



Observations and comments on the DDRB consultants' contract review

Introduction

The DDRB published their report into seven-day working and consultant contract reform on the 16th July 2015. This paper looks at the observations the DDRB have made and the issues they raise for hospital consultants and specialists.

The DDRB consider their report and observations a road map of what could and should be achievable in the interests of everyone with a stake in the NHS.

Their full list of observations is in the appendix attached to this document.

We hope that this document will generate local debate on the issues that can be fed back to the HCSA Executive Committee so that we can work with both Government and employers to ensure the NHS continues to provide a safe, efficient and quality service to patients whilst at the same time recognises that hospital consultants and specialists should have a safe environment to work in and one that provides excellent career opportunities that are properly remunerated.

The DDRB process

The DDRB used the following six criteria to guide their observations in an attempt to balance a number of important factors:

- Improved patient care
- Maintaining respect and trust for consultants and junior doctors as leaders and professionals
- Credibility and practicality of local implementation
- Appropriate remuneration (in order to recruit, retain and motivate)
- To help facilitate constructive, continuing relationships
- Affordability

DDRB review

1. Seven-day service

The issue of seven-day services revolves around the so-called "opt-out clause," schedule 3 paragraph 6, which allows consultants to decline non-emergency work outside core hours. Both the Government and employers want to remove this clause from the consultant contract.

The DDRB position

"In our view, the current 'opt-out' clause in the consultant contract is not an appropriate provision in an NHS which aspires to continue to improve patient care with genuinely seven-day services, and on that basis, we endorse the case for its removal from the contract."

"We support the inclusion of safeguards within the contract; and that the contract should include a specific reference to the safeguards on hours and rest contained within the Working Time Regulations, or any successor legislation. The wording contained within the contract should make clear that compliance is mandatory. The parties will also wish to consider any reasonable work-life balance issues when discussing safeguards."

HCSA comment

The HCSA has always supported the notion that any seven-day service must have a raft of safeguards built in to the consultant contract that provides a working environment that is safe for doctors and that work-life balance is not compromised.

Whilst the details have yet to be worked out and agreed, the DDRB has also supported this view, which is a positive step in the right direction.

2. Pay

On the issue of pay and pay progression the DDRB have endorsed the NHS Employers proposal for a revised pay system. Essentially their proposal would reduce the number of thresholds/pay points from the current system that takes 19 years for a consultant to reach the top of the pay scale to a system where the top of the scale is reached in five to six years based on successfully achieving performance objectives through an appraisal process. The proposals suggest a two to three-point pay scale, based on the following:

- Consolidation year (ie newly appointed)
- Early appointment
- Established consultant

HCSA comment

The salary levels proposed will be the subject of negotiation and should take into account the impact on recruitment and retention.

Notwithstanding the eventual salary levels agreed, the HCSA believes that moving through a salary scale quicker could be beneficial for consultants both in terms of salary and could provide a new entrant consultant a protected period to gain experience and competences with gradual exposure to additional responsibilities.



3. Payment for working unsocial hours

The DDRB considered the proposals from NHS Employers on unsocial hours payments. These included an hours-based system, an allowance-based system and a hybrid of the two.

The DDRB position

"Whatever model is used, the guiding principle should be that it is designed around the needs of the patient and what needs to be incentivised, balanced against the benefits of having a simple system to administer."

The report comments on the length of Programmed Activities during premium time, appropriate rewards and incentives to those specialties that will need to operate most heavily during unsocial hours, and what should constitute unsocial hours.

The definition of unsocial hours that the DDRB suggested was common in other sectors was 10pm-7am. It was observed that some public-sector workers such as police superintendents do not receive unsocial hours payments and work the hours as part of their professional salary arrangements.

The DDRB also observed that employers must be alive to the fact that working unsocial hours may diminish with age.

HCSA comment

It is clear from the report that more data is needed on the current level of unsocial hours worked. This is something that should be highlighted as negotiations progress.

Another important issue is the DDRB's reference to working age – an area that the HCSA specifically mentioned in our submission. We are pleased that the DDRB has agreed with our position on this matter, which we know is extremely important to many of our members.

DDRB review

4. Allowance for undertaking certain additional roles

NHS Employers had indicated that allowances should be available for “established” consultants who undertook roles with additional responsibility.

The types of roles that might be covered would include formal medical management roles, formal teaching roles, research leadership, formal clinical governance and assessment leads. These roles, NHS Employers suggested, would be locally agreed.

The DDRB position

The DDRB “noted the lack of detail in the evidence on this aspect of the contract proposals, and hope that the allowance can be used flexibly to ensure that all such additional roles are appropriately remunerated.”



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5. Clinical Excellence Awards (Local Awards)

NHS Employers had originally provided evidence to the DDRB on their proposals for performance-related pay. They proposed:

- ▶ payments would be based on an individual’s objectives and where overall achievement was identified as ‘above and beyond’ the standard expectations of the job
- ▶ that achievement should be more challenging
- ▶ three category awards would be considered – Individual, Team, and Organisation.
- ▶ a pot (of available funding) should be distributed to all consultants deemed to have met the required level of excellence with full consultation with the workforce
- ▶ a cap would also be placed on the amount that any one individual could receive in a single year
- ▶ the assessment process could be overseen by peer managers with measures put in place to ensure the approach was fair and transparent

The Department of Health suggested performance-related pay should be integrated into the pay system and reward those making the greatest contribution as individuals or teams.

HCSA comment

The HCSA supports the notion of payments for achieving excellence and has for some time been calling for the system to be reviewed. We support the move to integrate a future system into the contract to ensure its long-term stability.

Transitional arrangements

6. Clinical Excellence Awards (National Awards)

The DDRB support the continuation of national CEAs and say that the value of national CEAs will need further consideration.

The DDRB position

The DDRB “support consideration of the domains for national awards, to ensure that any payments made for achieving excellence in national awards do not reward achievements that in the future would be separately recognised by local payments for excellence. We note that the intention is for national CEAs to remain pensionable.”

“NHS Employers and ACCEA appear to have different views as to what should happen to the funding released from the national pot, following the re-calibration of national CEA values: either to increase the pot for performance pay, or to bolster the number of national awards.”

HCSA comment

This question will need to be addressed in any further negotiations.

The DDRB observe that rather than moving forward with a “big bang” approach to contract reform, an option would be to implement reform in two stages – first removing the “opt-out” clause to allow seven-day services to progress and, second, dealing with the other elements of contract reform as more information becomes available.

It suggested that issues aside from the opt-out clause could be progressed at different speeds, as appropriate, but urged that a timetable should be set for agreeing all changes of six to 12 months

NHS Employers proposed the following transitional plan:

- ▶ a period of shadowing of key provision at selected early implementer sites
- ▶ a period of early implementation to gather real data in real time
- ▶ a recalibration of the pay rates and allowances to ensure there was no windfall financial benefit for employers or taxpayer, and no overspend on the financial neutral requirement of the negotiations; and
- ▶ a full roll-out to the rest of the service

The DDRB added: “It will be important to model the proposed pay arrangements so that the numbers of winners and losers, and particularly the extent of winners and losers, can be ascertained.”

HCSA comment

It is clear that much more data is needed to model future assumptions.

The HCSA can bring a fresh approach to these discussions and will be meeting with Ministers in the near future to set out how we believe the HCSA can inform future negotiations.

Appendix: The DDRB's observations

In summary, our observations on the elements of the proposed consultant contract reform are as follows:

➤removal of the 'opt-out' clause: in our view, the current 'opt-out' clause in the consultant contract is not an appropriate provision in an NHS which aspires to continue to improve patient care with genuinely seven-day services, and on that basis, we endorse the case for its removal from the contract; we consider that the consultant contract should support patient care at the weekends, whether through direct consultant presence or through supervision of junior doctors, as a point of principle;

➤the inclusion of contractual safeguards: we support the inclusion of safeguards within the contract; and that the contract should include a specific reference to the safeguards on hours and rest contained within the Working Time Regulations, or any successor legislation. The wording contained within the contract should make clear that compliance is mandatory. The parties will also wish to consider any reasonable work-life balance issues when discussing safeguards;

➤pay progression to be linked to achievement of excellence (assessed at appraisal): we are able to endorse the proposal for progression to be linked to achievement of excellence (assessed at appraisal), although we wish to stress the importance of employers being properly resourced and supported to implement an appraisal-based incremental system;

➤basic pay 'spot rates' based on recognised stages of a consultant career: we consider that this should be the subject of further negotiation between the parties, but we would support either a two or three-point pay scale; the value of pay points should be subject to further negotiation between the parties, and should be rooted in a robust evaluation of recruitment, retention and motivation;

➤separate payment for working unsocial hours: whatever model for rewarding unsocial hours working is used, the guiding principle should be that it is designed around the needs of the patient and what needs to be incentivised, balanced against the benefits of having a simple system to administer. We observe that the proposed unsocial hours definitions are in line with practice in other sectors, and also in health services internationally. In line with our criterion 3 (credibility and practicality of local implementation) we ask that employers remain alive to the fact that ability to work unsocial hours safely may diminish with age;

➤an allowance for undertaking specific additional roles: the proposal for an allowance for undertaking specific additional roles would allow the types of roles that we intended to be covered by the principal consultant grade to be recognised in pay and we therefore (in line with criterion 4 for appropriate remuneration) support this proposal. We have, however, noted the lack of detail in the evidence on this aspect of the contract proposals, and hope that the allowance can be used flexibly to ensure that all such additional roles are appropriately remunerated, as per our criterion 4;

➤RRPs to incentivise certain specialties/regions: we would like to see the parties adopt a more flexible approach to encourage their wider use to address recruitment issues: for example, when RRP are paid, they need not be paid to every consultant in that trust in that specialty, although we recognise that this may be difficult to implement in practice. Of course, the parties may also wish to explore non-pay solutions to recruitment problems, such as sabbatical type leave or professional development;

➤reforming local CEAs as payments for achieving excellence and making such payments contractual: as the proposed approach will directly reward performance with targets linked to the objectives of the employing organisation, of consultant teams and of individuals (and given our criterion 3 for the credibility and practicality of local implementation) it will be essential to the successful implementation of an appraisal/objective-based performance pay system that employers and staff are properly resourced, trained and supported to deliver the new scheme. In our view the objectivity of the assessment, competence of those making it and buy-in of Consultants will need to be supported by national guidance and supported by appropriate local management capacity and training. We consider a more appropriate name would be 'payments for achieving excellence' to reinforce the stretching nature of objectives;

➤continuation of national CEAs: we support consideration of the domains for national awards, to ensure that any payments made for achieving excellence in national awards do not reward achievements that in the future would be separately recognised by local payments for excellence;

➤pensions: given the recent changes to the annual and lifetime pension allowance, it will be important for employers to provide appropriate flexibility for doctors in managing the new allowances;

►contractual changes for SAS doctors: we consider it important that SAS doctors are treated in an even-handed way, and should have their opportunity to input into negotiations: those discussions should be given priority;

►Consultants in Wales: the parties in Wales appear to be in agreement that negotiation is the best way forward and we support this; and

►clinical academics: we support the proposal for further work to ensure that academic careers remain attractive. We consider that pay structures for clinical academics should not inhibit the ability for staff moving in and out of such roles, which will also support the recruitment/retention elements of our standing terms of reference.

We also make the following general observations:

►read across to the observations made by the NHS Pay Review Body: we observe that definitions of core time/unsocial hours given to us in evidence differ to those given in evidence for the Agenda for Change groups. We observe that a common definition of core time/unsocial hours should be applied across all NHS groups.

If the definition needs to differ between groups, then a commonly understood rationale would be required;

►impact of seven-day services on pay: we observe that there needs to be a greater level of common understanding between the parties on what the proposals for seven-day services will actually mean in practice for patients and the working lives of staff, noting that one size will not fit all; rather than moving forward with a 'big bang' approach to contract reform, an option would be to implement reform in two stages: firstly, remove the 'opt-out' clause to allow seven-day services to progress; and secondly, deal with the other elements of contract reform as more information becomes available. These other elements could be progressed at different speeds, as appropriate, although we consider that a timetable should be set for agreeing all changes, say 6 to 12 months. This would be based on shared assumptions about career paths to inform pay modelling and the use of pilots to test and check impacts on the NHS, its staff and patients;

►transition costs: we question how realistic it is for new contractual arrangements, including transition costs, to be delivered within the current pay envelope;

Our observations on consultant contract reform above apply to England and Northern Ireland, as the proposals were formed on that basis. As indicated above, we consider that the Welsh Government and BMA Wales should enter negotiations on reforming the consultant contract in Wales. Scotland has not sought any observations on contract reform, as its approach to seven-day services is firstly to establish sustainable service models, before considering next steps with the parties, including the BMA. Nevertheless, the parties in Scotland may wish to consider our observations and come to a view as to whether or not they would want similar arrangements to apply in Scotland. As with junior doctors, we consider that the future is best served by a national contract, and that it should apply in all four countries of the UK, but accept that the Scottish Government wishes to consider matters further with the BMA. As there are several issues that still need to be resolved by the parties, we would hope Scotland would want to continue to be a part of those discussions. We ask the parties to report back to us on the outcome of the future discussions and negotiations. As ever, we stand ready to assist in any further work necessary.



**Hospital Consultants
& Specialists Association**

Number 1, Kingsclere Road, Overton,
Basingstoke, Hampshire, RG25 3JA

Tel: 01256 771777

Fax: 01256 770999

E-mail: conspec@hcsa.com

Website: www.hcsa.com