Draft heads of terms on consultant contract reform

July 2013
Background

The British Medical Association and NHS Employers and health officials from the devolved nations have held exploratory talks about possible changes to the contract that covers the employment terms and conditions for medical and dental consultants working in England and Northern Ireland.

The talks were initiated in December 2012, when the UK government and the devolved administrations said that they wanted to pursue changes to the consultant contract. The announcement was linked to the publication of the Doctors’ and Dentists’ Review Body (DDRB) review of consultant award schemes. The Department of Health in England also said it wanted to explore changes to consultants’ contracts to facilitate seven-day working.

The BMA consultants committees in Scotland and Wales have not taken part in the talks with NHS employers as they believe a UK-wide approach is not in the best interests of consultants in their respective devolved nations.

The exploratory talks have resulted in this draft heads of terms – a document that outlines the scope for possible formal negotiations to achieve a new or amended contract. The heads of terms are non binding and simply set out the areas for discussion without prejudice to the outcome. NHS Employers and the BMA are reviewing the heads of terms to determine whether or not they wish to proceed to formal negotiations and to seek the necessary mandates for such negotiations. The BMA’s decision on whether to enter negotiations will be made at the UK Consultants Committee meeting on 18 September 2013.

If negotiations were to go ahead, they would directly affect medical and dental consultants working in England and Northern Ireland. For public health doctors and dentists, and clinical and dental academics, any changes agreed to the consultant contract would be subject to further discussion with their local authority or university employers. These groups would, however, be directly affected by any changes made to consultant award schemes.

For further information please visit: bma.org.uk/consultantcontract
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1. This document sets out where the British Medical Association (BMA) and NHS Employers negotiating teams (the parties) believe there is scope for reaching an agreement in formal negotiations. It is the basis on which both sides will seek a mandate to enter formal negotiations.1

2. The parties agree that the contract must facilitate the provision of high quality care by applying the highest standards of excellence and professionalism to enable both parties to meet their shared responsibilities to patients.

3. The parties agree that national terms and conditions are important to support high quality care across the NHS.

4. 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.

5. The contract must therefore be fair for doctors and affordable for employers. The parties are committed to creating a pay system that attracts, retains and motivates the right number and the right mix of medical staff to do all that is required for high quality patient care.

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1 This heads of terms provides a framework for formal negotiation between the parties but it is not in itself a binding agreement.
6. Any changes agreed through this process will apply to consultants employed in England and Northern Ireland only. It must enable them, and the teams they work in, to deliver a high quality and sustainable service in keeping with the values of the NHS Constitution. Any non-contractual changes to the clinical excellence awards schemes will apply to all eligible doctors.

7. Any contractual changes resulting from this process for clinical academics will be the subject of separate discussions between the BMA, British Dental Association (BDA), NHS Employers and the Universities and Colleges Employers Association (UCEA) before they are considered for incorporation or translation to contracts of employment for academic staff. Any agreed changes will adhere to Follett Review principles. The parties will seek to create an environment where education, training, innovation and research by both NHS and academic consultants can flourish.

8. 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. In particular the new contract will, through clarity and simplicity, seek to reduce the prospect of contest and challenge on potentially ambiguous points.

9. It is not the intention of the parties to reduce current consolidated pay for any individual doctor currently on the 2003 contract to offset consultant expansion. The parties agree that the current expenditure on consultant remuneration (to include local and national Clinical Excellence Awards (CEAs)) will not be reduced as a consequence of these negotiations.

10. Subject to a settlement being reached, transitional arrangements can also be based on a level of pension protection which is greater than the minimum statutory requirements.

11. The parties will explore whether a new contract or an amendment to the current (2003) contract is the appropriate means of introducing any agreed changes.

Clinical excellence awards (CEAs) are not currently part of the consultant contract. Any changes to CEAs would affect all doctors eligible to apply.

Consolidated pay includes basic pay, CEAs, discretionary points or distinction awards; London weighting.

If changes were to be introduced through a new contract, they would only apply to those who chose to sign up to that new contract, and would be very likely to automatically apply to new starters. If they were introduced as an amendment, they would apply to all existing 2003 contract holders. Any changes made would not apply to pre-2003 contract holders. In both circumstances the proposals would be put to a ballot.

The key principle of the Follett Review is for NHS and university organisations involved in medical education and research to work together to integrate the separate responsibilities. Read the review here: bma.org.uk/practical-support-at-work/contracts/academics-contracts/follett-review-principles

Minimum statutory requirements are that accrued pension benefits are not affected.

In England this covers NHS consultants currently employed on the 2003 consultant contract and those employed in non-NHS bodies where the terms of the 2003 contract continue to apply. For Northern Ireland this refers to those covered by the 2004 contract.

As the consultant contracts in Wales and Scotland differ in significant respects from those in England and Northern Ireland, it will be for the parties in Wales and Scotland to consider whether there should be any changes to these contracts. Consideration would need to be given about how any national CEAs are administered across England and Wales if the present scheme changes for England only.
12. The following key principles will underpin any formal negotiations:
   
   a) The contract will facilitate consultants to use their skills and experience to develop high quality services. Employing organisations recognise the value of having Supporting Professional Activities (SPA) time properly job planned, which takes into account the provision of a range of facilities such as continuing professional development, teaching and training, innovation and research.
   
   b) The contract will maintain consultant practice as an attractive career choice while delivering value for money. It will ensure that consultants feel respected and appropriately rewarded.
   
   c) The contract will uphold the professional obligations and duties of all consultants to raise concerns within established procedures without detriment.
   
   d) The contract will enable and support appropriate consultant presence to deliver high quality patient care.
   
   e) The contract will support revalidation and remediation in line with General Medical Council and General Dental Council requirements.
   
   f) The contract will seek to ensure that there are no unintended consequences, for example, in relation to some specialty groups and geographical areas.
   
   g) Any agreement will be subject to an Equality Impact Assessment.

7-day services

13. The parties will explore contractual changes to facilitate 7-day services in the interests of patients. This will include discussing the handling of scheduled and unscheduled care and the replacement of Schedule 3, Paragraph 6 of the 2003 contract (the right to opt-out of non-emergency work in Premium Time). The parties recognise the need for the contract and any supporting good practice guidance to contain protections and incentives to ensure that consultants’ skills are used in an appropriate way. These protections and incentives should safeguard their health and work-life balance, with appropriate support being made available through the provision of comprehensive occupational health services. Where possible, flexible working will be promoted.

   The following areas will be explored:

   a) Facilitating 7-day services within current contractual provisions.
   
   b) How to create work patterns that are consistent with meeting patients’ needs, the delivery of high quality services, the safety and well-being of staff and appropriately supporting those individuals working for more than one employer, for example, clinical academic staff.
c) Safeguards to be applied and agreed locally to ensure that any work done by consultants in Premium Time is appropriate to clinical needs and sufficiently resourced and supported by other services to allow consultants to use their skills.

d) Timings and rates of pay for plain and Premium Time working.

e) The health, safety and social impact on consultants of any contractual changes.

f) Safeguards on the proportion of the job plan that can be delivered in Premium Time, taking into account all work whether scheduled or unscheduled.

g) Safeguards on the frequency and minimum rest between duties for different periods of Premium Time.

h) Safeguards on the provision of amenities to support consultants working in Premium Time to deliver safe and sustainable care, for example, rest and catering facilities.

i) Consideration of transition arrangements where local agreements for Premium Time working are already in place.

Clinical Excellence Awards

14. The parties agree that both local and national CEA schemes should continue to encourage and reward those eligible under current arrangements. Equally, the same arrangements will apply to future members of those eligible groups. The schemes will reward those who demonstrate excellence in some key areas (or combinations of) such as clinical care, leadership and management, innovation, education, training and research. Any changes to the schemes must meet these objectives.

15. The parties agree that in the context of an overall agreement being reached, they will seek to incorporate local CEAs into the consultant contract.

16. To ensure confidence in the national CEA scheme, the parties agree to explore a framework by which any future changes to the structure and level of investment in the scheme will be made only after full and meaningful consultation with the BMA, BDA, NHS employing organisations, UCEA and other key stakeholders representing academic medicine.

17. The parties agree to consider whether local and national awards will remain pensionable.

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4 Clinical Excellence Awards are currently a matter for the Department of Health to determine. However, the Department has indicated that it would accept recommendations on the reform of the current arrangements as part of a negotiated agreement.

5 Currently eligibility is set out in the guidance published by the Advisory Committee for Clinical Excellence Awards available from: www.gov.uk/government/organisations/advisory-committee-on-clinical-excellence-awards.
18. The following matters will be considered as part of any negotiations on changes to local and national CEA schemes:
   a) The encouragement of sustained excellence at all stages of a consultant’s career.
   b) The recognition of sustained excellence and whether awards will in future be time limited and, if so, their duration.
   c) Whether there should be separate arrangements for national and local CEA schemes.
   d) Fairness, transparency and equity in making awards with clearly defined appeals criteria and processes.
   e) Systems of self-nomination and automatic consideration will both be considered carefully for local awards ensuring that any agreed scheme is administratively proportionate.
   f) The engagement of clinical academics and their employers.
   g) If agreement is reached, transitional arrangements will respect the position of existing award holders.

Pay progression

19. The parties agree to review the current pay progression arrangements and explore potential new mechanisms for rewarding and recognising consultants’ contributions and development. The parties agree to approach this matter openly and inventively.

20. The parties agree to work together to develop models of potential new pay systems and to share these with a view to developing a sustainable system which pays consultants fairly for the effort, skills, innovation, knowledge and leadership and the value they add to the NHS and its patients.

21. The parties agree that any new pay system must be administratively simple.

22. The parties agree that any replacement pay system must ensure that the professional rights and duties to raise concerns are preserved and reinforced at all times. Furthermore, any new pay system must provide appropriate safeguards to ensure that pay progression is not withheld as a result of raising concerns.

23. Pay progression for individual clinical academics will be considered jointly by their NHS and academic employers and be subject to a Follett-compliant process that considers the full range of a clinical academic’s activities.
24. The parties will review pay progression mechanisms particularly regarding how progression may be linked to the overall contribution of individual consultants rather than purely length of service.

25. Both parties agree the intent is not to produce variation in pay by region or consultant specialty.

26. The parties agree to discuss the following areas:
   a) Which structure would best reward the acquisition of new skills, the development of new techniques, taking on leadership roles, teaching and mentorship, innovation and research. Both sides agree to consider a range of possible options.
   b) Whether the top and bottom of the current pay scale are at an appropriate point to recruit, retain and motivate consultants according to their overall contribution while being affordable in the long term.
   c) A pay structure that better reflects a Career Average Revalued Earnings pension scheme so as to continue to offer sufficiently attractive pension benefits.
   d) How thresholds for pay progression could fairly and objectively be judged by taking into account objectively measured job-based criteria. These criteria may include an appropriately constituted and evidenced job-weighting system, linked to team, organisational and system wide objectives.
   e) Robust appeals mechanisms.
   f) How to ensure that all consultants and clinical academics have the opportunity to progress throughout their consultant careers both in terms of pay and development of roles.
   g) Appropriate structures to enable accelerated progression for those consultants who make the greatest contribution.
   h) Which elements of pay should be basic, which should be supplements and allowances, and how out-of-hours work is paid.

Other Issues
27. The parties have noted the BMA’s concerns about the independent pay review process and that they intend to lobby government simultaneously on matters such as the setting of the Doctors’ and Dentists’ Review Body’s remit in any given year.
28. The parties will explore a means through which newly appointed consultants can be assured that their posts have adequate SPAs allocated, consistent with the recommendations of the 2003 contract.

29. The parties will review the study leave provisions to ensure that this enables consultants to meet their revalidation requirements.

30. The parties will review Schedule 6 of the Terms and Conditions (Extra Programmed Activities and spare professional capacity) and consider whether the current requirement to offer an additional Programmed Activity (PA) in exchange for working private practice should remain while ensuring that consultants are able to devote sufficient time to meet the needs of patients in the NHS.

31. The parties will consider how requests for work patterns such as working part-time or annualised hours and other arrangements are properly considered through national contracts or good practice guidance. A paid sabbatical scheme will also be considered.

32. The parties will explore whether other terms and conditions are in need of review to ensure that they are up to date and fit for purpose, for example, mileage and travel provisions.

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NB: This version of the draft heads of terms has been annotated by the BMA in order to clarify or highlight key facts of particular interest to doctors. The heads of terms content itself has not been modified in any way from the original version produced jointly with NHS Employers.