The evolving medical workforce agenda

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July 2015
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Contract reform for doctors in the NHS
Medical and dental basic pay scales (minimum, mean per full-time equivalent, maximum)
Medical and dental annual total earnings compared to UK annual total earnings (mean, 90th percentile)

Sources: (NHS Staff Earnings): Health and Social Care Information Centre, Provisional Statistics: Average Annual Earnings by non-locum staff group,
WHY change contracts?

- 2008 vision of doctors contracts
- Juniors scoping report

Simon Steven’s vision

Temple

5YFV

NHS Employers

AoMRC

- 7DS
- Commissioning standards

NHS England

DDRB
Medical contracts reform - key requirements

- Revenue neutral - must be affordable

- Provide for high quality care and highest quality of excellence and professionalism

- Meets the needs of patients and is fair for doctors

- Supports move to seven-day services and the wider aims of the NHS

- End of time served pay progression
Junior doctors’ contract
Junior doctors’ contract – key requirements:

- doctors in training feeling valued and engaged
- produce the next generation of medical professionals
- improving relationships (among doctors, employers and deaneries)
- new contract.
Junior doctors’ contract - proposals:

• higher basic and less variable pay

• supplementary pay targeted more specifically at additional hours and unsocial hours

• safer working hours – extra limits on consecutive long shifts and total hours in a seven-day period

• work scheduling – a form of job planning for doctors in training.
Junior doctors’ contract  
- nodal basic pay

One pay point for each stage of training.

Three possible designs proposed:

<table>
<thead>
<tr>
<th>Pay progression scenario</th>
<th>Stages of training</th>
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<td>A) 6 nodes - unique step for CT3/ST3 trainees</td>
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Higher basic pay at every level.
## Junior doctors’ contract - proposed out of hours payments

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- Plain time
- +50% on Saturday and Sunday
- 33% on Sunday
Junior doctors’ contract – specialty RRP

Scenario C) Nights 50% + Sundays (7am - 10pm) at 33%
Junior doctors’ contract – if a new contract goes ahead....

Implementation support products to cover:

• work scheduling
• new working hours rules
• new pay arrangements
• financial impact tools?

Medical staff leads need to develop and maintain links to existing medical personnel manager networks.
Junior doctors’ contract
- BMA concerns:

• pay should reflect experience
• lack of robust modelling and data regarding pay models
• concerned that doctors could end up without fair reward for the intensity of work undertaken
• potential impact on future recruitment

• Re-energised BMA comms campaign post DDRB response
Consultants’ contract
Consultants - agreed principles:

• patients deserve the same high quality of care across the entire week
  • requires changes in traditional working patterns including increased presence of senior clinical staff in evenings and weekends, and supporting resources

• needs to supported by appropriate safeguards to protect and promote health and wellbeing

• any contractual changes will fairly link reward and both number of hours worked and when they are worked.
Consultants - key requirements:

• expansion of plain time hours/fewer premium hours

• removal of consultant veto to non-emergency work outside of 7am -7pm Mon-Fri (Schedule 3 (6))

• convert local Clinical Excellence Awards into performance payments

• reduction in starting salary for newly appointed consultants

• new or amended contract – depending on an agreement being reached? (Transition costs).
Consultants - what was on offer?

• patient needs put first
• doctors wellbeing protected with safeguards in statute, contract and guidance
• maintenance of FTE average earnings for current post holders
• protections of accrued pensionable rights
• other transitional protections
• local performance pay using local CEA money guaranteed in contract for first time.
Consultants - revised pay structure proposal

- Additional responsibility payments
- Local performance payments
- Allowances for additional responsibilities
- Allowances for pattern of work – nights and weekends
- Established point
- Entry point

Principle: earnings increased where greater contribution and performance demonstrated.
Consultants - revised pay structure proposal

- Additional responsibility payments
  - Discretionary, as now
  - Objectives set and measured locally
    - eg clinical leadership, educational roles
  - Premium time to change
    - Reached earlier in career
      - 4-5 years

- Local performance payments
- Allowances for additional responsibilities
- Allowances for pattern of work - nights and weekends

- Established point
- Entry point

Principle: earnings increased where greater contribution and performance demonstrated.
Consultants - revised pay structure proposal for newly qualified

Discretionary
- Additional responsibility payments

- Allowances for additional responsibilities: c£7k
- Allowances for pattern of work – nights and weekends: c£12k

Entry point: c£70k

Newly qualified: £89.5k average (£98k)

Principle: earnings increased where greater contribution demonstrated.
Consultants - revised pay structure proposal for experienced consultants

Discretionary payments

- Additional responsibility payments
- Local performance payments

£7.5k
- Allowances for additional responsibilities
- Allowances for pattern of work – nights and weekends

£7k
£18k
£93k

Experienced: £130k average (£126k)

National CEA – domain changes only

Principle: earnings increased where greater contribution and performance demonstrated.
Local CEAs – employer based awards

- contractual provision
- non-consolidated
- non-pensionable
- explicitly linked to a performance assessment process.

Consultants - local performance payments
Consultants - local performance payments

Reward would be based on either:

a. exemplary performance across an individual’s objectives, or
b. achievement of tailored, more challenging ‘stretch’ objectives, (including core objectives).

Requires local development of an assessment process (based on national guidance) overseen by peer managers

Implementation risks?
Local performance payments - performance reward sum

Each NHS trust would identify a finite performance reward sum based on

• the size of their consultant workforce and
• a nationally set minimum amount per FTE value.

Value per FTE would aim at cost neutrality for the workforce as a whole.
Stage 1

In consultation with the workforce, the employer agrees to split the performance pay pot three ways.

For example:

- individual Awards – 70%
- team awards – 20%
- organisational awards – 10%
Stage 2
- Individual pot
- Team pot
- Organisational pot

Stage 3
- Assessment phase

Stage 4
- Individual award
- Team award
- Organisational award
Consultants - BMA concerns

- A framework for seven-day services is needed first detailing:
  - objectives
  - cost
  - impact on patients and staff
- strong contractual safeguards guaranteeing rest periods
- lack of credible evidence regarding the pay implications.
Latest developments

Summer budget 8 July 2015 – 1 per cent four-year pay deal

DDRB report 17 July 2015 “provide(s) a roadmap on what could and should be achievable in the interests of everyone with a true stake in the NHS”.

Written ministerial statement published:

- immediate removal of the consultant opt-out
- early implementation of new terms for
  - new consultants from April 2016 (moving existing consultants across by 2017) and
  - juniors from August 2016
- introduce a new performance pay scheme
- threat of imposition if no collective agreement.
Immediate next steps

• Engage with the DH/BMA and develop work programme:
  – finalise contractual provisions
  – develop implementation plan and associated tools

• counter BMA negative propaganda on the detail of our proposals

range of materials already published on NHS Employers’ web pages.
Immediate next steps – for employers:

- consider organisational readiness
- review local staff engagement activities
- develop/refresh links to existing medical personnel manager networks.
Next steps continued

• medical workforce management
  • review local agreements: locally agreed pay rates and local contract variations
  • review and strengthen the job planning process, appraisal and performance reviews
  • ensure that the criteria for pay progression is met
  • review additional programmed activities.
### Barriers to seven-day services

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Cultural</th>
<th>Contractual</th>
<th>Practical</th>
<th>Organisational</th>
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<tbody>
<tr>
<td>Adequate supply</td>
<td>Saturday and Sunday are ‘different’</td>
<td>Schedule 3 Para 6</td>
<td>Some downtime required</td>
<td>Effecting the changes</td>
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<td>Right values</td>
<td>Equating seven-day services with seven-day working</td>
<td>Premium pay</td>
<td>Staff childcare</td>
<td>Managing shifts and rotas</td>
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<td>right place (supply varies by geography)</td>
<td>Leadership example</td>
<td>Job planning</td>
<td>Social and primary care services</td>
<td>capacity for &amp; Quality of Partnership working with Trade Unions</td>
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<td>Expectations of older workers</td>
<td>Punitive banding payments</td>
<td>Affordability of evenings and weekends</td>
<td>Handovers and continuity of care</td>
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How will the NHS overcome these?
Keeping informed

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Contact us at:
doctorsanddentists@nhsemployers.org

@NHSE_Bill
NHS Employers’ Medical Director Engagement - *Doctors and the Changing Legal Context*

Rachael Heenan – Partner  
Alan Wishart – Assistant Director HR Advisory Services  

28 July 2015
Legal and HR update

Legal update:
• the duty of candour requirements
• new law on wilful neglect
• implications of The Corporate Manslaughter and Corporate Homicide Act 2007
• tackling concerns.

HR implications:
• implementing the duty of candour
• recruitment and AACs.
Legal update
Francis Inquiry Report 2014 - Recommendation:

“The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.”
Duty of candour (2)

• Already a requirement?

• 27 November 2014
  – Regulation 20 Health & Social Care Act 2008 (Regulated Activities) 2014 introduces statutory duty of candour on organisations.
Duty of candour (3)

• The organisational standard has two parts:
  – **general duty** – a health service body must act in an open and transparent way...in relation to care and treatment provided to service users...
  – **specific duty** - applies for ‘notifiable safety incidents’.

• June 2015
  – NMC, GMC – openness and honesty when things go wrong: the professional duty of candour sets out responsibilities for individuals.
Duty of candour (4)

• Organisational responsibility to encourage a culture of openness, honesty and transparency in the interests of patient safety and care
  – will be evaluated by CQC
  – role of clinical managers..

• Individual responsibility to be open and honest with patients in your care and those close to them when things go wrong and say sorry
  – who is the appropriate person?
  – are clinicians aware of Trust policy and process?
Duty of candour (5)

• Potential issues
  – ‘inappropriate’ person
  – refusal to become involved.
Wilful Neglect or Mistreatment: Criminal Justice and Courts Act 2015

- Introduced 13 April 2015 following Berwick Review
- New offences of ill treatment or wilful neglect by care workers and care providers of healthcare to adults/children
- Care worker offence – ‘ill treat or wilfully neglect’ a patient.
Wilful neglect: care provider offence

• Care provider offence
  – individual who has care of another as part of the care provider’s arrangements ill-treats or wilfully neglects that individual
  – care provider’s activities managed or organised in a way which amounts to gross breach of duty of care owed to the person ill treated or neglected
  – in the absence of the breach the ill treatment or wilful neglect would not have occurred/be less likely to occur.
Wilful neglect: sanctions

- if convicted, care worker faces maximum five-year jail sentence or an unlimited fine
- corporate bodies are liable to one or more of a fine, remedial order and/or publicity order
- CQC guidance for members of the public who wish to monitor levels of care via recording equipment.
Wilful neglect: potential issues

• Potential Issues
  – concerns from professional bodies
  – climate of fear?
  – unsupportive?
  – concerns may not be raised due to concerns about police investigation?
  – police investigations often take precedence over internal investigations leading to significant delay
  – how will courts interpret ‘wilful’?
The Corporate Manslaughter and Corporate Homicide Act 2007

• An organisation is guilty of the offence of corporate manslaughter where:
  – the way in which its activities are managed or organised causes a person’s death
  – the death is the result of a gross breach of a relevant duty of care owed to the deceased, and
  – the way in which senior management managed or organised the organisation’s activities is a substantial element of the breach.

• Sanctions: fine, remedial order, publicity order.
Corporate manslaughter: Maidstone and Tunbridge Wells NHS Trust

• First NHS corporate manslaughter prosecution case.
• Details of case
  – doctors charged with gross negligence manslaughter
  – trust charged with causing death by a gross breach of duty of care, failing to take reasonable care to ensure the anaesthetists involved held the appropriate qualifications and had the appropriate training
  – failing to take reasonable care to ensure there was an appropriate level of supervision for the anaesthetic treatment of the deceased.
Tackling concerns internally

• supervision and training
• informal action
• letter of Expected Standards?
• formal process: MHPS/local policy
  – process, process, process
  – terms of reference
  – investigator – internal or external?
  – conduct, capability, ill health, ‘some other substantial reason’.
HR implications
- duty of candour
- improving consultant recruitment
Duty of candour and the CQC

How does an organisation demonstrate it has met its responsibilities to encourage the culture of openness, honesty and transparency in the interests of patient safety and care?
Duty of candour (1) key points

• CQC will test staff, at all levels, if they are aware of the duty of candour and their responsibilities
  – recent CQC reviews demonstrate that senior managers have good awareness in comparison to more junior staff
  – do staff advise they feel supported in being open and honest and aware of their responsibilities?
  – is candour a concept that is well understood?
  – do clinical leaders reinforce message?
  – evidence of good practice, eg introduction of ‘disclosure coaches’.
Duty of candour (2)

• Is there a system in place to meet requirements?
  – links between SUI process and ‘being open and duty of candour P policy’
  – are staff aware of above policies?
  – is there compliance monitoring?
Duty of candour (3)

• Has there been a revision of other policies?
  – complaints policy
  – employee obligations
• has raising awareness sessions been provided to staff, including medical staff and clinical leaders?
• good practice – specific training for junior doctors
• examples of where ’local’ duty enacted
• demonstration of sharing information across teams as an outcome.
The AAC process – lessons learned from recent cases and Maidstone & Tunbridge Wells Prosecution

• the robustness of the AAC process
• on the GMC Register without restrictions – therefore competent and qualified?
• following on from recent MHPS cases and Maidstone & Tunbridge prosecution
  – interview processes?
  – don’t assume – check
    • surgeon’s operative log
    • qualifications
    • experience, especially if newly qualified consultant
    • mentorship and supervision on arrival?
Recruitment – what to take away

• follow up with robust secondary induction
• good examples of trust extending values based recruitment
• mock MDT sessions.
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