, but it is also affecting their pay.

Meanwhile, students have already realised that they can seek out better pay and conditions even before they graduate. Our survey of medical students in 2024 suggested that 39% plan to leave Wales after graduation to start their medical careers elsewhere with better pay and working conditions cited as the main reasons not to stay. 90% of respondents indicated that improved pay would influence them to stay in Wales.

The survey of students at Cardiff, Swansea, and Bangor's medical schools revealed that 80% of those who intend to leave Wales plan to begin foundation training in England and 15% in Scotland where junior doctors receive higher pay. Out of the students who intend to stay in Wales after graduation, just 25% are currently planning to stay beyond their foundation training.

66% of respondents planning to leave the NHS in Wales said current pay and working conditions had influenced their decision. 87% said higher, more competitive pay elsewhere was the main driver in their decision to leave with 46% saying the pay for doctors starting their careers in Wales didn't even meet the current cost of living in Wales.

Data availability

For doctors in training, vacancies should be clearly identifiable, being the difference between the identified and funded training posts advertised by HEIW and the doctors enrolled to a training programme who fill those posts. However, from a workforce perspective, rota gaps are arguably a more relevant measure, being the difference between the number of identified slots on junior doctor rotas (some, although not all, of which are also allocated as training posts) and the employed workforce on that rota.

Although there is substantial anecdotal evidence of the widespread use of locum labour and local appointments to plug gaps in service need in the absence of full recruitment to training posts, without accurate and up-to-date publicly available data provided by the Welsh Government, it is difficult to hold an informed discussion about this issue.

Industrial action

The pay campaign for resident doctors in Wales is focused on restoring pay to 2008/09 levels. By the outset of the 2023/2024 pay year, repeated sub-inflationary pay awards had led resident doctor pay to have eroded by 29.6%. Having already provided a commitment to the principle of pay restoration, Welsh Government agreed to enter pay talks for doctors and dentists working in secondary care before the outset of 2023/24. However, these pay talks quickly broke down in early August of 2023 following Welsh Government's first and final offer which only included an uplift to resident doctor pay of 5%. This offer did not make good on Welsh Government's commitment to restoring the pay of resident doctors and was significantly below the recommendation of the DDRB recommendation of 6% plus £1,250.

Following the breakdown of pay negotiations, in November 2023, resident doctors in Wales were balloted on whether to take industrial action to secure an improved pay offer which would begin to address the pay erosion faced since 2008/09. The strength of feeling amongst resident doctors was evident with 98% voting in favour of taking strike action and a turnout of 65% of members.

From January to March 2024, resident doctors in Wales participated in two 72-hour full walkouts and one 96-hour full walkout. Participation rates in strike action amongst resident doctors was high throughout each round of strike action. Patient safety was maintained throughout by consultants and SAS doctors covering for absent resident doctors, in addition to applying a robust derogation process that was agreed between us and NHS Wales employers.

With the sustained industrial action by resident doctors in Wales reaching a total cost to the NHS in Wales of £11 million by the third round of action, and the announcement of imminent strike action by consultant and SAS doctors, we were invited to re-enter pay negotiations for the 2023/24 pay year in April 2024. These negotiations resulted in a deal which provided an additional 7.4% uplift in pay for resident doctors for the 2023/24 pay year, bringing the total uplift to 12.4%. Taking into account

projected inflation at that point in time, and pay compounding, the pay deal achieved a quarter of pay restoration in one year. This increased pay by extension for resident doctors working in local roles, either in substantive posts or as locum tenens, where their contracts align their pay with the national rate.

The pay deal also secured a commitment from Welsh Government to work with us on agreeing changes to the current study budget and study leave system in Wales. It also achieved a recommitment from Welsh Government and NHS employers to the provisions set out in the NHS Wales fatigue and facilities charter. The pay deal was accepted by a majority of voting members in June 2024.

Pay erosion

As outlined earlier in this submission, the final pay deal for 2023/24 achieved a quarter of the pay restoration we have been seeking. Despite this, at the outset of the 2024/25 pay year, resident doctor pay was still far from being restored to 2008/09 levels, with pay awards for resident doctors in Wales from 2008/09 to 2023/24 still having delivered a real terms (RPI) pay cut of 23.4%.

Should the forecast of RPI for quarter 2 of 2025 be correct, Welsh Government's decision to fully implement this body's recommendation for resident doctors in Wales for the 2024/25 will continue the path towards restoring pay. However, it is worth noting that when considering the pay awards received since 2008/09, resident doctors will still have experienced real terms pay cuts of between 19.5% (for a foundation year 1 doctor) and 20.8% (for a registrar at the top of the pay scale).

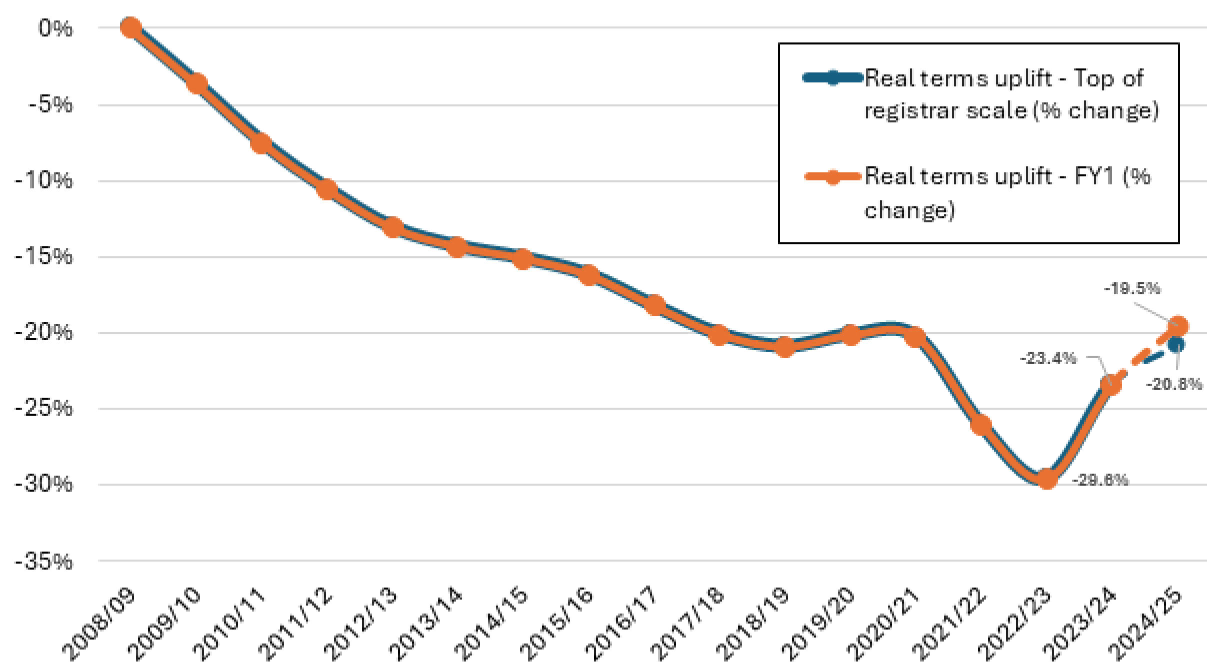

Figure 18: Resident doctor pay erosion in Wales

Contract reform

As part of the pay deal agreed with Welsh Government for resident doctors, we have agreed to re-enter negotiations to reform the resident doctor contract in Wales. In October 2022, our members rejected a contract proposal; we surveyed members at the time on their views on the proposals and the reasons for rejecting them. Since then, little further progress has been made on contractual

issues, although we remain convinced that contractual reform is necessary to address unsustainable workloads and unsafe rotas.

We hope to begin new contract negotiations in January and have agreed to focus on areas that were unpopular in the previous proposals. These included a longer range of hours and days that do not attract a premium time supplement and the direct tying of renumeration to progress through training (especially given the significant increases we are seeing in flexible training pathways) rather than the current system of automatic annual progression.

Study leave

We have recently begun work with Welsh Government, HEIW and NHS Wales Employers on reform of the study budget system for resident doctors. Agreement to work on this was part of the pay deal agreed earlier this year.

One of the aims of this work is to assess the amount of funding currently available to resident doctors compared against training needs; we are aware that for some specialties, course and exam fees can greatly exceed the amount available to claim each year, which leads to resident doctors paying out of pocket for opportunities to advance in their careers.

Another aim is to enhance access to, and transparency of, study budgets. The system for making claims is time-consuming and can deter resident doctors from claiming back funds. A more streamlined, simplified system where residents can claim back funds earlier in the process would help avoid potential financial hardship resulting from delays to reimbursement. There is also a lack of consistency in approach to underspent budgets. We are seeking to ensure any underspent budget in health boards is transparently monitored and invested back into resident doctor training. Although we hope that we will be able to agree improved study budget and leave arrangements that will support training in Wales, we do not see this as a replacement for credible progress towards pay restoration.

Contractor GPs

Recent Welsh GMS contract settlements

For 2023/24, GMS negotiations did not begin until September 2023, the delay being down to Welsh Government's significant budget challenges in that summer. The final offer from Welsh Government was the lowest across the UK, and below the DDRB's recommendation of 6%.

In recognition of the fact that zero-investment into the contract for that financial year would be irreparably damaging to practices, in February 2024, we reached a mutual decision to conclude negotiations without a negotiated contract agreement. The stance of GPCW around acceptability of the financial offer did not change but the investment of £20m into the GMS contract by Welsh Government provided some immediate cashflow relief to practices.

The 2024/25 GMS contract negotiations in Wales were extremely delayed: The joint mandate for discussions had been agreed in May by members of the tripartite negotiating group (GPC Wales, Welsh Government and Health Board representatives) although this did not receive ministerial sign off until 18 September.

This meant that negotiations for a financial settlement due to take effect from the beginning of the financial year (April 2024) were beginning months later, in September and October. The financial uncertainty this creates for GP practices, who are already liable from the start of the new financial

year for increased costs due to statutory wage increases and other price rises, should not be underestimated. We therefore welcome the efforts by the DDRB to reset the reporting timescale back to its previously intended arrangements. In negotiations GPC Wales pushed for a set of overriding principles which we believe would address some of the issues raised by the DDRB in the 2024 report. Welsh Government continues to insist that pay/expenses settlements are contingent on wider contractual change; an unacceptable situation that creates undue delay and complexity that is perhaps unique compared to other nations. The principles GPCW has pushed for are:

1. Dissociation of the annual GP pay award from wider contractual change.
2. New work necessitates new resource.
3. Pay awards will be enabled and protected each year by a sufficient expense uplift (as per the expectations of the DDRB).[114]
4. An ongoing commitment for an index-linked and ringfenced uplift to expenses, and a population growth factor to adjust global sum for local practice populations.

It is therefore disappointing that Welsh Government's offer to conclude negotiations did not take account of any of these reasonable principles. Information regarding the offer and Welsh GP referendum can be found at on our website.

The much-delayed negotiations concluded in late October with a 'final and best' written proposal to the GPC Wales negotiating team from Welsh Government. This offer was unanimously rejected in an extraordinary meeting of the full GPC Wales Committee on 4 November 2024. We are now putting the offer to a referendum of all BMA GP members in Wales, which opens on 25 November 2024.

We know that GP members in Wales are unsatisfied with recent Welsh GMS contract agreements, with 95% of respondents (n = 269) to an April 2024 survey by GPC Wales stating they felt negatively about the future of general practice following the conclusion of 2023/24 negotiations, and 75% of GP contractor respondents saying they would be willing to undertake industrial action short of a contract breach.

General practice investment erosion in Wales

Despite the rhetoric and stated aims of Welsh Government's *A Healthier Wales* long-term strategy calling for a "*shift in resources to the community*" to redress the health system's reliance on traditional hospital services, our analysis shows that the proportion of NHS funding provided to general practice has continually declined over the past 20 years: As of 2022/23 accounts, 6.1% of the NHS Wales budget is invested into GMS whereas this was once 8.7% in 2005/06. The Save Our Surgeries campaign calls for urgent action by Welsh Government to address this underfunding and other associated issues on workforce and wellbeing. GPC Wales has called upon the Welsh Government to provide a political commitment toward reversing the trend of disinvestment.

The below table illustrates the financial settlements emanating from recent GMS contract negotiations since 2017-18 and the relative increases to the GP pay and expenses components of the GMS contract.

[114] DDRB, July 2024

Table 14: Welsh GMS contract awards 2017/18 to 2024/25

Year	DDRB recommendation	GP pay		Expenses uplift		Other
		% increase	£	% increase	£	
2017-18	1%	1%	£1.4m	1.4%	2.9m	
2018-19	2%	1%	£1.5m	1.4%	3.1m	Plus non-recurring investment of £2.7m toward indemnity
2019-20	2.5%	2.5%	£4m	3%	7.4m	Plus non-recurring investment of £3.76m for Access standards
2020-21	2.8%	2.8%	£4.5m	2.5%	6m	Staff pay only, no general expenses uplift
2021-22	3%	3%	£4.7m	1.8%	4.8m	Staff pay only, no general expenses uplift
2022-23	4.5%	4.5%	£7.4m	3.8%	10.2m	
2023-24	6%	5%	£8.7m	3.9%	11.3m	No final contract agreement reached
2024-25	6%	Negotiations not concluded at time of writing				
***% uplift figures represent the uplift to that component area of the contract, based on NHS Digital TSC GP Earnings and Expenses Ratio. Where value of investment not stated in contract agreement documentation, figure is calculated relative to the whole contract value.**						

As recognised by the DDRB in the 2024 report[115] successive contract rounds have failed to deliver real terms pay uplifts for GPs. Contractor GP pay has seen severe erosion as a consequence of the inadequate funding provided: to a degree of -29% since 2008/2009 based on RPI. Sessional GPs have seen a similar erosion during that time period across the UK.

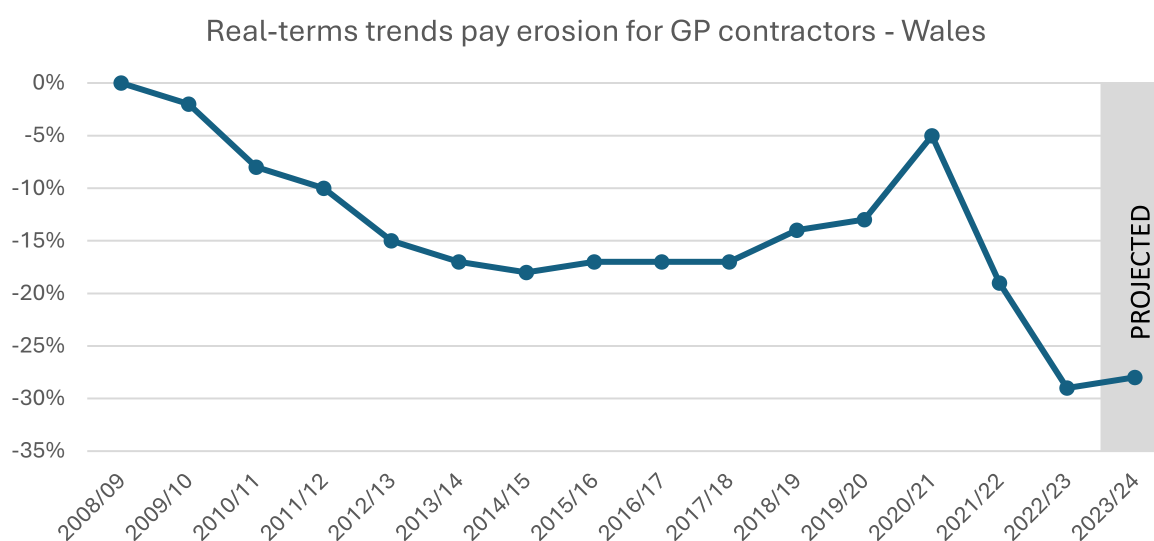

Figure 19: Real-terms trends pay erosion for GP contractors

[115] DDRB, July 2024

Independent GP contractors, as business owners, do have a degree of control of profit margins, yet their incomes are capped, and the only available method to control profit margins is to reduce their expenses (e.g. reducing staffing levels, staff pay or non-essential service provision). Ultimately, without a sufficient contract uplift to cover expenses, the DDRB's intended pay awards cannot be realised.

Comparing successive expense uplifts against inflation shows the inadequacy of the financial investment into this proportion of the GMS contract. The gap is particularly marked for the years of extremely high inflation from 2022-2023.

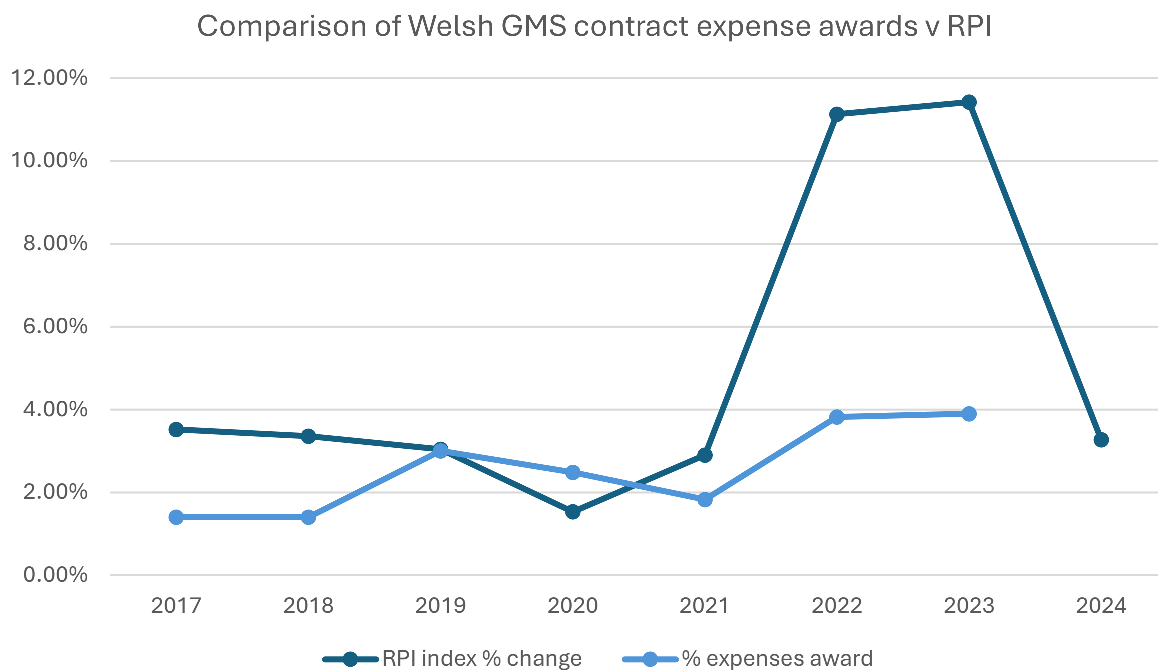

Figure 20: Comparison of Welsh GMS contract expense awards vs. RPI

In our recent Workforce, Workload and wellbeing survey 2024, we asked the GP profession about their pay uplift for the financial year 2023/24. GP contractors received a 0.3% uplift to their take-home pay, well short of the 6% DDRB recommendation or even the 5% that Welsh Government chose to offer. Salaried GPs (both health board and practice employed) told us that they received a mean average 2.3% uplift for that year, despite the requirements in the BMA Model Contract for Salaried GPs of an annual uplift in line with the DDRB's recommendations. Furthermore, the Welsh Government uplift of 5% uplift for staff expenses fell short of what practices were contractually obligated to pay salaried GPs, therefore leading to a significant funding gap for practices.

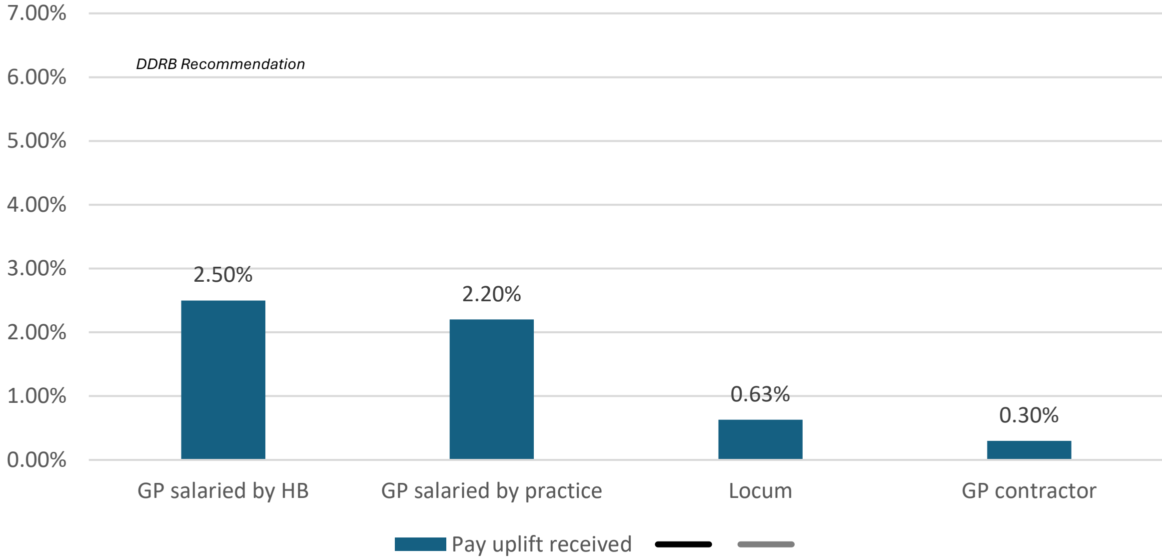

Figure 21: Mean average pay uplift received by GPs in 2023/24

Workload

General Practice in Wales continues to deal with unrelentingly high consultation rates as reflected in the national GP activity data, as shown by Figure 22, with 19.8m appointments provided in practices during 2023-24, and 29.1m phone calls received (c. 120k per working day). The vast majority of these appointments (67%) are carried out by GPs. Overall, the equivalent of 60% of the population of Wales will receive an appointment at their practice each month on average.

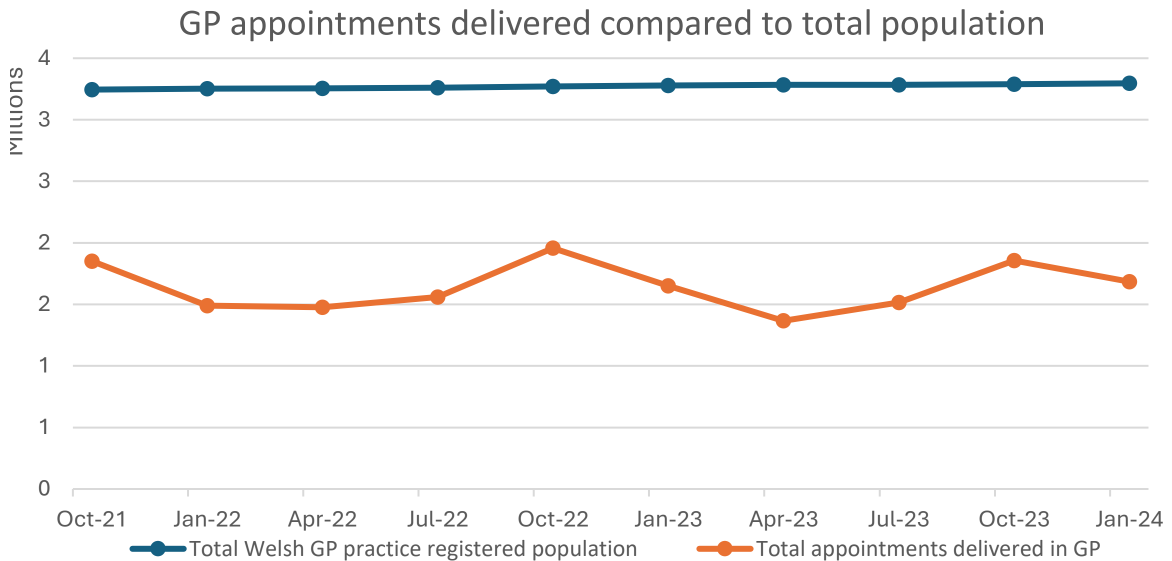

Figure 22: GP appointments delivered compared to total population

GPs perceive that workloads are increasing year on year. We asked members to rate their average weekly workload on a scale of 0-100 where the maximum represented a constantly excessive workload. For 2024, the average workload rating was 79/100 in comparison to around 76/100 for the

previous year. This can be broken down further by GP type, as illustrated in Figure 23. GP contractors rated their workload the highest at 83/100.

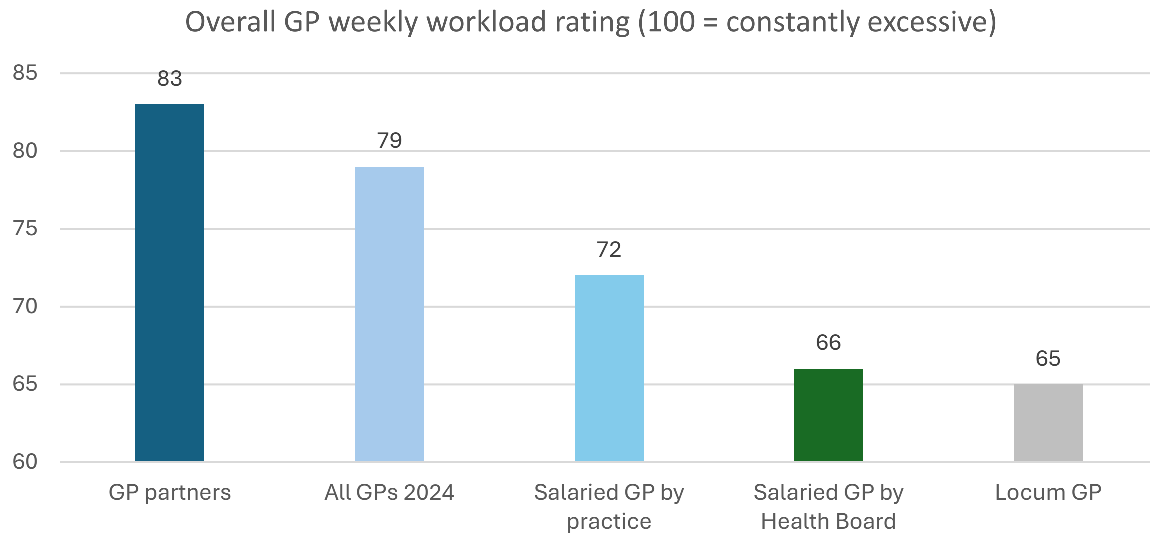

Figure 23: Overall GP weekly workload rating

This comes over a period where we have witnessed escalating numbers of patients per full-time equivalent GP, going from 1719 patients per FTE GP in 2017 to 2318 in 2024, an increase of 35%.

The fact that an incessantly high workload is being delivered by a thinning pool of doctors is unsurprisingly having an impact on the wellbeing of those providing the service. There are variations between types of type of GP role, as illustrated below, although when aggregated 92% of GPs are concerned about their personal wellbeing due to workload (occasional or constant concerns).

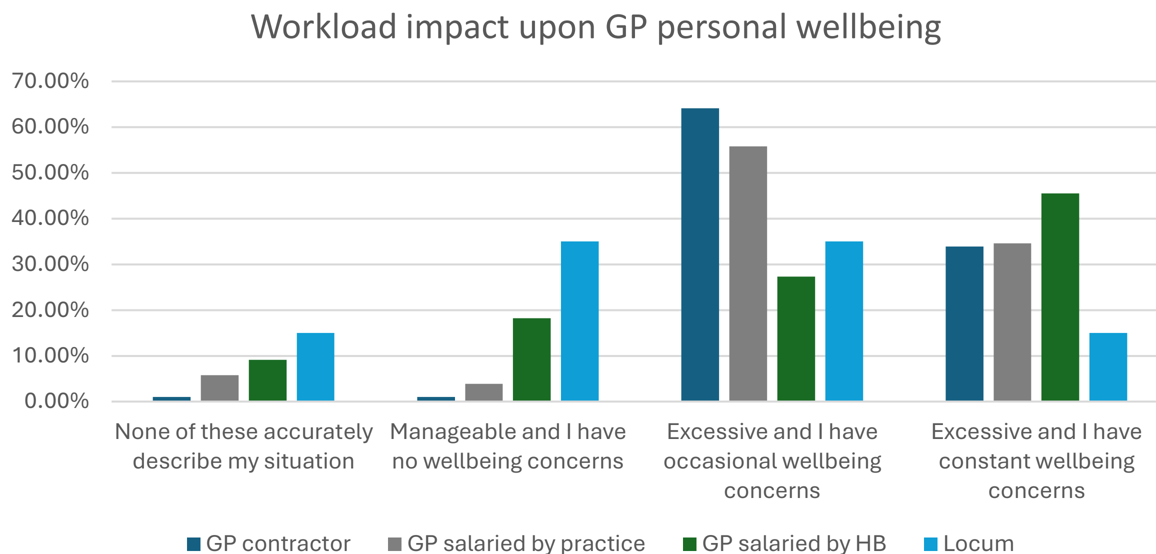

Figure 24: Workload impact upon GP personal wellbeing

Education and Training issues

In 2020, Healthcare Education and Improvement Wales reported that a record 200 GP trainees were recruited, an increase from the previous 186 in 2019. BMA Cymru Wales welcomed this news, having

long advocated for an intake of 200 GP registrars per year. Unfortunately, this level of intake was not maintained, with the intake reduced to 160 per year in 2022 onward but with assurances made regarding the intent to overrecruit if possible. The reason cited for this reduction was the impact of the pandemic on training programmes. For 2024, the number has been capped at 160 by Welsh Government.

Given the lead-in time for GP training, this situation is unacceptable in the face of a pending workforce crisis. Our modelling suggests that Wales needs an extra 718 GPs just to match the average number of GPs per 10,000 patients seen in OECD European nations. Similar grim projections regarding the future GP workforce have been recently made by the Auditor General for Wales, who demonstrated the gradually declining headcount GP numbers in the context of an ageing population. Welsh Government's own estimates in evidence received by its Technical Advisory Cell suggest that Wales could face a shortage of 1,000 FTE GPs by 2030-31 based on projected demand.

The trend of training multiple healthcare professions in general practice is welcome but the training network is at capacity: both in terms of GP trainers dealing with high workloads and the physical capacity in surgery premises. Surgeries need urgent capital investment to improve their ability to train the GPs and allied health professionals of the future in adequate premises.

Recruitment and retention

The decline in the number of full time equivalent (FTE) GPs working in Wales has been apparent over the last decade, and many have had no choice but to reduce their time spent in practice in the face of an unrelenting workload and inadequate investment.

The latest data on workforce are accurate as of 30 June 2024 and are extracted from the Welsh National Workforce Reporting System (WNWRS). At this point there were 2067 GP practitioners (partners and salaried) which represents a 2% increase in headcount terms from September 2012. However, comparing full time equivalent data is far more reflective of the true GP workforce picture, with the FTE figure being only 1389.5 – a 24% decrease since September 2013. This trend is illustrated below in Figure 25.

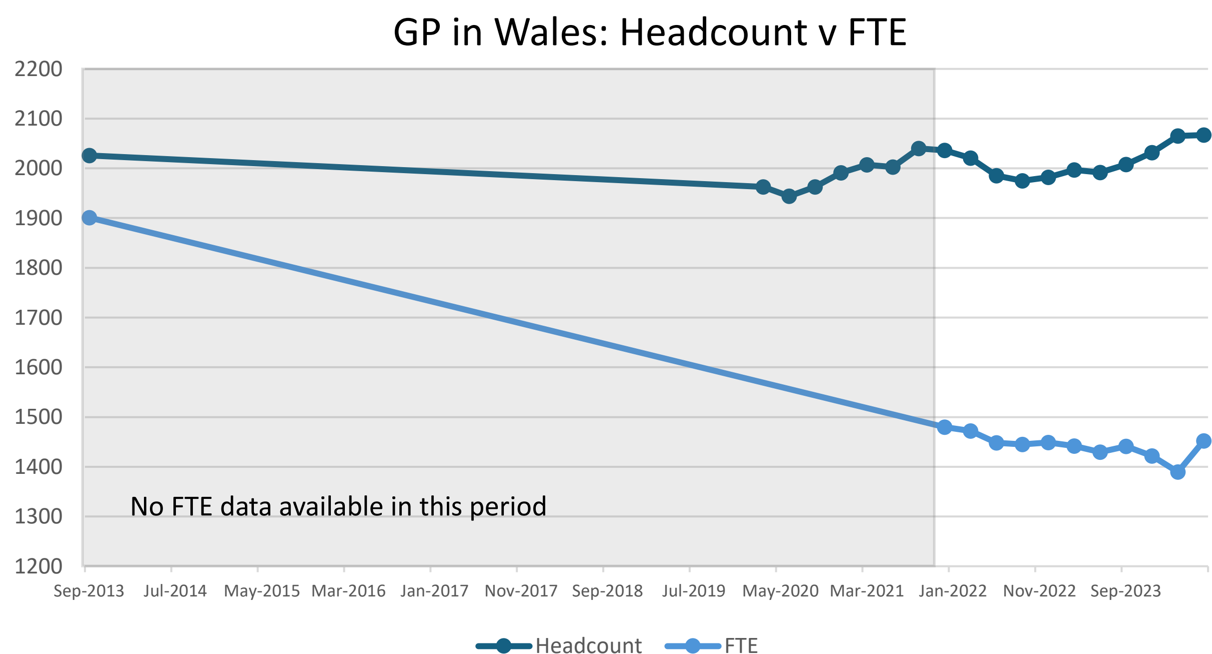

Figure 25: GP in Wales: Headcount vs FTE

Salaried GPs

Salaried GPs are a growing workforce in Wales. The number of salaried GPs has increased both by headcount (45.8%) and in FTE terms (17.9%) since March 2020 and December 2021 respectively (FTE data are only available from December 2021). GP Partner numbers, meanwhile, have declined both by headcount (7.7%) and in FTE terms (8.1%) since March 2020.

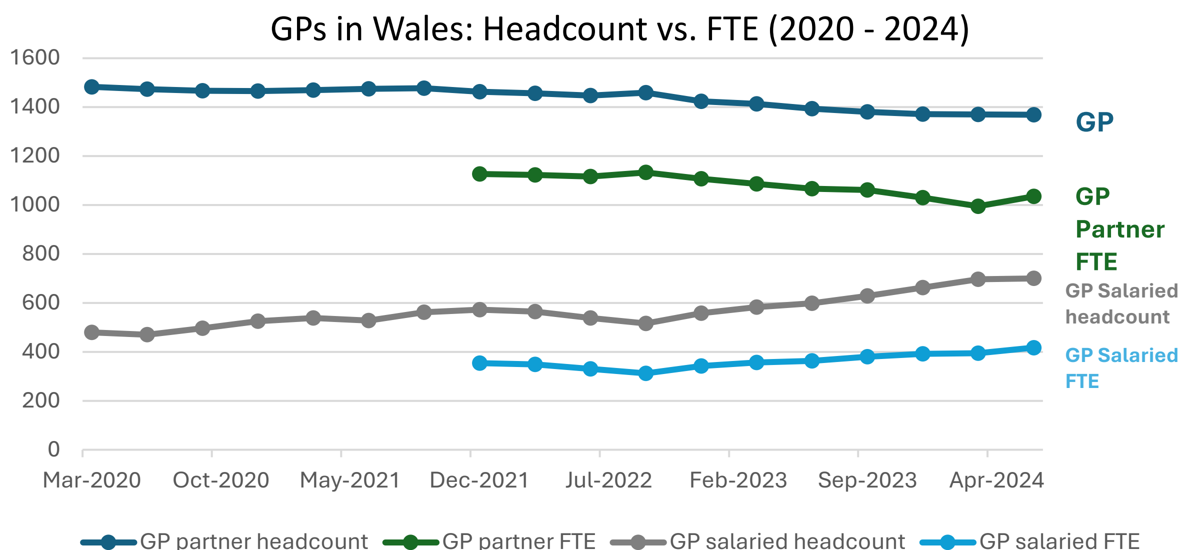

Figure 26: GPs in Wales: Headcount vs. FTE (2020 – 2024)

Recent surveys have indicated that this trend is likely to continue. According to respondents to the BMA Cymru Wales Workforce, Workload and Wellbeing Survey in April 2024, only 53% of current GP partners intend on remaining in post within three years and only 31% of practice-based salaried GPs see themselves continuing in their current work pattern. Furthermore, a survey of GP registrars in Wales conducted in 2023 revealed that only 40% saw themselves continuing to work as a GP in the UK after qualifying, with 26% intending to work abroad. If the Government is committed to the partnership model of general practice, this trend needs to be investigated and more done to understand why partnership is no longer the attractive career path it once was in Wales.

Job opportunities and underemployment

The underemployment of sessional GPs has been reported by members from across the UK, with reports of fewer salaried roles being advertised and fewer locum opportunities available. A detailed analysis of the situation is covered in the salaried GPs in England section.

This could reasonably be a considered consequence of the funding pressures being experienced by practices creating the need to reduce outgoings, although we currently do not possess substantive data for Wales to draw definitive conclusions. We suggest that DDRB would benefit from an analysis of the Locum pension returns data alongside the number of locum and salaried roles being advertised on the NHS Wales Locum Hub Wales site.

Recommendations

We recommend that the DDRB:

- Provide a recommendation for pay awards for secondary care doctors in Wales that accounts for RPI inflation during the 2025/26 pay year and further restores at least one-third of pay eroded since 2008/09;
- Provides recommendations that take into account inflation, GPs' financial circumstances and a sufficient expense uplift; and,
- Provide an uplift to travel, subsistence and study allowances payable to consultants.

Pensions (UK)

Pensions are a vital component of the overall remuneration for doctors. We therefore believe it is essential that the DDRB consider the detrimental impact of pay erosion and pension taxation policies on the value of doctors' pensions when making its recommendations. This is particularly important given the large waiting lists across the UK and the DHSC goal to deliver an extra 40,000 appointments per week in England through extra weekend and evening working.[116] The operation of the pension taxation system is a significant barrier to doctors taking on additional work as it can leave them financially worse off as a result and effectively "paying to do extra work".

The cause of this lost pension value is multi-faceted and includes the impact of tiered employee pension contribution rates and pay erosion, changes that limit accrual of pension benefits, and pension taxation, some of which we recognise are outside the DDRB's control. However, the terms of reference for the DDRB have been changed for this year and we firmly believe that the DDRB can make recommendations and observations to the UK Government that acknowledge this lost pension value and how this can be resolved. Indeed, we believe that this has always been the case, even under the previous terms of reference and note that other Pay Review Bodies have been much stronger in highlighting these vital issues to governments. As previously stated, to ignore this issue is to fail to tackle a key component of the crisis in recruitment and retention of medical staff.

The impact of tiered employee pension contribution rates and pay erosion

As highlighted in our previous evidence, the interaction between the design of the NHS pension and the pension taxation system is inappropriate and in effect penalises doctors and other higher earners in the NHS. Since 2007/08, there has been an increase in employee contribution rates in England and Wales and Northern Ireland from 6%[117] to a peak of 14.5% by 2014/15[118] for higher earners such as doctors in the NHS. Whilst a two-phase reform[119] has brought this peak down to 12.5% since April 2024,[120] with the lowest contribution rate at just 5.2%, the tiering structure remains the steepest across the public sector. In Scotland, the contribution rates have been slightly higher.[121]

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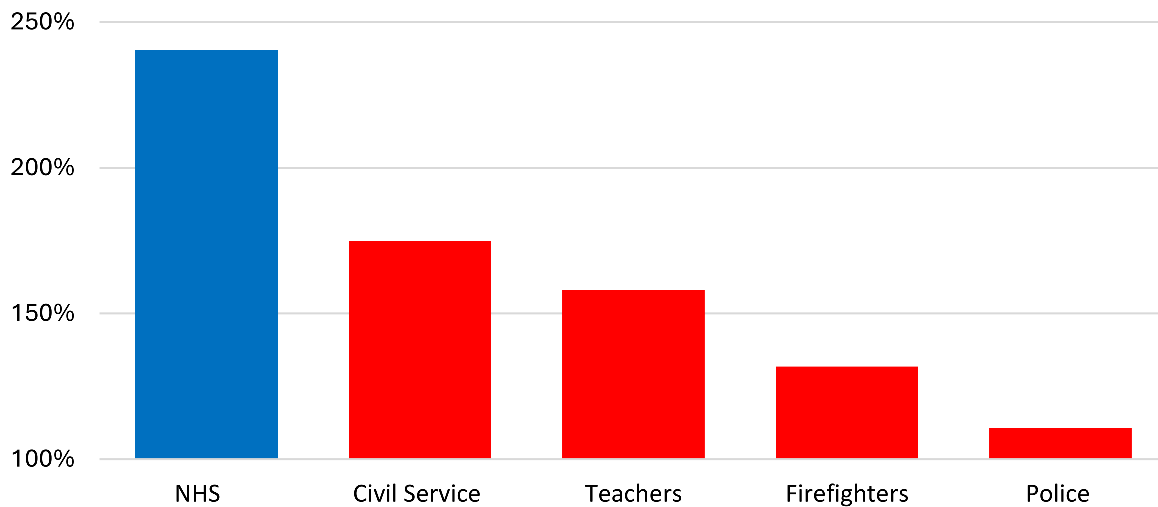
[116] Labour, June 2024
[117] NHS Business Services Authority, January 2008
[118] NHS Business Services Authority, December 2013
[119] BMA, November 2024
[120] NHS Business Services Authority, accessed November 2024
[121] A different implementation timeline in Scotland meant the top rate was still 13.7% in April 2024, dropping to 12.7% from October 2024; Scottish Public Pensions Agency, October 2024

Figure 27: Ratio of highest to lowest employee pension contribution rate within different pay as you go public sector pensions



Note: BMA analysis of employee pension contribution rates across the public sector pay as you go pensions as of 15 November 2024. The Armed Forces pension is non-contributary (i.e. members make no contributions, regardless of earnings level).[122]

Given that all pension scheme members moved to a career averaged revalued earnings (CARE) scheme from 1 April 2022 – the 2015 Scheme - this eradicates any justification for tiered employee pension contributions, let alone the steep tiering that persists following the contribution reform.

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. Furthermore, this tiered system almost completely corrects for higher rates of tax relief on employee contributions and yet doctors are still subjected to the annual allowance despite not benefitting in the same way from higher rate tax relief as those higher earners in other sectors.

The loss in pension is significantly increased by the impact of pay awards that have repeatedly fallen well below the rate of inflation. Despite many of this year's above-inflation awards, as discussed earlier in this submission, there is still a considerable amount of progress needed to realise pay restoration for both primary and secondary care doctors.

Where pay has not maintained its real value, this consequently means pension accrual is lower than it would have otherwise been. 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 (i.e. the 1995 or 2008 Sections in the NHS). The impact of pay restraint that resulted from the DDRB complying with the pay freezes and caps imposed by governments during the period of austerity, has resulted in huge losses to the lifetime remuneration of doctors, which recent progress with above inflation pay awards still leaves important work to resolve. As both pay and pensions have been impacted by real

[122] NHS England and Wales: NHS Business Services Authority, accessed November 2024; NHS NI: HSC Business Services Organisation, accessed November 2024; civil service: Civil Service Pensions, accessed November 2024; teachers: Teachers' Pensions, accessed November 2024; firefighters: Local Government Association, accessed November 2024, police: XPS Administration, accessed November 2024; armed forces: Ministry of Defence, accessed November 2024

erosion, transferring pension value into pay through flexible arrangements cannot be a solution to this problem, as rebalancing remuneration away from pensions and towards pay would, at best, rob Peter to pay Paul. It is essential that the DDRB recognise these losses and take corrective action to resolve the issues around recruitment and retention.

Changes that limit accrual of pension benefits

As outlined earlier in our submission, significant changes to the value of clinical excellence/impact awards and the current anomalous and inequitable ACCIA processes relating to the new non-pensionable NCIAs in England and Wales, represent a very significant reduction in the overall remuneration package for consultants and this significantly limits the ability of these countries to attract, recruit and retain the best doctors in an increasingly global healthcare market. Furthermore, freezing of the NCIA award values will only result in diminishing the real value of the funding for these awards, leaving less funding to potentially allocate to redress equalities concerns with the scheme in future. We urge the DDRB to encourage the Government to address NCIA anomalies and consider the loss of pension from overall remuneration of doctors from these changes when making its recommendation on pay uplifts.

We further note that the impact of reduced pensionable pay, such as following changes to clinical excellence/impact awards, could be mitigated by changing pension scheme regulations to allow for regular overtime (e.g. additional programmed activities for consultant and SAS doctors, banding supplements or additional hours for resident doctors) to be pensionable. This reform would also align the treatment of officer members, who cannot currently pension income beyond whole time, with the treatment of practitioner members, who pension all their income.[123]

Additionally, the movement of all NHS pension scheme members to the 2015 Scheme has generated a risk of exacerbating the gender pensions gap due to ending access to added years contracts, without ensuring that additional pension can be purchased at the same rate as pension earned through employment. An added years contract was a service-based benefit that was only available in the 1995 section of the scheme. It allowed members who could not achieve the maximum scheme membership at their normal pension age of 60 (or 55 for MHOs), such as due to taking a career break to raise children, to purchase additional membership. Added years ceased to be available from 1 April 2008 whilst half cost added years continued to be available up to the closure of the 1995 section on 31 March 2022.[124]

All NHS pension scheme members were moved to a career averaged revalued earnings (CARE) scheme from 1 April 2022 – the 2015 Scheme. Additional pension can now only be purchased on a less generous basis from the 2015 scheme, up to a cap equivalent to only £8,575 in additional annual pension payable at retirement.[125] Furthermore, as CARE benefits in the 2015 Scheme are impacted by pensionable earnings in every year of a member's career, periods of part-time working, such as when raising young children, generate a permanent reduction in pension benefits on retirement. By contrast, legacy final salary arrangements enabled periods of career break to be fully counteracted through added years contracts, and as pension was based on whole-time-equivalent (WTE) salary, periods of part-time working on reduced pay could be mitigated. Therefore, we urge the DDRB to make helpful observations regarding the need to restore access to added years contracts for legacy

[123] Legislation.gov.uk, accessed November 2024
[124] BMA, June 2024
[125] NHS Business Services Authority, July 2024.

scheme members or otherwise ensure that additional pension can be purchased at the same rate as pension earned through employment.

The pension taxation system

Although it was not the BMA's recommended solution to the NHS pension taxation crisis, which left thousands of doctors with little option but to reduce their hours, or to retire early, the abolition of the lifetime allowance (LTA) and the increase in the annual allowance (AA) announced in the Spring 2023 Budget by the previous UK Government were welcome.[126] We were pleased that the Labour Party did not include plans to reintroduce the LTA in their manifesto, nor did the new Government make any such move in the Autumn 2024 Budget. Such a move, especially without guarantees about how public sector workers would be protected, would cause many senior doctors to retire early at the very time when the nation needs their expertise most. Not only would this severely endanger the UK Government's manifesto commitments on reducing waiting lists but would likely lead to waiting lists growing further.

However, concerns with pension taxation remain, particularly relating to the interaction between pension contribution tiering and income tax relief on these contributions and unresolved flaws in annual allowance design, including the tapered annual allowance.

The interaction between tiered employee pension contribution rates and income tax relief

Taxpayers in the UK receive income tax relief on pension contributions at their marginal rate of income tax (i.e. the rate of income tax they would have paid on their pension contributions had they not contributed to their pension. Except for Scotland, which has different income tax bands, this rate of relief is mostly 20% (basic rate), 40% (higher rate), or 45% (additional rate), although the marginal rate of relief can be as high as 60%, due to interactions with the income tax personal allowance taper.[127]

One of the rationales repeatedly used to try and justify a tiered contribution structure in the NHS was a need to adjust for the benefits of higher/additional rate tax relief. Indeed, the current tiered contribution structure, with the highest employee contribution of 12.5% (compared to the lowest contribution tier of 5.2%), continues to do this, significantly and in some cases, entirely.[128]

As illustrated in Table 15, an NHS employee on £45,000 pensionable pay in England receives income tax relief at the basic rate (20%) and pays the overall average member contribution yield of 9.8% in the NHS.[129] This means their effective rate of income tax, "adjusted" for tiering in the NHS pension scheme, remains 20%, the same as for private sector employees on similar earnings.

However, an NHS employee on £95,000 receives higher rate 40% income tax relief. This results in nearly £2.4K more income tax relief than what they would receive if they were only eligible for tax relief as the basic 20% rate. However, they are paying the highest employee contribution rate (12.5%). Therefore, compared to the overall average member contribution yield of 9.8% in the NHS, the member is paying nearly £2.6K more in pension contributions than they would if there was not a tiered structure. Under a CARE scheme, all members, regardless of their earnings, accrue pension at the same rate. As higher earners are effectively paying proportionately more in gross terms for their

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[126] BMA June 2024 snap pension taxation survey
[127] Gov.uk, accessed November 2024
[128] 5.7% to 12.7% in Scotland only; Scottish Public Pensions Agency, October 2024
[129] Department of Health and Social Care, February 2024

pension, this in effect reduces the benefit of higher rate tax relief. In this illustration, the effective rate of income tax relief is 18.4% - less than basic rate relief.[130] By contrast, a private sector employee on similar earnings would receive the full 40% income tax relief.

An NHS employee on £160,000 receives income tax relief at the 45% additional rate. This results in £5K more income tax relief than they would receive if they were only eligible for tax relief at the basic 20% rate. However, they are still paying the highest employee pension contribution rate (12.5%). Therefore, compared to the overall average member contribution yield of 9.8% in the NHS, the member is paying about £4.3K more in pension contributions than they would if there was not a tiered structure. Again, higher earners effectively pay proportionately more in gross terms for their pension in the CARE scheme, which also effectively reduces the benefit of additional rate tax relief. In this example, the effective rate of income tax relief is 23.4%[131]. By contrast, a private sector employee on similar earnings would receive the full 45% income tax relief.

This is one of the reasons why applying the annual allowance to doctors in defined benefit schemes such as the NHS pension scheme that to a large extent corrects for the benefit of tax relief "at source" is unfair. Furthermore, this does not take into account the fact that the BMA believe that the average contribution rate or yield of 9.8% - a level higher than most other public sector schemes - is set unnecessarily high.

Table 15: Impact of tiered employee pension contribution rates on higher/additional rate tax relief (England NHS 2024/25)

Full-time employee type	Pensionable pay (£)	Employee pension contribution rate (%)	Income tax relief on contributions (%)	Income tax relief above 20% basic rate received (£)	Employee pension contributions above/below 9.8% member contribution yield to pay (£)
Basic rate NHS employee	£45,000	9.8%	20.0%	£0	£0
Higher rate NHS employee	£95,000	12.5%	40.0%	£2,375	£2,565
Additional rate NHS employee	£160,000	12.5%	45.0%	£5,000	£4,320

Note: We assume pensionable pay is also gross pay (i.e. no non-pensionable earnings) and that the employee is a pension scheme member in the above illustrations.

However, despite it being unclear why higher earners in the NHS should for some reason be denied the tax relief that other employees receive on their pension contributions, this is the result of tiering

[130] The member pays a 12.5% employee pension contribution (£11,875), which reduces their income tax by £4,750 (40% relief). The fact that their pension contribution is £2,565 higher than the 9.8% contribution yield would imply effectively reduces their relief experienced to 18.4% (i.e. £4,750 relief - £2,565 excess contributions = £2,185 relief, adjusted for tiering/£11,875 employee pension contributions paid = 18.4% adjusted relief).
[131] The member pays a 12.5% employee pension contribution (£20,000), which reduces their income tax by £9,000 (45% relief). The fact that their pension contribution is £4,320 higher than the 9.8% contribution yield would imply effectively reduces their relief experienced to 23.4% (i.e. £9,000 relief - £4,320 excess contributions = £4,680 relief, adjusted for tiering/£20,000 employee pension contributions paid = 23.4% adjusted relief).

that remains far too steep. Despite significant erosion of this tax relief on employee contributions in the first place, doctors and other higher earners are still subjected to the Annual Allowance (AA), which creates a particularly perverse incentive due to continued tapered AA rules.

The AA is designed to “claw back” tax relief and it is this compound impact of the tiered contribution structure and the AA (including risk of the taper) both 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 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.

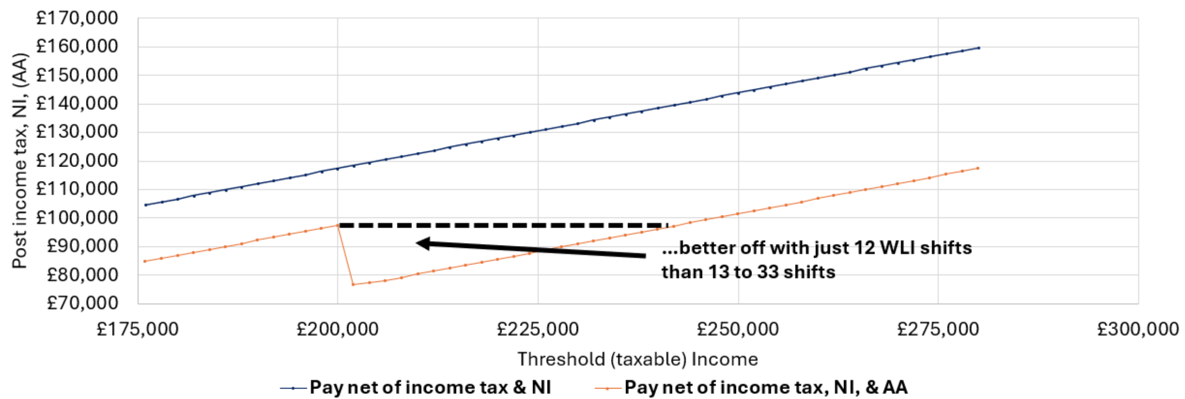
Unresolved flaws in annual allowance (including the tapered annual allowance) design

The increase to the AA in 2023 by the previous Government, while welcome, was not a long-term fix, as there has been no assurance that the AA will be indexed to inflation. The AA increase from £40,000 to £60,000 took effect from April 2023 and it remains unchanged. For example, had the AA been increased in line with previous September CPI inflation since 2023/24, the inflation statistic used to increase NHS and other public sector pension benefits, the AA would have grown to £64,020 in April 2024 and would be set to rise to £65,108 in April 2025.

Furthermore, the changes made by the previous Government did not address the impact of the tapered AA. The tapered annual allowance was not meaningfully reformed by the last Government, as although the adjusted income level (threshold income plus deemed pension growth) was increased from £240,000 to £260,000, the threshold income that applies for the taper has not changed and remains at £200,000. Indeed, this level has been frozen since 2020. Prior to the threshold income being increased in 2020, we saw senior doctors having to reduce their hours on an unprecedented scale and this is once again becoming a significant issue, given that the effective value of this has fallen in real terms. Had the threshold income been increased in line with previous September CPI inflation since 2020/21, the value would have grown to £243,448 in April 2024 and would be set to rise to £247,587 in April 2025.

Under current tax rules, crossing the tapered AA “threshold income” even by £1 can result in very significant financial penalties - with additional tax charges of up to £22,500. Doctors who exceed the threshold income usually do so on the basis of taking on additional work that is non-pensionable. Therefore, this additional tax charge is not related to any additional pensionable benefit. Indeed, if scheme pays is used to pay this tax charge, the amount of pension will fall because of taking on this extra work. Consequently, if members exceed this earnings threshold, they will be faced with the option of either paying this tax charge from their post-tax pay or permanently reducing the value of pension they will receive in retirement. Furthermore, the amount of additional tax will typically be higher than any income gained from the work itself – they are effectively paying to work. The best way to avoid this is by reducing hours or refusing to take on additional work in order to keep taxable pay below the threshold income limit. For example, in the illustration below, the hypothetical doctor would be financially better off keeping their “threshold (taxable) income” this year slightly under the £200,000 threshold income limit, unless they earn about £242,500 or more, after accounting for the AA tax charge. For example, this could equate to paying to work to undertake up to 21 waiting list initiative (WLI) 10-hour weekend shifts at £2,000 per shift.

Figure 28: Significant incentives for some senior doctors affected by the Annual Allowance to avoid extra/reduce current work in 2024/25; Estimated post-tax earnings after income tax, NI, and AA charge. Same pension at all incomes.



Source: BMA analysis based on actual Consultant (2003) England pay scales and 2024/25 tax & NHS pension rules. Hypothetical mid-career full-time consultant works only in NHS, has 23 years' service in 1995 pension scheme (after 'McCloud' rollback) & increments to top of pay scale in 2024/25. **Pensionable pay at all incomes is top of scale full-time basic pay, a medium (5%) on-call availability supplement & Level 6 Pre-2018 LCEA, which means pension benefits accrued do not vary.** All incomes also include 2 contractual additional programmed activities. What varies is other non-pensionable pay (e.g. waiting list initiatives, illustrated at £2,000 per 10-hour weekend shift. 0-52 shifts shown. AA tax charges vary by personal circumstances. Where pension growth is large due to increments, **additional AA tax charge may be up to £22,500 by going £1 over £200k taxable pay. Doctors should never #PayToWork.** Chart inspired by Institute for Fiscal Studies analysis of different tax cliff in Changes and challenges in childcare report (March 2023).

A further consequence of the operation of the tapered annual allowance is its impact on those who may choose to retire and return, rejoining the 2015 Scheme. This group, once they combine their pension (which is taxable) and taxable retire and return earnings, will be left perilously close to the "threshold income" limit of £200k. This may provide a further serious disincentive to do additional work due to the highly punitive nature of the tapered annual allowance - providing a "tax cliff" that a member may trip over even with a single shift. It is this issue that caused many to reduce hours and retire early when the tapered annual allowance was introduced.

The spectre of the tapered AA continues to present a significant barrier to NHS capacity, especially following recent, albeit crucial in the fact of sustained pay erosion, above inflation pay rises for some doctors. In a snap survey on pension taxation[132] in June 2024, over 5,600 BMA members from across the UK made clear that the punitive tapered annual allowance presents a serious risk to the Labour Government's goal to deliver an extra 40,000 appointments per week in England through extra weekend and evening working. More than 7 in 10 (71.1%) of all respondents indicated that if there were no further reforms to the tapered annual allowance following the general election, this will prevent or limit their ability to take on additional overtime. Amongst consultant respondents, this proportion rose to 77.1%.

We were disappointed that despite our entreaties[133], the Government did not index the AA in the Autumn 2024 Budget; it remains at £60,000[134]. Nor did the Government take any steps to resolve the tapered AA problem, such as scrapping the taper entirely, or introducing an Annual Allowance Compensation scheme for doctors working in the NHS (and elsewhere in the public sector) across the UK. It would be essential that such a scheme applied across the UK and was available to all of those

[132] BMA, June 2024
[133] BMA, October 2024
[134] Gov.uk, accessed November 2024

working in the NHS (as well as doctors in other public sectors such as universities, local authorities and armed forces), that are adversely impacted by pension taxation.

The BMA has previously said that our preferred solution would have been to remove the annual allowance from public sector defined benefit schemes, which would be the most cost-effective and simplest solution. It would also address this issue for the long-term. For the vast majority of people in the NHS, pension growth is already limited by nationally agreed pay awards and tax relief is already significantly addressed by contribution tiering, which is the steepest in the public sector and does not exist outside of the public sector.

Unresolved flaws in pension taxation design presents a major risk to NHS capacity. Failure to properly address the inappropriate tiering and to address further essential pension taxation reform represent missed opportunities to make the pension scheme fairer.

Whilst we accept that the DDRB cannot change the pension scheme design or pension taxation directly, we call for the DDRB to clearly support the BMA's recommendations to resolve this issue to mitigate the impending recruitment and retention crisis. However, we also welcome positive steps to retain doctors, particularly the pan-NHS Wales Flexible Pensions Policy[135] collectively agreed in October 2024. It contains many benefits designed to help retain NHS doctors in Wales, including recognition of the policy and pension flexibilities as contractual rights, and an expectation that flexible retirement applications will be supported and approved. The policy grants those who retire and return the right to return on existing terms, i.e. not on a fixed term contract, unless they prefer this. A right to retire and return for SAS doctors on the closed associate specialist grade has been formally incorporated. Recognition has been included that those who retire and return no longer need a break in service other than a 24-hour break, which preserves legal protection from statutory service. Partial retirement and the use of split contracts have also been incorporated into the All-Wales policy, which means that doctors can achieve the required 10% reduction in pensionable pay without necessarily reducing their gross pay or workload. A Flexible Retirement Employer Guide[136] was also published in Scotland in February 2024, which amongst other things, illustrates the possibility of a consultant achieving this. We will be closely monitoring whether the new All-Wales policy assists more doctors in undertaking flexible retirement options, enabling more doctors to retain in the NHS workforce longer, and therefore what good practice other nations may be able to take from this approach. By contrast, we have been engaging with DHSC and NHS Employers about concerning reports of inconsistent access to flexible retirement arrangements across England.

Recommendations

We urge the DDRB to engage with its new terms of reference in order to make recommendations and supportive observations that acknowledge and work to resolve the problem of lost pension value that we have identified. As explained, the cause of the problem is multi-faceted, including the impact of tiered employee pension contribution rates and pay erosion, changes that limit accrual of pension benefits, and pension taxation. To resolve the problem, we believe that reforms are vital, including:

- Further flatten the contribution tiering in the NHS pension scheme to ensure fairness for doctors;

[135] Fforwm Partneriaeth Cymru/Welsh Partnership Forum, October 2024
[136] Scottish Government, February 2024

- Continued above inflation pay rises to continue restoring not only the value of pay but also pension benefit for doctors. This cannot be resolved by transferring pension value into pay through flexible arrangements;
- Address NCIA anomalies and consider the loss of pension from overall remuneration of doctors from CEA/CIA changes when recommending pay uplifts. This could be mitigated by changing pension scheme regulations to allow for regular overtime to be pensionable;
- Restore access to added years contracts for legacy scheme members or otherwise ensure that additional pension can be purchased at the same rate as pension earned through employment to avoid exacerbating the gender pension gap; and,
- At least index the annual allowance in line with inflation and provide a solution for the poorly designed annual allowance taper.

Appendix 1

International comparators - cost of living

Reliable cost of living information is scarce. A crowd-sourced website exists,[137] and using their Cost of Living + Rent indices, we have calculated the multipliers shown in Table 16. Putting the reliability of the available data aside, the table shows that the change in cost of living varies with the exact origin and destination within countries. We have therefore not applied these multipliers to the international analyses. In any case, the change in cost of living does not change the direction of the analyses.

Table 16: Cost of Living multipliers

COL comparison	Multiplier
Australia whole country vs UK whole country	1.11
Melbourne vs London	0.92
Australia Average City vs London	0.79
Australia Average City vs Manchester	1.17
Republic of Ireland whole country vs UK whole country	1.14
Dublin vs London	0.83
Dublin vs Manchester	1.23
Canada whole country vs UK whole country	1.05
BC average city vs London UK	0.74
Alberta average city vs London UK	0.63
Ontario average city vs London UK	0.67
BC average city vs Manchester UK	1.09
Alberta average city vs Manchester UK	0.93
Ontario average city vs Manchester UK	1.00

[137] Numbeo, accessed November 2024

Appendix 2

Why does the BMA use RPI to calculate pay erosion?

RPI is the measure used to inflate many costs our members experience in the real economy. RPI is the best available measure to reflect the living costs of working people in England, which is why it is the preferred measure of inflation within the trade union movement.[138]

Unlike CPI, RPI is impacted by the very real expense of housing costs. (CPIH includes housing costs, so doesn't focus entirely on housing). Furthermore, the government and private business continue to use RPI to increase the cost of things that doctors need.

The Government still indexes student loan interest to RPI. Index linked gilts (the main form of government debt issued by the government) still use RPI and will continue to do so until 2030. The government also uses RPI to increase taxes, such as the Air Passenger duty[139] and Vehicle Excise Duty (VED).[140]

We look at pay erosion since 2008/09 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 several years.

Pay awards are decisions that are directly in the control of Government. Assessing pay awards against inflation is a common mechanism of assessing multi-year pay erosion.[141]

[138] TUC, November 2020
[139] UK Government, October 2024
[140] UK Government, October 2023
[141] TUC, June 2023