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BMA

Representation to Treasury – Autumn Statement 2023 - BMA

About the BMA

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population.

Summary of key asks

- Full additional funding for the NHS of an above inflation pay uplift for all doctors in 2023/24 (including full additional funding of the existing uplifts provided, alongside equivalent Barnett consequentials for the devolved nations) to be negotiated by the government with the BMA, as a step towards reversing the significant pay cuts doctors have faced, and ensure there is sufficient workforce to hit performance targets now and in the future.
- Further funding for general practice, including ringfenced funding for a 'New to Partnership Programme'; significant uplifts to global sum funding elements and the Statement of Financial Entitlements (accommodating inflation, rising staffing expenses and necessary practice running costs); greater flexibility in how general practice can use existing funding for the 2024/25 financial year; and a GP trainee pay premia uplift to ensure ongoing recruitment and necessary expansion of the GP workforce.
- On pension taxation, the Annual Allowance should be indexed with inflation and the taper should be removed.
- The NHS and DHSC capital budget should be uprated in line with inflation and provided with additional funding so that the real value of the allocation for 2023/24 and 2024/25 is at the level expected when the Spending Review was published.
- The local authority public health budget should be restored to 2015/16 levels per capita in real terms.

Many of the proposals in the representation are focussed on England but we are requesting additional funding in the DHSC allocation for staff pay and for capital spending, which will inevitably have Barnett consequentials. These should be used directly for sorely needed spending on health services, rather than on paying down debt.

Restoring secondary care doctor pay will ensure there is sufficient workforce to hit targets

Over the last decade and a half, public sector pay has been cut significantly in real terms. It is clear that doctors have faced the largest cuts, not just compared to other workers in the economy but also compared to other staff groups in the NHS.

As a result, pay is no longer commensurate with the skills and experience of doctors, compared to other highly qualified workers in the economy (for example, analysis published by the DDRB (Doctor's and Dentist's Pay Review Body) found that the median salary of consultants is 'substantially lower' than that of those working in tax and accounting, legal and actuarial groups).

The pay uplift offered for the 2023/24 financial year represents yet another cut. For many doctors this is below the average across the rest of the economy (consultants and some SAS doctors in England received a 6% uplift, yet current average weekly earnings growth across Great Britain is 8.5%; whilst doctors in Northern Ireland have received no pay uplifts at all). Consultants have also had the value of their Clinical Excellence Awards frozen so in effect receive less than 6%. Doctors do not feel this signifies a meaningful attempt to redress the impacts of this years' inflation on their pay, let alone the compound impact of cuts since 2008/09.

Doctors are also seeing better pay and conditions available elsewhere, for example in Australia, Canada, Ireland and the Middle East. As long as pay and conditions in the NHS remain inferior to other comparable nations, there is a significant risk of doctors leaving.

And the wellbeing of the workforce is suffering, staff are burnt out, and vacancy rates are high: as of June 2023, there were over 10,000 medical vacancies in the NHS in England, amounting to over 7% of all medical posts.). This creates a vicious circle of recruitment and retention issues leading to burnout and further staff leaving.

Therefore, doctors have had no choice but to take Industrial Action. This has had a significant impact on the NHS' ability to perform over the last six months, with over 500,000 staff reported absent across the total days of strike action in England, and over one million procedures cancelled. And regrettably, it is making it impossible for Trusts to reduce the waiting lists that were already so high prior to this period of Industrial Action. If waiting lists are not brought down, this will have a significant impact on the economy (IPPR estimates the value of bringing down the waiting list would be £73 billion over the next five years). Industrial Action itself is also very costly to the NHS, with the Chief Financial Officer reporting to the NHS England Board that action to the end of July has had a cost impact of £550 million with lost activity valued at a further £550 million.

As long as the government is unwilling to negotiate a credible offer with doctors, ongoing Industrial Action will continue to disrupt services and a lack of a meaningful offer on pay increases the risk of doctors leaving – so continuing to refuse to negotiate on the grounds of cost is a false economy. The BMA is calling for above inflation pay for all doctors, to address the real terms pay erosion they have experienced with the aim of reaching full pay restoration in the near future. The Treasury should urge governments across the UK to negotiate and commit to providing additional funding to the DHSC budget and Barnett consequentials in all nations for any agreed pay uplifts negotiated with the BMA, as well as any future deals in line with recommendations from a reformed Review Body on Doctors' and Dentists' Remuneration (DDRB)[1].

General Practice needs investment to fund necessary workforce expansion, staff and practice costs, so that patients may benefit from greater workforce stability resulting in improved access and continuity of care, and where the wider NHS will reap benefits from reduced activity at Trust level as a consequence

For the NHS to function properly, an efficient, well-functioning general practice is vital. In order to achieve this, dedicated funding and funding uplifts are urgently required. The population continues to expand and age with greater multimorbidity, yet the number of GPs are declining – meaning more

[1] The BMA is separately calling for reform to the doctors' annual pay review body, the DDRB. We have set out the key requirements for reform here, including a restoration of its independence in line with its original purpose, autonomy and authority.

each GP is responsible for more and more patients. General practice has seen a near 5% increase in activity post-pandemic whereas activity in other parts of the NHS have decreased. Historical underinvestment needs to be remedied, and funding should follow the required shift in patient activity out of hospital towards a more preventative approach to care.

Targeted additional investment in general practice will reduce overall NHS costs. Ringfenced funding to provide for a "New To Partnership Programme" will support those entering into partnership roles which embed continuity of care (coordinated care featuring a continuous caring relationship with preferred staff), an important goal for general practice) and thus reduce referrals, admissions, investigations, mortality and morbidity without reducing timely access. Funding is a particularly urgent requirement to cover necessary costs of the employed workforce in order attenuate the rapid attrition of the GP practice team. Practice roles require parity of terms offered and funded in other parts of the NHS - requiring further funding uplifts to the GP contract for staffing expenses and the Statement of Financial Entitlements, together with the global sum funding elements.

For trainees, GP specialty registrars' pay premia requires a commensurate funding uplift to ensure ongoing recruitment, retention, and necessary expansion of the GP workforce.

In the England GP contract, the vaccination and immunisation Item of Service fee was last uplifted in 2018, and the Covid vaccine tariff was reduced by 25% in August. We urgently need the tariff uplifted in line with inflation, and the tariff for Covid restored to make the remainder of the seasonal vaccination programme financially viable. In addition, there is an urgent requirement to fund flu vaccine staff costs and reimbursement for vaccination.

In addition to the above, and in order to support these aims, the BMA is calling for the Treasury to direct DHSC to grant greater flexibility in the use of existing funding in England's contract to support 2024/25 GP contract discussions. For example:

- Additional Roles Reimbursement Scheme funding could and should be made available beyond the end date of the PCN DES to recruit the staff determined by the PCN to be most effective at meeting the reasonable needs of the registered population. Such ARRS funds could and should be based within the core contract to improve practice stability and sustainability, with outcomes enabling the continuation of collaboration where this is working well.
- PCN funding for extended access appointments could and should be transferred into core practice funding to allow more varied appointment options for patients to seek access closest to home, and to allow practices to determine how such funding be used to drive efficiencies.

Changes are still required to continue the progress in the Spring Budget 2023 to protect doctors from punitive pension taxation

The removal of the lifetime allowance (LTA) and the increase in the annual allowance (AA) announced in the Spring Budget 2023 was welcome, although this was not the BMA's recommended solution to the NHS pension taxation crisis, which has forced thousands of doctors to reduce their hours, or to retire early, we do agree that these changes will have the impact of removing the vast majority of doctors from paying punitive pension taxation bills.

However, the increase in the AA and removal of the LTA whilst beneficial to the majority of senior doctors, does not address all of the issues we have raised. In particular, it does not address the impact

of the tapered AA, which has not been meaningfully reformed. This means that some senior doctors will continue to be disincentivised from taking on additional shifts and overtime as they may still be financially penalised for doing so. In addition, because of the inherent unsuitability of the AA in Defined Benefit (DB) schemes, such as the NHS pension scheme, doctors may continue to get unexpected AA tax bills and will continue to be faced with the complexity of managing this. In some cases, these tax bills may relate to a temporary pay rise (such as taking on a leadership role) and therefore doctors may be taxed on non-existent pension growth. The AA therefore remains a disincentive to taking on additional work or leadership roles for some. The BMA is therefore calling for the following additional solutions:

1. **Index the annual allowance with inflation**. The increase to the AA is not a long-term solution unless the AA limit is indexed with inflation, and the value is not eroded in real terms. Otherwise the NHS will find itself in a similar position in a few years' time with large numbers of doctors having to reduce their work.
2. **Remove the taper from the AA.** The taper in the AA adds a layer of unnecessary complexity and may mean that some doctors, particularly GPs, may still face large tax bills. The BMA is calling for the taper to be scrapped.

Capital funding should be increased to expand and improve infrastructure to improve staff productivity

Recent capital announcements represent a major uplift to the DHSC and NHS capital budget, has and have been welcomed by the BMA. Capital investment across the NHS over the current Spending Review period (2022/23 – 2024/25) is expected to average £8bn per annum, whereas the annual capital spending average was £3bn between 2010/11 – 2018/19. The increased commitment will therefore go some way towards reversing the estates' maintenance backlog, valued at £10.2 billion in 2021/22.

However, despite a cash injection, years of underfunding have led to crumbling estates, IT, a reduction in the number of available beds, and unsafe levels of bed occupancy. Furthermore, inflation is limiting trusts' capacity to deliver capital projects within cost estimates; in some cases trusts are delaying or abandoning projects and in others planned works are being rescaled. This is alarming, especially at a time when at least 27 sites have been confirmed to have unsafe RAAC plank construction. Funding allocations for this and the next financial year should be uprated in line with inflation to ensure that funding is protected in real terms and that the NHS is able to continue upgrading infrastructure as planned. This will amount to an additional £0.78bn in 2023/24 and £1.03bn in 2024/25.

In addition, the Treasury should provide a longer term funding settlement, up to at least 2030 and agreed with all political parties, in order to provide the certainty the healthcare system needs to properly invest in infrastructure, fully eliminate the maintenance backlog, improve IT systems and ensure there are sufficient facilities available for staff to properly be able to do their jobs and for patients to be cared for appropriately. This should include funding to eliminate RAAC in the NHS, following a full audit of where there is presence of RAAC in the estate and how much it will cost to eliminate.

This will be vital in order to as expand the number of beds available (the BMA alongside RCEM is calling for an additional 13,000 staffed beds across the UK to address shortages). Funding should also be specifically ringfenced for non-clinical space for staff, including dedicated office space and provision of doctors mess/dining rooms to allow recovery whilst working in intense environments.

Public health is vital to reducing pressures on the NHS

Without a strong, well-resourced public health system, the UK remains susceptible to future health shocks, including pandemics and remains in a weak position to tackle the worsening crisis of population health. The BMA has highlighted how doctors and the health service are picking up the pieces from the failure to properly resource public health. The BMA is calling for the local authority public health grant in England to be restored to 2015/16 levels per capita to allow sufficient investment in public health, with comparable additional funding provided for all other nations.

In addition, access to affordable childcare is key to child development and a productive and healthy society and workforce. The BMA believes that as the High Income Child Benefit Charge threshold has been frozen since its introduction in 2013, it is no longer fit for purpose and should be reviewed.

Medical academics are vital for the education of the workforce and their research is essential to the nation's health and wealth

The BMA welcomes the commitment to increasing medical school places in England by a third by 2028/29 and doubling the number of medical school training places by 2031/32 in the Longterm Workforce Plan, a commitment we have been long campaigning for.

It is vital this expansion of education places is accompanied by expansion across the whole medical education pipeline – specifically in the clinical educator workforce and in the physical capacity in medical schools and in the NHS. Between 2010/11 and 2022/23 there was a welcome 21% rise in medical students, yet over the same period the medical teaching workforce has fallen in England – demonstrating the pressure the current workforce is already under[2].

The Government must therefore increase the medical teaching workforce to meet increased teaching demands. A flexible return to work programme for educators is urgently needed to bolster that workforce. Furthermore, any pay uplift afforded to the NHS must be matched in the academic sector. To ensure this the government's commitment to pay parity for doctors working in the academic sector (life sciences) should be backed up by the funding necessary to maintain it without further reductions in posts. Finally, there should be funding for the creation of new research and educational programs that will fast track the stabilisation of decline academic FTE numbers with the goal of restoring the relative proportion of clinical academics to students and research requirements of the life sciences sectors.

[2] The 2010/11 medical student target was 6195, compared to 7,500 in 2022/23.