



Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2019-20

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Key recommendations

1. Pay Review Process

1.1 DDRB members can and should play a more vocal role if the pay review system is to be seen as legitimate within the profession. DDRB members can assist in this by adopting a significantly more robust and public approach towards advocating and defending their own recommendations.

2. Pay

2.1 The issue of changes to pay etc linked to any new Contract should not be allowed to obfuscate the need to reverse long-term pay restraint.

2.2 A pay award for all grades of:

- A base rise of 5.1%, which represents current RPI (November 2018) plus 1.9% to address historic erosion of pay.
- An additional 0.5% non-consolidated bonus in England to make up the shortfall between the DDRB's 2018 recommendation and the government award
- That in Scotland the medical pay award should be applied equally across all grades

2.3 In order to avoid a reduction to the Medical pay envelope by sleight of hand, the basic rise should also apply to all pay rates, allowances and awards, and the equivalent discretionary points in Scotland.

3. Retirement and retention

3.1 We reiterate our call for a joint task force, involving the NHS and Department of Health and the HCSA/BMA, to explore and seek better evidence around early retirement, and also those at the start of their careers who may be seeking to depart earlier than expected.

4. Ethnicity pay gap

4.1 An urgent joint investigation into the causes and to propose solutions around the ethnic pay gap, modelled on the ongoing Dacre review into the Gender Pay Gap involving the Department of Health, NHS, HCSA and BMA.

5. Productivity

5.1 Engagement with clinicians to tackle system issues including bed availability, patient flow, IT infrastructure and availability of medical and support staff.

5.2 Ensure that clinicians can access training and leadership development, to enable them to initiate and lead changes effectively.

5.3 Implement the Consultant Contract in the way that it was intended, making use of job planning by aligning personal objectives to organisational priorities.

5.4 Protect Supporting Professional Activities (SPAs) time, providing at least 2.5 PAs and recognising the link between training, additional time for education, research and training to improving morale and productivity.

Response to 2018-19 Executive Summary, Recommendations, Observations and Comments

Professional perception of the DDRB and pay review system

1. It is necessary prior to responding to the individual findings of the DDRB in 2018 to highlight the impact of the last pay round on professional morale and the faith of medical staff in the effectiveness of their Pay Review body to make meaningful recommendations that are heard and implemented by government.
2. The recommendations made by the pay review body were significantly below the Association's claim, and we disagree with the DDRB as we believe that evidence of the disastrous impact of drastic real-terms pay decline is robust and that it must be reversed. However, we could not agree more with the DDRB's sentiment that "if we are properly to balance the different factors listed in our terms of reference, a pay recommendation with a general uplift significantly greater than the 1 per cent which the UK Government says it has funded now becomes necessary."
3. In particular for the most experienced doctors, the DDRB also noted that "there is evidence that the value of the points on the Consultant pay scale has fallen relative to that of UK employees generally over the last twenty years."
4. We agree strongly with the DDRB comment that its members were "unconvinced by arguments that shortages are not amenable to pay. We recognised that there are non-pay approaches, but we had not seen any evaluation which suggested they could provide a substitute for pay-based solutions. We considered that non-pay measures had been given a more than reasonable time to address issues, and so pay solutions should now be explored."
5. The DDRB advised that pay values should not be further devalued and therefore opted to tie the 2018-19 award to projections for CPI inflation – a position of "treading water" on pay against this rather limited benchmark, with a specific uplift for SAS doctors recognising concerns around this grade.
6. It was with dismay, then, that aside from in Wales the deliberations of the DDRB were set aside by government. The reaction in England, where the Department for Health and Social Care ploughed on regardless with its Treasury-mandated 1 per cent pay award, albeit repackaged over six months, was a cause of particular concern and anger amongst Hospital Doctors.
7. The DDRB may be aware that a HCSA delegation spoke at the Trades Union Congress in September 2018 in support of calls for fundamental reform of the pay review body model, which is increasingly being questioned by public-sector workforces.
8. Indeed, HCSA has conducted research among HCSA members¹ which highlights the level of professional frustration and alienation with the DDRB process. Just under 1,000 (975) HCSA members responded to the survey, which represents a significant response by a high proportion of our membership - itself a reflection of the strength of feeling among the medical profession on this matter.

¹ Hospital Consultants and Specialist Association (2019) *November/December survey of members*

9. Respondents were offered a range of options around the pay review process:
- The current pay review mechanism should stay as it is
 - The DDRB's recommendations should be made binding
 - The DDRB should be retained in an advisory role, and direct pay negotiations should take place between doctors' representatives and the government
 - The DDRB should be abolished, and direct pay negotiations should take place between doctors' representatives and the government
 - Respondents were also given a "don't know" option.
10. The results reveal a high level of alienation with the effectiveness of the current DDRB process, with over half (51.11%) wishing to see the current system of independent pay review body-led awards replaced with direct pay negotiations between doctors' representatives and the government, either with the DDRB abolished (27.41%) or merely retained in an advisory capacity (23.6%).
11. At the same time, the figures do show that a majority of Hospital Doctors (56.62%) believe the DDRB should be retained, with either its recommendations made binding (33.02%) – the most popular option – or that it should be retained in a purely advisory role (23.6%) to inform direct negotiations.
12. It should be noted that only 0.74% of respondents felt that the current pay mechanism "should stay as it is."
13. Other parties have called for reform of the DDRB process. It is clear that HCSA members echo this sentiment in significant numbers, although from their response we have also been handed our own remit to continue to engage with the process in 2019-20.
14. HCSA believes that reform of the DDRB and pay review framework is indeed necessary, which is something we shall continue to work for in line with our members' views.
15. Despite contesting the scale of the DDRB recommendation in 2018, ultimately within the current system it is the government which must be held accountable for the insulting imposition of the Hospital Doctors' pay award in 2018-19.
16. That said, **DDRB members can and should play a more vocal role if the pay review system is to be seen as legitimate within the profession. DDRB members can assist in this by adopting a significantly more robust and public approach towards advocating and defending their own recommendations.**

Pay award: 2% Minimum Pay Rise

17. HCSA submitted a request for 2018-19 of RPI inflation, which at the time stood at 3.9%. We were surprised and dismayed, in particular given the evidence of widespread medical vacancies, and the DDRB's own recognition that pay is a motivating factor in retention and recruitment, that there was no recommendation to address the long-term real-terms decline in medical wages. We would also highlight that the 2% figure was fixed to the OBR and Bank of England projections for CPI.

CPI stood at 2.4% in April 2018, when the DDRB's recommended pay award should have been implemented. In the months since then, CPI has not fallen below 2.3%, and for all but November it has stood at 2.4% or higher due to higher energy and import prices. The Bank of England's most recent inflation projection² (November 2018) is that CPI will not reach 2% until 2021. Furthermore, actual wage rises have leapt ahead in the wider economy to 3.25%³ compared to the 2.5% noted in the DDRB's 2018 report.

Pay: CEAs

18. HCSA supported the DDRB's recommendation that CEAs, as part of the overall pay envelope for the Consultant body, increase in line with inflation. This call formed part of the HCSA evidence. However, we note that the government failed to implement this recommendation, preferring a short-term boost to the quantity of CEA points available. While we guardedly support reform of the awards scheme to make any system fairer, more encouraging of rewarding for clinical excellence, and more accessible to all specialisms and demographics, this decision by government means that in the longer-term the overall pay envelope for medical staff in England, including any new awards scheme, will be lower in real terms. This therefore represents a retrograde financial step for the entire Consultant body.

Pay: Targeting

19. We welcomed the DDRB's focus on SAS doctors, who play an important role within the Hospital workforce. However, we remain unconvinced and concerned by the DDRB's view that there is "no case at this stage for an uplift in the basic salary scales for consultants" although "increases may become appropriate in the future if negotiations over a new contract for consultants deliver substantial productivity increases." We return in some detail to the matter of productivity, and also offer fresh evidence of the growing crisis within senior medical staffing, in subsequent sections.
20. We also note the DDRB's conclusion that the new contract for doctors in training has increased average total monthly earnings for doctors in training in England. We did not agree with the conclusion that this apparent slight arrest to the long-term real-terms decline in trainee wages was significant enough to warrant a real-terms pay freeze against projected CPI. Drop-out rates are increasing and vacancy rates remain high. This places greater pressure on peers and more experienced colleagues and impacts on Consultant productivity as well as patient care. HCSA maintains that falling remuneration of trainees must therefore be addressed, particularly to counter the relative attractiveness of locum posts, whether bank or agency. We are also seeing a growing trend whereby former trainees have ended training and moving into Trust grade or Clinical Fellow posts, which have no national standard and as such are a growing cause for concern for HCSA. We return to this point in a later section.

² Bank of England (2018) *Monetary Policy Summary*. Available at <https://www.bankofengland.co.uk/monetary-policy-summary-and-minutes/2018/december-2018>

³ Bank of England (2018) *Prospects for Inflation*. Available at <https://www.bankofengland.co.uk/inflation-report/2018/november-2018/prospects-for-inflation>

Economic Outlook

21. We note the DDRB's conclusions around low projected growth, and additional costs to the NHS as a result of a weaker pound. Equally we note the uncertainties around Brexit. These continue. However, we would point out that the workforce, while the biggest component of the NHS budget, is also an essential and invaluable resource which is harder to maintain and replace than physical equipment and supplies. The resources ploughed into training each year represent an investment in developing experienced staff who, once lost from the NHS, will take years and thousands of pounds apiece to replace. We would therefore highlight that staffing is also a necessary "material cost" with a value that should not be artificially suppressed nor be counter posed to the value of tangible "things".

Update on contract negotiations and review

Consultants Contract

22. HCSA continues to engage critically with NHS Employers over the terms of the new Consultants Contract, although the progress of these talks remains extremely slow, and have not moved on since the BMA and employers signed off on their agreement on CEAs last year (which HCSA declined to sign due to a number of concerns about the future direction of the awards enshrined in the agreement).
23. We noted last year that a conclusion was not likely before 2020-21, which increasingly looks to be the earliest possible date for an outcome. It is possible that the timeline will stretch even further.
24. HCSA remains extremely concerned and disappointed that the other parties seemed content in their approach to CEAs to adopt a piecemeal approach to contractual discussions, rather than seeing Consultants' remuneration, terms and conditions as an interconnected whole. We believe that any attempt to continue such a fragmented approach to aspects of the contract will result in not only a detrimental outcome to Consultants but risks disincentivising the role and worsening the current morale and recruitment crisis.
25. We were also concerned at the suggestion by the Secretary of State in July that the outcome of the Consultants Contract could be tied to a new multi-year pay deal. **The issue of changes to pay etc linked to any new Contract should not be allowed to obfuscate the need to reverse long-term pay restraint. It is the latter which HCSA's 2019 pay submission focuses on. We urge the DDRB to focus on sufficient base remuneration for Hospital Doctors as distinct from the Secretary of State's suggestion of a multi-year deal linked to contractual changes.**

Doctors in Training

26. The terms of reference for the review of the imposed 2016 contract for junior doctors have now been agreed. HCSA is expecting to participate in this review on behalf of our trainee members on a number of matters of concern. These include:
 - Breaches of 72 hours in seven days rule not picked up by ALLOCATE electronic template calculators, contrary to national rostering guidance
 - Leave taken in days is prejudicial, when shifts could be 4.5 hours
 - F1/F2 Shadowing is outside JD contract and not properly remunerated
 - Dual training can lead to static pay and senior trainees experience static pay
 - Trusts should be able to use flexibility in setting pay on commencement
 - Uncertainty about the senior decision-makers' allowance
 - Weakness of exception reporting – does not cover rota gaps, intensity of working should be factored into exception criteria
 - ST3 equal pay for work of equal value issues owing to implementation
 - Trusts cancelling study leave at short notice and ability to carry over

SAS Doctors

27. We understand that the SAS contract review that shall begin at the earliest in 2019-20. HCSA looks forward to engaging in this process.

Review Body Request Areas

Recruit, Retain and Motivate

Motivation, morale, and workload

Overview

28. HCSA maintains there is a pressing urgency across all grades not just to tread water in terms of remuneration but to actively reverse the damaging impact of real-terms pay decline and pensions taxation changes over the past 10 years.
29. The recent General Medical Council Report⁴ into the state of medical education and practice in the UK confirms what our members have been telling us for a number of years, but it is highly significant to see such stark warnings from the regulator.
30. The report warns that pressures on the medical workforce are ‘huge,’ that the strategies that clinicians are having to take to cope are ‘risky or unsustainable,’ that doctors reported spending a ‘huge amount of time and energy’ on trying to source beds, that the medical profession is at a ‘critical juncture,’ and that the NHS is now ‘at the brink of a breaking point’.
31. A recent ComRes study⁵ commissioned by the GMC found that “staff shortages are creating such pressures that high numbers of doctors cannot cope and intend either to reduce their hours or to leave clinical practice entirely.”
32. HCSA has undertaken quantitative and qualitative research into the current landscape among Hospital Doctors in a number of areas. Taken together, the results produce an extremely concerning picture of low morale, which in turn is resulting in counter-productive outcomes around the motivation to work additional hours, career intentions, and in turn herald an ever-worsening workforce vacancy crisis, with a knock-on impact on productivity, finances and continuity of NHS services.

Significance of Decline in Pay and Benefits to Hospital Doctors

33. When asked to identify the three biggest issues for they and their teams, 75% of the 975 HCSA members responding⁶ highlighted an “End to decline in pay and benefits” as the top concern. “More control over work flow” (45.32%), “Fewer colleague vacancies” (37.23%), and “Better, and more inclusive relations with hospital management” (33.62%) were the next three highest priorities identified.
34. The fact that pay and benefits was placed so clearly in front of other issues signifies the cumulative impact of pay restraint policy on Hospital Doctors.

⁴ General Medical Council (December 2018) *The state of medical education and practice in the UK*. Available at <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk>

⁵ ComRes (2018) *What it means to be a doctor: survey findings excerpts*. Available at www.gmc-uk.org/somep2018

⁶ Hospital Consultants and Specialist Association (2018) *October/November survey of members*

Workplace morale

35. HCSA⁷ is now maintaining a statistical time series on the question of workplace morale. Asked the question, “How would you estimate the current level of morale in the workplace?”, of 940 respondents 86.71% said replied “Low” or “Very low”, 11.28% said “Neither high nor low”, and just 2.02% said “High” or “Very high”. These statistics represent a deterioration compared to the same question in 2017:

Morale level	2018	2017	Change
Very High or High	2.02%	2.37%	-0.35
Neither high nor low	11.28%	17.71%	-6.43
Very Low or Low	86.71%	79.92%	+6.79

The Impact of Pay Decline on Hospital Doctors’ Motivation, Morale, and Well-being

36. Research among our members on their feelings towards working in the NHS reveals the negative impact of long-term pay decline on their career intentions and life.⁸ When asked whether the 2018 award had altered their attitude towards the NHS, four in 10 said it had. Elaborating on their view, a common thread was that the 2018 pay award had left Hospital Doctors feeling low morale, and by extension reduced their motivation to “go the extra mile”. Comments such as “Loyalty runs both ways, and another pay cut after austerity has allegedly ended tells us exactly where we stand”, “I feel despondent”, “I feel less committed, I’m taking a harder line on additional work, and thinking more about leaving”, or “only motivation now is to leave” were typical.

37. Members were also asked whether pay decline had altered their career plans. In response 62.29% said that it had, elaborating on this further. The qualitative responses detailing the nature of such changes divided into the following broad categories:

- Taking early retirement
- Relocating abroad
- Moving into private practice
- Leaving medicine for an alternative career
- Reducing hours and sessions
- Having to work longer
- Restricting work to core duties

38. Typical narrative responses included: “Show me the exit and I’ll take it. Been a consultant for 17.5 years and not planning to stay a day longer than I have to”; “I now intend to retire early and have already gone part time to free up time for extra private work”; “Less likely to complete training and more likely to step into an SAS grade job”; “Trapped but I increasingly advise young people not to pursue medicine as a career.”

39. In terms of the impact on lifestyle, of the 448 who gave details, recurring themes included difficulties balancing income and childcare costs (in particular outside larger cities where childcare is more scarce), forcing Hospital Doctors to reduce their hours or consider leaving their post to become full-time carers for their children, general indebtedness – for instance, reliance on credit cards to pay basic bills - and the inability to fund courses relevant to their clinical practice.

⁷ Ibid

⁸ Ibid

Retirement Intentions and Impact of Pension Changes

40. The DDRB's 2018 report notes concern over the impact on retention of more senior doctors of changes to pension tax rules and recommends a task force to look at reforms that could address this potential problem. We are yet to see the fruits of this suggestion.
41. Our own research suggests that changes to Pensions Lifetime and Annual Allowances are affecting the behaviour of particularly senior doctors in two ways:
 - In disincentivising additional shifts which are effectively unpaid
 - In incentivising early retirement and retirement plans
42. HCSA made the point in our last submission that we are concerned at the paucity of accurate data around retirement and early retirement. We are aware that this is something that the DDRB itself has identified as a data gap. We also proposed in our last submission a joint task force, involving the NHS and Department of Health and the HCSA/BMA, to explore and seek better evidence around early retirement, and also those at the start of their careers who may be seeking to depart earlier than expected.
43. **We reiterate our call for such a taskforce.**
44. HCSA has in any case in recent months sought to understand the impact of pension tax changes on the behaviour of Hospital Doctors. In doing so we have sought to separate aspiration from firm intention.
45. Of 857 respondents, 41.67% said pension taxation changes had led them to change their plans to now retire earlier, while 13.29% said they would now retire later.⁹
46. HCSA has also warned that alongside tax changes, low morale and high stress levels within the medical workforce are resulting in senior doctors planning to leave their post earlier than previously planned. This position is reinforced by the findings of our most recent research.
47. Over a quarter (27.85%) of 833 respondents said they had made definite plans to leave the NHS, with destinations including retirement (30.26%), private practice (34.65%), and locum work (14.47%).
48. Of the 28.1% who had made definite plans to leave the NHS, 75.97% said they were leaving the NHS earlier than previously planned. This figure – those with definite plans to leave the NHS, and also leaving earlier than previously planned – represents one in five of all respondents (20.65%).

Vacancies crisis

49. The cumulative impact of long-term vacancies is a major concern for HCSA members.
50. In Scotland the WTE consultant vacancy rate for April to June 2018 was 7.6%, which is a dip from 8.5% for the same quarter in 2017; however, it remains an extremely significant increase on June 2011 when the vacancy rate was just 2.8%.¹⁰

⁹ Hospital Consultants and Specialist Association (2019) *November/December survey of members*

¹⁰ NHS Scotland (2018) *NHS Scotland workforce*. Available at <https://www.isdscotland.org/Health-Topics/Workforce/Publications/2018-09-04/2018-09-04-Workforce-Summary.pdf>

51. In Northern Ireland, there has been a small increase in the number of vacancies for hospital doctors, from 197 on 31st March 2017 to 203 on the 30th September 2018.¹¹
52. For England, the latest statistics from NHS Digital suggest that there were 6,895 FTE vacancies for Doctor positions advertised in the first quarter of 2018. There were 3,330 FTE vacancies for the Medical and Dental staff groups in March 2018, an increase of 441 or 15.26% since March 2015.¹²
53. This data is likely to underestimate the true level of vacancies, as jobs may be vacant but not advertised, jobs may be advertised through other routes and individual adverts can reflect numerous posts.
54. Additionally, the most recent quarterly figures include 51,964 Roles where “no Occupation Code is supplied.” In Q2 of 2015 when the figures were first compiled, there were 28,044 such unspecified vacancies and the number has been steadily increasing since. It is unclear how many of these vacancies are for Medical and Dental staff groups and we are concerned that this issue could further exacerbate any underestimate of the true level of vacancies.
55. In their most recent quarterly performance review¹³, NHS Improvement reported 11,576 WTE medical vacancies in Q1 of 2017/18, a vacancy rate of 9.3% and an increase of 728 or 6.78% in the last year.
56. The vacancy crisis continues to impact upon every area of England. NHS Improvement reported medical vacancy rates ranging from 7.2% in the South of England to 11.5% in the Midlands and East region. NHS Digital data shows a consistent and entrenched level of vacancies across the Health Education England regions. While there are regional and specialty variations, the reality is that the trend is seen in all areas to a greater or lesser degree, and in all specialties. As a result, HCSA is clear that the solution will not be found in simply attracting Hospital Doctors from one location to another: the key is to stem outflows of staff and ensure more substantive appointments.
57. Our members have ranked vacancies of medical and support staff respectively as the number three and four barriers to carrying out their jobs, after general lack of financial investment and availability of beds. Group them together, however, and medical and support staff vacancies easily represent the biggest barrier to carrying out their jobs identified by HCSA members.¹⁴
58. Our members inform us that many vacancies are not officially acknowledged. This supports the view that vacancy levels are significantly higher and current methods of reporting remain unsatisfactory.
59. Around one in five respondents (14.46%) to a recent HCSA survey involving 857 Hospital Doctors reported staffing gaps that were not officially recognised by their employer.¹⁵
60. Of the 77.08% who reported vacancies, nearly two-thirds (62.32%) said these were being covered by existing staff rather than locum or agency staff. This conflicts sharply with the statistics presented to the DDRB’s 2018 report which state that 95 per cent of vacancies are filled by agency or bank staff.

¹¹ Northern Ireland health and social care (2018) *workforce vacancies September 2018* <https://www.health-ni.gov.uk/publications/northern-ireland-health-and-social-care-hsc-workforce-vacancies-september-2018>

¹² NHS Digital (2018) *NHS Vacancy Statistics England, February 2015 – March 2018, Provisional Experimental Statistics*. Available at <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey>

¹³ NHS Improvement (2018) *Quarterly performance of the NHS provider sector: quarter 1 2018/19*. Available at <https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-1-201819/>

¹⁴ Hospital Consultants and Specialist Association (2019) *December/January survey of members*

¹⁵ Hospital Consultants and Specialist Association (2019) *December/January survey of members*

61. A canary in the mine can be found in Hospital Doctors' desire to reduce hours from their current workload.
62. Only 43.83% of respondents said they wished to stay on their current hours, while a third (33.14%) wished to cut down to 80% of full time, 13.8% wished to work 60 per cent of full time, and 10.26% said they wished to work less than 60% of full time if it were available.
63. Respondents were also asked why this was the case. Their responses are informative, with the top factors "work-life balance", "family" and "stress".

Attractiveness of the reward and employment offer

64. The previous section identifies in some detail the ways in which the medical profession is facing a major schism. Hospital Doctors are buckling under the weight of workplace stress caused by short staffing and resource issues, and the multiple blows to finances and morale caused by repeated real-terms pay cuts, changes to pensions taxation and the perception that they are being unfairly treated. These in turn are creating an impetus for more senior staff to leave and creating issues in recruiting. Ultimately the unattractiveness of the reward and employment offer can be measured in the number of long-term medical vacancies within the NHS.
65. We are concerned at reports that a rising number of trainees are leaving training to enter a growing phalanx of non-training "Trust grade" or "Clinical fellow" roles whose terms and conditions vary wildly and have no national oversight. Freedom of Information responses by English Trusts suggest a tangible growth in these roles (9.74%) compared to SAS (1.69%) or trainee posts (4.84%) from 2016-17, and in many cases this will represent doctors in training giving up on the route to Consultant.¹⁶ We believe the DDRB should pay close attention to this phenomenon and to the circumstances of Hospital Doctors in such roles, with a view to standardising the role and bringing these medics into its remit.
66. We have noted above our agreement with the DDRB's conclusion that "a pay recommendation significantly greater than the 1 per cent which the Government says it has funded now becomes a necessity." Equally, we have highlighted the dismay and anger within the profession in England and Scotland that even the DDRB's 2 per cent recommendation was ignored.
67. HCSA is of the view that while CPI may be a useful international standard to measure macroeconomic inflation, its use is not appropriate to measure actual cost-of-living rises, including for instance owner-occupier costs and taxation. We therefore maintain that RPI is a more effective measure than CPI on which to base pay rises. Additionally, given the inaccuracy of inflation projections, it is more appropriate to rely on the known facts: the actual inflation figure for the past 12 months should be taken into account when considering annual pay rises, rather than uncertain projections by the OBR and by the Bank of England in particular, which in any case generally projects a future figure for CPI of 2% since this is its remit target.
68. We maintain that in order to tackle the corrosive issues of morale, permanent recruitment and retention that we have identified, addressing the long-term erosion of real-terms pay has become a pressing factor across all grades. A meaningful rise to address historic undervaluing of the medical staff is urgently required.
69. **We therefore recommend a pay award for all grades of:**

¹⁶ Responses to FoI requests (2018) *Unpublished*

- **A base rise of 5.1%, which represents current RPI (November 2018) plus 1.9% to address historic erosion of pay.**
- **An additional 0.5% non-consolidated bonus in England to make up the shortfall between the DDRB's 2018 recommendation and the government award**
- **That in Scotland the medical pay award should be applied equally across all grades**

70. **In order to avoid a reduction to the Medical pay envelope by sleight of hand, the basic rise should also apply to all pay rates, allowances and awards.**

Consideration of where any pay uplift could be targeted

71. HCSA remains of the view that a base pay award should be consistent across all grades. We acknowledge the strategy of targeting pay to attract doctors in training to specific shortage specialities. Our main concern with such a strategy is that it must be undertaken with a very clear understanding of future need to ensure it does not overestimate staffing requirements. It is extremely difficult to retrain in a different specialty once a doctor has progressed past a certain point in their career.
72. If properly managed, the existing facility within the 2003 Consultants contract, which allows for recruitment premia of up to 30 per cent of pay scale, is adequate to meet any needs in terms of regional and specialty shortages among senior doctors. We are not in favour of any strategy which would introduce further local or regional variation as this merely risks shifting problems around the country.
73. The core issue remains the basic retention and recruitment of staff of all grades to substantive posts, and here we believe base pay is the most important aspect of remuneration.

Principle of equal pay for equal work

74. We identify two major areas of concern that fall under the principle of equal pay for equal work: gender equality and BME equality.

Gender Equality and the Gender Pay Gap

75. The HCSA welcomes the continued focus by the DDRB on tackling the gender pay gap. On average, women still earn less than men, continue to experience inequality, and face barriers in the profession.
76. The HCSA is contributing to the expert review, established by the Department for Health and Social Care and chaired by Professor Dame Jane Dacre, to consider the drivers of the gap and obstacles that stop a female doctor progressing her NHS career in the same way as male counterparts. The HCSA has actively encouraged members to contribute to the recent anonymous survey.

77. General Medical Council figures show that 46.11% of the medical workforce are women. This number has been steadily increasing in recent years and women make up a significant majority of younger doctors.¹⁷
78. Despite the steady increase in the female workforce, there is a significant gender disparity within specialities. For example, 12.62% of surgeons are women and 32.95% of those working in emergency medicine, compared with 53.34% working in paediatrics.¹⁸
79. As we await the outcome of the review, we need to acknowledge a painful truth: that female doctors earn less than their male colleagues and that this gap exists at all levels of responsibility. A BBC data request this year found that 95 out of the 100 highest paid consultants in England are male, and on average female consultants earn nearly £14,000 a year less than their male counterparts.¹⁹
80. Tackling the gender pay gap is not just essential if we are to provide fairness. There is a link in staff surveys between the proportion of staff “believing [their trust] provides equal opportunities for career progression or promotion” and patients’ experience of the care that they receive.²⁰

Ethnicity pay gap

81. For NHS doctors (excluding general practitioners), the proportion of black and minority ethnic (BME) staff varies from 37% for foundation year 1 doctors to 60% for specialty doctors.²¹
82. Across nearly all grades and types of doctors the gap in median basic pay is small, ranging from close to zero for foundation year 2 doctors, to 1% favouring BME associate specialist doctors. However, the Nuffield Trust recently found that the median basic pay for white consultants is 4.9% higher than for BME consultants. This is equivalent to additional basic pay of around £4,644 a year for white consultants.²²
83. While part of the explanation may be differences in the age profile of white and BME consultants, as with the gender pay gap there will be other explanations – some unwarranted – which are worthy of further investigation.
84. For example, research led by the Royal College of Physicians published in November 2018 found that although white British doctors apply for fewer posts when seeking to become consultants, they were both more likely to be shortlisted than BME colleagues and also more likely to be offered a job.²³

¹⁷ General Medical Council (2018) *Data Explorer*. Available at <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/gmc-data-explorer>

¹⁸ Ibid

¹⁹ BBC (2018) *Top women doctors lose out in NHS pay stakes*. Available at <https://www.bbc.co.uk/news/health-43077465>

²⁰ NHS England (2018) *Links between NHS staff experience and patient satisfaction: Analysis of surveys from 2014 and 2015*. Available at: <https://www.england.nhs.uk/publication/links-between-nhs-staff-experience-and-patient-satisfaction-analysis-of-surveys-from-2014-and-2015/>

²¹ Appleby, J (2018) *Ethnic pay gap among NHS doctors*. Available at: <https://www.bmj.com/content/362/bmj.k3586>

²² Ibid

²³ Royal College of Physicians (2018) *Survey raises concerns over equality and diversity in consultant appointments*. Available at: <https://www.rcplondon.ac.uk/news/survey-raises-concerns-over-equality-and-diversity-consultant-appointments>

85. **We therefore propose an urgent joint investigation into the causes and to propose solutions around the ethnic pay gap, modelled on the ongoing Dacre review into the Gender Pay Gap involving the Department of Health, NHS, HCSA and BMA.**

Productivity

86. Information is requested on the contribution of the various components of the remit group, particularly Consultants, towards improvements in productivity, with reference to the report by Lord Carter of Coles on Operational productivity and performance in English NHS acute hospitals: unwarranted variations.²⁴
87. Elimination of unwarranted variation is a common pursuit for clinicians and managers alike. Therefore, the call in the report to deliver “a mind-set shift from seeing people as the problem to seeing them as the solution”²⁵ is welcome, as is the recognition that staff can sometimes be regarded as a cost to be controlled rather than a creative and productive asset.”²⁶
88. The Health Foundation found that consultant productivity rates varied across the NHS, with output per FTE consultant 29% higher at the most productive hospital compared with the least.²⁷ This wide variation in productivity between Trusts is consistent with the findings from Lord Carter of Coles’ Review.
89. However, it should be noted that there are issues in measuring outputs of consultants working within different specialisms and environments in the same way, for example there are significant differences between teaching and non-teaching hospitals. This is because teaching activity introduces delays to the treatment process, as part of a consultant’s role is to train medical students. Furthermore, teaching hospitals tend to treat more complex and/or more severe patients.²⁸
90. Variances in productivity levels are not a reflection of how hard working or dedicated NHS clinicians are, rather they reflect a range of factors, including the effectiveness of the system in which they operate. To deliver care in an efficient way, the skills of staff need to be used effectively and the correct staffing mix needs to be in place.
91. Improving productivity outcomes and reducing variation can therefore only be achieved if systemic barriers to productivity are tackled and if clinicians are effectively engaged at a micro level. We share the view of Health Foundation Chief Executive Jennifer Dixon, who commented that, “for

²⁴ Lord Carter of Coles (2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted Variations*. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

²⁵ Ibid, p.15

²⁶ Ibid, p.81

²⁷ Lafond et al (2017) *A year of plenty? An analysis of NHS finances and consultant productivity*. Available at <https://www.health.org.uk/publications/a-year-of-plenty>

²⁸ Street et al (2010) *Determinants of hospital costs and performance variation: Methods, models and variables for the EuroDRG project*. Available at https://www.researchgate.net/publication/44131706_Determinants_of_Hospital_Costs_and_Performance_Variation_Methods_Models_and_Variables_for_the_EuroDRG_Project

Lord Carter’s review to be turned into reality, we need both a supportive working environment to motivate staff and a dedicated resource.”²⁹

92. Our members have set out a range of factors which most impede their ability to deliver their job plan/work schedule. Alongside “general lack of financial investment in services,” which was raised by over 50% of those who responded; availability of beds (45%), lack of medical staff (43%) and lack of support staff, including paramedics and nurses (41%) were the most commonly cited concerns.
93. A significant number of respondents also raised concerns about disorganised workflow, availability of theatre time, availability of equipment and problems with IT infrastructure. A smaller, but significant number of respondents raised concerns about micro-management, over-burdensome bureaucracy and bullying.
94. This supports the findings of the Health Foundation,³⁰ who reported that that higher consultant productivity is associated with a range of systemic factors, including:
 - a higher proportion of nurses within the hospital workforce
 - a higher proportion of clinical support staff within the hospital workforce
 - the hospital is not a teaching hospital
 - the hospital is more specialised
 - the hospital is in a more urban location
 - the average NHS wage at the hospital is high compared to general wages in the region
95. The Health Foundation also found that relative pay matters for productivity. This raises a clear concern that consecutive years of pay restraint could negatively impact upon consultant productivity, particularly as the wider economy returns to growth. The Office for Budget Responsibility expects wider economy earnings in the UK to improve, increasing by over twice the rate of planned NHS pay awards.³¹
96. Lemer et al³² argue that there are several issues with current financial incentives systems, and changes should be considered in order that they can be better used to tackle productivity. These changes include re-interpreting the consultant contract, and using job planning and Supporting Professional Activities time (SPAs) to align personal objectives with organisational priorities around productivity.

Productivity: Conclusions

97. There is a clear link between relative pay, morale and productivity. We share Lord Carter’s view that “evidence from other industries has shown that good staff wellbeing leads to increased productivity.” The impact of successive real terms cuts to wages on morale cannot be overstated. The House of Lords Select Committee on the Long-term Sustainability of the NHS³³ found that,

²⁹ Health Service Journal (2016) *Carter savings ‘won’t be enough’, experts warn*. Available at <https://www.hsj.co.uk/finance-and-efficiency/carter-savings-wont-be-enough-experts-warn/7002217.article>

³⁰ Lafond et al (2017) *A year of plenty? An analysis of NHS finances and consultant productivity*. Available at <https://www.health.org.uk/publications/a-year-of-plenty>

³¹ Office for Budget Responsibility (2018) *Economic and fiscal outlook – October 2018*. Available at <https://obr.uk/efo/economic-fiscal-outlook-october-2018/>

³² Lemer et al for the King’s Fund (2012) *Improving NHS productivity: The secondary care doctor’s perspective*. Available at <https://www.kingsfund.org.uk/sites/default/files/improving-nhs-productivity-lemer-allwood-foley-leadership-review2012-paper.pdf>

³³ House of Lords Select Committee on the Long-term Sustainability of the NHS (2017) *Report of Session 2016–17*. Available at <https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf>

“There is an indisputable link between a prolonged period of pay restraint, over-burdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other.”

98. No matter how hard consultants work, if they are not supported properly by the systems in which they operate then they will not be as productive as they could be. Therefore, to effectively address productivity, clinical leadership is required at all levels of the organisation.
99. **For clinician-led productivity improvements to be implemented, a number of additional steps are necessary:**
 - **Engaging with clinicians to tackle system issues including bed availability, patient flow, IT infrastructure and availability of medical and support staff.**
 - **Supporting, prioritising and valuing clinical leadership at an individual level.**
 - **Ensuring that clinicians can access training and leadership development, to enable them to initiate and lead changes effectively.**
 - **Implementing the consultant contract in the way that it was intended, making use of job planning by aligning personal objectives to organisational priorities.**
 - **Protecting Supporting Professional Activities (SPAs) time, providing at least 2.5 PAs and recognising the link between training, additional time for education, research and training to improving morale and productivity.**
 - **More closely relating SPAs to the priorities of the organisation.**

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