

Junior doctors'
contract

*Safer for patients,
fairer for doctors*



Junior doctors' contract offer – what it means for you

4 November 2015

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Introduction

Dear colleague,

I have this morning written to the chair of the Junior Doctors' Committee to make a firm offer of a revised contract for junior doctors in the NHS in England. A copy of this letter is available at www.nhsemployers.org/juniordoctors. You will note that I invite the BMA to meet with me to discuss how we might finalise the offer, which can be found on pages 17-35 of this booklet.



This firm offer is safer for patients and fairer for doctors. It will be implemented for new junior doctors and those junior doctors changing roles from August 2016. The offer does not apply to trust doctors, whose terms and conditions are set locally by their employer.

The offer reflects the work undertaken with the BMA from 2012 until 2014, as reflected in the Heads of Terms we agreed in July 2013. It addresses issues and concerns that you have raised over the last few weeks, including an increase in basic pay; a recognition that Saturday evening constitutes unsocial hours; flexible pay premia to supplement shortage specialties; limits on nights and days worked in any week and a guarantee that this contract will not impose longer hours. The offer is supported by a guarantee of protection, which means that your present earnings (other than any at band 3) will be at least maintained as at August 2016.

This booklet provides an explanation of the offer, the offer in full, and further information for you. There is also more information on our website, including a pay calculator and information on the key parts of the offer. You can access this at www.nhsemployers.org/juniordoctors

Your trust's medical and HR directors have been asked to organise local engagement meetings so that you can discuss the offer, so please look out for these. These meetings will also enable you to feedback your comments, so you can help inform the remaining details and the offer can be finalised. However, my preference is still for this to be done through negotiation with the BMA.

You can also ask questions via our email address at juniordoctors@nhsemployers.org, via our new Facebook page at [facebook.com/NHSEmployers](https://www.facebook.com/NHSEmployers) or on twitter [@nhsemployers](https://twitter.com/nhsemployers) #juniorcontract.

Yours sincerely

Daniel Mortimer

Chief Executive, NHS Employers

Section 1 – Why we need a new contract

Junior doctors are the clinical leaders of the future. Your valued contribution needs to be rewarded through transparent contractual arrangements that are fairer for you, better for your training - and better and safer for your patients.

Since 2008, employers and the British Medical Association (BMA) have agreed that the current contract needs to be modernised. They also agree that the current banding system (introduced in 2000) is outdated, unfair and operates with unintentional consequences.

A fairer system that rewards those who work the most unsocial hours is needed. For example, under the current contract, some doctors who work 41 hours could be paid the same as some who work 48 hours, and a doctor working 9am-6pm, Monday-Friday can be paid the same as a doctor working shifts 24/7.

The government also wants an end to the current system where NHS employees receive pay increases every year for time served. Some doctors continue to receive an incremental increase each year even though they are not progressing to an increased level of responsibility.

Timeline of activity

Below is a brief outline of how we got to where we are with the contract negotiations.

| | |
|---------------|--|
| June 2011 | <ul style="list-style-type: none">• Scoping study setting out a vision and principles for a new contract for doctors in training. |
| June 2013 | <ul style="list-style-type: none">• Heads of Terms agreed with the BMA for negotiations. |
| October 2013 | <ul style="list-style-type: none">• NHS Employers mandated by all four UK health departments to begin negotiations with the BMA on a new contract for doctors and dentists in training; negotiations to be completed by October 2014 and implementation to begin in April 2015. |
| February 2014 | <ul style="list-style-type: none">• Interim joint report submitted on the negotiations to Health Ministers. Report confirmed that both sides had agreed that the new contract must be cost neutral, that high-level definitions of pay had been agreed and discussions to develop a set of pay principles were continuing. |
| October 2014 | <ul style="list-style-type: none">• BMA withdraws from negotiations.• Doctors and Dentists Review Body (DDRB) asked to make observations and recommendations on new contractual arrangements based on the work undertaken in the negotiations and with reference to the agreed Heads of Terms. |
| July 2015 | <ul style="list-style-type: none">• DDRB report and recommendations published.• BMA and NHS Employers meet with Lord Prior. |
| August 2015 | <ul style="list-style-type: none">• BMA Junior Doctors' Committee confirm not re-entering negotiations. |

Section 2 – Understanding the offer

Who will the new contract cover?

From 3 August 2016, new contractual arrangements will cover those trainees in hospital posts approved for postgraduate medical and dental education, replacing:

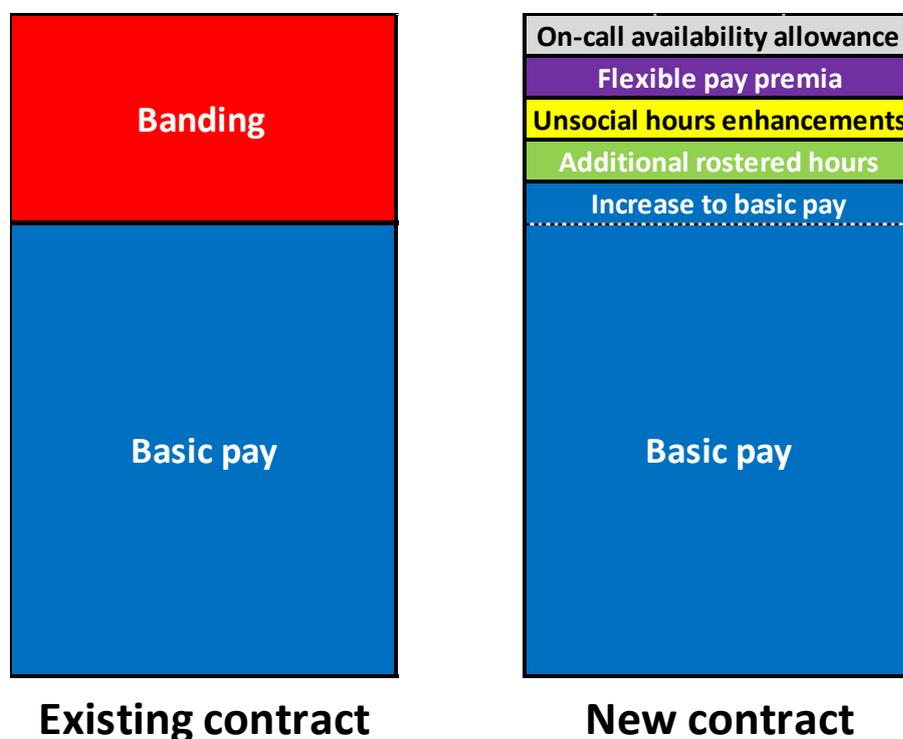
- the New Deal arrangements, 2000
- the Hospital Medical and Dental Staff Terms and Conditions of Service, 2002, as they apply to trainees.

The new arrangements will also apply to general practice trainees during the approved general medical practice placements that form part of postgraduate medical education.

They will not apply to those undertaking vocational training placements in general dental practice.

The new arrangements will not apply to trust grade doctors, as their terms are a matter for their employing trust.

What will the new contract offer?



Basic pay

Basic pay will increase on average by 11 per cent and junior doctors will be paid for every hour worked.

Transitional pay protection will be applied. This ensures that no junior doctor, working within the New Deal limits on working hours, will see their pay cut compared to their current contract.

Flexible pay premia

Under the new contract, flexible pay premia (FPP) will ensure the NHS is able to protect shortage specialties by increasing total pay in hard to fill training programmes, ensuring they are incentivised appropriately in line with changing system priorities. For example, FPP could apply to increase pay for training programmes where recruitment is poor and where there is evidence that increasing pay would improve recruitment and retention.

For 2016, FPP will apply to general practice, emergency medicine and psychiatry. Determining the application and level of such payments in the future will take account of the national shortage occupation list and advice from Health Education England and other stakeholders. The Doctors' and Dentists' Review Body (DDRB) will be provided with evidence to enable them to review the use of FPP and make recommendations to government on appropriate application and value.

In summary FPP will be used for:

- those in hard-to-fill training programmes (including those who choose to switch to hard-to-fill training programmes)
- those taking time out of the 'standard' training pathway in specific circumstances.

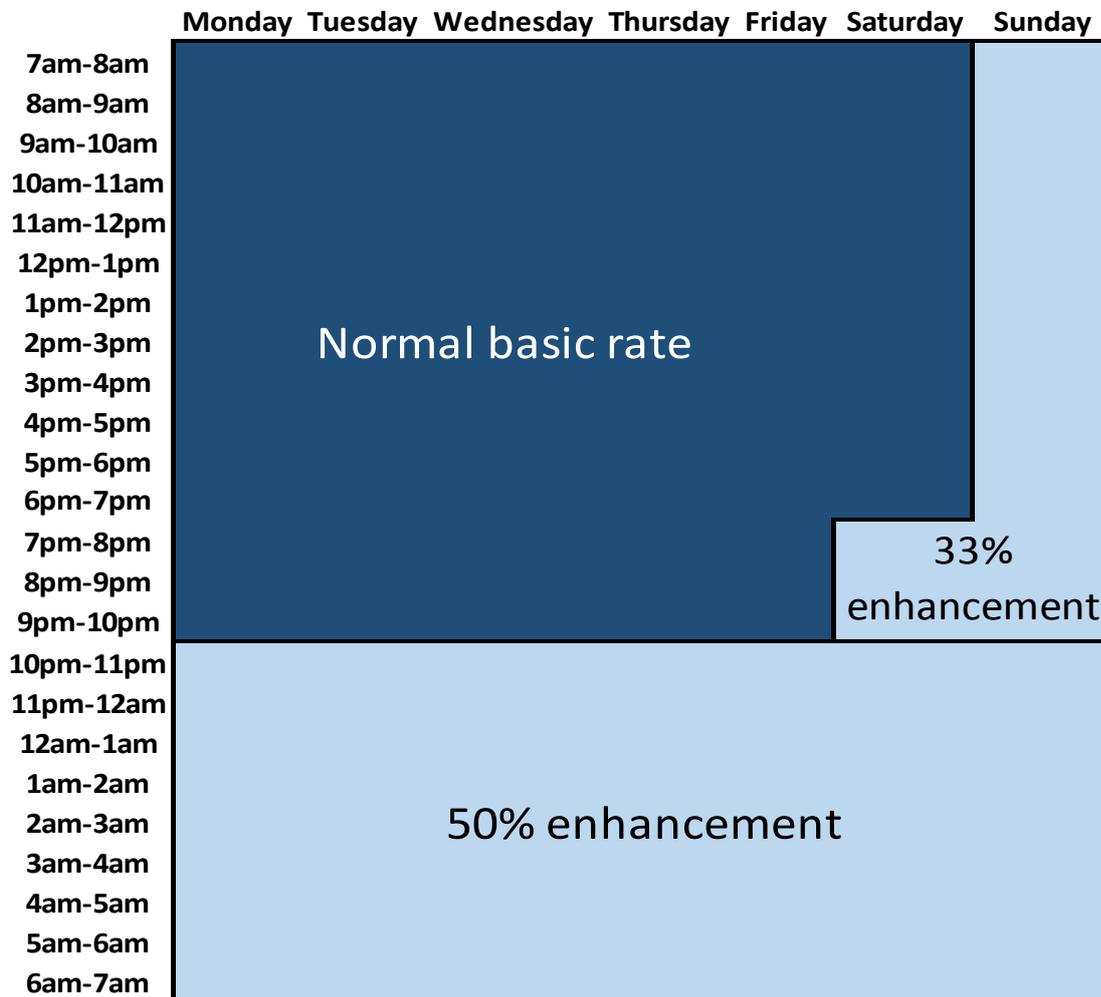
Unsocial hours

The new contract rewards those that work at the most unsocial times:

| | | |
|---|----------|------------------|
| Monday - Friday | 7am-10pm | Plain time |
| Saturday | 7am-7pm | Plain time |
| Saturday | 7pm-10pm | Time and a third |
| Sunday | 7am-10pm | Time and a third |
| Any work between 10pm - 7am (seven days a week) | | Time and a half |

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On-call allowances

These are availability allowances that are payable to trainees who are available to return to work. In addition, there will be payment for hours at work or giving advice remotely, which will be included in the work schedule and paid at the normal hourly rate, including any pay enhancement for work done in unsocial hours.

| Proposed Frequency | Proposed Rates |
|------------------------------------|----------------|
| 1:4 or more frequently | 6% |
| Less frequently than 1:4 up to 1:8 | 4% |
| Less frequently than 1:8 | 2% |

Additional rostered hours

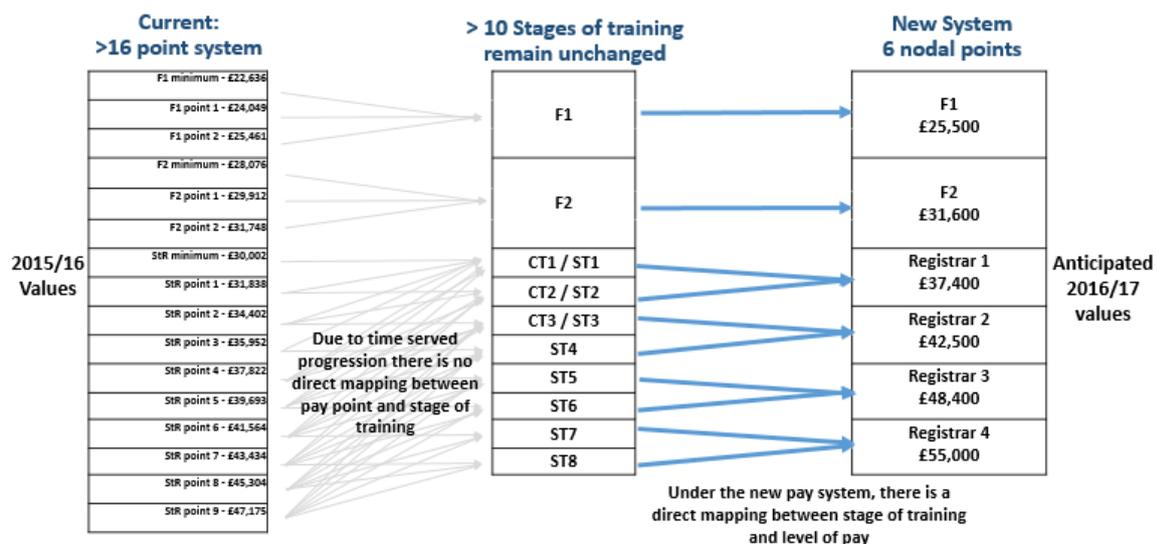
Additional rostered hours are any hours per week above the 40 basic, full-time hours. They will be paid at the basic hourly rate, with pay enhancements for hours falling in unsocial hour periods.

Pay progression

The new pay system rewards junior doctors as they progress through training and take on additional responsibility. Typically, over a ten-year period of training, most junior doctors will have four or five progression pay rises.

Base pay old and new number of pay points and levels

Base Pay old and new number of pay points & level



Working hours

The new contract includes further contractual limits on hours than the current limits in legislation and in the existing contract. These include:

- a maximum of 48 hours on average per week (extended to 56 hours a week on average for those trainees who choose to opt-out of the Working Time Regulations)
- a new maximum working week of 72 hours in any consecutive seven-day period (compared to the current contract which permits 91 hours)
- no shift (other than an on call duty period) to exceed 13 hours
- a new maximum shift pattern of four consecutive night shifts of any length can be worked (compared with the current contract which permits seven consecutive night shifts)
- a new maximum shift pattern of five long day shifts, (compared with the current contract which permits six long day shifts).

- no doctor should be on duty for more than seven consecutive on-call periods.

Work schedules and safeguards

A template work schedule for each post will set out the expected service commitments and those parts of the relevant training curriculum which can be achieved in the post.

The schedule will be discussed at the trainee's regular educational meetings to ensure the workplace experience delivers the anticipated learning opportunities.

A trainee can report exceptions to educational supervisors where day-to-day work varies significantly or routinely from that in the work schedule either in:

- hours of work (including rest breaks); or
- the agreed working pattern, including the educational opportunities made available.

A work schedule review can be triggered by one or more exception reports, or by a request from either the trainee or the supervisor for a review.

There will be an obligation on employers to complete annual returns on how work schedule reviews have been managed. These will be sent to: Health Education England, which is responsible for giving educational approval to training posts; the Care Quality Commission (CQC), to ensure that there is robust, external scrutiny of hours; and the DDRB.

There will be serious consequences for trusts and their boards who receive low inspection ratings for safe staffing requirements, including the risk of training programmes being withdrawn.

Equality

The new contract will continue to support junior doctors who have children, as parental leave arrangements will not change.

Doctors who take time out of training to have a baby will continue to be entitled to 12 months' maternity leave, and to existing maternity payments depending, as now, on length of service.

Part-time staff will be treated the same as full-time staff (pro-rata to full-time equivalent).

The new pay system and contract will not break any equality laws and will be subject to a full equality impact assessment before implementation.

Pay protection

The new contractual arrangements will lead to no reduction in the pay bill (per full-time equivalent) and no reduction in average earnings across the training grade medical workforce. There will be an initial period of transitional protection arrangements for existing trainees.

The following trainees will be moved onto the new terms and conditions effective from 3 August 2016, where they move between posts and/or contracts of employment, and will be offered cash pay protection:

- all trainees remaining on F1 or remaining on F2
- all trainees entering F2
- all new entrants to core or run through specialty training (CT1 / ST1 points)
- all trainees moving into CT2 / ST2 existing points (and CT3 point where it exists)
- all trainees remaining in the CT1, ST1, CT2, ST2 or CT3 (where it exists) grades in August 2016
- all new entrants to higher (non-run through) training (at ST3 point and in some specialties at ST4 point).

Their pay protection will be calculated and will be used as a baseline or “consistent cash floor” for each year until either the trainee exits training or until 31 July 2019, whichever is the sooner. This will then be compared against the trainee’s actual “new contract” pay on 3 August 2016. The same principle will apply to GP trainees in practice placements on 3 August 2016.

Annually until 2019, actual pay will then be compared with the cash floor established for 3 August 2016. Where actual pay on 3 August 2016 is higher than the cash floor, the trainee will receive actual pay, where actual pay is lower than the cash floor on 3 August 2016, a trainee will receive an additional amount in pay protection sufficient to return the trainee’s pay to the level of the cash floor.

Details on how pay protection will be calculated can be found in Annex A.

Trainees already in run-through or higher training at 2 August 2016 would be moved onto the terms of the new contract on 3 August 2016. The new terms and conditions would be used for the purposes of organising their work and all other matters. Under transitional pay protection, they would continue to be paid using the old system of banding (subject to the maximum of band 2A - 80 per cent - for those who have opted out of the Working Time Regulations, which is also the highest level to which protection can be applied under the current contract), and annual increments until they exit the programme or until 31 July 2019, whichever is the sooner. This preserves pay expectations, on the basis of the safe working patterns enshrined in the new contract, for those who could complete training during the transitional period.

Section 3 – Pensions

The new junior doctor contract will lead to a fairer pay system, and will include higher basic pay and the redistribution of earnings currently paid in the form of banding supplements. Currently, the banding supplement is not pensionable and pension benefits are not accrued in relation to this element of pay.

An increase in basic pay will mean an increase in pensionable pay. For those in the 2015 NHS Pension Scheme (likely to be the majority of junior doctors) this will mean a greater contribution towards your final pension received compared to the current pay system, as it takes account of pensionable earnings in every year of scheme membership.

The 2015 NHS Pension Scheme is a Career Average Revalued Earnings (CARE) scheme. The pension you earn each year is based on pensionable pay in that year and is revalued by a set rate, linked to inflation, for each year up to retirement. You earn 1/54th of your pensionable pay as pension for each year you work. This is then 'revalued' (increased to account for inflation) using an agreed formula until you retire. Each year of pensionable pay continues to be revalued until you retire.

Your total pension is equal to each year of pension you have earned (after it has been revalued). Your pension earned each year will be subject to 'revaluation' to account for inflation in the period before you retire or leave. In the 2015 NHS Pension scheme, the revaluation is based on the Consumer Price Index (CPI) inflation plus 1.5 per cent each year.

Illustrative example

**Pension value with new contract offer
(based on £26,920 basic pay)**

| | Work year 1 | Work year 2 | Work year 3 | Work year 4 |
|----------------------|-------------|--------------|--------------|--------------|
| Year 1 pension | £499 | £516* | £534* | £553* |
| Year 2 pension | | £499 | £516* | £534* |
| Year 3 pension | | | £499 | £516* |
| Year 4 pension | | | | £499 |
| Pension value | £499 | £1015 | £1549 | £2102 |

**Pension value with current offer
(based on £22,636 basic pay)**

| | Work year 1 | Work year 2 | Work year 3 | Work year 4 |
|----------------------|-------------|-------------|--------------|--------------|
| Year 1 pension | £419 | £434* | £449* | £465* |
| Year 2 pension | | £419 | £434* | £449* |
| Year 3 pension | | | £419 | £434* |
| Year 4 pension | | | | £419 |
| Pension value | £419 | £853 | £1302 | £1767 |

* Revalued at 3.5 per cent, assuming 2 per cent CPI + 1.5 per cent

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As you are earning more pensionable pay, the amount you contribute through your employee contribution towards your pension scheme will increase accordingly. Your employer will continue to contribute 14.3 per cent of your pensionable pay towards your pension. You can find more about employee pension contributions on the NHS Business Authority Services [website](#).

Section 4 - What happens next?

Annex A describes the offer in England, which will be for doctors and dentists in approved national training programmes overseen by Health Education England. It is the government's intention to provide a new contract for employers to introduce and use locally as of 3 August 2016, replacing the current contract for doctors in training programmes.

The information presented in Annex A is what is known at this stage. As stated previously, the government's preference throughout has been, and continues to be, to reach agreement through negotiations with the BMA.

All doctors and dentists in training will transfer to new terms and conditions on 3 August 2016. For those already employed under the existing arrangements, transitional arrangements and pay protection arrangements will apply, as described in Annex A.

It is recognised that trusts will have a significant amount of work to do in order to make arrangements in preparation for the introduction of new contracts in August 2016. NHS Employers will be working with trusts over the next few months to ensure these preparations can be made, including:

- publishing detailed resources and guidance on a range of topics such as work scheduling, work reviews, and rota design (to take in to account the new working hours rules)
- providing training to regional leads, and disseminating expertise through regional networks
- updating trusts regularly through targeted communications products.

Guidance on work scheduling and rota design should allow trusts to make a start on converting existing rotas to work schedules in advance of sending out offers to doctors in time for their August 2016 start date.

NHS Employers is in discussions with Allocate Software and Skills for Health. As the providers of rota software to trusts, both organisations are being asked to ensure that they are able to provide trusts with the services they need in order to transfer existing rotas across to new arrangements, check that rotas comply with the new rules on working hours, and ensure individual pay can be calculated.

NHS Employers is also in discussions to ensure that any necessary changes are made to the Electronic Staff Record (ESR) to accommodate new arrangements.

Recognising that this offer is firm but not final, the Department of Health has mandated NHS Employers to work on final details, including the continuation of detailed modelling, data gathering, and testing. **It is important to re-iterate that figures in this document are still illustrative at this time.**

It is recognised that the involvement of relevant stakeholders is essential to ensure the final contract is right for both doctors and the NHS. The expert knowledge of relevant stakeholders will continue

to be used as the final detail of the new arrangements is worked through. This will include working with Health Education England, the Universities and Colleges Employers Association, the Medical Schools Council, the Medical Royal Colleges, the Care Quality Commission, NHS employing organisations, Skills for Health, Allocate, ESR, and other interested parties.

An Equality Impact Assessment of the new arrangements will also be undertaken.

When all arrangements have been finalised, NHS Employers will publish the new Terms and Conditions of Service for doctors and dentists in training, and a Medical and Dental Pay and Conditions Circular containing new rates of pay.

Section 5 - Find out more

NHS Employers website

Access all the latest information and resources on the junior doctors' contract at www.nhsemployers.org/juniordoctors including:

- **Pay calculator.** Our new calculator will help you to calculate the typical salary for a junior doctor under the current and proposed contracts.
- **Video.** This short video lays out the facts about the junior doctors' contracts, dispels myths and tackles key concerns and issues.
- **FAQs.** Find answers to all your queries by reading our Frequently Asked Questions (FAQs), which will be continually updated.

NHS Medical Contracts Bulletin

Email juniordoctors@nhsemployers.org to subscribe to our new bulletin to receive the latest news direct to your inbox.

Facebook and twitter

If you have a Facebook account then join in the conversations and keep up to date with all the latest news by liking our junior doctors' Facebook page at facebook.com/NHSEmployers or on twitter [#nhsemployers](https://twitter.com/nhsemployers) [#juniorcontract](https://twitter.com/nhsemployers).

Questions

You can also ask questions via our email address at juniordoctors@nhsemployers.org

Annex A – The offer in full

New contractual arrangements for doctors and dentists in training: the offer

Introduction

1. This paper describes the offer on a new contract for doctors and dentists in training in England.
2. It has long been agreed, by all parties, including the British Medical Association (BMA), that the current “New Deal” contract introduced in 2000 is no longer fit for purpose and that there is a need for a new professional contract for service for doctors and dentists in training. That was reflected in Heads of Terms¹ agreed between NHS Employers and the BMA Junior Doctors’ Committee (JDC) in July 2013 that served as the basis for UK-wide negotiations (with the BMA JDC also representing the British Dental Association, BDA), which began in October 2013. The team negotiating with the BMA comprised employer representatives from England, Wales, Scotland and Northern Ireland, and included a Medical Director. Educational input and advice was provided by a Director of Postgraduate Hospital Training and a Director of Postgraduate GP Education as representatives of the Conference of Postgraduate Medical Deans (UK) and the Committee of General Practice Education Directors (UK). UK Health Departments had observer status.
3. The BMA JDC walked away just before the conclusion of those negotiations in October 2014. The Government – the four UK Health Departments - then asked the independent Review Body on Doctors’ and Dentists’ Remuneration (DDRB) to make recommendations on new contractual arrangements, including a new system of pay progression with a strengthened link between pay and better quality patient care and outcomes.
4. The Department of Health had also made clear that the current system of annual incremental pay progression on the basis of time served since commencing training, (separate to any cost-of-living pay increase) should end². This is consistent with the Government’s intention for the whole of the public sector in England. Furthermore the current position whereby doctors at a lower stage of training with less responsibility can earn more than others who are at a higher stage of training with greater responsibility is unfair.

¹ http://bma.org.uk/-/media/files/pdfs/news%20views%20analysis/in%20depth/junior%20consultant%20contracts/juniorscontract_headsofterms.pdf

² <https://www.gov.uk/government/publications/special-remit-letter-of-30-october-2014-from-department-of-health>

5. The DDRB took evidence from various parties including NHS Employers (whose evidence set out the UK-wide proposals made in negotiations)³, the BMA, NHS Providers, Health Education England, NHS England and the Government⁴. Its report in July 2015 made 23 recommendations⁵. The Government and NHS Employers accepted these as the basis for further negotiations and asked the BMA to return to the table.
6. Our preference throughout has been, and continues to be to reach agreement through negotiations. We have given assurances to the BMA JDC, further to our acceptance of the recommendations, to address their concerns⁶. The BMA JDC have refused to re-enter negotiations and their representation of the proposals has been misleading both for trainees and for the public. This paper represents the Government's offer in England, which will be for doctors and dentists in training programmes overseen by Health Education England.
7. This offer is firm but not final. This allows appropriate flexibility to further refine what is described in this paper, taking account of more detailed modelling on the distribution of pay and of the impact of the change on those currently in training. The final details will be published in Terms and Conditions and made available during January/February 2016, along with details of pay rates and model contracts for implementation from August 2016. Guidance and supporting tools will be also be made available during February/March 2016.
8. In the absence of national collective agreement, it is our intention to provide a new contract for employers to introduce locally for use in place of the current contract for doctors in training programmes as of 3 August 2016.
9. NHS Employers has been asked to continue to develop the new contractual arrangements. Engagement with stakeholders will continue to inform this work.

Scope

10. Doctors and dentists in postgraduate medical education (trainees) undertake a series of posts of employment in hospital and /or general practice settings; some also spend time in other environments as part of their required training. Training programmes are approved by the General Medical Council (GMC) or General Dental Council (GDC). Learning environments and posts used for training are recommended for approval by Health Education England for the purpose of postgraduate medical/dental education. Time spent in those posts/environments

³ <http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/medical-pay/ddrb-evidence---in-detail/consultants-and-junior-doctors-contract-reform-submission-of-evidence-to-the-ddrb>

⁴ <https://www.gov.uk/government/publications/evidence-for-pay-review-bodies-of-healthcare-professionals>

⁵ <https://www.gov.uk/government/publications/contract-reform-for-consultants-and-doctors-and-dentists-in-training-supporting-healthcare-services-seven-days-a-week>

⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/466589/Health_Secretary_to_JDC_Chair.pdf

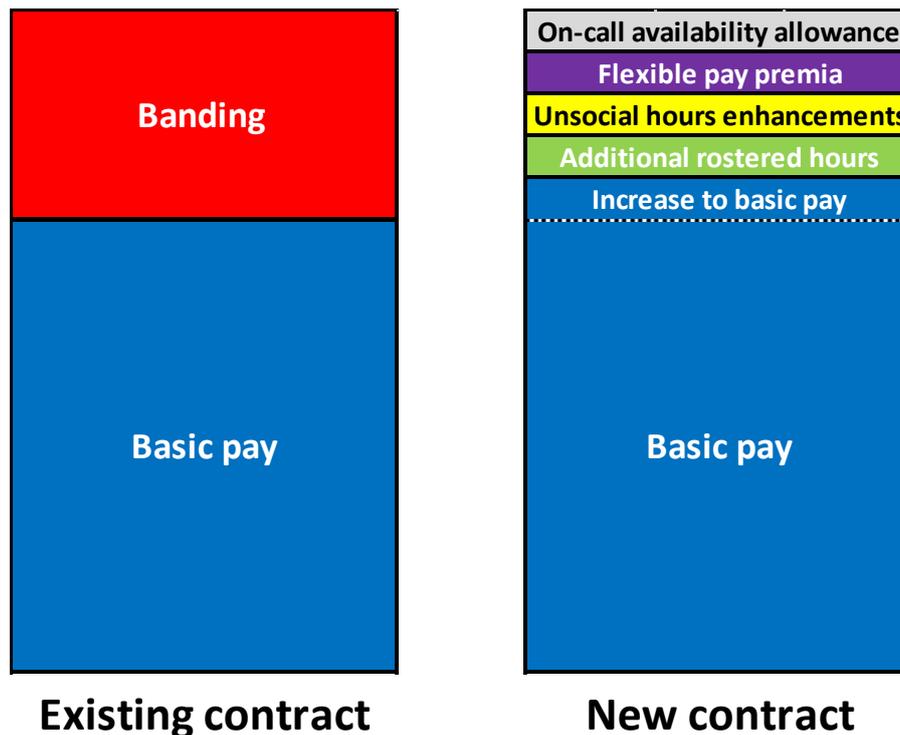
allows the trainee to acquire and demonstrate the competencies to progress through the training pathway for their chosen specialty (including general practice) and to acquire a Certificate of Completion of Training (CCT). The CCT allows the doctor or dentist to apply for entry onto the GMC's Specialist Register or GP Register – a legal requirement for practising as a fixed term, substantive or honorary medical consultant or as a general practitioner – or the GDC's Specialist lists. The offer outlined in this paper is intended to apply to all trainees whose training programme is described above.

11. From 3 August 2016 new contractual arrangements will cover those trainees in hospital posts approved for postgraduate medical/dental education, replacing the existing arrangements of:
 - a. the “*New Deal*” arrangements, 2000; and
 - b. the *Hospital Medical and Dental Staff Terms and Conditions of Service, 2002*, as they apply to trainees.
12. All doctors in training will transfer to new terms and conditions in August 2016. The existing terms and conditions will be closed and all trainees exit from them. For trainees already employed under the existing arrangements, transitional pay protection arrangements will apply, as described in paragraphs 64-67.
13. The new 2016 contractual arrangements will also apply to general practice trainees during the approved general medical practice placements that form part of postgraduate medical education, and will replace provisions currently contained in Schedules to the *Directions to Health Education England (GP Registrars)*. Again, for trainees already employed under the existing arrangements, transitional pay protection arrangements will apply, as described in paragraphs 64-68.
14. They will not apply to those undertaking vocational training placements in general dental practice.

Features of the new contract: Elements of pay

15. The current system of basic pay and broad banding supplements will be replaced with a new pay structure that more fairly rewards trainees for actual work done, and which will include:
 - a. Increased basic pay
 - b. Pay for rostered additional hours paid at an appropriate rate
 - c. Enhanced (higher) rates of pay for any hours (including additional hours) worked in the unsocial hours periods (nights / weekends)

- d. On-call availability allowances and payment for work undertaken as a result of being on-call
- e. Flexible pay premia



Basic pay

- 16. Pay arrangements will be consistent with the Government requirement to end systems of time-served incremental pay progression across the public sector in England, and with legislation that requires employers to ensure equal pay for work of equal value. They will also strengthen the link between pay and outcomes, as recommended by the DDRB.
- 17. Under the current contract, basic pay typically increases each year regardless of time commitment, level of responsibility or performance (it increases on the basis of time in employment). This means someone working at a lower level of responsibility can earn more for the same hours than someone working at a higher level of responsibility. Pay progression in future will be linked to promotion to posts with higher levels of responsibility, having established competencies through training to work at that higher level. This is consistent with the GMC's wishes to make progression through training programmes competence-driven rather than time-based.
- 18. Negotiators considered alternative systems of regular increases to basic pay that were not purely time-served but no suitable proposals could be devised. No appropriate measures could

be proposed by any party, other than progression increases occurring on the satisfactory completion of a stage of training through acquiring all necessary competences within the approved curricula and the subsequent taking up of a post at the next level of responsibility. The proposal, therefore, is for increases in rates of basic pay at 'nodal points' through the career pathway where there are distinct and significant increases in responsibility. Thus, the basic pay rate will be directly correlated to level of responsibility in the workplace. (Even if a suitable measure could have been found for annual increments, retaining them would have meant having several pay points, and therefore a lower 'starting' point and a lower salary at each change in level of responsibility).

19. The current extended payscale (with sliding rates of basic pay) will be replaced by a limited number of nodal points at which the rate of basic pay increases. Basic pay will increase on taking up a post at the next level of responsibility (for which the satisfactory and certified completion of necessary training through the acquisition of required competencies identified within the curricula is a pre-requisite). It is the taking up of the post, and not the acquisition of required competencies or completion of training, that would trigger the move to the higher rate of basic pay (nodal point). Most trainees will thus have four or five progression pay rises through training. GP trainees will have three, as their training path has a shorter curriculum and fewer step changes in responsibility.

20. **The final values of each element of pay will depend on the completion of final detailed pay modelling, which is why this is a firm, but not a final, offer.** The table below sets out *indicative basic pay points* on a nodal point scale.

| Experience Level | New Node | Recalibrated 16/17 Value (£ rounded) | Progression |
|------------------|----------|--------------------------------------|--------------|
| FP1 | F1 | 25,500 | 24.0% |
| FP2 | F2 | 31,600 | 18.4% |
| ST1 ST2 | ST1/2 | 37,400 | 13.8% |
| ST3 ST4 | ST3/4 | 42,500 | 13.8% |
| ST5 ST6 | ST5/6 | 48,400 | 13.8% |
| ST7 ST8 | ST7/8 | 55,000 | Top of scale |

Pay for additional rostered hours

21. Basic pay will be for a 40 hour week, including paid breaks. Additional rostered hours, up to a maximum of 8 hours, will be paid proportionately, i.e. at 1/40th of whole-time equivalent pay.

Enhanced pay for work at night and on Sunday

22. We want to increase basic pay for all trainees, to better recognise their ongoing professional contribution to a seven-day NHS. Research commissioned by the DDRB shows that other sectors increasingly reward work being carried out during evenings and Saturdays through enhancements to basic salary in this way.

23. In addition, we also want to reward appropriately those who work at the most unsocial times. Hours worked during the following periods will attract enhancements to pay rates compared with basic, as follows:

- i. Saturday 7pm-10pm and Sundays 7am-10pm will be enhanced by an addition of one third of the basic hourly pay rate;
- ii. nights 10pm-7am will be enhanced by an addition of one half of the basic hourly pay rate.

Pay for on-call availability

24. Trainees on an on-call rota where they are available to return to work or to give advice by telephone but are not expected to be on site for the whole period will be paid an on-call availability allowance.

25. The value of these allowances will take the form of a percentage multiplier applied to the value of the individual trainee's basic pay. The percentage will vary, depending on the frequency of the on-call rota commitment.

| Proposed Frequency | Proposed Rates |
|---|-----------------------|
| 1:4 or more frequently | 6% |
| Less frequently than 1:4 up to 1:8 | 4% |
| Less frequently than 1:8. | 2% |

Pay for work done while on-call

26. Trainees will be paid for actual work undertaken while on-call, at the rates of pay described in paras 21-23 above. The amount of work will be prospectively estimated and averaged over a rota

cycle and included in the work schedule for this purpose; this allocated amount can be reviewed at any time through the work schedule review process should activity increase or decrease over time.

Flexible pay premia

Flexible pay premia for those on training programmes in hard-to-fill specialties

27. The DDRB recommended that flexible pay premia should be used to incentivise recruitment to, and retention in, agreed hard-to-fill specialties.
28. Where flexible pay premia are applied they will be paid to those already in training at transition (if in one of the categories identified in paragraph 65 below), or to those entering training programmes at a time that a premium applies – and they will be payable to those trainees for the duration of that eligible training programme. Where the level of a premium changes, or where a premium is introduced or removed, in subsequent years, that change will not apply to those already in training, but only to new entrants to that programme.
29. *A flexible pay premium for general practice will replace the current GP training supplement, operating in much the same way and set at a value which preserves the parity in pay that GP trainees enjoy at present.* Trainees seeking to become general practitioners move through a series of approved posts in the hospital and general practice settings – two years foundation training followed by three years of vocational training. In the hospital-based posts they are paid in the same way as all other hospital trainees, and currently receive banding payments which are fixed percentages of basic salary (20%, 40%, or 50%) to recognise additional or unsocial hours worked. In the general practice setting - where these banding payments do not apply as trainees rarely work more than 40 hours per week, or during evenings, nights or weekends – GP vocational trainees are paid a GP training supplement to ensure that pay is broadly in line with average earnings for trainees in hospital-based training programmes. The GP training supplement has been reduced over a number of years, in line with the decrease in the average level of the hospital banding supplements in payment, to the current level of 45% of basic pay.
30. The application of the flexible pay premium as described above, coupled with an offer of pay protection on transition (described in paragraphs 64-68), will maintain current earnings for existing GP trainees.
31. In addition to general practice, flexible pay premia will also apply for those on training programmes in *emergency medicine* and *psychiatry*.
32. As set out in paragraph 20, the final values of each element of pay will depend on the completion of final detailed pay modelling. ***Therefore, the values of the flexible pay premia shown below are, as with the basic pay nodal points values, indicative only:***

- General practice (in vocational training practice placements): £8,200 p.a.
- Emergency Medicine (ST4 and above): £1,500 p.a.
- Psychiatry (ST1 and above): £1,500 p.a.

33. In determining the future application and level of such payments onwards, we will take account of the National Occupation Shortage List and advice from Health Education England and other stakeholders. The DDRB will in future be provided with evidence about hard-to-fill training programmes, to enable them to review the use of the premia and make recommendations to Government on appropriate application and value.

Flexible pay premia for those choosing to retrain/switch specialty

34. Flexible pay premia will also be used to provide pay protection to individuals choosing to retrain on agreed hard-to-fill training programmes, to offset any loss of salary that might otherwise apply in these circumstances.

Flexible pay premia for those taking time out of the 'standard' training pathway

35. There are some whose training pathway means stepping off the 'typical' trajectory of a hospital or GP training pathway and then returning – these include clinical academics and those training in public health.

36. Where this step off is to undertake an activity that is a requirement of the training curriculum and / or is essential for the achievement of a certificate of completion of training (CCT) or to the taking up of a training post at the next level of responsibility, eg undertaking a PhD – pay progression should be comparable to that achieved by trainees who did not step off for these purposes. We will therefore apply flexible pay premia when these trainees return to training following the successful completion of such qualifications, at the point that they take up a higher level of responsibility, to ensure that there is no disadvantage in pay progression for these trainees when compared with those on other training pathways. The value of the premium will be related to the expected length of time spent out of training to achieve the qualification. The detail of this is being completed, but the assurance of such progression is categorical and was endorsed by the DDRB's recommendation.

37. The same approach will apply to those who take a break from training to undertake other postgraduate qualifications not required for a CCT, but where the work is deemed to benefit the wider NHS and / or the continuing improvement of patient care and to those taking a break from training for exceptional reasons that benefit the NHS or health provision more broadly. There will be guidance on the circumstances in which employers should apply premia when trainees return to the training pathway. Those will include certain identified and agreed research work and identified, time out for attending to public health emergencies and successful completion of agreed leadership programmes.

38. To provide the assurance of payment of the premium to those junior doctors pursuing research, there would be:

- An agreed list of research funders whose funding of a doctor would mean they automatically qualified for the pay premium on return to training
- If a junior doctor pursues study outside these bodies, then HEE Locally (through its Postgraduate Deans) would decide whether their research would qualify them for the premium
- An appeals process to the National Institute for Health Research against any refusal by HEE Locally to agree to this.

The principles underpinning this approach to pay

39. The new contract will move away from a time-served pay system to one that rewards trainees equally with others as the same stage of training and level of responsibility. The proposals described in the paragraphs above are more equitable than the current arrangements. In general (with explicit provision for premia for hard-to-fill specialties), all trainees will be treated equally.

40. The proposals remove an existing, unfair, advantage that allows some trainees to be paid more than others at the same stage of training purely on the basis of time – including those who train part-time while working part-time in other roles (eg, for another employer or running their own business); and those who take a break from training but undertake activities that can be counted for (time-served) qualifying service, such as maintaining a minimal NHS commitment or working in hospitals in countries such as Australia.

41. For those taking a break for maternity/parental leave, there will be no change to the existing leave and pay entitlements. Pay on return will be the same as for other trainees working at the same level of responsibility. This is consistent with what happens for other public sector staff.

Features of the new contract: Working hours

42. There will be contractual limits on hours. These will go further than the limits in legislation and the “New Deal” limits in the existing contract. There will be limits of:

- a. Contractual hours between 40-48 hours as now
- b. A maximum of 48 weekly hours on average (extended, but still limited, to 56 hours a week on average for those trainees who choose to opt-out of the Working Time Regulations)
- c. New maximum of 72 hours in any consecutive seven day period (lower than the current 91 hour limit)

- d. No rostered shift to exceed 13 hours (excluding overnight on-call periods)
- e. A new limit of no more than five consecutive long shifts(i.e. More than 10 hours)
- f. No more than four consecutive night shifts (where at least three hours fall between 11pm and 6am)
- g. No more than seven consecutive days and nights on-call, and any such pattern remains subject to the rules identified above

43. There will be a mutual contractual obligation on employers and trainees to respect these limits. Employers will not roster trainees beyond these limits. Trainees will have a contractual obligation to ensure that their total hours of work, for any and all employers, do not exceed the limits set out in the contract or impact on their ability to work safely.

Features of the new contract: Work schedules and the review process

The Work Schedule

44. A work schedule will set out the duties of the post, the intended learning outcomes and the hours for which the trainee is contracted.
45. A 'template' work schedule for each post will set out:
- a. the expected service commitments; and
 - b. those parts of the relevant training curriculum which can be achieved in the post. This latter element must be consistent with the post's "Application for Approval of a Training Post" which will have been agreed with the Postgraduate Medical Education Deanery/ LETB / Health Education England.
46. The same template schedule might apply for several posts, but it will subsequently be personalised for each trainee entering each post, taking into account the individual's training experiences, competencies and needs.
47. The personalised work schedule will be discussed at the trainee's regular educational meetings (with the educational supervisor) to ensure the workplace experience delivers the anticipated learning opportunities. These regular meetings/reviews might lead to changes in the work schedule.

Exception reporting

48. A trainee can report exceptions where his/her day-to-day work varies significantly and/or routinely from that in the work schedule either in:
- a. hours of work (including rest breaks); or

- b. the agreed working pattern, including the educational opportunities made available.

49. Reports will be sent by the trainee to the educational supervisor for discussion at the next educational meeting. The employer must assess issues as they arise and make timely adjustments through either a routine work schedule review held as part of an educational meeting, or an interim review held in advance of the educational meeting, where this is appropriate on grounds of urgency.

Work Schedule Reviews

50. The current system of hours monitoring will be replaced from 3 August 2016 by a system of work schedule reviews. A work schedule review can be triggered by one or more exception reports, or by a request from either the trainee or the supervisor for a review. Reviews should consider safe working issues, including those related to working hours, as well as educational issues and issues relating to service delivery. The first stage in any review is an informal discussion, to attempt to resolve the issue quickly.

51. If this fails, stage two would be a formal meeting including the educational supervisor, the trainee, a service lead, and a nominee of the director of postgraduate medical/dental education.

52. If no agreement is reached at this meeting, stage three would be the final stage of the employer's local grievance procedure. An appeal panel, including the director of postgraduate medical/dental education acting in an advisory capacity, would consider whether or not a change to the work schedule is required, and would have the authority to impose such a change where it is necessary to do so.

53. Where an individual's work schedule review requires a change in the work pattern, there may be a need to consider compensatory time off, or, in exceptional circumstances, retrospective changes to remuneration of the individual (as work schedule reviews would normally result in prospective, rather than retrospective changes). Such cases should be exceptional as concerns ought to be raised and reviews take place in a timely fashion. There will be a contractual framework setting out the accountabilities of different parties, the required evidence and the timeframe within which reviews should happen.

External scrutiny of Work Schedule reviews

54. Annual reports on the outcome of all employee and employer-triggered work schedule reviews will be provided to Postgraduate Deaneries/Health Education England, who approve (and may withdraw approval for) training posts; and to the Review Body on Doctors' and Dentists' Remuneration, in line with their request.

55. We are also exploring how the Care Quality Commission can extend its criteria on safe staffing levels to include the safe working hours of trainees, taking into account these annual reports on

the outcome of employee-triggered and employer triggered work schedule reviews and findings from the NHS staff survey and the GMC survey of trainees.

56. We would expect that a robust and contractual system of work schedule reviews, with external scrutiny, would ensure that employers fulfil their obligations with regard to safe working hours. In exceptional circumstances, the Postgraduate Dean (on behalf of HEE) can recommend to the GMC that approval to train is withdrawn from the post(s).

Features of the new contract: other issues

Exceptional circumstances to secure patient safety

57. Exceptionally, because of unforeseen circumstances, a trainee may feel a professional duty to work beyond the hours described in their work schedule, to secure patient safety. Such additional hours normally would be approved by the trainee's line manager. In such exceptional circumstances, employers will appropriately compensate the individual trainee for such hours, if the work:

- a. has been undertaken for the needs of the service; and
- b. is authorised by an appropriate person (typically, this authorisation would be before or during the period of extended working).

58. Such compensation may be by additional payment (at the rate determined by the time of the over-schedule work) or by time off in lieu, or by a combination of the two. Where safe working hours are threatened by such an extension of working hours, time off in lieu will be the preferred, and in some cases the only, option. Where such instances occur, the employer will have a duty to review the work schedule to ensure such instances remain exceptional.

Private Fees

59. Fees earned for private professional work will be treated, within the proposed contract, in line with the principle that NHS staff should not be paid twice for the same time. Trainees will be paid by their NHS employer for the contractual duties set out in their work schedules. They will be entitled to carry out fee-paying work in periods for which they are not being paid by the NHS employer and to receive payment for that, additional to the payment for their NHS employment. However, the trainee cannot, without the prior agreement of the employer, time-shift NHS work into non NHS time in order to undertake private professional work in what was previously (before the time-shift) NHS time. If a fee is paid directly to a trainee for work done during time when they are being paid by their NHS employer, the trainee will be required to remit the fee to the employing organization. This will not be the case for work undertaken in the trainee's own time. However, the employer reserves the right to charge a trainee receiving such a fee for the

use of any of the employer's resources or services used in the provision of the private professional work.

Training

60. The Secretary of State has asked Health Education England and the medical Royal Colleges to continue working with the BMA and NHS Employers to look at how the *training experience* can be improved more generally. Specifically, postgraduate deaneries and trusts should both play their parts in ensuring that trainees are provided with timely notice of their next rotation (post).

Expenses

61. We will ask NHS Employers to complete the schedule in the terms and conditions to reflect the recommendations of the DDRB in relation to relocation expenses.

Leave

62. We will ask NHS Employers to complete the schedule in the terms and conditions to reflect the need for the use of fixed leave to be minimised.

Introducing the new arrangements: the offer to existing trainees on transition

63. The new contractual arrangements will lead to no reduction in the pay bill (per full-time equivalent) and no reduction in average earnings across the training grade medical workforce.

64. There will be an initial period of transitional protection arrangements for existing trainees. The following paragraphs describe how this will work in terms of hospital placements (including for those training for general practice but who will be working in hospital placements on 3 August 2016). See paragraph 69 for an explanation of how this will work in for trainees who will be working in general practice placements on 3 August 2016.

65. The following trainees will be moved onto the new Terms and Conditions effective from 3 August 2016, where they move between posts and/or contracts of employment, and will be offered cash pay protection.

- All trainees remaining on F1 or remaining on F2
- All trainees entering Foundation 2.
- All new entrants to core or run through specialty training (CT1 / ST1 points)
- All trainees moving into CT2 / ST2 existing points (and CT3 point where it exists) would be paid according to the new contract in August 2016.
- All trainees remaining in the CT1, ST1, CT2, ST2 or CT3 (where it exists) grades in August 2016

- All new entrants to higher (non-run through) training (at ST3 point and in some specialties at ST4 point)

66. Their pay protection will be calculated as follows on 3 August 2016 and this amount will apply as a baseline or “consistent cash floor” for each year until either the trainee exits training or until 31 July 2019 (the end of the current spending review), whichever is the sooner:

- Take the incremental pay point for eligible trainees as of 31 October 2015
- Add any cost of living increase that may be awarded in April 2016
- Add the value of the banding supplement for the rota on which they are working on 31 October 2015, up to a maximum banding supplement of 50% (band 1A) or, for those trainees who have opted out of the Working Time Regulations, to a maximum of Band 2A (80%), which is also the highest level to which protection can be applied under the current contract. Trainees protected at 80% supplement would however have to accept a contract for up to 56 hours per week for this protection to apply; accepting a contract of only 48 hours would reduce the protected supplement to 50%.

67. The trainee’s actual “new contract” pay on 3 August 2016 will be calculated as follows:

- Basic salary as at 3 August 2016 (new nodal system)
- Plus pay for any additional hours contracted (up to 8 hours)
- Plus pay enhancement for any hours rostered in premium time
- Plus an on-call availability supplement for trainees working on-call arrangements (as defined in the new contract – this does not refer to carrying the bleep whilst in the hospital)
- Plus one or more flexible pay premia (where these apply)

68. Annually until 2019, actual pay will then be compared with the cash floor established for 3 August 2016. Where actual pay on 3 August 2016 is higher than the cash floor, the trainee will receive actual pay, where actual pay is lower than the cash floor on 3 August 2016, a trainee will receive an additional amount in pay protection sufficient to return the trainee’s pay to the level of the cash floor.

69. For GP trainees working in practice placements on 3 August 2016, pay protection at transition will be calculated as follows and this amount will apply as a baseline or “consistent cash floor” for each year until either the trainee exits training or until 31 July 2019 (the end of the current spending review), whichever is the sooner:

- Take the incremental pay point for eligible trainees as of 31 October 2015
- Add any cost of living increase that may be awarded in April 2016

- Add the value of the GP supplement (45%).

The trainee's new salary would then be calculated as per paragraph 66 and the trainee paid the higher of the two amounts, as per paragraph 67.

70. Trainees already in run-through or higher training at 2 August 2016, and so not covered by paragraphs 64-67, would be moved onto the terms of the new contract on 3 August 2016. The new terms and conditions would be used for the purposes of organising their work and all other matters but under transitional pay protection, they would continue to be paid using the old system of banding (subject to the maximum of band 2A - 80% - for those who have opted out of the Working Time Regulations, which is also the highest level to which protection can be applied under the current contract as outlined in paragraph 65) and annual increments until they exit the programme or until 31 July 2019, whichever is the sooner. This preserves pay expectations, on the basis of the safe working patterns enshrined in the new contract, for those who could complete training during the transitional period.

Annex B – Your rota in numbers

Doctor A

Banding None

Averaging 40.00

Doctor A is a second year Foundation doctor working a steady 40 hours a week in the community. Working between 07.00 and 19.00 Monday to Friday only.

On the current contract Doctor A would earn: £28,357

On the new contract Doctor A would earn: £31,600

Doctor B

GP supplement

Averaging 40.00

Doctor B is an ST3 and works a standard working pattern for a GP trainee working in a GP practice setting. Hours may vary occasionally from this. (This pattern does not apply to Foundation doctors in a GP practice setting, or to any other trainees).

On the current contract Doctor B would earn: £50,382

On the new contract Doctor B would earn: £50,700

Doctor C

Banding 1B

Averaging 45.00

Doctor C is a first year core trainee and works a normal working week (Monday to Friday) with longer days that fall between 7.00 and 19.00 (e.g. 0900-1800). This contract is typically worked by trainees in non-acute specialties, where there is no input into a general, acute or on-call rota.

On the current contract Doctor C would earn: £42,423

On the new contract Doctor C would earn: £42,423 (£42,075 plus £348 pay protection)

Doctor D

Banding 1A

Averaging 47.50

Doctor D is a second year core trainee who works a high frequency (1:4) shift pattern with no night shifts, (a relatively uncommon working pattern), which involves working into the evenings and at weekends to provide ward or acute cover beyond the normal working day but not

overnight. Most rotas of this nature are a lower frequency than this, but these do exist in some smaller trusts/specialties.

On the current contract Doctor D would earn: £48,235

On the new contract Doctor D would earn: £48,235 (£45,659 plus £2,575 pay protection)

Doctor E

Banding 1B

Averaging 45.17

Doctor E is a third year specialty registrar in a unit running both inpatient and outpatient services and works a medium frequency shift pattern with no night shifts, a more common working pattern than Doctor D, based on the same principles but with a greater number of trainees sharing the rota. Typically found in small to medium sized trusts/specialties.

On the current contract Doctor E would earn: £48,644

On the new contract Doctor E would earn: £48,934

Doctor F

Banding 1B

Averaging 45.13

Doctor F is a third year registrar in a unit running both inpatient and outpatient services and who works a shift pattern based on the same principles as Doctor's D and E, but with an even greater number of trainees sharing the rota. Typically found in larger trusts/specialties. In some cases, there may be even greater numbers of trainees sharing the rota.

On the current contract Doctor F would earn: £48,644

On the new contract Doctor F would earn: £48,654

Doctor G (High frequency shift pattern including night shifts)

Banding 1A

Averaging 45.33

Moderately common working pattern, Doctor G is a second year core trainee in a small but acute service, works into the evenings and at weekends to provide ward or acute cover beyond the normal working day, as well as service provision overnight, possibly but not necessarily as part of a Hospital at Night team arrangement.

A lower frequency rota, but does exist in some smaller trusts / specialties.

On the current contract Doctor G would earn: £48,235

On the new contract Doctor G would earn: £48,235 (£48,231 plus £4 pay protection)

Doctor H (Medium frequency shift pattern including night shifts)

Banding 1A

Averaging 45.25

Doctor H is a second year Foundation doctor working in an acute service on a rota, based on the same principles as doctor G but with a greater number of trainees sharing the rota. More common working pattern than that of Doctor G and typically found in small to medium sized trusts / specialties.

On the current contract Doctor H would earn: £42,535

On the new contract Doctor H would earn: £42,535 (£39,451 plus £3,085 pay protection)

Doctor I (Low frequency shift pattern including night shifts)

Banding 1B

Averaging 45.20

Doctor I is a second year core trainee works in on a multi-specialty rota to provide cross-cover across a range of specialties, working into the evenings and at weekends to provide ward or acute cover beyond the normal working day, as well as service provision overnight, possibly but not necessarily as part of a Hospital at Night team arrangement.

Typically found in larger trusts/specialities and involving a greater number of trainees sharing the rota.

On the current contract Doctor I would earn: £45,019

On the new contract Doctor I would earn: £45,768

Doctor J (High frequency on-call rota)

Banding 1A

Averaging 47.33

Doctor J is a third year trainee in a surgical discipline and works into the evenings and for a period at weekends to provide ward or acute cover beyond the normal working day, as well as provision of an on-call service overnight from home.

Most rotas of this nature are a lower frequency than this, but these do exist in some smaller trusts / specialties.

On the current contract Doctor J would earn: £52,119

On the new contract Doctor J would earn: £54,382

Doctor K (Medium frequency on-call rota)

Banding 1B

Averaging 46.75 hrs. per week

Doctor K is also a third year trainee in a surgical discipline and works into the evenings and for a period at weekends to provide ward or acute cover beyond the normal working day, as well as provision of an on-call service overnight from home.

Involves a greater number of trainees sharing the rota. Found in small to medium sized trusts / specialties.

On the current contract Doctor K would earn: £48,644

On the new contract Doctor K would earn: £53,165

Doctor L (Low frequency on-call rota)

Banding 1C

Averaging 43.10 hrs. per week

Doctor L is a third year dermatologist who occasionally works short periods into the evening and may include weekend ward rounds.

Based on a provision of an on-call service overnight from home. Typically found in very quiet specialities with little demand for on-site presence.

On the current contract Doctor L would earn: £41,695

On the new contract Doctor L would earn: £47,299