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Evidence for the Review Body on Doctors' & Dentists' Remuneration

December 2014

Prepared by NHS Pay, Pensions & Employment Services Team

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Executive summary

A modern and sustainable NHS which is free at the point of delivery must be enabled by robust workforce terms and conditions, not just to survive, but to thrive. The public expect safe, quality services to be available when they need them, and the service needs to be designed to be affordable and flexible enough to cope with the direction of travel in which society is moving.

The drivers for seven day services can be summarised as:

- Improving patient safety
- Efficient resource management
- Reflecting 21st century employment best practice
- Meeting the needs of patients and improving the quality of patient care

The NHS should provide safe, high quality patient care at all times. Significantly higher mortality and morbidity rates at night and, in particular, weekends indicate that this is not currently the case. Delivering this is challenging and is about organising services around patient needs.

NHS England has set the direction of travel, calling for more services to be available in the evenings and at weekends. Currently, the consultant contract hinders trusts from offering safe, quality care across the week. Consultants can opt out of non-urgent work at the evenings and weekends and have different out of hours payment arrangements to most other senior professions. The contract does not recognise the reality that health care must be provided consistently throughout the week, and thus evening and weekend working should be a core part of the job.

Changes to employment contracts cannot of themselves deliver seven day services. However, it is clear that the current contracts for consultants and juniors, agreed at a time when many NHS services were delivered in daytime, during the week, hinder the delivery of seven day services and need to change to support better patient care.

Drivers for change

There is a compelling case for reforming the contractual arrangements for doctors and dentists in training (juniors) and for consultants.

The juniors' contract was introduced in 2000 specifically to drive down working hours. The view of many is that, having achieved that aim, the contract is no longer fit for purpose; it fails to reward doctors fairly for work done, and can actually hinder quality training and restrains the design of services which should centre on patient needs. A new contract is needed that supports the delivery of safe, high quality patient care and safe working arrangements and quality training for juniors.

Patient safety belongs at the very heart of the NHS, and in recent years a strong clinical case has emerged for the delivery of consistent NHS care every day of the week. A seven day NHS service has the potential to reduce mortality rates, speed up diagnosis and discharge times and reduce the amount of time that patients need to spend in hospital overall.

Local models that recognise the need for parity of care and are tailored to the unique circumstances of their localities and the needs of local patients are now emerging. More recently, NHS England has also committed to develop a framework for how seven day services can be implemented affordably and sustainably and that recognises the importance of local solutions and, we expect, will provide more detail in its evidence.

As the NHS's most senior clinicians, consultants, leading multi-disciplinary teams, will be critical to driving forward the change required. It is important that the contract supports this role and provides a catalyst for NHS services that provides safe, high quality patient care at all times.

The consultant contract was introduced in 2003 to properly reward consultants and to allow more patients to benefit from their expertise by enabling employers to manage a consultant's work commitments more effectively. However, it was also developed in the context of an increasingly outdated model of NHS provision that often prioritised the delivery of care during the working week.

The way services and contracts are organised should never harm the quality of patient care available, and in its current form the consultant contract increasingly serves as a barrier rather than an enabler of sustainable seven day care. A modernised contract is required that: provides consultants with a flexible pay and reward system that is better suited to support emerging models of seven day care; increases productivity; and engages and incentivises consultants as leaders of system change.

For these reasons, the Government announced its intention, in December 2012, to reform the contracts for juniors and consultants to promote higher quality medical education and research, motivate doctors to achieve excellent results for patients, ensure that the contracts remain fair, affordable and fit for the future; and make best use of the annual £8.5bn pay bill for these doctors.

The BMA's withdrawal from the negotiations

Following initial discussions and engagement with NHS Employers and the British Medical Association (BMA, representing also the British Dental Association, BDA), and based on Heads of Terms agreed between those two parties, the Government asked NHS Employers to negotiate new contractual arrangements. The Government was extremely disappointed that, close to the conclusion of 18 months of discussions and negotiations undertaken in good faith, the BMA chose to announce without notice that negotiations had ended.

It was particularly concerning that the BMA accused the management side negotiators (which includes consultant and clinical director representation) of pursuing proposals that would put patient and doctor safety at risk, and directed those same allegations at the Government. The subsequent demands made by the BMA for returning to negotiations led NHS Employers, and the management side negotiators from Scotland, Wales and Northern Ireland, to advise Ministers that there was no prospect of agreements being reached.

The DDRB remit for employed doctors

The Government therefore issued this remit to the Review Body on 30 October 2014 (Annex A).

The Francis report on the very poor quality of care provided at Mid Staffordshire NHS Trust showed that staff and managers must make the care and safety of patients their priority.

The safety and quality of care depends on having the right contractual arrangements in place – and that includes safe working arrangements for all staff. The intention is not to increase the working hours of doctors, for instance, by expecting seven day *working*. A *seven day service* is about ensuring that the workforce can be scheduled across the seven day week. There is no intention to dilute the protections that apply currently to ensure safe working hours; indeed, the Review Body will receive evidence showing that the intention is to maintain and increase those safeguards.

For these reasons, we have also asked the NHS Pay Review Body to make observations on the barriers and enablers in the Agenda for Change pay system for delivering health care services seven days a week in a financially sustainable way. We would also expect that the Review Body's observations would be relevant to some aspects of the contractual arrangements for other employed medical staff.

This evidence provides the strategic context for reform and sets out progress made to date. The evidence from NHS England will set out the strategic vision for seven day services. Separate evidence from NHS Employers will set out detailed options for new contractual arrangements for juniors and changes to the consultant contract.

This evidence:

- provides an outline of the emerging strategic vision for seven day services including key themes that are relevant to contractual reform for consultants; Evidence from NHS England and NHS Employers should cover this in greater detail.
- provides an overview of existing arrangements for doctors working unsocial hours and for other sectors in the wider economy;
- discusses the overarching case for reform of medical contracts ;
- outlines the Government's view on discussions and negotiations between NHS Employers and the BMA, including the Heads of Terms agreed between the parties;
- provides the Government view on the discussions in negotiations between NHS Employers and the BMA for juniors, and what we understood to be the key areas of disagreement;
- responds to questions posed by the Review Body where these have not been answered in the preceding chapters and are questions for the Department and explains where (some) questions are more appropriate to be addressed by other parties; and
- invites the review body to make recommendations on new contractual arrangements for juniors and observations on reform of contractual arrangements for consultants taking account of evidence that will be submitted by NHS Employers, NHS England and other parties.

Chapter 1: The strategic vision for seven day services

1.1 A considerable body of clinical research has emerged over the last decade that links unsatisfactory outcomes for patients and the level of service provision – including during the weekend¹. The 2012 Academy of Royal Colleges report ‘*The Benefits of Consultant Delivered Care*’ states that:

“Numerous reviews...have concluded that patients have increased morbidity and mortality when there is a delay in the involvement in their care... The increased mortality among patients treated in hospitals at weekends has been attributed by expert clinicians to decreased consultant involvement in care.”

1.2 The 2013 Dr Foster Guide² also sets out some concerning statistics about hospital care at weekends stating that:

- emergency overall mortality is 20% higher when admitted at a weekend;
- mortality for patients who had routine surgery is 24% higher if the operation is later in the week and just before the weekend;
- repairing fractures on the day of admission is 10% lower at weekends;
- waiting for more than two days for a broken hip replacement is 24% higher on weekends;
- emergency imaging (MRI scans) on the day of admission is 42% lower at weekends; and
- re-admissions are 3.9% higher following treatment at a weekend.

1.3 The Dr Foster report summarises:

“Patients admitted as emergencies at weekends are less likely to survive their treatment; less likely to get diagnostic tests on the day of admission; and less likely to have emergency operations within a day or two of being admitted. They are also more likely to have to return to hospital shortly after discharge.”

1.4 The prevailing situation is completely unacceptable. Patients should be at the heart of the NHS and be able to depend on it every day – not just Monday to Friday. Accidents do not cease to happen on the weekend, and people do not stop being ill at 8 pm on a Friday - so the NHS must be more responsive to patient needs, providing safe, high quality patient care at all times.

1.5 A seven day NHS service cannot be about “seven day working”. In order to safeguard the well-being of staff, deliver safe care and keep within budgets, we do not expect that the NHS will implement the same configuration of services over seven days that they currently

¹ For example, NHS Forum Seven days a week highlights evidence base and clinical standards for the care and onward transfer of acute inpatients in in this report <http://www.england.nhs.uk/wp-content/uploads/2013/12/evidence-base.pdf>

² <http://myhospitalguide.drfoosterintelligence.co.uk/downloads/report/Report.pdf>

deliver Monday to Friday. Effective seven day service provision is more about intelligent, flexible rostering, and resource management that increases the efficiency and productivity of the service, not places more pressure on it.

- 1.6 A range of consultant led multi-disciplinary professionals; all working in collaboration will deliver many of the changes necessary to improve patient care across the week. We therefore expect that there will be a number of consistencies between the evidence presented to the DDRB and the NHS Pay Review Body – and therefore neither review body should consider its remit in isolation.

The strategic vision

- 1.7 The responsibility for driving forward the delivery of a seven day NHS service falls to NHS England and is set out in the objectives outlined in the mandate between Government and NHS England for 2015-16. The mandate is structured around five key areas where the Government expects NHS England to make improvements, and each of these areas would be supported by more services being delivered more days of the week:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill health or following injury.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

- 1.8 Specifically, the mandate states:

“Timely access to services is a critical part of our experience of care. The NHS should be there for people when they need it; this means providing equally good care seven days of the week, not just Monday to Friday. More generally, over the last decade, the NHS has made enormous improvements in reducing waiting times for services. The people of England expect all parts of the NHS to comply with the rights, and fulfil the commitments set down in the NHS Constitution, including to maintain high levels of performance in access to care. NHS England’s objective is to uphold these rights and commitments, and where possible to improve the levels of performance in access to care.”

- 1.9 NHS England established the ‘NHS Services, Seven Days a Week Forum’ (the Forum) to provide evidence and insight to support commissioners and providers in their move to make routine NHS services available seven days a week. This Forum produced a report of its initial findings in December 2013, where it presented the evidence base for change, and set out proposals for moving forward. This initial view also highlighted the reform of consultants’ contractual pay and terms and conditions as a key enabler of seven day services.

- 1.10 In this report, Professor Sir Bruce Keogh, the National Medical Director states *“It is also clear that the lack of many seven day services has an adverse effect on measurable outcomes in each of the five domains of the NHS Outcomes Framework: mortality amendable to healthcare, treatment of long term conditions, outcomes from acute episodes of care, patient experience, and patient safety.”*
- 1.11 The Healthcare Financial Management Association (HFMA) also produced a report³ on behalf of The Forum that looked at the costs of delivering seven day services in which they state:

“There are four main drivers for seven day services:

- Reducing Mortality: mortality is generally worse at weekends.*
- Increasing efficiency in the system: if the quality of emergency care, and the services provided, were the same every day, there would be no backlog of cases requiring urgent action on Mondays. Staff would be used more effectively, and both emergency and elective work would be managed better.*
- Moving with the times: the NHS has not moved in line with other service industries. In most other areas, such as the retail sector, there is now no difference between a weekend and a weekday: why should the NHS be different?*
- The compassionate argument: patients should be entitled to receive the same standard of care regardless of the day of the week. Furthermore patients should be able to access care over the weekend if they need it regardless of whether it is an emergency. The potential benefits are a reduction in suffering and /or the provision of peace of mind.”*

- 1.12 NHS England’s Five Year Forward View⁴, published in October 2014, set out a vision for a modern NHS, suggesting that:

“...over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support jobs and service redesign, and encourage recruitment and retention in parts of the country and in occupations where vacancies are high.”

- 1.13 The Department of Health welcomes the vision outlined in the Forward View, and looks forward to working with its partners to ensure that the NHS can meet the challenges it faces over the next five years and beyond. The vast majority of the proposals in the Forward View will be for NHS England and its partners, including local clinical

³ Costing seven day services: The financial implications of seven day services for acute emergency and urgent services and supporting diagnostics, December 2013.

<http://www.hfma.org.uk/search/default.htm?sort=1&keyword=seven%20day&categories=0|1|2|3|4|5|6|7&searchtype=2>

⁴ <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

commissioning groups, to take forward, but in the context of this evidence it is useful to set out that we are working towards a common goal of high quality healthcare every day of the week.

Seven day services are about the whole care pathway

- 1.14 To deliver seamless care for patients, the whole care system - not just the NHS - must be organised around the patient.
- 1.15 Care pathways that start within acute hospitals are often reliant upon services provided by intermediate, mental health, primary and social care teams for example during the discharge process. Secondary care services cannot be delivered effectively, safely, and efficiently in isolation - other care sectors will also need to be active across the week.
- 1.16 We welcome the Forum's Clinical Standards, which describe the quality of care patients should receive every day of the week (Annex B). These standards take a holistic approach, including mental health, diagnostics, interventions, and community, primary and social care. Alignment across services will maximise the benefits of adopting clinical standards, prevent admissions, and support safe, timely discharge.
- 1.17 The Government's ambition is to make joined up care the norm by 2018. The £3.8bn Better Care Fund was announced in June 2013 and is the biggest ever financial incentive for councils and the local NHS to jointly plan and deliver health and care services. Better Care Fund plans have to set out how areas will achieve seven-day services in social care and health to support patients being discharged and prevent people being unnecessarily admitted at weekends. This is a significant step towards truly joined-up services for people who need support from both sets of professionals.
- 1.18 We are also committed to improving access to GP services. In September 2013 it was announced that £50m was being invested by NHS England in 20 pilot sites to test improved and innovative access to GP services, as part of the first wave of the Prime Minister's Challenge fund. This includes longer opening hours – such as evening and weekend hours – but also different ways of accessing services, for example use of Skype consultations.
- 1.19 A second wave of the Prime Minister's Challenge Fund has now been announced, through which another £100 million will be invested in new pilots, which will have the minimum requirement that they must be open 8 am – 8 pm Monday to Friday and offer appointments on weekends.
- 1.20 Delivering care that is centred on the individual's needs is a key priority. NHS and social care staff should be able to work together to provide seven day services so that people can leave hospital as soon as they are ready, delivering a noticeably improved service closer to the user and so relieve pressure on hospitals, allowing them to focus on specialist and emergency services.

The importance of experienced clinical care seven days a week

- 1.21 In December 2012, the Academy of Medical Royal Colleges published three standards in its report 'Seven Day Consultant Present Care', which was followed by a report on the implementation considerations in November 2013.
- 1.22 The Academy outlined a number of key findings, including 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. Its 2012 report, 'Benefits of Consultant Care', also suggests:
- “Studies designed to improve patient care which have incorporated earlier involvement of consultants have resulted in better patient outcomes, more efficient use of beds and decreased length of stay”.*
- 1.23 The NHS Forum has also cited the importance of early consultant involvement, for example consultants' management of patients admitted as an emergency is one of the most important factors in patient care, and that delays to consultant reviews and a lack of senior involvement in patient care have been linked to poor outcomes.
- 1.24 The Academy's standards are outlined in Table 1 below - and the full reports can be found at <http://www.aomrc.org.uk/projects/seven.html>

Table 1: AMRoC standards for seven day consultant present care

Standard 1	Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days per week, unless it has been determined that this would not affect the patient's care pathway.
Standard 2	Consultant-supervised interventions and investigations, and their reports, should be provided seven days per week if the results will change the outcome or status of the patient's care pathway before the next 'normal' working day – this should include interventions and investigations which will enable immediate discharge or a shortened length of hospital stay
Standard 3	Support services both in hospital and in the community and primary care setting should be available seven days per week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant review, can be taken.

- 1.25 In its reports, the Academy uses 'consultant' as a term broadly understood by doctors and the public. It uses the term to refer to the level of skill and expertise required of the individual, not their contract of employment, and recognises that the appropriate level of expertise may be found in those not on a consultant contract or in a formal consultant

grade, but with a Certificate of Completion of Training (CCT) or Certificate of Eligibility for Specialist Registration (CESR) or certain senior doctors with appropriate competencies, including those in Staff and Associate Specialist and Senior Specialty Doctor (SAS) grade posts.

Lessons for contractual reform

- 1.26 Just as the organisation of NHS services should not diminish the quality of the patient care available during the weekends, nor should employment contracts. It is therefore important that the consultant and other NHS contracts can support a move towards seven day service provision in a financially sustainable way. In particular, a contractual provision that enables consultants to refuse to work in the evening, at night or during weekends is wholly inappropriate in a patient centred NHS and restricts employers from implementing consultant led seven day provision sustainably.
- 1.27 The NHS Forum's initial view and the Academy's implementation report are clear that there can be no 'one-size fits all' model of seven day service provision, and that local circumstances should be reflected in the design of service changes. NHS England's 'Five Year Forward View'⁵ has also committed to develop a framework for how seven day services can be implemented affordably and sustainably, whilst recognising that different solutions will be needed in different localities and, we expect this will be set out in more detail in NHS England's evidence.
- 1.28 The consultant contract should support this development by providing employers with the flexibility to develop and maintain appropriate solutions for their patients that improve the quality and safety of care available every day of the week. This includes approaches to work undertaken out of hours and performance pay that can be adapted locally, and used to help drive the improvements required.
- 1.29 Working patterns and shift demands for some medical specialities – for example Accident and Emergency - are often markedly different from those of predominantly outpatient based specialities. It will be also important that the contract contribute to ensuring that medical careers in these specialities are attractive.

Engaging clinical leadership

- 1.30 Excellent leadership is critical to the delivery of quality care, including the development of seven day services. As highlighted in volume one of the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry '*Hard Truths – the Journey to putting patients first*', NHS Leadership should have a clear focus on safety, quality and the experience of patients and service users. The Government's ambition is for excellent leadership, including clinical leadership, to be the norm at every level of the health service.
- 1.31 The importance of clinical leadership has been highlighted by the NHS Forum, which noted that many early changes have generally been driven by individuals, and that "*many*

⁵ <http://www.england.nhs.uk/ourwork/futurenhs/>

organisations already moving toward seven day services have observed that this commitment requires real grit and leadership to deliver". The Academy's implementation report also notes that optimal value from consultant weekend presence will be achieved if the consultant is leading a team of health care professionals.

- 1.32 Caring for patients is also a team effort. For example, the availability of allied health professionals, including physiotherapists and radiographers, to support medical and nursing staff during the diagnosis, treatment, and discharge process is critical. As the senior leaders and clinicians closest to patients, consultants are often best placed to lead these teams and drive change. It is important that they can also align themselves with and contribute to the organisational decisions that impact on patients' safety.
- 1.33 We know that there are encouraging local examples of innovative consultant led working practices that have helped drive expansion of seven day services (explored by NHS Employers in its evidence). However, these changes are often made in spite of, rather than supported by, the employment contracts. To support this role, consultants deserve a professional employment contract that will act as a catalyst to engage and harness their expertise.

Chapter 2: Summary of the existing unsocial hours arrangements for doctors and other sectors

Introduction

- 2.1 Junior doctors and many consultants already work during unsocial hours, including the weekends.
- 2.2 However, consistent delivery across seven days has not historically been considered a priority, and the existing contractual unsocial hours payments for consultants in particular were not designed with the purpose of facilitating the delivery of affordable seven day services.
- 2.3 The HFMA report on the costs of delivering seven day services suggested that the NHS has not moved in line with other service industries which have moved to deliver services across the week. It states that “moving with the times” will be one of four key drivers for the delivery of seven day services going forward.
- 2.4 Facilitating a sustainable seven day NHS service is not about encouraging doctors to work long or unsafe hours, which would put at risk the wellbeing of staff and patients. Instead, to deliver a successful seven day service, a trust may require its staff to work more flexibly within their contracted hours for the benefit of patients. To deliver this in a financially sustainable way, it is important to look across the economy at how other sectors pay staff for work delivered during unsocial times.
- 2.5 This chapter provides a brief overview of the existing unsocial hours arrangements for doctors and dentists in training and for consultants. It also provides some comparisons with other sectors, which is also explored further in Chapter 3 on the case for reforming medical contracts.

Doctors and Dentists in Training

- 2.6 Doctors and dentists in training grades receive a non-pensionable banding supplement that is designed to provide compensation for extra hours worked and for more intense working patterns.
- 2.7 Supplements are payable to those juniors who work 40 hours a week or more, with the amount varying according to the numbers of hours and working pattern (for example for work done outside the hours of 8 am-7 pm Monday to Friday).
- 2.8 The banding supplements are divided into five bands. Bands 1A, 1B and 1C are for those who work up to 48 hours a week while bands 2A and 2B are for those who work more than 48 hours and up to 56 hours a week. All doctors on the same rota are allocated the same banding.

Table 2.1 Banding supplements for doctors and dentists in training

Banding Supplements – Doctors and Dentists in Training	
	% Supplement to basic pay
Band 3	100
Band 2A	80
Band 2B	50
Band 1A	50
Band 1B	40
Band 1C	20

Consultants

2.9 The consultant contract applies to most consultants, including all those appointed after 31 October 2003, as well as those who have chosen to transfer to it. It is based on a full-time work commitment of 10 programmed activities (PAs) per week, with each PA covering a work period of 4 hours (or three hours if the PA is undertaken in premium time). Each consultant should have a job plan that sets out the number of agreed PAs that the consultant will undertake. Any additional work above 10 PAs is by agreement only.

Premium time and out of hours work

2.10 Any time that falls outside the period 07:00 to 19:00 Monday to Friday, and any time on a Saturday or Sunday, or public holiday is considered 'premium time' or "out of hours work". During premium time the length of a PA is reduced to three hours (rather than four) or, by agreement, the rate of pay for a four-hour PA increases to time and a third.

2.11 In addition, non-emergency work cannot be scheduled during these times without the agreement of the consultant - this is known as the 'opt out' clause of the contract.

Consultant on-call availability supplement

2.12 Consultants on an on-call rota are paid an on-call availability supplement in addition to basic salary, which recognises the inconvenience of being on a rota and the duty to participate in it. There are two levels of on-call supplement:

- Category A applies to a consultant who needs to attend a place of work immediately when called, or to undertake analogous interventions (e.g. telemedicine or complex telephone consultations).
- Category B applies to a consultant who can attend a place of work later or respond by non-complex telephone consultations later.

2.13 The on-call availability allowance recognises the inconvenience of on-call availability but not the work actually done when on call. For many consultants there will be a predictable amount of emergency work arising from on-call duties factored into job plans. Unpredictable emergency work can also be factored in (which should not exceed a maximum of two PAs per week).

Table 2.2 Availability supplements for consultant doctors

Frequency of rota commitment	Value of availability supplement as a percentage of full-time basic salary	
	Category A	Category B
High frequency: 1 in 1 to 1 in 4	8.0%	3.0%
Medium frequency: 1 in 5 to 1 in 8	5.0%	2.0%
Low frequency: 1 in 9 or less frequent	3.0%	1.0%

Other sectors in the wider economy

2.14 In 2014, the Department of Health commissioned *Incomes Data Services (IDS)* to provide information on unsocial hours in a range of public and private sector organisations.⁶ IDS's report drew on surveys conducted in 2013 with employers from a range of sectors, including retail, call centres, housing and social care, other public services and others. It includes commentary on the position of senior professionals considered comparators for doctors - such as legal and finance professionals, who often train for a similar amount of time to develop in depth expertise and can expect similar levels of remuneration and responsibility.

2.15 The report offers a number of insights into how others sectors treat work that is delivered during unsocial hours, and notes that for other groups higher rates of pay are most often reserved for night working and for Sundays (if at all). It also suggests that these times are generally regarded as being a more inconvenient time to work and consequently less attractive to employees. Table 2.3 draws out some key information.

2.16 For ease of reference we have also summarised the arrangements for Consultants, doctors and dentists in training, and the existing NHS Agenda for Change employment contracts for both non-medical staff and ambulance staff. In the table 'T' stands for 'time'.

⁶ "Unsocial Hours Payments: A research report for the Department of Health from Income Data Services" January 2014

Table 2.3: Unsocial payments in other employment sectors (from IDS report)

	Proportion of employers from sample that pay a premium for unsocial hours (where applicable)	Typical unsocial payments (where applicable)		
		Evenings and Night Work	Saturdays	Sundays
NHS Consultants	All	<p>The contract is based on a full-time work commitment of 10 programmed activities (PAs) per week, with each PA covering a work period of 4 hours.</p> <p>Any time that falls outside of 07:00 to 19:00 Monday to Friday, and any time on a Saturday or Sunday is considered 'premium time'</p> <p>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 T+ 33%</p> <p>Non-emergency work cannot be scheduled during these times without the agreement of the consultant.</p> <p>Consultants on an on-call rota also receive an on-call availability supplement in addition to basic salary.</p>		
Doctors and Dentists in Training	All	<p>Staff receive a banding supplement to compensate for extra hours worked and more intense working patterns.</p> <p>Supplements are payable to those working 40 hours a week or more, which varying according to the numbers of hours and working pattern – including outside the hours of 8 am-7 pm Monday to Friday.</p> <p>The supplements are divided into five bands, and range from 20-100% of basic pay. All doctors on the same rota are allocated the same banding.</p>		
NHS – Agenda for Change	All	<p>Staff receive scaling hourly rates depending on their pay band (with evenings considered 8 pm-6 am) i.e.:</p> <p><i>Pay bands 1-3 (lowest paid):</i> -Scales between T+ 37% and T+50%</p> <p><i>Pay bands 4-9 (middle to highest paid):</i> -T + 30%</p>	<p><i>Bands 1-3:</i> -Between T+100% and T+74%</p> <p><i>Bands 4-9:</i> -T+60%</p>	
NHS - Ambulance Staff	All	<p>Staff receive a salary uplift based on the average number of unsocial hours worked, with different uplifts and qualifying hours for lower/middle earners and for higher earners.</p> <p>For pay bands 1-7, unsocial hours include 7 pm-7 am and any time on weekends:</p> <ul style="list-style-type: none"> - Up to 5 hours: local agreement - Over 5 hours: the uplift scales between 9% (for between 5 and 9 hours) up to 25% for 21 hours plus <p>For Pay bands 8 & 9, unsocial hours are between 10 pm-7 am and outside 9 am-1 pm on the weekend:</p> <ul style="list-style-type: none"> - Up to 5 hours: local agreement - Over 5 hours: 9% for up to 13 hours and 10% for 13 hours plus 		
Police	All	T+ 10% (between 8 p.m. and 6 a.m.)	Plain Time	

Housing and Social Care: Care Assistants and Supervisors	43% pay premiums for night working, 33% for Saturdays & 66% Sundays	T+33%	T+33%	T+50%
Housing and Social Care: Nurses or Care Home managers	A small minority of care organisations pay night premiums, and fewer weekend premiums			
Engineering: - Manual Workers	Common (shift premiums)	T+33%	+15% (weekend work uncommon)	
Retail	Most	T+33% (mostly between 10 pm-5 am or 11 pm-6 am)	Plain Time	T+50%
Call Centres	42%	Significant Variation		
Senior Staff Professionals in Legal and Finance	It is very unusual for unsocial hours payments to be made, with compensation generally reflected in higher basic and salaries and earnings packages.			

2.17 Some key observations from the report are:

- Many employers do not offer unsocial hours payments at all.
- Of those employers offering unsocial hours payments, higher rates of pay are most often reserved for night working and for Sundays. The report suggests that these times are traditionally regarded as being a more inconvenient time to work and consequently less attractive to employees, with Saturdays often paid at plain time.
- A majority of organisations in the housing and social care sector do not pay unsocial hours, and only a third pay above plain time for Saturdays. Very few pay unsocial hours payments to nurses or homecare managers.
- It is very unusual for unsocial hours payments to be made to senior professionals such as those working in law and finance, with compensation generally reflected in higher basic and salaries and earnings packages.
- More generally, the report points out that a number of important changes to unsocial hours have taken place in recent years. For example, in the retail sector the advent of extended weekend services has led to a reduction in the amount paid for work during unsocial periods, a process which has more recently stabilised.

2.18 It is fair for patients to expect health and social care services to have moved with the times, and that they will receive the same level of NHS services at the weekend as available generally in other sectors. The NHS has not generally kept up with a shift in cultural expectation - although some organisations have now started to meet the needs of patients in the evening and at weekends. It is our view that NHS employment contracts should make consistent quality care the norm every day of the week.

Chapter 3: The case for reforming medical contracts

- 3.1 The national employment contracts for doctors and dentists in training (juniors) and for consultants were introduced in 2000 and 2003 respectively and were primarily designed to drive down working hours for juniors and to properly better reward consultants.
- 3.2 The way that NHS services are organised should never harm patient care, and nor should employment contracts. These contracts are not fit for purpose in the modern NHS.
- 3.3 The juniors' contract does not reward doctors fairly for the work they do, and can actually hinder quality training and restrain the design of services, which should centre on patient needs. A new contract is needed that supports the delivery of safe, high quality patient care, safe working arrangements and quality training for juniors - who will also be the consultants of the future.
- 3.4 The amount spent on consultant remuneration is high overall, representing almost 13% of total NHS employment costs, for only 4% of staff. As the senior clinical leaders, consultants are critical for driving quality and it is right to continue to invest in the consultant grade.
- 3.5 Unfortunately, the structure of the contract prevents employers from using this investment efficiently - for example, the contract fails to allow employers to appropriately reward those who make the greatest contribution, or to fairly recognise those who work during the most unsocial hours. This restricts productivity and overall value for money.
- 3.6 As a result, the consultant contract serves as a disincentive - rather than an enabler - of consistent clinical care across the week that restricts the attractiveness of certain specialities and fails to enable sufficient coaching and supervision of doctors in training. The contract needs to be amended so that it better engages consultants as senior NHS clinical professionals and visible leaders of change.
- 3.7 With total spend on both contracts totalling 22% of the total NHS paybill, these flaws will inevitably harm the quality of care that the NHS can provide. This is completely unacceptable in a modern, patient focused NHS.
- 3.8 This section explores in greater detail the strategic case for change, presenting evidence that will help ensure that contracts continue to have a place in an NHS which puts the patient first.

Financial and clinical sustainability

- 3.9 Health should be designed around patients in a way which is affordable and flexible and which reflects modern employment practice. However, the drivers for the introduction of the existing consultant and junior contracts, and the current financial context over a decade later are very different.

- 3.10 The Department's priority is to protect front line NHS services, with a particular focus on clinical staff, including doctors. There are 4,906 more consultants and 3,761 more juniors doctors than in 2010. The proportion of the total NHS paybill consumed by doctors stands at 22%. Employers have shown a commitment to recruiting doctors in proportionally greater numbers than other staff groups, and it is absolutely essential that employment contracts enable employers to get the best value from their investment.
- 3.11 The "NHS Five Year Forward View" outlines a vision for a more sustainable, more integrated health service that cares for people closer to home. The government's Autumn Statement announced £2 billion of additional funding for the frontline NHS in England in 2015-16. This is part of a multi-year £3.1 billion UK-wide investment in the future of the NHS.
- 3.12 This commitment must be set within the context that public sector pay restraint, which remains an important element of the Government's fiscal consolidation plans, will continue. In the Autumn Statement, the Chancellor made clear that:
- "The government will need to continue to reform, and take tough decisions on, public sector pay while it continues to reduce the current budget deficit until 2017-18."*
- 3.13 In order to sustain and increase funding for the NHS, whilst meeting commitments to reduce the budget deficit, the Government has had to make very difficult decisions; rejecting pay recommendations for employed staff in the NHS made by the Pay Review Bodies, and reducing the budgets of other Government departments.
- 3.14 Pay accounts for over 60% of total expenditure of an NHS trust, and in the face of the unprecedented financial challenge, increasing demand, and an ageing population, employers need the flexibility to make better use of their pay bill if they are to keep patients at the heart of their service delivery and deliver quality outcomes.
- 3.15 The use of resources in one area must necessarily be balanced by a reduction in other areas. Any consideration of seven day services must therefore consider the overall pay package including progression and performance pay. More information on the financial context is in Chapter 4.

Towards a consultant contract fit for a seven day NHS

- 3.16 The case for seven day NHS service provision to reduce mortality rates, speed up diagnosis and discharge times and reduce the amount of time that patients need to spend in hospitals is proven. Making this happen will require consistent quality NHS care every day of the week, led by trained doctors and with less reliance on doctors in training.
- 3.17 As discussed in Chapter 1, excellent clinical leadership is critical to the development of a seven day NHS and consultants will often be best placed to lead the required change. As the senior clinicians and professionals within NHS organisations they are well placed to lead this change from the front, and deserve a professional 'contract for engagement' that empowers them to drive these changes forward. Solutions will come from local areas, and the consultant contract also has a part to play in terms of providing employers with the

flexibility to develop and maintain appropriate solutions that improves productivity and focuses on the delivery of safe, high quality care.

- 3.18 Facilitating a sustainable seven day NHS service is not about encouraging doctors to work increasingly long or unsafe hours, which would put at risk the wellbeing of doctors and patients. We expect that a seven day consultant presence will inevitably mean that some consultants will work more often during the weekends, but not necessarily longer overall. The consultant workforce has expanded by 14% since 2010, and we expect that any future expansion would support this approach.
- 3.19 Despite the financial pressures on the system, consultant remuneration remains very attractive. However, it will quickly become increasingly challenging to expand the consultant workforce under the current contract's terms. These challenges include:
- the built-in cost pressures of incremental progression stretching into the future;
 - the high cost of clinical excellence awards; and
 - the contractual right for consultants to refuse non-emergency work at weekends and in the evenings (the 'opt-out' clause).
- 3.20 The opt-out clause in particular allows consultants to set their own terms for weekend work, or decline entirely, which places unacceptable pressure on their medical and non-medical colleagues working across the week. This archaic mechanism restricts a common sense approach to workforce organisation that should otherwise allow employers the flexibility to rota clinical teams in a financially sustainable way; and drives up costs through locally negotiated rates.
- 3.21 The National Audit Office (NAO) and the Public Accounts Committee (PAC) referred to this issue as part of observations and recommendations they made in reports published in 2013. The PAC concluded:
- “The contract does not facilitate the provision of around-the-clock care and trusts continue to pay too much to secure work above contracted levels. The contract allows consultants to refuse to work at evenings and weekend. As a result, hospitals struggle to provide the appropriate level of consultant-led care for patients. Rather than paying standard contract rates, this has contributed to some trusts paying up to £200 per hour for additional work which is often done at weekends. In order to improve services for patients, the Department must ensure that any future contract is flexible enough to allow seven day working and should set a maximum limit on payments for additional work.”*
- 3.22 These issues will become more acute in a seven day NHS, and we must ensure that the substantial investment the NHS makes in consultants can be used more productively and in a way that facilitates any future consultant expansion.

A fair approach to unsocial hours

- 3.23 The Department favours an approach to unsocial hours that recognises the role of consultants as leaders of both the delivery of care with the clinical team and of system change - and empowers them as such.
- 3.24 Patient safety should be at the centre of a seven day NHS, and it will be important that any approach to unsocial hours payments, including weekend working, assures employers and consultants that patients will be protected from unsafe working practices, and allows consultants to maintain an appropriate the work-life balance. For example, no consultant should be asked to work an extensive number of weekends nor be required to work more than their contracted hours (typically 40 hours) without their consent.
- 3.25 The IDS report referred to in Chapter 2 noted that for other groups of senior professionals – who often train for a similar amount of time to develop in depth expertise - it is very unusual for unsocial hours payments to be made at all, with compensation generally reflected in higher basic salaries and earnings packages. The Department's view is that other professional contracts across the economy tend to place a premium on flexibility that in turn empowers leaders to focus on outcomes. This avoids stringent and bureaucratic hours-based approaches to unsocial hours that can reduce motivation and create a culture of conflict between employers and staff; and places the emphasis on promoting a shared focus on quality.
- 3.26 The report also noted that for other groups of staff receiving unsocial hours payments, higher rates of pay are most often reserved for night working and for Sundays. The report suggests that these times are traditionally regarded as being more inconvenient times to work and consequently less attractive to employees.
- 3.27 The current consultant pay system provides attractive premiums to consultants for working evenings and weekends, and it might be considered that these provide an incentive to encourage seven day working. However, the reality is that the consultant 'opt out' drives up the cost of non-urgent evening and weekend work beyond those agreed national rates (as highlighted above, some trusts have reported additional costs of up to £200 an hour). We do not consider these arrangements to be sustainable within the current financial context. Given the very high basic salaries of the consultants, it is unlikely that NHS organisations could afford to move fully to effective seven day services under existing terms.
- 3.28 The consultant body is also slightly different from most other staff groups including other professional groups; and, unlike most other sectors, will be expected to support and lead a seven day NHS which will mean occasionally working during the weekend, evenings and nights as a core part of their job.
- 3.29 The contract needs also needs to recognise the varied nature of the consultant role. Intensity and the amount of unsocial hours differ significantly between individuals, depending on factors such as medical specialism, location and the unique circumstances of their trust.

- 3.30 For example, a typical emergency consultant is more likely to work during unsocial hours than a typical consultant who specialises in dermatology. Similarly, smaller hospitals with fewer consultants often require more flexible working patterns to ensure that there is consistent cover across the week. This reflects the unique nature of the consultant role and we expect this to continue in a seven day NHS.
- 3.31 It would be unfair for those in high intensity roles to receive the same payments as those in less intense (and often more socially amenable) roles. Such an approach would be likely to lead to poor recruitment and retention in key consultant posts.
- 3.32 The Department supports a move to an approach that better reflects the professional nature of the consultant role, but which also recognises the most unsocial working patterns by compensating consultants working in such roles through comparatively higher levels of intensity payments. This should incentivise recruitment into shortage specialties with typically more unsocial working patterns and shift demands.
- 3.33 An additional complexity, compared to other staff groups, is in that we expect on call arrangements to remain the predominant model of securing consultant presence, particularly at night. This will also need to be reflected in a revised contract.

Pay that is linked with performance and responsibility

- 3.34 All consultants and other employees should be recognised for their performance. However, the existing consultant contract with its 19-year near automatic incremental pay system does not achieve this basic aim.
- 3.35 Many newly qualified doctors are already excellent doctors, yet their progression is based not on the outcomes they achieve, but on how long they remain in the job, meaning that a poor performer can rely on length of service alone to increase their pay. This demotivating approach fails to incentivise good performance and does little to encourage productivity - ultimately leading to poor value for money from the contract.
- 3.36 Progression pay is unfair to those public sector employees who have seen their pay awards frozen, or restricted to one per cent, and unfair to the many private sector workers who have seen no or low pay growth through the financial crisis. This is why the government wants to end, across the entire public sector, long pay scales with automatic incremental progression.
- 3.37 The National Audit Office (NAO) and the Public Accounts Committee (PAC) reports referred to earlier have also made observations and recommendations on this point. The NAO recommended that "*The Department and trusts should ensure that consultants' financial rewards reflect performance*". Noting that "*Pay progression in most trusts is not linked to performance*", the NAO recommended that "Trusts should ensure that pay progression is linked to consultant performance"
- 3.38 The Government supports an approach based on a spot scale for experienced consultants combined with a development rate for newly qualified consultants. This would recognise that newly qualified consultants are often less experienced than their peers, while offering fast progression to the rate for the job for those who consistently achieve their objectives.

Those who take on additional responsibilities, for example for managing other consultants, would also have access to additional locally agreed payments.

- 3.39 Key to this approach will be a robust system of performance appraisal based on clear, measurable objectives. One success of the 2003 contract is that most consultants now have a job plan. However, these are rarely linked to an effective performance appraisal process.
- 3.40 The Government is keen to see this concept taken further as part of system of clear; peer moderated performance appraisal and objective setting system that is driven by job planning. This could in turn be linked to the wider local organisational objectives, so that the link between performance and organisational success is clear.

Locally driven performance pay for those who contribute the most

- 3.41 Well targeted performance pay is a useful tool for incentivising and motivating staff and for promoting efficiency.
- 3.42 The existing local clinical excellence award (CEA) process provides consolidated payments for consultants that are not generally linked to a performance management process. The Review Body has previously made observations and recommendations on this approach⁷ which, for example, highlighted how the consolidated nature of the awards means they quickly escalate in cost, making it difficult for trusts to make new awards. This in turn means that higher performers can go unrecognised, resulting in an inflexible model that makes it more difficult to appropriately incentivise staff.
- 3.43 The Department's preference is for a new locally driven approach to performance pay that is linked to current, not past, performance - and therefore can be tailored to local priorities. Run locally and peer moderated, the annual performance payment system could be clearly linked to an objective-setting process that recognises criteria for exemplary performance on an individual, team and organisational basis.
- 3.44 Payment would be non-consolidated and shared locally between consultants or teams of consultants who reach an agreed standard, rather than a set quota. This would allow the money available to be better targeted to the highest performers in a given year. We would like to see a proportion of performance pay linked to the achievement of organisational objectives, recognising the critical role that consultants play in the success of an organisation.
- 3.45 This approach would harness the talent of the workforce, by rewarding all those who reach a set standard through a credible, transparent approach. Linking pay to performance

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229710/DDRB_CEA_Cm_8518_3_.pdf

would promote local leadership and innovation while driving productively and getting the most out of the existing envelope for consultant pay.

Juniors

- 3.46 The current contract for doctors in training intended to drive compliance with the New Deal of 1990 that set out limits on junior doctors' hours of working and included set rest periods. The contract provided a mechanism for rewarding juniors for hours worked over a basic 40 per week. A system of banding payments, paid in addition to basic pay, was introduced; linked to hours, patterns of work and intensity of work, this system provided a strong financial incentive for trusts to secure compliance with the New Deal.
- 3.47 The European Working Time Directive (EWTD) has applied to the vast majority of employees since 1998, with a few exceptions including doctors in training. The NHS has been reducing doctors' working hours gradually with the final move from 56 hours in 2007 to 48 hours in August 2009.
- 3.48 Having achieved the aim of reducing juniors' hours, the contract is now getting in the way of high quality, flexible training.
- 3.49 Arrangements for pay banding supplements represent a costly, financial risk for employers, and create an adversarial relationship between employer and junior doctors. Most trusts have managed this financial risk by adopting fixed shifts, which are inflexible and impede training.
- 3.50 Pay banding supplements are also volatile making juniors' earnings unpredictable. In its 2007 report, the Review Body noted that, once juniors are working 48 hours a week or less, it would be necessary to shift the balance away from the banding multipliers towards base pay in order to ensure pay comparability. In its 2010 report, as an interim measure, the Review Body recommended that a banding multiplier be introduced for foundation house officer 1 posts that only attract basic pay, and that the multiplier should be set at 1.05 of basic salary.
- 3.51 NHS Employers' scoping study⁸ described the existing arrangements and problems, considered the views of various parties and recommended wholesale renegotiation of a new contract that is 'professional' rather than time based. The report, which makes an overwhelming case for change, has been shared with the Review Body previously.
- 3.52 For juniors, the intention is to move away from the current system of banding supplements, which was introduced to encourage trusts to move towards compliance with the working time requirements which are now a legal requirement. An unintended consequence of that system is that it has had a cultural impact on a generation of junior doctors and has

⁸ <http://www.nhsemployers.org/your-workforce/pay-and-reward/national-negotiations/contract-reform-for-doctors-in-training/scoping-study-reviewing-the-contract-for-junior-doctors-in-training>

affected the interactions and relationships between juniors and employers. The sharp delineations between banding payments can lead to disputes between employers and juniors and there can be significant changes in salary between posts which do not necessarily reflect changes in responsibility or (significant) additional hours. The system also means (and the data collection for the negotiations supported this) that employers tend to schedule juniors to work fewer hours than those for which they are contracted and paid, to avoid any overruns triggering a higher level of banding payment.

- 3.53 We see the effect of fourteen years' experience of this system reflected in the response of the BMA to proposals made by the management side including how to deal with unplanned variations in working patterns. There is a perception that contractual requirements are necessary to ensure that juniors do not work excessive hours. However, the Working Time Regulations place a legal requirement on employers (in respect of all staff) and this critical factor would not change if the contract changed. From this position – of NHS compliance with the working time legislation – there is a need to look at what should now replace the (punitive) terms which were designed to contribute to arriving at that position of compliance.
- 3.54 The management side proposal is that there would be a level of tolerance in work schedules (an acceptable degree of variation from planned hours), and that variation outside of this would prompt a work review which might lead to a prospective change in the work schedule and in pay.
- 3.55 The BMA view is that all unplanned hours should be paid for, with juniors able to self-report and claim payment. The BMA sees this as a necessary replacement for the system of banding payments and the protections against unsafe working patterns inherent in that system. However, this fails to acknowledge the safeguards provided by the fact that the Working Time Regulations now apply (since 2011) to all doctors in training in the same way that they have applied to other employees since 1998 and that the imperative for trusts is that non-compliance would be a breach of the law. It is in this context that the management side offered a package of proposals with pay more appropriately linked to work done and stronger safeguards on working hours.
- 3.56 We believe that the management side proposals fit with the commitment in the Heads of Terms agreed between NHS Employers for 'professionalism without exploitation'. We are aware that the Review Body noted, in its 2010 report, that "*in comparator professions, working unpaid for extended hours can be normal practice*", and that it is the case that, in other professions, senior staff in particular work additional hours without additional pay. Neither we nor employers are proposing that juniors should be expected to work unpaid. We do, however, think that there are grounds for differentiating the approach for professional staff – particularly senior professionals – from that of the 'clocking in and out' approach that applies to hourly paid workers in other sectors. We think that there should be a system of recognising and dealing with variations from scheduled hours (both for hours above and below that), and that the management side has presented a reasonable proposal.

General practice trainees

- 3.57 NHS Employers recommended in its scoping study, and the Government agreed, that new contractual arrangements should extend to GP specialty trainees (GPSTs) in the general practice setting as well as in hospital posts.
- 3.58 For historical reasons - relating to the transfer (negotiated with the BMA in 1999) of funding from the non-cash limited General Medical Services budget to what is now the Multi-Professional Education and Training levy - the mechanism for publishing the terms and conditions for GPSTs is outdated, unwieldy to maintain and provides no single, consolidated, easily accessible set of terms and conditions. Secretary of State Directions to (over time), health authorities, strategic health authorities and, now, Health Education England (HEE) authorise the payment of reimbursements to employers in line with terms set out in schedules to the Directions. New Directions are issued whenever changes are made to pay rates or other terms and conditions, with amendments to the Schedules. The Schedules to the Directions (which have not been consolidated since 2003) represent the national terms and conditions for GPSTs.
- 3.59 On 1 April 2015, HEE, currently a special health authority, becomes a non-Departmental public body and it will no longer be possible for the Department to issue Directions to HEE. In terms of reimbursing payments, this is not an issue: the power for HEE to do this is in its establishing legislation, and HEE will continue to reimburse in accordance with nationally determined rates. However, there will no longer be the option of using Directions as the vehicle for publishing changes to terms and conditions for GPSTs in the practice setting. This change reinforces the need for new contractual arrangements, bringing GPSTs, at all stages of their training, under a single set of terms and conditions with other doctors in training.

Dental Foundation Trainees

- 3.60 We would also welcome views on the salary level for dental foundation trainees. This is currently out of line with the salary level for medical foundation trainees at the equivalent stage of training (and beyond). The current basic salary for a dental foundation trainee is £30,432, higher than that for a foundation year 2 (FY2) doctor at the same career level (£28,076). It is also higher than the starting salary for specialty registrar (£30,002), meaning that pay protection applies for dentists moving from foundation training into specialty training.
- 3.61 This did not form part of negotiations with the BMA (who were representing the BDA also), but we believe it is an issue that should be considered, taking account also of proposed changes to medical foundation salaries and salaries for doctors and dentists in specialty training. We would therefore welcome DDRB's views on this in the context of its recommendations on new contractual arrangements and salary levels for doctors and dentists in training.

Chapter 4: Funding Growth⁹

4.1 This chapter sets out the financial position for the NHS in 2015/16.

4.2 Between 1999/00 and 2010/11 NHS revenue expenditure increased by an average of 5.4 per cent in real terms. The first three years of the current spending review period (2011/12 to 2013/14) have shown subdued growth, averaging 1.2 per cent per year in real terms. Table 4.1 shows:

- Outturn NHS revenue expenditure figures from 1999/00 to 2013/14;
- Revenue Departmental Expenditure Limits (RDEL)

Table 4.1 – NHS Revenue Expenditure: England - 1999/00 to 2015/16

Year ⁽⁴⁾		Revenue ⁽⁵⁾ Net NHS Expenditure ⁽⁶⁾ £bn	% increase	% real terms increase ⁽⁷⁾
RB Stage 1⁽¹⁾				
1999/00	Outturn	39.3	-	-
2000/01	Outturn	42.7	8.6	6.2
2001/02	Outturn	47.3	10.8	9.1
2002/03	Outturn	51.9	9.8	7.0
RB Stage 2⁽²⁾				
2002/03	Outturn	56.9	-	-
2003/04	Outturn	61.9	8.7	6.6
2004/05	Outturn	66.9	8.1	4.8
2005/06	Outturn	74.2	10.9	7.9
2006/07	Outturn	78.5	5.8	3.0
2007/08	Outturn	86.4	10.1	7.0
2008/09	Outturn	90.7	5.0	2.5
2009/10	Outturn	97.8	7.8	5.1
2010/11	Outturn	102.0	4.3	1.5

⁹ This evidence has been updated to reflect the Autumn Statement, announced on 3/12/14 and latest financial figures. It therefore differs from evidence provided by DH to the Review Body for Doctors' & Dentists' Remuneration on contractors in September 2014.

<u>Resource Budgeting - Aligned</u> ⁽³⁾				
2009/10	Outturn	94.4	-	-
2010/11	Outturn	97.5	3.2	0.4
2011/12	Outturn	100.3	2.9	1.1
2012/13	Outturn	102.6	2.3	0.6
2013/14	Outturn	106.5	3.8	1.9
2014/15	Plan	110.4	3.7	1.5
2015/16	Plan	113.0	2.4	1.0

1. Expenditure figures from 1999-00 to 2002-03 are on a Stage 1 resource budgeting
2. Expenditure figures from 2003-04 to 2009-10 are on a Stage 2 resource budgeting basis.
3. Expenditure figures from 2009-10 to 2015-16 are on an aligned basis following the government's Clear Line of Sight programme.
4. Expenditure figures are not consistent over the period (1999-00 to 2015-16) and this should be noted when making comparisons between years.
5. Revenue is quoted gross of non-trust Depreciation and Impairments; prior to September 2007, revenue was quoted net of non-trust Depreciation and Impairments. This brings DH in line with HMT presentation of the statistics.
6. Expenditure excludes NHS (AME)
7. Real terms increase has been calculated using GDP as at 03/12/2014

Share of resource going to pay

- 4.3 Table 4.2 shows the proportion of the increased funding that has been consumed by the Hospital and Community Health Services (HCHS) paybill over time. Note that the HCHS workforce comprises staff working within hospital and community health settings; it therefore excludes General Practitioners, GP practice staff and General Dental Practitioners.

Table 4.2 – Increases in Revenue Expenditure and the proportion consumed by Paybill

Year	Increase in Revenue Expenditure	Increase in HCHS Provider paybill	Proportion of revenue increase on paybill	Increase in HCHS paybill due to prices		Increase in HCHS paybill due to volume	
	(£bn)	(£bn)	(%)	(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	7.0	1.4	4.7	1.0
2002/03	4.6	2.4	51	5.0	1.1	5.5	1.3
2003/04	6.5	2.6	41	5.0	1.3	5.4	1.4

2004/05	5.0	4.5	91	5.0	2.3	5.0	2.3
2005/06	7.3	2.5	34	5.4	1.5	3.4	1.0
2006/07	4.3	1.3	30	4.3	1.4	-0.3	-0.1
2007/08	7.9	1.3	16	3.5	1.2	0.2	0.1
2008/09	4.4	2.5	57	3.0	1.1	4.0	1.4
2009/10	7.1	2.8	39	1.8	0.7	5.1	2.1
2010/11	3.0	1.5	49	2.4	1.0	1.2	0.5
2011/12	2.8	-0.5	-18	0.9	1.5	-1.2	-2.0
2012/13	2.3	0.6	26	1.5	0.4	0.1	0.2
2013/14	3.9	0.5	13	2.3	0.3	1.3	0.2
Average	4.9	1.9	37	3.6	1.2	2.6	0.7

1. Revised 2010/11 to 2012/13, following accounts restatements and exclude inter-company eliminations
2. Excludes ALB and DH core staff expenditure
3. Excludes GPs
4. Volume & Price estimates changes methodology in 2010/11 to make use of a more detailed staff group breakdown from ESR
5. Figures may not sum due to rounding.

4.4 HCCHS pay is the largest cost pressure, on average, between 2001/02 and 2013/14; increases to the HCCHS paybill have consumed 37 per cent of the increases in revenue expenditure. Of this 37 percentage points, pay effects have consumed around 23 percentage points and volume affects around 14 percentage points. As pay represents such a large proportion of NHS resources, managing the paybill is key to ensuring the NHS lives within the funding growth it has been assigned in the next year.

Pressures on NHS funding growth

- 4.5 Different priorities compete for limited funding growth given to the NHS. They are grouped into three categories:
 - baseline pressures
 - underlying demand
 - service developments.
- 4.6 Baseline pressures cover the cost of meeting existing commitments that are essential for delivery of NHS services. They do not cover underlying demand, or increased levels of activity, which may arise due to demographic pressures or medical advance. Service developments are new areas of activity which arise due to new policies or ministerial commitments.

- 4.7 HCCHS paybill pressures are the largest component of the baseline pressures and usually form the first call on NHS resources. Managing baseline pressures effectively allows the NHS to treat a growing, ageing population whilst making best use of the funding available.

Allocation of resources

- 4.8 Table 4.3 shows how funding increases have been allocated across baseline pressures, demand and service developments in previous Spending Review periods.

Table 4.3 – Disposition of Revenue Increase across Expenditure Components

	Outturn			Plan	
	SR2004 £bn	CSR2007 £bn	First 3 years of SR10 £bn	2014/15 £bn	2015/16 £bn
Activity Growth	2.9	1.1	1.2	1.0	1.8
Service Development	1.6	1.7	0.4	0.9	0.0
HCHS Pay (Price only Component)	1.7	2.0	0.5	0.3	0.4
Secondary Care Drugs	0.3	0.4	0.3	0.4	0.3
Other (including central budgets)	0.3	0.1	0.1	1.1	-0.6
Primary Care Drugs	0.3	0.3	-0.1	0.2	0.2
General Dentistry, Ophthalmic and Pharmaceutical Services	0.2	0.2	0.1	0.1	0.1
Procurement	0.1	0.1	0.7	0.4	0.1
General Medical Services	0.1	0.2	0.0	0.0	0.2
Funding for Social Care			0.4	0.2	1.1
Productivity	-0.3	-0.3	-0.6	-0.6	-0.6
Average annual increase in revenue	7.2	5.7	3.9	3.9	3.4

Note:

SR2004 and CSR2007 activity growth numbers exclude purchases of healthcare from non NHS bodies, whereas they are included in the SR10 figures.

- 4.9 2013-14 saw a significant reduction in paybill per FTE drift, despite gross pressures from increments worth approaching 2% of the paybill. However, such low levels of drift are unlikely to be permanent. Apparent levels of drift were significantly affected by the

temporary costs of managerial exit packages, associated with the NHS reform, in 2012/13 making 2013/14 earnings seem low in comparison. Furthermore, 2013/14 saw a significant increase in the HCHS workforce – likely in response to the Francis Report and addressing unsafe staffing risks. The increase in workforce growth was particularly strong for non-medics which neutralised the contribution of medical workforce expansion to higher drift compared to recent years. As recruitment tends to be towards the lower end of the pay scales this also had a depressing impact on average experience and hence pay levels which translated into lower drift. Future recruitment patterns are critical to expectations for drift and depend on decisions by individual employers influenced by expectations for affordability constraints and how these are managed. Despite recent increases to NHS budgets, there will still be pressure on resources and limits to affordable recruitment levels. As such, the expectation is that pay drift will increase from its 2013/14 level. However, it is not clear that it will immediately fully return to its earlier levels, but note that it will be increased by around 0.2 percentage points due to changes in the NHS pension scheme employer contribution rate in 2015/16.

- 4.10 The difficulty of allocating resources is therefore more acute than it has been in the previous 10 years. As shown in table 4.3, of the £3.4bn increased revenue resources available, demand pressures consume £1.8bn, even after an assumption that demand growth will be lower than in recent years due to the Better Care Fund. With the cost pressures being absorbed by improved productivity, £0.4bn additional revenue resource is assumed to be available for pay.

Agency Spend

- 4.11 In 2013-14 NHS Trusts spent approx. £1.2bn on agency staff, and NHS Foundation Trusts spent approx. £1.4bn on agency staff¹⁰. There is concern that locally budgets are so limited due to large agency expense that this poses a barrier to employing more permanent staff.
- 4.12 The Department would like to see local organisations examine their agency spend and determine the reasons for such high spend locally:
- Is this a procurement issue, and could better agency rates be negotiated?
 - Are employers using regional and national frameworks to manage agency costs and ensure quality?
 - Is there a human resourcing issue which is preventing availability of permanent or bank staff? Is this due to lack of staff locally, inefficiency of recruitment exercises, resistance to appoint to permanent posts, or availability of bank staff for example?
- 4.13 Reducing agency spend is a focus for:
- The ongoing DH Strategic Workforce Review
 - Planning in respect of the forthcoming Spending Review round

¹⁰ <https://www.gov.uk/government/publications/department-of-health-annual-report-and-accounts-2013-to-2014>

- 4.14 Data from the London Procurement Partnership (LPP)¹¹ shows that approximately 40% of all of their region's nursing agency staff shifts fall during "unsocial hours" (nights, weekends, and bank holidays), showing that – at least within London – the demand for agency staff is high during unsocial hours. Similar data from across the nation would help inform the drivers for the high agency spend seen in the NHS, and better understand whether there is a link between seven day services and agency costs.
- 4.15 Additionally, in May 2014 a national collaborative framework was introduced which reduced enhancements to nursing agency rates for nights, weekends and bank holidays for the London region. The LPP report that the removal of these enhanced rates appears to have had no impact on the willingness and availability of agency staff to work at these times. We would strongly recommend that national frameworks are used when commissioning agency staff, to help keep costs down, ensure quality, and make services more affordable.
- 4.16 Introducing additional services at weekends could increase agency spend to fill the gap if permanent staff are unwilling or unable to change their working patterns to cover new weekend shifts. There is therefore a crucial requirement for robust staff engagement plans, and less reliance on agency staff through better procurement and human resources process, and more efficient use of local bank staff.

Financial Balance

- 4.17 Even after the extra funds announced in Autumn Statement 2014 the challenge for the service to deliver quality care to an ageing and growing population with limited resources is very hard. Therefore, achieving financial balance in 2015-16 is reliant upon the Better Care Fund diverting activity from the acute sector, high levels of labour productivity, and a continued bearing down on prices for procurement, drugs, and pay.

Conclusion

- 4.18 The NHS has received a better SR settlement than almost all other parts of the public sector, including a commitment to real terms increases in health spending in 2014-15 and 2015-16. However this still represents the biggest financial challenge in the history of the NHS.
- 4.19 The NHS is delivering on this challenge and has so far met its savings targets in 2011/12, 2012/13, and 2013/14. There is still work to do in shifting the focus from centrally driven savings to transformational changes which will reduce the long term cost pressures on NHS services. Any move to deliver seven day services must be cost neutral.

¹¹ Published data link unavailable, but LPP happy to share data on request.

Chapter 5: Discussions and negotiations between NHS Employers and the British Medical Association

- 5.1 In December 2012, responding to reports from the Review Body and NHS Employers, the Government announced its intention to seek reform of the contracts for consultants and doctors and dentists in training. The ambition was for a Heads of Agreement by spring 2013 with implementation of changes to both contracts beginning in April 2014.
- 5.2 NHS Employers and the BMA produced draft Heads of Terms for juniors¹² on 20 June 2013 and for consultants¹³ on 31 July 2013. These were submitted to Government and the BMA sought the views of its members. The BMA confirmed that it was prepared to enter into negotiations on the basis of these Heads of Terms – confirmation was on 22 July 2013 for juniors and 18 September 2013 for consultants.
- 5.3 In October 2013, the Government asked NHS Employers to begin negotiations on those terms. For doctors and dentists in training, the negotiations were UK-wide; for consultants, they involved England and Northern Ireland. The Government stated that proposals should be underpinned by robust modelling demonstrating that any new contractual arrangements would be cost neutral. The exception to this was that Ministers in each of the four countries were content to agree that funding for the employer contribution pressure (i.e. the *additional* contribution) arising from moving a proportion of juniors' earnings out of banding supplements and into basic pay would be met from outside the juniors' pay bill.
- 5.4 The parties were asked to reach agreements on reformed contractual arrangements by October 2014 with an interim report to Ministers in February 2014.
- 5.5 The Government requirements were set out clearly at the outset of negotiations. These, and the employer requirements, were articulated throughout by the management side and in meetings between the negotiating teams and the lead minister in the Department of Health.
- 5.6 For **consultants** the Government was seeking:

On facilitating the introduction of seven-day services, to:

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<http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/HoT%20final%20draft%20with%20explanatory%20notes.pdf>

13

http://www.nhsemployers.org/~media/Employers/Documents/SiteCollectionDocuments/HoT_final_for_website_ap290713.pdf

- introduce contractual changes to facilitate seven-day services in the interests of patients, including the removal of Schedule 3, Paragraph 6 of the 2003 contract (the right to opt-out of non-emergency evening and weekend work in premium time);
- create work patterns consistent with meeting patients' needs and the delivery of high quality services.; and
- Agree a fair approach to unsocial hours that would extend plain time (in-hours) working period to support seven day services.

On pay progression, to:

- review the current pay progression arrangements and explore potential new mechanisms for rewarding and recognising consultants' contributions with the aim of ending incremental progression based on time served, with a move towards progression based on the weight and rate of the job role;
- review the top and bottom of the current pay scale to determine if they are at an appropriate point to recruit, retain and motivate consultants according to their overall contribution while being affordable in the long term, with the aim of introducing a lower starting salary for new appointments (no higher than £70k), generating savings to be invested in the continued affordability of the expanding consultant workforce;
- link progression to higher levels of responsibility and competence;
- introduce a stratified career path based on job weights with spot rates and with progression contingent on performance;
- link reward to performance, including withholding annual pay rises for unsatisfactory performers;
- introduce annual, non-consolidated local performance awards for the best performers
- agree thresholds for pay progression developed through objectively measured job-based criteria; and
- agree structures to enable accelerated progression for those consultants who make the greatest contribution.

On Clinical Excellence Awards, to:

- reform local and national CEA schemes, so they reward current and not past excellence, are non-consolidated and more affordable (with local CEAs being generally annual payments);
- incorporate the local CEA scheme into the consultant contract; and
- introduce separate arrangements for national and local CEA schemes.

5.7 The Government set out that, in return for the above, it would be offering:

- continuation of a negotiated contract;
- a clear pay structure with earned progression for today's and tomorrow's juniors from leaving medical school to the top of the profession for the best;
- faster progression for the best doctors doing the heavier loaded roles;
- access to excellence awards with local awards being contractual; and
- a managed transition with protection of the pensionability of existing CEAs rather than ending pensionability going forward.

5.8 For **doctors and dentists in training**, the Government was seeking:

On contract issues:

- new arrangements that better support quality training and service, rather than hindering;
- an end to the monitoring of hours; and
- to address the current dissonance between New Deal and European Working Time Directive (EWTD).

On seven-day services:

- contractual changes to facilitate seven-day services in the interests of quality patient outcomes;
- the creation of work patterns consistent with meeting patients' needs and the delivery of high quality services; and
- the extension of the plain time (in-hours) working period in support of seven day services.

On pay and progression, to:

- replace the current system of monitored hours and banding payments with a higher basic salary (as recommended by the review Body), with an end to banding supplements, ensuring a more predictable pay bill for employers;
- end time-served progression, linking pay to a rate for the job;
- introduce clear rules for pay progression, linked to progressing through stages of training (and levels of responsibility and competence), with shorter pay ranges or spot rates at each stage;
- link reward to performance, including withholding annual pay rises for unsatisfactory performers;
- introduce a stratified career path based on job weights with spot rates and with progression contingent on performance; and
- align the pay arrangements for hospital and general practice trainees.

5.9 The Government set out that, in return for the above, it would be offering:

- continuation of a UK wide negotiated contract;
- better facilitated training for junior doctors;
- work schedules that include service provision, training, periods of formal and organised study (other than study leave), rest breaks and prospective cover where applicable;
- fair rewards for work done; and
- more predictable earnings for doctors in training.

Chapter 6: The BMA's withdrawal from negotiations

- 6.1 The parties to both negotiations submitted joint reports to Ministers in February 2014 (Annex C). For consultants, the report reflected a shared *“will to reach agreement on a fair and sustainable agreement which will allow both parties to deliver long term benefits for patients”*. The juniors report reflected that both sides had *“taken a positive and constructive approach to the discussions”*. In meetings with Dr Dan Poulter, Parliamentary under Secretary of State for Health, in February and July, the parties said that, although much work remained to be done, they were aiming to arrive at Heads of Agreements by the end of October 2014.
- 6.2 NHS Employers (for England) and representatives of the health departments and employers in the devolved administrations had been involved in negotiations in good faith for a year when, at a very late stage, and with no advance notification to any of the parties involved, the BMA announced via social media (Twitter), on the evening of 16 October 2014: *“junior contract and consultant contract negotiations end as Government’s unreasonable demands jeopardise patient safety”*.
- 6.3 At the same time, the co-chairs of the BMA’s juniors negotiating team emailed two members of the management side team – the chair (an employer representative) and a member of the secretariat (NHS Employers’ acting Director) – stating that *“NHSE’s requirements for a new doctor in training contract... would compromise patient safety and doctors’ well-being. We cannot continue these negotiations unless NHSE, and the Department of Health, reconsider and return with new proposals.”*
- 6.4 No notification was sent to the management side for the negotiations on consultants who, less than two hours earlier, had been in a negotiating meeting with the BMA which had concluded with an agreement that further work would be done on safeguards on hours and working, to be discussed at a subsequent meeting.
- 6.5 The announcement on Twitter that negotiations had ended was swiftly followed by a BMA press release stating that both negotiations had *“stalled after the Government refused to agree necessary safeguards to protect doctors from working dangerously long hours, compromising patient safety and doctors’ wellbeing”* (See annex). The BMA also immediately issued materials, including an infographic on juniors’ hours, explaining why the negotiations had stalled. Comments on social media, by the BMA negotiators, implied that additional Government demands had been made at a late stage of negotiations.

- 6.6 An hour after the Twitter announcement NHS Employers issued a statement to the Health Service Journal followed by a response¹⁴ the next morning setting out the deal that had been on offer and commenting on the areas where agreement had yet to be reached. This responded to the accusations that the BMA had made publicly, about patient and doctor safety. NHS Employers also made clear that they had been mandated by Government to conduct the negotiations and the proposals that had been made represented the position and requirements of employers, who wanted sustainable and adaptable contracts.
- 6.7 It remains unclear to the Government why the BMA took this decision, particularly in the way and at the time that it did. No notification was, or has been, sent by the BMA to any of the Health Departments at any stage. We understand that, in the following days, the BMA suggested to that it would be prepared to come back to the negotiating tables on certain conditions.
- 6.8 On 23 October, the management side chair for the negotiations on the juniors' contract wrote to inform Ministers that, as a result of the breach of trust and the demands laid down by the BMA, there was no prospect of reaching agreement.
- 6.9 On 28 October, the chairs of both the management sides informed Ministers of their views that:
- the actions of the BMA represented a serious breach of trust;
 - the accusations made were an attack on the professional integrity of the management side negotiators which included clinicians; and
 - there was no prospect, given the demands of the BMA, of reaching acceptable agreements.
- 6.10 As had been signalled in the letter from the Chief Secretary to the DDRB on 31 July 2014 (Annex D), the government issued a remit to DDRB on 30 October 2014, seeking:
- observations 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; and
 - recommendations on new contractual arrangements for doctors and dentists in training.

¹⁴ <http://www.nhsemployers.org/media-centre/2014/10/nhs-employers-disappointed-by-bma-abandonment-of-contract-talks>

Chapter 7: Government views on proposals and areas of disagreement

- 7.1 In this chapter, we set out our understanding of the management side offer that was on the table at the time the BMA ended the negotiations. We also comment on what we understand to be the areas on which the parties disagreed or had yet to reach agreement, giving the Government view on each of these.
- 7.2 NHS Employers' evidence will set out detailed proposals for new contractual arrangements, including details of the data collection and the modelling and costs of proposals.

Consultants

- 7.3 As observers, Department of Health officials were surprised and disappointed by the BMA's sudden, unilateral withdrawal from the consultant negotiations. A significant amount of work was developed on a cost neutral package of proposals that included input from all parties and which will be set out further in NHS Employers evidence. Although there remained a number of areas where full agreement had yet to be reached, an eventual agreement appeared within sight and the parties were in the process of a developing a 'heads of agreement' to set out key areas of agreement and areas for further discussion.
- 7.4 As a brief overview, the management offer had included:
- a commitment to maintain a negotiated national framework and the BMA's role in collective bargaining;
 - a maximum 40-hour contract, unless extended by mutual agreement. No requirement for the majority of consultants to be contracted for more hours than they are currently contracted;
 - accelerated access to higher pay - consultants will be able to access higher levels of pay earlier in their career than is possible under the current pay scales, as long as they meet the performance standards in job plans and annual performance assessment;
 - a fairer way to reward consultants who work frequent and intense shift patterns;
 - continued access to a national clinical excellence award (CEA) scheme, by competitive application;
 - transitional arrangements that provide protection to existing pensionable pay;
 - local clinical excellence awards to be incorporated into the consultants' contract as part of a revised performance payments structure. As a contractual entitlement all consultants will be considered for a pay award against jointly agreed access criteria;
 - jointly agreed safeguards (set out in the contract and supported by jointly agreed guidance), to ensure consultants are provided appropriate protections where service changes are necessary to deliver seven-day services;
 - a commitment to move towards greater consultant-led services which will require a growth in the consultant workforce;

- greater emphasis on clinical engagement when determining service delivery priorities with a duty to consult being placed on employers;
 - a strengthened the job planning and performance assessment process to be put at the heart of the process for determining the appropriate clinical activity to support local service delivery;
 - limitations to the number of weekends that consultants will need to be available for work, without mutual agreement;
 - maintaining an environment where education, training, innovation and research by both NHS and academics can flourish;
 - no changes (as part of *these* contractual changes) to any of the core contractual entitlements – redundancy, maternity, sick pay, leave entitlements, requests for flexible working etc.
- 7.5 Employers wished to see a contract that recognised the professionalism of consultants and as far as possible did not treat them like hourly paid workers - instead it would support the engagement of these senior clinical leaders in the objectives of their organisations.
- 7.6 During the course of these negotiations, employers responded creatively and constructively to concerns from the BMA. In particular, they agreed not to pursue an approach for progression within the main consultant pay scale to be by appointment rather than by attainment. Employers also offered to invest savings from a proposed lower starting salary for newly appointed consultants in increasing the per Full Time Equivalent (FTE) funding available for funding out of hours payments. Previously, employers had looked for this to support consultant expansion. Other elements included:
- jointly agreed safeguards designed to provide assurance to consultants and employers that patients would be protected from unsafe work practices;
 - a contractual entitlement to performance pay for exceptional performers that would replace local clinical excellence awards, and would be driven by a peer reviewed performance appraisal process with the amount of pay per FTE available being guaranteed;
 - a shorter pay progression scale with accelerated access to higher pay so that consultants would reach a level of core pay in five years close to that currently reached in 14 years; and
 - transitional arrangements offering pay protection to those above the proposed new pay levels for newly appointed and experienced consultants
- 7.7 The main area of work that remained to be done was how unsocial hours would be rewarded. Discussions were characterised by the BMA wishing to maintain hourly payments for time worked outside of current plain time, and employers wishing to use an approach based on allowances that reflected the differential requirements placed on consultants by their job plans (but avoiding incentivising a time counting culture).

The BMA's withdrawal from negotiations

- 7.8 The BMA provided information – frequently asked questions (FAQs) - for its members on why it withdrew from negotiations. A key passage from these states:
- “one of the most fundamental problems has been the lack of funding from the Government; they have determined that the process must be cost neutral and that costs associated with their aims such as the introduction of seven day services and the development of a new pay scale, must be met from within the current funding envelope. Practically, this means that NHS Employers have little to offer in return for what they want”.*
- 7.9 It appears that the BMA were uncomfortable with the per full time equivalent (FTE) cost of employing a consultant not increasing as a result of changing working patterns, even though they acknowledged these would benefit patients.
- 7.10 It is clear that the ‘opt out’ in the current contract has led to much of the work at weekends being paid for by trusts at locally agreed (higher) rates. This is because they cannot schedule programmed activities at the weekends and evenings without the agreement of consultants. Moving to an approach where working out of hours was at agreed rates would allow trusts to get much better value from their investment in consultants. This issue has nothing to do with patient safety, the BMA’s ostensible reason for withdrawing from negotiations.
- 7.11 There was a clear recognition by the management side negotiators that those consultants, particularly in acute specialties, who work the most challenging hours (and particularly at night) should have this reflected in their remuneration. An approach was offered by the management side whereby those consultants with the most demanding work patterns would receive payments of around £18,000 in recognition of this.
- 7.12 The BMA’s approach was to seek to negotiate higher hourly rates for working out of hours on the current definition. Employers felt that this would encourage an hours counting culture rather than a professional culture and would also make cost control very difficult. Employers noted that premium payments are rarely made in highly paid professional staff groups. This is because core pay is expected to provide compensation. However, given differences in the demands that different groups of consultants face, it is appropriate for the contract to reward them differentially.
- 7.13 Employers had also offered substantial safeguards to the BMA. A contractual guarantee was offered that consultants would only be required to work up to 13 weekends a year and would not be required to work more than 40 hours except by agreement. In addition, employers would not programme more than 40 hours work from a consultant without their agreement, and embedding the responsibility of consultants not to work the next day when their performance might be impaired through tiredness.
- 7.14 During the negotiations, the BMA appeared to conflate concerns about tiredness (that would general only effect a minority of consultants) with working during the daytime at weekends. This was despite the discussions being held in the context of the contractual

assurance that consultants would not be required to work more than 40 hours except by agreement.

- 7.15 A key patient safety concern for the negotiations was to ensure that any future consultant expansion remains affordable and that there are not barriers to consultants working when they are needed. There has been a substantial investment by the NHS in employing more consultants (an increase of 14% more since 2010). It is unrealistic for the BMA to expect that in addition to that substantial and continuing investment, employers would agree to increase the per FTE pay of consultants to get their agreement to removing the opt out; a contractual term that does not exist in any other NHS pay contract.
- 7.16 Given the financial position in the NHS, paying more to gain agreement to working hours shared by other NHS staff would have been poor value for money and would set a negative message to other less well paid staff groups. We do not see a case for increasing the per FTE cost of consultants to get agreement for consultants working when the NHS needs them.
- 7.17 In summary, our position is this:
- Although the end state for a seven day NHS service is not yet entirely clear, this should not prevent us from removing what are quite clear contractual barriers to change.
 - Pay should incentivise staff engagement and an amended contract needs to be a contract to support the engagement of consultants in delivering the objectives of their organisation.
 - Consultants are leaders and their contract should therefore be a professional contract reflecting this and moving away from an hours counting culture;
 - Consultants (like other staff) should be available when they are needed and there should be no contractual barriers to that - but the pay system should reflect that different groups of consultants will have different demands placed on them in relation to the unsociability of their hours.
 - Fundamental to an effective pay system is strong transparent job planning and performance review process. This enables employers to identify those consultants who make the greatest contribution and reward them accordingly;
 - Experienced consultants who have demonstrated their capability through job planning and performance review should receive the same basic pay for the job. Newly appointed consultants should receive a development pay rate until they have demonstrated that their skills and experience justify them moving to the rate for the job. Further pay progression for experienced consultants, for instance those taking on leadership roles, should be a matter for individual employers
 - Performance pay should be integrated into the pay system and reward those who make the greatest contribution as individuals or in teams as measured through performance review. In that context, it is appropriate to make it contractual

- The current level of investment in consultant pay per FTE, combined with the flexibility offered in negotiation by employers should have been sufficient to agree changes with the BMA; particularly given the importance, recognised by both sides of enabling any future consultant expansion;
- The inability of the BMA to accept change without increasing pay above the counterfactual is a missed opportunity and means that the government will have to reconsider the basis for making changes to the consultant contract, with the aid of the DDRB's observations.

Juniors

7.18 The management side set out that its offer had included:

A new pay framework (replacing the current system of bandings)

- An hours-based model of pay, with pay relating to work done.
- Progression through pay points to be linked to accepting a post at a particular level of responsibility.
- A basic full-time working week of 40 hours.
- An extension of plain-time working, with a higher rate for unsocial hours - the degree of extension and the rate for unsocial hours had not been decided and was still under discussion.
- An allowance for on-call availability.
- Increased basic pay.
- Pay protection during transition
- Potential to increase pay via work schedule review where there is a regular requirement for additional hours

Safe working hours

- Maximum shift length of 13 hours.
- Maximum of 72 hours in any seven consecutive days (lower than the limit of 78 suggested by the BMA).
- No more than four consecutive night shifts of up to 13 hours.
- No more than five consecutive long day shifts of 10+ hours.
- Maximum hours of 48 per week on average, and a cap of 56 hours per week on average for doctors who opt out of WTR.
- Reference period for pay purposes based on rota cycle or placement length.
- Contractual rest breaks in line with other NHS staff.

Work schedules, reviews and exception reporting (replacing the current system of monitoring)

- A 'template' work schedule for each post, mapped to the curriculum and setting out both training opportunities and service commitments. This would be personalised to the job holder taking account of individual training experience, competencies and needs and reviewed regularly and also on request.
- System for reporting exceptions (e.g. work overruns) which would trigger a work schedule review.

- System for resolving issues relating to the work schedule, including an appeals process.

Leave

- Removal of the four month eligibility criteria for sick pay, to bring in line with other NHS staff.

Expenses

- Business travel expenses that reflect the current Agenda for Change provisions, which would be more beneficial for most juniors.

Information for trainees

- A joint commitment to press for better information for trainees ahead of their placements.

Areas on which the parties disagreed or had yet to reach agreement

Costs

- 7.19 The Heads of Terms stated that the envelope for a new contract would be cost-neutral. Government observers to the negotiations confirmed that this meant that the cost of new arrangements should be no more than the costs that would have been incurred without a new contract, for a period of transition (length to be determined, relating to pay protection on transition).
- 7.20 There was a commitment at the time that the mandate for negotiations was issued that increased employer pension contributions arising from moving a greater proportion of earnings into basic pay would be outside the envelope (not met from within the juniors' pay bill).
- 7.21 The BMA negotiators sought:
- *Agreement that the baseline would be 2012/13 pay bill, as in the Heads of Terms.* At the meeting on 9 October 2014, NHS Employers noted that the 2012/13 paybill had been the latest data available when the Heads of Terms were agreed, but that using it would not reflect the 1% increase in pay implemented in 2013/14; the BMA wanted to consider this further. Our view is that the baseline for any counterfactual of what would have happened without change should normally be the year immediately preceding that change. That is the basis on which the National Audit Office has assessed the costs of new contractual arrangements previously.
 - *A commitment that any cost savings arising from the introduction of new arrangements would be retained in the pay envelope for doctors in training.* The management side was unable, and would have been irresponsible, to offer any agreement suggesting that it could commit this or any future government in that way. This Government has already made clear, in responding to the Review Body's recommendations for 2013/14, that the NHS cannot afford a pay increase as well as the cost of increments,

and had asked all the trades unions to consider changes that would have made consolidated pay awards affordable.

- *Confirmation that 'separate funding' will be provided to cover the cost of the additional employer contributions.* The management side explained that there might not necessarily be explicitly identified funding. They reiterated the commitment that this cost would not come out of the envelope (and therefore juniors' pockets). This cost could present a pressure on employers, unless we identify savings elsewhere, possibly, but not necessarily, within the NHS pay bill.

The new pay framework and pay rates

Progression through a new pay scale

- 7.22 In June 2013, the Chancellor announced that Government reforms to public sector pay included the ending of progression pay – automatic pay rises simply for time-served. The Heads of Terms stated that the parties would agree rules, consistent with government policy, within the new contract for pay progression.
- 7.23 Early in negotiations, the management side presented proposals for pay progression. The proposals were informed by the facts that: juniors are employed both to provide service and to acquire learning (and the two are interdependent, as reflected in the Heads of Terms); and as they progress through training, juniors will take on further levels of responsibility for the provision of service. The proposals included spot rates at each stage of training, linking increases in pay to significant and measurable increases in responsibility (which do not necessarily occur at each 'year' of training). The management side presented the proposals for discussion, acknowledging that consideration would be needed of how to treat those who took time away from the path through hospital training *to undertake activity that was a requirement of their training.*
- 7.24 These proposals were rejected by the BMA, on the basis that they would discriminate, unfairly, against those who take time out of training or train part-time. The management side view was that the proposed new arrangements would be less advantageous *than the current contract* which provides for time-served increments during time out (and which could be argued both to disadvantage full-timers who do not take any time out and to reward 'time not served'). However, their view was that the new contract, of itself and with provision for those taking time out for activities required as part of their training, would stand up to a challenge of discrimination.
- 7.25 The BMA negotiators said that annual progression was important to their members. They proposed a model in which progression would be dependent on meeting certain 'contingents'. They also wanted those taking time out of training (including on maternity leave) to be able to progress during those periods.
- 7.26 The management side view was that the proposed contingents were things that either juniors were already required to do, e.g. as part of maintaining registration or training status, or that the employer did not require, such as volunteering. The management side

questioned how the contingents could be satisfied by those taking a break from training and also considered that the proposal failed to meet the Government redline for ending time-served progression. We agree with that assessment.

7.27 The BMA also stated that 60% of juniors would see a fall in pay on moving to the proposed spot rate system. The management side proposed, and we agree, that, as part of transition, an element of pay protection would apply.

Distribution of the pay envelope

7.28 Early in negotiations in October 2013 the management side gave presentations on how, in theory, the current pay envelope could be distributed differently, starting with the assumption that basic salary should increase, as recommended by the Review Body. The management side proposed modelling a range of options for basic pay, different periods and rates for premium time, and different levels of on-call allowance.

7.29 The BMA was unwilling to discuss these models before data had been collected on current working patterns and pay, so that they could assess how each model would impact on individuals. Sufficient data to do this reasonably (90% returns) was available in early July 2014 but the BMA would not engage until all the data was received, which happened in early October 2014. The theoretical modelling was considered on 9 October 2014 – the management side analysts produced a range of illustrations based on some assumptions informed by the data collection (which suggested that average weekly hours were 46 or 47). The analysts had modelled one initial scenario requested by the management side and five by the BMA.

7.30 The management side scenario, proposed for illustration with the intention that further scenarios would be developed and discussed, showed that where:

- plain-time is extended to 7am-10pm seven days a week;
- 6 additional rostered hours are worked per week (46 hours in total);
- 5.6 hours of hours are in premium time with a premium payment of 33%; and
- an availability allowance of 5% of basic applies to 25% of staff
- the uplift to basic pay would be 17.2%. (In a 47 hour week, the uplift would be 14.8%)

7.31 The BMA scenarios included variations of the above variables. Four did not extend plain-time and one included paying premium time at double time, resulting in a reduction of 3% in basic pay. One scenario extended plain time by three hours per day, proposing that 10pm-7am be paid at double time, delivering an uplift of 8.8% on basic pay.

7.32 Accepting that an extension of plain-time was a government redline, the BMA negotiators said on 9 October that they wanted to model further scenarios. On 14 October they asked NHS Employers to model nine new scenarios for the final negotiating meeting on 23 October. The management side was also modelling five further scenarios to present on 23 October.

Additional hours

- 7.33 The BMA proposed that all unplanned hours be paid for, retrospectively, based on self-reporting by juniors. The BMA suggested that the amounts of money would be small as the data collected suggested that doctors were not working many hours over their contracted hours. (Elsewhere, the BMA has suggested that many doctors are working over their contracted hours).
- 7.34 The management side was unable to agree to juniors claiming overtime pay in this way, pointing out that:
- no other group of NHS staff can do so;
 - a “cheaper” penalty than banding was not acceptable, presenting an option for employers to avoid addressing issues that exception reporting would be intended to address;
 - it would require a sum of money to be identified from the pay envelope to meet the costs of claims, which would need to be adjusted each year depending on the extent of claims, with a commensurate reduction in pay elsewhere, e.g. a reduction in the basic pay rate for all; and
 - the proposal did not fit with the aims, reflected in the Heads of Terms, of supporting quality patient care and quality training, promoting a positive relationship between trainees and employers and allowing for simplicity of administration.
- 7.35 The management side proposed that:
- a level of tolerance should be agreed on the acceptable degree of variance from the exact theoretical hours without the need for a work review, reflecting current practice where juniors may be scheduled on rotas for fewer weekly hours than their contracted, paid hours to provide a buffer against overruns that would lead to a breach of the Working Time rules and the triggering of banding payments;
 - where variation occurred beyond that, a work review would be undertaken – there should be an expectation that juniors would report where they worked fewer hours than planned as well as overruns;
 - where needed, a prospective change to the work schedule would be made, which might result in a prospective change of pay; and
 - pay or time in lieu may be used to recompense doctors for additional work which has been requested by the employer and that compensatory rest may be necessary where unplanned hours led to a health and safety risk.
- 7.36 The Government view is that the management side proposal fits with the commitment in the Heads of Terms to ‘professionalism without exploitation’ and with the agreements expressed there that:
- Where a doctor or doctors in training are consistently exceeding their work schedule hours through unplanned changes to their working hours, a review will be triggered by exception reporting. This will ensure unsafe working patterns are addressed and that the training aspects of the placement remain at an appropriate level; and

- Where agreed patterns of hours are regularly altered in terms of start or finish times or breaks within shifts, then that working patterns should be reviewed to ensure it is appropriately designed.

Pay protection

- 7.37 The BMA was seeking a guarantee that a trainee's basic salary would never reduce including on appointment to a new post, e.g. when choosing to retrain in a different specialty.
- 7.38 The management side view was that, whilst pay protection would be a feature of transition, it would not be a standard feature of the new contract. Methods of pay protection, such as recruitment and retention premia, might be used where there is a recruitment need, and might arise where a trainee retrains in a shortage specialty. The Government supports this and believes it is consistent with the principle in the Heads of Terms to offer fair rewards for work done.

Safe working hours

- 7.39 The BMA wanted additional limits to those offered (see para xx above). These were under discussion, but the management side considered that some would not be necessary if those offered (i.e. maximum hours per week) were agreed.
- 7.40 The BMA wanted to retain current break requirements. The management side wanted Working Time Regulation breaks to apply, in line with all other staff.
- 7.41 The BMA wanted compensation when (paid) breaks were missed. The management side was unable to agree to this as breaks are a requirement of Working Time legislation.
- 7.42 The BMA wanted contractual provisions on facilities during night shifts and access to facilities free of charge for doctors who cannot safely return home if shifts overrun. The management side saw this as a matter for guidance, which should apply to all staff.
- 7.43 The BMA wanted juniors to be entitled to self-declare if they are fatigued and unsafe to work. The management side view was that this entitlement/obligation already exists under legislation covering Health and Safety at Work. The management side therefore proposed guidance on self-declaration, to include the employers' responsibility to investigate the situation and take appropriate action (whether the fatigue arises from work or from non-work activities).
- 7.44 The Government would support the proposals made by the management side as reflecting the principles in the Heads of Terms that:
- the contract must promote safe care for patients and safety for doctors in training, and be fair for doctors in training, employers and other staff;
 - the contract will deliver both safe working patterns and safe total hours of work; and
 - the contract will provide safeguards against unsafe working hours and practices.

Leave

Annual leave

7.45 The BMA wanted all doctors in training to have 30 days leave, arguing that this would be consistent with other doctors. We agree with the management side view that:

- this is not an appropriate comparator. For all NHS staff, the approach is for annual leave to increase to 30 days over time. We agree that there should be consistency in this way; and
- any increase in the time that can be taken (annual leave, together with study leave etc.) could be detrimental to foundation doctors achieving the required standards to progress to the next stage of training.

7.46 The BMA also sought agreement that juniors be allowed to: carry forward untaken leave from one post (and employer) to another; and opt, when they wish, to take payment in lieu of leave. We agree with the management side view that:

- in the interests of safe working, juniors should be able to take all their leave, where possible; but
- it would be reasonable to agree payment of up to five days, and that this could carry forward from one employer to another, with agreement, but the contract would not require it; recognising that
- there can be a direct impact on service coverage and training where a doctor is allowed to carry forward leave between employers.

Professional leave and study leave

7.47 The BMA wanted the contract to provide for a professional leave allocation, separate to study leave allocation. Employers wished professional leave to remain discretionary. This issue remained under discussion at the time the BMA ended negotiations.

Zero hour days on bank holidays

7.48 The BMA wanted the contract to require employers to give a day off in lieu for zero-hour days¹⁵ that fall on bank holidays. We are aware that:

- this matter had been discussed at length in the Joint Negotiating Committee (Juniors);
- agreement had been reached there that this would be a matter for guidance not contractual;
- this agreement was disseminated through a joint statement on 5 August 2014.

¹⁵ A day without any work or duty which has been included in a junior doctor's rota either to bring their hours below New Deal and/or EWTD limits by offsetting additional hours worked elsewhere, or to provide legally or contractually required rest after an overnight shift. A zero-hour day is therefore not a day of leave from duty, because the trainee will have worked their full hours, just on other days of the rota.

Expenses

Business travel

- 7.49 BMA wanted arrangements that reflect the current Agenda for Change provisions but with modifications including the payment of home to base travel.
- 7.50 The management side offer was the package that had been negotiated at the NHS Staff Council in July 2012 and implemented in July 2013 for Agenda for Change but rejected by the BMA. This does not include standard home to base travel within the mileage provisions, except where this is beyond the normal journey to work and back in which case the reserve rate is paid. We remain in support of this proposal, as when it was agreed at the NHS Staff Council, on which the BMA is represented.

Relocation expenses

- 7.51 The BMA wanted a contractual requirement to pay all relocation expenses.
- 7.52 The funding for these expenses is finite and from mixed sources (including organisations other than the employer), and payments are discretionary. The management side made clear that, for these reasons, such payments could not be mandated in a contract between an employer and a junior. They proposed, however, that the contract documentation could make reference to the source and nature of the payments. We would support this proposal.

Fees

- 7.53 The BMA wanted a new contract to include provisions currently in the Medical and Dental Terms and Conditions of Service 2002, specifying fee-paying services.
- 7.54 The management side view was:
- these provisions were not originally drafted for doctors in training, but for other medical and dental groups covered by those terms;
 - the list of fee-paying services includes some services that only consultants are legally allowed to perform;
 - there were issues of concern over competence, governance, supervision etc. on which it might prove necessary to seek a view from the General Medical Council if the proposal was pursued.
- 7.55 The management side proposed instead that the contract should include a schedule referring to the relationship between contracted work and private work, without listing fee-paying services. We believe this represents a sensible approach.

Generic provisions

- 7.56 The management side proposed that generic provisions covering all staff should be incorporated into the new contract, with the proviso that these are not separately negotiated for doctors but jointly negotiated for all staff (at the Staff Council).
- 7.57 The BMA wanted to incorporate the provisions but with changes where needed because of different arrangements for doctors in training.

7.58 We are not persuaded that, on generic provisions, there is any rationale for different provisions for doctors and dentists in training.

Information about future placements

7.59 The BMA wanted a contractual mechanism to ensure that trainees are provided with information about future placements in a timely fashion.

7.60 The management side was fully supportive of the aim, and prepared to press, jointly with the BMA, for this to happen. For purely technical reasons, this could not feature in the contract:

- employers rely on Deaneries/Local Education and Training Boards to provide timely information – the latter are not party to the contract of employment and so any contractual provision would have no bearing or effect; and
- at the time that the information should be provided, no contract is in force between the trainee and the employer – again, any contractual provision would therefore be irrelevant/unenforceable.

7.61 The management side proposed that the current guidance in the Code of Practice – Provision of Information for Postgraduate Medical Training should be reviewed with the other parties involved, with the aim of removing blockages to the provision of information, which create problems for employers as well as trainees. It suggested that the parties might bring pressure to bear by writing jointly to Health Education England, Deaneries and the Health Departments pointing out the implications for juniors and for employers of not being provided with timely information.

7.62 We would be supportive of efforts to provide timely information to juniors and employers in advance of placements. We would be keen to understand any practical issues that make this difficult and how these might be addressed. We would welcome the views of Health Education England.

Period of grace

7.63 The BMA wanted to retain provisions that a junior's employment as a trainee will not end for a period of six months after they become eligible for a certificate of completion of training.

7.64 The management side negotiators proposed that the contract should no longer provide for extension of employment beyond the rotation end date. They noted the difficulties this creates when a trainee is granted such an extension and then secures a consultant post, and leaves, before the rotation end date. This presents problems for both other trainees (waiting for placements) and for employers (in providing service cover between a doctor leaving early and the next intake). Placement beyond CCT date is a matter for the Deanery and there is a clear need to improve flow for trainees.

7.65 We believe that the management side proposal is consistent with the principle in the heads of Terms that the contract should be fair for doctors in training, employers and other NHS staff.

Annex A – DDRB Remit Letter



Department
of Health

POC5 896552

From Dr Dan Poulter MP
Parliamentary Under Secretary of State for Health

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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

Annex B : NHS Forum – Clinical Standards

<p>1. Patient Experience</p>	<p>Patients, and where appropriate families and carers, must be involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and ongoing care that reflect what is important to them. This should happen consistently, seven days a week.</p>
<p>2. Time to first consultant review</p>	<p>All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.</p>
<p>3. Multi-disciplinary Team review</p>	<p>All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, unless deemed unnecessary by the responsible consultant. The multi-disciplinary assessment should be overseen by a competent decision-maker, be undertaken within 14 hours and an integrated management plan with estimated discharge date to be in place along with completed medicines reconciliation within 24 hours.</p>
<p>4. Shift handovers</p>	<p>Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant incoming and outgoing shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.</p>
<p>5. Diagnostics</p>	<p>Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, echocardiography, endoscopy, bronchoscopy, and pathology. Consultant-directed diagnostic tests and their reporting will be available seven days a week:</p> <ul style="list-style-type: none"> • Within 1 hour for critical patients; • Within 12 hours for urgent patients; and • Within 24 hours for non-urgent patients.

<p>6. Intervention / key services</p>	<p>Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant speciality guidelines, either on site or through formally agreed networked arrangements with clear protocols, such as:</p> <ul style="list-style-type: none"> • Critical care; • Interventional radiology; • Interventional endoscopy; and • Emergency general surgery.
<p>7. Mental health</p>	<p>Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week:</p> <ul style="list-style-type: none"> • Within 1 hour for emergency care needs • Within 14 hours for urgent care needs
<p>8. On-going review</p>	<p>All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.</p> <p>Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.</p>
<p>9. Transfer to community, primary and social care</p>	<p>Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.</p>
<p>10. Quality Improvement</p>	<p>All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week.</p>

Annex C: Joint Report to Minister

Juniors

Joint BMA, NHS Employers and devolved nations' progress report on negotiations to achieve a new contract for doctors and dentists in training

Background

1. The current contract for doctors and dentists in training (the “New Deal” contract) was introduced in 2000. It applies to doctors in the training grades, i.e. both years of foundation training and all the subsequent years of specialty registrar training. The aims of the 2000 contract were to reduce the working hours of doctors in training and enforce minimum rest breaks and working conditions. It is accepted that those aims have been broadly achieved. Since the introduction of the current contract Working Time Regulations have been introduced that limit the working week to 48 hours (averaged across a reference period of 26 weeks).
2. The current contract was designed as an hours-based contract, with linkages between hours, rest and pay. However, it has led to rigid working patterns, unpredictable pay bills for employers and an unpredictable income for doctors in training. The contract also does not reflect the training environment that exists today.
3. In December 2012, NHS Employers published a scoping report on the current contract which acknowledged that there were varying views on the contract’s strengths and weaknesses. It proposed that an affordable new contract should be developed to ensure that in the present NHS and medical training environment , doctors in training feel better valued and engaged, leading to better patient outcomes and to improved relationships between doctors, employers and deaneries/LETBs.
4. Subsequently, NHS Employers and the British Medical Association (BMA), with representatives from each of the devolved nations, held exploratory talks. These resulted in a jointly agreed document “Draft heads of terms for negotiations to achieve a new contract for doctors and dentists in training”. The Heads of Terms envisaged a new contract, rather than amendments to the existing contract, and set the scope for possible formal negotiations to achieve this goal.
5. The Heads of Terms envisaged that the contract would cover all doctors in approved postgraduate training programmes in the UK, including those in GP training and approved less than full time training programmes, and academic and public health doctors in training where they have an NHS employment contract. It would exclude regular doctors and dentists in the armed forces. It would also include dental core and higher training posts offering hospital terms and conditions of employment and include those in approved less than full- time training programmes, as well as dental public health trainees when employed on hospital terms and conditions. It would exclude those for whom remuneration is specified in the Dental Statement of Financial Entitlement or the Statement of Dental Remuneration and those employed on salaried primary and community dental care service terms and conditions.

6. Formal negotiations on the contract commenced in October 2013, following a mandate from the BMA's Junior Doctors Committee (JDC) to "*develop a new contract for junior doctors*" and a mandate from the four UK health departments to negotiate with the BMA JDC to "*deliver joint proposals on a UK wide contract for all doctors and dentists in approved postgraduate training programmes, including those in GP training and approved less than full time training programmes, and academic and public health doctors where they have an NHS contract.*"
7. The UK health departments' mandate to NHS Employers asked for periodic updates to ministers, including one in early February 2014 (this one).

Overview of Discussions

8. The negotiating partners have met eight times, roughly on a fortnightly basis. The BMA is represented by members of the JDC from all four UK countries and a member of the BMA's General Practice Committee's GP Trainees Subcommittee and is supported by BMA staff. The employers' side comprises representatives from NHS Employers, NHS employing organisations, postgraduate deaneries, and representatives from the devolved governments. The meetings are chaired alternately by the JDC co-chairs and the employers' side chair. Discussions are conducted using the principled negotiating framework.
9. Both sides have taken a positive and constructive approach to the discussions, which have proceeded on the basis that nothing is agreed until everything is agreed. The discussions to date have covered a number of key topics, with further topics to be discussed during the negotiation timetable, which is scheduled to end in September/October 2014.
10. Reflecting the need to ensure continuity between formal meetings, the BMA/NHSE chairs have agreed to meet periodically outside the main meetings. The first of these meetings will be held in February.

Key Topics to date

Pay and Pay Progression

11. Both sides have agreed that the new contract must be cost-neutral, but that additional employer pension contributions arising from any increase to basic pay as a result of the new contract will be funded separately, from outside the doctors in training bill. They have also agreed high level definitions of the core elements of pay, for example what constitutes "on-call".
12. They have discussed the implications of the government's desire to remove automatic time based pay increments, and have undertaken some initial modelling to inform discussion of alternative approaches, including one linking pay progression to a measurable increase in responsibility. Further work is required to understand the detailed implications of a range of alternative models, including their potential impact on the overall paybill and individual earnings, particularly for those who take time out of training, for example those who take maternity/paternity leave or who undertake out of programme experience (e.g. PhDs). Work

will also be undertaken to ensure that any agreed model complies with current equality legislation.

13. Both parties have been developing a set of principles to underpin the pay elements of the negotiations and these discussions are on-going.

Data Collection and Pay Modelling

14. The discussions have investigated the scope for redistributing the current spend on banding payments. Indicative modelling considered the elements of work which could potentially be rewarded under a new contract (basic hours, rostered hours above 40, out of hours, on call, recruitment and retention premia and non-rostered overtime) and the extent to which the relative amounts of these payments could be varied whilst maintaining cost-neutrality and relatively stable pay. This modelling highlighted the need for more detailed data on the current working patterns of doctors in training.
15. A data collection exercise will take place in the four UK countries to improve understanding of doctors in training current hours of work and working patterns. The information, to be collected in respect of both hospital and GP trainees, will undergo testing and comparison with other sources to create a robust pay bill model. NHS Employers have discussed with HM Treasury the planned collection for hospital trainees in England scheduled for February 2014, and a similar exercise will take place in Scotland and Wales at the same time. Northern Ireland has already collected data as part of a separate exercise. Joint work is underway to develop a process for collecting data for GP trainees, which is expected to take place in March 2014.

Work Scheduling

16. Discussions have taken place to develop a work schedule for doctors in training. Broadly, the schedule would describe the duties of a postholder, how they are expected to spend their time, and the available training provision and learning opportunities. The work schedule would be prospectively designed in partnership between employers and trainees, and a robust review process will also be developed. This work is continuing, including mapping the work schedule to a new doctors in training contract and terms and conditions.

Other Topics

17. Initial discussions have taken place on safe working hours, fixed leave, and professional costs. The group has also considered a proposed structure for new doctors in training contract.

Next Steps

18. As well as on-going discussions, further topics scheduled for discussion include continuity of service, leave, termination of employment, equality and diversity in terms and conditions, and the rate of pay for out of hours. We plan to set up a reference group to consider issues relating to GP trainees, and also plan to discuss specialty specific issues that apply to training in a number of other specialties including public health, dentistry, and to clinical

academics. A key milestone will be the paybill modelling following the data collection exercises, and we anticipate that the results of this should be available during May.

Conclusion

19. Discussions are scheduled to continue, roughly fortnightly, until September/October 2014. Subject to agreement on all issues, a proposed contract will be submitted to Ministers and BMA members for their views in late 2014. If wider agreement is also reached, we anticipate a new contract could be implemented in 2015.

Consultants

Joint BMA and NHS Employers progress report on negotiations to achieve a new contract for consultants

Summary

1 The review partners agree that patients deserve the same high quality of care across the entire week. Putting this aspiration into practice inevitably entails changes in the traditional working patterns over time including the increased presence of senior clinical staff in the evening and at weekends, and the supporting resources needed for them to deliver that care.

2 The review partners recognise that such a change would present a significant affordability challenge. Both partners are currently engaged in modelling work to ascertain the potential cost of the consultant pay bill to facilitate increased consultant presence in evenings and at weekends. The results of this modelling work will determine decisions about contractual changes so that the partners can ensure that the overall cost neutrality of the contract review is maintained.

3 The partners agree that all changes will be supported by appropriate safeguards to protect and promote health and well-being of consultants and safe practice for patients.

4 The partners agree that any contractual changes will fairly link reward with the number of hours worked and when they are worked.

Background

5 The current contract for consultants was introduced in 2003 in England and 2004 in Northern Ireland and applies to NHS medical and dental consultants and for clinical academics employed in the higher education sector and with honorary NHS consultant contracts.

6 The aims of the contract were to improve the working lives of consultants while giving the NHS more control over its medical professionals to improve the quality and ease of access to care for patients. It is accepted that those aims have been broadly achieved but at a higher cost than was expected.

7. At the request of the four UK Health Departments, the Review Body on Doctors' and Dentists' Remuneration) carried out an independent review looking at compensation levels and incentive systems and the various Clinical Excellence and Distinction Award Schemes for NHS consultants at both national and local level in England, Wales, Scotland and Northern Ireland. The report, published in 2012, recommended substantial changes to the Clinical Excellence Awards scheme as well as changes to the consultant pay scale which would link pay progression more closely to current performance than to time served. Exploratory discussions between the BMA and NHS Employers followed the publication of the report to consider the possible reform of the consultant contract. These discussions also reflected the current debate on the provision of seven-day services and how the consultant contract could in future facilitate the provision of seven-day services for the benefit of patients, while at the same time remaining fair to consultants.

8 As a result of these discussions a jointly agreed document "Draft heads of terms on consultant contract reform" was produced, which set out a framework for future detailed negotiations on amendments to the current consultant contract in England and Northern Ireland and to the Clinical Excellence Awards scheme. As the consultant contracts in Wales and Scotland differ in significant respects from those in England and Northern Ireland, it will be for the parties in Wales and Scotland to consider whether there should be any changes to these contracts. Consideration will need to be given about how any national CEAs are administered across England and Wales if the present scheme changes for England only.

9 Formal negotiations on contract reform commenced in October 2013, following a mandate from BMA's Consultants Committee to enter negotiations and a mandate from health departments of England and Northern Ireland to NHS Employers '*to deliver joint proposals for a consultant contract for England and Northern Ireland that NHS organisations will continue to use.*'

10 The target date for implementation of new contractual arrangements is from 2015, allowing for a negotiating period of 12 months (to October 2014) and the mandate said that Ministers would welcome earlier progress on changes that would support seven day services. The mandate also asked the parties to submit a progress report to Ministers in early February 2014 with particular focus on changes that would support seven day services.

Overview of discussions

11 The negotiating partners have met six times. The initial focus of the discussions has been the facilitation of seven day services although other topics such as pay progression and, to a lesser extent, Supporting Professional Activities have been discussed.

12 In the discussions to date both parties have recognised that the principle of professionalism underpins the work of all doctors. Thus the General Medical Council document Good Medical Practice (2012) states that

"Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity".

13 Contractual changes and their implementation will need to reflect these principles and the desire to support and enhance both the professionalism and the professional leadership roles of consultants and clinical academics. Any such contractual changes should also enable

the creation of an affordable pay system that attracts, retains and motivates the right number and the right mix of medical staff to do all that is required for high quality patient care.

Key Topics to date

Seven day services

14 The negotiating partners have discussed some of the evidence around the benefits to patients, the service and to junior colleagues of increasing consultant presence in hospitals in evenings and at weekends and the extent to which the current contract can, in certain circumstances, restrict employers' abilities to provide some consultant delivered services at all times of the week.

15 The BMA has made it clear that it supports good services to all patients at all times and that consultants and clinical academics have played, and should continue to play, a leadership role in ensuring this. However, the BMA has also argued that priority must be given to patients who need care most urgently. Both partners accept that the current contractual arrangements should not be a barrier to meeting the needs of patients. Both sides are also exploring how non-emergency work might be provided in evenings and at weekends. There is agreement that the introduction of appropriate safeguards, through contractual or other means, is key to any acceptance of contractual changes to deliver this level of patient care.

16 Both partners have noted the financial restrictions currently enforced on public sector spending and the difficulties this causes any expansion of public sector provision.

17 Both partners have acknowledged that 'one size doesn't fit all' and that some hospitals will have more resources than others and will be better placed to provide consultant delivered services. Modelling work has been commissioned so this will be better understood.

18 Both partners are continuing to explore possible changes to contractual and non-contractual arrangements to provide a structure and safeguards for consultant delivered services across the whole of the week which might replace the current contractual provisions.

19 The aim of agreeing appropriate safeguards is to ensure that the provision of care is arranged in a way that is patient-centred, clinically driven, financially viable and doesn't risk the health and well-being of consultants.

Pay progression

20 The negotiating partners have also started to examine the current pay progression model. Although the current pay progression system for consultants is not automatic, very few consultants fail to progress.

21 The negotiating partners are currently considering a number of possible alternatives to the current structure which move towards more distinct methods of fairly linking pay to responsibilities and performance within the current pay envelope. There has also been some early discussion around reducing the starting salary of new consultants.

22 NHS Employers have made it clear that any changes should be affordable and administratively proportionate.

Other issues

23 The partners have also discussed, albeit briefly at this stage, other topics such as Supporting Professional Activity¹⁶ (SPA) time and specific protections for clinical academic staff whose main employer is a university. The BMA believes that any continued pressure to reduce access to SPAs by employers could have a medium to long-term impact on the quality of care patients receive and is keen to address this in negotiations.

24 The negotiating partners recognise the significance of educational, training, research and innovation activities as key components of medical professionalism and are committed to ensuring that such activities will not be adversely affected by the changes which may be introduced into the consultant contract.

Next steps

25 Should negotiations continue, the focus will remain on seven day services but will also address Clinical Excellence Awards, pay progression and other issues with the whole being taken together as part of a complete agreement

26 It is yet to be determined whether this would be a new contract applying only to newly appointed consultants or an amended contract applying to all consultants.

27 The current timetable for the negotiations suggests that they should conclude by the end of October 2014.

28 Should an agreement be agreed between the partners, it would be sent to the Ministers and the BMA's Consultants Committee for approval. The BMA would ballot its members on whether to accept the agreement. NHS Employers would continue to engage with employers during this period to prepare them for the outcome of the process. The implementation of the agreed contract in the Health and Education sector would be the subject of separate discussions between the key stakeholders.

Reception

29 The BMA is not able to concede any individual elements of the negotiation mandate at this time in isolation of a fully negotiated agreement. As a result of real terms pay cuts, reductions in the CEA budget and pension reform, persuading both the BMA's Consultants Committee and the wider membership of the benefits of a new agreement could prove very challenging. The partners wish the Minister to be aware of this as they work towards reaching formal agreement by October 2014.

¹⁶ Supporting Professional Activities (SPAs) are defined in the Terms and Conditions, Consultants (England) 2003 as "activities that underpin direct clinical care. This may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities."

Conclusion

30 Although reaching agreement on such significant changes to the consultant contract arrangements in England and Northern Ireland is challenging both partners agree that progress has been made in establishing common ground for future discussions. These will need to progress rapidly and productively as employers consider developing local solutions to help them respond to pressure to meet the new clinical commissioning standards from 2014/15. There is a clear will to reach agreement on a fair and sustainable agreement which will allow both partners to deliver long term benefits for patients.

BMA/NHSE
February 2014

Annex D: CST Letter

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HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Review Body Members
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Victoria House
Southampton Row
London
WC1B 4AD

31 July 2014

Dear Review Body Members

PUBLIC SECTOR PAY 2015-16

I would like to thank you for your work on the 2014-15 pay round. I am strongly convinced of the role of the pay review bodies in determining national pay awards in the public sector and appreciate the important part the pay review bodies have played over the last four years. For a number of review bodies this has included providing expert advice and oversight of wider reforms to pay policy and systems of allowances, in addition to the annual award. I am confident the changes brought about by the pay review body recommendations in these areas are making a significant contribution to the improvement and delivery of public services.

2. You will have seen that for the 2014-15 pay round there were some review body recommendations which, after careful consideration, the Government decided were unaffordable at this time. I hope you will appreciate this was a difficult decision and that the Government continues to greatly value the contribution of the pay review bodies in delivering robust, evidence-based pay outcomes for public sector workers.

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3. The Autumn Statement of 2013 highlighted the important role in consolidation that public sector pay restraint has played. The fiscal forecast shows the public finances returning to a more sustainable position. However, the fiscal challenge remains and the Government believes that the case for continued pay restraint across the public sector remains strong. Reasons for this include:

a. Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.

b. Affordability: Pay restraint remains a crucial part of the consolidation plans that are continuing to help put the UK back on to the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services.

4. As you are aware, for 2014-15 the Government adopted an approach by which all staff in the NHS received at least an additional 1% of their basic pay. All staff not eligible to receive incremental pay have been given a 1% non-consolidated payment in 2014-15. Other staff will have received an increase worth at least 1% through incremental progression.

5. Unfortunately, the NHS trade unions are not prepared to negotiate an affordable alternative, although we are still open to new proposals. Therefore it is our intention to take the same approach in 2015-16. As a result, the DDRB will not be asked to make recommendations on a pay award for employed doctors and dentists in the 2015 pay round.

6. I note that the DDRB would welcome a proactive and systematic approach to considering contractual issues at an appropriate stage of the consultant and doctors in training negotiations and we will consider taking up

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this offer, subject to progress in the negotiations. The Department of Health will write at an appropriate juncture with more details. They will also set out the remit for independent contractors in the usual manner.

7. I look forward to your reports, and reiterate my thanks for the invaluable contribution made by the Review Body on Doctors' and Dentists' Remuneration during the course of this Parliament.

A handwritten signature in black ink, appearing to read 'Danny Alexander', written in a cursive style.

DANNY ALEXANDER

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