The 2016 contract for doctors in training
Implementation guidance for employers

Updated September 2016
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Version 2
Drafted July 2016, last updated September 2016.
1. Introduction

1.1. This implementation guidance sets out the steps that employers should follow when introducing the new Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

1.2. This guidance should be read in conjunction with the TCS, Pay and Conditions Circular, model contract documentation, and other resources available on the NHS Employers website. This guide has been produced to aid staff working in HR / medical staffing departments, education departments and payroll departments in the implementation of the new contract.

1.3. When introducing this contract, each employer will need to take account of their individual Public Sector Equality Duty (PSED). Guidance on how to undertake your Public Sector Equality Duty is available on the NHS Employers website.

1.4. This document is divided into a range of separate, pull-out guides that reflect the contract, including:

Safe working:

- A guide to safe working hours and rota design
- A guide to work scheduling
- A guide to exception reporting
- A guide to work schedule reviews
- A guide to the appointment and role of the guardian of safe working hours

Pay:

- A guide to pay

Transitional arrangements:

- A guide to transitional arrangements
  a) Doctors moving to the new contract
  b) Transitional pay protection

1.5. For the purposes of this document, for ‘doctor’ read ‘doctor or dentist in training’ throughout.
Scope

1.6. The new contractual arrangements will come into effect from 3 August 2016.

1.7. From 5 October 2016, new contractual arrangements will be available to be introduced for doctors and dentists in training in hospital posts approved by the GMC / HEE for postgraduate medical/dental education. Once introduced, the new TCS will replace the existing national TCS/other arrangements of:

- The hospital medical and dental staff TCS of service, 2002, as they apply to doctors in training.
- The Schedules contained in the Directions to Health Education, as they apply to GP Registrars (GP Specialty Trainees).

1.8. The new terms can be introduced in a phased way, according to the suggested implementation timetable set out in Section 3 of this guide (and available separately on NHS Employers website), as doctors move between contracts of employment. For existing doctors there would be a period of transition during which pay protection arrangements will apply. These arrangements are described in section 10 of this document.

1.9. Where doctors in training are employed by lead employers but work and train within a host organisation, the lead employer and host organisation will find it useful to work together to ensure that systems of communication are in place to support the respective responsibilities of each party. Guidance specifically for lead employers and host organisations is covered in Section 11 of this document.

1.10. Once introduced, the new 2016 contractual arrangements will apply to doctors on general practice training programmes during approved general practice placements that form part of their postgraduate medical education, and will replace provisions currently contained in Schedules to the Directions to Health Education England (GP Registrars). Again, for doctors in training already employed under the existing arrangements, transitional pay protection arrangements will apply, as described in section 10 of this document.

1.11. These contractual arrangements do not apply to those undertaking vocational training placements in general dental practice (i.e. foundation dentists). The existing contractual arrangements for this group of staff will continue to apply.

Trust doctors

1.12. These contractual arrangements do not apply to doctors who are not doctors in training – i.e. locums appointed for service, trust doctors, clinical fellows, research fellows etc. These 2016 TCS are specific to doctors in training, as they have a strong focus on education and training as well as service delivery.
1.13. It is for employers to decide locally how to set contractual TCS for doctors who are not employed as doctors in training in recognised training posts. Even where employers seek to replicate pay and other terms of these TCS into any local terms, they are advised not to replicate the totality of these TCS but to tailor them to meet the different needs of and service requirements placed upon trust doctors. Additional guidance is at Section 13 of this document.

1.14. Employers are free to determine what terms and conditions they offer to new staff in such posts, or to those wishing to remain in employment in such posts when existing contracts expire.

**Shadowing**

1.15. Foundation programme shadowing will take place this year before the introduction of the 2016 contract and employers will have already made arrangements for this period separately. From 2017 onward, it should be noted that the 2016 contract is not suitable to engage F1 appointees for shadowing. Employers are advised to issue a separate contract for this period. [NHS Employers’ guidance](#) on how to engage F1 appointees for the shadowing period will be helpful for trusts when deciding how to provide indemnity and payment for F1 appointees for this period.
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2. Benefits of the new junior doctor contract

2.1 The 2016 national contract for junior doctors is fairer and encourages stronger safeguards to prevent doctors working excessive hours.

2.2 **Work scheduling** – This is a new feature of the 2016 contract, and employers will be required to complete work schedules for doctors in training. This will begin as a generic schedule setting out the hours of work, the working pattern, the service commitments and the training opportunities available during the post or placement. This must be done prior to any offer of employment to the post being made.

2.3 Once a doctor commences in post, the work schedule will be personalised to include appropriate and identified personal objectives that have been agreed between the doctor and his or her educational supervisor, and will set out the relationship between these personal objectives and local service objectives. The objectives will set out a mutual understanding of what the doctor will be seeking to achieve over the placement period and how this will contribute to the objectives of the employing organisation. Work scheduling can be used to drive improvements and quality of patient care.

2.4 **Exception reporting** – This is a new feature of the 2016 contract, enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose. This is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

2.5 **Guardian of safe working hours** – This is a new feature introduced in the 2016 contract. The guardian of safe working hours is required to ensure that concerns about the safety of doctors’ working hours are resolved in a timely and appropriate fashion. The work of the guardian will be subject to external scrutiny of doctors’ working hours by the Care Quality Commission (CQC) and by continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

2.6 **Annual leave** – Annual leave entitlement is 27 days in the 2016 TCS, incorporating the two extra-statutory days previously set out in the 2002 TCS, rising to 32 days following the completion of five years’ NHS service.

2.7 **Requests for leave** – Employers are expected to respond to leave requests positively wherever possible, provided that the doctor gives six weeks’ notice of the request [or fewer than six weeks’ notice if there are reasons beyond the doctor’s control].
Employers must allow leave for life-changing events, subject to the standard six weeks’ notice period.

2.8 **Fixed leave** – Employers will be asked to end the practice of fixed leave, which makes it difficult for doctors to take leave at a time that suits them and/or their families. There will be a mutual obligation to plan leave around requests, balancing the need for adequate staff cover to provide a safe service while ensuring that all staff can take full leave entitlement. While some leave may need to be allocated to ensure that all doctors take their full leave entitlement, the vast majority of leave requests should be managed without the need to resort to allocation of leave.

2.9 **Continuity of service** – will not be affected and will be preserved. It is particularly important where doctors, through educationally approved out-of-training programme arrangements (as at present) or voluntary/overseas service or short gaps between employments will, for example, retain access to maternity pay based on their last year’s earnings prior to taking time out. This means that continuity of service would be preserved in a variety of situations where there is a gap in usual working patterns, including when these occur as a result of a transitional situation in the doctor’s life.

2.10 **Expenses** – Doctors will continue to have access to expenses relating to travel, subsistence and other business expenses. They will continue to have assistance with relocation, removal or excess travel expenses and can request extra help should they take up employment that requires them to move home or incur extra travel expenses.

2.11 **Statutory rights** – Doctors will also continue to have access to a range of employment rights under statute and through their local employers’ own HR policies, which should allow them to seek support should they need it.

2.12 **Benefits** – Doctors will still be able to receive benefits above the statutory minimum. For example, sickness, maternity, paternity, adoption leave in line with the NHS Staff Handbook.

**Extra-contractual arrangements**

2.13 The contract negotiations also resulted in a separate, tri-partite workstream involving employers, the BMA and HEE. Further benefits were also agreed through the ACAS agreement between the BMA, NHS Employers and the government. Although the following items do not form part of the TCS, they will in future be included in the learning and development agreement (LDA) between HEE and employers, to which the TCS refer, and so form a part of the wider changes involved in implementing the new TCS.

2.14 **Notice of deployment** – HEE will provide employers with sufficient notice of rotations (target: 12 weeks) so that employers can make offers early enough to give doctors time to make the necessary adjustments before being redeployed, including
if necessary the need to move their family nearer to their place of employment. This will be particularly helpful to doctors who need to manage family or other aspects of their personal life whilst being employed in different locations. This will also give employers earlier warning of potential rota gaps, facilitating earlier local recruitment, and will allow an earlier start to pre-employment checks, ensuring all doctors are cleared to start work on their first day in employment.

2.15 HEE have committed to meeting this 12-week deadline for the provision of deployment information to employers and will be monitoring area office performance against this measure as part of its own internal performance management system. Employers should make offers of employment (including provision of the generic work schedule and roster information) to doctors no later than eight weeks in advance of starting a post. This will help to facilitate the removal of fixed leave, as doctors will be able to provide sufficient notice to employers of existing leave requirements or plan their leave requests around advance notice of rosters, without the need for employers to set fixed leave in those rosters.

2.16 HEE will lead a review of the processes which allow doctors to transfer within training programmes between regions, joint applications between married couples (or those in a civil partnership), and training placements for those with caring responsibilities within defined travel times. The delivery of this work will form part of the mandate set by the Secretary of State for HEE to be completed by the end of March 2017.

2.17 **Accelerated training support** - there is an agreement to develop innovative approaches to training, to remove as far as possible the disadvantage of those who take time out due to, for example, caring responsibilities. This approach would include targeted accelerated learning with the prime intention to enable the person who has taken time out to catch up. This will include access to mentorship, study leave funding and specially developed training inputs. The Secretary of State has confirmed that this enhancement will be additionally funded from outside the contract pay bill.

2.18 **Improving practice** - Approaches to good rostering practice will be reviewed, including the proper use of technology, which support greater flexibility for junior doctors and employers. Rostering experts will be engaged in this work to ensure that best practice can be applied.
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Implementation

Phased implementation timeline

3.1 The proposed implementation timeline has been developed to enable employers to introduce the contract in phased stages in a consistent way. The proposed implementation timetable is phased so as to ensure that employers have sufficient time to make the necessary changes in their organisations, to appoint a guardian of safe working hours, and to enable the delivery of safe working patterns, before implementing the full TCS for different cohorts.

3.2 The new contract is available for doctors to move onto when contracts of employment expire as they move through training according to table 1 below.

3.3 The 2016 junior doctors’ contract should be introduced in a phased way from October 2016 where there is a break in the contract of employment and a new contract is taken up. It is envisaged that the initial group will only be Obstetrics and gynaecology trainees at ST3 or higher. The table below details the full implementation timetable.

### Table 1:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016</td>
<td>Appoint guardians</td>
</tr>
<tr>
<td>26 July 2016</td>
<td>Guardian conference</td>
</tr>
<tr>
<td>3 August 2016</td>
<td>Contract is live</td>
</tr>
<tr>
<td>October 2016</td>
<td>Suggested transition to the new TCS for:</td>
</tr>
<tr>
<td></td>
<td>- Obstetrics and gynecology ST3 and above</td>
</tr>
<tr>
<td>November / December 2016</td>
<td>Suggested transition to the new TCS for:</td>
</tr>
<tr>
<td></td>
<td>- F1 doctors taking up next appointments</td>
</tr>
<tr>
<td></td>
<td>- F2 doctors taking up next appointments and sharing rotas with F1 doctors</td>
</tr>
<tr>
<td>February / April 2017</td>
<td>Suggested transition to the new TCS for:</td>
</tr>
<tr>
<td></td>
<td>- Psychiatry trainees taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>- Pathology trainees (lab based) taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>- Paediatrics trainees taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>- Surgical trainees (all disciplines) taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>- F2 doctors and GP trainees (ST1/2) taking up next appointments and sharing rotas with any of the above</td>
</tr>
<tr>
<td>August / October 2017</td>
<td>Suggested transition to the new TCS for:</td>
</tr>
<tr>
<td></td>
<td>- All remaining trainees taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>- All new starters (all grades)</td>
</tr>
</tbody>
</table>

**Notes:**

(1) The above does not include trainees employed on long-term contracts in lead employer arrangements (other than those who joined such arrangements on a single placement contract in August 2016, or those
whose contracts have a clause allowing for them to be varied in this way); these trainees would remain on the 2002 TCS until they finish training and/or their current contracts expire unless employers agreed changes locally.

(2) There will be some parts of the country where rotation dates do not coincide precisely with the above timetable. In such cases, it is suggested trainees will move to the new terms at the next rotation date following their scheduled transition date, and in most cases by October 2017 at the latest.

3.4 The new contractual arrangements do not apply to trust-grade doctors.

3.5 The following implementation steps are a guide only for employers, to ensure that they are able to introduce the new TCS in accordance with the above timescales. NHS Improvement will be monitoring the implementation of the new contract.

3.6 If a specialty/specialty group is not listed in the table above then it falls into the August-October 2017 phase of implementation.

3.7 If the timetable above is to be met, the following tasks will need to be completed:

Processes

3.8 **Guardian of safe working hours** – appoint a guardian of safe working hours as soon as possible, if you have not already recruited one. The guardian of safe working hours should be in post by 3 August 2016.

3.9 **Exception reporting** – Agree a local process and have mechanisms in place for exception reporting and work schedule reviews. This should be made available electronically. It may be in the form of an electronic device created by your software provider or it may be developed in-house.

3.10 **Training** – Identify and agree processes for managing exception reports and work schedule reviews, and provide training to those involved (educational supervisors, administrative staff etc).

Prior to offering employment

3.11 For each post that will be offered on the 2016 TCS, the following tasks need to be completed before any offer of employment can be made:

a) **Reorganise/remodel rotas** – Identify rotas that breach the new limits of hours and rest (as set out in Schedule 3 of the TCS)

b) **Consultation** – Arrange a consultation meeting with the doctors currently working on those rotas, and discuss how these might be remodelled to fit the new rules whilst maintaining patient care and meeting the doctors’ needs. Employers who use DRS, Allocate or another system can consult with their software provider for assistance in building the rotas. Please note that all rotas
will need to comply with the provisions of Schedule 3; breaches of the rules can no longer be offset by a penalty payment to the doctor (as is the case with Band 3 under the 2002 TCS).

c) **Agreement** - Agree the new working pattern. Please note that if there will still be doctors working on the 2002 TCS once the new working pattern has been introduced, current local arrangements for agreeing and approving rotas will remain in force.

d) **Work schedules** - Create generic work schedules for each post based on the new agreed working patterns.

e) **Pay** – Assess the pay for each working pattern and include in the work schedule.

f) **Offer** – Make conditional offer of employment, using the model contract.

3.12 When making offers to doctors who will be start work with your organisation before they are due to move to the 2016 contract, it is suggested they should be offered the existing 2002 terms and conditions of service with a fixed end date in their contract. This end date should coincide with when to the doctor is scheduled to move to the new arrangements, in line with the implementation timetable above.
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4. A guide to safe working hours and rota design

4.1 The 2016 national contract places a mutual obligation on employers and doctors to respect the new limits on work hours and consecutive shifts.

4.2 The employer has a contractual and regulatory responsibility for ensuring the doctor is not contracted, or otherwise required, to work outside of the limits set out in Schedule 3 of the TCS.

4.3 For any doctor engaged on the 2016 contract, employers and host organisations must ensure that rotas are revised to meet the new limits on hours and safeguards on rest. These need to be incorporated into the new rotas before sending out the employment offer and work schedule documentation.

4.4 The limits and safeguards are set out in Schedule 3 of the TCS, and are summarised below:

<table>
<thead>
<tr>
<th>Weekly hours</th>
<th>Consecutive shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly average hours</td>
<td>Night shifts (more than 3 hours between 2300 and 0600)</td>
</tr>
<tr>
<td>Weekly average hours if opting out of WTR</td>
<td>Long shifts (more than 10 hours)</td>
</tr>
<tr>
<td>Absolute limit on hours</td>
<td>Long late shifts (more than 10 hours, finishing after 2300)</td>
</tr>
<tr>
<td>Maximum shift length</td>
<td>All shifts (any length or combination of lengths)</td>
</tr>
<tr>
<td>Weekends (Saturday and Sunday)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--</td>
</tr>
<tr>
<td><strong>No doctor rostered to work more frequently than 1:2 weekends</strong>, averaged over the length of the rota cycle, the length of the placement, or 26 weeks, whichever is the shorter.</td>
<td></td>
</tr>
<tr>
<td><strong>Rest</strong></td>
<td></td>
</tr>
<tr>
<td>Paid meal breaks</td>
<td>30 mins if shift exceeds 5 hours; 2 x 30 mins if shift exceeds 9 hours</td>
</tr>
<tr>
<td>After any individual shift</td>
<td>11 hours’ minimum rest</td>
</tr>
<tr>
<td>After 3 or 4 consecutive night shifts</td>
<td>46 hours’ minimum rest</td>
</tr>
<tr>
<td>After 5 consecutive long shifts (more than 10 hours)</td>
<td>48 hours’ minimum rest</td>
</tr>
<tr>
<td>After 4 consecutive long late shifts (more than 10 hours, finishing after 2300)</td>
<td>48 hours’ minimum rest</td>
</tr>
<tr>
<td>After 8 or more consecutive shifts</td>
<td>48 hours’ minimum rest</td>
</tr>
<tr>
<td><strong>On-call duty</strong></td>
<td></td>
</tr>
<tr>
<td>Length of on-call duty period</td>
<td>maximum 24 hours</td>
</tr>
<tr>
<td>Rest whilst on call</td>
<td>minimum 8 hours (minimum 5 continuous)</td>
</tr>
<tr>
<td>Consecutive on-call duties</td>
<td>maximum of 1 duty period (maximum of 2 consecutive duty periods if first one begins on a Saturday)*</td>
</tr>
<tr>
<td>Shift on day following an on-call duty (or following 2nd on-call duty if 2 are rostered consecutively)</td>
<td>maximum 10 hours (maximum 5 hours if overnight rest not likely to be achieved)</td>
</tr>
<tr>
<td>Frequency of on-call duties</td>
<td>maximum 3 in 7 days*</td>
</tr>
</tbody>
</table>

* Doctors and employers may agree locally on an individual level to relax these limits up to a maximum of seven consecutive duty periods, provided that it is safe to do so and no other limits or safeguards would be breached as a result. It is expected that this would only be in departments where the amount of work carried out whilst on-call is very light and of a low intensity.
4.5 Employers will need to ensure that all team rotas are supported by, linked to and complemented by individual work schedules.

Mixed economy rotas

4.6 Where employers have rotas that are staffed by doctors on both the 2016 TCS, and the 2002 (‘New Deal’) TCS (i.e. mixed economy rotas), the following should be noted:

a) If the rota complies with the 2016 rota rules, then in the majority of cases, the rota will also comply with New Deal rules.

b) The exception to this will be on-call rotas, where compliance with the 2016 rules may not necessarily deliver compliance with New Deal rules. Where this is the case it is recommended to make sure that on-call aspects of rotas comply with New Deal rules, which will mean they will also comply with 2016 rules.

4.7 Rota system providers such as Allocate Software and Skills for Health should be able to help their customers with any complex issues. Once a rota is compliant with both sets of rota rules, individual doctors on the rota can be paid according to the TCS on which they are employed.

Rota redesign

4.8 The two main software providers (Allocate Software (formerly Zircadian) and Skills for Health (providers of DRS) have already released updated software to support employing organisations to assess their current rotas and to design new working patterns that meet the 2016 contractual rules.

4.9 Employers not using either software provider will need to liaise with their own provider [if any] or draw upon their own resources to ensure that they have a system that is and remains fit for purpose. The Secretary of State for Health stated in his statement to the House on 6 July 2016 “…last month at the NHS Confederation’s annual conference I set out my expectation that all hospitals should invest in modern e-rostering systems by the end of next year as part of their efforts to improve the way they deploy staff.”

4.10 When designing on-call rotas, employers should note that they will be required not only to identify the start and end times of the duty periods, but also to prospectively estimate the number of hours of actual work during the duty period (as is done now, both under the New Deal contract for ensuring enough rest, and in consultant and SAS job planning) and the time of day that the work would normally be done (to ensure that it is paid at the correct rate and that it is put into the correct day of the week, which is important for the 72-hour rule). Monitoring data from historic diary-
card exercises, bleep audits and other data available in employing organisations may help with this.

4.11 Although prospective cover as defined in the 2002 TCS does not feature in the 2016 TCS, annual leave does still need to be taken into account when designing rotas. To do this, an average amount of leave should be deducted from each rota cycle before assessing the average hours. For details, see paragraph 11 of Schedule 4 and paragraph 9 of Schedule 9 of the TCS. This calculation is done automatically in the rota software available from Allocate Software and Skills for Health.

4.12 Where there is a lead employer arrangement, the host organisation will normally be responsible for the redesign of rotas, and the incorporation of these into the work schedule (see section 5).

4.13 Note: Where limits on safe working hours (48 hours average week under WTR; 72 absolute limit in seven calendar days; breach of more than three hours in the 11 hour minimum rest period) are breached, then the doctor should be paid at the penalty rates which are contained in the Pay and Conditions Circular. In addition, a financial penalty will be levied on the employer for each hour above these limits at the rates contained in the Pay and Conditions Circular. This fine will be paid by the department to the Guardian of Safe Working Hours. Employers should therefore take care not to run rotas right up to the margins of these limits so as to ensure safe working hours can be maintained even in the event of a rota breach.

4.14 Full details on the changes made to ensure safe working hours can be found in Schedule 3 of the 2016 TCS.
5. A guide to work scheduling

Purpose of a work schedule

5.1 The work schedule brings together activities to achieve learning and service objectives within contracted hours. A work schedule expressly links work carried out to the training needs identified in the relevant curriculum. This ensures that, alongside commitments for the delivery of patient and other services, the doctor is able to train effectively toward the achievement of the competencies necessary to progress through training.

5.2 Employers may choose to use the generic work schedule template at Annex B or agree a local template providing it contains the same information.

5.3 A work schedule will apply for the duration of the doctor’s training placement, and will identify:
   a) the intended learning outcomes (mapped to the educational curriculum)
   b) the scheduled duties of the doctor
   c) time for quality improvement and patient safety activities
   d) periods of formal study
   e) the rota on which the doctor will be working
   f) the number and distribution of hours for which the doctor is contracted
   g) the pay the doctor can expect to receive for the hours set out in the work schedule.

5.4 Employers are required to ensure that any work pattern described in the schedule:
   • complies with the Working Time Regulations
   • complies with the rules on working hours detailed in Schedule 3 of the TCS.

5.5 In order to complete the work schedule process, employers may need to access information via a number of sources, including:
   a) HEE local office / Deanery
   b) software systems
   c) recent monitoring data
   d) ESR
   e) education outcomes set out in the GMC Form B (application for approval of a training post) – where the document is held by the employer and is up to date
   f) information held in the postgraduate medical education department.
   g) current training programme curricula
Further useful information may be obtained through discussion with junior doctors, senior clinicians and service managers.

5.6 The duties and responsibilities set out in a work schedule will include, as appropriate:
   a. Specific training
   b. Clinical care and service duties
   c. Professional duties for other organisations (required by the employer).

Designing the generic work schedule

5.7 It is the employer's responsibility to complete the generic work schedule prior to the offer of employment being made to the doctor.

5.8 The work schedule should include all of the following details:
   a) Name of doctor
   b) Name of educational supervisor
   c) Contact details for HR / medical staffing
   d) Training programme
   e) Specialty [if different from above]
   f) Grade
   g) Working pattern [description of hours to be worked – total hours and distribution of hours]
   h) Service commitment to unscheduled urgent or emergency care
   i) On-call arrangements [if any]
   j) Pay
   k) Training opportunities.

5.9 A standard full-time work schedule will be for a minimum of 40 and a maximum of 48 hours per week, averaged over the agreed reference period. The work schedule should also describe the rota commitment.

5.10 The work schedule of doctors working on-call working patterns will contain an estimated average amount of time, calculated prospectively, for anticipated work done during on-call periods. See section 4 for details on how this is done.

5.11 It is the employer's responsibility to ensure that the work schedule takes into account the training aspects and anticipated educational outcomes of the job, which may be similar to those described in the application for approval of a training post [Form B] where this information is held by the trust, although, as these forms are
mostly historical in nature, such information should be cross referenced against current curriculum requirements.

5.12 Where the Form B is not available locally, employers should liaise with the doctor’s prospective educational supervisor (the supervisor for the current doctor) and/or contact the postgraduate medical education department team, who should be able to provide the expected educational outcomes that should be achievable by the end of the placement in that post. The training information required for the generic work schedule will normally be the same for each post at the same level on the same training programme (e.g. all ST1 posts in obstetrics for trainees on an obstetrics and gynaecology programme should be the same) although there will be exceptions. For example, core training programmes in medicine and surgery, where posts may be in different departments.

5.13 Where there is a lead employer arrangement, the lead employer is responsible for sending the offer letter, along with the generic work schedule, to the doctor, although the host organisation would usually complete the work schedule and forward it to the lead employer prior to the offer of employment being made. Lead employer models operate in different ways across the country, and there is no intention that the new contract will change these established processes where they work well.

5.14 Once generic work schedule is complete, this should be sent to the doctor with the offer of employment.

5.15 The generic work schedule will be adapted into a personalised work schedule when the doctor commences employment and has the opportunity to discuss any personal objectives with the educational supervisor.

**Designing the personal work schedule**

5.16 Once the doctor commences employment, a personalised work schedule will need to be agreed with the doctor’s educational supervisor. This area of the work schedule will include the doctor’s individual personal development plan (PDP), and highlight any learning objectives the doctor may need to achieve in the work placement, in accordance with the Gold Guide.

5.17 Training is central to the personalised work schedule and should be included in the objectives.

5.18 The personalised work schedule will be discussed at the doctor’s regular educational meetings (with the educational supervisor), to ensure that the workplace experience delivers the anticipated learning opportunities.

5.19 These regular meetings/reviews may lead to changes in the doctor’s work schedule if aspects of the work schedule are not being achieved, for example where additional hours are found to be required to complete the work, or where educational opportunities cannot be accessed.
In the event of a disagreement

5.20 The work schedule is so central to the work of the doctor that it is worth taking the time to get it right. If an element of the work schedule cannot be agreed then the doctor may invoke a work schedule review as outlined in Schedule 5 of the TCS.

5.21 Work schedules should be kept up to date through educational reviews and work schedule discussions, supported by exception reporting when an individual doctor feels that the workload and/or work pattern is deviating significantly or routinely from the intended work schedule, or where (s)he feels that (s)he is unable to access the training specified in the schedule.

5.22 Employers need to ensure the generic work schedules remains fit for purpose. They will need to have a locally agreed process in how to manage and review work schedules. Ideally this should be done with the educational lead/manager:

a) annually; and/or

b) at the time of offer; and/or

c) when the service model changes.
6. A guide to exception reporting

6.1 The current New Deal system of monitoring is replaced by a new system of exception reports and work schedule reviews in the 2016 contract.

6.2 Monitoring and banding appeals that exist in the 2002 New Deal contract are not a feature of the 2016 contract, as exception reports will flag any issues in real time. However, where employers have rotas staffed by doctors on both the 2002 and the 2016 contracts, there will still be an obligation to monitor those on the 2002 contract until no such doctors remain in employment. This means that, if a rota contains a mix of doctors on both contracts, those on the 2002 TCS will still need to be monitored in line with the 2002 TCS.

6.3 A doctor on the 2016 TCS can report exceptions where day-to-day work varies significantly and/or routinely from that set out in the doctor’s work schedule, with respect to either:

a) the hours of work (including rest breaks); or

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

6.4 If rota hours are breached, this should be highlighted at the first available opportunity by an exception report. Employers will need to make assessments of such exceptions to identify whether they indicate breaches that attract a financial penalty, as set out in paragraph 68 of Schedule 2 of the TCS.

6.5 Exception reports, where they arise, will be sent to the educational supervisor for discussion at the next educational meeting.

6.6 The employer (in this instance, the educational supervisor) must assess issues as they arise and where necessary 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.

6.7 Employers are required by the TCS to have in place a local process, supported by an electronic system, for making and managing exception reports. Doctors using a software provider to manage their rotas and/or e-rostering may wish to discuss with that provider whether or not an exception reporting tool can be made available through the same system. Alternately, such a system could be developed in-house by one or more employers, or could be available from third party suppliers.

6.8 Educational supervisors will need to be trained in how to use the exception reporting system. Additionally, induction processes for new doctors will need to include
information on how/when to make exception reports, and the process for managing these.

6.9 Oversight of the exception reporting process will be the responsibility of the guardian of safe working hours, as set out in Schedules 5 and 6 of the TCS.

6.10 Further details can be found in the Schedule 5 of the TCS.
7. A guide to work schedule reviews

7.1 It is the employer’s responsibility to ensure that there is a locally agreed process in place to administer and manage work schedule reviews. All educational supervisors need to be trained in and understand the process.

7.2 This process should be in place by the time the first doctors commence on the new contract in your trust, e.g. from October 2016 for employers introducing the contract for Obstetrics and gynaecology trainees at ST3 or above.

7.3 A work schedule review should be undertaken, wherever there are regular or persistent breaches in safe working hours that have not been addressed, or wherever educational opportunities cannot be accessed due to pressures of workload.

7.4 A work schedule review can be triggered by one or more exception report(s), or by a request from either the doctor or the educational supervisor/service manager.

7.5 Reviews should consider safe working issues, including those related to working hours and rest, as well as any educational issues and/or issues relating to service delivery.

7.6 The first stage in any review is an informal discussion between the doctor and the educational supervisor/line manager in an attempt to resolve the issue quickly.

7.7 If this fails, stage two would be a formal meeting including the educational supervisor, the doctor, a service lead, and a nominee of the employer’s (or host organisation’s) director of postgraduate medical/dental education.

7.8 If agreement can still not be reached at this stage, the final level appeal process will be the employer’s final stage grievance appeal (the guardian of safe working hours may, in some circumstances, be involved at this stage). This will mean that even if the review reaches the final stage, the employer can sort the issue promptly, without the need for arranging for external representation on hearing panels, as is the case under the banding appeals that form a part of the 2002 TCS. However, where the doctor is appealing a decision previously taken by the guardian of safe working hours, a panel will be required. Such a panel will include a representative from the BMA or recognised trade union, but this representative must be provided within one calendar month.

7.9 More information about exception reports and work schedule reviews can be found in Schedule 5 of the TCS published on NHS Employers’ website.
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8. A guide to the appointment and role of the guardian of safe working hours

8.1 All employers (and/or host organisations, if appropriate) will, on the introduction of the new contract, need to establish a locally agreed recruitment process for the appointment of a guardian of safe working hours (hereafter referred to as the guardian. Doctors in training at the employing organisation will need to be involved in the appointment of the guardian. Schedule 6 of the TCS sets out the principles for the appointment for the guardian. A sample job description and person specification are available on the NHS Employers website and attached here as Annex C.

8.2 The guardian is a new role, which will oversee the safeguards outlined in the contract and will ensure that issues of compliance with safe working hours are addressed by the doctor and/or the employer/host organisation.

8.3 If a doctor’s concerns have not been resolved through the exception reporting and work schedule review processes, then doctors can escalate their concerns to the guardian.

8.4 The guardian can formally raise concerns regarding safe working hours with the management of the employing/host organisation and can insist that steps are taken to resolve matters of concern.

8.5 The guardian will be empowered to require departments to take necessary steps to improve the working conditions of doctors.

8.6 The guardian will levy a financial penalty on the department where the three key safe working hours limits are breached (weekly average of 48 hours; absolute total of 72 hours in seven days; 11 hours’ rest between shifts reduced to eight hours or fewer). This fine will go into a budget administered by the guardian, to be spent on improvements to the working and training environment of doctors. For more information on these financial penalties see Schedule 2 and Schedule 3 of the TCS.

8.7 The guardian will present regular reports on working hours to the board and will undertake regular consultation with doctors employed by the organisation for whom the guardian has responsibility. Specifically regarding consultation, the TCS state the guardian, with the DME, will establish a junior doctor forum to advise them.

8.8 The guardian will be directly accountable to a board-level executive and will report to the board, either directly or through a sub-committee of the board. The board must receive a report from the guardian no less than quarterly. Reports will also be submitted to Health Education England (via the local office) and will be available to other inspectors and regulators (CQC, Monitor, TDA, GMC etc.) on request. The
employer’s local negotiating committee (LNC) or equivalent, as well as the junior doctor forum, should also receive copies of the guardian’s reports. There is also a process for the junior doctor forum or the BMA or recognised trade union to raise concerns over the performance of the guardian if necessary.

8.9 For more information on the guardian, see Schedule 6 of the TCS published on NHS Employers website.
9. A guide to pay

The new pay structure

9.1 The current system of basic pay and broad banding supplements is being replaced with a new pay structure. The new pay structure rewards doctors for actual work done and directly links pay to the level of responsibility a doctor is required to discharge while employed in a particular post. The details of this system are outlined in Schedule 2 of the TCS and are summarised in table 1 below:

Table 1

<table>
<thead>
<tr>
<th>Basic pay on a 4-nodal point structure</th>
<th>FY1 £26,350</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nodal point 1</td>
<td></td>
</tr>
<tr>
<td>Nodal point 2</td>
<td>FY2 £30,500</td>
</tr>
<tr>
<td>Nodal point 3</td>
<td>CT1-2, ST1-2 £36,100</td>
</tr>
<tr>
<td>Nodal point 4</td>
<td>CT3, ST3-8 £45,750</td>
</tr>
</tbody>
</table>

Enhancement

<table>
<thead>
<tr>
<th>All hours between 8pm and 10am, as long as the night shift begins at 8pm or after and before the end of the same day, and lasts at least 8 hours.</th>
<th>37 per cent enhancement</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hours 9pm–7am, regardless of the above</td>
<td>37 per cent enhancement</td>
</tr>
</tbody>
</table>

Weekend allowance

A cash sum calculated on the frequency of shifts/duty periods rostered to begin on a weekend (Saturday or Sunday), set against WTE basic salary for the grade.

| 1 in 2 – 10%                                                                                      |
| <1 in 2 – 1 in 4 – 7.5%                                                                          |
| <1 in 4 – 1 in 5 – 6%                                                                            |
| <1 in 5 – 1 in 7 – 4%                                                                            |
| <1 in 7 – 1 in 8 – 3%                                                                            |
| <1 in 8 – No allowance                                                                           |
| Percentage based on basic salary                                                                   |

On-call availability allowance

Annual sum for any doctor working on-call, regardless of the frequency of the on-call [note FY1 - £2,108]
<table>
<thead>
<tr>
<th>Flexible pay premia</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice</td>
<td>Trainees on general practice programmes whilst in general practice placements - £8,200 per annum.</td>
</tr>
<tr>
<td>Hard-to-fill training programmes</td>
<td><strong>Emergency Medicine</strong> ST4 and above - £20,000 over the length of the training programme. Expected further 3 year programme from ST4: £6,667 p.a. Expected further 4 year programme from ST4: £5,000 p.a. Expected further 5 year programme from ST4: £4,000 p.a.</td>
</tr>
<tr>
<td>Psychiatry</td>
<td><strong>Psychiatry</strong> ST1 and above - £20,000 over the length of the training programme. Psychiatry [core - 3 year programme] : £3,333 p.a Psychiatry [higher – expected 3 year programme]: £3,333 p.a. Psychiatry [higher – expected 4 year programme]: £2,500 p.a. Psychiatry [higher – expected 5 year programme]: £2,000 p.a.</td>
</tr>
<tr>
<td>Academia</td>
<td>As per Schedule 2 paragraphs 33-38 - £4,000 per annum.</td>
</tr>
<tr>
<td>Dual qualification – OMFS</td>
<td><strong>Oral and Maxillofacial Surgery</strong> ST3 and above as per Schedule 2 paragraphs 39-41 - £20,000 over the length of the training programme.</td>
</tr>
<tr>
<td>Expected 3 year programme: £6,667 p.a.</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Expected 4 year programme: £5,000 p.a.</td>
<td></td>
</tr>
<tr>
<td>Expected 5 year programme: £4,000 p.a.</td>
<td></td>
</tr>
<tr>
<td>Expected 6 year programme: £3,333 p.a.</td>
<td></td>
</tr>
</tbody>
</table>

### Additional work

<table>
<thead>
<tr>
<th>Shift over-runs</th>
<th>Paid at prevailing rate unless a breach of WTR 48-hour average working hours, contractual 72-hour weekly limit or reducing rest between shifts to fewer than 8 hours, in which case paid at the penalty rate set out in the Pay and Conditions Circular, with a fine also being paid to the Guardian of Safe Working Hours.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum work</td>
<td>At the national locum rates set out in the pay circular</td>
</tr>
</tbody>
</table>

9.2 For full details on the new pay system, see Schedule 2 of the TCS published on NHS Employers website.

**Pay progression**

9.3 Pay progression will only take place as doctors move through training to take up positions at higher levels of responsibility (i.e. in line with career progression). The current pay scale will be replaced by a series of four nodal points (as above), each of which has a pay value (as per the pay circular) for the basic salary. Each nodal point will be pegged to a step change in responsibility, when the doctor takes on additional responsibility.

9.4 This system thus provides for increases in rates of basic pay at nodal points through the career pathway where there are distinct and significant increases in responsibility.

9.5 This is evidenced and monitored via the ARCP (Annual Review of Competence Progression) form. HEE (local office) will need to inform employers when a doctor
moves from one grade to the next following this process, and will need to inform employers of the stage of training for each doctor at the point of rotation.

9.6 Most doctors will have three progression-linked pay rises as they progress through training. These are when they move:
   a) from F1 to F2
   b) from F2 to CT1/ST1
   c) from CT2/ST2 to CT3/ST3.

9.7 All doctors at the same nodal point will receive the same level of basic salary (pro-rata for those working less than full time).

9.8 Once doctors reach the fourth nodal point (CT3/ST3) they will receive the same basic pay until they complete their training programme, unless they decide to re-enter training at a lower level.

9.9 From 2018/19 a senior decision makers’ allowance will be introduced, which will be paid to trainees designated as senior decision makers by their employers. Details on this will be published in due course.

9.10 Further details on the nodal points and the value of basic pay at each point can be found in the pay and conditions circular published on NHS Employers’ website.

Pay for additional rostered hours

9.11 Basic pay is for a 40-hour week, including paid breaks. Doctors working less than full-time will be paid a basic salary for all hours set out in their work schedule, up to a maximum of 39.75 hours.

9.12 Additional rostered hours can be worked without the need for an opt-out, provided that they do not take the weekly average hours to over 48 hours per week.

9.13 Hours rostered and worked over the average of 40 per week will be paid proportionately, i.e. at 1/40th of weekly whole-time equivalent pay. This means that a doctor working additional hours will receive 1/40th whole time equivalent pay for each additional hour worked. For example, a doctor employed for 12 months at ST3 level who is contracted to work 46 hours per week would be paid £45,750 for 40 hours, and for the additional 6 hours they will be paid (£45,750 / 40) x 6 = £6,863, making a total amount of £52,613. An enhancement of 37 per cent will additionally be added to any hour worked at nights as specified in Schedule 2, paragraphs 14-15 the terms and conditions.
9.14 The pay for these additional hours over the 40-hour weekly average is non-pensionable.

9.15 Alternatively, such work could be contracted for separately, outside of the main contract of employment, via the locum bank, in accordance with the locum provisions set out elsewhere in the contract.

9.16 Where a doctor works hours above their scheduled hours, and these are authorised [prospectively or retrospectively] they will be paid as follows:

a) At the prevailing hourly rate up to 48 average hours; or

b) At the penalty rates set out in the Pay and Conditions Circular if the work takes the doctor above the 48 average weekly hours and/or above the 72 absolute limit in a seven-day period, or causes the 11-hour minimum rest period in 24 hours to be reduced to fewer than eight hours. The Department will also have to pay a fine to the Guardian of Safe Working Hours if these safety limits are breached.

Enhanced pay for work at night, and on weekends

9.17 The new pay system recognises and supports appropriately the most onerous and disruptive working patterns. The key principles are:

a) hours worked at night should be paid at a higher rate

b) work at the weekend should be valued appropriately

c) the more frequently weekends are worked, the higher the reward should be.

9.18 Hours worked during the following periods therefore attract enhancements to the basic pay rate, as follows:

<table>
<thead>
<tr>
<th>7 days a week</th>
<th>7am–9pm</th>
<th>Normal basic rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>9pm–7am</td>
<td>Normal basic rate plus 37%</td>
<td></td>
</tr>
<tr>
<td>8pm–10am [night shifts meeting the definition of Schedule 2 paragraph 15]</td>
<td>Normal basic rate plus 37%</td>
<td></td>
</tr>
</tbody>
</table>

9.20 These enhancements will be calculated prospectively, based on the working pattern outlined in the work schedule for a doctor’s placement, and paid as a part of the doctor’s regular monthly salary. See sections 4 and 5 for details on how this is done.
9.21 The payment for the work schedule/placement will be averaged so that the doctor receives the same amount of pay each month whilst employed on a particular work schedule. It is not the intention that the doctor will receive a different amount of pay each month as a result of monthly variations in rostered hours arising from rota arrangements.

9.22 Work at the weekend is paid in exactly the same way as work Monday to Friday, in terms of paying for the hours worked and any enhancements for work at nights. However, where a doctor is rostered to start work on a weekend (on a Saturday or Sunday) they will be paid a weekend allowance, as long as they work at least 1 in 8 weekends. This allowance will be a cash sum based on a percentage of their basic salary, and according to the frequency of weekends they work. The table below sets out the frequency of weekends and the percentage of basic salary which the cash sum allowance is based on:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Cash value at Nodal point 1</th>
<th>Cash value at Nodal point 2</th>
<th>Cash value at Nodal point 3</th>
<th>Cash value at Nodal point 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 weekend in 2 (note that this is the maximum frequency of weekend working permitted by the TCS)</td>
<td>£2,635</td>
<td>£3,050</td>
<td>£3,610</td>
<td>£4,575</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 2 and greater than or equal to 1 weekend in 4</td>
<td>£1,976</td>
<td>£2,288</td>
<td>£2,708</td>
<td>£3,431</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 4 and greater than or equal to 1 weekend in 5</td>
<td>£1,581</td>
<td>£1,830</td>
<td>£2,166</td>
<td>£2,745</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 5 and greater than or equal to 1 weekend in 7</td>
<td>£1,054</td>
<td>£1,220</td>
<td>£1,444</td>
<td>£1,830</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 7 and greater than or equal to 1 weekend in 8</td>
<td>£791</td>
<td>£915</td>
<td>£1,083</td>
<td>£1,373</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 8</td>
<td>No allowance</td>
<td>No allowance</td>
<td>No allowance</td>
<td>No allowance</td>
</tr>
</tbody>
</table>
Less than full time doctors will be paid a weekend allowance when working on a rota where the full time doctors receive the allowance. The allowance will be pro-rata to their commitment to the weekend rota. So for example, if a full time doctor on nodal point four works 1 in 4 weekends, they will get a weekend allowance of £3,431. If the LTFT doctor works 60% of the weekend commitment the full time doctor works, they will receive 60% of the weekend allowance the full time doctor receives, so 60% of £3,431, which would be £2,059. If the LTFT doctor works the same number of weekends as the full time doctor, they will receive the same weekend allowance as the full time doctor, so the full £3,431.

Pay for doctors working on an on-call rota

Pay for doctors working on an on-call rota will be as set out above, with the addition that they will be paid an on-call availability allowance to recognise the inconvenience of having to be available to return to work whilst on-call. This allowance will be a cash sum based on 8% of basic salary and does not vary based on frequency of on-call. So for example the on-call availability allowance at nodal point 4 is £3,660 per annum.

For LTFT trainees the value of the allowance is pro-rata to the proportion of the full time commitment to the rota. For example, a doctor making a 50% contribution to the rota at nodal point four, would be paid 50% of £3,660, so £1,830.

Doctors working an on-call rota will be paid for the hours of work they do whilst on-call, including being paid enhancements if these hours are at night. Doctors working on-call patterns who do work or are on duty at the weekend will be entitled to the weekend allowance as described above. More information on pay for work done on-call is contained in Schedule 2 paragraphs 12-13. As an example, if there are 70 hours in a work schedule which attract the enhanced night rate, and the rota cycle is 7 weeks, then there are 10 hours per week which attract the 37% enhancement.

General

The additional pay enhancements described above are not a part of the fixed pay element, as they can vary as work schedules change. They are therefore not pensionable. Pensionable elements are described in Schedule 2 paragraphs 57-59.

For further details see Schedule 2 of the TCS.

For transitional pay protection arrangements, see section 10 of this guidance and Schedule 14 of the TCS.
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10. A guide to transitional arrangements

What are transitional arrangements?

10.1 There will be an initial period of protection for all doctors currently in training. Doctors will either carry on being paid their current salary on the 2002 TCS (i.e. on the current MN37 pay scale) plus a banding supplement, OR will have a cash floor calculated which they will not be able to fall below, providing the doctor remains and continues to work the same proportion of full time hours.

10.2 Full details on the transitional arrangements, including the time period in which they will continue to apply, are described in Schedule 14 of the TCS, with some additional exceptions to the general rules outlined in our FAQs.

10.3 Doctors will begin to move onto the new TCS from 5 October 2016, in line with the dates set out in the implementation timetable in section 3 of this guidance, when they move between posts and/or contracts of employment. Where required, the contract provisions contain transitional pay protection as described in Schedule 14 of the TCS.

10.4 Doctors covered by the transitional protection arrangements will fall into one of two categories. Those in the lower stages of training will be entitled to protection based on the calculation of a ‘cash floor’ below which pay cannot drop. Doctors in the higher stages of training will be entitled to have their pay expectations protected. This will be achieved by continuing to be paid on their existing pay scale, with annual increments, and to be paid, where appropriate, a banding supplement, based on a modified form of the New Deal arrangements.

10.5 Transitional arrangements will last for four years for each doctor, starting at the point at which the doctor first moves onto the new TCS. Doctors who take time out of training [e.g. for maternity leave] or who train less than full time can have this period extended. Details on this are set out in Schedule 14 of the TCS. In both cases, transition can only last until 3 August 2022 [inclusive], unless the Department of Health choose to extend transitional arrangements beyond this final end date. Any doctor whose four-year period has not elapsed by that point will nevertheless cease to be protected under these arrangements following that date.

Doctors who are entitled to cash floor pay protection.

10.6 The following doctors will be granted cash floor transitional protection under the arrangement described in Section ONE of Schedule 14 of the TCS:

a) All doctors commencing F1 on 3 August 2016.

b) All doctors remaining on F1 or remaining on F2 as at 3 August 2016.
c) All doctors entering F2 directly from F1 or from other training programmes on 3 August 2016.

d) All new entrants to core or run-through speciality training (CT1 / ST1) from F2 or from other training programmes on 3 August 2016.

e) All doctors moving into CT2, ST2 or CT3 grades from the grade immediately below or from other training programmes on 3 August 2016.

f) All doctors remaining in the CT1, ST1, CT2, ST2 or CT3 grades as at 3 August 2016

g) All doctors progressing directly from core training or from other training programmes to higher training at ST3 point (or for doctors entering higher training in psychiatry or emergency medicine at the ST4 point) from 3 August 2016.

10.7 Doctors entitled to cash floor protection will have their total pay, including basic pay and banding set as a cash floor below which their pay cannot fall whilst they are covered by the provisions of Schedule 14. This protection will end either when the doctor exits training, or when three years of continuous employment have elapsed from the point that the doctor is first employed on the new TCS, or on 3 August 2022, whichever is the sooner.

10.8 Detail on how to calculate the cash floor for each doctor can be found in paragraph 11 of Schedule 14 of the TCS.

10.9 Provisions for calculating the cash floor for doctors absent from training at the point of transition on maternity leave, paternity leave, adoption leave, shared parental leave or sick leave, or for approved out of programme purposes, are set out in paragraph 16 of Schedule 14 of the TCS.

10.10 Employers may request to see the doctor’s payslip to determine basic pay and banding supplement received. Alternatively, this can be done via an Inter Authority Transfer (IAT) request. The basic pay used is the pay point the doctor was on the day prior to starting work under the new terms, so employers will know this information through their usual processes. The banding supplement used in the cash floor calculation is the value of the supplement as at 31 October 2015 for the rota the doctor was working on the day prior to starting work on the new terms. If the doctor rotates to a new employer on the same day as they start on the new terms, the new employer may need to contact the previous employer to determine what rota they were working on immediately before leaving, and what banding this rota attracted at 31 October 2015.

10.11 In order to save time in the future when you receive queries about what banding applied on 31 October 2015, we recommend that employers compile a record now of
all of your rota, the banding which applied to them at 31 October 2015, and the posts which worked on the rota. This will enable you to accurately confirm this information to any trusts that enquire. The table below shows an example:

<table>
<thead>
<tr>
<th>Rota</th>
<th>Banding of rota at 31 October 2015</th>
<th>Posts which work on rota</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E F2/Core rota</td>
<td>1A</td>
<td>F2s in EM placement, CT1 and CT2 EM trainees.</td>
</tr>
<tr>
<td>Anaesthetics higher rota</td>
<td>1A</td>
<td>ST3+ trainees in anaesthetics</td>
</tr>
<tr>
<td>Etc</td>
<td>Etc</td>
<td>Etc</td>
</tr>
</tbody>
</table>

10.12  We are currently working with ESR to establish whether a field could be included to hold the cash floor total and the date on which pay protection entitlement will expire, so that for future rotations, these can be transferred via the IAT process. This will not be available when a doctor first accepts employment under the new TCS, as there is no requirement for it to be calculated prior to that point.

**Doctors who are entitled to transitional pay protection in higher training grades**

10.13  The following doctors will be granted the transitional pay protection under the arrangement described in Section TWO of Schedule 14 of the TCS:

a)  Doctors already at ST3 or above on a run through training programme on 2 August 2016.

b)  Doctors already in higher specialty training programmes on 2 August 2016.

c)  Specialist registrars (SpRs) on pre-2007 training programme.

10.14  The doctor’s described in paragraph 10.13 will have their pay protection value calculated as being:

a)  basic salary on the pay scale (MN37) as per the 2002 contract, with annual increments to continue as per the doctors previously agreed increment date, until the doctor exits training or until the period of protected pay expires, whichever is sooner; plus

b)  Banding supplement for the rota on which they will be working, which will be set by following an amended banding questionnaire found at annex B of the 2016 TCS.
10.15 Employers should follow existing processes for assessing the point on the payscale at which these doctors should be paid. Monitoring and re-banding as set out in the 2002 TCS will not be used under this contract. Should a doctor feel there is significant and/or regular variation from their work schedule they should follow the processes set out in the 2016 TCS, which may result in the work schedule being amended. If a work schedule is amended, the banding questionnaire should be followed again to assess if there is any change to the protected level of banding.

**Doctors who are not entitled to transitional pay protection**

10.16 The following doctors will not be granted the transitional pay protection under either arrangement described in Schedule 14 of the TCS:

a) Doctors who exit training.

b) Trust doctors.

c) Locum appointment for service (LAS) or other locally arranged locum positions or contracts.

d) Doctors who take a break in training between programmes (i.e. doctors with a gap in their employment).

e) Doctors not currently in training who enter training on or after 3 August 2016.

Please check the [FAQs on pay protection](#) regularly for updates on eligibility for pay protection.

10.17 The TCS are published on the NHS Employers website containing a temporary Schedule 14, which will expire on 3 August 2022, detailing transitional arrangements in full.
11. A guide for lead employers and host organisations

Lead employer arrangements offer a number of benefits both to employers and to employees. Under a lead employer arrangement, one employing organisation is responsible for issuing and holding the contract of employment throughout a doctor’s training programme, during which the doctor may be deployed into one or more host organisations.

This guidance provides detail on some specific lead employer arrangements relating to the introduction of the 2016 terms and conditions of service (TCS) for doctors and dentists in training.

It is important to note that all lead employer arrangements are different. There currently exists within the NHS a range of ways in which lead employer arrangements have been set up and operate. As a result, not every arrangement can be addressed by this guidance and a differing degree of interpretation will be required regionally. Employers and host organisations should check their own service level agreements and memorandum of understanding (MOU) carefully before implementing any of the suggestions contained within this guidance.

A model contract specifically tailored to lead employers has been produced for the 2016 TCS, and this can be found in Annex A. This sets out the principal terms for all new employees, or for any employee moving to the new terms.

Paragraph 4.2 of the model contract for lead employers asks you to insert the doctors “principal place of work”. The terms and conditions define this as “the place of work from which the doctor conducts their main duties”. If there will be one place of work that the doctor will conduct their main duties from for the duration of the contract then it will be fine for the employer to insert this location here.

However, if the doctor will not have one main place of work, for example they will work across a region at a number of different hospitals during their employment, then the employer should amend paragraph 4.2 of the model contract. In these circumstances we would recommend paragraph 4.2 should be replaced with the following wording:

4.2. Your principal place of work as defined for the purposes of Schedule 11 of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 is the place of work from which you conduct your main duties for your host organisation.
Implementation

Where lead employer arrangements do not exist, doctors in training are typically given a series of fixed term contracts by individual employers, with each contract corresponding to one or more of their specific training placements.

Lead employer arrangements are different, in that a doctor will remain with one employer for a number of placements (typically, although not necessarily, for the entirety of a training programme).

Within that arrangement, lead employers contract doctors in different ways. Some lead employers may issue a single contract of employment for a series of placements or for an entire training programme (this might be for a period of up to eight years). Other lead employers may offer shorter contracts, perhaps for individual placements or for a shorter succession of placements, with specific break points in the contract as and when placements change.

Although NHS Employers, the British Medical Association, and the Government reached agreement on the new 2016 contract, a referendum of relevant BMA members rejected the new terms, meaning that the new 2016 contract is being introduced without collective agreement. This means that existing contracts cannot be unilaterally changed. As a result employers will need to offer contracts on the 2016 TCS when existing contracts of employment expire in line with the implementation timeline in Section 3 of this document.

Lead employers should check on what basis they have contracted their doctors. For instance, are there any break points within those contracts allowing for either variation of terms or for new contracts to be issued when existing contracts expire? Some employers will have break points at each change of placement, in these cases offers can be made in line with the timeline referred to above, but there will be employers who have issued long fixed-term contracts that may not expire for a number of years.

For long fixed-term contracts, there are two suggested choices the employer has, either:

a. wait until the doctor(s) current contracts expire, if the doctor(s) remain in training thereafter, offer them the new 2016 contract at that point (note that many doctors may exit training when their current contract expires).

b. offer the new 2016 contract to those doctors already on the 2002 contract, in line with the suggested implementation timeline. The new 2016 contract offers significant benefits when compared to the 2002 contract so doctors may well choose to take up the offer of a new contract, although they do not have to accept and may choose to remain employed on their existing contract until it expires.

Employers should consider both the financial and the practical implications of offering the 2016 contract to those on long term contracts, as well as the implications of maintaining a mixed economy with different doctors on different TCS. Lead employers should agree with
host organisations which approach to take, as any additional costs would be met by the host organisation.

There is no expectation that employers (lead employers or otherwise) will dismiss staff on the existing 2002 contract and re-engage them on the new 2016 contract.

**How should offers be made to new starters?**

The implementation timeline contained in Section 3 above shows when it is envisaged that doctors would commence work under the new terms of the 2016 contract. This timeline is based around the assumed expiry date of existing contracts of employment and the related rotational dates, so will not be relevant where doctors have long fixed term contracts that do not expire during the transitional period. Organisations will have cohorts of new doctors joining them in August 2016 and beyond. Some of these doctors will be due to join the organisation before the implementation timetable suggests they move to the new contract.

Employers need to consider this when making contract offers. For example, if employers offer long contracts on the 2002 terms and conditions which subsequently cannot be changed, this will create difficulties when the employer wishes to move these doctors to the 2016 TCS.

To manage the issues that this might present, the following options could be considered:

- If doctors are starting with an employer before the date for their cohort in the implementation timetable, the employer could offer a fixed term contract on the existing 2002 contract which expires on the date that the employer plans to implement the new contract for that group of doctors.

- Organisations could make a longer offer provided that the offer makes it clear that from the date of joining the organisation, to a fixed date in the future, the doctor would be employed on the existing 2002 contract and that subsequently, from that date onwards, the doctor would be employed on the new 2016 terms. This is potentially a complex offer and the wording would need to be precise. Employers considering making an offer in such a way should seek legal advice regarding how such a contract should be worded.

Organisations may wish to agree regionally which approach they will be taking to ensure consistency when doctors rotate. Organisations hosting trainees employed elsewhere under a lead employer arrangement would also need to agree an implementation plan with the lead employer to ensure that all offers are correctly made.
Roles and responsibilities

In lead employer arrangements, the lead and host organisation share responsibilities and activities between themselves. The new 2016 contract sometimes specifies whether the lead employer or the host organisation should be undertaking a specific task; in other instances, the lead employer will need to determine locally where such responsibility should reside, using the MOU between the lead employers and the host organisation to set out where responsibility lies.

Lead employers and host organisations should have good channels of communication to ensure that relevant information can be easily shared and to enable the smooth operational running of the hosting arrangements, these would also traditionally be defined in the MOU.

The MOU should include timeframes around the transfer of information between organisations. It may set a timeframe around when the host organisation must inform the lead employer of work schedule details in order for the lead employer to meet the code of practice on making offers.

If the MOU between lead and host organisations does not already do so, it should additionally specify:*  

- which organisation is responsible for sending and receiving information to and from Health Education England to facilitate the management of the training programme
- whether the lead employer’s or the host organisation’s grievance procedure applies
- whether the lead employer’s or the host organisation’s local policies apply (for example in relation to special leave)
- which organisation will manage sickness absence
- which organisation will manage annual and study leave requests
- which organisation will appoint the guardian of safe working hours for trainees covered by the MOU
- whether the guardian will sends reports to the lead employer or to the host organisation (or both)
- when and how the host organisation should provide updated details on generic work schedules to the lead employer so they can fulfil their obligations to the doctor. Note that for lead employers it is possible that an offer of employment may only be sent to the doctor once, as they may be employed for the entire training programme. Therefore a process should be established which informs the doctor of relevant updated information as they rotate. It is likely this process will mirror whatever existing arrangements are in place for updating the doctor as they rotate under the 2002 contract.
- when and how the host organisation should provide details to the lead employer of changes to the work schedule resulting in changes to remuneration
- when and how the host organisation should provide details to the lead employer of exception reports resulting in the payment of additional salary and / or locum payments
*Note: this list is not exhaustive*

If host organisations are responsible for their own locum bank, or if a joint locum bank has been established in cooperation with the lead employer and/or other host organisations, then it may be necessary to include in the MOU details of how payments relating to this will operate. Doctors on the 2016 contract have to give fidelity to the NHS by offering to do locum work first for an NHS staff bank before offering such work elsewhere (for example to a private agency).

**The role of the guardian**

The guardian of safe working hours is a new feature of the 2016 contract. The role of the guardian is to oversee the safety of doctors in training by providing assurance on compliance with safe working hours. Every employer (and/or host organisation, if appropriate) must appoint a guardian of safe working hours to assure the safety of doctors.

Further information on the guardian is contained in Schedule 6 of the TCS.

The 2016 contract states that responsibility to appoint a guardian rests with the employer, and that where lead employer arrangements exist the guardian will be established in the host employer(s) and arrangements made clear in the MOU between the lead and the host.

Some lead employers will employ GP specialty trainees (GPSTs) who undertake placements in GP practices. Where lead employer arrangements exist for GP trainees it is the lead employer’s responsibility to appoint a guardian who must be familiar with GP issues or have access to support and advice on such issues. Separate guidance for GP practices employing GPSTs on the new TCS is available at Section 12 of this document and should be read in conjunction with this guidance where employers have a relationship with GP practices employing doctors in training.
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12. A guide for GP practices employing GP speciality trainees

The majority of GP practices employing doctors in training do so under a lead employer arrangement.

This guidance has been designed to provide detail of where key information can be found, and to answer some of the main questions that relate specifically to GP practices. GP practices covered under lead employer arrangements may also wish to read our guidance for lead employers and host organisations also contained within this guidance document at section 11.

What has changed?

For the first time, GP specialty trainees (GPSTs) will now be employed under the same arrangements as hospital-based trainees. Up until now, while in practice placements, GPSTs have been employed according to the provisions of the schedules contained in the Directions to Health Education England (GP Registrars) 2013, instead of the terms and conditions that apply to all other doctors in training.

It is important to note that as these are completely new terms and conditions, some things will be different from the terms which have been used in the past for GPSTs. The most obvious changes relate to the pay system, but it is important to be aware of other changes including changes relating to working hours, leave and expenses.

Employers / host practices should familiarise themselves with the terms and conditions of service (TCS) document which is available on NHS Employers website.

How are GPSTs paid on the 2016 contract?

Arrangements for pay are set out in Schedule 2 of the 2016 TCS, and pay values are set out in the latest medical and dental pay and conditions circular. Doctors will be paid a basic salary for 40 hours per week, at the nodal pay point linked to their grade (e.g, ST1/2 – nodal point 3, ST3/4 – nodal point 4).

The GP supplement (the 45 per cent supplement that was paid previously) has been replaced with a new GP flexible pay premium (FPP), payable to GP trainees while in their practice placement. Details of this are set out in paragraphs 25 to 28 of Schedule 2 of the TCS, the value of this premium from 3 August 2016 will be £8,200 per annum and it will be reviewed annually.
In addition, GPSTs may be entitled to other pay elements set out in Schedule 2. For example, should they work any hours that fall within unsocial hours periods, they will be entitled to be paid an unsocial hours enhancement for these hours. If they work more than 40 hours, they will be entitled to additional pay for those hours. Should they undertake on-call work, they will qualify for the on-call availability allowance and should additionally be paid for their average hours of work undertaken while on call.

How should we produce the work schedule for our GPSTs?

Detail around work schedules is contained in Schedule 4 of the 2016 TCS [paragraph 16 of Schedule 4 gives detail specific to GPSTs]. This paragraph explains that the GPST work schedule should reflect the 2012 Committee of General Practice Education Directors (COGPED) guidance around the sessional split. This is how typical working patterns for GPSTs operate now, so has effectively not changed.

How will the guardian of safe working hours role function in GP practices?

Where lead employer arrangements exist for GP trainees, the lead employer is responsible for appointing the guardian, who must either be familiar with the issues faced by GPs working in a practice setting or have access to support and advice on such issues. See the guidance for lead employers and host organisations at section 11 for more detail.

Where no such lead employer arrangements are in place and GP trainees are directly employed by practices, the responsibility for appointing the independent guardian rests with the employing practices.

Practices may consider working together to appoint a guardian to represent several practices. Alternatively, a practice may wish to ask an external person to fulfil the role, perhaps by a service level agreement to appoint an appropriate member of the CCG, neighbouring trust or another organisation. As the guardian appointment is the responsibility of the employer, the lines of accountability to the employer would need to be clear as it is the employer who has liability for breaches of contract. It is therefore the responsibility of the employer to ensure that there is a suitably appointed guardian.

Employing practices with fewer than 10 trainees must either
a) jointly appoint an independent guardian with another similar employer or employers with fewer than 10 trainees such that an appointed guardian has responsibility for a minimum of ten trainees; or

b) enter into a contract with a neighbouring trust or foundation trust to provide the guardian function for the employer.

It is important to keep in mind, when assessing the time commitment needed from a guardian, that most issues should be able to be dealt with by the educational or clinical supervisor. It is not the intention that the guardian is involved in resolving every issue. It may be that where lead employer arrangements exist, the appointed guardian for the lead employer should be able to comfortably manage all of the GPSTs employed.

The 2016 TCS enable employers to agree local processes, while laying down firm minimum standards that must be followed.
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13. A guide for employers on how to contract junior doctors not in approved training programmes (trust doctors)

Since 2008, employers and the British Medical Association (BMA) has agreed that the current contract for doctors in training needs to be modernised. The two parties also agreed that the current banding system (part of the current 2002 contract) is outdated, unfair and has consequences which were not intended. The 2016 terms and conditions of service (TCS) are being introduced without collective agreement (following the decision at ballot by BMA members to reject the contract) and existing contracts for doctors currently employed within the NHS cannot be unilaterally changed. Employers are therefore being asked to offer the 2016 contract to doctors in approved training programmes in a phased way, when existing contracts of employment expire.

Junior doctors not in approved training programmes

The 2016 contract is specific to doctors in training and does not apply to junior doctors who are not in approved training programmes, often referred to as trust grade doctors, LAS appointments, clinical fellows etc. The 2016 TCS has a strong focus on education and training alongside service delivery and is not intended, nor is it suitable, for such doctors.

It is for employers to decide locally the contractual terms and conditions for doctors who are not employed in approved training programmes.

Employers are free to determine what contract and terms and conditions of employment they offer to new appointments.

Our understanding is that not all employers have designed local contracts for trust doctors and that as a result, they are currently often employed on contracts which mirror the existing 2002 contract. The NHS Employers organisation has always advised employers not to replicate in full the pay and other terms of the national contract into local terms. The 2002 terms were designed for short term rotational training placements, and should not be used for any other purpose. Where trusts do wish to mirror elements of the national terms, they are advised not to replicate the totality of the TCS (either the current 2002 or the new 2016 TCS) but to tailor them to meet the different needs of and service requirements placed upon trust doctors.
Employing trust doctors under the 2002 contract terms and conditions

To avoid the risk of complications caused by changing contractual terms, employers who currently employ trust doctors under a contract that mirrors the 2002 contract may wish to continue with the current arrangements. **Note:** employers should tailor the contracts as described above, not employ doctors directly onto the 2002 TCS.

Employing trust doctors under the 2016 contract terms and conditions

Trust doctors should not be employed under the 2016 national contract, as the provisions for training (among other things) will not apply. If employers choose to mirror this contract for specific purposes, for instance pay, then employers would need to ensure they are not wholly replicating these terms and conditions. Employers may wish to consider developing a local, condensed version of the contract by removing or varying the terms and conditions that are not applicable to such posts, alternately it may be more suitable in some instances to use the specialty doctor contract (or a variation thereof).

Can existing trust doctors transfer on to the 2016 TCS?

Employers should not offer trust doctors the new 2016 contract, but may choose to offer doctors that are already employed a fresh contract based on similar terms. Those doctors may choose to accept these but where this is not the case, those trust doctors will remain on the terms and conditions they were employed on until their contract expires.

It is the employer’s responsibility to agree and issue locally agreed contracts for trust doctors. Please contact doctorsanddentists@nhsemployers.org with any specific queries relating to trust doctors.
Annex A: Model contracts for doctors and dentists in training

Both a lead employer and non-lead employer model contract template can be found on NHS Employers website. These documents are in Microsoft Word format and contain mail merge functionality.
## Work Schedule

<table>
<thead>
<tr>
<th>Training Programme:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty placement:</td>
</tr>
<tr>
<td>Grade:</td>
</tr>
<tr>
<td>Length of placement:</td>
</tr>
<tr>
<td>Employing organisation:</td>
</tr>
<tr>
<td>Host organisation (if different from the above):</td>
</tr>
<tr>
<td>Site(s):</td>
</tr>
<tr>
<td>Educational Supervisor:</td>
</tr>
<tr>
<td>Clinical Lead/Rota Co-Ordinator:</td>
</tr>
<tr>
<td>Name of Guardian:</td>
</tr>
<tr>
<td>Contact details of Guardian:</td>
</tr>
<tr>
<td>Medical Workforce Department Contact Details:</td>
</tr>
</tbody>
</table>

**Working pattern:**
Basic hours only / Full shift / On-call rota (delete as appropriate)

**Rota Template:**
Your working pattern is arranged across a rota cycle of <<insert number>> weeks, and includes:
- Normal days
- Long days
- Night shifts
- Weekend shifts
- On-call duties

(Delete any that do not apply)

A copy of your rota template is attached to the end of this document

*to be appended*

**Average Weekly Hours of Work:** *to insert*
Your contract is a full-time / less-than-full-time (delete as appropriate) contract for <<Insert number up to a maximum of 40>> hours

You will in addition be contracted for an additional <<insert number up to a maximum of 8>> hours, making for total contracted hours of <<insert sum of the above two figures>>

The distribution of these will be as follows:

Average weekly hours at basic hourly rate:

Average weekly hours attracting a 37% enhancement:

Note: these figures are the average weekly hours, based on the length of your rota cycle, as required by Schedule 2 of the Terms and Conditions of Service. These may not represent your actual hours of work in any given week.

Annual pay for role* (select elements as appropriate)

Basic Pay (Nodal Point): <<insert annual cash amount>>
Pay for additional hours above 40: <<insert cash amount>>
Enhanced pay at 37% rate: <<insert cash amount>>
Weekend allowance: <<insert cash amount>>
On-call availability supplement: <<insert cash amount>>
Flexible Pay Premia [Type]: <<insert cash amount>>

Total pensionable pay: <<insert cash amount>>
Total non-pensionable pay: <<insert cash amount>>

Total annual pay for this role: <<insert cash amount>>

Should your placement be for less than 12 months, your pay will be pro-rated to the length of your placement.

*Please note- if you are entitled to pay protection in line with Schedule 2 of the TCS or to transitional pay protection in line with Schedule 14 of the TCS, then your actual salary may be greater than the above figure. Where this is the case, your salary will contain one or more additional pay protection elements so as to maintain your salary at its protected level.

Training Opportunities:

Insert the curriculum mapped outcomes that can be achieved whilst in this placement, together with the formal and informal learning opportunities available to the post-holder.

Other:

Insert any other items relevant to the placement
Annex C: Guardian of safe working hours: sample job description & person specification

Job Description

<table>
<thead>
<tr>
<th>JOB TITLE:</th>
<th>Guardian of Safe Working Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCOUNTABLE TO:</td>
<td>Trust board or equivalent body</td>
</tr>
<tr>
<td>REPORTING TO:</td>
<td>Appropriate executive director</td>
</tr>
<tr>
<td>TIME COMMITMENT:</td>
<td>XX depending on the size of organisation</td>
</tr>
<tr>
<td>SALARY:</td>
<td>At same salary level as substantive appointment, and in line with time commitment</td>
</tr>
<tr>
<td>KEY RELATIONSHIPS:</td>
<td>Director of medical education (DME) or equivalent officer</td>
</tr>
<tr>
<td></td>
<td>LETB Director of Quality</td>
</tr>
<tr>
<td></td>
<td>Head of Medical Staffing</td>
</tr>
<tr>
<td></td>
<td>Local Negotiating Committee (LNC)</td>
</tr>
<tr>
<td></td>
<td>Junior Doctors Forum</td>
</tr>
<tr>
<td></td>
<td>Service leads and managers</td>
</tr>
<tr>
<td>TENURE</td>
<td>Three years, subject to annual review</td>
</tr>
<tr>
<td>NOTICE PERIOD</td>
<td>Three months</td>
</tr>
</tbody>
</table>

Job purpose

The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of doctors and dentists in training are outlined in the TCS and are designed to ensure that this risk is effectively mitigated and that this mitigation is assured.
The guardian is a senior person, independent of the management structure within the organisation for whom the doctor in training is working and/or the organisation by whom the doctor in training is employed. The guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training. The guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the trust board or equivalent body that doctors’ working hours are safe.

**Key results areas**

The guardian will:

1. Act as the champion of safe working hours for doctors in approved training programmes and ensure that action is taken to ensure that the working hours within the trust are safe.

2. Provide assurance to the trust board or equivalent body that doctors are safely rostered and are working hours that are safe and in compliance with the TCS.

3. Record and monitor compliance with the restrictions on working hours stipulated in the TCS, through receipt and review of all exception reports in respect of safe working hours.

4. Ensure that exception reports regarding training hours, as set out in the work schedule, are sent to the DME or equivalent officer.

5. Work in collaboration with the DME and the LNC to ensure that the identified issues within exception reports concerning both working hours and training hours are properly addressed by the employer and/or host organisation.

6. Escalate issues in relation to working hours raised in exception reports to the relevant executive body for decisions where these have not been addressed at a local level.

7. Require a work schedule review to be undertaken where there are regular or persistent breaches in safe working hours which have not been addressed.

8. Directly receive exception reports where there are immediate or serious risks to safety and ensure that the organisation at a local level has addressed the concerns that led to the exception report. Where this is not addressed within the timescales identified in Schedule 5, and the guardian deems it appropriate, the guardian will raise this with the executive of the employing and/or host organisation.

9. Review the reports received when a manager does not authorise payment for hours worked beyond those described in the work schedule in order to secure patient safety, and recommend action where appropriate.

10. Have the authority to intervene in any instance where the guardian feels the safety of patients and/or doctors is compromised, or that issues are not being resolved satisfactorily.
Distribute monies received as a consequence of financial penalties to improve the training and working experience of all doctors. These funds must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEE as fundamental requirements for doctors in training and which should be provided by the employer/host organisation as standard.

11. Examples may include and should not be limited to:
   - improving IT systems beyond what is fundamentally required.
   - facilitating study leave [but not funding the study leave itself]
   - improving rest facilities
   - improving handover systems
   - improving expertise in rota design
   - service improvement projects
   - examination/course/professional support
   - role redesign pilots
   - improving staff engagement
   - improving library facilities
   - corporate journal subscriptions.

12. Prepare, not less than quarterly a report for the trust board or equivalent body which summarises all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programmes.

13. Prepare, no less than annually a plan for improvement on rota gaps, and submit the plan in a statement in the Trust’s Quality Account, which will also need to be signed off by the Trusts Chief Executive.

14. Submit details of the disbursement of fines for inclusion in the organisation’s annual report, including clear detail of where fines have been spent.

15. Jointly establish with the DME, a junior doctors forum [or fora] to include relevant representatives from the LNC, including the chair, and other elected junior doctor members to provide quality assurance of safe working practice, and scrutinise the distribution of fines.

16. Oversee all diversity and equality issues associated with ensuring safe working practices. This will include liaison with the Director of Medical Education to ensure that a member of the educational faculty in the Trust is designated as a champion for flexible training.
Assignment and review of work

17. Accountable to the trust board or equivalent body and line managed by the appropriate executive director.

18. The work of the post holder is generated through exception reporting and work schedule reviews made by doctors in training.

19. The post holder is also expected to generate work in response to areas of concern.

20. The post holder will agree objectives with the line manager, who will also appraise or contribute to the appraisal for the post holder. The system of performance management will include the opportunity for representatives of the doctors in training to contribute to the assessment, for example, through a system of 360° appraisal.

Communications and working relationships

21. The role of the guardian must be independent from the line management arrangements in the host and/or employing organisation to ensure that the post holder has the confidence of doctors in training.

22. The post holder must be of sufficient seniority to ensure that the role has an effective voice within the organisation.

23. The post holder will have regular contact with doctors and dentists in training, the DME and any associate DMEs, educational and clinical supervisors, the postgraduate dean, other senior staff within the HEE area office/Deanery, the LNC, the Junior Doctors Forum, and both executive and non-executive board members.

24. The post holder will also have links with other guardians in other organisations.

Appointment to the role

25. The provisions for appointing the guardian will be in line with those set out in local appointment policies and with the provisions of Schedule 6 of the TCS.

Note

26. The guardian of safe working hours is a separate role from, and should not be confused with, other guardian roles within the organisation (e.g. Caldicott Guardian, Freedom to Speak Up Guardian).
# Person specification

Guardian of Safe Working Hours

Note: This is a sample only and should be adapted for local use

<table>
<thead>
<tr>
<th>SKILLS/ABILITIES/KNOWLEDGE</th>
<th>Essential (E)</th>
<th>Desirable (D)</th>
<th>Evidence sought from</th>
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<tbody>
<tr>
<td>Knowledge and understanding of TCS of doctors in training</td>
<td>E</td>
<td></td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Knowledge of recent development in medical education and of key issues.</td>
<td>D</td>
<td></td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Knowledge and understanding of Working Time Regulations and safe working patterns and rotas for doctors in training.</td>
<td>E</td>
<td></td>
<td>✓ ✓ ✓</td>
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<tr>
<td>Facilitation, interpersonal, mediation and negotiation skills in order to promote medical and dental education and challenge practice within the LEP.</td>
<td>E</td>
<td></td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Ability to manage budget.</td>
<td>E</td>
<td></td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Proven ability in leadership to achieve goals, manage change and deal with constraints.</td>
<td>E</td>
<td></td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Ability to act as an effective champion for safe working.</td>
<td>E</td>
<td></td>
<td>✓ ✓ ✓</td>
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### EXPERIENCE

<table>
<thead>
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<th>Essential (E)/Desirable (D)</th>
<th>Application Form</th>
<th>Interview</th>
<th>Test</th>
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<tbody>
<tr>
<td>Previous experience of postgraduate education &amp; training.</td>
<td>D</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Minimum consultant/GP level or equivalent senior medical or management level.</td>
<td>E</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Previous management experience and training.</td>
<td>D</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>Relevant experience and or employment with a local NHS organisation.</td>
<td>E</td>
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<td>✓</td>
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### QUALIFICATIONS

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<th>Application Form</th>
<th>Interview</th>
<th>Test</th>
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</thead>
<tbody>
<tr>
<td>Medical or dental practitioner with postgraduate qualifications or appropriate HR or management qualification.</td>
<td>E</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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### PERSONAL QUALITIES

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<tr>
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<th>Application Form</th>
<th>Interview</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enthusiasm for preserving safeguards for the benefit of patients and doctors in training.</td>
<td>E</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Excellent communication skills.</td>
<td>E</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clear understanding of equal opportunities.</td>
<td>E</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>