MEDICAL DIRECTORS BRIEFING

Reforming the consultant contract – the journey so far

Following the breakdown in negotiations on the consultant contract with the BMA, the Government has written to the Doctors’ and Dentists’ Review Body (DDRB) asking it to make observations on the reform of the consultant contract to better facilitate the delivery of healthcare services seven days a week in a financially sustainable way, based on the proposals developed so far. This briefing provides some background to the negotiations and outlines possible next steps.

The case for change

1. There is widespread agreement on the clinical, financial and training reasons for ensuring that the quality of NHS services is consistently high, seven days a week. Employers have made it clear that the current consultant contract hinders the development and delivery of services over the whole of the week, and there have been calls for change over a number of years. The needs and expectations have changed considerably since the 2003 contract was first introduced and employers have said that they need the flexibility to respond to these changes.

2. There a number of linked drivers for change:
   - **Workforce issues,** including the Temple Report, which included recommendations on a stratified consultant grade and better use of specialty doctors; the DDRB report on Clinical Excellence Awards (CEA) Scheme; parallel reforms to Agenda for Change to help sustainability and affordability; challenges to the notion of long scales of time-served incremental progression.
   - **Move towards seven-day services,** including NHS England’s report on seven-day services; the Academy of Medical Royal Colleges standards for seven-day consultant presence and NHS England’s Commissioning Standards.
   - **System reform,** including the Francis report and Simon Stevens’ *Five-Year Forward View.*
• **Sustainability**, including the financial challenge of flat funding and rising numbers of qualified doctors.

3. Heads of Terms were agreed in July 2013, and the remit for negotiation followed in October. This remit was based on a national contract for use by NHS organisations, which would:
   • be cost neutral
   • meet the needs of patients, be fair to doctors and affordable for employers
   • provide for highest quality of excellence and professionalism
   • support the wider aims of the NHS.

A deadline for agreement was set for October 2014 with implementation from 2015.

**The negotiations with the BMA**

4. Although there was some high-level agreement on general principles, it proved more difficult to reach agreement once discussion focused on matters of detail. The BMA, for example, agreed in principle on the removal of schedule 3, paragraph 6 [on non-emergency work in premium time] provided that a number of safeguards were put in place.

**The employers’ offer**

5. The employers’ side offer sought to balance putting patient needs first with reasonable safeguards in the contract and guidance to protect the health and wellbeing of consultants. Proposals included:

**Safeguarding the core contract**

- The retention of a negotiated national framework and the BMA’s role in collective bargaining.
- A maximum 40-hour contract, unless extended by mutual agreement. No requirement for the majority of consultants to be contracted for more hours than they are currently contracted for.
- No changes to any of the core contractual entitlements – redundancy, maternity, sick pay, leave entitlements, requests for flexible working etc.

**Safeguarding pay**

- Retention of the current lifetime earnings potential.
- Accelerated access to higher pay - consultants will be able to access higher levels of pay earlier in their career than is possible under the current pay scales, as long as they meet all necessary access criteria.
- The introduction of a fairer way to reward consultants who work frequent and intense shift patterns.
- Continued access to a national CEA scheme by competitive application.
• Transitional arrangements that provide protection to existing pensionable pay.
• The introduction of a pay structure which is better suited to a career average revalued earnings (CARE) scheme.
• Local CEAs to be incorporated into the consultants’ contract as part of revised performance payments structure. As this will be a contractual entitlement all consultants will be considered for a pay award against jointly agreed access criteria.

Safeguarding health and wellbeing and supporting professionalism
• Jointly agreed safeguards (set out in the contract and supported by jointly agreed guidance), to ensure consultants are provided appropriate protections where service changes are necessary to deliver seven-day services.
• A commitment to move towards consultant-led services, which will require a growth in the consultant workforce.
• Greater emphasis on clinical engagement when determining service delivery priorities with a duty to consult being placed on employers.
• Strengthened job planning at the heart of the process for determining the appropriate clinical activity to support local service delivery.
• A limit on the number of weekends that consultants will need to be available for work without mutual agreement.
• Protection of an environment where education, training, innovation and research by both NHS and academics can flourish.

A new pay framework
6. As well as contractual changes to support the delivery of seven-day services, employers offered a new pay framework to support the sustainable and affordable expansion in consultant numbers. Within the revised structure it is proposed that:
• there would be two ‘core’ payment bands equating to two levels of consultant - newly appointed and established
• transition through the gateway between the two levels would be subject to achievement of a series of successful yearly performance reviews and, once achieved, progress would be automatic
• most consultants would be expected to be in a position to pass through the gateway after four to five years, although some would achieve this level sooner
• in addition to core pay there will be three further allowances making up final pay:
  – An allowance for responsibilities undertaken out of hours.
  – An allowance for undertaking certain additional roles which may have elements of time and added responsibility.
Performance-related pay, replacing the current local CEAs, paid on an annual basis linked to the delivery of objectives above and beyond the standard job role – including elements of team and organisational performance.

7. The BMA agreed in principle with this framework – at the time that negotiations were curtailed discussions were still underway on the implications for pensions (i.e., pensionable elements) and transitional arrangements.

BMA concerns and areas of contention

8. Although there was much agreement in principle, it proved difficult to reach full agreement on matters of detail. In general, the BMA wanted to ensure that the majority of the safeguards described above were enshrined within the new contract. Employers agreed that safeguards were important, but they should follow a mix of statutory, contractual and good practice guidance. The BMA’s view was that relying on good practice offered consultants ‘insufficient protection against the actions of an unreasonable employer’. From the employers’ perspective, establishing safeguards as a contractual right risked limiting the flexibility that employers sought and could potentially lead to the position where one contractual ‘veto’ was replaced by another.

9. In the BMA’s own words, it could not continue with negotiations because of ‘unreasonable demands from the government that could undermine patient safety’. Among the BMA’s concerns were:

• patient welfare would be put at risk by employers demands
• priority should be given to urgent and emergency care
• data and modelling on future pay proposals was wholly inadequate to allow its members to make an informed decision
• there was an underlying lack of trust in the Government based on previous experiences on pay and pensions
• employers failed to move beyond broad statements of intent in respect of safeguards contingent on removal of schedule 3, paragraph 6.

10. The employers’ side, which includes medical directors and HR directors, refuted the suggestion that proposals would jeopardise patient care and considered that the safeguards contained within their proposals were reasonable and proportionate. Their view was that in trying to blame the Government, the BMA had shifted the focus from the clearly stated requirements of employers and commissioners.
What’s next?

11. NHS Employers has submitted written evidence to the DDRB based on employers’ views as expressed through the negotiations and other engagement activity. The DDRB will report to the Government in July 2015.

12. It may be some time before a new or amended contract is finally implemented. Meanwhile, the challenges set out earlier will continue to exert pressure and there a number of areas where employers may wish to act pending the agreement of new terms.

13. There is general support from employers for the continuation of a nationally, jointly agreed consultant contract. There does not seem to be the desire or the capacity to undertake extensive local negotiations. Some steps that employers have suggested as items for consideration include:
   - offering locally amended terms to new starters
   - the development of local terms based on a national template
   - use of CCT [in full] holders in ‘other than consultant’ roles.

14. More practical steps might be to improve the management of the current contract through:
   - improving the quality of job plans so that all consultants have patient-focused outcomes based job plans designed to meet the needs of employers, consultants and patients
   - ensuring regular review of job plans so that they are up to date and relevant
   - ensuring that the criteria for pay progression are met - while pay progression is the norm for most consultants it is not necessarily automatic and depends, for example, on participation in job planning and appraisal
   - strengthening appraisal and performance review processes
   - reviewing additional programmed activities.

15. Meeting the current challenges will require all members of the wider NHS team - managers, clinicians and support staff - to work together collaboratively. Staff engagement will be crucial to meeting those challenges collectively. High performing organisations tend to have good staff engagement policies and involving staff in decisions and communicating clearly with them will help ensure that, in the long run, it will be patients who benefit.