Best for patients, fair for doctors, sustainable for the NHS

Memorandum of evidence to the Doctors and Dentists Review Body: special remit on contract reform for consultants and doctors and dentists in training

December 2014
Executive summary

After 18 months of detailed negotiations, unreasonable demands from the Government which the BMA (British Medical Association) believes could jeopardise the safety of patients and doctors, coupled with a lack of credible evidence to support changes being proposed, resulted in talks stalling on contracts for consultants in England and Northern Ireland and doctors in training across the UK on 16 October 2014.

The DH (Department of Health) in England has since instructed the DDRB (Doctors and Dentists Review Body) to consider all evidence relating to contract negotiation talks for consultants and doctors in training in England and make observations for consultants and recommendations for doctors in training by next July.

We are extremely concerned that the DDRB may simply be being used to achieve the Government’s political priorities, without proper consideration of the reservations of the medical profession. In particular, health minister Dan Poulter’s remit letter places certain key restrictions on the DDRB’s freedom in carrying out this exercise. The same questions have been asked by Northern Ireland health, social services and public safety minister Jim Wells in his special remit letter. Therefore, the same limitations exist in relation to the Northern Ireland special remit letter.

Nevertheless, the BMA is taking this opportunity to demonstrate to the DDRB that any new contract deal must be best for patients, fair for doctors and sustainable for the NHS – the standard by which we negotiated with the Government.

This evidence is not equally applicable across the UK for all questions. The Scottish Government has not given the DDRB a remit to make either observations or recommendations for consultants in Scotland. Consequently, this evidence submission does not cover consultants in Scotland. However with less than two working weeks before the submission deadline to the DDRB, the Scottish Government has given the Review Body a remit to ‘make observations on new contractual arrangements including the new system of pay progression’ for doctors in training. The evidence provided for doctors in training, therefore, does apply to Scotland.

It is important to note that the Scottish Government does not require the end of automatic pay progression. Furthermore, the DDRB’s remit in England to make recommendations on new contractual arrangements for doctors in training is different to that in Scotland, where it has been asked to make observations. We would seek clarity on how this difference will be interpreted.

We have not included any specific evidence relating to the consultant contract or to seven-day services in Wales. This is because the BMA believes it is inappropriate at this moment in time to ask the DDRB to provide observations on the Welsh consultant contract when there have been no prior negotiations between BMA Cymru Wales and the Welsh Government. Further, the Welsh Government position appears to have changed, from requiring a 1 per cent saving from the medical pay bill to a position of not increasing the current spend. We believe, therefore, that the Welsh Government should have offered direct talks, before issuing its special remit to DDRB. Further details of the history of discussions with the Welsh Government are included in Annex D.

The exclusions above are implicit in any reference in this submission to national negotiations, policies or schemes.

As requested, we have concentrated our evidence on the domains requested, i.e. with reference to consultants and doctors in training. It must be kept in mind that there will be implications for other doctor groups who have not been part of contract negotiations about which we have not offered any evidence.
Consultant negotiations in England and Northern Ireland

Fundamentally, the BMA believes that patients should be able to expect the same quality of care whenever needed and that priority should be given to emergency care. However, a body of credible evidence on how to achieve this is a prerequisite for implementation of this scale of service delivery change. In order to plan for implementation, a framework for seven-day services is required. The service as a whole, as well as individual trusts, must know what the definition of a seven-day service is, what the pathway towards implementation will be, and what to prioritise for implementation.

The BMA would caution against starting implementation when neither the overall service nor individual trusts know what the end objective is, how much it is likely to cost, and what the impact will be on patients and staff. Badly thought through implementation could threaten both the standard of service patients receive and the viability of the service. The BMA wants to work with the Government and all other relevant stakeholders to develop this evidence base.

The BMA is concerned about the lack of credible evidence regarding the pay implications of implementing seven-day services for individual consultants. Credible evidence is also required in this area.

The BMA is willing to negotiate the removal of S3P6 (Schedule 3, Paragraph 6), which has been seen as a block to seven-day services, but only on the basis of strong contractual safeguards guaranteeing rest periods to ensure consultants are not overtired when caring for patients. Without adequate contractual safeguards, we believe that patient safety could be threatened.

The BMA wants to ensure there is meaningful clinical engagement when designing a seven-day service. Securing doctors’ engagement in the process is vital; without it, any seven-day service reconfiguration is unlikely to be successful.

Equally important is ensuring that service design does not undermine medical professionalism, by which we mean ensuring doctors have the time and space to pursue the research and educational activities which are crucial to delivering high-quality patient care.

Although we are willing to consider changes to the current pay progression system for consultants, we argue that any new system should be based primarily upon a fair assessment of merit, rather than the financial limits placed upon employers.

The heads of terms for the consultant contract negotiation supports a national contract. However, many of the proposals put forward by NHSE (NHS Employers) decentralised parts of the contract such as pay and CEAs (clinical excellence awards). The BMA is concerned about local flexibility in applying the contract, resulting in a postcode lottery for consultants and, potentially, patients. We strongly believe a national contract should continue to retain nationally-agreed standards for doctors and the patients for whom they care.

The BMA agrees with the DDRB’s previous recommendation: that consultants should continue to receive reward over and above their basic pay to reward and incentivise innovation and high performance. The BMA wants to negotiate a new updated model that better meets this objective, compared to the current CEA system. However, any replacement scheme must be based on a national structure with a ringfenced pot of money to maintain it.
Doctors in training negotiations

The BMA’s priorities throughout negotiations on a new contract for doctors in training were to ensure high-quality training, safe patient care and a better professional life for doctors in training.

When negotiating systems of pay and work patterns, we were focused on retaining effective safeguards to ensure working hours that protect patient safety and the welfare of doctors, and that pay reflects experience gained by doctors through the course of their training and delivers financial stability for doctors in training.

However, as for seven-day services, credible evidence is a prerequisite for introducing policy change in the NHS, particularly at the scale that was being discussed during contract negotiations. Robust modelling and data was lacking during any negotiation regarding pay models. As a result, the BMA has serious concerns that such a system, by not rewarding intensity of work fairly, would have a potential impact on future recruitment and retention to certain specialities. We were clear that we could not take this risk, due to the potential negative effect on the NHS’s ability to deliver high-quality patient care.

Total hours worked, as well as working patterns, must be safe. This principle was agreed in the heads of terms. During negotiations, the BMA proposed a number of new contractual safeguards against excessive working hours. However, we could not reach agreement with NHSE because of its refusal to incorporate those safeguards into a new contract and their insistence that they should only be issued as guidance. Given the effects on patient safety and doctor welfare, our strong view is that guidance is inadequate.

The BMA was willing to negotiate the current model for pay progression. In order to do this effectively, credible evidence is required on training pathways to ensure that contract reform is cost neutral. We could not reach agreement on changes to pay progression without this information. Indeed, the BMA is committed to changes to the contract for doctors in training being cost neutral. This will ensure that any changes negotiated are sustainable for the NHS. Equally, while we accept that the pay envelope cannot increase, we cannot accept a deal that penalises doctors in training financially.

Overall, contract negotiations stalled due to the lack of credible evidence available to underpin the changes being proposed. In the absence of robust data, we were being asked to make decisions that could have a huge impact on patient safety, doctors’ welfare and the sustainability of the NHS. This would have been at best irresponsible and at worst dangerous. The BMA calls on the DDRB to recommend gathering the required data as a matter of urgency. We would welcome the opportunity to work with all relevant stakeholders to develop this evidence base so that a deal can be reached on a new contract for consultants in England and Northern Ireland, and for doctors in training in the UK that is best for patients, fair for doctors and sustainable for the NHS.

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1 In this submission we use the term professional life to describe the quality of working life for junior doctors, including their work-life balance.