Evidence to the Review Body on Doctors' and Dentists' Remuneration 2025/26

HCSA – the hospital doctors' union

December 2024

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1 Introduction

1.1 The run-up to the 2024/25 pay round saw unprecedented industrial action by hospital doctors, action driven by steep and well-documented real-terms pay cuts over preceding years. Far from receding, the determination among hospital doctors to see these pay cuts finally reversed has solidified.

1.2 Doctors' desire to be properly valued for their work is set in the context of an extremely difficult working environment. The Secretary of State for Health and Social Care says that the NHS is 'broken'.[1]

1.3 The total NHS waiting list in England stood at 7.57 million in September 2024, a small reduction from the historic high of 7.7m 12 months previously.[2] The median waiting time is now 14.4 weeks, a huge increase on the pre-Covid-19 figure of eight weeks. Approximately 3.14m of these patients have been waiting for longer than the 18-week maximum and almost a quarter of a million have been waiting over a year.[3] The 18-week target has not been met since September 2015. And these figures likely do not capture the full scale of the crisis: the Office for National Statistics has found that more than one in five people in England are currently waiting for planned NHS care – an estimated 9.8m.[4] The Institute for Fiscal Studies forecasts that waiting lists will still be far above pre-pandemic levels at the end of 2027.[5]

1.4 The scale of the challenge hospital doctors face in their work is illustrated by the number of referrals from primary care that have failed owing to the absence of available

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[1] The Rt. Hon. Wes Streeting MP, 'The NHS is broken: Health and Social Care Secretary statement', Department of Health and Social Care, delivered 5 July 2024, https://www.gov.uk/government/speeches/statement-from-the-secretary-of-state-for-health-and-social-care.

[2] Total number of referral-to-treatment (RTT) pathways for consultant-led elective care. NHS England estimates the number of unique patients waiting to be around 6.3m, based on its 5 November 2024 analysis of the Waiting List Minimum Date Set. NHS England, Consultant-led Referral to Treatment Waiting Times Data 2024-25, 14 November 2024, https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2024-25/. See explanatory note: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2024/11/Sep24-RTT-SPN-Publication-PDF-387K-05682.pdf.

[3] *Ibid*.

[4] Office for National Statistics, 'NHS planned waiting care times across the UK', 18 June 2024, https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/nhsplannedcarewaitingtimesacrosstheuk/2024-06-18. Survey of 89,000 people over the age of 16. 21% said they were currently waiting for planned NHS care. This greater number reflects waits for planned hospital care not captured by the NHS's RTT data, such as non-consultant-lead care or follow-up consultations. See https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/nhsplannedcarewaitingtimesacrosstheuk/2024-06-18#glossary.

[5] Max Warner and Ben Zaranko, 'The past and future of NHS waiting lists in England', Institute for Fiscal Studies, 29 February 2024, https://ifs.org.uk/publications/past-and-future-nhs-waiting-lists-england.

slots in secondary care. There are 50.6% more appointment slot issues (ASIs) than the pre-pandemic baseline. While this represents a marked improvement on the post-pandemic high of an 84% change from the baseline, the weekly number of ASIs in late September 2024 was only slightly lower than the average over the preceding 12 months.[6] In October 2024, 399,747 referrals failed owing to no slots being available.[7]

1.5 HCSA's annual Hospital Doctors at Work survey paints a stark picture of consistently low morale and dangerous levels of stress and burnout. More than two-thirds (68.5%) estimate that morale in their workplace is currently low or very low.[8] Fewer than half of hospital doctors across all grades said they would recommend medicine as a career to others.[9] Concerningly, this is almost identical to the figure at the time of HCSA's previous full submission to the DDRB in 2021/22, which occurred at the height of the Covid-19 pandemic.[10]

1.6 Hospital doctors continue to emphasise the importance of higher basic wages to the future of the medical workforce, with 47% citing it as one of the steps that would most improve recruitment and retention.[11]

1.7 The overwhelming message from our annual survey is that hospital doctors do not feel valued. One member remarked that 'we do not need staff wellbeing initiatives like free yoga and ice cream. We need improvement in basic pay commensurate with peers outside medicine'.[12] At a minimum, the 2025/26 award must exceed inflation. It should also take into account the deflation of hospital-doctor pay over the last decade-and-a-half and take a real step towards reversing that trend.

2 Reflections on the previous pay round

2.1 The 2024/25 pay award represented limited progress. However, given the scale of pay erosion, we would urge DDRB members to be under no illusion about the extent of doctors' discontent.

2.2 The DDRB award followed separate, negotiated pay uplifts across England, Northern Ireland, Scotland and Wales. Without this important context, the DDRB award alone would have been greeted as wholly inadequate by the vast majority of hospital doctors.

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[6] There were 85,137 ASI events in the week to 23rd September 2024. The average for the preceding 12 months was 88,494. NHS Digital, NHS e-Referral Service (e-RS) open data dashboard, published 4 October 2024, https://digital.nhs.uk/dashboards/ers-open-data.

[7] NHS England, e-RS Appointment Slot Issue (ASI) Monthly Report, October 2024, https://digital.nhs.uk/services/e-referral-service/reports-and-statistics/appointment-slot-issue-reports.

[8] HCSA – the hospital doctors' union, Hospital Doctors at Work 2024. Online survey of 646 hospital doctors conducted October–November 2024.

[9] *Ibid.*

[10] HCSA, Hospital Doctors at Work 2021. Online survey of 905 hospital doctors conducted November–December 2021.

[11] HCSA, Hospital Doctors at Work 2024.

[12] Testimony from consultant HCSA member in Hospital Doctors at Work 2024 survey.

2.3 The previous pay round bucked the trend of recent years. It is important that this is not viewed as a one-off or an outlier: HCSA members' expectation of the reformed DDRB is for clear progress to be made towards restoring pay to pre-2008 levels.

2.4 HCSA appreciated that the DDRB award differed from the NHS Pay Review Body award, demonstrating a more bespoke approach rather than just 'cut and paste'.

2.5 HCSA members in Northern Ireland are yet to even be notified when they will receive their 2024/25 uplifts in pay. This is profoundly frustrating and demotivating. We are concerned that these doctors will be further left behind in the implementation of the 2025/26 round (see section five).

2.6 The previous two pay rounds have occurred in the shadow of industrial action. To ensure that doctors do not feel obliged to renew their mandate to take industrial action, it is crucial that 2025/26 does not represent a step backwards.

3 The pay review process going forward

3.1 In oral evidence in March 2024, HCSA General Secretary Dr Paul Donaldson told DDRB members that the structure of the pay review body was 'the root cause of a lot of problems on pay erosion'. He emphasised that the DDRB 'being fair and being seen to be fair and unshackled from government is crucial if we are going to resolve [then] current disputes'.

3.2 Following negotiations over reform to the consultant contract in England, HCSA, the BMA and the Department of Health and Social Care (DHSC) agreed a number of changes to the DDRB appointment process, remit letter and Terms of Reference.

3.3 A trade-union representative nominated by recognised trade unions will participate in the sifting stage of the appointment process. Trade unions have worked with DHSC to revise the role profile of the DDRB members and chair ahead of future appointments.

3.4 Per the agreement reached with consultants, the health secretary did not include information about inflation or wider economic performance in the remit letter. The remit letter did request that the DDRB consider 'the overall reward package and career progression for resident doctors to ensure that medicine is an attractive and rewarding career choice to deliver our consultants and GPs of the future'. HCSA's findings demonstrate that disquiet over reward and progression via training persists, and we wish for the DDRB to take this into account when making its recommendation.

3.5 The government also pledged, per the agreement reached with consultants, to improve the quality of data submitted to the DDRB so as to provide 'the best possible picture of the prevailing economic conditions and prices, as well as wages in the wider economy, and the impact of pensions on recruitment and retention'. The data and analysis provided by HCSA in this submission (see section eight) makes clear the ongoing need to mitigate the impact of pensions taxation.

3.6 The updated DDRB Terms of Reference state that members must consider 'the need to attract, recruit, retain and motivate doctors and dentists, including consideration of local and regional labour market factors, in view of their contribution to the health of the nation' and 'developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators'. HCSA noted that the 2024 DDRB report specified that data on remuneration was unavailable for key competitor countries such as Australia or Canada.[13]

3.7 The proof of whether these adjustments will be sufficient remains to be seen. In this pay round, HCSA calls on the DDRB to fully exert its independence from governments and recommend a pay award that will be a significant step in reversing real-terms pay cuts.

4 Economic outlook

4.1 The Retail Price Index (RPI) measure of inflation used for pay bargaining was 3.4% in October 2024, the most recent available data at the time of this submission.[14] While this is a significant and welcome decline from the 30-year high of 14.2% two years previously, it is of course not an indication that prices are decreasing. Everyday goods and services remain expensive and continue to rise in cost. The Office for Budget Responsibility forecasts RPI inflation to average 3.5% in 2025.[15]

4.2 Such increases are particularly felt by resident doctors. Rotational training often means that doctors have to live in expensive rental accommodation, incur costs from regularly moving and face difficulty in planning for the future financially (see sections five and 10).

4.3 That the rate of inflation has decreased from the historic levels seen following energy-supply shocks, the 2022 gilt-yields rise and pension-funds crisis, and the Covid-19 pandemic should not be seen as reason for a 'return to normal' in pay recommendations. Doctors' pay still sits well below pre-2008 levels.

4.4 While NHS secondary care was protected from employer National Insurance contribution rises announced in the Budget, details of 'funding allocations' promised to General Practice by the secretary of state for health are yet to be revealed.[16] In the absence of intervention, the predicted impacts on primary care, principally reduced

[13] Review Body on Doctors' and Dentists' Remuneration, *Fifty-second Report: 2024*, 29 July 2024, p. 76, https://assets.publishing.service.gov.uk/media/66a78e18ab418ab055592ebc/DDRB_52nd_Report_2024.pdf.
[14] ONS, RPI All Items: Percentage change over 12 months: Jan 1987=100, October 2024, accessed December 2024, https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/czbh/mm23.
[15] Office for Budget Responsibility, *Economic and fiscal outlook – October 2024*, 30 October 2024, p. 37, https://obr.uk/docs/dlm_uploads/OBR_Economic_and_fiscal_outlook_Oct_2024.pdf.
[16] HC Deb 1, 19 November 2024, vol. 757, col. 147 https://hansard.parliament.uk/Commons/2024-11-19/debates/FC40890E-6EBE-426F-9FEE-5CBF04F22215/OralAnswersToQuestions#contribution-A0F1807E-B672-462D-BADC-D8CB19ADE84D.

capacity through staff shortages, will mean knock-on effects on hospital doctors' working lives.[17]

5 Pay

5.1 Of those surveyed by HCSA who have already made plans to leave the health service, 63.5% say they do not feel valued within the NHS.[18] More than 40% cited pay deflation as a key reason behind their departure.[19] In 2025/26, all grades of hospital doctor across the United Kingdom should see an above-inflation pay award that also takes a step towards reducing years of real-terms pay deflation.

Consultants in England

5.2 The 2024 DDRB report notes both that 'consultants play a central role in terms of delivering healthcare and reducing waiting lists' and that professions equivalent to medicine retain higher earning potential.[20] HCSA consultant members voted to accept the contract reform negotiated with the government on the basis that a reformed pay-review process would see redress for years of pay erosion. It remains inappropriate that the pay of the most senior, most qualified healthcare professionals in our health service lags behind that of equivalent professions. When it comes to retaining senior doctors, this is unsustainable.

5.3 Even in light of reform to the Lifetime Allowance, HCSA remains deeply concerned about the impact of pensions taxation on senior doctor retention and retirement rates. Partial retirement represents an imperfect solution (see section eight), and even new pay uplifts are treated with caution given the fear of incurring Annual Allowance charges. The 2024 DDRB report notes the ambition of the NHS Long Term Workforce Plan to increase the number of consultants in England by almost 50%. To maintain the necessary decline in leaving rates, the pensions-tax issue must be resolved.

SAS doctors in England

5.4 It was the view of HCSA SAS doctor members that the DDRB pay award, and the preceding negotiated pay settlement to which HCSA was not a party, did not go far enough. This was especially the case for those on the 2008 specialty contract, although it was positive to see both SAS contract groups included in the DDRB's recommendation. Members remain concerned about levels of pay, disparity between contracts and career-development opportunities.

5.5 The 2021 specialist contract remains problematic. Of those SAS doctors surveyed by HCSA who are yet to move to the 2021 contract, over half have not done so because of

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[17] Kate Whannel, 'GPs and care homes fear impact of National Insurance rise', BBC News, 11 November 2024, https://www.bbc.com/news/articles/cgl409gww1go.
[18] HCSA, Hospital Doctors at Work 2024.
[19] *Ibid*.
[20] DDRB, *Fifty-second Report*, pp. 14 & 75.

changes to terms and conditions, with a similar number citing losses in pay.[21] And those who have not switched face deep unfairness, with attempts to browbeat them into changing to new terms by suppressing their pay. This is plainly unacceptable – and hugely damaging when it comes to retaining talented doctors. It was good to see the DDRB note the disincentives in its 2024 report.[22]

5.6 Given the issues with the 2021 contract, there was anger among HCSA SAS doctor members that the negotiated 2023/24 uplift initially made no offer to those on older contracts. The revised offer of £1,400 was still considered insufficient. The need for redress for both this group and those who suffered financial detriment by moving into specialist roles persists.

5.7 HCSA was a proud early supporter of the SAS Six, firm policies to improve career progression for and ensure fair treatment of SAS doctors, and remains committed to their implementation. Addressing the pay structure should go hand in hand with implementation of these policies to ensure SAS doctors get a fair deal in their careers.

Resident doctors in England

5.8 After years of significant pay erosion, and their exclusion from several pay awards, resident doctors engaged in strike action on an unprecedented scale over the last two years. For HCSA, this was the first time in our union's history that members had gone on strike.

5.9 HCSA resident-doctor members cautiously approved of progress made in the 2024/25 DDRB recommendation and the 2023/24 negotiated pay settlement on the understanding that together these represented an initial step on the path to pay restoration. Alongside their undiminished desire to see resident-doctor pay restored to 2008 levels, members cited the costs of exams, courses and childcare, the need to improve rotational training and the state of mental health of the resident-doctor workforce as issues that should be considered in future pay rounds.

5.10 HCSA's annual survey reveals that issues with work–life balance, which often affect individuals and families financially, persist. Nearly a third of resident doctors surveyed by HCSA had missed an event of major life significance owing to being unable to get leave approved.[23] Some even preferred fixed leave, reporting that 'sure, it was an inconvenience, but at least we got our leave' and that

> *"the restrictions on when leave can happen are so restrictive that nobody I know has ever used their full allowance – it's simply not possible to fit it in with the crazy regulations, so we just lose it".*[24]

[21] HCSA, Hospital Doctors at Work 2024.
[22] DDRB, *Fifty-second Report*, p. 140.
[23] HCSA, Hospital Doctors at Work 2024.
[24] All testimonies from resident doctors responding to HCSA's Hospital Doctors at Work 2024 survey.

5.11 There is also the enormous day-to-day and long-term impact that rotations can have. One member shared: 'I moved six trusts and nine departments in four years. I had to relocate almost every six months and it's excessive and unnecessary'. Another bemoaned 'lots of moving, no financial stability, effects on family life, lack of permanent residence, loss of finances over renting'. Rotations often leave doctors living some distance from their workplaces, with extended commutes prior to or following lengthy, tiring shifts 'compounded by no access to parking onsite'.[25]

5.12 Better pay and superior work–life balance are on offer to resident doctors abroad, with health authorities in several countries actively recruiting UK medical graduates. Indeed, HCSA is aware of multiple cases where members have left the NHS to work in medicine abroad. In one example, a Specialist Trainee who this year moved to Australia on completing their training told HCSA:

> *"Forty hours per week is regarded as full time here. Evenings you get 25% extra, Saturdays 50% extra, Sundays 75% extra and bank holidays 150% extra. Any hours above 80 per fortnight are paid at 50% extra. Although I am currently completing a fellowship, my pay is better than it would have been as a new consultant in the NHS, for less responsibility".*

> *"I am getting my UK qualifications accredited here. Although this is a very expensive process it will be worth it – if I go on to work in the private sector I could earn an NHS consultant salary just by working one day per week. If you work two to three days per week you can really have a very nice lifestyle. There is no comparison."*

5.13 Many HCSA resident doctor members in England were frustrated not to see the Westminster government propose a similar arrangement to that now agreed with resident doctors in Scotland, with a mutual commitment made to restoring pay in the short-to-medium term. The expectation is that in England this process must occur via the DDRB, with the body recommending a succession of pay uplifts as part of a roadmap to fully restore resident doctor pay within the next few years. The prospect of further industrial action cannot be ruled out otherwise.

[25] *Ibid*.

Locally employed doctors (LEDs)

5.14 LEDs now make up a sizeable proportion of the medical workforce.[26] It is vital that local contracts mirror national pay scales to ensure fairness, yet HCSA members report that local variation continues to be widespread.

5.15 HCSA's membership includes LEDs whose closest equivalent role is that of a core trainee, and who are likely counted as such in payroll data. But there are locally employed HCSA members whose closest equivalent role is at SAS grade, who are not on SAS contracts on trust payrolls. HCSA has called for all suitably qualified LEDs to be given the opportunity to transfer to SAS contracts.

5.16 These discrepancies, and variation in local payroll data, demand a nationally coordinated process of data consolidation and alignment. The relative over-representation of doctors who qualified outside the UK in locally employed roles, and the potential equalities ramifications, make this requirement all the more pressing.

Scotland

5.17 HCSA members were encouraged to see the Scottish Government acknowledge the principle of pay erosion in the 2023 settlement reached with resident doctors. Across all contract groups, the expectation is that the 2025/26 and future pay rounds in the immediate term will seek to restore pay via successive above-inflation uplifts.

5.18 Resident doctors in Scotland notably see the potential for superior work–life balance and/or earning potential abroad. One former member who did their training in Scotland told HCSA that, after moving to New Zealand,

> *"there are more protections on rostering for ED/ICU specifically – you can't be made to work more than five days in a row [and you get] a minimum of two consecutive days off in each seven-day period. All residents also get an extra day off after a set of night shifts … and you can't be made to work more than two long days per week".*

5.19 There was an outcry among HCSA resident-doctor members when NHS Education for Scotland (NES) announced new restrictions on already meagre study-leave budgets. While these were eventually withdrawn for further consultation following the pushback, the status quo still sees most residents paying out of pocket to attend necessary training.

Wales

5.20 We were encouraged to see the then cabinet secretary praise doctors for 'their value and their contribution to the NHS in Wales' as he accepted the 2024/25

[26] General Medical Council, 'The state of medical education and practice in the UK: Workforce report 2024', 28 November 2024, p. 6, https://www.gmc-uk.org/-/media/documents/somep-workforce-report-2024-full-report_pdf-109169408.pdf.

recommendations of the DDRB.[27] This was a welcome change from Welsh Government claims to trade unions in recent years that it was hamstrung by insufficient funds allocated to the NHS.

5.21 In consultations, HCSA consultant members in Wales remain concerned about the level of pay, with many feeling the negotiated and DDRB pay awards over the last 12 months were too low, and of commitment to reform of the DDRB. Resident doctors welcomed the negotiated agreement and the 2024/25 DDRB award, though dissatisfaction remains widespread.

5.22 We note with approval the Cabinet Secretary for Health and Social Care's wish in his remit letter to the DDRB that receipt of this year's award not be unduly delayed beyond April 2025.

Northern Ireland

5.23 Pay erosion has seen medical pay in Northern Ireland fall behind that in England, Scotland and Wales, contributing to doctors leaving to work in the Republic of Ireland and the erosion of doctors' professional standing.

5.24 The proximity of better-paid, higher-status roles in the Republic of Ireland present a unique challenge to NHS retention, in that many doctors living in Northern Ireland do not even need to move house in order to take up a role in the South.

5.25 In a historic first, over the summer HCSA consultant members in Northern Ireland voted to strike over pay. The dispute ended with members voting to accept the Northern Ireland Executive's offer on pay, which was backdated to 1st March 2024.

5.26 However, it took until late November 2024 for the Minister of Health to finally confirm he sought to implement the DDRB's 2024/25 recommendations in full – and to then claim that he required greater funds to be allocated to the health budget to do so. It is unacceptable that doctors' receipt of awards in Northern Ireland should lag behind that of colleagues in other jurisdictions. Aside from the financial detriment to our members, this has served to undermine recent progress on pay and trust. We request that the DDRB remind governments of the importance of swift implementation when it makes it recommendations.

6 Morale, health and wellbeing

6.1 HCSA found that almost half of hospital doctors have struggled with their mental health in the last 12 months.[28] Nearly half (44%) have suffered from anxiety, 20% from

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[27] Mark Drakeford MS, Cabinet Secretary for Health and Social Care, Written Statement: Responding to the 37th NHS Pay Review Body and 52nd Doctors and Dentists Review Body reports, 10 September 2024, https://www.gov.wales/written-statement-responding-37th-nhs-pay-review-body-and-52nd-doctors-and-dentists-review-body.

[28] HCSA, Hospital Doctors at Work 2024.

depression and 7.5% have had suicidal thoughts.[29] While these figures may shock, they are unlikely to surprise. They suggest, quite simply, an ongoing mental health crisis among hospital doctors.

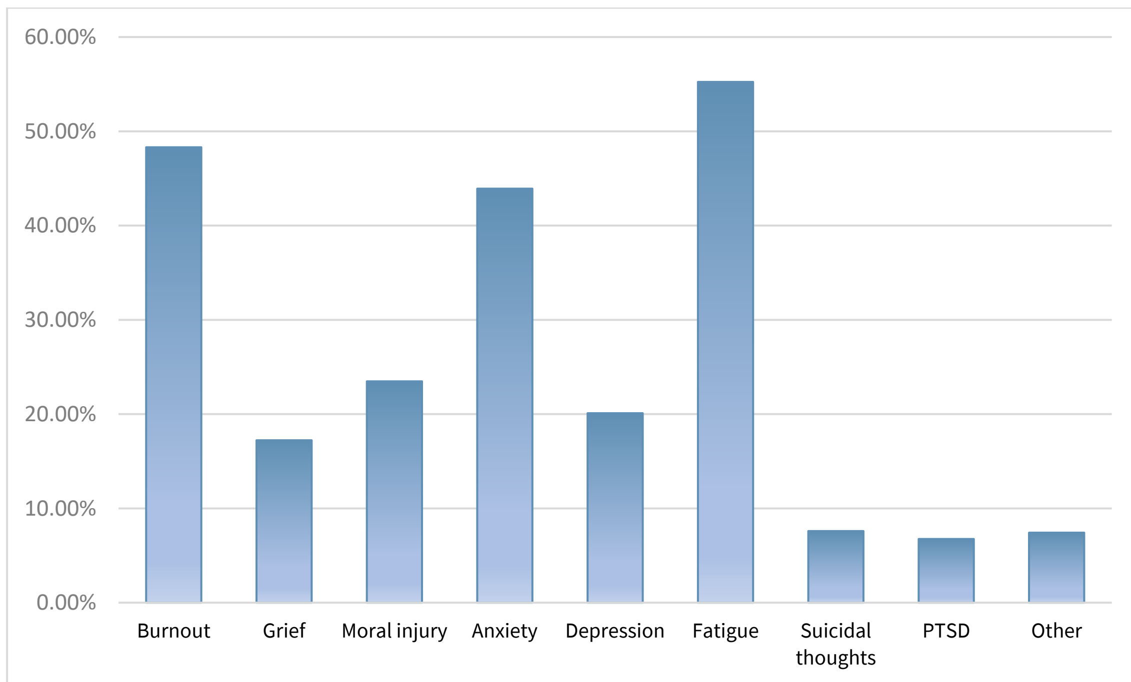

Figure 1. Mental health issues experienced by hospital doctors in the last 12 months[30]

6.2 Workload is a clear contributing factor, with 55% of respondents experiencing fatigue in the last 12 months and almost half experiencing burnout.[31] More than 60% would like to work fewer hours if the option were available, with work–life balance (57.5%) the most commonly cited reason, followed by stress and pension taxation.[32] More than one in five relinquished additional responsibilities or seniority early or before the term was due to end, and a quarter are doing less extra work – fewer additional lists or hours outside of their job plan.[33] The main reasons that why people are working less are work–life balance (37%), workplace stress and burnout (25.5%) and pensions taxation (17%).[34]

6.3 Of those who have already made definite plans to leave the NHS, 63.5% cite workplace stress or burnout and 53% cite poor work–life balance as major reasons behind their decision.[35]

[29] *Ibid*.
[30] Data from HCSA, Hospital Doctors at Work 2024 survey. 'Moral injury' refers to psychological damage owed to ethical dilemmas.
[31] HCSA, Hospital Doctors at Work 2024.
[32] *Ibid*.
[33] *Ibid*.
[34] *Ibid*.
[35] *Ibid*.

7 Vacancies

7.1 Despite both the medical and the wider NHS workforce having increased in size since 2020, in the latest NHS Staff Survey just 21% of consultants felt that there were enough staff at their organisation to enable them to do their job properly.[36]

7.2 According to HCSA's own research, fewer than one in five say there are currently no unfilled hospital doctor vacancies in their departments. Even more concerningly, of those with unfilled vacancies, only a third say all vacancies are officially recognised by their employer.[37] Issues in recruitment combine with other challenges to have an impact directly on patient care: 42% say that their department has rota gaps that remain uncovered once a week or more. For 8% of respondents, there are uncovered gaps *every day that they work*.[38]

7.3 Doctors are already being asked to do more, regardless of mooted new national policy solutions to tackle the backlog, and feel undervalued for doing so. Of those who report to HCSA that they are working more in the last 12 months, the greatest number are doing so to cover vacancies or assist with backlogs.[39]

7.4 Threats to retention across all grades in the face of eroded pay, pensions tax bills and poor work–life balance will not improve this situation. Twenty-nine percent have already made definite plans to leave the NHS, with 42% of these retiring, and medical roles in the private sector or abroad also commonly cited reasons.[40]

Reason	%
Not feeling valued	63.4%
Workplace stress/burnout	63.4%
Poor work–life balance	52.8%
Pay deflation	41.6%
Pension taxation	40.4%
Bullying culture in the workplace	32.9%
Unhealthy physical work environment	26.1%
Excessive hours	21.7%

Table 1. Hospital doctors' reasons for making definite plans to leave the NHS[41]

[36] National average of 20.99% for occupation group 'Medical / Dental – Consultant'. NHS, NHS Staff Survey 2023, 7 March 2024, https://www.nhsstaffsurveys.com/.
[37] HCSA, Hospital Doctors at Work 2024.
[38] *Ibid*.
[39] *Ibid*.
[40] *Ibid*.
[41] Data from HCSA, Hospital Doctors at Work 2024 survey; HCSA, survey of 905 hospital doctors, conducted November–December 2021; and HCSA, survey of 714 hospital doctors, conducted January–February 2021. Rounding differences may result in minor variation from percentages given in the body of the text.

8 Pensions

8.1 In HCSA's Hospital Doctors at Work survey, of those who have made definite plans to leave the NHS, 40.5% cited pension taxation as a major factor behind their decision.[42]

8.2 HCSA welcomed significant changes to pensions tax that came into force in April 2023, including the abolition of the Lifetime Allowance and an increase in the Annual Allowance to £60,000. However, Annual Allowance remains an issue for doctors, particularly in light of any uplifts in pay. HCSA continues to call for the abolition of Annual Allowance for defined benefit schemes.

Partial retirement

8.3 In HCSA's survey, 32% of consultants tell us they have considered partial retirement. Of those, almost half cite pensions tax as the reason, and 27% point to the ability to earn more income. Access is not equal, with variation by trust – some doctors report to HCSA that their employers were uncooperative when they sought to discuss partial retirement. Hence, as a method of encouraging our most qualified doctors to stay in the NHS, partial retirement is not a solution that works for everyone, given doctors are at the mercy of their employer's decisions on the matter.

8.4 A further issue is the nonsensical and arbitrary requirement that doctors drop their pensionable pay by 10 percent for 12 months. This incentivises doctors to cut back on work despite persistent staffing shortages. Meanwhile, in practice, these shortages make it difficult for many doctors to reduce their hours at all. Some employers have mitigated this by providing means for doctors to make part of their pay non-pensionable, to allow them to continue working at full capacity while drawing pension that may otherwise be lost owing to the lack of late-retirement factors in the 1995 scheme. HCSA's position is that DHSC should, through NHS Employers, compel all trusts to offer this provision, in order to retain senior doctors. This would however require clear central guidance, including how to record it on the NHS's Electronic Staff Record (ESR) system. There is currently confusion over how to manage scenarios such as split contracts and some trusts' legal teams are cautious in the absence of a nationally agreed position.

Tax-free lump sums

8.5 The 1995 scheme sees retiring doctors receive a fixed lump sum of three times their annual pension, which remains linked to their final salary. Rather than this automatic lump sum, those in the 2008 or 2015 schemes can choose to commute annual pension (at £1 of index-linked pension for £12 of lump sum) to receive a tax-free sum capped at £268,275 (25% of the now-abolished Lifetime Allowance).

8.6 Rumours over reductions to the tax-free lump sum have led to mistrust and uncertainty, especially among those in the 1995 scheme with a fixed lump sum. With pensions such

[42] HCSA, Hospital Doctors at Work 2024.

a significant component of pay, the effects of any such changes on workforce retention should not be underestimated.

Effect of pay uplifts

8.7 Almost a quarter of consultants are set to incur a pensions Annual Allowance charge as a result of recent pay uplifts, while over 60% are unsure whether they will or not. A striking 79% are concerned about incurring an Annual Allowance charge as a result of pay uplifts in the future.[43]

8.8 Stories shared with HCSA included testimonies such as:

> *"The recent pay uplift (increment and pay rise) has meant that I have had to significantly reduce my hours to mitigate an Annual Allowance pension taxation. I am a year nine/ten consultant and will be hammered by the charge if I remain working full time".*[44]

8.9 This concern is compounded by the sheer complexity of calculating pensions taxation. While the McCloud remedy may not be linked directly to pay, it does mean that doctors face a complicated task to calculate what they can safely earn. It is vital to understand that doctors view their pension as a central component of their pay. Disquiet over pay is likely to continue without the pensions-tax issue being resolved.

Conclusion

8.10 HCSA's long-held position is that Annual Allowance is not an appropriate tax for defined-benefit schemes. The uncertainty felt by hospital doctors who fear a brown envelope in the post adversely affects mental health, individuals' ability to plan for their futures and retention of senior doctors. Our data shows that many doctors prefer to take pre-emptive action by reducing their hours or leaving the NHS altogether. It is crucial that pensions policy does not inadvertently push senior doctors out of the NHS.

9 Consultant reward schemes

9.1 HCSA is concerned that National Clinical Impact Awards (NCIAs) cannot be an important component of the potential reward package if awareness is so low. As many as 38% of those surveyed by HCSA say they do not know what a National Clinical Impact Award is. Forty-eight percent know what one is but have no intention of applying for one in the future. Of those who currently hold an NCIA, one in 10 say the award has made them significantly more motivated but 77% say it has made no difference.[45]

9.2 Meanwhile, the vast majority of respondents say the existence of the NCIA scheme makes them neither more nor less motivated at work, with only 3.5% saying the

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[43] *Ibid*.
[44] Testimony from consultant HCSA member in Hospital Doctors at Work 2024 survey.
[45] HCSA, Hospital Doctors at Work 2024.

scheme's existence makes them more motivated and 18.5% saying it actually *reduces* their level of motivation.

9.3 During negotiations between HCSA, the BMA, NHS Employers, NHS England/Improvement and DHSC to establish a successor scheme to Local Clinical Excellence Awards (LCEAs), the strategic priorities for any new scheme stipulated that it should be more inclusive, seeking to address gender and ethnicity pay gaps, and transparent and fair, addressing the inequalities in process and outcome in the LCEA scheme. HCSA's research findings, however, suggests there may be work to be done in improving access to NCIAs.

9.4 This is compounded by the fact that the relationship between old-style Clinical Excellence Awards and NCIAs is confusing – this is currently the subject of active discussion between recognised trade unions and DHSC. At present, LCEA holders are effectively excluded from applying for NCIAs.

9.5 HCSA notes that the DDRB has felt unable to draw conclusions on the NCIA scheme in England and Wales owing to a lack of evidence.[46] HCSA's position is that while they can, when properly advertised and administered, contribute to a professional reward package, clearly for the vast majority of consultants such awards are no replacement for a robust basic pay structure that reverses historical deflation.

10 Training

10.1 At present the demands on the lives of resident doctors are not matched by pay or, for many, professional development. HCSA research shows that64.5% believe their employer doesn't make their training a priority. This is no surprise when 29% never receive training while on duty and only a quarter receive training more than once a week.[47] Trainees report an overwhelming focus on service provision at the expense of their training.

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[46] DDRB, *Fifty-second Report*, p. 140.
[47] HCSA, Hospital Doctors at Work 2024.

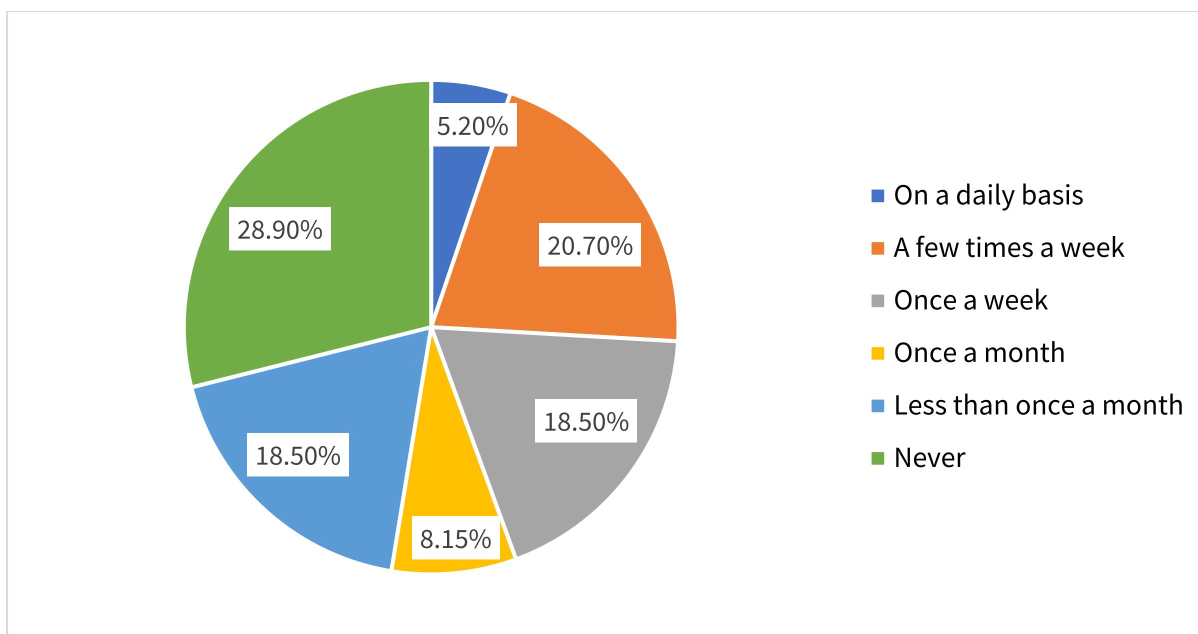

Figure 2. Frequency with which resident doctors receive training while on duty[48]

10.2 NHS England's Educator Workforce Strategy notes that if the health service doesn't 'train now and recover lost training', the result will be 'further demoralising trainees with a risk to retention'.[49] The increase in medical school places – the GMC estimates 6,213 more UK graduates starting training per year by 2034 – will not improve this situation, with bottlenecks in certain specialisms and strain on supervisors only set to increase unless we also see additional training places and prioritisation of in-work training.[50]

10.3 The Educator Workforce Strategy states plainly that 'without educators, we do not have a future workforce'.[51] If the consultants of tomorrow are to be properly trained, clinical and educational supervisors must also see their work properly reflected in their job plans.

10.4 HCSA is concerned by cases where members feel they have suffered significant detriment to their training and career-development owing to parenthood or caring responsibilities, as illustrated by the respondent to our survey who said training and rotations were

> *"hugely problematic with a new baby. [If I were to become] less than full time (LTFT) or [take] parental leave I have been told that I will have to delay*

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[48] Data from HCSA, Hospital Doctors at Work 2024 survey. Rounding differences may result in minor variation from percentages given in the body of the text.
[49] NHS England, Educator Workforce Strategy, 1 March 2023, updated 23 August 2024, https://www.england.nhs.uk/long-read/educator-workforce-strategy.
[50] GMC, 'The state of medical education and practice in the UK', p. 8.
[51] NHS England, Educator Workforce Strategy.

speciality applications by an entire year … I'm fed up with having ridiculously strict rules imposed to use progression as a stick to beat trainees with".[52]

Time out of training

10.5 A quarter of resident doctors surveyed by HCSA are either already taking time out of training or are planning to do so.[53] Of these, reasons cited include a lack of training places in certain specialisms, workplace stress and work–life balance factors such as caring responsibilities.

10.6 The GMC found that in between 2011 and 2023, almost 12,000 doctors who had completed two foundation years in postgraduate training never entered core or specialty training.[54] Part of this can be explained by the huge stress on the system. But research into the specific 'Post-Foundation Training Break', sometimes known as F3, found that 'personal fulfilment', taking 'a break from training or work environment' and 'improving health and wellbeing' were the three reasons most commonly cited by such doctors.[55] This aligns with HCSA's own research, with the grind of training not matched by fulfilment or reward.

11 Ethnicity pay gap

11.1 HCSA has been warning about the ethnicity pay gap in its submissions to the DDRB and in dialogue with employers for several years.

11.2 Over half of doctors surveyed by HCSA who identified as belonging to a minority ethnic/global majority group believe that their ethnicity has negatively impacted their career progression.[56] This can manifest in direct racial discrimination: 62% have not felt able to report incidents of racism over their career as a whole, an extraordinary 45% have experienced a racist incident in the workplace in the last 12 months alone and 28.5% have considered leaving their jobs due to a racist incident.[57]

11.3 But the negative impacts are multifaceted. NHS Workforce Race Equality Standard data identifies 61% of SAS doctors as belonging to an ethnic minority, but only 40.5% of consultants and 34.7% of senior medical managers are so identified.[58] This disparity in representation within senior roles means that proportionally fewer hospital doctors from ethnic minority backgrounds benefit from pay-progression uplifts than their

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[52] Testimony from resident-doctor HCSA member in Hospital Doctors at Work 2024 survey.
[53] HCSA, Hospital Doctors at Work 2024.
[54] GMC, 'The state of medical education and practice in the UK', p. 7.
[55] Dr Helen Church, Dr Steven Agius and Liam Jenkins, *The Post-Foundation Training Break ("F3"): Evaluating its Impact on Postgraduate Medical Training*, p. 27, 9 June 2023 https://www.gmc-uk.org/-/media/documents/final-report-postukmedreview_pdf-101155712.pdf.
[56] HCSA, Hospital Doctors at Work 2024.
[57] *Ibid*.
[58] NHS England, NHS Workforce Race Equality Standard (WRES): 2023 data analysis report for NHS trusts, 18 March 2024, p. 11, https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/.

white colleagues. Further, the GMC's 2024 workforce report found that 81% of SAS doctors and more than two-thirds of LEDs in England and Wales qualified outside the UK.[59] Local terms in many cases may not match national pay scales – and many LED roles provide limited scope for progression.

11.4 NHS England found that, 'in 98.6% of NHS trusts, a lower percentage of BME staff than white staff felt that their trust provide[d] equal opportunities for career progression or promotion'.[60] Similarly, alongside direct discrimination, such as racism, and fear of speaking out, those surveyed by HCSA cite cultural bias favouring white employees and bias in recruitment processes as key factors driving the ethnicity pay gap.[61] These experiences track with the NHS's own findings that the 'shortlisting and interview process discriminates against BME applicants' and that 'BME doctors are underrepresented in consultant-grade roles'.[62]

11.5 Development opportunities, transparent recruitment processes, support networks and a zero-tolerance approach to racism by employers are all popular ideas for changes that would help narrow the ethnicity pay gap.[63] HCSA welcomes NHS Providers' publication in October 2024 of a guide for employers to tackle ethnicity pay gaps in their organisations. However, its recommendations on career development do not specially address locally employed roles and disparities in the makeup of the medical workforce at different grades.[64]

12 Gender pay gap

12.1 Four years on from the publication of the findings of the Mend the Gap review of the gender pay gap in medicine, many of the same issues persist.

12.2 Addressing imbalance in the likelihood of receipt of additional payments such as Clinical Excellence Awards were a principal aim of HCSA, and an agreed focus of the wider group, during negotiations to reform LCEAs. HCSA is concerned that the lack of awareness and understanding of newer awards schemes discussed elsewhere in this submission may leave this imbalance unrectified.

12.3 Progress was made by HCSA, the BMA and DHSC on reforms to the consultant contract in England, which will reduce the number of pay points and see consultants reach the top of the scale more quickly. We anticipate this reducing the gender-discriminatory experiences of the previous pay scale. The equalities impact of new pay-progression

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[59] GMC, 'The state of medical education and practice in the UK', p. 6.
[60] *Ibid*, p. 25.
[61] HCSA, Hospital Doctors at Work 2024.
[62] NHS England, Medical Workforce Race Equality Standard (MWRES): WRES indicators for the medical workforce 2020, July 2021, pp. 4–5, https://www.england.nhs.uk/wp-content/uploads/2021/07/MWRES-DIGITAL-2020_FINAL.pdf.
[63] HCSA, Hospital Doctors at Work 2024.
[64] NHS Providers, 'Strategies for Minimising and Closing the Gap' in *Counting the Cost: Understanding Your Ethnicity Pay Gap*, 21 October 2024, https://nhsproviders.org/counting-the-cost-understanding-your-ethnicity-pay-gap/strategies-for-minimising-and-closing-the-gap.

pathways will need to be carefully monitored, including the potential for unconscious bias or direct discrimination in the review meetings that are mandatory for pay progression.

12.4 In our 2023 submission to the DDRB, HCSA highlighted how frequent rotation and time away from family in training roles can make LED roles appeal to those with caring responsibilities. In this year's HCSA Hospital Doctors at Work survey, one of the most common reasons given for taking time out of training was maternity leave.[65]

12.5 HCSA resident doctor members cite the unequal impact of pay erosion on those women who have children. One member, for example, shared that "As a working mum and a LTFT trainee this was particularly impactful, as my training was longer compared to many, and therefore the impact of each subsequent year's pay erosion cumulative". Others point to their concern that backdated pay agreements do not take into consideration those on maternity leave during the periods in question.

12.6 The gender pay gap also contributes to and manifests in a gender pensions gap. Under the career-average 2015 NHS Pension scheme, periods of reduced pay will have a long-term impact on a member's pension pot.

12.7 Too often doctors see little consideration by employers of the equalities impacts of non-pay financial issues. The restrictions on study-leave allowances that NES attempted to impose in October 2024, for example, would have had a disproportionate impact on LTFT trainees, who would have seen annual budgets reduced in relation to their working hours. This disregarded the necessary requirement for all mandatory training to be completed regardless of hours worked and therefore may have negatively affected working mothers and those with caring responsibilities.

[65] HCSA, Hospital Doctors at Work 2024.

13 Pay claim

In light of the severe challenges the medical profession continues to face, and the impact of these challenges on morale and retention, HCSA is lodging the following pay claim.

1. A significant pay award for all grades of doctors and dentists in England, Northern Ireland, Scotland and Wales: a baseline rise for all contract groups of at least the latest available RPI inflation figure, plus a meaningful additional uplift to address the erosion of pay, with the ambition of restoring pay to pre-2008 levels in the short term.

2. The award for SAS doctors in England, Northern Ireland, Scotland and Wales to include both the 2008 and 2021 contract groups.

3. The value of NCIAs to increase at the same rate as basic pay so as to avoid reduction in the overall pay envelope.

4. The recommendation that the NCIA scheme be reviewed to ensure it is fair and accessible to all consultants.

5. The DDRB to explicitly recommend the reversal of pay erosion for every grade of doctor across the UK, to be achieved via successive above-RPI awards over the short term.