



Review Body on Doctors' and Dentists' Remuneration

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Contract reform for consultants and
doctors & dentists in training – supporting
healthcare services seven days a week

Chair: Professor Paul Curran



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seven days a week

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Presented to Parliament by the Prime Minister and the
Secretary of State for Health

Presented to the Scottish Parliament by the First Minister
and the Cabinet Secretary for Health, Wellbeing and Sport

Presented to the National Assembly for Wales by the First
Minister and the Minister for Health and Social Services

Presented to the Northern Ireland Executive by the First Minister, Deputy First
Minister and Minister for Health, Social Services and Public Safety

by Command of Her Majesty

July 2015



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The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. Its terms of reference were introduced in 1998, and amended in 2003 and 2007 and are reproduced below.

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Parliament, the First Minister and the Minister for Health and Social Services in the Welsh Government and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

- the need to recruit, retain and motivate doctors and dentists;
- regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;
- the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

The Review Body should also take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

Reports and recommendations should be submitted jointly to the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Parliament, the First Minister and the Minister for Health and Social Services of the Welsh Government, the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive and the Prime Minister.

The members of the Review Body are:

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Lucinda Bolton
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John Glennie, OBE
Alan Henry, OBE
Professor Kevin Lee
Professor Steve Thompson
Nigel Turner, OBE

The Office of Manpower Economics provides the Secretariat.

Contents

	Executive summary	vii
<i>Chapter</i>	1: Introduction and remits	1
	2: The context for this review	7
	3: Comparative information on unsocial hours pay	13
	4: Junior doctor contract reform	21
	5: Consultant contract reform	43
<i>Appendix</i>	A: Remit letters for this review	63
	B: International unsocial hours rates sources	73
	C: Summary of Incomes Data Services' findings	75
	D: Our previous comments	79
	E: Background information on pay	83
	F: Proposed unsocial hours definitions	95
	G: Abbreviations and acronyms	99

Executive summary

1. This report covers two different contracts which together will provide the backbone to medical practice in hospitals over the next decade. The way they are developed from here will play a significant role in defining the relationships between doctors and NHS employers and between doctors and the governments of the countries of the United Kingdom (UK).
2. We consider that the recommendations and observations in this report provide a roadmap of what could and should be achievable in the interests of everyone with a stake in the NHS. It now depends on the parties to resume negotiations in the right spirit and with a commitment to long-term as well as short-term objectives. We were provided with a draft contract for doctors and dentists in training and with detailed proposals for new contractual arrangements for consultants.

The remits

3. We received remits from the UK Government, Welsh Government and Northern Ireland Executive to make *recommendations* on changed contractual arrangements for doctors and dentists in training, including a new system of pay progression. We were also asked by them to make *observations* on pay-related proposals for reforming the consultants' contract. In both cases, our remit was linked to a desire to facilitate the delivery of healthcare services seven days a week, in a financially sustainable way. The Scottish Government gave us a remit to make *observations* on new contractual arrangements for doctors and dentists in training only. We thank all parties for their written and oral evidence and we hope that our report assists them in reaching a negotiated conclusion on both contracts to support the provision of excellent patient care. We were asked to have regard to any read-across to the similar remit given to the NHS Pay Review Body (NHSPRB), and we have been made aware of their observations.

Our approach

4. We focused our examination around six criteria, set out below, which we decided at the outset would guide our recommendations and observations. They represent an attempt to balance different but important factors which transcend the short-term. They will provide a guide to any further work we can do as an independent Pay Review Body to help the parties settle on effective and forward-looking agreements that also have the support of doctors.
 1. Improved patient care
 2. Maintaining respect and trust for consultants and junior doctors as leaders and professionals
 3. Credibility and practicality of local implementation
 4. Appropriate remuneration (in order to recruit, retain and motivate)
 5. To help facilitate constructive, continuing relationships
 6. Affordability

Key messages from this review

5. There are similarities in the way that expectations on both doctors and dentists in training ('junior doctors') and consultants are changing, and the proposed pay systems seek to recognise that. Both of the proposed pay systems look to improve patient outcomes *across* the week, through providing separate unsocial hours payments. Both seek to

reward greater responsibility and professional competence, in their approach to basic pay and progression, and for consultants via what we call payments for excellence. We think these key principles are reasonable.

Doctors and dentists in training

6. We consider that there is a sound basis for negotiation of the junior doctors' contract, and make recommendations that we hope the parties will find helpful, in order to progress to negotiated agreement quickly. In line with our remit letters, our recommendations for junior doctors apply to England, Wales and Northern Ireland and these are set out in full at the end of this summary and in Chapter 4. We consider the proposals are fair and our observations could also form the basis for consideration of new contractual arrangements in Scotland.
7. We note that junior doctors are already working across seven days: indeed, they play a vital role in the delivery of services, particularly in the evenings, at night and at weekends. Unlike consultants, junior doctors do not currently have an 'opt-out' – a clause in the 2003 consultant contract that enables a consultant to choose whether or not to provide non-emergency care at weekends. We endorse the case for contractual change which underpinned the agreement of the Heads of Terms that provided the parameters for negotiation. We consider that the contract has an important role to play in recruitment and the choice of specialty for trainees.
8. Junior doctors and consultants are at differing stages on the same career path and their contracts should not be viewed in isolation. We regard the proposed new contracts as having the potential, over time, to smooth the transition from being a junior doctor to a consultant. They would also better reflect the changing NHS, in which both sets of doctors will work.

Consultants

9. For the consultants, we observe that the core principles for pay progression to be linked to achievement of excellence, separate payment for working unsocial hours and for reforming local Clinical Excellence Awards all look right. We note that key details are not yet in place. We also observe that employers and the British Medical Association (BMA) appear to be at very different starting points, with the former seeing the proposed pay system for consultants as enabling different models of patient care with no 'one size fits all', whilst the latter are looking for more certainty around the pay system and its safeguards, in light of the change its members are being asked to make.
10. In our view, the current 'opt-out' clause in the consultant contract is not an appropriate provision in an NHS which aspires to continue to improve patient care with genuinely seven-day services and on that basis, we endorse the case for its removal from the contract.
11. Our observations on consultant contract reform apply to England and Northern Ireland, as the proposals were formed on that basis. We consider that the Welsh Government and BMA Wales should enter negotiations on reforming the consultant contract in Wales. Scotland has not sought any observations on consultant contract reform.
12. We would urge the parties to not lose sight of this as a total package of reform. However we suggest that the parties could consider whether different elements of the consultants' pay system could be progressed at different speeds, within a 6 – 12 month timetable, reflecting service priorities as well as the current realities of limited data and pay modelling. We feel that early removal of the 'opt-out' clause by negotiation, agreement of contractual safeguards and confirmation of the unsocial hours premia could be done relatively quickly and then piloted. Addressing the basic pay points and approach to

payments for excellence could be progressed separately at first, with the next step being to agree assumptions for the pay modelling that will give some clarity on impacts on doctors in different specialties and at different stages of their career.

13. While we consider that removal of the 'opt-out' is important and significant, we know that hospital doctors in many places are already delivering services for seven days of the week, in the evenings and at night, so the current contract does not make this impossible. We urge that agreement on contractual reform should not get in the way of making progress in testing and developing the expansion of seven-day services, given their importance for patient outcomes.

United Kingdom-wide contracts

14. We encourage all four countries of the UK to work together in order to make progress on both contracts. We support UK-wide contracts for junior doctors and consultants as we feel that they best serve the needs of patients.

Importance of trust, working relationships and confidence-building

15. Both sets of proposed contractual arrangements require trust and confidence-building. Junior doctors and consultants need to believe the new arrangements can and will be operated fairly, given that each set of changes leads to a degree of reduction in their control over working patterns. The working hours of junior doctors will still matter and consultants will need a reasonable work-life balance. We feel that contractual safeguards are necessary given that management practice appears to be highly variable.
16. What society asks of doctors is changing. In addition, the expectations on employers to support work-life balance, the wellbeing of staff and the management of staff will also change. Clinical leadership is absolutely crucial to the re-design of services. There must be ongoing mutual respect and joint working between the medical profession and NHS management, with upskilling where necessary, so that service delivery is a joint enterprise.

Seven-day services

17. We find the case for expanded seven-day services in the NHS, in order to address the 'weekend effect' on patient outcomes, where studies show that mortality rates, the patient experience, length of patient stay and re-admission rates are all poorer for those patients admitted at weekends, to be compelling. We note that this is the area of common ground between the parties and our response to the proposals has been influenced by this broad agreement, although we realise that this is not the only driver for change to junior doctors' and consultants' contracts.
18. In responding to our remit, we commissioned research on pay arrangements for other workforces that are asked to deliver seven-day services. We found that 24/7 services have become more prevalent since the late 1990s. However we found that there was no agreed norm; employers decide the services that they need to provide and then establish pay systems that support them, taking account of the labour markets in which they operate. We also investigated the position in healthcare systems elsewhere in the world and it is our understanding that outside of accident and emergency services most international public healthcare systems are not providing a comprehensive twenty-four hour, seven-day service. We therefore conclude that the proposed new NHS arrangements would be trailblazing within healthcare systems.

Affordability and wider efficiency

19. In terms of financial sustainability, we note that the parties agreed a cost-neutral pre-condition at the start of their negotiations. We acknowledge that a fixed pay envelope provides a useful starting point for pay modelling, as pay elements can be moved around to explore what needs to be rewarded/incentivised and how. However, we note that this fixed pay envelope applies to the existing workforce only. Therefore, any additional staff needed to run or expand seven-day services would need to be funded separately. Also, there will be a 'cost of change' that can be estimated once agreement has been reached on a new system of pay. We have seen no evidence to suggest that this could be funded, even in part, from within the fixed pay envelope. Finally, it seems that seven-day services could offer potential for efficiency (e.g. better utilisation of fixed assets) both within the trust/board and within the local health system, as well as potential benefits for working conditions.

Our future role

20. We welcome the opportunity to make recommendations and observations on these critical reforms. In making them, we note where we can play a future role, either in monitoring any new arrangements or in reviewing further pay proposals. We would be happy to look at follow-up remits, should they be necessary.
21. Our standing terms of reference require us to have regard to recruitment, retention, motivation and affordability. High quality information and data will continue to be crucial to us performing our role and monitoring the changes that ensue.

Doctors and dentists in training contract reform: recommendations

Recommendation 1: Pay should be based on stages of training and actual progression to the next level of responsibility, evidenced by taking up a position at that level (paragraphs 4.16 – 4.19).

Recommendation 2: Flexible pay premia could be used to recognise, where appropriate, junior doctors who take a break from training for exceptional reasons that benefit the NHS or health provision more broadly (paragraph 4.20).

Recommendation 3: We support a contract based on work schedules, work reviews and exception reporting, and the end of banding payments (paragraphs 4.27 – 4.28).

Recommendation 4: Work reviews should be evidence-based, accountable and timely (paragraph 4.29).

Recommendation 5: We should be provided in the future with annual data on the outcome of employee-triggered work reviews on a UK-wide basis (paragraph 4.29).

Recommendation 6: We support the use of scenarios C and C+ as the basis for further discussion/negotiation between the parties (paragraphs 4.34 – 4.35).

Recommendation 7: A common definition of core time/unsocial hours is required for *all* NHS groups. If the definition needs to differ between groups, then a commonly understood rationale would be required (paragraph 4.36).

Recommendation 8: We support a contract based on basic pay (up to 40 hours per week), rostered hours (up to eight hours per week, on average) paid at the same rate as basic pay and an unsocial hours premium (paragraphs 4.34 – 4.36).

Recommendation 9: The contract should include an availability allowance to recognise an obligation to be on standby to return to work, with the rate of the allowance varied to reflect the frequency of on-call (paragraph 4.40).

Recommendation 10: The contract should include the potential use of RRP (or flexible pay premia) to incentivise hard-to-fill specialties and that they are paid where required (paragraphs 4.45 – 4.46).

Recommendation 11: For future rounds, the parties should submit evidence setting out what advice has been put forward on shortage specialties and RRP (or flexible pay premia) so that we are able to review retrospectively the effective use of RRP and make recommendations as appropriate (paragraphs 4.47 – 4.48).

Recommendation 12: Flexible pay premia should potentially be used to recognise additional experience, where appropriate, for junior doctors that choose to retrain in a different specialty (paragraph 4.49).

Recommendation 13: GMP trainees should be paid on the same basis as hospital trainees (paragraph 4.53 – 4.54).

Recommendation 14: Flexible pay premia should be used to recognise, where appropriate, academic trainees that take a break from training to undertake a relevant MD, PhD or other relevant postgraduate qualification, not only for academic work related to an individual's CCT, but also when the work benefits the wider NHS and the continuing improvement of patient care (paragraph 4.56).

Recommendation 15: Once the parties agree the pay and new contractual arrangements for junior doctors, then the BDA and Health Education England should discuss an appropriate level of salary for dental foundation trainees, based on an assessment of job weighting equivalency (paragraph 4.60).

Recommendation 16: The year immediately preceding contractual change should be used as the baseline for the cost-neutral pre-condition of the negotiations (paragraph 4.63).

Recommendation 17: The wording on contractual safeguards in Schedule 3 of the draft contract should be strengthened to a mandatory requirement to comply with the requirements of Working Time Regulations or any successor legislation (paragraph 4.66).

Recommendation 18: Further sensitivity testing should be undertaken on pay modelling data to determine an appropriate increase to basic pay and wider applicability of the proposals (paragraph 4.68).

Recommendation 19: Whilst fixed leave may be necessary, its use should be exceptional (paragraph 4.72).

Recommendation 20: The current arrangements for *ad-hoc* public holidays (via local implementation) should continue (paragraph 4.73).

Recommendation 21: Annual leave on first appointment to the NHS should be 25 days, rising to 30 days after 5 years' service (paragraph 4.74).

Recommendation 22: Fees earned for private professional work during NHS time should be remitted to the employing organisation (paragraph 4.75).

Recommendation 23: Junior doctors should be fully reimbursed for reasonable actual relocation expenses incurred in the performance of their duties (paragraph 4.76).

There are aspects of the proposals that require further detailed consideration. These are listed below.

- The most appropriate pay progression scenario to match the different stages of training (see Table 4.2) (paragraph 4.18);
- The new pay points and rates for unsocial hours working (paragraphs 4.37 – 4.38);

- The rate for the availability allowance (as noted above, we are recommending that the rate should vary according to the frequency of on-call working) (paragraph 4.40);
- The proportion of funding top-sliced for RRP (or flexible pay premia) (paragraph 4.47);
- Further consideration of issues impacting clinical academics and public health doctors that will result from the contract reform proposals (paragraph 4.56);
- The appropriate level of pay for dental foundation trainees, to be based on the parties' assessment of job weighting equivalency relative to other trainees (paragraph 4.60);
- The detail of the contractual safeguards within Schedule 3 of the contract (paragraph 4.66); and
- The format of our data requirement on the outcome of employee-triggered work reviews (our Secretariat will be happy to discuss further) (paragraph 4.29).

Consultant contract reform: observations

In summary, our observations on the elements of the proposed consultant contract reform are as follows:

- removal of the 'opt-out' clause: **the current 'opt-out' clause in the consultant contract is not an appropriate provision in an NHS which aspires to continue to improve patient care with genuinely seven-day services, and on that basis, we endorse the case for its removal from the contract; we consider that the consultant contract should support patient care at the weekends, whether through direct consultant presence or through supervision of junior doctors, as a point of principle** (paragraphs 5.9 – 5.14);
- the inclusion of contractual safeguards: **we support the inclusion of safeguards within the contract; and that the contract should include a specific reference to the safeguards on hours and rest contained within the Working Time Regulations, or any successor legislation. We consider that the wording contained within the contract should make clear that compliance is mandatory. The parties will also wish to consider any reasonable work-life balance issues when discussing safeguards** (paragraph 5.18);
- pay progression to be linked to achievement of excellence (assessed at appraisal): **we are able to endorse the proposal for progression to be linked to achievement of excellence (assessed at appraisal), although we wish to stress the importance of employers being properly resourced and supported to implement an appraisal-based incremental system** (paragraph 5.24);
- basic pay 'spot rates' based on recognised stages of a consultant career: **we consider that this should be the subject of further negotiation between the parties, but we would support either a two or three-point pay scale; the value of pay points should be subject to further negotiation between the parties, and should be rooted in a robust evaluation of recruitment, retention and motivation;** (paragraphs 5.25 – 5.27);
- separate payment for working unsocial hours: **whatever model for rewarding unsocial hours working is used, the guiding principle should be that it is designed around the needs of the patient and what needs to be incentivised, balanced against the benefits of having a simple system to administer. We observe that the proposed unsocial hours definitions are in line with practice in other sectors, and also in health services internationally. In line with our criterion 3 (credibility and practicality**

- of local implementation) we ask that employers remain alive to the fact that ability to work unsocial hours safely may diminish with age** (paragraphs 5.31 – 5.36);
- an allowance for undertaking specific additional roles: **the proposal for this allowance would allow the types of roles that we intended to be covered by the principal consultant grade in our previous report on Clinical Excellence Awards to be recognised in pay, and we therefore support this proposal (in line with criterion 4 for appropriate remuneration). We note however, the lack of detail in the evidence on this aspect of the contract proposals, and hope that the allowance can be used flexibly to ensure that all such additional roles are appropriately remunerated, as per our criterion 4 (see Chapter 1) (paragraph 5.38);**
 - RRs to incentivise certain specialties/regions: **we would like to see the parties adopt a more flexible approach to encourage their wider use to address recruitment issues: for example, when RRs are paid, they need not be paid to every consultant in that trust in that specialty, although we recognise that this may be difficult to implement in practice. Of course, the parties may also wish to explore non-pay solutions to recruitment problems, such as sabbatical type leave or professional development (paragraph 5.40);**
 - reforming local Clinical Excellence Awards as payments for achieving excellence and making such payments contractual: **as the proposed approach will directly reward performance of individuals, consultant teams and the organisation as a whole through targets linked to the objectives of the employing organisation, it will be essential to the successful implementation of this that employers and staff are properly resourced, trained and supported to deliver the new scheme (given our criterion 3 for the credibility and practicality of local implementation). In our view the objectivity of the assessment, competence of those making it and buy-in of consultants will need to be supported by national guidance and supported by appropriate local management capacity and training. We consider a more appropriate name would be ‘payments for achieving excellence’ to reinforce the stretching nature of objectives (paragraphs 5.44 – 5.45);**
 - continuation of national CEAs: **we support consideration of the domains for national awards, to ensure that any payments made for achieving excellence in national awards do not reward achievements that in the future would be separately recognised by local payments for excellence (paragraph 5.48);**
 - pensions: **given the recent changes to the annual and lifetime pension allowance, it will be important for employers to provide appropriate flexibility for doctors in managing the new allowances (paragraph 5.53);**
 - contractual changes for SAS doctors: **we consider it important that SAS doctors are treated in an even-handed way, and that SAS doctors should have their opportunity to input into negotiations: those discussions should be given priority (paragraph 5.57);**
 - consultants in Wales: **the parties in Wales appear to be in agreement that negotiation is the best way forward and we support this (paragraph 5.60);** and
 - clinical academics: **we support the proposal for further work to ensure that academic careers remain attractive. We consider that pay structures for clinical academics should not inhibit the ability for staff moving in and out of such roles, which will also support the recruitment/retention elements of our standing terms of reference (paragraph 5.63).**

We also make the following general observations:

- read across to the observations made by the NHS Pay Review Body: **we observe that definitions of core time/unsocial hours given to us in evidence differ to those given in evidence for the Agenda for Change groups. We observe that a common definition of core time/unsocial hours should be applied across all NHS groups. If the definition needs to differ between groups, then a commonly understood rationale would be required** (paragraph 5.34).
- impact of seven-day services on pay: **we observe that there needs to be a greater level of common understanding between the parties on what the proposals for seven-day services will actually mean in practice for patients and the working lives of staff, noting that one size will not fit all** (paragraph 5.35).

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OFFICE OF MANPOWER ECONOMICS
14 July 2015

CHAPTER 1 – INTRODUCTION AND REMITS

Introduction

- 1.1 In this report we set out our recommendations on junior doctors' contract reform, and our observations on consultant contract reform. Our aim is that these are evidence-based, constructive and help to resolve outstanding issues and where appropriate, facilitate further negotiation between the parties.
- 1.2 We sought to address all that was requested of us in each remit and used the same criteria that guide all our work. This was based on our standing terms of reference, used an independent and objective assessment, was driven where possible by evidence and had a clear focus on ensuring that patients are at the heart of our work.¹
- 1.3 We have taken as one important starting point the need to engage with how services could be provided over seven days of the week in order to improve patient outcomes. We note that the expressed desire to move to the provision of seven-day NHS services varies across the different countries of the United Kingdom (UK). We have therefore sought to be sensitive in this report to these differences of view about seven-day services as a shared driver for contract reform, whilst recognising the continuing support from all parties for UK-wide contracts for doctors in training and for consultants.
- 1.4 The challenges that stem from the rising demand for healthcare, increased public expectation and involvement in care and treatment, greater complexity of conditions and changing demographics (including an ageing population) make this a critical time for NHS medicine in the UK. The specific pressure to generate increased productivity and efficiency sits alongside these challenges.
- 1.5 This is also a critical period in the history of medical practice in the UK. The practice of doctors itself is changing in response to a variety of social and economic factors. These affect the profession as a whole and also impact on individual practitioners in different ways in specific specialties and across the length of a career. We have sought to reflect on these issues both in relation to the short-term context in which the negotiations have taken place to date and in relation to the longer-term context of the crucial role medicine plays in society and on the quality of life in the UK. The General Medical Council sets out the duties of a registered doctor as follows:

"Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains: Knowledge, skills and performance [..]; Safety and quality [..]; Communication, partnership and teamwork [..]; Maintaining trust [..]. You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions."²

This makes decisions on contract reform extremely important to get right and we suggest these need to be taken on the basis of a shared understanding and respect for the profession, and for the practice of medicine. This has to be the starting point for negotiations, with a commitment to partnership working and engagement as a preferred way of proceeding.
- 1.6 We also considered the relevance of evidence which shows links between high performance by health organisations, clinical outcomes and management practices. These include the degree of consultant engagement in the design of services, in improving patient outcomes and in assessing performance; the quality of clinical

¹ Our Terms of Reference are at the beginning of this report.

² *Good Medical Practice*, General Medical Council, April 2013.

leadership and management; and the effectiveness of human resources practices in creating the right culture and relationships.³ This makes the case for proper engagement and working relationships between doctors – as clinical leaders – and NHS trust management as an important success factor in any redesign of services. It also argues that the role of doctors as managers and leaders needs to be properly recognised and rewarded. In the context of the challenges facing the NHS, the need for these relationships to work well seems to us to be essential.⁴

- 1.7 Equally doctors do not work in isolation. In looking at the read-across to the work that the Government asked the NHS Pay Review Body to undertake in relation to the Agenda for Change pay system, we recognise that the way that doctors work alongside other health professionals is key to high quality patient care. However we also do not lose sight of the unique characteristics of the medical profession, in particular the critical role doctors have in clinical leadership, in driving forward improvement in diagnosis and through innovation in practice.

Our approach and its implications

- 1.8 In considering this remit, we tested the issues against the following six criteria that reflect our standing terms of reference as well as our aim to help the parties to move forward:
1. Improved patient care
 2. Maintaining respect and trust for consultants and junior doctors as leaders and professionals
 3. Credibility and practicality of local implementation
 4. Appropriate remuneration (in order to recruit, retain and motivate)
 5. To help facilitate constructive, continuing relationships
 6. Affordability

We refer back to these criteria throughout this report, where appropriate, and they inform the broad direction of our recommendations and observations. We have where possible sought to identify areas of agreement on which to build, rather than areas of difference.

- 1.9 For example, and most importantly, the drive to improve patient care underpins our broad support for seven-day services and the implications for doctors' contracts. One of our key messages is that contract reform should seek to ensure a level of consultant availability at weekends, so that patient outcomes are independent of when admission and treatment takes place.
- 1.10 We emphasise that contract reform should reflect the importance of consultants and junior doctors in leading and defining medical practice, and in shaping services. Contract reform that embeds suitable contractual safeguards and that integrates doctors into discussions on appraisal, promotion and progression, and on payments for excellence, will help promote partnership working between doctors and managers.
- 1.11 Our 'credibility and practicality' criterion drives another key message that contract reform for consultants could move forward in two stages, making rapid progress on the 'opt-out' clause and unsocial hours premia in the first stage, while working out the detail of negotiations over basic pay and payments for excellence in a second stage. Parties

³ Cited in *Managing NHS Hospital Consultants*, Report by the Comptroller and Auditor General, HC 885, Session 2012-13, 6 February 2013.

⁴ See for example: NHS England *Five Year Forward View*, October 2014; The Institute for Fiscal Studies *Challenges for Health Spending* February 2015; The Kings Fund *The NHS under the coalition government. Part One: NHS Reform* February 2015 and *Part Two: NHS Performance* March 2015; The Nuffield Trust *A decade of austerity in Wales?*, June 2014.

in particular need to agree working assumptions on consultants' career paths to enable modelling of pay proposals and piloting on the ground in order to fully understand their implications.

- 1.12 As a Pay Review Body, we are very aware of the need for remuneration to be appropriate to ensure recruitment, retention and motivation of junior doctors and consultants. We believe the principles of the proposed pay system – where basic pay is linked to responsibility and performance and unsocial hours are paid separately – are reasonable and meet this criterion for appropriate remuneration. We note that contract reform will invariably help define the career expectations of doctors and employers, and we support embedding the idea that individuals' pay will reflect their contribution to the service. However, we are cautious about setting the basic pay points in order to meet the cost-neutral pay envelope without a robust consideration of recruitment, retention and motivation.
- 1.13 On affordability, we recognise that for practical reasons it is a useful exercise for modelling purposes to work on the basis that contract reform is cost neutral. This means that the implications of contract reform can be considered in isolation from discussions on pay levels. In our report, we understand that cost neutrality was a pre-condition for negotiations to take place and that this therefore must factor into our deliberations too. However, we do not necessarily endorse the assumption. For example, in the absence of strong evidence on short-term efficiency or productivity gains that could follow from the introduction of a seven-day service, it is not clear to us that this change could be implemented without further resource.

The remits

England

- 1.14 The then Parliamentary Under Secretary of State for Health, Dr Dan Poulter MP, wrote to us on 30 October 2014 setting out the remit for this review. The letter said that national employment contracts were a critical element of how the Department put patients right at the heart of everything the NHS did, providing a seamless pathway of care no matter what day of the week. It said that during 18 months of discussions and negotiations, NHS Employers and the British Medical Association (BMA) had done a significant amount of work to design reward packages for consultants and junior doctors to facilitate services and training across the seven-day week. It said that the Government was disappointed that the negotiations had not resulted in agreements that were acceptable to all of the parties, and it was therefore asking us to make observations and recommendations that took into account the work undertaken during negotiations.
- 1.15 For **consultants**, the letter asked us to make *observations* based on information and data presented on pay-related proposals for reforming the consultant contract to better facilitate the delivery of health services seven days a week in a financially sustainable way, i.e. without increasing the existing spend. In the context of the policy aim to deliver financially sustainable seven-day services, we were asked to consider and critique proposals from the Department of Health and NHS Employers, taking account of views from all the parties. The letter said that we should also consider the following, including work already completed by us and work undertaken by the parties to the negotiations:
- our work on the payment of Clinical Excellence Awards and the government's response;
 - proposals for pay progression to be linked to responsibility and performance; and
 - arrangements in other sectors which provide seven-day services.

1.16 For **doctors and dentists in training**, we were asked to make *recommendations* on new contractual arrangements including a new system of pay progression with a strengthened link between pay and better quality patient care and outcomes. In doing so, the letter said we should consider information submitted including:

- proposals for pay structures that included the ending of time-served incremental progression;
- information on the working patterns of doctors in training; and
- how the current pay envelope could be used differently to increase basic pensionable salaries, providing appropriate reward of additional work, while supporting services and training across the seven-day week.

1.17 In undertaking both strands of this work, the letter said we should have regard to the Heads of Terms agreed by the parties prior to the contract negotiations, and to the read-across to the work that the Government had asked the NHS Pay Review Body to undertake to make observations on the barriers and enablers within the Agenda for Change pay system for delivering health services every day of the week in a financially sustainable way. The letter said that in considering our observations on seven-day services, the Government would also wish to consider the extent to which they would read across to other medical staff groups such as specialty doctors and associate specialists.

Northern Ireland

1.18 Jim Wells MLA, the Minister for Health, Social Services and Public Safety in Northern Ireland wrote to us on 5 November 2014. The letter noted that negotiations for the reform of consultants' and junior doctors' contracts had not resulted in agreement, and invited us to make *observations* and *recommendations* that took into account the work undertaken during the negotiations. It set out a remit the same as for England, and said that supplementary information and data reflecting the particular Northern Ireland context would be provided. It also asked us to consider the extent to which our observations on seven-day services would read across to other medical staff groups such as specialty doctors and associate specialists.

Wales

1.19 Mark Drakeford AM, Minister for Health and Social Services in the Welsh Government wrote to us on 9 December 2014. The letter asked that our *observations* and *recommendations* on contract reform for consultants and doctors and dentists in training (respectively) should extend to Wales. For our observations on consultants, it asked us to have particular regard to commitment payments and how consultants in Wales could be better rewarded for providing local excellence.

Scotland

1.20 Shona Robison MSP, Cabinet Secretary for Health, Wellbeing and Sport in the Scottish Government wrote to us on 18 December 2014. The Scottish Government's remit was different to the other countries of the United Kingdom, in that for doctors and dentists in training it sought our *observations* on new contractual arrangements including the new system of pay progression. It said that the Scottish Government did not require the end of automatic progression, but it would be willing to consider any system which was considered fair and equitable and was seen as offering fair reward to doctors and dentists in training. The letter did not provide any remit to consider consultants.

1.21 All of the remit letters can be seen at Appendix A.

The evidence and conduct of the review

1.22 We put out a call for evidence for this review on 30 October 2014. We subsequently received written evidence from:

- the Department of Health;
- the Department of Health, Social Services and Public Safety in Northern Ireland;
- the Welsh Government;
- the Scottish Government;
- NHS Employers;
- the BMA;
- the British Dental Association;
- the College of Emergency Medicine;
- the Universities and Colleges Employers Association;
- the Dental Schools Council/Medical Schools Council;
- the Medical Women's Federation;
- NHS Providers;
- NHS England;
- the Hospital Consultants and Specialists Association;
- the Association of Anaesthetists of Great Britain;
- the Advisory Committee on Clinical Excellence Awards;
- the Scottish Advisory Committee on Distinction Awards;
- Health Education England; and
- Abertawe Bro Morgannwg University Health Board.

1.23 In addition we took oral evidence from the then Parliamentary Under Secretary of State for Health, Dr Dan Poulter; officials from the Health Departments across the United Kingdom; NHS Employers; Sir Bruce Keogh, the Medical Director at NHS England; and the senior leadership of the BMA. We are grateful to all who submitted evidence for their time and effort in preparing and presenting evidence to us, both in writing and orally.

The remit groups

1.24 This review covers NHS consultants (in England, Wales and Northern Ireland) and doctors and dentists in training (across the four countries of the United Kingdom). Table 1.1 provides a breakdown of these groups.

Table 1.1: Hospital groups covered by this remit

Full-time equivalent in 2013 ¹	England	Scotland	Wales	Northern Ireland
Consultants ²	39,014	*	2,337	1,488
Registrar group	39,407	3,937	1,887	1,218
Foundation house officers 1 and 2 ³	13,991	1,860	912	542

¹ As at September.

² The grade of consultant also includes directors of public health.

³ Includes house officers, senior house officers and other doctors in training.

* Consultants in Scotland are not part of this remit.

1.25 Our report is divided into five chapters comprising:

1. This introduction
2. Context to this review
3. Comparative information on unsocial hours pay
4. Junior doctor contract reform
5. Consultant contract reform

1.26 The appendices are as follows:

Appendix A: The remit letters for this review

Appendix B: The sources of data on international unsocial hours rates

Appendix C: Overview of Incomes Data Services' research

Appendix D: Our previous comments

Appendix E: Background information on pay

Appendix F: Proposed unsocial hours definitions

Appendix G: Abbreviations and acronyms

CHAPTER 2 – THE CONTEXT FOR THIS REVIEW

- 2.1 Our consideration of these contract reform remits is set against the context of the existing contracts, the drive towards seven-day NHS services, and ongoing affordability constraints, each of which is explored in this chapter. Appendix D also contains a summary of our previous comments.
- 2.2 Our 43rd Report 2015 noted that there are specialties with ongoing recruitment issues, such as emergency medicine and psychiatry, and they exist for all grades of doctors across the United Kingdom. The lack of trainees choosing a career in general practice is also a cause for concern. A recent report by the King's Fund highlighted the importance of robust workforce planning for the future NHS.¹

Current pay structures

- 2.3 Currently, junior doctors receive basic pay and non-pensionable banding supplements for each of their postings. Depending on their posting, junior doctors routinely work across seven days and at night. Taking into account basic pay and additional supplements, for example by way of illustration, a registrar in England² earned £52,868 on average in the year to September 2014, whilst other doctors in training in England earned £35,974 on average over the same period. Full details are in Table E10 in Appendix E including a breakdown of non-basic pay per person by staff group.
- 2.4 Chapter 4 sets out the background to the negotiations on the junior doctors' contract, in more detail. In summary the existing contract is seen by all parties as complicated to administer, inflexible and no longer incentivising high quality patient care in the right way. This was reflected in the Heads of Terms³ agreed by the parties to underpin the negotiations on a revised junior doctors' contract.
- 2.5 Consultants currently receive basic pay and a combination of intensity payments and on-call supplements. Consultants are also eligible for Clinical Excellence Awards (and their equivalents) – local and national. Taking all elements of pay into account a consultant in England earned £111,717 on average in the year to September 2014. Full details are in Table E10 in Appendix E including a breakdown of non-basic pay per person by staff group.
- 2.6 Many consultants work over seven days of the week, in the evenings and at night, but consultants can currently 'opt out' of providing non-emergency care outside of the hours 7am to 7pm Monday to Friday.⁴ The National Audit Office found in its 2012 report that most trusts in their survey used locally agreed rates of pay for additional work outside that agreed in job plans. It found that contractual rates ranged between £36 and £64 per hour and that average locally agreed rates ranged from £48 to £200 per hour with a mean of £119 and median of £114.⁵

¹ *Workforce Planning in the NHS*, The King's Fund, April 2015. Available at <http://www.kingsfund.org.uk/publications/workforce-planning-nhs>

² Average earnings estimates are not available in other countries. This is consistent with the Organisation for Economic Co-operation and Development (OECD) use of Health and Social Care Information Centre's (HSCIC) England estimates to estimate UK earnings.

³ *Draft Heads of Terms for Negotiations to Achieve a New Contract for Doctors and Dentists in Training*. BMA, NHS Employers, June 2013. Available at: <http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/HoT%20final%20draft%20with%20explanatory%20notes.pdf>

⁴ Schedule 3, Paragraph 6 of the 2003 contract. The wording states that consultants have the right to refuse non-emergency work from 7pm to 7am during weekdays and at anytime at weekends. The Heads of Terms for negotiations describe the clause as "the right to opt-out of non-emergency work in premium time".

⁵ *Managing NHS Hospital Consultants*, Report by the Comptroller and Auditor General, HC 885, Session 2012-13, 6 February 2013

- 2.7 Chapter 5 sets out the background to the negotiations on the consultants' contract in more detail. The primary issues to be addressed, as set out in the Heads of Terms,⁶ were the delivery of seven-day services in the NHS, pay progression and Clinical Excellence Awards.

Seven-day services

- 2.8 Expanding seven-day NHS services is one of the key drivers behind the contract reform proposals put to us. Here we discuss the case made to us for this by governments and employers noting where there are differences of approach and priority between the countries of the United Kingdom that provided us with a remit. We do not set out every piece of evidence received,⁷ instead we summarise where the parties appear to be in their understanding.
- 2.9 In summary each government saw the case for seven-day services as broadly resolving into two areas. Firstly, to improve patient outcomes and alongside improve the supervision of doctors in training. Secondly, to offer wider efficiency. The aims sit within the context of tight affordability constraint, which for some governments was a dominant factor. The British Medical Association (BMA) were of the view that patients should be able to expect the same quality of care whenever needed and that priority should be given to emergency care. It is apparent that improved patient care is where the parties are in agreement on the case for seven-day services.
- 2.10 There is a body of evidence that shows there are significant variations in outcomes for patients admitted at weekends. Mortality rates, the patient experience, length of patient stay and re-admission rates were all poorer for those patients admitted at weekends. Table 2.1 shows that there is a significantly greater rate of dying within 30 days if admitted at the weekend, and increased mortality rates of 11%⁸ for admissions on a Saturday and 16% on a Sunday compared with those admitted on a Wednesday, known as the 'weekend effect'.⁹

Table 2.1 – Analysis of the risk of 30 day mortality

Admission Day	30 day mortality when compared to Wednesday admissions	
	2009-10	2013-14
Friday	0%	+2%
Saturday	+11%	+10%
Sunday	+16%	+15%
Monday	+2%	+5%

¹ The weekend effect remains even if people who die within 3 days of admission are excluded.

² While the overall number of patients admitted at the weekend is lower, the proportion of very sick patients is higher, on average, than during the week. There is an increased proportion of elderly and young admissions. On a risk score of 0=lowest risk of death to 4=highest risk, the proportion of low risk patients is constant throughout the week, but the proportion of high risk patients increases by around 25 per cent on a Saturday and around 30 per cent on a Sunday.

³ The ratio of harm to no harm incidents increases at weekends.

⁴ For the 2009-10 data the Wednesday to Saturday and Wednesday to Sunday differences are highly statistically significant.

⁵ For the 2013-14 data the Wednesday to Monday, Wednesday to Friday, Wednesday to Saturday and Wednesday to Sunday are all highly statistically significant.

Source: NHS England

⁶ *Draft Heads of Terms Agreement on Consultant Contract Reform*. NHS Employers, BMA, July 2013. Available at: http://www.nhsemployers.org/~media/Employers/Documents/SiteCollectionDocuments/HoT_final_for_website_ap290713.pdf

⁷ The evidence submitted for this review is available on the parties' websites.

⁸ This does not mean the mortality rates are 11 or 16 percentage points higher.

⁹ Analysis of Hospital Episode Statistics linked to Office of National Statistics data. Study conducted by University Hospitals Birmingham (UHB) and University College London through the Quality and Outcomes Research Unit at UHB.

- 2.11 NHS England's Seven Days a Week Forum set out ten clinical standards¹⁰ that described the standard of urgent and emergency care all patients should expect seven days a week, each supported by clinical evidence and developed in partnership with the Academy of Medical Royal Colleges. The BMA accepted that the Seven-Day Services Forum's initial focus on urgent and emergency care was correct, as this was where the bulk of the evidence of a 'weekend effect' on mortality rates could be found. The Welsh Government said that the overall purpose of seven-day services included timely assessment and diagnosis, treatment and discharge, noting that their overall priority was shifting activity from secondary care and into community and primary settings. A 2012 report by the Academy of Medical Royal Colleges, contained three standards for consultant presence over seven days based on the finding that the majority of hospital inpatients would benefit from daily consultant review at the weekends, and that a weekend consultant presence would enable greater coaching and supervision of doctors in training.¹¹
- 2.12 The Department of Health was clear that it did not expect that the NHS would implement the same configuration of services over seven days that it currently delivered Monday to Friday. The BMA welcomed that a 'one size fits all' approach would not be appropriate to every local area, however said that more clarity on the framework in which seven-day services would operate was needed to achieve such a fundamental shift in the way the NHS operated.
- 2.13 NHS England explained that development of proposals for improved weekend integration and alignment of primary, community, acute and social care services would follow its initial focus on emergency care within hospitals. It also pointed to the better use of expensive resources, such as staff, plant and equipment, and the avoidance of waste and repetition as being part of the case for providing services over seven days.¹² The Department of Health cited its plans for increasing access to general medical practitioners (GMPs) and also noted the need for integration between health and social care to improve service to patients and to help relieve pressure on hospitals.
- 2.14 For the Welsh Government there was an important distinction between running equitable unscheduled care seven days and using elective NHS facilities seven days a week. It thought that there was more work to do to assess actual demand from the public, although it judged that being better able to schedule activity into the early evenings and on Saturday mornings was something that would be welcomed by patients and families. The Welsh Government said that its national plan for primary care sought to improve and deliver services with a more community owned and led approach through primary care clusters, and described its plans for increasing access.
- 2.15 The Northern Ireland Executive described action to increase access to GMPs, with additional investment for in-hours extended surgeries; and the development of a planned network of 20 collaborative federations covering all GMP practices.
- 2.16 The BMA drew a distinction between services that were justified on clinical grounds such as to correct for heightened mortality rates at the weekend, and those which were designed to improve access from a patient convenience point of view. The British Dental Association (BDA) said it remained unclear precisely what the government wished to achieve in respect of seven-day services, and that it was unconvinced whether it would be financially or logistically viable, given the constraints faced across the NHS in terms of money and staff resources.

¹⁰ *NHS Services, Seven Days a Week Forum, Clinical Standards*. NHS England, December 2013. Available from: <http://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf>

¹¹ Academy of Medical Royal Colleges, *Seven Day Consultant Present Care*, December 2012

¹² NHS England set out the findings from a number of pilots in *Equality for All - Delivering Safe Care seven days a week*

- 2.17 Noting that patients admitted at weekends tend to be more unwell, the parties agree that addressing unequal patient outcomes at weekends must happen, that emergency and diagnostic services are where this is most acute and that these should therefore be the priority area of focus. The role of consultant presence at weekends to make a difference to patient outcomes is accepted, with the BMA noting that other factors must also be addressed. The parties also agree that associated primary and community care is needed in order to prevent unnecessary admissions, as well as to enable quicker discharge. However it is apparent that despite this core agreement, employers and the BMA are at very different starting points. Employers see the proposed pay system as enabling different models of patient care with no 'one size fits all', whilst the BMA are looking for more certainty about how seven-day services will operate.
- 2.18 So, whilst the focus for us in this remit is primarily on the services provided in hospitals, a lot more clarity is needed on both the meaning of seven-day services across health systems, and the detail of what it will look like in different localities. There are clearly consequences for others such as GMPs and social care providers. There is a need for greater understanding about where and how GMP services will feature in the vision, noting that GMPs are not currently required to provide a seven-day service under their contract.

Affordability of seven-day services

- 2.19 The Healthcare Financial Management Association¹³ was commissioned by NHS England to undertake a costing exercise with the aim of costing the financial implications of introducing seven-day services for acute and emergency care and supporting diagnostics in the NHS. Eight successful foundation trusts were selected with an interest in seven-day services representing different size hospitals in different locations (London, large conurbations and more rural). This is a small sample, however the results are instructive.
- 2.20 The report showed that the potential costs of implementing seven-day services varied. In most cases, the costs of implementing seven-day services were typically in the order of 1.5% to 2% of total income or, expressed another way, a 5% to 6% addition to the cost of emergency admissions. It is also our understanding that these would be the costs of *expanding* seven-day services beyond what is provided already. The biggest element of cost was the recruitment of additional medical staff to cover the extra hours being worked. Of course, extra costs driven by recruiting extra staff would also be expected to lead to an increased number of outputs, and it would therefore be useful for data to be available that showed the expected change in costs on a per patient basis.
- 2.21 The cost of agency staff and locums has been highlighted as a major issue in recent months. Agency staff bills (including doctors) are cited by the Department of Health as costing the NHS in England £3.3 billion in the last year. These costs do not enable analysis by day of the week, which misses an opportunity to understand whether local trust arrangements for unsocial hours working by doctors are sufficient or whether locums are generally doing the out-of-hours work.
- 2.22 We note the difficulties in providing the existing service, as evidenced by the growing number of trusts in financial deficit, the increasing costs of agency and locum staff, and existing shortages in specialist areas. It seems that seven-day services could offer potential for efficiencies both within the trust and within the local health system,¹⁴ as well as potential benefits for working conditions.

¹³ Costing seven day services: The financial implications of seven day services for acute emergency and urgent services and supporting diagnostics, December 2013.

¹⁴ The interim report of the Carter Review gives some examples of ways to improve workforce productivity. See *Review of Operational Productivity in NHS Providers, Interim Report June 2015, Lord Carter of Coles*

Pay envelope

- 2.23 For both groups of doctors, the negotiations were taking place within the existing funding envelope. We note that the basis for cost neutrality is set on a full-time equivalent basis. We understand this to mean that any increase in the workforce required to provide seven-day services would be funded from outside this envelope. Our understanding of this is also that, whilst the pay bill cost per full-time equivalent should remain the same, the component parts that make up the pay bill could change and that this principle forms the basis for the contract proposals given to us. We examine and comment upon the detailed proposals in Chapters 4 and 5 of this report.
- 2.24 For now we note that at this stage, without a clearer indication of the level of unsocial hours needing to be worked by the existing workforce – particularly consultants – it is difficult to predict the potential proportion of the pay bill that unsocial hours could represent under any revised contract.

CHAPTER 3 – COMPARATIVE INFORMATION ON UNSOCIAL HOURS PAY

Introduction

3.1 This chapter sets out our analysis of comparative information on unsocial hours pay in other sectors and in overseas healthcare systems. This information can be used to provide context for comparisons with our remit group. This chapter presents research carried out on our behalf by Incomes Data Services (IDS) into unsocial hours practice in other sectors in the United Kingdom¹ (UK) as well as research by our secretariat into unsocial hours practice in health services in other countries.

Our comments

- 3.2 Appropriate comparators for the NHS workforce and in particular consultants within the UK are difficult to identify. A worthwhile comparison can be made with airline pilots, as both groups are highly skilled, have long training, can be responsible for life and death situations and have limitations on their working hours on the grounds of safety. Local government offers an example of a public service sector that was embracing the need for more services to be offered in the evening and at weekends. Furthermore, as integration of health and social care services continues, increasingly local government staff will be working closely alongside NHS staff.
- 3.3 The IDS study showed that there is no clear pattern in approaches to unsocial hours pay in the UK. However, these hours are generally compensated for either in base pay or through unsocial hours rates. Out of the groups IDS surveyed, many had undergone or were undergoing some review of their approach to unsocial hours pay in order to complement a more 24/7 approach to service delivery/working. Where change had been successfully implemented this had been done with general recognition of the importance of culture change, the health and wellbeing of staff, and the requirement to pay premium rates to incentivise and secure unsocial hours working. Local level staff engagement was often mentioned as being needed before and during the transition, whilst one-off payments can be used to smooth transition. Camden Council offered an interesting example – they had introduced a new pay system for new entrants, maintaining the legacy system for existing employees, but offered an incentive for staff to move across to that new system. Whilst they had extended plain-time working hours, they continued to pay premia for hours considered unsocial (weekdays after 10pm, weekends after 5pm and bank holidays).
- 3.4 High-level comparisons with healthcare systems internationally suggest that unsocial hours' premia for consultants in the UK are lower than in some other countries. Internationally, unsocial hours premia are still seen as a core part of encouraging staff to work at night and weekends in healthcare systems. Similarly to the UK, other countries are increasingly looking to make more services available at weekends and into the evenings. However, providing comprehensive services at weekends and at night is not widespread.
- 3.5 Looking at the sectors surveyed by IDS, the current definition of plain time for junior doctors and consultants, starting at 7pm, is somewhat out of line. The proposals to move the start of the night window to 10pm for all NHS staff would bring junior doctors and consultants more in line with the other sectors. This would suggest that unsocial hours (attracting a premium payment) for junior doctors and consultants would *reduce* by three

¹ The report is available from: <https://www.gov.uk/government/organisations/office-of-manpower-economics/about/research>

hours each weekday evening. By comparison, Agenda for Change staff's unsocial hours would be reduced by two hours. Paying premia after 10pm and on Saturday and Sunday are still the accepted practice and eliminating this would take the NHS out of line with many sectors. Some of the sectors covered by the IDS report do not pay a premium for working on Saturdays and this may be the area, in certain sectors, in which we will see further movement towards widening the definition of plain time in the future. This is discussed further in Chapters 4 and 5 and the proposed definitions of core and premium time across all NHS staff groups are shown in Appendix F.

- 3.6 The provision of seven-day services have become more prevalent since the late 1990s, accommodated by more flexible working practices in sectors across the UK. However, there is no clear pay approach for unsocial hours working internationally or across other sectors in the UK, and so the unsocial hours approach for the NHS should be designed around the service needs of the patients.
- 3.7 Any transition to new work practices will require strong engagement with staff and in the absence of appropriate comparators for our remit groups in relation to out-of-hours working, it is important that robust data and modelling is used to understand the effects of any proposed changes to unsocial hours rates and definitions.

Current unsocial hours definitions in the NHS

3.8 Current unsocial hours rates for NHS staff are shown in Table 3.1.

Table 3.1: Current unsocial hours rates for NHS staff

Staff Group	Night Window	Nights	Saturdays	Sundays and public holidays
Consultants	7pm to 7am	T+33% or a reduction in hours (a three-hour Programmed Activity rather than four hours)		
Junior Doctors	7pm to 8am	Junior doctors receive a non-pensionable banding supplement of between 20-100% of basic pay, which is designed to compensate for extra hours worked and for more intense working patterns		
Staff and Associate Specialists	7pm to 7am	T+33% or a reduction in hours (a three-hour Programmed Activity rather than four hours)		
Agenda for Change Staff	8pm to 6am	T+30% (bands 4-9) to T+50% (band 1)	T+30% (bands 4-9) to T+50% (band 1)	T+60% (bands 4-9) to T+100% (band 1)

T – Plain time

Source: NHS Terms and conditions of service handbook, Department of Health Evidence

- 3.9 At nights and on Saturdays, unsocial hours premium rates for consultants are broadly in line with Agenda for Change staff in bands four to nine and also appear to be in line with the other sectors covered by the IDS report (as discussed later). Whilst some sectors covered by the IDS report do not pay a premium for Saturday, the majority still do. In other sectors, premia are usually higher for Sundays than for nights and Saturdays. In the current consultant contract there is no difference in premia for hours worked on a Sunday compared to nights or on Saturdays. The result is that consultants' Sunday premia are at the lower end of other sectors covered by the IDS report. It is difficult to compare meaningfully unsocial hours pay for junior doctors, as the banding premia are wider than just for unsocial hours work.

3.10 The picture on unsocial hours payments for senior staff and managers is more mixed than for junior staff. IDS identified a number of instances of senior staff being paid lower percentage premia than for more junior staff; for example in the airline industry where airline pilots receive flight allowances at a lower percentage rate than cabin crew. However, basic pay for senior staff is generally greater than for those they supervise, so even though they may be paid a smaller percentage premium, the cash value of the addition may be higher.

IDS's research on unsocial hours in UK sectors

- 3.11 IDS were commissioned to undertake case studies to research unsocial hours practices in other sectors in the UK. This was in order to help us form a view on the extent to which current NHS unsocial hours practices are similar or different to those elsewhere in the UK. Whilst the IDS research is not intended to be representative of all companies in all sectors, we believe it to be a reasonable summary of the sectors surveyed.² An overview of IDS's research findings on unsocial hours and overtime payments by sector is provided in Appendix C.
- 3.12 IDS found that premium payments on top of basic pay have traditionally been used to compensate staff for working unsocial hours. However as 24/7 services have become more prevalent since the late 1990s, unsocial hours working arrangements and the associated premiums across many sectors of the economy have changed in a variety of ways.
- 3.13 Overall premia are highest for Sundays, followed by night working, than for unsocial hours worked on Saturdays. Payments are generally higher for junior staff than for senior staff (as a proportion of basic pay), and in some cases senior staff do not receive any premia. However, the level and incidence of unsocial hours payments vary by sector and type of work.
- 3.14 IDS found there were different approaches to unsocial hours pay across different sectors; some consolidated unsocial hours pay into a higher base salary, some used shift patterns, some paid a premium per hour worked, whilst a few did not pay any unsocial hours premium.
- 3.15 The IDS case studies provided some commentary on issues to consider and their reflections for transition and successful implementation of changes to pay and work patterns. In particular a recurrent theme was making changes as part of a broader pay and employment package and the importance of local level staff engagement before and during transition.
- 3.16 For our remit group, one of the most relevant comparator industries considered by IDS was the **airline industry**. Here payments for working shifts and unsocial hours vary depending on the employee group and between airlines. As demonstrated in Table 3.2, long haul and international flights attract higher premia, whilst cabin crew receive a higher premium as a percentage of basic salary than airline pilots. IDS suggest that the average premium for airline pilots was about 14-17% although higher premia could be received for longer routes.

² Full details of the methodology can be found in Appendix 1 of the IDS report.

Table 3.2: Unsocial hours and overtime payments for airline industry

Airline Industry Staff Group	
Airline Pilots	T+14% average for captains; T+17% average for first officers
Cabin Crew	T+25% for domestic flights; T+50% or more for international flights

T – Plain time

Source: IDS Report – Table 1

3.17 Working hours for **airline pilots** are covered by regulations, issued by the European Air and Space Agency and implemented in the UK by the Civil Aviation Authority, which limit the maximum flying time to 900 hours per year.³ In practice the number of flying hours for captains in the UK, across a number of different types of airlines, ranges from 560 to 823 hours per year. In addition to this airline pilots will work between 1,300 and 1,500 duty hours.⁴ Working patterns typically cover extended day working, 6am to 12 midnight across any day of the week. Further details of hours of work for airline pilots as identified by IDS can be seen in Figure 3.1.

Figure 3.1: Hours of work for airline pilots

Hours of work for airline pilots – key points
<ul style="list-style-type: none"> • Early start is defined as between 5.00am and 06.59am; late finish is between 01.00am and 01.59am; night duty occurs between 02.00am and 04.59am. All of these times are in the time zone to which a crew member is acclimatised. • No more than three consecutive early/late/nights duty periods and a maximum of four in any seven-day period. • A consecutive run can only be broken by a rest period of at least 34 hours. • A rest day must include two local night periods, and each extended rest period must be a minimum of 36 consecutive hours. The maximum period between the end of one extended rest period and the start of another is 168 hours. • Pilots will be limited to flying no more than eight or nine hours, depending on when their shift starts. • Flying hours starts from when the plane first starts to move – ‘chocks away’ – and ends when the plane comes to a complete rest at the end of the same flight. There is a maximum of 900 flying hours in a calendar year or 1,000 hours in any consecutive 12-month period. • Duty hours include flying hours plus flight preparation time, time spent on training, all standby duty hours at an airport and 25% of standby duty hours away from the airport. The maximum length of a single period of duty is 16 hours. There is a maximum of 190 duty hours allowed in any 28 consecutive days. • Additional rest periods may apply to take account of the cumulative fatigue arising from differences in time zones and changes in home base. • Pilots away from home base must have a minimum of 10 hours rest between each shift, and eight of those hours must be uninterrupted sleep. Before, pilots could spend that time showering, eating or commuting between the airport and hotel. The minimum rest period at home base is 12 hours.

Source: Table 7 IDS Report

3.18 IDS suggested that, in some sectors, very highly-paid employees do not receive any unsocial hours enhancements. Here the assumption seems to be that basic pay (and bonuses/awards, where paid) are sufficient compensation for any inconvenience arising from instances of unsocial hours working. This seems to be the case with some of our

³ Flying time is measured from ‘chocks away’ to the time that the aeroplane has come to a complete standstill and is parked.

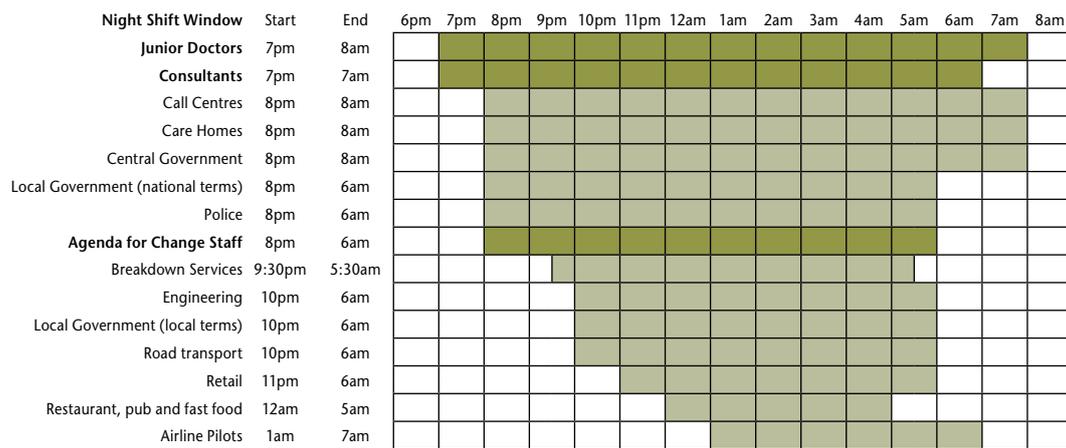
⁴ Duty hours include flight preparation times and mandatory training.

usual job-weighted comparator groups,⁵ for example **actuaries**, where basic salaries are high, starting at around the top decile of earnings, and bonuses often start at 10% of salary, making up an even greater proportion of remuneration with experience/seniority.

- 3.19 IDS identified **local government** as having recently made changes to some unsocial hours working payments, partly as a result of ongoing funding pressures. Employers have reduced overtime premiums, and many councils have also increased their 'plain-time hours', thereby limiting the scope for overtime and unsocial hours working. About a quarter of the London councils surveyed had moved the start of premium time back to 10pm on a weeknight (from 8pm). Camden Council, in particular, recently introduced a number of changes to payments for unsocial hours working as part of a wider package of changes. Staff moved across to the new system on a voluntary basis, receiving a one-off payment. Unsocial hours premia were reduced by ten percentage points to 23% for night work, and plain-time working hours are now defined as between 7am and 10pm Monday to Friday, and 8am to 5pm on Saturday and Sunday. This was part of the council's 'Camden Plan 2012 – 2017' and will deliver savings of around £2 million a year and provide a means of avoiding redundancies.
- 3.20 In general the IDS report indicates that different employers have different policies for compensating unsocial hours working. The common feature, however, is that employers set their policy, whether that be consolidation into basic pay, shift working, hourly premia or overtime, based on their business needs, and the labour markets in which they operate. For example, the **police**, where all officers need to be highly trained and a 24/7 service is needed, the allowances have largely been consolidated. For **engineering and manufacturing**, there is a frequent but variable need for shift working, and trained staff need to be available, so the unsocial hours premia incentivise workers to do shift working when the employer needs it, but not otherwise. The **retail and fast food sector**, whose opening hours will be flexible based on market demand and who can train most of their workers rapidly, have a much more adaptable approach to paying unsocial hours premia, if at all.
- 3.21 From the information in the IDS report, summarised in Figure 3.2, we can see that there is some variation in the current definitions of the night window across sectors. It appears that the 'standard' night window starts between 8pm and 10pm for most sectors and closes between 6am and 7am. For the definition of a night window, consultants and in particular junior doctors, appear to be out of line. The current night window for Agenda for Change staff begins at 8pm, whilst the proposed options, discussed in more detail in Chapters 4 and 5, suggest the night window for junior doctors and consultants should start at 10pm. Our analysis of the IDS research suggests moving the start of the night window to 8pm or 10pm would not be out of line with other sectors.

⁵ The pay comparators used are: legal, tax and accounting, actuarial and pharmaceutical. They were identified in the report: *Review of Pay Comparability Methodology for DDRB Salaried Remit Groups*. PA Consulting Group. Office of Manpower Economics, 2008.

Figure 3.2: Night shift window



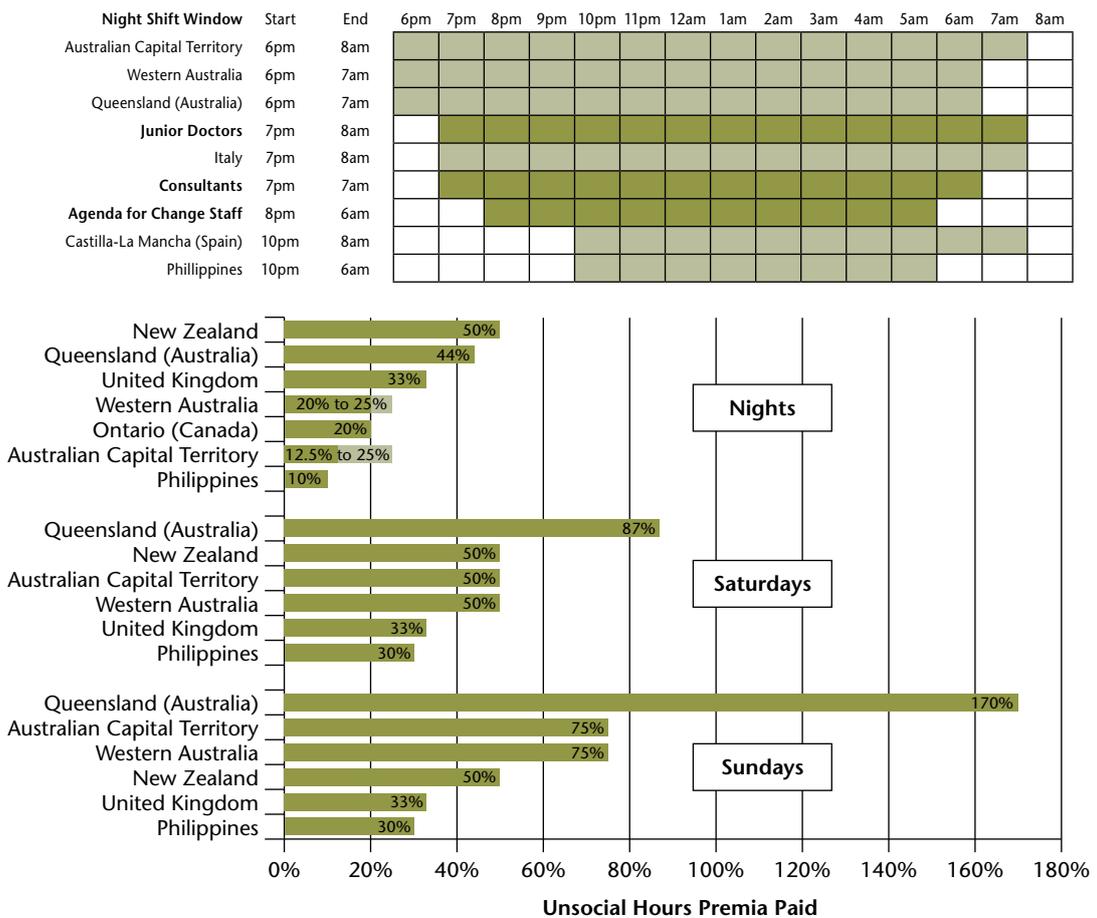
Source: OME Analysis of IDS Report

International research on doctors' unsocial hours

- 3.22 International comparisons are fraught with difficulty due to the inherent problem of ensuring like-for-like comparison across countries. As such, caution should be used when any direct comparisons are made. The roles and responsibilities of staff are varied across countries, as are other benefits, bonuses, taxes and allowances.
- 3.23 It is our understanding, based on desk research, that outside of accident and emergency services, most international public healthcare systems are not at the moment providing a comprehensive twenty-four hour, seven-day service. Many countries are, however, looking at expanding more services into weekends and evenings. With regard to NHS England, Sir Bruce Keogh argues that as the biggest integrated healthcare system in the world, the NHS is better placed than others to resolve the issues around fully integrated seven-day services.⁶
- 3.24 Most countries pay premia to incentivise unsocial hours working, but the level of these premia varies from country to country. The hours during weekdays which attract unsocial hours premia vary from country to country, starting from 6pm to 10pm and finishing between 6am and 8am. In general, Sundays (and bank holidays) receive the highest rate of premia, followed by Saturdays and night time hours, as shown in Figure 3.3.

⁶ NHS England's Sir Bruce Keogh sets out plan to drive seven-day services across the NHS - <https://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/>

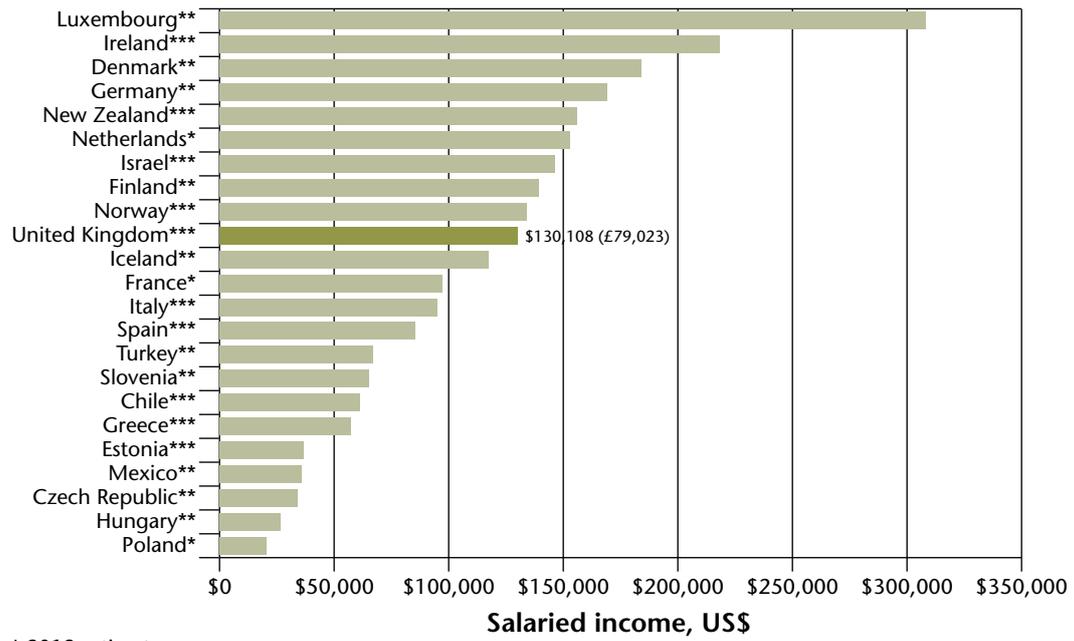
Figure 3.3: International night shift window and unsocial hours premia paid



Note: For some countries only night window timings or percentage premia rates were found.
 Source: Various, see Appendix B

3.25 To provide context to this international research for unsocial hours services, we have used the Organisation for Economic Co-operation and Development (OECD) Health Statistics 2015 to provide a comparison of doctors' income. This includes data about salary levels for salaried doctors in US\$ (see Figure 3.4). Adjustments to achieve like-for-like comparisons across countries mean that the absolute levels of pay may not be completely reliable (understating pay in the UK for example). However the figures provide a useful indication of relative pay across countries. Of the OECD countries compared, the average salary for UK specialist doctors (\$130,108, or £79,023) is ranked around the middle, ahead of France, Italy and Spain. In Ireland, Germany, New Zealand and the Netherlands specialists are paid more than UK doctors. Of the countries with data available, doctors in Luxembourg were paid the highest total salary of over \$300,000 (£197,073). It is important to note that the data covers all specialist doctors, so includes both consultants and junior doctors.

Figure 3.4: Gross total earnings⁷ of specialists (US\$)



* 2012 estimate
 ** 2013 estimate
 *** 2014 estimate

Source: OECD Health Statistics 2015

⁷ This is salaried income, not all countries within OECD are represented due to lack of data. Some countries only have self-employed specialists and these are not included here.

CHAPTER 4 – JUNIOR DOCTOR CONTRACT REFORM

Introduction

- 4.1 This chapter sets out the background to the recent negotiations for a new contract for doctors and dentists in training, before going on to consider the proposals for a new contract. Our remits from England, Wales and Northern Ireland ask us to make recommendations on new contractual arrangements for doctors and dentists in training. The Scottish Government sought our observations. The remits are described in more detail in Chapter 1 and in Appendix A. Our recommendations are summarised at the end of the chapter, along with the areas that we consider require further consideration.

Background and negotiations

- 4.2 The current contract for doctors and dentists in hospital training was introduced in 2000 and covered two key areas: training and service provision. The contract included the specific aim of improving working conditions through reducing junior doctors' hours and ensuring minimum rest breaks. This objective was met, and in June 2011, a scoping report¹ was published that reviewed the ongoing viability of the 2000 contract. The report gathered the views of a wide range of NHS employers across the United Kingdom (UK), as well as the views of the British Medical Association (BMA) and the British Dental Association (BDA). The report set out a vision and principles for a new contract, emphasising:

- better patient care and outcomes;
- doctors in training feeling valued and engaged;
- affordability;
- producing the next generation of medical professionals; and
- improving relationships (particularly among doctors, employers and deaneries).

The parties came to a consensus that the existing contract was no longer suitable and was hindering achievement of the vision above. In evidence NHS Employers told us that, in general, employers across the UK favoured a more flexible, locally determined approach within an overall national framework, while they said that the BMA advocated comprehensive nationally applied standards to ensure consistency. The Department of Health said that the current contract did not reward doctors fairly for the work they undertook, and could actually hinder training and restrain the design of services.

- 4.3 During December 2012, the Secretary of State for Health accepted that the scoping report provided the basis for negotiations, and invited NHS Employers and the BMA to discuss the prospects of negotiating changes to the junior doctors' contract. Those discussions led to the agreement of Heads of Terms² for possible negotiations. NHS Employers told us that the primary issues to be addressed were better patient care and outcomes; and better engagement and improved relationships in the development of the next generation of medical professionals. In October 2013, NHS Employers was mandated by all four UK health departments to begin negotiations with the BMA on a new contract for doctors and dentists in training, with a view to negotiations being completed by October 2014 and implementation to begin in April 2015.
- 4.4 The parties submitted an interim joint report on the negotiations to Health Ministers in February 2014. The interim report confirmed that both sides had agreed that the new

¹ *Scoping Report on the Contract for Doctors in Training – June 2011*. Department of Health, December 2012.

² *Draft Heads of Terms for Negotiations to Achieve a New Contract for Doctors and Dentists in Training*. BMA, NHS Employers, June 2013. Available at: <http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/HoT%20final%20draft%20with%20explanatory%20notes.pdf>

contract must be cost neutral, that high-level definitions around pay had been agreed (such as the definition of on-call), and that discussions to develop a set of principles to underpin the pay elements were continuing.

- 4.5 On 16 October 2014, the BMA withdrew from the negotiations. The BMA said that contract negotiations had stalled due to the lack of credible evidence available to underpin the changes being proposed. It was concerned that it was being asked to make decisions that had the potential to make a considerable impact on patient safety, doctors' welfare and the sustainability of the NHS without robust data.

Pay elements of proposed contract reform

Overview

- 4.6 We welcome the substantial progress that was made between the parties during the discussions before the breakdown in the negotiations. We note that junior doctors are already working across seven days: indeed, they play a vital role in the delivery of services, particularly at night and at weekends. Unlike consultants, junior doctors do not currently have an 'opt-out' clause from working at weekends or nights. The reforms to the contract for junior doctors are based on the view that the existing contract has fulfilled its main objective of reducing working hours, and that the contract is no longer fit for purpose. Reform is not directly linked to enabling seven-day services, although the proposals for reforming the contract do include some related provisions, such as changes to the definition of plain time/out-of-hours periods. We endorse the case for contractual change which underpinned the agreement of Heads of Terms for negotiation, and the rest of this chapter gives our views on the specific contract proposals. We consider that the contract has an important role to play in recruitment and the choice of specialty for trainees.
- 4.7 Junior doctors and consultants are at differing stages on the same career path, and the two contracts should not be viewed in isolation. We consider that the proposed contracts have the potential, over time, to smooth the transition from being a junior doctor to a consultant. They would also better recognise the changing NHS, in which both sets of doctors will work.
- 4.8 We note the importance of the vision for reforming the junior doctors' contract, set out in paragraph 4.2 above. This report is focused on the pay elements of contractual reform, in line with our remit, however we note that it will be important to measure the benefits of any new contractual arrangements against this vision.

Summary of the pay elements

- 4.9 NHS Employers sought to undertake negotiations on contract reform on behalf of the four countries of the UK, and our report therefore refers in the main to NHS Employers (and the BMA, the other party to the negotiations), rather than the individual health departments of the UK. NHS Employers summarised the main elements of the proposed junior doctor contract package. It consisted of the following elements, shown below in Table 4.1. The current pay structure is set out in Appendix E.

Table 4.1: Main pay elements of the proposed junior doctor contract package

Pay element	Description
Basic pay	Rate of pay for up to 40 hours a week, with a 'nodal' pay scale based on stages of training.
Rostered hours (additional to 40)	Up to eight per week (on average) over the reference period, paid at the same rate as basic pay.
Out of hours (OOH)	A premium rate (in addition to the standard hourly rate paid as part of basic pay or rostered hours), which applies to hours in the OOH period.
Availability allowance (AA)	An allowance that is paid in return for an obligation to be available on standby to return to work.
Recruitment and Retention Premia	Payments made to a group of doctors in a specialty or a geographic area for a defined period – paid on top of basic but not included in calculation of other payments.

Basic pay points and progression

The evidence

4.10 At present, junior doctors have an incremental salary scale and progress automatically through it on an annual basis. Details of the current scales are in Appendix E. NHS Employers noted to us in evidence that those training less than full time received annual progression, as did almost all those trainees that failed to progress to the next stage of training. They proposed moving to a 'nodal' system, whereby pay increases would correspond with stages of training, and thus increases in responsibility (rather than time served or years of experience), which they said would remove the anomaly whereby those for example taking a break from training or working part-time would reach higher pay points than someone who had not, despite equal experience. NHS Providers supported linking pay with moving to a post with a higher level of responsibility and Health Education England said incremental pay rises should reflect progress in training not just years worked. NHS Employers set out three alternative scenarios for pay progression, shown below in Table 4.2. In each scenario, the coloured blocks represent stages of training, and thus a pay point.

Table 4.2: NHS Employers' proposed pay progression scenarios

Pay progression scenario	Stages of training									
	F1	F2	CT1/ ST1	CT2/ ST2	CT/ ST3	ST4	ST5	ST6	ST7	ST8
A) 6 nodes – unique step for CT3/ST3 trainees	Green	Blue	Yellow		Orange	Red			Purple	
B) 6 nodes – ST4/ST5 differentiated	Green	Blue	Yellow		Orange		Red		Purple	
C) 5 nodes	Green	Blue	Yellow		Orange				Red	

4.11 The BMA argued that the proposal would disadvantage those taking time out of training compared to the current model, as it would those taking maternity, paternity or sickness leave, or those working less than full time or those pursuing academic careers. The Medical Women's Federation also highlighted the impact on women taking time out for maternity or working less than full time, and suggested that the proposed arrangements might fall foul of indirect discrimination. In response, NHS Employers told us that they had taken legal advice at an early stage of negotiations, and that on gender, the advice had provided reassurance that its proposals were objectively justified, and that provisions

that affected individuals differently were reasonably necessary to achieve business objectives.

- 4.12 The Department of Health referred to the Chancellor's June 2013 announcement that government reforms to public sector pay included the end of progression pay with automatic pay rises simply for time served.
- 4.13 The BMA said that there was a fundamental flaw in the proposed model of pay progression, whereby progression between the nodes was based upon a trainee's Annual Review of Competence Progression (ARCP) outcome, and pointed to General Medical Council (GMC) ARCP reports that indicated an unexplained variation in outcomes between geographical locations and specialties which it believed meant that the ARCP process could not be used to fairly determine pay progression. In response, NHS Employers said that whilst eligibility for a post might be dependent on evidence of satisfactory progress in training (amongst other factors), it was the actual progression to the next level of responsibility, achieved by taking up a position at that level, which would trigger an increase in remuneration. It said that it rejected the suggestion that pay increases should apply with every year of progression, since progression through training posts did not equate to additional responsibility at every level.
- 4.14 In its remit letter, the Scottish Government said that it did not *require* the end of automatic progression. However, recognising the strength of a national contract for junior doctors, it said it would be willing to consider any alternative system which offered junior doctors fair reward, and one that all parties signed up to. It said that the proposals would offer a significant rise in basic pay to junior doctors, as well as stability of earnings throughout training. With that in mind, the Scottish Government said that it was willing to support the proposals as an alternative to the current system, but would be looking for all parties, including the BMA, to support the adoption of such a system.
- 4.15 The BMA proposed an alternative model of pay progression, contingent upon what were described as appropriate and objective criteria. It suggested gateways to progression based upon: engagement with revalidation; completion of compulsory corporate training; engagement with rota assessment procedures; meeting GMC standards; and completion of a GMC training survey. NHS Employers rejected this approach, as the gateways put forward by the BMA were for things already required of a doctor in training to remain in training and employment.

Our comments

- 4.16 We note that the Heads of Terms committed the parties to agreeing new rules for pay progression, and agree with the basic principle of the ending of the time-served automatic progression that is a feature of the current junior doctor contract. We consider that the criteria put forward by the BMA for a gateway approach would allow progression for carrying out tasks that we would expect all doctors in training to undertake, and we therefore are unable to endorse this proposal.
- 4.17 We have previously commented that we would support a contract that strengthens the link between pay and better quality patient care and outcomes.³ The proposal for pay progression based on stages of training (and responsibility) best meets that objective, and we therefore support this proposal and consider that it forms the basis of a more professional contract. This also plays to our consideration of criterion 1 (see Chapter 1) for improved patient care and criterion 4 for appropriate remuneration. Whilst it will be the actual taking up of a post in a higher stage of training that would trigger an increase in pay, we note that the assessment of readiness to the next stage of training will play an

³ *Forty-First Report. Review Body on Doctors' and Dentists' Remuneration. Cm 8577. TSO, March 2013. Paragraph 6.14.*

important role and suggest that the parties should define the role of the Deaneries, Local Education and Training Boards, Royal Colleges and employers in this regard.

- 4.18 NHS Employers put forward three pay progression scenarios in Table 4.2. As an underlying principle is that pay progression should be aligned with stages of training, the most appropriate scenario should be the one that most accurately reflects when the level of responsibility increases. Given the current information available to us, we have not been able to comment at this stage on the various pay progression scenarios put forward. The BMA points to variations in ARCP outcomes by both geography and specialty as a reason to not implement the proposed pay system. Clearly the parties will wish to address any discrepancies in outcomes, but we do not consider this prevents us from endorsing the principle of pay being based on stages of training and actual progression to the next level of responsibility, evidenced by taking up a position at that level.
- 4.19 Whilst the Scottish Government does not require the end of automatic progression, it told us that it would be willing to consider an alternative system that offered junior doctors fair reward. Having considered the proposal on pay progression linked to stages of training, the Scottish Government told us that it would support the proposals, but would be looking to the BMA to support the proposal. For our part, we note that the parties consider the market for doctors to be a national market and believe there to be a strong argument for supporting a UK-wide contract and that we see the proposals as being fair.

Recommendation 1. Pay should be based on stages of training and actual progression to the next level of responsibility, evidenced by taking up a position at that level.

- 4.20 NHS Employers said that employers might want to consider a mechanism to compensate doctors who took a break from training to undertake MDs, PhDs or educational breaks that were required for their Certificates of Completion of Training (CCT) programme. We address this point in the later section on clinical academic trainees, but note here that a similar mechanism (flexible pay premia) might also be appropriate for junior doctors taking a break from training for other exceptional reasons that benefit the NHS or health provision more broadly: for example, those doctors that volunteered to help with the recent West African ebola outbreak.

Recommendation 2. Flexible pay premia could be used to recognise, where appropriate, junior doctors who take a break from training for exceptional reasons that benefit the NHS or health provision more broadly.

- 4.21 Responsibility for ensuring that contracts meet with any equality legislation rests with employers. Though we have not seen it, we take some assurance from the legal advice cited by NHS Employers that concluded that the proposed contractual changes could be objectively justified and that provisions that affected individuals differently were reasonably necessary to achieve business objectives. The Department of Health also considered that the proposals would withstand any legal challenge.

Professional contract vs amendment of current banding system

The evidence

- 4.22 NHS Employers described the pay elements it proposed to be rewarded under a new contract. They included basic pay, with a rate of pay for up to 40 hours per week, and a level of tolerance for additional rostered hours paid at the same rate as basic pay of up to eight per week (on average) over the reference period. Health Education England said

that unscheduled hours of work were sometimes necessary and needed to be reflected in the basic contract itself, and not paid on an *ad hoc* basis.

- 4.23 NHS Employers told us that it was clear to them that the development of a work schedule and work review process was an essential component of the development of new contractual arrangements. They said that proposals for managing work and training were built around providing a doctor in training with a work schedule, in order to let them know the hours they would be working and where they could expect to work those hours, including any on-call arrangements. The work schedule would detail the clinical services expected to be undertaken, and the training opportunities during a placement. The work schedule would be developed in partnership between the employer and the doctor in training, and would be personalised to take into account the individual training experience and competencies.
- 4.24 NHS Employers also said that work reviews would take place at each educational meeting, and at the beginning and end of a post as a minimum, but also at any point at the request of the employee or employer. A three stage process was proposed: first, an informal discussion, to attempt to resolve the issue quickly; a second stage of a formal meeting including the educational supervisor, the doctor in training, a service lead and a nominee of the director of postgraduate medical education; and a third stage of the employer's local grievance procedure, to consider whether or not a change to the work schedule was required, with that decision being final. The Department of Health supported NHS Employers' proposals. The BMA did not believe the proposals on work reviews to be robust enough, arguing that final stage reviews needed an external arbiter (such as the Postgraduate Dean) to overcome any perceptions of bias. NHS Employers said that work reviews would be triggered by exception reporting, used to inform the employer of variations to a work schedule, primarily relating to hours of work and rest, patterns of work and educational opportunities. The BMA said that whilst only reporting significant breaches was superficially attractive, it was vital to report all breaches, and that it was critical that any unplanned exception reported work was paid for.
- 4.25 The BMA argued that retaining a well-implemented banding based system (similar to the current contractual arrangements) had the dual advantage of retaining hours safeguards with a financial incentive but allowed for *ad hoc* overruns without excessively penalising trusts. The BMA asked us to call on NHS Employers to provide more detailed data on hours worked under current bandings. The BMA said that with doctors working beyond their planned hours, a move to a 'professional contract' would secure doctors working at least the same hours as currently, without any payment for those additional hours worked, exploiting the professionalism and goodwill of doctors in training.
- 4.26 NHS Employers, however, said that the scoping study had identified multiple problems with the banding process: its complexity and interconnected detail meant that it was poorly understood by both employers and trainees, and remained a fertile ground of dispute after 14 years in use. NHS Employers said that its proposals for a professional contract would be undermined if a system was in place where doctors in training could claim additional money for every extra minute spent carrying out their duties, that it would create an incentive to work slower, and would unfairly reward trainees who did not keep pace compared to their colleagues. They said that they could not agree to any system that would be open ended, where the employer had no control over the amount of money spent on paying doctors in training. The Department of Health and the Department of Health, Social Service and Public Safety in Northern Ireland said they were surprised by the BMA's proposal to reform banding: it had not been raised as a possibility by the BMA during the negotiations, and all parties had given their general support to a wholesale renegotiation of the contract.

Our comments

- 4.27 It is clear from the Heads of Terms agreed between the parties prior to the beginning of negotiations that the new contract would be based on work schedules, work reviews and exception reporting. Our previous reports have commented on the need to restructure the contract for junior doctors to shift the balance away from the banding supplements towards basic pay.⁴ We therefore support the proposal put forward to us for a professional contract based on work schedules, work reviews and exception reporting. We also consider that a professional contract approach also addresses our criterion 2, to maintain respect and trust for junior doctors as leaders and professionals. We note however that work reviews and schedules would need to be properly implemented to maintain the integrity of the new system.
- 4.28 Whilst we broadly accept the arguments put forward by the BMA for contractual safeguards linked to a new professional contract (addressed later in this chapter), we are not convinced that the proposal to retain a revised version of the current banding system could achieve the benefits of the proposed professional contract. A continuation of banding would not be in the spirit of the Heads of Terms. Further, retaining a banding system that enabled doctors to routinely claim for all unplanned breaches of planned working time would have implications for the cost-neutral aim of the negotiations (and our criterion 6 on affordability). We consider that increasing the level of basic pay (from the current banding envelope) adds weight to the notion of a professional contract. Furthermore, we consider it would be very unusual for any of the groups that we use as comparators for junior doctors (actuaries, lawyers, tax and accounting, pharmaceuticals) to have the ability to retrospectively self-authorise overtime payments, where working unpaid for extended hours can be normal practice.

Recommendation 3. We support a contract based on work schedules, work reviews and exception reporting, and the end of banding payments.

- 4.29 During oral evidence, NHS Employers told us that data would be recorded on the outcome of any disputes arising from work reviews. We have considered this in the context of our criterion 3, the credibility and practicality of local implementation and in the context of our annual pay recommendations particularly our look at motivation. In light of these factors we suggest that we could play a role in monitoring whether the professional contract is working as intended, and that employers are not routinely overworking junior doctors compared to their work schedules. In any case we would expect to receive evidence on all employee-triggered work reviews in order to inform our annual pay deliberations. The work reviews should be evidence-based, be accountable and given the length of postings of junior doctors, will need to be timely.

Recommendation 4. Work reviews should be evidence-based, accountable and timely.

Recommendation 5. We should be provided in the future with annual data on the outcome of employee-triggered work reviews on a UK-wide basis.

⁴ *Forty-First Report. Review Body on Doctors' and Dentists' Remuneration. Cm 8577. TSO, March 2013. Paragraph 6.10.*

Plain time/unsocial hours rates

The evidence

4.30 Under the current system, plain time is defined as 8am until 7pm, Monday to Friday, with banding supplements used to recognise both work in addition to the standard 40 hour week and more intense working patterns. As described above, NHS Employers proposed ending the current banding supplements in favour of a professional contract. A premium unsocial hours rate (in addition to the standard hourly paid rate as part of basic pay or rostered hours), was also proposed for hours worked in the unsocial hours period. NHS Employers set out four proposed scenarios for defining unsocial hours periods and the associated rates, as shown in Table 4.3. In addition to redefining unsocial hours periods and rates, the four scenarios explored the extent to which the level of basic pay could be increased by moving funding from the current banding supplements.

Table 4.3: Unsocial hours scenarios proposed by NHS Employers

Scenario	Increase to basic pay	Unsocial hours periods	Unsocial hours rates
A	19.1%	10pm to 7am every day of the week	33% for all unsocial hours periods
B	17.5%	10pm to 7am Monday to Saturday, all day Sunday	33% for all unsocial hours periods
C	15.3%	10pm to 7am Monday to Saturday, all day Sunday	50% for 10pm to 7am every day of the week, 33% for 7am to 10pm Sunday
C+	14.9%	10pm to 7am Monday to Saturday, all day Sunday	50% for 10pm to 7am every day of the week, 33% for 7am to 10pm Sunday

4.31 NHS Employers told us that while scenario A gave the largest increase to basic pay, and reduced the cost of delivering services on Sunday, it disproportionately rewarded those working fewer and less unsocial hours, to the detriment of those working a higher number of more unsocial hours. Scenario B improved the earnings of those working more unsocial hours, but NHS Employers thought the balance of reward needed to be moved further in that direction: they thought that those staff working through the night should be better rewarded for the important service they provided. Scenario C provided the most generous reward to doctors in training working in unsocial hours, and provided a clear differential in pay between those working unsociably through the night compared to those working all of their hours in plain time: this was NHS Employers' preferred scenario, although they went on to explore a further option (known as C+), described later in this chapter in paragraph 4.42.

4.32 In tandem with proposals for our remit groups, NHS Employers also put forward proposals for amending the current plain time/premium time definitions for staff working under Agenda for Change arrangements to the NHS Pay Review Body. Whilst the proposals for the various staff groups differed in their definition of unsocial hours, they did have one thing in common – the unsocial hours period began at 10pm. For full details, see Appendix F. Table 3.1 in Chapter 3 shows the current definitions and rates.

4.33 The BMA said it was not possible from the data presented to ascertain what the impact on income would be for different specialties, but that it was concerned that it would make some specialties with greater unsocial hours working less attractive, damaging recruitment and retention in those specialties.

Our comments

- 4.34 As noted earlier, our previous reports supported placing more emphasis on basic pay rather than on banding payments. This would give more stability in pay and would help to ensure that basic pay did not fall out-of-line with comparator professions. The scenarios set out by NHS Employers all meet this objective, but it is also the case that these negotiations are taking place within the existing pay envelope, so by placing greater emphasis on basic pay, this will give less emphasis to unsocial hours pay. Clearly there is a balance that needs to be struck, as we consider it appropriate for pay to also recognise the different unsocial hours responsibilities of posts and specialties, in line with our criterion 4 for appropriate remuneration.
- 4.35 We noted in Chapter 3 the findings that emerged from the research by Incomes Data Services (IDS) into other sectors providing seven-day services: amongst its main conclusions was that it was not uncommon for core time to be defined as finishing within the range of 8pm to 10pm; and that Sundays attracted the highest rate of premia; and that Saturdays were increasingly becoming normalised. On that basis, we support the logic behind NHS Employers' preference for unsocial hours scenarios C and C+ and support their use as the basis for further discussion/negotiation between the parties. The IDS research noted that in some areas, very highly-paid employees did not receive any pay enhancements: here, the assumption seemed to be that basic pay (and bonuses, where paid) were sufficient compensation for any inconvenience arising from instances of unsocial hours working.

Recommendation 6. We support the use of scenarios C and C+ as the basis for further discussion/negotiation between the parties.

- 4.36 Looking at the proposed definitions of core time/unsocial hours for the different NHS groups (see Appendix F), it appears to us that the variation in definitions has been driven partly by the cost-neutral pre-condition for the negotiations. This variation has the potential to complicate the implementation of seven-day services across the whole of the NHS. Noting the direction of travel in other sectors towards extension of plain time into the evenings and on Saturdays, there ought to be a common definition of core time/unsocial hours applied across all NHS groups, that we consider would be seen as being fairer to all staff, who will need to work in teams to deliver seven-day services. If the definition needs to differ between NHS groups, then a commonly understood rationale for such differences would be required.

Recommendation 7. A common definition of core time/unsocial hours is required for all NHS groups. If the definition needs to differ between groups, then a commonly understood rationale would be required.

Recommendation 8. We support a contract based on basic pay (up to 40 hours per week), rostered hours (up to eight hours per week, on average) paid at the same rate as basic pay and an unsocial hours premium.

- 4.37 We are not, however, commenting on the proposed *rates* for unsocial hours working, as we consider this to be an issue for the parties to agree, subject to the cost-neutral pre-condition for the negotiations. The parties might wish to consider whether unsocial hours premia (in terms of the multiple of basic pay) should align across NHS groups, particularly where the basic pay of our remit groups overlaps with the pay of Agenda for Change staff, although we recognise that this would then limit the ability to flex the total pay package, given the cost-neutral pre-condition for the negotiations.

4.38 Our earlier reports have also commented on the need to ensure that starting salaries for junior doctors do not fall behind those for other graduate-entry professions. Whilst all scenarios set out by NHS Employers will allow for an increase in basic pay, they do not lift basic pay above the current median starting salary of £27,000 reported by the Association of Graduate Recruiters. However, we consider it appropriate to also take into account unsocial hours pay: our recent reports show that total pay for junior doctors compares favourably with comparator groups and given the cost-neutral pre-condition for the negotiations, that position will continue. We will, of course, continue to monitor this situation to ensure that the rates of remuneration are and remain appropriate to enable effective recruitment and retention.

Availability allowance

The evidence

4.39 NHS Employers said that an availability allowance would be paid to doctors in training, in return for an obligation to be available on standby to return to work. They said that under each of the scenarios described above, any staff working on-call or hybrid rotas would receive an availability allowance of 5% of basic pay; alternatively, the rate of the availability allowance could vary to reflect the frequency of on-call working. The BMA, however, said that the proposed level of the allowance was derisory for very challenging, urgent, possibly lifesaving work and created the risk that employers could increase on-call shifts in order to reduce spending. It said that it could not agree to an availability allowance as proposed, and that it believed that non-resident on-call must continue to be remunerated at the prevailing hourly rate.

Our comments

4.40 We support the principle of an availability allowance for junior doctors, in line with our review criterion 4 (appropriate remuneration). NHS Employers suggest two approaches: a flat rate availability allowance, or variation in the rate according to the frequency of on-call working. We support the latter approach. We consider it is for the parties to agree on the amount of funding that is allocated for the availability allowance, taking account of the requirement from the Heads of Terms for a pay neutral outcome compared to the current pay envelope. We simply note here the current on-call rates for other NHS medical staff: for consultants, they vary between 1% and 8%; and for specialty doctors and associate specialists, between 2% and 6%. On-call rates for Agenda for Change staff are determined by local agreement.

Recommendation 9. The contract should include an availability allowance to recognise an obligation to be on standby to return to work, with the rate of the allowance varied according to the frequency of on-call.

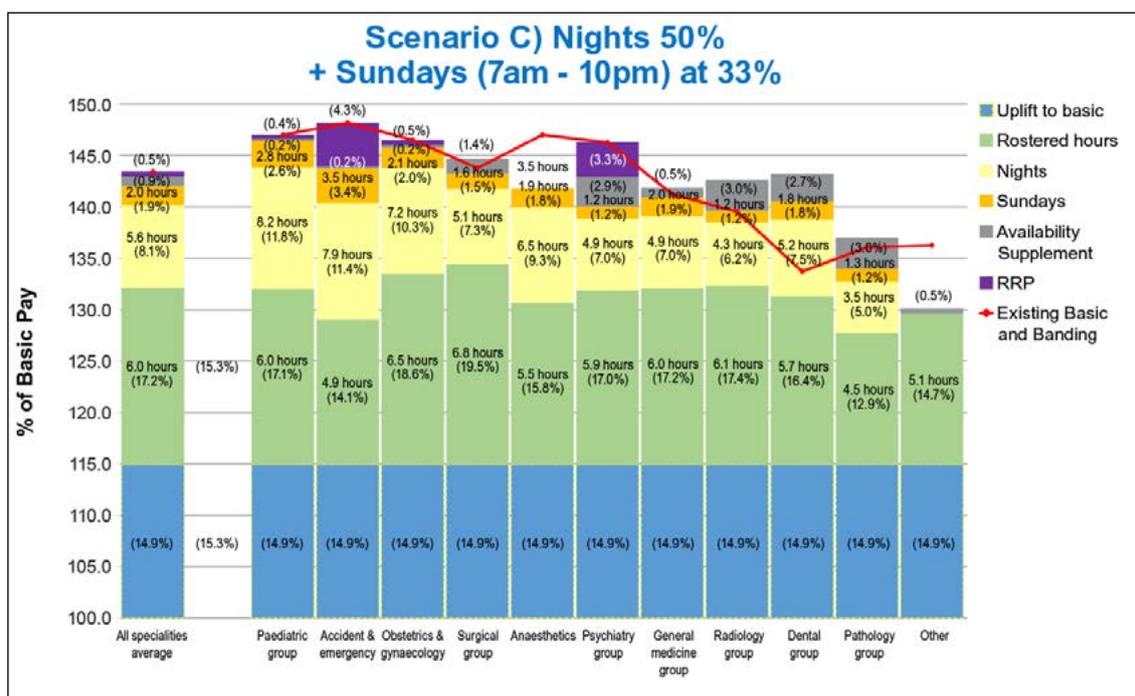
Recruitment and retention premium

The evidence

4.41 NHS Employers noted that changing the pay system so that doctors in training were rewarded for the number of hours worked and when those hours were worked would mean that some earnings would increase and some would decrease: this was unavoidable given the cost-neutral pre-condition for the negotiations. This meant that for some specialties where there were already nationally identified difficulties in recruiting and retaining staff, a potential relative reduction in earnings compared to the current system might exacerbate the situation.

4.42 NHS Employers said that the best way to solve the issue would be to introduce nationally-determined specialty-specific recruitment and retention premia (RRPs). They said that we might wish to consider asking relevant bodies to examine national workforce shortages in various specialties and subspecialties; at what stage of training was the particular difficulty; and whether there were regional variations in recruitment difficulties. Health Education England and the devolved administrations all gave their support to this proposal, indicating that they would put forward advice on shortage specialties after consulting with relevant bodies. NHS Employers said that an RRP avoided disincentives to train in a particular specialty, and retained the current workforce in that specialty. They said that money used to fund RRP could be applied flexibly year on year to address the workforce needs of the day. By way of illustration, NHS Employers said that if RRP were paid to four of the current hard-to-fill specialties – accident and emergency; the paediatric group of specialties; obstetrics and gynaecology; and the psychiatry group of specialties – this would require 0.5% of the existing spend on banding to be spent on RRP. This meant that under scenario C described above (see Table 4.3), the increase to basic pay would be 14.9%, rather than 15.3% – defined by NHS Employers as the C+ scenario. NHS Employers’ proposal for how RRP would work is illustrated below in Figure 4.1.

Figure 4.1: NHS Employers’ scenario C+ proposal using recruitment and retention premia (RRPs) for shortage specialties



- The chart shows the mean average hours worked by specialty based on rota data collected from 30 organisations. It also shows the corresponding payment for each pay element expressed as a percentage of existing basic pay.
- Availability supplements are assumed to be 5% of basic pay for all staff who work an on-call or hybrid rota. However as not all staff within a specialty work an on-call rota, the grey box represents the mean availability supplement within the specialty.

4.43 The BMA said that the inclusion of RRP by NHS Employers seemed to be an attempt to remedy problems caused by the system being proposed: it said that some specialties would be unfairly remunerated and so would require a RRP in order to be brought into line with the current pay for some specialties. It said that problematic recruitment went much deeper than just salary and required contractual change to improve quality of life.

The BMA said it could not support the introduction of targeted RRP when they were funded from the current pay envelope.

- 4.44 The BMA said that pay protection should continue to be available for those doctors who chose to retrain in another specialty, allowing doctors to move into specialties where there was an urgent need. NHS Employers said that pay protection would not be a standard feature of the contract (outside of transition), arguing that RRP would be available for specialties with a recruitment need.

Our comments

- 4.45 We have examined the proposal for RRP, as illustrated by Figure 4.1. We note that this is just an illustrative example of how the various pay elements might map out for the various specialties. Nevertheless, it does show the variation in rostered hours above the basic 40 hour working week for the different specialties, and that under the proposals, total pay will result in both winners and losers compared to the current position (as indicated by comparing the total height of the bars and the red line in Figure 4.1). Those specialties which currently carry out relatively smaller amounts of unsocial hours work will benefit from the increase to basic pay. However, some of those losers are in specialties currently identified as hard-to-fill specialties, and this is one reason for the proposal for RRP (indicated by the purple element of the bars) for some specialties.
- 4.46 It seems to us inevitable that a broad structure based on basic pay, plain time/unsocial hours and availability allowances could not expect to address the recruitment requirements of all specialties, particularly given the cost-neutral pre-condition for the negotiations and when current shortage specialties do not necessarily correspond with the specialties with the most onerous unsocial hours working. NHS Employers has described these proposed payments as RRP, but it appears to us that the payments serve two purposes: firstly as a transition payment to compensate some specialties that will lose out with the ending of banding payments; but secondly, to go towards addressing some current shortage areas. We suggest that a more appropriate name for these payments would be *flexible pay premia*. We support the use of these payments from within the negotiating envelope as part of contractual reform. We note that the current proposal for pay scenarios has the potential to result in some specialties which are currently hard to fill earning less than they do under the current contract. It is therefore important that flexible pay premia are paid where required to ensure appropriate total remuneration is paid in those specialties that are hard to fill.

Recommendation 10. The contract should include the potential use of RRP (or flexible pay premia) to incentivise hard-to-fill specialties and that they are paid where required.

- 4.47 However, the proposals put forward by NHS Employers suggest that a proportion of funding will be top-sliced indefinitely from the pay envelope to fund these flexible pay premia. This suggests that the remainder of the pay envelope will be embedded into the contract in the form of basic pay points, unsocial hours rates and the availability allowance. It seems certain that in the future, the calls on the top-sliced funding for flexible pay premia will change, and that the total amount of funding required will change. It is therefore not clear to us where the funding would come from if the proportion of top-sliced funding needed to increase, or indeed what would happen to the top-sliced funding should the demand for flexible pay premia decrease.
- 4.48 We also considered whether or not we might be able to serve a more formal role in the identification of specialties that should receive RRP, as this is part of our core business of pay, recruitment and retention. We accept, however, that the use of RRP needs to

be able to respond to recruitment problems on a more prompt basis than our annual reports would allow. Nevertheless, we take an ongoing interest in shortage specialties: our most recent report identified seven specialties with problems recruiting to training posts: general practice; nuclear medicine; chemical pathology; emergency medicine; psychiatry of learning disability; ophthalmology; and child and adolescent psychiatry. For future rounds, we ask that the parties submit evidence setting out what advice has been put forward to the relevant bodies on shortage specialties and RRP, and what action has subsequently resulted, so that we are able to review retrospectively the effective use of RRP and make recommendations as appropriate.

Recommendation 11. For future rounds, the parties should submit evidence setting out what advice they have put forward to the relevant bodies on shortage specialties and RRP (or flexible pay premia) so that we are able to review retrospectively the effective use of RRP and make recommendations as appropriate.

4.49 The BMA believes that pay protection should apply for those trainees choosing to retrain in a new specialty, whose training would require them to enter a lower stage of training than their current stage. We have already set out our support for the principle that pay should be based on the stage of training. But it is also the case that such trainees would have gained additional experience from their previous career that is likely to be of benefit to the NHS, and we consider that a flexible pay premia should potentially be available to recognise such experience, where appropriate, also taking into account the risk to retention.

Recommendation 12. Flexible pay premia should potentially be used to recognise additional experience, where appropriate, for junior doctors that choose to retrain in a different specialty.

Pension implications

The evidence

4.50 NHS Employers said that under its proposals, higher basic pay would directly benefit doctors in training in a move to a Career Average Revalued Earnings (CARE) pension scheme, as opposed to the current system where a high proportion of junior doctors' earnings was made up of non-pensionable supplements. Ministers in each country of the UK were content to agree that funding for the employers' contribution pressure arising from moving earnings from banding into basic pay would be met from outside the negotiating envelope.

Our comments

4.51 We support this view, but also observe that over the length of their career, junior doctors will be making higher contributions (as will employers) and working for longer before drawing their pensions. As ever, we will wish to monitor the impact of changes to pension arrangements on the recruitment and retention of our remit groups.

Other groups

GMP trainees

The evidence

4.52 NHS Employers said that the existing general medical practitioner (GMP) trainee supplement would be addressed under the proposed new arrangements via the RRP,

commenting that the current supplement was an RRP in all but name. The only change would be that the RRP would be under the control of Health Education England. Basic pay would increase, as for other (hospital) trainees. Health Education England said that for general practice, the trainee contract needed to be altered to remove the current in-built advantageous payments to doctors that reflected previous banding arrangements for hospital specialty trainees. On the other hand, the BMA argued that without pay parity among doctors in training, general practice would be seen as an even less desirable training option, further hampering the growth of the GMP workforce and worsening the existing problems.

Our comments

- 4.53 NHS Employers have described the current GMP trainee supplement as an RRP in all but name. We note that the GMP trainee supplement is based on the average supplement that is received across all hospital specialties, so that there is not a financial disincentive for trainees taking up general practice, rather than a hospital specialty. But it is also the case that the GMP trainee supplement in part recognises their unsocial hours commitment, although we acknowledge that the average unsocial hours requirement of GMP trainees is currently less than that for most hospital specialties.
- 4.54 Our previous reports have supported the principle of the alignment of contractual arrangements for GMP and hospital trainees, and that the pay for all trainees should reflect the number of hours worked and intensity of work.⁵ We are therefore content to support the proposal for the pay of GMP trainees to be set on the same basis as hospital trainees, in line with our criterion 4 for appropriate remuneration. As with hospital specialty trainees, it will be important for the unsocial hours requirement of GMP trainees to be agreed in work schedules. We acknowledge that as the current unsocial hours responsibility for GMP trainees is relatively light compared to the average hospital doctor, this will have implications for their pay. However, as noted in the section on RRP, GMP trainees would be likely to receive a flexible pay premium, given the current difficulties in recruiting sufficient numbers of GMP trainees in some parts of the UK. These payments could be adjusted over time to reflect the changing position on recruitment and retention.

Recommendation 13. GMP trainees should be paid on the same basis as hospital trainees.

Clinical academics and public health doctors

The evidence

- 4.55 NHS Employers said that the negotiations had focused on arrangements that would be relevant for the majority of doctors in training. They said that should the proposed arrangements be taken forward, additional consideration might need to be given to trainees on an academic pathway and public health doctors. In relation to pay progression, they said that employers might want to consider a mechanism to compensate doctors who take a break from training to undertake MDs, PhDs or education breaks that were required for their CCT programme. The Department of Health and Northern Ireland Executive said that attaining PhDs that were not directly relevant to a CCT was a choice, and might improve a doctor's personal portfolio and employability. The Medical Women's Federation said that women were underrepresented amongst clinical academics and that the pay system should aim to incentivise such roles.

⁵ *Thirty-Eighth Report*. Review Body on Doctors' and Dentists' Remuneration. Cm 7579. TSO, March 2009. Paragraph 3.76.

Our comments

- 4.56 We note that further consideration will need to be given to clinical academics and public health doctors: it is clearly important that these groups are not overlooked. We support the proposal for the parties to consider a mechanism (such as flexible pay premia) to compensate doctors that take a break from training to undertake a relevant MD, PhD or other relevant postgraduate qualification. However, we note that academic research can also be of benefit to the wider NHS and the continuing improvement of patient care, and think that there is a strong case for considering whether flexible pay premia should potentially apply for such research, even when not necessarily linked to an individual's CCT programme. It is also important to ensure that there will be staff in place to teach future generations of doctors, and as a underlying principle, we support pay mechanisms that do not act as a barrier to staff moving in and out of academic careers.

Recommendation 14. Flexible pay premia should be used to recognise, where appropriate, academic trainees that take a break from training to undertake a relevant MD, PhD or other relevant postgraduate qualification, not only for academic work related to an individual's CCT, but also when the work benefits the wider NHS and the continuing improvement of patient care.

Dental foundation trainees

The evidence

- 4.57 The Department of Health sought our view on the salary level for dental foundation trainees (DFTs). It said that the current basic salary for a DFT was £30,432, higher than the salary level for a medical foundation year two trainee (£28,076). However, it later said that no recent job weighting/evaluation of DFTs had taken place. It said that both medical and dental students spent five years at university before being awarded their degrees. On graduation, dentists were eligible for registration with the General Dental Council and were able to provide dental treatment in the private sector without restriction, or within an approved NHS primary care training practice. Doctors however did not receive full registration with the General Medical Council until after completing their FY1 posting. The Department of Health argued that DFT was not comparable with either FY1 or FY2, but that it was probably somewhere in between.
- 4.58 Health Education England also set out its views on DFTs. It said that it would like to see the salary for DFTs brought into line with the salaries of similarly qualified professions at a similar career stage. It noted that in recent years, there had been a shortage of DFT places, leaving some UK graduates without a place: in 2012-13, 41 UK graduates did not get a DFT place; but this year, all UK graduates received a place because Health Education England made extra places available at an overall cost of £1.8 million. It said that if salaries remained at the same level, then it might not be able to absorb a similar cost pressure next year. It said that the current salary of DFTs was based on the old Target Average Gross Income/Target Average Net Income (TAGI/TANI) system which it said had not applied to dental earnings since 1992. Health Education England also made the point that the contracted hours of a DFT was 35 hours per week, compared to 40 for a FY2.
- 4.59 The BDA noted that the pay of DFTs had not formed part of the contract negotiations and said that it opposed any reduction to the salary of DFTs to the level of FY2s. It said that the positions of DFTs and FY2s were not similar, that the two groups did not provide the same care, and that FY2s received banding supplements, whilst DFTs only received their basic pay.

Our comments

- 4.60 Although the Department of Health has sought our views on the pay of DFTs, we consider it pertinent that the BDA was not party to the main discussions on contract reform. Both the Department of Health and Health Education England are looking for the pay of DFTs to be brought into line with the salaries of similarly qualified professionals at a similar career stage, although they have not offered any job weighting evidence to allow us to make such an assessment. However, the pay of DFTs is currently set in relation to the old TAGI/TANI system, which we consider to be an outdated method of setting pay, since it has apparently not applied to dental earnings since 1992. Once the parties agree the pay and new contractual arrangements for junior doctors, then we think it appropriate for the BDA to discuss with Health Education England what an appropriate level of salary should be for DFTs, based on the parties' assessment of job weighting equivalency, to also include the factors identified in the evidence for this remit such as the reduced contracted hours of a DFT compared to a FY2. We ask the parties to report back to us on the outcome of such discussions: we are of course willing to take evidence if agreement cannot be reached.

Recommendation 15. Once the parties agree the pay and new contractual arrangements for junior doctors, then the BDA and Health Education England should discuss an appropriate level of salary for dental foundation trainees, based on an assessment of job weighting equivalency.

Pay envelope

The evidence

- 4.61 The Department of Health said that the 2012-13 pay bill was extant when the Heads of Terms were agreed, but that using it now would not reflect the 1% increase in pay implemented in 2013-14. The Department says that its view is that the baseline for any counterfactual of what would have happened without change should normally be the year immediately preceding that change, and that that was the basis on which the National Audit Office assessed the costs of new contracts previously.
- 4.62 The BMA said that the proposed new incremental pay system would lead to cost savings over the long term. NHS Employers were not willing to consider recycling such savings back into the pay envelope.

Our comments

- 4.63 We acknowledge that the Heads of Terms refer to the 2012-13 pay bill as the basis for ensuring the cost-neutral pre-condition of the negotiations, but also note that the National Audit Office has in the past assessed the cost of new contracts on the basis of the most recent year prior to change. We support the National Audit Office's methodology for assessing the cost of contractual change. Our criterion 6 on affordability leads us to conclude that long-term savings need not be recycled back into the pay envelope, although we note that the basis for cost neutrality is set on a full-time equivalent basis, so any increase in the workforce would necessitate an increase in funding.

Recommendation 16. The year immediately preceding contractual change should be used as the baseline for the cost-neutral pre-condition of the negotiations.

Contractual safeguards

The evidence

- 4.64 Safe working hours was seen as a key issue by the BMA, where it stressed the link between doctor fatigue and patient safety. It is the case that the Working Time Regulations have seen average working hours per week reduce: a maximum of 58 hours in 2004; to 56 hours in 2007; to 48 hours in 2009. In addition, European Court of Justice (ECJ) rulings (SiMAP and Jaeger) determined that all hours spent in residence and on-call counted towards working hours, and that compensatory rest should be taken as soon as a period of work ends, rather than at a later time (e.g. the next day).
- 4.65 The BMA said that to support safe working hours, contractual safeguards were needed. NHS Employers provided these in Schedule 3 (Working Hours) in the draft contract, noting where agreement had or had not been reached with the BMA. They included:
- a 72 hours limit on the number of hours that could be worked in a single seven-day period (agreed);
 - no shift to exceed 13 hours (agreed);
 - no more than 5 scheduled long shifts (more than 10 hours) to be worked consecutively (not agreed);
 - no more than 4 consecutive night shifts of any length (night shift is any shift with 3 hours falling between 11pm and 6am) (agreed);
 - employers and doctors to have due regard to the need for appropriate rest before and after night shifts when agreeing rota patterns (not agreed);
 - breaks during shifts as defined in Working Time Regulations, as amended from time to time by changes in legislation or subsequent case law (not agreed);
 - on-call working patterns to have an agreed average amount of time in work schedules for work carried out on-call (not agreed);
 - no doctor to be on duty for more than 7 consecutive on-call periods (not agreed);
 - doctors whose overnight rest was significantly disrupted, causing a breach in Working Time Regulation rest requirements, to inform employers as soon as practicable, and arrangements must be made for appropriate compensatory rest (not agreed); and
 - the ability to opt out of the Working Time Regulations, although overall hours should still be restricted to a maximum average of 56 hours per week, and be bound by the rest requirements (agreed).

Our comments

- 4.66 It is apparent to us that the issue of contractual safeguards is of vital importance to the possible acceptance of any new contractual arrangements for junior doctors, by building a level of reassurance and confidence into future discussions. The BMA is concerned that, left to guidance for local implementation, not all employers will follow best practice. Our criterion 3 on the credibility and practicality of local implementation has led us to conclude that we support the inclusion of safeguards within the contract; and that the contract should include a specific reference to the safeguards on hours and rest contained within the Working Time Regulations, or any successor legislation. Whilst we note that Schedule 3 in the draft contract does indeed include references to Working Time Regulation compliance, we consider that the wording contained within the contract should make clear that compliance is mandatory. Doctors, of course, also have a responsibility for ensuring that their total hours of work, including any work undertaken outside of their normal contract, do not impact on their ability to work safely. The parties will also wish to consider any work-life balance issues when discussing safeguards.

Recommendation 17. The wording on contractual safeguards in Schedule 3 of the draft contract should be strengthened to a mandatory requirement to comply with the requirements of the Working Time Regulations or any successor legislation.

Transitional arrangements/implementation

The evidence

4.67 NHS Employers said that full transitional arrangements had not yet been designed as it had not yet been determined to which pay structure they would be transitioning, but that basic pay would be protected during the transitional period. They said that full implementation would likely require wider consultation with employers, with arrangements tested across all four nations. NHS Employers said that it was confident that the data collected and modelling undertaken provided robust evidence in support of the proposed scenarios. They said that we might wish to consider further sensitivity testing to determine the appropriate increase to basic pay and the wider applicability of the proposals. The BMA, however, commented on the lack of robust modelling to ensure proposed changes in the system of pay would be sustainable. The Department of Health and Northern Ireland Executive said that costs of implementation needed to be met from within the negotiating envelope, and that the intention would be to protect basic pay during transition.

Our comments

4.68 In the light of NHS Employers' advice, (and in line with criterion 6 on affordability) we agree that further sensitivity testing should be carried out on the pay modelling data to determine the appropriate increase to basic pay and wider applicability of the proposals. This appears necessary as a minimum to ensure the robustness of the pay proposition and to enable transition planning to take place and to be able to fully consider any potential effects on recruitment and retention. We are, of course, ready to assist in any further deliberations, if necessary.

Recommendation 18. Further sensitivity testing should be undertaken on pay modelling data to determine an appropriate increase to basic pay and wider applicability of the proposals.

Miscellaneous issues – leave, fees and expenses

The evidence

4.69 NHS Employers set out provisions relating to leave (in Schedule 8 of the draft contract). The BMA said it was disappointed that proposals for addressing fixed leave were not included, and that annual leave should be in addition to public holidays "recognised by the NHS", meaning doctors might not access leave on *ad hoc* public holidays. NHS Employers said that employers were unwilling to place an absolute prohibition on fixed leave (it was sometimes necessary), but proposed guidance stating that the use of fixed leave should be minimal. With regard to *ad hoc* public holidays, NHS Employers said that (as in the case of the Diamond Jubilee and Royal Wedding bank holidays), it was a matter for local employers to decide on payment and leave arrangements for staff required to work on such days, but that it advised employers to give a paid day off or time in lieu. The BMA's call for all trainees to have 30 days annual leave was rejected by NHS Employers on the basis of affordability and the time spent away from training.

- 4.70 NHS Employers set out provisions relating to fees for private professional work (in Schedule 6 of the draft contract). The BMA argued that the provision for fees undertaken on NHS time being remitted to the employing organisation would lead to a significant loss of income for doctors in training, and restricted their potential income compared to currently.
- 4.71 Schedule 10 in the draft contract set out the provisions relating to expenses. The BMA said that few of the provisions relate to the particular needs of doctors in training, particularly removal expenses; and that the published rates were too low and did not reflect true costs. NHS Employers said that at a time of severe financial restraint, new contractual arrangements should give trusts discretion over how to use limited financial resources.

Our comments

- 4.72 The parties have raised several issues relating to leave. We agree that, on occasion, fixed leave may be necessary to ensure coverage of services, particularly in specialties with small numbers. However, we would expect fixed leave to be the exception rather than the rule.

Recommendation 19. Whilst fixed leave may be necessary, its use should be exceptional.

- 4.73 With regard to *ad hoc* holidays, the current arrangements for local implementation appear to be working, with employers recognising both of the additional bank holidays for the Diamond Jubilee and the Royal Wedding. We are therefore content to endorse continuation of the current arrangements.

Recommendation 20. The current arrangements for *ad hoc* public holidays (via local implementation) should continue.

- 4.74 Turning to the proposal for all junior doctors to have 30 days annual leave, we note that it is not unusual for employers to have different leave arrangements for new entrants compared to experienced employees. Within the NHS, annual leave arrangements vary across grades: from 27 to 33 days (plus 8 days public holidays) for Agenda for Change staff; 25 to 30 days (plus public holidays) for staff grades and specialty doctors; 30 to 32 days (plus public holidays) for associate specialists; and 30 to 32 days (plus public holidays) for consultants. Whilst we are content to agree with NHS Employers' proposal for annual leave for junior doctors, we note that there is an argument for standardising annual leave arrangements for all NHS staff in order to promote fairness and the workforce cohesion that we consider important to delivering seven-day services.

Recommendation 21. Annual leave on first appointment to the NHS should be 25 days, rising to 30 days after 5 years' service.

- 4.75 We consider it appropriate that junior doctors should be able to earn fees for private professional work, but agree that when such fees are earned *during NHS time*, then the fees should be remitted to the employing organisation.

Recommendation 22. Fees earned for private professional work during NHS time should be remitted to the employing organisation.

- 4.76 On the final point, we do not agree that trusts should have discretion over whether or not to pay relocation expenses. The guiding principle for relocation expenses should be that junior doctors should be fully reimbursed for reasonable actual relocation expenses incurred in the performance of their duties, and the Schedule should be amended accordingly.

Recommendation 23. Junior doctors should be fully reimbursed for reasonable actual relocation expenses incurred in the performance of their duties.

Recommendations and next steps

- 4.77 The remit letters for this review required us to make recommendations and observations on new contractual arrangements for junior doctors including a new system of pay progression with a strengthened link between pay and better quality patient care and outcomes. We were asked to consider proposals for pay structures that included the ending of time-served incremental progression; information on the working patterns of doctors in training; and how the current pay envelope could be used differently to increase basic pensionable salaries, provide appropriate reward for additional work, whilst supporting services and training across the seven-day week. We consider that our recommendations meet the requirements of the remits given to us, although as the proposals put forward to us were not fully formed, there are some areas on which we were unable to reach a final view and that we consider will require further consideration.
- 4.78 In line with our remit letters, our recommendations for junior doctors apply to England, Wales and Northern Ireland. The parties in Scotland will need to consider our recommendations and come to a view as to whether or not they would want similar arrangements to apply in Scotland. We consider that the future is best served by a national contract, and that it should apply in all four countries of the UK, but accept that the Scottish Government wishes to consider matters further with the BMA. As there are several issues that still need to be resolved by the parties, we would hope Scotland would want to continue to be a part of those discussions. We ask the parties to report back to us on the outcome of the future negotiations/discussions. As ever, we stand ready to assist in any further work necessary.
- 4.79 Our view is that the new contractual arrangements for junior doctors should be able to progress to implementation without significant delay. The parties should agree a deadline to consider any outstanding issues and for early implementation of the new contractual arrangements.
- 4.80 In summary, we recommend that the following elements of the junior doctor contract proposals be implemented in England, Northern Ireland and Wales, and consider that the proposals are fair and could also form the basis for consideration of new contractual arrangements in Scotland:

Recommendation 1: Pay should be based on stages of training and actual progression to the next level of responsibility, evidenced by taking up a position at that level (paragraphs 4.16 – 4.19).

Recommendation 2: Flexible pay premia could be used to recognise, where appropriate, junior doctors who take a break from training for exceptional reasons that benefit the NHS or health provision more broadly (paragraph 4.20).

Recommendation 3: We support a contract based on work schedules, work reviews and exception reporting, and the end of banding payments (paragraphs 4.27 – 4.28).

Recommendation 4: Work reviews should be evidence-based, accountable and timely (paragraph 4.29).

Recommendation 5: We should be provided in the future with annual data on the outcome of employee-triggered work reviews on a UK-wide basis (paragraph 4.29).

Recommendation 6: We support the use of scenarios C and C+ as the basis for further discussion/negotiation between the parties (paragraphs 4.34 – 4.35).

Recommendation 7: A common definition of core time/unsocial hours is required for *all* NHS groups. If the definition needs to differ between groups, then a commonly understood rationale would be required (paragraph 4.36).

Recommendation 8: We support a contract based on basic pay (up to 40 hours per week), rostered hours (up to eight hours per week, on average) paid at the same rate as basic pay and an unsocial hours premium (paragraphs 4.34 – 4.36).

Recommendation 9: The contract should include an availability allowance to recognise an obligation to be on standby to return to work, with the rate of the allowance varied to reflect the frequency of on-call (paragraph 4.40).

Recommendation 10: The contract should include the potential use of RRP (or flexible pay premia) to incentivise hard-to-fill specialties and that they are paid where required (paragraphs 4.45 – 4.46).

Recommendation 11: For future rounds, the parties should submit evidence setting out what advice they have put forward to the relevant bodies on shortage specialties and RRP (or flexible pay premia) so that we are able to review retrospectively the effective use of RRP and make recommendations as appropriate (paragraphs 4.47 – 4.48).

Recommendation 12: Flexible pay premia should potentially be used to recognise additional experience, where appropriate, for junior doctors that choose to retrain in a different specialty (paragraph 4.49).

Recommendation 13: GMP trainees should be paid on the same basis as hospital trainees (paragraph 4.53 – 4.54).

Recommendation 14: Flexible pay premia should be used to recognise, where appropriate, academic trainees that take a break from training to undertake a relevant MD, PhD or other relevant postgraduate qualification, not only for academic work related to an individual's CCT, but also when the work benefits the wider NHS and the continuing improvement of patient care (paragraph 4.56).

Recommendation 15: Once the parties agree the pay and new contractual arrangements for junior doctors, then the BDA and Health Education England should discuss an appropriate level of salary for dental foundation trainees, based on an assessment of job weighting equivalency (paragraph 4.60).

Recommendation 16: The year immediately preceding contractual change should be used as the baseline for the cost-neutral pre-condition of the negotiations (paragraph 4.63).

Recommendation 17: The wording on contractual safeguards in Schedule 3 of the draft contract should be strengthened to a mandatory requirement to comply with the requirements of Working Time Regulations or any successor legislation (paragraph 4.66).

Recommendation 18: Further sensitivity testing should be undertaken on pay modelling data to determine an appropriate increase to basic pay and wider applicability of the proposals (paragraph 4.68).

Recommendation 19: Whilst fixed leave may be necessary, its use should be exceptional (paragraph 4.72).

Recommendation 20: The current arrangements for *ad-hoc* public holidays (via local implementation) should continue (paragraph 4.73).

Recommendation 21: Annual leave on first appointment to the NHS should be 25 days, rising to 30 days after 5 years' service (paragraph 4.74).

Recommendation 22: Fees earned for private professional work during NHS time should be remitted to the employing organisation (paragraph 4.75).

Recommendation 23: Junior doctors should be fully reimbursed for reasonable actual relocation expenses incurred in the performance of their duties (paragraph 4.76).

4.81 There are aspects of the proposals that require further detailed consideration. These are listed below.

- The most appropriate pay progression scenario to match the different stages of training (see Table 4.2) (paragraph 4.18);
- The new pay points and rates for unsocial hours working (paragraphs 4.37 – 4.38);
- The rate for the availability allowance (as noted above, we are recommending that the rate should vary according to the frequency of on-call working) (paragraph 4.40);
- The proportion of funding top-sliced for RRP (or flexible pay premia) (paragraph 4.47);
- Further consideration of issues impacting clinical academics and public health doctors that will result from the contract reform proposals (paragraph 4.56);
- The appropriate level of pay for dental foundation trainees, to be based on the parties' assessment of job weighting equivalency relative to other trainees (paragraph 4.60);
- The detail of the contractual safeguards within Schedule 3 of the contract (paragraph 4.66); and
- The format of our data requirement on the outcome of employee triggered work reviews (our Secretariat will be happy to discuss further) (paragraph 4.29).

4.82 We urge the parties to work together in a constructive manner to progress new contractual arrangements without delay. As noted in recommendation 18, we consider it necessary for the pay proposals to be subject to sensitivity testing to determine an appropriate increase to basic pay and wider applicability of the proposals. However, in order to keep up momentum, the parties should agree a deadline to consider any outstanding issues and for early implementation of the new contractual arrangements. We are, of course, ready to provide assistance in any further deliberations.

CHAPTER 5 – CONSULTANT CONTRACT REFORM

Introduction

- 5.1 This chapter sets out the background to the recent negotiations for a new contract for consultants, before going on to consider the contract proposals put forward. In considering this we were asked to make observations only and these are summarised at the end of the chapter. The remits given to us by England, Wales and Northern Ireland are described in Chapter 1 and in Appendix A.

Background and negotiations

- 5.2 The current main United Kingdom (UK)-wide contract for consultants was introduced in 2003, with country-specific amendments made as relevant. In Wales, acceptance at ballot of the 2003 contract meant that all consultants were required to move across to the new contract. In England, Scotland and Northern Ireland, movement to the new contract was voluntary (although remaining on the pre-2003 contract was not an option for those changing employers or posts, and almost all new appointments since have been made under the 2003 contract). The vast majority of consultants are therefore now working under the 2003 contract.
- 5.3 We were asked to carry out a review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for consultants, and submitted our report to Ministers in July 2011. That report included our recommendations and observations for reforming the consultant reward structure. During December 2012, the Secretary of State for Health accepted that our report provided the basis for negotiations, and invited NHS Employers and the British Medical Association (BMA) to discuss the prospects for negotiating changes to the 2003 consultant contract. Those discussions led to the agreement of Heads of Terms¹ for possible negotiations. The primary issues to be addressed (as set out in the Heads of Terms) were the delivery of seven-day services in the NHS, pay progression and Clinical Excellence Awards. In October 2013, NHS Employers was mandated by the health departments in England and Northern Ireland to begin negotiations with the BMA on an amended consultant contract, with a view to negotiations being completed by October 2014 and implementation beginning in April 2015.
- 5.4 The parties submitted an interim joint report on the negotiations to Health Ministers in February 2014. NHS Employers told us that the interim report built on the oral assurances within the negotiations from the BMA that Schedule 3 Paragraph 6 (the 'opt-out' clause) could be removed from the contract, subject to acceptable safeguards being agreed in statute, contract, guidance and advice. They said that the interim report confirmed that the parties had agreed that patients deserved the same quality of care across the entire week. The interim report noted that:
- this would inevitably mean changes in the traditional working patterns over time, including the increased presence of senior clinical staff in the evenings and weekends;
 - such a change would present an affordability challenge;
 - modelling would be needed to ensure cost neutrality;
 - changes would be supported by appropriate safeguards to promote and protect health and wellbeing of consultants and safe practice for patients; and

¹ *Draft Heads of Terms Agreement on Consultant Contract Reform*. BMA, NHS Employers, July 2013. Available at: http://www.nhsemployers.org/~media/Employers/Documents/SiteCollectionDocuments/HoT_final_for_website_ap290713.pdf

- any contractual changes would fairly link reward with the number of hours worked and when they were worked.
- 5.5 However, on 16 October 2014, the BMA withdrew from the negotiations. The BMA said that overall, contract negotiations had stalled due to the lack of credible evidence to support the changes being proposed, which it believed could jeopardise the safety of patients and doctors.
- 5.6 The Welsh Government told us it considered the Heads of Terms used as the basis for negotiations to be relevant for Wales, although it noted that BMA Wales had not been part of the Heads of Terms discussions. The Welsh Government said that it had been in attendance (as observers) during the latter stages of contract negotiations, and that on 14 July 2014, its Ministers took the decision to revert to a UK contract, and that officials had sought to join the negotiations alongside England and Northern Ireland. It said that the Heads of Terms would require amendment to allow the Welsh Government to join the negotiations and some of the parties were concerned that the negotiations could be destabilised, particularly as BMA Wales was not around the table. As a result, the Welsh Government remained with its observer status, up until the point that the negotiations collapsed.

Link to seven-day services

The evidence

- 5.7 Changes to the consultant contract proposed by NHS Employers included the removal of contractual barriers to help facilitate the introduction of seven-day services, principally the removal of the 'opt-out' clause from non-emergency evening and weekend work in premium time and an extension to plain time hours. In place of the 'opt-out' clause, it was proposed that safeguards should be introduced to ensure staff were appropriately protected in the provision of seven-day services. The BMA said that it was willing to negotiate the removal of the 'opt-out' clause, but only on the basis of adequate contractual safeguards, a view supported by the Hospital Consultants and Specialists Association. The Department of Health said that the consultant contract needed to be amended to better engage consultants as senior NHS professionals and visible leaders of change.
- 5.8 NHS Employers told us that reforms to the consultant contract were necessary to make the contract more supportive of seven-day services and to make them financially sustainable for the future, a view supported by NHS Providers. In addition, NHS Employers said that junior doctors needed to be supported more effectively in their training and development during evenings and weekends. Health Education England said that training needed to be recognised in contracts to reflect the supervision of trainees across the whole week. It also said that the 'opt-out' clause did not reflect a patient-centred NHS, and that it should be renegotiated and redesigned to reflect employers' and patients' needs, while protecting staff's employment needs. The Department of Health said that the 'opt-out' clause in the contract restricted a common sense approach to workforce organisation to allow employers the flexibility to rota teams in a financially sustainable way; and drove up costs through locally negotiated rates. The Northern Ireland Executive said that the 'opt-out' clause could be used as an effective personal veto on efforts to effectively organise working patterns around patients.

Our comments

- 5.9 Measured against our criterion 1 for improving patient care (see Chapter 1) and our standing terms of reference to place patients at the heart of the NHS, we agree that the case to improve patient outcomes at weekends is a compelling one. Chapter 2 describes this in more detail.

- 5.10 We recognise that many consultants are already working at weekends, and that this can go well beyond providing emergency care. There are some trusts/boards where local arrangements have been agreed for the provision of weekend services, and at affordable rates.
- 5.11 Whatever sensible arrangements may in practice be made locally, the current contract gives consultants the right to decide for themselves whether or not they will provide non-emergency NHS services at the weekends. That is a highly unusual contractual clause. It does not exist for other NHS staff², or for other senior public sector workforces who are providing seven-day services, such as senior police officers or prison governors.
- 5.12 Consultants are senior NHS leaders in their localities, and will rightly have a significant voice in what services need to be provided for patients, and when. We are clear that a successful transition to expanded seven-day services will not be achieved if consultants are considered merely as units of resource to be slotted into rosters, rather than as strategic designers of services. Consultants also need reassurance, and appropriate safeguards, that they will not be compelled to work unlimited unsocial hours; a reasonable work-life balance is vital for them, as for other groups.
- 5.13 The removal of the 'opt-out' clause would reduce consultants' ability to control this part of their working patterns, which many may have seen as one of the key benefits of moving to the consultant grade from the junior doctor grade. However, we see this as an opportunity to smooth the transition between the junior doctor grade, which is routinely rostered for weekend working, and the consultant grade, which can choose whether to be rostered or not. As senior leaders, there is important symbolism in consultants' contractual arrangements, not least in the implicit message sent to other NHS staff. **In our view, the current 'opt-out' clause in the consultant contract is not an appropriate provision in an NHS which aspires to continue to improve patient care with genuinely seven-day services, and on that basis, we endorse the case for its removal from the contract.**
- 5.14 Following this logic, we would not want to see a differential contractual approach taken based on consultant specialty. The extent to which "planned services" are provided at weekends, alongside emergency services, can only be resolved locally. It seems plausible to us that the possibility of seven-day services for all specialties could have benefits for improving patient care more generally. **We therefore consider that the consultant contract should support patient care at the weekends, whether through direct consultant presence or through supervision of junior doctors, as a point of principle.**
- 5.15 Measured against our criterion 2 (maintaining respect and trust for consultants as leaders and professionals) and criterion 5 (to help facilitate constructive, continuing relationships), we note that consultants will be key to the shaping and delivery of seven-day services. **Consultants are clinical leaders and therefore it will be critical for employers and their consultant workforces to work together and agree the detail of any contractual change.** At a national level, the BMA and NHS Employers need to work together to agree any contractual changes or changes to terms and conditions; and at a local level, employers will need to engage with consultants, maintain open dialogue and take key decisions jointly, to improve service provision and training and make any new contract work.

Contractual safeguards

The evidence

- 5.16 NHS Employers said that Working Time Regulations 1998 stipulated limits on working time and entitlements to periods of rest between working time, in-work breaks and to

² Other than for associate specialists, a closed grade.

paid annual leave and had to be adhered to by all employers. They said that employers should ensure that provision was made to allow compensatory rest to be taken when a worker's daily or weekly rest requirements could not be met. NHS Employers' preference was to recognise the 'implied terms' contractual status of the statutory working time requirements. Job planning and work scheduling should adhere to the principles of good clinical governance and local policies agreed to handle situations where consultants were disturbed throughout the night whilst working on-call and had scheduled work the following day.

- 5.17 NHS Employers also put forward proposals for contractual safeguards: firstly that the contract should make clear that a full time contract was for 10 Programmed Activities (of four hours each); and a limit of 13 weekends in each year scheduled for any consultant, unless mutually agreed between the consultant and their clinical manager as appropriate and safe. The BMA said it could not agree to the safeguards, noting that a 1:4 rota would mean (for some) a significant increase in weekend working without good clinical reasoning. The Hospital Consultants and Specialists Association thought that a 1:4 rota was contradictory to family-friendly working policies and needed to be reduced. The BMA also said that on-call work undertaken from home was not specifically counted as work for the purposes of the Working Time Regulations. The Association of Anaesthetists said that if elective services were provided at weekends, then safeguards would be needed to ensure appropriate rest. The British Dental Association also supported strong contractual safeguards to guarantee rest periods. The BMA said it was concerned that some employers might seek to increase income by introducing elective services at weekends and argued that any change should prioritise urgent and emergency care.

Our comments

- 5.18 The principle of including contractual safeguards within the contract has been accepted by the parties, but they have not been able to agree on what those safeguards should look like. As we commented in respect of junior doctors in the previous chapter, it is very clear to us that the issue of contractual safeguards is of vital importance to the possible acceptance of any new contractual arrangements for consultants, by building a level of reassurance and confidence into future discussions. Our criterion 3 on the credibility and practicality of local implementation has led us to **conclude that we support the inclusion of safeguards within the contract; and that the contract should include a specific reference to the safeguards on hours and rest contained within the Working Time Regulations, or any successor legislation. We consider that the wording contained within the contract should make clear that compliance is mandatory.** Doctors and employers, of course, also have a responsibility for ensuring that their total hours of work, including any private work undertaken, do not impact on their ability to work safely. The BMA has also commented that a 1:4 rota could mean a significant increase in weekend working for some specialties without good clinical reasoning. We consider that the appropriate limit on weekend working is for the parties to negotiate, but in line with our logic in relation to the removal of the 'opt-out' clause for all consultants, we consider that any restrictions on weekend working should not be specialty specific. **The parties will also wish to consider any reasonable work-life balance issues when discussing safeguards.** We address the issue of age-related concerns later in this chapter in the section on unsocial hours.

Pay elements of proposed contract reform

Summary of the pay elements

- 5.19 NHS Employers negotiated contractual changes with the BMA, on behalf of the Department of Health and the Department of Health, Social Services and Public Safety in Northern Ireland, and our report therefore refers in the main to NHS Employers, rather

than the individual health departments of England and Northern Ireland. NHS Employers summarised the main elements of the proposed consultant contract package. It consisted of:

- two fixed payments points, equating to two levels of consultant (newly appointed and established), with transition between the points dependent on successful performance reviews;
- a redefining of unsocial hours periods and the applicable rates of pay;
- an allowance for undertaking certain additional roles;
- continuation of the ability for employers to use Recruitment and Retention Premia (RRPs).
- performance-related pay (payments for excellence), replacing local Clinical Excellence Awards; and
- continuation of the current national Clinical Excellence Award scheme.

The current pay structure is summarised in Appendix E.

Basic pay points and progression

The evidence

- 5.20 Under the current 2003 contract, the pay scales for consultants in England and Northern Ireland begin at £75,249 and finish at £101,451: there are a total of eight pay points, and it takes 19 years to progress from the first point to the last point. In Wales, the position is different: the pay scale for consultants begins at £72,927 and finishes at £94,679: however, once the top point of the pay scale is reached, consultants in Wales are eligible for a series of eight commitment awards, each valued at £3,204 (earnable every three years). It would therefore take 30 years for a consultant in Wales to reach a salary of £120,311. The current salary scales are in Appendix E.
- 5.21 NHS Employers described its proposals for basic pay and pay progression. They proposed introducing two fixed payment points equating to two levels of consultant: 'newly appointed'; and 'established'. Transition through the gateway between the two levels would be subject to achieving a series of successful yearly performance reviews, and once achieved, progress would be automatic: there would be an expectation that most consultants would be able to pass through the gateway after four to five years, although some would achieve this sooner. Progression to established consultant would be closely linked to a locally agreed, objective-based performance assessment process. All entry stage consultants would complete an initial consolidation year, during which they would be required at a minimum to meet their set objectives: in order to progress, they would then need to attain at least three 'fully achieving' annual performance assessments, of which the final two years should be consecutively fully achieving. Objectives would be internally moderated and would require sign off by the line manager's appraiser and would be subject to audit by a committee of peers and managers, with wider organisational objectives feeding into individual objectives and subsequent job planning. NHS Employers said that their pay modelling suggested a reduced starting salary for newly qualified consultants of £70,000 rising to £93,000 for an established consultant. The Department of Health said it supported an approach based on a spot rate for experienced consultants combined with a development rate for newly qualified consultants, as it recognised the differing levels of experience, while offering fast progression for those who consistently achieved their objectives.
- 5.22 NHS Employers acknowledged that it was clear that management of the proposed gateways by employers would need to be more robust than was currently the case, to ensure that the benefits of the new structure could be realised. They said that such improvements in employer behaviours would need to be supported by appropriate national implementation guidance and access to practical management tools.

5.23 The BMA said that proposals to split the consultant grade might undermine the grade as a whole and its professional and leadership role. Splitting the consultant grade was viewed as unattractive and consultants were concerned about devaluing the grade. It said that doctors in training were concerned about the implied lower starting salary. Despite this, the BMA said that if the rest of the package proved attractive and offered potential for good earnings and pension accrual, it would consider the proposed new pay arrangements. The Hospital Consultants and Specialists Association said the new entrant consultant period would provide a protected period to gain experience and competencies of working with gradual exposure to additional responsibilities and that it was not adverse to the principle. The Association of Anaesthetists said that if automatic progression was lost, then there must be contractual safeguards that defined progression as appropriate to prevent rogue trusts from simply ignoring progression to limit the salary bill.

Our comments

- 5.24 We have given a great deal of thought to the proposals relating to pay points, in line with our criterion 4 (see Chapter 1) for appropriate remuneration. In line with the view we set out in earlier reports (see Appendix D), **we endorse the proposal for progression to be linked to achievement of excellence (assessed at appraisal), although we wish to stress the importance of employers and consultants being properly resourced and supported to implement an appraisal-based pay system.** Appraisal can also bring about wider benefits: in its report on the consultant contract,³ the National Audit Office referenced academic literature that linked hospital performance and clinical outcomes with management practices, including how well performance management and appraisal were used. It commented that effective management would enable value for money to be improved and the expected benefits of the consultant contract to be fully realised.
- 5.25 Next, we considered the number of pay points. The proposal by NHS Employers is for two pay points: a newly appointed consultant; and an established consultant. We gave consideration as to whether additional pay points for consultants would be of benefit. Whilst this would allow for a clearly defined pay path, we acknowledge that any such path should be based on pay points being linked to clearly defined increases in levels of skill and responsibility, which is the basis for NHS Employers' proposal for the two pay points. We noted that NHS Employers' evidence talks about a consolidation year for newly appointed consultants, with movement to the established consultant grade following after this, subject to achieving a series of successful performance assessments. This description of a career path could therefore lend itself to a three-point pay scale: consolidation; early appointment; and established consultant. Ultimately, **we consider that this should be the subject of further negotiation between the parties, but we would support either a two or three-point pay scale.**
- 5.26 We then considered the value of the pay points. We note that the cost neutral pre-condition for the negotiations has created a trade-off between the value of basic pay and the other elements of the pay package, including the rates for unsocial hours working. Whilst logical, this has coloured the pay proposals put forward to us, requiring them to make savings in the basic pay bill in order to help fund the increased amount of weekend working envisaged. As a result, for example, the proposed starting rate of £70,000 would represent a reduction in basic salary of around £5,000 (in England, Scotland and Northern Ireland) from the current starting rate. Before implementing a package that results in this reduction in salary, it will be important for the parties to consider the potential impact of such a change on the recruitment and retention of consultants at the entry-level point.

³ *Managing NHS Hospital Consultants*. National Audit Office. February 2013. Paragraph 2.2.

5.27 In considering the value of the pay points, we noted that the BMA is concerned with the lack of credible evidence regarding the pay implications for implementing seven-day services for individual consultants. NHS Employers said that the lack of data on when unsocial hours are worked meant that they were concerned about the ability to ensure cost neutrality. Given the lack of a firm evidential base, we therefore are unable to endorse at this stage the specific pay point proposals. In our view, the parties should carry out further work, to include assumptions on the extent of unsocial hours working (as this will impact on the cost envelope and thus the pay points), so that the proposed new arrangements can be better modelled. This would allow the BMA to put a clear proposition to its members. **We consider that the value of pay points should be subject to further negotiation between the parties, and should be rooted in a robust evaluation of recruitment, retention and motivation.** This will involve recognising the tension between starting salary levels and subsequent growth where the number of pay points is small. A 'low-start – steep-growth' package provides good incentives for progress from 'newly appointed' to 'established' status, but could suffer from recruitment and retention problems as doctors achieve 'established' status. The parties will also wish to consider the impact on any further divergence between countries of the UK in the basic pay rates, particularly as it might impact on recruitment and retention. As ever, we stand ready to assist in any further deliberations.

Plain time/premium time/unsocial hours rates

The evidence

- 5.28 The consultant contract is based on a full-time work commitment of 10 programmed activities (PAs) per week, with each PA covering a period of four hours. Each consultant should have a job plan that sets out the number of agreed PAs that a consultant will undertake: any additional work above 10 PAs is by agreement only. Under the current system, plain time is defined as 7am until 7pm, Monday to Friday; premium time is any time outside this period, any time on a Saturday or Sunday or a public holiday. During premium time, the length of a PA is reduced to three hours or, by agreement, the rate of pay for a four hour PA increases to time and a third. Non-emergency work cannot be scheduled during premium time without the agreement of the consultant: this is known as the 'opt-out' clause of the contract. Current pay rates are set out in Appendix E.
- 5.29 The Department of Health said that any approach to unsocial hours payments, including weekend working, should assure employers and consultants that patients would be protected from unsafe working practices, and allow an appropriate work-life balance. NHS Employers told us that it was considering three different methods for allocating unsocial hours payments: an hours-based system; an allowance-based system; and an allowance-hours hybrid system. For the hours-based system, four options for unsocial hours rates were given, with rates set at between time and a third and double time, and with varying definitions of what days of the week constituted unsocial hours, although all definitions defined unsocial hours as between 10pm and 7am. NHS Employers said that due to lack of data on when unsocial hours were worked and when they would be required to work in the future, this approach raised great concerns about the ability to ensure cost neutrality. They said that discussions around the scope and cost of unsocial hours payments had not been completed by the time negotiations had stalled, but both parties were aware that any changes would need to fit within the existing overall cost envelope. NHS Employers said that its assumption was that the contract would be amended so that all PAs would be of four hours, even in unsocial hours. Health Education England commented that the current unsocial hours payments did not reflect the reality of care in many specialties.
- 5.30 The BMA said that it was willing to negotiate new rates and times for unsocial hours work, but that enhanced rates should be paid for work undertaken in unsocial hours.

Commenting on the proposal to make all PAs four hours, it said that it was cautiously willing to consider making all PAs the same length but agreement would hinge on the overall contract package and the financial value of PAs worked at different times of the day/week. It said that further research would be needed to determine the appropriate relative financial values. The College of Emergency Medicine said that where service demands required high frequency and high intensity unsocial hours working, it should be recognised, and argued that the current pay rates failed to reflect the reality that evening work was less onerous than night work. It also said that the ability to undertake high intensity late evening and night work deteriorated with age. The College suggested that regular unsocial hours working could be recompensed through enhanced annual leave entitlement. The Hospital Consultants and Specialists Association also highlighted issues about unsocial hours working and intensity of work. The Association of Anaesthetists said that evenings and weekends must be recognised as socially accepted recovery periods.

Our comments

- 5.31 Our analysis of unsocial hours payments for other employers providing seven-day services (see Chapter 3) suggests that there is no 'one size fits all' approach to unsocial hours payments. NHS Employers are considering three approaches: an hours-based system; an allowance-based system; and an allowance-hours hybrid system. **Whatever model is used, the guiding principle should be that it is designed around the needs of the patient and what needs to be incentivised, balanced against the benefits of having a simple system to administer.** In line with our criterion 4 (appropriate remuneration), we consider that unsocial hours working should be recognised in the contract. Whatever unsocial hours rates are in place, it will be important for the arrangements to facilitate the delivery of seven-day services and appropriately reward and incentivise those specialties that will need to operate most heavily during unsocial hours. **We observe that the proposed unsocial hours definitions are in line with practice in other sectors, and also in health services internationally.**
- 5.32 The research by Incomes Data Services (Chapter 3) noted that airline pilots, who in common with doctors have restrictions on their working hours, have an average unsocial hours supplement worth around 14% of the hourly rate, although payments could be worth as much as 40%. Other professional groups that we might consider as comparators (lawyers, accountants and actuaries) would typically have open-ended contractual arrangements in respect of definitions of plain time/unsocial hours; but it is also the case that they are not providing seven-day services in the same way as the NHS. Other professionals that provide seven-day services such as police superintendents do not receive any unsocial hours payments: they are expected to work any necessary additional hours as part of their professional salary arrangements.
- 5.33 Looking at other countries' healthcare systems, whilst most countries pay premia to incentivise unsocial hours working, the level of these premia vary from country to country. In general, Sundays and bank holidays receive the highest rate of premia, followed by Saturdays and night time hours. However no country is currently providing a full seven-day service in the way that the NHS is aiming to.
- 5.34 We have noted the lack of data on current unsocial hours working by consultants, and that this has impacted on the ability of any proposals to be appropriately costed to meet the cost-neutral pre-condition for the negotiations. We noted in the previous chapter that there is a variation in the proposed definitions of core time/unsocial hours for different NHS groups. This variation has the potential to undermine the principle of seven-day services in the NHS. We observe that a common definition of core time/unsocial hours should be applied across all NHS groups. That, we consider, would be seen as being fairer to all staff, who will need to work in teams to deliver seven-day services. If the definition

needs to differ between NHS groups, then a commonly understood rationale would be required.

- 5.35 NHS Employers and the BMA are at very different starting points. Employers see the proposed system as enabling models of patient care with no 'one size fits all', while the BMA are looking for more certainty about how seven-day services will operate. There needs to be a greater level of common understanding between the parties on what the proposals for seven-day services will actually mean in practice for patients and the working lives of staff. We consider that the parties need to undertake further work to develop shared assumptions on the extent of unsocial hours working, so that the proposed new arrangements can be better modelled to inform the unsocial hours rates. This would allow the BMA to put a clear proposition to its members.
- 5.36 During the evidence portion of this remit, we asked NHS Employers about whether restrictions on unsocial hours working for some specialties might be relevant on the basis of age, for example (as suggested by the Hospital Consultants and Specialists Association), obstetricians aged 55+. In response, NHS Employers said that they sought to avoid age-related provisions but instead wished to treat all staff equitably. Where there were health or capacity related concerns for individuals arising from a particular pattern of working, then local policies and procedures would be applied. They said that flexible working provisions would continue to be locally managed and that statutory safeguards already provided protections, and that annual appraisal and job plan reviews provided an opportunity to review and set new objectives where appropriate. The Department of Health, Northern Ireland Executive and Welsh Government described work being carried out by the NHS Staff Council's Working Longer Groups. Health Education England said that acute/emergency medical staff would need to see that they would not always be committed to working nights as they got older, but that their skills and experience could be utilised and valued differently at different stages of their career. **In line with our criterion 3 (credibility and practicality of local implementation) we ask that employers remain alive to the fact that ability to work unsocial hours safely may diminish with age.**

Allowance for undertaking certain additional roles

The evidence

- 5.37 NHS Employers said that an allowance would be available for established consultants for undertaking certain additional roles. They said that the roles would be locally agreed, as would the level of the allowance as they would vary in size and responsibility between, and possibly within, trusts. They proposed that undertaking such roles could be rewarded in a variety of ways: paid in time within the 10 PA contract; additional PAs awarded at the base rate of pay; and as allowances, where the additional roles were locally judged to be of a broader level of responsibility. NHS Employers said that the types of roles that might be covered would include formal medical management roles, formal teaching roles, research leadership, formal clinical governance and assessment leads. They said that funding for some of these roles was currently not identified in the 2003 contract, coming from a variety of sources, and that they were not proposing to include them in core pay. NHS Employers said that remuneration for such roles could be seen as having two elements: firstly, an additional degree of responsibility over and above that of other elements of the job plan; and secondly, a time commitment. They proposed that the responsibility element of the pay could be pensionable. The Department of Health said that pay progression for experienced consultants taking on leadership roles should be a matter for individual employers.

Our comments

5.38 Our report on compensation levels for consultants recommended the introduction of a principal consultant grade as part of an integrated package of reforms to recognise experienced, high-performing consultants who were undertaking a larger role in terms of service delivery, expertise or leadership. In general, our proposal did not gain support from either employers or the BMA. **The proposal for an allowance for undertaking specific additional roles would allow the types of roles that we intended to be covered by the principal consultant grade to be recognised in pay and we therefore (in line with criterion 4 for appropriate remuneration) support this proposal.** We have, however, noted the lack of detail in the evidence on this aspect of the contract proposals, and hope that the allowance can be used flexibly to ensure that all such additional roles are appropriately remunerated, as per our criterion 4 (see Chapter 1).

Recruitment and retention premium

The evidence

5.39 NHS Employers said that they were not proposing changes to the way that recruitment and retention premia (RRPs) were managed, allowing employers discretion to decide on the value and length of RRP. They said that they expected the value and length of RRP to be similar to current arrangements, and commented that RRP were not helpful where there was a labour supply issue, but were useful to incentivise recruitment in less popular locations.

Our comments

5.40 As the Heads of Terms on contract reform have not sought to produce variation in pay by specialty or region, then it seems inevitable that RRP will continue to be needed to incentivise certain specialties/regions (to address appropriate remuneration, our criterion 4 in Chapter 1). From past history, we understand that the use of RRP has been somewhat limited and that employers appear reluctant to use them. **We would like to see the parties adopt a more flexible approach to encourage their wider use to address recruitment issues: for example, when RRP are paid, they need not be paid to every consultant in that trust in that specialty, although we recognise that this may be difficult to implement in practice. Of course, the parties may also wish to explore non-pay solutions to recruitment problems, such as sabbatical type leave or professional development.**

Performance pay/payments for excellence

The evidence

5.41 NHS Employers set out their proposals on performance pay:

- It would be based on exemplary performance across an individual's objectives with performance pay made available where overall achievement was identified as 'above and beyond' the standard expectations of the job role (criteria for exemplary performance would be agreed as part of the objective-setting process), or
- achievement of tailored, more challenging 'stretch' objectives which would also require the consultant to reach their core objectives.
- Three category awards would be considered – Individual, Team, and Organisation.
- At the end of each annual assessment period, the pot (of available funding) would be distributed to all consultants deemed to have met the required level of excellence in a way agreed at local level, with consultation with the workforce and supported by an overarching national framework.

- Distribution would be agreed locally, but an example approach, might be to split the pot between those who had significantly exceeded their objectives and exemplary performers. The latter group would receive a higher proportion of the total pot. The proportional split between the types of award would be set locally and in consultation with the workforce.
- A maximum of one of each type of award would be available per person, and a proportion of the pot could be allocated to organisational awards.
- A cap would also be placed on the amount that any one individual could receive in any one year, any excess monies could be rolled over to the next year. The cap could be in line with our report which recommended a maximum value of local Clinical Excellence Awards (CEAs) at £35,000.
- Earnings would have the potential to fluctuate for individual consultants as varying numbers of high achievers were identified each year. This would mitigate against the risk of ‘assessment drift’ by promoting only deserving performers to receive payments.
- This approach would give greater certainty to employers about the cost of employing consultants and assurance to the consultant body about maintaining overall level of earnings.
- The assessment process would be overseen by peer managers with measures put in place to ensure the approach was fair and transparent. The intention would be for this to be developed locally, based on national guidance.
- Each NHS Trust would identify a finite ‘performance reward sum’ based on the size of their consultant workforce and a nationally set minimum per full-time equivalent (FTE) value.
- The reallocation of current local CEA payments to performance related payments would mean that the latter could be worth around £7.8k per FTE if only established consultants were eligible, but only £5.8k if all consultants were eligible.

5.42 The Department of Health said that performance pay should be integrated into the pay system and reward those making the greatest contribution as individuals or in teams as measured through the performance review. In that context, it said it was appropriate to make performance pay contractual.

5.43 NHS Providers also supported a strengthened link between pay and performance, and the end of the current system of local CEAs which it said was widely seen as unfair. The Hospital Consultants and Specialists Association also supported an alternative system to the current local CEAs which it said was inconsistently applied across trusts due to financial pressure. However, the BMA said that the new proposals for performance related pay could be controversial, divisive and difficult to administer. It commented that the failure of many employers to run effective job planning and appraisal systems at present cast doubt on their ability to manage more complicated systems. It also argued that the proposals would result in a great deal of uncertainty regarding earnings.

Our comments

5.44 We endorse NHS Employers’ proposed approach to performance pay since it broadly mirrors the recommendations in our report published in December 2012 on reforming local CEAs.⁴ **As the proposed approach will directly reward performance with targets linked to the objectives of the employing organisation, of consultant teams and of individuals (and given our criterion 3 for the credibility and practicality of local implementation) it will be essential to the successful implementation of an appraisal/objective-based performance pay system that employers and staff are properly resourced, trained and supported to deliver the new scheme.** As receipt

⁴ *Review on Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants.* Review Body on Doctors’ and Dentists’ Remuneration. Cm 8518. TSO, December 2012. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229710/DDR_B_CEA_Cm_8518__3_.pdf

of a payment would be dependent on meeting the individual, team or organisation objective(s), it will be important that the objective setting exercise is sufficiently stretching so that the receipt of a payment is competitive, rather than semi-automatic. It is also important that clinicians are closely involved in objective setting, appraisal and award decisions. **In our view the objectivity of the assessment, competence of those making it and buy-in of consultants will need to be supported by national guidance and supported by appropriate local management capacity and training.**

- 5.45 NHS Employers refers in parts of its evidence to calling the scheme 'performance pay', but **we consider a more appropriate name would be 'payments for achieving excellence' to reinforce the stretching nature of objectives.** We welcome the fact that the funding for the scheme will become contractual and that all consultants will have access to the scheme, and note that the payments will be non-pensionable. Finally, given the delay on taking this issue forward since we submitted our report in July 2011, we hope that this new scheme can be implemented without delay.

National Clinical Excellence Awards

The evidence

- 5.46 NHS Employers said that minimal consideration had been given to the reform of national CEAs, but that employers were content with the continuation of national awards to recognise demonstrated excellence beyond the employing organisation.
- 5.47 The Advisory Committee on Clinical Excellence Awards (ACCEA) said that it agreed that in the future, consultants should be able to hold both local excellence payments and national CEAs, but that further thought was needed on the value of national awards, and the criteria in the five national domains for evidence (for awards), to avoid duplication of payments for local and national excellence. ACCEA proposed that awards should be time limited, with a standard five year period for awards, rather than different periods of time for different individuals. ACCEA said that the pot of money available for national awards should be protected. NHS Employers, on the other hand, suggested that the existing 'local element' of national CEAs could be used to top up the performance pay pot. The Department of Health said that it believed that national awards could remain pensionable. The Universities and Colleges Employers Association (UCEA) and the Dental Schools Council/Medical Schools Council all stressed the importance of the national CEA scheme for clinical academics. The Hospital Consultants and Specialists Association said it supported the continuation of national CEAs, and that the local assessment for performance pay should ensure that no double counting occurred. The Scottish Advisory Committee on Distinction Awards (SACDA) also offered comments on the Distinction Award Scheme, but our remit for this report does not extend to consultants in Scotland. Nevertheless, SACDA made the general point that the pay structure for consultants needed to ensure the recruitment, retention and motivation of consultants for the effective and safe delivery of care and development of NHS services.

Our comments

- 5.48 We submitted our report to Ministers on reforming national CEAs in July 2011, with the report being published in December 2012. Whilst we are disappointed with the slow progress in considering our recommendations in that report, we are now pleased to broadly endorse the proposals put forward by ACCEA. We support the continuation of national CEAs, and given the separation of local CEAs (to be reformed as performance pay, or payments for excellence), that the value of national CEAs will need further consideration. NHS Employers and ACCEA appear to have different views as to what should happen to the funding released from the national pot, following the re-calibration of national CEA values: either to increase the pot for performance pay, or to bolster the number of national awards. This question will need to be addressed by the parties.

We support consideration of the domains for national awards, to ensure that any payments made for achieving excellence in national awards do not reward achievements that in the future would be separately recognised by local payments for excellence. We note that the intention is for national CEAs to remain pensionable. Given the changes to the lifetime and annual pension allowance, it will be important for employers to provide appropriate flexibility for doctors in managing the new allowances.

Pension implications

The evidence

- 5.49 NHS Employers' modelling suggested that under the revised contract, many full-time consultants were likely to receive similar pension values compared to now. Most completely new starters (without final salary benefits or service on the 2003 contract) were likely to receive higher pension benefits by the time they reached normal pension age than they would under the existing contract (although for working much longer given the change to the normal pension age). Those consultants that might (under the current arrangements) have been expected to earn local CEAs (currently pensionable) would receive slightly less valuable pension benefits overall, but this was offset by the ability to earn performance pay in the proposed new arrangements.
- 5.50 NHS Employers noted caveats to their modelling: the modelling did not take into account changes to the junior doctors' contract (although the proposal for higher basic pay would suggest a higher pension under Career Average Revalued Earnings (CARE) arrangements); and proposed transitional arrangements for those consultants with final salary protection (generally aged at least 52 in 2014) were for pensionable pay to be protected at the 'high watermark' level achieved to date.
- 5.51 NHS Employers' modelling suggested that most full-time consultants who retired in their 60s and nearly all full time new starters who retired close to their normal retirement age would breach their lifetime allowance. This would be mitigated by increasing the flexibility for individuals to manage their pensionable pay.
- 5.52 NHS Employers said that given final agreement on the pensionable elements of the amended contract had not yet been reached, the pension calculations were highly speculative. The BMA noted this and asked that pension calculations be independently verified. The Hospital Consultants and Specialists Association said that new entrant consultants achieving the higher tier of payment earlier was supportive of CARE pension arrangements.

Our comments

- 5.53 Under NHS Employers' proposals, consultants would be likely to achieve higher earnings earlier in a career (i.e. the proposed £93,000 basic salary for an established consultant in around five years, compared to a similar level of earnings in 14 years under the current contract), which we note is advantageous in a CARE pension scheme, although lifetime earnings are also crucial. As noted in the previous section, **given the recent changes to the annual and lifetime pension allowance, it will be important for employers to provide appropriate flexibility for doctors in managing the new allowances.** The BMA has suggested that any pension calculations should be independently verified, and we would be interested in learning the outcome of any such calculations. We will continue to monitor the impact of any changes to pension arrangements on the recruitment and retention of doctors.

Other groups

SAS doctors

The evidence

- 5.54 NHS Employers said that the 2008 contracts for specialty doctors and associate specialists shared many common features with the 2003 consultant contract, including: a 10 PA contract based on a job plan comprising direct clinical care and supporting professional activities; recognition of premium time between 7pm and 7am, weekends and public holidays; an out-of-hours on-call allowance; and time served incremental progression subject to meeting criteria. They said that there was no direct equivalent in the specialty doctor contract to the consultant 'opt-out' clause; but that associate specialists on the 2008 contract were currently able to refuse non-emergency work in premium time. They also noted that given the current overlap between the associate specialist and consultant pay scales, there was provision to appoint associate specialists that were promoted to consultant at a higher point on the consultant pay scale, so that there was no detriment on promotion. NHS Employers said it would be necessary to consider the effect of any revised working arrangements for consultants on the existing terms and conditions for SAS doctors, and they proposed to do so via the existing negotiating machinery with the BMA.
- 5.55 The remit letter from England said that the government would wish to consider the extent to which our observations on contract reform would read across to other medical staff groups such as specialty doctors and associate specialists. The remit letter from Wales did not refer to SAS doctors. However, the remit letter from Northern Ireland did ask us to consider the read across to SAS doctors: however, it did not provide any evidence on SAS doctors.
- 5.56 The BMA made the point that SAS doctors were not invited to participate in negotiations, and the BDA argued that SAS doctors should be given the opportunity to have their say if they were to be impacted by the proposed changes.

Our comments

- 5.57 We agree that any changes to SAS contracts in all countries of the UK should result from negotiation with the BMA. Our criterion 5 (from Chapter 1) aims to ensure constructive, continuing relationships, and **we consider it important that SAS doctors are treated in an even-handed way, and should have their opportunity to input into negotiations: those discussions should be given priority.** We note that, apart from associate specialists, SAS doctors do not have an 'opt-out' clause in their contract. Like consultants, many SAS doctors, including associate specialists, are already delivering services across seven days. They will continue to be an essential group to the ability of the NHS to deliver seven-day services.

Consultants in Wales

The evidence

- 5.58 The remit letter from Wales asked us to make observations for reforming the consultant contract to better facilitate the delivery of health care services seven days a week in a financially sustainable way, and that we should have particular regard to commitment awards – unique to Wales – and how consultants in Wales could be better rewarded for providing local excellence. The letter also said that we should have regard to the Heads of Terms agreed by the parties.
- 5.59 The BMA did not provide evidence on consultants in Wales, saying it was inappropriate to ask us to make observations when there had been no prior negotiations. The BMA

said that it was willing to enter consultant contract negotiations in Wales, provided the Welsh Government removed its precondition for discussions to include how £12 million a year could be cut from the medical pay bill. In oral evidence, the Welsh Government said that the £12 million was not the issue: its priority was for a UK-wide consultant contract, though it was willing to make Welsh specific amendments (such as consideration of the retention of the 37.5 hour working week). Welsh officials said that the Heads of Terms were relevant for Wales, and that if negotiations re-opened, it would seek to have a seat around the table and that if BMA Wales agreed to participate, that would be a welcome step towards the development of a UK contract. The Welsh Government said that depending on the design and transitional arrangements, it would be reasonable to consider that the current spend on commitment awards could, over time, be re-invested in any new local scheme: it said that the current annual spend on commitment awards was estimated at £10 million. We also received a submission from Abertawe Bro Morgannwg University Health Board: as payment of any national CEA required the consultant to give up any commitment awards earned during a career, it argued that if a national CEA was removed (such as during the regular review of national CEAs), then commitment awards should be reinstated.

Our comments

- 5.60 **The parties in Wales appear to be in agreement that negotiation is the best way forward and we support this**, in line with our criterion 5 (see Chapter 1) for facilitating constructive, continuing relationships. BMA Wales should have the opportunity to negotiate on contractual changes, particularly given the different form of the current contract in Wales. We note that whilst the Welsh Government is seeking a UK-wide contract, it is willing to consider Welsh-specific amendments. We encourage the parties to enter negotiations in a constructive and open frame of mind. Our previous reports have noted that we are unable to support the current commitment award scheme as it rewards length of service rather than the achievement of excellence, so we welcome the proposal by the Welsh Government to reinvest the current commitment award spend into performance pay. It will be important for any negotiations to address the 'opt-out' clause: we have already noted our support for the removal of the 'opt-out' clause earlier in this chapter.

Clinical academics

The evidence

- 5.61 NHS Employers said that the position of clinical academics would require detailed work with UCEA and ACCEA. They said that the intention was that research, innovation, education and training would continue to be incentivised, to ensure that academic careers remained attractive. We received evidence from UCEA and the Dental Schools Council/Medical Schools Council underlining the importance of clinical academics.
- 5.62 The BMA asked us to take into account the need to recognise and reward academic activity and to minimise disincentives to choosing an academic career in determining our recommendations (and observations). The Association of Anaesthetists said that any new consultant contract must include local and national incentives for staff to become academics.

Our comments

- 5.63 Clinical academics are a vital group of staff in relation to our remit groups, given their role in teaching future generations of doctors and in service delivery. **We support the proposal for further work to ensure that academic careers remain attractive**, and consider that such discussions should also take account of the views of all parties,

including UCEA, ACCEA and the BMA. In line with our recommendations for academic trainees, **we consider that pay structures for clinical academics should not inhibit the ability for staff moving in and out of such roles, which will also support the recruitment/retention elements of our standing terms of reference.**

Transitional arrangements/implementation

The evidence

- 5.64 The Department of Health, Northern Ireland Executive and Welsh Government all said that their preference was for moving across to changed contractual arrangements, with those on the pre-2003 contract having the option to move across. NHS Employers proposals were predicated upon all (2003) consultants moving across to the new contract. The Department of Health said that the inability of the BMA to accept change without increasing pay was a missed opportunity and meant that it would need to reconsider the basis for making contractual change.
- 5.65 NHS Employers' proposed approach to transition offered:
- base pay protection for two years;
 - employers to 'smooth' transition for consultants whose current base pay was higher than the new pay levels, by agreeing changes to job plans to match responsibilities to current pay levels;
 - pay protection for those consultants whose existing salary was below the level of the proposed new rate for established consultants until they reached the established consultant rate;
 - transitional pensionable pay protection of two years for payments earned in the new NHS Pension Scheme;
 - where pensionable pay was lost (e.g. the possible removal of CEA pensionability), it would be protected at the high watermark point for service up to that point, with lower pensionable pay applying to future service;
 - on a transitional basis, payments for excellence could remain pensionable up to the level of awards held under the current system; and
 - transitional pension protections for performance pay could be extended until retirement for those in the 1995 NHS Pension Scheme with final salary protection until they move into the 2015 NHS Pension Scheme.
- 5.66 NHS Employers set out some worked examples of how the pay protections and transition arrangements would work for an experienced consultant, a mid-career consultant and an early career consultant. They acknowledged that the examples did not take into account the potential for a pensionable approach to unsocial hours payments, or payments for additional responsibilities. NHS Employers also put forward a mitigating solution to reassure all parties:
- a period of shadowing of key provision at selected early implementer sites;
 - a period of early implementation to gather real data in real time;
 - a re-calibration of the pay rates and allowances to ensure there was no windfall financial benefit for employers or taxpayer, and no overspend on the financial neutral requirement of the negotiations; and
 - a full roll out to the rest of the service.
- 5.67 The BMA welcomed the commitment to protect pensionable pay, but said that the lack of similar protection for salary and CEAs would be unpopular. It commented that transitional arrangements had not been considered during the negotiations. The BMA said that the system would result in a great deal of uncertainty regarding earnings, and that without additional data it was not possible to predict whether, in general, there would be more 'winners' than 'losers', and that it could not sign up to such a system

in the absence of such knowledge that would allow it to prepare its members for any change. It said that introducing a new contract without the support of the profession would undermine the foundation of partnership and co-operation on which the NHS was built. Commenting on the proposed mitigating solution, the BMA said that it could result in having to renegotiate contracts on an annual basis and could be time consuming, resource intensive and difficult. The Association of Anaesthetists said that any attempt to force senior staff to move contracts would be likely to result in considerable disruption of services.

- 5.68 The BMA commented that the remit restriction on the pay envelope was unhelpful as it precluded the ability to recommend additional funding for transition. Health Education England also said that additional funding for transition was needed to support the workforce transformation and to protect and maintain the quality of services and training.

Our comments

- 5.69 We note that one of the main aims of the negotiations was to facilitate the delivery of seven-day services, and that the current expenditure on consultant remuneration would not be reduced. However, despite the commitment to safeguard the existing pay envelope, consultants are being asked to give up more attractive terms and conditions by the removal of the 'opt-out' clause.
- 5.70 **Rather than moving forward with a 'big bang' approach to contract reform, an option would be to implement reform in two stages: first, remove the 'opt-out' clause to allow seven-day services to progress; and second, deal with the other elements of contract reform as more information becomes available. These other elements could be progressed at different speeds, as appropriate, although we consider that a timetable should be set for agreeing all changes, say 6 to 12 months.** As indicated earlier in this chapter, there needs to be a greater level of common understanding between the parties on what the proposals for seven-day services will actually mean in practice for patients and the working lives of staff, noting that one size will not fit all. We consider that the parties need to undertake further work to develop shared assumptions on the extent of unsocial hours working, so that the proposed new arrangements can be better modelled to inform the unsocial hours rates. It will be important to model the proposed pay arrangements so that the numbers of winners and losers, and particularly the extent of winners and losers, can be ascertained to help the BMA in advising its members on the proposed package. Given the cost-neutral precondition for the negotiations, there will inevitably be some losers, so the parties should reach consensus on a reasonable or acceptable level of loss: this could then inform the design of the pay proposals, which should also take account of recruitment, retention and motivation. Once more developed, the proposal for a mitigating solution (as proposed by NHS Employers) could be utilised.
- 5.71 Measured against our criterion 6 on affordability, **we question how realistic it is for new contractual arrangements, including transition costs, to be delivered within the current pay envelope.** Normal practice would be for one-off transitional funding to be provided to meet the 'costs of change', and we would support such an approach for the consultant contract. We do not consider it appropriate for transition costs to be met by the existing workforce.

Private practice earnings

- 5.72 During oral evidence, we asked the parties whether private practice had any impact on the consultant contract negotiations. The BMA assured us that this was not the case. We support consultants having the right to practise privately provided this does not interfere

with their NHS obligations. In the final report of the investigation⁵ by the Competition and Markets Authority (CMA) into the private healthcare market there is a reference to 2006 when the National Audit Office estimated that 55 per cent of the total consultant workforce had some private practice, and the National Audit Office noted in 2012 that the extent of private practice had not increased.⁶ Under the current consultant contract arrangements (including the 'opt-out' of planned services at the weekend), consultants have some certainty about scheduling any private practice. If seven-day services are implemented, the parties will need to give appropriate consideration to the scheduling of NHS and private work when agreeing work schedules.

- 5.73 The BMA has placed great importance on the inclusion of safeguards in the consultant contract to ensure that doctors are not over-tired, and that the safety of patients is paramount. Any safeguards that are included within the consultant contract apply to NHS work, and it will be important for doctors and employers to also consider the implications of any work undertaken outside normal NHS contracts.

Observations and next steps

- 5.74 In summary, our observations on the elements of the proposed consultant contract reform are as follows:

- removal of the 'opt-out' clause: **in our view, the current 'opt-out' clause in the consultant contract is not an appropriate provision in an NHS which aspires to continue to improve patient care with genuinely seven-day services, and on that basis, we endorse the case for its removal from the contract; we consider that the consultant contract should support patient care at the weekends, whether through direct consultant presence or through supervision of junior doctors, as a point of principle** (paragraphs 5.9 – 5.14);
- the inclusion of contractual safeguards: **we support the inclusion of safeguards within the contract; and that the contract should include a specific reference to the safeguards on hours and rest contained within the Working Time Regulations, or any successor legislation. The wording contained within the contract should make clear that compliance is mandatory. The parties will also wish to consider any reasonable work-life balance issues when discussing safeguards** (paragraph 5.18);
- pay progression to be linked to achievement of excellence (assessed at appraisal): **we are able to endorse the proposal for progression to be linked to achievement of excellence (assessed at appraisal), although we wish to stress the importance of employers being properly resourced and supported to implement an appraisal-based incremental system** (paragraph 5.24);
- basic pay 'spot rates' based on recognised stages of a consultant career: **we consider that this should be the subject of further negotiation between the parties, but we would support either a two or three-point pay scale; the value of pay points should be subject to further negotiation between the parties, and should be rooted in a robust evaluation of recruitment, retention and motivation;** (paragraphs 5.25 – 5.27);
- separate payment for working unsocial hours: **whatever model for rewarding unsocial hours working is used, the guiding principle should be that it is designed around the needs of the patient and what needs to be incentivised, balanced against the benefits of having a simple system to administer. We observe that the proposed unsocial hours definitions are in line with practice in other sectors, and also in health services internationally. In line with our**

⁵ *Private Healthcare Market Investigation – Final Report*. Competition and Markets Authority. March, 2014.

⁶ *Managing NHS Hospital Consultants*. National Audit Office. Summary paragraph 9. February 2013.

criterion 3 (credibility and practicality of local implementation) we ask that employers remain alive to the fact that ability to work unsocial hours safely may diminish with age (paragraphs 5.31 – 5.36);

- **an allowance for undertaking specific additional roles: the proposal for an allowance for undertaking specific additional roles would allow the types of roles that we intended to be covered by the principal consultant grade to be recognised in pay and we therefore (in line with criterion 4 for appropriate remuneration) support this proposal. We have, however, noted the lack of detail in the evidence on this aspect of the contract proposals, and hope that the allowance can be used flexibly to ensure that all such additional roles are appropriately remunerated, as per our criterion 4 (see Chapter 1) (paragraph 5.38);**
- **RRPs to incentivise certain specialties/regions: we would like to see the parties adopt a more flexible approach to encourage their wider use to address recruitment issues: for example, when RRP are paid, they need not be paid to every consultant in that trust in that specialty, although we recognise that this may be difficult to implement in practice. Of course, the parties may also wish to explore non-pay solutions to recruitment problems, such as sabbatical type leave or professional development (paragraph 5.40);**
- **reforming local CEAs as payments for achieving excellence and making such payments contractual: as the proposed approach will directly reward performance with targets linked to the objectives of the employing organisation, of consultant teams and of individuals (and given our criterion 3 for the credibility and practicality of local implementation) it will be essential to the successful implementation of an appraisal/objective-based performance pay system that employers and staff are properly resourced, trained and supported to deliver the new scheme. In our view the objectivity of the assessment, competence of those making it and buy-in of consultants will need to be supported by national guidance and supported by appropriate local management capacity and training. We consider a more appropriate name would be 'payments for achieving excellence' to reinforce the stretching nature of objectives (paragraphs 5.44 – 5.45);**
- **continuation of national CEAs: we support consideration of the domains for national awards, to ensure that any payments made for achieving excellence in national awards do not reward achievements that in the future would be separately recognised by local payments for excellence (paragraph 5.48);**
- **pensions: given the recent changes to the annual and lifetime pension allowance, it will be important for employers to provide appropriate flexibility for doctors in managing the new allowances (paragraph 5.53);**
- **contractual changes for SAS doctors: we consider it important that SAS doctors are treated in an even-handed way, and should have their opportunity to input into negotiations: those discussions should be given priority (paragraph 5.57);**
- **consultants in Wales: the parties in Wales appear to be in agreement that negotiation is the best way forward and we support this (paragraph 5.60); and**
- **clinical academics: we support the proposal for further work to ensure that academic careers remain attractive. We consider that pay structures for clinical academics should not inhibit the ability for staff moving in and out of such roles, which will also support the recruitment/retention elements of our standing terms of reference (paragraph 5.63).**

5.75 We also make the following general observations:

- **read across to the observations made by the NHS Pay Review Body: we observe that definitions of core time/unsocial hours given to us in evidence differ to those given in evidence for the Agenda for Change groups. We observe that a common**

definition of core time/unsocial hours should be applied across all NHS groups. If the definition needs to differ between groups, then a commonly understood rationale would be required (paragraph 5.34);

- impact of seven-day services on pay: we observe that there needs to be a greater level of common understanding between the parties on what the proposals for seven-day services will actually mean in practice for patients and the working lives of staff, noting that one size will not fit all (paragraph 5.35); rather than moving forward with a 'big bang' approach to contract reform, an option would be to implement reform in two stages: firstly, remove the 'opt-out' clause to allow seven-day services to progress; and secondly, deal with the other elements of contract reform as more information becomes available. These other elements could be progressed at different speeds, as appropriate, although we consider that a timetable should be set for agreeing all changes, say 6 to 12 months. This would be based on shared assumptions about career paths to inform pay modelling and the use of pilots to test and check impacts on the NHS, its staff and patients (paragraph 5.70).
- transition costs: we question how realistic it is for new contractual arrangements, including transition costs, to be delivered within the current pay envelope (paragraph 5.71).

5.76 Our observations on consultant contract reform above apply to England and Northern Ireland, as the proposals were formed on that basis. As indicated above, we consider that the Welsh Government and BMA Wales should enter negotiations on reforming the consultant contract in Wales. Scotland has not sought any observations on contract reform, as its approach to seven-day services is firstly to establish sustainable service models, before considering next steps with the parties, including the BMA. Nevertheless, the parties in Scotland may wish to consider our observations and come to a view as to whether or not they would want similar arrangements to apply in Scotland. As with junior doctors, we consider that the future is best served by a national contract, and that it should apply in all four countries of the UK, but accept that the Scottish Government wishes to consider matters further with the BMA. As there are several issues that still need to be resolved by the parties, we would hope Scotland would want to continue to be a part of those discussions. We ask the parties to report back to us on the outcome of the future discussions and negotiations. As ever, we stand ready to assist in any further work necessary.

APPENDIX A – REMIT LETTERS



Department
of Health
POC5 896552

*From Dr Dan Poulter MP
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Professor Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
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30 OCT 2014

Dear Professor Curran,

Further to the letter you received from the Chief Secretary to the Treasury, Danny Alexander on 31st July 2014 and my letter of 26th August 2014 confirming the remit for independent contractor doctors and dentists, I am writing now to confirm the remit for employed doctors and dentists.

As I set out in my letter of 26th August, following the Government's announcement of a two year pay settlement for employed doctors and dentists in England the DDRB is not required to report or to make recommendations or observations for the 2015/2016 year on:

- the remuneration of employed doctors and dentists;
- the recruitment, retention and motivation of suitably able and qualified staff; and
- regional/local variations in labour markets and their effects on recruitment and retention of staff.

National employment contracts are a critical element of how we put patients right at the heart of everything the NHS does, providing a seamless pathway of care no matter what day of the week. In recent reports, the DDRB has identified the need for contract reform for consultants and for doctors and dentists in training. During 18 months of discussions and negotiations, NHS Employers and the BMA have done a significant amount of work to design reward packages for consultants and juniors to facilitate services and training across the seven day week. The Government is disappointed that these negotiations have not resulted in agreements acceptable to all parties. The Chief Secretary, in his letter of 31 July, noted the DDRB's offer to consider contractual arrangements at an appropriate stage of the negotiations. I am therefore now asking the DDRB to make observations and recommendations that take into account the work undertaken during negotiations.

There is a strong clinical case for seven day services. For example, recommendations of the *NHS Services, Seven Days a Week* Forum¹ accepted by NHS England, explore the consequences of the non-availability of clinical services across the seven day week and state that availability needs to be achieved in a clinically and financially sustainable way.

For 2015/16, **for consultants**, DDRB is asked to make observations, based on information and data presented on pay-related proposals for reforming the consultant contract to better facilitate the delivery of health care services seven days a week in a financially sustainable way i.e. without increasing the existing spend. In the context of the policy aim to deliver financially sustainable seven day services, the DDRB is asked to consider and critique proposals from the Department and the NHS Employers, taking account of views from all parties.

The DDRB should also consider the following, including work already completed by the DDRB and work undertaken by the parties to the negotiations:

- the work by the DDRB on the payment of clinical excellence awards (CEAs), and the Government's response to that;
- proposals for pay progression to be linked to responsibility and performance; and
- arrangements in other sectors which provide seven day services.

For doctors and dentists in training, DDRB is asked to make recommendations on new contractual arrangements including a new system of pay progression with, as DDRB has proposed, "*a strengthened link between pay and better quality patient care and outcomes*". In doing so, DDRB should consider information submitted including:

- proposals for pay structures that include the ending of time-served incremental progression;
- information on the working patterns of doctors in training; and
- how the current pay envelope could be used differently to increase basic pensionable salaries, providing appropriate reward of additional work, while supporting services and training across the seven day week.

In undertaking both strands of this work, the DDRB should have regard to the Heads of Terms agreed by the parties prior to the contract negotiations. It should also have regard to the read-across to the work that the Government has asked the NHS Pay Review Body to undertake to make observations on the barriers and enablers within the Agenda for Change pay system for delivering health care services every day of the week in a financially sustainable way.

¹ Summary of Initial Findings – First Published December 2013 - <http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf>

In considering your observations on seven day services, the Government would also wish to consider the extent to which they would read-across to other medical staff groups such as specialty doctors and associate specialists.

Although the DDRB's remit covers the whole of the United Kingdom, for this particular remit, we ask that you make observations for England only. It is for each of the devolved administrations to make decisions about the nature of the remit appropriate for their workforces for 2015/2016 and to communicate their intention to you directly.

In view of the work to which the DDRB is committed to support the pay review round in Scotland and the work on independent contractors, a realistic timetable for you to report on your work on contract reform would be July 2015.

Patients should be placed right at the heart of everything we do, and the way that the NHS organises and manages the workforce should be built around patients and their needs. I'd like to conclude by reemphasising the clinical case for seven day service provision, which has the potential to reduce mortality rates in the evenings and at the weekends, speed up diagnosis and discharge times and reduce the amount of time that patients need to spend in hospitals overall.

As always, my officials will be happy to work closely with your secretariat to ensure you have all the information you need to assist your task of providing independent observations and recommendations on reforms that are crucial to this vital area of service provision.

With Best Wishes,



DR DAN POULTER

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Jim Wells MLA



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and Public Safety**
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Professor Paul Curran
Chair of the Review Body on Doctors' and Dentists'
Remuneration
Office of Manpower Economics
8th Floor
Fleetbank House
2-6 Salisbury Square
LONDON
EC4Y 8JX

Our Ref: SUB/1063/2014

Date: 5 November 2014

Dear Professor Curran

Review Body on Doctors' and Dentists' Remuneration (DDR) Remit 2015/16

I wish to convey my thanks to the Review Body on Doctors' and Dentists' Remuneration (DDR) for its work on the 2014/15 pay round. My Department values the work of the pay review body in delivering its recommendations on remuneration in this important role. This is true, even where, as in the previous round we were unable to accept all your recommendation due to the exceptionally challenging financial position in which we find ourselves and HM Treasury's call for continued pay restraint

The Northern Ireland Executive has endorsed the principle of adherence to the UK Government's public sector pay policy and enforcement of pay growth limits is devolved to the Executive within the overarching parameters set by HM Treasury. The financial situation within Northern Ireland continues to present challenges which we are seeking to manage and it is within this context that I believe that pay restraint will continue to be required for 2015/16. Therefore I am not seeking a recommendation from the pay review body specifically in relation to pay for salaried doctors and dentists.

For independent contractors, the DDR are, however, invited to make recommendations on appropriate uplifts. Specifically, DDR are asked to make recommendations on what allowance should be made for GPs' and dentists' pay and for practice staff in the context of public sector pay policy for 2015/16. Northern Ireland will make their final decisions on the gross uplift for GMS and dental contracts in the light of the DDR's recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

In view of the demands placed on you to support the pay review round in the devolved administrations, and the lateness of this request, my officials would be very happy to work with you to agree a realistic timeframe for you to report on your findings for Northern Ireland.

I note that negotiations for the reform of consultants' and junior doctors' contracts and for doctors and dentists in training applying in Northern Ireland have not resulted in

 INVESTORS

agreement. However, I believe that much good work was achieved during these negotiations. Accordingly, I consider it is now appropriate to invite DDRB to make observations and recommendations that take into account the work undertaken during these negotiations.

For 2015/16, for consultants, DDRB is asked to make observations, based on information and data presented on pay-related proposals for reforming the consultant contract to better facilitate the delivery of health care services seven days a week in a financially sustainable way ie without increasing the existing spend. In the context of the policy aim to deliver financially sustainable seven day services, I am aware that the DDRB has been invited by the Department of Health to consider and critique proposals which they and the NHS Employers will present. Supplementary information and data reflecting the particular Northern Ireland context will also be provided.

The DDRB should also consider the following, including work already completed by the DDRB and work undertaken by the parties to the negotiations:

- the work by the DDRB on the payment of clinical excellence awards (CEAs), and the Government's response to that;
- proposals for pay progression to be linked to responsibility and performance; and
- arrangements in other sectors which provide seven day services.

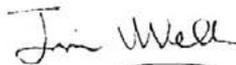
For doctors and dentists in training, DDRB is asked to make recommendations on new contractual arrangements including a new system of pay progression with, as DDRB has proposed, "*a strengthened link between pay and better quality patient care and outcomes*". In doing so, DDRB should consider information submitted including:

- proposals for pay structures that include the ending of time-served incremental progression;
- information on the working patterns of doctors in training; and
- how the current pay envelope could be used differently to increase basic pensionable salaries, providing appropriate reward of additional work, while supporting services and training across the seven day week.

In undertaking both strands of this work, the DDRB should have regard to the Heads of Terms agreed by the parties prior to the contract negotiations. It should also have regard to the read-across to the work that I have asked the NHS Pay Review Body to undertake on observations on the barriers and enablers within the Agenda for Change pay system for delivering health care services every day of the week in a financially sustainable way.

In considering your observations on seven day services, I would also wish you to consider the extent to which they would read across to other medical staff groups such as specialty doctors and associate specialists. I would expect the Review Body's observations for Northern Ireland to follow the same timetable as that for England and be included in their report in July.

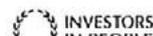
My officials look forward to continued engagement with you throughout this process and I look forward to receiving your reports in due course.



Jim Wells MLA

Minister for Health Social Services and Public Safety

Workforce for the Health and Social Care Sector



Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/3881/14

Professor Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Level 8, Fleetbank House
2-6 Salisbury Square
London
EC4Y 8AE

Deu Professor Curran,

9 December 2014

I am writing to confirm the Welsh Government's approach in respect of the Review Body on Doctors' and Dentists' Remuneration (DDRBS) special remit for 2015.

Following the BMA's withdrawal from national contract negotiations, the recommendations and observations on contract reform set out by the Department of Health in its letter of 30 October should extend to Wales, i.e.

- For 2015/16, for **consultants**, DDRB is asked to make observations, based on information and data presented on pay-related proposals for reforming the consultant contract to better facilitate the delivery of health care services seven days a week in a financially sustainable way, i.e. without increasing the existing spend. The DDRB should have particular regard to commitment awards - which are unique to Wales - and how consultants in Wales could be better rewarded for providing local excellence.
- For **doctors and dentists in training**, DDRB is asked to make recommendations on new contractual arrangements including a new system of pay progression with, as DDRB has proposed, "*a strengthened link between pay and better quality patient care and outcomes*".

In line with the position set out in England, the DDRB should have regards to the Heads of Terms agreed by parties prior to the contract negotiations.

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Wedi'i argraffu ar bapur wedi'i ailgylchu (100%)

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Printed on 100% recycled paper

My officials will be happy to work with your secretariat to ensure you have all relevant information to provide these observations and recommendations.

Yours sincerely,

Mark Drakeford

Mark Drakeford AC / AM

Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Cabinet Secretary for Health, Wellbeing and Sport
Shona Robison MSP

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In 2014 Scotland Welcomes the
World

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(by email: richard.chamberlain@bis.gsi.gov.uk)

18 December 2014

Dear Professor Curran

DDRB Remit for Doctors and Dentists in Training

I wish to thank the Review Body for the particularly valuable independent scrutiny with you continue to deliver and am writing to give you a remit specific to doctors and dentists in training.

The Scottish Government remains committed to a nationally agreed settlement for doctors and dentists in training and will join the other UK administrations in asking you to make recommendations for this group of staff, considering the work undertaken and the relevant evidence from the 18 months of negotiations between the four UK nations and the BMA.

For doctors and dentists in training, DDRB is asked to make observations on new contractual arrangements including the new system of pay progression. DDRB should consider information submitted including:

- Proposals for new pay structures. The Scottish Government does not require the end of automatic progression, but will be willing to consider any system which is considered fair and equitable and is seen as offering fair reward to doctors and dentists in training.
- Information on the working patterns of doctors in training, including the proposals around working hours
- How the current pay envelope could be used differently to increase basic pensionable salaries, providing appropriate reward for additional work, while supporting the delivery of training and service across seven days a week.

In undertaking both strands of work the DDRB should have regard to the Heads of Terms agreed by the parties prior to the contract negotiations.

My officials look forward to continued engagement with you throughout this process and I look forward to receiving your report in due course.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Shona Robison', with a stylized flourish at the end.

Shona Robison

APPENDIX B – INTERNATIONAL UNSOCIAL HOURS RATES SOURCES

United Kingdom

NHS Employers evidence to DDRB
<http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/medical-pay/ddrb-evidence---in-detail/consultants-and-junior-doctors-contract-reform-submission-of-evidence-to-the-ddrb>

Australian Capital Territories

<http://health.act.gov.au/sites/default/files/ACT%20Public%20Service%20Medical%20Practitioners%20Enterprise%20Agreement%202011-2013.pdf> [verified 24/06/2015]

Castilla-La Mancha (Spain)

http://docm.castillalamancha.es/portaldocm/descargarArchivo.do?ruta=2014/01/31/pdf/2014_1091.pdf&tipo=rutaDocm [verified 24/06/2015]

Italy

http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf?la=en [verified 24/06/2015]

New Zealand

http://www.wdhbcareers.co.nz/core/lib/other/wysiwyg/uploaded/SMOMECA2011to2013_1.pdf [verified 24/06/2015]

Ontario (Canada)

http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf?la=en [verified 24/06/2015]

Philippines

http://www.dole.gov.ph/labor_codes/view/4 [verified 24/06/2015]

Queensland (Australia)

<http://www.health.qld.gov.au/medical/medical-contracts/docs/attachment-3-trf-smo.pdf> [verified 24/06/2015]

Sweden

http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf?la=en [verified 24/06/2015]

Western Australia

[http://www.health.wa.gov.au/awardsandagreements/docs/Medical_Practitioners_\(Metro_Health_Service\)_AMA_Industrial_Agreement_2013.pdf](http://www.health.wa.gov.au/awardsandagreements/docs/Medical_Practitioners_(Metro_Health_Service)_AMA_Industrial_Agreement_2013.pdf) [verified 24/06/2015]

APPENDIX C – OVERVIEW OF IDS’S RESEARCH FINDINGS ON UNSOCIAL HOURS AND OVERTIME PAYMENTS

Table 1: Overview of research findings on typical unsocial hours and overtime payments by sector

Sector	Night window	Nights/evenings	Saturdays	Sundays	Bank holidays	Overtime
Actuaries						
	N/A	T (evenings)	N/A	N/A	N/A	TOIL
Air ambulances						
– pilots	N/A	T	T	T	T	TOIL
– paramedics	AfC	AfC	AfC	AfC	AfC	TOIL or AfC
– senior managers	None	None	None	None	None	None
– doctors/consultants	Varies depending on contract between air ambulance and the individual doctor and/or their NHS trust. Some volunteers who receive none					
Airline industry						
– pilots	T+14% average for captains; T+17% average for first officers					
– cabin crew	T+25% for domestic flights; T+50% or more for international flights					
– customer service	Range T+5%–T+25%					
– engineering	Typical shift premia T+8%–T+12% for technicians; T+6%–T+8% for supervisory/junior managers; none for senior/middle managers					
– operations	Varies by airport and airlines, worth around T+10%–T+15% at larger airlines					
Breakdown services						
– Forecourt and garage staff*	9.30pm to 5.30am	T+33%; T+100% Sat and Sun	Shift patterns; two-shift, T+15%; three-shift, T+25%			T+50%; T+100% Sun
Call centres						
– call centre agents	8pm to 8am	T+10%-T+50%	T+5%-T+40%		T+15%-T+100%	T+35%-T+100%
Care homes						
– care and nursing staff	8pm to 8am	T+33% or cons.	T+33% or cons.	T+50% or cons.	T+50% or T+100%	–
Central government						
– below management	8pm to 8am	–	–	T+100%	T+100%	T+50%; T+100% Sun
Engineering						
– manual workers	10pm to 6am	Typical shift premia T+33% for continuous shifts covering days and nights, 7 days; 33% for night shift			T+100%	T+50%; Mon-Sat; T+100% Sun
– white-collar staff	10pm to 6am	See overtime	See overtime	See overtime	See overtime	As above

Table 1: Overview of research findings on typical unsocial hours and overtime payments by sector cont'd

Sector	Night window	Nights/evenings	Saturdays	Sundays	Bank holidays	Overtime
Fire service						
– operational staff	Shift duty covers shifts 24 hours, 7 days no premia Shift premia 20% (flexible duty system)	T+33%	T+50%	T+50%	T+100%+TOIL TOIL	T+50% (T+100% Bank hols.)
– station managers						None
IT and e-commerce						
– IT and e-commerce staff	Call out payments for evenings and weekends vary significantly					T+50%; Mon-Sat; T+100% Sun
Local government						
– national terms	8pm–6am	T+33%	T+50%	T+50%	T+100%+TOIL	T+50%; Mon-Sat; T+100% Sun
– local terms	10pm–6am	T+33%	See above but some examples of variations (+/-) and cons.			T+50%; Mon-Sat; T+100% Sun
Pharmaceuticals						
– manufacturing staff	Typical shift premia 37% for continuous; 31% for nights; 24% for three-shift; 16% for two-shift					T+50%; Mon-Sat; T+100% Sun
Police						
– federated ranks	8pm–6am	10%	T	T	T	T+33% (casual); T+50% (planned)
Prison service						
– operational staff	Unsocial hours payment worth T+17% (fair and sustainable contract); consolidated (closed scales)					Unsocial hours Addition of £5,529 (managers E–G) (closed scales)
– managers	Unsocial hours payment worth T+15% (fair and sustainable contract); cons. + Required Hours Addition of £5,529 (managers E–G) (closed scales)					
Private hospitals						
– nursing & care staff	Common in the independent hospitals sector, paid at lower rates than in the NHS					Self-employed, unsocial hours work by consultants covered by fees charged
– doctors & consultants	Very few directly employed					
– consultants	Self-employed, unsocial hours work by consultants covered by fees charged					
Restaurants, pubs and fast food						
– hourly-paid staff	–	T	T	T	T	T
Retail						
– retail assistants	11pm–6am	T+27% (T+32% inc. cons.)	T	T+50%	T+50%	T+50%
Road transport						
– drivers	–	T+20%	T	T	–	T
– warehouse workers	10pm–6am	T+30% (T+36% inc. cons.)	T	T (T+20% inc. cons.)	–	–

* As set out by the Motor Vehicle Retail and Repair National Joint Council agreement (see section 2.4 of the IDS report).

Definitions:

T = plain time; TOIL = time of in lieu; Cons. = consolidated; AfC = NHS Agenda for Change pay system.

Table 2: Unsocial hours and overtime payments for the case studies

Organisation	Night window	Nights/evenings	Saturdays	Sundays	Bank holidays	Overtime
BMI Healthcare*						
- directly employed staff	After 7pm	Range T to T+100% depending on staff group/site	Range T to T+100% depending on staff group/site	Range T to T+100% depending on staff group/site	Range T to T+100% depending on staff group/site	Varies by site, but most commonly T+50% Mon-Fri; T+100% Sat & Sun
Camden Council**						
- service provider staff***	10pm to 7am	T+23%	T+23% (after 5pm)	T+23% (after 5pm)	T+10% (T+50%)	T+10% (T+50%)
- practitioners & managers	Mon-Fri****	TOIL	TOIL	TOIL	TOIL	TOIL
Devon Air Ambulance Trust						
- paramedics	7pm to 7am	T+25%	T+25%	T+25%	T+25%	TOIL of AfC rates*****
- pilots	7pm to 7am	T	T	T	T	TOIL
- operational managers	7pm to 7am	TOIL	TOIL	TOIL	TOIL	TOIL
- head office & shops	6pm to 8am	TOIL	T	TOIL	TOIL	TOIL
London Underground						
- admin and office staff	-	TOIL	T+50%	T+100%	n/a	TOIL
- operational staff	-	Consolidated	Consolidated	Consolidated	Consolidated	T+25%
- management	-	Consolidated	Consolidated	Consolidated	Consolidated	TOIL
Nissan Manufacturing UK						
- office staff	10pm to 6am	33% or 20%	See overtime	See overtime	See overtime	T+50% Mon-Sat;
- manufacturing staff	10pm to 6am	Shift premiums	Shift premiums	Shift premiums	Shift premiums	T+100% Sun
- senior staff	10pm to 6am	33% or 20%	See overtime	See overtime	See overtime	£9,811 a year

* Terms vary by site.

** In addition some staff are eligible for T+15% if working a highly disruptive working pattern, or T+10% for 'lower' levels of disruption

*** Normal hours are defined as between 7am and 10pm, Mondays to Fridays, and 8am to 5pm on Saturdays and Sundays.

**** Staff below point 25 (current salary up to £22,212).

***** Paramedics most commonly opt for payment at AfC overtime rates.

Definitions:

T = plain time; TOIL = time of in lieu; Cons. = consolidated; AfC = NHS Agenda for Change pay system.

Source: IDS Report

APPENDIX D – OUR PREVIOUS COMMENTS

By way of context, the following is a list of comments we made in our earlier reports that we consider relevant to this remit.

“We have long commented in our reports on the need to restructure the contract for junior doctors to shift the balance away from the banding supplements towards basic pay, and to ensure that starting salaries do not fall behind those of other graduate-entry professions.”¹

“In principle, we support the alignment of contractual arrangements for GMP registrars and hospital trainees: pay for all trainees should reflect the number of hours worked and intensity of work.”²

“We believe that the current [consultant] structure rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. Near automatic progression is not typically a feature of any of the professional roles we use for comparators at this level.

The consultant pay scale in Wales, with Commitment Awards made on a time-served basis, on top of the basic pay scale, exacerbates this issue. We are unable to support a pay system that rewards length of service, in this case for up to 30 years, rather than the achievement of excellence.”³

“It is apparent that existing local award schemes and the job planning and performance appraisal processes were created separately, without any serious thought as to their integration. This stands out as an obvious flaw with the current system. For the future, we believe there should be a much stronger link between local awards and performance appraisal of consultants.”⁴

“We acknowledge the concern that our proposal for one-off awards could suggest an additional administrative burden on employers. In response, we would simply say that if employers are already demonstrating best practice with regular job planning, objective setting and performance appraisal, then they should already have the tools to hand to enable them to deliver our proposed new scheme.”⁵

“...we observe that a single consultant grade, often attained relatively early in an individual’s career, limits the opportunities for career development and growth. We would like the parties to explore introducing a principal consultant grade, to which experienced, high-performing consultants, who are undertaking a larger role in terms of service delivery, expertise or leadership can be promoted.”⁶

¹ *Forty-First Report 2013*. Review Body on Doctors’ and Dentists’ Remuneration. Paragraph 6.10. Cm 8577. TSO, 2013.

² *Thirty-Eighth Report 2009*. Review Body on Doctors’ and Dentists’ Remuneration. Paragraph 3.76. Cm 7579. TSO, 2009.

³ *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*. Review Body on Doctors’ and Dentists’ Remuneration. Paragraphs 4.40 and 4.41. Cm 8518. TSO, 2012.

⁴ *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*. Review Body on Doctors’ and Dentists’ Remuneration. Paragraph 5.29. Cm 8518. TSO, 2012.

⁵ *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*. Review Body on Doctors’ and Dentists’ Remuneration. Paragraph 5.31. Cm 8518. TSO, 2012.

⁶ *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*. Review Body on Doctors’ and Dentists’ Remuneration. Paragraph 4.43. Cm 8518. TSO, 2012.

*"We expect the current junior doctor and consultant contract negotiations to address any pay mechanisms that might assist in recruiting to problem specialties across all grades, either by use of the consultant recruitment and retention premia or by some other mechanism, and also to consider whether some other sort of work/life balance measures might be more appropriate."*⁷

*"...where recruitment problems exist, there is the facility to use recruitment and retention premia, although we are aware that they are not used widely. Health Education England said that for some specialties, such as psychiatry, recruitment and retention premia had been used to good effect in some parts of the country, when employers worked together on a regional basis in taking forward recruitment initiatives, and in the focused application of the premia. It said that this kind of co-ordinated action should be encouraged and supported as the most effective long-term means of addressing such recruitment problems. We support such action, and hope that the consultant contract negotiations will include consideration of a more flexible approach to the use of recruitment and retention premia, so that they can be used more widely to address recruitment problems."*⁸

"For local award schemes, we recommend that such schemes should operate within a United Kingdom-wide framework of common principles and governance and should include the following:

- all employing organisations should have a local award scheme in place;*
- there should be measurable targets linked to both the objectives of the employing organisation and the individual objectives of consultants;*
- the scheme should be transparent, fair, and equitable;*
- awards should be linked to performance appraisals and should be made only for work that is done over and above job plans;*
- awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations.*
- consultants should no longer need to apply for local awards – all would be eligible. Employing organisations should make decisions on which of its consultants were the most deserving in any one year;*
- schemes should operate within a competitive environment, to reward a limited percentage of consultants working for an employing organisation within any one year;*
- nationally the parties should agree a cap on the cost of local schemes;*
- under the new schemes, local and national awards may be held simultaneously;*
- awards should be non-consolidated and non-pensionable;*
- one year local awards should be the norm, and the maximum length of local award, in exceptional cases, should be three years, to be paid in annual lump sums;*
- awards in excess of one year should require 'sign-off' by the employing organisation Chief Executive on an annual basis;*
- all existing award holders should have their awards reviewed on a regular basis, the awarding organisation to decide the length of time between reviews (but with a presumption of annual reviews) and with no grace period;*
- subject to accrued rights, there should be no pay protection; and*
- subject to accrued rights, consultants who retire and return to work should not retain any local award, although they should be eligible for consideration for new local awards alongside other consultants."*⁹

⁷ *Forty-Second Report 2014. Review Body on Doctors' and Dentists' Remuneration. Paragraph 2.54. Cm 8832. TSO, 2014.*

⁸ *Forty-Second Report 2014. Review Body on Doctors' and Dentists' Remuneration. Paragraph 8.7. Cm 8832. TSO, 2014.*

⁹ *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants. Review Body on Doctors' and Dentists' Remuneration. Recommendation 2. Cm 8518. TSO, 2012.*

“For national award schemes, we recommend that such schemes should operate within a United Kingdom-wide framework of common principles and governance and should include the following:

- awards should recognise those consultants with the greatest sustained levels of performance and commitment to the NHS and whose achievements are of national or international significance;*
- the system should be transparent, fair and equitable;*
- awards should be made only for work that is done over and above job plans;*
- awards should not reward activity already remunerated elsewhere, for example through Additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations;*
- under the new schemes, local and national awards may be held simultaneously;*
- all successful national awards should require ‘sign-off’ by the employing organisation Chief Executive on an annual basis;*
- application for an award should be by self-nomination;*
- the cost of national awards should continue to be met centrally;*
- awards should be non-consolidated and non-pensionable;*
- awards should be held for a period of up to an absolute maximum of five years, the length of which should be determined by the awarding body at the time of granting the award and should be linked to the sustainability of the achievements;*
- the level of the national award should be linked to the impact of the achievements;*
- consultants should be able to apply for a new award at any time;*
- subject to accrued rights, there should be no pay protection;*
- existing awards that remain subject to review should not include any grace period; and*
- subject to accrued rights, consultants who retire and return to work should not retain any national awards, although they should be eligible to apply for a new national award in the same pool as new applicants.”¹⁰*

“We can understand why, at the introduction of the award schemes in 1948, it was felt necessary to make these awards consolidated and pensionable. We recognise that a career average approach may be introduced, but as a point of principle, with the changes we are recommending for the award schemes, we think it is no longer appropriate for the awards to be pensionable. This is consistent with practice across the public and private sectors. Individuals have the option to make additional voluntary contributions from their award to the NHS (or a private) pension scheme.”¹¹

¹⁰ *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants.* Review Body on Doctors’ and Dentists’ Remuneration. Recommendation 5. Cm 8518. TSO, 2012.

¹¹ *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants.* Review Body on Doctors’ and Dentists’ Remuneration. Paragraph 8.25. Cm 8518. TSO, 2012.

APPENDIX E – BACKGROUND INFORMATION ON PAY

Introduction

E.1 In this appendix, we set out some background information on pay issues relevant to this remit: the main elements of the current pay structures;¹ and current earnings and pay comparability.

Main elements of the current pay structures

Junior doctors

E.2 The current junior doctor pay scales go from £22,636 (in England and Northern Ireland) to £48,123 (in Scotland), as set out in Table E.1. At present, progression between the pay points is annual and automatic, for both full and part-time staff, meaning that staff working less than full time are likely to progress to a higher pay point over the course of a career compared to full-time staff. The pay scales were originally the same in each country of the United Kingdom, but diverged in 2010 when the individual countries took different approaches as to whether or not to implement our recommendations, and on public sector pay policy.

Table E.1: Current pay scales for junior doctors, England/Northern Ireland, Wales and Scotland

Grade	Pay point	Basic pay point values at 2015, England, Northern Ireland	Basic pay point values at 2015, Wales	Basic pay point values at 2015, Scotland
F1	F1/PRHO/HO	£22,636	£22,748	£23,205
	F1/PRHO/HO	£24,049	£24,168	£24,654
	F1/PRHO/HO	£25,461	£25,587	£26,102
F2	F2/SHO	£28,076	£28,215	£28,782
	F2/SHO	£29,912	£30,060	£30,664
	F2/SHO	£31,748	£31,905	£32,546
Registrar	StR – 0	£30,002	£30,002	£30,605
	StR – 1	£31,838	£31,838	£32,478
	StR/SpR – 2	£34,402	£34,402	£35,093
	StR/SpR – 3	£35,952	£35,952	£36,675
	StR/SpR – 4	£37,822	£37,822	£38,582
	StR/SpR – 5	£39,693	£39,693	£40,491
	StR/SpR – 6	£41,564	£41,564	£42,399
	StR/SpR – 7	£43,434	£43,434	£44,307
	StR/SpR – 8	£45,304	£45,304	£46,215
StR/SpR – 9	£47,175	£47,175	£48,123	

Notes

F1 = Foundation Year 1

PRHO = Pre-registration house officer

HO = House officer

F2 = Foundation Year 2

SHO = Senior house officer

StR = Specialist registrar

SpR = Specialty registrar

Figures in green indicate the pay points which are currently only reachable by part-time staff, those who take a break from training or return to a lower level of training, or those who are credited for additional experience outside the NHS – this latter group can be appointed at higher pay points by employers

¹ This analysis does not look at all of the elements of total reward.

- E.3 In addition to their basic pay, junior doctors currently receive banding supplements for each of their postings. The number and hours and intensity of a working pattern will determine which Band a posting falls within. The following non-pensionable multipliers (Table E.2) apply to the basic pay of full-time doctors and dentists in training grades:²

Table E.2: Banding multipliers for junior doctors

	Multiplier
Band 2A (more than 48 hours and up to 52 hours)	1.8
Band 2B (more than 48 hours and up to 2 hours)	1.5
Band 1A (48 hours or fewer)	1.5
Band 1B (48 hours or fewer)	1.4
Band 1C (48 hours or fewer)	1.2

- E.4 For those trainees working less than full-time (flexible trainees), basic pay is calculated as shown below in Table E.3.

Table E.3: Proportion of basic pay for flexible trainees

	Proportion of full-time basic pay
F5 (20 or more and less than 24 hours of actual work)	0.5
F6 (24 or more and less than 28 hours of actual work)	0.6
F7 (28 or more and less than 32 hours of actual work)	0.7
F8 (32 or more and less than 36 hours of actual work)	0.8
F9 (36 or more and less than 40 hours of actual work)	0.9

² For F1 doctors in postings without a banding supplement (i.e. those working standard 40 hour contracts) a banding supplement of 1.05 is applied to basic salary.

- E.5 A supplement is added to the basic salary to reflect the intensity of duties. The intensity supplement is calculated as shown below in Table E.4.

Table E.4: Intensity supplement for flexible trainees

Band	Supplement payable as a percentage of calculated basic salary
FA – trainees working at high intensity and at the most unsocial times	50%
FB – trainees working at less intensity at less unsocial times	40%
FC – all other trainees with duties outside the period 8am to 7pm, Monday to Friday	20%

- E.6 Total salary = salary* + (salary* x intensity supplement), where salary* = F5 to F9 calculated above.
- E.7 General practice specialty registrars (GMP trainees) receive a supplement in addition to their basic pay. The supplement covers two aims: firstly to recognise their out-of-hours working; and secondly, so that the level of pay available to GMP trainees does not act as a disincentive to taking up a career in general practice, as opposed to a career in the hospital sector where total earnings are typically higher. The current level of that supplement is set at 45% of basic salary.

Consultants

- E.8 The current consultant pay scales go from £72,927 (in Wales) to £103,490 (in Scotland) and include pay thresholds, requiring consultants to meet given criteria before crossing the threshold, so the pay scales are not in that sense automatic. However, in practice we understand that the overwhelming majority of consultants pass through the pay thresholds. The pay scales are set out in Table E.5 below.

Table E.5: Current pay scales for consultants, England/Northern Ireland, Wales, Scotland

Year	England/ Northern Ireland	Wales	Scotland
0 (on appointment)	£75,249	£72,927	£76,761
1	£77,605	£75,249	£79,165
2	£79,961	£79,134	£81,568
3	£82,318	£83,646	£83,972
4	£84,667	£88,798	£86,369
5		£91,735	
6		£94,679	
7			
8			
9	£90,263	+£3,204*	£92,078
10			
11			
12		+£6,408*	
13			
14	£95,860		£97,787
15		+£9,612*	
16			
17			
18		+£12,816*	
19	£101,451		£103,490
20			
21		+£16,020*	
22			
23			
24		+£19,224*	
25			
26			
27		+£22,428*	
28			
29			
30		+£25,632*	

*In Wales, commitment awards are payable every three years once consultants reach the top of the pay scale. However, no commitment awards are paid if the consultant is also in receipt of a national Clinical Excellence Award.

E.9 The above pay scales in Table E.5 relate to the 2003 contracts.³ Some consultants remain (through personal choice) on the pre-2003 contract, although all new appointments or moves are made under the 2003 contracts. All consultants in Wales are employed under the 2003 contract. As the proposed contractual changes only relate to the 2003 contracts, we are not reproducing the detail of the pre-2003 contractual arrangements here, but they can be seen in our regular annual reports.

³ Actually the 2004 contract in Northern Ireland.

E.10 Consultants also receive intensity payments to recognise workload, contribution to the NHS and intensity of work. There is a flat-rate daytime intensity payment of £1,274 and a separate out-of-hours intensity payment, banded to recognise the varying demands of out-of-hours work, as shown below in Table E.6.

Table E.6: Out-of-hours intensity payments for consultants

	England, Scotland and Northern Ireland	Wales
Band 1	£960	£2,213
Band 2	£1,913	£4,426
Band 3	£2,860	£6,637

E.11 A consultant working an on-call rota will also be paid a supplement in addition to basic salary in respect of their availability to work during on-call periods. This is determined by the frequency of the rota they are working and which category they come under. To determine the category, the employing organisation should establish whether typically a consultant is required to return to site to undertake interventions, in which case they should come under category A. If they can typically respond by giving telephone advice, they would come under category B. The rates are as shown below in Table E.7.

Table E.7: On-call supplements for consultants

Frequency of rota commitment	Value of supplement as a percentage of full-time basic salary	
	Category A	Category B
High Frequency 1 in 1 to 1 in 4	8%	3%
Medium Frequency 1 in 5 to 1 in 8	5%	2%
Low Frequency 1 in 9 or less frequent	3%	1%

E.12 Consultants are also eligible for merit awards, known as Clinical Excellence Awards and Discretionary and Distinction Awards. The aim of the awards is to recognise the contribution of consultants and academics over and above the standard expected of their role, with awards given for quality and excellence, acknowledging exceptional personal contributions. Awards are competitive and are made at both local and national level. Local Clinical Excellence Awards are available in England and Northern Ireland, and local Discretionary Awards in Scotland. Our 2011 report⁴ on the award schemes noted that across the United Kingdom, 40.4% of consultants held local awards. Their values are as below in Table E.8.

⁴ *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants.* Review Body on Doctors' and Dentists' Remuneration. Cm 8518. TSO, 2012.

Table E.8: Local merit award payments for consultants

Local Clinical Excellence Awards, England and Northern Ireland		Discretionary Awards, Scotland	
Level 1	£2,957	1	£3,204
Level 2	£5,914	2	£6,408
Level 3	£8,871	3	£9,612
Level 4	£11,828	4	£12,816
Level 5	£14,785	5	£16,020
Level 6	£17,742	6	£19,224
Level 7	£23,656	7	£22,428
Level 8	£29,570	8	£25,632
Level 9	£35,484		

E.13 Wales does not have any local award scheme for consultants: instead, it has implemented a system of commitment awards, payable every three years after reaching the top of the pay scale, as described above in Table E.5.

E.14 National level awards are also available for consultants: either national Clinical Excellence Awards in England, Northern Ireland and Wales; or Distinction Awards in Scotland. Consultants in receipt of national awards do not retain local Clinical Excellence Awards, Discretionary Awards or commitment awards. Our 2011 report on the award schemes noted that 9.7% of consultants held national awards. The values of the national awards are as shown below in Table E.9.

Table E.9: National merit award payments for consultants

National Clinical Excellence Awards, England, Northern Ireland and Wales		Distinction Awards, Scotland	
Bronze (Level 9)*	£35,484	B award	£31,959
Silver (Level 10)	£46,644	A award	£55,924
Gold (Level 11)	£58,305	A+ award	£75,889
Platinum (Level 12)	£75,796		

*The value of the bronze national award is the same as the Level 9 local award

E.15 The consultant contract also includes the ability for employers to pay a recruitment and retention premium, of up to 30% of basic salary (on a time-limited basis).

Current earnings and pay comparability

E.16 Table E.10 gives the average annual earnings of doctors in this remit. Annual earnings are made up of basic pay and non-basic pay and in total, the average annual earnings for consultants in 2014 was £111,717, whilst it was £52,868 and £35,974 for registrars and other doctors in training respectively. Non-basic pay is made up of many different payments. Table E.11 gives estimates for each available payment: for consultants, the largest non-basic payments are payments for additional activity and medical awards; for junior doctors, it is mainly banding supplements.

Table E.10: Average Annual Earnings by Staff Group, per person, England 12 months to September 2014

Staff Group	Mean annual basic pay per FTE	Mean annual basic pay per person	Mean Annual non-basic pay per person	Mean annual earnings per person
Consultants (including Directors of public health)	£88,872	£83,657	£28,059	£111,717
Registrars	£37,324	£35,523	£17,345	£52,868
Other doctors in training	£25,961	£25,114	£10,860	£35,974

Source: Health and Social Care Information Centre

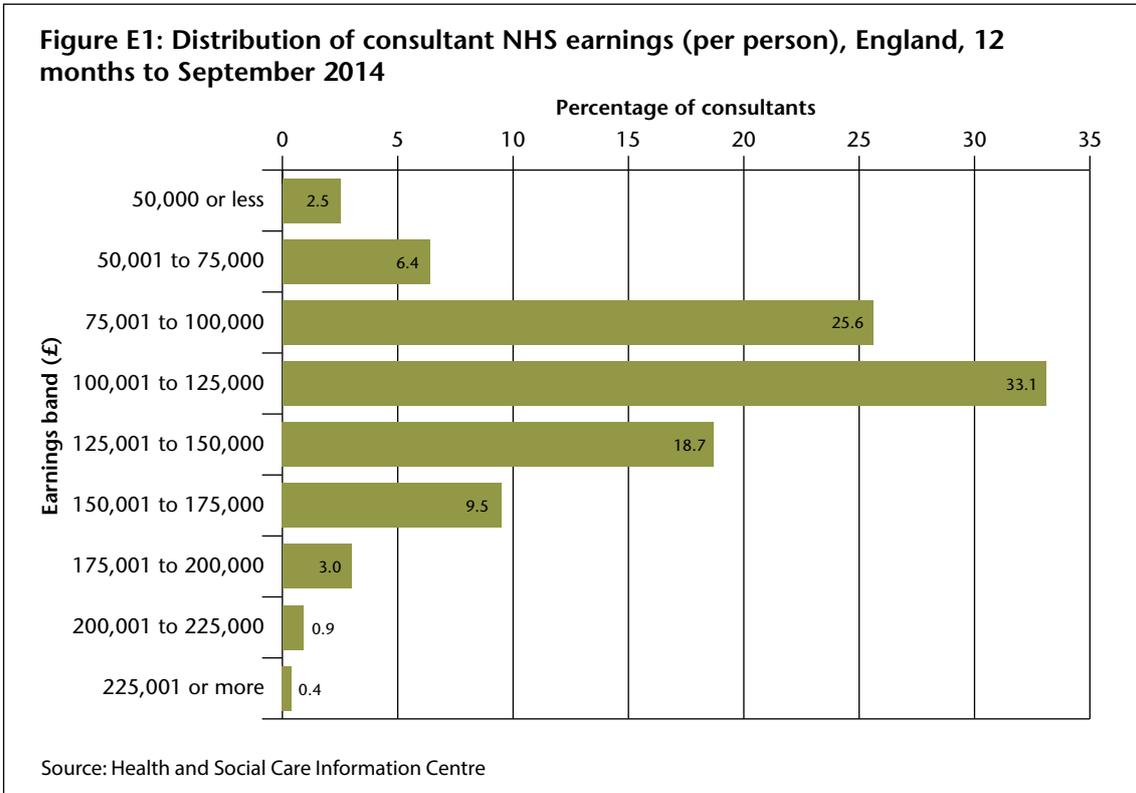
Table E.11: Non-basic pay per person by Staff Group, England, 12 months to September 2014

Staff Group	Payments for additional activity	Band supplement	Medical awards	Geographic allowances	Non-Basic pay components							
					Local payments*	On call	Overtime	RRP	Shift work payments	Other payments		
Consultants, inc												
Directors of public health	£12,668	£85	£7,673	£420	£3,750	£2,761	£30	£37	£23	£612		
Registrars	£526	£14,462	£0	£538	£1,136	£58	£15	£0	£0	£610		
Other doctors in training	£213	£9,591	£0	£369	£582	£37	£13	£0	£0	£54		

Source: Health and Social Care Information Centre

* local awards would be grouped under the 'medical awards' category

E.17 The number of years that a doctor works as a consultant is typically much longer than the time they work as a junior doctor. A long consultant pay scale and the availability of differing levels of medical awards leads to a large variability in consultant earnings. Figure E.1 shows the distribution of consultant NHS earnings and Table E.12 shows aspects of consultant earnings by age band. It includes estimates on the value of medical awards by age band.

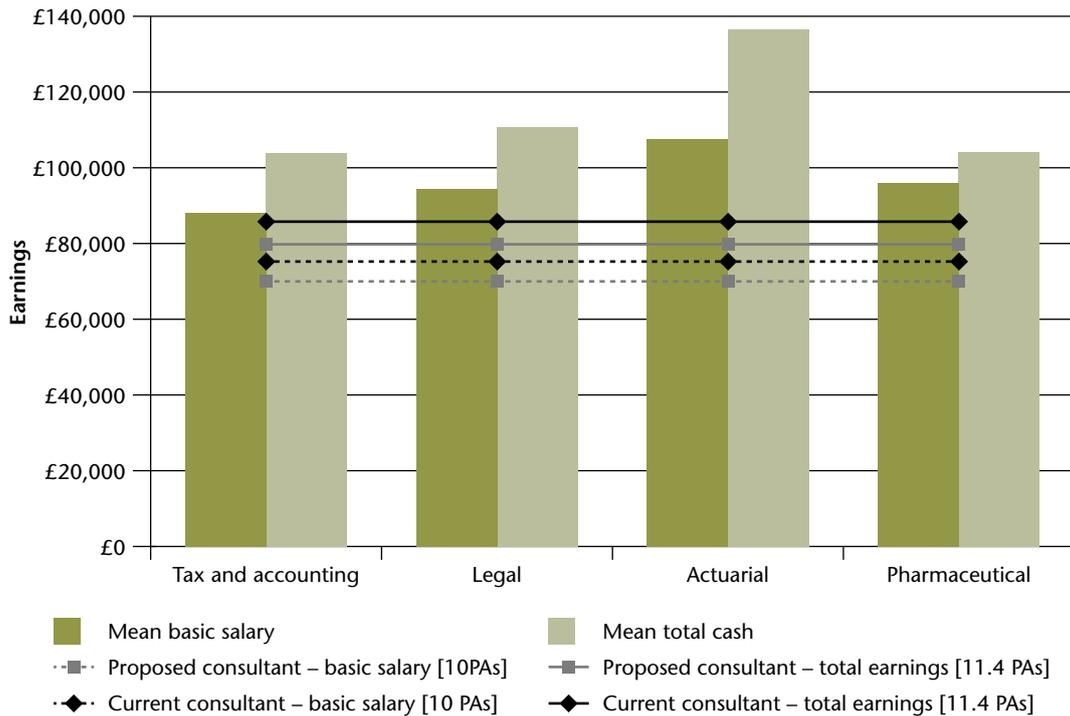


E.18 Figure E.2 looks at how entry-level consultants' basic earnings compare to other occupations. It also compares their total earnings (which assumes that the only non-basic earnings are earned by working an average 1.4 additional Programmed Activity). The figure shows that both basic earnings and total earnings would be behind those of the comparator groups.

Table E.12: Consultants' earnings by age band, England, 12 months to September 2014

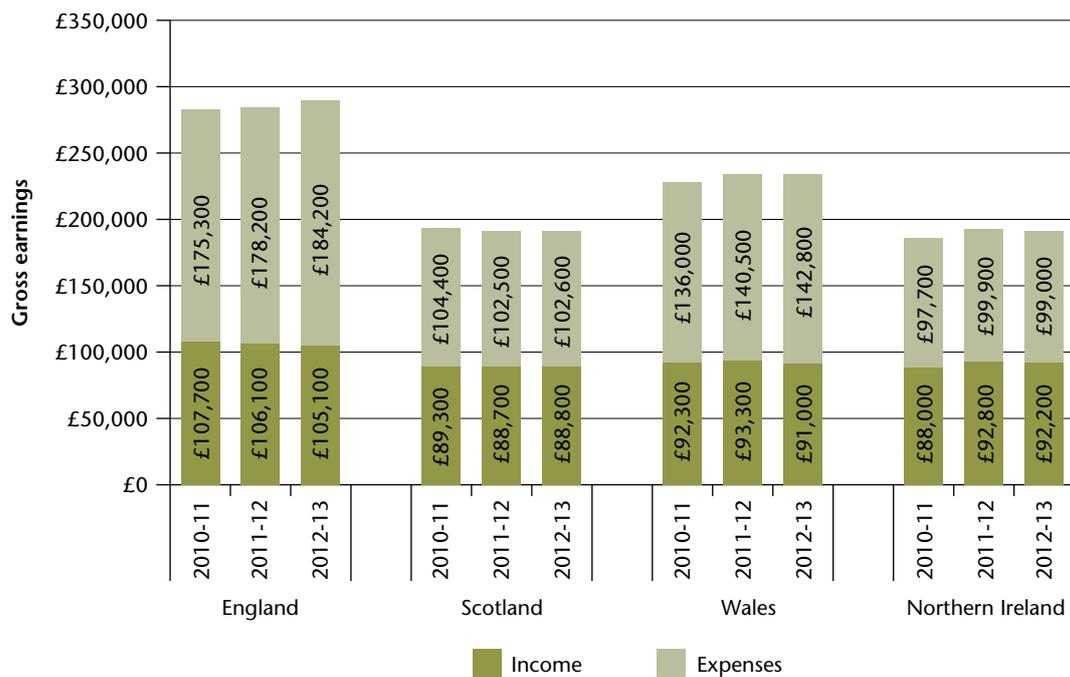
	Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 and over
Consultants' mean basic pay per FTE			£77,372	£80,449	£84,316	£88,836	£92,539	£96,209	£99,068	£100,354	£100,246
Consultants' mean basic pay per person			£72,557	£76,357	£80,423	£85,220	£88,706	£91,264	£84,957	£72,284	£54,434
(as a proportion of FTE basic pay)			(94%)	(95%)	(95%)	(96%)	(96%)	(95%)	(86%)	(72%)	(54%)
Consultants' mean non-basic pay per person			£11,004	£16,463	£21,929	£29,878	£36,561	£40,256	£29,906	£20,159	£12,229
of which medical awards			£96	£760	£2,950	£7,587	£12,529	£16,652	£11,654	£7,847	£3,982

Figure E2: Entry level consultant earnings comparison, 2014



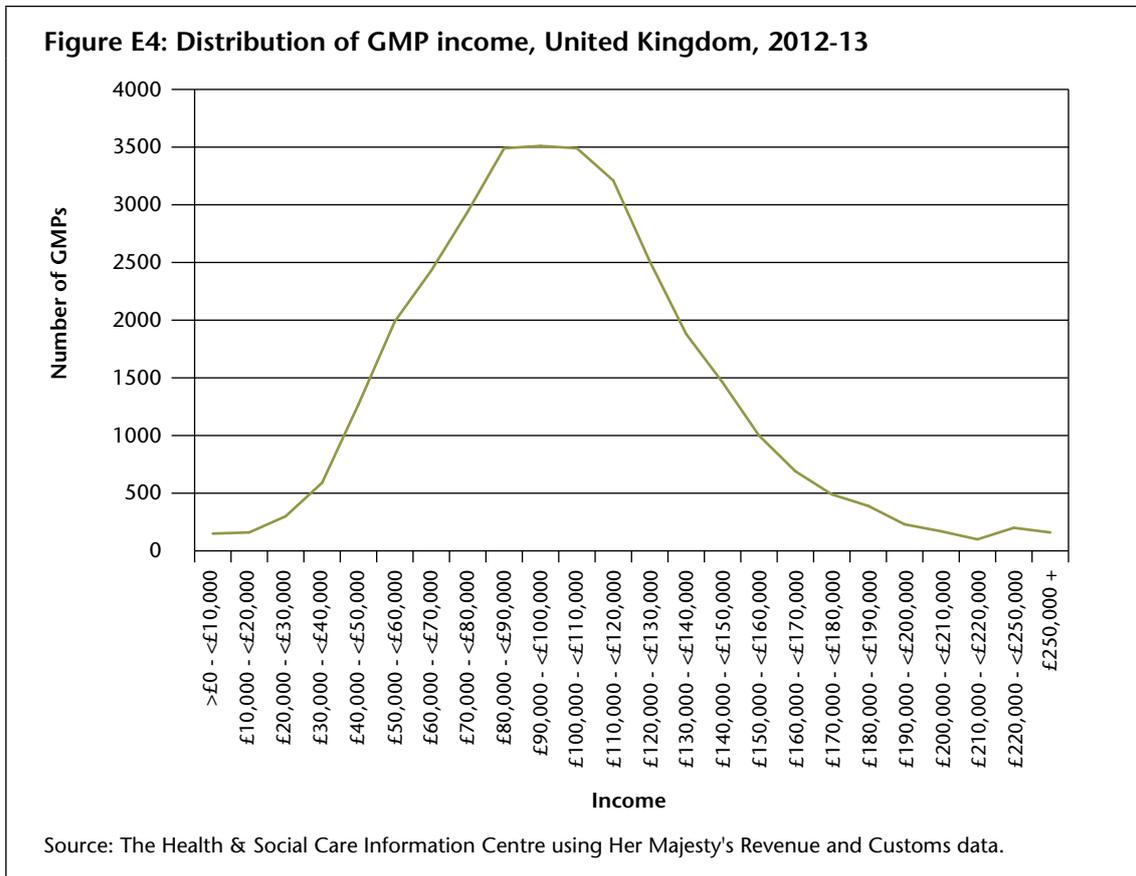
E.19 We also record here average earnings and expenses of general medical practitioners (GMPs) and general dental practitioners (GDPs), although we note that these groups have not been job weighted against hospital doctors. Figure 3.3 shows that the average taxable income of GMPs was: £105,100 in England; £88,800 in Scotland; £91,000 in Wales; and £92,200 in Northern Ireland.

Figure E3: GMPs' gross earnings: income and expenses, by United Kingdom country, 2010-11 to 2012-13



Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

- E.20 There is a large amount of variability in the income of GMPs: Figure E.4 shows the distribution of GMP income in the United Kingdom.
- E.21 Average taxable income for salaried GMPs was £56,400 in 2012-13, a decrease of 0.7 per cent on 2011-12. Many salaried GMPs work part-time, the average number of hours per week across all salaried GMPs (full-time and part-time) was 23.8 hours in 2006-07. As the most recent workload survey which gives information for contractors and salaried staff separately was in 2006-07, we do not know if the average amount of part-time work per week has changed since then.



- E.22 For GDPs, in 2012-13 the average income before tax of a providing-performer dentist in England and Wales was £114,100 and for a performer-only dentist was £60,800. For the same period: in Northern Ireland, principal dentists earned an average income before tax of £110,900, and associate dentists earned on average £53,000; and in Scotland, principal dentists earned £97,400, and associate dentists earned £57,200.

APPENDIX F – PROPOSED UNSOCIAL HOURS DEFINITIONS

Currently, in the evenings, the night window for consultants and junior doctors begins an hour earlier than for Agenda for Change (AfC) staff. In addition, the night window for AfC staff ends one hour earlier than consultants and two hours earlier than for junior doctors. Saturday and Sunday are currently considered unsocial hours for all staff. This is summarised in Figure F.1 below.

Figure F1: Current unsocial hours definitions

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday							
00:00 - 00:59	Unsocial hours for all staff													
01:00 - 01:59														
02:00 - 02:59														
03:00 - 03:59														
04:00 - 04:59														
05:00 - 05:59	Unsocial hours for Consultants and Juniors. Plain time for AfC													
06:00 - 06:59														
07:00 - 07:59								Unsocial hours for Juniors. Plain time for Consultants and AfC						
08:00 - 08:59								Plain time for all staff						
09:00 - 09:59														
10:00 - 10:59														
11:00 - 11:59	Unsocial hours for Consultants and Juniors. Plain time for AfC													
12:00 - 12:59														
13:00 - 13:59														
14:00 - 14:59														
15:00 - 15:59														
16:00 - 16:59	Unsocial hours for all staff													
17:00 - 17:59														
18:00 - 18:59														
19:00 - 19:59														
20:00 - 20:59														
21:00 - 21:59	Unsocial hours for all staff													
22:00 - 22:59														
23:00 - 23:59														

Source: OME analysis of NHS Employers evidence to the DDRB and NHSPRB

As part of their evidence NHS Employers provided the DDRB and NHSPRB with options and models for possible new unsocial hour rates and definitions. They provided four hours-based options for consultants (labelled i to iv), three options for junior doctors (labelled A-C) and three models for AfC staff (labelled 1-3).

All options for all staff groups suggest that the night window should start at 10pm and finish at either 6am for AfC staff or 7am for junior doctors and consultants. Whether Saturdays and Sundays should attract a premium depends on the option selected. All junior doctors' options suggest that Saturdays between 7am and 10pm should be considered as plain time, whilst some consultant and AfC options keep Saturdays as unsocial hours.

Although rates may vary, the definition of unsocial hours for consultant option i¹ is consistent with AfC model 1 (except for the extra hour in the morning per day) but is not consistent with any of the junior doctor options. Consultant options ii and iii² are consistent with junior doctor options B and C and AfC model 2. Consultant option iv³ is consistent with junior doctor option A and AfC model 3.

Figure F2: NHS Employers' proposed options definitions of unsocial hours



	Consultants (hours based)				Junior Doctors			AfC		
	Option i	Option ii	Option iii	Option iv	Option A	Option B	Option C	Model 1	Model 2	Model 3
Saturdays paid at plain time (between 6/7am and 10pm)	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Sundays paid at plain time (between 6/7am and 10pm)	No	No	No	Yes	Yes	No	No	No	No	Yes

Source: OME analysis of NHS Employers evidence to the DDRB and NHSPRB

Consultants – Other options⁴

Allowances based

Under an allowances approach, a supplement would be paid based on the appropriate allowances level. This would reward those with the most onerous unsocial hours working patterns. Substantial changes to the intensity of work would elicit an individual's allowances level being changed, in line with job planning arrangements. Any additional hours would continue to be paid at base rate.

¹ Saturdays and Sundays both considered unsocial hours.

² Saturdays considered plain time, but Sundays considered unsocial hours.

³ Saturday and Sunday both considered plain time.

⁴ NHS Employers Evidence to DDRB, Appendix, page 214

An allowances based system does not require knowledge or recording of when each hour is worked. It also supports providing a fixed salary as a 'rate for the job', with a distribution of additional allowances paid to those working at increasing levels of onerous unsocial hours.

Allowances and hours hybrid

A hybrid of the two previous suggested approaches is also considered. Under this system, premium rates would be paid for Sundays and Bank Holidays at time-and-a-half, along with further allowances for on-call/unpredictable activity after 10pm each night.

The first element is derived from the frequency of on-call and is given by $4/n$, where 'n' equals the individual consultant's on-call frequency. '4' is used as the numerator here to reflect the maximum weekend frequency that would normally apply. Individuals on a 1:4 weekend rota would thus get 100 per cent of this element. Less frequent duty would be reflected in a lower percentage of this element.

The second element is determined by the likelihood of the consultant being required to be on site after 10pm. It would be for each trust to determine how much of the available allowance was attributed to each specialty group based on local knowledge of activity levels.

As an example these categories could equate to:

- a. High: on site for > 3 hours after 10pm on 50 per cent of on calls
- b. Moderate: on site for > 3 hours 10 – 50 per cent of on calls
- c. Low: rarely on site for > 3 hours

Source: NHS Employers Evidence

APPENDIX G – ABBREVIATIONS AND ACRONYMS

AA	Availability Allowance
ACCEA	Advisory Committee on Clinical Excellence Awards
A&E	Accident and Emergency
AM	Assembly Member – National Assembly for Wales
ARCP	Annual Review of Competence Progression
BDA	British Dental Association
BMA	British Medical Association
CARE	Career Average Revalued Earnings
CCT	Certificate of Completion of Training
CEA	Clinical Excellence Award
CMA	Competition and Markets Authority
CT 1-3	Core training stage
DDRB	Review Body on Doctors’ and Dentists’ Remuneration
DFT	Dental Foundation Trainee
F1	Foundation House Officer Year 1
F2	Foundation House Officer Year 2
FHO	Foundation House Officer
FOI	Freedom of Information
GMC	General Medical Council
GMP	General Medical Practitioner
GP	General Practitioner
HCHS	Hospital and Community Health Services
HSCIC	Health and Social Care Information Centre
IDS	Incomes Data Services
MD	Doctor of Medicine
NHS	National Health Service
NHSPRB	NHS Pay Review Body
MLA	Member of the Legislative Assembly (Northern Ireland)
MP	Member of Parliament
MSP	Member of the Scottish Parliament
OECD	Organisation for Economic Co-operation and Development
OME	Office of Manpower Economics

ONS	Office for National Statistics
OOH	Out of Hours
PA	Programmed Activity
PhD	Doctor of Philosophy
RRP	Recruitment and Retention Premia
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	Specialty doctors and Associate Specialists
SPA	Supporting Professional Activity
ST1-8	Specialist training stage
TAGI/TANI	Target Average Gross Income / Target Average Net Income
TSO	The Stationery Office
UCAS	Universities and Colleges Admissions Service
UCEA	Universities and Colleges Employers Association
UHB	University Hospitals Birmingham
UK	United Kingdom

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