THE NHS EMPLOYERS
ORGANISATION’S SUBMISSION
TO THE DOCTORS’ AND
DENTISTS’ REVIEW BODY

Reform of national contracts for consultant doctors and for doctors and dentists in training

December 2014
This submission represents the views of the negotiating teams from across the UK in respect of doctors in training and from England and Northern Ireland in respect of consultants.

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Executive summary

- Patients are at the heart of everything done by and within the NHS, which must seek to safeguard patient safety, seeking to remove unacceptable variations in care and patient outcomes.

- This submission argues there is a compelling case for changes to the national terms and conditions contracts for consultant graded doctors employed in the NHS in England and Northern Ireland, and for doctors in nationally approved postgraduate training programmes employed in the NHS.

- Employers face a challenging environment as they seek to deliver efficiency challenges and generate more value from taxpayers’ investment in the NHS. This makes it important that they get the best value they can from the reward system.

- Employers want contracts and terms and conditions for their staff that are effective in helping them plan and deliver consistent high-quality services every day of the week.

- The DDRB is urged to support the introduction of these proposed new national contracts without delay, enabling employers to adopt and adapt them to better meet local needs.

Consultant contract reform

Consultants are our senior clinical leaders. It is through their hard work the quality of service can be maintained and increased. It is vital that their contract of employment fully engages them. It needs to be a contract for a mature professional occupation that incentivises the best clinical outcomes.

Reform is also necessary to make the contract more supportive of the delivery of seven-day patient care and to make them financially sustainable for the future. Junior doctors must be supported more effectively in their training and development during evenings and weekends.

Our evidence sets out our proposals to amend the current 2003 contract, not the introduction of a new contract, which entail:

- the removal of the contractual barriers to help facilitate the introduction of seven-day services, including the removal of the right to opt-out of non-emergency evening and weekend work in premium time and an extension to plain time coverage

- the introduction of a schedule of safeguards to ensure staff are appropriately protected where the service moves to the provision of seven day services

- a revised pay structure that appropriately rewards those staff that contribute the most and work the most onerous working patterns. This involves
• bringing to an end incremental pay progression based on time served,
• the introduction of new pay rates, and
• linking progression to higher levels of responsibility and competence, with progression being contingent on performance

• bringing to an end the current nationally prescribed local clinical excellence award arrangements and replacing them with new locally determined, non-consolidated payments for excellence

• transitional protection arrangements to support the revised contractual arrangements

• Based on the modelling of the employer team proposals, consultants (per full time equivalent) will progress from an entry stage consultant to established consultant with salary values of £70k rising to £93k after five years. For experienced consultants this could rise to £107k, to reflect additional activity and work undertaken out of hours. Up to £6.9k will be available for additional responsibilities and around £7.5k for performance-related payments for experienced consultants

• There is possibly another £5-6k additional payment available for out-of-hours work, generated from savings elsewhere in the contract. Funds for out-of-hours work will increase over time to reflect the shift to seven-day services.

Junior doctor contract reform

The aim of reforming the contract for doctors and dentists in training is to produce a new pay system and a new set of terms and conditions to replace the New Deal contract, which is no longer fit for purpose. This is consistent with both the DDRB and the BMA view that a greater proportion of pay should be fixed, with less variable pay.

The “banding” system with its penalty payments on which the New Deal is based is inherently adversarial for junior doctors and their employers. Banding was not the key driver to reducing junior doctor hours and is now an anomaly.

Our proposed pay system ends time based incremental progression. Increases to basic pay would be determined by changes in level of responsibility as the doctor progresses through training. Some levels of specialty training would be at a similar level of responsibility and so would attract the same pay.

Pay is based on hours and is similar to the specialty doctor arrangement. Raising the level of basic pay is important to stabilise the pay bill, but this tends to create a greater benefit for doctors who do not work out of hours, so the proposals include different rates of pay for Sundays and night shifts, and also suggest nationally set recruitment and retention premia (RRPs) for particular specialties to ensure that incentives are appropriately distributed.
Working patterns and training opportunities would be managed via a work scheduling process. This is similar to job planning, but the schedule would be designed around the post and then tailored to the individual postholder, due to the short-term nature of junior doctors’ placements.

Safe working hours are a priority and the new terms and conditions propose a set of simple rules to ensure that hours of work and duty are limited. However, it is not acceptable for health and safety breaches to be linked with additional reward, and we propose that any concerns about safe working hours should be addressed through the work schedule review process.

Other aspects of the terms and conditions, such as leave, private professional practice, and termination of employment, are simplified. The expenses provisions are brought in line with Agenda for Change, with an additional section incorporating existing provisions on relocation and excess travel, some of which are discretionary.

As DDRB are reporting in July 2015, our aim would be for the new arrangements to be in place for the August 2016.

Costs

The revised contracts must be cost neutral, with the exception of the higher employer National Insurance contributions related to increasing basic pay for junior doctors, which has been approved by the Department of Health as an allowable cost. Further modelling will be needed once final details have been confirmed on each contract and transitional arrangements established.
1. Introduction

1.1 This submission is a response to the Review Body on Doctors’ and Dentists’ Remuneration’s (DDRB) invitation (Annex A) to submit evidence on its special remit1 from the Department of Health (Annex B).

1.2 We believe that there is a compelling case for changes to the national terms and conditions contracts for consultant graded doctors employed in the NHS in England and Northern Ireland, and that for doctors in nationally approved postgraduate training programmes employed in the NHS. In relation to this special remit, NHS Employers has been leading the employer teams of the two negotiations on national contract reform. Those negotiations have been conducted with the British Medical Association (BMA), which has assured us that, in as much as the conditions of service cover NHS-employed dentists, they represent the British Dental Association in relation to these matters.

1.3 This submission, with its seven supporting annexes and appendix, describes the work we have undertaken both jointly with the BMA and separately with employers over the past 14 months. It describes employers’ views on the need for contract reform, the affordability of the medical workforce and views on the future of collective bargaining and partnership working. This is followed by separate sections in which we describe the contract discussions for doctors in training and consultants’ contract and make our proposals for change. Finally there is a reference to Specialty and Associate Specialist doctors.

Views of employers

1.4 We have extensive engagement with the employers of doctors in the NHS. These are both formal and informal. Over a number of years employers in the NHS have told us that:

• the needs of patients should be at the heart of the planning and delivery of service
• the current contracts detract from this objective
• the needs and expectations of patients have changed dramatically since the current national contracts were introduced some 12 years ago
• there is a clinical, moral, training and financial case for the provision of the same quality of services in the NHS, seven days a week
• the current consultant contract puts barriers in the way of developing and delivering the seven days a week imperative
• the ‘New Deal’ juniors’ contract is both adversarial and ineffective in providing both service and training
• they have sought changes to the national terms and conditions for many years

1.5 We conclude from this that reform of the contracts must happen, but our recent negotiations have failed to deliver in a reasonable time at a reasonable cost. The failure of the negotiations cannot mean that reform is vetoed by one of the parties unilaterally walking away. If the current risks for patients are to be minimised, new national contract arrangements that employers of doctors in the NHS will use, need to be established. If national collective bargaining is not able to do that, an alternative process must be found.

1.6 We have aimed to set out proposals for contracts that are fair, effective and affordable for the future. The DDRB is urged to support their introduction without delay, enabling employers to adopt and adapt them to better meet the needs of their patients.
The need for change

Consultants

1.7 Patients are at the heart of everything done by and within the NHS. The service must safeguard patient safety at all times, seeking to remove unacceptable variations in care and patient outcomes.

1.8 Employers want contracts and terms and conditions for their staff that are effective in helping them plan and deliver consistent high-quality services when and where patients need them.

1.9 They want to eradicate unacceptable variations in outcomes such as reported by Dr Foster Unit\(^2\) of Imperial College London, which identified higher mortality for patients admitted as emergencies at the weekend compared with emergency admissions during the week\(^3\).

1.10 NHS trusts are planning to improve the delivery of their services in an integrated way across all seven days of the week. New models of care are emerging. There is a need to engage effectively with clinical leadership to align clinical and financial decisions. The NHS needs, now more than ever, to find ways to balance the desire to improve quality of care with the pressure to contain costs. This is the conclusion of the Academy of Medical Royal Colleges and the NHS Confederation report _Decisions of Value._\(^4\)

1.11 The demands of patients in England are now expressed through the commissioning requirements of NHS England\(^5\). This is most evident in their work on promoting seven-day services, starting on correcting the variations in mortality outcomes at weekends and variations in patient experience and outcomes, delays in treatment and delayed discharge, related to the absence of senior medical decision makers. Employers have welcomed this focus on

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2 [http://www1.imperial.ac.uk/publichealth/departments/pcph/research/drfosters/](http://www1.imperial.ac.uk/publichealth/departments/pcph/research/drfosters/)

3 Using routinely collected hospital administrative data, in-hospital deaths for all emergency inpatient admissions were examined to all public acute hospitals in England for 2005/2006. Odds of death were calculated for admissions at the weekend compared to admissions during the week, adjusted for age, sex, socioeconomic deprivation, comorbidity and diagnosis. Of a total of 4317866 emergency admissions, 215054 in-hospital deaths were found with an overall crude mortality rate of 5.0% (5.2% for all weekend admissions and 4.9% for all weekday admissions). The overall adjusted odds of death for all emergency admissions was 10% higher (OR 1.10, 95% CI 1.08 to 1.11) in those patients admitted at the weekend compared with patients admitted during a weekday (p<0.001). [http://qualitysafety.bmj.com/content/early/2010/01/22/qshc.2008.028639.abstract](http://qualitysafety.bmj.com/content/early/2010/01/22/qshc.2008.028639.abstract)


5 Further information on NHS England’s 7 day services forum can be found here [http://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/7ds/](http://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/7ds/)
getting the right care for patients every day of the week and they recognise that doctors, especially those in training do work across the whole of the week at all times of the day.

1.12 However, they consistently argue for the removal of the barriers to improving service seven days a week that they find in the current contractual terms for consultants. For example, they find the term in the consultant contract at Schedule 3 Paragraph 6, which allows consultants to refuse non-emergency out-of-hours work, is a barrier to developing and delivering cost-effective and high-quality services in evenings and weekends. It has been used in places to only do the work at rates of pay noticeably higher than the national contract rates, creating unnecessary and unjustifiable financial pressures.

1.13 Fundamentally, employers find this 'opt-out' clause has a corrosive impact on doctors' willingness to work at weekends and has created a culture of consultants choosing when they do and do not work, which is not appropriate in any future pattern of care that can be envisaged.

1.14 The issues relating to doctors in training are rather different, although the absence of senior colleagues at the weekend is important to them. The General Medical Council's National Training Surveys disclose that junior doctors can feel unsupported out of hours and can feel that they are working beyond their competence. This was also said in Time for Training – a review of the impact of the European Working Time Directive on the quality of training by Professor Sir John Temple - as a strong reason to have more consultant doctors available out of hours, to improve the quality of the training experience and use handover effectively as a training tool. He concluded that:

“Many consultants still work in traditional ways. The mechanism to support consultant working such as the consultant contract and consultant job plans are frequently not used effectively to support training...there is great variation in the levels of support that different trusts offer consultants involved in education and training …the reliance upon doctors in training to deliver a 24/7 service has to change… All trainees need to be supported by close, appropriate supervision and this will increase the learning opportunities and improve the decision making, diagnosis and treatment pathways, improving patient safety.”

1.15 The 24 February 2014 Public Accounts Committee report on Emergency Admission to Hospitals reinforces this need when it says:

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6 Paragraph 6 of schedule 3 of the 2003 consultant contract states that “non-emergency work after 7pm and before 7am during weekdays or at weekends will only be scheduled by mutual agreement between the consultant and his or her clinical manager. Consultants will have the right to refuse nonemergency work at such times. Should they do so there will be no detriment in relation to pay progression or any other matter”.

7 http://www.gmc-uk.org/education/surveys.asp


9 http://www.publications.parliament.uk/pa/cm201314/cmpubacc/885/885.pdf
“We welcome the proposed shift to 24/7 consultant cover in hospitals, but are concerned about the slow pace of implementation and the lack of clarity over affordability. The introduction of round-the-clock consultancy care will start with A&E services, but will not be in place before the end of 2016-17. Round-the-clock hospital services are intended to reduce weekend mortality rates and make more efficient use of NHS assets and facilities. However, its implementation will rely on the British Medical Association and NHS Employers negotiating a more flexible consultants’ contract…”

1.16 In November 2014, NHS England published the *Five-year forward view*[^10], which called for future-proofing the NHS against the challenges to come and said:

“… over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage recruitment and retention in parts of the country and in occupations where vacancies are high.”

**Doctors in training**

1.17 Several DDRB reports, from as early as the 36th report in 2007, called for review of the New Deal contract for doctors in nationally approved training programmes, and stated:

“The BMA told us that, once junior doctors’ weekly hours fell below 48, it would be in favour of a system of remuneration which better remunerated a basic 40-hour week and where most of the overall salary came from basic pay. We accept that the current pay system, which is designed to make long hours proportionately more expensive in order to encourage a reduction in hours, will need to be revised once working hours are reduced” and “Once all junior doctors are working 48 hours a week or fewer, it will be appropriate to shift the balance away from the banding multipliers towards base pay.”[^11]

1.18 In the DDRB’s 37th report it was stated:

“We noted last year that once all junior doctors are working 48 hours a week or less, it would be necessary to shift the balance away from


[^11]: Extracts from the DDRB 36th report paragraphs 7.7 and 7.10
the banding multipliers towards base pay in order to ensure pay comparability, and we continue to believe this to be the case.”

1.19 The junior doctors scoping report reviewed the viability of the current contract for doctors in training. The current contract was implemented in 2000 with a specific remit to reduce junior doctors’ hours and enforce minimum rest breaks and working conditions. This contract applies to doctors in the training grades working in approved national training programmes below consultant level, including both years of Foundation training and all the subsequent years of specialty registrar training.

1.20 The views of a wide range of NHS employers across the UK were obtained with regard to the contract. The views of the British Medical Association (BMA) and the British Dental Association (BDA) were also obtained, including a written submission from the BMA Junior Doctors Committee.

1.21 A vision and principles for a new contract were set out, emphasising:

- better patient care and outcomes
- doctors in training feeling valued and engaged
- affordability
- producing the next generation of medical professionals
- improving relationships (particularly among doctors, employers and deaneries).

1.22 All parties came to a broad consensus that the existing contract is not suitable and is proving unable to deliver this vision in the current context. In general, employers across the UK, favoured a more flexible, locally determined approach within an overall national framework, while the BMA JDC advocated comprehensive nationally applied standards to ensure consistency.

Moving to negotiations

1.23 The rest of our submission describes in detail the negotiation process and partnership engagement activities, what was on offer during negotiations and what is now proposed by the employer teams.

1.24 The negotiations were built on the Ministerial response to two reports:

- DDRB report on clinical excellence awards
- NHS Employers Scoping Report on doctors and dentists in approved postgraduate training, arising from the recommendations of the DDRB

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12 Extract from the DDRB 37th report paragraph 7.11
1.25 During December 2012, the Secretary of State for Health accepted that the DDRB report on CEAs and NHS Employers' report on the juniors’ contract provided a basis for negotiations and invited the NHS Employers organisation and the BMA to discuss the prospects of negotiating changes to the 2003 consultant contract and the New Deal contract for junior doctors. Those discussions led to the agreement of Heads of Terms\textsuperscript{15} for possible negotiations. The primary issues that were to be addressed in relation to consultant doctors were the delivery of seven-day services in the NHS, pay progression and Clinical Excellence Awards. For junior doctors, the primary issues to be addressed were better patient care and outcomes; better training; better engagement and improved relationships in the development of the next generation of medical professionals.

1.26 Negotiating remits were given to the parties in October 2013 with a view to negotiations being complete by October 2014 and implementation to begin in April 2015. The remits for negotiations are given at Annex C.

1.27 The timetable allowed for periodic updates to Health Ministers, including in early February 2014 when there was to be evidence of clear progress towards the achievement of the objectives set out in the mandates. As a result, interim joint reports were made during February 2014.

1.28 In respect of the juniors’ contract, the interim report confirmed that both sides had agreed that the new contract must be cost neutral, that high-level definitions around pay had been agreed, for example the definition of on call, and that discussions to develop a set of principles to underpin the pay elements where continuing.

1.29 In respect of the consultant doctors’ contract the interim report built on the oral assurances within the negotiations from the BMA that Schedule 3 Paragraph 6 could be removed from the contract subject to acceptable safeguards being agreed in statute, contract, guidance and advice. Thus, the interim report confirmed that both parties had agreed that: patients deserved the same quality of care across the entire week
- this would mean inevitable changes in the traditional working patterns over time, including the increased presence of senior clinical staff in the evenings and weekends, together with the supporting resources needed for them to deliver that care
- such a change would present a significant affordability challenge
- modelling would be needed to ensure the overall cost neutrality of the contract review is maintained
- changes would be supported by appropriate safeguards to promote and protect health and wellbeing of consultants and safe practice for patients
- any contractual changes will fairly link reward with the number of hours worked and when they are worked.

\textsuperscript{15} \url{http://www.nhsemployers.org/SiteCollectionDocuments/HoT_final_for_website_ap290713.pdf}
1.30 The consultant negotiating partners reported that they were exploring how non-emergency work might be provided in evenings and at weekends and that they accepted that the current contractual arrangements should not be a barrier to meeting the needs of patients.

1.31 From the outset of the talks employers, patients and Government have wanted change sooner rather than later. This meant that the negotiations needed to be conducted with pace and with purpose and that is why Ministers wanted the negotiations completed by October 2014 with a view to implementation beginning in April 2015.

1.32 Reform of the terms and conditions of non-medical staff have begun, with porters, nurses and others accepting changes to their conditions compared with past practice. Employers in the NHS believe it is now time for doctors to accept that they must also change and set a leadership example to the rest of the system.
2. **Affordability**

2.1 The NHS is going through the biggest financial squeeze in its history\(^\text{16}\) as a result of funding control, rising demand for services and the need to safeguard quality of care following the Francis report. Since 2010, its budget has effectively been frozen, increasing by just enough to cover inflation. While this is generous compared to other areas of public spending, increasing demand for care means that services are under huge pressure.

2.2 The NHS has responded well to these challenges but financial pressures are growing, with large numbers of hospitals now in deficit. Looking further ahead, pressure to spend more will grow as the costs of treatment rise, public expectations increase and the population continues to age.

2.3 The third report from the National Audit Office\(^\text{17}\) (NAO) on the financial sustainability of NHS bodies explores key tests, including changes in the surplus or deficit of the NHS as a whole, spending by NHS bodies as a proportion of their funding, and the number and scale of organisations in financial distress. At the end of the year, Monitor gave 20 acute Foundation Trusts (24 per cent of the acute sector) continuity of service risk ratings of one or two, meaning that these trusts are of the most concern. The NHS Trust Development Authority (NHS TDA) rated more than half the NHS trusts – 55 of 98 – as having “formal action required”, “material issues” that had already been identified, or “concerns requiring investigation”.

2.4 NHS Employers’ September 2013 evidence to the DDRB said that the reports of Robert Francis QC, the Government’s initial response and the subsequent review by the medical director of NHS England, Sir Bruce Keogh, highlight the scale of the quality and organisational challenges facing NHS organisations. The priority has to be to ensure that any changes to the national pay and terms and conditions support the delivery of high quality, compassionate care in the context of significant financial and employment relations challenges.

2.5 The focus throughout the Francis report is on the delivery of high quality and compassionate care by everyone involved in its provision and commissioning. The report called for cultural change to improve the quality of services for patients. He clearly links patient care with staff experience. Employers have necessarily been considering all aspects of their employment practice, from recruitment and appraisal to management and leadership. They have been seeking to support staff to deliver the type and quality of care that is expected,

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and ensure that there is an effective and open performance management system to protect patients.

2.6 The NHS Confederation in its 2015 Manifesto Challenge\textsuperscript{18} says: “The pressures on the whole system have never been greater”. The NHS Providers organisation, in its Programme for the Next Parliament\textsuperscript{19}, says: “Delivering high-quality care in the right place at the right time for each individual means NHS providers must be freed-up to use their capabilities to their full extent,” and says we must “make pay, terms and conditions fit for purpose”.

2.7 This financial context inevitably means that there is no new money for these necessary contract reforms. Rather they must be delivered on a cost neutral basis – neither removing money from the system nor increasing cost pressures.

\textsuperscript{18} \url{http://www.nhsconfed.org/resources/2014/09/the-2015-challenge-manifesto-a-time-for-action}

\textsuperscript{19} \url{file:///C:/Users/billm/Downloads/nhs-providers-programme-for-the-next-parliament-final-2-.pdf}
3. The future of collective bargaining and partnership working

3.1 The parties entered into negotiations in good faith on the basis of principled bargaining where, rather than act as adversaries, the parties acted as co-designers of solutions to shared problems. The 18 months of talks and negotiations led to many areas of agreement. Such agreements were reflected in written and oral reports to Ministers. They formed the basis for draft agreements that were to be the subject of diarised meetings with Ministers when the BMA chose to unilaterally pull out of the negotiations in late October 2014.

3.2 The breakdown of the negotiations, in the manner that occurred, suggests to employers that, if national bargained solutions must be part of any recommendations and observations, this would lead to an asymmetrical relationship where the BMA is gifted a permanent veto on reform of the contracts regardless of the damage currently being done to patients’ interests.

3.3 The employer teams had sought to offer contracts that balanced putting patient needs first with reasonable safeguards in the contract and guidance to protect the health and wellbeing of doctors.

3.4 The BMA, in ending the negotiations, said that they could not continue because of “unreasonable demands from the government that could undermine patient safety”. The employer teams, which contain medical directors and workforce directors among their membership, rejected the suggestion that any proposals made would compromise patient safety standards and considered the safeguards contained within their proposals to be proportionate and reasonable, while meeting the legitimate requirements of employers and commissioners.

3.5 Partnership working in employment relations can be seen as a spectrum from boxing to dancing; from using transactional and adversarial bargaining to using principled bargaining processes to jointly problem solve and reach agreed changes in an open and transparent way.

3.6 It is the strategic choice of the trade union, such as the BMA, whether to dance or to box. The strategic choices for employers are about the scope, level and extent of bargaining – that is, what is bargained over, at what level of the industry does that occur, and what is the extent of bargaining at whatever level is chosen.

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20 Huzzard, T, Gregory, D, and Scott, R (eds) (2004), Strategic Unionism and Partnership, Boxing or Dancing, Palgrave Macmillan
3.7 The current system for doctors in the NHS is already a hybrid, not based on national collective bargaining alone.

3.8 There are pragmatic approaches that vary by issue, by location and by circumstance. Sometimes there are negotiations, sometimes consultations, and there are other matters imposed by government or by employers.
4. Junior doctors’ contract reform

Introduction

4.1 In October 2013, NHS Employers was mandated by all four UK health departments to begin negotiations with the BMA on a new contract for doctors and dentists in training. It is widely accepted by employers that the current contract, designed to fix a problem now over a decade old, is not fit for purpose. This was highlighted in the scoping report on the contract for doctors in training by NHS Employers in June 2011, and from continuous employer feedback since then highlighting that contract reform is essential.

4.2 It was with surprise and disappointment that we discovered, on 16 October 2014 via social media, that the BMA had withdrawn from both sets of negotiations before scheduled talks had concluded. The employer teams of both negotiating groups feel that the BMA acted in bad faith to withdraw from negotiations with no notice after a year of discussions and subsequently misrepresent the employer team’s position. NHS Employers has aimed to demonstrate in this report that at no point was there any suggestion of putting patient safety or the wellbeing of doctors in training at risk. Furthermore, continuing with current arrangements is in itself a risk to patient safety.

4.3 Although this section of the report looks specifically at contractual arrangements for doctors in training, there are two common themes for the NHS. First, the need to ensure that patients receive the same quality of care throughout the week. Second, there needs to be recognition that in a period of severe financial restraint, pay systems that are punitive to employers, unfair for doctors, and reward time served instead of performance, cannot continue.

Commencing negotiations

4.4 We began formal negotiations with the BMA on 24 October 2013. The employer team was chaired by an NHS director of workforce, and included strong medical staffing expertise, four-country representation, a medical director, a postgraduate dean, a director of general practice education, and a director of NHS Employers. We have referred to the employer team in the sections below.

The mandate for negotiations can be found at annex C.

Overall proposal

4.5 The employer team has proposed a new set of terms and conditions for doctors and dentists in training and a new model contract. These documents can be found at the end of this document as annex E and F. Various schedules from the terms and conditions document are referenced in the text below.
These documents have been written with the following principles in mind:

- Current arrangements are not optimum for patient care. New arrangements need to facilitate improvements to patient care, be fair to the doctor in training and the employer, and be affordable.
- We have tried to be as consistent as possible with other staff groups where appropriate. There is no reason why certain contractual provisions should be different for doctors in training compared with other NHS staff. Where there is a real reason why doctors in training should be treated differently, we have proposed arrangements that recognise this.

4.6 NHS Employers has not written the proposed Terms and Conditions of Service document from scratch for this submission. During negotiations with the BMA approximately 70 discussion papers were written, re-written and debated, with a number of areas of provisional agreement being reached. Since the breakdown of negotiations, NHS Employers has used these discussion papers to form the basis of the proposed terms and conditions document.

4.7 Since 16 October 2014, no further joint work with the BMA has taken place. As a result, we have further developed proposals based on what employers believe contractual arrangements should be. The DDRB will notice that on some areas, we have not recommended a firm proposal, but provided a range of options that we believe could be further investigated.

**Pay**

4.8 Reforming the pay system for doctors in training has been a priority for employers for a number of years. The current system is seen as unfair, punitive to employers, detrimental for the training of doctors, and results in significant financial swings over time for both employers and employees.

4.9 We feel strongly that pay and health and safety should not be intrinsically linked. The two matters are different, and should be treated separately. We believe that doctors in training have the right to work safely, and believe that a system that provides extra financial rewards for doctors when health and safety rules are breached is not acceptable.

4.10 In current pay arrangements, a system of banding applies depending on a complex set of rules linked to working hours, work patterns, rest and breaks. The system is so complex that an entire industry has evolved around the design of New Deal compliant rotas for doctors in training, and several specialist software packages are available designed for this purpose.

4.11 In our 2011 scoping study, regarding banding arrangements we said:

“There are concerns about the broadness of the delineations. Thus, someone working 47 hours per week may be paid the same as someone working 41 hours per week. Alternatively, a rota which overrun by less than an hour can require the payment of a greatly increased banding supplement by the employer. As the Temple report noted,
this makes costs unpredictable for employers, and it is also potentially inequitable for employees.”

“5.18 The JDC also recognises that banding can be an imperfect tool with which to assess and control working hours. Because the pay bands are broad but sharply delineated, there can be significant changes in salary between posts where there is little difference in the level of work, and this is seen as disadvantageous for doctors in training and their employers. The JDC is also concerned that where a doctor takes up a post with added responsibility, their additional pay can be offset or even outweighed by the change in out-of-hours work. However, while this system has its problems, they still see the remuneration of out-of-hours work as an improvement on the system, prior to banding introduction in 2000, of payments for Additional Duty Hours.”

“5.19 Employers, too, are concerned about the breadth of the bands, and the potential inequalities that are created. They also feel that it is internally inconsistent, as well as very different to the pay mechanism for other medical staff. Employers further say that banding creates adversarial relationships, encourages pay protection and banding appeals, incentivises applications to training programmes which include posts with a higher banding rate which skews the labour market, and does not encourage professional ways of working. In particular there are concerns around the higher banding supplements. As noted in the Temple report, these do not match the current employment legislation (EWTD) requirements. Employers also feel that ten years after the implementation of the contract, the punitive and highly expensive band 3 is no longer needed or justified.”

“5.20 The Temple report also notes that employers in England, in the face of the system and contract and in order to protect themselves against unexpected costs, have moved largely to rigid shift systems that do not help the provision of quality training. As the report states:

“Exceeding the New Deal limits results in higher pay bandings, which are a significant cost pressure to trusts. For example, one trust reported an additional £250,000 cost for an eight person rota over a six-month period when one person in that team exceeded the banding on one occasion. The result has been that trusts are inclined to move from rotas to full shift resident on-call systems to minimise this risk. As a result of this, rigid shift working, without alignment of shift patterns, has frequently been identified as detrimental to training, impacting on continuity of care, trainer and trainee contact and trainee wellbeing.”

“5.21 In conclusion, while the current banding system for out-of-hours work is considered to have improved upon the pre-2000 Additional Duty Hours system, all parties express dissatisfaction with the multiple problems that have arisen from the system..”

4.12 The banding system was brought in in 2000 to solve a problem of excess hours, which is now prevented by legislation. Since the introduction of New Deal, the European Working Time Directive (EWTD) has been incorporated
in to UK law as the Working Time Regulations, which put legal safeguards in place around working hours, work patterns, rest and breaks. The Heads of Terms stated that the new contract must “be consistent with all aspects of UK law, including working time regulations,” and also specifically stated that the contract will “address the current dissonance between New Deal and EWTD.”

4.13 Having two sets of different requirements around working time makes it extremely difficult for employers to design rotas. The interactions between New Deal requirements and the Working Time Regulations are complex and do not allow optimum working patterns to be created to deliver service and maximise training opportunities.

4.14 The DDRB may hear evidence from other parties that suggests banding penalty payments have been successful in reducing the hours that doctors in training work, and therefore financial penalties paid by the employer to the employee are a successful way of enforcing health and safety rules. The employer team feel this is incorrect, and that banding payments in reality had little effect on the reduction in doctors in trainings’ hours. The real reason for the reduction in hours was in fact the introduction of working time legislation.

Our view is that this penalty puts a tension in to the employment relationship, and we are not aware of any other industry where penalty payments are paid by the employer to the employee in such circumstances.
4.15 Figure 1 shows the percentage of doctors in training on band 1 rotas (40-48 hours per week) and the number on band 2 rotas (48-56 hours per week), from 2001 to 2009. Data was collected on a six-monthly basis for the purposes of monitoring first by the Department of Health, and latterly by NHS Employers. New Deal banding came into force on 1 December 2000 and the last ‘escalator’ increase to banding payments happened on 1 December 2002, yet there was hardly any shift in the percentage of Band 2 rotas between 2001 and 2003. The first phase of EWTD came into force for doctors in training in August 2004, and was fully implemented for doctors in training in August 2009. The graph shows clearly that this 2009 legal deadline and the significant increase in doctor numbers to meet it, are what brought the reduction in band 2 rotas, and therefore the reduction to working fewer than 48 hours on average.

4.16 In April 2008, the Junior Doctors Committee of the BMA referenced this trend in its document entitled *The Final Countdown - The rush to reband training posts explained*, which stated: “There are huge pressures to reduce junior doctors’ hours at the moment. The phased introduction of the EWTD for juniors is now starting to bite. All employers around the country must ensure all their junior doctor rotas are in band 1 by August 2009.”

4.17 The New Deal banding system did not create a financial incentive for 48-hour compliance. Any savings from rebanding (a process which also caused considerable conflict between doctors and employers) were reinvested in making rotas compliant, but this was insufficient to achieve 48-hour
compliance and had to be supplemented by £400 million from the Department of Health between 2008-2009.

4.18 It would therefore be wrong to assume that penalty payments were the driving factor in the reduction of the hours of doctors in training from 56 to 48. In fact it was the full implementation of legislation that caused employers to redesign rotas.

**Difficulties during negotiations**

4.19 It is important to note that although a number of proposals in this submission document have been the subject of joint working with the BMA during negotiations, it was very difficult to engage the BMA on the topic of pay.

4.20 The employer team tried to initiate discussions on pay as early as 24 October 2013, however the BMA was reluctant to discuss this topic in detail until the UK-wide data collection had taken place. NHS Employers was aware that the four country data collection was likely to be a lengthy process, and realised that discussions around various principles and scenarios relating to a new pay system could take place in the absence of data. The employer team persistently asked the BMA to engage in joint modelling of scenarios for a new pay system, including work on the pay bill distribution, which would have made the data modelling process more efficient. However the BMA did not agree to this.

4.21 By May 2014, 83 per cent of the planned data set for England had been collected, and by July 2014 this figure was almost at 100 per cent for England. The additional data that was collected between May and July did not significantly alter what the overall data set was showing. However it was not until late September/early October 2014 when the BMA agreed to discuss substantial pay proposals in a detailed and meaningful way. This caused severe problems given the final negotiating meeting had always been scheduled for 23 October 2014.

4.22 The Heads of Terms stated that:

“6.3 Joint analysis and modelling by analysts from the BMA, NHS Employers and the devolved administrations will be undertaken to explore the range of options available.”

4.23 The employer team does not feel the BMA has engaged in joint analysis until very late in the day when arguably it was too late. The majority of analysis and modelling has been done by NHSE analysts and analysts from the devolved administrations. NHSE and the devolved administrations conducted the data collection exercise which consisted of collecting 100 per cent of rota data from Scotland, Wales and Northern Ireland, and a 15 per cent representative sample of rota data from England. The BMA was responsible for collecting data for GP trainees, however this was sent to NHS Employers’ analysts just two days before the BMA withdrew from negotiations, and has proved to be of insufficient quantity and in a format that was not immediately useable.
4.24 It is important to note that although robust modelling has taken place, full implementation of a new contract will likely require wider consultation with employers. It will be important to ensure that arrangements are tested for real employers, across all four nations. The employer team are confident that the data collected and modelling undertaken provide robust evidence in support of the proposed scenarios. The DDRB may wish to consider further sensitivity testing to determine the appropriate increase to basic pay, and the wider applicability of the proposals.

Pay progression

4.25 Pay progression was a difficult topic to reach agreement on during negotiations. Under the current system, all doctors in training receive automatic incremental pay increases every year. In some cases, doctors in training receive a pay increase for a period when they have not been present at work, for example during periods of maternity leave.

4.26 The current system rewards doctors in training who train less than full time (LTFT) with an annual automatic incremental pay increase. This means that as LTFT doctors take longer to complete training, they reach a higher pay point than full-time trainees despite completing the same training programme, but over a longer period. Automatic pay increases are even awarded to those who fail to progress to the next stage of their training.

Figure 2

<table>
<thead>
<tr>
<th>Pay Scale point</th>
<th>Min</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainee 1</td>
<td></td>
<td>ST1</td>
<td>ST2</td>
<td>ST3</td>
<td>ST4</td>
</tr>
<tr>
<td></td>
<td>£30,002</td>
<td>£31,838</td>
<td>£34,402</td>
<td>£35,952</td>
<td>£37,822</td>
</tr>
<tr>
<td>Trainee 2</td>
<td></td>
<td>ST1</td>
<td>ST1</td>
<td>ST1</td>
<td>ST1</td>
</tr>
<tr>
<td></td>
<td>£30,002</td>
<td>£31,838</td>
<td>£34,402</td>
<td>£35,952</td>
<td>£37,822</td>
</tr>
</tbody>
</table>

4.27 As figure 2 shows, Trainee 1 progresses through training and receives automatic incremental pay increases to their basic salary. However, Trainee 2 stays at the same level of training for a number of years. This could be for a combination of reasons including failing to progress, maternity leave, changing training programme, or training less than full time. Despite there being no increase in the level of responsibility, Trainee 2 still receives an automatic incremental pay increase every year, which means they receive a basic salary significantly higher than Trainee 1 received at the equivalent point of training.
4.28 The Government, who will ultimately be responsible for the funding and the decision to implement this new contract, has made it clear that pay progression in the public sector can no longer be based on ‘time served’, i.e. an increase in pay simply for being employed for a greater length of time. This left the employer team in no doubt that a continuation of the current system was not acceptable.

4.29 The BMA was understandably keen to maintain this position, particularly as they told us during negotiations that a high number of their members were ‘out of sync’, i.e. being paid on a pay point higher than the pay point that would normally correlate with their stage of training. Despite this, they made no clear proposals that met the criterion of moving away from time-served pay progression.

4.30 The closest the BMA came to meeting this criteria was suggesting a slight variation to the current system, whereby an automatic pay increase would be awarded subject to doctors in training completing various tasks. The tasks listed however were things that were already required of a doctor in training in order to remain in training and employment, for example being registered with the GMC, or things that the employer did not require, for example annual voluntary work. Because of this, the employer team felt that the BMA proposal was still effectively time-served pay progression.

**Pay progression scenarios**

4.31 We have considered the relationships between experience, time served, responsibility and pay increases in the current system and under a pay system proposed by the employer team. This is referred to as the ‘nodal’ pay system. Under this system each level of responsibility is allocated a single level of pay, referred to as a ‘node’.

4.32 Under the nodal system, total basic earnings over the course of each training pathway is the same, regardless of full-time equivalent, length or number of breaks from training.

4.33 The following pages describe the impact of doctors in training taking a break from training under the current system and in a proposed nodal pay system.

4.34 When discussing pay progression, the terms ‘experience’ and ‘time served’ are often used interchangeably. For the purposes of this section, they have defined meanings:

- Experience = the number of levels of training completed (e.g. F2, ST1)
- Time served = the number of years since training as F1 commenced
4.35 Figure 3 shows 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.
4.36 Currently, when doctors in training take a break from training, for example for a PHD or maternity leave, it becomes clear that experience and time served are different.

4.37 Those taking a break from training benefit over those who don’t. A higher pay point is reached by those who take a break (ie SpR 8) than those who do not (ie SpR 5) over the course of a training programme. (see Figure 4)
The intended purpose of a nodal pay system

4.38 In the current system, pay increases throughout training frequently do not correspond with increases in responsibility.

4.39 Employers want to see a pay system:

- where pay increases correspond with increases in responsibility rather than years of experience or time served
- which removes the anomaly of those taking a break from training reaching higher pay points than someone who has not, despite having equal experience.

4.40 A nodal system will reward a doctor in training for the work they are doing and the level of responsibility they are discharging, which we believe is a fairer system.

4.41 Three scenarios were considered:

Figure 5

<table>
<thead>
<tr>
<th>Pay progression scenario</th>
<th>F1</th>
<th>F2</th>
<th>CT1/ST1</th>
<th>CT2/ST2</th>
<th>CT/ST3</th>
<th>ST4</th>
<th>ST5</th>
<th>ST6</th>
<th>ST7</th>
<th>ST8</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) 6 nodes - unique step for CT3/ST3 trainees</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>
<td></td>
</tr>
<tr>
<td>B) 6 nodes - ST4/ST5 differentiated</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>
<td></td>
</tr>
<tr>
<td>C) 5 nodes</td>
<td>Green</td>
<td>Blue</td>
<td>Yellow</td>
<td>Orange</td>
<td>Red</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.42 The employer team identified the points where changes in responsibility occur through training, see figure 5. We have proposed that there is a clear change in responsibility between Foundation year one, where doctors are provisionally registered with the GMC, and Foundation year two, where doctors become fully registered with the GMC. We also propose there is a clear change in responsibility when moving from the Foundation Programme to Specialty Training, which involves the doctor in training going through a recruitment process before being appointed to this higher position.

4.43 We believe that the first two years of Specialty (ST)/Core Training (CT) are similar in degree of responsibility, and have therefore grouped them in to one node. It should be noted that it is common in some specialties for the CT2 year to be repeated, we would not see this as a move to CT3 and the next node if there has not been a corresponding increase to responsibility. The stage(s) at which responsibility increases between ST3/ST6 is not wholly clear, which is why we have developed a range of options. We propose that ST7 and ST8 offer a further increase in responsibility as a doctor in training moves to sub-specialties.

4.44 The variables differentiating the scenarios are:
- number of nodes in higher specialist training
  - 2 or 3
- positioning of nodes in relation to increases in responsibility in higher specialist training
  - CT3/ST3 has a unique level of responsibility
  - An increase in responsibility between ST4 and ST5
  - CT3/ST3 - ST6 share a level of responsibility
- A further variable not investigated is the value of the nodes

4.45 The common features of all three scenarios are:
- separate nodes which correspond to F1 and F2.
- CT1 and CT2 share the same level of responsibility

Figure 6: Scenario A) Six nodes – unique step for CT3/ST3 trainees
THE NHS EMPLOYERS ORGANISATION’S SUBMISSION TO THE DOCTORS’ AND DENTISTS’ REVIEW BODY
Reform of national contracts for consultant doctors and for doctors and dentists in training

Figure 7: Scenario B) Six nodes – ST4/ST5 differentiated

<table>
<thead>
<tr>
<th>Node</th>
<th>Training level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purple</td>
<td>ST7 &amp; ST8</td>
</tr>
<tr>
<td>Red</td>
<td>ST5-ST6</td>
</tr>
<tr>
<td>Orange</td>
<td>CT3/ST3 &amp; ST4</td>
</tr>
<tr>
<td>Yellow</td>
<td>CT1 &amp; CT2</td>
</tr>
<tr>
<td>Blue</td>
<td>F2</td>
</tr>
<tr>
<td>Green</td>
<td>F1</td>
</tr>
</tbody>
</table>

Time (years) since commencing training

- Increase in responsibility between ST4 and ST5
- 2 years on orange + 2 years on red

Figure 8: Scenario C) Five nodes

<table>
<thead>
<tr>
<th>Node</th>
<th>Training level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>ST7-ST8</td>
</tr>
<tr>
<td>Orange</td>
<td>CT3-ST6</td>
</tr>
<tr>
<td>Yellow</td>
<td>CT1 &amp; CT2</td>
</tr>
<tr>
<td>Blue</td>
<td>F2</td>
</tr>
<tr>
<td>Green</td>
<td>F1</td>
</tr>
</tbody>
</table>

Time (years) since commencing training

- CT3/ST3 share a level of responsibility
- 4 years on orange
Figure 9: Illustrative example of a doctor taking a break from training under a nodal system

Scenario A) Unique step for CT3/ST3 trainees with a three-year break from training – Six year post-Foundation training programme

<table>
<thead>
<tr>
<th>Node name</th>
<th>No of pay increases since training began</th>
<th>Training Level</th>
<th>Experience</th>
<th>Time served</th>
<th>Numbered increases in responsibility since start of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>0</td>
<td>F1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Blue</td>
<td>1</td>
<td>F2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Yellow</td>
<td>2</td>
<td>CT1/ST1</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Yellow</td>
<td></td>
<td>CT2/ST2</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Yellow</td>
<td></td>
<td>PHD</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow</td>
<td></td>
<td>PHD</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow</td>
<td></td>
<td>PHD</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange</td>
<td>3</td>
<td>CT3/ST3</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Red</td>
<td>4</td>
<td>ST4</td>
<td>6</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Red</td>
<td></td>
<td>ST5</td>
<td>7</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Red</td>
<td></td>
<td>ST6</td>
<td>8</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

4.46 Figure 9 shows that under the nodal system, the same pay value is reached over the course of training, regardless of whether there is a break in training or not.
4.47 Employers may want to consider a mechanism to compensate doctors who take a break from training to undertake PHDs or other educational breaks that are required for their Certificates of Completion of Training (CCT) programme.

4.48 The following example (Figure 10) shows how the nodal pay system might work in practice, using pay progression scenario B (Figure 7). The example compares how individuals on some typical training pathways would move through the pay points under the current pay system with the nodal system. This is not an exhaustive list of possible training pathways. For example, doctors in training may take more than one break from training, change their hours, or be less than full time and take a break from training.

4.49 Under the present system some pay points can only be reached by staff who take breaks from training, or by less than full time staff. Under a nodal progression system where progression is contingent upon a move to the next stage of training, these points would be effectively redundant. These points are: F1, point 1 and 2, F2, point 1 and 2, and Registrar points 8 and 9. The ‘existing pay profile’ is based on the values in the 2014 medical and dental pay circular.

4.50 In this example, the value of these redundant points has been redistributed to the node under the new system, which would correspond to the stage of training.

- The value of F1, point 1 and 2 would be reallocated to the green nodal point.
- The value of F2, point 1 and 2 would be reallocated to the blue nodal point.
- The value of Registrar, point 8 and 9 would be reallocated to the purple nodal point.

4.51 This is just one possible way that the values of the newly redundant points could be redistributed elsewhere in the scale.

4.52 The increase in basic pay of 10 per cent is also illustrative, and the precise value would be contingent on the proportions of pay allocated to paying out-of-hours and on-call work.
Figure 10: Pathway 1 – Uninterrupted full-time progression

4.53 Figure 10 represents the pay profile of a full-time member of staff, who completes each stage of training in one year, and does not take any breaks.

4.54 Where the orange nodal line is above the blue line it shows the years where individuals on this training pathway would receive a higher level of basic pay under the nodal system than the current pay progression system.

4.55 The orange line (representing pay progression under the nodal system) is fractionally higher than the dashed blue line (existing pay profile) at F1 and F2. The reason for this slight increase is due to the value previously spent on the second and third points of F1 and F2, being reallocated to the new single nodal points representing F1 and F2.

4.56 The orange line is significantly above the blue line at points ST7 and ST8. This is because the money from points 8 and 9 of the registrar pay scale, which were previously only reachable by those taking a break from training or those working part time (£45,304 & £47,175), have been reallocated so that all staff reaching ST7 or ST8 will receive a share of this money.

4.57 Where the orange nodal line is horizontal it shows where a pay value is being used for more than one year.

4.58 On average, those progressing normally would receive 11 per cent more basic earnings over the course of training under the nodal pay system with a 10 per cent higher basic pay, than under the current pay system.
4.59 Although there is limited data on all the possible pathways that doctors in training take through training, it is thought that the majority of doctors follow the uninterrupted full-time pathway. These doctors would be unaffected by the introduction of the nodal system, and would benefit from the increase to basic pay. An estimated 94 per cent of junior doctors are full time at present. For accurate system costing, it would be necessary to understand the range of typical pathways through training, and the proportions of doctors in training following each pathway.

Figure 11: Pathway 2 – One-year break from full-time training

4.60 Figure 11 shows the impact of taking a year’s break from full-time training. Under the existing pay profile, it can be seen that the dashed blue line recommences at a higher point following the break from training. Under the nodal profile, the orange line recommences at the same basic salary following the break from training.
4.61 An estimated 6 per cent of doctors in training are less than full-time. The majority of these have an FTE of 0.6.

---

21 NHS Employers estimate based on analysis of ESR data warehouse.
The nodal pay scale is favourable to the majority who progress normally, at the expense of those who currently receive an advantage by taking longer to progress through training.

The increase to basic pay means that many staff who are part time for some of their training, or take a break from training, do not receive a reduction in basic pay because this is mitigated by the increase to the overall level of basic pay. All but the slowest to progress through training will receive a net increase to basic pay over the course of training.

**Pay distribution**

**Figure 15 – Average banding by country**

<table>
<thead>
<tr>
<th>Country</th>
<th>Average Banding</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>43.4%</td>
</tr>
<tr>
<td>Scotland</td>
<td>47.0%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>48.7%</td>
</tr>
<tr>
<td>Wales</td>
<td>45.1%</td>
</tr>
</tbody>
</table>

Figure 15 demonstrates the variation in average banding payments between the four countries. These figures are based on the rota data collection undertaken in 2014.

Annex G details rota data collected in each of the four countries. This shows that average hours worked per week in each country are very similar. The reason that the average banding is lower in England is due to lower proportions
of out-of-hours and on-call work being undertaken. It is intended that under a new system, the same rates of payment would be used in each country.

Cost modelling based on a sample of 30 trusts in England

4.66 Illustrative modelling considered the redistribution of the existing spend on banding payments to reward the same working patterns in a different way under a new contract.

4.67 The employer team considered that the elements of work they would like to separately reward were:

Figure 16 – Definitions of pay elements to be rewarded under a new contract

<table>
<thead>
<tr>
<th>Pay element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic pay</td>
<td>Rate of pay for up to 40 hours a week.</td>
</tr>
<tr>
<td>Rostered hours (additional to 40)</td>
<td>Up to eight per week (on average) over the reference period, paid at the same rate as basic pay.</td>
</tr>
<tr>
<td>Out of hours (OOH)</td>
<td>A premium rate (in addition to the standard hourly rate paid as part of basic pay or rostered hours), which applies to hours in the OOH period.</td>
</tr>
<tr>
<td>Availability allowance (AA)</td>
<td>An allowance that is paid in return for an obligation to be available on standby to return to work.</td>
</tr>
<tr>
<td>RRP</td>
<td>Payment made to a group of doctors in a specialty or a geography for a defined period – paid on top of basic but not included in calculation of other payments.</td>
</tr>
</tbody>
</table>
4.68 Modelling investigated how much basic pay might increase, whilst varying the rates of the other pay elements. Any part of the banding amount not spent rewarding rostered hours, out of hours, an availability allowance or RRP was used to increase basic pay.

**Figure 17 – Changing the distribution of existing banding payments**

4.69 The first column in Figure 17 shows the proportions of pay allocated to basic and banding under the current pay system. The proportions are based on the rota data collected in England. For simplicity, the values are based on full-time hours. The second column shows the proportion of pay that would remain (remaining earnings pot) if rostered hours above 40 are paid at plain time, out of hours are paid at time-and-a-third (1.33), and if a quarter of the workforce receives an availability supplement of 5 per cent. The third column shows that the remaining earnings pot ‘buys’ a smaller increase to basic pay than might be expected. This is because any increase to basic pay, simultaneously increases the cost of the same number of additional hours. Note that the proportion of pay allocated to out of hours reflects the premium supplement (0.33) which is payable on top of the standard hourly rate. The value of the standard hourly rate is included under the basic pay element (for hours up to 40), and under rostered hours (for hours over 40).

4.70 Assumptions about the number of hours and the times they are worked were based on doctor in training rotas collected from 30 organisations. Please see annex G for details on how the data was collected.
Figure 18: Hourly and daily coverage of template rotas – England (DRS)

<table>
<thead>
<tr>
<th>Time/Day</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Total by day</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:00 – 02:59</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>1.4%</td>
</tr>
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<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>1.4%</td>
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<td>0.2%</td>
<td>1.4%</td>
</tr>
<tr>
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<td>1.6%</td>
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<td>Total by day</td>
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<td>17.4%</td>
<td>6.5%</td>
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4.71 The data collected was used to construct a profile of how the hours worked by doctors in training in the sample were spread across the week. See Figure 18. The hours were grouped into blocks of times for which it made sense to pay the same rate. See Figure 19. As, the raw data does not provide a breakdown of hours into individual weekdays, the weekday total was split equally across five days, so the proportions could be readily compared with Saturday and Sunday.

Figure 19: Hours distribution grouped plain time, out of hours, and for consideration

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<tr>
<th>Time/Day</th>
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<th>Total by day</th>
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<td>1pm – 7pm, Mon – Fri 73.4%</td>
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<td>14:00 – 14:59</td>
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<td>7am – 7pm, Sat 3.7%</td>
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<td>80.7%</td>
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<td>7am – 7pm, Sun 3.4%</td>
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<td>7am – 7pm, Sat 3.7%</td>
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87.2% 6.5% 6.3% 100%
Pay structure and out of hours

4.72 One of the fundamental challenges of designing a new pay structure for doctors and dentists in training has been the desire to increase the basic pay of doctors and dentists in training whilst keeping the pay envelope constant. While these two desires are not contradictory in themselves, they impact upon the ability to reward those working the most hours and at the most unsocial times.

4.73 In 2007 the DDRB made the following remarks in its report:

2.14 We believe that this recommendation weighted in favour of the lowest paid members of the remit groups will help to ensure that starting salaries for junior doctors do not fall behind those of comparable graduate-entry professions. It also recognises the need for future rebalancing of basic pay and overtime payments (banding multipliers), which will be needed in 2009 as a consequence of compliance with the European Working Time Directive. We deal with this point more fully in chapter 7.
7.7. ...The BMA told us that, once junior doctors’ weekly hours fell below 48, it would be in favour of a system of remuneration which better remunerated a basic 40-hour week and where most of the overall salary came from basic pay. We accept that the current pay system, which is designed to make long hours proportionately more expensive in order to encourage a reduction in hours, will need to be revised once working hours are reduced and we say more about this in paragraph 7.10 below.

7.10 ...it is a foreseen consequence of the reduction in hours and intensity that pay will also drop. Once all junior doctors are working 48 hours a week or fewer, it will be appropriate to shift the balance away from the banding multipliers towards base pay. This will also have the benefit of ensuring that junior doctors’ starting salaries do not fall behind those of other graduate-entry professions. We therefore invite the parties to start giving consideration to restructuring junior doctors’ pay from 2009, including the banding multipliers, since we shall wish to address this issue in our next report and look forward to receiving evidence on it.

4.74 By definition, increasing basic pay in a cost-neutral environment means that the other variable components of pay must be reduced. However, it is variable pay which is used to reward and incentivise those working out of hours. Simply increasing basic pay and reducing variable pay has the effect of increasing earnings for those working fewer out of hours proportionally more than those doing a high proportion of out of hours.

4.75 It is with this in mind that NHS Employers has undertaken careful modelling of several possible scenarios, in order to present to DDRB our three preferred options.
### Figure 20: Out-of-hours scenarios at a glance

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Increase to basic pay</th>
<th>Out-of-hours periods</th>
<th>Out-of-hours rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>19.1%</td>
<td>10pm to 7am every day of the week</td>
<td>33% for all OOH periods</td>
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<tr>
<td>B</td>
<td>17.5%</td>
<td>10pm to 7am Monday to Saturday, all day Sunday</td>
<td>33% for all OOH periods</td>
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<tr>
<td>C</td>
<td>15.3%</td>
<td>10pm to 7am Monday to Saturday, all day Sunday</td>
<td>50% for 10pm to 7am every day of the week, 33% for 7am to 10pm Sunday.</td>
</tr>
<tr>
<td>C + example RRP allocation</td>
<td>14.9%</td>
<td>10pm to 7am Monday to Saturday, all day Sunday</td>
<td>50% for 10pm to 7am every day of the week, 33% for 7am to 10pm Sunday.</td>
</tr>
</tbody>
</table>

4.76 Under each scenario, it is assumed that up to eight rostered hours per week are paid at basic rate. Under this model any staff working on-call or hybrid rosters receive an availability allowance of 5 per cent of basic pay. Alternatively, the rate of the availability allowance could vary to reflect the frequency of on-call working.

4.77 Employers considered a number of models to reward out-of-hours working. They were assessed against a number of criteria:

- Reward for out-of-hours work at a higher rate than basic rate, as per the Heads of Terms point 6.5.
- Provision of flexibility to change when services are delivered without incurring a prohibitively expensive pay bill, linked to Heads of Terms points 1.8 and 3.6, and to the desire across the NHS for seven-day care.
- Reward for those staff working most unsocial working patterns.
- Provision of correct incentives to work the hours which are most valued by employers and extends the period for which plain time is paid.

4.78 To assess the impact on pay distribution for different working patterns, each out-of-hours scenario was tested against actual rota data for full-time trainees collected from 30 organisations in England.

4.79 Several out-of-hours scenarios were modelled by NHS Employers analysts, including a significant number of scenarios on behalf of the BMA. At the time the BMA walked away from negotiations a number of these scenarios were still under consideration by the negotiating teams. Since the breakdown of negotiations, the employer team has considered each scenario in detail with analysts from the four UK nations, and decided upon the following three out-of-hours scenarios.
4.80 **Scenario A**

In this scenario, every day of the week is paid at the same rates. With the hours between 10pm and 7am rewarded at time-and-a-third. The strength of this model is that services could be delivered on any day of the week at the same cost.

**Figure 21: Out-of-hours Scenario A**

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Figure 22: Pay distributions for example working patterns under Scenario A

Scenario A) Nights 33% + Sundays at plain time

- The chart shows the breakdown of earnings for 20 stylised working patterns under scenario A. The working patterns are not intended to be exhaustive but illustrate the range of variation.
- The horizontal red lines indicate the levels of existing banding payments for comparison.
- The percentages shown are the value of the pay element expressed as a percentage of existing basic pay. This allows the amounts allocated to each pay element to be readily compared with the amount of existing banding (which are always expressed as a percentage of current basic pay).
- The value of the availability supplement is shown with a dashed grey line. This is to indicate that this supplement is not always payable to staff on this working pattern. It is dependent on whether the rota includes on-call working.
4.81 Figure 22 shows a graphical representation of the impact of Scenario A on the distribution of pay. This configuration allowed for a relatively high proportion of existing banding to be moved into basic pay. The first column shows the average pay distribution across all staff in the sample. The subsequent columns show how Scenario A would affect the pay distribution of doctors in training working across 20 different stylised working patterns.

4.82 Analysis showed that this disproportionately rewarded those staff working relatively fewer hours i.e. those on working pattern A. These are staff that do not receive any banding payment at present, and would receive a pay increase of 19.1 per cent. Many staff working a higher proportion of out of hours and currently in receipt of a 40 per cent or 50 per cent banding supplement would receive a pay reduction. This is due to the fundamental challenge described earlier, in having to increase basic pay while simultaneously increasing out-of-hours periods to facilitate seven-day care.

4.83 This scenario achieved the aim of increasing basic pay by moving banding payments into basic. At the same time, the cost of delivering services on a Sunday is reduced. However we questioned whether this scenario appropriately rewards those staff working the most unsocial hours. This is due to the large increase in basic pay this scenario would deliver, which disproportionately rewards those working fewer and more social hours, to the detriment of those working a higher number of more unsocial hours.

Scenario B

4.84 Scenario B also rewards the hours between 10pm and 7am at time-and-a-third for every night of the week. In addition, it also pays all day Sunday at time-and-a-third. Figure 24 shows increased earnings of those with rota patterns covering Sunday working.

**Figure 23: Out-of-hours Scenario B**

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+33%

Plain time
Figure 24: Pay distributions for example working patterns under Scenario B

Scenario B) Nights 33% + Sundays at 33%

Working Pattern

- Uplift to basic
- Rostered hours
- Nights
- Sundays
- Availability Supplement
- Banding Rates

No Banding

Current Average Banding

1A & 2B

1B

1C

A B C D E F G H I J K L M N O P Q R S T

Working patterns average

100.0 105.0 110.0 115.0 120.0 125.0 130.0 135.0 140.0 145.0 150.0 155.0 160.0

% of Basic Pay

0.0 1.9 3.7 5.5 7.3 9.1 10.9 12.7 14.5 16.3 18.1 19.9

Scenario B) Nights 33% + Sundays at 33%
4.85 Overall, this had the effect of increasing basic pay to 17.5 percentage points of the existing banding payment, a smaller increase compared to Scenario A.

4.86 As with Scenario A, the employer team were content that this scenario met the aims of increasing basic pay, and helped in facilitating seven-day care. Because the increase to basic pay in Scenario B is less than Scenario A, more money is available to reward those working on Sunday, which in turn leads to higher reward for those staff working shift patterns that include Sundays.

4.87 Whilst this scenario improved the earnings of those working more unsocial hours, the employer team felt that the balance of reward needed to be moved further in this direction. We were of the view that those staff working through the night should be better rewarded for the important service they provide, which led to the development of Scenario C.

**Scenario C**

4.88 Scenario C continues to reward Sundays at time-and-a-third. Under this scenario, the hours between 10pm and 7am are rewarded at time-and-a-half for every night of the week.

**Figure 25: Out-of-hours Scenario C**

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Plan time 33%

+50%
Figure 26: Pay distributions for example working patterns under Scenario C

Scenario C) Nights 50% + Sundays (7pm 0 10am) at 33%
4.89 Scenario C provides the most generous reward to doctors in training working in out-of-hours periods. It also provides for a clear differential in pay between those working unsociably through the night compared to those working all of their hours in plain time. This was an issue that was important to the employer team, as it was felt that it would be preferential that those working more OOH periods receive pay that is proportionally greater compared with those only working in plain time. The night OOH rate has been increased from 33 per cent to 50 per cent in order to balance the effect of an increase in basic pay that will apply equally to all doctors in training regardless of working pattern.

Impact on specialty groups

4.90 Changing the pay system will change the existing pay differentials between specialties. Pay for doctors in training in the current system is unfairly distributed and does not closely correlate to hours worked. Changing the pay system so that doctors in training are rewarded for the number of hours, and when these hours are worked, will mean that some doctors’ earnings will increase and some will decrease. This is a direct consequence of redesigning a pay system that does not fairly distribute pay. In a cost-neutral environment this is unavoidable.

4.91 NHS Employers’ analysts modelled the potential impact of new arrangements against average working patterns in different specialties in the sample. This was to assess, on average, the specialties where on the whole earnings would be higher and lower compared to the current system. See Figure 27. Unsurprisingly, as a consequence of increasing basic pay, those specialties who work very few additional rostered hours benefit on the whole from an increase in basic pay. Some specialties where out-of-hours working is high, but overall weekly hours are less than elsewhere, see total earnings that are lower than under the current system.

4.92 The employer team considered that, where there are already nationally identified difficulties in recruiting and retaining staff in some specialties, a potential relative reduction in earnings compared to the current system may exacerbate the situation. After considering a number of options, we concluded that the best way to solve this issue would be to introduce a nationally determined specialty-specific recruitment and retention premium (RRP).
Figure 27: Impact of Scenario C on specialty groups within sample of 30 organisations in England

Scenario C) Nights 50% + Sundays (7am - 10pm) at 33%

- Uplift to basic
- Rostered hours
- Nights
- Sundays
- Availability supplement
- RRP

The chart shows the mean average hours worked by specialty based on rota data collected from 30 organisations. It also shows the corresponding payment for each pay element expressed as a percentage of existing basic pay.

Availability supplements are assumed to be 5% of existing basic pay for all staff who work an on-call or hybrid rota. However, as not all staff within a specialty work an on-call rota, the grey box represents the mean availability supplement within the specialty.
4.93 Figure 28 shows how an RRP could be allocated at a rate that brings the new level of average earnings up to the existing specialty average earnings in certain specialties. As an illustrative example of specialties that may require an RRP, the employer team chose to use:

- accident and emergency
- the paediatric group of specialties
- obstetrics and gynaecology
- the psychiatry group of specialties.

4.94 These examples are illustrative. DDRB may wish to consider asking relevant bodies to examine national workforce shortages in various specialties and subspecialties; at what stage of training is the particular difficulty; and whether there are regional variations in recruitment difficulties. The employer team envisages that Health Education England will be responsible for recommending who should receive RRPs in England, and the devolved administrations will separately have their own national arrangements.

4.95 The employer team realises that an RRP is not a solution to specialty shortages, which can only be solved by a redistribution of training numbers. However, an RRP does avoid disincentives to choosing to train in a particular specialty, and to retain the current workforce in that specialty. The employer team envisages that the money used to fund RRP will be able to be applied flexibly year on year to address the workforce needs of the day.

4.96 Paying an RRP as described in this section, for all of the specialties mentioned above, would require 0.5 per cent of the existing spend on banding to be allocated to be spent on RRPs. With the cost of an RRP allocation included, basic pay could be increased by 14.9 per cent under Scenario C.
Figure 28: Impact of Scenario C on specialty groups within sample of 30 organisations in England, with the inclusion of example recruitment and retention premia
Safer working hours

4.97 NHS Employers is committed to a system that ensures the health and safety of doctors and dentists in training and, as a result, the safety of patients. The current Working Time Regulations provide statutory protections on working hours, however both the employer team and the BMA agreed that in some cases further limits are required. As stated in the section on pay, we do not believe that health and safety issues should be linked to additional reward for doctors in training. The employer team take the view that unsafe hours are unsafe, regardless of the amount of money paid to the doctor in training, and regardless of where and when these hours are worked.

4.98 During negotiations, safe working hours was a major topic of discussion. As well as being discussed at the fortnightly negotiating meetings, it was felt by both sides that a separate ‘rota group’ would be helpful. The remit of this group was to look at specific proposals and test them against current rotas, to assess the impact. A significant amount of agreement was reached between the two sides during these discussions. The employer team were disappointed that, following the BMA walking away, an infographic was published implying the employer team wanted doctors in training to work “100+ hours a week”, which was entirely contrary to every discussion that had taken place on the subject.

4.99 The current contract allows a scenario where it is possible to work up to 91 hours in a single week. In negotiations, both NHS Employers and the BMA were committed to reducing this maximum number of hours. At the point the BMA walked away from negotiations, NHS Employers had proposed an absolute maximum of 72 hours in any seven consecutive calendar days.

4.100 The employer team are proposing a number of other safeguards in addition to statutory limits, which we believe are right for patient safety and doctor wellbeing. The proposed limits include a maximum of four consecutive night shifts, a maximum of five consecutive long days over 10 hours, and a maximum number of average hours that could be worked should a trainee choose to opt out of the Working Time Regulations.

4.101 There were areas of disagreement during these discussions but these were not principally to do with safe working hours. The employer team could not agree with the BMA on a number of areas for the following reasons:

- We felt that any contractual terms additional to the provisions of the Working Time Regulations should be minimal, simple to understand and easy to administer. The Heads of Terms stated new arrangements should address the current dissonance between New Deal and EWTD, and we did not feel introducing a new set of rules similar in complexity to the New Deal would meet this objective.
- We could not agree to privileges for doctors in training that would be in excess of other NHS staff groups. It would be unacceptable if doctors in
training had contractual access to more generous facilities than other staff groups.

4.102 Our complete proposal for the contractual schedule on Working Hours can be found at Schedule 3 in the proposed Terms and Conditions of Service document (annex F).

Work schedules

4.103 The following points from the Heads of Terms are relevant to this section:

1.10. Recognise that training and service provision by doctors in training are interrelated and be clear that the work schedule for the post will include service provision, training, periods of formal and organised study (other than study leave), rest breaks and prospective cover where applicable.

1.14. Promote transparency around both the expected working patterns and the total hours of doctors in training.

4.5 This is an employment contract which encompasses training, personal development and service delivery required as part of the job.

4.6 Jobs should come with a work schedule describing how a doctor in training in a job is expected to spend their time and the duties of the post holder, including the available training provision and learning opportunities.

4.7 The work schedule for a post should be based on hours of work, rather than sessions, and should be prospectively designed in partnership between employers and doctors in training.

4.8 The work schedule must be adaptable to allow adjustments in response to changes in numbers of doctors in training, the training curricula, or service needs. Where an adjustment cannot be mutually agreed, doctors in training or employers will be able to seek a ‘Work Review’.

5.1 The working hours and pattern of working hours for doctors in training need to:

• comply with relevant legislation

• be safe for patients and for doctors in training

• recognise that both service delivery and training will continue to take place throughout the seven day week
5.5 We will explore a model based upon a work schedule, hours based contract and exception reporting, aiming to replace the current practice of routine monitoring of working hours. This will require agreement of a robust mechanism for ensuring appropriate payment and/or compensation for additional work over and above that in the work schedule.

5.8 Where agreed patterns of hours are regularly altered in terms of start or finish times or breaks within shifts, then that working pattern should be reviewed to ensure it is appropriately designed.

4.104 It was clear to the employer team that the development of a work schedule and work review process was an essential component of the development of new contractual arrangements, and significant agreement was reached on these topics during negotiations.

4.105 Our proposals for managing work and training are built around providing a doctor in training with a work schedule, in order to let them know the hours they will be working and when and where they can expect to work these hours, including any on-call arrangements. The work schedule will detail the clinical services that the doctor in training will be expected to undertake, and the training opportunities available during the placement.

4.106 The doctor in training can expect the work schedule to contain a description of the work involved and the range of duties they are expected to undertake in the placement. The work schedule will also include opportunities for training linked to the curriculum as well as the expected learning outcomes that the doctor in training can expect to achieve. This can be reviewed with the doctor in training’s educational supervisor to ensure that the workplace is delivering the expected learning opportunities.

4.107 We have proposed that the work schedule should be developed in partnership between the employer and the doctor in training, being jointly personalised for the individual taking into account their individual training experience and competencies.

4.108 We believe that the work schedule will be something that is of significant benefit to doctors in training, and is something that junior doctors have told us they would welcome. We believe that it is unlikely a work schedule as described could be provided under current contractual arrangements because employers do not have the flexibility needed to plan working arrangements in a pragmatic way, for fear of being punished with penalty payments for straying across New Deal boundaries.

4.109 Our contractual schedule for the work schedule, which includes full details of arrangements and what might appear in a template and personalised work schedule, can be found in Schedule 4 in our Terms and Conditions of Service document (annex F) under ‘Work schedule’.
Work reviews

4.110 The Heads of Terms were also explicit that a robust work review process must be developed, triggered by exception reporting. The following sections of the Heads of Terms refer:

4.8 The work schedule must be adaptable to allow adjustments in response to changes in numbers of doctors in training, the training curricula, or service needs. Where an adjustment cannot be mutually agreed, doctors in training or employers will be able to seek a ‘Work Review’.

4.9 Doctors in training and employers will have access to robust Work Reviews where the agreed work schedule no longer matches the duties being undertaken. Where a doctor or doctors in training are consistently exceeding their work schedule hours through unplanned changes to their working hours, a review will be triggered by exception reporting. This will ensure unsafe working patterns are addressed and that the training aspects of the placement remain at an appropriate level.

5.5 We will explore a model based upon a work schedule, hours based contract and exception reporting, aiming to replace the current practice of routine monitoring of working hours. This will require agreement of a robust mechanism for ensuring appropriate payment and/or compensation for additional work over and above that in the work schedule.

5.8 Where agreed patterns of hours are regularly altered in terms of start or finish times or breaks within shifts, then that working pattern should be reviewed to ensure it is appropriately designed.

4.111 We have proposed that a work review would usually take place at each educational meeting, and at the beginning and end of a post as a minimum, but may also take place at any point at the request of the employer or employee. We have proposed a three-stage process that we believe the work review should follow, and suggested timescales for this process.

4.112 The first stage is an informal discussion, to attempt to resolve the issue quickly. If this fails, stage two would be a formal meeting including the educational supervisor, the doctor in training, a service lead, and a nominee of the director of postgraduate medical education. If no agreement is reached at this meeting, stage three is the final stage of the employer’s local grievance procedure. A review panel, which will include the director of postgraduate medical education acting in an advisory capacity, will consider whether or not a change to the work schedule is required. The decision of the panel will be final.
4.113 We believe that this process allows work reviews to take place swiftly in order to make quick changes to work schedules where they are required, while at the same time providing a method of escalation should either side be unhappy with proposed changes.

4.114 The employer team could not agree to suggestions that the work review process would have any degree of external oversight. Employers have told us that, with the removal of intermediate tiers of administration for the NHS, each NHS trust is entirely responsible for managing its own affairs.

4.115 We believe that the work review process should be able to operate quickly and smoothly, in order to sort out any problems identified in a particular work schedule. This is essential, especially as doctors in training may be in a placement for as little as four months on some rotations.

4.116 The employer team do not believe that inviting external bodies to scrutinise doctors in training and NHS trusts is the correct way to implement this process. Escalating the process quickly to final stage of the employers grievance process, when required, allows for an impartial review to be arranged at much shorter notice than would be possible if an external panel was required.

4.117 Our arrangements for the work review process can be found in Schedule 5 in our Terms and Conditions of Service document (annex F).

**Exception reporting**

4.118 The Heads of Terms made clear that the work review process would be “triggered by exception reporting. This will ensure unsafe working patterns are addressed and that the training aspects of the placement remain at an appropriate level.” The aim of this process was to “replace the current practice of routine monitoring of working hours.”

4.119 The employer team have proposed contractual provisions that make clear that exception reporting will be used to inform the employer of variations to the work schedule, primarily relating to hours of work and rest, patterns of work, and educational opportunities. The purpose of exception reporting is to alert the employer to any issues they were not previously aware of so these issues can be assessed and if required, a change to the Work Schedule can be made in a timely manner.

4.120 Should changes to a particular work schedule result in a greater number of hours, then remuneration would increase to match the increased hours being contracted for.
4.121 Exception reporting was an area where agreement could not be reached during negotiations. The BMA frequently amalgamated exception reporting with ‘payment for unplanned hours’, which is not how the Heads of Terms describes the issue. The BMA put forward a number of proposals for payment for unplanned hours, none of which the employer team could accept for following reasons:

- Fundamentally, we felt the exception reporting process was about identifying problems and putting them right, not a system to ‘replace band 3’ by paying additional money to doctors in training.
- We felt that a ‘professional’ contract would be undermined if a system was in place where doctors in training could claim additional money for every extra minute they spent carrying out their duties. Not only would this create an incentive to work slower, it would unfairly reward trainees who did not keep pace compared to their colleagues.
- We are not aware of any other staff group, within the NHS or otherwise, which has the right to decide what additional hours they are going to work, and subsequently be paid for. Doctors in training should be no different.
- We could not agree to any system that would be ‘open ended’, i.e. a system where the employer had no control over the amount of money that was spent on paying doctors in training. It would not be acceptable to devolve this control to doctors in training, or to other doctors such as supervising consultants.

4.122 Our arrangements for exception reporting can be found in Schedule 5 in our Terms and Conditions of Service document (annex F).

Private professional work

4.123 The employer team have proposed a schedule in contractual documentation relating to the private professional work of a doctor in training, arising originally from the discussion held around ‘fees’ during negotiations.

4.124 The BMA sought to replicate the provisions in the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002 in to new contractual arrangements for doctors in training. The employer team could not agree to this, given that the 2002 Terms and Conditions were written for all NHS medical and dental staff, including all higher grades up to consultant. It would therefore be inappropriate for doctors in training to perform some of the duties listed in the 2002 Terms and Conditions.

4.125 We have made sure in our proposals that patients and the NHS are put first, taking precedence over private work. We have also ensured that the use of NHS facilities for private work are clearly defined, and that arrangements for fee-paying services are set out.

4.126 Our proposed arrangements are under Schedule 6 of the Terms and Conditions of Service document (annex F).
Leave

4.127 Our provisions for leave cover annual leave, public holidays, study leave, professional leave, sick leave, special leave, and maternity leave. Our contractual provisions for leave can be found in Schedule 8 in our Terms and Conditions of Service document (annex F), under ‘Leave’.

4.128 We have set out entitlements for leave which we believe are fair, consistent with other NHS staff, and facilitate the study and completion of the doctors’ training programme.

4.129 The topic of leave appeared on the agenda for negotiating meetings 12 times. A number of areas of agreement were reached, however agreement could not be reached on the specific wording around some items of discussion. On other points, it was unlikely that agreement could have been reached given the opposing views of both sides.

4.130 For example, on discussions around the amount of annual leave doctors in training receive when they join the NHS, the employer team could not agree to increasing this from 25 days to 30 days. This would create an additional cost pressure both in terms of additional non-working days and service backfill. The employer team also felt that this additional time away would impact adversely on the doctors training programme. It would be unfair in principle if other NHS staff groups received less annual leave than doctors in training on joining the NHS.

Termination of employment

4.131 Termination of employment was a topic that was discussed during negotiations and agreement was reached on the majority of paragraphs in this schedule. There was a longer debate about paragraph 8 of the schedule, which explains how to investigate concerns around a doctor or dentist in training. To alleviate the BMA’s concerns, the employer team agreed to produce a diagram showing a process that should usually be followed when investigating concerns.

4.132 Our contractual provisions for termination of employment, and the diagram showing the process to follow when investigating concerns, can be found at schedule 9 of our Terms and Conditions of Service document (annex F).

Expenses

4.133 Expenses was a topic that was discussed thoroughly during negotiations, with agreement reached on some areas. However, at a time of severe financial restraint, where many NHS trusts are in deficit, we felt that it was essential that new contractual arrangements gave trusts discretion over how to use the limited amount of financial resources available.
4.134 We could not agree to ring-fencing or guaranteeing funding for certain activities, or to 'mixing and matching' various provisions from current arrangements, Agenda for Change arrangements, General Whitley Council arrangements, and arrangements outlined in historic health circulars.

4.135 Our provisions for expenses, which can be found at schedule 11 of our Terms and Conditions of Service document (annex F), are taken from the Agenda for Change Staff Handbook. The employer team have accepted that, in some cases, doctors in training are different to Agenda for Change staff because of their rotational nature, so we have added in extra provisions in relation to relocation and rotational travel expenses specifically for doctors in training. This is in keeping with our principle that doctors in training should be treated the same as other staff groups, except where there are specific differences.

Sections of the NHS Terms and Conditions of Service Handbook applicable to doctors and dentists in training

4.136 Throughout negotiations the employer team felt it was important, as a principle, that doctors in training should be treated the same as other NHS staff, unless there is a specific reason for them not to be. It is for this reason that we feel there is no reason to design separate arrangements for doctors in training for the issues below, when appropriate arrangements already exist in the NHS Terms and Conditions of Service Handbook, which applies for all NHS staff on Agenda for Change Terms and Conditions. These arrangements are negotiated for all staff at the NHS Staff Council, where the BMA is represented.

- Section 15 Maternity leave and pay
- Section 16 Redundancy pay
- Section 22 Injury allowance
- Section 25 Time off and facilities for trade union representatives
- Section 26 Joint consultation machinery
- Section 30 General equality and diversity statement
- Section 32 Dignity at work
- Section 33 Caring for children and adults
- Section 34 Flexible working arrangements
- Section 35 Balancing work and personal life
- Section 36 Employment break scheme
- Annex Z Managing sickness absences – developing local policies and procedures
4.137 Several of these schedules are already negotiated jointly for all staff by the Staff Council and simply reproduced in doctors’ terms and conditions of service. For others, instead of the updated schedules in the Staff Handbook, doctors’ contracts currently refer to the General Whitley agreement for all NHS staff, which has not been subject to negotiation or update since 2003.

4.138 NHS organisations will already be familiar with arrangements in the NHS Staff Handbook, and many will use it on a daily basis. Having the same arrangements for the majority of staff will reduce confusion, especially taking into account the number of external documents that will no longer have to be referred to.

4.139 As our proposed model contract (annex E) explains, the contract document and Terms and Conditions of Service form ‘entire terms’, supplemented only by local policies. This means that employers and doctors in training will no longer have to refer to the outdated General Whitley Council conditions of service, or the plethora of old Advance Letters and Circulars issued by the Department of Health over the years.

Other terms

4.140 The DDRB will notice contractual schedules in our Terms and Conditions of Service document around ‘General Duties and Responsibilities’ and ‘Other Conditions of Employment’. These topics were discussed during negotiations however the employer team do not expect these schedules to be contentious. A high level of agreement was reached around both of these schedules, although the specific wording was never officially finalised.

Groups of special interest

4.141 Before, and during, negotiations it was identified that arrangements for certain groups of NHS staff would need to be considered, as they may need to be marginally different to the majority of doctors and dentists in training. The groups identified were trainees on an academic pathway, public health trainees, and dental trainees.

4.142 The negotiations focused on arrangements that would be relevant for the majority of doctors in training. Should these arrangements be taken forward, additional consideration may need to be given to these minority groups of staff.

Model contract

4.143 To accompany the proposed Terms and Conditions of Service document we have also included a model contract, which can be found at annex E.
5. Consultant contract reform

The case for change

5.1 NHS Employers evidence to the DDRB review of Clinical Excellence Awards argued for stronger employer control over decisions on pay and reward on a local level in a system which should be strongly linked to local objectives, while being affordable, fair and effective.

5.2 NHS Employers views on the future shape of the medical career were set out in our Briefing 52, and made a case for a more supportive environment for learning and development, a small planned oversupply in the medical workforce, and new roles and structures to meet the needs of employers and patients with the flexibility to adapt the structure to suit local circumstances. This informed our evidence to the Shape of Training Review, which emphasised the importance of supporting the transition from junior doctor to the first few years as a consultant. That key time when a doctor moves from competence to mastery of their career specialty.

5.3 The first workforce plan for England from Health Education England (HEE) shows a 55 per cent growth in consultant doctor numbers (FTE) between 2002 and 2012, and indicates that the number of doctors completing their postgraduate training will lead to between 3,300 and 3,500 new CCT holders and increasing the consultant workforce by over 1,800 per year until at least 2020.

5.4 With steady budgets, the era of growing resource is unlikely to return over that same timescale, considering the extra pressure on NHS budgets from demographic changes, technology and drug advances and genomics emerging as an important factor in diagnosis and treatment. The cost of the current incremental progression (referred to in our evidence to the DDRB of Autumn 2013) will need to be contained.

5.5 The review of contracts is not about cutting pay, it is about getting the very best value for the benefit of patients. It is right to ensure that the £5.5 billion spent annually on consultants’ pay is used within national terms and

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22 http://www.nhsemployers.org/SiteCollectionDocuments/Evidence_DDRB_Clinical_Excellence_Distinction_Award_Schemes_fb011210.pdf

23 http://www.nhsemployers.org/~media/Employers/Publications/Medical%20training%20and%20careers.pdf


conditions which are affordable and fit for purpose, and ensure that the NHS has the right number of doctors, at the right levels.

5.6 Reform of national pay and conditions is also needed to make them more supportive of the delivery of seven-day patient care and to make them financially sustainable for the future. The barriers to developing more service provision and better outcomes for patients admitted during evenings and weekends, must be removed. Junior doctors must be more effectively supported in their training and development during evenings and weekends.

5.7 The reform of the medical contracts must align with the findings of the NHS medical director, Sir Bruce Keogh’s Seven Days A Week Forum, which includes national and local commissioners, providers and regulators, has been formed to identify how there might be better access to routine services every day of the week.

5.8 Clearer links between pay progression and performance are needed as a start to the process of reforming the national pay system and changing culture in the NHS. Employers in the NHS are working locally to apply performance management and appraisal arrangements for Agenda for Change staff, to help strengthen links between pay progression and performance including adherence to the values of compassion identified by Francis. Each local employer must decide how they want to make links to their organisational priorities and values. This requires effective staff engagement and partnership working at local level.

5.9 CEAs should be about creating engagement, but currently this is only for some consultants. Others fail to get them or fail to apply not liking the system. We need a system that recognises that all consultants have the potential for excellence in support of organisational objectives built on strengthened job planning and performance appraisal, as recommended by DDRB. Such a substantial amount of money as the local CEAs represents should be used more effectively.

5.10 The contract must fully engage the Consultant workforce - our senior clinical leaders through whom the quality of service can be improved. It needs to be for a mature, professional occupation incentivising the best clinical outcomes. The employer team has therefore sought to co-design, with the BMA representatives, appropriate amendments to the 2003 consultant contract, ensuring that the highest reward is achieved by those who contribute most, avoiding an hourly pay, clock-watching approach.

5.11 The contract also needs to reflect the levels of responsibility and different stages in a consultant’s career, aligning pay and reward, in order to:

- provide a tool for engagement of the medical profession as system and clinical leaders
- provide for good clinical management through doctors
- reward, retain, and incentivise current excellence and promote both the quality of care and medical education and research
• support an increasingly consultant-delivered service
• ensure greater consultant presence during evenings and weekends to improve patient care and support training better.

5.12 The world of medicine and healthcare has changed significantly since 2003 and it is no longer acceptable to rely on juniors for service out of hours.

5.13 It is important that the NHS does not lock itself into outdated models of delivery. NHS England’s Five Year Forward View states:

“Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery … [HEE will ensure] … we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it … so that we can ‘future proof’ the NHS against the challenges to come.” (Page 30).

This will require flexible and adaptable contracts for the employment of flexible and adaptable clinicians, rewarding high performance, supporting role and service redesign and encouraging recruitment and retention in all parts of the country and in all occupational specialties.

5.14 On assessing the financial situation of the NHS and the current funding envelope for consultant doctors in the NHS, the employer team concluded that the average full-time equivalent cost per consultant was about right. However, the resource needed to be distributed in a way that better rewarded those who contributed most, and transparently reflect the level, pattern and quality of the contribution made by consultant-graded doctors.

5.15 It is this thinking which underpins what was offered in negotiations. The employer team believes that the contract amendments being proposed are fair, affordable and effective.

Summary of the employer offer

5.16 The employer team sought amendments to the 2003 contract that would:

• Introduce two fixed payment points equating to two levels of consultant - newly appointed and established and an end to the current incremental progression;
• Make transition through the gateway between the two levels subject to achieving a series of successful yearly performance reviews and, once achieved, progress would be automatic;

• Have an expectation that most consultants would be able to pass through the gateway after four to five years, although some would achieve this level sooner;
• In addition to core pay would have three further allowances making up final earnings as follows:
  o An allowance for responsibilities undertaken out of hours;
  o An allowance for undertaking certain additional roles that may have elements of time and added responsibility;
  o 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;
• Make base pay and any allowance for responsibilities undertaken out of hours, together with some elements of allowances for undertaking certain additional roles, pensionable.
• aim to deliver cost neutrality, compared to the counterfactual situation of no contract reform;
• provide a transition which protects existing pensionable earnings so that no consultant would lose pensionable pay as a result of an agreement, assuming that individuals continue to meet agreed standards commensurate with their pay level;
• Provide potential for consultants to earn at least as much, through the proposed allowances payments, as the ‘guaranteed’ annual pay for consultants near the top of the current scale;
• redefine unsocial hours be to be night work after 10pm
• remain a 10-programmed activity (PA), 40-hour contract, with safeguards such as extra PAs only by agreement.

5.17 The draft of a Heads of Agreement, under discussion when the negotiations ended, covered the key design features set out above and provided safeguards for individual doctors that would have protected their health and wellbeing.

5.18 It is these proposed amendments to the 2003 consultant contract which are now described in detail in the subsequent sections of Chapter 5.
The provision of seven-day services and supporting safeguards for the consultant workforce

“We all know in our heart of hearts the service we offer at weekends isn’t as good, and we have to tackle that and do the right thing. How quickly you have your scan and your tests, or start your treatment, shouldn’t depend on how sick you are or when you turn up”.
Sir Bruce Keogh

“It is ethically unjustifiable to provide a lesser standard of care to patients at weekends.”
AoMRC (published letter to The Guardian)

5.19 The BMA and NHS Employers jointly agree that patients deserve the same high quality of care across the entire week.

It is clear that a range of barriers to the delivery of seven-day services exist beyond contractual matters. This includes the supply and availability of appropriate staff to lead alongside necessary support services, cultural acceptance of supporting the provision of services across seven days, physical infrastructure considerations and integration with social and primary care services.

5.20 The interdependencies for seven-day service delivery have been considered by NHS Improving Quality (NHSIQ) and underlines the importance of taking a whole-system approach when attempting to solve the problem.

“Seven-day services can be perceived as only being about increasing consultant presence seven days a week. But, increasing presence of one professional group may not optimise the care or flow of patients across the system. Similarly, changes in one part of the care pathway and service provision can affect another part of the pathway and services. Taking a whole-system approach will help to avoid unintended consequences”.
NHSIQ (Every Day Counts)

Contractual barriers

5.21 Both parties considered emerging evidence around the benefits to patients, the service and to junior colleagues of increasing consultant presence in hospitals in evenings and at weekends and the extent to which the current

27 http://www.healthcareconferencesuk.co.uk/news/sir-bruce-keogh-says-the-provision-of-7-day-services-across-the-nhs-is-his-number-one-priority
29 http://www.nhsiq.nhs.uk/resource-search/publications/every-day-counts-seven-day-services.aspx
contract can, in certain circumstances, restrict employers’ abilities to provide consultant-delivered services at all times of the week.

5.22 As employers move to consider new models of care a more adaptive delivery system is required. In the Five Year Forward View, NHS England talks about the need for these new models of care: “the traditional divide between primary care, community services and hospitals…is increasingly a barrier to the personalised and coordinated health service need”. To ensure that the consultant contract can effectively support different ways of working it needs to be capable of adapting to whatever models of care begin to emerge. The need for more different delivery system models has also been supported by the Dalton Review findings.30

5.23 Through negotiation, NHS Employers has sought to agree a number of changes to the current contract that would facilitate possible changes in the traditional working patterns of the consultant workforce, to meet ever-evolving local service delivery priorities.

5.24 It is these possible changes to traditional working patterns that have caused most concern among the BMA negotiators. So, to ensure that appropriate safeguards were put in place for consultants delivering services across the whole of the week, existing statutory health and safety legislation provisions were considered at length, alongside a range of protections offered by a revised contract of employment and supported by non-contractual arrangements, including those offered by the NHS Constitution and jointly agreed supporting guidance aimed at providing a framework for promoting best practice.

5.25 For employers, the key contractual changes sought were the removal of Schedule 3 Paragraph 6, which provides consultants with the right to opt-out of non-emergency work during premium time, and a reduction in the scope and scale of premium-time payments to meet the affordability challenges facing employers.

Schedule 3 Paragraph 6
‘Non-emergency work after 7pm and before 7am during weekdays or at weekends will only be scheduled by mutual agreement between the consultant and his or her clinical manager. Consultants will have the right to refuse non-emergency work at such times. Should they do so there will be no detriment in relation to pay progression or any other matter.’

5.26 During the negotiation phase, the BMA agreed to the removal of Schedule 3 Paragraph 6, subject to the introduction of appropriate safeguards to ensure that the provision of care is arranged in a way that is patient-centred, clinically driven, and financially viable and doesn't risk the health and wellbeing of consultants.

5.27 In response to this challenge, a range of appropriate safeguards were offered by the management side team, and these are set out below.

5.28 In addition to these safeguards a draft Code of Conduct was jointly developed to sit alongside a revised contract and any jointly agreed supporting guidance for adoption by employers. This Code emphasises the importance of:

- supporting professionalism to ensure consultants are appropriately supported to enable them to provide safe and effective care for patients
- promoting engagement between the employer and the consultant on service changes
- protecting the health and wellbeing of consultants.

5.29 The management side believes that this package of safeguards represents a comprehensive set of protections against any potentially unreasonable employer demands or behaviours towards their consultant workforce, as changes are made to the current models of care delivery. Given the importance of the consultant workforce in leading and delivering patient care and in recognition of their need to engage in different and variably working patterns, the management side was content to offer a wider range of protections than is currently available to other staff groups.

5.30 The proposed package of safeguards offered during negotiations is set out below (see paragraphs 5.31 to 5.46). Under each item, the purpose of the safeguard is highlighted alongside proposed references which would be placed within an amended contract and where appropriate, supported by jointly agreed guidance.

**Statement of principles (introduction to contract)**

5.31 Purpose: The statement of principles will provide a clear statement in the contract that patients are the first priority of all that the NHS does and emphasises that consultants and their employer must work together in a spirit of collaboration and cooperation to meet their needs.

5.32 The key duties and responsibilities of consultants and employers are clearly set out, summarising their respective roles in the contractual relationship.

**Working time and rest**

5.33 Purpose: To make it clear that health and safety law must protect both consultants and patients from unsafe working hours/rotas.

Proposed contractual reference: *There is a general responsibility for employers and employees, under health and safety law including the Working Time Regulations, to protect, as far as is practicable, the health and safety of all employees at work.*
The quality of patient care is of utmost importance. Individual performance is undermined by tiredness. NHS employing organisations and individual doctors must take steps to protect patients by making sure that they are treated by employees who are fit to work and who are not too tired to work.

Managing both the number of working hours and when they occur will be regarded as an integral element of ensuring health and safety at work and promoting health at work both for consultants and those for whom they provide care.

Employers should therefore establish local policies and procedures for working time and rest.

Supporting guidance to be jointly agreed

5.34 This would provide guidance for employers on the management of working hours including, unpredictable on-call activity, compensatory rest requirements, developing local policies for situations where staff are unsafe to work, providing both for self-declaration and for further action where necessary.

Prioritisation of workload

5.35 Purpose: To make sure that patient services are focused on clinical need employers need to ensure that clinical agreement is sought before any changes are made to provision of services. However, such a duty to consult with the consultant workforce will not provide individual clinicians with a veto regarding elective work.

Proposed contractual reference: Employers have a duty to engage with consultants to ensure that service delivery priorities are clinically driven, reflecting patient need.

Increases in availability of consultant time during evenings and weekends should be used first to enhance the quality of acute care, where this is required. Additional consultant availability can be used to provide scheduled and elective care, as necessary.

Individual and team job plans, along with associated service provision should aim to ensure that patients who require urgent care do not have their treatment delayed as a result of non-emergency care provision.

Organisations and consultants must work together to ensure that urgent care is not compromised.

Individual or minority groups of consultants will not be able to refuse to carry out non-emergency work.

SPA time, at whatever time of the working week, should be subject to job planning in accordance with the BMA/NHSE joint guidance on job planning.
Supporting guidance to be jointly agreed

5.36 Such guidance would include details of the right to raise concerns.

A maximum 40-hour contract, unless extended by mutual agreement.

5.37 Purpose: To make it clear that a full time contract is 10 Programmed Activities (with each PA equal to 4 hours).

Proposed contractual reference: Retain current wording (Schedule 3 para 2) and associated references - A standard full-time Job Plan will contain ten Programmed Activities.

Maximum frequency/number of weekends scheduled in job plans

5.38 Purpose: To set out a maximum frequency of working during weekends, subject to negotiation, within the contract.

Proposed contractual reference: There will be a limit of 13 weekends in each year scheduled for any consultant, unless mutually agreed between the consultant and their clinical manager as appropriate and safe.

Occupational Health

5.39 Purpose: To ensure the consultant workforce has good access to Occupational Health services.

Proposed contractual reference: Employers have a duty of care towards their staff and patients. Employers must protect the health and wellbeing of consultants (and patient safety) by ensuring that they have access to occupational health advice and support.

All night workers (including honorary employees) are entitled to free and confidential occupational health assessment and, additionally, when a work-related problem is identified, to determine whether the worker is fit to undertake night work.

The format and content of the health assessment will be established in accordance with local procedures and following appropriate advice.

Occupational health assessments will be during paid working hours. Where appropriate employees shall be entitled to reasonable adjustment to their work arrangements in the light of occupational health advice.

Duty to consult

5.40 Purpose: To detail the employer’s duty to consult all those likely to be affected by changes to service delivery.

Proposed contractual reference: Where service changes are proposed, including those which are designed to expand services across all days of the week, the employer has a duty to consult all those likely to be affected by the
change prior to any change being introduced. Normal job planning arrangements will apply, so job plans are reviewable on an annual basis and should be agreed in advance.

General provision that employers have due regard to code of conduct/good practice guidance/duty to consult

5.41 Purpose: To ensure that consultants have a say in service development and provision.

Proposed contractual reference: Where service changes are proposed, including those which are designed to expand services across all days of the week, the employer has a duty to consult all those likely to be affected by the change prior to any change being introduced.

Continuity of Care/covering colleagues

5.42 Purpose: To put in place some parameters for covering services where absences have created gaps.

Proposed contractual reference: Amendment to Schedule 2 para 3

Consultants shall be expected in the normal run of their duties to deputise for and cover for absent colleagues where they are part of the same rota so far as is practicable for up to 72 working hours unless by agreement. This work will be paid at the correct contractual rate.

Within 72 working hours the trust will have obtained suitable locum cover or reorganised the service provision to cope; where that has not been possible the trust will follow the established local policies and procedures.

Elective work during evening and weekends

5.43 Purpose: To facilitate reasonable elective service provision during premium time.

Proposed contractual reference: Elective work may take place during evenings and weekends although must be planned to finish by 9 p.m. with the start time to be agreed locally as appropriate and safe.

Facilities

5.44 Purpose: To highlight the importance of providing appropriate facilities to staff who are required to work in the evening, at night or during weekends.

Proposed contractual reference: Where consultants are required to work in the evening, at night, over weekends employers will provide an appropriate level of supporting facilities (rest areas, access to food and drink) as agreed locally as necessary for safe and effective provision of services.
Scope and cost of premium time

5.45 Discussions around the scope and cost of premium time payments had not been completed by the time negotiations had stalled. However, both parties were aware that any such changes would need to fit within the existing overall cost envelope.

5.46 The proposed revised pay arrangements are set out in the following section. These proposals contain a number of pay-related protections which have been identified to support transitional arrangements to any new contractual provisions.
BMA response to the proposed safeguards

5.47 The BMA did not ultimately accept the management side proposals on the basis that the proposed safeguards did not provide adequate protection for patients. It is unclear as to why such a package of safeguards could be interpreted by the BMA as having “failed to offer sufficient guarantees on safe working hours which are vital to protect patient safety, ensure that the quality of patient care isn’t compromised and to prevent burnout amongst consultants”. Link.

5.48 Both employers and the BMA are aware that significant numbers within the consultant workforce already work during evenings and weekends. It is unclear to the management side as to why a significant number of additional contractual protections beyond what was offered were now absolutely necessary to protect consultants from the impact of possible changes to their working patterns.

5.49 The BMA sought to enshrine the majority of the proposed safeguards within their contract of employment, fearing that they would continue to be put at risk as a result of changes in statutory legislation i.e. Working Time Regulations, or that jointly agreed guidance would not provide their members with the necessary reassurance of being treated reasonably by employers. The management side gave due consideration to the BMA’s concerns but did not accept that the employment contract was the sole or most appropriate vehicle to tackle these issues. Over prescription within a contract of employment limits flexibility and risks employers moving away from the national framework if it does not support the delivery of local services, which need to evolve over time.

5.50 The BMA were unconcerned about employers’ need to consider interactions with other medical and non-medical staff groups. Employers rightly need to consider these contract negotiations in light of their relationships with other staff groups. It is accepted that the consultant workforce is different in some respects but that those differences need to be justified to ensure that all staff are treated fairly. The BMA did not believe that this was a consideration that should affect their specific contractual demands.
Revised pay structure overview

5.51 The 42nd report of the DDRB restated its view, as set out in the publication *Review of compensation levels, incentives and the Clinical Excellence and Distinction Awards schemes for NHS consultants*, that ‘the current system pays increments for a consultant continuing to carry out their basic job, rather than reflecting the evidence of job growth that a progression system should reward. We believe that the current structure rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. Near automatic progression is not typically as feature of any of the professional roles we use for comparators at this level’.

5.52 The report also included a recommendation 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.”

5.53 NHS Employers recognises the crucial importance of creating a sustainable career whilst supporting the need to move away from long incremental pay scales, as emphasised by the DDRB.

5.54 The general conclusion of the management side has been that, going forward, it is necessary to agree a new pay framework that is fair to staff, better focused on appropriately rewarding the core consultant job and more adequately rewards the most onerous working patterns and those that contribute the most to patient care. Additionally, employers also sought a new pay structure that was responsive, adaptable to changing service demands and more affordable.

Proposals for the introduction of a revised pay structure

5.55 The proposed revised pay structure includes the following key features:

- ends incremental pay progression based on time served
- links progression to higher levels of responsibility and competence, with progression being contingent on performance
- introduces new pay rates that maintain employers’ ability to recruit, retain and motivate consultants according to their overall contribution while being affordable in the long term
- introduces pay rates that are better suited to a CARE scheme
- provides the opportunity for accelerated access to higher earnings earlier in a consultant’s career
- includes a lower starting salary for new entrants to the grade
- continues to support employers to use local flexibilities, such as recruitment and retention measures, to appoint to specialty posts that are hard to fill.
Payment for excellence

5.56 In respect of creating a stronger link between pay and performance, the intention of the management side is to:

- remove the current local clinical excellence award arrangements and replace it with a new payment for excellence system
- make the payment for excellence a contractual entitlement
- create a new inclusive scheme that pays those who meet an agreed standard of excellence
- reward individuals appropriately based on their performance at an individual, team and organisational level. Such rewards would be time limited and non-consolidated.

Entry to the revised consultant grade

5.57 Within a revised structure it is proposed that eligible doctors would continue to compete for consultant vacancies and be paid a spot salary for a 10-programmed activities (10PA), job-planned role.

5.58 New entrants to the grade would progress to established consultant status once they have gained the necessary competences and experience of working as independent practitioners, and demonstrated this via a job planning/performance assessment process.

5.59 This ‘gateway’ would grant the consultant pay progression to the base pay rate for the fully established practitioner, together with all appropriate additional payment allowances.

Earning additional allowances

5.60 Having progressed to this higher level of spot pay, again within a 10PA job-planned role, other additional earnings would be accessible where appropriate criteria were met. There would be three types of additional allowances that could be accessed:

- An allowance for responsibilities undertaken out of hours. As part of this the out-of-hours premium would be paid for a more limited range of hours than currently, to make wider service hours affordable in the long term. The most appropriate way to remunerate out-of-hours urgent activity has not yet been determined but the management side is continuing to explore available options (following the end of the negotiations). The emerging preference is for adopting an approach which recognises there are differences between consultants in the time they work delivering emergency/urgent activity across the 24-hour period, but is not directly linked to an hourly rate.
- An allowance for undertaking certain additional roles which may have elements of time and added responsibility. These would be locally agreed as would the level of allowance as they will vary in size and responsibility between, and possibly within, trusts. It is proposed that undertaking such roles could be rewarded in a variety of ways:
  - paid in time within the 10PA contract,
  - additional PAs awarded at the base rate of pay
as allowances, where the additional roles are locally judged to be of a broader level of responsibility.

- Performance-related pay, replacing the current local CEAs, non-consolidated and paid on an annual basis linked to the delivery of objectives above and beyond the standard job role - including an objectively measured mix of personal, team and organisational performance.

5.61 Both entry level and experienced consultants will be able to access each of these allowances to varying degrees. For example, entry level consultants would be able to access the full set of allowances associated with work undertaken out of hours but limited to team and organisational payments only as part of the performance-related pay element. In determining how these allowances will be structured it is envisaged that a degree of local determination would be beneficial to ensure appropriate access criteria is put in place, that support local priorities. For example, in relation to the allowances for undertaking additional responsibilities and performance-related pay.

5.62 Employers support the continuation of national performance awards payments in line with an amended national CEA scheme. As higher award holders would be eligible for performance-related pay as noted, employers accept that the assessment process must take care to ensure double counting of achievements does not occur.

**Medical leadership and managerial roles**

5.63 It is also assumed that formal medical leadership and management roles would continue to be paid allowances under Schedule 16, paragraph 16:

“A consultant may be entitled to certain other payments and allowances at the discretion of the employing organisation”.

5.64 These payments do not form part of the core pay. Such leadership and management roles would continue to be filled by appropriate recruitment processes in line with established local practice. Such leaders of other clinicians would continue to be eligible for allowances for undertaking certain additional roles and performance-related payments as appropriate, as described above.

5.65 Schedule 15 on threshold progression processes would be deleted – thus ending time-served progression in line with Treasury requirements.

**Other related matters**

5.66 The employer assumption is that the full-time role of consultant is 10 PAs, of a notional four-hour duration for each PA. The schedule 7 paragraph 5 provisions would be removed meaning that PAs will not be three hours’ work
for four hours’ pay, but actually four hours’ work with the appropriate enhancements if worked in ‘premium’ time.

5.67 The hours that attract premium pay rates will be more limited to enable the possibility of more affordable evening and weekend work (nights and Sundays only).

5.68 Additional programmed activities would be paid at the spot rate for pay for the appropriate level i.e. entry or experienced level.

5.69 Consultants would continue to be required to offer their employing organisation the opportunity to offer extra programmed activities as currently described in Schedule 6. This requires an additional PA being prioritised for NHS work before private work can be undertaken by the individual consultant.

5.70 Another consequent change, to assist affordability and predictability of costs, would be the ending of schedule 7 paragraph 6, which provides for negotiating higher rates where more than three PAs are in premium time.

Investment of money in this structure

5.71 There are some important design choices that have still to be made in relation to the value of each element of earnings. For example, what proportion of pay is fixed in the spot rates and what proportion is available for the additional allowances? How much is spent on each allowance? To what extent is the amount of each allowance protected or guaranteed, for example is there a performance pot that must be spent each year?

Transition

5.72 It will be necessary to agree transitional rules for moving from the current time served increments and thresholds to this new structure. The arrangements for handling transition are set out in paragraphs 5.173 to 5.186.

Considerations for progression from entry to established consultant

5.73 In the current training regime, consultants appointed to their first post will have a Certificate of Certified Training (CCT) and be on the GMC Specialist Register, achieved either through postgraduate training schools or following credentialisation of their experience via Article 14.

5.74 Should future training follow the recommendations of the Greenaway Report\(^\text{31}\), doctors will complete their initial postgraduate training posts with a Certificate of Specialty Training (CST), which is likely to result in a wider breadth of general experience in the chosen specialty and less sub-specialty knowledge.

\(^{31}\) [http://www.shapeoftraining.co.uk/reviewsofar/1788.asp](http://www.shapeoftraining.co.uk/reviewsofar/1788.asp)
5.75 Although these are slightly different potential entry points to a consultant post and the implementation of Greenaway is still far from certain, we should try to achieve a progression point that would be broadly suitable for either, albeit with some amendments should the change occur.

**Proposed approach overview**

5.76 Following attainment of a CCT/CST there would remain a competitive appointment process for posts to the consultant role.

5.77 Appointees in their first consultant post would receive a lower ‘entry stage’ spot base salary while they develop and consolidate their experience. They would be eligible for additional allowances for responsibilities undertaken out of hours and some for undertaking certain additional roles, but have limited access to performance payments.

5.78 Once they have demonstrated that they have the ability to consistently perform at the high level expected of an experienced consultant, they would move to an ‘established consultant’ base salary, and become eligible for all appropriate enhancements for working out of hours, undertaking certain additional roles and full access to performance-related payments. Consultants would not need to apply for a new post to access these arrangements.

5.79 We anticipate that this process would take an average of four to five years, with the opportunity for high flyers progressing within a shorter timeframe.

**Progression gateway**

5.80 As with performance-related pay, progression to established consultant would be closely linked to a locally agreed, objective-based performance assessment process.

5.81 All entry stage consultants would complete an initial consolidation year, during which they would be required at a minimum to meet their set objectives. In order to progress they would then need to attain at least three ‘fully achieving’ annual performance assessments, of which the final two years should be consecutively fully achieving.

5.82 The process would be moderated, with wider organisational objectives feeding into individual objectives and subsequent job planning. Objectives would be internally moderated and would require sign off by the line manager’s appraiser and would be subject to audit by a committee of peers and managers.

5.83 Principles for locally led development assessment and objective setting processes in the context of performance pay will need further consideration, but as an example, an employer could simply adopt a five-point assessment rating system for all consultants:
1. Did not meet objectives.
2. Met objectives.
3. Fully achieved objectives.
4. Significantly exceeded objectives.
5. Exemplary performer.

5.84 Under this scenario, a typical entry stage consultant might meet their objectives in their first year and therefore progress through the consolidation year. In their second year they again meet their objectives while they continue to develop their portfolio of experience.

5.85 Over the next three years, their standard of work increases and they receive three ‘fully achieved’ ratings in a row, automatically progressing to experienced consultant terms and as noted above, passing the gateway in an average of four to five years.

5.86 Ratings 4 and 5 would not be directly relevant during this progression process, but would mark out particularly high achievers. These ratings would come into play for performance awards upon reaching established level.
Entry stage objectives

5.87 Examples of skills and competencies that might be considered in objectives:

i. Undertaking or managing an agreed number of complex/high risk patients with appropriate outcomes. This provides an opportunity to demonstrate moving beyond satisfactory competence in areas of clinical practice.

ii. Completion and presentation of audits of personal clinical practice to a high standard. This would demonstrate ability to audit clinical practice, present findings to their wider team and focus on personal outcomes.

Completion, with satisfactory outcome, of one patient and one colleague multi-source feedback exercise. This would demonstrate team skills, organisational fit, patient satisfaction.

iii. Demonstrating awareness of the organisation’s key policies and relevant clinical guidelines. This would demonstrate involvement with organisational standards and values.

iv. Evidence of engagement in the organisation’s assessment and job planning processes to include sign off in both. This would demonstrate organisational fit and willingness to engage with employer.

Management of the progression gateway

5.88 It is clear that the management of the proposed gateway by employers will need to be more robust than is currently the case, to ensure that the benefits of any new structure can be realised. Such improvements in employer behaviours will only be realised if they are supported by appropriate national implementation guidance and have access to practical management tools.

5.89 There are a number of elements within the new structure that we believe will encourage a revitalised approach to the management of this gateway, such as the creation of a focused single gateway only, open and transparent investment levels and the requirement for a series of satisfactory performance reviews to enable progression to be achieved.

5.90 It will be incumbent on employers to manage the new structure fairly and effectively and ensure that they have the necessary capacity and capabilities to do so.
Pay Progression

5.91 If the DDRB was minded to agree a performance payment approach it would be necessary to create policies at local level to operationalise that approach.

5.92 Earnings beyond the entry spot salary would be conditional upon individuals demonstrating that they have the requisite knowledge and skills for their role, and that they have demonstrated the required level of independent clinical performance and delivery together with organisational ‘fit’.

5.93 Pay progression to the variable elements of earnings beyond from the established spot salary is conditional on local policies demonstrating the requisite application of skills/experience beyond their initial role, showing innovative, high quality, contributions to the patients, their teams, and their organisations.

5.94 This section gives the principles and criteria for determining local progression policies and aligns with Annex W of the NHS Terms and Conditions of Service Handbook. Expectations around standards and performance, and how these will be measured, should be made clear.

Principles

5.95 The following principles will inform the development of local progression policies:

- Assessment, performance and development reviews will need to be consistent with the local employer's objectives and the NHS Constitution.

- Local pay policies should be established.

- Regular assessment, performance and/or development reviews will continue to be the basis for determining whether an individual has met the standards required of them locally for progression, as set out in local policies.

- Consultant doctors on the entry spot salary will progress to the higher spot salary if they demonstrate and apply the required levels of performance and delivery and independent clinical practice in a sustained and consistent way during the performance review period.

- Consultants on the established spot salary who demonstrate the required level of performance in their local policies will be eligible for a share of the performance pot as set out in local policies.

- Systems must be consistent with the criteria set out below.

- There will be a locally determined moderator process and individuals will have the right to seek a local review of decisions made (It is envisaged that this would be a process internal to the employer).
- Systems must be equality assessed before implementation.

- Policies should apply equally to all staff covered by this agreement.

- Every line manager undertaking assessment should have access to appropriate training and development in relation to undertaking assessment and their equality responsibilities.

**Criteria for local schemes**

5.96 Employing organisations will need to operate an effective process for objective, evidence-based performance assessment, development and review, recognising team work wherever appropriate. Significant underperformance should be identified at the earliest opportunity by all concerned, addressed appropriately and not left to the annual review processes.

5.97 Schemes for local performance allowances will take account of the following:

- Relevant competency frameworks can be used in annual systems of review and development for staff.

- Information on performance throughout the year will need to be taken into account in the performance assessment and development review process, so that undue influence of experiences close to the review are avoided. Timely recognition of accomplishment (or feedback about poor performance) is more effective/motivational. Managers and staff will need to build a picture of performance during the course of the review period.

- In assessing an individual’s performance, line managers should be mindful of factors that have been outside the control of individual staff.

- Organisations may wish to adopt team and/or organisational performance measures that could be linked to indicators of quality of patient care. If this is part of the local solution, those involved should consider how these measures interact with individual performance assessment.

5.98 In addition, local schemes will need to:

- minimise the administrative burden on all staff

- be as simple as possible and focused on organisational values and objectives linked to patient care

- be monitored and reviewed regularly

- provide appropriate training and support for staff who fail to meet performance requirements.
5.99 The views of patients and colleagues may be used to inform performance reviews. For example, 360-degree tools and survey results may be helpful. Supporting information may be available from revalidation activity and could inform performance reviews. Views of other managers and other staff can broaden, inform and validate line manager and staff experiences. Good patient experience is known to be correlated with good clinical outcomes.
Allowances for undertaking certain additional roles

Scope

5.100 Allowances for undertaking certain additional roles that consultants may hold at variable times throughout their consultant careers. Whilst it is appropriate to include this allowance within the new contract proposals and to identify appropriate roles, given the variation of the size and complexities of them and to permit as much local flexibility in identifying and defining them as possible, it is not proposed to identify any one quantum of payment for the identified roles.

5.101 As these roles have not had any specific payment allocated to them, any payments made will not form part of the core pay.

Roles

5.102 As outlined above, the following categories of roles that would be subject to additional payments are not all-inclusive, as employers may wish to identify other specific roles relevant to their organisation and its objectives for payment under the contract.

5.103 Types of roles that may be covered include:

- formal medical management roles
- formal teaching roles
- research leadership
- formal clinical governance
- assessment leads.

5.104 Funding for some of these roles is currently not identified in the 2003 contract, coming from a variety of different sources including HEE, other trust resources etc. which is a further reason for not including them in core pay in these proposals. Some specific roles in the identified categories are:

- educational supervision (depending on number of trainees)
- college tutor
- programme director
- director of medical education
- foundation programme director
- clinical lead
- cancer lead
- audit lead
- appraiser (depending on number of appraisees)
- significant participation in research project(s)
- clinical/divisional director
- clinical governance lead
- interviewing for training schools
• external committee membership (on behalf of organisation) e.g. LETC, specialist committees, trauma, critical care.

5.105 Remuneration for such roles can be seen as having two elements. Firstly, an additional degree of responsibility over and above that of other elements of the job plan. Secondly, a time commitment. As with the initial identification of the roles, the amount that fits in to each category is a local decision. In addition, the responsibility element of the pay could be pensionable while the responsibility is carried on an enduring manner.
Outline proposal for exemplary performance payments under an amended contract

Overview

5.106 This section discusses the performance reward element of the earnings structure of an amended National Consultant Contract. It takes into account and builds on the DDRB’s *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*, which was published in 2012.

5.107 This new framework would replace local Clinical Excellence Awards (local CEAs), aiming to reward experienced consultants in return for an objectively measured mix of personal, team and organisational performance.

5.108 This framework is based on the following principles:

- The contract must be simple, responsive, adaptable, affordable and effective.
- Performance reward should recognise those who demonstrate excellence in some key areas such as clinical care, leadership and management, innovation, education, training and research.
- Payments should be closely aligned with the performance assessment process, and should reward the achievement of objectives at an exemplary level.
- It should encourage sustained excellence at all stages of an experienced consultant’s career, and reward those who contribute the most.
- Payments should focus on local exemplary achievement, with national CEAs continuing to recognise demonstrated excellence outside the employing organisation.
- The system should be transparent, fair and equitable with clearly defined appeals criteria and processes.
- It should be applied appropriately to clinical academics.

Outline proposal

5.109 The equivalent to the current local CEAs would be incorporated into the amended contract as non-consolidated, non-pensionable performance payments that are explicitly linked to a performance assessment process.

5.110 Reward would be based on either:

a) exemplary performance across an individual’s objectives, with performance pay made available where overall achievement is identified as ‘above and beyond’ the standard expectations of the job role (criteria for exemplary performance would be agreed as part of the objective-setting process)
b) achievement of tailored, more challenging ‘stretch’ objectives, which would also require the consultant to achieve their core objectives.

5.111 The assessment process would be overseen by peer managers with measures put in place to ensure the approach is fair and transparent (see section titled ‘Eligibility, types of award and governance part 2’). The intention is for this to be developed locally, based on national guidance.

The performance reward sum

5.112 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 full time equivalent (FTE) 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.

5.113 The value per FTE would aim at cost neutrality for the workforce as a whole when taken in combination with other elements of the reward package.

5.114 It is anticipated that the sum would be topped up from monies recycled from:

- the existing ‘local element’ of the national Clinical Excellence awards for NHS employed consultants (which could be incorporated into the tariff).
- the NHS Pension Scheme employer contribution costs of local CEAs, which is currently 14 per cent.

Distribution of performance reward

5.115 At the end of each annual assessment period, the pot would be distributed to all consultants deemed to have met the required level of excellence in a way agreed at a local level, with consultation with the workforce and supported by an overarching national framework.

5.116 As well as individual payments, elements of locally determined team and organisational based performance objectives would be incorporated into the system, where those who contribute to high-performing teams and local organisational objectives will be eligible for the highest performance pay.

5.117 Distribution would be agreed locally, but an example approach, illustrated on page 89, might be to split the pot between those who had significantly exceeded their objectives and exemplary performers. The latter group would receive a higher portion of the overall pot. The proportional split between types of award would be set locally and in consultation with the workforce.

5.118 There would also be a maximum of one of each type of award available per person, and maximum proportion of the pot could be allocated to organisational awards. A maximum cap would also be placed on the amount that any one individual could receive in any year, any excess monies could be
rolled over to the next year. The cap could be in line with the DDRB’s report, which recommended a maximum value of local CEAs of £35,000.

5.119 Under this approach, potential earnings have the potential to fluctuate for individual consultants, as varying numbers of high achievers are identified year on year. This may mitigate against risk of ‘assessment drift’, by promoting a mutual interest between peers and managers that only deserving performers receive payments. In contrast, the existing ratio-based system can also cause resentment among high performing consultants who don’t receive a CEA, or those contributing to others’ success.

5.120 This approach would provide much greater certainty to employers about the cost of employing consultants, and assurance to the consultant body about maintaining the overall level of earnings. Uncertainty in relation to future average earnings for the overall consultant workforce would also be diminished.

5.121 A basic illustration of the model is included on page 89, which should be read in conjunction with further detail of how this process might work in terms of eligibility, individual, team and organisational payments included in the section ‘Eligibility, types of award and governance’ from paragraph 5.130 to paragraph 5.155.

Example: Exemplary performance payment calculation.

5.122 Allocating current local CEA payments to performance-related payments means the latter can be around £7.8k per FTE if only experienced consultants are eligible, but only £5.8k per FTE if all consultants are eligible (although current award rates would suggest a skew of around £7.5k per FTE for experienced consultants and around £1k for the newly qualified).

5.123 Three categories of award are considered; Individual, Team and Organisational Level.

5.124 With the above values per FTE, many different scheme variants could be funded. The following diagram shows one example of how the resource pot could be allocated across the three categories. This assumes that there is one level of payment for each type of award.
Example: Experienced consultant workforce of 100 FTEs. Annual pot of £1,210,000 (12.1k per consultant)

In consultation with the workforce, the employer agrees to split the performance pay pot 3 ways:
70% - Individual Awards
20% - Team awards
10% - Organisational awards

Note: This example assumes that there is one level of payment for each type of award

Before objectives for the year are set

End of appraisal period

Individual award pot = £546k
Team award pot = £156k
Organisational pot = £78k

In year, 30% of consultants achieve high performance rating for their personal objectives
In year, 30% of Consultant’s work in teams that achieve high performer rating
In year, organisational performance objectives met

Individual award for each high achieving person = £18k
Team award for each person on a high achieving team = £5k
Organisational performance bonus for all = £0.8k
5.125 **Consultant A:** A high performer working as part of a high performing team would receive a £23.8k non-consolidated payment

5.126 **Consultant B:** A high performer working in a team that is not eligible for an award would receive a £18.8 non-consolidate d payment

5.127 These values could be increased by diverting available resources from other earnings streams. Similarly, sacrificing potential resources from additional roles payments could boost other earnings streams.

5.128 Local CEAs are currently pensionable. By making performance related payments non-pensionable, then the amount made available for performance related pay could be increased whilst still remaining cost neutral.

5.129 The current financial distribution for consultants, and illustrative examples under the proposed amended contract, are considered further at the Appendix.
Eligibility, types of award and governance

Eligibility for payments

5.130 All established consultants (ECs), including clinical academics, who have completed the gateway process would have access to exemplary performance payments. Entry stage consultants (ESCs) would be eligible for team-based and organisational payments once they have been in post for a minimum of one year.

5.131 This approach will help ensure there are sufficient monies in the pot to continue to motivate experienced consultants, while incentivising ESCs to progress to the established consultant pay rate.

5.132 Consultants with less than five years of service currently account for a very small portion of local CEAs, and therefore we anticipate that most ESCs will not have developed to a standard that is likely to attract these payments. By allowing ESCs to access team and organisational payments and enabling high flyers to pass the gateway in four years rather than the expected five, we could incentivise this group without substantially reducing the reward pot available to ESCs.

5.133 Excluding this group from team and organisational awards would also seem unfair, as they are likely to play a part in team achievements from earlier in their consultant careers and may also prove counterproductive when looking to promote team-based outcomes.

5.134 A number of outstanding questions remain that will require further consideration before this aspect of the model is finalised:

- Will this approach provide sufficient access to performance pay to ESCs for recruitment and retention purposes?
- Do we agree that ESCs should only have access to the team/organisational payments if they have also fully achieved their individual objectives?
- Should employers have the discretion to open up individual performance payments to ESCs?
- Should ESCs also have access to team/organisational awards in their first year?

Individual awards

5.135 In line with the DDRB’s recommendations, performance payments for individuals would be closely aligned with the objective setting and performance assessment process, and made for outcomes that are significantly ‘above and beyond’ contractual expectations. An example might
be highly successful contributions to an objective in support of the
Commissioning for Quality and Innovation payment framework32.

5.136 Linking performance payments to achievements across objectives would help keep performance pay available for all consultants, including those who focus on achieving the very best outcomes within their standard job role.

5.137 Each objective would be agreed at the beginning of the performance year between line managers and the appraisee, and include clear criteria for what good/exemplary performance looks like.

5.138 At the end of the year, line managers would agree the ratings with individuals across their objectives. Overarching guidelines and employer-based moderation would be used to ensure that the process is transparent, fair and equitable.

5.139 For example, an employer might agree an approach where a peer line manager and their appraisee use a five-point rating system to summarise performance for each objective:

1  Did not meet objectives
2  Met objectives
3  Fully achieved
4  Significantly exceeded
5  Exemplary contribution.

5.140 The short rating scale used in this example would aim to reduce the complexity around identifying a suitable level of attainment, which is a common criticism of the existing arrangements.

5.141 Under option a of the outline proposal, eligible consultants whose average rating across objectives was a 4 or 5 would be eligible for an award, with payments for level 5s receiving a higher proportion of the total pot.

5.142 Under option b, a consultant who fully achieves their core objectives will have access to performance pay where they also achieve a rating of 3 across their ‘stretch’ objectives (or a 4/5 for the highest level levels of award).

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32 http://www.institute.nhs.uk/commissioning/pct_portal/cquin.html
Team awards

5.143 Team payments would aim to recognise the efforts of teams of consultants and incentivise team-based outcomes. Academic research cited by the DDRB report also suggested that team approaches could encourage mutual monitoring of performance.\(^{33}\) This may be particularly suitable in clinical settings and could feed into the effectiveness of the wider performance management process.

5.144 The mechanisms for agreeing how to determine successful achievement would be agreed locally to reflect local priorities and circumstances.

5.145 One approach would be to integrate team performance objectives within the objectives of every individual in a specific consultant clinical team. Where the objectives are met, the whole team could be put forward for an award. Alternative approaches could include:

- Individual teams submit an evidence-based application for a payment. The application would ask for measurable evidence of exemplary team performance, backed up where appropriate with qualitative data such as examples of driving innovation.

- Clinical directors nominate high performing teams, which are then moderated at senior level.

5.146 All approaches would aim to mitigate against the risk of staff gravitating towards high performing teams and associated risks of ‘brain drain’, i.e. awards could be made available for payments based on high levels of improvement in a team in any one year.

5.147 A number of outstanding questions remain that will require further consideration before this aspect of the model is finalised:

- Should consultants who receive an individual award for objectives also receive a team award for similar team outcomes? How could this be mitigated against?
- Should a member of a team who does not meet his individual objectives awards still be eligible for a team award?
- Does the group have a preferred approach in terms of setting and awarding team-based objectives?

Organisational awards

5.148 Likely to be the smallest element of the performance pay pot, organisational payments would be linked to locally agreed performance outcomes for the

\(^{33}\) Review Body on Doctors’ and Dentist’s Remuneration – Review of compensation levels, Incentives and the Clinical Excellence and Distinction award schemes for NHS consultants. 2012, p40
employer as a whole. They would be measurable and developed by Board and clinical managers through consultation with workforce.

5.149 The payment would be for achieving an agreed number of relevant trust objectives, not necessarily all organisational objectives, as this might be an impossible target.

5.150 The maximum amount that could be attributed to these awards would be capped and where performance standards aren’t met, the payment would be withheld.

**Governance**

5.151 The administration of performance pay would be locally determined and informed by a national framework.

5.152 We envisage that governance arrangements would vary between employers, but generally local ‘performance pay committees’, which would include peer representation, would moderate and approve agreed award recommendations submitted by managers. These committees could be constituted similarly to the existing local review award committees, including high levels of peer participation.

5.153 Committees would have number of functions, including:

- moderation of objectives set at the beginning of the assessment process (for individuals and teams) to ensure consistency across the workforce
- approval of the high-level individual awards and auditing a proportion of lower level awards
- approval of team performance awards
- appeals.

5.154 In addition to trust-level performance pay committees, larger employers might choose to adopt directorate-level pay committees, which would be led by clinical directors. Directorate-level committees would moderate individual awards, although team awards would be approved on a trust-level basis.

5.155 To mitigate conflicts of interests, managers would not generally be involved in approving their own performance, and a separate subgroup of the committee may be required for the most senior clinical staff. This would be overseen by senior management and informed by feedback from non-lead consultants. It may also be appropriate to use a separate reward sum for individual payments to peer managers.
**Example: Performance Award Governance Process for Larger Trusts**

**Trust Level Committee:**
- Approves highest levels of individual award
- Approves ratings for clinical leadership roles (possibly through subgroup).
- Audits proportion of other individual awards
- Considers team award recommendations
- Administers appeals process

**Trust Board:**
- Approves senior leadership awards
- Agrees split at the beginning of the performance year and sets local objectives (in consultation with workforce).
- Considers whether organisational targets have been met

**Directorate level Committee:**
Approves individual ratings for non-lead consultants.

Ratings agreed with individuals and submitted by peer managers to a directorate level committee (non-leads) or trust level (leads).

**Clinical Director recommends team awards to Trust Committee**

**Trust Level Performance Pay Committee**

**Trust Board**

**Directorate Level Performance Pay Committee**

**Individual Awards**

**Team Awards**

**Organisational Awards**
Implications for job planning arrangements

5.156 The working assumption is that the current joint guidance A Guide to Consultant Job Planning\(^\text{24}\) remains generally fit for purpose and that we keep an approach based on objectives and outcomes. For those staff working with academic and clinical responsibilities the Follett principles\(^\text{35}\) will continue to be applied.

Monitoring of individual performance

5.157 Although the current joint guidance does mention monitoring progress, we may have to strengthen this if meeting/exceeding objectives will determine pay. For example, where someone does not achieve objectives and does not qualify for exemplary performance payments but alleges that they were not given sufficient support during the year.

5.158 The PAC report Department of Health: Managing the NHS hospital consultants said that there needed to be better monitoring of job plans. One challenge might be in trying to manage different processes.

Medical appraisal – Professional and developmental

5.159 The general view is that this should rise above performance assessment. The Medical Appraisal Guide says that medical appraisal can be used for four purposes:

- To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in Good Medical Practice and thus to inform the responsible officer’s revalidation recommendation to the GMC.
- To enable doctors to enhance the quality of their professional work by planning their professional development.
- To enable doctors to consider their own needs in planning their professional development.
- To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practice in.

5.160 There is a potential conflict of interest when this last purpose, which is normally part of the job planning process, is combined with the revalidation and developmental elements of appraisal. For this reason, organisations should (and most do) separate the two processes of appraisal and job planning, though the outputs from each will inform the other.

5.161 For the foreseeable future, appraisal elements that support revalidation should remain separate to those that address performance assessment and job planning. They will therefore occur as two distinct processes but with one informing the other.

\(^{24}\) http://www.nhsemployers.org/Aboutus/Publications/Pages/AGuideToConsultantJobPlanning.aspx

5.162 Revalidation appraisal will address the requirements laid out in *Good Medical Practice* and agree a personal development plan. Its summary output will also inform the medical manager and the process of performance review, which will set the main consultant objectives.

**Job plan review**

5.163 The job plan review will continue to be a necessary requirement in order to determine the extent to which the objectives in the job plan have been met.

**Performance review and assessment**

5.164 The new pay model suggests that continuing payment of the allowances for responsibilities undertaken out of hours, and for undertaking certain additional roles, would be subject to satisfactory performance assessment. Performance-related payments would be entirely dependent on the outcome of the performance review process.

5.165 Another challenge will be improving the quality of performance assessment. The PAC report\(^{36}\) responded to consultant performance with the following:

a) **Information on consultants’ performance is inadequate.** Comparable data to measure consultants’ clinical performance is limited. 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. In 2008, the Department withdrew its national toolkit to measure productivity levels and now only 8 per cent of trusts believe there is effective national guidance to measure individual consultant productivity. We welcome the Department’s plan to publish consultant performance in ten speciality areas. However, the Department urgently needs to make sure that individual consultant performance is measured consistently and published in every speciality area, and support this with appropriate national guidance.

b) Consultants’ performance is not managed effectively. The NHS needs to be focused on delivering the best possible care for patients. But the performance management structures and incentives across trusts are rarely aligned to achieve this.

c) Consultants are rarely held to account for their performance through assessments. For example, nearly half of trusts do not assess whether consultants have met the objectives set out in their job plans during assessments, and pay progression is linked to years in service rather than performance. To tackle this issue, all trusts should improve the value for money of consultants by linking the achievement of job plan objectives and good clinical outcomes with the assessment process and pay progression.

\(^{36}\) [http://www.publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/358/35802.htm](http://www.publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/358/35802.htm)
5.166 Under the current arrangements there is little risk in practice to basic pay if a consultant fails to take part in job planning.
Financial modelling

5.167 The current financial distribution for consultants, and illustrative examples under the future contract are set out in the appendix.

5.168 Whilst they are grounded in real data, the generation of the examples presented has required the use of assumptions, particularly on consultants’ out-of-hours working patterns.

5.169 Based on the employer team proposals, the financial model in the appendix suggests:

- a reduced starting salary for newly qualified consultants of £70k, rising to £93k for experienced consultants after five years
- £107k per FTE for experienced consultants for salary, additional activity and out of hours. Possibility for £5-6k additional payment for out-of-hours work, generated from savings elsewhere in contract
- up to £6.9k per FTE for additional responsibilities
- around £7.5k per FTE for performance related payments for experienced consultants.

5.170 Discussions on additional data sources with NHS England are continuing to better inform this work and if available, further analysis will be submitted to the DDRB as part of the NHS Employers supplementary evidence.

5.171 The appendix covers the following information and analysis:

- Current distribution of consultant earnings with all examples based on latest consultant data covering 2013/14
- Reduced starting salary for entry stage consultants – consideration of options which sets this below the current starting salary
- Establishing base-case average values for payments for additional roles. These values are dependent on design preferences on the balance between the use of local allowances and defined additional roles payments.
- Establishing base-case average values for performance related payments. These are grounded in the current value of local CEA earnings and design preferences regarding the eligibility of newly qualified consultants.
- Establishing the balance between salary and out-of-hours payments

5.172 The appendix goes on to consider options for:

- additional roles payments
- performance related payments
- unsocial hours payments, with payments being based on allowances or hours or a hybrid of allowances & hours.
Handling of transition

5.173 This chapter sets out an approach for handling of the transitional arrangements for consultants moving onto an amended contract.

5.174 The arrangements have been developed in the context of proposals outlined earlier in this evidence, and assume that all consultants on the 2003 contract would move onto the new terms.

5.175 It is unlikely that this approach would be affordable or preferable in an alternative scenario where some consultants remain on an unchanged contract or a significantly altered model.

5.176 The proposed approach is based on the following principles:

- Transitional costs need to be financially sustainable and cost neutral i.e. they should cost no more than the counterfactual in any one year.

- There should be pay protection arrangements in place to protect consultants’ base pay for a defined period of time, while recognising the need to comply with the principles of equal pay. Generally, employers provide up to a maximum of two years’ pay protection.

- Appropriate transitional protections should also include pensionable pay protection.

Implications of cost neutrality

5.177 The underlying assumption for compliance with the funding envelope is that a revised contract should cost no more (or less) than the existing cost per full time equivalent would have in any one year without any changes.

5.178 This approach to transition means that there can be no additional transitional funding. However, other potential sources of funding from have been identified which could be used for pay protection, including:

- holding back pay progression for other consultants compared with the end state while transitional arrangements are active
- holding back some money assigned for performance pay and assigning the monies for transition - for example the employer contribution costs
- potential to introduce lower initial costs of unsocial hours payments compared with the anticipated end state of seven-day services (i.e. unsocial payments would increase after the transition is complete)
- additional funding from incremental pay drift in the counterfactual

5.179 Sources of funding could not include:
• additional payments made by hospitals to their consultants working in the private sector. If it was possible to increase work done at an agreed rate within the NHS, this would feed through overall as an overall productivity improvement.
• theoretical cost releasing savings (reduced paperwork, improved IT etc.)

**Proposed approach**

5.180 On the basis that a sufficient source of funding from transition is agreed, the following outline approach is proposed:

• Base pay should be protected in line with local procedures, usually two years.

• Employers should seek to smooth the transition for consultants whose base pay is above new pay levels, for example by agreeing changes to an individual’s job plan to match their responsibilities to current levels of remuneration.

• Pay protection for those consultants whose existing salary is below the level of the proposed new rate for experienced consultants, should remain until they reach the experienced consultant rate, which on average would take five years. This would be a ‘light’ process taking account of experience already achieved.

• In terms of pension protections:
  o There would be transitional pensionable pay protection of two years for payments earned in the new NHS Pension Scheme (NHSPS).
  o Where pensionable pay is lost (for example, removal of pensionability from Clinical Excellence Awards) it would be protected at the high watermark level for service up to that point; with the lower pensionable pay applying to future service.
  o As discussed at paragraph 5.56, payments for excellence should be decided annually, be non-consolidated and should no longer be pensionable. However, on a transitional basis, payments made to consultants could remain pensionable up to the level of awards held under the current system.
  o The transitional pension protections for performance pay could be extended until retirement for those in the 1995 NHS Pension Scheme with final salary protection (including the tapering group) until they move into the 2015 NHS Pension Scheme. The rationale for this would be that it would reduce the impact and cost of protecting pensionable pay for staff who would never enter the career average scheme with higher accrual rate.
Further protections
5.181 It would be possible to offer pay protection of existing CEAs for a defined period (say two years) for all consultants. However, as this would be funded from the pot of ‘performance related pay’ money available it would mean that very little funding would be available for funding new payments during the period of protection.

5.182 It would be possible to offer consultants the opportunity to forgo protection to access the new performance pay scheme. This type of protection would not be additional to the new scheme.

Pace of implementation
5.183 It is recognised that an amended contract represents a major change in the way consultants are paid. The key change is the linking of progression and performance pay to job planning and performance assessment set through local standards.

5.184 Implementation will need to be taken forward on a controlled basis to maximise the benefits for consultants and employers. It is envisaged that implementation would be on the following basis.

- October 2015 new appointments on new terms
- October 2015 new performance pay arrangements begin with transitional protection
- October 2015 early implementer sites do dry run of new performance approach
- April 2016 early implementers begin using the new system: transitional arrangements begin for base pay
- April 2016: rest of NHS do their dry run based on feedback from early implementers
- April 2017 rest of NHS begin full implementation
- April 2019?: transitional pay protection ends

Worked examples
5.185 Notes: these are simplified examples using notional figures based on the modelling included in the appendix.

5.186 The examples do not take into account the potential for a pensionable approach to unsocial hours payments, or payments for additional responsibilities which are likely to mean that the pensionable pay post transition illustrated here would be higher than shown.
Example 1: Experienced consultant

Current circumstances:
- Aged 57 with 33 years’ service in the 1995 section of the NHSPS and final salary protection.
- Base salary of £101K
- Five CEAs £15K
- One additional Programmed Activity (PA) £11.5K

Total Pay: £127.5K (£116K pensionable)

New arrangements:
- New salary for experienced consultant is assumed to be £93K.
- Plus a 9.4k worth of additional PAs (or other unsocial/premium time arrangements in an amended contract).
- The consultant is assessed for an annual performance awards each year and receives:
  - Year 1 - £20,000
  - Year 2 – £5,000
  - Year 3 – £10,000

Transitional protections
Pay protection offered in line with local procedures (usually two years) for the £8K difference in base pay.

Ongoing pensionability of performance payments up to the level of existing CEAs provided for members of the 1995 section of the NHSPS with protected scheme membership applies in this case.

The trust would work with consultant to identify additional responsibilities that would attract a pensionable £8K payment. If these are not identified base pay would move to new level after pay protection period. This would be ‘best endeavours’ but not a promise to retain wage.

If the consultant continued with the additional PA then, assuming the new payment was lower in this case, the £2.1K additional cost of the PA at the old pay level would also be protected for two years.

Calculation:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>£132.5K (£116K pensionable)</td>
</tr>
<tr>
<td>Base Pay</td>
<td>£93K+£8K protection</td>
</tr>
<tr>
<td>20K performance payment (15k with pensionable protection)</td>
<td></td>
</tr>
<tr>
<td>9.4k unsocial hours plus 2.1k worth of protection (for the additional PA)</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>£117.5K (£106K pensionable)</td>
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<tr>
<td>Base pay - £93K+£8K protection</td>
<td></td>
</tr>
<tr>
<td>£5K performance payment (all with pensionable protection)</td>
<td></td>
</tr>
<tr>
<td>9.4K PA plus £2.1K protection</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>£119,400 (£110k pensionable)</td>
</tr>
<tr>
<td>Base pay: £93k plus agreed £7K of additional pensionable responsibility but with protection ended</td>
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</tr>
<tr>
<td>£10K performance pay pensionability protected</td>
<td></td>
</tr>
<tr>
<td>£9,400 for PA (additional PA protection ended)</td>
<td></td>
</tr>
</tbody>
</table>
• The consultant retires at end of year 3. Pensionable service of 36 years, but for final salary purposes best of last 3 years applies which is Year 1 = £116K x 36/80ths = £52,200 plus £156,600 lump sum. – the pension would be unaffected compared with counterfactual.

• Had he chosen to work another year, he continued with £93K basic +£7K tier 2 but did not receive a performance payment (resulting in pensionable pay of £100). His pension was protected up to the point of pensionable pay reducing: 34 years at £116K, best of last three years for pay after step down based on three years at £110K= pension of £53,425 + £160,275 lump sum. Had pensionable pay continued at the counterfactual then pension would have been £53,650 plus £160,950 lump sum.

Example 2: Mid-career consultant

Current circumstances:
• 20 years’ service aged 45 moving to 2015 pension scheme
• Paid £90k basic
• 2 CEAs (6K)
• two additional PAs £19.2K

Total salary: £115.2K (£96K pensionable)

New arrangements & protections
• Experienced consultant is assumed to be £93K, but as base pay is currently lower than this cannot be paid until pay protection ends. Difference is instead increased by 33 per cent per year with full amount from year 3.
• Continued to receive additional PAs worth 19.2k in years 1 and 2, and £18,800 in year 3.
• The consultant is assessed for an annual performance awards each year and receives:
  o Year 1 - £5,000
  o Year 2 – £5,000
  o Year 3 – £5,000

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>£115,200 total.</td>
</tr>
<tr>
<td></td>
<td>(£96,000 pensionable)</td>
</tr>
<tr>
<td>Base pay of £91,000 (increased by 33%)</td>
<td></td>
</tr>
<tr>
<td>£5K performance (pensionable for first 2 years)</td>
<td></td>
</tr>
<tr>
<td>Additional PAs of £19.2K</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>£116,200</td>
</tr>
<tr>
<td></td>
<td>(£96,000 pensionable)</td>
</tr>
<tr>
<td>Base pay of £92000</td>
<td></td>
</tr>
<tr>
<td>Performance payment of £5k (Pensionable but high water mark reached)</td>
<td></td>
</tr>
<tr>
<td>Additional PAs of £19.2K</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>£116,800</td>
</tr>
<tr>
<td></td>
<td>(£93,000 pensionable)</td>
</tr>
<tr>
<td>Base pay of £93k</td>
<td></td>
</tr>
<tr>
<td>Performance payment of £5k (not pensionable as transition over)</td>
<td></td>
</tr>
<tr>
<td>Additional PAs of £18,800 PAs</td>
<td></td>
</tr>
</tbody>
</table>
Pensionable pay for final salary purposes is initially £96K (being the level incorporating pensionable CEAs). This is likely to be overtaken as consultant receives pay increases plus possibly payments for additional responsibilities in future years & potential for pensionable out of hours payments.

**Example 3: Early career consultant**

**Current circumstances:**
- 11 years’ service aged 35 two years as a consultant
- Base salary of £80k
- one PA £8K
- no CEAs

**Total pay:** £88k (£80K pensionable)

**New arrangements & protections**
- Newly qualified consultant pay is assumed to be 70k for an average of five years. As base pay is currently higher than this, her pay is frozen until she is eligible to progress to the experienced consultant rate (year 4 in this example).
- Continued PAs of 8k for first three years, increasing to 9.4k in year 4.
- The consultant is assessed for an annual performance awards each year and receives:
  - Year 1 - £5,000
  - Year 2 – £0
  - Year 3 – £5,000
  - Year 4 - £5,000

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>£93,000 total. (£80,000 pensionable)</td>
</tr>
<tr>
<td>Base pay of £80k</td>
<td>£88,000 (£80,000 pensionable)</td>
</tr>
<tr>
<td>£5K performance (not pensionable as no existing CEAs)</td>
<td></td>
</tr>
<tr>
<td>Additional PA of 8K</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>£93,000 total. (£80,000 pensionable)</td>
</tr>
<tr>
<td>Base pay of £80k</td>
<td>£107,400 (£93,000 pensionable)</td>
</tr>
<tr>
<td>No performance payment</td>
<td></td>
</tr>
<tr>
<td>Additional PA of 8K</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>£93,000 total. (£80,000 pensionable)</td>
</tr>
<tr>
<td>Base pay of £80k</td>
<td></td>
</tr>
<tr>
<td>Performance payment of £5k</td>
<td></td>
</tr>
<tr>
<td>Additional PA of 8K</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Base pay 93k - successfully reached experienced consultant rate</td>
<td></td>
</tr>
<tr>
<td>Performance payment of £5k</td>
<td></td>
</tr>
<tr>
<td>Additional PA of 9.4k</td>
<td></td>
</tr>
</tbody>
</table>

- A counterfactual in sixth year of consultant career with one old style CEA would see pensionable pay of £88K plus £8,800 additional PA= £96,800
Pension implications

5.187 This section provides a rough illustration of the potential pension implications for consultants who move to an amended contract. It is based on modelling from the Government Actuary’s Department, and acknowledges that from April 2015, most consultants will move from a Final Salary Pension Scheme to one based on Career Average Revalued Earnings (CARE).

5.188 It provides an indication of the projected value of NHS Pension Scheme (NHSPS) benefits for several career pathways, and broadly estimates how pension accrual might be affected compared to the status quo.

Important caveats:

5.189 This paper does not take into account potential changes to the Junior doctors’ and Dentists’ contracts at this stage, although we expect that the contractual changes proposed for this group would lead to an increase to Junior’s pensionable pay, and therefore a marked uplift to the CARE pension calculations for new doctors presented in this document.

5.190 The potential pension implications for consultants with Final Salary pension protection (generally aged at least 52 as at 2014) are discussed in the previous section, which looked at proposed transitional arrangements.

5.191 The transition paper proposes that that this group could have their pensionable pay protected at the ‘high watermark’ level achieved to date - and therefore could feasibly receive a similar pension compared to if they had stayed on the existing arrangements.

Key observations:

5.192 The modelling suggests that under the revised contract, many full time consultants are likely receive broadly similar pension values compared to now. Most completely new starters (i.e those will no final salary benefits or service on the 2003 consultant contract) are likely to receive higher pension benefits by the time they reach their normal pension age than they would have under the existing contract.

5.193 The exception is consultants outside the protected group who have or could have expected to earn CEAs, who will receive slightly less valuable pensions benefits overall. However, this is offset by the potential opportunity to earn higher value performance pay, which would incorporate employer contribution costs from the local CEA system.

Lifetime Allowance

5.194 Consultants tend to receive some of the most valuable pensions in the country, and increasing numbers are accruing pension benefits that are likely to surpass the HMRC ‘Lifetime Allowance’ (LTA) which provides tax relief on the value of pension savings.
5.195 Most people pay a charge on pension savings above the lifetime allowance – this is currently £1.25 million or up to £1.5 million for those with protection, and applies both to public and private sector pensions.

5.196 This modelling suggests that most existing full time consultants who retire in their 60s, and almost all full time new starters who retire close to their normal retirement age are likely to breach the lifetime allowance. Section 2 considers the implications of this and how an amended contract might be used to mitigate the impact for individuals.

Comparisons for sample consultant career pathways under an amended contract

5.197 This section provides comparative examples of consultant career pathways for consultants who transition onto the amended contract, and for brand new starters who join the consultant grade on an amended contract.

5.198 Given that final agreement on the pensionable elements of the amended contract has yet to be reached, the examples remain highly speculative and based on an ‘average’ consultant working patterns - rather than those of a particular speciality.

5.199 Key assumptions for these examples are that:

- all doctors are assumed to have entered service at age 24, with service as Junior doctors paid at existing rates.
- for consultants on the existing contract, an average on call allowance is taken into account.
- Existing consultants will move onto the amended contract in April 2016 and:
  - newly qualified consultants will receive a pensionable spot salary of 70k, rising to 93k after an average of 5 years.
  - performance payments will be non-pensionable.
  - payments for additional responsibilities aren't assumed to pensionable - but we our working is assumption is that they may be in the end state.
  - pensionable ‘intensity payments’ for out of hours payments are included. This currently comes to roughly 12k for experienced consultants and (proportionally, speaking) 9k for new starters (note: the proportional approach would slightly increase the total cost envelope, which would need to be accounted for from elsewhere within the counterfactual - or from lower intensity payments from experienced consultants).

- All examples include actuarial reductions where appropriate, and with the exception of new starters, all the examples combine pension accrual in the
1995 section of the NHPS with future accrual in the 2015 Scheme – providing a single pension figure plus a lump where relevant.

- Normal pension age in the 2015 scheme is linked with the state pension age, which is 67 for examples 1-3 and 68 for example 4. For all new starters it would be 68. The pension values listed refer to the LTA capital value.
- Where staff with final salary benefits in the 1995 section choose to retire later than 60, they may benefit by moving onto the 2008 Scheme under the second ‘Pensions Choice’ exercise - although this is not modelled here.

**Example 1 – Low Flyer**

Became a consultant at 36, and did not expect to receive any CEAs under the existing contract. He moves to the amended contract when he is 42.

<table>
<thead>
<tr>
<th></th>
<th>Draws pension at 60</th>
<th>Draws pension at 65</th>
<th>Draws pension at state pension age (SPA)</th>
<th>Pension value at 60 (LTA capital value)</th>
<th>Pension value pension at 65</th>
<th>Pension value at SPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remains on 2003 contract</td>
<td>£49,400 (+£66,600 Lump Sum (LS))</td>
<td>£68,900 (+£66,600 LS)</td>
<td>£79,800 (+£66,600 LS)</td>
<td>£1,055,000</td>
<td>£1,445,000</td>
<td>£1,663,000</td>
</tr>
<tr>
<td>Moves onto amended contract</td>
<td>£51,800 (+£66,900 LS)</td>
<td>£72,200 (+£66,900 LS)</td>
<td>£83,600 (+£66,900 LS)</td>
<td>£1,102,000</td>
<td>£1,511,000</td>
<td>£1,739,000</td>
</tr>
<tr>
<td>New starter on similar career pathway</td>
<td>£46,300</td>
<td>£73,300</td>
<td>£88,200</td>
<td>£926,000</td>
<td>£1,466,000</td>
<td>£1,764,000</td>
</tr>
</tbody>
</table>

**Example 2 – High Flyer**

Became a consultant at 36 and moves over to the new contract when she is 42. Had she remained on the 2003 contract, she would have expected to earn 5 CEAs, receiving the first at 40 and the last at 57.

<table>
<thead>
<tr>
<th></th>
<th>Draws pension at 60</th>
<th>Draws pension at 65</th>
<th>Draws pension at SPA</th>
<th>Pension value at 60</th>
<th>Pension value at 65</th>
<th>Pension value at SPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remains on 2003 contract</td>
<td>£55,500 (+£76,100 Lump Sum (LS))</td>
<td>£77,400 (+£76,100 LS)</td>
<td>£89,600 (+£76,100 LS)</td>
<td>£1,185,000</td>
<td>£1,623,000</td>
<td>£1,868,000</td>
</tr>
<tr>
<td>Moves onto amended contract</td>
<td>£51,800 (+£66,900 LS)</td>
<td>£72,200 (+£66,900 LS)</td>
<td>£83,600 (+£66,900 LS)</td>
<td>£1,102,000</td>
<td>£1,511,000</td>
<td>£1,739,000</td>
</tr>
</tbody>
</table>
Example 3 – Middle Flyer
Became a consultant at 33, and moves to the new contract at 46. He expected to receive 1 CEA by age 55.

<table>
<thead>
<tr>
<th>New starter on similar career pathway</th>
<th>Draws pension at 60</th>
<th>Pension at retirement age of 65</th>
<th>Draws pension at SPA</th>
<th>Pension value at 60</th>
<th>Value of pension at 65</th>
<th>Value of pension at SPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remains on 2003 contact</td>
<td>£50,300 (+£84,600 LS)</td>
<td>£68,100 (+£84,600 LS)</td>
<td>£78,000 (+£84,600 LS)</td>
<td>£1,090,000</td>
<td>£1,446,000</td>
<td>£1,645,000</td>
</tr>
<tr>
<td>Moves onto amended contract</td>
<td>£50,100 (+£82,700 LS)</td>
<td>£67,800 (+£82,700 LS)</td>
<td>£77,800 (+£82,700 LS)</td>
<td>£1,085,000</td>
<td>£1,440,000</td>
<td>£1,639,000</td>
</tr>
<tr>
<td>New starter on similar career pathway</td>
<td>£49,700</td>
<td>£78,000</td>
<td>£93,600</td>
<td>£994,000</td>
<td>£1,560,000</td>
<td>£1,873,000</td>
</tr>
</tbody>
</table>

Example 4 – Career Break followed 10 years part time.
Becomes a consultant at 36 and moves straight onto an amended contract. Non-pensionable career break for 2 years at age 38 followed by part time (60% FTE) for 10 years - and then back to full time. No CEAs.

<table>
<thead>
<tr>
<th>New starter on similar career pathway</th>
<th>Draws pension at 60</th>
<th>Pension at retirement age of 65</th>
<th>Draws pension at SPA</th>
<th>Pension value at 60</th>
<th>Value of pension at 65</th>
<th>Value of pension at SPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remains on 2003 contact</td>
<td>£39,900 (+£43,100 LS)</td>
<td>£58,000 (+£43,100 LS)</td>
<td>£74,000 (+£43,100 LS)</td>
<td>£840,000</td>
<td>£1,203,000</td>
<td>£1,523,000</td>
</tr>
<tr>
<td>Moves onto amended Contract</td>
<td>£41,500 (+£43,300 LS)</td>
<td>£60,200 (+£43,300 LS)</td>
<td>£76,800 (+£43,300 LS)</td>
<td>£873,000</td>
<td>£1,248,000</td>
<td>£1,579,000</td>
</tr>
<tr>
<td>New starter on similar career pathway</td>
<td>£34,700</td>
<td>£56,300</td>
<td>£75,300</td>
<td>£694,000</td>
<td>£1,127,000</td>
<td>£1,506,000</td>
</tr>
</tbody>
</table>
Considerations on the lifetime allowance

5.200 Under the existing and an amended contract, many full time consultants who work beyond 60 without a career break will be at risk of breaching the lifetime allowance. The position is more flexible for those on part time contracts (depending on their circumstances).

5.201 Those who do breach the allowance will be subject to a charge on their NHS Pension benefits on the excess - at a rate of 55% on lump sums and 25% of the capital value.

5.202 The main option for reducing the impact of the lifetime allowance is increase the flexibility for individuals to manage their pensionable pay. The proposed approach to local performance pay (outlined in chapter 5) offers this both by making these payments non-pensionable and by allowing for the 14% employer contribution currently paid for by employers for Local Clinical Excellence Awards to be folded into the total reward pot available in any given year.

5.203 This will reduce the immediate impact of performance pay on a consultant’s pension value, but also provides the option for individuals to use some or all of the performance payment (or other remuneration) to purchase Additional Pension from the NHSPS and ‘top up’ their benefits (up to £6,500 worth). This will allow them to manage the overall value of their pension benefits more effectively.

5.204 For example, the new starter consultant in example 4 looking to retire at 65 years of age might choose to purchase additional pension worth 6.15k, which would bring their total pension value to approximately £1,215,000 – just under the limit at which a charge becomes payable.

5.205 Another advantage of restricting the pensionability of local performance pay is that the proposals for non-consolidated performance pay may lead to varying levels of award every year (because the amount of performance pay received is tied to the annual performance of the consultant).

5.206 If these payments were pensionable, there would be an increased risk of breaching the separate ‘Annual Allowance’ limit, which is a threshold which restricts the amount of tax free pension growth available each year (currently 40k). More information on the annual allowance can be found at the following link:

https://www.gov.uk/tax-on-your-private-pension/annual-allowance
Risks and mitigation

5.207 A number of issues arising in the course of negotiation needed further modelling or introduced the potential for consequential risks. This was particularly about the financial consequences of proposals for doctors, employers and taxpayers. It also was important in relation to the unknown effects on the discretionary effort by consultant doctors; the practical implementation of performance appraisal linked to pay; and the infrastructure needed to make best use of the amended elements of the contract.

5.208 As a result, the employer team offered a mitigating solution to reassure all parties. This meant that the introduction of new arrangements would, where necessary, be subject to a staged process of introduction involving:

- a period of shadowing of key provisions at selected early implementing sites to establish the correct metrics
- a period of early implementation to gather real data in real time to establish the costs to doctors and to employers, the efficacy of the processes, and the capacity building requirements to make the system work well
- a re-calibration of the pay rates and allowances to ensure there was no windfall financial benefit for employers or taxpayer, and no overspend over and above the financial neutral requirement of Treasury on behalf of the taxpayer
- a full roll out to the rest of the service.

5.209 Some elements would be introduced straight away while testing the overall design of the changed arrangements. For example, it would be envisaged that Schedule 3 Paragraph 6 would be removed immediately.

5.210 Modelling work undertaken during the negotiations and talks showed the parties the challenge faced in achieving cost neutrality during a period of austerity, which was set to continue during implementation and transition, with flat cash for the employers in the NHS and the growth in the numbers of doctors being supplied through training.

5.211 It is clear to employers that maintaining the status quo is no longer appropriate or defensible. There is a need to deliver better outcomes in evenings and weekends and improve mortality figures, initially around acute and emergency care, but also to use resources effectively and provide responsive services to patient needs. Clinical Commissioning Standards also need to be met and so over time we must see elective work at weekends and in evenings and diagnostic clinics increasingly occur in these periods. This will need to be affordable and will mean fewer premium rate hours in the week, regularising evenings and some weekend work into plain time rates.

5.212 In the context of a negotiated settlement which is affordable and fit for purpose, employers would envisage a range of safeguards, protections, transitions, and implementations rules also being agreed. For example, making local CEAs contractual and pensionable; making the investment in them more secure for
recipients than ever before and protecting pension accruals and pensionable pay. However, in the absence of an agreement, affordability would mean fewer protections since two contracts would have to be operated in parallel for a period of time.
Employer views on contract reform and the barriers to provide services over seven days

5.213 This section details specific employer views related to the reform of the consultant contract gathered by NHS Employers during the course of negotiation phase.

The case for change
5.214 The current consultant contract has served the purpose of attracting, rewarding, incentivising and promoting clinical excellence for the benefits of patients, but it is widely recognised that the contract has its limitations. Contract arrangements and reward systems in the NHS need to be reviewed periodically to ensure that they meet the needs of the NHS today and for the future, while ensuring that they remain affordable. The current position is that no change to the contracts is not an option and we cannot maintain the status quo.

Employer views
5.215 NHS Employers has undertaken regular engagement activities with NHS employing organisations during the course of negotiations, to ensure that the management side’s negotiation strategy clearly reflects their requirements. Additional work has been carried out to understand employer views on the main barriers to providing services over seven days across all staff groups.

5.216 Employer views have been gathered during the course of partnership discussions and formal negotiations via:

- employer engagement on the management team’s negotiation priorities and obstacles to providing services over seven days (40 organisational responses)
- combination of online survey and voting button responses at regional HRD network events (79 individual responses but action is ongoing) on the main barriers to providing services over seven days
- HSJ Barometer (60 responses) on the main barriers to providing services over seven days

5.217 Contract reform – what do employers want from negotiations?

- Support for the continuation of a national, jointly negotiated contract for consultants.
- Many organisations have stated that they would find it difficult to undertake extensive local negotiations. With the pressures on the labour market, employers believe it would be difficult to reach agreement locally to any significant changes to the current contract.
- Greater flexibility sought regarding working hours (core and non-core hours) with increased availability without excessive additional cost i.e. expand plan time coverage and limit allowances for out of hours work.
• The ability for employers to develop and implement affordable and sustainable seven-day services is severely compromised by the restrictions created by Schedule 3 Paragraph 6. Removal is seen as essential.
• Acceptance that pay needs to be better linked to performance.
• Base pay progression should be better linked to appraisal and job planning/productivity. Ratification by line manager against contract performance by an agreed process of verification.
• More effective recognition and reward for shift work vs. on call
• Need to ensure that any new arrangements don’t lead to less qualified doctors dominating any ‘new’ core hours.
• A phased approach of implementation of any new arrangements.

Seven-day services
5.218 The vast majority of employers recognise that the removal of schedule 3 and a cap on premium pay were minimum requirements for the implementation of seven-day services. The removal of the 7pm session block and extension of plain hours would be welcomed. The right to refuse out-of-hours work and the ability for consultants to negotiate higher rates appears to be a common issue across organisations. It was felt that national agreement on this aspect of contract negotiation was essential to avoid the increased costs associated with local negotiations.

Pay scales and progression
5.219 Employers accept that pay progression should be linked to performance, not time served. Suggestions for the principles of performance-related progression were given by a number of organisations. There is general consensus on the need to reform the pay scales, which are felt to be too long. A number of organisations stated that an entry level consultant scale is desirable. It is recognised that the creation of a sub-consultant grade would simultaneously improve quality whilst reducing costs. Trainee consultants would receive further opportunities to develop skills and clinical experience whilst boosting senior rotas. It is recognised that speciality-specific arrangements may be required to address challenging recruitment areas.

Job planning
5.220 Organisations are calling for increased flexibility in the design of job plans. This means the removal of hours-based PA contracts and the (re)introduction of sessional-based professional contract. A number of organisations stated the desire to move to group job planning, where teams review the whole of the work requirement, and weight it to personal and organisational need. This would require differences in the current structure of PAs.

Clinical Excellence Awards (CEAs)
5.221 Employers see CEAs as they currently stand as outdated and inequitable. There is more to consultant engagement than just financial reward and the current system for discretionary awards is unsatisfactory to both parties. However, employers believe that there remains merit in national
recognition of the most exceptional contributors, whose national contribution augments that locally, rather than sacrifices their local contribution.

5.222 Employers believe that there has to be a better way of doing performance-related pay for doctors, but there are some concerns that this doesn’t apply to any other population in the NHS. A revised approach better aligned to trust objectives and outcomes, with reference to behaviours, values, quality improvement etc, would be preferable.

5.223 In many instances, CEAs are seen to be awarded for doing little more than can be reasonably expected by the employer. Frequently, the granting at local level is without any reference to efficiency/workload expected and unsupported with evidence that would be expected in a performance-related pay scheme i.e. little to no quantification.

5.224 Employers also believe that awards should be regularly reviewed to ensure the continuation of any payments is justified. They should be better linked to pay progression where the work is quantifiably sustained.

Employer surveys
5.225 The emerging results of our employer survey, which asked “What are the main barriers to providing services over seven days?” are set out in the diagram given below. This question has been posed in relation to the whole workforce, but highlights the difficulties employers face in terms of the recruitment and cost of employing an additional medical workforce and the motivations to work out of hours (which includes the consultant workforce). This work is ongoing and the results will be updated as additional regional networks are engaged.
Health Service Journal (HSJ) Barometer

5.226 In November 2014, as part of a collaborative piece of work with NHS Employers, the HSJ published responses to its online survey, which included the question “What are the significant barriers to implementing seven-day services in your organisation?”

5.227 The results highlight the difficulties facing employers posed by the right of consultant doctors to refuse non-emergency work and the cost of out-of-hours payments.

![Barometer Pie Chart]

- The right of consultant doctors to refuse non-emergency work, 20.59%
- The cost of enhancements to pay unsocial hours, 26.47%
- Availability of additional staff, 14.71%
- Organisational Culture – i.e. unwillingness of the organisation to function in the same way every day of the week, 5.88%
- Individual culture – i.e. unwillingness of staff to work their 5 days over 7, 14.71%
- Cost of additional staff, 17.65%
6. Specialty and Associate Specialist (SAS) doctors

6.1 The majority of specialty doctors are employed under the Terms and Conditions of Service for Specialty Doctors 2008. There is also a number of associate specialists employed under The Terms and Conditions for Associate Specialists 2008 and a smaller number who remain on the NHS Hospital Medical and Dental Staff and Doctors in Public Health Medicine and in the Community Service Terms and Conditions of Service 2002.

6.2 The joint employer/BMA forum for maintaining these contracts is JNC (SAS). There have been no proposals to amend or review SAS contracts in the same way as those for consultants and doctors in training.

6.3 The 2008 contracts for specialty doctors and associate specialists share many common features with the 2003 consultant contract, including

- A 10 PA contract based on a job plan comprising direct clinical care and supporting professional activities
- Recognition of premium time between 7am and 7pm, weekends and public holidays
- An out-of-hours on-call allowance
- Time served incremental progression subject to meeting criteria

6.4 There is no direct equivalent in the specialty doctor contract to schedule 3 paragraph 6 in the consultants’ terms and conditions that allows for consultants to refuse non-emergency work in premium time. However, there is a provision that states that ‘subject to agreement via the job planning process and in accordance with employers’ change management policies, doctors may be expected to take part in non-emergency work …(in premium time).’

6.5 Associate specialists on the 2008 contract, like consultants on the 2003 contract, currently have the right to refuse non-emergency work in premium time. The nature of the 2002 contract is different. As with those remaining consultants also covered by these arrangements, the contract is professional rather than time based and there is no provision for premium hours.

6.6 There is some overlap at the moment between the associate specialist and consultant pay scales, where the maximum of the associate specialist pay scale is higher than the current minimum of the consultant pay scale. This means that there is provision within the consultant terms and conditions for associate specialists who earn more than the minimum of the consultant pay scale to be placed at the next highest point on the consultant scale on promotion, so that there is no detriment on promotion.
6.7 It will be necessary to consider the effect of any revised working arrangements for consultants on the existing terms and conditions for SAS doctors. We propose to do that through the existing negotiating machinery of JNC (SAS).
Annex A – invitation to submit evidence

Review Body on Doctors’ and Dentists’ Remuneration

Special remit on contract reform for consultants and for doctors and dentists in training: call for evidence

Overview
The Parliamentary under Secretary of State for Health has asked the Review Body on Doctors’ and Dentists’ Remuneration (DDRB):

- to make observations, based on information and data presented on pay-related proposals for reforming the consultant contract, to better facilitate the delivery of health care services seven days a week in a financially sustainable way; and
- to make recommendations on new contractual arrangements for doctors and dentists in training.

DDRB has been asked to submit its report, for England only, by July 2015.

Remit on contract reform
Details of the remit were included in the letter from the Parliamentary under Secretary of State for Health dated 30 October 2014 (Annex A).

Consultants
DDRB is asked to make observations based on information and data presented on pay-related proposals for reforming the consultant contract, to better facilitate the delivery of health care services seven days a week in a financially sustainable way i.e. without increasing the existing spend. In the context of the policy aim to deliver financially sustainable seven day services, DDRB is asked to consider and critique proposals from the Department and NHS Employers, taking account of the views from all parties.
In so doing DDRB is also asked to consider:

- the work already undertaken by DDRB on the payment of Clinical Excellence Awards (CEAs)\(^\text{37}\) and the Government’s response to that report;
- proposals for pay progression to be linked to responsibility and performance; and
- arrangements in other sectors which provide seven-day services.

**Doctors and dentists in training**

DDRB is asked to make *recommendations* on new contractual arrangements including a new system of pay progression with as DDRB has previously proposed “a strengthened link between pay and better quality patient care and outcomes”.

DDRB should also consider:

- proposals for pay structures that include the ending of time-served incremental progression;
- information on the working patterns of doctors in training; and
- how the current pay envelope could be used differently to increase basic pensionable salaries, providing appropriate reward of additional work, while supporting services and training across the seven day week.

In considering both strands of this remit, DDRB should have regard to the Heads of Terms agreed by the parties prior to the contract negotiations. It should have regard to the read-across to the work that the Government has asked the NHS Pay Review Body to undertake to make observations on the barriers and enablers within the Agenda for Change pay system for delivering health care services every day of the week in a financially sustainable way.

In considering DDRB’s observations on seven day services, the Government would also wish to consider the extent to which they would read-across to other medical staff groups such as speciality doctors and associate specialists.

It is possible that some or all of the Devolved Administrations may wish to be included in this remit. We will inform the parties promptly should this prove to be the case.

The parties to the evidence process

While the Review Body would welcome evidence from any party, the following parties are being invited to submit evidence:

- Department of Health
- Foundation Trust Network
- Health Education England
- NHS Employers
- NHS England
- Advisory Committee on Clinical Excellence Awards
- British Medical Association

Factors to cover in evidence

Submissions of written evidence should cover the specific factors set out in the remit letter (Annex A). The Office of Manpower Economics is commissioning research on seven-day working arrangements in other sectors, but additional evidence would be appreciated. The parties are welcome to submit evidence on any element of the remit; however, a list of questions is included below to assist the parties in focusing their evidence. Your responses should focus on the DDRB remit groups, but you should also cover other NHS staff groups where appropriate, or to provide a wider context. Background on the work of DDRB can be found at https://www.gov.uk/government/organisations/review-body-on-doctors-and-dentists-remuneration

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?

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?

3. What evidence do you have on other sectors which provide seven-day services, and what is your justification for such comparators?

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?

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?

7. What seven-day services/unsocial hours’ services are currently provided and what is the cost differential compared to normal working hours?

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? (i.e. what is the model for the workforce?)

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?

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?

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?

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

13. What evidence can be provided on the impact for patients of seven-day services?

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?

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

16. What are the pay, staffing and motivational issues and costs around any transition to seven-day service provision?

It would be helpful if the details of any external reports or research that are already available, and which you intend to refer to in your evidence, could be submitted as soon as possible, in advance of your main evidence.

Submission of evidence
Submission of written evidence, preferably electronically, is invited by Wednesday, 31 December 2014, to:

richard.chamberlain@bis.gsi.gov.uk and cliff.wilkes@bis.gsi.gov.uk

Richard Chamberlain
Office of Manpower Economics
8th Floor, Fleetbank House
2-6 Salisbury Square
London EC4Y 8JX

Please address any enquiries to Richard Chamberlain at the above address or telephone 020 7211 8809.

The Office of Manpower Economics provides secretariat and research support to all the Pay Review Bodies.

In the interests of the transparency of the process, DDRB asks that written evidence submitted to this review is shared with the other parties and published on the organisations’ websites at the time of submission.
Next steps

DDRB will consider the written responses to this review and may ask supplementary questions following receipt of the written evidence. Responses to supplementary questions and comments on the other parties’ evidence should be made by Friday, 13 February 2015. DDRB will invite some of the parties to give oral evidence in March 2015. It will take into account all relevant factors raised in evidence and will make observations in accordance with the remit. DDRB expects to submit its report to Ministers by July 2015.

DDRB

30 October 2014
ANNEX B: Remit letter from the Department of Health

From Dr Dan Poulter MP
Parliamentary Under Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 4850

Dear Professor Curran,

Further to the letter you received from the Chief Secretary to the Treasury, Danny Alexander on 31st July 2014 and my letter of 26th August 2014 confirming the remit for independent contractor doctors and dentists, I am writing now to confirm the remit for employed doctors and dentists.

As I set out in my letter of 26th August, following the Government’s announcement of a two year pay settlement for employed doctors and dentists in England the DDRB is not required to report or to make recommendations or observations for the 2015/2016 year on:

- the remuneration of employed doctors and dentists;
- the recruitment, retention and motivation of suitably able and qualified staff; and
- regional/local variations in labour markets and their effects on recruitment and retention of staff.

National employment contracts are a critical element of how we put patients right at the heart of everything the NHS does, providing a seamless pathway of care no matter what day of the week. In recent reports, the DDRB has identified the need for contract reform for consultants and for doctors and dentists in training. During 18 months of discussions and negotiations, NHS Employers and the BMA have done a significant amount of work to design reward packages for consultants and juniors to facilitate services and training across the seven day week. The Government is disappointed that these negotiations have not resulted in agreements acceptable to all parties. The Chief Secretary, in his letter of 31 July, noted the DDRB’s offer to consider contractual arrangements at an appropriate stage of the negotiations. I am therefore now asking the DDRB to make observations and recommendations that take into account the work undertaken during negotiations.

30 OCT 2014
There is a strong clinical case for seven day services. For example, recommendations of the *NHS Services, Seven Days a Week Forum*¹ accepted by NHS England, explore the consequences of the non-availability of clinical services across the seven day week and state that availability needs to be achieved in a clinically and financially sustainable way.

For 2015/16, **for consultants**, DDRB is asked to make observations, based on information and data presented on pay-related proposals for reforming the consultant contract to better facilitate the delivery of health care services seven days a week in a financially sustainable way i.e. without increasing the existing spend. In the context of the policy aim to deliver financially sustainable seven day services, the DDRB is asked to consider and critique proposals from the Department and the NHS Employers, taking account of views from all parties.

The DDRB should also consider the following, including work already completed by the DDRB and work undertaken by the parties to the negotiations:
- the work by the DDRB on the payment of clinical excellence awards (CEAs), and the Government’s response to that;
- proposals for pay progression to be linked to responsibility and performance; and
- arrangements in other sectors which provide seven day services.

For **doctors and dentists in training**, DDRB is asked to make recommendations on new contractual arrangements including a new system of pay progression with, as DDRB has proposed, “a strengthened link between pay and better quality patient care and outcomes”. In doing so, DDRB should consider information submitted including:

- proposals for pay structures that include the ending of time-served incremental progression;
- information on the working patterns of doctors in training; and
- how the current pay envelope could be used differently to increase basic pensionable salaries, providing appropriate reward of additional work, while supporting services and training across the seven day week.

In undertaking both strands of this work, the DDRB should have regard to the Heads of Terms agreed by the parties prior to the contract negotiations. It should also have regard to the read-across to the work that the Government has asked the NHS Pay Review Body to undertake to make observations on the barriers and enablers within the Agenda for Change pay system for delivering health care services every day of the week in a financially sustainable way.

Annex C: Mandate for negotiations

Consultants

1. This mandate is given by the Departments of Health for England and Northern Ireland and commissions NHS Employers (NHSE) to enter into formal negotiations with the British Medical Association (BMA) to deliver joint proposals for a consultant contract for England and Northern Ireland\(^\text{38}\) that NHS organisations will continue to use. The negotiations should be on the basis of the Heads of Terms agreed on 18 September 2013.

2. The target date for implementation of new contractual arrangements is from 2015, allowing for a negotiating period of 12 months, although Ministers would welcome earlier progress on changes that would support seven day services. Proposals should include transitional arrangements to move doctors to the revised arrangements.

3. The timetable should allow for periodic updates to Health Ministers, including in early February 2014 when there should be evidence of clear progress towards the achievement of the objectives set out in this mandate.

4. Proposals should be supported by robust modelling demonstrating that changes will be revenue neutral and will contribute to the affordability of continuing expansion of the consultant workforce.

5. Any new arrangements must facilitate the provision of high quality care by applying the highest standards of excellence and professionalism to enable consultants and employers to meet their shared responsibilities to patients and must support the wider aims of the NHS.

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\(^{38}\) In England this covers NHS medical and dental consultants currently employed on the 2003 consultant contract and those employed in non-NHS bodies where the terms of the 2003 contract continues to apply. For Northern Ireland this refers to those covered by the 2004 contract.
**Mandate for negotiations – Junior Doctors**

1. This mandate is given by the four UK Health Departments and commissions NHS Employers (NHSE) and representatives from Scotland, Wales and Northern Ireland to enter into formal negotiations with the British Medical Association (BMA) to deliver joint proposals on a UK wide contract for all doctors and dentists in approved postgraduate training programmes, including those in GP training and approved less than full time training programmes, and academic and public health doctors in training where they have an NHS contract. The negotiations should be on the basis of the Heads of Terms agreed on 22 July 2013.

2. It is intended that a new contract should come into force from 2015, taking account of the national recruitment timetable for junior doctors and dentists in training and allowing for a negotiating period of 12 months, with a further three months for implementation preparations.

3. The timetable should allow for periodic updates to Health Ministers, including in early February 2014 when there should be evidence of clear progress towards the achievement of the objectives set out in this mandate.

4. Proposals should be underpinned by robust modelling demonstrating that any new contractual arrangements will be revenue neutral. The exception to this is that Ministers in each of the four countries are content to agree that funding for the employer contribution pressure (i.e. the *additional contribution*) arising from moving a proportion of earnings out of banding supplements and into basic pay will be met from outside the juniors’ pay bill.

5. Any new contract must facilitate the provision of high quality care by applying the highest standards of excellence and professionalism to enable juniors and employers to meet their shared responsibilities to patients and must support the wider aims of the NHS.
# Annex D: Heads of Terms annotated table with NHSE comments

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<thead>
<tr>
<th>Heads of Terms text</th>
<th>NHS Employers comments</th>
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<tbody>
<tr>
<td><strong>1. Preamble</strong></td>
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<tr>
<td>1.1 Doctors in training are professionals whose first responsibility, like that of their employers, is the care of patients. A new contract will respect and support this.</td>
<td>NHSE recognised that doctors in training are professionals, as are other staff groups. A point of disagreement during negotiations was on the definition of professionalism. NHSE felt that a professional should carry out their duties using the required knowledge and skills and upholding their ethical and moral obligations. We did not feel that professionalism should automatically be tied to a monetary reward.</td>
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<tr>
<td>1.2. The contract must promote safe care for patients and safety for doctors in training, and be fair for doctors in training, employers and other NHS staff.</td>
<td>NHSEs primary concern in creating new contractual arrangements was to improve patient arrangements. Current contractual arrangements provide a barrier to delivering optimum patient care. We have put forward a comprehensive package of safeguards for doctors in training, as well as a fairer pay system, and arrangements which are the same as all other NHS staff where appropriate. The arrangements are also consistent with what employing organisations told us they would want to see from a new contract, and we believe provide a number of benefits for doctors in training.</td>
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<td>1.3. The contract must be affordable for employers now and in the foreseeable future; this means that any proposals for a new contract must not result in changes to the pay bill compared with keeping the current contracts. Average gross pay across the doctors in training workforce should not change.</td>
<td>NHSE have undertaken robust modelling of a number of scenarios to ensure pay neutrality. For this reason, NHSE were unable to accept scenarios which had open ended or unpredictable costs which could render the contract unaffordable, for example self-authorised overtime. NHSE noted during</td>
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</table>
1.4. It is intended to apply to employers in all four UK nations.

The management side were united throughout negotiations with all four UK nations in agreement.

1.5. This draft heads of terms document has been agreed through discussion between NHS Employers and the BMA. In order to receive a mandate to commence negotiations the document will require approval by Ministers in the four Health Departments and by the BMA.

Health Ministers from the 4 UK Health Departments approved these Heads of Terms and negotiations commenced in October 2013.

<table>
<thead>
<tr>
<th>The contract must:</th>
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<tr>
<td>1.6. Be consistent with all aspects of UK law, including working time regulations and the Equalities Act.</td>
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<tr>
<td>We believe our Terms and Conditions of Service meet this requirement.</td>
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<tr>
<td>1.7. Facilitate high quality NHS patient care through sustainable service provision, delivered by suitably trained doctors and dentists, working in an approved training environment. GP trainees work in an environment where work is split into sessions and this needs to be accommodated in the new contract. They are an integral part of the practice team but are additional, not intrinsic, to the practice workforce. At no point should the effective running of the practice be dependent on the GP trainee’s attendance and they will not be used as a substitute for a locum in the practice.</td>
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<td>Arrangements for GP Specialty Trainees (GPST) were looked at during negotiations and also in a separate GP reference group. There was no intention to change current arrangements where GPSTs are supernumerary.</td>
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<tr>
<td>1.8. Accommodate likely future changes in the training and working practices of doctors in training in the medical and dental professions, and in the location and nature of NHS services. This will include any qualified provider.</td>
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<td>The management side had considered whether this contract will be compatible with the Shape of Training recommendations made by Professor Greenaway’s report, and concluded that it would be. The provisions for private professional work (known as Fees previously) were also discussed during negotiations. NHSE felt these provisions were in need of updating and our new</td>
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</table>
provisions can be found in the Schedule “Private Professional Work”.

| 1.9. Ensure that the pay system remains fit for purpose in the future by basing arrangements on robust modelling. | NHSE has undertaken modelling based on a large data collection exercise covering a 15% representative sample of trusts in England, and 100% of trusts in Scotland, Wales and Northern Ireland. |
| 1.10. Recognise that training and service provision by doctors in training are interrelated and be clear that the work schedule for the post will include service provision, training, periods of formal and organised study (other than study leave), rest breaks and prospective cover where applicable. | The provisions in our Terms and Conditions of Service around the Work Schedule recognise that service, training, and study are interconnected. |

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<tr>
<th>The contract will:</th>
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<tr>
<td>1.11. Promote professionalism and an environment where doctors in training are engaged and valued.</td>
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<td>1.12. Deliver both safe working patterns and safe total hours of work.</td>
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<tr>
<td>1.13. Address the current dissonance between New Deal and EWTD.</td>
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</table>
1.14. Promote transparency around both the expected working patterns and the total hours of doctors in training.

In our proposed system, doctors in training would receive a Work Schedule which would detail their working patterns and hours at the start of their placement. The system includes a review process for situations where working patterns and hours differ from the Work Schedule. There are also clear limits on the total number of hours that can be worked and the patterns these hours can be worked in. See our Schedules on “Working Hours”, “Work Schedules”, and “Work Reviews and Exception Reporting”.

1.15. Reflect reasonable expectations around work-life balance.

Our proposals on working hours mean introducing stricter limits around night shifts, long days, and total hours worked in a single week, than under current contractual arrangements. When doctors in training do have to work at the most unsocial times they will be rewarded for this in a fair way at a higher rate than basic salary.

1.16. Offer fair rewards for work done, without exploitation and offer value for money in the administration of the contract.

Our proposals offer doctors in training the chance to be paid for the work they do, instead of for the broad pay band which they fall in to. We believe this is a fairer pay system for all. Where it is found that a doctor in training is regularly working more hours than detailed in their Work Schedule, the Work Schedule will be amended by the employer to include these additional hours and these will be paid. We believe this new system will be much easier to administer than the previous system, as there is no requirement for routine diary card collection and monitoring exercises.

1.17. Minimise conflict and misinterpretation so as to facilitate good relations between doctors in training and their employers.

Employers and doctors in training have told us that certain aspects of the current system are adversarial. We have removed these elements and have replaced them with fair, simply, and easy to understand processes.
### 2. Scope of talks

**We agree that:**

<table>
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<tr>
<th>2.1 The contract will cover all doctors in approved postgraduate training programmes in the UK, including those in GP training and approved less than full time training programmes, and academic and public health doctors in training where they have an NHS employment contract. It will exclude regular doctors and dentists in the armed forces.</th>
<th>This was agreed and these groups were all considered, although further work will be needed in this area of the contract.</th>
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<tr>
<td>2.2 The contract will cover dental core and higher training posts offering hospital terms and conditions of employment and include those in approved less than full time training programmes, as well as dental public health trainees when employed on hospital terms and conditions. It will exclude those for whom remuneration is specified in the Dental Statement of Financial Entitlement or the Statement of Dental Remuneration and those employed on salaried primary and community dental care service terms and conditions.</td>
<td>As above.</td>
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### 3. Overall design of the contract

**We agree that:**

<table>
<thead>
<tr>
<th>3.1 The contract must be as simple as possible to understand, administer and implement, and be suitable for all specialties and for all four UK administrations.</th>
<th>We believe the proposals put forward are simple to understand, administer, and implement, especially in comparison with current arrangements. The proposals are suitable for all specialties. All four UK administrations have aided the development of these proposals and all agree that these arrangements will be suitable for their respective nations.</th>
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<tr>
<td>3.2 Each of the administrations will apply the contract with agreed necessary adjustments to reflect local circumstances.</td>
<td>For the most part these arrangements will be able to be applied consistently across all four nations. Where there are adjustments for local circumstances, for example differences in statutory public holiday entitlement, these adjustments will be minimal and easy to implement.</td>
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<tr>
<td>3.3 The contract will minimise reference to extra documents in the interest of simplicity, and to ensure that employers and doctors in training are able to maintain the contract in an effective way in the future.</td>
<td>The management side agreed with the principle of minimising reference to extra documents. However, we felt that where standard contractual terms are agreed for all NHS staff, e.g., the NHS redundancy provisions, these should be dealt with by referencing the provisions from the NHS Staff Handbook. Any re-negotiation of these standard terms should be dealt with through the existing negotiation machinery, namely the NHS Staff Council. It is inappropriate for terms common to all NHS staff to be negotiated separately for doctors in training. However, these references are contained within a single page of the draft TCS and there is no intention to refer to any other document.</td>
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<td>3.4 The contract will be designed in line with other NHS employment contracts if the parties agree it is appropriate.</td>
<td>The management side took the view that provisions for doctors in training should be the same as provisions for other staff groups, except where there is valid reason for them to be different. As noted above, for terms which apply equally to all NHS staff, we have reproduced the provisions in the NHS Staff Handbook. Other contractual Schedules in our proposed terms and conditions have been designed where appropriate in line with the Specialty Doctor contract, which was implemented in 2008 and is working well.</td>
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<td>3.5 We will continue to use the existing national negotiating mechanisms to ensure that the contract can be maintained at a UK-wide and national level. This will include provision for maintenance of the contract at a local level through existing local negotiating committee (LNC) structures.</td>
<td>The management side were happy for existing national and local negotiating mechanisms to continue. However, we could not agree to increase the scope of items covered under the Joint Negotiating Committee for Juniors (JNC(J)) or to negotiate all staff issues covered under the remit of the Staff Council to be negotiated at JNC(J).</td>
</tr>
</tbody>
</table>
3.6 The contract will be adaptable to changes in medical and dental policies and practices and future organisational and training structures.

As at point 1.8, the management side had specifically considered Professor Greenaway’s Shape of Training report and its recommendations, in relation to our proposals. We believe that these proposals are sufficiently flexible that they will be “future proof” in relation to the implementation of Shape of Training and other workforce developments such as changes to the Foundation Programme.

### 4. Work planning

**We agree that:**

<table>
<thead>
<tr>
<th>4.1 The contract will support forward planning providing for a more predictable pay bill for employers and more predictable earnings for doctors in training.</th>
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<tr>
<td>By replacing the banding system, pay will be stabilised for doctors in training and for employers. The new system will pay fairly for work done, so there will be no “cliff edges” between bandings, where under the current system slight changes in working patterns can result in huge financial penalties and significant changes in earnings. This will give employers the confidence to plan working patterns that are safe, of benefit to the service, and of benefit to the doctor in terms of training opportunities, which are often missed under the current system.</td>
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<tr>
<th>4.2 Both employers and doctors in training benefit from receiving adequate notice about where doctors in training will be working and what they will be doing.</th>
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<tr>
<td>We agree with this principle. We examined this issue during negotiations and concluded that it is impossible for this to be a contractual requirement at a point where no contractual relationship exists. Furthermore, employers often do not hold this information until very close to the start date. Information flows from the deanery function/LETB to the employer, and this is where there is often a delay. This therefore needs to be addressed outside the contract. As part of a package of measures offered in negotiations, we had agreed to jointly lobby (with the BMA) the Department of Health, to put pressure on Health Education England to speed up the flow of information from the deanery functions.</td>
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<td>4.3 The contract will be useable in a number of employment models, allowing for both lead employer and local employer arrangements.</td>
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<tr>
<td>4.4 The contract should seek to make it easier for employers to offer longer contracts of employment than the present contracts do.</td>
</tr>
<tr>
<td>4.5 This is an employment contract which encompasses training, personal development and service delivery required as part of the job.</td>
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<tr>
<td>4.6 Jobs should come with a work schedule describing how a doctor in training in a job is expected to spend their time and the duties of the post holder, including the available training provision and learning opportunities.</td>
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<tr>
<td>4.7 The work schedule for a post should be based on hours of work, rather than sessions, and should be prospectively designed in partnership between employers and doctors in training.</td>
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<tr>
<td>4.8 The work schedule must be adaptable to allow adjustments in response to changes in numbers of doctors in training, the training curricula, or service needs. Where an adjustment cannot be mutually agreed, doctors in training or employers will be able to seek a ‘Work Review’.</td>
</tr>
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</table>
4.9 Doctors in training and employers will have access to robust Work Reviews where the agreed work schedule no longer matches the duties being undertaken. Where a doctor or doctors in training are consistently exceeding their work schedule hours through unplanned changes to their working hours, a review will be triggered by exception reporting. This will ensure unsafe working patterns are addressed and that the training aspects of the placement remain at an appropriate level.

See above. This requirement had been met through our proposed “Work Review and Exception Reporting” Schedule.

<table>
<thead>
<tr>
<th>4.10 The group will explore the information currently contained within the Code of Practice to determine how much of the information specifically relating to employers and doctors in training could be included in the contract.</th>
<th>See point 4.2 which is related. It was found that the majority of information in the Code of Practice was out of the hands of employers, meaning they could not be contractual bound to provide it. We did propose that the Code of Practice was redrafted with the relevant stakeholders, and that NHSE and the BMA jointly lobby the Department of Health to encourage Health Education England to take action by reducing some of the ‘information blockages’ in the system. It was also noted that doctors in training themselves can cause delays to the provision of information, by not passing on personal details, or by switching placements or not taking them up at all, causing entire rotas to be re-written.</th>
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| 4.11 The amount of, and access to, study leave will be discussed in the negotiations. | Study leave was discussed extensively in negotiations. We believe that the provisions detailed in our Terms and Conditions of Service document under “Leave” are fair and adequate for doctors in training, based on advice from educational experts. |
5. Working hours

<table>
<thead>
<tr>
<th>5.1 The working hours and pattern of working hours for doctors in training need to:</th>
<th>Working hours are explained in detail in our Terms and Conditions document under the “Working Hours” Schedule. These provisions comply with legislation and are safe for patients and for doctors in training, reducing the total number of hours doctors can work and adding in a range of other safeguards. Service delivery and training will be enshrined in the Work Schedule, however training over the seven day week is dependent on consultant trainers being available at the times when doctors in training are working.</th>
</tr>
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<tr>
<td>• comply with relevant legislation</td>
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<tr>
<td>• be safe for patients and for doctors in training</td>
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</tr>
<tr>
<td>• recognize that both service delivery and training will continue to take place throughout the seven day week</td>
<td></td>
</tr>
<tr>
<td>5.2 The contract will provide safeguards against unsafe working hours and patterns.</td>
<td>See various above. Our Schedule “Working Hours” goes in to full detail.</td>
</tr>
<tr>
<td>5.3 There will be a whole time working week of 40 hours. The working hours of a job may be up to 48 hours on average to meet the needs of the service, provided that this is consistent with statute, safety and the demands of the training programme.</td>
<td>Our proposals meet this requirement. NHSE were always clear that a whole time working week would be 40 hours. See our Schedules on “Working Hours” and the “Work Schedule” for more detail on these areas.</td>
</tr>
<tr>
<td>5.4 Negotiations will determine how average working hours are defined and the period over which they are referenced.</td>
<td>This was discussed during negotiations. NHSE, for consistency and ease of administration, suggested that the reference period for health and safety purposes should be the statutory reference period set out in the Working Time regulations. Point 1.13 of these Heads of Terms states the dissonance between New Deal and EWTD should be addressed. The management side did not feel that adding in a new rule which would be different to EWTD, and to all other staff groups, would be consistent with this theme. The period used for averaging working hours for pay purposes was yet to be agreed but NHSE had suggested that this should remain as it is at present, the length of the rota cycle or of the placement as appropriate. This would avoid the hours of every rota having to be reassessed, which would not only be...</td>
</tr>
</tbody>
</table>
### 5.5 We will explore a model based upon a work schedule, hours based contract and exception reporting, aiming to replace the current practice of routine monitoring of working hours. This will require agreement of a robust mechanism for ensuring appropriate payment and / or compensation for additional work over and above that in the work schedule.

- **See points 4.6, 4.7, 4.8, 4.9 and 5.1. Also see our Terms and Conditions Schedules, “Work Schedule” and “Work Reviews and Exception Reporting”.** We believe our arrangements for recompensing doctors in training for extra hours where they are worked are fair and appropriate. We could not agree to a system where doctors in training would be responsible for retrospectively self-authorising payments to themselves.

### 5.6 Where it is possible to opt out of all or part of statutory working hours limits, the employment contract will enable doctors in training who wish to opt out to do so, but they will not be required by employers to opt out.

- **Provisions in our Schedule “Working Hours” mirror arrangements for staff on Agenda for Change Terms and Conditions, i.e. opt out is a voluntary decision.**

### 5.7 We will investigate limiting the number of actual working hours (as defined by statute) in a defined (in days) period.

- **See our Schedule “Working Hours” for full details on our proposed limits on hours and working patterns.**

### 5.8 Where agreed patterns of hours are regularly altered in terms of start or finish times or breaks within shifts, then that working pattern should be reviewed to ensure it is appropriately designed.

- **See our Schedules “Work Schedule” and “Work Reviews and Exception Reporting”.**

### 5.9 The parties will consider agreeing guidance on the rights and obligations of both employers and doctors in training under UK working time regulations.

- **See our Schedule “Working Hours”, which provides contractual rights and obligations in excess of statutory rights and obligations.**

### 6. Pay

**We agree that:**

### 6.1 Cost modelling must demonstrate that proposed new pay arrangements would not (of themselves) change the pay bill compared to a scenario in which the contracts do not change.

- **NHSE and the devolved nations have undertaken robust modelling based on real data from over a thousand rotas. We have demonstrated as far as is possible that our proposals would be cost neutral.**
6.2 For the purpose of cost modelling, that pay bill comprises the following, using staff numbers appropriate for the 2012/13 financial year:

- Total value of current basic pay
- Total value of current additional earnings (including banding payments but excluding non-contractual fees)
- Total value of employer National Insurance contributions as at 31.3.13
- Total value of employer pension contributions as at 31.3.13

Planned changes to National Insurance contributions outside the scope of these negotiations will take place regardless of whether a new contract is negotiated. Modelling (and the counterfactual) will take into account any planned changes to contributions. Additional employer pension contributions arising from any increase to basic pay as a result of a new contract will be funded separately, from outside the doctors in training pay bill.

6.3 Joint analysis and modelling by analysts from the BMA, NHSE and the devolved administrations will be undertaken to explore the range of options available.

6.4 Negotiations will also include assessment of the way in which any changes would interact with the move to a CARE pension scheme.

6.5 There should be a higher than basic rate for OOH work and the negotiations will determine which periods are considered OOH.

NHSE proposed using the latest pay data available when implementing the new contract as this is generally the custom used, and the method that has been used when previously implementing new contracts. The BMA felt strongly that the older pay bill data should be used. This topic was still under discussion at the time the BMA walked away from negotiations.

Detailed analysis and modelling has taken place by analysts from NHSE and the devolved administrations, however engagement from the BMA has been limited.

NHSE have been clear that under our proposals, higher basic pay would directly benefit doctors in training in a move to a CARE pension scheme, as opposed to the current system where a high proportion of doctors’ earnings is made up of non-pensionable supplements.

Our proposals detail a higher rate for OOH work. Negotiations failed to determine which periods should be considered OOH, however we believe our proposals are fair and will facilitate seven day care.
6.6 We will agree rules within the new contract for pay progression. The negotiating teams failed to reach agreement on rules for pay progression. The BMA had great difficulty in proposing rules which met the Government requirement that pay in the public sector should not be based on time served. In some cases, the BMA even sought pay progression for time not served, for example time out of training. Our proposals offer a rate for the job which the doctor in training is doing, with higher rates linked to an increase in duties and responsibility. We believe this is a fair system.

7. Other

Fixed leave

We agree that:

<table>
<thead>
<tr>
<th>7.1 We recognise that the use of fixed leave is a concern for doctors in training. We will explore the reasons why fixed leave arrangements are currently used, the consequences for doctors in training and for employers and how the position could be improved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The management side recognised the concerns of doctors in training and explored the reasons why fixed leave is used. It was found that employers would be unwilling to place an absolute prohibition on fixed leave, because in certain circumstances this was considered necessary, such as on some smaller rotas where hours were tightly restricted for safety. In those situations fixed leave ensured that everyone was guaranteed their full leave allocation and that a safe level of cover could be maintained, in situations where leave might otherwise “pile up” and doctors would end up being refused leave if several of them requested it at the same time. The management side did propose issuing guidance stating the use of fixed leave should be minimal, however it was presumed that this was not a BMA priority as since they first raised the issue in October/November 2013, it was never raised again, despite leave being on the agenda twelve times.</td>
</tr>
</tbody>
</table>
### Facilities

**We agree that:**

<table>
<thead>
<tr>
<th>7.2 We will review the existing contractual arrangements for facilities bearing in mind changes in working practices and the importance of safety.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities were discussed during negotiations but agreement could not be reached on what could be included around facilities in a contractual document. NHSE had proposed guidance documentation around the issue could be produced.</td>
</tr>
</tbody>
</table>

### Salary packaging

**We agree that:**

<table>
<thead>
<tr>
<th>7.3 We will consider whether the contract could make it easier to have the legitimate professional costs of doctors in training recognised.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The BMA raised this issue once during negotiations but did not put forward any clear proposals on how the issue could be resolved. The management side concluded that this was probably an issue for HMRC, and for the Royal Colleges that are collecting the fees from doctors in training.</td>
</tr>
</tbody>
</table>
Annex E

Doctor or Dentist in an Approved Training Post

CONTRACT OF EMPLOYMENT

BETWEEN:

[Insert name of employing organisation] and

[Insert name and address of employee]

Notes for Employers

This contract is for use only for doctors and dentists in training where the post is accredited for training by the General Medical Council (GMC) and the post holder is registered as having been accepted as a trainee under the auspices of the Postgraduate Dean.

The contract may be adapted as indicated below for full time, less than full time appointments and locum appointments for training (LAT) and fixed term training appointments (FTTA). It may not be used for service posts either temporary or permanent.

References to ‘schedules’ are references to the associated Terms and Conditions of Service for NHS Doctors and Dentists in Training 20[16].

The obligations of the employer and employee under this contract should be read in conjunction with the training agreement between the doctor and the local representatives of Health Education England (HEE). The employer will have an agreement with HEE to provide training to a standard acceptable to the GMC.
1. **Doctor in Approved Training**

1.1. Your job title is \[ ^{iii} \] in \[ insert specialty \]v.

1.2. The appointment is subject to the national Terms and Conditions of Service for doctors and dentists in training (“the TCS”) which may be amended by collective negotiation from time to time.40

1.3. Your employment under this contract is dependent on you continuing to be registered on the recognised training programme of which this placement forms a part. Removal or resignation from the training programme would automatically give rise to termination of this contract of employment.

2. **Commencement of Employment**

2.1. Employment under this contract [begins/began\[^{iv}\] on \[ vi \] and ends on \[ vii \]

2.2. Your continuous employment with this employing organisation, for the purposes of the Employment Rights Act 1996, [begins/began] \[^{viii}\] on \[ vii \].

2.3. For the purposes of certain NHS conditions of service, previous service within the NHS, whether with this Trust or another NHS employer, although not continuous for the purposes of the Employment Rights Act 1996 will count as reckonable, so that for some purposes other dates prior to the dates in 2.1 and 2.2 above may count.

2.4. Full time working under this contract is 40 hours per week on average. Up to eight additional hours of work on average per week may be required by your work schedule, see para [7].

3. **General Mutual Obligations**

3.1. While it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a professional employee. It is essential that you and your employing organisation work in a spirit of mutual trust and confidence. Your employment in a training post requires you to actively progress in your training and your employer to provide an appropriate training environment. You and we agree to the following mutual obligations in order to achieve the best for patients and to ensure the efficient running of the service:

3.1.1. to co-operate with each other and maintain goodwill;

3.1.2. to carry out our respective obligations in operating a work schedule;

3.1.3. to carry out our respective obligations in accordance with educational and appraisal requirements; and

3.1.4. to carry out our respective obligations relating to the organisation’s policies, objectives, rules, working practices and protocols.

---

40 A copy of the TCS may be found at www.nhsemployers.org
THE WORK

4. Location

4.1. Your principal place of work is [ ]. Other work locations including off site working may be incorporated in your work schedule where appropriate. You will generally be expected to undertake your duties at the principal place of work or other locations agreed in the work schedule. Exceptions will include travelling between work sites and attending official meetings away from the workplace.

4.2. You may be required to work at any site on your rotation, including new sites. Provisions for excess travel or relocation may be agreed as appropriate and are set out in the TCS schedule [11].

Note for employers: this para is more relevant to lead employers who may use one contract for the whole rotation. Employers for individual sections of a rotation where there is no lead employer will issue separate contracts at each stage

5. Duties

5.1. Except in emergencies or where otherwise agreed with your manager, you are responsible for fulfilling the duties and responsibilities and undertaking the activities set out in your work schedule, as reviewed from time to time in line with the provisions in clause [6.1] below.

5.2. You are responsible for the general duties set out in Schedule 1 of the TCS.

6. Emergency Responses

6.1. We may in exceptional circumstances ask you to return to site or remain at work for emergencies outside of the expectations in your work schedule, if we are able to contact you. You are not however, required to be available for such eventualities.

7. Work scheduling

7.1. The purpose of your work schedule is to set out in clear and transparent terms what you and your clinical manager have agreed should reasonably be covered in the training placement. The plan is not contractually binding in itself, but you have a duty to make all reasonable efforts to follow it. It should be read alongside your educational objectives for the post.

7.2. The process for discussion and review of work schedules are set out in Schedules 4 and 5 of the TCS.

7.3. Scheduling of Activities

7.3.1. The work schedule will set out the hours and activities that are necessary to fulfill your duties and responsibilities under this contract, and include the times and locations at which these activities are scheduled to take place.
7.3.2. Your Work schedule will contain \[x\] hours per week on average, [inclusive of emergency work arising from on-call rotas] [Note- Delete if on-call is not applicable to this post]

7.3.3. Any variations in your scheduled weekly commitments should be averaged out over twenty-six weeks, so that your average commitment is consistent with the provisions of the Working Time Regulations as amended from time to time.

7.3.4. Additional hours (up to the maximum permitted by the Working Time Regulations) may be contracted for separately from time to time. The rates for basic pay are set out in the latest Pay and Conditions Circular. [Note: Delete this para if number of hours in para 7.3.2 is 48]

7.4. Where you have External Duties (eg BMA activity) included in your Work schedule you will provide 6 weeks written notice of the dates upon which the External Duties will be carried out. Shorter notice periods may be agreed by local arrangement or by agreement between you and your clinical manager.

7.5. Where emergency work takes place at regular and predictable times, your clinical manager will seek to schedule it as part of work schedule. You may, be required to participate in an on-call rota to respond to unpredictable emergencies.

8. Spare Professional Capacity

8.1. While in training we do not normally expect you to undertake professional services other than such work carried out under the terms of this contract, whether for the NHS, for the independent sector or for another party. See schedule 3 on working hours and schedule 6 on private professional work.

9. Out of Hours

9.1. The provisions in Schedule 2 of the TCS will apply to recognise the unsocial nature of work done out of hours.

10. On-Call Rotas

10.1. Where you are on an on-call rota, the provisions in Schedule 2 of the TCS will apply.

10.2. Your on-call duties will be set out in your work schedule and the published rota or in accordance with any alternative arrangements that you agree with your colleagues for providing on-call cover.

PAYMENTS
11. PAY

11.1. Your basic salary on commencement at \( \xi \) is \( \mathbf{\xi} \) per annum. Your salary will be payable monthly.

11.2. If you are working less than full time your salary will be adjusted pro rata to the contracted hours of work.

11.3. Progression to the next pay point will be dependent on moving to a role at the next level of training (see definitions).

*Note for employers, this will only be relevant if a contract spans more than one level of training.*

11.4. If part of the work in your schedule is defined as ‘out of hours’, that part will be paid as set out in schedule [2]

11.5. If you are on a rota requiring you to be on call while away from the workplace (an on-call rota), you will receive an on-call availability supplement calculated in accordance with schedule 2 of the TCS. Payment will cease when you cease to be on an on call rota.

11.6. The frequency of your on call availability will be detailed in your work schedule.


12. Deductions from Pay

12.1. We will not make deductions from or variations to your salary other than those permitted by law without your express written consent.

13. Pension

13.1. You will automatically be enrolled as a member of a NHS Pension Scheme subject to its terms and rules, which may be amended from time to time.

13.2. Up to 40 hours of work per week are pensionable in the NHS Pension scheme.

13.3. Pensionable pay will include basic salary and London weighting.

13.4. You are contracted out of the State Second Pension Scheme. *[Note for employers, not for use after 1 April 2016]*

14. Expenses

14.1. You may be entitled to be paid expenses, which should be submitted in a timely manner (normally within one month), for travel, subsistence and other expenses. Expenses will be as set out in the model provisions in Schedule [11] of the TCS
OTHER CONDITIONS OF EMPLOYMENT

15. Leave and holidays

15.1. You will be entitled to [xiii] annual leave with full pay each year. Full details of annual leave and public holidays, professional and study leave, sick leave, special leave, maternity, paternity, parental, carer’s and adoption leave as set out in Schedules [8 and 10] of the TCS.

16. Registration Requirements

16.1. It is a condition of your employment that you are, and remain, [a registered dental practitioner] [a fully/provisionally][xiv] registered medical practitioner] [Note: employing organisations to delete as appropriate] and continue to hold a license to practise.

16.2. The requirements for revalidation of your licence are set by the General Medical Council.

17. Policies and Procedures

17.1. You are required to comply with the Policies and Procedures of the NHS organisation that you are working in as may from time to time be in force. Among others, these will include:

17.1.1. Clinical governance requirements

17.1.2. Confidentiality and raising concerns see also schedule [7]

17.1.3. Policy on Gifts and Gratuities

17.1.4. Grievance Procedures The grievance procedures, which apply to your employment, are set out in [xv].

18. Disciplinary Matters

18.1. Wherever possible, any issues relating to conduct, competence and behavior should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behavior may be in breach of our code of conduct, or that your professional competence has been called into question, the matter will be resolved through our disciplinary or capability procedures and will be subject to the appeal arrangements set out in those procedures, which will be consistent with the ‘Maintaining High Professional Standards in the Modern NHS’ framework and Schedule [9] on termination of employment.
19. Intellectual Property


20. Termination of employment

20.1. Provisions governing termination of employment are set out in Schedule 9 of the TCS.

21. Entire terms

21.1. This contract and the TCS and any local agreements contain the entire terms and conditions of your employment with us, such that all previous agreements, practices and understandings between us (if any) are superseded and of no effect. Where any external term is incorporated by reference such incorporation is only to the extent so stated and not further or otherwise.
AGREEMENT

I [insert name]*

and

[insert employer]*

have understood and agree to honour the terms and conditions set out in this contract of employment

[ ] Doctor’s signature

[ ] Representative of employing organisation’s signature

Date of this agreement [ ]*

Notes:

You are normally covered by the NHS Hospital and Community Health Service indemnity against claims of medical negligence. However, in certain circumstances you may not be covered by the indemnity. We therefore advise you to maintain membership of a medical defence organisation. Details of the NHS indemnity scheme may be obtained from the Human Resources department upon request.

Updates on salary values are published in the NHS Employers website www.nhsemployers.org
Data required for mail merge

i Name of employing organisation
ii Name and address of employee
iii Job title
iv Specialty
v Delete as appropriate
vi Insert date (actual start date under this contract)
vii Insert end date
viii Insert date [ERA date]
ix Insert location [base or main location for this contract] this should be the base for the contract and may not be the first post. May be complicated if not a lead employer and there are a series of linked contracts
x Insert average weekly hours
xi Insert training level
xii Insert value of pay point
xiii Insert no of days annual leave
xiv delete as appropriate
xv Insert location of local grievance process.
Terms and Conditions of Service for NHS Doctors and Dentists in Training 2016 [Draft]

Version 1
Contents

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Schedule 1 - General Duties and Responsibilities
Schedule 2 - Arrangements for Pay
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Schedule 10 - Expenses
Schedule 11 - Sections of the NHS Terms and Conditions of Service Handbook applicable to Doctors and Dentists in training
Schedule 12 - Transitional Arrangements (temporary schedule)
Definitions

[To be added]
Schedule 1 – General Duties and Responsibilities

1. Whilst on duty a doctor has clinical and professional responsibility for their patients or, for doctors in public health medicine, for a population. It is also the duty of a doctor to:
   • keep patients (and/or their carers if appropriate) informed about their condition;
   • involve patients (and/or their carers if appropriate) in decision making about their treatment;
   • maintain professional standards and obligations as set out from time to time by the General Medical Council (GMC) and the General Dental Council (GDC), as appropriate;
   • comply in particular with the GMC’s guidance on ‘Good Medical Practice’ and ‘The Trainee Doctor’, as amended or substituted from time to time.

2. A doctor is responsible for carrying out any work related to and reasonably incidental to the duties set out in their work schedule such as:
   • the keeping of records and the provision of reports;
   • the proper delegation of tasks;
   • acquiring and maintaining skills and knowledge.

3. Doctors will be expected to be flexible and to cooperate with reasonable requests to cover for their colleagues’ absences where they are safe and competent and where it is practicable to do so. Where doctors undertake duties in accordance with this paragraph and such duties take place outside of their contracted hours they will receive either an equivalent off duty period or remuneration.

4. Other than under the circumstances in paragraph 3 above, where a doctor is asked to work outside their agreed work schedule they may choose whether or not to do so.
Schedule 2 - Arrangements for Pay

Pay and other Allowances

1. Doctors shall be paid at the rates set out in Annex A.

2. The value of basic salary for Less Than Full Time doctors will be pro rata to the levels in Appendix 1, based on the proportion of full time work that has been agreed.

Additional hours

3. Additional hours will be remunerated at the standard rate, 1/40th of whole time equivalent.

Out of Hours Work

4. A premium supplement of [x] of basic rate will be paid on any hours worked between [y].

5. The number of hours for which a premium supplement is paid will be assessed as an average when drawing up the work schedule.

Counting of hours

6. Average total hours, and average hours which attract a premium supplement, may be assessed in part hours of not less than 15 minutes.

On-Call Duties

7. Doctors who are required to be on an on-call rota (i.e. where they are available to return to work but not expected to attend on site for the whole period) will be paid an on-call availability supplement. This shall be calculated as a percentage of full-time Basic Salary (excluding any additional hours above 40, recruitment and retention premium, out of hours premium, or any other fees, allowances or supplements). The supplement payable will depend on the frequency of on-call duties. The percentage rates are set out in Table 1 below.

<table>
<thead>
<tr>
<th>On-Call Availability Supplement Frequency [ILLUSTRATIVE ONLY]</th>
<th>Percentage of Basic Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>more frequent than or equal to 1 in 6</td>
<td>TBC</td>
</tr>
<tr>
<td>less frequent than 1 in 6 but more frequent than or equal to 1 in 10</td>
<td>TBC</td>
</tr>
<tr>
<td>less frequent than 1 in 10</td>
<td>TBC</td>
</tr>
</tbody>
</table>
8. If a doctor participates in an on-call rota then the frequency of this will be set out in their work schedule.

9. This supplement will not be payable where a doctor is working only shifts and/or standard working days.

Changes to pay

10. Where pay is increased as a result of agreed changes to the work schedule, pay should be altered from the date that the agreed change comes into effect.

11. Where total pay would be decreased as a result of agreed changes to the work schedule, the doctor’s total pay will be protected on a mark time basis until the end of that particular placement. Protection will not extend to any subsequent placement, even where this takes place within the same department.

London Weighting

12. London weighting will be paid at the rates set out in Annex A. This will be applicable to all doctors whose principal place of work is within the boundary of the M25 London Orbital Motorway.

Recruitment and retention premia

13. A recruitment and retention supplement may be payable as determined by Health Education England.41

14. This is a supplement to basic salary, and is not included in salary for the purpose of calculating any other allowances or supplements.

15. Where a recruitment or retention premium is applicable, this should be paid to less than full time trainees pro rata to their proportion of full time.

Pension Arrangements

16. The doctor will be eligible for membership of a NHS Pension Scheme, the provisions of which are set out in the NHS Pension Scheme Regulations 2015 (as amended).

17. The following will be pensionable in the NHS Pension Scheme:
   - all hours worked up to 40 hours per week on average;
   - any London weighting supplement.

41 This is for England – devolved administrations’ versions of TCS will set out which body is responsible for setting RRP in that administration.
18. The following will not be pensionable in the NHS Pension Scheme:

- any on-call availability supplement;
- any premium supplement for out of hours work;
- any recruitment and retention premium;
- travelling, subsistence, and other expenses paid as a consequence of the doctor’s work for the employing organisation or the wider NHS;
- any payments for hours above 40 per week.
Annex A: Rates of pay

[To be agreed]
Schedule 3 – Working Hours

Principles

1. Doctors and dentists in training should not, during the course of their normal, scheduled work, breach the statutory limits set out by the Working Time Regulations, as amended from time to time by changes in legislation or subsequent case law. In addition to the Working Time Regulations, the following limits apply.

2. No more than 72 hours actual work should be undertaken, in any working pattern, in any period of 7 consecutive calendar days.

Limits when working shifts

3. No shift should exceed 13 hours.

4. No more than 5 scheduled long shifts (where a long shift is defined as being a shift scheduled to last longer than 10 hours) can be worked consecutively.

5. No more than 4 consecutive night shifts of any length can be worked. A night shift is defined as any shift where a minimum of three hours of work falls into the period between 11 pm and 6 am.

6. Both employers and doctors should give due regard for the need for appropriate rest before and after night shifts when agreeing rota patterns.

7. Breaks during shifts are as defined in the Working Time Regulations, as amended from time to time by changes in legislation or subsequent case law.

Limits when working on-call

8. On-call working patterns should have an agreed average amount of time noted in the work schedule for work carried out, on average, during an on-call period. The balance of the on call period will be defined as non-working time, unless the period is residential, in which case all hours will be counted as work for the purposes of the Working Time Regulations, although not for the
purposes of paragraphs 9-12 below, for which only the hours of work noted in the work schedule will be taken into account.

9. No doctor should be on duty for more than seven consecutive on-call periods.

10. Doctors whose overnight rest is significantly disrupted, causing a breach in the rest requirements of the Working Time Regulations, must inform their employer as soon as practicable, and arrangements must be made for them to take appropriate compensatory rest to avoid fatigue.

**Opting out of the Working Time Regulations average weekly working hours**

11. Individuals may choose to agree to work more than the 48 hours average weekly limit if they agree with their employer in writing. A decision to exercise this option is an individual, voluntary one and no pressure should be placed on an employee to take this option. Such an individual agreement may either relate to a specified period or apply indefinitely. To end any agreement, a worker must give written notice to his/her employer. This can take the form of a previously specified notice period of up to three months written in any agreement or, if no notice period is specified, only seven days’ notice would be required. Records of such agreements must be kept and be made available to locally recognised unions.

12. Where a doctor or dentist in training has opted out of the Working Time Regulations average weekly working hours, overall hours should be restricted to a maximum average of 56 hours per week.

13. Doctors opting out of the hours requirements of the Working Time Regulations are still bound by the rest requirements, and by the contractual limits specified in paragraphs 2-12 above.
Schedule 4 – Work Scheduling

Principles

1. Work scheduling for doctors in training allows employers to plan and deliver clinical services whilst delivering appropriate training to doctors in training.

2. Educational planning and work scheduling are interdependent, reflecting the interdependence of training and service commitments of doctors in training.

3. Work scheduling also ensures that doctors in training are provided with a description of the work and the range of duties they will undertake prior to starting the placement.

4. Work scheduling is based on a partnership between the employer and the doctor in training. The employer will be responsible for ensuring that a “template” work schedule is prepared for the post which takes into account (i) the expected service commitments and (ii) those parts of the relevant training curriculum which can be achieved in the post. This latter element must be consistent with the post’s “Application for Approval of a Training Post” which will have been agreed with the relevant Deanery function. The doctor in training and employer are jointly responsible for personalising the work schedule, taking into account the doctor in training’s individual training experience, competencies and needs at the time they are in the post (placement).

5. A work schedule will apply for the duration of a training post (placement) and will list all the scheduled duties of the doctor in training, the intended learning outcomes, and the number of hours for which the doctor in training is contracted.

6. A work schedule will include service provision, training (with objectives mapped to the educational curriculum) and periods of formal and organised study (other than study leave).

7. Discussion of the personalised work schedule should be included in the doctor in training’s regular educational review (with the educational supervisor\(^{42}\)) to ensure that their workplace experience delivers the anticipated learning opportunities.

\(^{42}\) Recognised Educational Supervisor (or approved Clinical Supervisor in General Practice)
8. The doctor in training may ask for a review of their work schedule if they find that the reality of their post is not consistent with the agreed personalised schedule.

**Template Work Schedule**

9. A post’s (or placement’s) “template” work schedule will include a description of the hours to be worked, including any shift or on-call working, in a given post (placement), and will set out in general terms when and where the doctor in training’s duties and responsibilities will be delivered.

10. The duties and responsibilities set out in a template work schedule will include, as appropriate:

   a. Clinical care and service duties
   b. Specific training
   c. Professional duties for other organisations (required by the employer)

11. Where the post (or placement) requires a doctor in training to participate in a service commitment to unscheduled, urgent or emergency care, the template work schedule will set out the expected requirements of the doctor in training to contribute to a duty roster for the service’s safe provision. The template work schedule may therefore include duties throughout the 24 hour day and the seven day week, including statutory holidays.

12. A standard full-time template work schedule will be for a minimum of 40 and a maximum of 48 hours per week, averaged over the agreed reference period.

**Personalised Work Schedule**

13. The template Work Schedule will form the basis for a personalised Work Schedule which will be agreed between the educational supervisor and the individual doctor in training, taking into account:

   a. the doctor in training’s personal objectives (typically described in a personal development plan (PDP)), and
   b. the facilities and resources available in the post (as described in the “Application for Approval of a Training Post”), and
   c. any specific training needs which require attention as determined by the doctor-in-training’s ARCP and/or TPD, and
   d. the objectives of the employer.
14. Every effort will be made to achieve an agreed personalised work schedule which aligns the objectives of the trainee and those of the employer.

15. The employer may propose changes in a personalised work schedule during the post/placement if there are significant changes in the facilities and resources (or services themselves). Every effort should be made to anticipate such changes in the template work schedule and reach an agreed change.

**Work Schedule objectives**

16. The template work schedule will describe the training opportunities that have been identified in the post and the service commitments of the post-holder.

17. The personalised work schedule should add personal objectives in:

   a. training (consistent with the education/training contract between the Deanery function and the doctor in training, and typically described in an agreed PDP) and
   b. service delivery, both to align the doctor in training’s service commitments to the service’s (employer’s) objectives and to recognise that competencies can be achieved through service delivery.

18. The training objectives will set out a mutual understanding of the training requirements of the doctor in training over the period of the work schedule, and of how, in working to achieve these objectives, the doctor in training will contribute to the objectives of the employer.

19. A doctor in training’s individual work schedule objectives will depend in part on their specialty and the level of competencies they have achieved, but they may include training and service delivery objectives relating to some or all of the following (many of which will also feature in their training-based PDP):

   a. Safety
   b. Outcomes
   c. Clinical standards
   d. Management of resources, including efficient use of NHS resources in the provision of clinical services
   e. Local service objectives
   f. Service development
g. Multi-disciplinary team working  
h. Continuing professional development  
i. Completing postgraduate medical and dental examinations required by the curriculum  
j. Appropriate training courses

20. A doctor in training will make all reasonable efforts to achieve their agreed objectives.

21. Employers will make all reasonable efforts to provide the facilities, resources and support identified as necessary for the doctor in training to achieve their objectives and to deliver the service and undertake training commitments in the agreed personalised work schedule.

22. Where there are factors or circumstances outside the doctor in training's control which impact on achievement of objectives (training or service or both), these should be considered and documented at the educational and work schedule review(s) with their Educational Supervisor.

23. The work schedule may refer to employer policies, procedures or protocols with which the doctor in training is expected to comply.

Review of the Work Schedule

24. The doctor in training and their educational supervisor will review the personalised work schedule during the course of regular educational reviews.

25. The principal purpose of the educational review is to monitor progress against the doctor in training's agreed objectives regarding the curriculum. The principal purpose of the work schedule review is to establish whether any changes in support or resources, or in planned service duties, are needed to enable the doctor in training to achieve their objectives (both educational and service) within rostered working hours.

26. The reviews will seek to identify current or potential organisational or systems barriers that would prevent the doctor in training from carrying out the work schedule commitments. The review may consider ways of improving management of the doctor in training's workload, and changes to the doctor in training's duties, responsibilities or working hours.
27. The educational and work schedule reviews are thus interdependent, reflecting the interdependence of service and training commitments. The reviews will consider the doctor in training’s accumulated experience and competencies and whether these require an agreed resetting of the balance between the doctor in training’s commitments to their training and to the service in which they are training.

28. As a minimum, there should be educational and work schedule reviews at the start and finish of the post (placement).

29. At the first review the personalised work schedule should be agreed, as should a timetable for any further reviews.

30. Each review should consider whether changes should be made to the template work schedule. Following the review, the educational supervisor will document the outcome.

31. Ad hoc reviews should be undertaken if either the employer or the doctor in training believes that the training opportunities, duties, responsibilities, accountability arrangements or objectives have changed significantly, or need to change significantly, or that the agreed objectives may not be achieved for reasons outside the doctor in training’s control.

**Resolving disagreements over the Work Schedule**

32. The educational supervisor will make every effort to agree with the doctor in training any proposed changes to the work schedule at scheduled or ad hoc review (i.e. at local level) held within a reasonable time. If it is not possible to reach agreement (or to do so within a reasonable time) the doctor in training may invoke the provisions of Schedule 5.

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43 The timeframe for resolution should take into account the remaining duration of the post (or placement).
Schedule 5 – Work Reviews and Exception Reporting

The Work Review

Purpose

1. The purpose of a Work Review will be to ensure that a work schedule for a doctor, or a group of doctors in training, remains fit-for-purpose.

Process

2. The Work Review should be conducted promptly and be fairly light-touch, short and informal in most cases, unless greater depth of review is required. A work review would routinely take place at each educational meeting (as a minimum, at the start and end of each post) but may also take place at any time during the placement, at the request of either party.

Stage 1 Work Review – informal discussion

3. If not part of the routine review, the educational supervisor and doctor(s) in training will meet, or correspond as soon as is practicable and ideally no later than 7 days after a request for a review is made. This discussion will normally lead to one of the following three outcomes:

   a. An agreement that no change to the Work Schedule is required, no further review action required
   b. A documented and agreed change to the Work Schedule, no further review action required. Any changes agreed are prospective, and not retrospective in nature.
   c. No agreement reached, proceed to Stage 2 Work Review

Stage 2 Work Review – formal meeting

4. When required, a second stage review shall take place as soon as is practicable and no later than 14 days after the stage 1 review. This review will be a formal meeting between the educational supervisor, the doctor(s) in training, the service lead and a nominee of the director of postgraduate medical education. The meeting will lead to one of the following outcomes:
a. An agreement that no change to the work schedule is required, no further review action required
b. A documented and agreed change to the work schedule, no further review action required. Any changes agreed are prospective, and not retrospective in nature.
c. No agreement reached, either party may appeal to the stage 3 review under the employer’s local grievance policy.

Stage 3 Work Review - final stage of the employer’s local grievance procedure

5. The final stage for a Work Review will be the final stage of the employer’s local grievance procedure, with the proviso that the director of postgraduate medical education must be present to act in an advisory capacity to the panel. This meeting will take place as soon as is practicable after the Stage 2 meeting and in any case within the timeframe specified in the local grievance policy.

6. At this review the panel will consider the proposed change to the work schedule and determine whether or not a change to the work schedule is required. Any changes agreed are prospective, and not retrospective in nature. The decision of the panel will be final in regard to the proposed change.

Exception Reporting

Purpose

7. Exception reporting will be the mechanism used by a doctor in training to inform the employer when their day-to-day work is varying significantly from the agreed work schedule. Primarily these instances will either be a difference in:

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

Exception reports will offer employers the opportunity to assess issues as they arise and to make timely adjustments to work schedules through the use of work schedule reviews.

Process

8. Exception reports should include:
- The dates and times of exceptions
- The nature of the variance from the work schedule
- The name, grade, and specialty of the doctor in training involved

Exception reports should be sent to the educational supervisor for consideration at the next educational meeting.
Schedule 6 – Private Professional Work

Provisions Governing the Relationship between NHS Work and Private Professional Work

1. The doctor or dentist in training is responsible for ensuring that any provision of private professional work by them does not result in detriment to NHS patients or services.

Disclosure of Information about Private Commitments

2. The doctor or dentist in training should inform their educational/clinical supervisor of any regular commitments in respect of private professional work. This information should be disclosed as part of the initial work schedule review and include details of the work involved. The doctor should also provide information in advance about any significant changes to this information.

Scheduling of Work

3. NHS or other contractual commitments must take precedence over the provision of private professional work, except where a doctor or dentist in training is asked at short notice to undertake NHS work beyond their agreed work schedule and this would prevent them from meeting pre-existing private professional commitments.

Use of NHS Facilities

4. Doctors and dentists in training must obtain the employing organisation’s prior agreement to use NHS facilities or NHS Staff for the provision of private professional work.

5. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities, if any, a doctor or dentist in training is permitted to use for private purposes and to what extent.

6. If doctors or dentists in training, with the employing organisation’s permission, undertake private professional work in any of the employing organisation’s
facilities, they should observe the relevant provisions in the ‘Code of Conduct for Private Practice’\textsuperscript{44}.

7. The doctor or dentist in training will also comply with the employing organisation’s policies and procedures for private practice.

Patient Enquiries about Private Treatment

8. Where, in the course of their duties, a doctor or dentist in training is approached by a patient and asked about the provision of private professional work, the doctor or dentist in training may provide only such standard advice as has been agreed with the employing organisation for such circumstances.

Fee Paying Services

9. Fee Paying Services are services that are not part of a doctor or dentist in training’s Contractual and Consequential Duties and are not reasonably incidental to them.

10. If a fee is paid directly to the doctor for work done during time when they are being paid by their NHS employer, the doctor or dentist in training must remit the fee to the employing organisation.

11. A doctor or dentist in training can receive payment for fee paying work, additional to the payment for their NHS employment.

12. Fee paying work must be carried out in periods for which the doctor or dentist in training is not being paid by the NHS employer i.e. the doctor’s own time, or during unpaid leave. A doctor or dentist in training cannot be paid twice for the same time.

13. The doctor or dentist in training is responsible for managing the tax and insurance liabilities of any private work they undertake.

14. When undertaking any such work the doctor or dentist in training must make clear their trainee status.

\textsuperscript{44} \url{http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/DH_085195.pdf}

THE NHS EMPLOYERS ORGANISATION’S SUBMISSION TO THE DOCTORS’ AND DENTISTS’ REVIEW BODY
Reform of national contracts for consultant doctors and for doctors and dentists in training
Schedule 7 – Other Conditions of Employment

Outside Employment and Financial Interests

1. A doctor or dentist in training must declare:

   a. any financial interest or financial relationship with an external organisation they may have which may conflict with the policies, business activity and decisions of the employing organisation; and/or

   b. any financial or pecuniary advantage they may gain whether directly or indirectly as a result of a privileged position within the employing organisation.

Research

2. Doctors and dentists in training must comply with all reporting requirements, systems and duties of action put in place by the employing organisation and appropriate external bodies to deliver research governance.

Confidentiality

3. A doctor or dentist in training has an overriding professional obligation to maintain patient confidentiality as described by guidance from the GMC or GDC, subject to relevant legal exceptions. In addition, they must not disclose without permission any information of a confidential nature concerning other employees, contractors or the confidential business of the employer.

Publications

4. A practitioner shall be free, without prior consent of the employing authority, to publish material and to deliver lectures or speak, whether on matters arising out of their NHS service or not, provided that such communications are in good faith and without malice, and take place in the doctor or dentist’s own time. Where payment is received, the practitioner should ensure they comply with the requirements of Schedule 6 - Private Professional Work. This freedom is subject to the requirements regarding information of a confidential nature laid out in paragraph 3 above, and the requirements regarding research set out in paragraph 2 above. The practitioner should make themselves aware of the employing organisation’s local policy regarding intellectual property.
Raising Concerns

5. Should a doctor have cause for genuine concern about an issue (including one that would normally be subject to the requirements regarding information of a confidential nature laid out in paragraph 3 above) they have professional obligations to raise that concern.

6. If a doctor believes that a disclosure about malpractice, patient safety, financial impropriety or any other serious risk (including one that would normally be subject to paragraph 3) would be in the public interest, they have a right to speak out and be afforded statutory protection as required under the Public Interest Disclosure Act 1998 (PIDA). As far as practicable, local procedures for disclosure of information in the public interest should be followed.
Schedule 8 – Leave

Annual Leave

1. The leave entitlement for doctors and dentists in training is as follows, based on a standard working week of five days:

   On first appointment to the NHS: 25 days
   After 5 years’ service: 30 days

   Arrangements for trainees working non-standard weeks should be calculated in hours.

2. The leave year runs from the starting date of the doctor’s appointment and will be prorated to the length of the contract if it is for less than 12 months.

3. Doctors and dentists in training working less than full time will be allocated leave on a pro rata basis.

4. Trainees shall normally provide 6 weeks’ notice of annual leave to be approved in accordance with local policies and procedures. In the case of doctors or dentists contracted by a lead employer, the decision to approve leave requests rests with the host organisation. Use of leave allowances should also be notified to the lead employer according to local policy.

5. Doctors and dentists must make every effort to take their annual leave. In cases where exceptional circumstances or service demands have prevented the doctor or dentist from taking their full leave allowance, up to five days of leave may be carried forward to the next post with the same host employer with the agreement of the employer, in line with local policy. In exceptional circumstances, with agreement of the employer and in line with local policy, payment in lieu can be made for up to five days annual leave which could not be taken before a move to a new host employer. Leave required by the Working Time Regulations must be taken in each leave year.

6. The annual salaries of full-time employees who are paid monthly shall be apportioned as set out in Table 1.
Table 1

<table>
<thead>
<tr>
<th>For each calendar month</th>
<th>one twelfth of the annual salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each odd day (including Sundays and Saturdays, in the case of a working week of five days)</td>
<td>the monthly sum divided by the number of days in the particular month</td>
</tr>
</tbody>
</table>

**Full-time employees leaving one NHS employer to join another**

7. Where full-time salaried employees terminate their employment immediately before a weekend and/or a public holiday and take up a new salaried post with another NHS employer immediately after that weekend and/or that public holiday, payment for the intervening day or days, i.e. the Saturday (in the case of a five day working week) and/or the Sunday and/or the public holiday, shall be made by the first employer.

**Public Holidays**

8. The annual leave entitlement for doctors and dentists in full time training is additional to:
   a. Public holidays recognised by the NHS, and
   b. Two extra-statutory days, or
   c. Days in lieu of a) and/or b) above

Less than full time trainees will be entitled to public holidays and extra-statutory days on a pro rata basis.

9. In addition to the provisions of paragraph 8, a doctor or dentist who in the course of their duty was required to be present in hospital or other place of work at any time on a public holiday, including a shift from a previous day that runs into the bank holiday, should receive a full day off in lieu.

   The same arrangement for time off in lieu should apply to an employee who is listed on an on-call rota at any time on a public holiday.

10. Public holidays including Christmas Day (25 December), Boxing Day (26 December) and New Years’ Day (1 January) shall be treated as follows:
   a. Where any of these days fall on a Saturday or a Sunday, then the bank holiday will be taken instead on the first weekday thereafter which is not otherwise identified as being a paid public holiday.

   b. On any occasion in which a paid holiday other than 25 or 26 December or 1 January falls on a Saturday or a Sunday, the paid public holiday will be taken instead on the first weekday thereafter which is not otherwise treated as a paid public holiday.
Study and Professional Leave

11. Study Leave includes but is not restricted to, participation in:

   a. study (linked to a course or programme)
   b. research
   c. teaching
   d. taking examinations
   e. attending conferences for professional/educational benefit
   f. training, including scheduled training events

Professional Leave is leave in relation to professional work.

12. Any grant of leave is subject to the need to maintain NHS services and must be authorised by the employer (where there is a lead employer arrangement, it must be authorised by the host employer and notified to the lead employer).

13. Study and Professional leave is paid time agreed with the employer and the doctor or dentist is obliged to use that time for the purpose for which it has been granted. Safe working practices as set out in Schedule 3 will continue to apply.

Period of Leave

14. Study leave up to the limits described below will normally be granted to the maximum extent consistent with maintaining essential services in accordance with the recommended standards, or may exceptionally be granted under the provisions of paragraph 16. The limit for doctors at Foundation Year 2 and above is thirty days paid study leave each year (running from the date of commencement of post). Study leave for Foundation Year 1 doctors is 15 days and will take the form of a regular scheduled teaching/training session (or similar arrangement) as agreed locally. Study leave for higher grades will also include periods of regular scheduled teaching/training sessions, but may also, with approval from the educational supervisor and service manager, include periods of leave for individual study. Shorter periods of employment should accrue pro rata periods of study leave.

Where the trainee undertakes an approved external course (eg an MSc) as part of their training and their work schedule, this will typically be considered study leave.

Study leave for all trainees may include periods of sitting (or preparing for) an examination for a higher qualification where it is necessary as part of the training programme of the trainee.

15. Doctors in training may be entitled to reasonable study leave expenses in accordance with local policy.
Additional Periods of Study Leave

16. Employers may at their discretion grant Study Leave above the period recommended in paragraph 14, inside or outside the United Kingdom, with or without pay and with or without expenses or with some agreed proportion thereof.

Less than full time staff

17. Study and professional leave entitlements will be granted on a pro rata basis to staff who are working less than full time.

When granting study leave to less than full time trainees, employers should, however, adopt a flexible approach to ensure that these doctors have access to study leave opportunities sufficient to fulfil the requirements of the training programme.

Sick Leave

These sick leave provisions are supplemented by Annex Z of the NHS Staff Handbook which sets out a framework to support employers and staff in the management of sickness absence and manage the risk of premature and unnecessary ill health retirements.

Notification of Sickness Absence

18. A doctor or dentist who is incapable of doing his or her normal work because of illness shall immediately notify his or her employer in accordance with the employers procedures.

If a doctor or dentist falls sick during annual leave and produces a statement to that effect, he or she will be regarded as being on sick leave from the date of the statement. A doctor or dentist who is incapable of doing their normal work because of illness, or who becomes ill whilst on annual leave, shall immediately notify their employer in accordance with the employer’s procedures on the first day of sickness. A self certificate will cover days 1 to 7 of the period of sickness (including any non-working days). The doctor or dentist must obtain a medical certificate for subsequent days. Further annual leave will be suspended from the date of the first statement.
Health Assessment

19. Doctors are required to notify their employer as soon as possible of any illness, disease or condition, which prevents them from undertaking their duties.

The employer may at any time require a doctor who is unable to perform some or all of their duties as a consequence of illness to attend an examination by the organisation’s occupational health services in accordance with local procedures.

20. A doctor or dentist absent from duty owing to illness (including injury or other disability) shall, subject to the provisions of paragraphs 22 to YY, be entitled to receive an allowance in accordance with the following table:

<table>
<thead>
<tr>
<th>Period of Service</th>
<th>Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the first year of service</td>
<td>One month's full pay and two months' half pay</td>
</tr>
<tr>
<td>During the second year of service</td>
<td>Two months' full pay and two months' half pay</td>
</tr>
<tr>
<td>During the third year of service</td>
<td>Four months' full pay and four months' half pay</td>
</tr>
<tr>
<td>During the fourth and fifth years of service</td>
<td>Five months' full pay and five months' half pay</td>
</tr>
<tr>
<td>After completing five years of service</td>
<td>Six months' full pay and six months' half pay</td>
</tr>
</tbody>
</table>

21. The employer shall have discretion to extend a doctor or dentist's sick leave entitlement. A case of a serious character, in which a period of sick leave on full pay in excess of the period of benefit stipulated above would, by relieving anxiety, materially assist a recovery of health, shall receive special consideration by the employer.

22. To enable rehabilitation, the employer has the discretion to allow a doctor or dentist to return to work on reduced hours or to be encouraged to work from home without loss of pay to aid rehabilitation. Any such arrangements need to be consistent with statutory sick pay rules.
Calculation of Allowances

23. The rate of allowance shall be calculated according to Table 2. The period for which absence due to illness is to be paid shall be calculated by, on the first day of absence, deducting from the appropriate allowance (in Table 2) the combined total sickness absence during the 12 months immediately prior to this.

In calculating the periods of absence, no account shall be taken of:

   a. unpaid sick leave; or
   b. injuries sustained, or diseases contracted by, members of staff in the actual discharge of their duties; or
   c. injury resulting from a crime of violence not sustained on duty but connected with or arising from the doctor’s employment or profession, where the injury has been the subject of payment by the Criminal Injuries Compensation Authority (CICA); or
   d. due to injury as at sub-paragraph (iii) above which has not been the subject of payment by the CICA on the grounds that it has not given rise to more than three weeks loss of earnings, or was not one for which compensation above the minimum would arise.

24. The employer may at its discretion also take no account of the whole or any part of the period of absence due to injury (not on duty) resulting from a crime of violence not arising from or connected with the doctor’s employment or profession.

Previous Qualifying Service

25. For the purpose of calculating the appropriate allowance of paid sick leave under paragraph 22, previous qualifying service shall be determined in accordance with the doctor’s statutory rights and all periods of service, (without any break of 12 months or more, subject to paragraph 26 below), with a National Health Service employer shall be aggregated. Previous service with a non-NHS employer (such as a local authority) where placement is required should be included when calculating the allowance.
26. Where a doctor or dentist has broken their regular service for one of the following reasons:
   a. in order to go overseas in a rotational appointment forming part of their recognised training programme,
   b. for any other appointment which is considered by the Postgraduate Dean or College or Faculty Adviser in the specialty concerned (if necessary, with the advice of the consultant) to be part of a suitable programme of training,
   c. for an approved period of time out of programme for clinical training (OOPT), clinical experience (OOPE) or research (OOPR),

the doctor's previous NHS or approved service, as set out in paragraph 25 above, shall be taken fully into account in assessing entitlement to sick leave allowance, provided that: the employer considers that there has been no unreasonable delay between the training or OOP ending and the commencement of the subsequent NHS post.

27. For the purpose of sick leave allowances, a doctor's or dentist's previous contracted NHS locum service shall be recognised.

Limitation of Allowance when Insurance or other Benefits are Payable

28. The sick pay paid to a doctor or dentist when added to any statutory sickness, injuries or compensation benefits, including any allowances for adult or child dependants, must not exceed full pay.

Recovering of Damages from Third Party

29. A doctor or dentist who is absent as a result of an accident is not entitled to sick pay if damages are received from a third party. Employers may agree to advance to a doctor or dentist a loan, not exceeding the amount of sick pay under these provisions, providing the doctor or dentist repays to the employer when damages are received, the full amount or portion thereof corresponding to the amount in respect of loss of remuneration including the damages received. Once received, the absence shall not be taken into account for the purposes of the scale set out in Table 1.

30. Any absence of more than seven days shall be certified by a doctor (other than the sick doctor). Statements shall be submitted in accordance with the employer’s procedures.

Accident due to Sport or Negligence

31. An allowance shall not normally be paid in a case of accident due to active participation in sport as a profession, or where contributory negligence is proved.
Injury Sustained on Duty

32. An absence due to injury sustained by a doctor or dentist in the actual discharge of their duty, for which the doctor was not liable, shall not be recorded for the purposes of aggregation against future sickness absence.

33. The Injury Allowance provisions will apply as set out in Section 22 of the NHS Terms and Conditions of Service Handbook, and should be read alongside the accompanying guidance issued by NHS Employers.

Termination of Employment

34. The sick leave provisions of these TCS shall cease to apply to a doctor on the termination of employment by reasons of permanent ill-health or infirmity of mind or body, of resignation, of age, or any other reason.

Forfeiture of rights

35. If it is reported to the employer that a doctor has failed to observe the conditions relating to the granting of sick leave, or has been guilty of conduct prejudicial to their recovery, and the employer is satisfied that there is substance in the report, the payment of the allowance shall be suspended until the employer has made a decision regarding the continued payment of the allowance. Before making a decision, the employer must give the doctor an opportunity of responding to the report. If the employer decides that the doctor has failed without reasonable excuse to observe the conditions relating to the granting of sick leave, or has been guilty of conduct prejudicial to their recovery, then the practitioner shall forfeit their right to any further payment of allowance in respect of that sickness or period of absence.

Special Leave With or Without Pay

36. Special leave means leave granted in exceptional circumstances, on a short-term basis, that would not be covered under annual, study, professional or sickness leave. All requests for Special Leave will be considered by the employer in line with statutory requirements and local policy.

Maternity Leave and Pay

37. See Schedule 11.
Schedule 9 – Termination of Employment

Period of Notice

1. Where termination of employment is necessary, an employer will give a doctor notice in writing.

2. Doctors are required to give their employer written notice if they wish to terminate their employment.

3. The minimum notice periods for each grade will apply, unless the statutory notice period is longer:

Table 1: Minimum notice periods

<table>
<thead>
<tr>
<th>Grade</th>
<th>Notice Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>One month</td>
</tr>
<tr>
<td>F2</td>
<td></td>
</tr>
<tr>
<td>STR (Core Trainee)</td>
<td></td>
</tr>
<tr>
<td>STR (Fixed Term Specialty Training Appointment)</td>
<td></td>
</tr>
<tr>
<td>Dental Foundation Trainee</td>
<td></td>
</tr>
<tr>
<td>Dental Core Trainee</td>
<td></td>
</tr>
<tr>
<td>STR (Run-through)</td>
<td>Three months</td>
</tr>
<tr>
<td>STR (Higher Specialty Training)</td>
<td></td>
</tr>
<tr>
<td>GP Specialty Trainee</td>
<td></td>
</tr>
<tr>
<td>SpR</td>
<td></td>
</tr>
</tbody>
</table>

Statutory Notice Periods

4. Shorter or longer notice periods may apply where agreed between both parties in writing and signed by both.

5. An employing organisation shall give as the minimum period of notice to terminate the employment of a practitioner (unless the period specified in paragraph 6 is longer) who has been continuously employed for at least four weeks:

   a) one week's notice if the period of continuous employment is less than two years;
   b) one week's notice for each year of continuous employment if the period of continuous employment is at least two but less than twelve years;
   c) twelve weeks' notice if the period of continuous employment is twelve years or more.
6. The minimum period of notice to be given to his or her employing authority by a practitioner who has been continuously employed for at least four weeks shall be one week. The period of continuous employment shall be computed in accordance with Schedule 13 of the Employment Protection (Consolidation) Act 1978.

7. For the minimum period of notice appropriate to the practitioner’s case set out in paragraph 5, reference shall be made to the rights available to the practitioner under Schedule 3 of the Employment Protection (Consolidation) Act 1978. This applies whether the employing authority gives notice to the practitioner or whether the practitioner gives notice to his or her employing authority.

Investigating Concerns

8. All employers of doctors and dentists in training must have procedures for handling serious concerns about an individual’s conduct and capability. These procedures must allow for informal resolution of less serious problems where deemed appropriate. Concern about the performance of doctors and dentists in training should be handled in line with those for other medical and dental staff, with the proviso that in all cases the deanery function should be involved from the outset. The onus still rests with the employer for the conduct of the investigation and any necessary action. The diagram shown at Annex B demonstrates the process which should usually be followed when investigating concerns. Where lead employer arrangements exist, the responsibility for managing this process rests with the lead employer unless other arrangements have been agreed with the host employer. Where responsibility is delegated to the host employer, the lead employer must be kept informed of the progress and outcome of this process.

Grounds for Termination of Employment

9. A doctor’s employment may be terminated for the following reasons:

a. conduct;

b. capability;

c. redundancy;

d. failure to hold or maintain a requisite qualification, registration, approval of training or licence to practice;

e. in order to comply with a statute or other statutory regulation; or
f. where there is some other substantial reason to do so in a particular case.

10. Should the application of any disciplinary or capability procedures result in the decision to terminate a doctor’s contract of employment, they will be entitled to invoke a locally recognised appeals process.

11. In cases where employment is terminated, a doctor may be required to work his or her notice, or if the employer considers it more appropriate, the doctor may be paid in lieu of notice, or paid through the notice period but not be required to attend work.

12. In cases of gross misconduct, gross negligence, or where a doctor’s registration as a medical doctor (and/or their registration as a dental doctor) has been removed or has lapsed without good reason, employment may be terminated without notice. The postgraduate dean will be informed immediately by the employer when this circumstance arises.
Annex B – diagram to be used in conjunction with Schedule 9 Paragraph 8, Investigating Concerns

Managing concerns raised about doctors in training*

Concern raised about a Doctor in Training to employer or deanery?

Notify partner arm (Deanery function or Employer Professional Head (MD or DPGME))

Is exclusion / restriction proportionate and necessary (Can be reconsidered at any stage of process as evidence is gathered) [ONE OR BOTH ARMS]

Prima facie fact gathering [HOST EMPLOYER]

Deanery function and employer decide jointly whether this is principally a competency issue (i.e. a possible shortfall in knowledge or technical skill, given expected progress in training programme)

Yes

FOR EDUCATIONAL CONSIDERATION & MANAGEMENT: generally by DPGME

Manage through agreed educational framework

Is there also a possible shortfall in professional or employee conduct?

No

Inform deanery function of outcome

Case closed

Yes

FOR EMPLOYER INVESTIGATION & MANAGEMENT

Manage through employers procedures

Inform deanery function of outcome

Are there also concerns about competency as described above?

Yes

No

Case closed

* This may be at a formal or informal stage of the policy, depending on the nature of the concern, as defined in the local policy.

NB. Responsibility for carrying out any fact gathering or investigation will sit with the employer.

Where a doctor in training is employed on a lead employer basis, the responsibility will sit with the lead employer unless otherwise defined.
Schedule 10 – Expenses

General

1. Expenses relating to travel, subsistence and other business expenses shall be paid to meet actual disbursements of doctors in the performance of their duties, and shall not be regarded as a source of pay or reckoned as such for the purposes of pension.

2. Claims for expenses shall normally be submitted within one month and as soon as possible after the end of the period to which the claim relates, subject to local procedures.

3. The following terms are used throughout these provisions:
   - "Principal place of work" means "the place of work from which the doctor conducts their main duties". Where a doctor has a joint contract with more than one employer, the term "principal place of work" means the place from which the doctor conducts their main duties within that joint contract, irrespective of employer.
   - “Official journey” means “a journey in the performance of a doctor’s duties”

Business Travel Expenses

4. Costs incurred by doctors shall be reimbursed when, with the agreement of their employer, they use their own vehicles or pedal cycles to make official journeys.

5. When doctors use their vehicles for official journeys they must possess a valid driving licence, Ministry of Transport (MOT) test certificate and motor insurance which covers business travel. Doctors must be fit to drive, drive safely and obey the relevant laws e.g. speed limits. The doctor must inform the employer if there is a change in status.

6. When authorising the use of a vehicle, the employer must ensure that the driver has a valid driving licence and MOT certificate and has motor insurance which covers business travel.

7. The employer and doctor will agree the most suitable means of transport for the routine journeys which the doctor has to make in the performance of their
duties. If a particular journey is unusual, in terms of distance or purpose, the mode of travel will be agreed between the employer and doctor before it starts.

8. There may be circumstances where newly appointed or lower paid doctors need assistance to obtain a vehicle to undertake business travel. Where the use of a vehicle is essential to the job the organisation may wish to assist by providing a lease or pool vehicle or a salary advance. Principles underpinning lease vehicle policies are in Annex B. If the employer withdraws the offer of a lease vehicle in line with the provisions of Annex B the doctor is entitled to the appropriate rates of reimbursement in Table 1.

9. The reimbursement of travel costs when doctors are required to change their principal hospital as a result of a reorganisation or merger of NHS employers will be for local partnerships to determine, subject to a maximum period of reimbursement of four years from the date of transfer.

Rates of reimbursement

10. For doctors who use their own vehicles or pedal cycles to make official journeys, their travel costs will be reimbursed at the appropriate rates shown in Table 1.

11. The rates of reimbursement in Table 1 are obtained by referring to costs for the average private vehicle user included in the AA guides to motoring costs. A summary of motoring costs which are taken into account is in Annex A.

12. The rate of reimbursement for motorcyclists in column 4 in Table 1 and the reserve rate in column 4 will move in line with the rate for car users in column 2 (see Annex A).

Table 1: Rates of reimbursement from [insert date]

[Table to be added]

Review

13. The standard rate of reimbursement in Column 2 in Table 1 will be reviewed each year, soon after the new AA guides to Motoring Costs are published, normally in April or May. Any changes to the standard rate of reimbursement, the reserve rate and the rate for motorcycle users in Table 1, resulting from this review, will apply to all miles travelled from the following 1 July.
14. A second review will be conducted in November each year to ensure the rate in Column 2 in Table 1 (the standard rate) continues to reimburse doctors in line with motoring costs. Any changes to the standard rate of reimbursement, the reserve rate and the rate for motorcycle users in Table 1, resulting from this review, will apply to all miles travelled from the following 1 January.

**Eligible mileage**

15. Doctors shall be reimbursed for official journeys which are in excess of their return journey from home to principal place of work. Normally, the miles eligible for reimbursement are those travelled from the principal place of work to place visited and back. However, when the journey being reimbursed starts at a different location, for example home, the mileage eligible for reimbursement will be as set out in the example in Table 2.

**Table 2: Eligible mileage**

[To be added]

**Passenger rate**

16. With the exception of lease, pool or hire vehicle users, where other doctors or members of an NHS organisation are conveyed in the same vehicle on NHS business and their fares would otherwise be payable by the employer, the passenger allowance in Table 1 will be payable to the vehicle driver.

**Reserve rate of reimbursement**

17. A reserve rate of reimbursement, as in Table 1, will apply to doctors using their own vehicles for business purposes in the following situations:

- If the doctor unreasonably declines the employers’ offer of a lease vehicle:
  - in determining reasonableness the employer and doctor should seek to reach a joint agreement as to whether a lease vehicle is appropriate and the timeframe by which the new arrangements will apply. All the relevant circumstances of the doctor and employer will be considered including the
doctor’s personal need for a particular type of car and the employers’ need to provide a cost effective option for business travel;

- if the doctor’s circumstances subsequently change the original decision will be reviewed. The agreed principles underlying local lease vehicle policies are in Annex B;

- when a doctor is required to return to work on any day (e.g. when called out in an emergency), and thereby incurs additional travel to work expenses.

- if the doctor uses his or her own vehicle when suitable public transport is available and appropriate in the circumstances, subject to a maximum of the public transport cost which would have been incurred and the rules on eligible miles in paragraph 15 and Table 2.

**Attendance on training courses**

18. Additional travel costs incurred when attending courses, conferences or events at the employer’s instigation will be reimbursed at the standard rates in Table 1 when the employer agrees that travel costs should be reimbursed.

19. Subject to the prior agreement of the employer, travel costs incurred when doctors attend training courses or conferences and events, in circumstances when the attendance is not required by the employer, or who are on professional or study leave, will be reimbursed at the reserve rate in Table 1, in line with the rules on eligible mileage in paragraph 15 and Table 2.

**“Out of pocket” expenses**

20. This paragraph applies to doctors for whom regular travel in a motor vehicle is an essential part of their duties. During a period when the doctor’s vehicle is temporarily “off the road” for repairs, “out of pocket” expenses in respect of business travel by other appropriate forms of transport, should be borne by the employer. Reimbursement of these expenses will be subject to the rule on eligible mileage in paragraph 15 and Table 2.

**Other allowances**

21. Doctors who necessarily incur charges in the performance of their duties, in relation to parking, garage costs, tolls and ferries shall be refunded these
expenses on production of receipts, whenever these are available. Charges for overnight garaging or parking, however, shall not be reimbursed unless the doctor is entitled to night subsistence. This does not include reimbursement of parking charges incurred as a result of attendance at the doctor’s principal place of work.

Transporting equipment

22. Doctors who use their vehicles in the performance of their duties may be required to take equipment with them. Employers have a duty of care under the Health and Safety at Work Act 1974 and related legislation, to ensure that this does not cause a risk to the health and safety of the doctor. Doctors should not be allowed to carry equipment which is heavy or bulky, unless a risk assessment has been carried out beforehand. When, after the necessary assessment has demonstrated it is safe to carry equipment, an allowance (see Table 1) shall be paid for all eligible miles (see paragraph 15 and Table 2) for which the equipment is carried, provided that either:

- the equipment exceeds a weight which could reasonably be carried by hand; or
- the equipment cannot be carried in the boot of the vehicle and is so bulky as to reduce the seating capacity of the vehicle.

Public transport

23. If doctors use public transport for business purposes the cost of bus fares and standard rail fares should be reimbursed.

Relocation Expenses

24. Assistance with relocation expenses, including removal or excess mileage, shall be provided to doctors who:

- Need to move their home or incur extra daily travel expenses as a result of being required by their employer to transfer principal hospitals.
- Are required to change their employer or who otherwise have to move home or incur extra daily travel expenses in order to satisfy the requirements of their professional training i.e. change of principal hospital on a rotational training programme.

25. Assistance may also be granted, at the employer’s discretion, to doctors who as a result of taking up employment either need to move their home or incur
extra daily travel expenses i.e. on first appointment to principal hospital. In exercising their discretion, employers shall take into consideration the Equality and diversity statement (see Schedule 11).

26. If the doctor has a home convenient to the principal hospital in which the second or subsequent post in the rotational appointment is to be held they may decide to travel the extra distance to where the previous post or posts are held and in such cases the doctor may be paid excess travel expenses when travelling to the previous post or posts.

27. Except where another body provides the assistance, the employer and the doctor can agree either:

- assistance with removal expenses; or
- excess travel expenses where the doctor travels daily the greater distance between their home and second or subsequent principal hospitals.

Removal expenses

28. Except where another body provides the assistance, the scope and level of financial assistance to be provided should be determined by the employer, in agreement with the prospective doctor, prior to the post being accepted. In agreeing the assistance to be provided, the employer shall have regard to all the individual doctor’s circumstances, including the need to re-house dependents and the comparability of new and previous accommodation.

29. The employer shall clearly indicate to the doctor the level of assistance that will be provided, the aspects of removal costs that will be reimbursed and, where applicable, the upper limit of payment in all usual circumstances. In providing assistance, authorities should ensure equity, while balancing their own interests with the needs of prospective employees.

30. The employer shall stipulate in the agreement reached with the doctor the procedure to be followed and the costs that will be reimbursed in circumstances where an authority has entered into an agreement with solicitors or others to provide house purchase/conveyancing services, private structural surveys, estate agency services and/or a removal service at preferential cost.
Excess travel expenses

31. As outlined in paragraph 26, excess mileage may be paid instead of relocation expenses where appropriate and this should be agreed by the employer and the doctor prior to the doctor starting in post.

32. Excess mileage is deemed to be the difference, for each single journey, between the distance from the doctor’s home to their principal place of work (the first place of work in the doctor’s current training programme except under the circumstances described in paragraph 26) and the distance from their home to any second or subsequent principal place of work. Excess mileage may be payable at the first appointment to a principal place of work under the circumstances described in paragraph 26.

33. The appropriate mileage rate will be paid in accordance with Table 1.

Subsistence Allowances

34. The purpose of travel and subsistence allowances is to reimburse the necessary extra costs of meals, accommodation and travel and any other business expenses that arise as a result of official duties away from home (or principal hospital).

35. Where locally, staff and employer representatives agree arrangements which are more appropriate to local operational circumstances or which provide benefits to staff beyond those provided by these provisions, or are agreed as operationally preferable, those local arrangements will apply.

Night subsistence

36. When doctors stay overnight in commercial accommodation with the agreement of the employer the actual, receipted cost up to £55 shall be paid.

37. Where the maximum limit is exceeded for genuine business reasons (e.g. the choice of hotel was not within the employee’s control or cheaper hotels were fully booked) additional assistance may be granted at the discretion of the employer.

38. Regardless of accommodation type, doctors staying overnight with the agreement of their employer will be reimbursed for the cost of meals up to a total of £20, per 24 hour period, subject to the production of receipts. If meals are provided free of charge the cost of meals cannot be reimbursed. Additional assistance may be granted at the discretion of the employer.
39. Where doctors stay for short overnight periods with friends or relatives a flat rate of £25 is payable. This includes an allowance for meals. No receipts are required.

40. Where accommodation and meals are provided without charge to doctors e.g. on a residential training course, an incidental expenses allowance of £4.20 will be payable. All payments of this allowance are subject to the deduction of appropriate tax and national insurance contributions via the payroll system.

41. Travel costs between the hotel and any temporary place of work will be separately reimbursed on an actual costs basis.

**Travelling Overnight in a Sleeping Berth (Rail or Boat)**

42. The cost of a sleeping berth (rail or boat) and meals, excluding alcoholic drinks, will be reimbursed subject to the production of receipts.

**Day subsistence**

43. The cost of meals is payable when the doctor is absent from home or principal hospital on the business of the employer, subject to locally agreed arrangements. If meals are provided free of charge the cost of meals cannot be reimbursed.

**Other business subsistence**

44. Any expenditure necessarily incurred by doctors on postage or telephone calls in the service of their employer shall be reimbursed subject to evidence of expenditure.
Schedule 11 – Sections of the NHS Terms and Conditions of Service Handbook applicable to Doctors and Dentists in training

Section 15 Maternity leave and pay
Section 16 Redundancy pay
Section 22 Injury allowance
Section 25 Time off and facilities for trades union representatives
Section 26 Joint consultation machinery
Section 30 General equality and diversity statement
Section 32 Dignity at work
Section 33 Caring for children and adults
Section 34 Flexible working arrangements
Section 35 Balancing work and personal life
Section 36 Employment break scheme
Annex Z Managing sickness absences – developing local policies and procedures
Schedule 12 – Transitional Arrangements (temporary schedule)

[To be added]
Annex G: Four Country Junior Doctors Rota Collection– Data Summary

This report details the results of the data collected in England, Wales, Scotland and Northern Ireland. This dataset will be the basis for initial cost-modelling of a new contract.

This is the final version of the data summary. Final cost-modelling will be updated to reflect the final data summary. Significant changes to this version will be notified to representatives of all four countries.

1. Sample Coverage

<table>
<thead>
<tr>
<th>Country</th>
<th>Rota system used</th>
<th>Rotas verified as live</th>
<th>Sample coverage</th>
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</thead>
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<tr>
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<td>DRS and Allocate</td>
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<td>15%</td>
</tr>
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<td>Scotland</td>
<td>DRS</td>
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</tr>
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Data was extracted from electronic rota systems, and sent to organisations to verify that the rotas on the systems were those presently in use, and not historic/redundant or test rotas. In Scotland, data was verified through the central New Deal monitoring returns.

The sample in England is based on rotas from 30 organisations, which represents 15% of all NHS organisations who employ at least 30 junior doctors in England. UK averages are based on an estimated England number of 50,653 doctors on training rotas (7,598 rota slots divided by 15%). This estimate will be revised as and when a more accurate total of trainee doctors (excluding trust grades) is calculated.

In Scotland, Wales, and Northern Ireland rotas have been collected from all organisations who employ junior doctors.

Only those rotas which were verified by the employing organisations as live and correct were included in the following analysis.

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45 Health and Social Care Information Centre, May 2014, Provisional Statistics – HEE by Org tables (xls)
Assumptions

- The following pages contain a series of charts which allow visual comparison between the average hours per week by shift type, grade, full-time / less than full-time, the hours metric and country.
- The number of hours refers to the average (mean) number of hours per week including prospective cover, weighted by the number of doctors on the rota.
- Less than full-time rotas have been separated from full-time rotas to prevent this artificially distorting the average hours worked per week. Current modelling is based on full-time rotas only at this stage.
- Initial modelling has been based on the worked hours recorded on the template rotas. This is because:
  - rota templates are negotiated and agreed between junior doctors, employers, and educational representatives which should be an accurate reflection of the expected working hours of junior doctors.
  - the coverage and quality of monitoring data is variable across the UK.
- Work hours are shown in orange, and duty hours in blue.
- Hours shown are calculated to 1 decimal place.
- DRS does not distinguish between Full Shift and Normal Working Day working patterns. These rotas have been manually separated by assuming that those with banding are Full Shift, whilst those without banding are Normal Working Day.
- If there is a difference between the total number of slots/posts on the rota and the sum of the slots/posts for each grade, this difference has been added to the number of doctors of unknown grade.

Key:

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<thead>
<tr>
<th>Orange</th>
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<tr>
<td>Template Work</td>
<td>Template Duty</td>
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* Estimated values for England, extrapolated from the sample
2. Comparison of Work and Duty Hours on template rotas by shift type (Full-time)

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<tr>
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3. Grade distribution

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<th>Country</th>
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<th>FY2</th>
<th>ST1/CT1 &amp;</th>
<th>Number of ST3+</th>
<th>Unknown grade</th>
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<td>Northern Ireland</td>
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### 4a. Comparison of template work hours and Template Duty hours by grade (Full-time)

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<td>47.4</td>
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<td>Number of rotas x number of doctors by grade (England only)</td>
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### 4b. Distribution of Full-time trainees by country and shift type

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<tr>
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<td>ST1/CT1 &amp; ST1/CT2</td>
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<td>27%</td>
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</tr>
<tr>
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</tr>
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<td>Total</td>
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</tbody>
</table>

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201

THE NHS EMPLOYERS ORGANISATION'S SUBMISSION TO THE DOCTORS' AND DENTISTS' REVIEW BODY
Reform of national contracts for consultant doctors and for doctors and dentists in training
### 5. Hourly Coverage of template rotas - England (DRS)

<table>
<thead>
<tr>
<th>Time/Day</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Total by year</th>
</tr>
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<td>2.1%</td>
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<td>21:00 - 21:59</td>
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</tr>
</tbody>
</table>

**Total by day**

|                | 17.5% | 17.5% | 17.5% | 17.5% | 17.5% | 6.3%   | 6.1%   | 100.0%        |

Note. Data does not break down hours into individual weekdays. Weekday total has been split equally across 5 days, so as to be comparable with Saturday and Sunday.
6. Hourly Coverage of template rotas - Scotland (DRS)

<table>
<thead>
<tr>
<th>Time/Day</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Total by hour</th>
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<td>0.2%</td>
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<tr>
<td>01:00 - 01:59</td>
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<td>9.0%</td>
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<td>1.4%</td>
</tr>
</tbody>
</table>

Total by day: 17.6% 17.6% 17.6% 17.6% 17.6% 6.1% 6.0% 100.0%

There is no equivalent hours coverage table for NI or Wales, as it was not possible to extract this information from Allocate.
7. England Only - Average template hours by sample dimension

The analysis below shows a comparison of average template hours by each sampling dimension.

<table>
<thead>
<tr>
<th>Third according to total number of doctors</th>
<th>Number of total slots/posts on rota</th>
<th>Duty Hours</th>
<th>Work Hours</th>
<th>Statistical significance</th>
</tr>
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<tbody>
<tr>
<td>Bottom third</td>
<td>388</td>
<td>47.8</td>
<td>44.9</td>
<td>The sample mean Duty Hours and sample mean Worked Hours for organisations of each number of doctors type were estimated to be within 95% Confidence Limits</td>
</tr>
<tr>
<td>Middle third</td>
<td>1856</td>
<td>47.1</td>
<td>45.6</td>
<td></td>
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<tr>
<td>Top third</td>
<td>5287</td>
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<td>44.8</td>
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<tr>
<td>Total</td>
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<td>46.6</td>
<td>45.0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisation type</th>
<th>Number of total slots/posts on rota</th>
<th>Duty Hours</th>
<th>Work Hours</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>7270</td>
<td>46.6</td>
<td>45.0</td>
<td>The sample mean Worked Hours for Community Provider Trusts were found to be below 95% confidence limits.</td>
</tr>
<tr>
<td>Community Provider Trust</td>
<td>72</td>
<td>45.3</td>
<td>42.5</td>
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<tr>
<td>Mental Health and Learning Disability Trust or Care Trust</td>
<td>189</td>
<td>49.2</td>
<td>45.3</td>
<td>The sample mean Worked Hours for all other organisation types and sample mean Duty Hours for the other organisation types were estimated to be within 95% Confidence Limits</td>
</tr>
<tr>
<td>Total</td>
<td>7531</td>
<td>46.6</td>
<td>45.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rota system</th>
<th>Number of total slots/posts on rota</th>
<th>Duty Hours</th>
<th>Work Hours</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocate</td>
<td>3254</td>
<td>47.3</td>
<td>45.7</td>
<td>The sample mean Duty Hours and sample mean Worked Hours for both rota systems were estimated to be within 95% Confidence Limits</td>
</tr>
<tr>
<td>DRS</td>
<td>4277</td>
<td>46.1</td>
<td>44.5</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7531</td>
<td>46.6</td>
<td>45.0</td>
<td></td>
</tr>
</tbody>
</table>
### Average hours

<table>
<thead>
<tr>
<th>Inside/Outside London</th>
<th>Number of total slots/posts on rota</th>
<th>Duty Hours</th>
<th>Work Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>1888</td>
<td>44.8</td>
<td>43.3</td>
</tr>
<tr>
<td>Outside London</td>
<td>5643</td>
<td>47.2</td>
<td>45.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7531</strong></td>
<td><strong>46.6</strong></td>
<td><strong>45.0</strong></td>
</tr>
</tbody>
</table>

The sample mean Worked Hours for London trusts were found to be below 95% confidence limits.

The sample mean Duty Hours for all trusts, whether inside or outside London, and the sample mean Worked Hours for trusts outside London were estimated to be within 95% Confidence Limits.

<table>
<thead>
<tr>
<th>Teaching/Non-Teaching</th>
<th>Number of total slots/posts on rota</th>
<th>Duty Hours</th>
<th>Work Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Teaching</td>
<td>4201</td>
<td>47.1</td>
<td>45.6</td>
</tr>
<tr>
<td>Teaching</td>
<td>3330</td>
<td>46.1</td>
<td>44.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7531</strong></td>
<td><strong>46.6</strong></td>
<td><strong>45.0</strong></td>
</tr>
</tbody>
</table>

The sample mean Duty Hours and sample mean Worked Hours for both teaching and non-teaching trusts were estimated to be within 95% Confidence Limits.
Appendix: Consultant contract reform financial modelling: Illustrative examples

Overview
This section details the current financial distribution for consultants, and illustrative examples under the future contract. Note that, whilst grounded in real data, the generation of examples has required the use of assumptions particularly on out-of-hours working patterns. It is hoped that work commissioned by NHS England may be able to better inform this. However, currently these examples should not be considered exact indications of the financial values defining proposed pay options. Instead, their purpose is to help demonstrate proof of concept and provide illustrative examples of different pay options.

Summary

- Reduced starting salary for newly qualified consultants of £70k, rising to £93k for experienced consultants after five years.
- £107k per full time equivalent (FTE) for experienced consultants for salary, additional activity and out of hours. Possibility for £5-6k additional payment for out-of-hours work, generated from savings elsewhere in contract.
- Up to £6.9k per FTE for additional responsibilities.
- Around £7.5k per FTE for performance-related payments for experienced consultants.

Current distribution of consultant earnings
All examples are based on latest consultant data covering 2013/14. Our starting point is to consider the current distribution of consultant earnings. This can then be used to consider the equivalent resource ‘pots’ that would be available to fund counterfactual alternative pay arrangements with given assumptions about how resources would be allocated. For simplicity, and ease of comparison to the current situation, this is initially considered in the context of the current workforce. Subsequent modelling of pursued options will need to consider transition and the future.

Table 1 presents the distribution of consultant earnings per person across payment types, as published by the Health and Social Care Information Centre. It also converts this published data into a per-FTE format and aggregates it.
Table 1: Distribution of consultant earnings across payment streams – 2013/14

<table>
<thead>
<tr>
<th></th>
<th>Published Earnings per Person - £</th>
<th>Derived Earnings per FTE - £</th>
<th>Implied Aggregate Earnings - £m</th>
<th>Share of Earnings</th>
<th>Share of Non-Basic Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Pay</td>
<td>83,581</td>
<td>88,296</td>
<td>3,443</td>
<td>75%</td>
<td>n/a</td>
</tr>
<tr>
<td>Payments for additional activity</td>
<td>12,569</td>
<td>13,278</td>
<td>518</td>
<td>11%</td>
<td>45%</td>
</tr>
<tr>
<td>Medical awards (CEAs etc)</td>
<td>7,813</td>
<td>8,254</td>
<td>322</td>
<td>7%</td>
<td>28%</td>
</tr>
<tr>
<td>On call</td>
<td>2,773</td>
<td>2,929</td>
<td>114</td>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td>Geographic allowances</td>
<td>418</td>
<td>441</td>
<td>17</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>RRP</td>
<td>33</td>
<td>35</td>
<td>1</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Local &amp; other payments</td>
<td>4,168</td>
<td>4,403</td>
<td>172</td>
<td>4%</td>
<td>15%</td>
</tr>
<tr>
<td>Total Earnings</td>
<td>111,354</td>
<td>117,636</td>
<td>4,588</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes:
- Excludes employer national insurance and pension contributions so does not represent full paybill costs.
- The aggregate substantive consultant paybill is around £5.7bn (annualised).
- Excludes employee deductions so does not represent take-home pay.
- Excludes locum consultants. They would add around £175m to the annualised paybill.
- The ‘Local & other’ payment stream is quite large, but reflects the available detail in the data. 83% of it reflects locally determined payments by employers (labelled as ‘Local’, and may pick up many allowances, 14% of it reflects a similarly vague ‘Other category’. The rest reflects small payments in fields you would not necessarily expect such as banding supplements. This could reflect data issues or real but minor oddities such as consultants promoted mid-month and receiving banding supplements for the first part of the month.

Reduced starting salary for entry stage consultants

The employer team looked to pursue options where the starting salary of the entry stage consultant is set below the current starting salary. A reduced spot rate basic salary of £70k, with it typically taking five years to clear the gateway into the experienced consultant pay scale, was considered.

Table 2 provides a version of Table 1 split between the newly qualified and experienced consultants to support consideration of this differing treatment. For the purposes of the table it is assumed that it typically takes five years to pass the experienced consultant gateway.
Table 2: 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>Experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimated Earnings per FTE - £</td>
<td>Estimated Aggregate Earnings - £m</td>
</tr>
<tr>
<td>Basic Pay</td>
<td>80,024</td>
<td>817</td>
</tr>
<tr>
<td>Payments for additional activity</td>
<td>7,044</td>
<td>72</td>
</tr>
<tr>
<td>Medical awards (CEAs etc)</td>
<td>949</td>
<td>10</td>
</tr>
<tr>
<td>On call</td>
<td>2,804</td>
<td>29</td>
</tr>
<tr>
<td>Geographic allowances</td>
<td>425</td>
<td>4</td>
</tr>
<tr>
<td>RRP</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td>Local &amp; other payments</td>
<td>6,707</td>
<td>68</td>
</tr>
<tr>
<td>Total Earnings</td>
<td>97,992</td>
<td>1,000</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 to the remaining sample to match the full population to minimise problems, but the information should be considered an estimate.
- As such 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.

From the latest 2013/14 data, we estimate there are around 10.2k non-locum FTE in their first five years compared to 28.6k FTEs in their subsequent career. This is a 26 per cent to 74 per cent split.

Under the current system, salaries would average just around £80k in these five years. The option modelled would, once fully implemented, save £10k per year from basic pay alone, for each full-time consultant in this career entry stage. Considering the knock-on consequences on additional earnings, for additional activity and on call, this rises to around £12k per year per FTE. Adding in the knock-on consequences for employer on-costs, this rises to around £15k per year per FTE.

This would still reflect significant gains on promotion. Those promoted from specialty training to consultant would be expected to have a salary of £41.5k (seven years’ experience) to £47.2k (top of pay scale). This would further increase if, for example, junior doctor contract changes resulted in around half of banding supplements (currently averaging around 42 per cent) being diverted to basic pay, this would increase to around £50k to £57k.
A £70k starting salary would represent 22 per cent to 39 per cent gains on these values. This is a like-for-like comparison. It does not reflect additional activity or out-of-hours payments still received as a junior. It reflects the rate for 40 standard hours. The £70k consultant salary would also be boosted by additional activity and out-of-hours remuneration if applicable. Upon entry to the experienced consultant grade, consultants would also be accessing a higher salary earlier in their career then currently.

If these savings from the newly qualified can be secured, the proposal is that average earnings neutrality will be sought for the experienced group.

**Establishing base-case average values for additional roles payments**

The base-case average values for payments for additional roles depend on design preferences on the balance between the use of local allowances and defined additional roles payments.

Local and other payments are currently £6.8k per FTE for experienced consultants and set a limit for the maximum value of these payments.

**Establishing base-case average values for performance related payments**

The base-case average values for performance-related payments are grounded in the current value of local CEA earnings and design decisions about whether newly qualified consultants were eligible for these payments.

The employer team example implies a separate treatment of local and national CEAs. These are not separately identifiable in tables 1 and 2, or in the Electronic Staff Record data that underpins them, but it is possible to make estimates as provided in Table 3.

**Table 3: Estimated local & national CEA breakdown – 2013/14**

<table>
<thead>
<tr>
<th></th>
<th>Newly Qualified Estimated Earnings per FTE - £</th>
<th>Estimated Aggregate Earnings - £m</th>
<th>Experienced Estimated Earnings per FTE - £</th>
<th>Estimated Aggregate Earnings - £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical awards (CEAs etc)</td>
<td>949</td>
<td>10</td>
<td>11,230</td>
<td>323</td>
</tr>
<tr>
<td></td>
<td>of which Local CEAs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>949</td>
<td>10</td>
<td>7,486</td>
<td>215</td>
</tr>
<tr>
<td></td>
<td>National CEAs</td>
<td>0</td>
<td>3,745</td>
<td>108</td>
</tr>
</tbody>
</table>

Notes:
Figures are heavily estimated combining published earnings data, ACCEA information and assumptions.

This suggests performance-related payments of:

- £5.8k per FTE if all consultants are eligible, although based on current award rates this would likely be skewed with around £7.5k per FTE for experienced consultants and around £1k for the newly qualified.

- £7.8k per FTE for experienced consultant if the newly qualified were ineligible and the entire pot went to the experienced.

**Establishing the balance between salary and out-of-hours payments**

It should be highlighted that out-of-hours payments are somewhat bundled up with basic pay and payments for additional activity. Out-of-hours work can be rewarded either through a high rate for the session or through a reduced length PA. The specific out-of-hours component of these earnings streams is not separately identifiable in the data. It is also worth bearing in mind that some additional activity payments may only be necessary if basic pay is associated with shorter PAs.

By considering basic pay and payments for additional activity from Table 2, this gives an average of £104k per FTE for experienced consultants. Including on-call payments, which will account for some out-of-hours work, this gives a total of around £107k per FTE for salary and out-of-hours payments for experienced consultants, shown in Table 4.

**Table 4: Estimated salary & out of hours payments for experienced consultants**

<table>
<thead>
<tr>
<th>Estimated earnings per Experienced FTE - £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Pay</td>
</tr>
<tr>
<td>Payments for additional activity</td>
</tr>
<tr>
<td>On call</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

The data underpinning the calculations requires an estimate of the average number of PAs provided per FTE. This is needed to convert resource pots expressed per FTE into standard contract values consistent with a standard 40 hour week.

To estimate this additional activity payments and basic pay payments across pay points are compared. Broadly speaking if additional activity pay is 10 per cent of basic pay, then assume 1 additional PA per FTE. However, before this comparison is made, recorded additional activity payments are deflated for the extent they are inflated by CEA payments. Doing so gives an estimated average of 11.2PAs per week for experienced consultants.
From available data, we do not know and cannot estimate the proportion of consultant working hours delivered outside the plain time period. In order to generate examples, relative staffing levels across different time blocks are considered, which in turn provides a percentage split between plain and premium time. This percentage split is then applied to the average 11.2PAs. For premium time working, the reduced length PA is considered.

Rebasing on a standard contract week of 10PAs at four hours each gives a base salary of around £93k. Table 5 shows the payment distribution for additional activity and out of hours where around 10 per cent of work is paid at current premium rates. This gives a pot of around £6k per experienced FTE to allocate for out-of-hours work, and generates just under 1 PA of additional activity.

**Table 5: Estimated salary and out of hours split for experienced consultants**

<table>
<thead>
<tr>
<th>Time period</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday-Friday</td>
<td>10</td>
<td>10</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Saturday</td>
<td>2</td>
<td>1</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Sunday</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

| % Plain Time | 91% |
| % Premium Time | 9% |
| Base Salary per FTE - £ | 92,724 |
| Additional Hours Pay per FTE - £ | 8,069 |
| OOH per FTE - £ | 6,190 |
| Total Core Pay + OOH per FTE - £ | 106,983 |

**Options for additional roles payments**

As described earlier, modifications to additional roles payments depend on design preferences on the balance between the use of local allowances and defined additional roles payments.

Local and other payments are currently £6.8k for experienced consultants and set a limit for the maximum value of additional roles payments.

This could be increased by diverting resources from other earnings streams. Similarly, sacrificing potential resources from additional roles payments could boost other earnings streams.

The distribution of the available resources would depend upon design decisions about roles and associated payments.
Options for performance-related payments

As described above, there is a key question about whether they were available to newly qualified consultants. Allocating current local CEA payments to performance related payments means the latter can be around £7.8k per FTE if only experienced consultants are eligible, but only £5.8k per FTE if all consultants are eligible (although current award rates would suggest a skew of around £7.5k per FTE for experienced consultants and around £1k for the newly qualified).

Three categories of award are considered: Individual, Team and Organisational Level.

With the above values per FTE, many different scheme variants could be funded. The following diagram shows one example of how the resource pot could be allocated across the three categories. This assumes that there is one level of payment for each type of award.

| Individual Award Pot:  
| (Experienced Consultants only)  
| £546k |
| Team Award Pot:  
| £156k |
| Organisational Award Pot:  
| £78k |

In year, 30% of consultants achieve high performance ratings for their personal objectives  
Individual award per FTE for high achievement = £18k

30% of consultants work in teams that achieve high performer rating  
Team award per FTE on a high achieving team = £5k

In year, all organisational performance objectives met  
Organisational award per FTE = £0.8k

Example: Experienced consultant workforce of 100 FTEs. Annual pot of £780k (based on estimated current aggregate Local CEA payments applied to experienced consultants)
Consultant A: A high performer working as part of a high performing team would receive a £23.8k non-consolidated payment.

Consultant B: A high performer working in a team that is not eligible for an award would receive a £18.8k non-consolidated payment.

These values could be increased by diverting available resources from other earnings streams. Similarly, sacrificing potential resources from additional roles payments could boost other earnings streams.

Local CEAs are currently pensionable. By making performance-related payments non-pensionable, then the amount made available for performance-related pay could be increased whilst still remaining cost neutral.

Options for out-of-hours payments

From Table 5, a resource pot of £6k per experienced FTE is available for out-of-hours payments, from a total of £107k for salary, additional hours and out of hours. Illustrative examples are provided on how this might be distributed in the future. For ease of modelling this is shown for experienced consultants only.

Three methods of allocating out-of-hours payments are considered:

- An hours-based system.
- An allowance-based system.
- An allowance-hours hybrid system.

Examples are provided below on how each of these systems may be costed. As previously stated, due to lack of data on out-of-hours working patterns, examples are provided on an illustrative basis.

A). Hours based

Different options for changing the premium rates and the periods they apply to are considered. Due to lack of data on when unsocial hours are worked, and when they will be required to be worked in the future, this approach raises great concerns about the ability to ensure cost neutrality.

The following four options for premium rates are illustrated:

i. Time-and-a-third for nights (10pm-7am) Monday-Friday, and all of Saturday and Sunday
ii. Time-and-a-third for nights (10pm-7am) Monday-Saturday, and all of Sunday.
iii. Double time for nights (10pm-7am) Monday-Saturday, and all of Sunday.
iv. Double time for nights (10pm-7am) Monday-Sunday
Table 6 shows an example of relative staffing levels used to generate an increased proportion of premium time.

**Table 6: Example of relative staffing levels with increased out of hours working**

<table>
<thead>
<tr>
<th>Time period</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Staffing Levels</td>
<td>Monday-Friday</td>
<td>10</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Saturday</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sunday</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| % Plain Time | 83% |
| % Premium Time | 17% |

Table 7 illustrates the costs of each of the four options, based on the relative staffing distributions in Table 6.

**Table 7: Examples of payment distribution from changing premium rates and periods**

<table>
<thead>
<tr>
<th>Option</th>
<th>i</th>
<th>ii</th>
<th>iii</th>
<th>iv</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium Element per FTE - £</td>
<td>2,954</td>
<td>2,613</td>
<td>7,840</td>
<td>7,082</td>
</tr>
<tr>
<td>Difference from current example - £</td>
<td>1,299</td>
<td>1,149</td>
<td>3,448</td>
<td>3,114</td>
</tr>
<tr>
<td>Inferred base salary per FTE - £</td>
<td>92,888</td>
<td>93,202</td>
<td>88,393</td>
<td>89,091</td>
</tr>
<tr>
<td>Inferred additional hours payment per FTE - £</td>
<td>8,328</td>
<td>8,355</td>
<td>7,937</td>
<td>7,998</td>
</tr>
</tbody>
</table>

Table 7 shows the premium element per FTE for each option – that is the earnings relating to anything paid at above base rate. The difference from current example shows the extra cost per FTE incurred from the increased distribution of hours in unsocial periods. Average on-call payments of £3k are still assumed to be paid.

From Table 7, options i and ii would appear to be able to still generate a £93k base salary. However, this would be highly dependent on the number of hours worked on Sundays and nights not increasing substantially. With a move to increased working on a Saturday, option i (which includes premium rates for Saturday) would be particularly at risk of understating the number of hours that would be claimed for.

**B). Allowances based**

Under an allowances approach, a supplement would be paid based on the appropriate allowances level. This would reward those with the most onerous unsocial hours working patterns. Substantial changes to the intensity of work would
elicit an individual’s allowances level being changed, in line with job planning arrangements. Any additional hours would continue to be paid at base rate.

An allowances based system does not require knowledge or recording of when each hour is worked. It also supports providing a fixed salary as a ‘rate for the job’, with a distribution of additional allowances paid to those working at increasing levels of onerous unsocial hours.

In order to give higher reward to those working the most onerous out-of-hours patterns, it may be possible to incorporate savings from elsewhere in the contract to the allowances pot. Table 8 shows possible values that could potentially be included, though this would naturally limit their ability to be used elsewhere.

**Table 8: Possible sources of savings to incorporate**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saving from new consultant salary per FTE - £</td>
<td>~3.9k</td>
</tr>
<tr>
<td>Saving from future counterfactual paybill per FTE - £</td>
<td>~1.5-2.5k</td>
</tr>
<tr>
<td>Saving from national CEAs per FTE - £</td>
<td>~1.5k</td>
</tr>
<tr>
<td>Total saving per FTE - £</td>
<td>~6.9-7.9k</td>
</tr>
</tbody>
</table>

Savings from new consultant salary come from the reduced starting salary of £70k for consultants in their first five years, and could provide around £3.9k per FTE.

The future counterfactual pay bill ‘saving’ accounts for the additional cost expected to be incurred when modelling pay bill based on the future, rather than current, staffing distribution. This would depend on updated workforce planning assumptions, but may be in the region of £1.5-2.5k per FTE.

Changes to national CEA rates could go towards around £1.5k per FTE.

Table 9 shows an illustrative example of how payments could be spread across different notional levels. The definition of the different levels is flexible to design options. It would also allow for recalibration of payment amounts based on job planning results if there was a significant shift in consultants moving up or down levels.
Table 9: Notional allowances pay distribution with additional £6k per FTE

<table>
<thead>
<tr>
<th>Levels</th>
<th>% of base pay</th>
<th>Allowance</th>
<th>Agg. Allowance - £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20%</td>
<td>22%</td>
<td>£20,000</td>
</tr>
<tr>
<td>2</td>
<td>20%</td>
<td>16%</td>
<td>£15,000</td>
</tr>
<tr>
<td>3</td>
<td>20%</td>
<td>11%</td>
<td>£10,000</td>
</tr>
<tr>
<td>4</td>
<td>20%</td>
<td>8%</td>
<td>£7,500</td>
</tr>
<tr>
<td>5</td>
<td>10%</td>
<td>3%</td>
<td>£2,500</td>
</tr>
<tr>
<td>6</td>
<td>10%</td>
<td>0%</td>
<td>£</td>
</tr>
</tbody>
</table>

If an additional £6k from savings elsewhere in the contract was made available, Table 9 shows a possible distribution of this across out-of-hours levels, making it possible to provide allowances of up to £20k for those with the most onerous out-of-hours working patterns.

C). Allowances and hours hybrid

A hybrid of the two previous suggested approaches is also considered. Under this system, premium rates would be paid for Sundays and Bank Holidays at time-and-a-half, along with further allowances for on-call/unpredictable activity after 10pm each night.

The first element is derived from the frequency of on-call and is given by 4/n, where ‘n’ equals the individual consultant’s on-call frequency. ‘4’ is used as the numerator here to reflect the maximum weekend frequency that would normally apply. Individuals on a 1:4 weekends would thus get 100 per cent of this element. Less frequent duty would be reflected in a lower percentage of this element.

The second element is determined by the likelihood of the consultant being required to be on site after 10pm. It would be for each trust to determine how much of the available allowance was attributed to each specialty group based on local knowledge of activity levels.

As an example these categories could equate to:

- a. High: on site for > 3 hours after 10pm on 50 per cent of on calls
- b. Moderate: on site for > 3 hours 10 – 50 per cent of on calls
- c. Low: rarely on site for > 3 hours

Illustrative examples can be provided with further development of design of hybrid system.

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