HSJ LOCAL briefing

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THE RENEGOTIATION OF JUNIOR DOCTORS' CONTRACTS

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

shaun.lintern@emap.com
@ShaunLintern

In brief

Issue It is more than 12 years since the current junior doctors' contract was put in place in an attempt to reduce excessive working hours for trainees and ensure the NHS was compliant with the European Working Time Directive. More than a decade on, the contract has succeeded in its aim but is now perceived by NHS trusts and doctors' bodies as no longer being fit for purpose. The government is expected to give NHS Employers a mandate in the next few months to begin talks on renegotiating the contract in full with a view to implementing the deal by April 2014.

Context With more than 52,000 doctors in training working in the NHS, with a total pay bill of approximately £3.3 billion, renegotiating the junior doctor contract is a significant project. It is agreed by both sides that the existing contract can no longer be relied on to deliver the training and education needs for trainees and it is too heavily geared towards working hours and pay. Junior doctors remain sceptical of the government's intentions following the NHS reforms and pension changes, while employers face increasing financial strains which cannot be ignored.

Outcome In forthcoming negotiations the government will seek to try and remove the expensive and unpredictable banding supplements while boosting the basic pay for trainees, but a balance will need to be struck in order to reward those working predominantly antisocial hours. Doctors will seek improvements to training for juniors but they will need to accept pay progression being linked to competencies and skills. The negotiations will not be completed in time to meet the April 2014 deadline set by the health secretary Jeremy Hunt.

A new world and a new problem

Many hospital consultants working in the NHS today will be able to describe the experience of working 100-hour weeks and seemingly never ending night shifts when they first began their careers.

That kind of gruelling shift pattern was seen as a rite of passage for trainees who would see a greater numbers of patients for longer than they do today and gain all important frontline experience.

Before 1991, there were no limits on trainee doctor hours. The Review Body on Doctors' and Dentists' Remuneration report in 1986 talked of average 86-hour weeks. Some juniors worked 100-hour weeks or worse.

In 1991, a first step was made to reduce excessive working hours with the New Deal contract and this was followed by a second New Deal contract in 2000.

The New Deal

The New Deal was conceived to ensure junior doctors' hours were compliant with those demanded by the European Working Time Directive. In 2007, working hours were limited to 56 hours a week and then reduced to the current 48 hours a week by August 2009.

The contract was also meant to ensure minimum rest breaks and working conditions for the trainee workforce.

Simply put, the contract financially punishes NHS trusts that make doctors work longer hours, or more unsocial rotas through a system of banding supplements added on top of their basic pay for those working antisocial hours.

The banding involves basic salary being boosted by a supplement of 20 per cent to 100 per cent depending on how far from the normal working week the rota is. It is based on the average working week for all staff on the rota rather than an individual medic.

The current contract demands a 75 per cent compliance rate for most working limits across a rota. However, when it comes to maximum length of duty in a single shift or minimum length of time off between shifts, hospital rotas must be 100 per cent compliant.

If a breach of these limits takes place, even on just one occasion, it can make the whole rota non-compliant. As a result, all the doctors on that rota would be paid the highest band three, 100 per cent, supplement – a significant financial penalty for NHS organisations.

The cost of such a breach will vary between rotas and trusts but there have been examples of organisations having to spend an extra £250,000 a year for a group of eight trainees after one breached the hours limit.

Impact of the New Deal

The contract has been successful in achieving a reduction in excessive hours. According to NHS Employers, since 2007 only one per cent of the workforce were in receipt of band three, 100 per cent, payments.

This is while the number of doctors in training has increased every year for the last 11 years, growing by 5.1 per cent in 2008, 1.1 per cent in 2009 and an average 4.5 per cent on the previous 10 years.

There are approximately 52,200 doctors in training, including registrars, according to the NHS Information Centre's latest data for September 2012.

But while junior doctors have benefited from a reduction in hours this has meant overall the level of pay has fallen.

Complaints about training

There remains a debate around the quality of education, training and ultimately whether junior doctors are adequately prepared with the skills and competencies they will need later in their careers. Many doctors complain of difficulties in being able to attend training due to the demands of their job.

To protect themselves from spikes in pay NHS trusts have moved to rigid shift patterns and resident on-call rotas, where the doctor is present on the hospital site throughout the shift, in order to comply with the rules. But this has led to complaints by trainees who often are unable to make training sessions because of work demands. This has led to a feeling of isolation among some junior doctors and less of a team working approach.

While the current contract is heavily focussed on the hours, rest and pay for trainees it does not place the same emphasis on the training the same doctors receive.

In his Time for Training report in 2010, Sir John Temple said the effect of the contract on working patterns "can have a serious impact on training opportunities".

Reopening the debate

In December the government accepted a scoping report on the future of the junior doctors' contract by NHS Employers which recommended a full renegotiation of the contract. Both employers and doctors' bodies accepted within that report that the contract is no longer "fit for purpose".

A mandate to begin talks is expected within the next two months and health secretary Jeremy Hunt has given the date of April 2014 for any deal to be implemented in his formal response to the review body reports in December.

While both employers and the

HSJ LOCAL briefing

hsj.co.uk/briefing January 2013

THE RENEGOTIATION OF JUNIOR DOCTORS' CONTRACTS

British Medical Association accept a new contract is needed, there are significant differences between the two sides, with trust a key issue.

In the past year the dispute with the government over pensions resulted in the first industrial action by doctors since the 1970s. The changes particularly hit junior doctors, while the Health and Social Care Act and efficiency savings have also contributed to a deteriorating relationship between Whitehall and the medical profession.

One negotiator told HSJ: "Juniors are feeling the most put upon because of the changes to pensions, NHS reforms and pay freezes and they have been the most forthright in their opinions.

"I don't think employers are lying when they say it's not about saving money and we know the government is quite prepared to impose a contract; but we have to take the suggestion of a renegotiation in good faith and assume the government is doing the same.

"They have tried very hard to convince us saving money is not their aim."

One employer source added: "Trust is key, we have attempted to reassure [the BMA] that the objective is not about saving money. The aim is to renegotiate it within existing resources."

NHS trusts say they want to see greater local flexibility to set their own terms within a national framework, but the BMA's junior doctors committee wants to retain a national prescriptive approach.

Banding is the key

There has been concern about the banding supplements the New Deal contract puts in place for a number of years.

In 2009 and again in 2010, the Review Body on Doctors' and Dentists' Remuneration said pay for juniors should be restructured to place "less emphasis on the banding multipliers" but it backed away from making recommendations, instead saying contract negotiations were the best route.

For junior doctors banding supplements can be problematic and lead to some perverse payments. One doctor could earn considerably more than a colleague due to how the rota is written rather than their duties or responsibilities.

A doctor working 48 hours a week, working nights one in every four weekends, will be paid the same as one working nights every other weekend.

Meanwhile, a doctor in training who also moves into a position with a higher responsibility but a less intense working rota can see their pay fall.

Banding makes up a significant amount of pay for junior doctors and is a key criticism of the existing contract. Its complexity and occasional perversity can lead to poor relationships between the workforce and management, especially because it is such an important element of pay.

NHS Employers is also concerned the existing contract encourages doctors to work longer hours.

Pay bands are broken down into those working under 40 hours, those working under 48 hours and those working under 56 hours. Within this there are then allowances for the frequency of out-of-hours shifts and on-call responsibilities.

It can result in a doctor working 47 hours being paid the same as one working 41 hours a week. Meanwhile, a rota which overruns by just one hour can lead to a large supplement having to be paid to all the doctors, which is unpredictable and a challenge for trusts.

The NHS Employers scoping report cited one example of a trust which reported an extra £250,000 cost for an eight-person rota over six months because one person breached the banding limit on just one occasion. This has led to many trusts imposing rigid shifts to protect themselves from unexpected costs but which can be to the detriment of training.

One employer source told HSJ: "We have to begin to recognise that there is a difference between people who work three weekends in four and who work nine to five.

"Banding spikes the pay bill for employers which is difficult for them, and for juniors it is quite hard to plan and know what they will earn.

"This can be difficult for mortgage applications, for example, as that will only be based on your basic pay."

The scoping report highlighted that as junior doctors have seen the number of hours they work fall, their level of pay has gone down as well compared to previous generations. The current average banding supplement paid to doctors across England is 45 per cent of their basic salary.

The doctors' representatives want to ensure they are fairly paid for the work they do. For employers, reducing payments is seen as an indication that the contract is delivering in its aims. They do not want the system to encourage doctors to work overtime.

While basic pay for junior doctors is judged to be favourable by employers, given the level of recruitment and staff retention, the BMA believes basic pay for those on a 40-hour week is poor compared to other professions, particularly for the foundation year trainees. They have been repeatedly hit in recent years with the loss of onsite accommodation, increased student debt, pension contributions, and costs of training and registering with professional bodies.

The effect of banding is clear when you examine the basic pay rates of junior doctors. For April-June 2010, according to the NHS staff earnings estimate, a foundation year one doctor had a basic pay rate of £22,600 but their average total earning was £32,300 – a 42.5 per cent increase on basic pay as a result of banding.

Foundation year two doctors had a basic pay rate of £29,400 but a total earnings average of £42,200, though this was down by 2.5 per cent on 2009.

Registrar doctors had a basic salary of £38,700 but with the banding increases their total average earnings reached £57,800.

The two sides' objectives

Employers want to see a shift away from banding payments towards a more substantial basic pay for trainee doctors and a removal of the band three payments entirely. This will encourage a more flexible approach, they claim, and by linking pay progression to competencies it will place a focus on training and education.

HSJ was told NHS Employers would seek a "slight shift" upwards in basic pay: "We need to strike a balance between paying for work done and a level of basic pay for all staff. All of the monitoring – the system that we have at the moment involves diary cards and endless monitoring – is costly, outdated and less necessary than it was."

Junior doctors themselves want greater stability and an improved quality of life, with more advanced information about their next placements and rotas to enable them to plan their lives more effectively.

Although trainees should be given at least six weeks' notice of their next job rotation and work pattern, some have complained it can be much

HSJ LOCAL briefing

hsj.co.uk/briefing January 2013

THE RENEGOTIATION OF JUNIOR DOCTORS' CONTRACTS

shorter with no guarantee of being close to families or partners, which puts a strain on their personal lives.

Giving greater flexibility in the way leave, travel and relocation is managed could help to improve relationships between organisations and their doctors and ultimately the quality of patient care.

One way to achieve this kind of stability could be the provision of centrally held contracts lasting throughout the length of the particular training programme. Currently rotations last just six months and each employer will issue contracts for that placement. This is thought to be one suggestion the doctors side could make during the talks.

But within the contract doctors receive pay protection while in post, with working hours monitored twice a year. If work intensity increases then pay rises, but if work intensity and bandings decrease then pay protection ensures salary does not fall below the protected level while the doctor remains in the same post. Pay is protected at the level in place immediately prior to the band reduction.

This pay protection leaves trusts nervous about issuing such long running contracts that could lock in years of pay protection.

But there could be room for manoeuvre here if the overall pay system is shifted more towards basic pay and away from the banding supplements.

The BMA and its junior doctors committee will not sign up to a deal which would see an overall reduction in pay for the junior doctor workforce. A source close to the talks said as a minimum the contract changes would have to be cost neutral.

Reducing banding supplements but increasing pay would improve doctors' pension positions as banding supplements are not pensionable and under the government's reforms from 2015 doctors will move to a career average pension rather than a final salary one. This means pay in the early years of training is more important than it historically was.

But as one doctor told HSJ, this is a double edged sword because an increase in basic pay would also mean an increase in monthly ongoing pension contributions and junior doctors already feel they have been unfairly affected by the pension changes brought in by the coalition.

Doctors will have to weigh different proposals within the contract against each other but with no specific proposals on the table yet how this will work is far from clear.

HSJ was told: "There has to be something in the round for [doctors] to go forward. There has to be a definite benefit for the majority of junior doctors. If our terms and conditions are worse than they are today that would be a no.

"We will look at what is proposed but we have been clear no group should be disadvantaged as a result of the changes."

The likely outcome

For employers any new contract must be affordable and easier to administer. They will not support a contract that is less flexible than existing arrangements.

Costs cannot be overlooked and while employers have said the motivation for contract talks is not a move to try and find savings, the pressure on the NHS budget and the pay bill dominates the landscape and will inevitably feature in the talks.

While overall the contract budget may remain broadly the same, employers will want to remove anything they feel can no longer be justified, such as the band three supplement.

If employers risk a dispute with doctors and seek a wholesale reduction in costs in an attempt to make savings they know they have a growing workforce coming through the training pipeline. By 2025 the Department of Health has estimated there will be 27,000 more doctors than currently working in the NHS. It has already cut training numbers this year and we know that by 2020, according to the Centre for Workforce Intelligence there will be 2,000 more consultants than jobs in the NHS. These statistics could embolden employers to risk a raid on the junior doctors' contract.

HSJ has been told by representatives on both sides that a new contract will not be ready by April 2014.

While the government could attempt to force the speed of the negotiations, ultimately such an attempt could alienate the medical profession further and lead to the collapse of talks. A contract imposition would likely ignite the junior doctor workforce and could lead to industrial action.

A senior figure at the BMA said: "It's never been done that quickly before. It's a lot of work to do a full contract negotiation and it could require a ballot of members and even non-members. It just isn't a realistic timetable to have it completed and ready to implement by April 2014."

HSJ understands initial talks could begin as soon as February or March.