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, ie 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\(^1\).

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.
Introduction

The BMA is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of more than 153,000, which continues to grow every year.

This evidence is not applicable across the UK for all questions.

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 the Welsh Government should have offered direct talks, before issuing its special remit to the DDRB. Further details of the history of discussions with the Welsh Government is included in Annex D.

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 DDRB submission deadline, 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.

For the avoidance of doubt, where phrases such as ‘national’ are used anywhere in this evidence, they should be taken as referring to either England and Northern Ireland only, for consultants or England, Wales, Scotland and Northern Ireland for trainees.

The BMA does not underestimate the challenge facing the DDRB in trying to make recommendations and observations on the issues now placed before it.

The lack of credible evidence and modelling to underpin NHSE’s proposals in both sets of negotiations was a significant barrier to progress in those talks, and one which we urge the DDRB to address via this process.

It is also vital that changes to doctors’ working patterns are accompanied by appropriate safeguards against excessive hours of work, to ensure both safe patient care and the welfare of doctors. This submission will expand on proposals discussed in negotiations which had the potential to remove these key safeguards. We believe the opportunity for the DDRB to demand credible evidence and modelling is welcome. We are, however, extremely concerned about the DDRB being used simply to achieve the Government’s political priorities without considering 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. We believe the independence of such a body is undermined when the questions it needs to answer² have been so confidently and, in our view, misleadingly answered by the Government in its remit letter to the review body³.

The restriction placed on the DDRB to look at barriers and enablers to seven-day services in a ‘financially sustainable way ie without increasing existing spend’ is particularly unhelpful. It reflects the diversion from heads of terms during consultant negotiations from affordability to cost neutrality, which was a key reason preventing the negotiations from reaching agreement. Furthermore, not even the most optimistic estimations have suggested that extending services can be done without increasing spend at all and asserting so is likely to make achieving such a fundamental change in the way the NHS operates more difficult.

Similarly, the insistence that the DDRB should consider ‘how the current pay envelope’ could be used to fund changes to the doctors in training contract is unhelpful if this precludes the ability to recommend additional funding to meet the costs of transition.

It is difficult to fully articulate the sense of frustration felt by the BMA as a result of our experience across both the consultant and doctors in training negotiations. Throughout this submission we focus on the substance of the negotiations and the issues on which we failed to make progress. However, throughout the talks there was an overriding sense that the negotiating meetings were not in fact driving any decisions on the future of the contracts. Although we negotiated with teams drawn from NHSE and individual hospital trusts, it was increasingly apparent that they had little autonomy to explore options outside of a strict mandate enforced by the DH, and that this mandate was often constrained by Treasury restrictions and requirements. This removed any opportunity to jointly develop imaginative solutions to the issues identified in the heads of terms for both sets of negotiations. As a result, all too often the BMA found itself negotiating with representatives of the Government insistent that we agree their red lines – while ignoring those we knew were important to our membership – rather than partners determined to find solutions to benefit patients while being fair to doctors.

We urge you to consider the evidence on its merit and look at it beyond the unrealistic restrictions expressed in your remit letter.

We answer each of your questions in turn below.

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² Question 13 of the Review Body on Doctors’ and Dentists’ Remuneration, Special Remit on Contract Reform for Consultants and for Doctors and Dentists in Training: Call for Evidence
³ DDRB remit letter from the DH, 30 October 2014
1. What were the pay-related issues in the consultant contract negotiations for which agreement could not be reached? What proposals were put forward? How do these proposals link to the heads of terms?

The heads of terms agreement identified a range of areas of the contract to be addressed in negotiations. These were: seven-day services, pay progression, CEAs, SPAs (supporting professional activities, flexible working, and study leave among other issues. The vast majority of the time spent in the negotiations focused on seven-day services and pay progression. Latterly, some time was spent on examining a possible replacement to the CEA scheme and there was a small amount of time allocated to professionalism and SPAs. Below we set out a summary of the pay-related issues on which agreement could not be reached. More detail on each point is provided in Annex A of this submission.

The limited scope of the negotiations and cost neutrality

The DH and NHSE appeared to adhere to some parts of the heads of terms and not to others. Although the BMA recognised that affordability was a constraint from the outset the Government’s desire to achieve cost neutrality only became explicit through the course of the negotiations. Some areas which reinforce quality such as SPA time and study leave were not given adequate time in the negotiations.

The negotiating process and focus

The negotiations focused almost entirely on the removal of S3P6 from any new contract and moving away from the current pay structure – both of which were political priorities for the Government. The BMA sought to focus on what resources would be required to facilitate the delivery of more seven-day services. Our concerns about the lack of support, diagnostics, administrative and community services available across seven days – all necessary for the expansion of clinical services - were largely ignored.

BMA concerns about ongoing real terms pay cuts

Any deal would have to be supported by affected members of the BMA. After years of real terms pay cuts, attacks on pensions and CEA investment, consultants feel unwilling to reduce their pay and conditions further.

Linking pay to contribution rather than time served

Both sides were willing to explore changing the pay progression system for consultants in England and Northern Ireland. Discussions progressed relatively well although the BMA was concerned about the proposed mechanisms for determining whether a consultant should progress. The BMA was particularly concerned that financial limits on employers rather than fair assessment of merit would be a key factor in a replacement pay progression system.

Using the contract to save money

The Government wanted to move money around within the system to pay for increased seven-day services. It was never clear how the Government thought that it was realistic to ask for more work to be done without paying for it. The BMA was concerned that this would mean removal of resources
from other areas and specialties. The association was especially concerned at the low rate of pay being offered for out-of-hours work.

**Implementation of new contract**

Despite the heads of terms being supportive of a national contract, many of the proposals put forward would increase the decentralisation of parts of the contract such as pay and CEAs. This was in contrast to the statement in the *Handbook to the NHS Constitution* that national pay policy for the NHS is ‘designed to provide fair, affordable pay in order to recruit, retain and motivate staff for the benefit of patients and to provide value for money for taxpayers’.

The BMA was concerned about local flexibility in application of the contract resulting in a postcode lottery for consultants and, potentially, patients. The BMA was unconvinced NHS HR departments would be able to introduce and smoothly run a more complex pay system given the problems with implementation of the 2003 contract.

**The lack of credible evidence**

The DH and NHSE failed to produce credible evidence demonstrating how much expansion of seven-day services would cost the NHS and what the pay implications would be for individual consultants. This is particularly concerning in the context of an overarching lack of detail from the Government about how it is envisaged expanded seven-day services would be resourced.

**Transitional arrangements**

The BMA was concerned that transitional arrangements were to be funded through the pay envelope – an envelope which might not have been properly calculated.

**Contractual safeguards for out-of-hours working**

The BMA was willing to negotiate the removal of S3P6, but only in exchange for strong contractual safeguards guaranteeing rest periods (referenced later in answer to question 9 among others), a voice in service development and other protections to ensure consultants were not overtired when treating patients.

As stated in the introduction, further detail on each point is provided in Annex A of this submission.

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4 Department of Health. The Handbook to the NHS Constitution. March 2013
2. What are your views on the recommendations and observations as set out in the DDRB’s report *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*?

The BMA’s detailed views in response to the DDRB’s report on CEAs and how they might apply in England and Northern Ireland are set out in Annex B to this submission.

The principle that the DDRB recommended, whereby consultants should continue to receive reward over and above their basic salary, is one that the BMA supports provided that any replacement scheme is based on a national structure with a ringfenced pot of money to maintain it. However, it should be clarified that, as stated in the executive summary, this evidence submission only applies to England and Northern Ireland, and not to Scotland and Wales.

The BMA supports the DDRB’s recommendation that all employing organisations should have a rewards scheme in place and believes that a national structure should apply to all organisations as this would introduce some degree of equity across employers. The BMA has concerns about employers moving away from a central mechanism because employers could be motivated to save money intended for rewarding excellence, thus leading to a downward spiral of reduced excellence, recruitment problems and further financial difficulties.

Where possible rewards should be based on assessment of measurable targets linked to individual objectives within a fair, transparent and equitable system. The BMA supports a stronger link to performance with improved links to measures of activity, quality of patient care, patient feedback, cost and a clear definition of excellence for each discipline. This is particularly important given that many consultants do not have patients registered under their own name and thus could be potentially disadvantaged under a CEA system. We believe that the association must be centrally involved in developing such mechanisms if they are to have perceived legitimacy among the medical community. Currently, measures of activity and quality are inadequate and this must be addressed. This is an area of work in which the BMA has experience and expertise.

The DDRB’s report was written before the changes to the NHS pension scheme came into place. As part of a CARE (career average revalued earnings) scheme, it is perfectly possible and even desirable to make the award pensionable even if its value is removed in subsequent years. The BMA believes that it is not, therefore, appropriate to suggest that further pension reform is necessary within the CEA scheme given the much more widespread changes outside the scheme.

The fact that CEAs are now reviewed and can be taken away without pay protection has resulted in some consultants losing tens of thousands of pounds annually and the additional loss of contributions to their pensions. They will have paid pension contributions at increasing rates but will derive no pension benefit from these contributions.

Local award committees must continue to have a majority of clinicians on them in order that consultants are judged by their peers, who are best placed to assess the quality of the work delivered. While some management and lay person input is appropriate, it is essential that any judgement of clinical performance must be made by those who understand clinical performance. Clearly, this must be considered in the context of service delivery and the patient experience but that does not require a lay majority and may be impeded in its aim of providing an objective assessment by a lay majority.
The BMA supports a national structure governing a reward mechanism for NHS consultants in England and Northern Ireland which promotes clinical excellence in all its forms. The gradual trend towards increasing employer freedoms regarding the governance of the scheme has been haphazard and often driven by financial concerns. For this reason, the BMA supports a return to a clear national structure with limited scope for local interpretation written into the contract. This would encourage consistency, promote excellence and limit the scope for financial considerations dominating over all others. The mechanisms by which consultants’ work is assessed need to be much more standardised and centralised so that the scheme is more transparent and fairer than it is now.
3. What evidence do you have on other sectors which provide seven-day services, and what is your justification for such comparators?

Credible evidence is a prerequisite for implementing any policy change to the NHS on the scale of seven-day services. The BMA welcomes meaningful comparisons with other sectors, as this can contribute to the body of credible evidence. However, as we set out in more detail in our answer to question 6, the Government is yet to articulate a clear definition of how seven-day services would work in the NHS in England and Wales. We would, therefore, caution that careful consideration needs to be given to the comparisons that are made. There have been suggestions likening providing NHS services over seven days to Tesco supermarkets opening seven days a week; these take no account of the challenges faced by the NHS in implementing seven-day services. Indeed even supermarkets do not operate at full capacity or offer a full suite of services throughout the day, seven days a week. The challenges the NHS faces are articulated fully elsewhere in this written evidence submission.

In-depth research will provide more appropriate comparisons. For example, we believe airline pilots offer a sensible comparison when looking at contractual safeguards around sufficient rest and working hour restrictions. The BMA welcomes the research that will be carried out by Incomes Data Services commissioned by the Office of Manpower Economics about the arrangements and pay for seven-day working in several sectors across the UK economy. While this research was commissioned explicitly for the NHS Pay Review Body and the staff groups they advise upon, we believe some of the findings may be applicable to doctors, although the appropriate sectors for comparison are unlikely to be the same.

The findings of this research would contribute to the body of credible evidence required before the NHS implements seven-day services. However, it must be emphasised that implementing seven-day services is a multi-faceted change process and this is just one element of the evidence and modelling that is required to implement seven-day services in a way that is best for patients, fair for doctors and sustainable for the NHS. The BMA wants to work with the Government and all other relevant stakeholders to develop this evidence base.

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5 NHS will order doctors to work at weekends, Sunday Times, 16 December 2012
www.thetimes.co.uk/sto/news/uk_news/Health/article1177687.ece
4. What were the issues in the doctors and dentists in training contract negotiations for which agreement could not be reached? What proposals were put forward? How do these proposals link to the heads of terms?

The BMA has answered questions 4 and 5 together, below.

5. What pertinent information do you have on the working patterns of doctors and dentists in training?

Introduction

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. The heads of terms, published in June 2013, outlined a wide-ranging and challenging scope for negotiations, including a shared commitment to explore how the contract could be improved to make it fairer, simpler to administer, and more transparent, in particular in relation to the current system of banding. The Government was also clear that discussion would include exploration of alternatives to the current model of pay progression, and, moreover, that any changes agreed must be delivered within a fixed cost envelope.

Our key aims in negotiating a new contract were to:

- Improve the quality and safety of patient care and improve the professional lives of doctors in training
- Enshrine high-quality training within the contract and avoid disincentivising training in particular specialities
- Be simpler to understand and administer
- Ensure doctors in training are fairly rewarded for the work they do
- Maintain the per capita average pay of doctors in training, across the duration of training and during any transition period.

Below is a summary of the issues discussed, the BMA’s proposals and relevant information to support our position. More detail on each of these points can be found in Annex C.

Work patterns and systems of pay

NHSE and the BMA entered negotiations with the shared goal of agreeing a simpler and more predictable system of pay and an effective system of ensuring safe and fair work patterns. Our priorities were ensuring any new system incorporated effective safeguards to ensure safe working hours for junior doctors and which addressed current concerns about the monitoring of hours and the lack of financial stability for junior doctors.
In negotiations, we looked at a number of different models of pay that we hoped might improve on, or at least match, the effectiveness of banding. Intensity of working was considered and discarded due to lack of simple metrics and the inherent complexity of implementing an intensity-based system of payment. An alternative discussed during the negotiations was a pay framework based on an underlying hourly rate of pay.

However, a lack of robust data and modelling meant we had serious concerns that such a system would risk disincentivising training in certain specialties by not recognising antisocial working patterns. In addition, such an hours-based system has the potential to greatly add to the complexity of the pay system. Careful consideration as to how an hourly rate would operate in practice is also required; for example how unplanned activity not authorised in advance is remunerated.

We are prepared to consider this model further but, as noted above, we were unable to do so properly in negotiations because of a lack of relevant data meaning that we risked designing a system which could fundamentally destabilise medical recruitment. In the absence of such data, the BMA would recommend key improvements to the current system of banding. In particular, the current bands should be restructured to better reflect the needs of junior doctors and the service today and a simpler and more transparent system of monitoring introduced to reduce costly and unnecessary disputes. Our detailed recommendations can be found in Annex C.

**Safer working hours**

Safety – for patients and doctors – must be at the heart of any new contract. ‘Safe working hours’ was one of the key strands of our negotiation with NHSE.

In the heads of terms, we agreed that a new contract would ‘deliver both safe working patterns and safe total hours of work’. Linked to this, we also agreed to ‘investigate limiting the number of actual working hours (as defined by statute) in a defined (in days) period’.

We proposed a number of new contractual safeguards against excessive working hours. The safeguards we proposed are outlined in detail in Annex C, but included a maximum shift length of 13 hours, as per the current WTR (Working Time Regulations), a maximum number of consecutive day or night shifts of up to 13 hours that can be worked, as well as a new contractual reference period for the 48-hours average.

These issues were exacerbated by NHSE’s insistence on an extension of plain time to cover 7am to 10pm, seven days a week, without sufficient consideration of the impact on patient safety and the welfare of doctors in training, or a broader and coherent model of seven-day services, discussed in more detail earlier in our evidence.

Unlike consultants, there is no opt out to choose not to work outside of plain time for doctors in training. Any extension to plain time is therefore a cost-cutting measure and not about greater service provision. Any extension to plain time will see doctors in training regularly working these ‘antisocial periods’.
Pay progression

As they progress, doctors in training gain valuable skills and experience. The current model of pay progression recognises the increased contribution doctors in training make as they progress.

However, the removal of public sector pay progression in England is a political priority for the Government and, in negotiations, at the request of NHSE, the BMA developed a number of alternative models of pay progression.

It is important to note that the Scottish Government’s position is different and health, well-being and sport secretary Shona Robison’s remit letter to the DDRB states ‘the Scottish Government does not require the end of automatic progression, but will be willing to consider any system which is considered fair and equitable’.

However, NHSE was only willing to consider its own proposal which linked pay progression to a trainee’s current post. We had serious concerns that such a model would result in widespread pay fluctuation, and would disadvantage those taking time out of training as compared to the current model. This would include those taking maternity, paternity or sickness leave, who train at a less-than-full-time rate (for example due to disability or caring commitments) and those pursuing academic courses, including PhDs.

Crucially, the BMA repeatedly emphasised the importance of data on training pathways to ensure the contract reform was cost neutral. Unfortunately, NHSE was unable to provide any data on how trainees progress through their training. Over time the proposed model would result in a reduction to the total pay envelope, as doctors in training remain on the same pay points for longer. We were clear that, in line with the heads of terms, these savings should be reinvested into the doctor in training pay envelope. NHSE and the Government were not prepared to give this commitment.

Funding of the contract

The pressures on NHS funding pose a serious threat to the sustainability of NHS services and the delivery of safe, high-quality patient care. In spite of the DDRB’s own recommendations, NHS employees continue to experience real terms pay cuts. We believe it is possible to develop a new contract that, in and of itself, does not cost any more than the current contract.

However, NHSE was not prepared to recycle direct savings that would have been made from a new contract back into the envelope beyond a short and unspecified transitional period. This would lead to a gradual erosion in the value of the junior doctor contract.

Other key BMA proposals in negotiations

- Work scheduling, work reviews and exception reporting: The current doctor in training contract does not give adequate attention to issues of training. The BMA proposed a system of work scheduling, work reviews and exception reporting. Such a system would help employers and trainees ensure high-quality training, planning for the efficient delivery of clinical services and monitoring hours worked/training received.

- Leave: In line with the Government’s desire to remove ‘time served benefits’ from the doctor in training contract the BMA proposes that all doctors in training should receive the same annual
leave allowance (30 days). We also proposed minimum study leave and expenses for training and development, and strict limits on fixed leave

- **Expenses**: Provisions related to expenses should be made clearer and those relating to public health trainees maintained

- **Period of grace**: The period of grace provision should be codified in the contract to allow smooth transition between the grades and maintain local workforce links

- **Fees**: The current provisions relating to fees should be retained for doctors in training

- **Structure and maintenance of the contract**: The BMA is seeking to incorporate all relevant provisions into any new or revised contract

- **Information on future placements (code of practice)**: The BMA would like to see provisions to define the level of information that employers should be providing to doctors in training at the relevant stages of the recruitment and employment process

- **Pay protection**: Pay protection is crucial for any doctor who retrain in a different specialty. We believe the skills and experience gained through training should be transferred into a new training post, and this should be recognised by protecting their pay

- **Professional costs and salary packaging**: The contract should explicitly say that junior doctors are in training. This would reduce the ambiguity as to whether training costs are deductible. In addition, we would like to introduce a salary packaging arrangement, often known as salary sacrifice, which could be put towards training, as well childcare, travel and other uses.
The following questions deal with seven-day services. For the reasons outlined above, the BMA response is only applicable to the situation in England and Northern Ireland and should not be interpreted as covering either Scotland or Wales.

6. What are the services that the NHS would like to be able to provide seven days a week, but which it does not provide at the moment, and why?

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 for this scale of service delivery change. 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 priority for seven-day services

Currently many services do run seven days a week and, indeed, around the clock, as we describe in detail in the next question. However when extending these services, there needs to be some process of prioritisation as a full NHS service 24 hours a day, seven days a week, is neither desirable nor feasible:

- It is not desirable because it would be wasteful – the costs of implementation would outweigh the benefits; there is no clear clinical argument for extending many services across seven days; and it would likely induce demand for NHS services that is not currently present. It is unlikely that patients would want or need that level of service. Furthermore, as we will discuss in detail later, attempting to forecast what future demand for seven-day services might be is extremely difficult, particularly as the focus moves away from secondary care and towards treating patients within the community
- It is not feasible given the funding crisis the NHS currently faces in delivering its present services
- Even with extra investment, it is imperative that any additional or reallocated direct clinical contact with patients is not achieved at the expense of other elements of doctors’ time. For the health service to innovate and make sustainable progress, and for doctors to develop their professional skills, it is critical that consultants have protected time for education and training, and sufficient SPA time within normal weekday working hours to provide the clinical leadership needed.

The BMA would like clarification on the Westminster Government’s and NHS England’s priority aim of implementing seven-day services, be that patient safety, patient experience, convenience and access or political gain.

At times, rhetoric has confused the huge difference between services that are justified on clinical quality grounds, such as to correct for heightened mortality rates at the weekend, and those which are designed to improve access from a patient convenience point of view. The BMA believes that the former should be prioritised, informed by robust evidence on how to correct the problem; whereas the latter should be considered both within the wider financial context and a cost-benefit analysis perspective given that the extra funding required might be used to better effect elsewhere in the
system. This would ensure that implementation of seven-day services achieves the most it can for patients given finite resources.

As will become apparent throughout the rest of our evidence, it is very difficult to make comments on the likely costs, the impact on patients, the effects on staff and recruitment for future posts without a clear vision for a future seven-day service.

Such a vision would include the services we propose to provide seven-days a week and the workforce model for delivering them, including the other support services (and associated staff) they rely upon. This vision would have to be underpinned by robust evidence at each step. For example the services we propose to provide and the staff mix providing them should have a previously demonstrated impact on clinical outcomes. These services should be assigned a total cost and provision decided on cost-benefit calculations compared with other proposed seven-day services.

For example, the Seven-Day Services Forum’s initial focus on urgent and emergency care was, we consider, correct, as it is where the bulk of the evidence of a ‘weekend effect’ on mortality rates can be found. However there is an absence of robust data on how to correct for this ‘weekend effect’. It would be wrong to assume that simply increasing specialist presence at the weekend will solve this: there are myriad other essential confounding factors that need to be taken into account. Following that, services aimed at improving patient access should be considered following a rigorous cost-benefit analysis.

While the BMA welcomes the acceptance that a ‘one size fits all’ approach will not be appropriate to every local area, we do believe that more clarity on the framework in which seven-day services will operate is needed to achieve such a fundamental shift in the way the NHS operates. We agree that seven-day services will operate differently in different parts of the country and believe that in some areas, for example, networks of trusts working together will be the only feasible service model. However, we do believe that greater clarity on the framework in which seven-day services will operate is needed to enable local areas to do this.

There has not yet been a real public debate on what sort of seven-day service patients want and what value they would attach to such services. The public’s views ought to be sought and taken into account if the proposals for seven-day services are to have credibility.

The issues around the provision of services on a Saturday, on a Sunday, and through the night are markedly different, not least, we suspect, in the public’s appetite for attending at hospital for outpatient consultations and elective services. For brevity these issues are grouped together in this submission but when more detail becomes available on the proposed seven-day service model, the different enablers and barriers to providing a service on a Saturday, on a Sunday, and through the night need to be explored. No model of seven-day services could proceed to successful implementation in the absence of a shared understanding between the BMA, NHSE and other stakeholders of the enablers and barriers to success.

The risks of proceeding without credible evidence

Credible evidence is needed before a significant policy change is implemented in the NHS, particularly on the scale of seven-day services. The BMA would caution against commencing 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. Ill-thought-through implementation could threaten both the standard of service patients receive and the viability of the service. Therefore, we believe robust modelling and testing is urgently required, which would give greater clarity on both the framework and the implementation and ongoing running costs.

A focus of evidence development should be how to achieve clinical benefits for patients. There is currently an absence of data in this area. We need to know more about how to maximise clinical outcomes for patients by implementing seven-day services, which should inform the services that are prioritised for implementation ahead of others.

The BMA is also concerned about whether one part of the system can operate seven days a week or whether entire system change is needed across the whole health and social care system. Proposals for seven-day services must be considered in light of current policy developments, such as the Five Year Forward View, and tested against a changing landscape. Our concerns require further investigation, using properly evaluated seven-day service pilot schemes, the findings of which should be used to inform planning for implementing seven-day services.

Overall there is simply not enough credible evidence available to determine what services the NHS should provide seven days a week. A body of credible evidence, such as robustly evaluated local pilot schemes, is necessary for implementation. The BMA therefore strongly feels that it is currently impossible to make an informed decision about the seven-day service model the NHS should operate, which renders strategic planning for implementation impossible. Furthermore, we believe that pursuing an ill-informed seven-day service model would be, at best, wasteful for the NHS and, at worst, threaten patient safety. Implementation of seven-day services should enhance patient outcomes and experience, be sustainable for the NHS and fair for doctors.
7. What seven-day services/antisocial hours’ services are currently provided and what is the cost differential compared to normal working hours?

A large number of doctors work across seven days of the week. However there is no complete picture of seven-day working across trusts and specialties. Without a more extensive and wide ranging assessment of doctors’ working patterns, we cannot form a properly-costed model of seven-day services. The BMA believes a properly-costed model for seven-day services is a prerequisite for implementation, otherwise the model risks being unsustainable for the NHS.

Doctors’ working patterns

Many doctors provide services across seven days of the week and throughout the night.

However, no data source provides a complete picture of seven-day working across trusts and specialties. The BMA was able to use data on doctors in training in the form of a rota data collection exercise from NHSE and consultants from a survey conducted by the BMA. However, neither source provides a complete picture of seven-day working. For this, a comprehensive workplace diary exercise would be needed.

Instead, we have limited information about the patterns that doctors work. We know, for example, that on average doctors in training will work approximately a quarter of their time outside of plain hours and that this varies considerably by specialty with doctors in some specialties working a considerably greater proportion of their time outside plain hours.

The BMA’s survey of consultants showed a high proportion of consultants reported being on call during a Saturday or Sunday in the last week they worked. Those on-call at the weekend were more likely to receive calls, have to attend hospital and spend longer in hospital when called to attend than those in the week. We also know that consultants working in urgent care specialties are more likely to report working at antisocial times.

The doctor in training rota data covers approximately 30 trusts and is too narrow to allow us to fully explore the data by specialty or model seven-day working comprehensively. The BMA’s consultant survey attracted sufficient response for a margin of error of 2 to 3 per cent for most high-level analyses. Nevertheless, the data lacks granularity in patterns of work for some specialties and is relatively insensitive to variations in consultant presence across the full spectrum of plain and premium time. For these reasons we cannot assume that our surveys can directly inform a fully-costed model of consultant seven-day services. The BMA believes that a more extensive and wide ranging assessment of the working patterns of consultants is needed to contribute to the credible evidence required to inform the implementation of seven-day services.

Payment for out-of-hours work

In terms of cost, consultants are effectively paid time and a third for the service they are contracted for during antisocial hours (premium time 7pm-7am in the week and at weekends) when one PA

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6 NHSE, Juniors On-call Data Collection Exercise, July 2014
(programmed activity) measures three hours, compared to four hours otherwise. Consultants do generally work beyond their contracted hours, in order to meet the needs of their patients. Currently, non-emergency work in evenings and at weekends can only be scheduled by mutual consent of the employer and individual consultant.

At present, doctors in training are not paid an out-of-hours rate but are likely to be in a higher pay band if they work on a rota with greater out-of-hours commitments. From the available data, it is not possible to say what the cost differential between normal working hours and providing seven-day services are for junior doctors as a whole. The extent to which we can do this for specific working patterns is described in Annex C. As discussed extensively above, there are problems with the proposed alternatives to pay banding from NHSE regarding seven-day working. Better and more credible evidence is required to understand this before implementation of seven-day services.

In an attempt to add to the evidence, NHS England commissioned Deloitte to look at seven-day service cost implications. While welcoming any attempt to inform the debate, Deloitte’s research is based only on three local health economies and, accordingly, we have concerns about upscaling these findings to paint a national picture.

At present there is no data source that provides a comprehensive picture of which doctors work during antisocial hours. While it is widely acknowledged that those in training work a considerable amount during antisocial hours, we have insufficient data to analyse this information by specialty. For consultant doctors, we know that many are working, whether resident or on call, during the night and at weekends but our data is insufficient to model seven-day services. Without a more extensive and wide ranging assessment of their working patterns, we cannot form a properly-costed model of seven-day services. Again, this evidence is required to inform necessary planning before seven-day services are implemented.

In summary, without a more extensive and wide ranging assessment of doctors’ working patterns, we cannot form a properly-costed model of seven-day services. The BMA believes a properly-costed model for seven-day services is a prerequisite for implementation, otherwise the model risks being unsustainable for the NHS.

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8 In the 2013 BMA consultant survey respondents self-reported working an average 6.6 unplanned hours during their most recent full working week. Unplanned hours referred to hours not agreed in a respondent’s job plan and/or may not be paid.
8. **Which staff groups will be needed to provide the desired seven-day services and what will be the impact on staffing levels on each day of the week (ie what is the model for the workforce)?**

The workforce requirements for seven-day services are currently unknown. Credible evidence needs to be developed to fill this information gap. All types of doctors are likely to be affected by a roll out of seven-day services. The BMA recommends that a credible workforce model is developed as a matter of urgency and we will work with all relevant stakeholders to achieve this.

If resources are to be shifted from weekday services to the weekend this will have an unknown impact on current services. It is likely that extra resources will be required to deliver seven-day services.

**Staff groups**

As stated in response to question 6, without clarification on what the desired seven-day service model would be for the NHS, it is impossible to predict the workforce model required. In lieu of a clear and detailed blueprint for seven-day services, we are unable to answer conclusively many of these further questions set out by the DDRB.

In terms of doctors, the vast majority are likely to be affected. This evidence will focus on the possible impacts on doctors in training and consultants, although these cannot be conclusively identified until we know what model(s) of seven-day services are proposed.

For example, there is a real possibility that providing additional services at the weekends will lead to services being under-resourced in the week, with associated risks to patient safety, quality of clinical and patient care, and patient experience.

In addition, a wide range of other staff groups will be required to implement a seven-day service, including nursing staff, allied health professionals and therapists. However, the breadth of staff groups required to deliver a full-seven-day service is much wider; including diagnostics, laboratory and pharmacy staff, as well as receptionists, cleaning and catering teams and other building support staff. It will also include managers and those in HR roles, who may not currently work or be prepared to work across seven days. Outside of the hospital setting, it will include community and social care teams, potentially primary care providers, social services staff and nursing home staff, who may not currently be set-up to admit at the weekend.

In fact, the lack of additional support services is a source of frustration for doctors who currently work at the weekend, as are other issues, such as the lack of childcare facilities provided at the weekend – we are unaware of any hospitals with open nurseries at the weekend, for example. All of these associated staff groups would need to be included in workforce modelling and cost-benefit analysis work.

For some of these groups there will be minimal impact. Some employees may be able to increase the number of shifts they work in a week without affecting their working pattern on other days. Others will already be working the maximum number of hours they can in a week. They will therefore not be able to increase the number of shifts they work and resource will have to shift from other days of the week, or extra resource invested to cover periods over the weekend.
Shifting resources

We are concerned about shifting resource from other days of the week as most services do not operate with significant excess capacity at present. Leaving services under-resourced during weekdays could have serious safety implications for patients and lead to worse outcomes. Policymakers need to ensure that the introduction of seven-day services does not undermine NICE (National Institute for Health and Care Excellence) guidance on safe staffing levels published in the wake of the Francis Inquiry into failings at the Mid Staffordshire NHS Foundation Trust 9, that the NHS has only recently started to address systematically. In the absence of detailed workforce modelling it is impossible to quantify these risks but they must be kept in mind throughout the discussion. Getting this wrong has the potential to undermine the good work that has been done in response to the Francis Inquiry. Planning for service delivery change on the scale of seven-day services must take into account recent service improvements that are designed to prevent patient safety breaches, such as those seen at the Mid Staffordshire NHS Foundation Trust.

Extra resources

We are concerned at the constraint placed upon the DDRB’s remit – to look at services without increasing existing spend – as we believe that extending a service to seven days will necessarily require additional investment in the NHS.

It is difficult to see how investing in extra resources is possible without increasing existing spend. Besides, additional staff resource from many of the necessary staff groups will be difficult to resource in the short term due to the lengthy training periods necessary for producing highly-skilled doctors, nurses and other health workers.

In summary, as outlined in our answer to question 6, to date no credible and comprehensive seven-day service model has been produced by those in a position to do so. A systematic data collection exercise of working patterns completed by employers is necessary to inform the evidence base required to plan for implementation of seven-day services. In the absence of this it is not possible to design a workforce model.

A workforce model needs to understand there will be a huge difference between the staffing implications of designing a seven-day emergency and urgent care model and a seven-day elective care model, for example. However for any seven-day service, the staffing implications will be varied and wide-ranging as demonstrated above and we would stress the importance of accounting for the breadth of these implications. Overall, the BMA believes that without significant resource investment, a seven-day service will not be possible without compromising and/or re-evaluating existing service provision in the NHS. There is a real risk that patient safety could be compromised in the week if the Government attempts to implement seven-day services without additional resource investment.

The BMA recommends that a credible workforce model is developed as a matter of urgency and we will work with all relevant stakeholders to achieve this.

9. What are the pay, staffing and motivational barriers and enablers to seven-day services in the NHS? Are there examples of how any of these barriers have been overcome?

It is difficult to answer a hypothetical question on the pay barriers and enablers to seven-day services in the NHS in the absence of a clear understanding of the model(s) proposed, any credible evidence on what that model is likely to cost and what those changes will mean for doctors. However working with clinicians to design a seven-day service and securing their engagement in the process is vital; without it any seven-day service reconfiguration is unlikely to be successful. Examples of the introduction seven-day services can be found in a number of specialties such as intensive care, obstetrics and gynaecology and the provision of stroke services. In these examples, the increased coverage has been developed through partnership between doctors and trusts without the need for contractual change.

We know from our research, as outlined in question 8, that doctors in training and consultants provide services at the weekend in the emergency and elective setting. However, there are limits to what our data can tell us and we believe a more comprehensive workplace diary exercise would contribute to the credible evidence base required to plan for seven-day services. Replicating the best aspects of seven-day services at present, such as clinician engagement in identifying a real need for a service, will be a key enabler in implementing seven-day services in the NHS.

For consultants, the majority of antisocial hours work will have been paid at time and a third and non-emergency work is scheduled by mutual consent of employer and individual consultant. It is unclear how their motivation would change if the nature of the work altered significantly ie became compulsory, but it is clear that imposing working conditions upon doctors runs a strong risk of demotivating them. Moreover, while pay is only one motivator, anecdotal evidence from consultants, heard for instance at BMA deliberative events in spring 2014 on the value of doctors, suggests that a significant increase in antisocial hours working would open up the issue around the rate paid for premium time working. We are prepared to negotiate on the removal of S3P6 if contractual safeguards and fair rates for antisocial hours working were established.

For doctors in training, while those rotas with greater out-of-hours commitments often sit within the higher pay bands we do not have sufficient data to analyse rota patterns by specialty. Therefore we do not know how pay motivates seven-day working, if at all. Having a better understanding of this would help to inform planning for implementation of seven-day services.

**Motivation: engaging doctors in seven-day services**

Research, both within the BMA and externally, has shown that pay is one of a range of factors important to motivating doctors that should be taken into account. When asked why they chose their specialty the most regularly cited reasons by a cohort of 2006 medical graduates were enjoyment or interest in a specialty, or that a specialty provided variety and a challenge\(^\text{10}\). In addition, 98 per cent of cohort doctors strongly agreed or agreed that work-life balance was important to them, and is a key determinant of career choice\(^\text{11}\). A belief and interest in the service they are delivering, and a good

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\(^{10}\) Career Choices, Findings from BMA Cohort Studies, August 2012, BMA health policy and economic research unit

\(^{11}\) Seventh Report, Cohort Study of 2006 Medical Graduates, April 2013, BMA health policy and economic research unit
work-life balance are clearly important motivational factors which will have to be taken into account when thinking about the enablers for seven-day services in the NHS.

Therefore, engaging doctors in the design of a seven-day service, as opposed to imposing such a service upon them, will be a key enabler to providing seven-day services in the NHS. The BMA believes that clinicians and other staff delivering day-to-day services are often best placed to devise effective means of extending these services where necessary; they have a unique understanding of the needs of patients in the local health economy in which they work. Furthermore, as has been raised by the Seven-Day Services Forum and others, such a fundamental change to how the NHS functions cannot be done without the buy-in of staff: ‘Moving to the delivery of a consistent high quality service every day of the week requires a significant cultural shift ... To succeed, widespread support for the clinical standards and the introduction of seven-day services is needed.’

This is particularly important given the pressure the NHS is facing and the morale of staff that, according to our research, is at its lowest level since we started regularly collecting data through our quarterly omnibus survey. The results from our most recent omnibus survey, Q4 2014, showed that average morale among doctors has declined from 2.9 out of 5 to 2.5 over the last year and only 20 per cent of all doctors reported being satisfied with their current career when asked about their future intentions. This highlights the potential risk of skilled staff emigrating or leaving the profession if changes are forced through without proper clinical engagement. This risk may be exacerbated if service reconfigurations worsen work-life balance for doctors, which our surveys suggest would have a further negative impact on morale. Moreover, any service reconfigurations are unlikely to be successful without the support of medical staff.

**Welfare of doctors and patient safety**

Without investment in additional resource in terms of staffing numbers, and contractual safeguards to protect the health of both patients and practitioners, there is a risk of overstretching already tight resources. For example we have concerns that, were doctors to work increasing amounts at night and the weekend without sufficient rest, they are likely to become sleep deprived. The BMA fears this could threaten patient safety. More detail is provided in Annex E.

There are numerous studies demonstrating the negative effect of sleep deprivation (both acute total and chronic partial) on attention and working memory that we believe could apply to a medical setting. Studies have shown that long-term shift work is linked to impaired cognitive functioning with effects on memory and processing speed.

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12 NHS Services, Seven Days a Week Forum, Summary of Initial Findings, December 2013, page 21
14 Using a five-point scale (1= very low, 3 = moderate, 5=very high)
17 Chronic Effects of Shift Work on Cognition, Jean-Claude Marquié, Philip Tucker, Simon Folkard, Catherine Gentil, David Anstiau, Occupational and Environmental Medicine, 3 November 2014
There is a significant body of evidence to suggest a link between fatigue and reduced performance.\(^{18}\) There are also potential health implications for doctors working such hours and employers have a responsibility for the health and well-being of their employees. Various studies have shown a link between sleep loss and adverse metabolic traits and a growing number of experiments are suggesting this is a causal relationship.\(^{19}\) Implementation of seven-day services cannot be at the expense of the welfare of the doctors delivering that service.

Taken together the studies outlined in Annex E present a compelling argument for managing doctors’ workloads carefully. The need for sufficient, regular compensatory rest for doctors whose sleep is disturbed should be met by contractual safeguards. This was an issue which arose during both sets of negotiations but was never resolved. The BMA feels safeguards should be guaranteed in contracts as there is evidence from our consultant survey that they are not currently implemented when included in the form of guidance. The potential threat this poses to patient safety is not to be underestimated. Further, it is hard to understand why it would not be acceptable to include safeguards in employment contracts.

Our consultant survey\(^{20}\) showed the vast majority of consultants never had access to compensatory rest following a night spent on call when their sleep had been disturbed. Seven in 10 of all respondents (71.1 per cent) reported they never had access to compensatory rest while a further one in 10 (10.2 per cent) replied that such rest was rare. Just one in 10 respondents (10.5 per cent) reported that they always or most of the time had access to compensatory rest.

What is more, the availability of compensatory rest was no different for consultants whose employer considered seven-day service provision a ‘high’ versus ‘normal’ priority.\(^{21}\) This highlights the need for compensatory rest requirements to be included as contractual safeguards as there is no guarantee doctors will have access to compensatory rest without such safeguards even in trusts where seven-day services are a ‘high’ priority.

**Safeguards for patient safety**

Comparing medicine to other sectors suggests that providing such safeguards in both the doctor in training and consultant contracts will be a key enabler to delivering a seven-day service in the future. During the negotiations, the BMA highlighted the comprehensive protections provided to airline pilots to guard against fatigue. As professionals who have undergone a significant period of training and who are responsible for the safety of their passengers, pilots are well placed to serve as comparators to consultants. In the aviation industry, BALPA (British Airline Pilots’ Association) has campaigned for flight time limitations to guard against fatigue compromising safety in commercial air travel. They believe that ‘the UK has one of the best safety records in Europe thanks, in part, to a strict set of “flight time limitations”’.

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\(^{19}\) The Metabolic Burden of Sleep Loss, Sebastian M Schmid MD, Manfred Hallschmid PhD, Bernd Schultes MD. The Lancet Diabetes & Endocrinology, 25 March 2014 DOI: 10.1016/S2213-8587(14)70012-9


\(^{21}\) Respondents separated into two groups according to the priority given by their employing trust to progression towards seven-day services in the NHS England survey

\(^{22}\) [www.balpa.org/campaigns/flight-time-limitations.aspx](http://www.balpa.org/campaigns/flight-time-limitations.aspx)
The safeguards the BMA was seeking to introduce into the contract were similar and included: limits on working hours, rest breaks and compensatory rest, and limits on weekend working. That air passenger safety in the UK appears to have benefitted from the introduction of clear national standards suggests, due to the similarities outlined above, that patient safety may benefit from clearer safeguards being written into the contracts of those who are responsible for their care.

In summary, the motivational barriers and enablers to seven-day services are much wider than pay alone. Clinical engagement and buy-in to service change are vital if this change is to be successful, especially at a time when staff morale is so low. There are also significant risks to patients and doctors from extending an already stretched service. The BMA believes that safeguards to combat these risks must be placed in contracts to guarantee patient safety and enable seven-day services to be implemented.
10. What evidence do you have on the willingness of staff to work on every day of the week? Does willingness vary by staff group, and/or by the availability of premium payments? If so, how?

Neither we nor the Government know how willing staff will be to work on every day of the week because we do not know which services they will be providing, how this will fit into their work pattern in terms of working hours limits and compensatory rest, and how they will be remunerated. Credible evidence is needed in this area.

Both doctors in training and consultant doctors currently work at weekends and on public holidays, as described in question 7, although predicting how this is likely to change in the future is extremely difficult. For example, many consultants provide elective care services at the weekend at present; however, if this became mandatory and imposed upon them as opposed to voluntarily and through a constructive dialogue process, this goodwill may change causing some to reconsider their commitment to this service. Answering such hypothetical questions definitively in the absence of a clear picture of the type of service we want to provide over seven days, and thus how the workforce is likely to be affected, is extremely difficult.
11. What would be the likely long-term impact on recruitment for posts that require seven-day working, compared to posts that do not require seven-day working?

Credible evidence is needed to determine the impact on recruitment for doctors’ positions that require working across seven days. Work-life balance is an important motivational factor for doctors. Doctors that provide a seven-day service have a poorer work-life balance compared to others which could result in recruitment problems to these positions, particularly emergency medicine.

It is very difficult to predict what the long-term impacts on recruitment for posts that require seven-day working will be in the future for a number of reasons. First, although we have information on posts that have recruitment difficulties at present, we do not know why this is and any assumptions we make will not be directly linked to evidence. Secondly, recruitment will depend on the relative attractiveness of a post and so depends not just on the working patterns in one post but how this compares to others. Without a coherent workforce model we cannot predict what these differences will be. Despite these difficulties, we do hold some information that could be used to inform any predictions about future recruitment.

When looking at prospective posts, we know that doctors take a number of factors into account. When asked about which factors would encourage them to reconsider their existing choice of specialty the modal answer given was an improved quality of life elsewhere. This is also true for those considering relocation.23

As we can see, work-life balance is a crucial factor influencing career choices and posts that require seven-day working, we hypothesise, will have greater negative impacts on work-life balance than those which do not.

The most recent results from the BMA’s cohort study24 showed that those cohort doctors working in emergency medicine, a specialty where seven-day working is prevalent, reported a much poorer work-life balance than other specialties. Three-quarters said their work-life balance was bad or very bad, a much higher proportion than other specialties as seen in Figure 1 below. These figures should be treated with some caution as the sample sizes used here are relatively small and crucially, we do not know not whether work-life balance is directly related to seven-day working.

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23 Career Choices, Findings from BMA Cohort Studies, August 2012, BMA health policy and economic research unit

24 A 10-year longitudinal study of 431 doctors who graduated from UK medical schools in 2006
We also know that recruitment of doctors to emergency medicine is a challenge, with high vacancy rates and low fill rates for higher specialist training. The reasons for shortages in emergency medicine are multi-faceted; however, there are indications that the demands of working seven days a week and a lack of a good work-life balance are significant factors in the shortage of doctors wanting to work in this speciality. The RCP (Royal College of Physicians of London) annual census data has good information on recruitment by specialty. However the results of the 2014 census will not be released until 2015.

Overall it is very difficult to make evidence-based predictions about recruitment in posts that require seven-day working, although we do know that recruitment to emergency medicine is a challenge. We can infer that seven-day posts will offer a worse work-life balance which would probably hinder recruitment; however, the magnitude of this effect is not known.

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12. What are the implications of equality policies and legislation for seven-day working?

Under the Equality Act 2010 (and the equivalent pieces of legislation in Northern Ireland), it is against the law to discriminate against anyone because of:

- Age
- Being or becoming a transsexual person
- Being married or in a civil partnership
- Being pregnant or having a child
- Disability
- Race including colour, nationality, ethnic or national origin
- Religion, belief or lack of religion/belief
- Sex
- Sexual orientation.\(^26\)

The BMA believes there is potential for gender and age to differentially impact on antisocial hours worked. However, the uncertainty over how seven-day working would be introduced makes it difficult to assess whether employers would be likely to be in breach of the act but there is certainly potential for breaches of equality legislation.

We would have concerns about the impact on parents and carers who may struggle to secure child or respite care at weekends or evenings. Likewise, doctors belonging to religious groups may have particular requirements relating to holy days and festivals.

Paragraph 19 of the Equality Act describes the conditions under which indirect discrimination would be deemed to have occurred:

19 \(\text{Indirect discrimination}\)

(1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B’s.

(2) For the purposes of subsection (1), a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B’s if—

(a) A applies, or would apply, it to persons with whom B does not share the characteristic,

(b) it puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,

\(^{26}\) www.gov.uk/discrimination-your-rights/types-of-discrimination
(c) it puts, or would put, B at that disadvantage, and

(d) A cannot show it to be a proportionate means of achieving a legitimate aim.\(^\text{27}\)

It is likely that any discrimination arising from the expansion of seven-day services would be ‘indirect discrimination’ rather than ‘direct discrimination’. Indirect discrimination only applies when the employer cannot show the provision or practice complained of to be ‘a proportionate means of achieving a legitimate aim’. This raises two questions:

- Is there a legitimate aim in this case?
- Are the proposed working arrangements a proportionate means of achieving it?

It is not possible to answer these questions in the absence of a clear idea of how seven-day services would work in practice, and what the demands on staff would be.

\(^{27}\) www.legislation.gov.uk/ukpga/2010/15/section/19
13. What evidence can be provided on the impact for patients of seven-day services?

Although there is evidence on the presence of a ‘weekend effect’ – worse patient outcomes at the weekend in a variety of settings – the findings are based on association and indicate a variety of confounding factors. In addition, the literature provides limited evidence on how to combat this effect. In particular, given that doctors must demonstrate a commitment to patient-centred care, clarity is required on the actual changes which are necessary beyond the professional standards of care which already exist. This information is crucial for making seven-day services work for patients, and the BMA would be happy to work with other stakeholders to establish this evidence base. A body of credible evidence is a prerequisite for implementation for this scale of service delivery change. Guarantees are also needed to ensure that increasing specialist presence at the weekend does not have negative effects on clinical outcomes and patient experience in the week.

Without knowing exactly what model of seven-day service we are looking to implement it is extremely difficult to predict the impact such a model will have on patients. Furthermore, while the literature is very strong on the presence of a ‘weekend effect’ in a variety of settings, there is limited evidence of how to combat this ‘weekend effect’. Therefore apart from predicting that the gap in outcomes between the week and the weekend will close to some degree, which in itself is an assumption, we do not have any more detailed evidence on the likely impact for patients of a seven-day service. Any evidence is also likely to be applicable to a very specific setting and therefore generalising nationally the effects of a seven-day service without knowledge of the delivery model is very hazardous.

Emergency care

The poorer clinical outcomes experienced at the weekend are well established in the emergency care literature both in the UK and abroad.28,29,30

Differential staffing levels – in particular, senior staffing levels – between weekdays and weekends are commonly identified as a potential cause of higher mortality at weekends; however the evidence does not demonstrate a clear causative link. There are other potential explanations. For example, it may be the case that sicker patients are admitted over the weekend and this may be an important factor in higher weekend mortality rates.31,32 The literature is, however, mixed. Some studies show an association between overall staffing levels and mortality rates;33 some find it only for nursing staffing

32 Goddard AF, Lees P. Higher Staffing Levels at Weekends and Reduced Mortality. BMJ 2012;344:e67
levels and others for changes in the numbers of registrars and consultants. As highlighted in a recent Nuffield Trust report, there is little evidence on how many senior staff are needed, of what type, and for what time periods. Overall, the BMA, along with NHS England’s Seven-Day Services Forum and others, believe more evidence is needed to establish a conclusive, causal relationship between specialist presence and mortality rates at the weekends and evidence on how to combat best reduce mortality.

We are aware that the High-intensity Specialist-Led Acute Care project is attempting to do this and we will welcome the results when they are published. We understand there will also be some information on how acute care units can operate with increased specialist presence which will be useful in informing the debate. However, this data will just deal with the emergency care setting, and the crucial distinction between elective and emergency care is important to keep in mind.

Elective care

A weekend effect on mortality rates has also been established in elective care settings. Weekend admission appears to be an independent risk factor for dying in hospital and this risk has been shown to be more pronounced in the elective setting. Similarly, patients who had elective operations on weekdays were more likely to survive if their operation took place earlier in the week rather than later, when their immediate post-operative period would take place over the weekend. There is very limited evidence on how to close this gap.

Having said this, increased consultant presence at the weekend will probably improve outcomes for patients to some degree, both in clinical terms and in terms of patient experience. However, consultants work in multi-disciplinary teams and increasing consultant presence alone would be an inefficient use of limited resources and any expanded service should be designed holistically: including other healthcare professionals such as nurses, and other hospital staff, as well as community and social care services. However this will clearly take significant resource and it should be acknowledged that providing a full seven-day elective service will require resource investment. The insistence in the DDRB’s remit letter on providing seven-day services ‘without increasing existing spend’ is not a helpful

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36 Dr Foster Health. Reducing Mortality at Night and Weekends, www.drfosterhealth.co.uk
approach. It will be especially difficult given the significant financial constraints the NHS is operating under at present and we believe will prevent patients benefitting from elements of the work that we all agree are necessary.
14. How has the demand for the delivery of seven-day services altered in recent years and what are the reasons for this? How do you see the demand for seven-day services changing in the future both in terms of changing patients’ demographics and the additional choices that seven-day services would give to patients?

There needs to be a better understanding of both current and future patient demand for seven-day services. This is required to ensure that implementation of seven-day services is sustainable for the NHS.

Demand for seven-day services

The ‘demand’ for seven-day services is a very hard concept to quantify or indeed to define. For example, the ‘demand’ for seven-day services may not be the same as clinical need for services, which the BMA believes should be the determining factor. Furthermore, there is a difference between ‘demand’ as viewed by a rational healthcare planner and ‘demand’ as viewed by a consumer advocate.

Assessing how this has changed over time is arguably more difficult. While seven-day services as a concept has certainly been discussed more widely and regularly over recent years, it is not entirely clear if this reflects increasing ‘demand’ for these services or who this ‘demand’ comes from.

Although NHS England’s Seven-Day Services Forum has involved patient representation from the outset, and patient representatives have been involved in steering committees, much of the debate has taken place within the health policy and political arenas, with contributions from policy stakeholders such as NHS England and the medical royal colleges. It is vital that patients drive this debate.

The BMA is planning engagement work with patients and the public in early 2015 to explore potential models of seven-day services and how these could be implemented to meet the needs of patients. As is clear throughout the entirety of our evidence, we believe this information about exactly what sort of seven-day service we want to implement needs to be understood before continuing.

It is vital during a period of intense financial constraint that the design of any model of seven-day services is firmly based on patient need. In order to design with patients a model of seven-day services which is sustainable for the NHS and best for patients, it is necessary to identify which patient needs are not met by the current system, and which should be a priority.

Demand for a seven-day service: emergency medicine

As noted elsewhere, at present the best example of a seven-day service model is emergency medicine. The literature demonstrates that both attendances and admissions at emergency medicine units nationally have increased over previous years as has the conversion rate (the number of admissions divided by the number of attendances). However, as outlined by the National Audit Office\(^\text{43}\) there are a number of confounding factors that influence this. This boost in demand supports the BMA position that we should concentrate on emergency service provision initially with regards to seven-day working and that elective care should be tackled at a different juncture.

\(^{43}\) Emergency Admissions to Hospital: Managing the Demand, National Audit Office, October 2013
Future demand

Attempting to model the future demand for seven-day services is hugely complex because, as highlighted above, it is affected by many factors including political rhetoric at the time. An accurate picture of current demand for seven-day services is a prerequisite to accurate modelling of how demand will change with changing patient demographics.

There are a number of possible trends that could affect future demand for seven-day services. An increased number of older, frailer patients with multiple conditions, who are less likely to be in full-time employment, could theoretically lessen demand for a weekend service. However, with a broader trend towards weekend services provided elsewhere in society, the expectation may be that seven-day services are provided in the health service.

Notably, it has been demonstrated in the emergency care setting that providing increased services can, in fact, boost overall demand for healthcare services. The evidence comes from reviews of walk-in centres. Further work has shown that while demand for emergency services has risen considerably over the past 15 years or so, nearly all of this is attributable to increasing activity in walk-in centres and minor injuries units.

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15. What is the underlying cost model for the delivery of seven-day services? What would be the costs and savings?

Developing a cost model for seven-day services is a huge undertaking, especially in the absence of a clear picture of what a seven-day service model actually looks like. The attempts to do this to date have been flawed either because data is not available or because the mechanisms to collect it have been limited. The data requirements for a comprehensive cost model are outlined below. Any successful attempts to do this would have to be centrally coordinated as the data requirements are significant, and we are unsure whether appropriate models are being developed. The BMA recommends that credible evidence is needed in this area before seven-day services are implemented, otherwise implementation could threaten the sustainability of the NHS.

The only serious attempt to do this published to date is a paper by the HFMA (Healthcare Financial Management Association) regarding the financial implications of introducing seven-day services for acute and emergency care and supporting diagnostics in the NHS.\(^{46}\) This report suggests that differences in the geography, specialty, and case mix of a trust have a strong impact on the cost of implementing services. This research, however, is based on a very small non-random sample (eight NHS trusts); it does not provide enough detail about the costs, and the assumptions that have been made are not explicitly stated. Further, the costs are calculated for emergency and acute care only and compared to the total costs of the trust. Unfortunately, the HFMA paper is not a sufficient source of information for the reasons listed above, and thus cannot be used to design the structure of the model.

Modelling the financial impact of seven-day services requires a large amount of data about the current hospital expenses during daytime, nights, and weekends and bank holidays and we will briefly set out what is needed below. However, we do not have access to the relevant information on a large enough scale to accurately model costs at present and it is not certain that research due to be published soon will do this.

Seven-day services will likely require an alternative workforce model but more research is needed to determine how this would operate in practice.

Data available on other costs at present\(^{47}\) (overheads, supporting costs, and laboratory and radiology services costs, social care costs) are mostly not sufficient to model how they will change if a seven-day service proposal is implemented. While some of these headings can be excluded from the model without a significant impact on the results, others like social care, pharmacy, radiology and laboratory, and administration represent a larger share of the total bill and should not be left out.

Another factor that cannot yet be estimated is the growth in the number of patients per week due to increases in demand for healthcare and to a shorter length of stay. The demand could expand –

\(^{46}\) NHS Services, Seven Days a Week Forum - Costing Seven-day Services, Healthcare Financial Management Association, 2013

\(^{47}\) Using a combination of data sources listed below among others:
Summary of Scottish Health Service Costs, ISD NHS Scotland, 2012
especially for elective services – because of the provision of services on worker-friendly hours. The length of stay is likely to decrease because of the possibility of avoiding discharging delays due to the weekend. Information about how the volume of patients will change is important to understand how some costs (eg pharmacy, radiology and laboratory services) will increase. A statistically based estimate may only be calculated when a sufficient number of trusts will start delivering seven-day care and monitoring patient volumes. A theoretical model could represent an alternative solution.

NHS England has commissioned a study from Deloitte to look at the cost implications of a seven-day service model, and the BMA welcomes any attempts to improve the data underpinning discussions around seven-day services. While we cannot comment on the relevance and results of the study until it is published, we are concerned about the results being scaled up nationally. This is because while it is likely to collect comprehensive data on health economies, as opposed to just trusts, which we think is a sensible approach, the study relies on data from just three health economies. We do not believe this relatively narrow information could be used to comment on the likely cost implications nationwide.

In summary, the BMA and others could develop a theoretical methodology for a seven-day service cost modelling exercise. However, the data is not currently held centrally to allow this to be done in practice. Attempts are being made to develop a seven-day service cost model for individual health economies but, despite valuably adding to the scant literature on seven-day services, it is unlikely that these will allow a national cost model for seven-day services to be constructed. The BMA believes credible evidence in this area is a prerequisite for implementation of seven-day services.
16. What are the pay, staffing and motivational issues and costs around any transition to seven-day service provision?

Transitional arrangements from the current service to a seven-day service will have a substantial impact on costs and the earnings of doctors. Accurate modelling is therefore especially crucial. The negotiations did not focus on this specific piece of modelling due to lack of agreement on the wider pay structure. The BMA does not hold sufficient information to carry out independent modelling. We call on all relevant stakeholders to work together to determine this information before seven-day services are implemented.

In order to calculate total costs of transition and its impact on earnings we would need a much higher level of detail on the current distribution of pay. This would allow us both to identify and quantify the affected doctors and to calculate the amount needed to fund pay protection, for both doctors in training and consultant doctors.

Without pay protection, those doctors who are detrimentally affected by changes are unlikely to engage with the new seven-day service and, as discussed extensively above, clinical engagement with service reconfiguration is vital for its success. Another transitional issue touched on earlier is that the additional staff that will likely be needed to provide seven-day services must be recruited and trained over a number of years. This time lag will have to be taken into account when modelling the transition to seven-day services.

In summary, neither contract negotiation progressed far enough to consider transitional arrangements. However the principles adopted about whether any doctors should be worse off under a new system, and the unhelpful adoption of a fixed cost envelope, will have significant impact on these arrangements.
ANNEX A

What were the pay-related issues in the consultant contract negotiations for which agreement could not be reached? What proposals were put forward? How do these proposals link to the heads of terms?

Background

The heads of terms agreement identified a range of areas of the contract to be addressed in negotiations. These were: seven-day services, pay progression, CEAs, SPAs, flexible working, and study leave among other issues. The vast majority of the time spent in the negotiations focused on seven-day services and pay progression. Latterly, some time was spent on examining a possible replacement to CEAs scheme and there was a small amount of time allocated to professionalism and SPAs.

The limited scope of the negotiations and cost neutrality

The heads of terms agreement began with an introduction setting out the principles governing any changes to the contract. These included commitments to a ‘national contract’ which ‘must ... be fair for doctors and affordable for employers’, ‘simple to administer’ and would ‘facilitate consultants to use their skills and experience to develop high-quality services’. 48 Both parties signed up to these, and other principles, but over the course of the negotiations, the Government stressed the need for the contract to be cost neutral.

Although the issue of explicit cost neutrality only became a concrete demand of the Government during negotiations, affordability was recognised as a constraint from the outset. This requirement made discussions on the expansion of services difficult from the start. However we were willing to make progress within the constraints of affordability. The BMA recognises the financial difficulties facing the NHS and seeks changes to the contract which prioritise the quality of patient care, protect safe working patterns for consultants and can be delivered without considerable financial costs. Doctors are fundamentally motivated by a desire to care for their patients, and the changes the BMA seeks to the contract are with patient interests in mind. For example, the BMA is willing to look at ways of expanding consultant presence in hospitals across the week, on the condition that contractual safeguards are put in place to protect safe rest periods between shifts to ensure patients will not be treated by tired consultants. The Government was unwilling to include, within the contract, these necessary safeguards, although not all of the safeguards would have had a financial cost and would protect both patients and consultants.

Similarly, despite it already applying to consultants (with derogations), the Government would not write into the contract key WTR protections. It felt that such a change would create difficulties if the EWTD (European Working Time Directive) was ever to be revised. The BMA was concerned that future revision of the WTR would result in reduced protections and wanted existing protections included in the contract as a safeguard as a way of pre-empting any change at a legislative level. The BMA fully

48 Heads of terms, July 2013
supports the limits set out in the existing legislation and this has been backed up by a recent study which found that, as working hours increase, productivity decreases.49

**The negotiating process and focus**

During negotiations, the Government was predominately focused on the removal of S3P6 of the consultant contract, which states that non-emergency work in evenings and at weekends can only be scheduled by mutual consent of employer and individual consultant. It is important to note that this clause does not limit the delivery of urgent patient care at any time or day of the week. Under the existing contract, consultants deliver urgent and emergency care seven days a week and 24 hours a day.

The Government failed to provide an adequate narrative as to what the removal of S3P6 would allow employers to do or how the expansion of seven-day services would be paid for. Without this information, it appeared that the DH’s focus on the removal of S3P6 was politically driven.

The BMA was willing to negotiate on this clause on the condition that safeguards would be put into the contract to protect against tiredness (the effects of which are discussed elsewhere in this submission) – and with it patient safety, the impacts on consultant health and detriment to work-life balance.

In parallel to discussions on what safeguards would need to be in place to support expanding consultant presence across seven days, the parties discussed possible new pay systems, which would include mechanisms for paying for out-of-hours work. The two areas – working hours and pay – are inextricably linked. Discussions about an increase in out-of-hours work and the rates of pay allocated to this work must be considered together if a clear understanding of the negotiating process is to be gained. Similarly, amendments to the pay progression system were tied up with discussions on how the CEA scheme might be changed. The BMA wanted to discuss flexible working, study leave and a number of other issues that are important parts of the consultant contract but were not given any time in the negotiations.

**BMA concerns about ongoing real terms pay cuts**

The BMA negotiators entered the process willing to consider amending the contract to meet commissioning needs and address some relatively long-standing concerns expressed by consultants about their working lives. However, they were also acutely aware of the reduction in real terms pay consultants had experienced in recent years. When considered alongside the fact that investment for new CEAs in England had been almost halved in 2009 (the effect in Northern Ireland was greater and occurred earlier) as a result of a unilateral decision by the DH and thousands of consultants had been left worse off as a result of the changes to the NHS pension scheme, it was always essential that consultants saw something positive in any proposed change to their contracts. Figure 2 shows the difference between the CPI (consumer price index) and the recommended pay increase proposed by

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49 www.economist.com/blogs/freeexchange/2014/12/working-hours
the DDRB over recent years. It should be noted that some years the DDRB was told not to report. It is also worth noting that this chart represents all four UK nations and several branches of practice.

**Figure 2**

![Graph showing financial years and percentage change](image)

*Note: in some years, different staff groups received different recommendations, so this chart should be treated as illustrative only*

We know from past experience that consultants value time and work-life balance at least as highly as pay.\(^{50}\) The BMA consultants committee decided any change agreed by negotiators would have to be put to the relevant BMA members in a vote. Failing to address the persistent reduction in consultants’ pay and benefits while forcing more out-of-hours working without adequate safeguards would mean acceptance of changes in a ballot would have been unlikely.

**Linking pay to contribution rather than time served**

It was repeatedly stated that a Government red line in the negotiations was to link pay progression ‘to the overall contribution of individual consultants rather than purely length of service’.\(^{51}\) The current contract contains a section which sets out what consultants must do in order to meet the requirements for pay progression. A key requirement is for the consultant to meet ‘the personal objectives in the job plan’\(^{52}\). Both the BMA and NHSE jointly published guidance in 2011 stressing the importance of effective objective setting.\(^{53}\) BMA negotiators were of the view that strengthening this

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\(^{50}\) [news.bbc.co.uk/1/hi/health/2375285.stm]
\(^{51}\) Paragraph 24, Heads of terms, July 2013
\(^{52}\) Schedule 15, paragraph 1, 2003 terms and conditions of service
existing process could provide a simple solution to addressing the Government’s desire to link contribution to pay progression.

However, NHSE and the DH wanted to introduce more radical changes and two different pay systems were considered.

First, a ‘gateways’ model which would involve a series of points in a pay system through which consultants would pass only if they could demonstrate that they had met a number of stipulated requirements. In principle this system could have worked like a strengthened version of the current system and had tentative BMA support.

Alternatively, the NHSE/DH proposed a VPTU (variable pay top up) model which would include a set level of basic pay, possibly with two or three levels which would be similar to the gateway model but with additional ‘tiers’ of pay which consultants would access depending on their contribution in three areas: out-of-hours work; taking on additional responsibilities; and/or excellence. The BMA has considerable reservations about the administrative burden this model could create and its potential for instability of income, dispute and division. However, similar systems are in place around the world (notably, in Queensland, Australia) and the BMA is willing to explore it as a possibility.

In September 2014, NHSE shared a paper which detailed their vision of the VPTU model with the BMA. The paper set out the principles governing their support for the model and its key components. The proposed system included:

- A two-tier consultant grade of ‘newly qualified’ and ‘experienced’ consultants. Progression from lower to higher would depend on consistently performing at the high level expected of an ‘experienced’ consultant. NHSE expected this would take approximately five years.

As part of this system, progression would be based on locally-set objectives including both wider organisational objectives and individual objectives. Objectives might include:

  - Undertaking or managing an agreed number of complex/high risk patients with appropriate outcomes. The BMA had concerns about how these patients would be identified and what would be considered an ‘appropriate outcome’. Establishing outcomes without factoring in access to resources (staff, facilities, time) could result in the outcomes being unachievable and not representative of an individual consultant’s contribution. Furthermore, many consultants do not have outcome data available as their outcomes are subsumed into those of the team, while NHS outcome monitoring serves activity goals
  - Completion and presentation of audits of personal clinical practice to a high standard. As with the previous point, the BMA felt that this should depend on the arrangements put in place to ensure appropriate time, support and facilities. Many consultants experience wildly different levels of personal support from their employers
  - Completion, with satisfactory outcome, of one patient and one colleague multi-source feedback exercise
  - Demonstrating awareness of an organisation’s key policies and relevant clinical guidelines. While these are appropriate, the BMA also thought policies would have to be realistic, with
appropriate time, resource and facilities allocated to them. Furthermore, consultants should be able to question the clinical appropriateness of implementing certain policies

- Evidence of engagement in the organisation’s appraisal and job planning processes to include sign-off in both. This should not result in pressure being placed on consultants to sign off inappropriate job plans or job plans which are subject to mediation and appeals procedures.

- Access to three tiers of additional earnings under the VPTU model:
  - Supplements (tier 1) for out-of-hours commitments
  - Additional roles (tier 2) – paid in time within the 10 PA contract, extra PAs at the base rate of pay, or, where the additional roles are locally judged to be of a broader level of responsibility, as allowances. Medical leadership and management roles would continue to be paid for under Schedule 16 of the contract
  - Performance rewards (tier 3). These would be replacements for local CEAs and be awarded in return for an objectively measured mix of personal, team and organisational performance

‘Newly qualified’ consultants would have limited access to any of these additional earnings.

The BMA was concerned about the mechanisms which would be used to determine whether these payments would be given to individual consultants, how long they would last for, what the level of pay would be, equality of access for all consultants and the impact on certain specialties.

Removal of S7P5 (Schedule 7, Paragraph 5) of the contract would mean all PAs would last four hours. Currently, those worked in evenings and weekends last three hours or are paid at a higher rate of time and a third.

The BMA was willing to discuss the removal of S7P5 on the basis that other contractual safeguards to protect against tiredness and to appropriately reward out-of-hours work were agreed.

- Extended plain time rates so that work between 7am and midnight, Monday to Saturday, would be at plain time rates, while hours between midnight and 7am and all day Sundays would attract time and a third. The BMA opposed these rates, further detail below

- Additional PAs paid at the spot rate for pay for the appropriate level ie entry or base level

- A new reward system (tier 3) which would recognise exemplary performance judged against agreed objectives that feed into job planning. Payments would only be made where an appraisal suggested a consultant had performed above and beyond the expectations set out in their objectives. Each organisation would identify a finite ‘performance reward sum’ based on the size of their consultant workforce and a nationally set minimum amount per FTE (full-time equivalent) value. The revised approach would move away from a system of mandating a minimum ratio of new local awards, moving instead to a system based on agreed standards. At the end of each annual appraisal period, the pot would be distributed to all consultants in a way agreed at a local level and with consultation with the workforce. As well as individual payments, elements of team-based performance and locally-determined organisational objectives could also be incorporated
into the system. Under this approach, those who contribute to high-performing teams and local organisational objectives would be eligible for the highest performance pay.

The BMA had concerns about the mechanisms for assessing ‘exemplary performance’, transitional arrangements and unforeseen consequences of the proposed system. These concerns are explained in more detail below.

**Transitional arrangements for those moving from the 2003 contract to the new arrangements**

These would offer pay protection for basic pay which would be taken out of the overall consultant funding envelope.

The BMA felt transitional arrangements should be put in place but did not agree these should be taken out of the consultant funding envelope because this would involve an irreconcilable logical conflict between priorities in that protecting pay for some must reduce pay for others, thus requiring them to need protection in their turn. Therefore, additional funding would be required for transition.

**Using the contract to save money**

The BMA believed there was scope for agreement on a new pay system assuming it was adequately resourced. NHSE and the DH made it clear that their intention was to move money around within the current pay envelope so that those who worked more evenings and weekends would be paid more than those who didn’t. Essentially, this mirrors the current system but in a more exaggerated way, the likely consequence being that pay differentials between consultants would be likely to be greater under the VPTU system, for example. This would almost certainly mean that certain specialties would be less able to access some of the money allocated to the tiering system since their work patterns require less of the work rewarded by the tiering system. The BMA had concerns about the potential impact of this on recruitment into those specialties.

The DH, in particular, expressed its intention to reduce the starting salary for consultants in order to increase the money available to the tier 1 (out-of-hours) payments. The BMA negotiators were concerned about a reduction in starting salary and the perception that the grade itself would be devalued. This concern was raised with NHSE and the DH and this led to some, ultimately unresolved, discussion about how speedier progression for some new consultants could offset the potential damage to career earnings caused by the lower starting salary. Any negotiated deal would have to maintain the value of the consultant grade both financially and reputationally.

The proposed pay rate for out-of-hours work put forward by NHSE and the DH was considered, at best, extremely challenging to sell to consultants. Plain time rates for working at 11pm on a Saturday night on both elective and emergency work would represent a major reduction in earnings for some consultants and completely fail to recognise the impact on work-life balance. Currently, consultants on the 2003 contract, earn time and a third for work carried out in evenings and at weekends. Some employers have agreed higher rates for non-emergency work carried out at weekends (waiting list initiative work, for example). Both the extension of plain time to cover the vast majority of the week and the rates offered by NHSE and the DH were unacceptable to the BMA. Again, the key to this change appeared to be about savings at the expense of potential tiredness and low morale resulting from poor work life balance.
The BMA was willing to consider a consultant grade with a reduced number of basic pay points included in it. The BMA thought there was a case for adding one or two more points to the scale but was not tied to a particular number. However, the process for progressing from ‘newly qualified’ to ‘experienced’ over five years seemed arbitrary and there was no clear reason given as to why it should take this long. Such a distinction is not recognisable in clinical practice and over the course of their careers many consultants’ duties do change but not simply at a single time point. Recruitment to the consultant grade on a lower starting salary was also questioned by BMA negotiators but could have been acceptable as part of an overall package which facilitated faster progression to higher pay points where merited. Such a system would have to include safeguards which would ensure that pay increases were not denied once a consultant had met the agreed standards.

There was concern from the BMA that the process of assessing progression could be unduly influenced by financial constraints rather than being based on development of skills, knowledge and roles, if it were not measured by very clear and consistent criteria. This point was raised in negotiations but was never discussed in sufficient detail.

Broadly, the BMA could have accepted the proposal of a major change to the pay progression system, as part of a mutually beneficial package, to recognise contribution through the three tiers proposed by NHSE. However, the BMA was concerned about the ability to expand services across seven days and reward consultants fairly within a limited cost envelope. If a consultant were to be asked to work on a Saturday, that would create a gap in service on another day of the week which would require extra resource to provide the necessary cover – a point the BMA made in negotiations but which was not satisfactorily addressed by NHSE/DH. Furthermore, based on the modelling data received from NHSE, the new system would result in some groups of consultants, determined largely by specialty, having a reduced income under the proposed arrangements. As explained above, against the long-term real terms pay decreases consultants have experienced, such a proposal would almost certainly be rejected in a ballot of affected members.

The BMA was willing to consider longer PAs in evenings and at weekends provided that the tier 1 payments were adequate and other safeguards were written into the contract. NHSE and the DH were unwilling to do this.

There was no formal review of a replacement system for CEAs, but NHSE produced a written proposal setting out the basis of a new scheme in September 2014. Within the brief time the BMA negotiators were given to consider this, the main concerns centred around the process for assessing consultants and the introduction of team and organisational awards. Reflecting again on the report published by the Commons PAC (public accounts committee), which stated that ‘only 43 per cent of trusts and 27 per cent of consultants consider that information currently available is good enough to assess individual consultant performance’, it is difficult to feel confident in the assessment process as it stands and even less so if expanded to start assessing teams. As stated above, introducing more complex pay systems in a time of austerity could be likely to be extremely challenging to NHSE HR departments.

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Link to heads of terms

The proposals described above largely adhered to the heads of terms. However, NHSE referred regularly to the need to put in place local mechanisms for dealing with pay progression and assessment which the BMA felt sat uncomfortably with the agreed statement in the heads of terms: ‘The parties will aim to produce a national contract that values the consultant workforce, is responsive to patients’ needs and meets the needs of employers and consultants to deliver sustainable improvement in the quality of care, consistently, across the NHS.’

A common feature of the negotiations was the tension between NHSE wanting to introduce a new contract with extensive local freedoms and the BMA wanting a stronger, more resilient national structure. Consultants have told the BMA that they have more confidence in a nationally-applied contract rather than a contract subject to extensive local interpretation. This also seemed to BMA negotiators to better align with the intention to produce a national contract as described in the bilaterally agreed heads of terms.

The BMA and its members strongly support a national contract since it offers consistency both to those who work to that contract and their employers. Local arrangements could give rise to significant variation in standards, employment practices and rates of pay, creating a risk that some employers would be seen as less attractive than others, with consequent risks to availability of services in some parts of the country.

Over the course of the negotiations, the DH in particular stressed the need for the contract to remain within the current consultant pay envelope. However, the heads of terms did not make that explicit; indeed, they proposed a new concept which provided limited protection for current employees and limited investment in new ways of working. Instead, it used the term ‘affordable’: ‘The contract must therefore be fair for doctors and affordable for employers.’

The proposals put forward were, in relation to the VPTU system and the replacement for the CEA scheme, quite complex. Given the difficulties many employers had apparently experienced in implementing the relatively straightforward 2003 contract, the BMA negotiators were concerned that focus was moving away from the commitment in the heads of terms to a simple solution: ‘The parties will seek to agree a contract that is simple to administer, suitable for all consultants and responsive to changes in medical practice and NHS structures.’

NHSE and the DH never offered a clear explanation of why they were confident that employers, who had failed to deliver effective oversight of the relatively simple pay structures in the 2003 contract, would be able to effectively administer a much more complex pay system with limited HR resources. With expanding patient numbers and the current financial squeeze on the NHS, it is hard to imagine HR departments in trusts being able to expand sufficiently to meet the necessary demands of a more complex pay system.

55 Paragraph 4, Heads of Terms on Consultant Contract Reform, July 2013
56 Paragraph 5, Heads of Terms on Consultant Contract Reform, July 2013
57 Page 7, PAC report on the consultant contract
www.publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/358/358.pdf
58 Paragraph 8, Heads of Terms on Consultant Contract Reform, July 2013
Both sides acknowledged that objective setting under the 2003 contract had not been universally successful. The PAC, when it appraised the consultant contract in 2013, found ‘nearly half of trusts do not assess whether consultants have met the objectives set out in their job plans’. It was and remains the view of the BMA negotiators that focusing effort on establishing why this problem existed rather than creating new systems which could well founder on the same problem would be a beneficial way forward. The BMA has no confidence that the same difficulties would not be encountered in the future, particularly if new more complex pay systems were to be introduced.

As stated above, a strengthened objective-setting system applied within the current contractual framework would have met the principle of progression based on contribution as set out in the heads of terms.

The BMA negotiators were keen to explore the possibility of negotiating amendments to the contract which would clear up long standing and common tensions around study leave and compensatory rest, for example. These were not requests for more money but attempts to address common problems which waste the time of both consultants and their employers. But these concerns were never satisfactorily addressed, despite the agreement in the heads of terms: ‘In particular the new contract will, through clarity and simplicity, seek to reduce the prospect of contest and challenge on potentially ambiguous points.’

The lack of accurate data

The data underpinning the discussions on pay progression and expansion of seven-day services was patchy and speculative. This made it impossible to model how the changes would affect individuals, and in what numbers. Without a clear understanding of the financial consequences of contractual changes on consultants and employers, the BMA was very concerned that the changes should not be rushed through, and felt that political expediency related to a perceived ‘need’ for more seven-day services had inappropriate influence over the negotiations. While the BMA accepts there is evidence outcomes could be improved with more services offered at more times during the week, it is concerned about the lack of clarity over how these services would be delivered and that spreading existing resources more thinly could be counterproductive. However, this must be done in an environment where supporting resources to deliver high-quality care are all in place by the NHS and social care systems.

Without accurate data and with a reliance on untested assumptions, discussion on actual figures was only lightly touched on in the negotiations. The primary focus was on how the systems might work and what difficulties might occur in their application.

The lack of accurate data was a recurrent theme throughout the negotiations and the BMA negotiators repeatedly voiced their concerns about the ability of the DH/NHSE to populate any pay models with figures without an accurate idea of how extensive expansion of services might be. In July of this year, the joint negotiating meeting minutes record such concerns being raised without satisfactory reply and this continued until October. As late as September, the DH acknowledged that ‘data was still lacking in some areas…’ and again, later in September, the BMA continued to push for better data:

59 Paragraph 8, Heads of Terms on Consultant Contract Reform, July 2013
60 Minutes of the joint negotiating meeting, 11 September 2014
‘Further concerns were raised that the model’s assumptions drastically underestimated the amount of tier 1 activity being undertaken at present, which distorted the overall distribution.’\(^61\) And that the models put forward by NHSE and the DH were creating difficulties in the process: ‘It was accepted that the inclusion of scenario E (one such model) was of limited use and had produced some confusion.’\(^62\) Also, on the same day: ‘NHSE recognised the need to populate the models with more realistic data but also stressed the need to be realistic about how far this could be developed before the end of October when they would report to the ministers. There was a common agreement that the modelling was not correct...’\(^63\)

A few days later, on 30 September, the minutes record the DH’s approach to the problem of a lack of data: ‘[DH] accepted the issues around the use of appropriate data to inform modelling and developing a clearer idea of how services might change. Nevertheless, [the DH] noted that this data would not be obtained before the negotiating partners would have to report to the ministers on progress.’\(^64\) The BMA remained uncomfortable with committing to specific models without more data and made this clear shortly after, on 1 October: ‘The BMA acknowledged the agreement previously made but stated that, given the current situation with a lack of accurate financial modelling, it would be premature to state a commitment to this.’\(^65\) Two weeks later, BMA negotiators made the same point again when they ‘restated that the lack of data presented a major obstacle to any agreement; without hard numbers to present to the [BMA consultants committee], it would be a significant challenge to gain their approval. The BMA noted that, at present, there existed only speculative modelling based on assumptions and there was no data to detail the current position, let alone how it could look under widespread adoption of seven-day services. This made it very difficult to conclusively identify who would benefit from the contract and by how much.’\(^66\)

The jointly agreed minutes present a detailed record of these discussions and demonstrate that these concerns were raised for months without a solution being found. This became a major obstacle to a heads of agreement.

**Transitional arrangements**

The transitional arrangements for those moving from the 2003 contract to the new arrangements seemed, in the most part, sensible but the BMA had concerns about the impact these costs would have on the overall envelope.

The envelope itself was defined by the DH in a table which is replicated below:

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\(^{61}\) Minutes of the joint negotiating meeting, 25 September 2014  
\(^{62}\) ibid  
\(^{63}\) ibid  
\(^{64}\) Minutes of the joint negotiating meeting, 30 September 2014  
\(^{65}\) Minutes of the joint negotiating meeting, 1 October 2014  
\(^{66}\) Minutes of the joint negotiating meeting, 16 October 2014
Table 1: Distribution of consultant earnings across payment streams – 2013/14

Split by newly-qualified and experienced consultants

<table>
<thead>
<tr>
<th></th>
<th>Newly Qualified</th>
<th></th>
<th>Experienced</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimated</td>
<td>Estimated Aggregate</td>
<td>Estimated</td>
<td>Estimated Aggregate</td>
</tr>
<tr>
<td></td>
<td>Earnings per</td>
<td>Earnings - £m</td>
<td>Earnings per</td>
<td>Earnings - £m</td>
</tr>
<tr>
<td>Basic Pay</td>
<td>£60,024</td>
<td>£817</td>
<td>£91,365</td>
<td>£2,630</td>
</tr>
<tr>
<td>Payments for additional activity</td>
<td>£7,044</td>
<td>£72</td>
<td>£12,561</td>
<td>£322</td>
</tr>
<tr>
<td>Medical awards (CEAs etc)</td>
<td>£949</td>
<td>£10</td>
<td>£11,230</td>
<td>£323</td>
</tr>
<tr>
<td>On call</td>
<td>£2,804</td>
<td>£29</td>
<td>£3,068</td>
<td>£88</td>
</tr>
<tr>
<td>Geographic allowances</td>
<td>£425</td>
<td>£4</td>
<td>£437</td>
<td>£13</td>
</tr>
<tr>
<td>FHP</td>
<td>£38</td>
<td>0</td>
<td>£50</td>
<td>1</td>
</tr>
<tr>
<td>Local &amp; other payments</td>
<td>£6,707</td>
<td>£83</td>
<td>£6,855</td>
<td>£197</td>
</tr>
<tr>
<td>Total Earnings</td>
<td>£97,932</td>
<td>1,000</td>
<td>£125,555</td>
<td>3,614</td>
</tr>
</tbody>
</table>

Notes: This analysis necessitates going beyond published data sources and using unvalidated data for the Electronic Staff Record. Data filtering and clean-up processes are applied and the remaining sample is scaled up to match the full population to minimise problems, but the information should be considered an estimate.

As such this does not exactly tally with the aggregate figures from the published data. This reflects additional data-cleaning requirements when working with data more detailed than staff group. Essentially the two sets of figures are based on slightly different samples of data.

Table 1 represents what is known about consultant pay through the Electronic Staff Record. However, it almost certainly does not include all the money currently paid to consultants, for example, waiting list initiative payments, and the BMA was concerned that the overall consultant pay pot could be reduced by basing the new contract on the figures set out in this table. If this were the case, it would constitute a breach of the heads of terms which stated: ‘The parties agree that the current expenditure on consultant remuneration (to include local and national CEAs) will not be reduced as a consequence of these negotiations.’

Even if the size of the consultant pay envelope had been agreed, significant challenges would have remained. With a view to expanding service provision across seven days, it would be likely that some reduction in pay would result under the VPTU system for certain groups of consultants who would not have had the opportunity to maintain their salary through tier 1 (out-of-hours) payments. The BMA has long-standing policy on pay parity between specialties in the consultant grade and to move to a system which appeared to be more explicit about differentials between specialties would present a problem. Moving to a system which valued some specialties above others could lead to new recruitment difficulties or exacerbate existing ones.

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67 Taken from NHSE negotiating paper JCCM 62, shared during the negotiations with the BMA
68 Paragraph 9, Heads of Terms on Consultant Contract Reform, July 2013
Contractual safeguards for out-of-hours working

Although not a pay element, the package of non-pay safeguards which the BMA sought in exchange for the removal of S3P6 of the 2003 contract was a source of constant discussion and debate throughout the negotiations. While this is not the appropriate place for a detailed explanation of those safeguards, the disagreements over them and where they should sit in the contract should be noted. The BMA stressed in the negotiations ‘the importance of the full suite of safeguards ... in recommending a potential deal on seven-day services to the BMA membership when it came to ballot’ and, in September ‘expressed disappointment at the lack of progress made by the negotiating parties over the summer in the two subgroups on variable pay and compensatory rest’. Although the BMA had attempted to move to a mutually agreeable solution: ‘[The BMA] argued that the BMA’s wording had been modified to facilitate a commonsense approach from both parties’ NHSE refused to move to a united approach: ‘[NHSE] stated that solutions would have to be on a flexible scale, locally determined, which would be better placed in guidance.’ This quoted exchange essentially summarises the approaches taken to the safeguards issue throughout the process.

69 Minutes of the joint negotiating meeting, 7 July 2014  
70 Minutes of the joint negotiating meeting, 11 September 2014  
71 Minutes of the joint negotiating meeting, 24 September 2014  
72 Ibid
ANNEX B

2. What are your views on the recommendations and observations as set out in DDRB’s report Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS consultants?

The Government published the DDRB’s report in December 2012 although it was submitted to the health secretary 18 months earlier, in July 2011. Three years on from the time it was written, it may be the case that some of the evidence and data the report was based on is now outdated. Therefore, although we welcome the opportunity to comment on the report, we believe that a revision of the observations and recommendations is timely and should take into account the significant change to the NHS pension scheme and the continuing reduction in consultants’ real terms earnings in recent years.

While the DDRB’s previous report was applicable to the whole of the UK, for reasons stated throughout this document, this evidence submission covers consultants in England and Northern Ireland. The comments therefore will discuss the recommendations if and when they apply to consultants in England and Northern Ireland, but will not cover consultants in Scotland and Wales. The Scottish Government has not given the DDRB a remit on these matters, and Welsh consultants have not been involved in the negotiation process.73 Where we use the word ‘national’ in this section, we are referring to England and Northern Ireland only.

The BMA’s response to the various observations and recommendations is set out below.

Recommendation 1: We recommend that consultants continue to receive reward above their basic pay scales, where appropriate, and are eligible for incentives to reward excellence.

Accordingly the principle that the DDRB has suggested, whereby consultants should continue to receive reward over and above their basic salary is one that we support provided that any replacement scheme is based on a national structure with a ringfenced pot of money to maintain it.

Consistently, BMA surveys of consultant members have shown that opinion on the existing scheme is split. Some consultants favour abandoning the system as they perceive it to be unfair and some consultants are more supportive of the scheme and do not want it to change.

Any scheme which seeks to reward work which can never be entirely objectively assessed is always going to be subject to criticism. Also, when poorly implemented, such schemes may not deliver useful excellence for employers and may only serve as a regular source of disagreement and tension.

Given that the value of the CEA system is estimated by the DDRB at around £500m per year, one option, without increasing the cost envelope, would be to abandon the local CEA process altogether and redistribute this money among all the consultants who would otherwise have been eligible to apply for CEAs. However, it is likely that NHSE and the DH would prefer that the money be used for specifically directed purposes. The BMA is concerned that, without clear national guidance, there is a risk that a replacement scheme would result in the money being redirected toward short-term projects which are designed to save employers money rather than advance patient care. By

73 For more detail of this see Annex D
maintaining a national structure and putting in place mechanisms for excellent work to be peer reviewed and judged, this could be avoided to a large extent.

**Recommendation 2:** For local award schemes, we recommend that such schemes should operate within a UK-wide framework of common principles and governance and should include the following.

We agree with this overarching statement if an award system is to continue although would stress that our evidence here does not cover Scotland and Wales.

**DDRB recommendations in bold; BMA view in plain text.**

- **All employing organisations should have a local award scheme in place.** We support this but it should NOT be locally determined it should be based on a nationally agreed structure

- **There should be measurable targets linked to both the objectives of the employing organisation and the individual objectives of consultants.** The BMA supports this in principle but is concerned about the ability of employers to deliver this

- **The system should be transparent, fair and equitable.** The BMA fully supports this and believes it to be an essential prerequisite. Awards should be linked to work that is done over and above job plans; The BMA supports excellent work being rewarded – that work may not necessarily be ‘over and above’ a job plan

- **Awards should not reward activity already remunerated elsewhere, for example through additional PAs or SPAs, unless the outcomes are significantly above expectations.** The BMA supports this

- **Consultants should no longer need to apply for local awards – all would be eligible. Employing organisations should make decisions as to which of its consultants were the most deserving in any one year.** The BMA agrees that all consultants should be eligible for awards

- **Schemes should operate within a competitive environment, to reward a limited percentage of consultants working for an employing organisation within any one year.** The BMA supports the competitive nature of the process but believes that the competition could be against a standard rather than colleagues. The BMA accepts that, in a system based on a fixed pot of money, more consultants receiving awards will result in the awards being of a smaller value

- **Nationally, the parties should agree a cap on the cost of local schemes.** The BMA supports this on the proviso that the money should be spent on excellence each year

- **Under the new schemes, local and national awards may be held simultaneously.** Where warranted, holding both levels of award should be possible

- **Awards should be non-consolidated and non-pensionable; one-year local awards should be the norm, and the maximum length of local award, in exceptional cases, should be three years, to be paid in annual lump-sums.** The BMA does not support these statements

- **Awards in excess of one year should require ‘sign-off’ by the employing organisation chief executive on an annual basis.** The BMA is concerned that this could concentrate too much power in the hands of the chief executive who might not understand enough about each individual situation
• All existing award-holders should have their awards reviewed on a regular basis, the awarding organisation to decide the length of time between reviews (but with a presumption for annual reviews) and with no grace period. The BMA supports the principle of review but this must be administratively simple and fair with an appeals mechanism built in. Subject to accrued rights, there should be no pay protection; and the BMA has concerns about this but analysis of the detail is necessary before an assessment can be made of the fairness surrounding pay protection. Subject to accrued rights, consultants who retire and return to work should not retain any local award, although they should be eligible for consideration for new local awards alongside other consultants. The BMA supports the DDRB’s recommendation that all employing organisations should have a rewards scheme in place and believes that a national structure should apply to all organisations as this would introduce some degree of equity across employers. The BMA has concerns about employers moving away from a central mechanism because employers could be motivated to save money intended for rewarding excellence thus leading to a downward spiral of reduced excellence, recruitment problems and further financial difficulties. Where possible this should be based on assessment of measurable targets linked to individual objectives within a fair, transparent and equitable system.

However, several points must be made in relation to the various points within this recommendation. Since the Advisory Committee on Clinical Excellence Awards stopped producing guidance for local schemes in 2013, the BMA has learned of an increase in the number of employers seeking to make amendments to local awards systems. As a result of this change, significant concern has been expressed by consultants about the operation of local CEA schemes. Consultants have cited a lack of transparency, together with a loss of objectivity and fairness both within an individual employing organisation and between organisations. A good national system with some degree of limited local flexibility has the potential to be beneficial to all parties but excessive local control could and indeed does seem to lead to confusing variation between employers, causing transfer problems and, indeed, recruitment difficulties.

A UK-wide local award scheme operating within a UK-wide framework of common principles and governance would resolve the inter-employer discrepancies that are currently being identified by consultants at local level.

Linking awards to performance appraisals is only a realistic prospect if employers have robust appraisals mechanisms in place which many employers do not, even with revalidation now introduced. Although each employer will have responded to the GMC to say that they do have a system of appraisal in place, whether this is rigorous enough to be able to be used to make local CEAs is debatable. Because of the lack of effective appraisal mechanisms in some areas, the BMA is very concerned about using the appraisal system to judge whether a consultant merits an award for excellence. This is because there is a distinction between systems of appraisal to support revalidation and those for the review of performance.

The BMA is open to the possibility of moving away from an application process with some caveats. A common complaint about the current CEA scheme is that it rewards consultants who are well disposed to or well supported within their departments for promoting their own work and completing detailed application forms. It is difficult to ascertain whether there is compelling evidence to support this claim but it is something the BMA hears from members on a regular basis. However, consultation on the replacement process would be essential. In the negotiations which have just ended, NHSE and the DH were proposing a system where all consultants would be judged on their appraisal rather than only those who applied. Although the BMA has concerns about using the appraisal system to assess
consultants, it believes that the proposal has some merit and is worth exploring further subject to the
detail and modelling.

The DDRB’s report recommends moving away from awards which are pensionable. Until the report
was published, the DDRB had not expressed any concern about awards being pensionable and, indeed,
in its 39th report stated: ‘NHS pensions are more generous than private sector comparators and even
more rewarding than private sector comparators for new entrants. However, the non-pension aspects
of total reward are potentially significantly higher for most private sector comparators, so overall we
are not concerned about the pensions of our remit group.’

The DDRB’s report was written before the changes to the NHS pension scheme came into place. As
part of a CARE scheme, it is perfectly possible and even desirable to make the award pensionable even
if its value is removed in subsequent years. Recent pension changes have resulted, for example, in
some doctors working for an additional seven years, paying an additional £225,000 in pension
contributions and receiving a pension that is 7.5 per cent less than under the previous scheme. The
BMA believes that it is not, therefore, appropriate to suggest that further pension reform is necessary
within the CEA scheme given the much more widespread changes outside the scheme. Instead, we
consider that the DDRB should revert to its previous position as quoted above now that the pension
scheme has been downgraded.

Turning to the length of CEAs, the DDRB is correct that, until recently, some consultants viewed them
as an addition to basic pay on a permanent basis. However, recent changes to the scheme both locally
and nationally have removed some of that certainty. Awards are now reviewed and can be taken away
without pay protection. This has resulted in some consultants losing tens of thousands of pounds
annually and the additional loss of contributions to their pensions. They will have paid pension
contributions at increasing rates but will derive no pension benefit from these contributions.

The suggestion that one-year awards should be the norm is not likely to be attractive to consultants,
as it limits their ability to plan financially for the future. The suggestion may also encourage a culture
where only short-term pieces of work are undertaken and rewarded rather than long term projects.
The BMA is more supportive of awards lasting in the region of three to five years, allowing movement
of awards money on a regular basis to act as an incentive, but also capable of rewarding short, medium
and long-term pieces of work. For example, if a consultant started a piece of work which would take
two or three years to complete, there would be an opportunity for a reward to cover the period of
that work rather than only part of it.

Reviewing existing awards is entirely appropriate – but it is important that the presumption would be
that the award should be retained unless there are very clear, objective and categorical reasons why
the award should be removed. The BMA has no confidence that financially strained trusts would not
use the review mechanism as an opportunity to remove awards in order to facilitate savings. A robust
appeals mechanism should be introduced to act as a safety net for poor local decision making driven
by financial savings. Ensuring that all money saved is directed back into the awards pot would go some
way toward ensuring that motives for award removal are reasonable.

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74 Review Body on Doctors’ and Dentists’ Remuneration 39th Report 2010
There must be absolute pay protection and protection of accrued rights including pensionability for future service even if the award schemes are drastically changed. A line must be drawn when a new scheme is introduced and all of the consultants who are in receipt of awards up until that point must have them protected on the basis that they were when they were accepted; to do otherwise is unfair and risks demoralisation and decreased productivity from consultants who perceive the new system as being unfair, particularly if they have had awards effectively removed.

**Recommendation 3:** We recommend that the health departments provide annual evidence to the DDRB on the level of funding for local award schemes.

The BMA supports this recommendation and that any shortfall in a given year at a local trust is fully compensated for in the next year.

**Recommendation 4:** We recommend that employing organisations publish annual data on the awards made and details of their local award schemes.

The BMA supports this recommendation. Annual reporting has been patchy in the past and this needs to be addressed. Mechanisms should be developed to ensure local reporting is completed.

**Recommendation 5:** For national award schemes, we recommend that such schemes should operate within a United Kingdom-wide framework of common principles and governance and should include the following:

- Awards should recognise those consultants with the greatest sustained levels of performance and commitment to the NHS and whose achievements are of national or international significance

- The system should be transparent, fair and equitable

- Awards should be made only for work that is done over and above job plans

- Awards should not reward activity already remunerated elsewhere, for example through additional PAs or SPAs, unless the outcomes are significantly above expectations

- Under the new schemes, local and national awards may be held simultaneously

- All successful national awards should require ‘sign-off’ by the employing organisation chief executive on an annual basis

- Application for an award should be by self-nomination; the cost of national awards should continue to be met centrally

- Awards should be non-consolidated and non-pensionable; awards should be held for a period of up to an absolute maximum of five years, the length of which should be determined by the awarding body at the time of granting the award and should be linked to the sustainability of the achievements

- The level of the national award should be linked to the impact of the achievements

- Consultants should be able to apply for a new award at any time

- Subject to accrued rights, there should be no pay protection
• Existing awards that remain subject to review should not include any grace period

• Subject to accrued rights, consultants who retire and return to work should not retain any national awards, although they should be eligible to apply for a new national award in the same pool as new applicants.

The same points made under the response to recommendation 2 apply here.

Recommendation 6: We recommend that clinical academics holding honorary NHS contracts continue to have access to any future local and national award schemes alongside NHS consultants.

The BMA supports this recommendation.

Recommendation 7: We recommend that payments made under any new award scheme, at national or local level, should be made on a non-pensionable basis.

Recommendation 8: We recommend that existing awards are no longer pensionable for future service, following a suitable transition period, to be determined by the parties.

The BMA opposes these recommendations for the reasons set out under the response to recommendation 2.

Recommendation 9: We recommend that, in the light of the changes that we are recommending for the schemes, the awarding bodies should revisit the domains and their weightings, in particular to distinguish elements of the domains with a local focus from those elements with a national focus, while ensuring that work carried out at a local level for the wider NHS is still recognised.

The BMA supports this recommendation.

Recommendation 10: We recommend that work undertaken for the royal colleges should continue to be recognised through the award schemes, where appropriate.

The BMA supports this recommendation on the basis that such work is not paid for twice. The BMA supports the principle of rewarding a range of different activities to demonstrate excellence, of which work for royal colleges is one.

Recommendation 11: We recommend that public health consultants and directors of public health should continue to be eligible for the award schemes and that, in the light of the forthcoming changes in England to their employment arrangements, the rules and guidance should be amended to ensure their continued inclusion in the schemes.

The BMA supports this recommendation, although it should be noted that the changes to employment arrangements described above have since been implemented. We would reiterate our point made in answer to question 2 that those consultants who do not have patients registered under their own name, such as those working in public health, should not be disadvantaged under a CEA system.

Recommendation 12: We recommend that, in order to form a balanced committee, the composition of members in the national awards committees should be comprised of an equal ratio (for example 6:6:6) of clinicians (some of whom may be academics), employers and lay members, and that the ultimate decisions on national awards should rest with the national awards committees. We
recommend that employer-based awards committees conducting reviews of existing local awards should have a similar constitution to that of the national awards committees.

Local award committees must continue to have a majority of clinicians on them in order that consultants are judged by their peers, who are best placed to assess the quality of the work delivered. While some management and lay person input is appropriate, it is essential that any judgement of clinical performance must be made by those who understand clinical performance. Clearly, this must be considered in the context of service delivery and the patient experience but that does not require a lay majority and may be impeded in its aim by providing an objective assessment by a lay majority.

The number of lay representatives could be increased on local awards panels to be close to the number of clinical representatives. However, the selection method for the lay representatives must be agreed nationally in order to avoid appointment of individuals who may automatically support clinicians or management representatives.

**Recommendation 13:** We recommend that, in order to obtain value for money from the consultants’ award schemes, there should be a stronger link to performance with improved links to measures of activity, quality of patient care, patient feedback, cost and a clear definition of excellence for each discipline. We recommend that the royal colleges and equivalent bodies define excellence for their disciplines.

The BMA supports this recommendation, with caveats. We believe the association must be centrally involved in developing how assessment of performance for reward purposes is concerned, if those mechanisms are to have perceived legitimacy among the medical community. This is an area of work in which the BMA has experience and expertise; the colleges are not best placed to advise on changes to pay systems.

Quality must remain the key measure. All performance assessment parameters must be capable of objective assessment if they are to be fit for purpose in this context. The BMA has reservations regarding the introduction of patient feedback, which may have some unintended consequences. Care should be taken to ensure that any new pay system applies equally well to all specialties. Those specialties which involve no or minimal patient interaction may not be well suited to patient feedback. Equally, it is essential that ‘performance’ does not simply equate to high turnover of patients.

**Recommendation 14:** We recommend that the parties give consideration to how some of the funding released from existing national awards is redistributed to employing organisations to add to the funding for the new local schemes and implementation of the new principal consultant grade.

The BMA supports the part of the recommendation which proposes consideration of transferring funding from the national award system to the local. However, any transfer of funds should be justified and calculated with clear reasoning.

The BMA has reservations about the introduction of the principal consultant grade, not least because it was only described in overarching terms in the DDRB’s report. An absolutely essential requirement of any change is that funding should explicitly follow work and excellence.

Without understanding exactly what a new grade is designed to recognise, it is impossible to support it with confidence. If it is to reward management-only roles then that limits excellence and these roles
already have well-established reward mechanisms in place. If it is to reward excellence then what are reward schemes for? If it is to reward time then why have a time-based contract? However, if more clarity can be offered, the BMA is willing to explore introducing reward structures which recognise, within a national structure, those who take on more senior roles.

**Recommendation 15:** We recommend that award holders should not be able to hold awards simultaneously on the old and new schemes, and that it should be implicit in accepting an award under the new schemes, or moving into our proposed new principal consultant grade, that individuals must relinquish any awards under the current or previous schemes.

The BMA does not believe that this is necessary. Consultants could retain existing clinical excellence awards and continue to apply in the new scheme. The system must ensure that mechanisms are in place such that, if consultants wish to retain their old award, the total remuneration of the basic salary + old award + new award would not exceed the total remuneration of the basic salary + maximum local old award unless the consultant moved to the new scheme and relinquished the old award going forwards (subject to protection of all accrued rights) on acceptance of a new award.

**Recommendation 16:** We recommend that the parties consider carefully ways in which award holders could be encouraged to move from the old schemes for national and local awards to the new, while respecting accrued rights.

Based on the premise that the BMA supports a new system, the BMA would prefer to minimise the differences between reward systems for consultants. This is both for administrative purposes and for reasons of fairness. Consideration should be given to the ways in which consultants on the current scheme could be successfully encouraged to transfer to a scheme which may, on the face of it, appear less beneficial.

**Observation 1**

The parties should review the basic pay scale, with a view to moving the emphasis towards rewarding performance and encouraging career development, and away from paying for length of service.

While the BMA would prefer that the current pay structure was strengthened rather than entirely changed, we are willing to explore a range of possible changes if they can be demonstrated to benefit all (consultants and employers) involved. The current pay scale reflects the long period of maturation for a skilled workforce and was introduced at the request of the DH during the contract negotiations in 2003. The pay scale no longer fits well with a CARE pension scheme and needs revision to ensure that consultants are not further demotivated by an even greater financial loss in the shape of a loss of pension benefit. We believe that a new pay scale should be shorter. However, as stated elsewhere in this evidence, the current pay progression system for consultants on the 2003 contract is not automatic. Progression is limited to those who meet agreed objectives. It would be worth the DDRB considering whether bolstering the objective-setting and performance review processes would be a relatively simple way of addressing this perceived problem.

**Observation 2**

The parties should consider introducing a principal consultant grade.
The BMA has reservations about the introduction of the principal consultant grade, not least because it was only described in overarching terms in the DDRB’s report. An absolutely essential requirement of any change is that funding should explicitly follow work and excellence.

Without understanding exactly what a new grade is designed to recognise, it is impossible to support it with confidence. If it is to reward management-only roles then that limits excellence and these roles already have well-established reward mechanisms in place. If it is to reward excellence then what are reward schemes for? If it is to reward time then why have a time-based contract? However, if more clarity can be offered, the BMA is willing to explore introducing reward structures which recognise, within a national structure, those who take on more senior roles.

**General comments**

The BMA supports a national structure governing a reward mechanism for NHS consultants which promotes clinical excellence in all its forms. The gradual trend towards increasing employer freedoms regarding the governance of the scheme has been haphazard and often driven by financial concerns. For this reason, the BMA supports a return to a clear national structure with limited scope for local interpretation written into the contract. This would encourage consistency, promote excellence and limit the scope for financial considerations dominating over all others. The mechanisms by which consultants’ work is assessed need to be much more standardised and centralised so that the scheme is more transparent and fairer than it is at the current time.

Raising the quality of care should always be seen as the starting point to achieve a ‘target’ rather than the target seen as an end point in itself. For example, too many employers focus on achievement of the four-hour target (no matter how useful it has been in reducing lengths of stays in emergency departments) rather than focusing on improving the care delivered in the emergency department, and the rest of the hospital, with consequent improvements in the achievement of the target.
ANNEX C

This section provides the detail to support our answers to questions 4 and 5. The BMA has answered questions 4 and 5 together.

4. What were the issues in the doctors and dentists in training contract negotiations for which agreement could not be reached? What proposals were put forward? How do these proposals link to the heads of terms?

5. What pertinent information do you have on the working patterns of doctors and dentists in training?

Introduction

In September 2013, the BMA entered into negotiations with NHSE with the aim of agreeing a new contract for doctors in training in the UK which was best for patients, fair for doctors and sustainable for the NHS.

Discussion of topics took place concurrently, rather than consecutively. As a result, it was not until late in the process that it became clear agreement could not be reached. In October 2014, following receipt of a paper from NHSE outlining their requirements for a new contract, we announced negotiations had stalled.

We remain willing to negotiate with NHSE to develop a new contract for doctors in training. We believe that full and open negotiation between the BMA and NHSE could still produce a sustainable contract that takes into account the needs of all groups and would remain fit for purpose into the foreseeable future.

However, we would need assurances that enough time would be allowed for sufficient data collection and modelling to ensure a contract that is sustainable for the NHS and fair for doctors in training. Likewise, robust contractual safeguards must be incorporated to ensure patient safety and the welfare of doctors in training.

The main obstacles that prevented agreement being reached were:

Insufficient data and modelling

A lack of detailed evidence and robust modelling to ensure proposed changes to the system of pay for doctors in training would be sustainable in both the short and long term. A lack of information on current working practices, working patterns and the number of trainees for whom their training grade is out of sync with their pay point prevent accurate prediction of the size of any future pay pot.

Potential workforce implications

The negative impact that changes to the pay progression framework would have on groups of trainees, notably doctors who take time out of training, those training less-than-full-time and trainees who pursue careers in academic medicine. We remain concerned that the proposed changes would discourage individuals with a wide range of career options from choosing medicine, and would encourage many current junior doctors to complete their training outside the UK.
Our concern that some proposals to redistribute the pay bill would discourage trainees from studying in some specialties, such as emergency medicine. We proposed extending the negotiations to allow time for more data to be collected and properly considered, but our negotiating partners were not prepared to agree to either collecting more data or extending the talks.

**Lack of safeguards to ensure patient safety and the welfare of doctors in training**

Crucial hours safeguards cannot be left to non-binding unenforceable guidance.

Proposals to extend plain time to cover 7am to 10pm, seven days a week, without sufficient consideration of the impact on patient safety and the welfare of doctors in training. These proposals were made in the absence of a broader and coherent model of seven-day services, discussed in more detail earlier in our evidence.

NHSE were not prepared to recycle direct savings that would have been made from a new contract (for example, many of the changes to pay progression we investigated would have led to a gradual reduction in the pay bill over the next 10-15 years) back into the envelope beyond a short and unspecified transitional period. This would lead to a gradual erosion in the value of the doctors in training contract. The pressures on NHS funding pose a serious threat to the sustainability of NHS services and the delivery of safe, high-quality patient care. In spite of the DDRB’s own recommendations, NHS employees continue to experience real terms pay cuts. We still believe that, it is possible to develop a new contract that, in and of itself, does not cost any more than the current contract. We have come to the conclusion that any transitional costs incurred moving from the current contract to a new contract must be funded from outside of the envelope. Any new recruitment and retention premiums should be funded with new money – to take it from the current pay of doctors in other training programmes could lead to a vicious circle of recruitment problems that need to be patched.

**Work planning**

In agreeing to discuss alternatives to banding, we hoped to address the following concerns expressed by junior doctors:

- A feeling that monitoring is insufficiently robust and that some junior doctors feel pressurised to under-report their hours
- Rotations between placements with different rates of banding attached to them make financial planning difficult.

However, in discussing alternatives to banding the BMA was keen to ensure that any new system retained safeguards which prevented junior doctors being forced to work excessive hours.

In our negotiations with NHSE we looked at a number of different models of pay that we hoped might improve on, or at least match, the effectiveness of banding.

We expect any alternative model to:

- Acknowledge the antisocial nature of some working hours
- Be simpler to understand and administrate
• Reduce the fluctuation in doctors’ salaries, and lead to a more predictable pay bill for employers.

One alternative discussed during the negotiations was to pay junior doctors for the hours they work. In the negotiations we discussed the possible introduction of a pay framework based on an underlying hourly rate of pay.

However, we have serious concerns about the viability of this model. In particular, we are concerned that such a system would:

- Not provide a mechanism to ensure a good balance in pay between doctors working in low intensity and high intensity specialties
- Risk making some specialties less attractive than they are currently, affecting recruitment and retention
- Greatly add to the complexity of the pay system and therefore risk an increase in the number of disputes between individual doctors and their employers
- Remunerate unplanned hours of work to prevent exploitation of doctors in training by their employers. Trainees regularly cover service gaps, emergencies and excessive workload but should be paid for their time
- Ensure that specialties (eg psychiatry) in which non-resident on-call shifts are prevalent do not become unappealing to trainees. Non-resident on-call working, in which junior doctors are on-call, but not based on site at the hospital, should be reimbursed at the prevailing plain time or premium time (as applicable) hourly rate.

If an hours-based pay structure is to be seriously considered by the DDRB, we believe further data should be collected so that the impact of any changes can be fully understood. However, in the absence of such data to support and model any new proposal, the BMA believes the current system of banding should remain in place, although it can still be improved upon. In particular:

- The current bands should be restructured to better reflect the needs of junior doctors and the service today
- The rules regarding monitoring should be adjusted for clarity to avoid costly and unnecessary disputes
- Improvements could also be made to the monitoring process to remove much of the ambiguity which currently exists. This would reduce the reported tensions between employers and junior doctors and reduce the need for both employers and junior doctors to seek recourse through banding appeals.

Any alternative pay structure must retain the key safeguards incorporated within the system of banding payments.

Banding

In this section of the evidence we will expand on the reasons for which we are reluctant to move away from banding without a suitably defined alternative which has been sufficiently modelled.
How banding works today

The current banding system was introduced in December 2000. It was designed to ensure that junior doctors, whether they are working full or part-time, are fairly paid for the hours that they actually work, the frequency of their out-of-hours work and the distribution of their hours. It applies to all doctors in training, with the exception of GP trainees working in general practice posts.

The ‘New Deal’ was originally agreed in the early 1990s and sets limits on doctors’ working hours. Since 2000 it has formed part of doctors in training’s terms and conditions of employment.

A full-time doctor in training is contracted to work a standard 40-hour week, plus further contracted hours that are requested by an employer. These can include:

- Out-of-hours work
- Prospective cover for annual/study leave of colleagues
- Other regular commitments, including early starts and late finishes
- Other duty hours necessary for continuity of patient care.

Under the banding system, junior doctors are paid a basic salary, which varies depending on grade. This basic salary can be topped up by banding supplements, which are paid on top of the basic salary as a percentage of basic salary. The value of banding supplements increases as the total number of hours worked and the total number of antisocial hours worked increases.

There are three bands currently in operation, as follows:

- Band 3. This includes all rotas which are not compliant with the New Deal’s hours limits or rest requirements. These will be rotas that require more than 56 hours of actual work per week, or that do not deliver the required rest or natural breaks. Today, it is illegal to contract a junior doctor on a band 3 rota, but they are still paid occasionally where poor planning leads to, for example, inadequate rest or excessive periods of duty
- Band 2. This includes all posts that are compliant with the New Deal and require between 48 and 56 hours of actual work per week
- Band 1. This includes all rotas that are compliant with the New Deal and require between 40 and 48 hours per week
- Unbanded. Included for completeness, this includes full-time rotas that consist of a maximum of 40 hours per week, all worked between 7am and 7pm, Monday to Friday.

Pay bands are subdivided to reflect the amount of antisocial work that is undertaken. Band 2 is split into bands 2A and 2B, and Band 1 is split into bands 1A, 1B and 1C, as follows:

- Bands 2A and 1A include all rotas that, within their respective hours limits, require the most frequent work at the most antisocial times, as defined by the specific banding criteria. This includes:
  - Posts where at least one third of the hours of work fall outside 7am to 7pm Monday to Friday

Page 64 of 101
Posts where work includes at least one in three weekends (Band 2A) or one in four weekends (Band 1A)

On-call posts where, for at least half of the periods of duty outside 7am to 7pm Monday to Friday, trainees are required to be resident at their place of work or otherwise to work for at least four hours in that out-of-hours period (where the above criterion is also met)

- Bands 2B and 1B include all rotas that, within their respective hours limits, require less frequent and less antisocial hours work. This covers posts which do not fall into Bands 2A or 1A, but which are more onerous than to fall into Band 1C. This includes:
  
  - Posts where less than one third of the hours of work fall outside 7am to 7pm Monday to Friday
  
  - Posts where work is less frequent than one in three weekends (Band 2B) or one in four weekends (Band 1B)
  
  - On-call posts where trainees are not required to be resident at their place of work, or otherwise to work for at least four hours, for as much as half of the periods of duty outside 7am to 7pm Monday to Friday (where the above criterion is also met)

- Band 1C includes all rotas that require junior doctors to work between 40 and 48 hours per week with a low frequency non-resident on call pattern of work. This includes:
  
  - On-call rotas with duty no more frequent that one in eight, and with no requirement for trainees to be resident at their place of work while on duty outside 7am to 7pm Monday to Friday.

This is a summary; the precise details of the banding criteria are outlined in the terms and conditions of service.

The percentage supplements for each band are given as a multiplier that is applied to the doctor in training’s basic salary to give the total salary. These multipliers are as follows:

**Table 2: Multipliers given to each band, applied to a junior doctor’s basic salary**

<table>
<thead>
<tr>
<th>Band</th>
<th>Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 3</td>
<td>100%</td>
</tr>
<tr>
<td>Band 2A</td>
<td>80%</td>
</tr>
<tr>
<td>Band 2B</td>
<td>50%</td>
</tr>
<tr>
<td>Band 1A</td>
<td>50%</td>
</tr>
<tr>
<td>Band 1B</td>
<td>40%</td>
</tr>
<tr>
<td>Band 1C</td>
<td>20%</td>
</tr>
<tr>
<td>Unbanded</td>
<td>0%</td>
</tr>
</tbody>
</table>
Data that NHSE shared with us during the negotiations indicates that the average banding multiplier across the junior doctor workforce is 41.7 per cent.

An adapted version of the banding model is used to calculate pay for less-than-full-time (formerly known as flexible) trainees. Their basic pay is calculated using the actual hours of work, with an additional percentage banding supplement to reflect the frequency and antisocial nature of a trainee’s out-of-hours work. The five categories of basic pay that apply to less than full time trainees are:

- **F5.** This applies to trainees who work between 20 and 24 hours per week, and attracts 50 per cent of full time basic pay
- **F6.** This applies to trainees who work between 24 and 28 hours per week, and attracts 60 per cent of full time basic pay
- **F7.** This applies to trainees who work between 28 and 32 hours per week, and attracts 70 per cent of full time basic pay
- **F8.** This applies to trainees who work between 32 and 36 hours per week, and attracts 80 per cent of full time basic pay
- **F9.** This applies to trainees who work between 36 and 40 hours per week, and attracts 90 per cent of full time basic pay.

The banding supplements (FA, FB, FC and Band 3) then follow the same model and principle as the full time bands. For precise details, see the terms and conditions of service.

**How banding ensures safe and fair working patterns**

A benefit of banding is that, as well as providing a mechanism to ensure that junior doctors are paid fairly for the work they do, it acts as a safeguard to ensure that limits on working hours and breaks are actually implemented.

We believe that the reduction in hours seen over the lifetime of the current contract was driven firstly by contractual mechanisms linked to financial incentives for employers and then by a further combination of that contractual mechanism with legislation.

Unless the link between hours limits and a financial incentive for employers is maintained, the hours that junior doctors work and the intensity of work patterns, will begin to creep up again. This will put the safety of patients and doctors at risk. This would be unacceptable to the BMA and to the wider public.

**How banding is used to deliver flexible medical care**

A recent study has shown that using the banding system to provide efficient utilisation of the available workforce could be achieved. This study demonstrates how different working patterns could be modelled under the constraints of the current contract to provide a more flexible workforce while allowing best practice guidance on rota design to be followed. Further modelling at a national level is
need to consider the cost implications of this. Additional consideration must also be given to the implications for individual doctors’ working lives from working such arrangements.\textsuperscript{75}

**Refinements that could improve the effectiveness of banding**

There are two key refinements to banding that we wish to propose at this time. Firstly, that the current bands should be restructured to better reflect the work patterns of junior doctors and the service today. Secondly, that the rules regarding monitoring should be adjusted to avoid costly and unnecessary disputes while ensuring robust safeguards remain in place to protect both doctors and patients.

In its 38\textsuperscript{th} report, in 2009, the DDRB said: ‘For a number of years, we have felt that the parties should give consideration to restructuring junior doctors’ pay to place less emphasis on banding multipliers.’

In its contract scoping report\textsuperscript{76}, NHSE noted that employers and the BMA believed there were flaws with the current banding system. One of the key concerns identified, noted in paragraphs 5.18 (BMA) and 5.19 (employers), was that the pay bands are broad and sharply delineated.

We believe that there is a strong case for restructuring the bands themselves. The percentage supplements that are linked to each band could be amended slightly, and the difference in pay between each band could be reduced. New bands could also be introduced if necessary to smooth differentials in pay. Rarely used bands could, if appropriate, be closed or reallocated. Crucial to the acceptability of any restructuring would be the maintenance of the pay envelope with modelling to demonstrate this.

There is also scope to link the protections outlined in the safe working hours section of this evidence to any revised banding mechanism. This would provide a contractual safeguard to ensure that they are implemented.

We have struggled to cost potential changes to the banding system in detail because of the limited data made available to us, and the reluctance of NHSE to provide this data.

Given the concerns we have about the hours-based pay model, outlined below, we believe it is vital that more detailed information on banding payments is needed to complement the information we have collected about the hours that junior doctors are actually working. In particular, we would like the DDRB to ask NHSE to collect the following data and to share it with the DDRB and the BMA:

- Average banding by specialty
- Distribution of bands by specialty (ie percentage of doctors on each band)
- More comprehensive data on working patterns by specialty (ie extension of the existing data from rota verification to include a sufficiently high number of rotas from underrepresented specialties)

\textsuperscript{75} Moreton A, Cowdery N. How Would Seven-day Elective Care Look for Junior Doctors? British Journal of Healthcare Management 2014;20:338-343

• Estimated impact of seven-day services on existing working patterns.

Refinements that could improve the effectiveness of monitoring

Improvements could also be made to the monitoring process to remove much of the ambiguity which currently exists. This would reduce the reported tensions between employers and junior doctors and reduce the need for both employers and junior doctors to seek recourse through banding appeals. NHSE and the BMA should work together to streamline the process of monitoring.

Implementations considerations

Refinement of the existing system of banding and monitoring would allow human resources departments already familiar with the concept of banding to quickly adapt to a refined pay model. An all-new system of hours-based remuneration would be disruptive and the benefits of any new pay structures uncertain.

An hours-based model

During the contract negotiations, we explored an hours-based model of pay in some depth. This section gives more detail about the model explored and our concerns with how it would work in practice.

How an hours-based model should work

An hours-based pay framework should be based on a minimum full-time contract of between 40 and 48 hours – the hours worked would vary depending on the requirements of the post. This would be pro-rated for doctors working less than full time – for example, a doctor working 50 per cent FTE would be contracted to work between 20 and 24 hours.

Pay for planned hours

Pay for planned (rostered) hours would need to be at a plain time rate or at an out-of-hours/antisocial hours rate, depending on timing.

The actual number of planned hours a junior doctor works in a given week would be dependent on their rota and the shifts or periods of on call they have been allocated to work that week. As a result, the number of hours worked may vary from week to week and from month to month. Therefore, to ensure pay stability for both employers and junior doctors, the number of hours that make up the planned hours for pay purposes would need be averaged out over the rota cycle.

We believe a weakness in the hours-based pay model is that it would greatly add to the complexity of the pay system. It would be difficult for doctors to understand how their pay was linked to the hours they actually worked, increasing the opportunity for disagreements and ill-feeling between employer and employee. It would also be burdensome for employers to administer.

Pay for unplanned hours (including missed breaks)

Unplanned hours would include additional hours (beyond rostered hours) that junior doctors are explicitly asked to work by their employer. They would also include additional hours that a junior has to work to ensure the safety of their patients, and additional hours incurred as a result of not being
able to take planned breaks, which may need to be worked even if employers do not explicitly request them on a case by case basis.

In an hours-based model of pay, it would be vitally important to record, and pay for, these hours, which effectively represent service demand that has not been fully planned for and where junior doctors are covering the gaps. Pay for unplanned hours provides employers with a direct financial incentive to plan and implement effective rotas that minimize the risk of excessive working.

Junior doctors have lives outside of work. Unplanned work disrupts the lives of doctors in training. Because of the negative impact that unplanned work has on doctors’ lives, we would expect pay for all unplanned hours to be paid at the appropriate rate for the time of day they are worked, plus an additional percentage premium.

Pay for unplanned hours would need to be paid in addition to pay for planned hours and in arrears. Pay for missed breaks would need to be paid at a pro-rata rate to cover the actual duration of breaks missed.

The chart below contains an illustrative example of an unplanned rate.

**Figure 3: Example of unplanned rate***

<table>
<thead>
<tr>
<th>Time</th>
<th>Rate of pay for additional hours</th>
<th>Antisocial hours paid at 1.5 times</th>
</tr>
</thead>
<tbody>
<tr>
<td>7am to 7pm</td>
<td>7.5</td>
<td>22.5</td>
</tr>
<tr>
<td>7pm to 7am</td>
<td>15</td>
<td>11.25</td>
</tr>
</tbody>
</table>

*Please note that these rates are for illustrative purposes only*

During our negotiations, the BMA and NHSE jointly invested considerable time in developing a system called exception reporting. Exception reporting would have formed a part of the work scheduling and work reviews system, more details of which can be found later in this evidence.
Under an hours-based model of pay, exception reporting could be used to confirm instances where a trainee’s day-to-day work differed from their agreed work schedule. Primarily, those differences would have been a difference in either the doctor in training’s:

- Hours of work, including unplanned hours and missed opportunities for rest breaks, or
- Agreed working pattern, including missed educational opportunities.

Exception reports would have also offered employers the opportunity to assess issues as they arose and to make timely adjustments to work schedules, while also reducing the degree to which their pay bill is unpredictable in nature. To ensure that accurate information was captured, the exception reporting system would include safeguards to ensure that doctors in training did not feel pressurised to withhold exception reports.

Although both the BMA and NHSE were able to agree that unplanned activity that had been explicitly authorised in advance by a doctor in training’s employer should be remunerated, NHSE were not prepared to agree to remunerate activity that could not be explicitly authorised in advance.

This is important because there will inevitably be some circumstances where a doctor in training is not able to seek approval for unplanned hours in advance. For example, in an emergency, or when no-one able to authorise additional hours is available.

**Non-resident on-call shifts**

Under an hours-based model of pay, a mechanism would also need to be developed to pay for non-resident on-call shifts. These are shifts in which junior doctors are on call, but not based on site at the hospital. They are required to be immediately available by telephone and able to come into the hospital at very short notice. Because of their antisocial nature, we would expect non-resident on-call shifts to be reimbursed at the prevailing plain time or premium time (as applicable) hourly rate.

On-call working is desirable from a service perspective as it allows medical cover to be provided at antisocial times without the additional loss of medical staff during daytime hours. Uncertainties around working while on call and the need to respond to clinical matters immediately mean that this time should be paid for as work.

**Valuing hours worked in plain time and premium time**

One of the biggest challenges we faced in negotiations with NHSE was how to allocate funding between different elements of the contract. In particular, how to value hours worked in plain time and hours worked in premium time in a way that was both fair and would not destabilise the current or future workforce.

As noted above, our work was hindered by a lack of available data, plus a lack of time to analyse and consider the implications of different approaches. In this section of the evidence, we have presented some of the concerns we expressed to NHSE, concerns which we believe make the hours-based model unviable.

The assumptions we have made below are based on figures obtained through the NHSE data collection exercise, which produced data we would consider to be below the standard necessary to model
effectively. The sample size was low and therefore granularity does not really allow to compare specialties in depth but it does allow us to give an overview. The data is not robust as in some cases it was based on only two or three rota. However we believe it is important to illustrate the impact that changes could have on different specialties, especially given the recent recruitment crises in such specialties as emergency medicine.

It has also not been possible to explore the impact of an hours-based model in as much depth as we would have liked, as there are a number of unknown variables, for example different rates of pay for plain time, out-of-hours time, the definition of plain time and premium (out-of-hours) time; whether and how savings made through the proposed pay progression method would be recycled (for example, to bolster basic pay), and lack of robust data on working patterns across all specialties.

However, the limited data available to us gave us significant cause for concern. NHSE proposed the expansion of plain time hours and a reduction in the number of hours in premium time. Their preferred option was to extend plain time to cover 7am to 10pm, seven days a week.

In broad terms, expanding plain time hours is likely to reduce the remuneration afforded to trainees working in specialties with significant antisocial hours (like emergency medicine). By contrast, it is likely to increase the economic rewards of training in specialties without significant antisocial hours (like dermatology).

With the limited data available, the below chart gives an indication of the comparative differences between emergency medicine, general surgery and dermatology, to extending plain time (with a premium time pay rate equivalent to time and a third):

**Figure 4: Comparison of specialties with overall average earnings, with premium rate set at 1.3 times**

This chart shows that under the current system, trainees in emergency medicine receive around 6 per cent more than the average earnings for all trainees combined, while those in dermatology earn...
around 10 per cent less than the average. When plain time hours are extended, the monetary rewards from working in a specialty with a significant proportion of antisocial hours working will fall. In this instance, a plain time until 10pm will mean that emergency medicine trainees now earn only 2.4 per cent more than the average earnings across all specialties, and dermatology trainees around 5 per cent less than average.

Of course, if the rate paid for antisocial hours working is increased, then the impact of changes to plan time hours is partially offset. Figure 5 illustrates this with a premium time rate of 1.8 times, compared with 1.3 times in the chart above. The impact of changes to the definition can be partially offset by adopting a higher rate for out-of-hours, as the difference between Figure 4 and Figure 5 suggests. It is worth noting that data around average and emergency medicine working patterns is sufficiently robust to raise concerns around incentives to train in emergency specialties, although more comprehensive data will be needed to complete an accurate assessment.

These pay cuts and pay rises could make the balance between pay and hours considerably less attractive than it currently is in some specialties, and considerably more attractive in others. This would make it even more difficult than it currently is for some specialties (in this case emergency medicine) to recruit new trainees and to retain current trainees.

If a higher rate for premium time was applied the situation would be slightly different. The below chart gives an indication of the comparative differences between emergency medicine, general surgery and dermatology with a premium time rate that equivalent to 1.8 plain time (180 per cent of the plain time rate), and the difference made when extending plain time:

**Figure 5: Comparison of specialties with overall average earnings, with premium rate set at 1.8 times**
These pay cuts and pay rises could make the balance between pay and hours considerably less attractive than it currently is in some specialties, and considerably more attractive in others. This would make it even more difficult than it currently is for some specialties (in this case emergency medicine) to recruit new trainees and to retain current trainees.

Changes to the way out-of-hours work is rewarded are going to affect the incentive structure underlying the choice of a specialty. Respondents to the BMA quarterly tracker survey consistently reported hours of work as one of the main factors that influence their career choices. A similar result has emerged from our cohort study, a 10-year longitudinal study following the life and career developments of a group of doctors since graduation from medical school. These findings suggest that junior doctors attach a high value to their work-life balance, therefore the way antisocial working is rewarded should be keenly explored when designing a new pay system. We strongly recommend that the DDRB should collect further data on current banding distribution and working patterns at specialty level.

Another factor to take into account with regards to pay is the way different out-of-hours rates have an impact on basic pay. A fixed pay envelope implies that basic pay will be reduced or increased to offset any increase or decrease of the cost of out-of-hours, on-call allowances, and additional activity. Depending on the rate of the availability allowance, any rate above 1.8 times plain time is likely to cause a reduction to basic pay.

It is important to make clear that this data does not take into account any savings made through the pay progression proposals. In negotiations, NHSE and the DH made it clear that these would, at best, only be available for a short, time limited, period. We believe that it is essential that any savings made through changes to pay progression are recycled into the envelope.

**Safer working hours**

Safety – for patients and doctors – must be at the heart of any new contract. ‘Safe working hours’ was one of the key strands of our negotiation with NHSE.

In the heads of terms, we agreed that a new contract would ‘deliver both safe working patterns and safe total hours of work’. Linked to this, we also agreed to ‘investigate limiting the number of actual working hours (as defined by statute) in a defined (in days) period’.

We propose the following new limits for junior doctors working full-shift working hours, all of which we believe should be adopted as contractual requirements. Many could be linked to refinements of the banding system as described above:

- A maximum shift length of 13 hours (as per the current WTR):

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77 Themes arising from the Ninth BMA 2006 Cohort Study Focus Groups, August 2014, BMA health policy and economic research unit
o A 13-hour contractual limit would align the junior doctors contract with the WTR and resolve outstanding confusion. It would also allow flexibility for working patterns to incorporate good handover periods, and adequate patient contact time

o However, working patterns should be designed on the basis of a 13-hour day being the exception, with most shifts falling well below this limit, on the understanding that every breach of the 13-hour limit would trigger compensatory rest under the WTR

- A maximum number of hours that can be worked in any seven consecutive calendar days – 72 should be an achievable number, but we believe further research should be undertaken to identify the optimum maximum

- A maximum number of consecutive day shifts of up to 13 hours that can be worked; no more than four would be our recommendation – this would allow doctors a period of recovery after sustained day working, in order to ensure the safety of their patients

- Feedback from doctors has indicated that working patterns that reflect the current WTR maximum of 12 days of 13-hour shifts are unacceptable, and consecutive day shifts should be limited further

- No more than four consecutive night shifts of up to 13 hours – this would ensure the sleeping patterns of doctors are not disrupted for an extended period

- Bearing in mind the evidence that suggests consecutive night shifts bring about an increase in tiredness and should be limited, the number of consecutive night shifts should be lower than that prescribed for day shifts

- Night shift definition is taken from gov.uk – www.gov.uk/night-working-hours/hours-and-limits

- A minimum number of rest days/hours before and after night shifts – we recommend a minimum of 24 hours rest before or after any night shift to allow proper adequate rest before their next shift

- Current New Deal break requirements of 30 minutes every four hours to be retained

- A break is defined as a period free from work and from any interruption that requires a doctor in training to resume work. For example a doctor could carry a bleep during his/her break, and could be bleeped provided that this is not persistent and provided that they are not required to act immediately, thereby disturbing their break. To ensure doctors in training can take time away from work responsibilities in order to eat, rest and undertake other personal activities, within the contract there should be both a clear definition of a break and an understanding of when a break should be taken. Existing contractual arrangements about natural breaks and rest are unclear and often the subject of dispute. New contractual arrangements must be clearly defined

- A new contractual reference period for the 48-hours average – we would recommend that this should be 26 weeks or the length of the post, whichever is the shorter. This would recognise that many contracts are shorter than the reference period outlined in the WTR

- A clause enabling doctors who wish to do so to opt out of the WTR

- Employers required to provide facilities during night shift (eg access to hot food and drinks, access to hygienic areas to rest comfortably and quietly while taking breaks); RCP guidance on working
the night shift promotes the benefits of junior doctors taking short naps of no longer than 45mins, arguing that napping is ‘essential for maintaining vigilance and alertness’

- Access to facilities free of charge should shifts overrun and a doctor in training is not able to return home safely (eg access to a bed and rest facilities, access to hot food and drink), to ensure the safety of the doctor. This is important in both rural and urban areas, where late night transport is not always available and travelling home alone may not be safe

- Doctors in training required to self-declare if they are fatigued and unsafe to work.

The current contract, in tandem with the WTR, was successful in reducing the overall number of hours worked. Previously, doctors in training were regularly working 100-plus hours a week.

However, although the contract and WTR set a normal limit of 48 hours per week, this is averaged out over 26 weeks. As a result junior doctors are often still required to work gruelling shifts over short periods of time.

Feedback the BMA has received from doctors in training indicates they are often being asked to work 90 hours or more in a single week and/or long runs of night shifts. Doctors in training have told us they find this exhausting and they believe working patterns like this put the safety of both patients and doctors at risk.

On top of the rostered working hours, due to the rotational nature of training, trainees often have to commute a considerable distance to and from work. Most doctors in training are required to move regularly from one training placement to another, which can happen as frequently as every three months. Due to long shift lengths couple with long commutes a number of juniors have told us they are concerned about falling asleep while driving to and from work.

Doctors in training are also concerned the implementation of the WTR has caused many employers to ‘default’ to running full-shift rotas instead of on-call rotas, which has led to a perceived worsening in work-life balance.

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78 Working the Night Shift: Preparation, Survival and Recovery www.rcplondon.ac.uk/publications/working-night-shift-preparation-survival-and-recovery

79 Examples of the feedback the BMA has received can be found in surveys about the EWTD and working hours conducted in 2008 and 2010, and the feedback received on the recent heads of terms.

80 Links refer to footnote on the previous page.


http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/N87EGV42A3KJMS352EMKJ2KDNH8KA5.pdf

http://bma.org.uk/-/media/Files/PDFs/Working%20for%20change/Negotiating%20for%20the%20profession/BMA%20Junior%20Doctors%20Report%202013.pdf

Proposals for safer working hours

These crucial hours safeguards should be incorporated directly into the contract with a financial mechanism to ensure compliance. We believe that these changes could be implemented at no cost or minimal cost and would properly ensure that patient and doctor safety is protected.

The benefits of safe working patterns defined by limitations on working hours and minimum rest provisions have been well researched and documented in a number of publications; a recent article in BMJ Careers\textsuperscript{81} states that ‘it remains unknown whether the WTR will be sufficient to keep working hours down in the absence of a junior doctor contract that financially incentivises WTR compliant rotas’, therefore we feel it is important that provisions for safe working hours make up a substantial section of any new contract for doctors in training.

The provisions we are proposing would go a long way to improving the working conditions of doctors in training in the UK, leading to better performing and safer doctors who provide safer care to patients. The BMA and its members are committed to providing patients with the best possible doctors; one measure that could ensure this is through providing safe and realistic conditions under which doctors are able to perform their best work.

Pay progression

The current model of pay progression broadly works as an effective proxy to recognise the increased contribution that doctors in training make to the health service in that doctors who are more skilled and experienced receive a higher rate of pay. However the proposals put forward in negotiations seemed to originate from Treasury cost-saving measures, had perverse consequences on different groups of trainees including academics, did not recognise skill acquisition over time and did not include provisions for recycling money into the cost envelope. For these reasons, progress on pay progression systems was hard to make.

The current pay progression system

Doctors in training are employed to provide a service and to acquire learning, knowledge and experience; the two strands are interdependent. As they progress through their training, trainees will take on further levels of responsibility for the provision of service.

The current model of pay progression works as an effective proxy to recognise the increased contribution that junior doctors make to the health service over the years and rewards accordingly. In a broad sense, doctors who have devoted more time to the NHS are more skilled and experienced, and therefore receive a higher rate of pay.

The current provisions for pay progression for junior doctors are annual increments along three-point (MN13 and MN15), five-point (MN39 and MN35), six-point (MN21) and 10-point (MN37 and MN25) pay scales.

\textsuperscript{81} The acrimonious road to the 48 hour week, Adam Moreton, November 2014: careers.bmj.com/careers/advice/view-article.html?id=20019902
A few points on the pay scales may be withheld in cases of unsatisfactory performance as instructed by AL(MD) 7/98 for example points 07, 08 and 09 of the Specialist Registrar (MN25) and the Specialty Registrar (MN37).

The table and chart below (provided by NHSE during the contract negotiations) show the relationship between pay point changes, stages of training, and time served under the current pay system. Where there is no break from training, experience and time served are indistinguishable after each year.

**Table 4: Relationship between pay point changes, stages of training and time served under the current pay system**

<table>
<thead>
<tr>
<th>Pay name</th>
<th>No of pay increases since training began</th>
<th>Year of Training</th>
<th>Experience</th>
<th>Time served</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1min</td>
<td>1</td>
<td>F1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>F2min</td>
<td>2</td>
<td>F2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>SpR min</td>
<td>3</td>
<td>CT1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>SpR 1</td>
<td>4</td>
<td>CT2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>SpR 2</td>
<td>5</td>
<td>CT3/ST3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>SpR 3</td>
<td>6</td>
<td>ST4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>SpR 4</td>
<td>7</td>
<td>ST5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>SpR 5</td>
<td>8</td>
<td>ST6</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>
Figure 6: Relationship between pay point changes, stages of training and time served under the current pay system

This shows that those following the normal transition through training would receive an increment in line with their transition through training, reaching each level and providing a year’s service to the NHS.

Model proposed by NHSE

As part of the contract negotiation, the NHSE proposed a nodal model of pay progression based on pay for the grade. The proposal outlined six nodes as follows:

Table 5: NHSE-proposed nodal model of pay progression

<table>
<thead>
<tr>
<th>Pay progression scenario</th>
<th>F1</th>
<th>F2</th>
<th>CT1</th>
<th>CT2</th>
<th>CT/ST3</th>
<th>ST4</th>
<th>ST5</th>
<th>ST6</th>
<th>ST7+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six nodes</td>
<td>Green</td>
<td>Blue</td>
<td>Yellow</td>
<td>Orange</td>
<td>Red</td>
<td>Purple</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It was unclear what NHSE proposed in respect of progression between nodes.
When considering the above table, alongside the graph showing transition against pay, it becomes evident that those following the normal transition through training would be held at a pay point for longer (for example, CT1 and CT2 are at the same level of pay). Their continued contribution to the health service and increase in knowledge, skills and experience would not be recognised as effectively as it is today.

This proposal also means that anyone who takes time for additional training for any reason, would return to the pay point from which they left. This effectively means that anyone who wishes to further their training to pursue an academic degree, for example a PhD, would be disadvantaged compared to the current system. It also effectively means that those who wish to pursue a family, and take time out to do so (predominantly women taking maternity leave and then returning to training at a less-than-full-time rate\(^\text{82}\)) would also be disadvantaged compared to their counterparts today. In addition, those who take time out for sickness, or who have a long term disability that means they can only train at a less-than-full-time rate would also be disadvantaged.

We believe that this would discourage many groups from entering the trainee workforce as a whole, would disincentivise recruitment to some specialties and longer training programmes (particularly, but not exclusively, academic training).

The chart below shows some common pathways and the difference in overall earnings expressed as a percentage of current earnings, and indicates that while those who follow the normal transition through the training programme may receive a 1 per cent increase to the total career earning (career being the training programme), others would receive substantially less than currently, particularly women who take time out for maternity (receiving almost 4 per cent less) and medical academics (receiving over 3 per cent less).

\(^{82}\) It is important to note here that there are more female doctors in training than male. [www.gmc-uk.org/20131004_Chapter_1_SoMEP.pdf_53706030.pdf](http://www.gmc-uk.org/20131004_Chapter_1_SoMEP.pdf_53706030.pdf)
Figure 7: Career total earnings by common career pathways

Savings to the pay envelope

The changes envisaged by the NHSE model would prevent doctors from receiving pay increments during their time out of training, as they currently do. This reform would result in a reduction of total earnings for the duration of training for any trainee that, for instance, does a PhD. The lower cost of such non-standard training pathways would result in savings to the pay envelope, the size of which depends on the number of trainees following each pathway.

The BMA has repeatedly stressed the importance of collecting data on the subject of non-standard training pathways in order to insure that the contract reform is neutral to the pay envelope. As stated in the heads of terms (paragraph 1.3) ‘any proposals for a new contract must not result in changes to the pay bill compared with keeping the current contracts’ now and in the foreseeable future. Unfortunately, NHSE was unable to provide any data on how trainees progress through their training. In an attempt to gain some insight, in August 2014 the BMA surveyed recently-qualified doctors and doctors in their last years of training. The size and the composition of the sample was not sufficient to draw any robust conclusions. However, our findings suggest that only slightly more than half of the workforce completes training without any delay. This survey indicates that out-of-sync pathways could result in savings equivalent to 5 per cent of the pay envelope (c£94m). This estimate was for one year. It is possible that it may be compounded over several years, but there is no robust basis for estimating the effect over several years. The impact on the total pay envelope of non-standard pathways cannot be ignored and needs thorough examination. The BMA would expect – in accordance with the heads of terms – that any saving under the new system will be recycled back into the pay envelope for reuse...
in other areas. This could be used, for example, to incentivise those taking time out of training to study or retrain in a different specialty, to ensure they suffer no loss of earnings.

**Gateway model of pay progression**

As an alternative to NHSE’s proposals, the BMA put forward suggestions we believed were more appropriate. This section explains such a model.

As doctors in training work through their careers their pay needs to increase to reflect their growth as professionals.

If automatic pay progression is to be removed, and there is an escalation in pay over the career of a doctor in training, progression through the pay scale must be ‘contingent’ upon appropriate and objective criteria.

The criteria on which pay progression is afforded should be of value to the employer, undertaken by all doctors in training and be the responsibility of the doctor to complete.

Having considered the ARCP (annual review of competence progression) process as a possible gateway for progression through the pay scale this was discounted during negotiation due to unacceptable regional variation in outcomes as identified by the GMC. If ARCP outcomes (or a linked outcome eg training grade) were to be used to assess an individual’s eligibility for a pay increase an overhaul of the current ARCP system will be required to avoid future legal challenge.

During negotiations, alternative gateways were sought and the followed identified as appropriate measures on which the decision to award a pay increase can be made:

- Engagement with revalidation
- Completion of compulsory corporate training
- Engagement with rota assessment procedures
- Meeting standards set by GMC for doctors in training
- GMC training survey completion.

The BMA believes under a gateway model of pay progression that if a trainee completes the identified indicators of progression a pay award should be issued.

It goes without saying that any changes from the current system of time based pay progression be proportionate and justifiable. Pay progression must not be withheld as a local measure of controlling costs. Pay progression should reflect that doctors in training occupy a transitional position and there should not be a large jump or fall in pay when moving into career roles.
Other key BMA proposals in negotiations

Work scheduling, work reviews and exception reporting

Work scheduling, work reviews and exception reporting formed a key strand of our negotiations with NHSE. They were developed to meet key employer and trainee needs, particularly with regard to delivery of appropriate training, planning for the efficient delivery of clinical services and monitoring hours worked/training received.

We believe that work scheduling will provide a mechanism that:

• Allows employers to plan and deliver clinical services While also delivering appropriate training to junior doctors, delivering significant opportunity for efficiency savings
• Ensures that junior doctors are provided with information about their posts and placements prior to starting each.

We believe that work reviews will provide a mechanism that:

• Can be used to monitor compliance in each of the above areas
• Can monitor the actual number of hours and the pattern of hours worked.

The text below provides a summary of the system.

Work scheduling

The work schedule should list the duties of a doctor in training, their intended learning outcomes and the number of hours for which they are contracted. It should also include the frequency and length of work breaks and periods of rest.

Work scheduling will work most effectively if it is based on a genuine partnership between employer and doctor in training. The employer would be responsible for ensuring that a ‘template’ work schedule is prepared in advance. Then, the doctor in training and employer should be jointly responsible for personalising that work schedule, taking into account the doctor’s individual training experience, competencies and needs at the time they are in the post (or placement) and any previous problems highlighted for this area of work (ie where a work review has taken place previously, this should be taken into account).

Work reviews

Without a robust mechanism to ensure enforcement, work schedules alone will not be useful. Therefore, we believe a system of work reviews should be put into place to run alongside work scheduling.

A work review would ensure that a work schedule for a doctor, or a group of doctors in training, remains fit for purpose. Recognising that underlying circumstances can and do change, the work review would also allow doctors in training and employers to consider and agree changes to the work schedule.

It must be possible for either a doctor in training or an employer to call a work review at any point.
For the majority of trainees the work review process will never progress beyond an informal stage one review, but in order to be effective must include a two-stage appeal process. These should have provision for external advice from an educationalist.

**Exception reporting**

Exception reporting is a mechanism that can be used by a doctor in training to confirm instances where their day-to-day work differs from their agreed work schedule. Primarily, these would be a difference in:

- The agreed hours of work (including opportunities for rest breaks)
- The agreed working pattern, including the educational opportunities to be made available to the junior doctor.

Exception reports would offer employers the opportunity to assess issues as they arise and to make timely adjustments to work schedules almost in real time. They would also help employers to reduce the degree to which their pay bill is unpredictable and deliver a significant opportunity for employers to improve their efficiency.

Accurate information must be collated by the exception reporting process for the mutual benefit of employers and doctors in training. To this end, contractual safeguards should be included to ensure that doctors in training do not feel pressurised to withhold exception reports.

Exception reports would also ensure that junior doctors receive appropriate training, in accordance with their curricula. They could also be used to monitor compliance with any new ‘safe working hours’ requirements.

The exception reporting system was initially designed to work alongside an hours-based model of pay, to ensure that doctors in training were appropriately paid for the work they completed, including work outside of the agreed work schedule (unplanned hours). As noted above, we do not believe that an hours-based model of pay is appropriate for a junior doctor contract, but we do believe that, in order to access the significant benefits listed above, the exception reporting model could be adapted easily to integrate with a banding model of pay.

**Leave**

Provisions for leave for junior doctors are set out in paragraphs 205-262 of the current terms and conditions of service, and fall under a number categories.

This section sets out the key principles that the BMA believes should be written into a new contract for junior doctors.

- **Annual leave**: the leave entitlement for doctors in training is currently set at 25 days for some and 30 days for more senior doctors in training, based on a standard working week of five days, normally providing six weeks’ notice. The BMA is proposing that all junior doctors should receive 30 days annual leave. The BMA believes that recognition of public holidays (of not less than eight in England) and the two extra-statutory holidays or days in lieu thereof should continue without change. However, alternative provisions could be put in place for clinical academics, for whom
time off in lieu could be inappropriate as they could be required to use such time to pursue commitments with their main academic employer

- **Study leave**: the BMA believes that full-time doctors in training (including those in the foundation programme) should receive a maximum of 30 days study leave and reasonable expenses to facilitate training and development of essential skills. Study leave for less-than-full-time trainees should be at least pro-rata to reflect their hours of work/training

- **Professional leave**: this is leave in relation to professional work, for example duties as an officer, committee member or member of a working party of a royal college, faculty, professional or scientific society or NICE. Professional leave should be allocated in addition to study leave allocation, the amount of which should be mutually agreed between the doctor and the employer when required

- **Sick leave**: existing provisions for sick leave should be maintained, with the amendment to remove the four-month eligibility criteria that applies to doctors in their first year of service. This places undue pressure on some trainees to return from sick leave earlier than they should. The BMA believes that the employer should continue to be able to request an examination by a nominated medical doctor for any doctor in training making use of the sick leave provision, provided proper procedures and relevant legislation is followed, but any expense incurred in connection with such an examination should be met by the employer

- **Special leave**: existing provision for special leave should be maintained. This is leave granted in exceptional circumstances, on a short-term basis, that would not be covered under annual, study, sickness or professional leave. This could be paid or unpaid as agreed between the doctor and the employer in advance. This leave provides both the employer and doctor with an amount of flexibility

- **Maternity leave**: current provisions within the temporary appendices should be maintained.

- **Other leave**: current provisions within the temporary appendices should be maintained with regard to parental leave, maternity support (paternity) leave, ante-natal leave, adoption leave, and leave/time off for domestic reasons. In addition, we would recommend that a further provision be included whereby employers should allow time in addition to professional and study leave for a doctor requiring absence from work to attend interviews for any posts for the furtherance of their professional career

- **Fixed leave**: fixed leave is often found on the rotas of doctors in training. It is more common where rotas are tight, even more so where numbers of doctors are small. Fixed leave restricts the times when doctors in training can and cannot take annual leave, sometimes to an unacceptable degree. Restrictions placed on when annual leave may be taken have a profoundly negative impact on junior doctors’ quality of life. They make it difficult to accommodate unexpected life events, to manage family life as a working parent, and to create a healthy work-life balance.

Although there may be a few exceptional cases where resorting to fixed leave for junior doctors is justified, we believe that it is almost always used unnecessarily. We note that fixed leave is not
a system that is in place in most other professions, including others within the NHS workforce such as consultants and nurses.

A new contract should allow greater flexibility and more choice about when annual leave can be taken. In addition, fixed leave should not be used except in very exceptional and time-limited circumstances which should be justified in writing and suitable recompense afforded to the trainee.

**Expenses**

Doctors should not be financially disadvantaged by costs they have legitimately incurred in the interests of the service and/or to further their training (which would in turn be in the interests of the service).

A wide variation in practice between employers makes it difficult for many trainees to claim for appropriate work related expenses.

Provisions related to expenses should be made clearer and be incorporated directly into a new contract to ‘minimise reference to extra documents in the interests of simplicity’ (paragraph 3.3 of the heads of terms) and create a common process that applies to all employers. A number of trainee-specific issues should also be included in any new terms and conditions to ensure clarity and proper safeguards.

Doctors in training are often required to transfer hospital or change employer to satisfy the requirements of, and remain in, professional training and therefore have to move home (or incur increased daily travel expenses). These can lead to increased travel expenses in the course of one’s daily work, and/or a large relocation expense and should be covered by the employer.

The BMA’s principles for expenses provisions are:

- Doctors in training who are required to travel on NHS business (‘official journeys’) should be entitled to receive mileage allowance and be reimbursed for miles travelled which are in excess of the home to agreed work base return journey. Specific mileage entitlements currently in place for public health trainees should also be retained. Due to the nature of the work for doctors in training, they are often required to travel to other hospitals to work, and so should be provided with reimbursement for journeys above their normal home to base allowance, when appropriate (ie if a doctor regularly travels 15 miles to work, but is required to work from another hospital which is 20 miles from their home, this extra travel expense should be covered)

- A single rate of reimbursement (up to a maximum annual mileage after which the rate changes) should apply to doctors in training; using rates that are set and regularly reviewed using the Automobile Association Trust guides as stated in Section 17 of the NHS handbook, Reimbursement of travel costs

- Reimbursement should be paid when doctors in training are required to attend training courses or events away from their normal base

- Doctors in training who are required to travel on NHS business (‘official journeys’) may be offered a Crown/lease car
• Subsistence allowances should be paid in addition to travelling and other expenses when doctors in training are required to be away ('as a result of official duties') from home.

• A meal allowance should be paid when a junior doctor is absent from home and more than five miles from headquarters, by the shortest practical route.

• When an employer invites a doctor in training to appear before a selection board or invites a shortlisted doctor to attend in connection with an application for appointment, reimbursement of eligible expenses should be paid by the prospective employer at the appropriate rates. These rates should be determined in accordance with local practice and a mechanism should be developed to ensure that they increase in line with current costs.

• The existing provision for removal expenses should be maintained. The rotational nature of a doctor in training’s work means they are often required to move home to further their training, or in the interests of the service; these doctors should be eligible to receive removal expenses. Alternatively, doctors in training could choose to travel the greater distance between their home and place of work on a daily basis, instead of moving house, and be paid excess travelling expenses (for anything in excess of the normal home to base) at the appropriate rate.

• Employers should, prior to the post being accepted, determine the scope and level of financial assistance to be provided to a doctor in training. In doing this employers should have regard to the trainee’s circumstances, whether dependents need to be ‘rehoused’ and the comparability of new and previous accommodation.

• There is nothing which precludes full reimbursement of removal expenses to doctors in training moving to take up appointments, including where they are moving from a full-time to a less-than-full-time post.

• Employers should meet any reasonable cost incurred in relocation including (but not limited to):
  - Reasonable expenses incurred in the search for accommodation in the new area.
  - Reasonable vouched expenditure incurred in the purchase and sale of property.
  - The removal of furniture and effects and continuing commitments in the old area.
  - Grants to cover general and miscellaneous removal costs.
  - Assistance with additional housing costs in the new area.

• Expense costs should be standardised for all doctors in training to ensure fairness (ie any maximum rates for reimbursement should be the same across the country, with the exception of an increase for London weighting); a mechanism should be put in place to ensure that these expenses increase in line with costs on an annual basis.

We believe that these expenses provisions cover the minimum requirements of doctors in training. Where possible they align with provisions for other staff groups, but some differences are necessary to reflect the different nature of employment of junior doctors.

**Period of grace**
The principles for the period of grace are underpinned by an existing paragraph (10) within the terms and conditions of service, which states: ‘Training placements will be arranged by the postgraduate dean in consultation with employers ... The final placement will end six months after the completion of training, or six months after notification of completion of training, whichever is the later. In certain circumstances the postgraduate dean will recommend a new fixed-term contract. A practitioner appointed to a post of specialty registrar (fixed term) shall be appointed for a fixed period of one year.’

The period of grace was introduced to aid the process of applying for posts at the end of training. This is necessary because, as set out in the Orange Guide\(^8^3\), this can take some time. It is used extensively by trainees who complete their training in order to find a post within the area and, without it, we would see doctors facing periods of unnecessary unemployment in the period between the completion of their training and the start of their first consultant post.

The BMA believes that the ability to appoint trainees beyond their CCT (certificate of completion of training) also helps employers to address rota gaps. It can also facilitate trainees remaining in the region in which they have been trained, when mismatched timings between CCT dates and consultant recruitment rounds could otherwise oblige them to apply for consultant posts outside their training area.

We note that doctors employed under this provision are able to work at the standard of a consultant while being paid at junior doctor rates.

Data collected by the BMA suggests that of those not immediately securing a consultant (or equivalent) post, after obtaining CCT, over 50 per cent made use of the period of grace. This reinforces the anecdotal evidence that suggests that the period of grace is a highly valued part of the contract which provides an element of stability between the point of qualification and the appointment to a consultant post.

This provision should be codified in the contract, and guidance can be prepared to support its use.

### Fees

The current contractual provisions for services that attract a professional fee are set out under paragraphs 31-39 of the current terms and conditions of service, effectively stating that a doctor in training may undertake and retain fees for work, whether at a hospital or elsewhere, which do not fall into the definition of private practice, and do not make up part of the practitioners ‘normal’ duties; a list of such work is provided within the provision. These duties can be carried out by an appropriate doctor including consultants, GPs and doctors in training with much of this work being completed outside of regular NHS time.

It is important that these provisions are retained for junior doctors. Without them, we are likely to see:

- A lack of training to complete such duties, meaning future GPs and consultants would be untrained in these areas

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\(^8^3\) Orange Guide, section 16, paragraph 2
www.copmed.org.uk/document_store/1314202372_JJxf_16._leaving_the_grade.pdf
• Delays to patients, public services (eg for courts and tribunals), families of patients (completion of death certificates) and would lead to undue stress on patients, families and other services

• The loss of much needed independent medical input in various aspects of public life (courts, tribunals etc).

Structure and maintenance of the contract

The provisions of the current contract of employment between junior doctors and their employers are contained within a number of documents:

• The statement of particulars [model contract] and banding questionnaire\(^{84}\)

• The Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002, version 10\(^{85}\)

• Sections of the GWC (General Whitley Council) agreement\(^{86}\), listed within an appendix of the terms and conditions of service

• Sections of the AfC (Agenda for Change) Terms and Conditions of Service\(^{87}\) as appendices in the terms and conditions of service

• Pay circulars\(^{88}\), referenced in an appendix of the terms and conditions of service

• Advance letters\(^{89}\)

• Personnel memoranda

• Chief executive letters

As part of the contract negotiations, both parties recognised the difficulties that employers and junior doctors faced in utilising multiple contractual documents. The heads of terms therefore stated that the new ‘contract will minimise reference to extra documents in the interest of simplicity’.

With this in mind, the BMA is seeking to incorporate all relevant provisions outlined above into any new or revised contract. We expect that some provisions will not need to be retained, as some aspects of GWC are no longer relevant, and that some provisions will need to be adjusted to adapt them for junior doctors.


\(^{86}\) Sections 1, 2, 7A, 7B, 7C, 22, 26, 33-34, 38-39, 41, 46, 48, 52-59 and 61-62.

\(^{87}\) Sections 15, 16 and 33-36.


\(^{89}\) Multiple letters of correspondence between governments of each nation and employers that provide direct authority on implementation of the TCS
The BMA proposes that this approach should be adopted for all GWC sections, rather than adopting any AfC sections, including for sections 7A, 7C, 38 and 39.

Six sections of the AfC agreement (15, 16, 33-36) should continue to apply to doctors in training (including the current dispensations) and be retained as separate contractual provisions in the terms and conditions.

All relevant historic advanced letters, personnel memoranda and chief executive letters should be incorporated into the schedules of the new terms and conditions of service, rather than retaining them as separate documents. The BMA has carried out an audit of the above correspondence and can provide this if it is helpful.

The resulting terms and conditions of service, model contract and guidance documentation should, as is currently the case, be maintained and updated as necessary by the negotiating parties within the existing national negotiating framework, the joint negotiating committee (juniors), alongside notification of adjustment to rates of pay via circulars.

The national negotiating framework should also continue to provide a forum for the negotiating parties to jointly agree non-contractual best practice advice and guidance on the employment of doctors in training. Other documentation related to the contractual arrangements for doctors in training that may need to be agreed from time to time should also be handled through this framework.

**Local representation of doctors in training**

Ideally the doctor in training contract should stipulate that both LNCs (local negotiating committees) and local medical committees are the regional representatives of all doctors in training in the UK and should be consulted on local issues relating to terms and conditions.

**Information on future placements (code of practice)**

Doctors in training have continually identified a need to be made aware of details about upcoming posts in good time before they commence. This view is echoed by both the Academy of Medical Royal Colleges, in its charter for postgraduate medical training, and the GMC.

In many cases doctors in training suffer genuine detriment due to a lack of information about their upcoming posts. Timely provision of information about pay arrangements, working hours and annual leave will enable doctors in training to better plan their lives in advance and will, as a consequence, also reduce the number of short notice requests for leave and changes to rota arrangements.

Doctors in training are required to provide information (copy of passport, contact information, etc) to their employer in advance of commencing their post or placement, as are employees in most other professions, but there is currently no obligation for the employer to provide information to the doctor in advance of commencement of their placement.

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90 The joint negotiating committee (juniors) is where the BMA and NHSE maintain and negotiate changes to junior doctors contracts (outside of major contract negotiations)

Timely production of this information itself is in the interests of both parties as this also serves to help employers to improve their forward planning, allowing them to identify rota gaps, reduce the use of fixed leave, etc.

Timely provision of this information is also important in ensuring that trainees safely transition between different employers. Doctors in training are often informed of their future working patterns with very little notice meaning that they may complete a final shift with one employer with only a few hours before their first shift with a new employer. This leaves them with little time to warn their employers, and often leaves junior doctors feeling pressured to work unsafe shifts that would breach the WTR.

The heads of terms for the contract negotiations committed to exploring how the information currently contained within the Code of Practice for the Provision of Information for Postgraduate Medical Training specifically relating to employers and doctors in training could be included in the contract.92

During the contract negotiations, the BMA produced proposals based on the code of practice93 that was published in 2011. The code of practice is supported by the BMA, Department for Business, Innovation and Skills, NHSE and (formerly) Medical Education England. It sets out the minimum standards for the provision of information to doctors applying for, training, and working on training rotations. Versions of the code of practice have been adopted across the devolved nations, which are similar in structure though contain relatively minor specific differences in their requirements.

Guidance developed by the National Association of Medical Personnel Specialists, which formulates and disseminates best practice to staff dealing with medical and dental terms and conditions in the NHS, states that information on postgraduate medical training could be provided to the trainee in a standard letter of conditional employment at the beginning of each post. Building on this, the BMA recommends that specific information should be provided at the point of advertisement, as well as 12 weeks prior to the start of the first post in a rotation, and 12 weeks prior to each subsequent rotation.

The BMA would like to see provisions to define the level of information that employers should be providing to doctors in training at the relevant stages of the recruitment and employment process; for example we recommend that at least eight weeks prior to commencing placement, the trainee should receive relevant information including (but not limited to) start date, duration of the post, hours of duty, location of hospital(s) or work location(s) for the post.

In 2008, it was announced that postgraduate medical deaneries ‘appear to be employment agencies and as such would be required to comply with the requirements of the Employment Agencies Act 1973 and the Conduct of Employment Agencies and Employment Businesses Regulations 2003’; these state that information is required to be provided by the employer to the employee before starting a new post. The BMA is pushing for this to be properly implemented as part of the contract.

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92 Paragraph 4.10, Heads of Terms

Codifying this information within the new contract will provide a simple process for both doctors and employers to follow, so that necessary information can be provided efficiently and promptly.

**Pay protection**

Under the current terms and conditions of service, if a doctor in training wishes or needs to retrain in a different specialty, his/her pay will be protected.

NHSE guidance states: ‘Pay protection can offer a measure of financial security to the doctor in training to whom it might apply’ and that the rationale for pay protection is ‘to allow financial planning and so that doctors are neither financially disadvantaged nor discouraged from complying with this downward trend, pay protection covers the post currently occupied, and future contracted posts’.

There are many reasons for protecting pay, not least of which is that the vast skills and experience gained through a former training period would be transferred to the new training post – communication skills, clinical procedures and techniques etc – and that the level of commitment to the health service is recognised. It also provides a valuable opportunity for the health service, by allowing doctors to move into specialties where there is an urgent need for more doctors (for example emergency medicine) without fear that their pay would be reduced.

Moving between specialties is a highly important and valued option for junior doctors.

To remove pay protection for those who retrain in another specialty would highly disincentivise any doctor in training wishing to retrain, and would exacerbate the underemployment currently being experienced in some specialties (like emergency medicine, psychiatry and acute medicine), creating a more unstable and demoralised workforce.

Similarly, other doctor groups have provision in place for protection of pay; for example staff, associate specialist and specialty doctors retain their level of pay if they return to a training grade.

We believe the skills and experience gained through training will be transferred into a new training post, and this should be recognised by protecting their pay.

**Professional costs and salary packaging**

Training is an intrinsic part of employment as a junior doctor. Doctors in training are required to take assessments and examinations, which carry substantial costs. Likewise, maintenance of a national training number usually requires attendance at a series of training courses and events, which also often carry a cost.

These costs, which doctors are required to pay to remain as a doctor in training, have been of concern to doctors in training for a number of years.

As part of the heads of terms, both parties agreed to ‘consider whether the contract could make it easier to have the legitimate professional costs of doctors in training recognised’ (paragraph 7.3) and NHSE agreed with the BMA that professional costs should be codified in the contract.

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94 www.dhsspsni.gov.uk/hrd__pay_protection__guidance.pdf
HM Revenue and Customs categorises some of the costs incurred by doctors in training as integral to their training, and therefore tax deductible, some other costs, such as certain college examination fees, are not. The BMA is supported by doctors in its belief that all of these costs are integral to the work and training of junior doctors – some in order to maintain their training, and others in order to advance their training and career in service to the NHS.

The contract should explicitly say that junior doctors are in training. This would reduce the ambiguity as to whether expenses are deductible.

In addition, we would like to introduce a salary packaging arrangement, often known as salary sacrifice. These are contractual arrangements whereby an employee gives up the right to receive part of their cash remuneration, usually in return for their employer’s agreement to provide some form of non-cash benefit, for example private dental insurance.

The ability to join a salary sacrifice scheme should be written into the contract to be reviewed every 12 months or the duration of the contract, whichever is the shorter. This allows for the fact that, despite being on a multi-year training programme, doctors in training are only employed for brief periods, sometimes as little as a few months. This issue would be simplified further if all doctors in training were allocated to a lead employer.

A number of employers already use these schemes for benefits such as childcare vouchers and for travel involving cycles and public transport (eg a cycle to work scheme). Doctors in training have committed themselves to a career in the NHS and the BMA would like to see a mechanism developed which enables them to access these schemes.

**GP trainees**

**The GP training supplement**

The supplement is important for a number of reasons:

- Without it, GP trainees would be paid 31 per cent\(^{95}\) less, a considerable reduction in salary
- It ensures that general practice remains an equitable training option and attractive career for medical graduates.

**Why it is currently needed**

The supplement was introduced to ensure that GP trainees were not disadvantaged in terms of their pay in comparison to other specialty doctor trainees and is still needed now.

Removing the GP training supplement would result in a significant pay differential between GP and hospital specialty trainees. This is likely to result in medical graduates continuing to predominantly

\(^{95}\) \(0.45/1.45 = 0.3103\)
opt for hospital specialty training posts, leaving general practice with the substantial recruitment and retention problems it is currently facing. About 400\textsuperscript{96} GP training posts were unfilled this year.

For many trainees who are seriously considering general practice, this kind of relative pay cut could prove to be a huge disincentive. Those with fixed family or financial commitments could find themselves unable to pursue careers in general practice due to the financial burden of a substantially reduced salary.

**Potential workforce shortages**

Anything that negatively impacts on medical graduates choosing GP training could exacerbate existing workforce shortages. This is already a major concern across the UK.

The DH has mandated HEE (Health Education England) to ensure 50 per cent of all medical graduates choose General Practice training\textsuperscript{97}. While very much needed, this is ambitious in the current climate.

The HEE GP Taskforce report\textsuperscript{98} and the Centre for Workforce Intelligence’s In-depth Review of the General Practitioner Workforce\textsuperscript{99}, both published in July 2014, not only highlight the current problems with GP recruitment, but recommend a substantial increase in GP training numbers is required to address anticipated patient demand.

Earlier this year, HEE confirmed to the BMJ that local education and training boards/deaneries were only able to fill 88 per cent of GP training vacancies following recruitment in 2014; a 2.8 per cent decrease on 2013. This included an unprecedented third round of recruitment. The final year’s intake, 2,688, was below another HEE target to ensure an annual intake of 3,250 GP trainees by 2016 (originally 2015).

Without pay parity among doctors in training, general practice will be seen as an even less desirable training option, further hampering the growth of the GP workforce and worsening the existing problems.

**The history behind the supplement**

The supplement was introduced to ensure doctors who opted to train for a career in general practice were not financially disadvantaged in relation to hospital doctors in training. The level was set to ensure doctors in training were not discouraged from entering the GP vocational training scheme.

Following a recommendation from the health departments and the NHS Confederation, and acknowledgement by the DDRB in the supplementary paper\textsuperscript{100} accompanying its 32\textsuperscript{nd} report that GP trainee pay had fallen behind increases in the average banding supplement paid to hospital trainees, the supplement was increased from 50 to 65 per cent in 2003/04. This ensured GP trainee pay was

\textsuperscript{96} (page 2) www.cogped.org.uk/images/docs/trainee/atcf-final-guidance-v-3-11-14.pdf
\textsuperscript{98} hee.nhs.uk/2014/07/22/gp-taskforce-report/
\textsuperscript{99} www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce/@@publication-detail
\textsuperscript{100} www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-supplement-to-the-thirty-second-report-2003
commensurate with hospital specialty training pay and helped protect recruitment into general practice.

In its 32nd report, the DDRB made clear that its intention would be to review the level of the supplement payable to GP registrars in light of both further progress in reducing the hours of doctors in hospital training, and further evidence on the recruitment of GP registrars.

Business travel

GP trainees have to carry out home visits as part of their existing contract. They are also contractually obliged to provide their own transport to carry out this task, as it is not usually practical for them to use public transport or affordable for training practices to offer Crown car facilities.

It has been known for recruitment centres to insist that GP trainees sign an agreement to use their own car for home visits too.

This is not just an essential part of GP training; it alleviates workload pressures for practices as well. While trusts are able to offer mileage reimbursement or the use of hospital owned transport at no cost to the trainee, GP training practices cannot do this.

GP trainees should not be disadvantaged and should be treated the same as all other specialty doctor trainees for the purposes of business related travel expenses.

It should be noted that Scotland currently allows hospital trainees to claim reimbursement of excess travel expenses for home to base travel. Trainees in Wales and Northern Ireland can choose to have relocation costs or travel expenses.

Occupational health vaccinations

Chapter 12101 of Public Health England’s Immunisation against Infectious Disease: the Green Book102, formerly owned by the DH, provides information about the protection healthcare staff should be offered.

The Green Book says that ‘all staff should be up to date with their routine immunisations, eg tetanus, diphtheria, polio and MMR’ and also recommends BCG (if in close contact with infectious patients), hepatitis B, seasonal flu and varicella.

All doctors in training should receive these vaccinations free of charge. Immunisation should occur in medical schools and via local occupational health services. In Northern Ireland, these services are provided to trainees and sessional GPs free of charge and are accessed through occupational health providers.

However, to ensure that trainees receive necessary immunisation, the contract of employment should state clearly that any outstanding vaccinations should be arranged and paid for by the employer.

ANNEX D – Information relating to BMA Cymru Wales

Introduction

We consider that it is inappropriate at this moment in time for the Welsh Government to be asking the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) to provide observations for reforming the consultant contract in Wales in relation to better facilitating the delivery of health care services seven days a week, including by considering the role of commitment awards. This is because these are not issues over which there have been negotiations with BMA Cymru Wales prior to this referral to the DDRB. This is entirely in contrast to the situation regarding the consultant contract in England and Northern Ireland, which has been subject to formal negotiations between the relevant governments and the BMA. Whereas the Department of Health and the Northern Ireland Executive have each sought to refer such matters to the DDRB for observation after such negotiations have stalled, no comparable situation exists in relation to Wales since no such negotiations have ever begun.

We further note that in his letter to the DDRB dated 31 July 2014, the UK Government’s Chief Secretary to the Treasury made reference to the DDRB welcoming “a proactive and systematic approach to considering contractual issues at an appropriate stage of the consultant and doctors in training negotiations”. We would contend that the situation with regard to the consultant contract in Wales cannot be regarded as being at an appropriate stage of negotiations since, as we have indicated above, there have to date been no such negotiations.

Whilst we note that, in the last year, Welsh Government and Welsh NHS employers have sought to enter talks with BMA Cymru Wales which might have involved discussions on aspects of the consultant contract which we outline below, such engagement has only been offered to us on the basis of it including the identification of ways for the Welsh Government to make a saving of 1% from the pay bill for medical and dental staff in Wales. This objective was described to us by Welsh Government as being designed “to release £12 million in each of the next three financial years.”

Moreover, the Welsh Government has specified in its letter of 9 December 2014 that the DDRB should make observations regarding how this can be done “without increasing the existing spend”, in contrast to an earlier offer of talks on the basis of identifying savings of £12 million a year from the medical pay bill. We believe that before referring such matters to the DDRB for consideration, they should first offer to have talks directly with BMA Cymru Wales on this new basis. BMA Cymru Wales is also deeply concerned that the Welsh Government has only provided its special remit letter to the DDRB on 9 December 2014, when we are being required to submit this evidence in response by the end of the same month. In our view, this is an unacceptable timeframe.

Background history of relevant discussions and correspondence between Welsh Government and BMA Cymru Wales

The Welsh Minister for Health and Social Services made a request for discussions with representatives of BMA Cymru Wales at a meeting held on 16 December 2013. At that meeting, he explained the Welsh Government had identified what it saw as the need to make a 1% saving from the pay bill for medical staff. He explained that he was only giving consideration to this saving affecting employed doctors and then further indicated that since doctors in training, specialty
doctors and associate specialists are on UK contracts, this saving would therefore be sought solely from consultants as the only group of employed doctors on a separate Welsh contract.

This request was duly considered by a meeting of BMA Cymru Wales’ Welsh Consultants Committee held on 24 January 2014. At that meeting, the committee understandably recognised that this request for talks concerning how to save £12 million in each of the next three financial years from the pay bill for Welsh Consultants was not one to which they could reasonably agree as representatives of the BMA’s wider Welsh consultant membership. It was also recognised that whilst a £12 million saving might constitute 1% of the overall pay bill for medical and dental staff, it would represent a 5% saving when just applied to the consultant pay bill alone. As a result, the committee did not feel able to provide its negotiators with a mandate to enter talks with Welsh Government on the requested basis.

In conveying this decision to Welsh Government, the Chair of the committee made it clear that BMA Cymru Wales was however “willing to work with Welsh Government and employers across a range of activities – to improve the management of the NHS in Wales, in order to secure both the best return for taxpayers and the optimal outcome for patients.” This statement clearly indicated that BMA Cymru Wales would have been happy to have considered entering talks at that time that were not simply based around the premise of how to save £12 million a year from the pay bill for Welsh consultants.

On 25 February 2014, the Chief Executive of Cwm Taf Health Board wrote on behalf of NHS employers to the Chair of the Welsh Consultants Committee stating that “as employers we now have no alternative but to directly engage with our staff on these issues. To that end, the only proposals we can present for consideration are those we had prepared for discussion with the JWCCC103 which we will now share with LHB and Trust Local Negotiating Committees in order to open discussions.” Local Negotiating Committee (LNC) chairmen wrote collectively in response on 13 March 2014 advising that LNCs are tasked “to ensure the effective implementation of nationally-agreed terms and conditions of employment at the local level” and that therefore “LNCs are not the appropriate bodies to participate in the negotiations you envisage.”

On 13 March 2014, following the publication of the DDRB’s 2014 report giving recommendations on pay, the Welsh Health Minister issued a written statement indicating that Welsh Government would make a pay award of the same quantum as that which the Department of Health was awarding in England.

The Chief Executive of Cwm Taf Health Board wrote to the BMA’s Welsh Secretary on 14 March 2014, inviting BMA Cymru Wales to enter into negotiations to consider, as part of a single discussion, “the financial savings required to sustain the NHS in Wales as previously outlined in my letter dated 25 February 2014” and “how an award based on the same quantum as the Department of Health’s pay settlement can be appropriately distributed in Wales amongst consultants.”

This offer was subsequently declined by the Chair of the Welsh Consultants Committee in a letter also dated 14 March 2014 on the basis it seemed to the committee that BMA Cymru Wales was only being offered the chance to discuss how a very limited pay award might be distributed differently

103 Joint Welsh Consultant Contract Committee
from England in return for agreeing how to make other savings that would remove £12 million a year from the consultants’ pay bill.

The Chair of the Welsh Consultants Committee also wrote to the Chief Executive of Cwm Taf Health Board on 14 March 2014 in response to her letter of 25 February 2014 stating that “your letter implies that Welsh Consultants Committee has effectively ‘closed the door’ on any all-Wales discussions with NHS employers, which is not the case. While my committee declined the invitation to enter into discussions given your pre-condition, there may be a willingness to hold discussions about other matters if that pre-condition were dispensed with.”

The Chief Executive of Cwm Taf Health Board wrote back on 24 March explaining that “it would be disingenuous for me to suggest that the requirement for a reduction in the paybill is not extant.”

The Chief Executive of Cwm Taf Health Board wrote again to the Chair of the Welsh Consultants Committee on 26 March 2014, reiterating that the previous offer made was to consider the two elements previously set out “as a single discussion”, thereby again ruling out any talks unless they were linked to making a 1% saving off the medical pay bill.

In a letter dated 14 April 2014 regarding the 2014-15 pay award for Welsh consultants, the Chair of the Welsh Consultants Committee wrote to the Chief Executive of Cwm Taf Health Board. As part of that letter, she again asked that “the notion of reducing the medical pay bill by 1% is removed as a pre-condition to the discussions on the consultant contract.”

In a reply dated 17 April, the Chief Executive of Cwm Taf Health Board made clear that “the specific requirement of the Minister, as clarified in our joint meeting on the 19th December, was to negotiate a 1% reduction on the paybill.” She went on to say “we continue to see the benefits in having a ‘Welsh Contract’ and value the relationship with the BMA in Wales that enables us to have our current negotiating mechanisms.”

In a letter to the Welsh Health Minister dated 20 June 2014, the Chair of BMA Cymru Wales’ Welsh Council wrote asking him to “withdraw the pre-requisite to cut the medical pay bill by 1%.”

The Minister wrote back in response on 25 June 2014 stating that he felt BMA Cymru Wales was unfairly characterising his request for conversations as “a Welsh Government demand to save 1% from the overall medical pay bill.”

The Chair of Welsh Council responded in a letter dated 9 July 2014, stating “You claim that my letter ‘unfairly characterises as a Welsh Government demand to save 1% from the medical pay bill’. At every meeting held with your officials and NHS employers’ representatives has, at their insistence, included this constraint, you may well understand how Welsh Consultants Committee reached this interpretation of your standpoint. If your position has been misrepresented to us, now is the time to correct that, please.”

The Minister responded in a letter dated 24 July 2014 by simply referring to a Written Statement he had issued on 9 July 2014. That statement announced that he had asked his officials “to ensure Wales formally joins the England and Northern Ireland negotiations on the consultant contract.”

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104 http://wales.gov.uk/about/cabinet/cabinetstatements/2014/nhspay/?lang=en
stated intention, however, was not subsequently agreed to by the parties involved in those negotiations as it would have effectively involved starting those negotiations afresh under a new heads of terms agreement – something that was not viewed as feasible.

On 13 October 2014, the First Minister clarified on public record via an answer to a Written Assembly Question (WAQ67821) that talks had only been offered to BMA Cymru Wales that involved discussing the need to achieve “£12 million in savings from the medical and dental paybill”.

On 6 November 2014, the BMA’s Welsh Secretary and the Chair of Welsh Council met with the Minister to discuss what Welsh Government might do following the referral by the Department of Health of contract issues relating to consultants and doctors in training in England to the DDRB. The BMA’s Welsh Secretary subsequently met with the Chief Executive of NHS Wales on 10 November. At both these meetings, BMA Cymru Wales’ representatives conveyed a willingness to enter without prejudice discussions regarding the possibility of entering Welsh-based contract negotiations for both consultants and doctors in training.

This led to a further meeting between representatives of BMA Cymru Wales, Welsh Government officials and representatives of Welsh NHS employers held on 24 November 2014. At that meeting the Welsh Government’s Director of Workforce and Organisational Development explained that, as the Minister had made clear in July his desire to join the consultant contract negotiations for England and Northern Ireland, he was not intending to change his mind and was therefore not willing to enter into any Welsh-based negotiations for either consultants or doctors in training.

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ANNEX E – Evidence on fatigue in a medical setting

In support of the arguments we make throughout this document, and made throughout both negotiation processes, regarding the need to include contractual safeguards to protect both doctors and patients, we present a short summary of the literature regarding fatigue, specifically in the medical setting.

Fatigue in a medical setting

Research has shown that the more tired doctors get, the more likely they are to make mistakes. A report produced for the GMC in 2012 found that fatigue ‘is associated with adverse effects on cognitive and psychomotor skills, such as working memory capacity, attentional issues and performance on simulator tasks.’ The report also noted that although reducing the overall number of working hours can reduce fatigue, it is not the only factor and fatigue ‘is also affected by different work schedules (eg number of consecutive days or nights worked, lengths of intervals between shifts). Effects of fatigue have been found to be more pronounced after night shifts than after day shifts.’ The report noted that, although further work needs to be done to explore the impact on patient safety, ‘there are therefore potential consequences for patient safety, such as increased clinical errors and diagnostic mistakes’.

The BMA has been researching safe working hours and patterns for a number of years. In 2010, the BMA board of science published a paper entitled Health Effects of Working Unsocial Hours and Shift Work which looked at the international literature and research into safe working patterns for doctors. Research from this paper was used to inform the BMA position during the contract negotiations. The BMA is currently preparing further research in this area, which will be available from February 2015. The RCP is also working on this topic and will be publishing their findings shortly; the BMA will consider this for submission as supplementary evidence.

Furthermore, work has shown that junior doctors do not always, or are not always able to, take the recommended rest to limit fatigue and suggests more may need to be done to promote this.

Fatigue and reduced performance

There are numerous studies demonstrating the negative effect more generally of sleep deprivation (both acute total and chronic partial) on attention and working memory that we believe would apply to a medical setting. Studies have shown that long-term shift work is linked to impaired cognitive

107 bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/77N84N5KQ1LVMF7XR5FI06MQNG287F.pdf
functioning with effects on memory and processing speed. A number of studies have considered the design of shift systems and suggested having shorter length shifts, fewer shifts before a rest day, stable rather than rotating shifts, and frequent rest breaks or scheduled napping within a shift.

There is a significant body of evidence to suggest a link between fatigue and reduced performance. There are potential health implications for doctors working long hours and employers have a responsibility for the health and well-being of their employees. Various studies have shown a link between sleep loss and adverse metabolic traits and a growing number of experiments are suggesting this is a causal relationship. Implementation of seven-day services cannot therefore be at the expense of the welfare of the doctors delivering that service.

Effects of fatigue have been well-studied in several domains, but there are a number of relevant medicine related studies. A review from Vorona et al. (2009) drew the conclusion that physicians do suffer sleep loss in the course of their training and practice, that sleep loss affects mood, physiology and all areas of performance, and that impaired performance leads to errors and less than optimal outcomes. The effects of fatigue as they relate to medicine fall into three main areas – cognitive effects, psychomotor effects, and stress.

The study by Gohar et al. (2009), conducted over two months in an internal medicine training programme adhering to Accreditation Council for Graduate Medical Education work-hour restrictions, identified effects on the ability to retain and manipulate information or sensory input to perform multiple tasks, for those who worked extensive on call shifts as part of their rota.

Gander et al. (2008) tested anaesthetic trainees (n=28) on a psychomotor vigilance performance test and compared their performance after day and night shifts. Performance was poorer following night shifts and increasing shift length was generally associated with slower reaction times in trainees, particularly following a night shift.

A comparative, cross sectional study by Smith et al. (2006) of male junior doctors (n=32, age 24-38 years) examined psychological and hormonal changes when working a full shift system involving blocks of seven nights. It found significant falls in cortisol levels (a reduction in cortisol being associated with chronic stress), and a reduction in general well-being, as measured by GHQ-12, following both a normal working week (9am-5pm) and, more so, following a week of nights, in comparison to after a week of holiday.

**How to guarantee patient safety**

Any or all of the effects shown through these, and many more studies, can create a risk to patient safety (eg clinical errors, diagnostic mistakes), personal safety (eg injury at work, vehicle accidents), and well-being (cardiovascular problems, burnout).

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110 Chronic Effects of Shift Work on Cognition, Jean-Claude Marquié, Philip Tucker, Simon Folkard, Catherine Gentil, David Ansiau, Occupational and Environmental Medicine, 3 November 2014
111 Barger, 2009; Folkard, 2005; Fritschi, 2009; Kauth, 2003; Murray, 2005
113 The Metabolic Burden of Sleep Loss, Sebastian M Schmid MD, Manfred Hallschmid PhD, Bernd Schultes MD. The Lancet Diabetes & Endocrinology, 25 March 2014 DOI: 10.1016/S2213-8587(14)70012-9
In the aviation industry, BALPA has campaigned for flight time limitations to guard against fatigue compromising safety in commercial air travel. They believe that ‘the UK has one of the best safety records in Europe thanks, in part, to a strict set of “flight time limitations”’.

The safeguards the BMA was seeking to introduce into the contract were not dissimilar and included: limits on working hours, rest breaks and compensatory rest and limits on consecutive night shifts. That air passenger safety in the UK appears to have benefitted from the introduction of clear national standards suggests that patient safety in England may benefit from clearer safeguards being written into the contracts of those who are responsible for their care.