Department of Health

Supplementary Evidence for The Review Body on Doctors' and Dentists' Remuneration

Supplementary written evidence from the Health Department for England – February 2015

February 2015

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Supplementary Evidence for The Review Body on Doctors' and Dentists' Remuneration

Supplementary written evidence from the Health Department for England – February 2015

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Contents

Executive summary

This document contains the Department's response to the Review Body on Doctors' and Dentist' Remuneration (DDRB) supplementary questions following submission of our written evidence, which can be found at:

https://www.gov.uk/government/publications/evidence-for-pay-review-bodies-of-healthcare-professionals

1. Response to the Review Body on Doctors' and Dentists' Remuneration supplementary questions

1.1 You are invited to submit any comments you may have on the evidence submitted by the other parties

We note the BMA's comments about the parameters within which the management side operated during negotiations and its suggestions that these restrained the ability to negotiate. The parameters – including 'redlines' relating to wider public sector pay policy and to affordability – were fully understood by the BMA prior to the Government mandating NHS Employers to commence negotiations on the basis of jointly agreed Heads of Terms. These parameters also informed the management side's proposals from the outset – it is not the case that they were introduced at a late stage or would have come as any surprise to the staff side.

We are surprised by the BMA's proposal to reform the current system of banding supplements for juniors. NHS Employers' scoping study in 2011 examined this option, noted the disadvantages and, on the balance of consideration of several options, recommended wholesale renegotiation of the contract. There was general support for that proposal, including from juniors, and it was the basis on which the parties entered into negotiations. Negotiations were conducted in partnership, with both parties free, and encouraged, to bring ideas and solutions to the table. At no stage during that process did the BMA present arguments and proposals for refining the banding supplement arrangements.

In terms of consultants, the BMA appears primarily concerned about the amount of information available on seven day service implementation. This is not a robust argument for removing barriers, such as the-opt out from non-emergency work that inhibit employers from developing the very innovative working patterns that the BMA is so keen to understand - or from introducing changes that would facilitate the workforce's engagement in this process.

NHS Providers' evidence, suggests that the opt-out:

'Either prevents consultants from being deployed outside of core... or pushes up the cost of doing so as to become unaffordable. A handful of trusts have reported finding local solutions…

the fact that most trusts have been unable to agree local solutions, suggests that relying on the goodwill of consultants in not going to result in England wide change at scale and pace.'

Yet, the BMA remain reluctant to give up the use of the opt-out, which is itself a risk to efforts to improve patient safety. This is despite NHS Employers' proposals for sensible safeguards such as a contractual entitlement that consultants would not be required to work more than 13 weekends in a year and more than a 40 hour week without their consent, or to initially run the new arrangements in shadow form.

It should also be highlighted that these barriers also extend to supervision of juniors, who regularly work across the weekend. The General Medical Council (GMC) recently published a consultation on draft standards for medical education and training including that says organisations must 'make sure that each doctor in training has access to a named clinical supervisor, who oversees the doctors' clinical work throughout a placement.' This raises challenges for organisations looking to appoint consultants as clinical supervisors who might be unwilling to work during the weekends.

2. Seven Day Services

2.1 How do you respond to the suggestions that employers may need to provide additional childcare cover or that pay should reflect additional childcare costs from a move to seven-day working?

There is already a requirement for trusts to have a policy in place – drawn up jointly between the employer and the local staff side - that addresses the needs of staff with caring responsibilities (child care and dependent care). Amongst other things, the policy should cover care needs relative to matters such as place of work, working patterns (including shift patterns) and hours worked. As set out in our evidence, the delivery of successful seven day services may require staff working more flexibly *within their contracted hours.* Trusts already operate seven days a week - there is a desire for increased flexibility to be able to provide more services across the seven day week. It does not follow from this that trusts or staff would need to make additional provision or that trusts or staff would incur additional costs.

2.2 What consideration has been given as to whether seven-day services would meet any equality issues, such as those based on gender or religion, perhaps through indirect discrimination? How would such issues be addressed in working patterns?

Trusts, as all other employers, must comply with the requirements of equality legislation, and will have addressed these issues in respect of their current working arrangements and patterns. Trusts already operate seven days a week. A move to providing more services across the seven day week would not, of itself, introduce any additional equality issues.

2.3 Your evidence notes (paragraphs 1.14 – 1.20) that seven-day services would need changes across the whole care pathway. How will access to GMPs be improved? Are there plans to reverse the opt-out of out-of-hours working given to GMPs (and GDPs) in their current contracts?

In our previous evidence we referred to the Prime Minister's Challenge Fund, which is a key route for improving access to GPs. Pilots are expected to cover 7.5 million people by March 2015. In addition, NHS England will be announcing successful bids for a second wave of pilots shortly.

In the 2014 Autumn Statement, the government announced a £2 billion additional investment in the NHS for 2015/16. This funding aims to improve access to GMPs by developing new models of care, and by improving primary care infrastructure.

We are investing £200 million in supporting NHS England's ambition, as set out in the Five Year Forward View, to develop new models of care such as Multi-Speciality Community Providers (MCPs), and Primary and Acute Care Systems (PACS).

We have also committed to a £250 million investment every year for the next four years to improve primary care infrastructure. GPs across the country have been invited to submit bids to improve their premises. This extra funding will enable practices to progress many of the bids for premises improvement and development that have been previously submitted, but will also help progress new bids which reflect opportunities for enhancing primary care capacity.

We are empowering patients to take greater interest and responsibility for their care through changes made to the GP contract. This year, all patients in England will have the ability to view their own medical record. The 2015/16 GP contract will extend named GPs to all patients in England from April. These GPs will oversee patients' care and support to ensure continuity of care, and identify potential issues early.

As well as having access to more information about themselves, patients will also have more information about the services that they use. MyNHS will give patients a clear view of how

providers compare to each other, allowing them to make informed choices about their care. We aim to strengthen the clinical triage and advice service to link the system together and help patients navigate it successfully.

We have recognised the need to further increase numbers of GPs. The number of GP registrars (i.e. GPs in training) has increased from 2,153 in 2003 to 4,093 in 2013 – an increase of over 90%.
We have introduced a commitment to increase the number of GP trainees from 40% to 50% of all trainee doctors and expect Health Education England (HEE) to ensure this happens. This will mean 3250 training places for GPs by 2016 and we expect 5000 extra GPs to be available by 2020.

NHS England have been working closely with Health Education England, the Royal College of GPs, and the British Medical Association to produce a 10 point action plan to increase the size of the General Practice workforce, to which we have allocated £10 million of funding. This will focus on recruiting more GP trainees, retaining those already in General Practice, and supporting those who wish to return after a career break.

HEE has established an independent Primary Care Workforce Commission which is chaired by Professor Martin Roland of University of Cambridge. The Commission will identify models of primary care that will meet the needs of the future NHS including greater emphasis on community, primary and integrated services.

With regard to out-of-hours services, in 2004 the majority of GPs had already delegated responsibility to GP co-operatives or commercial providers. At the beginning of 2004, it is estimated that only 5% of GPs provided out-of-hours services themselves.

Changes made to the 2014/15 GMS contract mean that GP practices who have opted out of out-of-hours services will have to monitor the quality of those services and report any concerns they may have.

Any future GMS contract changes would be subject to the usual processes of negotiation between NHS Employers- who act on behalf of NHS England and the General Practitioners Committee of the BMA, acting on behalf of GPS.

There was no opt in option for General Dental Practitioners. The 2006 dental contract change removed responsibility for out of hours care from dental contractors and transferred it to Primary Care Trusts (as was). NHS England commissions in and out of hours dental care as required for their populations

2.4 Several of the parties have commented on the need for the move to seven-day working to be supported by fundamental cultural change across the NHS workforce so that seven-day working is accepted as the norm. How is this being approached?

There can be no ‘one size fits all’ solution to implementing a seven day service, but the department agrees with other parties that moving to this model will require local system wide change. There are several examples where encouraging progress has been made – some of which have been highlighted by NHS Employers and the Hospital Consultants and Specialist Association in their evidence.

Our view is that engagement with staff is important to this success, and that acceptance of working patterns that are conducive to seven day working will be more readily achieved when staff are active in the development of the changes and can see first-hand the impact on patients.

Just as employers benefit from engaging their staff on service change, building local flexibilities into the contracts will provide further ways for employers to promote staff engagement and to agree appropriate workforce solutions. This will also provide employers with the flexibility to respond to local challenges and opportunities that arise.

It is also clear that consultants, as the senior clinicians closest to patients and leaders of clinical teams may often be well placed drive forward this change – including by promoting a cultural shift towards working more flexibly across the week.

Unfortunately, contractual barriers in the consultant contract are particularly difficult to reconcile with this role. For example, the opt-out can be used as an effective personal veto on efforts to more effectivity organise working patterns around patients. This puts additional pressure on

medical and non-medical colleagues who do work across the week, and reduces the visibility of those who may often be at the vanguard of this change.

There is also a requirement to train and support doctors in training at the weekend and evenings. The GMC is currently consulting on its draft standards for medical education and training, which includes a recommendation that organisations must make sure that at all times there is senior medical supervision of learners by a named doctor who can provide ongoing clinical supervision.

Contractual change is an opportunity to begin to overcome these barriers – and an important step towards embedding a culture within the NHS that is motivated to realise the improved patient outcomes that can be achieved through seven day service provision.

2.5 Comparator groups

We expect to have some questions about comparator groups, once the results of the IDS research about arrangements and pay for seven-day services in a variety of sectors are available (expected March 2015).

3. Junior doctors' contract reform

3.1 What consideration has been given as to whether the proposals to reform pay progression for junior doctors (in particular the end to annual incremental progression that will impact those working less than full-time) have addressed any equality issues, such as those based on gender, perhaps through indirect discrimination?

We agree with the management side view during negotiations (and as referred to in our evidence at 7.24) that the proposals made by the negotiating team (as set out in the evidence that NHS Employers submitted on behalf of the UK-wide negotiating teams) would withstand such challenge and, indeed, would be fairer than the current system.

The proposal, to base the level of pay on the work being done and the level of responsibility being discharged, seems fair. A move to the next stage of training recognizes the acquisition of skill and experience and the increased contribution that the doctor has demonstrated s/he is able to make; linking pay to this (demonstrated) increase in skill and the taking on of an increased level of responsibility seems fair.

The BMA's evidence states: "*As they progress, doctors in training gain valuable skills and experience*." We believe that this is reflected in the proposals for linking pay to progression through the stages of training, where the skills and experience are both demonstrated and applied.

The BMA's evidence then states: "*The current model of pay progression recognises the increased contribution doctors in training make as they progress*." We do not agree that this is the case. Rather, the current model provides for an annual increase in pay *whether or not* a doctor progresses through training - acquiring, demonstrating and applying increased skills, experience and contribution; and this could be argued as inherently unfair.

We note the BMA's statement that the proposal made by the management side would disadvantage some doctors *"as compared to the current system",* and would comment that the proposals made by the management side would end the current situation whereby doctors

training less than full time will no longer be advantaged over doctors training full time. Again, we believe that this is fair.

The management side proposals recognise that there are cases that require consideration – specifically those taking time out of the hospital training pathway to undertake other required training. Where the other training/activity is part of the approved training pathway and required for the Certificate of Completion of Training, we agree with the negotiating teams that there should be consideration of whether a mechanism is needed to compensate doctors who undertake such training/activity.

Taking time out of the approved training pathway to pursue other training/activities not required for completion of training (e.g. attaining a PhD that is not a requirement of the training programme) is a choice. Such activities might, for example, improve a doctor's personal portfolio and employability on completion of training.

3.2 What is your assessment of the impact of the proposed new junior doctor contractual arrangements on the key elements of our standing terms of reference: recruitment, retention, motivation and affordability?

The proposals made by the management side reflect the aims in the Heads of Terms (HoTs) agreed with the BMA. We believe that the package of proposals represents a fair and attractive offer to juniors.

Juniors would have the predictability of earnings that they stated was important to them. Pay would be linked to work done – something the BMA said, in negotiations, that they wanted. A greater proportion of earnings would be in basic pay and therefore pensionable, which is better in the Career Average pension scheme. The proposals also include the flexibility to address specific recruitment and retention issues.

3.3 How do you respond to the specific points from the BDA's evidence: that dental specialty training might not map onto the revalidation process seamlessly enough to be used for progression purposes; and that there is no current mechanism for monitoring progression from years one to two of core dental training?

We understand the BDA to be commenting on proposals about mechanisms for pay progression which were made by the BMA and rejected by the management side during negotiations. Those mechanisms do not form part of the proposals in NHS Employers' evidence. We support NHS Employers' proposals that pay progression should be linked to moving to a job with a higher level of responsibility (and at a higher stage of training).

3.4 Assuming that new junior doctor contractual arrangements would extend to GMP trainees, what are the likely implications for the typical GMP trainee's pay? Does this suggest the end of matching the average hospital trainee supplement to the GMP trainee's supplement? If so, what consideration has been given to the implications for the recruitment of GMP trainees?

The proposals are based on the same principles for all trainees, including linking pay to work done. However, as described above, there is also provision for the use of recruitment and retention premia in the proposed new arrangements.

The GMP trainee supplement, in the existing arrangements, is a recruitment premium. It was introduced to ensure that there was no disincentive to doctors choosing general practice training, recognising that, during the general practice based stage of GP training; trainees did not have the requirement/opportunity to work the patterns that apply during the hospital based stages of training and earn the associated pay banding supplements.

The proposals for a new contract include that it would be for Health Education England to take a view on recruitment issues and the use of the pay flexibilities to address those.

3.5 What are the proposed transitional arrangements for junior doctors? How would juniors under the current arrangements be moved across to the new arrangements?

The intention is that basic pay would be protected during the period of transition. The detail of this would need to be determined once the pay structure was clear – the proposals made by NHS Employers include several options. The costs of implementation would need to be met from within the envelope - the new arrangements should cost no more, in any one year, than the costs would have been in keeping the existing arrangements. Therefore the level of pay protection required might mean that the proposed increase to basic salary (for all) would need to be lower during transition.

4. Consultant contract reform

4.1 What consideration has been given to the need for any new arrangements for consultants to provide sufficient scope for career development?

The government's ambition is for excellent leadership, including clinical leadership, to be the norm in the NHS. It is therefore important that consultants, supported by the contract have access to opportunities that can harness their expertise and support their role as the leaders – while rewarding those who contribute the most to patient outcomes. Appropriate scope for career development is also an important recruitment and retention tool. The current 19 years of pay progression does not support career development, rather it rewards time served.

The department supports the proposals put forward in NHS Employer's evidence, which includes mechanisms designed to enable employers to offer attractive opportunities for career development, including allowing:

- payment of allowances to consultants for additional roles and responsibilities that consultants may hold at variable times throughout their career
- retention of supporting professional activities time (SPAs) provided it is properly job planned around specific objectives

- the most capable consultants to progress more quickly through the pay system
- a more equitable system of local performance pay that rewards current rather than past performance.

The proposed performance assessment processes will also facilitate more opportunities for consultants to develop managerial and other skills required for greater responsibility, while encouraging peer moderation in performance pay will also support a more credible process based on informed assessments of what excellent performance looks like.

4.2 What is your assessment of the impact of the proposed new consultant contractual arrangements on the key elements of our standing terms of reference: recruitment, retention, motivation and affordability?

Our evidence makes clear that the existing contractual arrangements ultimately work against patients and delivers poor value for money. 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 and has a corrosive effect on the motivation and retention of staff.

NHS Employer's evidence seeks to address these concerns by proposing rebalancing existing spend with an offer of more equitable terms that would reward most those who contribute the most – an offer that we consider will appeal to many doctors.

This approach will contribute to the maintenance of safe staffing levels, and drive productivity by promoting a more engaged and motivated workforce with a clearer stake in the trust's performance. This includes supporting:

Recruitment – NHS Employer's modelling suggesting that new consultants could expect to progress from a starting salary of £70k rising to £93k after an average of five years – or sooner depending on performance. This is significantly faster than existing terms. Total pay would average £107k when taking into account out of hours and additional responsibilities, not including additional payments for local performance related pay.

Retention - Clear contractual commitments to support an appropriate work life balance and patient safety, including no requirement to work in excess of a 40 hour, 10 Programmed Activity, working week or 13 weekends in a year without consent. An equitable approach to unsocial hours so that those specialities that work during the most unsocial hours are recognised fairly.

Motivation - A transparent and locally driven approach to performance pay that is linked into objective based appraisal that rewards excellent current performance, with scope for performance pay based on an individual, team and organisational basis. A professional contract that engages consultants as leaders of clinical teams, moves away from an hours counting culture and rewards those who perform roles and responsibilities that are above the standard role.

4.3 To what extent will local performance related pay schemes be expected to take account of consultants' contribution to education and training, research etc. as well as service delivery?

We expect any consultant to have wider objectives than just service delivery.

NHS Employer's proposal suggests that local performance related pay should recognise those who demonstrate excellence in the context of an objective based appraisal system, with locally determined objectives linked to patient outcomes and organisational objectives and values. This does not preclude objectives relating to, for example education and training - which would in turn contribute to the performance reward received.

4.4 What consideration has been given to reforming national Clinical Excellence Awards? What is the current proposal for the pensionability (or otherwise) of national CEAs? When did the DH's position on the pensionability of CEAs (both local and national) change and what was the basis for any change in view?

The government is committed to working with key stakeholders to take forward the DDRB's recommendations on National Clinical Excellence awards, as set out in the 2012 report '*Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants'*.

The Written Ministerial Statement on 17 December 2012 said "I therefore believe that longer – term national awards can remain pensionable. I would also be prepared to consider affordable proposals on pensionability of future local awards". This position is unchanged in relation to national awards.

NHS Employer's proposals for local performance payments would reward a much shorter period than national awards, be provided on a non-consolidated and non-pensionable basis and vary in value depending on individual performance and local arrangements. In line with this approach we do not think that local performance payments should be pensionable, but that, as set out in NHS Employer's evidence, the employer pension contributions should be recycled into the overall contract value – for example into any pot of money made available for local performance reward.

Linked to this issue, most full time consultants who retire in their 60s and almost all full time new starters who retire close to their normal retirement age are likely to breach the HMRC 'Lifetime Allowance' (LTA). The LTA provides tax relief on the value of pension savings up to a limit (currently £1.25 million), with any excess value attracting a charge. The variable reward value may also have an impact on the separate 'Annual Allowance' arrangements, which is a threshold restricting the amount of tax free pension growth available.

Depending on individual circumstances, many consultants may consider that they have an interest in limiting their pensionable pay going forward. Non-pensionable local performance pay is one way to achieve this, and would provide more flexibility for consultants to manage the value of the pension – for example by topping up their pension by using existing mechanisms in the NHS Pension Scheme.

4.5 How do the proposals to allow employers flexibility to use RRPs for hard-to-fill consultant specialties differ to the current RRP arrangements? Do you expect the proposed new arrangements to lead to an increase in the use of RRPs for consultants?

NHS Employers' proposals do not include making substantive changes to existing RRP arrangements and have not been specifically developed with the objective of increasing the use of RRPs.

Hard-pressed specialties are often those where the out-of-hours demand is greater and this was considered in discussions on how to reward these periods. However, there are some specialties where this is not the case but it remains more difficult to recruit and retain staff, so there is no exact 'fit'. Whilst this had not featured in discussions before the negotiations ended, the proposals aim to facilitate more equitable contractual arrangements between specialisms so that those contribute the most and work during the most unsocial hours receive higher levels of reward.

4.6 What consideration has been given to restricting out-of-hours commitments for some specialties where they are age-related concerns particular to specialties (e.g. obstetricians aged 55+, as suggested by the Hospital Consultants & Specialists Association in its evidence at page 4)?

The department is working alongside trade unions and NHS Employers as part of the NHS Staff Council's Working Longer Group (WLG). This group was established to review the implications

to the NHS workforce having a later normal pension age (NPA) linked to state pension age (SPA) as set out in the Public Services Pension Act 2013. This group is considering how the potential impact of shift working as the NHS moves towards a seven day service combines with an increasingly older workforce on service delivery - particularly during night shifts.

The WLG's initial findings suggest that further work is required to fully understand the potential impact on an average older workforce will have on working arrangements and environments - and ultimately for patient outcomes. The group did note some evidence that shift work is detrimental to health across all age groups (although it does not follow that day time work on a Saturday and Sunday should be treated in kind to night work). There was no recommendation in favour of introducing age related retirement provisions into contractual arrangements.

A number of recommendations are now being taken forward by the Department and the WLG to develop this work further, including (but not limited to):

- Ensuring good quality information is available for employees about the existing flexibilities available in the NHS Pension Scheme.
- Enabling staff to take informed decisions for staff during their working lives about their employment arrangements
- Ensuring all staff having access to relevant education and training throughout their working lives.
- Introducing supportive, high-quality programmes to protect and promote health, well-being and safety.
- Supporting staff to work effectively and productively throughout their working lives, acknowledging that this may require change and/or adaptation of their roles and working environment and/or patterns at appropriate times.

The department's view is that in tandem with this work, existing statutory safeguards already provide a number of protections at all ages - for example the provision of reasonable adjustments. Appropriate contractual safeguards have also been proposed on safe working limits for all consultants as part of the contract and locally managed approaches to flexible working will also continue to be available.

4.7 The proposals on consultant contract reform rely on job planning being the driver for performance appraisal and objective setting. What measures will be put in place to ensure that management will be able to drive this agenda forward?

One success of the 2003 contract is that most consultants now have a job plan. However, these are not always linked to an effective performance appraisal process, which is essential to an effective pay system.

The department supports a system of peer moderated performance appraisal that is linked to the achievement of wider local organisational objectives. This will help promote engagement and productivity by more clearly recognising the critical role that consultants play in the success of an organisation.

NHSE and the BMA have already developed a best practice framework for job planning, but we also anticipate that linking job planning more clearly to performance appraisal and pay will encourage individuals and management (including clinical management) to adopt and develop good practice. We understand that a similar effect may have occurred following the introduction of medical revalidation, which led to a renewed focus on the importance of appraisal.

One way to support this process is to ensure that comparable data on individual consultants is available. In their report *Department of Health: Managing NHS Hospital Consultants* the Public Accounts Committee suggested that only 43% of trusts and 27% of consultants consider that the information available at the time was good enough to assess individual consultant performance – despite most consultants agreeing that comparing their performance against their peers motivated them.

Clear progress is being made on this issue. NHS England is currently working with the Healthcare Quality Improvement Partnership and national clinical audit providers to publish consultant level outcomes from appropriate NHS funded national clinical audits by 2020. In its 5 Year forward view, NHS England also committed to publish meaningful and comparable measurements for all major pathways of care for every provider.

We also expect that NHS Employers' proposals to introduce team and organisational local performance awards will feed into the effectiveness of the wider performance management process. Academic research cited by the DDRB's *Review of compensation levels, Incentives and the Clinical Excellence and Distinction award schemes for NHS consultants* suggested that team approaches could also encourage mutual monitoring of performance that may be particularly suitable in clinical settings.

4.8 How realistic do you consider it to require consultants to move to regular weekend working without any increase in the overall pay envelope? Do you have any funding set aside, perhaps on a transitional basis, until acceptance of regular weekend working is more entrenched in working patterns?

During negotiations we identified resources within the funding envelope which could be used to increase out of hours payments.

The proposal is to restructure pay so that the rewards for weekend working reflect a more equitable approach to out of hours, as proposed in NHS Employers' evidence, making it more attractive than the current arrangements. This includes trialing approaches in shadow form. Therefore, we do not consider it necessary to have any additional transitional funding to incentivise weekend working.

There are examples where appropriate seven day working patterns have been achieved locally, although as highlighted by NHS Providers' evidence, reliance of the goodwill of consultants not to exercise their contractual right to opt out will not facilitate change at scale and pace. Removal of this barrier will allow employers to engage with staff to deliver fairer, more efficient and more productive schedules based on patient need – without being dependent on the provision of the good will of the willing while the unwilling continue to stand apart from necessary service development.

4.9 Health Education England's evidence (at paragraph 3.7) calls for transitional funding to support the workforce transformation required and to maintain the quality of services and training. How do you respond?

The department agrees that there should be appropriate arrangements in place for staff transitioning onto revised contracts. Any transitional protections should be inline with protections offered by employers (generally for 2 years) while recognising the need to comply with the principles of equal pay. However, we do not agree that additional funding is required, and endorse in principle NHS Employers' proposals for the consultant transitional arrangements - which would be funded from flexibilities within the cost envelope. This includes access to at least 2 years of pay and pensionable pay protections.

4.10 Did the current spend on locums (estimated by the College of Emergency Medicine as £150 million) form part of the negotiating envelope? If not, why not? How are locum costs distributed across the week? The use of locums might suggest that some shifts are harder to cover and the current premium is not providing sufficient incentive for doctors? How will you get staff to work these hours if these premia are removed or reduced?

The negotiating envelope agreed as part of Heads of Terms is reflected in NHS Employers' evidence on the handling of transition - cost neutrality meaning that new arrangements should cost no more (or less) than the existing cost per FTE would have been in any one year without the changes. This would include the pay of locum consultant appointments who are paid through national pay rates – e.g., those employed in place of a substantive consultant to cover vacancies. We do not recognise the figure quoted by the College of Emergency Medicine, or what it includes.

A more flexible contract, for example that removes the opt out, will allow employers to rota staff more effectively and reduce the risk of consultants driving up the demand for and cost of locums by refusing to work during unsocial times - and charging rates that are above those set out in

national frameworks. This has the potential to free up resources and productivity to ensure that safe staffing levels are achieved in a cost effective way.

Any changes would also be set in the context of a more equitable contract that rewards those who contribute the most and who work during most onerous hours with the highest levels of financial compensation – which the department believes will be attractive to many doctors.

4.11 NHS Employers modelling assumes all consultants on the 2003 contract move across to the new terms (paragraph 5.174). How would you propose moving all consultants across to the new contractual arrangements? What about those consultants still on the pre-2003 contract? What consideration have you given to the impact on motivation of such a move?

The negotiations were focused upon, and the department's preference was for, a collective agreement to amend the consultant contract, this would cover over 98% of the workforce, with those on the pre-2003 contract having the option to move across.

As outlined in earlier responses, the department considers that the proposals outlined by NHS Employers' will provide a fairer and more equitable reward package, which we expect will prove attractive for many doctors.

Several parties have highlighted the importance of maintaining an appropriate work life balance to recruitment and retention, and there is a risk that by not adopting a workforce wide approach, the next generation (and those who move across) could be left with a greater proportion of the unsocial hours work associated with a seven day service. This risks:

- reducing the recruitment, retention and motivation of new consultants and thereby increasing reliance on locums or causing wider staff shortages.
- proving complex for employers to administer, thereby increasing costs.
- equality issues, i.e as more unsocial hours work falling to an increasingly feminised and younger consultant workforce.

Finally, NHS Employers' proposals for transitional arrangements are predicated upon all consultants moving onto a revised contract. It is unlikely that this approach would be affordable or preferable in an alternative scenario where some consultants remain on an unchanged contract or a significantly altered model.

5. Other groups

5.1 Clinical academics are not part of our remit groups, but what action has been taken to ensure that the recruitment/retention/motivation requirements of clinical academics have been addressed by the proposed new contractual arrangements?

The department agrees with other parties' evidence, including from the Advisory Committee on Clinical Excellence Awards (ACCEA) that clinical academics should continue to be incentivised so that academic careers remain attractive.

The proposals outlined in NHS Employers evidence were developed with a focus on recruitment, retention and motivation concerns, and the government's view is that clinical academics should continue to have access where appropriate to an amended contract. This includes access to the revised arrangements for local performance pay as set out in NHS Employers' evidence, and continued access to National Clinical Excellence awards.

As outlined in the earlier response, the department is also committed to working with key stakeholders to take forward the recommendations on National Clinical Excellence awards.

It will also be for consideration, in designing the pay structure for doctors and dentists in training, how to treat trainees who follow different training paths to achieve completion of training.

5.2 Consideration of dental foundation trainees would appear to fall outside the scope of this remit. What opportunity has the BDA had to comment on the juniors' contract proposals insofar as they will impact on dental foundation trainees?

The BMA represented the BDA in negotiations about doctors and dentists in hospital training. It is correct that dental foundation training is outside the explicit scope of this remit insofar as DDRB has been asked to make recommendations on a new contract for doctors and dentists in training, to replace the 2000 'juniors' contract, taking account of proposals in NHS Employers' evidence. Dental foundation trainees are on separate contractual arrangements.

However, as set out in our evidence (paragraphs 3.60-3.61), it is an issue that should be considered. Specifically, we would welcome DDRB's views on any read-across between what it is minded to recommend on the 'juniors' contract and any impact/considerations for dental trainees progressing from dental foundation training into specialty training. Subject to that, we would consider this further, including with the views of the BDA.