

Scoping report on the contract
for doctors in training – June 2011

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1. Executive summary

- 1.1 In response to a request from the Review Body on Doctors' and Dentists' Remuneration (DDRB), the NHS Employers organisation has undertaken a scoping exercise to review the viability of the current contract for doctors in training.
- 1.2 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 below consultant level, including both years of foundation training and all the subsequent years of specialty registrar training. For the purposes of this report, the terms "doctors in training" and "junior doctors" refer to doctors across all these training grades.
- 1.3 The views of a wide range of NHS employers across the UK were obtained with regard to the contract.
- 1.4 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 (referred to as the "JDC" throughout this report). We have incorporated their views into this document and reflected on these when drawing our conclusions. However, we and the BMA would like to note that this is not a joint report and its conclusions are those of NHS Employers.
- 1.5 A vision and principles for a 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 between doctors, employers and deaneries).
- 1.6 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.
- 1.7 However, there were varied views on some of the strengths and weaknesses of the current contract and how a future contract should be designed. In general, employers in England favoured a more flexible, locally determined approach within an overall national framework, while the BMA JDC advocated comprehensive nationally applied standards to ensure consistency. Employers in the devolved administrations also supported nationally applied standards.

- 1.8 The current context for reform was considered. Three broad options for reform were set out and evaluated:
- no change
 - amending the current contract
 - full renegotiation of the contract.
- 1.9 In this report, we argue that no change will result in retaining a contract which all parties agree is no longer fit for purpose. Amending the contract has the potential to address some of the problems, and would allow negotiation around currently known parameters, but will leave many problems unaddressed and could possibly undermine any future negotiation on the contract. A full renegotiation would be the most demanding option, but would allow the contract to be fully redesigned around the current context, the actual needs of the service and the training needs of the doctors.

2. The scoping study

- 2.1 The Review Body on Doctors' and Dentists' Remuneration (DDRB) has for some time been encouraging the four administrations to commission a review of the pay and conditions contract for doctors in training. Their 38th report in 2009 said,¹

"For a number of years, we have felt that the parties should give consideration to restructuring junior doctors' pay to place less emphasis on the banding multipliers. [In 2008] the BMA said that it wished to begin talks in earnest by August 2009, and we gave our support. ... We were told that serious discussion would begin early in 2009. We welcome this news and ask the parties to update us on progress for our next review."

- 2.2 It was this encouragement, and also awareness of employers' own disquiet over the punitive nature of the contract, the burden of monitoring and the financial risks and changing context for the pay banding system, that motivated the health departments to commission NHS Employers to study the effectiveness of the current contractual arrangements. In oral evidence to the DDRB late in 2009 the Department of Health said that it saw the juniors' contract as a key area for reform and that progress would be made early in 2010. The DDRB welcomed this sign of commitment to reform and asked the parties to update them for their next review.
- 2.3 The DDRB continued to support the review of the contract in their 2010 recommendations. The DDRB considered making recommendations that placed greater emphasis on basic pay with corresponding reductions in banding multipliers. However, they stated that they believe *"...that the most appropriate route for addressing [the contractual arrangements of doctors in training] is via contractual negotiations that we expect to follow the current scoping study on the juniors' contract."*²
- 2.4 The Secretary of State for Health in the coalition Government requested that this work be taken forward in the light of the findings of *Time For Training*, the report by Professor Sir John Temple.³

¹ Review Body on Doctors' and Dentists' Remuneration, Thirty Eight Report 2009, CM 7579, paragraph 7.14

² Review Body on Doctors' and Dentists' Remuneration, Thirty Ninth Report 2010, CM 7837, paragraph 6.16

³ Time for Training: A Review of the impact of the European Working Time Directive on the quality of training. Medical Education England, June 2010. <http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf>

- 2.5 An interim report was submitted by NHS Employers to the four health departments in early February 2010 detailing the findings of this work to date.
- 2.6 The views of employers, the British Medical Association (BMA) and the British Dental Association (BDA) had been obtained with respect to:
- pay
 - other contractual requirements
 - aspects relating to the employment and training of doctors and dentists in the hospital
 - principles for possible new arrangements.
- 2.7 The study draws on the views of a broad range of stakeholders. Employers, the BMA and the BDA have all engaged fully in the consultation process. We are grateful to them for their time and contributions.
- 2.8 An extensive UK-wide employers' consultation exercise was conducted. A series of focus groups were held to discuss the contract, including one with the BMA and one with the BDA. These involved chief executives, human resources directors, medical directors, medical education experts, medical staffing personnel, finance and payroll specialists.
- 2.9 The study considered the strengths and weaknesses of the current contract and reviewed the issues that have emerged for employers and for doctors and dentists in training (referred to as "doctors in training" or "juniors" in much of this report).
- 2.10 The study established a strong case in principle for change. There are strengths to the current arrangements, but significant weaknesses have also been highlighted. There is a strong view, particularly among employers, that the contract is no longer fit for purpose.
- 2.11 Broad options for reform are explored further in this report.
- 2.12 A vision and a set of priorities which should underpin any new arrangements were also established; see section 4 for more details.

3. The current contract

- 3.1 The current contract was agreed in 2000, at a time when doctors in training were working excessive hours. It was based upon the New Deal agreement of 1991, which was specifically aimed at reducing actual and contracted working hours and providing adequate rest periods, but which had not at this point been fully enforced. The reduction of excessive working hours was also greatly influenced by changes in the UK Government's approach to the European Working Time Directive (EWTD) and its inclusion in UK Health and Safety legislation as the Working Time Regulations 1998. After 1997, the Government recognised that EU working time limits would apply in the UK, and would eventually be extended to doctors in training, but subject to a deliverable transition period after 1998. (For ease of reference, the most common acronym "EWTD" is used throughout this report to refer to the limits set out in the European directive and enacted via the UK regulations.)
- 3.2 Prior to the introduction of the New Deal agreement in 1991, there were no limits on the working hours of doctors in training. At the time the agreement was being negotiated, 22 per cent of doctors were working rotas more onerous than one (night) in three, and the average hours of work across all specialties was 86 hours per week.⁴ The New Deal agreement between the Government, the NHS and the BMA in 1991 was designed to remedy this situation, by introducing limits on hours, minimum rest breaks, and other measures to improve the working conditions of hard-pressed doctors in training such as standards for accommodation and catering.
- 3.3 By 2000, although progress had been made, compliance with the hours and rest requirements was still some way off. At this point the new employment contract was introduced to drive forward compliance with the New Deal limits. This contract – the current contract – transferred doctors to a detailed system of banding, designed to pay more for greater numbers of working hours and more unsocial working patterns. In this way the contract for employment incentivised employers to limit doctors' hours.⁵
- 3.4 The New Deal contract was designed to be punitive, in order to address the "hard core of problems" that remained.⁶ The punitive nature of the payments was intended to lead to robust monitoring to identify pressure points. It also provided a strong incentive towards introducing sustainable solutions to underpin future compliance with EWTD.

⁴ Review Body on Doctors' and Dentists' Remuneration, Sixteenth report (1986), cited in BMJ. 1991 Oct 26;303(6809):1050-2. Junior doctors. The new deal. The negotiating perspective. Valley S. Royal Victoria Hospital, Belfast.

⁵ "The objective of the contract is, over time, to reduce the hours worked by junior doctors." (AL(MD)1/2001)

⁶ EL(97)2, The New Deal on Junior Doctors' Hours: The Next Stage

- 3.5 Junior doctors' out-of-hours work under this contract is paid based on broad bands related to total hours and work intensity. Working patterns which are under 40 hours on average between 7am-7pm on weekdays do not attract banding. Working patterns between 40 and 48 hours per week on average will attract bands 1A (50 per cent addition to basic pay), 1B (40 per cent addition to basic pay) or 1C (20 per cent addition to basic pay) depending on the frequency of out-of-hours work. Working patterns between 48 and 56 hours per week on average attract bands 2A (plus 80 per cent) or 2B (plus 50 per cent) depending on frequency of out-of-hours work. Any rotas above 56 hours per week, or which breach any of the New Deal compliance limits, for example rest breaks or shift length, will attract band 3 (plus 100 per cent).
- 3.6 Band 3, the penalty pay band, was put in place to enforce compliance with all aspects of the New Deal. This penalised any substantive breach of the hours or rest limits, whether related to insufficient natural breaks, doctors working beyond the maximum shift length, or excessive average hours.
- 3.7 One particular incentive for employers to reduce hours quickly was a 'banding escalator' which meant that the bandings rose in percentage value over the first two years of the contract. The escalator rose by stages until 1 December 2002, when the bandings reached their current levels.⁷

Band	1 Dec 2000	1 Dec 2001	1 Dec 2002 onwards
3	62% (1.62 x basic salary)	70% (1.7)	100% (2.0)
2A	50% (1.5)	60% (1.6)	80% (1.8)
2B	42% (1.42)	42% (1.42)	50% (1.5)
1A	42% (1.42)	42% (1.42)	50% (1.5)
1B	30% (1.3)	30% (1.3)	40% (1.4)
1C	20% (1.2)	20% (1.2)	20% (1.2)

- 3.8 New Deal banding is applied to a working pattern (rota), rather than to individual doctors. The working pattern is assessed across all the participating doctors in training, as this is considered the most efficient and reliable method. It means that a snapshot of data can be taken across the whole rota, rather than having to assess each doctor for the entire duration of the rota cycle. This also allows any individual variations to be balanced out across the rota, to achieve more stable and reliable results. However, this also means that any changes in banding will apply to all doctors on that rota.
- 3.9 Most of the New Deal compliance limits require compliance on 75 per cent of occasions. This means that occasional breaches of those limits will not result in punitive band 3 payments, unless the threshold is reached. However, the limits on maximum length of duty period and minimum length of time off duty must be compliant one hundred per cent of the time to avoid Band 3 payments. A single breach of these limits during a monitoring period can make the whole rota non-compliant, resulting in Band 3 being paid to all the doctors on the rota. This can happen if a doctor stays at work late or starts early.

⁷ Table from Junior Doctors Contract Part A: A General Guide to the New Pay System

- 3.10 There has been considerable success in achieving compliance with the New Deal. Fewer than 1 per cent of doctors in training in England are now in receipt of band 3 payments, and this has been the case since 2007.
- 3.11 This system was tailored very specifically to the doctors' working patterns, at least as these predominantly existed when it was designed. For example, the New Deal explicitly recognised aspects of a junior doctor's working life, such as non-resident on call, which are not recognised by the EWTD. The use of financial penalties to drive change successfully contributed to considerable reductions in working hours across the country, and hours were subsequently restricted still further by the EWTD.
- 3.12 Although the Working Time Regulations came into force in 1998, the first stage of their application to doctors in training began in 2004, with the introduction of the full EWTD limits on rest and breaks, and the capping of maximum average hours at 58 per week. In August 2007, the limit on working hours was reduced to an average of 56 hours per week, and in August 2009 it was reduced to 48 hours.
- 3.13 The SIMAP (2000)⁸ and Jaeger (2003)⁹ judgments in the European Court of Justice added significantly to the hours and rest restrictions under EWTD, defining all resident on-call time as actual work, and requiring that any compensatory rest must be taken "immediately".
- 3.14 The EWTD (health and safety) limits are not the same as the New Deal (contractual) limits, and both sets of rules have to be observed. In *Time For Training*, the report on the impact of EWTD on medical training in England,¹⁰ Professor Sir John Temple noted that New Deal had improved pay and conditions, but he raised concerns over the way in which the New Deal and EWTD rules now interact to constrain working patterns, and stated that this "can have a serious impact on training opportunities".¹¹ While it is possible for an individual to opt out of EWTD limits on overall hours of work, this opt out cannot be required by the employer, and anybody opting out will still be constrained by all of the New Deal limits, as well as by service need, affordability and employer agreement.
- 3.15 The current contract for doctors in training is, due to its original purpose, an hours-based rather than a professional contract, and it has highly detailed connections between hours, rest and pay. The system has ensured that doctors can be paid correctly for the number and pattern of the hours they work, and the use of punitive pay to incentivise changes to working patterns has successfully resulted in reduced average hours of work. However, at the same time it has created opposing financial incentives for employers and doctors in training. This has led to strains in the employment relationship within workplaces. The New Deal has contributed to substantial change in the number and pattern of doctors' working hours and working conditions since the agreement was formed in 1991, and doctors' working hours and minimum rest are now also restricted

⁸ Judgment of the Court of 3 October 2000 in case C-303/98, Sindicato de Médicos de Asistencia Pública (SIMAP) v. Conselleria de Sanidad y Consumo de la Generalidad Valenciana, ECR 2000, p. I-07963

⁹ Judgment of the Court of 9 September 2003 in case C-151/02, reference for a preliminary ruling:

Landesarbeitsgericht Schleswig-Holstein (Germany) in the proceedings pending before that court between Landeshauptstadt Kiel and Norbert Jaeger, ECR 2003, p. I-08389.

¹⁰ *Time for Training* - see footnote 3.

¹¹ *Time for Training*, p.26 – see footnote 3.

by the Working Time Regulations. In this context it is necessary to consider whether it is still appropriate that the overriding emphasis of these doctors' employment contract should still be on the detailed control of hours and rest breaks, rather than the work and training that takes place within those hours.

- 3.16 The next section will therefore review what the purpose and principles of the employment contract for doctors in training should be in 2010, in order to assess whether the current contract can fulfil that vision.

4. The vision

The vision – the five key points from stakeholders

4.1 This study has found a remarkable degree of congruence among stakeholders of what our vision for pay and contracts for doctors in training should be. Broadly that vision is that the contract for doctors in training should work towards achieving the following aims:

- better patient care and outcomes
- doctors in training feeling valued and engaged
- affordable
- produces the next generation of medical professionals
- improves relationships (employers with juniors, juniors with deaneries and deaneries with employers).

The purpose of pay and reward

4.2 The purpose of any pay and conditions system is to enable the employer to recruit and retain the correct number of staff with the correct mix of skills to provide for the requirements of the employer's business.

4.3 In the case of doctors in training, the pay and reward system needs to also provide for the training and development of the next generation of medical professionals.

4.4 A significant difference which affects medicine as a career is that entry to the profession is rarely driven by a desire to earn the wages of a junior doctor. Rather, to the extent that there is a financial driver for entrants to medical schools and subsequently into the training grades, it is a longer-term vision of the career rewards available for doctors at more senior levels of the profession, such as general practitioners, consultants and specialty doctors.

4.5 However, the purpose of having an effective contract for doctors in training can be more succinctly expressed as making sure that in both the short and long term, patients receive high-quality services from doctors skilled, able and motivated to provide those services.

4.6 In addition to the pay and contractual issues there is a range of related workplace issues that arise from the current contract which cover behaviour and interaction between employers and doctors in training. Any new arrangements should seek to improve relationships and the quality of working life for doctors in training, their clinical managers, and their employers.

4.7 The key issues that doctors in training raise, fall into five broad areas:

- stability – certainty about the details of their placements and earnings
- travel and relocation, and the flexibility to vary this where necessary
- leave – annual, study and other forms of leave and how this is managed
- facilities
- involvement, clarity and simplicity.

4.8 Doctors in training believe that addressing these would improve relationships and the quality of their working lives. By improving the working lives of doctors in training it should be possible to improve the quality of patient healthcare.

The principles

4.9 A set of principles which should underpin any new arrangements emerged from the employer discussions. These say that any new arrangements should:

- reward appropriately - ensuring that the overall reward package (including pay, pensions, career opportunities, education and training, and job security) remains competitive and attractive and rewards doctors in training fairly, equitably and consistently in accordance with their value to organisational service delivery
- be affordable for employers
- consider a range of potential comparators in developing new pay arrangements, including external professional groups, non-medical professional groups within the NHS and other medical staff with a view to ensuring that any new arrangements are based on appropriate comparisons
- incentivise appropriate overtime and patterns of working hours while being consistent with the EWTD
- link pay progression to progress through the training programme and the achievement, and effective application of, competences rather than be based on time served in employment
- comply with employment legislation
- seek to be more straightforward to apply and administer than the existing contractual arrangements
- harmonise education, training and service delivery needs
- recognise the need for doctors in training to attain competences through training and that achievement of these is dependent on participation in service delivery
- minimise the need for pay protection; in addition, any protection should be wholly justifiable and non-discriminatory
- facilitate good working relationships between employers, doctors and dentists and other staff and promote a professional ethos for this group of staff

- ensure that employers are able to effectively manage doctors in training, applying the same organisational and governance standards as for other employees
- assign all responsibilities for the contract to the employing organisation, thus removing any supra-employer requirements.

5. Consensus for change

- 5.1 At a series of focus groups and other meetings and events, employer representatives were asked for their views. The JDC representatives were also asked for their views on the strengths and weaknesses of the current contract for doctors in training, and a wide-ranging discussion took place on what a new contract could look like. There was an overall consensus that while the current contract has some strengths, it is no longer suitable for the current environment.
- 5.2 The following sections will examine and compare the views of employers and the JDC in more depth, in relation to the various aspects of the existing contract.

UK-wide contract

- 5.3 Both employers and the JDC continue to support a UK-wide contract. The current contract was negotiated in 2000 as a contract for the whole of the UK, and this is seen by both employers and doctors in training as a strength of the current contract, in that it promotes career mobility, fairness and equity. Throughout their training, a doctor in a recognised training grade may work in different parts of the UK. Having a uniform contract across all four nations ensures that individual doctors are able to move between locations as demanded by their training without detriment or significant change in their terms and conditions of service. This is particularly important in some of the smaller specialties.
- 5.4 Employers recognise that the labour market is both national and international. The JDC likewise considers that any changes to the current contract should be negotiated and implemented on a UK-wide basis. Such an approach is seen as a way to ensure fairness and equity for doctors in training and also to ensure each area of the UK is able to attract sufficient doctors to work and train. While there can be subtle differences in the precise contractual provisions among the four nations, this should normally be in relation to the differences in the set up of the health services in those countries. There should be no substantial differences in the key principles in the contracts in the four nations.
- 5.5 However, views on what a UK-wide contract should cover tend to vary considerably between employers and the JDC. Employers in England, in general, favour a degree of local autonomy and flexibility within a national framework, while the devolved administrations and the JDC tend to favour a more centrally prescriptive arrangement with limited room for flexibility at employer level.

Remuneration

- 5.6 The current contract, designed to provide an incentive to employers to reduce excessive working hours, has been successful in reducing average hours and has accordingly led to a decrease in the out-of-hours component of remuneration for doctors in training. Banding supplements are now usually limited to a maximum of 50 per cent of basic salary (the current average for doctors in training across England is approximately 45 per cent). Now that doctors in training are working considerably fewer hours, their average earnings have correspondingly reduced compared to previous generations.
- 5.7 Employers consider that generally the overall earnings are sufficient to recruit, motivate and retain the right numbers of doctors in training. UK medicine continues to attract the brightest students and attrition rates thereafter remain relatively low. The JDC have argued that as hours have come down, greater consideration needs to be given both to how to compensate any doctors in training who continue to work over 48 hours per week on average, and also to ensuring that those who are compliant with the Working Time Regulations are remunerated fairly. However, employers consider that the reductions in payments were designed into the system and are an indicator of success in reducing hours, and that rotas and shifts exceeding the 48 hour maximum will reduce to zero over time, including the small number of formal derogations from the EWTD which allow doctors to work up to 52 hours a week by exception until 1 August 2011.¹²
- 5.8 Employers consider that it is inappropriate for a pay system to contain provisions for additional payment for rotas which exceed EWTD limits, as this effectively discourages doctors' efforts to comply with the law. Any pay and terms and conditions system must be compliant with current legislation. Instances where rotas exceed EWTD limits without agreement from the individual and the employer should be dealt with as a breach of the working time legislation using the same recourse mechanisms that apply to all other members of staff, rather than paid as mandatory overtime. However, it may well be appropriate to agree (nationally, regionally or locally) remuneration for individuals who legally choose to opt out of the limit, in situations where there is a genuine need for extra work to be undertaken.

Basic pay

- 5.9 Basic pay for doctors in training is generally determined by UK-wide pay scales. Unified pay scales are also seen as a strength of the current contract. When pay scales have differed, for example when England stage implementation of the DDRB awards but Scotland do not, this can cause problems for those moving between the two countries. The latest DDRB recommendation again led to differences in pay for some FY1 posts.
- 5.10 Opinions about the appropriate level of basic pay are more varied. Employers consider that basic pay is at an appropriate level for this group of staff, as they are able to recruit, retain and motivate the right number of doctors and dentists to deliver their objectives. The JDC believe that, increasingly, the basic pay of doctors in training (for a 40-hour week) compares poorly with that for other professions, particularly in the earlier years of

¹² The New Deal monitoring report for 31st March 2010 showed 91.5% of doctors in England on bandings reflecting 48 hours work or less per week.

training. The DDRB's 2009/10 report takes a line between these two views, stating that the basic salaries of doctors in training are below the lower quartile for their comparator groups at each stage, although median gross earnings (including pay supplements) compare favourably to their comparators. The DDRB also notes that in other professions, graduate entrants often work many extra unpaid hours.

- 5.11 The JDC highlights the increase in posts which undertake only daytime work of 40 hours or less, and which therefore attract no supplementary pay, particularly during the first two years of training (Foundation Year 1 and 2). They state that this has had a significant negative impact on the pay of doctors in training, especially when viewed in conjunction with the increasing levels of student debt and the ending of mandatory residency on site and thus removal of most free Foundation Year 1 accommodation in England, Scotland and Northern Ireland. (The mandatory requirement for Foundation Year 1 doctors to be resident on site was removed from the 1986 Medical Act in 2007.) They also highlight the costs of training and of being a doctor (including, mandatory fees associated with, for example, professional registration with the General Medical Council (GMC), membership of a medical Royal College, examination fees, certificate of completion of training (CCT) fees and professional indemnity insurance). Given these issues, they are particularly concerned about the level of basic pay, and consider that this needs to be addressed to ensure that the NHS can continue to recruit and retain the best candidates.
- 5.12 Employers note that the staff survey shows high levels of staff satisfaction which is generally increasing among all doctors, including those in training, and that the continuing attractiveness of medicine as a career in the UK is demonstrated by rising numbers of applications to study medicine at university (just over 80,000 in the 2010 round – a rise of 14.5 per cent over the previous year). The attraction of the NHS for careers in medicine and dentistry was emphasised by a study from the UK Medical Careers Research Group at the University of Oxford reported in *bmj.com*¹³ on 3 June 2009, which showed that most British medical graduates from British medical schools practise in the NHS for many years, and that attrition from the NHS had not increased in recent cohorts compared with older ones at similar times after graduation. The study concluded that the majority of British medical graduates from British medical schools practise in the NHS in both the short and long term. Employers argue that these figures suggest current pay levels are not causing problems for recruitment and retention.
- 5.13 Employers do, however, have concerns about the way in which the pay scales are organised. They feel that the length of these incremental pay scales make the contract vulnerable to challenges under employment legislation both on age discrimination and equal pay grounds.¹⁴ They also highlight as a problem the fact that incremental progression within the pay scale is not dependent on performance, as there are no gateways or review points based on competences, as there are with other grades of doctors.
- 5.14 As a key purpose of their role is to develop competence through training, employers consider that linking pay progression directly to competences, in a way that is tailored to the role of a doctor in training, could help address some of these concerns.

¹³ http://www.bmj.com/cgi/content/abstract/338/jun02_1/b1977; <http://www.uhce.ox.ac.uk/ukmcrq/>

¹⁴ See, for instance, *Cadman v. HSE* (C-17/05, 3 October 2006) and the subsequent case of *Wilson v HSE* [2009] EWCA Civ 1074 regarding a 10 year incremental payscale.

- 5.15 The question of whether to pay doctors in training while on work breaks needs to be agreed. Work breaks are an integral part of compliance with the Working Time Directive. It would be necessary to describe what would happen were breaks interrupted for work reasons and how compensatory rest would be arranged. In most places there are already local arrangements in relation to what happens when breaks are interrupted – these may well be readily applied to doctors in training.

Banding supplements

- 5.16 The current contract is based on a few broad but sharply delineated pay bands, based on hours worked and frequency of out-of-hours commitment, which attract pay supplements and introduce variation in pay from post to post. As described above, these bandings vary from 20 per cent to 80 per cent of basic salary (and 100 per cent for band 3 rotas, designed to penalise the employer for non-compliance with New Deal). EWTD-compliant rotas will normally fall within the 20 per cent to 50 per cent pay bands. This means that the banding component constitutes a large proportion of overall earnings, which can result in significant variations in earnings across different posts and placements. The JDC report that this is problematic for doctors who wish to make future financial commitments, such as purchasing a house. It can lead to disputes between employers and employees, particularly during monitoring periods, as so much is at stake financially depending on the outcome. It can also mean that a doctor in training who progresses to a position with higher responsibility but a less intensive working pattern may experience a reduction in total take home pay.
- 5.17 Where a banding system of this sort exists, employers say that it is appropriate that earnings should reflect intensity of work and the pattern of hours. However, employers feel that the current banding system can incentivise doctors to seek to work longer hours beyond their contractual or service requirements as this attracts substantially higher supplements. The hours of work are effectively placed into three broad bands:
- under 40 hours per week
 - under 48 hours per week
 - under 56 hours per week.

These bands are then broken down into higher and lower frequency of out of hours. Both the JDC and employers have criticised 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 overruns 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.¹⁵
- 5.19 Employers, too, are concerned about the broadness 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 states¹⁶:

“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. This will be discussed further in subsequent sections.

¹⁵ Additional Duty Hours (ADHs) were supplements payable to doctors and dentists in training for additional contracted duties over 40 hours per week, up to a maximum of 32 extra hours. Almost all these doctors worked the maximum 32 hours extra as a condition of their contract. ADHs were paid at different rates depending on the working pattern of the doctor (Class 1 for full shift, Class 2 for partial shift, and Class 3 for on call).

¹⁶ *Time for Training*, pp26-27 - see footnote 3

Pay progression between the grades

- 5.22 For most professionals, progression through their career and acquisition of skills and greater responsibility is recognised through increases in pay. Employers generally view the progression in basic salary between medical training grades as fair, but the JDC questions whether it is significant enough to reflect the increase in responsibility. The banding system for doctors in training can also have a significant effect on pay progression, resulting in a doctor at a far higher grade having less take-home pay than they had at a lower grade, as it is weighted towards reflecting any change in time commitment rather than the significant increase in clinical responsibility between these grades.
- 5.23 Further, the higher levels of banding (in particular, band 2A and band 3) are so significant that it is possible for a trainee on a high banding to experience a drop in salary when they finish their training and progress to a consultant position. This only occurs in exceptional cases, but indicates the lack of continuity between the different medical grades.
- 5.24 The JDC suggests that a possible way of addressing this is to change the emphasis of pay away from banding supplements, which can vary widely from post to post, and towards either an alternative supplement or an increase in basic pay. They are aware that this has implications for pension contributions for both doctors in training and employers but feel they could not support additional costs being placed on doctors in training. Employers, meanwhile, would be reluctant to impose higher employer contribution costs without being confident that any new arrangements would deliver better training, more efficiency and better services for patients. Nonetheless both parties recognise the problems inherent in the current structure of basic pay and supplements.

Pay protection

- 5.25 Pay protection, both rotational and in-post, is built into the current contract. There are effectively two types of pay protection: salary protection, whereby a doctor who leaves a career grade to return to training can continue to be paid according to the career grade pay system; and banding protection, where the original banding continues to be paid after the work pattern has been changed and the official banding decreased.

Salary protection

- 5.26 Employers and the JDC were positive about the fact that salary protection encouraged career grade doctors to return to training. The JDC felt that this was an important incentive for those wishing to undertake further training or retrain for a different career path. Employers agreed that this also maintained service flexibility and helped to fill posts, as well as recognising experience in the grade. However, employers also felt that the process was costly, complex, and sometimes led to inequities (for instance, doctors in training being paid more than the consultants who supervised them). Some employers felt that returning to training was a career choice and therefore protection should not apply. All parties expressed concerns about the inconsistent application of salary protection across the service.

Banding protection

- 5.27 Employers and the JDC have differing views on banding protection. Employers have profound concerns about the high cost of banding protection and the way in which it is perceived to discourage and limit service changes. The perception of many employers is that banding protection requires them to pay employees for out-of-hours work which they are not undertaking. Some employers express particular dissatisfaction with the fact that even where doctors have been contracted at a compliant band, if their rota then tips into New Deal non-compliance for any reason (including a single shift overrun), they are subsequently pay protected for the whole length of their contract in that post on approximately 80 per cent banding, even if the problem is immediately resolved. This creates heavy and sustained financial consequences which employers consider wholly disproportionate.
- 5.28 However, the JDC sees banding protection as essential, at least within the current system. For them, it allows doctors to plan financially for the future. Over recent years it has also ensured that doctors in post do not experience a loss of earnings when their rotas are rebanded.
- 5.29 The issue of banding protection also underlines problems surrounding long-term stability for doctors in training. Due to the rotational nature of training, placements may last for only a few months and in most cases employers will only be able to issue contracts for the length of the current placement, particularly if the doctor is subsequently rotating to another organisation. The JDC reports that very short contracts make it difficult for doctors in training to make any long-term plans. Accordingly, the JDC suggests that centrally held contracts, lasting for the duration of a training programme, could be considered as part of contract negotiations.
- 5.30 However, employers are seriously concerned about the financial consequences of issuing such long-running employment contracts, which would need to cover several different posts with different employers and might detail bandings for each post, even though these could reduce during the course of the contract. Under the current arrangements, where employers reduce the banding of a rota, such long-term contracts could lock employers into years of pay protection at the higher rate. As protection prevents any decrease in pay, but would not prevent banding from being increased via monitoring, employers are extremely concerned about the potential for the inflation of pay costs.
- 5.31 The parties' strongly held views about banding protection, and its financial implications, reflect the fact that, as noted above, out-of-hours banding is currently a large component of the salaries of doctors in training, and banding protection therefore has substantial financial implications for employer and employee.

Complexity of pay protection arrangements

- 5.32 With various different contractual clauses for pay protection, the calculation of pay protection is extremely complex and administratively burdensome. All parties see this as a weakness in the current arrangements. There have been differing interpretations as to how protected payments should be calculated, and the calculation of pay protection can cause disputes between employee and employer which can undermine workplace relationships.

Working patterns and hours of work

Intensity of work

- 5.33 The JDC has argued that the decrease in the number of hours worked by the same number of doctors in training means that they are required to work more intensively. They also believe that doctors are more likely to be on an unsociable rota in order to ensure compliance with the EWTD, in addition to working more intensively while at work.
- 5.34 Employers, however, note that the number of doctors in training has increased every year for approximately 11 years, growing by 5.1 per cent during 2008, 1.1 per cent during 2009, and an average increase of 4.5 per cent over the preceding ten years. This represents an unprecedented growth in the number of doctors in training. This has arguably made it possible to spread the work more evenly and less intensively. As noted earlier, before 1991 at least 22 per cent of doctors were working out of hours more frequently than 1 in 3, with an average of 86 hours per week, whereas such high frequency and hours of work is now virtually outlawed by both EWTD and New Deal.
- 5.35 The word “intensity” can, of course, be used in different ways with reference to doctors’ working hours. In the context of New Deal it normally refers to the frequency and unsociability of out-of-hours work. However, doctors often also use the word “intensity” to refer to their levels of activity during their working hours. It is important to keep these definitions distinct, especially because the first is reflected in the contract while the second is not. The business and complication of the work may in some cases not have changed significantly, but the staffing levels available to carry out the work may be affected by the rigidity of current shift patterns.
- 5.36 It is also suggested that if the recommendations in the Temple report for a consultant-delivered service were taken forward, this might have a beneficial effect not only on training but upon the levels of staffing during standard working hours. However, the affordability of this approach would need to be considered.

Recognition for working unsociable hours

- 5.37 Both employers and the JDC highlighted problems within the current contract in recognising those who are working a rota with an especially unsociable working pattern. They feel this should be considered in any changes to the contract. For example, a doctor working up to 48 hours per week with 1 in 4 weekends will be paid the same as a colleague working 1 in 2 weekends. The JDC in particular does not feel that the current contract protects juniors from high frequency of out-of-hours work and feel that this should be more fairly distributed and rewarded. The use of a single banding for a range of different on-call frequencies is, of course, also a feature of the consultant and specialty doctor contracts, but in those contracts the out-of-hours supplement makes up a far smaller proportion of overall pay.
- 5.38 While the majority of specialties involve out-of-hours commitments as part of the training programme, there are a range of views on whether out-of-hours work should be required for training in all specialties, and how much out-of-hours commitment is essential. This will need further discussion with the medical profession, particularly following the recommendations in the Temple review of the quality of training.

Rota design

- 5.39 Working unsociable hours, the intensity of work while on duty and shift frequency can in combination have a detrimental impact on work-life balance. Overall hours have reduced to achieve compliance with the EWTD. However, the JDC reports that many doctors in training feel they are still experiencing working patterns that are detrimental to their health and to their training. Employers meanwhile feel that the reduction of average working hours has mainly led to a better work-life balance for doctors in training compared to resident on call with unacceptably extensive hours.
- 5.40 The JDC feels that in the push to change rotas by 1 August 2009, the newly-designed rotas often failed adequately to consider doctors' educational requirements. If that is the case, then it is likely that, regardless of the contract, rotas need to be better organised and managed. However, the combined New Deal and EWTD restrictions will naturally limit, to a greater or lesser extent, the working patterns which can be put in place while being affordable and predictable for costs. There has also been a tendency to establish rigid shift systems as reported by Professor Temple.
- 5.41 Good rota design is essential in ensuring that both the needs of the service and the educational needs of doctors in training are met. The JDC believes that the involvement of doctors in the design of their own rotas is something that needs to be addressed through contractual mechanisms. Employers, while agreeing that staff should be involved in the process as good employment practice, would not necessarily want to codify that involvement in the pay and conditions contract. Nevertheless there is consensus that the involvement of those working the rotas improves the rota design. This was also highlighted as an important issue within the Temple Review.

Flexible training (less than full time training)

- 5.42 Both employers and the JDC have expressed support for changes made to flexible (less than full time) training in 2005 as outlined in the NHS Employers document *Principles Underpinning the New Arrangements for Flexible Training*.¹⁷ The JDC highlighted that all doctors can apply for flexible training and every application should be treated positively. They also strongly supported the expectation that the number of less than full time trainees will increase. Employers felt that current arrangements were equitable and agreed with the JDC that properly applied pro-rata pay had made it easier to accommodate less than full time trainees.
- 5.43 However, both also felt that there were problems in areas of the 2005 arrangements. Employers were concerned about the cost of employing less than full time trainees, particularly in supernumerary posts, given that the deaneries only fund basic pay and not banding. This can lead to cost pressures when there is no funding or service requirement for the doctor in training to work out of hours but this is still required for training purposes. Although supernumerary doctors in training could be particularly costly, employers also reported that slot shares are sometimes hard to fill, leaving them with gaps in cover or a dependence on expensive locum cover. There was also concern that

¹⁷ http://www.nhsemployers.org/SiteCollectionDocuments/doctorstraining_flexible_principles_cd_080405.pdf

the guidance was not always clear about the employment and remuneration of less than full time trainees.

- 5.44 The JDC's primary concern was with the lack of integration of less than full time training into mainstream training, due to the organisation of less than full time training and their separate contractual arrangements. This can make less than full time trainees appear "different" rather than being doctors in training who work different hours. The JDC felt that integration should be promoted through the use of slot-shares, the development of permanent part time posts, guaranteed equality of access to study leave, access to out-of-hours working and other employment rights and protections, including the right of timely return to appropriate work from maternity leave.
- 5.45 The 2005 arrangements put in place a number of mechanisms for collecting data on less than full time training. The JDC has raised concerns over the implementation of data collection, which they feel is not adequately accurate to identify and rectify problems within the less than full time training arrangements.
- 5.46 The arrangements in *Equitable Pay for Flexible Medical Training*¹⁸ implemented a pro rata structure in pay, which aligned the pay and pay banding for less than full time doctors in training more accurately with that of full timers. However, employers and the JDC were concerned about the complexity of these pay calculations, and the high level of expertise needed to ensure doctors in training were paid correctly. There was concern that this could again increase the likelihood of employer/employee disputes.
- 5.47 In summary, both parties generally support the principles of less than full time training but see a number of weaknesses in the implementation of these principles that need to be addressed.

GP and dental trainees

- 5.48 While the contract provides a consistent set of terms and conditions for most junior doctors, some distinct groups of medical and dental trainees are not included within its provisions. Vocational dental trainees working in dental practices are not included within the provisions of the contract. And GP Specialty Trainees (GPSTs) when working in general practice currently have only a model contract which is both independent of the contractual terms and provisions for the rest of the cohort of medical trainees, and lacking some of their provisions.
- 5.49 This means that the terms and conditions for such trainees are not equivalent to those of other junior doctors.

GP Specialty Trainees (GPSTs)

- 5.50 GPSTs, unlike other groups of medical staff, have no universally agreed terms and conditions and no formal joint negotiating committee. The BMA view is that a local negotiating mechanism for GPSTs has not proven necessary and that this can be covered nationally by the BMA General Practitioners Committee (GPC) and local issues dealt with by the regional constituencies of the GPC and the GP Trainees subcommittee. At the

¹⁸ <http://www.nhsemployers.org/PayAndContracts/JuniorDoctorsDentistsGPRReg/Pages/DoctorsInTraining-FlexibleMedicalTraining.aspx>

same time, GPSTs are given a flat 45 per cent supplement to bring their pay in line with the average salary of hospital trainees. This supplement was introduced for recruitment and retention purposes, and differs from hospital doctors' banding in that it is not assessed against their working pattern; unlike the banding supplement payable to most hospital trainees it does not necessarily reflect the hours and intensity of the work done. The variability of out-of-hours work and the lack of requirement to monitor were raised as both positive and negative issues by the GP specialist trainees. The discussions also noted that recruitment is not currently a particular problem for GP training, but that the incentive structure of the pay system needed to be reviewed. Like the JDC, the GPC specifically highlighted the problems around the definition of intensity, and how this should be rewarded.

- 5.51 It may also be valuable to consider the viability and desirability of single lead employer arrangements for GP trainees, and whether this could usefully incorporate GP trainees onto the same contract throughout as that used for hospital trainees. During the discussion with the GPC and London Deanery the use of lead employer arrangements was suggested as a potentially helpful way to provide consistency and expertise in contracts and pay for these doctors. It was noted that in such an arrangement, employment would be kept separate from the educational process, and many saw this as an advantage, separating the responsibilities of the employer from that of the trainee, and allowing both trainer and trainee to focus on training. The GPC emphasised that the strong relationship between the trainer and trainee needed to be preserved.

Vocational dental trainees

- 5.52 The BDA focus group, which consisted of dental trainees and BDA representatives, made very similar points to those made by the JDC, but also emphasised the need to support recruitment and retention in maxillofacial and restorative dentistry. The group called for clarification of how vocational training fits in with the rest of the training system, coherent and integrated terms and conditions which nevertheless recognise the difference between dentists and doctors, and clarity on who actually employs the dental trainee.
- 5.53 A review of the contract should examine the equity of pay and conditions for GPSTs and dental trainees, and consider properly integrating these with the pay and conditions of the rest of the junior doctor workforce. It should also aim to clarify the employment relationships for these trainees.

Assessment of hours and pay

Monitoring

- 5.54 Monitoring is undertaken (typically on a twice-yearly basis) to verify the actual hours that are being worked by doctors on a particular rota. This is in order to ensure that these hours are reflected correctly in pay, and is a requirement of the current banding system. It has also contributed to ensuring that natural breaks are provided even where there are high levels of intensity in the work pattern.

- 5.55 The current contract obliges employers to perform regular monitoring exercises and obliges doctors in training to participate in these exercises. Employers feel that these mechanisms are administratively burdensome and often ineffective and report that doctors often appear unenthusiastic about undertaking regular monitoring processes. While the current banding system is reliant on monitoring, the JDC regards the monitoring and related appeals mechanisms as essential safeguards for doctors in training. For instance, they particularly highlight the use of monitoring to ensure that natural breaks are taken.
- 5.56 Both employers and the JDC highlight difficulties with collecting and analysing data. These can cause significant problems in calculating the banding supplement to which doctors are entitled. The JDC is concerned that monitoring can often be given a lower priority when competing for resources in busy medical staffing departments. This can be seen as exacerbating the problems for employers and doctors in complying with the contractual obligations for monitoring. Deadlines for monitoring data are not always met by either doctors or employers (for instance, the JDC reports that doctors often do not receive notification of monitoring results within 15 days). Employers report difficulties obtaining valid returns from doctors where doctors are not likely to benefit, and while it is possible to take disciplinary action against doctors who fail to complete monitoring returns, most employers are reluctant to do so, and it is thought to be impractical given the transient nature of doctors in training.
- 5.57 Monitoring is a complicated system, and all parties feel it is vulnerable to inaccuracy and also to potential "gaming". Employers are concerned about the impossibility of verifying accuracy where diaries have been retrospectively completed, and also about the potential financial incentive to misreport hours. Some issues raised by monitoring such as marginally insufficient rest breaks are exceptionally difficult to validate but can have major financial consequences. The JDC, conversely, reports that doctors in training are frequently pressurised to understate their hours on monitoring returns. The JDC reports that some employers also carry out monitoring at times that are not reflective of normal working practices, or ask juniors to leave earlier than is normally possible.
- 5.58 Both parties' viewpoints reflect a deep dissatisfaction with the way in which the diary monitoring process highlights conflicting interests, and with the frequent disputes which arise between employers and doctors in training over the validity of diary monitoring results. Given the opposing financial interests of the parties and the sensitivity of the system to small variables, the perception that results are open to being manipulated by the other party (whether or not this is actually happening) can in itself be deeply damaging to the employment relationship.
- 5.59 However, despite issues with the practicalities of monitoring, the JDC sees the link between monitoring and pay as an essential part of the current contract. They state that if carried out correctly, monitoring ensures that doctors in training are paid correctly for their worked hours, helps employers to justify changes to pay as a result of monitoring, and provides a transparent mechanism to deal with inevitable disputes.
- 5.60 Employers are more reluctant to maintain the monitoring process. They consider that it fails to encourage professional ways of working; that it is reliant on statements by doctors in training about their working hours which (except in Northern Ireland) are not

subject to independent validation, leaving it open to criticism by auditors; that it makes it more difficult for employers to change working patterns; and that it imposes too much of an administrative burden. They also find it unhelpful that it is subject to two different sets of rules, New Deal and EWTD. They also argue that other staff groups are not required routinely to monitor their working hours.

- 5.61 There will be a continuing need to monitor the hours of staff who have opted out or derogated from the 48-hour limit, or who are at risk of non-compliance with the EWTD, and the New Deal monitoring exercises are currently used as an effective proxy. However, unlike New Deal, EWTD is not linked to pay, and it would be possible that under a redesigned pay system, monitoring might not need to form such a critical element in pay determination. As EWTD compliance is a requirement for all employees, not just doctors in training, it might be appropriate to have a harmonised system for monitoring any staff who are at risk of breach.

Rebanding protocol

- 5.62 Under the current system, any changes to banding take place via a structured rebanding protocol, which is designed to ensure that such banding changes are appropriate, accurate and involve the necessary people. The process requires consultation with the majority of current/incoming post holders which contributes towards doctor engagement in the process. There are also key provisions to ensure that educational needs as well as service provision are taken into account. The process is required to be signed off at the end by the Regional Action Teams (RATs), or their equivalent, to confirm that the process has been completed correctly.
- 5.63 All parties generally agree that under the current contract this process provides fairness and consistency. The JDC is particularly positive about the rebanding mechanism and the fact that it requires junior doctor engagement and educational approval. However, there are differing views on the involvement of the RATs. The JDC reports that the involvement of RATs is viewed extremely positively by doctors in training, with a lot of support for such bodies to continue in the future. Employers, however, do not generally support the involvement of external bureaucracy in the rebanding process. Most employers tend toward the view that agreeing contractually permitted amendments to local working patterns and pay should be within the employer's authority, rather than involving external oversight on each occasion. In addition the RATs are not all still in existence.

Rebanding appeals

- 5.64 All parties also agree that the rebanding appeals process provides fairness and consistency, allowing doctors in training a fair hearing and ensuring transparency. The JDC particularly welcomes the fact that the banding appeals process provides an incentive for problems to be resolved before they reach the actual appeal stage.
- 5.65 However, again there are differing views on the need for supra-employer involvement. Employers do not welcome the involvement of external bodies (the RATs and their successor bodies), preferring an internal process and the ability to develop local procedures. They also feel that the panel is often too heavily made up of doctors in training. The JDC, however, says that it is extremely important to doctors in training that there is both outside representation and doctors in training on the panel, to ensure that

the outcome from appeals panels is seen to be fair and equitable. The JDC believes that the reduction in RATs and the increase in internal processes has resulted in an increase in conflict and a growth in employer/employee disputes. They support the maintenance of external involvement in the appeals mechanism, and argue that the maintenance of such provisions in Scotland has led to fewer disputes. Employers consider that this approach takes what should be an internal employment process and places it in the hands of external groups.

- 5.66 The banding system and the appeals process are lengthy and complex. All parties feel that this complexity is a weakness of the current system. Employers and the JDC highlight that it can lead to adversarial working relationships, conflict and ill feeling between employer and employee. Employers also point to the administrative burden of these processes and feel that they are overly time consuming.
- 5.67 In summary, all parties broadly feel that the appeals mechanism is a good process for the current banding arrangements. However, there are differing views about the role of independent representation, and the process has some weaknesses, notably the complexity and the length of the appeals mechanisms and the adversarial relationship that can result.

The employment relationship

- 5.68 Doctors in training have a dual role as both trainees and service providers, but in their service role are seen as professional members of their clinical team. Employers feel that the contract should seek to reflect this balance, rather than emphasising the difference between doctors in training and other NHS staff.
- 5.69 However, it is recognised that, as the JDC notes, doctors in training are unique in the medical workforce as they move employers far more frequently than other doctors, have different responsibilities, and can have multiple managers or organisations to report to. The provisions in the current contract can cause dispute on a wide range of issues including pay, banding, travel and relocation expenses, study leave and expenses and annual leave. All parties express concern over the problems this can cause between employer and employee from the outset of the employment relationship, and they emphasise the need for any contract change to help foster collaborative working relationships.

Knowledge about future employment

- 5.70 Doctors in training above Foundation Year 2 have both a training contract with the deanery, which covers their training scheme over a number of years, and an employment contract with the individual employer with whom they have been placed. Where a single lead employer arrangement exists, doctors in training will hold the same contract for the entire period of their appointment as a specialty/specialist registrar (StR/SpR), although this may not specify the details of all their placements; where there is no single lead employer, wholly new contracts are normally issued for each new placement, which will change on a 3-12 month basis.

- 5.71 While the training contract may last for several years, doctors in training are not usually told of all the posts in their training scheme in advance. These may be set out on an indicative timetable, but will often be adjustable in order to take account of particular training needs. The JDC regards this state of affairs as unhelpful, as it limits doctors' ability to plan their lives and finances. Employers say that under the current system it is not practically or financially viable to guarantee doctors in training' posts so far ahead, given the changing training provisions and changes within the training programme. This could potentially also guarantee the New Deal pay banding for all the doctor's posts across several years and under a range of different employers, leading to large-scale pay protection and restricting the flexibility of training programmes and out-of-hours service cover.
- 5.72 All parties acknowledge that consecutive short-term contracts involve recurrent administration, which can be time consuming and in some cases lead to more delays or errors in calculating pay, which can create conflict between doctors in training and HR/payroll. It may be possible that this could be reviewed and streamlined under any revised contractual arrangements, perhaps by using the technology available in each nation (such as the Electronic Staff Record (ESR) in England and Wales) to improve inter-employer transfers.

Provision of information before starting work

- 5.73 A good work-life balance is determined by a number of different factors. One issue that can have a significant impact on work-life balance is the level of information provision when doctors start a new post. All parties recognise that this is problematic under the current arrangements. Work has already been undertaken to support better information provision.
- 5.74 The JDC argues strongly that this has to be enshrined within any changes to the current contract or a new contract. The JDC would like to see doctors in training given four to six months' notice of where they will be moving to for their next rotation. This is in order to enable better life planning, ensure better employer/employee relations, and improve the morale of the workforce as it allows for people to move with their partners and make any arrangements for the care of dependants in advance of rotating. The JDC also argues that timely provision of information, at least six weeks in advance of commencing each post, should be required throughout an individual's training programme. They also suggest that information on benefits available unique to a post could be used to increase the attractiveness of posts.
- 5.75 Employers, like the JDC, express frustration with the difficulties experienced in forward planning and providing information. They note that they are sometimes unable to provide information, as they are not themselves informed in a timely manner about who will be on the next rotation. However, employers do not see this as a contractual issue. Work is being undertaken on the development of a Code of Practice in relation to this information and how it is provided to doctors, and employers and the JDC are involved in this process. Employers would not see any reason to enhance such a code via contractual provisions.
- 5.76 Again, the current banding and protection arrangements strongly discourage employers from investing effort in forward planning and information provision. If the employer hopes to make changes to rotas before the next rotation starts in post, it can be a serious

financial risk to contract doctors well in advance of their start date, as they are then locked into the higher banding even if the rota were to change before they take up the post, and this can act as a discouragement to necessary changes.

Lead employer arrangements

- 5.77 Lead employer arrangements have been introduced in some areas of England, and employers and the JDC both recognise some of the advantages these have brought both to doctors in training and employers, such as reducing external costs (for example, Criminal Records Bureau disclosures), internal costs and paperwork (for instance, pre-employment checks). Employers also note that this results in continuity of employment for doctors on maternity leave. The JDC is particularly positive about the use of lead employer arrangements and would like to see this broadened by any contract negotiations.
- 5.78 However, some employers also see a number of disadvantages in lead employer arrangements. In particular, they are concerned about the loss of control for the individual employer, and argue that such arrangements may actually dilute the relationship between the employer and employee, resulting in doctors in training lacking a sense of belonging at employers other than their lead employer. They also note that service level agreements, consistency checks, and good communication links are a basic requirement for making such a system work.
- 5.79 As discussed above, the issue of lead employers is also bound up with the nature of the current pay system. As part of the lead employer model, the JDC would like to see centrally held contracts for the duration of the training programme. Employers are concerned that under the present contract, such arrangements might restrict an individual employer's ability to alter working patterns without incurring long-term pay protection, which would be highly costly and restrictive.
- 5.80 In summary, all parties recognise that in practice, the current contract arrangements are failing to support good employer-employee relationships, the provision of clear information, and stability and continuity for doctors and employers. This would have to be a priority in any contract negotiations.

Education and training

- 5.81 Employers and the JDC highlight that the contract for doctors in training in fact makes little reference to training. As noted above, the employment contract and training contract are separate and held by different bodies. However, one of the primary purposes of the work of a doctor in training is to train to become a consultant or GP, and the JDC considers that this is implicit within these doctors' employment. All parties note that the distinction between service provision and training is not referenced within the employment contract, although it is also noted that that this may be variable and difficult to classify. The JDC argues that within the contract and additional agreements, such as the Gold Guide,¹⁹ there is a clear commitment to high-quality training and patient care.

¹⁹ A Guide to Postgraduate Specialty Training in the UK (The Gold Guide) - http://www.mmc.nhs.uk/specialty_training/specialty_training_2011_final/gold_guide.aspx

Their view is that any new contract would have to be equally firm in its commitment to both training and patient care.

- 5.82 Employers regard clinical competence as arising from training, and confidence as arising from consolidating that competence by gaining experience in the service. They recognise that the quality of the service is enhanced with training, and consider it positive that training is competency based and that curriculum requirements are clear in approved training programmes.
- 5.83 However, they still have substantial practical and philosophical reservations about the extent to which the requirements of training can be built into the contract of employment. Employers have concerns about how training is structured into doctors' jobs. They note that there are no pay thresholds linked to training, and feel that there is a lack of performance management (as opposed to competence assessment) across the rotation. They also query whether funding from the deanery is appropriately set up, and whether consultants have adequate responsibility for ensuring education and training. Further, they note that training is not necessarily designed around a 24/7 service, and question whether out-of-hours work is service delivery, education or both. They also state that dedicated training time reduces the number of training posts.
- 5.84 There are also differing views over the way in which study leave is provided. Employers' interpretation of the contract is that although up to 30 days of study leave is allowable, this is at the employer's discretion, and subject to the individual needs of the doctor. Employers sometimes find it very difficult to provide study leave at short notice and within the constraints of service provision and compliant rota design. The JDC says that this means many doctors in training are refused time off for study. They consider that the study leave allowable to doctors in training at Foundation Year 2 (F2) grade and above is essential to their training. They argue that study is an essential part of a doctor's educational progression and thus fundamental to the NHS's long-term ability to provide high-quality patient care. They also feel that study leave should be granted to Foundation Year 1 (F1) doctors in training.
- 5.85 The structure of full shift patterns and the reductions in daytime working hours can also impact on doctors' availability to attend set training days. Rotas which use fixed leave also decrease the ability for individuals to attend courses, as often a fixed day of study leave will not coincide with the date of a course. On some occasions it will not be possible for doctors in training to attend internal or external training without breaching either New Deal or EWTD rules.
- 5.86 The JDC also expresses concerns over the payment of study leave expenses, the variability of deaneries' study leave budgets, and the lack of ringfencing for such funding. The JDC also notes that while employment issues are negotiated via the Joint Negotiating Committee (Juniors), there is no joint negotiating body for educational issues. They would like both these issues to be reviewed in any discussions about changes to the contract.

Annual leave

- 5.87 Problems arise in general with the calculation of the leave entitlement. Different grades of doctor have different annual leave entitlements, which employers find a source of confusion and dispute. There has also always been some difficulty assessing what constitutes a “week’s leave” in terms of number of days off, because most doctors in training work more than a standard 40-hour working week. The JDC notes that this has led to employers adopting different ways of calculating annual leave entitlements and states that this has led to a lack of consistency and regional variations. This is difficult for both doctors and employers.
- 5.88 Employers and doctors in training both have difficulties in managing leave under the current New Deal arrangements. Juniors can experience problems taking their leave allocation for the year, due to the limits on the working hours available and the employers’ need to provide adequate service cover. Although in such circumstances doctors in training are allowed to carry up to five days over, subject to service need and employer authorisation, this is often difficult to put into practice. In such situations the doctor will often be rotating into a new post, and the new department may find it difficult to provide the retrospective quota of leave as well as the new year’s allocation.
- 5.89 In many cases employers fix all leave into the rota to ensure cover is maintained while allowing doctors to take their quota of leave, albeit at fixed times. Employers believe that fixed leave is not only fair but essential in some specialties, particularly during popular holiday periods and on small rotas where the combined restrictions of New Deal and EWTD limits leave very little room for manoeuvre. Their main concern is the need to provide sufficient clinical cover, which can be particularly difficult during holiday and exam periods. However, the JDC reports that doctors in training would like to see a contract that prevents the use of such fixed leave, as they find it bad for work-life balance and causes great difficulties with taking leave during school holidays, getting time off for a particular event or occasion, or coordinating their leave with their partner.

Travel and relocation expenses

- 5.90 The JDC also raises concerns over inconsistency in local policies on travel expenses. They support the principle stated in the 2006 joint guidance²⁰ that a doctor should not be financially disadvantaged by reasonable costs incurred through moving in the interests of service, or to further training. They say that local policies can often be ambiguous and open to interpretation, creating a “postcode lottery”, and that particular groups – notably those who rent properties, and F1s – can often be disadvantaged under local policies. They also note that claiming back travel and relocation expenses is often a very complicated process, and any delays can also result in problems with HM Revenue & Customs. The JDC notes that there is an agreement for trainees in Scotland and is in favour of this type of wide-ranging policy.
- 5.91 Employers, on the other hand, do not all favour such a rigid national structure for travel expenses. In many cases they find local determination to be a helpful element, and report that the ability to use employer discretion facilitates recruitment at more geographically

²⁰ http://www.nhsemployers.org/SiteCollectionDocuments/removal_guidance_doctors_training_cd_221205.pdf

remote workplaces. However, they do also note that this flexibility can lead to competition between employers and less continuity for doctors. They are also concerned about the way that GPST and hospital doctors in training are treated differently.

- 5.92 Employers generally feel that the expenses are fair and appropriately reimburse costs genuinely incurred by the doctors in training. However, they raised issues around lack of clarity which can lead to conflict between employer and employee, on aspects such as home-to-work journeys and the allocation of the base hospital. They are also concerned that long commuting distances can have poor health and safety implications which are not addressed by the current system of expenses.

Facilities

- 5.93 Within the current contract, the agreement of HSC 2000/036 in England, in HDL(2001)50 in Scotland, HSS(TC8)1/2002 in Northern Ireland and WHC(2001)34 and amended Annex A in Wales ensured that standards were in place for the provision of facilities, such as accommodation, food and hospital messes. Improving living and working conditions went hand in hand with reducing working hours under the 1991 New Deal, and the 2000 contract reflected this.
- 5.94 The JDC reports that doctors in training view these standards as a strength of the current contract, as they protect doctors who rely on facilities provided by their employer. They are concerned over the perceived lack of enforcement of these standards. The JDC raises additional concerns over lack of office space for confidential phone calls and administrative tasks, the absence of contractual entitlements to facilities for education and training purposes, and difficulties securing car parking, all of which they would like to see improved and strengthened within the contract.
- 5.95 Employers, on the other hand, were not supportive of the accommodation and facilities provisions and standards built into the contract. They noted that the contract had incorporated this range of provisions when hours and working patterns were considerably longer and relied on more extensive periods of onsite working during unsocial hours. The requirements in the contract were felt to be overly rigid and employers reported that this created substantial additional expense for the organisation.
- 5.96 Employers also highlighted the problem that this provision differentiated doctors in training from other members of staff, including nursing staff and other doctors and dentists. The JDC, however, argued that such differentiation is sometimes necessary, as doctors in training move more frequently and have far shorter placements than many other staff groups.

The design of the contract

- 5.97 All parties emphasise the need for simplicity and clarity in any revised contract. Fairness is also paramount, with any revised contract taking both remuneration and other contractual benefits into account, and considering overarching changes in the NHS such as EWTD.

5.98 Employers would want any future contract to support team working and professional ways of working, and to incorporate a change of focus towards objectives and outcomes rather than simply time spent at work. The JDC would wish the contract to integrate training and service delivery, and to acknowledge that doctors in training are different to other groups within the healthcare workforce due to the rotational nature of their work and the type of work that they do. All parties recognise that the contract would need to encourage and support team working, and doctors' active involvement in designing their patterns of work.

How should the contract change?

5.99 As we have seen, there is a widespread consensus view that the current arrangements are no longer suitable for the NHS. What is needed instead, however, is more open to a range of views, depending on whether you represent the workforce or the employers, and at employer level where you work. For example, those in Medical Staffing Departments often have a more detailed operational understanding of what would make for an arrangement in line with the key principles than the generalised concerns of employer boards about service cover and affordability. Medical directors and deaneries will have other specific nuances of understanding about what would improve the system.

5.100 This means that in considering what would be better, there is a complicated mix of interests at play. It is possible that what is needed may please some of the people some of the time, or all of the people but to a less than full extent. Contracts are inevitably like that – they represent compromises between the interest groups involved.

5.101 Any transition between the current contract and a future contract would require separate and careful consideration. The transition from an old contract to any new one lies outside the scope of this study and would arise only should negotiations be mandated and those negotiations make progress to a new agreement.

5.102 The JDC made it clear that they cannot support any changes to the current contract that disadvantage doctors in training compared to the current contractual position. This raises the question of how to define what would be disadvantageous in a situation when the shape and character of any new contract may be quite different from what went before, for example:

- would more basic pay but lower variable pay be disadvantageous or advantageous?
- how can perceived improvements in one aspect of the contract be weighed against perceived detriments in another?

5.103 Employers, meanwhile, would not support changes that made the contract more expensive, less flexible or more onerous to administrate.

6. The context for reform

- 6.1 This scoping study has been conducted in the context of the current financial challenges facing the NHS. It has also been in the shadow of the eminent analyses of Professor Temple²¹ in relation to whether quality training can be provided in an average 48-hour Working Time Regulations compliant rota, and of Professor Collins evaluating the Foundation Programme five years after its introduction in 2005.²² We have also reached the peak of the unprecedented growth in the medical workforce numbers with about 60 per cent more doctors than ten years previously.
- 6.2 It is hardly surprising that the study finds a remarkable degree of congruence among stakeholders of what our vision for pay and contracts for doctors in training should be. The themes outlined in section 3 (better patient care and outcomes, doctors in training feeling valued and engaged, affordability, producing the next generation of medical professionals, and improving relationships) are themes with quite a long provenance. There has been a series of reforms to medical education and to the terms and conditions of training for doctors stretching back to the 1986 report *Hospital Medical Staffing: Achieving a Balance*, which proposed changes in the balance between consultants and doctors in training. At the time it was perceived that there existed a large surplus of registrar training posts compared to the number of consultant positions. Indeed, previous reports dating back as far as 1969 had called for an increase in the ratio of consultant to training posts but no significant progress had been made. A bottleneck at “senior registrar” level meant that “consultant-level” doctors were waiting for years for the opportunity to become a consultant. Better workforce planning, growth in consultant numbers and the introduction of a “staff grade” level were all introduced at that time.
- 6.3 *Achieving a Balance* was followed in April 1993 by the *Calman Report*. This arose from a court case which required UK medical training to be aligned with European medical training approaches, principally on the length of specialist training. Under European Law, specialists registered with one country had the right to practice as a specialist elsewhere in the EU. British training was far longer than elsewhere in Europe and had to be brought closer to European approaches.

²¹ See note 3.

- 6.4 The *Calman Report* led to a mandatory defined end point to training; the introduction of a Certificate of Completion of Specialist Training validated by the Royal Colleges and recognised by the GMC to establish consultant-level competence; and reduced the maximum length of specialist training to seven years.
- 6.5 The trend for having less time for training in any year and in any training programme in total has been increased with the requirement for the working hours of doctors in training to be compliant with the Working Time Regulations in the UK, introduced to meet the requirements of EWTD. EWTD had been introduced as a health and safety at work provision and full compliance was required (subject to a small number of derogations) on 1 August 2009.
- 6.6 Concerns about whether this requirement was compatible with the provision of quality training for doctors led to Professor Temple being commissioned to report on this. His report on the situation in England, *Time for Training*, concluded that it was possible to deliver quality training in a 48-hour average working week. However, there were important caveats.
- 6.7 In essence he saw it as essential that the service moved increasingly to a consultant-delivered service, got better at rota design and management, managed handover better, and used every moment for training.
- 6.8 The Temple report saw that at least part of the problem of providing quality training was not to do with the EWTD alone but its interaction with the requirements of the New Deal contract. The report was particularly critical of the penalty bandings which could lead to unexpected financial penalties when the requirements of New Deal were breached. This is most extreme in relation to Band 3, where, it was found that it was possible for a single breach for a single doctor to lead to the whole 8 person rota doubling their pay for the whole programme and that this could cost an employer an unexpected £250,000 over six months.
- 6.9 Temple found that this led employers to avoid this risk by increasingly introducing rigid shift patterns, often putting clock watching ahead of quality training provision. It also makes it impractical for employers to take advantage of individual opt outs under the EWTD arrangements. These inflexibilities have been further exacerbated by the undoubted pressure on budgets at employer level.
- 6.10 Affordability of pay dominates the thinking of employers in the NHS across the UK at the current time. NHS Employers is being told by employers that any increase in pay costs will be unaffordable unless matched by commensurate increases in available finance. Cost pressures from increased pay costs from whatever source will not be affordable and savings will need to be found elsewhere from efficiencies or reductions in service or both.

Financial position - England

- 6.11 The current financial position at NHS organisations is very tight indeed. Acute trusts have less confidence that funding will be available to them, given the savings required in the system and the announcement of future changes to commissioning arrangements. Therefore most mental health, acute and ambulance trusts are looking to make efficiency savings of at least 10 per cent.
- 6.12 Primary care trusts and strategic health authorities are required to save on average 45 per cent of management costs by 2013. Their interim target of returning to 2008/09 baselines by April 2011 is very challenging indeed.
- 6.13 Pay efficiency is part of a wider programme of workforce transition, to support the delivery of changes to the healthcare system.
- 6.14 There is cross-government agreement on pay restraint. However, the figures suggest that this will not provide enough cash-releasing savings for the NHS to avoid the pay bill going up for the 2011/12 and 2012/13.
- 6.15 Employers are facing unprecedented pressure on budgets. This is shown in the analysis of the NHS Confederation's publications *Dealing with the Downturn*²² and *Dealing with the Downturn: Using the Evidence*²³ which look at the size and scale of the challenge faced by the NHS and explore a number of areas for cash releasing savings which could be used to fund growth and take account of non-pay costs growth. Under the Comprehensive Spending Review the NHS will see an increase in funding each year reaching a total of £114 billion by 2015. This assumes some £20 billion in efficiency and productivity savings by 2014. The total incorporates £1 billion a year to support social care.
- 6.16 There are high levels of unavoidable pressure on NHS finances, from increasing demand to new technology, structural reform and productivity. So, within this settlement, the NHS faces a difficult mix of pressures and will have to work very hard to minimise the impact on services. Achieving more will be immensely difficult while delivering a major programme of structural reform.
- 6.17 While employers tell us that they will make every effort to protect frontline services, the changes that will be required are so significant that there is likely to be an impact on frontline services, even if it is possible to restrain earnings. Employers are concerned about containing pay costs within the tariff, particularly in light of the in built incremental cost of the NHS system which is accentuated by current low turnover.
- 6.18 Thus, affordability of any increase in pay bill dominates the thinking of employers in the NHS in England. This is the clear message that employers in the NHS have given to NHS Employers in relation to pay costs.

²² Dealing with the Downturn: The NHS Confederation <http://www.nhsconfed.org/Publications/leadership/Pages/Dealing-with-the-downturn.aspx>

²³ Dealing with the Downturn: Using the Evidence <http://www.nhsconfed.org/Publications/reports/Pages/Dealing-with-the-downturn.aspx>

- 6.19 NHS Employers has concluded that medical and dental pay costs need to be restrained. Financial pressures mean employers will want to look at all aspects of current pay bill. It is clear that unjustified costs in the current arrangements will need to be removed if the pay system and structures are to achieve the agreed vision of what the contract should achieve as set out earlier.
- 6.20 The position in the devolved administrations is broadly similar.

Financial position – Scotland

- 6.21 The financial position in Scotland for 2010/11 was already challenging. In 2011/12, NHS boards will need to deliver and retain around £320 million cash-releasing efficiency savings, or 3.7 per cent of funding baseline, to achieve financial balance. In cash terms the total healthcare funding in 2011/12 of £11.4 billion reflects an increase of £190.5 million (1.6 per cent). NHS boards will have around 1 per cent additional cash funding, after taking account of government priorities and commitments to meet cost pressures and service demands.

Financial position – Wales

- 6.22 The financial position for NHS Wales is also already challenging in 2010/11. NHS Wales organisations are planning to deliver over £400 million cash-releasing savings this year, equating to over 7 per cent of NHS funding. The health and social services revenue budget for 2011/12 to 2013/14 is flat in cash terms, but represents a real terms reduction of 6.3 per cent over the three years when measured against economy-wide inflation, and significantly greater than that when increased demand and other service pressures are taken into account.

Financial position – Northern Ireland

- 6.23 The financial position in Northern Ireland is also very challenging. There is a significant shortfall in the anticipated funding to meet demographics and residual demand in 2011/12. There will be little service development and a radical reform of the Health and Social Care system will be required in order to deliver a service within the available funding.

Earnings

England

- 6.24 The NHS Information Centre produces a quarterly publication of NHS Staff Earning Estimates which show medical workforce earnings by staff group, taken from the Electronic Staff Record (ESR). Roll out of the ESR is now complete and the most recent data covers every NHS organisation, except two foundation trusts who have not joined the ESR.

- 6.25 Changes in the average earnings by staff group arise from actual increases in individuals' pay due to pay awards, back pay and incremental progression or changes in the composition of the workforce due to pay reforms and/or the impact of new organisations joining the sample. A separate analysis of earnings has shown that some of the changes in earnings arise from changes in the sample rather than true changes in average salary.²⁴
- 6.26 The figures which follow are taken from the NHS Staff Earnings Estimates in September 2010. They give annual basic pay and total pay for April to June 2010.
- 6.27 Doctors in Foundation Year 1 receive an average basic salary of £22,600 and their average total earnings are £32,200. These figures show an average additional earnings equivalent to £9,600 or 42.5 per cent of basic pay. Their average basic pay has increased by 0.4 per cent since the previous year with the average total earnings 0.3 per cent less. Doctors in foundation year 2 receive an estimated basic pay of £29,400 and total pay of £42,200. These figures equate to average additional payments of £12,800 or 43.5 per cent of basic pay. This shows a decrease of 2.5 per cent in total earnings compared with the comparable quarter of 2009 for this category of doctor.
- 6.28 The registrar group of doctors earn an average basic salary of £38,700 and an average total salary of £57,800. The estimated average additional earnings for this group add 49 per cent to their basic pay. These figures are 1.8 per cent more and 0.3 per cent less than the 2009 figures for basic and total pay respectively.

Wales

- 6.29 The figures which follow were taken from the ESR Data Warehouse in November 2010. They give annual basic pay and total pay based on the period from April to June 2010.
- 6.30 Doctors in Foundation Year 1 receive an average basic salary of £22,300 and their average total earnings are £32,600. These figures show an average additional earnings equivalent to £10,300 or 46.5 per cent of basic pay. Their average basic pay has increased by 0.9 per cent since the previous year with the average total earnings 0.8 per cent less. Doctors in Foundation Year 2 receive an estimated basic pay of £27,400 and total pay of £41,800. These figures equate to average additional payments of £14,400 or 52.6 per cent of basic pay. This shows an increase of 1.6 per cent in total earnings compared with the comparable quarter of 2009 for this category of doctor.
- 6.31 The registrar group of doctors earn an average basic salary of £35,400 and an average total salary of £56,100. The estimated average additional earnings for this group add 58.6 per cent to their basic pay. These figures are 0.2 per cent less and 1.9 per cent less than the 2009 figures for basic and total pay respectively.

Northern Ireland

- 6.32 Annual estimated salaries for 2010/11 based on figures from April – June 2010 show doctors in Foundation Year 1 receive an average basic salary of £22,350 and average total earnings of £33,815. This shows an average additional earnings equivalent to £11,465 or 51 per cent of basic pay.

²⁴ <http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-earnings/nhs-staff-earnings-january--march-2010>

- 6.33 Doctors in Foundation Year 2 receive a basic salary of £27,415 and total pay of £42,055. These figures equate to average additional earnings of £14,640 or 53 per cent of basic pay.
- 6.34 Specialty registrars earn an average basic pay of £34,157 and an average total salary of £55,257. The estimated additional earnings for this group are 62 per cent on their basic pay.

Numbers

- 6.35 In 2009²⁵ the overall NHS workforce increased by 4.6 per cent compared to 2008.

England

- 6.36 In England, the total headcount increase was 63,303. Of 1.2 million full time equivalent (FTE) hospital and community health services (HCHS) staff employed in the NHS in England, 96,598 are doctors, making up 8.2 per cent of the workforce.
- 6.37 The medical and dental workforce continued to grow significantly during 2009. There were 96,598 FTE HCHS medical and dental staff in September 2009, compared to 91,596 in 2008. These figures show an increase of 5,013 FTE or 5.5 per cent. Since 1999, the number of FTE HCHS medical and dental staff has increased by 60 per cent from 60,338.
- 6.38 The 36,950 consultants is the highest headcount figure ever. The growth rate in headcount for 2008/09 was 4.3 per cent for all medical posts. The number of doctors in training increased significantly by 4.7 per cent compared. The growth rate averaged 5 per cent over the preceding ten years.
- 6.39 The annual growth rate over ten years for doctors in training was 5 per cent. The growth since 2008 was 4.7 per cent. Effects of the Modernising Medical Careers (MMC) programme brought more expected grade changes in 2009. Registrar group numbers increased by 5.9 per cent to 37,108 (35,042 in 2008) and SHO's continued to decline, a 22 per cent decrease on last year's figures.

Scotland

- 6.40 As at 30 September 2010 the overall NHS Scotland workforce decreased by 0.6 per cent compared to 30 September 2009. In Scotland, the total headcount decrease was 994. Of 168,051 full time equivalent Hospital and Community Health Services (HCHS) staff employed in the NHS in Scotland, 16,356 are doctors, making up 9.7 per cent of the workforce.
- 6.41 There were 16,356 FTE medical and dental staff in September 2010, compared to 16,256 in 2009. These figures show a increase of 100 FTE or 0.6 per cent. Since 2001, the number of FTE medical and dental staff has increased by 28 per cent from 12,771.

²⁵ <http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/provisional-monthly-nhs-hospital-and-community-health-service-hchs-workforce-statistics-in-england>

- 6.42 The number of doctors in training reduced by 2.2 per cent compared with 2009. However, since 2001 the number of doctors in training has increased from 4,732 to 5,486, an increase of 16 per cent.

Wales

- 6.43 In 2009 the overall NHS Wales workforce increased by 3.4 per cent compared to 2008. There were 2,825 doctors in training employed in Wales in September 2009. Of 73,000 full time equivalent HCHS staff employed in the NHS in Wales, 5,390 are doctors, making up 7.4 per cent of the workforce.
- 6.44 There were 5,390 FTE medical and dental staff in September 2009, compared to 5,420 in 2008. These figures show a decrease of 30 FTE or 0.6 per cent. Since 1999, the number of FTE medical and dental staff has increased by 52 per cent from 3,556.
- 6.45 The headcount for consultants is 2,062. The growth rate in headcount for the September 2009 census was 0.1 per cent for all medical posts. The number of doctors in training reduced by 3.0 per cent compared with 2008. The growth rate averaged 4.6 per cent over the preceding ten years.

Northern Ireland

- 6.46 There were 55,839 Whole Time Equivalent (WTE) staff working in health and social care in Northern Ireland in March 2010 (Figures as at 31 March 2010, Source Human Resources Management System). Of these, 3566 WTE (6.6 per cent) were medical and dental staff.
- 6.47 The whole time equivalent of medical and dental staff has increased by 40.6 per cent overall.

Doctors' morale

- 6.48 The purpose of the reward package in the NHS, as for any employer, is to ensure the recruitment and retention of the appropriate numbers of staff, the appropriate skill and knowledge mix among the staff and the correct quality of application of that skill and knowledge at the correct place and time, to provide the services required. While economic conditions have effects on the labour market and on affordability, earnings need to reflect this purpose.
- 6.49 Reward is not only about pay rates. It is also about tangible and non-tangible non-pay rewards. It encompasses pensions, deferred wages, conditions of service, such as annual leave, sick pay, enhancements for work out of hours and payments for additional duties; and how staff are managed. It is about the total reward.
- 6.50 In comparison to other professional jobs in the economy, doctors and dentists are in an occupation on which prevailing economic circumstances have a more limited effect since the employment and contracting of doctors and dentists is largely within the NHS. In the UK, only 3 per cent²⁶ of doctors receive their primary income from other sources, such as

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http://www.ic.nhs.uk/webfiles/publications/workforce/NHS%20Staff%20Earnings/staffearnaprjun09/NHS_Staff_Earnings_Estimates_April_to_June_2009_Bulletin.pdf

academic work. Competition with the wider labour market and the wider economic circumstances are not thought to be the primary factors in the recruitment and retention of doctors and dentists.

NHS staff survey – England

6.51 An element of the effectiveness of the pay rates and pay systems is reflected in the staff satisfaction and attitudes and how that affects staff morale as a key driver of the motivation of staff. An NHS staff survey has been conducted annually since 2003 in England, enabling changes in the reported levels of job satisfaction to be seen. A more satisfied workforce is likely to be more sustainable and provide better patient care. Motivated and involved staff are better placed to know what is working well and how to improve services for the benefit of patients and the public. Data extracted from the 2009 survey, the most recent, have been used in this submission. The complete data is available from the Care Quality Commission.²⁷ The factors that are important to staff are linked, to one degree or another, to better patient and public satisfaction, and enhancement of the reputation of the NHS.

6.52 The 2010 NHS staff survey, overall, shows high and rising levels of job satisfaction. It indicates that doctors and dentists remain more likely than their colleagues in other occupations to report that they are satisfied or very satisfied with their level of pay. When compared to their colleagues, doctors and dentists are:

- more satisfied with their pay
- less likely to be planning to leave their organisation
- more satisfied with their jobs
- healthier
- get better access to training and learning
- safer and less stressed.

They report experiencing a poorer quality of life than the average for all NHS staff. The measures of work/life balance for doctors and dentists, while being poorer than other occupations, have improved since the previous survey.

6.53 From the 2010 NHS staff survey in England, doctors in training are likely to feel satisfied with the quality of work and patient care they are able to deliver (81 per cent say this compared with 77 per cent for all doctors, 73 per cent for all staff, and 70 per cent for nurses). In addition, 92 per cent of doctor in training respondents agree that their role makes a difference to patients and that they have an interesting job (85 per cent say they feel valued by their work colleagues, compared with 85 per cent of all doctors, 78 per cent of all staff, and 81 per cent for nurses).

²⁷ <http://www.cqc.org.uk> The CQC took over responsibility for the survey from the former Healthcare Commission on 1 April 2009.

- 6.54 They have a slightly poorer view of the quality of the job design (i.e. whether the job content is clear, there is good feedback and there is involvement of staff in the design) than other staff. They report poorer work-life balance than the average for all staff, although slightly better than consultant doctors, and are more likely to report working extra hours compared to other colleagues, with the exception of consultant doctors.
- 6.55 Doctors in training are, by far, the most likely of NHS staff to say that they “feel there are good opportunities to develop their potential at work” (73 per cent compared with 41 per cent for all staff). They are also the most likely to say that they have received job-relevant training. They report better support from their immediate managers than other doctors and than other staff.
- 6.56 However, doctors in training are less likely to feel that:
- there are good communications between management and staff
 - they understand where their role fits in
 - they are able to contribute to work improvement
 - they are satisfied that their trust values their work.
- 6.57 On overall job satisfaction they score higher at 3.62 out of a possible 5 (up from 3.57 in the previous survey), compared with all doctors at 3.59, all staff at 3.54 and nurses at 3.53.
- 6.58 Compared with other staff, they are more likely to report working contracted hours of more than 30, slightly less likely to be working extra paid hours, similar levels of reporting extra unpaid hours as other doctors and nurses, more likely to be working rotating shifts and more likely to be working between 7pm and 7am.
- 6.59 In relation to pay doctors in training are more satisfied at 50 per cent (up from 40 per cent in 2009) than the all staff figure of 42 per cent (up from 38 per cent in 2009) but less satisfied than consultant doctors at 68 per cent (63 per cent in 2009) and more satisfied with their pay than other grade doctors at 45 per cent (33 per cent in 2009). (NHS staff survey 2010 figures.)
- 6.60 A further source of data on the experience of doctors in training is found in the General Medical Council’s National Training Survey 2010.²⁸ This found that doctors in training:
- rate the quality of the supervision they receive highly
 - the majority of foundation trainees felt prepared for their first job
 - most report that their rotas are EWTD compliant, but many are working longer hours.

The report also found that 79 per cent of doctors in training rated the quality of experience in their current post as good or excellent, compared with 77 per cent in 2009.

²⁸ http://www.gmc-uk.org/static/documents/content/Training_survey-FINAL2010.pdf

- 6.61 Additionally, the NHS continues to be seen as a desirable place to work. A 2008 study by NHS Careers and Skills for Health – joint sponsors of the Health Learning and Skills Advice Line - showed that healthcare was the third most desirable sector to work in. It was surpassed only by the creative and cultural sector and the broadcast, film and video industries.
- 6.62 The attraction of the NHS for careers in medicine and dentistry was emphasised by a study by the UK Medical Careers Research Group, Department of Public Health, University of Oxford, reported in *bmj.com* on 3 June 2009.²⁹ This shows that most British medical graduates from British medical schools practise in the NHS for many years. Of home-based doctors, 88 per cent of men and women worked as doctors in the NHS two years after qualification. The corresponding values were 87 per cent of men and 86 per cent of women at five years; 86 per cent of both men and women at 10 years; 85 per cent and 84 per cent at 15 years; and 82 per cent and 81 per cent at 20 years. Attrition from the NHS had not increased in recent cohorts compared with older ones at similar times after graduation. The study concludes that the majority of British medical graduates from British medical schools practise in the NHS in both the short and long term. Subsequent data from the same group, published in *BMJ Careers* in October 2010 in response to speculation that doctors in training were leaving the service, indicated that there is nothing to suggest that attrition from the NHS is greater in the latest cohort than in the older cohorts.³⁰
- 6.63 The continuing attractiveness of medicine as a career in the UK is seen from the number of applications to study medicine at university rising, compared with 2009, by 14.5 per cent in the 2010 round of applications to just over 80,000.³¹

Wales

- 6.64 Wales has not conducted a staff survey since 2007 in view of the recent NHS reforms and reorganisation of health bodies. However, the position for junior doctors is understood to be broadly similar to that described for England.

Pension

- 6.65 Pay is only one element of employment reward. It also encompasses tangible and non-tangible non-pay rewards. Pensions have always been a valuable part of the reward package for doctors and dentists in the NHS. The value of the NHS Pension Scheme is an increasingly important element of the NHS reward package. We believe it compares well to pensions offered to comparable occupations outside the NHS. Private sector employers often contribute less to employees' pension savings. Increasingly they make those contributions to less attractive defined contribution pension schemes. The DDRB's 39th report, February 2010, states that the BMA observed to them that "while pension arrangements for doctors and dentists were relatively beneficial compared with those of employees as a whole, they remained broadly in line with those of comparable groups in the public sector and the higher paid in the private sector".³²

²⁹ http://www.bmj.com/cgi/content/abstract/338/jun02_1/b1977; <http://www.uhce.ox.ac.uk/ukmcrg/>

³⁰ <http://careers.bmj.com/careers/advice/view-article.html?id=20001543>

³¹ http://www.ucas.ac.uk/about_us/media_enquiries/media_releases/2010/releasetables

³² http://www.ome.uk.com/DDRMain_Reports.aspx

- 6.66 Employers and NHS trade unions regard pensions as deferred pay. They recognise that the employer contribution is a significant part of earnings for NHS Pension Scheme members.
- 6.67 The contributions made by employees reflect the benefits structure and the cost of providing benefits. The tiered contribution arrangements are a method of sharing those costs between members more equitably in future. The contribution rates are reviewed periodically and reflect a balance between current pay and deferred pay.
- 6.68 NHS Employers believe there is an increased awareness of the importance of pension provision and the value of public service pension schemes, within and outside the service. A "choice exercise" for all staff has started, where members of the 1995 section of the NHS Pension Scheme will decide whether to transfer their accrued benefits to the 2008 section of the scheme, with its higher normal retirement age of 65. This is further raising awareness about the value of the pension scheme to staff.
- 6.69 Lord Hutton of Furness published his final report on public service pension provision on 10 March 2011 in which he set out his recommendations to the Government on pension arrangements that are sustainable and affordable in the long term, fair to both the public service workforce and the taxpayer and consistent with the fiscal challenges ahead, while protecting accrued rights.³³
- 6.70 The Government accepted Lord Hutton's recommendations as a basis for consultation with public sector workers, unions and others. The Government will set out proposals in the autumn of 2011.

³³ http://www.hm-treasury.gov.uk/indreview_johnhutton_pensions.htm

7. Options for reform and further work

- 7.1 Three broad options for reform have emerged:
- maintain the current arrangements as they stand
 - make revisions to the current arrangements, while retaining their basic structure
 - consider wholly new arrangements.
- 7.2 Each of these three possibilities needs to be considered with reference to the vision and principles already outlined, and the concerns raised by the employers and the JDC over the existing contract.
- 7.3 The possibility of local or regional pay as a solution to contractual arrangements for doctors in training is not supported either by employers or by the JDC. The labour market for medical graduates is not local. To create local job markets would risk escalating pay without improving anything for doctors in training or their patients, through churning of the workforce as they moved around seeking out the latest highest paying region or locality before eventually settling down in the long term for their career.

Option 1: Keep the current arrangements – do nothing:

- 7.4 As outlined, the current contract was successful in achieving its original purpose of reducing average hours of doctors in training, but ten years on from implementation this contract presents numerous difficulties. Although we have identified strengths in the current contract, there are also many significant weaknesses which employers and the JDC would like to address. These include:
- the nature of the pay banding system, which is seen as unpredictable and unexpectedly expensive
 - the downward trend in overall pay due to the introduction of EWTD
 - the lack of engagement of doctors in training and a perceived lack of belonging
 - some inconsistencies between regions or UK countries
 - inflexibilities such as those created by the interaction of pay protection and the banding system
 - the problems with adequately recognising intensity of work within the existing structure.

- 7.5 The Temple report also concluded that the New Deal has unhelpful conflicts with EWTD. Combined with the evidence above, this makes the no-change option extremely difficult to support. If the existing contract was to be left unaltered, many practical questions would still need to be resolved, for instance, how the contract interacted with training and education; how professional ways of working could be encouraged; and how doctors in training could be engaged and supported by their employers.
- 7.6 It is also important to examine how this option would address the principles outlined in the vision for the contract.

Better patient care and outcomes

- 7.7 It seems unlikely that retaining the current arrangements unchanged would lead directly to improvements in patient care and outcomes. While the restrictions of the current contract were designed in large part to improve quality and safety of patient care, particularly at a time when there was no other health and safety restriction on doctors' working hours, the past ten years has seen the context change significantly. The EWTD limits now apply to doctors in training in full, and the conflicts between New Deal and EWTD standards, the adversarial nature of relationships which are encouraged by some elements of the contract, and the inflexibility of particular New Deal rules, could potentially militate against improvements to patient care. The greater likelihood is that if the arrangements remain unchanged then the behaviours and problems will also remain unchanged.

Juniors feeling valued and engaged

- 7.8 As we have discussed, there are currently substantial problems with doctors in training not feeling valued and engaged. Although the way in which doctors are rewarded is designed around their specific working patterns, all parties agree that there are flaws in this system, and there are questions over whether it is rewarding the right things. The contractual arrangements are very different in intention and scope to those of other staff. While some of these differences can be beneficial, in that they recognise unique aspects of the work of doctors in training, this further emphasises a perceived separation from the rest of the workforce. The engagement of doctors in training is encouraged by certain elements of the system (such as the rebanding protocol), but discouraged by others (such as conflicts over banding and pay protection).

Affordable

- 7.9 Maintaining the current contract would, to some extent, avoid additional cost on a national level. However, aspects of the current contract such as banding protection are felt by employers to be disproportionately expensive, and, even more significantly, employers express particular concern over the unpredictability of costs. The level of risk is clearly unaffordable for NHS organisations and could be eliminated by appropriate changes to the contractual arrangements.

Produces next generation of medical professionals

- 7.10 It is possible to continue to train doctors under the current contract. However, particularly following the Temple review, we must consider whether the current contract is geared towards effectively training doctors to become the consultants of the future. The Temple report proposes significant changes to the ways in which doctors in training work, which would not necessarily fit well with the current system of pay and reward which heavily incentivises out-of-hours work.
- 7.11 The current contract emphasises the details of hours worked and rest breaks taken, rather than training and clinical objectives. While this was an appropriate means of driving the required reform of working hours, it is not necessarily the optimum way of developing the next generation of consultants, GPs and specialty doctors. Indeed the Temple report suggests that it can be a barrier to the delivery of high-quality training.

Improves relationships between employers, doctors in training and deaneries

- 7.12 One of the most recurrent themes in our examination of the current contract is how much various elements tend to create adversarial relationships and poor communication. Retaining the current contract would not improve these relationships.
- 7.13 We note that, at the junior doctors' conference on 7 and 8 May 2010, the resolution was carried that the JDC should "resist entering contract negotiations until such a time that a benefit to working conditions, working practices, training and salary can be secured". However, within this scoping study NHS Employers has seen broad agreement that the New Deal arrangements need to change, although there is inevitably a difference of emphasis between employer perspectives and those of the JDC.

Option 2: Amend the current contract:

- 7.14 A number of possibilities exist for amending the current contract to address some of these difficulties and allow for compliance with the EWTD. For instance, the New Deal contract could be amended to:
- amend the banding definitions (for instance, so that an 8:30am-5pm weekday working pattern would not attract a 40 per cent supplement)
 - remove Band 3 – i.e. the banding that relates to breaches of New Deal limits which are specifically different from EWTD limits
 - dispose of, or reduce the frequency of, monitoring
 - dispose of or reduce pay protection, which is unsafe as regards equality
 - maintain earnings.
- 7.15 In theory, these changes might arguably be easier to implement in a short time than a full redesign of the contract. However, they will still require negotiation with the BMA, and a limited negotiation may not address all concerns and could potentially hinder any further, more comprehensive discussions or negotiations. Furthermore, a limited set of changes may not address the needs of all those with an interest in the contract (for

instance, patients, doctors, employers, the BMA, the DDRB, the four health departments and the Treasury).

- 7.16 Even if these basic changes were possible to implement in isolation, there would still be numerous additional issues which needed addressing. For instance:
- On call is now predominantly non-resident. Should it include the same clause as the consultant contract regarding residing within 10 miles or 30 minutes when on call?
 - How should issues of clinical governance be addressed within the contract?
 - Is it appropriate for the core working hours to remain 7am to 7pm?
 - How can the employment relationship be improved within the contract?
 - The typical pattern of hours is now full shift. Can the contract be amended to reflect the intensity issues that are of concern to both employers and doctors?
 - Should pay progression be dependent on competency progression rather than being automatic?
 - Retention of the banding system will still potentially encourage the undertaking of substantial out-of-hours work, although this may not be optimum for training, health and safety, or for service need. Given the conclusions of the Temple report, is this appropriate for the NHS?
- 7.17 This raises the inevitable question of how far the contract can be amended by a piecemeal approach without turning it into an entirely new contract. The changes needed to address all these issues would move the contract substantially away from the original New Deal, but without allowing a thorough review of how the contract could be redesigned around the needs of the service.
- 7.18 Again, it is essential to examine how this fits the vision already outlined.

Better patient care and outcomes

- 7.19 There is some scope for amendment of the contract to allow better use of the flexibilities of EWTD. For instance, if the penalty band 3 payments were to be removed, and more of doctors' earnings transferred into standard basic pay rather than variable out-of-hours pay as suggested by the JDC, this might allow employers more flexibility in paying for and utilising the hours released by individual opt out. It would, however, still be constrained by the nature of the banding system and by the need to ensure doctors were working safely and opting out by genuine choice.
- 7.20 However, while it is possible that such an amendment might contribute to better patient care and outcomes, it would not be a system specifically designed around the current needs of the service. It is hard to assess how an amendment, or a series of amendments, to the contract of employment would be able to have a significant impact on patient care without taking into account the whole scope of the contract. For instance, the Temple report suggests that the work of the medical staff should be rebalanced to create a more consultant-delivered service out of hours, with doctors in training undertaking more work in normal working hours. This would require a more substantial rethinking of how doctors in training are rewarded and incentivised.

Juniors feeling valued and engaged

- 7.21 Simply amending the current structure, rather than re-examining and redesigning how doctors are rewarded for what they do, may not in itself help doctors in training to feel more valued. Some changes could contribute to doctors in training being more engaged, for instance in the active design of their rota; however, this would require a thorough review of how doctors in training are supported, how objectives are created and how team working is fostered. Maintaining the current contractual structures, even with amendments, may limit the progress that can be made.

Affordable

- 7.22 Affordability would be crucial in making these changes. Amendments to bandings and to pay protection could mitigate some of the problems currently experienced by employers, in particular reducing the level of unpredictability and financial risk. This would need to be done with considerable care and with regard to appropriately rewarding doctors in training for the work they are required to undertake.

Produces next generation of medical professionals

- 7.23 It would be possible to continue training doctors in an amended version of the current contract, and as already discussed, additional opt-out hours could be utilised for additional training opportunities. However, it would not be possible to use additional opt-out hours to deliver essential training, as such hours by definition have to be voluntary, not mandatory.
- 7.24 More fundamentally, retaining the essentially hours-based structure of the contract, rather than reorganising the employment relationship on a professional basis, would not create scope to rethink the way in which doctors in training work, the way in which objectives are set and the method by which they are rewarded. There is a concern, for instance, that the current contract can often reward poor performance through automatic annual increments. Amendments to the current contract may or may not effectively address such issues. It would also hamper the ability to rethink the contract in the light of the Temple report and its far-reaching recommendations on training.

Improves relationships between employers, doctors in training and deaneries

- 7.25 There are elements of change which could improve relationships between the parties; for instance, it might be possible to build on the work already being done to improve communication about future posts. That said, while the banding system remains in place, the adversarial nature of the relationship between doctors in training and employers will remain difficult to displace.
- 7.26 Retaining the structure of the existing contract would also make it difficult fundamentally to address the role of the deaneries in organising training, and how relationships between them and the doctors and employers could be improved.
- 7.27 In summary, this is a potential option but is unlikely to address all the areas of concern and may even hamper any future redesign of the contract.

Option 3: A new contract:

- 7.28 The third option is to negotiate new contractual arrangements designed to fit the current context, including current working practices, training needs and employment law. This would allow for a contract that:
- reflects service and educational activities
 - links progression to the continued demonstration of competence
 - incorporates relevant gateways/thresholds
 - has local flexibilities
 - more closely aligns doctors in training with the contracts of other doctors.
- 7.29 The contract would need to be based upon service needs, with a focus on flexible delivery of service, quality and affordability. Education and training could be linked in via competence-based progression. The contract would also be designed around the skills, knowledge, attitudes and professionalism that are needed and that will allow doctors in training to develop into the trained doctors of the future.
- 7.30 The contract would need to reflect the structure of training (foundation, core training, and run-through) in an appropriate way. Any negotiation would need to consider aspects such as the number of pay points on a scale (for instance at foundation level), and how the scales related to those of other grades.
- 7.31 There would be a range of possible ways to envisage pay and reward. For instance, there are a range of options for supplementing basic pay currently in use for other staff groups, which could be considered as part of any revised arrangements. It would also be possible to look at creating more consistency and equity between the doctors in training pay scale and the other medical grades such as specialty doctor and consultant, which could potentially also make career progression a smoother transition.
- 7.32 A renegotiated contract would also allow a full review of all the areas of concern and all aspects of the contract, including the provision of leave, career development, and statutory benefits such as maternity leave (which is not currently designed to take account of rotational placements). It would also be possible to look at the use of local flexibilities and also at having more clarity about where, when and how such flexibilities might apply.
- 7.33 This also addresses all aspects of the vision for the contract.

Better patient care and outcomes

- 7.34 A system fit for purpose, specifically designed around the current needs of the service, should be directly aimed at achieving better patient care and outcomes. This is the first priority of all parties. One way of doing this would be to configure the contract more directly around competences, which would recognise the training aspect of the junior doctor's role and allow for more equitable progression. It would also be possible to build the contract more around team and organisational objectives rather than just around hours of work, making the contract consistent with those of the other grades. Both these aspects would be aimed at the improvement of quality of care. Clinical governance

arrangements would be enabled to be more clearly aligned to the competence and progression of doctors as they go through training. Better objective setting would also support the service and the doctor's development and align their contract with those of other medical grades.

Juniors feeling valued and engaged

- 7.35 The parties would wish to redesign the contract to ensure that remuneration was fair and reflected appropriate working patterns for doctors in training. A contract which maintains a professional ethos would more expressly value doctors in training for their activity and competences rather than the hours they spend at work. Additional focus on team working within the contract could also support trainee engagement. More continuity with the contracts of other staff might help to combat the sense of isolation and could support integration with the rest of the staff body.

Affordable

- 7.36 Any new contract would have to be designed within the funds available. However, when looking at affordability it is also essential to ensure that the contract recognises and rewards specifically what the service needs, both nationally and locally. A complete review of the contract would allow this to be done without the constraints of keeping the previous system, and could also allow for local flexibilities to fit service need where appropriate.
- 7.37 A new contract could also reduce the level of financial risk to employers. If the current system of broad pay bands was to be replaced by a system which was weighted more towards basic pay, the level of variability would decrease, and stability could be improved both of the pay bill for employers, and of income for doctors in training. .
- 7.38 However, weighting the system more towards basic pay would potentially result in increased pension costs for both employers and employees. This would have to be accounted for in order to maintain the contract within the current funding available.

Produces the next generation of medical professionals

- 7.39 By redesigning the contract on a new basis, it would be possible to define what the next generation of medical professionals should look like and how they should work. There would be scope to take into account changing patient needs and the current landscape of healthcare provision, rather than only the practices that have been followed in the past. However, it should be recognised that there are strengths in the current contract and any new contract would aim to reflect on and learn from the successful elements.
- 7.40 Significantly, such a redesign would allow the contract to take account of the findings of Professor Temple and to be tied in with any potential changes in the overall structure of patient care and training, for instance around the move to a consultant-delivered service. It would allow a full reconsideration to be given to the role and development of doctors in training, and how best to incentivise and reward their activities within the contract.

Improves relationships between employers, doctors in training and deaneries

- 7.41 A renegotiated contract would allow some of the most difficult and contentious issues inherent in the current banding system to be completely rethought. This could include redrawing or replacing the elements of the contract which create the most adversarial relationships, such as banding, pay protection, monitoring, and the current complexity of appeals and expenses procedures.
- 7.42 A wholly new contract would require negotiation to be conducted between the BMA and the employers. This would require government agreement (Public Expenditure Committee) on a negotiating mandate and cost envelope, and ideally, four country agreement on a UK-wide approach. NHS Employers would be asked along with employer representatives or health departments in the other UK countries to negotiate with the BMA.
- 7.43 The timeframe would require approximately two months for cross-government, UK-wide agreement on a mandate, a minimum of 12 months for negotiation between employers and the BMA to arrive at proposals, and three months for employer consultation and BMA consultation with members and voting on any proposals.

Conclusion

- 7.44 All parties agree that the current contract is no longer fully fit for purpose. We conclude that without change, the vision set out in this report cannot be delivered.
- 7.45 While amending the current contract might address some of the many problems which have been raised, and would allow negotiation around currently known parameters, this is not a satisfactory solution. It could leave many problems unaddressed, would restrict the ability to think creatively about the real needs of patients and of doctors in training, and could possibly undermine any future more comprehensive negotiation on the contract.
- 7.46 We recommend a full renegotiation of the contract for doctors in training. This would allow the contract for these doctors to be designed around their role and development, and could reduce the level of financial risk in the system and improve relationships between employers and employees. It could support integration with other members of the medical team and give value to doctors' activity and competences. Such a contract would be focused on the needs of patients and designed to fit the current landscape of healthcare provision.
- 7.47 Failure to change the current system will result in continuing financial risk, is likely to encourage increasingly adversarial relationships between doctors and their employers, and would potentially work against attempts to improve the way doctors are trained and developed. A full renegotiation would be considerably the most demanding option, but it would allow the contract to be fully redesigned around the current context, the actual needs of the service and the training needs of the doctors.

NHS Employers

The NHS Employers organisation is the voice of employers in the NHS, supporting them to put patients first. Our vision is to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.

We help employers make sense of current and emerging healthcare issues to ensure that their voice is front and centre of health policy and practice. We keep them up to date with the latest workforce thinking and expert opinion, providing practical advice and information, and generating opportunities to network and share knowledge and best practice.

We work with employers in the NHS to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

NHS Employers is part of the NHS Confederation.

Contact us

For more information on how to become involved in our work, email getinvolved@nhsemployers.org

www.nhsemployers.org

enquiries@nhsemployers.org

NHS Employers

4th Floor, 50 Broadway

London

SW1EH 0DB

2 Brewery Wharf

Kendell Street

Leeds LS10 1JR

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Ref: EGUI21701