2016 terms and conditions of service for doctors and dentists in training (England)

Frequently asked questions

1. General contract

Q 1.1 Why is the 2016 contract being introduced?
NHS Employers and the British Medical Association (BMA) have been lobbying for change to the new deal contract since 2008 – it is no longer fit for purpose. A scoping study in 2011 set this out and proposed principles for a new contract.

We have always wanted to reach agreement on a new, safer and fairer contract and had been working in partnership with the BMA junior doctors' committee (JDC) since late 2012 when talks originally began on the new contract. We jointly agreed heads of terms for negotiation with the JDC and worked together during the formal negotiation period, which started in October 2013. The JDC walked away from negotiations in October 2014. Conciliation talks between the government; the BMA and NHS Employers took place with ACAS in a bid to avert strike action in November 2015. A revised offer was made to the BMA in January 2016 that made concessions on several areas of conflict. Following further talks, including agreement on about 90 per cent of the items discussed, the government made an offer in March 2016 which included a further concession on Saturday pay, in the hope of reaching agreement with the BMA. The BMA again rejected the offer and initiated industrial action. Further ACAS talks took place with agreement finally reached in April 2016 and was the subject of a BMA referendum of BMA members.

Following the decision at referendum to reject the contract, on the 6 July the Secretary of State announced in the House that further talks were unlikely to bring resolution and that the new terms would therefore be introduced in England from August 2016, with the first doctors transitioning to the new terms in October 2016. A revised timeline has been published, reflecting the need to transition doctors to the 2016 terms at rotational dates when existing contracts expire.

Q 1.2 What is the scope of the 2016 contract?
The 2016 contract for doctors and dentists in training applies in England for trainees in hospital and community posts and public health posts approved for postgraduate medical/dental education. It replaces the current new deal arrangements, 2000 and the hospital medical and dental staff terms and conditions of service 2002, as they apply to trainees.
The new contractual arrangements also apply in England to general practice trainees during approved general medical practice placements that form part of postgraduate medical education and replace provisions currently contained in schedules to the directions to Health Education England (GP registrars).

Q 1.3 How does the 2016 contract apply to dentists in training?
The 2016 contract applies to dentists in hospital based posts approved for core and specialty dental training. It does not apply to dentists undertaking foundation training in general dental practice (vocational training placements).

Q 1.4 Why do I have to offer to work additional hours to the NHS before I can take up locum work?
The 2016 contract sets a clear limit on weekly average hours of work in any setting at 56 hours (where a doctor has opted out of the working time regulations). Doctors have a responsibility to ensure that when working any additional hours outside their work schedule those hours are safe and in line with the contractual limits, which are binding on both the employer and the doctor.

Before undertaking additional locum work, doctors will need to show their fidelity to the NHS by offering to work locum hours through an NHS staff bank (or equivalent). This can be with any NHS staff bank, trust or NHS service provider. Where employers do not wish to take up the offer of additional locum hours, they will still need to be informed of any additional work that doctors are doing to ensure that they are working safely.
This provision is not intended to infringe on the time that doctors spend undertaking voluntary work, such as supporting sports teams, St John Ambulance or other charitable organisations, although employers must be informed where such work is being undertaken and such work needs to be considered by both the doctor and employer when determining whether a doctor is working within safe limits.

Q 1.4a What is the process for offering additional locum hours to the NHS?
The policy intention is that where a junior doctor wishes to undertake locum work, they must offer their availability first to the NHS, via an NHS staff bank. The offer of work by the individual can be with any NHS trust, including the individual's substantive or host employer, to fulfil this requirement. It is important to note however that the intention of this clause, in line with the description in Q4, is to require doctors to offer specified hours of locum work as defined by the junior doctor themselves. If a doctor has no intention of working extra hours above their contracted hours they cannot be compelled to work extra hours. The TCS 2016 state that the employer will agree with the LNC local processes for the implementation of this clause.

Q 1.5 How does funding for postgraduate education work with the new contract?
Funding for postgraduate education has changed over the last few years and trusts now receive a proportion of basic pay plus an education tariff for each trainee they employ. It will be for HEE to determine the level of funding it provides in light of the implementation of the 2016 contract, but we do not anticipate that there will be any significant change in the overall level of funding that trusts receive from HEE.

Q 1.6 Do the changes to the NHS Staff Handbook related to enhanced shared parental leave and child bereavement leave apply to doctors and dentists in training in England employed under the 2002 terms and conditions?
New terms and conditions for doctors and dentists in training were introduced in England in 2016, which have a direct link to the All Staff Sections of the handbook. As such the revised section 15 and new section 23 of the NHS Staff Handbook. This came into effect on 1 April 2020 and will automatically apply to any staff employed under that 2016 contract.

Q 1.7 In the UK the clocks go forward 1 hour at 1am on the last Sunday in March, and back 1 hour at 2am on the last Sunday in October. When they go back in October, this can affect some shifts and on call periods – can this be exception reported?
If this has resulted in extra time worked then yes, the trainee(s) can exception report. Additionally, if this has resulted in a breach of the safety and or rest limits it will need to be exception reported. Employing organisations need to ensure that local arrangements are in place to address any impact on working hours when the clocks change so that doctors can continue to work safely.

2. Pay

Q 2.1 What does the 2016 contract mean for the pay for doctors in training?
Overall average earnings are expected to remain the same and individual pay will be more predictable and less variable between placements. Doctors will be paid more accurately for actual work done, with an increase in basic pensionable pay, additional pay for additional rostered hours, enhanced rates for unsocial hours, allowances for weekend working, on-call availability supplements for those required to be on-call, pay for anticipated work done whilst on-call and (where appropriate) flexible pay premia.

Some doctors may require transitional pay protection to maintain their level of pay under the 2002 new deal arrangements (protected at the level of banding for their current post as it was on 31 October 2015 excluding band 3). These are likely to include those on working patterns which were unfairly advantaged under the new deal banding system (e.g. those receiving a band 1B supplement for a 42.5 hour week in which all hours of work fall between 9am-5.30pm Monday to Friday), as well as those doctors whose current basic salary is significantly out of line with their current level of training, perhaps as a result of switching training programmes or training less than full time. These examples represent an inherent unfairness in the new deal contract that the 2016 contract seeks to rectify going forward.

Q 2.2 How will monthly pay be calculated where hours vary from week to week in a rota?
The annual salary should be calculated according to the working pattern set out in the individual work schedule for each post, taking all the pay elements into account. Monthly pay will be a consistent amount each month and a month's pay will reflect 1/12 of that annual amount.

Payments for exceptional additional and unscheduled hours of work, that have been approved to secure patient safety at the time the hours were worked, should be paid in the next available payroll.

Q 2.3 How will pay be calculated for trainees who are less than full time (LTFT)?
Pay for trainees working less than full time will be apportioned as follows:

- basic pay (and the value of any applicable flexible pay premia) will be calculated pro rata to their agreed proportion of full time work
- the on-call availability allowance will be calculated pro rata, based on the proportion of the full time commitment to the rota that has been agreed in the doctor's work schedule
- unsocial hours enhancements will be paid according to the working pattern detailed in the work schedule
- weekend allowance will be paid pro-rata based on the proportion of full time commitment to the weekend rota. For example, if the LTFT doctor contributes 60 per cent of the FTE weekend rota, they will receive 60 per cent of the cash sum outlined in Annex A for the FTE rota frequency according to their nodal point.

Q 2.4 What are flexible pay premia and what is their value?
The 2016 contract offers new flexible pay premia for those training in GP practice placements and recognised hard-to-fill training programmes where there is the greatest need – currently this includes emergency medicine (ST4+) Histopathology, and psychiatry (all grades).
Premia will also be payable to doctors who return to clinical training after successfully undertaking a pre-agreed period of approved academic research, to those who train in oral

and maxilla-facial surgery (OMFS) and, in some circumstances, to those who take time out of training to undertake other recognised activities that may be of benefit to the wider NHS.

The full criteria for flexible pay premia are set out in the terms and conditions in Schedule 2 paragraphs 21-44, with the values of those premia set out in Annex A.

In future years, evidence will be provided to the Doctors and Dentists Review Body (by Health Education England and other stakeholders) about hard-to-fill training programmes and other uses for flexible pay premia, to allow them to review the use of the payments and make recommendations on their application and value.

Q 2.5 If a doctor has chosen to undertake academic research between training programmes (for example between finishing core training and applying for higher training) eligible for a flexible pay premium when they return to training?
The 2016 terms and conditions of service (TCS) state that to be eligible for an academic flexible pay premia (FPP), the doctor must return to the same training programme that they left to undertake the academic activity. However, there is no intention to withhold a flexible pay premia from those doctors who made the decision to undertake academic research between training programmes prior to the publication of the full 2016 TCS. Therefore, those doctors who have accepted an appointment to start an academic activity prior to 31 March 2016 without having secured a place on a GP or specialty training programme, who would otherwise qualify for a flexible pay premium on their return to training under the 2016 TCS, will be considered as being eligible for the appropriate flexible pay premium. To be eligible, they must enter a nationally recognised specialty training programme (excluding foundation programme) at the first available opportunity, in line with the national specialty training recruitment timetable, following the successful completion of that academic or leadership work. This provision will only be extended to those who have made the decision to take up such an academic programme prior to 31 March 2016. Employers should ask doctors to provide evidence of the date upon which they accepted this academic or leadership work in order to be awarded the FPP.

Q 2.6 How should additional contracted hours be paid?
Basic pay will be for a 40-hour week, including paid breaks. Additional rostered hours, up to maximum of eight hours can be additionally contracted and reflected in the work schedule. Such additional hours will be paid at the basic hourly rate with appropriate enhancements payable for any hours which fall into the unsocial hour periods.

Q 2.7 How can work done on-call be prospectively estimated and paid?
The arrangements set out in the TCS for paying for work undertaken while on-call, are similar to those which are currently used for speciality doctors and consultants.

Employers already have an understanding of the typical hours of work already done by doctors across the full range of specialties, as they currently need to estimate this for the purposes of scheduling rest breaks for doctors under the 2002 New Deal TCS. Employers can also use historical data from diary card monitoring to support their estimates. Where there is no data available, or where such data is not sufficiently robust, doctors currently in post and clinical and service managers can be consulted to validate this information for work schedules.

On-call frequency and prospectively estimated work done while on-call will be outlined in work schedules upon which a doctor's pay is based. Should working patterns vary from the schedule, this should be addressed through the work schedule review process and pay adjusted accordingly.

Q 2.8 What elements of pay will be pensionable under the 2016 contract?

Pension arrangements are set out in Schedule 2 paragraphs 67-69 of the TCS as follows: The following pay elements of the 2016 contract fall into the definitions contained in the NHS Pension Scheme Regulations 2015 (as amended):

- all hours worked up to 40 hours per week on average and paid at the basic pay rate
- London weighting
- pay protection amounts outlined in Schedule 2 para 49-62 of the 2016 terms and conditions (excludes transitional pay protection set out in Schedule 15).

Q 2.9 Will there still be annual cost of living increases in pay rates?
The review body on doctors' and dentists' remuneration (DDRB) advises the government on rates of pay for doctors and dentists and are given a remit each year from the Secretary of State for Health. This process will continue following the introduction of the 2016 contract, although in the future, the DDRB may also be asked to review the value and application of flexible pay premia and other aspects of the new pay system.

Q 2.10 What should we do for doctors who have only received offers of employment for their first placement who ask for confirmation of their salary for mortgage/property rental agreement purposes?
NHS Employers have always advised that doctors should not rely on variable pay (eg banding supplements and other supplements and allowances) for mortgage applications. Basic pay is confirmed in the pay circular, so F1s on the new contract from December know they will not be earning less than this. As soon as you are in position to offer employment to F1s on the 2016 contract on placements from December there is no reason why you cannot send offers out including template work schedules.

Q 2.11 Does the fidelity to the NHS clause for locum work apply to doctors on the 2002 TCS?
No, it is a feature of the 2016 terms and conditions of service. The national locum rate is similarly a feature of the 2016 contract; however, it is suggested that employers use this locum rate for all of their junior doctors employed through bank arrangements to ensure consistency and to help to control locum spend.

Q 2.12 The work schedule templates ask for details of the number of different types of shifts, this may be different depending on the slot on the rota, how is the individual paid?

The details on the numbers of different types of shifts can be lifted from the rota. Doctors will be paid according to the rota, not their individual pattern. This is detailed in various paragraphs in Schedule 2 for the different pay elements, and also at Schedule 4 paragraph 12 of the new terms and conditions of service.

Q 2.13 How is the £20k flexible pay premia (FPP) calculated for emergency medicine trainees?
The emergency medicine FPP is payable to emergency medicine trainees from ST4 and above. The total amount (£21,867 as per the 2021 pay circular) is divided over the eligible years of training. This means that if you are due to receive your certificates of completion of training (CCT) following completion of your ST6 year, you will receive £7,289per annum for the three years (ST4, ST5, and ST6). Trainees will continue to be paid this annual amount until they exit this training programme, so if your CCT date is put back by a year, you should receive £7,289 for that additional year. Less than full time trainees will receive the FPP amount pro-rata.
Trainees who transition or join the programme part-way through may only receive part of the FPP. For example, those who transition into ST5 should receive £7,289per annum for each of the remaining two years at ST5 and ST6 only, instead of the full £21,867. Trainees who

are pay protected under Section 2 will not receive the FPP and continue to be paid under the 2002 pay scales.

Q 2.14 The 2016 terms and conditions state that flexible pay premia (FPP) is fixed. Will the 1 per cent pay uplift awarded in April 2017 therefore not apply to FPP?

Schedule 2 paragraph 21 of the 2016 terms and conditions of service states:

“Flexible pay premia will be fixed at the rate applicable at the point in time at which the doctor becomes eligible, as described in paragraphs 25 to 44 below, and shall continue to be paid at that same rate for the remaining period in which the doctor is working in a post as part of the training programme that attracts the premium."

This condition was intended to ensure that trainees eligible for FPP would receive that agreed rate of FPP for the remainder of their programme, and that any future substantive changes made to the value or eligibility criteria for FPP would not adversely affect those trainees.

However, this condition was never intended to apply to changes to the FPP value as a consequence of the annual pay uplift. The 1 per cent pay uplift granted in April this year has been applied to the FPP and should be paid to all eligible doctors. These are detailed with the uplift applied in the latest pay and conditions circular (MD 2017/01) on page 7 which is available on the NHS Employers website.

Q 2.15 Is the FPP applicable to all trainees in histopathology, for example, forensic histopathology trainees?

Yes, the FPP will be applicable to those entering training at ST1 now who are on training programmes for histopathology, forensic histopathology, diagnostic neuropathology, and paediatric and perinatal pathology. These are the eligible training programmes for this FPP.

Q 2.16 How is the FPP applied for those at ST1 and above?

This flexible pay premium is being applied as a recruitment premium. It applies to those entering the eligible training programmes at the point the FPP is introduced, such as for those entering at ST1 from August 2018. In line with paragraph 29 of Schedule 2 of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the premium will continue to apply for these trainees for the duration of their training programme at the amount set out as applying to that programme at the point in time that the doctor first entered that programme (and as uprated), regardless of any subsequent changes to the premium (or removal of it) for subsequent entrants to the training programme.

3. Working hours

Q 3.1 What are the working hours and patterns a doctor can work?
The 2016 contract is safer and fairer for doctors and dentists in training and for patients. In addition to the protections offered by the working time regulations (WTR), the proposals provide the following safeguards on working hours and patterns which will be reflected in work schedules:

- Maximum average 48 hour working week with doctors who opt out of the WTR capped at maximum average of 56 working hours per week.
- Maximum 72 hours' work in any consecutive 168 hour period.
- Maximum shift length of 13 hours.
- Maximum of four consecutive long (>10 hours) shifts* with a minimum of 48 hours rest rostered immediately following the conclusion of the fourth such shift.
- Maximum of four consecutive night shifts with minimum 46 hours rest after a run of either three or four consecutive night shifts.
- All reasonable steps should be taken to avoid rostering doctors to work at the weekend at a frequency of greater than 1 in 3 weekends.
- Maximum seven consecutive shifts* (apart from low-intensity non-resident on-call rotas, for which a 12-day maximum applies), there must be a minimum 48-hours' rest rostered immediately following the conclusion of the seventh shift.
- No more than three rostered on-calls in seven days except by agreement, with guaranteed rest arrangements where overnight rest is disturbed.
- Maximum 24-hour period for on call which cannot be worked consecutively except at weekends or by agreement that it is safe to do so.
- Work rostered following on-call cannot exceed 10 hours, or 5 hours if rest provisions are expected to be breached.

Q 3.2 Under what circumstances should overtime be paid?
Exceptionally, because of unforeseen circumstances, a trainee may feel a professional duty to work beyond the hours described in their work schedule. Such additional hours normally would be approved by the trainee's line manager. In such exceptional circumstances, employers will appropriately compensate the individual trainee for such hours, either by payment, time off in lieu, or a combination of the two, if the work:
a. has been undertaken for the needs of the service; and
b. is authorised by an appropriate person (typically, this authorisation would be before or during the period of extended working).

Such work should normally be approved prospectively, but where this is not possible, the doctor should submit an exception report within seven days. Where such additional hours are paid, this should be paid at the doctor's own nodal point and include any enhancements for unsocial hours, except at the weekend, where this will be the locum rate. Penalty rates will apply where such additional hours are worked in breach of contractual terms or working time regulations on hours or rest. Details are set out in Schedule 2 paras 73-82 of the TCS.

Q 3.3 Will the 2016 contract allow for time to be taken out of programme (OOP) activity?

The educational decision to approve time of out a training programme to pursue other activities such as research, Masters qualifications, fellowships, voluntary work or other experience is made according to the provisions clearly set out in the Gold Guide. The 2016 contract for doctors in training allows for such OOP activity to occur.

The key part of arranging OOP activity is to have that activity prospectively planned and approved so that employers can accommodate it as part of their workforce and rota

planning. There is no difference between the 2002 New Deal terms and the 2016 contract in this regard.

Q 3.4 How will doctors' hours be protected if Article 50 is invoked and we leave the EU, or the current UK working time regulations no longer apply?

The protections built into the 2016 contract to limit hours have been done so to promote safer working. In addition to the role of the guardian of safe working hours and the penalties that the guardian can apply, the restrictions are contractual and therefore normal legal routes could be followed should an employer knowingly break their obligations under that contract, once it has been implemented. The provisions of the UK working time regulations are embedded into the TCS, so even if they were to be repealed, the contractual provisions would continue to apply.

Q 3.5 Will doctors still be able to swap shifts with colleagues for their own personal reasons?

The 2016 contract does not prevent shift swaps, but doctors must not breach the hours requirements set out in the contract. These rules have been designed to ensure safe working and were agreed with BMA leaders through negotiation. Doctors cannot swap shifts in such a way as to cause a breach of the safety provisions.

Should doctors decide between themselves to swap shifts, employers will not need to pay any additional pay enhancements or additional hours for the shift that a doctor chooses to work (if it differs in length and timing from their rostered shift) and doctors will not be able to raise an exception report on the basis that they elected to work a different shift to the one for which they were rostered.

Q 3.6 Will there still be a requirement to maintain a residence close to place of work for the purposes of on-call?

The proposals do not change current operational on-call arrangements, which are for local determination.

Q 3.7 What are the 2016 contract arrangements for annual leave and bank holidays?

Annual leave under the new proposal will be stated in days, rather than weeks. In addition, statutory days will be incorporated into the annual leave allowance. This means that leave allowance on first appointment will be 27 days, increasing to 32 days after five years' service. Annual leave for LTFT trainees will be pro-rata. Leave arrangements can be calculated in hours for non-standard working patterns. Existing arrangements for the definition of a 'day', giving notice for annual leave, time off in lieu for bank holiday working and payment for untaken leave remain unchanged.

Q 3.8 What is the rota sign off process?

For doctors employed on the 2002 terms and conditions of service (TCS), your existing process will still apply. The 2002 TCS set out at paragraph 22 the process for re banding a rota. Where the rota is not changing banding, the TCS are silent, however we advise following the same consultative process where possible, unless your local change management policy sets out a different process. Some regions will have agreed local processes, for example in the North West, where a junior doctor advisory team remains in place.

The 2016 TCS do not contain a process for changing rotas and there is no external sign off, so employers should use agreed local processes. We would always advise consulting with the doctors working on the rota to ensure that the new arrangements are robust and reflect what actually happens.

Doctors will be able to use the exception reporting system to flag issues with the rota, which may lead to a work schedule review. The guardian of safe working will be the ultimate

backstop guarding against unsafe rotas, with the director of medical education (DME) providing assurance that rotas are educationally appropriate.

4. Exception reporting

Q 4.1 What safeguards does the contract offer to ensure that doctors are working in line with their work schedule?
The system of exception reporting outlined in the 2016 contract will ensure that departures from planned working hours, working pattern or access to planned training opportunities are recorded. Work schedule reviews should take place where this happens consistently and can be requested by the employer or the doctor.

The role of the guardian of safe working hours is designed to reassure junior doctors and employers that rotas and working conditions are safe for doctors and patients.
The guardian will oversee the work schedule review process and will seek to address concerns relating to hours worked and access to training opportunities. They will support safe care for patients through protection and prevention measures to stop doctors working excessive hours and will have the power to levy financial penalties where safe working hours are breached.

Fines will be levied when working hours breach one or more of the following provisions:
a) The 48 hour average weekly working limit
b) Contractual limit on maximum of 72 hours worked within any consecutive 7-day period
c) Minimum 11-hour rest has been reduced to less than 8 hours
d) Where meal breaks are missed on more than 25 per cent of occasions.
e) The minimum non-resident on-call (NROC) overnight continuous rest of five hours between 22:00 and 07:00
f) The maximum 13-hour shift length
g) The minimum 11 hours rest between resident shifts
h) The minimum 8 hours total rest per 24-hour NROC shift

Where the guardian can validate such exception reports, penalties will be levied against the department where the doctor works; the fine will be set at four times the basic or enhanced rate of pay applicable at the time of the breach. The doctor will receive 1.5 times the applicable locum rate, the guardian will retain the remainder of the penalty amount.

The guardian will convene a junior doctors' forum at regular intervals to provide advice on the role and to scrutinise the disbursement of penalty fines. The guardian will provide regular and timely reports on the safety of doctors' working hours, rota gaps and annually on improvement plans to resolve rota gaps to the trust board. This information will be incorporated into the trust's quality account and made available to the Local Negotiating Committee (LNC), Care Quality Commission (CQC), Health Education England (HEE), General Medical Council (GMC) and the General Dental Council (GDC). The doctors and dentists review body may also ask for annual reports on the outcome of work schedule reviews.

Q 4.2 How will exception reporting work and how quickly will issues be resolved?
The process for reviewing work schedules based on exception reports is designed to be more agile and reactive than the old contract system of hours monitoring and banding appeals. Employers will need to have an electronic system in place to manage exception reports by October 2016 when the first doctors transition to the 2016 contract. Existing rota software providers are working to create such a system for their customers.

Doctors should report exceptions where day-to-day work varies from that set out in the work

schedule either in hours of work (including rest breaks) or the agreed working pattern, including the educational opportunities made available. Reports should be submitted, and copied to the locally agreed actioner, as soon as possible, and in any case within 14 days (7 days if payment is requested and within 24 hours where there are immediate safety concerns).

Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the exception and to ensure that it remains an exception. Where exceptions become more regular or frequent, a work schedule review will usually be required.

The process is designed to address issues as they arise within a training programme, so that any subsequent changes put in place as a result of discussion or more formal review can benefit the doctor in post as well as doctors moving into that placement in the future.

Employers should agree local policies or processes for exception reporting that provide a local framework and process for the submission and review of exception reports.

Q 4.3 What systems can we use for the exception reports for the guardian?
Skills for Health and Allocate have exception reporting systems. Employers who wish to create their own system are free to do so, and those who do not use either system will need to make their own arrangements .

Q 4.4 Who will be the guardian of safe working for GP trainees for the period that they are in their general practice placement and not in a hospital?
Where lead employer arrangements exist, the lead employer will be responsible for ensuring that there is a guardian appointed for all trainees, including GP trainees. GP practices and the lead employer should work in partnership to ensure arrangements are in place which facilitate this arrangement. Where no such lead employer arrangements are in place, it will be for the employer (the GP surgery) to identify and appoint an appropriate person to act as the guardian, in line with the requirements of the 2016 contract. The terms and conditions of service (CS) sets out provisions for the appointment of guardians where an employing organisation has fewer than 20 trainees.

Q 4.5 For doctors in lead employer arrangements, how are any potential fines managed while the doctor is in a general practice placement?
The nature of placements in GP practices mean that it is extremely unlikely that a guardian fine would ever be levied.

However, if for some reason a doctor working in a practice placement does breach the rules and a guardian fine needs to be levied, then the system will work in the same was as for hospital-based trainees. The employer will need to make a penalty payment to the doctor and to the guardian (or in the case of breaks, just to the guardian). In lead employer arrangements, the general practice will need to inform the lead employer where a fine has arisen, so that the lead employer can make any payments necessary to the doctor (as they pay the doctor) and transfer the relevant fine amount to their guardian responsible for trainees in general practices. The lead employer may then arrange to re-charge the general practice for this sum, as obviously better management of the situation could have meant the fine was avoided. This will depend on any agreements/memorandum of understanding (MOU) governing the lead employer arrangement between the lead trust and the practices.

Q 4.6 Do fines for 5 hrs and 8-hour rest breaches occur in the case of one single breach or will they be dependent on averages?
The introduction of these fines will in many cases mean that on call rotas can no longer be sustained for most specialties.

The fine is applied to a breach of the core rest limit and concerns arrangements around safe working in the shift immediately following the NROC where the rest breach occurs (see provisions in schedule 3 para 31-33 of the terms and conditions of service). It is a measure to ensure doctor and patient safety are not compromised. These breaches shouldn't be happening on a regular basis and if they are, that's an indicator that reviewal of the pattern is needed to look at the root causes and to put measures in place to avoid recurrent breaches.

Q 4.7 Will the trust have the authority to allocate time off in lieu (TOIL) in the event that agreement cannot be reached between doctor and trust within 4 weeks?

If TOIL has been agreed as the compensatory outcome of an exception report by both parties, it should be done so under the expectation that the TOIL can be reasonably taken. Where this does not occur, the TOIL should automatically be converted to pay after that 4-week period. At the end of a placement, any untaken TOIL will be converted into pay.

5. Pay protection

Q 5.1 What are the pay protection arrangements and to which doctors should protection be applied?

The 2016 contract provides an initial period of pay protection for doctors who were in training programmes on 2 August 2016 who remained in those programmes or progressed directly to their next programme on or after 3 August 2016, and to F1 doctors who began their training programme on 3 August 2016.

There are two sections to the pay protection provisions.

Section one

Section one covers foundation doctors, core trainees and doctors in the early stages of run-through training. Doctors covered by section one include:

- All doctors commencing F1 on 3 August 2016.
- All doctors remaining on F1 or remaining on F2 as at 3 August 2016.
- All doctors entering F2 directly from F1 or from other training programmes on 3 August 2016.
- All new entrants to core or run-through speciality training (CT1 / ST1) from F2 or from other training programmes on 3 August 2016.
- All doctors moving into CT2, ST2 or CT3 grades from the grade immediately below or from other training programmes on 3 August 2016.
- All doctors remaining in the CT1, ST1, CT2, ST2 or CT3 grades as at 3 August 2016.
- 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) on 3 August 2016.

Pay protection for section one trainees will be through calculation of a cash floor. Should earnings under the 2016 contract be lower than this cash floor amount, an additional payment will be made to make up the difference. The cash floor is calculated as:

- the value of incremental point on the day immediately prior to moving to the 2016 TCS, plus
- the value of the GP supplement or banding supplement payable on 31 October 2015 (subject to a maximum of 1A or if the doctor has opted out of WTR, 2A) for the post the doctor was in on the day immediately prior to moving to the 2016 TCS.

Section Two
Section two covers doctors in higher specialty training and the later stages of run-through training. Doctors in section two include:

- Doctors already at ST3 or above (or ST4 or above for Emergency Medicine or Psychiatry training programmes) on a run-through training programme on 2 August 2016.
- Doctors already in higher specialty training programmes on 2 August 2016.
- Specialist registrars (SpRs) on a pre-2007 training programme.

Doctors in section two will continue to be paid a basic salary based on the current 2002 New Deal pay scales (MN37), annual increments and a banding payment. A banding questionnaire is included with the TCS as Annex B for the purposes of calculating the banding supplement payable.

Full eligibility for pay protection is set out in Schedule 15 of the TCS.

Q 5.2 How long will pay protection apply?

The 2016 contract provides for transitional pay protection to apply for four years of continuous employment from the point at which a doctor moves to the new contract, or until they exit training, or 3 August 2025 whichever is the sooner.

If during the period of transition a doctor is absent from work on maternity leave, adoption leave, shared parental leave, or long-term sick leave (more than three consecutive months), this period can be extended by the length of that absence up to a maximum of two years, or until 3 August 2025, or until they exit training, whichever is the sooner.

Doctors training less than full time (LTFT) will have their period of transitional pay protection extended to reflect the full time equivalent entitlement. For example, a trainee working at 80 percent FTE will receive pay protection for five years, or until 3 August 2025 or until (s)he exits training, whichever is the sooner.

Q 5.3 Will doctors currently absent due to maternity, shared parental, adoption or long term sick leave or an approved OOP be eligible for pay protection when they return to training?
Yes, provided that the doctor still holds a national training number (NTN) or were part way through their foundation or core training programme when their out of programme (OOP) was agreed or absence started, pay protection will apply.

For the purposes of Section One pay protection, the protected level of pay for doctors absent at the point of transition shall be:
1. the incremental pay point the doctor would have reached had they not been absent, plus
2. the value of the banding supplement paid on 31 October 2015 for the rota the doctor would have been working on had they not been absent at the point of transition, subject to a maximum of 50 per cent (or 80 per cent for those opted out of the working time regulations.

Q 5.4 What pay protection will apply for a doctor who switches training programme or returns to training from being a SAS doctor (or other nationally recognised grade)?

If during the period of transition, doctors in training choose to switch training programmes, without a break in training of more than three months, subject to qualification periods, they will benefit from transitional Section One cash floor pay protection until the end of their transition period. See Schedule 15 para 4 of the 2016 terms and conditions (TCS).

Additionally, and also subject to qualification periods outlined in the TCS, the 2016 contract permanently provides for pay protection at the level of basic pay, where doctors either re-

enter training from another nationally recognised grade or switch from a specialty training programme directly into an agreed hard to fill training programme. Currently these are general practice, psychiatry and the higher stages of emergency medicine (ST4+). See Schedule 2 of the TCS.

Q 5.5 What will happen to doctors from other nationally recognised career grades who have applied to return training this year?
They will have made those applications based on an assumption that para 132 of the 2002 contract will apply and that pay protection will apply. We recognise that some doctors may have made the decision to apply to return to training prior to when the full terms and conditions of service (TCS) were available.

The 2016 contract provides permanent pay protection for some doctors re-entering training into the recognised hard to fill specialties (Schedule 2 paragraphs 59-62). However, where doctors in the nationally recognised career grades have already successfully applied to re-enter training in the 2016 recruitment rounds, and they meet the eligibility criteria set out in paragraph 60, the pay protection outlined in paragraph 61 will apply irrespective of their training programme (except for re-entry to the foundation programme). The extension of this provision to doctors entering programmes in any training programme (except foundation programme) will only apply to those who applied in 2016 recruitment rounds as it will protect the pay expectations they had when making that application. Doctors who successfully applied for training in previous years who have deferred their entry to training will be covered under other transitional arrangements for pay protection.

Q 5.6 Will the payment of band 3 supplements that were payable on 31 October 2015 be protected during transition?
No. The highest level to which protection can be applied under the proposed contract will be Band 2A (80 per cent) for those who have opted out of working time regulations, or Band 1A for those who have not opted out. As a consequence of the proposed contractual safeguards on working patterns that would have previously triggered band 3 payments are no longer permitted under the 2016 contract.

Q 5.7 Can a doctor choose to receive pay under Schedule 2 of the 2016 contract during the transition period rather than Schedule 15 (Section Two) pay protection based on the New Deal pay system?
No. In order for the 2016 contract to deliver cost neutrality, one of the fundamental requirements for the introduction of the new offer, the costs have been modelled by including Section two pay protection values for trainees in the higher stages of training. Any divergence from this plan may result in higher costs.

Q 5.8 How much will pay protection cost and how is it funded?
As we are protecting junior doctors' current pay in cash terms (except for those on band 3 rotas), protection costs will decrease over the period of transition (up to 2 August 2022) as trainees on Section One protection progress through the nodal pay points and their basic pay increases and catches up with their cash floor. The costs of protection are a relatively small part of the overall medical pay bill and are largely funded within the pay envelope due to fluctuations in the numbers of starters and leavers. Any residual cost will be small, short-lived and well within the scale of any annual fluctuations in the pay bill. The money used to fund planned pay protection costs (those within the cost envelope) will be recycled back into the pay envelope as the need for pay protection diminishes.

Q 5.9 What will happen for doctors with previous NHS service who re-enter training from a post that was not in a nationally recognised grade e.g. trust grade, clinical fellow etc? Will they have any of their pay protected on transition to the new contract?

We recognise that some doctors may have made the decision to apply to return to training from trust doctor posts, or other types of medical posts that are not nationally recognised, expecting their previous NHS service to be recognised in determining their future pay. These doctors are not afforded pay protection in Schedule 2 of the 2016 contract.

Q 5.10 Will banding supplements be protected if hours and banding change within a rotation?

If hours change during a placement, the provisions of Schedule 2 paragraphs 60-62 will apply. If pay increases due to a work schedule review, pay will increase from the date the change is implemented (other than in exceptional circumstances). Where the work schedule review is required by your employer and, as a consequence pay will decrease, total pay will be protected until the doctor moves to their next placement. Where changes to the work schedule are requested by the doctor, any pay decreases will be reflected in total pay from the point the change is implemented.

Q 5.11 For the purposes of pay protection in Schedule 2 paragraph 59, what are the agreed hard to fill training programmes?

The agreed hard-to-fill training programmes will be set out in the Medical and Dental Pay and Conditions Circular. Pay and Conditions Circular (M&D) 2/2016 identifies applicable training programmes as higher training in emergency medicine (ST4+), general practice, psychiatry and Histopathology

Q 5.12 What are the 2016 contract arrangements for annual leave and bank holidays?

Annual leave under the new proposal will be stated in days, rather than weeks. In addition, statutory days will be incorporated in to the annual leave allowance. This means that leave allowance on first appointment will be 27 days, increasing to 32 days after five years' service. Annual leave for LTFT trainees will be pro-rata. Leave arrangements can be calculated in hours for non-standard working patterns. Existing arrangements for the definition of a 'day', giving notice for annual leave, time off in lieu for bank holiday working and payment for untaken leave remain unchanged.

Q 5.13 How will pay protection work practically?

Transitional pay protection has two elements – those in the early stages of their training will be entitled to a cash floor that their total salary cannot fall below; those in the higher stages of their training will continue to be paid on their 2002 contract pay scale with annual increments and banding for the duration of their transitional period.

We are asking the electronic staff record (ESR) organisation to create a field so that the cash floor amount, once calculated, can be input on to the doctor's record on ESR. This will ensure that the cash floor value is transferred in the inter authority transfer (IAT) process when the doctor rotates. We are also asking ESR to create a field showing the doctor's individual transition end date, so that it is clear to employers when pay protection should cease.

Q 5.14 I notice the method of calculating the cash floor has changed slightly compared to the March edition of the TCS?

The cash floor is now calculated using the basic pay the day before the doctor transitions, plus the 31 October 2015 banding of the rota they are working on the day before they transition. Finding out the doctor's pay point the day before they transition should be simple for employers who are used to finding out this information anyway. We would recommend that if you have any outstanding banding appeals concerning the banding of a rota at 31 October 2015, you need to resolve them as quickly as possible.

If a doctor has rotated from another employer, the new employer may need to contact the former employer to find out what the banding supplement of the rota they were working on

was at 31 October 2015. To make this process easier we would recommend that all employers create a document containing the bandings of all rotas at 31 October 2015, and the posts that worked on these rotas. This will make it easier to provide this information when requested.

Q 5.15 Schedule 15 paragraph 16b requires us to use the rota the doctor 'would have been working on' had the doctor not been absent prior to transition. How do we know which rota this is?
Schedule 15 paragraph 16 specifically deals with situations where, on the day prior to transition, doctors are absent on maternity, paternity, adoption, or shared parental leave, on long term sick leave, or on an approved OOP.

To work out the cash floor in these cases, you need to know the value of the banding supplement, as at 31 October 2015, for the rota on which the doctor would have been working had they not been absent. Where this cannot be easily determined, the most sensible approach would be to use the rota which the doctor works upon return, as in most cases, it is likely that, but for the period of absence, this is the rota on which they would have otherwise been working, as the doctor would have moved onto this rota some time earlier alongside his/her peers.

In such cases then, it would be the banding, as at 31 October 2015, for the rota on which the doctor is employed immediately on transition, that should be used for this purpose. We have created a template for employers to use with doctors in training on cash floor and transition.

Q 5.16 The banding of the rota has changed since 31 October 2015. Does this mean the rota 'did not exist' on 31 October 2015, in which case the cash floor should be based on the banding at the time of appointment?

It depends on the circumstances, the 31 October 2015 banding is not automatically superseded by banding changes.

Where a rota existed on 31 October 2015 but has subsequently undergone minor alterations, and this has resulted in a banding change, the 31 October 2015 banding will apply. Many rotas will need to undergo minor amendments to comply with the new 2016 arrangements, for example, which may result in a higher or lower banding than on 31 October 2015 due to the new working hour limits. This would not supersede the 31 October 2015 banding for cash floor purposes.

However, it might be considered that the current rota 'did not exist' on 31 October 2015 in the following circumstances:

- where these posts did not exist on 31 October 2015
- where the doctor(s) were working daytime only on 31 October 2015, and have only been put on an out of hours rota after that point
- where there has been such a substantial change that the doctors are effectively doing an entirely different working pattern – for instance, if they have changed from a single specialty rota to a cross cover rota, or from a full shift only to a pattern including non-resident on-call (or vice versa), or a significant increase in the frequency of weekends worked.

Q 5.17 If a doctor on Section 2 pay protection is working in a GP practice, what banding should they get?
As these doctors continue to be paid as if they were on the previous pay system, they should receive the 45 per cent GP supplement while they are in their practice placement. There is no need to try and assess the banding supplement for these doctors during their placement.

When the doctor rotates back into a hospital setting, they will then receive a banding based on their rota, just like all other doctors on Section 2 pay protection.

Q 5.18 Where a doctor in training has a gap in training arising because the end date of one training programme does not match up to the start date of their first post/placement on the next training programme (either because the doctor is training less than full time and therefore out of sync with the programme, or because of a simple mismatch between the start and end date of training programmes e.g between core and higher training), does the doctor continue to be eligible for pay protection?
Yes. Where a trainee exits one training programme, having secured entry to another training programme but is unable to take up a place on that second training programme due to a mismatch between the start and end dates of the two programmes, the break in training will not affect the doctor's entitlement to transitional protection. In such circumstances, it is envisaged that the provisions of Schedule 15, paragraph 8 should apply. This provision does not apply where a doctor voluntarily leaves on programme prior to completion in order to take up a different programme. In those circumstances, the provisions of schedule 2, paragraphs 49-54 would apply, but a break in service, other than for reasons set out in paragraphs 49 would remove the entitlement to transitional protection.

Q 5.19 Schedule 15, paragraph 37 indicates that a previous career grade salary (which was protected under the 2002 TCS) should be taken into account when calculating the doctor's earnings in line with paragraph 25. How do we calculate any additional payments in the new post?
The agreed intention of Schedule 15 is that for doctors qualifying for section two, pay should continue in line with the 2002 TCS for the period in which such transitional protection applies, apart from the agreed modifications to banding.
This means, for doctors in receipt of career grade protection who transition to the new TCS, if pay protection applies in a particular post they would have their total pay in that post calculated as if they were doing that work under the terms of the previous career grade contract.

So if a doctor is receiving pay protection on a point of the specialty doctor scale, their total pay in the new post would be calculated as if they were doing that work under the specialty doctor arrangements. This might include additional programmed activities, premium time and/or on call availability allowance.

Q 5.20 Schedule 15, paragraph 25 indicates that a previous career grade salary, which has been protected under paragraph 132 of the 2002 TCS, should be taken into account when calculating the cash floor. How does this work?
The intention of this paragraph is that where a doctor is in receipt of career grade pay protection, the cash floor should not fall below the protected career grade basic salary. The paragraph is clear that only basic pay can be considered, not any additional payments. Where a trainee due to transition is in receipt of career grade pay protection under paragraph 132a of the 2002 TCS, the employer should still undertake the standard cash floor calculation in paragraph 12, using the trainee basic salary which would apply if there was no career grade pay protection. If, however, the career grade basic salary is higher than this cash floor calculation, then the career grade basic salary should become the cash floor. For instance, if a specialty trainee has career grade pay protection from a specialty doctor post on £66,734, and their cash floor on training grade pay is calculated as £47,647 plus 1B banding = £66,034, then their cash floor should be set at the higher level of £66,734. However, if their protected career grade basic salary was £60,168, then the higher cash floor of £66,034 calculated on training grade pay would apply.

Q 5.21 What pay protection do dental trainees receive? Is it section one or section two of the transitional arrangements?

The nomenclature used to describe dental training differs from that used for medical trainees.
This is set out in the pay and conditions circular, dentists on the Dental Core Training programme become higher trainees at the Dental Specialty year 1 (DST1) level. This should be recognised when determining the pay protection. So, for example, a dental trainee who was a ST2 in August 2016, would qualify for section two transitional arrangements, as per Schedule 15 of the TCS. Trainees already in the higher stages of training, who are transferring to the 2016 contract should be eligible for section two pay protection. This means that all dental trainees at DST1 and above at the dates set out in the TCS should be eligible for section two pay protection.

Any dentists in training not at DST1+ level (ie. still a DCT) on 2 August would be eligible for section one pay protection.

6. Implementation

Q 6.1 Do we need to give formal notice of the intention to change the contract?
Technically you are not changing a doctor's contract of employment, you are offering a new contract of employment upon expiration of their existing contract. However, our advice would to be open and honest with your doctors. Examine any existing employer policies and use them as a guide. Employers may have standard change policies or procedures that they use in other circumstances and should continue to use in this situation. It would be good practice to give doctors the notice of a change as early as possible and open up a sensible dialogue with doctors.

Q 6.2 Could we have mixed economy rotas? How do we deal with these?
You may have rotas staffed by doctors employed on the 2016 TCS and doctors on the 2002 TCS. This may only be for a short time during the phased implementation period, or could be for a longer period if you have doctors on long term contracts of employment on 2002 terms (for example in lead employer situations or in employers who employ trust doctors on long-term contracts based on the 2002 TCS). In such cases, all the rotas affected must comply with both the 2002 contract rota rules and the new 2016 rules.

To ensure compliance with both sets of rules you should ensure the rota complies with 2016 rules first. If the rota reflects a full shift pattern, it should also then comply with the 2002 rules. For on-call working patterns there is a possibility it will not comply with 2002 rules on hours of work following a period of on-call. The 2016 rules allow the day after an on-call period to be up to 10 hours, whereas 2002 rules only allow up to 8 hours.

If the 2016 on-call rota does not meet the 2002 rules, ensure that there is no more than 8 hours of work after an on-call period. This should ensure compliance with both sets of rules. The software providers Allocate and Skills for Health should be able to help with this if necessary. Once the rota complies with both sets of rules, doctors can be paid according to their individual TCS. Doctors on the 2002 TCS still have a contractual entitlement to monitoring. When monitoring a mixed economy rota, take the same approach as you would when monitoring a rota which includes trust grade doctors (i.e. only include the doctors in training on the 2002 TCS). This may mean extending the monitoring period to get a valid return.

Q 6.3What contract should we offer? How long should we offer it for?
Doctors will be employed on the 2002 contract until they are due to transition to the 2016 contract. Therefore all offers before a particular doctor transitions will be as now, on the 2002 TCS. Employers will need to look at the suggested implementation timetable and see when different groups are due to transition, and take this in to account when setting the end date of their contract on the 2002 TCS.

Employers are free to use their own offer letters to make offers, adjusting the end date of the contract accordingly. The template offer letter NHS Employers published was simply designed to help employers make offers to new appointees on a single placement basis, in order to allow doctors to take up employment on the 2016 contract from December. Employers can continue to use this where it is appropriate to do so.

Q 6.4 How can we develop the educational component of the generic work schedule if we don't have a copy of Form B, or it is out of date?
There is no requirement to use the information on Form B as a basis for the educational outcomes that should be included in the template work schedule. It has been identified as a source of reference that may be helpful in developing the first set of work schedules as it will contain information that maps the curriculum against the post.

Where available, this information will need to be cross checked against the current curriculum (as they are subject to a continuous cycle of review). Where Form Bs are not held locally, the GMC will not supply copies due to the historic nature of the information.

Training programme directors, educational supervisors, medical education departments and medical royal college websites can all be consulted to supply the required information for the template work schedule. See our published examples for ST3 and ST4 in obstetrics and gynaecology.

Q 6.5 Where a trainee would have been due to transfer to the new contract but is on maternity leave, how should she be contracted? And how should maternity pay be calculated?
If a doctor would have been due to transition to the new pay arrangements had she not been on maternity leave, she should be given the option to move to the new contract at the transition date for her cohort. If she chooses to do so and if this results in an increase in pay, her maternity pay should be recalculated and increased accordingly from the date of transition.
The process should be as follows:
When a trainee notifies the employer that she is going on maternity leave, the employer would extend the contract of employment on current terms up until the expected date of return from maternity leave, or until the otherwise expected transition date for the doctor's cohort, whichever is the sooner.
If the transition date is earlier than the expected date of return, then the employer would additionally offer the doctor a further contract from the transition date to the expected date of return, under the 2016 TCS.
Should the doctor accept the new offer, then the 2016 TCS would apply to the doctor from the date of her transfer to the new terms. If such a transfer occurs during the paid maternity leave period, her maternity pay will be recalculated and uplifted from the date of transfer.
Should the doctor insist that she wishes instead to remain on the 2002 TCS, then she would of course forego any entitlement to be paid under the 2016 TCS during maternity leave, and the employer would then offer a further contract under the 2002 TCS to cover the period to the expected date of return, with the doctor subsequently transferring to the 2016 TCS on her return.

Q 6.6 What should happen if a trainee transfers to the new contract before going on maternity leave, but after the relevant weeks from which maternity pay is calculated?
If such a transfer takes place prior to the start of maternity leave, and this results in an increase in pay, her maternity pay should be calculated on the basis of her new increased pay throughout the paid maternity leave period.

Q 6.7 What happens if the cohort of a doctor on maternity leave have already transitioned to the 2016 contract?

The employer will need to go back and identify any doctors that were/are on maternity leave when their cohort transferred to the 2016 TCS, to ensure that they were offered the opportunity to transfer with their cohort. If they were not, they need to be given this opportunity retrospectively. If the doctor chooses to transfer to the 2016 contract and this would alter their maternity pay in any way, this alteration will need to be backdated from the date that their cohort transferred to the 2016 contract.