HSJ LOCAL briefing

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THE FUTURE OF THE NHS CONSULTANT CONTRACT

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 The government has instructed NHS Employers to negotiate with the British Medical Association on changing the contract for consultants working in the NHS. It wants to limit their pay progression, possibly to create a new principal consultant grade, increase consultant care on weekends and evenings, and reduce the cost of clinical excellence award schemes.

Context Ten years after the consultant contract was last negotiated, the NHS is facing significant financial and operational challenges. NHS England says it faces a funding gap of £60bn by 2025; the 60 per cent rise in the number of consultants, predicted by the Centre for Workforce Intelligence, will add £2.2bn to the NHS pay bill.

Outcome A heads of terms agreement outlining the scope of discussions is likely to be signed within weeks and negotiations could begin later this year. There is little appetite for the idea of a principal consultant on both sides of the negotiations. Employers will seek a way to further restrain consultant pay.

Renegotiation of a 'something for something' deal

Former health secretary Alan Milburn proclaimed the 2003 contract for NHS consultants as a "something for something deal". But did the NHS get the "something" it was promised?

Ten years on, the health service faces a financial squeeze. This has resulted in renewed questioning of whether the contract offers value for taxpayers. A renegotiation of the contract is on the cards, although the British Medical Association is cautious about sitting down at the bargaining table with NHS Employers.

The relationship between the BMA and government has taken a severe turn for the worse following attacks on doctors' pensions, a three year pay freeze and the NHS reforms.Despite this, heads of terms have already been agreed for junior doctors where there is more common ground around problems with contract and could be agreed for consultants within weeks, HSJ understands.

The case for change

The independent Doctors' and Dentists' Remuneration Body in December recommended a series of changes to the way consultants are paid and also suggested amending the clinical excellence award scheme. Ministers accepted the body's report and instructed NHS Employers to seek talks based on the DDRB recommendations, with an ambitious target of implementing a new contract by April 2014.

The remuneration body said it would like to see a break in the current eight point pay scale for consultants. The scale sets out consultant pay levels from the starting salary of £75,249 up to the maximum £101,451. For the first four years of service pay rises annually up to point five, which is worth £84,667, and then it rises every five years. Consultants continue to receive inflationary pay rises alongside the incremental pay points.

Under the body's plan, a break in the pay scale would be achieved through the creation of a new grade of "principal consultant". Ten per cent of consultants would be in this grade at any one time. Although pay progression is technically linked to performance the DDRB found it was in fact almost "near automatic" and very few increments were ever withheld.

The DDRB wants to see slower pay progression through the first five pay points, meaning it will take doctors longer to earn their increases. For general consultants, these would be held up to a maximum of approximately £84,000. A principal consultant would receive a 10 per cent increase from whichever pay scale point they are promoted from, up to a maximum of £120,000.

So while the majority of consultants will see a slower pay progression, thereby holding down pay, and only a small proportion – the principal consultants – will have the chance to earn more, this would give others an aspirational role to aim for.

The principal consultant grade

HSJ understands there appears to be little appetite from all sides for the creation of a principal consultant grade but NHS Employers has publicly said there does need to be pay restraint for doctors.

As described above, the progression through the pay scale would be slower for most consultants with the maximum pay held at about £84,000 while principal consultants would earn salaries up to a maximum of £120,000. This group would only account for 10 per cent of the workforce, meaning 90 per cent would be held on lower salaries.

Pay linked to performance

HSJ understands there will be a push to link pay progression more closely with performance. Employers will look to expand the provision of consultant care at evenings and weekends – something that is unlikely to go down well with the British Medical Association.

The board felt clinical excellence awards, which cost the taxpayer about £500m a year, were treated as an extension to the basic pay scale and not based on merit. It felt there was a strong argument for the awards to be one-off annual lump sum payments, rather than the current situation where awards are rarely reviewed and added to the pensionable salary of recipients.It said they should be held by each individual for a maximum of five years, subject to regular review and should no longer be pensionable.

The DDRB also called for a reduction in the value of Clinical Excellence Awards to a maximum of £35,000 for local awards and £40,000 for national awards, with limits on how many consultants could receive an award.

Consultants can apply for CEAs, which are administered by the Advisory Committee on Clinical Excellence Awards. National awards are paid out centrally by the ACCEA while local awards are maintained and funded by local employers.

In March, the BMA's consultant committee agreed to begin exploratory talks with NHS Employers but it has yet to commit to full negotiations. The committee has indicated it will only take part if it believes it will be in the best interests of consultants.

The 2003 contract

The negotiation of the current consultant contract, which was adopted in 2003, was the first major change in the working terms and conditions of consultants since the NHS was created. It was designed to achieve a number of objectives including better management of the consultant workforce, increasing the amount of direct clinical care, ensuring consultants prioritised NHS services before private practice and to support 24 hour, seven day working.

The Labour government was

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prepared to invest considerable money in increasing consultant salaries in an attempt to ensure the NHS got more from the workforce and to allow consultant pay to "catch-up" with comparable professions.

Workload requirements

Under the contract consultants are obliged to do 10 programmed activity (PA) sessions between 7am and 7pm on weekdays, the equivalent of a 40 hour week. If consultants wish to do private work they must first do an extra PA, or four hours, for the NHS. Trusts can also seek additional activity from consultants at an extra cost. Under the contract all consultants were made subject to a job plan, which should list all of their duties and objectives the trust expects them to meet.

The contract was initially rejected by BMA members, but when John Reid took over as health secretary he pushed for talks, although to get the deal signed compromises had to be made by the government. One of these was the dropping of the requirement for consultants to carry out non-emergency work on evenings and weekends.

The deal was adopted in October 2003. Approximately 97 per cent of consultants are on the 2003 contract.

Implementation of the 2003 contract

From its beginning the contract had teething problems, partly due to its complexity and the difficulty its implementation posed for NHS trusts at the speed the government demanded.This was hampered by an absence of effective guidance and a lack of capacity at trust level to draw up job plans and objectives for consultants in the short timescale available.

Implementation of the contract cost about £90m more than the projected £250m because the average number of PAs negotiated was 11.2, when it was expected the number would be 10.7. In addition to this, more consultants received higher on-call supplements than anticipated.

Under the contract, consultants who are available on call for emergencies out of hours receive a supplement, which ranges from 1 to 8 per cent of their salary depending on the number of nights and weekends affected and the complexity of the on-call work carried out.

A tick box exercise

A 2006 report for the King's Fund, by Sally Williams and James Buchan, highlighted these problems and quoted one HR director as saying: "We were told to implement the contract in a matter of months. There wasn't time to sit back and think 'what will we get out of it?'."

The King's Fund report found the pressure to deliver the contract led to it being viewed as a "compliance issue – a box to be ticked rather than a mechanism for change".

Ultimately the responsibility for managing the performance of hospital consultants lies with NHS trusts and crucial to the success of this is effective job planning.

National Audit Office report

In its report Managing NHS Hospital Consultants, published in February this year, the National Audit Office found there was "significant room for improvement" in the way consultants are managed. The NAO also found 16 per cent of consultant job plans had not been reviewed in the past 12 months and 17 per cent of consultants had not had an appraisal in the past 12 months.

It also said only 18 per cent of trust job plans contained SMART – or specific, measurable, achievable and agreed, realistic, timed and tracked – objectives. Meanwhile, only 56 per cent of trusts said consultant job plans were aligned with the trust's strategic aims; a third of job plans had been rolled over without review in the previous 12 months.

Despite specific links between performance and pay progression in the contract, less than a third of trusts told the NAO pay progression depended on consultants meeting the objectives set in either their job plans or appraisals. Under the contract this would mean pay progression would automatically take place.

In its recommendations on changing the consultant contract the DDRB concluded "near-automatic progression" was "not typically a feature of any of the professional roles we use for comparators at this level".

The contract was aimed at increasing the amount of direct patient care that consultants delivered but the NAO found the amount of direct clinical care, both paid and unpaid, in 2012 was just 64 per cent of their total time.

Consultant productivity

Another area of focus is whether the contract had any impact on consultant productivity. This is a difficult outcome to measure and there is a lack of robust data available. According to the NAO, consultant productivity fell by an average of 0.2 per cent a year from 2003 to 2010.

To arrive at these figures, however, the NAO accepts it used crude data on finished consultant episodes (FCEs). An FCE essentially measures the time a patient spends under the care of a particular consultant.

But there are significant limitations to this when you consider the increasing complexity of patients who often have numerous comorbidities in an ageing society. If a consultant spends more time caring for a patient their productivity may fall but he or she may actually be delivering better care, ultimately saving vital NHS resources.

One study by researchers at the University of York did adjust FCEs for case mix and severity of patients in 10 surgical and medical specialties over the period 1999-2009. This showed a statistically significant negative trend, or reductions, in FCEs per consultant in five areas and concluded the contract changes had not led to an increase in consultant clinical activity.

However, it is widely accepted that consultants undertake considerable unpaid work beyond their contracted hours. Approximately 90 per cent of trusts told the NAO most consultants in their trust work beyond what they are contracted to do.

Affordability and the NHS

The NHS is facing a £60bn funding gap by 2025, according to NHS England, and the 60 per cent rises for consultants by 2020 predicted by the Centre for Workforce Intelligence will add £2.2bn of cost.

The Department of Health has said NHS pay accounts for more than 40 per cent of NHS revenue expenditure and that between 2001-02 and 2011-12, it made up 45 per cent of the overall increase in revenue.

For the government and employers, managing the pay bill is a route to ensuring the NHS can free up resources to meet the rising pressures and funding gaps on the horizon.

Consultant pay

According to the NAO, between

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2002-03 and 2003-04, the bottom of the consultants' pay band, at the lowest pay scale, increased by 24 per cent and the top by 28 per cent. Between these dates total earnings per full-time equivalent consultant had increased by 12 per cent in real terms.

The median average annual total earnings of consultants between October 2011 and September 2012 was £109,000.

NHS Employers believes the current situation is not affordable. However, the BMA says the impact of pay freezes and inflation has reduced the level of earnings in real terms back to that when the contract was first introduced in 2003.

Incremental drift

On average, incremental pay progression for all doctors can result in an individual salary increase of between 3 and 8 per cent per year, according to NHS Employers. But when examining the total effect of pay drift on the overall pay bill the result for all doctors in 2011-12 was negative, a drop of 0.7 per cent. Pay drift was also negative in 2010-11 by 1 per cent. The reasons for this are thought to be staff turnover as those on higher pay levels retire and are replaced by staff at the lower end of the pay scale.

This led the DDRB to conclude the recruitment and retention of consultants was "not a major concern". The DDRB compared the total earnings range for consultants with a string of "comparator professions" and concluded the median total earnings were above the 95 percentile for those in the wider economy.

Morale and workload

A BMA survey on workload and morale for the DDRB in 2012 was sent to 2,000 consultants with about a third, 656, responding. According to the union, 70 per cent of the consultants said morale was lower while an increasing number say the intensity and complexity of their work is rising.

While the BMA freely admits in its evidence to the DDRB that the surveys it relies on are from a small sample, it does maintain the view there is a "weakening commitment to an NHS career", which could exacerbate any recruitment and retention issues in future years.

However, the larger number of doctors in training does give NHS Employers some strength in the negotiations. Basic supply and demand means times have changed and the NHS knows it won't struggle, in the main, to fill vacant consultant jobs in future years.

Getting a consultant post in the NHS is likely to become increasingly competitive to the benefit of employers. However, pushing for a tougher deal could also impact on the number of doctors who choose to work abroad or in the private sector rather than the NHS.

Working 24/7

One of the biggest targets for NHS Employers in negotiations is to bring about an increase in seven day working across the health service. Employers argue it is a myth to suggest you will need substantially more doctors to deliver a seven day service – a claim often cited by clinicians. It is not about doing more work but doing what is already done differently, they argue.

NHS England medical director Sir Bruce Keogh has been a strong advocate for moving the NHS to a 24/7 service with consultants present on NHS wards.

A study of 14 million hospital admissions found patients admitted on a Saturday or Sunday were at greater risk of dying within 30 days. Mortality risk increased 11 per cent on Saturdays and 16 per cent on Sundays.

The BMA supports the idea of a greater proportion of consultant level doctors providing more out of hours care.

Under schedule 3 of the contract, consultants can refuse non-emergency work between 7pm-7am. This is something employers will seek to change, certainly with respect to emergency and urgent care.

Some trusts have already used the job planning process effectively to introduce more of a consultant presence on their wards during evenings and weekends and so this is possible, although complex, under the existing agreements.

Conclusions and outcomes

The NHS has to tackle the question of affordability but some trusts have failed to implement the 2003 contract adequately. Greater flexibility, stronger performance management and an ability to limit pay progression are all available to employers under the existing rules but have not been implemented adequately.

NHS Employers will have to demonstrate why better implementation of the existing deal would not achieve the results it wants. The BMA has to accept consultants are on a good deal but it is likely to vigorously defend its members' benefits.

In a modern era of social media and 24 hour news, issues under negotiation are likely to spill into the public domain and the BMA will have to take account of public opinion and the willingness of doctors to take any form of industrial action. The bulge in workforce numbers by 2020 could add strength to the employers' bargaining position. However, the morale and recruitment of doctors needs to be considered in the long term.

Meanwhile, the level of public outrage over poor care and interest in the Francis report, and the government's determination to apparently tackle the issues, can't be ignored. Heads of terms for negotiations are likely to be agreed within months and negotiations could start later this year. The suggestion of a principal consultant is unlikely to materialise out of any negotiations but there will be an attempt to limit pay progression further.

Any success for NHS Employers on this issue will lead to future potential changes to the Agenda for Change framework to ensure other staff groups work alongside consultants at weekends. This will make service transformation a more realistic possibility and given the challenges facing the NHS this is likely to be a prize the health service cannot fail to win.