

McMillan says employers are keen for pay to be linked more closely to organisational objectives and performance at a local level. However, Kane argues that linking pay with managerial targets, rather than personal appraisal goals, risks creating a bonus culture similar to that in banks.

The heads of terms talks about making the consultant contract “affordable for employers.” Importantly, it states that the negotiations are not intended to reduce consolidated pay—that is, basic pay; clinical excellence awards, discretionary points, or distinction awards; and London weighting—for any individual doctor currently on the 2003 contract.

Clinical excellence awards

The DDRB recognises the importance of clinical excellence awards and the other UK incentive schemes in recruitment and retention of NHS consultants. However, as with other elements of consultants’ remuneration, it has concerns that the awards are treated “as an extension to the basic pay scale” and reward length of service, rather than contribution to the NHS.

The solution the DDRB has put forward is to limit the funding available for these awards and to cap the proportion of consultants who could receive an award, to 10% of doctors for national awards and 25% for local awards.

The heads of terms doesn’t explicitly put forward these proposals. Instead, it looks at whether national and local awards schemes should be managed together or separately. One proposal is that local clinical excellence awards should be incorporated into the consultant contract. At the moment, local and national awards are administered independently by the Advisory Committee on Clinical Excellence Awards.

Kane says that putting local awards in the contract would ensure that the appropriate number and sum of awards are given each year without fail. He points to the reduction in employers’ allowance of local awards from 0.35 per consultant to 0.2 per consultant in 2011 as an example of something that wouldn’t be possible if the local scheme was in the contract rather than a stand alone system.

“What we have at the moment is that there is a contractual mechanism for the existence of a reward system but there is no contractual right



“What they’re actually saying is that there will only be 10% of people called consultants and everyone else will be called a subconsultant”
Tom Kane, deputy chair of the BMA’s Consultants’ Committee

for the local CEAs [Clinical Excellence Awards] system to progress each year,” he says. “[Putting local awards in the contract] will safeguard them and make sure that the whim of a secretary of state can’t remove them.”

Another issue on the table is whether local awards should continue with the system of self nomination or whether automatic consideration should be introduced. The BMA and NHS Employers have also agreed to discuss whether awards will be time limited to encourage “sustained excellence at all stages of a consultant’s career.”

Seven day working

At present, consultants have the right to refuse non-emergency work after 7 pm and before 7 am on weekdays, and at weekends. Those who do work during this “premium time” receive a higher rate of pay. The fact that consultants have an “absolute right” to refuse non-emergency work in premium time creates problems for employers, says McMillan. “If you want to extend clinics to 8 or 9 in the evening, then you’re paying premium rate. It’s a disincentive to do it when funds are tight,” he says. “We end up not planning services around patients’ needs but more with the needs of the doctors in mind.”

The out of hours and premium time arrangements, as well as the handling of scheduled and unscheduled care more generally, will be key in any discussions about using the consultant contract to facilitate seven day services. The heads of terms also state that negotiators will consider the possibility of facilitating seven day working within current contractual provisions.

The DDRB report did not tackle consultants’ working patterns. However, in its response to the report, the government expressed an explicit desire to push towards seven day working in the NHS.⁹

The BMA supports the concept of seven day working in urgent and unscheduled care, but it isn’t keen on elective and non-emergency care being provided in the evenings and at weekends. Kane says that consultants who work out of hours shifts can’t provide good care unless all the relevant support staff, such as radiographers and porters, are working the same hours too.

“If you start looking at how elective care is provided, there’s a raft of people you need to have there [as well as the consultant],” he says. “If the NHS is being asked to reduce its costs, how it can then expand the service it provides?” The heads of terms does mention that any work done by consultants in premium time should be sufficiently supported by other services in the hospital. That would in theory end the situation where doctors are hampered by not being able



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to get hold of scans or laboratory results out of hours.

Importantly, the document includes a commitment to making sure any changes to the consultant contract do not hamper consultants’ health and their work-life balance. Any contractual changes will include safeguards on the proportion of the job plan that can be delivered in premium time and on the frequency and minimum rest between duties for different periods of premium time.

What next?

The heads of terms is fairly clear that any changes will maintain a national contract, but “national” only encompasses consultants in England and Northern Ireland. The BMA’s consultants committees in Scotland and Wales have decided not to take part in the contract talks with NHS Employers. Consultants in Scotland and Wales are already on different contracts, and the consultants committees in these two regions are not convinced that negotiations on a UK-wide contract are in the best interests of doctors in their respective devolved nations.

Neither the BMA nor NHS Employers has yet formally agreed to enter negotiations on the consultant contract. The BMA needs a mandate from its members first, which it will seek at a meeting on 18 September, and NHS Employers needs a mandate from the English and Northern Irish departments of health. For any changes that are agreed, the BMA would need to put the proposals to a ballot. The best case scenario is that any contract changes will be agreed by Easter next year, although both sides agree that this is an optimistic goal.

A seemingly innocuous addition to the heads of terms is whether the negotiations will lead to a new contract or amendment of the current 2003 contract. If a new contract was introduced, it would apply only to the consultants who agreed to sign it and likely new starters. However, amendment of the existing contract would mean that all consultants on the 2003 version would be subject to the changes.

Competing interests: None declared.

References are in the version on careers.bmj.com

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