Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2022-23

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1. Introduction

1.1 As we approach the two-year anniversary of the first wave, it is clear that the Covid pandemic is far from over. There remain many thousands of patients in hospital with Covid across the United Kingdom and we saw multiple Trusts declaring "critical incidents" earlier this month.[1] While there is cautious optimism that Omicron has now peaked, the medical profession continues to battle with overwhelmed workplaces. Far from settling in to a 'new normal', hospital doctors are stepping up to new challenges and changed working practices without respite.

1.2 As the 'Plan B' Covid restrictions ease, we will soon see what impact this will have on Covid hospital admissions and the NHS capacity to respond. Additionally, the Vaccination as a Condition of Deployment policy for Healthcare Workers is likely to further squeeze staffing levels as an estimated 73,000 NHS workers in England could be dismissed under the policy.[2]

1.3 Despite the best efforts of staff, backlogs are mounting, with a waiting list in October 2021 of 6 million patients.[3] IFS modelling paints a bleak picture, taking into account the additional 'missing' waiting list of around 7.4 million patients who would have presented for treatment in pre-pandemic times.[4] This presents a best case scenario of waiting lists returning to pre-pandemic levels by 2025, and a worst case scenario of a waiting list of 15 million by 2025. This will translate to an increased workload and strain on hospital doctors for years to come. It also underlines the necessity of retaining the hospital doctors we do have.

1.4 HCSA Doctors at Work survey findings this year demonstrate a worsening situation in terms of morale, stress and burnout, even when contrasted with the peak of the second wave in January 2021. HCSA is alarmed by survey responses relaying the mental health of our members and warn that urgent action is required to alleviate the pressures NHS staff are under.

[1] UK Government, Coronavirus Dashboard, (accessed on 20.01.21) https://coronavirus.data.gov.uk/
[2] Department of Health and Social Care, Impact statement: making vaccination a condition of deployment in health and wider social care sector (2021)
[3] NHS England, Statistical Press Notice (9.12.21) https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/12/RTT-statistical-press-notice-Oct-21-PDF-421K-03857.pdf
[4] Institute for Fiscal Studies, Could NHS waiting lists really reach 13 million? (08.08.21) https://ifs.org.uk/publications/15557

1.5 HCSA is concerned to see vacancies amongst medical professionals have increased by 14 percent from September 2020 to September 2021 – and total vacancy levels are likely to be a significant underestimate due to poor reporting systems. Pay represents an important retention and recruitment tool.

1.6 Inflation has soared to a 30-year high, exceeding forecasts.[5] This cost of living rise represents significant wage decline. A number of other cost pressures, including likely National Insurance rises and proposed pensions contribution increases for lower-paid hospital doctors, threaten to further press down take-home pay. Together with historic pay decline, we are deeply concerned about the impact of these factors on recruitment and retention.

1.7 One overwhelming message from our annual survey is that hospital doctors do not feel valued. The 2022-23 pay award must recognise both new challenges and existing extraordinary pressures faced by staff. It must seek to combat declining morale in order to shore up retention and productivity. In order to do so, the award must exceed inflation, pension contribution rises and National Insurance increases.

2. Reflections on last year

2.1 The 2021-22 pay award was met with great discontent. It failed to reflect the sacrifices of our members and the strain they are under. It was a particularly bitter blow to Junior Doctors and some SAS doctors in England who were excluded on the basis of the multi-year pay awards previously agreed.

2.2 Last year, HCSA called for a 3 percent uplift across the board, plus an additional 0.8 percent for Junior Doctors to rectify their exclusion the previous year. It was therefore highly disappointing that the DDRB chose to stick rigidly to the government remit to again exclude this group, further widening the pay gap between the lowest and highest grades.

2.3 We made our submission prior to the sharp rise in inflation covering the award period, which was significantly higher than projected. We were dismayed that the profession did not gain a real-terms uplift in wages.[6] We call on the DDRB to rectify this in this year's award.

2.4 Given the strength of feeling from the profession, HCSA and other unions moved to consultative ballot. While we fell just short of the legal thresholds to take action under industrial legislation restraining health-sector unions, the response from our members nonetheless conveyed a great sense of anger at a decade of wage restraint.

[5]House of Commons Library, Research Briefing: Rising cost of living in the UK (20.01.22)
[6]Office for National Statistics, CPI Annual Rate 00 (15.12.21)
https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/d7g7/mm23

3. The pay review process

3.1 In HCSA's 2019-20 submission, we described a "high level of alienation" within the profession towards the pay review process. We cited our research that showed less than 1 percent of respondents felt the DDRB should "stay as it is", with our respondents split between making the recommendations binding, retaining the DDRB in a purely advisory role and abolishing the DDRB altogether.

3.2 Last year's process failed to restore faith in the role of the DDRB. We appreciate efforts by the body to conduct a thorough and meaningful process. However, this process is seriously undermined by a high degree of political control over its membership and remit. Regrettably, the imbalance of power places the DDRB in an impossible situation. The government can choose, as it has done on many occasions, to ignore their recommendations, rendering the process meaningless. This appears in recent times to have encouraged the DDRB to 'play safe' with recommendations that go little beyond what would be considered acceptable by the Treasury.

3.3 We have a remit from membership to continue to engage with the DDRB, but HCSA believes significant reforms are now required to improve its legitimacy. Transparency, representation of the medical profession and true independence from government are key elements that require reform to restore faith amongst doctors.

3.4 HCSA's position on reform is as follows:

Remit: Governments should not be allowed to set the DDRB remit. All parties should be invited to make comment at the beginning of the process on what they feel the remit should be. The DDRB should have greater independence to make recommendations beyond the government remit.

Appointments: DDRB Members should be appointed through an entirely independent process without political involvement.

Accountability: Members should not be accountable to government ministers, to ensure independence.

Composition: There must be at least one member with clinical experience and one with trade union experience on the DDRB. HCSA welcomes the addition of a member with such experience since August 2021 but notes that this is an anomaly in the history of the DDRB. Further, there is nothing within the framework of the DDRB to require this moving forward. Membership should also be reflective of the medical profession from an equalities perspective, particularly as we have deep concerns related to gender and ethnicity pay gaps, although we acknowledge some progress has been made in recruiting women to the body.

Terms of reference: The DDRB should not be required to assess the funds available to the health department. The DDRB should be allowed to consider historic pay decline in its own right, and not merely limited to make recommendations within the context of in-year

recruitment, retention and motivation.

Timeline: the timeline and process should be instigated by DDRB independently. Governments should not have control of the timeline.

Conclusion of process: The final report should be published in the public domain for transparency at the point when it is handed to governments. Governments should be required to implement its recommendations.

3.5 HCSA calls this year on the DDRB to exert its independence from governments with a recommended pay award that bucks the trend of pay deflation. We will continue to engage with the DDRB while we mount our campaign for reform.

4. Economic outlook

4.1 At the time of writing, we are situated in a unique economic context. Even CPI, a macroeconomic measure which is an inappropriate benchmark for pay bargaining, soared to a 30-year high of 5.4 percent in December 2021.[7] This unexpected rise exceeded forecasts in the latest Bank of England (BoE) monetary report, dated November 2021, which suggested CPI inflation would be at 4.5 percent over the winter and reach 5 percent in April.[8]

4.2 Rises in inflation this year are largely attributed to energy prices and supply chain costs which are feeding through into prices for everyday goods and services. In response, the Bank of England increased interest rates on 16th December from 0.1 percent to 0.25 percent, the first increase in interest rates in three years.[9] The impact of this measure is yet to be seen. The average of forecasters for CPI inflation in the BoE November report was 2.7 percent in 2022 Q4 but this no longer appears reliable based on recent unexpected rises.[10]

4.3 Meanwhile, the ONS reports RPI, the measure used for pay bargaining, at 7.5 percent, which is the highest it has been in 20 years.[11]

4.4 This is a wholly different context from the 1.5 percent CPI and 2.9 percent RPI upon which the DDRB based last year's award. We would argue that this change has rendered last year's award wholly inadequate. It is for this reason that we recommend a starting point for this year's recommendation of RPI inflation, upon which to base a pay award over and above.

[7] Ibid.
[8] Bank of England, Monetary Policy Report (November 2021) https://www.bankofengland.co.uk/-/media/boe/files/monetary-policy-report/2021/november/monetary-policy-report-november-2021.pdf Nov 2021
[9] Bank of England, Monetary Policy Summary (December 2021) https://www.bankofengland.co.uk/monetary-policy-summary-and-minutes/2021/december-2021
[10] Ibid.
[11] Office for National Statistics, RPI All Items (15.12.21) https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/czbh/mm23

4.5 Take-home pay will be impacted by increased National Insurance contributions of 1.25 percent from April 2022 if the government progresses planned policy. As public-sector employees, the extra contributions of our members should be recycled back into a higher value pay award which serves to strengthen the NHS by retaining, recruiting and motivating the workforce.

4.6 Junior doctors in particular are also likely to be hit by an increase in pensions contributions as part of planned reforms to be implemented in 2022. We address this issue elsewhere in this paper.

5. Pay

5.1 HCSA was pleased to see the detail on pay deflation set out in the DDRB 49th Report 2021. It is only by examining the long-term picture for our members, some of whom have been in the workforce for several decades, that trends in recruitment and retention can be understood.

Consultants in England

5.2 HCSA noted in the 2020 DDRB report that in 2019, the 5th point of the Consultant pay scale was 15 percent below the 2008 level. This was out of step with earnings across the wider economy which had by 2019 recovered to 2008 levels.

5.3 The 2021 DDRB report reveals this has now reduced to 13 percent below the level in 2008, while average wages across the economy are 1 percent above 2008 levels.[12] This is a move in the right direction, but clearly much greater investment is needed to bring the profession back in line with wages across the rest of the economy.

5.4 Real-terms wage deflation devalues the hard work of the profession. It is not sustainable for the wages of the most experienced doctors to lag behind the rest of the economy. HCSA remains deeply concerned about the role of a declining reward package in incentivising retirement rates among Consultants.

SAS in England

5.5 We are disappointed that last year's pay award excluded SAS doctors in England on the 2021 contract. There is a clear intention in the transition guidance that no doctor would experience financial detriment on their basic pay by moving to the 2021 contract.[13] Yet the pay award has upended this, creating a situation wherein many of those moving to the 2021 contract, agreed prior to inflationary rises, would see their pay fall immediately for the first year in comparison

[12] Review Body on Doctors' and Dentists' Remuneration 49th Report (2021) https://www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-49th-report-2021

[13] NHS Employers, Transition to the 2021 Contracts (September 2021) https://www.nhsemployers.org/sites/default/files/2021-09/SAS-reform-Impact-of-3-per-cent-uplift-summary.pdf

to their peers.

5.6 This serves as a disincentive for our members to move from the 2008 contract, and further complicates their decision-making process. Our members must now investigate their individual circumstances and ascertain whether they will be disadvantaged by moving. It is also extremely disheartening for those who had moved onto the contract prior to the pay award under the impression there would be no detriment and now find themselves excluded.

5.7 This year's pay award must be implemented consistently to improve fairness, boost morale and avoid impacting on the desirability of new contracts. There should be an additional reimbursement for any SAS doctors who faced financial disadvantage as a result of moving to the new contract prior to the pay award.

Junior Doctors in England

5.8 Spanning the past decade, there has been significant pay erosion for Junior Doctors in England, and their exclusion from the past three pay awards means that the picture has only worsened. DDRB analysis demonstrates that average total earnings of those in the second year of foundation training fell back from just below the 80th percentile in 2010-11 to just ahead of the 72nd percentile by 2019-20.

5.9 Similarly, for those in core training, there was a drop from the 88th percentile in 2010-11 to the 85th percentile in 2015-16, and earnings have maintained that relative position since. Meanwhile the registrar group have fallen from above the 92nd percentile in 2010-11 to in line with the 90th percentile in 2019-20.

5.10 The remit from the Westminster government to stick rigidly to the multi-year pay deal in England, while awarding higher pay rises to other medical staffing groups, has further demoralised Junior Doctors. This is particularly offensive in the context of an award framed as being an acknowledgement for efforts in the Covid response. The multi-year pay deal was negotiated pre-pandemic and it should be seen as a minimum, not a maximum.

5.11 HCSA Doctors at Work study also uncovered major issues around work-life balance for doctors in training, which often lead to financial and personal impacts.[14]

5.12 Nearly a third received less than six weeks' notice of the location of a post, inevitably leading to implications for arranging housing and travel. Three-quarters of Junior Doctors received the rota for their current post less than six weeks before the post was due to begin, rendering it impossible to plan around shift patterns.

5.13 Two-thirds of Junior Doctors report having missed an event of major life significance due to being unable to book leave or being on-call. A striking example on the impact of this on retention comes from a respondent who relayed that they took a year out of training to guarantee they would get the days off work required for their honeymoon.

[14] HCSA, Hospital Doctors at Work survey of 905 hospital doctors (conducted November-December 2021).

5.14 Only one in 10 Junior Doctors have the opportunity to take the breaks they are entitled to on every shift. Nearly two-thirds can only take such breaks half the time or less.

5.15 Nearly half encounter NHS payroll errors frequently or very frequently, inevitably leaving Junior Doctors waiting for the money they are owed. This is likely to be more common than for the rest of the staff group due to administration involved in rotations.

5.16 Such poor working practices make it challenging for Junior Doctors to rest, plan personal lives and manage finances. HCSA is concerned that these practices are engrained within the NHS, impacting on the morale of many in the early stages of their careers. The role of a Junior Doctor requires flexibility, yet the safeguards in policy must be enforced to prevent fatigue and burnout. These factors play an important role in influencing career decisions for this group. Remuneration is a key tool in retaining this group of doctors.

Scotland and Wales

5.17 The 3 percent award was implemented for all doctors in Scotland and Wales, and we welcome the uniform approach taken by governments in both nations. We are also supportive of the decision of the Welsh government in to make a supplementary Covid payment of £735 in recognition of the extraordinary efforts during the pandemic. The Scottish government had also already made a welcome one-off Covid payment of £500 in December 2020. However, we maintain that 3 percent has been rendered inadequate in the context of inflation. We repeat our calls for a substantial award this year.

Northern Ireland

5.18 While the Health Minister has committed to implementing the 3 percent recommendation in full, we are disappointed that our members have not yet received this and the updated pay circular is yet to be released. This will undoubtedly have a profound impact on morale and motivation.

5.19 We also welcome the recent announcement from the Minister of Health to make an additional non-consolidated pay award of 1 percent to F1 doctors and 0.5 percent for the rest of the medical workforce.[15] However, as a non-consolidated payment, it does not address the gulf created by year-on-year pay deflation.

6. Impact of pandemic on careers

6.1 Last year our submission reported a significant change in career intentions, and this year we have continued to monitor this while also seeking to uncover whether changed intentions are beginning to translate into action.

[15]Department of Health, Swann announces plan for additional HSC pay award (19.01.22) http://www.health-ni.gov.uk/news/swann-announces-plan-additional-hsc-pay-award

6.2 In our most recent study 62 percent of hospital doctors reported that Covid has changed their career intentions in some way, an increase of 12 percentage points from 2020-2021[16]. The most common change is a significant group of 18.2 percent of total respondents who plan to retire early, followed by 11.9 percent of respondents planning to go less than full time and 6 percent who no longer wish to progress to a more senior role or through training. There is also an increase of 5 percentage points on last year in the number of respondents who would like to work fewer hours, now at 67 percent.[17]

Table 1: Has Covid changed your career intentions in any way?

I now plan to retire early	18.2%
I now plan to go less than full time	11.9%
I no longer wish to progress to a more senior role or through training	6%
I now plan to move to a portfolio career	4.5%
I now plan to leave medicine	4.2%
I now plan to take a career break	4.2%
I now plan to work exclusively in private practice	3.4%
I now plan to progress to a higher grade	1.3%
It has not changed my career intentions	38.1%

6.3 In terms of enacted changes, one in four hospital doctors have relinquished additional responsibilities or seniority since the beginning of the pandemic, while one in six report doing less additional work. Respondents are split on the primary reason for this, with 32.9 percent of those doing less work reporting workplace stress and burnout as the main factor, followed by 30.1 percent reporting work-life balance. Pensions taxation follows as the main factor for 21.2 percent of respondents.[18]

Table 2: Why are you working less?

Workplace stress and burnout	32.9%
Work-life balance	30.1%
Pensions Taxation	21.2%
Working outside the NHS	0.7%

6.4 This can be contrasted with the two in five doctors who told us that since the pandemic began, they have taken on more additional work, with the main reason for doing so "to assist with Covid effort and backlogs" at 44 percent. A further 34 percent have done so to cover vacancies. It is of note that only 12 percent have done so for financial or personal reasons.[19] This implies that the additional work is carried out due to a feeling of obligation to colleagues and patients in the context of understaffing, but not necessarily because it is of personal

[16] HCSA, Hospital Doctors at Work survey of 905 hospital doctors (conducted November-December 2021), HCSA, Hospital Doctors at Work survey of 714 respondents (conducted January-February 2021).
[17] Ibid.
[18] Ibid.
[19] Ibid.

benefit to our members. Once again this year, HCSA warns that goodwill cannot carry on forever, and we see signs that it is waning as staff increasingly burn out and lose motivation through a sense of not feeling valued.

6.5 HCSA is increasingly concerned by retention of senior doctors. In 2020-21, 20 percent of doctors told us they had made definite plans to leave, and in our 2021-22 study, the figure had risen to 29 percent[2021]. The most common reason continues to be "not feeling valued", followed by "workplace stress/burnout". However, "poor work-life balance" and "pay deflation" have overtaken "pension taxation" as the immediate runners up.

Table 3: Reasons for making definite plans to leave the NHS

	2021-22	**2020-21**
Not feeling valued	64.4%	67.1%
Workplace stress/burnout	56.3%	58.2%
Poor work-life balance	55.5% (+6.8%)	48.6%
Pay deflation	51% (+6.5%)	44.5%
Pension taxation	47.8%	49.3%
Bullying culture in the workplace	28.3%	37%
Better flexible working opportunities outside the NHS	24.3%	27.4%

7. Morale, health and wellbeing

7.1 HCSA's annual survey has tracked morale, health and wellbeing for several years. This year we have seen a leap of nearly 10 percentage points in respondents indicating morale level in their workplace as either low or very low – from 60.9 percent in January 2021 to 70.3 percent in December 2021.[22] The rise is particularly significant given that in January 2021 the workforce was coping with peak Covid hospitalisations and winter pressures, and thus we would have hoped to see improvement in morale levels since then. The rise indicates a workforce facing burnout.

7.2 Workplace stress is also continuing to increase in our survey, now 68.6 percent report experiencing about half the time or more, up 5 percentage points on last year.[23]

7.3 HCSA is increasingly concerned that we are experiencing a mental health crisis within the workforce. While data from the charity Mind suggests that one in four people will experience a mental health problem each year, 59.5 percent of hospital doctors reported struggling with

[20] HCSA, Hospital Doctors at Work survey of 714 respondents (conducted January-February 2021).
[21] HCSA, Hospital Doctors at Work survey of 905 hospital doctors (conducted November-December 2021),
[22] Ibid.
[23] Ibid.

their mental health in the last 12 months in our study.[24] Burnout, fatigue and anxiety were the most prevalent conditions.

7.4 This chimes with GMC data, which uses seven measures to give an overall risk of burnout for both trainees and trainers.[25] The GMC report that 15 percent of trainees are at high risk of burnout, which compares to 10 percent prior to the pandemic. Burnout in trainers has also risen by two percentage points.

7.5 GMC also reported that three in five Junior Doctors describe "always" or "often" feeling worn out at the end of their working day. Meanwhile, 44 percent of trainees feel their work is emotionally exhausting to a high or very high degree. Just under a third of secondary care trainers feel frustrated by their work to a high or very high degree.[26]

7.6 HCSA is concerned that the multiple pressures from the pandemic, on top of historical failure to recruit and retain sufficient staff, has taken its toll on the mental health of the profession. A notable one in five hospital doctors reported experiencing moral injury, which is a condition brought on by responding to challenging ethical dilemmas.[27] Such life-or-death decisions became commonplace for doctors during the pandemic.

7.7 It was deeply troubling to find that one in 10 hospital doctors reported experiencing suicidal thoughts in the last 12 months.[28] Clearly, there is a need for urgent investment in staff wellbeing. This must include investment in the basics: ensuring adequate breaks, work-life balance, supportive management and a sense of being valued.

7.8 It is clear that the medical workforce is in a fragile state in terms of wellbeing. This puts into sharp focus the need for rapid action on staffing pressures to shore up vacancies. Pay is a central mechanism in reducing vacancies through recruitment and retention.

8. Sickness rates

8.1 As we reported last year, sickness rates remain lower among hospital doctors than other NHS staff groups. Yet the numbers are steadily rising, as detailed in the table below. The absence figure of 1.65 percent in 2020-21 represents 794,490 FTE days lost this year, equivalent to 2,178 doctors absent for a year. This is an additional 312 doctors compared to last year.

Table 4: Sickness absence amongst HCHS Doctors[29]

[24] Mind, Mental Health Facts and Statistics. Accessed on 15.12.21 https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#References
[25] GMC, National training survey results (2021)
[26] Ibid.
[27] HCSA, Hospital Doctors at Work survey of 905 hospital doctors (conducted November-December 2021)
[28] Ibid.
[29] NHS Digital, NHS Sickness Absence Rates (29.7.21) https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

2016-17	2017-18	2018-19	2019-20	2020-21
1.25%	1.29%	1.29%	1.49%	1.65%

8.2 Stress and mental health issues remain by far the single biggest cause of sickness absence, consistently causing around a quarter of absences in the Consultant and Speciality Registrar groups, and closer to a fifth in doctors in training.

8.3 However, we are concerned sickness absence does not give the full picture and our survey data on mental health suggests a hidden crisis driven by presenteeism. We expect this crisis to become more obvious in coming months.

9. Annual leave suspended

9.1 Nearly a third of hospital doctors indicated that they will be unable to take their full annual leave allowance this year. Of these, nearly half indicated they would lose two weeks or more of leave.

9.2 While this is an improvement on last year, we are far beyond the initial pandemic response and leaders have had opportunity for reflection and strategic planning. It is therefore deeply concerning that resources and systems have not been able to support staff to utilise their contractual leave allowance. Rest is essential for wellbeing. Our survey responses on wellbeing demonstrate a workforce that is at the end of its tether.

10. Training

10.1 While it was necessary in the initial wave to prioritise the pandemic response ahead of training needs, it is now becoming clear that investment is urgently required to avoid a break in the chain of doctors completing their training. We will see an impact on SAS and Consultant numbers if this is not urgently acted upon.

10.2 We appreciate the efforts by HEE to adapt assessments and move to virtual working models in order to maintain training. However, issues remain. For example, the GMC Training Survey indicates that two in five (41 percent) felt they had not been able to compensate transferable skills from other parts of their training, and almost half had not been provided with effective alternatives through simulation facilities and/or exercises.[30] HCSA survey data found a further two in five do not feel they will have fulfilled sufficient competencies and skills to CCT on their predicted date.[31]

[30] GMC, National Training Survey (2021) https://www.gmc-uk.org/-/media/documents/national-training-survey-results-2021---summary-report_pdf-87050829.pdf

[31] HCSA, Hospital Doctors at Work survey of 905 hospital doctors (conducted November-December 2021)

10.3 We are also concerned about the impact on learning from colleagues in a day-to-day context while on placement, which is a less formalised but nonetheless crucial part of the learning package. HCSA data showed a clear majority of applicable respondents (61.7 percent) do not feel they have the time to support junior colleagues on a regular basis. Meanwhile, around 90 percent of Junior Doctors do not receive training on a daily basis while on duty, and more than a third receive this less than once a week.[32]

10.4 Workplace pressures have also impacted study leave, and we found a quarter of Junior Doctors will be unable to take any study leave other than mandatory teaching days in 2021/2022. Meanwhile, four in five Junior Doctors do not have time within normal working hours to complete all requirements for ARCPs.[33]

11. Vacancy crisis

11.1 Once more this year, HCSA would like to place on record its concern that the data on medical staff vacancies vastly understates the reality in hospitals. An illustration of this is in the significant discrepancy between NHS datasets estimating the number of vacancies. Currently, these place medical vacancies at 8,333, 1,003 or 2,526 depending on which NHS digital measure is used.[34]

11.2 Furthermore, a quarter of HCSA survey respondents reported that there were vacancies in their department not officially recognised by their employer.

11.3 Albeit incomplete, the latest NHS England/Improvement figures reveal a significant increase in vacancies of 14 percent. In September 2020, there were 7,262 FTE equivalent vacancies for the medical and dental workforce, whereas by September 2021 there were 8,333. Where we compare June 2020 to June 2021, the rise is 20 percent.[35]

11.4 This trend is replicated in HCSA survey data, with 79.5 percent of respondents reporting unfilled vacancies in their department in 2021-22, a rise of 8 points from 2020-21.

11.5 We are also concerned with how vacancies are covered and the impact on the existing workforce. Three-quarters of hospital doctors said that vacancies were being covered from within the existing staff complement, in part through overtime and additional shifts. Some gaps remain entirely uncovered, with over half of respondents indicating there are unfilled rota or on-call gaps at least once a week or more. Unfilled gaps indicate an unsafe working environment, with staff expected to compensate for fewer colleagues on shift.

[32] Ibid.
[33] Ibid.
[34] NHS Digital, Current vacancy datasets (September 2021) https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey
[35] Ibid.

11.6 An important measure of turnover is through the rate of leavers. NHS Digital turnover tables indicate a leaver rate amongst HCHS Doctors of 13.3 percent - higher than the average for other staff groups, but this is mitigated by its inclusion of external rotations and the completion of training schemes.[36] Unfortunately, NHS Workforce Statistics only capture 'Reason for Leaving' at a global HCHS workforce level, without breakdowns for staff group or job role. However, breakdowns are available in the form of an ESR extract which was published as an FOI response. Of the 17,137 HCHS doctors who left their role in 2020-21, the reason for doing so for 7,791 is unknown.[37] Work must be done to ensure reasons for leaving are adequately captured so that a better understanding of retention issues can be gleaned. Moreover, this data must be published with detailed breakdowns on a regular basis, without the need for FOI requests.

11.7 HCSA warns that we are in the middle of an ever-worsening vacancy crisis, with an increase in declared vacancies on top of many more hidden vacancies that have been absorbed into the existing staff complement.

12. Workforce planning

12.1 The first step in resolving the vacancy crisis is in better data collection to understand the scale of the problem. This must then underpin strategic workforce planning.

12.2 HCSA is in agreement with this evaluation by the DDRB last year on workforce planning: "*However, we are deeply concerned that neither plan included assessments of future medical and dental workforce needs, or specific plans about how to ensure that these needs are met. […] We agree with NHS Providers that comprehensive and fully costed long-term workforce plans need to be published to ensure the sustainability of medical and dental workforces across the UK".*[38]

12.3 Of further interest is the recent report from the Health & Social Care Committee, and we note the comment that, *"Without better short and long-term workforce planning, we do not believe the 9 million additional checks, tests and treatments will be deliverable".* Its report highlights 93,000 NHS vacancies encompassing shortages in nearly every specialism.[39]

[36] NHS Digital, HCHS staff in NHS Trusts and CCGs (March 2021) https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2021#
[37] NHS Digital, HCHS staff leavers by staff group and reason for leaving (15.11.21) https://digital.nhs.uk/supplementary-information/2021/hchs-staff-leavers-by-staff-group-and-reason-for-leaving-mar20-to-mar21
[38] Review Body on Doctors' and Dentists' Remuneration 49th Report (2021)
[39] Health and Social Care Committee, Clearing the backlog caused by the pandemic: Ninth Report of Session 2021–22 (06.01.22) https://committees.parliament.uk/publications/8352/documents/85020/default/

13. Gender Pay Gap

13.1 The Mend the Gap review on the gender pay gap in medicine highlighted the main drivers which include the overrepresentation of women among the less-than-full-time workforce, the underrepresentation of women in roles at higher grades and the imbalance in likelihood of being in receipt of additional payments, including Clinical Excellence Awards (CEA).

13.2 HCSA's engagement as a stakeholder in CEA reform aims to ensure that replacement schemes reflect the findings of Mend the Gap, introducing a fairer and more transparent system and putting proper review processes in place to ensure that these wide-ranging reforms do indeed deliver on the aspiration to reduce biases around protected characteristics and less-than-full-time working. We discuss Local CEA reform elsewhere in this submission.

13.3 Childcare and other caring duties have a significant impact on career prospects. HCSA's 2021 submission highlighted the difficulty experienced by female medics in overcoming career disadvantage caused by taking time out for childcare.

13.4 We are concerned that the pandemic has worsened this issue as school closures and shielding family members required additional care. During the first lockdown, women working in health took on an average an additional 11.22 hours of non-work caring responsibilities per week and reduced their working hours by 1.44 hours in order to address this.[40] This represents additional unpaid work for the female NHS workforce, who were also juggling increased pressures at work. Women in medicine must be supported to recover career opportunities that were missed due to the pandemic.

13.5 Menopause at work is another facet of the gender pay gap. In September 2021, HCSA undertook a survey of members who had experience of the menopause. Over half of survey respondents reported that menopause had a severe or moderate impact on their working life and the majority of respondents did not feel supported by their employer during this time. Survey respondents reported reducing or changing hours, retiring early, taking sick leave, being overlooked for promotion and changing or leaving their roles as a result of menopause. More support for doctors experiencing the menopause to stay in the workplace and maximise their full potential will serve to reduce the gender pay gap.[41]

13.6 The Mend the Gap Implementation Panel has been tasked with putting the recommendations into practice and HCSA is a stakeholder in this process.

13.7 We hope the DDRB will play a role in ensuring these important structural issues are firmly on the agenda. Furthermore, we ask the DDRB to join HCSA in highlighting the additional career detriment that women in medicine have faced as a result of the pandemic.

[40] Health & Care Women Leaders Network, Covid-19 and the female health and care workforce (August 2020)
[41] HCSA, Menopause at Work survey, unpublished (2021)

14. Ethnicity Pay Gap

14.1 HCSA reiterates our call for a full review of the ethnicity pay gap in medicine. This was achieved for the gender pay gap in the Mend the Gap review, which gave useful recommendations on rectifying structural barriers.

14.2 Black, Asian and minority ethnic (BAME) colleagues make up 46 percent of the medical staff group, and this proportion is growing.[42] There is therefore a pressing need to examine issues of recruitment, retention and morale in the context of ethnicity.

14.3 The ethnicity gap is multifactorial, and HCSA is of the view that an important factor is institutional racism within the NHS. Both direct and indirect discrimination place barriers in progression. The GMC Fair to Refer highlights the link between ethnicity and likelihood of a GMC referral.[43] This is an extremely challenging environment for Black, Asian and minority ethnic doctors to advocate for themselves within.

14.4 The pandemic has further exposed and exacerbated existing disparities. Analysis from the first wave showed 18 out of the first 19 UK doctors to die of Covid-19 were from the BAME workforce.[44] An understanding of the factors driving this disparity is paramount.

14.5 Black, Asian and Minority Ethnic members from HCSA have also identified the impact a mentoring scheme could have in supporting their progression. HCSA suggests once more that the DDRB consider how financial incentives could be used to support this key area.

14.6 HCSA notes that in its 49th report DDRB welcomed moves to understand and address the ethnicity pay gap and the impact of Covid-19 on this workforce. HCSA is dismayed by the lack of progress on these issues. While we acknowledge the reference to an ethnicity pay gap review in last year's report, it is now time for the DDRB to join calls for a full review on the ethnicity pay gap in medicine.

15. LCEA reform

15.1 At the time of this submission negotiations on an LCEA successor scheme are at an advanced stage. These talks bring together HCSA, the BMA, NHS Employers, NHS England/Improvement and the Department of Health and Social Care. The strategic priorities set for the group envisaged a scheme which:

- is more inclusive than the current scheme (and which seeks to address issues with gender and ethnicity pay gaps).

[42] UK Government, Ethnicity Facts and Figures – NHS workforce (26.01.21) https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#download-the-data

[43] GMC, Fair to Refer? (2019) https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf

[44] HSJ, Exclusive: deaths of NHS staff from covid-19 analysed (22.04.20) https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

- encourages and rewards excellence and improvement
- is transparent and fair, to address the inequalities in process and outcome in the current scheme.
- is flexible and future-proof, to reflect the differing and changing NHS priorities and available resources among trusts and their consultant workforce locally.
- requires proportionate resource to administer it (proportionate to the funds/benefits).
- underpins the delivery of local or employer priorities.

15.2 Discussions, which have been severely delayed by the pandemic, have attempted to find common ground on a number of central issues including lack of wider Consultant engagement and unequal distribution by protected characteristics which were identified with the historical scheme, while continuing to encourage and reward excellent clinical practice.

15.3 HCSA's over-riding concern is to deliver a scheme which is accessible to the widest possible cross-section of Consultants, and which reduces inequity by race, gender, geography and specialty. Only time will tell whether these fundamental principles are met by the new scheme currently taking shape.

15.4 To ensure that they are, HCSA is of the firm view that it will be crucial to put in place proper reporting systems to measure the success or failure of the LCEA replacement scheme against its key objectives, and we would welcome the DDRB's support for central reporting which would also benefit its assessment of the scheme in future.

15.5 While we are unable to present further detail on the specifics of the discussion, it is currently expected that draft proposals will emerge during the course of the DDRB process. We therefore propose that HCSA's detailed perspective on this area is covered at oral session and through supplementary written evidence.

15.6 The expected timeline for implementation of the LCEA replacement scheme falls within the year in which the DDRB shall make its recommendations. Given that the core justification for failing to uplift this component of the Consultant pay envelope in recent years has been the continuing negotiations around the replacement, we therefore expect the DDRB to now include this component of pay in its recommendations.

16. Pensions

16.1 Pensions remain a valuable element of the overall pay package.

16.2 HCSA survey data indicates that Lifetime and Annual Allowance taxation continues to impact on retention of senior Consultants. Over a third of Doctors at Work survey respondents rated "improved annual/lifetime pension allowance" as one of the top three actions that could be taken to increase recruitment and retention. One in 20 survey respondents want to work fewer hours for pensions taxation reasons, and 3 percent have already reduced their hours

since the beginning of the pandemic for pensions taxation reasons. A further 13 percent have made definite plans to leave the NHS primarily because of pensions tax.

16.3 The Westminster government is currently consulting on a flattening of member contributions to the NHS Pension scheme in England and Wales. Continuing to ask those on higher salaries to pay more than their fair share, or those on lower incomes to contribute more of their already stretched salaries, not only threatens the future viability of the NHS Pension scheme should individuals opt out, but also lessens the attractiveness of the total remuneration package at a time when the health service can least afford it.

16.4 The current government proposal lays out plans to increase contributions for the majority of those earning less than £47,846. For Junior Doctors earning up to £42,120, contributions will increase by 0.5%. For those earning between £42,121 and £47,845, contributions will increase by 0.7% in 2022 and a further 0.7% in 2023. These rises would deliver a considerable impact on take-home pay. If implemented, it will make life less affordable for those starting out on their medical careers, affecting Junior Doctors for at minimum their initial four years of training, and longer dependent on an individual's chosen career path.

16.5 In our view, the government itself should meet any funding needs under a scheme which it chose to introduce, and which, due to its own errors in implementation, breached equalities legislation. Such costs should be seen as a crucial investment in NHS workforce and should not be "solved" by further reducing take-home pay for scheme members through higher contributions.

16.6 However, should the plans go ahead as planned this adds yet a further element to the case for a tangible uplift for Junior Doctors in England over and above the four-year pay deal which the government and DDRB have doggedly adhered to for the past three years.

HCSA pay claim:

Given the extremely challenging landscape now facing the medical profession, in terms of morale and threats to retention but also in terms of the real-terms value of salaries, we are lodging the following pay claim:

- A significant pay award England, Scotland, Wales and Northern Ireland:
    - For all grades: a baseline rise of at least RPI plus the costs of any NI rise for all groups, with a meaningful additional uplift to address erosion of pay for doctors at every grade
    - For Junior Doctors in England and Wales: an additional component mitigating the impact of any pension contribution increase
    - For Junior Doctors in England: an additional 1.8 percent in recognition of the devastating impact of last year's pay award in the context of inflation, Covid pressures and interruption to training
    - For SAS Doctors in England: an additional reimbursement for SAS doctors on the 2021 contract to reflect inflation and financial disadvantage compared to those who did not sign the new contract
- Clinical Excellence Awards and Commitment awards value to increase at the same rate to halt a further reduction to the overall pay envelope