HCSA Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2024-25

February 2024

NOTE: HCSA will not be making a full submission in the 2024-25 pay review round. This submission intends to give our perspective on the state of affairs in medical pay, in the absence of a reformed DDRB.

1. Introduction

Regrettably, the medical profession enters another pay review round discouraged by little appetite from the Government to address long term pay erosion. At the time of writing, February 2024, we remain in dispute for junior doctors, SAS and consultants in England. In the devolved nations, our members are also deeply dissatisfied. In Wales, the government tells us they are hamstrung by the limited funds allocated for the NHS, which they say constrains their ability to make a satisfactory pay award. In Northern Ireland, a political stalemate has paralysed the public sector and doctors are yet to see any pay uplift for the 2023-24 round. In Scotland, junior doctor strikes were narrowly avoided by an offer from the Scottish Government. Primary feedback from members in Scotland was that it was encouraging to see government acceptance of the principle of pay erosion and a tacit acknowledgement that the current pay review system is not satisfactory. A commitment has been made to exploring pay mechanisms outside of DDRB, yet the solution remains to be seen.

HCSA broke with convention last year in its' DDRB submission, using the opportunity to make the case for DDRB reform rather than a 'business as usual' submission. It is with great disappointment that we can report limited progress since last year. Therefore, our evidence to the DDRB is constrained once again. Until we see significant progress on DDRB reform, and the resolution of medical pay disputes, we will not be able to submit comprehensive evidence to the DDRB. Instead, this reduced submission will provide our assessment of the present state of affairs and repeat our call for reform.

This is a defining year for the medical profession. We write in a General Election year. A colossal task awaits any future government and we are expecting more robust details to emerge of how

each political party intends to address waiting lists. All stakeholders must recognise that cutting waiting lists can only be achieved with a healthy workforce. Doctors must feel valued and paid appropriately for the work they do. They must be given the time they need to train and develop skills that are of benefit to patients. The service must be made sustainable with slack built into the system. Fully staffed rotas are necessary to prevent appointment cancellations and avoid staff burnout.

Crucially, all stakeholders must recognise that the greatest asset the NHS has is its staff. This principle must sit at the core of all policy.

2. DDRB reform

HCSA has laid out its vision of DDRB reform in our previous two submissions to the Review Body.

Our principles are as follows:

- True independence from government
- Transparency and autonomy
- Representation of the medical profession

At the time of writing, we are involved in Consultant pay negotiations. For HCSA, a crucial component of pay is the system through which pay awards arise. We have therefore put a number of proposals for DDRB reforms forward to the Department of Health and Social Care during negotiations. HCSA is clear that DDRB reform is necessary to fix pay for now and the future. Any cash award that comes without significant DDRB reform is only a quick fix and not a sustainable solution to stemming pay erosion. Members have already rejected a previous formation of the offer, with 'DDRB reforms do not go far enough' cited as a primary concern by those rejecting. It is yet to be seen whether the final package will offer the radical reform that is required, otherwise the campaign will continue for the medical profession.

3. Ongoing disputes

HCSA's Consultant and SAS members voted 77% in favour of strike action in a formal ballot in November 2023; a historic moment for HCSA. Senior doctors did not take this decision lightly and it was an uncomfortable decision for many, driven by a loss of faith in the system and the deep felt

injustice of decades of pay erosion. As referenced above, Consultant talks are ongoing to reach an offer that HCSA can put to members in good faith. We are negotiating on the basis that any award does not preclude the DDRB from making a recommendation as part of the normal pay process in the summer. We would urge the DDRB to consider the pay erosion that the Consultant group has faced, greater than any other NHS staff group.

At the time of writing, an offer has also been made to HCSA SAS doctors. It was rejected by HCSA members in a 75% reject vote and we are awaiting news on the next steps. Our SAS members reacted strongly to the presentation of a pay scale uplift that remains less attractive than old contracts. The status of SAS has so eroded over a series of contract reforms that the Associate Specialist grade on old contracts is far more valuable than the ceiling for any SAS doctor on new contracts. This blatant unfairness shows disregard for the specialist grade. A stated aim of the Government pay offer is to incentivise the new contract, yet an uplift that still appears as a pay cut will not do so. Nor is it fair for the fifty percent of SAS doctors on old contracts to be kept out of pay awards and effectively locked in to the ceiling of their current award. The SAS workforce also faces barriers to progression and a lack of educational opportunities. While HCSA members welcomed the acknowledgment of this in the pay offer, they also told us that the measures did not go far enough and felt employers should be mandated to promote best practice for SAS, rather than 'encouraged'. These aspects are key to retaining senior SAS doctors in the NHS. We urge the DDRB to make an award for all SAS doctors that takes into account the significant pay erosion this entire group faces.

Finally, we are particularly dismayed by the direction of travel for junior doctors. At the time of writing, HCSA junior doctors, including locally employed doctors, have served strike notices for five days of strike in February. In the fourteen months since HCSA's original junior doctor strike ballot, we are discouraged to see a government that has not yet tabled a credible offer. The over-emphasis on non-pay items overlooks the very serious grievance junior doctors have with the erosion of their pay. HCSA used its 2022-23 submission to highlight a broken rotation system, where employers rarely comply with their contractual obligations such as providing rotas in good time and ensuring accuracy of payslips. Such matters should be addressed with employers immediately, regardless of the pay dispute. Meanwhile, we urge the DDRB to consider the junior doctors' valid call for pay restoration as a factor when considering what to recommend.

Most of all, HCSA calls on the DDRB to step beyond its usual practice this year by making the case for reversal of pay erosion for every grade of doctor.

4. Workforce

Once more this year, HCSA would like to highlight the link between pay and workforce. From our members' perspective, the state of the workforce is bleak. Hospital doctors continue to report extreme pressures working amidst persistent staffing vacancies. We have used previous submissions to call for workforce planning. We must therefore acknowledge the publication of the NHS Long Term Workforce Plan in June 2023[1].

The publication of the plan, although overdue, was nonetheless welcome. Of particular note to our members is the pledge to double medical school places to 15,000 a year by 2031/32, which recognises the need to firm up a pipeline of new doctors coming through. Yet we noted the absence of plans for the specialty placements that new medics will graduate into. We cannot have a situation where students graduate without training jobs in their specialty available, nor can the NHS afford to risk training new doctors up in the wrong specialties. Data gathering and analysis must be conducted urgently to anticipate the health needs of a changing population so doctors can be funneled through appropriately.

Meanwhile, retention of doctors at every grade continues to be of great concern. Retention issues are in part perpetuated by a sense of being overworked and undervalued that is intrinsically linked to pay. We would have liked to see greater focus on this area in the workforce plan and note with concern that the plan cites a predicted shortfall of consultants amounting to 4 – 8 % by 2036/7. It is not viable to have a mass expansion of new doctors-in-training without retaining the senior doctors who will be their mentors and tutors. This is further compounded by the widespread reduction in Supporting Professional Activities (SPA) time. Protected time for senior doctors to carry out critical activities such as training and service improvement has never been more important.

The workforce plan also aims to support medical schools to compress medical degrees from five- or six-year to four year programmes, and to pilot medical internships. HCSA is not convinced by the effectiveness of these untested models. Our Student Associate members tell us that the medical degree is already extremely intense, and burnout, anxiety and depression are high amongst their peers. Furthermore, we have reservations about final year medical students being used in the place of a junior doctor on understaffed wards. This practice has the potential to exploit future

[1] NHS England, Long Term Workforce Plan, June 2023

doctors as unpaid labour and create patient safety risks. We would caution that any acceleration of the medical degree would be likely to burn out aspiring doctors and potentially lead to an increase in drop out rates. We also remain unconvinced by proposals for medical internships and would caution that far more work, including stakeholder engagement, is required on the detail.

The growth of Locally Employed (LEDs) within the medical workforce is of note to HCSA. Many LEDs are doctors-in-training on a break, and we understand this option often appeals to those with caring responsibilities. It gives stability without the turbulence of rotations and long commutes. Yet this is also a reminder that the current rotation system does not work for so many junior doctors. We have provided data in our 2022-23 DDRB submission on the discrepancy between what the contract stipulates should happen and the lived experience of junior doctors. We would suggest that the growth of doctors-in-training taking time out for LED roles is illustrative of how impractical the training pathway can be for many doctors.

HCSA is also aware of the exploitative practices that many LEDs face at work. Trusts are not mandated to provide mirror Ts&Cs to national contracts for LEDs, and as such LEDs can be excluded from pay uplifts and not assigned the contractual entitlements of their peers, for example SAS-grade LEDs often do not receive SPA time. It is not a coincidence that there is higher representation amongst LEDs from International Medical Graduates (IMGs), a group whom we know to experience discrimination and hurdles in progressing. We were heartened to see in last year's DDRB report a commitment from DHSC to eliminating the ethnicity pay gap. HCSA has seen little movement in this area since then and therefore must reiterate our call from previous submissions of the need for analysis to be conducted on the ethnicity pay gap, and the experiences of IMGs and LEDs must form part of this analysis. With the projected growth of the LED workforce looming, now is the time for employers to review their practices and implement fair treatment to ensure LED doctors are valued and treated with dignity. This will be crucial in creating a stable medical workforce for the future.

Finally, we must also comment on plans to grow the medical associate workforce to 12,000 and note the workforce is due to be regulated by the end of 2024, through Physician Associate (PA) and Anaesthesia Associate (AA) roles[2]. HCSA's position is that the current trajectory has the potential to be extremely unsafe. We are calling for clarity, transparency and safety as key principles to accompany this expansion. In particular, we object strongly to the blurring of boundaries, where employers inappropriately substitute associate professionals for doctors. If mismanaged this could

[2]General Medical Council, PA and AA Regulation hub, January 2024

leave patients at higher risk, because when procedures inevitably go wrong these clinicians won't have the wider training needed to respond. Our members are also concerned about how training opportunities can be allocated fairly, when the expansion of associate roles will inevitably create a new cohort who will also need the same exposure to clinical situations to learn as junior doctors do.

We have been alarmed to see valid concerns of the medical profession disregarded as protectionist, rather than considered seriously in constructing a safer pathway forwards. Hospital doctors work side by side with colleagues in multi-disciplinary teams. HCSA understands that when deployed correctly, the role of associate professional can be invaluable. We also support regulation of associate professionals to set standards for their work and ensure safe practice. However, we do not believe that the GMC is the correct regulator for associate professionals, and we note that the GMC does not plan to set standards for AAs/PAs in the same way as it does doctors. There must be further clarity on the roles, responsibilities and limits to the work of associate professionals. It cannot be left for employers to define this. We also oppose the move to bring associate professionals under the same code of practice as doctors, with both referred to as 'medical professionals'[3]. This misleading title creates ambiguity for patients that will lead to safety issues. HCSA calls for a review of titles with the aim of renaming associate professional roles to provide utmost clarity.

5. Pensions

HCSA welcomed significant changes to pensions tax that came into force in April 2023, including the abolishment of the Lifetime Allowance (LTA), an increase in the Annual Allowance to £60,000 and the ability to offset negative growth in one NHS pension scheme against positive growth in the other. HCSA has long campaigned for action to end punitive pensions taxes, which have led senior doctors to retire early from the NHS or cut down hours in order to avoid penalties for working. Whilst we expect the changes to have a positive impact, we would caution that it is too early to see this. The vast majority of senior doctors will be affected by the McCloud remedy but will not have received recalculated pension growth figures for the remedy period nor for the tax year 22-23. This means they may not have a clear view of how much work they are able to do as individuals without incurring disproportionate charges. Once the remedy has been applied and

[3] General Medical Council, Good medical practice, January 2024

doctors informed of how they are affected, it will then be possible to measure the impact on behaviours.

HCSA is also concerned by divergence in approach from NHS Trusts on partial retirement since changes which came into effect in October 2023. Those with 1995 pension rights can access their legacy benefits whilst building up new pension in the 2015 scheme by applying for partial retirement. However, they are required to drop pensionable pay by 10 percent. HCSA disagrees with this requirement - an arbitrary restriction that incentivises doctors to cut back on working hours. Some Trusts have mitigated this by providing means to make part of the pay non-pensionable, to allow doctors to continue working at full capacity if they wish, while drawing pension that may otherwise be lost (due to the lack of late retirement factors in the 1995 scheme). HCSA's position is that NHS Employers should compel all Trusts to offer this provision in order to retain senior doctors.

HCSA's long held position is that Annual Allowance is not an appropriate tax for Defined Benefit Schemes. Although the increase in the taper threshold has helped to mitigate the impact, we have some members who continue to be adversely affected. It is important for policymakers to understand that the creation of uncertainty or fear greatly impacts behaviours. Individuals often feel inclined to take pre-emptive steps to avoid hitting thresholds, rather than await a retrospective bill. HCSA notes with caution touted proposals to bring back the LTA, albeit with the caveat that doctors would be excluded from this tax. We are greatly concerned that any such move would impact retirement plans for senior doctors. We encourage any future government to work with all relevant stakeholders, including trade unions, to work through policy proposals and ensure their viability. It is crucial that pensions policy does not inadvertently push senior doctors out of the NHS.

6. Conclusion

The medical profession has demonstrated its determination at every opportunity throughout this year of disputes. Junior doctors in particular have acted with commitment to their cause of Pay Restoration, returning votes for strike in every ballot and firmly withdrawing their labour in ten rounds of action, despite the personal impacts on individuals. Senior doctors have taken action that would at other times have been unthinkable and returned a resounding mandate. While the disputes are with the Government, the Review Body must not disregard the significance of this moment to its own role, and the responsibility it carries in creating and rectifying issues with medical pay.

HCSA therefore calls once more for the Review Body to be bold. HCSA asks that you make recommendations for every grade of doctor that take into account the significant pay erosion medical professionals have faced. We understand the constraints that the current system places on the work of the DDRB but ask that you look beyond your usual scope in light of this year's context.

HCSA will continue to make the case for reform to the Review Body in order to create a system that is truly independent from government and can act with transparency and autonomy. This is crucial to securing fair pay awards for the medical profession.